Road to Success: Towards Sustainable Harm Reduction Financing

First year of the Regional Program “Harm Reduction Works – Fund It!”

December 2015, Vilnius, Lithuania
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This report analyses the current state of harm reduction investment and services for people who inject drugs in East Europe and Central Asia (EECA): Belarus, Georgia, Kazakhstan, Lithuania, Moldova, and Tajikistan. Monitoring of harm reduction services and investments in harm reduction programs has been conducted within the Regional Program “Harm Reduction Works – Funded It!” being implemented by Eurasian Harm Reduction Network (EHRN) with financial support of the Global Fund to fight AIDS, tuberculosis and malaria. The report presents research-based recommendations for improved investment based on needs assessment. It formulates key messages for decision makers in order to assure that sufficient, strategic and sustainable harm reduction is available throughout EECA.

“Harm Reduction Works—Fund It” is a three-year (2014–2017) regional advocacy program funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. The program is implemented by the Eurasian Harm Reduction Network and aims to strengthen advocacy by civil society, including people who use drugs, for sufficient, strategic, and sustainable investments in harm reduction as HIV prevention in the region of Eastern Europe and Central Asia (EECA).

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The HIV epidemic in Eastern Europe and Central Asia has been unique in the global context. While the region is home to significant health care infrastructure, a confluence of injecting drug use, harsh prohibition law enforcement policies, and poor access to harm reduction and health services for people who inject drugs, have allowed HIV to take root with devastating consequences. While people who inject drugs still account for more than 45% of all new infections, across the region less than 1% of them have access to harm reduction services. And so, thousands of lives are lost each year to a preventable and treatable condition.

Yet there is cause for hope. Once devoid of needle and syringe programs and opioid substitution therapy, several countries in the region now offer harm reduction programs to reduce the spread of HIV and other injecting-related harms. This progress is due in large part to the dissemination of the joint recommendations from WHO, UNAIDS and UNODC on prevention and treatment for people who inject drugs, and to the significant financial support of the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has been a leader in investing to save the lives of people who inject drugs for over a decade. With the support of these international partners, a few EECA countries have taken ownership of their programming, with strong civil societies and committed governments steering the future of harm reduction programming.

The region is now at the next critical juncture: moving to sustainable harm reduction programming, fully supported by governments and owned by domestic actors. This will not be an easy transition, but it is a necessary one; many countries in the region are heading towards economic development levels that leave them ineligible for donor assistance. Harm reduction is a vital public health measure, and now is the time that governments must commit to it, to safeguard the lives of some of their most vulnerable citizens.

This report provides guidance, driven by findings from the community of people who inject drugs and their allies, for countries and international partners alike to make this transition.

Michel Kazatchkine, UN Secretary General Special envoy on HIV/AIDS in Eastern Europe and Central Asia
ACRONYMS AND ABBREVIATIONS

<table>
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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>EECA</td>
<td>Eastern Europe and Central Asia</td>
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<td>HCV</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>NGO</td>
<td>Non-governmental organization</td>
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<td>NSP</td>
<td>Needle and syringe program</td>
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<td>OST</td>
<td>Opioid substitution therapy</td>
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<td>PEPFAR</td>
<td>US President’s Emergency Plan for AIDS Relief</td>
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<td>PLHIV</td>
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<td>PWID</td>
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<td>UNAIDS</td>
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The term ‘harm reduction’ refers to a set of measures that aim to reduce the harms associated with the use of drugs. Throughout Eastern Europe and Central Asia (EECA), epidemics of HIV, and viral hepatitis are highly concentrated among people who inject drugs. Therefore, harm reduction should be a core and high-priority component of all countries’ efforts to respond to and reverse the spread of these deadly infections.

Evidence from around the world shows that needle and syringe programmes (NSPs) and opioid substitution therapy (OST) are two particularly advantageous and cost – effective harm reduction interventions\(^1\). Their proven benefits in every country and context, including EECA, are why leading global experts and guideline-setting institutions – such as the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) – strongly recommend that NSPs and OST be accessible and available throughout the region.

Harm reduction has established several footholds in EECA over the past two decades, and has contributed to notable declines in HIV incidence and other health and social gains across society. Progress in the adoption of harm reduction services has often been slow, however, and gains are at risk of being reversed due to factors including policy constraints and uncertain funding. A particularly worrying development is the decrease of funding from EECA of the Global Fund to Fight AIDS, TB and Malaria, which has provided the bulk of funding for harm reduction in most of the region’s countries.

This report, Road to Success: Towards Sustainable Harm Reduction Funding, details the opportunities, and challenges of harm reduction investment and implementation in EECA. Prepared by the Eurasian Harm Reduction Network (EHRN) in conjunction with the Futures Group, Health Policy Project, as well as local and international partners, the report presents findings from two types of assessments – a financial analysis of NSP and OST services costs and a community – led quality of services assessment. The assessments were conducted in six EECA countries: Belarus, Georgia, Kazakhstan, Lithuania, Moldova, and Tajikistan.

The research was wide – ranging and extensive. For the financial analysis, 104 NSP sites and 59 OST sites were surveyed across the six countries. For the services assessment, specially trained members of community groups of people who inject drugs organized discussion groups with more than 600 participants and reviewed responses from more than 1,800 questionnaires completed by NSP and OST clients.

\(^1\) For example, a World Bank study released in 2013 concluded that significant reductions in HIV prevalence among people who inject drugs would be achieved by scaling up their access to and uptake of four key interventions: NSP, OST, antiretroviral therapy (ART), and HIV testing and counselling (HTC). The report, The Global HIV Epidemic among People Who Inject Drugs, is available at https://openknowledge.worldbank.org/handle/10986/12215.
Key findings

Key findings from the extensive research are summarized below. They highlight current and future funding and coverage gaps that must be understood and addressed for harm reduction services to be sustained, and to become an integral part of all countries’ HIV programming.

Service coverage. Guidance from the WHO and its United Nations partners suggests that reversing an HIV epidemic requires 60% of all people who inject drugs to be reached regularly by an NSP, and that 40% of all opiate users be enrolled in OST.

Achieving sufficient coverage levels should be a top consideration for planning investments and programming in harm reduction. Yet according to 2013 data used for this report, most of the six surveyed countries are not meeting optimal coverage levels for either NSP or OST. For example, although Kazakhstan reported 59% coverage for NSP, rates for the other five countries were much lower (between 12% and 38%). The situation is even worse for OST, with the best-performing country (Lithuania) reporting coverage of only 11%.

Funding and investments. Improving coverage levels – and ensuring that services meet a minimum standard of quality – is essential for the future of each country’s HIV response. Analysis indicates that achieving internationally recommended coverage levels (at acceptable quality levels) requires increased investments of varying degree across the surveyed countries - including, for example, an additional $335,934 needed for NSPs in Lithuania through 2018 and an additional $3,277,823 needed for NSPs in Georgia over the same period.

Domestic funding for harm reduction for 2016-2018 (projections of mid-2015)
- Governments provide less than 15% of harm reduction funding in the region, which indicates region’s strong dependency on international donors’ support.
- While Georgia currently projects no domestic contributions for NSPs through 2018.
- Moldova and Tajikistan project domestic contributions that are below 15% and 2% of total needed funding, respectively.
- Kazakhstan has committed substantial domestic funding for NSP, but support to OST is still pending for policy reasons.
- While Lithuanian government is the only source for country’s harm reduction programs (and has never been funded by the Global Fund), the projected contributions are not likely to be sufficient to meet overall demand and cover only 37% of the demand for NSP.

Quality of services. While the clients overall appreciate the availability of services community – led assessment found significant dissatisfaction among many surveyed clients with the quality of harm reduction services. The concerns included, among many others: inadequate numbers
and accessibility of outreach workers; limited availability of basic NSP commodities (e.g., alcohol wipes); low quality of counselling and social support; and lack of access to HIV prevention programmes for women and youth who use drugs.

A substantial number of survey respondents said they wanted greater access to HIV rapid testing in a community-based setting as well as to take-home doses of methadone.

**Example of improving service quality strategies**

The most important initial step is to realize that improving services and making them more efficient, acceptable and accessible to clients requires listening to what they want and need. Many survey respondents said they wanted greater access to HIV rapid testing in a community-based setting. Many also rated the availability of take-home doses of methadone as a high priority, given the limited hours of OST clinics and associated barriers such as time-consuming and expensive travel to get to them. Positive change in these two areas alone could have a major impact on adherence and linkage to care for current and future clients, thereby making the investments pay off quickly.

**Unit costs.** The financial assessment offered extensive information on the annual cost of serving an individual client with NSP and OST services in each country. These ‘unit costs’ varied greatly: for NSP, from $38 (Belarus) to $332 (Lithuania); for OST, from $525 (Kazakhstan) to $1,372 (Georgia).

Low costs may signal efficiency, but they could also indicate deficiencies such as inadequate staffing, insufficient service packages (e.g., lacking naloxone for opioid overdose prevention), or meagre support options. High costs, meanwhile, may result from excessive procurement costs (e.g., of OST medicines in Georgia) or policies that mandate excessive interventions (e.g., extensive routine urine tests for OST patients in Kazakhstan).

**Examples of optimizing unit costs strategies**

- Greater flexibility for take-home doses among OST clients (which is a notable quality-related barrier cited by clients),
- Scaling up OST programs to achieve economy of scale,
- Allowing over-the-counter provision of the overdose – reversal drug naloxone,
- Greater efforts to reduce drug – procurement costs, by negotiating bulk discounts with pharmaceutical companies,
- Cutting back on the quantity of services that are infrequently requested by people who inject drugs.

