TOWARDS DOMESTIC PUBLIC FINANCING AND SOCIAL CONTRACTING FOR HARM REDUCTION

HARM REDUCTION INTERNATIONAL

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Gaj Gurung & Catherine Cook

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61 Mansell Street, Aldgate
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HARM REDUCTION INTERNATIONAL

Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

HRI is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

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EXECUTIVE SUMMARY

Harm reduction funding in low- and middle-income (LMI) countries totalled US$ 131 million in 2019,[1] just 5% of the US$ 2.7 billion that UNAIDS estimates to be required annually by 2025 to meet global targets to address HIV, viral hepatitis and sexually transmitted infections (STIs).[2,3] The funding shortfall has progressively worsened over the past decade, as resource needs have increased and support from the small pool of international donors has reduced. Middle-income countries, where the majority of people who inject drugs live, are particularly susceptible to reductions in funding from international donors, since country income status is often used to determine eligibility for funds.

However, a country's wealth does not predict investment in harm reduction. Increases in domestic support for national HIV and broader health responses are rarely targeted to people who use drugs. Moreover, vast amounts from national drug policy budgets are spent on punitive drug law enforcement, while they are rarely a source for harm reduction investment.[4]

Understanding the extent, nature, and direction of domestic funding for harm reduction is hampered by limited quality data and a lack of adequate disaggregation in financial monitoring systems at national, provincial, and local levels. Harm Reduction International's global monitoring research indicates that government investment may be increasing, representing a greater share of overall harm reduction funding in 2019 than in 2016, but increased access to data is likely also behind this finding.[5] Overall, funding has decreased, which means that reductions in international donor funds are outpacing any real increases in domestic contributions. Harm reduction remains over-reliant on international donor funding. For the transition away from international donor support to be successful, domestic funding must support quality, human rights-based harm reduction programmes, including community-led responses.

Normative guidance and global commitments place due importance on community-led responses as integral to an effective response to communicable diseases, pandemic preparedness, and resilient systems for health.

The 2022 updated World Health Organization's Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations include

1 Harm Reduction International (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. London: Harm Reduction International.
2 UNAIDS (2021) Global AIDS Strategy, End Inequalities. End AIDS. Geneva: UNAIDS.
3 World Health Organization (2022) Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. Geneva: World Health Organization.
4 Harm Reduction International (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. London: Harm Reduction International.
5 Harm Reduction International (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. London: Harm Reduction International.

community empowerment as 'essential for impact' and places key population-led networks and organisations as essential partners and leaders in designing, planning, implementing, and evaluating health services.[6]

The Global AIDS Strategy 2021-2026 envisions empowered, resourced, and integrated community-led HIV responses for a transformative and sustainable HIV response, with the 30:80:60 targets (see Box 1) articulating ambition in this regard.[7] The inherent challenges to achieving these goals are great, particularly for already under-resourced networks and organisations operating in punitive environments where they are criminalised.

To avoid set-backs and protect the gains made so far, countries must include community-led, community-based, and civil society actors in transition plans to shift from international to domestic funding. They must ensure structures and mechanisms are ready to channel domestic public funds to these organisations to provide quality, human rights-based harm reduction programmes. There also must be domestic support for community-led monitoring and advocacy, provided in a manner which does not compromise independence and the ability to scrutinise and hold governments to account. This work to future-proof community systems through transition must begin early to allow for laws and policies to be reformed and new mechanisms to be put in place, or existing mechanisms to be adapted.

Social contracting mechanisms and funding can offer an important framework for sustaining harm reduction community systems, safeguarding HIV prevention achievements made so far, and ensuring people who inject drugs have uninterrupted access to harm reduction services through transition. Drawing upon global data-gathering, country studies, and a review of the literature, this report explores the current state of public financing for harm reduction. It presents key elements and principles for successful social contracting and highlights those that may be particularly crucial for community-led responses for criminalised and marginalised populations, including people who use drugs. It summarises the readiness for public financing for harm reduction in six countries across East and Southern Africa, West and Central Africa, and Asia, and provides details on social contracting for HIV and harm reduction in practice.

6 World Health Organization (2022) Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization.

7 UNAIDS (2021) Global AIDS Strategy, End Inequalities. End AIDS. Available at https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026-summary_en.pdf

Box 1:

Key global targets related to people who use drugs and community-led responses

Global AIDS Strategy 2021-2026

HIV prevention for key populations received unprecedented urgency and focus in the Global AIDS Strategy 2021-2026 'End Inequalities. End AIDS', which calls on countries to utilise the full potential of HIV prevention tools, including for people who inject drugs and people in prison settings.

The strategy also includes the 30:60:80 targets relating to community-led responses, indicating that by 2025:

- 30% of testing and treatment services to be delivered by community-led organisations
- 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population and women-led organisations
- 60% of the programmes support the achievement of societal enablers to be delivered by community-led organisations.

In addition, by 2025, there is a target to ensure that:

- Less than 10% of countries have punitive legal and policy environments that lead to the denial or limitation of access to services

Global Health Sector Strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030

The Global Health Sector Strategies include people who inject and use drugs as a potential priority population across national responses to HIV, viral hepatitis and sexually transmitted infections. Harm reduction and treatment interventions for people who inject drugs is articulated as a shared intervention for a people-centred response to HIV, viral hepatitis and sexually transmitted infections.

The Strategies include a shared target to:

- Reduce the number of new HIV and viral hepatitis cases per year to less than 1.5 million by 2025

While within the viral hepatitis strategy, there is a target to:

- Reduce the number of new hepatitis C infections among persons who inject drugs per year to 3 per 100 by 2025

The Strategies include community engagement as one of the five strategic directions to end AIDS and the epidemics of viral hepatitis and sexually transmitted infections by 2030. The pivotal role of community and civil society in advocacy, policy making, delivering services, addressing stigma and discrimination and tackling social and structural barriers is highlighted as a shared action across responses to HIV, viral hepatitis and sexually transmitted infections.

