

€ Donor retreat

£

The funding crisis for harm reduction

Government neglect

?

?

\$

The way forward

?



Harm Reduction International (HRI) is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights-based approaches to drug policy through an integrated programme of research, analysis, advocacy and civil society strengthening. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.



The International Drug Policy Consortium (IDPC) is a global network of more than 110 non-governmental organisations that come together to promote objective and open debate on drug policies. Our vision is that national and international drug policies are grounded in the principles of human rights and human security, social inclusion, public health, development and civil society engagement.



The International HIV/AIDS Alliance is a unique global alliance of civil society organisations in 40 countries dedicated to ending AIDS through community action. We are building knowledge, mobilising people, inspiring leadership and allowing all voices to play significant roles in the local, national and global response to HIV. Our experience shows that together, we can achieve more impact.

The funding crisis for harm reduction:

Donor retreat, government neglect and the way forward

Catherine Cook, Jamie Bridge, Susie McLean,
Maria Phelan, Damon Barrett

© International Harm Reduction Association

ISBN 978-0-9927609-1-5

Acknowledgements

We would like to thank all the individuals and organisations who provided information for and comments on this report, in particular Rosalind Fennell, Olga Golichenko, Oanh Khuat, Nora Kriausaite, Annie Madden, Ele Morrison, Naomi Seiler, Jason Wright and Daniel Wolfe. We are also very grateful for financial support from amfAR, Open Society Foundations and the World Health Organization to produce this report.

Design by Anne Heasell
Copy editing by Jennifer Armstrong

Published by
International Harm Reduction Association
Unit 2C09
South Bank Technopark
90 London Road
London SE1 6LN
www.ihra.net



THE GLOBAL STATE
OF HARM REDUCTION



Contents

02

Executive summary

04

Introduction: Resourcing harm reduction in a changing financial landscape

06

1. How much money is needed?

10

2. How much money is being spent?

10	2.1	The changing donor landscape and middle-income countries
10	2.1.1	Poor political will for harm reduction
11	2.2	Challenges in tracking harm reduction expenditure
12	2.3	Domestic investment
13	2.3.1	Threats to HIV prevention programmes
14	2.3.2	Failure to take harm reduction programmes to scale
14	2.4	International donor investment
16	2.4.1	The Global Fund to Fight AIDS, Tuberculosis and Malaria
19	2.4.2	UK government – Department for International Development (DFID)
23	2.4.3	Dutch government
23	2.4.4	US government – President’s Emergency Plan for AIDS Relief (PEPFAR)
26	2.4.5	Open Society Foundations (OSF)

27

3. Discussion and recommendations

27	3.1	Keep the Global Fund global
29	3.2	Invest strategically in harm reduction
30	3.3	Increase national harm reduction investment
31	3.4	Rebalance existing resources in favour of health and harm reduction

32

References

Executive summary

Funding for HIV-related harm reduction programmes globally is in crisis. There can be no 'AIDS free generation' without targeted efforts with and for people who inject drugs, yet, as this report shows, funding for harm reduction falls dangerously short of estimated need. As a result, coverage of essential HIV and harm reduction programmes targeting people who inject drugs is very low and wholly inadequate to respond effectively to HIV among this community. While this has been the case for some time, the data and policy analysis conducted for this report shows that rather than action being taken to address this problem, the situation looks set to deteriorate.

US\$ 2.3 billion annually is estimated by UNAIDS to be required to fund HIV prevention among people who inject drugs in 2015. At last estimate only US\$ 160 million was invested by international donors – approximately 7% of what is required.

This situation is likely to get worse. International donor policy and practice is changing. Increasingly, funds are directed towards low-income countries with a high disease burden and related HIV treatment services. More countries are becoming ineligible for international donor support due to their middle-income status, regardless of epidemiological need or the willingness of the national government to step in and cover the remaining funding gaps. This is despite the fact that the majority of people who inject drugs (approximately 75%) live in these countries.

The focus on disease burden also deprioritises prevention. But the lack of access to harm reduction services is one of the most important factors driving HIV transmission in middle-income countries and in key regions – Central and Eastern Europe and Central Asia, South and South-East Asia and the Middle East and North Africa.

Donor governments are increasingly relying on their contributions to multilateral agencies such as The Global Fund to Fight AIDS, Tuberculosis and Malaria to fulfil their commitments to key population programming. Yet Global Fund policy has also changed and now, like some of its main contributors, it favours investment in low-income countries with a high disease burden. Without urgent action this will result in a decrease in Global Fund resources for harm reduction, just as the Global Fund was becoming instrumental in financing large-scale, high-impact harm reduction programmes, and at a time when it has received larger pledges than ever in its most recent replenishment.

National governments are not taking responsibility for their own key populations and their own epidemics. For the second consecutive year, domestic spending has outweighed international donor spending on HIV responses in low- and middle-income countries. While this is a positive step, these increased state commitments have yet to benefit people who inject drugs and other key populations. Even where HIV prevalence rates are increasing and harm reduction programme coverage is dismally low, many governments are not prioritising these programmes.

This is not due to a lack of money, but rather a lack of appropriate allocation of resources. At the same time as harm reduction services are lacking, these governments spend vast amounts on drug enforcement, too often targeting and harming the very people in need of support, not punishment. Indeed, it has been estimated that global drug enforcement easily exceeds US\$ 100 billion annually. One tenth of this would cover global HIV prevention for people who inject drugs (as estimated by UNAIDS) for four years.

Without significant changes to the way in which HIV funding is allocated and drug policy budgets distributed; without significant increases from international donors and national governments; and without a commitment to fair and equitable responses for all key populations in low- and middle-income countries, HIV epidemics among people who inject drugs will continue unabated and commitments to 'getting to zero' new infections will be abandoned.

Solutions to this crisis are set out in this report:

1

Keep the Global Fund global

2

Invest strategically in harm reduction

3

Increase national harm reduction investment

4

Rebalance existing resources in favour of health and harm reduction

Introduction:

Resourcing harm reduction in a changing financial landscape

The international response to HIV and AIDS over the last thirty years of the epidemic has been unprecedented. Communities, civil society organisations, governments, multilateral agencies and researchers have invested heavily in HIV prevention, treatment and care. This momentum has led to financial investment rising steadily to reach US\$ 18.9 billion in 2012, up 10% from the previous year.¹ This exceptional investment has led some to claim that the 'End of AIDS' is in sight.² However, spending on HIV and AIDS programmes in 2012 was still substantially short of the US\$ 22–24 billion global target.³

"Few could have imagined this day...marking the beginning of the end."
Barack Obama, 2011⁴

Throughout the HIV epidemic, the investment to prevent and treat HIV among marginalised and criminalised populations has not met the need.⁵ This is evident in the consistent failure to establish and scale-up HIV-related harm reduction programmes for people who inject drugs in low- and middle-income countries.⁶

As part of global efforts to reach an AIDS-free generation, the international community committed to reducing HIV transmission among people who inject drugs by 50% by 2015.⁷ However, this commitment has not been matched by the required funding, with fewer than half of international donors who invest in the HIV response supporting harm reduction programmes.⁸ Domestic HIV expenditure, while on the increase in low- and middle-income countries, only rarely focuses on programmes to prevent HIV transmission among people who inject drugs, even where this population accounts for the majority of new HIV infections.

Throughout the HIV epidemic, the investment to prevent and treat HIV among marginalised and criminalised populations has not met the need.

International development donors are the main funders of harm reduction programmes. But this funding, particularly in middle-income countries in Asia and Eastern Europe, is diminishing.

'Given the severity of the challenge, HIV prevention programming for people who inject drugs is badly under-resourced.'
(UNAIDS, 2013)⁹

The unwillingness to invest in harm reduction from governments and donors cannot be attributed to a lack of evidence of the cost-effectiveness of interventions to prevent HIV transmission among people who inject drugs. It has consistently and repeatedly been proven that scaling-up priority harm reduction interventions saves lives and saves money – to such an extent that economic experts call upon those countries with significant HIV epidemics among people who inject drugs to invest immediately.¹⁰ They warn that not doing so will bring an exponential rise in HIV transmission, which will very quickly bring enormous human costs as well as additional and avoidable costs to government health budgets.¹¹

'These services should be a high priority for fiscally-minded governments'
(Joanne Csete, 2014)¹²

Due in large part to this financial shortfall, the coverage of harm reduction interventions remains unacceptably low in most low- and middle-income countries (see Figure A).¹³

In 2010 it was estimated that, worldwide, just two needles and syringes were distributed per person who injects drugs per month.

Figure A
Service coverage for people who inject drugs in 2010¹⁴



Per month



In the same year, just 8% of people who inject drugs had access to opioid substitution therapy (OST)^a



Just 4% of people who inject drugs living with HIV received anti-retroviral treatment (ART)¹⁴

Seventy-one countries report injecting drug use within their borders yet do not provide needle and syringe programmes (NSPs), and 81 countries report injecting drug use yet do not provide OST.¹⁵ Since 2010, funding cutbacks have resulted in closures of NSPs in countries in Central Europe and Asia; two of the regions most affected by HIV transmission related to unsafe injecting.¹⁶

Even where harm reduction programmes have been established, coverage remains uneven, with some programmes reaching very few people. In others, while a national policy may include harm reduction, punitive drug policy measures act as a major impediment to service delivery.

If the adoption of harm reduction in new countries continues at the current pace, it will be 2026 before every country in need has even one or two programmes operating, or has endorsed harm reduction within national policy.^b

This report tells the story of HIV-related harm reduction funding over time and explains why an AIDS-free generation will not be possible if the present rate and pace of investment continues. It also highlights the changing donor landscape and the particular problem for harm reduction funding in middle-income countries experiencing decreasing international donor support.

While the challenges are considerable, there are concrete actions that donors, governments and harm reduction advocates can take to build a fully funded, sustainable harm reduction response. The resources needed are minimal when compared with the level of funding invested in drug law enforcement, imprisoning those convicted of minor drug offences, and treating HIV and hepatitis C infections that could have been averted.

The resources needed are minimal when the real potential to avert new HIV and hepatitis C infections and save lives is factored in. Strategic investment in HIV programmes targeting key populations is required, regardless of country income status. Bilateral investments must be re-prioritised, and existing resources in drug policy should be rebalanced in favour of health and harm reduction.

^aIt should be noted that this analysis included people who injected non-opioids, but the estimate nonetheless raises serious concerns about OST coverage.

^bBased on findings from the Global State of Harm Reduction project of Harm Reduction International (2008–2012).

1. How much money is needed?

In 2011, UNAIDS launched the Strategic Investment Framework (SIF).¹⁷ This model was developed to guide ‘more focused and strategic use of scarce resources’.¹⁸ Economic modelling illustrated that implementation of the SIF – which covers the full range of HIV interventions, including harm reduction programmes – was not only highly cost-effective, but also would avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020.¹⁹

The SIF estimated that US\$ 2.3 billion would be required in 2015 to implement the core package (see Box 1.1) of harm reduction interventions for people who inject drugs at the recommended coverage levels (see Table 1.1). This amount, invested appropriately, would significantly reduce new infections among people who inject drugs. Based on evidence from countries with well-established high-coverage harm reduction programmes, it would reverse, or avert, HIV epidemics among this population in low- and middle-income countries.

Investment would then reduce by 2020, due to coverage levels having reached targets, fewer new HIV infections and a reduced need for HIV treatment and other services.²⁰

The SIF also introduced the term ‘critical enablers’, which refers to activities such as advocacy to increase political commitment and access to services, policy and law reform and community mobilisation. This is the core work of many harm reduction civil society organisations and networks around the world. This work is essential to the delivery of effective, sustainable and scaled-up harm reduction responses, but it is often the hardest work to fund. So when the resources necessary for harm reduction in 2015 are being calculated, a portion of the estimated US\$ 3.4 million needed for ‘critical enablers’ must also be factored in (see Table 1.1).

Box 1.1

Package of core interventions for HIV prevention, treatment and care among people who inject drugs²¹

1. Needle and syringe programmes (NSPs) (priority intervention)
2. Opioid substitution therapy (OST) and other drug dependence treatment (priority intervention)
3. HIV testing and counselling
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for injecting drug users and their sexual partners
7. Targeted information, education and communication for injecting drug users and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

While this list is sometimes referred to as the comprehensive harm reduction package of interventions, harm reduction advocates argue for the implementation of a wider range of interventions including, for example, drug consumption rooms and peer naloxone distribution, as well as access to legal support and advocacy for structural changes such as drug policy reform.²²

Despite the clarity with which the SIF provides estimations for reaching the 'tipping point' in the epidemic, not much has changed for harm reduction programmes in the three years since its publication. There is no clear evidence of improvements in funding to support the scale-up of HIV prevention for people who inject drugs.

Despite the clarity with which the SIF provides estimations for reaching the 'tipping point' in the epidemic, not much has changed for harm reduction programmes in the three years since its publication. There is no clear evidence of improvements in funding to support the scale-up of HIV prevention for people who inject drugs.

'While [The U.S. President's Emergency Plan for AIDS Relief] PEPFAR and the Global Fund have taken steps to increase the strategic focus of their investments, concrete evidence that allocations in countries have shifted toward an alignment of national spending with investment principles is incomplete. In particular, the persistent under-prioritization of programs for key populations at highest risk reduces the strategic impact of programs.' [AmfAR and AVAC, 2013]²⁴

While the level of investment required will vary across and within regions, some have argued that the proportion of overall HIV funding directed towards harm reduction should be

equal to the proportion of new infections attributed to injecting drug use.²⁵ Globally, this figure has been estimated to be in the region of 10%;²⁶ however, it reaches 36% in the Philippines, over 40% in parts of Eastern Europe and 68% in Iran,²⁷ indicating a need for a more substantial proportion of overall funds in these places.

