

FAILURE TO FUND:

THE CONTINUED CRISIS FOR HARM REDUCTION
FUNDING IN LOW- AND MIDDLE-INCOME COUNTRIES

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HARM REDUCTION
INTERNATIONAL

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THE CONTINUED CRISIS FOR HARM REDUCTION FUNDING IN LOW- AND MIDDLE-INCOME COUNTRIES

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Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

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ACRONYMS AND ABBREVIATIONS

| | |
|---------------|------------------------------------------------------------------|
| ART | Antiretroviral treatment |
| BMZ | German Federal Ministry for Economic Cooperation and Development |
| EECA | Eastern Europe and Central Asia |
| EJAF | Elton John AIDS Foundation |
| FLR | Funding landscape reports |
| GAM | Global AIDS monitoring |
| GPDPD | Global Partnership on Drug Policies and Development |
| HRI | Harm Reduction International |
| IHME | Institute for Health Metrics and Evaluation |
| INPUD | International Network of People who Use Drugs |
| LMI | Low- and middle-income |
| MENA | Middle East and North Africa |
| MoFA | Dutch Ministry of Foreign Affairs |
| NGO | Non-governmental organisation |
| NSP | Needle and syringe programme |
| OAT | Opioid agonist therapy |
| PEPFAR | The US President's Emergency Plan for AIDS Relief |
| PrEP | Pre-exposure prophylaxis |
| PWID | People who inject drugs |
| PWUD | People who use drugs |
| RCF | Robert Carr Fund |
| UHC | Universal health coverage |
| UMI | Upper middle-income |

Executive Summary

As the COVID-19 pandemic has brought global health to centre stage, it has never been clearer that ensuring access to health care for all is paramount. People who use drugs are criminalised and marginalised in much of the world, resulting in greater barriers to accessing health services than for the rest of the population. Harm reduction services such as needle and syringe programmes (NSPs) and opioid agonist therapy (OAT) are proven to be effective and cost-effective protection from blood-borne viruses. A comprehensive package of interventions has been endorsed at the highest political level. Insufficient financial support, both for services and the advocacy necessary to garner political will at the national level, remains the major barrier to implementing at scale.

Governments have committed to ending AIDS and tuberculosis, eliminating viral hepatitis and providing universal access to health care by 2030. We will not reach these goals without the leadership of people who use drugs and a fully funded harm reduction response.

Since Harm Reduction International commenced monitoring funding for harm reduction almost 15 years ago, the findings have been consistently dire. Available funding continues to be so far from meeting estimated need that the funding 'gap' is more accurately described as a failure to fund. The total number of international donors investing in harm reduction remains small, and the total funds invested by international donors appears to be shrinking. At national level, more data has become available on domestic funding for harm reduction. However, spending on drug law enforcement and imprisonment continues to dwarf investment in harm reduction; with case studies showing over 600 times more spent on punitive policies.¹

This report explores the state of harm reduction funding in low- and middle-income countries, drawing upon existing public data on domestic funding and information collected from international harm reduction donors. The data shows that we are further away from meeting the needs of people who use drugs than ever before.

KEY FINDINGS

1. Harm reduction funding is only 5% of the level required in low- and middle-income (LMI) countries.

Overall, US\$131 million harm reduction funding was identified for 2019, just 9% of the US\$1.5 billion that UNAIDS estimated to be required annually by 2020. Considering funding levels in the context of UNAIDS' new resource needs estimates, harm reduction is funded at just 5% of the US\$2.7 billion annual requirement by 2025.

2. The funding gap for harm reduction is widening.

Despite the evidence of effectiveness of harm reduction interventions, high-level political support and staggering unmet need for services in low- and middle-income countries, identified overall funding for harm reduction in 2019 was one-third lower than in 2016.

3. The split between donor and domestic funding for harm reduction is almost equal – half of the total identified funding for harm reduction in 2019 has been allocated from domestic sources.

This could be in part due to more available data on domestic funding, but given the overall decrease in funding levels, it is also suggestive of donor funding decreases outpacing any domestic funding increases.

4. Funding availability is not aligned with need – funding levels vary considerably within and across regions with these variations not fully aligned to the need for services.

For example, while Eastern Europe and Central Asia is home to 38% of people who inject drugs in LMI countries, it accounts for only 27% of funding for harm reduction, from both domestic and donor sources.

5. The Global Fund to Fight AIDS, Tuberculosis and Malaria remains the largest donor for harm reduction, but the mechanism must work harder for people who use drugs – while available data provide a partial picture, funding levels appear to have dropped; and forty-six countries where injecting drug use is reported do not include harm reduction in their HIV funding proposals.²

while available data provide a partial picture, funding levels appear to have dropped; and forty-six countries where injecting drug use is reported do not include harm reduction in their HIV funding proposals.²

1. HRI (2020) Assessing law enforcement expenditure in Indonesia: a case study, in *Summing it up: Building evidence to inform advocacy for harm reduction funding in Asia*. Harm Reduction International, London.

2. For 23 of these countries there are no population size estimates of people who inject drugs and, across the remainder, this amounts to over 26,000 people who inject drugs (data sourced from *The Global State of Harm Reduction 2020* and UNAIDS).

Understanding and tracking our progress is essential. We made the following key observations in relation to data:

- **Information on harm reduction expenditure remains fragmented and of low quality** – since there remains no data collection mechanism that accurately monitors harm reduction expenditure in LMI countries, HRI continues to play a civil society watchdog role. Publicly available spending data from repositories held by UNAIDS and the Global Fund do not cover all countries and data within them are not always comparable or verified.
- **Improvement in domestic expenditure data collection is essential** – with growing reliance on domestic investment, particularly in the context of universal health coverage (UHC), it is important that information on government expenditure is collected, validated and systematically monitored. When comparing domestic harm reduction funding reported by countries to UNAIDS and the Global Fund for this research, we found significant discrepancies. Standardised data collection processes and verification procedures are needed to improve the quality and consistency of data. National Health Accounts may be useful for this, although are limited to capturing health-related financial data.
- **There is limited information on household spending for harm reduction** – user fees, co-payments and informal out-of-pocket spending for harm reduction can be a significant financial barrier for individuals accessing services, particularly in countries with no international donor support. This household spending – by people who use drugs, and their families – is rarely counted. It is essential that this spending is counted and monitored, given that in many LMI countries, the share of household spending for health can constitute as much as 40 to 75% of overall health expenditures in the country.



Available funding continues to be so far from meeting estimated need that the funding 'gap' is more accurately described as a failure to fund



RECOMMENDATIONS

We need an additional US\$2.5 billion per year in order to fully fund harm reduction and reach global HIV, TB, viral hepatitis and UHC goals. Donor and domestic funding for harm reduction must be urgently and dramatically increased. Any further withdrawals or reductions in international donor funding would mean an effective abandonment of people who use drugs in LMI countries.

At the same time, it is essential that we achieve maximum impact from the funding that is currently committed. As such we recommend five interlinked strategic approaches:

1. International donors must communicate and coordinate at the global, regional and national levels to ensure investments are strategic and complementary. Donors should closely monitor their investment in harm reduction.
 - a. International donors must place greater priority on funding advocacy for harm reduction, particularly as it relates to advocacy for increased funding. This will be crucial to securing increases in domestic funding for harm reduction and changing legal and policy environments to enhance the impact of interventions like NSPs and OAT.
 - b. International donors should commit to a process of aligned systems to track investment and expenditure, disaggregation of data and shared efforts to monitor progress against global goals and targets including those relating to community-led organisations.³
2. Both international donors and national governments must increase their focus on transition.
 - a. International donors must support mechanisms and policy change which will enable transition to domestically funded, quality, person-centred harm reduction; all and any funding reductions must be undertaken in conversation with national governments, civil society and communities.
 - b. National governments should invest in their own harm reduction responses. They should critically evaluate their drug policy spending and redirect resources from ineffective drug law enforcement to harm reduction.
3. International donors must recognise their ongoing role in protecting the rights and health of people who use drugs, particularly in hostile environments. In a number of countries around the world, punitive and ideological approaches mean transition is unlikely to be feasible in the next ten years. International donor withdrawal in these cases would be catastrophic.
4. International donors must become harm reduction advocates and champion the impact that their investments are having, particularly with international donors in adjacent sectors such as health, development, gender, criminal justice and human rights.
5. Civil society partners and implementing agencies should record their harm reduction expenditure. They should monitor the impact of these investments and make this evidence available for national, regional and global advocacy for harm reduction funding.

3. The Global AIDS Strategy includes the following targets: 30% of testing and treatment services to be delivered by community-led organisations; 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organisations; and 60% of the programmes support the achievement of societal enablers to be delivered by community-led organisations.

1.

Introduction and background

1.1 INTRODUCTION

Harm reduction aims to reduce the health, social, legal and economic harms associated with drug use and drug policy, without requiring people to stop using drugs. *The Global State of Harm Reduction 2020* reported that harm reduction implementation, having stalled since 2014, had now worsened since 2018. Large regional differences remain; while needle and syringe programmes and opioid agonist therapy are available in most LMI countries in Eastern Europe and Central Asia, these core harm reduction interventions are severely lacking in the majority of LMI countries in other regions. Even where harm reduction services are available, there is often insufficient coverage and quality, or a lack of access to these services.

An unfavourable drug policy environment hinders harm reduction service implementation in many countries across Asia, Latin America and the Caribbean, the Middle East and North Africa (MENA), sub-Saharan Africa, and Eastern Europe while a chronic and continuing lack of funding for harm reduction across LMI countries means international implementation targets are routinely missed.

Since the onset of the COVID-19 pandemic in early 2020, serious disruptions to harm reduction service delivery due to lockdown measures and physical distancing rules have been reported in all regions.⁴ In addition to the threat to public health, the pandemic poses a threat to the already precarious funding situation for harm reduction in many LMI countries.

Harm reduction funding has been a topic of research for Harm Reduction International (HRI) for almost 15 years. The lack of systematic monitoring of funding levels across countries, and the vital role funding plays in the implementation of harm reduction, has made this issue a key area of concern. With the recent adoption of UNAIDS' 2021-2026 Global AIDS Strategy and updated resource needs estimates, this report aims to provide a timely insight into the state of harm reduction funding in LMI countries.



Since we began monitoring harm reduction funding in low- and middle-income countries, the data has consistently shown a drastic shortfall in international donor and domestic funding, far below the level required to meet the targets set for harm reduction globally.

1.2 BACKGROUND AND POLICY CONTEXT

Since we began monitoring harm reduction funding in LMI countries, the data has consistently shown a drastic shortfall in international donor and domestic funding; far below the level required to meet the targets set for harm reduction globally. HRI's research (*The Lost Decade*) revealed that an estimated US\$188 million was allocated to harm reduction in LMI countries based on 2016 data, with funding levels unchanged from those found in the original 2007 research.^{5,6} Equating to just 13% of the US\$1.5 billion that UNAIDS estimated to be required annually by 2020 for an effective HIV response, it amounted to a "lost decade" of opportunity to scale up evidence-based services for people who use drugs.