**Key messages**

Most of the quality and coverage concerns can be addressed with the right mix of policy change, capacity building, and sustainable financing.
The findings therefore are instructive for all advocates and decision-makers in the region. Moreover, they are likely to be useful for bilateral and multilateral donors and development agencies as they consider decisions on technical support provision to EECA countries.

EHRN and its partners have identified the following three key messages based on the findings. These messages are intended to help guide strategies, planning and priorities for harm reduction in EECA over both the short – and long – term future. The ultimate goal is to ensure fully funded, high-quality services that meet the needs of all current and potential harm reduction clients. Achieving that goal will have positive and long – lasting economic, social and public health consequences because rates and incidence of HIV, TB and viral hepatitis will almost certainly decline.

**Epidemics among people who inject drugs cannot be reversed without greater, and sustained, state funding of harm reduction.** Investments are needed to improve service quality and coverage levels of both NSPs and OST. Governments and other domestic sources have ultimate responsibility for meeting these investment needs. Their increased and sustained engagement is essential because the Global Fund is withdrawing from the region to concentrate its funding in low – income countries.

**Detailed and responsible transition plans for harm reduction are needed in every EECA country.** Proper planning is vital in the transition from donor to domestic funding of harm reduction. This requires coordinated attention and collaboration by a full range of government agencies and other actors with responsibility for policies and regulations, budgeting and funding mechanisms, and programme implementation. An important consideration is that cost – effectiveness can best be obtained not by cutting services, but by making them more efficient (i.e., ‘optimizing’ them).

**Policy reform can maximize the impact and success of harm reduction.** Transition plans should focus not only on filling in resource gaps, but also on improving social contracting policies and other policies that have a direct impact on people who use drugs. Legal reform is among the most important areas for policy change – including changing laws and policies to allow the direct funding of non – governmental organisations (NGOs) to provide services and introducing legal frameworks to specifically protect harm reduction services and their clients.

**Examples of improving legal adjustments strategies**

- Introduce policies clearly stating that harm reduction activities, including possession of injecting equipment, cannot be misconstrued as promoting illegal drug use.
- OST should be formally registered as a medical service and be recognized as such in legislation.
- Reduce police abuse and violence so that clients are willing and able to access services in the first place.
INTRODUCTION

EPIDEMIOLOGY AND POLICY ENVIRONMENT

For over a decade, Eastern Europe and Central Asia (EECA) have been home to the world’s fastest growing HIV epidemic. While the rest of the world has seen new infections decline in recent years, the HIV epidemic in the EECA region nearly doubled between 2002 and 2012 (UNAIDS Global Report, 2013), and incidence remains high: with an estimated 100,000 new HIV infections reported in 2005, and 110,000 in 2013 (UNAIDS Gap Report, 2014). Across the region, the HIV epidemic is concentrated among people who inject drugs (PWID) and their sexual partners; PWID experience an HIV prevalence of 20% (Dutta et al., 2013). Harm reduction interventions to reduce HIV transmission amongst PWID have been repeatedly endorsed by WHO, UNODC and UNAIDS (2009, 2012, 2014), and are evidence-based, rights affirming and cost-effective (Dutta et al., 2013; Wilson et al., 2015). With $679.5 million designated for HIV and tuberculosis EECA programming in 2014-2016, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) is at the front lines of support for harm reduction in many EECA countries.

But while Global Fund investments have ensured that needle/syringe programs (NSP) and opioid substitution therapy (OST) have gained a foothold in the region, still less than 15% of harm reduction funding comes from national governments (UNAIDS Global Report, 2012). This lack of commitment is not uncommon: globally, governments are hesitant to take up funding of harm reduction programs because of stigma towards drug users and political perceptions of spending state funds on needles, syringes, and other harm reduction commodities (Cook et al., 2014). Without a formal place in the welfare system and compelling campaigns on their public health and social value, harm reduction programs and the non-governmental organizations that implement them face uneasy prospects as countries graduate from Global Fund funding eligibility.

HARM REDUCTION WORKS

There is no doubt that harm reduction works in EECA. An eight-country review of the effectiveness and cost-effectiveness of NSP found that between 10% and 40% of HIV infections were averted as the result of NSPs, making NSPs either cost-effective or cost-saving (Wilson et al., 2012). The same study found that, when considering HIV cases averted alongside averted Hepatitis C virus (HCV) infection, NSPs were either very cost-effective or cost-saving in all eight countries. Likewise, OST has been proven to yield reduced HIV transmission and improved health status for PWID (Lawrinson et al., 2008). In support of these findings, recent analysis by Kim et al. (2014) in Ukraine observed that, when implemented together, NSP and OST provide complementarity, making harm reduction even more cost-effective than NSP or OST alone.
In addition to epidemiological impacts, harm reduction has provided positive benefits to PWID, their families, and the public at-large. PWID in Moldova report linking to other necessary health services, such as obstetric care; prevention of opioid overdose; and access to legal services as positive gains due to harm reduction programs (Moldova Report, 2015). In Tajikistan, NSP clients recount improved psychosocial support and overall quality of life through group therapy (Tajikistan Report, 2015), and in Kazakhstan, OST has been linked to reductions in criminal behavior and recidivism (Boltaev et al., 2012).

With evidence of the effectiveness and cost-effectiveness of harm reduction mounting over the last decade, many countries have expanded their harm reduction programs in order to harness these benefits. The Georgian government uses state funds to procure methadone, and
provides the full spectrum of OST services free-of-charge to people living with HIV (PLHIV) and to clients who live under poverty line (Georgia Report, 2015; Addiction Research Development in Georgia Project, 2015). Kazakhstan’s state budget purchases syringes and condoms, and substantially contributes to covering the costs of outreach workers (Kazakhstan Report, 2015). In Moldova, national health insurance mechanisms have been amended to include purchasing of OST (Moldova Report, 2015), and in Tajikistan, the government has committed to scaling-up harm reduction through integration with primary care (Tajikistan Report, 2015). These steps to support harm reduction are encouraging, and present an opportunity for strengthening and expanding harm reduction programming.

FUND IT!

Despite the positive advances and results of harm reduction in EECA, there is still much work to be done. As many countries in EECA stand on the precipice of graduating from Global Fund support based on their economic development status, we are at a critical juncture to consider the future of harm reduction. As countries are faced with reduced investments from outside sources, we must safeguard the achievements to date, while recommitting to defend the lives of PWID and bring EECA’s HIV epidemic under control.

This will require a strong vision for the future, where national governments take ownership of harm reduction efforts and work with civil society partners to ensure effective implementation. This scenario will require not only commitment to financial investment; it will also require a strong, persistent commitment to optimizing technical efficiency of harm reduction programs, so that they meet the needs of PWID and deliver a return on investment: the effective aversion of additional HIV infections.

It is in this context that the Eurasian Harm Reduction Network (EHRN) is implementing a grant from the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) to promote a supportive environment for harm reduction. The regional program, entitled “Harm Reduction Works – Fund It!” is a three-year initiative\(^2\), with the goal to strengthen advocacy by civil society, including people who use drugs, for sufficient, strategic and sustainable investments in harm reduction as HIV prevention in the region of Eastern Europe and Central Asia. There are two discrete objectives under this goal:

**Objective 1:** To build an enabling environment for sufficient, strategic and sustainable public and donors’ investments in harm reduction.

**Objective 2:** To develop the capacity of the community of people who use drugs to advocate for availability and sustainability of harm reduction services that meet their needs.

\(^2\) The program “Harm Reduction Works – Fund It!” is being implemented from April 2014 to March 2017.
Through this regional initiative, EHRN is assessing and documenting both promising practices and shortcomings in harm reduction in select sentinel countries, and will work over the course of the next two years to build an advocacy movement that supports both of these objectives.

This report examines current state of harm reduction investment and implementation in six sentinel EECA countries, and presents opportunities for improved investment and program implementation practices, to assure sufficient, strategic and sustainable harm reduction is available throughout EECA.
As a foundation for the advocacy of “Harm Reduction Works – Fund It!”, two types of assessments were conducted. These assessments, a financial analysis and a community-led quality of services assessment, were designed to explore not only how much is invested in harm reduction, but how it is invested, from a variety of perspectives. Each assessment was conducted in six sentinel countries: Belarus, Georgia, Kazakhstan, Lithuania, Moldova, and Tajikistan, which represent a range of eligibility for Global Fund funding.

The financial analysis, designed by the USAID and PEPFAR-funded Health Policy Project in collaboration with EHRN, was conducted by national financial experts to assess current investment levels and costs in harm reduction programs, as well as future resource requirements in comparison with resources currently available. This analysis utilized three distinct yet integrated tools: an expenditure tracking tool, a unit costing tool, and a funding gap tool. These tools show disaggregated and detailed results, and are comprehensive in that they capture direct and indirect costs and expenditures across multiple categories, differentiate sources of funding, allow for comparability across countries due to standard definitions and methodology, and facilitate prioritization as harm reduction activities are classified as high, medium or low priority. Using the tools to build funding scenarios that reflect the necessary scale-up and improvement of harm reduction programs and transitions to domestic funding, financial experts and civil society at national or sub-national levels can use the results to inform planning, advocacy, and implementation of harm reduction programs. A total of 104 NSP sites and 59 OST sites were surveyed across the six sentinel countries. This report does not present an exhaustive analysis of findings from these sites, as detailed findings are presented in country reports; rather it highlights some of the key findings to inform regional-level advocacy for sufficient, strategic and sustainable harm reduction funding.

The community-led assessment of service quality and priorities had dual aims of building PWID community capacity and formally documenting service quality issues that require attention through further investment and greater political will. Led by community groups, the two-part assessment included structured discussion and qualitative data collection at PWID community sessions and the administration of questionnaires to assess five elements of quality: accessibility, acceptability, continuity, linkage to other services, and safety. The assessment was conducted by PWID community groups, who were trained by EHRN project staff in use of the assessment instruments. A total of 68 discussion groups were held.