The last assessment of total harm reduction expenditure by international donors in low- and middle-income countries showed that far from representing 10% of their overall HIV spend, just 1.4% went to harm reduction, which was equal to only 7% of the estimated resource-needs at the time.²⁸

As in 2010, assessing the extent of the gap between harm reduction funding and need, both global and national, remains very difficult. Many countries still do not have reliable data on HIV incidence and prevalence among people who inject drugs.²⁹ And where there is investment, establishing current spending on harm reduction is fraught with challenges.

The proportion of overall HIV funding directed towards harm reduction should be equal to the proportion of new infections attributed to injecting drug use

Table 1.1 Resources required for SIF 2011–2020 (US\$ billions)²³

	2011	2015	2020
Basic programmes (total)	\$7.0	\$12.9	\$10.6
Prevention of mother to child transmission	\$0.9	\$1.5	\$1.3
Condom promotion	\$0.4	\$0.5	\$0.6
Sex work	\$0.2	\$0.2	\$0.2
Men who have sex with men	\$0.3	\$0.7	\$0.7
Injecting drug users	\$0.5	\$2.3	\$1.5
Treatment, care and support (including provision of provider-initiated counselling and testing)	\$4.5	\$6.7	\$5.5
Male circumcision	\$0.1	\$0.2	\$0.1
Behaviour change programmes	\$0.2	\$0.7	\$0.7
Critical enablers	\$5.9	\$3.4	\$3.7
Synergies with development sectors	\$3.6	\$5.8	\$5.4
TOTAL	\$16.6	\$22.0	\$19.8

Box 1.2

Harm reduction's cost effectiveness: a summary of the evidence

In times of austerity, dwindling health budgets and a shift in donor priorities, investment in proven cost-effective interventions in order to optimise investment is critical. The cost-benefit and cost-effectiveness of harm reduction interventions are well documented. A number of studies (see below) have concluded that interventions which target key populations are not just highly effective in reducing the incidence of HIV and hepatitis C but are cost-effective also.

A recent systematic review of 91 studies concluded that HIV prevention interventions that focus on sex workers, men who have sex with men and people who inject drugs offer better value for money than those aimed at the general population. The review authors recommend that while there may be political barriers to the allocation of funding towards these groups, decision makers would be 'wise to do so'.³⁰

Several studies at national and regional levels support the assertion that where NSPs are implemented quickly and to scale they are cost-effective. For example, in Australia it was estimated that the cost of NSPs from 1988 to 2000 was AUD\$ 122 million. This investment had prevented 25,000 new HIV infections and 4,500 AIDS-related deaths by 2010, producing an estimated saving of AUD\$ 2.4 billion.³¹ A second study in Australia estimated that for every dollar invested in NSP, four dollars were returned in healthcare savings.³²

A more recent study in eight countries in Eastern Europe and Central Asia concluded that the implementation of NSPs could avert between 10 and 40% of HIV infections across the countries. NSPs were found to be extremely cost-effective across all eight countries when considering prevention of both hepatitis C and HIV infections, with a return on investment of between 1.6 and 2.7 times the original investment.³³ Similarly, an evaluation found that NSP implementation in Tajikistan from 2005 to 2010 had averted 4,004 HIV infections and 6,124 hepatitis C infections. It was estimated that for every US dollar spent on NSP programmes, three US dollars were saved in healthcare costs.³⁴

It is also well established that expanding access to OST programmes can play an important role in reducing new HIV infections and increasing the length and quality of life for people who inject drugs.³⁵ In terms of cost-effectiveness, the benefit return for OST is estimated to be four times the treatment cost.

According to the National Institute on Drug Abuse in the United States, methadone treatment is 'among the most cost-effective treatments, yielding savings of \$3 to \$4 for every dollar spent'.³⁶ Similarly, recent studies from China have concluded that investment in OST provision will yield substantial savings for the government through averted HIV infections and decreased HIV treatment costs.³⁷

A study of the available evidence by UNODC, UNAIDS and the World Health Organization concluded: 'According to several conservative estimates, every dollar invested in opioid dependence treatment programmes may yield a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1.'³⁸

A US study has estimated the cost-effectiveness of methadone maintenance treatment for HIV prevention at US\$ 6,300–10,900 per quality-adjusted life years gained, which is significantly lower than the cost of lifetime treatment for HIV.³⁹

The combined implementation of NSP, OST and ART for people who inject drugs offers the highest return on investment. This was demonstrated through modelling the potential impact of scaled-up NSP, OST, HIV testing and treatment in Kenya, Pakistan, Thailand and Ukraine from 2011 to 2015. Analysts found that the cost-effectiveness of combination prevention, implemented at 'ambitious but achievable' coverage levels, was significantly more than what would be achieved if programmes continued at current coverage levels.⁴⁰

Despite the compelling evidence to suggest that harm reduction programmes are not just effective but also represent excellent value for money, some countries continue to invest substantial HIV resources in programmes that target the general public. For example, in twelve countries in Asia and Eastern Europe (none with generalised HIV epidemics), eight spend over 30% (and up to 72% in some) of all HIV prevention resources on interventions targeting the general population.⁴¹

'The scientific evidence ... the public health rationale, and the human rights imperatives are all in accord: we can and must do better for PWID [people who inject drugs]. The available tools are evidence-based, right affirming, and cost effective. What is required now is political will and a global consensus that this critical component of global HIV can no longer be ignored and under-resourced.'
(World Bank, 2013)⁴²

2. How much is being spent?

2.1 The changing donor landscape and middle-income countries

Changes in the wider funding environment and in donor priorities have great significance for the funding of harm reduction programmes. International donors are shifting funding away from middle-income countries and focusing on low-income countries, despite the fact that just 13% of people living with HIV will live in low-income countries by 2020.⁴³ Crucially – and more so than for any other key population in the HIV response – the majority of people who inject drugs live in middle-income countries, particularly in Eastern Europe and Asia. Figure 2.1 shows the 15 countries prioritised by UNAIDS for harm reduction programmes, of which only one (Kenya) is still in the low-income category according to the World Bank's classifications.

Donors are retreating from these countries, under the premise that they are wealthy enough to resource their own HIV responses. Yet national governments are often unwilling to invest in services for key populations, leaving existing programmes under threat and scale-up impossible. One example is Romania, where, following the end of Global Fund support, many harm reduction programmes have closed and a rise in HIV transmission via unsafe injecting has been reported.⁴⁵

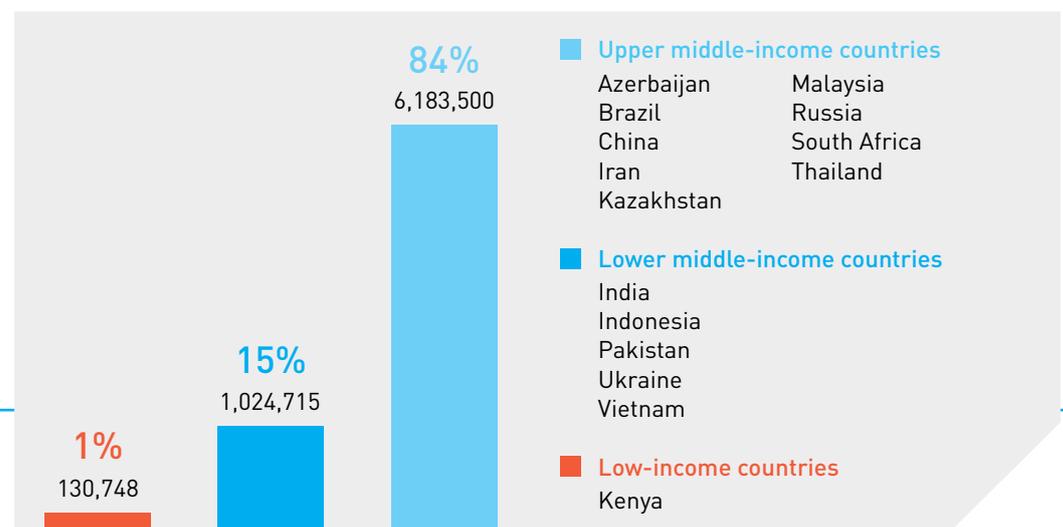
2.1.1 Poor political will for harm reduction

Underpinning many of these resource gaps lies a fundamental inhibiting factor: harm reduction services for people who inject drugs are often politically unpopular. Governments all over the world struggle with the interlinked problems of (a) high levels of stigma against people who use drugs and (b) weak or no commitment to harm reduction approaches such as distributing sterile injecting equipment, providing methadone for treatment of drug dependency, and policy reform. Stigmatising attitudes to people who use drugs are widespread and are formed around beliefs that drug users are 'unworthy', 'bad' or otherwise undeserving of health services. These stigmatising attitudes exist in public and community discourse, and amongst decision makers. They inhibit investment in harm reduction.⁴⁶

Funding for harm reduction may be further threatened after 2015. The Millennium Development Goal on HIV has catalysed investment in the HIV response. It is not yet clear what the post-2015 international targets will evolve to be, but it is likely that HIV will not be prioritised as highly within them, and this will affect donor priorities and has the potential to result in a significant reduction in HIV funding, particularly in middle-income countries. Most funding for harm reduction comes from HIV budgets, so this may further restrict investment.

Figure 2.1

Estimated numbers of people who inject drugs[†], categorised by country income status, in the 15 UNAIDS priority countries for HIV and drug use*.⁴⁴



[†] Estimates of PWIDs: Mathers, Bet al. (2008) 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review,' *The Lancet* 372(9551): 1733-1745

* List of countries from UNAIDS (2010). 'Getting to Zero: 2011-2015 Strategy,' p.23.

2.2 Challenges in tracking harm reduction expenditure

Establishing what is currently being spent is critically important for the assessment of trends and unmet need, and for informing advocacy for increased investments. However, this is no easy task. International donors and national governments are not systematically tracking their investments in harm reduction programmes. They also have varying definitions of what constitutes harm reduction programming.

Government reports to UNAIDS

The UNAIDS National AIDS Spending Assessment (NASA) and the Global AIDS Progress Reporting systems have the potential to provide spending data, but these systems are not currently serving this purpose. The NASA invites countries to report on HIV-related spending, but not all countries submit reports and relatively few disaggregate spending in a way that allows for the tracking of allocations to harm reduction programmes. For example, over the past five years, from a list of 29 Eastern European and Central Asian countries, only Belarus and Tajikistan submitted country reports through the NASA system.⁴⁷

International donors

Despite being crucial to the funding of harm reduction programmes, even the most transparent international donors do not make disaggregated spending information on harm reduction publicly available. Most do not systematically track their harm reduction expenditure, even as an internal exercise. The result of this is that the majority of donors find it challenging to establish how much they are investing in harm reduction programmes and exactly what that investment supports. To date, the Global Fund is the only multilateral agency to produce detailed analysis in this regard – albeit as a one-off rather than a routine exercise.⁴⁸ Attempts by civil society to follow up and update this analysis with the Global Fund have thus far proven difficult.

Harm Reduction International's 2010 **Three cents a day is not enough** report remains the only published assessment of total international donor funds for harm reduction in low- and middle-income countries. The technical and policy challenges inherent in this process were well documented in that report.⁴⁹ Without this information, strategic improvements to current investment cannot be properly informed and donors cannot be held to account.

Differences in budget disaggregation

A standardised methodology for disaggregating harm reduction spending across donors, governments and implementers does not currently exist. Moreover, a standardised definition of what constitutes harm reduction programmes is also lacking, which presents challenges in clarifying the extent and nature of investment in harm reduction programmes. The definition used by PEPFAR to categorise funding for HIV prevention programmes targeting people who use drugs, for example, includes activities such as training, community mobilisation and the prevention of sexual transmission within this population, but does not, due to the US federal funding ban, include the provision of sterile injecting equipment.⁵⁰

Capturing out-of-pocket spend

Spending on harm reduction by people who use drugs is rarely factored into assessments of investment. The out-of-pocket investment required for people to receive OST, for example, can be a significant obstacle to accessing treatment in some countries.⁵¹ Other costs may include purchasing injecting equipment, basic and emergency healthcare, condoms, drug treatment and travel costs to and from harm reduction sites. There is no easy way to track these expenditures. But given the estimated investment in harm reduction from international donors at last count, amounting to three cents per day per person injecting drugs, it is likely that many drug users themselves spend more on harm reduction than governments and donors.⁵²

Harm Reduction International's 2010 **Three cents a day is not enough** report remains the only published assessment of total international donor funds for harm reduction in low- and middle-income countries.

