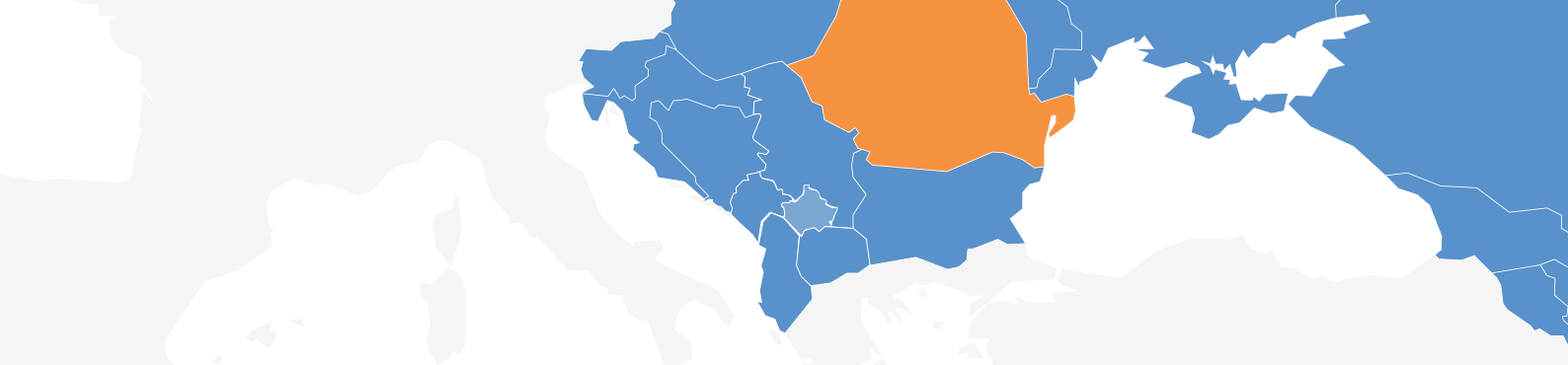


THE IMPACT OF TRANSITION FROM GLOBAL FUND SUPPORT TO GOVERNMENTAL FUNDING ON THE SUSTAINABILITY OF HARM REDUCTION PROGRAMS

A CASE STUDY FROM ROMANIA
EURASIAN HARM REDUCTION NETWORK



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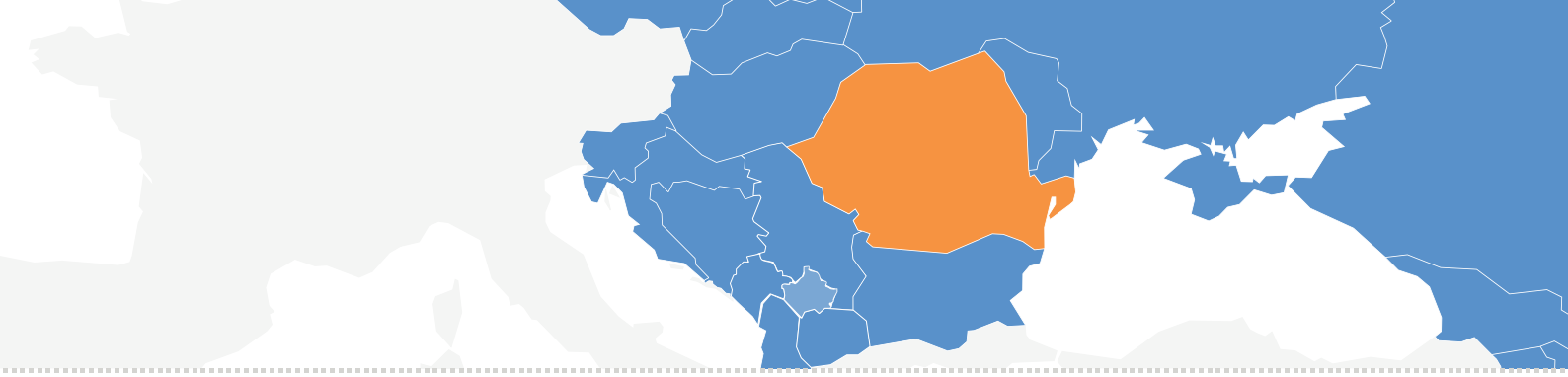
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Executive Summary

Becoming a member of the European Union in 2007, Romania has seen its Gross Domestic Product (GDP) rise 2.8% in 2014 and 3.7% in 2015, one of the highest in the EU with the World Bank categorising the country as 'upper middle income' but with the Government only putting 13% of its resources towards the health sector in 2014. Although Gross National Income (GNI) per capita in 2014 was \$9,520, one-quarter of the population were reported to be living below the national poverty line.

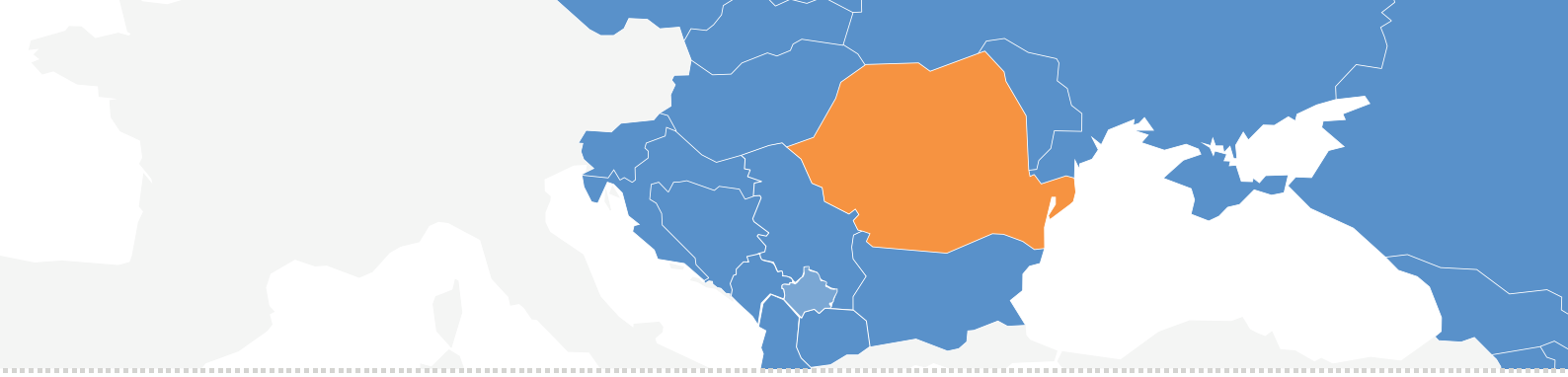
31%
Romania
readiness to sustain
harm reduction
interventions

Romania has a relatively low - at under 1% - but steadily increasing HIV prevalence among the adult population with the disease concentrated in key populations, with 13,766 people living with HIV/AIDS in the country as of the end of 2015.

Agreements have been signed by the Global Fund for HIV/AIDS (\$37,671,819) between June 2003 and June 2010, and for Tuberculosis (TB) (\$40,058,225) between June 2003 and 31 March 2018. Global Fund support of HIV ended in June 2010 due to the relatively low burden of the disease and the economic growth of the country but with no transition plan in place for domestic and other resources to sustain the interventions, resulting in a collapse in services, especially the availability of needle/syringe programmes (NSP) for people who inject drugs (PWID). This lack of funding coincided with a dramatic increase in HIV among PWID especially in the capital, Bucharest, whereby in 2009 - prior to the end of Global Fund support - HIV prevalence among PWID was estimated at 1.1% but then - following the end of the Global Fund HIV grant - rose dramatically to 6.9% in 2012 and spiked at 53% in 2013. Thanks primarily to the response of non-governmental organisations (NGOs) and funding from the EU (structural funds), Norway and various private foundations, some NSP services were reestablished after the exit of the Global Fund but not at the scale needed, with HIV prevalence among PWID falling back somewhat to 21.4% in 2014; prevalence of HIV among PWID aged 25-29 years and 30-34 years was the highest in 2015 at 28% and 27%, respectively. In comparison, HIV prevalence among men who have sex with men (MSM) and sex workers in 2015 was 16% and 4.6%, respectively, although some members of civil society believe the rates to be far higher owing the lack of access by MSM and SW to VCT services across the country. In addition, viral hepatitis C (HCV) is rampant in the PWID community with prevalence in 2011 at 79% - the highest rate in Europe - compared to 3.2% among the general population.

Over recent years, the Global Fund has considered there to be not only a low burden of HIV but also no 'political barriers' to the implementation of harm reduction interventions in Romania and, consequently, funding under its 'NGO rule' is not available, a situation disputed by many civil society organisations in the country. But whilst the legislative and policy environment in Romania does provide for harm reduction services to function, the Government has shown little commitment to fund such interventions, especially NSP. Furthermore, the five opioid substitution therapy (OST) sites that are run by various Government agencies, together with four more sites operated by NGOs, is far from being at a level of coverage that will have an impact on stopping the further transmission of HIV, nor to reverse the prevalence and incidence of the epidemic in the future. It is noteworthy, however, that OST is available in a small number of prisons in Romania.

TB has continued to be endemic in Romania over the past decade or more and has, therefore, continued to be supported by the Global Fund with the most recent TB grant agreement due to run until the end of March 2018.



Significantly, the current Global Fund TB grant includes transition planning for the entire TB sector to be financed by the Government from 2018. The grant also has a component for harm reduction for PWID, including NSP, in Bucharest with services implemented by two NGOs.

To analyze the readiness and risks of transition from donor funding of the harm reduction program to sustainable domestic financing in Romania and other countries, the Eurasian Harm Reduction Network (EHRN) and APMGlobal Health have developed a 'transition readiness tool' covering policy, governance, finance and program. Each area has nine benchmarks that capture key factors that are absolutely essential to a sustainable transition. The result is a 'readiness for transition' score, with a higher percentage score indicating a greater readiness of a country to transition fully from donor to domestic funding of its harm reduction program. Romania scores 31%, meaning that Romania shows minimal readiness to sustain harm reduction interventions after the end of the current Global Fund TB grant and other external donor support such as from the EU, Norway and various private foundations.

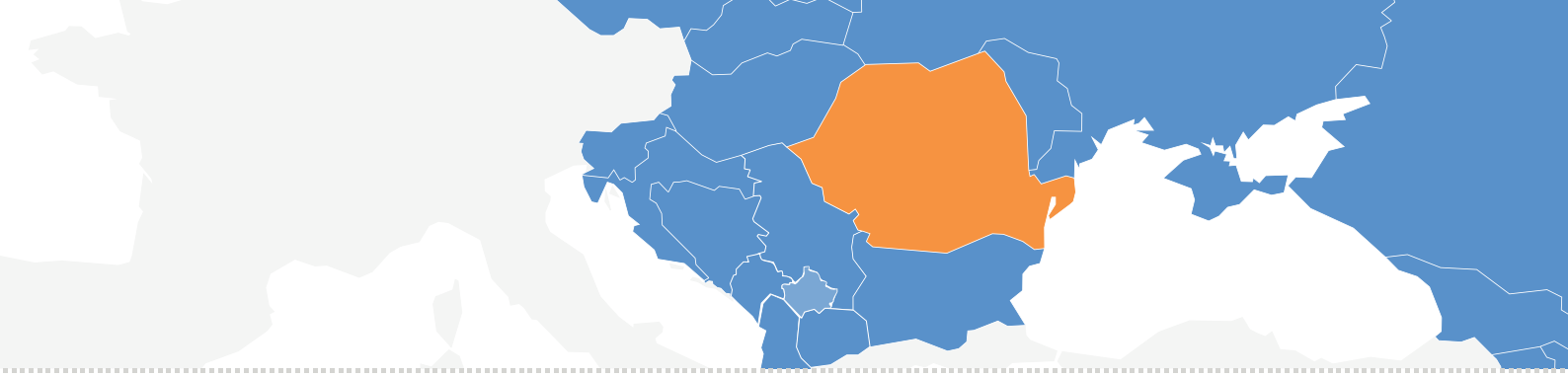
Using the lessons learnt from the development of the national TB control strategy and the current Global Fund TB grant, the Government needs to develop and integrate a sustainability plan for the HIV/AIDS program, including harm reduction interventions, that includes relevant components of the National Anti-Drug Strategy (under the Ministry of Interior) and the National Public Health Strategy (of the Ministry of Public Health); this could be in the form of a new, stand-alone National HIV/AIDS Strategy or as a revision, or addendum, to the existing National Public Health Strategy, 2014-2020. Local authorities as well as existing EU and Norway funds, together with the support of NSP through the current Global Fund TB grant, could make use of such a HIV/AIDS document as guidance to make sustainability of HIV/AIDS interventions a reality through a coordinated and managed approach. Such an approach would clearly show the Government's commitment to addressing HIV/AIDS issues in Romania, including support for the harm reduction program.

As part of sustainability planning, the Government needs to undertake a cost estimate for harm reduction services in collaboration with relevant NGOs/CBOs working in the sector as well as a financial gap analysis for the HIV/AIDS sector. This can be achieved through the Government taking an holistic approach by ensuring that NGOs are an integral component of the service delivery modalities, especially interventions for KAPs, and give NGOs a 'public utility' status in order for them to be legally funded by the Government to deliver services. Such an approach will support the scale-up of harm reduction services - especially NSP and OST - so that coverage is high enough to reduce, and then stop and reverse, the HIV epidemic in Romania.

Introduction

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

In 2014, the Global Fund introduced the New Funding Model (NFM), a new approach to resource allocation that has transformed financing for the three diseases. In upper-middle income countries (UMICs), Global Fund invests 100% of its financing to support key and vulnerable populations. According to World Bank classification, there are no longer low income countries in Eastern Europe and Central Asia (EECA), including the countries of the Balkans in Southeast Europe. Although pledges by donors to the Global Fund increased from \$10.08bn. for the period



2011-2013 to \$12.23bn. for 2014-2016¹, the EECA region saw an overall reduction of 15.1% as a result of the NFM allocation methodology². Furthermore, the recent UN Secretary-General's report includes a table that calls for a significant pullout of international funding from Upper-Middle Income Countries (UMICs) by 2020 that could lead to dramatic consequences in terms of the spread of the HIV epidemic among Key Affected Populations (KAPs) in these countries³.

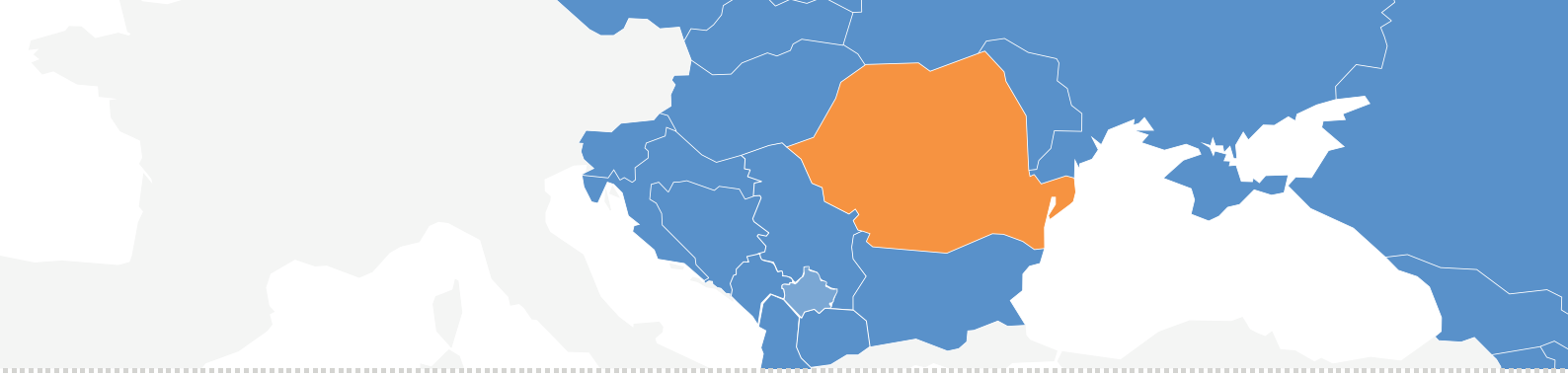
Consequently, there is widespread concern as to how to ensure the successful transition from Global Fund supported HIV and TB programs to national funding and the sustainability of such programs, especially those programs targeted at key affected populations (KAP). As a result, EHRN decided to conduct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

Methodology

A **desk review** of relevant documents (both available in English and in the Romanian language) was undertaken to analyze the availability of internal and external funding for harm reduction projects in the country, as well as the processes around transitioning from Global Fund to national or other donor funding, together with sustainability planning for harm reduction and related services. This has included, for example, an analysis of the National Health Strategy, 2014-2020, of the Ministry of Public Health; the National Anti-Drug Strategy, 2013-2020, of the National Anti-Drug Agency of the Ministry of Interior; the Romanian Country Coordination Mechanism for the HIV/AIDS and Tuberculosis Programs; the current Global Fund/CCM TB Concept Note; HIV/AIDS and TB grant agreements between the Global Fund and the PR in Romania from June 2003 to the present; the Health System Financing Profile of Romania, 2014, by the World Health Organization; and the Romania National Report 2014 of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), amongst others.

