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MEASURING THE SUSTAINABILITY OF OPIOID AGONIST THERAPY (OAT)

A GUIDE FOR ASSESSMENT IN THE CONTEXT OF DONOR TRANSITION

MAY 2020

This Guide was initiated by the Eurasian Harm Reduction Association (EHRA) to provide countries with an approach and tools to assess their progress in building the sustainability of opioid agonist treatment (OAT) 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. In early 2020, the tool was piloted in three countries: Belarus, Ukraine, and Tajikistan. This publication is available in the English and Russian languages.

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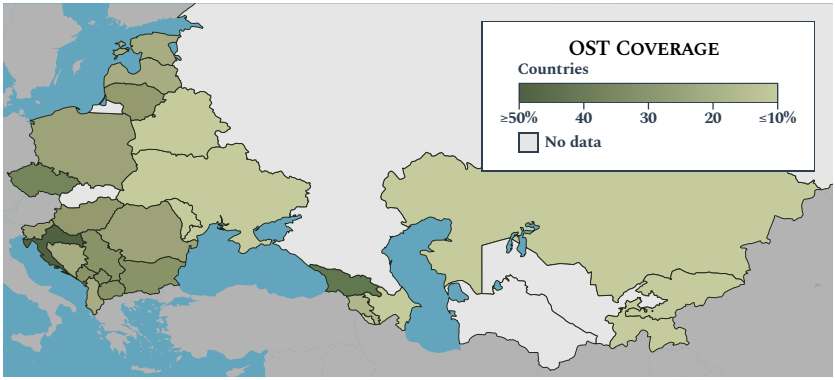
Introduction

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. The results could support country planning and management of donor transition and arm OAT advocates with tools to meaningfully engage in donor transition related processes.

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 upon 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, the Measurement Framework can be used to provide national stakeholders with an overview for the measurement of sustainability.

B. ***National Assessment Guidance***

National Assessment Guidance is designed for use by an assessment team. It provides an overview of tasks, methods, and a step-by-step process for preparing, implementing and utilising the results of an assessment. The National Assessment Guidance starts with a checklist of tasks in different stages of the assessment process.

C. ***Annexes and Tools***

Annexes to this Guide provide a list of abbreviations; 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. All of them, with the exception of the overview of existing frameworks, are provided in separate files available at the following weblink: https://harmreductioneurasia.org/oat-sustain-method/.

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 evidence-based 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.

EHRA is committed to consulting the organisations planning an assessment based on this publication and national experts conducting such an assessment. However, the Association insists that both organisations and experts familiarise themselves with this publication first.

Part 1: Measurement Framework

The OAT sustainability framework is a conceptual approach to understanding and measuring OAT sustainability in the context of transition of donor funding and international support. It aims to support public health experts and OAT advocates with evidence that could be used in national processes related to transition and to broader efforts for improving drug policy, universal health coverage (UHC) and the responses to HIV, TB, hepatitis and prison health. The framework 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.

The *Measurement Framework* starts by 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.

The *Measurement Framework* offers a matrix for measurement, comprising issue areas, indicators and benchmarks. For each of the three issue areas, namely *Policy & Governance*, *Finance & Resources*, and *Services*, a set of indicators is proposed, as indicated below in a table, 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.

TABLE: Issue Areas and Indicators

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	

For national stakeholders, the *Measurement Framework* 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.

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 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

[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.

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

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. Moreover, the countries of the former Soviet Union traditionally rely on heavily medicalised abstinence syndrome treatment (detoxification) as its main treatment modality, using non-evidence based medicines[8 9]. Therefore, the term 'MAT' lacks specificity for being relevant in this region.

The International Network of People who Use Drugs (INPUD) has not defined their position on treatment terminology other than a clear recommendation in favour of using '*clients*' and '*users of services*' and against the use of the term '*patients*' when describing people who engage in treatment[10].

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[11]. WHO defines high coverage of

[8] Torban MN, Heimer R, Ilyuk RD, Krupitsky EM (2011) Practices and Attitudes of Addiction Treatment Providers in the Russian Federation. J Addict Res Ther 2:104.

[9] Elovich R, Drucker E. On drug treatment and social control: Russian narcology's great leap backwards. *Harm Reduct J*. 2008;5:23.

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

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

OAT programmes as 40% or more of the estimated number of people who are opioid dependent that are in receipt of OAT[12]. 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[13].

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 2*.

1.2. Why the new framework?

Several frameworks for sustainability and donor transition have been developed in the HIV, TB and malaria sectors. PEPFAR — the U.S. President's Emergency Plan for AIDS Relief — 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

[12] WHO, UNODC, UNAIDS, Ibid.

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

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 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 2* provides an overview of some of the available tools.

