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A brief overview of the results of the sustainability assessment of the HIV response among Key Populations in nine countries of the EECA region in the context of transition from Global Fund support to domestic funding

Eurasian Harm Reduction Association (EHRA)

2021

#SOS_PROJECT
Alliance for Public Health
100%LIFE
CAAPL Central Asian Association of PLHIV
EURASIAN KEY POPULATIONS COALITION

This document is a publication of the Eurasian Harm Reduction Association (EHRA), a not-forprofit public membership-based organization that unites harm reduction activists and non-governmental organizations from Central and Eastern Europe and Central Asia (CEECA) region.

EHRA's mission is actively to unite and support communities and civil societies to ensure the rights and freedoms, health, and well-being of people who use psychoactive substances in the CEECA region.

The document is published within the framework of the regional project Sustainability of Services for Key Populations in Eastern Europe and Central Asia, which is implemented by the Alliance for Public Health (APH) in a consortium with the 100% Life (All-Ukrainian Network of PLWH), the Central Asian Association of PLWH and the Eurasian Key Populations Health Network with the financial support of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund).

Recommended citation: A brief overview of the results of the sustainability assessment of the HIV response among Key Populations in nine countries of the EECA region in the context of transition from Global Fund support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021.

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Acronyms and abbreviations

APT	Antiretroviral Therapy
ARV	Antiretroviral
EECA	Eastern Europe and Central Asia
HIV	Human Immunodeficiency Virus
The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
CS	Civil Society
EHRA	Eurasian Harm Reduction Association
KP	Key Population
PWUD	People Who Use Drugs
PD	Places of Detention
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
OAT	Opioid Agonist Therapy
CCM	Country Coordinating Mechanism
SW	Sex Worker
CSS	Community Systems Strengthening
IBBS	Integrated Biological and Behavioural Survey
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
SMART	Specific - Measurable – Achievable – Relevant - Time bound

Introduction

In 2020, the Eurasian Harm Reduction Association (EHRA) developed a conceptual framework, methodology, and transition monitoring tool[1] to help key populations most affected by HIV strengthen their capacity in monitoring the transition from donor support (particularly, the Global Fund) to national funding in the HIV response. The assessment tracked the implementation of government commitments to a sustainable HIV response among key populations within programmatic areas essential for them.

This methodology was developed for the programme 'Sustainability of Services for Key Populations in Eastern Europe and Central Asia', implemented by a consortium of organisations from the EECA region led by the Alliance for Public Health (APH, Ukraine) and funded by the Global Fund. The implementation period of the programme is 2019 to 2021 and includes 14 EECA countries. The Eurasian Harm Reduction Association (EHRA) is a regional partner of the programme.

In 2021, EHRA piloted the developed methodology and tool in nine countries in the EECA region as part of the programme to assess states' fulfillment of their commitments to ensure a sustained response to HIV among key populations in the context of the transition from Global Fund support to public financing. The assessment was conducted in the following countries: Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, North Macedonia, Serbia, Tajikistan, and Montenegro. To implement it, EHRA involved local consultants. National experts from various sectors, including the public sector, communities, and relevant NGOs, were also involved in the assessment in each country.

The purpose of this document is to compare the key findings of the assessments conducted in different countries and to develop recommendations for refining the assessment methodology and tool according to the results of the piloting.

It is expected that in 2022, EHRA will finalize the assessment methodology and tool based on the results of pilots. And in 2023, the organization will conduct a reassessment in some countries.

[1] Serebryakova L. Benchmarking Sustainability of the HIV Response in the Context of Transition from Donor Funding. A Methodological Guide. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2020. Available in English language from: https://harmreductioneurasia.org/tmt/.

Approach to drafting the document and restrictions

The review in this document includes analysis of country assessment reports prepared by national experts from nine countries. Recordings of webinars on assessment results from each of the countries (except Kazakhstan) also served as a source of information. The author of the report clarified some wording directly with the experts. The experts who conducted the country assessments were not interviewed as part of the preparation of the review.

This review focuses primarily on comparing quantitative data on the commitments that were prioritized in the assessment in relation to programmatic areas and health systems components. It also draws attention to comparison in implementing commitments in each area and component in selected countries.