International policies have been adopted that should, ostensibly, garner political support for the funding and expansion of harm reduction services. The UN Political Declaration on Ending AIDS adopted in 2016⁷ specifically focused on access to harm reduction services and programmes for people who inject drugs, including those living with HIV or viral hepatitis. Calling attention to the lack of global progress in reducing HIV among people who inject drugs, the Declaration called upon member states to focus on evidence-based approaches for harm reduction and to reduce the marginalisation of and discrimination against people who use drugs.

4. HRI (2020) *The Global State of Harm Reduction 2020*. Harm Reduction International, London

5. HRI (2010) *Three cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis*. International Harm Reduction Association, London

6. HRI (2018) *The lost decade: Neglect for harm reduction funding and the health crisis among people who use drugs*. Harm Reduction International, London

7. United Nations General Assembly (2016) Seventieth Session, Agenda item 11. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.

Similarly, UNAIDS Fast Track Strategy targets stressed the importance of having supportive policies and legislation at country level to meet 2020 obligations.⁸

This update on the state of harm reduction funding in LMI countries, provides an insight into whether harm reduction funding has benefited from these international policies. It assesses whether there have been improvements that would give cause for optimism following the shocking findings of *The Lost Decade* report.

The findings of this research also provide a baseline for tracking the impact of the new 2021-2026 Global AIDS Strategy *End Inequalities. End AIDS*⁹ adopted by UNAIDS in March 2021 and give an indication of the extent of the funding gap following the publication of new resource needs estimates alongside the Strategy.

BOX 1

CURRENT HIGH-LEVEL TARGETS AND COMMITMENTS RELATED TO HARM REDUCTION

In March 2021, UNAIDS adopted its 2021-2026 Global AIDS Strategy 'End Inequalities. End AIDS'. The Strategy uses an inequality lens to close the gaps preventing progress towards ending AIDS and aims to reduce the inequalities that drive the AIDS epidemic. It recognises that inequalities are a key reason why the 2020 global targets were missed and are key drivers that underpin stigma, discrimination and criminalisation that enhance people's vulnerability to acquire HIV and make people living with HIV more likely to die of AIDS-related illnesses.

The three strategic priorities are to:

1. maximise equitable and equal access to comprehensive people-centred HIV services;
2. break down legal and societal barriers to achieving HIV outcomes;
3. fully resource and sustain HIV responses and integrate them into systems for health, social protection and humanitarian settings.

HIV prevention for key populations received unprecedented urgency and focus in the Strategy, which calls on countries to utilise the full potential of HIV prevention tools, including for people who inject drugs and people in prison settings.

In order to reach the 2025 high-level targets for prevention, the Strategy calls on countries to intensify and redouble efforts to scale up comprehensive harm reduction for people who inject drugs in all settings, including needle and syringe programmes, opioid agonist therapy, naloxone, and interventions for non-injecting drug use, as well as prevention, diagnosis and treatment of TB and viral hepatitis, community-led outreach and psychosocial support.

Other key targets relevant to people who inject drugs include:

- ▶ 30% of testing and treatment services to be delivered by community-led organisations.
- ▶ 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organisations.
- ▶ 60% of the programmes support the achievement of societal enablers to be delivered by community-led organisations.
- ▶ Less than 10% of countries have punitive legal and policy environments that lead to the denial or limitation of access to services.

8. UNAIDS (2016) Fast track – Ending the AIDS Epidemic by 2030. UNAIDS, Geneva.

9. UNAIDS (2021) End inequalities. End AIDS. Global AIDS Strategy 2021-2026.

https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf

2.

Harm reduction funding in low- and middle-income countries

2.1

THE CURRENT STATE OF HARM REDUCTION FUNDING IN LOW- AND MIDDLE-INCOME COUNTRIES

This study identified US\$131 million of funding¹⁰ for harm reduction in LMI countries in 2019. This is less than the US\$188 million identified in *The Lost Decade*¹¹ and our previous harm reduction funding research¹² and equates to just 9% of the estimated US\$1.5 billion required annually by 2020.¹³ To accompany the 2021-2026 Global AIDS Strategy, UNAIDS has prepared new resource needs estimates, which state that US\$2.7 billion is required annually for harm reduction by 2025 in LMI countries.¹⁴ **The amount of funding identified in this study amounts to only 5% of need, which leaves a staggering shortfall of 95%.**



The amount of funding identified in this study amounts to only 5% of need, which leaves a staggering shortfall of 95%

BOX 2

THE CHALLENGES IN ESTIMATING HARM REDUCTION FUNDING LEVELS

There is no systematic mechanism for monitoring harm reduction funding in LMI countries. A number of data sources were used to compile the best available estimate of harm reduction funding, but there are several methodological challenges and caveats that should be considered.

Data sources for this study included survey responses from international donors, which included detailed data provided directly from the Global Fund and PEPFAR, country reports to UNAIDS Global AIDS Monitoring, Funding Landscape Reports submitted to the Global Fund along with country applications, civil society research from HRI, Eurasian Harm Reduction Association and the Alliance for Public Health in Ukraine, as well as verification with experts where possible.

Those data sources differ in what they capture in terms of content, type of financial data captured, and methods used to collect and validate the information.

Content: What is categorised as harm reduction or programmes for people who use drugs may vary across international donors, with some considering a

broader definition (for example including community empowerment, human rights and advocacy activities) and others limited to medical service provision. Sometimes harm reduction funding is subsumed in wider budget categories and difficult to disaggregate, such as in the case of integrated service provision by the Global Fund, or broad drug policy reform funding.

Type of financial data captured: Data available included expenditures (funds spent), consumptions (utilised at the end user level), budget allocations (planned) and disbursements.

Data collection and validation: Data reported to UNAIDS Global AIDS Monitoring and within Global Fund applications is not necessarily verified and reporting is not consistent.

Donors update their methods of reporting: For example, in between this study and *The Lost Decade*, both PEPFAR and the Global Fund changed how they record and categorise data, limiting our ability to compare like with like and critically assess funding over time.

10. 'Funding' is an umbrella term used here to capture the different types of financial data identified in this analysis. This included budget allocations, disbursements, expenditure and consumption data. Where we could identify the type of data, we have been specific.

11. HRI (2018) *The Lost Decade: Neglect for harm reduction funding and the health crisis among people who use drugs*. Harm Reduction International, London

12. HRI (2010) *Three cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis*. International Harm Reduction Association, London

13. UNAIDS (2016) *Do no harm: Health, human rights and people who use drugs*. UNAIDS, Geneva

14. UNAIDS Strategic Information and Evaluation Department/Resource Tracking and Finances (2021). Direct communication. UNAIDS, Geneva.

BOX 3**DEFINING HARM REDUCTION IN RELATION TO FUNDING**

Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.

Harm reduction encompasses a range of health and social services and practices that apply to illicit and licit drugs. These include, but are not limited to, drug consumption rooms, needle and syringe programmes, opioid agonist therapy, non-abstinence-based housing and employment initiatives, drug checking, overdose prevention and reversal, psychosocial support, and the provision of information on safer drug use. Approaches such as these are cost-effective, evidence-based and have a positive impact on individual and community health.

Harm reduction is rooted in a commitment to addressing discrimination and ensuring that nobody is excluded from the health and social services they may need because of their drug use, their race, their gender, their gender identity, their sexual orientation, their choice of work, or their economic status. People should be able to access services without having to overcome unnecessary barriers,

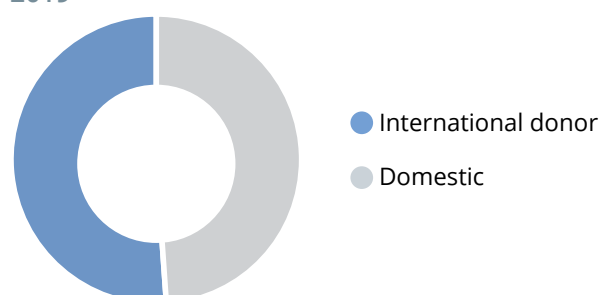
including burdensome, discriminatory regulations. Furthermore, the meaningful involvement of people who use drugs in designing, implementing and evaluating programmes and policies that serve them is central to harm reduction.

UN guidance, endorsed at the highest political level and by major donors, describes a comprehensive package of interventions for HIV prevention, treatment and care for people who inject drugs, which includes NSPs and OAT as priority interventions.¹⁵

For this study, as for *The Lost Decade*, we attempted to capture funds directed to the comprehensive package of interventions as well as funding for related training, capacity building, research and advocacy. The difficulties inherent in isolating funding for services such as antiretroviral treatment (ART) for people who use drugs mean that this is unlikely to be captured here. Since NSPs and OAT are priority interventions within UN guidance, particular effort was made to identify funding supporting these interventions. It was important to examine the extent to which funding for community-led organisations could be identified. In addition, efforts were made to capture funding for particular areas of harm reduction that remain neglected, for example harm reduction for women or young people, within prisons and for non-injecting or non-opioid drug use.

Domestic and international funding for harm reduction in 2019 represented equal shares of total investment. Of the identified harm reduction funding, domestic and donor funding represented broadly equal shares in 2019 (see Figure 1). This is a departure from previous reports where international donor funding has been identified as the primary source of support for harm reduction in low- and middle-income countries.