3 Sentinel countries range from high income (Lithuania), upper middle income (Kazakhstan, Belarus), upper-lower middle income (upper – Georgia), lower-middle income (lower – Moldova), to low income (Tajikistan).
4 For further details on the methodology, the financial tools and their user guides are available on the EHRN website: http://www.harm-reduction.org/library/methodology-assess-harm-reduction-funding
5 Further details on the service quality assessment methodology are available on the EHRN website: http://www.harm-reduction.org/library/methodology-assess-and-monitor-access-harm-reduction-services
including 612 participants, with a further 1,829 questionnaires completed. 1,310 of the questionnaires were completed by NSP clients, while the remaining 519 were completed by OST clients; 77% of questionnaires were completed by male respondents, and 23% of respondents were female. As with the financial analysis noted above, this report does not present an exhaustive analysis of all data from this assessment, more of which can be found in individual country reports; rather, it summarizes the most urgent and compelling messages that were common across countries.

LIMITATIONS

This report aims to contribute to a larger discussion on ensuring the sustainability of harm reduction in the EECA region. The methods described above, and data presented below, provide vital insight to average unit costs per client per year, as well as broad trends in service quality that were identified by clients across different service sites, and projected resource needs in sentinel countries. This report brings together data from sentinel countries in order to identify differences and similarities throughout the region, and, in some cases, to draw attention to areas where available data are highly irregular or altogether unavailable. It is intended that the data presented here be used alongside other existing data in the region, including analyses of technical efficiency and modeling scenarios, to create a rich, holistic picture of the present and future of harm reduction in EECA. Specific limitations for this report are presented below.

These assessments were the first of their kind in countries: systematic assessments of harm reduction expenditure and service quality, conducted entirely by local assessors. Preparation for the assessments involved capacity building for each assessment group, and EHRN provided assessment methodologies and ongoing technical support for assessors after initial training, supporting the process of conducting the assessment as a ‘learning by doing’ experience. While this experience is considered critical for building local capacity to assure sustainable monitoring, evaluation and assessment led by local actors, the first-time status of both assessors and the assessment protocols made some elements of data collection challenging.

In particular, financial assessment limitations are acknowledged as follows:

1. Because this effort, while locally-driven, was not part of a government-required exercise to assess costs, data sets received from some sites were incomplete, and in some cases sites were not responsive to verifying data. For future assessments of this type, full government support and mandate would be likely to yield better response rates.
2. Many countries used a sample of harm reduction sites to estimate costs and expenditures rather than conducting a census of all NSP and OST sites in the country. As a result, total harm reduction expenditures are extrapolated based on the sample and may be imprecise, and cost estimates may not be generalizable to the whole country. The sampling approach may over- or under-estimate expenditures due to site variations, such as clients receiving more or fewer services; differences in the types of services delivered; differences in compositions of staff teams and in operating hours and days; or structural barriers and other exogenous determinants that would lead to differing costs. This was particularly of concern for NSP costs in Kazakhstan and Tajikistan, and OST costs in Georgia and Lithuania, where some sampled sites’ results varied significantly from expectations.

3. The unit costing tool has limited ability to capture above site-level costs, which can be significant. For example, due to lack of clarity and standard operating procedures for central management of harm reduction services, some indirect expenditures were subject to estimation, and may have suffered inaccuracy. As a result, cost projections could be underestimating true resource requirements.

4. None of the sentinel countries sampled have a defined level of effort or existing time-use data on staff providing NSP and OST, making it challenging to estimate staff time inputs per client or service. This affects unit cost calculations. As these inputs affect calculations of expenditure, unit costs, and projections, inaccurate base assumptions may ripple through calculations and result in significant impacts on unit costs. To address this, for the purpose of this exercise, assessors conducted direct observation of staff using the time-motion method or via inquiry of staff working in service provision; however, in the latter case staff may have overestimated the time invested in a single client, whereas in the former case staff might have modified their performance in response to their awareness of being observed (Hawthorne effect).

5. Harm reduction expenditures and costs in prison settings are excluded from the analysis. Financial assessments in these settings should be conducted in order to plan for comprehensive harm reduction.

For the community-led assessment of quality of services, the following were considered to be the primary limitations:

1. Recruitment for assessment participations was voluntary and done through word-of-mouth. Therefore, sampling was not random, and participants were limited to those who are already reached by existing services. These individuals’ experiences may not be representative of all clients.

2. Attracting clients who are willing and able to sit through community meetings and surveying can be challenging, especially without
incentives for participation. In terms of data quality, this may mean that clients who are hardest to reach with services were not engaged in these exercises; they may require even lower threshold services than those who participated in this assessment.

3. Attracting younger clients, particularly to complete questionnaires, was challenging. As discussed in more detail below, findings presented here may not adequately reflect the needs of young PWID.

4. Some clients found the assessment concepts and language used in questionnaires to be confusing. While assessors tried to address this with supplementary explanations, it is possible that lack of understanding limits data reliability.

5. Assessment teams also found that entry of data into Excel forms was challenging, indicating need for continued capacity building.

“Participants were surprised and shocked. ‘Who else is thinking about us? And is spending time and money on drug users?’ [After showing a video about harm reduction programs] it was a key moment to open a platform for discussion of why certain programs are absent or ineffective. Through this meeting, PWID realized their importance and significance of each voice in the formulation of the problem, advocating for solutions, and participating in projects and programs.”
Current Challenges in HARM REDUCTION

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Harm reduction funding is not sufficient, strategic or sustainable.

We need:

- Increased Investment
- Community Involvement
- Well-Planned Transitions
MAIN FINDINGS

In conducting these assessments, the community of PWID and their stakeholder allies have amassed considerable amounts of primary and secondary data that will be used at the country level to further improve advocacy, planning and implementation. This report showcases the main findings that can best inform the coordination and implementation of regional level advocacy efforts, and guide regional trends to assure that harm reduction is sufficient, strategic and sustainable.

1. INCREASED COVERAGE IS STILL NEEDED FOR NSP AND OST PROGRAMS.

Desired coverage levels must be a core consideration for planning investments and programming in harm reduction. In order to reverse an HIV epidemic, WHO/UNODC/UNAIDS guidance (2009, 2012) recommends that 60% of all PWID be reached regularly by NSP, while 40% of all opiate users be enrolled in OST\(^6\).

In the sentinel countries surveyed for this report, 2013 data showed that most countries were not meeting optimal coverage levels for either NSP or OST. While Kazakhstan reported 59% coverage for NSP, coverage in other sentinel countries ranged from 12% to 38%. Though these coverage levels constitute considerable improvements in many countries, where communities of PWID have worked tirelessly to increase the number of people reached each year, more people must be reached to have a considerable impact on the HIV epidemic.

Figure 1a: Actual NSP Coverage vs. Recommended Coverage Levels

<table>
<thead>
<tr>
<th>Country</th>
<th>Current Coverage</th>
<th>Coverage Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belarus</td>
<td>37.6% 22.4%</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>11.7% 48.3%</td>
<td></td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>59.2% 0.8%</td>
<td></td>
</tr>
<tr>
<td>Lithuania</td>
<td>21.4% 38.6%</td>
<td></td>
</tr>
<tr>
<td>Moldova</td>
<td>28.1% 31.9%</td>
<td></td>
</tr>
<tr>
<td>Tajikistan</td>
<td>37% 23%</td>
<td></td>
</tr>
</tbody>
</table>

\(^6\) Targets of 40% coverage for OST are based on outcomes of the HIV epidemics in countries with well-established OST programs.
In addition, as will be explored in further findings, these statistics do not reflect the quality of services – e.g., each country has its own definition for what constitutes coverage, and these definitions do not necessarily consider whether individuals are reached often enough to meet their needs, or to effectively prevent transmission of HIV; nor does it consider the range or quality of services provided to those who are ‘covered’ by NSP.

On the other hand, 2013 OST coverage ranged from less than 1% to 11%, exposing a significant gap between reality and the optimal target of no less than 40%. While countries such as Belarus, Georgia and Lithuania have made marked progress in scaling up the number of OST sites – resulting in more significant coverage levels at 6%, 8% and 11%, respectively – the remaining sentinel countries maintained coverage levels of under 2%, indicating the need for massive scale-up in order to reach target coverage levels.

![Figure 1b: Actual OST Coverage vs. Recommended Coverage Levels](image)

The number of NSP sites available to provide harm reduction services, relative to PWID population size, varied significantly by country. In Georgia, there is just one NSP available for every 3 214 PWID, and in Belarus, one site for every 2 344 PWID. Meanwhile, each site correlated to just 458 PWID in Lithuania, and to only 462 PWID in Tajikistan; the remaining countries fell in the middle range, as shown in Table 1, below.

7 Simple ratios are calculated using data displayed in Table 1 and Table 2. Ratios do not account for distribution of PWID or sites, geographically.
Table 1. Number of NSP Sites in Relation to Total PWID Population

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of NSP Sites</th>
<th>Estimated Number of PWID</th>
<th>Ratio of NSP Sites to PWID</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia</td>
<td>14</td>
<td>45,000</td>
<td>1:3,214</td>
<td>4 of 14 sites in capital</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>151</td>
<td>112,740</td>
<td>1:747</td>
<td></td>
</tr>
<tr>
<td>Moldova</td>
<td>28</td>
<td>30,200</td>
<td>1:1,079</td>
<td></td>
</tr>
<tr>
<td>Tajikistan</td>
<td>50</td>
<td>23,100</td>
<td>1:462</td>
<td>24 at NGOs, 26 at government facilities</td>
</tr>
<tr>
<td>Lithuania</td>
<td>12</td>
<td>5,500</td>
<td>1:458</td>
<td></td>
</tr>
<tr>
<td>Belarus</td>
<td>32</td>
<td>75,000</td>
<td>1:2,344</td>
<td>20 at NGOs, 12 at government facilities</td>
</tr>
</tbody>
</table>

Ratios of OST sites per population also varied by country, ranging from one site per every 289 PWID in Lithuania to one site per every 14,093 PWID in Kazakhstan, as shown in Table 2.