The review did not analyze overall trends in the sustainability of the HIV response across countries within any of the programmatic areas or health systems components. Also, there was no comparative analysis of the results of the progress assessment concerning the achievement of the impact indicators of the HIV programmes since a wide range of such indicators was selected for evaluation in different countries. At the same time, these indicators often do not correlate with each other, making it impossible to compare progress in achieving them across countries.

Comparative analysis of some assessment results in nine EECA countries

Sources for the commitments

In the countries that have adopted national HIV/AIDS strategies and programs (Georgia, Kyrgyzstan, Moldova, North Macedonia, Serbia, and Montenegro), these documents with their annexes served primarily as sources of information for the commitments analyzed in the assessment. In the countries that do not have national HIV strategies and programmes as separate documents due to the peculiarities of the state planning system, the sources of information on commitments were state health programs and relevant subprograms with corresponding implementation plans, budgets, etc. For example, there were such documents as 'The State Health Development Program of the Republic of Kazakhstan 'Densaulyk' for 2016–2019' in Kazakhstan or the State Program 'Public Health and Demographic Security of the Republic of Belarus for 2016–2020' in Belarus). In several countries, researchers used national plans/roadmaps as primary sources of information on government commitments, as these documents aim to ensure sustainability of the HIV response and transition to public funding of HIV/AIDS prevention, treatment, care and support programmes. The exception was the Republic of Kazakhstan, which does not have a formal plan for the transition of the HIV response to public funding to ensure the sustainability of HIV programmes supported by the Global Fund. In Tajikistan, the draft plan for the transition to public funding was developed but not approved as a separate document by the Government of the Republic of Tajikistan or the National Coordinating Committee. In Serbia, the National Transition Plan for 2020–2022 was developed in 2020, but it has not even been approved at the level of CCM. In North Macedonia, the Action Plan for Transition from Global Fund Support to National Funding for HIV Prevention Programmes for KPs has been approved only at the CCM level. Other documents used as data sources for the commitments in the assessment were grant agreements with the Global Fund.

An overview of the assessments carried out

The experts who conducted the assessments in nine EECA countries, together with the members of the reference groups, prioritized and assessed 255 commitments that the experts considered essential to implement to ensure the sustainability of the HIV response among key populations in the context of the transition from Global Fund support to national funding. The prioritized commitments were properly captured according to the proposed methodology and assigned to the appropriate health system components and programmatic areas for further analysis. The period over which the selected commitments were assessed varies by country: for Kazakhstan and Belarus, from 2016 to 2020; for Moldova, North Macedonia, and Tajikistan, from 2017 to 2020; for Georgia and Montenegro, from 2019 to 2020; for Kyrgyzstan, from 2018 to 2020; and for Serbia, from 2019 to 2021. According to the proposed methodology, 2016 was used as the baseline for selecting commitments for the assessment, as this was the year in which the Global Fund officially adopted the Sustainability, Transition, and Co-financing Policy (STC). At the same time, several assessments included data on commitments that would have been due by 2020 but were not implemented until 2021 in order to obtain accurate assessment results.

Table 1 shows the distribution of the total number of priority commitments in all countries across the six components of health systems: Financing; Governance; Service Provision; Drugs, Supplies and Equipment; Human Resources; and Information Systems.

Table 1. The number of assessed commitments for health systems components.

Health systems components	The number of assessed commitments by country									TOTAL	Percentage of assessed commitments, %
	Belarus	Georgia	Kazakhstan	Kyrgyzstan	Moldova	North Macedonia	Serbia	Tajikistan	Montenegro		
Financing	7	5	11	3	13	2	2	3	4	50	19,7%
Drugs, Supplies and Equipment	2	4	9	1	1	1	5	4	4	31	12,2%
Service Provision	4	10	7	13	3	16	6	7	6	72	28,3%
Governance	3	6	3	7	9	6	6	7	4	51	20,1%
Information Systems: Data and Information	4	4	6	2	3	4	4	3	4	34	13,4%
Human Resources	1	1	4	0	2	3	1	2	2	16	6,3%
TOTAL	21	30	40	26	31	32	24	26	24	**254**	**100%**

The highest number of commitments to be evaluated was prioritized in Kazakhstan (**40**), the lowest - in the Republic of Belarus (**21**).

