EURASIAN HARM REDUCTION NETWORK
ЕВРАЗИЙСКАЯ СЕТЬ СНИЖЕНИЯ ВРЕДА

# Quitting While Not Ahead

**The Global Fund's retrenchment and the looming crisis for harm reduction in *Eastern Europe & Central Asia***

**May 2012**

This report was produced by Eurasian Harm Reduction Network (EHRN) and Civil Society Action Team (CSAT) for Eastern Europe and Central Asia.

EHRN acknowledges the support that made this publication possible by:

- German BACKUP Initiative, a programme commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ) and implemented by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
- Open Society Foundations (OSF)
- International Council of AIDS Service Organizations (ICASO)

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EHRN, co-writers and editors, who worked on the publication, express their gratitude for providing valuable insights through interviews, correspondence and draft reviews to: Roland Bani, Institute of Public Health, Albania; Arian Boci, Stop AIDS, Albania; Genci Mucollari, Aksion Plus, Albania; Anahit Harutyunyan, Positive People Armenian Network; Olga Atroshchanka, UNDP, Belarus; Oleg Eremin, Association of HIV-Service NGOs "Belset anti-AIDS," Belarus; Liudmila Trukhan, Positive Movement & CCM Member 2012/2013, Belarus; Larisa Bashmakova, UNAIDS & CCM Member 2012/2013, Kyrgyzstan; Anna Chernyshova, UNDP, Kyrgyzstan; Aibar Sultangaziev, Partnership Network & CCM Member, Kyrgyzstan; Karile Levickaite, Global Initiative in Psychiatry, national co-writer of the country proposal to Round 11 & coordinator of the NGO working group on proposal writing, Lithuania; Andrei Mosneaga, Liliana Caraulan, Stela Bivol, NGO PAS Center, Moldova; Gabriela Ionascu, UNAIDS, Moldova; Viorel Soltan, Head of the EECA Delegation to the Global Fund Board and Chair of the Finance and Operational Performance Committee (FOPC); Fidelie Kalambayi, Silvia Asandi, NGO Romanian Angel Appeal (RAA), Romania; Valentin Simionov, Romanian Harm Reduction Network; Alina Bocai, formerly UNODC, Romania; Daan van der Gouwe, Evaluator of the UNODC Romania project, The Netherlands; Pavel Aksenov, ESVERO, Russia; Anna Potomova, Ksenia Eroshina, Open Health Institute, Russia; Pavlo Smyrnov, Liudmila Shulga, International HIV/AIDS Alliance, Ukraine; Marina Smelyanskaya, EHRN Consultant; Nicolas Cantau, Elena Zaytseva, Vitaly Zhumagaliev, Global Fund to Fight AIDS, Tuberculosis and Malaria; Daniel Wolfe, Shannon Kowalski, Open Society Foundations (OSF); Susie McLean, International HIV/AIDS Alliance; Jamie Bridge, Global Fund to Fight AIDS, Tuberculosis and Malaria; Arben Fetai, Stop AIDS Alliance; Damon Barrett, Harm Reduction International; Simona Merkinaite, Ivan Varentsov, EHRN.

This report would not be possible without the inspiration and contributions of the participants at the Regional Consultation "Responding to the Financial Crisis of the Global Fund in Eastern Europe and Central Asia," organized by EHRN on 26-27 January 2012 in Vilnius, Lithuania.

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## Acronyms and abbreviations

| | |
|---|---|
| ART | antiretroviral treatment |
| CCM | Country Coordinating Mechanism |
| CSS | community systems strengthening |
| EECA | Eastern Europe and Central Asia |
| EHRN | Eurasian Harm Reduction Network |
| ESF | European Social Fund |
| EU | European Union |
| Global Fund | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| M&E | monitoring and evaluation |
| NSA | National Strategy Application (of the Global Fund) |
| NSP | needle and syringe programme |
| OECD | Organisation for Economic Co-operation and Development |
| OST | opioid substitution therapy |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| PLHIV | people living with HIV |
| PWID | people who inject drug |
| QALY | quality-adjusted life year |
| RCC | Rolling Continuation Channel |
| TFM | Transitional Funding Mechanism |
| UNODC | United Nations Office on Drugs and Crime |
| WHO | World Health Organization |

Note on text: All "$" figures are U.S. dollar amounts, unless specified otherwise.

# Executive Summary

***The Global Fund's General Manager firmly stated to the media: "Discontinuing programs is not an option. […] There is an ethical responsibility that is well understood by the donor countries, and we are very proud of keeping those populations with a good quality of life."***[1]

**Over the last decade, the Global Fund has played a unique and indispensable role in responding to the HIV epidemic among people who use drugs in Eastern Europe and Central Asia (EECA).**[2] From 2002 to 2009, it approved $263 million for harm reduction in EECA alone—more than all other international sources combined. This enabled the steady expansion of harm reduction programs in the region. The Global Fund supported not only syringes and medicines, but also programs to reduce stigma, mobilize communities, and build the service and advocacy capacity essential to the establishment of sustainable, nationally supported programs. In a region where people who use drugs have traditionally been criminalized and excluded, the Global Fund pushed for their human rights and full inclusion.

In 2011, a sharp reduction in donor support forced the Global Fund to halt new funding and impose cost-cutting measures. EECA, which is home to a fast-growing HIV epidemic concentrated among people who inject drugs (PWID), has already been affected and will be hit particularly hard by these changes in the near future. The Global Fund's decision to reduce funding availability based on country income ignores the fact that income is not the determining factor for the availability of HIV services for PWID; rather, the decisive factor is political will. With few alternate funding sources available, there is the risk of the growth of the region's concentrated HIV epidemic, and loss of the many gains made in the last decade with Global Fund support.

**Global Fund changes in 2011 included:**

**Cancellation of Round 11,** scheduled to begin its support in 2013 (originally planned to begin in 2012). At least eleven Round 11 HIV/AIDS applications from EECA were being prepared that focused on harm reduction. Eight planned to focus on key populations and high-impact interventions through the Global Fund's Targeted Pool funding stream.[3] Moldova's proposal was for the second wave of National Strategy Applications (NSAs).[4]

- When they began developing Round 11 proposals, Albania, Azerbaijan, Belarus, Moldova, and Tajikistan all foresaw potential interruptions of harm reduction services previously funded by the Global Fund. Since the Round 11 proposals were to finance services starting from 2013 at the earliest, the affects of cancellation will become apparent only in the longer term.
- EHRN planned a regional proposal covering nine countries with a high burden of HIV and a severe burden of TB. It would have been the region's first large scale advocacy and technical support initiative to address key regional barriers to an effective and sustainable HIV response.

**Replacement of Round 11 with a Transitional Funding Mechanism (TFM)** available only "to provide for continuation of essential prevention, treatment and/or care services by current grantees."[5] Essential services were defined as HIV 'prevention and treatment targeted at key populations with high levels of incidence,' including people who inject drugs. The emergency TFM aimed to prevent disruptions of services but not disruption of community systems strengthening and advocacy work. **In EECA, few of those**

[1] 'It is difficult to find investments that give a return higher than those made in health'. El Mundo 03/26/2012 (English transcript available at: http://www.theglobalfund.org/documents/generalmanager/GM_GeneralManagerElMundo2012March_Interview_en/)
[2] For the purposes of this report, EECA includes all countries of the former Soviet Union plus all those in Eastern Europe that are not part of the European Union (with the exception of Bulgaria and Romania). Specifically, the overall list includes the following 24 countries: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Estonia, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Romania, Russia, Serbia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan. Of these countries, all but Latvia and Lithuania have received grants from the Global Fund at some point. (Note: Kosovo is not a UN member state and is not recognized by many nations.) All countries in this list are covered by EHRN.
[3] Targeted Pool requires focusing on specific populations and high-impact interventions. Those most-at-risk populations in case of HIV include PWID, men who have sex with men and sex workers, among others.
[4] Information about National Strategy Applications may be found at www.theglobalfund.org/en/nsa/
[5] Global Fund, Transitional Funding Mechanism information note.

**planning to submit Round 11 proposals were able to apply to the TFM and even those applying could only do so for the very basics: services, but not advocacy work.** Compared with the ten national and one regional HIV/AIDS proposals originally planned for Round 11 and the second wave of NSAs, only Russia (2 NGO grants, including the Russian Harm Reduction Network/ ESVERO after a special decision by the Global Fund Board to allow it to apply), Serbia, and Tajikistan applied for HIV TFM support by the 31 March 2012 deadline.[6]

**A new rule that 55% of all funding should go to low-income countries**, thus limiting the funding for middle-income countries. This rule affects the EECA region particularly, since more than 95% of people living with HIV there live in middle-income countries.[7] **During Phase 2 grant renewals in 2012 most of the ongoing HIV projects funded by the Global Fund will have to create savings of 25% or more, compromising the quality and scope of activities.[8]** Following the adoption of the 55% rule, the Global Fund's Secretariat defined the indicative levels for savings and cuts in renewal processes, which are differentiated for low-income countries (and lower lower-middle income countries) and for others. **PWID and community groups are frequently bearing the largest share of the cuts, and the bulk of the PWID-focused HIV prevention cuts fall on activities such as NGO development, service capacity building and other types of community systems strengthening.**

- Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, and Montenegro can now implement only 75%[9] of the activities in Phase 2 that they had identified as necessary in earlier plans. In **Armenia**, the biggest HIV-related funding cuts foreseen are to prevention services for PWID, though this is the population in which HIV prevalence is the highest (about 10%) and harm reduction coverage is only 15%. The budget for NGO capacity building has been cut by 96%.

**2011 changes, outlined above, took place in the context of previous developments in the Global Fund policies:**

**Tight eligibility requirements**: as of 2012, Albania, Bosnia-Herzegovina, Croatia, Kazakhstan, Macedonia, Montenegro, and Romania are no longer able to apply in future due to low HIV prevalence among key populations.

- **Romania** offers one example of what can happen to harm reduction when Global Fund support is no longer available. It has been ineligible since Round 7, and its Global Fund grant stopped disbursing in 2010. No government funding has ever been made available for NGO harm reduction programmes. Harm reduction coverage of PWID fell from 76% in 2009 to 49% in 2010. In 2011, the number of newly reported HIV infections among PWID was higher than in previous years, and PWID as a share of newly reported HIV cases was larger.
- In **Albania,** which in 2012 became ineligible due to increased income level, two NGOs have already shut down their NSPs and another is in imminent danger of closing due to lack of funding. (OST is still funded, through the Continuity of Services mechanism.)

