Regional Report

December 2021

Changes in the Harm Reduction Packages and Unit Costs during Transition from International to Domestic Funding among Selected Countries of EECA Region

Based on the Experience of North Macedonia, Georgia, Ukraine, and the Kyrgyz Republic

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Executive Summary

This regional report is a summary of the country reports of North Macedonia, Georgia, the Kyrgyz Republic, and Ukraine based on national case studies to track changes in the harm reduction packages and unit costs during the transition from international to domestic funding.

The report summarizes country changes in harm reduction approaches in the transition period, including unit cost per client and list/package of services, describes the rationale behind the changes, and analyzes the impact of occurred changes in unit costs and package of harm reduction services on services provision, quality of provided services, and client satisfaction.

KEY FINDINGS:

Decrease in funding for harm reduction programs

Despite a slight increase in funding for opioid substitution therapy (OST) programs, in general, the allocated funds from the Global Fund and local budgets for harm reduction programs have significantly decreased. This has had an influence on the procurement of consumables (syringes, condoms, etc.) and has reduced the list of services in a package. At the same time, program progress indicators have increased and are likely to grow further. The focus of services has shifted from their quality and clients' needs to the number of units to reach.

Reduced quality of services and lack of quality assurance mechanism for harm reduction services

OST and needle and syringe programs (NSP) require constant technical support of service providers, advanced professional training for doctors and peer consultants, procurement of high-quality consumables, and developed quality standards of service provision that are being monitored and supervised.

Social contracting mechanisms

All countries have demonstrated the readiness to establish, have already established, or are in the process of establishing "social contracting" mechanisms for sustainable financing of HIV prevention interventions for key populations. For example, North Macedonia and Georgia have mechanisms for contracting with non-governmental organizations (NGOs). Ukraine is piloting approaches that include social contracting with NGOs and community-based organizations (CBOs) to maintain harm reduction activities after the Global Fund transition. The Kyrgyz Republic developed a national transition plan that includes measures on creating enabling conditions for NGOs to ensure the possibility of social contracting in the next five years.

Challenges and risks of the post-transition period

There is a high need to identify the alternative mechanisms to support countries post transition. A number of transition challenges, such as access to quality-assured OST medication, availability of naloxone in drop-in centers, and well-trained friendly healthcare professionals, can affect gains made in countries post transition (demonstrated by the North Macedonia case).

Expectation gaps in communication between service providers and state agencies responsible for post-transition funding

Despite the fact that NGOs want to continue activities in the same format as during the direct financing of the Global Fund, changes are inevitable and must be voiced by all parties and carefully discussed before the end of the transition.

MAIN RECOMMENDATIONS:

Increase the budget for financing the needle and syringe program in accordance with the needs of people who inject drugs (PWID) as the beneficiaries of this program.

Adopt framework standards for the needle and syringe program. This framework should cover the standard operation procedures and recommended package of services for different drug scenes and respond to the needs of people who use drugs.

Introduce realistic indicators responding to a broad understanding of harm reduction aims for civil society organizations (CSOs) to meet in accordance with current evaluations on the size of the population of people who use drugs.

Conduct regular monitoring and evaluation **of the quality of needle and syringe programs** and of opioid substitution treatment, including client satisfaction.

Meaningful involvement of key populations (KP). This includes the participation of KP representatives in decision-making, continued progress on addressing human rights–related barriers in the context of the disease responses and access to services, and proactive monitoring of the quality of NSP and OST services.

Awareness-raising country-level campaigns to support the visibility of transition processes. Sharing the best practices and experiences of countries starting, going through, and/or accomplishing the transition process from international to domestic funding. Awareness raising is important in order to ensure the commitment of the general population to services for key populations to secure stable funding regardless of major changes in political will.

Emergency funding. The global COVID-19 pandemic has particularly highlighted how vulnerable key communities remain in times of global crises. In the context of tight budgets linked to rigid indicators, many needs of key populations are left unaddressed. Emergency funding is essential to the success of the sustainability of harm reduction services.

Acknowledgments

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The Eurasian Regional Consortium joins the efforts of the Eurasian Coalition on Health, Rights, Gender, and Sexual Diversity (ECOM), the Eurasian Women's AIDS Network (EWNA), and the Eurasian Harm Reduction Association (EHRA) to effectively address the lack of financial sustainability in prevention, treatment, care, and support programs for the key populations vulnerable in terms of their rights violation and the risk of HIV.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
BDD	Basic data and directions
CCM	Country coordinating mechanism
CBO	Community-based organization
CSO	Civil society organization
EECA	Eastern Europe and Central Asia
FSW	Female sex workers
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IBBSS	Integrated biological and behavioral surveillance survey
MoH	Ministry of Health
MSM	Men who have sex with men
NCDC	National Center of Disease Control and Public Health

Abbreviations

NGO	Non-governmental organization
NSP	Needle and syringe program
OST	Opioid substitution therapy
PBF	Performance-based financing
PLHIV	People living with HIV
PR	Principal recipient
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
RBF	Results-based framework
STI	Sexually transmitted infection
TB	Tuberculosis
TSP	Transition and sustainability plan
VAT	Value-added tax
VCT	Voluntary counseling and testing

Introduction

International funding of health programs has been experiencing significant constraints over recent years, leading to the first moves to shift the financial burden of health programs from external donors to sustainable domestic sources. Due to economic growth and a shift towards higher income status and/or lower disease burdens, many low- and middle-income countries are gradually transitioning from donor financing towards domestically funded health systems. Nevertheless, this transition process carries risks and challenges for national service providers and their clients from key populations. At the time when it is essential that countries are able to scale up and sustain programs to achieve lasting impact in the fight against HIV and its comorbidities and to move towards eventual achievement of Universal Health Coverage, in a vast number of countries, the available packages and quality of harm reduction services are decreasing, and fewer services for key populations are being supported. Lack of political support for harm reduction, not only as an HIV prevention measure but as a social service, is one of the main obstacles to sustainable and sufficient funding for quality programs.

Eastern Europe and Central Asia (EECA) is one of several regions where transition away from Global Fund support is moving forward fairly rapidly. The Global Fund supports transition processes and promotes strategies and actions in the region to improve long-term sustainability and domestic resource mobilization. Currently, all countries in the EECA region are undertaking or have undertaken transition and sustainability planning. This report presents the analysis of the countries that have already developed formal sustainability and transition plans and have started to implement them (Ukraine and Georgia), along with the countries that are now in the post-transition period (North Macedonia) and only at the early stage of transition planning (the Kyrgyz Republic).

Thus, this regional report is the result of four country analyses undergoing the changes in the harm reduction packages and unit costs during the transition from international to domestic funding. It brings together the experiences of selected countries of the EECA region at different stages of transition funding in order to reach the following objectives:

1. Identify and document regional and country-specific mechanisms, approaches, good practices, challenges, and lessons learned on the transition from international donor to domestic funding of harm reduction programs for people who inject drugs in the EECA region.
2. Analyze specific thematic areas and gaps that hinder the successful transition of the countries in the EECA region to further international and national discussions of possible solutions and address them in order to ensure the sustainability of services for PWID.
3. Define technical assistance needs of countries and responding measures and next steps to support the transition and post-transition periods.

Methodology

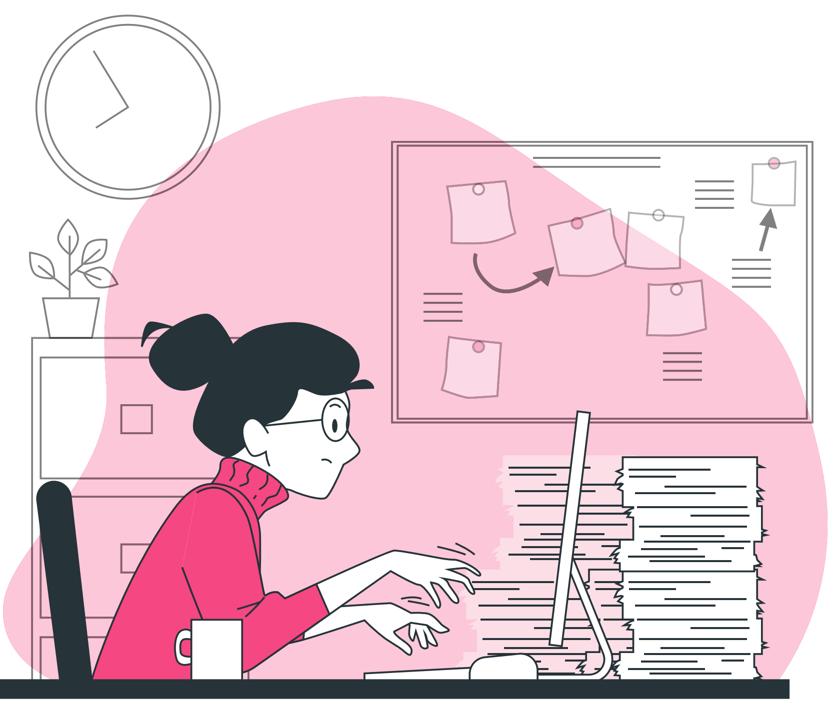
This report is based on case studies undertaken in four countries—Georgia, Ukraine, North Macedonia, and the Kyrgyz Republic—between April and July 2021, using the methodology and guidance from EHRA, and it is part of a multi-country study looking at similar aspects.

