Sustainability of CSO provided HIV and TB Services During and After Transition in East Europe and Central Asia Region

Final Report

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ALB	Albania
BGR	Bulgaria
BIH	Bosnia and Herzegovina
CCM	Country Coordinating Mechanism
CSO	Civil Society Organization
EECA	Easter Europe and Central Asian
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
KP	Key Population
LMI	Lower Middle Income
MDR/RR TB	TB Resistant to Rifampicin
MKD	N. Macedonia
MNG	Montenegro
MSM	Men Who Have Sex With Men
PWID	People With Injecting Drug Use
RCN	South East Eropean Reginal Community Network
RMN	Romania
SDG	Sustainable Development Goals
SEE	South East Erope
SRB	Serbia
SW	Sex Worker
STC	Sustainability, Transition, and Co-financing Policy
TB	Tuberculosis
TG	Transgender
TFR	Transition Fund Request
UMI	Upper Middle Income
UNAIDS	Joint United Nations Programme on HIV/AIDS
XKX	Kosovo

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Executive Summary

Background

Eastern Europe and Central Asia (EECA) is the only region in the world where annual rate of HIV infections continues to rise at a concerning rate. The HIV epidemic has, for the most part, hit people who inject drugs. In South East European countries (SEE) new HIV cases are increasingly reported among MSM. Harm reduction service coverage remains low and where it does exist the services offered are often are not comprehensive. Antiretroviral treatment coverage remains well below the global average at 38%. New infections continue to outpace ART enrolment. Conservative legislation around same sex relationships, drug use and sex work continues to fuel stigma, obstructing the HIV response in some countries within the region. Improved surveillance of the HIV epidemic is needed, often data is unavailable for populations or disputed. The region also faces epidemics of tuberculosis (TB) and hepatitis C virus (HCV) which require an integrated approach to prevention, diagnosis and treatment that is currently lacking.

In 2016, the Global Fund agreed to a Sustainability, Transition, and Co-financing (STC) Policy. The policy allows for extra time for governments and civil society to plan for Global Fund exit, and provides guidance (and in some cases, extended financing) for countries to plan well in advance how their programs will be funded and implemented once Global Fund resources are no longer available. It also emphasizes the particular vulnerabilities of prevention services run by and for key populations (like harm reduction services for people who use drugs, or programs for sex workers, men who have sex with men, and transgender communities) that are unlikely to be funded by national and local governments without sustained pressure and advocacy. Some countries in EECA region had already lost Global Fund support or were in their final funding cycle by the time this policy was enacted, however, and have faced challenges during the transition process as a result. In some graduated countries reverse in transition is observed, by HIV component becoming re-eligible for funding (Table 2). Certain countries are expected to graduate from the Global Fund support before 2025 as they move to the high income group and components are categorized as low or moderate disease burden.

Purpose and aim of the research

Given that countries in EECA region are scheduled to gradually transition from the GF financial support in or before 2025 (for HIV), it is timely to assess CSO sector's readiness to transition, identify areas which have to be emphasized while developing/updating national transition plans. Although no "one-size-fits-all" approach exists to transition, previous experiences highlight a need for both early planning and monitoring of the transition along several key dimensions observed at present.

Table 1: Status of transitions from Global Fund support in the EECA region

Code	Country	Disease	Last funding from GF	Transition projections	Transition in reverse
BGR	Bulgaria	HIV	2017		
		TB	2018		
BIH	Bosnia and Herzegovina	HIV/AIDS	2018		
		Tuberculosis	2016		
MKD	N. Macedonia	HIV/AIDS	2017		
		Tuberculosis	2017		
MNG	Montenegro	HIV	2015		Since 2017
RMN	Romania	HIV/AIDS	2010		
		Tuberculosis	2016		
SRB	Serbia	HIV/AIDS	2014		Since 2016
		Tuberculosis	2015		
XKX	Kosovo	HIV/AIDS		2022-2024	
		Tuberculosis		2022-2024	
MNG	Montenegro	HIV/AIDS	2009		Since 2016
		Tuberculosis	2009		

Source:
Projected transitions from Global Fund country allocations by 2025: projections by component, GF, March 2018 update and January 2020
* Transition grant

The overarching aim of this research is to assess national governments' and CSOs' readiness to transition of HIV and TB services provided by CSOs and define a way forward to ensure a smooth transition from TGF funding towards fully domestic funding.

The research attempts to answer following questions:

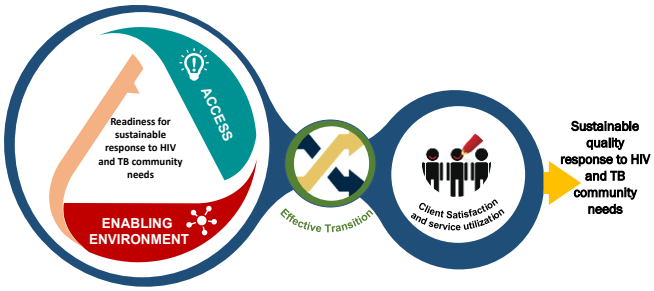
1 What are gaps and challenges faced by CSO's in the transition from Global Fund assistance to government support of services for key populations (KP) and TB patients in EECA region?

2 Are countries equally attending issues related to sustainment and expansion of CSO provided services in the field of HIV and TB during transition planning and implementation of transition plans?
3 What is the CSO sector readiness to transitions?
4 How the government plan for transition?
5 What are the strategies utilized by CSOs to ensure smooth transition and sustainability?
6 What are transition related challenges CSOs face?
7 What are the lessons learned from countries which graduated from Global Funs support.
8 What is a way forward to ensure sustainability of CSO provided services?

Research methodology

The research was guided by conceptual framework. In order to meet Sustainable Development Goals (SDG) goals by year 2030, countries have to aim at ensuring sustainable quality response to HIV and TB community needs measured by service utilization and client satisfaction. Attainment of the given objective will be unrealistic if countries fail to sustain quality response to HIV and TB community needs. To sustain quality response to HIV and TB community needs, national governments have to establish enabling legal environment, ensure adequate supply of service providers, particularly of non-public, including CSOs, foster demand for services and warrant effective transition of CSO provided services from external support to domestic financing. All these elements will ensure client satisfaction and service utilization (Figure 1).

Figure 1: Research framework



The study was commissioned by the SEE Regional TB and HIV Community Network (RCN) and implemented with active participation of its members. In total 9 countries (Albania (ALB), Bosnia and Herzegovina (BIH), Georgia (GEO), Kosovo (XKX), Moldova (MDA), Montenegro (MNE) North Macedonia (MKD), Romania (RMN) and Serbia (SRB) expressed their willingness to be included in the study and contribute to this knowledge product. Countries were grouped in three clusters. The first cluster included countries which completely graduated from GF support for both or one of the disease components (Albania, Bosnia and Herzegovina, North Macedonia, Romania) inform on the experience with transition planning, transition process and an impact of transition on sustainability of HIV and TB services in these countries. To inform strategies applied for transition planning Cluster 2 included countries (Kosovo) scheduled for transition by 2025 for both or one of the components. And finally, the third cluster included countries yet eligible and having time for long-term sustainability and transition planning and countries with components that regained their eligibility (Georgia, Moldova, Montenegro and Serbia).

For the research purpose, Initial contacts were made with the members of the RCN and interested CSOs in studied countries that covered both large CSOs and their Sub-recipients (SRs) (i.e., smaller NGOs and CBOs) to ensure that they had ever been or were currently engaged in collaborative relationships with the Government and had work experience in the field of HIV/AIDS and TB. In total 27 CSOs participated and filled in the quantitative survey.

Two major methods were utilized and triangulated to gather data – quantitative interviews of CSOs, health professionals and direct beneficiaries and review of organizational documents of the countries and CSOs to allow for an in-depth analysis and detailed description of the origins and elements of the transition preparedness of CSOs and what their successes and challenges might be. In case of N. Macedonia, the research was limited to only document review. The wider literature on CSOs and HIV/AIDS/TB and information on the internet was used to enhance the reliability and external validity of the findings. In total, 27 quantitative interviews were conducted with participants from the CSOs, 81 health professionals and 216 direct beneficiaries (108 Key

affected Population and 108 TB patients). The interviews were conducted consecutively until a point of saturation (e.g., when additional interviews yielded no new insights for the study) was reached. Both, qualitative and quantitative data analysis, from the above sources have been triangulated to arrive at conclusions and formulate recommendations, presented in this report.

Research findings

Role of CSOs in HIV and TB national response (enabling environment): The review of the countries' national HIV and TB response documents shows that albeit CSOs are represented at CCM, their role and engagement in advocacy, policy planning and ensuring transparency in accountability is not commonly acknowledged and highlighted in these documents. Partnership with civil sector, affirmed in national disease response documents, is mostly seen by the governments in service delivery, being it provision of preventive, treatment, care and support services to key affected population groups and TB patients. The role of civil society is less appreciated in the area of treatment adherence support services.

CSOs and the Role they perform in HIV and TB National Response (supply): All studied CSOs are non-profit, non-commercial organizations. More than half of them are either associations or Foundations. The size of CSOs measured by number of employees varies. One third of CSOs studied are large CSOs (>50 individuals), mostly operating in BiH, Romania, Moldova and Georgia. 56 percent represent small CSOs with less than 20 staff members and only 11 percent are medium size CSOs (20-50 individuals). Some CSOs are only service providers, some in addition to service provision also protect rights of particular groups of population or represent particular groups of population. Organizations that protect the rights of various groups represent only one third of surveyed organizations and only few (7 percent) in addition to service provision are think tank organizations. Certain CSOs serve particular groups of population, while the others' mandate is wider representing and providing services to various groups of population.

CSOs perform different functions. Few of them report performing advocacy function, while all provide services to one or several groups of population. Majority of small CSOs target particular group of population such as People Living with HIV (PLHIV), Sex workers (SW), Men who have Sex with Men (MSM), People with Injecting Drug Use (PWID); Transgender, etc. and provide preventive, care and support services. Medium and large CSOs have wider coverage of different KP groups and TB patients.

Majority of surveyed CSOs (88 percent) have work experience for more 8 years, 10 percent from 2 to 5 years, and only 2 percent are young, working only for about 2 years. Most of CSOs are based in the capital and cover the whole country (Figure 7). 41 percent CSOs have regional representation in other geographical areas outside of the place of registration. 22 percent cover more than 2 provinces/regions and only 7 percent serve 1-2 provinces/regions.

CSO client base varies across organizations. Interestingly, no correlation have been observed in the size of the organization and number of clients served. Less than 100 clients are served by 3 small CSOs with up to 20 staff members and 1 large CSO with more than 50 staff members. Similarly, more than 3000 clients are served by 3 small CSOs and 2 large CSOs. In graduated countries (BIH and RMN) small CSOs provide services to about 1000 to 3000 beneficiaries, whereas client base for medium and large CSOs varies between 300 to 3000 beneficiaries.

While it is understood that range of services provided by CSOs are different in different countries, this finding raises concerns whether CSOs are using their human and financial resources efficiently and whether there is a room for staff optimization, or a room for further expansion of client base and or a room for expanding types of services provided to their clients. In light of diminishing external funding and yet slow uptake of CSO contracting (social contracting) for the provision of preventive, treatment, care and support services, CSOs have to more strategically approach human resource planning and ensure optimization of their workforce and operational costs.

Financial Viability of CSOs (Enabling Environment)

In the era of diminishing foreign assistance, the essential functions civil society organizations provide, linking individuals and communities to healthcare and extending the reach of government programs, are at high risk. If this transition to self-reliance is to succeed, countries have to strengthen their capacity to implement policies, mobilize and manage public resources, and incorporate locally-led development principles, while maintaining progress already gained and to further expand. One crucial piece to these transitions is the continued role of civil society organizations, organizations that have typically been supported by external donors.

CSO funding changed over the past five years. Dynamics around the funding landscape for especially prevention services to key populations through CSOs is of great concern as reduced funding may lead to their total shutdown or substantial downscaling. 11 percent of CSOs reported no changes in revenues, whereas 56 percent of them expressed concerns with declining funding and 7 percent reported discontinuation of funding from existing sources. Only 11 percent of CSOs noted slight increase of funding their activities. Main source of funding remain to be the Global Fund and other donors. Number of CSOs financed from public purse, national or provincial/regional budgets, are few. CSOs from graduated countries (BIH and RMN), are financed mostly by other donors or external sources.

Social contracting

Social contracting is one of the key pillars of ensuring continued service provision to key populations and people living with HIV and sustainable financing in many countries of the region. It however is not a magic bullet but rather one of the mechanisms by which CSOs can access funding at various states levels. The study found that Social contracting is practiced in other sectors in all countries covered by the research. The governments are gradually utilizing social contracting mechanism in the health sector including in the sphere of HIV and TB. Main sources of funding are national government institutions (various sector ministries, other public agencies, local self-governments, etc.). CSOs from five countries (GEO, XKX, MNE, MLA, SRB) reported having experience of social contracting in the field of HIV. Among these countries are countries, which already graduated from GF support and those which yet remain eligible for the next couple of years. While it is commendable, that countries which yet remain eligible for GF funding already practice social contracting (GEO, MLA, MNE, SRB) and have sufficient time for refinement and expansion of this mechanism, 2 graduated countries (ALB and RMN), dependent on the domestic and/or other external funding for HIV response, don't apply social contracting.

Availability of social contracting mechanism in a country does not necessarily mean that all CSOs have access to public funding. Only half of CSOs from six countries where social contracting is practiced in the field of HIV, reported having experience tapping public funding. Funding from domestic sources is extremely low (<10 percent of organization's annual budget). Consequently, social contracting requires to be scaled-up to allow self-sustainment and continuation of services provided by CSOs after the seize of external funding. However, the scale up of social contracting is challenged by number of factors and if not addressed in immediate terms will adversely affect the outcomes and impact of national disease responses.

Challenged faced by CSOs during social contracting

- Lack of government willingness to invest
- Insufficient fiscal space and budgetary allocations, absence of dedicated budget line, insufficient core funding for CSOs, short-term contracts -funding on annual basis;
- Lack of costed standard service packages for budget forecasting;
- Ambiguity of application, contract award and contract management processes and practices;
- Barriers for new, less experienced CSOs to tap domestic funding;
- Poor financial management systems resulting in payment delays, insufficient payments, absence of advance payment practices and paying only for services but not for administration costs; and
- Accountability challenges - the benefits of reporting are not well understood neither by financier, nor by CSOs themselves. Information collected for reporting purposes are not regularly used for evidence based planning and implementation.

CSO capacity - Knowledge and skills (Supply)

Staff capacity building is a common practice in many CSOs, though 21 percent of them, mostly young and less-experienced ones, do not offer regular staff trainings. Capacity building activities are predominantly financed by external resources (81 percent). 28 percent of CSOs uses GF grant funding and more than a half of CSOs report using other donor funding. Main topics covered by the capacity building activities related to communication skills development, quality of preventive services, innovations in working with key populations, conducting peer driven intervention among KPs, TB case management, active case finding, phycological support etc. Notably few CSOs also considered and provided training to their staff in advocacy, budget advocacy, project design and management, human resource management, computer literacy, etc. all being externally funded. The analysis of national disease response strategies and transition plans where applicable, revealed that a need for CSO capacity building in programmatic and organizational issues are acknowledged in six countries (ALB, GEO, XKX, MKD,MNE, ROM, SRB), but all planned trainings are yet externally financed.

It has to be emphasized that CSOs, with their various missions, expertise and outreach capacities can, and should cover a wide spectrum of roles, and therefore should not be concentrated on mere service provision and staff capacity building in topics related to service provision only.

Access to Services (Access)

To estimate demand for HIV and TB services and unmet needs, the study examined: i) access to information about available services and source of information; ii) geographical access to health facility based services, waiting times for appointment; iii) access to treatment and medicines; and iv) needs not covered by provided service packages.

The analysis of the quantitative study revealed that access to available services is guaranteed either from CSOs, health personnel, family members and or peers and friends. Whether access is ensured for all, including the most marginalized and hard to reach KPs, is difficult to affirm, as only those already receiving services have been included in the study. In case of HIV, main source of information on available services are CSOs (51 percent). This result clearly display the important role CSOs play in identification of KP and generating demand for HIV services among them. Information about available TB services are predominantly received through health professionals (62 percent) and the role of CSOs in creation of demand for TB services is insignificant. This could be explained by less engagement of CSOs in TB response in EECA, compared to HIV. As CSO engagement remains limited in TB response, and in most countries HIV component will be the first to graduate from the Global Fund support, without effective fundraising from all, public, private and external resources, CSO engagement will dimmish in national HIV response and adversely affect demand for HIV services, especially among hard to reach groups of KP.

Geographical access to health facility services are challenged in the field of HIV. About half of PLHIV travel longer distances for care (more than 1 hour travel time) because of limited availability of specialized HIV services close to their residency. To receive health facility based HIV and TB services appointments are to be schedules 1 week in advance (83 and 85 percent in case of HIV and TB respectively). TB patients have better geographical access to needed services as only 17 percent of respondents reported travelling more than 1 hour to the nearest health facility. The international evidence display an inverse association between a geographic or transportation-related barrier and an HIV-related outcome. The presence of geographic barriers would be associated with unfavorable outcomes at all points along the continuum of HIV care, and that this effect would be observed across different countries of the region, time periods, and study populations.

Apart from geographical access to services, PLHIV also report on barriers in collecting ARVs. Almost one fourth of respondents informed inconvenience in collecting ARVs. However, it may have a marginal effect considering that majority PLHIVs have to travel once to collect the ARV stock for more than a one month. Similarly, access barriers to anti-TB medicines are negligible in TB.

The study also examined whether KP and TB patients received all needed services and what are the services not covered. Majority of respondents (71 percent KPs and 86 percent of TB patients) reported receiving all needed services. Nevertheless, around one third of KP respondents and one

fifth of TB patients expressed a need for additional services such as psychological support, access to free food and hygiene packages, social/cash benefits, free access to other health services and support for employment. Respondents from Bosnia and Herzegovina highlighted a need for improved access to harm reduction services, particularly to dop-in centers. These findings indicate that service packages differ among countries and within the country among CSOs serving KPs and TB patients, requiring a standardization of services packages according to local context and client needs. This is especially important when countries move towards domestic funding of preventive services.

Access to Services during COVID-19 pandemic (Access)

COVID-19 has spread across the world at a terrifying speed, with waves of infections crashing over countries, cities and communities. This new pandemic has had far-reaching effects on health systems and other public services. HIV & TB services have been disrupted, and supply chains for key commodities have been stretched. The COVID-19 pandemic threatens progress against HIV and TB around the world[1]. The study revealed challenges in accessing needed services during COVID-19 pandemic in studied countries. Less TB patients experienced problems with access to services, compared to KP groups and PLHIV. Respondents found difficult to access emergency and planned consultations, testing, hospital treatment, social and psychological support. Lockdowns, restriction on gatherings of people and transport obstructions along with re-assignment of health facilities and medical staff to COVID-19, threatened service provision. Additional causes of disruption include COVID-related stigma and reluctance of health workers to attend to people suspected of having TB, which have many of the same initial symptoms as COVID-19; and clients not seeking health services as usual, resulting from fear of getting infected with COVID-19 as well as economic hardships caused by the pandemic.

Yet, COVID-19 has catalyzed the accelerated implementation of innovations that pre-date the pandemic but that have previously struggled to obtain traction. Community groups moved swiftly in response to the pandemic to maintain service access, including using telephone or email for personal counselling and for monitoring treatment and health status. They set up and use online communication platforms to provide support. Social media is used to share information, including on risk reduction. Though, doing so presented challenges for some people. Multi-month dispensing of antiretroviral medicines to people living with HIV has been critical to easing the impact of lockdowns.

The COVID-19 pandemic has underscored the agility of the HIV response and the many spillover benefits of HIV and TB investments in health systems and development infrastructure. Through policy and service delivery innovations and especially through the innovation of communities, the HIV and TB response has in large measure risen to the challenge posed by the COVID-19 pandemic, ensuring continuity of services by adopting alternative service provision modalities. The HIV/TB and COVID-19 pandemics and their responses underline the importance of increasing the resilience of civil societies, communities and health systems, and the importance of addressing underlying inequalities.

A high proportion of participants expressed satisfaction with HIV & TB services, being provided by health personnel or CSOs. However, some dissatisfaction is masked in this high satisfaction level. This dissatisfaction underscores need to improve staff attitudes, staff-patient-communication, shortening waiting times and improving access to harm reduction services particularly in graduated countries.

Effective Transition

National planning for transition of service delivery funding from external sources to domestic financing: The review of the most recent country specific Transition and Sustainability Plans and disease specific national strategies revealed five key objectives addressing transition and sustainment of CSO provided services: i) Empowerment and engagement of CSO in HIV policy, programming, advocacy (Albania, Kosovo, N. Macedonia and Serbia); ii) Standardization of service

[1] https://www.theglobalfund.org/en/covid-19 accessed on March 1, 2021

packages (Bosnia and Herzegovina); iii) Development/enhancement of the CSO contracting/social contracting mechanisms (Bosnia and Herzegovina, Georgia, Kosovo, N. Macedonia, Moldova, Romania); iv) CSO capacity building (Albania, Georgia, Kosovo, N. Macedonia, Montenegro, Romania, Serbia); v) Increase of public funding for CSO provided services (Bosnia Herzegovina, Kosovo, N. Macedonia). In summary, the review of the transition and sustainability planning revealed, that albeit countries in general acknowledged the role of CSOs, assigned functions and planned activities related to transition and sustainment of CSO provided services, implementation progress is sub-standard, and it is less likely that will produce planned results. Currently, there is a clear lack of communication and comprehension of the expectations of the transition.

Impact of declining funding on service provision and service users: Transition has presented a number of challenges for countries in the region. Prevention activities are vulnerable in the context of transition given little-to-no domestic investment and the potential political obstacles to prioritizing services for certain populations. The study indicates that countries generally prioritize costly curative care with very limited funding allocated towards more cost-effective prevention interventions. Above all, all countries experienced budget shortfalls and service interruptions and deteriorating coverage of target populations. 65 percent of CSOs included in the research highlighted decreasing funding adversely affecting service delivery. Only few noted about no or increased funding. Declining funding also hampered service delivery to service recipients. 57 percent of CSOs noted decrease in number of beneficiaries serviced. The decrease of funds and services to KP in the regions prior to government firm commitment and alternative options being available will not only disrupt the existing services but will also have a negative impact on the takeover of those services by local CSO's.