RECOMMENDATIONS

Based on this review, we have developed the following concrete recommendations for introducing or improving social contracting for harm reduction:

Recommendations for government agencies and national mechanisms on HIV, viral hepatitis and drug policy:

- **Ensure social contracting mechanisms are in place to fund community and civil society organisations.** Where these mechanisms are in place, ensure these are fit-for-purpose. Where these are not yet in place, governments should undertake a consultation process that includes community and civil society, service providers and health financing experts to determine the preferred model for social contracting within the country context.
- **Include bold commitments for transitioning to domestic funding within national HIV, hepatitis and drug policy strategies.** These should include a roadmap for success and accountability mechanisms for monitoring and reporting on progress.
- **Establish linkages and open dialogue with technical partners and international donors on transitioning to domestic funding.** Technical support needs can be highlighted and addressed and required flexibilities in international donor funding can be planned to support the shift to domestic funding via social contracting.

Recommendations for international donors and technical agencies:

- **Provide learning platforms on social contracting.** Awareness and understanding of social contracting mechanisms vary widely. Creating learning opportunities for government and community and civil society organisations to share experiences from varied settings is valuable for understanding what supports and hinders successful social contracting for harm reduction, including community-led responses.
- **Emphasise the importance of introducing social contracting mechanisms early and with the meaningful involvement of communities.** The process to develop these mechanisms can be long and involved, so it should start as early as possible and not wait until a country begins transition from international donor funding. The best way to ensure these mechanisms will work well for community-led responses is to involve communities in their development.
- **Provide technical assistance and funding to governments to introduce social contracting for harm reduction.** While one size does not fit all, international donors and technical agencies can support governments to learn from existing examples and develop their own context-specific mechanisms, policies, and regulations for social contracting.

- **Support and encourage governments and national mechanisms on HIV, hepatitis and drug policy to include bold commitments for transitioning to domestic funding within national strategies.** Provide funding and technical support for implementation and monitoring progress.
- **Provide technical support and bridge funding through transition.** During the transition period, technical support and/or bridge funding may be required to ensure services run continuously and interruptions are avoided.
- **Provide core, flexible funding that allows responsive advocacy within ever-changing policy environments.** Social contracting for harm reduction will only work if governments have the political willingness to fund programmes for people who use drugs. This will require sustained, strong community and civil society advocacy for legal and policy reform, including decriminalisation.
- **Build the capacity of community and civil society organisations.** Social contracting requires a robust and vibrant community and civil society sector. Building capacity to ensure readiness and eligibility to receive domestic public funds may be necessary. Fluency in domestic budget processes and budget advocacy is also important in order to engage in budget decision-making processes.
- **Collect and share data on social contracting.** Existing data collection mechanisms of international donors and technical agencies should include indicators on social contracting, the extent to which it is in place and working well for harm reduction and broader key population programmes, including community-led responses.

Recommendations for community-led, community-based, and civil society organisations:

- **Prepare for domestic funding for harm reduction.** Accessing domestic funding may require new skills and capacity, including budget advocacy training to understand, influence and monitor government budgets. Learning about government costing and funding practices, as well as contracting and reporting requirements will help to identify capacity gaps and technical support needs.
- **Assess the current status, scope, and appetite for social contracting.** Social contracting, if not yet introduced, may require a long process of policy formulation and then implementation. It is never too early to start gathering evidence on current practices including from other social and health sectors, supportive policies and challenges to inform advocacy for social contracting.
- **Include research, advocacy and monitoring activities on social contracting within funding and technical assistance requests.** There is increasing attention from international donors and UN agencies on social contracting, presenting opportunities to receive support for work in this area. Where social contracting is in place, community and civil society organisations can play an important role in monitoring and advocating for improved practices.

- **Advocate for social contracting that works for harm reduction and for community-led, community-based and civil society organisations.** Some countries, such as Indonesia, have social contracting policies and regulations that are not implemented for harm reduction. In such cases, advocacy should focus on revising policy regulations and pushing for implementation. In other countries, advocacy may be required to improve overly stringent or problematic aspects of social contracting mechanisms.
- **Form alliances with other community-led, community-based, or civil society organisations.** Introducing and improving social contracting mechanisms that work for harm reduction will also work for other areas of programming. Advocating with allies from key population networks and broader programming will strengthen the call for change. Broad alliances engaged in consistent domestic budget scrutiny and advocacy have seen positive results in some countries, such as Georgia.

1. THE CURRENT STATE OF DOMESTIC FINANCING FOR HARM REDUCTION IN LOW AND MIDDLE-INCOME COUNTRIES

Domestic financing encompasses public funds from national/central or local budgets, social insurance/protection schemes, and private expenditures, which would include direct spending from households. The extent to which people cover their own harm reduction expenses is an important area of investigation, but is rarely captured by studies or reporting mechanisms.

Establishing the extent to which governments invest in their own harm reduction responses is very challenging. There remains no adequate mechanism for systematically monitoring domestic harm reduction investment and there are many gaps, quality issues, and contradictions in the available data.[8] For example, country reports to UNAIDS Global AIDS Monitoring and Funding Landscape Requests provided to the Global Fund may include some information but may not undergo stringent checking or validation. There may also be incentives to over or underestimate domestic investment. There are significant gaps in our knowledge due to the lack of available data. For example, information on domestic harm reduction investment in China is not publicly available, but we know the government makes significant investment in harm reduction. These uncertainties make it difficult to reach concrete conclusions on the state of domestic investment in harm reduction in low- and middle-income (LMI) countries, which both inhibits our understanding of the situation and threatens the ability of communities and civil society to hold governments to account.

8 In HRI research, we have utilised country reports to UNAIDS via Global AIDS Monitoring (GAM) and information provided by countries to the Global Fund during the grant application process, contained in national Funding Landscape Reports (FLRs).

