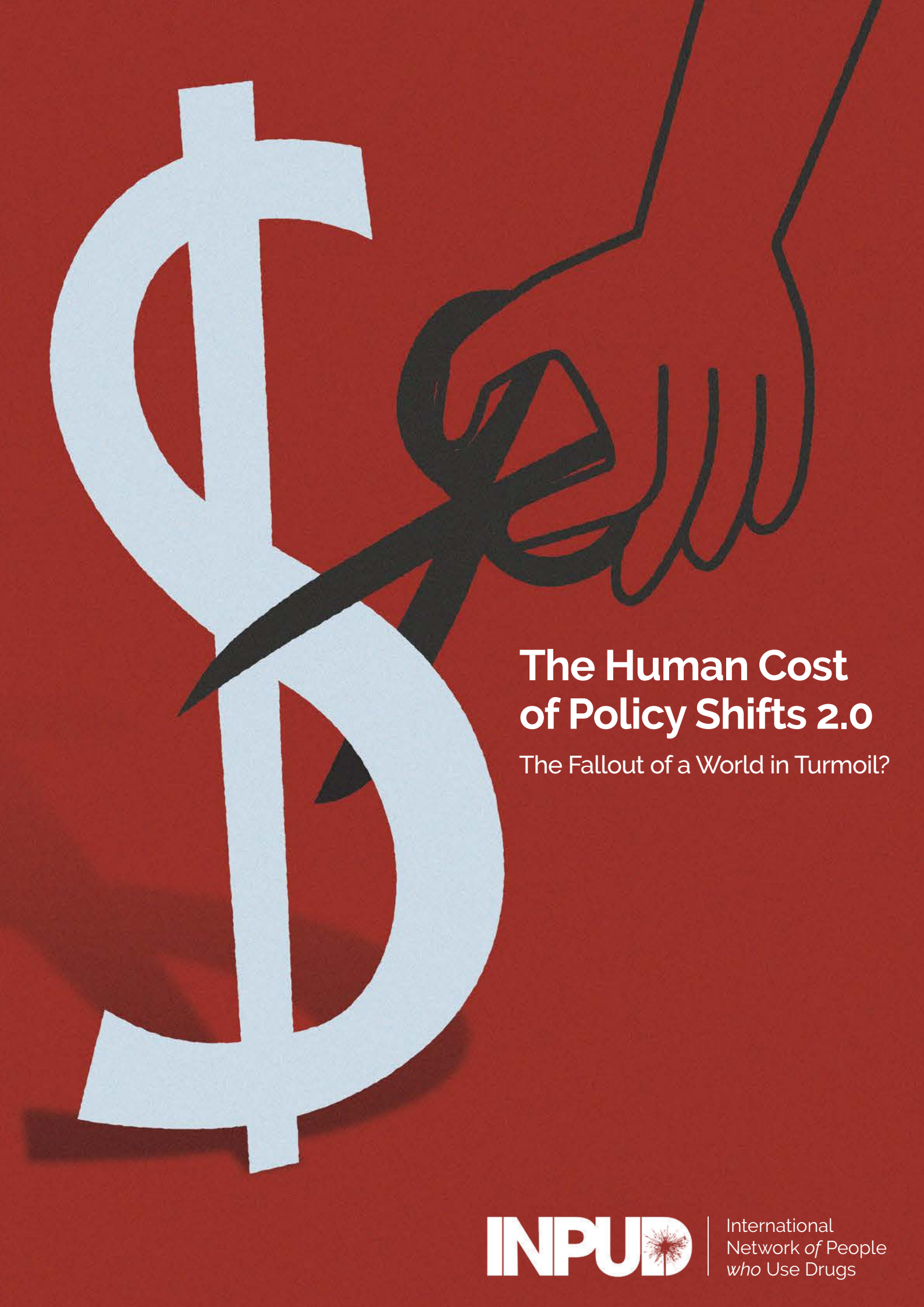


The Human Cost of Policy Shifts 2.0

The Fallout of a World in Turmoil?

INPUD

International Network *of* People *who* Use Drugs

The Human Cost of Policy Shifts 2.0: The Fallout of a World in Turmoil

TABLE OF CONTENTS

Executive Summary

In April 2025, the impact of the immediate withdrawal of U.S. foreign assistance on the health and well-being of people who use drugs was profound. Now one year later, the International Network of People who Use Drugs (INPUD) has conducted a follow-up global survey to check the pulse of our community and ascertain how it has fared over the last 14-months. The survey 2.0 (wave 2), was administered online and was open from 8 May to 22 May 2026. It was designed to preserve comparability with the 2025 survey (wave 1) while adding new questions on emerging funding, policy, service delivery and community-level impacts. Over the course of the 2 weeks, 149 respondents participated in the survey.

EIGHT KEY MESSAGES are drawn from our findings:

1. **The health, rights and dignity of people who use drugs are being pushed underground.** The emergency is no longer solely a financial one. The downstream harms to the community are also quickly escalating. Today, we are observing the consequences of a year of service disruption, and **the crisis is now transitioning to a state of emergency for the rights, dignity and lives of our community.**

2. **Significant and ongoing disruption to needle and syringe programming (NSP) is setting off our alarm bells.** Low threshold access to free sterile injecting equipment provided by needle and syringe programming reduces HIV transmission among people who use drugs by approximately 50% and 76% for hepatitis C infection. Needle and syringe programming is also in many cases, the first point of contact with people who use drugs and because of this, are vital gateways to a breadth of comprehensive health and social support services. The absence of such programming increases the likelihood that community members **remain entirely out of reach, allowing epidemics of HIV, HCV, and tuberculosis (TB) to spread unchecked**.

3. **Drug user community-led organisations/networks are confronting a critical funding gap.** Community-led responses can't exist on volunteerism and goodwill alone, they need to be funded with direct, flexible and predictable funding.

4. **The triple hitter: drug user-led harm reduction organisations and networks have been the hardest hit by funding shifts and are on the brink of extinction.** Our findings show consecutive funding shocks to be concentrated among the same community-led organisations. The first financial shock was the U.S. withdrawal of its foreign assistance. The second financial shock was the Global Fund's GC7 reprioritisation process. The triple hitter has been the withdrawal and changing priorities of other donors, including bilateral government programmes, philanthropies, and UN agencies. Relatedly, community participation in decision-making processes has shown no protective effect: closure rates are similar across organisations regardless of whether communities were 'at the table' (19% versus 17%).

5. Spoiler alert: we know this story because we've been here before. Steep increases in service disruptions are giving way for burgeoning levels of stigma, low access to harm reduction supplies (likely related to the closure of NSPs) combined with higher police surveillance, harassment and punitive legal environments. **Each of these occurrences signify crucial factors that drive people into hiding, away from available services and into high-risk settings for HIV transmission and other bloodborne infections.** Stark increases in disrupted overdose prevention activities across the two survey periods (30% to 43% respectively) shows that we are witnessing the brewing of another perfect, but preventable, storm.

6. **The connection is clear: the shifts in the funding environment are happening in tandem with increased punitive drug policy landscapes**. Intensified police presence, raids on hotspots, arbitrary arrests, ICE activity, and harassment of harm-reduction workers are driving our community further underground and making it difficult for our organisations to provide the services needed. Repressions on civic space in many countries are making it a *challenging operating environment* for community-led organisations, outreach workers, and for the lives and safety of people who use drugs.

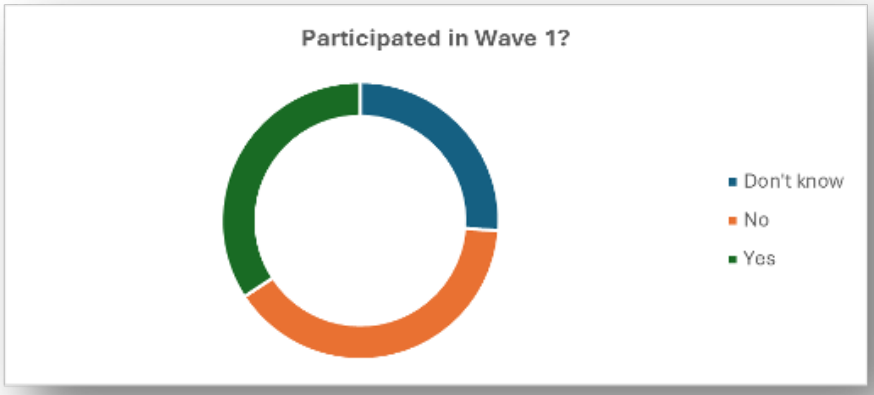
7. Women who use drugs are identified as the most impacted group experiencing the greatest reductions in services in addition to the category of people who inject drugs. Further research is urgently needed to better understand the extent to which women, lesbian, gay, bisexual, trans and gender diverse people who use drugs are being affected by this new funding environment, and what health responses are needed.

8. Advocacy priorities – It is of no surprise that the growing funding gap, the sustainability risks to harm reduction and community-led service delivery, and the safety and security of people who use drugs have risen as the most prominent and urgent concerns of our community today. Financial mechanisms at global, regional and national level must urgently respond in a coordinated manner to prevent service collapse and resultant public health crisis with spiking rates of new HIV/HCV infections and preventable overdose deaths.

Highlighting Key Findings:

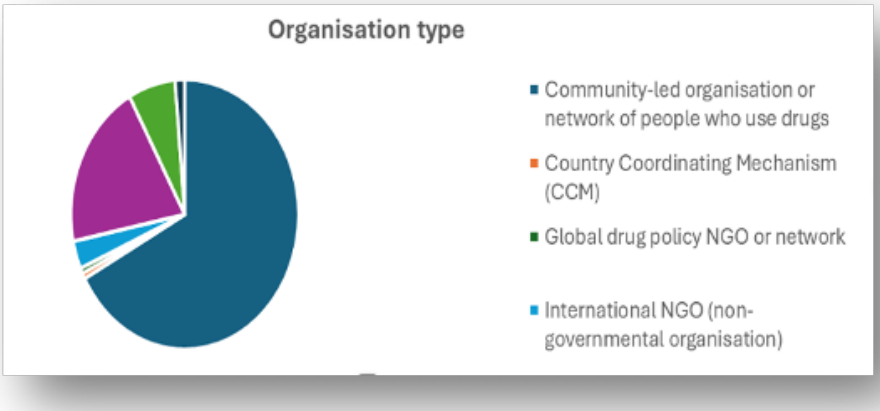
Respondents were drawn primarily from community-led organisations and networks of people who use drugs, local civil society organisations, harm reduction service providers, international NGOs, and other community, policy and service-delivery actors. Just over one-third of respondents (n=51), or their organisations, reported participating in the 2025 survey, while a larger proportion were new respondents (n=59), supporting both continuity with the 1.0 survey and expanded reach (Figure 1).

Figure 1: Continuity in Respondent Participation in 2025 and 2026 Survey



Respondents represented a broad range of regions, with the largest proportion from Africa (n=62), followed by Asia (n=21), Eastern Europe and Central Asia (n=10), the Middle East and North Africa (n=10), the Pacific, Latin America and the Caribbean (n=7), Western Europe (n=4) and global (n=5) respondents. Most respondents represented community-led organisations or networks of people who use drugs (n=100), with others from local non-governmental civil society organisations (n=30), international NGOs (n=5), state-funded hospitals (n=2), Country Coordinating Mechanisms (n=1), global drug policy networks (n=1), and other organisational types (Figure 2). Analysis indicates a very stable organisational mix across both waves: approximately 67% of respondents were community-led organisations, which makes for robust comparison by organisational type. The regional mix of respondents is broader in wave 2 (Africa 42% versus 53% in Wave 1, with more respondents from other regions), making regional shifts in the trends above partly reflective of who answered, not only the changing conditions.

