EURASIAN HARM REDUCTION NETWORK

THE IMPACT OF TRANSITION FROM GLOBAL FUND SUPPORT TO GOVERNMENTAL FUNDING ON THE SUSTAINABILITY OF HARM REDUCTION PROGRAMS

A CASE STUDY FROM ALBANIA

EURASIAN HARM REDUCTION NETWORK

JUNE 2016

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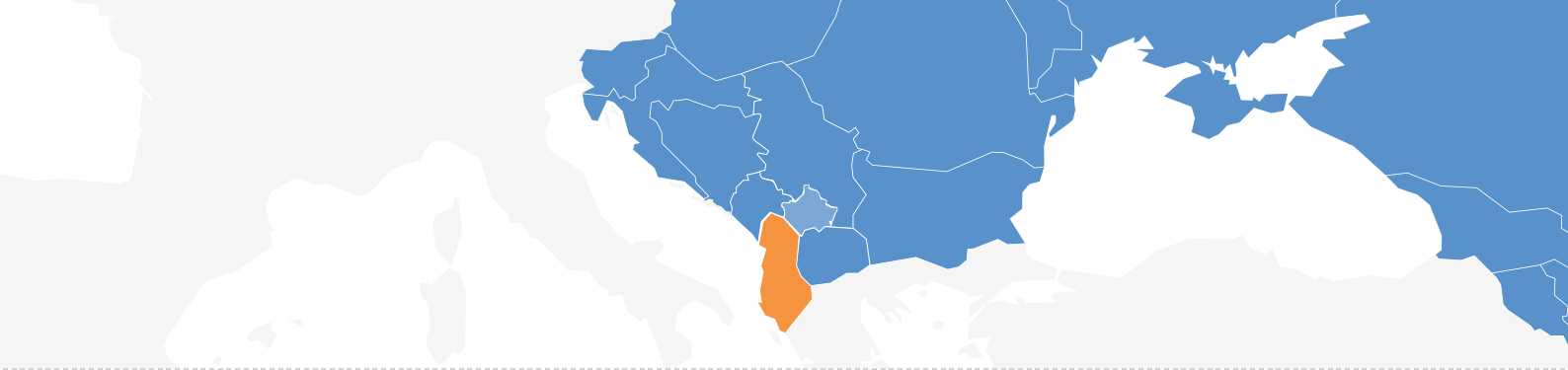

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The case study was prepared by Graham Shaw with additions from Ivan Varentsov, between March and May 2016.

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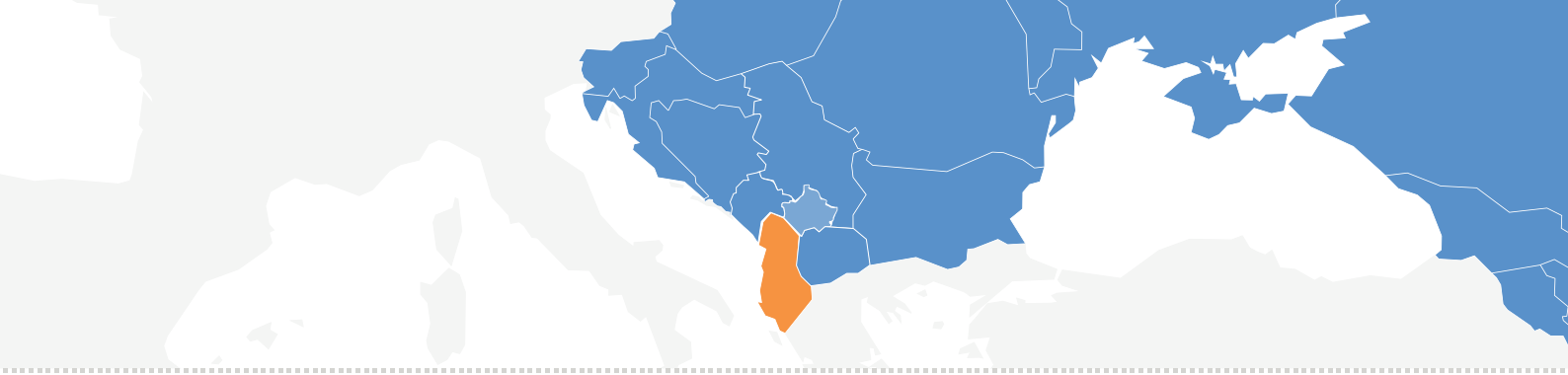


Executive Summary

Although Albania currently reports a low-level HIV epidemic, the high proportion of patients diagnosed at a late stage indicates a relatively large number of people unaware of their HIV infection. WHO, et al, have recognised that Albania is therefore likely to experience a rapid increase in the number of people diagnosed with HIV and requiring treatment over the next few years.

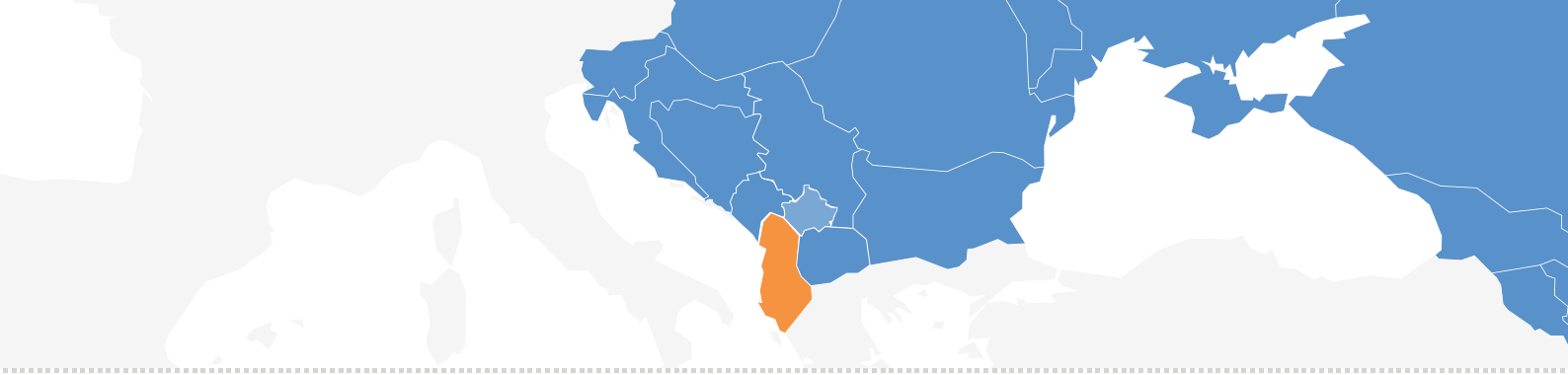
19%
Albania
readiness to sustain harm reduction interventions

Since the end of the Global Fund Round 5 grant in 2012, the Albanian Government has failed to support the cost-effective functioning of the HIV and TB programs in Albania, resulting in the degredation of services over recent years. The Government has taken over funding of some parts of the HIV Continuum of Care (CoC) for the general population - such as voluntary testing and counselling (VCT) plus first and second line antiretroviral (ARV) drugs - but has only partially supported certain aspects of the priority compoents of the comprehensive package of harm reduction interventions for people who inject drugs (PWID) as recommended by WHO, UNODC and UNAIDS, notably sterile needle/syringe programs (NSP), opioid substitution therapy (OST), rapid HIV tests in the community through outreach services, and the costs incurred by NGOs and CBOs in the referral of Key Affected Populations (KAPs) to confirmatory HIV testing and enrolment into antiretroviral therapy (ART). The only commitment to harm reduction interventions made by the Ministry of Health (MoH) is the procurement of methadone medication at an unspecified time in the future; but this commitment does not include the crucially important associated support services, including medical staff and psycho-social support personnel, without whom international good practice has shown there will likely be considerable drop-out from the methadone maintenance therapy (MMT) program in the future.

To analyze the readiness and risks of transition from donor funding of the harm reduction program to sustainable domestic financing in Albania and other countries, the Eurasian Harm Reduction Network (EHRN) and APMGlobal Health have developed a 'transition readiness tool' covering policy, governance, finance and program. Each area has nine benchmarks that capture key factors that are absolutely essential to a sustainable transition. The result is a 'readiness for transition' score, with a higher percentage score indicating a greater readiness of a country to transition fully from donor to domestic funding of its harm reduction program. Albania scores 19%, meaning that Albania shows little readiness to sustain harm reduction interventions after the end of the forthcoming Global Fund grant.

At the time of writing, negotiations were ongoing between the Global Fund Secretariat and the Ministry of Health as the designated Principal Recipient. Consequently, there are now opportunities to provide the Government with the opportunity to re-energise with the HIV and harm reduction programs, as well as to meaningfully and substantially engage in the process of transition from external funding to the use of domestic resources. Such an approach could benefit more than 5-10,000 people who use, and/or inject, drugs, and potentially stop a rapid increase in HIV if evidence-based prevention interventions - such as NSP and OST - are funded at scale in a sustainable way. Such a high impact and low cost approach will pay great dividends in the medium-to-long term in controlling HIV in Albania.

It is impractical to assume that the approved Global Fund Concept Note will result in a transition to Government funding of the HIV and harm reduction program in Albania within the next few years if the Government itself is not



given the financial and technical means to identify its role, to assess its ability to provide the necessary funding within the three-year Global Fund grant window, and the impact of the identified gaps if domestic funding is not provided by the end of that forthcoming Global Fund grant. To achieve the objective of increasing Government provision of funding to HIV and harm reduction program interventions in Albania, the Global Fund needs to assist the Government as a whole, and the Ministry of Health specifically, through the process of transition. Such support should include the development of a specific and detailed transition plan based on (1) financial resource mapping and (2) a financial sustainability plan, as well as (3) a comprehensive assessment of the Government's readiness to take on the programmatic, governance and policy-related components of the HIV program, including harm reduction. It is incumbent upon the Global Fund to stand by its rhetoric of making disbursement of funds at the end of Year 1 of the new HIV/AIDS grant conditional upon the Government producing a realistic transition plan that includes domestic funding for harm reduction interventions for people who inject drugs (PWID) in Albania.

Introduction

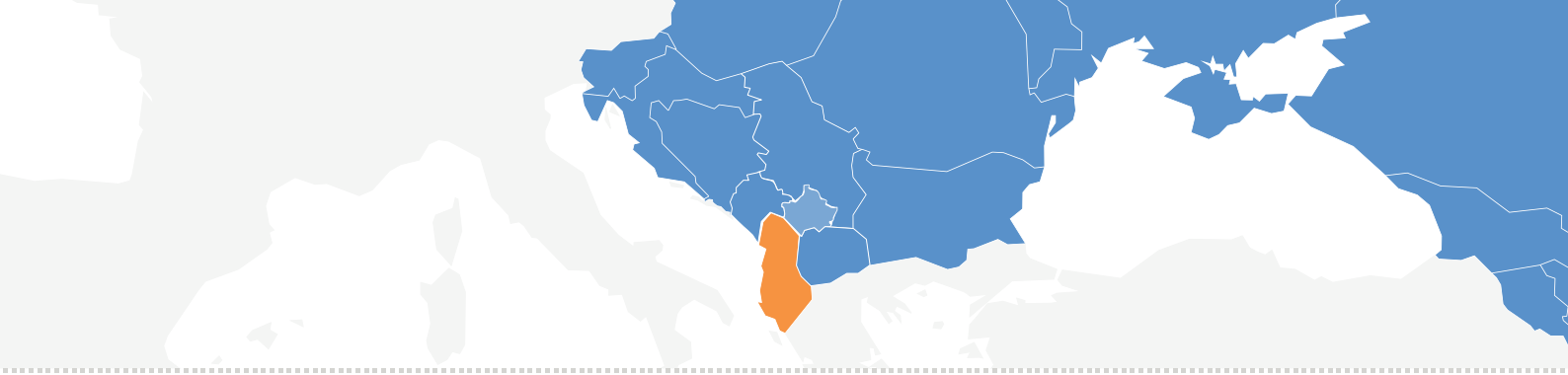
Rapid economic growth over the last decade in large parts of the Eastern Europe and Central Asia, including the Balkan area, has coincided with important economic and public health shifts that have rendered countries of the region ineligible for development assistance, in particular support from the Global Fund concerning HIV/AIDS. The exponential growth in international aid for health that was previously seen followed by the economic crisis has resulted in a decrease in donor funding available, including for HIV and tuberculosis programs.

In 2014, the Global Fund introduced the New Funding Model (NFM), a new approach to resource allocation that has transformed financing for the three diseases. In upper middle income countries (UMICs), Global Fund invests 100% of its financing to support key and vulnerable populations. According to World Bank classification, there are no longer low income countries in Eastern Europe and Central Asia (EECA), including the countries of the Balkans in Southeast Europe. Although pledges by donors to the Global Fund increased from $10.08bn. for the period 2011-2013 to $12.23bn. for 2014-2016[1], the EECA region saw an overall reduction of 15.1% as a result of the NFM allocation methodology[2]. Furthermore, the recent UN Secretary-General's report includes a table that calls for a significant pullout of international funding from Upper-Middle Income Countries (UMICs) by 2020 that could lead to dramatic consequences in terms of the spread of the HIV epidemic among Key Affected Populations (KAPs) in these countries[3].

