

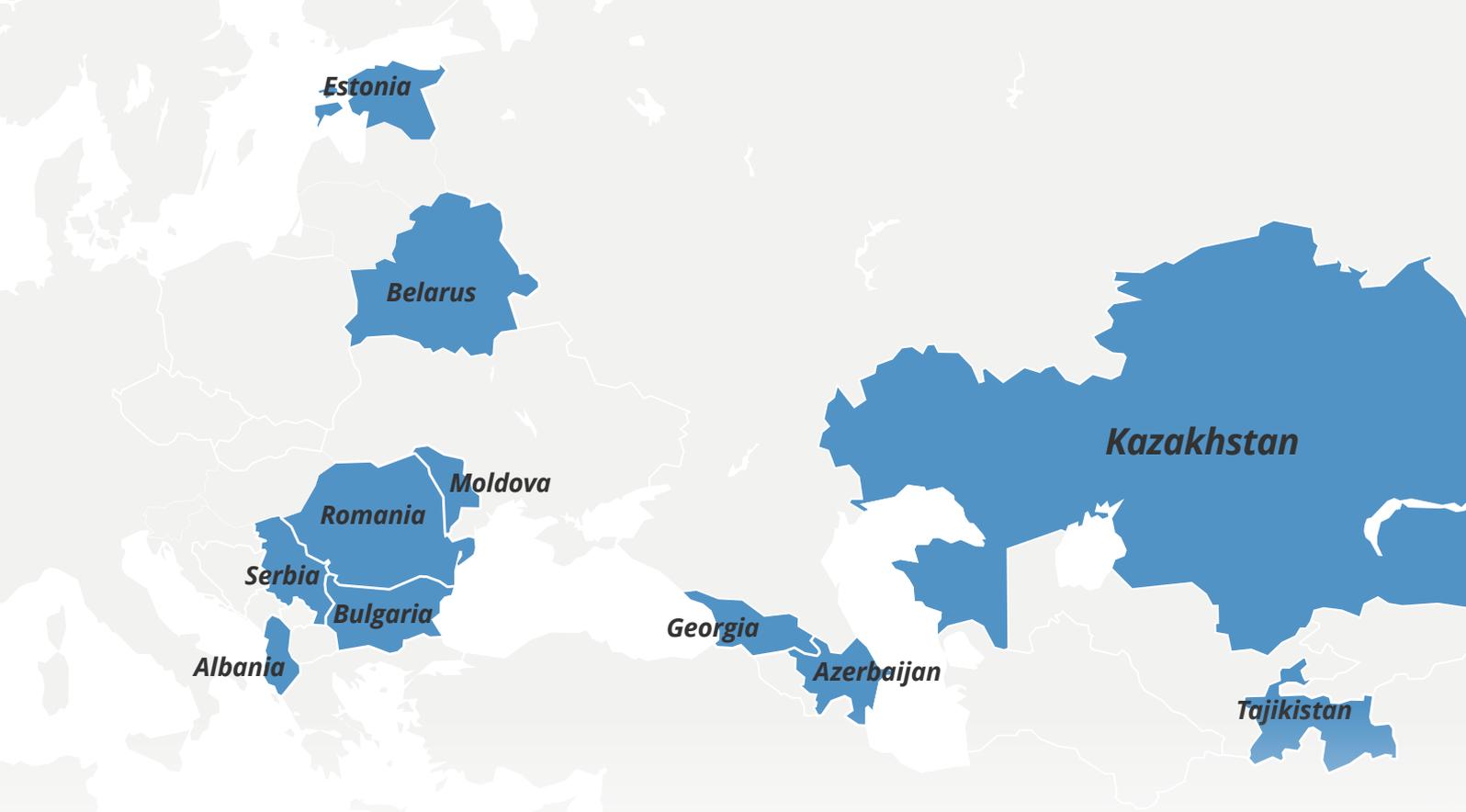
SITUATION ANALYSIS OF SUSTAINABILITY PLANNING AND READINESS FOR RESPONSIBLE TRANSITION OF HARM REDUCTION PROGRAMS

FROM GLOBAL FUND SUPPORT
TO NATIONAL FUNDING IN EECA



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This report is a publication of the Eurasian Harm Reduction Network (EHRN). EHRN is a regional network of harm reduction programs, groups of people who use drugs, and their allies from across 29 countries of Central and Eastern Europe and Central Asia who advocate for the universal human rights of people who use drugs. EHRN's mission is to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and well-being, whilst protecting human rights at the individual, community and societal levels.

The report was prepared by David Otiashvili, M.D., Ph.D., for EHRN between June and August 2015. The author collected and reviewed a range of background materials and gathered input from key informants familiar with the Global Fund projects in reviewed countries. The desk review included analysis of country reports, program evaluation reports and data from international organizations. In-depth interviews with country respondents covered topics related to the progress of Global Fund funded programs, and the process of preparation for transition to domestic funding.

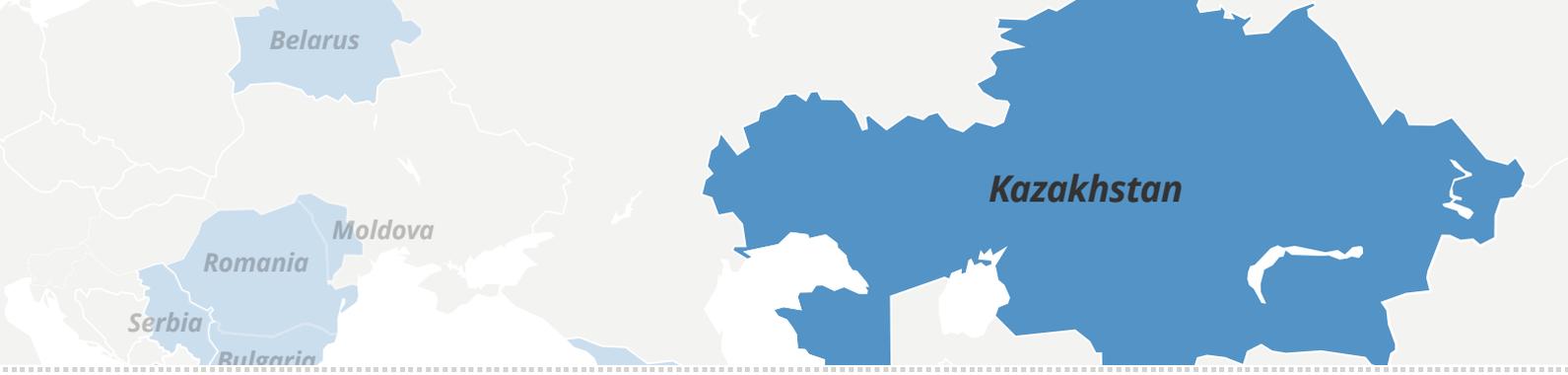
Key informants included fund portfolio managers (FPMs), recipients of Global Fund grants, members of Country Coordinating Mechanisms (CCMs), representatives of civil society organizations and key affected groups in 11 countries reviewed in this report. EHRN is grateful to all who contributed to this document.

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral
CCM	Country Coordinating Mechanism
CSO	Civil society organizations
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
FPM	Fund portfolio manager
EECA	Eastern Europe and Central Asia
GAVI	Global Alliance for Vaccines and Immunization
GF	Global Fund
HI	High income
HIV	Human immunodeficiency syndrome
KP	Key population
LI	Low income
L-LMI	Lower lower-middle income
MSM	Men who have sex with men
NFM	New funding model
NGO	Non-governmental organization
NSP	Needle and syringe program
OST	Opiate substitution program
PR	Principal Recipient
PEPFAR	President's Emergency Plan for AIDS Relief
PIU	Program Implementation Unit
PWID	People who inject drugs
SW	Sex workers
TB	Tuberculosis
U-LMI	Upper lower-middle income
UMI	Upper-middle income
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization



EXECUTIVE SUMMARY

- Experience accumulated in the field of international health assistance indicates that any transition to national funding should be implemented gradually, should follow a well prepared plan and reasonable timeline, and should include financial and technical support to make the transition successful.
- Experience of countries that have already graduated (fully or partially), or are in the process of graduating from Global Fund support, suggests that harm reduction programs and community-based services implemented by CSOs will be at most risk of being affected in the post-Global Fund period.
- Current Global Fund eligibility criteria (i.e. income level and burden of disease) are neither adequate, nor sufficient to provide a comprehensive analysis of country situations, and cannot be used as conclusive factors for assessing readiness to transition. Perceived ability to pay, expressed in GNI per capita, does not indicate an adequacy of current allocations to health sector or access to health services, nor does it reflect adequately a government's readiness and willingness to scale-up investment in the health sector, including in HIV and TB.
- No adequate service coverage levels have been achieved in the vast majority of countries covered in this report. Strictly speaking, whatever the economic indicators may suggest, a country cannot and should not be considered as ready for transition if the coverage of populations in need of prevention and/or treatment services is far below the level that would make an impact on the spread of the HIV epidemic.

The Global Fund should:

- Develop specific guidelines on the content and process for transition and sustainability plans to guide countries. As an essential part of transition planning, countries will need to do a financial resources mapping and gaps analysis, and project the cost of their transition and sustainability plans.
- Together with a broad range of partners, develop a clear definition, criteria and requirements for successful transition to domestic funding. The mechanisms for transition evaluations should allow for informing participants in the process in a timely manner, and for making relevant changes/re-programming if needed.
- Together with other technical assistance partners, provide necessary funding and technical support to secure a successful transition. Areas for assistance can include, but are not limited to, program management capacity, integration of services, governance, coordination, policy and regulatory reforms.

Governments should:

- Conduct a comprehensive assessment of its readiness to transition, focusing on financial, programmatic, governance and policy-related components.
- Work closely with Global Fund and civil society to develop a detailed transition plan (informed by the readiness assessment) with clear roles and responsibilities of involved parties stipulated, a realistic timeline, and clearly articulated criteria for successful completion.
- Do a financial resource mapping and develop a realistic financial sustainability plan. Revisit current allocations to service categories and prioritize high-impact cost-effective interventions. Examine current program management practices and explore options for optimizing management costs.
- Transform CCMs into a permanent formal structure and maintain the multi-sectoral nature of the CCM. Ensure participation of civil society organizations and key affected groups. Coordination mechanisms should serve as



a platform for all sectors involved to contribute and inform policy and program development, monitoring and coordination efforts, including those related to the transition to national funding.

- Support collaboration between NGOs and national health institutions and promote integrated service delivery models. Community organizations are key for access to marginalized affected populations.