FIGURE 1:
Identified funding for harm reduction by source, 2019

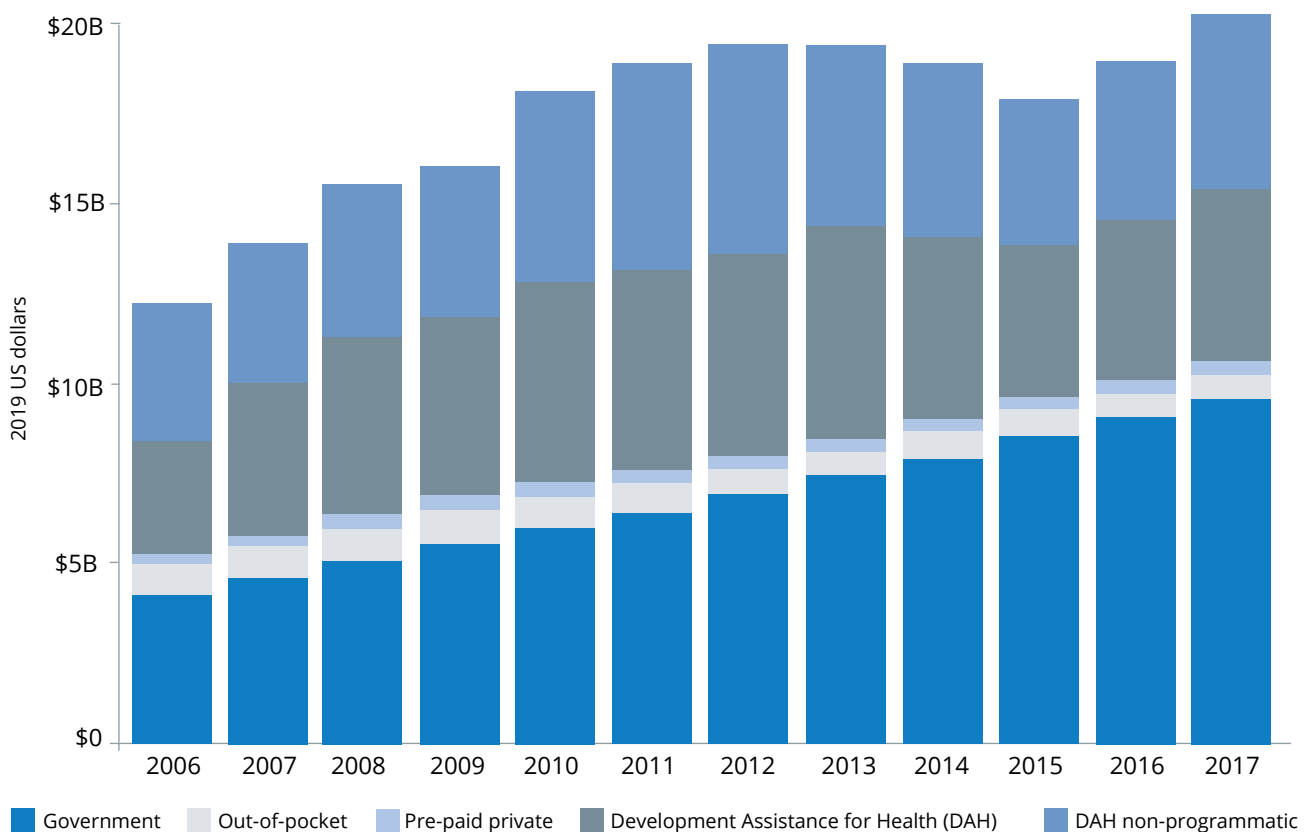


15. WHO (2016) *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update*
<https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>

As the gross domestic product of many countries has increased, there has been a growing expectation that they will fund their own health responses, allowing donors to target low-income countries. This process is known as “transition”, particularly within the Global Fund-supported programmes. While a steady increase in domestic support for HIV programmes broadly is evident, advocates remain concerned that this increase has not benefitted key population programmes, such as harm reduction. Identified domestic funding for harm reduction in 2019 represents a greater share of overall funding than it did in 2016. However, given that the overall amount of identified funding has decreased, it is suggestive of reductions in international donor funds outpacing increases in domestic contributions.

Despite representing a smaller proportion of harm reduction funding than previously, international donors still have a crucial role to play in providing assistance to LMI countries both in terms of harm reduction and the wider HIV funding landscape. Indeed, 2019 saw donors pledge an unprecedented US\$14 billion to the Global Fund for 2020-2022 – the largest amount ever raised for a multilateral health organisation. According to estimates from the Institute for Health Metrics and Evaluation (IHME), international donors have provided nearly half of the total global expenditure for HIV/AIDS since 2006 with the share of domestic expenditure growing steadily over time. (see Figure 2).

FIGURE 2:
Funding trends for HIV/AIDS¹⁶



16. Institute for Health Metrics and Evaluation (IHME) Financing Global Health | Viz Hub. Available at: <http://ihmeuw.org/5f2o>

2.2 HARM REDUCTION FUNDING AND ESTIMATED RESOURCE NEEDS

To achieve the aims set out in UNAIDS' 2021-2026 Global AIDS Strategy 'End Inequalities. End AIDS', annual spending on primary HIV prevention will require an increase from US\$5.3 billion in 2019 to US\$9.5 billion by 2025. The Strategy highlights a necessary and significant increase for combination harm reduction services for people who inject drugs, calling for a rapid ramping up of funding and advising against incremental progress.

It estimates that US\$2.7 billion is required annually to meet the service needs for people who inject drugs in low- and middle-income countries by 2025. This includes outreach services, NSPs, pre-exposure prophylaxis (PrEP) and OAT services.

Overall, the US\$131 million harm reduction funding identified for 2019 in our research represents just 5% of this estimated resource need, leaving a staggering 95% funding gap to be filled by 2025.

The new resource estimate is significantly higher than the previous estimate of US\$1.5 billion for 2020.¹⁷ When considered alongside the reduction in identified harm reduction funding reported here, this represents an ever-widening gap.

Harm reduction resource needs are not equally distributed across countries. Low-income countries require only 11% of total resource needs, while 48% and 40% are needed for lower-middle income and upper-middle income (UMI) countries respectively (see Table 1).¹⁸ The role of international donor funding for harm reduction services in middle-income countries is extremely important. Given that harm reduction services are mostly funded as a part of the HIV prevention activities by international donors, the growing economy of these countries creates significant challenges for accessing donor harm reduction funding. Currently, out of the estimated total resource needs for countries, in low- and lower-middle income countries 7% is covered by international donors, while this figure is only 3% for upper middle-income countries. The comparatively higher income of this group of countries does not mean that harm reduction resources are mobilised domestically – only 14% of estimated need for harm reduction was reported to be covered.¹⁹

TABLE 1:
Estimated resource needs by country-income status for people who inject drugs by 2025¹⁸

| | Harm reduction US\$ | PrEP US\$ | NSP US\$ | OAT US\$ | Total US\$ | % |
|---------------------|---------------------|------------|-------------|-------------|----------------------|-----|
| Low-income | 29,980,059 | 10,824,734 | 104,734,131 | 156,716,452 | 302,255,376 | 11% |
| Lower middle-income | 271,200,181 | 44,320,226 | 421,265,341 | 555,734,013 | 1,292,519,761 | 48% |
| Upper middle-income | 196,571,098 | 48,820,746 | 309,060,865 | 524,806,360 | 1,079,259,069 | 40% |

With overall harm reduction spending representing only 5% of the amount estimated to be needed for a fully funded response by 2025, a dramatic increase in harm reduction allocations from donors, as well as from national governments is required. With UMI countries receiving diminishing funding from international donors, increasing domestic funding for those services is essential. However, the sheer size of the funding gap and

the urgency to act before the gap widens further suggest that international donors should allocate additional harm reduction funding based on where funding gaps are largest, rather than on the basis of country income status. We found that donor support accounts for a smaller proportion of resource need for harm reduction in upper middle-income countries than in low and lower middle-income countries. Despite the likelihood of unit

17. It should be noted that PrEP and resource needs for the Russian Federation were not included in the previous resource needs estimates due to country income status.

18. UNAIDS Strategic Information and Evaluation Department/Resource Tracking and Finances (2021). Direct communication. UNAIDS, Geneva.

19. This figure is based on 23 UMI countries for which data are available.

costs being higher in these countries, funding per person who injects drugs in UMI countries continues to be lower than that in low and lower middle-income countries.²⁰

At a regional level, we found that while EECA was home to 38% of people who inject drugs in LMI countries, it accounted for only 27% of identified funding for harm reduction, from both domestic and donor sources.

UNAIDS resource needs estimates by region show that Asia and the Pacific region has the highest need (Table 2).



A dramatic increase in harm reduction funding from international donors, as well as from national governments is required

TABLE 2:
Estimated resource needs by regions for people who inject drugs by 2025¹⁸

| | Harm reduction US\$ | PrEP US\$ | NSP US\$ | OAT US\$ | Total US\$ |
|---------------------------------|---------------------|--------------------|--------------------|----------------------|----------------------|
| Africa – East and Southern | 15,821,722 | 5,464,439 | 56,576,332 | 108,324,080 | 186,186,573 |
| Africa – West and Central | 13,380,088 | 6,781,841 | 75,643,190 | 89,538,650 | 185,343,769 |
| Asia and Pacific | 360,754,438 | 53,787,824 | 332,221,619 | 591,233,396 | 1,337,997,277 |
| Caribbean | 2,154,363 | 998,811 | 7,761,133 | 14,160,561 | 25,074,868 |
| Eastern Europe and Central Asia | 51,125,146 | 22,425,412 | 226,908,313 | 239,851,504 | 540,310,375 |
| Latin America | 7,785,851 | 5,936,386 | 43,221,628 | 61,874,036 | 118,817,901 |
| Middle East and North Africa | 46,729,730 | 8,570,991 | 92,728,122 | 132,274,597 | 280,303,440 |
| TOTAL | 497,751,338 | 103,965,704 | 835,060,337 | 1,237,256,824 | 2,674,034,203 |

The UNAIDS resource needs estimate suggests that the highest resource need is for OAT, accounting for 46% of the total resources needed. In Latin America, the Caribbean and East and Southern Africa, OAT accounts for over half of the total resource needs for people who inject drugs.

At a national level, filling such huge gaps in provision and funding will not happen quickly and greater urgency must be given to start ambitious programmes of intervention scale-up. While UNAIDS' estimates reflect the overall need, national strategic plans and programmatic targets are set at country level. Even at the country programme

level, we found significant gaps in current programme funding required to achieve programmatic targets, which were well below the targets set within the Global AIDS Strategy. Across 30 countries providing this information to the Global Fund within applications, the estimated funding gap for their proposed programmes for people who inject drugs, was US\$65 million per year.²¹

The size of the programmes included in the national plans are not aligned with the huge investment targets proposed by UNAIDS, and the difference shows how difficult it is to overcome this gap. **When reviewing programmatic gap analyses provided to the Global**

20. For the year 2019, funding per person who injects drugs amounted to US\$75 in low-income countries; US\$77 in lower middle-income countries and US\$68 in upper middle-income countries.

21. This figure is an estimation based on country reported funding needs for the people who inject drugs module to the Global Fund, where countries report projected funding gaps for programmatic modules. The base year selected was 2019. However, to ensure that data is more complete, for a number of countries that have not provided such estimates for 2019 the next closest year's figure was used.

Fund, we found OAT to be the most underfunded intervention for people who inject drugs. The estimated funding gap for OAT among the reporting countries was 89%. Domestic funding sources covered just over half of identified funding available for OAT, with international donors covering the rest.²²

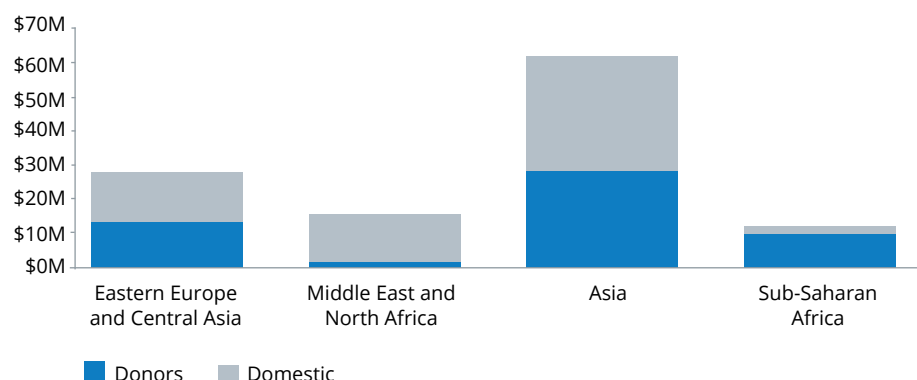
In our research, Asia accounted for the greatest share of identified funding; 48% of identified donor spending and 54% of identified domestic funding for harm reduction. The latter would likely be substantially higher if funding data on harm reduction in China was available. EECA and sub-Saharan Africa were the regions with the next highest share of total identified funding, accounting for 27% and 24% respectively (see Figure 3). Identified funding for harm reduction in Latin America and the Caribbean amounted to US\$0.4 million, predominantly from international donors.

