HA·REACT
JOINT ACTION ON HIV AND CO-INFECTION PREVENTION AND HARM REDUCTION

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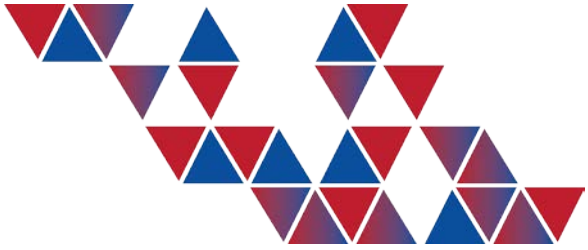
Guide to funding mechanisms for harm-reduction programmes in European Union Member States



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Executive summary

This guide outlines funding sources and mechanisms for programmes that provide harm reduction and other health services to people who inject drugs (PWID) in the European Union (EU). It covers funding sources ranging from municipalities to international organizations and private donors. The document provides brief country examples to illustrate the variety of funding arrangements, which are often quite complex.

In addition, it summarizes three case studies that examine at greater length the government mechanisms that dispense funding for harm reduction programmes in Croatia, Poland and Spain (Annexes 1–3). These case studies provide detailed insights into national funding schemes and how well the funding mechanisms work in practice.

The annexes also include "tip sheets" on two underutilized financing mechanisms, EU structural funds and joint procurement (Annexes 4 and 5). They describe, in layman's terms how to access the structural funds, and how joint procurement can reduce the costs of medicine, needles and other harm reduction supplies.

1. Introduction

The European Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT) aims to address gaps in the prevention of HIV and other co-infections, particularly tuberculosis and viral hepatitis, in priority countries of the EU. This joint action builds on the best practice models of several EU networks. It brings together health authorities, researchers and non-governmental organizations (NGOs) such as patient organizations.

This report provides an overview of current funding mechanisms for harm reduction and other health services for people who inject drugs (PWID). It is thus aligned with the objectives of HA-REACT work package 8 on obtaining sustainable funding for HIV, hepatitis and tuberculosis services for PWID. The report provides guidance on how to utilize different funding mechanisms for actions on HIV, viral hepatitis and TB. It addresses resource allocation and mobilization and the use of diversified funding approaches to provide services to PWID and other targeted population groups.

The guide outlines funding mechanisms available from municipal, regional, national and international governmental bodies, as well as private donors, and provides brief examples to illustrate the variety of models used in different EU Member States.

Annexes 1–3 summarize case studies from Croatia, Poland and Spain that examine the mechanisms through which these three governments dispense harm reduction funding. These case studies also provide detailed insights into national funding schemes, including how funding mechanisms can work in practice and what lessons may be transferable to other countries.

Two “tip sheets” explore concrete EU funding opportunities, focusing on EU structural funds and joint procurement (Annexes 4 and 5). The tip sheets are written in plain language to show how to access the structural funds and how joint procurement can reduce the costs of medicine, needles and syringes and other materials.

Ultimately, by highlighting the strengths and weaknesses of existing mechanisms to fund harm reduction and related health services in EU Member States, this guidance document should provide a useful complement to other EU publications and online tools.

2. Taxonomy of funding types

EU harm reduction services vary greatly in the ways they are implemented and funded. This section provides an overview of the various support and funding mechanisms available in the EU and the European Economic Area (EEA). National examples and information have been extracted from the national information pages of the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA).

Even within a given country, however, different funding models often exist. For example, in the French-speaking regions of Belgium, harm reduction services are funded by the Home Affairs Federal Public Service, whereas the Flemish region funds harm reduction projects itself (1). Therefore, when a specific country is mentioned to illustrate a funding modality, it should be understood that that modality may not apply to all harm reduction services in the country.

For clarification, please note that the taxonomy below is organized by funding source, and not by who is implementing the harm reduction activities.