CSO Transition and Sustainability Strategies

The resulting financial pressures led CSOs to undertake a variety of strategies to stay afloat. In response to shrinking funding base, CSOs took decisive steps to sustain services to their target population groups through development and application of various strategies.

- Fundraising: Around 60 percent of studied CSOs (Bosnia Herzegovina, Georgia, Moldova, Montenegro and Kosovo) reported having fundraising strategy and implementing it. Noteworthy to mention that majority of CSOs, which have fundraising strategy are small or medium size organizations. The funding trend of these CSOs for the last 5 years show that results of fundraising are not promising. Subsequently, the effectiveness of the fundraising strategies and/or implementation process requires further research and refinement as needed.
- Functions and Services: To maintain financial viability, CSOs also considered revisiting their functions, extending services to other groups of populations and expanding the package of services. Some CSOs in Bosnia and Herzegovina, Romania, Serbia and Kosovo initiated income generating projects. CSOs (44 percent) also considered diversification of client base by adding other populations groups such as TB patients, transgender population, MSM and/or SW and women of reproductive age. less than a half of them expanded outreach activities, testing and counseling, treatment and treatment adherence support, social support and started provision of legal services to their clients.
- Human resource planning: In order to efficiently use scarce financial resources on the one hand, and to expand services and clients base on the other, CSOs optimized staffing, revised staff salaries and benefits. CSOs used these strategies in combination for optimization of human resource expenses. 70 percent of them reported downsizing their workforce, 48 percent lowered staff salaries and 57 percent decreased staff benefits. Funds released from human resource strategies implemented were used for the expansion of the service package and client base.
- Geographical representation and operation hours: Apart from optimization of human resource costs, CSOs strategically approached costs related to administrative functions. More than half of them (57 percent) revisited effectiveness and efficiency of maintaining various office/program sites and downsized them by introducing the alternative service modalities and retention of local staff. Some CSOs (26 percent) also took decision to

shorten office operation hours, while others maintained regular working hours. The recent experience with COVID-19 demonstrated possibility of using on-line/phone consultations and alternative service delivery modalities.

- Partnership with other CSOs: 26 CSOs reported having established partnerships with other civil society organizations to allow expansion of coverage and diversification of services provided to their clients.

Lessons Learned from Transitioned Countries

Lessons learned from transitioned countries are gloomy but serves a s good practice example for countries scheduled for transition in the next 3 to 5 years. The transitioned countries report the consequences of unplanned or poorly managed transitions:

Non-functional Country Coordination Mechanism (CCM)- CCM meetings became sporadic or non-functional (Romania, Serbia)

Fading CSO advocacy: the critical role CSOs have played in advocacy over the last decade remained at risk, since external funding opportunities were uncertain and the use of domestic government funding for advocacy risked significant conflicts of interest (Bosnia Herzegovina, Montenegro, Serbia);

Lack of awareness activities among KPs resulting in prejudices and stigma towards HIV remains among the LGBTI community and the rest of society, pushing many people not to get tested or to refuse treatment, very often leading to serious health complications and even death (Albania, Bosnia Herzegovina);

Deteriorated access to ARVs, testing and other commodities (Albania);

Closure of CSOs and/or services: CSOs have been forced to shut down their services, such as harm reduction services, services for MSM, cut human resources and return many assets to the Project Management Unit (Albania, Bosnia Herzegovina, Montenegro, N. Macedonia, Romania, Serbia).

Summary of Key Findings

In summary, the study revealed six key findings that have to be considered while planning for transition and sustainability:

Finding 1: Sustainability of quality response to HIV and TB community needs is at risk in all countries, regardless of their eligibility status

Finding 2: Insufficient political and legal acceptance of civil sector engagement in national disease response results in deterioration of service provision and worsening epidemiological situation

Finding 3: Absence or underdeveloped mechanisms for state financing of CSOs have a powerful impact on supply, access to CSO provided services and outcomes of the national disease response during and after transition.

Finding 4: Demand for services is challenged by deteriorating access to services, medicines and uncovered needs in both, graduated and transitioning countries.

Finding 5: Inadequate transition planning and sub-optimal implementation of the transition and sustainability plans has unfavorable effects on sustainability of preventive, care and support of key population groups and TB patients.

Finding 6: High client satisfaction masks some dissatisfaction related to attitudes, staff-patient-communication, waiting times and deteriorating access to harm reduction services particularly in graduated countries.

Recommendations

Recommendations for the Government:

Recommendation 1: Definition of roles, responsibilities and positioning of the legally authorized coordinating authority in the government hierarchy to ensure its sustainable operation after the transition.

Recommendation 2: Ensure that there are already tested and functional mechanisms in place to provide domestic resources to civil society, including KP communities and to forge working mechanisms for their meaningful engagement in effective and cost-efficient service delivery.

Recommendation 3: Ensure HIV and TB services as essential services in contingency planning and the response to the emergencies, including COVID-19.

Recommendation 4: Adapt policies, technical guidelines, and protocols for alternative HIV and TB service delivery models, including telemedicine, to ensure access to these services during and after COVID-19 pandemic.

Recommendations for Civil Society Organizations

Recommendation 5: Enhance Advocacy and streamline communication

Recommendation 6: Ensure powerful advocacy for and vigorous engagement in the development /streamlining and scale-up of CSO funding modalities, mechanisms and procedures.

Recommendation 7: Ensure establishment of systems and mechanisms for continuous CSO capacity building.

Recommendation 8: Promote alternative service delivery modalities to efficiently use available scarce resources and ensure continuity of service delivery.

Recommendation 9: Streamline planning and implementation of national transition and sustainability activities.

Recommendation 10: Advance collective and individual CSO transition and sustainability planning and ensure effective implementation.

1. Introduction

1.1 Background

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund (GF)) recognizes that ending the HIV and tuberculosis epidemics and eliminating malaria will only be possible through strong, sustainable national systems for responding to the 3 diseases. For this reason, the Global Fund has been urging countries to build sustainability planning into their national programs and their grant designs. A country's eligibility for funding is determined by its income classification, based on the World Bank (Atlas Method) Income Classification and Gross National Income (GNI) per capita (Atlas Method), and disease burden indicators for HIV, tuberculosis and malaria. Countries with high income classifications and/or Upper Middle Income (UMI) countries with a low disease burden are not eligible for Global Fund financing. The process of planning for transition and sustainability is critical to minimize disruptions to programmes and potential negative impacts on the achievements made to date.

Since its launch in 2002, the Global Fund has been having a major impact especially in countries where national governments have been reluctant to invest in programs for key and vulnerable populations. The Easter Europe and Central Asian (EECA) region has benefitted from the support of the Global Fund since its inception. Global Fund programs support community systems, recognizing that CSOs and communities have a unique capacity to reach those that are most vulnerable to the three diseases. For this reason, the Global Fund is investing in efforts to align community systems and responses with formal health systems to maximize impact and to build resilient and sustainable systems for health.

But now, just like the rest of the world, the EECA region is undergoing fundamental changes in several areas that will determine the setting, opportunities and challenges for an effective response to HIV, TB and malaria within the context of the Global Fund's transition. As low and middle - income countries grow economically, they can increase spending on health, progressively moving away from donor financing towards domestically funded health systems. The Global Fund Strategy 2017-2022[2] places a strong emphasis on the need to support sustainable responses for epidemic control and successful transitions away from direct grant support. It also stresses the need to support countries to use existing resources more efficiently and to increase domestic resource mobilization.

Reductions in the size of the allocation require a country to progressively assume key parts of the national disease response even multiple allocation cycles prior to transition. GF encourages countries to plan early, and work to increase financing of all key interventions of the national disease response as they move along the continuum. While the HIV and TB response has made great strides in scaling up biomedical approaches, especially testing and treatment, the failure to address important societal and structural issues diminishes the reach, impact and sustainability of HIV and TB services[3]. Therefore, changes in funding landscape also require civil society to undergo a process of reflection and critical adaptation into a new framework of relations with those who design, approve, implement and evaluate public policies in their countries.

1.2 Brief Epidemiological Context

HIV/AIDS: At the end of 2019, an estimated 1.7 million people were living with HIV in Eastern Europe and Central Asia[4]. It is one of two regions in the world where the HIV epidemic continues to grow rapidly, with a 27% increase in annual HIV infections between 2010 and 2018.[5] In 2019,

[2] https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy
[3] https://www.unaids.org/sites/default/files/media_asset/prevailing-against-pandemics_en.pdf
[4] UNAIDS, "AIDSinfo", http://aidsinfo.unaids.org/ Accessed in August 2020
[5] Ibid

there were roughly 170,000 new HIV infections. In the same year, there were 35,000 AIDS-related deaths.

The region's epidemic is concentrated predominantly among key affected populations – in particular, people who inject drugs (sometimes referred to as PWID) – yet there is low coverage of harm reduction and other HIV prevention programmes in key countries within the region.[6] Unprotected sex is causing an increasing number of HIV infections and is now the leading cause of transmission in some countries. In addition, growing HIV epidemics among transgender people, gay men and other men who have sex with men are understudied and unrecognized by several national HIV responses.[7]

There are roughly 3.1 million people who inject drugs in Eastern Europe and Central Asia. The region is home to roughly one in four people who inject drugs worldwide.[8] Russia has the highest number of injecting drug users in the region (1.8 million), about 2.3 percent of the adult population. Moldova (1 percent), Belarus (1.1 percent) and Ukraine (0.8 -1.2 percent) also have significant numbers of this population.[9] HIV prevalence among women who inject drugs is higher than their male counterparts in Kazakhstan, Uzbekistan, Kyrgyzstan, Belarus, and Ukraine.[10] Women who inject drugs also tend to be younger, to engage in more risky sexual behaviours and to share injecting equipment more often than men who inject drugs. In Eastern Europe, only 0.003 percent of women who inject drugs have access to opioid substitution therapy (OST) and have poor access to sterile injecting equipment and condoms, as well as limited access to sexual and reproductive health services.[11]

National HIV prevalence among sex workers varies throughout the region, from less than 1 to 7 percent,[12] although it is higher in certain geographic locations, particularly cities. For example, in Ukraine, HIV prevalence among sex workers in 2015 was estimated to as high as 18.6 percent in Cherkasy oblast and as low as 0.7 percent in Zhytomyr oblast be.[13] In Moldova, HIV prevalence among female sex workers is estimated at 6.9 percent in Chisinau, and 24.7 percent in Balti.

Despite limited data, it is thought that HIV prevalence is even higher among male sex workers than female sex workers.[14] In many countries, HIV data relating to Men Who Have Sex With Men (MSM) is grossly under-reported, inconclusive or not reported at all. According to data reported to UNAIDS in 2019, national HIV prevalence among men who have sex with men ranges from between 1.1 percent in Bosnia and Herzegovina to 16.2 percent in Georgia. However, a number of countries do not report on this.

Stigma and discrimination towards people living with HIV and key populations remain high. New conservative legislation is placing additional restrictions on same-sex relationships, sex work and drug use, which could further prevent key populations accessing HIV services. Prevention programmes are under threat as international support for HIV responses decreases and domestic funding for HIV prevention fails to keep pace.[15]

A broadly threatening environment for key populations discourages HIV testing and treatment enrolment. Results from the Stigma Index show that at least 20 percent of people living with HIV in Kyrgyzstan and 18 percent in Kazakhstan reported being denied health services; disclosure of HIV status by healthcare workers without consent is alarmingly common in all countries with available data.[16] In wider society, discriminatory attitudes and misconceptions about HIV are yet

[6] Prevention Gap Report, UNAIDS, 2016
[7] Miles To Go Closing Gaps- Breaking Barriers Righting Injustices, UNAIDS, 2019
[8] Regional overview, Eurasia, Harm Reduction International, 2016
[9] World Drug Report, UNODC, 2016
[10] Easter Europe and Central Asia: Let's not Lose Track, Eastern Europe and Central Asia Union of PLHW (ECUO), 2016
[11] Ibid
[12] UNAIDS, "AIDSinfo", http://aidsinfo.unaids.org/ Accessed in August 2020
[13] McClarity, L etal, Estimating female sex worker's early HIV and Hepatitis C risk in Dnipro, Ukraine: Implications for epidemic control, 2016
[14] UNAIDS "Gap Report", 2014
[15] Prevention Gap Report, UNAIDS, 2016
[16] People Living with HIV Stigma Index surveys, 2013–2015

common with at least half of adults in eight countries saying they would not buy vegetables from a shopkeeper who is living with HIV [17].

High coverage and quality of harm reduction services remain essential in a region where nearly one third of new HIV infections are among people who inject drugs. Needle–syringe programmes are in place across the region, but they are often at limited scale. Several countries, including Belarus, Kazakhstan, the Republic of Moldova and Ukraine, have maintained and scaled up harm reduction programmes with government resources, leading to reductions in new HIV infections among people who inject drugs. The coverage of opioid substitution therapy, which has proven to be efficacious and cost-effective, remains suboptimal throughout the region. There are fewer than 10 operational sites in many countries and opioid substitution therapy is not available in the Russian Federation, Turkmenistan and Uzbekistan[18].

By the end of 2019, 70 percent of people living with HIV were aware of their HIV status. 44 percent of all people living with HIV (PLHIV) were accessing ART in EECA at the end of 2018, one of the lowest coverage rates in the world. The estimated percentage of PLHIV who achieved viral suppression marginally increased from 26 percent in 2017 to 43 percent in 2018.[19]

A majority of countries in the region have officially adopted a test-and-treat policy, but due to resource constraints and barriers to treatment among key populations, the pace of treatment scale-up is slow and coverage remains among the lowest in the world[20].

The region also faces epidemics of tuberculosis (TB) and hepatitis C virus (HCV) which require an integrated approach to prevention, diagnosis and treatment that is currently lacking. The TB incidence rate is falling in EECA region, but not fast enough to reach the first milestone of the End TB Strategy; that is, a 20 percent reduction between 2015 and 2020. The Region has almost reached the 2020 milestone, with a reduction of 19 percent between 2015 and 2019.[21] The annual number of TB deaths is also falling and is on track to reach the 2020 milestone, with a 31 percent reduction from 2015 to 2019 (35 percent reduction 2015-2019 target).

The burden of drug-resistant TB is of major interest and concern at global, regional and country levels. In 2019 in EECA region out of estimated proportion of TB cases, 19 percent were new rifampicin-resistant TB (MDR/RR TB) and 52 percent previously treated cases. The highest proportions (>50 percent in previously treated cases) were recorded in countries of the former Soviet Union. 89 of new and 93 percent of bacteriologically confirmed previously treated TB cases are tested for rifampicin resistance in the region.

TB treatment coverage is high 88 percent. Treatment success rates of new and relapsed TB cases remains unchanged for the last decade and account for 75 percent. 55 percent of HIV positive people are undergoing the preventive TB treatment.

The annual number of TB deaths is falling in the region and is on track to reach the 2020 milestone, with a 31 percent reduction in TB deaths from 2015 to 2019. In 2019 HIV -negative TB deaths represented 2.2 and HIV positive TB death 0.45 per 100,000 population.

1.3 Transition Context in EECA Region

In the era of declining development assistance for health, transitioning externally funded programs to governments becomes a priority for donors. This process requires a careful approach not only to preserve the public health gains that have already been achieved but also to expand on them.

In 2016, the Global Fund agreed to a Sustainability, Transition, and Co-financing (STC) Policy. The policy allows for extra time for governments and civil society to plan for Global Fund exit, and

[17] Miles to go: closing gaps breaking barriers righting injustices, Global Aids Update, 2018
[18] Ibid
[19] UNAIDS, "AIDSinfo", http://aidsinfo.unaids.org/ Accessed in August 2020
[20] Treat all: policy adoption and implementation status in countries, November 2017. Geneva: World Health Organization; 2017 http://apps.who.int/iris/bitstream/handle/10665/259532/WHO-HIV-2017.58-eng
[21] Global TB Report, World Health Organization, 2020

provides guidance (and in some cases, extended financing) for countries to plan well in advance how their programs will be funded and implemented once Global Fund resources are no longer available. It also emphasizes the particular vulnerabilities of prevention services run by and for key populations (like harm reduction services for people who use drugs, or programs for sex workers, men who have sex with men, and transgender communities) that are unlikely to be funded by national and local governments without sustained pressure and advocacy. Some countries in EECA region had already lost Global Fund support or were in their final funding cycle by the time this policy was enacted, however, and have faced challenges during the transition process as a result (Table 2). Some countries are expected to graduate from support from the Global Fund before 2025 as they move to the high income group and components are categorized as low or moderate disease burden.

Table 2: Status of transitions from Global Fund support in the EECA region[22]

Code	Country	Disease	Last funding from GF	Transition projections	Transition in reverse
ALB	Albania	HIV	2017	2020-2022*	
		TB	2018		
BGR	Bulgaria	HIV	2017		
		TB	2018		
BIH	Bosnia and Herzegovina	HIV/AIDS	2018		
		Tuberculosis	2016		
MKD	N. Macedonia	HIV/AIDS	2017		
		Tuberculosis	2017		
MNG	Montenegro	HIV	2015		Since 2017
RMN	Romania	HIV/AIDS	2010		
		Tuberculosis	2016		
SRB	Serbia	HIV/AIDS	2014		Since 2016
		Tuberculosis	2015		
XKX	Kosovo	HIV/AIDS		2022-2024	
		Tuberculosis		2022-2024*	
MNG	Montenegro	HIV/AIDS	2009		Since 2016
		Tuberculosis	2009		

Source:
Projected transitions from Global Fund country allocations by 2025: projections by component, GF, March 2018 update and January 2020
* Transition grant

Countries and components graduated from the GF support:

Bulgaria HIV. The last HIV grant was a rounds-based grant that was originally planned to end on 31 December 2015. In order to support the country with HIV prevention activities for key populations, the grant was extended and then went through a closure period that ended in September 2017. In both 2016 and 2017, as per the Global Fund's eligibility list, Bulgaria HIV was potentially eligible for funding under the NGO Rule. However, Bulgaria did not meet the political barriers requirement of the rule. Therefore, Bulgaria has been determined not to be eligible for an HIV allocation for the 2020-2022 allocation period. Bulgaria had an existing TB grant from the 2014–2016 allocation period which ended in September 2018.

Bosnia and Herzegovina: The last rounds-based HIV grant ended on 30 September 2016, after which it went through a grant closure period. At the end of 2017, the Global Fund Secretariat, using flexibilities under the STC Policy, exceptionally approved to continue the grant closure period through 31 November 2018. This allowed the continuation of a limited number of activities to facilitate the transition of prevention and care and support services for key populations in Bosnia and Herzegovina. The end date for the last TB grant was 31 July 2016.

North Macedonia: lost eligibility for Global Fund support with the introduction of the New Funding Model and the 2014 eligibility criteria. The last rounds-based HIV grant came to an end in

[22] There are no active Global Fund malaria grants in the EECA region.

December 2017. This was after a 12-month non-costed extension of the grant was made using flexibilities under the STC Policy to help ensure a responsible transition of HIV activities, and to support ongoing efforts at the country level to advocate for increased domestic resources for key and vulnerable populations. With this slightly extended time period for adjustment, Macedonia has engaged in transition planning to prepare for total domestic responsibility for HIV response. This process has taken place against a background of significant political instability, coming to a head in late 2016, after which the country remained without a functioning government for approximately six months. The last TB grant formally ended in September 2016. There was a non-costed grant extension to 31 March 2017 to support the country to transition from Global Fund support.

Macedonia and Bosnia and Herzegovina were ineligible for Global Fund support as early as 2010 because they were categorized as upper-middle-income (UMI) countries and had less than a high disease burden for both HIV and TB. Both countries benefited from a previous policy provision which allowed them to still be considered as lower-middle-income (LMI) countries.

Romania: Although Romania is not ineligible to receive the Global Fund funding for HIV response since 2010 when its last Global Fund HIV grant came to an end. The current TB "transition grant", as well as all previous TB grants to Romania, includes a significant component on HIV prevention among key affected populations (KPs). Romania was considered eligible for an allocation for HIV/AIDS for non-governmental or civil society organizations if the country demonstrates the barriers to providing funding for interventions for key populations, as supported by the country's epidemiology. However, as 2020 is an allocation year, the Secretariat has conducted an assessment and has determined that Romania does not meet the requirements under Paragraph 9b of the Eligibility Policy. Therefore, Romania has been determined not to be eligible for an HIV allocation for the 2020-2022 allocation period.

Serbia TB. The last rounds-based TB grants ended on 31 March and 30 June 2015.

Countries started transition planning for some components. The Global Fund expects all eligible UMI countries and all eligible LMI countries with components whose disease burden is classified as low or moderate to begin sustainability and transition planning, or to build upon existing planning, during the 2017–2019 period. While it is not possible to predict with certainty transition timelines, components from low-income countries (regardless of disease burden)[23] and components from Lower Middle Income (LMI) countries with a disease burden classification of high or above are not expected to transition from the Global Fund support imminently. But under the STC Policy, they are expected to focus on long-term sustainability planning by supporting the development of robust national health strategies, disease-specific strategic plans and health financing strategies. There are few countries in the EECA with components that are in this cohort and that are not already on the list of components projected to transition by 2028: Armenia (HIV) and Kosovo (HIV & TB) have moved to UMI status between 2018-2020 and eligible for transition funding in 2020-2022 and Kazakhstan (HIV & TB) projected to become ineligible in the 2026-2028 allocation period (not eligible for transition funding). Countries yet eligible already started working on transition. For example, both Belarus and Georgia have already developed formal transition plans and have started to implement them[24].

Albania: Albania was successful in getting Global Fund support for the period of 1 October 2017 to 31 December 2019 for TB and HIV but was unable to commence implementation before mid-2018. The selection of Sub-Recipients (SR's) was finalized in July 2018 and the procurement of goods was concluded at the end of 2018. Consequently, all SR's, especially CSO's, were left with only one year for implementation. Grant indicators did not change as a result of the delay and this put considerable pressure on CSO's, leading to a lack of motivation to implement the Grant.

By April 2019, Albania submitted a Transition Fund Request (TFR) to the Global Fund which was approved by the Board in June 2019. The TFR covers the period 2020–2022 and, "the overall

[23] There are no low-income countries in EECA region.

[24] Status of transitions from Global Fund support in the EECA region, EHRA, 2018

focus of the request is on preparing Albania for a gradual transition from a national HIV response with major support from the Global Fund to one that is sustainable with national resources."