NGOs from Bulgaria, Lithuania and Russia could apply for the Global Fund funding within Round 11, despite the fact that these countries have upper-middle income status and are part of EU or G8. This NGO rule presented a unique opportunity for countries like Lithuania and Russia, where the political will is lacking to fund harm reduction, in order to sustain and scale up programs for PWID. Preserving the NGO rule for countries with high HIV prevalence among PWID in the new Global Fund funding model is absolutely essential.

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[6] According to Nicolas Cantau, Regional Manager for Eastern Europe & Central Asia, Grant Management at the Global Fund, in an interview on 11 April 2012.

[7] WHO, UNAIDS & UNICEF. Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011.

[8] The list of grant renewals and relevant ceilings is available in Global Fund, 2012 Renewals Forecast (Phase 2, RCC mid-term and Periodical review). January 2012

[9] The Global Fund's Board put limitations of 75% of the amounts requested in Round 8, Round 9 and NSA proposals for their second phases in the 18th and 20th Board meetings, however, agreed to reduce the 75% limitation to 90% when new resources become available (see Decision Points: GF/B20/DP9, paragraph 3; GF/B18/DP13, paragraph 2). Additionally, based on countries previous performance and country needs further cuts can be conducted – those cuts are decided on case-to-case basis. Given the early timing in renewal processes during writing this report, no information was available about the final negotiated on budget cuts for any of the EECA countries.

**With increasing, sustained domestic engagement—particularly from governments—EECA has made a number of notable achievements in the response to HIV, including reduction of vertical transmission according to goals. Unfortunately, national governments are far more reluctant to support targeted prevention and treatment services for people who inject drugs, and they are unlikely to fill the gap left by the Global Fund's changes.** Evidence from around the world has shown that harm reduction programs—including needle-syringe programs (NSPs), opioid substitution treatment (OST), anti-retroviral treatment (ART) for PWID, and peer outreach and counselling—can curb the spread of HIV and increase ART access in this highly vulnerable population. Yet only 10% of PWID in Eastern Europe and 36% in Central Asia access NSPs, and only 23% of people in need of ART in the region were receiving it at the end of 2010--the second lowest rate in the world. People who inject drugs comprise 62% of those living with HIV in the region, but only 22% of those receiving ART. Since ART not only saves lives but also reduces the risk of HIV transmission,[10] this has an impact on prevention as well. **As a result, EECA is the only region in the world where the HIV epidemic continues to grow. Continued advocacy is needed to support sustainable national funding for harm reduction; until this is achieved, the Global Fund is indispensable to the HIV response in the region.**

**There is no substitute for the Global Fund in EECA.** Other donors in the region operate on a far smaller scale than the Global Fund, and are often much more restricted in their scope of work. While EU institutions embrace harm reduction as one of their drug policy principles at the highest political levels, their tools to support harm reduction, even within their own territory, remain limited. Through its European Social Fund, the EU can provide structural funds for HIV responses in its member states. However, these are primarily accessible to large, established NGOs, rather than to the smaller, community-based groups that often provide harm reduction services.

**As a result of sharply decreased funding, harm reduction services in EECA will be unable to reach many of those in need, imperilling the health of people who inject drugs and threatening the gains of the last decade.** The HIV epidemic will likely continue to grow in countries with large epidemics. Given the rapidity with which HIV can spread through shared injecting equipment, there is also the risk of new, fast-growing epidemics in countries that have succeeded in averting HIV epidemics among PWID so far, through wise use of Global Fund support. Funding cuts could also mean that EECA harm reduction organizations will lose experienced, well-trained staff. In short, many of the hard-won gains of the last decade will be lost if the Global Fund, its donors, the European Union institutions, and other actors do not act quickly to restore support to harm reduction in the region.

The Global Fund and donor governments, as well as the European Commission and other funders, must recognize that given its large, concentrated epidemic among people who inject drugs, who are highly stigmatized, further investments in EECA are the most strategic choice. Donors have an ethical and moral imperative to restore funding to desperately needed HIV programmes in the region.

## Summary Recommendations

***Governments and other donors must increase their contributions to and fully fund the Global Fund. Only then will it be possible to get EECA's HIV epidemic under control.***

**The Global Fund Board should**:

- Ease restrictions on engagement in middle-income countries with epidemics concentrated among PWID, especially where other sources of funding are unavailable. Eliminate the rule that 55% of funding per year must go to low-income countries.
- In new Global Fund funding model, strengthen Targeted Pool to generate more focused investment in PWIDs, along with other marginalized and highly affected populations.
- More comprehensively ground funding decisions in the UNAIDS Strategic Investment Framework for the global AIDS response proposed in 2011, which prioritizes increased and sustained

[10] Donnell D et al. Antiretroviral Therapy and HIV Transmission Partners in Prevention Study. Lancet, 2010, 375(9731):2092–2098.

involvement by civil society and communities, including community mobilization, advocacy, capacity building and human rights programming.[11]
- Preserve the multi-country funding channel for Regional Coordinating Mechanisms and regional organizations to provide a less politicized and safer platform than at a country level through which to advocate for the needs of key affected populations.

**The European Union institutions should**:

- Honour existing pledges and scale up support for the Global Fund in the context of the on-going negotiations on the new EU multi-annual financial framework (MFF) 2014-2020 and 11th European Development Fund.
- Actively promote harm reduction at the global level and through political dialogue with partner countries in EECA.
- Provide financial and technical support for sustaining harm reduction activities in EECA, including through long-term investment to support the work of NGOs in the region.

**Other donors, including bilaterals, should**:

- Devise strategies to maximize their engagement in harm reduction as part of broader health and development programming.

[11] Schwartländer et al (June 2011). "Towards an improved investment approach for an effective response to HIV/AIDS". *The Lancet*, Vol. 377, Issue 9782: pp 2031-2041.

# 1. Background, Aims and Methodology

## 1.1 Background

Facing severely reduced contributions from donor governments, in November 2011 the Global Fund to Fight AIDS, Tuberculosis and Malaria[12] (the Global Fund) cancelled its upcoming 11th round of grants. Round 11 was replaced with a Transitional Funding Mechanism (TFM) to continue only those grants providing certain "essential" services such as antiretroviral treatment (ART), needle and syringe program (NSP) and opioid substitution therapy.[13] TFM money can only be used to sustain existing programmes, not to scale up services to reach additional clients or advocate for national funds to sustain harm reduction programming.

In another measure to cut costs, grants entering Phase 2 renewal are required to make substantial cuts—reducing spending to 90% of the original grant amount for low-income countries and lower lower-middle-income countries and 75% of the original grant amount for all others.[14] These country income level-related rules for cuts resulted from the new rule that 55% of total funding for grants per year must go to low-income countries, a rule that has already proved problematic.

**Eastern Europe and Central Asia (EECA),[15] a region where HIV is concentrated among people who inject drugs (PWID), has already been affected and will be hit hard by these changes in the nearest future.** Almost none of the EECA countries are classified as low-income (two exceptions are Kyrgyzstan and Tajikistan). As of 2012, more than half of the region's countries, Russia included, reached the level of upper middle income, and more than 95% of the people living with HIV in the region live in middle-income countries (primarily Russia and Ukraine).[16] The eligibility policy severely limits the possibility of Global Fund support for the region, putting programmes sustained by the Global Fund at risk: as of 2012, a third of the countries will no longer be able to apply due to low national prevalence among key populations. In another four countries—Bulgaria, Lithuania, Latvia, and Russia—NGOs only can apply for funding in the future, because they are not on the OECD development assistance committee list of aid-eligible countries, if the current eligibility policy does not change. For a complete breakdown of how the Global Fund changes have affected the countries of the region, and for information on HIV prevalence levels and PWID populations, see the chart, *"Global Fund eligibility and funding availability for harm reduction in EECA"* on page 12.

**Harm reduction services in EECA depend more on the Global Fund than on any other donor**. While governments are making substantial progress towards investing more in HIV treatment, their funding for harm reduction is scarce. Many countries of the region were preparing applications for badly needed new grants to support HIV services for PWID when Round 11 was cancelled. Very few other HIV and harm reduction sources exist in the region. This publication discusses some of the consequences, current and future, of the massive loss of support for HIV services in EECA.

## 1.2 Methodology

The Eurasian Harm Reduction Network (EHRN) produced this report between March and May 2012. It conducted a review of the Global Fund's documentation, country reports and other literature. The most substantial information was gathered through interviews and correspondence with representatives from Principal Recipients, Sub-Recipients, Country Coordinating Mechanisms and working groups on proposal writing, representing NGOs, government sector and UN agencies in Albania, Armenia, Belarus, Kyrgyzstan, Lithuania, Moldova, Romania, Russia, and Ukraine. The Head of the Global Fund Board EECA Delegation and Global Fund Secretariat staff were also interviewed.

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[12] In-depth information about the cancellation of Round 11, the TFM and other developments since November 2011 may be found on the Aidspan website: www.aidspan.org.

[13] Global Fund. Transitional Funding Mechanism Information Note.

[14] Global Fund, 2012 Renewals Forecast (Phase 2, RCC mid-term and Periodical review). January 2012

[15] For the purposes of this report, EECA includes all countries of the former Soviet Union plus all those in Eastern Europe that are not part of the European Union (with the exception of Bulgaria and Romania). Specifically, the overall list includes the following 24 countries: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Estonia, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Romania, Russia, Serbia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan. Of these countries, all but Latvia and Lithuania have received grants from the Global Fund at some point. (Note: Kosovo is not a UN member state and is not recognized by many nations.) All countries in this list are covered by EHRN.

[16] WHO, UNAIDS & UNICEF. Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011.

# 2. Why EECA needs the Global Fund

## 2.1 Concentrated epidemics and the need for targeted interventions

**EECA is home to the world's fastest-growing HIV epidemic. No other region in the world has experienced an epidemic so strongly and consistently concentrated among people who inject drugs, and among their sexual partners.** In 2010, 42% of newly diagnosed HIV cases in EECA were reported to be acquired through injecting drug use;[17] this proportion is lower than in past years, but higher than it is in other regions. HIV prevalence among PWID is nearly 10% in most countries of the region, with particularly high rates in Russia (74% in some cities), Ukraine (42%) and Estonia (72%).[18] (It is important to note the major variation across the region. HIV prevalence is much lower in Southeast Europe than in states of the former Soviet Union, for example.)