The study has employed the following strategies for data collection:

1. Desk review: the reviewed documents included national AIDS response strategies and reports on public program implementation, documents reflecting packages of services, national and Global Fund budgets and their execution, and State procurement tenders and service provider contracts.

2. Interviews with key stakeholders (harm reduction service providers and decision-makers) regarding the packages of services and unit costs.

3. Interviews and focus groups of NSP and OST clients on the list and quality of services.



Overview of the Harm Reduction Programs for PWID in North Macedonia, Georgia, Ukraine, and the Kyrgyz Republic

North Macedonia

Transition process

Stage of transition	**Completed**
Start of harm reduction programs (year)	**1996**
Start of transition from international to domestic funding (year)	**2018; transition completed**
Country TSP	**Developed and followed**
Country legislative framework to support transition	**Fully adapted**

Key country numbers and indicators

Country population
2 million people

HIV prevalence rates amongst general adult population
469 cases of HIV (as of 31 Dec 2019)[1]

Estimates of PWID
6,800 people

PWID covered by the NSP program, number of clients in 2020 (% of estimates)
56.8% 3,838 clients

PWID covered by the OST program, number of clients in 2020 (% of estimates)
27.5% 1,860 clients

Number of items of consumables per year per client (NSP) in 2020
150 syringes per client in 2020

Georgia

Transition process

Stage of transition	**In progress**
Start of harm reduction programs (year)	**2003**
Start of transition from international to domestic funding (year)	**2017**
Country TSP	**Developed but needs revision (as the country is still illegible for GF funding)**
Country legislative framework to support transition	**Undergoing adaptation**

Key country numbers and indicators

Country population
3.7 million people

HIV prevalence rates amongst general adult population
0.3%

Estimates of PWID
52,500 people

PWID covered by the NSP program, number of clients in 2020 (% of estimates)
86% 32,607 clients

PWID covered by the OST program, number of clients in 2020 (% of estimates)
28% 14,996 clients

Number of items of consumables per year per client (NSP) in 2020
70 syringes per client in 2020

Ukraine

Transition process

Stage of transition	**In progress**
Start of harm reduction programs (year)	**1996**
Start of transition from international to domestic funding (year)	**2017**
Country TSP	**Developed and followed**
Country legislative framework to support transition	**Fully adapted**

Key country numbers and indicators

Country population
44.1 million people

HIV prevalence rates amongst general adult population
0.9–1%

Estimates of PWID
350,300
317,000 in controlled territories

PWID covered by the NSP program, number of clients in 2020 (% of estimates)
73,2% 256,319 clients

PWID covered by the OST program, number of clients in 2020 (% of estimates)
5,3% 14,868 clients

Number of items of consumables per year per client (NSP) in 2020
65 syringes per client in 2020

Kyrgyz Republic

Transition process

Stage of transition	**Anticipated**
Start of harm reduction programs (year)	**1999**
Start of transition from international to domestic funding (year)	**2018 (on ART), 2020 (according to TPS)**
Country TSP	**Newly developed**
Country legislative framework to support transition	**Undergoing adaptation**

Key country numbers and indicators

Country population
6.7 million people

HIV prevalence rates amongst general adult population
0.2%

Estimates of PWID
25,000 people

PWID covered by the NSP program, number of clients in 2020 (% of estimates)
66.5% 16,636 clients the last 6 month of 2020

PWID covered by the OST program, number of clients in 2020 (% of estimates)
3.9% 979 clients the last 6 month of 2020

Number of items of consumables per year per client (NSP) in 2020
122-176 syringes per client per 6 month

Transition Context for Harm Reduction Services

North Macedonia

The HIV situation in North Macedonia

The current population of the Republic of North Macedonia is approximately

2 million citizens

and there is a low-level, concentrated HIV epidemic[2] with

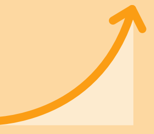
469 registered cases of HIV

(as of 31 December 2019)

However, in recent years, there has been an **increasing trend in the number of newly registered HIV cases,** and the highest number of new diagnoses was in 2019 (n=66)

Among the registered cases,

The high proportion of male individuals in the number of newly registered cases has been a trend in the past 10 years.



2 World Bank. 2015. Optimizing Investments in Former Yugoslav Republic of Macedonia's HIV Response. World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/25378 License: CC BY 3.0 IGO.

Moreover, during this period of time, there have been only two new HIV cases related to drug injection. No estimated number of people living with HIV (PLHIV) is available. According to The Continuum of HIV Care in North Macedonia: Assessment Report, the HIV epidemic is under control among people who inject drugs (PWID) and female sex workers (FSW), but prevalence is rising among men who have sex with men (MSM)[3].

PWID latest estimates

around **6,800** people in North Macedonia have continuously injected drugs stressing that

Drug use in North Macedonia increased considerably at the end of the 1980s and the beginning of the 1990s. According to data from the 2017 *Report on the Use of Psychoactive Substances among the General Population*[4], almost 9% of Macedonian citizens have used an illegal drug at some point in their life, as was the case for almost 19% of young people aged from 15 to 24 years. The recent report on the bio-behavioral study[5] estimates that around 6,800 people in North Macedonia have continuously injected drugs (i.e., in the past month), stressing that around 72% of them were infected with hepatitis C virus (HCV) but indicating no newly registered HIV cases.

around **72%** people were infected with hepatitis C virus but indicated no newly registered HIV cases

4 PHI (2017). Use of Psychoactive Substances among the General Population in the Republic of Macedonia, 2017. Skopje: Public Health Institute.

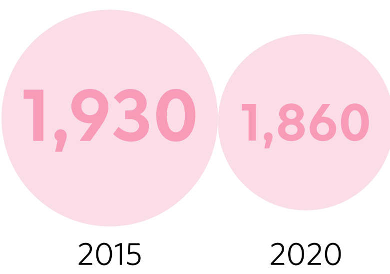
5 PHI (2018). Report on the Bio-Behavioral Study and Assessment of the Number of People Injecting Drugs in Skopje, Republic of Macedonia, 2017. Skopje: Public Health Institute.

Harm reduction programs and stage of transition

North Macedonia has a relatively long history of harm reduction programs, including OST and NSP, both of which predate Global Fund grants. Between the 1980s–early 1990s and the first Global Fund grant in 2004, methadone became available at the Psychiatric Hospital in the capital city, Skopje, and at three major penal institutions. Between 2005 and 2011, due to Global Fund support, substitution treatment was scaled up, and 12 OST centers were opened across the country, from which one was in Prison Idrizovo. In 2009, the University Clinic for Toxicology and Emergency Medicine in Skopje introduced treatment with buprenorphine funded by the government. These days, OST is available primarily within the developed national network of public health institutions.

In 2020, 1,600 clients received methadone, and 260 clients received buprenorphine through the national treatment program. Therefore, the total number of clients receiving OST amounted to 1,860 in 2020, which marked a slight decrease from 1,930 in 2015 and equated to a coverage rate of approximately 27.5% of the officially estimated 6,756 PWID, according to the last estimation undertaken by the Institute for Public Health in 2017.

