Three cents a day is not enough

Resourcing HIV-related Harm Reduction on a Global Basis

ihra

INTERNATIONAL HARM REDUCTION ASSOCIATION

About the International Harm Reduction Association

The International Harm Reduction Association (IHRA) is one of the leading international non-governmental organisations promoting policies and practices that reduce the harms from all psychoactive substances, harms which include not only the increased vulnerability to HIV and hepatitis C infection among people who use drugs, but also the negative social, health, economic and criminal impacts of illegal drugs, alcohol and tobacco on individuals, communities and society. A key principle of IHRA's approach is to support the engagement of people and communities affected by drugs and alcohol around the world in policy-making processes, including the voices and perspectives of people who use illicit drugs.

IHRA is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

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Resourcing HIV-related Harm Reduction on a Global Basis

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Executive Summary

In 2006 the United Nations General Assembly adopted the Political Declaration on HIV/AIDS and committed to achieving the goal of universal access to comprehensive HIV prevention programmes, treatment, care and support by 2010. Although this commitment has been accompanied by an increase in resources for HIV/AIDS, not enough money is being spent on harm reduction for drug using populations.

HIV can spread rapidly via unsafe injecting. An estimated 15.9 million people inject illicit drugs in a reported 158 countries and territories worldwide. Four out of five injecting drug users live in low and middle income countries, particularly in Asia and Eastern Europe, and in many of these countries people who inject represent the largest share of HIV infections. HIV infection and other health risks associated with injecting are preventable. Effective, affordable interventions exist to prevent the spread of HIV among people who inject drugs and drug users have responded well when offered harm reduction advice and tools.

Harm reduction was supported or tolerated in policy or practice in at least 84 countries and territories in 2009. Countries across Asia, the Middle East and North Africa have in recent years introduced, and in a few cases rapidly scaled up, harm reduction programmes. Substantial evidence demonstrates that harm reduction interventions work in a wide range of social and cultural settings. However, global implementation lags behind need: 76 countries and territories with people who inject drugs have no harm reduction interventions whatsoever. And no low or middle income country makes both needle exchange and opioid substitution treatment available at the scale required to counter injecting-driven HIV epidemics.

People who inject drugs should benefit from the large increases in the global resources available for HIV. However, it is difficult to measure how much of global HIV spending actually goes into harm reduction. Although harm reduction is relatively invisible in national and international budgets, it is possible to calculate a plausible estimate of HIV-related harm reduction expenditure in low and middle income countries between 2007 and 2009. These results demonstrate the degree to which the international community is failing to address the issue of HIV among injecting drug using populations.

Despite the difficulties in identifying harm reduction expenditure, and of obtaining accurate estimates, there is no doubt that the overall volume of spending on HIV-related harm reduction is small. A cautious estimate for 2007 is that approximately $160 million[1] was invested in HIV-related harm reduction in low and middle income countries, of which $136 million (90%) came from international donors. This spending equates to $12.80 for each injector each year in low and middle income countries, or just three US cents per

1.All figures are in US dollars ($) unless otherwise stated.

injector per day. This figure is almost certainly an overestimate of actual spending on harm reduction services, which would have received only one-third to one-half of this total harm reduction investment.

To put this $160 million in context, UNAIDS estimated that the resources needed for harm reduction were $2.13 billion in 2009 and $3.2 billion in 2010. Rather than $12.80 per injector per year, the needs estimated by UNAIDS averaged $170 in 2009 and $256 in 2010 per injector per year. These figures do not take into account the additional resources required for antiretroviral therapy, care and support. Current spending is clearly only a small proportion of that required and is nowhere near proportionate to need.

Rather than national or international donors, the biggest providers and funders of harm reduction commodities are probably drug users themselves. The needles and syringes and the treatment needed by people who inject drugs in low and middle income countries are bought mainly with their own 'out-of-pocket' money. This is an unfair burden on a population that in general lacks resources and is a situation that would be unacceptable in any other medical or public health field.

The clear conclusion is that spending on harm reduction needs to be increased urgently and dramatically, especially for direct frontline services. There are a number of concrete areas in which action should be taken.

At present, global funding on harm reduction is provided by only a handful of donor countries. A greater number of high income countries need to fund harm reduction if progress towards the goal of universal access is to be achieved among people who inject drugs.

There also needs to be a significant increase in domestic allocations to harm reduction. National governments have been reluctant or unable to provide their own resources. As a result, much of the funding for both government- and civil society-led HIV prevention activities among people who inject drugs comes from international donors, mainly The Global Fund to Fight AIDS, Tuberculosis and Malaria and a few bilateral donors. However, several national examples demonstrate that where there is political will, domestic funding can make a significant contribution to harm reduction.

Only a few philanthropic donors fund harm reduction (or are able to identify some harm reduction spending in their budgets). Discrimination against drug using populations is inconsistent with philanthropy, yet the list of international philanthropic donors is notable more for the absence of major donors than for their presence. Those that do donate, spend only a fraction of their funds on harm reduction. Philanthropic donors must invest in harm reduction.

Many donors find it difficult to track expenditure on harm reduction. This indicates the need to set up a global resource monitoring system with specialist knowledge of harm reduction. Resource tracking should efficiently monitor the total global spending on harm reduction, list the recipient countries and map spending onto the epidemiology of injecting drug use and HIV infection. Such a system would help to increase donor accountability, reduce duplication amongst donors and increase donor coordination. It would also enable protection of progress to date, monitor scale-up, identify gaps and responses, recognise potential funding crises (such as gaps between funding rounds) and generally feed into advocacy and policy work.

Better estimates of resource needs are required to more effectively advocate for and allocate harm reduction resources on the basis of need, rather than on donor idiosyncrasies. The current resource gap is so huge that refined estimates of resource needs might appear to be a luxury. However, current resource needs estimation is either too global or only patchily available at national level. There also needs to be work on estimating the size of other vulnerable drug using populations. Basing resource needs estimates solely on the size of current populations of people who inject drugs excludes consideration of other drug using populations and populations vulnerable to HIV transmission via non-injecting drug use and/or the spread of injecting, as in much of Africa, the Middle East and Latin America.

There is a critical need to explore new models of service delivery. Given the scale of the funding gap, it is reasonable to ask whether it can ever be bridged by scaling up the current ways in which harm reduction services are delivered. Most countries have a low number of harm reduction services and therefore scale-up tends to be achieved by the replication of specialist micro-projects. Understandably, given the marginalisation of people who use drugs in many countries, harm reduction services have mainly been delivered by community-based organisations. But there is a danger that these services are themselves marginalised. Different models of service delivery should be explored, including the implications of integrating harm reduction into general health and social welfare systems.

The resource gap is so huge that resource mobilisation is unlikely to occur without funding for civil society organisations to advocate for harm reduction, and harm reduction resources, at national, regional and global levels. With the shift of donor interest from earmarked funding to general budget support, and the need to encourage country ownership, much more needs to be done to stimulate political interest at national level in seeking funds for harm reduction. Advocacy can help create the demand for harm reduction resources. Yet only a handful of civil society organisations are funded for international or regional harm reduction advocacy and numerous structural barriers exist to changing this situation.

There are considerable difficulties in calculating harm reduction expenditure and the estimates in this report are admittedly based on poor quality data. However, even if the margin of error was such that global spending had been underestimated by 100%, or even 200%, it would still be clear that not enough money is being spent on harm reduction, whether in absolute terms, proportionate to needs or proportionate to global spending on HIV/AIDS. $160 million – or less than three cents a day for each person who injects drugs – falls far short of the estimated $2 billion to $3 billion required each year for HIV prevention for people who inject drugs.

Rather than coming close to ensuring universal access, the current funding represents about one-twentieth of what is required. People who use drugs are not receiving the harm reduction services that they need and to which they have a right. At current rates of progress, universal access to HIV prevention for people who inject drugs will not be achieved for decades, let alone in 2010. The scale of investment in harm reduction needs to be quickly and radically increased.

More money is needed for harm reduction, and it is needed now.

Recommendations

1. **More global resources are needed for harm reduction.**
2. **Resources for harm reduction and HIV services for people who use drugs should be proportionate to need within countries.**
3. **Donors should set targets for the proportion of global spending going to HIV-related harm reduction, with 20% of global prevention funds going to harm reduction.**
4. **Global expenditure on harm reduction must be properly monitored by UNAIDS and NGOs.**
5. **Better estimates are required of the resources needed for HIV-related harm reduction.**
6. **New ways of delivering harm reduction services may be needed.**
7. **A global Community Fund for Harm Reduction should be established to advocate for increased resources for harm reduction.**

1 | Preventing HIV infection among people who inject drugs

It is estimated that about 15.9 million people inject illicit drugs[2] in a reported 158 countries and territories worldwide.[3] Four out of five people who inject live in low and middle income countries.[4] Asia and Eastern Europe have the largest populations of people who inject, with the highest numbers residing in Russia and China (estimated at 1,825,000 and 2,350,000 respectively).

Globally, it is estimated that 3 million people who inject drugs are living with HIV.[5] It is further estimated that up to 10% of all HIV infections globally are related to unsafe drug injecting, with much higher percentages in many countries. HIV can spread rapidly in uncontrolled epidemics, with 40% or more of the injecting population becoming HIV positive within one to two years of the introduction of the virus into a community.[6]

In approximately 20 countries in Eastern Europe and Asia, people who inject represent the largest share of HIV infections.[7] For example, in Indonesia approximately half of new HIV cases are linked with injecting;[8] this figure is 66% in Russia and Kazakhstan;[9] while in Bangladesh 90% of HIV infections are related to unsafe injecting.[10] In addition to HIV, people who inject drugs are also vulnerable to other health concerns including blood-borne viruses such as hepatitis B and C, tuberculosis, overdose and bacterial infections.