2.1 Municipal funding

In some countries, actions to prevent infectious diseases, including harm reduction services, are the responsibility of local government. Examples of municipally funded programmes are described in Box 1 (Norway) and Box 2 (Romania). Municipal bodies are in charge of establishing, running and financing such services in Denmark, Finland, Latvia, Lithuania, Norway and some municipalities in the larger cities of Spain.

Box 1. Norway – the municipalities are responsible

Norwegian municipalities, supported by a government grant scheme, are responsible for arranging low-threshold harm-reduction activities on the basis of local needs and challenges. Approximately 50 of 426 municipalities have such measures in place. Some have developed the measures in cooperation with NGOs, while others provide them as part of larger health and social programmes (2).

Box 2. Romania – Bucharest city council

Bucharest has the most serious problem with injecting drug use in Romania. To address it, the General Council of Bucharest approved financial support for harm reduction services. These resources helped fund an NGO-led project providing harm reduction and reintegration programmes for PWID in 2012–13 (3).

2.2 Regional funding

In some countries, regional bodies are in charge of disease treatment, and therefore they are also responsible for financing and running health care systems. Such regional entities typically finance and run specialized services like opioid substitution therapy (OST) programmes and treatment for infectious disease.

Low-threshold centres that provide harm reduction services to drug users may be the responsibility of municipalities, as described above, or they may be directly financed by regional or national funds.

The availability of health services may differ from region to region in a country, depending on the availability of funds and the priorities of regional policymakers. That is the situation in Spain, as described in the case study summarized in Annex 1. In Germany, which has a decentralized health system, federal funds finance the operation of low-threshold services and counselling facilities for PWID across the country, but the regions ("Bundesländer") decide on the legality of drug consumption rooms within their own borders.

2.3 National funding

At the national level, harm reduction services are most commonly financed by government budgets, national social security systems or health insurance. Examples of these models are described in Boxes 3–5 below and in the Croatian case study summarized in Annex 3. In practice, the harm reduction programmes are usually implemented by regional or municipal bodies, or in some cases NGOs, any of which may also co-fund the services.

Box 3. France – the social security system

In France, services designed to reduce drug-related risks and harms include specialized drug treatment centres and agencies that provide low-threshold services. They are available in almost all regions (departments) and receive funding directly from the French social security system (4). General health care is the responsibility of each department, and the availability of services depends on departmental resources and priorities. As a result, access to hepatitis C treatment, for instance, varies across the country (5) – a situation not unique to France.

Box 4. Estonia – the national HIV strategy

The Estonian government started funding needle and syringe programmes (NSPs) in 2003 as part of the national HIV prevention programme. In addition, harm reduction measures were specifically mentioned in the National Strategy for the Prevention of Drug Dependency 2004–12 and were continuously funded by the National HIV/AIDS Strategy 2006–15. As a consequence, NSP coverage and quality improved over the years, according to NSP self-assessments (6).

Box 5. Slovenia – Slovenian Health Insurance Institute

In Slovenia, injecting equipment is purchased centrally and distributed by the Koper Regional Unit of the National Institute for Public Health. It is funded by the Slovenian Health Insurance Institute and is distributed to harm reduction programmes and outreach locations across the country (7). The Institute also fully funds hepatitis C treatment, which is provided at hospital-based clinics (5), with few restrictions on access to treatment.

2.4 External funding (international organizations and funds)

In the past, the United Nations Office on Drugs and Crime (UNODC) funded NSPs in some EU countries, such as Latvia and Romania, while the Global Fund to Fight AIDS, Tuberculosis and Malaria financed NGOs that implemented prevention activities for drug-related infectious diseases in Bulgaria, Estonia and Romania. The UNODC and the Global Fund no longer provide assistance to EU/EEA Member States or other high-income countries, triggering a major harm reduction funding crisis in many countries, where domestic financing has not replaced these external sources.

Several private international funds have contributed to specific harm reduction projects and programmes. For example, the Irish Pharmacy Foundation, with support from the Elton John AIDS

Foundation (8), has provided needles and syringes in Ireland through community-based pharmacies. In addition, the Open Society Foundation has supported harm reduction programmes in Lithuania (9).

