Global Fund investments in harm reduction from 2002 to 2009

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\section*{ABSTRACT}

\textbf{Background:} Injecting drug use has been documented in 158 countries and is a major contributor to HIV epidemics. People who inject drugs have poor and inequitable access to HIV services. The Global Fund to Fight AIDS, Tuberculosis and Malaria is the leading multilateral donor for HIV programmes and encourages applicants to include harm reduction interventions in their proposals. This study is the first detailed analysis of Global Fund investments in harm reduction interventions.

\textbf{Methods:} The full list of more than 1000 Global Fund grants was analysed to identify HIV grants that contain activities for people who inject drugs. Data were collected from the detailed budgets agreed between the Global Fund and grant recipients. Relevant budget lines were recorded and analysed in terms of the resources allocated to different interventions.

\textbf{Results:} 120 grants from 55 countries and territories contained activities for people who inject drugs worth a total of US$ 361 million, increasing to US$ 430 million after projections were made for grants that had yet to enter their final phase of funding. Two-thirds of the budgeted US$ 361 million was allocated to core harm reduction activities as defined by the United Nations. Thirty-nine of the 55 countries were in Eastern Europe and Asia. Only three countries with generalised HIV epidemics had grants that included harm reduction activities.

\textbf{Conclusion:} This study represents the most comprehensive assessment of Global Fund investments in harm reduction. This funding, while substantial, falls short of the estimated needs. Investments in harm reduction must increase if HIV transmission among people who inject drugs is to be halved by 2015.

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\section*{Introduction}

Globally, there are an estimated 15.9 million people who inject drugs, 3 million of whom are living with HIV (Mathers et al., 2008)—representing a prevalence of around 19 percent among this population. Injecting drug use remains a major contributor to HIV transmission, accounting for 10 percent of global infections and around 30 percent of infections outside of sub-Saharan Africa (Cook & Kanaef, 2008). It has also been estimated that 10 million people who inject drugs have hepatitis C (Nelson et al., 2011). Drug injection has been formally documented in 158 countries, and 120 of them report HIV transmission among this population (Cook, 2010). United Nations Member States committed in 2011 to “working towards reducing transmission of HIV among people who inject drugs by 50 percent by 2015” (UN General Assembly, 2011).

Harm reduction can be broadly defined as “policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption” (International Harm Reduction Association, 2011). In 2009 the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) endorsed a “comprehensive” harm reduction package of nine interventions for people who inject drugs (Box 1). No single intervention alone can prevent or reverse HIV epidemics among people who inject drugs. However, there is a “wealth of scientific evidence supporting the efficacy of these interventions in preventing the spread of HIV” (WHO, UNODC, & UNAIDS, 2009). The UNAIDS Strategic Investment Framework – which aims to support more efficient and effective targeting of resources for HIV – includes harm reduction for people who inject drugs as one of the core programme activities that “have a direct effect on reduction of transmission, morbidity, and mortality from HIV/AIDS, and should be scaled up according”. It also recommends funding of a series of related “critical enablers” including community mobilisation, stigma reduction and human rights advocacy (Schwartländer et al., 2011). Nonetheless, people who inject drugs
Box 1
The United Nations “comprehensive package”  
(WHO, UNODC, & UNAIDS, 2009)

1. Needle and syringe programmes
2. Opioid substitution therapy and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections
6. Condom distribution programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

consistently have poor and inequitable access to services (Mathers et al., 2010) and often face stigma, discrimination, marginalisation and abuse in every walk of life (Beyrer, Malinowska-Sempuch, Kamarulzaman, & Strathdee, 2010).

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is a public–private partnership and international financing institution dedicated to attracting and investing additional resources to tackle the three pandemics. Its model is based on country ownership and performance-based funding, which means that countries implement programmes based on their own priorities and the Global Fund provides financing on the condition that verifiable results are achieved. Since its creation in 2002, the Global Fund has approved more than 1000 grants worth a total of US$ 22.6 billion in 150 countries (Global Fund, 2011a).

