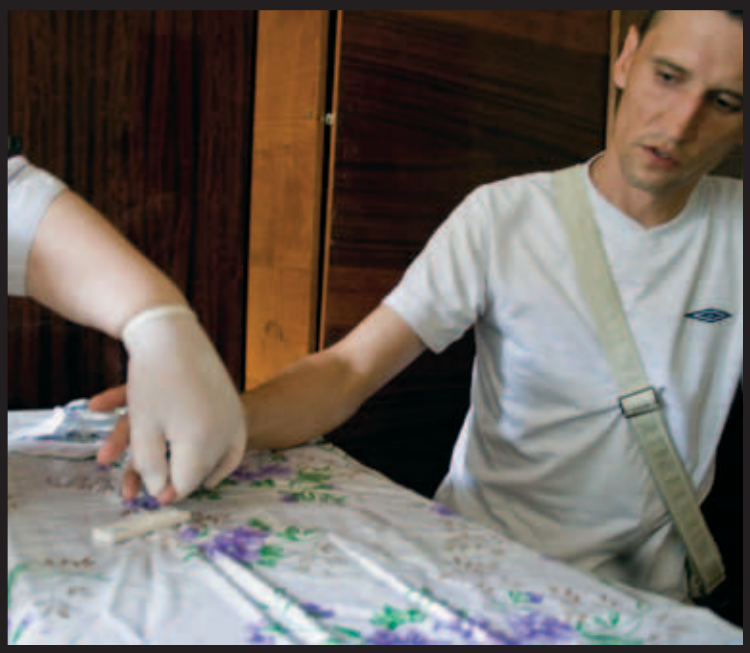
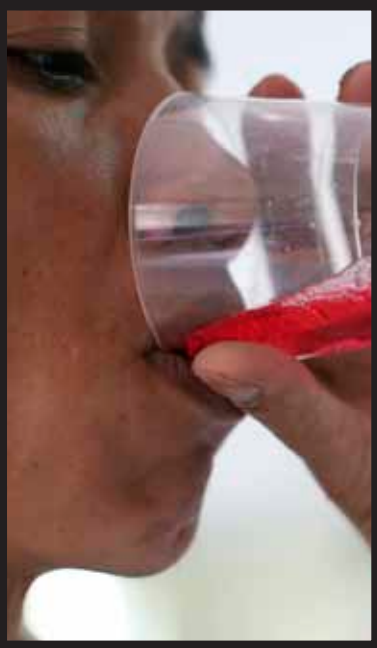
International HIV/AIDS Alliance

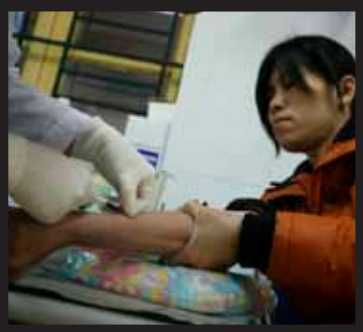
Supporting community action on AIDS in developing countries

HIV, DRUG USE AND THE GLOBAL FUND










DON'T STOP NOW

The International HIV/AIDS Alliance

The International HIV/AIDS Alliance supports communities in developing countries to play a full and effective role in the global response to HIV/AIDS. It is a partnership of 39 Linking Organisations (national, independent, locally governed and managed NGOs) around the world that support approximately 2,000 community organisations delivering HIV prevention, treatment and care services to just under 3 million people.

www.aidsalliance.org

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Альянс
International HIV/AIDS Alliance in Ukraine

SCDI SUPPORTING COMMUNITY DEVELOPMENT INITIATIVES

Front cover photography, clockwise from top left:
Alexey takes a HIV rapid test at an outreach clinic in Cherkassy, Ukraine © the Alliance
Nga, peer educator, gives out condoms and needles to sex workers in Hanoi, Viet Nam © Pham Hoai Thanh
Thong HIV care centre worker. He is bring HIV test to laboratory every day © Pham Hoai Thanh
Drug user receives information, advice and materials, including clean syringes, through a street outreach programme in Cherkassy, Ukraine © the Alliance
Nga, peer educator, shares her experience with sex workers in Hanoi, Viet Nam © Pham Hoai Thanh
Hai, pregnant and visiting clinic for HIV testing © Pham Hoai Thanh
Isaiah, an outreach worker with DARAT, an Alliance partner organisation, sits with injecting drug users 'Niko' and 'Omar', Mombassa, Kenya © Nell Freeman for the Alliance

EXECUTIVE SUMMARY

This report examines the impact of the cancellation of Global Fund Round 11 funding and subsequent changes in Global Fund policies and practices relating to HIV and drug use programmes. It focuses on how future HIV and harm reduction programming will be affected by the Global Fund's current funding crisis given the very low existing levels of funding for such programming.

This issue has particular significance for Eastern European and Asian countries where HIV epidemics are largely shaped by injecting drug use.
A forthcoming report by the Eurasian Harm Reduction Network will focus on the dynamics of HIV, drug use and Global Fund funding in those countries.

This report is a follow-on to *Don't stop now: how underfunding the Global Fund to Fight AIDS, Tuberculosis and Malaria impacts on the HIV response,* produced by the International HIV/AIDS Alliance earlier in 2012. The first Alliance report discussed the impact of the cancellation of Round 11 on HIV programmes generally, and also highlighted impacts in Bangladesh, Bolivia, South Sudan, Zimbabwe and Zambia.

The sharing of injecting equipment is a major driver of HIV transmission globally. Yet historically resources have been very low for HIV and harm reduction programmes targeting people who inject drugs, with the underfunding of needle and syringe programmes and opioid substitution therapy being especially notable. The result is insufficient coverage to halt or reverse HIV epidemics and, worse, the continued spread of HIV epidemics in some regions due to unsafe injecting practices.

The stigmatisation of people who use drugs and the resulting controversies surrounding harm reduction services create obstacles for the funding of interventions proven to reduce the health and social harms associated with such behaviour. People who use drugs are an unpopular target for national and global health care spending.

IN RECENT YEARS, THE GLOBAL FUND HAS BECOME THE MAIN FUNDER OF HARM REDUCTION INTERVENTIONS TO ADDRESS HIV AMONG PEOPLE WHO INJECT DRUGS. SO WHEN THE GLOBAL FUND FALTERS, HARM REDUCTION WILL SUFFER.

The Global Fund has rapidly become the largest donor of HIV and harm reduction programmes targeting people who inject drugs. In Rounds 9 and 10, resources for harm reduction programming grew substantially. The total investment by the Global Fund from Rounds 1 to 10 in HIV and drug use programmes is $582 million, with funding awarded in 59 of the 148 countries where injecting drug use has been documented. The dramatic funding increase represents a major breakthrough in the history of HIV and harm reduction programming.

Most countries with a high burden of HIV among people who inject drugs are now classified as middle income countries. Of the 15 priority HIV and drug use countries identified by UNAIDS, 14 have middle income country status.

The Global Fund's new 55% rule limiting funding for countries with middle income status will have a dramatic effect on the scale-up of HIV and drug use programmes. Unless a more nuanced policy is applied to identify disease burden and intervention priorities, the opportunity to reach the global target of reducing HIV transmission among people who inject drugs by 50% by 2015 will be lost, the 2011 High Level Commitment to end AIDS will not be met and the possibility of achieving Millennium Development Goal 6 will be significantly undermined.

Bilateral funding for harm reduction programmes targeting people who inject drugs is low. Where it can be identified, it represents a tiny fraction of spending on HIV. The concentration of bilateral funding in low income countries, without an additional concern for HIV disease burden, threatens the future of the scale-up of HIV programmes targeting people who use drugs. The US government's retreat on the funding of needle and syringe programmes is part of this problem.

