THE COST OF COMPLACENCY: A HARM REDUCTION FUNDING CRISIS

HARM REDUCTION INTERNATIONAL

The Cost of Complacency:
A Harm Reduction Funding Crisis
Charlotte Davies, Catherine Cook
and Gaj Gurung
© Harm Reduction International

ISBN 978-1-915255-15-0
Copy-edited by Hester Phillips
Designed by Escola
Harm Reduction International, 61 Mansell
Street, Aldgate London E1 8AN
E-mail: office@hri.global
Website: www.hri.global

Harm Reduction International (HRI) envisions a world in which drug policies uphold dignity, health and rights. We use data and advocacy to promote harm reduction and drug policy reform. We show how rights-based, evidence-informed responses to drugs contribute to healthier, safer societies, and why investing in harm reduction makes sense. HRI is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

Acknowledgements
This report would not be possible without data made available or shared by international donors, multilateral agencies and civil society and community experts, many of whom provided advice throughout the drafting process. We would specifically like to thank Aura Frangioni, David Traynor, Susie McLean, Maria Phelan and Jadmin Mostel, the Global Fund to Fight AIDS, TB and Malaria; William Miller, PEPFAR; Thomas Brigden, Elton John AIDS Foundation; Laetitia Drean and Eric Fleutelot, Expertise France; Caterina Gironda, Funders Concerned About AIDS; Georg Bröring and Olga Rychkova, Robert Carr Fund; Sarah Evans and Matthew Wilson, Open Society Foundations; Binod Mahanty, Ministry Of Health, Government of Germany; Daniel Brombacher and Hanna Rozhkova, GIZ; Jamie Bridge, International Drug Policy Consortium; Ardhany Suryadarma, Rumah Cemara; Raya Dashovska and Fariba Soltani, UNODC; Ancella Voets, Mainline; Karen Timmermans, UNITAID; Finn Jarle Rode and Maria Carolina Salazar, The Hepatitis Fund; Deepak Mattur, UNAIDS; Elie Aaraj, Middle East and North Africa Harm Reduction Association; Moira Beery, Love Alliance; Shaun Mellors, Savita Garg and Jenny Cozins, ViiV Healthcare; To Chau Tran, Sidaction; Monica Djupvik, Jolijn van Haaren, Dutch Ministry of Foreign Affairs; Raúl Félix Tovar, Corporación Viviendo; Shaun Shelly, HIV/TB Care; Maja Stošić, President of the Association Health Mission, Serbia; Goran Radisavljević, Association for the Development of Sustainable Communities, Zajecar, Serbia; Kunal Kishore, India HIV/AIDS Alliance; Yatie Jonet, Community Advocate, Malaysia.

Thanks are also owed to colleagues at Harm Reduction International for their feedback and support in preparing this report: Cinzia Brentari, Naomi Burke-Shyne, Paulina Cortez, Colleen Daniels, Ugochi Egwu, Giada Girelli, Marcela Jofre, Ajeng Larasati, Lucy O'Hare, Maddie O'Hare, Suchitra Rajagopalan, and Anne Taiwo.

Any errors are the sole responsibility of Harm Reduction International.

This report was made possible by financial contributions from the Robert Carr Fund and the Elton John AIDS Foundation.

CONTENTS

EXECUTIVE SUMMARY

Harm reduction encompasses a range of health and social services and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws. Grounded in justice and human rights, it focuses on positive change and on working with people without judgement, coercion and discrimination or requiring that people stop using drugs as a precondition of support. Harm reduction services, such as needle and syringe programmes (NSPs) and opioid agonist therapy (OAT), are proven to be effective and cost-effective public health interventions. Investing in these programmes not only improves people's lives and public health outcomes, it also contributes to reducing the social and economic impacts associated with drug use. Despite this, governments around the world prioritise punitive responses to drugs. People who use drugs are criminalised and marginalised, resulting in people who use drugs experiencing greater barriers to accessing health services than other people.

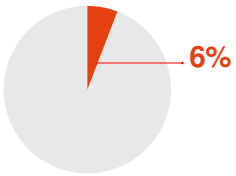
Historically, funding for harm reduction in low- and middle-income countries has been part of the HIV response, with a comprehensive package of interventions endorsed at the highest political level as part of the global commitment to end AIDS by 2030. However, in the 15 years that Harm Reduction International (HRI) has monitored harm reduction funding, our findings have been consistently bleak. Inadequate financial support for services and for the advocacy efforts needed to drive political commitment within countries continues to prevent harm reduction initiatives being implemented at scale.

The number of international donors investing in harm reduction remains small, there is increasing dependence on the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and harm reduction funding is vulnerable to donors' shifting priorities. Domestic funding for harm reduction is even more fragile, while a lack of data prevents civil society from monitoring funding levels and holding governments to account.

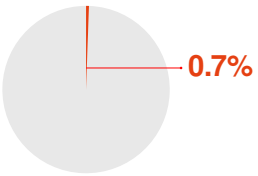
This report explores the state of harm reduction funding in low- and middle-income countries, using information collected from harm reduction donors and a desk review of literature and data on domestic funding. The findings show that, despite many high-level political commitments, we are no closer to achieving a sustainable harm reduction response.

Governments have committed to ending AIDS and tuberculosis, eliminating viral hepatitis and providing universal access to healthcare by 2030. These goals cannot be reached while prevention programmes for key populations, such as people who use drugs, continue to be underfunded. Furthermore, any progress achieved by 2030 is unlikely to be sustainable without greater investment in community-led programmes and law and policy reform.

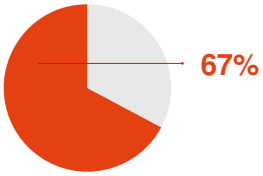
Key Statistics



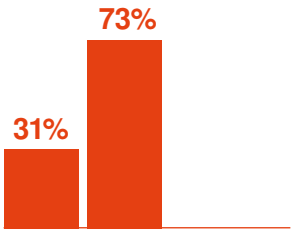
Identified harm reduction funding amounted to USD 151 million in 2022. This is just 6% of the USD 2.7 billion needed annually by 2025. This leaves a funding gap of 94%, which compares to a funding gap of 29% for the overall HIV response.



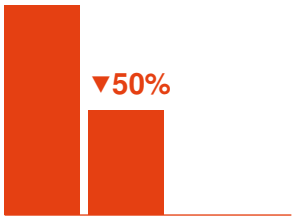
Harm reduction funding accounted for only 0.7% of total HIV funding in 2022 (from donors and domestic budgets).



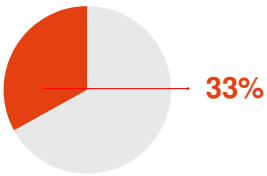
While donor investment accounted for 52% of total harm reduction funding in 2019, it constituted 67% (USD 101.6 million) of the total funding we have identified for harm reduction in 2022.



Bilateral funding has reduced substantially and harm reduction is more reliant on multilateral funding than ever before. In 2022, the Global Fund accounted for 73% of all donor funding for harm reduction, compared to just 31% in 2007.



Donor funding for harm reduction has halved in real value over the past 15 years. Had donor funding levels remained stable over the past 15 years, rising in line with inflation, low- and middle-income countries would have received USD 202.1 million of harm reduction funding from donors in 2022.



We identified USD 49.7 million of domestic funding for harm reduction,[1] representing 33% of all harm reduction funding identified in 2022. Domestic investment in harm reduction accounted for a mere 0.4% of all domestic funding for HIV in 2022.[2]

1. For some countries we used data for 2021 when data for 2022 were unavailable.
2. Estimated at USD 12.5 billion, see UNAIDS' HIV Financial Dashboard.

Key findings

Harm reduction funding is only 6% of the estimated need in low- and middle-income countries.	Overall USD 151 million of harm reduction funding was identified in 2022 amounting to just 6% of the USD 2.7 billion needed annually by 2025. This leaves a funding gap of 94%, which compares to a funding gap of 29% for the overall HIV response. This vast funding gap has the potential to destabilise the HIV response.
Community-led responses to drugs are effective but there is currently no way to hold donors accountable on funding for community-led organisations.	The majority of donors do not record data on their funding for community-led organisations, and there are no mechanisms to hold donors or donor governments accountable for their political commitments. Where there is funding, it is minimal and it does little to support sustainable community-led programmes. This is despite clear evidence of the positive impact of community-led actions during COVID-19 lockdowns and in Ukraine, particularly when community-led organisations were provided with flexible and enhanced funding. At the same time, donors that have traditionally provided funding for advocacy, policy change efforts and community system strengthening are diminishing.
There has been a decrease in identified domestic funding for harm reduction.	Domestic harm reduction investments are reducing in countries that previously had the highest levels of investment. Many countries have no identifiable domestic financing. The absence of harm reduction funding in public budgets and the poor availability and quality of domestic funding data hinders the monitoring of domestic harm reduction funding levels.
There is little evidence of sustainable domestic harm reduction responses particularly following donor withdrawal.	The failure to put communities at the heart of harm reduction responses, to ensure harm reduction is embedded in health systems and to fund ongoing advocacy efforts has inhibited sustainable domestic harm reduction responses.
Harm reduction funding has been negatively impacted by the shift away from bilateral funding to multilateral funding.	Despite the proven effectiveness of harm reduction and the significant unmet need for services in low- and middle-income countries, multilateral funding models have not sustained the funding levels that were reached when bilateral investments in harm reduction were most common. This has led to a deficit in funding from donor governments.
The Global Fund remains the largest donor for harm reduction, but it requires additional funding mechanisms to boost harm reduction funding.	While the Global Fund is the largest harm reduction donor, political dynamics and priorities within countries make it difficult for harm reduction services to get a slice of the funding pie. Furthermore, structural barriers and financial reporting requirements inhibit access to funding for marginalised, key population-led organisations. Addressing these inequities requires a dedicated funding stream for community-led key population organisations.

Recommendations

Harm reduction donors and governments must make substantial additional investments to meet global goals to end AIDS as a public health threat by 2030.	Failure to do so has the potential to destabilise progress in reducing HIV and rollback the gains that have been made.
Funding for advocacy should be increased to help drive the drug law and policy reform required for sustainable harm reduction responses.	The 10-10-10 targets are crucial to ending AIDS as a public health threat by 2030.[3] Decriminalising drug use and people who use drugs will maximise the impact of existing harm reduction investments and will also save governments money. International donors and governments must put an end to ineffective and unjust punitive responses to drugs. This will free up essential funds to invest in programmes that prioritise community, health and justice. This includes harm reduction as well as other social and community programmes that benefit marginalised people and lead to healthier, safer societies.
International donors and governments must invest in community-led organisations as part of national health systems to create and protect resilient and sustainable harm reduction programmes.	Community-led organisations must be given the flexibility to advocate, deliver services, monitor programmes and engage as experts in decision-making processes. Mechanisms should be put in place to measure progress on the extent to which community-led organisations are supported, in line with the 30-80-60 targets within the Global AIDS Strategy.[4]
International donors should support governments to establish the financing mechanisms required for domestic funding of harm reduction.	Where it is not yet in place, efforts to support readiness for the public financing of harm reduction must be supported. This includes funding technical assistance for governments to develop social contracting mechanisms and to integrate harm reduction within health insurance schemes that include people who use drugs, plus core funding for community-led and civil society budget advocacy.
Harm reduction needs to be viewed as broader than disease prevention.	It is a social justice movement to challenge exclusion, criminalisation, stigma and discrimination. It has natural allies in racial justice, Indigenous rights, climate justice, criminal legal reform, women's rights, sex workers' rights and LGBTQI+ rights. Looking beyond HIV donors, the harm reduction sector must champion the broad health and social value of harm reduction investments. The economic, health and social benefits of harm reduction investments should be rigorously documented, including by showing how harm reduction programmes have wider health and social benefits beyond HIV and viral hepatitis prevention, and how repealing punitive drug laws and policies benefit the wider community.

3. See UNAIDS (2021), *Global AIDS Strategy 2021-2026 – End Inequalities. End AIDS*, p.10.
4. See UNAIDS (2021), *Global AIDS Strategy 2021-2026 – End Inequalities. End AIDS*, p.62.

1.

INTRODUCTION AND BACKGROUND

1.1 The global state of harm reduction

Harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.[5] Since 2007, HRI has monitored the implementation of harm reduction services, policies and programmes around the world. After a period of stagnation between 2014 and 2020, we have reported an increase in the number of countries including harm reduction within their national policies, up to 109 countries globally in 2023. However, only half of all low- and middle-income countries (n=67) included harm reduction in their national policies in 2023, and less than half (n=57) had at least one needle and syringe programme (NSP) or opioid agonist therapy (OAT) service operational. There has been an increase in countries implementing key harm reduction services, with new NSPs opening in five African countries[6], two new low- and middle-income countries opening officially sanctioned drug consumption rooms[7] and four countries[8] introducing OAT for the first time.[9] While these increases are encouraging, the coverage and scale of harm reduction is still limited overall. Access to these services remains unequal within and between regions and countries.

Governments continue to prioritise punitive approaches to drugs in their laws and policies. This directly hinders harm reduction service implementation across the globe, particularly in certain countries in Latin America and the Caribbean, the Middle East and North Africa (MENA), Asia, and West, East and Southern Africa. Women, young people, LGBTQI+ people, people who are migrants or refugees, Black people, Brown people and Indigenous people face additional barriers to accessing services and lack services tailored to their needs.