Table 2. Number of OST Sites in Relation to Total PWID Population

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of OST Sites</th>
<th>Estimated Number of PWID</th>
<th>Ratio of OST Sites to PWID</th>
<th>Geography Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia</td>
<td>15(^7)</td>
<td>45,000</td>
<td>1:3,000</td>
<td>8 of 15 in capital</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>8(^8)</td>
<td>112,740</td>
<td>1:14,093</td>
<td></td>
</tr>
<tr>
<td>Moldova</td>
<td>5</td>
<td>30,200</td>
<td>1:6,040</td>
<td>3 of 5 in capital</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>5</td>
<td>23,100</td>
<td>1:4,620</td>
<td></td>
</tr>
<tr>
<td>Lithuania</td>
<td>19</td>
<td>5,500</td>
<td>1:289</td>
<td></td>
</tr>
<tr>
<td>Belarus</td>
<td>17</td>
<td>18,450(^9)</td>
<td>1:1,085</td>
<td></td>
</tr>
</tbody>
</table>

These ratios indicate the scale at which each current site must perform in order to make meaningful contributions towards coverage targets. This showcases the limited **absorptive capacity** in the current programmatic infrastructure to reach the desired coverage, and indicates a need for additional sites (particularly for OST) in most countries. At the same time, it highlights the need for those **sites that may be performing under capacity** to increase their reach and retention of clients, in order to assure greater cost-efficiency with existing resources.

It should be noted that the ratios presented above do not address the **significant geographical limitations** of current programming, under which entire regions and/or sub-regions of countries remain without harm.

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8 Excludes private Suboxone® clinics.
9 Kazakhstan offers 10 OST access sites, though they are considered to be 8 administrative units.
10 OST coverage and site-to-PWID ratio in Belarus are calculated using a population size estimation for opioid users only.
reduction programs – particularly OST. Kazakhstan, for example, has only 8 OST sites for its 16 oblasts (administrative regions), and Moldova, while it has 5 sites for just over 30,000 PWID, hosts three of those sites in its capital city, leaving other regions, including the breakaway autonomous republic of Transnistria, completely without access to OST.

These figures represent national coverage averages, and do not take into account the distribution of sites throughout each country’s geography, leaving pockets where coverage of PWID is desperately low or even non-existent. Geographical expansion was noted as a priority in all six sentinel countries, including expanded mobile unit availability for more remote sites in Tajikistan; expansion of OST to Transnistria territory of Moldova; and expansion to assure at least one OST site in each of Kazakhstan’s 16 oblasts.

Overall, while countries have made progress in reaching increased numbers of PWID with NSP, OST coverage remains extremely low. Scaling-up coverage must address geographical distribution of PWID, as well as the number of NSP and OST sites available. Countries have wide variation in unit costs for NSP and OST programs due to differences in the types of services provided, and the percentage of clients who receive services.
In Support of Scaling-Up Coverage Alongside HIV Testing and Treatment

Recent cost-effectiveness analyses supported by UNAIDS (2015) in five out of six sentinel countries supports the need for scale-up of NSP and OST services, and highlights the cost-effectiveness of this approach alongside increases in HIV testing and antiretroviral treatment, as called for in the UNAIDS 90-90-90 targets*.

In Kazakhstan and Tajikistan, study findings support the effectiveness and cost-effectiveness of scale-up of NSP and OST alongside HIV testing and ART to reduce community viral load and onward transmission of HIV (UNAIDS – Kazakhstan, 2015; UNAIDS – Tajikistan, 2015). Increases in all four interventions were cost-effective by the 10 year time horizon in both countries, and in Kazakhstan a combination approach in increased coverage was projected to be cost-saving within 15 years.

In Georgia, current coverage levels were assessed as sufficient to decrease HIV prevalence, but that increasing HIV screening alongside existing NSP and OST services would result in further gains (UNAIDS – Georgia, 2015), and become cost-effective at the 10-year time horizon. In Belarus and Moldova, while current coverage levels would decrease both HIV and HCV, scale-up of NSP and OST alongside scale-up of HIV testing and ART would produce more dramatic results; in Belarus, this strategy would become cost-effective in 10 years (UNAIDS – Belarus, 2015), and avoid increased expenses when compared to scaling up NSP and OST only.

These findings lend further evidence to the well-established value of harm reduction in the EECA region, while underscoring the importance of combination prevention for PWID. This report focuses on safeguarding the future of NSP and OST in the region, as critical components of this combination prevention approach.

*UNAIDS’ 90-90-90 strategy calls for 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression by the year 2020. (More information at: http://www.unaids.org/en/resources/documents/2014/90-90-90)
2. COUNTRIES HAVE WIDE VARIATION IN UNIT COSTS FOR NSP AND OST PROGRAMS DUE TO DIFFERENCES IN THE TYPES OF SERVICES PROVIDED, AND THE PERCENTAGE OF CLIENTS WHO RECEIVE SERVICES.

The cost of serving an individual client\(^{11}\) with NSP and OST services varies greatly from country to country. Some variation in unit costs should be expected across a range of economically diverse countries: higher personnel costs may be expected in more economically developed countries; procurement costs may vary based on the type and quality of commodity procured (i.e. methadone versus buprenorphine) as well as procurement mechanism used; and economies of scale dictate that the larger the population served, the greater the division of costs (i.e. facility overhead costs) across clients. However, as we will explore below, the variations observed in sentinel countries were mostly the result of differing approaches to service delivery, including differing standards of care and prioritization of key services and commodities. This differentiation, and its financial impact, has important implications for planning cost-effective services and optimizing efficiency.

In project countries, unit costs for NSP per client per year\(^{12}\) range from just $38 in Belarus and $48 in Moldova to $110 in low-income Tajikistan, $240 in Georgia, $247 in Kazakhstan, and $332 in Lithuania.

**Figure 2a: Comparative NSP Unit Costs**

<table>
<thead>
<tr>
<th>Country</th>
<th>Unit Cost per Client per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithuania</td>
<td>$332</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>$247</td>
</tr>
<tr>
<td>Georgia</td>
<td>$240</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>$110</td>
</tr>
<tr>
<td>Moldova</td>
<td>$48</td>
</tr>
<tr>
<td>Belarus</td>
<td>$38</td>
</tr>
</tbody>
</table>

\(^{11}\) The Harm Reduction Unit Costing Tool used in the financial analysis provides a weighted average unit cost per NSP or OST patient per year based on the percentage of clients who receive certain packages of services and the costs by package of services. The unit cost per client consists of site-level costs, including personnel, commodities, equipment, and overhead. For further information on the categories of direct and indirect costs, please refer to the financial assessment tools, available at: http://www.harm-reduction.org/library/methodology-assess-harm-reduction-funding

\(^{12}\) All unit costs are expressed in USD. Exchange rates utilized are as follows: 1 USD = 1.65 GEL; = 185.19 KZT; = 12.59 MDL; = 2.60 LTL; = 10,215 BYR. Tajikistan calculations were made using a USD standard. The utilization of standard exchange rates was necessary for the purpose of meaningful comparison; however, it should be noted that exchange rates fluctuate over time, and real values of past expenditures or future investments may differ.
Similar variation is observed in OST unit costs. Kazakhstan has the lowest cost per client per year at $525, followed by Tajikistan at $553, Belarus at $612, Moldova at $682, and Georgia at $1,372. Data on unit costs of OST services in Kazakhstan were not available for comparison due to limitations discovered during data collection.

Simple examination of unit cost, while instructive for making broad comparisons throughout the region, does not reflect variations in service that may have a significant impact on service quality – such as the package of services included for each client, average number of client visits to NSP sites to receive core services, service delivery models and the amount or structure of staff time included. Further examining such constituent elements within unit costs gives us a clearer picture of some of these cost drivers.

Table 3. NSP Unit Cost Components by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Needles and Syringes</th>
<th>HIV tests</th>
<th>Condoms</th>
<th>Direct Staff</th>
<th>Other Direct Costs</th>
<th>Indirect Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belarus</td>
<td>$6.05 (16%)</td>
<td>$1.60 (4%)</td>
<td>$1.29 (3%)</td>
<td>$13.00 (35%)</td>
<td>$4.06 (11%)</td>
<td>$11.00 (31%)</td>
</tr>
<tr>
<td>Georgia</td>
<td>$15.40 (6%)</td>
<td>$0.62 (&lt;1%)</td>
<td>$1.95 (&lt;1%)</td>
<td>$67.00 (28%)</td>
<td>$107.03 (45%)</td>
<td>$48.00 (20%)</td>
</tr>
<tr>
<td>Lithuania</td>
<td>$30.00 (9%)</td>
<td>$6.70 (2%)</td>
<td>$7.50 (2%)</td>
<td>$16.00 (5%)</td>
<td>$132.50 (40%)</td>
<td>$139.50 (42%)</td>
</tr>
<tr>
<td>Moldova</td>
<td>$11.72 (24%)</td>
<td>$10.33 (21%)</td>
<td>$1.60 (3%)</td>
<td>$11.83 (24%)</td>
<td>$6.47 (13%)</td>
<td>$6.61 (14%)</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>$24.60 (22%)</td>
<td>--</td>
<td>$13.80 (13%)</td>
<td>$21.90 (20%)</td>
<td>$31.50 (29%)</td>
<td>$18.50 (17%)</td>
</tr>
</tbody>
</table>

Direct costs, defined as costs that are directly related to specific harm reduction activities, comprise the majority of countries’ NSP and OST unit costs. Direct costs for NSP, which include but are not limited to needles and syringes, condoms, HIV tests, and direct staff (outreach workers, social workers, etc.), were the primary costs for NSP programs: from
58% (Lithuania) to 86% (Moldova) of the total cost. The cost of needles and syringes ranged from to $65.05 (16%) 90 per client per year in Belarus to $30.00 (9%) per client per year in Lithuania, as presented below in Table 3.