**Unlike in other regions, including much of Africa, the spread of HIV continues in EECA, despite the unprecedented amount of evidence on how to prevent HIV among PWID.** Such high HIV rates persist largely because of stigma and discrimination against PWID throughout the region. Though international experience has shown clearly that targeted services for key populations are crucial to HIV prevention, EECA countries rarely prioritize such services. As a result, adequate services for PWID are limited, and those in need are often unable to access services because they have used, or are currently using, illicit drugs. Only 23% of people in need of ART in the region were receiving it at the end of 2010, the second lowest rate in the world.[19] While 62% of those living with HIV in the region are PWID, they account for only 22% of those receiving antiretroviral therapy (ART).[20]

**Harm reduction** refers to a range of pragmatic and evidence-based public health policies and practices aimed at reducing the negative consequences associated with drug use and other related risk factors such as HIV. It includes: [1]

- services within the nine UN recommended areas (needle-syringe programmes, opioid substitution therapy, interventions to prevent & treat TB, viral hepatitis and sexually transmitted infections etc.),
- measures to address "critical enablers" – advocacy and policy dialogue, PWID community strengthening, capacity building, and human rights programming.

The World Health Organization (WHO) and other leading international health bodies strongly support harm reduction, as do many global institutions focused on reducing drug use, such as the United Nations Office on Drugs and Crime (UNODC). According to the International Federation of the Red Cross, "These interventions exemplify human rights in action by seeking to alleviate hazards faced by the injecting drug users, where needed, without distinction and without judgement." [2]

[1] Global Fund Information Note on Harm Reduction. Round 11
[2] IFRC Advocacy Report, Out of harm's way: injecting drug users and harm reduction, December 2010

## 2.2 Limitations of national funding

**In many ways, EECA has achieved notable progress in responding to HIV.** All countries of the region have adopted national AIDS programs and created multisectoral bodies to address HIV and review responses. Among the most laudable achievements is that infant antiretroviral prophylaxis coverage is the highest in the developing world, and prevention of vertical transmission has nearly reached its goal.[21] This victory was largely the result of increased, sustained domestic engagement, particularly from governments.

[17] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2010. Stockholm: European Centre for Disease Prevention and Control; 2011.
[18] Mathers BM, Degenhardt L, Phillips B, Wiessing L, Hickman M, Strathdee SA, et al (2008). Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *The Lancet*; 372(9651): 1733-45
[19] UNAIDS/WHO World AIDS Day Report 2011. Geneva, Joint United Nations Programme on HIV/AIDS, 2011.
[20] WHO, UNAIDS & UNICEF, 2011.
[21] Ibid.

This trend expanded over the past decade; data from 2008-2009, for example, indicated that nearly 86% of all investment in HIV was coming from national resources.[22]

**Unfortunately, national governments are far more reluctant to support effective, targeted services for PWID, even though most countries are by now middle-income[23] and have increased domestic resources.** Among the most well-known and effective interventions to prevent HIV among PWID are needle-syringe programmes (NSPs), which provide clean injecting equipment (often exchanging used equipment for new items), and opioid substitution therapy (OST), which provides oral medicines such as methadone to help patients stop injecting illicit drugs. A number of EECA countries cover some institutional costs of OST run in state medical clinics,[24] but countries most often do not fund NGO-run needle exchange.[25] There are exceptions: for example, Kazakhstan estimates that it covered 50% of the costs of harm reduction in the last 3-4 years.[26] But overall, rigid anti-drug legal regimes and lack of political will severely limit harm reduction programming in EECA. Possession of even small amounts of illegal drugs—in some cases, even the drug residue in syringes brought for exchange—is criminalized in most contexts, thus raising risks for PWID who might be interested in such services. Clients and providers continue to be regularly harassed and subjected to arbitrary raids, closures and arrests in some countries.

This has meant that **EECA has made far less progress in prevention than it could have.** According to recent data, only 10% of PWID in Eastern Europe and 36% in Central Asia access NSPs.[27] Access to OST is even less common; it is explicitly prohibited by law in Russia,[28] the country where it is most needed. Uzbekistan closed OST after its piloting. OST is not available in Turkmenistan.[29]

## 2.3 The Global Fund's crucial investment in harm reduction in EECA

**In EECA, NSPs have been designed and implemented primarily by NGOs. Most have had to obtain support from outside the region, and the Global Fund has been by far the most important funder.** Between 2002 and 2009, the Global Fund approved an estimated $430 million for activities targeting PWID, of which 61%—$263 million—was in 22 countries from EECA.[30] That amount is much more than all other international sources combined.[31] The Global Fund's direct involvement is a key reason that the number of NSPs increased steadily after 2002. In 2003, a total of 213 NSPs reportedly existed across 25 EECA countries,[32] and just seven years later there were more than eight times that number in Ukraine alone.[33] Notably, in Round 10 (2010) the Global Fund announced a dedicated funding reserve for most-at-risk populations including people who inject drugs ("MARPs reserve"), and a further $152 million was approved for PWID – including $109 million (64%) for new grants in five EECA countries.[34] The performance of the

[22] Based on UNGASS country report data extracted from www.aidsinfoonline.org. Note that data were available only for 16 countries (all for 2009 with the exception of Russia, for 2008). The percent of domestic investment among total expenditure ranges quite substantially among the countries with a non-weighed mean of 52.2 percent.

[23] According to the World Bank classification of countries updated in July 2011, there were only two low-income countries and two countries that used to receive the Global Fund grants are high-income. Other 7 countries have lower-middle income and remaining 14 have upper-middle income.

[24] Latypov, A., Bidordinova, A., & Khachatrian, A. (2012) Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality. IDPC Briefing Series on Drug Dependence Treatment No 1. January 2012.

[25] See chart "Global Fund eligibility and funding availability for harm reduction in EECA" on page 12.

[26] Stuikyte, R. & Bonnell, R. (2011), *Mapping donor support for harm reduction in Kazakhstan and Kyrgyzstan* (Commissioned by AIDS Foundation East-West (AFEW) & the Technical Support Facility on behalf of the Informal Working Group of Major Harm Reduction Donors)

[27] Mathers, BM. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*, 2010. 375(9719): p. 1014-28.

[28] Федеральный закон Российской Федерации от 8 января 1998 г. N 3-ФЗ "О наркотических средствах и психотропных веществах"

[29] Latypov et al, 2012.

[30] Bridge, J, Hunter, BM and Lazarus, A (2012). Global Fund investments in harm reduction from 2002 to 2009. Int J Drug Policy. 2012 Mar 13.

[31] Other notable sources since 2002 include bilateral aid from the U.S., British and Dutch governments ranging from $13 million to $32 million in total, as well as smaller amounts from sources including the European Commission and the Open Society Foundations.

[32] Aceijas C, Hickman M, Donogoe MC, Burrows D, Stuikyte R. Access and coverage of needle and syringe programmes (NSP) in Central and Eastern Europe and Central Asia. *Addiction*. 2007 Aug;102(8):1244-50.

[33] Ministry of Health of Ukraine, Ukraine harmonized AIDS response progress report. Reporting period: January 2010- December 2011", Kyiv – 2012.

[34] Unpublished Global Fund data, 2012, from Jamie Bridge, May 1, 2012.

majority of those grants is high—higher, in fact, than in other regions, with only one grant having a lower rating of B2 and none having the worst C ratings as of April 2012.[35]

**Box 1. Cost-effectiveness of NSPs and OST in EECA: Harm reduction proved its value for money in the region**

NSPs have now operated in much of EECA for several years, which means new and emerging regionally specific data are available to consider health and social costs. Nearly all reports published to date indicate that NSPs and OST are indeed cost-effective, given the high health and treatment costs associated with HIV infection and other harms associated with unsafe drug injecting. Avoiding new infections is far less expensive than providing treatment.

A recently completed analysis of the Technical Working Group to Evaluate the Cost-effectiveness of NSPs in Eastern Europe and Central Asia[1] concludes: "NSEPs [needle and syringe exchange programmes] have reduced the prevalence of HIV and HCV [hepatitis C] among IDUs in EECA and led to significant health benefits and economic savings."

- In Russia, studies showed a 15% decrease in the cumulative number of HIV cases among PWIDs in the regions covered through Global Fund harm reduction projects and infection rates 2.5 times lower among those participating in NSP.[2]
- An evaluation of NSPs in Odessa, Ukraine determined that the early stage of their implementation was cost-effective, at $97 per infection averted.[3]
- OST was found to be "associated with a substantial reduction in HIV exposure risk associated with IDUs" in Lithuania, Poland and Ukraine,[4] and similarly positive results were reported from an OST programme in prisons in Kyrgyzstan.[5]
- In Ukraine, analysis concluded that offering OST to 25% of PWID would avert 4,700 infections and add 76,000 quality-adjusted life years (QALYs) compared with no intervention (at $530/QALY gained). Even more positive effects were projected if OST were expanded together with ART.[6]

[1] The report had not been released as of the time this publication was finalized; instead, a draft report was obtained from one of the researched sites. Wilson D, et al. The cost-effectiveness of needle-syringe exchange programs in Eastern Europe and Central Asia: costing, data synthesis, modeling and economics for eight case study countries.
[2] PEPFAR (2011). Russia FY 2011 Country Operational Plan. Retrieved from: www.pepfar.gov/documents/organization/170280.pdf. & Плавинский С.Л., Баринова А.Н., Ерошина К.М., Кубасова К.А., Распространенность и заболеваемость ВИЧ-инфекцией и ИППП в группах риска и эффективность проектов снижения вреда в Российской Федерации. – М., 2011. – 104 с.
[3] Vickerman, P et al. The cost-effectiveness of expanding harm reduction activities for injecting drug users in Odessa, Ukraine. Sex Transm Dis, 2006. 33(10 Suppl): p. S89-102.
[4] Lawrinson, P et al.(2008). Key findings from the WHO collaborative study on substitution therapy for opioid dependence and HIV/AIDS. Addiction, 103: 1484–1492.
[5] Subata, E, Karymbaeva, S & Moller L (2011). Evaluation of opioid substitution therapy in prisons. Pilot study in Kyrgyzstan (Copenhagen: WHO).

## 2.4 The Global Fund, human rights, and community strengthening for PWID

**The Global Fund's support has been distinguished not only by scale, but also by quality. In EECA, frequent political opposition to harm reduction, along with laws that directly or indirectly criminalise people who inject drugs, makes it imperative to provide support for community strengthening, advocacy capacity, and work toward the inclusion and human rights of people who use drugs.** The Global Fund has helped fill this need by being able and willing to support a greater range of harm reduction programming than most donors, and to support this programming in a more systematic way. In addition to providing funds for commodities such as clean needles and syringes, some Global Fund

[35] Performance ratings of all grant ratings are available on the Global Fund's website. As of April 2012, 57% of all – HIV, TB and malaria—grants in EECA had highest rating of A1 or A2; in other regions those ratings ranged from 0.8 to 41 percent.