Global Fund funding cuts as a result of transitional arrangements and grant negotiations in countries with injecting-led epidemics threaten to reduce the range of harm reduction interventions that are resourced. Programme quality, innovation to address changing drug use practice and the needs of different sub-populations, technical support, drug user participation, community mobilisation, advocacy and legal services are *essential features* of harm reduction programmes and need support.

Examples of what Global Fund resources have been able to achieve in terms of HIV and drug use in Ukraine is described in this report. Case studies of the impact of the removal of Global Fund resources on community based harm reduction programming in China, along with a case study of the impact of the cancellation of Global Fund's Round 11 on harm reduction in Vietnam, are provided in this report.

The International HIV/AIDS Alliance concludes this report with a series of recommendations calling on the Global Fund to continue to prioritise the scale up of HIV and harm reduction interventions, recognising that country income status is too blunt a tool to guide investments. Achieving global targets on HIV and drug use requires a more nuanced approach to setting priorities. We also call on national governments and bilateral donors to honour their commitments to HIV and drug use programmes. Finally, we recommend that the funding of HIV programmes targeting people who inject drugs includes efforts at the community level such as peer education and community based outreach, along with legal and policy interventions to ensure that HIV programmes targeting people who use drugs are feasible, and most importantly, are based on evidence and use a human rights based approach.

1. INTRODUCTION: A CRISIS FOR THE GLOBAL FUND IS A CRISIS FOR HARM REDUCTION

In November 2011, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) announced that its next scheduled funding round (Round 11) was cancelled and that no new grants would be funded until 2014 because of a lack of resources. As a result of this crisis, many life-saving HIV, TB and malaria programmes will not be funded or scaled up. The Global Fund Board is implementing a set of measures to ensure that contingency funding for "essential services"[1] is available up to 2013 through a Transitional Funding Mechanism. This funding cannot be used for new patients accessing needle and syringe programmes, or community advocacy or capacity-building.

The Global Fund crisis is occurring just as a series of scientific developments have demonstrated the promise of HIV prevention and treatment programmes for people who use drugs. Many countries have brought new HIV infections among people who inject drugs to virtually zero through a combination of needle and syringe programmes (NSPs); substitution treatment; peer education and advocacy and antiretroviral treatment for those with HIV. The Global Fund funding crisis cancels out much of the optimism generated by these gains.

The Global Fund funding crisis also comes at a time when funding and commitment for HIV and harm reduction programming targeting people who use drugs are starting to feature in many national HIV programmes, following years of chronic under-funding and invisibility. Funding for large-scale HIV and harm reduction programmes was finally on the rise, and had the trajectory continued, the potential to reach ambitious targets such as 50% reductions in HIV transmission among people who use drugs would seem more like an achievable plan than an unfounded aspiration.

GLOBAL EPIDEMIOLOGY OF HIV AMONG PEOPLE WHO INJECT DRUGS

Injecting drug use has been documented in 148 countries. The sharing of injecting equipment leads to an estimated 10% of global HIV infections and approximately 30% of HIV infections outside of sub-Saharan Africa. It is estimated that 15.9 million people worldwide inject drugs, approximately 3 million of whom are HIV-positive. This represents an average HIV prevalence among injecting drug users of 19%. In Eastern Europe and Central Asia, injecting drug use now accounts for up to 80% of HIV infections, with the annual rate of new infections in the region having increased by more than 250% between 2001 and 2010.

Sources:

Mathers, B. et al. (2008) 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review,' The Lancet 372(9651): 1733-1745.

UNAIDS (2010) 'UNAIDS Report on the Global AIDS epidemic:'

Peer educator in Viet Nam collects used needles to reduce risk to other people © Pham Hoai Thanh

1 For a discussion of the reasons for the Global Fund funding crisis, see Appendix 1 in the Alliance's previous report on the Global Fund crisis and its impacts; International HIV/AIDS Alliance (2012). 'Don't Stop Now: How underfunding the Global Fund to Fight AIDS, Tuberculosis and Malaria impacts on the HIV response.'

In recent years, the Global Fund has become the main funder of harm reduction interventions to address HIV among people who inject drugs. So when the Global Fund falters, harm reduction will suffer.

In this report we describe some of the impacts of the Global Fund funding crisis on harm reduction, along with the measures the Global Fund is taking to address this crisis. The report illustrates the urgent need for the Global Fund issues to be fully addressed and the Global Fund fully funded.

HIGH-LEVEL COMMITMENTS RELEVANT TO HIV AND DRUG USE

- Millennium Development Goal 6: "Combat HIV/AIDS, malaria and other diseases"
  Target 6A "Have halted by 2012 and begun to reverse the spread of HIV/AIDS"
  Millennium Development Goals www.un.org/millenniumgoals/aids.shtml
- In 2011, United Nations Member States committed to "..working towards reducing transmission of HIV among people who inject drugs by 50% by 2015."
  UN General Assembly (2011) 'Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS' http://daccess-dds-ny.un.org/doc/UNDOC/LTD/N11/367/84/PDF/N1136784.pdf?OpenElementinject
- In its Getting to zero: 2011-2015 strategy, UNAIDS commits to "all new HIV infections prevented among people who use drugs."
  UNAIDS (2010). 'Getting to Zero: 2011-2015 Strategy' http://www.unaids.org/en/aboutunaids/unaidsstrategygoalsby2015/
- The Global Fund in its 2012-2016 strategy commits to "focus on highest-impact countries, interventions and populations while keeping the Global Fund global" and to "increase investments in programs that address human rights-related barriers to access." It also calls for "prevention interventions … for most-at-risk populations."
  Global Fund (2011). 'The Global Fund Strategy 2012-2016: Investing for Impact'

KEY HIV AND HARM REDUCTION INTERVENTIONS

A harm reduction approach to HIV programming identifies a range of key interventions:

1. Needle and syringe programmes
2. Opioid substitution therapy and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy
5. Sexual and reproductive health services, including sexually transmitted infection services and services to prevent vertical transmission of HIV
6. Behaviour change communication
7. Vaccination, diagnosis and treatment of viral hepatitis
8. Prevention, diagnosis and treatment of tuberculosis
9. Basic health services, including overdose prevention and management
10. Services for people who are drug dependent or are using drugs in prison and detention
11. Advocacy
12. Psychosocial support
13. Access to justice/legal services
14. Children and youth programmes
15. Livelihood development/economic strengthening

The World Health Organization has also produced a list of key harm reduction interventions that is shorter and more focused on clinical interventions in its *Technical guide for universal access to HIV prevention, treatment and care for injecting drug users.* We have added some community-orientated interventions to this list, such as psychosocial support and children and youth programmes. We have also expanded the range of clinical services to include sexual and reproductive health and prevention of vertical transmission of HIV.

Source: International HIV/AIDS Alliance (2010) 'Good Practice Guide: HIV and Drug Use: Community responses to injecting drug use and HIV'.

WHO, UNODC, UNAIDS (2009) 'Technical guide for universal access to HIV prevention, treatment and care for injecting drug users' www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf

2.
HIV, DRUG USE AND HARM REDUCTION – UNPOPULAR, UNDERFUNDED AND UNDERMINED

Despite evidence of the effectiveness of harm reduction, and despite high levels of need for HIV and harm reduction programmes targeting people who inject drugs, global coverage of these programmes remains very low.[2]

The provision of clean injecting equipment via needle and syringe programmes is a prominent harm reduction intervention. Distributing clean injecting equipment and information on how to inject safely is controversial, but it works.[3] It reduces HIV transmission and also helps to reduce other injecting-related harms. Similarly, providing substitution treatment to people who are opiate dependent is difficult for many governments to endorse. However, it also works. Substitution treatment prevents HIV and hepatitis C transmission by reducing rates of injecting, and it helps HIV-positive drug users access and adhere to antiretroviral therapy.[4] It has been implemented successfully in some countries, and has prevented HIV epidemics among people who inject drugs.[5] [6] Furthermore, it is cost-effective.[7]

A harm reduction approach to drug use is not in opposition to an abstinence-based approach. But telling people to stop using drugs rarely works, even though that's what policymakers often want to do. Harm reduction works – it prevents HIV transmission and it brings HIV-positive drug users closer to care. But it's still controversial, and many national governments remain opposed to or unsupportive of harm reduction interventions, investing instead in traditional law enforcement and abstinence-based responses to drug use.