The Global Fund Board periodically announces calls for proposals, or financing “Rounds”. Eligible countries or regional bodies then develop and submit proposals through multisector Country Coordinating Mechanisms. To support the proposal development process, the Global Fund and a range of partners produce guidance and information notes on a range of topics, including harm reduction (Global Fund, 2011b). Once submitted, proposals are reviewed by an independent Technical Review Panel which makes recommendations to the Global Fund Board. Successful proposals are approved for two years (“Phase 1”); after which an in-depth review of progress, results and impact is conducted before deciding on continued funding for the next three years (“Phase 2”). Selected successful grants in Rounds 1–5 were also then invited to apply for a further six years of funding (in two periods of three years) through the “Rolling Continuation Channel” (although this mechanism has since been discontinued).

The Global Fund explicitly supports harm reduction as part of its commitment to fund evidence-based, cost-effective interventions. Although proposals are country-driven, applicants are strongly encouraged to include harm reduction interventions—both in community and prison settings (Global Fund, 2011b). However, previous research has shown that a relatively small proportion of the Global Fund portfolio is directly targeted at most-at-risk populations such as people who inject drugs, sex workers and men who have sex with men (Global Fund, 2010a; Avdeeva, Lazarus, Abdul Aziz, & Atun, 2011). The Global Fund has previously estimated that around US$180 million was invested in harm reduction in 42 countries between Round 1 (2002) and Round 7 (2007) (Atun & Kazatchkine, 2010). This article employs a more detailed methodology to review how much the Global Fund invested in harm reduction interventions between Round 1 (2002) and Round 9 (2009).

Box 2: Calculations used for budget projections (where required).

<table>
<thead>
<tr>
<th>Latest grant performance rating</th>
<th>Grant renewal amount used for project budgets where required</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 (exceeding expectations) or A2 (meeting expectations)</td>
<td>90%</td>
</tr>
<tr>
<td>B1 (adequate performance)</td>
<td>80%</td>
</tr>
<tr>
<td>B2 (inadequate performance, but demonstrating potential)</td>
<td>60%</td>
</tr>
<tr>
<td>C (unsatisfactory performance)</td>
<td>30%</td>
</tr>
</tbody>
</table>

Note: If a performance rating was not available, calculations for B1 ratings were used as this is the most common rating. More information on Global Fund performance ratings is available from http://www.theglobalfund.org/en/performancebasedfunding/.

Methods

The Global Fund has financed more than 1000 grants. The full list of grants (Global Fund, 2011c) was filtered to identify a sub-set of HIV grants that may contain harm reduction interventions. Grants from Round 9 included those created under the new “single stream of funding” model, whereby multiple grants to the same recipient are consolidated in order to simplify monitoring and grant management (Global Fund, 2011d). The filtering process was conducted by triangulating several sources of information: published estimates of Global Fund investments in harm reduction (Atun & Kazatchkine, 2010) and most-at-risk populations (Global Fund, 2010a); advanced searches of the Global Fund portfolio for grants with the service delivery area “HIV Prevention: Programmes for specific groups” (Global Fund, 2011e); the Global Fund’s internal database of grant performance indicators; searches for key terms – IDU [injecting drug use], inject, user, harm, needle, syringe, methadone, buprenorphine and substitution – in proposal documents available from http://portfolio.theglobalfund.org; and verifications from grant management staff within the Global Fund Secretariat.

Data were collected from the final detailed Phase 1, Phase 2 and Rolling Continuation Channel budgets that were available by the end of 2011. These complex documents provide the most detailed source of financial data for a grant – including planned expenditures, staff salaries and procurement costs – and are not publicly available. This elaborate method was selected because the standard Global Fund financial reporting does not accurately capture investments or expenditures for harm reduction: these interventions are often classified by different countries under different headings and cost categories because of their politically sensitive nature.

For budgets in languages other than English, translation was facilitated by Global Fund staff. Where required, an online currency converter (www.xe.com) was used to convert figures into US$ using the historical exchange rate from the grant’s start date.