A case study interview guide was developed by EHRN and adapted to the Romanian situation and key informants were identified and then **interviewed using skype and email**. A total of five key informant interviews were conducted with participants from the Global Fund and local NGOs, including those implementing harm reduction services in Romania. Feedback on the draft case study was provided by the Global Fund Secretariat, the Romanian Angel Appeal Foundation/GFATM PR, and the NGO, ARAS.

Information and data obtained through this process was then entered into a **'Transition Readiness Tool'** developed by EHRN⁴ and APMGlobal Health⁵ to analyze the readiness and risks of transition from donor funding to sustainable domestic financing, identifying key barriers that must be addressed before sustainable transition is possible with a particular emphasis on assessing the sustainability of harm reduction services through and beyond the transition period.



Background

Country context

Located in the south-eastern part of Central Europe, Romania shares borders with Hungary to the north west, Serbia to the south west, Bulgaria to the south, the Black Sea to the south east, Ukraine to the east and to the north and the Republic of Moldova to the east, Romania has a surface area of 238,391 sq. km⁶ and a total population estimated at 19,904,360 (48.5% male, 51.5% female) as of 2014⁷, with urban areas comprising 54.4% of the total population; however, the population of Romania is falling by an average of 0.3% per year as deaths outstrip births⁸.

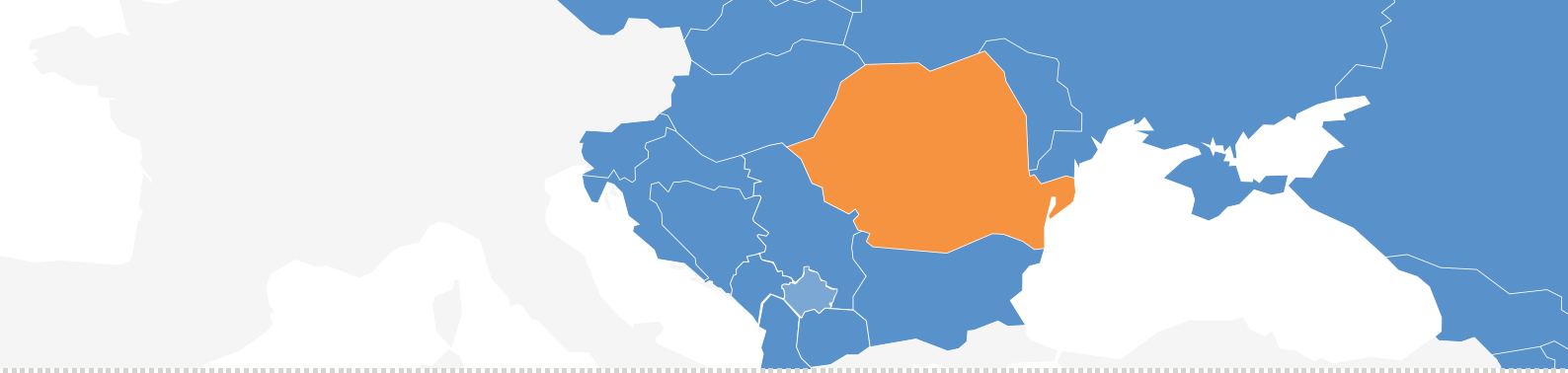
The World Bank defines Romania as an 'upper middle income' country⁹ within the European Union (EU) - to which Romania has been a member since 1 January 2007 - viewing Romania as a 'semi-presidential republic'¹⁰. The country has experienced relatively strong economic growth over recent years with GDP rising 2.8% in 2014 and 3.7% in 2015, one of the highest rates in the EU¹¹. Gross national income (GNI) per capita in 2014 was \$9,520 (Atlas method), higher than the \$7,926.30 average in 2014 for developing countries of Europe and Central Asia, and GDP per capita was \$10,000 (Atlas method). However, 25.4% of the population in 2013 were reported to be living below the national poverty line¹².

The Government of Romania put 13% of its resources towards the health sector in 2014, a level it has roughly maintained since around 2003. Health expenditure per capita in 2014 was \$556.80 and 5.6% as a proportion of GDP, up from 5.3% in 2013¹³. Household out-of-pocket private expenditures on health was estimated at \$149 (or 19%) on average during 2014¹⁴.

Epidemiological situation with HIV/TB and current trends

Romania has a low - at under 1% - but steadily increasing HIV epidemic among the adult population. HIV is concentrated in key populations. First diagnosed in Romania in 1985, there has been a cumulative total of 21,263 cases of HIV diagnosed since then of which 343 have been PWID (81% male) which may be as a result of the unwillingness of PWID to self-report their status as a KAP, or do not self-identify as PWID, for fear of arrest by police or stigmatisation and discrimination by healthcare workers. As of 31 December 2015, there were 13,766 people living with HIV/AIDS (PLHA) in Romania (62% male). HIV prevalence among the adult population aged 15 years and older has steadily risen from 14.53 per 100,000 in 2010 to 24.30 per 100,000 in 2014, significantly higher than the 7.8 per 100,000 reported in the WHO European region and the 1.9 per 100,000 population in the central European region. Incidence of HIV in Romania among adults in 2014 was 2.38 per 100,000¹⁵.

HIV prevalence among PWID in Romania in 2009 was estimated to be 1.1%, rising to 6.9% in 2012. The prevalence then shot up to an estimated 53% in 2013 - likely as a consequence of the end of Global Fund support to NSP - before falling back somewhat to 21.4% in 2014¹⁶. Among a sample size of 809 PWID in 2013, HIV prevalence was 49.2%, up from 24.9% in 2012 (n=398)¹⁷, however civil society organisations (CSOs) believe this figure to be higher¹⁸. In 2015, a total of 149 diagnosed cases of HIV were attributed to the use of contaminated injecting equipment, a rate of 7.5 cases per million population¹⁹. The number of HIV cases arising among men who have sex with men (MSM) who also inject drugs has remained relatively stable in recent years but rose slightly from 1% (9 cases) in 2014 to 1.3% in 2015 (also 9 cases). PWID in the age groups of 25-29 years and 30-34 years had the highest number of new HIV infections in 2015 at 28% and 27%, respectively. Of the 149 new cases of HIV diagnosed among PWID during 2015, 78% were in the capital, Bucharest²⁰. Most new cases of HIV have a low CD4 count with 60% of PWID <350 cells/mm³ at post-



diagnosis evaluation, indicating that PWID are not accessing voluntary counselling and testing (VCT) of HIV earlier enough. In comparison, HIV prevalence among MSM in 2015 was 16% (although the sample size was relatively small) and among Sex Workers in 2015 it was 4.6% (but, again, the sample size was relatively small)²¹.

Hepatitis C appears to be rampant throughout the PWID community in Romania although sample sizes are relatively small. Anti-hepatitis C (HCV) prevalence among PWID was reported in 2011 to be 79%²² compared to 3.2% among the general population²³, the highest rate in Europe²⁴. Of 149 PWID diagnosed in 2015 as being HIV-positive, 122 of them (81.9%) had anti-HCV prevalence²⁵; similar results were found in 2014 in which 82% (n=165) of PWID living with HIV also had hepatitis C²⁶.

Hepatitis B (anti-HBsAg) prevalence among PWID was reported at 5% in 2011²⁷. Of PWID found to be HIV-positive in 2015, the prevalence of HBV was 2.01% (3 of 149 PWID) and a combination of HBV and HCV was diagnosed among 12 of the 149 (8.05%) PWID.

Of the same 149 HIV-positive PWID in 2015, a total of 47 (31.5%) had some form of tuberculosis (TB). In addition, 13 of the 149 (8.7%) had one or more sexually transmitted disease (STD)²⁸, although this was lower than the rate in 2014 at 24%²⁹.

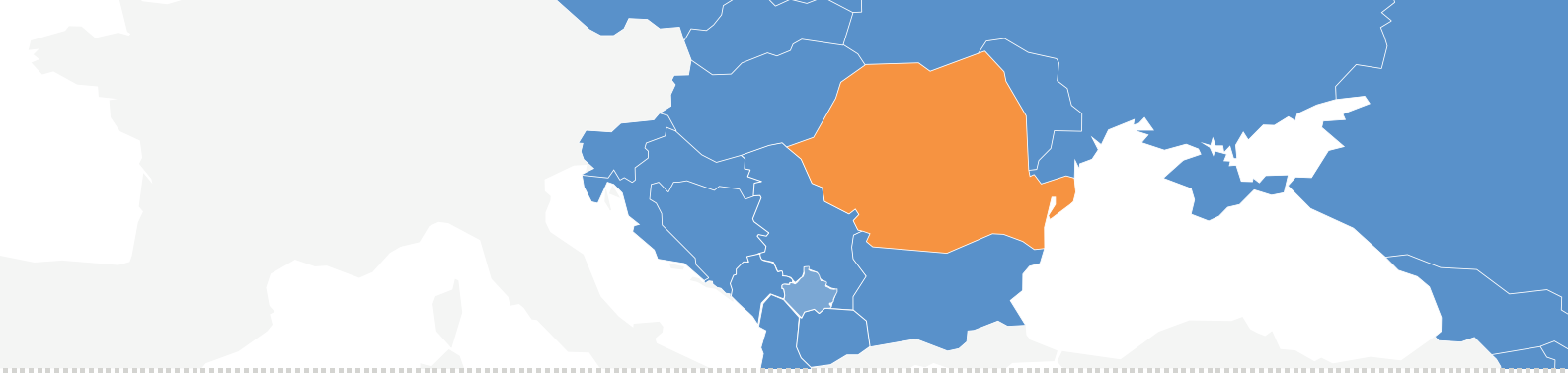
Global Fund eligibility

Agreements have been signed by the Global Fund for a total of \$77,730,044 for HIV/AIDS (\$37,671,819) and TB (\$40,058,225) interventions in Romania over the period 6 June 2003 to 31 March 2018³⁰.

Romania was successful in getting two Global Fund HIV grants, the first being from Round 2 (Grant ROM-202-G01-H-00) between 6 June 2003 and 31 December 2008 of \$26,482,189³¹ for which the Ministry of Health was the Principal Recipient (PR), and the second from Round 6 (Grant ROM-607-G03-H) from 15 May 2007 to 30 June 2010 for a total of \$11,189,630³² for which the Romanian Angel Appeal³³ was the PR. Following this, the Romanian CCM developed a HIV proposal for submission to the Global Fund for Round 11 which, however, was cancelled. At the same time, the 23rd meeting of the Global Fund Board made a decision in May 2011³⁴ on new eligibility criteria for countries that resulted in Romania being ineligible to apply for another Global Fund HIV grant³⁵ owing to its classification as an 'Upper Middle Income' (UMI) country with a 'moderate' HIV disease burden and not being included in the OECD/DAC list³⁶.

In 2012, Romania's ineligibility to apply for Global Fund HIV grants was reconfirmed. However, in 2013, Romania's HIV disease burden had been assessed to have increased to 'high', allowing it to apply for a Global Fund HIV grant under the New Funding Model (NFM) through the 'NGO rule'³⁷. A targeted concept note was developed and submitted but was not supported by the Global Fund. The Global Fund's 'Eligibility and Counterpart Financing Policy' of November 2013³⁸ - which 'remains applicable to grant programs originating from the 2014-2016 allocation period'³⁹ - notes that, 'Applicants must provide confirmation that the services requested in the application are not being provided due to political barriers', with regards to the 'NGO rule'⁴⁰. Unfortunately, the Global Fund does not provide a definition of 'political barriers' and, consequently, this terminology is open to interpretation; to-date, Russia is the only country which has been granted the Global Fund support for HIV activities within the 'NGO rule'.

Some Romanian NGOs have taken a view that there are, indeed, 'political barriers' to the delivery of harm reduction services that take the form of (1) the lack of a strategic HIV framework since 2007; (2) the lack of targeting by the National HIV Program on prevention measures for PWID and MSM even though official data indicates that these are the most affected key populations; (3) the ongoing lack of government funding for harm reduction interventions



even after the government made a commitment to provide such public funds; and, (4) the lack of political will to publicly address the steady increase of HIV among MSM⁴¹. However, such issues are viewed by the Global Fund Secretariat as a 'lack of funding or political will rather than political barriers', per se⁴².

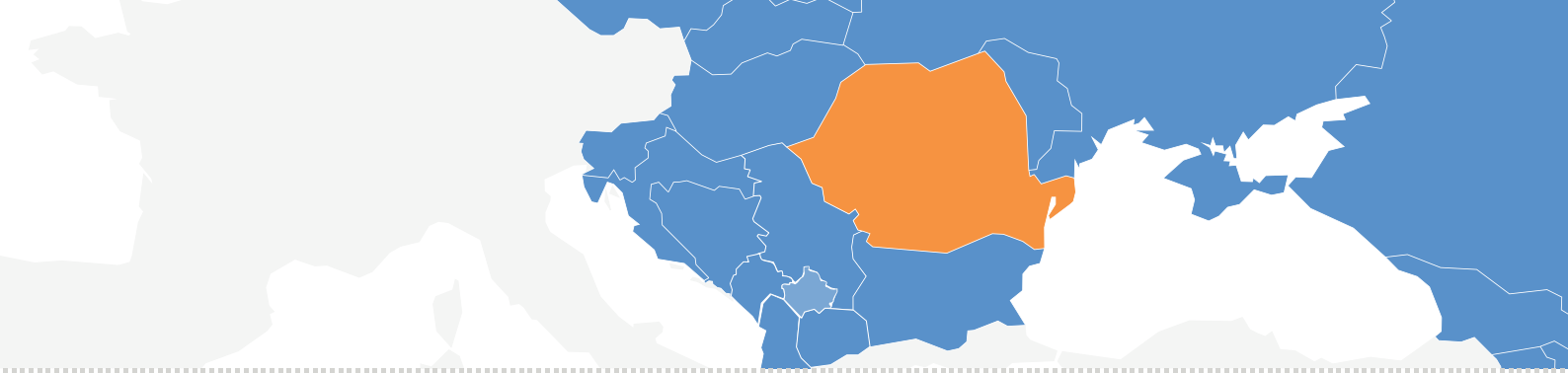
No funding allocation was made by the Global Fund for HIV support to Romania for the period 2014-2016⁴³ and no change was made to Romania's eligibility for HIV support in 2015⁴⁴, nor in 2016⁴⁵. Consequently, at the time of writing, there are no Global Fund supported harm reduction interventions taking place in Romania through a HIV grant; harm reduction support from the Global Fund in Romania is currently funded through a TB grant.

For TB, the Global Fund has made three agreements with Romania. Under Global Fund Round 2 from 6 June 2003 to 31 July 2008, Romania received \$16,684,709 (Grant ROM-202-G02-T-00)⁴⁶ and through Round 6 the country received \$14,470,539 between 24 September 2007 and 31 March 2015 (Grant ROM-607-G04-T)⁴⁷. Romania's success in gaining Global Fund TB support is due to its ongoing 'high' disease burden. This status allowed the country to be eligible in 2012 to apply for the Global Fund 'Targeted Funding pool'⁴⁸; in 2013, this changed to eligibility for targeted components only⁴⁹. Within the Global Fund's 'New Funding Model' (NFM), Romania was allocated \$12.8m in March 2014 for TB for the period 2014-2016⁵⁰. The Global Fund Round 6 grant was due to end on 30 September 2012 but through the Global Fund's 'Transitional Funding Mechanism' (TFM) implementation continued (as Grant ROM-607-G04T TFM)⁵¹ for a further two years until 30 September 2014 following which a no-cost extension of the grant was agreed for the period 1 October 2014 to 31 March 2015 (as Grant ROM-607-G04T TFM NCE)⁵². In both 2015⁵³ and 2016⁵⁴, still with a 'high' TB disease burden, Romania was again designated by the Global Fund as 'eligible' for TB funding. Following submission of a Concept Note⁵⁵, TB support from the Global Fund to Romania continued from 1 April 2015 (through Grant ROU-T-RAA) for \$8,902,977 with implementation planned to continue until 31 March 2018⁵⁶. Although there is no certainty that additional funds will be available for TB support in Romania in the future, indications are that in the next Global Fund allocation period the country will get a transition grant for the TB program as part of the new transition and sustainability policy passed by the Global Fund Board at the end of April 2016.