Consequently, there is widespread concern as to how to ensure the successful transition from Global Fund supported HIV and TB programs to national funding and the sustainability of such programs, especially those programs targeted at key affected populations (KAP). As a result, EHRN decided to conduct a number of case studies in 2016 to evaluate the processes and the consequences of the transition from the Global Fund financing of the HIV response among KAP with the sustainability of harm reduction services used as an example in five Balkan countries: Albania, Bosnia, Macedonia, Montenegro and Romania.

Methodology

A **desk review** of relevant documents (both available in English and in the Albanian language) was undertaken to analyze the availability of internal and external funding for harm reduction projects in the country, as well as the processes around transitioning from Global Fund to national or other donor funding, together with sustainability planning for harm reduction and related services. This has included, for example, an analysis of Global Fund Round



5 implementation and close-out plan; the new Global Fund Concept Note; the National Strategy for the Prevention and Control of HIV/AIDS in Albania 2015-2019; the National Drugs Strategy 2012-2016; the WHO report on HIV in Albania: A National Programme Report, 2015; the EMCDDA national report on Albania, 2014; the impact of treatment and needs for qualitative improvement of the services to drug user offenders in the Probation Service, 2015; and, the National Study on Problematic Drug Users: Size Estimates and Patterns of Drug Abuse in Albania, 2014-15, amongst others.

A case study interview guide was developed by EHRN and adapted to the Albanian situation and key informants were identified and then **interviewed using skype and email**. A total of five key informant interviews were conducted including the the Ministry of Health, the National AIDS Program; the Global Fund Secretariat; the UN in Albania (UNAIDS); and one local non-governmental organization (Aksion Plus) implementing harm reduction services in Albania. Feedback on the draft case study was provided by the Global Fund Secretariat and the NGO, Aksion Plus**.**

Information and data obtained through this process was then entered into a **'Transition Readiness Tool'** developed by EHRN[4] and APMGlobal Health[5] to analyze the readiness and risks of transition from donor funding to sustainable domestic financing, identifying key barriers that must be addressed before sustainable transition is possible with a particular emphasis on assessing the sustainability of harm reduction services through and beyond the transition period.

Background

Country context

The Republic of Albania is located in SE Europe, bordering Italy via the Adriatic Sea and the Ionian Sea in the west, Greece in the south and south-east, the former Yugoslav Republic of Macedonia in the south-east, Kosovo in the north-east and north, and Montenegro in the north and north-west[6]. Albania has a surface area of 28,748 sq km's and a total population estimated at 2,886,026 (51% male, 49% female) in January 2016, of which 58% are estimated to live in urban areas[7]. The capital city, Tirana, has the highest urban population in the country with 811,649 (28.1%) of inhabitants[8]. As of 2013, gross domestic product per capita was estimated at USD 4,066.40 and gross national income per capita at USD 4,077.90[9]. The World Bank defines Albania as a middle-income country with a multi-party democracy and market economy developed over the last two-and-a-half decades[10].

Albania spends about 2.6% of GDP on health care, substantially lower than other countries with comparable income levels. As a result, out-of-pocket expenditures at the point of service accounts for about 60% of health funding, indicating that the existing health financing system offers limited protection to the general population against catastrophic illness or injury and allows for little redistribution of resources to protect the most vulnerable groups from health shocks[11].

Epidemiological situation with HIV/TB and current trends

Albania has a low HIV prevalence but data shows an upward trend in new diagnoses, suggesting a larger number of undiagnosed cases[12]. Since 1993 when the first case of HIV was diagnosed, there have been a cumulative total of 780 cases (of which 555 were male) of HIV infections reported by the end of 2014 although Albania has the lowest HIV testing rates of any country in the WHO region for Europe at 3,063 individuals in 2013[13]. Furthermore, 60% of HIV cases are reported at a late stage of the infection suggesting that most new infections may come from people

uninformed about HIV transmission or their HIV-positive status[14].

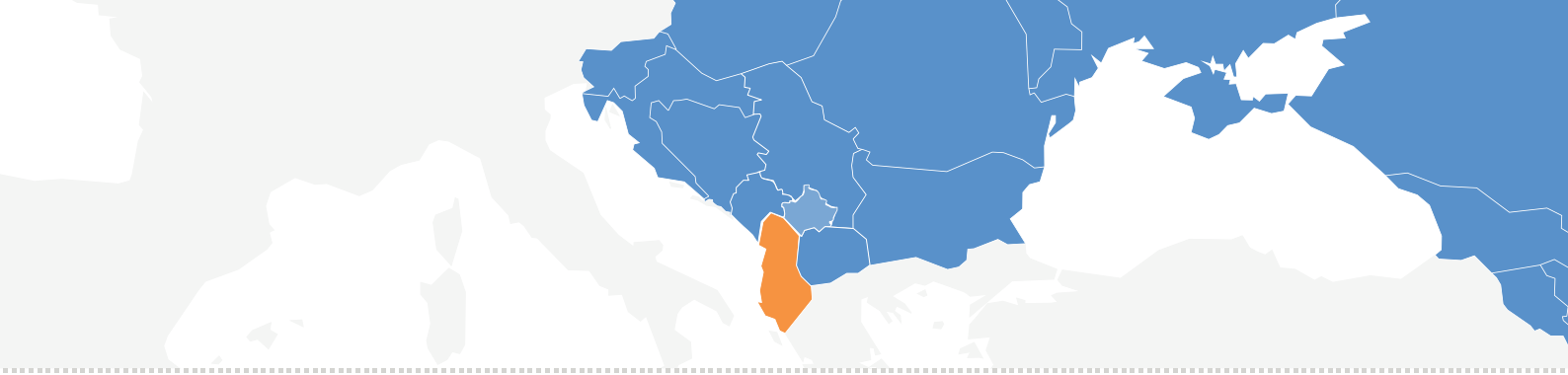
The overall number of HIV diagnoses in 2013 was equivalent to 4.3 per 100,000 population, lower than the 7.8 per 100,000 reported in the WHO European region but more than double the 1.9 per 100,000 population in the central European region. 52% of all HIV diagnoses were made in Tirana, followed by other major cities such as Durres, Elbasan and Vlora[15]. AIDS-related deaths were 0.1 per 100,000 population in 2012 and deaths due to tuberculosis among HIV-negative people were 0.64 per 100,000 population in 2013[16]. Based on HIV diagnosis data, the proportion of people living with HIV in Albania who are undiagnosed is believed to be relatively large, likely leading to ongoing transmission of the virus. There are no estimates of HIV incidence in Albania[17]. A cumulative total of 5 HIV cases were among PWID as of the end of 2014[18] but this is likely to be a substantial underestimate[19].

A 2008 study in Tirana of hepatitis C seroprevalence among PWID found that 8% of respondents (n=200) had anti-HCV prevalence[20], with more recent studies indicating an increase in HCV prevalence to 28.8% and hepatitis B prevalence among PWID at 11.5%[21]. The viral hepatitis prevention and control program within the Department of Infection and Disease Control of the MoH does not target PWID, or any other KAPs, for testing or treatment of viral hepatitis[22]. PWID are, however, included in national clinical guidelines for hepatitis C management[23]. A WHO report in 2013 notes that, "the government does not collaborate with in-country civil society groups to develop and implement its viral hepatitis prevention and control programme", although there is reportedly a national surveillance system for acute hepatitis A, B and C but not for any type of chronic hepatitis. There is no national strategy in Albania for the prevention and control of viral hepatitis although interferon alpha is on the national essential medicines list for the treatment of hepatitis C[24]. Of particular concern is that in the approved Global Fund Concept Note, the MoH is focused on the treatment of hepatitis C for PWID through the use of Pegylated Interferons rather than with Direct-Acting Antivirals (DAA) that are far more effective with fewer side effects and, in many countries (such as Egypt, Ukraine and Bangladesh), are cheaper[25]. There is, therefore, an opportunity during the grant negotiations for DAA's to be included in the list of health products to be purchased using Global Fund support rather than the less effective Pegylated Interferons.

The prevalence of TB in Albania in 2014, including PLHA with TB, was 26 per 100,000 people (with a range of 12-45) with the trend in TB cases gradually falling since 1990. The incidence of TB, including PLHA with TB, was 19 per 100,000 in 2014 (with a range of 16-22); data for key affected populations is not available[26].

Global Fund eligibility

Albania has received a cumulative total of $5,443,976 for HIV interventions from the Global Fund Round 5 (1 April 2007 to 31 March 2012) and 'Continuation of Services' (April 2012 to March 2015)[27]. In 2013 and 2014, Albania was eligible for Global Fund HIV grants with its categorization by the World Bank as being an Upper-Lower Middle Income country (Upper-LMIC)[28], resuling in $5.1m being allocated to Albania for HIV within the Global Fund's new funding model (NFM) for the period 2014-2016[29]. In 2015, Albania's categorization changed to an 'Upper-Middle Income Country' (UMIC) and, therefore, its Global Fund eligibility changed to 'transition (new)'. Albania continued as an UMIC in 2016 with its Global Fund eligibility as 'Transition (2015)', meaning that the HIV program moved into a transitional category in 2015 and that it is, therefore, eligible to make use of the existing $5.1m allocation for the period 2014-2016 and may receive one more funding allocation during the next period of 2017-2019[30]. However, it is encumbent upon Albania to have its new Global Fund HIV grant approved by the Global Fund Board before the end of 2016, otherwise it will have to await a decision on new allocations of funding by the Global Fund for 2017-2019. The decision as to whether Albania will receive further Global Fund assistance during the next allocation period of



2017-2019 is based on various factors; allocations will be announced in early 2017 and it is not yet known whether Albania will receive funds in that new allocation.

Following ongoing discussions between the Global Fund and the CCM, and revisions aimed at strengthening the sustainability of the HIV program overall, a Concept Note was approved by the Technical Review Panel (TRP)[31] so that grant negotiations can now proceed between the Global Fund Secretariat and the Ministry of Health as the nominated Principal Recipient (PR). At the time of writing, these HIV and TB grant negotiations are ongoing with the hope that a final agreement can be signed by the last quarter of 2016. Many of the stakeholders in Albania interviewed for this case study expressed considerable concern at the departure of the former CCM co-Chair, and Deputy Minister of Health, Milva Ikonomi, owing to her vision and abilities. However, the CCM Chair, the Minister of Health, has appointed an 'Adviser' to support the grant negotiations. The Global Fund Secretariat considers Albania to be a 'special case' owing to the closure of the previous HIV grant in 2012 followed by its re-eligibility and classification as a 'transition country'.

In addition, the Global Fund views the forthcoming HIV grant in Albania as an opportunity for the Government to put in place a transition mechanism by which the country will move towards fully funding and implementing its health programs - especially those targeting key and vulnerable populations - independent of the Global Fund.

Overview of the status of harm reduction in Albania

Albania is a party to all three international drug control conventions. National legislation on illicit drugs is summarized in the Albanian Penal Code (Law No. 7895) of 27 January 1995, as amended by various laws in 1998, 2001 and 2004. Of note is that the possession of a 'day dosage' of drugs for personal use is not punishable under the law[32]. An inter-ministerial 'National Committee for the Coordination of the Fight against Drugs' was established in April 2011 supported by a Secretariat and the 'Office of the National System of the Information on Drugs'[33]. The National Committee developed the 'National Drug Strategy, 2012-2016'[34]. The drug strategy includes four main pillars: (1) Strategic coordination; (2) Supply reduction; (3) Demand reduction; and, (4) Harm reduction[35]. Although OST is included in the drug strategy, there is no legislative, nor strategic, provision for sterile needle/syringe programmes (NSP) in Albania. However, through the facilitation of the UNODC office in Albania, the police have entered into agreements with local NGOs for the implementation of NSP in Tirana. Law No. 9952 on HIV/AIDS was adopted on 14 July 2008 protecting the rights of PLHA, followed in February 2011 by a Council of Ministers Decree on the prevention of HIV/AIDS and the provision of care, counseling and treatment for PLHA in a range of facilities and environments[36].

The National Program for Prevention and Control of HIV/AIDS was established by the Ministry of Health in 1987 at the Institute of Public Health (IPH) through the support of WHO[37]. There is only very limited data available on the socio-economic and health status of people who inject drugs (PWID) in Albania. The number of PWID nationwide is estimated to be between 4,000 and 8,600[38]; a slightly more recent study estimated there to be 6,182 Problematic Drug Users (PDU) (with a range of 3,626-8,737) with more than 60% reporting injecting drug use[39]. Mean and median age of starting drug use is around 18 years of age with 62% having first used drugs in their teenage years and some as early as 8 years of age[40]. However, no formal studies have been conducted amongst children and young people below the age of 15 years who use drugs. Most users have been incarcerated at least once for drug use-related issues[41]. Most PWID appear to be located in urban areas including Tirana, Durres, Vlore, Shkoder, Korca and Elbasan, with heroin the most popular illicit drug for injection[42].

HIV prevalence among PWID in 2011 was reported to be very low, at less than 0.5%[43]. PWID comprised 0.6% of all HIV infections in 2015[44], resulting in only 1-2 PWID living with HIV, although this may be greatly underestimated due

to difficulties in accessing most PWID nationwide. 17% of PWID accessed voluntary counseling and testing (VCT) for HIV in 2009, rising to 41.35% by 2011[45]. The prevalence of hepatitis C was also estimated in 2011 at 28.8% (with a range of 20.5%-37.2%)[46].