CSOs should:

- Demand and seek participation in the readiness assessment, transition planning and monitoring. No other actors have a better understanding of the needs and demands of populations that are key to the success in responding to the HIV/AIDS epidemic. The role of CSOs is to bring this knowledge to the fore, to inform the decision-making process.
- Advocate for inclusion of high-impact interventions targeting key populations into national strategies and action plans. Demand adequate financial allocations for these interventions in national budgets.
- Develop their own sustainability plans, which would include alignment with government laws and regulations and integration with public health services.
- Create coalitions and work together (advocacy and fundraising for instance) rather than compete with each other.



INTRODUCTION

The economic growth of developing countries, with growing numbers moving from “low” to a “middle income” category, coupled with the slow recovery of developed (donor) countries after the recent economic crisis, has changed traditional development assistance models. Many bi-lateral and multi-lateral donors have been rethinking their assistance strategies and moving towards establishing development partnerships with middle-income countries (MICs) rather than maintaining traditional donor-recipient relationships [4]. As a result of these changes, some donors have significantly reduced their allocations and revised their priority areas for development aid. An important part of the debates focused on this process has looked at elements of donors’ withdrawal and the need for exit strategies to be agreed on between donor and recipient country [5]. There seems to be a common understanding that when decisions are made to stop supporting programs, funding should be phased out in a planned and predictable way.

The Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) adopted the Eligibility and Counterpart Financing Policy, designed to optimize funding based on economic and health indicators in 2013. Eligibility was determined by income level and disease burden in a specific country context [6]. The rationale behind this approach was that relatively well performing economies, in particular with moderate burdens of disease, can and should assume responsibilities for funding programs addressing these diseases. With the introduction of the New Funding Model (NFM), the Global Fund’s allocations for 2014-2017 for countries in Eastern Europe and Central Asia (EECA), many of which are middle-income countries, have been reduced by 15% in comparison with 2010-2013 disbursements [7]. The Global Fund has been gradually scaling down or fully withdrawing its support from many countries in EECA.

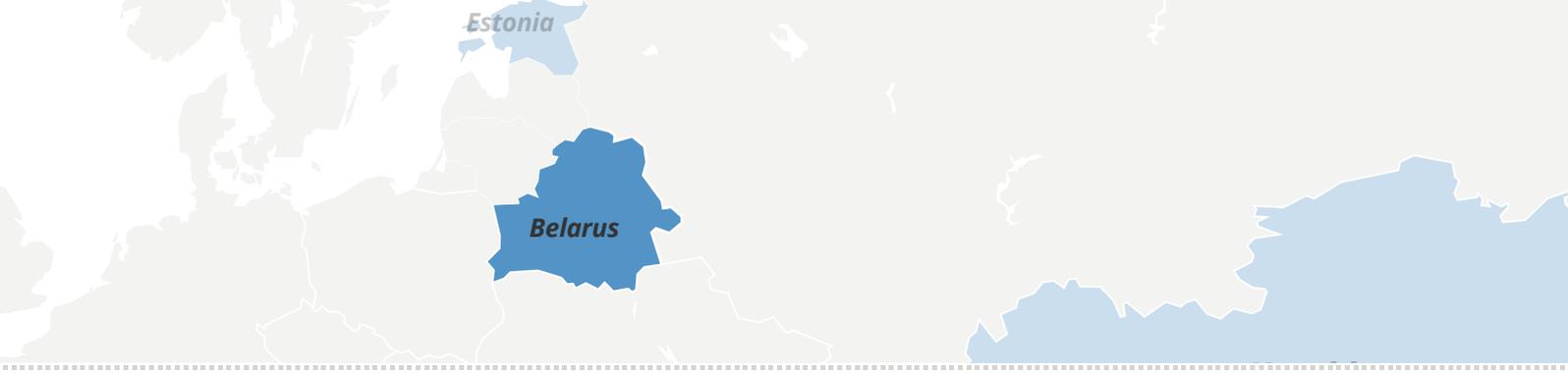
People who inject drugs (PWID) represent a major risk group for HIV transmission in the region. UNAIDS estimates that 57% of all new HIV infections in Eastern Europe are attributed to the sharing of injection equipment [8]. As stated in the *Global Fund Investment Guidance for Eastern Europe and Central Asia*, “the Global Fund’s vision for the EECA region is to stabilize the prevalence and reduce the incidence of HIV, and to contain the spread of drug-resistant TB. The aim is to ensure that EECA will no longer be the region with the highest rate of HIV growth and the highest levels of multidrug-resistant TB in the world” [9]. Access to key target groups (affected or high risk of infection) such as PWID, sex workers (SW), and men who have sex with men (MSM), and adequate coverage of prevention, treatment and care programs are critical to achieving these aims.

This report aims to: 1) Assess the readiness of countries in the region for transition from Global Fund funding for HIV responses to national funding; and/or 2) Experience of countries related to the process of transition planning and implementation. Eleven countries¹ with relatively diverse economic and health landscapes were selected for this analysis.

Experience of other donors

Along with the Global Fund, many other donors have been exploring approaches of transitioning their programs to national funding. Summarized below are some common features, successes and challenges of transition experiences reported in relation to three major donors: PEPFAR transition from HIV/AIDS programs in South Africa; transition

¹ Albania, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Moldova, Romania, Serbia, Tajikistan.



of a Bill and Melinda Gates Foundation's HIV/AIDS program (AVAHAN) in India; and multi-country experience with post-donor sustainability of GAVI programs.

Factors contributing to success:

- High level of political support and buy-in have played a critical role.
- Detailed early transition planning, with clear criteria and guidelines for developing transition plans that include realistic components on financial sustainability and comprehensive assessment of potential challenges to address them over the course of transition [10].
- Extended, multi-stage and gradual transition timeline and allocation of funds for transition (8 years in the case of AVAHAN and almost 1/3 of program budget for transition)[11].
- Co-ownership and continued alignment with government at each stage of transition, as well as the engagement of multiple stakeholders to ensure accountability.
- Provision of technical and managerial support to build domestic capacity, active engagement of staff in the transition process, in some cases with dedicated units supporting the transition process.

Challenges:

- Significant funding gaps remained for many countries despite the development and adaptation of financial sustainability strategies [12].
- Where sustainability plans were developed, strategies to ensure the reliability and predictability of funding were the weakest elements of the plans; mobilizing donor resources was more frequently indicated than increasing government resources [12].
- Termination of direct donor support resulted in the interruption of delivery of care to patients transferred out of NGO clinics, private medical practices, or public sector facilities [13].
- In many countries trained staff were not retained and public health systems were unable to accommodate them. This was true in particular of NGO staff. The main reasons for this attrition were the lack of mechanisms for contracting NGOs, lack of funding and a mismatch with government salaries.
- Attrition of staff resulted in the discontinuation of some services.
- The exclusive focus on transitioning to the government, with no other partners considered, had a negative impact on community mobilization, and affected components of the programs that government institutions were not in the best position to provide [11, 14].
- With many countries having weak health systems, gross domestic product was a limited and inadequate indicator to assess the ability of a country to fund HIV/AIDS related activities [15].



METHODOLOGY

Data for this report was collected through the review of available literature and open data sources, and interviews with key informants. We reviewed a wide variety of publications that focused on HIV/AIDS situation analyses in selected countries, epidemiology, program reviews, national reports, strategies and action plans. Publications focusing on transition-related experience of other (than Global Fund) donors were also reviewed. A number of web resources such as databases of the Global Fund, UNAIDS, the World Bank, WHO and European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) were consulted. We collected, via this desk review, both quantitative data and contextual information that informed this report.

We conducted individual online (Skype) or telephone interviews with key informants that were well familiar and/or personally involved with implementation of Global Fund-supported programs in all eleven countries. Key informants comprised Fund Portfolio Managers, representatives of principal recipients and/or sub-recipients, representatives of key population groups, and civil society organizations involved with service delivery and/or participating in Country Coordination Mechanisms (CCM). Interviews focused on the current situation related to service provision, the funding landscape, experience with and/or the process of preparation for transition, and the roles and responsibilities of different actors.

For the purpose of assuring coherence, the results of desk review and qualitative data analysis are combined and presented in conjunction with topics/issues which emerged during the analysis.



FINDINGS

Harm reduction funding landscape and program coverage in EECA

The Global Fund currently represents the major funding source for HIV prevention programs with PWID in the EECA region. The establishment of the Global Fund has resulted in other donor agencies withdrawing from the HIV/AIDS field, or shifting their priorities towards supporting advocacy and capacity building. In addition, donors have recently withdrawn from EECA countries entirely or have significantly reduced their scale of funding.

Funding for harm reduction programs, in particular for needle and syringe programs – the critical component of HIV prevention among PWID – in many cases comes from the Global Fund exclusively. The share of domestic spending in overall harm reduction spending equates to zero (Bulgaria), or is extremely low in the majority of countries. On a positive note, Estonia funds all HIV programs, including harm reduction from domestic sources, Kazakhstan covers around 34% of harm reduction spending from local (central and regional) budgets, and Georgia covers 51% of harm reduction (exclusively OST) spending from the national budget (see Figure 1).

In no country have recommended coverage targets for HIV prevention among PWID been achieved (60% for NSP and 40% for OST) [16]. With an overall tendency of having coverage for NSP remarkably higher than for OST, there are significant variations among countries. The most alarming is an extremely low and insufficient provision of OST in selected countries (see Figures 2 and 3). The best coverage is in Estonia (15%), with Azerbaijan, Belarus, Kazakhstan and Moldova providing this treatment to less than 1% of the population in need. [17-21]

Problems that could affect successful transition and sustainability

Organizational and systemic capacity

The Global Fund has greatly contributed to developing national capacities to respond to three diseases. However, the Global Fund also created parallel management and service delivery systems, which are not always integrated into national health systems. With regard to project management, the Global Fund's reporting requirements are difficult to fulfil and there are huge parallel (to existing national health systems) administrative units. It is not clear what will happen with these units, following the end of Global Fund funding. In terms of service delivery, Global Fund funding gave stimulus to both the establishment of new NGOs and re-focusing existing ones towards HIV/TB related activities. With many NGOs delivering critical services too hard to reach key populations, but functioning as a parallel service delivery system, there is an obvious lack of integration of Global Fund funded programs within national health systems.

