HARM REDUCTION IN GLOBAL FUND GRANT CYCLE 7

ehra
eurasian harm reduction association
NAPUD
NETWORK OF ASIAN PEOPLE WHO USE DRUGS
HARM REDUCTION INTERNATIONAL

HARM REDUCTION IN GLOBAL FUND CYCLE 7: A compilation of evidence to support advocacy

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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.

Eurasian Harm Reduction Association (EHRA) is a non-for-profit public membership-based organization uniting harm reduction activists and organisations from Central and Eastern Europe and Central Asia (CEECA) with its mission to actively unite and support communities and civil societies to ensure the rights and freedoms, health, and well-being of people who use psychoactive substances in the CEECA region.

The **Network of Asian People who Use Drugs (NAPUD)** is a regional network of people who use drugs working to defend, support, and promote health, human rights and harm reduction and end the criminalisation, marginalisation, stigma, and discrimination of people who use drugs living in Asia.

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1.

INTRODUCTION

1. INTRODUCTION

The Global Fund is the largest funder of harm reduction services in low-and-middle income countries.[1] Global Fund Grant Cycle 7 (GC7) is an important opportunity for countries to access funding for comprehensive harm reduction services for people who use drugs and supportive structural interventions such as advocacy for legal and policy reform, including decrimalisation. In order to make a strong case for funds to be allocated to harm reduction, the impact of these investments on HIV outcomes must be highlighted in funding requests.

This briefing compiles key information to support advocacy for the inclusion of harm reduction within GC7 funding requests. It provides an overview of important changes for Global Fund funding for harm reduction under GC7; compiles key data, evidence and references to support advocacy for harm reduction inclusion within Grant Cycle 7 processes. It also provides related observations and recommendations from the Global Fund Technical Review Panel, who are responsible for reviewing submitted country funding requests.[2] Lastly, the relevant modules and indicators from the Global Fund modular framework are compiled for easy reference. This information may be useful for organisations of people who use drugs and harm reduction advocates in your negotiations with decision makers, as well as members of the application writing teams and Country Coordinating Mechanisms (CCMs).

2.

HARM REDUCTION IN GLOBAL FUND GRANT CYCLE 7

2. HARM REDUCTION IN GLOBAL FUND GRANT CYCLE 7

The Global Fund has released a new information note on harm reduction for Grant Cycle 7. This provides information on what is expected within funding requests and what is allowed to be covered by the Global Fund in Grant Cycle 7. The following developments are key:

Key changes for harm reduction under Grant Cycle 7	
Harm reduction is a "program essential"	• All countries must describe status of their harm reduction programmes in their funding requests and those countries classified as high impact must describe their plan for implementation. • Top priority harm reduction interventions are needle and syringe programming (NSP), opioid agonist therapy (OAT) and naloxone for overdose.
Programming for people who use drugs	• Funding requests can include programmes for people who use/inject drugs and their sexual partners, rather than only people who inject drugs. • This allows increased scope for stimulant harm reduction to be funded
Human rights "program essentials"	• The information note highlights the key role for people who inject drugs in planning
Emphasis on community-led monitoring	• The information note highlights the key role for people who inject drugs in planning, delivery and evaluation of services and policy change.
Clarity on hepatitis B and C	• The Global Fund will fund hepatitis B and C treatment for people who inject drugs regardless of HIV status if there is a strong epidemiological case and it is part of comprehensive HIV programming.
Abstinence-focused programming	• WHO key populations guidelines now state clearly that programmes demanding abstinence are not shown as effective for HIV prevention and are explicitly not prioritised by the Global Fund

The harm reduction information note is an annex to the Grant Cycle 7 updated HIV information note. Other useful documents include: new information notes on programming in prisons and other closed settings and removing barriers to HIV services. Funding requests will be reviewed by the Technical Review Panel (TRP) against a set of criteria.

TIP: The following annexes are to be submitted along with Grant Cycle 7 funding requests:

- Gender Assessment (no standard template, see more details on page 9)
- Human Rights Assessment (no standard template, see more details on page 9)
- Country Dialogue narrative
- Funding Priorities from Civil Society & Communities

These new annexes provide an opportunity to advocate for including harm reduction and community priorities within the funding request and for alerting the CCM and the TRP to the importance of this programming.

TIP: The International Network of People who Use Drugs (INPUD) has produced a useful guide to support the engagement of people who use drugs within the Global Fund processes for Grant Cycle 7.