2.5 EU funding

EU funds typically support small-scale pilots, but do not serve as a sustainable source of harm reduction funding. The following our EU financial programmes provide funding for drug-related projects for the period from 2014 to 2020 to help implement the objectives set by the EU Drugs Strategy 2013–20 (10) and to foster cross-border cooperation and research on drug issues. Box 6 below describes one example of how such funding is being used, in Ireland.

- Justice programme 2014–20 funds actions, including drug prevention and information work, that produce results for multiple Member States. The programme also focuses on supporting work that promotes and protects equality and the rights of individuals. It funds training activities, awareness raising and analytical activities, and it supports major implementers, including NGOs, through partnership agreements.
- Health programme 2014–20 is the European Commission's main instrument for implementing the EU Health Strategy. Annual work plans for the programme set out priority areas and funding criteria. The programme seeks to promote health, prevent diseases and foster supportive environments for healthy lifestyles, as well as facilitate access to better healthcare. It supports multi-stakeholder policy projects and provides financial support to NGOs.
- Horizon 2020 is the EU's framework programme for research and innovation. It sets out funding opportunities in two-year work programmes, including opportunities for health and well-being projects. Horizon 2020 funds larger research projects with innovation potential.
- The internal security fund 2014–20 focuses on asylum, migration and integration, borders and security, and drug policy issues. Within drug policy, the fund supports projects relating to drug supply, including cross-border cooperation and research on drug issues, the development of innovative approaches to understanding drug markets, and the improvement of drug law enforcement.

These programmes have two main funding mechanisms: grants and tenders. Grants can take the form of project grants, operating grants, direct grants to international organizations and grants to Member State authorities and bodies for co-funded actions, known as joint actions (of which HA-REACT is one). Calls for grants and tenders are issued regularly and published on an online participant portal.

Box 6. Ireland – bridging the gap in hepatitis C treatment

The HepCare Europe project, funded through the EU's 3rd Health Programme 2014–20 of the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA), is implementing a community-based integrated care model for the treatment of hepatitis C. This model is designed to facilitate the diagnosis and screening of vulnerable and marginalized groups who are at risk for the hepatitis C virus (HCV). In it, a liaison nurse uses a portable FibroScan test to evaluate patients' HCV status. The test can be administered in general practices, addiction clinics and prisons. The aim of the model is to increase the low frequency of referrals to secondary care – a common problem throughout the EU.

The European structural and investment funds, which together form the EU's biggest investment tool, are another important source of harm reduction funding (see Annex 4).

Finally, the Europe TB Coalition has developed a useful guide that includes a series of recommendations for civil society on how to apply for EU funding, including for harm reduction activities. The guide also contains country-specific cases and tips on how NGOs in Eastern Europe and Central Asia can access different EU funding mechanisms for health initiatives (11).

Other relevant EU funds

There are other EU funds that are not described in detail in this report, but which can be used to promote the social inclusion of PWID through services that support employment, social entrepreneurship, research and innovation, lifelong learning and anti-discrimination in 2014–2020 (Table 1). In addition, several EU funding instruments are designed for a variety of initiatives in specific groups of countries, both inside and outside the EU (Table 2).

Table 1. EU funding instruments for social inclusion initiatives

Programme for Employment and Social Innovation (EaSI)	**EURES** (The European Job Mobility Portal) programme for European employment services
	European Progress Microfinance Facility to encourage social entrepreneurship
Erasmus+ Programme for education, training, youth and sport	
Rights, Equality and Citizenship Programme to combat all forms of discrimination; to promote children's rights, the rights of the disabled and Roma inclusion; and to fight violence against women, young people and children	

Table 2. EU funding instruments for particular countries

Funding programmes	Objective
Norway Grants	To strengthen bilateral relations between Norway and 16 EU countries and reduce economic and social disparities in the European Economic Area
Enlargement Policy	To support health in EU candidate and potential candidate countries via the instrument for pre-accession (IPA II)
Neighbourhood Policy	To promote health in the EU's neighbouring countries to the east using the European Neighbourhood Instrument (ENI)
Development Cooperation Policy	To promote the political, economic and social development of developing countries using the Development Cooperation Instrument (DCI)
Human Rights Policy	To promote human rights and democracy in non-EU countries using the European Instrument for Democracy and Human Rights (EIDHR)