For policymakers, providing an opiate substitute and/or clean syringes requires an acceptance that drug dependency is a health problem requiring an effective public health response. But people who use drugs are highly stigmatised, marginalised and criminalised, so changes in social and political norms, as well as in laws and policies, are needed. As long as people who use drugs are considered "social evils," criminals or not worthy of care, they will continue to encounter widespread incarceration, police harassment, arbitrary detention, denial of services – including HIV services – and social and family exclusion, among other human rights violations.[8]

The sharing of injecting equipment drives HIV transmission in many countries, yet resources for addressing HIV among injecting drug users have historically been very limited.[9] The stigmatisation of people who use drugs, and the resulting controversies surrounding harm reduction services, create problems for the funding of harm reduction. People who use drugs are an unpopular target for national health care spending. Governments in many of the countries with the highest burden of injecting-led HIV epidemics consistently oppose funding harm reduction programmes.

However in the last few years, this has started to change.

2 Mathers, B. et al. (2010). 'HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage,' The Lancet 375: 1014-1028.

3 WHO. (2004). 'Effectiveness of Sterile Needle and Syringe Programming in Reduction HIV/AIDS among Injecting Drug Users.' Retrieved April 2012, from http://www.who.int/hiv/pub/idu/pubidu/en/.

4 WHO (2006) 'Effectiveness of drug dependence treatment in preventing HIV among injecting drug users'.

5 See WHO/UNODC Evidence for Action series and policy briefs: www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html.

6 Committee on the Prevention of HIV Infection among Injecting Drug Users in High-Risk Countries (2006). 'Preventing HIV infection among injecting drug users in high-risk countries an assessment of the evidence,' Washington, DC: Institute of Medicine.

7 Alistar, S. et al. (2011) 'Effectiveness and Cost Effectiveness of Expanding Harm Reduction and Antiretroviral Therapy in a Mixed HIV Epidemic Modeling Analysis for Ukraine,' PLOS Medicine 8(3): e1000423. doi:10.1371/journal.pmed.1000423.

8 Jürgens, R. et al. (2010) 'People who use drugs, HIV, and human rights,' The Lancet 376(9739): 475-485.

9 Stimson, G. et al. (2010). 'Three cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis,' London: International Harm Reduction Association.

3. THE GLOBAL FUND SUPPORTS HARM REDUCTION

3.1 Increased resources for harm reduction

The Global Fund has become the largest worldwide funder of HIV and harm reduction programmes targeting people who inject drugs.[10]

In a study tracking resources for harm reduction programmes conducted prior to recent Global Fund investments, Harm Reduction International estimated that approximately $160 million was available for HIV and harm reduction programmes in low income and middle income countries in 2007.[11]

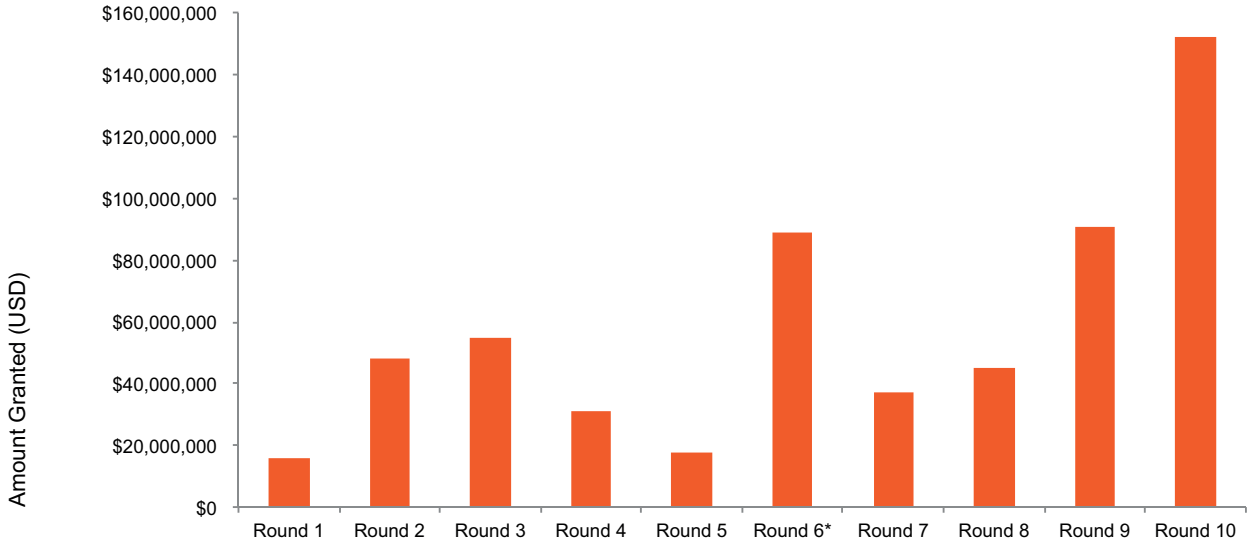
The Global Fund has changed this picture dramatically. Global Fund funding for harm reduction programmes has grown steadily, particularly in Rounds 9 and 10. The Global Fund now funds programmes targeting people who inject drugs in 59 countries.[12] Injecting drug use has been documented in 148 countries. Thus, the Global Fund has invested in 40% of countries where injecting drug use is known to occur.
The estimated total Global Fund funding in Rounds 1 to 10 for HIV and drug use programmes is $582 million.[13]

Rounds 9 and 10 of the Global Fund brought an unprecedented boost in funding for harm reduction programmes.

This dramatic increase in funding from one source alone represents a major breakthrough in the history of HIV and harm reduction. The potential for large-scale programming is within reach and reaching global coverage and impact targets seems possible.

A critical factor in the Round 10 investment was the Most-At-Risk Populations (MARPs) Reserve.[14] This allocation for work with MARPs, particularly those in middle income countries, greatly benefitted harm reduction programmes. The MARPs Reserve was for Round 10 only.

Figure 1: Global Fund to Fight AIDS, Tuberculosis and Malaria funding for HIV and drug use programmes by round †



† Source for R1 - R9 = Bridge, J. et al. (2012). 'Global Fund investments in harm reduction from 2002 to 2009,' *International Journal of Drug Policy* in press; Source for R 10 - unpublished data
* Round 6 includes large grants for Ukraine worth US$69 million targeting people who inject drugs

10 Bridge, J. et al. (2012). 'Global Fund investments in harm reduction from 2002 to 2009,' International Journal of Drug Policy in press; in addition, for further analysis that includes Round 10 data, personal correspondence from J Bridge 2012.

11 Stimson, G. et al. (2010). 'Three cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis,' London: International Harm Reduction Association.

12 Bridge, J. et al. (2012). 'Global Fund investments in harm reduction from 2002 to 2009,' International Journal of Drug Policy in press.

13 Ibid.

14 The Global Fund (2010). 'The Global Fund Twenty First Board Meeting,' Geneva, Switzerland, 28-30 April 2010 GF/B21/DP1.

3.2 Policy support for harm reduction

In addition to making financial resources available for harm reduction programming, the Global Fund model has promoted robust discussion at the national level in support of evidence-based and progressive harm reduction responses.[15] The Global Fund requirement for Country Coordinating Mechanisms to involve civil society has opened up national HIV planning processes, and in some countries has allowed drug users to participate in decision-making on HIV resource allocation.