Looking at the situation in all countries that participated in the assessment, the highest number of commitments was identified and prioritized in the component Service Provision – 72 or 28.3% of prioritized commitments. However, the distribution of commitments under this component across countries varied widely, ranging from three prioritized for assessment in Moldova to sixteen in North Macedonia. Financing and Governance accounted for 20% of the total priority commitments. The picture is reversed for the Financing component. The lowest number of commitments under this component was prioritized for assessment in North Macedonia and Serbia (two in each country), and the highest number – in Moldova (**13**). This may be explained by the fact that North Macedonia has not been implementing HIV grants from the Global Fund for several years, and the country's government has been providing funding for HIV services to KPs since 2018[2]. Therefore, the focus of the assessment in this country was on ensuring the sustainability of the HIV response among KPs, and the transition context was not as relevant as in other countries. The main problem in ensuring funding for HIV services in this country is the lack of a well-established mechanism for timely transfer of funds from the Ministry of Health to NGOs, which was the focus of the assessment under this component.

2 Bozhinoska E., Senih A. North Macedonia: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021, p. 26. Available in English language from: https://eecaplatform.org/en/tmt-macedonia/

The lowest number of commitments was prioritized for assessment within the Human Resources component (among all countries in general and almost every country in particular). Within this component, most experts prioritized commitments related to education and training of non-governmental organizations staff (social workers, peer counselors, and other specialists) involved in HIV prevention, care, and support. The low number of commitments identified for assessment under this component may indicate that countries in the transition context are not focusing on the sustainability of educational activities for civil society sector representatives. Currently, these activities are funded by external donors in most countries. This conclusion was drawn in particular from the assessment results in Moldova[3]. Several experts also noted in their reports that the implementation of commitments identified under this component often cannot be assessed because they are declarative. In other cases, there were no documents or indicators to confirm the implementation of the commitments, so they were not included in the final list for the assessments[4,5]. For example, during the research in Kyrgyzstan, only one commitment fell under the Human Resources component, but it was not prioritized and assessed by the reference group.

In Belarus, Kyrgyzstan, Moldova, and North Macedonia, one or two commitments were prioritized for assessment under the Drugs, Supplies and Equipment component. The authors of the assessment suggest that the reason for that may be the fact that some of these countries (North Macedonia and Moldova) have already made significant progress under the commitments made have achieved some level of sustainability in ensuring uninterrupted supply of ARVs, enrollment into HIV treatment, and adherence to ART[6,7].

The national response to HIV includes several activities/interventions. While they all play an important role in ending the HIV epidemic at the national level, meeting commitments to specific programmatic areas in the transition of the HIV response can ensure the sustainability of all essential services for key populations. According to the assessment methodology, there are five programmatic areas: HIV Prevention Programmes for KPs, Diagnostics and Treatment of HIV, Care, and Support, CSS and Advocacy, Human Rights and Overcoming Legal Barriers; and OAT.

Table 2 shows the distribution across the five programmatic areas of the total number of commitments identified and prioritized for assessment in all countries.

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[3] Marandich L. The Republic of Moldova: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021, p. 53. Available in Russian language from: https://eecaplatform.org/ru-tmt-moldova/.

[4] Boltaeva M. The Republic of Tajikistan: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021, p. 46. Available in Russian language from: https://eecaplatform.org/tmt-tajikistan/.

[5] Katkalova O. The Republic of Kyrgyzstan: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021, p. 55. Available in Russian language from: https://eecaplatform.org/ru-tmt-kyrgyzstan/.

[6] Bozhinoska E., Senih A. North Macedonia: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021, p. 21. Available in English language from: https://eecaplatform.org/en/tmt-macedonia/.

[7] Marandich L. The Republic of Moldova: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021, p. 42. Available in Russian language from: https://eecaplatform.org/ru-tmt-moldova/.

Table 2. The number of commitments assessed for programmatic areas.

Programmatic areas	The number of assessed commitments by country									TOTAL	Percentage of assessed commitments, %
	Belarus	Georgia	Kazakhstan	Kyrgyzstan	Moldova	North Macedonia	Serbia	Tajikistan	Montenegro		
HIV Prevention	8	30	21	18	15	27	21	14	11	165	65%
Diagnostics and Treatment	7	0	8	4	7	5	2	4	6	43	16,9%
Human Rights	1	0	4	1	0	0	1	3	4	14	5,5%
CSS and Advocacy	1	0	1	1	5	0	0	3	3	14	5,5%
OAT	4	0	6	2	4	0	0	2	0	18	7,1%
TOTAL	21	30	40	26	30	32	24	26	24	**254**	**100%**

Most of the commitments prioritized for assessment, both overall and in individual countries, were in the HIV Prevention programmatic area – 165 or 65% of the prioritized commitments. At the same time, in several assessments (Georgia, North Macedonia, Tajikistan, Moldova), experts additionally highlighted commitments related to HIV prevention among specific KPs, e.g. PWUD, SWs and MSM, and sometimes for people in PD.