Table 1:

Top 10 countries with the highest level of identified domestic funding for harm reduction, 2019

	Country	Income Status	Identified domestic funding US$	Identified donor funding US$	Total identified funding US$	Share of domestic funding	Number of people who inject drugs (GSHR 2020/ UNAIDS)	Total funding per person who inject drugs, 2019 US$
1	Malaysia	UM	1,708,624	-	1,708,624	100%	75,000	23
2	Serbia	UM	2,225,063	17,834	2,242,897	99%	20,500	109
3	Iran	UM	14,222,829	481,417	14,704,246	97%	186,686	79
4	India	LM	11,000,000	963,273	11,963,273	92%	850,000	14
5	Kazakhstan	UM	2,255,590	459,600	2,715,189	83%	120,500	23
6	Indonesia	LM	2,806,375	622,148	3,428,523	82%	33,492	102
7	Vietnam	LM	12,531,341	3,846,275	16,377,616	77%	189,000	87
8	Georgia	LM	3,877,889	1,455,822	5,333,711	73%	52,500	102
9	Belarus	UM	1,438,426	906,510	2,344,936	61%	66,500	35
10	Thailand	UM	1,334,711	2,524,532	3,859,243	35%	51,000	76

In 2021, Harm Reduction International (HRI) used the best available data to establish the state of harm reduction funding in LMI countries.[9] We identified domestic harm reduction investment in 38 LMI countries in 2019, totaling US$ 63.2 million, an increase from US$ 48 million in 2016. However, this uptick in domestic investment is likely less pronounced than it seems, as there was an increase in available data during this period. Domestic funding for harm reduction constituted around 48% of the total amount identified in 2019.

While it is encouraging that some governments are investing in harm reduction, whether priority interventions such as needle and syringe programmes (NSP), opioid agonist therapy (OAT), and peer naloxone distribution are supported, the quality of programmes delivered and the extent to which funds are directed to community-led, community-based, and civil society organisations requires further scrutiny. This scrutiny is particularly important for programmes funded by governments that also criminalise and marginalise the populations that they aim to reach.

In general, domestic funding for harm reduction, as with other health programmes, is managed directly by the relevant government department and implemented via health facilities, or contracted out to non-governmental entities, including civil society, community-based, and community-led organisations – a process sometimes termed social contracting. When international donors fund harm reduction, this is often directed towards civil society and community-based organisations. While funding for community-led organisations is sorely lacking, the Global AIDS Strategy 2021-2026 and several international donors place an emphasis on rectifying this.

We do not have the necessary data to compare the extent to which community and civil society organisations are funded from domestic budgets for harm reduction, but this is likely to be a small proportion of the investments reported. HPP+ found that within PEPFAR countries, the level of domestic funding for civil society organisations was “dangerously low”, with less than 10% of those working in HIV being financed domestically.[10] More research is necessary to assess this for harm reduction in LMI countries, but a general trend observed was that where OAT was supported by government funding, it was often implemented by the government. Contracting out to community and civil society organisations was more likely to be for implementing less-medicalised programming such as harm reduction outreach, counselling and condom distribution.

In order to encourage domestic public finances to be directed to community and civil society organisations, the importance of their role in health responses must be understood by governments and the practice of social contracting to be supported within laws and policies.

9 Harm Reduction International (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. London: Harm Reduction International

10 Health Policy Plus presentation on supporting sustainability for national HIV programs. Available from https://onusida-lac.org/1/images/2017/10LACIII-Forum-HP-Presentation.pdf

Box 2:

Harm reduction in low- and middle-income countries is reliant on international donor funding

International donors provide the majority of funding for harm reduction in low- and middle-income (LMI) countries, accounting for 52% of identified harm reduction resources in 2019. This funding supported harm reduction in 50 low and middle-income countries, with a total investment of US$ 68.1 million, dropping from US$ 121 million in 2016. The largest shares of international donor funding for harm reduction were identified in Asia, Eastern Europe and Central Asia, and Sub-Saharan Africa. The Global Fund continues to be the largest donor for harm reduction (60%), followed by PEPFAR (12%), Open Society Foundations (10%), Dutch MOFA (7%), Elton John Foundation (4%), Robert Carr Fund and UNODC (3%), and Frontline AIDS, GiZ, and ViiV Health Care Positive Action (>1%).

International donor funds were provided through long-term grants, short-term projects, and short-term technical assistance. Less than 7% of international donor funds for harm reduction in 2019 were directed towards community-based organisations. While the extent to which community-led organisations were supported was not possible to establish since it was not tracked by donors, this figure was clearly very low.[11] Information on international donor support for advocacy, legal, and policy reform and human rights – all crucial for ensuring access to harm reduction services – is fragmented. Of concern, opportunities for advocacy funding have reduced in recent years as a result of shifts in donor priorities and structural changes.

11 Harm Reduction International (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. Harm Reduction International, London

2. SOCIAL CONTRACTING – WHAT IS IT AND HOW DOES IT WORK?

The term social contracting is used within international discourse on health financing practices to describe an overarching mechanism defining the partnership between the government and non-government actors to achieve shared goals. In relation to health, social contracting is the process by which government resources are used to fund non-governmental entities to provide health services that the government has a responsibility to provide, in order to assure the health of its citizens.[12] It is sometimes also described as public financing for programmes and services implemented by civil society or social provision of services. While this paper will use the term social contracting, we recognise that this term may not be globally understood and is not often explicitly used within national or local regulations, laws, or policies that support its implementation.