Inappropriate legal and regulatory environment

It has been widely acknowledged (and supported by data in this review) that inappropriate legal and regulatory environments can dramatically affect the provision of HIV/TB services to the most affected and vulnerable groups [22]. Criminalization of drug use, the quasi-legal status of harm reduction programs, the absence of financial and technical support from governments, and the lack of quality standards, all limit the potential impact of these otherwise effective *and* cost-effective interventions on the spread of the epidemic. A lack (or absence) of professional and educational standards in the field of harm reduction is yet another issue that needs careful attention. Service



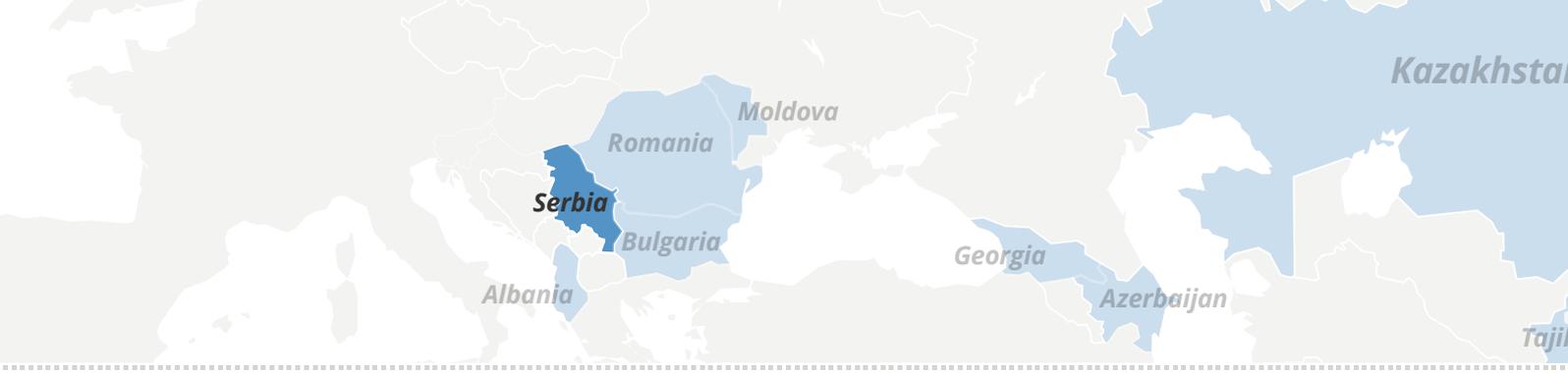
quality standards should be seen as an important (but hardly sufficient) prerequisite for decision makers in national governments to support the continuation of these services via funding from national sources. In a number of cases, the provision of HIV prevention and treatment services was associated with the introduction of new (to a specific country) professions. For example, the professions of social worker, outreach worker and peer educator are often absent in national registers of professions. This creates barriers for supporting these staff positions when services need to be incorporated into public health systems.

Inappropriate national regulations concerning procurement, and the import and registration of medical commodities can create barriers for effective service delivery and cost-efficiency of interventions. Local regulations have been cited as a reason for the high price of ARV medications in Kazakhstan and Serbia. Opiate substitution treatment has been functional in Tajikistan since 2009 (although on a very limited scale), but methadone still is not registered in the country. Compared to other countries, methadone in Tajikistan is imported at a high price. National regulations can prevent the expansion of HIV prevention services to key populations. In Estonia and Tajikistan, NGOs providing low threshold services and needle/syringe programs are not allowed to perform HIV rapid testing. Such testing can be offered only by a licensed medical facility. Given the fact that low threshold programs are key to ensuring access to the most affected populations, this limitation may result in both missed opportunities to identification of new HIV cases and/or delays in diagnosing HIV among these groups [23, 24].

A lack of effective mechanisms for social contracting poses a risk to the successful continuation of service delivery schemes currently working under Global Fund funded programs. In every country covered by this report, the vast majority of HIV prevention services for key populations are provided by civil society organizations. Following the transition from Global Fund funding, these organizations are expected to be contracted by governmental agencies to continue delivering services. At least in Albania, Bulgaria, Belarus, Moldova, Georgia, and Kazakhstan, current mechanisms and requirements for social contracting are seen as inappropriate. In many cases this is related to the requirement for service providers to implement programs at their own cost and be reimbursed later. For many NGOs this is an unrealistic demand. In other cases, such as Belarus for instance, HIV is not included in the list of social problems that can be covered by social contracts. In Bulgaria, even with Global Fund, it takes the Ministry of Health (as principal recipient) about six months to process the funds received from the Global Fund and disburse the money to sub-recipients. In Tajikistan, inappropriate procurement and supply management regulations have been cited as a cause of shortages and stock-outs of medical commodities [25].

Lack of prioritization of high-impact interventions and cost-effective management practices result in suboptimal utilization of limited financial resources

Unit costs of similar interventions vary dramatically across countries (for example unit cost/year for OST is \$1,372 in Georgia, compared to \$682 in Moldova) which suggests the need for a careful revision of program management models and unit cost structures, and exploring options for optimization. In other situations, HIV testing coverage remains low and does not adequately cover the groups most at risk of infection. In Georgia and Tajikistan, more than 70% of people tested annually, represent low-risk populations such as pregnant women and blood donors, while the testing rate of the large risk group of PWIDs remains low [26, 27].



Effective governance is important

The willingness of governments to prioritize effective HIV prevention interventions, in particular those components that closely relate to human rights-based programming and community system strengthening, is critical to the process of successful transition and sustainability of these programs. In this regard, we identified a number of factors that can negatively impact the process of prioritization and building of government commitment. Political instability and frequent changes in government, including that of key staff in government agencies, and the resulting lack of continuity, have been reported as important factors hindering governmental efforts to ensure sustainability of HIV prevention among key populations in Bulgaria, Romania, and Serbia. In these and other countries, multiple donor withdrawal has not been assessed from the perspective of financial or programmatic risks, and no preparatory measures were implemented. Issues related to the sustainability of Global Fund- supported programs have been discussed and prioritized rhetorically, while practically, often no steps have been followed. Even those governments who provide formal commitments to filling the gaps after the departure of the Global Fund, are reluctant to allocate national funding as long as possible, if ever. Universally, governments tend to take full advantage of international funding up until the very end of donor support.

Respondents have acknowledged that the Global Fund can play a vital role in “building” the willingness of governments to increase domestic financing for HIV/AIDS programs and the health sector in general. In Belarus and Georgia, direct communication by the Global Fund with heads of governments has resulted in the sensitization of relevant government agencies (Ministry of Finance, Ministry of Health) and contributed to the readiness of decision makers in these agencies to take the responsibilities related to the gradual takeover of Global Fund funded programs. In many countries, the active engagement of Fund Portfolio Managers (FPMs) was crucial to this process.

Sustainability of coordination mechanisms in the post-Global Fund period is seen as a critical component of the overall successful transition process. In the field of international development aid, the Global Fund has deservedly been credited for departing from traditional, an exclusively donor/government-driven approach in program development, implementation and monitoring, and for introducing an innovative concept of country-owned and driven process. The inclusive and participatory process of proposal development, and multi-sectoral country coordination mechanisms allowed for meaningful engagement of all interested groups, including affected and at-risk populations. However, in many cases, CCMs are established largely in response to it being a Global Fund requirement. CCMs are involved only with Global Fund programs and are often not perceived (and do not function) as an integral part of the national health system architecture. This poses an evident risk of discontinuing CCMs when GF programs no longer exist in a country, such as in Serbia. From a positive perspective, Estonia was able to sustain an effective coordination structure through the establishment of a high-level, multi-sectoral HIV/AIDS Committee that includes representatives of relevant government agencies, professional associations, and CSOs, including key population groups.

There are a number of ideological and epidemiological factors that contributes to low prioritization of harm reduction approaches and programs in many countries of the region. Harm reduction has long been a subject of political and ideological debates, with opponents often neglecting a great deal of scientific and empirical evidence accumulated on the effectiveness of these approaches. In this regard, a trend to discredit OSTs in some countries is alarming. Data derived from interviews suggest that harm reduction is sometimes “accepted” as the Global Fund is promoting and funding it. However, the programs are at risk of losing “legitimacy” as soon as the Global Fund



leaves the country. In an environment of ever limited resources, while many other health and/or social problems concern large numbers of people in respective countries, the low prevalence of disease in general populations (for example HIV/AIDS in Albania, Bulgaria, Georgia) is used as an excuse by decision makers for moving HIV prevention, in particular for marginalized groups, down in the list of priorities. In some countries, there is no political support for the scale-up of harm reduction programs, even within Global Fund financing.

Role of civil society

Following the fall of communist regimes, the civil society sector emerged relatively recently in the EECA region. Largely thanks to Global Fund support, both the organizational capacity and technical expertise of CSOs, including community-based ones working in the field of HIV and TB, have dramatically improved (often developed from scratch.)

Estonia

Global Fund grant ended in 2007.

- *Preparation for transition started well in advance, from the second phase of GF grant*
- *100% of HIV prevention (among KAPs) and treatment was taken over by government*
- *PIU (government structure) was the leading force for transition and advocacy*
- *CCM was actively involved; high-level, multi-sectorial HIV/AIDS Committee composed of representatives of relevant government agencies, professional associations, and CSOs, including key affected groups, took over CCM responsibilities*
- *HIV incidence has been steadily reducing*
- *Success was a combination of factors:*
 - + *high burden of disease – HIV was a national issue*
 - + *leadership of PIU (National Institute for Health Development, NIHD)*
 - + *involvement of service providers (government clinics and NGOs)*
 - + *involvement of professional associations*
 - + *good data used for advocacy (M&E was established early during GF grant)*
 - + *high standards and ambitions surrounded the EU accession process*
- *Legislation allowing contracting NGOs was existent, however, no mechanism for advance payments was considered. As a solution, government provided one-time start-up funding to NGOs; the formal condition was that in case NGOs discontinue services, government could request start-up money back [3].*

While civil society, and particularly communities, has played a critical role in fighting these epidemics, there are still many issues affecting their effective participation in service delivery, meaningful involvement with program and policy development, and coordination mechanisms. Many NGOs are fully dependent on international donor funding (mostly Global Fund) and do not receive any support from national budgets, making them extremely vulnerable in terms of financial sustainability. It has been acknowledged that governments are more keen to fund pharmaceuticals, and treatment and care, but less keen to extend it to prevention (in particular with key populations) [28]. They are often much more willing to support services provided by public health systems, rather than community organizations. Notably, following the end of Global Fund grants, NGOs working on HIV prevention and harm reduction lost funding and suspended operations in Albania, Bulgaria, Serbia, and Romania.