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 rumours among clients about an uncertain future, as donor and other international support is transiting out of their countries. 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 includes 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 accessible 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[14]. While OAT is strongly recommended by WHO and other UN and European Union (EU) agencies[15], and while methadone and buprenorphine are included in the WHO Model List of Essential Medicines, many EECA countries continue seeing their OAT programmes as pilots. As the pilot OAT assessments confirmed in Belarus, Tajikistan and Ukraine, OAT's political acceptance and implementation is largely driven not by the national drug policies but by the HIV responses. For example, resourcing of OAT largely comes from HIV donors or national HIV programmes. In state drug systems (narcology systems), OAT is often the marginalised modality for management of drug dependence despite being the most effective treatment option for opioid dependence, according to WHO[16]. Failing other treatment modalities might be required for becoming eligible for OAT. The rigour to which OAT is met by health professionals, health

[14] 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*.

[15] 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.rzhivayuschiey-terapii

[16] Harm Reduction International. Global State of Harm Reduction. London; HRI, 2018.
Utyasheva, Leah, et al. Effects of UN and Russian influence on drug policy in Central Asia. *At What Cost? HIV and Human Rights Consequences of the Global "War on Drugs"* (2009).

decision-makers and law enforcement is not applied to measure the validity, effectiveness and evidence of other narcology operations that are state funded[17]. The Russian Federation views "the prevention of the application of OAT in its territory" as the "main means to improving effectiveness and development of its narcology care"[18]. This affects the politics, practice and views in other EECA countries[19] [20]. Needless to say, the long-term effectiveness of OAT makes it highly unpopular among drug traffickers and dealers. There are also many myths among people who use drugs about OAT.

This Guide will not resolve the political complexities of OAT development and institutionalisation in the region. However, it will arm public health experts and OAT supporters with the detailed evidence of the current status of, and risks to, sustainability in policy, governance, resourcing and services. This evidence could be used in national processes related to donor transition in order to advance political and practical solutions for OAT to become a core part of a state drug policy response and linked responses to HIV, TB, hepatitis and prison health. At a minimum, such evidence could support efforts for OAT not to be omitted in the national costed HIV and TB transition plans from the Global Fund and PEPFAR.

Unlike other frameworks, this Guide merges transition-related aspects

[17] Torban MN, Heimer R, Ilyuk RD, Krupitsky EM (2011) Practices and Attitudes of Addiction Treatment Providers in the Russian Federation. J Addict Res Ther 2:104.

[18] Позиция Минздрава России в отношении заместительной опиоидной поддерживающией терапии [*Position of the Ministry of Health of Russia with Regards to Substitution Opioid Maintenance Therapy, in Russian*], 14 March 2016. Accessed at: https://www.rosminzdrav.ru/news/2016/03/11/2832-pozitsiya-minzdrava-rossii-v-otnoshenii-zamestitelnoy-opioidnoy-podderzhivayuschiey-terapii

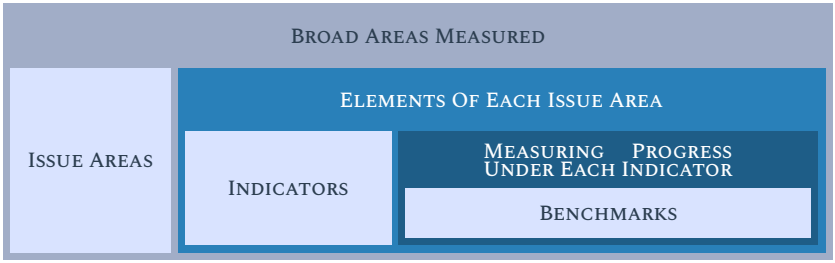
[19] Harm Reduction International. Global State of Harm Reduction. London; HRI, 2018.

[20] Utyasheva, Leah, et al. Effects of UN and Russian influence on drug policy in Central Asia. *At What Cost? HIV and Human Rights Consequences of the Global "War on Drugs"* (2009).

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. This Guide includes issues around drug treatment and policy, hepatitis C, and 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 issue areas, or dimensions; indicators for each of the issue areas; and benchmarks to measure progress under each indicator. The framework combines elements from several previous frameworks, including the TRAT by EHRA and the Treatment Preparedness Assessment tool by Curatio, and the human rights component proposed by Oberth & Whiteside.



The three Issue Areas (dimensions) cover different questions:

A. **Policy & Governance**

- 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 management of 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[21] [22], 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 Guide's methodology. The priority indicators, benchmarks, and the approach to their measurement, are chosen from existing programmatic guidance and quality assurance indicators, particularly WHO sources and the consensus study below:

[21] 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.

[22] 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).*

- 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 of 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[23] (2017), which is based on a review of other guidelines.

1.4. 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 or Benchmark A1.4 if law enforcement and justice systems have limited impact on drug treatment policy in the country.