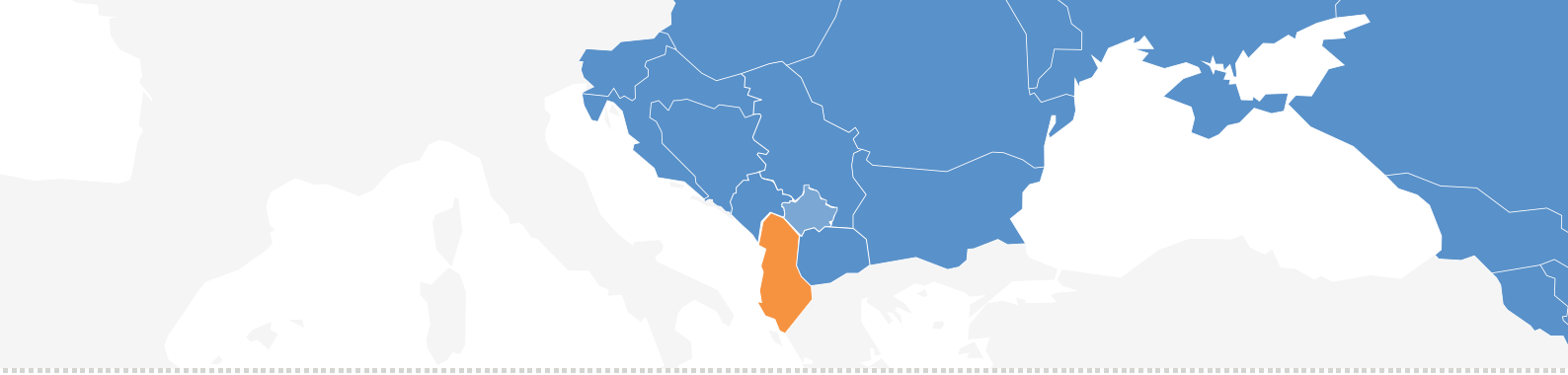
Of the seven components of the National Strategy for the Prevention and Control of HIV/AIDS in Albania, 2015-2019, the first concerns, 'maintaining the HIV prevalence among particularly vulnerable groups at one per cent (1%) until 2019'. This component includes the scaling-up of NSP and OST nationwide as well as improved access to diagnosis and treatment of HIV and other STIs and also TB and viral hepatitis, including hepatitis C. There are also activities within Component 2 ('increased coverage and frequency of HIV testing through existing VCT services and healthcare services') and Component 7 ('strengthening and improving the monitoring and evaluation system based on the epidemiological and behaviour indicators') that relate to the harm reduction program[47]. The total estimated cost of the national HIV/AIDS strategy in Albania between 2015 and 2019 is $33.2m of which approximately $6.6m - or 19.9% - is for harm reduction program-related interventions[48].

The lack of Government willingness and commitment to support the HIV sector after the end of the Global Fund Round 5 grant in March 2012 was clearly seen in the collapse of HIV service provision in Albania, including that of the fledgling harm reduction program. As a result, the number of NGOs implementing services to PWID fell from four to two. At the height of Global Fund Round 5 grant assistance, the number of sterile needles/syringes distributed per PWID rose from 90 per year in 2011 to 104 per year in 2014[49]. At the time of writing, only a small number of sterile needles/syringes are being distributed by two NGOs and only in Tirana - Aksion Plus through the use of remaining stocks purchased with the previous Global Fund grant, and some support from UNFPA through Stop AIDS - although only 80-150 PWID are receiving such NSP services[50] compared with over 4,100 at the end of Global Fund Round 5 grant implementation in 2012[51]. Effective collaboration mechanisms between NGOs and police at the community level, developed during Global Fund Round 5 grant implementation, have proven successful. OST services were also badly affected by the end of the Round 5 Global Fund grant. Aksion Plus started the MMT program in 2005 and has 578 people being dosed every day at five sites as of March 2016, including 61 people in prison; OST services have been supported through the use of remaining stocks of methadone medication purchased with the Global Fund continuation of services (COS) grant between 2012 and 2014 and the use of UN funding to cover staff salaries, such as medical, psychosocial support and administrative personnel costs[52]. Methadone for detoxification is only available at one Government-run hospital in Tirane. There are estimated to be in the region of 250 cases of opioid overdose per year in the six main urban areas of Albania, resulting in an estimated 10 fatalities per year. In a 2014-15 study of problematic drug users, 4.2% had self-reported experience of one overdose over the previous one year period. Only 2 drug-related deaths were officially reported by the Forensic Medicine Institute Registry in Albania for the same period[53]. Whilst naloxone is not officially available in Albania for opioid overdose management, it is unofficially available through some private pharmacies.

Analysis of the transition process

Policy

Following a significant transformation process between the first Concept Note submitted to the Global Fund by the CCM, a stronger approach to the sustainability of the HIV/AIDS interventions to be supported by the Global Fund has been made. As noted in the Concept Note approved by the TRP, 'In order to ensure sustainability and address programmatic gaps and lessons learned, the Concept Note would not focus on closing all the gaps in prevention



activities, but would rather present a grant, which serves as a catalyst for building structures that support the link between the government and a strengthened civil society, and create structural and functional changes within the public health care system to ensures the continuation of prevention activities and the continuum of care after GF funding ends'**.** However, although a costed transition plan is envisaged as a key output in Year 1 of the forthcoming HIV grant, no such costed transition plan currently exists and, for this reason, **Indicator 1** ('A fully-resourced Transition Plan including harm reduction is proactively guiding transition') of the transition readiness assessment tool **is ranked as '0'**.

The focus of the capacity development is to utilize UNDP contracted staff to undertake on-the-job training of MoH personnel over a period of one year with a gradual phase-out during that period with an emphasis very much on procurement processes. Although this approach is included in the approved Concept Note, it will undergo further consideration during the grant negotiations and this provides an opportunity for revisions of the timeframe to take place in order to better enable a transfer of skills and mentoring of those taking over responsibility within the MoH for procurement and related systems and processes.

The existing 'National Strategy for the Prevention and Control of HIV/AIDS in Albania, 2015-2019' has been costed and does include harm reduction and other support for PWID and has been used as the guidance document for writing the approved Global Fund Concept Note. The government has indicated in the approved Global Fund Concept Note the areas in which it plans to provide domestic funding but this only includes the purchase of methadone medication as part of the harm reduction program and until the grant negotiations have been completed later in 2016, it is unclear as to whether the Government will increase, or even decrease, its initial projected investments into the harm reduction sector in Albania. Even if the Government agrees to use domestic resources in the future for key harm reduction interventions - especially NSP and OST as recommended by WHO, UNODC and UNAIDS - there are no guarantees that the rhetoric will result in actual financial disbursements by the Government.

Whilst the legislative and policy environment in Albania appears relatively comprehensive, implementation and enforcement is lacking. Legal and policy barriers to the implementation of harm reduction programs have been documented by some stakeholders, most especially as part of the 'National Strategy for the Prevention and Control of HIV/AIDS in Albania, 2015-2019'. Although revisions to legislation have taken place between 1995 and 2004, and OST services are being implemented without impediment, the distribution of sterile needles/syringes remains illegal. However, in practice, NSP is being undertaken through community-based memoranda entered into by local NGOs implementing harm reduction programs and local police and authorities. As a result, **Indicator 2** ('There are no legal or policy barriers to the implementation of harm reduction programs') of the transition readiness assessment tool **is ranked at Stage 2** ('Actions have been taken to amend problematic legislation and policies, but some barriers still exist').

Of note, however, is that current drug control legislation does allow for the personal use and possession of drugs although such legislation does not state what quantity of each type of drug, or the purity of each type of drug, is defined as being for personal consumption rather than for trafficking. As a result, it is difficult for PWID, as well as for law enforcement and the judiciary, to clearly implement the law in terms of personal possession and trafficking unless very large quantities of drugs are seized that are clearly beyond the realms of personal use.

There is currently no policy or legislation that supports a mechanism for the government to fund NGOs - through a grant or contract - for the implementation of HIV, or other, activities, including harm reduction services. Whilst legislation is under development by the Government with the support of the EC and UNDP to put in place such a funding mechanism, it is uncertain as to when this will be passed by Parliament; optimistic views suggest this could

be realised as early as April/May 2016, whilst others view the end of 2016 - or later - as more realistic. Consequently, **Indicator 3** ('Policy or legislation is in place to state and/or municipal governments to contract or grant NGOs for the delivery of harm reduction and other HIV prevention services') of the transition readiness assessment tool **is ranked as '0'**.

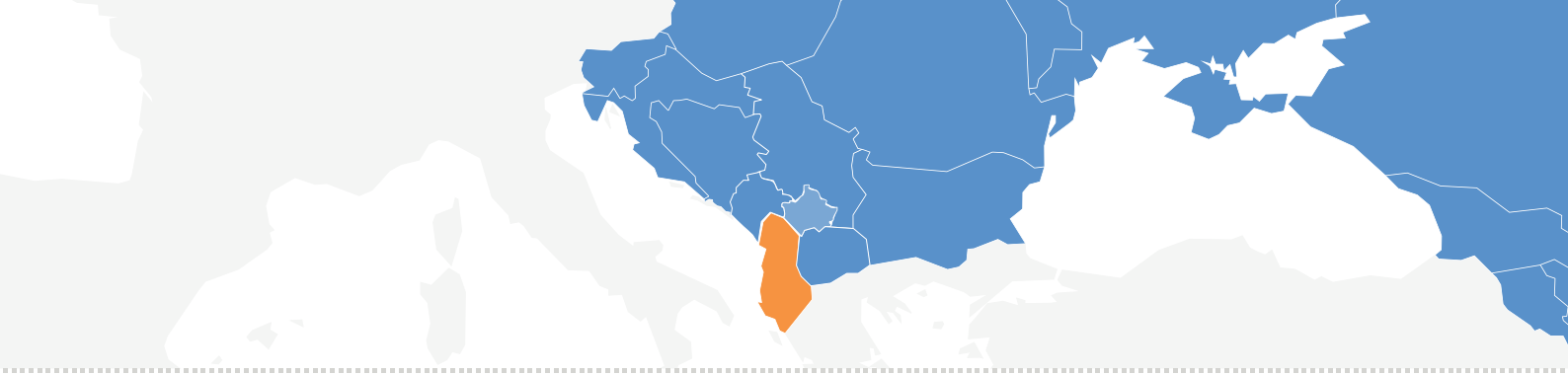
Governance

The Country Coordination Mechanism (CCM) in Albania has improved its performance in recent years as shown by success of the revisions it has made to its HIV/AIDS and TB Concept Paper between its initial submission and the approval of the final version by the TRP in November 2015. The current CCM includes a range of stakeholders from the Governmental, non-governmental and donor sectors. However, whilst the CCM also includes a representative of people living with HIV/AIDS (PLHA) as well as a representative of people living with TB, as well as a NGO representative working with Roma people, there is no direct representation for PWID or for any other KAPs[54] with such groups reliant on NGOs to speak for them.

There is currently no plan by the Government, nor of any other stakeholders of the CCM, for how the CCM will evolve and be institutionalized as a national governance body with decision-making power for HIV programming. All key informants shared similar views that the existing CCM established for Global Fund grants would - ideally - make for an inclusive and transparent coordination and collaboration mechanism for HIV/AIDS in the future, possibly as an inter-ministerial committee. For the CCM mechanism to become sustainable, it requires the CCM Secretariat to be funded by the Government in full and for the committee to be given decision-making powers rather than to just act in an advisory role. Furthermore, a future CCM mechanism must be accountable for the success or failure of its HIV strategy, direction, management and resource allocation, including for the harm reduction program. As a result, **Indicator 4** ('A multi-stakeholder national governance body, including at least government, civil society, and technical partners, is institutionalized to steer the transition process, and to continue program planning and oversight after the end of donor funding') of the transition readiness assessment tool **is ranked as '0'**.

A key component of good governance is for the Government to have in place strong, visionary leadership with effective communication skills and decision-making authority to use the available international and regional good practices for the HIV CoC and to adapt them to the Albanian context. In addition, there is currently no plan by the Government as to how current programmatic monitoring and oversight functions of the CCM will be transferred and strengthened through a potentially new governance body. Although civil society plays an important role as part of the CCM, it has had no role in the monitoring of government HIV expenditures during Global Fund Round 5 grant implementation. Furthermore, although NGOs that are part of the CCM have been involved in the discussions undertaken to develop the Global Fund Concept Note, they have not had any role in the decision of the Government to provide domestic funding as part of the forthcoming Global Fund HIV grant for the components of the HIV program.

As a result, **Indicator 5** ('The multi-stakeholder national governance body has an oversight function to monitor implementation of the National HIV Program, and harm reduction/PWID outcomes are measured as a distinct program area') and **Indicator 6** ('The new governance body has an oversight function to monitor expenditure against the planned budget, and harm reduction/PWID expenditure is measured as a distinct track of expenditure') of the transition readiness assessment tool **are both ranked as '0'**.