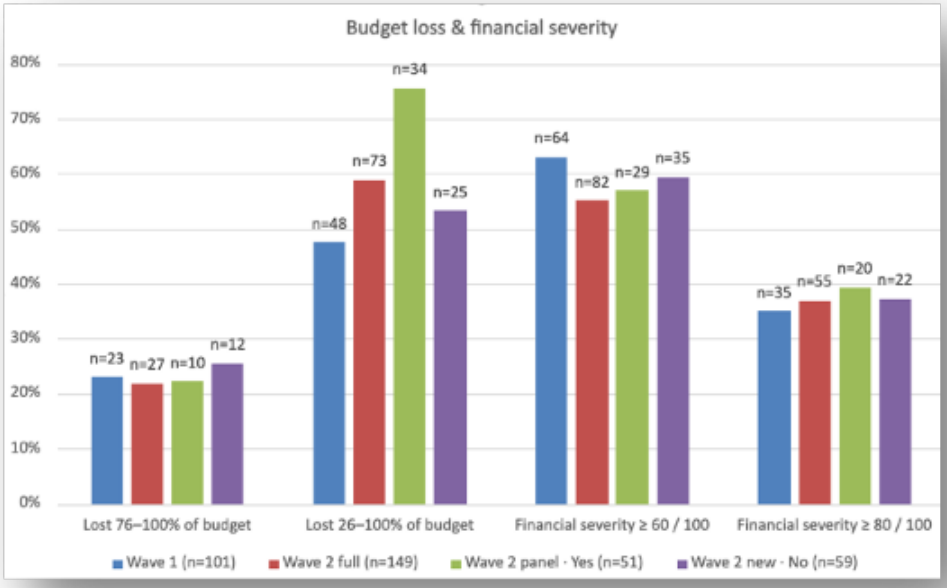
Figure 2: Respondent Profile – Organisation Type



Responding organisations and networks reported providing a wide range of harm reduction, health, legal, social and community services. The most reported services included harm reduction

education and training, outreach and peer-led harm reduction programmes, HIV testing, psychosocial support, legal and human rights support, needle and syringe programmes, overdose prevention including naloxone distribution, and services for women who use drugs. Other services included hepatitis C testing and treatment, HIV treatment and care, opioid agonist therapy (OAT), PrEP, safer smoking kits, low-threshold support, gender-based violence prevention services, TB screening and treatment support, and programming for stimulant use.

Figure 3: Budget Loss and Financial Severity

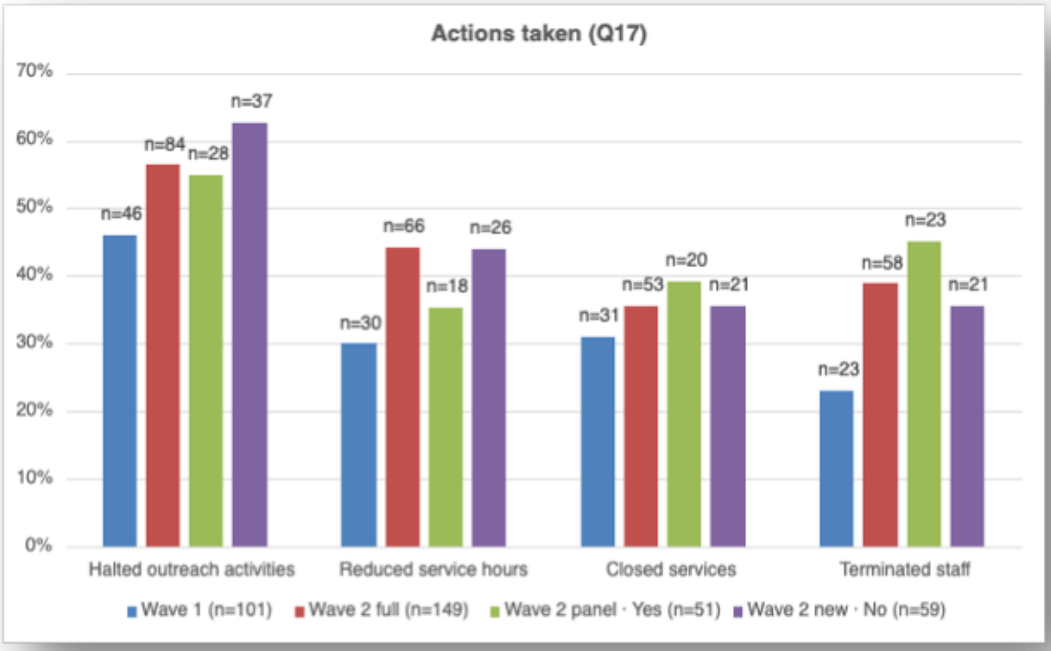


When we compared responses across time (Figure 3), 48% of respondents in wave 1(2025) had identified a loss of 26-100% of their funding. Under wave 2 (2026), the total number jumped an alarming 11 percentage points (pp) to 59%. **Interestingly, when we isolated for repeat respondents (those who had self-reported completing both survey waves), the number rose by an astounding 28 pp to 76%.** This means that for the cohort of respondents who participated in both surveys, there are a greater number of organisations who are currently experiencing precarious financial stability as a result of losing 26-100% of their funding due to U.S. funding cuts (Figure 3).

The analysis is directional in nature because the responses are based on a self-reported quasi-panel rather than an ID-matched panel. However, the message is crystal clear: **Harm reduction organisations, and drug user-led organisations in particular, are confronting a critical funding gap placing the sustainability of harm reduction and the drug-user rights movement as a human rights and public health approach, under urgent question.**

"Many drug user outreach workers and peer educators lost their job, resulting in overburden among those remaining." - Respondent

Figure 4: Mitigating Actions Taken to Offset Financial Losses



Looking at patterns over time, financial challenges have continued to intensify across both survey waves. Figure 4 tells us that organisations who responded during wave 2 were more likely to have halted outreach (63% versus 55% for the panel) and more likely to have terminated staff (39% versus 15%). These findings also show that each mitigating measure has intensified over the 14-months between March 2025 and May 2026. Staff terminations show the sharpest rise (+16 pp, now 39%) and reduced hours are up more than 14 percentage points. **This is evidence that the initial cuts in 2025 have moved from initial pauses in service delivery to a deeper, structural downsizing of the harm reduction workforce.** Remaining staff face heavier workloads, unstable pay, and an emotional toll from witnessing community deaths and political hostility.

Table 1: Top 10 Service Disruptions Across Wave 1 and Wave 2

Top 11 Service Disruptions following U.S. foreign aid work stop orders and terminations (2025)	% of respondents (N=101)
Outreach and peer-led harm reduction services	41%
Legal and human rights support	36%
HIV testing	35%
Services for women who use drugs	33%
HIV treatment and care	32%
Services to address gender-based violence	28%
Overdose prevention (Naloxone distribution)	25%
Needle and syringe programming	23%
Hepatitis C testing	20%
Opioid agonist treatment (OAT)	16%
Hepatitis C treatment	16%

Top 11 Service Disruptions following U.S. foreign aid work stop orders and terminations (2026)	% of respondents (N=149)
Harm reduction education and training	48%
Outreach and peer-led harm reduction programs	39%
HIV testing	35%
Psychosocial support	33%
Needle and syringe programming	31%
HIV treatment and care	30%
Legal and human rights support	28%
Overdose prevention (Naloxone distribution)	27%
Services for women who use drugs	23%
PrEP (pre-exposure prophylaxis)	23%
Hepatitis C testing	22%

"There are increases in overdose deaths, increases in death among community members living with HIV and increases in new infections" - Respondent

"Most of our beneficiaries have gone back to unsafe injecting practices". - Respondent

"People who use drugs are switching from opioids to stimulants due to limited harm reduction services for opioid use". - Respondent

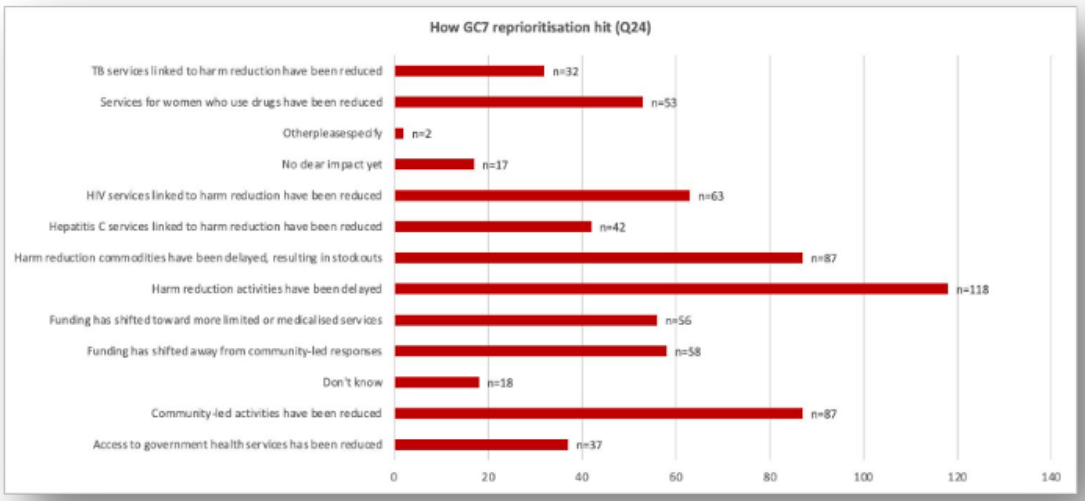
Whilst disruptions to HIV testing among people who use drugs remained relatively consistent across the two survey periods (35% in 2025; 35% in 2026), **the 8-percentage point spike in disruptions to needle and syringe programming is alarming. The foundational, basic harm reduction service is witnessing a scale-back, not a scale-up.**

Over the last two survey periods, the most reported challenges experienced by people who use drugs resulting from service disruptions include:

- Experiences of stigma and discrimination (jumped from 60% to 77%)
- A lack of access to harm reduction supplies (spiked from 47% to 64% in 2026)
- Experiences of increased policing, harassment or criminalisation (increased from 42% to 64%), and

- Reliance on underground/informal networks for accessing harm reduction supplies (46% to 47%).

Figure 5: How GC7 Reprioritisation Affected Access to Harm Reduction and Related Services



Whilst 15% indicated that the reprioritisation process had brought positive results for harm reduction programming in their country (e.g., expansion to new provinces/ districts, introduction of or expansion of OAT), a significant group of respondents (40%) indicated negative outcomes. As depicted in Figure 5, the impact of GC7 reprioritisation has been substantial and sweeping across harm reduction interventions and settings.

Of the149 respondents:

- 79% indicated that harm reduction activities have been delayed
- 58% pointed to delays in harm reduction commodities resulting in stockouts
- 58% noted that community-led activities have been reduced
- 42% reported reductions in HIV services linked to harm reduction programming
- 38% reported a shift in funding towards more limited or medicalised services
- 36% indicated reductions in service availability for women who use drugs
- 28% noted reductions to hepatitis C services linked to harm reduction programmes
- 22% noted reductions in TB services that were linked to harm reduction programmes.

Deeper cross-analysis within wave 2 found that the organisations most dependent on U.S. funding were also the most exposed to the impacts of the Global Fund's GC7 reprioritisation process. **The key takeaway here is the nature of the 'double hit': the funding shocks appear to be concentrated among the same community-led organisations.** In other words, among the most U.S.-dependent organisations (76-100% of their budget), 63% also reported negative impact from the outcome of the Global Fund GC7 reprioritisation process. Relatedly, community participation in decision-

making processes has shown no protective effect: closure rates are similar across organisations regardless of whether communities were 'at the table' (19% versus 17%).