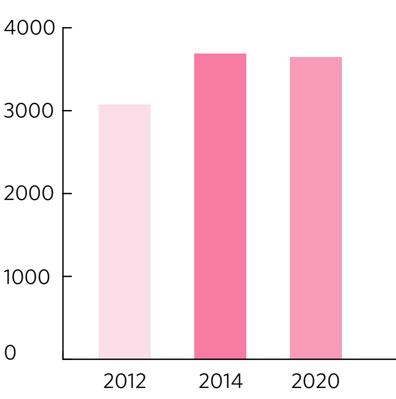
Therefore, the total number of clients receiving OST amounted to



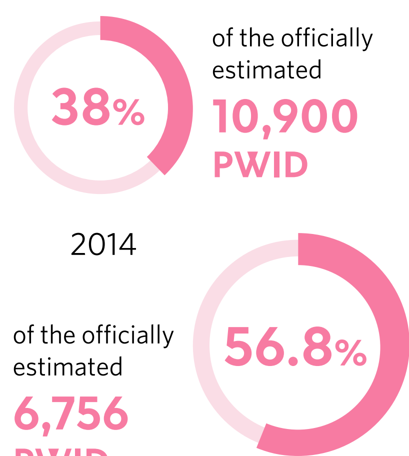
Since 2009, OST has been funded exclusively from the state budget, and this was one of the first components of the HIV program that transitioned from Global Fund to domestic funding. A total of 17 sites now deliver OST in 11 cities across the country. Of those, ten have the official status of centers for the treatment of dependence, with three within psychiatric hospitals, one at the University Clinic of Toxicology, and three located in prisons. In addition to the government program, several private psychiatric clinics also offer OST.

NSPs were first introduced in 1996 by the NGO Mask and soon after continued by the NGO HOPS. Starting from 2004, the Global Fund helped expand NSP across the country so that there was a scale-up to 16 NSP sites in 13 cities. Currently, there are 15 NSP sites in 12 cities, and since 2018, all have been financed by the Ministry of Health (MoH). The total number of clients in all NSPs has slightly increased in recent years (from 3,236 in 2012 to 3,885 in September 2014 and 3,838 in November 2020). After the Global Fund project, the number of clients has remained almost the same. Voluntary HIV counseling and testing (VCT) has been available through mobile outreach units for all key populations since 2007.

The total number of clients in all NSPs has slightly increased in recent years



When NSPs were financed by the Global Fund, the NSP coverage rate



In 2014, when NSPs were financed by the Global Fund, the NSP coverage rate was 38% of the officially estimated 10,900 PWID, and in 2020, the rate was 56.8% of the officially estimated 6,756 PWID, according to the last estimation conducted by the Institute for Public Health in 2017[6].

In 2015, the MoH allowed community-based VCT to be performed in drop-in centers through an NGO-led program with medical professionals engaged onsite only to perform the test. Naloxone in North Macedonia is not readily available at NGO drop-in centers nor through outreach services. Naloxone can only be accessed through OST centers across the country and through the emergency medical service in some cities and can be applied only by a medical professional. Over the last few years, there has been civil society advocacy towards making naloxone more easily accessible to people who need it.

Country legal framework and work plan to support transition

NSPs are a key component of the harm reduction program; they have been a part of three national HIV strategic plans since 2003 and of the last two national drug strategies and even included in earlier Government policy documents. Moreover, harm reduction is recognized in the Law on the Control of Opioids and Psychotropic Substances as part of a range of activities, including "exchange of sterile equipment" and "working with a hidden population"[7]. The OST program is fully supported by the State with the finances allotted from the Program for Health Protection of People with Dependence Illnesses within the MoH for 2006–2021.

6 Mikik V. et al., Ibid.

7 Law on the Control of Opioids and Psychotropic Substances. Official Gazette of the Republic of Macedonia, No. 103/2008. August 2008.

Transition Context for Harm Reduction Services

Georgia

The HIV situation in Georgia

The total population in Georgia was estimated at

3.7 million people

in 2020, according to the latest census figures

Georgia has **a low HIV prevalence of**

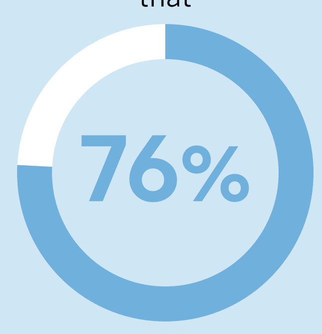
↓0.3

amongst the adult population[8]

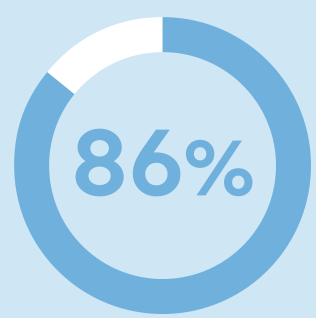
The estimated number of PLHIV is

8,400

In 2020, it was estimated that



of PLHIV were **aware of their status,** and



of those were **on antiretroviral (ART) treatment**[9]

HIV/AIDS is largely concentrated **among key affected populations, including MSM, PWID, and FSW.**

Although the HIV epidemic **remains stable** among PWID and FSW

(<2.3%) prevalence

the alarmingly high HIV prevalence

(20.7% and 21.5%)

was observed among MSM in previous years (IBBSS, Tbilisi and Batumi, 2015 and 2018)

8 UNAIDS data.

9 UNAIDS data.

The number of PWID is estimated at

52,500

and HIV prevalence among PWID is estimated at

2.3%

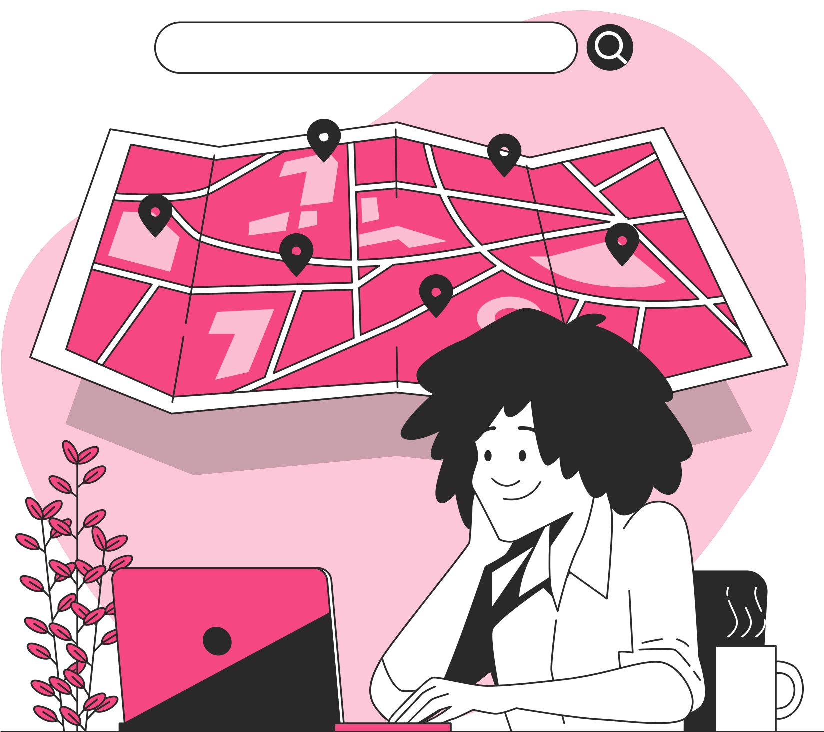
PWID latest estimates

Georgia has one of the highest prevalences of problematic drug use in the EECA region. The number of PWID is estimated at 52,500[10], and HIV prevalence among PWID is estimated at 2.3%[11].

According to the National Strategic Plan for HIV (2019-2022), PWID are one of the priority groups for HIV control in the country. The National Strategic Plan defines the provision of a comprehensive harm reduction package to PWID as one of the priorities through domestic and international funding.

Harm reduction programs and stage of transition

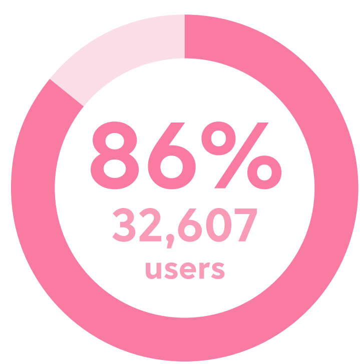
Since 2003, harm reduction has been developing rapidly in Georgia; with the efforts of international donor organizations, services have expanded geographically, and the variety of services provided has broadened. The number of sites providing the needle and syringe programs has increased from 6 in 2006 to 15 sites in 2020, delivering harm reduction services in 11 cities, including in Abkhazia. State organizations are also involved in providing harm reduction services. Namely, the OST program is implemented by the Center for Mental Health and Prevention of Dependence, which has 20 sites around the country.



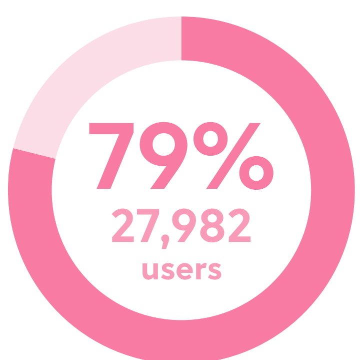
10 PWID Population Size Estimate. Curatio International, 2017.

