The financing and sustainability of harm reduction services in the EU

HA-REACT: WP8 meeting

6 April 2017, Vilnius, Lithuania

Jeffrey Lazarus (CHIP), from the HA-REACT Steering Committee, opened this meeting of the Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT) by reminding the almost 30 participants (See Annex 1) that one aim of HA-REACT's Work Package 8 is to help countries access harm reduction funds, especially via EU structural funds. EU structural funds are most often used for infrastructure but can also be used for health improvements and countries in need should consider pursuing this avenue. The WP8 team has prepared draft "tips sheets" on structural funds and joint procurement that will be publicly released in 2017. For the meeting, the team also shared three country examples presenting different harm reduction funding flows (See Annex 2-4) and a document containing key financial terms (See Annex 5). Professor Lazarus then invited participants to provide feedback and suggest ideas for future tips sheets.

Lazarus posed two questions for the meeting:

1. What do participants need, and how can HA-REACT help stakeholders in EU Member States over the next 18 months?
2. More specifically, do we need more research, information gathering or opportunities to meet/discuss/plan?

Charles Gore (World Hepatitis Alliance) said that one of the major challenges we are currently facing in hepatitis elimination is getting countries to commit to harm reduction. Advocacy is critical, he said, and it must be stressed that harm reduction improves health and saves money. As we shift away from external funds countries need innovative funding mechanisms for their health system and one of these could be pooled procurement. Additionally, countries could follow the example of England, which is trying to get the pharmaceutical industry to bear some harm reduction costs.

Integrated approaches using existing services (e.g. HIV) are cost-effective. HCV treatment for people who inject drugs (PWID) without harm reduction leads to high reinfection rates. Needle and syringe programmes (NSPs) are a great way to engage PWID with services, and it is easy to provide direct-acting antivirals at the same time as opioid substitution therapy (OST), for example.

Rob Walton (HB&CPPA) argued that because governments will not increase health expenditure funding, harm reduction scale-up should employ some of the alternative funding mechanisms used in other sectors. He summarized these mechanisms, with particular focus on bonds (See Annex 5). Floating 30-year bonds requires minimal government financial outlay, investors make money, the government saves on long-term health costs and harm reduction is scaled-up. **Charles Gore** observed that while this scale-up will not end drug addiction it will save money in the long run for the treatment of HIV and HCV. Elimination provides an endpoint, which is attractive to politicians and this agenda therefor has great political capital. Gore ended by suggesting to use the phrase *health promotion* instead of *harm reduction* – it's easier to sell to politicians potential funders. The investment case developed by experts was significant in changing the HIV landscape; the European Association for the Study of the Liver (EASL) could do something similar with HCV. **Jeff Lazarus** agreed that it made sense to frame scale-up in terms of hepatitis C elimination, in line with the WHO strategy. **Rob Walton** concurred, but warned of the consequences of leaving out a long-term commitment to uninfected PWID.

*Highly relevant to harm reduction settings
**Could be relevant in principle – not available examples from high-income countries

Several presenters then quickly presented harm reduction funding situations in their respective countries. **Jurgita Poškevičiūtė** (I Can Live) described how, in **Lithuania**, NSPs obtain most of their funding from municipalities. Twenty percent of this funding comes from the state budget and an NGO underwriting rapid HIV tests. NSP coverage in Lithuania is about 20% and NGOs distribute just 75 items per person each year. Funding has been slowly declining, while the cost per client has more than doubled; half the sites are on the verge of closing and staff sometimes do not receive salary. The state has actually received EU structural funds for site and service expansion, but it has been stuck "in the planning process" at the Ministry of Health for three years now. OST is now funded through the National Patient Fund – and while it is a positive development that it is now considered routine medical treatment, coverage has halved since 2010. The Ministry of Justice will not allow OST in prisons. **Gergely Horváth** (REITOX) described a similar situation in **Hungary.** After buprenorphine was available free of charge; it reduced the administrative burden, but a decline in heroin use has led to less demand for the service.

