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MEASURING THE SUSTAINABILITY OF OPIOID AGONIST THERAPY (OAT)

A GUIDE FOR ASSESSMENT IN THE CONTEXT OF DONOR TRANSITION

DECEMBER 2019

This guide was initiated by the Eurasian Harm Reduction Association to provide countries with an approach and tools to assess their progress in building the sustainability of opioid agonist treatment within the context of donor transition. This material builds upon previous assessment frameworks and experiences in measuring sustainability and transition readiness in the areas of HIV, tuberculosis, malaria, and harm reduction. Unlike other tools and instruments, this guide provides a much deeper analysis into one specific intervention – opioid agonist treatment – and, in particular, its programmatic elements and heavily relies on international policy related to, and programmatic guidance on, opioid agonist therapy. This publication is available in the English and Russian languages.

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Abbreviations

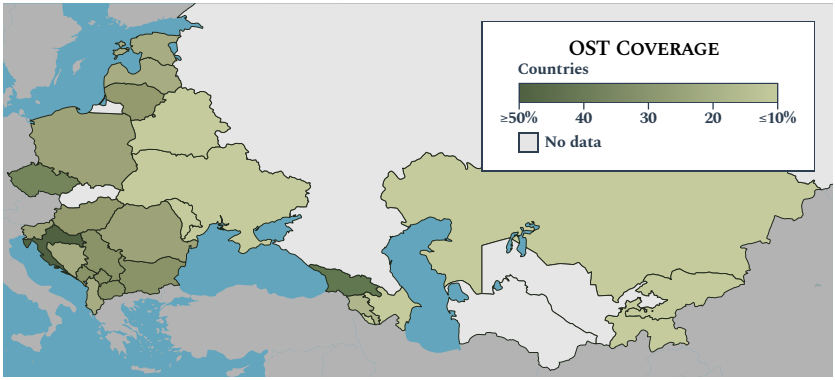
ART	Antiretroviral Treatment
CCM	Country Coordinating Mechanism
CEECA	Central and Eastern Europe and Central Asia
CESCR	United Nations Committee on Economic, Social and Cultural Rights
ECDC	European Centre for Disease Prevention and Control
EECA	Eastern Europe and Central Asia
EHRA	Eurasian Harm Reduction Association
EU	European Union
FGD	Focus Group Discussion
GAM	Global AIDS Monitoring
GAVI	Global Vaccine Alliance
GF	See Global Fund
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDUIT	Injecting Drug User Implementation Tool
INCB	International Narcotic Control Board
INPUD	International Network of People who Use Drugs
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MAT	Medication-Assisted Treatment
MDR-TB	Multi-Drug Resistant Tuberculosis
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NIDA	United States National Institute on Drug Abuse
OAT	Opioid Agonist Therapy
OMT	Opioid Maintenance Treatment
OST	Opioid Substitution Therapy (another term for OAT)
PEPFAR	The United States President's Emergency Plan for AIDS Relief

PSM	Procurement and Supply Management
PWID	People Who Inject Drugs
SDG's	Sustainable Development Goals
SID	Sustainability Index and Dashboard (PEPFAR)
TB	Tuberculosis
TOR	Terms of Reference
TPA	Treatment Preparedness Assessment (Curatio)
TRAT	Transition Readiness Assessment Tool (EHRA)
UCLA	University of California, Los Angeles
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Introduction

Context

The majority of countries in Central and Eastern Europe and Central Asia (CEECA) developed their opioid agonist therapy (OAT) programmes — often also referred to as opioid substitution therapy (OST) — by relying on international support. The reported coverage of the estimated number of people with opioid dependence remains under 10% in a number of countries, with the lowest coverage reported in Kazakhstan (0.4%) and Azerbaijan (1.5%), followed by Tajikistan, Moldova, Ukraine, Belarus, Kyrgyzstan and Armenia. The greatest coverage is reported in Croatia (55%), Georgia (49%) and the Czech Republic (38%). The Baltic States and the remaining countries of Central and South-Eastern Europe have programme coverage of between 10% and 30%[1].



Coverage of opioid agonist therapy in Central and Eastern Europe and Central Asia. UNAIDS Key Population Atlas, 2019.

[1] Based on the latest available data from the UNAIDS Key Population Map as of November 2019. Data was not available from the Russian Federation, Slovakia, Uzbekistan and Turkmenistan; other sources confirm that such programmes are not available in those countries, except Slovakia.
http://www.aidsinfoonline.org/gam/libraries/aspx/home.aspx

Domestic public, and in some cases private, sources now fully fund OAT in Central Europe, most of South-Eastern Europe and the Baltic States. Several countries of Eastern Europe and Central Asia (EECA), notably Azerbaijan, Belarus, Georgia, Kazakhstan and Ukraine, started to finance, or co-finance, OAT services from domestic funds, while others continue depending on donor support, largely from The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

As the Global Fund reduces its support in the EECA region, OAT programme managers, researchers, service providers and clients are raising their concerns regarding the future of OAT once donor support and international technical assistance cease to be provided.

Purpose

This Guide provides an approach and tools for countries to take stock and assess the sustainability of OAT within the context of transitioning out of Global Fund, and other donor, support. This assessment covers the current situation, progress achieved, risks, and opportunities for sustainability with a focus on programmatic aspects of OAT.

Whilst this Guide has been developed for countries of the EECA region, it can be adapted for use in other regions facing similar issues. Due to the unique focus on programmatic sustainability, this Guide is built on a combination of existing tools for measuring preparedness for transition, particularly the *Transition Readiness Assessment Tool* (TRAT) for Harm Reduction[2] and tools for assessing OAT services.

[2] Transition Readiness Assessment Tool (TRAT) — User Manual Version 1.0: Assessing the Sustainability of Harm Reduction Services Through and Beyond the Transition Period from Global Fund Support to Domestic Funding. Vilnius; Eurasian Harm Reduction Network, August 2016. https://harmreductioneurasia.org/wp-content/uploads/2019/01/transition-readiness-assessment-tool-user-manual_final_0.pdf, and, https://harmreductioneurasia.org/wp-content/uploads/2019/01/ehrn_trat_final_2016.xlsx

Structure

This publication is comprised of three main parts:

A ***Measurement Framework***
This outlines a conceptual approach to a country assessment including definitions; areas at issue; indicators for measuring sustainability and the effects of transition; rationale of the selected approach; links to other frameworks; and key programmatic guidance for OAT. Assessors will find this component of the Guide instrumental when/if they decide to adapt these tools to a specific country context. Additionally, this component can be used to provide national stakeholders with an overview for the measurement of sustainability.

B ***National Assessment Guidance***
This component is designed for use by an assessment team. It provides an overview of the methods, and a step-by-step process, for preparing, implementing and utilising the results of an assessment.

C ***Annexes and Tools***
Annexes to this Guide provide an overview of existing frameworks; a reporting template; tools for collecting information that detail the dimensions, benchmarks and indicators as well as guidelines for conducting interviews and focus group discussions.

What is needed for a national assessment?

A national assessment undertaken through use of this Guide will be of a small scope, involving up to approximately 12–15 working days for a researcher over a period of two months by conducting a desk review, key informant interviews (KII) and focus group discussions (FGD). Informants will comprise of government officials, including those responsible for OAT management and financing, service providers, international donor(s) who fund, or previously have

funded, OAT as well as civil society advocates and expert activists from the community of people who use drugs who can speak to the experiences of OAT clients.

Engaging an advisory group is recommended to provide advice on the adaptation of the methodology, to support access to literature for review and identification of interviewees, as well as to shape the recommendations to be implemented. This group can assist in planning the presentation of assessment results and specific advocacy follow-up. Alternatively, a focus group with relevant stakeholders can be organised to discuss preliminary results and to formulate specific recommendations.

Whilst the methodology does not foresee the need to survey a representative pool of OAT clients given its limited scope, the existing client reports and testimonies could be used as part of the desk review. Moreover, expert activists representing OAT clients should be included among interviewees and as part of an advisory group; a separate focus group with OAT clients is highly recommended.

In some country contexts, getting ethical approval may help advocacy efforts by increasing the credibility of the research results with the government. However, obtaining such clearance might be lengthy and incur additional cost. Similarly, engaging a neutral researcher from academia might help with increasing the acceptance of the research results among officials.

The assessment should be conducted by a national expert with the following attributes:

- Good knowledge of the national state system related to the management of opioid dependence;
- Preferably with links to national advocacy networks;

- Good access to relevant stakeholders to be interviewed, including community members, OAT client groups, experts and government officials;
- Experience of similar assessments and a strong record of adherence to evidenced-base approaches;
- No conflict of interest (no shares, consultancies, income from manufacturers and distributors of medicines used for OAT or by private service providers);
- Fluent in English or Russian and the national language; and,
- Proven set of skills for interviewing, conducting a literature review and writing.

Part 1: Measurement Framework

The OAT sustainability framework is a conceptual approach to understanding and measure OAT sustainability in the context of transitional funding. It breaks down the concept of sustainability into a matrix of key elements comprising broad issue areas, indicators for each of the dimensions, and benchmarks to measure progress under each indicator.

This component starts with defining key terms and providing an overview of existing frameworks and tools for measuring sustainability within the transition process. Why a particular framework was needed is explained and examples are given of the concerns it seeks to address.

For national stakeholders, this component is a useful overview of the assessment approach and consultants can use it, together with other tools, to adapt the framework to the national context.

The *Measurement Framework* offers a matrix for measurement, comprising issue areas, indicators and benchmarks. For each of three issue areas, namely *Policy & Governance*; *Finance & Resources*; and *Services*, a set of indicators is proposed, and several benchmarks are offered on how to measure progress under each indicator for the programmatic component that utilises existing WHO, UN and international guidance on OAT.

1.1. Key concepts

Opioid agonist therapy (**OAT**), also known as **opioid maintenance treatment** (**OMT**) or **opioid substitution therapy** (**OST**), is an evidence-based, effective treatment of heroin and other forms of opioid dependence. It involves prescribing opioid medications such as

methadone and buprenorphine (buprenorphine or a combination of buprenorphine and naloxone) at a maintenance dose. Both medications are included in the WHO Model List of Essential Medicines for the treatment of opioid dependence. Some countries use other medicines, notably slow-release oral morphine and diamorphine (heroin). Adding psychosocial interventions can improve outcomes. WHO clinical guidance recommends this approach for the treatment of opioid dependence and for a comprehensive public health response to HIV, tuberculosis (TB) and hepatitis C (HCV) among people who inject drugs (PWID)[3][4][5][6].

Terminology: OAT or OST or OMT? In this publication, the terms 'OAT' and 'clients of OAT' are used. But this terminology has not been established internationally or in EECA countries. It is, therefore, recommended that the terminology be adapted to the specific country context and that key stakeholders, including people who use drugs, are asked about which terminology is most appropriate. Currently, countries use various terms, such as opioid substitution therapy, methadone maintenance treatment, opioid maintenance therapy, pharmacotherapy treatment of opioid dependency, medication assisted therapy, and others. The WHO Department of HIV and hepatitis, the European Monitoring Centre

[3] WHO. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Geneva; WHO, 2009.

[4] WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users — 2012 revision. Geneva; World Health Organization, 2012. https://apps.who.int/iris/bitstream/handle/10665/77969/9789241504379_eng.pdf

[5] WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations — 2016 update. Geneva; WHO, 2016.

[6] WHO. Access to Hepatitis C Testing and Treatment For People Who Inject Drugs and People in Prisons A Global Perspective. Policy Brief; Geneva, WHO, April 2019.

on Drugs and Drug Addiction (EMCDDA) and the Global Fund use the term 'opioid substitution therapy' (OST). The WHO Department of Mental Health and Substance Abuse, as well as the Cochrane Collaboration, stopped using the term 'OST', advising against it due to stigmatisation and misconceptions brought to this treatment method[7], and now use the term OAT. Medication-assisted treatment (MAT) is a terminology proposed by the U.S. National Institute on Drug Abuse (NIDA) but is seen as an oversimplification of the neurobiological side of dependence, use and treatment, without acknowledging that psychosocial support provided to OAT clients might significantly improve treatment outcomes. The International Network of People who Use Drugs (INPUD) has not defined their position on treatment terminology other than a clear recommendation in favor of using 'clients' and 'users of services' and against the use of the term 'patients' when describing people who engage in treatment[8].

Sustainability of OAT programmes within the context of transition from external to domestic funding of HIV responses is the ability of OAT programmes to both maintain and scale up service access and coverage to a level, in line with the epidemiological context, that will provide for epidemic control of HIV and hepatitis C among people who are opioid dependent and for ensuring access to OAT to all in need, even after the withdrawal of external donor funding[9]. WHO defines high coverage of OAT programmes as 40% or more of the estimated number of people who

[7] Samet JH, Fielling DA. Opioid substitution therapy-time to replace the term. Lancet: Vol. 385, Issue 9977, P1508-1509, April 18, 2015.

[8] INPUD. Statement and Position Paper on Language, Identity, Inclusivity and Discrimination. London; INPUD, November 2011.

[9] Adapted from the Sustainability, Transition and Co-Financing Policy of the Global Fund.

are opioid dependent are in receipt of OAT[10]. In this Guide, the following issue areas are used for measuring sustainability: policy and governance; finance and resources (i.e. inputs from health systems including finance); and services.

Transition of OAT programmes from donor-support to domestic funding sources is a process by which the country moves towards fully funding and implementing its OAT programme independent of donor support while continuing to sustain the gains already achieved and to scale up services as appropriate[11].

The OAT sustainability framework is a conceptual approach to measuring the degree of sustainability of a national OAT programme in a given country. It breaks down the concept of sustainability into a matrix of: key issues; indicators for each issue; and benchmarks to measure progress under each indicator. The framework is used for a national assessment using the methodology described in detail in *Part 2* of this Guide. As part of the assessment preparation, the framework can be adapted, incorporating national concerns and more elements from the international guidance listed in *Section 1.3* or by using examples from other frameworks mentioned in *Annex 1*.

1.2. Why the new framework?

Several frameworks for sustainability and donor transition have been developed in the HIV, TB and malaria sectors. PEPFAR developed one for their funded programmes, while the Global Fund commissioned several agencies to develop their transition readiness assessment tools and cooperated with UNAIDS and other organisations to conduct assessments and support countries in developing transition plans. All EECA countries that receive Global Fund support have undergone such assessments and have developed transition plans. The Eurasian Harm

[10] WHO, UNODC, UNAIDS, Ibid.

[11] Adapted from the Sustainability, Transition and Co-Financing Policy of the Global Fund.

Reduction Network developed a tool focused on harm reduction, called the Transition Readiness Assessment Tool (TRAT), and applied it in several South East European countries. *Annex 1* provides an overview of some of the available tools.

The Eurasian Harm Reduction Association (EHRA) has developed this Guide, with a focus on programmatic sustainability of OAT, in response to the multiple concerns and requests for assistance from its members concerning the prospects for OAT once international political, technical and financial support ends.