11 UNAIDS data.

Coverage of PWID with a needle and syringe program in 2020 was



and coverage with HIV testing was



Coverage of PWID with a needle and syringe program in 2020 was 86% (32,607 users), and coverage with HIV testing was 79% (27,982 users). The distribution of needles and syringes has increased from 22 units in 2011 to 70 units in 2020 . OST coverage (including prisons) was over 14,900 clients (135%) in 2020, which is a substantial overachievement compared to the target of 11,000 clients defined in the NSP 2019–2022.

The process of transitioning of the harm reduction program funding from the Global Fund to domestic financing has already started. Georgia has shown progress with regards to taking over the funding of HIV preventive services for key populations and, from 2020, has been financing the harm reduction voluntary counseling and testing (VCT) service for PWID through the non-governmental organization (NGO), Georgian Harm Reduction Network (GHRN), and NGO/civil society organizations (CSOs) under the network umbrella.

OST services have been fully transitioned to the State since mid-2017, with ensured funding and increased enrollment in the program.

Despite the strong will of the Government to fulfill its transitional commitments, funds currently reflected in the Basic Data and Directions 2022–2025 do not support the need to fully cover HIV prevention services for key populations by 2022 at 50% for PWID services and 45% for FSW, even though the new method of unit cost calculation has reduced overall funding needed.

10 PWID Population Size Estimate. Curatio International, 2017.
11 UNAIDS data.

In 2019, the plan was integrated into the National Strategic Plan and endorsed by the Government of Georgia (GoG)

Country legal framework and work plan to support transition

Georgia was one of the first countries in the region to develop the Transition and Sustainability Plan in 2017 and, with the involvement of stakeholders, prepared the basis for a successful transition. In 2019, the plan was integrated into the National Strategic Plan and endorsed by the Government of Georgia (GoG). The initial plan reflected the full transition of harm reduction services by 2022. However, the transition context differs from the National Strategic Plan–defined processes in Georgia because the country is still eligible for Global Fund support for the next allocation period.

With the involvement of the national stakeholders and donor organizations, in January 2020, Decree 01-16/O[13] was issued by the Ministry of Health (MoH), and guidelines for prevention services for key populations were approved. Amongst them are the guidelines and protocol for the harm reduction services for PWID. The guidelines reflect compliance with international guidelines/recommendations and the service package. In addition, the guidelines emphasize the importance of advocacy activities for legislative changes and policy reforms for facilitating the provision of harm reduction services.

OST implementation is regulated by Ministerial Decree No. 01-41/n[14], approved by the MoH on July 3, 2014, which outlines client selection criteria, treatment, and a list of opioids for treatment. New special rules are introduced through amendments to the regulation reflecting the changing environment and program needs.

13 HIV Prevention in High-Risk Groups – National Guidelines in Public Health, Decree #01-16/O. Skopje; Ministry of Health, 24 January 2020.

14 OST Program Implementation, Decree #01-41/N. Skopje; Ministry of Health, 3 July 2014. https://matsne.gov.ge/ka/document/view/2374811?publication=0

Transition Context for Harm Reduction Services

Ukraine

The HIV situation in Ukraine

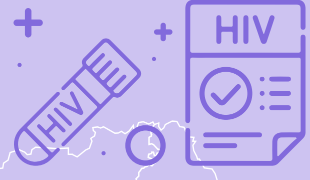
The total population in Ukraine was estimated at

44.1

million people

in 2020, according to the latest census figures

Ukraine bears **the second-largest HIV epidemic in** Eastern Europe and Central Asia



With the estimated

240,750[15]

PLHIV in 2018 (Spectrum),

Ukraine registered

3,448

AIDS-related deaths and

15,787

newly diagnosed HIV cases

Ukraine's HIV epidemic is mixed, with around

0.9–1%

of the general population living with HIV **and significantly higher** HIV prevalence **among certain population groups**

The epidemic is concentrated in key populations with a prevalence of

22.6% **among PWID,**

5.2% **among sex workers**

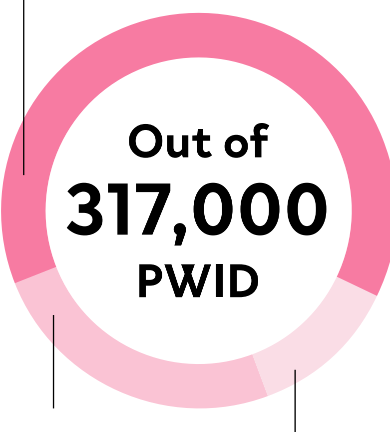
7.5% **among MSM**

(IBBS 2017)[16]

15 Global AIDS Monitoring 2018: Ukraine Summary. UNAIDS. https://www.unaids.org/sites/default/files/country/documents/UKR_2019_countryreport.pdf

16 Global AIDS Monitoring 2018: Ukraine Summary. UNAIDS. https://www.unaids.org/sites/default/files/country/documents/UKR_2019_countryreport.pdf

63.3%
200,661
are opioid users



24.5%
77,665
are simultaneous users of several drugs

12.2%
38,674
are stimulant users

PWID latest estimates

The estimated number of PWID in Ukraine is 350,300 people[17]. The coverage of PWID with harm reduction services is 73.2%[18]. According to the Center for Public Health (CPH), approximately 5.3%[19] of the estimated number of people using opioids in Ukraine received substitution therapy at the beginning of 2021. According to the estimated data from the bio-behavioral study[20], there are 317,000 PWID[21] in the territories controlled by Ukraine (the estimated number for calculations of harm reduction coverage differs, including uncontrolled territories of Ukraine). Out of 317,000 PWID, 200,661[22] are opioid users (63.3%), 38,674[23] (12.2%) are stimulant users, and 77,665[24] (24.5%) are simultaneous users of several drugs, including opioids. Thus, the group of PWID who can receive OST services is estimated at approximately 278,000[25].

Harm reduction programs and stage of transition

Ukraine has a long history of harm reduction programs, which began before the GF funding; the first NSP in Ukraine opened in Odessa in 1996. Since 2004, the vast majority of harm reduction programs in Ukraine have been implemented, financed, and developed with the help of the Global Fund and other donors. The State, to a certain extent, contributed to the development of these programs; in particular, it ensured the formation of the regulatory and legal framework for their implementation. However, the amount of funds allocated from the state budget for this area of work was insignificant, and the funding was of an ad hoc nature. From the beginning of 2004 to 2018,

17 Глобальний моніторинг зі СНІДу — 2021 (GAM — Global AIDS Monitoring). Available by the link: https://phc.org.ua/sites/default/files/users/user90/Indicators_GAM_2016_2020_fin.docx

18 Глобальний моніторинг зі СНІДу — 2021 (GAM — Global AIDS Monitoring). Available by the link: https://phc.org.ua/sites/default/files/users/user90/Indicators_GAM_2016_2020_fin.docx

19 Звіт за результатами впровадження програми замісної підтримувальної терапії у 2020 р. Доступно за посиланням: https://phc.org.ua/sites/default/files/users/user90/ZPT_2020_zvit.pdf

20 Звіт за результатами біоповедінкового дослідження 2017 р. серед людей, які вживають наркотики ін'єкційно, в Україні. — Ю. Середа, Я. Сазонова. — К.: МБФ «Альянс громадського здоров'я». 2020 р. — 224 с.

21 Звіт за результатами біоповедінкового дослідження 2017 р. серед людей, які вживають наркотики ін'єкційно, в Україні. — Ю. Середа, Я. Сазонова. — К.: МБФ «Альянс громадського здоров'я». 2020 р. — 224 с.

22 Звіт за результатами біоповедінкового дослідження 2017 р. серед людей, які вживають наркотики ін'єкційно, в Україні. — Ю. Середа, Я. Сазонова. — К.: МБФ «Альянс громадського здоров'я». 2020 р. — 224 с.

23 Звіт за результатами біоповедінкового дослідження 2017 р. серед людей, які вживають наркотики ін'єкційно, в Україні. — Ю. Середа, Я. Сазонова. — К.: МБФ «Альянс громадського здоров'я». 2020 р. — 224 с.

24 Звіт за результатами біоповедінкового дослідження 2017 р. серед людей, які вживають наркотики ін'єкційно, в Україні. — Ю. Середа, Я. Сазонова. — К.: МБФ «Альянс громадського здоров'я». 2020 р. — 224 с.

25 Звіт за результатами біоповедінкового дослідження 2017 р. серед людей, які вживають наркотики ін'єкційно, в Україні. — Ю. Середа, Я. Сазонова. — К.: МБФ «Альянс громадського здоров'я». 2020 р. — 224 с.