Transition in reverse: Components that regained their eligibility: Components are eligible to receive an allocation following their disease burden classified as 'high', and after they were determined to be eligible for a second year in succession.

Montenegro (HIV). Montenegro became ineligible for Global Fund support in 2014, and its remaining grant funds were expended by June 2015. This was one of the shortest windows for transition experienced by any country in South Eastern Europe, and it pre-dated the Sustainability, Transition and Co-Financing Policy. Montenegro had been encouraged to think about sustainability from the start of the second grant period, and during that time, the government took over responsibility for many of the expenses of the HIV response, including full funding for expanded ART, opioid substitution therapy, and center-based testing and counseling. The country became re-eligible for a limited allocation of Global Fund support in the 2017-2019 period on the basis of its alarming 12.8 percent disease burden among MSM.

Serbia HIV. As a UMI country, Serbia's funding ended abruptly after its HIV burden was lowered to moderate. Its HIV burden classification went back up to high in 2015.

Both Montenegro and Serbia were told, via their allocation letters, that their allocations for 2017–2019 were conditional on their funding requests focusing on key affected populations. Specifically, the letters stated that the allocations "are dependent on the functionality, in form and substance acceptable to the Global Fund, of a social contracting mechanism for engagement of non-governmental organizations through which the … governmental institution(s) and the Global Fund will finance HIV prevention, care and support activities."

Eligible components: For the 2020-2022 allocation period, the Global Fund made minor refinements to the allocation methodology to deliver the aims of its 2017-2022 Strategy and to increase the impact of country programs that prevent, treat and care for people affected by HIV, TB and malaria, and build resilient and sustainable systems for health. All countries that were eligible for an allocation for the 2017–2019 period were included in the 2020 list except Albania. Albania's HIV and TB components were allocated Transition Funding during the 2017–2019 period following the country's upgrade to upper-middle-income status in 2015. Listing of the components eligible for 2020-2022 allocation period is provided in the Table 3 (only for countries included in the research).

Table 3: 2020-2022 Allocation Table

Code	Country		Disease	Allocation Currency	Allocation (USD Equivalent)	Country Total (USD Equivalent)	Planned for transition [25]
GEO	Georgia	ULMI	HIV/AIDS	USD	12 076 771	17 556 486	
GEO	Georgia		Tuberculosis	USD	5 479 715		
XKX	Kosovo	UMI	HIV/AIDS*	EUR	1 990 223	3 275 872	2020/2022
XKX	Kosovo		Tuberculosis*	EUR	1 285 649		2020/2022
MDA	Moldova	ULMI	HIV/AIDS	EUR	9 554 788	19 920 798	
MDA	Moldova		Tuberculosis	EUR	10 366 010		
MNG	Montenegro	UMI	HIV/AIDS	EUR	620 000	620 000	
SRB	Serbia	UMI	HIV/AIDS	EUR	1 663 981	1 663 981	

* Transition grant

[25] Projected transitions from Global Fund country allocations by 2028: projections by component, The Global Fund, January 2020 update https://www.theglobalfund.org/media/9017/core_projectedtransitionsby2028_list_en.pdf?u=637104488100000000

1.4 Rationale and Objectives

Historically, the HIV response has been largely funded by international donors and governments. However, in the era of declining development assistance for health, transitioning externally funded programs to governments becomes a priority for donors. Low- and middle-income countries are now beginning to lead on efforts to finance their HIV and TB response. However, the process requires a careful approach not only to preserve the public health gains that have already been achieved but also to expand on them.

Although challenging for low- and middle-income countries, shifting towards domestic funding has advanced. Despite rising financial commitments, the future outlook of global funding for the HIV and TB response remains uncertain. Concerns have been raised regarding the effect transition may have on the HIV response. The Global Fund Advocates' Network argues that using a country's income level as a measure of its ability to sustain a public health response does not factor in that country's willingness and ability to absorb programmes into its domestic funding and operational structures.

Despite the government's commitments, and numerous low and middle income countries deploying a range of strategies to increase the efficiency and sustainability of their HIV and TB programmes, it is unlikely that many, will be able to shoulder the financial burden for tackling the HIV epidemic in the near future. This signals that current funding gaps will remain and may increase in future years.

Throughout the HIV pandemic, civil society organizations (CSOs) often have been first responders to the HIV response. Reflecting this reality, CSOs have been an integral part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) activity implementation since the inception of both landmark global health initiatives, playing a critical role across global, country, and community levels. CSOs have been able to extend and expand the reach of government-led health systems, adding value to HIV and TB prevention efforts and supporting persons living with HIV (PLHIV) and TB in adherence and retention of services. CSOs were instrumental in shaping public health policy and governance of country programs, as well as in leading advocacy for reforms that reflect rights-based approaches. The benefits CSO service delivery provides to national governments are essential to any HIV and TB response, including their unique role in reaching vulnerable and marginalized persons impacted by HIV and TB.

While many governments have shown a strong willingness to fund HIV and TB treatment, very few have stated their commitment to continuing and expanding community-based prevention programmes aimed at key populations, the people who are most affected by HIV & TB.[26]

In order to make significant progress, the investments to reach the end of AIDS and TB as a global public health threat by 2030 need to be increased and front-loaded during the next few years or countries will be overwhelmed with increasing costs.

Given that countries in EECA region are scheduled to gradually transition from the GF financial support in or before 2025 (for HIV), it is timely to assess CSO sector's readiness to transition, identify areas which have to be emphasized while developing/updating national transition plans. Although no "one-size-fits-all" approach exists to transition, previous experiences highlight a need for both early planning and monitoring of the transition along several key dimensions observed at present.

The overarching aim of this research is to assess national governments' and CSOs' readiness to transition of HIV and TB services provided by CSOs and define a way forward to ensure a smooth transition from TGF funding towards fully domestic funding.

The research will attempt to answer following questions:

[26] Transition from donor funding to domestic reliance for HIV responses- Recommendations for transition countries, AIDSPAN/APM Global Health, 2016

9 What are gaps and challenges faced by CSO's in the transition from Global Fund assistance to government support of services for key populations (KP) and TB patients in EECA region?
10 Are countries equally attending issues related to sustainment and expansion of CSO provided services in the field of HIV and TB during transition planning and implementation of transition plans?
11 What is the CSO sector readiness to transitions?
12 How the government plan for transition?
13 What are the strategies utilized by CSOs to ensure smooth transition and sustainability?
14 What are transition related challenges CSOs face?
15 What are the lessons learned from countries which graduated from Global Funs support.
16 What is a way forward to ensure sustainability of CSO provided services?

1.5 Research Methodology

1.4.1 Conceptual framework

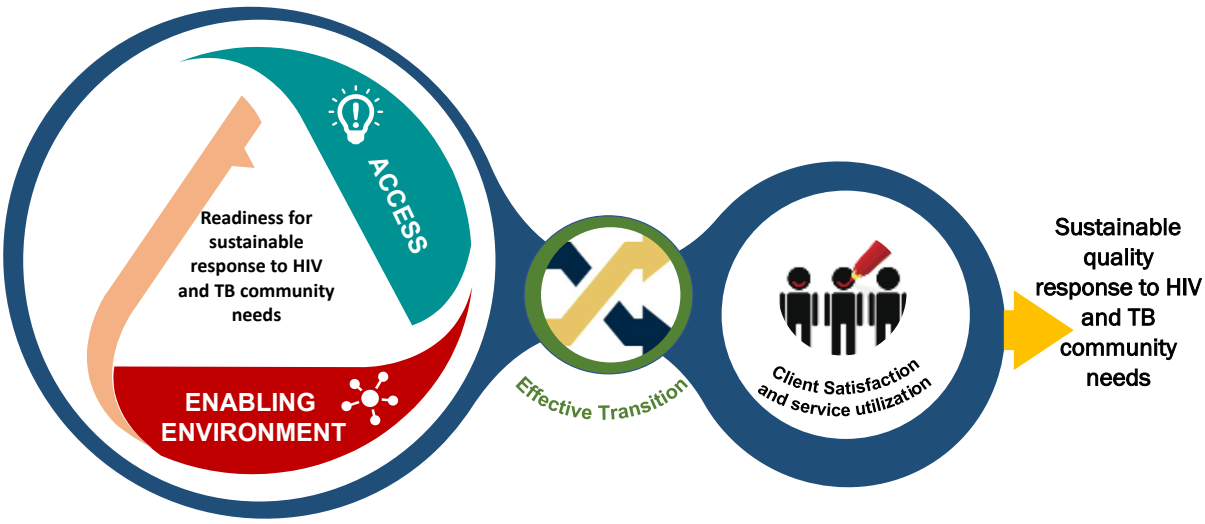
To answer research questions, the research was guided by conceptual framework detailed below and schematically presented on Figure 2.

In order to meet Sustainable Development Goals (SDG) goals by year 2030, countries have to aim at ensuring sustainable quality response to HIV and TB community needs measured by service utilization and client satisfaction. Attainment of the given objective will be unrealistic if countries fail to sustain quality response to HIV and TB community needs.

In order to sustain quality response to HIV and TB community needs, national governments have to establish enabling legal environment, ensure adequate supply of service providers, particularly of non-public, including CSOs, foster demand for services and warrant effective transition of CSO provided services from external support to domestic financing. All these elements will ensure client satisfaction and service utilization.

The research will examine the following domains of the research framework to draw conclusions and formulate recommendations.

Figure 2: Research framework



Enabling environment : Extent to which the national governments ensure adequacy of the legal base for CSOs to continue and further expand preventive, treatment, care and support services to their clients

- Disease policy and CSO role: Government disease specific policy/strategy/state program is approved and has sufficient legal power; clearly defines target population (KP groups and TB patients) and outlines CSO roles and functions in national response to HIV & TB.

- Legal and regulatory enablers for CSO contracting and practice: availability of the legislative and regulatory framework for CSO contracting; current practice of CSO contracting and funding levels; CSO perceptions on the barriers to contracting and challenges with implementation; availability of costed standard service packages for each type of key affected population.
- Service standards: standard service packages defined and approved for each KP groups and TB patients; services listed in the standard service package are well aligned with client needs, clearly define coordination and referral mechanisms between CSOs and other service providers and are costed

Extent to which national governments mobilize adequate domestic financial resources and allocate sufficient public funding for CSO provided services guided by standard service packages, as well as ensures national planning for effective transition.

- Budgeting: Funding sources for the provision of preventive and outreach services by CSOs defined in the National State programs/NSPs and dedicated budget line for CSO contracting included in annual budgets
- Funding: CSO funding trends and composition by financier;

Supply domain: Under supply domain the research will examine:
- CSO engagement: Availability and number of CSOs engaged in national disease responses; CSO legal status and organizational structure;
- CSO resources and capacity: funding sources and knowledge skills of human resources

Access: Extent to which KP and TB patient needs are met and access to needed services guaranteed. Access is defined as the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled. Access will be measured by i) access to information about available services and source of information; ii) geographical access to health facility-based services, waiting times for appointment; iii) access to treatment and medicines; and iv) needs not covered by provided service packages.

Effective Transition:

Availability of approved national transition plans
- Availability of national transition plans with sufficient legal power based on the findings of country's transition readiness assessment or elements of transition plan included in the NSPs
- TSP or NSPs address issues related to the sustainment of CSO provided services
- TSP implementation shows satisfactory progress

Strategies applied by CSOs to sustain services addressing needs of the patients and clients.

Client Satisfaction: Under this domain the research will examine client access to needed services and overall client satisfaction with received services.

1.4.2 Study setting and sample

Figure 3: Geographical scope of the research

The study was commissioned by the South East European (SEE) Regional HIV and TB Network (RNC) and implemented with active participation of its members. The country sampling methodology aimed at sampling and grouping countries in three clusters.

The first cluster included countries which completely graduated from GF support for

both or one of the disease components to inform on the experience with transition planning, transition process and an impact of transition on sustainability of HIV and TB services in these countries (Table 4).

To inform strategies applied for transition planning Cluster 2 included countries scheduled for transition by 2025 for both or one of the components. And finally, the third cluster included countries yet eligible and having time for long-term sustainability and transition planning and countries with components that regained their eligibility. In total 9 countries (Albania (ALB), Bosnia and Herzegovina (BIH), Georgia (GEO), Kosovo (XKX), Moldova (MDA), Montenegro (MNE) North Macedonia (MKD), Romania (RMN) and Serbia (SRB) expressed their willingness to be included in the study and contribute to this knowledge product.

Table 4: Countries and CSOs included in the study

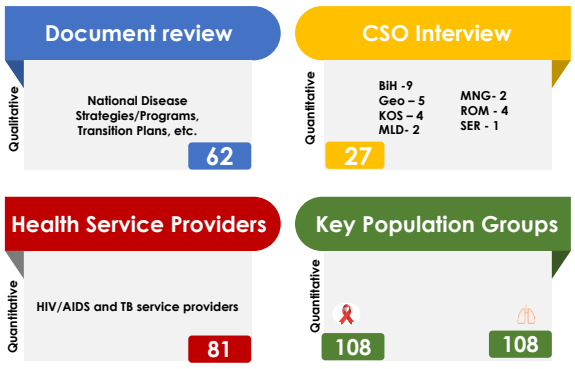
Cluster	Country	# of CSOs
Cluster 1	Albania (ALB)	-
	Bosnia and Herzegovina (BIH)	9
	N. Macedonia (MKD)	-
	Romania (RMN)	4
Cluster 2	Kosovo (XKX) (also represent cluster 3)	4
Cluster 3	Georgia (GEO)	5
	Moldova (MDA)	2
	Montenegro (MNE)	2
	Serbia (SRB)	1
Total	**9 countries**	**27**

For research purpose, Initial contacts were made with the members of the Association and interested CSOs in studied countries that covered both large CSOs and their Sub-recipients (SRs) (i.e., smaller NGOs and CBOs) to ensure that they had ever been or were currently engaged in collaborative relationships with the Government and had work experience in the field of HIV/AIDS and TB. In total 27 CSOs participated and filled in the quantitative survey.

1.4.3 Structure of the Assessment, Data Collection Tools, Methods and Analysis

A qualitative and quantitative methodologies was adopted to allow for an in-depth analysis and detailed description of the origins and elements of the transition preparedness of CSOs and what their successes and challenges might be.

Figure 4: Data sources and type of analysis



Two major methods were utilized and triangulated to gather data – quantitative interviews of CSOs, health professionals and direct beneficiaries and review of organizational documents of the countries and CSOs. In case of Albania the research was limited to quantitative data collected from service providers and clients (KP and TB patients) and desk review, whilst in N. Macedonia, the research was informed by findings of the document review only. The wider literature on CSOs and HIV/AIDS/TB and information on the internet was used to enhance the reliability and external validity of the findings. In total, 27 quantitative interviews were conducted with participants from the CSOs, 81 health professionals and 216 direct beneficiaries (108 KP and 108 TB patients). The interviews were conducted consecutively until a point of saturation (e.g., when additional interviews yielded no new insights for the study) was reached.

Both, desk review and quantitative data analysis, from the above sources have been carried out to arrive at conclusions and formulate recommendations, presented in this report. Findings were triangulated across key informants and compared with available documentary evidence. Qualitative data analysis entailed documentation, conceptualization, coding in Nvivo (qualitative analysis software), categorization and examining relationships. The quantitative data was derived from the data obtained through quantitative research caried out in countries included in the study. Analytical methods included trend analysis for quantitative data, where possible.

To assure the quality of findings the evaluation team used: i) elements of multiple coding, with regular cross checks of coding strategies interpretation of data between local and international experts participating in the study; ii) used grounded theory[27] for data analysis that helped to mitigate the potential bias enshrined in the experts' prior theoretical viewpoint; iii) triangulation from different sources of data collected during the evaluations, helped to addresses the issue of internal validity by using more than one method of data collection to answer research questions; and iv) respondent validation, which involved cross checking interim and final evaluation findings with key informant respondents enhanced the rigor of the evaluation results.

1.6 Report structure

This report presents data and findings from the study in 3 chapters:

Chapter 1 Outlines the regional context, purpose of the study and its objectives and research methodology;
Chapter 2 Presents findings
Chapter 3 Summarizes the findings of the study and its general recommendations for sustaining and enhancing the role of CSO during and after transition

[27] Thomas DR. (2018) Grounded theory. Chapter 22 in How To Do Primary Care Research, edited by Goodyear-Smith F and Mash R.

2. Research findings

2.1 Role of CSOs in HIV and TB national response (enabling environment)

Civil society organizations (CSOs) are generally recognized as playing an exceptional role in the global AIDS and TB response[28]. They mobilize communities to demand services, act as service providers, and gather strategic information that informs policies. In most countries, these early civil society initiatives are the foundations on which the national response has been built, and it is civil society which remains at the forefront of prevention, care and support programmes, particularly among the most vulnerable and hard-to-reach populations.

As the fight against HIV and AIDS shifts from an emergency response to a long-term response, the role of civil society organizations, including community-based, non-governmental and faith-based organizations in HIV and AIDS prevention, care and support efforts became even more important. Civil society plays a critical role in HIV and AIDS advocacy and service delivery. Without civil society, fewer services be available to key populations, people in remote areas would have to travel further for services and many of the gains made in treatment because of civil society advocacy would not exist.

The research examined the weather studied countries introduced enabling environment for CSOs to play their role by examining the roles and functions delegated to CSOs as outlined in the national HIV and TB response. There are at least two critical roles CSOs play globally and in specific country settings: advocacy and service delivery.

Advocacy: In most countries CSOs have extensive experience in advocacy related to HIV/AIDS, though less in TB. Whether it is a global campaign for universal access to antiretroviral therapy or a national campaign to strengthen men who have sex with men networks to advocate for increased and improved services, CSOs can point to many successes in a variety of settings. At the country level, community and civil society representatives participate actively in the decision-making process through membership in the Country Coordinating Mechanism (CCM), the national body that is responsible for creating the requests for funding and overseeing implementation. While it is still a challenge to ensure that everyone is able to contribute in a meaningful way, CSOs are increasingly making their voices heard.

> The advocacy role of civil society and communities – questioning the status quo, demanding change, mobilizing action, seeking accountability from governments and non-government actors – is critical to ending TB, AIDS and Malaria
>
> *RD Marte, GFAN Asia Pacific & APCASO*

In addition to participation in the CCM, community and civil society play a key role in ensuring a thorough and empowering country dialogue around the responses to AIDS and TB. Community and civil society organizations also play an important role in influencing how government budgets address health and in delivering messages that hold governments accountable and transparent. In both donor and implementing countries, communities and civil society are an important partner in advocating for increased government health spending and resource mobilization.

Aspects of advocacy related to HIV/AIDS and TB in which CSOs are engaged include but are not limited to increasing accountability and transparency of a government's national commitments and planned results; reducing legal and policy structural barriers to a quality HIV and TB response; reduce stigma and discrimination for key affected populations; support civil society networks/coalition and promoting the ability of citizens to recognize and demand quality services in their communities.

[28] Buse K, Blackshaw R, Ndayisaba MG, Zeroing in on AIDS and global health Post-2015.Global Health. 2012 Nov 30; 8():42.

These organizations also play a critical role in representing the needs and interests of key and vulnerable populations in the design and implementation of programs, and in monitoring for quality and equitable access, to ensure that programs are implemented as intended.

Service Delivery: CSOs work across the spectrum of HIV/AIDS and TB response providing a range of services. it is clear that CSOs play a critical role in supporting populations marginalized and excluded from mainstream health services. There is ample evidence demonstrating that programs implemented by communities and civil society are fundamental to ending the three diseases.

> Government s and the private sector have key roles in global health, but civil society is the oil in the engine. An engaged civil society drives progress
>
> Peter Stands, Executive Director of the Global Fund

The review of the countries' national HIV and TB response documents shows that albeit CSOs are represented at CCM, their role and engagement in advocacy, policy planning and ensuring transparency in accountability is not commonly acknowledged and highlighted in these documents (Table 5).

Table 5: Role of CSOs in national HIV & TB response

	Cluster 1				Cluster 2	Cluster 3			
	ALB	BIH	MKD	RMN[29]	XKX	GEO	MDA	MNE	SRB
Advocacy									
Seat in CCM	*	-[30]	*	na			*	*	*
Advocacy	*	*		na	*	*			
Policy Planning		*		na		*	*	*	*
Monitoring		*			*				
Service Delivery						*	*		*
Partnership with the civil sector	*		*	na	*	*	*	*	*
Prevention activities	*		*	na	*	*	*	*	*
Treatment/distribution of commodities	*		*	na	*	*	*	*	*
Treatment adherence support				na	*	*	*		*
Care and support (psycho-social, legal, etc.)			*	na	*		*		*
Referral to health and social services		*		na			*		*
Information, education, behavior change communication		*	*	na		*			*
Na – not available									

Partnership with civil sector, affirmed in national disease response documents, is mostly seen by the governments in service delivery, being it provision of preventive, treatment, care and support services to key affected population groups and TB patients. The role of civil society is less appreciated in the area of treatment adherence support services.

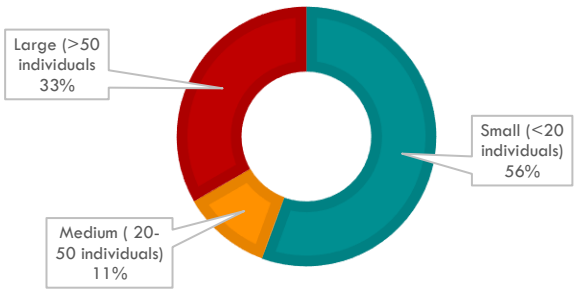
2.2 CSOs and the Role they perform in HIV and TB National Response (supply)

All studied CSOs are non-profit, non-commercial organizations. More than half of them are either associations or Foundations. The size of CSOs measured by number of employees varies (Figure 5). One third of CSOs studied are large CSOs, mostly operating in BiH, Romania, Moldova and Georgia. 56 percent represent small CSOs with less than 20 staff members and only 11 percent are medium size CSOs (Figure 5).

[29] Health Ministry has developed a strategic national plan for the supervision, control, and prevention for HIV-AIDS for the 2019-2021 period. However, it was not approved and implemented

[30] CCM discontinued its operations after transition from GF funding

Figure 5: Size of CSOs



Majority of CSOs represent particular groups of population and are service providers.

Some are only service providers, some in addition to service provision also protect rights of particular groups of population or represent particular groups of population. Organizations that protect the rights of various groups represent only one third of surveyed organizations and only few (7 percent) in addition to service provision are think tank organizations (Figure 6).