Service providers and clients alike report challenges that they have already faced, and rumors among clients about an uncertain future. Concerns have been raised about a range of issues, all of which may impact upon the scale, quality and accessibility of an OAT programme that include the following:

- Will OAT be continued and integrated into state-guaranteed services and health systems and included under Universal Health Coverage (UHC) in national health programmes?
- Will procurement of controlled medicines, such as methadone and buprenorphine, be reliable, uninterrupted, and include quality assurance mechanisms?
- Will unsupportive policing or restrictive regulation of treatment and rights of OAT clients shrink or reduce the scale and accessibility of OAT programmes?
- Will services be of high-quality standards, comprehensive and responsive to the concerns of users?
- Will there be community and civil society involvement in planning, increasing uptake and monitoring of the services?
- Will OAT be fully financed from public sources without user fees, under the principles of UHC and access to all without financial hardship being the result?

These concerns are not unique to Global Fund-related transition and have been seen at different stages of OAT history in the region, such as in Ukraine[12]. While OAT is strongly recommended by WHO and UN and European Union (EU) agencies[13], and while methadone and buprenorphine are included in the WHO Model List of Essential Medicines, OAT remains outside core state drug treatment modalities in many EECA countries, often linked to the national HIV response and not integrated into a country's response to problematic drug use.

Many of the concerns mentioned above are only partly addressed in the otherwise comprehensive tools described in the previous section. Unlike other frameworks, this Guide merges transition-related aspects and in-depth analysis of programmatic aspects including quality assurance and focuses on just one service type, OAT, making it less comprehensive but manageable and appropriate for advocacy purposes. It includes issues around drug treatment and policy, hepatitis C, and universal health coverage (UHC) in addition to the response to HIV and TB through the strong recommendations of WHO and the commitments of the global Sustainable Development Goals (SDG's) for major changes by 2030 in all of these areas.

1.3. Conceptualising the OAT sustainability framework

The OAT sustainability framework is an approach to understanding and measuring sustainability, with a focus on programmatic aspects. It breaks down the concept of sustainability into a matrix of key elements: broad

[12] Dvoriak S, Karagodina O, Chtenguelov V, Pykalo I. Ten Years of the Opioid Agonist Therapy Implementation Experience in Ukraine. What Further? Part 1: *Вісник АПСВТ, 2018, No2* and Part 2: *Вісник АПСВТ, 2019, No1*.

[13] References to WHO and UN documents are provided in the next section. The EU documents include: its Council's Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence; European Centre for Disease Prevention and Control and EMCDDA. Prevention and control of infectious diseases among people who inject drugs. Stockholm; ECDC. 2011; Other sources are available at http://www.emcdda.europa.eu/topics/treatment.

issue areas, or dimensions; indicators for each of the areas; and benchmarks to measure progress under each indicator. The framework combines several previous frameworks, including the TRAT by EHRA, the Treatment Preparedness Assessment tool by Curatio, and the highlights of the human rights component proposed by Oberth & Whiteside.

The following is a more detailed explanation of the issue areas:

A Policy & Governance

Key information under this issue area should answer the following questions:

- Is there a political commitment for the continuation, and adequate scale-up, of OAT?
- Do the country's donor-related transition plans foresee clear plans on how domestic funds and systems will take over the financing and managing OAT?
- Are there operational structures in charge of the development of oversight, coordination and management of OAT?

B Finance & Resources

This issue area addresses whether the critical inputs of health systems are in place in a sustainable way to ensure the smooth and uninterrupted delivery of OAT services including registration; procurement and supply of medicines; information systems and evidence generation; and human and financial resources.

C Services

This issue area measures the level of access to OAT, adapting the concept of the critical elements of the right to health suggested by the UN Committee on Economic, Social and Cultural Rights[14 15], including: 1) availability; 2) accessibility (non-discrimination, physical accessibility, economic accessibility or affordability, and information accessibility); and, 3) quality and integration. Acceptability is not

included in this particular assessment Guide as this more nuanced aspect requires a representative sample of OAT clients, which is not planned under this methodology of this Guide. The priority indicators, benchmarks, and the approach to their measurement, are chosen from existing programmatic guidance and quality assurance indicators, that include the following:

- WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (2012 revision)
- WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009) [summary minimal criteria and good practice recommendations on p.XIV-XVII]
- WHO consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (2016 update)
- WHO Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations (2015, Supplement to the 2014 Consolidated Guidelines for HIV Prevention, Diagnosis, Treatment and Care for Key Populations)
- Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions (the "IDUIT")
- Monitoring quality and coverage of harm reduction services for people who use drugs: a consensus study[16] (2017), which is based on a review of other guidelines.

[14] All UN member states in Central and Eastern Europe and Central Asia have ratified the UN Covenant on Economic, Social and Cultural Rights. Status of ratification of the Covenant by Kosovo could not be defined while developing this Guide.

[15] CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). *Adopted at the Twenty-Second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4).*

In constructing the indicators and benchmarks, the above WHO sources and the final reference were extensively used.

Summary framework for OAT sustainability (followed by a detailed version with benchmarks)

Issue Areas	Indicators			
A. Policy & Governance	Political commitment		Management of transition from donor to domestic funding	
B. Finance & Resources	Medications	Financial resources	Human resources	Evidence and information systems
C. Services	Availability and coverage	Accessibility	Quality and integration	

1.4. Measuring issue areas, indicators and benchmarks

Under each issue area and related indicators, a set of benchmarks are identified and measured. Measuring each indicator combines quantitative and qualitative information and is summarised in the following table:

1 The degree of sustainability for each benchmark followed by the average range (in percentage) for the indicator.

- Scale used for each indicator[17]:

[16] Wiessing L, Ferri M, et al. Monitoring quality and coverage of harm reduction services for people who use drugs: a consensus study. *Harm Reduction Journal* 2017 14:19.

[17] Scale adapted from Amaya AB, Gotsadze G, Chikovani I. The Road to Sustainability: Transition Preparedness Assessment Framework, Version 3.0. Tbilisi, Georgia; Curatio International Foundation, July 2017.

Indicators & dimensions: Scale for status of sustainability	Description	Approximation of the scale as a percentage	Colour coding
High	High level of sustainability with low or no risk	>85–100%	Green
Substantial	Substantial level of sustainability with moderate to low risk	70–85%	Light green
Moderate	Moderate level of sustainability, at moderate risk	50–69%	Yellow
At moderate to high risk	Sustainability at moderate to high risk	36–49%	Orange
At high to moderate risk	Moderate to low level of sustainability, at high to moderate risk	25–35%	Light red
At high risk	Low level of sustainability, at high risk	<25%	Red

- Scale used for each benchmark with its components measured through a points system (with 2 being the maximum and 0 being the minimum point):

Benchmarks: Scale of status of sustainability	Description	Approximation of the scale as a percentage	Colour coding
High	High or good level of sustainability; no major risks	≥70–100%	Light green
Moderate	Moderate level of, and risk for, sustainability	36–69%	Yellow
At high risk	High risk for sustainability	≤35%	Light red

2 Providing qualitative information on the following:

- Summary of the sustainability status;
- Progress: *developments, good practices and enabling factors for progress in building sustainability in the previous 2 years*;

- Barriers and challenges: *key gaps in sustainability, their underlying causes and factors*;
- Transition impact: *How does donor transition impact the level of sustainability? How has that impact leveraged and/or mitigated sustainability in the previous two years? What is expected in the next 2–5 years?*
- Opportunities and way forward: *Opportunities, plans and suggested recommendations to sustain success, address the challenges and mitigate the impact of transition.*

The detailed version of the indicators, benchmarks and templates for measuring indicators is provided in *Annex 3, Part A for Policy & Governance*; *Annex 3, Part B for Finance & Resources*; and *Annex 3. Part C for Services*. Please note that the assessor is expected to enter assessment data into the forms provided and indicate the sources of such data.

In case that the assessment is repeated after 2–3 years, the degree of sustainability can be compared, reflecting on the changes between the previous and the current status. The templates provided in this Guide will need to be adjusted accordingly by adding a column to record previous scores.

1.5. Framework for measuring OAT sustainability

All measurement of issue areas should focus on the initial situation and, in the descriptive part, outline the impact of transition. Indicators (and benchmarks) that are not relevant for a country can be skipped, e.g. Indicator A2 is not applicable outside the settings experiencing donor transition. Some indicators are optional and marked with an asterisk (*).

Issue Areas	Indicators and Benchmarks			
A. Policy & Governance	*Indicator A1:* **Political commitment** • OAT is included in national drug control, HIV and/or hepatitis strategies and action plans, with a commitment to WHO-recommended targets • Legislation explicitly supports the provision of OAT • OAT is a core part of national policy for opioid dependence management • (*) Law enforcement and justice systems support implementation and expansion, as needed, of OAT • (*) Effective governance and coordination oversee the development of OAT in the country • (*) Civil society, including OAT clients, are consulted in OAT governance and coordination at country leve		*Indicator A2:* **Management of transition from donor to domestic systems** • Country has adopted a plan which defines transition of OAT from donor to domestic funding including a timeline • There is a multi-year financial plan for the OAT transition to domestic sources, with unit costs developed, co-financing level, the (future) domestic funding sources for OAT identified and agreed among country representatives • Donor transition oversight in the country effectively supports implementation of the OAT transition to domestic systems • There is good progress in the implementation of the OAT-component in the transition plan	
B. Finance & Resources	*Indicator B1:* **Medications** • OAT medicine procurement is integrated into domestic PSM system and benefits from good capacity without interruptions • Both methadone and buprenorphine are registered and their quality assurance system is operational • Methadone and buprenorphine are secured at affordable prices	*Indicator B2:* **Financial resources** • Methadone and buprenorphine are included in the state reimbursed medicine lists and are funded from public sources • OAT services are included in universal health coverage or state guaranteed package of healthcare including for people without health insurance • OAT services are paid through sustainable public funding sources which secure adequate funds to cover comprehensive services • In the countries with active HIV grants, OAT services are co-financed by the Government in accordance with the Global Fund Sustainability, Transition and Co-Financing Policy	*Indicator B3:* **Human resources** • OAT is included in the job description of main health staff and core functions of the state system for drug dependencies with relevant capacities to prescribe and dispense OAT to a required scale • Capacity building system is adequate for OAT implementation in a sustainable way	*Indicator B4:* **Evidence and information systems** • OAT monitoring system is in place and is used for managing the OAT programme including programme need, coverage and quality assurance • Evidence-base for OAT effectiveness and efficiency are regularly generated and inform policy and programme planning • OAT client data are stored in a database; they are confidential, protected and not shared outside of the health system without a client's consent

Issue Areas	Indicators and Benchmarks		
C. Services	*Indicator C1:* **Availability and coverage** • OAT is available in hospitals and primary care; take-home doses are allowed • Coverage of estimated number of opioid dependent people with OAT is high (in line with WHO guidance: 40% or above) • OAT is available in closed settings (including for initiation onto OAT), during pre-trial detention and for females • (*) OAT is possible and available in the private and/or NGO sectors in addition to the state sector	*Indicator C2:* **Accessibility** • There are no people on a waiting list for entering the service • Opening hours and days accommodate key needs • Geographic coverage is adequate • There are no user fees and barriers for people without insurance • OAT is available and, in general, accessible for populations with special needs (pregnant and other women, sex workers, underage users, ethnic groups) • Illicit drug consumption is tolerated (after dose induction phase) • Individual plans are produced and offered, with involvement of the service user • OAT inclusion criteria are supportive of groups with special needs and are not restrictive, i.e. failure in other treatment programmes is not required prior to enrolling into the OAT programme.	*Indicator C3:* **Quality and integration** • Adequate dosages of methadone/buprenorphine are foreseen in national guidelines and practice in line with WHO guidance • OAT programs are based on the maintenance approach and have a high retention of users • A high proportion of OAT maintenance sites is integrated and/or cooperates with other services and support continuity of care for HIV, TB and drug dependency (in line with WHO guidance: 80% or more of the sites) • A high proportion of OAT clients receive psycho- and social support (in line with WHO guidance: 80% or more of the sites)

Part 2: Guidance For National Assessment

The national assessment process should follow the following three stages:

A **Preparation:** form an advisory group, if relevant, and adapt the framework and methodology, as needed;

B **Assessment:** conduct a desk review, interviews with key informants, and assess and score the benchmarks of the three issue areas for measuring OAT sustainability;

C **Finalisation:** Draw conclusions, write the report and plan its dissemination.

This Guide provides an overview of considerations to be made in the preparatory and finalisation stages with an assumption that the assessors will already have experience of similar processes. However, the main focus of this Guide is the second stage — the assessment itself.

2.1. Preparation

To support the assessment, engaging an **advisory group** is recommended, composed of 3–7 members from different sectors and bringing a combination of expertise in the issue areas. If the assessor decides to use such a group, it can assist with tasks before, during and after the assessment that include:

- contextualising the framework and methodology of the assessment;
- defining the list of key informants and timeline;
- assist with the gathering of relevant literature;
- provide advice during the assessment, as needed;

- provide feedback on the draft analytical report and help to draw conclusions; and,
- assist in planning the dissemination of the assessment results.

It is preferable for the **planning and adaptation** of the framework (and methodology) to the national needs to be undertaken in consultation with the advisory group if such a body exists. Maintaining the core methodology, and tracking any changes, along with a justification for such alterations, is recommended. Such documentation has two purposes: to describe the methodology in the report; and to provide suggestions to EHRA and future assessors in the specific country, as well as for potential use by other countries, on how to improve these tools. For example, this stage should answer the following questions:

- ***Based on the ongoing debates within the context of donor transition and sustainability efforts, which critical questions should the assessment answer?***
  How can data from the assessment be used for advocacy at the national level?
  What are the ongoing discussions on the future of OAT in the country? What other ongoing, and broader, processes in health systems or drug policy should be addressed in the assessment?
  For example: in Ukraine, the assessment could add questions on the models of care and ongoing health system reform — which of these models is more sustainable? Or should different models co-exist? What does the health system reform mean for OAT governance, funding and coverage of services? What are the unanswered questions in terms of universal health coverage and the new hepatitis programme?
- ***Are all the issue areas of the framework, indicators and benchmarks relevant?*** Are some adjustments needed? If yes, why and what adjustments should be made, or even whether one or more should be removed or additional issue areas are important and should be added? Should the optional benchmarks be included? (These changes will need

to be recorded and included in the detailed methodology; please note, however, that the more changes are undertaken, there will be less comparative information available across countries). Which of issue areas are a priority, and which are of less importance, given the resources available? Which benchmarks are most relevant, and/or which are irrelevant?