However, as this additional categorization and more focused assessment of implementation of commitments in this area has not been conducted in all countries; relevant comparative data are not provided in this report. In the case of Georgia, the expert categorized all 30 identified commitments under HIV Prevention, which can be considered a controversial decision.

The lowest number of commitments relates to the programmatic areas of CSS and Advocacy and Human Rights – 5.5% of the total. In several countries, such as Moldova, North Macedonia and Serbia, no commitments within these programmatic areas were prioritized for assessment; in some other countries – no more than one.

The authors of the North Macedonia assessment report attribute this result to the fact[8] that the documents they used as data sources for the commitments, while acknowledging some components of Community System Strengthening (e.g., capacity building and participation in decision making), do not include clear and measurable targets related to these commitments. As a result, it is not possible to assess progress in their implementation. During the webinar presentation of the findings and report on the Belarus assessment, the authors of the report noted that only one commitment from the programmatic area of Human Rights had been analyzed as part of the research. There were no other identified commitments that had been properly formulated and documented as part of the assessment. They were not related to clear indicators and targets, but were declarative or part of broader commitments. The experts who conducted the assessment in North Macedonia could not identify any commitments related to the transition from donor support to public financing of the HIV response in the programmatic area of Human

[8] Bozhinoska E., Senih A. North Macedonia: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021, p. 22. Доступно на английском языке по ссылке: https://eecaplatform.org/en/tmt-macedonia/.

Rights and Legal Barriers in their review of official documents. According to the author of one of the assessments[9], there are many activities in the country in these programmatic areas, but they are either implemented outside of government commitments by civil society partners or they are routine and integrated into other ongoing activities. Therefore, there are no clear targets and indicators to track their progress.

On the other hand, some components of community systems strengthening related to service delivery by community-led organizations were integrated into the assessment process in North Macedonia and considered within other programmatic areas such as HIV Prevention among SWs, PWIDs and MSM, and HIV Diagnosis and Treatment.

Another possible explanation for the low number of identified government commitments in these programmatic areas could be that governments are generally less inclined to support and ensure the sustainability of activities aimed at CSS, Advocacy, and Overcoming Legal Barriers. Moreover, support for those activities has traditionally been the prerogative of external donors. Therefore, the sustainability of the HIV response in these areas may be questionable in the context of the transition from donor support to national funding.

In four countries, there were no priority commitments within the programmatic area OAT. In the case of North Macedonia, this can be explained by the fact that the state completed the transition from donor support to national funding of OAT back in 2011. Therefore, the experts did not prioritize sustainability commitments related to the OAT transition from external support. The same reason can be given for the cases of Serbia and Montenegro.

Table 3 shows the prioritized commitments by programmatic area for components of the health system.

Table 3. Breakdown of prioritized commitments by programmatic areas and health system components.

Programmatic areas	Health system components						TOTAL
	Financing	Drugs, Supplies and Equipment	Service Provision	Governance	Information Systems: Data and Information	Human Resources	
HIV Prevention	29	21	58	24	28	5	165
Diagnostics and Treatment	13	9	3	11	3	4	43
Human Rights	2	0	2	8	2	0	14
CSS and Advocacy	1	0	0	7	0	6	14
OAT	5	1	9	1	1	1	18
TOTAL	50	31	72	51	34	16	**254**

[9] EHRA received this comment in writing from the author of one of the assessments on 16.03.2022.

As the table shows, most of the commitments prioritized for the assessment fall under the Service Delivery component and the HIV Prevention programmatic area. And there are no commitments prioritized for research under the Drugs, Supplies and Equipment, Service Provision, Information and Data components within the CSS and Advocacy programmatic area. There are also no prioritized commitments for the Drugs, Supplies and Equipment and Human Resources components within the Human Rights programmatic area.

The methodology proposed a color scale, shown in Table 4, to visualize the results of the assessment of final progress in implementing prioritized commitments by health system components or programmatic areas.