1.1 HIV is preventable

HIV infection and other health risks associated with injecting are preventable. The first insights into this came over 25 years ago with the implementation of harm reduction projects – mainly needle and syringe programmes, low-threshold methadone services and outreach – in Europe, Australia and North America.[11] The effectiveness of outreach, opioid substitution therapy, needle and syringe programmes, education and sexual risk interventions for people who inject drugs has since been extensively documented and evaluated in high, middle and low income countries.[12]

2. Mathers B, Degenhardt L, et al. (2008) 'Global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review' The Lancet 372: 1733–1745.
3. Cook C and Kanaef N (2008) Global State of Harm Reduction 2008: Mapping the Response to Drug-related HIV and Hepatitis C Epidemics London: International Harm Reduction Association.
4. Mathers et al. (2008) op. cit.
5. ibid.
6. ibid.
7. Wolfe D (2007) 'Paradoxes in antiretroviral treatment for injecting drug users: Access, adherence and structural barriers in Asia and the former Soviet Union' International Journal of Drug Policy 18(4): 246–254.
8. Sharma M, Oppenheimer E et al. (2009) A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region. AIDS. 23(11):1405-1413.
9. UNAIDS (2008) AIDS Epidemic Regional Update 2007: Eastern European and Central Asia Geneva: UNAIDS and WHO: 2.
10. Ministry of Health and Family Welfare. Bangladesh (2008) UNGASS Country Progress Report. In. Dhaka: National AIDS/STD Programme (NASP) 2008 (page 26).
11. Cook C, Bridge J and Stimson GV (2009) 'The diffusion of harm reduction in Europe and beyond' in T Rhodes (ed.) Harm Reduction: Evidence, Impacts and Challenges Lisbon: European Monitoring Centre on Drugs and Drug Addiction.
12. Ball A, Beg M, et al. (eds) (2005) 'World Health Organization – Evidence for action for HIV prevention, treatment and care among injecting drug users' International Journal of Drug Policy 16, supp. 1.

The US Institute of Medicine concluded, after an extensive examination of the scientific literature, that opioid substitution therapy, access to clean needles and syringes and outreach to drug users are effective measures for decreasing risky drug-related behaviour.[13] These interventions can prevent and reverse HIV epidemics, reduce other significant health burdens and reduce the health, social and criminal costs of drug use.

Prevention of HIV is also cheaper than treatment of HIV/AIDS. For example, in Asia it is estimated that the comprehensive package of HIV-related harm reduction interventions costs $39 per disability-adjusted life-year saved,[14] whereas antiretroviral treatment costs approximately $2,000 per life-year saved. Such figures demonstrate that harm reduction is a low-cost, high-impact intervention.

The comprehensive package of evidence-based HIV prevention interventions that has developed over the last two decades has been endorsed by the United Nations General Assembly (see Box 1), the Joint United Nations Programme on HIV/AIDS (UNAIDS; see Box 2), the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC)[15] as well as by key international donors including The Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and by numerous international agencies including the International Federation of Red Cross and Red Crescent Societies.[16]

13. Institute of Medicine (2006) Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence Washington, DC: The National Academies Press.
14. Commission on AIDS in Asia (2008) Redefining AIDS in Asia: Crafting an Effective Response New Delhi: Oxford University Press: 90.
15. International Harm Reduction Association and Human Rights Watch (2009) Building Consensus: A Reference Guide to Human Rights and Drug Policy London: IHRA.
16. International Federation of Red Cross and Red Crescent Societies (December 2003) 'Spreading the light of science – Guidelines on harm reduction related to injecting drug use', www.ifrc.org/what/health/tools/harm_reduction.asp.

Box 1.
The UN General Assembly endorsed harm reduction as an essential HIV prevention measure in the Political Declaration on HIV/AIDS in 2006[17]

'Reaffirm that the prevention of HIV infection must be the mainstay of national, regional and international responses to the pandemic, and therefore commit ourselves to intensifying efforts to ensure that a wide range of prevention programmes that take account of local circumstances, ethics and cultural values is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmitted infections'

Box 2.
UNAIDS policy on preventing HIV/AIDS among injecting drug users – the comprehensive package[18]

'Preventing transmission of HIV through injecting drug use—by developing a comprehensive, integrated and effective system of measures that consists of the full range of treatment options, (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confidential HIV counselling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary healthcare, and access to antiretroviral therapy. Such an approach must be based on promoting, protecting and respecting the human rights of drug users.'

17. UN General Assembly (15 June 2006) 'Political declaration on HIV/AIDS', UN Doc. No. A/RES/60/262, para. 22.
18. UNAIDS (2005) Intensifying HIV Prevention: UNAIDS Policy Position Paper Geneva: UNAIDS: 34.

1.2 Universal access to services is not yet universal

The commitment of UN Member States to work towards universal access to HIV prevention, care and treatment services by 2010 was enshrined in the 2006 Political Declaration on HIV/AIDS.[19] The implications of this declaration are that all people who inject drugs should have access to HIV prevention, treatment and care. These commitments were reaffirmed at the 24th meeting of the UNAIDS Programme Coordinating Board in 2009 [20] and at the meeting of the UN Economic and Social Council (ECOSOC) also in 2009. [21]

In the last 25 years there has been some significant progress. By 2009 harm reduction was supported or tolerated in policy or practice in at least 84 countries and territories. [22] In recent years countries across Asia, the Middle East and North Africa have introduced – and in a few cases rapidly scaled up – harm reduction programmes. Substantial evidence demonstrates that harm reduction interventions work in a wide range of social and cultural settings. For example, harm reduction has been successfully introduced in Iran, China, Malaysia, Viet Nam, Morocco and Mauritius. Needle and syringe programmes exist in 77 countries, while opioid substitution therapy is available in 65 countries and territories, 37 of which also have some opioid substitution therapy in prisons. [23]

However, global implementation lags behind need: 76 countries and territories with people who inject drugs have no harm reduction interventions whatsoever. And no low or middle income country makes needle exchange or opioid substitution treatment available at the scale required to counter HIV epidemics among people who inject drugs.

Universal access is a commitment to scale up national programmes for HIV treatment, prevention, care and support for all those who need it. This means that HIV prevention programmes need to be introduced where they do not yet exist, and existing programmes need to be scaled up to adequate levels of coverage.

Good levels of coverage have been achieved in Australia and Western Europe. [24] In Iran coverage is estimated at 75% in prisons. Cities providing high coverage include Sumy in Ukraine, Dhaka in Bangladesh and Salvador in Brazil, which by 2005 had documented 73%, 69% and 68% coverage of harm reduction programmes respectively. [25] Taiwan has had extremely rapid implementation and subsequent reduction in HIV prevalence (see Box 3). However, coverage of harm reduction programmes is entirely inadequate in virtually all low and middle income countries with substantial HIV epidemics among people who inject drugs. The goal of universal access to HIV prevention, treatment, care and support is therefore far from being achieved for this key population.

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19. UN General Assembly (15 June 2006) op. cit.
20. UNAIDS (June 2009) 24th meeting of the Programme Coordinating Board, http://data.unaids.org/pub/InformationNote/2009/20090603_pcb_24_decisions_en.pdf.
21. United Nations Economic and Social Council (24 July 2009) Joint United Nations Programme on HIV/AIDS (UNAIDS) (E/2009/L.23 and E/2009/SR.36).
22. Cook C (2009) Harm Reduction Policy and Practice Worldwide, an Overview of National Support for Harm Reduction in Policy and Practice London: International Harm Reduction Association.
23. Cook and Kanaef (2008) op. cit.
24. Cook et al. (2009) op. cit.
25. UNAIDS (2006) High Coverage Sites: HIV Prevention among Injecting Drug Users in Transitional and Developing Countries – Case Studies Geneva: UNAIDS.

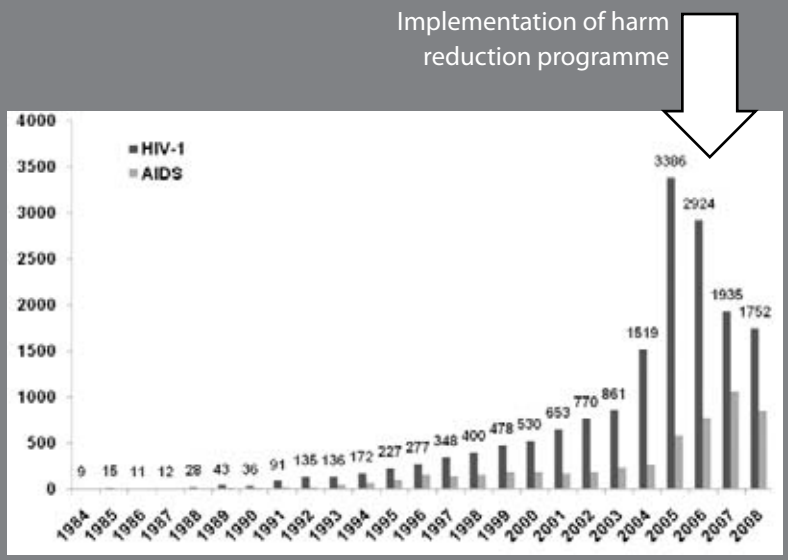
Box 3.

Case study: Taiwan: High investment, rapid scale-up, high coverage and reductions in HIV[26]

'Taiwan has a population of 23 million people, with a median age of 36.5 years and a GDP per capita of $31,900 in 2008.[27] In December 2005 there were 10,709 people with HIV/AIDS, with increasing levels of infection in the previous five years. Eighty per cent of the newly reported HIV cases in 2005 were among people who inject drugs. In 2005 it was estimated that the cumulative national losses due the HIV epidemic would be $1.6 billion by 2010.

In September 2005 the Taiwan Centers for Disease Control (CDC) funded harm reduction pilot programmes in Taipei, Taoyuan and Tainan. A national harm reduction programme was developed based on these pilots, previous harm reduction experiences in Hong Kong, external expert consultations and legislative support from the Taiwanese government. It included a needle and syringe programme, methadone and buprenorphine maintenance therapy, as well as HIV education, counselling and testing.