Some CSOs serve particular groups of population, while the others' mandate is wider representing and providing services to various groups of population. Out of 27 CSOs included in the study, 4 CSOs serve only TB patients, 2 CSOs People who inject drugs (PWID), 3 CSOs Men who have sex with men (MSM). Remaining CSOs service a multiple groups of populations including transgender, People living with HIV (PLHIV) and women of reproductive age. CSOs perform different functions. Few of them report performing advocacy function, while all provide services to one or several groups of population. Majority of small CSOs target particular group of population such as People Living with HIV (PLHIV), Sex workers (SW), Men who have Sex with Men (MSM), People with Injecting Drug Use (PWID); Transgender, etc. and provide preventive, care and support services. Medium and large CSOs have wider coverage of different KP groups and TB patients.

Figure 6: Type of Organizations

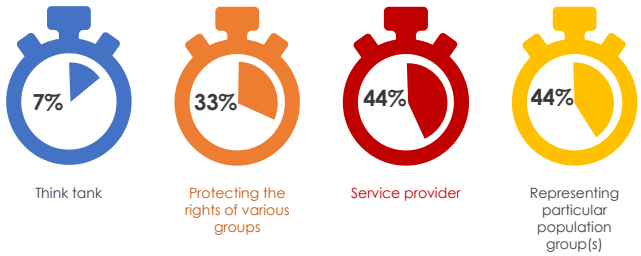
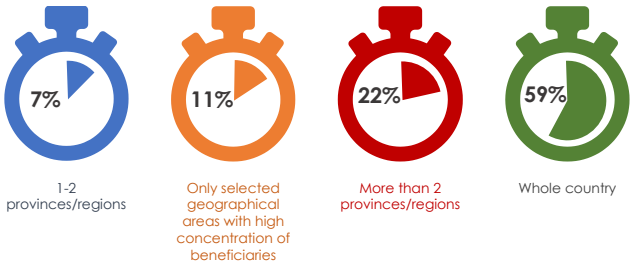


Figure 7: Geographical coverage



Majority of surveyed CSOs (88 percent) have work experience for more 8 years, 10 percent from 2 to 5 years, and only 2 percent are young, working only for about 2 years.

Most of CSOs are based in the capital and cover the whole country (Figure 7). 41 percent CSOs have regional representation in other geographical areas outside of the place of registration. 22 percent cover more than 2 provinces/regions and only 7 percent serve 1-2 provinces/regions.

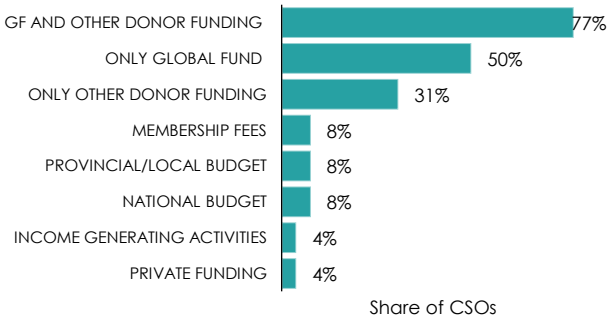
2.3 Financial Viability of CSOs (Enabling Environment)

External donors have historically contributed a significant amount of financing for health programmes in low- and middle-income countries. Current reliance on international donors for a substantive portion of HIV and TB financing, coupled with a substantial expected reduction in international assistance in the short-term, are key challenges to the sustainability of HIV & TB programming.

In recent years, international donors have begun tapering foreign assistance. Donors are instead focusing on transitioning the management of development programs and disease responses to country governments—helping reduce countries' dependence on foreign aid and preparing them to manage their own development challenges, without the need for external funding.

If this transition to self-reliance is to succeed, countries have to strengthen their capacity to implement policies, mobilize and manage public resources, and incorporate locally-led development principles, while maintaining progress already gained and to further expand. One crucial piece to these transitions is the continued role of civil society organizations, organizations that have typically been supported by external donors.

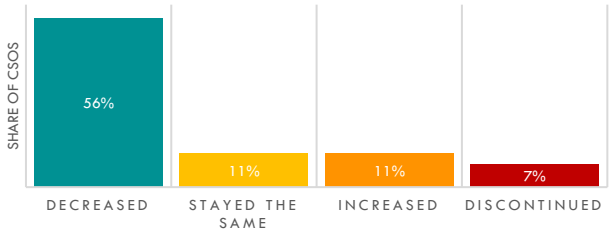
Figure 8: CSO Revenue Sources



The study revealed that CSOs yet remain heavily dependent on the external support. Two third of CSOs reported being mostly financed by GF and other donors (Figure 8). Half of CSOs in target countries are purely financed by GF and few have other sources of funding from membership fees and private sources. Notably, number of CSOs financed from public purse, national or provincial/regional budgets, are few. CSOs from graduated countries (BIH and RMN), are financed mostly by other donors or external sources.

CSO funding changed over the past five years. 11 percent of CSOs reported no changes in revenues, whereas 56 percent of them expressed concerns with declining funding and 7 percent reported discontinuation of funding from existing sources. Only 11 percent of CSOs noted slight increase of funding their activities (Figure 9).

Figure 9: Change in CSO revenues



In this era of diminishing foreign assistance, the essential functions civil society organizations provide, linking individuals and communities into healthcare and extending the reach of government programs, are at high risk.

Financial and economic crises have affected the levels of public spending on health and social services to varying degrees in all the countries of the EECA region. The need to achieve greater impact in the face of declining resources have pushed many governments to re-examine the ways being used to deliver prevention, treatment, support and care services to their citizens. The notion of what constitutes the appropriate level and the "right mix" of services is open to debate.

Dynamics around the funding landscape for especially prevention services to key populations through CSOs is of great concern as reduced funding may lead to their total shutdown or substantial downscaling.

Social contracting is one of the key pillars of ensuring continued service provision to key populations and people living with HIV and sustainable financing in many countries of the region. It however is not a magic bullet but rather one of the mechanisms by which CSOs can access funding at various states levels.

Social Contracting Definition

While there is no universally adopted definition of social contracting, it is broadly understood as Civil Society Organizations (which include and serve key populations) receiving government funding to deliver health prevention, treatment, care and support services.

Source: UNDP

While there is no universally adopted definition of social contracting, it is broadly understood as Civil Society Organizations (which include and

serve key populations) receiving government funding (contact, grant, etc.) to deliver health prevention, treatment, care and support services[31].

Social contracting is practiced in other sectors in all countries covered by the research. The governments are gradually utilizing social contracting mechanism in the health sector including in the sphere of HIV and TB. Main sources of funding are national government institutions (various sector ministries, other public agencies, local self-governments, etc.).

Table 6: Experience with social contracting by eligibility status

Country	Eligibility Status for 2020-2022 allocation period	Experience with social contracting
Albania	Not Eligible (HIV & TB)	No
Bosnia and Herzegovina	Not Eligible (HIV & TB)	Yes
Georgia	Eligible (HIV & TB)	Yes
Kosovo	Eligible (HIV & TB)*	No
Moldova	Eligible (HIV & TB)	Yes
Montenegro	Eligible (HIV)	Yes
N. Macedonia	Not Eligible (HIV & TB)	Yes
Romania	Not Eligible (HIV & TB)	No
Serbia	Eligible (HIV)	Yes

** Transition grant*

CSOs from six countries (BIH, GEO, XKX, MNE, MLA, SRB) reported having experience of social contracting in the field of HIV (Table 6). Among these countries are countries, which already graduated from GF support and those which yet remain eligible for the next couple of years.

While it is commendable, that countries which yet remain eligible for GF funding already practice social contracting (GEO, MLA, MNE, SRB) and have sufficient time for refinement and expansion of this mechanism, 2 graduated countries (ALB and RMN), dependent on the domestic and/or other external funding for HIV response, don't apply social contracting. Further research is required to examine the impact of disruptions in the provision of HIV preventive, care and support services to KP groups.

Albania: Civil Society Organizations and community-based organizations in Albania implementing HIV prevention programmes targeting KPs face challenges accessing domestic funding. There is no full visibility on the funding opportunities, and ability of community-based organizations to access such funding. The national commitment to support a dedicated budget line for KP HIV services has not yet materialized and the breakdown of the current budget of the primary health care system does not provide the necessary clarity as to whether it includes only administrative staff costs or community-based interventions. If during 2018-2019 one CSO supported trainings of doctors and nurses and people affected by TB, after the end of available donor funding the CSO is struggling to get funds in support of TB actions. As reported, there is no interest among donors to support capacity building activities in TB sphere.

Given the efforts that CSOs have previously made in providing services to key populations in Albania, their active engagement in the process of transition that the country is undergoing is important. Assessing the efficiency and effectiveness of community-led interventions will allow them to advocate for budgetary allocations for community-led service delivery activities and to strengthen their collaboration with public institutions through the streamlining of a social contracting process. Notably, support to TB related activities, during the transition phase has been excluded by GF.

Availability of social contracting mechanism in a country does not necessarily mean that all CSOs have access to public funding. Only half of CSOs from six countries where social contracting is practiced in the field of HIV, reported having experience tapping public funding. Funding from domestic sources is extremely low (<10 percent of organization's annual budget). Consequently, social contracting requires to be scaled-up to allow self-sustainment and continuation of services provided by CSOs after the seize of external funding.

The scale up of social contracting is challenged by number of factors. Unlike foreign donors, governments often face legal, regulatory, structural, human resource, financial, and political barriers to supporting and contracting with civil society organizations to provide services. Hence

[31] UNDP definition

there is a need for governments to ensure that there are mechanisms in place to provide resources to civil society, including KP communities using domestic resources and to forge working mechanisms for their meaningful engagement in effective and cost-efficient service delivery.

Examples of CSO Contracting

BiH: Although BiH does not have legislation regulating CSO contracting, available grant schemes allow CSOs to tap public resources. Each year, in accordance with the annual State Budget Rebalance, the Ministry of Civil Affairs of BiH announces a public call for small grants. CSO/NGO implementing HIV-related programmes of interest to BiH are eligible to apply. The same goes for the announcement of CSO/NGO grants by various ministries and agencies at the level of Federation of Bosnia and Herzegovina and Republic of Srpska, and cantonal level in Federation of Bosnia and Herzegovina. CSO/NGOs have to submit a proposal that clearly describes activities to be performed.

N. Macedonia: HERA was involved in the participatory process of drafting the national HIV strategic programme. This resulted in recognition of young people in the 2009 National HIV Programme and moreover a budget was allocated for HIV education. In 2012, an inter-party parliamentary group on HIV was established by HERA as an advocacy strategy for improved domestic financing for HIV programmes. In 2013, with the contribution of the members of the Parliament, a public hearing was held in the parliament of the N. Macedonia, resulted in the 2014 budget for ARVs increased for 190% compared to the budget available in 2012. In 2014 in partnership with 15 NGOs, HERA established Platform on Sustainability of Services for HIV Prevention and Support with the mission to advocate for providing financial sustainability of HIV services beyond GF and their integration into the national and local self-governments programmes. As a result of the activities of the Platform, the 2015 HIV/AIDS Government programme recognized the need for accreditation of NGOs (drafting standards and setting up a registry of civil associations), including budgeting 14 NGOs to carry out HIV prevention activities among key populations.

Serbia: In 2013, Association RAINBOW launched an advocacy campaign for the access to funding for HIV prevention programmes at the local level. Nine districts in West and Central Serbia were covered, including 59 municipalities where the association implemented HIV prevention programmes among MSM. The advocacy process started with a conference in Belgrade, followed by the HTC on city squares, jointly with local partners (public health institutes, Red Cross and hospitals), meetings with representatives of local self-governments (LSG), where the current epidemiological status of HIV and other STIs, cost benefit analysis for HIV prevention and promotional material were presented and the need of continuation of prevention services after the GF was discussed. Local media reported widely about the campaign activities. As a result of the campaign, seven municipalities (39% of those covered by the advocacy campaign) announced calls for funding and Association submitted 16 applications out of which only seven projects were approved.

Lack of government willingness to invest in sufficient core funding for CSOs: Almost all countries, included in the research, highlight the role of CSOs in national disease responses. However, CSOs are often seen as a source and not a recipient of public funding. Their role is perceived more as a mechanism to attract donor funding to various parts of the country. CSOs are not seriously viewed as a recipient of national/local self- government funding for the provision of HIV and TB services.

Fiscal space and budgetary allocations: Ability to allocate sufficient funds for social contracting paired with lack of political will appears challenging for the scale up of the social contracting. Forecasted economic hardship caused by COVID-19 pandemic rises concerns on available fiscal space and level of resources government will be able to allocate to the health sector and within health budget extent to which governments will be able to allocate sufficient funding for HIV and TB national programs provided various competing priorities and additional funding needs for COVID-19 response.

Moldova: Domestic funding is mainly channeled via the mechanism of the so-called "2% law", which allows physical persons the right to donate 2% of their income tax to CSOs. Several legal changes were passed for this provision between 2014 and 2016 when the Government adopted rules of procedures to make operational funding for NGOs through the 2% designation, leading to a situation where this provision is fully operational.

Albania: The national commitment to support a dedicated budget line for KP HIV services has not yet materialised and the breakdown of the current budget of the primary health care (PHC) system does not provide the necessary clarity as to whether it includes only administrative staff costs or community-based interventions. Furthermore, there is no apparent role for CSO's in the TB sector.

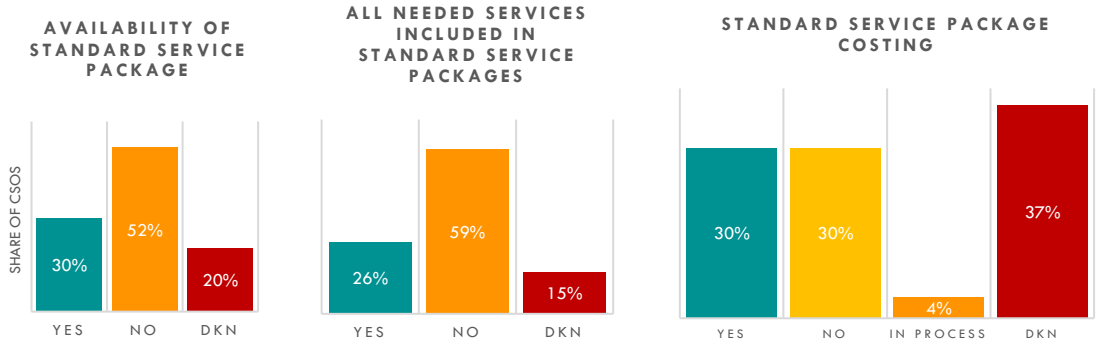
Countries, where social contracting operates, make insufficient efforts to assign a dedicated budget line for social contracting.

In case CSOs do get contracted, they are usually engaged in a project up to one year or provide one part of the required services. There are no reported cases of multi-year funding for service provision. In addition, signing of long-term contracts is difficult in practice, as most government's budgeting is performed on annual basis.

Lack of costed standard service packages for annual budget forecast: Service packages currently used for social contracting, are based on the package of services financed by the GF grant. Only one third of studied CSOs reported availability of the standard service packages for both HIV and TB services. Majority of them think that standard packages approved by the government do not meet client needs (Figure 9). Not all standards outline client referral and counter-referral pathways between CSOs, health facilities and other services to ensure service quality and continuity in service provision. Lack of referral and counter- referral mechanisms adversely affect treatment adherence rates and final outcomes.

Some CSOs are concerned whether governments will be able to afford funding of all types of services at a rate offered through GF grants. Notably, 37 percent of CSOs surveyed did not know whether the service packages for particular KP were costed.

Figure 10: Availability of comprehensive costed standard packages

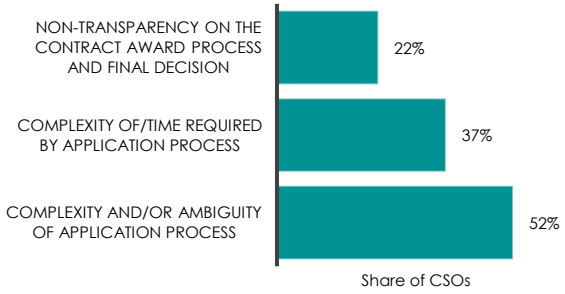


In order to bring the services in correspondence with the needs of the target population and with available public funds as well as allow annual budgeting for social contracting, CSOs together with KP have to proactively advocate for standardization of service packages ensuring coverage of all critically important services and be actively involved in the development process. The Ministry of Health in collaboration with CSOs and technical partners to revise the package of services for KP groups, elaborate definition of the covered clients as well as carry out costing of the service packages. The budget of the services to be publicly procured and provided by CSOs have to be

recalculated based on the actual unit costs according to the government tariffs and coverage targets for years to come.

Ambiguity of application and contract award processes: Weak social contracting regulatory base undermines effective implementation. More than half of CSOs noted complexity and ambiguity of the application process restricting access to public funding. More than one third of CSOs find the application process complex and time consuming and about one in every five CSOs reported lack of transparency in decision making and contract award processes (Figure 10).

Figure 11: Challenges of contracting/ granting CSOs



Georgia: While the general regulation allowing contracting of CSOs by the GoG exists in Georgia, yet the detailed rules and procedures for contracting CSOs for health services delivery do not exist.

Albania: Public funding for CSOs is limited and procedures for funds allocations are not clear.

Kosovo: Even though that the MoH and municipalities have been practicing to fund CSOs, there are no detailed rules and procedures for CSO contracting for health service delivery

Requirement of experience in provision of the required services precludes new/other CSOs to apply. Initially, social contracting tenders aimed at continuation of the previously implemented activities financed under the TGF grant and requested the applicant organizations to have working experience in provision of these services.

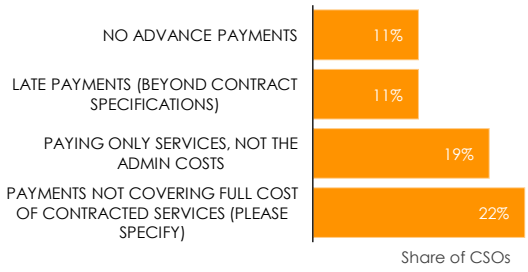
The latter requirement limited the participation of organizations not having sufficient work experience and created challenges for the delivery of services to KP and TB patients in particular geographical locations. There is no blueprint that can be applied in each country, but CSOs have to aggressively advocate for context specific funding options that allow provision of publicly funded services by less experienced and/or new CSOs under the supervision and guidance of more experienced ones in particular geographical areas and for particular population groups.

Georgia: Despite the fact that Georgian legislation allows social contracting, many organizations face problems with meeting requirement of the Public Procurement Law to present a bank guarantee worth 1-2% of the total budget specified in a respective tender proposal. Thus, ability of organizations to participate in public tenders is limited.

N. Macedonia: The CSO is required to have appropriate expertise and experience - realized at least three projects or one multi-year project, with total duration no less than three years, in provision of preventive and support services to HIV key populations, independently or in partnership.

Financial management: Delays and other problems related to payments were reported in countries, where the social contracting is practiced (Figure 11). In cases, when CSOs have benefited public funds to deliver HIV or TB services, problems related with the payments were named making it difficult for CSOs to properly implement and deliver the required services. Such problems are related with insufficient payment for the services delivered (22 percent); absence of advance payments (11 percent) and reimbursement after the service is delivered; delays in payments (11 percent) or paying only for services but not for administration costs (19 percent).

Figure 12: Challenges with funding rules and practices



Public call for selection of associations and allocation of funds to associations that will implement activities determined in the Program for protection of the population from HIV infection in the Republic of Northern Macedonia for 2020
("Official Gazette of the Republic of Northern Macedonia no. 278/2019 from 28.12.2019")

Expenditures that will be financed through the Program for protection of the population from HIV infection in the Republic of Northern Macedonia for 2020:

- Human resources (allowances / salaries for the persons who will be hired for the realization of the program activities);
- Planning and administration (costs for accounting services, procurement of office supplies);
- Directing costs (costs for renting space, electricity, water supply and sewerage, central heating, telephone, internet, maintenance of space hygiene, costs for maintaining a web application / website and other costs for maintaining services according to the needs of the association);
- Travel expenses (registration, insurance and vehicle service, petrol / oil / gas, tolls, bus transport, train transport);
- Procurement of medical devices and consumables for the users of the service;
- Procurement of hygienic material for the users of the service;
- Costs for realization of program activities in relation to providing space, necessary materials and other costs for (holding a workshop, trainings, seminars).

Accountability challenges: Challenges with reporting have been named as another problem faced by CSOs. Different types of reports and reporting frequency puts additional pressures on civil society. Complex, labor and time consuming reporting leaves limited time for service delivery as reported by respondents.

Type of Report	Reporting frequency
Narrative reports	Quarterly
Beneficiary/units of services data	Quarterly/By-annual
Outcome data	Annual
Finnancial data	By-annual/Annual

Figure 14: Accountability challenges

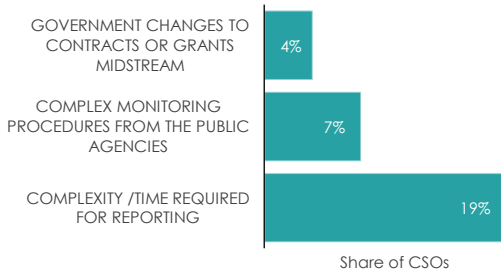
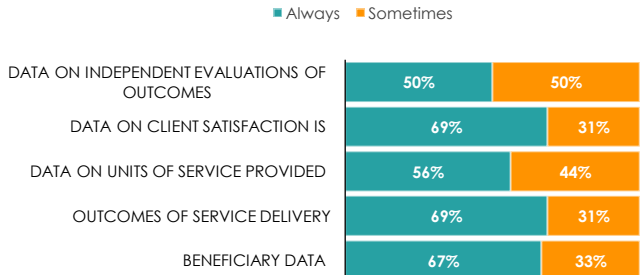


Figure 13: Use of data to Improve Programs and Services



The benefits of reporting are not well understood neither by financier, nor by CSOs themselves. Information collected for reporting purposes are not regularly used for evidence based planning and implementation (Figure 12).

7 percent of CSOs highlighted problems with complex monitoring procedures from public financier and 4 percent changes to contracts introduced by the financier in the midstream of implementation (Figure 13).

2.4 CSO Services and Client Base (Supply)

Achievement of national SDG targets related to HIV and TB by 2030, will require reaching key populations with HIV prevention and treatment services. Key populations, however, face high levels of stigma and discrimination and other barriers that may make them unable or unwilling to access government services. CSOs, with strong ties and more trust among key populations, act as a critical link to health services.