- ***What transition stage is the country in, and how does that affect how/what to measure?*** Which donors, and their respective transition plans, are most relevant for OAT? If it is in its early stages, should the transition progress be measured as suggested, especially if there is a more detailed OAT transition plan available? If donors no longer fund OAT, should only progress of building sustainability be measured? Is there the possibility of measuring indicators and benchmarks at the stage of early transition versus the current situation, and should that be included, or at least qualitative information be reflected upon, as an impact of donor transition?
- ***How to ensure credibility of the results with the government and decision makers?*** For example, would getting ethical approval prior to the start of the assessment help in advocacy efforts and would it be feasible for the resources and time available? If the country is developing and planning OAT services through regional authorities instead of central government, should a geographic perspective be added?
- ***What are the upcoming opportunities for discussing the results of the assessment?*** What is the timeline? Are transition reviews, or general sustainability assessments, planned that might be relevant and to which this assessment could be fed? How best to inform, and link, this assessment with these discussions and opportunities?
- ***Who should be key informants from the authorities, health professionals, civil society and communities, international partners, and technical assistance providers?*** This list should be adapted, as needed, after the literature review if gaps in knowledge are identified and could be covered through additional key informant interviews.

Once these questions have been answered, **adjustment of the tools** provided in the Part 3 are recommended, including:

1 Outline of the report (*Annex 2*);

2 Instruments for structuring the collected information from the literature review and interviews (and focus groups, if any) (*Annex 3* with the instructions for all instruments, *3.A*, *3.B*, and *3.C*); and,

3 Interview guide (*Annex 4*).

Adjusting the first two instruments — the outline and the instruments for structuring information – is recommended to be undertaken first. The changes in the interview guide should follow the main desk review once available and missing information is identified.

2.2. Overview of the assessment

To conduct a thorough and comprehensive assessment, the following steps must be undertaken:

- Throughout the data collection process, use the annexed tables to assess **each indicator for each** sustainability issue area (see Annexes *3.A*, *3.B*, *3.C*) and the outline of the report (*Annex 2*);
- The collection of quantitative and qualitative data through a **desk review** (see below *Section 2.1*);
- The collection of quantitative and qualitative information through **interviews with selected key informants** (see *Section 2.2*); and,
- Preparing the **quantitative information** for the report.

Guidance on how to complete each of the above key steps is given below. In accordance with the OAT sustainability framework, the focus of all of these steps should be around the three issue areas of sustainability which have already been described above. Further details as to information to look for is provided below. The annexed tables will assist in the

quantification of each benchmark and indicator. In the following subsection, consideration is made of the types of information to collect for the desk review for each of the issue areas.

2.2.1. Desk review

As a first step, it is recommended that the assessor conducts a comprehensive desk review with due diligence of the following information before conducting key informant interviews. Inputs from the desk review should feed into the detailed outline of the report (all sections with the exception of the findings) and the adjusted templates for collecting information for each of the issue areas (based on Annex *3.A*, *3.B* and *3.C*). The assessor might submit inquiries for official information on key programmatic data in particular, in the event that such data is not available in published or grey literature or from online sources.

A ***Policy & Governance***

The assessor should pay particular attention to the existence, in whole or in part, of the following:

- National **programme and guidelines on drug dependence or**, specifically, on **OAT**;
- References to OAT in a **national drug strategy** and action plans, and national **HIV, TB, hepatitis** and universal health coverage plans;
- Legal or policy **enablers and barriers to** the implementation of **OAT** programmes, including police guidelines on harm reduction or vulnerable groups in the context of public health, HIV or hepatitis;
- The existence and functioning of a **multi-stakeholder national governance body**, including, at least, government, civil society, and technical partners, that is institutionalised to steer the transition process and to continue OAT programme planning and oversight after the end of donor funding, either under policy coordination for drug control, drug treatment, AIDS, TB and/or hepatitis;

- The national **government body/ies** charged with the **management** of OAT programme development in the country, including organization of monitoring and evaluation;
- A fully resourced '**Transition Plan**' **for HIV or TB which includes OAT**, that is proactively guiding the transition of the programme from a donor-support project to national systems at the current time and with a good level of progress in implementation.

Some of the documents that might be of assistance to the assessor in responding to the above key points may include, but not limited to, the following:

- ✔ Additional strategic documents which govern, or impact upon, OAT programming, e.g. drug strategy and action plans; HIV/TB/hepatitis strategies and programmes; drug dependence programmes; OAT guidelines; Universal Health Coverage Programme; Health System Reform Framework, etc.;
- ✔ Historic overview of OAT with key milestones;
- ✔ Past evaluations of the OAT programme;
- ✔ Global Fund Concept Notes from recent/active grants;
- ✔ Current state legislation governing drug policy and documents regulating to the provision of drug treatment services;
- ✔ Any critical documents from technical partners and/or civil society regarding OAT, harm reduction, HIV, hepatitis, TB or universal health coverage from the last three years – reports, evaluations, policy briefs, etc. – particularly those that give insights into the status of rights-based care approaches and ongoing barriers that people who use drugs face in accessing care;
- ✔ Transition and/or sustainability plan(s) for transition from Global Fund and PEPFAR support to domestic funding (if such exist) in either finalised or draft form;

- ✔ Recent sustainability and transition readiness assessments;
- ✔ Relevant documents related to the Country Coordinating Mechanism (CCM), AIDS commission and drug control council, if available, such as bylaws, reports, membership, participation in meetings, minutes of meetings held, etc.; and,
- ✔ Other multi-stakeholder national governance bodies that exist and regularly function such as commissions, councils, etc., including their authority, rules of governance, membership, and impact to-date, etc.

It is expected that key informant interviews will be necessary to verify such information.

B *Finances & Resources*

The assessor should pay particular attention to the existence, in whole or in part, of the following:

- Funding model foreseen, or under implementation, including funding sources for OAT once donor support ends that is available in a transition plan, and/or national drug policy, drug treatment, HIV and other documents and/or communication with the Global Fund and relevant donors;
- Resource plans contained within the transition and national policy documents on drug control, drug treatment, HIV, hepatitis and universal health coverage, including financial, human and pharmaceutical resources and information systems;
- Inclusion of OAT in the functions and TOR of state drug treatment (including health professionals working in that system);
- Funds for OAT that are allocated according to an optimised budget scenario;
- Core OAT elements (e.g. medicine, human resources, infrastructure) that are funded by the government;

- Donor procurement systems that are integrated into national systems and that are ensuring reasonable price and quality controls; and,
- Written commitments from the government or the CCM, if any, to co-finance OAT and written conditions and requirements from PEPFAR or the Global Fund, if any, requiring the government to co-finance OAT for at last 5 years.

Some of the documents that might be of assistance to the assessor in responding to the above key points may include, but not be limited to, the following:

- ✔ The list of diseases and medicines covered through essential, reimbursable medicines and minimum packages of universal health coverage;
- ✔ Statute of the national drug treatment centres/system and their budgets;
- ✔ Costing of OAT services;
- ✔ Extract from online, or other, databases of registered medicines — if/what methadone, buprenorphine and other maintenance medications are registered (the registration date, expiration date, product supplier, product name);
- ✔ Information about inclusion of OAT in simplified registration procedures;
- ✔ Ability to buy in bulk and to produce the medicine locally;
- ✔ Description of the M&E system and plan for the evaluation of OAT;
- ✔ TOR's of health staff in one or two selected OAT sites or government approved templates;
- ✔ Evaluation reports on OAT from the last 5 years;
- ✔ Reports from capacity building of OAT;

- Scientific papers on OAT, including its effectiveness and efficiency;
- Conclusions, if any, from national societies for psychiatry and of drug dependence experts on estimating human resource and capacity building needs, including information about the inclusion of sensitisation in trainings; and,
- Information about the database of OAT clients, including its description and regulation.

Completing the following tables is recommended:

TABLE: Funding levels and progress of financial transition (in national currency and USD or EUR)

Please add relevant rows for each funding source as needed, e.g. if there is more than one public funding source.

	2015	2016	2017	2018	2019	2020	2021	SOURCE(S)	NOTE(S)
Budget designated for OAT per national strategies, plans, etc.									
Actual budget realised for OAT									
Amount, and share, of domestic public funding (*list the sources of public funding and indicate contributions from each*)									
Amount, and share, of domestic private funding and out-of-pocket costs									
Amount, and share, of Global Fund support									
Amount, and share, of other external/donor funding (list the sources)									
Calculated need for OAT funding*									
Gap between the need and funds available									

* Information might be available in OPTIMA studies where costing inputs might be used, though they might not be indexed against inflation. Another potential source could be the Global Fund grant application and costing of the transition plan. There might be specific studies available on OST costing in OST assessment and development reports by national drug dependence agencies, the Global Fund grant management institution, UNAIDS, UNODC, WHO or others. Please indicate sources of information used.

TABLE: Breakdown of components supported by different funding sources

Please adjust/list all sources relevant to the country; please revise the budget categories, if needed. If amounts are not available, please indicate at least which source is funding the type of expense is derived without the specific amount. The Global Fund grant should have costs indicated for funding from the Global Fund, other donors and domestic sources as co-financing for the overall costs of OAT.

PERCENTAGE OF COSTS COVERED BY EACH SOURCE	2018				2019			2020		
	MoH	GF	Out-of-pocket	...						
Medicines										
Staff (including top-ups)										
Operational and management, including premises										
Capacity building for staff										
Research, information systems										
Other (please specify)										

TABLE: Human resources

	LAST YEAR FOR WHICH DATA IS AVAILABLE	SOURCE(S)	NOTE(S)
OAT human resources			
Number of health professionals involved in OAT			

Number of health professionals that received training on OAT in the last year			
Number of health professionals who received sensitisation to client needs			
Number of sites that include peer educators			
Number of OAT clients per one doctor			
Number of OAT doctors that are not drug dependency specialists			
OAT and narcology (drug dependence) care			
Number of doctors in narcology system			
Number of nurses in narcology system			
% of doctors involved in OAT			
% of doctors trained in OAT			
% of nurses involved in OAT			
% of nurses trained in OAT			

TABLE: Research and assessments in the country in the last 8 years

LEAD RESEARCH INSTITUTION, FUNDER	INVOLVEMENT OF NATIONAL ACADEMIA AND OAT CLIENTS OR THEIR REPRESENTATIVES	NAME OF THE STUDY, YEAR	KEY CONCLUSIONS OR EVIDENCE ON OAT EFFECTIVENESS AND EFFICIENCY

C *Services*

The assessor should pay particular attention to the existence, in whole or in part, of the following:

- Coverage of OAT services, and its availability in various settings, is in line with WHO recommendations;
- Quality standards for OAT are implemented in the country;
- Other quality standards for OAT service delivery are in compliance with the standards and recommendations in IDUIT and WHO guidance;
- An expansion of access to OAT and no regression over the last four years, i.e. to coverage and availability, accessibility, financial affordability, acceptability, dosages, quality and integration, unless they are related to the changed needs of the community;
- There is no planned reduction in the scale of, and access to, OAT; and,
- The level of inclusion of service users and implementers is adequate in the planning of OAT developments at country and service delivery levels.

Some of the documents that might be of assistance to the assessor in responding to the above key points may include, but not be limited to, the following:

- ✔ National OAT clinical guidelines;
- ✔ Reports on the estimated number of people who are opioid dependent or — less preferably — an estimation of the number of people who inject drugs[18] (including verification as to whether it is

[18] OAT is only for people dependent on opioids, whether they inject or not. However, most countries do not have this level of sophistication in their data. Hence, it is recommended to use the population size estimate of people who inject drugs as a proxy for the OAT coverage denominator.

current and that the number is agreed among key stakeholders, including civil society);

- Official reports on the number of people on OAT, the geographic distribution of OAT sites, availability of OAT in detention sites and prisons (national drug reports, UNGASS/GAM reports, programme implementation reports, reports to donors);
- Plans for OAT in proposals to the Global Fund and other donors, national policy documents on drug dependence, drug control, HIV, TB and hepatitis;
- Programmatic reports from the monitoring database of OAT services;
- External evaluation reports;
- Assessments and case studies from the perspective of service users; and,
- If needed, assessors might submit an inquiry to the OAT coordination body with specific questions using the indicators, in addition to assessing the implementation of WHO recommendations on OAT.

TABLE: Analysis of the number of OAT clients and sites for the last 3 years and for the upcoming year

Note: *This information should be available within the OAT coordination body or in national drug reports. If there are gaps, please take a note of them and reflect this in the analysis on information systems.*
Some of the requested information can be broken down by substance, e.g. methadone and buprenorphine, or add the numbers of clients from different groups (prisoners, young people, etc.)

	2017	2018	2019	2020
Coverage, including females				
Estimated number of opioid dependent people				
Estimated number, and ratio, of opioid dependent females				

	2017	2018	2019	2020
Number of OAT clients				
Number, and ratio, of female OAT clients				
Coverage of OAT (% of opioid dependent people[19])				
Coverage of OAT among opioid dependent females				
Coverage of OAT, based on the WHO scale: Low ← 20% ← Mid → 40% → High				
Number of people registered by state institutions as being opioid dependent				
OAT coverage among people registered by state institutions as being opioid dependent (%)				
Coverage, including females				
Coverage of OAT (% of opioid dependent people[19])				
Geographic coverage				
Number of OAT sites				
Ratio of main administrative units of the country that have OAT				
Integration of OAT				
Ratio of OAT sites with integrated care for HIV/TB/HCV				

[19] Ibid. If needed, use the population size estimate of people who inject drugs as a proxy for the OAT coverage denominator.

	2017	2018	2019	2020
Number of OAT sites in specialised state drug dependence institutions (narcology)				
Number of OAT clients in specialised drug dependence institutions (narcology)				
Number of sites in health service primary care				
Number of OAT clients in primary care				
Number of people on OAT and in detention at the end of the reported period				
Number of people on OAT and imprisoned at the end of the reported period				
Number of OAT clients receiving OAT from NGO's				
Number of OAT clients receiving OAT from the private sector				
Ratio of OAT clients who are living with HIV				
Ratio of OAT clients living with HIV who receive ART				
Ratio of OAT clients who have HCV				
Ratio of OAT clients who are diagnosed with TB				
Ratio of OAT clients diagnosed with TB who undergo treatment for TB (including MDR-TB)				
Number of HIV and TB specialised services that provide OAT				

TABLE: Average dosage by site

	METHADONE	BUPRENORPHINE
Country average dose		
The proportion of sites that meet WHO recommendation for the minimum dosage		

2.2.2. Guide for key informant interviews and focus group discussions

This section assumes that the assessor has been able to gather all key data described in *Sub-Section 2.2.1, Desk Review*, above. If any such data was unavailable during the desk review stage, the assessor is advised to add relevant questions to prompt key informants and focus groups in order to gather such data, or to ask for assistance from key informants and/or the advisory group in accessing the required data.

The questions in the annexed key informant interview guide and the focus group guide are intended to provide a minimum set of questions that should be asked in order to supplement the desk review and to complete the OAT sustainability assessment. The assessor should feel free to use additional questions to obtain relevant information based on the country and programme context. For a reminder on how to conduct key informant interviews, the following source — from the UCLA Center for Health Policy Research — can be used:

http://healthpolicy.ucla.edu/programs/health-data/trainings/documents/tw_cba23.pdf

An interview guide is provided in *Annex 4* and is expected to be adapted to the expertise of different interviewees (i.e. some sections will be relevant to some stakeholders but not to others).