Table 4. Scale for assessing overall progress on prioritized commitments by health system components or programmatic areas according to the Transition Monitoring Tool (TMT).

Definition of Sustainability	Progress description	Achievement Percentile and Colour code
Significant progress	A high degree of progress in fulfilling the commitments regarding planned indicators and / or baseline	>85–100%
Substantial progress	A significant degree of progress in fulfilling the commitments regarding the planned indicators and / or baseline	70–84%
Average progress	The average degree of progress in fulfilling the commitments regarding planned indicators and / or baseline	50–69%
Moderate progress	Moderate progress in fulfilling the commitments regarding planned indicators and / or baseline	36–49%
Fairly low progress	A fairly low degree of progress in fulfilling the commitments regarding planned indicators and / or baseline	25–35%
Low progress	Low degree of progress in fulfilling the commitments regarding planned indicators and / or baseline	<25%

Tables 5 and 6 below summarize the results of the assessments of progress on commitments related to each health system component and programmatic area. In reviewing the assessment results, it should be clear that they do not represent an assessment of progress toward sustainability or readiness for HIV response transition in any health component or programmatic area as a whole. The assessment results only describe progress toward specific commitments that were identified and prioritized during the research. According to the members of the national reference groups, these commitments are of great importance to ensure the sustainability of the national HIV response in their respective countries, particularly among KPs.

Table 5. Overall assessment of progress in implementing commitments by health system components.

Health system components	Progress in meeting commitments by the countries								
	Belarus	Georgia	Kazakhstan	Kyrgyzstan	Moldova	North Macedonia	Serbia	Tajikistan	Montenegro
Financing	67%	67%	85%	78%	27,2%	80%	87%*	0%	51%
Drugs, Supplies and Equipment	96%	85%	81%	72%	94%	43%	68%	25%	100%
Service Provision	50%	98%	88%	80%	58.3%	73%	127%	85%*	59%
Governance	73%	27%	90%	100%	61%	0%	61%*	90,4%*	38%
Information Systems: Data and Information	76%	0%	90%	15%	66,7%	55%	58%	100%	81%
Human Resources	15%	0%	80%	**	100%	63%	100%	88,6%*	70%

Table 6. Overall assessment of progress in implementing commitments by programmatic areas.

Programmatic areas	Progress in meeting commitments by the countries								
	Belarus	Georgia	Kazakhstan	Kyrgyzstan	Moldova	North Macedonia	Serbia	Tajikistan	Montenegro
HIV Prevention	69%	46%	90%	43%	48%	57%	75%	56,7%*	66،2%
Diagnostics and Treatment	76%	**	99%	100%	58%	71%	70%	100%*	93،6%
Human Rights	80%	**	75%	100%	**	**	267%	77,6%*	25%
CSS and Advocacy	15%	**	65%	100%	100%	**	**	94,4%*	80%
OAT	55%	**	60%	75%	46,5%	**	**	62%*	**

Based on the country results presented in Tables 5 and 6, it is difficult to identify clear trends for significant or, conversely, truly slow progress in meeting commitments for specific health system components or programmatic areas that apply to all countries. For the Service Provision component, it can be admitted that the overall progress of countries in implementing commitments is above average compared to planned indicators and/or baselines. A similar trend can be observed in the programmatic areas of HIV Prevention and Diagnostics and Treatment. However, it is difficult to say whether this is a random trend or a discernible, meaningful pattern. Over the course of the assessment, priority commitments within the same areas/components varied significantly across countries, both in terms of content and quantity, and in terms of the time period chosen to analyze progress in implementing the commitments. At the same time, it should be noted that the experts in different countries had different approaches to assessing the final progress in the considered commitments within specific areas/components. For several countries, they calculated the final score for each health component and programmatic area as an average estimate of the commitments analyzed in relation to that component or programmatic area. For other assessments, such mathematical calculation of progress was additionally adjusted in consultation with reference group members, taking into account additional important factors to obtain more accurate assessment results.

Limitations of the methodology and the monitoring tool

In the course of the assessment, the authors of the methodology and the experts conducting it identified several methodological limitations and technical issues that should be considered when finalizing the methodology and assessment tool after it has been tested in nine countries in the EECA region. This section lists the limitations and problems reflected in the national reports on the results of the assessments, which were identified by the authors of the methodology during the cooperation with the national experts during the research. At the same time, before refining the methodology, it is recommended to conduct semi-structured interviews with experts who have conducted the assessment in nine countries to review the list of problems and limitations. This will also help to define additional problems that are not included in this list.