3.

EVIDENCE FOR ADVOCACY

3. EVIDENCE FOR ADVOCACY

The following section provides an overview of key data and evidence to support the inclusion of harm reduction and related programming areas within GC7 funding requests.

3.1 COMMUNITY LEADERSHIP AND COMMUNITY SYSTEM STRENGTHENING

- Community leadership in harm reduction research, advocacy, programme planning, decision making and delivery is necessary to ensure the response is rooted in the realities faced by the community and that services are effective, people-centred and deliver the greatest impact. Peers are uniquely able to win the trust of clients and have the knowledge and expertise to understand their experiences. Evidence shows that peer involvement in HIV and harm reduction services is linked to better health outcomes, including reduced incidence of HIV, increased accessibility, acceptability and quality of services, reduced risk behaviours and reduced experiences of stigma and discrimination.[3]
- Strong community systems are central to the HIV response and during the COVID-19 pandemic, proved crucial to the continuation of life-saving services (including providing food and shelter). Countries with strong harm reduction programmes and networks of people who use drugs provided some of the best examples of innovation and resilience in adapting service provision and pushing through policy reforms. Communities of people who use drugs were on the frontlines, providing life-saving and critical services and advocacy on behalf of their community.
- Global Fund Country Coordinating Mechanisms (CCMs) must include community representation, including people who use drugs. This is necessary to ensure community engagement in key decision making, effective oversight of programmes for people who use drugs and to provide a direct conduit for channeling community feedback on implementation of Global Fund programmes.
- Strong community-led networks play an important role in research and data-gathering as well as advocacy and campaigns. Organisations of people who use drugs increase accountability of decision-makers and in monitoring all aspects of programming, including the planning, delivery and evaluation of services, as well as related policy change.
- The Global AIDS Strategy 2021-2026 includes the “30-80-60 targets” to drive action for community-led responses by 2025:
    - » 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

The TRP observed insufficient inclusion of, and funding for, community-led approaches and interventions in previous Global Fund grant applications. When community-led and community-based interventions were mentioned, the TRP noted that most of these tended to be included in the Priority Above Allocation Request (PAAR). The TRP found that many funding requests stated that they planned to address quality but few invested in monitoring and measuring quality of services delivered. Community-led monitoring is a priority that the TRP recommends for greater investment.

In addition, the TRP stated that few funding requests addressed the broader aspects of community system strengthening, including strengthening community organisations and investing in advocacy, as well as building leadership of the most affected communities. Moreover, strategies for public financing and sustainability of other important functions of community systems like advocacy, human rights, community-led monitoring and needs assessment were missing in most funding requests.

Community systems and responses are incorporated in many funding requests, yet these investments are limited and overly focused on community health workers (CHWs) rather than the full scope of community infrastructure and services envisaged. CHWs are an essential health systems component – not solely related to community systems – yet the scale of investment in funding requests is currently not commensurate with the level of ambition envisaged and certainly not for CHWs employed by community organizations, including services led by key and vulnerable population peers.[4]

3.2 DECRIMINALISATION

- Most governments around the world focus overwhelmingly on prohibitive and punitive drug responses, at significant cost and despite the well-documented harms associated with this approach.[5] A 2017 systematic review found that criminalising drug use has a negative effect on HIV prevention and treatment and poses a significant barrier to an effective HIV response.[6] Yet, in 2022, UNAIDS reported that at least 115 countries around the world criminalised limited amounts of drugs for personal possession (data was not available for 65 countries).[7]
- Imprisonment, arbitrary detention and compulsory forced rehabilitation are experienced by many people who use drugs. A systematic review found that 58% of people who inject drugs have had experience of incarceration at some stage during their life.[8]
- The decriminalisation of drug use, drug possession and people who use drugs is critical to an effective HIV response. As outlined in the United Nations common position on drug policy, drug policies need urgent reform to remove barriers to effective HIV prevention, treatment and care.[9] UNAIDS has called on governments to decriminalise drug use and possession for personal use in order to reduce the stigma and discrimination that hampers access to health care, harm reduction and legal services.[10]
- The Global AIDS Strategy 2021-2026 includes the target that *less than 10% of countries criminalize sex work, possession of small amounts of drugs, same-sex sexual behaviour, and HIV transmission, exposure or nondisclosure by 2025.*[11]