Since 2020, the world has experienced several acute crises which have tested the resilience of harm reduction services. Economic, political, humanitarian and environmental crises have also put harm reduction at risk. Harm reduction services, particularly those led by the community of people who use drugs and civil society have shown their ability to reach those most in need and adapt to changing circumstances in times of crises.[10] [11]

"Governments continue to prioritise punitive approaches to drugs in their laws and policies. This directly hinders harm reduction service implementation across the globe."

1. 2 High-level political commitments supporting scaled-up harm reduction

Harm reduction in low- and middle- income countries has historically been framed within the global effort to end AIDS. However, since we began monitoring harm reduction funding in low- and middle-income countries, data has consistently shown a drastic shortfall in international donor and domestic funding, far below the level required to meet globally-agreed harm reduction targets. *Failure to Fund*, HRI's last funding report, identified a large reduction in harm reduction funding in low- and middle-income countries between 2016 and 2019 (from USD 188 million to USD 131 million), following a decade of stagnation in funding levels (USD 160 million, equivalent to USD 187 million in 2016 prices).[12]

5 Harm Reduction International, 'What is harm reduction?' [webpage, accessed May 2024].
6 Burundi, Côte d'Ivoire, Democratic Republic of the Congo, Guinea and Uganda.
7 Mexico and Colombia.
8 Algeria, Mozambique, Uganda and Egypt.
9 Harm Reduction International (2022), The Global State of Harm Reduction 2022 and The Global State of Harm Reduction 2023: Key data update.
10 Csak R et al (2021), 'Harm reduction must be recognised an essential public health intervention during crises', *Harm Reduction Journal*, 18:128
11 INPUD (2022), Surviving and Thriving: Lessons in Successful Advocacy from Drug User-Led Networks.
12 Harm Reduction International (2016), *The Lost Decade: Neglect for harm reduction funding and the health crisis among people who use drugs*.

Since we last reported in 2021, harm reduction has gained further support in UNAIDS and the World Health Organization's (WHO) global strategies. It is identified as a key component to ending AIDS by 2030 as set out in UNAIDS' Global AIDS Strategy 2021-2026. The WHO's global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections (STIs) for 2022-2030 further emphasise the need for an intensified harm reduction response and demonstrate harm reduction's wider impact outside of the HIV response (see Box 1).

Emphasis has also increased on the need for legal and policy reform. UNAIDS' 10-10-10 targets (see Box 1) recognise the damaging impact of stigma and the criminalisation of key populations, including people who use drugs. The strategy sets a target for 90% of countries to have repealed punitive laws and policies by 2025. At last count, of 128 countries reporting to UNAIDS, 115 still criminalised drug use or possession for personal use.[13] Updated guidance from WHO on key population programmes lists the removal of punitive laws and policies and other structural barriers to health services as 'essential for impact'.[14]

The historic adoption of a harm reduction resolution at the UN Commission on Narcotic Drugs in 2024 marked the first time this forum recognised harm reduction as an important part of an effective public health response.[15] However, spending on drug law enforcement and imprisonment continues to dwarf investment in harm reduction; with countries spending over 600 times more on punitive policies than on harm reduction.[16] So entrenched is this approach, that even aid budgets intended to support progress towards health and development goals are used to fund punitive drug control.[17]

While new strategies from the two largest harm reduction donors the Global Fund's 2023 to 2028 strategy[18] and PEPFAR's five-year strategy, which began in 2022[19] are in alignment with international commitments and guidance, it is unclear how far these strategies will translate into the action needed to kickstart harm reduction and close the funding gap.

More broadly, competing priorities are contributing to shifts in donor funding and there is mounting concern among donors and implementers about fragmentation and inefficiencies within the global health architecture. This concern arises from numerous multilateral and bilateral institutions vying for resources, investing in overlapping areas and imposing excessive coordination and reporting burdens on recipient countries.[20]

As we move closer to the target deadlines there is increased focus on the sustainability of the HIV response. UNAIDS' HIV Response Sustainability Primer highlights the need for adequate, sustainable and equitable financing alongside enabling policies, political commitment, evidence-based programmes and people-centred healthcare and social systems.

This report assesses whether global political commitments have galvanised donor and government action and measures the progress that has been made in moving towards a sustainable harm reduction response.

13 Harm Reduction International (2022) *Global State of harm reduction 2022*
14 World Health Organization (2022) *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*
15 Commission on Narcotic Drugs (2024), *Sixty-seventh session Vienna, 14–22 March 2024 Agenda item 5 (e).*
16 Harm Reduction International (2020), 'Assessing law enforcement expenditure in Indonesia: a case study', *Summing it up: Building evidence to inform advocacy for harm reduction funding in Asia.*
17 Harm Reduction International (2023), *Aid for the war on drugs.*
18 The Global Fund (2022), *Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy (2023-2028).*
19 PEPFAR (2022), *PEPFAR's Five-year Strategy: Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030.*
20 UNAIDS (2024), *HIV response sustainability primer.*

Box 1

Current high-level targets and commitments related to harm reduction

UNAIDS' Global AIDS Strategy 2021-2026

HIV prevention for key populations received unprecedented urgency and focus in UNAIDS' Global AIDS Strategy 2021-2026 – End Inequalities. End AIDS, which calls on countries to utilise the full potential of HIV prevention tools, including for people who inject drugs and people in prison and other closed settings.

To reach the 2025 high-level targets for HIV 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. This includes NSPs, OAT, naloxone and interventions for non-injecting drug use as well as prevention, diagnosis and treatment of tuberculosis and viral hepatitis, community-led outreach and psychosocial support.

The strategy also includes the 30-80-60 targets relating to community-led responses. By 2025, these aim for:

- 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 that support the achievement of societal enablers to be delivered by community-led organisations.

In addition, by 2025 there is a target to ensure that:

- Fewer than 10% of countries have punitive legal and policy environments which lead to the denial or limitation of access to services.

The WHO's Global Health Sector Strategies 2022-2030 on HIV, viral hepatitis and STIs

The WHO's global health sector strategies include people who inject and use drugs as a potential priority population across national responses to HIV, viral hepatitis and STIs. Harm reduction and treatment interventions for people who inject drugs is articulated as a shared intervention for a people-centred response to HIV, viral hepatitis and STIs.

The strategies include a shared target to reduce the number of new HIV and viral hepatitis cases per year to less than 1.5 million by 2025. Within the viral hepatitis strategy, there is an additional target to reduce the number of new hepatitis C infections among people who inject drugs per year to 3 per 100 by 2025.

The strategies include community engagement as one of the five core approaches to end AIDS and the epidemics of viral hepatitis and STIs by 2030. Supporting the pivotal role of community and civil society in advocacy, policy making, delivering services, addressing stigma and discrimination and tackling social and structural barriers is highlighted as a shared action across responses to HIV, viral hepatitis and STIs.

1. 3 The epidemiological case for investing in harm reduction

While harm reduction has many benefits beyond HIV prevention, funding has historically been provided as part of the HIV response. Even in this narrow framework, epidemiological data clearly shows that greater targeted investment is needed. Globally, HIV infections decreased from 1.7 million in 2010 to 1.1 million in 2022, mainly as a result of scaled up prevention, testing and treatment in countries with high transmission among the general population (primarily in East and Southern Africa). But in regions where most HIV transmission occurs among key populations there has been little change as underlying inequalities continue to slow progress in reaching global AIDS targets.[21]

The proportion of HIV infections happening among people who inject drugs increased between 2010 and 2022 (from 6.8% to 8%). People who inject drugs are 15 times more likely to acquire HIV compared to the general population, although this differs substantially across regions with four regions showing higher than average risk: the MENA region (88 times higher), Latin America (46 times higher), Asia Pacific (42 times higher) and Eastern Europe and Central Asia (EECA) (19 times higher).[22] UNAIDS reports that new HIV epidemics appear to be emerging in some regions, such as MENA and EECA. This is mainly due to a lack of prevention services for key populations and to the barriers posed by punitive laws, violence, social stigma and discrimination.[23]

Drug use trend monitoring suggests an increase in stimulant use and a decline in heroin use in some parts of the world.[24] UN guidance recognises the importance of reaching people who use and inject stimulants with harm reduction programmes due to increased risk of HIV, hepatitis B and C transmission.[25]

People do not fit neatly into one group, therefore integrated, person-centred services and health interventions tailored to meet people's needs are far more effective than siloed approaches.[26] Integrated services can provide holistic care and support and combat the effects of stigma and discrimination. These types of services enable healthcare providers to get to know their clients and make sure they can access the safest and most relevant commodities, such as condoms and PrEP to prevent the sexual transmission of HIV.

Communities and countries need better control of strategic information and data to understand the needs of their communities and to inform appropriate responses. However, a systematic review found that only 15 low- and middle-income countries had carried out HIV and/or HCV incidence studies, many of which were old,[27] while UNAIDS found that investments in HIV prevention are poorly linked with epidemiological trends.[28] Without accurate data, it is difficult to prioritise interventions, allocate resources effectively and evaluate the impact of interventions over time.

While harm reduction has traditionally been housed within HIV responses, its benefits to individuals and communities is far wider. This includes the reduction of other blood borne viruses such as hepatitis C, which is highly prevalent among people who inject drugs. Recognising these wider benefits, the WHO includes harm reduction as an essential component of universal health coverage. However, many countries are falling far short of recommended targets for investment in health,[29] and failing to reach people who use drugs through health insurance schemes.[30]

Embedding community-led harm reduction programmes into public health responses would help facilitate timely responses to changing patterns of use, harms and needs, while advocacy for the removal of policy and legal barriers will help ensure people who use drugs can actually access healthcare services.

21 Ibid.
22 Korenromp, E. L. et al. (2024), 'New HIV Infections Among Key Populations and Their Partners in 2010 and 2022, by World Region: A Multisources Estimation', *Journal of Acquired Immune Deficiency Syndromes*, 95(1S):p e34-e45. Supplementary material qai-95-e34-s002.xlsx
23 UNAIDS (2023), *The path that ends AIDS: 2023 UNAIDS global AIDS update*.
24 UNODC (2024) World Drug Report
25 UNODC, WHO & UNAIDS (2019) *HIV prevention, treatment, care and support for people who use stimulant drugs*
26 Harm Reduction International (2021), *Integrated and Person-Centred Harm Reduction Services*.
27 Artenie A, et al. (2023), 'HIV and HCV Incidence Review Collaborative Group. Incidence of HIV and hepatitis C virus among people who inject drugs, and associations with age and sex or gender: a global systematic review and meta-analysis', Supplementary Material *Lancet Gastroenterol Hepatol*, 8(6):533-552.
28 UNAIDS (2010), *Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies 10 to Reduce New HIV Infections A UNAIDS Discussion Paper.*
29 Human Rights Watch (11 April 2024), 'Global Failures on Healthcare Funding' [web article, accessed May 2024].
30 UNAIDS (2022), *Key populations are being left behind in universal health coverage: landscape review of health insurance schemes in the Asia-Pacific region.*

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 report identified USD 151 million of funding for harm reduction in low- and middle-income countries in 2022.[31] This is more than the USD 131 million identified for 2019 in HRI's *Failure to Fund* report but substantially less than the amount identified in our previous research, particularly when adjusting for inflation.[32]

In 2022, a total of USD 22.4 billion was made available for the HIV response in low- and middle-income countries, leaving a 29% funding gap to meet estimated need by 2025. Historically, countries tend to spend relatively little on HIV prevention and key population programmes, leading UNAIDS to describe the resources committed to HIV prevention efforts as inadequate and not on a large enough scale.[33] It is therefore unsurprising that the funding gap for HIV prevention for key populations is much larger than the funding gap for the HIV response as a whole, standing at an estimated 90% in 2022.[34] Despite years of global political commitments supporting the scaling up of harm reduction services, there is a huge chasm between need and existing funding levels. Harm reduction funding accounted for only 0.7% of total HIV funding in 2022, with the harm reduction funding gap standing at a staggering 94% of the resources needed by 2025 (USD 2.7 billion).

While donor investment accounted for 52% of total harm reduction funding in 2019, it constituted 67% (USD 101.6 million) of the total funding we have identified for harm reduction in 2022. This demonstrates how important it is for donors to continue supporting harm reduction efforts, especially as domestic governments are failing to provide the resources needed to fully implement harm reduction programmes. Domestic funding for harm reduction appeared to be increasing in 2019. But substantial decreases in identified funding for countries with previously large investments, such as Iran and Vietnam, mean that we were only able to identify USD 49.7 million of domestic harm reduction funding in 2022. This is below the levels identified in 2019 and a similar level to 2016 without adjusting for inflation.

UNAIDS reports that, overall, domestic funding for HIV in low- and middle-income countries has fallen for three consecutive years. Transitions from donor to domestic funding for HIV have been delayed due to the COVID-19 pandemic and other emergency situations, including increasing conflicts and subsequent humanitarian crises.[35] This has led to worsening poverty, deepening debt crises and increases in the cost of programme delivery and commodities. Meanwhile, progress on human rights has stalled, and drug use continues to be criminalised and stigmatised. Spending on key populations lags far behind the estimated need across all regions but particularly in MENA (*see Figure 1*).