The tripe-hit becomes apparent through responses laying bare experiences of concurrent financial pressures and the concomitant loss of financial support not only from the U.S., the Global Fund, but from other sources as well. This phenomenon is reflected by other donor withdrawal, reductions to bilateral programme funding, reductions to ODA, philanthropic and UN funding on top of grant disbursement challenges causing delayed grant payments and more stringent grant requirements. Respondents observed:

- The full withdrawal of another donor (23%)
- Reductions to other bilateral funding (30%)
- Reductions to philanthropic/private donor funding (26%)
- Reductions in UN funding or support (22%)
- No major funding change (7%)

Alongside these monumental shifts, respondents indicated supplementary pressures having contributed to even further pressures on the organisation's already stretched capacity and fiscal space, Such additional constraints include:

- Delays in disbursements of existing funds (37%)
- Increased restrictions or conditions attached to funding (42%)
- Pressure to align programming with new government or donor priorities (meaning, not necessarily aligned with community priorities or needs) – (39%)

Together, these findings provide prime illustration of the knock-on impacts of the American withdrawal of its foreign assistance. Our findings similarly speak to the broader financial ecosystem buckling under new pressures because of shifting geo-political priorities away from HIV and global health more broadly, towards national priority-setting for trade, defence and military spending. The USD 5 billion shortfall in the Global Fund's 8th Replenishment outcome forewarns of difficult trade-offs and prioritisation processes going forward under Grant Cycle 8 as a result of much smaller country funding envelopes. This does not bode well for people who use drugs and the drug user-led organisations that serve them and will require intensive strategic advocacy and engagement strategies at the country level. **Respondents warn that the collapse of these services dismantles the 'trust infrastructure' that is so critical to ensuring that prevention services and health commodities reach the hands of and are appropriately used by the drug user community at all.**

"Ongoing uncertainty erodes trust in systems at large and may ultimately impact our rapport with those we serve" – Respondent

"People are withdrawing; they have stopped approaching NGOs for services" - Respondent

Table 2: Respondents Identify Their Top Advocacy Priorities

Top Advocacy Asks:	Percentage
Flexible / core funding for community-led organisations	44%
Immediate emergency funding for harm reduction	40%
Protection of community-led and peer-led services	40%
Legal and human rights protections for people who use drugs	30%
Protection of HIV treatment and care access	24%
Protection of NSP and OAT	21%
Protection of services for women who use drugs	21%
Greater community participation in funding and implementing decisions	16%
Global Fund flexibility / reprogramming for harm reduction	15%
Domestic financing to sustain harm reduction	14%
Opposition to punitive drug policy shifts / "narcoterrorism" framing	13%
Better donor coordination and transparency	3%

As the final section in the survey, respondents were invited to share their top three (3) advocacy asks, or priorities. It is of no surprise that the growing funding gap, the sustainability risks to community-led service delivery, and the safety and security of people who use drugs have risen as the most prominent and urgent concerns of the sector today.

Our calls to action remain consistent with those in our first report, The Human Costs of Policy Shifts: The Fallout of United States' Foreign Aid Cuts on Harm Reduction Programming and People who Use Drugs. Fourteen months later, we see no alternative solutions coming to the fore to ensure the continuity of equitable access to harm reduction services. Little alternative funding has helped to bridge service closures of HIV/hepatitis C prevention, treatment, care and support for and by our community. Our lives and lived realities, our leadership, innovations and commitment are being erased in the name of "integration". Fourteen months since the original financial shock and the fallout has only deepened, inequity has widened, and the environment has gotten much harder for community members and community-led organisations alike.

CALL TO ACTION:

1. Alternative pooled funding mechanisms must be urgently established by global and regional partners to prevent service collapse and resultant spiking rates of new HIV/HCV infections, and preventable overdose deaths.

2. National governments must step up to support harm reduction services, including equitable access to opioid agonist treatment (OAT) and social contracting arrangements that prioritise community-led responses.

3. International and multilateral organisations must prioritise resource allocation to affected programs and key populations, including people who use drugs.

4. Advocacy efforts must be intensified to restore funding and highlight the long-term public health consequences of such dramatic funding and policy shifts.

1.0 Introduction

In January 2025, the immediate withdrawal of American foreign assistance sent shockwaves through harm reduction systems, community-led services, and drug user networks across the world. For people who use drugs, this was not simply a funding adjustment or a technical policy shift. It was a rupture in the fragile infrastructure that keeps our communities alive.

Fourteen months later, the crisis has deepened.

INPUD's follow-up global survey, conducted from 8 to 22 May 2026 with 149 respondents across regions, documents a rapidly escalating emergency affecting the health, rights, dignity, and survival of people who use drugs. The findings show that the initial financial shock has now become a broader community crisis: services have been disrupted, organisations have downsized or closed, outreach workers have lost their jobs, harm reduction commodities are running out, and people are being pushed further underground.

The evidence is stark. In 2026, 59% of respondents reported losing between 26% and 100% of their funding due to U.S. funding cuts, compared with 48% in 2025. Among repeat respondents, this figure rose to 76%, showing that the same organisations are experiencing intensifying financial precarity over time. These are not abstract numbers. They represent closed drop-in centres, lost peer workers, interrupted needle and syringe programmes, reduced overdose prevention activities, and communities left without trusted points of care.

The survey also shows that the crisis is not only financial. It is political, structural, and deeply human. Funding cuts are occurring alongside increasingly punitive drug policy environments, intensified policing, harassment, raids, arbitrary arrests, shrinking civic space, and the erosion of community-led responses. People who use drugs are facing rising stigma and discrimination, reduced access to sterile injecting equipment, growing reliance on underground networks, and increased risks of HIV, hepatitis C, tuberculosis, overdose, violence, and death.

Needle and syringe programming — one of the most basic, proven, and life-saving harm reduction interventions — is being disrupted at alarming levels. At the same time, overdose prevention activities are increasingly affected, rising from 30% disruption in 2025 to 43% in 2026. This combination of funding collapse, service interruption, criminalisation, and community fear is creating the conditions for a public health disaster that is completely preventable.

The report also highlights the devastating impact on drug user-led organisations and networks. These organisations are not peripheral actors. They are the trusted infrastructure through which services reach people who are otherwise excluded, criminalised, and pushed away from formal systems. Yet they are now facing a "triple hit": the withdrawal of U.S. foreign assistance, the consequences of the Global Fund's GC7 reprioritisation process, and the withdrawal or shifting priorities of other donors, including bilateral programmes, philanthropies, and UN agencies.

For women who use drugs, people who inject drugs, LGBTQI+ people who use drugs, sex workers who use drugs, and communities living in highly criminalised settings, the impact is especially

severe. The closure or reduction of low-threshold, community-led services means the loss of safe spaces, gender-based violence responses, child-friendly services, mobile medication-assisted treatment, peer support, and trusted harm reduction access points. When community-led harm reduction collapses, people do not simply move to another service. Many disappear from care altogether.

This is not a moment for business as usual. The lives, rights, and dignity of people who use drugs are at stake.

2.0 Methodology

2.1 Survey Design

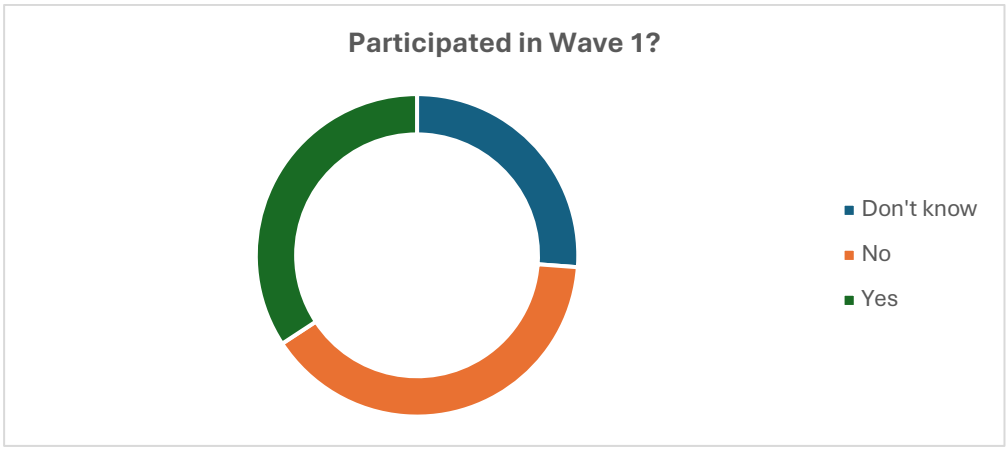
The Human Costs of Policy Shifts on Harm Reduction 2.0 Online Survey was designed by INPUD as a follow-up to *The Human Costs of Policy Shifts on Harm Reduction 1.0* survey conducted in March 2025. The 2.0 survey aimed to generate timely, community-led evidence on how ongoing global funding shifts, donor withdrawal, Global Fund reprioritisation, reductions in official development assistance, and related policy changes are affecting harm reduction services and the lives, health and rights of people who use drugs. The survey was designed to preserve comparability with the 2025 survey while adding new questions on emerging funding, policy, service delivery and community-level impacts.

The survey was predominantly quantitative, using single-select and multi-select questions, with targeted open-text fields included to capture qualitative detail and examples. Key themes included funding changes, donor withdrawal, service disruptions and closures, access to harm reduction services, impacts on priority populations, community participation in planning and decision-making, adaptation and mitigation strategies, and priority advocacy asks. The survey was designed to take approximately 15–20 minutes to complete and was made available in English, Spanish, French, Russian and Arabic. (See Annex I)

2.2 Participants

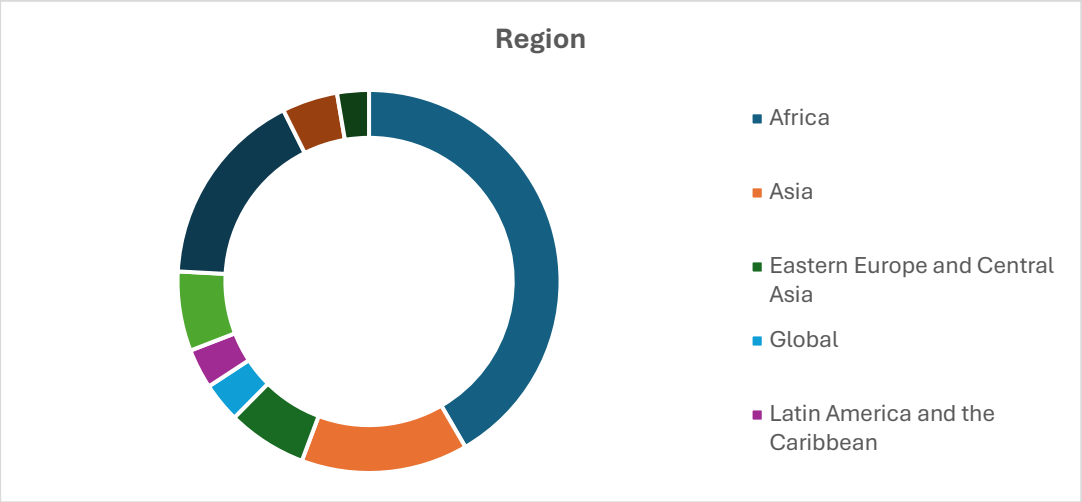
A total of 149 respondents completed the survey. Respondents were drawn primarily from community-led organisations and networks of people who use drugs, local civil society organisations, harm reduction service providers, international NGOs, and other community, policy and service-delivery actors. Just over one-third of respondents (n=51), or their organisations, reported participating in the 2025 survey, while a larger proportion were new respondents (n=59), supporting both continuity with the 1.0 survey and expanded reach (Figure 1). A smaller number of respondents (n=39) were unsure whether their organisation had participated in the previous survey, potentially reflecting staff turnover or changes in organisational personnel since the 2025 survey.