Additional commodity costs included HIV rapid test kits, which at $10.33 are 10% of total unit cost in Moldova\(^\text{13}\); while in Lithuania\(^\text{14}\) and Belarus\(^\text{15}\) HIV test costs account for only 2% ($6.70) and 4% ($1.60) of total costs, respectively. In Georgia\(^\text{16}\) HIV test kit costs are just 0.26% ($0.62) of the total; and Tajikistan does not currently include testing as part of the NSP package.

**Figure 3a: Composition of NSP unit costs (abs.)**

13 Assuming that 50% of clients in Moldova receive two rapid HIV tests per year.
14 Assuming that 100% of clients in Lithuania receive two rapid HIV tests per year.
15 Assuming that 28% of clients in Belarus receive one rapid HIV test per year.
16 Assuming that 100% of clients in Georgia receive one rapid HIV test per year.
Costs for condom distribution as part of NSP also varies, with under 4% of total costs attributable to condom procurement in Georgia\textsuperscript{17}. Moldova\textsuperscript{18}, Lithuania\textsuperscript{19} and Belarus\textsuperscript{20}; while Tajikistan estimates 14% of average NSP costs per patient is needed for this commodity. This variety of commodity costs belies not only differing procurement costs (based on types of commodity, as well as procurement mechanisms), but also important programmatic decisions: as footnoted below, testing and condom coverage assumptions vary widely, indicating that some countries may benefit from closer adherence to internationally-recognized targets for commodity distribution.

The share of direct on-site staff costs ranges from just $11.83 (24% of Moldova’s unit cost) to $67 (28% of Georgia’s unit cost) of total costs. However, in Moldova and Tajikistan, community assessments indicated that a shortage of outreach workers is a significant barrier to accessing high-priority commodities through NSP, indicating that direct staff costs – at 24% and 20% of total unit cost, respectively – may need to be either increased as a share of program costs, or applied in a manner more responsive to client needs.

Indirect costs are also varied, ranging from just under $7 (14%) in Moldova, to $140 (42%) in Lithuania. Indirect costs include indirect personnel, non-medical equipment, and overhead at sites. Higher indirect costs may be indicative of suboptimal distribution of costs, including larger amounts of indirect staff involved in programmatic administration,

\textsuperscript{17} Assuming that 100% of clients in Georgia receive 23 condoms per year.
\textsuperscript{18} Assuming that 80% of clients in Moldova receive 60 condoms per year.
\textsuperscript{19} Assuming that 81% of clients in Lithuania receive 52 condoms per year.
\textsuperscript{20} Assuming that 92% of clients in Belarus receive 36 condoms per year.
in comparison to direct staff to interface with clients; shortages of direct staff, particularly outreach workers, are further discussed below in the findings of the community-led assessment.

Table 4. OST Unit Cost Components By Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Methadone</th>
<th>Other Commodities</th>
<th>Direct Staff</th>
<th>Other Direct Costs</th>
<th>Indirect Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belarus</td>
<td>$118.00 (19%)</td>
<td>$20.00 (3%)</td>
<td>$368.00 (60%)</td>
<td>$31.00 (5%)</td>
<td>$75.00 (12%)</td>
</tr>
<tr>
<td>Georgia</td>
<td>$816.00 (59%)</td>
<td>$25.00 (2%)</td>
<td>$356.00 (26%)</td>
<td>$4.00 (&lt;1%)</td>
<td>$171.00 (12%)</td>
</tr>
<tr>
<td>Lithuania</td>
<td>$235.00 (29%)</td>
<td>$24.40 (3%)</td>
<td>$193.00 (24%)</td>
<td>$336.60 (41%)</td>
<td>$27.00 (3%)</td>
</tr>
<tr>
<td>Moldova</td>
<td>$110.17 (16%)</td>
<td>$16.16 (2%)</td>
<td>$410.97 (60%)</td>
<td>$10.27 (2%)</td>
<td>$134.13 (20%)</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>$157.00 (28%)</td>
<td>$45.46 (8%)</td>
<td>$42.30 (8%)</td>
<td>$33.34 (6%)</td>
<td>$275.00 (50%)</td>
</tr>
</tbody>
</table>

Figure 3c. Composition of OST unit costs (abs.)
Variations were also observed when disaggregating unit costs for OST. Direct costs for OST range from 50% of total costs in Tajikistan ($278) to 97% ($789) in Lithuania. In Georgia, the purchase and storage of methadone and buprenorphine accounts for 59% ($816) of the OST unit cost, while methadone accounts for only 16% ($110) of unit cost in Moldova, 28% ($157) in Tajikistan, and 29% ($235) in Lithuania.

**Figure 3d: Composition of OST Unit Costs (%)**

<table>
<thead>
<tr>
<th></th>
<th>1372$</th>
<th>681$</th>
<th>553$</th>
<th>816$</th>
<th>612$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia</td>
<td>12%</td>
<td>26%</td>
<td>2%</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Moldova</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>60%</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>2%</td>
<td>2%</td>
<td>50%</td>
<td>41%</td>
<td>24%</td>
</tr>
<tr>
<td>Lithuania</td>
<td>53%</td>
<td>2%</td>
<td>8%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Belarus</td>
<td>16%</td>
<td>28%</td>
<td>2%</td>
<td>29%</td>
<td>19%</td>
</tr>
</tbody>
</table>

**Site staffing** costs for OST varied from 8% of total unit cost in Tajikistan, to 60% of total unit cost in Belarus and Moldova; though, notably, 19% of that staff expenditure in Moldova goes to group counseling sessions for clients. The latter is absent in other OST unit costs in sentinel countries.

There are limitations on what we can assume by examining the composition of unit costs. While some differences may be explained by economies of scale – e.g. Tajikistan’s 50% spending on indirect costs, due to low OST enrollment numbers – other differences may be due to procurement arrangements and commodity costs, while other are due to programming choices, such as the number of commodities provided per client per year. At the country level, dynamics that may drive variations in unit cost compositions relative to other countries in the region need to be examined critically.

In addition, programmatic decisions that affect unit cost composition need to be further considered in terms of effectiveness and client satisfaction. The next set of findings explores additional, service delivery-related factors for consideration in planning strategically for scale-up and sustainability of harm reduction services.
Significant difficulties arose in sourcing data to calculate some unit costs, which limits the power of the financial analysis, both at the national and regional level. While some inputs were difficult to access because of bureaucratic barriers, other inputs were entirely unavailable and had to be estimated (e.g., staff time devoted per client, as discussed above). Assessment leaders faced skepticism from some groups regarding initial calculations, and several rounds of revision were done to produce final data; in a number of cases, it was possible to reach consensus on unit costs only after extensive dialogue with numerous country stakeholders. For instance, in Kazakhstan it was possible to reach the consensus on direct costs only, and therefore full unit costs are not presented for comparison with other sentinel countries. These challenges highlight the fact that costing has not been undertaken regularly as part of considering harm reduction programs. In order to properly budget and advocate for harm reduction investments going forward, countries should formalize routine harm reduction costing exercises (e.g., every three years), and utilize financial data alongside other measures of technical efficiency and client satisfaction, as further discussed below.

3. SERVICE DELIVERY METHODS AND POLICIES ARE NOT CONSISTENTLY ORIENTED AROUND COMMUNITY NEEDS.

Delivering services in a way that make them accessible and acceptable to clients is key for uptake and retention – factors that will, ultimately, dictate the impact of harm reduction on social public health. Community-led assessments identified a variety of gaps in services that should be considered when planning services through a successful transition from international donor to domestic funding. While specific issues are based on each country’s context, there were similarities that ran across all sentinel countries, indicating that they may be instructive of larger trends that will need to be addressed throughout EECA.

One of the most frequently cited problems was lack of adequate numbers and accessibility of outreach workers. This was noted in all six sentinel countries as a significant issue: in Kazakhstan, only 43% of clients were able to find an outreach worker whenever they needed one; in Tajikistan, only 57% reported that they were able to regularly find outreach workers; and in Georgia 87% of respondents reported that they never use outreach workers, because they are simply not available. In Moldova, respondents noted that high-priority community-based HIV testing is severely limited by the low accessibility of outreach workers. This finding exposes a critical gap in the NSP infrastructure, and suggests appropriate costing and budgeting for outreach workers would be a priority for meeting client needs; additionally, creating and enforcing
standards for expected client reach per outreach worker is necessary to assure that available outreach workers are performing as expected to meet coverage targets.

“I have no possibility to go to work, because I have to travel to OST, 60 km one-way. Half a day is spent on getting the medicine. 110 GEL [$50] - my mother’s pension money - must be paid once a month for this OST. Narcology debts grow. Instead of giving me the medication for a week so that I am able to work, in couple of months they will kick me out of the program to the street.”

Georgian OST client, noting difficulties in daily transport and out-of-pocket payments for OST

Assessment participants also reported serious problems with availability and quality of NSP commodities. Specific findings varied significantly across settings – for instance, in Tajikistan, 67% of respondents noted a critical need for alcohol wipes; while in Moldova respondents noted that the addition of butterfly vein sets would provide an improvement in injecting equipment; and in Georgia, 69% of assessment participants noted sterile water for injecting as a lacking commodity. In Kazakhstan, more broadly, participants recorded poor quality of commodities – especially syringes and condoms – due to procurement mechanisms that only consider the cost, and not the quality of commodities. While each country must address its own specific shortcomings, it is clear that PWID community feedback is not regularly being incorporated into budgeting or procurement processes.