HIV/AIDS grants have specified funding for stigma reduction, community mobilization, strengthening civil society and political advocacy.

The Global Fund increased its emphasis on human rights and inclusion through recent guidance on human rights programming and a Community System Strengthening (CSS) Framework, which resulted in increased investment and community responses.[36,37] The introduction of key population-focused funding streams (the MARPs reserve, which was transformed into the Targeted Pool in 2011) were instrumental in putting more focus on key populations. Moreover, as a major financial instrument the Global Fund used its weight to create pressure on countries to have real dialogues, find ways to implement programs, and include civil society and even people who inject drugs in decisions—for example, in the implementation of OST in Ukraine and Kazakhstan, or inclusion of people who inject drugs in the Country Coordinating Mechanisms (CCM) in Belarus, Kyrgyzstan and other countries.

Support for community organizations and capacity building is particularly critical for services targeting PWID. Sensitization and capacity building is essential in attracting marginalized groups such as PWID to available health care services—for example, ART. Such activities are also essential to overcome policy obstacles that hinder provision of needed services. Through its CSS Framework, engagement of PWID leaders in some CCMs, MARPs reserve and Targeted Pool, and emphasis on human rights in the last few years, the Global Fund contributed significantly to building civil society capacity to advocate effectively for policy reform.[38] Its beneficial influence has often been very clear: in several EECA countries (e.g. Belarus, Kazakhstan and Tajikistan), OST pilots were first introduced within the implementation of the HIV prevention programs supported by the Global Fund.[39]

The Global Fund's focus on the human rights of PWID and on building their capacity to fight for their rights has been unusual in a region where drug users are routinely ignored, if not demonized. HIV and PWID advocates in the region agree that the Global Fund's importance to PWID in the region cannot be overstated. They were optimistic that the heightened emphasis on the human rights of marginalized, HIV-affected groups in the new 2012-2016 Global Fund Strategy[40] would lead to an increase in support and, ideally, help overcome some of the resistance of national governments to harm reduction programming.

## 3. With donor exit, bleak future for harm reduction in EECA

The cancellation of Round 11 raised immediate concerns about the viability of harm reduction programming in many countries, but the restrictions on funding eligibility are likely to have an even greater impact over time. Due to ceilings on the amount of funds available for Phase 2 renewals of existing grants and restrictions for the Targeted Pool,[41] for the foreseeable future upper middle income countries can only receive a reduced share of HIV funding than promised and needed. These funding ceilings ignore the fact

[36] Bidordinova, A., Khachatrian, A (2011). Civil Society in Action: participation of civil society in 10 countries of Eastern Europe and Central Asia in preparation of applications for Global Fund Round 10. EHRN, January 2011.
[37] EHRN/CSAT (2011). You Can Do It! A guideline for communities of people who use drugs, men who have sex with men, sex workers and people living with HIV and other key affected populations in South-Eastern, Eastern Europe and Central Asia on how to access resources from the Global Fund to Fight HIV, TB and Malaria for Community Systems Strengthening.
[38] The Global Fund Board approved two major thematic strategies to address gender equality (in 2008) and sexual orientation and gender identities (or SOGI, in 2009), which were both independently evaluated in 2011. The evaluation found that the two strategies "set an important precedent" for the reduction of inequalities in the HIV response, and recommended that the SOGI approach be extended to all the major most-at-risk populations - including PWID (Pangaea Global AIDS Foundation, "Formative Evaluations of the Gender Equality and Sexual Orientation and Gender Identities Strategies of the GFATM," 2011). The Global Fund responded and agreed to work with partners to develop work plans for PWID (GFATM, "Response to the Evaluation of the Global Fund's Gender Equality and Sexual Orientation and Gender Identities (SOGI) Strategy", 2011), but this has yet to be done.
[39] Latypov et al, 2012.
[40] See The Global Fund Strategy 2012-2016: investing for impact. It specifies that the Global Fund will i) integrate human rights considerations throughout the grant cycle, ii) increase investments in programs that address human rights-related barriers to access, and iii) ensure that the Global Fund does not support programs that infringe human rights.
[41] The current *Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization of Proposals for Funding from the Global Fund* makes all EECA countries with upper middle income eligible for the Targeted Pool only or ineligible at all. At the same time the Targeted Pool can make not more than 10% of all funding provided by the Global Fund and require each proposal to be limited to roughly $2.5 million per year. Upper middle income countries are not the only ones that can apply to the Targeted Pool and proposals from others are prioritized. Other countries, particularly upper low-middle income countries are encouraged to apply to the Targeted Pool too, since their funding requests have major disadvantage in the General Funding Pool in prioritization formula greatly prioritizing the poorer countries. The Targeted Pool rules are applied in the TFM. It is not clear whether and how the Targeted Pool will be applied in the new Global Fund model, which should replace the rounds system.

**Box 2. Need for advocacy: governments stress wasteful criminalisation over health**

Despite evidence of the cost-effectiveness of health-based responses to drug use (see Box 1), many EECA governments continue to stress punishment over public health. EHRN's recent "Count the Cost" project documented some of the negative financial consequences of this approach, which demonstrates the need for ongoing advocacy for policy reform:[1]

- **Kyrgyzstan's** government spends around $1.25 million per year to enforce the criminal law against possession of drugs with no intent to supply. By comparison, the budget for OST programs is $500,000, and is currently covered exclusively by external donors. OST costs $500 per patient a year, while punishment costs at least $625 per each person convicted for drug possession.

- In 2010 alone, the prosecution of drug offenders (for use and supply) cost at least $100 million in **Russia**. In comparison, HIV prevention programming through the Federal Budget Law receives less than 3% of the total $640 million to be allocated in 2012 for HIV, hepatitis B and C, and the government continues to prohibit OST. The government therefore will spend millions more treating people infected with HIV than it would have in reducing transmission.

- **Georgia** spends around $10.5 million annually on random street drug testing and an additional $4.7 million on imprisonment of drug offenders. This not only fails to deter people from using drugs, but also increases criminality, social isolation and stigma. Only about 10% of the estimated 40,000 people who inject drugs are currently receiving harm reduction services, yet even that small share means that up to 1,000 new HIV infections have been averted. NSPs have now operated in much of EECA for several years, which means new and emerging regionally specific data are available to consider health and social costs. Nearly all reports published to date indicate that NSPs and OST are indeed cost-effective, given the high health and treatment costs associated with HIV infection and other harms associated with unsafe drug injecting. Avoiding new infections is far less expensive than providing treatment.

[1] Merkinaite, S. *A war against people who use drugs: the costs*. Eurasian Harm Reduction Network (EHRN), Vilnius: 2012.

that country income is not the determining factor for the availability of HIV services for PWID; rather, the decisive factor is political will. Even in many of the upper-middle income countries of the region, there is little chance that the government will fund harm reduction programs with the quality and scope enabled by Global Fund grants, especially as they are affected by the economic crisis.

This could have a devastating impact in the region. Efforts to halt new HIV infections will be severely weakened, placing tens of thousands of people's health and lives at risk. As harm reduction programs are cut, experienced and well-trained staff members may be forced to find new work, thus losing the gains made through extensive capacity building efforts. Countries that have successfully averted HIV epidemics among PWID, such as Albania and Romania, will be at risk of increased HIV transmission as effective prevention programs are forced to close.

## Box 3. Changes in Global Fund eligibility criteria

The Global Fund has always sought to direct its resources to countries deemed most in need, defining need through eligibility criteria. The most recent eligibility update took place in early 2011. It excludes some higher-income countries from the possibility of (re)applying to the Global Fund. Specifically, only those upper-middle income countries with a generalized epidemic or where HIV prevalence in a key population is above 5% can apply. If the epidemic is concentrated in one or more key populations, upper-middle income countries can apply only for the "Targeted Pool." The Targeted Pool requires a focus only on measures to address those populations and has a budget cap of $12.5 million over 5 years (regardless of country size, epidemic, or funding needs). Upper-middle income countries that managed to sustain HIV prevalence of less than 5% among key populations, or even to reduce it to that level, are not eligible. The 2011 eligibility policy changes had one positive aspect: upper-middle income countries that are not on the OECD list of aid-eligible countries (which excludes EU member states regardless of income) could again apply for HIV funding, but only through NGOs. The Global Fund has applied a demand and country-driven approach that encourages countries to demonstrate real needs so that donor resources could be mobilized to address them. The eligibility policy, however, represents a different direction, putting clear limits on possible requests from upper-middle income countries.

To see how eligibility changes have affected EECA countries, see Chart, "Global Fund eligibility and funding availability for harm reduction in EECA" on page 12.

## Notes to the Chart on page 12

n.d. = no data

**Data sources**

(1): World Bank, 2011. LIC = low-income countries; LMIC = low-middle income; UMIC = upper-middle income; HIC = high income.
(2), (3): 2012 Country Progress reports on HIV, available at the UNAIDS website as of 5 May 2012 (unless otherwise indicated)
(2), (3): Estonia - Rüütel et al. HIV Epidemic in Estonia: Analysis of Strategic Information. WHO/Europe. In collaboration with TAI and Ministry of Social Affairs in Estonia. 2011
(2): Latvia, Lithuania, Kazakhstan, Uzbekistan, Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Kosovo, Macedonia, Montenegro, Romania - EMCDDA country profiles at http://www.emcdda.europa.eu/publications/country-overviews (last update in November 2011)
(2): Armenia - Davidyants, A and Malintsyan, G (2010)."The Prevalence of Injecting Drug Use in Armenia and Seroprevalence of Hep B and C among Institutionalized Injecting Drug users" pp 152-153
(2); (3): Russia - Mathers, B., Degenhardt, L., et al. (2008). Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. Lancet, 372(9651), 1733-1745.
(3): Albania, Bosnia-Herzegovina, Croatia, Kosovo, Macedonia, Romania - EMCDDA country profiles at http://www.emcdda.europa.eu/publications/country-overviews (last update in November 2011)