For example, in Albania, the Agency for the Support of Civil Society (ASHMC) is the only donor agency run by a government that provides financial support for CSOs. However the mission of ASHMC does not include support for harm reduction or NEP [29]. Continuity of services provided by NGOs in countries having graduated (fully or partially) from Global Fund funding was a function of the ability of every single organization to obtain alternative funding from either national or international sources. In some cases,



organizations were able to continue their provision of services on a significantly reduced scale through the voluntary engagement of the staff and use of leftover equipment and distribution materials.

In many cases, the credibility of CSOs has been compromised due to the lack of communication skills, a suboptimal technical capacity within sector competition for scant funding, and a limited degree of coordination. It is also true that NGOs are sometimes included in service delivery and strategic planning and coordination, largely due to it being a Global Fund requirement. Nevertheless, without the involvement of NGOs, access to key populations and implementation of interventions addressing their needs will be heavily affected, if at all possible. Greater partnerships between government/public health systems and NGOs, and the development of integrated services are therefore required. One model that seems to be functioning well so far is the one in Kazakhstan where outreach services being provided by public health institutions (mainly AIDS Centers) with the involvement of outreach workers previously employed by NGOs. As most of the regions of the country prevention services has used this model for few years, it is expected that the government will successfully take over any remaining programs that are currently funded by the Global Fund. This will mean that there will be no interruption in provision of services or a reduction in coverage. The obvious advantage of the model lies with the capacity and retention of skilled workers, which is essential to ensuring a smooth transition from donor support. In addition, in 2014, the government contracted 27 NGOs for HIV-related services [21]. However, it is expected that the number of NGOs currently providing these services within the Global Fund grant mechanism, are at risk of being shut down. Overall – and this is applicable to all countries – it is unrealistic to expect that governments will fund NGOs at the same level as the Global Fund did. NGOs will need to create coalitions and work together (in advocacy and fund raising) rather than compete with each other.

Getting ready for transition

In the section below we describe the experience of countries in relation to their preparation for transition from Global Fund funding. There is a great deal of variety in terms of comprehensiveness of transition processes, with the majority of countries exercising less structured, fragmented attempts to deal with this issue. The common baseline for all countries studied is a limited experience with the development of transition plans. None of the countries that have already graduated, with the exception of Estonia, have adopted transition planning. None of those currently in the process of graduating have transition plans. However, in many cases, transition is reflected in the national HIV strategies and NFM concept notes (Albania, Belarus, Georgia, Azerbaijan, Kazakhstan). In all these cases the Global Fund has requested countries to develop national HIV strategies and plans, include transition-related activities, and then build the concept note, aligned with these strategies. A common feature of the process is a gradual decrease in Global Fund spending for TB and HIV prevention, treatment and care, and a corresponding increase in national spending for these programs. As defined by the Global Fund Eligibility and Counterpart Financing Policy: *“The minimum threshold for Counterpart Financing shall be 5 percent for LICs, 20 percent for Lower LMICs, 40 percent for Upper LMICs, and 60 percent for UMICs. UMICs will be encouraged to increase their Counterpart Financing contribution to above 90 percent during the duration of grant implementation to facilitate graduation out of Global Fund financing”* [6]. In addition, based on the Global Fund Investment Guidance for Eastern Europe and Central Asia, by the end of the current GF allocation period (2017), UMI countries are expected to cover 100% of the costs of ARV treatment, related laboratory services, and support for treatment adherence from domestic sources, with Upper LMICs to cover a minimum of 75%, Lower LMICs to cover a minimum of 60%, and LICs to cover a minimum of 30% of these costs [9].

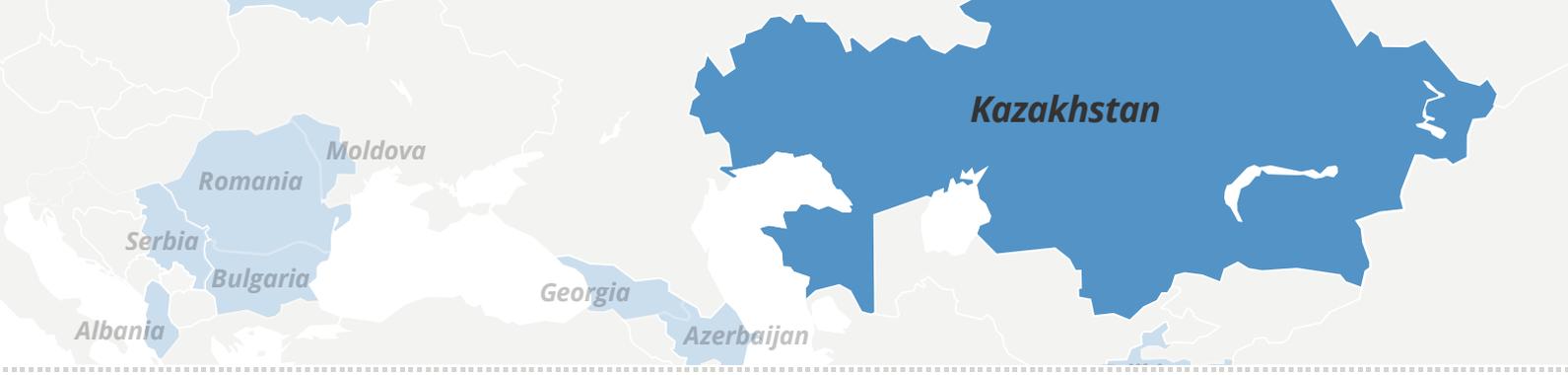


Table 1. Counterpart financing requirements and co-financing targets for selected countries

	Low Income (LI)	Lower Low-Middle Income (Lower LMI)	Upper Low-Middle Income (Upper LMI)	Upper Middle-Income (UMI) and/or High Disease Burden	High Income No Longer Eligible for New Global Fund Financing
Counterpart financing	5%	20%	40%	60%	n/a
Co-financing targets for 2017 (ARV & lab services)	30%	60%	75%	100%	n/a
		Moldova Tajikistan ²	Georgia	Albania Azerbaijan Belarus Bulgaria Kazakhstan Romania Serbia	Estonia

In some countries (Belarus, Azerbaijan), governments commit to filling the gaps in funding for all programs that are currently covered by the Global Fund. In others (Albania, Georgia), projected domestic contributions will cover all programs, except for needle and syringe programs.

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In Moldova, the government is taking over the cost of rapid tests for key populations, and is gradually starting to fund harm reduction projects during the NFM grant. Over the course of the NFM, the government intends to develop program sustainability plans, including mechanisms for NGO social contracting and licensing. Since 2014, the National Insurance Fund has been covering the cost of OST treatment for 30 insured patients, and there are plans to expand the coverage in 2015. In 2015, the government procured methadone for all patients on opiate substitution treatment for the first time. In addition, the government allocated funding to cover the cost of at least two harm reduction programs in 2015.

Development/improvement of social contracting mechanisms is addressed explicitly in HIV strategies in Azerbaijan, Georgia, Belarus, Tajikistan, and Moldova. In Azerbaijan, a new “Law on Social Services” has been adopted and an “NGO Support Fund” under the president has provided funding for HIV related projects.[30] In Belarus, the “Law

² Tajikistan moved from LI to Lower LMI in July 2015. Within the current allocation period, it should comply with counterpart financing requirements and co-financing targets applicable to LI.



Serbia

Global Fund HIV funding ended in 2014. At that time:

- *HIV prevention among KAPs was funded exclusively by GF*
- *Lack of integration of GF projects with national health programs*
- *No transition plan, no exit strategy by GF*
- *CCM with limited mandate*
- *Degree of NGO collaboration and collective advocacy was not optimal*
- *Financial resources channeled for emergency response to natural disaster (flooding)*

The following services were discontinued or dramatically reduced:

- *Outreach VCT*
- *Harm Reduction Programmes among PWID—other than substitution treatment*
- *Outreach/Mobile Medical Unit and Drop-in centres for the Key Population (SWs, MSM, IDUs)*
- *Care and support programmes for PLHIV*
- *CD4 tests for treatment monitoring*

CCM not functioning in post-Global Fund period. Harm reduction was included in both National HIV/AIDS Strategy (2010-2015) and National Drug Strategy (2014-2021), however, budget was not allocated. [50]

on Social Services” that was adopted in January 2013, regulates the provision of social services to specific groups of population. However, the law does not include HIV prevention in the list of services that can be provided. In the same manner, the “Law on Health Care” covers activities related to the promotion of healthy lifestyles and HIV prevention, but does not consider the use of social contracting mechanisms for NGOs. Civil society organizations are currently engaged in active advocacy to eliminate these discrepancies, with legal amendments developed and submitted to Parliament. In preparation for transition, CSO advocacy has also focused on improving/reforming specific regulatory mechanisms related to the provision of services for key populations. For example, the inclusion of the profession of social worker into the national register of professions was initiated, and so on.

In Georgia, the government has been increasingly interested in considering a cost-effectiveness component in HIV prevention interventions, particularly in relation to harm reduction programs. Local and international NGOs and coalitions have been able to respond to this demand, and propose a number of studies specifically focusing on economic and costing components of harm reduction programs. The EHRN costing study [50] is being finalized and there are two ongoing cost-benefit studies (OST and NSP), with results to be available in early 2016. In addition, *per se* criminalization of drug consumption and overall extremely harsh drug legislation have been identified as critical barriers affecting the demand for and access to HIV prevention services for people who inject drugs, Georgia’s major risk group [31]. The national HIV Strategic Plan (2016-2018) states that “*specific measures will be taken to introduce legislative changes and develop regulations and operational policies required to ensure uninterrupted delivery of essential HIV prevention and care services with special focus on the*

key affected populations” [32]. However, it is not clear what specific changes will be proposed and whether the most problematic articles in drug legislation will be addressed. What will be most affected?



CONCLUSIONS

What will be most affected?

Experience accumulated in relation to sustainability of donor funded programs (PEPFAR, GAVI, and AVAHAN cases), and the results of Global Fund withdrawal from Albania, Romania, Bulgaria, Estonia and Serbia, provide useful examples to be taken into consideration for planning and implementing transitions from GF funding in countries of Eastern Europe and Central Asia. This experience in relation to the epidemiology of HIV/AIDS, program financing and coverage, analysis of the process of preparation for transition in selected countries, suggest that this will be a very challenging process and there are considerable risks to the sustainability of HIV programs in the region. In the environment of ever-limited funding and too many competing priorities for scarce public health resources, harm reduction interventions, still subjects of political and ideological controversy, seem to be the most vulnerable to these risks. Even now, under the Global Fund funding, no single country, including those who succeeded to achieve universal coverage of specific groups by prevention and/or treatment services (for example testing of pregnant women, or universal access to ARV treatment), was able and/or willing to scale up HIV prevention among PWID to the degree that would see recommended targets reached. These programs were affected in the first place in countries from which the Global Fund has withdrawn (partially or fully). Where national strategies and NFM proposals are being developed and include transition related strategies, harm reduction programs, in particular needle and syringe programs are the only programs with very low or no projected domestic contributions; they range from 0% in Georgia to just 1.6% in Tajikistan, and 15% in Moldova [50].