Across all six sentinel countries, two other issues related to service delivery mechanisms came up repeatedly: access to community-based rapid testing for HIV, and availability of take-home doses for methadone clients.

In addition, sentinel countries all noted that increased accessibility to HIV rapid testing in a community-based setting was a priority to help PWID access stigma-free pre- and post-test counseling from trusted outreach workers, who communicate in an accessible manner. Taken with the demand for more (or more accessible) outreach workers noted above, our findings suggest that inadequate access to outreach workers and community-based testing may be driving low rates of linkage to care and enrollment on antiretroviral treatment among HIV-positive PWID (DeHovitz et al., 2014). Given the synergistic effects of combination prevention, as discussed above, countries should further investigate potential gains in cost-effectiveness by bolstering these key mechanisms for engaging PWID in care.
In all countries, the availability of take-home doses of methadone was rated as a high priority; participants noted limited hours of OST clinics, as well as costly and time-consuming travel as major barriers to accessing daily directly-observed OST sites.

The data presented here were gathered as part of a first of its kind community-led assessment of service quality. In conducting the assessment, assessors encountered some challenges as described above in the Methods section. While data presented here should be considered valid for decision-making, ongoing community-based monitoring is needed to assess whether programmatic changes have the desired effects. In order to assure that community capacity continues to be developed, and that there is space for regular involvement of communities of PWID in monitoring of service quality, technical and financial support will be needed from the international community.

We need OST programs that allow clients the flexibility to work and revitalize their lives. We need take-home methadone doses. Now. #HarmReductionWorks

4. CURRENT HARM REDUCTION PROGRAMS DO NOT ADEQUATELY ADDRESS THE SPECIAL NEEDS OF WOMEN AND YOUTH.

While significant issues of quality of services were noted across all assessment participant groups, particular sub-populations of participants reported facing more extreme challenges in accessing acceptable services. While the new WHO consolidated international guidance on programming for key populations (WHO, 2014) gives special attention to accessibility for women and youth as vulnerable sub-populations, our findings show that program implementation still struggles to effectively serve these populations in the field.

In particular, women found it difficult to access many harm reduction services because of gender norms and lack of access to gender-sensitive programs. For example, women in Georgia – who comprise only 1.6% of Georgia’s 2300 OST clients – report that stigmatization by narcologists and nurses is such a strong barrier that it deters women from accessing services. Both lack of staff capacity to deliver sensitized services and shortcomings in the clinical environment that allows for client confidentiality were noted as serious barriers across sentinel countries.

“You almost need to cover your head if you take OST. Medical staff and male patients do not hide their scorn towards us, women who use drugs. And how can we survive without the OST?”

Female Georgian OST client
In Moldova, participants noted the lack of female outreach workers, and 30% of female assessment participants in Georgia reported having no support they could turn to inside or out of harm reduction programs. In all six countries, community members noted the need for gender-specific commodities, including female condoms, hygiene kits and hormonal birth control. In Tajikistan, only 10% of women surveyed reported access to these commodities.

In addition, countries noted barriers to services for youth, including limitations on harm reduction programs in serving minors. Out of over 2400 participants in this assessment, none were under the age of 20 years old, due primarily to restrictions on serving clients in this age range. The inability of this assessment to identify and attract a sufficient sample of youth is indicative of a larger problem in assessing youth needs, as well as meeting their needs with programmatic planning and implementation.

35% of Georgian women experienced violations of confidentiality from harm reduction staff. We need harm reduction that works for all. #HarmReductionWorks

Findings from this community-based survey are inherently limited by the current lack of accessibility and acceptability of programming for these two groups; without harm reduction services that are readily reaching significant numbers of women and youth, it is difficult to achieve adequate levels of their representation in service quality assessment studies. Therefore, while our findings are limited both by sample size and by sampling bias (reaching primarily clients who are already engaged in care), the circumstances indicate a need to urgently adapt programming aimed at reaching these groups.

5. COMMUNITY GROUPS IDENTIFIED SIGNIFICANT LEGAL BARRIERS RELATED TO ACCESSING HARM REDUCTION SERVICES, INCLUDING SAFETY AND LAW ENFORCEMENT THREATS, WHICH NEED TO BE ADDRESSED THROUGH POLICY CHANGES RATHER THAN BUDGET.

In a setting of limited resources, it is of utmost importance to assure that legal and policy structures are aligned to support harm reduction services. As with service quality issues, community-led assessments revealed a variety of issues relating to specific legal and policy environments by country, but several themes emerged to be addressed in all six countries.

The first category of these deals with the legal framework protecting harm reduction services. In Georgia, despite over a decade of
implementation, NSP is not included in any legislation or policy that protect its activities from being misconstrued as promotion of illegal drug use; NGOs cite this as a reason for outreach worker turnover, since outreach workers themselves can be targeted for carrying injecting equipment.

Similarly, though policies must be in place to support the provision of OST as a medical treatment, OST is not protected by legislation in Kazakhstan or Tajikistan, and therefore may be discontinued at any point if political will shifts – a factor undermines patient confidence in program continuation. In addition, lack of permanent registration and/or inclusion of methadone on the essential drug list is a problem throughout sentinel countries, both for assuring access in a range of geographical locations, and for protecting the status of OST programs over time. Despite being ranked as high-priority by PWID communities in all sentinel countries except for Kazakhstan\(^{21}\), naloxone is also limited in accessibility - limited in most countries by lack of inclusion in clinical protocols as a medication to prevent opioid overdoses, or by restrictions on use by non-medical staff.

Legal restrictions on who can administer HIV tests also restricts access to community-based rapid testing, particularly in Kazakhstan and Tajikistan. Despite being noted as a high priority for expansion, current legal frameworks do not allow for non-medical professionals to administer HIV tests. This severely limits potential access to a large number of PWID, who may regularly come in contact with non-governmental, non-medical outreach workers, but may be reluctant to access government health care service for testing. \textbf{HIV testing provided by NGO outreach workers} and/or social workers is necessary to ensure client-centered services – with reduced stigma, in comfortable and convenient environments, rapid testing provides timely and reliable access to knowledge of status, from a trusted service provider.

The second category of legal barriers related to \textbf{policing of drug use}, and encounters with law enforcement. In Georgia, 50% of men and 49% of women surveyed reported experiencing police harassment. In Moldova, harassment extends beyond clients: surveyed clients cite police intimidation of pharmacists, leading to refusal to sell syringes to people who are suspected of drug use; steep fines imposed on pharmacists who do not comply has led to lack of availability of syringes through pharmacies, and further stigmatization and intimidation of PWID. Assessment participants also noted fear of forcible detox as a police tactic. In Kazakhstan in 2012-2013, more was spent on drug testing of OST clients ($167 per client per year, for 24 tests per client per year) than was spent on procurement of methadone ($135 per client per year), highlighting a strong preference towards policing drug use over public health-based approaches for treating drug dependency.

\(^{21}\) In Kazakhstan, assessment participants ranked naloxone as medium priority, but it was also acknowledged that PWID have very low knowledge of what naloxone is.
While individual countries need to address specific policy and legal barriers, common barriers exist throughout sentinel countries, and strong regional advocacy and leadership will be needed to overcome entrenched interests that may resist change throughout EECA.

People who use drugs have a right to health. Police interference with harm reduction services is a violation of human rights. #HarmReductionWorks

6. WITH CURRENT COSTS AND SERVICE DELIVERY MECHANISMS IN PLACE, IMMEDIATE INCREASED INVESTMENT IS NEEDED TO INCREASE THE COVERAGE AND QUALITY OF HARM REDUCTION SERVICES.

To increase coverage to the internationally-recommended levels with rent programming costs and delivery mechanisms in sentinel countries, immediate resource needs for increased investment range from an additional $335,934 needed for NSP in Lithuania to an additional $3,277,823 needed for NSP in Georgia.

Figure 4a shows these NSP funding scenarios for 2016-2018, juxtaposing calculated resource needs with planned investments, including both domestic and international resources. Funding gaps for NSP are observed in all countries. Surpluses are rare: only Tajikistan exhibits a projected surplus for all years available, though this includes significant contributions from the US President’s Emergency Plan For AIDS Relief (PEPFAR), which cannot be used to purchase critical NSP commodities; and Belarus experiences a significant modest surplus in 2016, but it quickly becomes a 6-digit deficit by 2017. In 2017, Georgia experiences a brief and minor surplus ($570), but by 2018 experiences a deficit almost twice the size of committed funds.

With improved technical efficiency, countries may be able to achieve significant cost-savings and achieve greater return on investment, affecting the amount of investment needed in coming years. However, it is beyond the scope of this analysis to proposed scenarios for increased technical efficiency that would affect resource needs; therefore, resource needs are calculated assuming continuation of current service delivery mechanisms. This should in no way discourage countries from striving for improved technical efficiency to increase returns on investment.

Forward-looking resource needs and projected investments are not currently available for Kazakhstan.

Resource needs and projected investments for 2018 are not currently available for Tajikistan.

Calculated resource needs are based on planned levels of coverage, which vary by country. More details on each country’s scale-up scenario is available in country reports.

For Lithuania, no planned investment levels were available, so data is presented assuming that 2013 funding levels are maintained.