2.3 Domestic investment

‘National ownership of the HIV response for people who inject drugs is critical. Currently, many countries have yet to face up to the gap between current responses and the agreed target of halving new infections among people who inject drugs by 2015.’
(UNAIDS, 2013)⁵³

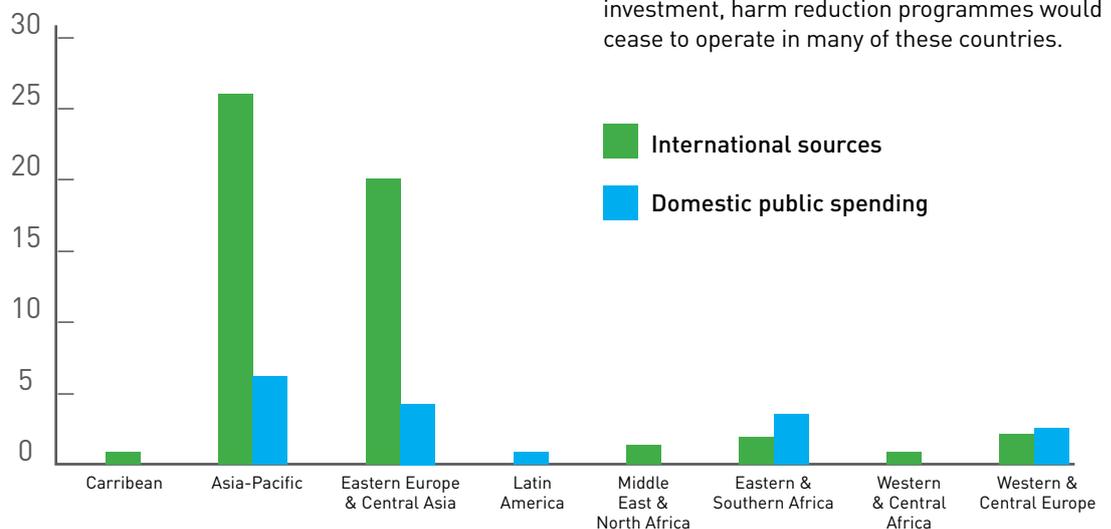
Governments in low- and middle-income countries are increasingly investing in their own national HIV responses. In recent years, public funds invested in HIV in low-income countries and lower middle-income countries have increased by over one-quarter.⁵⁴ Within upper middle-income countries, national governments increased their investment by 6%.^c ⁵⁵ Globally, domestic investments now account for the majority of HIV funding. In 2012, this amounted to an estimated US\$ 9.9 (7.7–12.2) billion, equal to 53% of all global resources available for HIV.⁵⁶

In 2013, UNODC established a list of high-priority countries to guide global efforts to meet the UNGASS target of 50% reduction in HIV transmission among people who inject drugs. These countries are: Argentina, Belarus, Brazil, China, Egypt, India, Indonesia, Iran, Kazakhstan, Kenya, Kyrgyzstan, Moldova, Morocco, Myanmar, Nigeria, Pakistan, Philippines, South Africa, Tajikistan, Tanzania (mainland and Zanzibar), Thailand, Ukraine, Uzbekistan and Vietnam.⁵⁷

The extent to which harm reduction programmes in these countries have benefited from this increased investment from national governments is difficult to establish for reasons described above. However, UNAIDS estimates that increases in national investments in harm reduction programmes are minimal in the majority of low- and middle-income countries.⁵⁸ According to government reports submitted to UNAIDS,^d the proportion of overall harm reduction investment that comes from domestic sources averaged 10% in low-income countries, 18% in lower middle-income countries and 36% in upper middle-income countries. Within their own domestic HIV investments, governments that reported the highest allocations towards harm reduction included Macedonia (31% of the national government investment), Pakistan (23%), Georgia (18%) and Bangladesh (16%).⁵⁹ It is not clear, however, how ‘harm reduction spending’ is categorised within the government reports and whether definitions align across countries. Such information is critical to our understanding of the extent and nature of domestic investment in harm reduction programmes.

In 2013, UNAIDS reported that in ten countries with HIV prevalence rates of over 10% among people who injects drugs, domestic spending on harm reduction represented less than 5% of overall HIV spending.⁶⁰ Figure 2.2 provides a dramatic illustration of the extent to which harm reduction programmes in the two hardest hit regions are still heavily dependent on international donor funds. Without this investment, harm reduction programmes would cease to operate in many of these countries.

Figure 2.2
International and domestic public spending for harm reduction programmes for people who inject drugs in low- and middle-income countries, by region (2007–2012).
(Adapted from UNAIDS global report 2013.)



^c Data limited to those countries reporting to UNAIDS on their domestic investment in the national HIV response.

^d Data from the National AIDS Spending Assessment (NASA) and Global AIDS Response Progress Reporting systems. While these are very useful sources of information, it must be noted that not all countries report and that these are often limited to government reflections

In 2013, UNAIDS reported that in ten countries with HIV prevalence rates of over 10% among people who injects drugs, domestic spending on harm reduction represented less than 5% of overall HIV spending.⁶⁰

2.3.1 Threats to HIV prevention programmes

Increases in domestic HIV investment often represent a problem for harm reduction programmes as domestic funding tends to favour interventions that do not specifically aim to reach key populations. Within national HIV responses, governments are increasing their spending on HIV treatment and care rather than on HIV prevention, leaving HIV prevention programmes heavily dependent on a shrinking pot of international donor funds. Kazakhstan, for example, became ineligible for new Global Fund monies for HIV in 2011. In response to this the Kazakhstan government now funds HIV treatment provision, whereas harm reduction programmes, and other programmes targeting key populations, still largely depend on international funding sources.⁶¹

A closer examination of domestic investment in HIV in Asia provides additional insights. Within eight high-priority countries for harm reduction,^e the proportion of total (international and domestic) HIV spending that went to harm reduction programmes ranged from 1% in Thailand to 29% in Pakistan (see Table 2.1). Only Malaysia, Myanmar and Thailand reported any domestic investment in HIV prevention, at 76%, 11% and 44% respectively.⁶²

Governments do not routinely report on the extent to which their domestic investments go towards harm reduction programmes.

However, it is clear that government support, both financial and political, is lacking in some countries, despite the fact that many HIV epidemics are driven by the sharing of injecting equipment amongst people who inject drugs. The problem of poor political will for harm reduction, described above, shapes this under-investment.

In Thailand, for example, the government reports that it is funding 90% of annual HIV investments, which amounts to US\$ 300 million. Between 2015 and 2017, the Thai government intends to increase its domestic commitment by US\$ 75 million to cover the shortfall and fully fund the national HIV response.⁶⁴ Will this result in a fully funded harm reduction response? The latest estimates suggest that only 44% of the HIV prevention investment is paid for by national government funds, indicating a reliance on international donor funds for this part of the HIV response.⁶⁵ Furthermore, only 1% of the total (international and domestic) HIV spending goes to harm reduction, indicating minimal overall investment.⁶⁶ In 2012, Harm Reduction International reported that 'Without support from the Global Fund, the national response to HIV transmission among PWID would be limited to small-scale community-led programmes whose operations have been under continued threat from police and government crackdowns.'⁶⁷ Financial support from the existing Global Fund grant for HIV programmes in Thailand will cease at the end of 2014, which may prove too soon for the Thai government to be willing, or able, to pick up the shortfall.⁶⁸

Country	Year of data	Harm reduction spend as a percentage of total (international and domestic) HIV spend
Cambodia	2009	2%
India	2009	not reported
Indonesia	2010	3%
Malaysia	2011	15%
Myanmar	2011	10%
Pakistan	2010	29%
Thailand	2011	1%
Vietnam	2010	7%

Table 2.1
Government-reported spending data extracted from AIDS Data Hub 2014⁶³

^e With either over 100,000 people who inject drugs or HIV prevalence among people who inject drugs of over 15% and available data from 2009 or later: Cambodia, India, Indonesia, Malaysia, Myanmar, Pakistan, Thailand, Vietnam

2.3.2 Failure to take harm reduction programmes to scale

According to government reports submitted to UNAIDS, 45 countries consider HIV prevention for people who inject drugs to be a national priority, and 27 of these countries state they are on target to meet the goal to reduce new infections among people who inject drugs by 50% by 2015.⁶⁹ However, the evidence to support this is contested.⁷⁰ Many of these countries lack reliable population-size estimates of people who inject drugs, and have low coverage of priority harm reduction interventions such as NSP and OST. Further, criminalisation, stigma and discrimination limit the effectiveness of current service provision in many of these countries. According to UNAIDS, while countries that have introduced NSPs, OST and other harm reduction components should be applauded, urgent attention is now needed to bring these services to scale. In Azerbaijan, only 68 people are receiving opioid substitution therapy. In Georgia and Kazakhstan, the figures are 650 and 207 people, respectively – a tiny fraction in each country of the number of people who need the service.⁷¹

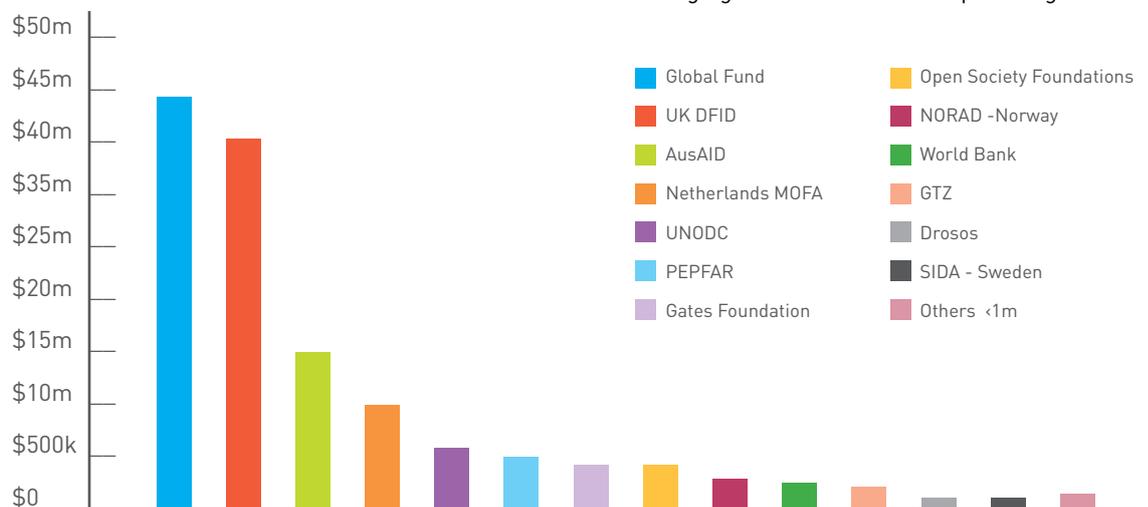
Poor national prioritisation and investment remain major obstacles to the scale-up of HIV and harm reduction programmes targeting people who use drugs.

2.4 International donor investment

Thirty-seven international donors (including bilaterals, multilateral mechanisms, foundations and trusts) provide funds for HIV responses in low- and middle-income countries.⁷² The US government and the Global Fund account for 80% of the total international assistance for the HIV response.⁷³ In 2012, a total of US\$ 8.9 billion was invested by international donors into HIV responses around the world. International donors contributed 47% of the overall HIV spend in 2012. This was made up of bilateral government spending (67%), multilateral spending (28%) and philanthropic investment from foundations and trusts (5%).⁷⁴ While domestic investment in national responses was higher overall, international donors remained overwhelmingly responsible for the financing of HIV prevention among key populations in low- and middle-income countries.

In 2010, Harm Reduction International identified seventeen international donors that directed significant funding towards harm reduction programmes in low- and middle-income countries between 2007 and 2010.[†] For 2007, it was estimated that US\$ 160 million was spent on harm reduction programmes (see Figure 2.3). This represented only 1.4% of overall international donor HIV spending that year and only 7% of the estimated resource-need for harm reduction.⁷⁵ This picture is changing as the donor landscape changes.

Figure 2.3
Identified donor funding for harm reduction in 2007⁷⁶



[†] These were the Global Fund, DFID, AusAID, Netherlands Ministry of Foreign Affairs, UNODC, Bill and Melinda Gates Foundation, PEPFAR, Open Society Foundations, NORAD, World Bank, GTZ, DROSOS Foundation, Swedish SIDA, Canadian CIDA, Levi Strauss Foundation, AIDS Fonds and American Jewish World Service

Box 2.1

Civil society taking the lead to analyse the harm reduction funding gap

Changes in international funding dynamics are requiring civil society to develop greater fluency in investment tracking and increased advocacy for harm reduction funding. Civil society initiatives have been established to inform harm reduction resourcing advocacy in middle-income countries within Asia and Eastern Europe and Central Asia.

Harm Reduction Works – Fund It: Advocacy for increased domestic investments in harm reduction in Eastern Europe and Central Asia

The Eurasian Harm Reduction Network is leading a regional advocacy programme (with financial support from the Global Fund) focusing on the need for increased domestic investment in harm reduction programmes in the context of shrinking donor funding for HIV responses in middle-income countries. The programme, 'Harm Reduction Works – Fund It', aims to strengthen civil society advocacy for sufficient, strategic and sustainable investments in HIV-related harm reduction in Eastern Europe and Central Asia. In particular, it seeks to build an enabling environment for harm reduction investment; and to develop the capacity of people who use drugs to advocate for the availability and sustainability of harm reduction services that meet their needs. The regional programme is implemented in five countries: Belarus, Georgia, Kazakhstan, Moldova and Tajikistan.

The programme is assessing levels of harm reduction funding and funding gaps, as well as the quality and availability of harm reduction services in the five focus countries. The findings will be critical for the development of national and regional advocacy, which will in turn focus on influencing budget allocations and service quality at national and regional levels.

Asia Action on Harm Reduction: National advocacy on harm reduction in Asia

The International HIV/AIDS Alliance's Asia Action on Harm Reduction project (with financial support from the European Commission) supports national civil society-led advocacy for scaled-up, government-supported, evidence-based harm reduction and drug policy responses in six Asian countries. This programme has a focus on the urgent need for increased national government investment in harm reduction programmes in Cambodia, China, India, Indonesia, Malaysia and Vietnam.