“

Eastern Europe and Central Asia is home to 38% of people who inject drugs in low- and middle-income countries, but accounts for only 27% of funding for harm reduction.

FIGURE 3:

Identified international donor and domestic funding for harm reduction by region, 2019



While investment in harm reduction falls short in all regions, variations in identified funding levels are not aligned with need for services. For example, while Eastern Europe and Central Asia is home to 38% of people who inject drugs in LMI countries, it accounts for only 27% of funding for harm reduction, from both domestic and donor sources.

22. These estimations are based on the review of programme gap information from Global Fund recipient countries.

3.

Domestic funding for harm reduction

3.1
LEVEL OF FUNDING FROM
DOMESTIC SOURCES

As economies have changed, an increasing share of resources for health comes from domestic sources, in line with the global commitment to achieve universal health coverage by 2030. Harm reduction services for people who use drugs are an essential component of domestic healthcare programmes, as listed in the WHO compendium outlining essential health packages for UHC.²³ However, two-thirds of LMI countries do not yet provide resources to cover essential interventions such as HIV testing for people who inject drugs, NSPs, overdose prevention programmes and OAT. With a 95% estimated funding gap for harm reduction,²⁴ it is essential

that harm reduction services receive sustainable funding from overall domestic health resources.

Establishing the current state of domestic investment in harm reduction is a challenging task. Few data sources record these expenditures and, where available, there is a significant level of variation and uncertainty around the validity of the data.

As a part of this research, we identified harm reduction funding (from both international donors and governments) in 64 out of 135 LMI countries. Of these, we identified domestic harm reduction investment in only 38 countries. In total, the identified domestic funding totalled US\$63.2 million in 2019,²⁵ constituting around 48% of the total amount of identified harm reduction funding in 2019.

BOX 4
METHODOLOGICAL CHALLENGES IN ESTIMATING DOMESTIC HARM REDUCTION
INVESTMENT

Domestic funding includes public funds from national/central or local budgets, social insurance/protection schemes and private expenditures, which would include direct spending from households. The extent to which people cover their own harm reduction expenses is an important area of investigation, but the lack of available data meant that only public sources of domestic funding could be captured within this study.

There remains no adequate mechanism for systematically monitoring domestic harm reduction investment. We used two sources of national level expenditure data reporting: country reports to UNAIDS via Global AIDS Monitoring (GAM) reports and information provided by countries to the Global Fund during the grant application process, contained in national Funding Landscape Reports (FLRs). Funding landscape reports include budget and expenditure data and programme gap tables (which outline estimated target population for interventions, share covered from domestic sources and share covered by donors). These are submitted to the Global Fund by countries as part of country grant applications.²⁶

Not all countries report into these systems so we were not able to obtain information from some countries where there may be some domestic harm reduction investment. Furthermore, when comparing data from these two sources, discrepancies were observed at a country level. For example, Afghanistan reported US\$0.6 million domestic expenditure via Global AIDS Monitoring and US\$1.05 million in its FLR for 2018 while Bangladesh reported domestic expenditure of US\$32.18 million and US\$10.72 million respectively.

Country reports to UNAIDS and FLRs provided to the Global Fund may not undergo stringent checking or validation and there may be incentives to over- or underestimate domestic investment. Where differences existed between sources, the choice of which data to include was made on a country-by-country basis, and also drew upon civil society research into national harm reduction funding situations in Asia and the EECA region.^{27, 28}

Given this uncertainty, it is difficult to make concrete conclusions on the state of domestic investment in harm reduction in LMI countries. This study provides a best estimate using current available information.

23. World Health Organization UHC Compendium of Health Interventions. Available at <https://www.who.int/universal-health-coverage/compendium/>

24. Based on UNAIDS estimate of US\$ 2.7 billion required annually and our estimate of US\$131 million for harm reduction in 2019.

25. Estimations were performed using UNAIDS GARPR Reports, Global Fund funding landscape reports and data collected from independent studies.

26. It was confirmed by Global Fund colleagues that Funding Landscape Reports could be considered a valid data source for this research, since they are compiled as part of national applications, with support of government and technical experts, then verified by Local Fund Agents.

27. Alliance for Public Health in Ukraine. Sustainability of services for key population in EECA region (#SoS Project)

28. HRI (2020) in *Summing it up: Building evidence to inform advocacy for harm reduction funding in Asia*. Harm Reduction International, London.

Since HRI last carried out research on harm reduction funding in LMI countries for *The Lost Decade*, the availability of data on domestic spending has increased, largely due to the availability of Funding Landscape Reports submitted to the Global Fund. Data sources on domestic funding for *The Lost Decade* were varied and, in some instances, it was not possible to disaggregate domestic funding from the total amount identified at country level. In 2016, at least US\$48 million of domestic funding was identified from 19 countries while in 2019 we identified US\$63.2 million from 38 countries. The increase in countries and in funding level may be a result of more data availability rather than a real uptick in domestic investment.

Between them, China and the Russian Federation have 3.7 million people who inject drugs accounting for more than one-third of the global population of people who inject drugs. Information on domestic harm reduction investment remains unavailable for China, where we know the government makes significant investment in harm reduction. In the Russian Federation, where the use of OAT remains prohibited, there was US\$584,000 domestic funding for programmes for people who inject drugs reported to UNAIDS Global AIDS Monitoring in 2017.²⁹ Domestic investment was not identified in some large countries in Latin America, such as Mexico and Colombia, but it is possible that this is due to lack of available data rather than a complete absence of domestic funding.

TABLE 3:

Top 10 countries with the highest level of identified domestic funding for harm reduction, 2019

| | | Income Status | Identified domestic funding US\$ | Identified donor funding US\$ | Total identified funding US\$ | Share of domestic funding | Number of people who inject drugs (GSHR 2020/UNAIDS) | Total funding per person who injects drugs, 2019 US\$ |
|----|------------|---------------|----------------------------------|-------------------------------|-------------------------------|---------------------------|------------------------------------------------------|-------------------------------------------------------|
| 1 | Malaysia | UM | 1,708,624 | – | 1,708,624 | 100% | 75,000 | 23 |
| 2 | Serbia | UM | 2,225,063 | 17,834 | 2,242,897 | 99% | 20,500 | 109 |
| 3 | Iran | UM | 14,222,829 | 481,417 | 14,704,246 | 97% | 186,686 | 79 |
| 4 | India | LM | 11,000,000 | 963,273 | 11,963,273 | 92% | 850,000 | 14 |
| 5 | Kazakhstan | UM | 2,255,590 | 459,600 | 2,715,189 | 83% | 120,500 | 23 |
| 6 | Indonesia | LM | 2,806,375 | 622,148 | 3,428,523 | 82% | 33,492 | 102 |
| 7 | Vietnam | LM | 12,531,341 | 3,846,275 | 16,377,616 | 77% | 189,000 | 87 |
| 8 | Georgia | LM | 3,877,889 | 1,455,822 | 5,333,711 | 73% | 52,500 | 102 |
| 9 | Belarus | UM | 1,438,426 | 906,510 | 2,344,936 | 61% | 66,500 | 35 |
| 10 | Thailand | UM | 1,334,711 | 2,524,532 | 3,859,243 | 35% | 51,000 | 76 |

29. This may have been small grants and subsidies supporting programmes in St Petersburg and it is not clear to what extent this support has continued.

3.2 SHARE OF OVERALL FUNDING FROM DOMESTIC SOURCES

The US\$63.2 million of domestic funding identified in 2019 represents 48% of the total funding for harm reduction. This is a higher share than in previous studies although methodological differences mean they are not directly comparable. In addition, data from the missing countries, particularly China, would likely have a large impact on the share of domestic funding.

International donor policies help shape decisions of national public health authorities on investing in harm reduction programmes. The Global Fund Sustainability and Transition Policy calls for integrating transition to domestic funding in all its grants. Countries with a low overall HIV burden and higher income level are required to provide co-financing to the Global Fund grant, with mandatory investment in programmes targeting key populations. However, given the lack of publicly available information on the impact of the Global Fund approach, whether it has increased domestic investment for harm reduction and other key population programming is not yet clear.

There is little information or research to date on the impact that transition has on funding levels and harm reduction service coverage and quality. Coupled with a lack of routine monitoring of harm reduction funding at a country level, it is difficult to assess whether reductions in donor funding are replaced by increased domestic investments at the level required to provide quality harm reduction services at an existing level let alone at UNAIDS' target coverage levels.



With the urgent need to increase domestic investments in harm reduction, it is essential that financial data disaggregated by services becomes more accessible and verifiable

3.2.1

Services funded from domestic sources

Information about which services are funded from domestic sources is even more limited than information on the level of funding. With the urgent need to increase domestic investments in harm reduction, it is essential that financial data disaggregated by services becomes more accessible and verifiable.

The Global State of Harm Reduction 2020 reports that only 39 LMI countries have NSPs, with OAT available in 33 and overdose prevention with peer distribution of naloxone available in six. Trying to establish how many of these countries receive domestic funding for these interventions is challenging. Efforts to gather this information through UNAIDS Global AIDS Monitoring provides only a partial picture. For 2019, country reports to UNAIDS GAM included only 13 countries with reported spending on OAT and 15 with reported spending on NSPs. This is unlikely to represent all LMI countries investing in these services, since not all countries submitted reports.

4.

International donor funding for harm reduction

4.1

AN OVERVIEW OF INTERNATIONAL DONOR SUPPORT OF HARM REDUCTION

In 2016, we identified US\$121 million of funding in LMI countries from international donors, with this amount having dropped by a quarter over the previous decade. In 2019, we identified just US\$68.1 million of funding from international donors.³⁰ Changes in the reporting of funding from the two largest donors make it difficult to determine the real extent of the reduction, but available data suggests that harm reduction funding from international donors has continued to fall.

International donor funding accounted for 52% of all identified harm reduction funding in LMI countries

in 2019 demonstrating the continuing importance of this funding source for the implementation of harm reduction. Donor funding was identified in 50 out of a total of 135 LMI countries. The largest shares of donor funding for harm reduction were identified in Asia, EECA and sub-Saharan Africa.

Information available to monitor donor funding levels for harm reduction has increased, but there are still many challenges inherent in this task. The data remains fragmented, reporting approaches are inconsistent across donors and time periods, and further information is required from implementing partners to improve our understanding of how much core and unrestricted donor funding goes towards harm reduction.