Figure 4b depicts resource needs and projected investments for OST, exposing them as less uniform. Projection data are not available for Kazakhstan and Lithuania, and Tajikistan data are available only for 2016 and 2017. Data for Kazakhstan only include direct costs of methadone. Only Belarus and Georgia appear to trend towards sustainable financing, moving from small sizeable deficits to small surpluses from 2016 to 2018. However, a strong note of caution should accompany interpretation of Georgia’s investment projections: a full 39% of projected funding for OST comes “other” private sources, and are currently assumed to be paid out of the pocket of OST clients themselves. There is no international experience showing this client-paid model of providing OST to be feasible for sustainable funding of OST programs, and this assumption of client cost-sharing may pose a threat both for sustainability and, more significantly, for the program’s ability to attract and retain clients.
Figure 4b: Resource Needs vs Planned Investment for OST 2016–2018

These data reflect the calculated need versus projected funding. There is a significant risk that funding that has been committed may not be realized. In particular, the large amounts of funding committed by the United States government to supporting Tajikistan’s harm reduction programs could dramatically alter the funding landscape if not fully delivered, or not committed strategically to support program implementation – e.g. through direct support of service delivery for prevention, rather than for technical assistance or other indirect support. In order for countries to responsibly project their resource needs, it is vital that donor partners clearly communicate and commit to how much funding will be available, and precisely how it will be spent to support harm reduction programming.

7. WITH CURRENT COST PROJECTIONS AND WITHOUT DONORS, THE GAP IN HARM REDUCTION INVESTMENTS WOULD TOTAL OVER $13.6 MILLION IN 2016 ALONE.

While the gap between calculated resource need and committed funding is significant in itself, the picture of harm reduction investments becomes rather more alarming when committed funds are examined by source: domestic versus international.
Figures 5a and 5b, below, mirror Figures 4a and 4b, above – but distinguish domestic funding from international donor resources. In most sentinel countries, projected domestic contributions for NSP are alarmingly low: Georgia has no projected contributions through 2018, and all other countries maintain domestic contributions of well under 25% for the projected futureand Moldova and Tajikistan project domestic contributions that are below 15% and 2% of total committed funding, respectively. Only Lithuania and Kazakhstan provide funding fully from domestic sources; however, it should be noted that the currently projected amounts meet less than 40% of need in Lithuania whereas in Kazakhstan projected funding will cover the whole calculated need in NSP. Belarus, on the other hand, offers some cause for hope, with its domestic contribution rising from just 5% of total committed funding in 2016 to 74% of total committed funding in 2018 (at which point total committed funding will meet 97% of calculated need).

For OST, projected domestic contributions are hardly better, ranging from 1.5% in Tajikistan to 77% in Belarus and 79% in Georgia for 2016. By 2018, all three sentinel countries for which projections are available have committed to significant increases in domestic funding for OST – though it must again be noted that in Georgia this includes significant contributions from out-of-pocket payments from OST clients, a potentially dissuasive burden for PWID.
It is a most concerning scenario to consider national harm reduction programs without the current, promised level of external donor support: in 2016 countries would experience gaps of up to 100% for NSP (Georgia) and up to 98% for OST (Tajikistan). In these two cases alone, this would amount to over 6,000 clients without services immediately, and over 36,000 clients potentially in need\(^{28}\). Thus while international donor funding allows for a sense of security in funding in the coming years, transition plans must account for a stark reality in the absence of international funding.

Additionally, it must be noted that, historically and in future commitments, domestic expenditures do not necessarily cover a portion of all line items for harm reduction services. For instance, while Moldova covers 9% of OST costs, that investment does not include any direct support for the purchase of methadone. Likewise, Tajikistan's 1.56% projected investment in NSP does not include commodities. This is important to take into account for the purposes of both systems strengthening (e.g. developing supportive policy and building procurement systems for methadone), and also political commitment to funding core aspects of harm reduction programs, including basic commodities.

\(^{28}\) Assuming that 60% of Georgia's 75 000 PWID need NSP, and 40% of Tajikistan's 23 100 PWID need OST.
### Improving Investments in HARM REDUCTION

#### ESTABLISH PLANS FOR RESPONSIBLE TRANSITION

<table>
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<tr>
<th>PLANS DRIVEN BY DATA</th>
<th>INCREASED COVERAGE</th>
<th>IMPROVED SERVICE QUALITY</th>
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<td>National governments, including Ministries of Health and Finance, with the participation of communities of PWID, must create and implement data-driven transition plans to assure adequate domestic funding for harm reduction services.</td>
<td>Transition plans must guide national governments and international donors to actively and urgently invest in harm reduction to achieve targets recommended by WHO/UNAIDS/UNODC.</td>
<td>Transition plans must guide national governments and international donors to invest in improvements in the quality of harm reduction services to meet client needs and improve cost-efficiency.</td>
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- Regularly track harm reduction expenditure
- Address geographic gaps
- Reach and retain clients
- Invest more strategically
- Safeguard service quality
- Support scale-up
- Support legislative changes
- Support PWID-led monitoring

#### ADDRESS LEGAL & POLICY BARRIERS

National governments must diligently and swiftly make amendments to legal and policy barriers that prevent available harm reduction funding from being used in a cost-effective manner.

- Establish legal protections
- Support legal redress
- End extreme policing

#### SUPPORT TRANSITION WITH INTERNATIONAL RESOURCES

International donors must use their influence to assure that transition plans are adequate to support high-coverage, high-quality harm reduction in an enabling environment.

- Support scale-up
- Support PWID-led monitoring

Harm reduction is sufficient, strategic & sustainable.
In order to build a harm reduction investment environment that is sufficient, sustainable and strategic, we need action from both national and international decision-makers. The following key advocacy messages arise from the assessment findings above.

MESSAGE #1: National governments, including Ministries of Health and Finance, and with the participation of communities of PWID, must create and implement data-driven transition plans to assure adequate domestic funding for harm reduction services.

In sentinel countries alone, over 291,000 lives are at stake as Global Fund and other donors scale-back and withdraw from EECA countries. In order to maintain adequate harm reduction funding throughout this transition, national governments must develop realistic, data-driven transition plans to gradually take responsibility for providing sufficient, strategic and sustainable harm reduction services.

At a minimum, transition plans must:
1. Involve PWID in planning through producing realistic estimates of the unmet need for evidence-based harm reduction services and defining priority items for a policy change agenda and financing;
2. Utilize accepted international targets for NSP (60%) and OST (40%) as goals for scale-up of services; and
3. Allow for direct financing of civil society, through social contracting or similar mechanisms, to deliver harm reduction and HIV and TB services to PWID.

In addition, countries must critically examine their current spending and budgeting in a systematic way. There are three elements recommended to achieve this:

Regularly Track Harm Reduction Expenditures
One of the most powerful limitations in the assessments described above was the lack of available data on harm reduction expenditures. Many expenditure data, particularly for staffing, were not available at a local or centralized level. In order to effectively track expenditures, governmental authorities at Ministries of Health and Ministries of Finance must work together to create systems that allow for both centralized and local attribution of expenditures to harm reduction programming, and include both governmental- and non-governmental-run programs. These data can then be used for accurate, responsible budgeting to maintain and scale-up harm reduction programs throughout transitions.

29 Using latest available estimates as of 2013, there are 291,000 PWID across the six sentinel countries surveyed.
Conduct Periodic Costing Exercises

With more reliable expenditure data available, countries should regularly undertake costing exercises to examine changes in unit costs over time. With scale-up to meet more ambitious targets, countries can expect to achieve economies of scale on some services, and may be able to redirect cost savings elsewhere. In addition, as client needs change or programmatic indicators show improved or declining performance, strategic decisions may need to be made about cost allocations to adjust programming quality. Special attention should also be paid to cost-savings associated with different service delivery mechanisms, e.g. governmental versus non-governmental, and community versus facility-based (see more details on this under Message #3). In order to support effective budgeting, variations in unit costs may also need to be considered to support appropriate adaptations to the standard packages of services for different sub-sets of programming - including different geographies and different populations served. It is recommended that these exercises be undertaken, at a minimum, every three years, as part of strategic planning and mid-term review processes.

Coordinate Budgeting with Regular Community-led Monitoring and Evaluation

In order to inform changing trends in expenditure and unit costs over time, financial data must continue to be cross-checked with data on client satisfaction and experience with service quality. Routine, ongoing community-led monitoring should be considered as part of regular programmatic monitoring, as described in national M&E plans. In addition to this, it is advised that a full-scale community-led evaluation of service quality be conducted in the same time-frame as costing exercises, e.g. no less than once every three years, to assess any changes in client experience that can be linked to changes in investment and implementation patterns. These efforts may be conducted alongside assessment of technical efficiency, and in concert assure that funds are being spent in a way that gives maximum return for investment. This element of transition and responsible programmatic monitoring is essential to guard against assumptions that cost-savings are always beneficial, or that increases in spending are always due to waste; in reality, optimization of investments should find the nexus between efficient expenditure and effectiveness of services - from both a technical and client perspective.

For better harm reduction, we need stronger, data-driven budgeting with PWID communities front and center #HarmReductionWorks

MESSAGE #2: Transition plans must guide national governments and international donors to actively and urgently invest in harm reduction to achieve coverage targets recommended by WHO/UNAIDS/UNODC.
With average NSP coverage well below the WHO-recommended target of 60% in five out of six sentinel countries, and with OST coverage at extremely low levels (<0.3% to 11%) in all six countries, action must be taken to scale-up these core harm reduction services now.

Reaching the recommended coverage levels of 60% for NSP and 40% for OST will require improved service efficiency, increased resources and broadened geographic coverage; in most settings, significant expansions of outreach will be needed.

**Address Geographical Gaps**

In order to facilitate this scale-up and reach the recommended coverage targets, countries will need to systematically map areas where PWID are active and assure that harm reduction is available not only in capital cities, but in all geographic locations in need. Expansion of OST should be made a particular priority, as should accelerating the practice of take-home doses, which will help OST sites to serve a broader range of clients and better facilitate their more successful social reintegration.