Joana Lamas (SICAD) presented **Portugal**'s programme for integrated responses, addressing: addiction prevention and treatment, harm reduction and social reintegration in all healthcare settings. In 2012, restructuring created a lot of communication and administrative barriers between different national and local entities. She said SICAD funds 80% of programmes approved by the Ministry of Health, but asked, "Where do NGOs find the other 20%?" Programmes can be renewed every two years, yet costs are rising. **Adriana Curado** (GAT) noted that while Portugal is held up as a model for harm reduction in Europe, its current policies allow no room for innovation and is generally problematic – an example of unsuccessful integration.

Inma Gisbert Civera (consultant) said that **Spain** provides universal healthcare free of charge at the point of use for anyone with resident status in Spain. People who inject drugs (PWID)'s HIV situation in Spain has changed in the last 20 years. In 1990, the most common risk was sharing syringes. In the same year, 64% of new HIV infections were among PWID. This percentage fortunately has decreased. Between 2009 and 2015, HIV incidence among PWID fell by two-thirds, from 8.4% to 2.8%.

NGOs play a central role in harm reduction. Besides NSPs and OST, their sites offer various other social assistance services – all covered by social funds. Harm reduction funding is provided by the Ministry of Health (National Plan on Drugs, National AIDS Plan and the Social Service & Equality Secretary) and the Prison Health Department (Ministry of the Interior). The National AIDS Plan's budget to finance HIV NGOs (including its harm reduction budget) plummeted 75% in 2012. Drug intervention funding in many autonomous community budgets has also fallen. Public budgets are published by institutions. Harm reduction services are included in other categories such as addiction and drug prevention, HIV prevention or public health in general. Harm reduction is not always a funding priority for public institutions. The annual call for grants is not the best way to fund sustainable services and doesn't allow outcome evaluation. **Jeff Lazarus** noted that in Barcelona, for example, the police support harm reduction and help connect PWID to social services.

Artur Malczewski (REITOX) said that, in **Poland**, the number of NSPs has stabilized after a period of decline. There are now more people on OST, though coverage is still insufficient. The growing use of new psychoactive substances, which involve high-frequency injections, poses new problems. Harm reduction is incorporated into Poland's drug law. The new issue in Poland is the rise of conservative, nationalistic attitudes, which may lead to budget cuts. NGOs are the main provider of harm

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reduction. They are supported at various levels of government, but not by foreign grants. Unfortunately, only a few NGOs are interested in providing harm reduction. Municipal support varies greatly. Funding is awarded by annual tender. Drug treatment (including OST) and antiretroviral therapy are free, but HCV treatment is not free for PWID, despite a 75% HCV prevalence rate. The National Health Fund provided 94% of OST funding in 2015. Needles are not available in addiction counselling centres.

Iva Jovović (LET/Flight) explained that since **Croatia**'s Global Fund grant expired in 2006, the government has been the primary funder. General practitioners administer OST on a daily basis, though it must first be prescribed by an addiction specialist. Nearly half of the cost of OST comes from Croatia's Health Insurance Fund. Harm reduction funding comes from the state and from local communities. As Croatia is a conservative country, public HIV funding activities are often disguised, e.g. "synergies with the development sector." Lottery funds are crucial for HIV harm reduction funding. Funding decreased during the global financial crisis and has not yet recovered to 2007 levels. Long governmental delays in disbursing money to NGOs are a major problem. Sometimes these delays take many months. A grant from the Global Fund has been used for major investments, like vehicles and opening new sites. Jovović warned about becoming dependent on structural funds for daily operations, saying it was better to use them for one-time investments.

Jeff Lazarus closed by inviting participants to let him know how to make the Joint Action work best for everyone in its last 1.5 years. What do countries need for successful harm reduction financing and sustainability – and how can our partner organizations support it? He mentioned that the event was being promoted on social media (see Annex 6) and noted three upcoming events:

- 12–14 June 2017: Drug-related infectious diseases (DRID) expert meeting (EMCDDA)
- 6-8 September 2017: International Network on Hepatitis among Substance Users conference (New York)
- 24–26 October 2017: Lisbon Addictions conference; there will be an HA-REACT Partnership Forum the next day.

He said that while it is great to have a document outlining funding possibilities – and he would like feedback on the draft in the end we need to press governments to honour their national and international commitments, including WHO targets and the United Nations' Sustainable Development Goals.