Figure 1: Continuity in Respondent Participation in 2025 and 2026 Survey



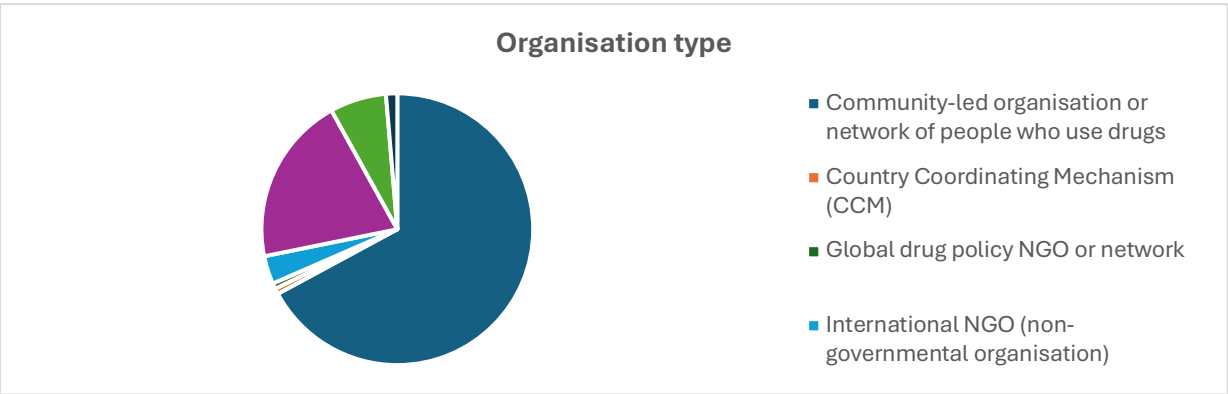
Respondents represented a broad range of regions, with the largest proportion from Africa (n=62), followed by Asia (n=21), Eastern Europe and Central Asia (n=10), the Middle East and North Africa (n=10), the Pacific, Latin America and the Caribbean (n=7), Western Europe (n=4) and global (n=5) respondents. (Figure 2)

Figure 2: Participant Regional Profile



Most respondents represented community-led organisations or networks of people who use drugs (n=100), with others from local non-governmental civil society organisations (n=30), international NGOs (n=5), state-funded hospitals (n=2), Country Coordinating Mechanisms (n=1), global drug policy networks (n=1), and other organisational types (Figure 3). Analysis indicates a very stable organisational mix across both waves: approximately 67% of respondents were community-led organisations, which makes for robust comparison by organisational type. The regional mix of respondents is broader in Wave 2 (Africa 42% versus 53% in Wave 1, with more respondents from other regions), making regional shifts in the trends above partly reflective of who answered, not only the changing conditions.

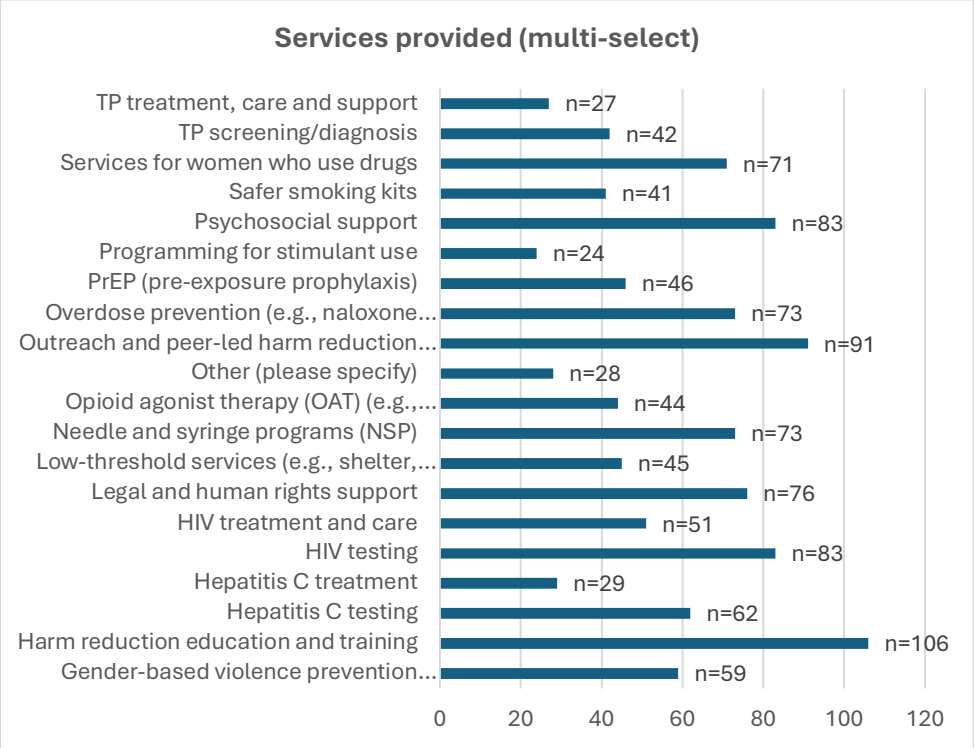
Figure 3: Respondent Profile – Organisation Type



Responding organisations and networks reported providing a wide range of harm reduction, health, legal, social and community services (Table 1). The most reported services included harm

reduction education and training, outreach and peer-led harm reduction programmes, HIV testing, psychosocial support, legal and human rights support, needle and syringe programmes, overdose prevention including naloxone distribution, and services for women who use drugs. Other services included hepatitis C testing and treatment, HIV treatment and care, opioid agonist therapy, PrEP, safer smoking kits, low-threshold support, gender-based violence prevention services, TB screening and treatment support, and programming for stimulant use.

Table 1: Services Provided By Respondents



The survey was administered online and was open from 8 May to 22 May 2026. It was disseminated through INPUD's global and regional networks using targeted outreach, including direct email invitations, partner distribution lists, listservs and secure messaging channels. Recruitment used a purposive, criterion-based sampling strategy focused on organisations providing harm reduction services, drug user-led networks, peer-led groups, community advocates, and service providers in settings affected by international donor funding changes.

The survey was anonymous, with no unnecessary personally identifying information collected. Given the sensitive and, in many contexts, criminalised nature of drug use, the study applied an ethics-in-practice approach, including informed consent, voluntary participation, the option to skip questions, secure data storage, restricted access to data, and anonymised reporting of findings.

2.3 Data Analysis

Quantitative survey data were exported, cleaned and analysed using descriptive statistics, including frequencies and cross-tabulations where appropriate. Analysis focused on identifying patterns across respondent type, region, service area and reported impacts, as well as examining

emerging trends since the 2025 survey. Where questions were retained from the 1.0 survey, findings will be used to support cautious comparison over time.

Open-text responses were reviewed and manually coded using a rapid thematic analysis approach. Qualitative analysis focused on recurring themes related to funding changes, service disruptions, policy and legal shifts, community impacts, mitigation strategies, and priority advocacy messages. Survey findings were interpreted using a four-level analytical framework linking global funding and policy shifts, national-level changes, service delivery impacts, and community-level outcomes for people who use drugs. This approach was used to ensure that the analysis connects high-level financing and policy decisions to their real-world effects on harm reduction services, community-led organisations and the lives of people who use drugs.

2.4 Limitations

Several methodological limitations should be considered when interpreting these findings.

First, this was a convenience sample recruited through INPUD's networks (n=149), not a probability-based sample from a defined sampling frame. Self-selection likely biased participation toward organisations most affected by funding disruptions, potentially overstating the prevalence and severity of impacts relative to the broader harm reduction sector. As an advocacy-led survey, some degree of response framing cannot be excluded.

Second, geographic and organisational representation was uneven. African respondents comprised 42% of the sample, with a further 35% classified as "Other" (predominantly US-based domestic organisations). Western Europe (n=4), Latin America and the Caribbean (n=5), and Eastern Europe and Central Asia (n=10) were substantially under-represented. Community-led organisations accounted for 67% of respondents, limiting generalisability to other organisational types.

Third, many disaggregated analyses rested on small cell sizes, rendering subgroup estimates unstable. Differences between small subgroups should not be interpreted as statistically meaningful, and disaggregated figures should be regarded as indicative rather than precise.

Fourth, comparisons with Wave 1 (n=101, January 2025) are constrained by differences in sample composition, instrument design, and the absence of individual-level linkage between waves. The 51 respondents who self-identified as having participated in Wave 1 could not be matched to their original responses. Apparent temporal trends may partly reflect compositional change rather than true change over time, and wave-over-wave comparisons should be interpreted as directional only.

Fifth, all data were self-reported by a single organisational representative, introducing potential recall bias and reliance on one individual's assessment of organisation-wide impacts. Key outcome measures—service impact and financial impact—were subjective 0–100 slider scales, not validated instruments or objective administrative data. Estimates of US funding dependence were respondent-approximated and may not capture indirect funding flows.

Sixth, quantification of open-ended and multi-select responses relied on keyword-based text matching, which is sensitive to variation in spelling and phrasing and should be considered approximate.

Seventh, cross-tabulations demonstrate association, not causation. The observed relationship between US funding dependence and impact severity is consistent with, but does not establish, a causal effect. Attribution of specific harms to US funding decisions is respondent-reported and occurs against a backdrop of concurrent shocks, including Global Fund GC7 transitions and broader reductions in official development assistance, precluding isolation of any single causal pathway.

Eighth, the survey captured a point-in-time snapshot of an evolving situation. A substantial proportion of respondents reported anticipated rather than realised impacts, suggesting that downstream consequences, including service closures, workforce attrition, and health harms, were likely undercounted at the time of data collection.

Finally, participation required internet access and proficiency in one of five survey languages (English, French, Spanish, Russian, or Arabic), introducing digital and linguistic barriers that may have excluded smaller, less resourced, or non-Anglophone organisations.

Notwithstanding these limitations, the survey provides timely, frontline evidence on the scale and nature of disruptions experienced by harm reduction organisations during a period of acute funding instability. The findings are best interpreted as a rapid, directional account of impacts among a self-selected sample of predominantly African and community-led organisations, well-suited to characterising the texture and lived experience of harm, though not to generating precise population-level estimates or establishing causal attribution.

3.0 Key Findings

This section of the report has been broken into two parts. The first part focuses on patterns and trends over a 14-month period and illustrates important changes that have occurred between the first and second wave of research. The second part of this section, explores new areas of inquiry including:

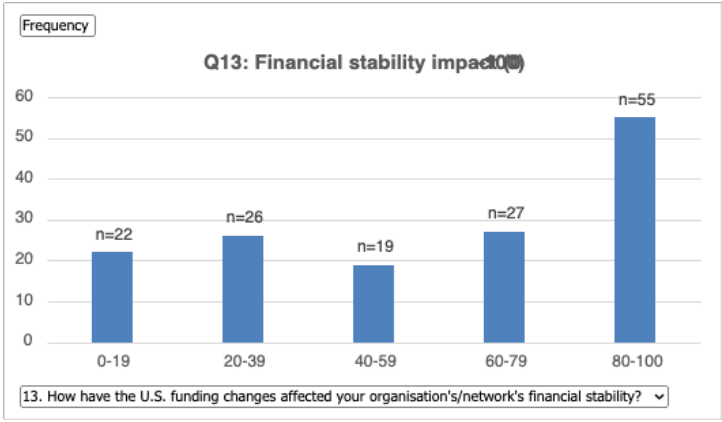
i. Other donor withdrawal and cuts to Official Development Assistance (ODA);
ii. Global Fund mid-cycle reprioritisation of Grant Cycle 7 (GC7);
iii. Domestic financing and transition;
iv. Service disruptions and mitigation strategies;
v. Shifts in policy and legal environments;
vi. Health, safety and security of people who use drugs; and,
vii. Meaningful community engagement in decision-making around planning and resource allocation.