As with the advocacy plans in Eastern Europe and Central Asia, Asia Action advocates have identified that the tracking of international and national investments in harm reduction is essential to inform their advocacy for increased resources for harm reduction. In 2014/15, Harm Reduction International is working with local researchers to establish the current state of harm reduction funding. It will investigate the amount invested and the sources of funding and aims to assess how funds are spent (e.g. interventions, geographical area and target groups reached). The research will also seek to establish whether current spending is proportionate to epidemiological need within the context of national spending on HIV programmes. Where possible, it will also assess national spending on punitive drug policy approaches such as incarceration within prisons and other closed settings such as compulsory drug detention centres. The information gathered through this research will inform national and regional advocacy for increased funding (particularly government funds) for harm reduction programmes.

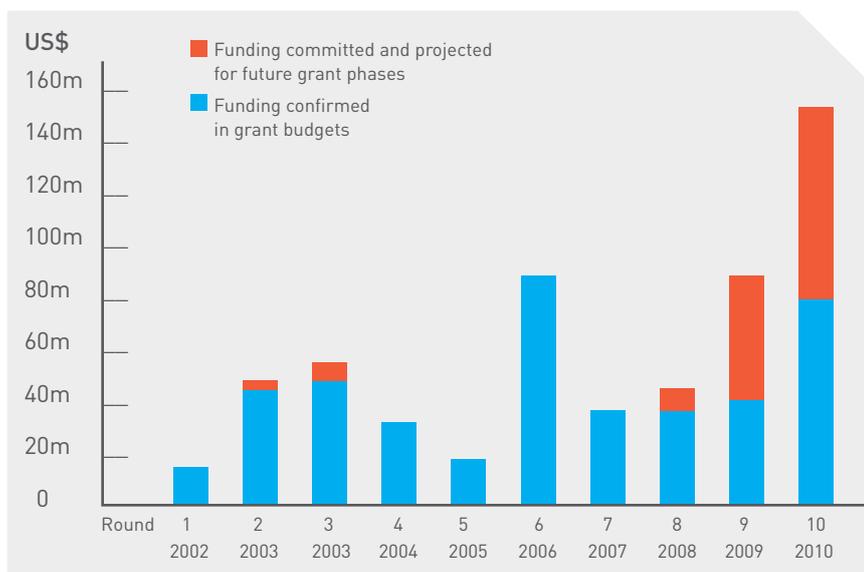
The remainder of this section analyses some of the main harm reduction investors to date, and also examines recent spending and general trends in funding. It is not a comprehensive review of the total funding available for harm reduction, nor of all donors. Instead, it provides an insight into recent funding trends from a selection of important donors, including the Global Fund, the UK government, the Dutch government, the US government and the Open Society Foundations.

2.4.1 The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund was created in 2002, described by then UN Secretary General Kofi Annan as a 'war chest' to fight the three diseases.⁷⁷ Its aim was to mobilise and disburse funds on a new scale, and it rapidly became the leading international donor for harm reduction programmes in low- and middle-income countries.

The Global Fund is the only multilateral donor to have analysed and published its investment in harm reduction programmes. In 2012, it released data from its inception in 2002 up to the ninth funding round in 2009. During that time 120 HIV grants from 55 countries funded activities targeting people who inject drugs – with an estimated investment of US\$ 430 million.⁷⁸

Figure 2.4
Global Fund investments in harm reduction, from Round 1 (2002) to Round 10 (2010)



As Figure 2.4 shows, there was a promising general upward trend over time. The significant increase in the sixth funding round in 2006 includes large grants awarded to Ukraine for its national harm reduction programme.

In 2010, the Global Fund launched its tenth funding round and included a new 'MARPs Reserve'.⁹ This reserve allocation ring-fenced 10% of the HIV funds for programmes that specifically targeted the most-at-risk populations. In 2010, the Global Fund's secretariat also released its first explicit guidance on harm reduction programming, making it clear to countries that the Fund 'supports evidence-based interventions aimed at ensuring that key populations have access to HIV prevention, treatment, care and support ... [including] the comprehensive package for the prevention, treatment and care of HIV among people who inject drugs.'⁷⁹

These initiatives led to large increases in the funding allocated to harm reduction in the tenth funding round (see Figure 2.5). An estimated US\$ 152 million for harm reduction programming was approved in this round – taking the total from 2002 to nearly US\$ 600 million.^h Of the 32 approved HIV proposals, 15 included some level of activity targeted at people who inject drugs, and two MARPs Reserve proposals focused entirely on this population: the regional grant for the Middle East and North Africa Harm Reduction Association (MENAHRRA)⁸⁰ and the grant for Kazakhstan.

⁹ 'MARPs' are most-at-risk populations such as men who have sex with men, transgender people, sex workers, and people who inject drugs.

^h Data due to be published in 2014.

The Round 10 grant in Malaysia aimed to increase the coverage of existing harm reduction services from 18,000 to 57,000 people who inject drugs. In Kenya and Syria, the proposals were to introduce services such as NSPs for the first time. As Figure 2.5 shows, approximately 11% of the total approved HIV funding was directed towards harm reduction – an increase from the previous three years.

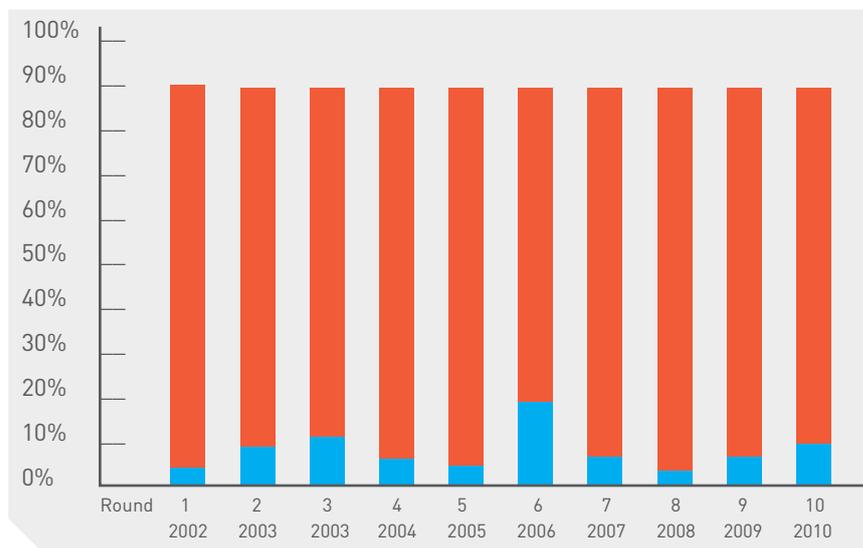
Round 11 and the Transitional Funding Model

The MARPs Reserve approach to funding was due to be repeated in the eleventh funding round. However, this round was cancelled by the Global Fund in November 2011 due to financial uncertainties and donor countries retreating from commitments that they had made.⁸² Amidst the confusion and anxiety that this decision created, the Fund established a 'Transitional Funding Mechanism' to ensure that services were not disrupted. Whereas the tenth round saw US\$ 732 million approved for HIV grants in 32 countries, the Transitional Funding Mechanism comprised just US\$ 112 million for HIV grants in 16 countries.⁸³

Although updated data are not available, it is clear that the Transitional Funding Mechanism led to a dramatic drop from the figures presented in Figure 2.4. The cancellation of Round 11 undermined many national funding plans. In Eastern Europe and Central Asia, for example, eleven countries had prepared applications with strong harm reduction components that they could no longer submit.⁸⁴

The New Funding Model

In 2013, donor countries pledged a record US\$ 12 billion to the Global Fund. In late 2013, the Global Fund announced a major change in how it provides grants, launching the 'New Funding Model' to 'enable strategic investment for maximum impact' and to 'provide implementers with flexible timing, better alignment with national strategies and predictability on the level of funding available'.⁸⁵ The New Funding Model moves away from the competitive funding rounds that had been implemented previously. Instead, countries are assigned to one of four 'country bands' and are given funding allocations based on their income level and disease burden.



The Global Fund's policy commitment to, and guidance on, harm reduction remains clear.⁸⁶ Yet the New Funding Model is a major threat to investments in harm reduction programming, as many of the countries with the greatest need for harm reduction investment are now either ineligible for further funding or are not receiving any 'new' resources until at least 2017 – all as a result of the Global Fund's use of country income status to determine national allocations.⁸⁷ This is likely to lead to dramatic cuts to harm reduction programmes.

This policy shift epitomises the broader de-prioritisation of middle-income countries by international donors discussed earlier. Funding allocations based on country income and population-level disease burden could prove disastrous for investments in harm reduction programming – which predominantly relates to concentrated epidemics, and to middle-income countries in Eastern Europe and Asia that are often not politically prepared to replace donor funding for harm reduction with national funding.

Figure 2.5

Global Fund investments in harm reduction, as a portion of total HIV and HIV/tuberculosis grant commitments (2002–2010)⁸¹

■ All other allocated funding
■ Funding allocated towards harm reduction

The New Funding Model is a major threat to investments in harm reduction programming

Box 2.2

Harm reduction in Ukraine

Changes in donor funding policy are having dramatic effects on harm reduction in Ukraine. Following substantial grants for harm reduction from the Global Fund and PEPFAR, changes in Ukraine's country income status are leading to cuts to services for people who inject drugs.

Ukraine's HIV and harm reduction programme targeting people who inject drugs is one of the largest in the world and is widely considered an example of good practice.⁸⁸ It is also a success: following over ten years of investment in highly targeted harm reduction interventions, HIV rates are going down.⁸⁹ The programme is one of the very few in low- or middle-income countries to be operating at national scale, with an annual reach to 200,000 people who inject drugs. It consists of outreach-based and pharmacy-based NSP, OST, counselling, rapid HIV and hepatitis C testing, STI testing and treatment, legal services and innovations such as peer education for stimulant drug users and couples counselling to address sexual transmission risks and gender-based violence. The national harm reduction programme works alongside national HIV treatment and tuberculosis programmes, and efforts to increase integration between these are well under way, despite the very vertical nature of Ukraine's health system.

This progress is now threatened by investment problems. Despite significant political unrest, Ukraine is considered an upper middle-income country by the World Bank, and therefore by the Global Fund.

As a result Ukraine is facing dramatic cuts to its national harm reduction programme (expected to be 50% at the time of writing). Programme managers predict that plans to scale-up access to OST will cease, along with funding for legal services, STI testing and treatment, and that outreach programmes will have a reduced reach.

Funding for HIV treatment and tuberculosis programmes was better protected in Global Fund grant negotiations. Harm reduction advocates report concerns that the harm reduction programme was 'competing' for funds alongside these other programmes.

The Ukrainian government has historically been very reluctant to invest in harm reduction programmes. It is difficult to predict whether this position will change in light of current political and economic instability in Ukraine. It is also difficult to predict the impact that cutting harm reduction programmes will have on the HIV epidemic.

The situation in Ukraine raises many concerns about the effect of investment decisions on harm reduction programmes. Will investment in HIV treatment programmes undermine harm reduction programmes? Will the national government invest when the Global Fund makes its cuts?

Overall bilateral funding for HIV has dropped by UK£ 75 million since 2010, and as a result the number of DFID-funded HIV programmes has dropped from 26 to 16.⁹⁹ All harm reduction programmes have closed or are due to close by the end of 2014, with the exception of programmes in Myanmar.¹⁰⁰

2.4.2 UK government – Department for International Development (DFID)

The United Kingdom boasts a reputation as a global leader in overseas development assistance (ODA). It has achieved this through prioritising 0.7% of its gross domestic product towards ODA, and it fulfilled this promise for the first time in 2013.⁹⁰ This move made the UK the second largest funder of ODA in the world. In the same year, DFID also pledged UK£ 1 billion to the Global Fund.

DFID has an important history in the funding of harm reduction programmes, investing in both programmatic and advocacy activities. However, in recent years, DFID has joined other donors in a retreat from funding for harm reduction.⁹¹

Under its two HIV strategies, **Taking action** and **Achieving universal access**,⁹² DFID prioritised both financial and political support for key populations. It set out a position on harm reduction in the 2005 paper **Harm reduction: Tackling drug use and HIV in the developing world**, stating that 'the UK views harm reduction as an integral and important part of the overall HIV prevention strategy ... the UK supports equitable access to HIV prevention, treatment and care services especially for vulnerable and marginalised groups including drug users'.⁹³ Within its current HIV position paper, **Towards zero infections**,⁹⁴ DFID continues to highlight key populations as a policy priority for the department.

From 2008 to 2013, DFID's overall HIV funding was steady at around UK£ 300 million per year, UK£ 180 million of which was channelled into bilateral programmes.^{1,95} The majority of harm reduction programmes supported by DFID were based in South East Asia and Central Asia. The DFID programmes that targeted people who inject drugs achieved impressive results and scored highly within DFID's annual review.⁹⁶ In 2007, Harm Reduction International found that DFID harm reduction spending amounted to US\$ 40.8 million (around UK£23.3 million).⁹⁷

However, recent changes in funding policy along with a shift in priorities have impacted negatively on investment in harm reduction programming. The decrease in harm reduction programme funding is framed within a wider decision to withdraw funding from middle-income countries and instead direct UK bilateral aid only towards the poorest countries.⁹⁸

Overall bilateral funding for HIV has dropped by UK£ 75 million since 2010, and as a result the number of DFID-funded HIV programmes has dropped from 26 to 16.⁹⁹ All harm reduction programmes have closed or are due to close by the end of 2014, with the exception of programmes in Myanmar (funded through the Three Diseases Fund until 2016).¹⁰⁰

DFID asserts that it is working to ensure the sustainability of these programmes when their funding ends. However, concerns have been raised that transitional funding arrangements have not been put in place. For example, the final evaluation of the joint DFID and World Bank funded programme in Vietnam notes 'concerns in relation to sustainability and, in particular, the lack of a clear pathway or transitional strategy to secure domestic funding for harm reduction interventions after [the project is] phased out'.¹⁰¹ At present those programmes previously supported by DFID and the World Bank in Vietnam are unlikely to continue at their current scale.¹⁰²

DFID has continued to prioritise funding for civil society advocacy and has increased its contribution in this area from 21% in 2008/9 to 34% in 2012/13.¹⁰³ However, civil society organisations focusing on harm reduction advocacy have not benefited from this increase in support. DFID's primary mechanism of programme partnership agreements (PPAs) currently supports just one HIV civil society organisation and it is not yet clear if PPAs will continue past the current funding round.¹⁰⁴

In recent years, DFID has joined other donors in a retreat from funding for harm reduction.⁹¹

¹ This included projects identified as targeting people who inject drugs, as well as those targeting 'vulnerable populations' for which it was assumed that one-third would be targeted towards people who inject drugs.