Annual reports of new HIV/AIDS cases, Taiwan[28]



Box 3 continues on next page..

26. Information provided by Centers for Disease Control, Taiwan and Asian Harm Reduction Network. Information also taken from Taiwan Centers for Disease Control (2009) Annual Report 2009 Taiwan: CDC, Department of Health; Chen Y-MA and Kuo SH-S (2007) 'HIV-1 in Taiwan' The Lancet 369(9562): 623–625.
27. CIA World Fact Book (2010) 'East and Southeast Asia: Taiwan', www.cia.gov/library/publications/the-world-factbook/geos/countrytemplate_tw.html (7 January 2010).
28. Centers for Disease Control, Taiwan (2008) 'HIV/AIDS 2008', www.cdc.gov.tw/lp.asp?ctNode=2237&CtUnit=1263&BaseDSD=7&mp=5 (10 January 2010).

Box 3... continued from previous page

By February 2006, 85 needle and syringe projects had been established, and CDC committed to purchase 10 million syringes and 120 litres of methadone. In July 2006 every city and province started giving out free needles to drug users. The numbers of needles and syringes distributed increased from 450,000 in 2006 to 4 million in 2007.

In 2007 the national HIV/AIDS prevention budget was doubled to $ 8.5 million, indicating political commitment. Taiwan's Bureau of Controlled Drugs had approved the first methadone pilot programme in February 2006, and proposed to start the national production of methadone in 2009. CDC introduced a harm reduction and education programme in detention centres and prisons.

The 2,924 new HIV infection cases in 2006 represented a drop from the 3,386 cases in 2005, reversing a twenty-year growth trend. In addition, the percentage of all newly reported cases attributable to people who inject fell from a high of 72% in 2005 to 60% in 2006 and 22% in 2008. Other benefits reported by the Minister of Health include an 11% reduction in burglaries and a 27% decrease in robberies in Tainan County.

There has been extensive debate about the meaning of the term 'coverage' and how to measure it. UNAIDS states that coverage is 'the percentage of the population needing a service that has access to the service … as a practical matter, it is often better to measure coverage in terms of service utilization'.[29] WHO, UNAIDS and UNODC have developed a target-setting guide for measuring the availability, coverage, quality and impact of needle and syringe programmes, drug dependence treatment, HIV testing and counselling, antiretroviral therapy, prevention and treatment of STIs, condom programmes and other elements of the comprehensive package.[30] For example, coverage of needle and syringe programmes is defined as the number of people who inject drugs who accessed a programme at least once a month or more in the past twelve months.

There is also debate about the levels of coverage that are required for effective HIV prevention. Targets set with regard to public health objectives are different from targets set according to human rights principles. The former approach derives coverage targets with respect to the proportion of the population that needs to be reached in order to protect the whole community. The analogy is to immunisation programmes, where not all the population needs to be immunised in order to achieve population-level benefit. A human-rights-based approach demands that every member of the target population should be granted access to essential medicines and harm reduction services.

Many public health specialists argue, based on epidemic modelling studies, that less than 100% coverage is required to prevent epidemics and that, in practice, it will be impossible to achieve 100% coverage. Expert consensus, although based on limited evidence and analysis, is that there needs to be 60% coverage for needle and syringe programmes and 40% coverage for opioid substitution therapy. These are the figures used in UNAIDS resource needs estimates.[31] This level of coverage falls short of the UNAIDS HIV prevention coverage target of 80% of injecting drug users accessing HIV prevention services. Elsewhere, UNAIDS defines coverage in terms of injecting drug users' knowledge of places to receive an HIV test, having received condoms in the last 12 months and having received sterile needles and syringes.[32]

Even by the most liberal definition of coverage, harm reduction programmes in much of the world are nowhere near achieving good coverage. In the 84 countries that have some kind of harm reduction, many only have small pilot harm reduction programmes reaching low numbers of people who inject. In South East Asia, for example, only 3% of people who inject drugs have access to harm reduction programmes. In East Asia this figure is 8%.[33] In Thailand, Indonesia, Myanmar, Nepal, India and Bangladesh it is estimated that less that

29. UNAIDS (2005) op. cit.
30. World Health Organization (2009), WHO, UNODC, UNAIDS Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users. Geneva: World Health Organization.
31. Verster AD, Clark NC, et al. (2007) Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support: Methodological Annex – IX Geneva: UNAIDS.
32. UNAIDS (2007) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators Geneva: UNAIDS.
33. Commission on AIDS in Asia (2008) op. cit.

12,000 (1.5%) of the estimated 800,000 people who inject drugs have access to opioid substitution therapy.[34] In Russia an estimated 1.9 million people inject drugs, however, opioid substitution therapies are prohibited and there are only 69 needle and syringe programme sites, which are under threat due to discontinuation of funding. The UN Secretary-General reported that, in 2005, 92% of people who inject in 94 low and middle income countries had no access to HIV prevention services of any kind.[35]

There are many obstacles to scaling up the response to HIV/AIDS for people who use drugs, including ignorance, apathy and antipathy by governments, penal environments where HIV prevention and treatment are unavailable, overinvestment in criminal justice approaches to drugs and drug users, legal barriers to harm reduction interventions and the stigmatisation and marginalisation of drug users and those who work with them.[36] Getting harm reduction into place and delivering it with good coverage requires overcoming these obstacles and achieving adequate financial investment.

34. Sharma M, Oppenheimer E et al. (2009) op. cit.
35. UN General Assembly (20 March 2007) 'Declaration of commitment on HIV/AIDS and political declaration on HIV/AIDS: Focus on progress over the past 12 months – report of the secretary-general', UN Doc. No. A/61/816, para. 53.
36. Cook and Kanaef (2008) op. cit.

2 | Global spending on HIV/AIDS

The international commitment to improving coverage and to achieving universal access has been accompanied by an increase in resources for HIV/AIDS. An examination of the global resources being spent on HIV/AIDS generally will provide a backdrop against which the scale of harm reduction funding may be assessed.

2.1 Global spending on HIV/AIDS has increased substantially

Global expenditure on HIV/AIDS has increased substantially in the last decade, with total annual resources from all sources reaching over $11.3 billion in 2007 and $13.7 billion in 2008.[37] Most of these resources are destined for low and middle income countries and include the expenditure allocated to HIV/AIDS prevention, care, treatment and support.

- In 1996 the establishment of UNAIDS was followed by the first major increase of international funds for HIV/AIDS since 1993, from $257 million to $292 million.
- A progressive increase in funds continued until 2000, a year marked by the launch of the World Bank's HIV programme and the Bill & Melinda Gates Foundation.
- Added efforts of international and national donors impelled by the Declaration of Commitment on HIV/AIDS, UNGASS, saw the level of global resources for HIV/AIDS rise to $1.6 billion in 2001.
- Further increases followed with the creation of The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) in 2002 and the launch of the US President's Emergency Plan for AIDS Relief (PEPFAR) in 2003. Global resources increased to $8.3 billion, $8.9 billion and $11.3 billion in 2005, 2006 and 2007 respectively.[38]

The Global Fund's annual HIV/AIDS disbursement was approximately $1 billion in 2007,[39] $1.6 billion in 2008 and $2.8 billion in 2009.[40] From 2002 to 2009 the Global Fund has approved a total grant amount of $10 billion for HIV/AIDS prevention, treatment and care. For the 2008 to 2010 biennium, $9.7 billion has been pledged to the Global Fund for all activities by countries and private donors.[41]

37. UNAIDS (2009) What Countries Need: Investments Needed for 2010 Targets Geneva: UNAIDS: 12.
38. UNAIDS (26 September 2007) Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support Geneva: UNAIDS.
39. The Global Fund to Fight AIDS, Tuberculosis and Malaria (2009) Scaling Up for Impact: Results Report Geneva: The Global Fund: 31.
40. The Global Fund total grant disbursement in the period from 1 January to 31 December of the reported year. Source: Global Fund Online Grant Portfolio, www.theglobalfund.org/programs/search/?search=3&lang=en (14 January 2010).
41. The Global Fund to Fight AIDS, Tuberculosis and Malaria (2009) Updated Demand Estimate: 2008–2010 Geneva: The Global Fund.

The main countries contributing to global HIV/AIDS funds in 2007 – whether through multilateral support to the Global Fund or to UN agencies, or through bilateral programmes – were the USA, UK, France and the Netherlands (see Table 1).[42] In 2008 the countries were the USA, UK, Netherlands and Germany.[43]

Table 1. International funds allocated to HIV/AIDS by donor country, in $ million, 2007[44]

	Bilateral		Global Fund	Global Fund	Total	
Government	Commitment	Disbursement	(100%)	Adjusted (58%)	Commitment	Disbursement
Australia	$ 74.7	$ 66.3	$ 15.3	$ 8.9	$ 83.6	$ 75.2
Canada	$ 79.5	$ 79.1	$ 42.4	$ 24.6	$ 104.1	$ 103.7
France	$ 54.4	$ 54.1	$ 424.9	$ 246.4	$ 300.8	$ 300.5
Germany	$ 155.0	$ 154.2	$ 116.7	$ 67.7	$ 222.7	$ 221.9
Ireland	$ 93.2	$ 93.2	$ 27.0	$ 15.7	$ 108.9	$ 108.9
Italy	$ -	$ -	$ 180.4	$ 104.6	$ 104.6	$ 104.6
Japan	$ 20.2	$ 20.2	$ 130.2	$ 75.5	$ 95.7	$ 95.7
Netherlands	$ 348.1	$ 332.5	$ 82.7	$ 48.0	$ 396.1	$ 380.5
Sweden	$ 168.7	$ 168.7	$ 60.1	$ 34.9	$ 203.6	$ 203.6
United Kingdom	$ 867.4	$ 867.4	$ 202.5	$ 117.5	$ 984.9	$ 984.9
United States	$ 3,337.5	$ 1,686.0	$ 531.0	$ 308.0	$ 3,645.5	$ 1,994.0
European Commission	$ 35.6	$ 74.0	$ 91.1	$ 52.8	$ 88.4	$ 126.8
Other Governments	$ 154.9	$ 118.0	$ 213.7	$ 123.9	$ 278.8	$ 241.9
TOTAL	$ 5,389.2	$ 3,713.7	$ 2,118.0	$ 1,228.4	$ 6,617.6	$ 4,942.1

PEPFAR was established in 2003 with the objective of allocating $15 billion from 2004 to 2008. $10 billion was allocated to 15 focus countries, which between them account for 50% of people living with HIV/AIDS. This group comprises 12 African countries plus Viet Nam, Haiti and Guyana. $4 billion was allocated to more than one hundred additional countries, as well as $1 billion to the Global Fund.