Overview of the status of harm reduction in Romania

Estimates as to the number of PWID in Romania are limited due to the lack of suitable data sources. An estimate in 2011 suggested there were 19,265 PWID (range from 14,564 to 26,296) aged 18-49 years in the Romanian capital, Bucharest⁵⁷. In 2013, the estimated number of PWID had reduced to 10,583. In 2014, there were estimated to be 6,288 PWID (range 4,703-8,492) in Bucharest based on drug treatment services using a multiplier method⁵⁸; this equates to 5.3 PWID per 1,000 inhabitants aged 18-49 years. Of the 6,288 PWID, 52.5% used heroin and 28% consumed new psychoactive substances, mainly the injecting of synthetic cathinones (a form of stimulant)⁵⁹ and piperazines (new forms of synthetic psychoactive stimulants, also known as 'party pills' in some countries)⁶⁰.

The provision of a sterile needle and syringe program (NSP) began in Romania in 1999 as part of the first HIV prevention program among sex workers run by the Romanian Association Against AIDS (ARAS)⁶¹ as well as through a fixed site needle exchange service operated by the Alliance for the Fight Against Alcoholism and Drug Abuse (ALIAT)⁶². Access to sterile injecting equipment - especially insulin syringes - at pharmacies was poor as PWID were viewed as 'difficult customers' who represented 'a danger to the security of pharmacy staff'⁶³. A total of 1,254 PWID were reached with harm reduction services - including NSP - in 2006 and 460,779 sterile needles/syringes were distributed, equivalent to an average of 367.45 sterile needles/syringes per PWID during the year. In 2007, with the addition of UNODC financial and technical support to that already being provided by the Global Fund HIV grant, this



had risen to 4,434 PWID reached⁶⁴, and in 2008 a total of 7,284 PWID received NSP with 1,108,762 sterile needles/syringes distributed, equating to 152.22 needles/syringes per PWID. This rose further to 1,665,776 in 2009 to 7,334 PWID, or 227.13 needles/syringes per PWID⁶⁵ through services delivered by six NGOs⁶⁶.

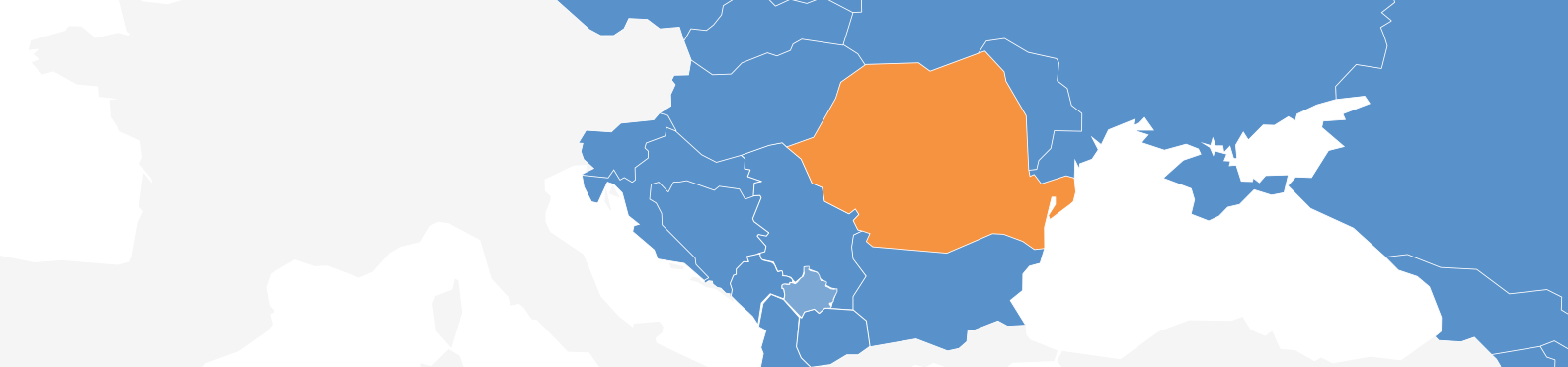
However, by 2010, the number of harm reduction NGOs had dropped from six to two⁶⁷ due to the end of Global Fund HIV support as well as the end of the UNODC financial assistance. As a result, an estimated 984,000 sterile needles/syringes were distributed in 2010, falling further to 895,110 in 2011⁶⁸ with only four NSP sites remaining in the country⁶⁹ and an estimated 49.11 sterile needles/syringes distributed per PWID; this number increased slightly to 52 per PWID in 2012. Such NSP services were able to operate in large part due to support provided by the National Anti-Drug Agency (NADA) supplying the required commodities through the National Program of Medical, Psychological and Social Care of Drug Users between 2009 and 2012⁷⁰. However, the number of PWID who reported using sterile injecting equipment the last time that they injected fell significantly from a relatively high level of 85% in 2009 to 16% in 2012⁷¹. By the end of 2013, as a result of funding available from the European Structural Funds⁷², Norwegian Funds and SIDACTION⁷³, NSP coverage had increased dramatically to an estimated 155.4 sterile needles/syringes per PWID through services delivered by two NGOs - ARAS, as noted above,⁷⁴ and Carusel⁷⁵ - to a total of 5,148 PWID, or 81.9% of the estimated number of PWID, in Bucharest and two counties of Romania⁷⁶ with approximately 1m. syringes donated by the French organization, SIDACTION, as emergency aid following the procurement of 800,000 syringes by NADA in January of that year that were subsequently rejected by NSP clients due to various faults of the syringes and poor quality needles, amongst other issues. In 2014, an estimated 2,051,770 sterile needles/syringes were distributed to PWID⁷⁷. The NGO-implemented NSP services have been funded since April 2015 through the Global Fund TB grant as well as through funding in 2015 and the first half of 2016 from SIDACTION, France, and operate from five fixed locations and via 114 outreach sites through street workers and mobile teams. NSP is also reportedly available in two prisons⁷⁸ through the same GF TB grant.

Of particular note is that under the Global Fund TB support provided by the TFM from late 2012, and subsequently by the TB grant from April 2015, harm reduction services have been included as a joint TB/HIV strategy targeting most at-risk populations totalling 6.5% (Eur 545,291) of the current TB grant as of February 2015. Those harm reduction interventions covered by such TB funding include needle exchange, condoms, and IEC materials as well as services provided to the broader group of key populations including HIV, HBV, GBC testing; hepatitis A and B vaccinations (HAV and HBV); referral of suspected TB cases, DOTS, distribution of vouchers, and Rifabutine^{79 80}.

Methadone Maintenance Therapy (MMT) was introduced to Romania in 1998⁸¹ and buprenorphine became available in 2007, and with the combination buprenorphine/naloxone arriving in 2008⁸². Four OST sites were operational by 2007⁸³ but OST coverage was less than 5% of the estimated number of PWID in Bucharest⁸⁴ with a total of 424 clients⁸⁵ by the end of 2009. Piloting of NSP in two detention centres and OST in three detention facilities was underway by the end of 2009 with more than 160 PWID benefitting from NSP and more than 50 prison inmates on OST⁸⁶. However, NSP services in prisons ceased in 2013 due to a reported lack of interest by prisoners⁸⁷.

In 2010, there were estimated to be 601 clients on OST⁸⁸ but this figure dropped to 500 clients in 2011⁸⁹, equating to approximately 9% coverage in community settings; no data was available at that time as to OST coverage in prison settings⁹⁰. In 2011, there were ten OST sites operational in the country⁹¹ but this then fell to 8 sites by 2014⁹² with 387 clients⁹³. As of 2013, OST coverage was estimated to be low at 371 clients of which 338 (91.1%) received MMT⁹⁴. In 2014, the local NGO, ARAS, reported 556 OST clients, a coverage of 8.8%, whereas NADA stated that the total number of OST clients in 2014 was 'about 1,219', or 19.4% coverage with OST⁹⁵.

OST is currently provided by medical units of the Ministry of Public Health (MoPH) at two centres and through three



'Drug Prevention, Evaluation and Counselling Centres' of NADA that provide integrated care. OST is also provided by the NGO, ARAS - through the 'Arena' and 'Ocolului' Centres - and 'The National Association for Addiction Actions' (ANIT), as well as through several, for-profit, clinics in Bucharest⁹⁶. Prisoners have access to methadone in only one prison, funded by the government.

With regards to opioid-related overdose, as a 2014 EHRN report notes, 'From the data available, it is not possible to estimate the number of opiate users at risk of overdose...There is no information available regarding the numbers of non-fatal overdoses (either witnessed or self-reported), and, similarly, we have been unable to obtain data about emergency service attendances for overdose'⁹⁷.

Although the EMDCCA reports the availability of naloxone in Romania, this is based on a 2003 report concerning drug dependence in the EU and candidate countries that states that 'Take Home Naloxone' THN is available to PWUD, peers and relatives who have completed first aid training in overdose management⁹⁸. However, the 2014 EHRN report states, 'there are no formal or strategic responses to overdose prevention and management. Indeed, we are unaware of any educational programmes or specific policies in relation to overdose prevention, and it is unclear as to what is occurring around overdose prevention'⁹⁹. The same report does note, though, that 'Naloxone is available to medical/ambulance personnel and is used accordingly'¹⁰⁰. Enquiries undertaken for this case study with NGOs in Romania found none to have access to naloxone, including those providing OST services. Consequently, it is assumed that naloxone is not readily accessible to most PWID in Romania, nor to those caregivers who would be in a position to expeditiously administer naloxone to a victim of an opioid overdose.

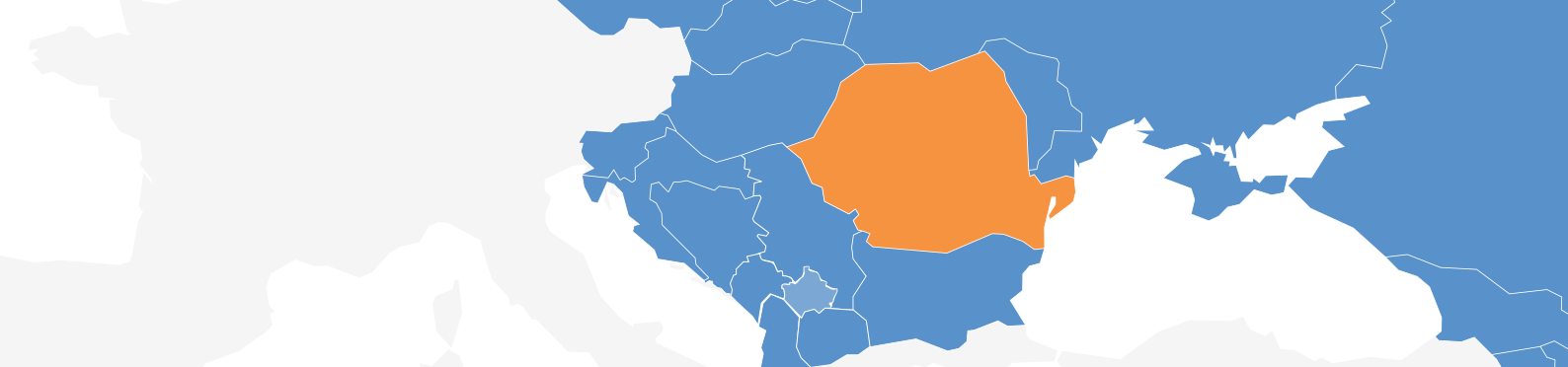
In addition, drug-induced deaths among the adult population aged 15-64 years totalled 30 cases in 2014, equivalent to 2.2 per million population¹⁰¹. However, NGOs working with opioid users dispute such low figures and believe that overdose and drug-related deaths have been under reported due to bureaucracy in medical settings and the cause of death attributed to respiratory failure with no further investigation undertaken¹⁰².

Of additional concern is that 626 PWID were tested for HIV in public health facilities in 2007 but only 49 did so in 2011 and with a slight improvement in numbers to 103 tested in 2013¹⁰³. Even so, possibly as a result of this reduction in harm reduction interventions due to the lack of Global Fund and domestic funding, the number of HIV cases among PWID rose from 3% in 2010 to 18% in 2011. As noted by UNAIDS in the 2010-2011 Global AIDS Response Progress Report (GARPR) for Romania, 'Despite consistent advocacy efforts to MoH, no funds were allocated for prevention programmes for vulnerable groups, in the context of HIV increase among IDUs and MSMs'¹⁰⁴.

Analysis Of The Transition Process

Policy

At the culmination of the last GF HIV grant in 2010 there was no plan for the transition from any forms of external donor assistance to domestic resources in Romania for the HIV sector. At the time of writing, there continues to be no guidance document for any financial transfer to take place in order to continue to support the sustainability of any HIV/AIDS activities in Romania. The dire impact on HIV transmission among PWID in Romania as a result of this lack of any form of transition from GF support was noted in a January 2016 article in the International Journal of Drug Policy: "A specific HIV outbreak among drug users (around 2011) has been directly linked to the significant decline in harm reduction services following the Global Fund transition out of the country."¹⁰⁵

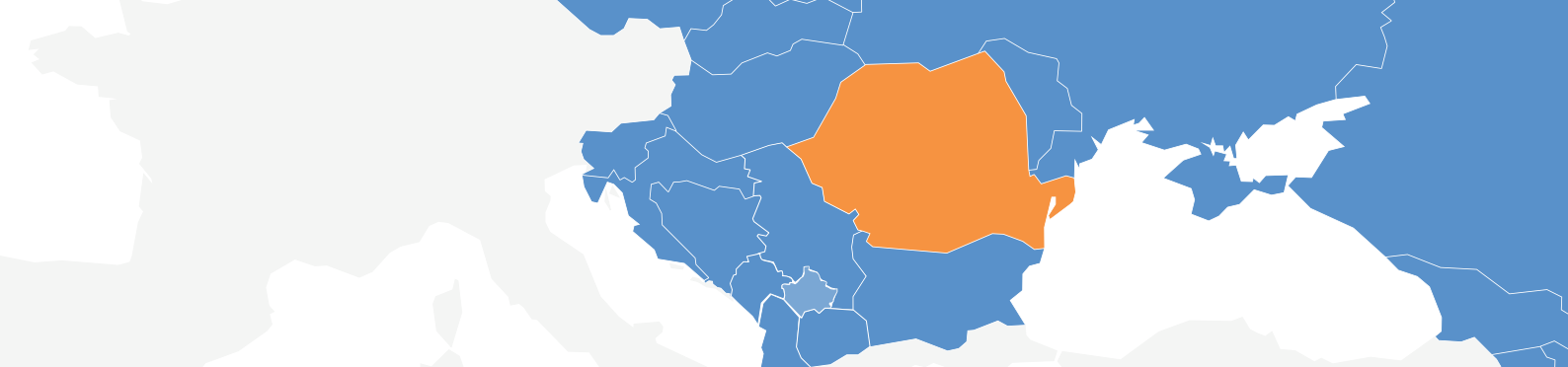


There has been no explicit, stand-alone, HIV/AIDS strategy since 2007. A plan was developed for the period 2008-2013 under the authority of the National Multisectoral HIV/AIDS Commission but due to the political situation in 2008, approval of the strategy was not finalized. The newly appointed Government in December 2009 expressed interest in finalizing a HIV/AIDS strategy for the period 2011-2015¹⁰⁶ but, again, this updated strategy was never approved by the Government after which the HIV/AIDS program was integrated into the National Public Health Strategy, 2014-2020¹⁰⁷ and its costed action plan¹⁰⁸. Harm reduction services are included in the National Anti-Drug Strategy but no budget is attached to its work plans for 2013-2016 and 2017-2020, respectively. The national HIV program does not include NSP and OST as such services are part of the National Mental Health Program.

It is highly significant that the TB program in Romania has succeeded in producing a costed transition plan from GF support to other sources of funding that is embedded within the National Strategy for TB Control, 2015-2020¹⁰⁹. The basis of the programmatic transition in the TB sector is from in-patient units - that are expensive and less effective - to out-patient ambulatory services, together with the piloting of psycho-social services. This approach is funded through applications submitted by agencies designated as GF Sub-Recipients (SR's) and its effectiveness will be assessed towards the end of the current GF TB grant. Financially, the approach is to use GF support to spearhead the programmatic transition and then utilise EU Structural Funding and MoH funding to support the ongoing work of the TB program after the exist of the GF. If such an approach is evaluated as being effective, then they could be included in the social protection package provided by the Government¹¹⁰. Many NGO and CBO stakeholders view a similar process for HIV to be impossible without first having a standalone, costed and formally approved HIV/AIDS Strategic Plan. However, as harm reduction interventions are a part of the current Global Fund TB grant, it should, therefore, become a component of the National Strategy for TB Control and thereby part of the TB transition plan. Such an approach could, in effect, compensate for the failure of any transition taking place under the last Global Fund HIV/AIDS grant in 2010.