DFID, harm reduction and multilateral investment

As a result of its bilateral aid review, DFID took the decision to 'shift its bilateral footprint' and invest its remaining HIV funding primarily through multilateral organisations – notably the Robert Carr civil society Networks Fund (RCNF) and the Global Fund.

The UK government has pledged UK£ 1 billion to the Global Fund, and indicates that the Global Fund has become the UK's major mechanism for financing the HIV response.¹⁰⁵ DFID's investment in the Global Fund is, however, shaped by Global Fund policy that limits investment in middle-income countries, which in turn reduces DFID's investment in harm reduction programmes. DFID acknowledges that Global Fund support in middle-income countries is uncertain and that a 'robust debate' should take place in order to ensure that UK priorities, including harm reduction, are supported.¹⁰⁶

The RCNF was launched at the International AIDS Conference in Washington in July 2012, with the goals to 'support the work of global and regional civil society networks to address critical factors for scaling up access to prevention, treatment, care and support and to protect the rights of inadequately served populations'.¹⁰⁷ It is currently supported by four international donors: DFID, the Norwegian Ministry of Foreign Affairs, the Bill and Melinda Gates Foundation and PEPFAR.

The RCNF focuses on funding regional and global networks to engage in advocacy activities. This is an important investment as dedicated funding for advocacy and network strengthening is a vital area of activity often overlooked by donors.

Prior to the establishment of the RCNF, DFID channelled direct investment to harm reduction and drug user organisations and other key population groups. However, as set out in **Towards zero infections**, DFID took the decision to channel the majority of funding for advocacy activities and civil society strengthening for key populations through the RCNF. Civil society organisations have raised concerns that by relying entirely upon this mechanism the UK has reduced funding for key population advocacy networks working at the global level.¹⁰⁸ A marked decrease in DFID funding for UK-based global harm reduction advocacy organisations led to a period of funding instability for several international harm reduction organisations and a decrease in overall harm reduction funding from DFID.¹⁰⁹

DFID's investments into the Global Fund and the RCNF have been widely welcomed by civil society.¹¹⁰ However, it is clear that DFID should rethink its strategy around financing key population programming and advocacy through these mechanisms alone if it is to ensure that its financial commitments further their policy priorities.¹¹¹

Box 2.3

Harm reduction at the crossroads: Vietnam

Vietnam is a priority country for harm reduction. It is home to over 150,000 people who inject drugs, of whom an estimated 13% live with HIV and around two-thirds live with the hepatitis C virus.¹¹² For people who inject drugs in Vietnam, middle-income country status has posed a huge threat to the continuation of services that they rely upon daily.

DFID, PEPFAR, the World Bank and the Global Fund have been the major funders of the HIV response in Vietnam – where 71% of the HIV spending is supported by international funding sources.¹¹³ In 2012, DFID and World Bank funding ceased, and both PEPFAR and the Global Fund are reducing their contributions and will cease funding in 2015 and 2016 respectively.¹¹⁴ Under the Global Fund's New Funding Model, Vietnam was allocated around US\$ 67 million for HIV, of which just US\$ 8 million was 'new' funding (the remainder being money that had already been approved for previous grants, but not yet disbursed).¹¹⁵ The latest progress report to UNAIDS highlights a 'clear lack of funding for harm reduction, community outreach and [voluntary HIV counselling and testing] since the [World Bank] project closed and the HAARP project cut its budget earlier than planned.'¹¹⁶

DFID funded a highly successful UK£ 17 million 'Preventing HIV in Vietnam Project' from 2003 to 2009 – with the purpose of reducing vulnerability to HIV infection in Vietnam, primarily through harm reduction programmes to provide needles, syringes and condoms to people who inject drugs and sex workers. In parallel, the World Bank launched its own US\$ 38.5 million 'HIV/AIDS Prevention Project for Vietnam' in 2005 – providing comprehensive support for a range of prevention and treatment activities in 18 provinces, as well as national policy studies, research and training. In 2009, DFID and the World Bank decided to combine resources into the existing World Bank project until 2012. DFID allocated an additional UK£ 18.3 million, and over 60% of the resources were allocated to harm reduction activities.¹¹⁷

A recent evaluation of the DFID and World Bank project concluded that it had a 'significant impact on prevention of HIV infection' and was cost-effective. Modelling illustrated that without these harm reduction programmes, HIV prevalence would have increased by approximately 18% among people who inject drugs. The NSPs implemented between 2003 and 2012 'averted an estimated 31,000 infections and 872 HIV-related deaths'.

Box 2.3 continued

Evaluators conclude that if the funding for these prevention programmes is not sustained, 'then there could be a significant increase in the number of new infections by 2020 (4,698 extra infections), mostly attributable to PWID (4,061), [female sex workers] (59) and their clients (327)'.¹¹⁸

The impending impact of funding cuts on the HIV epidemic and on the lives of people who inject drugs and female sex workers in the country is of great concern. The latest government progress report to UNAIDS cites 'financial and human resources' as the 'major challenges' to sustaining and scaling-up the national OST programme, which already has low coverage in some of the provinces where demand is highest.¹¹⁹

The recent evaluation report concluded that it will fall to the Vietnamese government 'to fill these funding gaps in order to sustain effective HIV programmes, particularly for primary prevention programmes'.¹²⁰ The Vietnamese government has committed to increasing domestic HIV funding by 20% annually between 2012 and 2020, but nevertheless estimates that it will need US\$ 100 million per year in external aid to fund an effective HIV response.¹²¹ Without this 'bridging' funding from international sources, the increasingly high targets set by the National Strategy for HIV AIDS Prevention and Control will not be met. This includes a target to increase the number of people receiving methadone from 16,000 to 80,000 by 2015, currently an unimaginable achievement given the diminishing funds and overloaded existing OST services.¹²²

In Vietnam, and the many other countries with new middle-income country status, the progress made through years of investment in harm reduction is about to be reversed.

2.4.3 Dutch government

The Dutch government, through the international aid programme of the Ministry of Foreign Affairs, is continuing its support for harm reduction programming in high-need countries and as such acts an example of ongoing commitment. HIV programmes for key populations, including harm reduction programmes for people who inject drugs, remain a priority in Dutch HIV/AIDS policy. Further, the Dutch government considers its support for harm reduction as one of its 'added value' contributions to the international HIV response.

The Dutch government supports two main programmes to demonstrate this commitment: 'Bridging the Gaps',¹²³ managed by AIDS Fonds, a multi-country HIV programme targeting key populations (€17.5 million over five years for the harm reduction component); and 'Community Action on Harm Reduction'¹²⁴ (€10 million over four years), managed by the International HIV/AIDS Alliance, another multi-country programme focused entirely on harm reduction programming and advocacy. In both programmes, investment in harm reduction programmes in middle-income countries remains.

The Dutch government acknowledges that chronic under-resourcing of harm reduction continues to be a problem in many middle-income countries. Compared with DFID, it has a longer term perspective on the need to transition to domestic funding for harm reduction. In addition, the funding supports innovation in harm reduction programming, and advocacy for drug policy reform where harm reduction is limited by law enforcement practices and human rights violations. The Dutch government is seeking to intensify the impact of its investments by convening national policy dialogue on harm reduction and the needs of people who use drugs through its embassies in, for example, Indonesia and Kenya.

2.4.4 US government – President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR funds represent the largest contribution to the HIV response from any single nation. Since its inception in 2003, it has committed over US\$ 52 billion to the global HIV response.¹²⁵ However, policy constraints undermine investments in harm reduction programmes. PEPFAR has, since its inception, operated under a Congress-imposed ban on funding NSPs. In 2009, the ban was lifted, and in July 2010, PEPFAR released **Comprehensive HIV prevention for people who inject drugs, revised guidance**, which includes a summary of the evidence for the effectiveness of NSPs and states that 'PEPFAR-supported NSPs can include the distribution of injection equipment, exchange of sterile syringes for previously-used syringes, and opportunities for safe disposal of injection equipment'.¹²⁶ However, in 2011, the ban was returned by Congress, and to date, PEPFAR investment has not included funds for the purchase of needles and syringes.¹²⁷

At the International AIDS Conference in 2012 in Washington, Hillary Clinton (then US Secretary of State) announced three new initiatives to increase attention to key populations through PEPFAR:

US\$ 15 million for implementation research to identify the specific interventions that are most effective for reaching key populations

US\$ 20 million to launch a challenge fund that will support country-led plans to expand services for their key populations

US\$ 2 million investment in the RCNF to bolster the efforts of civil society groups in addressing key populations.¹²⁸

¹ Includes bilateral HIV programmes, contributions to the Global Fund, and bilateral TB programmes until fiscal year 2013.

However, an analysis of PEPFAR spending demonstrates how few resources are committed to HIV prevention among people who inject drugs. The review of a snapshot of PEPFAR country operational plans from fiscal years 2009 through 2012, conducted by George Washington University, found little HIV prevention or treatment spending targeted to people who inject drugs in most countries analysed. This was despite acknowledgement of existing or growing epidemics among people who inject drugs in several of the country operational plans. The researchers also found that the extent to which the PEPFAR spend on HIV prevention among people who inject drugs was proportionate to the epidemiological need varied dramatically between countries.¹²⁹

In South Africa, for example, both the 2012 and 2013 plans state: 'Unfortunately, limited attention is being paid to the HIV needs of People Who Inject Drugs (PWIDs), and prevention, care, treatment and psychosocial services for PWIDs are limited' despite a recognition that 'almost 1/3 of new HIV infections in South Africa are related to

Commercial Sex Workers (CSW), Men having Sex with other Men (MSM), and People who inject drugs (PWID).'¹³⁰

While the 2012 report states that PEPFAR South Africa is 'strengthening its overall MARPs program with the goal of reducing the number of new HIV infections in South Africa among sex workers (SW), persons who inject drugs (PWID), MSM, and their sex partners', there is little evidence of investment being directed towards priority harm reduction interventions for people who inject drugs.¹³¹

There are certainly indications that PEPFAR investment in programmes targeting people who inject drugs has increased since 2007, when an estimated US\$ 5.7 million was spent (US\$ 23.1 million in total between 2007 and 2009).¹³² These figures represented spending on HIV prevention among people who inject drugs in Cambodia, China, India, Kenya, Russia, Tanzania, Ukraine and Vietnam. They did not include any funding for NSPs, and methadone provision was only supported in Ukraine and Vietnam.¹³³

Table 2.2
PEPFAR spending on HIV prevention for people who use drugs in 2011

Country/region	PEPFAR spending on HIV prevention for people who use drugs (US\$)	PEPFAR total HIV spending (US\$)	Spending on HIV prevention for people who use drugs as a percentage of total PEPFAR HIV spending (%)
Cambodia	474,000	18,500,000	2.56
Central Asian Region	4,215,695	15,814,000	26.66
China	909,003	8,000,000	11.36
Guyana	2,000	14,881,575	0.01
India	200,000	33,000,000	0.61
Indonesia	262,177	13,000,000	2.02
Kenya	931,385	517,287,175	0.18
Mozambique	800,000	268,789,597	0.30
Russia	2,750,000	5,000,000	55.00
Tanzania	3,950,000	357,193,489	1.11
Thailand	53,405	5,500,000	0.97
Ukraine	3,200,000	22,178,000	14.43
Vietnam	9,957,550	84,833,168	11.74
TOTAL	27,705,215	1,363,977,004	2.03

PEPFAR operational reports state that US\$ 23.8 million was spent in 2010 on HIV prevention programmes targeting people who use drugs; the figure increased to US\$ 27.7 million in 2011.¹³⁴ They state that this includes prevention among injecting and non-injecting drug users (e.g. methamphetamine users) and covers activities such as 'policy reform, training, message development, community mobilization and comprehensive approaches including medication assistance therapy to reduce injecting drug use', as well as programmes to prevent sexual transmission.¹³⁵ In 2011, this funding went towards programmes in Cambodia, Central Asian Region, China, Guyana, India, Indonesia, Kenya, Mozambique, Russia, Tanzania, Thailand, Ukraine and Vietnam (see Table 2.2). The largest share, over one-third of the 2011 investment for people who inject drugs, went to programming in Vietnam (US\$ 9.9 million). PEPFAR is currently reducing their funding in Vietnam and ceasing support for programmes in favour of technical support in the coming years (see Box 2.3). In most of the countries receiving PEPFAR support for programmes targeting people who use drugs, this represents a very small proportion of overall HIV spending (see Table 2.2).