(4): Global Fund information from http://portfolio.theglobalfund.org/en/Home/Index
(5), (6), (7), (8): Global Fund information from relevant Round guidelines (received from proposals@theglobalfund.org or available in the EHRN). On Round 11, information about recent funding received and unsuccessful attempts to go through preliminary review is from the EHRN and confirmed by Zhumagaliev & Zaytseva, the Global Fund (March 2012). Note on Albania added based on the World Bank classification and the current Global Fund Eligibility Policy
(9): EHRN, personal communication with Zaytseva & Zhumagaliev, Global Fund (March 2012)
(10): List of countries that applied from communication with Cantau, Global Fund (11 May 2012); data on eligibility/decision not to apply - from country informants
(11): Global Fund; 2012 Renewals Forecast, January 2012

(12), (14): country informants/interviewees unless indicated otherwise
(13): Latypov et al, 2012 unless indicated otherwise

(12), (14): Armenia - Zaruhi Beglaryan for EHRN Armenia Country Profile (28 February 2012) & 2012 Country HIV Progress report
(12), (14): Georgia - communication with David Otiashvili, Alternative Georgia (04 May 2012)
(12), (14): All Central Asian countries - PEPFAR ROP11 2012, communication with Azizbek Boltaev, Tashkent Medical University & Alisher Latypov, EHRN (04 May 2012)
(12), (14): Russia - communication with Pavel Aksenov from ESVERO (04 May 2012) & Ivan Varentsov from EHRN/Andrey Rylkov Foundation (11 April 2012)
(12), (13), (14): Bosnia-Herzegovina - communication with Samir Ibisevic from NGO UG PROI (04 May 2012)
(12): Bulgaria & Serbia - 2012 Country HIV Progress report; communication with Vitaly Zhumagaliev, Global Fund (05 May 2012)
(12), (14): Croatia - Croatian Red Cross website (http://www.hck.hr/?path=en/static/page/What_we_do.Health_Programmes.Harm_Reduction, accessed on 5 May 2012)

(12), (14): Kosovo - EHRN communication with Brikena Krasniqi from NGO Labyrinth (12 April 2011) and NGO Labyrinth website (http://www.labirinti-ks.org/DonorsandProjects.aspx, accessed on 04 May 2012)
(12), (13), (14): Macedonia - communication with Hristijan Jankuloski, NGO HOPS (04 May 2012)

## Chart: Global Fund eligibility and funding availability for harm reduction in EECA

| Sub-region | Country | Country income status (as of beginning of 2012) | No. of PWIDs (in thousands, rounded) | High HIV among PWIDs (prevalence >=5%) | Global Fund history & eligibility for HIV | | | | | Global Fund: Funding opportunities affected by the November 2011 decisions | | | Government targeted funding for harm reduction | | Other external major donors for harm reduction in 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Received grants before Round 8 | Eligible for Round 8 | Eligible for Round 9 | Eligible for Round 10 | Eligible for Round 11 | Planned to apply to Round 11/NSA | Applied to TFM | Renewals 2012 (% ceilings of continued funding) | NSP (incl NGOs) | OST | |
| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) | (14) |
| **Baltics** | Estonia | HIC | 13.8 | + | + | | | | | | | | + | + | |
| | Latvia | UMIC | 18 | + | | | | | NGO only (from 2012) | + | | | + | + | |
| | Lithuania | UMIC | 5.5 | + | | | | | NGO only | + | | | Not in 2011 | + | |
| **Caucasus** | Armenia | LMIC | 3.3 | + | + | + | + | + | + | | | 75% | | Some | |
| | Azerbaijan | UMIC | n.d. | + | + | + | + | + | + | + | | 75% | n.d. | + | n.d. |
| | Georgia | LMIC | 40 | | + | + | + | + | no, due to recent funding received | | | 75% | | Some | |
| **Central Asia** | Kazakhstan | UMIC | 100 | | + | + | + | + | | | | | + | Some | + |
| | Kyrgyzstan | LIC | 25 | + | + | + | + | + | no, due to recent funding received | | | | | Some | + |
| | Tajikistan | LIC | 25 | + | + | + | + | + | + | + | + | | | | + |
| | Turkmenistan | LMIC | n.d. | n.d. | | + | + | + | + | | | | n.d. | (no OST) | |
| | Uzbekistan | LMIC | 80 | + | + | + | + | + | no, due to recent funding received | | | | n.d. | (no OST) | + |
| **European CIS** | Belarus | UMIC | 50 | + | + | + | + | + | + | + | | 75% | | Some | |
| | Moldova | LMIC | 31.6 | + | + | + | + | + | + | + | decided not to apply | 90% | | | |
| | Russia | UMIC | 1,800 | + | + | | | | NGO only | + | + (2 NGOs) | | | (no OST) | + |
| | Ukraine | LMIC | 290 | + | + | + | + | + | no, due to recent funding received | | | | | Some | + |
| **South-east Europe** | Albania | UMIC | 4.5 | | + | + | + | + | + (but one year grace period ended in 2011, so not in the future) | + | could not apply due to income level, low epidemic | | | | |
| | Bosnia-Herzegovina | UMIC | 7.5 | | + | + | + | + | | | | 75% | | Some | |
| | Bulgaria | UMIC | 25 | + | + | + | + | | NGO only | | | | n.d. | + | |
| | Croatia | HIC | 3.1 | | + | | | | | | | | + | + | |
| | Kosovo | LMIC | 4 | | (Part of Serbia until independence) | | | + | + | + | | | | (no OST) | |
| | Macedonia | UMIC | 8 | | + | | + | + | | | | | | (from 2012) | |
| | Montenegro | UMIC | n.d. | | + | | + | | | | | 75% | n.d. | + | n.d. |
| | Romania | UMIC | n.d. | | + | | | | | | | | Not in 2011 | + | |
| | Serbia | UMIC | 30.4 | | + | | + | | + | + | + | | n.d. | Some | |

**Box 4. Withering of harm reduction in Romania: how and why other funding options are often poor substitutes for the Global Fund**

In Romania, the human price of cessation of Global Fund support is clear. The Romanian national HIV response received support from the Global Fund in two rounds, most recently through Round 6 for work in 2007-2010 (the country was not eligible to apply after Round 7).[1] The principal recipient for that grant, which disbursed money until 2010, was an NGO, Romanian Angel Appeal (RAA). About one-quarter of the $11.4 million in total funding was allocated for harm reduction; much of the rest funded activities among and for other key populations, including sex workers, the Roma population, MSM, prisoners and young PLHIV. Harm reduction activities were a major reason that HIV prevalence among PWID nationwide remained relatively low, at about 1%.

Despite such success, no government funding has ever been made available for NGO harm reduction programmes. According to RAA, so far most NGOs have survived through small grants from various international agencies that fund health services targeting groups vulnerable to HIV, while others have received some support from the European Social Fund (ESF)—including projects run by two NGOs, ARAS and Integration.[1] However, RAA reports that funding levels are lower now Global Fund support has ended, and ESF funds have proved to be a poor substitute: "Under ESF most medical consumables [such as needles and condoms] are not eligible expenditures or have to be purchased in limited amounts…most of the money [instead] has to be spent on social inclusion activities."[2] RAA staff note that ESF regulations mean that harm reduction itself cannot be the direct objective, but instead must be conceptualized as one method to promote the social integration of PWID.

Services have subsequently scaled down; while 76% of PWID reported being reached by harm reduction programs in 2009, in 2010 the proportion sank to 49%. One of the four harm reduction sites in the capital city closed shortly after the end of the Global Fund support, and another site is expected to shut down in 2012. Reports indicate that the number of newly reported HIV infections among PWID in 2011 was higher than in previous years, and their share of all new cases (15%) was also larger.[3]

[1] van der Gouwe, D. Final Evaluation. Project: ROMJ19 "HIV/AIDS prevention and care among injecting drug users and in prison settings in Romania". United Nations Office on Drugs and Crime: Vienna, November 2011.
[2] Interview with Fidelie Kalambayi and Silvia Asandi, M&E Manger and Executive Director at RAA, on 6 April 2012.
[3] Joint EMCDDA and ECDC rapid risk assessment. HIV in injecting drug users in the EU/EEA, following a reported increase of cases in Greece and Romania. January 2012. The 15 percent share corresponded to a total of 62 cases.

### 3.1 Round 11 cancellation eliminates plans for harm reduction and sustainability efforts

When Round 11 was cancelled, at least eleven HIV/AIDS applications from the region were being prepared that focused on harm reduction. Eight of these proposals planned to focus on key populations and high-impact interventions through the Global Fund's Targeted Pool funding stream.[42] Moldova's proposal was for the second wave of National Strategy Applications (NSAs).[43]

When they began developing Round 11 proposals, Albania, Azerbaijan, Belarus, Moldova, and Tajikistan foresaw potential interruptions in harm reduction programs previously supported by the Global Fund. Since the Round 11 proposals were to finance services starting from 2013 at the earliest, the affects of cancellation are not immediately evident, and will become apparent only in the longer term.

EHRN was developing a regional application covering nine countries with a high burden of HIV and TB. The Global Fund's regional funding channel is used to address cross-border challenges and marginalized populations severely underserved through national programs. In many cases, regional grants provide a less politicized and safer platform for advocacy for the needs of key affected populations, and are often almost

[42] Targeted Pool requires focusing on specific populations and high-impact interventions. Those most-at-risk populations in case of HIV include PWID, men who have sex with men and sex workers, among others.
[43] Information about National Strategy Applications may be found at www.theglobalfund.org/en/nsa/

the only source of support for such groups.[44] The proposed project would have been the region's first large scale advocacy and technical support initiative to address key regional barriers to an effective and sustainable HIV response in EECA, including:

- Repressive drug policies and longstanding records of human rights violations against people who use drugs;
- Lack of formal state recognition of the role of harm reduction and priority on drug user health and human rights, as manifested by the lack of supportive policy, practice, and funding in countries across the region;
- Marginalization of communities of people who use drugs in the design, implementation, and evaluation of programs that affect them, which results in lack of support for community mobilization as a critical enabler of rational HIV/AIDS responses.