Mr Pham Thanh Van, NGO member, CCM Viet Nam & Program Manager, AIDS Program (Viet Nam Community Mobilization Center for HIV/AIDS Control) observed:

Through the Global Fund there has been a change, with the active engagement of vulnerable people in HIV/AIDS activities, in which people who use drugs have a part. That's a wonderful change, in a country where the government still has a conservative attitude towards people who use drugs.

In settings where people who use drugs are criminalised and excluded, the community systems strengthening effect[16] of greater policy space for civil society is very important. The Global Fund's guidance on programming for HIV and drug use is clear, as it is on community systems strengthening. Its harm reduction guidance note prioritises evidence-based harm reduction interventions such as NSPs and opiate substitution treatment (OST) programmes.[17] The focus on investing in evidence-informed HIV and drug use programmes, along with the availability of substantial resources, has made the Global Fund the most important funder of harm reduction, in a relatively short space of time. It is funding comprehensive programmes that are having a demonstrable impact on HIV transmission among people who inject drugs.

Thus, the impact of the Global Fund on HIV and harm reduction programmes is three-fold:

- The Global Fund has been responsible for major increases in resources for harm reduction, particularly in Rounds 9 and 10.
- The Global Fund has spurred improvements in national decision-making processes on resource allocation and programme priorities, and has fostered support for evidence-based programmes, civil society participation, and greater transparency and accountability.
- Global Fund investments are reducing rates of HIV transmission among people who use drugs.

Reading HIV information at a Chinese support centre
© 2008 Kevin Sare / Alliance

15 Atun, R. and M. Kazatchkine (2010). 'The Global Fund's leadership on harm reduction: 2002–2009,' International Journal of Drug Policy, 21(2): 103-106.

16 UNAIDS (2010). 'Supporting community based responses to AIDS, TB and malaria: A guidance tool for including Community Systems Strengthening in Global Fund proposals,' Geneva: Joint United Nations Programme on HIV/AIDS.

17 The Global Fund (2011) 'Harm reduction for people who use drugs'.

THE GLOBAL FUND FUNDS HARM REDUCTION IN UKRAINE: A SUCCESS STORY

The Global Fund has been supporting HIV and harm reduction programmes in Ukraine since 2002. Rounds 1, 6, and 10 HIV grants have targeted populations most vulnerable to HIV, namely people who inject drugs, sex workers and men who have sex with men.

Highlights of the programme include the following:

- HIV prevalence among new injectors (people who inject drugs for less than three years) has declined from 29.9% of new infections in 2004 to 5.5% of new infections in 2011.
- National HIV incidence rates have fallen dramatically.
- The national HIV prevention programme reaches approximately 50% of people who inject drugs.
- OST was introduced in 2009 after a long advocacy effort. The programme had reached 6,632 people as of January 2012, leading to a range of health and social impacts such as reduced injecting, increased employment and reduced criminal activity.
- Over 120 civil society organisations across Ukraine have benefited from increased HIV prevention and care capacity-building programmes.
- State and civil society HIV programmes have become more integrated.
- Programming has been cost-effective, and programming innovations have included large-scale peer-driven interventions; pharmacy-based NSP; the introduction of rapid tests for HIV; new programming for stimulant users; and programmes and services for women who use drugs.

The International HIV/AIDS Alliance in Ukraine has been a Principal Recipient for the three Global Fund grants, amongst others. Alliance Ukraine has demonstrated the ability of civil society organisations to implement high-quality large-scale HIV programmes in settings where governments will not or are unable to prioritise HIV prevention services for marginalised groups.

A ten-year advocacy effort to engage the Ukrainian government in the HIV prevention/harm reduction programme – in implementing, policymaking and funding roles – has been only partially successful. The government remains largely uncommitted to the HIV prevention effort targeting people who inject drugs, and refuses to dedicate appropriate levels of domestic health funds to the national HIV prevention programme.

In light of the government's persistent resistance to harm reduction and to HIV prevention among vulnerable groups, the success of the Ukrainian HIV prevention programme remains dependent on international resources, in particular the Global Fund's resources.

Summary report of the ICF International HIV/AIDS Alliance in Ukraine on the performance under the "Support for HIV/AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine" Program supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. February 15, 2012 www.aidsalliance.org.ua/ru/news/pdf/23.02.2012/EN_narrative_%20report_jul_dec_2011.doc

Two friends receive information, advice and materials, including clean syringes, through a street outreach programme in Cherkassy, Ukraine © the Alliance

4. OTHER FUNDS FOR HARM REDUCTION

Other developments in the funding of harm reduction fill out this picture.

As a major donor to the Global Fund, the US government makes a substantial contribution to the Global Fund's $582 million investment in harm reduction. However, the US government delivers very little direct bilateral harm reduction funding through its President's Emergency Plan for AIDS Relief (PEPFAR).

While PEPFAR increased its investment in HIV programmes targeting people who inject drugs from $18.1 million in 2009[18] to $27.7 million in 2011[19], direct PEPFAR funding for harm reduction in 2011 still only represents less than 0.65% of the PEPFAR budget, a serious under-investment given that 10% of cases of HIV globally are attributable to unsafe needle sharing.[20]

The recent re-instatement of a ban on needle exchange funding will further undermine these small gains in harm reduction funding. For many years, the US government was opposed to the funding of NSP in its global health programmes. The US Congress removed this restriction in 2009, and its guidance issued by the Obama administration endorses the World Health Organization's HIV and drug use guidelines prioritising NSP.[21] However a backlash in Congress in late 2011 led to the ban being reinstated[22], with the result that US government funding for NSP in low income and middle income countries has been further restricted.

This development has far-reaching consequences. Not only does it create disincentives for US Missions to prioritise work with people who inject drugs, it also leads to unbalanced investment strategies such as investments in capacity-building without complementary investments in service delivery. Most problematically, reinstating the ban on NSP funding removes global resources for NSP, a high-impact intervention for a high-need population, with one of the strongest and most compelling evidence bases in the HIV prevention "toolbox."

The governments of Australia, the United Kingdom and the Netherlands are other prominent donors to HIV and drug use programmes in lower income and middle income countries. They also contribute to the Global Fund. Their bilateral investments specifically in HIV and drug use programmes are not easy to track or quantify. But it is important to note that these donors are increasingly reducing the countries on their priority lists, and in some cases reducing spending on AIDS. For example, the details of the UK government's spending on harm reduction are unclear, but it has been a major funder of harm reduction in Viet Nam (see Viet Nam case study, p. 20), for example. The UK's Department for International Development (DFID) is ending this programme even though the Vietnamese government is unlikely to fill the gap left behind. More broadly, while we hope that DFID's funding for the Global Fund will increase in the near future, DFID's bilateral HIV programmes are being cut by 30% over the next three years, and what funding remains will focus largely on low income countries instead of the middle income countries where injecting drug use is likely to be prominent.[23]

18 PEPFAR (2010). 'Fiscal Year 2009 Operational Plan,' Washington, DC: President's Emergency Plan for AIDS Relief (PEPFAR).

19 PEPFAR (2012). 'Fiscal Year 2011 Operational Plan,' Washington, DC: President's Emergency Plan for AIDS Relief (PEPFAR).

20 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.

21 PEPFAR (2010) 'Comprehensive HIV prevention for people who inject drugs, revised guidance'.

22 The White House (2012). 'Federal Funding Ban on Needle Exchange Programs,' The White House Blog. Retrieved 23 April 2012, from http://www.whitehouse.gov/blog/2012/01/05/federal-funding-ban-needle-exchange-programs.

23 Tran, M. and C. Provost (2011) 'HIV/Aids overseas budget to be cut back by almost a third,' The Guardian. Retrieved 1 May 2012, from http://www.guardian.co.uk/global-development/2011/oct/04/hiv-aids-overseas-budget-cut.