HIV/AIDS: CSOs deliver a range of HIV prevention and nonclinical care and support services that are vital for prevention and for linking and retaining otherwise hard to reach populations in care. These services include demand creation, testing outreach, linkage facilitation, referral systems, patient tracing, adherence counseling, harm reduction services and community/peer support.

TB activities: TB awareness creation, behaviour change communication, reducing stigma, screening and testing, facilitating access to diagnostic services, referral, treatment adherence support, home based care and DOTS.

CSO client base varies across organizations (Table 6).

Interestingly, no correlation have been observed in the size of the organization and number of clients served. Less than 100 clients are served by 3 small CSOs with up to 20 staff members and 1 large CSO with more than 50 staff members. Similarly, more than 3000 clients are served by 3 small CSOs and 2 large CSOs.

Table 7: Client Base

Client base	Small SCO (0-20 staff members)	Medium CSO (20 -50 staff members)	Large CSO (>50 staff members)	Total
<100	3		1	4
100-300	3		2	5
300 - 500	4		2	6
500 - 750			1	1
750 - 1000		2		2
1001-2000	2		1	3
2001 - 3000				0
>3000	3		2	5

In graduated countries (BIH and RMN) small CSOs provide services to about 1000 to 3000 beneficiaries, whereas client base for medium and large CSOs varies between 300 to 3000 beneficiaries.

While it is understood that range of services provided by CSOs are different in different countries, this finding raises concerns whether CSOs are using their human and financial resources efficiently and whether there is a room for staff optimization, or a room for further expansion of client base and or a room for expanding types of services provided to their clients.

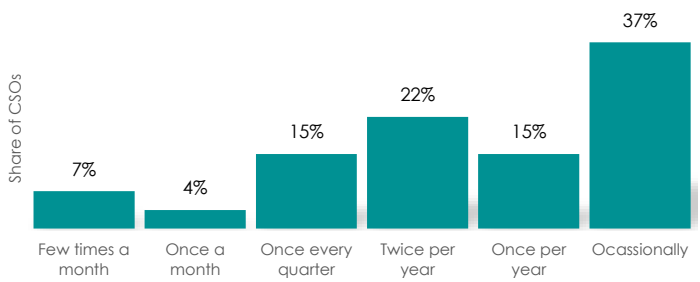
In light of diminishing external funding and yet slow uptake of CSO contracting (social contracting) for the provision of preventive, treatment, care and support services, CSOs have to more strategically approach human resource planning and ensure optimization of their workforce.

2.5 CSO capacity - Knowledge and skills (Supply)

Staff capacity building is a common practice in many CSOs, though 21 percent of them do not offer regular staff trainings. Interestingly, the latter are young and non-experienced CSOs. Training regularity varies across CSOs. 22 percent of them provide trainings at least twice a year (Figure 14). One six of organizations offer trainings to their staff once every quarter and another 15 percent once per year. More than one third of civil society organizations train their staff occasionally.

Nevertheless, 76 percent of CSOs reported having trained staff within last 12 months. Capacity building activities are predominantly financed by external resources (81 percent). 28 percent of CSOs uses GF grant funding and more than a half of CSOs report using other donor funding.

Figure 15: Regularity of staff capacity building



Main topics covered by the capacity building activities related to communication skills development, quality of preventive services, innovations in working with key populations, conducting peer driven intervention among KPs, TB case management, active case finding, phycological support etc. Among service

delivery related knowledge and skills development, only two CSOs were able to train staff in COVID-19 preventive activities and infection prevention and control measures while delivering services to target population groups.

It has to be emphasized that CSOs, with their various missions, expertise and outreach capacities can, and should cover a wide spectrum of roles, and therefore should not be concentrated on mere service provision and staff capacity building in topics related to service provision only. Notably few CSOs also considered and provided training to their staff in advocacy and budget advocacy, project design and management, human resource management, computer literacy, etc. all being externally funded.

The analysis of national disease response strategies and transition plans where applicable, revealed that a need for CSO capacity building in programmatic and organizational issues are acknowledged in six countries (ALB, GEO, XKX, MKD,MNE, ROM, SRB), but all planned trainings are yet externally financed. Training needs assessment and planning is not a common practice among CSOs due to the scarcity of potential funding for realization of staff capacity activities.

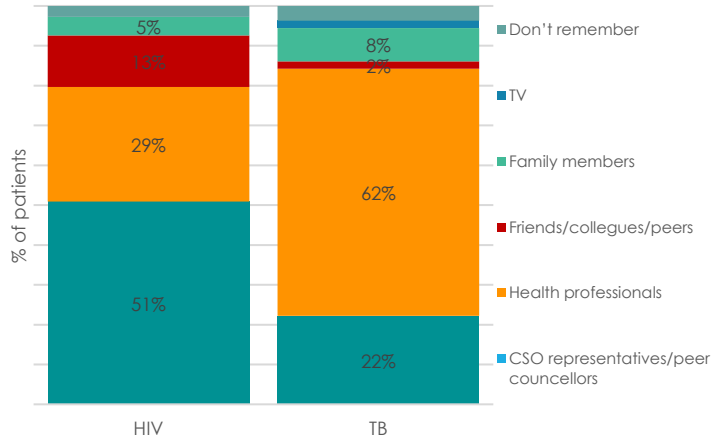
2.6 Access to Services (Access)

In this section of the report, we analyze extent to which KP groups and TB patient needs are met and access to needed services is guaranteed by governments. Access is defined as the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled.

2.6.1 Access barriers

To estimate demand for HIV and TB services and unmet needs, the study examined: i) access to information about available services and source of information; ii) geographical access to health facility based services, waiting times for appointment; iii) access to treatment and medicines; and iv) needs not covered by provided service packages.

Figure 16: Access to information on available services



The analysis of the quantitative study revealed that access to available services is guaranteed either from CSOs, health personnel, family members and or peers and friends. Whether access is ensured for all, including the most marginalized and hard to reach KPs, is difficult to affirm, as only those already receiving services have been included in the study.

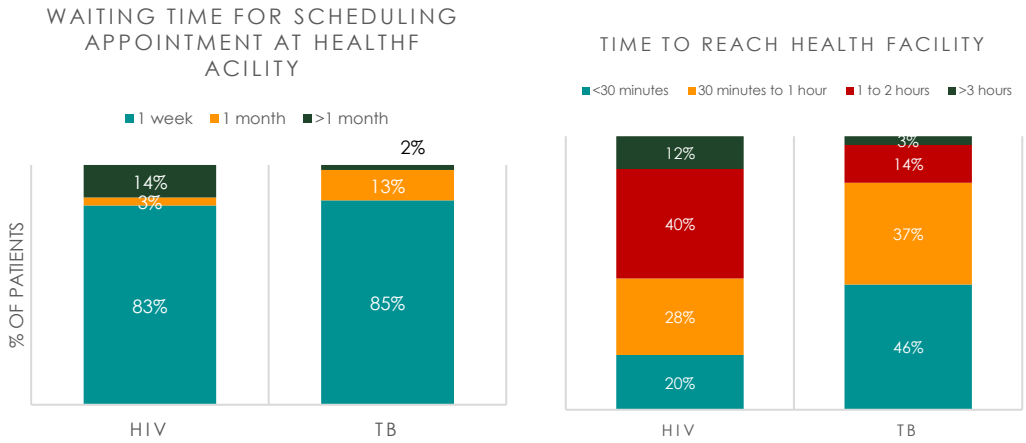
In case of HIV, main source of information on available services are CSOs. More than half of respondents (51 percent) received information about available services from CSOs, about one third (29 percent) from health professionals and about one fourth from other sources (friends, family members and peers). Thiese results clearly display the important role CSOs play in identification of KP and generating demand for HIV services among them (Figure 15).

Information about available TB services are predominantly received through health professionals (62 percent) and the role of CSOs in creation of demand for TB services is insignificant. Only one fifth (21 percent) of the respondents stated receiving information from CSOs (Figure 15). This could be explained by less engagement of CSOs in TB response in EECA, compared to HIV.

As CSO engagement remains limited in TB response, and in most countries HIV component will be the first to graduate from the Global Fund support, without effective fundraising from all, public, private and external resources, CSO engagement will dimmish in national HIV response and adversely affect demand for HIV services, especially among hard to reach groups of KP.

To receive health facility based HIV and TB services appointments are to be schedules 1 week in advance (83 and 85 percent in case of HIV and TB respectively) in majority of cases (Figure 16).

Figure 17: Access to health facility based services

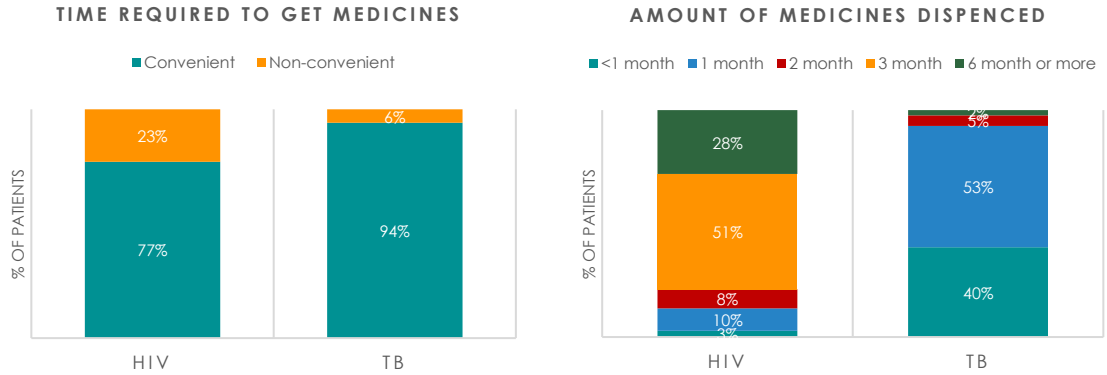


However, geographical access to health facilities measured by travel time are challenged in case of HIV. About half of PLHIV travel longer distances for care (more than 1 hour travel time) that may be driven by limited availability of specialized HIV services (Figure 16). TB patients have better geographical access to needed services as only 17 percent of respondents reported travelling more than 1 hour to the nearest health facility.

The international evidence display an inverse association between a geographic or transportation-related barrier and an HIV-related outcome. The presence of geographic barriers would be associated with unfavorable outcomes at all points along the continuum of HIV care, and that this effect would be observed across different countries of the region, time periods, and study populations.

Apart from geographical access to services, PLHIV also report on barriers in collecting ARVs. Almost one fourth of respondents informed inconvenience in collecting ARVs. However, it may have a marginal effect considering that majority PLHIVs have to travel once to collect the ARV stock for more than a one month (Figure 17). Similarly, access barriers to anti-TB medicines are negligible in TB.

Figure 18: Access to medicines



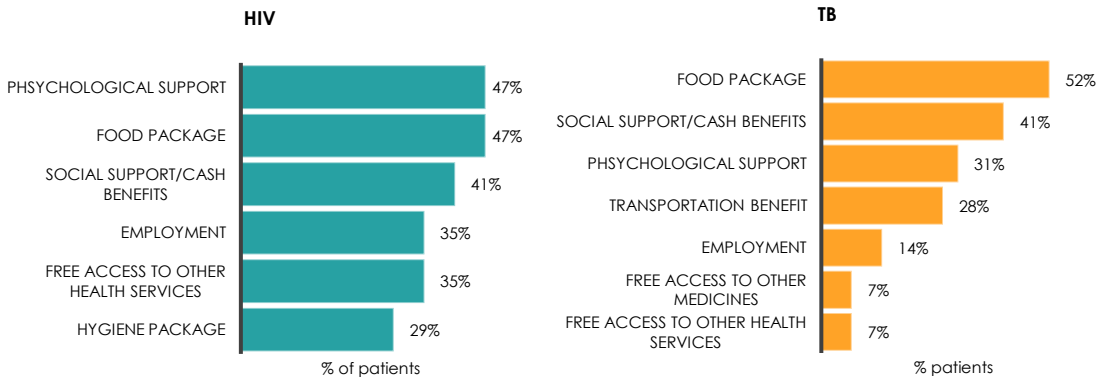
2.6.2 Client Needs

The study also examined whether KP and TB patients received all needed services and what are the services not covered. Majority of respondents (71 percent KPs and 86 percent of TB patients)

reported receiving all needed services. Nevertheless, around one third of KP respondents and one fifth of TB patients expressed a need for additional services. Main services demanded by KP respondents are psychological support, access to free food and hygiene packages, social/cash benefits, free access to other health services and support to get a job (Figure 18). Respondents from Bosnia and Herzegovina highlighted a need for improved access to harm reduction services, particularly to dop-in centers.

Likewise, most demanded services among TB patients are access to free food packages,

Figure 19: Needs for additional services



social/cash benefits and transportation benefits, psychological support and support for employment.

These findings indicate that service packages differ among countries and within the country among CSOs serving KPs and TB patients, requiring a standardization of services packages according to local context and client needs. This is especially important when countries move towards domestic funding of preventive services.

2.6.3 Access to services during COVID -19 pandemic

COVID-19 has spread across the world at a terrifying speed, with waves of infections crashing over countries, cities and communities. This new pandemic has had far-reaching effects on health systems and other public services. HIV & TB services have been disrupted, and supply chains for key commodities have been stretched. The COVID-19 pandemic threatens progress against HIV and TB around the world[32].

The Global Fund reacted decisively to the emergence of COVID-19, quickly making available to support countries through:

- COVID-19 response mechanism through which countries can access funding to reinforce the response to COVID-19, mitigate the impact of the pandemic on HIV, TB programs, and make urgent improvements in health and community systems
- Grant flexibility allowing countries using up to 5% of existing Global Fund grants to fight COVID-19 and mitigate the impact the pandemic has on HIV, TB.

Table 8: Countries of EECA region which received COVID-19 support from GF

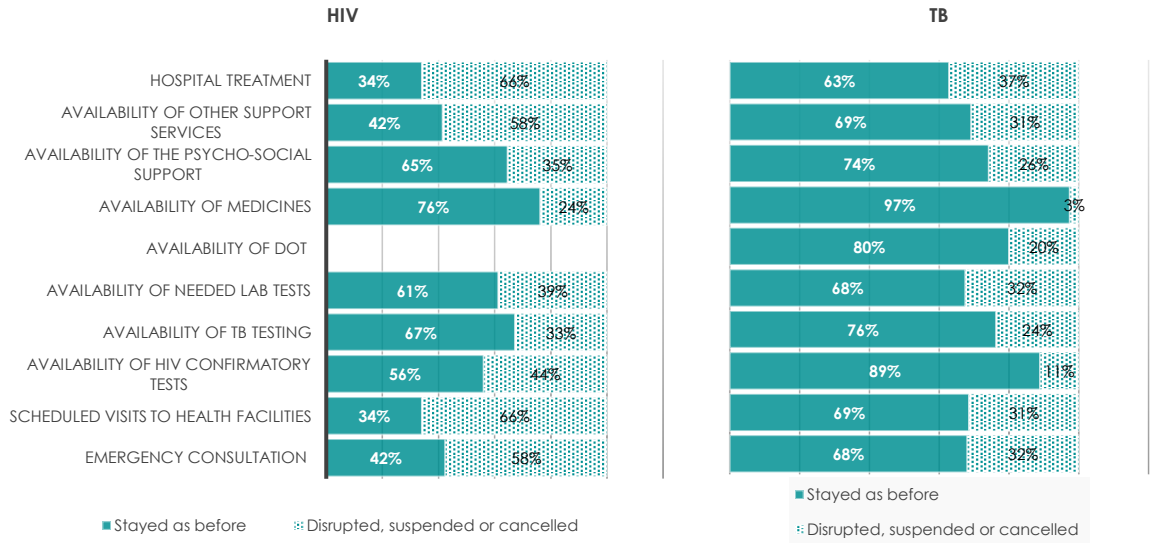
Country	Currency	Mitigating COVID-19 impact on HIV, TB and malaria programs	Reinforcing national COVID-19 response		Urgent improvements in health and community systems	Total immediate funding
			Other response	COVID-19 diagnostic tests		
Albania	USD	29 972	24 485	103 040		157 497
Armenia	USD	375 100	200 750	275 498		851 348

[32] https://www.theglobalfund.org/en/covid-19 accessed on March 1, 2021

Azerbaijan	USD	1 107 834				1 107 834
Belarus	USD	487 435	491 600	141 360	75 530	1 195 925
Georgia	USD	175 600	495 440	600 109		1 271 149
Kazakhstan	USD	18 506	739 050	140 616		898 172
Kosovo	USD	141 029	28 773		60 294	230 097
Kyrgyzstan	USD	759 983	99 200			859 183
Moldova	USD		722 247			722 247
Montenegro	USD		27 530	34 542		62 072
Serbia	USD	21 111	6 922	75 079	66 189	169 301
Ukraine	USD	2 681 590	3 057 975	4 585 260	513 500	10 838 325
Uzbekistan	USD	943 493	282 128	403 744	370 821	2 000 186
Multicountry HIV EECA APH	USD	379 345	128 677			508 022

Nevertheless, the results of this study indicate challenges in accessing needed services during COVID-19 pandemic in studied countries (Figure 20). Less TB patients experienced problems with access to services, compared to KP groups and PLHIV. Respondents found difficult to access emergency and planned consultations, testing, hospital treatment, social and psychological support.

Figure 20: Access to services during COVID-19 pandemic



Access to ARVs deteriorated during the pandemic. Around 8 PLHIV out of 10 reported having problems in getting ARVs during emergency state, whereas access to anti-TB medicines have sustained. More than a third of people living with HIV who were surveyed reported some impact on HIV services, including about 24% who reported that they had missed taking antiretroviral therapy because they could not get the medicine.

Efforts are being made in several countries to provide 2-6 months of ARV medicines to patients. In Romania, there seems to be a move towards extending the supply of antiviral treatment from one to three months. In several locations this effort pre-existed the COVID-19 crisis, in others the extension of provision resulted from contingency planning. In some locations, provision is very limited. Respondents from Romania and Albania reported some shortages reported. 80 percent of

In many locations, health services responsible for HIV and TB are now focused on COVID-19…

In Romania, TB treatment is reported to be delayed as doctors are focused on care for COVID-19…

TB patients reported receiving DOTs and only 20% noted about services being suspended or disrupted.

Lockdowns, restriction on gatherings of people and transport obstructions along with re-assignment of health facilities and medical staff to COVID-19 centers/hospitals, threatened service provision. Lockdowns and physical distancing mandates have made it difficult or even impossible to conduct face-to-face encounters, thus affecting community services.

The ability to provide services depend on the severity of confinement measures locally and access to protective materials. Routine testing appears to be deferred or suspended until further notice in several locations, with a noted exception of emergencies. Limitations on the freedom of movement are impacting access to treatment for PLHIV in certain locations. For instance, in Albania, challenges are reported for PLHIV who have to travel to get their medication.

Additional causes of disruption include COVID-related stigma and reluctance of health workers to attend to people suspected of having TB, which have many of the same initial symptoms as COVID-19; and clients not seeking health services as usual, resulting from fear of getting infected with COVID-19 as well as economic hardships caused by the pandemic.

Yet, COVID-19 has catalyzed the accelerated implementation of innovations that pre-date the pandemic but that have previously struggled to obtain traction. Community groups moved swiftly in response to the pandemic to maintain service access, including using telephone or email for personal counselling and for monitoring treatment and health status. They set up and use online communication platforms to provide support. Social media is used to share information, including on risk reduction. Though, doing so presented challenges for some people. Community testing is suspended, but some centres are still operating on an appointment-only basis or provide mobile services. Facilitation of medicines delivery is being organized, e.g. pick up at community pharmacy, post or direct delivery on a case by case basis. Civil society in Moldova started delivering medicines to the homes of PLHIV. There was little information reported regarding harm reduction services for people who use drugs, but this information is provided by specialized organizations.

Multi-month dispensing of antiretroviral medicines to people living with HIV has been critical to easing the impact of lockdowns. Although WHO first recommended shifting to multi-month prescriptions and antiretroviral medicine dispensing in 2016, adoption of the approach was slow prior to the COVID-19 pandemic, partly due to challenges related to adapting procurement and supply management systems.

COVID-19 is likely to have concrete negative effects on the trajectory of the HIV and TB response. Despite this, the ability of HIV and TB programmes to adapt inspires confidence that these negative effects could, with necessary investment, be short-lived.

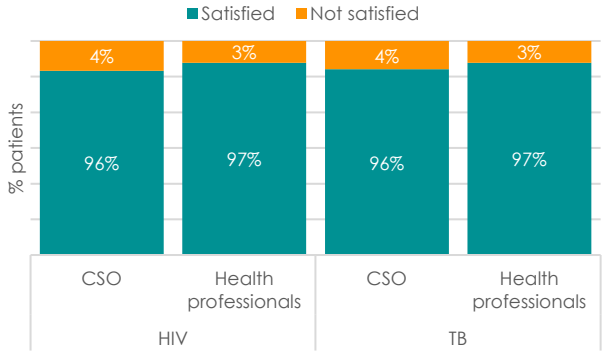
At the same time, the COVID-19 pandemic has underscored the agility of the HIV response and the many spillover benefits of HIV and TB investments in health systems and development infrastructure. Through policy and service delivery innovations and especially through the innovation of communities, the HIV and TB response has in large measure risen to the challenge posed by the COVID-19 pandemic, ensuring continuity of services in the face of extraordinary impediments by adopting alternative service provision modalities.

The HIV and COVID-19 pandemics and their responses underline the importance of increasing the resilience of societies, communities and health systems, and the importance of addressing underlying inequalities.

2.6.4 Client Satisfaction

In literature, the significant role of patient satisfaction indicators in evaluating the service quality has been well-documented. Assessing patient satisfaction also assists in the estimation of service's performance and the treatment outcomes, as well as identification of patients' unmet needs. Highly satisfied patients are more likely to build long-lasting relationships with service providers, resulting in better treatment compliance and retention in care.

Figure 21: Client satisfaction



A high proportion of participants expressed satisfaction with HIV & TB services, being provided by health personnel or CSOs (Figure 20). However, some dissatisfaction is masked in this high satisfaction level. This dissatisfaction underscores need to improve staff attitudes, staff-patient-communication, shortening waiting times and improving access to harm reduction services particularly in graduated countries. Future studies need to focus on assessing long-term progression of satisfaction levels with services and determinants of satisfaction involving larger samples in many treatment centres.