- Criminalisation, stigma and discrimination increase vulnerability to HIV and prevent access for people who use drugs to harm reduction and broader health care services. Certain populations experience these barriers particularly acutely; most notably, women, LGBTQI+ people, people who are migrants or refugees, young people, and Black, Brown, and Indigenous people, all of whom face a lack of services tailored to their needs.
- To mark International Drug Users' Day in November 2021, UNAIDS issued a statement reaffirming its commitment to the decriminalisation of people who use drugs and the promotion of community-led services.[12]
- Despite evidence of people in closed settings using drugs and the elevated risk of HIV and HCV transmission, people in prisons and other closed settings do not have access to HIV or HCV treatment in many parts of the world. It is crucial that harm reduction services be provided both within and outside closed settings. Efforts are needed to ensure continuity of HIV and TB treatment, needle and syringe programmes (NSP) and opioid agonist therapy (OAT) at all stages – upon arrest, during pre-trial detention, transfer to and during time within prison and other closed settings and upon release. Provision of OAT in prisons, for example, improves multiple health outcomes during incarceration and reduces overdose risk upon release.[13]

The TRP states that increased investment is required to address human rights and gender-related barriers, including legislative barriers such as criminalisation.[14]

3.3 HIV AND VIRAL HEPATITIS AMONG PEOPLE WHO USE AND INJECT DRUGS

- While key populations make up less than 5% of the total population, 70% of new HIV infections are among key populations and their sexual partners.[15] People who inject drugs are disproportionately vulnerable to HIV and viral hepatitis. The risk of acquiring HIV is 35 times higher among people who inject drugs than among adults who do not.[16] Almost 4 in 10 people who inject drugs have active hepatitis C and 1 in 12 have active hepatitis B.[17]
- According to a 2022 systematic review in the Lancet Global Health, injecting drug use has been documented in 190 of 207 countries and territories around the world, with an estimated 14.8 million people who inject drugs globally. Approximately 2.8 million women inject drugs globally, compared to 12.1 million men.[18]
- The same systematic review found that 25% of people who inject drugs had experienced recent homelessness or unstable housing and 58% had experience of incarceration. The review found an estimated 15% of people who inject drugs are living with HIV; 39% have current HCV infection; 19% have recently overdosed, and 32% had a recent skin or soft tissue infection.[19]
  - People who inject drugs represent:
  - 12% of new HIV infections in the Asia and the Pacific

» 4 % of new HIV infections in Latin America

» 1 % of new HIV infections in Caribbean

» 30 % of new HIV infections in the Middle East and North Africa

» 39 % of new HIV infections in Eastern Europe and Central Asia

» 3 % of new HIV infections in Eastern and Southern Africa

» 2 % of new HIV infections in Western and Central Africa[20]

TIP: The Viral Hepatitis Data Repository is a useful resource for accessing national data for a range of indicators related to viral hepatitis and people who inject drugs, sourced from a range of publicly available international datasets, including the UNODC World Drug Report, UNAIDS, the Global Health Observatory, the Global Burden of Disease, the Polaris Observatory and academic modelling studies.

The TRP encourages applicants to prioritise high-impact interventions within the specific country context, in respect to epidemiology, available resources, and cross-cutting challenges. These should focus on populations that are inadequately reached by prevention programming and populations that lack access to, and/or show lower retention in treatment and care services.[21]

3.4 COMPREHENSIVE HARM REDUCTION PROGRAMMING

- Harm reduction is a ‘program essential’ for Global Fund Grant Cycle 7. This means that the Global Fund is placing particular emphasis on this area of programming and funding requests should reflect this. Community and civil society advocates should highlight harm reduction as a ‘program essential’ in their advocacy.
- Key UN global policy and strategy documents recognise that an effective and evidence-based HIV response must focus on people who use drugs. The WHO’s Global Health Sector Strategies,[22] the Joint United Nations Programme on HIV/AIDS (UNAIDS)’ Global AIDS Strategy 2021-2026,[23] and the United Nations General Assembly’s 2021 Political Declaration on HIV and AIDS,[24] signed up to by governments globally, all emphasise the urgent need to scale up HIV prevention among key populations, including people who use drugs.
- The 2021-2026 Global AIDS Strategy explicitly prioritises the need to focus on community-led responses and ‘intensify and redouble efforts to scale up comprehensive harm reduction for people who inject drugs in all settings’.[25]
- Evidence shows that implementing comprehensive harm reduction programming reduces HIV, HCV & TB incidence; reduces overdose and other drug related deaths; increases referrals to support programmes and health

and social services; reduces stigma and discrimination and increases access to health services; reduces sharing of drug using equipment; increases knowledge around safer drug use; increases knowledge around safer sex, sexual health and increases condom use.