5. CHANGES AT THE GLOBAL FUND – WHAT WILL THEY MEAN FOR HARM REDUCTION?

5.1 Cancellation of Round 11

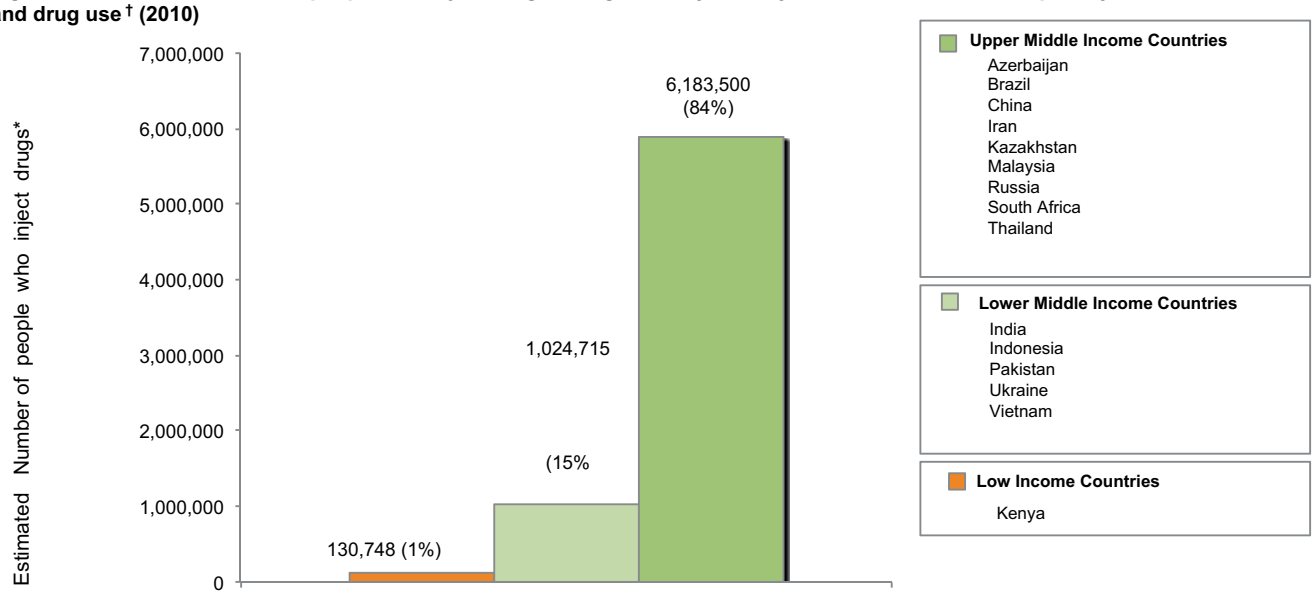
The Global Fund's decision to cancel Round 11 has interrupted the general trend towards improved funding for harm reduction described earlier in this report. Countries such as Viet Nam, Bangladesh, the Philippines, Afghanistan and Indonesia – all with significant or emerging HIV and drug use burdens – were eligible for Round 11 funds but are now unable to seek support for scaled-up or new programmes. This impact extends well into the future, since the Global Fund's decision to cancel any new funding until 2014 will shut out countries that had hoped to submit proposals in 2012 and 2013 funding rounds.

An analysis of the impact on harm reduction programmes resulting from the cancellation of Round 11 in Viet Nam is provided in the case study on page 20. The scale-up of the national NSP programme, as well as resources for community-based drug treatment services and community systems strengthening, were dependent on a successful Round 11 application, and all of these efforts will falter now that Round 11 has been cancelled.

Much of the impact on harm reduction programmes will be better understood when we are able to analyse the Global Fund's transitional arrangements. Following the cancellation of Round 11, the Transitional Funding Mechanism was established by the Global Fund to manage the emergency financing needs of Global Fund recipients. Strict criteria are applied to recipients' transition plans, with the Global Fund only committing to support "essential" programmes. It is noteworthy that the Global Fund's definition of "essential" for this purpose explicitly includes "prevention and treatment targeted at key populations with high levels of incidence (including evidence-based programs reaching men who have sex with men, people who inject drugs, prisoners and sex workers)." [24] [25]

But crucially, the Transitional Funding Mechanism is strictly for maintaining existing services. These funds do not allow for any scale-up. This limitation threatens to lead to the unravelling of the global commitments to halt the spread of HIV among people who inject drugs.

Figure 2: Estimated numbers of people who inject drugs, categorized by country income status, in the 15 priority countries for HIV and drug use † (2010)



† List of countries from UNAIDS (2010). 'Getting to Zero: 2011-2015 Strategy,' p.23.
* Estimates of PWIDs : Mathers, B. et al. (2008) 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review,' *The Lancet* 372(9651): 1733-1745.

24 The Global Fund (2011). 'Transitional Funding Mechanism (TFM) Information Note'.

25 Analysis of the TFM outcomes from a harm reduction perspective will be important, but will only be possible later in 2012 once the submitted proposals have been reviewed and published online.

5.2 HIV, drug use and middle income country status

UNAIDS has identified 15 countries as priority countries in terms of HIV and drug use.[26] These are Azerbaijan, Brazil, China, India, Indonesia, Iran, Kazakhstan, Kenya, Malaysia, Pakistan, Russia, South Africa, Thailand, Ukraine and Viet Nam. Fourteen of these countries have middle income country (MIC) status according to World Bank criteria for classifying national economies.

Kenya is the only UNAIDS priority country with a high burden of HIV among people who inject drugs excluded from the MIC list.

This trend is not particular to HIV and drug use. The Center for Global Development's report *Global Health and the New Bottom Billion*[27] describes how most of the world's poor now live in MICs, and how the global disease burden has shifted to MICs.

In November 2011, the Global Fund Board put into place a new policy limiting the allocation of resources to MICs. The so-called "55% rule" is an attempt to direct resources to low income countries, particularly those in sub-Saharan Africa where disease burden is high.

GIVEN THE HIGH LEVELS OF HIV AND DRUG USE IN MIDDLE INCOME COUNTRIES, THE 55% RULE IS A THREAT TO THE FUTURE OF GLOBAL FUND FUNDING FOR HARM REDUCTION.

Monitoring at an IDU drop in centre, China © the Alliance

26 UNAIDS (2010). 'Getting to Zero: 2011-2015 Strategy.'

27 Glassman, A. et al. (2011). 'Global Health and the New Bottom Billion: What Do Shifts in Global Poverty and the Global Disease Burden Mean for GAVI and the Global Fund?', Working Paper 270, Center for Global Development..

The 55% rule is proving difficult to implement. As an interim measure, the Board recently announced a cap on Phase 2 renewal levels for existing grants: 75% of the original totals for all upper lower-middle income countries and upper middle income countries (compared to 90% for all other countries).[28] This will affect numerous countries with high HIV and drug use burdens, such as Indonesia (ULMI) and Thailand and Malaysia (UMI).

Some upper middle income countries, including China, Russia and Brazil, can no longer use Global Fund resources because of new eligibility criteria. Income status and/or G20 membership means that increasingly these countries are seen as *donors* or potential donors to the Global Fund, rather than as Global Fund *recipients.* The argument that wealthier countries should pay for these programmes themselves is theoretically sound. But in practice, investments in harm reduction are not happening, or else they happen at the expense of the community organisations whose participation is essential to success. The Russian government's rejection of harm reduction approaches is widely recognised.[29] [30] [31] It is opposed to harm reduction generally and OST specifically, and its HIV investments are not targeting or reaching the most vulnerable people. Although people who inject drugs represent 83% of Russia's reported HIV cases, they represent only 20–30% of people receiving antiretroviral therapy.[32]

The impact of the withdrawal of the Global Fund on China's harm reduction efforts is discussed in the case study on page 18. Unlike the Russian government, the Chinese government has announced its ongoing commitment to resourcing its own HIV and harm reduction programmes. However, key informants fear that this investment may be applied to a very limited range of interventions, with a particular focus on state-run OST and other services at the expense of NSP and other community-based outreach and peer-based services.