This is an alarming situation. It shows that more effort is needed to achieve sustainable financing for harm reduction, and to support underlying social enablers and health systems strengthening. The recent closure of the UNAIDS MENA regional office led civil society to raise concerns about the lack of commitment, retreating resources and the waning focus on HIV.[36]

"Despite years of global political commitments supporting the scaling up of harm reduction services, there is a huge chasm between need and existing funding levels."

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

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

33 Global Prevention Coalition (2024), *HIV Prevention: From Crisis to Opportunity Key findings from the 2023 Global HIV Prevention Coalition scorecards.*

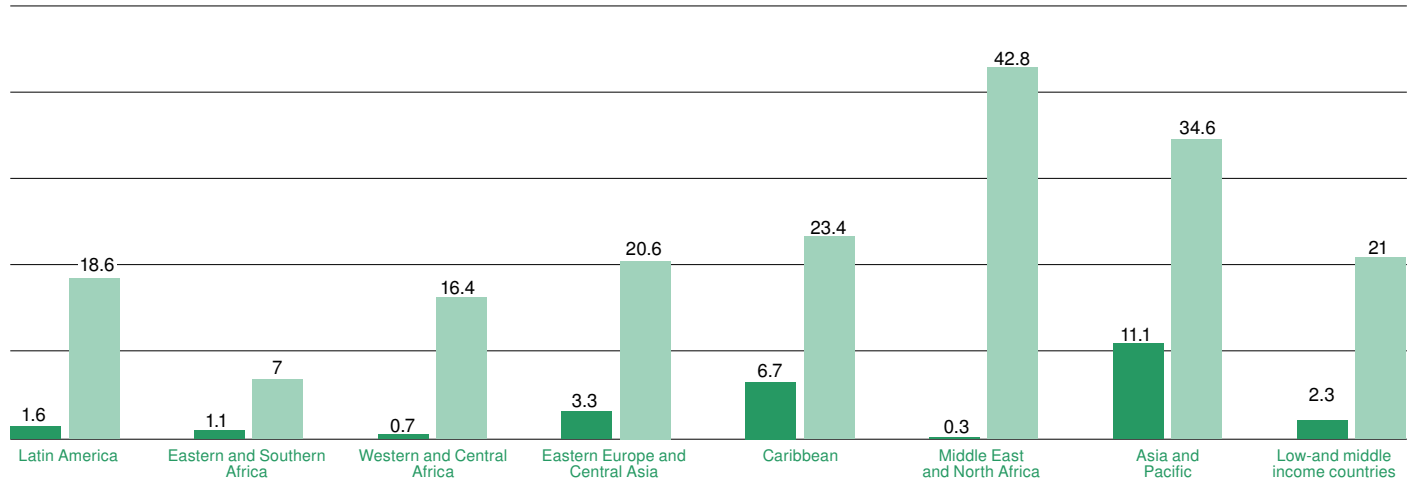
34 UNAIDS (2023), World AIDS Day 2023 Fact Sheet.

35 UNAIDS (2023), *The path that ends AIDS: UNAIDS global AIDS update 2023.*

36 MENA H Coalition (2023), *Safeguarding the fight against HIV/AIDS in the MENA region: Collaboration and resource mobilization. Regional Advocacy Brief for the Global Fund Board Meeting 2023.*

Figure 1

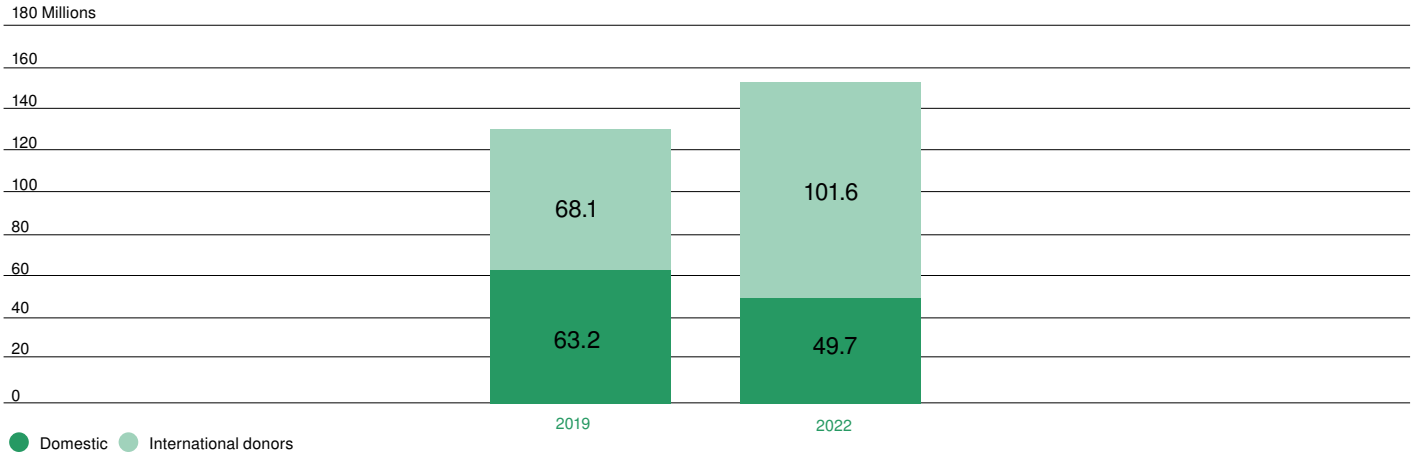
Percentage of total HIV spending on prevention and societal enablers for key populations, 2022, and projected share needed, 2025, in low- and middle-income countries, by region



Source: UNAIDS 2023 [37]

Figure 2

Amount of harm reduction funding (USD millions) by funding source in 2019 and 2022



37 UNAIDS (2023), *The path that ends AIDS: UNAIDS global AIDS update 2023.*

Box 2

Defining harm reduction in relation to funding

Harm reduction encompasses a range of health and social services and programmes. These include, but are not limited to, drug consumption rooms, NSPs, OAT, non-abstinence-based housing and employment initiatives, drug checking, overdose prevention and reversal, psychosocial support and the provision of information on safer drug use. These approaches are cost-effective, evidence-based and have a positive impact on individual and community health. The meaningful involvement of people who use drugs in designing, implementing and evaluating programmes and policies for people who use drugs is central to a successful harm reduction approach.

Harm reduction also seeks to improve drug laws and policies so they are not detrimental to the health and wellbeing of people who use drugs and associated communities. Many policies around the world create and exacerbate the potential risk and harms of drug use. Harm reduction challenges laws and policies that contribute to drug-related harms.

For this report, as in previous editions, we attempted to identify funds directed to the comprehensive package of harm reduction interventions as well as funding for related training, capacity building, research, policy reform and advocacy in low- and middle-income countries. The difficulties inherent in isolating funding for services such as antiretroviral treatment (ART) for people who use drugs mean these types of services are unlikely to be captured here. Given current political commitments, it was important to examine the extent to which funding for community-led organisations could be identified.

2.2 Harm reduction funding data problems hinder the monitoring of progress

HRI continues to play a civil society watchdog role by monitoring funding for harm reduction. However, as in previous reports, we have encountered difficulties tracking harm reduction expenditure. Publicly available data in UNAIDS and Global Fund databases do not cover all countries, and data within them is not always comparable or verified. Often, the kind of data available are budgets or estimates rather than actual expenditure data. Despite efforts to make data more publicly available in online repositories, we found a marked reduction in data availability and quality during this research.

Due to data recording and quality issues, the Global Fund was unable to provide complete data on harm reduction for its allocation period 2020-2022. To provide an overall estimate, assumptions were made and applied across the entire HIV prevention budget (*see Box 3*). This issue has been rectified for the 2023-2025 grant cycle, and the Global Fund is making efforts to improve HIV prevention funding data. Nevertheless, our inability to track changes in funding for different types of interventions delivered to people who use drugs during a period in which a shift in drug use has been recognised leaves a gaping hole in our understanding of the harm reduction funding landscape.

The Global Fund data issues mean that, unlike in our previous reports, we are unable to identify donor funding at a country level. Resource needs estimates vary immensely between countries and regions, and it is essential that we are able to assess the extent to which harm reduction funding is meeting actual need. Without accurate and up-to-date funding data, we are unable to hold governments and donors to account. These data gaps must be filled to allow the monitoring of harm reduction funding over time and to inform the decision-making processes that are vital for effective resource allocation.

There remains a lack of quality data on domestic harm reduction funding, despite the growing emphasis on domestic investment. Data gaps limit our ability to determine the extent to which harm reduction has been integrated into universal health coverage efforts

at a national level. Furthermore, we do not have data on the level of user fees, co-payments and informal out-of-pocket spending that people make towards their own harm reduction services, yet this is likely to be a substantial amount.

To facilitate a comprehensive and evidence-based approach to public health and to safeguard the progress made, these data gaps need to be urgently addressed.

"HRI continues to play a civil society watchdog role by monitoring funding for harm reduction. However, as in previous reports, we have encountered difficulties tracking harm reduction expenditure."

"There remains a lack of quality data on domestic harm reduction funding, despite the growing emphasis on domestic investment."

3.

INTERNATIONAL DONOR FUNDING FOR HARM REDUCTION

3.1 Overview of donor support of harm reduction

Donor funding for harm reduction has halved in real value over the past 15 years. In 2022, we identified USD 101 million of harm reduction funding in low- and middle-income countries from international donors. This is an increase from the USD 68.1 million of funding identified in 2019 but well below levels identified in 2016 (USD 121 million) and 2007 (USD 136 million, or USD 159 million in 2016 terms).[38] Had donor funding levels remained stable over the past 15 years, rising in line with inflation, low- and middle-income countries would have received USD 202.1 million of harm reduction funding from donors in 2022. This means donor funding has halved in real value over this period, despite increased acknowledgement of the importance of HIV prevention for key populations within the HIV response.

In 2022, total HIV donor funding amounted to USD 8.2 billion. This is a similar level to 2020 but a reduction in the levels seen almost a decade ago.[39] Apart from the United States, donor governments have reduced their bilateral HIV funding by 57% in the last decade,[40] but contributions to multilateral organisations such as the Global Fund have not offset this reduction.

The harm reduction funding landscape has experienced an even more extreme shift away from bilateral funding, with further recent reductions occurring after two important Dutch Government funded programmes ended in 2020: the Partnership to Inspire, Transform and Connect the HIV Response (PITCH) and Bridging the Gaps. Harm reduction funding accounted for just 1% of all HIV donor funding in 2022.

"Donor funding for harm reduction has halved in real value over the past 15 years. In 2022, we identified USD 101 million of harm reduction funding in low- and middle-income countries from international donors. This is an increase from the USD 68.1 million of funding identified in 2019 but well below levels identified in 2016 (USD 121 million) and 2007 (USD 136 million)."

"In 2022, the Global Fund accounted for 73% of all donor funding for harm reduction, compared to just 31% in 2007."

Harm reduction funding is more heavily reliant on the Global Fund than at any point in the past. In 2022, the Global Fund accounted for 73% of all donor funding for harm reduction, compared to just 31% in 2007. Bilateral funding (excluding PEPFAR) has reduced from USD 73 million in 2007 to USD 5 million in 2022. While funding through the Global Fund has increased from USD 45 million to USD 74 million during this period, the level of donor government funding for harm reduction in 2022 represents a shortfall of USD 39 million compared to 2007, and this rises to USD 55 million when adjusted for inflation.

Donor governments that used to fund harm reduction bilaterally point to their funding of the Global Fund and UNAIDS as proof of their continued support for harm reduction. While these multilateral agencies are central to harm reduction, donor contributions are not earmarked and the shift to multilateral funding has clearly had a damaging effect on harm reduction funding levels. In the vast landscape of HIV funding, harm reduction often feels like a needle lost in the haystack, overshadowed by broader priorities.

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

39 Kaiser Family Foundation and UNAIDS (2023), *Donor Government Funding for HIV in Low- and Middle-Income Countries in 2022.*

40 UNAIDS (2022), *In Danger: UNAIDS Global AIDS Update 2022.*

Table 1 **Identified donor funding for harm reduction in USD, 2022**

Donors	2022	%	Notes on funding
The Global Fund	74,473,840	73%	Data has been provided by the Global Fund for prevention spend and estimated using assumptions due to incomplete data and quality issues. Other spend in non-prevention modules has not been captured.
United States President's Emergency Plan for AIDS Relief (PEPFAR)	7,949,017	8%	Data was downloaded from the PEPFAR Dashboard and includes information on funding for HIV prevention for people who use drugs. It is expected that overall funding for harm reduction is higher, given that some countries include people who use drugs in their overall key population programming.
Robert Carr Fund (RCF)	4,235,207	4%	Data has been provided by RCF; no further disaggregation possible.
Open Society Foundations (OSF)	3,860,008	4%	Data has been provided by OSF and adjusted by the research team to include only harm reduction low- and middle-income countries.
Expertise France	3,501,011	3%	Data provided by Expertise France and adjusted by the research team to estimate spend on people who use drugs among key population spend.
Elton John AIDS Foundation (EJAF)	3,104,254	3%	Data has been provided by EJAF.
Dutch Ministry of Foreign Affairs (MOFA)	1,530,048	2%	Data is for the Love Alliance programme and was provided to HRI by Aidsfonds.
United Nations Office on Drugs and Crime (UNODC)	1,400,000	1%	Data has been provided by UNODC. Data refers to intervention spend and excludes UNODC staff and running costs.
ViiV Healthcare	1,215,397	1%	Data provided by ViiV Healthcare covering both Positive Action and Government Affairs.
Yayasan Sime Darby (YSD)	200,750	<1%	Estimated from YSD Annual Report providing funding levels over a 3-year period.
Gilead	112,559	<1%	Data extracted from the Funders Concerned About AIDS database and provided to HRI.
Total	**101,582,092**		

PEPFAR continues to be an important supporter of harm reduction through bilateral channels in its focus countries, although it is still unable to fully support NSP due to the US Federal ban on purchasing needle and syringes. However, the large reduction in funding support for harm reduction from the Dutch Government in 2021 shows the fragility of donor funding and how vulnerable it is to political shifts; in 2019 the Dutch Government accounted for 8% of identified harm reduction spend but this reduced to 1% in 2022. The French Government is now the biggest source of non-PEPFAR bilateral harm reduction funding, accounting for 3% of all donor funding.