BOX 5

METHODOLOGICAL CHALLENGES IN ESTIMATING HARM REDUCTION INVESTMENT BY INTERNATIONAL DONORS

International donor funding usually takes the form of a grant and can be delivered as financial aid, service provision, technical assistance or commodities and infrastructure. Some donors distribute funds directly while others provide funding to organisations that then implement or further distribute grants to organisations in recipient countries.

Harm reduction donors covered in this section include those that distribute funds directly (e.g., bilateral donors such as The US President's Emergency Plan for AIDS Relief (PEPFAR)) and multilaterals and intermediary organisations that go on to distribute grants having received funding from donors (e.g., the Global Fund, Robert Carr Fund, Aidsfonds). When identifying funds from intermediary organisations, we sought to establish the original donor source to avoid double counting. During data collection, we surveyed all harm reduction donors known to us and made enquires about potential new donors in the field. Despite best

attempts, for the period covered by this report we were not able to identify funding amounts from l'Initiative (former Initiative 5%), the European Commission or the World Bank.

An additional challenge relates to identifying funding amounts. Donors do not all disaggregate their financial data in a way that is conducive to identifying harm reduction funding. Available data from donors differed in whether it was allocation data, or expenditure data and the extent to which sub-categories of harm reduction funding could be identified. While gathering data on donor funding, it must also be considered that only a share of the overall funding amount may actually be spent on services for people who use drugs in the target country. The overall amount may include a number of add-on costs at the donor level, as well as at the implementing organisation level. It is also likely that there would be funds that would not be spent in the expenditure year and would be held for future use.

30. Data was collected through a survey. Donors were asked about funding for comprehensive harm reduction services, as well as support provided to the creation of an enabling environment for harm reduction.

4.1.2

Which international donors are funding harm reduction in LMI countries?

The number of international harm reduction donors remains limited. In 2019, the largest donors continued to be the Global Fund, which accounted for 60% of total donor funding, and the US bilateral funding programme PEPFAR, which accounted for 12%. This section will explore harm reduction funding from these two largest donors in more depth.

All other donors combined made up 28% of total donor funding in 2019 and none of these contributed more than 10% of total resources identified.

Identified bilateral funding for harm reduction is lower than it was in 2016, suggesting a continued decrease in this funding source since *The Lost Decade*. While changes in PEPFAR reporting may account for some of this difference – and bilateral donors do contribute crucial support for the Global Fund, the Robert Carr Fund (RCF) and intermediary organisations which go on to provide funds for harm reduction (e.g., Aidsfonds and Frontline AIDS) – direct support from bilateral donors accounts for an ever smaller share of harm reduction funding.

The Dutch Ministry of Foreign Affairs (MoFA) has been an important supporter of harm reduction with multi-country multi-year programmes such as The Partnership to Inspire, Transform and Connect the HIV response (PITCH) and Bridging the Gaps, with identified funding in 2019 accounting for 7% of all donor funding. However, these programmes ended in December 2020. In mid-2020, concerns that the Dutch MOFA had reduced its strategic focus on, and funding for harm reduction led 330 organisations from 95 countries to urge the Dutch Parliament to recommit to political and financial support for the health and rights of people who use drugs around the world. The MoFA funding priority for 2021-25 is women's rights and gender equality. While harm reduction will be a component of the MoFA-funded

2021-2025 'Love Alliance' programme for key populations with a total budget of €62.9 million, this programme is limited to Burkina Faso, Burundi, Egypt, Kenya, Morocco, Mozambique, Nigeria, South Africa, Uganda and Zimbabwe. For 2021-2022, €8.87 million is allocated towards supporting community-led advocacy of people who use drugs at the national, regional and global level, including on harm reduction and drug policy. A further €3.1 million will be used to support service delivery across all key populations, which may include harm reduction pilot programmes.³¹

In 2019, the Norwegian Agency for Development Cooperation (Norad) spent close to US\$70 million on HIV/AIDS programming in low- and middle-income countries; a significant share of this funding was channeled to The Global Fund. Norad also provides support to harm reduction through partners like RCF and UNAIDS. Unfortunately, it was not possible to disaggregate harm reduction-related funding from Norad, or at the level of Norad's implementing partners.

Open Society Foundations is a leading donor supporting drug policy and harm reduction initiatives, with funding amounting to 10% of international donor funding for harm reduction in LMI countries in 2019. Funding is made available via International Harm Reduction Development in the Public Health Program, as well as through the Global Drug Policy Program, regional and country foundations. The Elton John AIDS Foundation (EJAF) provides earmarked funding for harm reduction, in addition to funding some harm reduction activities as part of its broader HIV prevention and linkage to care portfolio. Identified harm reduction funding from EJAF in 2019 was more than double that identified in 2016. ViiV Healthcare's Positive Action has been increasing its visibility as a donor for harm reduction, and provides support for community-based organisations and HIV prevention services for people who use drugs. Continued funding from this small number of philanthropic harm reduction donors will be crucial, but they remain very few among the numerous philanthropic donors providing support to HIV and other adjacent sectors.

31. Aidsfonds (April 2020) Direct Communication

TABLE 4:
Identified donor funding for harm reduction, 2019

| | Donors | 2019 (USD) | % | Notes on funding between 2017-2020 |
|----|----------------------------------------|-------------------|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Global Fund | 40,915,623 | 60% | Data has been provided by the Global Fund Community, Rights and Gender team and it covers budget allocations for comprehensive prevention programming for people who inject drugs. It is expected that overall funding for harm reduction is higher by the organisation. Uncaptured costs include, for example, partial harm reduction components within multi-country grants, harm reduction commodities coded to other modules, harm reduction in prisons coded to TB modules and some management and monitoring and evaluation costs. |
| 2 | PEPFAR | 8,365,748 | 12% | Data has been provided by PEPFAR and includes information on funding for HIV prevention for PWID. It is expected that overall funding for harm reduction is higher given that some countries include people who inject drugs in their overall key population programming. |
| 3 | OSF | 6,900,000 | 10% | Data has been provided by OSF and adjusted by the research team to include harm reduction services, advocacy and legal and policy reform initiatives which contribute to an enabling environment in LMI countries. |
| 4 | Dutch MOFA | 5,010,752 | 7% | This figure includes identified funding for harm reduction for the projects Bridging the Gap and PITCH. MoFA potentially provides more funding to harm reduction, but this funding cannot be extracted from the overall funding for HIV. |
| 5 | EJAF | 2,531,784 | 4% | Data has been provided by EJAF and adjusted by the research team to exclude Canada and the US. |
| 6 | RCF | 1,875,387 | 3% | Data has been provided by RCF; no further disaggregation possible. |
| 7 | UNODC | 1,741,375 | 3% | Data has been provided by UNODC. |
| 8 | Frontline AIDS | 466,000 | >1% | Data provided from Frontline AIDS was adjusted to exclude funding from OSF. |
| 9 | GPDPD/GIZ | 196,000 | >1% | Data is an estimation; information was collected through the survey. |
| 10 | ViiV Healthcare Positive Action | 101,713 | >1% | Data is an estimation; information was collected through the survey. |
| | Total | 68,104,382 | | |

4.2 THE GLOBAL FUND

The Global Fund is the largest funder of harm reduction services in low- and middle-income countries. In 2019, it contributed US\$41 million towards comprehensive prevention programmes for people who inject drugs; during the budgeting period of 2017-2019 funding amounted to US\$128 million in total. In 2020, there was an increase in the annual disbursement to US\$55.6 million. Since the Global Fund were only able to provide a partial picture of their harm reduction related allocations, it is challenging to compare with previous allocation periods where more comprehensive data are available. For context, at its peak, the Global Fund allocated over US\$100 million per annum to harm reduction.³² **Based on the funding we identified, the Global Fund contributed 32% of total funding for harm reduction in 2019, and 60% of total international harm reduction donor funding in 2019.**

Between 2017 and 2019, Global Fund funding provided HIV testing for more than 2.1 million people who use drugs in 55 countries, and more than 2.8 million people who use drugs were reached by HIV prevention programmes.³³ Global fund support has facilitated the introduction of priority harm reduction interventions in many countries and also funds key and neglected areas of harm reduction, for example, chemsex research and interventions for men who have sex with men in several countries in Asia. While full data were not available, identified funding for comprehensive prevention programmes for people who inject drugs represents 14% of the Global Fund's total spending on prevention and only 2.56% of the Global Fund's total spending on HIV for the same period.³⁴ Overall, if UNAIDS targets are to be met, the Global Fund contribution to harm reduction must become a much greater component of its funding and a priority within its next strategy.³⁵

4.2.1 Transparency of data and data quality

For this study, data on Global Fund harm reduction funding was obtained from the Global Fund Community Rights and Gender team (CRG). However, since *The Lost Decade* when poor transparency of funding data was highlighted, the Global Fund has made significant efforts to improve data availability and accessibility. As a result, funding data are now available online through the Global Fund Data Service³⁶ and The Global Fund Data Explorer.³⁷

While increased availability of online Global Fund data is welcome, there remain several limitations in providing a clear picture on the Global Fund contribution to harm reduction. As illustrated in Table 5 below, the differences between CRG-provided data and that available online is considerable. One part of the reason for the different figures is that the online data does not capture a significant overhang from previous funding periods. Between 2017 and 2019, \$60.8m of Global Fund disbursements were from the 2014-16 allocation cycle and \$2.4m were from 2002-2013 allocations accounting for almost half of all disbursements reported during this period. Another reason for the difference in data is that CRG-provided data uses budget period year, whereas Global Fund Data Explorer uses funding cycle data.

It is important to accurately track whether the intention to fund actually results in funds spent on harm reduction. For this to be possible, data on allocations, disbursement and spending in-country are necessary. A proportion of allocations may never be spent on harm reduction – expenditure analysis by the Global Fund is ongoing but current estimates suggest that harm reduction expenditure is within range of the projected portfolio average of 85%.³⁸ In 2019, this spend rate amounts to US\$6.1 million less funding for harm reduction.

32. Harm Reduction International (2018) *The Lost Decade: Neglect for harm reduction funding and the health crisis among people who use drugs*. Harm Reduction International, London.

33. Analysis is based on the reported results dataset available for download from the Global Fund Data Service [Accessed on 2 March 2021]. We attempted to generate a longer time series for this data, but the archived dataset did not contain the same indicators – information on programmes for people who use drugs was not recorded separately.

34. These figures were calculated using estimates for Global Fund HIV and HIV prevention spending from the IHME Financing Global Health database (<http://ihmeuw.org/53sb>) and data provided by the Global Fund CRG team on expenditure and allocations for the module on HIV prevention for people who inject drugs and their partners, for 2017, 2018 and 2019.