Finance

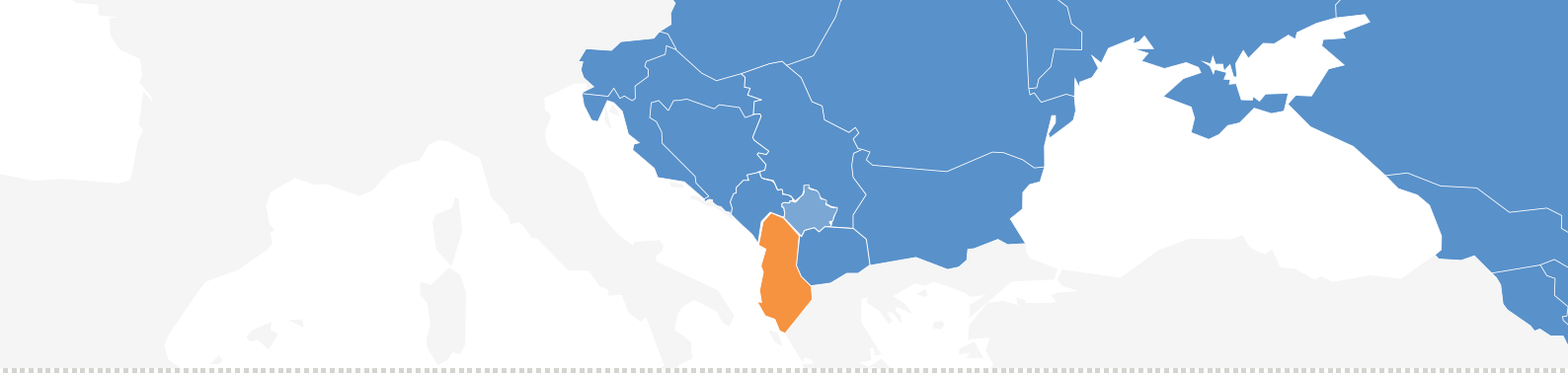
As noted previously, Albania has received a cumulative total of $5,443,976 for HIV interventions from Global Fund Round 5 (1 April 2007 to 31 March 2012) and 'Continuation of Services' (April 2012 to March 2015)[55]. Prior to Global Fund support, much smaller scale funding for harm reduction services has come from the Open Society Foundations (OSF), amongst others. Although the European Union (EU) has provided a program of civil society support in Albania, the NGOs providing harm reduction services have had very limited access to such funds and none of it has been for harm reduction service delivery. Albania has also benefited from the EU 'Instrument for Pre-Accession Assistance' (IPA) through the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) but the focus of that support has been on monitoring systems and technical assistance rather than for service delivery[56].

In addition to external donors, the HIV and TB sectors in Albania are funded by the Government through the Ministry of Finance (MoF) by public taxation and other revenues including the former Health Insurance Fund (HIF), now known as the National Health Funds (NHF) that pools financial resources from the MoF and from taxes for purchasing services such as primary care and hospital care. The Govenment allocates funds to the Ministry of Health and then onwards to public health institutions with $1,020,900 made available in 2013 for HIV/AIDS services rising slightly to $1,180,020 in 2015.

A needs projection and costing process was undertaken as part of the development of the 'National Strategy for the Prevention and Control of HIV/AIDS in Albania, 2015-2019' upon which the approved Global Fund Concept Note has been based. As noted above, the total estimated cost of the national HIV/AIDS strategy over the period 2015 and 2019 is $33.2m of which approximately $6.6m - or 19.8% - is for harm reduction program related interventions[57]. The Government has committed itself to providing $1,333,020 in 2016, rising to $1,964,210 in 2018 to the HIV sector as a whole, including harm reduction interventions[58]. Although the Government funding commitment for 2019 is not yet known, its projected domestic investments into the sector are less than one-third of the estimated cost of $33.2m in the Government's own HIV/AIDS strategy for 2015-2019[59].

Consequently, based on the National Strategy for the Prevention and Control of HIV/AIDS in Albania, 2015-2019, the funding for harm reduction for the period 2017-2019 (three years) totals $4,010,315[60] (see Attachment 2). The Global Fund has indicated in its approved Concept Note a grant of $856,364 for the same three year period[61], or 21.6% of what is needed, with the resulting financial gap being $3,153,951. This financial gap is only slightly less than the entire Government indicative funding commitment to the whole HIV/AIDS sector over the same timeframe. Therefore, it is highly likely that other external donors will be required to help fill at least some of this gap unless the Central Government, and the Ministry of Health, can be persuaded to allocate substantially more financial resources to support its own national strategy for HIV/AIDS.

Based on the existing situation, including those interventions initially supported by the previous Global Fund HIV grant and its continuation of services, the Government is currently providing its own resources for (1) Elisa, Western Blot, and HIV rapid test procurement; (2) Operational and human resource costs of VCT centers; (3) First- and second-line ART for 360 patients; (4) CD4 and Viral Load tests; and, (5) Opportunistic Infection diagnosis. From the indications given in the approved Concept Note but yet to be confirmed through the grant negotiations, the Government may provide additional domestic funding in the near future for (a) HIV prevention interventions for up to 150 MSM and Transgender people; (b) OST medication for up to 100 clients; (c) first and second line ART for up to 740 patients; and, (d) VCT services at antenatal clinics and primary healthcare facilities. It is also possible, but not confirmed, that beyond the duration of the new Global Fund HIV grant, the Government may also provide domestic funding for HIV



testing conducted through outreach as well as the purchase of OST medications to a larger number of clients.

As a result, **Indicator 7** ('Funds for harm reduction are allocated according to an optimized budget scenario') of the transition readiness assessment tool **is ranked at Stage I** ('There has been a need projection and costing process to develop a budget for the transition period and/or beyond').

The Government plans to undertake a mid-term review (MTR) of the HIV Program in 2017 followed by the development of a 'Strategic Investment Case' to develop a framework for the sustainable financing of the HIV program 'following the end of the proposed programme's implementation' in 2019[62]. Therefore, even after the forthcoming grant negotiations between the Global Fund and the Government have been completed, we will not know the final position of the Ministry of Health in terms of what domestic funding will be made available as a result of the Strategic Investment Case.

Furthermore, a considerable challenge in realising any commitment by the Ministry of Health to transition to domestic funding is the future economic development of Albania and the resultant finances allocated by the Government to the Ministry of Health and, subsequently, by the Ministry of Health to the National AIDS Program of the Institute of Public Health and its NGO partners. As a result, the current situation shows that the harm reduction program in Albania cannot rely on the Ministry of Health for funding of its services after the departure of the Global Fund. Even the TRP notes that, 'The concept note does not clearly explain how key populations and vulnerable groups will continue to be prioritized by the Ministry of Health so that their access to TB and HIV prevention, treatment and care is guaranteed in the context of national health reform, including decentralisation and the formulation of the new National Health Strategy and, most importantly, the imminent transition from Global Fund support'[63]. Interim UN funding, such as for MMT staff costs, condoms and IEC materials, will allow a minimal level of service delivery but will not enable NGOs to scale-up services to the coverage levels recommended by the UN, especially for NSP and OST[64]. NGOs are, consequently, actively seeking a wide range of alternative funding support including that from other Ministries of the Goverment, including Interior, Justice and the Ministry of Finance. Ongoing fundraising from the public, both within Albania and beyond, is a further safeguard for the protection of life-saving harm reduction services for PWID.

Furthermore, donor procurement systems, such as those for implementation of the Global Fund Round 5 grant, have not been integrated into national systems, resulting in a lack of assurance of reasonable price controls when purchasing equipment or commodities. Consequently, **Indicator 8** ('Core harm reduction services are funded by the government and delivered by NGOs via grants or contracting mechanisms') of the transition readiness assessment tool has been **ranked at Stage I** ('Either needles and syringes for harm reduction OR opioid substitution therapy medications (not both) are included in the domestic budget'; in the case of Albania, methadone medication has been included); **Indicator 9** ('Donor procurement systems are integrated into national systems and assuring reasonable price controls') has also been **ranked at Stage I** ('A plan exists to integrate Global Fund procurement systems into national systems') for similar reasons.

The lack of willingness so far shown by the Ministry of Health to use its own public funding in the future for the delivery of high-impact and low-cost HIV prevention interventions will further undermine achievement of its stated vision of a 'move toward ***total prevention of new infections of HIV***, to offer support, quality care ***and medical treatment to all infected and affected***, in a society against stigma and discrimination' (author's emphasis)[65].

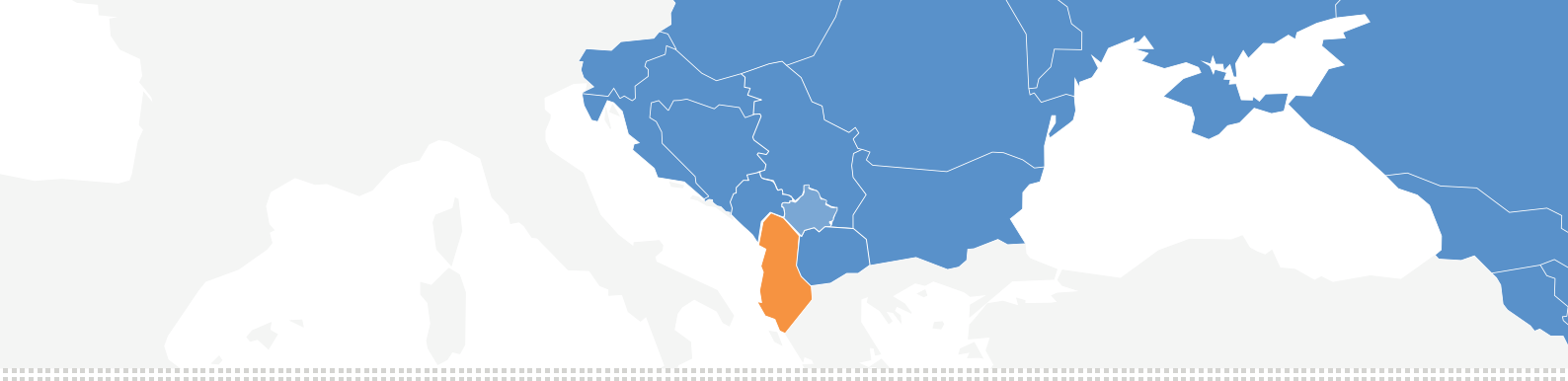
Programme

Whilst the new national strategy for HIV/AIDS for 2015-2019 gives hope of a far more effective HIV program in the future, as a WHO review of the national HIV program in 2015 has highlighted, there are several programmatic areas that need to be urgently prioritised and addressed, including: (1) the lack of political and financial commitment by the government together with the building of a partnership with NGOs to establish sustainable HIV prevention, and management and treatment programmes; (2) increased access to HIV testing **-** including access to rapid tests - and outreach to KAP and persons who attend MMT; (3) development of an effective HIV treatment and care programme to ensure high enrolment and retention as well as high ART coverage; (4) improved access to, and increased scope of harm reduction services for, KAP including optimal dosing of methadone, ongoing psychological support, and the provision of methadone in prison settings; and, (5) development of friendly and non-judgmental services and the reduction of stigma and discrimination against PLHIV and KAPs[66].

There are currently no national service delivery standards for components of the harm reduction programme in Albania, including NSP and OST. NGOs implementing such services currently use their own standards/manuals that are largely based on WHO guidance and good practices from other countries of the region, such as Slovenia. As part of the new Global Fund Concept Note, national standards for NSP and OST, including standard operating procedures, etc., will be developed by the end of Year 1. Consequently, **Indicator 10** ('Provision of core harm reduction services is monitored according to defined standards') of the transition readiness assessment tool has been **ranked as '0'**.

Only as part of the Global Fund Round 5 grant was harm reduction service monitoring included in the MoH monitoring strategy and, as such services were implemented by NGOs, such monitoring was undertaken with the involvement of civil society. Coverage of harm reduction services in Albania is below what is needed and recommended by WHO to have an impact on stopping the expansion of HIV or in reducing its spread throughout the country[67]. Using the PWID population size estimate of 6,300 as used by the Global Fund, OST coverage as of March 2016 was a mere 9.17%[68] with concerns that many methadone clients are underdosed due to the relatively limited stock of methadone medication in the country at present. However, not all PWID will be opioid dependent and even those that are dependent may not be eligible for methadone maintenance for other reasons. For example, if 75% of the 6,300 PWID in Albania are eligible for OST, then current coverage would be 12.2%. Therefore, it is recommended that a review of the estimate of the number of PWID who may benefit from OST be undertaken in order for coverage figures to better reflect the reality in Albania.

The major obstacles to reaching NSP and OST service coverage levels have been the focus of services in the capital, Tirana, and the lack of NGOs willing and able to implement such services in other main urban areas of the country, plus the limited funding available, especially since the end of Global Fund Round 5. The approved Global Fund Concept Note provides for an expansion of harm reduction services, including NSP, to six cities of Albania in addition to the continuation of the existing MMT services at six sites around the country. Although the Concept Note target of 65% of PWID targeted with NSP is commendable, a conservative target for MMT (850 clients, or 15% of the total estimated population)[69] indicates that the Global Fund is trying to entice a transition of funding of such services so that the Government will be more willing to fund such interventions after the end of the forthcoming Global Fund grant. Efforts should be made to push forward with the expansion of OST more quickly in order to save lives and to contribute more fully to the prevention of HIV/AIDS in Albania whilst taking into consideration the capacity of NGOs to deliver a rapidly expanded OST service nationwide. Concerns have been expressed as to the extent that both the forthcoming Global Fund grant and future Government funding will include adequate provision for identifying the most hidden PWID, such as female injecting drug users, KAPs with overlapping risks, such as MSM,



sex workers or transgender people who inject drugs, and children and young people who inject drugs (CYPID), etc. Good practice from around the world has shown that peer-driven interventions supported by NGOs and CBOs are the most effective ways in accessing such groups and should, therefore, be crucial facilitators in undertaking the programmatic mapping exercise planned in Year 1 of the grant currently being negotiated. However, as mentioned earlier, there is no legal mechanism yet in place by which NGOs can be contracted by Government entities to deliver services, including harm reduction interventions.