The World Bank is also a major funding agency through its system of loans and grants. Since 2000 the World Bank has committed a total of $4.2 billion: $782 million as non-reimbursable grants and the rest as loans or 'credits' (zero-interest loans with repayment over 35 to 40 years for the poorest 79 countries). Between July 2002 and June 2005 there was a special provision made that all HIV financing to countries with per capita incomes below $865 was to be in the form of grants. Since that time, except for the poorest and most indebted countries, most commitments have been as national loans or credits to be reimbursed to the World Bank.

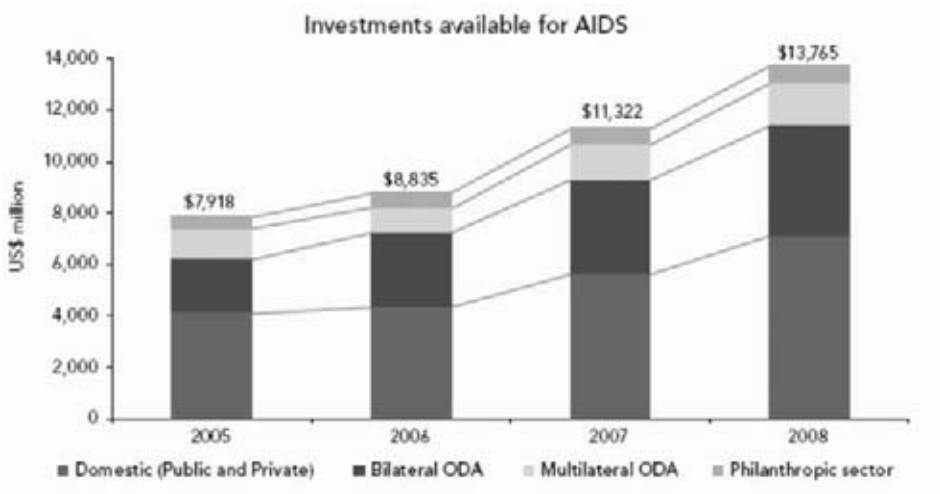
Domestic funding contributions – funding within countries from, for example, governments, philanthropic organisations and individuals – vary significantly by region. The median values range from 100% in Oceania to 22.8% in South and South East

42. ibid.
43. Kates J, Lief E and Avila C (2009) Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from the G8, European Commission and Other Donor Governments in 2008 California/Geneva: Kaiser Family Foundation and UNAIDS.
44. Kates J, Izazola J-A and Lief E (2008) Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from the G8, European Commission and Other Donor Governments, 2007 California/Geneva: Kaiser Family Foundation and UNAIDS.

Asia. UNAIDS estimates that domestic resources provide approximately one-third of global funds, demonstrating the dependence of low and middle income countries on international funding and donors.

The total resources made available for HIV/AIDS increased from $7.9 billion in 2005 to $13.8 million in 2008. Nevertheless, there continues to be a resource gap. UNAIDS estimates that overall the funding needed in 2007 was $18 billion,[45] indicating that resources need to be increased by about 60%.

Figure 1. Investments available for AIDS ($ million) [46]



45. UNAIDS (2006) 'Financing the response to AIDS' in 2006 Report on the Global AIDS Epidemic Geneva: UNAIDS: Chapter 10.
46. UNAIDS (2009) op. cit.: 12.

3 | Global spending on harm reduction

People who inject drugs should benefit from the large increases in the global resources available for HIV/AIDS, but it is difficult to measure how much of global HIV/AIDS spending actually goes into harm reduction. There is no single reliable source of information on international harm reduction expenditure and harm reduction is relatively invisible in national and international budgets. Given the limited availability of the data, and the variable quality of the data that is accessible, it is not possible to arrive at a definitive figure for HIV-related harm reduction expenditure in low and middle income countries between 2007 and 2009, however, it is possible to determine a plausible estimate.

The main sources of information used in calculating this estimate were the UNAIDS National AIDS Spending Assessments and details provided directly by donors and implementing agencies. In addition, information was obtained from the websites of donors and multilateral agencies, from various project reports and financial reports, from country and philanthropic donors and through personal contacts. All information was cross-checked in order to compare our estimate with those of others, and against country-level estimates.

3.1 Problems in estimating global spending on harm reduction

Information was collected on HIV-related harm reduction, which was defined as the comprehensive package of interventions including needle exchange, opioid substitution therapy, outreach, voluntary testing and counselling, access to primary health care and prevention of sexual transmission for people who inject drugs. In gathering information, efforts were made to exclude consideration of spending on HIV antiretroviral treatment (ARV), research and capacity building, as the aim was to focus on frontline HIV prevention. However, disaggregating the spending data in such a manner was often impossible in practice.

Potentially the most useful source of information is the UNAIDS National AIDS Spending Assessments (NASA). The UNAIDS Resource Tracking, Resource Needs, and Costing Team collects information from national governments according to the main source of funding and area of activity, including harm reduction programmes for drug users. It collects information from donors and aims to track money from source to spend.

In 2008 NASA reported data from 77 countries, with reporting periods ranging from 2005 to 2007. However, the level of detail obtained does not match the aspirations of this reporting system. Some 15 countries only reported main budget lines of activity such as prevention, care and treatment, orphans and vulnerable. An additional 24 countries reported large proportions of their HIV/AIDS prevention budget under the general categories of 'prevention activities not specified by kind' or 'prevention activities not elsewhere classified'. This means that it is not possible using this system to analyse resource

allocations within the country according to specific prevention activities, including harm reduction. Most of the expenditure reported under these broad headings came from international bilateral donors and the Global Fund. Lack of specificity of NASA data leads to an under-reporting of harm reduction expenditure (see Box 4).

Box 4.
Case study: UNAIDS NASA: Unclear reporting of harm reduction expenditure in Indonesia

Indonesia's HIV epidemic is driven by injecting. It first reported NASA data in 2008, based on information from 2006. Total HIV expenditure was $56,576,587, 73% ($41,538,103) of which was financed by international sources and 27% ($15,038,484) by central and local government. From this total, $23,179,628 was allocated to HIV prevention in 2006. Only $124,436 was reported as earmarked for harm reduction, all of which came from domestic funding.[47] The conclusion to be drawn from NASA data is that little is spent on harm reduction in Indonesia, either by government or donors.

NASA also reported a total of $18,149,885 under 'prevention activities not specified by kind', of which $15,581,136 came from bilateral donors, $1,477,949 from UN agencies and $1,090,521 from the Global Fund. Because this was reported under the general category, none of this was identified as being allocated to harm reduction. However, IHRA's check on donor activity suggests that substantial sums were in fact allocated to harm reduction, and donor contributions for programmes targeting injecting drug use amounting to $18,716,000 were identified. [48] This total is suspiciously close to that reported by NASA for 'prevention activities not specified by kind' ($18,149,885), suggesting that substantial funding for harm reduction in Indonesia is not being reported in NASA.

It is therefore reasonable to conclude that, in 2006, approximately $18,716,000 of international donor funding was allocated to harm reduction in Indonesia, compared with the UNAIDS NASA report of $0.

It would appear that the failure in UNAIDS NASA data to disaggregate donor funding leads to a serious under-reporting of budgets for harm reduction in the NASA reports.

47. UNAIDS (2008) untitled (AIDS funding matrix – Indonesia), http://data.unaids.org/pub/report/2008/rt08_INO_en.pdf.
48. The sums identified are: (a) UK Department for International Development (DFID) is the main donor for the Indonesian Partnership Fund for HIV/AIDS (IPF) and committed a total of $47,080,979. Out of this, we estimate that, during 2006, $8,944,921 was used to fund HIV prevention interventions targeting injecting drug use. This was done through Family Health International's AKSI Stop AIDS (ASA) programme ($3,829,501), GRM ($3,519,860) and WHO ($1,595,560). (b) In 2002 AusAID endorsed the Indonesia HIV/AIDS Prevention and Care Project Phase 2 (IHPCP), committing $27,880,000 over a six-year period. It might be assumed that nearly 100% of this budget was allocated to HIV prevention strategies targeting injecting drug users. (c) USAID pledged $9 million to the IPF for 2006 and it can be assumed that nearly $5 million was directed to the ASA programme, which attempts to prevent HIV infections among people who inject drugs and their partners.

Money allocated for HIV prevention, treatment, care and support can also be tracked in UNGASS country progress reports, which sometimes include information unavailable in NASA data regarding main funding agencies and the main donors supporting national AIDS strategies. However, only general activities supported by multilateral or bilateral agencies are reported, and no information is available on the specific monetary distribution for different activities including harm reduction.

Given the problems with the NASA data, information was also gathered from the various sources identified above. As there is no existing database of harm reduction donors, information was collected from personal contacts working with relevant donors and multilateral agencies, and confirmed by cross-checking with implementing agencies in receipt of funds. Although this process inevitably failed to identify all donors, it is unlikely that the donations that have been missed would significantly alter the conclusions reached.