35. Global Fund Data Explorer and Institute for Health Metrics and Evaluation estimates for global health financing.

36. Reports and datasets have been downloaded from this service to collect information about existing grants, contributions and results of the Global Fund-funded programmes: <https://data-service.theglobalfund.org>

37. Specific country information and country applications have been accessed here: <https://data.theglobalfund.org>

38. The Global Fund (2020) 44th Board Meeting Report of the Executive Director, GF/B44/03, 11-12 November 2020, Virtual, Geneva, Switzerland

In addition, in order for the Global Fund contribution to harm reduction to be monitored over time, data must be collected and presented in such a way that time series analysis is possible. Changes in application and reporting processes make this challenging. The fact that there is no consistency between data sources on the Global Fund harm reduction allocation and expenditure, limits the extent to which funding levels can be actively monitored using publicly available sources.



From 2017 to 2019, the Global Fund supported comprehensive prevention programmes for people who inject drugs in 53 countries

TABLE 5:
Global Fund harm reduction funding data comparison by source

| | 2017 | 2018 | 2019 | Total |
|--------------------------------------------------------|------------|------------|------------|-------------|
| Global Fund data provided by CRG team | 52,859,758 | 34,259,332 | 40,915,623 | 128,034,713 |
| Global Fund online grant implementation budget dataset | 296,885 | 25,946,179 | 41,131,826 | 67,374,890 |

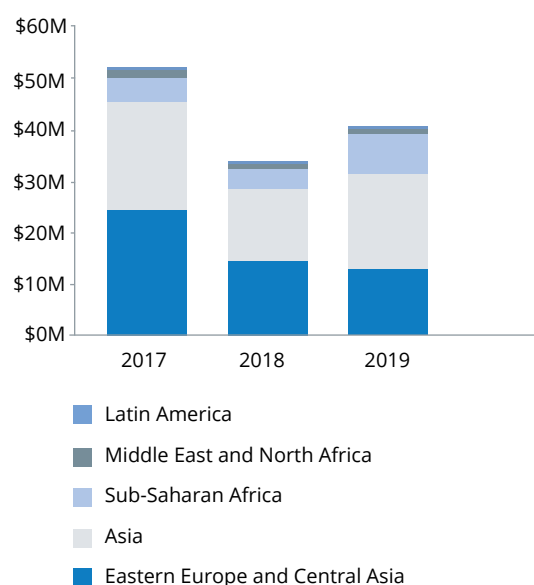
4.2.2

Geographic coverage

Which countries receive funding from the Global Fund and how much they receive is based on eligibility criteria and an allocation-based funding model introduced in 2011. Allocation envelopes for eligible countries are determined by country-income status, disease burden and a qualitative adjustment process.³⁹ In exceptional cases, countries that meet co-financing requirements set by the Global Fund may receive more than the envelope amount set. Allocations are disbursed based on a country's grant agreement budget, which is submitted along with a proposal prepared by Country Coordinating Mechanisms, in line with National Strategic Plans.

From 2017 to 2019, the Global Fund supported comprehensive prevention programmes for people who inject drugs in 53 countries across Africa, Asia and Europe. However, 46 countries where injecting drug use is reported do not include harm reduction in their HIV funding proposals.⁴⁰ Even if there are existing funds supporting harm reduction in these countries (and in most there are not), this may be indicative of missed opportunities. In the 2020-22 funding cycle, the Global Fund has worked to make funding available for NSP and OAT in 18 additional countries.

FIGURE 4:
Global Fund comprehensive prevention programming for people who inject drugs funding by region 2017-2019



39. The qualitative adjustment process allows the Global Fund to adjust country envelopes to account for legal and policy factors. This is particularly important for middle-income countries with harm reduction and other key population programming areas that may be particularly reliant on Global Fund support.

40. For 23 of these countries there are no population size estimates of people who inject drugs and across the remainder, there are an estimated 26,684 people who inject drugs (data sourced from The Global State of Harm Reduction 2020 and UNAIDS).

4.2.3

Funding key services for people who use drugs

The Global Fund's 2020 Sustainability, Transition and Co-Financing Policy⁴¹ has put pressure on national governments to allocate more resources for HIV, and particularly for HIV prevention among key populations. Specifically, lower-middle and upper-middle income countries applying for funding must use 100% of the budget for key populations, out of which 50% must go towards underserved populations and this funding must support implementation of the highest-impact interventions.⁴² In some countries, this policy has visibly increased domestic allocations for harm reduction (e.g., Georgia and Belarus), but there is no systematic evaluation of the policy that we could draw upon for this study to assess whether the results produce a tangible improvement for key populations, including people who use drugs.

All countries that have evidence of people who use drugs affected by HIV should include harm reduction programme funding in their proposals. For this to happen, people who use drugs must be part of Country Coordinating Mechanisms and their voices heard. Community representation along with an understanding of harm reduction among those involved in Global Fund application processes, including the Local Fund Agents, the Fund Portfolio Managers and the Technical

Review Panel are crucial to ensuring that proposals are not accepted by the Global Fund when they omit harm reduction despite there being a clear need in the country.

Needle and syringe programmes and behavioural interventions for people who use drugs together account for over 60% of Global Fund funding for comprehensive prevention programmes for people who inject drugs. Opioid agonist therapy accounts for only 14% of Global Fund funding for comprehensive prevention programmes for people who inject drugs. As a key intervention, and the service that UNAIDS identifies as having the biggest resource need, this is a cause for concern. The \$5.5 million identified as for OAT in 2019 represents only 0.004% of the \$1.2 billion that UNAIDS estimates is annually required for OAT in LMI countries.

Overdose prevention programmes are funded by the Global Fund in 14 countries and, in 2019, the majority of countries receiving funding were provided with less than US\$10,000 per annum for these programmes.

The Global Fund, with its diverse programming addressing legal and structural barriers, as well as the funding for comprehensive prevention programmes for people who inject drugs documented here, will continue to be a crucial donor for harm reduction.

4.2.4

COVID-19 related funding

In the face of the COVID-19 pandemic, the Global Fund rearranged its financing arrangements swiftly to allow countries to re-programme existing budgets, to access additional funding in order to strengthen national health systems to respond to COVID-19, as well as to mitigate and maintain programmes for key populations.

Wide disruptions in services have been reported globally in HIV prevention and care as the result of national responses to COVID-19, such as lockdowns, transformation of service delivery points and even more limited access to services by key populations.^{43,44} A Global Fund survey assessing COVID-19-related disruptions in 38 countries found that services for sex workers and people who inject drugs had been reduced by approximately 20%.⁴⁵

41. The Global Fund (2020) Sustainability, Transition and Co-financing

https://www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf

42. The Global Fund (2020) Harm reduction for people who use drugs: Information note

https://www.theglobalfund.org/media/1279/core_harmreduction_infonote_en.pdf

43. Harm Reduction International (2020) The impact of COVID-19 on harm reduction in seven Asian countries. Harm Reduction International, London

44. INPUD (2020) COVID-19 Survey Reports: Health & Rights of People who Use Drugs in a Pandemic Environment,

available at <https://www.inpud.net/en/covid-19-survey-reports-health-rights-people-who-use-drugs-pandemic-environment>

45. International Network of People who Use Drugs (April 2020) Direct Communication

In 2020, in total the Global Fund approved 120 country and multi-country requests allocating US\$979 million via the COVID-19 Response Mechanism. Over 24% of those funds have been allocated to mitigate the impact of

COVID-19 on TB, HIV and malaria programmes. However, it is unknown what share of those funds have been used to support services for key populations and people who use drugs specifically.

TABLE 6:

Global Fund comprehensive prevention programming for people who inject drugs funding by module

| | Overall amount (US\$), 2019 | Share of total (%) | Number of countries funded 2017-2020 |
|----------------------------------------------------------------------------------------------|--------------------------------|-----------------------|-----------------------------------------------|
| Addressing stigma, discrimination and violence against people who inject drugs | 536,038 | 1% | 19 |
| Behavioral interventions for people who inject drugs | 9,830,655 | 24% | 51 |
| Community empowerment for people who inject drugs | 995,536 | 2% | 14 |
| Condoms and lubricant programming for people who inject drugs | 310,635 | 1% | 21 |
| Diagnosis and treatment of STIs and other sexual health services for people who inject drugs | 719,488 | 2% | 16 |
| HIV testing services for people who inject drugs | 3,008,731 | 7% | 40 |
| Interventions for young people who inject drugs | 182,291 | 0% | 8 |
| Needle and syringe programmes for people who inject drugs and their partners | 15,049,520 | 37% | 35 |
| OAT and other medically assisted drug dependence treatment for people who inject drugs | 5,537,353 | 14% | 33 |
| Other intervention(s) for people who inject drugs and their partners | 2,826,251 | 7% | 21 |
| Overdose prevention and management | 189,339 | 0% | 14 |
| Prevention and management of coinfections and co-morbidities for people who inject drugs | 1,729,787 | 4% | 15 |
| Total | 40,915,623 | | |

4.3 PEPFAR

The US role as a funding organisation for the global HIV response has been significant, particularly since the launch of the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003. All US funding for global HIV is considered to be part of PEPFAR, including both bilateral HIV efforts and contributions to multilateral organisations.⁴⁶

Out of an estimated US\$9.3 billion of global donor funding for HIV/AIDS in 2019, PEPFAR has contributed an estimated US\$6.8 billion – US\$5.4 billion for bilateral programmes and US\$1.4 billion to the Global Fund.

PEPFAR funding for HIV prevention in 2019 was US\$610 million, representing just 9% of that year's allocation. However, put into broader context, PEPFAR provided every other dollar for HIV prevention in LMI countries in 2019. Total donor funding for HIV prevention in LMI countries was US\$1.3 billion in 2019.⁴⁷ This is of concern given that HIV prevention funding in LMI countries overall must increase to US\$9.5 billion by 2025 if targets are to be met.

In *The Lost Decade*, PEPFAR expenditure for harm reduction was estimated to be US\$25.8 million, representing 0.9% of total PEPFAR HIV expenditure for 2016. At that time, PEPFAR supported programmes for people who use drugs in 22 countries and had two regional programmes focused on Asia and Central Asia.

For this study, we identified US\$8.36 million for harm reduction funding from PEPFAR in 2019, accounting for 12% of all identified donor funding in 2019. This amount represents only 1% of PEPFAR's HIV prevention funding and 0.15% of PEPFAR's overall HIV funding in 2019.

While PEPFAR remains the second largest donor for harm reduction, the amount provided in 2019 is substantially lower than that identified in 2016. However, profound changes in reporting of programmatic results, budgets and expenditures in 2017 make it difficult to draw direct



PEPFAR will continue to be a crucial donor for harm reduction in its focus countries, several of which only have nascent harm reduction responses

comparisons. As a result of those changes, for example, services provided for people who use drugs as part of broader HIV prevention services, were not accessible. **Nevertheless, PEPFAR has reduced its funding for harm reduction** with reductions noted for Central Asian countries and for Kenya. In 2019, this funding level had decreased by 17% compared to the previous year, and by a further 6% in 2020.