Multiple analyses have confirmed the need to increase, rather than retreat from, commitments to fund harm reduction. The Global Fund's 2012–2016 strategy[33] sets ambitious targets and emphasises the highest-impact countries, interventions and populations. A funding policy that excludes high-impact interventions such as NSP and other harm reduction interventions, and that excludes services for high-need populations such as people who inject drugs, *based on country income status,* is inconsistent with the Global Fund's strategy and will significantly undermine the likelihood of reaching the established targets.

In June 2011, a new model to guide investment in HIV/AIDS was published in *The Lancet*[34] and promoted by UNAIDS and other key stakeholders. This investment framework identifies a list of high-priority programme interventions – including interventions to address HIV-related needs in key populations such as people who inject drugs – along with a set of "critical enablers" essential to the impact of HIV programming. Critical enablers include community mobilisation; advocacy; law reform and legal services; stigma reduction; and community-based design and delivery of programmes.

Many of these critical enablers are precisely the elements that are regarded as dispensable under the Global Fund's plans for emergency continuation of services.

28 Global Fund (2010). 'Twenty-First Board Meeting Decisions.'

29 Audoin, B. and C. Beyrer (2012) 'Russia's retrograde stand on drug abuse,' International Herald Tribune. Retrieved 24 April 2012, from www.nytimes.com/2012/03/03/opinion/russias-retrograde-stand-on-drug-abuse.html?_r=2&partner=rss&emc=rss;

30 Canadian HIV/AIDS Legal Network (2011) 'Russia at risk of HIV epidemic hitting catastrophic levels' Retrieved 24 April 2012, from http://www.aidslaw.ca/publications/interfaces/downloadDocumentFile.php?ref=1246.

31 Holt, E. (2010) 'Russian injecting drug use soars in the face of political inertia,' The Lancet 376(9734).

32 Wolfe, D. et al. (2010) 'Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward,' The Lancet 376 (9738): 355-366.

33 Global Fund (2011). 'The Global Fund Strategy 2012-2016: Investing for Impact'

34 Schwartländer, B. et al. (2011) 'Towards an improved investment approach for an effective response to HIV/AIDS,' The Lancet 377(9782): 2031-2041.

5.3 Cost savings – at what cost?

The Global Fund's new measures to achieve cost savings and to intensify grant management procedures are a potential threat to harm reduction. When a harm reduction grant is being negotiated in an era of cost-cutting and "efficiency savings" what gets cut?

Many commentators fear that the widespread cost-cutting and emergency measures will privilege HIV treatment services at the expense of HIV prevention programmes and human rights-based programming. The imperative to continue paying for medicines and commodities is strong. While this imperative drives budgeting, comprehensive HIV prevention programming is suffering. Reports are emerging from a number of countries such as Thailand and Armenia about Phase Two grant renewal processes resulting in the elimination of essential programming elements such as technical support, community-based outreach services and advocacy for legal and policy reform.

Alliance Ukraine's negotiation of its Global Fund Round 10 HIV prevention and harm reduction grant illustrates some of the losses to harm reduction in an effort to cut costs. Alliance Ukraine provides onward grants to more than 120 local organisations that provide direct HIV prevention and care services to people who inject drugs. Because of heavy cuts to the proposed budget, grants to these implementing organisations have also been cut. Many implementing organisations are already reporting to Alliance Ukraine that they have eliminated legal services and counselling services, along with outreach programmes and new programming innovations.

Furthermore, funding for the national programme of technical support provided to implementing organisations has been cut dramatically. In an increasingly sophisticated harm reduction programme, in a context where drug use practices change, where new high risk sub-populations are identified and new interventions are required, it is essential to have resources to develop, test and build capacity for new approaches. For example, changing epidemic dynamics call for new interventions to meet the needs of the sexual partners of people who inject drugs, most-at-risk adolescents, recently released prisoners and stimulant users. And as these new interventions are designed, piloted and rolled out, the harm reduction workforce – the 120 organisations that deliver the interventions to new sub-populations – needs guidance. Alliance Ukraine's technical support resources have been greatly reduced in the grant negotiation process, and much of this work to innovate and improve will be cancelled.

Is programme quality and innovation possible without technical support?

Members of Sunflower Garden Group, HIV positive people who attend the government methadone treatment programme in Gejiu city. © 2008 Kevin Sare / Alliance

6. RECOMMENDATIONS

Recognising that the Global Fund has become the largest funder of HIV and harm reduction programmes targeting people who inject drugs, the International HIV/AIDS Alliance calls on donors, national governments and the Global Fund Board to act to protect and expand this investment so that people who inject drugs get the services they so urgently need. We specifically recommend the following:

1. Donors must honour existing pledges to the Global Fund, and ensure that new pledges fully fund the Global Fund's 2012–2016 strategy. The scale-up of HIV programmes targeting people who inject drugs depends directly on a fully funded Global Fund.

2. National governments must have the political will to increase investment in their own HIV responses. In countries where HIV transmission is driven by needle sharing, evidence-based programmes targeting people who use drugs need resources. These programmes are the responsibility of national governments, even though they can be unpopular.

3. Bilateral donors must increase resources for HIV and harm reduction programmes targeting people who inject drugs, even when their priority countries don't match with high-priority HIV and drug use countries. Commitments to AIDS must include commitments to harm reduction efforts in countries with high HIV burdens among people who inject drugs.

4. The Global Fund's 55% rule has an unintended and dramatic effect on harm reduction and will significantly undermine the scale-up of these programmes. The Global Fund Board must find an alternative prioritisation mechanism that takes into account disease burden along with country income status, and that recognises the poor record of many national governments in regard to prioritising programmes for people who use drugs.

5. The MARPS Reserve from Round 10 was effective at providing resources for harm reduction. The Global Fund Board should develop a continuing mechanism like this for situations in which national governments are unable or unwilling to fund harm reduction. It requires more resources than those that were available in Round 10 to make any impact on scale-up targets.

6. Grant negotiations by the Global Fund secretariat must explicitly protect and advance harm reduction programmes in HIV epidemics where the sharing of injecting equipment is a key factor in HIV transmission. Programme quality, innovation, drug user participation and comprehensive programming, including structural/policy interventions, are essential ingredients in a harm reduction programme and require support from the Global Fund.

7. Global Fund plans for so-called "iterative processes" that shape national HIV programmes must address the stigma surrounding HIV and drug use, and must provide incentives to expand national plans for harm reduction programming, including interventions that increase the participation of people who use drugs and that advance their human rights.

COUNTRY CASE STUDY 1:
THE EXITING OF THE GLOBAL FUND FROM CHINA: WHAT DOES IT MEAN FOR HARM REDUCTION?

HIV AND DRUG USE IN CHINA

China is home to 2.35 million people who inject drugs.[35] An estimated 12.3% of these people are living with HIV[36]; they account for around 40% of the total reported HIV cases in China.[37] The HIV prevalence rate among people who inject drugs varies from province to province. In Yunnan and Xinjiang provinces, HIV infection rates are as high as 53% and 41% respectively.[38]

To respond to high levels of drug dependence, the Chinese government supported the piloting of eight opiate substitution treatment clinics in five provinces in 2004.[39] Since then, the programme has grown dramatically: there are now over 600 OST sites in China[40] providing methadone treatment for approximately 104,000 people.[41] Despite the scale-up of China's harm reduction programme and the large numbers of OST clinics and needle and syringe program sites, coverage remains low and recruitment and retention is an ongoing challenge. Furthermore, drop-out rates are high, particularly where outreach, psychosocial support and community engagement are lacking.[42 43 44]

The Global Fund in China

The Global Fund's AIDS programme in China is funded by a consolidated Rolling Continuation Channel of Global Fund grants from Rounds 3, 4, 5, 6 and 8, managed by the Chinese Centre for Disease Control (CDC).[45] Since 2003, China's Global Fund grants have funded interventions for people who use drugs.[46] Much of the support has been directed to capacity development for local drug user groups and community-based organisations (CBOs) to supplement the government's OST programme with peer-led interventions including outreach, drug user support groups, family support services and community education. The effects of such services have been documented: CDC-affiliated OST clinics receiving funding from the national HIV prevention programme have better adherence rates and coverage than non-CDC-affiliated clinics.[47] This demonstrates the crucial impact of these types of community-based and peer-based services on the quality and therefore the impact of the OST programme.