A recent case study analysis by Aidsplan of how the Global Fund's willingness-to-pay policy leveraged additional Romanian government resources in the new funding model noted that, 'The Global Fund made it clear that the country must submit a viable transition plan. Indeed, key informants indicated that The Global Fund grant was conditional on such a plan. With this in mind, when the country developed its new National Strategic Plan for 2015-2020, transition from Global Fund and long-term sustainability was important considerations'¹¹¹, adding that, 'The Global Fund Secretariat told Aidsplan that "we made it a requirement for them to make this transition plan before the [TB] grant."¹¹² It is unfortunate that such an approach by the Global Fund was not taken with the Government during the last, and final, HIV grant negotiations and in the lead up to the 2010 close-out of that grant. Furthermore, as part of the National Public Health Strategy, 2014-2020, the Government needs to show its political will to change its approach to funding the HIV/AIDS sector in general, and harm reduction interventions specifically, in order to reach its stated objectives. Advocacy to this end should continue with an emphasis on how domestic investments now in HIV prevention among KAPs will save the Government considerable money in the medium-to-long term and thereby make HIV/AIDS a priority for the Government itself. As a key informant stated in an interview for this case study, 'The Romanian state will act according to its own priorities, not the priorities of international donors'¹¹³. As a result of these factors, **Indicator 1** (A fully-resourced Transition Plan including harm reduction is proactively guiding transition) of the transition readiness assessment tool **is ranked as '0'**.

Romania is party to all three international drug control conventions¹¹⁴. National legislation on illicit drug use, possession and trafficking is contained in Law No. 143 of 26 July 2000 on combating illicit drug trafficking and consumption as amended and supplemented by Law No. 522 of 24 November 2004 on preventing and combating trafficking and the abuse of illicit drugs¹¹⁵. The consumption of illicit drugs is not penalised by law, but its possession



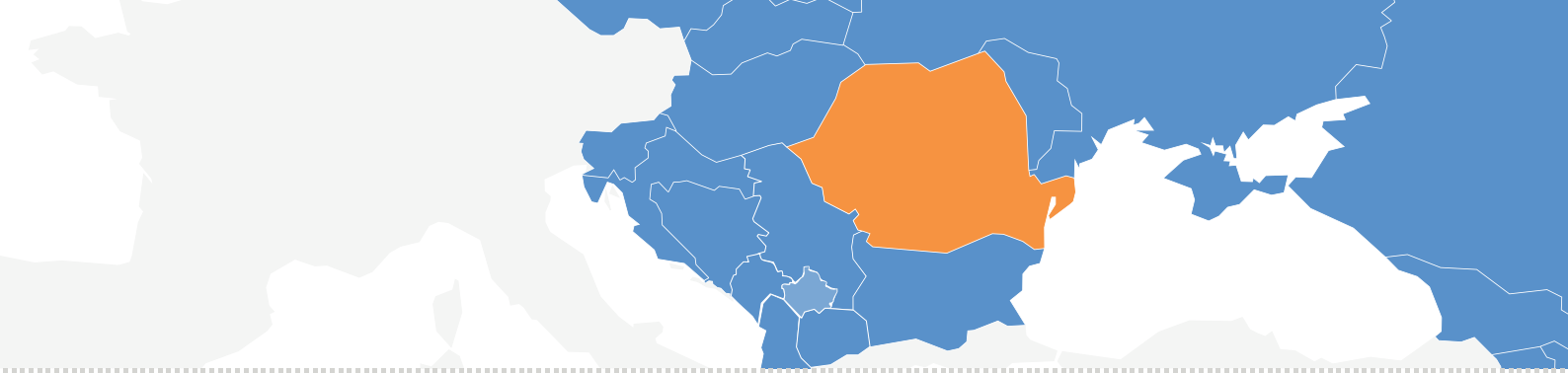
is illegal as are all other aspects such as its sale, trafficking, delivery and production, etc., with penalties ranging from the payment of a fine or imprisonment from three months to three years depending on whether the type of drug used is 'risk' or 'high risk'¹¹⁶. The Criminal Procedure Code - Law No. 135 of 1 July 2010 - that came into force on 7 February 2014¹¹⁷ is viewed by some as being an improvement on the previous penalties for the possession and/or use of illicit drugs in Romania as 'community service can replace or accompany either the fine or the jail sentence' of between 3 months and 2 years, with some local police taking a more lenient view of illicit drug use than previously¹¹⁸. Cases of abuse and harassment by some police officers against PWUD/PWID and sex workers continue to be reported and documented. Abuses against PLHIV are also being reported to NGOs but victims are reluctant to take action against doctors. For legislation on HIV/AIDS, Law No. 584 of 29 October 2002 provides measures to prevent the spread of AIDS in Romania and to protect people infected with HIV or AIDS¹¹⁹. In addition, Article 354 of the Criminal Procedure Code (Law No. 135 of 1 July 2010 that came into force on 7 February 2014) is concerned with penalties for the transmission of AIDS¹²⁰.

The national coordination of the policing of illicit drugs is the responsibility of the National Anti-Drug Agency established in 2003 under the jurisdiction of the Ministry of Interior¹²¹. The National Anti-Drug Strategy for 2005-2012¹²² was developed, together with an Action Plan¹²³, that included harm reduction with the objective of, 'ensuring the drug users' access to harm reduction services, by promoting and developing adequate programmes and policies necessary in the medical care system, outside it and in the penitentiary system¹²⁴. The government has made a commitment to step-up and expand harm reduction responses through implementation of its new National Anti-Drug Strategy, 2013-2020¹²⁵ and its related action plans for 2013-2016 and 2017-2020¹²⁶, but this rhetoric has yet to be realised in reality due to the lack of domestic funding from the Government to the harm reduction components of the strategy.

Whilst NSP and OST services are being implemented - albeit at a much reduced level now as compared to the late 2000's, there is a lack of clear commitment from the Government to sustain such services at the necessary scale using domestic resources. Consequently, **Indicator 2** ('There are no legal or policy barriers to the implementation of harm reduction programs') of the transition readiness assessment tool **is ranked at Stage 3** ('Implementation of core harm reduction services of needle/syringe exchange and opioid substitution therapy is fully allowed, in both policy and practice').

Current legislation in Romania allows for the contracting and granting of NGOs by some Government agencies for the delivery of services. For example, the Ministry of Public Health cannot currently give grants to NGOs whereas the Ministry of Labor can. The local authorities in Bucharest have also given grants to NGO service providers, although some individuals interviewed for this case study have suggested that the selection of such implementing agencies was not made through an open and transparent public tendering process. Furthermore, as there is no stand-alone and costed HIV/AIDS strategic or action plan, there is no national level guidance to local authorities as to what services need to be prioritised in the HIV/AIDS and related harm reduction sectors. As a result, **Indicator 3** ('Policy or legislation is in place to state and/or municipal governments to contract or grant NGOs for the delivery of harm reduction and other HIV prevention services') of the transition readiness assessment tool **is ranked at Stage 1** ('There is policy or legislation that supports a mechanism for the government to fund NGOs (grant or contract) for some activities, but it does not currently include provision of harm reduction services').

Overall, Romania scores 4 out of 9 in the transition readiness assessment tool for Policy.

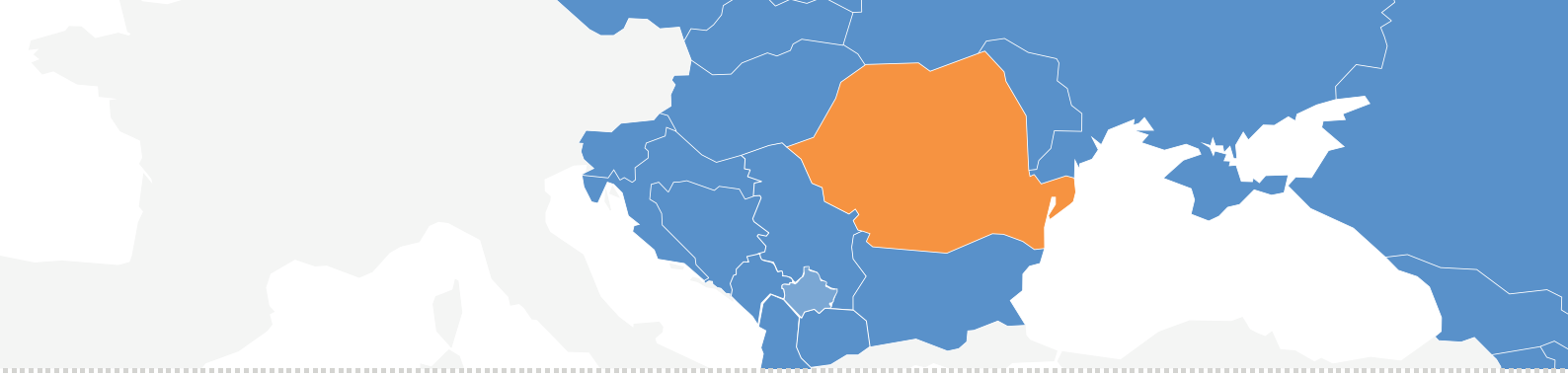


Governance

The Country Coordination Mechanism (CCM) in Romania is chaired by the Ministry of Public Health with the vice-chair from the National Union of the Organizations of People Affected by HIV/AIDS and comprises representatives of governmental, NGOs/CBOs, the pharmaceutical industry, the academic/educational sector, multilateral and bilateral development partner agencies, as well as the current Principal Recipient (PR) of the Global Fund grants - the Romanian Angel Appeal Foundation (RAAF) that has been the PR since 2006; in addition, it is understood that there is one NGO member of the CCM, called INTEGRATION, that is comprised of former and current drug users. The CCM Secretariat is run by the Romanian Harm Reduction Network (RHRN) which was also a member of the CCM under the NGO/CBO category until 2014¹²⁷. Concern has also been expressed by some civil society members that many of the NGOs that are members of the CCM are also Global Fund grant sub-recipients (SRs) which conflicts with the stipulated policy and by-laws of the CCM. Even though a significant number of NGOs are members of the CCM, in an interview with a key informant for this case study it was noted that, 'the problem is the lack of leadership from the governmental side, which results in the unpleasant feeling that NGOs are talking to walls'¹²⁸. Feedback from those involved in the development of the Global Fund TB Concept Note have noted that the MoPH took the lead in its development but, following the signing of the implementation grant, lost interest soon after and moved to other priorities. Concerns have also been expressed by members of civil society organizations as to the overall weakness of the MoPH, the high turnover in Ministers over the past decade or more, and the poor management of apparent endemic corruption as reported by many media outlets in the country and internationally.

The CCM is functioning and has played an important role since before the Global Fund Round 2 HIV/AIDS and TB applications. Although a key informer has said that the MoPH intends to give the CCM a legal status, there is no government-endorsed plan as to how the CCM will become institutionalized and no vision appears to exist as to the continuation by a future CCM-type mechanism to undertake program planning and oversight after the final exit of the Global Fund from Romania. A respondent interviewed for this case study noted that, 'the current CCM is losing power; as everybody knows, this is the last grant from the Global Fund: there is no motivation to continue, at least from the governmental side'¹²⁹. The status of the CCM is further questioned by some owing to the fact that, 'the current Ministry of Public Health is not too active - elections are coming. In general, the MoPH is unstable, fragile and attacked from many directions, including being taken as a target by campaigning politicians'¹³⁰. In order to strengthen the authority of a future CCM-type mechanism and a future transition process to domestic funding of the HIV program, one respondent suggested that both 'should be initiated under the Prime Minister; the ministries have difficulties in cooperating among each other'¹³¹. However, a CCM funding agreement for the period 2016-2018 should provide impetus as one of its main objectives is the development of a vision for the role of the CCM going forward with regards to the country's HIV and TB strategies¹³².

Between 1994 and 1996, a multisectoral AIDS commission existed under the authority of the Ministry of Public Health but ceased to exist following the elections of 1996. A group comprising government officials, NGOs, and UN agencies proposed the establishment of a National AIDS Commission in 1997 under the authority of the Prime Minister but political instability during the second half of 1997 and the beginning of 1998 delayed the process. At the same time, UNAIDS facilitated the work of an informal AIDS commission that was called the 'Analysis and Evaluation Commission' (AEC) that included representatives from ministries, NGOs, and international organizations¹³³. Within the National Health Strategy, 2014-2020, there is the stated intention of, 'reinstating the national AIDS multi-sectoral commission'¹³⁴ and although there are references to the existence of such a Commission - such as in the Global AIDS Response Progress Report (GARPR) for Romania for 2013 - there appears to be little in the way of a substantive organisation or stakeholder representation in it. Consequently, **Indicator 4** (A multi-stakeholder national governance



body, including at least government, civil society, and technical partners, is institutionalized to steer the transition process, and to continue program planning and oversight after the end of donor funding') of the transition readiness assessment tool **is ranked as '0'**.

Furthermore, the existing National AIDS Commission undertakes no apparent oversight function to monitor the implementation of the National HIV Program and seems to act as simply a figurehead and no other body undertakes any similar role. Therefore, with regards to **Indicator 5** ('The mutli-stakeholder national governance body has an oversight function to monitor implementation of the National HIV Program, and harm reduction/PWID outcomes are measured as a distinct program area') of the transition readiness assessment tool **is ranked as '0'**.

As a result of the absence of an operationally effective government-endorsed governance body, and the limited role played by the CCM that is confined to oversight of only Global Fund grants, **Indicator 6** ('The new governance body has an oversight function to monitor expenditure against the planned budget, and harm reduction/PWID expenditure is measured as a distinct track of expenditure') of the transition readiness assessment tool **is ranked as '0'**.

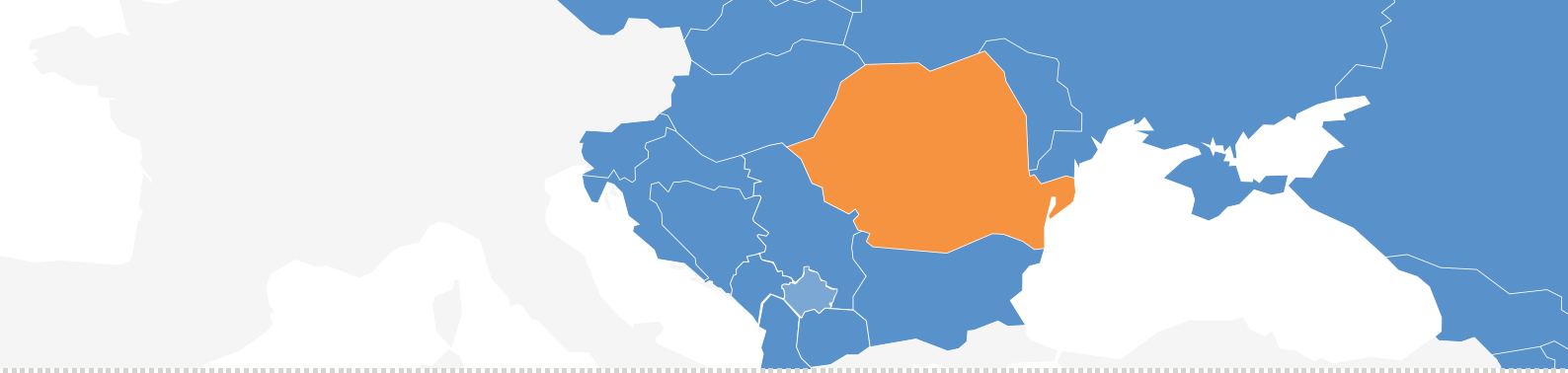
Overall, Romania scores 0 out of 9 in the transition readiness assessment tool for Governance.

Finance

Between 2006 and 2010, the Global Fund supported the harm reduction program in Romania, primarily NSP distribution through NGO service delivery. UNODC also provided financial support in 2007, particularly to NSP¹³⁵, and to the first NGO-run methadone maintenance therapy (MMT) centre, opened by ARAS. In 2011, only 7% of harm reduction spending for PWID came from domestic sources in Romania, the remainder from external donors and with harm reduction comprising 23.1% of the total spending in Romania on HIV/AIDS (domestic and external donors combined)¹³⁶; more recent data is not available at the time of writing. Under Chapter XI (Budget Implications) of the National Anti-Drug Strategy, 2013-2020, NADA estimates the cost of the Strategy between 2013 and 2016 to be a minimum of 166.031m lei (in the region of USD43.6m). A new Action Plan for 2017-2020 is expected by the end of 2016¹³⁷.

In 2013, 2014 and 2016, the General Council of Bucharest approved financial support for harm reduction and reintegration services and channeled that support through NGOs. Through the Norwegian Financial Mechanism, 2009-2014, on the 'Strengthening the prevention and control of HIV/AIDS, HVB, HVC in Romania', Eur 1,373,470 was provided between 1 May 2014 and 30 April 2015 that sought 'to prevent further spread of the HIV outbreak among IDUs' through the provision of integrated harm reduction services, including needle/syringe exchange, HIV, HVB and HVC testing for 2,000 PWID, and that worked directly with harm reduction professionals and groups of PWUD/PWID 'to monitor, prevent and inform on the HIV infection'¹³⁸.