In general, countries that employ social contracting practices have formulated regulations, laws, and policies to support their implementation. The most common regulation encompassing social contracting is the public procurement act or regulation. In Indonesia, for example, the Presidential Regulation No. 16 of 2018 on the Procurement of Government Goods and Services consists of four types of self-management grant. The third type stipulates community organisations as the implementing partner and recipient of government funds, thereby allowing a form of social contracting practice. Similar procurement regulations that enabled governments to provide funding to non-state organisations (such as civil society, community-based, or community-led organisations, including profit-making enterprises) were found in Kenya, Nigeria, and South Africa, though the implementation practice differed between countries. The key differences were observed in terms of partner selection, such as bidding process (competitive process versus selected by the government); payment mechanism (capitation, reimbursement or advance payment); monitoring and oversight (properly formulated process versus ad-hoc practices); focal government department managing the grants (ministry of health, social development, or finance). There are also countries where the government provides funding to non-profit organisations without employing any formal mechanisms. For instance, the Government of Nepal has provided conditional grants or prioritised funding to civil society organisations without any viable social contracting regulations.

12 Open Society Foundations, UNDP and the Global Fund (2017) A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society. A meeting report. Available from http://shifthivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf

Box 3:

Community-led, community-based and civil society organisations: distinctions and definitions[13]

Community-led organisations (CLOs), groups, and networks, irrespective of their legal status (whether formally or informally organised), are entities for which the majority of governance, leadership, staff, spokespeople, membership, and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. Not all community-based organisations are community led.

Community-based organisations (CBOs) are organisations that have arisen within a community in response to needs or challenges and are locally organised by community members.

Civil society organisations (CSOs) or non-governmental organisations (NGOs) are any non-profit, voluntary citizens' groups organised on a local, national, or international level.

13 Adapted from UNAIDS 2020 progress report of the multi-stakeholder task team on community-led aids responses retrieved from https://www.unaids.org/sites/default/files/media_asset/Report_Task_Team_Community_led_AIDS_Responses_EN.pdf and UN webpage retrieved from https://www.un.org/en/civil-society/page/about-us

2.1 What are the funding models used in social contracting?[14]

There are three main funding models adopted by governments to finance community and civil society organisations through social contracting:

Results-based financing: The government makes payments once the agreed upon results of the service provision have been achieved. This model can be used with larger organisations that have sufficient core funding and savings to finance their activities in advance, but may exclude smaller organisations with limited funds. Governments have also utilised this model to provide conditional grants to community and civil society organisations, meaning funds are withheld if the agreed upon results are not achieved.

Procurement and contracting: The government makes payments at set times based on a contract laying out the level of service provision and contract timeline. Reimbursements from insurance schemes for services provided can also fall into this category. Many countries that employ social contracting mechanisms utilise this model, including India, South Africa, and Thailand.

Grants: The government provides funds in advance to a community or civil society organisation that uses it to deliver services and reports back to the funder on activities undertaken. There are two scenarios in which this advanced payment method is most used. Firstly, where the government intends to provide a grant with some flexibility, indicating a level of trust in its grantees. Secondly, where outpatient services delivered by community or civil society organisations have sufficient data on the number of the populations they are likely to reach within a time period. This is also known as a capitation model.

2.2 What are the requirements and steps that governments must consider in order to implement social contracting?

Where social contracting practices are not yet in place, there are some key factors that can increase readiness to introduce this practice. These include political will to fund community and civil society organisations; enabling policies, laws, and regulations to provide this funding; a vibrant community and civil society sector able to receive government funds and deliver programmes; and dedicated international donor funding for technical support.

Once the readiness to implement social contracting is there, effective implementation requires a robust government body to provide oversight, skilled human resources, and mechanisms and systems in place. These should include a transparent procurement processes, community and civil society-friendly policies, an efficient payment mechanism, supportive monitoring and evaluation processes, and streamlined reporting systems. Not all countries that have initiated social contracting end up with smooth implementation that is

14 Adapted from FH360 presentation on sustainable funding models - funding diversification for long-term sustainability, presented on August 30, 2022 in Bangkok.

optimal or favourable to community and civil society organisations.[15]

The following principles are considered important for successful social contracting:[16]

1. Arrangements should be purpose-oriented.
2. Competition should be free and fair.
3. Selection processes should be transparent and fair.
4. Governmental entities should be accountable.
5. Implementers should be given independence from governments and afforded due flexibility.
6. Monitoring and evaluation mechanisms should not be overly onerous.
7. Rapid disbursement systems to ensure uninterrupted work should be in place – this is particularly important for community-led and community-based organisations with limited ability to absorb costs due to limited funding flows and/or reserves.

Countries that have initiated social contracting have distinct features, legal structures, and processes. Here are some of the elements that played a part in successful social contracting for harm reduction and HIV programmes in different countries identified through a global consultation:[17]

1. Consistently evolving laws and policies on public procurement; grants awarded to organisations through competitive and transparent bidding processes, rather than closed selection; efficient payment mechanisms; clear and efficient systems for managing grants and grantees over time until it is institutionalised with proper regulations; adequate staff to manage social contracting processes (numerous countries).
2. Clearly defined and communicated guidance on what can be funded through public funds and how this works (e.g., Croatia).
3. Reliable and predictable domestic funding for HIV programmes in the form of steady annual funding allocations written into national laws and policies (e.g., Macedonia) and sub-national budgets (e.g., Ukraine).
4. Commitment to achieve Universal Health Coverage (UHC). For example, in Thailand, this prompted domestic financing and social contracting for HIV and harm reduction programmes in order to reach marginalised communities.

15 Open Society Foundations, UNDP and the Global Fund (2017) A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society. A meeting report. Available from http://shifthivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf

16 Open Society Foundations, UNDP and the Global Fund (2017) A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society. A meeting report. Available from http://shifthivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf

17 Open Society Foundations, UNDP and the Global Fund (2017) A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society. A meeting report. Available from http://shifthivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf

5. Global Fund funded country transition plans (e.g., Mexico, Georgia, Montenegro). For instance, Montenegro retained the core Global Fund funding structures and systems, including the country coordinating mechanism (CCM), for social contracting.
6. Implementation of pilot projects, such as the social contracting diagnostic tool, that explored opportunities, barriers, and priorities for public funding of civil society service delivery to key and vulnerable populations (e.g., Guyana).