Some of the activities left without funding can be seen in the chart below.

| Country | Results of loss of new funding opportunities, including Round 11 |
|---|---|
| Albania | Due to end of Round 5 grant, two previous unsuccessful attempts to receive the Global Fund funds and impossibility of applying for a new one or get bridging support:<br>• Beginning on 1 April 2012, NGOs providing NSPs no longer had any support for such services, as no interested donors exist in the country and no national funds are available for such activities.<br>• Two NGOs shut down their NSPs and one has continued working, as they still had needles and other supplies on hand. But those supplies are expected to run out shortly, thus forcing the projects' closure unless new funding is found.<br>Note: Unlike the NSPs, Albania's methadone programme (run by an NGO, Aksion Plus) will continue to receive Global Fund funding for another two years beginning in May 2012 through the donor's Continuity of Services (CoS) funding channel.[45] |
| Belarus | Cancellation of plans to submit proposal largely focused on PWID[46] that included:<br>• Institutionalization of harm reduction services (with government, UN partners and NGOs)<br>• Advocacy for establishment of harm reduction services in prisons<br>• Community systems strengthening to build civil society groups and organisations comprising and led by key populations, particularly PWID and PLHIV<br>• Piloting innovative approaches targeting highly marginalized sub-groups of PWID, such as women and MSM who inject drugs<br>• Providing services to rural areas which had not been reached |
| Lithuania | Cancellation of potential proposal to compensate for a reduction in government funding and increasingly unsupportive political environment regarding harm reduction, as well as the end, in 2011, of a five-year UNODC project in the Baltics providing support for NGO-driven needle exchange programmes. Overall funding for low-threshold harm reduction programs in Lithuania, most of which are run by NGOs, declined by 20% in 2010 in comparison with 2007.[47] Partly as a result, from 2008 to 2010 the number of contacts reported by NSPs fell from 56,548 to 42,736. OST reached an estimated 12.5% of all PWIDs by the end of 2011, with the national health system reimbursing methadone. However, even that apparently successful effort is at risk, as OST is regularly questioned in the media and by politicians opposed to most health initiatives for PWID.<br><br>The proposal would have sought to sustain and scale up harm reduction services and support political advocacy by:<br>• Sensitizing politicians and the media |

[44] In most circumstances, these grants cannot be used to directly deliver services due to concerns over creating parallel systems.
[45] Continuity of Services. Operational Policy Note. Issued on 11 July 2011. (In The Global Fund Operations Policy Manual. Date of Issue: December 2011, pp 303-308).
[46] As cited during an interview with Liudmila Trukhan, a member of the CCM proposal-writing group in the last four rounds—who is also a newly elected CCM member and the VCT coordinator in one sub-recipient (SR), NGO Positive Movement on 29 March 2012.
[47] Drug, Tobacco and Alcohol Control Department of Lithuania (2011). "Lithuania: New Development, Trends and in-depth Information on Selected Issues: 2011 National Report to the EMCDDA by the REITOX National Focal Point." European Monitoring Centre for Drugs, Drug Addiction and Drug, Tobacco and Alcohol Control Department, p. 95 (Lithuanian version).

| | |
|---|---|
| | • Raising funds for harm reduction programming from municipalities and at the national level<br>• Supporting community systems and NGOs<br>• Working to further legalize and expand harm reduction in prisons<br>• Working toward decriminalizing drug possession. |
| Region-wide/ EHRN | Cancellation of a regional proposal covering nine EECA countries[48] that combine high HIV and severe TB burdens of disease. The proposal would have targeted PWIDs as the key affected and underserved population in EECA, and supported policy reform and harm reduction program sustainability on the national and regional level by:<br>• Mobilizing people who use drugs on a regional level in response to the hostile environment at the country level<br>• Encouraging client advocates to campaign for policy reform<br>• Empowering people who use drugs and clients of OST programs in order to benefit health programs and promote a human rights- and community ownership-based culture capable of bringing about longer term policy change<br>• Linking progressive policy and practice development across the region to leverage positive changes in particular countries<br>• Supporting prior investment by the Global Fund and other international donors by replicating good practices of the Global Fund projects and thus contributing to more sustainable, cost effective, and locally appropriate health care systems. |

Without Round 11, there will be far fewer possibilities to build advocacy and technical capacity in EECA to implement evidence-based, sustainable and cost-effective harm reduction programs. There will be minimal support to strengthen community systems and advocacy that would improve the quality of services and policy, sustaining programs over the long term.

### 3.2 TFM limitations put advocacy and community strengthening at risk

The Global Fund sought to compensate for the cancellation of Round 11 through creation of a "transitional funding mechanism" (TFM) for countries that had existing grants but are expected to face disruptions before 2014. The TFM does not support scale-up, and with a few important exceptions, eligibility was restricted to those that could show clear evidence of need for "emergency" support to ensure that "essential" services already being provided would not be disrupted or cut off. According to the Global Fund, "prevention and treatment targeted at key populations with high levels of incidence (including evidence-based programs reaching men who have sex with men, people who inject drugs, prisoners and sex workers)" are specified as essential within the TFM.[49] Advocacy and community systems strengthening are not.[50]

**Most EECA countries planning Round 11 proposals were not eligible to apply to the TFM at all. Even those that were eligible could apply only for the very basics: services, but not advocacy or community systems strengthening work.** Compared with the ten national and one regional HIV/AIDS proposals originally planned for Round 11 and the second wave of NSA, only Russia (2 NGO grants, including the Russian Harm Reduction Network/ ESVERO after a special decision by the Global Fund Board to allow it apply), Serbia, and Tajikistan applied for HIV TFM support by the 31 March 2012 deadline.[51]

[48] Azerbaijan, Belarus, Kyrgyzstan, Lithuania, Moldova, Russia, Tajikistan, Ukraine and Uzbekistan

[49] Global Fund, Transitional Funding Mechanism information note.

[50] According to the Global Fund Transitional Funding Mechanism information note, "Critical enablers (such as stigma reduction, gender equality and community mobilization) and program efforts in relation to wider development sectors (health systems, social protection, gender-based violence, etc.), as applicable to each disease, will only be considered where they are deemed by the Global Fund as essential for the continuation of delivery of essential treatment, prevention and care services based on clear and precise justification by the applicant."
The deadline for TFM proposals was 31 March 2012; the Global Fund expects to disclose results in July 2012, after this publication was finalized. Countries were asked to define what they would ideally like to fund (in case new funding becomes available), and then what they deem as "essential" for TFM. It is important to note that only when the proposals are made public after TRP review will it be clear what has been eliminated in this process. (Information provided by Jamie Bridge, May 1, 2012.)

[51] According to Nicolas Cantau, Regional Manager for Eastern Europe & Central Asia, Grant Management at the Global Fund, in an interview on 11 April 2012.

**Box 5. Moldova threatened with loss of harm reduction funding by 2014**

Moldova, a "lower lower-middle-income" country, has an HIV epidemic concentrated among PWID, of whom about 14% are HIV-positive. Before the cancelation of the Second Wave of National Strategy Applications (NSAs), Moldova was supposed to become the first EECA country to apply for the Global Fund's NSAs mechanism, in 2011-2012. Its focus was on key populations and social determinants of health, along with building government and civil society systems in order to "move from fire-fighting to a sustainable HIV response."[1]

The country now faces a troubling future. Two ongoing HIV/AIDS grants were consolidated through single-stream funding. However, funding for critical services such as ART and harm reduction, first approved through a Round 6 grant, will end in 2013. There have been no other major external donors for HIV (and TB) since 2008. The government, which struggles to find money for nearly all activities in Europe's poorest country, has few resources to sustain such services even at reduced levels. Harm reduction programming, traditionally run by NGOs, has been fully funded by the Global Fund.

Nevertheless, Moldova's CCM decided not to apply for the TFM, as applying would have required cuts to funding priorities that the CCM considers essential for the HIV response (but which are not considered essential under the TFM guidance)—including human rights support, advocacy and community systems strengthening. Moreover, the CCM realized that its main concern was the service gaps expected in 2014; TFM funding would have been available by 2013 and expected to be allocated that year, when funding was not needed. This would have meant one less year of spending on the key funding priorities identified by the CCM.

Unless new funding opportunities arise, prevention for key populations and work around critical enablers will be cut. No national funds have been made available, or are expected to be made available, for NSPs, CSS, capacity building and human rights support.

[1] As cited during an interview on 5 April 2012 with Gabriela Ionascu National Coordinator at UNAIDS.

Even those NGOs that could apply to the TFM face drastically reduced scopes of work. The Russian Harm Reduction Network/ESVERO applied for TFM support to sustain harm reduction programs, but TFM funding cannot be used for advocacy and community systems strengthening. (A substantial grant from the EU to ESVERO will help them fill some of the advocacy gaps.) The Open Health Institute (OHI), another NGO operating harm reduction projects in Russia, could only ask for an amount about 40% of what it had earlier expected for continuing services, because they are still restricted to Targeted Pool ceilings that do not differentiate funding by country size. Russia, with a population of 145 million, has the same ceiling of $5 million over two years as Serbia, which has less than 8 million people and a disproportionately smaller HIV epidemic. Both countries are in the same Global Fund income category.[52] Thus OHI's programme expects a 50% reduction in Global Fund support for "lifesaving prevention services" for key populations that have been funded by the Global Fund since 2004.[53]

The TFM is, however, an improvement on the other Global Fund instrument used for quite some time already in "emergency" situations—Continuity of Services (CoS),[54] which is available when countries no longer have support from the Global Fund and have no alternative funds. CoS supports only ART and opioid substitution therapy, not support prevention activities such as needle and syringe exchange (NSP), or advocacy.

[52] According to a January 2012 information note on the Global Fund's Eligibility, Counterpart Financing and Prioritization policy. Upper middle-income countries from EECA (such as both Russia and Serbia) can apply only for targeted pool and the maximum for a grant is $5 million for two years.

[53] The previous support for OHI was decided by the Board on extraordinary basis "[i]n recognition of the emergency situation of the lifesaving prevention activities supported by the OHI Grant being discontinued, the Board approves [...] continued emergency funding for lifesaving prevention services in an amount of up to $24 million" for two years until the end of 31 December 2011. Source: Decision Point GF/B20/DP29, Twenty-First Board Meeting. Geneva, Switzerland, 28-30 April 2010.

[54] Continuity of Services. Operational Policy Note. Issued on 11 July 2011. (in The Global Fund Operations Policy Manual. Date of Issue: December 2011, pp 303-308).

### 3.3 Budget cuts marginalize community, cut sustainability efforts

**Budget cuts during grant renewals in 2012 will affect roughly half of the ongoing HIV projects supported in the region. Most will have to create savings of 25% or more, compromising the quality and scope of activities.** Global Fund HIV/AIDS grants are to undergo renewals in 2012 in Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Moldova, and Montenegro. All except Moldova have ceilings of 75% of originally planned Phase 2 amounts due to the 55% rule; as such, they will need to find savings of 25% or more.[55] In Belarus, only 40% of the work proposed by sub-recipients will be funded.[56]

While all countries face difficult choices, **PWID and community groups are frequently bearing the largest share of the cuts, and the bulk of the PWID-focused HIV prevention cuts fall on activities such as NGO development, service capacity building and other types of community systems strengthening.** For example, both Armenia and Belarus reportedly plan to cut budgets for prevention among PWIDs, NGO development and CSS. Their CCMs reportedly plan to further scale up harm reduction, while capacity building is postponed for times when financial situation is better.