4.1 The Immediate Effects of U.S. Withdrawal on Harm Reduction Organisations

The impact of the U.S. withdrawal of its foreign assistance in January 2025, ruptured essential health service delivery for key and vulnerable populations across low-and middle-income countries, including for people who use drugs. Findings from the second wave of our survey (2026), indicate that these ruptures continue to deepen and funding gaps for harm reduction programming continue to widen thus putting at stake the lives, health and well-being of people who use drugs.

When asked "*How have the U.S. funding changes affected your organisation's or network's financial stability?*", 55% of wave 2 respondents indicated that these policy shifts had greatly or severely impacted their organisation's (or network's) financial stability (Table 2, Figure 4).

Figure 4: Impact of U.S. funding shifts on organisation's financial stability (Q13)

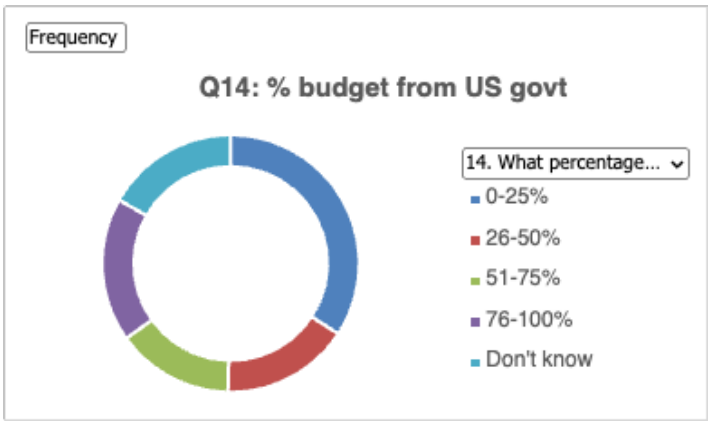


Forty-nine percent (49%) of wave 2 respondents reported having lost between 26-100% of their funding because of the withdrawal of U.S. foreign aid; 33% indicated a loss of 50-100% of their annual budget (Table 3, Figure 5).

As noted in the first edition of The Human Cost of Policy Shifts (2025), losing even 20% of annual revenue has an inevitable impact on the sustainability of an organisation. This is particularly true for small community-led organisations of and for people who use drugs. Drastic drops in revenue inescapably force unfavourable measures that often constrict an organisation's structure, staffing, programming mix, and ability to deliver lifesaving services. For the 33% of the respondents who indicated they had lost 50-100% of their funding, the financial shock has directly translated to devastating consequences for people who use drugs. For the community of people who use drugs, it has impacted their access to lifesaving harm reduction services such as, reductions in the number and availability of sterile needles and syringes, condoms and other health commodities, access to opioid agonist therapy, naloxone kits that help save lives in the event of an overdose, and counselling and information from peer workers who help to keep the community safe and healthy. For the staff, it means financial hardship. It means being furloughed or placed on reduced work hours, many of whom are from the community themselves and who provide core harm reduction services such as peer outreach, peer counselling and peer education.

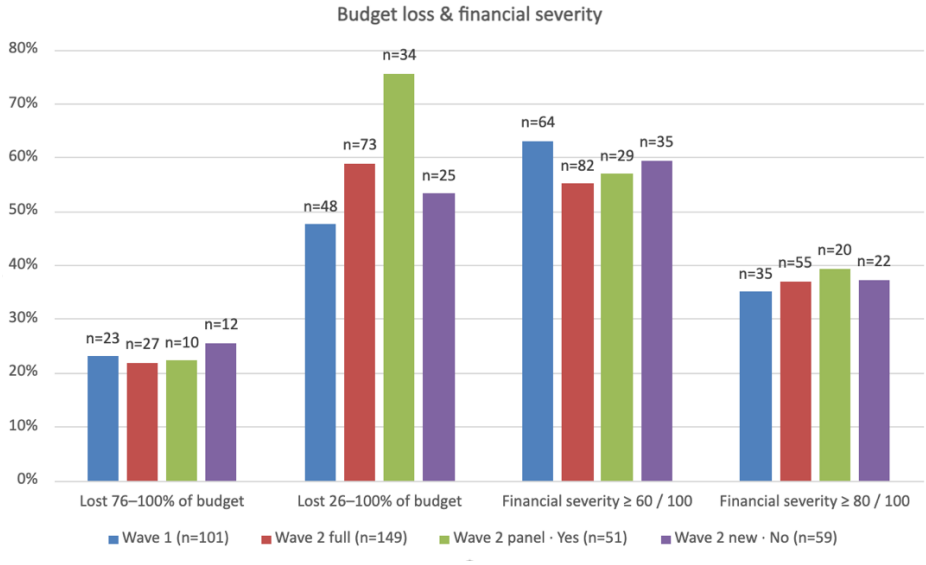
Table 2 and Figure 5: % of organisational budget reliant on U.S. funding

Q14. What percentage of your organisation's budget comes directly or indirectly from the United State	Frequency
0-25%	51
26-50%	24
51-75%	22
76-100%	27
Don't know	25
Grand Total	**149**



When we compare responses across time (Figure 6), 48% of respondents in wave 1 had identified a loss of 26-100% of their funding. Under wave 2, the total number jumped an alarming 11 percentage points (pp) to 59%. Interestingly, when we isolated for repeat respondents (those who had self-reported completing both survey waves), the number rose by an astounding 28 pp to 76%. This means that for the cohort of respondents who participated in both surveys, there are a greater number of organisations who are currently experiencing precarious financial stability as a result of U.S. funding cuts (Figure 6).

Figure 6: Budget Loss and Financial Severity



The analysis is directional in nature because the responses are based on a self-reported quasi-panel rather than an ID-matched panel. Regardless, the message is crystal clear: **Harm reduction organisations, including drug user-led organisations, are confronting a critical funding gap that has placed the sustainability of harm reduction as a human rights and public health approach under urgent question.** (Table 3).

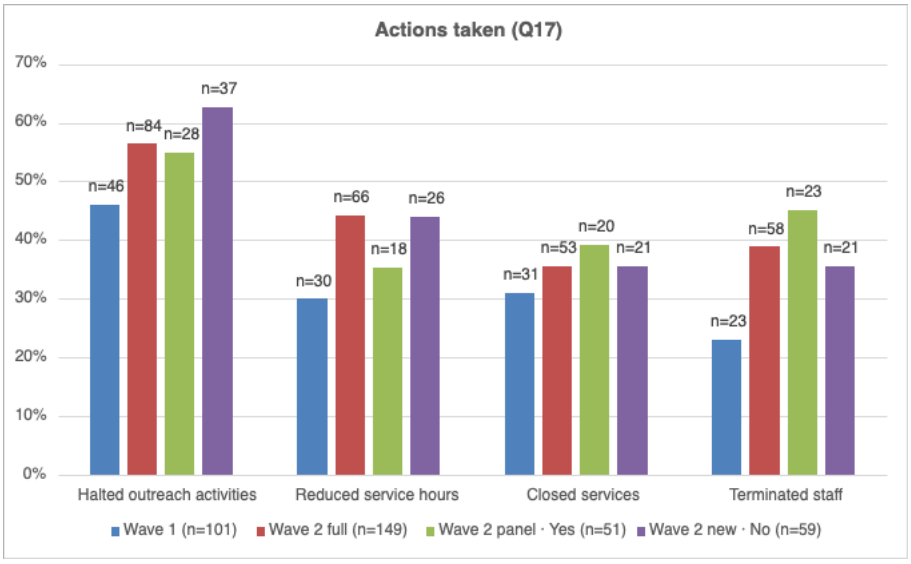
Table 3: Level of Financial Impact

Metric	Wave 1 %	Wave 2 %	Wave 2 panel %	Panel vs W1 (% points)
Lost 76-100% of budget	23%	22%	22%	-0.8 pp
Lost 26-100% of budget	48%	59%	76%	+28 pp
Financial severity ≥ 60/100	63%	55%	57%	-6.1 pp
Financial severity ≥ 80/100	35%	37%	39%	+4.2 pp

In response to the U.S. funding cuts, organisations have been forced to take abrupt mitigating measures (Figure 7). Fifty-six percent (56%) of respondents reported having halted their organisation's outreach activities; 36% indicated that they had closed their services completely; 44% had reduced their service hours; and 39% had terminated staff. Fourteen respondents (9.4%) reported that they had been forced to undertake all four of these actions.

"Many drug user outreach workers and peer educators lost their job, resulting in overburden among those remaining." - Respondent

Figure 7: Mitigating Actions Taken to Offset Financial Losses



Looking at patterns over time (Figure 7), financial challenges have continued to intensify across both survey waves. Figure 7 tells us that organisations who responded during wave 2 were more likely to have halted outreach (63% versus 55% for the panel) and more likely to have terminated staff (39% versus 15%). These findings also show that each mitigating measure has intensified over the 14-months between March 2025 and May 2026. Staff terminations show the sharpest rise (+16 pp, now 39%) and reduced hours are up more than 14 percentage points. This is evidence that the initial cuts in 2025 have moved from initial pauses in service delivery to now what appears to be a deeper, structural downsizing of services and the harm reduction workforce. Remaining staff face heavier workloads, unstable pay, and emotional toll from witnessing community deaths and political hostility.

"Staff burnout and lack of motivation, [it] feels unstable, undervalued, and unsupported" - Community respondent

When we looked at what types of organisations were experiencing these dramatic consequences, we found that among wave 2 respondents who reported having lost 51-100% of their organisational annual budget:

- **71% were community-led organisations or networks of people who use drugs;**
- 14% were local civil society organisations;
- 8% were classified as "Other" (hospital, CCM, global organisation), and
- 6% were international non-governmental organisations (INGOs).

Community-led organisations of people who use drugs excel where traditional healthcare systems often struggle. They develop strong peer-driven connections, foster trust with low-barrier, wrap-around services and culturally safe care. Losing over one half (or more) of one's annual revenue points to the fact that drug user-led harm reduction organisations and networks have been the hardest hit by funding shifts and are on the brink of extinction. Drug user-led organisations are not optional service providers. We are the very agencies that connect often the hardest to reach communities with healthcare and support and yet have the fewest financial reserves to rely upon during times of crisis and system shock. We are the infrastructure of survival for our communities. If we disappear, the people most excluded from health systems will be left with nowhere to go.

When we cross tabulate this data with wave 2 respondent profiles, we are able to see those being hardest hit are located in: i) Africa (44%); ii) Asia (44%); Eastern Europe and Central Asia (30%); MENA region (20%); Latin America and the Caribbean (20%); Global (20%), Other (primarily respondents from the U.S., 20%), the Pacific (14%); and, Western Europe (0%).

3.2 The Immediate Impact of Funding Cuts on Service Disruptions

Table 4 tells us that outreach and peer-led harm reduction services remain among the topmost commonly experienced service disruptions across both survey periods with 41% (2025) and 39% (2026) respectively. Disruption to harm reduction education and training has escalated to the most reported response in 2026, having not even registered in the top 10 responses in 2025. Other increased service disruptions include overdose prevention (25% in 2025 to 27% in 2026), psychosocial support, which rose to the 4th greatest service disruption in 2026; and, needle and syringe programming, which jumped from 23% to 31% in 2026. These notable increases are likely explained by the withdrawal of U.S. foreign assistance compounded by the implications of the Global Fund's mid-Grant Cycle 7 reprioritisation process on harm reduction programming, which took place during the second half of 2025.