For grants that were still in Phase 1 of implementation (or in the first period of Rolling Continuation Channel implementation), detailed budgets were not yet finalised for Phase 2 (or the final period of Rolling Continuation Channel implementation). Financial figures for the full lifetime of these grants were therefore projected using existing budget data and the Global Fund’s recommended grant renewal ranges that are tied to performance ratings. For example, budget totals for a grant rated “B1” were projected by multiplying the two-year Phase 1 budget by 1.5 (for the three years in Phase 2) and then multiplying this amount by 80 percent (Box 2).

The budget lines for activities that specifically targeted people who inject drugs were identified and recorded. Where one activity covered several most-at-risk populations the budgeted amount was divided by the number of target groups. For example,
if US$ 200,000 was budgeted for “condoms for sex workers and people who inject drugs”, then US$ 100,000 was included in this analysis. We did not attempt to apportion and include budget lines aimed at the general population, nor to apportion and include indirect or administrative costs within the budget that were not explicitly targeting people who inject drugs.

Highlighted budget lines were categorised according to the “comprehensive package” (Box 1) and other key activities. As Global Fund budget documents are complex and not standardised, activities were listed in various different ways. Where necessary, clarifications were obtained from proposal documents. A random sample of 12 grants was also cross-checked between researchers, and results were compared to detect, record and rectify variations. Small differences were identified for some of these grants (with an average difference of just 1.14 percent of the budgeted totals), and all discrepancies were resolved.

Data collected from the detailed budgets were analysed using Microsoft Excel 2010. Additional information – including Principal Recipient details and grant agreement amounts – was also recorded from original proposal documents and the Global Fund website (www.theglobalfund.org).

### Results

Between Round 1 (2002) and Round 9 (2009), a total of 411 HIV grants in 118 countries and territories were approved by the Global Fund Board, as well as 13 multicountry HIV grants. After the systematic filtering process, 120 grants from 55 countries and territories were found to identify specific activities for people who inject drugs (Table 1). Sixty-six (55 percent) of these grants were managed by governmental bodies, 28 (23 percent) by civil society organisations, seven (6 percent) by private sector recipients, and the remaining 19 (16 percent) by multilateral agencies such as the United Nations Development Programme.

The final, detailed budgets from these grants contained US$ 361 million for activities targeting people who inject drugs. When projections were made for grants that had yet to enter their final stages of implementation, the total investment for people who inject drugs amounted to US$ 430 million.

Of the 55 countries and territories, 22 were from the Global Fund’s Eastern Europe and Central Asia Region, nine from its South and West Asia Region, and eight from its East Asia and Pacific Region. Only three countries with generalised HIV epidemics were

### Table 1

<table>
<thead>
<tr>
<th>Countries and territories with HIV grants from the Global Fund that include interventions for people who inject drugs (Rounds 1–9).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
</tr>
<tr>
<td>Indonesia</td>
</tr>
<tr>
<td>__________________________</td>
</tr>
</tbody>
</table>
| Grants included less than US$ 100,000 per year for people who inject drugs.
Grants included with existing grants to the same recipient in order to simplify the Global Fund grant architecture (Global Fund, 2011d).
Zanzibar is a semi-autonomous part of the United Republic of Tanzania. For the purposes of the Global Fund, it has its own Country Coordinating Mechanism and receives grants.

Fig. 2. Distribution of Global Fund investments for major interventions and cost categories. Note: Percentages are rounded.