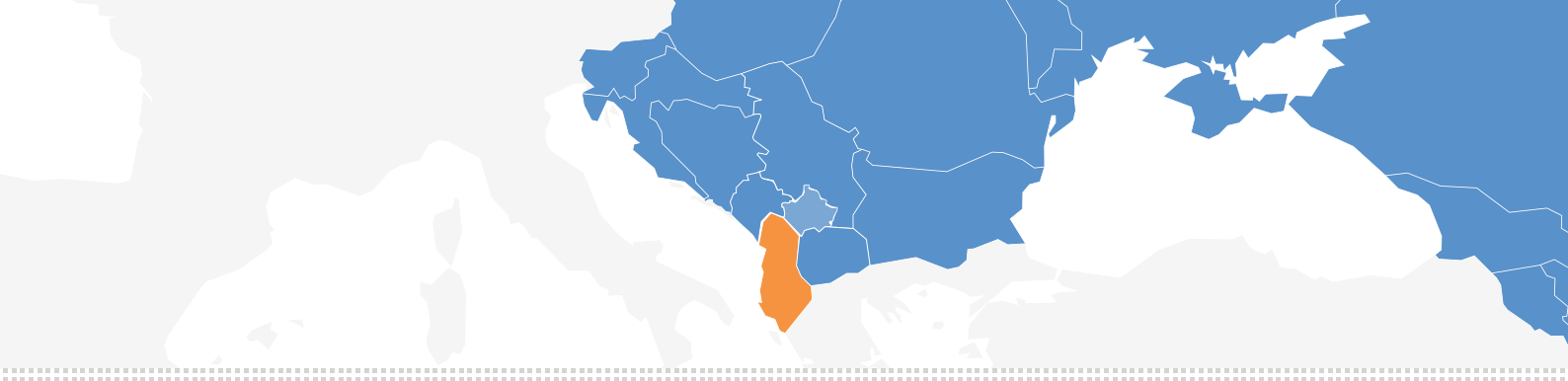
It was noted, or inferred, by many key informants that although the continuation and the expansion of harm reduction services appears secured 'on paper', implementation and longer-term funding of the harm reduction programme remains uncertain and, consequently, the reality may differ markedly from the written strategic plan and the approved Global Fund Concept Note. As a result, **Indicator 11** ('Core harm reduction services are available at levels of coverage recommended by the World Health Organization') of the transition readiness assessment tool has been **ranked at Stage I** ('Coverage gaps have been assessed and targets set to expand coverage') with **Indicator 12** ('NGOs are critical partners in delivery of harm reduction and other HIV prevention services financed by domestic resources') also being **ranked at Stage I** ('A limited number of NGOs receive grants or contracts for providing harm reduction services').

Identified challenges and barriers

Fundamentally, the reliability of funding is the major obstacle to the implementation, and the scaling-up, of the harm reduction program in Albania rather than a lack of an enabling environment or technical skills, although both could be further improved. The extent to which Albania economically develops in the coming years will impact the extent to which the Government is able to allocate more funds to the Ministry of Health budget and thereby to the harm reduction program. Furthermore, donors are unlikely to provide an increase in financial support to Albania due to their own economic challenges and the needs of other countries and regions of the world.

Consequently, HIV programme challenges include inadequate coverage of HIV prevention, treatment and care interventions for KAPs; a low uptake of HIV testing; and the lack of CD4 and Viral Load testing that prohibits effective monitoring and management of patients. More specifically:

- Albania's surveillance and program monitoring system is weak and there is no funding available for conducting the necessary surveys and population size estimates;
- The OST program reaches only a limited number of PWID (8.4-12.6%) and largely relies on external financing;
- Support for the scaling-up of community outreach activities, including the identification of more female drug injectors as well as children and young people who inject drugs;
- Late testing for HIV, especially by KAPs;
- Pregnant women, including women who inject drugs, are not routinely offered HIV testing and counseling, with most of the infants diagnosed with HIV only when they present clinical signs;
- Linkage to care is sub-optimal and hampered by the absence of a pre-ART register, with retention data being only available in clinical records and retention in care is not sufficiently monitored;
- The provision of integrated HIV and related services for KAPs in the community;



- Clinical monitoring of PLHIV and ART patients is seriously hampered by the absence of Viral Load and CD4 monitoring and resistance testing;
- The diagnosis and treatment of Opportunistic Infections remains limited;
- Stock-outs of essential medications, including types of ARVs as well as methadone, is resulting in treatment interruptions;
- National guidelines and protocols need to be developed and periodically updated in order to be compliant with the latest guidance from WHO, UNODC and UNAIDS for each stage of the HIV CoC as well as for optimisation of OST and NSP services;
- Health care workers and other professional service providers in the social sector have attitudes that negatively influence health seeking behaviours of KAPs and PLHIV; and,
- The link between the Government and civil society organizations is underdeveloped. The HIV program, and other sectors, would gain from a stronger network of NGOs that is well coordinated and has targeted prevention programs implemented by NGOs and financed and monitored by the Government. Further building of NGO capacity is also required.

Lessons learnt

The collapse of the HIV (and TB) programs at the end of the Global Fund Round 5 grant is, perhaps, the greatest lesson learnt for all stakeholders, especially for the Government and the Global Fund Secretriat, respectively. The apparent willingness and commitment by the Government to support the HIV program beyond the end of the Global Fund Round 5 grant did not materialise to the extent hoped for by many even though some aspects of the program did receive domestic funding in whole or in part, such as VCT services and ARVs.

The ability of the MoH to gain the necessary budget allocation from the Government treasury to fund more of the HIV program did not materialise. With more assistance from the Global Fund and technical partners to undertake detailed planning well in advance of the end of the Global Fund Round 5 grant - such as the development of a proper transition plan and the existence of a multi-stakeholder national governance body to coordinate the transition process - perhaps the MoH would have had greater success in its interactions with the treasury and others in the Government. The MoH and NGOs became too reliant on one major donor - the Global Fund - and when that funding ended, such stakeholders either had no back-up funding strategy in place, or had to rapidly scale-back service delivery. Two harm reduction NGOs were forced to close as a result of the end of Global Fund support after March 2012. The number of people who could access methadone had to be considerably reduced from a high of 813 clients in the first quarter of 2012 to 457 in the first quarter of 2014 (a reduction of 356 clients, or nearly 44%)[70]. The quality of the OST service had to also be reduced with doses reduced in order to allow the remaining stocks to last as long as possible. NSP services were also scaled-back to only two NGOs in Tirana from a high of four in the first quarter of 2009[71].

A further lesson learnt is that to achieve the objective of increasing Government funding to the HIV and harm reduction programs, the Global Fund needs to assist the Government through the process of transition, including the development of a specific and detailed transition plan based on financial resource mapping and a financial sustainability plan as well as a comprehensive assessment of the Government's readiness to take on the programmatic,

governance and policy-related components of the program. It is impractical to assume that the existing Global Fund Concept Note will result in a transition to Government funding of the HIV program if the Government itself is not given the means to identify its role, its ability to provide the necessary funding within the three-year grant window, and the impact of the identified gaps that will result if the Global Fund does not continue support to the HIV program in Albania beyond 2019.

The lesson learnt for civil society is to have a medium-to-long term fundraising strategy that allows for a portfolio of small, medium and large donors and to ensure that basic staff costs and services can be supported no matter which individual donors cease funding of the NGO. A more effective approach would also be to enlist support from a portfolio of Government entities, including the Ministries of Finance, Interior and Justice, for harm reduction interventions. In addition, ongoing fundraising among the public should be undertaken and is particularly notable as such income is not earmarked for specific interventions and, therefore, can be used to fund expenditures that are traditionally less attractive to international donors, such as staff salaries. It is apparent that the local NGO, Aksion Plus, has a strategy in place that incorporates such a dyanmic range of funding options and this is why they have continued - albeit at a much smaller scale - to implement the MMT program nationwide beyond the end of the Global Fund continuation of services support in 2015 that only covered the purchase of methadone rather the service delivery costs including staff salaries.

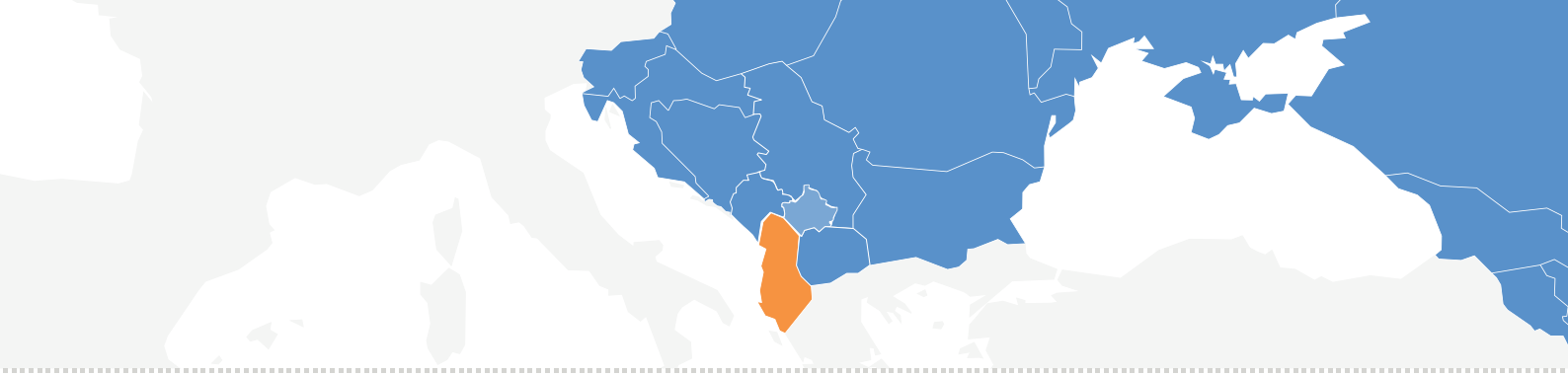
Furthermore, greater awareness is needed by MoH decision-makers of the harm reduction program and the cost-effectiveness of investing domestic resources in high impact and low cost NSP and OST services in particular. This would be a far more effective approach to population health than investing in widespread health assessments for the general public as is currently being provided by the MoH. The lack of a direct voice from PWID is also inhibiting the advocacy efforts in Albania. Greater efforts are needed to help PWID, and other groups of KAPs, to organise themselves and to network. Eventually, such groups should be helped to develop their capacity to speak and advocate for themselves in all fora rather than having to rely on NGOs to speak on their behalf.

Recommendations for key stakeholders

A. Government

1. The Government should immediately undertake **a comprehensive assessment of its readiness to take on the financial, programmatic, governance and policy-related components** of the HIV and harm reduction programs with the financial and techncal support of the Global Fund and UN as well as domestic and regional NGO partners, and - ideally - with representatives of KAPs; financial resource mapping and a financial sustainability plan should be key componets of the assessment, as envisioned in Year 1 of the new HIV grant implementation. Such transition readiness planning for the HIV sector in Albania should begin even prior to the conclusion of negotiations for the forthcoming Global Fund grant with the results being available to guide Year 1 activities and the subsequent disbursement of Global Fund resources to the Government at the end of Year 1 of the HIV grant;

2. Informed by the transition readiness assessment and plan, the Government should **develop a specific and detailed transition funding plan,** as envisioned in Year 1 of the new Global Fund HIV grant, in close coordination and collaboration with the Global Fund, UN, NGO partners and other donors, and representatives of KAPs, including male and female PWID. Such a transition funding plan should include clear roles and responsibilities of each stakeholder, a realistic timeline, and clear criteria to measure the success of each stage of the plan. **High-impact and cost-effective interventions should be prioritized** in the transition funding plan and the efficient management and coordination of service delivery and monitoring;



3. Reconsider the approach and timeframe for the **building of human resource capacity** within the Ministry of Health for procurement and management systems in order to ensure that experience of local staff is gained through mentorship over time;

4. Ensure that sufficient domestic funds are made available to NGOs and CBOs in order to scale-up NSP and OST interventions for PWID to coverage levels as recommended by WHO, UNODC and UNAIDS; failure to do so will make any NSP and OST support ineffective in stopping, or reducing, the HIV/AIDS epidemic among PWID and their partners;

5. In collaboration with the Global Fund, NGO partners, and the UN, develop a **clear definition of, and criteria and requirements for, successful transition** from support given through the forthcoming Global Fund grant to domestic funding in Albania for the HIV program in general and for the harm reduction program specifically;

6. To **appoint a new CCM co-chair** who possesses the vision and capacity to guide the CCM as a strong, decision-making body into an authoritative coordination and decision-making body in the future;