It is recommended that the assessor records, and takes detailed notes

from, the interviews. Within 24 hours after the interview, this information should be reviewed and archived in data collection files on a highly secure computer. Additionally, the information from the interview should be fed into the tools for the development of findings (tables for each issue area), summarising the essence of, and providing quotes in a short bullet point format for, each issue area, using relevant techniques for the anonymisation of the source (e.g. government partner 1, technical partner 1). Undertaking such work within one working day, without delay, while impressions from the interview are fresh, is recommended as doing so will take a shorter time and, as needed, prompt follow-up with the respondent will be easier to get clarifications or, for example, to receive written inputs promised during the interview.

Additionally, it is highly recommended that the assessor conducts one or two focus groups; one with OAT clients and another with the practitioners to gain additional service insights. The same rules apply for note-taking and analysis of the inputs from focus groups. Data collected should be saved at a secured location, with a copy saved to the cloud or an online drive in case of a loss of, or damage to, a computer. The data should also preferably be encrypted to prohibit unauthorized access and use. Guidance for focus group discussions with OAT clients is provided in *Annex 5*.

All key informant and focus group participants who agree to participate in the assessment will first be provided with a verbal explanation of the aim of the study, interview procedures and a detailed explanation of their rights as participants, including their right to withdraw from the interview at any time, or procedures to safeguard their data and confidentiality in case they do not want to be identified as an assessment participant. Their informed consent will be obtained orally at the beginning of informant interview or focus group recording on an audio recording device and before detailed notes are taken with the subsequent analysis of the information provided and used as a direct quotation and for systematic analysis for the final report.

2.3. Producing the report and recommendations

Once the assessment has been conducted, the assessor will compile the data and draft the report. Conducting data verification is highly recommended in one of two ways, based on the assessor's judgement. One option is to provide the Advisory Group with an overview of collected information and prioritise a request for advice where conflicting, or one-source, or incomplete, data is available. The second option is to draft the report and ask the Advisory Group to carry out a thorough review of the draft report and its tables before finalisation of the report and the drawing of conclusions.

A report outline is provided in *Annex 2*. The report should include contextual sections, findings and conclusions for each of the issue areas as well as general conclusions and recommendations to government institutions, practitioners, civil society, technical partners and donors.

At this stage, the assessor should have the filled-in tools for structuring the collected information from the literature review and interviews, which will be the basis of the findings section of the report. Additionally, there should be information for other sections of the report, particularly from the desk review. The completed tools should be saved and maintained in their full format as internal documents in case there are questions about sources of information. Guidance on how to adjust tables for quantified measurements of each indicator and issue area are provided in the first of the assessment tools.

To sharpen and prioritise the recommendations, the assessor can either conduct a working meeting with an advisory group or — more preferably — with a diverse focus group of key stakeholders. Such a process can verify the most critical areas and challenges that have been concluded by the assessor. It can identify what specific steps, and by which institutions, would have the most impact in the next 2–5 years for the sustainability of OAT. It can also help to narrow down to 7–15 specific recommendations focused on specific stakeholders on how to improve the sustainability and

transition process.

A useful resource — again, from the UCLA Center for Health Policy Research — on how to prepare and conduct a focus group discussion is available through this link:

http://healthpolicy.ucla.edu/programs/health-data/trainings/Documents/tw_cba21.pdf

2.4. Dissemination and planning for implementation of recommendations

The assessment report and its messages need to be presented and delivered to relevant stakeholders in order to be heard and to make an impact. The advisory group can help to draft a dissemination plan and to share responsibilities. Another option is to set up a partnership with a governmental body, or a NGO, and organise a launch event.

This process should consider at least some of the following steps to deliver the report in different formats to different audiences to increase awareness of the conclusions and to discuss what specific steps should be taken for improving sustainability:

- produce a **policy brief** with a summary of the findings and recommendations, translated into English and Russian;
- produce a **set of slides** for possible presentations;
- **translate** the report, or relevant parts of it, as the report should be in the national language in order to potentially achieve the greatest impact among national stakeholders, as well as in the English language (and/or Russian language) to reach international partners, including WHO, UNAIDS, the Global Fund and PEPFAR;
- present and discuss at **governance meetings**, i.e. to the Country Coordination Mechanism, National HIV, TB and Hepatitis Coordination Council, Universal Health Coverage Review and the

National Drug Commission, and/or other relevant bodies;

- write and publish an article in the **scientific literature** in the country and internationally;
- submit an abstract to **international and national conferences** on HIV, hepatitis, drug policy, drug dependence and global health;
- share through regional and global networks;
- organise a presentation to key stakeholders, particularly from governmental authorities and practitioners;
- share and highlight key conclusions and recommendations in **individual messages and meetings** with key stakeholders, especially to whom the recommendations are addressed.

The country might choose to develop a plan for addressing OAT sustainability based on an analysis of the assessment. The advisory group for the assessment might be instrumental in defining the relevance of such planning, the appropriate format, and the process to achieve such a result. A press-release could be issued after the key government officials have been briefed on the findings and recommendations.

ANNEX 1: Overview of frameworks and tools used for assessing transition and sustainability in the fields of HIV, TB and malaria

AGENCY, NAME OF THE TOOL	APPROACH	AREAS FOR INDICATORS
PEPFAR Sustainability Index and Dashboard (SID)	Completed every 2 years by PEPFAR and partner stakeholders to assess the current state of sustainability of national HIV/AIDS responses and to assist PEPFAR in making informed investment decisions. Results are presented as a 3-page analysis, accompanied by 40-pages of detailed tables with a colour-coded dashboard. For example, see Ukraine's SID 2018.	Based on responses to 90 questions, it covers 15 elements across the following four domains: 1. Governance, Leadership, and Accountability; 2. National Health System and Service Delivery; 3. Strategic Investments, Efficiency, and Sustainable Financing; 4. Strategic Information.
Transition Preparedness Assessment (TPA) framework and TPA tool (developed by Curatio International Foundation, commissioned by the Global Fund)	One of the most comprehensive tools that uses a health system approach, taking lessons from other health fields, like GAVI, and has reworked them. It is most widely applied for Global Fund programmes. Like PEPFAR's SID, it uses large tables, and a colour-coding system, to define the level of risk and sustainability of programme elements.	Issue and sub-issue areas and components are measured, including: 1. External environment: (a) Political; (b) Economic; 2. Internal environment • Inputs: (a) Financing; (b) Human resources; (c) Health information systems; • Governance: (a) Governance; (b) Accountability; • Programme: (a) Service delivery; (b) Organisational capacity; (c) Transition planning.
Transition Readiness Assessment Tool (TRAT) (commissioned by EHRN, originally produced by APMG Health)	Focused on harm reduction services through and beyond the transition period from Global Fund support to domestic funding, it is recommended to be conducted periodically. So far, it was applied in a number of South-East European countries. The application of the tool was undertaken by hired consultants — either national or international. The tool produces a numeric percentage of readiness/preparedness and has a major descriptive part. For example, the report is for Macedonia.	Four areas are measured through 12 indicators (3 per area) which, in turn, are each measured through three benchmarks: 1. Policy: transition plan, legal and policy environment, NGO contracting mechanism; 2. Governance: sustainable governance body, programme oversight and financial oversight; 3. Finance: optimised budget, financing for NGO's, procurement systems; 4. Programmes: standardised monitoring, service coverage, partnership with NGO's.

Agency, Name Of The Tool	Approach	Areas For Indicators
Guidance for Analysis of Country Readiness for Global Fund Transition (developed by ACESO Global and APMG Health, commissioned by the Global Fund)	Developed using other above listed tools, it complements the other tools but with a stronger focus on two areas: health care financing and fiscal space; and the role and sustainability of civil society (including analysis of the context for social contracting). Additionally, it "broadens the approach adding analyses to checklists". The tool is recommended for use by transition working groups in a country through a participatory approach with support of a consultant.	It is comprised of 6 modules, the first four being core: 1. Global Fund financial and non-financial support to a country; 2. Epidemiological situation and disease response; 3. Institutional and enabling environment; human rights and gender issues that have a bearing on successful transition; 4. Health care financing and fiscal space, including efficiency; 5. Delivery system enablers and barriers to transition, including supply chain, information systems and health workforce; 6. Role of civil society organisations (CSO's) in the response, including the ability of government to fund CSO's (social contracting).
Proposed new framework for the sustainability of the AIDS response by *Oberth and Whiteside*[20]	The framework has not been developed into a tool or matrix of indicators. The approach is more oriented towards sustainability and less towards donor transition. It is the only framework that outlines human rights as a separate dimension.	Proposed issue areas for sustainability: 1. Financial; 2. Epidemiological; 3. Political; 4. Structural; 5. Programmatic; 6. Human rights.

[20] Oberth G, Whiteside A. What does sustainability mean in the HIV and AIDS response? *African Journal of AIDS Research* 2016, 15: 1–9.

ANNEX 2: Report Outline

Cover page:

- *Suggested title:* Country name: Analysis of the sustainability of opioid agonist therapy in the context of transition from Global Fund support
- Year
- Organisation/author

Inner page:

- Acknowledgements
- Recommended citation
- Contacts

Table of contents

Abbreviations

Executive summary:

- *Up to 2 pages;*
- *One paragraph on the context/purpose/work undertaken;*
- *Key findings of the assessment. The analysis should include an overview of common cross-cutting aspects first and then address findings for each issue area;*
- *Key recommendations;*
- *Summary table of progress towards sustainability; a possible format for this is provided below.*

Overview of sustainability status:

A sample:

Issue Areas	Indicators		
Policy & Governance	At moderate to high risk	Political commitment	Moderate
		Management of transition from donor to domestic funding	At moderate to high risk
Finance & Resources	At high to moderate risk	Medications	At high risk
		Financial resources	At high risk
		Evidence and information systems	Moderate
		Human resources	At moderate to high risk
Services	Moderate	Availability and coverage	High
		Accessibility	Moderate
		Quality and integration	At moderate to high risk

Legend:

Scale: Status of sustainability	Description	Approximation of the scale as a percentage
High	High level of sustainability with low or no risk	>85–100%
Substantial	Substantial level of sustainability with moderate to low risk	70–85%
Moderate	Moderate level of sustainability, at moderate risk	50–69%
At moderate to high risk	Sustainability at moderate to high risk	36–49%
At high to moderate risk	Moderate to low level of sustainability, at high to moderate risk	25–35%
At high risk	Low level of sustainability, at high risk	<25%

Main part of the report

Note: *It is important to acknowledge sources of information in the narrative text substantiate statements. Sources could be either a regulation or a publication (with a weblink if there is one), a key informant if the interview is*

not anonymous or anonymised and/or a focus group. Sources should be indicated in footnotes, while others could be in the text.

1 **Context**
Up to 1.5 pages:

- One paragraph: Country health system context (how it is organised, funded, which sector dominates among service providers, narcology/dependence disease system and place in the health system).
- One paragraph: Drug policy and context of the drug scene, e.g. are drugs a high priority? Are opioids the main drugs of use based on estimates and official records? Is public health a priority for drug policy and are there indications of the impact of OAT?
- Include 1–2 paragraphs on the history of OAT history including its introduction and evolution (its purpose and status) and the role of donors in support of OAT in the country throughout its history.
- One paragraph: Funding: national funding of drug treatment (narcology); current status of support from donors that had funded, or currently fund, OAT (Global Fund, PEPFAR) including changes to its funding in the current and upcoming periods; donor transition timeline and reductions in funding.
- One paragraph addressing the context of donor transition, including the country's eligibility for Global Fund support.

2 **Purpose and methodology**
Up to 1 page:

- Purpose: includes why the assessment is important, what processes it should support;
- Methodology:
  - Infographics of methodology (an example is provided below);

- The list of informants should be as an annex or in the acknowledgements to the report;
- Tools used, implementation time period, any important elements of the methodology (validation by an expert or policy committee, engagement of an expert committee to support the study, who implemented the study); and,
- Key limitations of the methodology.

Infographics of methodology — a sample:

Adaptation of the regional EHRA methodology	Desk review of >40 sources	18 interviews with informants
2 focus groups: one with OAT clients and one with OAT practitioners	Finalisation in a multi-stakeholder round table	Advisory Group throughout the process

3 Key findings: Policy and governance

Up to 4 pages in total (here, and elsewhere, the length limitations are for the text; tables and graphics/boxes can use extra space as needed).

3.1 *Overview of the status of sustainability*

Up to 1 page:

Policy & Governance	**At moderate to high risk**
Political commitment	Moderate
Management of transition from donor to domestic funding	At moderate to high risk

In 2–3 paragraphs:

- High-level summary of sustainability status in the areas of:
  - Progress;
  - Challenges and lessons learnt;
  - Impact of transition; and,
  - Opportunities and the way forward.

3.2 *Political commitment*

Up to 1 page:

Give an overview of findings in this area, based on the general picture provided through the indicators. Give specific examples of documents, dates, steps by agencies and leaders, to illustrate the points.

- Progress: *Developments, good practices and enabling factors for progress in building sustainability, in particular over the last two years.*
- Barriers and Challenges: *Key gaps in sustainability, their underlying causes and factors.*
- Impact of Transition: *How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*
- Opportunities and Way Forward: *Opportunities, plans and suggested recommendations to sustain success, address the challenges and mitigate any negative impact of transition.*

3.3 *Governance and coordination*

Up to 0.75 page:

- Same issues as above, under 3.2.

3.4 *Management of transition from donor to domestic funding*
Up to 1 page:

- Same issues as above, under 3.2.

To add:

- Scheme: Key milestones for building OAT sustainability (past, present and future).

4 Key findings: Finance and other resources
Up to 5 pages in total:

4.1 *Overview of the status of sustainability*
Up to 1 page:

- Same as under previous issue areas (see 3.1.).

Finance & Resources	**At high to moderate risk**
Medications	At high risk
Financial resources	At high risk
Human resources	At moderate to high risk
Evidence and information systems	Moderate

4.2 *Medications*
Up to 0.75 pages:

- Same as 3.2.

4.3 *Financial resources*
Up to 1 page:

- Same as 3.2.

To add:

- Tables from 2.2.1 Desk review adapted and included if there insights are available.
  - Table: Funding levels and progress of financial transition (in national currency and USD or EUR);
  - Table: Breakdown of the components supported by different funding sources.

4.4 ***Human resources***
Up to 0.75 page:

- Same as 3.2.

To add:

- A schematic of a standard OAT team (if there is more than one model of service delivery, then provide a schematic for each model; indicate the structures and specialties of the team members)
- Tables from 2.2.1 Desk review adapted and included if insights are available (Table: Human resources).

4.5 ***Evidence and information systems***
Up to 0.75 page:

- Same as 3.2.

To add:

- A box with an extract from the evidence base — key arguments of the impact, effectiveness and efficiency of OAT in the country.

5 Key findings: Services
Up to 5 pages in total:

5.1 *Overview*

Up to 1 page:

- Same as under previous issue areas (see 3.1.).