Despite these elements that were instrumental to initiating social contracting, there remain many limitations to social contracting within these countries and more broadly.

3. SOCIAL CONTRACTING AND HARM REDUCTION

3.1 Why is it important for harm reduction?

Community-led, community-based, and civil society organisations are an integral part of health systems in many countries. Strong community systems[18] are particularly crucial to ensuring access to health services by and for poor, marginalised, and criminalised populations. This underscores the importance of social contracting as an essential mechanism for sustaining and scaling up the roles of community and civil society organisations when governments, rather than international donors, are the source of funds.

Community organisations led by people who use drugs play a critical role in service provision, outreach, leadership, advocacy, and activism within the HIV response and have contributed to the reduction in new HIV infections amongst people who use drugs in many settings. The established connections, deep trust and understanding that community-led organisations have with their communities make for extremely effective provision of tailored, people-centred services able to reach all community members.[19]

3.2 The global state of social contracting for harm reduction – an overview

Domestic public financing for harm reduction must include mechanisms that allow community-led, community-based, and civil society organisations to receive funds. Literature exclusively on social contracting for harm reduction is very limited. Documentation of social contracting within HIV responses either describe harm reduction as being integrated within HIV programmes (such as in India and Thailand), or there is no mention of harm reduction at all (for example, in Brazil). It is highly suggestive that due to punitive laws and policies against people who use drugs, social contracting for harm reduction programmes is limited and under strict government control. The limited number of countries that have social

18 Community systems are the processes, structures, and mechanisms that communities use to coordinate and deliver responses to their health-related and broader social needs. They are essential to strengthening health systems and ensuring that services are designed and delivered to be people-centred, accessible, equitable, cost effective, and accountable. Strengthening the community systems involves development of informed, capable and coordinated communities, and community-based organisations, groups, and structures through capacity building, sustained funding, meaningful engagement, and other enabling factors. (adapted from the Global Fund Community System Strengthening Framework, available at https://www.theglobalfund.org/media/6428/core_css_framework_en.pdf)

19 International Network of People who Use Drugs. Surviving and thriving: lessons in successful advocacy from drug-user led networks [Internet]. 2022; Available from https://inpud.net/surviving-and-thriving-lessons-in-successful-advocacy-from-drug-user-led-networks/

contracting for harm reduction have primarily funded behavioural prevention interventions such as drop-in centres, needle and syringe programmes (Thailand), behavioural communication and change (BCC) interventions such as counselling, awareness, IEC materials, outreach, and HIV testing. However, in several countries, OAT has been strictly managed and implemented by the government, even if supported by international donor funding (e.g., Cambodia), or can be managed by the government authorised license holding agencies such as hospital, clinics, etc. A study from Thailand found low enrolment in the government managed OAT sites and highlighted pilot community-led OAT sites as successful in reaching people who use drugs in remote areas.[20]

20 Schardt S and Kramarz P (2017) Assessment to improve the Harm Reduction Program in Thailand, 2017. Available from https://www.careevaluations.org/wp-content/uploads/PWID_RTF-Final-Report_S.pdf

Box 4:

Social contracting for harm reduction in middle-income countries – a summary of findings from the Global State of Harm Reduction 2022[21]

Community and civil society organisations contributing information for the Global State of Harm Reduction 2022 provide some insight into experiences around the world. Data was available for 29 middle income countries, within which the key international donors funding harm reduction were the Global Fund, PEPFAR and USAID. Where domestic public financing for harm reduction was reported, this was most often from national government budgets, with a small number of mostly upper middle-income countries such as South Africa, reporting provincial domestic public financing.

Ten countries reported domestic public financing for harm reduction via social contracting mechanisms, including South Africa, Sierra Leone, Mauritius, Botswana, Bangladesh, and Thailand. Data on which particular components of harm reduction were funded through social contracting was not available. Around 23 respondents (52%) were not aware of social contracting for harm reduction in their countries. A total of five countries (South Africa, Sierra Leone, Mauritius, Kenya, and Botswana) included harm reduction, most often OAT, within Universal Health Coverage (UHC) essential packages of health interventions and/or insurance packages. Interestingly, responses from four of these five countries, with the exception of Kenya, also stated that social contracting mechanisms were used to fund harm reduction. The vast majority of respondents (93%) reported harm reduction funding in their countries to be inadequate or highly inadequate and unsustainable, with many quoting the lack of domestic investment as the main challenge to sustainable harm reduction funding.

> There is ***"… a long history of harm reduction programming in the country but the government […] has not invested a single penny for the services, which is very dangerous. Once donors stop funding, harm reduction programmes may stop abruptly in the country."*** — A respondent from Asia.

> ***"[….] does not have laws to force government to fund harm reduction, because harm reduction still does not exist in the law."*** — A respondent from Africa.

21 This draws upon analysis of 44 responses from harm reduction organisations and networks, drug user organisations, researchers, academics and advocates in 29 low and middle-income countries, gathered through the Global State of Harm Reduction 2022 data collection process.

The key prerequisites for increasing social contracting for harm reduction exist. The number of LMI countries with harm reduction in national policy and implementing priority harm reduction programmes, albeit often funded by international donors, is increasing.[22] Community and civil society organisations are the primary implementers in many countries, including OAT in some countries (e.g., Nepal and Thailand). Importantly, there are social contracting practices employed to fund harm reduction (see examples below) and available support from agencies such as the Global Fund and UNAIDS for countries taking steps towards its implementation.

In 2022, HRI conducted a landscape analysis on domestic financing for harm reduction in Indonesia, Kenya, Nepal, Nigeria, South Africa, and Uganda. In five of these six countries, there was a legal basis for social contracting, most often in the form of a Public Procurement Act (PPA), while Uganda reported not having any legal framework or mechanism for social contracting. The term 'social contracting' did not feature in legal documents within any country but was broadly understood as some sort of collaboration between government and non-state (non-profit or community and civil society organisations) actors in the form of funding to provide services. In Nepal and Kenya, the Public Procurement Act (PPA) provides the opportunity for non-state actors to participate in the process. In Nigeria, social contracting is guided by the Health Policy Act 2007 and Financial Act 2020, in addition to the PPA.