Open Society Foundations (OSF) has been crucial in providing funding for harm reduction and drug policy advocacy, but recent organisational changes have reduced this support and there are concerns that this could reduce even further. Other important donors such as the Robert Carr Fund (RCF) and Elton John AIDS Foundation (EJAF) continue to be vital sources of funding for advocacy and supporting networks of people who use drugs as well as championing harm reduction. In addition, funding from ViiV Healthcare has increased tenfold since our last research.

Of note is philanthropic in-country harm reduction support from Yayasan Sime Darby in Malaysia to fund a community-led organisation that was under threat of closure.[41] To assist countries in moving away from international donor support, harnessing the support of local actors will be crucial.

Other donors provide important funding for harm reduction but fell below our USD 100,000 threshold for inclusion in the table below. Nevertheless, small grants provided by donors such as Sidaction can have a large impact on community organisations. In addition, we know there are some harm reduction grants from governmental organisations, such as the German Government,[42] the Swiss Government and the European Commission, but either these fall below our inclusion threshold, we were unable to identify the amount of spend or there were concerns about double counting with international organisations such as UNODC.[43]

3.2 The Global Fund to fight AIDS, Tuberculosis and Malaria

The Global Fund is the largest funder of harm reduction services for people who use drugs in low- and middle-income countries. It plays a vital role in introducing and increasing access to harm reduction services through its country partnerships.[44] [45] Global Fund country grants provide a lifeline to sustain and scale-up harm reduction programmes for people who use drugs. The importance of the Global Fund as a source of support for harm reduction service provision, advocacy and the legal and policy reform required to reduce the barriers that prevent people who use drugs from accessing services cannot be overstated.[46] In 2022, it is estimated that the Global Fund's investments helped reach 6.8 million people from key populations with HIV prevention services, including 1.1 million people who use drugs.[47]

The Global Fund estimates that USD 74.5 million of funding was budgeted for harm reduction in 2022.[48] This represents 73% of all funding for harm reduction identified from international donors that year and an increased reliance on this funding. This dependence means that any reduction in harm reduction funding from the Global Fund is likely to dramatically and disproportionately affect harm reduction programmes in low- and middle-income countries, resulting in service closures and a reversal of gains made in preventing HIV among people who use drugs.

41 Sime Darby Yayasan (31 May 2021), 'Media: Malaysia's leading NGO for recovering People Who Inject Drugs receives critical lifeline from Yayasan Sime Darby' [web article, accessed May 2024].

42 We identified harm reduction funding through GIZ from the Global Partnership on Drug Policies and Development, working on behalf of the Federal Ministry for Economic Cooperation and Development (BMZ) and the Ministry of Health.

43 For example, the German Ministry of Health provided USD 1.4 million to the UNODC HIV Section, including for harm reduction interventions for people who use drugs in Ukraine and neighbouring countries (Moldova, Serbia, Montenegro) to mitigate the impact of the Russian war on Ukraine.

44 The Global Fund partnership included governments, multilateral agencies, bilateral partners, the private sector and civil society groups.

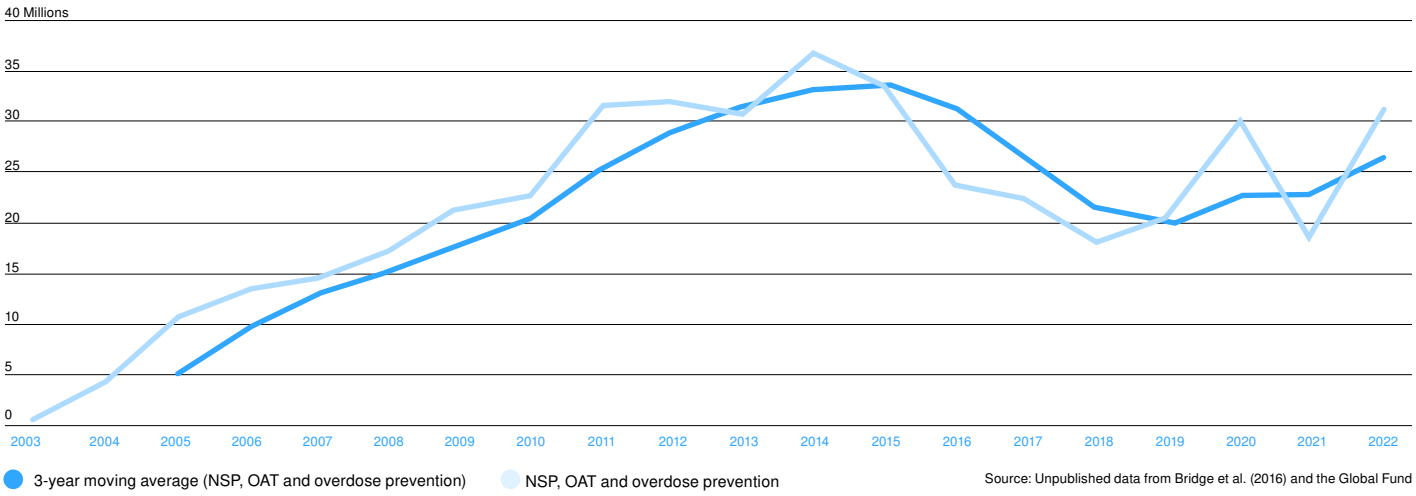
45 The Global Fund (2022), *Technical Brief Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact in HIV Programming Allocation Period 2023-2025.*

46 Global Fund Advocates Network, Harm Reduction International, International Network of People who Use Drugs, Eurasian Harm Reduction Association (2022), *Fully fund the Global Fund: Harm reduction brief.*

47 Global Fund (2023), 'Result Report 2023' [webpage accessed May 2024].

48 Data provided by the Global Fund, April 2024.

Figure 3 **Estimated Global Fund budget allocations to NSP, OAT and overdose prevention per year and as a 3-year moving average**



Source: Unpublished data from Bridge et al. (2016) and the Global Fund

Funding fluctuates annually; USD 44.9 million was identified from the Global Fund in 2021, reflecting, in part, the timing of funding applications from different countries in the various application windows, their different implementing periods and the extent to which harm reduction features in each country's funding request. Further information is required at a country level to better understand funding lifecycles and how they interact with service delivery.

The Global Fund's budget for harm reduction over the three-year period 2020-2022 was an estimated USD 174 million. This represents around 20% of the Global Fund's HIV prevention budget during this period. Harm reduction identified in HIV prevention modules accounted for under 3% of the total HIV budget during this time.[49]

The harm reduction funding identified here represents an increase since 2017-2019 (USD 128 million) but remains below the levels identified in the early 2010s.[50] Harm reduction funding was estimated to be USD 240 million between 2014-2016, but methodological changes makes it difficult to draw firm conclusions.

To our knowledge, no assessment has been carried out on the extent to which Global Fund harm reduction allocations result in budgeting, disbursement and actual expenditure. The lack of tracking of harm reduction funding through the Global Fund process, from application to grant-making, means that we are unable to identify barriers to funding or to the implementation of harm reduction grant components. We received anecdotal evidence during our research which suggested there were difficulties in implementing budgeted harm reduction plans in some countries. Furthermore, it is unclear to what extent harm reduction interventions for people who use drugs that are within a country's 'priority above allocation request' become funded (these are priority interventions which are part of a country's strategic plan that do not currently have funding).[51] Analysis shows that the value of unfunded plans for NSP and OAT exceeds those included within main Grant Cycle 6 country grants.[52]

The most consistent trend data available for Global Fund harm reduction funding is for the three key interventions of NSP, OAT and overdose prevention. Between 2011 and 2015, annual funding for these interventions was estimated to be over USD 30 million with a peak of around USD 37 million in 2014.[53] Funding decreased substantially after this, amounting to only USD 18 million in 2018 before increasing again from 2020 onwards.

Due to the fluctuations in annual budgets, Figure 3 shows funding as a three-year rolling average with the most recent trend upwards.

49 Data provided by the Global Fund, April 2024.

50 Unpublished data from Bridge J et al. (2016), 'The Global Fund to Fight AIDS, Tuberculosis and Malaria's investments in harm reduction through the rounds-based funding model (2002–2014)', *International Journal of Drug Policy*, 27, p132-137.

51 For more information on priority above allocation requests see the Global Fund (2020), *Frequently Asked Questions: Register of Unfunded Quality Demand.*

52 The Register of Unfunded Quality Demand for 2020-2022 contains USD 94.5 million of unfunded NSP and OAT interventions. See the Global Fund 'Underfunded Quality Demand' [webpage accessed May 2024].

53 Analysis of unpublished data from Bridge et al. (2016) 'The Global Fund to Fight AIDS, Tuberculosis and Malaria's investments in harm reduction through the rounds-based funding model (2002–2014)', *International Journal of Drug Policy*, 27,p132-137. Due to an absence of data, it was assumed that the first year of the grant budget was the year after the funding round took place. Data were also provided by the Global Fund.

Table 2 **Global Fund budget allocations for NSP, OAT and overdose prevention across grant cycles (USD); actual budget and budget adjusted for inflation (2014 prices)**

Donors	Grant cycle 4	Grant cycle 5	Grant cycle 6
Actual budget	USD 73.7 million	USD 74.6 million	USD 79.1 million
Budget (2014 prices)[55]	USD 73.7 million	USD 71.1 million	USD 72.4 million

The reasons for the decline from 2014 to 2018 are unclear. But it may partly stem from the change made to the Global Fund's funding model, which resulted in decreased HIV funding being available for a range of countries and less funding being rolled-over across multiple years, something which happened in the previous rounds-based funding model. Many upper-middle-income countries in Eastern Europe and Central Asia with concentrated HIV epidemics among people who use drugs had previously received high levels of funding and then received reduced funding amounts. For example, Kazakhstan received over USD 3 million a year in the early 2010s but USD 0.5 million in 2018. Vietnam, another country with large amounts of funding for NSP and OAT, planned to transition to domestic funding by 2018, and consequently Global Fund funding for these interventions reduced from around USD 9 million a year in 2015 and 2016 to USD 0.6 million in 2018.[54]

In addition to the impact of a country's application window, the timing of commodity purchases can affect annual trends over the grant cycle, as these account for over half of all budgeted funding for NSP and OAT. Analysis by grant cycle shows similar levels of funding on the three key interventions across Grant Cycle 4 to 6 (see Table 2).

The percentage of the funding that is spent on the two priority interventions (NSP and OAT) has changed over time. OAT accounted for 37% of funding on the three key interventions in Grant Cycle 4 and 49% in Grant Cycle 6, reflecting both a decrease in funding for NSP and an increase in funding for OAT (see Figure 4).

There has been an increase in the number of countries receiving funding for OAT across grant cycles, from 29 countries across Grant Cycle 5 to 37 countries across Grant Cycle 6. With Global Fund support, OAT was introduced in Algeria and Mozambique in 2020. In 2022, USD 17.6 million of funding was budgeted for OAT in a total of 35 countries. This is a large increase from USD 6.4 million in 2021, but it still only represents 1% of the estimated OAT resource need for 2025 across low- and middle-income countries. A substantial share of this funding went to Ukraine, including a large emergency grant via UNICEF, to support the uninterrupted supply of methadone following the Russian invasion; funding for OAT in Ukraine increased from USD 0.9m in 2021 to USD 6.6m in 2022.