2.7 Effective Transition

This section of the report examines and presents results on impact of the declining funding on HIV and TB prevention services and service users; how countries addressed transition planning and implemented respective activities to allow smooth transition from GF support to domestic financing and ensure sustainability. More specifically, the study assessed availability of approved national transition and sustainability plans (TSP) with sufficient legal power based on the findings of country's transition readiness assessment or elements of TSP included in the disease specific NSPs and extent to which TSP or NSPs address issues related to the sustainment of CSO provided services. In addition, it takes stock of strategies applied by CSOs to maintain services addressing needs of the patients and clients.

2.7.1 National planning for transition of service delivery funding from external sources to domestic financing

As part of its efforts to accelerate malaria elimination and end the HIV and tuberculosis epidemics, the Global Fund's 2017-2022 Strategy[33] emphasizes the critical importance of strengthening sustainability of programs and supporting successful transitions to full domestic financing and management of the national disease response. The Global Fund believes long-term sustainability is a key aspect of development and health financing and that all countries, regardless of economic capacity[34] and disease burden, should be planning for and embedding sustainability considerations within national strategies, program/grant design and implementation.

As part of its Sustainability, Transition and Co-financing (STC) Policy[35], the Global Fund encourages and proactively supports early, robust, multi-stakeholder, and country-owned sustainability and transition planning, to maintain and accelerate gains against the three diseases. Recognizing that a successful transition takes time and preparation, the Global Fund strongly encourages countries to start planning for eventual transition at least 10 years – or approximately three allocation cycles – before funding for disease components projected to end. For each of these disease components, countries are advised to incorporate transition and sustainability considerations into country dialogue, co-financing commitments, grant design, and program design. To further enhance transition preparedness and support sustained impact against the HIV and TB, the Global Fund

[33] April 2016. Annex 1 to GF/B35/02 – Revision 1. The Global Fund Strategy 2017-2022: Investing to End Epidemics. https://www.theglobalfund.org/media/1176/bm35_02-theglobalfundstrategy2017-2022investingtoendepidemics_report_en.pdf
[34] Income level as measured by the World Bank Atlas Method.
[35] April 2016. Annex 1 to GF/B35/04 – Revision 1. The Global Fund Sustainability, Transition and Co-financing Policy. https://www.theglobalfund.org/media/4221/bm35_04-sustainabilitytransitionandcofinancing_policy_en.pdf

also applies co-financing and application focus requirements tailored to these disease components[36], and proactively supports country transition planning (where relevant).

The review of the most recent country specific TSP and NSPs revealed five key objectives addressing transition and sustainment of CSO provided services (details can be accessed in Annex 2: Activities addressing sustainability of CSO provided services).

1. **Empowerment and engagement of CSO in HIV policy, programming, advocacy:** Albania, Kosovo, N. Macedonia and Serbia emphasized an importance of the state – civil society partnership and aimed at empowerment and engagement of CSO in advocacy, policy dialogue, program design to better address community needs.

2. **Standardization of service packages** for KP groups was acknowledged as an important element for smooth transition and sustainment of CSO provided services only in Bosnia and Herzegovina. However, according to CSOs interviewed, BIH does not have approved standard service packages.

3. **Development/enhancement of the CSO contracting/social contracting mechanisms:** six out of 8 countries (BiH, GEO, XKX, MKD, MNE, MDA, ROM) planned to develop or further streamline social contracting mechanisms, regulations and procedures. Nevertheless, countries yet report this mechanism yet been underdeveloped creating challenges for CSOs to tap public resources and continue supporting their communities and service users.
4. **CSO capacity building**: A need for CSO capacity building in programmatic and organizational issues has been highlighted in six countries (ALB, GEO, XKX, MKD,MNE, ROM, SRB). A thorough analysis of this objective revealed countries yet relying on the external funded trainings and ignore establishment of a system that can sustain after transition and provide capacity building for CSOs.
5. **Increase of public funding for CSO provided services**: All countries reported declining external funding for CSO provided services, but only three countries (BiH, XKX, MKD) considered planning activities for mobilization of sufficient domestic financing. Outcomes of this objective is described in the following section.

In summary, the review of the transition and sustainability planning revealed, that albeit countries in general acknowledged the role of CSOs, assigned functions and planned activities related to transition and sustainment of CSO provided services, implementation progress is sub-standard, and it is less likely that will produce planned results. Currently, there is a clear lack of communication and comprehension of the expectations of the transition.

Albania national strategy on the Prevention and Control of HIV/AIDS 2015–2019 reflected the important work undertaken by CSO's with KP's, although no national resources were allocated to such activities. The letter of commitment submitted by MoHSP does not display the strategies and mechanisms for taking over, and financially supporting, CSO's during the phasing out of Global Fund support.
Source: The Challenges of Global Fund Transition in Albania: Harm Reduction Services on the brink of Collapse, EHRA, 2019

[36] April 2016. GF/B35/04 – Revision 1. The Global Fund Sustainability, Transition and Co-financing Policy. https://www.theglobalfund.org/media/4221/bm35_04-sustainabilitytransitionandcofinancing_policy_en.pdf

2.7.2 Impact of declining funding on service provision and service users

Transition has presented a number of challenges for countries in the region. Prevention activities are vulnerable in the context of transition given little-to-no domestic investment and the potential political obstacles to prioritizing services for certain populations. The study indicate that countries generally prioritize costly curative care with very limited funding allocated towards more cost-effective prevention interventions. Above all, all countries experienced budget shortfalls and service interruptions and deteriorating coverage of target populations.

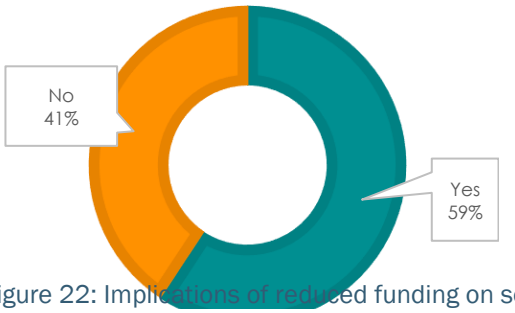
65 percent of CSOs included in the research highlighted decreasing funding adversely affecting service delivery. Only few noted about no or increased funding. Declining funding also hampered service delivery to service recipients (Figure 21). 57 percent of CSOs noted decrease in number of beneficiaries serviced. The decrease of funds and services to KP in the regions prior to government firm commitment and alternative options being available will not only disrupt the existing services but will also have a negative impact on the takeover of those services by local CSO's.

2.7.3 CSO Transition and Sustainability Strategies

The resulting financial pressures led CSOs to undertake a variety of strategies to stay afloat. In response to shrinking funding base, CSOs took decisive steps to sustain services to their target population groups through development and application of various strategies.

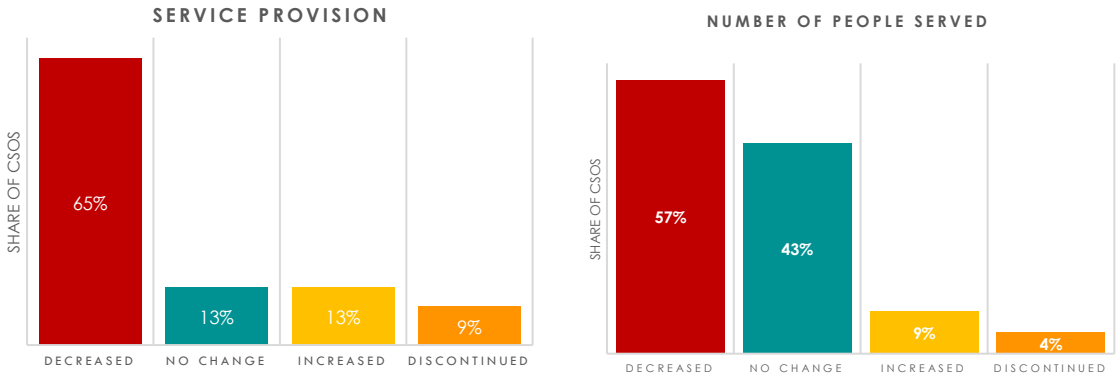
Fundraising: In today's volatile financial climate CSOs need to continually reassess their ability to generate funding, adapting current strategies and introducing new income streams when needed to ensure continuous provision of preventive, treatment, care and support services and increase of coverage required and attain HIV and TB SDG goals. For many organizations, particularly those once reliant upon external funding, this means venturing into a brave new world of fundraising. This is no mean feat – the fundraising climate is tough and looks set to remain that way into the future. Whatever the economy will be doing, key to successful fundraising is a strong fundraising strategy.

Figure 23: Availability of fundraising strategy



The research attempted to examine whether CSOs in studied countries were adequately equipped with fundraising strategy and plan outlining what to do, how and when to do it,

Figure 22: Implications of reduced funding on service provision

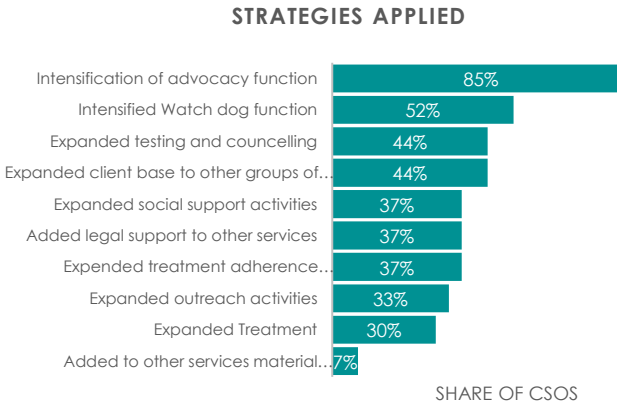


planned amount of funds to be leveraged and how to allocate resources of time and money. Around 60 percent of studied CSOs (BiH, GEO, MLA, MNE and XKX) reported having fundraising strategy and implementing it. Noteworthy to mention that majority of CSOs, which have fundraising strategy are small or medium size organizations and only one is a large size CSO (BiH).

The funding trend of these CSOs for the last 5 years show that results of fundraising are not promising. Majority of CSOs noted declining of revenues and marginal share of their revenues being leveraged from other sources, particularly from domestic funding. Subsequently, the effectiveness of the fundraising strategies and/or implementation process requires further research and refinement as needed.

Functions and Services: To maintain financial viability, CSOs also considered revisiting their functions, extending services to other groups of populations and expanding the package of services. Some CSOs in Bosnia and Herzegovina, Romania, Serbia and Kosovo initiated income generating projects.

Figure 24: Expansion of functions, services and client base



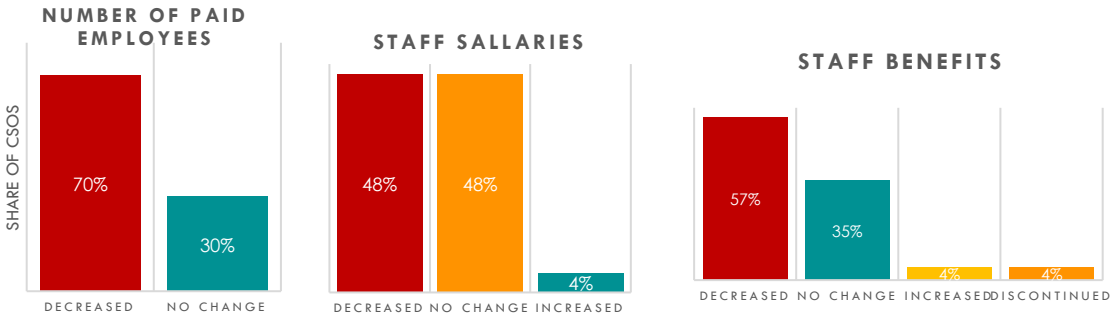
Two third of CSOs intensified advocacy functions and half of them increased monitoring/watchdog functions to ensure effective advocacy around various issues related to safeguarding rights of their clients, policy development, leveraging financial resources, etc. (Figure 23).

CSOs (44 percent) also considered diversification of client base by adding other populations groups such as TB patients, transgender population, MSM and/or SW and women of reproductive age (Figure 23). Furthermore, less than a half of them expanded outreach activities, testing and counseling, treatment and treatment adherence support, social support and started provision of legal services to their clients.

These decisions were guided by national priority targets such as improved coverage and possibility of tapping additional external resources dedicated for particular groups of populations. Only two CSOs (BiH and GEO) reported expanding the coverage to other geographical areas.

While this is commendable, it is not clear how CSOs manage to expand services and client base, when there is a common tendency of reducing annual revenues. To answer this questions the research further explored strategies applied that enabled CSOs to expand functions, service package and client base.

Figure 25: Human Recourse strategies



Human resources: In order to efficiently use scarce financial resources on the one hand, and to expand services and clients base on the other, CSOs optimized staffing, revised staff salaries and benefits. CSOs used these strategies in combination for optimization of human resource expenses. 70 percent of them reported downsizing their workforce, 48 percent lowered staff salaries and 57 percent decreased staff benefits (Figure 25). Funds released from human resource strategies implemented were used for the expansion of the service package and client base. Only 1 CSO, which was successful to mobilize increased funding for the last 5 years, reported increasing staff salaries and benefits.

Geographical representation and operation hours: Apart from optimization of human resource costs, CSOs strategically approached costs related to administrative functions. More than half of them (57 percent) revisited effectiveness and efficiency of maintaining various office/program sites and downsized them by introducing the alternative service modalities and retention of local staff (Figure 26). Some CSOs (26 percent) also took decision to shorten office operation hours, while others maintained regular working hours. The recent experience with COVID-19 demonstrated possibility of using on-line/phone consultations and alternative service delivery modalities.

Figure 26: Offices/Program sites

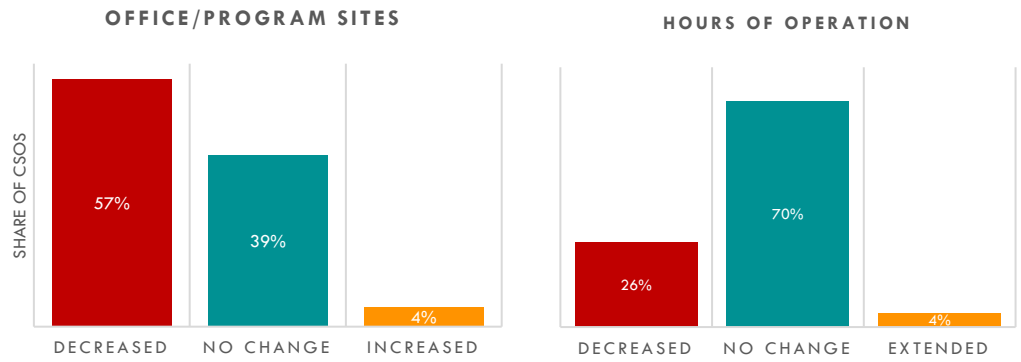
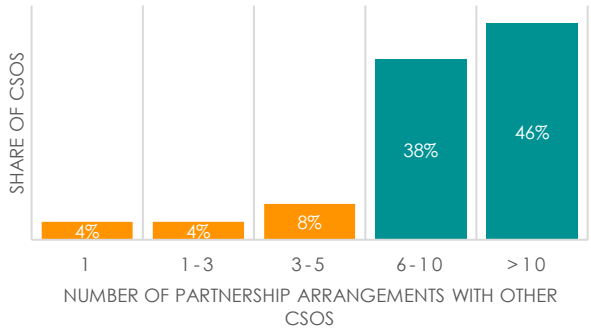


Figure 27: CSO partnerships



Partnership with other CSOs: 26 CSOs reported having established partnerships with other civil society organizations to allow expansion of coverage and diversification of services provided to their clients. Majority of CSOs partner and work closely with more than 6 civil society organizations (Figure 26) to widen and sustain the impact of its work and increase access for key vulnerable communities in different geographical areas.

2.7.5 Lessons Learned from Transitioned Countries

ALBANIA fails its HIV fight: At a time of successful HIV prevention mechanisms, and as more European countries are bringing cases of new HIV infections to historical lows, Albania, a candidate country for EU membership, reports a distressing situation of continuously interrupted services, inefficient treatment plans and procurement mechanism, and lack of transparency and communication by the Ministry of Health and Social Protection and CCM.

CSOs report a worrying and pessimistic situation. For years on, Albania does not purchase and import in a timely manner the necessary antiretroviral drugs, which need to be continuous and uninterrupted. As such, HIV patients are forced, during stock-out, to change their treatment schemes frequently, the consequences of which can be devastating for their health. Even though CSOs have continuously raised awareness and advocated against this problem, the situation repeats itself each year. To make matters worse, Albania frequently lacks testing kits for CD4, viral loads and virus resistance, forcing patients to do such tests in private clinics with very high costs for most.

In addition, local organizations report a total lack of awareness activities by the Ministry of Health and Social Protection, even less with the MSM population as a target. As a result, prejudices and stigma towards HIV remains very high among the LGBTI community and the rest of society, pushing

many people not to get tested or to refuse treatment, very often leading to serious health complications and even death. While Albania proud itself as a low-prevalence country, the number of HIV related deaths in the country is alarming: 27 persons died in 2018 and 24 in 2019. LGBTI people remain the most affected key population due to double-stigma, fear of discrimination and exclusion.

The year 2020 has started with disruption of services not only for about 200 people living with HIV/AIDS but also for 1800 People who Inject Drugs (PWID), 380 Methadone clients, 1200 Men Having Sex with Men (MSM), 290 Sex Workers (SW) and 30 prisoners.

Consequently, NGOs have been forced to shut down their services, cut human resources and return many assets such as computers, printers, minivan, tables and shelves to the Project Management Unit. Many of the human resources trained for such purposes in NGOs are losing their jobs, support services for PLHIV, harm reduction services for PWID and MSM are closing down. NGOs are not permitted to use any longer the mobile units and most importantly two methadone centres have run out of methadone.

One would think that the Albanian government would create and provide its own budget for such an important public health issue. In fact, the Country Coordinating Mechanism (an inter-ministerial coordinating body) hasn't met since June 2019 and local NGOs have absolutely no information as to how and when will the transition grant start, what will be the role of each actor and how will the sustainability of services be ensured. The CCM role and function as local ownership and participation in decision-making has been decreased. It can be said without a single doubt that both institutions have failed their leadership and coordinating role consistently.

BOSNIA AND HERZEGOVINA finds hard to sustain all elements of national HIV/AIDS response: BiH became ineligible for new Global Fund support before the Global Fund policy on transition funding was adopted in 2016, and its existing funding ended in 2018. The process of transition from Global Fund support was guided by a national transition plan. The development of such a plan was initiated by the United Nations Development Program (UNDP) (which had been a primary recipient of Global Fund grants) in close collaboration with national stakeholders, including CSO's and government. The final plan was rigorously reviewed by the Global Fund and eventually became a basis for a no-cost extension in 2015.[37]

At a time of transition, the country lacked the law on social contracting. While there were possibilities for CSOs to receive funds from different sectoral ministries, CSO contracting by the Health Care Fund for service provision is yet restricted. Support to KAPs, preventive actions remain challenging. Lack of funding resulted in lack of activities directed towards fight against stigma and discrimination, lack of advocacy activities, promotion of PLHIV and KAP rights and social support to PLHIV. Almost all prevention, including mobile VCT services, harm reduction, promotional and educational services provided by CSOs remain unfunded.

BiH has a complicated public administrative system that is highly fragmented with public health responsibilities undertaken by different agencies within different administrative units. Therefore, public commitments to fund HIV services are hard to realize and difficult to execute. Albeit public funding for HIV has been steadily increasing over the last decade, the rate of increase has not been sufficient to generate the same level of funding as with the Global Fund grant[38]. Public funding in BiH, like in many other countries is primarily focused on the treatment provision.

The Ministry of Health first budgeted specific support through CSO's working in the field of HIV in 2019. However, the lack of funding resulted in the closure of harm reduction services in the cities of Sarajevo, Mostar, Bihać and Banja Luka with the only remaining services operating in Zenica and Tuzla. CSO service providers were pushed to either close or scale down their activities and operate through volunteers as they have no means to pay staff salaries[39].

[37] https://eecaplatform.org/wp-content/uploads/2017/12/BiH-global-fund-case-study-2016.pdf
[38] Sustainability bridge financing: Case study from Bosnia and Herzegovina, Montenegro and Serbia, EHRN, 2019
[39] Letter to Dr. Kaberuka et al on the emergency situation concerning the sustainability of harm reduction services in the South East European countries of Albania, Bosnia and Herzegovina, Bulgaria and Romania, 2019

MONTENEGRO struggles to sustain all elements of its HIV response: Montenegro became ineligible for Global Fund support in 2014, and its remaining grant funds were expended by June 2015. This was one of the shortest windows for transition experienced by any country in South Eastern Europe, and it pre-dated the Sustainability, Transition and Co-Financing Policy. Montenegro had been encouraged to think about sustainability from the start of the extended grant period, and during that time, the government took over responsibility for many of the expenses of the HIV response, including full funding for expanded ART, opioid substitution therapy, and center-based testing and counseling.

However, Montenegro has struggled to sustain other elements of its HIV response. Funding for HIV prevention has been insufficient, and the country lacked a sustainable mechanism for including civil society in the ongoing implementation of the national program. As a result, many of the achievements made with Global Fund support were disrupted, because NGOs were no longer providing the bulk of prevention services. In the year following the termination of Global Fund support, NGO-led prevention services in Montenegro nearly collapsed.

Even after the end of direct Global Fund support, the CCM continued operations with Global Fund support to the CCM Secretariat. The Global Fund portfolio manager continued to actively support the national dialogue on HIV response. Montenegrin NGOs came together to conduct high-volume advocacy, reaching out to the government, the Montenegrin public, embassies, and international bodies to raise their awareness of the challenges and engage more partners to help find solutions. These dialogues laid the ground for a new commitment to secure HIV funding in the budget process. In mid 2016, the Montenegrin Parliament passed legislation to allocate €100,000 for NGOs "that provide services for support to people living with HIV/AIDS and affected populations"—a first in the region, in terms of its explicit commitment to funding NGO services to key populations.

The country became re-eligible for a limited allocation of Global Fund support in the 2017-2019 period on the basis of its alarming 12.8 percent disease burden among MSM. The Ministry of Health launched its first open public call for proposals for HIV prevention programs in November 2017, with €80,000 allocated for prevention services for key populations.