—Misha Hoekstra, rapporteur

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Annex 1: List of Participants

Massimo Colombo	Clinical and Research Center Humanitas Rozzano, Italy
Helena Cortez-Pinto	European Association for the Study of the Liver (EASL), Portugal
Adriana Curado	Grupo de Ativistas em Tratamentos (GAT), Portugal
Anna Dovbakh	Eurasian Harm Reduction Network (EHRN), Ukraine
Ágnes Galgóczy	Office of the Chief Medical Officer (OCMO), Hungary
Inma Gisbert	Consultant, Spain
Charles Gore	World Hepatitis Alliance, United Kingdom
Misha Hoekstra	HA-REACT consultant, Denmark
Kirsten Lea Horsburgh	National Naloxone Coordinator, Scotland
Gergely Horváth	Reitox Hungarian National Focal Point, Hungary
Iva Jovovic	Consultant (Life Quality Improvement Organisation Flight), Croatia
George Kalamitsis	Hepatitis B and C Public Policy Association (HBCPPA), Greece
Kristel Kivimets	National Institute of Health Development, Estonia
Aljona Kurbatova	National Institute of Health Development, Estonia
Joana Lamas	Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD), Portugal
Jeffrey Lazarus	HA-REACT, CHIP, Rigshospitalet, University of Copenhagen, Denmark
Artur Malczewski	Consultant (Reitox National Focal Point of EMCDDA in Poland), Poland
Viktor Mravcik	National Monitoring Centre for Drugs and Addiction, Czech Republic
Denise Ocampo	ISGlobal, Hospital Clínic, University of Barcelona, Spain
Jurgita Poskeviciute	I Can Live, Lithuania
Tatjana Reic	European Liver Patients' Association (ELPA), Croatia
Eberhard Schatz	Correlation Network, Netherlands
Miran Solinc	Škuc Association, Slovenia
Emilis Subata	Vilnius Center for Addictive Disorders, Lithuania
Tuukka Tammi	HA-REACT, National Institute for Health and Welfare (THL), Finland
Rob Walton	Hepatitis B and C Public Policy Association (HBCPPA), United Kingdom

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Annex 1: Croatia – funding flows for harm reduction

Opioid substitution therapy (OST) was the first harm reduction that was introduced in Croatia in 1991. The first needle and syringe programme (NSP) was launched in 1996. OST started with methadone, and then in 2009 suboxone was added as an alternative substance.

Croatia has a unique system in which general practitioners may administer OST but only specialist office-based doctors can prescribe it. NSP programmes are only implemented by NGOs; a mechanism for NGOs to receive funding from the state budget was created in 1999. Calls for proposals are issued by the relevant ministries and government offices, and approximately €210 million is disbursed each year to NGOs in all sectors. While most calls are issued annually, calls for NSP proposals are issued every three years. NGO funding is provided by the state budget and from lottery and gambling taxes; allocation is predetermined by a bylaw that assigns a fixed percentage to NGOs providing drug prevention services. While EU funds are used for actions at the policy level – for instance through joint action mechanisms – only domestic funds are used for NSPs and OST. The Ministry of Health remains the main funder of NSPs, with some contributions from local authorities.

Drug-related treatment is the responsibility of the Ministry of Health, while related programmes (such as those for young drug users and for the rehabilitation and resocialization of drug addicts) are the responsibility of the Ministry of Demography, Family, Youth and Social Policy.

HIV and HCV treatment are covered by the Croatian Health Insurance Fund; they are not provided by NGOs as part of harm reduction services because such treatment can only be provided by medical institutions. While HCV is treated in local hospitals, ART is centralized due to treatment and distribution costs.

The average total funds expended annually for HIV prevention, treatment, monitoring and evaluation, surveillance and research was approximately €8.6 million in 2010–2013. Currently, the largest expenditure is prescribed methadone, which cost €5.3 million annually. For 2017, €302,000 is projected to be allocated from the state budget to NGOs for the implementation of harm reduction programmes. While that is sufficient for existing programmes, it might make the contracting of new NGOs problematic. A 2011 study calculated that the cost of the National Drug Prevention Strategy and all drug-related public expenditures represented 0.2% of the country's gross domestic product.