The methodological problems and limitations include the following:

1. Often there is a situation where the obligations prioritized for assessment may be weighted differently. Therefore, it is necessary to consider such cases when determining progress outcomes between health system components and/or programmatic areas. Although there is no instruction in this regard in the current version of the methodology description, almost all experts tried to take into account additional important factors when calculating the final progress score by health system components and programmatic areas so that the final results would reflect the practical situation. Thus, the final assessment results were not just a mathematical calculation of average estimates for all obligations within a given component or programmatic area. Nevertheless, each expert did so to the best of his or her subjective understanding and not on the basis of a single recommended, justifiable approach. The methodology should include clear instructions on how to deal with the issue of different weighting of commitments (or a rationale for why this difference does not affect the final assessment result). It should also include instructions on how and what factors to consider when calculating the final progress score of prioritized commitments by health system component and/or programmatic area.

2. In some cases, the identified commitment may be attributed to different health system components or defined as an indicator of impact on the epidemic. The methodology does not clearly and understandably explain where to assign the identified commitments in such a case. For example, many experts assigned KPs coverage indicators to either the impact indicators block or the Services component, and treatment coverage indicators to the Drugs, Materials, and Equipment component. At the same time, the methodology states that the impact indicators should include indicators of financial stability, but in fact no such indicators were included in any assessment in this block. They were all assigned to the Financing component. To address these issues, it is necessary to propose a minimum set of indicators/commitments that should be primarily addressed and included in the assessment for each block. The way it is presented in Annex 3 (the methodology description) does not very helpful in practice. This table should be improved to make it more understandable and informative. It should include a list of commitments that experts should first identify for each block for further assessment. Among other things, this will make it possible in the future to compare progress in achieving similar indicators across countries. For example, the block of impact indicators must include, at a minimum:

- Indicators for UNAIDS targets 95–95–95 related to KPs (knowing their status, getting treatment, viral suppression);
- HIV prevalence rates;
- Coverage by prevention programmes; and OAT.

- The Data and Information block needs to reflect commitments to estimate KPs size and conduct IBBS, etc. for each block. Relevant recommendations for mandatory indicators/commitments to be identified and analyzed should also be reflected in the Excel tool used in the assessment.

3. The proposed methodological approach for selecting and prioritizing commitments based on the criteria of SMART is not very clear and understandable in practice. It is possible to apply it, but it might also be worthwhile to add more understandable and practical criteria for prioritizing commitments. During the assessment, the experts suggested the following exclusion criteria for the process of prioritization of identified commitments:

- Commitments not directly related to ensuring the sustainability of the HIV response for KPs: commitments to HIV prevention programmes for the general population, prevention of mother-to-child HIV transmission, blood safety, and social programs, although states fund most of these activities.
- Commitments fully funded by the Global Fund, PEPFAR, and other external donors.
- Declaratory commitments without descriptions of specific actions and those that cannot be reworded.
- Commitments, the realization of which cannot be tracked because indicators and data on targets and planned outputs are missing or their implementation is not confirmed by the availability of relevant documents.

4. In the Excel tool on the "Sample Tables for Output" sheet, the programmatic area of Prevention is divided into three parts: HIV prevention for PWUD, HIV prevention for MSM, and HIV prevention for SWs. This division is confusing for experts conducting assessment, as the tool does not provide any guidance (nor does the methodology) that when categorizing identified commitments by programmatic area, prevention commitments need to be further divided into three key groups. It is also not entirely clear whether the subdivision should be limited to only these three KPs or whether this is just an example and one can categorize the identified commitments under other KPs as well. It is unclear whether it is possible to avoid this further categorization. Some experts who conducted the assessment in 2021 divided the commitments assigned to the Prevention programmatic area into three subcategories, while others did not. But many of those who did subdivide (with the exception of experts from Tajikistan and Moldova) limited themselves to only three groups indicated in the Excel tool: PWUD, SW, and MSM.

5. The methodology should make clear that the assessment is not an evaluation of progress toward sustainability or readiness for transition of the HIV response in a health component or programmatic area as a whole. The assessment findings only describe progress toward specific commitments identified and prioritized for evaluation within specific health system components and programmatic areas. According to the members of the national reference groups, these commitments are important to ensure the sustainability of the national HIV response, particularly among Kps.