Grants from Iceland, Liechtenstein, Norway and the EU, known as EEA and Norway Grants, have provided some financial support to the drug use and HIV/AIDS sector, albeit focused primarily on IEC rather than any other component of the WHO, UNODC and UNAIDS recommended nine interventions for the prevention of HIV/AIDS among PWID. Specifically, out of a total of €40,566,861 in grants to Romania between 2007 and 2009, the EEA provided €2,041,827 for a HIV/AIDS prevention campaign and €269,875 for a national drug use prevention campaign¹³⁹. A new grant totalling €502.5m (EEA Grants: €275.2m., Norway Grants: €227.3m.) for Romania between 2014 and 2021 will include a focus on 'improving the situation of vulnerable groups' and 'strengthening civil society to promote social justice, democracy and sustainable development', although no details as to what support may go to the harm reduction



sector is yet available¹⁴⁰. In addition, for several years the French NGO, SIDACTION, has continuously supported the harm reduction activities of ARAS.

It is also possible that the HIV/AIDS program, including the development and expansion of harm reduction services, could benefit from the new 'Partnership Agreement' (PA) between the European Commission (EC) and the Romanian Government that totals €43 billion over the period 2014-2020 although NGOs have found accessing and reporting on such EU funding to be complex. The PA is designed to help Romania to respond to the priorities of the 'Europe 2020 Strategy' as well as country-specific needs and includes policy reforms in 'social inclusion' and 'public administration', amongst others¹⁴¹.

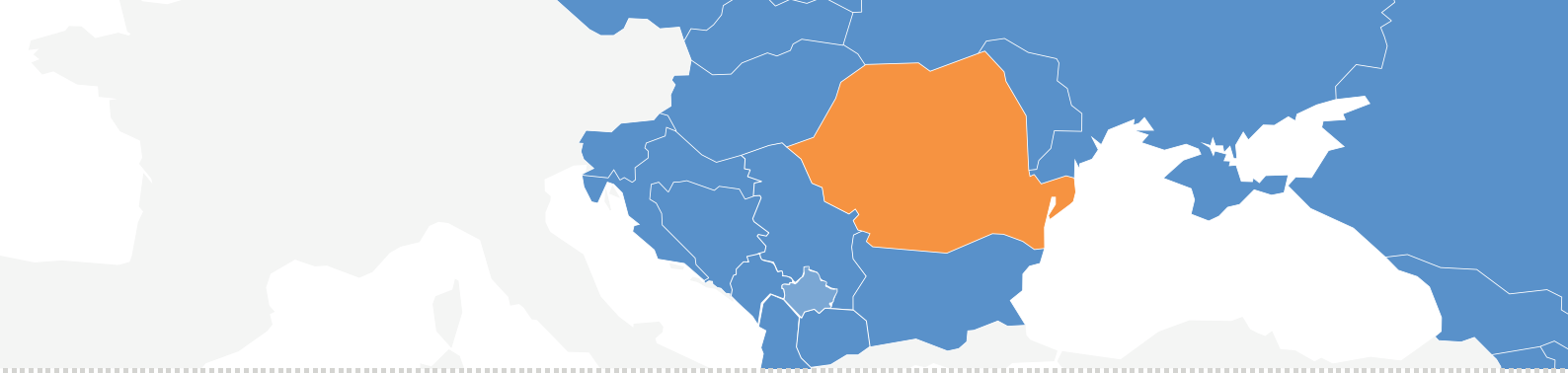
There has been no needs projection nor a costing process undertaken to inform a sustainability plan for HIV/AIDS, including harm reduction, in Romania. The only available financial data has been produced by NGOs. In addition, there is no financial gap analysis within the context of the current financial landscape. Funding available to different ministries, such as the Ministry of Public Health and the Ministry of Interior, for example, is not coordinated and public funds are only allocated to public institutions and not to NGOs. Furthermore, as one key informant commented, 'the MoH lacks the will in developing funding procedures to support NGOs providing public health services even when other Ministries and local authorities have starting doing so', with another noting that, 'State funding to NGOs is indirect, reactive, unintended and insufficient...with lack of political will to determine a shift toward contracting NGO services from the current system, based on outdated structures, heavy and expensive state services'¹⁴².

Fundamentally, there is a lack of political will by the Government, and the Ministry of Public Health in particular, to shift from the current system that is based on outdated structures together with heavy and expensive state services, towards the contracting of NGOs to deliver services in the public sector, including harm reduction. Consequently, **Indicator 7** ('Funds for harm reduction are allocated according to an optimized budget scenario') of the transition readiness assessment tool **has been ranked as '0'**.

For core harm reduction services, the Government does provide a very small budget for the purchase of specific medications for OST but such provision is far too small to adequately address the need. NSP supplies are not funded by any Government entity but rather by the GF through the current TB grant as well as from an EEA grant, Norwegian Funds and SIDACTION. In addition, the Government does not include funding for personnel costs of the NGOs delivering OST services, be they at a fixed site or through outreach into the community. Complicating issues further is that OST services under the MoPH are financed by the National Program on Mental Health whereas OST provided by the National Anti-Drug Agency is covered by the budget of the Ministry of Interior. Consequently, there is a need for the coordination of funding in order to ensure the resources needed are available to provide good quality and inclusive service provision at both public institutions and through NGOs. As a result, **Indicator 8** ('Core harm reduction services are funded by the government and delivered by NGOs via grants or contracting mechanisms') of the transition readiness assessment tool **has been ranked at Stage I** ('Either needles and syringes for harm reduction OR opioid substitution therapy medications (not both) are included in the domestic budget').

Between 2008 and 2014, the procurement of medication for the HIV/AIDS sector, including harm reduction services, was decentralized; this decision was taken against warnings from NGOs and technical experts concerning the lack of efficiency of a decentralized procurement system. As a result, frequent stock-outs took place as documented by NGOs. For the current Global Fund TB grant, procurement - such as for needles, condoms, HIV, HVB and HVC rapid tests, as well as HAV and HBV vaccines for PWID - is being undertaken by the PR rather than by the Ministry of Public Health. Consequently, **Indicator 9** ('Donor procurement systems are integrated into national systems and assuring reasonable price controls') of the transition readiness assessment tool **has been ranked as '0'**.

Overall, Romania scores 2 out of 9 in the transition readiness assessment tool for Finance.



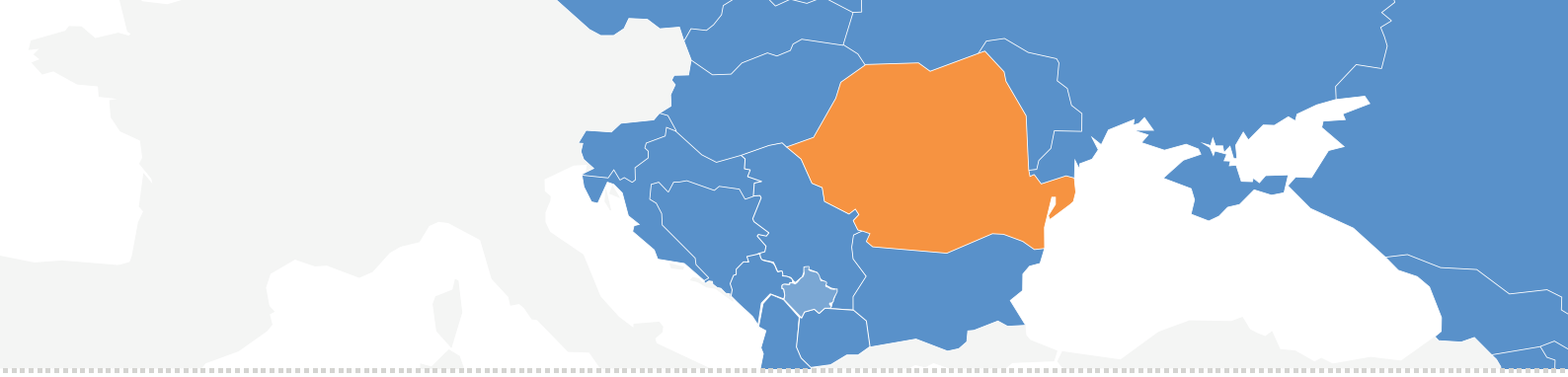
Program

Currently, there is no stand-alone national HIV/AIDS strategy in Romania. The 'National Public Health Strategy, 2014-2020' of the Ministry of Public Health covers the main strategic objectives from the previous 'National Strategy for surveillance, control and prevention of HIV/AIDS cases: 2004-2007'¹⁴³. The 2004-2007 HIV/AIDS strategy was developed in 2003 by the 'National Multisectoral Commission for the surveillance, control and prevention of HIV/AIDS cases' (CNMS), an inter-ministerial body under the authority of the Prime Minister and attached to the General Secretariat of the Government but with no legal authority¹⁴⁴. Of particular note in the 2004-2007 strategy is Priority 1.3, 'Prevention of HIV transmission among IDUs', in which the stated goal is the 'prevention of an HIV outbreak among IDUs and reduction of the infection rates of viral hepatitis and sexual transmitted infections'. The main elements in achieving this goal are listed as (a) demand reduction; and, (b) reduction of the risks associated with drug use through the 'development of harm reduction programs and services in order to reach at least 60% of the IDUs'¹⁴⁵.

The current 'National Anti-Drug Strategy' for Romania covers the period 2013-2020¹⁴⁶ and includes harm reduction objectives targeting PWID; the document was approved by the Government but contains no budget. Harm reduction mainly appears under Chapter VII (Drug Demand Reduction), Section B.1 (Identifying, attracting and motivating drug users for inclusion in specialized assistance services - Objectives), in which there are five objectives related to (1) diversification of approaches to include OST, NSP, and harm reduction; (2) encouraging KAP to seek assistance from specialized services; (3) improving PWID access to VCT, vaccination and treatment of all communicable diseases including HIV, HBV, HCV and TB in the community and in custodian settings (prisons); (4) improved coordination between all public services to assist PWID to access specialized services; and, (5) prevention of drug-related death¹⁴⁷. However, no targets were set in the first Action Plan for 2013-2016 although the NADA is undertaking annual monitoring of the progress of all indicators in the Action Plan. Under Chapter XI of the Strategy (Budget Implications), NADA estimates the cost of the Strategy between 2013 and 2016 to be a minimum of 166.031m lei (in the region of USD43.6m). A new Action Plan for 2017-2020 is expected by the end of 2016¹⁴⁸.

As noted previously, the harm reduction program in Romania was severely depleted in 2010 as a result of the closure of the Global Fund HIV grant without any transition plan in place for the use of domestic and/or alternative external donor support. In addition to the massive reduction in funding to the HIV/AIDS sector as a whole from 2010, the prevention of HIV has clearly not been a priority for the Ministry of Public Health in Romania. This reflects a more general trend in the public health sector - as noted by respondents interviewed for this case study - in which national programs in Romania are focused on diagnosis and treatment. As a result, NGOs have had to step in to fulfil this void in the harm reduction program, although NGO personnel have noted that government health staff at the facility level understand the value of working with civil society organisations. Therefore, to make health service delivery potentially more cost-effective, and also accessible by PWID and their partners, NGOs should be integrated into government programs rather than just being used from time-to-time on an ad-hoc basis. For example, the National Anti-Drug Agency procured cheap sterile needles/syringes for distribution by a NGO to PWID but failed to consult with the local NGOs regarding the technical specifications of the syringes and gauge of needle preferred by most PWID; as a result, NADA purchased sterile needles/syringes that are not commonly used by PWID in Romania and thereby waste the limited financial resources available as a result of a lack of communication with those people - working with NGOs - who possess such knowledge.

The monitoring of harm reduction services is the responsibility of the National Anti-Drug Agency (NADA) which collects data from all harm reduction service providers, including NGOs. The NADA has produced national standards



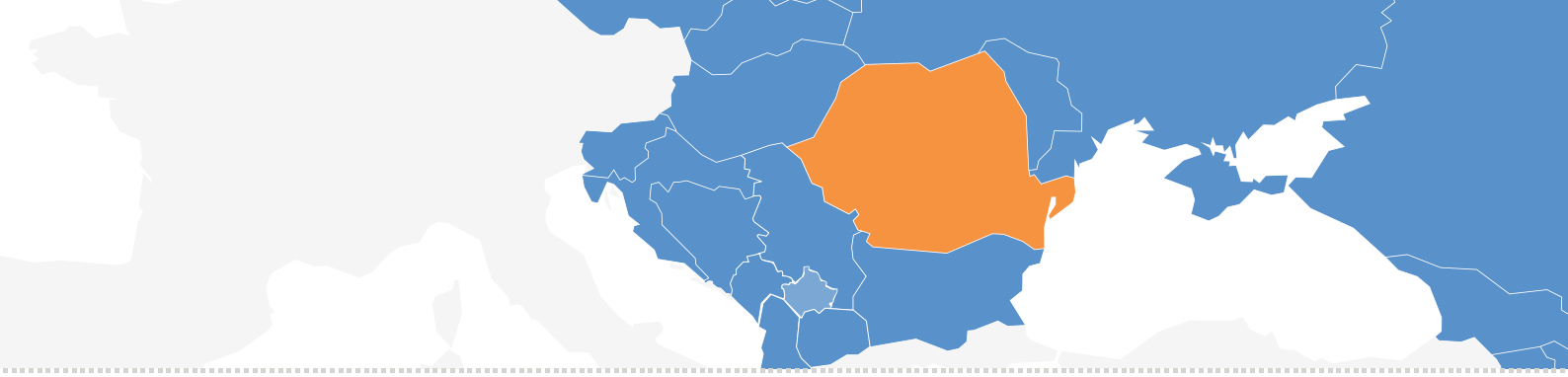
for medical, psychological and social assistance for PWUD/PWID that were produced in collaboration with NGOs and other public institutions. All registered drug services have to be accredited by the NADA and this includes NGO services. However, the NADA and the Ministry of Public Health have different accreditation procedures and service providers have to comply with both regardless as to whether or not they have access to public funding.

Feedback to this case study from civil society members suggests strongly that the standards that do exist for harm reduction services are not implemented. Furthermore, monitoring is undertaken based only on quantitative indicators with little, or no, regard for the gathering of qualitative information that can put into context the quantitative data available. For example, the current monitoring indicators consider the number of sites providing OST or NSP and the number of clients reached; this tells us nothing of the quality of those services or the reasons why some sites may not be as accessible to some PWID than other sites. Equally, the number of sterile needles/syringes distributed tells us nothing as to whether the gauge of syringe and/or needle were what the recipient actually uses for injecting drugs, nor does it provide information as to what counselling took place during meetings with PWID. In addition, whilst there is no national monitoring and evaluation strategy in Romania, NGOs are included as critical partners in the National Anti-Drug Strategy and their contribution to the national response on HIV is acknowledged by the Ministry of Public Health, the NA as well as others, such as the National Administration of Penitentiaries.

Therefore, although **Indicator 10** ('Provision of core harm reduction services is monitored according to defined standards') of the transition readiness assessment tool **has been ranked as 'Stage III'** ('Harm reduction service provision is regularly monitored according to schedule, with involvement from civil society') it fails to take into account the quality of such services delivered nor feedback from the recipients of such services and how they can be improved.

To reach harm reduction service coverage levels indicated by the WHO, UNODC and UNAIDS, adequate funding of such services - especially NSP and OST - is required; this has not been the case since the close-out of the last Global Fund HIV/AIDS grant in 2010, although improvements have occurred since a low point in 2011. Less than 25% of PWID in the capital, Bucharest, had access in 2007 to a minimum package of HIV prevention services¹⁴⁹ rising to 41.3% in 2009 while Global Fund HIV funds were still available¹⁵⁰. Following the exit of Global Fund support in June 2010, coverage of services fell dramatically to 25.1% by the end of 2011¹⁵¹. Through access to EU funds by NGOs in particular, coverage then increased to 37.9%, or 4,012 individuals, by the end of 2012, still far below the estimated coverage rate of 2008 at 7,284 individuals¹⁵². By the end of 2014, coverage had increased once again, up to 59.2% through services delivered by two NGOs and to 69.2% in 2015¹⁵³. OST coverage was less than 5% in Bucharest in 2007¹⁵⁴ rising to approximately 9% in 2011¹⁵⁵ but then falling to around 3.5% by 2013¹⁵⁶. As a result, **Indicator 11** ('Core harm reduction services are available at levels of coverage recommended by the World Health Organization') of the transition readiness assessment tool **has been ranked as 'Stage II'** due to the NSP coverage although this is not the case for OST ('Coverage of either needle/syringe programs or opioid substitution therapy has reached the set target').