Ministry of Health delays in contracting NGOs lead to delayed funding transfers – one of the main challenges in implementing harm reduction activities in Croatia. In additional, calls for proposals are only issued every three years, and administrative mistakes often result in the rejection of proposals, causing programmes to close. Monitoring and evaluation of HCV prevention programmes need to be scaled up, just as they have been for HIV prevention programmes.

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Annex 2: Poland – funding flows for harm reduction

Harm reduction programmes have been conducted in Poland since 1996, mainly by NGOs. The first NSPs were launched as early as 1989, as extra services provided by selected outpatient clinics. According to the most recent data, the number of OST clients has increased while the number of NSPs has decreased. Reasons include limited financial support from local and regional governments for NSPs, a decrease in injecting drug use and a lack of willingness from NGOs to operate harm reduction programmes. In addition, open drug scenes – where people who use drugs meet and purchase drugs – have started to disappear, which has made it much harder for outreach workers to reach drug users.

Health care in Poland is publicly funded and available to all citizens of Poland, provided that they are insured. Drug treatment is provided by both public and non-public health care units. Drug users have access to free drug treatment and harm reduction programmes. Harm reduction funding is provided by a central budget from the National Health Fund (NHF) and the National Bureau for Drug Prevention (NBDP). It also includes funding from regional governments (marshal offices) and local governments (municipalities). Drug prevention programmes and harm reduction services, are financed in a similar way. In Poland, calls for grant applications are organized by central institutions (such as the NBDP) and municipal authorities.

In 2015, a total of €5.64 million was spent on harm reduction programmes, including OST, NSPs, nightlife outreach, condom distribution, health education, emergency support for overdoses and leaflet dissemination. Support for local activities is also provided by a few local governments. In 2015, harm reduction programmes were financed by 99 of 2478 municipal authorities through locally organized competitions.

Antiretroviral therapy (ART) is provided in hospitals, which serve as referral centres for HIV patients. ART is also available in penal institutions for people who began treatment prior to imprisonment. In 2015, 30 referral centres were financed by the National AIDS Centre. These centres offer anonymous and free HIV tests, also to PWID. HCV and HIV treatment is provided through medical drug programmes financed by the Ministry of Health. Every year, the Ministry distributes funds to purchase antiretroviral drugs, totalling €69 million in 2015. According to the 2015 National Drug Report, there were 24 non-custodial OST programmes in 14 of the 16 provinces. Regional branches of the NHF have specific competitions for OST funding. The winning bidders sign multiyear contracts with the NHF.

Annex 3 Spain – funding flows for harm reduction

The Spanish health system is publicly financed and provides nearly universal, free healthcare at point of use for permanent residents of Spain. The system is decentralized; the governments of the Spanish autonomous communities (regions) manage and finance all services.

The first ministerial order authorizing OST with methadone was approved in 1983, and in 1990 the first NSP started, in Barcelona. The first prison NSP was organized in 1997 at Basauri Prison, in the

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Basque Country. In 2000 the first safe injection room opened, in Madrid, and in 2015, the first safe injection room opened, in a drug users' shelter in Bilbao.

Harm reduction services in Spain have two objectives: first, to reduce the harms associated with drug use and second, to bring PWID into contact with healthcare networks. While all 17 autonomous communities provide some harm reduction services through their healthcare networks, NGOs manage most of these services and programmes. The services include NSPs, OST, safe injection centres in some regions, such as Catalonia and the Basque Country, and drug users' shelters in Bilbao. Harm reduction centres also provide other services such as showers, laundromats, rest rooms, snacks, social assistance and healthcare.

Local, provincial, regional and national institutions support harm reduction services and programmes. However, funding has decreased in recent years (2010–2015). At the national level, three institutions (National Plan on Drugs, National AIDS Plan and Social Services, and the State Secretariat for Equality) provide some funding for these services. They provide grants to NGOs, though none of these grants are specifically dedicated to harm reduction.