Gaining information from these other sources has not been without its difficulties. The data supplied by national and philanthropic donors was of variable quality. Some donors do not make budget information available in the public domain. Some countries do not keep central records of international spending, having devolved responsibility to regional offices. Not all donors report detailed functional budgets, therefore harm reduction expenditure may be subsumed under broader budget headings such as AIDS or development. Some donors (for example the European Commission and EU Member States) are moving away from earmarked funding.[49]

HIV prevention may be differently defined by different donors. For example, some donors such as PEPFAR do not use the term 'harm reduction', but nevertheless target some of their activities for HIV-related measures for people who inject drugs. For the purposes of this report, such activities have been included within the global estimates if they funded any of the items in the comprehensive package of HIV-related harm reduction.

Where HIV/AIDS expenditures can be identified, donors do not always disaggregate HIV prevention resources targeted at different populations. Harm reduction programmes may be included under budget lines for information, education and communication strategies or behaviour change interventions. Some donors were unable or unwilling to disaggregate data.

Budgets that do specify spending on harm reduction may include within this category a wide range of disaggregated expenditure, such as capacity building, care, treatment, support and impact mitigation, as well as direct services. As a consequence, it is not always possible to disaggregate overall programme budgets to see how much is spent on actual

49. Commission of the European Communities (29 May 2009) 'Progress report on the implementation of the European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007–2011)', Doc. No. Sec (2009) 748 Final.

harm reduction services, or to identify the types of services funded. This might lead to an overestimation of the amount dedicated to actual interventions and services.

In many cases, budgets were unclear and educated assumptions had to be made about, for example, the proportion spent in each year, and the allocation of within-budget expenditures for HIV-related harm reduction.

In addition, donors' accounting years vary, spending across total budgets might not specify actual spending by year and donors do not always differentiate budget allocations from actual expenditure (disbursements).

The current diversity of donor agencies and implementing partners can also lead to double-counting of funding. This is particularly the case where resources go to UN agencies and to the Global Fund. For example, donor countries may include their contributions to the UN agencies and/or the Global Fund within their HIV prevention budget. UN agencies and/or the Global Fund then allocate that money to programmes. National governments integrate those funds within their HIV prevention expenses, and implementing NGOs (national or international) will report that same money on their budgets. Any double-counting that may have occurred in the preparation of this report would serve to overestimate harm reduction expenditure.

Finally, expenditure on harm reduction by people who are actually injecting drugs (i.e. the costs borne by individuals for the purchase of injecting paraphernalia, of basic and emergency health care, condoms, drug treatment and so on) is rarely reported. Although some behavioural surveys collect this information, only one of the countries reporting to NASA – Mexico – included 'out-of-pocket' expenditure on harm reduction.

The donor funds for harm reduction identified are shown in Table 2. IHRA would be pleased to hear of any additions or amendments.

Table 2. Identified donor funding for harm reduction, 2007–2009 ($ million)

Donor	Total 2007	Total 2007– 2009	Comments and assumptions
The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)	45	180	2004–2008. Four years, annual total calculated pro rata. [50]
UK Department for International Development (DFID)	40.8	227.5	2007–2009. Total for period includes all projects identified that have some injecting drug user (IDU) component. For specific IDU projects, the total value has been included. For those targeting several vulnerable groups, it is assumed that one-third is for IDUs. In the case of projects including both vulnerable groups and the general population, it is assumed one-quarter is for IDUs. Data obtained from online searches and implementing agencies and unconfirmed by DFID. [51]
Australian Government Overseas Aid Program (AusAID)	16.2	38.5	2007–2009. [52] Possible overestimation of annual expenditure due to overlap of the Asia Regional HIV/AIDS Project (ARHP) and the HIV/AIDS Asia Regional Program (HAARP) in 2007.
Netherlands Ministry of Foreign Affairs	10.4	34	2007–2009. Includes funding to UNODC for harm reduction implementation. Includes UNODC MATRA (maatschappelijke transformatie = social transformation). Excludes funding for international conferences, Eastern European and Central Asia AIDS Conference and the Donors Conference on Harm Reduction.
United Nations Office on Drugs and Crime (UNODC)	5.8	52	2006–2007 and 2008–2009 UNAIDS Unified Budget and Workplan (UBW) allocations for UNODC. [53] Only HIV prevention activities targeting drug injectors and other vulnerable populations in the UBW is included. While efforts have been made to include donor money to UNAIDS that is not included in other donor returns, some double-counting is possible.
Bill & Melinda Gates Foundation	4.8	14.5	2006–2009. Source: online searches. Data unconfirmed by the Bill & Melinda Gates Foundation. For assumptions, see Box 5.
President's Emergency Plan for AIDS Relief (PEPFAR)	5.7	23.1	2007 and 2008. [54] The total given is for PEPFAR budgets for HIV-related drug user projects in Viet Nam, Cambodia, China, India, Kenya, Russia and Tanzania. PEPFAR does not fund needle exchange and funds methadone only in Ukraine and Viet Nam.
International Harm Reduction Development (IHRD) Program (Open Society Institute)	4.8	15.1	2007: $4,765,000 2008: $5,165,000 2009: $5,165,000 [55]

Table 2.. continues on next page

50. Atun R and Kazatchkine M (2010, forthcoming) 'The Global Fund's leadership on harm reduction: 2002–09' International Journal of Drug Policy 21(2).
51. UK Department for International Development, www.dfid.gov.uk/Where-we-work/ (14 January 2010).
52. AusAID Health and HIV Thematic Group (2008) 'Towards a new international HIV strategy for Australia: Consultation paper.
53. UNAIDS (2005) UNAIDS Unified Budget and Workplan 2006–2007 Geneva: UNAIDS; UNAIDS (undated) Unified Budget and Workplan 2008–2009 Geneva: UNAIDS.
54. Country information derived from www.pepfar.gov/countries/cop/ (14 January 2010).
55. Daniel Wolfe (2009) IHRD Program of the Open Society Institute, personal communication.

Table 2 Continued:

Donor	Total 2007	Total 2007– 2009	Comments and assumptions
Norwegian Agency for Development Co-operation (NORAD)	2.6	8.8	2007: NKR 9,000,000 2008: NKR 11,400,000 2009: NKR 12,000,000 Includes funding to UNODC.
World Bank	2.4	24	2001–2010. Estimates for projects and grants as provided by World Bank staff, and not official WB data.
GTZ (Germany)	1.1	5.3	2007:€ 807,000 2008:€ 525,000 2009:€ 2,450,000
DROSOS Foundation (Switzerland)	1	3	Source: IHRA.
Swedish International Development Cooperation Agency (SIDA)	1	2.3	2007–2008 [56] Lao People's Democratic Republic, Cambodia and Viet Nam.
Canadian International Development Agency (CIDA)	0.8	2.3	2007–2009 [57] 2001–2009 Viet Nam, $4.7 million. STD and HIV/AIDS control: 80% of total budget. 2006–2010 Russia, Georgia, Ukraine $2.8 million. STD and HIV/AIDS control: 40% of total budget.
Levi Strauss Foundation	0.4	0.46	2007: $355,000 2008: $100,000 Information from Levi Straus Foundation staff.
AIDS Fonds, Netherlands	0.3	0.86	2007: € 150,000 2008: € 20,000 2009: € 450,000 Information from AIDS Fonds Netherlands staff.
American Jewish World Service	0.06	0.24	2007: $61,300 2008: $91,500 2009: $91,500 Information from American Jewish World Service staff.

• Conversions to US dollars calculated using weighted average exchange rates.
• Total period equals 2007 to 2009 for all donors.
• Funds allocated to pre-existing programmes and those extended beyond the reported period, for which yearly information was not available, have been annualised to obtain a pro-rata estimates of the annual expenditure.
• No information was available from the Elton John Foundation or Ford Foundation.
• No information was available from the European Commission, which is moving away from earmarked project financing towards general budget support as a preferred aid modality.

56. World Health Organization Regional Office for the Pacific (2007) 'Building comprehensive harm reduction services for injecting drug users in the Lao People's Democratic Republic, Cambodia and Viet Nam: Towards universal access to HIV/AIDS prevention, treatment & care: Project summary' in Report of the Harm Reduction SIDA Project for the Greater Mekong Subregion (HR3) First Project Advisory Committee Meeting, 20–21 November 2007 Phnom Penh, Cambodia Manila: WHO Regional Office for the Western Pacific.
57. Canadian International Development Agency project browser, http://les.acdi-cida.gc.ca/project-browser.

3.2 Estimated total spending on harm reduction

Despite the difficulties in identifying harm reduction expenditure and of obtaining accurate estimates, the overall volume of spending on HIV-related harm reduction is undoubtedly small.

- A cautious estimate is that approximately $160 million was invested in HIV-related harm reduction in 2007, of which $136 million (90%) was from international donors.
- There is no reason to think that spending has increased since 2007. Indeed, there is evidence in some countries that spending on harm reduction may have decreased during this time.

Given the limitations identified above in obtaining data, there is obviously plenty of room for error in this estimate. This situation clearly points to the need for better data collection.

The assumptions used in calculating these estimates are open to challenge. However, given the multiple sources used and cross-checking performed, the overall estimated total is plausible, even if the separate figures that contribute to it are less than optimal. For example, it is likely that domestic expenditure was undercounted as the NASA reports were relied upon as the source for this information. On the other hand, some of the budgets reported here are likely to have lower harm reduction components than have been estimated. It is fair to assume therefore that errors resulting in over- or under-estimation are likely to cancel each other out.

The estimate of $160 million is also plausible when cross-checked against per capita daily spending per injector for those countries where most harm reduction budgets were able to be identified, most of which were countries with higher than usual investment (see below).