Community systems strengthening and related activities are deemed critical by PWID and their advocates. The UNAIDS Strategic Investment Framework, proposed in 2011,[57] established that "critical enabler" are needed to mobilize communities and create viable, sustainable community-centred service delivery structures. They are essential to the development of sustainable, effective national-level HIV responses in the long term.

| Country | Effects of budget cuts and other GF changes |
|---|---|
| Armenia | Cuts identified by CCM for its Rolling Continuation Channel (RCC) from the Round 2 HIV/AIDS grant:[58]<br>• CCM-requested budget for services for key populations cut by 23% from the original Phase 2 budget<br>• The biggest cuts, of more than 450,000 euros (US$600,000), are foreseen for prevention among PWID, despite the fact that PWID are the population in which HIV prevalence is the highest (about 10%) while coverage is less than 15%.[59]<br>• Budget for NGO capacity-building was cut by 96%. The overall capacity-related impact will be even greater, because the portion of the grant budget managed by the NGO co-principal recipient (PR) is to be cut by 40%. No cuts are reportedly foreseen for the budget managed by the other co-PR, the Ministry of Health, which is focusing on ART and HIV testing. |
| Belarus | Cuts planned to an RCC from Round 3, including:<br>• PWID-focused HIV prevention<br>• Only 39% of resources needed for NGO capacity and community systems strengthening activities[60] will be made available.<br>Note: Although the number of NSPs supported through RCC from Round 3 and another HIV grant from Round 8 will be reduced from 28 to 20 in Belarus, the territories of those closed will be covered through the introduction of six mobile units. |

[55] Moldova is an exception because it is classified in a lower income bracket than the other countries. It will still be expected to make cuts, but has a ceiling of 90% instead of 75%.
[56] Interview with Olga Atroshchanka, Programme Associate, UNDP Belarus on 6 April 2012
[57] Schwartländer et al (June 2011). "Towards an improved investment approach for an effective response to HIV/AIDS". *The Lancet*, Vol. 377, Issue 9782: pp 2031-2041.
[58] Data were obtained from the Armenia CCM Request for NGO PR RCC Continued Funding to the Global Fund as of 1 March 2012 (document received from Anahit Harutyunyan). As of May 2012, this request was undergoing review by the Global Fund.
[59] Out of estimated 12,700 PWID living in the country in 2010, only 1,883 PWID were reached with harm reduction in Phase 1 of the RCC. Plans call for increasing coverage by more than 2.5 times (to 4,980 PWID) in the second phase.
[60] The indicative numbers were provided by Oleg Eremin, head of the Belset AntiSPID association on 17 April 2012, at which time the final agreed budget was not yet available.

### 3.4. The wrong time for the Global Fund to step away from sustainability and advocacy efforts

Like most donors, the Global Fund seeks to ensure sustainability by increasing national funding. It does this in part by urging recipient country governments to provide a share of resources to the national HIV/AIDS response through the counterpart financing requirement. Such overall efforts have often been successful in EECA in regard to HIV treatment and reduction in vertical transmission. For HIV prevention for PWID, however, efforts to rally funds have been far less successful. Few EECA countries consider investment in harm reduction a priority for counterpart financing; as noted by a respondent from Moldova, "Counterpart financing works better in the case of treatment."[61]

While World Bank income rankings may deem a number of countries in the region wealthy enough to sustain, and even scale up, harm reduction services, with a few exceptions they are unwilling to do so, even in those countries that have joined the European Union.

Estonia represents one example of successful transition to funding harm reduction from national resources. Estonia phased out Global Fund support while maintaining the same level of harm reduction funding before and after the economic crisis. Among countries of the region it is wealthy, small, and unified, with a well-developed civil society sector. The government and civil service have more planning expertise: Estonia has a national HIV plan reaching years into the future. Nonetheless, Estonia's experience shows the possibility of phasing out Global Fund harm reduction support and replacing it entirely with government funding. Other countries have been less successful: in Romania, harm reduction services have been scaled back considerably since the Global Fund's exit, leading to a resurgence of HIV infections among PWIDs (see Box 4).

**This is the wrong time for the Global Fund to reduce support for the HIV response in EECA, stepping away from sustainability and advocacy efforts on behalf of harm reduction.** HIV epidemics in many countries remain unchecked and needs are increasing among the most vulnerable and marginalized populations, for which the Global Fund has been a central supporter. The Global Fund made important investments in capacity building and advocacy efforts by civil society, but this work is far from complete; more, not fewer, funds are needed to build harm reduction capacity and political support, critical components in establishing sustainability.[62] **The need to protect harm reduction services from ideologically driven attacks and laws that directly or indirectly criminalise people who inject drugs makes it imperative to do more and better on critical enablers[63] of harm reduction in the region.**

The Global Fund has revisited eligibility and prioritization criteria for middle-income countries several times in the past, with countries moving on and off lists at different times. It could therefore shift again and provide more windows for applications from countries such as Romania, where NGOs are prepared to seek support for harm reduction and other essential HIV services that are otherwise unavailable. At the same time, the Global Fund could help maintain the relative success of some countries in keeping HIV prevalence low among PWID and other vulnerable populations through effective harm reduction programmes. Concentrated epidemics among key populations do not exist in countries such as Albania because stakeholders have used Global Fund support wisely and consistently. If they are "punished for success" by having such support withdrawn, HIV prevalence may begin to climb as access to services declines.

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[61] As cited during an interview on 9 April 2012 with Viorel Soltan, deputy minister of health, head of the EECA delegation of the Global Fund Board (until May 2012) & Chair of the Finance and Operational Performance Committee of the Global Fund Board.

[62] Increasing programme sustainability is prioritized in the new Global Fund Strategy, however, so far no specific policy around sustainability exists.

[63] Schwartländer et al, 2011. According to the article, critical enablers are activities that are necessary to support the effectiveness and efficiency of these programmes and include social enablers for conducive environments for rational HIV/AIDS responses; and programme enablers in order to create demand for and help improve the performance of key interventions. "Social enablers consist of outreach for HIV/AIDS testing and HIV/AIDS treatment literacy, stigma reduction, advocacy to protect human rights, and monitoring of the equity and quality of programme access and results and mass communication designed to raise awareness and support change in social norms. Programme enablers include incentives for programme participation, methods to improve retention of patients on antiretroviral therapy, capacity building for development of community-based organisations, strategic planning, communications infrastructure, information dissemination, and efforts to improve service integration and linkages from testing to care."

Sustained Global Fund engagement should also remain a possibility in Russia. While the Russian government has allocated hundreds of millions of dollars to address HIV,[64] only a small share of those funds has gone to prevention, and of that only a token amount targets key populations. Federal policies toward harm reduction are uniformly negative, with rejection of NSP as a prevention strategy and a complete ban on methadone. The Global Fund has joined other critics in calling for the government to overturn that ban and implement OST and other evidence-based interventions to address the rampant HIV epidemic among PWID. Yet it is hard to see how these efforts could bear fruit if they stop now.

Most Global Fund-supported programmes providing harm reduction funding support community groups in service delivery and advocacy. Such support is essential in building civil society capacity and expertise in a region with weak non-governmental sectors. It has also proved critical in developing flexible, PWID-friendly models for harm reduction that, ideally, will eventually be accepted and sustained by national sources. Continued Global Fund support is needed until such sources are available.

## 4. Limitations of other international funding sources

In EECA, harm reduction support from other donors, such as EU institutions and bilateral development organizations, is limited in terms of scale, scope and geography. The UK's DFID has invested around $14 million in harm reduction services, capacity and advocacy in Central Asia in over 7 years,[65] but the project ends in late 2012. The Netherlands Ministry of Foreign Affairs contributed EUR 20 million to the UN Office on Drugs and Crime to support HIV prevention among PWIDs and prisoners in 2006-2011[66] and also provides support to some NGO projects targeting key populations.[67] Other smaller donors include the Canadian International Development Agency, OPEC, Open Society Foundations, and others. Often the handful of countries prioritized by other donors overlaps with the group of countries still eligible for more comprehensive Global Fund support, while countries being phased out from the Global Fund do not have alternative sources of external funding.

**These donors have far more limited capacity for support than the Global Fund, and are no substitute.** Some are restricted not only financially but also due to programmatic restrictions. For example, the return of the US ban on federal funding for needles[68] means that PEPFAR, which committed to investing $43 million in Ukraine, Central Asia and Russia in 2011,[69] is not allowed to fund the essential element in preventing HIV among PWID. Further, in many countries receiving support, the emphasis is on technical support, rather than services or advocacy. Overall, few HIV donors prioritize PWID in their investments in EECA or engage in the highly effective, targeted activities that national governments so often oppose.

### 4.1 Role of European Union institutions

The EU embraces harm reduction as one of its drug policy principles at the highest political levels, but its tools to support harm reduction, even within its own territory, remain limited. Through its European Social Fund (ESF), the EU can provide structural funds for social services in its member states. Currently, as per this publication's definition of EECA, EU member states in the region include Bulgaria, Estonia, Latvia, Lithuania and Romania. However, these structural funds are primarily accessible to large, established NGOs rather than to the smaller, community-based groups that often provide harm reduction services.

ESF limitations sometimes mean that grants fail to address the root problems that are obstacles to an effective HIV response. A Lithuanian respondent gave the following account of developments after ESF and

[64] Andrey Rylkov Foundation for Health and Social Justice, Additional Information to the Report to the International Committee on Economic, Social and Cultural Rights on Implementation by the Russian Federation of Article 12 of the International Covenant on Economic, Social and Cultural Rights as It Relates to Access of People Who Inject Drugs to Drug Treatment and HIV Prevention, Care and Treatment Programs. Retrieved on May 08, 2012 from: http://en.rylkov-fond.org/wp-content/uploads/2012/01/AFR-ICESCR-may-5-2011.pdf

[65] UK Department of International Development. Project data base. Central Asian Regional HIV/AIDS Programme. Retrieved on 6 May 2012 from: http://projects.dfid.gov.uk/project.aspx?Project=110182

[66] UNODC. UNODC gets 20 million euros from the Netherlands to address HIV/AIDS among injecting drug users in Eastern Europe, Russia. Press release. Available at: http://www.unodc.org/unodc/en/press/releases/press_release_2006_08_10.html

[67] E.g. see Aids Fonds. Bridging the gaps: health and rights for key populations. Project Factsheet March 2012.