7. **Transition the existing CCM** and its current membership/representation into an inter-ministerial committee that includes multisectoral civil society, UN and other relevant representatives and that has decision-making powers with a Secretariat funded by the Government to monitor and direct the virtual elimination of HIV in Albania in the longer term;

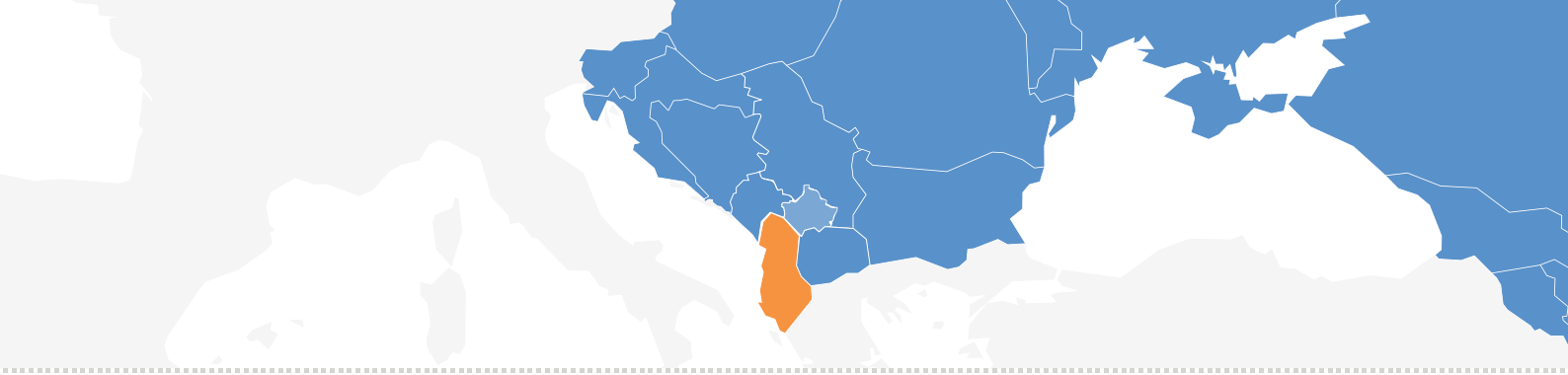
8. **Recognise the difference between people living with HIV/AIDS and/or TB and those people who are at risk of, or vulnerable to, contracting HIV/AIDS and/or TB** and ensure that people at risk of, or vulnerable to, HIV/AIDS and/or TB are represented as members of the CCM and any future coordination and decision-making body;

9. In collaboration with the EU and UNDP, **rapidly move forward with completion of new legislation for the contracting of civil society groups by Government entities,** including the provisin of Government funding to such groups, so that hidden population groups, such as PWID, can more cost-effectively receive health and other services through NGO services in the community with referral to Government facilities when needed;

10. To recognise the crucial role played by NGOs and CBOs in facilitating access to PWID and other KAPs and to thereby support such agencies in the **identification of more hidden communities** during Year 1 of the new grant implementation, especially female drug injectors and children and young people who inject drugs. In addition, undertake **timely surveys**, such as behavioral (IBBS) and demographic and health surveys (DHS) that include KAPs; for this to be realised, collaboration with civil society groups and NGOs that have contact with such clients is essential;

11. Establish **a more systematic approach** to support NGOs delivering a comprehensive package of harm reduction interventions through the **use of funds raised through the sale of seized assets, etc., of drug traffickers** and related criminal activities so as to ensure a reliable funding stream to such NGOs upon which **longer-term planning and scale-up of harm reduction services** can be based;

12. **Provide training to healthcare workers,** as envisioned in Year 1 of the new HIV grant, who are most likely to come into contact with members of KAPs on issues concerning (a) sexual orientation and gender identity (**SOGI**); and, (b) reducing **stigma and discrimination**; training curricula and techniques already exist for the provision of such training and follow-up and these can be adapted to the Albanian socio-cultural context;



13. Train relevant healthcare workers and their managers in the **use of case management techniques and community-based peer support,** as envisioned in Year 1 of the new HIV grant, so as to implement an **integrated package of services** to PWID and other KAPs in a more cost-effective manner and to have **greater impact** than the current approach; such case management should also be introduced into undergraduate curricula as well as in the training of GPs;

14. For the **treatment of viral Hepatitis C**, replace Pegylated Interferons with Direct-Acting Antivirals (DAAs) that are far more effective with fewer side effects and, in many countries (such as Egypt, Ukraine and Bangladesh), are cheaper;

15. Recognize that the **funding of OST requires more than the purchase of medications** and to thereby ensure that domestic funding is increasingly provided to all components of the OST program including, but not limited to, the salary of staff disbursing OST to clients as well as those providing crucially important pyshco-social and economic support services that international good practice has shown to improve adherence to, and retention in, such OST interventions;

16. **Review the estimate of the number of PWID who may benefit from OST** in order for coverage figures to better reflect the reality in Albania, noting that not all opioid-dependent PWID will be able to benefit from OST for a variety of health as well as socio-economic reasons;

17. Similarly, recognize that the **funding of NSP requires more than the purchase of sterile needles/syringes** and to thereby ensure that domestic funding is increasingly provided to all components of NSP including, but not limited to, the salary of staff disbursing NSP at fixed and mobile facilities;

18. **National guidelines and standards of care** should be established, including harm reduction interventions, especially NSP and OST services for PWID delivered by NGOs in the community;

19. Make continual efforts to **identify, and apply for, external donor assistance** for the HIV and TB programs, including for harm reduction interventions, so as to avoid a total reliance on any one donor - such as the Global Fund - for financial and technical support to the sector(s);

B. Global Fund

20. In order to encourage progressive and eventually complete financing of all aspects of the TB and HIV programs, including the harm reduction program, provide **financial and technical support** to the Government and its partners to immediately undertake **financial resource mapping, gap analyses, and sustainability planning** in order to develop a 'transition readiness plan' during Year 1 of the new HIV grant;

21. Make the **disbursement of funding at the end of the Year 1 HIV grant conditional** upon the successful completion of a transitional readiness plan developed with multi-stakeholder inclusion;

22. Establish within the Secretariat, and provide resources for the effective functioning of, a **'Transition Team'** to support in-country stakeholders in the implementation of the transition readiness plan. The Transition Team should comprise expertise from the financial, human rights, key affected populations, gender and other relevant sectors and will assist in documenting and sharing good practice as well as in engaging with key stakeholders in the transition process;

23. Review calculations and assumptions used for **MMT coverage** in Albania, especially the proportion of the total estimated PWID population nationwide who may be eligibile for MMT services (the denominator);

24. Recognize that the **funding of OST requires more than the purchase of medications** and to thereby ensure that funding is made available for all components of the OST program including, but not limited to, the salary of staff disbursing OST to clients as well as those providing crucially important pyshco-social and economic support services that international good practice has shown to improve adherence to, and retention in, such OST interventions;

25. Similarly, recognize that the **funding of NSP requires more than the purchase of sterile needles/syringes** and to thereby ensure that domestic funding is increasingly provided to all components of NSP including, but not limited to, the salary of staff disbursing NSP at fixed and mobile facilities;

26. Ensure that sufficient Global Fund and domestic funds are made available to NGOs and CBOs in order to **scale-up NSP and OST interventions for PWID to coverage levels as recommended by WHO, UNODC and UNAIDS**; failure to do so will make any NSP and OST support ineffective in stopping, or reducing, the HIV/AIDS epidemic among PWID and their partners;

27. Encourage NGOs and the Government to support members from each **KAP to establish groups and networks** that can represent their interests and advocate directly with the Government, NGOs and donors on their needs and are able to report abuses of their rights without retribution;

28. Use the leverage of Global Fund support to persuade the Government to **treat viral Hepatitis C** through the use of Direct-Acting Antivirals (DAAs) rather than Pegylated Interferons owing to the fact that DAAs are far more effective with fewer side effects and, in many countries (such as Egypt, Ukraine and Bangladesh), are cheaper;

29. For the **treatment of viral Hepatitis C**, replace Pegylated Interferons with Direct-Acting Antivirals (DAAs) that are far more effective with fewer side effects and, in many countries (such as Egypt, Ukraine and Bangladesh), are cheaper; and,

30. **Recognise the difference between people living with HIV/AIDS and/or TB and those people who are at risk of, or vulnerable to, contracting HIV/AIDS and/or TB** and ensure that people at risk of, or vulnerable to, HIV/AIDS and/or TB are represented as members of the CCM and any future coordination and decision-making body;

C. Civil Society

31. Support the **development of a drug user advocacy group or network** so that PWID in particular can advocate directly with decision-makers and donors themselves for the services that they want to access;

32. Advocate with the CCM, the Ministry of Health and the Global Fund Secretariat to **recognise the difference between people living with HIV/AIDS and/or TB and those people who are at risk of, or vulnerable to, contracting HIV/AIDS and/or TB** and for people at risk of, or vulnerable to, HIV/AIDS and/or TB are represented as members of the CCM and any future coordination and decision-making body;

33. Advocate with the Global Fund and the Government to make sufficient funds available to NGOs and CBOs in order to **scale-up NSP and OST interventions for PWID to coverage levels as recommended by WHO,**

UNODC and UNAIDS; failure to do so will make any NSP and OST support ineffective in stopping, or reducing, the HIV/AIDS epidemic among PWID and their partners;

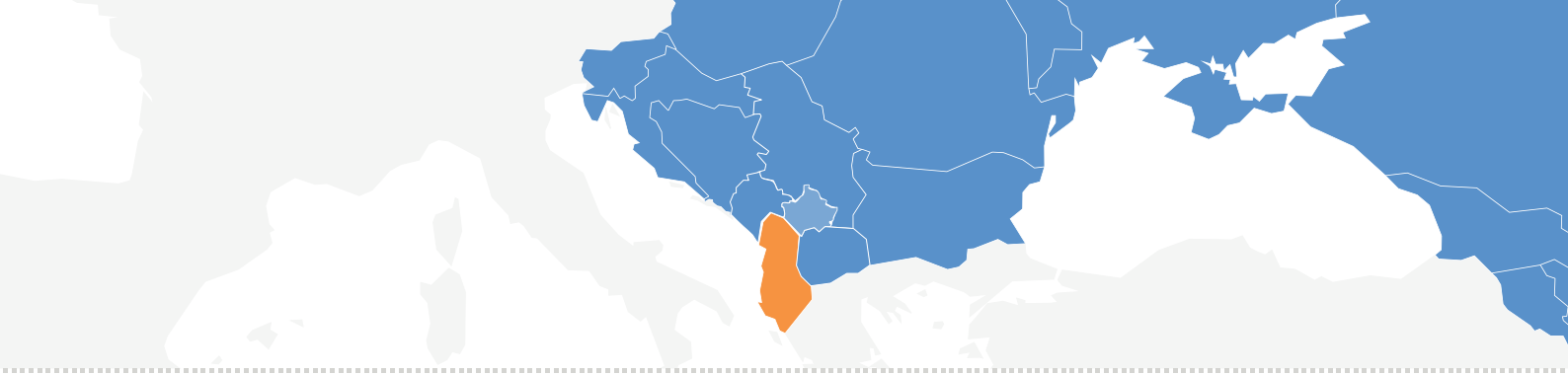
34. Continue to **further strengthen collaboration between civil society groups** so as to act as one as a coalition in negotiations with the Government over domestic funding for harm reduction services, as well as improvements in the operational environment for harm reduction services, including in prisons and for KAPs with overlapping HIV, and other, risks, e.g. MSM who inject drugs and share injecting equipment;

35. Advocate to be **partners with the Government and the Global Fund**, plus others, in undertaking a 'readiness assessment' and the development of a subsequent transition plan from donor to domestic funding for the harm reduction program;

36. Advocate for the prioritization of high impact interventions targeting KAP, especially male and female injecting drug users. This could be achieved through the identification of harm reduction good practices and the **establishment of integrated good practice models of service delivery in close collaboration with relevant Government entities**;

37. Monitoring and evaluation of progress should be undertaken as well as the provision of **on-the-job training** to relevant NGO and Government personnel in each aspect of the good practice model including, for example, community-based outreach; rapid testing in the community; referral to fixed site facilities; peer-led management of individuals from KAPs who are living with HIV; retention and adherence to treatment in the community, both ART and OST, as appropriate; social reintegration; access to economic opportunities, etc. As a result, demands by NGOs for adequate financial allocations from Government will be more meaningful to those receiving such requests in Government;

38. Each NGO should **develop its own sustainability plan** that includes alignment with government norms and regulations and integration with public health services but which are not solely reliant on any one external or domestic funder.



Attachment 1
The Transition Readiness Assessment Tool

This case study was guided by a Transition Readiness Assessment Tool (TRAT), which provides a quantitative framework for measuring a country's progress towards readiness for sustainable transition of harm reduction services from external donor funding to domestic resources.

The TRAT is based on **four thematic areas** of transition, as previously defined by the Global Fund Secretariat and the Eurasian Harm Reduction Network[1]: policy, governance, finance and program. The TRAT was designed with the underlying assumption that in order for a country to be prepared for a sustainable transition, it must make progress on specific indicators in each of these thematic areas. Under each thematic area, three indicators help measure this progress.