NGOs from the HIV field have been actively engaged in larger dynamic dialogue between the Montenegrin government and civil society regarding a law adopted in June 2017 that should contribute to the sustainability of their activities. Previously, NGOs could only receive state funding via the Lottery Fund, but now 0.3 percent of the state budget is earmarked for NGO projects, an additional 0.1 percent is dedicated to protection of people with disabilities, and another 0.1 percent is allocated for co-funding EU-supported projects. This funding will be distributed by sector based on annual priorities defined within the sector.

However, Montenegro is not without cautionary lessons. While the prospects for sustainability look promising now, the country has experienced a real disruption in services since June 2015, with a significant impact on the lives of people living with or at risk for HIV. Earlier investment in bridge funding could have maintained service provision while sustainable systems were under development, addressing an increased infection rate and saving lives.

Additionally, the funding interruption had an institutional impact on long-standing NGO implementers, particularly with respect to human resources and operational capacity. This impact is hard to quantify, but likely considerable. Finally, even with the reintroduction of funding for service delivery, the critical role these organizations have played in advocacy over the last decade remained at risk, since external funding opportunities were uncertain and the use of domestic government funding for advocacy risked significant conflicts of interest. There was also a need to diversify funding, so NGOs were not dependent on a single source of support

NORTH MACEDONIA transition process has seen a disruption in services: Despite the efforts of civil society groups to sustain the gains and investments made, the transition process has seen a disruption in services. Despite considerable progress in approaching the UNAIDS 90-90-90 targets by 2015, Macedonia saw a concerning slide in progress in 2016.

While HIV transmission continues to grow unchecked, enrollment on treatment is not keeping pace. by mid 2017, only 75 percent of people diagnosed with HIV were receiving treatment. Most of the CSO programming previously supported by the Global Fund was supposed to be included in the Ministry of Health budget during the no-cost extension period but has actually been unfunded since July 2017 due to the lack of a functioning mechanism for contracting.

The shortfall has resulted in the closure of several needle-syringe exchange thus far, and the departure of trained staff who are currently not being paid is causing further service interruption. The NGO responsible for implementation of the community-based testing and counseling services has managed to sustain that work in the short term with small bridging funds from a pharmaceutical company. EGAL, an NGO providing services for MSM, closed two drop-in centers, including one that served a Roma-majority area.

In the context of unfolding funding interruptions, civil society groups mobilized to engage in the transition planning process. In 2014, 16 Macedonian civil society organizations united to establish a platform with the aim to advocate for sustainable financing of HIV programs. Despite limited financial support, the platform has initiated advocacy towards development of social contracting and pushed for a budget for services for key populations in the 2015 Annual Program on HIV. As a result of its advocacy efforts, starting from 2016 program on HIV includes a budget for services for key populations through social contracting.

Transition of HIV component in ROMANIA resulted in collapse of services: 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. Romania used to be a regional champion through having established a comprehensive HIV prevention and treatment programme for all key populations, including people who inject drugs. However, due to the withdrawal of the Global Fund, this situation has changed drastically over the past decade. Some seed money was provided by local authorities in Bucharest, but no formal mechanism is yet in place by the government for the subcontracting of HIV prevention services. Since 2010, Romania has had no multi-sectoral coordination mechanism, nor a national HIV/AIDS strategy in place. Moreover, the country recently experienced ARV treatment interruptions on several occasions due poor management of ARV stocks and delays in the procurement of drugs.

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. Thanks primarily to the response of non-governmental organizations (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. 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.

SERBIA's transition adversely affected harm reduction service provision: As an upper-middle-income country, Serbia's funding ended abruptly when it became ineligible for further Global Fund's support after its HIV burden was deemed "moderate" based on official disease burden data provided by UNAIDS in 2012. Due to the increase in the HIV epidemic among KAPs (especially MSM), it regained eligibility in 2015; however, as it was the middle of the Global Fund 3-year allocation period, the country could not receive any funding . Serbia HIV component met the criteria for two consecutive eligibility determinations, in 2015 and 2016[40] and the country's new grant[41] implementation commenced in 2019. Consequently, there has been a significant funding gap in Serbia's response to HIV among KAP between 2014 and 2019.

[41] Comments included in the 2017 Global Fund Eligibility List.
https://www.theglobalfund.org/media/5601/core_eligiblecountries2017_list_en.pdf

When the Global Fund left Serbia, Serbia did not have a tenable plan and sufficient resources in place to maintain its HIV and AIDS programming and the government was not ready to lead and coordinate Serbia's HIV response -- especially among key populations. The cessation of Global Fund investment came at the worst possible time for Serbia. In the spring of 2014, the country had been devastated by major flooding that shook its economy. Disaster response and relief efforts required Serbia to re-direct major national resources to the task, as well as EU support that was previously allocated to reforms to help Serbia meet EU standards in governance, the rule of law, and similar areas. As a result, NGO services among key populations collapsed during the more than two-year break in international support that followed Global Fund withdrawal.

The transition led to the collapse of both NGO led services, and a coherent dialogue among HIV stakeholders around HIV. The country lacked an institutional framework for navigating the transition. With Serbia's non-operational CCM and with no replacement, there was no platform for planning and coordination, and no institution to hold accountable for leading the process and delivering results. This also meant civil society had no legitimate space to participate and voice concerns.

Serbia's experience also shows that a government's policy commitments are not sufficient if there is no money behind them. Despite its clearly articulated support for HIV and AIDS programming, Serbia's government had no financing plan for using domestic money to fill the gaps left by the Global Fund's withdrawal. Consequently, funding support to NGOs has declined steeply. Services for key populations, including people who inject drugs, sex workers and MSM/LGBT communities, were particularly hard hit. None operated in Belgrade, the country's capital and largest city. A drop-in center for people who inject drugs in Novi Sad, the second largest city, was supported by a municipal grant and was basically maintained by volunteers, who needed to find ways to bring needles and condoms from services in nearby countries where supplies remained available because of Global Fund support. A drop-in center for sex workers run by the same NGO received a two-year grant of €100,000 from a Roma-focused EU project, as most of their clients are Roma. According to the UNDP, community-based groups continue to the provide some MSM and sex worker services in several other towns and cities with small amounts of support from municipal and local governments.

As a result of these setbacks Serbia became again eligible for Global Fund support in the allocation period of 2017-2019, due to the rise in disease burden among MSM. However, the amount allocated is only $1 million—roughly twice the amount allocated to Montenegro, but for a country ten times the size—which was not sufficient to cover the need.

However, there were also some positive signs that may help lay the groundwork for progress toward sustainability. There was a solid government support for funding ART treatment and opioid substitution therapy, and a relatively strong Institute of Public Health. Other sources of external funding such as, EU funds for Roma programming was also promising to support some HIV services. Other positive steps included the establishment of the new National AIDS, TB, and Hepatitis Council in accordance with Global Fund criteria, which assumed the role of the CCM, and the development of a new National AIDS Strategy.

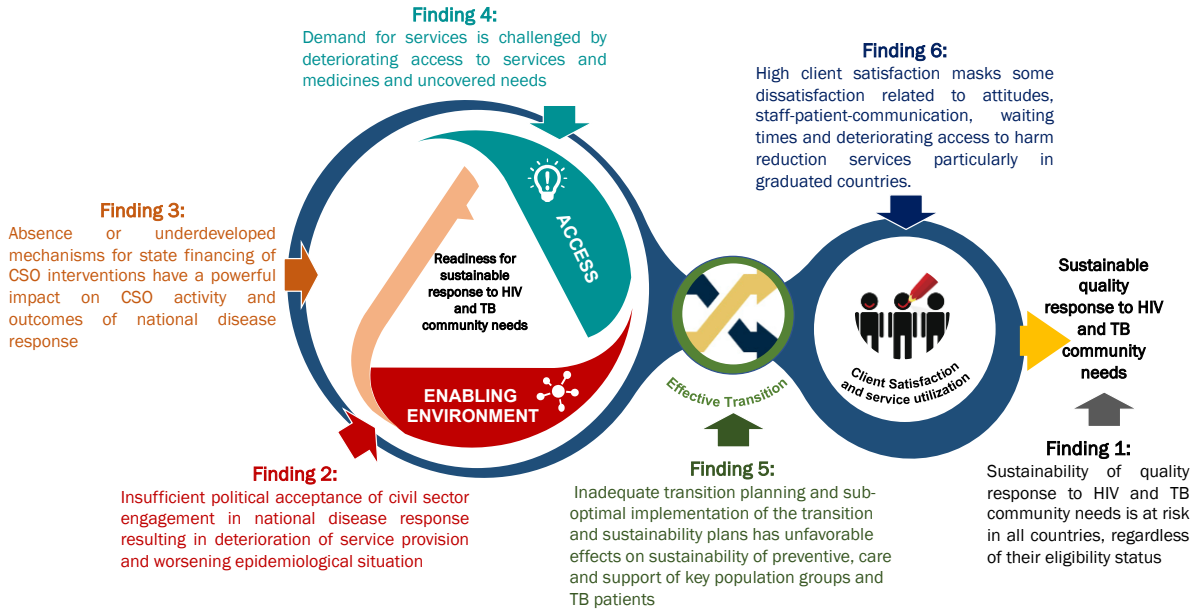
Serbia's limited transition and sustainability planning and the absence of external support during transition have left many gaps that could be remedied by sustainability bridge funding. Key areas that would benefit from grants are technical support for social contracting mechanisms in the Ministry of Health (and improvement of those already existing in the Ministry of Labor, Employment, Veteran and Social Affairs and the Ministry of Youth and Sports), including the process of identifying future funding sources for key populations; efforts to ensure the new CCM can function sustainably after external support ends; immediate bridging funds to re-establish drop-in centers and other services for key populations in several cities; and assistance to NGOs to develop their capacity for coordination and budget advocacy and monitoring.

3. Key Findings and Recommendations

3.1 Conclusions: Key Findings

This section of the report summarizes key findings of the study across research framework domains schematically presented on the Figure 28 and detailed below.

Figure 28: Key Findings Across Domains of Research Framework



Finding 1: Sustainability of quality response to HIV and TB community needs is at risk in all countries, regardless of their eligibility status.

- **Graduated countries failed to ensure long-term sustainability:** Graduated countries failed to ensure long-term sustainability of CSO provided services. Graduated countries failed to sustain coordination function, ensure continuity of preventive, care and support services, particularly of harm reduction services in the situations where HIV prevalence among people who inject drugs is a leading cause of the epidemic.

- **Countries scheduled for transition not yet ready:** Countries scheduled for transition in coming years are not proactive enough to ensure smooth transition. Albeit some of them already started transition planning and gradually increase funding for national response, preventive, care and support services provided by CSOs are largely underfunded. Mechanisms for continuation of these services are either absent, or without clear rules, procedures, funding sources and adequate allocations. If issues related to sustainment of these services not addressed in an immediate future, it is likely that these countries will face same epidemiological challenges as already graduated countries had after transition. There is a window of opportunity to share lessons learned from graduated countries, plan accordingly and ensure effective implementation of activities targeted at sustainment of CSO provided services.

Finding 2: Insufficient political and legal acceptance of civil sector engagement in national disease response results in deterioration of service provision and worsening epidemiological situation.

In recent years, international donors have begun tapering foreign assistance. Donors are instead focusing on transitioning the management of development programs and disease responses to country governments—helping reduce countries' dependence on foreign aid and preparing them to manage their own development challenges, without the need for external funding. If this transition to self-reliance is to succeed, countries have to strengthen their capacity to implement

policies, mobilize and manage public resources, and incorporate locally-led development principles, while maintaining progress already gained and to further expand. One crucial aspect of transition is the continued role of civil society organizations, organizations that have typically been supported by external donors.

The relationship with the state is commonly noted to be a determinant of impact. The study reveals that albeit the role and participation of the civil society in the fight against HIV/AIDS and TB is highlighted in the national disease strategies in all countries studied, the reality is different. CSO provided services yet remain heavily dependent on external funding. Half of CSOs in countries scheduled for transition are merely financed by GF and few have other sources of funding from membership fees and private sources. Number of CSOs financed from public purse, national or provincial/regional budgets, are few.

CSOs from graduated countries, are financed mostly by other donors or external sources. Insufficient CSO advocacy and ability to leverage funding, forced some CSOs to discontinue or scale down their activities. As experience of graduated countries display, limited state finances, state capacities and the unwillingness of the state to spend resources on CSO participation mechanisms negatively affects disease responses and enable them to meet SDG targets. Failure to achieve these goals will keep increasing both the budgetary demands and the social and human toll of the AIDS and TB epidemic well into the future.

An effective and successful participation of the civil society in the fight against HIV/AIDS and TB during and after transition will depend on three key factors (i) the existence of a legal framework that enables CSOs participation without political and legal restrictions; (ii) the willingness of the government to engage constructively with the civil society through adequate procedures, processes and funding that will guide the relationship between CSOs and the government; and (iii) the effective engagement of CSOs in the fight against HIV/AIDS.

Finding 3: Absence or underdeveloped mechanisms for state financing of CSOs have a powerful impact on supply, access to CSO provided services and outcomes of the national disease response during and after transition.

Financial sustainability remains the top concern for civil society. In the absence or limited public funding, CSOs are forced to hunt for donor funds. Majority of surveyed CSOs report declining revenues over the past 5 years. Study indicates that Albania and Romania, countries which already graduated from the Global Fund, do not practice CSO contracting and lack the mechanism for public procurement of CSO provided services, consequently affecting access to prevention, care and support services, largely provided by CSOs.

In countries, where CSO contracting (social contracting) is practiced, the evidence is contradictory, but in all cases indicates that its impact on CSO interventions and outcomes can be profound. CSO contracting mechanisms applied are not streamlined and pose challenges. Funding from domestic sources is extremely low (<10 percent of organization's annual budget). Consequently, CSO contracting has to be scaled-up to allow self-sustainment and continuation of services provided by CSOs after the seize of external funding.

The scale up of social contracting is challenged by number of factors. Unlike foreign donors, governments often face legal, regulatory, structural, human resource, financial, and political barriers to supporting and contracting with civil society organizations to provide services. Hence there is a need for governments to ensure that there are mechanisms in place to provide resources to civil society, including KP communities using domestic resources and to forge working mechanisms for their meaningful engagement in effective and cost-efficient service delivery.

Social contracting in these countries contribute to imbalance between large and small CSOs and limits access to public funding for the new one ones. Hence, establishment of free and fair competition, clear and transparent application and selection procedures that provides maximum clarity and openness of the process along with equal treatment of applications (a set of pre-established clear and objective criteria, which ensure non-discrimination and selection of the most qualified applicant based on the merit of the proposal) is the area requiring improvements. In addition, standardization of service packages for each key population groups, procedures for

application, documentation, reporting requirements, oversight and supervision to the programme activities are required to be proportionate of funding provided for expansion and effective implementation of social contracting.

Getting the funding relationship right is increasingly important if the financial stability of service delivery organizations is to be assured, and so that government can look confidently to the civil society sector to deliver HIV and TB services. Four key points have to be addresses: i) allow multi-year funding; ii) permit advance payments; iii) cover full cost of service provision including administrative costs; iv) ensure timely payments. Mutual trust, understanding, partnership and coordination are the core values for successful implementation of CSO funding modalities.

Finding 4: Demand for services is challenged by deteriorating access to services, medicines and uncovered needs in both, graduated and transitioning countries.

Despite universal recognition of the right to HIV and TB services, people continue to be deprived of access and timely care.

- **Importance of the CSO role in demand creation should not be underscored:** Survey of people living with HIV and TB indicate the important role CSOs play in identification of KP and generating demand for HIV services among them, whereas the role of CSOs is less evident in case of TB patients which mostly receive information about available services from health personnel. As CSO engagement remains limited in TB response, and in most countries HIV component will be the first to graduate from the Global Fund support, without effective fundraising from all, public, private and external resources, CSO engagement will dimmish in national HIV response and adversely affect demand for HIV services, especially among hard to reach groups of KP.
- **Health services providers** Even if the CSO provided services will be provided by health facilities, current challenges service users face will further aggravate. At present, to receive health facility based HIV and TB services appointments are to be schedules one week in advance and in case of KP majority of them have to travel long distances, while TB patients have better geographical access to needed services. The international evidence display an inverse association between a geographic or transportation-related barrier and an HIV-related outcome. The presence of geographic barriers would be associated with unfavorable outcomes at all points along the continuum of HIV care, and that this effect would be observed across different countries of the region, time periods, and study populations. Apart from geographical access to services, PLHIV also report on barriers in collecting ARVs. Almost one fourth of respondents informed inconvenience in collecting ARVs. However, it may have a marginal effect considering that majority PLHIVs have to travel once to collect the ARV stock for more than a one month. Similarly, access barriers to anti-TB medicines are negligible.
- **Stigma and discrimination remains as distressing regular experience:** Stigma and discrimination is a distressingly regular experience for people living with HIV, key populations at higher risk of HIV infection and TB patients. This ill treatment is a major barrier to seeking services and other potentially life-saving health services. Stigma delays treatment and makes it more difficult to adhere to treatment.
- **COVID-19 pandemic highlights an emergency response planning need for HIV and TB services and underscores essential role civil society played.** COVID-19 has imposed profound challenges on all countries and communities, including on HIV and TB responses. As reported by study respondents, COVID-19-related restrictions had a disproportionate impact on the HIV and TB service users, especially affecting most vulnerable, marginalized and stigmatized communities. Travel restrictions, service suspension and disruptions created access barriers. But even as COVID-19 has disrupted HIV and TB services, the pandemic has underscored the transformative nature of HIV and TB investments and the essential role that communities play in responding to pandemics. The challenges created by lockdowns and other COVID-19-related restrictions have often been met with accelerated adoption of differentiated service delivery approaches by CSOs. Even in cases where health service access has been sustained or improved, CSO inputs have become more important with the increasing attention paid to improving the responsiveness of HIV and TB services to client needs. These factors have to make

governments more willing to explore links with non- governmental actors to enhance the coverage and quality of HIV and TB services.

Finding 5: Inadequate transition planning and sub-optimal implementation of the transition and sustainability plans has unfavorable effects on sustainability of preventive, care and support of key population groups and TB patients.

National Planning for transition and sustainability is undermined by sub-optimal implementation progress. Many countries of the region have developed some kind of medium to long term action plan to reflect on the relationship of the CSO sector with the state. The review of the most recent country specific TSP and NSPs revealed five key objectives addressing transition and sustainment of CSO provided services:

1. Empowerment and engagement of CSO in HIV policy, programming, advocacy;
2. Standardization of service packages for KP groups;
3. Development/enhancement of the CSO contracting/social contracting mechanisms;
4. CSO capacity building; and
5. Increase of public funding for CSO provided services;

However, political declaration and planning itself means little in terms of the impact of governmental measures if planned activities are not implemented as scheduled. In graduated countries CSO involvement in policy making, programming and advocacy is jeopardized by absence of a common platform or non-functional coordination mechanisms.

While CSOs in countries, planned for transition, continue their engagement in policy design and programming, impact of their advocacy efforts are not tangible. Funding mechanisms for financing CSO provided services are either absent or underdeveloped and to the large extend remain funded through external sources though at a limited scale. Stigma and discrimination still prevails and hinders access to services; CSO trainings needs not assessed, systems and mechanisms for domestically funded continuous CSO capacity building are not established. Lack or insufficient advocacy efforts with its consequences can be explained by lack of knowledge and advocacy skills among CSOs.

States should invest in the capacity development of CSOs. While this presents a dilemma in terms of timing and resource constraints, this is of utmost importance in the region, where the authorities need to shift from service provision to policy-making and monitoring of quality standards, while CSOs need to ensure continuity of service provision and standards in order to become efficient service providers.

To maintain financial viability in the context of diminishing funding, CSOs revisited their functions, extended service packages and coverage to other groups of populations along with introducing three key strategies:

- To allow expansion of coverage and diversification of services provided to their clients **established partnerships with other civil society organizations**. Majority of CSOs partner and work closely with more than 6 civil society organizations to widen and sustain the impact of its work and increase access for key vulnerable communities in different geographical areas.
- To efficiently use scarce financial resources on the one hand, and to expand services and clients base on the other, CSOs **optimized staffing, revised staff salaries and benefits**.
- Apart from optimization of human resource costs, CSOs **strategically approached costs related to administrative functions**. More than half of them revisited effectiveness and efficiency of maintaining various office/program sites and downsized them by introducing the alternative service modalities and retention of local staff. Some shortened office operation hours.

Finding 6: High client satisfaction masks some dissatisfaction related to attitudes, staff-patient-communication, waiting times and deteriorating access to harm reduction services particularly in graduated countries.

The study revealed satisfaction with HIV & TB services, being provided by health personnel or CSOs. However, some dissatisfaction is masked in this high satisfaction level. This dissatisfaction underscores need to improve staff attitudes, staff-patient-communication, shortening waiting

times and improving access to harm reduction services particularly in graduated countries. Future studies need to focus on assessing long-term progression of satisfaction levels with services and determinants of satisfaction involving larger samples.

3.2 Recommendations

3.2.1 Recommendations for the Government

Recommendation 1: Definition of roles, responsibilities and positioning of the legally authorized coordinating authority in the government hierarchy to ensure its sustainable operation after the transition

The experience of the graduated countries shows deterioration of the national coordination function (Country Coordination Mechanism (CCM)). It has to be acknowledged, that albeit CCM liabilities cover only programs funded by the Global Fund, after the the seize of GF funding, countries should maintain national coordination function not only for the TGF grants, but for the overall HIV and TB national response. The Global Fund encourages all countries to build on their national structures, wherever possible, and to position Country Coordinating Mechanisms and/or their functions within existing health platforms to centrally coordinate health programs and policies. Positioning is a pathway to sustainable health governance, aimed at a progressive alignment of Country Coordinating Mechanism core principles with national institutions. COVID-19's impact on HIV and TB responses has stressed the need for well-integrated health mechanisms, thus the imperative for robust heath governance.

The Governments are advised to ensure the leading role in coordinating overall national disease response during and after transition, as well as its role in planning, implementation and provision of resources. The future institutional set-up of the coordination function should ensure adequate civil society actors' engagement.

Recommendation 2: Ensure that there are already tested and functional mechanisms in place to provide domestic resources to civil society, including KP communities and to forge working mechanisms for their meaningful engagement in effective and cost-efficient service delivery.