Table 2

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Total budgeted investment (US$ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle and syringe programmes</td>
<td>76.6</td>
</tr>
<tr>
<td>Opioid substitution therapy</td>
<td>56.3</td>
</tr>
<tr>
<td>HIV testing and counselling</td>
<td>13.8</td>
</tr>
<tr>
<td>Antiretroviral therapy</td>
<td>16.3</td>
</tr>
<tr>
<td>Prevention and treatment of sexually transmitted infections</td>
<td>7.0</td>
</tr>
<tr>
<td>Condom distribution programmes</td>
<td>20.0</td>
</tr>
<tr>
<td>Targeted information, education and communication</td>
<td>44.4</td>
</tr>
<tr>
<td>Vaccination, diagnosis and treatment of viral hepatitis</td>
<td>2.2</td>
</tr>
<tr>
<td>Prevention, diagnosis and treatment of tuberculosis</td>
<td>3.2</td>
</tr>
<tr>
<td>Development of supportive environments</td>
<td>15.1</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>17.5</td>
</tr>
<tr>
<td>Programme management and overheads</td>
<td>49.4</td>
</tr>
<tr>
<td>Psychosocial or legal support</td>
<td>14.5</td>
</tr>
<tr>
<td>Training and capacity building</td>
<td>9.9</td>
</tr>
<tr>
<td>Drug detention centres</td>
<td>5.1</td>
</tr>
<tr>
<td>Other(^b)</td>
<td>9.7</td>
</tr>
<tr>
<td><strong>Total budgeted</strong></td>
<td><strong>US$ 361 million</strong></td>
</tr>
</tbody>
</table>

Note: Figures are rounded.

\(^a\) Round 9 includes “single stream of funding” grants, where new proposals are consolidated with existing grants to the same recipient in order to simplify the Global Fund grant architecture (Global Fund, 2011d).

\(^b\) “Other” activities include, for example, nutritional support, primary care and first aid, and the prevention of mother-to-child HIV transmission.

included. The majority (US$ 263 million; 61 percent) of the US$ 430 million projected investment was for Eastern Europe and Central Asia, Latin America, the Caribbean, Africa and the Middle East collectively accounted for just 5 percent.


A number of Global Fund grants were almost entirely dedicated to people who inject drugs: including India (Round 9), Pakistan (Round 9), the Russian Federation (Round 5) and Thailand (Rounds 3 and 8). By contrast, some of the 120 grants had less than 1 percent of their overall value allocated for people who inject drugs.

Table 2 and Fig. 2 show how the budget lines targeting people who inject drugs were allocated between key interventions. Of the total budgeted funding, 66 percent was allocated to the nine interventions that comprise the United Nations’ “comprehensive package” (Box 1). Of these, the interventions with the largest proportions of funding were needle and syringe programmes, opioid substitution therapy, and information, education and communication (Fig. 2). Overall, 43 countries and territories had grant budgets that included needle and syringe programme activities, and 33 had grant budgets that included opioid substitution therapy activities. Ukraine was the only country that included all nine components of the “comprehensive package” in their grants.

For all grants, programme management and overheads represented the largest cost category outside of the “comprehensive package” (Table 2). The budget analysis also showed that three
countries (Cambodia, China and Viet Nam) incorporated activities related to compulsory drug detention centres.

Discussion

The results presented in this study confirm earlier findings that the Global Fund is a leading source of international support for harm reduction programmes. Through 120 grants in 55 countries between Round 1 (2002) and Round 9 (2009), US$ 361 million was budgeted for activities for people who inject drugs. This was projected to increase to US$ 430 million during the full lifetimes of these grants. The only previously published estimate of Global Fund investments in harm reduction was US$ 180 million between Rounds 1 (2002) and 7 (2007)—or an average of US$ 25.7 million per Round (Atun & Kazatchkine, 2010). The total presented in this analysis represents an average of US$ 48 million budgeted and projected per Round, and there was an upward trend between Rounds 7 and 9.

Nonetheless, more than half of the countries with HIV grants approved between Rounds 1 and 9 did not include harm reduction activities in their budgets. In particular, only three African countries with generalised HIV epidemics were included in this analysis – Burundi, Kenya and Nigeria – despite injecting drug use being a major issue in these epidemiological settings as well as in countries with concentrated epidemics (Reid, 2009; WHO, 2011). Previous reports found that, in 2006, no funds were allocated for this population in countries with generalised epidemics (Global HIV Prevention Working Group, 2009)—highlighting the need for greater technical support, advocacy and political commitments in these settings.

Around 95 percent of the budgeted and projected investments (US$ 408 million) was for Eastern Europe and Asia, where HIV epidemics are predominantly concentrated among most-at-risk populations. In sub-Saharan Africa, only Madagascar and Mauritius were funding needle and syringe programmes through Global Fund support, and only Mauritius was funding opioid substitution therapy.