In 2019, PEPFAR supported methadone-assisted treatment programmes reaching around 17,000 people in eight countries (India, Kazakhstan, Kenya, Kyrgyzstan, South Africa, Tajikistan, Tanzania, and Ukraine), which represents around 2% of the total estimated people who inject drugs in those countries.

Between 2018-2020, PEPFAR increased the number of countries where it supports programmes for people who inject drugs to 31. While this includes funding for HIV testing in Vietnam and Ukraine with established harm reduction programmes, this also includes support to many countries with small-scale programmes. In 2019, PEPFAR supported the launch of PrEP programmes for people who use drugs in 10 countries.^{48,49}

PEPFAR will continue to be a crucial donor for harm reduction in its focus countries, several of which only have nascent harm reduction responses. Given this, PEPFAR can play a vital role in supporting countries to introduce and scale up their harm reduction programmes, as well as through supporting advocacy and policy reform. Overall, if UNAIDS targets are to be met, PEPFAR's contribution to harm reduction must become a much greater component of its funding and a priority within its next strategy.

46. <https://www.kff.org/hiv/aids/fact-sheet/u-s-federal-funding-for-hiv-aids-trends-over-time/#footnote-394843-4>

47. Figures and estimates are based on the Institute for Health Metrics and Evaluation dashboard on financing global health <https://vizhub.healthdata.org/fgh/>

48. PEPFAR has provided support for PrEP programmes in Brazil, eSwatini, Kenya, Nigeria, South Africa, Tanzania, Uganda, Ukraine, Vietnam, Zambia, Zimbabwe and to one person in Lesotho, not counted towards the reported 11 countries.

49. This analysis is based on the information provided by PEPFAR on the results of PEPFAR-supported programmes. The list of countries, where the operating unit that receives funds is located and where programmatic results are recorded, is different with the latter including more countries.

4.4 INTERNATIONAL DONOR FUNDING FOR KEY AND NEGLECTED AREAS OF HARM REDUCTION

Collecting information on which harm reduction interventions and initiatives donors fund has been a significant challenge. Other than the Global Fund and PEPFAR, donors found it challenging to isolate harm reduction funding amounts and many could not disaggregate this support further to allow an understanding of the amount of funds that go towards key and neglected areas. While we could not identify funding amounts, four donors indicated that their funding was in part directed to harm reduction for women and for young people. EJAF and ViiV Healthcare Positive Action also stated that harm reduction for both women and for young people will feature among their future strategic priorities.

The following section compiles what we could identify in relation to donor support for community-led organisations and programming, overdose prevention interventions, advocacy, research and harm reduction in prisons.

4.4.1 Overdose prevention interventions

Many countries have reported an actual or anticipated increase in overdose deaths since the COVID-19 pandemic began,⁵⁰ highlighting an urgent need for overdose prevention programmes, including peer distribution of naloxone, to be more widely available.

The Global State of Harm Reduction 2020 reports that peer distribution of naloxone is not widely available, despite its cost-effectiveness and potential to save many lives. Among LMI countries, based on the report, Afghanistan, India, Myanmar, Vietnam, Ukraine, Mexico and Puerto Rico have peer distribution of naloxone and, to the best of our knowledge, also Georgia. However, the number of countries that run overdose prevention programmes, or have naloxone available in a less accessible form, is larger.



Many countries have reported an actual or anticipated increase in overdose deaths since the COVID-19 pandemic began

In 2019, the Global Fund provided US\$0.2 million for overdose prevention programmes and, from 2017 to 2020, the amount spent for this component was US\$0.7 million, which is 0.4% of total harm reduction spending for the same period by the donor.⁵¹ Myanmar and Kenya accounted for most of this spending with very small amounts for some other countries.

The PEPFAR guidance note from 2010⁵² also acknowledges the importance of overdose prevention programmes, and in its 2021 Country Operational Guidance says that it is critical to include naloxone distribution for drug overdose management. However, information on implementation of such activities is not available.

4.4.2 Community-based and community-led service delivery and funding provided to drug user communities and community empowerment

The Global AIDS Strategy includes targets that aim to increase the role of community-led organisations in the delivery of services (see Box 1).

Community-led organisations, groups and networks, whether formally or informally recognised are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experience, perspectives and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. They are self-determining and autonomous and not influenced by government, commercial or donor agendas.⁵³

50. Harm Reduction International (2020) *The Global State of Harm Reduction 2020*. Harm Reduction International, London.

51. By reviewing country-specific data in more detail, we are aware that the Global Fund's contribution is higher to overdose prevention and management interventions, although those activities are not always classified under the modular framework of the organisation, resulting in the distortion of the information.

52. https://www.ghdonline.org/uploads/PEPFAR_HIV_Prevention_for_IDU.pdf

53. UNAIDS PCB47 Progress Report of the Multi-stakeholder Task Team on Community-led AIDS Responses, December 2020

Community-led responses are actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organisations, groups and networks that represent them. Community-led responses are determined by and respond to the needs and aspirations of their constituents. They include advocacy, campaigning and holding decision-makers to account, monitoring of services, practices and service delivery, participatory research, education and information-sharing, service delivery, capacity building and funding of community-led organisations, groups and networks.⁵⁴

Community-based organisations are not all community led. 'It is the self-determining and self-governing nature of an organization, and its commitment to pursue the goals that its own members have agreed upon, that makes it a genuinely community-led organisation.'⁵⁵

Current reporting systems for both domestic and donor spend on harm reduction are not yet set up to capture information that is essential for monitoring progress on the Global AIDS Strategy targets. It is also crucial that the Global AIDS Monitoring sets specific indicators to measure how much funding goes towards community-led responses. Without changes to allow this, it will not be possible to assess whether donors and governments are directing funds towards meeting these targets.

Overall, identified funding for community-based organisations (including those that provide harm reduction services) amounted to US\$4.5 million in 2019, which equates to 7% of identified harm reduction funding from international donors.⁵⁶ While an amount could not be identified, we know that not all community-based organisations are community-led, so the amount going to these organisations would be less than 7% of international donor funding. The following outlines what information has been possible to gather on donor spending through responses to our survey and from publicly available information on donor websites.

- The **Global Fund**, which is the largest harm reduction donor of harm reduction in LMI countries, channels most of its funds for programmes for people who inject drugs through government agencies and local NGOs (estimated to be 39% and 36% respectively); an estimated 8% of funds were to be channelled through community-based organisations in 2019.⁵⁷ Since not all community-based organisations are community led, we can assume that community-led organisations play a relatively insignificant role in leveraging Global Fund resources at a country level.
- **ViiV Healthcare's Positive Action** directs the majority of its harm reduction funding towards community-based service delivery.
- The **Robert Carr Fund** continues to provide support for drug user organising and community empowerment. RCF funding is largely provided through regional and global civil society and community networks and consortia.
- **EJAF** places importance on supporting community-based and community-led organisations through its funding policies and decisions. Over US\$4.3 million was disbursed to community-based organisations in LMI countries for the period 2017-2020.

4.4.3

Advocacy, legal reforms, policy change, human rights, addressing stigma and discrimination

Despite the overwhelming evidence and consensus in international guidance that harm reduction is effective, cost-effective and essential for preventing and treating HIV among people who use drugs, governments continue to underfund health programming for people who use drugs while investing enormous resources in punitive measures. Strong civil society and community-led advocacy is crucial to ensuring access to high quality, human rights-based harm reduction, and to reaching global goals to end AIDS and TB, eliminate viral hepatitis and provide universal health coverage.

54. UNAIDS PCB47 Progress Report of the Multi-stakeholder Task Team on Community-led AIDS Responses, December 2020

55. United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization, United States Agency for International Development. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on Drugs and Crime; 2017

56. This figure comprised funding data from the Global Fund, EJAF and ViiV. Other donors could not identify amounts going towards community-based and/or community-led organisations.

57. This analysis is based on the Global Fund grant budget information available publicly through the organisation's data service.

In addition to highlighting the funding need for harm reduction services, the Global AIDS Strategy also calls for increased funding for societal enablers to fight inequalities, stigma, discrimination and criminalisation. It is estimated that annual funding to support a social enabling environment would need to reach US\$3.1 billion per annum by 2025 in order to end AIDS by 2030. This includes funding for advocacy, policy and legal changes and to address stigma and discrimination at a country level.

The Global Fund continues to provide support for advocacy, although this is not an explicit module within national grants. As a result, we could not disaggregate the level of funding provided for advocacy activities alone. If we consider activities to reduce stigma, discrimination and violence against people who use drugs, as well as community empowerment to include advocacy-related funding, this amounts to 2.4% of Global Fund country and multi-country grant funding from 2017 to 2020. This amounted to US\$1.53 million in 2019. It was not possible to estimate the extent to which Global Fund Strategic Initiative funding supported harm reduction advocacy, but we know that there were some efforts that covered this area during this period.⁵⁸

Information on donors that offer dedicated support for legal reforms, policy change, human rights and advocacy is fragmented. This is largely due to the fact that most donors do not have information systems in place that collect this data.

As part of this study, we have identified funding by donors to support advocacy-related activities in order to bring about legal and policy change with an increased focus on human rights.

- **EJAF** has dedicated funding towards supporting harm reduction advocacy at the global, regional and local levels. This has included support for advocacy efforts to mobilise domestic resources for harm reduction. Over the period 2017-2020, EJAF directed 5% of its harm reduction budget towards global advocacy. EJAF plans to make support for legal reforms, drug policy change and human rights a cornerstone of its new grant-making strategy and anticipates increasing investments in these areas as well as in advocacy.



Donor investment in harm reduction advocacy, legal and policy change and human rights is crucial in addressing the overall funding gap for harm reduction

- **ViiV Healthcare Positive Action** directed between 10-20% of its harm reduction funding towards advocacy activities during 2017-2020.
- The **Robert Carr Fund** provides important support for harm reduction advocacy, which represents the majority of its funding for harm reduction. Areas of advocacy support include drug policy reform, increased domestic investment for harm reduction and improved access to services for people who use drugs.
- The **PITCH** project implemented by Frontline AIDS and funded by the **Dutch MoFA** has been a major funding source supporting harm reduction advocacy in recent years. However, this project ended in December 2020.
- The **Global Partnership on Drug Policies and Development (GPDPD)**, through funding from the **German Federal Ministry for Economic Cooperation and Development (BMZ)** classifies its support as international and national advocacy work, including work aimed at supporting policy and legal changes in Asia.
- **OSF** provided over US\$25.8 million in drug policy funding globally in 2019 (including some funding incurred by the organisation itself). Out of those funds, US\$6.9 million has been identified as funding for harm reduction services, advocacy and legal and policy reform initiatives which contribute to an enabling environment in LMI countries. OSF's support for global drug policy reform (US\$11.5 million), community empowerment in drug economies (US\$1.2 million), and policing (US\$1.7 million) in 2019 has made a significant contribution to advocacy, legal and policy reforms in LMI countries.