[23] 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.

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 level		*Indicator A2:* **Management of transition from donor to domestic funding** • 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 funding • 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 enroling into the OAT programme	*Indicator C3:* **Quality and integration** • Adequate dosage of methadone/buprenorphine is foreseen in national guidelines and practice in line with WHO guidance • OAT programmes are based on the 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 (*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*)

1.5. 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:

1 Providing qualitative information on the following:

- Summary of the sustainability status of each indicator;
- 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 (impact of donor transition from the country and of the move to national systems): *How does OAT sustainability depend on donor and other international support? What are the risks or — to the contrary — enablers in the context of reducing international support? To what extent are the national systems ready for the reduction in international support in the short- and long-term? How has the transition planning and management enabled long-term solutions for sustainability in this area 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 the impact of transition.*

2 The degree of sustainability is measured, starting with each benchmark. The indicator is measured as the composite average of the sustainability levels of its benchmarks. The status of sustainability for each issue area is the composite average of its indicators.

- Scale used for **components that compose a benchmark** are measured through a points system (with 2 being the maximum and

meaning full or to large extent true and 0 being the minimum point)

- The sustainability degree for **each benchmark** is calculated from the points for the benchmark's components out of maximum possible points and expressed through the following scale:

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

- Scale used for each **Issue Area** and **Indicator**[24] is more nuanced and, therefore, comprises 6 levels as it is a composite measure derived from the sustainability levels of its benchmarks:

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

The detailed version of the indicators, benchmarks and templates for measuring indicators is provided in an excel file with tools in *Annex 4*. The assessor is expected to enter assessment data into the forms provided and indicate the sources of such data, using the instruction page to the instruments in *Annex 4*.

In case 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.

[24] 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.

Part 2: Guidance For National Assessment

The national assessment process comprises preparation; assessment; and finalisation. This Part of the 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. An overview of tasks is given below.

Checklist For Organising The Process

Preparation

- ☐ Familiarisation with the Guide;
- ☐ Inform stakeholders about the Assessment;
- ☐ Set up the Advisory Group;
- ☐ The first meeting of the Advisory Group should help to:
  - adjust the methodological approach, including changes in the Framework, necessity/feasibility of Ethical Committee's approval and terminology;
  - agree on the Group's role; and,
  - set a plan to gather materials, define the list of key informants and focus group(s), compensation and key dates;
- ☐ Seeking approval from an Ethical Committee, if relevant.

Assessment

A. *Desk review*

- ☐ Prepare the instruments (tables and report outline) in Word or

Excel. If needed, translate;

- Desk review:
  - adjust the Guide's suggested list of required materials;
  - gather materials and send inquiries to agencies;
  - fill the instruments based on the desk review;
  - track materials received and pending;
- Identify gaps for extra resources and/or interviews and focus groups.

B. *Interviews and focus groups*

- Adjust guides for interviews and focus groups (based on the informants' competence and information gaps);
- Interviews and focus groups:
  - schedule;
  - conduct; and,
  - enter results into the instruments (including draft quotes for the report).

Finalisation

A. *Analysis and production*

- Preliminary analysis of instruments-tables:
  - Calculate the level of sustainability for benchmarks, indicators and issue areas;
  - Prepare the tables for review by the Advisory Group;
  - Draft preliminary conclusions and recommendations for each Issue Area;

- Together with the Advisory Group, review the preliminary analysis of instruments-tables and prioritise conclusions and recommendations;
- Write the report;
- External review of the report, if possible.

B. *Dissemination and use*

- Together with the Advisory Group and other partners, plan presentations, other means of dissemination and the use of advocacy over the following year;

  Translate, prepare presentations and other information materials.

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;
- assisting with the gathering of relevant literature;
- providing advice during the assessment, as needed;
- reviewing the draft information in the instruments (tables) before finalising the measurement of sustainability of the benchmarks, indicators and issue areas;
- providing feedback on the draft analytical report and in helping to

draw conclusions; and,

- assisting in the planning of 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?*** How much is the OAT programme in the country integrated within drug policy? Or is it largely a part of the HIV response? What are the ongoing discussions on the future of OAT in the country? Is there a vision agreed among stakeholders on how the OAT programme should look, be resourced, and managed and its access ensured in the long-term, for example by 2025? What other ongoing, and broader, processes in health systems and 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 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 whether additional issue areas are important and should be added? Should optional benchmarks be included, for example, on the external political and economic stability that might impact political commitment and transition in the longer term? (These changes will need to be recorded and included in the detailed methodology; please note, however, that the more changes are undertaken, the less comparative will be the information across countries). Which issue areas are a priority, and which are of less importance, given the resources and time 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 there is no such OAT transition plan, is that to be explored through the assessment if there is a need for some planning and how to monitor it? If donors no longer fund OAT, what sustainability dimensions, indicators and benchmarks could benefit from auditing and which could be omitted? 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, is it critical to add a geographic perspective (e.g. you could add a case study of different levels of sustainability in two regions recommended by the Advisory Group and add 1–2 service leaders and clients from outside the capital to your interviewee list)?