Romania

Global Fund HIV funding ended in 2010, at which time:

- Frequent reorganizations taking place at Government or MoH levels, inducing loss in technical capacity and affecting the continuity
- Lack of integration of Global Fund projects with national health programs
- CCM with limited mandate
- Risks of multiple donor withdrawal not assessed
- No transition plan, no exit strategy by Global Fund
- EU structural funds were not properly utilized

Results:

- Capacities built by Global Fund lost
- Novel models of service delivery not transferred to permanent structures
- Qualified and trained staff lost
- NGOs terminated HIV prevention services, or stopped functioning
- Compared to 2010, NSP coverage in 2011 reduced twice
- HIV incidence among PWID dramatically increased
In 2013 PWID represented 29.2% of the new cases of HIV/AIDS (compared to 3% in 2010) [1, 2]

How do we know countries are ready to transition?

The section below focuses on components of sustainability that should be examined when developing a common approach to the transition process and defining specific criteria to assess the “readiness for transition” or “graduation” from Global Fund funding. These components are reviewed within four major areas that should be assessed in order to determine whether a country is ready to assume responsibility for funding and implementing programs: financing, program implementation capacity, governance and policy. Epidemiological components/indicators are also considered.



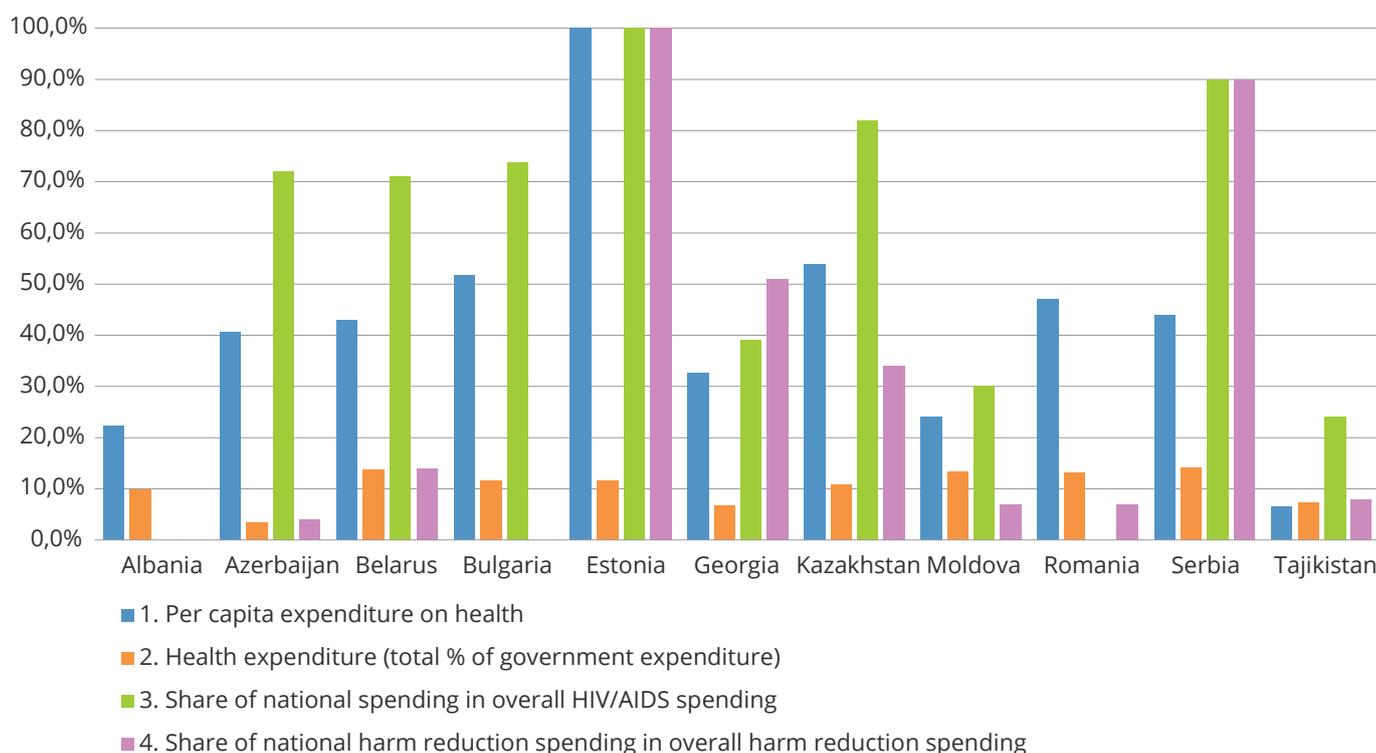
Financing and epidemiologic indicators

It has been increasingly recognised that income level and disease burden are not sufficient indicators to measure readiness of countries to graduate from Global Fund funding [1, 28]. Perceived ability to pay, expressed in GNI per capita³, is hardly sufficient to measure development and sustainability. It does not indicate an adequacy of current allocations to the health sector or access to health services, nor does it reflect adequately governments' readiness to scale-up investment in the health sector, including HIV and TB. More sensitive complementary indicators in this regard can be per capita expenditure on health, share of health expenditure in overall government expenditure, or share of government spending in overall health (including HIV and TB) spending. These indicators can be useful for understanding an overall health financing landscape in the country and may act as enabling factors for successful transition. Ideally, the higher the value of these indicators, the more willing and able the government should be to take full responsibility for sustaining GF funded programs. However, any of these general health indicators should be treated with caution for a number of reasons. Firstly, they do not necessarily reflect governments' financial contributions to HIV and AIDS. As seen in Figure 1, there is hardly any clear association between general health financing indicators and governments' share in HIV and AIDS funding in selected countries.

Figure 1.

Health financing indicators, overall HIV/AIDS and harm reduction spending in selected countries

Note: per capita expenditure shown as relative to Estonia (\$1,072=100%); no data were available for indicators 3,4 – Albania, indicator 3 – Romania.



3 GNI per capita (formerly GNP per capita) is the gross national income, converted to U.S. dollars using the World Bank Atlas method, divided by the midyear population 33. World Bank. *GNI per capita, Atlas method (current US\$)*. 2015 [cited 2015 5 August]; Available from: <http://data.worldbank.org/indicator/NY.GNP.PCAP.CD>.



Furthermore, relying on economic health indicators may be misleading if funding for a given service category and/or coverage by specific intervention is unacceptably low. Even if domestic contributions to HIV/AIDS funding have been steadily increasing, HIV prevention among PWID is currently funded at a very low scale, or not funded at all from domestic sources in a majority of countries (see indicators 3 and 4 in Figure 1). Coverage by these services, in particular by OST, is extremely low in all countries reviewed in this report (see Figures 2 and 3). In strict terms, whatever the economic indicators might suggest, a country cannot and should not be considered as ready for transition if coverage of populations in need by prevention and/or treatment services is far below the level that would make an impact on the spread of HIV. In particular, when we speak about irreplaceable prevention interventions targeting key population groups (e.g. PWID), in the region of the world with the fastest growing HIV epidemic, [9] there cannot be alternatives to the levels of coverage that would allow controlling the epidemics, if the role of Global Fund is in achieving a sustainable impact. In eight countries, out of eleven, HIV incidence has been steadily increasing (see Figure 4).

Figure 2.

OST coverage in selected countries

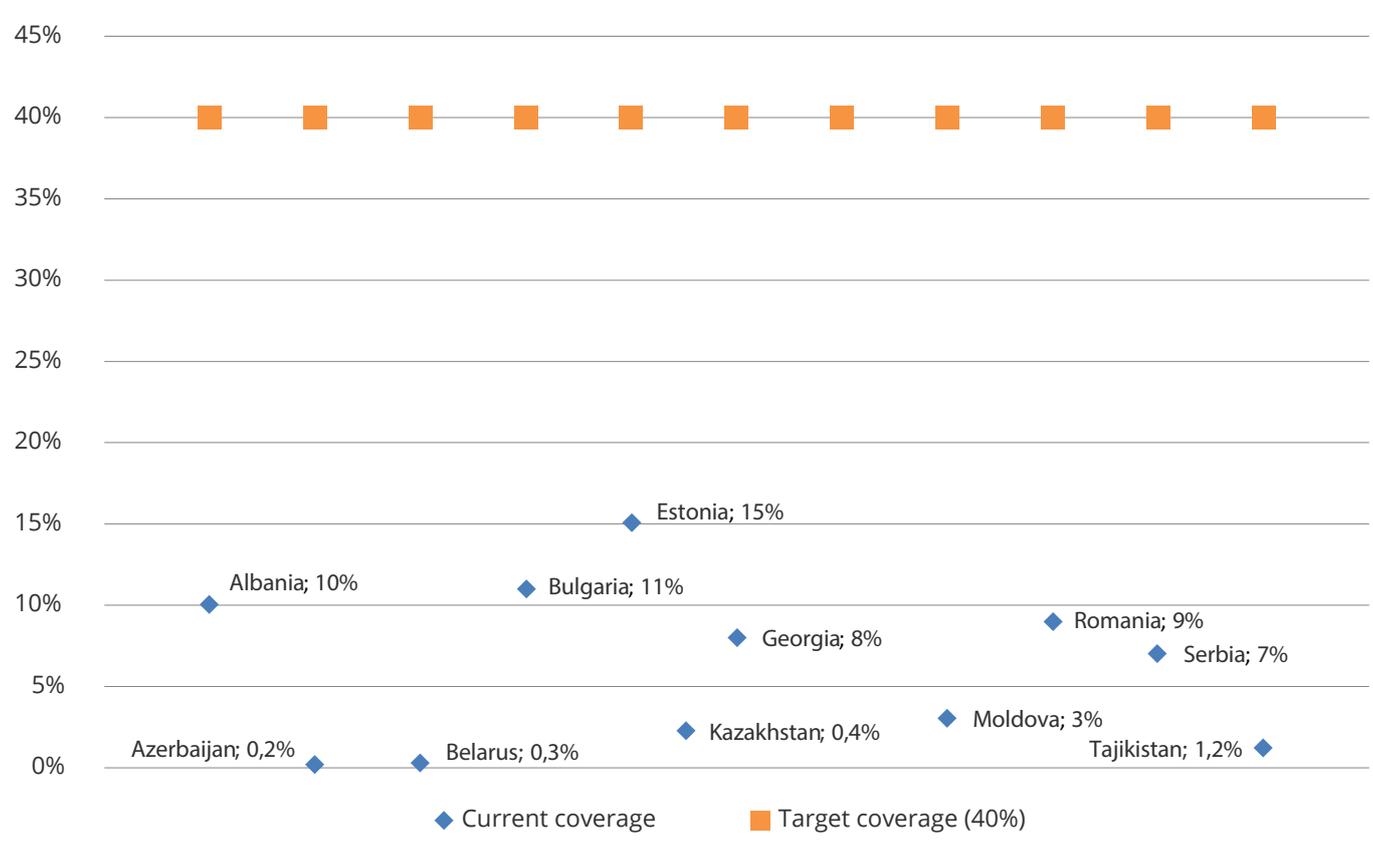




Figure 3.