2.6 Mixed funding and co-funding

Mixed funding and co-funding are often used to finance harm reduction services, as illustrated by the examples from Denmark, Portugal and Hungary in Boxes 7–9 below. Harm reduction programmes

and services may be co-funded by state and municipal budgets. They may also receive additional support from other private or public sources, including public-private collaborations. In Poland, for example, the National Bureau co-funds projects operated by NGOs that sometimes include significant contributions from local governments (12).

Box 7. Denmark – Shared Addiction Care Copenhagen (SACC)

The aim of the SACC project is to decrease HCV transmission and HCV-related morbidity and mortality among drug users. The project uses a decentralized, shared care model that integrates diagnosis and treatment at 10 local counselling centres for PWID in Copenhagen. The centres offer rapid testing of HIV and hepatitis A, B and C, while hepatitis C treatment is prescribed by specialists and delivered locally. The three-year project is financed by three complementary funders, the Capital Region of Denmark, the City of Copenhagen and a private foundation. The Capital Region, through the Department of Infectious Diseases at Rigshospitalet, funds medicine, medical staff and treatment for hepatitis C patients. The Region also funds day-to-day management by a part-time study nurse, IT tasks and data management, and coordination of the project steering committee. The City of Copenhagen runs the local counselling centres and also funds a PhD student who functions as project leader. Finally, the project has used private funds to acquire a mobile FibroScan device.

Box 8. Portugal – the national NSP

In Portugal, the National Commission for the Fight Against AIDS cooperates with the National Association of Pharmacies (Associação Nacional de Farmácias) to implement Say No to a Second-Hand Syringe, the national NSP. The programme was set up more than 20 years ago to prevent HIV transmission among PWID. The programme involves pharmacies, primary care health centres, NGOs and several mobile units (13).

Box 9. Hungary – a co-funding approach

The National Office for Rehabilitation and Social Affairs in Hungary funds low-threshold services for PWID through a three-year contract (the last contract covered 2012–14) with service providers who are selected through a tendering process. Complementary funding for low-threshold activities may come from local governments and or other ministries. Delays in the tendering process and reductions in the availability of financial resources have adversely affected the availability of injecting equipment. The funding reductions have also resulted in shorter operating hours and the temporary or permanent closure of several programmes (14).

Table 3. Taxonomy of funding types and models

Funding types					
Municipal/city	**Regional**	**National (e.g., ministry of health)**	**External (international)**	**EU**	**Other**
Prevention and social services, city councils	Health care systems (including hospitals, clinics and dedicated OST sites)	Social security system, specific commissions, public funds, government grant schemes, national health insurance	Private donors, international funds, NGOs, foundations, etc.	EU (European structural and investment funds, Health Programme, etc.)	Community (including private and local funds)
Funding models					
• Complementary funding (e.g., municipal-regional, national-regional, national-EU, public-private)					

- National funding that is topped up by other funders (e.g. the city council, regional government, private funds)
- Disease-specific budget (e.g., the national HIV action plan or viral hepatitis action plan)
- National health promotion budget (for broad public health prevention activities, etc.)

3. Conclusion

This guidance document describes a range of funding mechanisms for harm reduction services in European Union Member States.

In some of these countries, national funding for harm reduction is situated firmly within a single area, such as the national health insurance system. More frequently, however, different funding mechanisms finance different aspects of harm reduction, e.g. municipalities fund prevention interventions, while regional bodies funding for treatment interventions.

Complementary funding of harm reduction services appears to be widespread across the EU. Reliance on multiple funding sources can have both advantages and disadvantages. While multiple funding sources may provide higher overall levels of funding, for instance, they can also be challenging to manage.