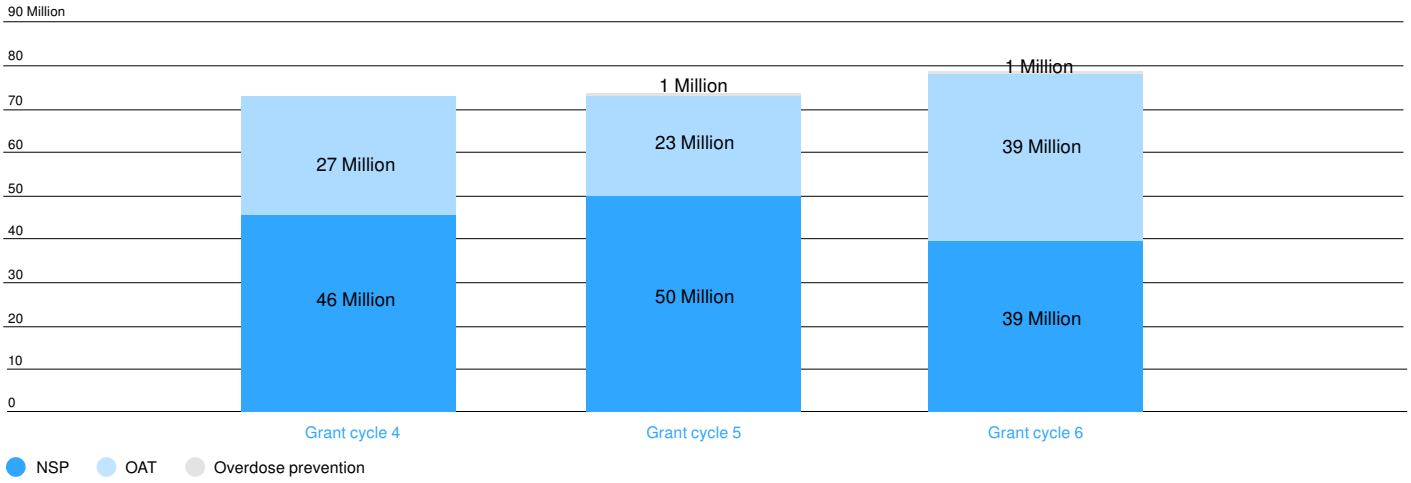
There has been a reduction in OAT funding going to countries in Southeast Asia and an increase in OAT funding going to countries in Africa. In 2022, USD 4.7 million went to African countries compared to only USD 0.2 million in 2017. The majority of this funding went to Tanzania (USD 1.9 million), South Africa (USD 0.9 million), Ethiopia (USD 0.5 million) and Nigeria (USD 0.5 million). Of note are the small amounts of funding that went to countries in West and Central Africa where no OAT was reported in the *Global State of Harm Reduction 2022*. These include Cameroon, Democratic Republic of Congo and Togo.

Identified funding for overdose prevention amounted to USD 0.26 million in 2022. The majority of this funding went to Kazakhstan and Ukraine, plus seven other countries which received smaller amounts. Between 2020 and 2022, 15 countries[55] received some funding for overdose prevention totalling USD 0.7 million.

54 For more information on transition from Global Fund funding in this period and detailed information on Kazakhstan and Vietnam, see Harm Reduction International (2018), *The Lost Decade: Neglect for harm reduction funding and the health crisis among people who use drugs*.

55 Bangladesh, Cabo Verde, Cambodia, Democratic Republic of Congo, Guinea-Bissau, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Myanmar, Russian Federation, Senegal, South Africa, Tajikistan, Thailand and Ukraine.

Figure 4 **The Global Fund budget for NSP, OAT and overdose prevention across grant cycles (USD millions)**



In 2020, under Grant Cycle 5, 55% of all identified harm reduction funding was for the three key interventions. But in 2022, under Grant Cycle 6, this reduced to 42%. Due to data quality issues, it is not possible to determine whether this represents an actual change in the type of harm reduction services being funded or whether this reduction is due to the methodology used to attribute harm reduction funding from the non-disaggregated prevention category.

Behavioural change interventions were the second largest funded intervention for people who use drugs in 2020 after NSPs, but we were unable to track the level of Global Fund support for these interventions between 2020 and 2022. We have also been unable to establish whether the large increase in Global Fund funding for community empowerment for people who use drugs which occurred between 2017 (USD 38,000) and 2020 (USD 1,544,133) has continued.

It is essential to monitor whether funding is supporting the delivery of combination prevention and harm reduction packages, particularly when the HIV and drug use landscape is shifting (see Section 1.3). During a period of reported shifts in drug use away from injecting heroin use and towards more stimulant use, a lack of oversight regarding the level of funding for different harm reduction interventions is deeply concerning and has a huge impact on our ability to monitor progress and support strategic allocations going forward.

Further funding for advocacy and human rights activities for people who use drugs is not identified within the data provided to us by the Global Fund. For example, the sustainability of services for key populations in the MENA regional grant, which includes a focus on harm reduction and people who use drugs, is recorded under a number of different module headings (including Reducing human rights-related barriers to HIV/TB services and RSSH: Community systems strengthening).

The Global Fund is the largest source of funding for community strengthening and advocacy and a key mechanism for driving domestic investment through its focus on sustainability and transitions. Evidence of this is provided in Chapter 4 on domestic spend. Continuous support for this type of activity using multi-country grants and other catalytic investments, such as strategic initiatives, is essential to ensure that people who use drugs are not left behind.

Box 3

Global Fund data methodology and challenges

Tracking trends in the Global Fund's harm reduction investments for people who use drugs across years has historically been challenging due to overlaps in grant cycles, changes in recording practices and the lack of granularity in publicly available data. Starting from Grant Cycle 5 (2017-2019 allocation period), budget data was made publicly available at the modular level,[56] allowing identification of aggregated budget data on the comprehensive prevention package for people who inject drugs and their partners.[57]

For Grant Cycle 6 (2020-2022 allocation period), which covers our years of interest for this report, a change in the modular framework did not allow identification of programmes for people who use drugs at the modular level.[58] This means that, when this report was compiled, no financial data on programmes for people who use drugs was publicly available for Grant Cycle 6.

Budget implementation periods vary across countries for each allocation cycle depending on which window their application was submitted in. All of the funding for 2020 in this report is from Grant Cycle 5, while funding data for 2021 and 2022 mainly comes from Grant Cycle 6 with around 14% of harm reduction funding for countries in these years coming from Grant Cycle 5 allocations.

To access more granular data, it was necessary to request access to intervention-level data from the Global Fund and enter into a legal data use agreement. This provided access to data for all interventions under the Comprehensive prevention programs for people who inject drugs and their partners module in Grant Cycle 5.

However, for Grant Cycle 6 there was no relevant module for people who use drugs, and only interventions that are specifically for people who use drugs such as NSP, OAT and overdose prevention could be identified. This causes problems in data completeness as behavioural interventions were the second most funded Global Fund intervention for people who use drugs in our previous report (24% of the identified harm reduction budget in 2019), while HIV testing accounted for 7% of the identified harm reduction budget in that year.

To address the data recording problems with Grant Cycle 6 and provide an overall estimate of harm reduction funding, the Global Fund provided data based on assumptions about the proportion of the overall prevention budget that was used for harm reduction[59] as this is the module heading that most of harm reduction interventions are likely to fall under. Partial data on target populations was available in 72% of grants, which made it possible to identify funding for harm reduction programmes for people who use drugs. For these grants, this amounted to 16% of the prevention budget. This percentage was then applied across the whole of the HIV non-disaggregated prevention module budget to estimate overall harm reduction funding outside of the three key interventions (OAT, NSP and overdose prevention).

Consequently, it has not been possible to assess Global Fund harm reduction funding at a country or regional level nor to understand funding shifts across countries or say with confidence how many countries received grants with a harm reduction component in Grant Cycle 6. This inconsistency in data collection significantly hinders our ability to monitor harm reduction funding from the largest donor.

Grant cycle allocation period	Module title for programmes for people who use drugs
Grant Cycle 5 (2017-2019)	Comprehensive prevention programmes for people who inject drugs and their partners
Grant Cycle 6 (2020-2022)	None
Grant Cycle 7 (2023-2025)	Prevention package for people who use drugs and their sexual partners

56 The Global Fund's Modular Framework guidance documents describe this classification system. They change over each allocation period.

57 See the Global Fund Grant Agreement Implementation Period Detailed Budgets, available at https://data-service.theglobalfund.org/file_download/grant_agreement_implementation_period_detailed_budgets_dataset/CSV.

58 The Global Fund (2019). *Modular Framework Handbook*.

59 Across HIV and AIDS, TB/HIV and multi-component grants' budgets.

3.3 Bilateral funding for harm reduction through PEPFAR

The US Government has been an instrumental funder for the global HIV response, particularly since the launch of 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.

Out of an estimated USD 8.2 billion of global donor spending for HIV in 2022, PEPFAR contributed USD 6.1 billion (USD 5.3 billion for bilateral programmes and USD 0.8 billion to multilateral organisations).

PEPFAR's dashboard data shows that expenditure on programmes for people who inject drugs amounted to USD 7.9 million in 2022, a decrease from the USD 8.4 million identified in 2019.[60] However, expenditure in 2022 does not include Ukraine as reporting requirements were removed following the Russian invasion.[61] In 2016, PEPFAR expenditure for harm reduction was estimated to be USD 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. However, profound changes in reporting of programmatic results, budgets and expenditures in 2017 make it difficult to draw direct comparisons. As a result of these changes, for example, data on services provided for people who use drugs as part of broader HIV prevention services is not accessible. Most recorded expenditure on programmes for people who inject drugs in 2022 was for HIV prevention (81%). This totalled USD 6.4 million, which is an increase from USD 4.5 million in 2021 but a similar level as 2018 (USD 6.3 million). In 2022 this represented only 1% of all PEPFAR prevention spend and 0.2% of PEPFAR's overall spend. There may be additional harm reduction expenditure falling under the non-disaggregated key population prevention category, but this would still amount to a small proportion of overall PEPFAR prevention spend going to people who use drugs.

In 2022, PEPFAR supported medically-assisted treatment (MAT) programmes reaching around 27,000 people (an increase from 17,000 in 2019) in eight countries (India, Kenya, Kyrgyzstan, South Africa, Tajikistan, Tanzania, Uganda and Zambia), which represents around 2% of the total number of estimated people who inject drugs in those countries. Around USD 0.5 million was provided in new funding for MAT in Uganda in 2021. The biggest increase in MAT expenditure over this period was in South Africa where USD 1.3 million was provided in 2022. Because of US Federal regulations PEPFAR remains unable to purchase needles and syringes, requiring close collaboration with other donors to ensure comprehensive service provision for people who inject drugs.

Vietnam was the largest recipient of PEPFAR funding for people who use drugs before 2016, receiving USD 3.4 million for MAT in 2015. However, funding decreased significantly in 2017, and from 2020 onwards no PEPFAR funding was provided for people who use drugs in Vietnam following a move towards domestic financing of harm reduction. Overall, PEPFAR's funding for harm reduction has shifted from Asia. Since 2020 it has been predominantly directed towards Kenya, Nigeria, South Africa, Tanzania and Ukraine.

In 2019, PEPFAR embarked on a major programming restructure in Asia when it combined individual operating units in Central Asia and Southeast Asia into one unit currently made up of 12 countries.[62] Harm reduction funding for countries within this programme decreased from USD 12.1 million in 2017-2019 to USD 2.5 million in 2020-2022, despite PEPFAR stating that special attention would be given to key populations within the reconfigured unit.[63] There were major reductions in harm reduction funding in Central Asian countries. Worryingly, PEPFAR's Regional Operational Plan 2022 reported rising HIV infections in Kazakhstan where there is a

60 See PEPFAR Panorama Spotlight, 'Financial Management Datasets' [webpage accessed May 2024].

61 In 2021, community-based testing in Ukraine accounted for 47% (USD 5.4 million) of all PEPFAR expenditure on programmes for people who inject drugs. Across all programming, PEPFAR reports a decrease in budget execution for Ukraine, from 70% in 2021 to 23% in 2022.

62 Cambodia, India, Indonesia, Kazakhstan, Kyrgyz Republic, Laos, Myanmar, Nepal, Papua New Guinea, Philippines, Tajikistan and Thailand.

63 USAID (2019), *The USAID Asia Regional HIV Program*.

large number of people who inject drugs (113,000).[64] It also reported rising infections in the Philippines, where punitive policies are identified as a barrier to accessing services, and Kyrgyzstan where a shift from heroin to synthetic drugs is reported.[65]

The Key Population Investment Fund (KPIF), first announced by PEPFAR in 2016, was a USD 100 million initiative to expand key populations' access to and retention in HIV prevention and treatment services.[66] Aimed at four key populations (gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs), it faced delays in implementation until late 2019. Funding was mostly provided in 2020 and 2021. There is a lack of available data on the activities funded under the KPIF. However, it appears that very little was directed towards people who inject drugs. Four countries (Kenya, Nigeria, South Africa and Uganda) accounted for over half of KPIF funding (USD 52 million), but only USD 5.0 million is reported in PEPFAR's dashboard as being spent on people who inject drugs in these countries in 2020 and 2021. This represents a 22% reduction from PEPFAR's expenditure on people who inject drugs in these countries in 2017 and 2018 (USD 6.5 million). Initiatives like the KPIF show recognition of the need to have dedicated funding for key population programmes. But delays in its implementation are indicative of the fragility of funding, and the watering down of KPIF's community-led aspect demonstrates the flaws in the current implementing model where funding is directed through international NGOs or large US-based organisations (see Chapter 5).

PEPFAR remains a crucial donor for harm reduction in its focus countries. It plays a vital role in supporting countries to introduce and scale up their HIV response and harm reduction programmes. Indeed, UNAIDS reports that in the majority of PEPFAR-supported countries, the increase in funding from PEPFAR and the Global Fund has led to an increase in domestic HIV funding.[67]

PEPFAR's importance for harm reduction extends beyond its bilateral support. PEPFAR was reauthorised for only one year in 2024, a shorter than usual reauthorisation period. This is a cause for concern, given the fundamental support provided by PEPFAR for the Global Fund, the WHO, UNAIDS and RCF. In 2023, a delayed US disbursement to RCF for critical funding for community and civil society networks led to all grantees experiencing unscheduled adjustments and interruptions to their cash flow. This created operational crises amongst grantees, many of whom depend on this funding for salaries and other core costs. This shows how any changes in PEPFAR funding would be disastrous for harm reduction and would destabilise the global HIV response. To further illustrate this point, PEPFAR support is credited with providing ART to 20 million of the 29 million people currently receiving it.[68]

"PEPFAR remains a crucial donor for harm reduction in its focus countries. It plays a vital role in supporting countries to introduce and scale up their HIV response and harm reduction programmes."