58. For example, see https://www.theglobalfund.org/media/9012/fundingmodel_2017-2019strategicinitiatives_list_en.pdf

Donor investment in harm reduction advocacy, legal and policy change and human rights is crucial in addressing the overall funding gap for harm reduction in LMI countries and meeting global goals. Relatively small donor investments can have a huge impact in increasing political and financial support for harm reduction at

the national, regional and international level. As donors transition away from funding health services in middle-income countries, the value of advocacy funding increases further and is likely to play a crucial role in ensuring that national governments invest in people-centred and evidence-based harm reduction services.

BOX 6 DONOR SPENDING TO ADDRESS STIGMA AND DISCRIMINATION

“Support. Don’t Punish” is one of the most active and long-standing movements by global grassroots organisations focused on promoting and raising awareness about harm reduction and drug policies that prioritise public health and human rights. It aims to place harm reduction high up on the political agenda.

The annual global day of action for the campaign is 26 June, which is the International Day Against Drug Abuse and Illicit Trafficking, which acts as a protest against

punitive measures against people who use drugs applied by governments worldwide.

This campaign is supported by EJAF, OSF and RCF worldwide, but numerous grassroots organisations and harm reduction activists also use their core funds to support the campaign.

Since 2017, EJAF has allocated more than US\$217,000 to Support. Don’t Punish.

4.4.4

Research and evidence generation in the field of harm reduction

Research and evidence generation play an important role in demonstrating the effectiveness of harm reduction services, as well as helping to shape policies and strategies for harm reduction globally and in LMI countries.

As part of this study, we identified a number of research activities supported by the donors, but it is important to recognise that significant evidence generation work is also undertaken that supports legal and policy reform and budget advocacy work, although its funding might not be specifically labelled as research related.

We are aware that the largest donors (PEPFAR and the Global Fund) have supported the gathering of national population size estimates for people who use and or inject drugs at country level, although this may not be captured within the identified funding. While the presence of harm reduction programming should not be dependent on having these estimates, they are fundamental to ensuring programmes reach need, to galvanising domestic support for harm reduction and holding governments to account. *The Global State of Harm Reduction 2020* noted that while 179 of 206 countries worldwide report injecting drug use,

110 countries and territories worldwide have no data on its prevalence.

Donor funding identified in this study included UK£242,321 (US\$332,557) provided by ViiV Healthcare’s Positive Action programme to the London School of Hygiene and Tropical Medicine in 2017 to carry out a qualitative research study exploring how young people’s lived experiences of injecting drug use shapes their health and access to care, particularly in relation to HIV in Kenya and Mauritius.

GPDPD on behalf of the German Federal Ministry for Economic Cooperation and Development has funded several studies since 2017 (e.g., *Speed Limits* by Mainline, *Smokable cocaine markets in Latin America and the Caribbean* by TNI, *Methamphetamine use in Thailand, Myanmar, and Southern China* by TNI, and a snapshot of harm reduction funding in Myanmar by HRI).

HRI has been engaged in a number of research and evidence generation activities including, through funding from the Swiss government, carrying out research on harm reduction in Western Europe, as well as literature reviews into evidence for core harm reduction interventions and harm reduction for stimulants and new psychoactive substances, since 2017.

4.4.5

Harm reduction services in prisons

People use drugs in prisons worldwide. However, the provision of harm reduction services within prisons is very limited. Donor support for prison-based interventions is also limited. One of the reasons is the lack of a supportive legal and policy environment in many countries, which prohibits engagement of civil society or donor organisations in the delivery of prison-based services.

The United Nations Office on Drugs and Crime plays a role in promoting harm reduction services within prisons as a

part of the broader HIV prevention package. However, we have been unable to determine the extent of that funding through this study.

EJAF has supported community-based harm reduction work (in the context of wider HIV programming) that provides services to individuals in closed settings, those who have experience of the criminal justice system, and those released from prisons and places of detention with an overall disbursement of more than US\$0.9 million between 2017-2020.

4.5

FUTURE PROSPECTS FOR HARM REDUCTION FUNDING FROM INTERNATIONAL DONORS

Harm reduction services are severely underfunded globally. International donor support identified in 2019 is one-third lower than in 2016. Overall donor funding for harm reduction must increase dramatically and with urgency. However, while there are several harm reduction champions among the list of international donors providing support, there are no real indications that harm reduction funding prospects are set to improve in the near future.

The composition of international donors who fund harm reduction services has not grown.⁵⁹ Donors surveyed for this research could not identify any new funders for harm reduction. This overreliance on a small number of international donors is of great concern.

As for the existing donors, the data obtained from the largest donors for this study, PEPFAR and the Global Fund, seem to indicate a declining trend over time, some of which can be attributed to changes in reporting systems, and perhaps a small proportion to the transition to domestic funding. A crucial determinant of the overall funding level from these donors going forwards will be whether their new respective strategies give due emphasis to harm reduction. This will impact upon the extent to which they encourage countries to include ambitious

programming for people who use drugs in their funding applications and the level of funding subsequently allocated for these requests. Drug use and the need for harm reduction services has been highlighted under the Biden administration, which may potentially impact the funding for global HIV prevention.⁶⁰

Some donors intend to increase their role and scope for harm reduction funding. ViiV Healthcare's Positive Action plans to increase its funding dedicated to harm reduction under its 2020-2023 strategy.⁶¹ EJAF's new grant-making strategy, to be launched in 2021, aims to broaden its support and will focus more on supporting policy and advocacy initiatives targeting structural and legal barriers to harm reduction. EJAF will continue funding community-based harm reduction and HIV services but aims to support innovative programming – such as services for women, young people, LGBTQI communities, people who use stimulants – to drive evidence and data creation. EJAF will also support global level advocacy focused on resource mobilisation and stigma reduction for people who use drugs. Overall, there is a projected increase in EJAF's funding for harm reduction.

In conclusion, this study has shown that domestic funding for harm reduction, which is seen as a more sustainable funding source, remains limited across LMI countries. While this may have increased since *The Lost Decade*, fragmented data limit the extent to which we can draw conclusions on trends. Given this, and the enormity of

59. As in *The Lost Decade*, there are 10 international donors with identified harm reduction funding of over US\$100,000 in the year of study. The DROSOS Foundation has changed its strategy focus and no longer funds harm reduction. ViiV Healthcare Positive Action now funds harm reduction. EJAF UK and US have merged and in 2019, GiZ has identified harm reduction funding, whereas in 2016 their contribution could not be quantified.

60. <https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf>

61. <https://viiivhealthcare.com/en-gb/supporting-the-community/new-positive-action-strategy-and-funding/>

the funding gap overall, the role of international donors remains paramount for harm reduction in LMI countries. They have a crucial role to play in supporting service provision and in funding advocacy, particularly relating to domestic resource mobilisation. International donor funding will be necessary in order to strengthen budget advocacy efforts by national civil society and community-led organisations.

The funding 'gap' for harm reduction remains so pronounced that it is more accurately described as a failure to fund. International commitments made to date have had little impact on the overall funding situation for harm reduction in LMI countries. More must be done to hold governments and donors to account for their role in ending AIDS and TB, eliminating hepatitis and reaching universal health coverage for people who use drugs by 2030. Without a dramatic increase in international donor and domestic funding, the gap in availability and access to harm reduction services in low- and middle-income countries is likely to continue to widen.



Without a dramatic increase in international donor and domestic funding, the gap in availability and access to harm reduction services in low- and middle-income countries is likely to continue to widen



5. Methodology

This study builds upon the previous work undertaken by HRI to establish the harm reduction funding situation in low- and middle-income countries. As with previous efforts, this was a challenging task that required gathering and analysis of different types of data from a variety of sources.^{62,63}

In order to assess donor funding for harm reduction, the following approaches were taken:

1. **Donor survey:** the survey instrument devised for *The Lost Decade* was revised and updated to capture the level and nature of funding for harm reduction from donors between 2017-2020, with the most detailed information requested for 2019. The list of international donors surveyed for *The Lost Decade* was used as a baseline and further enquiries were made to identify any new donors. Donors surveyed were also asked to provide any information they had on new harm reduction donors. Surveys were sent to 20 international donors and implementing partners in December 2020. Overall, responses were collected from 16 donors, including bilateral and multilateral donors, philanthropic donors and implementing partners. Six of these provided responses using the survey, while others provided information using their own reporting formats, or through email exchanges and calls. All non-respondents were followed up on two or more occasions. Where identifiable, funding for high-income countries was excluded. Double-counting was avoided through identification of source donor and through follow-up with intermediary organisations.
2. **Desk review:** published materials including UN reports, civil society reports and academic literature were reviewed to provide additional information to that available from donors.

3. **Database review:** for the purposes of establishing total donor funding for harm reduction, information reported by donors was used. UNAIDS GAM data available online was also reviewed and provided additional insights into donor funding at country level, where this was reported. However, when compared with information provided by donors, large discrepancies were observed.

Overall, data provided by the international donors is a compilation of disbursements, allocations and expenditures. Identifying the level of funding directed to harm reduction remains a challenge for many donors, with the two largest international donors indicating that data provided does not capture the full extent of harm reduction funding provided. Wherever possible, intermediary organisations or implementing partners were contacted where bilateral donors could not identify the level of their funding directed to harm reduction.

Available sources for assessing domestic funding for harm reduction have increased since *The Lost Decade*. We used the following sources in order of priority:

1. **Country specific studies:** In some countries within Asia and Eastern Europe, data on domestic expenditure has been captured through civil society-led studies into harm reduction funding at country and local levels. Where available, data was included in the study.
2. **Funding Landscape Reports to the Global Fund:** these reports are submitted by countries as a part of country grant applications and include data on the funding landscape and a programmatic gap analysis. Preparation of these reports, and the applications overall are overseen by the Country Coordinating Mechanism and closely reviewed by Global Fund Local Fund Agents and Fund Portfolio Managers.

62. Stimson G, Cook C, Bridge J et al. *Three cents a day is not enough. Resourcing HIV-related Harm Reduction on a Global Basis*. London: Harm Reduction International; 2010.

63. Harm Reduction International, *The Lost Decade: Neglect for harm reduction funding and the health crisis among people who use drugs*. London: Harm Reduction International; 2018.

Following consultation with Global Fund colleagues, we determined data on domestic expenditure within these reports to be of sufficient quality for use in this study.

3. **UNAIDS Global AIDS Monitoring:** data from UNAIDS GAM reports available online has also used to identify domestic harm reduction expenditure in countries for which Funding Landscape Reports were not available, or included no data on domestic harm reduction expenditure. Although the year of focus was 2019, if GAM reports included data for any year between 2017-2020, data for the closest year was used.

It was not possible to gather data on domestic expenditure in some countries where governments may provide some support. Data was unavailable for China, where we know the government invests in extensive harm reduction programming. Data gaps also remain for several countries in Latin America and the Caribbean.

Throughout the report, we have referred to 'identified' amounts of funding for harm reduction. This is to indicate that data included was not estimated by HRI, but gathered through the sources referred to above. The term 'funding' was used to capture the mixed nature of the data gathered, with specifics included where possible.

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