- Despite these benefits, effective harm reduction interventions are lacking in many countries. The Global State of Harm Reduction 2022 identified 92 countries implementing at least one NSP (up from 86 in 2020) and 87 countries with at least one OAT programme (up from 84 in 2020).[26] Services remain very limited in most parts of the world, with only 2% of people who inject drugs living in countries with high coverage.[27]
- The WHO Key Populations Consolidated Guidelines (updated in 2022) recommend implementation of a comprehensive set of interventions for people who use drugs in order to prevention HIV, TB and viral hepatitis B and C, as well as to prevent overdose and other harms.
    - » Enabling interventions that are essential for impact including removing punitive laws, policies and practices; reducing stigma and discrimination; community empowerment; addressing violence
    - » Health interventions for the prevention of HIV, viral hepatitis and STIs; harm reduction (NSPs, OAT and naloxone for overdose management; condoms and lubricant, pre-exposure prophylaxis for HIV; post-exposure prophylaxis for HIV and STIs; prevention of vertical transmission of HIV, syphilis and HBV; hepatitis B vaccination; addressing chemsex;
    - » Testing and treatment for HRI, STIs, hepatitis B and C
    - » Broader health interventions including conception and pregnancy care; contraception; mental health; prevention, assessment and treatment of cervical cancer; safe abortion; screening and treatment for hazardous and harmful alcohol and other substance use; TB prevention, screening, diagnosis and treatment.[28]
- The updated WHO guidelines also advise countries that counselling behavioural interventions that aim to change behaviours are not effective in preventing HIV, viral hepatitis or TB and create barriers to service access. Abstinence-focused programming is explicitly not recommended[29] and as such, should not be included in Global Fund funding requests.[30]
- People in prison and other closed settings are disproportionately affected by HIV, hepatitis B and C and TB. WHO guidelines call on states to recognise the right to equivalent health services for people in prisons and reflect this in prison policies and practices.[31]
- The Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs (IDUIT)[32] describes how services can be designed and implemented to be accessible and acceptable to people who use and/or inject drugs. It also includes sections on meaningful community involvement, human rights and alternatives to criminalisation. The IDUIT is endorsed as the normative guidance for services for people who use drugs by UNODC, UNAIDS, WHO and the Global Fund and was collaboratively developed with people who use drugs.

- Integrated and person-centred harm reduction services increase engagement and improve health outcomes. Reviews of evidence find that integrating HIV and harm reduction not only increased the number of people accessing those services, but also improved their access to primary care in general. Integrated services provide greater opportunity to respond to health needs in one place. For example, programmes that have expanded hepatitis C testing and treatment services at the same site within primary healthcare and harm reduction facilities have achieved great success in reaching and treating people.[33]
- Not only are integrated services effective, they are also cost-effective. Evidence shows this is true of any type of integration of HIV services with sexual and reproductive health, tuberculosis or primary health care, and that this may make services cheaper for clients where that is a factor.[34]

TIP: Where it is available, evidence of the impact that harm reduction interventions have already had on HIV outcomes within the national or local context should be included in funding requests as supportive evidence for further investment.[35]

The TRP observed that funding requests often paid insufficient attention to intersectionality and the connections between various key and vulnerable populations. In addition, too frequently, key population programming within funding requests were insufficient to meet the scale of need, were siloed, and often included in the PAAR. The TRP continues to observe the following prevention gaps, especially for key pops, including gay men and other MSM, sex workers, transgender people, people who inject drugs, and people in prisons and other closed settings. Few funding requests disaggregated key populations by gender and age. Very rarely did funding request demonstrate the overlaps between sub-groups of adolescent girls and young women (AGYW) and key populations (e.g., AGYW who inject drugs).[36]

3.5 THE COST-EFFECTIVENESS AND COST BENEFIT OF HARM REDUCTION INTERVENTIONS

- Compelling evidence from across the world shows that harm reduction interventions are cost-effective and can be cost-saving in the long-term.
- UNAIDS estimates the cost of NSP provision to be $23–71 per person per year. Measured against the cost of treating blood-borne infections, this makes NSPs one of the most cost- effective public health interventions ever funded.[37]
- OAT, while more expensive to implement than NSP, is cost-effective. OAT's cost-effectiveness increases when wider societal benefits, such as reduced crime and incarceration, are factored in.[38]
- Adaptations to harm reduction service delivery, particularly those that are

community-driven, can significantly reduce unit costs of harm reduction interventions. An example of this is offering take-home OAT, which many countries did during the COVID-19 pandemic. This benefits the person receiving OAT and reduces the service provision costs.