Table 4: Top 11 Service Disruptions Across Wave 1 and Wave 2

Top 11 Service Disruptions following U.S. foreign aid work stop orders and terminations (2025)	% of respondents (N=101)	Top 11 Service Disruptions following U.S. foreign aid work stop orders and terminations (2026)	% of respondents (N=149)

Outreach and peer-led harm reduction services	41%
Legal and human rights support	36%
HIV testing	35%
Services for women who use drugs	33%
HIV treatment and care	32%
Services to address gender-based violence	28%
Overdose prevention (Naloxone distribution)	25%
Needle and syringe programming	23%
Hepatitis C testing	20%
Opioid agonist treatment (OAT)	16%
Hepatitis C treatment	16%

Harm reduction education and training	48%
Outreach and peer-led harm reduction programs	39%
HIV testing	35%
Psychosocial support	33%
Needle and syringe programming	31%
HIV treatment and care	30%
Legal and human rights support	28%
Overdose prevention (Naloxone distribution)	27%
Services for women who use drugs	23%
PrEP (pre-exposure prophylaxis)	23%
Hepatitis C testing	22%

"There has also been a noticeable increase in transmission of HIV as recent test statistics in my locality indicate." - Respondent

"There are increases in overdose deaths, increases in death among community members living with HIV and increases in new infections" - Respondent

While disruptions to HIV testing among people who use drugs remained relatively consistent across the two survey periods (35% in 2025; 35% in 2026), **the 8-percentage point spike in disruptions to needle and syringe programming should raise alarm bells.** Low threshold access to free sterile injecting equipment provided by needle and syringe programming is shown to reduce HIV transmission among people who use drugs by approximately 50% and 76% for hepatitis C infection. Decades of international evidence collected by the World Health Organisation (WHO) and the Centres for Disease Control and Prevention (CDC) demonstrate that these programmes serve as the cornerstone for effective harm reduction strategies and the prevention of bloodborne infections. Needle and syringe programming is also in many cases, the first point of contact with people who use drugs and because of this, are vital gateways to a breadth of comprehensive health and social support services. **The absence of such programming may mean that community members** remain entirely out of reach, allowing epidemics of HIV, HCV, and tuberculosis (TB) to spread unchecked**.**

"Most of our beneficiaries have gone back to unsafe injecting practices". - Respondent

"People who use drugs are switching from opioids to stimulants due to limited harm reduction services for opioid use". - Community respondent

3.3 The Immediate Effects of Service Disruptions on the Community of People who Use Drugs

Over the last two survey periods, the most reported problems experienced by people who use drugs as a result of service disruptions include: (Table 6)

- ✓ Experiences of stigma and discrimination (jumped from 60% to 77%)
- ✓ A lack of access to harm reduction supplies (spiked from 47% to 64% in 2026)
- ✓ Experiences of increased policing or criminalisation (increased from 42% to 64%), and
- ✓ Reliance on underground/informal networks for accessing harm reduction supplies (46% to 47%).

It is important to note that in the 14-months between March 2025 – May 2026, the reported incidence of overdose in the community climbed a stark 13 percentage points (from 30% to 43%). The data shown here, further compounds the findings from above. For instance, the steep percentage point increase across each of these categories reveals burgeoning levels of stigma, low access to harm reduction supplies (likely related to the closure/reduced hours of needle and syringe programming) combined with higher police surveillance and harassment. Each of these occurrences signify crucial factors that drive people into hiding, away from available services and into high-risk environments for HIV transmission and other bloodborne infections. Furthermore, the stark increase in disrupted overdose prevention activities is particularly alarming given the 13 pp increase in overdoses recorded by the community across the two survey periods (30% to 43% in 2026). **We are witnessing the brewing of a perfect storm.**

"The drug supply has gotten more toxic making toxic drug poisonings complex" - Community respondent

"We have lost 8 drug users from September to date…Many are dying before they find help - People will die without services & supplies." - Community respondent

Table 5: Most Reported Problems Experienced by People who Use Drugs

Problems Reported	Wave 1 (2025)	Wave 2 (2026)	% change (pp)
Increased stigma and discrimination	60%	77%	+17%
No access to harm reduction supplies	47%	64%	+17%
Increased policing or criminalisation	42%	64%	+22%
Reliance on underground/informal networks	46%	47%	+1%
Increase in overdoses in the community	30%	43%	+13%

One of the key takeaways here is that service disruption to harm reduction programming remains at very high levels. The emergency is no longer solely a financial one. The downstream harms to people who use drugs are also quickly escalating. Today, we are observing the consequences of a

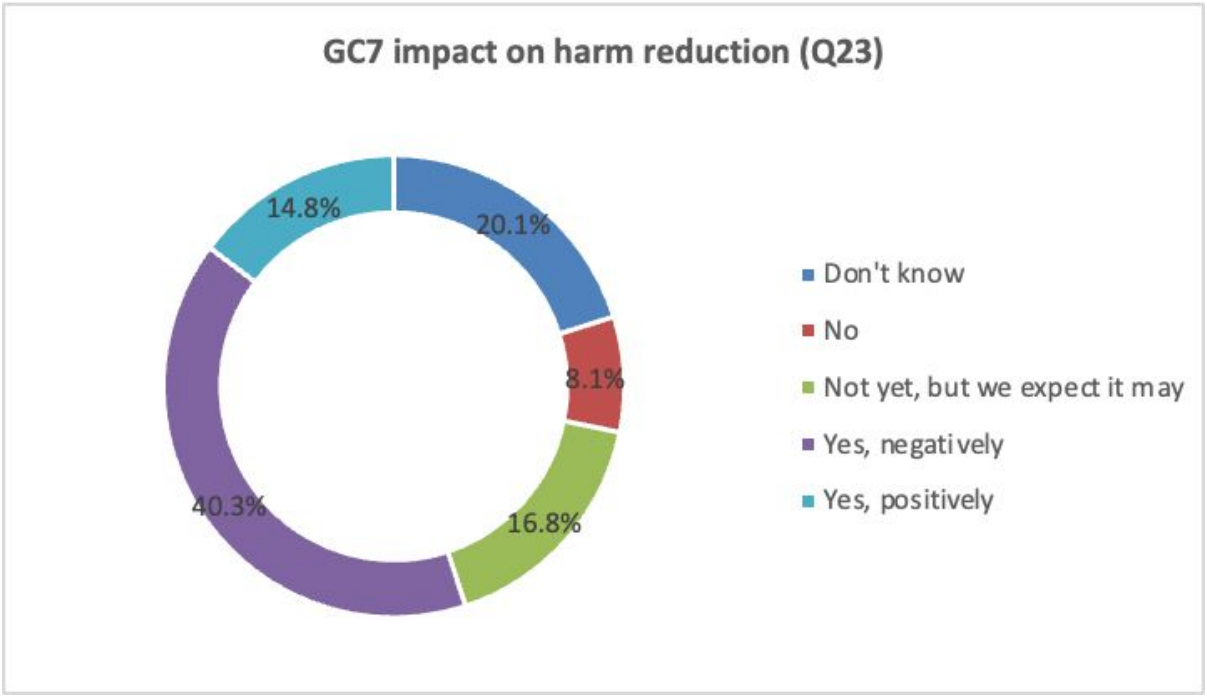
year of service disruption, and **the crisis is now transitioning to a state of emergency for the rights, dignity and lives of our community.**

3.4 The Double Hit: The Impact of the Global Fund GC7 Mid-Cycle Reprioritisation Process on Harm Reduction

As we transition now to the second part of our findings, we begin by looking at the double impact of broader, concurrent funding shifts. These include the Global Fund's Grant Cycle 7 (GC7) mid-cycle reprioritisation process, other donor withdrawal, ODA reductions and the implications of other funding challenges on the health and sustainability of harm reduction organisations and networks.

The Global Fund remains the single largest international funder of harm reduction in low- and middle-income countries.[i] At the beginning of the last grant cycle (GC7 in 2022), the Global Fund accounted for 49% of total harm reduction funding and 73% of total donor funding to LMICs. The Global Fund's mid-cycle reprioritisation process in GC7, which began in mid-2025, would bring another round of financial shocks and disruption to harm reduction interventions in the countries where it invests. While the Global Fund has yet to announce the total funding reductions across each programme area in its portfolio, analysis provided by Harm Reduction International (HRI) points to a total reduction of USD 12.83 million for harm reduction programming across 24 countries. Our wave 2 survey findings suggest that the GC7 reprioritisation process catalysed a second round of financial shocks for organisations delivering harm reduction services at country level.

Figure 8: The Impact of Global Fund's GC7 Reprioritisation Process on Harm Reduction Programming

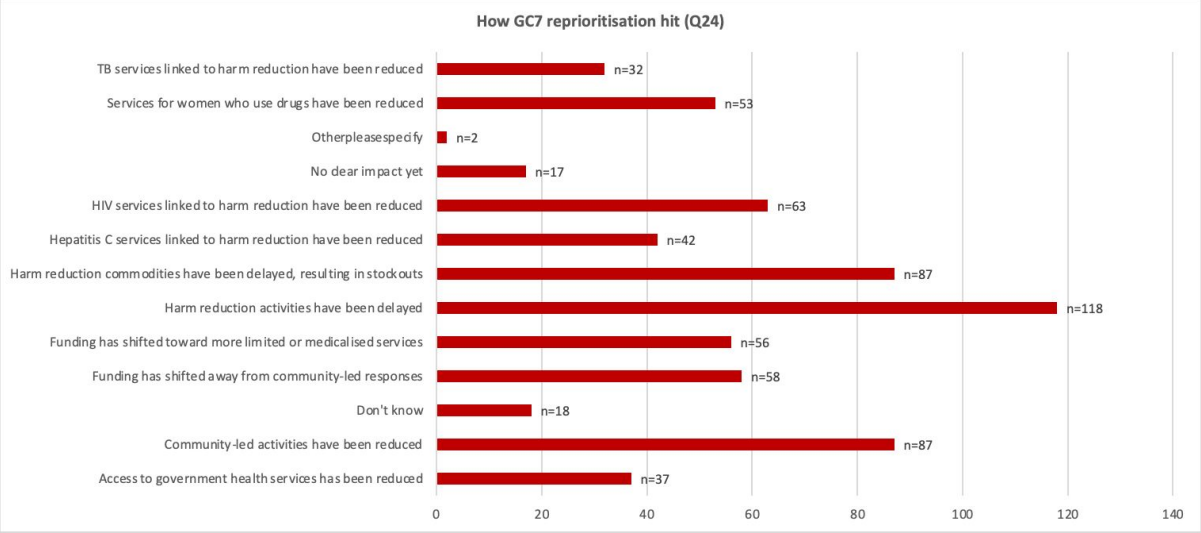


Whilst 15% indicated that the reprioritisation process had brought positive results for harm reduction programming in their country (e.g., expansion to new provinces/districts, introduction of or expansion of OAT), a large group of respondents (40%) expressed negative outcomes (Figure 8).

Deeper cross-analysis within wave 2 found that the organisations most dependent on U.S. funding were also the most exposed to the impacts of the Global Fund's GC7 reprioritisation process. The key takeaway here is the nature of the 'double hit': the funding shocks appear to be concentrated among the same community-led organisations. In other words, among the most U.S.-dependent organisations (76-100% of their budget), 63% also reported negative impact from the outcome of the Global Fund GC7 reprioritisation process. Relatedly, community participation in decision-making processes has shown no protective effect: closure rates are similar across organisations regardless of whether communities were 'at the table' (19% versus 17%).

"Reprioritization of GF cycle 7 PWUD priorities led to key empowerment programs and security interventions being dropped... The peer led program was minimized as some peer educators and outreach workers were laid off" - Respondent

Figure 9: How GC7 Reprioritisation Affected Access to Harm Reduction and Related Services



As depicted in Figure 9, the impact of GC7 reprioritisation has been substantial and wide sweeping across harm reduction interventions and settings. Of the149 respondents:

- 79% indicated that harm reduction activities have been delayed
- 58% pointed to delays in harm reduction commodities resulting in stockouts
- 58% noted that community-led activities have been reduced
- 42% reported reductions in HIV services linked to harm reduction programming
- 38% reported a shift in funding towards more limited or medicalised services
- 36% indicated reductions in service availability for women who use drugs
- 28% noted reductions to hepatitis C services linked to harm reduction programmes

- 22% noted reductions in TB services that were linked to harm reduction programmes.