PEPFAR's 2011 investment in HIV prevention for people who use drugs amounted to just 2% of the PEPFAR spending in those countries. It represented 0.6% of total PEPFAR bilateral spend, and 0.4% of the total PEPFAR budget (including contributions to multilaterals such as the Global Fund).¹³⁷

PEPFAR's overall investment in programmes reaching people who inject drugs has increased over time. In some PEPFAR-funded countries, other international donors are picking up the cost of NSP commodities while PEPFAR funds 'wraparound services'. However, in most of the countries listed in Table 2.2, coverage of priority harm reduction interventions remains well below UN recommended levels,^k and the extent to which PEPFAR can contribute to harm reduction scale-up remains hampered by the federal funding ban on NSPs.

The future of PEPFAR's bilateral funding for programmes targeting people who use drugs is uncertain. While an explicit retreat from middle-income country funding has not been announced, there are indications of this trend. PEPFAR's move to increase 'country ownership' and its emphasis on treatment is resulting in a reduction of financial support for HIV prevention programmes. The impending end of harm reduction programme funding in Vietnam, for example, will reduce PEPFAR spend on HIV prevention for people who inject drugs by over one-third.¹³⁸

PEPFAR's 2011 investment in HIV prevention for people who use drugs amounted to just 0.6% of total PEPFAR bilateral spend.

^k UN guidance recommends 40% coverage of OST and 60% coverage of NSPs to have an impact upon HIV epidemics among people who inject drugs

2.4.5 Open Society Foundations (OSF)

OSF is a key donor for harm reduction, albeit with an annual investment significantly lower than the donors listed above. Through the International Harm Reduction Development (IHRD) programme, OSF prioritises funding for advocacy, technical assistance and pilot harm reduction services, as well as community organising, legal reform and human rights protection in countries around the world. Its presence and support is crucial in many countries where there is still a need to demonstrate the feasibility of harm reduction programmes. OSF has historically played a pivotal role in the uptake of harm reduction across Eastern Europe and Asia.

In 2013, total OSF investment in harm reduction was US\$ 10.4 million. This comprised US\$ 7 million from IHRD, and an additional US\$ 3.4 million from other OSF programmes including the Law and Health Initiative, Access to Essential Medicines Initiative, Sexual Health and Rights Project, Public Health Program general fund, the various OSF geographic programmes (such as those in Russia, China, Latin America and the USA), the Global Drug Policy Program, the Human Rights Initiative, and the Soros foundations in Armenia, East Africa, Georgia, Kyrgyzstan, Macedonia, Moldova and Ukraine. Figures 2.6 and 2.7 illustrate the OSF harm reduction spend in 2013 by expense type and by region.

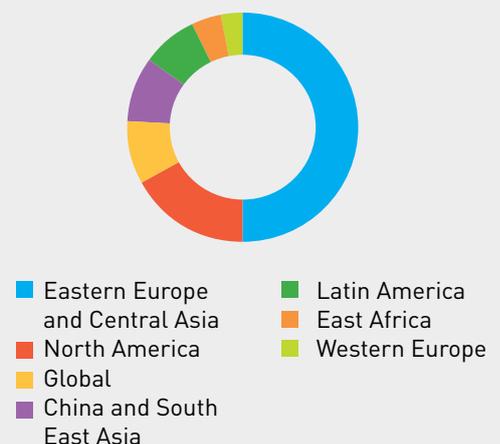
Spending for 2012 and 2011 reached similar levels. Harm reduction work in Latin America is a new addition to the OSF portfolio.

OSF funding goes towards naloxone distribution and NSPs, where these interventions are not yet fully accepted. It also supports advocacy for greater access to hepatitis C medicines. IHRD's emphasis shifted to advocacy and human rights protections following the arrival of the Global Fund. The Global Fund now funds services in most of the countries where IHRD had initiated work. With current resources, however, there is limited scope for OSF to fill the gaps left by the departure of the Global Fund in the middle-income countries that are becoming ineligible or that have no new funding available through the New Funding Model. Nonetheless, OSF continues to support advocacy to examine the impacts of the changes at the Global Fund, and to increase support for health and human rights protections for people who use drugs from bilateral and private donors.¹

Figure 2.6
OSF harm reduction spend in 2013 by expense type



Figure 2.7
OSF harm reduction spend in 2013 by region



¹ Based on information provided by Open Society Foundations International Harm Reduction Development Programme, in June 2014.

3 Discussion and recommendations

3.1 Keep the Global Fund global

The Global Fund's New Funding Model, launched in 2013, reflects the period of soul-searching and crisis management at the Global Fund that followed the cancellation of Round 11 in 2011. Even as the model was being designed and developed, however, civil society groups were raising concerns about its potential impacts on harm reduction.¹³⁹

As described earlier, HIV epidemics amongst people who inject drugs are most often found in middle-income countries, and are **concentrated** epidemics in most cases. In some countries such as Kenya and Tanzania, these epidemics are classified as **mixed epidemics** whereby concentrated HIV prevalence amongst key populations exists as part of broader high levels of HIV prevalence among the general population. Concentrated epidemics are a lower priority in Global Fund funding policy, as disease burden is a dominant factor in determining need.

The use of gross economic indicators to determine investment levels for HIV poses a huge threat to harm reduction programmes – and by extension a direct threat to the global HIV response. Country income status, the general World Bank measure of country wealth, does not factor in the dynamics of HIV transmission and access to services.

Of the 58 countries that have previously received harm reduction funding from the Global Fund, 41% are now either ineligible for support due to their income level (14 countries) or remain eligible but have not been assigned any 'new' HIV money beyond what had already been pledged in previous funding rounds (10 countries).¹⁴⁰

Of the eligible countries, 59% have been formally labelled by the Global Fund as 'over-allocated' or 'significantly over-allocated' – meaning that the money they have received in the past is greater than what they would have received if the New Funding Model had been in place earlier. Of even greater concern, this implies that their funding allocation will continue to be cut in future allocations as the Global Fund seeks to reshape its portfolio.¹⁴¹

Only ten of the 58 countries are eligible for 'incentive funding', which is available to some countries on a competitive basis for applications that demonstrate the greatest case for additional funds.¹⁴² This funding was originally proposed to support the implementation of so-called 'critical enabler' interventions, upon which programme implementation depend, such as advocacy to build enabling policy and legal environments for harm reduction programming.

Despite these threats, the Global Fund remains the leading international donor for harm reduction, and its support is vital to ongoing efforts to increase the coverage of harm reduction programmes for people who inject drugs. Crucially, there is still time for the Fund to implement measures to protect the progress that has been made – but its investments in harm reduction must **increase** rather than **decrease**.

'Mid-term reviews urgently called on the international community not to abandon the HIV response, especially at a moment when historic progress could be jeopardized by funding uncertainties. Even with increased domestic allocations, some countries, especially those with few resources and heavy HIV burdens, will be unable to close their resource gap without external assistance.' (UNAIDS, 2013)¹⁴³

The use of gross economic indicators to determine investment levels for HIV poses a huge threat to harm reduction programmes – and by extension a direct threat to the global HIV response.

Recommendations: Global Fund, donors to the Global Fund

The Global Fund must acknowledge that population-level disease burden and country income status are insufficient indicators to guide investments for key populations, including people who inject drugs. This approach fails to reckon with a country's unwillingness to pay for essential services, as well as the concentrated nature of many HIV epidemics amongst key populations. A more nuanced approach is necessary to determine funding needs – one that recognises the need for gradual transitions to national funding and that analyses and addresses the political barriers to funding for key populations. The Global Fund needs new measures and protections for those whose governments resolutely refuse to support harm reduction and human rights-based programmes.

National governments and bilateral and other donors must honour and increase their contributions to the Global Fund. The scale-up of harm reduction programmes depends on a fully funded Global Fund. Further, Global Fund donors can assert their influence over Global Fund policy to ensure that investment in harm reduction programmes continues to grow and that **no one is left behind** in the global effort to end AIDS. As described earlier, bilateral donors such as the UK and US governments have made important commitments to key populations. These commitments must be **advanced** in Global Fund funding policy, not **undermined**.

The Global Fund must demonstrate strong leadership and commitment to harm reduction programmes, as the largest funder of these programmes. This includes coordinating UN agencies, placing pressure on less supportive governments and ensuring that grant proposals are deemed technically unsound if they do not include priority harm reduction interventions. The New Funding Model's emphasis on 'country dialogue' provides important opportunities for this role.

The Global Fund should seek to build upon the successful MARPs Reserve approach from Round 10 (2010) to optimise the New Funding Model and to ensure dedicated funding for most-at-risk populations such as people who inject drugs. This could be achieved through a specified reserve in each of the four 'country bands', or through a parallel funding mechanism to the regular allocations. Such an approach will allow the Global Fund to continue to prioritise the scale-up of harm reduction programmes.

The Global Fund needs to urgently revisit its communication with regards to 'over-allocated' and 'significantly over-allocated' countries. According to UN guidance, the coverage of NSPs needs to reach 60%, and OST 40%, before 'high' coverage levels are reached in order to impact upon HIV transmission dynamics among people who inject drugs.¹⁴⁴ These levels have not been reached in the vast majority of low- and middle-income countries and, until they are, it is misleading to refer to these countries as being over-allocated.

The Global Fund must ensure better representation of people who use drugs and other civil society stakeholders in Country Coordinating Mechanisms. Meaningful participation requires resources for capacity building of networks and for sensitisation and education measures targeting decision makers. Decision makers need to **understand** harm reduction programmes in order to support them.

3.2 Invest strategically in harm reduction

UNAIDS calls on countries to 'know their epidemic'.¹⁴⁵ For people who inject drugs, there is still very much that is unknown. People who inject drugs are still uncounseled and invisible in national HIV data in many countries, and data on HIV and hepatitis C prevalence, on HIV and hepatitis C treatment need and on barriers to services are missing. There are notable efforts under way to increase the availability of reliable data. But in 2014, while there are reports of injecting drug use in at least 158 countries worldwide,¹⁴⁶ UNODC found population-size estimates of the numbers of people who inject drugs in only 89 countries and estimates of HIV prevalence among people who inject drugs from only 111 countries.¹⁴⁷

Concerted efforts are needed to ensure that countries 'know their spend'. This is important to ensure that national budgets are made on the basis of both epidemiological and resource need.

Our understanding of what is currently being spent on harm reduction must drastically improve. Donors and governments must get better at tracking their investment in harm reduction and must do so transparently, according to value-for-money principles and evidence of effectiveness.

The evidence base for the effectiveness of harm reduction programmes is strong, yet governments and others continue to favour abstinence-based interventions that are more politically popular, but less effective in reducing HIV transmission. Low-threshold, community-based interventions, using outreach and peer-based methods, are essential to the success of harm reduction, and investments must be directed to communities along with clinics and commodities.

Recommendations: International donors and UN agencies

Commitments made by international donors are met, in part, by investing in harm reduction programmes through bilateral mechanisms. This is particularly important in countries where domestic investment in harm reduction is lacking. International donors, where they are exiting from bilateral HIV funding, must ensure that adequate measures are in place for transitional funding, so as to not force the closure of harm reduction programmes. For sustainability of harm reduction programmes, exit strategies should include the funding of advocacy efforts so that national advocates can monitor and defend harm reduction programmes, and engage in national debate on health spending and human rights.

International donors must use their influence to encourage increased domestic investment in harm reduction programmes. International donors must ensure that their multilateral investments are targeted to fulfil their commitments on key populations, including access to services for people who inject drugs.

Data on harm reduction investments must improve. International donors and governments should be systematically tracking disaggregated harm reduction investment and this information should be transparent.

To support this investment tracking effort, UNAIDS and UNODC should be monitoring harm reduction spending more directly. A successful system would enable monitoring of investment fluctuations or gaps and facilitate early recognition of potential funding crises. It should also equip civil society and others with data on investment in order to advocate for sustainable funding for harm reduction programmes.

3.3 Increase national harm reduction investment

Injecting drug use has been identified in 158 countries.¹⁴⁸ In many of these countries, the dynamics of HIV transmission are directly affected by the sharing of injecting equipment. Many governments are failing to grapple with the impacts of injecting drug use, including by preventing HIV and hepatitis C amongst people who inject. A complex mix of poor or no data, stigmatising attitudes towards people who inject drugs, low levels of public support for services for people who inject drugs and low levels of knowledge about the effectiveness of harm reduction interventions all lead to low levels of investment. This situation needs to change. Some national governments, for example the Malaysian government, have overcome these barriers and are investing in harm reduction.

There is an urgent need for many more governments to prioritise spending on harm reduction programmes for people who inject drugs.

Fluency in budget tracking and resourcing advocacy is fast becoming an essential part of the harm reduction advocate's role. In 2014, for example, civil society advocacy programmes were established to inform harm reduction resourcing advocacy in middle-income countries within Asia and Eastern Europe and Central Asia (see Box 2.1). UNAIDS and UNODC, with their systems for tracking national HIV responses, should be more directly supportive of this effort to identify national spending on harm reduction, and identify gaps.

'In the same way that we taught people safe injection techniques and how to reverse overdose, we need to be able to read budgets, understand budget cycles and press for local funding.' (Daniel Wolfe, 2013)¹⁴⁹

Recommendations:

National governments, international donors, UN agencies

National governments in countries with HIV epidemics driven by unsafe injecting must fund national harm reduction programmes. An over-reliance on international funds for services for people who inject drugs is an unsustainable strategy to end AIDS. This recommendation particularly applies to the 24 national governments whose countries are prioritised by UNAIDS and UNODC: Argentina, Belarus, Brazil, China, Egypt, India, Indonesia, Iran, Kazakhstan, Kenya, Kyrgyzstan, Moldova, Morocco, Myanmar, Nigeria, Pakistan, Philippines, South Africa, Tajikistan, Tanzania (mainland and Zanzibar), Thailand, Ukraine, Uzbekistan and Vietnam.