If anything, the figure is likely to overestimate the amount of funding that actually goes to frontline services and interventions. In the case of multi-component HIV/AIDS projects that target both general populations and several vulnerable populations, assumptions were made about the proportions spent on injecting drug using populations. Even where harm reduction is identified in budgets, the total budgets reported often do not include any breakdown of how much is spent on each sort of activity, for example on opioid substitution therapy and on needle and syringe programmes. Most budgets include costs for capacity building, training, advocacy and strengthening national HIV/AIDS programmes. For example, it is estimated that about one-third of the Netherlands Ministry of Foreign Affairs and the German GTZ funding goes on direct health services such as needle and syringe programmes and opioid substitution therapy; the equivalent figure would be between 30% and 60% for AusAID.

Even if the final estimated figure underestimates the amount spent on harm reduction by a factor of two or three (which is unlikely), it does not change the overall conclusion of this report, as the amount of money being invested in harm reduction is extremely low.

As is the case with funding for HIV/AIDS generally, the limited number of governments funding harm reduction is particularly noteworthy. The main international donors are the UK, Australia and the Netherlands, which between them accounted for $67.4 million, or 42%, of donor funding (a total greater than that provided by the Global Fund).

Only a small number of philanthropic organisations invest in harm reduction, which highlights the potential to expand global philanthropy in this area by increasing the number of country and private donors. It also indicates the dependence of recipient countries and their vulnerability to the funding policies of a small range of donors. Even for those philanthropic organisations that do fund harm reduction, this often amounts to only a small proportion of their total funding (see Box 5).

Box 5.
Case study: Bill & Melinda Gates Foundation

Between 2006 and 2009 the Bill & Melinda Gates Foundation allocated a total of $7.113 billion for activities, 63% of which went to the Global Health Program. Two programmes specifically funded HIV prevention for drug using populations – the Avahan programme in India (which included $7.5 million under Project Orchid) and the China HIV prevention programme (which had a total budget of $50 million and included an unspecified amount for HIV prevention for people who inject drugs).

If the $7.5 million for Project Orchid is apportioned equally over project years, it can be estimated that $4.5 million ($1.5 million per annum) was spent on HIV prevention for injecting drug users for the years 2006/7, 2007/8 and 2008/9. Assuming that the $50 million for the China programme is apportioned equally over project years, and that one-third of the programme goes to each of the high-risk groups, it can be estimated that a maximum of $10 million ($3.3 million per annum) was committed for HIV prevention for people who inject drugs in the calendar years 2007, 2008 and 2009.

Under these assumptions, we estimate that total Gates Foundation funding for HIV prevention for injecting drug users in the period is a maximum $4.8 million, of which much less goes to direct interventions. This amounts to 0.001% of the annual Gates Foundation budget for 2008/9, and 1.96% of the total HIV grants for 2006 to 2009.

The Gates Foundation has funded other projects that contained components relevant to injecting drug use. For example, a grant to UNAIDS that ran from 2006 to 2009 included work relevant to people who inject drugs in Russia and Indonesia, and a grant to the International Council on AIDS Service Organisations for 2005 to 2010 included work relevant to drug injectors in Russia, Ukraine and China. Details of these grants or of any of the other $738.1 million HIV grants made by the Gates Foundation between 2006 and 2009 are not available. Beginning in 2006 the Gates Foundation's website does not provide information on the purpose of grants awarded to different organisations. Information is provided only for general programmes of work.

Approximately $15 million of harm reduction expenditure in low and middle income countries reportedly came from domestic sources, although this probably underestimates the actual figure. There are marked differences around the world in domestic spending on harm reduction. For example:

- Malaysia, where approximately 70% of HIV infections over the period 1997 to 2005 were related to unsafe injecting, committed $150 million in 2005 for harm reduction programmes, including opioid substitution therapy and needle and syringe programmes.[58]
- The Russian Federation, where also approximately 70% of HIV infections over the period 1997 to 2005 were related to unsafe injecting, provides national funding support for its HIV/AIDS National Strategy. This support doubled in 2007 compared with 2006. However, of $289 million, only $7.75 million was allocated to HIV prevention. Federal funding for needle and syringe programmes was not delivered, leading to the threatened closure of programmes that had been supported by the Global Fund and necessitating a last-minute financial rescue by the Fund. [59]

Overall, however, most funding for harm reduction in low and middle income countries comes from international donors. According to estimates from UNAIDS, for example, 100% of funding in Central Asia is international but this reporting probably misses some domestic contribution; international donors provide 76% of funding in Eastern Europe and 92% in East and South East Asia. [60]

Closer examination of donor budgets provides some indication of total funding at country level and enables estimates of per capita spending. [61] For example:

- Ukraine has an estimated 375,000 people who inject, and a reported HIV prevalence rate of 42%. [62] Between 2007 and 2009 Ukraine received a total harm reduction investment of nearly $19 million, including $12 million from the Global Fund, [63] $3.9 million from the International Harm Reduction Development Program (IHRD) of the Open Society Institute, $1,050,000 from GTZ, $1,008,000 from NORAD (to the Clinton Foundation) and $50,000 from the Levi Strauss Foundation. [64] This equates to about $25 in harm reduction expenditure per person who injects drugs per year.

58. UNGASS Country Progress Report 2008 – Malaysia (2008). http://data.unaids.org/pub/Report/2008/malaysia_2008_country_progress_report_en.pdf
59. Goliusov, AT et al. (2008) Country Progress Report of the Russian Federation on the Implementation of the Declaration of Commitment on HIV/AIDS Moscow: Ministry of Health and Social Development of the Russian Federation.
60. Data from UNAIDS National AIDS Spending Assessments reporting system, www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/.
61. Exchange rates from International Monetary Fund, 10 July 2009.
62. Mathers et al. (2008) op. cit.
63. This includes ARV treatment and hence the sum overestimates prevention spend.
64. There was also funding from the Elton John Foundation, USAID (for methadone) and European Commission (for advocacy).

- Russia has an estimated 1,825,000 people who inject, and a HIV prevalence rate of 37%. [65] Between 2007 and 2009 Russia received approximately $48.5 million for harm reduction, including $23 million from the Global Fund, $3.4 million from IHRD, $771,000 from the Canadian International Development Agency and approximately $21.3 million from the World Bank. This is approximately $13.50 in harm reduction expenditure per injector per year.
- Viet Nam has an estimated 135,305 people who inject, and a HIV prevalence rate of 33.8%. [66] Between 2007 and 2009 Viet Nam received approximately $25.4 million for harm reduction, including $10.4 million from PEPFAR (for 2007/8), $2,101,000 from the Netherlands Ministry of Foreign Affairs (in 2009), $331,882 from AusAID (via the HAARP programme 2006–2008), $3.8 million from CIDA (for 2001–2009), $28.5 million from DFID (for 2001–2009), $285,396 from GTZ (for 2007), $55,000 from IHRD and $57,000 from American Jewish World Service. This equates to approximately $62.50 in harm reduction expenditure per person who injects per year. This estimate does not include possible national or domestic contributions due to the lack of information available about the national HIV/AIDS budget.
- Taiwan, with 60,000 people who inject, spent $141.60 per injector in 2007, all of it from national funding. [67]

3.3 Estimated annual spending on HIV-related harm reduction per injector

The estimated global spending equates to $12.80 for each injector each year in low and middle income countries, or just three US cents per injector per day. This is based on the global spending of $160 million (see above) divided by an estimated 12.5 million people who inject in low and middle income countries. [68] This calculation almost certainly overestimates spending on actual harm reduction services, which would have received only one-third to one-half of this amount.

Expert advice from researchers confirms that three cents a day is less than drug users themselves spend daily on needles and syringes and other harm reduction commodities.

65. Mathers et al. (2008) op. cit.
66. Cook and Kanaef (2008) op. cit.
67. Chen YM, Huang KL, et al. (2001) 'Temporal trends and molecular epidemiology of HIV-1 infection in Taiwan from 1988 to 1998' Journal of Acquired Immune Deficiency Syndrome 26: 274–282.
68. Mathers et al. (2008) op. cit.

4 | How much money needs to be spent on harm reduction?

The international community committed to universal access by 2010; this will not be achieved for people who inject drugs. At an estimated $160 million – or three cents per injector per day –spending on harm reduction is trifling by any measure. And yet HIV is a preventable disease and 25 years of harm reduction experience show that there are effective and relatively cheap interventions that can prevent the spread of HIV among people who inject drugs.

4.1 Estimating resource needs

Most estimates of the money required for HIV prevention adopt a relatively simple model using the size of the target population, the unit cost of each intervention and the coverage required. For example, in the UNAIDS Resource Needs Model:

Resources Needed	=	Size of Target Population	x	Unit Cost of Each Intervention	x	Coverage Required

This equation is straightforward and easily understood, but ignores many factors that might affect costs and impacts. These include, for example, interaction effects (where providing two or more services in the same place reduces overhead costs), economies of scale (where scaling up and bulk purchasing can lead to cost savings), synergies between different interventions (such as where successful opioid substitution therapy reduces the need for needle and syringe distribution) and the relative cost-effectiveness of different interventions.[69] However, given the generally low expenditure that is being reported, this equation is adequate for present purposes.

4.2 Unit costs for harm reduction

Although the size of the population can be estimated using a variety of research methods, in practice most countries lack good estimates of the target population. Current best estimates of population size are reported by the UN Reference Group on HIV and Injecting Drug Use.[70] Good estimates of the size of the target population are essential. The choice of coverage levels has been discussed in Section 1.

Little work has been done on calculating the unit costs for HIV-related harm reduction interventions in a sufficient range of countries. There are considerable problems in making such calculations, for example there are different types of delivery systems for each intervention: needle and syringe programmes, for instance, may be delivered

69. Shepard DS et al. (2007) Critical Review of Costing Models to Estimate Resource Needs to Address Global HIV/AIDS Geneva: UNAIDS.
70. Mathers et al. (2008) op. cit.

through pharmacies, specialist programme sites, vending machines, vehicles or outreach. Additionally, most projects provide a mixture of services: needle and syringe programmes might also deliver, for example, information, voluntary testing, counselling, legal advice and social support. Besides material costs (such as needles and syringes), there are also costs associated with service start-up, staff, premises and overheads to be considered.