At present, there is only one NGO that receives a grant from a local authority for the delivery of harm reduction interventions in the capital, Bucharest. Based on feedback to this case study, one respondent has noted that a possible reason why more NGOs are not funded in a similar manner may be as a result of a provision in the current law on social assistance in which local authorities have to produce a situation analysis as the basis for an action plan; very few local authorities have developed such plans for harm reduction interventions without which there is no basis for the legal contracting of services to NGOs. However, the 'National Public Health Strategy' of the Ministry of Public Health as well as the 'National Anti-Drug Strategy' of the National Anti-Drug Agency, together with the Global



Fund's CCM all recognise the vital role played by NGOs in facilitating access by PWID to harm reduction services and in the delivery of those services themselves; they are also recognised as crucial mechanisms for the referral of PWID and their partners to a range of diagnosis and treatment options for both communicable and non-communicable diseases.

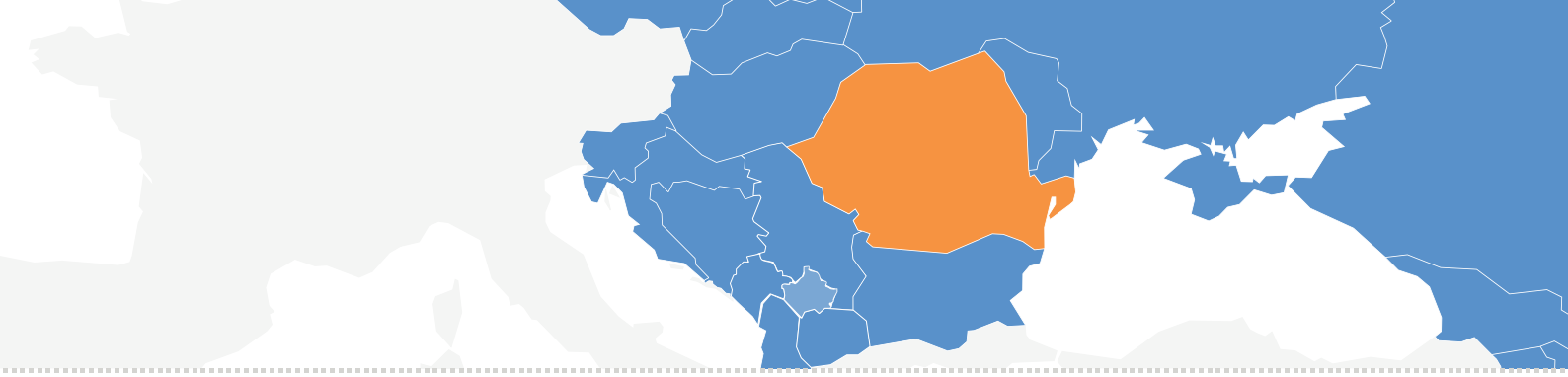
Consequently, **Indicator 12** ('NGOs are critical partners in delivery of harm reduction and other HIV prevention services financed by domestic resources') of the transition readiness assessment tool **is ranked at Stage I** ('A limited number of NGOs receive grants or contracts for providing harm reduction services'). Overall, Romania scores 6 out of 9 in the transition readiness assessment tool for Program.

Identified Challenges And Barriers

The key barrier to a sustainable harm reduction program and HIV/AIDS sector in Romania is the lack of political will to fund the program by the Government.

Other challenges and barriers identified include the following:

- The lack of a standalone national HIV/AIDS strategy and annual action plans means that there is no national level guidance to local authorities as to the services that need to be prioritized in the HIV/AIDS and related harm reduction sectors;
- The CCM is not institutionalised and therefore has no impact on HIV/AIDS programming as there is no Global Fund HIV/AIDS grant; for harm reduction under the current Global Fund TB grant, CCM responsibilities only go as far as Global Fund supported activities and not more broadly;
- The role of NGOs in the formal monitoring of the HIV/AIDS program is limited to the provision of data reports concerning the implementation of harm reduction services rather than a formalised and broader scope that includes, for example, financial, programmatic and strategic monitoring;
- Lack of cost estimates for harm reduction services; no financial gap analysis for the HIV/AIDS sector and the current financial landscape; and no sustainability plan for harm reduction or the HIV/AIDS sector more broadly;
- Funding of OST and related HIV/AIDS services is complex and uncoordinated between the Ministries/institutions involved;
- No part of the Government funds NSP;
- The Ministry of Public Health lacks the will to develop funding procedures to contract services to NGOs even when other Ministries and local authorities have started to do so; when it does occur, state funding to NGOs is indirect, reactive and insufficient;
- An apparent lack of understanding within the Government in general, and the Ministry of Public Health and the National Anti-Drug Agency specifically, of the need to rapidly scale-up NSP and OST interventions to stop the further transmission of HIV and HCV; and,
- Multiple cases of abuse and harassment committed by police officers against PWID have been documented by NGOs as have abuses by doctors against PLHIV but victims are reluctant to take action against perpetrators.



Lessons Learnt

Fundamentally, the failure of the Government to continue to support the HIV/AIDS program following the closeout of the last Global Fund HIV grant in 2010, and its ongoing failure to provide sufficient funding to the sector, is testament to the lack of political will. Other lessons learnt include the following:

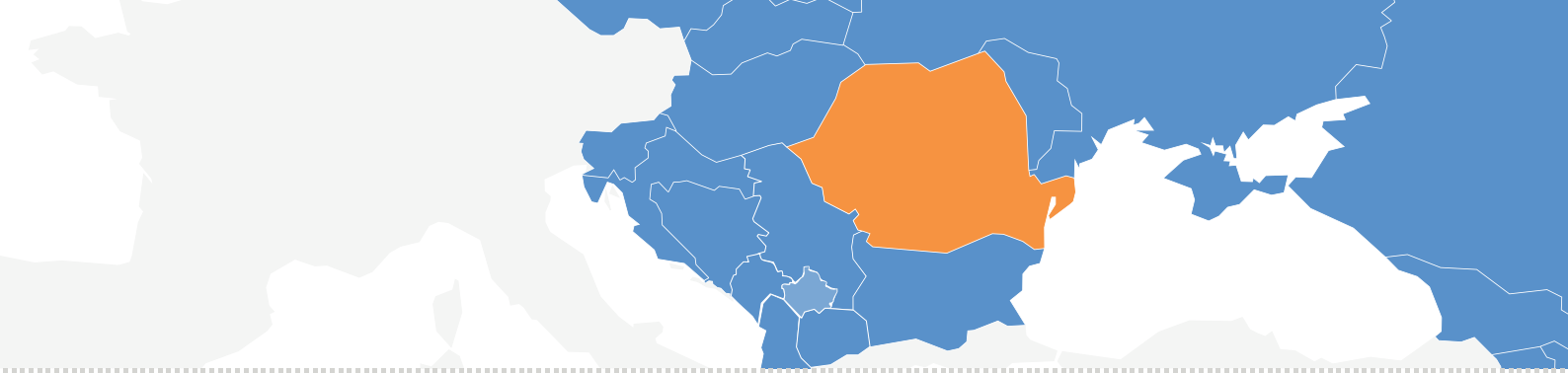
- There appears to be no policy barriers to the provision of harm reduction services in Romania but there is a major lack of political will on behalf of the Romanian Government to making adequate domestic funding available to support the implementation of the comprehensive package of harm reduction interventions as recommended by WHO, UNODC and UNAIDS, particularly NSP and OST services at a scale that will stop the further transmission of HIV/AIDS among PWID and their partners and to then reduce HIV prevalence and incidence over time;
- There is a direct correlation between the dramatic fall in funding of harm reduction services, especially NSP, and a substantial increase in HIV/hepatitis transmission among PWID;
- The funding transition plan integrated into the existing Global Fund TB grant demonstrates that the Romanian Government is capable of undertaking transition planning when it has the will to do so and the technical support from partners;
- The costed national TB control strategy was instrumental in the development of the transition plan within the Global Fund TB grant and, consequently, it would appear that a sustainability plan for the HIV/AIDS sector would be more likely to occur if there was a stand-alone HIV/AIDS strategy for Romania;
- The inclusion of a viable funding transition plan in the TB grant was due, at least in part, to the imposition of conditionality by the Global Fund including the 'willingness to pay' commitment to which the Government had no choice but to adhere;
- The only exercise similar to a needs projection and a costing process was undertaken as part of the financial gap analysis performed in the country dialogue following the explicit request of the Global Fund Secretariat;
- Some NGOs consider international funding or private funding as preferable to public funding in order to avoid any risk of control from the governmental side; and,
- In the absence of a government-endorsed governance body, the oversight and monitoring functions of the current CCM do not have any legally binding power and they are operating only within Global Fund projects.



Recommendations For Key Stakeholders

A. Government

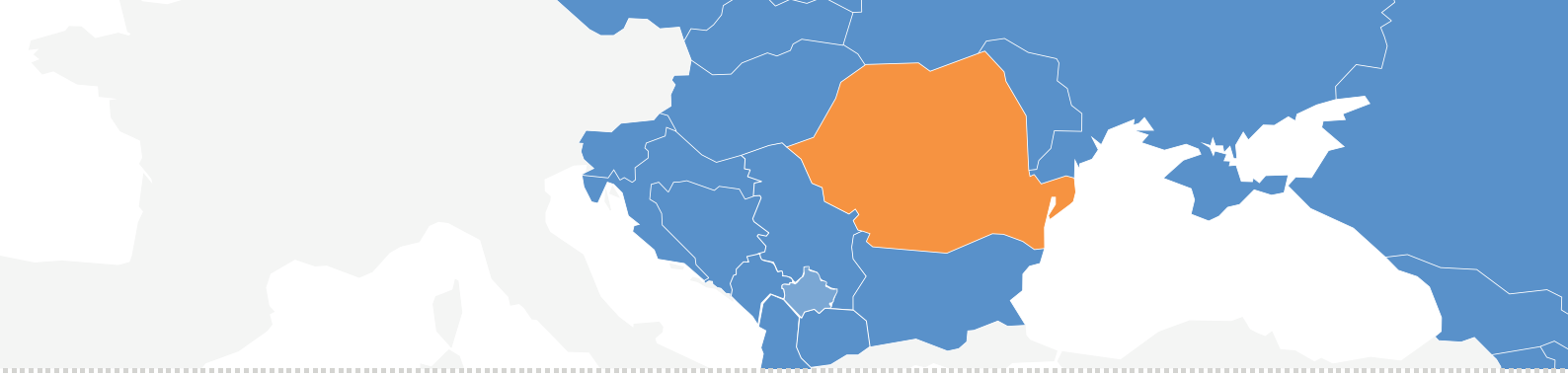
1. Using the lessons learnt from the development of the national TB control strategy and the current Global Fund TB grant, develop and integrate a sustainability plan for the HIV/AIDS program, including harm reduction interventions, that includes relevant components of the National Anti-Drug Strategy (under the Ministry of Interior) and the National Public Health Strategy (of the Ministry of Public Health); this could be in the form of a new, stand-alone National HIV/AIDS Strategy or as a revision to the existing National Public Health Strategy;
2. Integrate relevant aspects of harm reduction interventions into the National Strategy for TB Control and thereby ensure that such harm reduction interventions will be part of the transition plan from Global Fund support to the TB sector to domestic and other funding;
3. Use the opportunity of developing a more comprehensive national HIV/AIDS strategy, or revisions to improve the HIV/AIDS sections of the National Public Health Strategy, to create annual action plans that can serve as guidance to local authorities as to the actions required of them in the harm reduction program;
4. Decriminalize the possession of illicit drugs for personal consumption as this will facilitate improved access to health and related services for PWID and thereby help to increase coverage of key services in a more cost-effective manner;
5. Ensure that naloxone is made easily available without prescription to, and accessible by, opioid-dependent people, including caregivers who have rapid access to such users;
6. Provide funding from domestic sources for sterile needle/syringe programmes (NSP);
7. Undertake an official cost estimate for harm reduction services in collaboration with relevant NGOs/CBOs working in the sector;
8. Undertake a financial gap analysis for the HIV/AIDS sector including a comprehensive package of harm reduction interventions for PWID as recommended by WHO, UNODC and UNAIDS;
9. Support the National AIDS Commission to develop its technical skills and give it the authority and decision-making power to undertake effective coordination and to provide program guidance in the HIV/AIDS sector, including for the harm reduction program;
10. Coordinate funding between Ministries for harm reduction services, including the streamlining of OST funding from different government agencies;
11. Take an holistic approach to the national HIV/AIDS program and ensure that NGOs are an integral component of the service delivery modalities, especially interventions for KAPs and grant NGOs a 'public utility' status in order for them to be legally funded by the Government to deliver harm reduction services;
12. For the Ministry of Public Health to use the lessons learnt and good practices of other Ministries and local authorities to develop funding procedures to contract services to NGOs;



13. Use open and transparent public tendering processes in the selection of health service providers, including those to implement harm reduction interventions;
14. Simplify and streamline service protocols for both Governmental and Non-Governmental service providers, including those delivering HIV/AIDS and related harm reduction interventions;
15. Ensure that strategies and annual implementation plans related to harm reduction interventions include the rapid scale-up sterile needle/syringe program (NSP) and opioid substitution therapy (OST) interventions so that coverage of both components are at high enough levels - as recommended by WHO, UNODC and UNAIDS - to stop the further transmission of HIV and viral hepatitis C (HCV) and to thereby reduce the prevalence and incidence of HIV and HCV among PWID in the future;
16. For local authorities to produce local action plans and organise funding programs for social and health service providers of harm reduction interventions;
17. Collaborate with NGOs working in sector to build skills and synergies in the coordinated formal monitoring of the HIV/AIDS program;
18. Use data provided by NGOs working in the sector as part of official statistics even when such data is from individuals who wish to remain anonymous;
19. The CCM should be officialised in all aspects of its structure, functioning, work plan, and regulations to become the main multi-sectoral program direction and decision making body for HIV/AIDS and TB, respectively; and,
20. Establish a process whereby individuals can seek redress without retribution for instances of abuse, stigmatisation or discrimination as a result of their attempts to access health and related services;

B. *Global Fund*

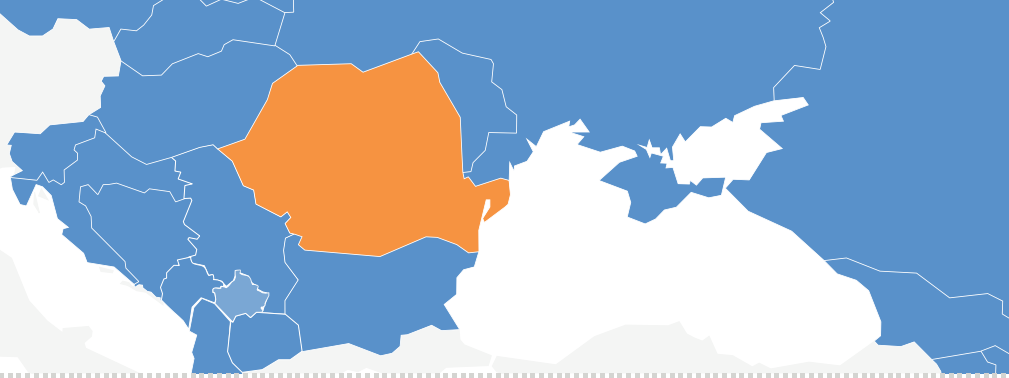
21. A clear definition of 'political barriers' is required within the context of the 'NGO rule';
22. Consideration must be given to the provision of funding through NGOs to UMICs where the respective Government has demonstrated a lack of political will to fund harm reduction interventions, especially NSP and OST;
23. Ensure that harm reduction interventions are part of the TB transition planning process, are properly costed and budgeted;
24. Make the formal acceptance by the Ministry of Public Health of NGOs as service providers and monitoring entities for the implementation of the national HIV/AIDS strategy and program a condition of future financial disbursements to the Government from the current Global Fund TB grant;
25. Make funding and/or technical support available to NGOs/CSOs to strengthen their capacity in identifying, documenting, signalling and following-up human rights violations against KAPs;
26. Make funding and/or technical support available to the Government and its NGO/CBO partners to establish a process by which people from KAPs can seek redress without retribution for instances of abuse, stigmatisation or discrimination as a result of their attempts to access health and related services; and,



27. Fully enforce the requirements of CCM functioning, especially those related to the meaningful participation of KAP (based on a transparent and documented election process) and NGOs (all NGOs have to prove that they have a representative mandate);

C. *Civil Society*

28. Using the lessons learnt from the development of the national TB control strategy and the current Global Fund TB grant, work with the Government to develop and integrate a sustainability plan for the HIV/AIDS program, including harm reduction interventions; this could be in the form of a new, stand-alone National HIV/AIDS Strategy or as a revision to the existing National Public Health Strategy;
29. Continue to advocate with the Government to show its political will to change the approach to funding the HIV/AIDS sector in general, and harm reduction interventions specifically, as part of the National Public Health Strategy, 2014-2020, with an emphasis on how domestic investments now in HIV prevention among KAPs will save the Government considerable money in the medium-to-long term;
30. Advocate with the National Anti-Drug Agency (NADA) and the Ministry of Public Health (MoPH) to make naloxone easily available to, and accessible by, opioid-dependent people, including caregivers who have rapid access to such users;
31. Consider the costs and benefits of being granted 'public utility' status by the Government in order to legally receive Government funding to deliver services, including harm reduction interventions;
32. Advocate with the National Anti-Drug Agency (NADA) and the Ministry of Public Health (MoPH) to make sure NGOs are integrated into government programmes, not just used from time to time;
33. Seek financial and technical mechanisms to strengthen capacity in identifying, documenting, signalling and following-up human rights violations; and,
34. Encourage PWID and other KAPs to work with registered NGOs - even though this is an indirect form of representation - and assist such groups to identify leaders capable of representing, inspiring and mobilising their respective constituencies.