According to the Transition Plan, in 2017–2018, the Global Fund grant was supposed to cover

80%

of the costs, and the state budget,

20%

the main recipients of grants from the Global Fund and other international donors were two national NGOs: the Alliance for Public Health and the All-Ukrainian Network of People Living with HIV.

According to the Transition Plan, in 2017–2018, the Global Fund grant was supposed to cover 80% of the costs, and the state budget, 20%; in 2018–2019, expenses were to be divided 50/50; in 2019–2020, 80% of funding should have come from the budget of Ukraine. For the first time, the third recipient of the Global Fund grant was the public institution Center for Public Health (CPH), created on the basis of the MOH.

In 2018–2019, CPH and national partners piloted two models of transition to public funding and administration of service delivery (centralized and decentralized). Both models involved subgranting of NGOs as service providers.

Since 2019, centralized models of public funding have been used with tender announcements and selection via ProZorro online system.

Services are now being covered by the state budget, and the consumables are paid from the GF. All the additional services are also covered by GF and/or other donors via subgranting through Alliance for Public Health and the All-Ukrainian Network of People Living with HIV.

Country legal framework and work plan to support transition

In 2019, by order No.1415-r of the Cabinet of Ministers of Ukraine, the Strategy for Combating HIV/AIDS, Tuberculosis, and Viral Hepatitis for the period until 2030 was approved.

In 2017, the Strategy for Ensuring a Sustainable Response to TB and HIV/AIDS Epidemics was developed and implemented. This was basically the Strategy for the transition until 2020.

The government and the Ministry of Health (MoH) prepared a number of changes to the regulatory acts that allowed to launch the process of allocating funds from the state budget to finance HIV-related services and identified the main manager of these funds. In addition, the MoH has prepared and approved a number of normative legal acts that regulate the organizational framework for the provision of HIV-related services for representatives of the KPs and PLHIV, as well as determine the mechanism for calculating the maximum tariffs for the provision of these services.

Transition Context for Harm Reduction Services

Kyrgyz Republic

The HIV situation in Kyrgyz Republic

The population of the Kyrgyz Republic is approximately **6.7 million people**

HIV prevalence among the general population **0.2** in 2020, unchanged from the previous period

HIV prevalence rates of over **5%** are found in three key populations: **PWID, prisoners, and MSM**

As of December 31, 2020, **10,343 cases of HIV infection were** registered in the country, and the incidence rate is **9.7 people per 100,000 population**

In total, as of December 31, 2020, only **4,442 people living with HIV** (or 63% of the total number of registered PLHIV) **received antiretroviral therapy (ART)**

including **4,062 adults**

♂ 2,189 ♀ 1,873

and **332 children**

♂ 196 ♀ 136

In prisons, **187 people** received ART

The number of PWID is estimated at

52,500

and HIV prevalence among PWID is estimated at

2.3%

PWID latest estimates

The latest data on the prevalence of injecting drug use was obtained in 2016 during the routine integrated bio-behavioral survey. The estimated number of PWID was 25,000. According to the statistics of the Republican Center for Narcology, 5,113 people with drug addiction were registered at the beginning of 2021.

Harm reduction programs and stage of transition

Harm reduction programs in the Kyrgyz Republic appeared at the end of 1999 in Bishkek (the capital city). The OST program with methadone was launched in the country in April 2002 with the support of the FGC and UNDP after a thorough preparatory period.

OST and ART programs are available in prisons, and NSP operates in nine prisons in the country.

From 2003 to the present day, the Kyrgyz Republic has been receiving funding under a Global Fund grant, due to which harm reduction programs are mainly implemented in the country. In recent years, other projects have also provided support for the methadone OST program. Certain services are funded under various short-term projects, determining the temporary nature of these services.

Since 2012, the harm reduction programs have been implemented by NGOs selected through the annual tenders of UNDP, the main recipient of the grant from the GF in the country.

In 2019, the Republican AIDS Center piloted a state social order to provide services to PLHIV

In recent years, a lot has been done in the context of preparations for the transition of HIV programs to state funding. As a result of a fairly long-term work actively carried out by the Republican AIDS Center, the list of professions includes a concept of a “patronage worker”, which allows state medical organizations, in particular FMCs, to employ outreach workers/peer consultants/social workers to provide services for KPs or PLHIV. Since 2018, the Republican AIDS Center has been purchasing part of ART drugs, and the share of this contribution is growing every year. In 2019, the Republican AIDS Center piloted a state social order to provide services to PLHIV. In 2020, tenders within the framework of the state social order did not take place due to the COVID-19 pandemic.

Country legal framework and work plan to support transition

Service standards for PWID were first developed in the Kyrgyz Republic in 2009

Service standards for PWID were first developed in the Kyrgyz Republic in 2009 and approved by order of the Ministry of Health (MoH).

By order of the MoH of the Kyrgyz Republic of August 22, 2014, No. 482, the Standards for the implementation of harm reduction programs and provision of services to injecting drug users were approved.

The documents of 2014 became the basis for the revision and addition of the Service Standards for KPs and PLHIV under the State Social Order (social contracting) in 2018.

The country has developed a Transition Plan on Ensuring Sustainability of HIV and TB Programs for 2020–2025

The revision of the Standards on social contracting was planned for 2021, based on the pilot results. The revision of the OST standards (clinical protocol with the inclusion of buprenorphine, as well as other documents) was also planned for 2021.

The country has developed a Transition Plan on Ensuring Sustainability of HIV and TB Programs for 2020–2025.

Composition of Harm Reduction Services: Current NSP and OST Packages in North Macedonia, Georgia, Ukraine, and the Kyrgyz Republic

Harm reduction package of services available in each country / type of funding

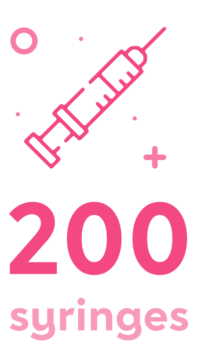
	North Macedonia	Georgia	Ukraine	Kyrgyz Republic
NSP				
Counseling by social/ outreach workers	State funding	Donor funding	State funding	Donor funding
Syringe distribution	State funding	Donor funding	Donor funding	Donor funding
Needle exchange	State funding	Donor funding	Donor funding	Donor funding
Condom distribution	State funding	Donor funding	Donor funding	Donor funding
NSP in prison	Not available	Not available	Partially available	Donor funding
OST	State funding	State funding	State funding	Donor funding
OST in prison	State funding	State funding	Not available	Donor funding
Other services				
HIV testing and counseling	State funding	State funding	State funding	State funding + Donor funding
Antiretroviral therapy	State funding	State funding	State funding	State funding + Donor funding
STI prevention and treatment	Data n/a	State funding	State funding + Donor funding	Donor funding
PrEP	Data n/a	State funding	State funding	Data n/a
Targeted information, education, and communication materials and counseling	State funding	Donor funding	State funding + Donor funding	Donor funding
HBV/HCV	State funding	State funding	State funding	State funding + Donor funding
TB prevention and treatment	State funding	State funding	State funding	Donor funding

Country-level highlights

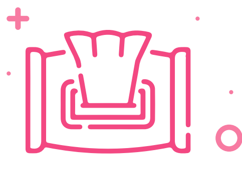
Within the Global Fund projects, the minimum package of services in North Macedonia included one syringe, two needles, a condom, and information-education material. Today, the minimum package is the same plus lubricant.

The current service package for the needle and syringe program in Georgia includes the following limits per client per year: VCT service twice a year, including HIV, HCV, HBV, syphilis, and TB screening (second testing is based on medical indication or risky behavior); 130 syringes distributed; consultation with a specialist, including doctors and psychologists, case management and hygiene packages on demand (the number is defined based on available funding); monthly meetings with peers and client school; and an HIV self-testing intervention, with tests provided at the center or online through a self-testing platform.

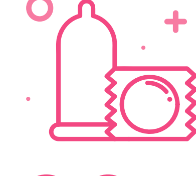
The estimated number of consumables to distribute to harm reduction clients in Ukraine is being calculated by the norms of maximum units per client per year:



200 syringes



200 antiseptic wipes



20 condoms

2 lubricants

Regarding the minimum package of services provided to PWID in the Kyrgyz Republic, throughout the history of NSP implementation, the standard for the number of distributed medical products (syringes, condoms, and disinfectant wipes) has been phased out. More than 10 years ago, clients received consumables based on their demand; then, the standard was two syringes per day, and later, one syringe per day; the number was gradually reduced according to the needs of the clients. Currently, the standard for one client is as follows: four syringes per week, one condom per week, and eight disinfectant wipes. The employees of most NGOs confirm that it is enough to address clients' needs.