Some cost data can be found in the 2007 UNAIDS resource needs estimates. [71] More detailed estimates are found in the Redefining AIDS in Asia report [72] and estimates for selected Asian countries are reported by the UN Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific. [73] Careful interpretation and use of these estimates is required because most use costings of diverse service delivery modes and ranges of activities, mainly in developed countries or in projects managed by international agencies.

As shown in Tables 3 and 4, costs vary from country to country. They range from $51 to $235 for needle and syringe programmes in Asia (based on drop-in and outreach programmes), with the costs of needles and syringes themselves accounting for between 30% and 40% of the total costs. Annual costs for opioid substitution therapy range from $132 (Indonesia) to $1,811 (Estonia) for methadone treatments, and are higher for treatment using buprenorphine.

Further economic analyses are required to derive indicative unit costs for delivering needle and syringe programmes and opioid substitution therapy in a range of low and middle income countries. A plausible estimate of the unit cost of programmes delivering needle and syringe programmes based on the available data is approximately $100 per person per year in low income countries. For methadone, the cost is approximately $500 per person per year. The figures are markedly influenced by labour costs, hence they will be higher in middle income countries. It should be stressed that these figures are not normative, but are for generating approximate estimates of global resource needs.

71. UNAIDS (2007) Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support Geneva: UNAIDS [hereinafter Financial Resources].
72. Commission on AIDS in Asia (2008) op. cit.: Technical Annex.
73. United Nations Regional Task Force (UNRTF) on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (July 2009) Estimation of Resource Needs and Availability for HIV Prevention and Care Among People Who Inject Drugs in Asia: Report Bangkok: UNRTF.

Table 3. Examples of unit costs for needle and syringe programmes ($)

	Unit cost per person per year	Multi-component projects including distribution of needles and syringes
Nepal	59	Syringes and needles were 35% of unit cost; [74] estimate used in Redefining AIDS in Asia. [75]
Bangladesh	157	Estimate used in Redefining AIDS in Asia.
Pakistan -1	131	Drop-in centre and outreach using motorcycles. Syringes and needles were 38% of unit cost; [76] estimate used in Redefining AIDS in Asia.
Pakistan - 2	166	Drop-in and mobile centre. Syringes and needles were 30% of unit cost. Estimate used in Redefining AIDS in Asia.
China, India, Indonesia, Myanmar, Nepal, Pakistan, Bangladesh	Range from 51 to 235	United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific. [77]
Estonia	233	UNAIDS [78]
Low and Middle Income Countries	4 to 10	UNAIDS estimate of needles and syringes alone. [79] Costs derived from retrospective analysis of the coverage required to reverse the HIV epidemic among IDUs in New York and on coverage targets achieved by European countries that averted or prevented the epidemic. Amount of resources needed to reach 60% or more of the IDU population more than once a month.

Table 4. Examples of unit costs for opioid substitution therapy ($)

Estonia	1,811	UNAIDS[80]
Low and Middle Income Countries	363 to 1,057 for methadone 1,236 to 3,166 for buprenorphine	UNAIDS [81]
China, India, Indonesia, Myanmar, Nepal	132 to 228 for methadone 314 for buprenorphine	United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific [82]

74. Alban A and Manuel C (2007) Cost-Effectiveness of Injecting Drug User Interventions to Prevent HIV in Kathmandu, Nepal Manila/Bangkok: ADB and UNAIDS: 1–22.
75. Commission on AIDS in Asia (2008) op. cit.
76. Alban A et al. (2007) Cost-Effectiveness of Injecting Drug User Interventions to Prevent HIV in Karachi, Pakistan Manila/Bangkok: ADB and UNAIDS: 1–23.
77. UNRTF on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (July 2009) op. cit.
78. Alban A (2005) 'Estimation of costs of HIV interventions in Estonia, 2005', internal UNAIDS report.
79. Verster et al. (2007) op. cit.
80. Alban (2005) op. cit.
81. Verster et al. (2007) op. cit.
82. UNRTF on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (July 2009) op. cit.

4.3 Resource needs estimates: UNAIDS

UNAIDS estimates that the total global resources needed for HIV/AIDS for the period 2009 to 2013 is almost $200 billion to achieve universal access by 2010, and $140 billion for a slower scale-up to achieve universal access by 2015. [83]

The UNAIDS estimates for harm reduction assume 60% coverage for needle and syringe programmes and 40% for opioid substitution therapy. [84] These estimates are based on the resources needed for prevention-related activities in order to reach 6.2 million people who inject drugs by 2010 in 132 lower and middle income countries. UNAIDS assumes the cost of opioid substitution therapy using methadone to be between $363 and $1,057 per person per year (which is higher than other estimates in Table 4) and the costs of needle and syringe programmes to be $10 per person per year (lower than other estimates in Table 3).

Using these figures, UNAIDS estimates that the resources needed for harm reduction are $2.13 billion in 2009 and $3.2 billion in 2010, an average of $170 and $256 respectively per injector per year. Additional resources will be required for antiretroviral treatment, care and support. [85]

Subsequent estimates from the Commission on AIDS in Asia suggest that UNAIDS underestimated costs for Asia, which the Commission put at $376 million for HIV programmes for injectors compared with the UNAIDS estimate of $192 million. However, the report does not specify the size of the injecting population on which these figures are based. [86]

More detailed estimates of harm reduction resource needs are provided by the UN Regional Task Force (UNRTF) on Injecting Drug Use and HIV/AIDS for Asia and the Pacific.[87] It provides country and regional estimates of the funding required to implement the comprehensive package of HIV prevention, treatment and care interventions for injection drug users in South Asia (Afghanistan, Bangladesh, India, Pakistan, Nepal and the Maldives) and South East Asia (Cambodia, China, Indonesia, Myanmar, Malaysia, Lao PDR, Philippines, Thailand and Viet Nam). Resource needs are estimated on the basis of the size of the population at risk, based on data published by the Reference Group to the United Nations on HIV and Injecting Drug Use, 60% coverage for needle and syringe programmes and 40% for opioid substitution therapy.

The UNRTF estimates that the total resources needed amounted to $500 million in 2009, including 37% to be spent on medicines and consumables, 30% on workforce, 16% on management and enabling environment and technical assistance. The $500 million can

83. UNAIDS (2007) Financial Resources op. cit.
84. Verster et al. (2007) op. cit.
85. UNAIDS (2007) Financial Resources op. cit.
86. Commission on AIDS in Asia (2008) op. cit.
87. UNRTF on Injecting Drug Use and HIV/AIDS in Asia and the Pacific (July 2009) op. cit.

also be broken down into 69% for needle and syringe programmes and opioid substitution therapy, 20% for antiretroviral therapy and 12% for condoms, voluntary counselling and testing and treatment for sexually transmitted infections. The programme costs for condoms, voluntary counselling and testing and treatment for sexually transmitted infections were not included in the UNAIDS estimates.

4.4 The resource gap: Current spending on harm reduction compared with estimated need

Despite the problems in estimating both current spending and the resources needed, the gaps are clearly so huge as to over-ride any errors in current measurements. At approximately $160 million in 2007, the estimated total spending on HIV-related harm reduction in low and middle income countries is extremely low, and would still be insufficient even if this figure was underestimated by a factor of two or three. It amounts to about three US cents a day, or $12.80 a year, for each person who injects drugs. It is clearly inadequate when compared with indicative unit costs of providing needles and syringes (approximately $100 per person per year) and methadone (approximately $500 per person per year).

Using UNAIDS calculations, HIV-related harm reduction spending should instead average between $170 and $256 per injector per year. Therefore, the actual spending is only a very small proportion of that required, and consequently current spending is nowhere near proportionate to need. There is a huge resource gap between what is being spent and the investment that is needed.

- At an estimated $160 million, the spending on harm reduction in 2007 was only 7% of the $2.13 billion estimated by UNAIDS to be needed in 2009 for HIV prevention for drug users, and is only 5% of the $3.2 billion needed in 2010.
- The resources needed for HIV prevention for people who inject drugs are between 14 and 20 times greater than those currently allocated.

These estimates of the resource gap are higher than, but not dissimilar to, those of the UN Regional Task Force for Asia and the Pacific, which considers that the current harm reduction spending in countries in the region is 10% of the amount required. [88]

Current spending on harm reduction is also not proportionate in terms of the global spend on HIV/AIDS. The estimated spend on HIV-related harm reduction in 2007 in low and middle income countries was only 1.4% of the total global spend on HIV/AIDS prevention, treatment, care and support in 2007 ($11.3 billion). People who inject drugs have not benefited sufficiently from the increase in funds for HIV/AIDS.

88. Bergenstrom A et al. (2010, forthcoming) 'How much will it cost? Estimation of resource needs and availability for HIV prevention, treatment and care for people who inject drugs in Asia' International Journal of Drug Policy 21(2).

4.5 You get what you pay for

The low level of resources allocated to harm reduction in 2007, in comparison with the resources needed, is consistent with the low levels of coverage reported for low and middle income countries. Global coverage is estimated at between 3% and 8% of what is needed.

One way to begin to redress this gap is for donors to consider funding in terms of the proportion of the HIV/AIDS burden linked with injecting. This might be done with reference to the share of infections. The difficulty with this method is that it does not take into account vulnerability (including countries that may be particularly vulnerable to the spread of injecting drug use) or the proportion who might benefit from prevention activities in different populations.

Another way to bridge the resource gap is to consider making funding proportionate to the total estimated UNAIDS prevention needs. UNAIDS estimated that the total resources needed for prevention in 2009 was $11.3 billion, of which $2.13 billion is needed for harm reduction for people who inject. This means that 19% of the total donor spending available for resources to achieve universal access to HIV prevention, treatment and care should be allocated to people who inject drugs. [89]

Therefore, a conservative guideline for donors is that approximately 20% of funds allocated for HIV/AIDS prevention should go specifically to harm reduction.