- The cost of antiretroviral treatment for a person living with HIV is estimated at between USD 1,000-2,000 per person per year, making cost-effective HIV prevention a sensible public health and economic decision.[39]
- Substantial evidence indicates that a combined package of NSP, OAT and ART is the most effective and cost-effective HIV strategy for people who inject drugs.[40] The peer distribution of naloxone for overdose prevention is an extremely cost effective public health intervention.
- There is evidence that reduction or total cessation of funding and closure of services can lead to a spike in HIV and HCV infections, which highlights the importance of sustainable funding and continuity in harm reduction service provision.[41]
- Many governments spend huge amounts on punitive drug policies. As well as violating human rights, this approach places a substantial economic burden on public health, society and the individual. Many countries imprison people for drug use and possession. This incarceration is expensive to fund and also incurs a huge public health cost. People in prisons are five times more likely to be living with HIV than the general population.[42]
- However, cost-effectiveness analyses should not be the only basis on which funding decisions are made. Prioritising finances over the quality of services being delivered poses a threat to human rights-based, people-centred harm reduction. Communities must be at the centre of all decisions that relate to their health, including financial ones. Sustainable financing for health and harm reduction requires equity, human rights and community to be central.[43]

The TRP observed that funding requests had an over-emphasis on commodities and short-term support for human resources, rather than investing in building longer-term sustainable processes, systems and policies, with a focus on efficiencies, integration, coherence and maintaining government expenditure on health. TRP also observed that many funding requests still request costly international technical expertise and do not pay enough attention to strengthening local capacity, and to leveraging local or regional expertise. Deploying local expertise and building in-country capacity would be in line with the new Global Fund's new strategy and the TRP's commitment to advancing the decolonisation and non-discriminatory frameworks that are designed to empower the most affected communities.[44]

3.6 HARM REDUCTION FUNDING

- As HIV continues to rise among people who inject drugs, the harm reduction funding crisis deepens. Financial support for an effective HIV response for people who inject drugs in low- and middle-income countries totaled US$131 million in 2019 - just 5% of the US$2.7 billion that is needed annually by 2025.[45] The total number of international donors investing in harm reduction remains small, and the amount of funding invested appears to be shrinking.[46]
- Middle-income countries are increasingly vulnerable as donors either reduce or withdraw funding. This has particularly affected upper-middle income countries, where the majority of people who inject drugs live, with the justification that wealthier countries can fund their own health services. While many governments are investing more in domestic health and HIV responses, few are substantially investing in harm reduction, even where the need is great. Sizeable domestic funding for harm reduction is identified in only a small number of countries and remains inadequate. Furthermore, it is under constant threat because of a lack of political commitment and will to fund harm reduction services.[47]
- Funding for harm reduction services is heavily dependent on international donors, especially the Global Fund. The Global Fund is the largest donor for harm reduction in low-and-middle income countries, accounting for over 60% of international donor support in 2019. PEPFAR is the second largest donor, with a contribution that amounts to 1% of its overall HIV prevention budget. The federal ban prohibiting the funding of procurement of needles or syringes continues to be a limitation.[48]

3.7 INCREASING DOMESTIC PUBLIC FINANCING FOR HARM REDUCTION

- The Global Fund investment case outlines the need to catalyse domestic health investments up to US$59 billion (45% of total resource need) through co-financing requirements and technical assistance on health financing.[49]
- Domestic public financing for harm reduction and other key population programming lags far behind that of the broader HIV response. Domestic investment in harm reduction is determined by political support rather than country-income status. COVID-19 has further constrained health budgets, with many governments scrambling to prop up overburdened and underfunded health systems.
- Strong community and civil society advocacy is necessary to call for increased domestic public financing for harm reduction and to hold governments to account for their investments. The Global Fund is the largest source of funding for this work, which is particularly important in transitioning countries where donors are reducing funds or withdrawing.