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Annex 1: Croatia – funding flows for harm reduction

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

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

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

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

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

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

Annex 2: Poland – funding flows for harm reduction

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

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

In 2015, a total of EUR 5.64 million was spent on harm reduction programmes, including OST, NSPs, nightlife outreach, condom distribution, health education, emergency support for overdoses and leaflet dissemination. Support for local activities is also provided by a few local governments. In 2015, harm reduction programmes were financed by 99 of 2,478 municipal authorities through locally organized competitions.

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

Annex 3. Spain – funding flows for harm reduction

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

The first ministerial order authorizing opioid substitution therapy (OST) with methadone was approved in 1983, and in 1990 the first needle syringe programme (NSP) started, in Barcelona. The first prisons needle and syringe programme was organized in 1997 at Basauri Prison, in the Basque Country. In 2000 the first safe injection room opened, in Madrid, and in 2015, the first safe injection room opened, in a drug users' shelter in Bilbao.

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

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

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

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

Annex 4. EU structural funds – Tip Sheet #1

What are the European structural funds?
Structural funds are the biggest EU investment tool and consist of a family of five funds – European Regional Development Fund (ERDF) (1), the European Social Fund (ESF) (2), the Cohesion Fund (CF) (3), the European Agricultural Fund for Rural Development (EAFRD) (4) and the European Maritime and Fisheries Fund (EMFF) (5)– together referred to as the European Structural and Investment Funds (ESIF). The purpose of these funds is to invest in job creation and a sustainable, healthy European economy.

These funds are not intended to replace national, regional and local investments in the Member States, but instead to provide co-funding for such investments. The funds provide reimbursement for project costs rather than pre-financing projects. All EU regions are eligible to receive structural funds, but the level of co-financing differs from region to region and depends on the GDP per capita. The EU has set three funding categories, as displayed in Figure 1.

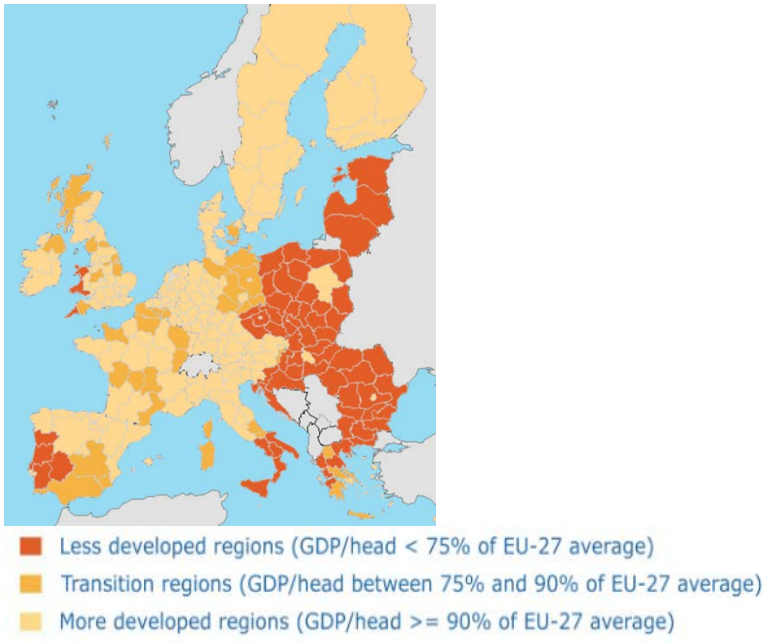

Figure 1. Map of GDP per capita in the European Union (6)

More information on the funding categories and general guidance on ESIF 2014–20 can be found in the European Social Network guideline on *How to access EU structural and investment funds* (7).

How to use the structural funds for health
Health investments supported by ESIF 2014-20 are required to support the Member States in achieving EU health goals. Relevant areas include the following:

- research and innovation in health, support to small and medium sized enterprises, e-health;
- health promotion, active and healthy ageing, health in the workplace;

- access to healthcare, addressing health inequalities, mental health;
- transitioning from institution-based care to community-based care, including infrastructure and equipment investments;
- healthcare system capacities and reform for effective and sustainable care;
- health workforce, health professionals' education and lifelong training; and
- cross-border healthcare and cooperation between Member States and regions.