[68] Harm Reduction International. U.S. reinstates federal funding ban for needle and syringe exchange programmes. Posting on website. 31 December 2011.

[69] PEPFAR. Fiscal Year 2011. PEPFAR Operational Plan. December 2011

other structural funds were made available to Lithuania: "Harm reduction was never among the priorities [for ESF and other structural funds coming to Lithuania] because of political issues."[70] The experience in Romania (see Box 4) is a cautionary tale showing the dangers of imbalanced and uncoordinated funding for harm reduction, with basic prevention services withering, while funds are still available for structural responses.

In Albania, one of the countries that hope to join the EU, UN agencies are involved in the search for ways to support NSPs, as Albania is no longer eligible for Global Fund support. According to the national AIDS coordinator,[71] support is not likely from one source that would seem to be among the most obvious: the EU. The EU's European Monitoring Centre for Drugs and Drug Addiction can provide technical support only, not money for services, and the EU Delegation in the country had yet to express interest in helping fill the gap or encourage government to do so. No mechanism or will exists to support NGO-run services for PWIDs from the national health budget, which is limited in general. This creates a paradoxical situation in which funds are available for technical support to build monitoring systems, but not for the services that such auxiliary activities are meant to monitor. Such a situation demands a reappraisal of EU instruments and policies, taking into consideration the dramatically different landscape left by Global Fund cuts, particularly in Southeast European countries that are already or are to become candidates to join the EU.

EU funding is also available to countries in the EU "neighbourhood" (most of EECA). In one positive recent development, the EU established a new HIV funding stream for the EU neighbourhood that started in 2011 and will provide 6.75 million euros ($8.8 million)[72] for civil society and UN initiatives in three years (in comparison, USAID/PEPFAR funding for 2011 alone for Russia, Ukraine and Central Asia was almost $42 million). But it is not harm-reduction specific and does not fund services, and therefore does not address one of the most urgent needs in the wake of the Global Fund's budget cuts—which are a result, in part, of the reduced combined contributions of EU governments and the European Commission to the Global Fund. Within this new EU HIV funding stream, a grant is to provide some support for advocacy in Russia on HIV prevention for PWID, but this grant, too, does not include funding for NSP.

Finally, EU accession has shown itself to be a powerful tool in shaping national policy. With its own commitment to harm reduction, the EU should actively promote harm reduction during the EU accession process, for example, by making accession conditional on honouring sustainability of the Global Fund grants and investing in harm reduction. Moreover, the EU's support for harm reduction could be activated through delegations in all the countries in the region and elsewhere, as well as through human rights funding mechanisms that could be used to prioritize human rights programming of PWIDs and other key populations. Those elements could be reflected not only in various EU regional policies but also in the upcoming EU Drug Policy Strategy for 2013-2020.

## 5. Conclusions and Recommendations

The Global Fund has given critical support to the development and scale-up of harm reduction programs, advocacy, and community strengthening, playing a decisive role in the response to HIV among people who inject drugs in the region. Unfortunately, the intense stigmatization of PWID in the region has meant that national governments remain largely unwilling to fund life-saving harm reduction programmes and community systems strengthening activities that are required to prevent the continued rapid growth of EECA's large-scale epidemic among PWID. This means that an effective response to HIV among PWID in EECA depends on international donors—but there are no donors who can offer support with the scale and scope of the Global Fund. So far, the European Union has taken few steps to help sustain harm reduction despite its major interest and role in the region.

The cancellation of Round 11, limitations of the Transitional Funding Mechanism, budget cuts during grant renewals, and changes in eligibility criteria mean that harm reduction programmes in EECA will have far

[70] As cited by Karile Levickaite, Project Manager, Global Initiative in Psychiatry - Lithuania, in an interview on 29 March 2012.
[71] Interview with Roland Bani, 28 March 2012.
[72] Total budget of the Programme calculated based on the list of approved funding for the programme. More about the Programme "*Capacity building for non-state actors in relation to HIV-AIDS prevention, treatment and care for the European Neighbourhood and Partnership countries*" is available at: https://webgate.ec.europa.eu/europeaid/online-services/index.cfm?do=publi.welcome&nbPubliList=15&orderby=upd&orderbyad=Desc&searchtype=RS&aofr=130355

fewer opportunities for funding. Crucial community strengthening and advocacy components will be left unfunded, compromising the survival and sustainability of services for PWID.

As detailed in this report, the negative effects of the Global Fund changes have already become evident, and are likely to increase with time, as grants end in the absence of new funding opportunities. The Global Fund must work swiftly to reverse the changes that are compromising the HIV response among PWID in EECA. It should adopt funding policies that reflect epidemiological and political realities, rather than ones based only on country income or disease burden. Other donors should also act quickly to support harm reduction in the region and to compensate for funding gaps caused by Global Fund changes.

Harm reduction programmes have safeguarded the health and saved the lives of thousands of people across EECA. More and expanded services are needed to reach the thousands more who have no access due to geographical distance, stigma and discrimination, legal and economic restrictions, and deliberate neglect. With little support from national governments for harm reduction, an effective HIV response in EECA relies on external donors, among whom the Global Fund is the most important. Support is urgently needed to prevent the further spread of HIV, to continue the positive but incomplete work that the Global Fund has supported over the last decade, and to maintain the success of countries where Global Fund-supported programs have averted HIV epidemics among PWID.

The loss of support for harm reduction will be catastrophic to PWID and other vulnerable populations in the region. To avoid such consequences, the following actions should be prioritized:

**Governments and other donors** should increase their contributions to and fully fund the Global Fund – only then will it be possible to get the growing HIV epidemic in EECA under control.

**The Global Fund should**:

- The **Board** should agree to issue a new call for applications as soon as possible and no later than November 2012. The new call for applications should emphasize the importance of investing in "critical enablers" to increase the effectiveness of core program activities, including community-based program design and delivery and programs to address human rights and barriers to access to services.

- Ease restrictions on engagement in middle-income countries with epidemics concentrated among PWID. Eliminate the rule that 55% of funding per year must go to low-income countries. Eligibility and access should be simplified and encouraged for countries where i) the Global Fund currently provides the majority of resources for harm reduction; ii) few other reasonable sources are identifiable; iii) governments are unable or unwilling to support harm reduction; and iv) NGOs rely on Global Fund support to sustain and scale up services for PWID and other vulnerable populations. The countries that manage to maintain or reduce HIV prevalence among PWIDs below 5% should not be excluded from future funding.

- In the new Global Fund funding model, strengthen the Targeted Pool to generate more focused investment in PWIDs, along with other marginalized and highly affected populations. For new and renewed grants, i) increase funds available for the Targeted Pool; ii) adjust maximum amounts for individual grants considering country size and needs; iii) strengthen guidance on investment in critical enablers.

- More comprehensively ground funding decisions in the strategic investment framework for the global AIDS response proposed in 2011.[73] Along with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO, the Global Fund has signalled its support for the framework's approach, which prioritizes increased and sustained involvement by civil society and communities, including community mobilization, advocacy, capacity building and human rights programming. Understanding of the importance of 'critical enablers' should be firmly established across the Global Fund and among its partners. Investment in 'critical enablers' should be encouraged in all funding mechanisms. Such efforts are critical to help build eventual sustainability.

[73] Schwartländer et al, 2011.

- Preserve the multi-country funding channel in the form of a Regional Coordinating Mechanism and from Regional Organizations to provide a less politicized and safer platform than at a country level on which to advocate for the needs of key affected populations severely underserved through national programs.

- Work to ensure sustainability of investment in harm reduction in middle-income countries. This role could focus on i) helping countries to take specific steps towards establishing mechanisms for governments to sub-contract NGOs; ii) supporting policy dialogue in proposals and CCMs around institutionalization of harm reduction; iii) seeking NGO and regional proposals strengthening harm reduction capacity and advocacy.

- The Global Fund Secretariat should enact the recommendations of the 2011 evaluation of the SOGI Strategy and work with partners to develop a specific action plan for PWID, ensuring that the Secretariat continues to support and protect the large portfolio of investments in harm reduction.

**The European Union institutions should**:

- Honour existing pledges and scale up support to the Global Fund in the context of the on-going negotiations on the new EU multi-annual financial framework (MFF) 2014-2020 and 11$^{th}$ European Development Fund.

- Actively promote harm reduction at the global level and through political dialogue with partner countries in EECA. The European External Action Service should make full use of its potential to become a progressive force for advancing human rights within the EU's HIV response at global and country levels. Notably, it should engage more EU delegations in a policy dialogue with national governments and in the Global Fund Country Coordinating Mechanisms.

- Provide financial and technical support for sustaining harm reduction activities in EECA, including through long-term investment to support the work of non-governmental organisations in the region. Thematic instruments such as the European Instrument on Democratisation and Human Rights (EIDHR) and thematic instruments under the Development Cooperation Instrument (DCI) can be useful complementary tools for projects targeting PWID.

- In ENP countries, translate the new EU Health Programme priority objective on preventing HIV/AIDS into concrete allocations to support NGOs that contribute to that objective through their harm reduction activities.

**Other donors, including bilaterals, should**:

- Devise strategies to maximize engagement in harm reduction as part of broader health and development programming. This may involve more extensive analysis of key gaps such as access to HIV prevention services for those most in need and an understanding of the need for more evidence-based interventions, as well as geographical areas with less investment available. Bilaterals should consider collaborating with each other as well as other funding sources to create harm reduction programming opportunities with reasonable and sustainable funding.

- Develop strategies to support government officials and policymakers to reform laws and policies blocking harm reduction activities, including NSP and OST. Such efforts may rely on one or more demonstration projects as well as exposure to facilities and projects elsewhere.

**National governments and CCMs**:

- Define country-specific harm reduction sustainability plans. This planning will require reviewing specific steps for moving from external funds to integration of harm reduction and NGO-run services in national systems and funding streams. The implementation of those plans should be given sufficient time for making the transition into national funding truly operational.

***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 350 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.

Since 2008 EHRN hosts the Civil Society Action Team (CSAT) in CEECA. CSAT is a civil society-led global initiative that coordinates, brokers and advocates for technical support to civil society organizations implementing or seeking grants from the Global Fund to Fight AIDS, TB and Malaria.

***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.

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