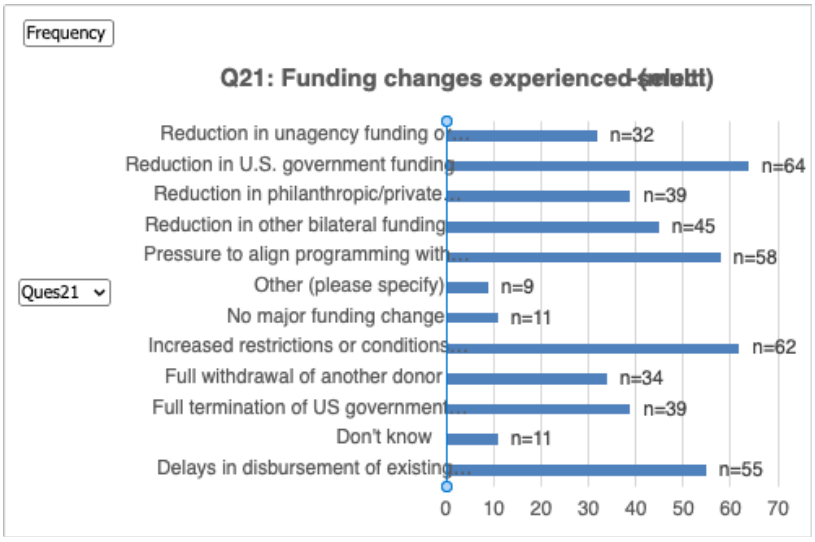
3.5 And, The Triple Hit: The Impact of Broader Financial Policy Shifts on Harm Reduction Programming

Figure 10 uncovers an increasingly bleak picture and a much broader, more substantial funding crisis for harm reduction, and for community-led harm reduction responses in particular. In addition to the reductions and/or full termination of American funding, coupled with the negative impacts resonating from the GC7 reprioritisation process, respondents articulated other financial pressures and the concomitant loss of financial support from other funding sources. This phenomenon is reflected by the withdrawal of other donors of harm reduction as well as reductions to bilateral funding, reductions to philanthropic and UN funding for harm reduction and drug user-led service delivery. Additionally, grant disbursement challenges have increased causing delayed grant payments and more stringent grant requirements for grantees.

Respondents observed:

- The full withdrawal of another donor (23%)
- Reductions to other bilateral funding (30%)
- Reductions to philanthropic/private donor funding (26%)
- Reductions in UN funding or support (22%)
- No major funding change (7%)

Figure 10: Funding Changes Experienced (Q21)



Alongside these monumental shifts, respondents indicated supplementary pressures having contributed to even further stress on the organisation's already thinly stretched capacity and fiscal space. These additional constraints include:

- ✓ Delays in disbursements of existing project funds (37%)
- ✓ Increased restrictions or conditions attached to project funding (42%)
- ✓ Pressure to align programming with new government or donor priorities (meaning, not necessarily aligned with community priorities) – (39%)

When asked, "*What is the current status of harm reduction services in your setting*" (Q26), wave 2 respondents spoke of delays, closures, reduced access, and stockouts.

Table 6: The Current Status of Harm Reduction

26. What is the main current status of harm reduction services in your setting?	Frequency
Services are continuing but at reduced scale	44
Some services have closed permanently	19
We are experiencing stockouts or reductions in harm reduction materials	18
Services are continuing but with interruptions	18
We are relying mainly on informal/community-led responses	17
Services are continuing as normal	16
Some services have closed temporarily	10
Don't know	7
Grand Total	**149**

Forty-two percent (42%) of wave 2 respondents confirmed that services were currently running at a reduced scale or with interruptions. Only 11% indicated that services in their setting were continuing as normal. Thirteen percent (13%) observed the permanent closure of some harm reduction services; 7% indicated only temporary closures. **Importantly, 12% of respondents expressed recent experiences of stockouts or reductions in the availability of harm reduction supplies, and 11% pointed to a reliance on informal networks or community-led responses for their harm reduction needs.**

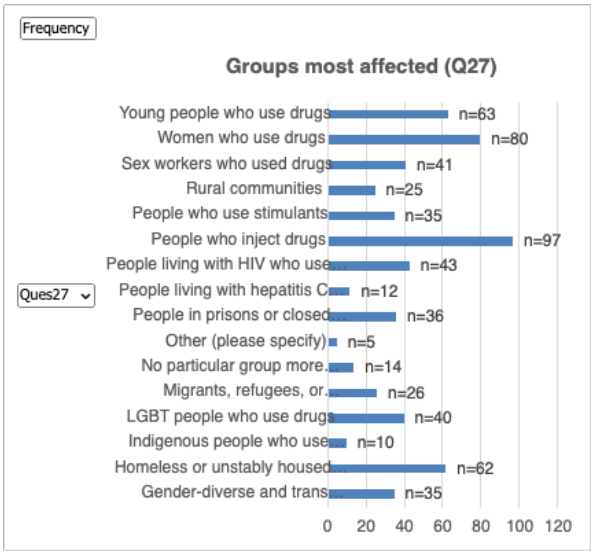
Together, these findings are prime illustrations of the knock-on impacts of the U.S. withdrawal of its foreign assistance. Our findings show the direct effects of funding cuts on the health and sustainability of drug user community-led organisations, as well as the impact of Global Fund rebudgeting/reprogramming on harm reduction programming. Our findings similarly speak to the broader financial ecosystem buckling under pressure because of shifting geo-political priorities away from HIV and global health more broadly, towards national priority-setting for trade, defence and military spending. The USD 5 billion shortfall in the Global Fund's 8th Replenishment outcome forewarns of difficult trade-offs and prioritisation processes going forward under Grant Cycle 8 as a result of much smaller country funding envelopes. This does not bode well for our community of people who use drugs and the drug user-led organisations and will require intensive strategic advocacy and engagement strategies at the country level.

The 'domino effect' of the U.S. funding cuts is the most consistent pattern in our dataset. Reprioritisation, integration into primary healthcare systems, and competitive grant landscapes are systematically observed as favouring larger organisations and 'life-saving commodities' over community engagement, peer education, advocacy, and women-specific care. Respondents warn that the collapse of these services dismantles the trust infrastructure that is so critical to ensuring that prevention services and health commodities reach the hands of and are appropriately used by the drug user community at all.

"Ongoing uncertainty erodes trust in systems at large and may ultimately impact our rapport with those we serve" - Respondent

"People are withdrawing; they have stopped approaching NGOs for services" - Respondent

Figure 11: Groups Most Affected by Funding Changes and Policy Shifts



In Q27, the survey captures broad categories and does not necessarily account for the depth of intersectionality across the drug user community. In response to, "*Which groups are being most affected by current funding changes and policy shifts in your setting?*" (Figure 11), more than half of respondents reported women who use drugs (54%) as the most impacted group experiencing the greatest reductions in services (see Q24, Figure 9). Other groups most affected include, young people who use drugs (42%), homeless or unstably housed people who use drugs (42%), people living with HIV who use drugs (29%), LGBT peoples (27%), including trans and gender diverse people (23%), and people who use drugs in prisons or closed settings (24%).

"*Mobile MAT [medication assisted treatment] services which favoured women who use drugs and sex workers who use drugs have shut down, GBV [gender-based violence] response services have been reduced drastically... child-friendly spaces at drop-in centres are no longer available*" - Community respondent

When asked "*Are services for women who use drugs currently being affected in ways that are different from the broader harm reduction response?* (Q28)", 42% of Wave 2 respondents agreed with this statement, 33% indicated not knowing, and 25% disagreed. Responses from across this survey point to the pressing need for further research to better understand the extent to which women, LGBT, trans and gender diverse people who use drugs are being affected by this new funding environment, and what health and development responses are needed.

"Most programs directed to Sex Workers have been permanently stopped" - Community Respondent

"They don't want us to help the LGTBQ" - Respondent

3.6 The Impact of Shifting Funding and/or Policy Environments on People who Use Drugs

From our findings, there is a clear correlation between the shifts in the funding environment and the increase in punitive drug policy landscapes. To the question, "*To what extent have recent funding changes or policy shifts contributed to a more punitive environment for people who use drugs*? (Q29)", an overwhelming majority of respondents (73%) agreed with this statement and identified moderate or significant examples of increased punitive environments targeting people who use drugs (Figure 12).

"Many immigrants are in too much danger to be seen in public and accessing services." - Respondent

"When the state acts as a punitive body, our only hope lies with international donor and human-rights organisations" - Respondent

Figure 12: Impact of Funding and/or Policy Shifts on Punitive Environments for People who Use Drugs

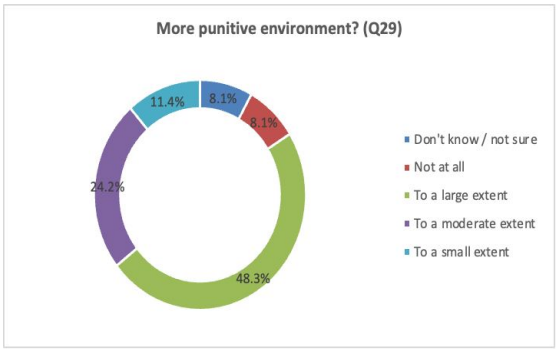
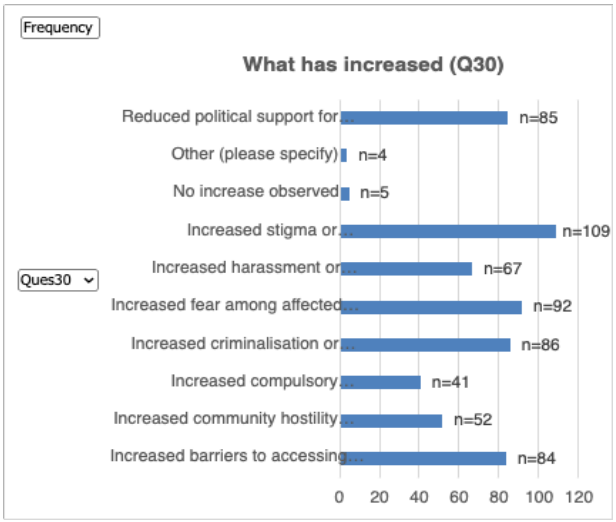


Figure 13: What Changes Have Increased in Your Setting?



A large majority of respondents (73%) identified increased experiences of stigma or discrimination toward people who use drugs. Other changes in local environments include (Figure 13):

- 62% witnessing increased fear among affected communities
- 58% observing increased criminalisation or policing of people who use drugs
- 57% noticing reduced political support for harm reduction
- 56% identifying increased barriers to accessing services
- 45% aware of increased harassment or violence by authorities
- 35% noting increased hostility or scapegoating
- 27% seeing an increase in compulsory treatment or detention
- Only 3% of respondents noted no increase to changes in connection with the shifts within funding and policy environments

Respondents in the U.S., Asia and Africa reported an intensified police presence, including raids on hotspots, arbitrary arrests, ICE activity, and harassment of harm-reduction workers and unhoused people who use drugs.

"*Police have been steadily harassing employees for the last year*" - Respondent

This raises immediate concerns about the safety and security of people who use drugs and their service providers, particularly as environments become increasingly dangerous for community members. These shifting environments magnify the importance of negotiated safe spaces provided by community-led harm reduction services and the knock-on consequences of collapsing sources of funding, service closures and tenuous policy shifts. Our communities are being forced into hiding at the exact moment when services are disappearing. This is a deadly combination. When sterile equipment is unavailable, when outreach workers are harassed, when police presence increases, and when people fear being seen accessing services, preventable deaths and infections become inevitable.