- ***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 such 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. How to compensate the time of community experts engaged (including, but not limited to, OAT clients included in focus groups)?

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

1. Outline of the report (see the separate file for *Annex 3*);
2. Instruments for structuring the collected information from the literature review and interviews (and focus groups, if any) (see the separate file for *Annex 4* with the instructions and instruments for each of the indicators); and,
3. Interview and focus group guides (see separate files for *Annex 5* and *Annex 6* accordingly).

Adjusting of the first two instruments — the outline and the instruments for structuring information — is recommended to be undertaken first. Once the main desk review is available and missing information is identified, then the interview and focus group questionnaires can be reviewed to exclude the questions that have been answered through the desk review and thereby to then focus on the missing answers.

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 tools to assess **each indicator for each** sustainability **issue area** (see *Annex 4*, a separate Excel file with tools) and the outline of the report (see *Annex 3*, a separate Word file);
- The collection of quantitative and qualitative data through a **desk review** (see Section 2.2.1 below);
- The collection of quantitative and qualitative information through **interviews with selected key informants** and **focus group**(s) (see Section 2.2.2.); and,
- Preparation of 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 sub-section, 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 indicator for each of the issue areas (based

on *Annex 4* **in a separate file to this Guide**). 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 be 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 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) on HIV and Tuberculosis, 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 total budget realised for OAT from all sources									
This actual budget for OAT is broken down by the sources of funding:									
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)										
Total:										

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, and 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[25] (including verification as to whether it is

[25] 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 recommen-

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[26])				
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 (%)				
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				
Number of OAT sites in specialised state drug dependence institutions (narcology)				
Number of OAT clients in specialised drug dependence institutions (narcology)				

[26] 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 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, and filled in the instruments (information for each benchmark including scoring of its components). 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.

As part of your synthesis of the results of the desk review, you should extract the unanswered benchmark components in a table format, keeping a column for their scoring (see the sample below). This table could be used for collecting targeted, short answers from informants in writing or through interviews. If you use the table as part of an interview, please make sure to send it to the person in advance or print it out for an in-person meeting. You can also use the Advisory Group to fill in the gaps in the scoring and the unanswered components of the benchmarks or if different assessments (scoring) come from different stakeholders.

TABLE: The sample table of missing scoring as you would present it to informants:

STATEMENT	SCORING ***Add your scoring either '0', '1' or '2'*** *where the range is* *0 = Fully or largely not true* *1 = Partly true (True in a significant part, half-true but not fully true, progress is needed)* *2 = Fully or largely true*	COMMENTS
[Component from the tools in *Annex 4*]		
[Component]		

The questions in the annexed key informant **interview guide** and the **focus group** guide (*Annexes 5 and 6*) are intended to provide questions that

should be asked in order to supplement the desk review and to complete the OAT sustainability assessment. The guide needs to be adapted to your interview based on informant competence and identified issues. For example, questions on services would be naturally relevant for service providers, organisers and clients. The assessor should feel free to use additional questions to obtain relevant information based on the country and programme context. In addition to interviews, it is highly recommended that the assessor conducts **one or two focus groups**; one with OAT clients and another with practitioners to gain additional service insights. The focus groups could be organised after the interviews so that you can get reactions to the collected information and focus on recommendations on how to improve the situation.

For a reminder on how to conduct key informant interviews and focus groups, the following source — from the UCLA Center for Health Policy Research — can be used:

- Interviews: http://healthpolicy.ucla.edu/programs/health-data/trainings/documents/tw_cba23.pdf
- Focus groups: http://healthpolicy.ucla.edu/programs/health-data/trainings/Documents/tw_cba21.pdf

It is recommended that the assessor **records**, and takes detailed **notes** from, the interviews. Within 24 hours following 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 and/or outline of the report, 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, follow-up with the respondent will be easier to get clarifications or, for example, to receive written inputs promised during the interview.

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 model report outline is provided in a separate file at *Annex 3*. 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.

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 a 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;
- based on the report, prepare **specific recommendations to the donor transition plan**, with suggested timeline, responsibilities, milestones and its monitoring;
- 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, with donors** and **international partners**;
- 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.

Part 3: Annexes and Tools

Annex 1: 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
CSO	Civil Society Organisation
ECDC	European Centre for Disease Prevention and Control
EECA	Eastern Europe and Central Asia
EHRA	Eurasian Harm Reduction Association
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
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
UNFPA	United Nations Population Fund, formerly the United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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*[27]	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.

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