89. UNAIDS (2007) Financial Resources op. cit.

5 | Three cents a day is not enough: More money is needed for harm reduction

Not enough money is being spent on harm reduction for drug using populations. People who use drugs are not receiving the harm reduction services that they need and to which they have a right. At current rates of progress, universal access to HIV prevention will not be met for decades, let alone in 2010.

The biggest providers and funders of harm reduction commodities are probably drug users themselves. The needles and syringes and the health care needed by people who inject drugs in low and middle income countries are bought mainly with their own 'out-of-pocket' money. This is an unfair burden on a population that – in general – lacks resources, and it is a situation that would be unacceptable in any other medical or public health field.

International organisations have produced policy briefs and technical advice. The research community has provided the evidence. A select number of donors have committed funds to HIV-related harm reduction. But despite these good intentions, people who inject drugs remain neglected in the fight against HIV/AIDS.

If nothing is done to address this neglect, high levels of HIV infections will continue in drug using populations. Outside Africa, 30% of new HIV infections occur among drug users. New populations in Africa and Latin America are vulnerable to the spread of injecting and, by extension, to new HIV epidemics.

More resolutions at UN meetings will help, as too will more vocal support for harm reduction from the heads of all relevant UN agencies and other international organisations. More research will start to fill in the gaps in knowledge about effectiveness and costs. More technical advice will also help. But ultimately what counts is the amount of money committed in international aid budgets – by states, by philanthropic organisations, by The Global Fund to Fight AIDS, Tuberculosis and Malaria – and in domestic budgets.

HIV infection among people who inject drugs is preventable. Harm reduction is cost-effective and drug users have responded well when offered harm reduction advice and tools. It is time for the international community to match its words and gestures with money.

Recommendation 1 – More global resources are needed for harm reduction

Recommendation 2 – Resources for harm reduction and HIV services for people who use drugs should be proportionate to need within countries

Recommendation 3 – Donors should set targets for the proportion of spending going to HIV-related harm reduction, with 20% of global prevention funds going to harm reduction

Implications for: The Global Fund, states providing international aid, national governments, philanthropic donors

The estimates in this report are admittedly based on poor quality data. However, even if the margin of error is such that the report has underestimated global spending by 100% or 200%, it would still be clear that not enough money is being spent on harm reduction in absolute terms, proportionate to needs or proportionate to the global spending on HIV/AIDS. More money is needed for harm reduction, and it is needed now.

The current spending is about one-twentieth of what is required. Spending on harm reduction needs to be increased dramatically, especially for direct frontline services.

Global funding on harm reduction is provided by only a handful of donor countries. More rich countries need to fund harm reduction.

There needs to be a significant increase in domestic allocations to harm reduction. National governments have been reluctant or unable to provide their own resources. As a result, much of the funding for both government- and civil society-led HIV prevention activities among injecting drug users comes from international donors, mainly the Global Fund and a few bilateral donors. Several national examples demonstrate that where there is political will, domestic funding can be a significant contribution to harm reduction.

Only a few philanthropic donors fund harm reduction or are able to identify some harm reduction spending in their budgets. The list of international philanthropic donors is particularly notable for the absence of major donors, yet discrimination against drug using populations is inconsistent with philanthropy. Those that do donate, spend only a fraction of their funds on harm reduction.

The Global Fund spent $1 billion on HIV/AIDS in 2007, $1.6 billion in 2008 and $2.8 billion in 2009. Yet each year between 2004 and 2008, only approximately $45 million was spent on harm reduction. The Global Fund, as a matter of urgency, needs to investigate the

reasons for its underperformance with respect to harm reduction. It urgently needs to increase the amount of funding for harm reduction and must encourage grant bids that include harm reduction: all applications for funding should be required to state whether and how they have addressed drug use issues; and if they have not, to explain their reasons why (as is currently the case for gender issues). All applications should reflect needs assessed according to an agreed methodology so as to ensure that the needs of most at-risk groups are properly reflected in bids. The Global Fund must also take measures to ensure that NGOs and organisations that represent drug using populations are properly involved in grant bids, and that NGO-led applications are made more achievable.

Recommendation 4 – Global expenditure on harm reduction must be properly monitored by UNAIDS and NGOs

Implications for: UNAIDS, UN Reference Group on HIV and Injecting Drug Use, state and philanthropic donors, advocacy organisations

It was difficult to obtain good data on harm reduction funding for this report. There was also great difficulty in obtaining information on harm reduction expenditure from otherwise well-intentioned donors. Harm reduction is often invisible in budgets and reports. The lack of good information on resources spent on harm reduction, and the difficulty in obtaining this information, is symptomatic of the neglect of people who inject.

There are concerns about the utility of UNAIDS spending assessments. UNAIDS National AIDS Spending Assessments (NASA) aim to follow money from source – including donors – to spending on services. However, there are discrepancies between NASA country-level data and the information about actual budgets that we obtained from the public domain. UNAIDS needs to improve the accuracy of NASA reporting so as to provide a more truthful reflection of spending on harm reduction.

The fact that many donors find it difficult to track expenditure on harm reduction indicates the need to set up a civil society led global resource monitoring system that has specialist knowledge of harm reduction. This could sit alongside other global monitoring mechanisms such as NASA or the UN Reference Group on HIV and Injecting Drug Use. Part of the task would be to work with international agencies – especially UNAIDS – so that global spending is better reported by national governments. UNAIDS also needs to use its persuasive powers to encourage principal donors to record HIV/AIDS spending according to agreed criteria and functional budget lines.

Resource tracking should efficiently monitor the total global spend on harm reduction, list the recipient countries and map spending onto the epidemiology of injecting drug use and HIV infection. This would help to increase donor accountability, reduce duplication

amongst donors and increase donor coordination. It would also help to protect progress to date, monitor scale-up, identify gaps and responses, recognise potential funding crises (such as gaps between funding rounds) and generally feed into advocacy and policy work.

Recommendation 5 – Better estimates are required of the resources needed for HIV-related harm reduction

Implications for: The Global Fund, WHO, UNAIDS, UNODC, academic institutions and research funders

The evidence base for resource mapping and estimation is weak. Better estimates of resource needs are required to advocate for and allocate harm reduction resources more effectively on the basis of need, rather than on donor idiosyncrasies. The current resource gap is so huge that refined estimates of resource needs might appear to be a luxury. However, current resource needs estimation is either too global, as is the case with the UNAIDS resource needs model, or only patchily available at national level. Resource needs models also use simplistic methods and, given the shortage of resources, some improvement in resource allocation might come with more dynamic and cost-effective models. There has to be transparent discussion about the interventions to be included in resource needs models, and better information on unit costs.

Advances have been made in measuring the size of drug using populations, although there is clearly more work to be done on the epidemiology of injecting drug use and other drug using populations. There also needs to be accurate and reliable estimates of the size of other vulnerable drug using populations. Basing resource needs estimates solely on the size of current populations of people who inject drugs excludes consideration of other drug users and populations vulnerable to the spread of injecting – as in much of Africa, the Middle East and Latin America.

The Global Fund should develop and implement a method for resource needs estimation and require applicants to adopt a standard methodology for assessing need. This would enable the Global Fund to assess whether the balance of resources requested in grant applications matches national need, and ensure that bids are appropriate to needs.

Recommendation 6 – New ways of delivering harm reduction services may be needed

Implications for: The Global Fund, WHO, UNAIDS, UNODC, academic institutions and research funders

Given the size of the funding gap, it is reasonable to ask whether it can ever be bridged by scaling up the current ways in which harm reduction services are delivered. Given the low scale of harm reduction services, scale-up tends to be by the replication of specialist micro-projects. As drug users are marginalised in many countries, it is understandable that harm reduction services have mainly been delivered by community-oriented organisations. But there is a danger that these services are themselves marginalised. Different models of service delivery should be explored, including the implications of integrating harm reduction into general health and social welfare systems. Some donors, for example the European Commission and EU Member States, [90] are shifting away from donor-driven earmarked financing and towards more general budget support for countries. This should allow for greater country ownership and the potential integration of harm reduction into general health and social systems. However, there are risks in this approach, given the unpopularity of government funding for drug using populations and the potential that general budget support to governments may tend to exclude civil society organisations that are essential to the response to HIV/AIDS.

As harm reduction moves through its third decade, there is a critical need to explore new models of service delivery. Yet at present there is no centre of excellence for such global analytic capacity in the UN system or in academic institutions.

Recommendation 7 – A global Community Fund for Harm Reduction should be established to advocate for increased resources for harm reduction

Implications for: Country and philanthropic donors, UNAIDS, The Global Fund

The resource gap is so huge that resource mobilisation is unlikely to occur unless there is funding for civil society organisations to advocate for harm reduction, and resources, at the national, regional and global levels. With the shift of donor interest from earmarked funding to general budget support, and the need to encourage country ownership, much more needs to be done to create the political interest at national level in seeking funds for harm reduction. Advocacy can help create the demand for harm reduction resources. Only a handful of civil society organisations are funded for international or regional harm reduction advocacy and numerous structural barriers exist to changing this situation.

90.Commission of the European Communities (29 May 2009) op. cit.

Although the Global Fund can provide money in grants for community systems strenghtening, harm reduction organisations are small and there is a vicious circle whereby they tend to lack the capacity to bid for the funds that will increase their capacity. Country and philanthropic donors are often unenthusiastic about funding advocacy. Funding restrictions often prevent donors from funding international and regional organisations. Large donors often lack mechanisms for handling what for them are relatively small amounts of money. These barriers need to be addressed in order for civil society organisations to advocate for harm reduction. Mechanisms need to be found to bridge the gap from large donors to small organisations.

A time-limited emergency Community Fund for Harm Reduction could address these needs and provide resources for organisations to build capacity to advocate for harm reduction and to bid for harm reduction resources.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