CSOs and Governments are advised to ensure:

i) Ensure prioritization of CSO contracting in national reform policies: Given the national reforms that are currently happening in countries (decentralization, service provider network optimization/rationalization, healthcare financing, Primary Health Care Reform, etc.), ensure that CSO financing/contracting is included as an important priority in the reform policy documents developed. It should also be ensured that when drafting the various legal amendments related to the current reforms (e.g. local government reform or social care reform), it should be ensured that social contracting is regulated properly. Key stakeholders should come together and define the key elements of the social contracting mechanism which should then be regulated in the law. This process should be a joint effort of CSOs, national government and local authorities to ensure that each of these partners understands the process and its role in it.

ii) Clearly define national targets with the involvement of all related partners, including CSOs: Consensus should be reached on: i) annual targets of KPs and suspected TB cases to be detected and treated; ii) standard service packages to be provided to each KP group and TB patients; iii) total annual budget required and the contracting of CSOs and public healthcare facilities to deliver these services; iv) appropriate distribution of the budget in relation to geographical locations; and v) roles and responsibilities of each key stakeholder in terms of supporting effective social contracting in as financial support, M&E, and capacity building in both technical capacity and organizational management.

iii) Map out and provide detailed analysis of the domestic financing mechanisms available to civil society organizations (CSOs) that are involved in the national responses to HIV and tuberculosis (TB). It identifies the barriers CSOs face when attempting to access and execute public and private domestic funds, and also highlights areas of opportunity, providing

specific recommendations for government and international donors to support expanded grant-giving to CSOs. The report's annexes contain step-by-step training materials to guide CSOs through the at times complex and confusing processes required to access public funding.

iv) Introduce effective, transparent, application, monitoring and supervision system: The social contracting mechanism should ensure that the selection is transparent; there is monitoring on spending, quality of the services and satisfaction of clients.

v) Balance the outreach of support: A typical dilemma in government funding for CSOs is the breadth of the outreach - should government support encompass the widest possible range of CSOs, or should it focus on just a smaller segment that is considered important, strategic for the national disease response. There is no blueprint whether countries should focus on broad reach of CSOs vs. more concentrated. Reach out broadly is usually to support CSO sector development as such (in order to enhance democratic development or increase CSO capacity to assist in resolving problems). The reason to concentrate the outreach is to make more effective use of the limited resources that are available. Thus, the decision has to be contextualized.

vi) Get the funding relationship right:
   a. A sustainable sources of funding – guarantee availability over the long-term through funding sources that do not burden the annual budgets by direct spending but rather mobilize additional resources whether from the governmental or private sector.
   b. Stability in the funding relationship - moving from one year funding to longer-term funding arrangements where appropriate;
   c. Timing of payments and the balance of risk - recognize that payment in arrears often results in CSOs' bearing the upfront costs of borrowing and the risks that this entails;
   d. Full cost recovery - ensuring that it is legitimate for CSOs to recover the appropriate level of overhead costs associated with the provision of a particular service;
   e. Reducing the burden of bureaucracy - streamlining access and performance management requirements for multiple, and often very small, funding streams.

vii) Start the CSO contracting process as early as possible: While it is important for all pieces of the puzzle to find their right places, it is important to start the social contracting process as early as possible - as long as there is a legal possibility and sufficient funding to contract some services. Practicing the process will give important feedback that will help improve the mechanism in the future

viii) Design and Institutionalize CSO capacity building system and mechanisms

Recommendation 3: Ensure HIV and TB services as essential services in contingency planning and the response to the emergencies, including COVID-19

Beyond the direct impacts of COVID-19, the pandemic has triggered access to SRH services, severely undermining prospects of achieving SDG 3. This reality shows that health care services and systems matter more than ever. It is not surprising that the additional burden of planning and responding to the pandemic runs the risk of overwhelming health systems, leaving ongoing preventive care by the wayside. This inevitably leads to increased morbidity, mortality particularly in vulnerable populations and increased health care costs. Therefore, while the Government must scale up immediate health response to curb the spread of COVID-19, it must also ensure essential health services, including core HIV and TB services, continue, keeping progress towards SDG3 at the forefront of the health agenda.

New guidelines are drawn up to help countries maintain essential health services during the COVID-19 pandemic[42], the WHO defines 'HIV and TB services' as essential services for which governments should produce contingency plans. The Government is called to treat HIV and TB services as integral to the national response to the COVID 19 or any other emergencies. This will allow people to travel for HIV and TB services—even in areas under stay-at-home orders or

[42] WHO guidelines to help countries maintain essential health services during the COVID-19 pandemic, 2020 https://www.who.int/news-room/detail/30-03-2020-who-releases-guidelines-to-help-countries-maintain-essential-health-services-during-the-covid-19-pandemic

travel restrictions—without fear of legal consequences. Meeting these core obligations is essential and mandatory in the time of COVID-19 and/or other emergencies.

Recommendation 4: Adapt policies, technical guidelines, and protocols for alternative HIV and TB service delivery models, including telemedicine, to ensure access to these services during and after COVID-19 pandemic.

Digital Health strategies adopted during COVID-19 outbreak could be turning the crisis into an opportunity. Digital health technologies offer significant opportunities to reshape current health care systems. From the adoption of electronic medical records to mobile health apps and other disruptive technologies, digital health solutions have promised a better quality of care at a more sustainable cost[43].

In support of telemedicine, which benefits service users and the public more widely, we strongly believe that irrespective of consultation modality, best practice and guidelines must be adhered to at every user contact to ensure safety and quality of care. Therefore, the Government jointly with professional associations is advised to develop a set of 'best practice' standards of care for those providing HIV and TB services through avenues other than traditional face-to-face services. These could include a range of modalities from real-time interactive health care via a video link to web-based questionnaires. This recommendation should be implemented while ensuring patient and staff safety regarding cross-contamination

3.2.2 Recommendations for Civil Society Organizations

Recommendation 5: Enhance Advocacy and streamline communication

Achieving the SDGs will require vast sums of finance to be mobilized from the widest range of sources in support of the agenda at a time when governments face mounting pressure on their budgets. In 2021, as countries map a path to recovery from the pandemic, the advocacy role of CSOs becomes even more important than ever. Thus, CSOs are advised:

i) Establish CSO advocacy coalitions: develop the network of CSOs, which now undertakes joint advocacy to support the implementation of national commitments to HIV and TB national response. Collaborative CSO advocacy can best support national efforts.

ii) Develop and ensure effective implementation of advocacy plan: Advocacy for sustainable HIV and TB response should be a combined effort of a group of individuals or organizations to persuade influential individuals and groups and organizations through various activities to adopt an effective action as quickly as possible, use multiple complementary strategies, target many influential individuals and groups at the same time to achieve goals and establish supportive environment for sustainable response. The latter consequently needs a comprehensive national advocacy and communication strategy and a plan outlining the roles of each member organization, key issues, providing details of specific issue in terms of the key messages, target audience, advocacy partners, steps to be taken for conducting advocacy, and challenges and opportunities for conducting advocacy for the particular issues. Finally, a costed workplan should be developed and funds leveraged for carrying out said activities and implementation of the advocacy plan monitored and revised as needed.

Key advocacy topics

- Advocacy for retive and regulatvision of legislative and regulatory framework to minimize stigma and discrimination against KP and people affected by TB;
- Allocation of higher share of domestic funding for prevention, care and support
- Development/streamlining and scale-up of CSO contracting mechanisms
- Introduction of the system for continious capacity buidling og CSOs (advocacy, communication, HR management, Financial management, service delivery related trainings, etc.)
- Development of contigency planning for CSO provided services during emergencies to ensure service continuity

[43] Pol Perez Sust, et al., Tuning the Crises into an Opportunity: Digital Health Strategies Deployed During the COVID-19 outbreak, JMIR Public Health Surveill, May 2020

iii) Build CSO advocacy and communication capacity: Identify and address advocacy and communication capacity needs of members in order to effectively implement HIV and TB advocacy.
iv) Sharing of best practices across regions and internationally: Supporting CSO advocacy collaboration in countries remains a critical component to achieve HIV and TB SDG goals. This will naturally happen at different rates in different countries, according to available resources and factors such as political will and leadership. However, more rapid advances can be made if country CSO coalitions take steps to learn from each other how best to advocate and greater accountability. Recommended actions for the future include increased sharing of best practices across regions and internationally.
v) Enhance watch dog function and ensure transparent accountability

Recommendation 6: Ensure powerful advocacy for and vigorous engagement in the development /streamlining and scale-up of CSO funding modalities, mechanisms and procedures.

CSOs or CSO advocacy coalitions are advised to accelerate advocacy to ensure sustainability of prevention, outreach, support and care services provided by CSOs for this purpose it is recommended to:

i) Intensify advocacy efforts to safeguard increased resource allocation in coming years as well as in annual disease budgets for prevention, outreach and care through social contracting.
ii) Aggressively advocacy at higher level of the government to identify funding mechanism and funding sources where needed
iii) Advocate and participate in the refinement of legislative framework allowing CSO funding.
iv) Actively engage in the development/refinement of the CSO funding procedures (standard costed service packages for KP and TB patients, tendering and application requirements, application and contract award processes; funding rules and supervision and monitoring schemes).

Recommendation 7: Ensure establishment of systems and mechanisms for continuous CSO capacity building

CSO capacity building remains to be heavily dependent on external funding sources in all graduated countries and countries scheduled for transition. While CSOs are expected to perform varied functions in the field of HIV and TB, they face a range of capacity constraints and challenges. The challenges differ from organization to organization and are diverse in each country. Many of them do not have stable funding sources and rely on unpredictable, donor-driven project funding. Chronic limited human resource capacity, the inability to recruit and retain high quality staff, and high staff turnover are other areas where CSOs face urgent capacity challenges.

Countries in EECA region lack well-established systems that ensure channeling domestic investments for continuous CSO capacity building. While governments largely ignore a need for such investments, the evidence from countries in EECA region and outside, highlights the risk of depleting CSO capacity after seizing of external funding. Equally, the focus on CSO capacity building is not on an advocacy agenda of CSOs.

These deficits impact CSO effectiveness and credibility to provide citizens with a voice, provide services and also engage with governments and stakeholders in substantive dialogues on key development issues. Thus, CSOs are advised to:

- Advocate and lead the dialogue with the government and all key stakeholders on possible mechanisms for funding and delivery of CSO capacity building activities: CSOs are advised to obtain the government's buy-inn for the importance and a need for establishing CSO capacity building systems, delivery mechanisms and funding modalities. Asist the government in elaboration of such mechanisms and development of training programs, building the capacity of designated institutions/organizations.
- Conduct CSO capacity assessment: Undertake a systematic assessment of the CSOs' capacity to understand and document the capacity constraints that civil society

organizations face in the region. Mindful of the sensitivity of such an exercise, the capacity assessment has to be conducted in a participatory manner in the development of the questionnaire, in the conduct of the assessment itself, and in the validation of the results. This will help to shape the capacity building agenda and development of training programs.

Recommendation 8: Promote alternative service delivery modalities to efficiently use available scarce resources and ensure continuity of service delivery

Promotion and institutionalization of alternative service delivery modalities adopted during COVID-19 outbreak by CSOs could be an opportunity for provision of these services at a more sustainable cost. Thus, CSOs are advised to advocate and take an active part in the development and approval of the policies, technical guidelines, and protocols for alternative HIV and TB service delivery models, including telemedicine, to ensure access to these services during and after COVID-19 pandemic.

Recommendation 9: Streamline planning and implementation of national transition and sustainability activities

CSOs in all countries regardless of their transition status, are advised to advocate for inclusion of activities ensuring smooth transition and sustainability of CSO provided HIV and TB services into the national disease responses and ensure active involvement and rigorous monitoring of implementation.

Recommendation 10: Advance collective and individual CSO transition and sustainability planning and ensure effective implementation

In countries planned for transition or in transition, CSOs are recommended to develop collective (for all CSOs) or individual transition and sustainability planning. In planning process emphasis should be placed on the development and implementation of fundraising strategies, optimization of human resources and operational costs, institutionalization of alternative service delivery modalities for expended coverage and optimization of operational expenditures, continuous staff capacity building.

Annexes:

Annex 1: List of Core Country Documents Reviewed

1. The Global Fund Strategy 2017-2022, https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy
2. Prevailing against pandemics by putting people at the centre, world AIDS Day, 2020, https://www.unaids.org/sites/default/files/media_asset/prevailing-against-pandemics_en.pdf
3. Prevention Gap Report, UNAIDS, 2016
4. Miles To Go Closing Gaps- Breaking Barriers Righting Injustices, UNAIDS, 2019
5. Regional overview, Eurasia, Harm Reduction International, 2016
6. World Drug Report, UNODC, 2016
7. Easter Europe and Central Asia: Let's not Lose Track, Eastern Europe and Central Asia Union of PLHW (ECUO), 2016
8. UNAIDS, "AIDSinfo", http://aidsinfo.unaids.org/ Accessed in August 2020
9. McClarity, L etal, Estimating female sex worker's early HIV and Hepatitis C risk in Dnipro, Ukraine: Implications for epidemic control, 2016
10. UNAIDS "Gap Report", 2014
11. Prevention Gap Report, UNAIDS, 2016
12. People Living with HIV Stigma Index surveys, 2013–2015
13. Treat all: policy adoption and implementation status in countries, November 2017. Geneva: World Health Organization; 2017 http://apps.who.int/iris/bitstream/handle/10665/259532/WHO-HIV-2017.58-eng
14. Projected transitions from Global Fund country allocations by 2025: projections by component, GF, March 2018 update and January 2020
15. Projected transitions from Global Fund country allocations by 2025: projections by component, GF, January 2020
16. Status of transitions from Global Fund support in the EECA region, EHRA, 2018
17. Transition from donor funding to domestic reliance for HIV responses- Recommendations for transition countries, AIDSPAN/APM Global Health, 2016
18. Thomas DR. (2018) Grounded theory. Chapter 22 in How To Do Primary Care Research, edited by Goodyear-Smith F and Mash R.
19. Buse K, Blackshaw R, Ndayisaba MG, Zeroing in on AIDS and global health Post-2015.Global Health. 2012 Nov 30; 8:42.
20. Sustainability bridge financing: Case study from Bosnia and Herzegovina, Montenegro and Serbia, EHRN, 2019
21. Letter to Dr. Kaberuka et al on the emergency situation concerning the sustainability of harm reduction services in the South East European countries of Albania, Bosnia and Herzegovina, Bulgaria and Romania, 2019
22. Comments included in the 2017 Global Fund Eligibility List. https://www.theglobalfund.org/media/5601/core_eligiblecountries2017_list_en.pdf
23. National strategy for the prevention and control of HIV/AIDS in Albania 2015-2019
24. National TB strategy, Albania 2015-2019
25. Instrument for pre-accession assistance (IPA II), 2014-2020
26. GLC/Europe mission for monitoring of the implementation of the national M/XDR-TB response plan in n Albania, 2013
27. Georgia Transition Plan, Curatio International Foundation, 2017
28. Optimizing investments in the former Yugoslav Republic of Macedonia's HIV Response, 2014
29. Public call for selection of associations and allocation of funds to associations that will implement activities determined in the Program for protection of the population from HIV

infection in the Republic of Northern Macedonia for 2020 ("Official Gazette of the Republic of Northern Macedonia no. 278/2019 from 28.12.2019")
30. National HIV Strategy Action Plan 2015 – 2020, Montenegro
31. National TB Control Program 2016-2020
32. National Program for the Prevention and Control of HIV/AIDS and STI 2016-2020
33. National TB Control Program 2021-2025, Moldova
34. National Program for the Prevention and Control of HIV/AIDS and STI 2021-2025, Moldova
35. Evaluation Report of NGO grants for TB services in Moldova, 2017
36. Sustainability and Transition Plans for HIV & TB 2017-2020, Moldova
37. Assessment of the National TB and HIV/AIDS & STIs Programs' management, and scenarios aimed at improving overall NPs management, governance and control in Moldova, 2015
38. Mid-term evaluation of the Sustainability Plan pf the National HIV / AIDS / STI Prevention and Control Program 2017-2019.
39. Costing and budgeting TB program components to be transitioned form Global Fund support in Moldova, 2019
40. Analysis of possibilities of state funding of NGOs active in TB sphere, Moldova, 2020
41. TB Transition Plan 2015-2020, Romania
42. National Strategy for TB Control in Georgia 2019-2020
43. Georgia HIV/AIDS National Strategic Plan 2019-2020
44. Information on ensuring the sustainability of the National Response to HIV in the Republic of Macedonia within the budget of the Ministry of Health
45. National strategy on HIV 2017 – 2021, N. Macedonia
46. HIV: opportunities and suggestions to ensure sustainability of activities supported from the Global Fund in the republic of Macedonia, 2017
47. Action plan for transition from Global Fund support to national financing of HIV prevention and support programs for key affected populations, N. Macedonia, 2016
48. EATG Rapid Assessment COVID-19 crisis' Impact on PLHIV and on Communities Most Affected by HIV, 2020
49. Transition Plan for the Continuation of HIV and AIDS Prevention, Treatment and Care in Bosnia and Herzegovina 2015-2017, 2015
50. Towards Domestic Financing of National HIV Responses Lessons Learnt from Serbia, UNDP, 2016
51. Transition of TB program in Romania: the role, opportunities and priorities for civil society, EHRA, 2019
52. National HIV/AIDS Strategic Action Plan Kosovo 2018-2022
53. The impact of the global fund's withdrawal on harm reduction programs: a case study from Serbia, Eurasian Harm Reduction Network, 2015
54. Discussion Paper Handing Over Health: Experiences with Global Fund Transitions and Sustainability Planning in Serbia, Thailand and South Africa, ECASO, 2016
55. Sustainability bridge financing: Case study from Bosnia and Herzegovina, Montenegro and Serbia, EHRN, 2019
56. Open Society Foundations. Lost in Transition: Three Case Studies of Global Fund Withdrawal in South Eastern Europe. New York, NY, USA; Open Society Foundations Public Health Programs, December 2017. https://www.opensocietyfoundations.org/uploads/cee79e2c-cc5c-4e96-95dc-5da50ccdee96/lost-intranslation-20171208.pdf
57. Drug Policy Network South East Europe. Addressing the acute funding crisis facing harm reduction services in South-East Europe. Belgrade, Serbia; Drug Policy Network South East Europe, November 2018. http://dpnsee.org/wp-content/uploads/2019/07/Addressing-the-acute-funding-crisis-facing-harmreduction-services-in-South-East-Europe.pdf
58. Sanigest International. Transition Readiness Assessment: Tuberculosis & HIV Supported Programs in Albania. Draft, March 2019.

59. The impact of transition from global fund support to governmental funding on the sustainability of harm reduction programs: A Case study from Romania, EHRN, 2016
60. Transition Plan for the Continuation of HIV and AIDS Prevention, Treatment and Care in Bosnia and Herzegovina 2015-2017
61. People Living with HIV Stigma Index surveys, 2013–2015
62. Miles to go: closing gaps breaking barriers righting injustices, Global Aids Update, 2018

Annex 2: Activities addressing sustainability of CSO provided services

Country	Issues addressed for sustainability of CSO provided services
ALB	- Strategic partnership with CSOs - Engagement of CSOs in service provision for different KP and other vulnerable groups - Identify, and raise the capacity of, locally based CSO's to continue the provision of prevention services
BIH	- Initiation of multi-sector dialogue between the governments and CSOs/NGOs aiming at provision of comprehensive services for KP migrants and mobile population and allocate funds into national programs - Synchronization of standards of packages of services for working with KP
GEO	- Review State Procurement Law and relevant regulations to identify potential barriers for CSO-contracting to deliver HIV and TB community services under the state funding - Assess the barriers and opportunities for CSOs to satisfy the state procurement requirements - Develop and adopt detailed operational manual describing the rules and procedures for contracting CSOs for health service delivery - Build Capacity for CSOs, their networks and coalitions – through training and technical assistance in management, resource mobilization for CSOs/CBOs to satisfy the state procurement requirements. - Develop a comprehensive policy for production/training of qualified CSO personnel - Training of CSO staff to support practical application of the national HIV and TB standards and guidelines - Build Capacity for CSOs/CBOs, their networks, and coalitions – through training and technical assistance in management, resource mobilization for CSOs/CBOs to satisfy the state procurement requirements.
XKX	- Create a sustainable legal mechanism for CSO Contracting - Assessment of CSO landscape - Increase public funding for services delivered by CSOs to KAPs - Training of local civil society organizations to increase their capacity for fundraising, proposal development, and resource mobilization - Empowerment and engagement of CSO in HIV policy, programming, advocacy and HIV services in the community through community systems strengthening
N.MCD	- Cooperate with CSO on the topics of prevention, support and treatment for HIV/STI - Clearly define the competencies (competencies, scope of work) of the civil society organizations during the implementation of the national strategy. - Lay down general and specific criteria for the financing of preventative activities to be conducted by CSO - Define improved and optimized packages of services, including peer support, escort, legal aid and individual and group education - Provide legal basis for sustainability of the HIV prevention programs managed by the CSOs - Ensure functional links between civil society organizations and public health organizations, social services and other institutions - Enable participation by key and affected populations and individuals living with HIV in the process of planning, program activities implementation and decision making, as well as in corporate social responsibility activities - Specify the manner of funding/transferring funds to the citizen associations, which would enable an uninterrupted implementation of the activities - Capacity building of CSOs working with KP
MNE	- Preparation and submission of proposed amendments to the Law on Health Insurance for NGOs that will be recognized as providers of preventive health services - Organize trainings for peer educators for HIV and STIs
MLD	- Support for non-governmental organizations with small grants

Country	Issues addressed for sustainability of CSO provided services
ROM	- Development of a functional mechanism for CSO contracting - Pilot NGO subcontracting model implemented by MoH - Engage and facilitate involvement of impacted communities and civil society organizations in TB control - CSO capacity building in community based TB service provision - Work with decision makers to identify and overcome barriers to funding and providing HIV/TB prevention and care services, including universal access for health education and provision of services by CSOs.
SRB	- Increasing capacity of institutions and associations for recognizing health and social needs and possibilities to respond to the specific needs of the men who have sex with men population - Developing capacity of associations of citizens as well as state institutions or field workers in working with KP - Strengthening capacity of state institutions and authorities, associations of citizens, to respond to the needs of KP, including the legal aspect - Sensitization of local self-governments to support programmes within social care for and health of PLHIV as well as to population vulnerable to HIV at the local level, provided by NGOs - Involvement of associations of citizens dealing with PLHIV and especially vulnerable groups in education of employees in health, educational and institutions of social protection - Strengthening capacity of institutions and associations for monitoring and evaluation