Thematic Area	Indicators		
POLICY	**Indicator 1. Transition Plan:** A fully-resourced Transition Plan including harm reduction is proactively guiding transition.	**Indicator 2. Legal and Policy Environment:** There are no legal or policy barriers to the implementation of harm reduction programs.	**Indicator 3. NGO Contracting Mechanisms:** Policy or legislation is in place for state and/or municipal governments to contract or grant NGOs for the delivery of harm reduction and other HIV prevention services.
GOVERNANCE	**Indicator 4. Sustainable Governance Body:** A multi-stakeholder national governance body, including at least government, civil society, and technical partners, is institutionalized to steer the transition process and to continue program planning and oversight after the end of donor funding.	**Indicator 5. Program Oversight:** The multi-stakeholder national governance body has an oversight function to monitor implementation of the National HIV Program and harm reduction/PWID outcomes are measured as a distinct program area.	**Indicator 6. Financial Oversight:** The new governance body has an oversight function to monitor expenditure against the planned budget and harm reduction/PWID expenditure is measured as a distinct track of expenditure
FINANCE	**Indicator 7. Optimised Budget:** Funds for harm reduction are allocated according to an optimized budget scenario.	**Indicator 8. Financing for NGOs:** Core harm reduction services are funded by the government and delivered by NGOs via grants or contracting mechanisms.	**Indicator 9. Procurement Systems:** Donor procurement systems are integrated into national systems and assuring reasonable price controls.
PROGRAM	**Indicator 10. Standardised Monitoring:** Provision of core harm reduction services is monitored according to defined standards.	**Indicator 11. Services Coverage:** Core harm reduction services are available at levels of coverage recommended by the World Health Organization.	**Indicator 12. Partnership with NGOs:** NGOs are critical partners in the delivery of harm reduction and other HIV prevention services financed by domestic resources.

1 Eurasian Harm Reduction Network. *Transition and Sustainability of HIV and TB Responses in Eastern Europe and Central Asia: A Regional Consultation Report and Draft Transition Framework.* (2015)
http://www.harm-reduction.org/library/transition-and-sustainability-hiv-and-tb-responses-eastern-europe-and-central-asia

For the purpose of standardizing measurement of progress against each indicator, the TRAT also assumes that there are three stages of readiness for countries actively preparing for transition:

- Stage I indicates that a country has made some progress towards preparing for a sustainable transition, but significant barriers remain.
- Stage II indicates that a country is actively in the process of making positive changes, but some time is still needed before systems will be prepared for a sustainable transition to domestic financing.
- Stage III indicates a country that is imminently ready to transition, with all core mechanism in place to sustain programming after external donor funding ceases.

Each indicator has three benchmarks corresponding to the stages to aid assessors in judging progress against the indicator. In order to quantify this progress, each benchmark achieved under each indicator is valued at one point, leading to a maximum possible score of 36 points.

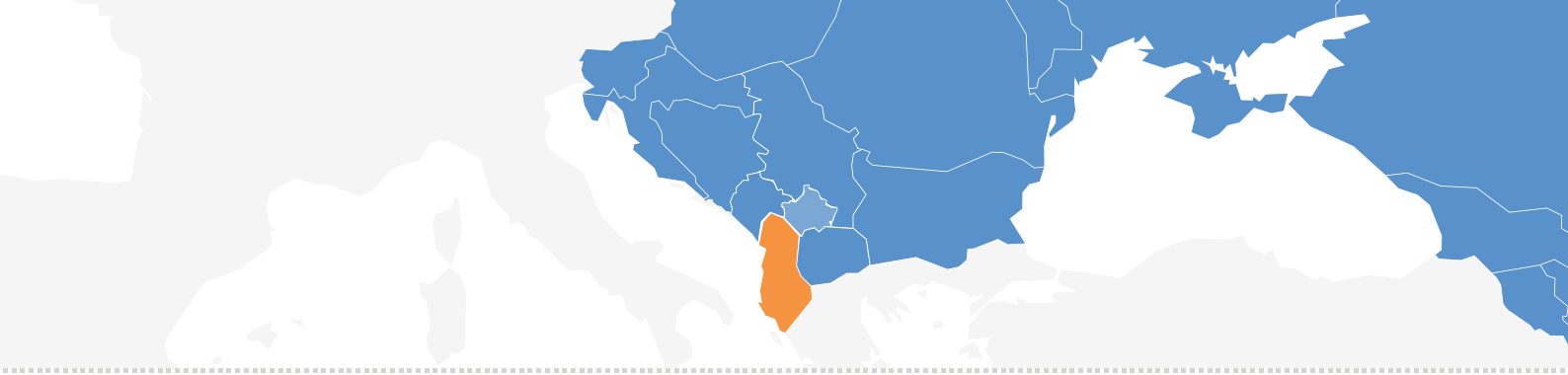
[4 Thematic Areas] x [3 Indicators] x [3 Stages of Readiness] = [Max. 36 Readiness Points]

Ultimately, the TRAT assembles a readiness profile for each country that reflects both a raw quantitative readiness score, and a visual depiction of readiness in each thematic area, by indicator. This allows the reader to visualize not only overall degree of readiness but also distribution of readiness across the thematic areas – highlighting strengths and weaknesses, and pointing to major gaps that need intensified effort in order to support a well-balanced effort towards sustainable transition to domestic financing.

Albania's Transition Readiness Profile

Out of the maximum possible 36 readiness points, Albania achieved 7, giving it a raw readiness score of 19%. This score reflects Albania's low level of preparedness in all thematic areas. Policy and governance are particularly concerning, with several Stage I benchmarks still unmet: no transition plan has been drafted, significant legislative barriers are in place (NSP is still illegal), and there is no mechanism by which NGOs can receive government funding. The existing CCM has had a gap in leadership from the government side until very recently, and no plans exist for an alternative or successor body.

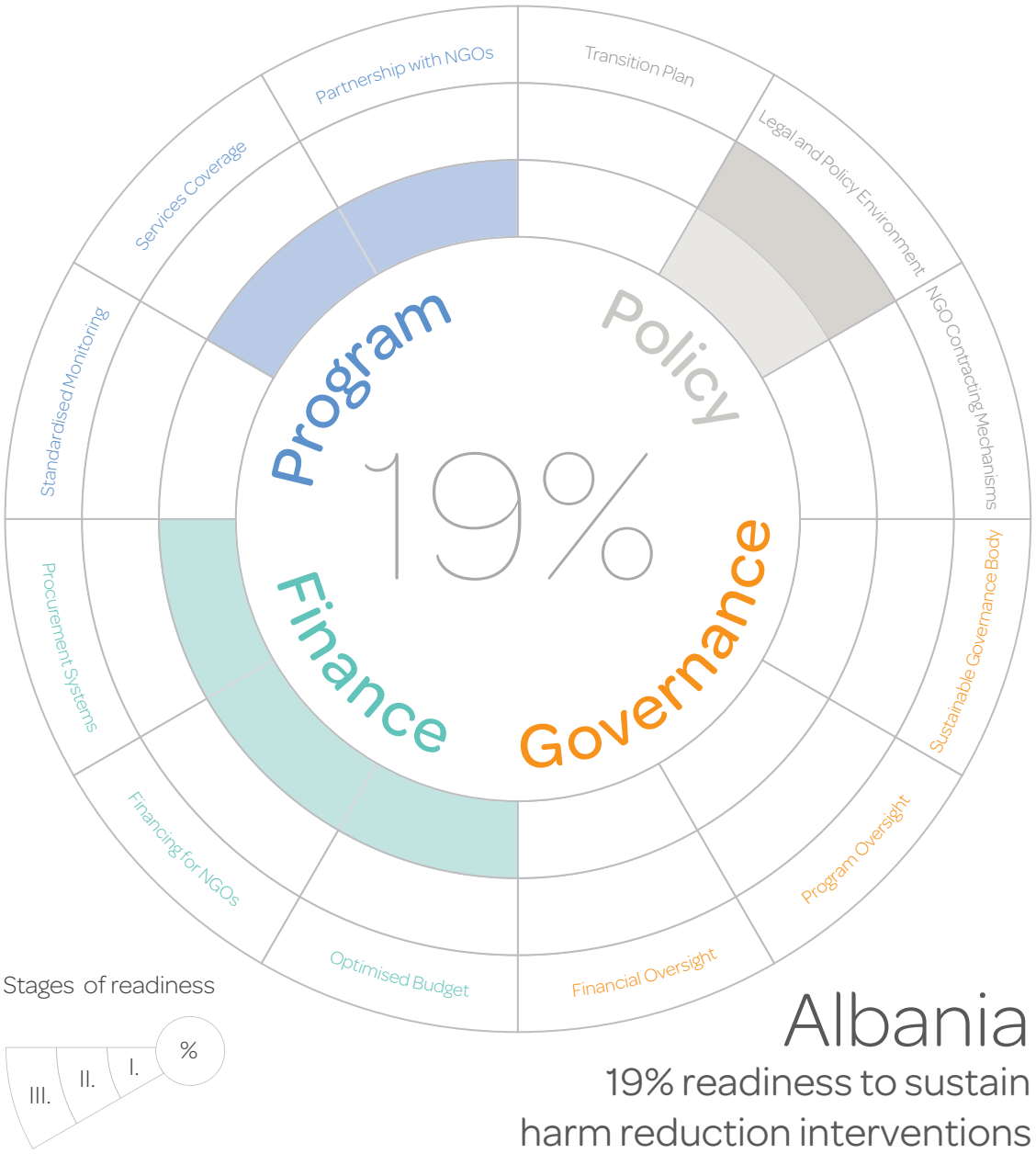
The figure below depicts Albania's readiness by indicator in each of the four thematic areas. The lighter, innermost ring represents achievement of Stage I benchmarks for each indicator; the middle-level ring indicates achievement of Stage II benchmarks; and the darkest, outermost ring represents achievement of Stage III benchmarks. In instances where no benchmarks have been achieved, an outline serves as a placeholder to indicate that the indicator is pre-Stage I.



Transition Readiness Profile - Albania

Albania has made relatively more progress in preparing for financial and programming transitions, but the situation is still quite dire. A needs projection study was undertaken as part of the planning process for the 2015-2019 national program, and the government has committed to fund the purchase of methadone for MMT in the future but for no other aspects of the program such as medical staff or psycho-social support services; however, there are no intentions to fund the procurement of needles or syringes. There are still no national standards for harm reduction services, and while coverage targets for the future are ambitious, current coverage remains low. CSOs are not able to be funded by government funding, making the scale-up of coverage after transition highly unlikely.

Without immediate, intensive action to improve Albania's readiness for transition, the country is poised to once again experience a collapse of its HIV program following the cessation of Global Fund assistance.



Attachment 2

Budgetary and epidemiological characteristics of harm reduction programs in Albania

Exchange Rate: Albania Lek 1.00 = USD0.0081665 (as of 14 April 2016, source: xe.com)

Comp: Component SA: Strategic Action NAP: National AIDS Programme

NSP 2015-19: National Strategy for the Prevention and Control of HIV/AIDS in Albania, 2015-2019

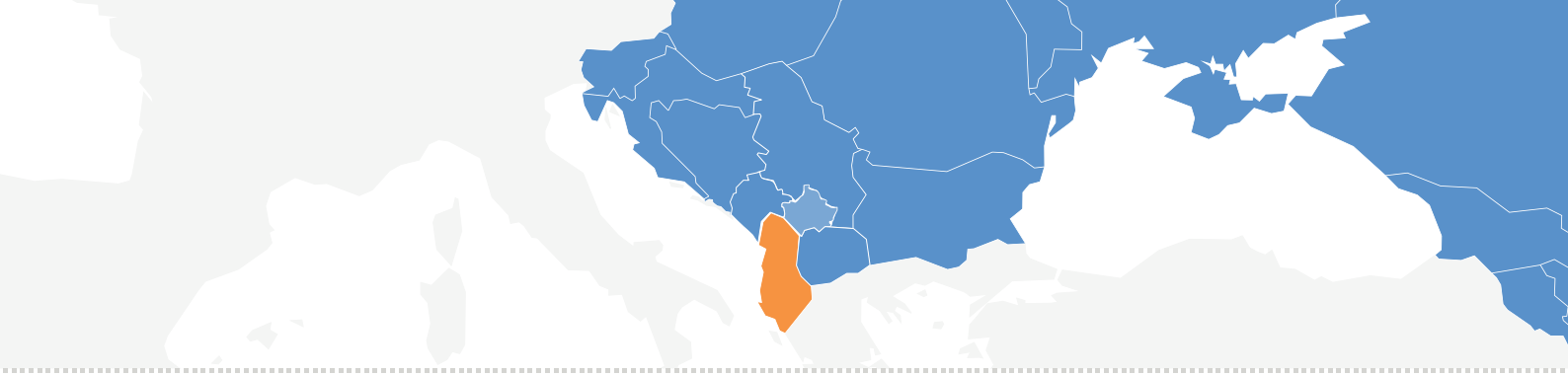
Budget Details	Component	2015	2016	2017	2018	2019	TOTAL (2015-2019)	Source(s)	Notes
Budget designated for harm reduction per national strategy	NSEP	$69,899	$143,118	$137,442	$116,577	$116,577	**$583,603**	NSP 2015-19	Comp 1, SA 1.1, 1.2, 1.3 (@50%), 22.4
	OST (incl prisons)	$283,141	$388,856	$417,178	$425,712	$455,111	**$1,969,997**	NSP 2015-19	Comp 1, SA 1.3 (@50%), 1.4, 1.5, 22.1-22.3
	HTC	$114,935	$115,034	$110,200	$109,677	$108,452	**$558,295**	NSP 2015-19	Comp 1, SA1.6; Comp 2, SA5; Comp 2, SA7
	ART	$9,652	$1,486	$1,078	$0	$0	**$12,217**	NSP 2015-19	Comp 1, SA2.1-2.3
	STIs	$11,188	$11,188	$11,188	$11,188	$11,188	**$55,941**	NSP 2015-19	Comp 2, SA3.1
	Condoms	$24,500	$24,500	$24,500	$24,500	$24,500	**$122,498**	NSP 2015-19	Comp 1, SA3.1-3.3
	IEC	$24,500	$24,500	$24,500	$24,500	$24,500	**$122,498**	NSP 2015-19	Comp 1, SA8.1-8.2
	Viral hepatitis	$415,757	$414,042	$414,042	$414,042	$414,042	**$2,071,923**	NSP 2015-19	Comp 1, SA5.1-5.3; Comp 1, SA7.1
	TB	Included in TB programme.						NSP 2015-19	-
	Enabling environment, strategic info., M&E	$326,905	$175,318	$142,914	$142,097	$304,611	**$1,091,845**	NSP 2015-19	Comp 1, SA4.1; Comp 2, SA4.1-4.2; Comp 7, SA1.1; Comp 7, SA2.1-2.3; Comp 7, SA7.1
	TOTAL	**$1,280,466**	**$1,298,042**	**$1,283,041**	**$1,268,293**	**$1,458,981**	**$6,588,814**	NSP 2015-19	-