Services	**Moderate**
Availability and coverage	High
Accessibility	Moderate
Quality and integration	At moderate to high risk

To add:

- The table from 2.2.1 Desk review adapted (or even split into two).
  - Table: Analysis of key numbers of OAT clients and sites for the last 3 years and for the upcoming year.

5.2 *Availability and coverage*

Up to 1 page:

- Same as 3.2.

5.3 *Accessibility*

Up to 1 page:

- Same as 3.2.

To add:

- Geographic map of the OAT sites in the country.

5.4 *Quality and integration*

Up to 1 page:

- Same as 3.2.

To add:

- A box with the list of WHO, and internationally recommended, elements in the national guidelines and a tick for those that have been implemented.

6 **Conclusions and recommendations**
Up to 2.5 pages, including:

1 0.5–1 page of conclusions;

2 Up 1.5 pages of recommendations.
The overarching 4–5 recommendations should be followed by recommendations that are grouped by authorities/stakeholders:

- Ministry of Health, other health authorities where possible, to be specified;
- OAT practitioners and the medical community, including professional associations and academia;
- Civil society, including groups and activists of people who use drugs, drug policy activists, AIDS, TB and Hepatitis C coalitions (be as specific and tailoured to the country as possible);
- Drug control and political leadership, if relevant;
- Technical and donor partners (including WHO, UNODC, UNAIDS, the Global Fund, PEPFAR, etc.).

7 **References**

Recommended approach to referencing the reviewed literature through the desk review is as follows:

Minister of Civil Affairs of Bosnia and Herzegovina: Decision of December 2018 '*Regarding the Allocation of Funds of the Current Grant Co-financing of NGO Projects in the field of prevention of HIV and TB in Bosnia and Herzegovina in 2018.*' [*in Bosnian*]

Sachs, J., Schmidt-Traub, G., Kroll, C., Lafortune, G., Fuller, G. Sustainable Development Report 2019. New York: Bertelsmann Stiftung and Sustainable Development Solutions Network, 2019.

U.S. Department of State. *2018 Country Reports on Human Rights Practices: Namibia*, March 2019.

Annex 1: Detailed methodology and list of respondents

Summary of the methodology used and a link to the assessment tool; key changes, if any, to the methodology during the planning and implementation of the assessment.

List of respondents grouped by:

- Individual informants;
- Focus groups.

Annex 2: Overview of measurement scoring of sustainability

This annex should provide the table of scoring for all indicators and benchmarks. It should provide a summary of the sources for each benchmark — either the number from the reference list and/or that it originates with an informant or a focus group without providing further identification details.

The assessor should have a more detailed internal file with key details of the progress for each benchmark, even specific percentages calculated (what has been accomplished and what gaps/challenges exist, quotes from key statements made by an official to the media or from an official document if that is particularly illustrative) in a short format. Some scoring might be finalised by the Advisory Group, especially if there are contradictory perspectives from different stakeholders, or from a focus group.

The following is an example of how the table can be populated:

	Scoring	Source(s)
Issue Area: Name	*Indicate using the scale below (one of the six scales)*	
***Indicator 1:** Name*	*Indicate*	
Benchmark 1.1 name (the wording can be shortened)	*Indicate*	Focus group of OAT clients; National OAT guidelines.
Benchmark 1.2 name (the wording can be shortened)	*Indicate*	Three key informants; National Programme on Drug Control, 2016–2020.

Legend for scoring the status of sustainability:

Indicators & issue areas: Scale for status of sustainability	Description	Approximation of the scale as a percentage	Colour coding
High	High level of sustainability with low or no risk	>85–100%	Green
Substantial	Substantial level of sustainability with moderate to low risk	70–85%	Light green
Moderate	Moderate level of sustainability, at moderate risk	50–69%	Yellow
At moderate to high risk	Sustainability at moderate to high risk	36–49%	Orange
At high to moderate risk	Moderate to low level of sustainability, at high to moderate risk	25–35%	Light red
At high risk	Low level of sustainability, at high risk	<25%	Red

Benchmarks: Scale of status of sustainability	Description	Approximation of the scale as a percentage	Colour coding
High	High or good level of sustainability; no major risks	≥70–100%	Light green
Moderate	Moderate level of, and risk for, sustainability	36–69%	Yellow
At high risk	High risk for sustainability	≤35%	Light red

ANNEX 3: Instructions in the use of the three tools 3.A, 3.B and 3.C

The tools in Annexes 3.A, 3.B and 3.C are provided in the format that can be used by the Assessor to organise data including the desk review, analysis of interview and focus group notes, and for writing Section 3, 'Key findings: Policy and Governance' in the report. Additionally, it can feed into other sections of the report (see for the report outline).

Structure of the tools
The tools are comprised of the following parts:

- Indicator-related tables; for each indicator, they comprise of:
  - quantitative scoring of benchmarks and the indicator; and,
  - qualitative information to summarise the following aspects: Progress, Barriers and Challenges, and Transition Impact;
- Additional tables and other tools to analyse the collected data.

Approach to quantitative measuring
The scales for scoring the status of sustainability have been adapted from the approach by Curatio International Foundation in the Transition Readiness Assessment Framework. Given the very limited composition of data for producing a precise percentage, EHRA decided not to use the percentages in the final presentation of the results and, instead, use the rating scales. However, for internal use, the calculation of percentages can be used to define these values which are also expressed as an approximation of the scale. Hence, the assessment will state the level of sustainability and the possible risk instead of providing the percentage of sustainability.

The following is the simplified table used for the quantitative measuring of an indicator:

Indicator	Scoring	Notes and Sources
Benchmark 1		
• Component		
• Component		
Scoring of benchmark 1		
Benchmark 2		
• Component		
• Component		
Scoring of benchmark 2		

Quantitative measuring and scales
Each benchmark is measured through the scoring of components in a 3-level points system, i.e. 0 point being the lowest value through to 2 points being the highest value.

Once the components are fully scored, then the percentage of all received scores can be calculated out of the maximum possible points. This percentage is for internal use, not in external documents. In the external report and final analysis, this percentage is converted into the following scale for benchmarks:

Benchmarks: Scale of status of sustainability	Description	Approximation of the scale as a percentage	Colour coding
High	High or good level of sustainability; no major risks	≥70–100%	Light green
Moderate	Moderate level of, and risk for, sustainability	36–69%	Yellow
At high risk	High risk for sustainability	≤35%	Light red

Scoring of the benchmarks is used for calculating the score of each indicator. The average percentage of the benchmark's status for sustainability serves as a proxy percentage and is converted into the value in the 6-level scale used for indicators. Similarly, in the case of issue areas, the average percentage of relevant scoring for the indicators defines the level from the same 6-level scale used both for indicators and benchmarks.

Indicators & issue areas: Scale for status of sustainability	Description	Approximation of the scale as a percentage	Colour coding
High	High level of sustainability with low or no risk	>85–100%	Green
Substantial	Substantial level of sustainability with moderate to low risk	70–85%	Light green
Moderate	Moderate level of sustainability, at moderate risk	50–69%	Yellow
At moderate to high risk	Sustainability at moderate to high risk	36–49%	Orange
At high to moderate risk	Moderate to low level of sustainability, at high to moderate risk	25–35%	Light red
At high risk	Low level of sustainability, at high risk	<25%	Red

To establish the scoring, the Assessor will fill in the 'notes and sources' first, i.e. undertake the review and analysis of interviews and focus groups for each benchmark. Once this is completed, s/he will identify the level of fulfillment of the elements of the benchmark. S/he will use bullet points as a reference for the full degree of sustainability (achieved in full), with bullet points seen as a composite index. In case of uncertainties due to conflicting or missing information, the Assessor can ask the advisory group to give its mark or to validate the score.

Qualitative information and tables

The current version of the forms have not copied the tables from Section *2.2.1 Desk review* to avoid duplication and due to considerations of length. Copy and paste relevant tables into the tools and adjust tools for the collection of qualitative information, as needed.

INDICATOR A1: POLITICAL COMMITMENT

There is political support for OAT implementation and scale-up in line with international recommendations.

SCORING OF BENCHMARKS	SUSTAINABILITY SCORE (0, 1 POINT OR 2 POINTS)	MAXIMUM SCORE	PERCENTAGE AND SCORING, BASED ON A 3-LEVEL SCALE FOR BENCHMARKS	NOTES AND SOURCES
BENCHMARK A1.1: OAT is included in national drug control, HIV and/or hepatitis strategies and action plans, with a commitment to WHO-recommended targets.				
• OAT is explicitly listed in the current plan(s) as part of the approved national policy documents guiding drug control, HIV and hepatitis in line with WHO recommendations		2		(add information from the desk review and interview notes using bullet points and quotes)
• There is a good level of long-term policy support for OAT in health and drug policy		2		
Total points and scoring:	*(fill, summing the points above)*	4	% *(fill, calculating the percentage; indicate the scoring and change the colour of the cell based on the colour-coding of the scoring)*	
BENCHMARK A1.2: Legislation explicitly supports the provision of OAT. *Note: this benchmark is modified from UN guidance and corresponds to the indicator OST.Q1a in the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users — 2012 revision (p.67) and the policy and legislation audit checklist ENV-1 in the WHO Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations (p.28).*				
• The provision of OAT is authorised by the law, i.e. there is legislation* with unambiguous support for OAT.		2		
• Legislation* is unambiguous on the legal status of OAT, i.e. there are no legislative barriers to OAT. * *The legislation can be either drug-related or HIV and communicable diseases or under the framework of the right to health and criminal justice.*		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• Being an OAT client does not imply negative consequences on basic rights (for example, the right to drive, get married, housing, parental rights, becoming a government official, etc.). The records of OAT clients are not disclosed to the police (unless required by a court decision). Legal requirements do not limit basic rights of OAT clients that are not clinically justifiable. OAT clients are not required to relinquish their basic rights (e.g. to be included in a state narcology register which might be shared with the police) in order to access OAT.		2		
OPTIONAL • Current legislation does not include laws criminalising drug use, or the possession of drugs for personal use. *Extracted from sub-indicator ENV-1 1 in the WHO Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations (p.28).*		2		
Total points and scoring:		8		
Benchmark A1.3: OAT is a core part of national policy for opioid dependence management. This benchmark implies the commitment of the MoH to OAT implementation.				
• The country's authoritative agency, normally the Ministry of Health, has approved national treatment protocols for drug dependence management or guidelines specifically for opioid dependence management.		2		
• Such guidelines, or a national programme on drug dependence, explicitly foresee the clinical application of OAT as the main method for opioid dependence management.		2		
• Guidelines are in full compliance with WHO recommendations.		2		
• There is a designated body responsible for OAT development and support and for the implementation of OAT guidelines at the national level.		2		
Total points and scoring:		8		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
OPTIONAL **Benchmark A1.4: Law enforcement and justice systems support implementation, and expansion as needed, of OAT.** *Note: this benchmark is modified from the UN guidance and corresponds to the indicator OST.Q1b in the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users — 2012 revision (p.67) and the indicator ENV–5 in the WHO Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations (p.30).*				
• There is guidance for police and prison staff towards harm reduction in general or OAT specifically. In the last year, formal measures were put in place to support implementation of the guidance.		2		
• If the criminal justice system is entitled to mandate a person to offer treatment as an alternative to incarceration, or to mandate treatment for opioid dependence, OAT is used as a treatment option.		2		
• There have been no reports from health practitioners and/or civil society of systemic law enforcement practices to target OAT clients in the last year.		2		
• At least half of law enforcement officers received sensitisation training about people who use drugs, drug dependence and OAT over the last 5 years. *Adapted from sub-indicator ENV–5 in the WHO Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations (p.30).*		2		
Total points and scoring:		8		
OPTIONAL **Benchmark A1.5: Effective governance and coordination oversees the development of OAT in the country.**				
• There is a designated institution(s) or department(s) or a governance body(ies) responsible for OAT development oversight and coordination.		2		
• Over the last two years, the body designated for OAT development reviewed the progress, acknowledged successes and challenges and made tangible recommendations with a plan of how these recommendations would be implemented.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Total points and scoring:		4		
OPTIONAL **Benchmark A1.6: Civil society, including OAT clients, are consulted about OAT governance and coordination at the country level.** *Note: this benchmark is modified from UN guidance and corresponds to indicator ENV–2 in the WHO Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations (p.29) and indicator OST.Q.1e in the — WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users 2012 revision (p.67).*				
• There are formal and effective processes to include civil society, including OAT clients, in the structures for the governance and coordination for OAT, or regularly (at least once per year and with regards to the most important documents, such as the transition processes) consult with them at national level.		2		
• Civil society and OAT clients are proactive and effective in these processes over the last year, i.e. they have agenda items accepted for meetings, or even initiate meetings concerning evidence and recommendations to the governance and coordination processes.		2		
Total points and scoring:		4		

General matters concerning this indicator	
Average percentage of benchmark scoring (from above)	
General scoring, based on the 6-value scale	
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*	*If needed, a quote from a document / interview / focus group.*
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*	
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*	

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*				

Indicator A2: Management of transition from donor to domestic systems

Transition from donor support to domestic systems is planned, costed, and making good progress.

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Benchmark A2.1: Country adopted plan which defines transition of OAT from donor to domestic funding and which includes a timeline.				
• The transition plan has been adopted at government level, i.e. not only by the governance of donor-focused projects.		2		
• OAT is addressed in a transition plan on HIV or TB that is approved through a consultative process by a multisectoral governance body in the HIV or TB field.		2		
• The plan sets a timeline for OAT transition.		2		
OPTIONAL • Governance of drug control (and, if relevant, universal health coverage or health insurance leadership) is informed of the transition plan or transition process, i.e. they have been sent the information or this information was shared in one of their governance meetings in the last, or current, year.		2		
Total points and scoring:		8		
Benchmark A2.2: There is a multi-year financial plan approved for OAT transition to domestic sources with unit costs developed, co-financing levels, the (future) domestic funding sources for OAT identified and agreed among country representatives.				
• The financial plan as to how OAT will transit to domestic funding has been produced through a consultative process and reflects co-financing.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• The domestic funding source for OAT, during and after donor transition, has been agreed among stakeholders and it is agreed that OAT will be included in the universal health coverage package(s).		2		
• The costing (unit cost) is developed and approved as part of the transition planning by a body in charge of transition. Normally, this should include MoH and/or insurance finance experts, civil society and implementers of OAT programmes and the national coordination body for OAT programmes.		2		
Total points and scoring:		6		
Benchmark A2.3: Donor transition oversight in the country effectively supports implementation of the OAT transition to domestic systems.				
• There is a body and/or consultative process in charge of overseeing the implementation of transition of OAT to domestic funding and structures; this could be the CCM.		2		
• The body and/or consultative process regularly (at least once in the last year and at least once in the current year) reviews the progress, and sets the steps for, addressing challenges, including OAT.		2		
• The body and/or consultative process overseeing the implementation of transition of OAT includes the governance of the drug dependence system, i.e. there is a link between the drug dependence system review and management and the governance of transition.		2		
• Civil society, including OAT client representatives, are involved in these processes and can raise awareness of progress among OAT clients and vice versa.		2		
Total points and scoring:		8		
Benchmark A2.4: There is good progress being made in the implementation of the OAT-component of the transition plan.				
• The steps in relation to OAT in the transition plan have been delivered so far.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• The relevant financial, technical and human resources have been allocated for implementing the steps for planning and for conducting the transition.		2		
• Progress in the last year is in line with the set timeline. There is management in place to support timely delivery, or revision, of plans, as needed, or in addressing barriers.		2		
Total points and scoring:		6		

General matters concerning this indicator	
Average percentage of benchmark scoring (from above)	
General scoring, based on the 6-value scale	
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*	*If needed, a quote from a document / interview / focus group.*
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*	
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*	
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*	

Add tables from *2.2.1 Desk Review* as relevant.

