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Research paper

The Global Fund to Fight AIDS, Tuberculosis and Malaria's investments in harm reduction through the rounds-based funding model (2002–2014)

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ABSTRACT

Background: Harm reduction is an evidence-based, effective response to HIV transmission and other harms faced by people who inject drugs, and is explicitly supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In spite of this, people who inject drugs continue to have poor and inequitable access to these services and face widespread stigma and discrimination. In 2013, the Global Fund launched a new funding model-signalling the end of the previous rounds-based model that had operated since its founding in 2002. This study updates previous analyses to assess Global Fund investments in harm reduction interventions for the duration of the rounds-based model, from 2002 to 2014.
Methods: Global Fund HIV and TB/HIV grant documents from 2002 to 2014 were reviewed to identify grants that contained activities for people who inject drugs. Data were collected from detailed grant budgets, and relevant budget lines were recorded and analysed to determine the resources allocated to different interventions that were specifically targeted at people who inject drugs.
Results: 151 grants for 58 countries, plus one regional proposal, contained activities targeting people who inject drugs–for a total investment of US$ 620 million. Two-thirds of this budgeted amount was for interventions in the "comprehensive package" defined by the United Nations. 91% of the identified amount was for Eastern Europe and Asia.
Conclusion: This study represents an updated, comprehensive assessment of Global Fund investments in harm reduction from its founding (2002) until the start of the new funding model (2014). It also highlights the overall shortfall of harm reduction funding, with the estimated global need being US$ 2.3 billion for harm reduction in 2015 alone. Using this baseline, the Global Fund must carefully monitor its new funding model and ensure that investments in harm reduction are maintained or scaled-up. There are widespread concerns regarding the withdrawal from middle-income countries where harm reduction remains essential and unfunded through other sources: for example, 15% of the identified investments were for countries which are now ineligible for Global Fund support.

Introduction

Harm reduction – 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" (Harm Reduction International, 2011) – is a proven, effective

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Box 1. The United Nations ''comprehensive package'' (WHO, 2012)

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. Prevention, vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

and cost-effective approach for people who use drugs, and especially for preventing the transmission of HIV, viral hepatitis, tuberculosis and other harms among people who inject drugs. The World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) have elaborated and endorsed a ''comprehensive'' package of nine harm reduction interventions for people who inject drugs (Box 1) – stating that delivery of the whole package is key, but that ''countries should prioritise implementing NSPs [needle and syringe programmes] and evidence-based drug dependence treatment (specifically OST [opioid substitution therapy])'' (WHO, UNODC, & UNAIDS, 2012).

Other international partners have expanded on this package defined by the United Nations. For example, the United States President's Emergency Plan for AIDS Relief (PEPFAR) adds community-based outreach to the list (PEPFAR, 2010); the International HIV/AIDS Alliance has outlined a package of 15 interventions including overdose prevention, advocacy, psychosocial support, and legal support (International HIV/AIDS Alliance, 2010); and the International Drug Policy Consortium (IDPC) also includes drug consumption rooms/safer injecting facilities (IDPC, 2012).

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is the leading international donor for harm reduction services (Bridge, Hunter, Atun, & Lazarus, 2012). Founded in 2002, the Global Fund is a partnership between governments, civil society, the private sector and affected populations. It raises and invests nearly US$ 4 billion each year for programmes, and works in line with three core principles: partnerships, country ownership and performance-based funding – meaning that local partners implement programmes based on the specific priorities in each country, and the Global Fund provides financing on the condition that verifiable results are achieved.

From 2002 until 2013, the Global Fund operated via a 'rounds-based model' whereby proposals from eligible countries or regional bodies were developed and submitted during designated funding windows, with guidance from the Global Fund and its partners. Once submitted, proposals were reviewed by an independent Technical Review Panel, which then made funding recommendations to the Global Fund Board. Successful proposals in each 'round' were approved for 2 years (''Phase 1''), after which a review of progress, results and impact was conducted before continued funding was approved for the next three years (''Phase 2''). Some grants from Round 1 (2002) to Round 5 (2005) were also invited to apply for a further two three-year periods of funding known as the ''Rolling Continuation Channel'' (this mechanism was discontinued after Round 5).

Since its inception, the Global Fund has encouraged applicants to include harm reduction interventions in their proposals. A series of information notes on harm reduction, released since Round 10 (2010), make it clear that the Global Fund ''supports evidence-based interventions aimed at ensuring that key populations have access to HIV prevention, treatment, care and support … [including] the comprehensive package for the prevention, treatment and care of HIV among people who inject drugs'' (Global Fund, 2010, 2011a, 2014a). In Round 10, the Global Fund also created a dedicated funding reserve for HIV proposals that focused on most-at-risk populations (which, in practice, were people who inject drugs, men who have sex with men, sex workers and transgender individuals). A similar mechanism was due to be rolled out in Round 11 (2011), but in November 2011 the Global Fund Board took the decision to replace Round 11 with a 'Transitional Funding Mechanism'. In response to economic uncertainties at the time, this Mechanism limited proposals to the continuation (rather than scale-up or introduction) of essential services that faced disruption due to existing grants ending.

In 2012, data were released from a detailed portfolio analysis from Round 1 (2002) to Round 9 (2009) – showing that the Global Fund had invested or approved US$ 430 million for activities that specifically targeted people who inject drugs. This total included 120 HIV grants for 55 countries and territories – and represented around 4% of the total amount approved for HIV grants during this period (Bridge et al., 2012). A subsequent analysis aimed to include data from Round 10 (2010), taking the total to US$ 580 million (Harm Reduction International, 2012).

Despite these substantial resources from the Global Fund, the global funding for harm reduction remains woefully short of the actual needs (Harm Reduction International, International Drug Policy Consortium, International HIV/AIDS Alliance, 2014). UNODC, WHO, UNAIDS and the World Bank have jointly estimated that there are 12.7 million people who inject drugs globally, although the broad range provided (8.9–22.4 million) underlines the paucity of reliable data (UNODC, 2014). Research has consistently confirmed that people who inject drugs have poor and inequitable access to services (Mathers et al., 2010), and face widespread stigma, discrimination, marginalisation and abuse (Beyrer, Malinowska-Sempruch, Kamarulzaman, & Strathdee, 2010). In 2010, it was estimated that just 8% of people who inject drugs have access to NSPs worldwide, just 8% of people who inject opiates have access to OST, and just 4% of eligible people who inject drugs have access to antiretroviral therapy (ART) (Mathers et al., 2010). Updated global coverage data is urgently needed.

In February 2013, the Global Fund announced a new funding model – moving away from its rounds-based, competitive approach to ''invest more strategically, achieve greater impact, and engage implementers and partners more effectively'' (Global Fund, 2013). Under this new model, the Global Fund determines funding allocations for each eligible country based on calculations of country income and national disease burden. Additional funding has also been set aside for regional proposals. This article employs the same methodology from previous analyses of Global Fund investments in harm reduction (Bridge et al., 2012), thus providing a complete dataset for the entire duration of the Global Fund's rounds-based funding model – from Round 1 (2002) to the Transitional Funding Mechanism that replaced Round 11 (2011).

Methods

The methodology for this Global Fund portfolio analysis has been outlined in greater detail elsewhere (Bridge et al., 2012). Specifically, this study focused on analysing budget data from applicable Round 10 (2010) and Transitional Funding Mechanism (2011) grants, alongside ''Phase 2's'' and other grant extensions from earlier rounds for which the final budgets were unavailable