Concrete actions to illustrate these areas of activities can be found in the section 'ESIF Thematic Objectives' in EU's Policy Guide for ESIF 2014–20 (8), which provides guidance for EU Member States on investments in health.

Partnership agreements

Countries prepare a partnership agreement with the European Commission on how the funds will be used for the seven-year funding period (2014–2020). Boxes 10 and 11 below show examples from Lithuania and Romania. The partnership agreements cover all of the ESIF, and outline for each country the areas where the funding should be channelled, in accordance with the Commission's main policy areas.

- Current partnership agreements and operational programmes can be found here (9).

The agreements reflect current EU policy focus areas in health, as outlined above. One priority is to support concerted efforts to shift funding from government structures to community-based solutions within health services. Another priority is to provide support for migrants, for instance to improve integration into the labour market.

Box 10. Lithuania – partnership agreement for 2014–2020

This agreement covers all five ESIF. Among the listed priorities is the reduction of poverty and of social exclusion. Both are key issues in Lithuania, where more than 30% of the population is at risk for poverty or social exclusion. To address these issues, the agreement will ensure the compatibility and synergy of active labour market policy and social inclusion measures, as well as equal availability throughout Lithuania of adequate social and healthcare services for all residents, in particular by promoting a shift towards community-based services ("de-institutionalization") (10).

Where does harm reduction fit?

The ESIF policy guide does not directly mention harm reduction as a priority or mention PWID as a target group. However, aspects of harm reduction activities or the services themselves often fit into broader ESIF focus areas.

The European Regional Development Fund (ERDF) (1) aims to strengthen economic and social cohesion in the EU by correcting imbalances among its regions. Particular attention is given to specific territorial characteristics and the reduction of economic, environmental and social problems, both in urban areas and in areas that are naturally disadvantaged from a geographical viewpoint (such as remote, mountainous or sparsely populated areas). For the 2014–2020 funding period, the ERDF focuses especially on *promoting social inclusion and combating poverty* through investments in health and social infrastructure and in measures that reduce social inequalities, promote social inclusion or contribute to the transition from institutional to community-based services.

Box 10. Romania – partnership agreement for 2014–2020

The health sector is one of the priorities listed in the agreement with Romania. The focus is on deprived communities and promoting alternatives to hospitals, such as primary care, ambulatory care and e-health services, as well as efforts to shift from institutional structures to community-based solutions for children, the elderly and people with disabilities (11).

The European Social Fund (ESF) (2) is the EU's main instrument for supporting jobs, assisting people to obtain better jobs and ensuring fairer job opportunities for all EU citizens. It does these things by investing in Europe's human capital – its workers, its young people and all those seeking employment. ESF financing of €10 billion a year improves job prospects for millions of Europeans, in particular those who find it difficult to get work; see Boxes 12–14 below for examples from Latvia, Estonia and Romania.

One ESF priority focuses on helping people from disadvantaged groups to get jobs (12). That helps promote social inclusion – a sign of the important role that employment can play in helping people integrate better into society and everyday life. The financial crisis led to a redoubling of EU efforts to keep people in work, or help them return to work quickly if they lose their jobs.

Box 11. Latvia – helping drug users to live better lives

Drug users are at serious risk of continued social exclusion and find it difficult to keep jobs. A project based in the Latvian town of Kuldīgā, financed by the ESF, provided a range of support to help this group of people find their way back into mainstream society and into employment in 2011–2013. The Saules Sala (Sun Island) project offered treatment and rehabilitation to 55 users, some of whom had previously served prison sentences. The project brought together social workers, psychologists, addiction specialists and trainers who worked as a team to provide expert services. Each participant was given a personalized programme of support that included work therapy and experience. The professionals who delivered the course were also able to improve their own skills and understanding of addiction and the needs of drug users. Through their involvement, they saw the potential for holistic treatment programmes that combine different areas of expertise to deliver life-changing interventions (13).