National governments must address stigma related to HIV and drug use, both in public debate and in the attitudes of decision makers, including those who decide on budget priorities. People who inject drugs have the same rights to services as other citizens. Further, a public health approach to HIV must address the needs of people who use drugs in order to end AIDS.

National governments and international donors must invest in efforts to understand injecting drug use in those countries where no or little data exists. Estimates of the numbers of people using drugs, injecting practices and the dynamics of HIV transmission amongst people who inject drugs, and social and cultural factors that influence drug use and HIV risk, are all examples of the essential information that must guide harm reduction programming.

International donors and others with influence must intensify pressure on priority countries to increase domestic investment in harm reduction.

UNAIDS, UNODC, the World Bank and researchers should expand their work to develop investment cases for harm reduction programmes, demonstrating cost-effectiveness and modelling the impact of diminished investment on HIV epidemics among people who inject drugs, with a particular focus on those countries where governments demonstrate weak or no commitment to harm reduction programmes.

International donors should financially support civil society to build their capacity in advocacy for budget transparency, accountability and increased domestic investment.

3.4 Rebalance existing resources in favour of health and harm reduction

Where can money for intensified investment in harm reduction come from? A call for the scale-up of HIV-related harm reduction funding is not a call for diversion of funding from other aspects of healthcare, social policy or HIV prevention. It is a call for better spending of existing resources. Large sums of money are currently invested in drug control measures; for example, policing and court costs, prison costs, drug supply reduction costs. This investment often fails to meet the most basic value-for-money measures, and undermines public health efforts such as HIV prevention.

Governments often call for, and promise, a health-centred approach to drugs, but in country after country around the world the balance of funding is massively weighted in favour of drug law enforcement measures. Even where there have been reductions in resources for drug policy across the board, this has disproportionately affected the health components versus enforcement.¹⁵⁰

To highlight this problem, harm reduction organisations from around the world are challenging governments to rebalance their public health and law enforcement responsibilities. In the lead-up to the UNGASS on drugs in 2016, advocates are calling for a scale-up of harm reduction funding to just one-tenth of what is spent on drug enforcement, and to do so by 2020.

In the European Union, for example, between €3.7 and 5.9 billion is spent annually on imprisoning people for drug offences.¹⁵¹ One-tenth of this money would double the Global Fund's Round 10 allocation for harm reduction programmes.

It is estimated that drug enforcement spending across policing, prisons, courts and probation services is in excess of US\$ 100 billion annually.¹⁵² That figure is uncertain. But even if it is wrong by a factor of four, if annual spending on drug enforcement is only one-quarter of this estimate, just one-tenth of it would fund harm reduction programmes around the world. To put it another way, one-tenth of one year's drug enforcement spending would cover global HIV prevention for people who inject drugs for four years.

Nationally, harm reduction spending rarely achieves more than a small fraction of the allocations for enforcement. A small rebalancing of funding priorities can change the landscape in favour of cost-effective health interventions and fund national harm reduction programmes entirely.

Achieving an appropriate balance of funding in drug policy is complicated, with budgets distributed across different, often competing, ministries. But it is not impossible. In order to control HIV epidemics, governments can make better use of the resources available to them by attending to the HIV needs of people who inject drugs.

One-tenth of one year's drug enforcement spending would cover global HIV prevention for people who inject drugs for four years

Recommendations:

National government, international donors and UN agencies

National governments must undertake cost-effectiveness analyses of current spending on drug policy and take action on failing or ineffective investments.

National governments must estimate the resource needs for HIV and harm reduction programmes and rebalance spending towards health.

International donors and UN agencies must work together to define an international target for global investment in harm reduction programmes, based on the principles of the UNAIDS Investment Framework, and commit to meeting that target, in partnership with national governments.

References

- 1 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 2 For example, see www.unaids.org/en/resources/campaigns/togetherwewillendaids/ (accessed 4 July 2014).
- 3 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 3 Speech given by Barack Obama at World AIDS Day Event 2011. See www.youtube.com/watch?v=ABr11GNs3u8&feature=plcp (at 41.15 minutes) (accessed 3 July 2014).
- 5 Arán-Matero, D. et al. (2011) 'Levels of spending and resource allocation to HIV programs and services in Latin America and the Caribbean', *PLoS One*, 6(7):e22373. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 6 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.
- 7 United Nations General Assembly (2011) **Political declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS**. A/RES/65/277 8 July 2011. Geneva: United Nations.
- 8 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.
- 9 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS: 34.
- 10 Collins, J. (ed.) (2014) **Ending the drug wars: Report of the LSE Expert Group on the Economics of Drug Policy**. London: The London School of Economics and Political Science. Dutta, A. et al. (2012) **The global HIV epidemics among people who inject drugs**. Washington, DC: The World Bank. Craig, A.P. et al. (2014) 'Spending of HIV resources in Asia and Eastern Europe: Systematic review reveals the need to shift funding allocations towards priority populations', *Journal of the International AIDS Society*, 17:18822.
- 11 Dutta, A. et al. (2012) **The global HIV epidemics among people who inject drugs**. Washington, DC: The World Bank.
- 12 Csete, J. (2014) 'Costs and benefits of drug-related health services' in J. Collins (ed.) **Ending the drug wars: Report of the LSE Expert Group on the Economics of Drug Policy**. London: The London School of Economics and Political Science: 76.
- 13 Mathers, B. et al. for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) 'HIV prevention, treatment and care for people who inject drugs. A systematic review of global, regional and country coverage levels', *Lancet*, 375(9719):1014–28.
- 14 Ibid.
- 15 Stoicescu, C. (2012) **Global state of harm reduction 2012: Towards an integrated response**. London: Harm Reduction International.
- 16 Ibid.
- 17 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2011) **A new investment framework for the global HIV response**. UNAIDS Issues Brief. Geneva: UNAIDS.
- 18 Ibid.
- 19 Ibid.
- 20 Ibid.
- 21 World Health Organization, Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Office on Drugs and Crime (UNODC) (2012) **WHO, UNAIDS & UNODC technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2012 revision**. Geneva: World Health Organization.
- 22 For example, see International HIV/AIDS Alliance (2010) **Good practice guide: HIV and drug use. Community responses to injecting drug use and HIV**. Brighton: International HIV/AIDS Alliance.
- 23 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2011) **A new investment framework for the global HIV response**. UNAIDS Issues Brief. Geneva: UNAIDS.
- 24 AmfAR and AVAC (2013) **An action agenda to end AIDS: Where are we in realizing the promise of beginning to end AIDS? September 2013**. Available at: www.housingworks.org/wad/Ending_AIDS_Sept_2013.pdf (accessed 4 July 2014).
- 25 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.
- 26 Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Office on Drugs and Crime (UNODC) (n.d.) 'Facts about drug use and the spread of HIV'. Available at: www.unodc.org/documents/frontpage/Facts_about_drug_use_and_the_spread_of_HIV.pdf (accessed 4 July 2014).
- 27 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.

- 28 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.
- 29 Harm Reduction International (2013) 'Concerns regarding new estimates on HIV, hepatitis C and injecting drug use', Harm Reduction Advisory No. 1, November 2013. London: Harm Reduction International.
- 30 Craig, A.P. et al. (2014) 'Spending of HIV resources in Asia and Eastern Europe: Systematic review reveals the need to shift funding allocations towards priority populations', *Journal of the International AIDS Society*, 17:18822.
- 31 Health Outcomes International Pty Ltd (2002) **Return on investment in needle and syringe programs in Australia: Summary report**. Canberra: Commonwealth of Australia. Australia Commonwealth Department on Health and Ageing (2002) **Return on investment on needle and syringe exchange programs in Australia**. Canberra: Commonwealth of Australia.
- 32 Australian Government, Department of Health and Ageing (2009) **Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia**. Canberra: Department of Health and Ageing.
- 33 Wilson, D. et al. (2012) 'The cost-effectiveness of needle-syringe exchange programs (NSEPs) in Eastern Europe and Central Asia: Costing, data synthesis, modelling and economics for eight case study countries', paper presented at the XIX International AIDS Conference in Washington, DC (22–27 July 2012).
- 34 Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Program (UNDP), University of New South Wales and The Global Fund to Fight AIDS, Tuberculosis and Malaria (2012) 'Evaluating the cost-effectiveness of needle and syringe exchange programs (NSEPs), Tajikistan'. Available at: www.slideshare.net/undpeuropeandcis/evaluating-the-cost-effectiveness-of-needle-and-syringe-exchange-programs-nseps-tajikistan (accessed 4 July 2014).
- 35 World Health Organization (2005) **Effectiveness of drug dependence treatment in preventing HIV among injecting drug users. Evidence for action technical paper and policy brief**. Geneva: World Health Organization.
- 36 Center for Substance Abuse Treatment (2005) **Medication-assisted treatment for opioid addiction in opioid treatment programs**. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 37 Xing, Y. et al. (2012) 'Economic evaluation of methadone maintenance treatment in HIV/AIDS control among injection drug users in Dehong, China', *AIDS Care*, 24:756–62. Mingjian, J. et al. (2012) 'Net financial benefits of averting HIV infections among people who inject drugs in Urumqi, Xinjiang, People's Republic of China (2005–2010)', *BMC Public Health*, 2:572.
- 38 World Health Organization, Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Office on Drugs and Crime (UNODC) (2004) **Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV prevention**. Geneva: United Nations.
- 39 Zaric, G.S. et al. (2000) 'Methadone maintenance and HIV prevention: A cost-effectiveness analysis', *Management Science*, 46.8:1013–31.
- 40 Dutta, A. et al. (2012) **The global HIV epidemics among people who inject drugs**. Washington, DC: The World Bank.
- 41 Craig, A.P. et al. (2014) 'Spending of HIV resources in Asia and Eastern Europe: Systematic review reveals the need to shift funding allocations towards priority populations', *Journal of the International AIDS Society*, 17:18822.
- 42 Dutta, A. et al. (2012) **The global HIV epidemics among people who inject drugs**. Washington, DC: The World Bank.
- 43 Schwartländer, B. for Joint United Nations Programme on HIV/AIDS (UNAIDS) (2012) 'What will it take to turn the tide?' Presentation to the International AIDS Conference in Washington, DC (July 2012).
- 44 International HIV/AIDS Alliance (2012) **HIV, drug use and the Global Fund: Don't stop now**. Brighton: International HIV/AIDS Alliance.
- 45 Botescu, A. et al. (2012) **HIV/AIDS among injecting drug users in Romania. Report of a recent outbreak and initial response policies**. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.
- 46 Stoicescu, C. (2012) **Global state of harm reduction 2012: Towards an integrated response**. London: Harm Reduction International.
- 47 NASA country reports. Available at: www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports/ (accessed 4 July 2014).
- 48 Bridge, J. et al. (2012) 'Global Fund investments in harm reduction from 2002 to 2009', *International Journal of Drug Policy*, 23(4):279–85.
- 49 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.
- 50 The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (2011) **Fiscal year 2010: PEPFAR operational plan**. Washington, DC: PEPFAR.

- 51 Stoicescu, C. and Cook, C. (2013) **Support don't punish: Experiences from community advocacy and harm reduction programmes**. London: Harm Reduction International.
- 52 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.
- 53 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 54 Ibid.
- 55 Ibid.
- 56 Ibid.
- 57 See www.unodc.org/unodc/en/hiv-aids/new/drugs.html (accessed 4 July 2014).
- 58 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 59 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 60 Ibid.
- 61 Ibid.
- 62 HIV & AIDS Data Hub for Asia Pacific (n.d.) 'Datasheet PWID May 2014, HIV expenditure'. Available at: www.aidsdatahub.org/Key-Populations (accessed 15 June 2014).
- 63 Ibid.
- 64 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Smart investments**. Geneva: UNAIDS: 19.
- 65 HIV & AIDS Data Hub for Asia Pacific (n.d.) 'Datasheet PWID May 2014, HIV expenditure'. Available at: www.aidsdatahub.org/Key-Populations (accessed 15 June 2014).
- 66 Ibid.
- 67 Stoicescu, C. (2012) **Global state of harm reduction 2012: Towards an integrated response**. London: Harm Reduction International: 169.
- 68 Malikaew, S. (2014) 'Harm reduction: A lifeline for drug users we cannot afford to lose', **The Nation**. Available at: www.nationmultimedia.com/opinion/Harm-Reduction-A-lifeline-for-drug-users-we-cannot-30237160.html (accessed 1 July 2014).
- 69 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 70 Ibid.
- 71 Ibid.
- 72 The Henry J. Kaiser Family Foundation and Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Financing the response to HIV in low- and middle-income countries: International assistance from donor governments in 2012**. Menlo Park, CA: Kaiser Family Foundation.
- 73 Ibid.
- 74 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 75 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.
- 76 Ibid.
- 77 United Nations (2001) 'Secretary-general proposes global fund for fight against HIV/AIDS and other infectious diseases at African leaders summit', press release, SG/SM/7779/Rev.1. Available at: www.un.org/News/Press/docs/2001/SGSM7779R1.doc.htm (accessed 1 July 2014).
- 78 Bridge, J. et al. (2012) 'Global Fund investments in harm reduction from 2002 to 2009', **International Journal of Drug Policy**, 23(4):279–85.
- 79 The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (2010) **Harm reduction information note**. Geneva: GFATM.
- 80 The Global Fund to Fight AIDS, Tuberculosis and Malaria (2013) 'MMM-011-G01-H – Multicountry Middle East – North Africa (MENAHRRA)'. Available at: <http://portfolio.theglobalfund.org/en/Grant/Index/MMM-011-G01-H> (accessed 1 July 2014).
- 81 HIV and HIV/Tuberculosis totals from www.theglobalfund.org/en/fundingdecisions (accessed 3 July 2014); Round 10 data reflect first two years of grants only.
- 82 Aidspan (2011) 'Board cancels Round 11 and introduces tough new rules for grant renewals'. Available at: www.aidspan.org/gfo_article/board-cancels-round-11-and-introduces-tough-new-rules-grant-renewals (accessed 1 July 2014).
- 83 The Global Fund to Fight AIDS, Tuberculosis and Malaria (2014) 'Funding decisions'. Available at: www.theglobalfund.org/en/fundingdecisions (accessed 1 July 2014).