However, while these acts and policies indicate that community and civil society organisation participation in government funding processes is allowable, they do not explicitly define the role that they play. In practice, most of these countries have not implemented social contracting within their HIV or harm reduction responses. Of note, Indonesia had the most defined policy on social contracting among the six countries, and South Africa was the only country where social contracting for harm reduction was being implemented.

In Indonesia, the Presidential Regulation (No. 16) of 2018 on the Procurement of Government Goods and Services consists of four types of self-management fund.[23] Self-management type 3 stipulates community and civil society organisations as the implementing partner and recipient of government funds. It is applicable to all types of community and civil society organisations engaged in the development sector and does not specifically regulate certain sectors or fields (i.e., health, HIV, harm reduction). There are two mechanisms for selecting community and civil society organisations for type 3 social contracting; firstly, via a direct offer when there is only one organisation that meets the criteria and requirements set; and secondly, via competitive bidding through a call for proposals. The eligibility criteria for the community organisations include legal registration and taxpayer status, having a physical office, and having a staff team. The monitoring process includes reporting, supervision visits, and spot-checking. While the policy and

22 The Global State of Harm Reduction 2022 reported 92 countries with at least one NSP and 87 countries with at least one OAT programme. Available from: https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2022/

23 Self-management (term used in Indonesia) is one of the ways for procuring government goods/services that ministries, institutions, regional apparatuses manage on their own in partnership with other government units or involving community groups. This method has long been used by the Indonesian government. (adapted from webpage https://www.ksi-indonesia.org/en/stories-of-change/detail/1270-achieve-inclusive-development-through-type-iii-self-management)

mechanism provide for social contracting for harm reduction and HIV programmes, this has not yet been implemented in practice.

In South Africa, there are distinct government funds via the National Department of Health and the National Department of Social Development for HIV prevention and treatment at national and provincial level, and dedicated harm reduction funding in the City of Tshwane (see 4.4). The National Department of Health transfers around 1% of its annual budget to non-profit organisations, though the funding is targeted to larger civil society organisations and lesser amounts to smaller community-based organisations. The applications are determined via tenders and invitations to submit a business plan that includes targets. This process includes a legal agreement between the civil society organisation and the National Treasury. These are essentially grant payments as opposed to direct service delivery agreements, even though tranches are dependent on results. One concern is that often payments are delayed and this presents a significant risk to the continuity of services. Percentage contributions of provincial budgets to civil society vary widely between the provinces.

4. SOCIAL CONTRACTING FOR HARM REDUCTION IN PRACTICE

The following case studies provide some insights into different social contracting practices employed by countries in their HIV and harm reduction responses. While approaches vary, these examples demonstrate the mechanisms by which governments are providing public funds to community and civil society organisations.

4.1 Social contracting for HIV prevention and continuum of care for key populations in Thailand[24]

In Thailand, social contracting within the HIV response is managed by Ministry of Health (MoH) and National Health Security Office (NHSO). The NHSO funds HIV prevention (targeting key populations including men who have sex with men, transgender people, male sex workers, female sex workers, and people who inject drugs) and continuum of care for people living with HIV. The MoH also funds HIV prevention for people who inject drugs, prisoners, migrants, and sexual partners of people living with HIV.

The NHSO HIV prevention grant is governed by NHSO, development partners, and regional/provincial AIDS committees, while the care grant for people living with HIV is governed by NHSO and the Thai Network of People Living with HIV/AIDS. The MoH grant is governed by the Disease Department within the MoH, local governments, and civil society organisations, including the regional and provincial health offices.

Payment model:

The NHSO grant for HIV prevention employs a grants or capitation model (see 2.1). The cost of delivering the HIV prevention package per person (unit cost) is calculated in advance and payment is provided according to the output, i.e., the number of people reached with the package. Grants covering care for people living with HIV (NHSO) and HIV prevention (MoH) employ a project-based budget or procurement and contracting model (as explained in 2.1).

24 International Health Policy Program Foundation (2019) Report of Effective Contracting Model for HIV Service Delivery in Thailand, 2019. Available from https://www.aidsdatahub.org/sites/default/files/resource/report-effective-social-contracting-hiv-service-delivery-thailand-2019.pdf

Application Process:

- Announcement of proposal. The NHSO sets national service delivery targets in advance.
- Proposal submission.
- Proposal considered by regional AIDS committee for NHSO and a committee for MoH.
- Proposal approval by a regional director for NHSO.
- Contracting.

Reporting system:

- Reach, Recruit, and Retain data are recorded in the Real Time Cohort Monitoring (RTCM) programme.
- Test and Treat data are recorded as part of the National AIDS Programme's monitoring system.

Monitoring and evaluation are conducted at provincial and national levels, mainly focusing on financial management. The NHSO provincial office provides scrutiny of the activities implemented at the provincial level while the central body compiles and validates all the provincial expenses.

4.2 Social contracting for civil society and community organisations in Brazil[25]

The Regulatory Framework of Civil Society Organizations provided a legal basis for civil society engagement in Brazil and its backbone is Law 13.019/2014, which defines civil society organisations as autonomous entities and sets clear legislation, processes, and procedures for the funding of civil society organisations through public resources. The law has three structural pillars: clear and transparent contracting mechanisms; sustainability and certification; and knowledge and information management. The National Council for Development and Collaboration manages the social contracting discussion and decisions.

In 2017, according to official data, US$ 1.3 million was allocated to civil society organisations for work on HIV, STIs, and viral hepatitis. The contracting used bidding processes in two areas – one for combination prevention and another for human rights programming. Combination prevention received most of the funding, with US$ 1 million for 14 projects. However, civil society organisations are not the service providers but rather play a complementary role to the health system's services. It is not clear whether social contracting includes harm reduction services, though Brazil includes harm reduction within national drug policy.