64 Degenhardt, L et al. (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, 11:5, e659-672.

65 PEPFAR (2022), *Asia Region Operational Plan ROP 2022 MASTER FINAL Strategic Direction Summary.*

66 PEPFAR (2020), *Key Populations Investment Fund Fact Sheet.*

67 UNAIDS (2023), The path that ends AIDS: UNAIDS Global AIDS Update 2023.

68 PEPFAR, 'What is PEPFAR?' [web page accessed May 2024].

3.4 Harm reduction funding is vulnerable to changing donor priorities

A number of international donors have provided important funding for often neglected areas of harm reduction, such as advocacy, legal and policy reform, human rights and community strengthening. These activities are critical in addressing the overall funding gap for harm reduction and building societal enablers for a person-centred and human rights orientated approach to the needs of people who use drugs. Strong community-led and civil society advocacy is especially important in countries with punitive drug policies.

This report has identified large reductions in funding from donors that have historically played a key role in funding community programmes and capacity building, supported advocacy and policy reform efforts and invested in projects for overlooked populations, such as women who use drugs and people who use stimulants. In 2016 and 2019, OSF was the biggest harm reduction donor outside of the Global Fund and PEPFAR. But OSF's harm reduction funding has almost halved since 2019 from USD 6.9 million to USD 3.9 million in 2022, meaning it is no longer the third largest donor. Organisational changes and shifting priorities further threaten this essential funding.

In addition to providing core funding for civil society organisations, OSF has traditionally been a supporter of innovative pilots, testing new harm reduction approaches in various contexts. For example, the Wings of Hope project, funded in 2012-2013, tested the feasibility and effects of an intervention that aimed to increase the identification of gender-based violence and improve outreach services for women who use drugs in Kyrgyzstan. Based on these findings, similar initiatives were subsequently created in India, Ukraine and Georgia.

OSF has also been one of the only harm reduction donors making significant investments in Latin American countries, but the loss of OSF funding is threatening community services. For example, in Cali, Colombia, Corporación Viviendo currently serves 600 people, and has an average of 110 visitors a day who come for sterile injecting equipment, wider harm reduction services and onward referrals. A supervised consumption room was due to open in 2024 with the support of the government, but the loss of OSF funding is threatening the entire service.

Many initiatives and activities now funded by the Global Fund began with OSF funding. Examples from South Africa include advocacy for reduced methadone prices, reporting human rights violations and many research outputs. Perhaps the most significant achievement of the unrestricted OSF funding in South Africa is the establishment of the South African Network of People who Use Drugs (SANPUD). SANPUD is the only peer-led and representative national organisation for people who use drugs and their networks in South Africa.

Similarly, the PITCH project funded by the Dutch Government was an important source of funding for community advocacy and supported community-based organisations to uphold the rights of people who use drugs. The programme's final evaluation highlights the creation of new advocacy groups for people who use drugs in Myanmar and Ukraine as a key achievement.[69] Bridging the Gaps, which like PITCH ended in 2020, supported 95 local, regional and global civil society organisations working across 15 countries between 2016 and 2020 with a focus on capacity building. The harm reduction funding within the Dutch Government's new programme for key populations, Love Alliance, is 70% lower in 2022 than the funding for the two projects was in 2019.

Some donors have increased their funding over the period. We noted an increase in bilateral funding through Expertise France for community strengthening and improving service accessibility.

RCF provides important support for harm reduction advocacy, which represents the majority of its funding for harm reduction. Areas of advocacy it supports include drug policy reform, increasing domestic investment for harm reduction and improved access to services for people who use drugs. It also supports organising and community empowerment by strengthening networks of people

69 Results in Health et. al (2021), PITCH End Term Evaluation Report.

who use drugs. Funding is primarily through regional and global civil society and community networks and consortia. RCF funding for harm reduction increased significantly between 2019 and 2022, largely due to some COVID-19 grants in 2022. Nevertheless, funding was higher in 2020 (USD 2.7 million) and 2021 (USD 3 million) than in 2019 (USD 1.8 million) or 2016 (USD 1.2 million). With its participatory grant-making model and support for core organisational funding, RCF will continue to play a vital role in the funding of advocacy and community networks.

The Elton John AIDS Foundation has also increased funding for harm reduction, providing USD 3.1 million in 2022 compared to USD 1 million in 2016 and USD 2.5 million in 2019. EJAF provides funding for advocacy, policy change, legal support, service delivery and community empowerment in addition to championing harm reduction and challenging stigma through its statements and events.

ViiV Healthcare is another donor that has increased its funding from USD 0.1m in 2019 to USD 1.2m in 2022. It directs a large share of its funding to neglected areas of harm reduction, such as advocacy work, community-led services for women who use drugs and services for young people who use drugs and people who use stimulants.

4.

DOMESTIC FUNDING FOR HARM REDUCTION IN LOW- AND MIDDLE-INCOME COUNTRIES

4.1 The state of domestic funding for HIV and harm reduction

Domestic funding for HIV has increased over the last decade, demonstrating a growing ownership of the HIV response within national health agendas. However, the slowdown in domestic funding increases since the mid-2010s and the recent flattening of funding levels since 2018 are concerning trends. In 2022, overall domestic funding for HIV was 3% lower than in 2021, although it still accounted for 60% of the total HIV investment.[70]

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 (see Box 4).

Nevertheless, as part of this research we identified USD 49.7 million of domestic funding for harm reduction,[71] representing 33% of all harm reduction funding identified in 2022. Domestic investment in harm reduction accounted for a mere 0.4% of all domestic funding for HIV in 2022.[72] The amount and proportion of harm reduction funding from domestic budgets has reduced since 2019. It appears that a backwards step has been taken and we are further away from the goal of a sustainable harm reduction response than in 2019. The amount of domestic harm reduction spending identified by this report is a paltry 1.7% of the estimated harm reduction resource need by 2025.

The amount of domestic funding identified by this report is substantially less than that identified in 2019 (USD 63.2 million) and similar to that identified in 2016. Exchange rate fluctuations can affect funding levels in USD. However, it is clear the significant increase in government harm reduction investment that is needed to reach global targets and to ensure the sustainability of harm reduction and the broader HIV response has not occurred.

We identified domestic harm reduction funding for 27 countries in 2022, compared to 38 countries in 2019. However, we identified domestic funding for more countries in 2022 than in 2016 (19 countries). Countries where we identified domestic spend for this report, but not in our previous financing report, include Egypt (USD 4.4 million) and South Africa (USD 2.5 million), the latter identified through an HRI report on the national financial landscape.[73] For some countries that had identified funding in 2022, we were also able to identify data for 2019 that was not available for our last report. This demonstrates the difficulty in determining trends based on patchy data.

There are signs that provincial or city governments may be providing more funding, but accessing this funding data is difficult due to a lack of effective reporting systems. These investments may also be ad-hoc in nature and fluctuate from one year to another. Nevertheless, such funding has proven critical both for initiating harm reduction services (see Box 7 on South Africa) and for maintaining services after international donor withdrawal (see Box 5 on Serbia). Provincial governments have also reportedly funded activities outside of service delivery.[74]

4.2 Sustaining domestic harm reduction investment

The decrease in identified domestic funding is mainly due to substantial decreases in the top 10 countries recording the highest amount of identified funding in 2019, particularly Iran and Vietnam (see table 3). These 10 countries accounted for 85% of all identified domestic funding in 2019 but only 74% in 2022. Many of the countries reporting decreases in funding had a large proportion of domestically funded harm reduction in 2019.[75] This suggests a reduction

70 UNAIDS, 'Welcome to the HIV Financial Dashboard' [web page accessed May 2024].
71 For some countries we used data for 2021 when data for 2022 were unavailable.
72 Estimated at USD 12.5 billion, see UNAIDS' HIV Financial Dashboard.
73 Harm Reduction International (2022), *Harm Reduction Financing Landscape Analysis South Africa.*
74 Harm Reduction International (2023), *Harm Reduction International (2022) Harm Reduction Financing Landscape Analysis Indonesia.*
75 We are unable to comment on domestic harm reduction funding proportions by country in 2022 due to data recording and quality issues with the Global Fund's data.

Box 4

Challenges identifying domestic funding for harm reduction

Data on the extent, scope and direction of public funds for harm reduction are limited, and there is no global systematic monitoring process to gather this information. Poor data quality and limited availability and accessibility of data are some of the issues.

Identifying domestic funding data requires resources and specific technical skills in order to understand and analyse the data. The key sources of domestic HIV spending data, such as UNAIDS Global AIDS Monitoring (GAM) and National AIDS Spending Assessments (NASA), are not regularly updated by most countries and there is no robust accountability mechanism on data reporting. It is neither mandatory for governments to report to GAM nor is there a mechanism or routine adequate support to quality assure the data.

In 2022, UNAIDS GAM listed only 15 countries reporting expenditure on HIV prevention for people who inject drugs, out of which only 9 countries reported domestic investment. Furthermore, many countries do not seem to complete the HIV Funding Gap table within their Global Fund Funding Landscape reports, and the accuracy of the data in those that do is questionable. There is no simple verification process for domestic spending within the reports, and it is unclear how the funding need is calculated.

In countries where harm reduction service provision is integrated into wider health facilities, expenditures may not be easily identifiable in earmarked budgets. Harm reduction services may be embedded within wider HIV prevention packages or spread across different sectors, as is the case in Cambodia and Indonesia.

It is possible that the low level of domestic investment we identified is impacted by the lack of available data rather than due to a complete absence of domestic funding. For example, information on domestic harm reduction investment remains unavailable for China, where we know the government has made significant investment in harm reduction in the past.

Table 3 **Countries with the highest domestic investment in 2019 and funding identified in 2022**

Country	Income status (upper middle/lower middle)	2019 (USD millions)	2022 (USD millions)	Domestic funding as % of overall funding 2019
Iran	UM	14,222,829	4,102,995	97%
Vietnam	LM	12,531,341	8,555,796	77%
India	LM	11,000,000	10,170,038	92%
Georgia	LM	3,877,889	3,144,291	73%
Indonesia	LM	2,806,375	3,284,659	82%
Kazakhstan	UM	2,255,590	1,364,113	83%
Serbia	UM	2,225,063	2,719,926	99%
Malaysia	UM	1,708,624	686,274	100%
Belarus	UM	1,438,426	943,178	61%
Thailand	UM	1,334,711	1,718,745	35%
Total		**50,594,473**	**33,405,356**	

in support for harm reduction among countries with historically more ownership of their harm reduction response.

The funding reduction in Iran is believed to stem from political factors, alongside shifts in drug usage patterns and reductions in HIV incidence. Drug policies have become even more punitive in the country, and there has been a move away from harm reduction.[76] This underscores the precarious nature of domestic harm reduction funding and the threat posed by shifts in political will.

Some countries with the highest previous identified domestic funding did increase their investments, which may have been a result of Global Fund co-financing requirements. For example, Serbia was the recipient of a Global Fund grant between 2019 and 2022 which encouraged the financing of services from the national budget (see Box 5).

Indonesia increased domestic funding for HIV prevention programmes for people who use drugs and their sexual partners from USD 2.8 million in 2019 to USD 3.3 million in 2022, as reported through the Global Fund Funding Landscape report. The Global Fund has obtained a co-financing commitment from Indonesia which amounts to USD 20.1 million domestic funding for HIV prevention programmes for people who use drugs and their sexual partners over three years during the 2023-2026 allocation period.[77] This represents only 3% of Indonesia's total co-financing commitment for HIV and would amount to a mere 9 cents per day per person who injects drugs.[78]

Co-financing can have a catalytic effect on increasing government financial ownership of national harm reduction programmes. Other Global Fund tools encouraging domestic investment include the matching funds mechanism, which allows the Global Fund to use its influence as a donor to incentivise investment in evidence-based prevention programmes for key populations, such as harm reduction, where political will is often lacking.[79] The Global Fund's matching funding tracker suggests 14% of matched funds were for key population programming across 13 countries for the 2020-2022 allocation, but further monitoring of the extent to

76 Harm Reduction International (2022), *The Global State of Harm Reduction.*

77 The Global Fund (2023), *Update on Co-financing: 50th Board Meeting.*

78 Population size estimates used to calculate cents per day for domestic funding in 2022 were taken from Degenhardt, L. et al. (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', The Lancet Global Health, 11:5, e659-672.

79 Harm Reduction International (2019), *Why catalytic investments funding is crucial to preventing HIV among people who use drugs.*

which these led to increased domestic investment in harm reduction is necessary. We were unable to identify any domestic harm reduction funding in most countries with matched funds, with the exception of Ukraine and Indonesia where there was an increase in domestic harm reduction funding.

Better data is needed to ascertain the direction and scope of domestic financial support for harm reduction and the quality, scale and suitability of the programmes being supported. Even in countries where identified domestic funding has increased, it is still woefully low. India, with the highest amount of estimated funding in 2022,[80] spends just 3 cents a day per person who injects drugs.