NSP coverage in selected countries

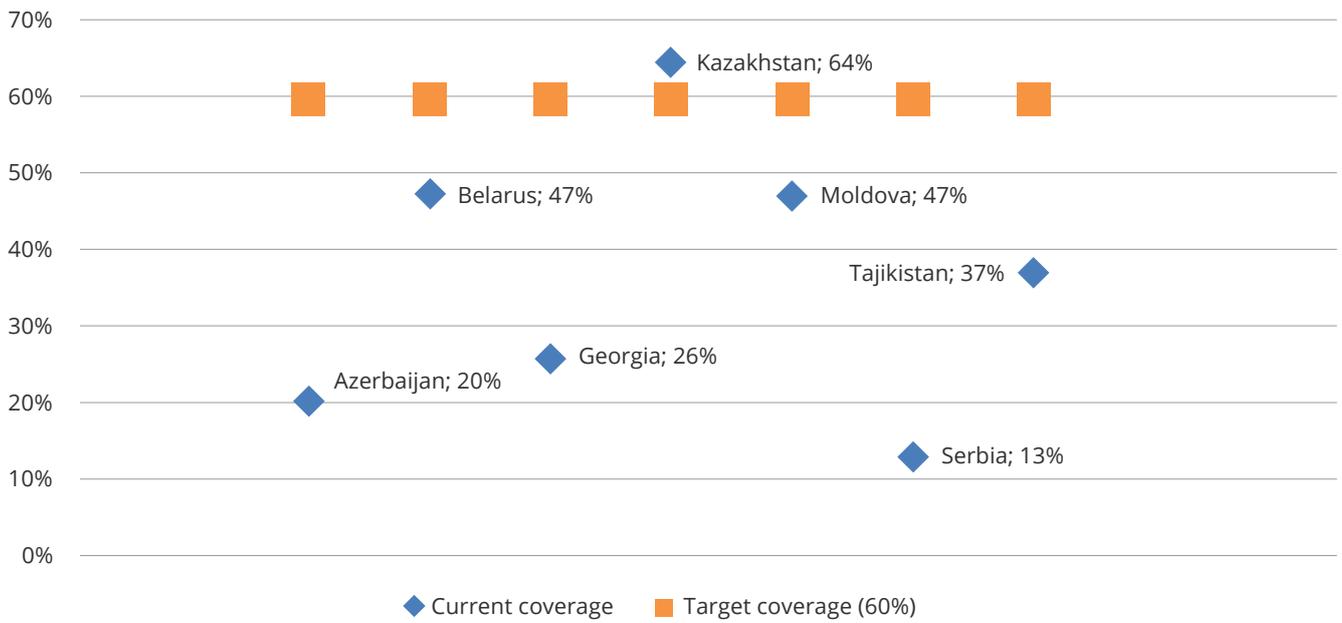
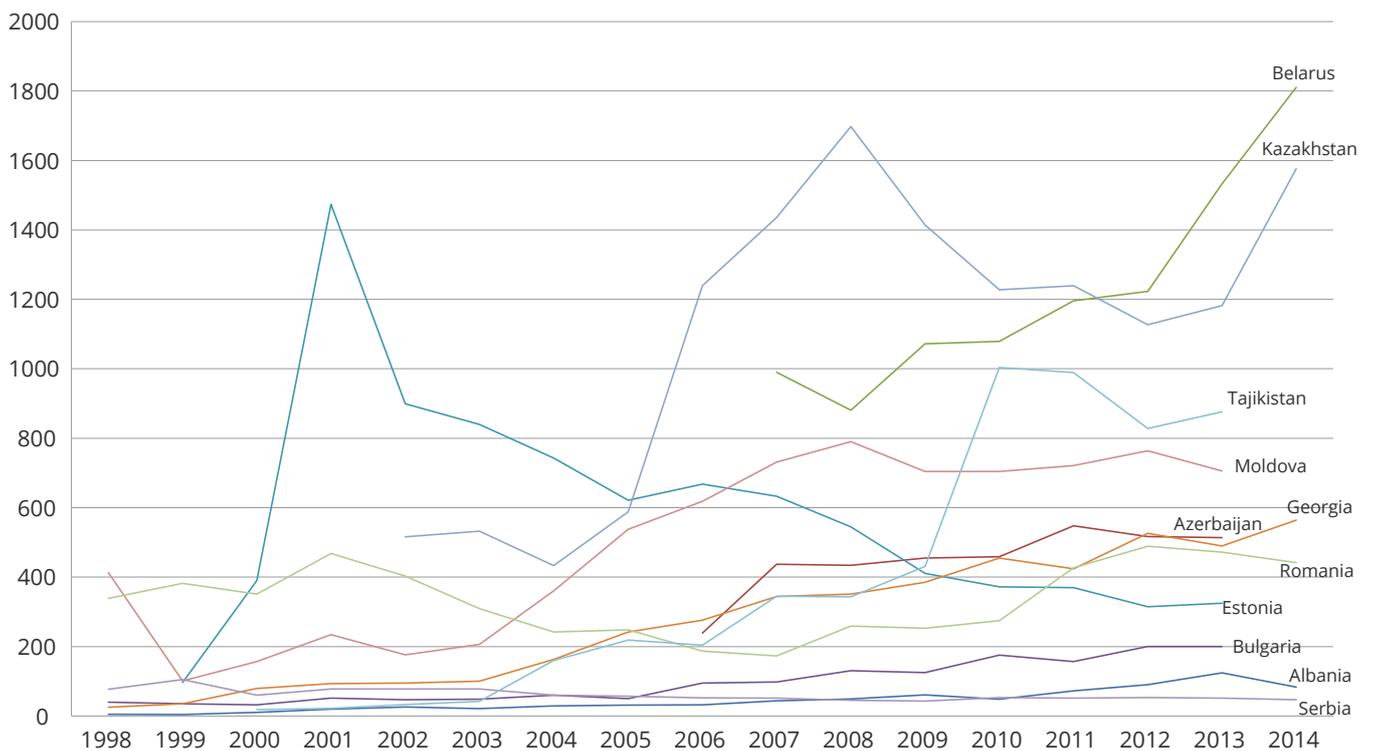


Figure 4.

Newly registered HIV cases



(Sources: [1, 18-21, 25, 34-38])



Along with economic indicators, a lower burden of disease is seen as a condition that puts a country in a better position to assume greater responsibility for funding programs following the end of Global Fund support. At the same time, a low burden can play a demotivating role in the process of prioritization. In too many cases, governments tend to focus on instant solutions for current big problems rather than adopting rational and informed decision making and long term planning. Regardless of the income level and spread of the epidemics, we need to look at how much countries are willing to allocate for HIV/TB and work with governments to make those allocations adequate.

Program implementation capacity

Health infrastructure (organizational and systemic capacity) has equally critical importance in determining how effectively countries can convert resources into health outcomes. Expectedly, for many countries, increased financing of the health sector have resulted in higher human and institutional capacities and, ultimately, in greater capacity to implement programs. Assessment of programmatic capacities should aim to understand if the country has adequate systems that allow for delivery of services to populations in need and includes the ability to support community groups to provide those services. Such an assessment would focus on components related to financial management, procurement and supply management, effective monitoring and evaluation, CSO contracting mechanisms, qualified human resources, et al.

Governance

Effective governance is associated with better performance and health outcomes. In general, good governance is about strong leadership, participatory policy development and transparency and accountability in program planning and implementation. Critical elements of transition and sustainability related to governance should seek answers to the following questions:

- Are there national strategies and action plans that are approved and have legal power?
- Is there a well-functioning governance body that oversees the HIV response?
- Is governance representative of multiple sectors/stakeholders, including key population groups?
- Have transparency and accountability mechanisms been developed that will allow civil society to monitor government HIV expenditures and implementation of the transition plan?

Policy

In many situations there may be a sufficient ability to pay, but the leadership to implement effective HIV/AIDS policies may be lacking. Obviously, political will is hard to measure/quantify and is often assessed through looking at written obligations by governments to support transition and ensure sustainability of Global Fund programs, adoption of relevant regulations and policies, and other commitments made by political leaders. Assessment of a policy environment should focus on regulations that create an enabling environment for service delivery and include legislative/regulatory safeguards for non-discriminatory access to services for key populations. These may include, but are not limited to, regulations decriminalizing drug use, defining non-disclosure practices, supporting provision of needle-syringe programs and opiate substitution treatment, and many others.



RECOMMENDATIONS

Countries differ in terms of both stages of graduation (losing eligibility) and readiness for transition (being able and willing to take over funding for programs currently supported by the Global Fund). Estonia (successfully) completely graduated from Global Fund support. Bulgaria, Romania and Serbia are currently experiencing drawbacks of unplanned and unprepared transition. Azerbaijan, Belarus, Georgia, Kazakhstan and Moldova are approaching the critical stage of graduation from Global Fund HIV funding. There are a number of ongoing initiatives implemented, aimed at developing transition-related approaches and tools to be used by the Global Fund and national actors. These initiatives intend to propose specific criteria and instruments for comprehensive assessments of readiness for transition (or risks for unsuccessful transition) and provide recommendations that should help countries to make their transition a successful one. EHRN's report on regional consultation related to sustainability of the Global Fund proposes a useful framework that can be used to guide individual countries in developing their roadmaps for transition [39]. The framework suggests three stages of transition readiness: 1) Pre-transition; 2) Some transition steps taken; and 3) transition well established and underway. It further outlines four areas of transition (policy, finances, governance, and programs) and suggests specific roles and responsibilities for all stakeholders. As indicated in the report *"This inclusion of each group indicates the shared responsibility for transition across all partners; no one group is responsible for any element of transition without partnership and support from other groups. In order to guide countries in engaging all stakeholder groups, the framework outlines specific roles and responsibilities at each stage and across each transition area"*.

