KEY HARM REDUCTION MESSAGES ON INTEGRATION FOR GRANT CYCLE 8

HARM REDUCTION INTERNATIONAL

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Key messages

- **Rushed integration is an equity risk.** Sudden and dramatic funding and political shifts in global health have resulted in a push for integration as an effective pathway to UHC and financial sustainability for HIV, TB and malaria programmes. However, for key population programmes, including harm reduction, this poses serious risk. A rushed integration process without undertaking careful planning could further dismantle already inadequate HIV prevention and harm reduction services for key populations.
- **The foundations for meaningful integration have been weakened.** Global Fund GC7 reprioritisation and US funding cuts have stripped back essential enablers of integration - human rights and gender work, community led interventions, advocacy, and efforts to secure government investment in harm reduction.
- **Harm reduction funding is now critically fragile.** Evidence shows that the double hit of US cuts and GC7 reductions, combined with minimal to non-existent government financing, has left harm reduction programmes at breaking point. Pushing accelerated integration in this context risks deepening marginalisation and cutting people who inject drugs and other key populations off from essential, life-saving services.

Key recommendations

- **Secure government funding before integration.** The Global Fund should obtain concrete government commitments and financing for key populations and harm reduction programmes *before* initiating integration. Co-financing policies should include strict, enforceable conditions such as tying disbursements to earmarked government allocations for HIV prevention programmes and harm reduction.
- **Protect and resource community-led organisations.** The Global Fund should allocate dedicated funding to community-led organisations, including support for budget advocacy to mitigate the equity risks of integration and to ensure community-led service delivery is not interrupted. Community-led and civil society organisations must have sufficient resources to meaningfully engage throughout the integration process and to drive domestic resource mobilisation. Integration must not equate to the closure of community-led services.
- **Prioritise social contracting as a core integration safeguard.** The Global Fund should prioritise establishing and expanding social contracting mechanisms for community and key population organisations, recognising community systems as a critical component of the wider health system. Community-led and civil society organisations must be engaged meaningfully throughout this process and the Global Fund should allocate resources to budget advocacy to unlock social contracting grants at national, provincial and county levels.

The Global Fund, in its Grant Cycle 8 (GC8), announced its intention to **promote integrated** HIV, TB and malaria into primary health care (PHC) and broader health systems to enhance system resilience and efficiency for Low Income Countries (LIC), Lower Middle-Income Countries (LMICs) and countries with Challenging Operating Environments (COEs). It also aims to **drive focused integration** processes for Upper-Lower Middle (U-LMICs) and Upper-Middle Income countries (UMICs).[1] The integration process of various interventions across HIV, TB and Malaria are not straightforward and some interventions such as harm reduction require a more nuanced approach and preparedness than others, primarily due to legal barriers, deeply rooted structural stigma and discrimination resulting in grave human rights violations, and minimal or non-existent domestic financing and commitment. Notably, integration processes instigated by the sudden and dramatic funding and political shifts in global health have the potential to be more damaging for key populations, defined as the **equity risk** within the Global Fund Technical Brief.[2] As clearly outlined by INPUD (International Network of People Who Use Drugs), such hasty processes without undertaking careful planning will very likely result in the **further disintegration** of already inadequate harm reduction responses.[3]

The Global Fund is the largest donor to harm reduction, accounting for 49% of total harm reduction funding and 73% of total donor funding to harm reduction in LMICs in 2022. Domestic funding constituted only 33%.[4] The U.S. funding cuts severely impacted harm reduction programmes[5] and the wider health infrastructure which it relies upon in many countries. The Global Fund GC7 reprioritisation process reduced allocations for some programming areas important in ensuring **key pre-requisites for integrating services for key populations and harm reduction into primary health care**. Significant reductions include community-led advocacy and monitoring of domestic resource mobilisation (71%), monitoring and reforming policies, regulations and laws (69%), addressing needs of people in prisons and other closed settings (61%).[6] HRI's analysis found that due to reprioritisation, allocations for interventions for people who inject drugs and their sexual partners across 24 countries with a heavy reliance on the Global Fund for harm reduction funding have seen a total reduction of USD 12.83 million.[7]

The evidence indicates that the harm reduction funding situation in many countries is precarious due to the dual impact of US funding cuts and the Global Fund GC7 reprioritisation reductions. HRI's Global State of Harm Reduction 2025 found that almost 92% of respondents deemed harm reduction to be under threat in their country, with 62% describing the threat as high or critical.[8] Declaring an accelerated integration in such fragile circumstances could risk further marginalising people who inject drugs from essential services.

We call upon the Global Fund Board and Secretariat to avoid a one-size-fits-all approach to integration across countries, but to have a nuanced and robust planning process with secured domestic funding guided by evidence and community insights. Anything less risks rolling back gains made through Global

[1] The Global Fund Strategic Shifts and adaptations for Grant Cycle 8 (GC8) https://resources.theglobalfund.org/en/strategic-shifts-gc8/
[2] Global Fund Technical Brief on Integration
[3] INPUD 2025 Integration Without Erasure: Brief to the Global Fund https://inpud.net/integration-without-erasure/
[4] Harm Reduction International 2024. Cost of Complacency- A Harm Reduction Funding Crisis https://hri.global/flagship-research/funding-for-harm-reduction/cost-of-complacency/
[5] Harm Reduction International 2025- The Impact of US funding cuts on harm reduction https://hri.global/publications/impact-of-the-us-funding-cuts-on-harm-reduction/
[6] The Global Advocacy Data Hub https://www.dataetc.org/projects/reprioritization/?lang=EN
[7] The amount is calculated using data from https://www.dataetc.org/projects/reprioritization/?lang=EN
[8] Harm Reduction International 2025- Global State of Harm Reduction 2025 Update to Key Data https://hri.global/publications/global-state-of-harm-reduction-2025-update-to-key-data/

Fund investments and as the largest donor to harm reduction, the accountability to maintain funding and deliver on commitments is significant.