- The country-level structures established by the Global Fund, such as CCMs, and the standards with which they operate serve as a blueprint for good practice beyond the life of the Global Fund grant.
- Alongside advocacy to increase political support for domestic financing of community-led, community-based and civil society harm reduction, it is necessary to ensure that supportive laws, policies and mechanisms, such as social contracting are in place. This work must start well before transition as it can be a lengthy process.

The TRP encourages implementer governments to increase domestic financing for comprehensive community systems, including for community-based organisations and service delivery led by key populations. The TRP noted that few funding requests directed adequate domestic (and Global Fund) funding to key populations. Sustainability plans should include public funding and contracting mechanisms (social contract) and co-financing for civil society and community-led advocacy, monitoring and other functions. All are critical for government accountability, political commitment and quality of services, especially in countries planning for transition from Global Fund support.[50]

4.

KEY INTERVENTIONS FROM THE MODULAR FRAMEWORK

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The activities you include within your GC7 funding request must fit within the Global Fund GC7 Modular Framework.[51] This section compiles the key interventions for harm reduction and programming for people who use drugs from the Modular Framework and directs you to the relevant module and page number within the handbook.

Community-based service delivery

Intervention	Module & Modular Framework Handbook Page
Needle and syringe programs for PWID	HIV: Prevention Package. Page 72
Opioid substitution therapy and other medically assisted drug dependence treatment for PWID	HIV: Prevention Package. Page 72
Overdose prevention and management for PWID	HIV: Prevention Package. Page 72
Condom and lubricant programing for PUD	HIV: Prevention Package. Page 73
Pre-exposure prophylaxis (PrEP) programing for PUD	HIV: Prevention Package. Page 73
HIV prevention communication, information and demand creation for PUD	HIV: Prevention Package. Page 74
Sexual and reproductive health services, including STIs, hepatitis, post-violence care for PUD	HIV: Prevention Package. Page 75
Community-based testing for KP programs	HIV: Differentiated HIV Testing Services. Page 95
Self-testing for KP programs	HIV: Differentiated HIV Testing Services. Page 96
TB/HIV - Community care delivery	HIV/TB Page104

Service delivery within prisons and other closed settings

Intervention	Module & Modular Framework Handbook Page
Condom and lubricant programing for prisoners	HIV: Prevention Package. Page 77
Pre-exposure prophylaxis (PrEP) programing for prisoners	HIV: Prevention Package. Page 77
HIV prevention communication, information and demand creation for prisoners	HIV: Prevention Package. Page 78
Sexual and reproductive health services, including STIs, hepatitis, post-violence care for prisoners	HIV: Prevention Package. Page 79
Harm reduction interventions for drug use for prisoners	HIV: Prevention Package. Page 79
Removing human rights-related barriers to prevention for prisoners	HIV: Prevention Package. Page 80

Human resources for service delivery

Intervention	Module & Modular Framework Handbook Page
Community health workers: Selection, preservice training and certification	RSSH: Human Resources for Health and Quality of Care. Begins on page 33
Community health workers: contracting, remuneration and retention	RSSH: Human Resources for Health and Quality of Care. Begins on page 34
Community health workers: In service training	RSSH: Human Resources for Health and Quality of Care. Begins on page 35
Community health workers: Integrated supportive supervision	RSSH: Human Resources for Health and Quality of Care. Begins on page 36

Sustainability of service delivery

Intervention	Module & Modular Framework Handbook page
Community-led advocacy and monitoring of domestic resource mobilization	RSSH: Health Financing Systems. Page 19
Social contracting	RSSH: Health Financing Systems. Page 20

Human Rights

Intervention	Module & Modular Framework Handbook page
Removing human rights-related barriers to prevention for PUD	HIV: Prevention Package for People Who Use Drugs (PUD) (injecting and non-injecting) and their Sexual Partners. Page 76
Eliminating stigma and discrimination in all settings	HIV: Reducing Human Rights-related Barriers to HIV/TB Services. Page 106
Legal literacy ("Know Your Rights" campaign)	HIV: Reducing Human Rights-related Barriers to HIV/TB Services. Page 107
Ensuring non-discriminatory provision of health care	HIV: Reducing Human Rights-related Barriers to HIV/TB Services. Page 108
Increasing access to justice	HIV: Reducing Human Rights-related Barriers to HIV/TB Services. Page 108
Ensuring rights-based law enforcement practices	HIV: Reducing Human Rights-related Barriers to HIV/TB Services. Page 109
Improving laws, regulations and polices relating to HIV and HIV/TB	HIV: Reducing Human Rights-related Barriers to HIV/TB Services. Page 109