In all the autonomous communities, there is coordination between harm reduction services and health services that provide OST in drug addiction centres. At times, however, there has been wide variation in the distribution of competences at local, provincial and regional levels. For example, in some regions, such as Catalonia, the Basque Country, Navarra and the city of Melilla, pharmacies are involved in NSPs. Catalonia and the Basque Country have some of the most comprehensive harm reduction service networks, including drug addiction centres, mobile units, safe injection rooms, day centres (low-threshold centres) and drug users' shelters that offer NSP, OST, social assistance and healthcare.

The current system, in which NGOs working with harm reduction must apply for new grants every year, is challenging and not the optimal way to fund stable, sustainable services. In addition, monitoring and evaluation of services and programmes remain weak.

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Annex 5: Mechanisms for lending/investing[1]

- **Secured lending**: funds the purchase of fixed assets, buildings or equipment. The contract is for the return of original investment plus regular payments of interest within an agreed time period. Risk of loss is mostly determined by the quality of the collateral asset (e.g. buildings) and interest rates charged are typically 2.5–7% depending on the term of the loan.

- **Unsecured lending**: provision of working capital or funding day-to-day trading. Similar contracts as for secured lending, but risk assessment is usually based on credit rating, trading history and existing assets/liabilities of the enterprise. Interest rates are typically 9–20% depending on the type of loan and term.

- ***Bond finance**: debt security issued to fund long-term investments, or in the case of government bonds, to finance current expenditure. The bond issuer owes the holder's a debt and, depending on the terms of the bond, pays interest (the coupon) and agrees to repay the principal on a fixed maturity date. Usually low-risk, low-return. However, traditional bond finance involves a guaranteed return on investment, with changes in bond prices and expectations of inflation being the major risk factors (assuming the creditworthiness of the issuer). Bonds have a defined term, and bondholders (being creditors) take priority over equity investors, which makes bonds a safer and more appropriate vehicle for our context.

- **Equity or quasi-equity investment:** to fund development of an enterprise or build reserves. The contract is usually between the investor and the enterprise; the investor buys a right to a share of revenues over a defined period. The whole investment is at risk: if expected financial performance is not achieved, a lower, possibly zero, financial return will result. Expected rates of return are usually 10–25%.

Categories of asset classes[2]

An asset class is a group of securities that exhibits similar characteristics, behaves similarly in the marketplace and is subject to the same laws and regulations.

- **Private debt**: terms usually less than 10 years but may be as long as 20. These products may have a wide range of variable and fixed interest rates and may be offered as fixed-income investments in community finance organizations, community loan funds or 'community bonds'. The primary focus is non-profits and social enterprise.
  - For example, Triodos Bank offers a range of liquid offerings to individual, business and institutional customers and "only lends to and invests in organisations that benefit people and the environment."

- **Public debt**: exchange-traded fixed-income securities issued by either private or public (local, regional or national level) entities. Typically provide the market with low-risk, low-return investment opportunities. These financial instruments are freely tradable on a public exchange or over-the-counter with few, if any, restrictions.

[1] Davison R, Heap H. Can Social Finance Meet Social Need [Internet], 2013.
[2] World Economic Forum. From the Margins to the Mainstream Assessment of the Impact Investment Sector and Opportunities to Engage Mainstream Investors, 2013.

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- **Public equity**: exchange-traded products typified by Socially Responsible Investment (SRI) mutual funds. These are available to retail and institutional investors through financial institutions, asset management firms and credit unions. Few have explicitly stated impact mandates. The first Social Stock Exchange was launched in London in 2013; it showcases a small number of impact enterprises that trade on the London Stock Exchange.

- **Social venture capital**: these products are a form of private equity which provide accredited and institutional investors with opportunities to invest in early-stage companies with social or environmental objectives. The primary focus is environmental technology and renewable energy, with a typical term for investments of 10 years. To attract institutional investors, who would not deal directly with small programmes, over 250 impact investment funds exist. Originally designed for-profit social enterprises. However, non-profit organisations deploy venture capital strategies to fund events and activities.