**Construct Scale-up Scenarios**

To assure that commitments translate into action, countries should include WHO-recommended targets in their national strategic plans, and should assure that a targeted, line-item budget is included for both NSP and OST activities. Where coverage levels are still low, budgets should reflect a well-planned, step-wise scale-up to meet targets. Scale-up plans should be made taking into consideration geographical expansion, as discussed above. National monitoring and evaluation frameworks should also be updated to reflect more ambitious targets, and harm reduction indicators should be considered as a central part of measuring of the national HIV response.

**Support Scale-up with Strategic Investment**

International donors, including the Global Fund, must assist EECA countries to bridge the gap in their budgets, and steward the scale-up of harm reduction programs to levels that translate into HIV prevention impact. However, this is not just a matter of increased funding. In situations like Tajikistan’s, where a budget surplus is predicted for all of 2016-2018 at current levels of coverage, and Georgia, where projected OST investments will result in a surplus by 2018, surpluses can and must be investment in improving quality of services, or – in the case of Georgia, where a 2018 OST surplus will be experienced alongside an NSP shortfall of almost $2 million – reallocation of planned investments to other areas of programming to ensure a continuum of all required services. All resources must be committed strategically to address identified bottlenecks, and technical support must be available to build absorptive capacity of human and institutional resources in countries. Increased budget for, and training of, outreach workers must be considered to address bottlenecks in NSP
scale-up, while adequate stocks of high-priority commodities must be available to assure that outreach has maximum impact.

**To get maximum value from investments to date, EECA must meet plan for 60% NSP and 40% OST coverage from national budgets. #HarmReductionWorks**

**MESSAGE #3:** Transition plans must guide national governments and international donors to invest in improvements in the quality of harm reduction services, in order to meet client needs and improve both technical efficiency and cost-efficiency.

While additional funding is needed for increased coverage by NSP and OST programs, attention is also needed to the quality of harm reduction services and to maximizing resource utilization to ensure the greatest return on investment. Community-led assessments outline a number of service quality issues that must be addressed by both increased financing and more optimal use of existing financing.

**Reorient Service Delivery Around Reach and Retention**
In order to assure that services meet client needs enough to attract and retain them – and ultimately prevent and treat HIV infection – transition plans will need to commit to funding services and service-delivery models that are client-oriented. This means addressing the quality of NSP commodities, as well as improving service delivery mechanisms like the provision of take-home doses and availability of naloxone through outreach workers. Gender- and age-sensitive services will also need to be strengthened, including prioritized budget items to meet the needs of these groups. In addition, services should be adequately linked to other elements of combination prevention, including community-based testing and antiretroviral therapy, and play a supportive role in helping HIV-positive PWID to attain viral suppression.

**Expand Social Contracting Mechanisms**
In order to assure that clients have access to peer-driven services, which they trust and are willing to utilize, and that outreach programs are sufficiently funded – including scale-up in the number of outreach workers – social contracting mechanisms and other forms of state support for NGOs as HIV service-providers will need to be created or expanded. As international donors exit the funding scene, national governments will need to assume the responsibility of funding of NGOs as core service providers for NSP and – assuming that policy barriers are removed – for front-line testing for HIV through rapid testing technology. Funding for social contracting should be allocated with attention to the fact that harm reduction services are ongoing, and cannot suffer gaps; it is recommended that specific funds, based on projected coverage needs,
be allocated and made available through open competition on a regular, publicly-known basis, e.g. once per year. Funds should be available to cover all high-priority elements of harm reduction, including staffing costs for outreach workers, commodities, and organizational overheads. This will allow harm reduction organizations to plan their operational budgets appropriately, maintain coverage of clients, and conduct additional fundraising from outside sources as needed.

**Institute Safeguards to Maintain Quality**

In order to avoid declines in quality as harm reduction programs become fully owned by national governments, community-led assessments of services must be a core feature of monitoring and evaluations. In addition, countries must develop standards of practice for all harm reduction services, including those provided by governmental and NGO service providers, against which community groups and other assessors can measure staff performance. Standards should address, at a minimum, basic quantitative elements of service provision, including the optimal number and composition of both operational and program staff, the number of needles, syringes and condoms to be distributed per PWID per year, as well as guidance for how often community-based HIV testing should be offered.

Ultimately, investments in improved quality of services should have a high return, making services more cost-effective by recruiting and retaining more clients, and providing larger benefits to public health.

**Client-centered harm reduction is cost-efficient harm reduction. Fund NGO service providers to meet client needs. #HarmReductionWorks**

**MESSAGE #4: National governments must diligently and swiftly make amendments to policy and legal barriers that prevent available harm reduction funding from being used in a cost-effective manner.**

Harm reduction services will only function at full cost-effectiveness when an enabling environment is in place to allow PWID to access services safely. Establishing legal protections and addressing law enforcement barriers are a prerequisite for a successful transition and to assure sustainability of services after international donors are gone.

**Establish Legal Protection for Harm Reduction**

The first priority for assuring the safety of harm reduction programs and their clients is to assure that all elements of harm reduction are protected through appropriate legislation and policy. This means prioritizing a legal base for NSP, as well as OST, and assuring that methadone,
buprenorphine and naloxone are all included on Essential Drug Lists and are available at quantities to meet need, nationwide. Additionally, allowances for critical functions of trained outreach workers, such as rapid HIV testing and provision of naloxone, should be considered as high priority to assure that client-oriented harm reduction can function safely and without interruption.

**Establish Redress Mechanisms**

In conjunction with policy and legislative updates to protect the human and civil rights of PWID, redress systems are needed to address abuses by law enforcement, medical personnel, or others. Expansion of ‘street lawyer’ programs should be put in place to build an environment of safety and trust in which services may be accessed.

**End Extreme Policing of Drug Use**

An ultimate goal for the enabling environment should be to end extreme policing and prosecution of drug crimes. Entrenched police corruption, excessive fines, and arrest quotas are all issues that take strong political leadership to overcome.

**Client-centered harm reduction means no more extreme policing and no more threats to OST programs. #HarmReductionWorks**

**MESSAGE #5: International donors must use their influence to assure that transition plans are adequate to maintain responsible levels of funding for high-quality harm reduction.**

As noted in the Global Fund-commissioned Sustainability review, involvement of the Global Fund itself in transitions, as well as coordination with other development partners present, is a critical enabler for sustainability (Mogeni et al., 2013). In coming years of transition, while the Global Fund and other international donors remain active in EECA countries, they must use the opportunity and their remaining leverage to positively influence countries in their transition planning processes. Specifically, donors must insist on – and provide technical support for – the development of responsible, data-driven transition plans, based on partnership between the state and civil society, including PWID communities.

**Support Scale-up of Coverage**

In order to plan successful strategies for scale-up to meet recommended targets of 60% for NSP and 40% for OST, countries will need the technical and financial support of donors in the short term. Technical assistance may be needed to assist countries, particularly those who have not been included as sentinel countries in these
exercises, to build capacity and conduct costing and quality of service assessments. In addition, short-term financial support may be needed to address geographic expansion and improvement of service quality noted above, until economies of scale and improved returns on investment can be realized.

**Support Policy and Legislative Changes**

The policy and legislative changes outlined above are significant, and will require strong commitment from donors in order to move policy agendas. Preconditions for donor funding may help to persuade countries to act on policy or legislative changes that are particularly entrenched. Additionally, technical support and participation in high-level policy dialogue may be needed to assist in drafting improved policy and legislation in line with international best practices.

**Support Engagement and Capacity-Building of PWID Communities**

Finally, in order to assure that PWID networks have the capacity to participate in planning, implementation and monitoring of transition plans, international donors must continue to support networks of PWID through regional projects and special grant circumstances that allow for continued community capacity-building. In particular, support extended through *Harm Reduction Works – Fund It!* should be considered for other countries throughout EECA, in order to expand the capacity of PWID networks region-wide.

*International donors must use influence to assure successful transitions to sustainable investment in harm reduction. #HarmReductionWorks*
WHAT NEXT?

This report has highlighted main findings and limitations of first-of-their-kind, locally-led assessments of harm reduction financing and service quality. It calls for better collection and use of data for investment decision-making, and stresses the imperative of reaching adequate coverage levels as recommended by WHO in order to maximize the impact of investments. It calls for client-centered investments – both in terms of program design, and in terms of creation of an enabling environment that allows harm reduction programs to work unhindered. And it calls on international partners, from donors to technical support providers, to assist in planning and capacity-building to be sure that the environment is right for a responsible transition, in which harm reduction gains and programming are safeguarded.

These messages must now make their way off of this paper and into the minds of decision-makers at all levels.

You, as the reader of this report, are a key link in the advocacy chain. We ask that you support this movement in one of the following ways:

• Recognize your role in the Key Messages above, and commit to act in supporting countries to make a responsible transition to domestic funding.
• Tweet one of the messages prepared throughout this report, or tweet your own thoughts on your favorite finding or message, with the hashtag: #HarmReductionWorks
• Share this report by email, social media or in hard copy, with someone you know.
• Go to www.harm-reduction.org for more information on the regional campaign, “Harm Reduction Works - Don’t Quit!”

By spreading the advocacy messages outlined in this report, we’re on our way to securing the future of harm reduction in EECA through the transition to domestic funding.

We know harm reduction works. Now join us, to make sure that we fund it – sufficiently, strategically and sustainably.
REFERENCES


Global Fund to Fight AIDS, Tuberculosis and Malaria (2013) Turning the tide against HIV and tuberculosis: Global Fund investment guidance for Eastern Europe and Central Asia


[References for country reports to be inserted when citations are available.]