Attachment 1

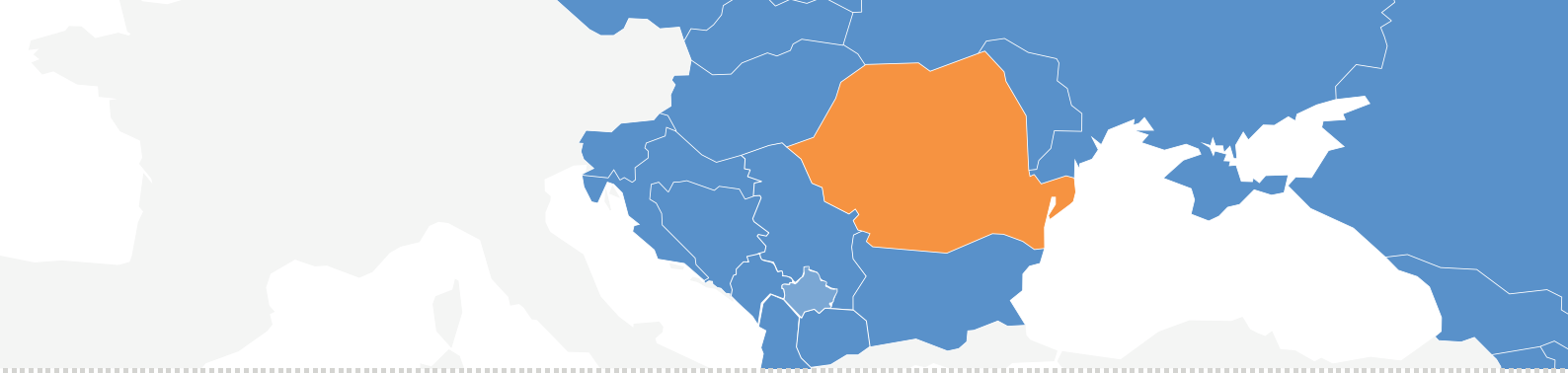
The Transition Readiness Assessment Tool

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

The TRAT is based on **four thematic areas** of transition as previously defined by the Global Fund Secretariat and the Eurasian Harm Reduction Network¹: policy, governance, finance and program. The TRAT was designed with the underlying assumption that in order for a country to be prepared for a sustainable transition, it must make progress on specific indicators in each of these thematic areas. Under each thematic area, three indicators help to measure this progress.

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

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



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

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

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

$$\left[\begin{array}{c} 4 \\ \text{Thematic} \\ \text{Areas} \end{array} \right] \times \left[\begin{array}{c} 3 \\ \text{Indicators} \end{array} \right] \times \left[\begin{array}{c} 3 \\ \text{Stages of} \\ \text{Readiness} \end{array} \right] = \left[\begin{array}{c} \text{Max. 36} \\ \text{Readiness} \\ \text{Points} \end{array} \right]$$

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

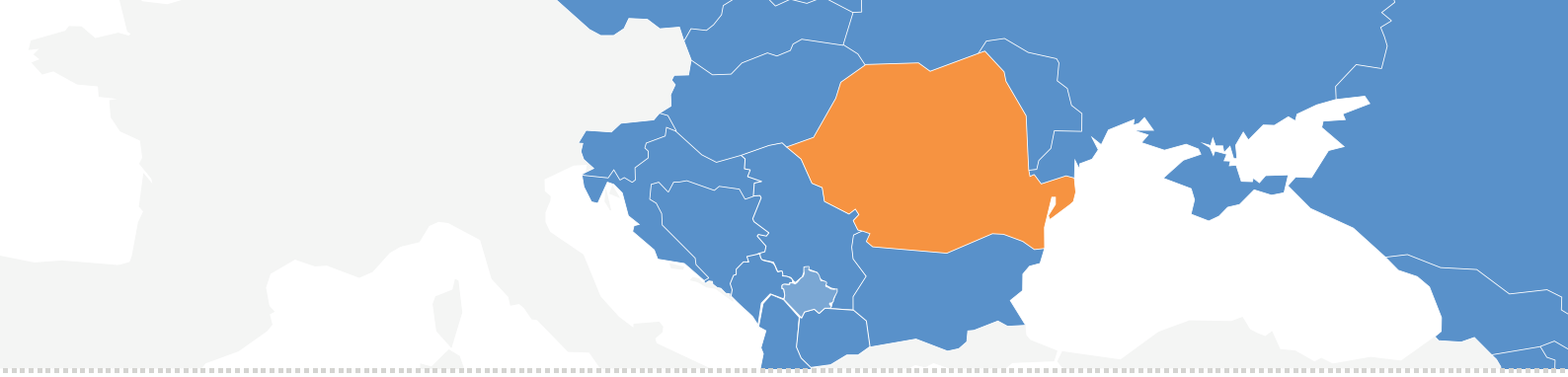
Romania's Transition Readiness Profile

Out of the maximum possible 36 readiness points, Romania achieved 11, giving it a raw readiness score of 31%. This score reflects Romania's low level of preparedness in all thematic areas. Governance and Finance are particularly concerning, with five of the six Stage I benchmarks still unmet: no domestic funding for NSP or any other harm reduction services besides a limited number of OST sites; no sustainability plan has been drafted; no institutionalised governance mechanism for the HIV/AIDS sector is envisaged; and there is no formal mechanism by which NGOs can receive government funding. Although there are no legislative, nor police, barriers to harm reduction interventions in Romania, there is a clear lack of Government commitment to fund, and to thereby sustain, such services.

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

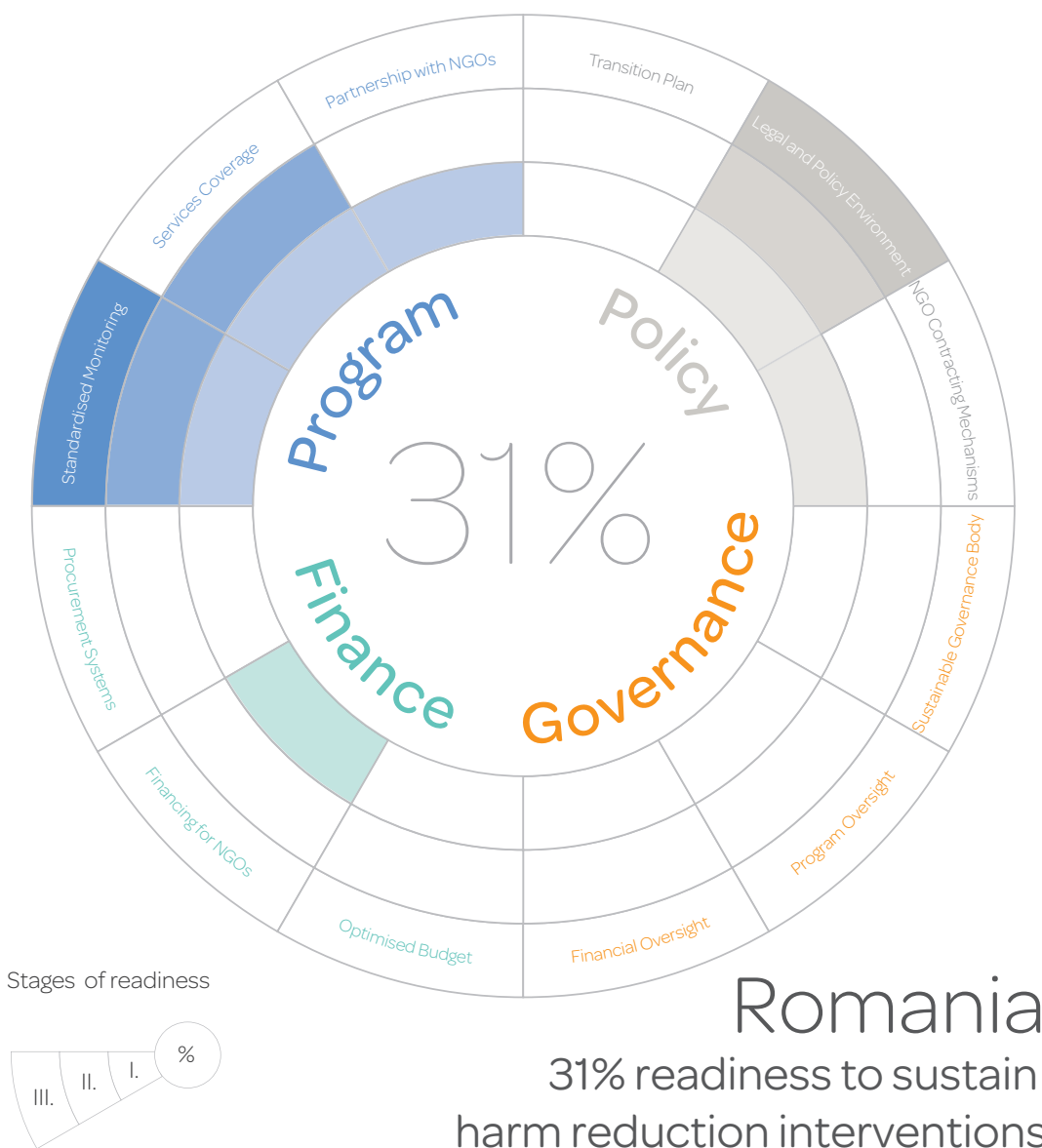
Transition Readiness Profile - Romania

ade relatively more progress in preparing for policy and programming transitions, but the situation is still far from adequate. Since the exit of the Global Fund from the HIV/AIDS sector in June 2010, there has been no stand-alone and costed national HIV/AIDS strategy, nor annual action plans, with the sector but a small part of the much



larger National Health Strategy, 2014-2020. No costing of harm reduction services has been undertaken by the Government and no financial gap analysis has been developed, no sustainability plan for the sector as a whole. Government funding of harm reduction has been confined to a limited number of OST sites in the capital, Bucharest, implemented by two different Ministries; several other OST sites are run by a NGO, including OST in two prisons. NSP services are solely operated by two NGOs through the current Global Fund TB grant to March 2018 and through other donor support. Whilst NSP coverage has been around 60% for the past two years, OST coverage is abysmal, with both services largely confined to the capital. CSOs are not able to formally receive government funding, making the scale-up of coverage inefficient, slow and costly.

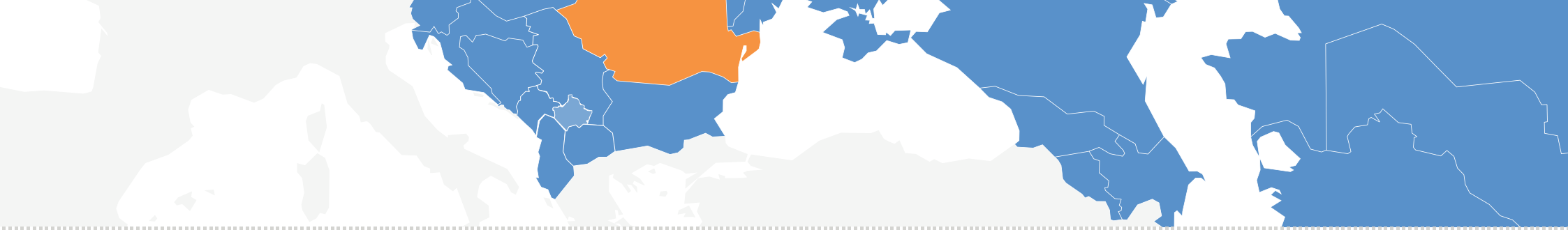
Without immediate, intensive action to improve Romania's readiness to sustain the HIV/AIDS program, including harm reduction interventions, through the use of domestic resources, the country is poised to once again experience an explosion of HIV among PWID and their partners when Global Fund TB support, and external donor assistance from the likes of the EU and Norway, ceases in the coming 2-3 years.



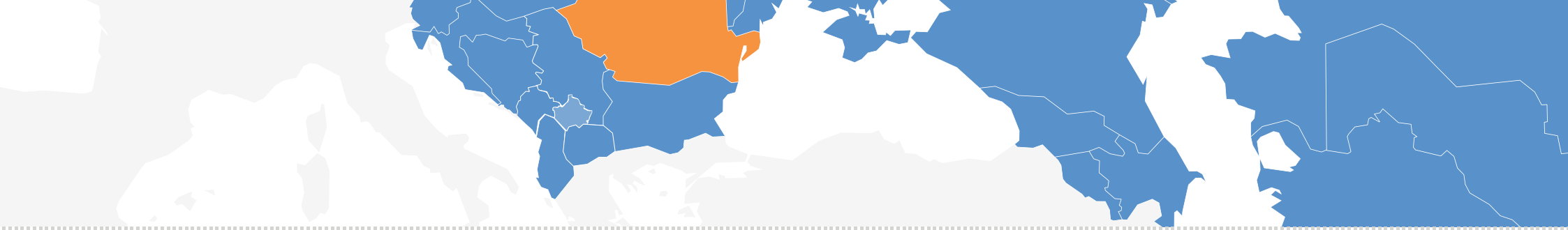
Attachment 2

Budgetary and epidemiological characteristics of harm reduction programs in Romania

Budget Details	Component	2015	2016	2017	2018	2019	TOTAL (2015-2019)	Source(s)	Notes
Budget designated for harm reduction per national strategy	NSP							NADA National Anti-Drug Strategy, 2013-2020; Key Informant Interviews.	-
	OST								
	(incl prisons)								
	HTC								
	ART								
	STIs								
	Condoms								
	IEC								
	Viral hepatitis								
	TB								
Enabling environment, strategic information, M&E									
TOTAL									



Budget Details	Component	2015	2016	2017	2018	2019	TOTAL (2015-2019)	Source(s)	Notes
Actual budget realized for harm reduction	NSP	See summaries below				-	Eur 545,291	GFATM TB grant; National Health Insurance House; Norwegian Funds; SIDACTION	Implemented by the NGOs ARAS (Asociatia Romana Anti-SIDA) and Carusel
	OST					-			
	Other					-			
Amount from domestic funding	NSP	Not available				-	-	-	-
	OST	130 vulnerable persons (pregnant women, drug users with HIV/Hepatitis C, etc., paid for by the National Health Insurance House; other clients pay 450 Ron = 100 Euros/month from their own pocket.				-	-	National Health Insurance House	Implemented by ARAS (Asociatia Romana Anti-SIDA)
	Other (please specify)	-	-	-	-	-	-	-	-
Amount from GF funding	NSP	1 Apr 2015-31 Mar 2018: Harm reduction services (needle exchange, condoms, IEC); HIV, HBV, GBC testing; HAV, HBV vaccination; referral of TB suspects, DOT, distribution of vouchers, Rifabutine: Eur 545,291				-	Eur 545,291	Implementation Map: TB NFM grant, rev. 16/02/2015	SR is the City of Bucharest through 2 fixed units, 2 outreach mobile units, 1 outreach mobile unit/team for DOTs
	OST					-			
	Other					-			
Amount from other external/donor funding	NSP	Not available				-	-	Norwegian Funds; SIDACTION	Implemented by ARAS (Asociatia Romana Anti-SIDA)
	OST					-			
	Other					-			
Calculated need for harm reduction		Not available						-	-
Gap between need and funds available		Not available						-	-

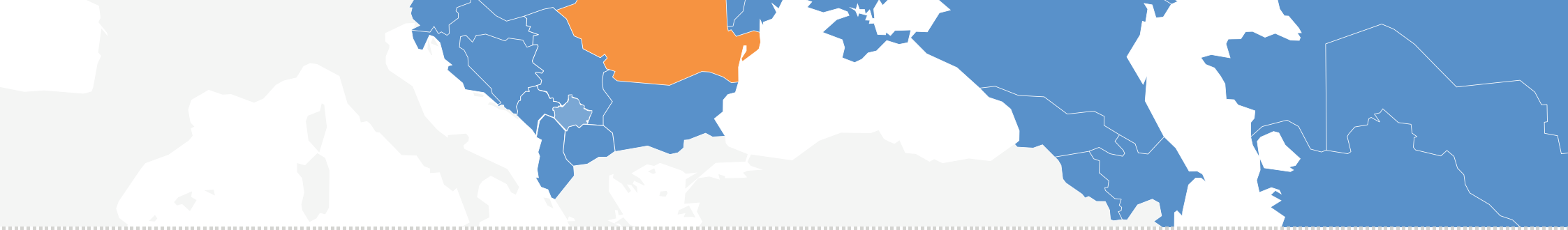


NSP related data	2013	2014	2015	2016	Source	Notes
Number of government-based needle/syringe exchanges	0	0	0	0	ARAS	-
Number of NGO-based needle/syringe exchanges	7	2	2	2	ARAS, KIIs, GARPRs	ARAS, Carusel
Number of drug users enrolled in NSP	5,148	2,292	3,238	-	ARAS	-
Number of clients receiving minimum package of services*		3,720	4,352	-	EMCDDA, ARAS	Through NGOs
Number of clients receiving expanded or comprehensive package of services^	-	-	-	-	-	-
Coverage of NSP among drug users nationwide	-	36.5%	51.5%	-	EMCDDA	No consensus; Bucharest only.