- ****Debt forgiveness schemes**: creditor countries agree, by means of individual agreements, to write off loans to developing countries on condition that the repayments are redirected to specified investment vehicles.
  - For example, the Debt2Health programme uses the existing Global Fund system to channel loan repayments into healthcare. As of 2013, four Debt2Health agreements and one framework agreement had been signed. Germany and Australia were the creditor countries and Indonesia, Pakistan and Côte d'Ivoire the contracting beneficiaries. For example, in exchange for Germany forgoing a debt of US$27 million, Côte d'Ivoire was required to invest at least half of the proceeds on national HIV treatment and prevention programmes.[3]

- ****Hypothecated taxes**: Hypothecated taxes are also known as dedicated or earmarked taxes. They generate revenue designated for a particular expenditure. The notion of setting aside revenues from taxation and reserving them for a specific purpose is not new. The ancient Athenians raised taxes for explicit purposes: the Greek word, "hupotheke," means pledge or deposit and is the root of our modern English word "hypothecate." When hypothecation of tax revenue is successful, distinct benefits can be achieved. In each case, the taxpayer understands the reason for the tax and how it is apportioned. In a 2010 report by the World Health Organization (WHO), these conferred benefits were identified to include increased transparency, improved accountability and trust in the public sector to protect resources that could otherwise be at risk of reallocation under general taxation.[4] Numerous examples of hypothecated taxation exist:
  - In the US a portion of fuel taxes are set aside for building roads and transport infrastructure.[5]
  - Established in 2000, Zimbabwe's AIDS Trust Fund works by receiving proceeds from a 3% tax levied on formal sector employers and employees. While the figures for funding generation are not available between 2000-2008 as the estimated figures were distorted due to hyperinflation, the figures from 2009-2011 showed a rapid increase from US$5.7

[3] Atun R. et al. Innovative financing for HIV response in sub–Saharan Africa; *Journal of Global Health,* 2016.
[4] Doetinchem O. Hypothecation of tax revenue for health. World Health Organzation, 2010.
[5] Bousquet F, Queiroz C. Road financing systems: A cross-country comparison of typical issues and good practices. World Bank, 2009.

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million to US$26.5 million. Of the funds generated, 50% were earmarked for antiretroviral treatment programmes, 10% for HIV prevention and 40% towards administration costs. [3]

Types of bond financing in healthcare context

- **Pharmaceutical Market Access (MAS) Schemes**: Post-authorisation market access schemes originated as simple discounts or rebates negotiated by payers for drugs they considered expensive. This expanded to include risk-sharing schemes for drugs whose clinical trials had been successful but had not convincingly demonstrated cost-effectiveness.
  - E.g. in Sweden, a 5-year MAS for Levodopa in Parkinson's allowed a premium price while evidence was generated to demonstrate incremental cost-effectiveness ratio (ICER).[6]

- ***Vaccine bonds**: The International Finance Facility for Immunisation (IFFIm), sells "vaccine bonds" to raise funds for the GAVI Alliance, a public-private partnership (PPP) providing access to vaccination in 70 low-income countries. A 2011 report claimed that 2.1 million lives had been saved. No outcome measures are involved.[7]

- ***Municipal bonds**: Easy to adapt to social investment purposes, as maturity periods can vary over a wide range. Usually applied to local projects (schools, hospitals, public housing, and public infrastructure such as transport, power and waste disposal) and they can be secured by specified revenue streams rather than general obligations. This makes them amenable to discrete projects with measurable outcomes; however, typical municipal bonds are not outcomes-based.

- **The Private Finance Initiative (PFI)**: encourages groups of private investors to manage the design, build, finance and operation (DBFO) of public infrastructure. In a typical PFI project, a Special Purpose Vehicle (SPV) manages and finances the design, build and operation of a new facility. The financing of the initial capital investment is provided by share capital and loan stock from the owners of the SPV together with senior debt from banks or bond-holders. The return on both equity and debt capital is sourced from a periodic "unitary charge" paid by the public authority from the time when the contracted facility is available for use. The charge may, to some extent, depend on outcomes: if there is a delay in construction, if the facility is not fully operational, or if services fail to meet contracted standards. In theory, this not only transfers risk to the private sector but also encourages timely delivery, since the SPV is not paid until the asset has been delivered.
  - In 2001, Helios-Kliniken won a tender to operate and replace a 1,100-bed hospital in Berlin that had been facing financial losses due to decreasing patient volumes combined with overstaffing. The €215-million build, own and operate hospital model was privately financed in full, without the use of public funds. Under the concession contract, HK assumed the hospital license and the assets and liabilities of the existing facilities. Staff contracts were transferred to HK, and the government monitors quality through pre-established key performance benchmarks.[8]

[6] Jarosławski S. et al. Market access agreements for pharmaceuticals in Europe: diversity of approaches and underlying concepts. *BMC Health Services Research,* 2011.
[7] GAVI Alliance. Progress 2011.
[8] Global Health Group.; Public-Private Investment Partnerships for Health: An Atlas of innovation, 2010.