In October 2010, funding for CBOs through the Rolling Continuation Channel was interrupted when the Global Fund suspended disbursements for all grants in China citing inadequate financial management and possible misuse of grant funds.[48] One example given by the Global Fund was the CDC's failure to allocate 20% of programme budgets to civil society implementers, as had been agreed.

This year-long suspension of funds had a damaging impact on local CBOs and drug user groups involved in the harm reduction response. Peer leaders were in some cases unable to continue participating in support groups and providing outreach services. A key informant from civil society described the suspension of grants in the following terms:

35 Mathers, B. et al. (2008) 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review,' The Lancet 372(9651): 1733-1745.

36 Ibid.

37 Lin, C. et al. (2010). 'Structural-level factors affecting implementation of the methadone maintenance therapy program in China,' Journal of Substance Abuse Treatment 38(2): 119-127.

38 Li, J. et al. (2010). 'The Chinese government's response to drug use and HIV/AIDS: A review of policies and programs,' Harm Reduction Journal 7: 4.

39 Ibid.

40 Cook, C. (2010). 'The Global State of Harm Reduction 2010: Key issues for broadening the response,' London: International Harm Reduction Association.

41 Mathers, B. et al. (2010). 'HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage,' The Lancet 375: 1014-1028.

42 Lin, C. et al. (2010). 'Structural-level factors affecting implementation of the methadone maintenance therapy program in China,' Journal of Substance Abuse Treatment 38(2): 119-127.

43 Li, M. et al. (2007). 'Achieving a high coverage – the challenge of controlling HIV spread in heroin users,' Harm Reduction Journal 4: 8.

44 Liu, Y. et al. (2010). 'Looking for a solution for drug addiction in China: Exploring the challenges and opportunities in the way of China's new Drug Control Law,' International Journal of Drug Policy 21(3): 149-154.

45 This is not to be confused with the US Centers for Disease Control and Prevention. CDC used within this case study is referring to the Chinese Centre for Disease Control.

46 Bridge, J. et al. (2012) 'Global Fund investments in harm reduction from 2002 to 2009,' International Journal of Drug Policy, in press.

47 Lin, C. et al. (2010). 'Structural-level factors affecting implementation of the methadone maintenance therapy program in China,' Journal of Substance Abuse Treatment 38(2): 119-127.

48 Aidspan (2011) 'NEWS: Disbursements for China Grants Temporarily Suspended: Global Fund raises concerns relating to financial management and involvement of civil society, Possible misuse of grant funds alleged,' Global Fund Observer 148. Retrieved 23 April 2012, from www.aidspan.org/documents/gfo/GFO-Issue-148.pdf.

"The loss of a stabilising space for former and current injecting drug users … and the supportive environment and shared sense of responsibility built up within communities of drug users was lost."

Other CBOs dissolved due to a lack of funding or to lost human resource capacity.

Just as funding resumed in 2011, there were indications that the Chinese government was willing to engage with civil society in the HIV response in a more systematic and formalised way. In July 2011, the CCM released a call for proposals from civil society organisations for the role of civil society sub-recipients under the Global Fund AIDS programme.[49] At the time, many believed that the winning sub-recipient would transition during 2012 to become the civil society principal recipient. Alliance China was one of six civil society finalists.[50] However, following the Global Fund Board decision in November 2011 to exclude upper middle income countries from future funding, the CCM abandoned the process. In 2012, the national HIV and STI Association will onward grant to CBOs. This will allocate approximately $18 million to be spent by the end of 2012. As of May 2012, the money had yet to be disbursed and communities of drug users were pessimistic about whether the capacity development plans and the scale-up of services would be possible over such a short period of time.

After the Global Fund

On 1 December 2011, in response to the Global Fund Board decision to discontinue Global Fund funding for middle income countries, the Chinese government pledged to fill the resource gap in HIV funding.[51] CBOs involved in the harm reduction response welcomed this news, but they remain concerned about what it will mean for the harm reduction response and their own autonomy and independence. Post-2012, it is anticipated that the government will contract the services of CBOs and drug user groups to provide essential services. However, community members are uncertain about what the government's priorities will be and about whether it will adopt the strategy and approach endorsed by the Global Fund.

According to CBOs and drug user groups, Global Fund grants in China have always emphasised the capacity development of CBOs. Through this funding, local organisations run by and working with people who inject drugs have been able to build their systems and capacity to engage with local government agencies, negotiating for services and even entering into partnerships. A key informant for this case study gave examples of this occurring in two places in Sichuan Province where CBOs have engaged with the local CDC, Community Committees and Public Security Bureau, developing relationships and securing funding commitments for the local OST peer-led programmes. What will happen to these gains in civil society strengthening when funding priorities change? Will the Chinese government, freed of Global Fund requirements, support community organisations to grow, develop and engage in decision-making processes to improve the scope and quality of the Chinese HIV and harm reduction programme?

The Chinese Government has already committed $15 million within its AIDS programme for CBOs in 2013. CBOs working with people who inject drugs embrace this opportunity but are concerned that the distribution of funds across services and key populations may be uneven. In recent years, sexual transmission of HIV has overtaken injecting drug use as the primary mode of transmission for new HIV infections in China. In particular, HIV transmission among urban men who have sex with men is rising. It is likely that the government will adjust budgets accordingly. But beyond this, many CBOs and drug user groups fear that the stigma surrounding drug use and the criminalisation of drug users will lead to drastic reductions in funding for harm reduction interventions when the Chinese government re-programs and re-budgets.

Most importantly, CBOs and drug user groups hope that the future make-up of harm reduction in China will include *a range of services* for people who use drugs, in particular HIV-positive drug users, and their families and partners, and that harm reduction is not reduced to only OST and other clinical interventions. In China, as elsewhere, effective harm reduction programming requires outreach, peer education, peer support, family support services and adherence support programmes, along with the mobilisation of people who use drugs. Harm reduction needs to happen in communities and on the streets, not just in clinics.

49 China CDC (2011). 'Call for Expressions of Interest for CBO-Sub-Recipient of China Global Fund RCC AIDS Program.' Retrieved April 23 2012, from www.chinaglobalfund.org/en/110729/ff808081315cdab60131731de99a000a.html

50 China CDC (2011). 'Results Announcement of Qualification Screening of CBO-SR Applicants of China Global Fund AIDS Program.' Retrieved 23 April 2012, from http://www.chinaglobalfund.org/en/110901/ff80808131ff17a4013224c5d9d1005c.html.

51 UNAIDS. (2011). 'UNAIDS applauds China's decision to fill its HIV resource gap.' Retrieved 23 April 2012, from http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/december/20111201pschina/

COUNTRY CASE STUDY 2:
VIET NAM ROUND 11 CANCELLATION – COVERING THE GAP

HIV AND DRUG USE IN VIET NAM

In Viet Nam the sharing of injecting equipment is the main driver of HIV transmission (53%).[52] The estimated size of the population of people who inject drugs in Viet Nam is 273,579.[53] Among identified people who inject drugs, 18.4% are HIV-positive.[54] HIV prevalence among people who inject drugs ranges from 1.9% in Da Nang to 65.8% in Hai Phong.[55] Harm reduction programmes in Viet Nam have been funded by bilateral and multilateral donors (i.e. the US government, DFID, the World Bank and the Global Fund) as well as the Vietnamese government. In 2009, the Vietnamese government initiated a pilot methadone treatment programme which reached 1,735 people who inject drugs. Following the success of this pilot, the government established the goal of scaling up methadone treatment to reach 80,000 drug users by 2015.[56] [57] Uncertainty about the current funding environment raises questions as to whether this target will be met.