Other comments on the section and recommendations	

INDICATOR B1: MEDICATIONS

OAT medications are fully integrated into the national essential medicine system with quality assurance, good procurement and price controls.

** Please note that this benchmark might require adjustment in line with a specific country's health system.*

SCORING OF BENCHMARKS	SUSTAINABILITY SCORE (0, 1 POINT OR 2 POINTS)	MAXIMUM SCORE	PERCENTAGE AND SCORING, BASED ON A 3-LEVEL SCALE FOR BENCHMARKS	NOTES AND SOURCES
BENCHMARK B1.1: OAT medicine procurement is integrated into the domestic PSM system and benefits from good PSM capacity, without interruptions.				
• Procurement of OAT medications is performed in line with other essential medicines in the country following the rules for controlled medicines.		2		(add information from the desk review and interview notes using bullet points and/or quotes)
• There is no parallel system to the national procurement and supply management system due to donor funding, i.e. the PSM system will not change after the donor leaves the country.		2		
• The country received import (or production) permission for an adequate amount of OAT medications from the International Narcotic Control Board (INCB) in the last, and current, years.		2		
• OAT clients and providers have not reported systemic interruptions in medicine supply in the last 12 months in any of the regions of the country.		2		
OPTIONAL • If the PSM system used for OAT medications differs from the national system of other state paid medicines, a transition plan is in place to pass their procurement and supply to relevant agencies. These agencies have capacity to procure and manage the supply of controlled medicines and the ability to get similar prices to those that currently apply. This transition process is making good progress.		2		
Total points and scoring:		10		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Benchmark B1.2: Both methadone and buprenorphine are registered and their quality assurance system is operational.				
• OAT medicines that are currently used in the country for OAT (at least one version of methadone and one version of buprenorphine, even if these versions are not yet used) are registered with national authorities. Other medicines that could be used for OAT include a combination of buprenorphine and naloxone, slow-release morphine and diacetylmorphine (heroin).		2		
• Additional versions of OAT medicines could be swiftly registered in the country through the simplified procedures for WHO prequalified medications or medicines registered with European Medicines Agency (EMA) and other stringent authorities or due to other national registrations.		2		
• OAT doctors and patients are aware of a pharmacovigilance system and do not have major barriers to report adverse reactions to these medications.		2		
• Over the last year, there have been no systematic reports about the quality of medicines, including adverse reactions. If there have been systematic reports, they have been, or are being, addressed.		2		
Total points and scoring:		8		
Benchmark B1.3: Methadone and buprenorphine are secured at affordable prices.				
• Prices for OAT medications are compatible with those in neighbouring countries and/or prices used through the procurement system with donor support.		2		
• If methadone and/or buprenorphine are not currently paid from public sources, the country has a mechanism for obtaining good prices for both methadone and buprenorphine (e.g. simplified procurement for essential medicines; no patent related barriers, particularly for buprenorphine-containing medicines).		2		
Total points and scoring:		4		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
General matters concerning this indicator				
Average percentage of benchmark scoring (from above)				
General scoring, based on the 6-value scale				
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*				
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*				
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*				
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*				

Indicator B2: Financial Resources

Sustainable financial resources are secured for OAT.

** Please note that this benchmark might require adjustment in line with a specific country's health system.*

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Benchmark B2.1: Methadone and buprenorphine are included in the state reimbursed medicine lists and are funded from public sources.				
• The list of government-paid medicines includes both methadone and buprenorphine. This list could be approved by the Ministry of Health, by a national health insurance fund, or by a similar body. Additionally, it could potentially include other OAT medicines if they are included in the national drug treatment guidelines.		2		(add information from the desk review and interview notes using bullet points and/or quotes)
• These medicines are paid for from public, domestic sources, i.e. by national or local authorities.		2		
Total points and scoring:		4		
Benchmark B2.2: OAT services are included in universal health coverage or state guaranteed package of healthcare, including people without health insurance.				
• The list of minimum guaranteed health services for all citizens as well as permanent and temporary residents (or also foreigners) established by law or MoH includes drug treatment and, specifically, OAT.		2		
• Alternatively, or additionally, in insurance-based health systems, there are special schemes to cover OAT for people without insurance and/or there is a scheme for OAT programmes to support re-establishing insurance for potential and current clients who do not currently have insurance, so that uninsured people have equitable access to OAT. Such schemes might be approved by municipalities or MoH initiatives of universal health coverage.		2		
Total points and scoring:		4		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Benchmark B2.3: OAT services are paid through sustainable public funding sources which secure adequate funds to cover comprehensive services.				
• Public funding source(s) that finance OAT services (beyond medication) exist for more than one year and will exist for at least a further year, i.e. it is more than a short-term funding source. Such a public funding source is established in legal documents either as part of the national health insurance scheme or as a national drug treatment programme or other relevant way to establish a budget line in the country's health system.		2		
• The amount allocated for OAT by the state is ringfenced and is adequate to meet needs in the current year.		2		
• There is a process for tracking these funds and to correct the amount if there is an additional need.		2		
• The amount allocated for OAT in the last year is adequate to pay for the services foreseen in the national treatment guidelines in line with WHO recommendations (i.e. co-payments for staff, if relevant, in the country or in addressing testing and other services).		2		
Total points and scoring:		8		
only for countries with active HIV grants from the Global Fund that concern OAT **Benchmark B2.4: In countries with active HIV grants, OAT services are co-financed by the Government in accordance with the Global Fund Sustainability, Transition and Co-Financing Policy.**				
• The Global Fund has communicated its Sustainability, Transition and Co-Financing Policy and how that translates in practical terms to co-financing of programmes in the country, including OAT.		2		
• The country has made commitments to co-finance OAT in line with the Global Fund policy and communicated that commitment within the country and to the Global Fund.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• The country has made good progress with implementation of its co-financing commitment in the last year and there is clarity in the implementation of co-financing in the forthcoming year.		2		
Total points and scoring:		6		

General matters concerning this indicator	
Average percentage of benchmark scoring (from above)	
General scoring, based on the 6-value scale	
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*	
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*	
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*	
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*	

Indicator B3: Human Resources

Human resources are secured currently and in long term at levels to achieve WHO-recommended scale and quality of OAT programmes.

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Benchmark B3.1: OAT is part of the job description of main health staff and in core functions of the state system for drug dependence with relevant capacity to prescribe and dispense OAT at the required scale.				
• MoH documents outlining the functions of drug treatment or mental health systems clearly specify OAT among their core functions.		2		(add information from the desk review and interview notes using bullet points and/or quotes)
• Specialised doctors and other health professionals in the drug treatment system have implementation of OAT as their core function in their terms of reference. Their work on OAT services does not require special supplementary payments.		2		
• Prescribing of OAT is not limited to a small number of medical doctors, i.e. the human resources available are sufficient to achieve an adequate scale of OAT coverage commensurate with the WHO recommended level. Hence, if drug treatment is not developed, doctors of other specialisations are enabled, supported and trained to prescribe and/or support OAT. ***Note:*** *According to WHO guidelines on HIV and key populations, "sites where OST is prescribed may include: specialist services, general practitioner prescribers/office-based and other primary care settings. Sites where OST is dispensed may include: pharmacies, specialist services, mobile dispensing services".*		2		
Total points and scoring:		6		
Benchmark B3.2: Capacity building system is adequate for OAT implementation in a sustainable way.				
• The national guidelines stipulate that treatment of opioid dependence is carried out by trained health-care personnel. The level of training for specific tasks is determined by the level of responsibility and national regulations.		2		
• OAT is integrated within professional health training, at least for drug dependence doctors and nurses and infectious disease specialists.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• OAT staff are provided continuous training (work-based training, sharing scientific and other literature, training sessions and mentoring before starting and at least once every two years during implementation).		2		
• Capacity building for OAT staff, as a minimum, includes sensitisation and destigmatisation towards people who use drugs, OAT, and also WHO recommendations on OAT.		2		
Total points and scoring:		8		

General matters concerning this indicator	
Average percentage of benchmark scoring (from above)	
General scoring, based on the 6-value scale	
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*	
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*	
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*	
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*	

Indicator B4: Evidence and Information Systems

The development of OAT is supported through adequate evidence generation and information system in line with the protection of patient data.

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Benchmark B4.1: A monitoring system for OAT is in place and is used for managing the OAT programme, including programme needs, coverage and quality assurance.				
• A M&E plan for OAT is adopted. OAT M&E system regularly collects information based on the essential WHO recommended indicators (the list of the main WHO guidance documents is provided in *Section 1.3. Conceptualising the OAT sustainability framework*).		2		(add information from the desk review and interview notes using bullet points and/or quotes)
• The OAT M&E system publishes reports in the national language based on these indicators and targets for these indicators if there is any change or progress.		2		
• Reports produced by the OAT M&E system are used by national OAT governance at a strategic level, and by the OAT national coordination body at the technical level, to improve OAT.		2		
• As part of the OAT M&E system, there is a regular, updated estimation of the number of people who are opioid dependent which is agreed through a national consensus. This estimation is used to calculate current service need (and as a denominator in calculating the OAT service coverage and gaps, if any). The current estimation is updated (i.e. for it to not be more than 5 years old).		2		
Total points and scoring:		8		
Benchmark B4.2: The evidence base for OAT effectiveness and efficiency is regularly generated and informs policy and programme planning.				
• There have been comprehensive or independent evaluations of OAT effectiveness and efficiency. In case the OAT is piloted, the evaluation summarises the pilot results and is used for policy decisions on next steps after the pilot stage. ***Note:*** *There is sufficient evidence from various settings around the world that OAT is effective and efficient.*		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• Local academia has been engaged in supporting scientific research on OAT in the country in the last 3 years.		2		
• In the last 3 years, there has been an evaluation from the perspective of OAT clients. The results of these studies have been discussed; the recommendations are being implemented. The key conclusions of the studies have been disseminated beyond the drug treatment community — including among policy makers.		2		
Total points and scoring:		8		
Benchmark B4.3: OAT client data is confidential and stored in a secure, protected database and data is not shared outside of the health system without a client's consent. *Note: this benchmark is modified from UN guidance and corresponds to indicators OST.Q1r, Q.1s, and Q.1t in the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users — 2012 revision (p.68).*				
• There is an OAT client database. The database supports OAT patients to receive OAT in different locations of the country (in case they move to another location, are on vacation or longer business trips) without a major bureaucratic burden and doctors can access information about dosage and the needs of a patient.		2		
• National policy stipulates that OAT programmes maintain client confidentiality. Data is kept using good practice for patient data protection, i.e. it is confidential, not shared outside of the health system without an OAT client's consent, and the database is well-protected electronically, without reported breaches and hacking in the last year.		2		
Total points and scoring:		4		
General matters concerning this indicator				
Average percentage of benchmark scoring (from above)				
General scoring, based on the 6-value scale				
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*				

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*				
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*				
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*				

Add tables from *2.2.1 Desk Review* as relevant.

Other comments on the section and recommendations	

INDICATOR C1: AVAILABILITY AND COVERAGE

OAT is available at adequate scale and in various settings.

SCORING OF BENCHMARKS	SUSTAINABILITY SCORE (0, 1 POINT OR 2 POINTS)	MAXIMUM SCORE	PERCENTAGE AND SCORING, BASED ON A 3-LEVEL SCALE FOR BENCHMARKS	NOTES AND SOURCES
BENCHMARK C1.1: OAT is available in hospitals and primary care. Take-home doses are allowed.				
• OAT is available, at least to some degree, for people when hospitalised.		2		
• OAT is possible through primary care centres if OAT clients meet certain conditions (e.g. stable on OAT).		2		
• Take-home doses are allowed and practiced for at least some category of patients (stable patients), i.e. patients do not need to come for their medication on a daily basis.		2		
Total points and scoring:		6		
BENCHMARK C1.2: Coverage of estimated number of opioid dependent people with OAT is high. *More details on this benchmark are available in the WHO tool for setting and monitoring targets: Supplement to the 2014 Consolidated Guidelines for HIV prevention, diagnosis, treatment and care for key populations; see indicator OST-3 (p.43).*				
• Coverage is high, in line with the WHO definition. WHO defines the coverage as high, medium and low, when it reaches the following levels: Low ← 20% ← Mid → 40% → High. High equates to 2 points, mid equates to 1 point. *The calculation of this indicator uses the following corresponding nominator and denominator : (1) the number of all individuals on OAT at the latest possible, specified date (latest possible or the end of a specific period for which the data is collected for the assessment); and, (2) the estimated number of people who are opioid dependent or an estimated number of people who inject opioids. The latter number should derive from estimations of the number of people who inject drugs using the last IBBS report that provides a percentage of people who injected opioids. It is important that the most recent estimates are used. The country might use different approaches to calculate coverage in its national policy documents and for reports on the implementation of the UN political declaration. For example, they might base coverage on the*		2		(add information from the desk review and interview notes using bullet points and/or quotes)

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
number of people registered with the state narcology (drug) system in the country. Such an approach means that people who are not registered in the system are not calculated in the estimation of the need for treatment and, therefore, it does not accurately show coverage. Any concerns over data should be added in the notes.				
Total points and scoring:		2		
Benchmark C1.3: OAT is available in closed settings including initiation onto OAT as well as during pre-trial detention and for females. *Note that the level is measured through the availability of OAT in different criminal justice settings and not the level of accessibility or scale. However, comments can be added on observations about the expansion or contraction of the number of OAT clients or on institutions providing OAT in the criminal justice system, especially in relation to donor transition.*				
• OAT is provided to opioid dependent people who are arrested, in detention before/during trial, or serving a sentence. *Note: The institutions where a person is placed might be under the jurisdiction of different agencies, for example, the Ministry of Interior, Ministry of Justice or a penitentiary service.*		2		
• There is a possibility to initiate OAT while in prison, in addition to the continuation of OAT that was initiated outside of prison.		2		
• OAT is provided to female inmates. *Note that females constitute a small proportion of people in the criminal justice system, while a high proportion of them might be there because of drug-related charges. Therefore, it is important that institutions serving females provide OAT.*		2		
Total points and scoring:		6		
OPTIONAL **Benchmark C1.4: OAT is possible and available in the private and/or NGO sectors in addition to the state sector.** *Note: The use of this indicator should be contextualised for an individual country. For some countries, it might be irrelevant. The country's health system might be relying on different sectors — state, private and NGO sectors — for the provision of essential state-funded services. In that case, availability of OAT in other than the state sector is important. In some countries, there is a proportion of people who are opioid dependent and prefer using a private system in order to maintain full confidentiality of records, i.e. giving a choice to a proportion of people in need. This is often done, however, only on the condition of full or co-payment for the service and medication and, therefore, these sectors might be available but not accessible for most people. For this assessment, it is important that non-state sectors are following general national treatment and quality assurance guidelines.* *Note: this benchmark is modified from UN guidance and corresponds to indicators OST.Q1r, Q.1s, and Q.1t in the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users — 2012 revision (p.68).*				

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• OAT is available in the private sector.		2		
• OAT is available through licensed NGO's.		2		
• Services in the private and NGO sectors are provided by following general national treatment guidelines, including quality assurance.		2		
Total points and scoring:		6		

General matters concerning this indicator	
Average percentage of benchmark scoring (from above)	
General scoring, based on the 6-value scale	
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*	
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*	
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*	
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*	

Indicator C2: Accessibility

OAT is accessible without barriers in terms of physical access, enrollment, and in a timely fashion, with due consideration of different population needs.