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- ***The Social Impact Bond:** at first glance appear to be a kind of municipal bond (they are fixed term and the investment upside is capped), they are not secured by hard assets or cash flows; like equity. Returns vary based on performance and investors bear a higher risk of losing their principal. They are therefore a promising means of transferring risk to investors through the use of outcomes measures.
  - Originated in the United Kingdom in 2007 in response to Prime Minister Gordon Brown's request for the Council of Social Action "to generate initiatives through which government and other key stakeholders could develop and celebrate social action." The first social impact bond programme was implemented in the UK at Peterborough Prison. If there was at least a 10% reduction in reoffending per cohort, or a 7.5% reduction across all cohorts, the Ministry of Justice, supported by the Big Lottery Fund, agreed to repay investors their capital and a return on the investment equivalent to an annual internal rate of return of around 7.5%.[9]

[9] Disley E, et al. Lessons learned from the planning and early implementation of the Social Impact Bond at HMP Peterborough; 2011.

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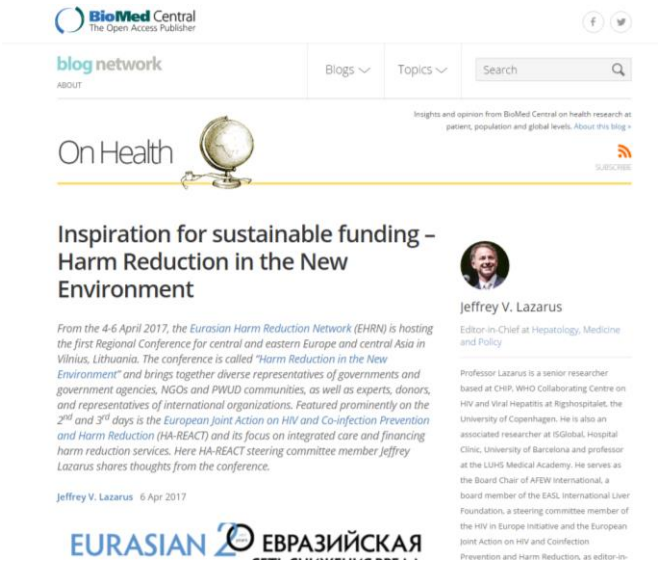
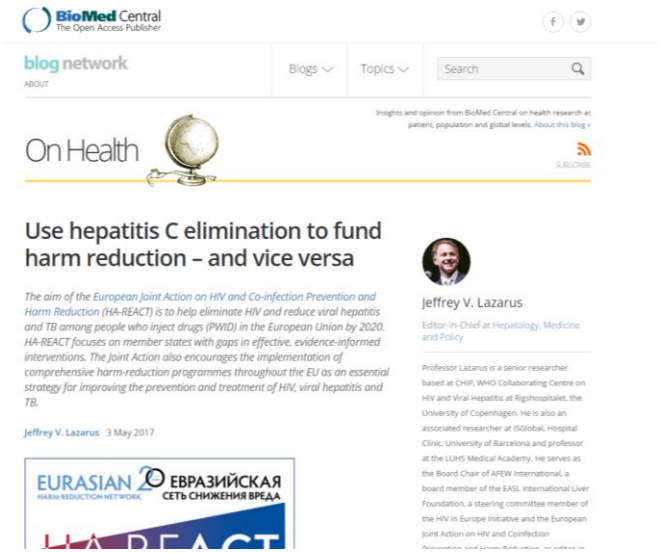
Annex 6: Social Media Promotion (#HAREACT)