- **Secure tangible government funding and commitment for key populations and harm reduction before integration**

During the Grant Cycle 7 reprioritisation process several countries experienced substantial reductions in harm reduction funding. For example, Ethiopia (USD 1.3 m), Kenya (USD 2.4m), Nigeria (USD 1m), Tajikistan (USD 470.8K) and Tanzania (USD 1.5m).[9] These countries have high HIV prevalence amongst people who inject drugs, minimal or non-existent domestic funding on harm reduction, and the majority also experienced US funding cuts. Any further reductions, or the initiation of rapid integration without substantial government commitment and preparedness could jeopardise HIV programmes for people who use drugs and wider key populations.

Even countries that have begun integrating harm reduction into primary health care have encountered budgetary challenges during implementation. Recently, Indonesia integrated HIV, harm reduction and mental health into primary health care. However, harm reduction and mental health struggle to deliver comprehensive services resulting in inequity due to a lack of national and donor funding.[10] Similar situations have been observed in other countries with piloted harm reduction integration programmes through donor funding without securing government funding. There were clear messages of unsustainability, inequitable access and the lack of comprehensive services at integrated sites without government commitment.

- **Dedicated funding for community and community-led responses, services including budget advocacy at both global and national level**

We echo INPUD's recommendation[11] for a dedicated funding stream in GC8 for community-led services and responses. US funding cuts and GC7 reprioritisation have reduced community systems and reduced advocacy, monitoring, outreach, training, campaigns and caused the loss of skilled human resources consistently across countries. However, examples from integration experiences in Indonesia and Lebanon, for example, confirm that community-led responses and activities (outreach, peer-education) for marginalised populations such as people who inject drugs is crucial for successful transition and ensuring equitable access, improved retention and overall quality of health service delivery in the integrated service sites.

Such dedicated funding will be crucial to ensure that communities and civil society organisations can meaningfully engage and make valuable contributions throughout the integration process - and ensure that equity risks are mitigated and results in quality harm reduction programmes that meet the needs of people who use drugs. Integration processes must not equate to the closure of community-led services. Governments are unlikely to prioritise equitable access to healthcare for populations they criminalise. Community-led services are a lifeline for key populations including people who inject drugs, and an entry point to HIV services and healthcare more broadly. The closure of community-led services should be non-negotiable.

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[9] The Global Advocacy Data Hub https://www.dataetc.org/projects/reprioritization/?lang=EN

[10] KARISMA 2026 Strengthening Integrated Services for HIV, Drug Use, and Mental Health through Collaboration of Primary and Community Health Care Systems: An Analysis of Implementation and Advocacy Strategies in Four Cities in Indonesia- to be published

[11] INPUD 2025 Integration Without Erasure: Brief to the Global Fund https://inpud.net/integration-without-erasure/

Investing in community-led budget advocacy is crucial to strengthen and sustain co-financing efforts of the Global Fund. Many Global Fund eligible countries are devolved with autonomous provinces, counties and states with unique budgetary and social contracting regulations distinct from federal government. Importantly, the majority of primary health care elements fall under provincial jurisdictions. Without community-led budget advocacy, the Global Fund's leverage on co-financing does not sufficiently support targeting provincial level opportunities. For example, community-led and civil society budget advocacy in Indonesia, Kenya and South Africa unlocked provincial and county level funding for HIV prevention and harm reduction.[12]

- **Secure social contracting mechanisms for key populations from governments to support critical community systems**

Social contracting mechanisms and funding can offer an important framework for sustaining community systems in the face of fragile donor uncertainty. However social contracting mechanisms are developed and defined within each country's social, legal and policy contexts and this poses challenges for criminalised populations. Efforts should be made to learn from and evaluate Global Fund supported social contracting during GC7, to inform integration processes in GC8 and maximise opportunities for community and civil society organisations to secure funding from government. Many countries have well-established social contracting models for HIV and harm reduction such as in India, Thailand and South Africa[13] offering guidance and inspiration from varying contexts.

Devolved provincial and county governments may have unique social contracting grants and regulations which require technical assistance and budget advocacy support for community-led and civil society organisations to tap into and unlock funds. For example, a budget advocacy grant in two provinces of Indonesia enabled civil society to navigate social contracting mechanisms and unlock provincial grants.[14] Global Fund grants should allocate resources for budget advocacy opportunities which will be crucial for successful integration.

[12] Harm Reduction International with financial support from the Elton John AIDS Foundation supported budget advocacy subgrants in three countries targeting provincial governments, which were successful in unlocking funding.
[13] Harm Reduction International (2023) Domestic Funding and Social Contracting for harm reduction https://hri.global/publications/towards-domestic-public-financing-and-social-contracting-for-harm-reduction/
[14] Harm Reduction International with financial support from the Elton John AIDS Foundation sub-granted Rumah Cemara, a community-led organisation based in Bandung, with budget advocacy grant, which led to social contracting grants for three organisations in the province.