"Clients increasingly refuse to provide phone numbers due to confidentiality, stigma, mobilization and safety concerns" - Community respondent

At the same time, many countries around the world have increased repressive steps to further criminalise behaviours and population groups. They threaten to revoke access to opioid agonist therapy, shut down harm reduction programming, shutter safe injection sites, and have instilled restrictive policies on non-governmental organisations providing services to the community. Drug user-led and other harm reduction organisations are working in increasing repressive and constrained environments of increased administrative audits, reporting, surveillance, and shifting governmental and external donor priorities. Without adequate support, drug user-led harm reduction initiatives will be eviscerated.

"Suddenly everything we were working toward was [now] banned language" - Community respondent

3.7 Policy, Decision-Making and Government Response

When asked about their engagement in their country/regional Global Fund Country Coordinating Mechanism (CCM), only 28% responded affirmatively. Forty-seven percent (47%) indicated no involvement with their CCM. Twenty-five percent (25%) were unsure. Only 11% of respondents noted the consistent and meaningful involvement of people who use drugs and/or community-led organisations in recent decisions about funding changes, reprioritisation, transition, and/or service continuity in their setting. Fifty-two percent (52%) acknowledged their irregular (partial) engagement.

In response to, "*Which spaces has your organisation or network been able to raise concerns or influence decisions*", 42% answered that they have engaged in Ministry of Health or other governmental processes. Thirty percent (30%) indicated that they were able to engage in Global Fund grant-making and revision processes; 29% noted their engagement in Global Fund Country Coordinating Mechanisms.

Table 7: In Which Spaces Have Your Organisation/Network Been Able to Raise Concerns or Influence Decisions?

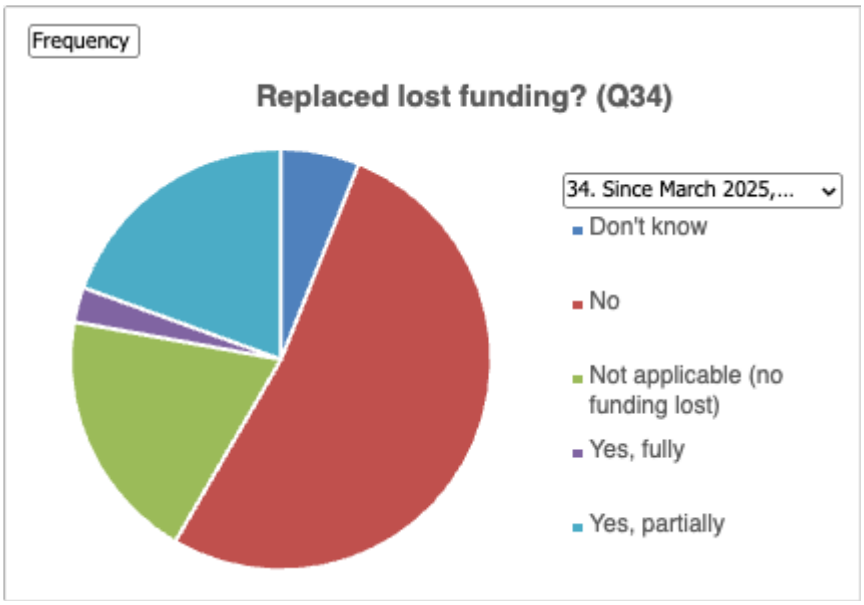
Policy Spaces	Percentage (multi-select)
Ministry of Health or other government process	42%
Global Fund grant-making or grant revision process	30%
Global Fund Country Coordinating Mechanism (CCM)	29%
We have not been included in any such space	26%
National AIDS Coordinating Body	24%
Drug policy or narcotics policy process	22%
Donor consultation	21%
Emergency response/continuity planning process	14%
UN agency process	9%
Other	6%

"Community-led organizations should be part of decision making so that the interests and actual needs of the community will be heard." - Respondent

3.8 Adaptive Measures and Advocacy Priorities

Of the 149 respondents in wave 2, the majority (52%) have not successfully identified replacement funding while 22% have been able to partially (n=29) or fully (3%; n=4) replace the funding lost. Nineteen percent (19%) of respondents indicated they had not lost funding due to the U.S. policy shifts.

Figure 14: Has Your Organisation Been Able to Replace Lost Funding Due to U.S. Funding Shifts?



So how have organisations been able to adapt to this rapid set-change of the HIV financial architecture? The top three responses show a real downsizing of harm reduction services, personnel, and the shrinking of organisations. On the flip side, these findings also illustrate resilience, tenacity and dedication of the sector as organisations work to strengthen referral services through strategic collaborations with other service providers. Volunteerism is on the rise as is a greater reliance on unpaid peer-led responses. These solutions, while valiant, are short-term fixes and will never contribute to the goal of sustainability. Several respondents implicitly warn that donors are treating this resilience as a substitute for funding rather than evidence of a crisis. Some organisations are intensifying advocacy at state/provincial level, pursuing legal channels to halt service disruptions, or engaging in GC8 grant writing as a strategic priority.

Table 8: Adaptive Measures to Offset Funding Restrictions

Adaptive Measures	Percentage (multi-select)
Prioritising only core services	44%
Increasing volunteer or peer-led responses	40%
Referring clients to other services	37%
Increasing advocacy with donors/governments	37%
Diversifying funding sources (e.g., new donors, new funding streams)	37%
Sharing commodities/resources with partner organisations	36%
Reducing staffing or stipends	34%
Seeking domestic government support	27%
Reducing geographic coverage	24%
Seeking emergency bridge funding	23%
Integration with government services	22%
Seeking global funding, reprogramming, or emergency flexibility	21%
Using underground or informal community distribution channels	18%
We have not been able to adapt	7%

“Any funding opportunities are supposed to be channelled to community-led organizations."- Respondent

"Stop funding the same regional and national networks. Impossible to compete with monopolists." - Respondent

As the final section in the survey, respondents were invited to share their top three (3) advocacy asks, or priorities. It is of no surprise that the growing funding gap, the sustainability risks to harm reduction and community-led service delivery, and the safety and security of people who use drugs have risen as the most prominent and urgent concerns of the sector today. Only with greater funding support, political commitment and improved legal environment will the calculus of today change for the better. Without this change, drug user-led organisations are running up against a financial cliff. Without them, we are likely to see a return to the past with spiking rates of HIV and HCV among our community.

Table 9: Top Priority Advocacy Asks

Top Advocacy Asks:	Percentage
Flexible / core funding for community-led organisations	44%
Immediate emergency funding for harm reduction	40%
Protection of community-led and peer-led services	40%
Legal and human rights protections for people who use drugs	30%
Protection of HIV treatment and care access	24%
Protection of NSP and OAT	21%
Protection of services for women who use drugs	21%
Greater community participation in funding and implementing decisions	16%
Global Fund flexibility / reprogramming for harm reduction	15%
Domestic financing to sustain harm reduction	14%
Opposition to punitive drug policy shifts / “narcoterrorism” framing	13%
Better donor coordination and transparency	3%

4.0 Key Messages and Call to Action

Our Call to Action is guided by the findings of wave 1 and 2 of our global survey on the *Human Costs of Policy Shifts*. Our analysis signals an alarming escalation in the drivers of a looming, but fully preventable, public health and human crisis. Indeed, without rapid and increased investment in harm reduction, and community-led harm reduction programming and services in particular, ‘a perfect storm’ is on the very near horizon for the lives of our community.

Over the span of the last 14 months, we have seen no alternative solutions coming to the fore to ensure the continuity of equitable access to harm reduction services. Little alternative funding has helped to bridge service closures of HIV/hepatitis C prevention, treatment, care and support for

and by our community. Our lives and lived realities, our leadership, innovations and commitment are being erased in the name of "integration". Fourteen months since the original financial shock and the fallout has only deepened, inequity has widened, and the environment has gotten much harder for community members and community-led organisations alike.

EIGHT KEY MESSAGES are drawn from our findings:

1. **The health, rights and dignity of people who use drugs are being pushed underground.** The emergency is no longer solely a financial one. The downstream harms to the community are also quickly escalating. Today, we are observing the consequences of a year of service disruption, and **the crisis is now transitioning to a state of emergency for the rights, dignity and lives of our community.**

2. **Significant and ongoing disruption to needle and syringe programming (NSP) is setting off our alarm bells.** Low threshold access to free sterile injecting equipment provided by needle and syringe programming reduces HIV transmission among people who use drugs by approximately 50% and 76% for hepatitis C infection. Needle and syringe programming is also in many cases, the first point of contact with people who use drugs and because of this, are vital gateways to a breadth of comprehensive health and social support services. The absence of such programming increases the likelihood that community members **remain entirely out of reach, allowing epidemics of HIV, HCV, and tuberculosis (TB) to spread unchecked**.

3. **Drug user community-led organisations/networks are confronting a critical funding gap.** Community-led responses can't exist on volunteerism and goodwill alone, they need to be funded with direct, flexible and predictable funding.

4. **The triple hitter: drug user-led harm reduction organisations and networks have been the hardest hit by funding shifts and are on the brink of extinction.** Our findings show the funding shocks to be concentrated among the same community-led organisations. The first financial shock was the U.S. withdrawal of its foreign assistance. The second wave of financial shock was the Global Fund's GC7 reprioritisation process. The triple hitter has been the withdrawal and changing priorities of other donors, including bilateral government programmes, philanthropies, and UN agencies. Relatedly, community participation in decision-making processes has shown no protective effect: closure rates are similar across organisations regardless of whether communities were 'at the table' (19% versus 17%).

5. Spoiler alert: we know this story because we've been here before. Steep increases in service disruptions are giving way for burgeoning levels of stigma, low access to harm reduction supplies (likely related to the closure of NSPs) combined with higher police surveillance, harassment and punitive legal environments. Each of these occurrences signify crucial factors that drive people into hiding, away from available services and into high-risk settings for HIV transmission and other bloodborne infections. Stark increases in disrupted overdose prevention activities across the two survey periods (30% to 43% respectively) shows that we are witnessing the brewing of another perfect but preventable storm.

6. **The connection is clear: the shifts in the funding environment are happening in tandem with increased punitive drug policy landscapes.** Intensified police presence, raids on hotspots, arbitrary arrests, ICE activity, and harassment of harm-reduction workers are driving our community further underground and making it difficult for our organisations to provide the services needed. Repressions on civic space in many countries is making it a *challenging operating environment* for community-led organisations, outreach workers, and for people who use drugs.

7. Women who use drugs are identified as the most impacted group experiencing the greatest reductions in services in addition to the category of people who inject drugs. Further research is urgently needed to better understand the extent to which women, lesbian, gay, bisexual, trans and gender diverse people who use drugs are being affected by this new funding environment, and what health responses are needed.

8. Advocacy priorities – It is of no surprise that the growing funding gap, the sustainability risks to harm reduction and community-led service delivery, and the safety and security of people who use drugs have risen as the most prominent and urgent concerns of our community today. Financial mechanisms at global, regional and national level must urgently respond in a coordinated manner to prevent service collapse and resultant public health crisis with spiking rates of new HIV/HCV infections and preventable overdose deaths.

CALL TO ACTION:

1. Alternative pooled funding mechanisms must be urgently established by global and regional partners to prevent service collapse and resultant spiking rates of new HIV/HCV infections, and preventable overdose deaths.

2. National governments must step up to support harm reduction services, including equitable access to opioid agonist treatment (OAT) and social contracting arrangements that prioritise community-led responses.

3. International and multilateral organisations must prioritise resource allocation to affected programs and key populations, including people who use drugs.

4. Advocacy efforts must be intensified to restore funding and highlight the long-term public health consequences of such dramatic funding and policy shifts.

[i] The Global Fund Advocates Network (GFAN). (2025). Fully Fund the Global Fund: Harm Reduction Brief.