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Benchmark C2.1: There are no people on a waiting list for enrolment into the OAT service. *Note: In some countries, OAT might have a number of fixed places or slots. WHO recommends that the capacity meets the demand and the number of people on a waiting list is minimised.* *More details on this benchmark is available in the WHO tool for setting and monitoring targets: Supplement to the 2014 Consolidated Guidelines for HIV prevention, diagnosis, treatment and care for key populations: see indicator OST–2 (p.43).*				
• OAT capacity is sufficient to meet demand and, at the most recent available date, there were no people on a waiting list for enrolment onto OAT according to programmatic data, reports from service providers and community representatives.		2		
Total points and scoring:		2		
Benchmark C2.2: OAT opening hours and days accommodate the key needs of clients. *Note: this indicator is modified from UN guidance and corresponds to indicator OST.Q1m in the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users — 2012 revision (p.68).*				
• National guidelines stipulate that the dispensing of OAT is available at various times of the day and beyond standard office hours, if required, and on weekends to allow clients who are employed to access the service.		2		
• In practice, more than 75% of OAT sites in the country operate beyond standard office hours (e.g. they are open in the morning before normal office hours and/or during the standard office lunch break) and offer a possibility to pick up OAT medicines during weekends.		2		
Total points and scoring:		4		
Benchmark C2.3: Geographic coverage is adequate.				
• At a minimum, OAT is available in all of the main geographic administrative regions of the country where opioid dependence, and the need for OAT, has been reported.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• In cities with more than one million inhabitants, there are two or more OAT sites in different geographic districts.		2		
Total points and scoring:		4		
Benchmark C2.4: There are no user fees and no cost-barriers for people on low income and without insurance. *More details on this benchmark is available in the WHO tool for setting and monitoring targets: Supplement to the 2014 Consolidated Guidelines for HIV prevention, diagnosis, treatment and care for key populations: see indicator OST–4–c (p.45).*				
• National policy includes provision to ensure that OAT is affordable, so as to maximise access.		2		
• There are mechanisms to implement this affordability policy.		2		
• Costs are eliminated for financially disadvantaged clients, including people without health insurance in the case of insurance-based health systems.		2		
• There are no hidden fees or barriers (e.g. there is a support mechanism for proving a lack of insurance and low income to guide a client through the bureaucracy; there are no major fees for documentation or examinations required for being considered for OAT).		2		
Total points and scoring:		8		
Benchmark C2.5: OAT is available and accessible for populations with special needs (pregnant and other women, sex workers, young users, ethnic groups, etc.).				
• National guidelines are considerate of different groups that might have difficulties in accessing OAT if their particular needs are not addressed.		2		
• Guidelines do not set counter-indications for pregnant women, age limits, and parental consent requirements.		2		
• In the largest cities (the top 5 cities, or cities with a population of more than 500,000) and/or key regions, there are either targeted programmes or sensitised services for the main populations with particular needs.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
At a minimum, sensitised and targeted programmes should have trained staff with an understanding of the needs of the population. Examples of the special considerations for different groups are outlined in the WHO Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence.				
• The list of populations with particular needs is relatively complete and contextualised to the country based on evidence. Those populations could be, depending on the country's context, pregnant and other women, sex workers, young people, including adolescent users, and ethnic groups. *WHO clinical guidelines have specific sections addressing the needs of the following groups eligible for pharmacological treatment: adolescent (14–18 years old); women, pregnancy and breastfeeding, opium users; patients with HIV/AIDS, hepatitis and TB; psychiatric comorbidity; polysubstance dependence (p.49–52, WHO Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence).*		2		
Total points and scoring:		8		
Benchmark C2.6: Illicit drug consumption is tolerated while enrolled in OAT (after the dose induction phase).				
• National guidelines are clear that illicit drug consumption is not a criterion for exclusion (involuntary discharge) of a person from the OAT programme, i.e. people who use drugs can receive OAT and their drug use is not used for excluding them from the programme.		2		
• In case of illicit drug consumption, the national guidelines recommend, as needed, a re-evaluation of the dosage or the treatment approach used.		2		
• The national guideline is implemented in at least the majority of OAT sites. In the last year, no systematic non-compliance with this WHO recommendation has been reported by OAT community groups or practitioners or technical support providers.		2		
• OAT clients have access to needle/syringe exchange if they inject drugs.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Total points and scoring:		8		
Benchmark C2.7: Individual plans are produced and offered with involvement of the user of the service. *In line with WHO guidelines, as a minimum standard, a "detailed individual assessment should be conducted which includes: history (past treatment experiences; medical and psychiatric history; living conditions; legal issues; occupational situation; and social and cultural factors, that may influence substance use); clinical examination (assessment of intoxication/withdrawal, injection marks); and, if necessary, investigations (such as urine drug screen, HIV, Hepatitis C, Hepatitis B, TB, liver function)." As a good practice, "[t]he choice of treatment for an individual should be based on a detailed assessment of the treatment needs, appropriateness of treatment to meet those needs (assessment of appropriateness should be evidence based), patient acceptance and treatment availability."*				
• National guidelines require a detailed individual assessment conducted which includes: history (past treatment experiences; medical and psychiatric history; living conditions; legal issues; occupational situation; and social and cultural factors, that may influence substance use); clinical examination (assessment of intoxication / withdrawal, injection marks); and, if necessary, investigations (such as urine drug screen, HIV, Hepatitis C, Hepatitis B, TB, liver function).		2		
• National guidelines indicate that the choice of treatment for an individual should be based on a detailed assessment of the treatment needs, appropriateness of treatment to meet those needs (assessment of appropriateness should be evidence based), patient acceptance and treatment availability and do not set counter-indications for pregnant women, age limits and parental consent requirements.		2		
• In the last year, no systematic non-compliance with the provisions in the national guidelines were reported by OAT users or other stakeholders.		2		
Total points and scoring:		6		
Benchmark C2.8: OAT inclusion criteria are supportive of groups with special needs and not restrictive, i.e. failing other treatments is not required to join the OAT programme.				
• In national guidelines, there are no provisions to prevent people without experience of drug treatment in the past to enter OAT, i.e. failing other treatment is not a requirement for entering the OAT programme.		2		
• There are provisions and practices to facilitate quick enrolment onto OAT of people with significant health needs (e.g. people living with HIV, pregnant women).		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• In practice, people who are opioid dependent and assessed for eligibility for OAT are not required to have failed previous attempts at treatments for drug dependence.		2		
Total points and scoring:		6		

General matters concerning this indicator	
Average percentage of benchmark scoring (from above)	
General scoring, based on the 6-value scale	
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*	
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*	
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*	
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*	

Indicator C3: Quality and Integration

OAT services are provided in line with WHO quality standards, good practice and address the different needs of clients.

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
Benchmark C3.1: Adequate dosage and no restrictions on duration of methadone/buprenorphine maintenance are foreseen in national guidelines and practices are in line with WHO guidance. *Note: According to WHO guidelines, "[t]o maximize the safety and effectiveness of agonist maintenance treatment programmes, policies and regulations should encourage flexible dosing structures, with low starting doses and high maintenance doses, and without placing restrictions on dose levels and the duration of treatment." WHO recommends a minimum dose of 60 mg for methadone and a minimum dose of 12 mg for buprenorphine. The level of adequate dosing is recommended to be measured as a percentage of people receiving a recommended minimum or higher dosage among all OAT clients at a specified date. The level is graded by WHO as follows: Low ← 60% ← Mid → 90% → High.* *More details on this benchmark on OAT programme quality is available in the WHO tool for setting and monitoring targets: Supplement to the 2014 Consolidated Guidelines for HIV prevention, diagnosis, treatment and care for key populations; see indicator OST-6 (p.46).*				
• National guidelines recommend a minimum dose of 60 mg for methadone and a minimum dose of 12 mg for buprenorphine. No restrictions are indicated on dose levels.		2		
• A high proportion of people, at a specified date, maintained on methadone receiving a dose ≥60 mg. Alternatively, 90% of sites in the country report the average dose for methadone maintenance ≥60 mg.		2		
• A high proportion of people, at a specified date, maintained on buprenorphine receiving a dose ≥12 mg. Alternatively, 90% of sites in the country report the average dose for buprenorphine maintenance ≥12 mg.		2		
Total points and scoring:		6		
Benchmark C3.2: OAT programmes are based on the maintenance approach and have a high retention of users. *More details on this benchmark on OAT programme quality is available in the WHO tool for setting and monitoring targets: Supplement to the 2014 Consolidated Guidelines for HIV prevention, diagnosis, treatment and care for key populations; see indicator OST–5 (p.46).*				
• National guidelines are clear that OAT is aimed at maintenance, not short-term or mid-term treatment (including withdrawal symptom treatment, also called detoxification).		2		
• Community members report no systematic violation of this guideline provision in the majority of OAT sites.		2		

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
• The retention of clients in OAT programmes is high. *Retention is defined as a percentage of those individuals receiving OAT who continue treatment after six months among those who were on treatment 6 months ago. WHO considers retention as high if it is 80% or above, middle if it is between 60% and 80%, and low if it equals, or is less than, 60%.*		2		
Total points and scoring:		6		

Benchmark C3.3: A high proportion of OAT maintenance sites are integrated and/or cooperate with other health services and support continuity of care for HIV, TB, and drug dependence.

A site is considered integrated and/or cooperating with other health services to ensure multiple health needs are met if it has a shared location or on-site specialists or operational referrals to the following minimum services: needle/syringe programmes, management of opioid withdrawal (detoxification), counselling and testing for HIV/TB/hepatitis, antiviral and other medical treatment and care, and overdose prevention. The proportion of sites meeting this criteria is considered high, medium and low based on the following demarcation: : Low ← 50% ← Mid → 80% → High.

• A high proportion of OAT maintenance sites are integrated and/or cooperate with other services.		2		
Total points and scoring:		2		

Benchmark C3.4: A high proportion of OAT clients receive psychological and social support.

The percentage is calculated as proportion of OAT maintenance users in the last 12 months who have received psychosocial support in the same period. The psychosocial support may include, at a minimum:

- *Assessment of psychosocial needs;*
- *Supportive counseling;*
- *Links to existing family and community services.*

WHO recommends the following benchmark levels: Low ← 50% ← Mid → 80% → High.

There might be certain low-threshold services dispensing OAT where psychosocial support is not provided unless requested and people are not on maintenance.

More details on this benchmark on OAT programme quality is available in the WHO tool for setting and monitoring targets: Supplement to the 2014 Consolidated Guidelines for HIV prevention, diagnosis, treatment and care for key populations; see indicator OST–7 (p.47).

• A high proportion of OAT clients receive psychological and social support. If there is no national data on this, proxy data from 2–3 sites can be used and feedback from OAT client advocates.		2		
Total points and scoring:		2		

General matters concerning this indicator	
Average percentage of benchmark scoring (from above)	

Scoring of benchmarks	Sustainability score (0, 1 point or 2 points)	Maximum score	Percentage and scoring, based on a 3-level scale for benchmarks	Notes and sources
General scoring, based on the 6-value scale				
Progress *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.*				
Barriers & Challenges *Key gaps in sustainability, their underlying causes and factors.*				
Transition Impact *Developments, good practices and enabling factors for progress in building sustainability, in the last two years in particular.How does donor transition impact the level of sustainability? How is that impact leveraged and/or mitigated for sustainability over the last two years? What is expected in the next 2–5 years?*				
Opportunities & Way Forward *Opportunities, plans and suggested recommendations to sustain success, address challenges and mitigate any negative impact of transition.*				

Add tables from *2.2.1 Desk Review* as relevant.

Other comments on the section and recommendations	

ANNEX 4: Key Informant Interview Guide

The following document is a guide for conducting in-depth interviews. The questions are prompts, intended as starting points to cover the main issues of interest, and to generate stories and descriptions. This is a conversational guide, not a questionnaire. Each area should be asked, but the ordering of questions can vary if needed, depending on the flow of the interview.

Template for the interview:

Cover page

Start time __ : __ / End time __ : __ / Total time ____ minutes

Date: __/__/____

Participant Name: _____

Position _____

Institution _____

Email/phone _____

City/region (if relevant) _____

Type of stakeholder (*underline all relevant*)

government official
practitioner
civil society or client advocate
technical partner or donor

Consent received _____

What is their expertise/involvement in OAT? _____

Introduction used at the beginning of the interview:

Hello, my name is [*Insert Name*]. I am an assessor conducting an assessment to measure the sustainability of opioid agonist therapy in [*Insert Country*] in the context of donor transition. This

assessment aims at understanding the current status of various aspects of sustainability — political, resources and access to services including good practices and progress, challenges, the impact of the transition process and opportunities to improve. We seek a range of perspectives, and I appreciate you speaking to me today. I will be using the information you provide today, along with information that I collect from other key informant interviews and from a desk review, to develop a country report with the results of this sustainability assessment. We expect the report to be drafted by [*Insert Month/Year*] and presented to [*Insert a Body or Meeting*].

Before starting, I want to inform you that this interview will be confidential. However, I also would like to ask in advance for your written permission to potentially use some of the information you provide during the conversation as direct quotes in the report that will be published. These quotes will be anonymised (i.e. indicated by the type of informant but depersonalised) unless you explicitly agree that we can use your name. I will be recording and taking notes of our interview. If you do not want your name to be connected with anything said in this interview, please let me know; in this case, I will put in place measures to protect your confidentiality.

You can stop this interview at any time if you feel you do not want to continue the conversation.

Guiding questions for the interview

Policy and governance

1 What are the signs and limitations of the **political support** for OAT in the country and its sustainability at WHO-recommended scale? Any specific developments in the last two years?

- Prompts:
  - Is OAT included in the national health and drug strategies or in some types of long-term commitment by the government?