1. The Round 11 cancellation: a lost opportunity for community systems strengthening

The cancellation of Round 11 has left a significant gap in Viet Nam's HIV response. PEPFAR is the main funder of methadone treatment expansion, but cannot support needle and syringe programmes due to the Congressional funding ban. The lack of US funding gives the Vietnamese government and the Global Fund a significant imperative to fund NSPs. Viet Nam's Round 11 proposal was to focus on scaling up methadone treatment and NSPs. The cancellation has been particularly detrimental for these two essential components of harm reduction.

Community systems strengthening programmes were included for the first time in Viet Nam's Round 9 proposal, following complicated negotiations. This was the first time that civil society was directly funded to provide outreach, peer education, clean needles and condoms to communities. Within the Round 9 civil society component, only a small portion was allocated for activities involving people who inject drugs. The Round 9 grant is currently going through Phase 2 reprogramming and there are fewer resources than expected for community-based harm reduction programmes such as outreach and peer education. Viet Nam was depending on Round 11 to expand outreach, community-based methadone programmes and related services for people who inject drugs. The cancellation of Round 11 is resulting in a setback for community systems strengthening and for civil society engagement in the HIV response, in particular the engagement of people who use drugs in decision-making forums such as the Country Coordinating Mechanism. The loss of the Round 11 opportunity means that fewer community organisations and key population networks will be funded and strengthened to participate in the HIV and harm reduction response in Viet Nam.

"Community-based harm reduction programmes are critical in addressing drug users' needs and preventing HIV transmission. The loss of Round 11 has significantly impacted scale-up of these and other potentially innovative programmes. It has been a set-back for the expansion of community systems strengthening for the HIV response in the country." – Eamonn Murphy, UNAIDS Viet Nam Country Coordinator

52 Percent distribution of reported HIV cases by mode of transmission, 2000 – September 2009 21 Source: Prepared by www.aidsdatahub.org based on Vietnam Administration of HIV/AIDS Control, 2010 No data available for homosexual transmission, Retrieved 25 April 2012.

53 The Socialist Republic of Viet Nam (2010). ' - 2010 Country Progress Report,' Hanoi. Retrieved 25 April 2012, from http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2010countries/vietnam_2010_country_progress_report_en.pdf.

54 UNAIDS. 'Viet Nam Country Profile,' Retrieved 25 April, 2012, from http://www.unaids.org/en/regionscountries/countries/vietnam/.

55 'HIV prevalence among IDUs, 2005-2006' Source: Prepared by www.aidsdatahub.org based on National Institute of Hygiene and Epidemiology Vietnam, FHI, Vietnam Administration of HIV/AIDS Control, et al. (2006). Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam 2005 – 2006, Retrieved: 25 April 2012.

56 The Socialist Republic of Viet Nam (2010). ' - 2010 Country Progress Report,' Hanoi. Retrieved 25 April 2012, from http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2010countries/vietnam_2010_country_progress_report_en.pdf.

57 (2011). 'UN praises Hai Phong methadone clinic,' Thanh Nien News. Retrieved 25 April 2012, from http://www.thanhniennews.com/2010/pages/20110622155830.aspx.

Community-based drug treatment programmes have shown promise in Viet Nam. In 2011, pilot programmes in Hai Phong, supported by the Vietnamese government and international donors demonstrated that a combination of community-based methadone treatment and access to other support services led to improved health and quality of life for drug users.[58 59] Some provincial-level governments are reallocating resources from drug detention centres[60] given widespread reports of forced labour, torture and other severe punishment that takes place in these centres in the name of "drug treatment."[61] As a rights-based and cost-effective alternative to drug detention centres, community-based drug treatment and harm reduction programmes need resources.

"According to the preliminary findings from an evaluation conducted by a team from Yale University, people who inject drugs involved in harm reduction programs implemented by organisations of drug users in Hanoi reported higher quality of life and higher self-efficacy. International literature has found that low self-efficacy is consistently associated with risky injection behaviours. Unfortunately, very little funding has been invested in this model of community-based organization of drug users." – Khuat Thi Oanh, Executive Director, Supporting Community Development Initiatives (SCDI) Viet Nam

2. The Global Fund and middle income countries: will Vietnam cover the gap?

At the end of 2009, the DFID harm reduction project was coming to an end in Viet Nam. Instead of renewing the funding for harm reduction through a bilateral mechanism, DFID, in line with the Paris Declaration principles, invested its funds into a "basket fund" with the World Bank. Contract negotiations between the Vietnamese government and World Bank took nearly two years, leaving a significant gap in the funding of harm reduction programmes. In at least 12 provinces, all NSP and condom distribution stopped because DFID had been the only donor funding NSP in those provinces. The Vietnamese government did not provide additional resources to "plug the gap".

A cadre of peer educators and outreach workers were trained through the DFID-funded project, the majority of whom implemented NSP and condom programmes for people who inject drugs. As a result of the DFID resources stopping and the lag time before a restart, the peer educators and outreach workers were not paid and needed to stop working. Around 50% of the provinces were able to keep people working. Other peer educators chose to continue working as volunteers distributing clean syringes and condoms and collecting used syringes. As the syringes ran out, they continued to collect the used and discarded syringes.

While the programme was operating, about 80% of people who inject drugs who engaged with peer educators reported not sharing injecting equipment.[62] Anecdotal reports suggest that in the two-year period when the project was suspended, rates of syringe sharing increased. The 2009 behavioural survey report from that period shows an increase in syringe sharing in a number of cities and a dip in the percentage of people who inject drugs who accessed free injecting equipment.

When a country moves into middle income country status, the assumption that follows is that the country will fund its own HIV response. When Viet Nam applied for Global Fund resources for harm reduction, the government recognised the importance of harm reduction interventions for preventing HIV in Viet Nam. However, after the DFID-funded project ended, there was an immediate loss of funding and programme capacity. The Vietnamese government did not use its own resources to cover the gap and ensure access to NSPs for people who inject drugs. There is currently little political commitment by the Vietnamese government, as with so many other governments, to fund comprehensive harm reduction programmes from domestic resources.

58 Ibid.

59 (2011) 'Hai Phong starts healthcare programme for drug addicts,' VOV Online Newspaper. Retrieved 25 April 2012, from http://english.vov.vn/Home/Hai-Phong-starts-healthcare-programme-for-drug-addicts/20112/123957.vov.

60 Under the Ordinance on Administrative Violations 04/2008/PL-UBTVQH12, drug use and sex work are administrative violations and result in detention for up to two years in centers managed by the Ministry of Labor, Invalids and Social Affairs (MOLISA). These centers are referred to as 05 Centers for female sex workers and 06 Centers for drug users. (Source: The Socialist Republic of Viet Nam (2010). ' - 2010 Country Progress Report,' Hanoi. Retrieved 25 April 2012, from http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2010countries/vietnam_2010_country_progress_report_en.pdf.)

61 Human Rights Watch (2011). 'Vietnam: Torture, Forced Labor in Drug Detention Companies, Donors Should Press Government to Close Centers.' Retrieved 25 April 2012, from www.hrw.org/news/2011/09/07/vietnam-torture-forced-labor-drug-detention.

62 Key informant interview with WHO Viet Nam, 25 April 2012.

“In recent years, the Global Fund has become the main funder of harm reduction interventions to address HIV among people who inject drugs. So when the Global Fund falters, harm reduction will suffer.”

HIV, Drug Use and the Global Fund: Don't Stop Now (May 2012)

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