* There is no formalised definition of a minimum package of services used by HR programs in Romania.

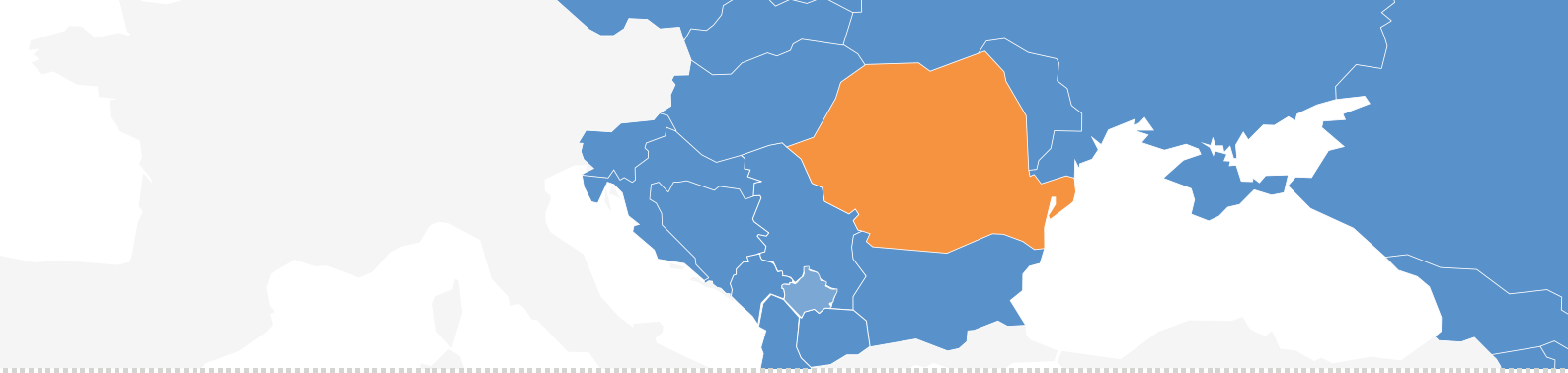
^ There is no formalised definition of an expanded or comprehensive package of services used by HR programs in Romania.

OST related data	2013	2014	2015	2016	Source	Notes
Number of OST clinics nationwide (Government)	13	5	5	5	ARAS	Total of 9 OST sites as of May 2016; additional private OST services exist.
Number of OST clinics nationwide (NGO)		4	4	4	ARAS	
Number of clients on methadone	828	556 (ARAS)	-	-	ARAS; NADA 2015 report, p110	Data not aggregated between methadone & buprenorphine
Number of clients on other substitutions therapies		1,219 (NADA)	-	-		
Coverage of OST among drug users nationwide (Numerator: the number of drug users enrolled in OST; Denominator: the estimated size of drug users)	13.2%	8.8% (ARAS) 19.4% (NADA)	-	-	-	-



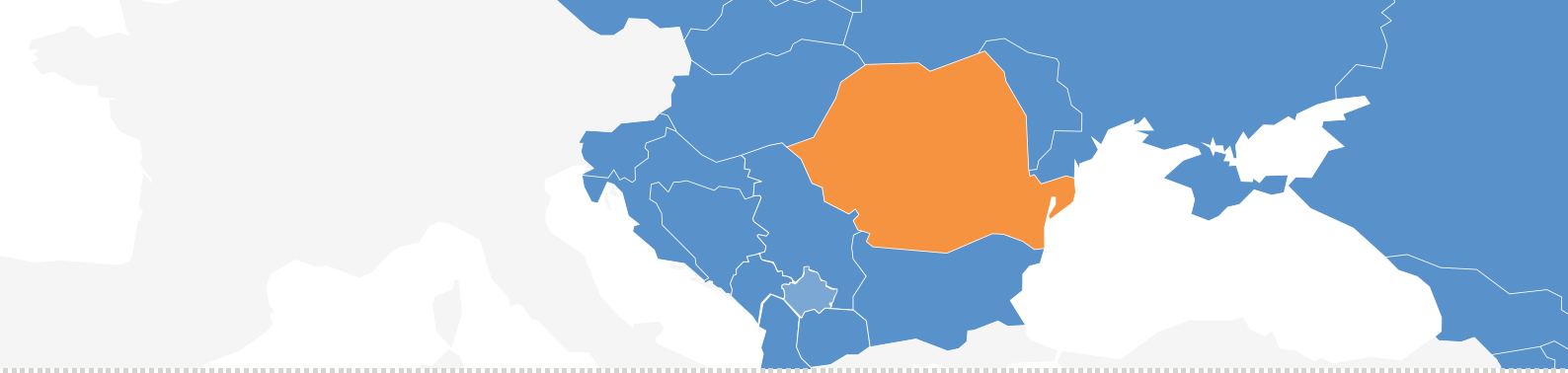
PWID ¹	2013	2014	2015	Source	Notes					
Tested for HIV (by year)	611	739	3,238	ARAS	Not aggregated by NSP, OST, etc., recipient					
Newly diagnosed with HIV (by year)	148 (24.2%)	114 (15.4%)	914 (28.2%)	ARAS	Not aggregated by NSP, OST, etc., recipient					
On ART (cumulative)	Not available									
Living with HIV but not on ART (cumulative)										
Screened for TB (by year)										
Diagnosed with active TB (by year)										
Treated for TB (by year)	Not available									
Tested for HCV (by year)						364	150	3,238	ARAS	Not aggregated by NSP, OST, etc., recipient
Newly diagnosed with HCV (by year)						196 (53.9%)	55 (36.7%)	892 (27.6%)	ARAS	Not aggregated by NSP, OST, etc., recipient

¹ No data on OST clients similar to the listed in this table is available.

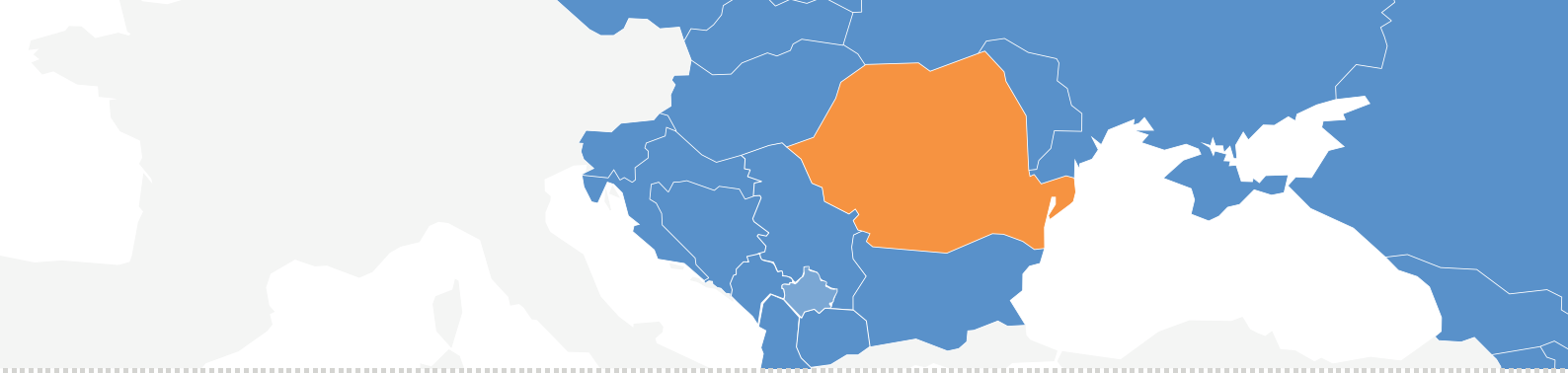


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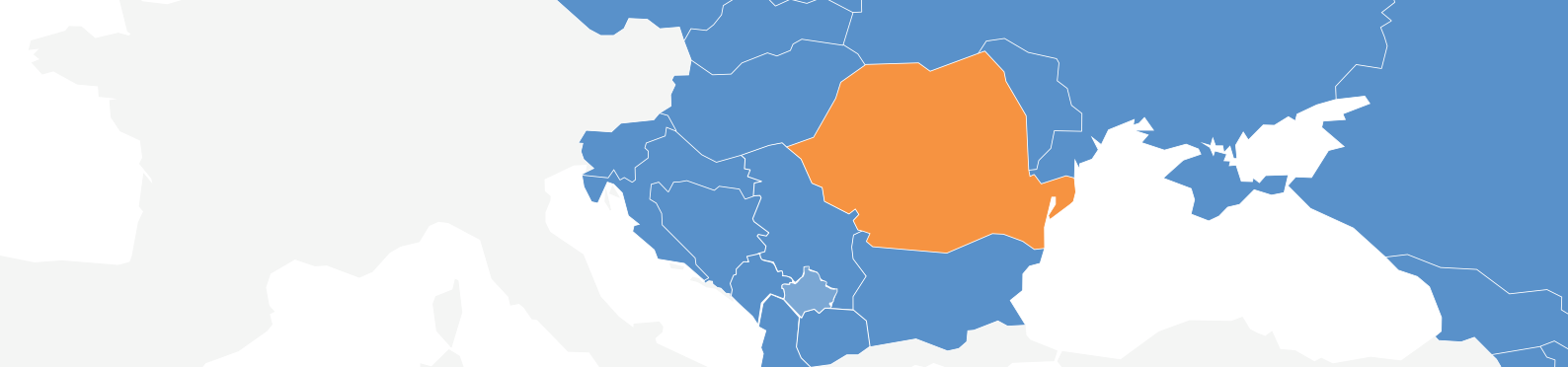
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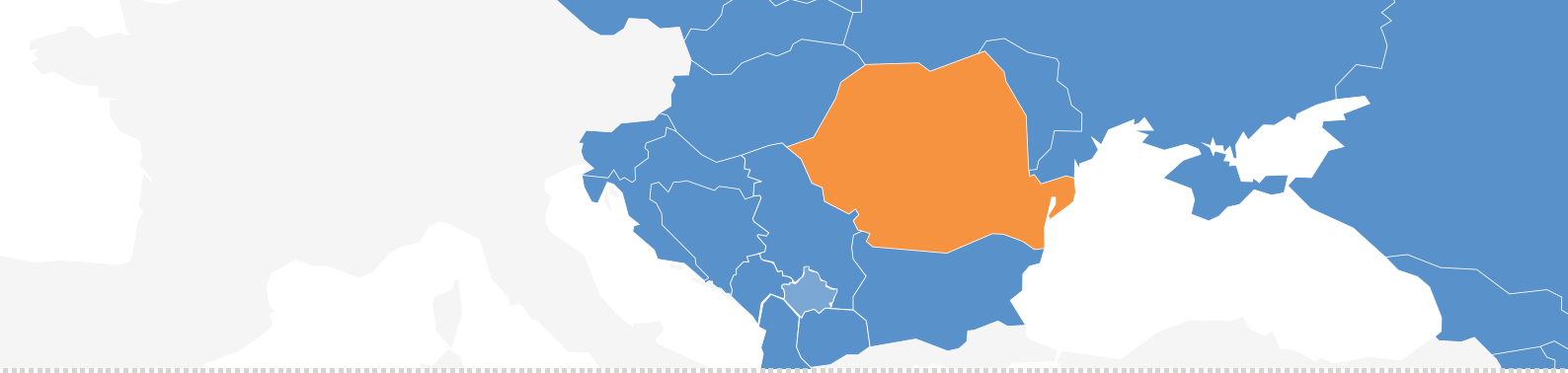
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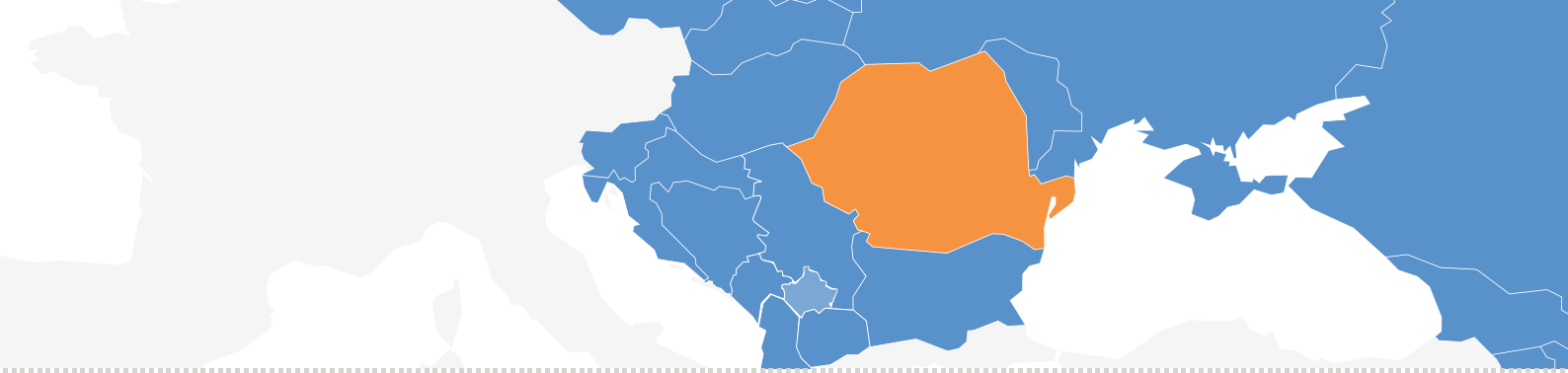
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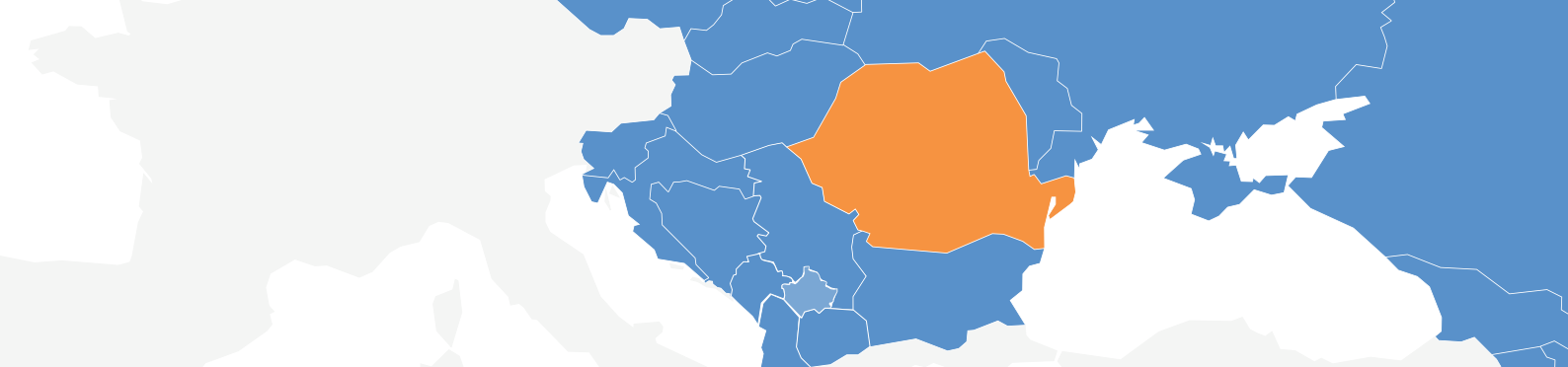
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Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programs and their allies from across 29 countries in the region of Central and Eastern Europe and Central Asia (CEECA). Together, we work to advocate for the universal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

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

BECOME AN EHRN MEMBER:

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

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