Composition of Harm Reduction Services: Current NSP and OST Packages in North Macedonia, Georgia, Ukraine, and the Kyrgyz Republic

	NORTH MACEDONIA	GEORGIA	UKRAINE	KYRGYZ REPUBLIC
HIV-related harm reduction funding available (for the latest period)	annual 339,000€ allocated by MoH (161,000€ less than by GF)	13 million 805,000$ in 2020	7 million 642,959$ (UAH 207,492,400) state funding	26 million 045,361$ for the period 2017–2021
International funding	0%	22%	Exact data n/a, but planned to be 20%	86.7%
Domestic funding	100%	78%	Exact data n/a, but planned to be 80%	13.3%
In-country unit cost per client per year—NSP	75.3€ in comparison to 155€ by GF	32$ per client per year in 2020	19.25$ per client per year	36$ per client per 6 months
In-country unit cost per client per year—OST	from 27.6€ to 27.6€ per patient per month	244$ per patient per year	150.36$ per patient per year	182.5$ per patient per year

Country-level highlights

North Macedonia

On average, the NSPs in North Macedonia within the Global Fund received EUR 500,000 annually. Expenses per client averaged at EUR 155.00[26] per year (USD 174.50)[27].

Annually, the Ministry of Health allocates EUR 339,000 for these programs on average, which is EUR 161,000 less than the Global Fund support[28].

The newly opened OST centers have been completely financed by the MoH since 2009 through the Program for Health Protection of People with Dependence Illnesses, and the program's budget increased from EUR 1.27 million in 2015 and 2016 to EUR 1.37 million in 2021[29]. In 2012, for the first time, nine packages of OST services were introduced, but they were reduced to only four in 2021. This change was of a technical nature and did not affect the number of services offered. The cheapest package of services, at EUR 9, is the hospital treatment of clients; however, this package does not include the necessary therapy, materials spent, and laboratory services. The prices of other packages depend on how many different services the client receives, ranging anywhere from EUR 27.60 to EUR 34.10 per patient per month (from EUR 331.20 to EUR 409.20 per patient per year).

Georgia

Domestic funding for the HIV response in Georgia has increased by 12% in 2021 compared to 2020, comprising USD 13,805,000.

Georgia does not have an approved unit cost for harm reduction services, and over the past few years, approaches to budgeting and reimbursement have been changing. Therefore, in order to understand the changes in the unit cost during the transition, the estimates were made for the unit cost of key harm reduction services, i.e., the NSP and OST. The average unit cost per client per year was calculated based on the total estimated budget and NSP projected coverage indicators.

26 Dekov V., 2015, Ibid.

27 World Bank, 2016, Ibid.

28 Ministry of Health. Program for Protection of the Population from HIV in the Republic of Macedonia, 2018, 2019, 2020, and 2021.

29 Ministry of Health. Program for the Health Care of People with Diseases of Dependence for 2015, 2016, and 2021. Skopje; Ministry of Health.

Thus, the unit cost of NSP per client per year changed from USD 75 in 2016 to USD 32 in 2020 (and is expected to be USD 30 in 2021). The change of the costing method had a big influence on harm reduction budgeting and financing. The decrease in total volume compared to 2016 comprises 23% in local currency (GEL) and up to 44% in USD. The difference in percentage change is related to GEL/USD foreign exchange fluctuations. The estimated unit cost per client per year in the OST program changed from USD 570 in 2016 to 244 USD in 2020 and to 287 USD in 2021.

Ukraine

Under its 20–50–80 transition plan, which began in 2018, the government of Ukraine committed to increasing its share of the funding of HIV prevention, care, and support programs, which were previously fully funded by international donors over three years. In the first year of the transition plan, the State was to finance 20% of those programs, with the Global Fund providing 80%. In the second year, the ratio was to reach 50/50, and in the third year, 80% of funding was to be provided by the State, with 20% from the Global Fund.

NGOs are now able to apply for state funding of HIV prevention programs via the ProZorro procurement system. Additionally, NGOs can receive additional GF funding for NSP-related services via Alliance for Public Health, but only if they receive the state funding for harm reduction.

The current in-country unit cost per client per year in Ukraine is USD 19.25 for NSP and USD 150.36 for the OST program. These unit costs are the smallest among all four countries presented in the report. At the same time, additional harm reduction services in Ukraine continue to be funded by international donors (GF, USAID, UNAIDS, and others). Due to the fact that in 2021, some new internationally funded programs started (e.g., Community Action for HIV Control and USAID) and previous programs are coming to an end (e.g., HealthLink and USAID), at the moment, there is no exact data on the total budget for harm reduction programs available.

Kyrgyz Republic

The Program of the Government of the Kyrgyz Republic to overcome HIV infection in the Kyrgyz Republic for 2017–2021 defines the goals, objectives, and main directions of the state policies of the Kyrgyz Republic to prevent the spread of HIV infections. The Program is financed from the state budget and donor funds. When the Government Program was approved

at the end of 2017, its total budget was determined at USD 48,674,064, but USD 33,104,953 were allocated (the total deficit of the necessary funds amounted to 33%). Within the framework of the Program, the main strategy that covers services for PLHIV and harm reduction programs for key populations is funded by international donors at 86.7% (22,589 out of 26,045 thousand USD). The remaining 13.3% of state funds are allocated for ART and HCV programs, which have been funded from the state budget since 2018.

In the Kyrgyz Republic, there are no fixed unit costs; those are being calculated every six months based on the actual spending within the ongoing harm reduction program. Thus, the current unit cost for NSP programs is USD 36 per client per 6 months. The unit cost for OST is USD 182.5 per patient per year. Based on the program data of the ICAP project, there were no significant differences in unit costs from 2016 to 2021.

The Voices of Communities: Feedback from PWID, CBOs, and NGOs about the Transition Process

Feedback from service providers

The overall impact from the transition of the harm reduction services to domestic funding is **most tangible for the service providers (CBOs and NGOs)** since it changed the procedures for interaction between those who provide and receive funding. However, given that international funding still dominates in harm reduction services in most of the countries, it is rather difficult to understand the final impact.

Service providers indicate the major changes in procedures and interaction with the State as the provider of financing:

"We trade [our services] through the ProZorro public procurement system because we want to use state budget money. There are nuances in the package of documents; it cannot change as flexibly as it used to be. Moreover, now it's not the tender commission to decide on the winner; this is done completely by the electronic system."

SERVICE PROVIDER REPRESENTATIVE, UKRAINE

"We receive 40% less funding compared to funding from the Global Fund. Accordingly, the range of services is reduced by 40%, the unit cost per client is reduced, the salary is reduced, the number of services is reduced."

SERVICE PROVIDER REPRESENTATIVE, UKRAINE

The key informants from CSOs from all countries state that the quality of the harm reduction programs has decreased. There were many reasons voiced, including very high indicators, insufficient number and quality of consumables, and external monitoring without quality assessment and follow-up technical support:

"The quality of our services needs to be evaluated... I'm not sure that every organization gives the same information about prevention of HIV during consultations with social workers or doctors as we did."

SILVANA NAUMOVA,
PROGRAM MANAGER AT THE NGO HOPS,
NORTH MACEDONIA

Moreover, there is a lack of new approaches and innovative services for reaching specific key population subgroups.

"Great consideration should be given to new groups, such as young injectors, non-injecting drug users, and female injectors. Harm reduction service centers should create appropriate and comforting environments for all age and gender groups."

CSO REPRESENTATIVE, GEORGIA

Feedback from the PWID community

Regarding the **clients of the NSP programs,** they usually do not know the funding sources or project names while receiving services.

"Previously, they gave out [consumables] without restrictions, as much as I asked for and was needed. Eleven years ago, we went to the NSP point, and they gave us enough for the following month or more in advance... Then, it became less and less; now, I don't know at all whether it makes sense to go to these programs. In my opinion, now they give five units per hand."

NSP CLIENT, UKRAINE

Clients in all countries have experienced cutbacks in the package of services.

"The staff of the service center are like family to me; they do their best to support us, but lately the social support package, like case management and providing minor medical supplies, has reduced due to financing issues."

PROGRAM BENEFICIARY, GEORGIA

At the same time, in the opinion of most harm reduction clients, the attitude and dedication of the staff have not changed in the past few years, i.e., in comparison to the period when the program was fully supported by the Global Fund:

"The people working in these programs are the biggest benefit to us."

PROJECT CLIENT, NORTH MACEDONIA

Many clients noted the importance of OST programs. Some of them have been participating in the OST program for a rather long period of time — five years or more.