Budget Details	Component	2015	2016	2017	2018	2019	TOTAL (2015-2019)	Source(s)	Notes
Actual budget realized for harm reduction	NSEP	0	GF grant negotiation has not started					Aksion Plus	-
	OST	Euro 34,000	GF grant negotiation has not started				Euro 34,000	Aksion Plus	-
	Other	0	GF grant negotiation has not started					NAP; Aksion Plus	-
Amount from domestic funding	NSP	0	0	0	0	0	0	NAP; Aksion Plus	-
	OST	0	Medication only for 100 clients	Medication only for 100 clients	Medication only for 100 clients	Medication only for 100 clients	Medication only for 100 clients	MoH/IPH via GF Secretariat	-
	Other (please specify)	0	0	0	0	0	0	NAP; Aksion Plus	-
Indicative amount from GF funding	NSP	0	0	$19,800	$31,350	$42,900	$94,050	GF Secretariat	HIV/TB grant negotiations are underway; completion expected by final quarter 2016
	OST	0	0	$112,685	$140,856	$159,637	$413,117		
	Other	0	0	$86,591	$115,478	$147,068	$349,137		
Amount from other external/donor funding	NSP	0	0	0	0	0	0	-	-
	OST	Euro 34,000 ($38,600)	0	0	0	0	0	Aksion Plus	From UN (WHO).
	Other	0	0	0	0	0	0	-	-
Calculated need for harm reduction	See 'Budget designated for harm reduction per national strategy', above.								
Gap between need and funds available	All	$1,241,866	$1,298,042	$1,283,041	$1,268,293	$1,458,981	$6,550,214	NSP 2015-19	OST 2015: $283,141 - Euro 34,000 ($38,600) = $244,541

NSP related data	2013	2014	2015	2016	Source	Notes
Number of government-based needle/syringe exchanges	0	0	0	0	NAP	-
Number of NGO-based needle/syringe exchanges	2	2	2	2	NAP; Aksion Plus	Tirana only.
Number of drug users enrolled in NSP	4,142 (2012)	unknown	unknown	80-150	GF; NAP; Stop AIDS	UNFPA funding in 2015-6 thru Stop AIDS; Tirana only.
Number of clients receiving minimum package of services*	4,142 (2012)	unknown	unknown	unknown	GF; Components of package unknown	-
Number of clients receiving expanded or comprehensive package of services	unknown	unknown	unknown	unknown	Components of package unknown	-
Coverage of NSP among drug users nationwide (Numerator: the number of drug users enrolled in NSP; Denominator: the estimated size of drug users)	-	104 per IDU, pa	-	-	GF	Tirana only.

OST related data	2013	2014	2015	2016	Source	Notes
Number of OST clinics nationwide	5	5	5	5	Aksion Plus	-
Number of clients on methadone	-	457	-	578	GF; Aksion Plus report to GF, 16 March 2016.	Incl. 61 clients in prison.
Number of clients on other substitutions therapies	unknown	unknown	unknown	unknown	-	-
Coverage of OST among drug users nationwide (Numerator: the number of drug users enrolled in OST; Denominator: the estimated size of drug users)	-	7.25%	-	9.17%	GF; Aksion Plus report to GF, 16 March 2016.	Incl. 61 clients in prison.

PWID and OST clients	2013	2014	2015
Tested for HIV (by year)	No data available		
Newly diagnosed with HIV (by year)			
On ART (cumulative)			
Living with HIV but not on ART (cumulative)			
Screened for TB (by year)			
Diagnosed with active TB (by year)			
Treated for TB (by year)			



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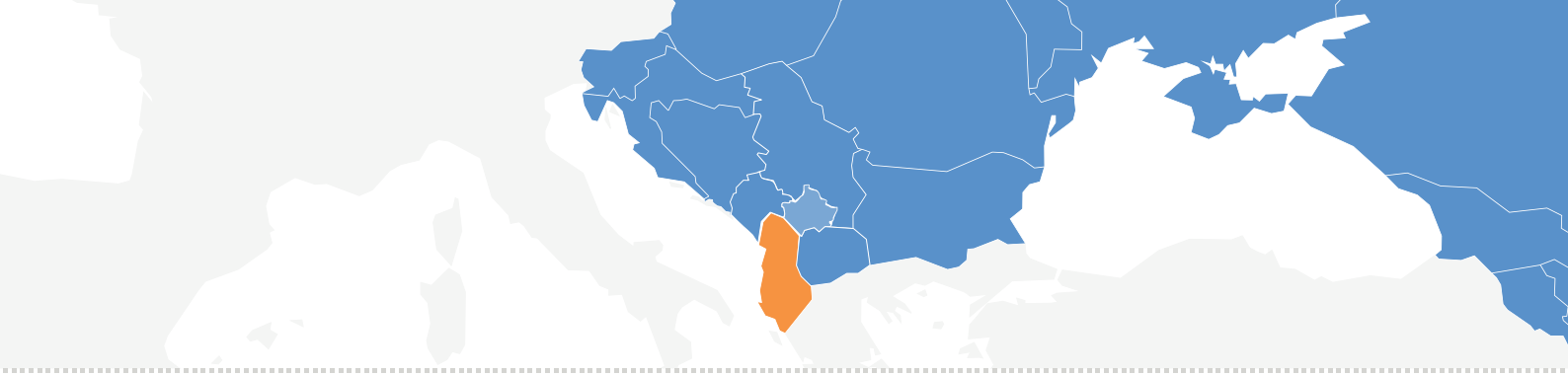

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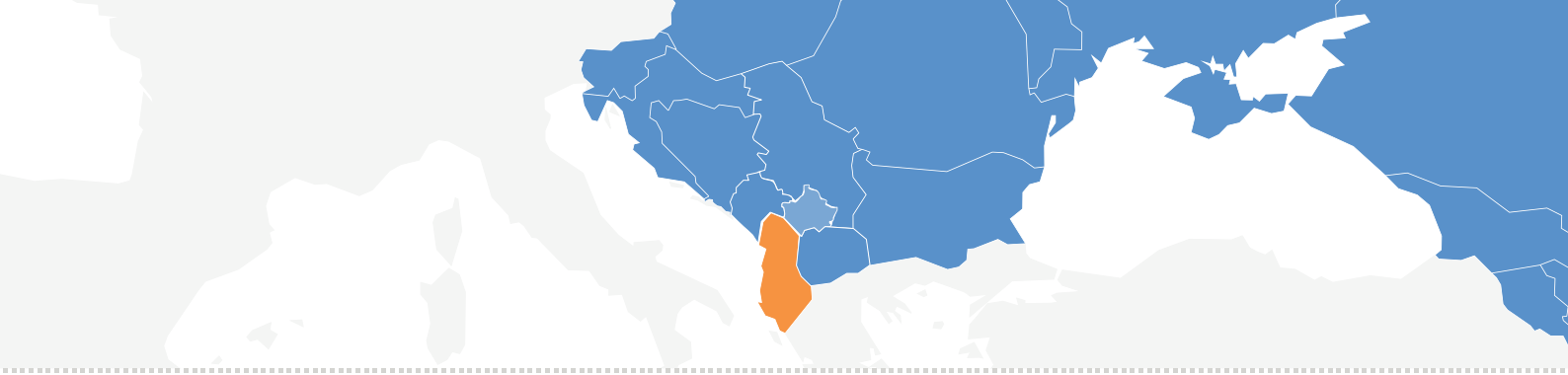

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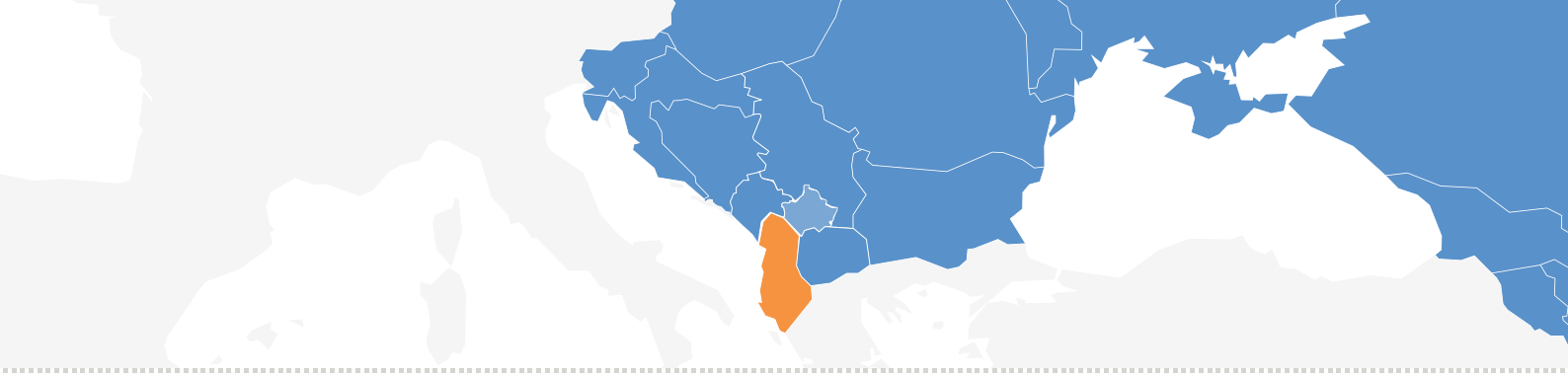

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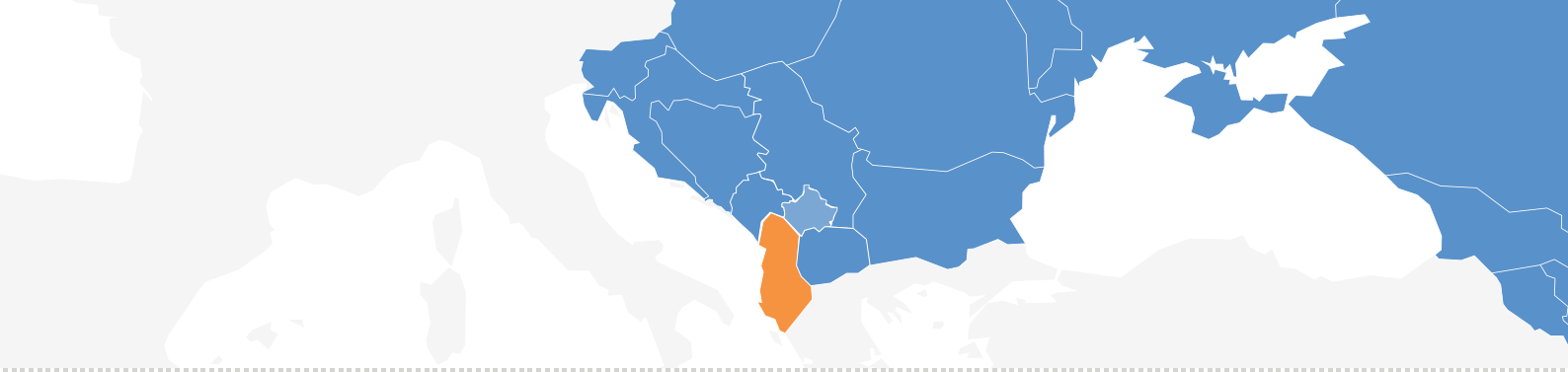

61 The Global Fund to Fight AIDS, Tuberculosis and Malaria. TB and HIV Concept Note: Albania. Module Budget: Prevention programs for people who inject drugs (PWID) and their partners. Geneva, The Global Fund to Fight AIDS, Tuberculosis and Malaria, 15 October 2015.

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69 GFATM/CCM, Op.cit.

70 GFATM. Grant Performance Report, Op.cit.

71 GFATM. Grant Performance Report, Op.cit.

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

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

BECOME AN EHRN MEMBER:

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

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