25 United Nations Development Programme (2019). Using Social Contracting in National HIV Responses: Country case studies from Africa, the Caribbean, Eastern Europe and Latin America. New York: UNDP

Contracting process:

Civil society organisations must be registered in a national database to participate in social contracting opportunities.

Three mechanisms exist through which civil society organisations can receive funding from the state:

1. The 'Term of Development' is a funding mechanism that enables civil society organisations to apply for funding to develop new methodologies for addressing recognised social problems. Under this mechanism, civil society organisations present a proposal outlining the justification for the project, as well as goals, objectives, activities, a timeline, and a budget.
2. The second mechanism is a 'Term of Collaboration', which is designed to engage civil society organisations in implementing public policy through making public offers presenting the terms and parameters and specific actions that are needed to complement the actions of the state.
3. The third is a 'Manifestation of Social Interest', which allows persons or organisations to submit projects so that the public administration can decide to open a public call based on the project proposed.

Process:

- Tender announcements are made publicly at least 30 days in advance of closing.
- A selection committee is formed with at least one full time staff of the Public Administration and other people who have expertise in the subject matter of the call.
- The proposal assessment takes place in two phases. Firstly, screening of the content and other technical aspects; secondly, submission of more detailed work plan and due diligence documents by those who pass the first stage.
- Contracting is done after passing second stage.
- Reporting is published in official communications media which enables any citizen to monitor the progress of activities and amounts spent.
- Third party technical support is available to the public administration to carry out monitoring and evaluation of projects and the results are presented to a Monitoring and Evaluation Committee.

4.3 Social contracting for targeted interventions for key populations in India

In India, the National AIDS Control Organization (NACO) has contracted community-based, community-led, and civil society organisations since 1996 within the National AIDS Control Program (NACP). Since then, the NACP has evolved through five phases each five years in length. Phase I piloted social contracting of NGOs and CBOs for HIV prevention programme delivery. Phase 2 introduced targeted interventions for key populations, decentralised programmes to provincial level and established the Program Management Unit to manage the programme. Phases 3-5 introduced more guidelines, toolkits, and

frameworks to strengthen the programme, including standard operating procedures for the selection of NGOs and CBOs.[26] The programme is supported financially by the Government of India (covering more than 60% of total HIV funding), the Global Fund, World Bank, and other multilateral and bilateral agencies.[27]

Targeted interventions include NSP and OAT programmes, condom promotion and distribution, and linkages to HIV and sexually transmitted infection testing and treatment services through an outreach-based service delivery model implemented by civil society and community-based organisations.[28]

Each targeted intervention is contracted according to the assigned target and costing based on NACO operational and financial guidelines, and the funds are released on a quarterly basis to NGOs and CBOs, similar to the procurement and contracting model (see 2.1). All the payments are processed through the Public Financial and Management System portal, while the reports are submitted as per the prescribed format at the end of every month, including a final audit report at the end of the financial year. Unit costs inform the budgeting for each key population covered by the targeted interventions.[29]

The selection of NGOs and CBOs for NACP is guided by the NGO/CBO Operational Guidelines summarised below:[30]

1. Call for applications from NGOs, CBOs, and networks through open advertisement on the website of State AIDS Control Societies and NACO.
2. Desk appraisal for preliminary screening of applications to reach shortlist.
3. Field visits to shortlisted applicants to assess their institutional capacity and programme effectiveness using a standardised template and scoring system.
4. Needs assessment by the shortlisted applicants to gather site prevalence estimates, programmatic needs based on drug use and harms, and to determine interventions required.
5. Proposal development workshops for the shortlisted applicants, including documents to be submitted for the application process.
6. Review of proposals using a standardised scoring matrix and selection of final grantees.
7. Capacity development of the grantees.
8. Technical and financial monitoring of partners.
9. Extension and termination of the grants.

26 Informed by Government of India National AIDS Control Programme presentation on social contracting and reimbursement mechanism under National AIDS Control Programme in India in Bangkok from August 30-31, 2022 during a regional workshop on social contracting organised by the Global Fund, USAID and UNAIDS.

27 Tanwar S, Rewari BB, Rao CD, et al. India's HIV programme: successes and challenges. J Virus Erad. 2016;2(Suppl. 4):15.

28 Informed by Government of India National AIDS Control Programme presentation on social contracting and reimbursement mechanism under National AIDS Control Programme in India in Bangkok from August 30-31, 2022 during a regional workshop on social contracting organised by the Global Fund, USAID and UNAIDS.

29 Tanwar S, Rewari BB, Rao CD, et al. India's HIV programme: successes and challenges. J Virus Erad. 2016;2(Suppl. 4):15.

30 NGO/CBO operational guidelines: selection—part 1. Delhi: National AIDS Control Organization, India; 2007. Available from: http://naco.gov.in/sites/default/files/16,%20NGO%20CBO%20Operational%20Guidelines.pdf

4.4 Publicly financed city-level programming for a harm reduction programme in South Africa[31]

The Community Oriented Substance Use Programme (COSUP) in the City of Tshwane presents a unique, bold, and science-based harm reduction programme funded by the government and implemented by non-government actor, which is the University of Pretoria (UP) in this case.

In 2015, the City of Tshwane Mayor collaborated with UP to develop evidence-based programming for people who use and inject drugs. The City of Tshwane had an existing Memorandum of Understanding with UP that allowed for a research study. The Department of Family Medicine and the Community Oriented Primary Care Research Unit of UP conducted a rapid survey and analysis of drug use and response, and presented the Community Oriented Substance Use Programme (COSUP) to the City of Tshwane Mayoral Committee. An agreement was prepared and underwent several oversight processes and final scrutiny and approval by the legal department. In May 2016, the City signed a service-level agreement with the University. The aim of COSUP is "to minimise the health, social and economic impacts of substance use through the prevention, identification and resolution substance use disorders in the City of Tshwane using a community oriented primary care approach."[32] The US$ 3.5 million, 36-month service-level agreement was established in accordance with the Municipal Systems Act, 32 of 2000.