"Methadone gives me freedom; at my age with my poor health, heroin is expensive, and now [thanks to the program] I have a job, a family..."

OST CLIENT, KYRGYZ REPUBLIC

However, service providers often hear from clients of the OST program about the deterioration in the quality of the methadone drug:

"The methadone solution has become weaker compared to 2013; before, 20–30 mg was enough; now, 50–60 mg is needed. One batch is different from the other, everyone complains..."

OST CLIENT, KYRGYZ REPUBLIC

In Ukraine, with the transition of OST programs to state funding, methadone began to be purchased domestically, which caused many complaints among clients regarding its quality.

"This drug from Kharkiv sucks. I can say with confidence that if this drug is used further, then all the work of previous years will be reduced to zero. I see how people start drinking or additionally use «barbitura» in incredible quantities ... This is not the drug that should be used in substitution therapy..."

CLIENT OF OST, UKRAINE

Nonetheless, as the programs are not anonymous, OST patients are afraid to write complaints so that they do not lose their place in the program, and thus, they do not have an opportunity to defend their patient rights.

"When we were actively advocating this issue several years ago and collected a lot of signatures, then in some areas, there was pressure from the administration. People from initiative groups were called into offices; doctors told patients that they [representatives of initiative groups] were doing this for their own benefit. And because of this, they will suffer; in general, they got manipulated. People refused to complain... Until doctors of a new formation come, such methods will be continued to be used, unfortunately."

CLIENT OF OST, UKRAINE

Key Findings and Lessons Learned

Decrease in funding for harm reduction programs

Despite a slight increase in funding for opioid substitution therapy (OST) programs, in general, the allocated funds from the Global Fund and local budgets for harm reduction programs have significantly decreased. This has had an influence on the procurement of consumables (syringes, condoms, etc.) and has reduced the list of services in a package. At the same time, program progress indicators have increased and are likely to grow further. The focus of services has shifted from their quality and clients' needs to the number of units to reach.

Reduced quality of services and lack of quality assurance mechanism for harm reduction services

OST and needle and syringe programs (NSP) require constant technical support of service providers, advanced professional training for doctors and peer consultants, procurement of high-quality consumables, and developed quality standards of service provision that are being monitored and supervised.

Social contracting mechanisms

All countries have demonstrated the readiness to establish, have already established, or are in the process of establishing "social contracting" mechanisms for sustainable financing of HIV prevention interventions for key populations. For example, North Macedonia and Georgia have mechanisms for contracting with NGOs. Ukraine is piloting approaches that include social contracting with NGOs and CBOs to maintain harm reduction activities after the Global Fund transition. The Kyrgyz Republic developed a national transition plan that includes measures on creating enabling conditions for NGOs to ensure the possibility of social contracting in the next five years

Barriers to social contracting of CBOs

While most NGOs have managed to build their organizational capacity and adapted to the new social contracting procedures to receive state funds, for the majority of CBOs, state budgets are still not available for a number of reasons. Community-based organizations often face legal and regulatory constraints

to receiving funding from public sources. Either the CBOs lack appropriate legal status or governments have no mechanism to fund these entities for service delivery, or in many cases, legal and/or tax issues and delays in payment through the state treasury prevent CBOs from applying. Another issue can be related to the criminality codes around risk behaviors that might limit access to public funding. Others are constrained through bureaucratic processes that are not made to suit small organizations. While partially addressed in transition planning, earlier and more directed efforts are needed to ensure access to prevention and care services by key populations

Challenges and risks of the post-transition period

There is a high need to identify the alternative mechanisms to support countries post transition. A number of transition challenges, such as access to quality-assured OST medicines, availability of naloxone in drop-in centers, and well-trained friendly healthcare professionals, can affect gains made in countries post transition (demonstrated by the North Macedonia case).

Improvement required in monitoring transition grants

Standard grant indicators alone are not sufficient for measuring the performance of specific transition activities.

Expectation gaps in communication between service providers and state agencies

In addition to the above issues and risks, there are expectation gaps in communication between service providers and state agencies responsible for post-transition funding. Despite the fact that NGOs want to continue activities in the same format as during the direct financing of the Global Fund, changes are inevitable and must be voiced by all parties and carefully discussed before the end of the transition.

It should be once again mentioned that the **COVID-19 pandemic** has also influenced the transition plans and activities in all countries. Due to the lockdown, planned estimates of the size of the key populations were postponed, the transition plans were affected, and the access of key groups to the necessary services was limited.

Based on the countries' transition experiences and expectations, the **key elements for a successful transition from international to domestic funding** can be highlighted:

1. Sufficient state funding and long-term contracting of CSOs via transparent and flexible tender procedures
2. Timely, well-designed supporting policies and legislative framework, including early transition planning
3. Quality assurance of harm reduction services; strong MEL system that includes qualitative indicators
4. Trained and motivated service providers, including friendly doctors on OST sites
5. Meaningful involvement of key populations in the design of harm reduction package of services
6. Documenting of best practices and knowledge sharing
7. Communication and collaboration of all key stakeholders
8. Emergency funding available

Recommendations

It is important that the recommendations at all levels should be inclusive of and focused on: individual and community levels to ensure their proactive access to high-quality health and social support services so that they take care of their own health and the health of their families; skilled health workers, social workers, and other public health professionals providing quality, people-centered care; grassroots organizations ensuring linkage of key populations to relevant services; and policy-makers committed to investing in universal health coverage (both via domestic and international funding).

The recommendations drawn in the report should contribute to building a dialogue between all stakeholders at the national and international levels in order to support NGOs, CBOs, and, most importantly, their clients, both during the stages of preparation and implementation of the transition and in the post-transition period. Only through joint efforts will it be possible to facilitate the improvement and effectiveness of the program in achieving its targets while ensuring the service is quality oriented to the individual needs of clients.

Recommendations for state governments (local Ministries of Health responsible for taking over the harm reduction services)

General recommendations for all countries:

1. **Increase the budget** for financing the needle and syringe program in accordance with the needs of PWID as the beneficiaries of this program.

2. **Adopt framework standards** for the needle and syringe program. This framework should cover the standard operation procedures and recommended package of services for different drug scenes and respond to the needs of people who use drugs.

3. **Introduce realistic indicators responding to a broad understanding of harm reduction aims** for CSOs to meet in accordance with current evaluations on the size of the population of people who use drugs and add qualitative indicators.

4. Conduct regular monitoring and evaluation **of the quality of needle and syringe programs and of opioid substitution treatment,** including client satisfaction. Support ongoing **community-led monitoring** of harm reduction services on the country level as an effective feedback system from clients.

5. Develop a proper mechanism to attract well-trained and **friendly medical professionals** (especially from the younger generation) who would like to work in opioid substitution treatment. Allow employment of the necessary professional staff in opioid substitution treatment.

6. **Improve communication** between the competent authorities for the HIV prevention program at the Ministry of Health and CSOs.

7. **More cooperative and service-oriented state procurement and tender procedures.** It is important to use the already existing cooperation between the State and NGOs more effectively to further increase the funding of harm reduction services through the NGO platform. Despite the existence of state procurement procedures that allow for the contracting of NGOs/CSOs, a more specific legal environment should be developed for contracting NGOs/CSOs in the health sector. The procurement rules and procedures should be detailed, and bid evaluation should be based on the proposed program, quality indicators, and service pricing. Procedures for monitoring the volume and quality of the services delivered should be defined. This will lead to better program implementation, budgeting, and evaluation of the effectiveness of interventions. Currently, the countries' tender tools and procedures (e.g., ProZorro in Ukraine) still do not work properly to select services based on the quality of their provision, and they mainly rely only on the price (the lowest tender bid) when choosing the winner.

8. **Capacity building of NGOs and CSOs in financial management** is important for ensuring strong skills to manage diversified sources of funding and to adjust to new payment mechanisms.

9. **More flexible harm reduction package of services.** Ensure that the needle and syringe service package better reflects the needs of existing clients and is attractive to new clients through

the scaling-up of existing services and by introducing new activities in line with the changing drug scene that will allow new groups of drug users, especially younger sub-populations, to be reached. Improving accessibility to harm reduction products to diversify the service packages should be considered. The discussion of the package of services, the proposed changes, and the decision-making process should be carried out with the obligatory participation of representatives of the PWID community. Funding mechanisms and target indicators should also be developed jointly with all interested partners, including service providers and clients.

10. **Regular revision of unit costs and budgets for services.** The assumptions used in the budget calculation should be reviewed periodically (every 3–5 years) to reflect changes in the macroenvironment and service provision.