Blog posts from the WP8 meeting on financing and sustainability of harm reduction services in the European Union:

1. Inspiration for sustainable funding – Harm Reduction in the New Environment - On Health

2. Use hepatitis C elimination to fund harm reduction – and vice versa - On Health





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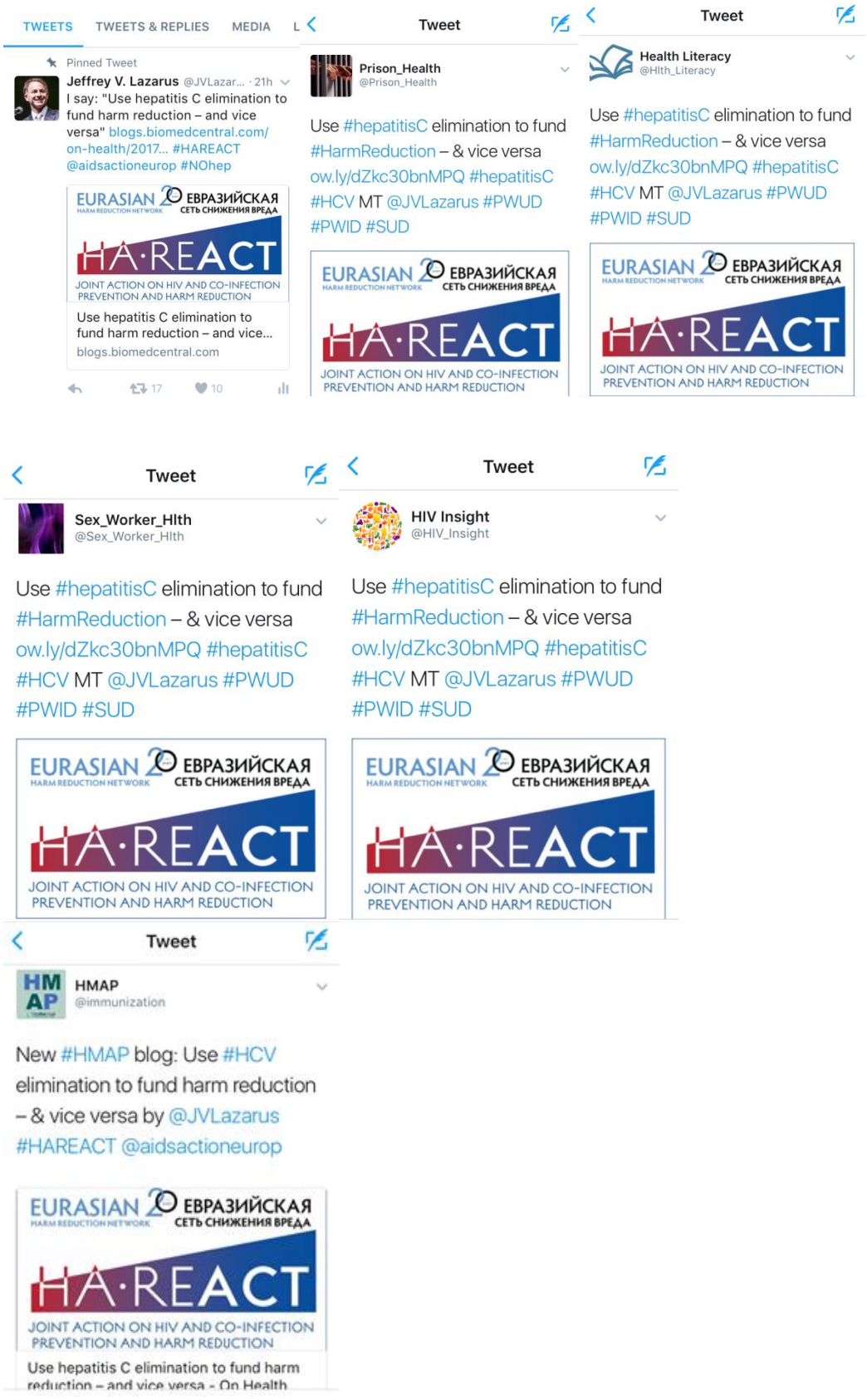

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