The recommendations are intended to assist governments, the Global Fund and civil society organizations in preparing more effectively for the transition process. They are based on specific information collected and reviewed for the report; they are neither exhaustive, nor comprehensive enough to cover all the areas and issues that relate to sustainability of HIV/AIDS programs and transition from Global Fund funding. Nevertheless, these recommendations can meaningfully complement the work of other colleagues and on-going efforts to discuss and develop common approaches to program sustainability.

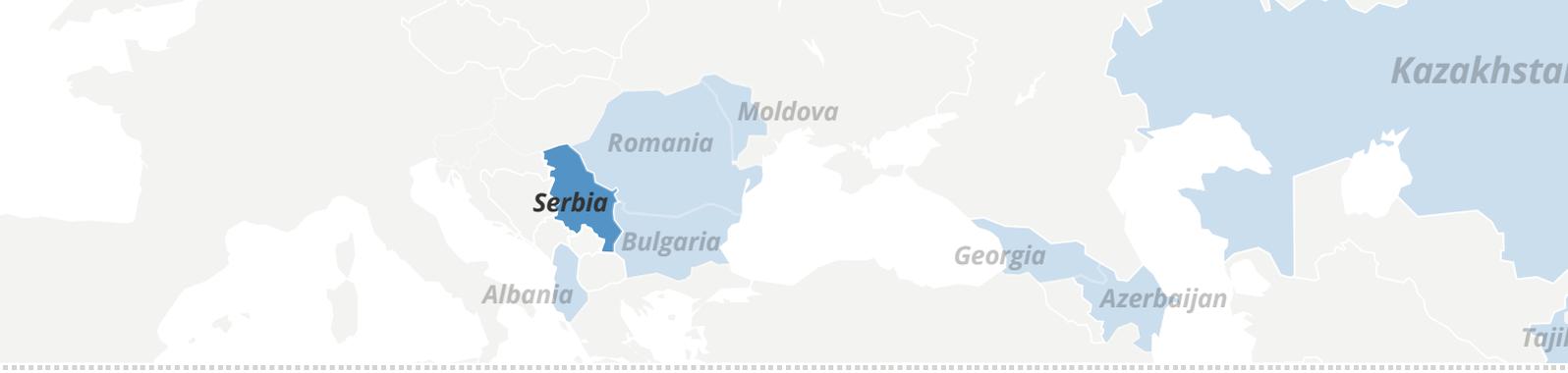
Recommendations for governments

1. Assess readiness

Conduct a comprehensive assessment of readiness to transition, focusing on financial, programmatic, governance and policy related components. Work closely with the Global Fund and civil society to develop a detailed transition plan (informed by a readiness assessment) with clear roles and responsibilities of involved parties, a realistic timeline, and clearly articulated criteria for successful completion.

2. Make the best use of financial resources

Conduct financial resources mapping, costing, gaps analysis and develop a realistic financial sustainability plan. Revisit current allocations to service categories and prioritize high-impact cost-effective interventions. With ever-limited public resources, not to do so can be ill-afforded, if at all. Examine current program management practices and explore options for optimizing management costs.



3. Enforce effective coordination

Transform CCMs into permanent formal structures and maintain the multi-sectored nature of the CCM. Good programming cannot be done without effective coordination. Ensure the participation of CSOs and key population groups. Coordination mechanisms should serve as platforms for all involved sectors to contribute and inform policy and program development, and monitoring and coordination efforts.

4. Sustain community-based services

Effective collaboration between NGOs and national health institutions needs to be developed during the implementation of grants. Support integrated service delivery models (NGOs and public health systems collaborate) versus full takeover by public institutions (NGOs left out.) Community organizations are key for access to marginalized affected populations. It would be unrealistic to expect that public health institutions can reach hidden target groups as effectively as community organizations do.

5. Reform policy

Implement policy and legal reforms to make sure existing regulations: 1) Support implementation of evidence-driven and human rights-based programming, and 2) ensure smooth functioning of technical mechanisms for program delivery (for example ensuring that social contracting mechanism works; inclusion of new professions into the national framework; introducing professional and education standards; effective procurement mechanisms to be established; and removing legal barriers for effective service delivery, such as discriminatory criminalization of drug users and disclosure practices).

Recommendations for CSOs

1. Be credible

Be a credible partner for government and other stakeholders; enhance communication and technical capacities. NGOs, including community organizations, have played an indispensable role in delivering life-saving services to most affected and marginalized groups. Keep quality standards high. Make sure you employ the most effective service delivery models and optimal management practices. To enhance participation in decision making, support communications skills building and advocacy capacity development for your staff.

2. Engage in transition

Initiate discussion on transition early during program implementation. Demand and seek participation in readiness assessments, transition planning and monitoring. No other actors have a better understanding of the needs and demands of populations that are key to the success in fighting HIV/AIDS epidemic. It is your obligation and role to bring this knowledge to the fore, and inform the decision making process.



3. Push for prioritization of high-impact and cost-effective interventions

Advocate for inclusion of high-impact interventions targeting key populations into national strategies and action plans. Push for adequate financial allocations for these interventions in national budgets. Initiate costing and cost-effectiveness studies to support advocacy efforts. Where such studies have been done, actively use the results as advocacy tools. Utilize accepted international targets for NSP (60%) and OST (40%) as goals for the scale-up of services.

4. Do your own strategic planning

Develop your own sustainability plans which would include alignment with government norms and regulations and integration with public health services. The departure of Global Fund will inevitably affect established models of service delivery. Be ready to work close with government health institutions and prepare for reforming your convenient management practices.

5. Work together

It is unrealistic to expect that governments will fund NGOs to the same scale as the Global Fund did. NGOs will need to create coalitions and work together (advocacy, funds raising), rather than compete with each other. There are no alternatives to collective work/efforts, in particular in advocacy.

Recommendations for Global Fund



1. Assess readiness

Assessing the readiness of countries to take over programs supported by the Global Fund is critical. Countries have to be capable and willing to fund and implement these programs. To effectively support the assessment of transition readiness, the Global Fund will need to define clear and realistic criteria for readiness. Along with economic and epidemiologic indicators, such criteria will have to consider countries' readiness in terms of programmatic capacities, policy/regulatory environment and governance, including political will to support programs following the departure of Global Fund.

2. Guide countries through the process

The Global Fund should develop specific guidelines on the content and process for elaborating transition and sustainability plans to guide countries. As an essential part of transition planning, countries will need to do financial resources mapping and gaps analyses, and forecast costs of their transition and sustainability plans. Time frames for transition should be developed on a country-by-country basis and should be based on readiness



assessment results. More importantly, transition planning and implementation should be viewed as native (not standalone) components of a program with relevant elements of a program being identified and transferred to government continuously throughout the program implementation [40]. It is obvious that the diversity of national epidemiological, financial, political and programmatic contexts makes it extremely difficult to develop a universal approach to the process of transition. The challenge will be to create a workable, but flexible, model that would allow for tailoring of the process to the specifics of different countries.