Strong advocacy from communities and civil society and the diplomatic influence of donor and multilateral agencies is crucial to sustain domestic financial support for harm reduction and to remove the political and legal barriers that are constraining it. Community and civil society advocates can play a watchdog role by monitoring the extent to which governments and donors are investing in harm reduction programmes and hold them accountable for their commitments to end AIDS, eliminate hepatitis C and provide universal health coverage by 2030.

Domestic funding data for harm reduction provides only part of the picture. There are data gaps on the extent to which various harm reduction components are supported, the nature of funding mechanisms and the type of funding recipients (including community-led organisations). Deep dive country-specific investigations exist for some countries, but these rely on civil society efforts and donor funding to support them.[81] An initial scoping of social contracting for harm reduction, in which governments fund community and civil society organisations, found that examples were few but working well where in place.[82] Filling these data gaps is crucial to inform advocacy and capacity building on domestic financing.

The extent to which harm reduction is integrated into universal health coverage schemes remains unclear, despite WHO guidance on the need for its inclusion. Available data suggests that efforts are mostly directed to the procurement of ART and condoms, human resources (health service providers) and behavioural change interventions.[83] The same is true of national health insurance programmes where these are in place. For instance, the national health insurance schemes in Indonesia, Kenya, Nepal and Cambodia have readily included ART, condoms and behavioural change interventions but continue to omit harm reduction. Insurance policies in some countries align with punitive policies against people who use drugs and explicitly forbid the inclusion of harm reduction interventions.[84]

80 HRI calculation based on activity data and unit costs data for India.

81 Harm Reduction International conducted financial landscape studies in South Africa, Uganda, Nepal, Nigeria, Kenya and Indonesia in 2023. See HRI, 'Increasing funding for harm reduction' [web page accessed May 2024].

82 Harm Reductional International (2023),*Towards domestic public financing and social contracting for harm reduction*.

83 Harm Reduction International (2022), *Harm Reduction Funding Landscape analysis in Indonesia, Nepal, Kenya*.

84 UNAIDS (2022), *Key populations are being left behind in universal health coverage: landscape review of health insurance schemes in the Asia-Pacific region.*

Box 5

Counting the costs of poor donor withdrawal planning in Serbia

In 2012, Serbia's HIV burden was deemed 'moderate' and, due to its status as an upper-middle-income country, it became ineligible for funding from the Global Fund. In the final year of its existing grant implementation, Serbia received around USD 1 million from the Global Fund to provide NSP, OAT and community outreach.

Following the withdrawal of Global Fund support in September 2014, services largely collapsed. One civil society organisation in Novi Sad received financial support from the municipal government and was able to continue. Other civil society organisations tried to continue outreach and NSP on a voluntary basis. But they did not have sufficient budget to cover operating expenses and harm-reduction commodities, such as condoms, needles, syringes and HIV test kits. These organisations' harm reduction services were forced to close down. Despite support for HIV programming, the Serbian Government did not have a financial plan for providing domestic funding to fill the gaps left by the Global Fund's withdrawal. Due to an increase in the HIV burden, Serbia became re-eligible for Global Fund support during the allocation period, 2017-2019.

Between July 2019 and June 2022, Serbia received USD 2.2 million from the Global Fund to support HIV prevention services for key populations. Crucially, this funding was conditional on Serbia increasing financing of services from its national budget during the period. This resulted in the introduction of a specific budget line within the government budget for HIV civil society organisation programmes and the allocation of funds. In addition, Timok Youth Center, a Serbian civil society organisation, received a sub-grant as part of the Global Fund's HIV regional grant Sustainability of Services for Key Populations in Eastern Europe and Central Asia.[85]

Coverage of harm reduction has increased since the Global Fund returned to Serbia but it is still extremely limited. This reflects the current low funding levels and the loss of five years of civil society organisation capacity building and health systems strengthening due to poor transition planning. The experience in Serbia demonstrates the key role the Global Fund can play in mobilising domestic financing and the responsibility it has to ensure its smooth withdrawal from a country. Strengthening civil society organisations and putting them at the centre of sustainability and transition planning will help minimise service disruptions caused by funding shifts.

85 Eurasian Harm Reduction Association (2021), *Republic of Serbia: Benchmarking Sustainability of the HIV Response among Key Populations in the Context of Transition from Global Fund's Support to Domestic Funding*

5.

INVESTING IN COMMUNITY-LED RESPONSES

5.1 The importance of community and community-led harm reduction responses[86]

Incorporating harm reduction services delivered by communities and civil society organisations into the broader health system is essential for ensuring comprehensive and inclusive healthcare delivery. Empowering communities and civil society to lead in harm reduction not only enhances access to essential services but promotes inclusivity, dignity and human rights within healthcare delivery. Communities are best placed to articulate their needs and can better identify and respond to changing community circumstances than other health system actors.

UNAIDS' Global AIDS Strategy 2021-2026 includes the 30-80-60 targets which aim to increase the use of community-led services and programmes for HIV prevention, testing and treatment by 2025 (see Box 1).

The COVID-19 pandemic emphasised the resilient, creative and critical role of community-led organisations and responses. 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.

5.2 The need to improve monitoring of funding for community-led responses

This report has found little evidence to suggest that progress towards the 30-80-60 targets is being adequately monitored. Qualitative information collected through UNAIDS' National Commitments and Policy Instrument is patchy and unreliable as it is mainly completed by governments. For example, in 2022, 14 countries reported that they require a certain percentage of government funding for community-led organisations but civil society actors were unable to verify this when consulted. In 2024, the Global Prevention Coalition (GPC) found that fewer than half of GPC countries had set targets for community-led services, and this was even less common among countries with HIV epidemics that primarily affect key populations (4 out of 14 countries).[87]

While the amount of funding provided to community-led organisations is not a direct measure of progress on the targets, it is an important indicator to track. Donors recognised the need to understand the extent to which funding was reaching community-led organisations, and some could provide insights, but there was no systematic tracking, which is what is needed to measure progress over time. Some concerns were raised about the ramifications for organisations identifying themselves as community-led in environments with restrictive policies and laws. This demonstrates the importance of advocating for policy and legal reform and empowering communities in order to reach the targets.

"Donors recognised the need to understand the extent to which funding was reaching community-led organisations, and some could provide insights, but there was no systematic tracking, which is what is needed to measure progress over time."

86 Community-led organisations, groups, and networks – irrespective of their legal status (whether formally or informally organised – are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies and have transparent mechanisms of accountability to their constituencies. Not all community-based organisations are community led. (Adapted from UNAIDS (2020), *Progress report of the multi-stakeholder task team on community-led aids responses.*)

87 Global Prevention Coalition (2024), *HIV Prevention: From Crisis to Opportunity Key findings from the 2023 Global HIV Prevention Coalition scorecards.*

Box 6

COVID-19 and the resilience of communities

The COVID-19 pandemic caused disruption and exposed vulnerabilities in healthcare systems around the world. While there were serious disruptions to harm reduction services, the unprecedented situation showed how effective communities are in delivering flexible healthcare and how enhanced donor funding can facilitate this.

Almost all donors reported providing some emergency COVID-19 harm reduction funding. Some implementors found they were able to better meet the needs of their communities because their COVID-19 grants were unrestricted and flexibility was allowed, whereas traditionally they are restrained by programmatic targets that may not reflect community needs. The International Network of People who Use Drugs (INPUD) has documented how the COVID-19 response mechanism was used to enable community-led responses in Kyrgyzstan to deliver harm reduction services.[88] Although access to services decreased, positive service delivery changes took place during the pandemic that helped to mitigate the impact.[89] [90]

The key role of communities in reaching the most vulnerable people during the COVID-19 pandemic – providing services, commodities, support and information when public services were unable to do so – shows how critical communities are to sustainable and resilient national healthcare systems, and for pandemic preparedness. PEPFAR reports that local partners reached clients with essential services during COVID-19, achieving higher rates of continuous HIV treatment than international partners.[91]

COVID-19 placed significant strain on health budgets in low- and middle-income countries, exacerbating existing challenges and underscoring the importance of sustainable financing mechanisms. Increased debt due to pandemic response efforts has reduced the capacity of low- and middle-income countries to allocate sufficient resources to some areas of healthcare. Yet the COVID-19 pandemic has clearly demonstrated the benefits of community-based and community-led healthcare and the need for commodities to be locally produced. These are lessons that must be acknowledged and built upon.

88 INPUD (2021), *From Invisibility to Influence: The evolution of participation of people who use drugs in the Global Fund.*

89 The Global Fund (2022), *Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact in HIV Programming.*

90 Eurasian Harm Reduction Association (2020), *Harm reduction service delivery to people who use drugs during a public health emergency: Examples from the COVID-19 pandemic in selected countries.*

91 PEPFAR (2022),. *PEPFAR 2022 Country and Regional Operational Plan (COP/ROP) Guidance for all PEPFAR-Supported Countries.*

Some funders, such as the Elton John AIDS Foundation provided data on community-led organisations through its knowledge of the grant recipients, both principal recipients and implementing organisations. ViiV Healthcare was also able to provide information on funding to community-led services through project descriptions.

Outside of the Global Fund and PEPFAR, donors appear to have greater knowledge of the extent to which community-led organisations are being funded although they may not have specific recording systems. Community-led programmes appear to be a key part of most donors´ strategies and funding commitments, but community-led organisations seem more likely to be contracted directly through small grants. These can appear tokenistic, covering small projects or items such as meeting costs without providing the core funding required to build both capacity and sustainable community-led organisations.

The only PEPFAR data on organisation type indicated whether funding had been provided to local or international organisations, reflecting its 2018 goal to direct 70% of PEPFAR funds to local partners through direct prime awards by the end of 2020. This target had not been reached by the beginning of 2022, and progress in shifting funding to local partners working on HIV prevention considerably lagged behind those delivering care and treatment with only 53% of prevention funding going to local partners in 2022.[92] The definition of local partners, however, is broad and can include partners that are not indigenous to the country but are instead based in the region. Data shows that many prime partners of programmes for people who use drugs are either US based or subsidiaries of US organisations. Local partners can also include government partners, such as health ministries. This means current data collection is far away from being able to monitor community-led programme delivery.

The Global Fund monitors the type of implementing partner but it has not identified community-led organisations, only community-based organisations. In 2020, USD 30.4 million of the USD 54.0 million budget for comprehensive prevention programmes for people who inject drugs went to civil society organisations. Almost one-third of this (USD 9.3 million) went to international NGOs or international faith-based organisations with only USD 5.1 million going to local community-based organisations. This represents just under 10% of all funding for prevention for people who inject drugs in 2020 and with many of these unlikely to be community-led, the 30-80-60 targets remain far out of reach. Indeed, across the total 2020-2022 grant allocation for prevention, only 13% of the budget is labelled as going to community-based organisations. In addition, there are no targets in the Global Fund's results database relating to community-led service delivery, suggesting this has not been a priority for its programmes. With no key performance indicator, no disaggregated programmatic and financial data is collected to understand the financing, and achievements of, community-led responses. In 2024 the Global Fund did add community-led organisations to its implementer classification, but this will only identify the principal recipient not any sub-recipients. The Global Fund should start collecting data on community-led sub-recipients in order to monitor progress on the 30-80-60 targets.

92 PEPFAR (2022), *PEPFAR 2022 Country and Regional Operational Plan (COP/ROP) Guidance for all PEPFAR-Supported Countries.*

6.

BUILDING A SUSTAINABLE HARM REDUCTION RESPONSE

Box 7

Enhancing sustainability through community-oriented harm reduction in South Africa

Domestic financing for harm reduction has been almost non-existent in South Africa, with almost all funding coming from international sources. While 70% of South Africa's HIV response is domestically funded, HIV prevention receives a small proportion of national funds (8%) and there has been no national spend on harm reduction. Government-funded services for people who use drugs are abstinence-based, and the only public funding for harm reduction comes from the City of Tshwane. The Community-oriented Substance Use Programme (COSUP), which started in Tshwane in 2016, shows how partnership working at the community level can create an enabling environment that is able to withstand political changes.

COSUP is a community-based, evidence-informed response to drugs that uses and supplements existing resources, such as government structures and community-based organisations, to deliver essential drug prevention, treatment, harm reduction, health, well-being and support services to people at risk of using drugs or who already use or inject drugs and the communities they live in. The services provide a continuum of care for all stages along the spectrum of drug use and drug-related harms. COSUP prioritises risk reduction and health over abstinence. It addresses the social determinants of drug use by reducing stigma and exclusion through education and by the results it gets – people who use drugs involved in the programme often become accepted and productive members of the local community. People who use drugs are included in all stages of design, implementation and research, and community advisory groups are consulted to ensure the services provided match people's needs. COSUP works through collaboration, coordination and capacitation and is not in competition with existing services or organisations. It uses formal peer-reviewed research to justify and monitor the effectiveness of its services.

The COSUP model has survived through 3 government changes and has produced local empirical data that can provide valuable local evidence for programme adoption in the specific South African context.

There are significant barriers to building a sustainable harm reduction response that go beyond the amount of funding provided for harm reduction. While increased harm reduction funding from donors and domestic governments is essential for closing the pressing issue of the resource-needs funding gap, increasing the involvement of communities and civil society lies at the heart of a sustainable and just healthcare response.