6. We recommend that the period covered by the assessment be clearly defined so that it is the same in all countries conducting such assessment. The year of the assessment should not be included in the analysis.

7. It is recommended to review and further clarify the goals and objectives of the methodology and tool, as well as the expected outcomes of the assessment. The latter may include:

- assist in raising awareness and re-focusing national transition planning processes;
- ensure greater participation of civil society and community representatives in transition monitoring processes;
- establish national CSO and community advocacy goals with a focus on ensuring transition sustainability;
- strengthening public sector accountability;
- a better understanding by the Global Fund of the processes that are taking place in relation to sustainability and transition in the countries of the region;
- a better understanding of the processes involved in transitioning and ensuring sustainability at the regional level.

Technical issues and limitations include:

1. It is necessary to review and further develop the sample outline of the national report from the Transition Monitoring tool, taking into account the following aspects:
- Revise the recommended page length for each report, taking into account the actual average length of relevant parts in already completed reports.
- Review the structure and content of the "Context" section. The current subsections require a text length of at least 20 pages (in some cases, the length of this section was even longer).
- The structure of the "Purpose and methodology" section needs standardizing based on examples of the description of this section in the most successful reports for 2021 (Tajikistan, Belarus). Several subsections should include standard text, figures, and tables that are the same for all assessment reports, regardless of the country where the assessment took place. For example, this section must include tables with a breakdown of the total number of commitments prioritized for the assessment according to programmatic area and health system component (indicating their proportional distribution), as well as the number of commitments initially identified before prioritization, etc.
- The structure of the "Results" section needs to be revised based on the examples of the description of this section in the most successful reports for 2021 (Tajikistan, Belarus, Moldova). The logic for presenting the assessment results should be as follows: results by impact indicators, health components, and programmatic areas. There should be clear instructions for the graphs and tables so that they have the same format in each report. The instructions should specify which graphs are presented in which subsections and in what order; which tables are presented and how they are structured.
- Include a "Recommendations" section that explains how it should be structured (to whom the authors should make recommendations based on the assessment results).
- In the Annexes, establish a clear format for presenting the "Commitment Matrix" so that it is the same for all reports.

2. In the Excel tool, on the sheet "Sample Tables for Output", set templates for all graphs to be included in the report, not only for some of them.

3. It is necessary to review all Excel tool sheets in two languages to verify the clarity of the instructions for working with each sheet and to check the correctness of all formulas.

4. It might be worth revising the name of the assessment methodology/tool. Some partners, including colleagues from the Global Fund, feel that the current title ("Benchmarking Sustainability of the HIV Response in the Context of Transition from Donor Funding. Transition Monitoring Tool") does not accurately reflect the essence of the assessment. It may lead to a gap between the expectations of the target group and the results achieved.

Conclusions

The methodology developed by EHRA to assess the implementation of government commitments to ensure a sustainable response to HIV among key populations in the context of the transition from Global Fund support to public funding was first applied in nine countries of the EECA region in 2021. Piloting the methodology has shown that both the methodology itself and the assessment tool require some refinement. At a minimum, there is a need to ensure a consistent approach to the assessment and the format of the results obtained from it in all countries where such an assessment is conducted.

Assessment in certain countries can be considered successful. For example, in Moldova, Serbia, and Kazakhstan, the assessment results were well accepted and taken into account by the relevant government agencies. And the results of the assessment in Georgia caused a vigorous debate with the participation of representatives of the Global Fund and the National Center for Disease Control, which is also a positive outcome. But, despite this, it is impossible to compare the results of the progress in realizing the commitments within certain programmatic areas or health system components between countries since, in different countries, the analyzed commitments within the same components/areas significantly differed from each other both in content and quantity.

At the same time, by comparing quantitative data on the commitments selected for the assessment in various countries, one can note particular patterns typical for all countries. So, in most countries, the lowest number of identified commitments was in the Human resources component, the CSS and advocacy, and Human rights programmatic areas. And the highest was in the component Provision of Services and programmatic area of HIV prevention. From the facts mentioned above, it is possible to make some conclusions considering the types of commitments States are more likely and less likely to make in sustaining the HIV response.

Overall, despite the methodological limitations, this type of assessment provides important analytical information for further planning aimed at the sustainability of the HIV response in key populations in the context of the transition from donor support to national funding.