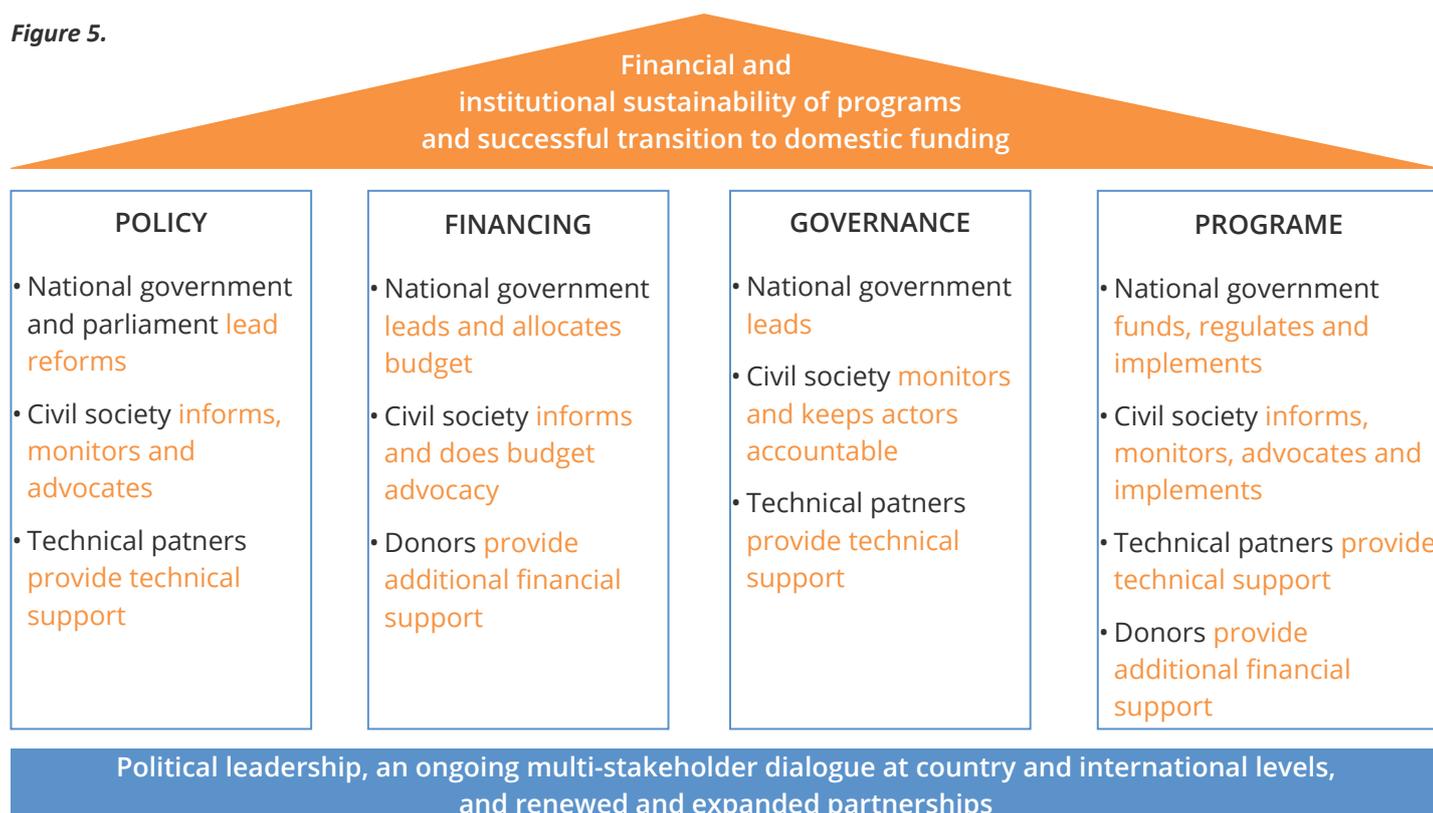
3. Support transition

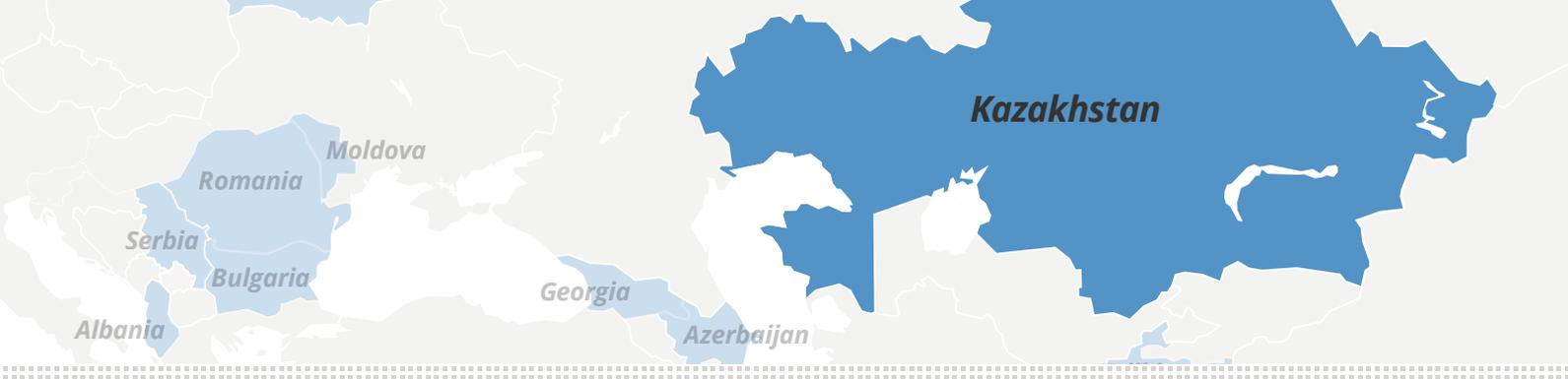
It is critical that countries have access to financial and technical assistance to prepare their systems for sustaining these programs. Areas for assistance can include, but are not limited to, program management capacity, integration of services, governance, coordination, policy and regulatory reforms. In order to secure successful transition, both the Global Fund and other donors will need to provide the necessary funding and technical support.

4. Ensure broad participation

A variety of stakeholders should be involved in transition processes, including government officials and agencies, civil society organizations, international development partners, and private sector representatives. Involvement of a broad range of stakeholders should ensure that actors at all levels understand the intentions of the planned activities and accept stakeholder responsibilities [13]. All in all, the sustainability of programs is a shared responsibility of all stakeholders, with all having their share to contribute (see Figure 5).

Figure 5.





In addition to securing the continuous financial support to services provided by NGOs (hopefully from national budgets), the Global Fund should consider providing lasting support to civil society actors, allowing them to remain engaged in strategic planning, monitoring and coordination both during the transition and at the post-transition period. It is critical to support local advocacy groups to keep governments accountable beyond the termination of Global Fund grants. Where governments are not able (or willing) to provide funding for NGO services targeting key populations, the Global Fund will need to develop and implement alternative funding mechanisms. This can be the expansion of the “NGO rule” or the introduction of a new mechanism that would assure continuation of services. The major challenge here would be how to make sure governments won’t take advantage of their “unpreparedness” indefinitely. Again, the success of advocacy efforts depends on how effectively involved parties can partner in advocating and pushing for relevant decisions in respective governments.

The process of transition would obviously benefit from the involvement of international development partners (IDP). Given the great deal of experience and technical support capacities accumulated within international donor agencies present in the region, development partners can engage both in independent evaluation of countries’ readiness for transition, and in monitoring of transition processes and outcomes of transition. At all stages of transition planning and implementation, they can contribute to identifying key technical support needs and provide access to such technical support.

5. Monitor transition

The Global Fund, together with a broad range of partners, will need to develop a clear definition of, and criteria and requirements for successful transition to domestic funding. As indicated earlier, civil society groups and development partners can play an important role in monitoring the governments’ adherence to the commitments made and reflected in transition plans. The mechanisms for transition evaluation should allow for a timely process of informing participants and for making relevant changes/re-programming as needed.



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Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programs and their allies from across 29 countries in the region of Central and Eastern Europe and Central Asia (CEECA). Together, we work to advocate for the universal human rights of people who use drugs, and to protect their lives and health.

The Network unites over 600 institutional and individual members, tapping into a wealth of regional best practices, expertise and resources in harm reduction, drug policy reform, HIV/AIDS, TB, HCV, and overdose prevention. As a regional network, EHRN plays a key role as a liaison between local, national and international organizations. EHRN ensures that regional needs receive appropriate representation in international and regional forums, and helps build capacity for service provision and advocacy at the national level. EHRN draws on international good practice models and on its knowledge about local realities to produce technical support tailored to regional experiences and needs. Finally, EHRN builds consensus among national organizations and drug user community groups, helping them to amplify their voices, exchange skills and join forces in advocacy campaigns.

BECOME AN EHRN MEMBER:

EHRN invites organizations and individuals to become part of the Network. Membership applications may be completed online at:

www.harm-reduction.org/become-a-member

ANNEX 1: ECONOMIC AND HEALTH CHARACTERISTICS OF 11 COUNTRIES

Country	HIV burden/ eligibility	Income category[41]	GNI per capita (\$)[33]	Per capita expenditures on health (\$) [42]	Health expenditure (total % of government expenditure)[43]	% national funding in overall HIV	Share of harm reduction spending in the total HIV/AIDS spending (%) [44]	Share of harm reduction spending in HIV/AIDS prevention spending from domestic sources (%) [44]	Share of domestic harm reduction spending in overall harm reduction spending (%) [44]	Coverage by NSP and OST
Albania	Low/trans(new)	UMI	4,460	240	9.8%					OST - 8-12%[45]
Azerbaijan	High/elig	UMI	7,590	436	3.5%	72%[35]	11.3%	0.7%	4%	NSP - 20% OST - 0.2%[35]
Belarus	High/elig	UMI	7,340	463	13.7%	71.1%[19]	15.1%	2.8%	14%	NSP - 37.5% OST - 0.3%[19]
Bulgaria	High/NGO rule	UMI	7,420	555	11.7%	73%[36]	14%	0%	0%	OST - 11%
Estonia	n/a / non	HI	18,530	1,072	11.7%	100%[20]	46.9%	47%	100%	OST - 15%[20]
Georgia	High/elig	Upper-LMI	3,720	350	6.7%	39%[32]	64.7%	71%	51%	NSP - 12% OST - 8%[32]
Kazakhstan	Mod/non	UMI	11,670	580	10.9%	82%[46]	29.1%	27.6%	34%	NSP - 64% OST - 0.4%[21]
Moldova	High/elig	Lower-LMI	2,550	263	13.3%	25%[18]	19.1%	2%	7%	NSP - 31% OST <1%[18]
Romania	High/NGO rule	UMI	9,370	504	13.2%		23.1%	6%	7%	OST < 10%[47]
Serbia	High/elig	UMI	5,820	475	14.1%	90%[38]	37.4%	49.7%	90%	NSP - 13% OST - 7%[48]
Tajikistan	High/elig	Lower-LMI ⁴	1,060	70	7.3%	24%[49]	22.3%	10%	8%	NSP - 37% OST - 1.2%[49]

Notes

Income category: The Global Fund income categories are based on the World Bank (Atlas Method) Income Classifications: Low Income Countries (LI); Lower-Middle Income Countries (LMI); and Upper Middle Income Countries (UMI). The GNI-per-capita thresholds which determine income classifications were published by the World Bank in July 2014 and these, together with the updated GNI per capita data published in December 2014, were used for the 2015 eligibility list. The Global Fund

⁴ Tajikistan moved from “low” to “lower-LMI” in July 2015

classification further divides LMI countries into two groups, namely Lower-LMI countries and Upper-LMI countries based on the midpoint of the GNI per capita range of the World Bank's LMI category.

Disease burden: Disease burden data are provided to the Global Fund Secretariat by WHO and UNAIDS. The disease burden criterion applies to UMI countries in order to determine their eligibility, with the exception of the 'malaria-free' criterion (below) which applies to all countries regardless of income level:

- Members of the Group of 20 countries (G-20 members) that are UMI with less than an extreme disease burden are not eligible, unless they meet the criteria to apply under the 'NGO Rule.'
- UMI countries with 'moderate' or 'low' disease burden are not eligible for funding. UMIs that are designated under the 'small island economy exception' to the International Development Association lending requirements are eligible for funding regardless of national disease burden.
- For HIV: UMI countries must be listed on the OECD's DAC list of ODA recipients to be eligible for funding, unless they meet the criteria to apply under the 'NGO Rule.'
- For malaria:
 - The Global Fund uses malaria data from earlier years (2000), as recommended by WHO. Each year, WHO provides revised 2000 estimates, which has changed the disease burden score for some countries; and
 - Countries that are certified as 'malaria-free' by WHO or are on the WHO's 'Supplementary List' of countries where malaria never existed or disappeared, are not eligible to apply for malaria funding and will not be eligible for an allocation for malaria, regardless of their income level.

NGO rule: For HIV/AIDS only, UMIs not listed on the OECD-DAC list of ODA recipients³ will only be able to access funding if they meet all the conditions as described in the eligibility policy, in particular the confirmation that the services requested in the application are not being provided due to political barriers. In all cases, such applications must be submitted by an NGO and must comply with all of the conditions.

Transition funding: Components funded under an existing grant that become ineligible may receive funding for up to one additional allocation period immediately following their change in eligibility. The Secretariat, based on country context and existing portfolio considerations, will determine the appropriate period and amount of funding.

- Transition_(new): Components that moved to transition during this allocation period and may receive funding during the next allocation period
- Transition_(current): Components receiving transition funding

Source: The Global Fund to Fight AIDS Tuberculosis and Malaria. (2013). THE GLOBAL FUND ELIGIBILITY AND COUNTERPART FINANCING POLICY. Geneva, Switzerland.