Governance:

The COSUP governance committee is made up of directors from the city's Department of Health and Social Development; the Director of Support Services, the Dean of the Faculty of Health Sciences and the Head of Family Medicine from the University of Pretoria, or their appointed representatives. The committee meetings are scheduled quarterly and the role of the Governance Committee is to ensure legal and financial accountability, strategic direction, and oversight.

A management team in the government, comprised of the project leads and a Deputy Director from the city, meet every two weeks and are responsible for daily operations, resource allocations, assigning operational roles and tasks, and are held accountable for all operational aspects of COSUP.

Implementation:

The University of Pretoria is responsible for operating the programme and the individual sites. In addition to the clinical and service activities, the university is also responsible for the employment, support, training, capacitation, evaluation, and monitoring of all staff across all COSUP sites. Research and training are two essential components of the programme. The university collaborates with a broad range of stakeholders to implement COSUP.

31 The case study content was prepared by Shaun Shelly at the South African Network of People who Use Drugs (SANPUD).
32 Shelly, Hugo, Kroukamp, Scheibe, Marcus (2015, updated 2016) Implementation of Community Oriented Substance Use Programme in Tshwane: A brief synopsis.

Peer educators from the community of people who use drugs are central to the programme and services. Peers distribute and collect needles and syringes and provide behaviour change interventions, as well as navigation into and between services. Peers are the first point of contact for people who want to access COSUP services.

Community advisory groups provide regular feedback on services. Groups decide their structure and may be led by a variety of stakeholders. COSUP also engages with homeless people and sex workers.

Financial Arrangements:

The city agreed to an initial up-front payment of 55% of the first-year budget, followed by quarterly payments within 30 days of receipt of the invoice being received, similar to the procurement and contracting model (see 2.1). The invoice amounts are described in the budget, and annual budget adjustments must be determined and agreed upon between the city and the university before the new contract year begins.

Monitoring:

The university submits monthly reports to the City Management, and in accordance with ACT 32 of 2000, a complete progress report is submitted in the final year of the three-year contract to ensure compliance, measure progress, identify areas for improvement, and inform the next three-year cycle of funding and the associated service level agreement.

5.CONCLUSION

Globally, governments have committed to reach the global goals and targets set out in the Global AIDS Strategy 2021-2026, the WHO Global Sectoral Strategies and the Sustainable Development Goals. These all require increased domestic public financing for harm reduction programming and advocacy, including community-led responses. Community and civil society organisations are the backbone of harm reduction programmes and advocacy in LMI countries and as international donor funding reduces, it is crucial that all governments are ready to provide funds to these organisations for service delivery, advocacy, and monitoring.

Data on the extent, scope, and direction of public funds for harm reduction are limited and there is no global systematic monitoring process to gather this information. Better data is needed in order to ascertain the direction and scope of domestic support for harm reduction and the quality of programming supported. This lack of quality data limits the extent to which governments can make strategic allocation decisions on their harm reduction investments. It is also crucial to inform evidence-based advocacy for domestic investment in harm reduction.

Countries that are incorporating social contracting of community and civil society organisations to deliver HIV and harm reduction programmes have employed varied approaches, illustrating that one size does not fit all. Rather, social contracting mechanisms are developed and defined within the country's social, legal, and policy context. For harm reduction, and community-led responses in particular, there are several elements of a social contracting mechanism that are likely to improve its success including the use of equitable, fair, and transparent processes and government accountability. These are particularly crucial for communities that are criminalised and marginalised within societies and by laws and policies instated by the same governments providing funds.

It is also clear that even with social contracting mechanisms in place, while people who use drugs are criminalised and marginalised in societies, by both laws and policies, they will likely experience the same marginalisation within public financing priorities. Alongside advocacy and technical assistance to instate strong social contracting mechanisms, community and civil society advocacy must be supported to call for decriminalisation and for harm reduction to be politically supported.

ANNEX 1: KEY ACTIVITIES FOR CONTRACTING TO CIVIL SOCIETY

Table 2:

Key activities for developing social contracting to civil society[33]

Steps in the social contracting process	Civil Society Organisations	Government agencies and policymakers	External donors
Review and understand legal and regulatory needs for social contracting mechanisms	Support and engage in analysis on country ability to provide funding to CSOs	Determine which funding mechanism would be the most appropriate for the country context	Assist with the development of the social contracting funding mechanism
Develop/adapt regulatory process for selecting CSOs for contracting	Advocate for transperancy and accountability in the contract selection process	Develop transparent procurement and contracting processes	Provide best practices globally on transparent review and accountability processes
Ensure domestic finances are available for social contracting mechanisms	Conduct analyses of funding sources for social contracting and advocate for annual predictable financing to be included as a budget line item	Ensure adequate, predictable funding is available for social contracting to civil society	Provide seed money for pilot initiatives of social contracting in country
Provide quality implementation and monitoring of publicly-financed services	Strengthen capacity in organisation for management, reporting, and technical monitoring and evaluation for public financing	Develop systems to fund monitor CSO contract work	Assist CSOs and government on effective implementation and monitoring of work

33 Extracted from Regional Platform for Communication and Coordination for Anglophone Africa Hosted by EANNASO report Social Contracting: A Mutual agreement made between the CSOs and the Government. https://eannaso.org/internal-publications/#70-70-community-voices-p2

CHARITY NUMBER: 1117375
COMPANY NUMBER: 3223265

A 61 MANSELL STREET, ALDGATE, LONDON E1 8AN
E INFO@HRI.GLOBAL
W WWW.HRI.GLOBAL

HARM REDUCTION INTERNATIONAL