Specific recommendations for each country

North Macedonia:

1. Adopt a **proper mechanism for financing civil society organizations** that are implementing HIV prevention programs among people who use drugs in order to provide a regular transfer of finances. The current process is ad hoc and, therefore, subject to political interference. The establishment of a long-term contracting mechanism for NGOs would help to remove some uncertainty and potentially ensure sustainability.

2. **Establish the price of a package of services** offered in the needle and syringe program.

3. **Ensure availability of naloxone** in all opioid substitution treatment and needle and syringe programs. Naloxone can only be accessed through OST centers across the country and through the emergency medical service in some cities, and it can be applied only by a medical professional. Over the last few years, there has been civil society advocacy towards making naloxone more easily accessible to people who need it.

4. Ensure that there is an **adequate and formal participatory process** with the inclusion of civil society for developing the annual HIV program based on the National Strategic Plan.

Georgia:

1. **Sufficient state funding.** Allocate sufficient funds for the HIV Prevention Component of the State HIV Program budget directed to key populations to ensure a sustainable and smooth transition; furthermore, the Government of Georgia has clearly shown a commitment to increase funding for HIV prevention services for key populations, but the composition of the needle and syringe service package should be further discussed. To ensure service continuity and quality in the long-term, the service package funded by the State should expand and cover not only the VCT component and the basic package but also add-on services that attract and retain clients.

2. By the end of 2021, the **development of innovative funding mechanisms** — the performance-based financing (PBF) model — in Georgia should be completed with the engagement of national stakeholders in order to adequately reflect the new model in the public health programs for 2022. The model should define a new payment mechanism, quality indicators, and a strong monitoring framework that will enhance efficiency and cost-effectiveness of the harm reduction program through facilitating the uptake of services by PWID, increasing funding utilization, and motivating staff to provide high-quality care. The monitoring capacity at the implementer level should be adequately enhanced. A pilot may be introduced in several sites and scaled up afterward. The newly developed funding mechanisms should consider the experience of the countries such as North Macedonia and Ukraine, which have already passed the relevant transition stage.

3. **Increase accessibility of OST by expanding geographic coverage** through the opening of new service sites and increasing the capacity at existing facilities. Introduce differentiated OST service delivery to improve program effectiveness, such as mobile OST units.

4. To increase adherence and **effectiveness of the OST program, more client-oriented services** should be offered. The criteria for an individually adjusted treatment plan, including take-home doses and psychosocial support, should be developed and offered to clients.

Ukraine:

1.

Ensure patients' confidentiality and access to OST programs (regardless of the private or public form of ownership). The newly approved Ukrainian legislation on OST allowed legitimization of the private medical OST sites. In addition to the fact that it is a long-awaited important achievement, it carries additional risks of increased control of patients by law enforcement agencies. In order to avoid negative consequences in the form of increased vulnerability and unwanted visibility of such patients, it is necessary to conduct additional negotiations and explanatory work with law enforcement agencies.

2.

Training of peer counselors to support OST clients. There is a need to improve the qualifications and skills of peer counselors who provide psychosocial support services for OST patients. A specialized training course/professional development program should be developed and certified.

3.

Allow OST patients the ability to provide feedback and influence their treatment (via filing official complaints). Given the current context, it is necessary to develop and implement alternative ways of anonymously filing complaints from OST patients that would not jeopardize their treatment.

Kyrgyz Republic

1.

Advance planning of the transition, taking into account the experience of other countries. Despite the "guaranteed" support of the country by the Global Fund and other donors for the next 2–3 years, as well as the hope of receiving further donor funding, it is important to immediately step up activities to promote support for harm reduction and HIV prevention programs in each region and for each key population group, piloting mechanisms for allocating funds both through local governments and through the health system. The process of promoting, elaborating, and implementing the transition is long and difficult, requiring both the formation of political will and the preparation of the necessary regulatory documents, the development of mechanisms, training, etc.

Recommendations for international donors

Advocacy support. Support civil society advocacy initiatives, especially continued community monitoring of program implementation and budget monitoring of related expenditures. Consider taking action if certain interventions for key affected populations are neglected or missing. Take steps to ensure that civil society will continue to be meaningfully involved in all national processes related to the HIV program and that the voice of civil society and affected communities is heard.

Support of social contracting, especially for CBOs (budget advocacy and capacity building). CSO capacity should be strengthened while donors are still present to ensure that CSOs are prepared for service delivery and advocacy activities and are able to deliver services adequately and to advocate for their sustained financing after the exit of external financing.

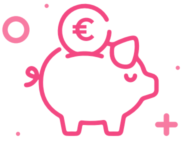
Provide capacity building for the program and financial management of the HIV prevention sector **of the Ministry of Health** as the responsible department for management of the National HIV Program.

Quality assurance of harm reduction services. Support initiatives that will improve HIV programming, scale up services, and improve their quality. This should also include continued capacity building for all actors engaged in HIV programs. Support ongoing community-led monitoring of harm reduction services on the country level as an effective feedback system from project clients.

Emergency funding. The global COVID-19 pandemic has particularly highlighted how vulnerable key communities remain in times of global crises. In the context of tight budgets linked to rigid indicators, many needs of key populations are left unaddressed. Emergency funding is essential to the success of the sustainability of harm reduction services.

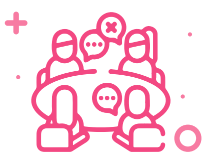
Recommendations for international and national level CSOs

Awareness-raising country-level campaigns to support the visibility of transition processes. Sharing the best practices and experiences of countries starting, going through, and/or accomplishing the transition process from international to domestic funding. Awareness raising is important in order to ensure the commitment of the general population to services for key populations to secure stable funding regardless of major changes in political will. It is important to provide vast visibility support for the activities of the Ministry of Health (and its representative bodies, e.g., Center for Public Health in Ukraine) responsible for the provision of harm reduction services on the national country level and help them to inform society about the goals and objectives of the transition and also about the role of the State and MoH team in these processes.



Advocacy to increasing domestic finances. To leverage additional domestic financing, there is a need to support domestic advocacy for increased health spending and to assess what alternative innovative financing mechanisms can be developed to reduce dependence on donors.

Recommendations for local NGOs, CBOs, and initiative groups



Representatives of NGOs and CBOs should improve their skills in understanding, initiation, and creation of legal regulations and other normative acts. Adopting supportive regulations that guarantee the right of key populations to receive specific services provides an excellent basis for advocacy efforts, including monitoring the implementation of government commitments.

Meaningful involvement of key populations. This includes the participation of KP representatives in decision-making, continued progress on addressing human rights-related barriers in the context of the disease responses and access to services, and proactive monitoring of the quality of NSP and OST services.

Cross-cutting recommendations

Quality assurance mechanism for harm reduction services. Improvements to the quality of the needle and syringe programs and the substitution treatment programs are impossible without strong cooperation between all stakeholders.

Adjusting standards to the needs of different key populations. To improve the efficiency of service delivery, it is necessary to standardize them. Develop/update/supplement standards, in particular for harm reduction programs, in a timely manner and on a regular basis, focusing on changing situations, real needs of clients, changing financial capabilities, and other factors. While it is assumed that such standards should be developed at the domestic country level, there is a need for broad involvement of international and national partners in the development of such standards, open dialogue with a wide circle of stakeholders, and the exchange of experience between different countries.

Development of mechanism of funding allowing flexibility of services provider organizations **to change package of services** responding to specific needs of different key populations.

Extending the package of harm reduction services beyond HIV. The harm reduction package has not been updated for a long time and does not fully take into account the current needs of the PWID community. The package of services should include more services related to mental health and psychosocial support. There is still a high demand for services of community drop-in-centers, shelters, and household service.

Conclusion

The findings from the regional analysis on unit costs and packages of harm reduction services during the transition from international donors to domestic state funding conducted in four selected countries of the EECA region demonstrate a number of common challenges and specific areas for improvement. Despite the fact that all countries are at different stages of transition, they have all faced issues such as a decrease in quality of provided services, insufficient training of medical personnel involved in OST, and a strong need for further capacity building of NGOs and, especially, CBOs.

The country reports clearly indicate the step back from the client-oriented approach of comprehensive harm reduction package of services to the inflexible indicators-dependent basic list of prevention actions with strict reporting in order to receive funding for the following periods. In the current situation, a strong necessity has arisen to once again prioritize the needs of harm reduction clients and involve them in the ongoing revision of the relevance of the packaged services. This revision of services should be primarily based on the constant changes of the drug scene and local contexts of the countries. There is a need to engage individuals from key population communities in active roles of quality monitoring and oversight and accountability of programs and services designed or operated for their benefit.

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