- 84 Eurasian Harm Reduction Network (2013) **Quitting while not ahead: The Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe and Central Asia**. Vilnius: Eurasian Harm Reduction Network.
- 85 The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (2014) 'New funding model'. Available at: www.theglobalfund.org/en/fundingmodel/ (accessed 1 July 2014).
- 86 The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (2010) **Harm reduction information note**. Geneva: GFATM.
- 87 Stoicescu, C. (2012) **Global state of harm reduction 2012: Towards an integrated response**. London: Harm Reduction International; The Global Fund to Fight AIDS, Tuberculosis and Malaria (2014) **Global Fund country allocation table 2014 – 2016 Allocation Period** www.theglobalfund.org/documents/fundingmodel/FundingModel_CountryAllocationExcel_Table_en/ (accessed 15 June 2014).
- 88 World Health Organization (2014) **Good practice in Europe. HIV prevention for people who inject drugs implemented by the International HIV/AIDS Alliance in Ukraine**. Geneva: World Health Organization.
- 89 Ibid.
- 90 Provost (2014) 'Shh, don't tell anyone, but UK government meets foreign aid target', **Guardian**. Available at: www.theguardian.com/global-development/2014/apr/03/uk-meets-foreign-aid-target (accessed 1 July 2014).
- 91 STOPAIDS (2014) **Stock take: A review of DFID policy and financial commitments to tackling HIV among key populations**. London: STOPAIDS.
- 92 Department for International Development (DFID) (2004) **Taking action: The UK government's strategy for tackling HIV and AIDS in the developing world**. London: DFID. Available at: www.hivpolicy.org/Library/HPP000497.pdf (accessed 1 July 2014). DFID (2009) **Achieving universal access – the UK's strategy for halting and reserving the spread of HIV and AIDS in the developing world**. London: DFID. Available at: www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127511.pdf (accessed 1 July 2014).
- 93 HM Government (2005) **Harm reduction: Tackling drug use and HIV in the developing world**. London: DFID. Available at: www.eldis.org/vfile/upload/1/document/0708/DOC23859.pdf (accessed 1 July 2014).
- 94 Department for International Development (DFID) (2013) **Towards zero infections – two years on. A review of the UK's position paper on HIV in the developing world**. London: DFID. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/261341/Towards_Zero_Infections_-_Two_Years_On_22_November_FINAL_word_version.pdf (accessed 1 July 2014).
- 95 Ibid.
- 96 Ibid.
- 97 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.
- 98 Department for International Development (DFID) (2011) **Bilateral aid review: Technical report**. London: DFID. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/214110/FINAL_BAR_20TECHNICAL_20REPORT.pdf (accessed 1 July 2014).
- 99 STOPAIDS (2014) **Stock take: A review of DFID policy and financial commitments to tackling HIV among key populations**. London: STOPAIDS.
- 100 Ibid.
- 101 Zhang, L. et al. (2013) **Evaluation of a decade of DFID and World Bank supported HIV and AIDS programmes in Vietnam from 2003 to 2012**. Sydney: University of New South Wales.
- 102 Ibid.
- 103 STOPAIDS (2014) **Stock take: A review of DFID policy and financial commitments to tackling HIV among key populations**. London: STOPAIDS.
- 104 Independent Commission for Aid Impact (ICAI) (2013) **DFID's support for civil society organisations through programme partnership arrangements**. London: ICAI. Available at: <http://icai.independent.gov.uk/wp-content/uploads/2013/12/ICAI-REPORT-DFIDs-Support-for-CSOs-through-PPAs.pdf> (accessed 1 July 2014).
- 105 Department for International Development (DFID) (2013) **Towards zero infections – two years on. A review of the UK's position paper on HIV in the developing world**. London: DFID. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/261341/Towards_Zero_Infections_-_Two_Years_On_22_November_FINAL_word_version.pdf (accessed 1 July 2014).
- 106 Ibid.
- 107 See Robert Carr Fund for Civil Society Networks: www.robertcarrfund.org/about/mission-objectives/ (accessed 1 July 2014).

- 108 STOPAIDS (2014) **Stock take: A review of DFID policy and financial commitments to tackling HIV among key populations**. London: STOPAIDS. Department for International Development (DFID) (2013) **Towards zero infections – two years on. A review of the UK's position paper on HIV in the developing world**. London: DFID. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/261341/Towards_Zero_Infections_-_Two_Years_On_22_November_FINAL_word_version.pdf (accessed 1 July 2014).
- 109 STOPAIDS (2014) **Stock take: A review of DFID policy and financial commitments to tackling HIV among key populations**. London: STOPAIDS.
- 110 For example, see STOPAIDS (2014) 'UK pledge raises world's ambition on AIDS'. Available at: http://stopaids.org.uk/uk_pledge/ (accessed 2 July 2014).
- 111 Department for International Development (DFID) (2013) **Towards zero infections – two years on. A review of the UK's position paper on HIV in the developing world**. London: DFID. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/261341/Towards_Zero_Infections_-_Two_Years_On_22_November_FINAL_word_version.pdf (accessed 1 July 2014).
- 112 Stoicescu, C. (2012) **Global state of harm reduction 2012: Towards an integrated response**. London: Harm Reduction International.
- 113 Socialist Republic of Vietnam (2014) **Vietnam AIDS response progress report following up the 2011 political declaration on HIV AIDS. Reporting period Jan 2012 – Dec 2013**. Ha Noi: Vietnamese Government.
- 114 Zhang, L. et al. (2013) **Evaluation of a decade of DFID and World Bank supported HIV and AIDS programmes in Vietnam from 2003 to 2012**. Sydney: University of New South Wales.
- 115 The Global Fund to Fight AIDS, Tuberculosis and Malaria (2014) 'Global Fund allocations for 2014–2016 allocation period – HSS existing funds split out', spreadsheet. Available at: www.theglobalfund.org/documents/fundingmodel/FundingModel_CountryAllocationExcel_Table_en/ (accessed 1 July 2014).
- 116 Socialist Republic of Vietnam (2014) **Vietnam AIDS response progress report following up the 2011 political declaration on HIV AIDS. Reporting period Jan 2012 – Dec 2013**. Ha Noi: Vietnamese Government.
- 117 Zhang, L. et al. (2013) **Evaluation of a decade of DFID and World Bank supported HIV and AIDS programmes in Vietnam from 2003 to 2012**. Sydney: University of New South Wales.
- 118 Ibid.
- 119 Socialist Republic of Vietnam (2014) **Vietnam AIDS response progress report following up the 2011 political declaration on HIV AIDS. Reporting period Jan 2012 – Dec 2013**. Ha Noi: Vietnamese Government: 21.
- 120 Zhang, L. et al. (2013) **Evaluation of a decade of DFID and World Bank supported HIV and AIDS programmes in Vietnam from 2003 to 2012**. Sydney: University of New South Wales.
- 121 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 122 Socialist Republic of Vietnam (2014) **Vietnam AIDS response progress report following up the 2011 political declaration on HIV AIDS. Reporting period Jan 2012 – Dec 2013**. Ha Noi: Vietnamese Government.
- 123 See www.hivgaps.org (accessed 4 July 2014).
- 124 See www.cahrproject.org (accessed 4 July 2014).
- 125 See www.pepfar.gov/documents/organization/189671.pdf (accessed 4 July 2014).
- 126 The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (2010) **Comprehensive HIV prevention for people who inject drugs, revised guidance**. Washington, DC: PEPFAR. Available at: www.pepfar.gov/documents/organization/144970.pdf (accessed 3 July 2014).
- 127 Smart Global Health.org (2012) 'A history of the ban on federal funding for syringe exchange programs'. Available at: www.smartglobalhealth.org/blog/entry/a-history-of-the-ban-on-federal-funding-for-syringe-exchange-programs (accessed 1 July 2014).
- 128 International AIDS Society (2012) 'International AIDS Society welcomes new funding commitments by the US government announced at AIDS 2012 by Secretary Hillary Clinton', press release. Available at: www.iasociety.org/Web/WebContent/File/US_Government_funding_Press_release_26_July_2012.pdf (accessed 1 July 2014).
- 129 Analysis conducted by George Washington University in 2013, commissioned by AmfAR (unpublished).
- 130 The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (2013) **South Africa operational plan report FY 2012**. Washington, DC: PEPFAR. Available at: www.pepfar.gov/documents/organization/212156.pdf (accessed 1 July 2014).
- 131 Ibid.
- 132 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International. Information derived from PEPFAR budgets for HIV-related projects reaching people who inject drugs in Cambodia, China, India, Kenya, Russia, Tanzania and Vietnam.
- 133 Stimson, G. et al. (2010) **Three cents a day is not enough: Resourcing HIV-related harm reduction on a global basis**. London: Harm Reduction International.

- 134 The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (2011) **Fiscal year 2010: PEPFAR operational plan**. Washington, DC: PEPFAR. PEPFAR (2011) **Fiscal year 2011: PEPFAR operational plan**. Washington, DC: PEPFAR.
- 135 Ibid.
- 136 Figures taken from 'Table A.1: FY 2011 approved funding in PEPFAR operational plans by funding source' and 'Table A.2: FY 2011 approved funding in PEPFAR operational plans by operating unit and budget code: prevention'. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (2011) **Fiscal year 2011: PEPFAR operational plan**. Washington, DC: PEPFAR.
- 137 The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (2011) **Fiscal year 2011: PEPFAR operational plan**. Washington, DC: PEPFAR.
- 138 The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (2011) **Fiscal year 2011: PEPFAR operational plan**. Washington, DC: PEPFAR.
- 139 International HIV/AIDS Alliance (2012) **HIV, drug use and the Global Fund: Don't stop now**. Brighton: International HIV/AIDS Alliance. Eurasian Harm Reduction Network (2013) **Quitting while not ahead: the Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe and Central Asia**. Vilnius: Eurasian Harm Reduction Network.
- 140 The Global Fund to Fight AIDS, Tuberculosis and Malaria (2014) Global Fund country allocation table 2014 – 2016 Allocation Period www.theglobalfund.org/documents/fundingmodel/FundingModel_CountryAllocationExcel_Table_en/ (accessed 15 June 2014).
- 141 Ibid.
- 142 Ibid.
- 143 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2013) **Global report: UNAIDS report on the global AIDS epidemic 2013**. Geneva: UNAIDS.
- 144 World Health Organization, Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Office on Drugs and Crime (UNODC) (2012) **WHO, UNAIDS & UNODC technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2012 revision**. Geneva: World Health Organization.
- 145 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008) 'HIV prevention toolkit. Know your epidemic and your current response'. Available at: http://hivpreventiontoolkit.unaids.org/Knowledge_Epidemic.aspx (accessed 1 July 2014).
- 146 Cook, C. (ed.) (2008) **The global state of harm reduction: Mapping the response to drug-related HIV and hepatitis C epidemics**. London: International Harm Reduction Association.
- 147 United Nations Office on Drugs and Crime (UNODC) (2014) **World drug report**. New York: United Nations.
- 148 Cook, C. (ed.) (2008) **The global state of harm reduction: Mapping the response to drug-related HIV and hepatitis C epidemics**. London: International Harm Reduction Association.
- 149 Wolfe, D (2013) 'Financing of harm reduction' presented to the International Harm Reduction Conference in Vilnius, Lithuania (9-12 June 2013).
- 150 European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) (2014) **European drug report 2014: Trends and developments**. Lisbon: EMCDDA: 70. Available at: www.emcdda.europa.eu/attachements.cfm/att_228272_EN_TDAT14001ENN.pdf (accessed 4 July 2014).
- 151 European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) (2014) **Estimating expenditure on drug law offenders in Europe**. Lisbon: EMCDDA. Available at: www.emcdda.europa.eu/publications/emcdda-papers/public-expenditure-drug-law-offenders-in-prison (accessed 1 July 2014).
- 152 Transform Drug Policy Foundation (2010) **Count the costs: 50 years of the war on drugs**. London: Transform Drug Policy Foundation.

This report tells the story of HIV-related harm reduction funding over time and illustrates why an AIDS-free generation will not be possible if the present rate and pace of investment continues. It highlights the changing donor landscape and the particular problem for harm reduction funding in middle-income countries with decreasing international donor support. While the challenges are considerable, there are concrete actions that donors, governments and harm reduction advocates can take to build a fully funded, sustainable harm reduction response.

The resources needed are minimal when compared with the level of funding invested in drug law enforcement, imprisoning those convicted of minor drug offences, and treating HIV and hepatitis C infections that could have been averted. The resources needed are minimal when the real potential to avert new HIV and hepatitis C infections and save lives is factored in.

Strategic investment in HIV programmes targeting key populations is required, regardless of country income status. Bilateral investments must be re-prioritised, and existing resources in drug policy should be rebalanced in favour of health and harm reduction.