6.1 Meaningful involvement of people who use drugs in donors' decision-making processes

While donors emphasise the importance of meaningful community engagement, from funding request development to grant-making and monitoring,[93] political and institutional barriers often inhibit this. Community engagement in donor processes is often unfunded work, despite the expertise and time required. The complexities of national planning processes for Global Fund country funding requests and PEPFAR Country Operational Plans can present significant barriers that prevent communities from meaningfully engaging. Lack of meaningful participation, power imbalances and discrimination within Global Fund Country Coordinating Mechanisms (CCMs) can undermine the ability of key populations and communities to influence decision-making processes and advocate for funding that addresses their specific needs.[94] This may result in funding priorities that do not adequately reflect the realities and priorities of those most affected.

Even where there is involvement, there is often a lack of transparency in the way that decisions on final allocation and prioritisation are made. In many countries submitting country grant funding requests to the Global Fund for Grant Cycle 7, the involvement of the community of people who use drugs in national dialogues and processes remained far from optimal.[95] Communities reported having a seat at the CCM table, but only in one of ten case study countries, communities reported being meaningfully engaged in the process and had seen the final funding request, while only 20% were aware of the final grant design.[96]

While political barriers remain a challenge, donors must use all supportive mechanisms they can to ensure communities are heard within budget decision-making processes. RCF's participatory grant-making model offers a powerful example of a system that seeks to shift power to inadequately served populations and contribute to community resilience and sustainability.[97]

6.2 Reducing barriers to funding particularly for community-led organisations

Funding opportunities from donors often favour larger, established civil society organisations that have the capacity to comply with stringent financial controls, policy and reporting requirements. For example, it can be difficult for community-led organisations to receive grants as Global Fund sub-recipients when principal recipients are often large international NGOs or even multilateral agencies, such as UNDP, which have their own vast guidance documents for sub-recipients.[98] The Global Fund's Thematic Evaluation on Community Engagement and Community-led Responses states that, while community principal recipients receive high ratings, many community organisations fail to meet the

93 For example, the Global Fund Strategy 2023-2028 emphasises the importance of meaningful community engagement at all stages of the grant cycle, including funding request development and revision post-review, during the grant-making cycle and in monitoring. See the Global Fund (2021), *Fighting Pandemics and Building a Healthier and More Equitable World Global Fund Strategy (2023-2028).*

94 RISE (2024), *Community Engagement in Global Fund Country Coordinating Mechanisms: Findings from the RISE Study.*

95 INPUD (2023), *Communities at the Centre A report back on the experiences of key populations in the Global Fund Grant Cycle 7 (Windows 1 and 2).*

96 The Global Fund (2023), *Thematic Evaluation on Community Engagement and Community-led Responses.*

97 Robert Carr Foundation (2023), *When Communities Decide: RCF Participatory Grantmaking Model.*

98 In the 2020-2022 allocation period, UNDP was principal recipient for grants under the Prevention module worth at least USD 67 million. The UNDP-Global Fund Partnership has its own web guidance, see UNDP 'UNDP- Global Fund and Health Implementation' [web page accessed May 2024].

capacity criteria necessary to qualify as grant-funding recipients.[99] Similarly, PEPFAR funding is often directed through large and/or non-Indigenous organisations (see Chapter 5). More investment is needed to build the capacity of civil society, including community-led organisations, to become principal recipients of grants from large donors.

The focus also needs to shift from programmatic outcomes to sustainability and place communities and civil society as central to achieving sustainable responses. This will require the barriers that stop smaller organisations from accessing funding to be reduced and more emphasis on funding the core costs of community-led organisations and civil society organisations, alongside capacity building. There are signs that the biggest donors are moving in this direction. For example, PEPFAR's Country and Regional Operational Plan 2022 states that its current goal is to support capacity development for enhanced and diversified funding sources for key population CSOs.[100]

Research on capacity building within some projects in the Dutch-funded Bridging the Gaps programme found that people who use drugs were primarily engaged by civil society organisations as volunteer outreach workers or key population council members. This restricted opportunities for personal capacity building and to becoming an employee of the organisation. In the key population led organisations, there was greater integration and opportunity for personal capacity building for key population members. This demonstrates the need to fund capacity building specifically for community-led organisations not just civil society in general in order to empower the community.[101]

The current lack of funding provided to community-led organisations for capacity building, and the reduction in funding for advocacy work arising from the loss of donors, programmes and the reduction in Global Fund multi-country grants, necessitates urgent, targeted investments in these activities. It is clear that current structures are ineffective and have not changed the funding landscape to better meet the targets on estimated resource needs or to make progress on the 30-80-60 targets. Mechanisms for funders to directly fund community-led programmes, such as a dedicated community/key population fund, are necessary. Failing to act will put these targets at risk.

6.3 Enhancing public financing mechanisms for community-centred health responses

The UNAIDS 2021 Political Declaration calls on countries to empower communities of people living with, at risk of and affected by, HIV by "adopting and implementing laws and policies that enable the sustainable financing of people-centred, integrated, community responses, including peer-led HIV service delivery, including through social contracting[102] and other public funding mechanisms."[103] However, domestic public financing for harm reduction often does not include mechanisms that allow community-led, community-based and civil society organisations to receive funds. These are necessary to prepare for transition from international to domestic funding.

Work to protect community systems during and after transition must begin early to allow for laws and policies to be reformed and new mechanisms to be put in place, or existing mechanisms to be adapted.

99 The Global Fund (2023), *Thematic Evaluation on Community Engagement and Community-led Responses.*

100 PEPFAR (2022), *Country and Regional Operational Plan (COP/ROP) Guidance for all PEPFAR-Supported Countries.*

101 Aantjes, C.J., Armstrong, R., Burrows, D. (2020), *Capacity development in the Bridging the Gaps programme. Examining the processes and outcomes of capacity development in a global health and human rights programme* and Aantjes, C. et al. (2022), 'Capacity development in pursuit of social change: an examination of processes and outcomes', Development in Practice, 32:4, p536-550.

102 The term 'social contracting' is used within international discourse on health financing practices to describe an overarching mechanism that defines the partnership between the government and non-government actors to achieve shared goals. In relation to health, social contracting is the process by which government resources are used to fund nongovernmental entities to provide health services that the government has a responsibility to provide, in order to assure the health of its citizens. See: Open Society Foundations, UNDP and the Global Fund (2017), A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society. A meeting report.

103 UNAIDS (2021), Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030.

Community-led, community-based and civil society actors must be included in transition planning processes. For this to lead to domestic funding of harm reduction (and other key population programming), the role of donors in supporting community-led and civil society advocacy, as well making the investment case for quality, human rights-based harm reduction programmes, will be crucial.

Punitive laws and policies and a lack of political will remain barriers to domestic funding for harm reduction. Social contracting mechanisms are rarely used to support harm reduction programmes, and most domestic public financing is under strict government control.[104] More needs to be done to increase the understanding of harm reduction and the community and civil society organisations that deliver services as important components of a resilient and sustainable health system. Reducing stigma towards people who use drugs is a necessary step towards making harm reduction an essential part of universal health coverage.

The development of public financing mechanisms is only one step in increasing the sustainability of harm reduction responses. To adequately finance equitable universal health coverage that includes harm reduction, new sources of financing are required. Donor investments in community-led programmes outside of the HIV field, such as Unitaid´s HCV Combination Prevention in People who inject drugs and Prisoners Project, provide a welcome boost to funding but it is not enough to reverse years of underfunding of harm reduction.

6.4 Decriminalising drug use is key to a sustainable harm reduction response

While people are still criminalised for using drugs they will continue to be stigmatised and discriminated against, and they will continue to be marginalised within society and in the funding landscape. A sustainable harm reduction response requires the decriminalisation of drugs.

The human rights, social and economic costs associated with punitive drug laws and policies are widely documented.[105] They result in human rights violations, increase risk of HIV and hepatitis, impede access to health services and fuel stigma and discrimination. Yet governments and donors around the world continue to waste vast amounts of money on funding punitive responses to drugs, with little transparency or accountability.

The biggest funding boost to harm reduction would be for governments and donors to divest from the unjust drug war and related punitive drug law enforcement and invest in programmes that prioritise community, health and justice.[106]

104 Harm Reductional International (2023),*Towards domestic public financing and social contracting for harm reduction.*

105 Csete J et al (2016) *Public health and international drug policy*, The Lancet Volume 387, Issue 10026, p1427-1480, April 02, 2016

106 See investinjustice.net [web page accessed May 2024].

7.

METHODOLOGY

This study is the latest iteration of HRI's research monitoring of the harm reduction funding landscape in low- and middle- income countries. As in previous studies, we sought to identify both donor funding and domestic government funding.

Identifying donor funding for harm reduction

We identified donors from our previous research reaching out with an invitation letter in November and December 2023. Our previous experience showed that data sources are diverse, patchy and that funding data do not fit into neat classifications. Therefore, we followed up the invitation letter with an email asking donors to provide us with data and contextual information in a format that best suited them. We requested data based around three main questions:

1) What was your overall expenditure on harm reduction in low- and middle-income countries for each of the years, 2020, 2021 and 2022?

2) What was the breakdown of harm reduction funding by country (or region if funding is provided at this geographical level) for each of these years?

3) What was the breakdown of funding by type of activity? Where possible, please provide funding amounts by intervention (e.g. NSP, OAT, overdose prevention) and/or nature (advocacy, legal reform, policy change, human rights, community empowerment etc.) for each of these years.

We also asked for data and information on specific areas of interest including funding for community-led organisations inviting funders to discuss their data with the research team through online meetings. Over the course of the study (December 2023 to April 2024), we contacted a total of 23 donors, some of which were identified during the course of our study. We received harm reduction funding data directly from 10 donors, with data from 3 donors identified either by their implementing agencies, their annual reports or through Funders Concerned About AIDS (FCAA). The inclusion criteria for donors in this study was $100,000 of funding in 2022.

We held calls with six donors including numerous meetings with the largest donor, the Global Fund. We also conducted online meetings with implementing agencies and civil society actors to better understand the donor landscape.

Harm reduction funding for people who use drugs is often part of wider key population programmes. If donors were happy to do so, the proportion of their funding that was for harm reduction was estimated using an approach that best fitted the specific programme characteristics.

We cross-referenced data with donors and implementing agencies to prevent double counting.

Identifying domestic funding for harm reduction

We used a number of sources to estimate domestic funding for harm reduction. This included UNAIDS' Global AIDS Monitoring data. We downloaded the UNAIDS GARPR16-GAM2023 Programme Expenditures dataset and used the expenditure reporting line 3.7 "Prevention, promotion of testing and linkage to care programmes for persons who inject drugs" to identify harm reduction expenditure. Only nine countries reported domestic harm reduction in 2022 with four countries reporting expenditure for 2021. Our use of these data and the data limitations were discussed in a meeting with UNAIDS.

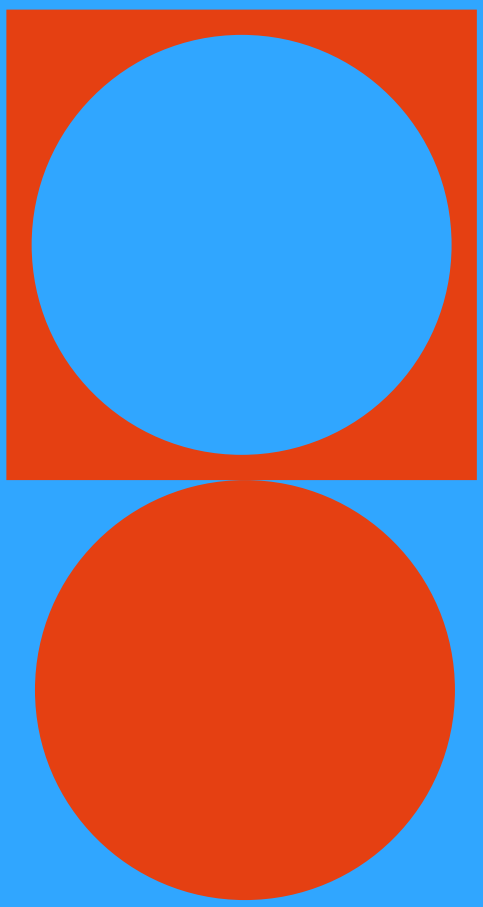
Data on domestic funding was also captured through Funding Landscape Reports to the Global Fund, either for the 2020-2022 allocation cycle or the 2023-2025 allocation cycle. Where data was different across the various sources, we reached out to key informants in the individual countries to guide our selection of data.

We also carried out an extensive literature review searching UN reports, civil society reports, PEPFAR Country Operational Plan documents, academic literature and government documents including budget documents. We used some of HRI's country specific studies to identify domestic funding. Where we were missing data from countries with previously high levels of identified harm reduction spend or where the funding levels had changed significantly, we made a focussed effort to identify funding. This included contacting key informants such as government officials and civil society in those countries. We used activity data and unit costs to estimate expenditure for India due to the fact that previous domestic funding data for this country had been derived from HRI studies using a similar bottom-up methodology.

We included countries with an estimate of domestic expenditure for either 2021 or 2022 in the final domestic expenditure estimate.

In addition to identifying sources of harm reduction funding data, we conducted extensive online searches for relevant policy, research and guidance documents to provide us with contextual information. We interrogated the online databases of the Global Fund, UNAIDS and PEPFAR to better understand their data collection related to organisation type and community-led organisations overall not just in relation to harm reduction funding.

THE COST OF COMPLACENCY: A HARM REDUCTION FUNDING CRISIS



HARM REDUCTION INTERNATIONAL