- Is there authorisation of OAT in legislation and no ambiguity in legislation on OAT, no barriers to OAT?
- Is OAT recognised as the main approach to drug dependence management by the national health system?
- Is OAT explicitly supported by the police (leadership and practice)?
- Is OAT explicitly recognised as the main approach to drug dependence management by the prison health and criminal justice system?
- Are civil society groups and OAT clients engaged in the governance and coordination of OAT?

2 What is the **transition plan** for OAT to move to national systems? How much has it been developed, agreed, costed, planned and its implementation is on the way?

3 Any **good practices** or examples of the progress you could name in the fields of politics and governance, including the management of transition from donor support to domestic systems? If yes, what/who enabled them?

4 Any specific **challenges and lessons learned that** you see for these fields in ensuring OAT sustainability? What are the underlying causes?

5 How do political and governance aspects of **transition** impact on the sustainability of OAT? Any examples of positive impact/opportunities or negative influence that you have observed?

6 What are the **opportunities** and ways to sustain and improve policy and governance, including transition planning for OAT?

Finance and resources

7 What **medicines** are used for OAT in the country?

8 To your knowledge, are these **medicines** fully integrated into the

national essential medicine system with relevant quality assurance, good procurement and price controls?

- Prompts:
  - Is OAT produced and supplied using domestic national systems and is there good capacity, i.e. there have been no interruptions in the last 12 months? In case the PSM system is not integrated with domestic systems, is there a good transition plan?
  - Are the medicines – both methadone and buprenorphine – registered and, overall, would it be easy to register other versions of medicine?
  - Is the pharmacovigilance system operational for these medicines with no complaints over quality received in the last 12 months?
  - Is the country able to secure affordable prices comparable with other countries in the region?
  - Any areas of specific progress in the last 2 years for pharmaceutical sustainability?
  - Any barriers and challenges?
  - Any impact of transition seen already or potentially?
  - Any opportunities?

9 Is **sustainable funding** secured?

- Prompts:
  - Is methadone and buprenorphine included in the reimbursement lists and are they funded from public sources?
  - Are OAT services (i.e. not only the medicines) included in universal health coverage or the state guaranteed package of healthcare, including for people without health insurance?
  - Are OAT services paid through sustainable public funding

sources which secure adequate funds to cover comprehensive services?

- Since when did this funding start?
- Would you say that this funding is ringfenced?
- Is this funding allocation indicated in some legal acts?
- Would you say that the funding allocated, and prospects of funding in the future, are possible for implementing OAT at the scale recommended by WHO [the coverage of 40% of the estimated number of people who are opioid dependent]?

10 In countries with active HIV grants, is there **co-financing** of OAT services by the Government in accordance with the Global Fund Sustainability, Transition and Co-Financing Policy?

- Prompts:
  - What is the current co-financing and what is planned for next year?
  - Is there some specific commitment from the government expressed in the country or to the Global Fund to co-finance OAT? What are these commitments? In what format have they been expressed?
  - Does co-financing from public sources aim to finance all budget lines of the OAT programme?

11 To sum up, what is the status of **financial sustainability**?

- Progress, good practices and their enablers in the last 2 years?
- Challenges and barriers to financial sustainability?
- Positive and negative impact of transition?
- Opportunities and ways forward to sustain and improve financial sustainability?

12 Would you agree that **human resources** are currently secured and also for the long term for WHO-recommended scale and quality of OAT programmes in the country?

- Prompts:
  - Is OAT part of the core functions of staff in the drug dependence (narcology) system? Why do you say so? Give some examples.
  - Would you say that prescribing of OAT is not limited to a small number of medical doctors? Are the number of doctors sufficient for scaling up OAT to the WHO recommended levels?
  - What is the capacity building system for OAT health professionals in the drug treatment system and outside of the drug treatment system?
  - Are WHO treatment guidelines and national treatment protocols part of that training?
  - Is sensitisation of health professionals concerning people who are opioid dependent part of the curriculum?
  - Is this capacity building sustainable?
  - Any good practices in the last 2 years?
  - Any challenges and barriers that you see for human resource needs?
  - What is the impact of transition?
  - What are the opportunities?

13 Is OAT programme development supported through adequate **evidence generation and information systems** in line with patient data protection in the country?

- Prompts:
  - Is there a M&E plan and system?
  - Is it used for governance and management?
  - Have there been assessments and/or evaluations of OAT in terms of its impact, effectiveness and efficiency?
  - Have OAT clients and local academia been involved in such assessments and evaluations?
  - Is there an OAT database?
  - How is data used? Could it be used to enable clients to access OAT in other city?
  - Is data confidential, not shared outside of the health system, and have there been data breaches in the last year?
  - Any other comments on progress and good practices in this area in the last 2 years?
  - Any challenges and barriers?
  - What is the impact of transition?
  - What are the opportunities?

Services

14 Is OAT **available** at an adequate scale, and in various settings?

- Prompts:
  - Is OAT available in prisons, arrest houses, pre-trial detention? Is initiation onto OAT available in prisons and also for females in the detention system?
  - Is OAT available in hospitals?
  - Is OAT available in primary care as well as at HIV, TB hospitals?

- Are take-home doses allowed and practiced?
- Is there OAT in the private and NGO sectors? Are they following the national treatment guidelines?
- Based on the WHO definitions of OAT coverage, the country has [Insert the level — high, middle, low] level of coverage with [insert the percent of opioid dependent people currently on OAT]. What have been the successes, challenges and opportunities related to that?
- Any general comments on developments in the last 2 years, including transition impact?

15 To your knowledge, is OAT **accessible** without barriers in terms of physical access and enrollment in timely fashion, with a consideration of different population needs?

16 When it comes to **quality and integration**, are OAT services provided in line with WHO quality standards, good practice and do they address the different needs of their clients?

17 I would like to ask you more specific questions on several categories against the WHO recommendations of minimum standards and good service practices– how they are implemented in the country. I have reviewed the national treatment standards and, therefore, I am particularly interested in practical implementation. I would appreciate it if you would tell me how OAT is implemented in practice and give an example to illustrate.

Before the interview, it is assumed that you will review the following aspects against the national treatment guidelines. Therefore, your clarifying questions could focus on the following benchmarks and further clarifications using Tool 3.C, as needed:

- There are no people on a waiting list for entering the service;
- Opening hours and days accommodate key needs;

- Geographic coverage is adequate;
- There are no user fees or barriers for people without insurance;
- OAT is available and accessible for populations with special needs (pregnant and other women, sex workers, young users, ethnic groups);
- Illicit drug consumption is tolerated (after the dose induction phase);
- Individual plans are produced and offered with involvement of the service user;
- OAT inclusion criteria are supportive of groups with special needs and are not restrictive, i.e. failing other treatments is not required to join the OAT programme;
- If an OAT client injects drugs, s/he has access to needle/syringe exchange;
- Adequate doses of methadone/buprenorphine are foreseen in national guidelines and in practice;
- OAT programmes are based on a maintenance approach and have a high retention of users;
- A high proportion of OAT maintenance sites are integrated and/or cooperate with other services and support continuity of care for HIV, TB and drug dependence;
- A high proportion of OAT clients receive psychological and social support.

18 Overall, in terms of service development — their availability, coverage, accessibility, quality and integration — what has been the **progress** in the last 2 years? Any good practices and enabling factors to highlight?

19 What have been the **challenges and barriers** to sustainability of services that we have not discussed yet? Any specific factors?

20 How does **transition** impact on services and access to services? Give examples.

21 What are the **opportunities** and ways forward for sustaining access to services?

General

22 Any other insights or recommendations you would like to share before we end the interview?

Closure

As you close the interview, please thank the respondent for their valuable time and insights shared. Please remind them how the interview will be used. You should leave your contacts with the respondent in case they have additional thoughts. Agree on follow-up data or documents to be provided if any were discussed during the interview.

Preparation

Preparation for focus group discussions should include the selection of the group of clients. You should seek 4–7 OAT clients, preferably from 2 or more sites and from at least one (in case of limited geography) or more locations. The group should ideally be balanced in terms of substance used, the site they attend (if there are different approaches and models), and gender, etc.

The space where the focus groups discussions will take place should be safe, quiet and comfortable, without other people in the room and with water and snacks available. People should be reimbursed for their travel and time as they are giving their expertise and are doing this, most likely, during their otherwise uncompensated time. In some settings with limited funding, fair compensation of people's time might be challenging, and this should be discussed in advance.

One should plan the timing of the focus group to accommodate people's needs of taking OAT, employment etc.

Guidance

The following document is a guide for conducting a focus group. The questions are prompts, intended as starting points to cover the main issues of interest, and to generate stories and descriptions. This is a conversational guide, not a questionnaire. Each area should be asked, but the ordering of questions can vary, if needed, depending on the flow of the focus group.

Template for the focus group

Cover page

Start time __ : __ / End time __ : __ / Total time ____ minutes
Date: __/__/____

Participant Name	OAT Site, City	Contact	Number Of Years On OAT	Consent Received
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Introduction used at the beginning of the focus group:

Hello, my name is [*Insert Name*]. I am an assessor conducting an assessment to measure the sustainability of opioid agonist therapy in [Insert Country] in the context of donor transition. This assessment aims at understanding the current status of various aspects of sustainability — political, resources and access to services, including good practices and progress, challenges, and the impact of the transition process and opportunities to improve. We seek a range of perspectives, and I appreciate you speaking to me today. I will be using the information you provide today, along with information that I collect from key informant interviews and from a desk review, to develop a country report with the results of this sustainability assessment. We expect the report to be drafted by [*Insert Month/Year*] and presented to [*Insert a Body or Meeting*].

Before starting, I want to inform you that this focus group will be confidential. However, I also would like to ask in advance for your oral permission to potentially use some of the information you provide during the conversation as direct quotes in the report that will be published. These quotes will be anonymised (i.e. indicated by the type of informant but depersonalised). I will be recording and taking notes of our group discussion. If you have concerns over the quotes associated with your specific OAT site, please let me know; in

this case, I will put measures in place to protect your confidentiality.

Guiding questions for the focus group

Services

1. Is OAT **available** at an adequate scale and in various settings?
   - Prompts:
     - Is OAT available in prisons, arrest houses, and in pre-trial detention? Is initiation onto OAT available in prisons and also for females in the detention system?
     - Is OAT available in hospitals?
     - Is OAT available in primary care as well as in HIV, TB hospitals?
     - Are take-home doses allowed and practiced?
     - Is there OAT in the private and NGO sectors? Are they following the national treatment guidelines?
     - Based on WHO definitions of OAT coverage, the country has [Insert the level – high, middle, low] level of coverage with [insert the percent of opioid dependent people currently on OAT]. What have been the successes, challenges and opportunities related to that?
     - Any general comments on developments in the last 2 years, including transition impact?
2. To your knowledge, is OAT **accessible** without barriers in terms of physical access and enrollment and in a timely fashion, with a consideration of different population needs?
3. When it comes to **quality and integration**, are OAT services provided in line with WHO quality standards, good practice and address different needs of their clients?

4 I would like to ask you more specific questions on several categories against the WHO recommendations of minimum standards and good service practices — how they are implemented in the country. I have reviewed the national treatment standards and, therefore, I am particularly interested in practical implementation. I would appreciate it if you would tell me how OAT is implemented in practice and give an example to illustrate.

Before the focus group, it is assumed that you will review the following aspects against the national treatment guidelines. Therefore, your clarifying questions could focus on the following benchmarks and further clarifications using Tool 3.C, as needed:

- There are no people on a waiting list for entering the service;
- Opening hours and days accommodate key needs;
- Geographic coverage is adequate;
- There are no user fees or barriers for people without insurance;
- OAT is available and accessible for populations with special needs (pregnant and other women, sex workers, young users, ethnic groups);
- Illicit drug consumption is tolerated (after the dose induction phase);
- Individual plans are produced and offered with involvement of the service user;
- If an OAT client injects drugs, s/he has access to needle/syringe exchange;
- OAT inclusion criteria are supportive of groups with special needs and are not restrictive, i.e. failing other treatments is not required to join the OAT programme;
- Adequate doses of methadone/buprenorphine are foreseen in national guidelines and practiced;

- OAT programmes are based on a maintenance approach and have a high retention of users;
- A high proportion of OAT maintenance sites are integrated and/or cooperate with other services and support continuity of care for HIV, TB and drug dependence;
- A high proportion of OAT clients receive psychological and social support.

5 Have you — or any other OAT clients you know — been involved in **sensitisation trainings** or are you aware that such education is made available for health professionals and the police in your country? Give an example.

6 Have you — or any other OAT clients you know — been **involved in an assessment and improvement** of OAT quality? If yes, how?

7 Overall, in terms of service development — their availability, coverage, accessibility, quality and integration or how they are organised — what have been the **changes** in the last 2 years? Give examples.

Policy, governance, funding and transition

8 What are the signs and limitations of the **political support** for OAT implemented in the country sustainably and at WHO-recommended scale? Any specific developments in the last two years?

- Prompts:
  - Is OAT included in the national health and drug strategies or other long-term commitments by the government?
  - Is there authorisation of OAT in legislation and no ambiguity in legislation on OAT, no barriers to OAT?
  - Is OAT recognised as the main approach to drug dependence management by the national health system and criminal justice system?

9 Are civil society groups and OAT clients engaged in the **governance and coordination** of OAT at a national level? Give an example of that engagement and what that engagement contributes (e.g. what issues are raised).

10 Is OAT explicitly supported by the **police** (leadership and practice)?

- Prompts:
  - Have there been no reports of systematic law enforcement practices to target OAT clients in the last year?
  - Any public remarks from the leadership, or drug law enforcement, on OAT in the last year? Give an example.

11 Any **good practices**, or examples, of progress that you can name in the fields of politics and governance, including the management of transition from donor support to domestic systems? If yes, what/who enabled them?

12 Is **sustainable funding** secured for OAT based on what you know?

- Prompts:
  - Is methadone and buprenorphine included in the reimbursement lists and are they funded from public sources?
  - Are OAT services (i.e. not only the medicines) included in universal health coverage or the state guaranteed package of healthcare, including for people without health insurance?
  - Are OAT services paid through sustainable public funding sources which secure adequate funds to cover comprehensive services?
    - Since when did this funding start?
    - Would you say that this funding is ringfenced?
    - Is this funding allocation indicated in some legal acts?
    - Would you say that the funding allocated, and the prospects of funding in the future, are sufficient for implementing

OAT at the scale recommended by WHO [the coverage of 40% of estimated number of people who are opioid dependent]?

13 How does **transition** impact on OAT — the services, funding, policy, or sustainability in general? Any examples of positive impact/opportunities or negative influence that you have observed?

General

14 If you could change one thing about OAT in your country, what would that be? How could that be achieved?

Closure

As you close the focus group, thank the participants for their valuable time and insights shared. Remind them how the focus group results will be used. You should leave your contacts with each participant in case they have additional thoughts. Agree on follow-up of data or documents to be provided if any were discussed during the focus group.