Community Systems Strengthening

Intervention	Module & Modular Framework Handbook page
Community-led monitoring	RSSH: Community Systems Strengthening. Page 13
Community-led research and advocacy	RSSH: Community Systems Strengthening. Page 14
Community engagement, linkages and coordination	RSSH: Community Systems Strengthening. Page 15
Capacity building and leadership	RSSH: Community Systems Strengthening. Page 16
Technical assistance, capacity building and operational support, health financing data and analytics	RSSH: Health financing data and analytics. Page 21
Community-based and community-led surveys	RSSH: Monitoring and Evaluation Systems. Page 51
Analyses, evaluations, reviews and data use	RSSH: Monitoring and Evaluation Systems. Page 53
Operational research	RSSH: Monitoring and Evaluation Systems. Page 55
Community empowerment for PUD	HIV: Prevention Package for People Who Use Drugs (PUD) (injecting and non-injecting) and their Sexual Partners. Page 75

REFERENCES

1. HRI (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. Harm Reduction International, London https://www.hri.global/files/2021/08/09/HRI-FAILURE-TO-FUND-REPORT-LOWRES.PDF
2. For more information on the Global Fund Technical Review Panel see: https://www.theglobalfund.org/en/technical-review-panel/
3. Chang J, Shelly S, Busz M, Stoicescu C, Iryawan AR, Madybaeva D, et al. Peer driven or driven peers? A rapid review of peer involvement of people who use drugs in HIV and harm reduction services in low- and middle-income countries. Harm Reduction Journal 2021;18(1):15
4. Technical Review Panel (July 2022). 2020-2022 Technical Review Panel Observations Report. Available at: https://www.theglobalfund.org/media/12137/trp_2020-2022observations_report_en.pdf
5. Csete J et al (2016) Public health and international drug policy. The Lancet Commissions, Volume 387, Issue 10026, p1427-1480, April 02, 2016
6. The Lancet HIV (2017), HIV and the criminalisation of drug use among people who inject drugs: a systematic review, https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(17)30073-5/fulltext
7. UNAIDS 2022. IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf
8. Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. (under review), ‘A global systematic review of the epidemiology of people who inject drugs: Prevalence, sociodemographic characteristics, risk environments and injecting-related harm’, Lancet Glob Health
9. United Nations System Chief Executive Board (2019), UN system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration, https://www.unsystem.org/CEBPublicFiles/CEB-2018-2-SoD.pdf
10. UNAIDS (2019), Health, Rights and Drugs, https://www.unaids.org/sites/default/files/media_asset/JC2954_UNAIDS_drugs_report_2019_en.pdf
11. https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026
12. UNAIDS (1 November, 2021), ‘On International Drug Users’ Day, UNAIDS calls for action against the criminalization of people who use drugs and for community-led harm reduction programmes’ [internet, cited 22 August, 2022]. Available from www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2021/november/20211101_international-drug-users-day
13. World health Organization (2022) Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. WHO: Geneva
14. Technical Review Panel (July 2022). 2020-2022 Technical Review Panel Observations Report. Available at: https://www.theglobalfund.org/media/12137/trp_2020-2022observations_report_en.pdf
15. UNAIDS 2022. IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf
16. UNAIDS 2022. IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf
17. Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. (under review), ‘A global systematic review of the epidemiology of people who inject drugs: Prevalence, sociodemographic characteristics, risk environments and injecting-related harm’, Lancet Glob Health
18. Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. (under review), ‘A global systematic review of the epidemiology of people who inject drugs: Prevalence, sociodemographic characteristics, risk environments and injecting-related harm’, Lancet Glob Health
19. Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. (under review), ‘A global systematic review of the epidemiology of people who inject drugs: Prevalence, sociodemographic characteristics, risk environments and injecting-related harm’, Lancet Glob Health
20. UNAIDS 2022. IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf
21. Technical Review Panel (July 2022). 2020-2022 Technical Review Panel Observations Report. Available at: https://www.theglobalfund.org/media/12137/trp_2020-2022observations_report_en.pdf
22. World Health Organization (2022) Global Health Sector Strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030 (GHSS)
23. https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026
24. Seventy-fifth session Agenda item 10 Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS THE GENERAL ASSEMBLY Adopts the political declaration entitled

"Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030" annexed to the present resolution. 74TH PLENARY MEETING 8 JUNE 2021

25. https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026
26. Harm Reduction International (2022) Global State of Harm Reduction 2022. London: Harm Reduction International
27. Colledge-Frisby, S., Ottaviano, S., Webb, P., Wheeler, A., Grebely, J., Cunningham, E., Hajarizadeh, B., Leung, J., Peacock, A., Vickerman, P., Farrell, M., Dore, G., Hickman, M., & Degenhardt, L. (under review). The global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: A multi-stage systematic review of the evidence. The Lancet Global Health.
28. World health Organization (2022) Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. WHO: Geneva
29. World health Organization (2022) Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. WHO: Geneva
30. The Global Fund (2022) Technical Brief Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact in HIV Programming Allocation Period 2023-2025
31. The Global Fund (2022) Technical Brief Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact in HIV Programming Allocation Period 2023-2025
32. International Network of People who Use Drugs (2017), Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs, https://inpud.net/wp-content/uploads/2022/01/The-IDUIT-Brief-Guide-for-PUDs-Online.pdf
33. Harm Reduction International (2022) Global State of Harm Reduction 2022. London: Harm Reduction International
34. Harm Reduction International (2021) Integrated and Person-Centred Harm Reduction Services. Available at https://hri.global/wp-content/uploads/2021/11/HRI_Integrated_Services_Briefing-2021.pdf
35. UNAIDS 2022. IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf
36. Technical Review Panel (July 2022). 2020-2022 Technical Review Panel Observations Report. Available at: https://www.theglobalfund.org/media/12137/trp_2020-2022observations_report_en.pdf
37. Harm Reduction International (2021) Making the investment case: Cost-effectiveness evidence for harm reduction. London: Harm Reduction International. Available from https://hri.global/wp-content/uploads/2020/04/HRI-BRIEFING-APRIL-2020-NOV21-LOWRES.pdf
38. Wilson, D. et al. (2015) The cost-effectiveness of harm reduction, International Journal of Drug Policy, 26, p.S5–11.
39. Wilson, D. et al. (2015) The cost-effectiveness of harm reduction, International Journal of Drug Policy, 26, p.S5–11.
40. Wilson, D. et al. (2015) The cost-effectiveness of harm reduction, International Journal of Drug Policy, 26, p.S5–11.
41. Wilson, D. et al. (2015) The cost-effectiveness of harm reduction, International Journal of Drug Policy, 26, p.S5–11.
42. UNAIDS 2022. IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update_en.pdf
43. Harm Reduction International (2021) Making the investment case: Cost-effectiveness evidence for harm reduction. London: Harm Reduction International. Available from https://hri.global/wp-content/uploads/2020/04/HRI-BRIEFING-APRIL-2020-NOV21-LOWRES.pdf
44. Technical Review Panel (July 2022). 2020-2022 Technical Review Panel Observations Report. Available at: https://www.theglobalfund.org/media/12137/trp_2020-2022observations_report_en.pdf
45. Harm Reduction International (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. Harm Reduction International, London https://www.hri.global/files/2021/08/09/HRI-FAILURE-TO-FUND-REPORT-LOWRES.PDF
46. Harm Reduction International (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. Harm Reduction International, London https://www.hri.global/files/2021/08/09/HRI-FAILURE-TO-FUND-REPORT-LOWRES.PDF
47. Harm Reduction International (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. Harm Reduction International, London https://www.hri.global/files/2021/08/09/HRI-FAILURE-TO-FUND-REPORT-LOWRES.PDF
48. Harm Reduction International (2021), HRI (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. Harm Reduction International, London https://www.hri.global/files/2021/08/09/HRI-FAILURE-TO-FUND-REPORT-LOWRES.PDF
49. The Global Fund (2021) Fight for what counts Investment case Seventh Replenishment 2022. Available from: https://www.theglobalfund.org/media/11798/publication_seventh-replenishment-investment-case_report_en.pdf
50. Technical Review Panel (July 2022). 2020-2022 Technical Review Panel Observations Report.

Available at: https://www.theglobalfund.org/media/12137/trp_2020-2022observations_report_en.pdf

51. Extracted from The Global Fund (2022) Modular Framework Handbook Allocation Period 2023-2025. Available from: https://www.theglobalfund.org/media/4309/fundingmodel_modularframework_handbook_en.pdf

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