Of the budgeted US$ 361 million, the majority (66 percent) was earmarked for the nine components of the “comprehensive package” (Box 1)—including US$ 76.6 million for needle and syringe programmes, and US$ 56.3 million for opioid substitution programmes. This is in line with the Global Fund’s commitment to funding proven, cost-effective interventions. These core interventions were included in grant budgets in most countries, but only Ukraine appeared to include the complete package through its Global Fund grants.

Some interventions appeared to receive relatively little funding specifically for people who inject drugs – such as HIV testing and counselling (US$ 13.8 million), and interventions for viral hepatitis (US$ 2.2 million) and tuberculosis (US$ 3.2 million). This may reflect the decision to only include budget lines that explicitly identified people who inject drugs as a target group. While this approach minimises the incorrect inclusion of activities, it excludes population-level activities (such as testing and counselling) that may also conceivably benefit people who inject drugs. The US$ 430 million figure also excludes additional activities and budgets that are possibly directed toward people who inject drugs through tuberculosis and health system strengthening grants.

Around US$ 120 million was budgeted for activities beyond the “comprehensive package”—including development of supportive environments (US$ 15.1 million), training and capacity building (US$ 9.9 million), and monitoring and evaluation (US$ 17.5 million). These interventions remain integral despite their omission from the United Nations package: the International HIV/AIDS Alliance, for example, has outlined 15 interventions that form a “harm reduction approach” (International HIV/AIDS Alliance, 2010). Fourteen percent of the budgeted funding was allocated to programme overheads including staffing, building costs, administration and grant management. This is higher than expected and may reflect high start-up costs for these interventions in many settings.

Notably, US$ 5.1 million was budgeted for activities within drug detention centres in Cambodia, China and Viet Nam. These compulsory, extrajudicial centres are often run by police or the military, and their existence raises major public health and human rights concerns (Global Fund, 2011f)—with reports of forced labour, coerced treatment and torture (Human Rights Watch, 2010). The Global Fund and partners have repeatedly called for these centres to close (Kazatchkine, 2010). Since these grants were approved, the Global Fund has worked closely with the relevant Country Coordinating Mechanisms and programme implementers to remove these activities from grant budgets and workplans—ensuring that Global Fund funding does not support the operation of these centres nor legitimise their existence.

Between Rounds 1 and 9, the Global Fund approved US$ 10.8 billion for HIV grants (Global Fund, 2010b). The US$ 430 million identified in this analysis therefore represents around 4 percent of this total approved funding. This is a higher percentage than found in earlier analyses (Atun & Kazatchkine, 2010; Global Fund, 2010a) which may reflect an increasing level of investments, helped also by the more detailed methodology used for this study. Nonetheless, there is clear evidence that the global resource needs for harm reduction are not being met by the current funding available from all sources (Mathers et al., 2010; Stimson et al., 2010). Recent modelling for the UNAIDS Strategic Investment Framework showed that US$ 2.3 billion will be needed in 2015 to deliver harm reduction at levels that can impact upon the epidemic—compared to the US$ 0.5 billion currently estimated to be available (Schwartztänder et al., 2011). In 2007, it was estimated that just US$ 160 million of domestic and international funding was spent on harm reduction – less than US$ 13 per person who injects drugs – with more than 25 percent coming from the Global Fund (Stimson et al., 2010). In 2009, a study commissioned by the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific found that only around 10 percent of the resource needs for harm reduction in the region were being met (Bergenstrom et al., 2010).

In 2010, UNAIDS identified 20 target countries for “intensive and comprehensive support” based on their epidemiological contexts: Afghanistan, Bangladesh, Belarus, China, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Lithuania, Mauritius, Moldova (Republic), Myanmar, Nepal, Nigeria, Pakistan, South Africa, Tanzania (United Republic), Ukraine and Viet Nam (UNAIDS, 2010). Of these, all but two are included in this analysis – the exceptions being Lithuania (which is ineligible for Global Fund support) and South Africa.

In Round 10 (2010), the Global Fund created a dedicated funding reserve for HIV proposals that focus on most-at-risk populations. This should further boost investments in harm reduction. Although many of the Round 10 grants were still being negotiated at the time of the study, nearly half of the approved HIV proposals contained activities for people who use drugs. These include the first Global Fund proposal from Malaysia, new programmes planned in Kenya, and a multicountry proposal from the Middle East and North Africa Harm Reduction Association (MENHARA) to support advocacy and capacity building in 13 countries.

However, in November 2011 the Global Fund Board took the decision to replace Round 11 with a ‘Transitional Funding Mechanism’. Against a backdrop of economic uncertainty, this new mechanism allows for the continuation (but not the further scale-up) of “essential” services that face disruption between 2012 and 2014 (for example, due to an existing grant ending). Although the

Global Fund has included “[HIV] prevention and treatment targeted at... people who inject drugs” as an example of the “essential” services to be continued (Global Fund, 2011g), the impact of this decision – and the broader financial constraints being experienced globally – remains to be seen.

Limitations

This study has some notable limitations. The analysis only includes HIV grants, omitting possible investments in people who inject drugs through tuberculosis and health system strengthening grants. It also does not include grants that were approved in Round 10 (2010), as many of these were still being negotiated at the time of the study. This means that the US $430 million budgeted and projected investment for people who inject drugs likely underestimates the true total that has been invested since the inception of the Global Fund in 2002. Future research should review new grants from Round 10 and beyond to assess ongoing trends over time.

For grants that were still in Phase 1 (or the first period of their Rolling Continuation) at the end of 2011, projections were made for their remaining years of implementation. This approach assumed that these grants will remain active for their full lifetime. The performance-based funding matrix used for the projections reflects the decision-making process at the Global Fund, but grant budgets can be revised during reviews and this is something that cannot be reliably predicted. Future analysis should replace these projections with data from new detailed budgets once they are available.

In addition, budget lines that focus on multiple most-at-risk populations were divided between the target groups. This methodology has been used in previous Global Fund portfolio analyses, but assumes that an equal number of individuals from each target group will benefit from the activity. Although this scenario is unlikely, it remains the most time-effective method available for assessing these multiple population budget lines.

Finally, the study did not look at unit costs being paid, nor variations in costs for core harm reduction products between countries (such as needles, syringes, methadone and buprenorphine). There have been numerous studies demonstrating the cost-effectiveness of harm reduction—such as a major study from Australia which showed that needle and syringe programmes returned AU$4 in direct health care cost savings for every AU$1 invested (Australian Government, 2009). Future analyses should explore returns on investment, the numbers of people reached by these grants, and cross-country cost comparisons to help programmes determine if they are overspending on key products. Further studies could also analyse the proposals that were not approved by the Global Fund Board, and assess the quality of the interventions that are being funded.

Conclusions

In conclusion, this study represents the most comprehensive assessment of Global Fund investments in harm reduction to date. It demonstrates that the Global Fund is a major donor for services targeting people who inject drugs—with an estimated US $430 million budgeted or projected for grants in Rounds 1 (2002) to 9 (2009). Two-thirds of this money was allocated for the “comprehensive package” of interventions as defined by WHO, UNAIDS and UNODC.

Nonetheless, more than half of the countries with approved HIV proposals between Rounds 1 and 9 did not include harm reduction activities in their budgets. The investments currently available through the Global Fund, other international donors and domestic sources fall short of the estimated needs for this population. In order to reach the recently agreed target of “reducing transmission of HIV among people who inject drugs by 50 percent by 2015" (UN General Assembly, 2011), countries should continue to apply for interventions addressing people who inject drugs, basing their proposals on the evidence-based guidance from the Global Fund and partners.

Resource tracking exercises such as this, coupled with an estimation of resource needs and gaps, are critical to inform advocacy and financing decisions. These should be continued by the Global Fund and others—not least to assess the impact of the current global economic downturn on HIV responses for this key population.

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References


UNAIDS. (2010). We can protect drug users from becoming infected with HIV: Joint action for results. Geneva: UNAIDS.