Box 12. Estonia – financing harm reduction with EU structural funds

The ESF does not support harm reduction activities directly, but it does focus on improving the labour market competitiveness of vulnerable groups, including PWID. After identifying funding gaps and possibilities, Estonia was able to use the ESF to provide psychological, social and peer counselling services to PWID and people living with HIV and to fund related media campaigns. By transferring some counselling services from national to structural funding, Estonia was able to increase its funding of the harm reduction services where funding gaps existed, including NSPs, OST and condom distribution.

Harm reduction NGOs bid for contracts to provide the counselling services through a public tender process. Their services were funded based on unit costs, and payments were made monthly upon approval of reports. Both ESF and national funds for harm reduction were implemented by the same state agency (14).

Box 13. Romania – a consortium of NGOs receives funding from structural funds

Within the 2014–20 Partnership Agreement between EU and Romania one of the main priority areas is to promote social inclusion and reduce the population at risk of poverty or social exclusion , in particular helping disadvantaged people, including Roma and people suffering from addictions, to access the labour market and improve their health and social status. Some of the planned actions seek to improve vulnerable groups' access to health care and support transition to community-based care models. The implementation of the actions covered by the EU-Romania partnership agreement relies on collaborations with a range of social partners including NGOs and community based organisations (15).

Since 2010, a group of NGOs engaged in providing harm reduction services has established a consortium in order to access the structural funds available at the national level. The consortium responded successfully to general calls for proposals in the social area, and received funds for several projects between 2010–15, which helped to close the funding gap in harm reduction services (3).

The Cohesion Fund (CF) (3) aims to reduce economic and social disparities and promote sustainable development in Member States whose gross national income (GNI) per inhabitant is less than 90% of the EU average – see Box 15 below for an example from Greece that used CF investment in connection with an HIV outbreak. In 2014–20, the countries qualifying for CF support are Bulgaria, Croatia, Cyprus, the Czech Republic, Estonia, Greece, Hungary, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovakia and Slovenia.

Box 14. Greece – scaling up actions after an HIV outbreak

In Greece, following a reduction in funding for harm reduction services followed by low coverage, there was an outbreak of HIV infection among PWID in Athens. As a result, treatment and harm reduction service provision were scaled back up in 2011 with a range of new activities, chiefly financed by European strategic funds under the 2007–2013 National Strategic Reference Framework (NSRF) (16) (17) (25).

Within the NSRF, the Cohesion Fund supported two projects implemented by the NGO Praksis, The first aimed to increase HIV testing for vulnerable groups in the Athens area (migrants, sex workers and their clients, victims of trafficking, men who have sex with men and PWID) and to link confirmed positive cases to treatment, care and support services. In the second project, the NGO hired additional personnel to facilitate access to HIV treatment and support services (18).

The Ministry of Health also received CF support, for the ARISTOTLE study, which helped increase HIV testing and diagnosis among hard-to-reach PWID, and for a project led by the Greek Organization Against Drugs (OKANA) to educate and promote better health among active drug users, raise public awareness, train police officers on drug-related issues and pilot an initiative providing alternatives to imprisonment for drug offences. The ARISTOTLE has been operated by the NSRF 2007-13 program.

How are the funds distributed? (19)

ESIF do not fund projects centrally. Instead, each Member States is responsible, through its delegated national managing authority, for allocating the ESIF funds and implementing the funded projects at the national level through an operational programme. The government is also responsible, in partnership with major stakeholders such as regional and local governments, for

preparing a strategy that addresses the priorities, instruments and performance indicators for the delivery of ESIF funds.

Distribution of the funding in each country is carried out through specific thematic calls for tenders in accordance with funding priorities. Application procedures, deadlines, requirements, etc. thus vary from country to country.

- Organizations interested in ESIF funding should contact the ESIF managing authority in their country or region. To find the relevant contact details, visit the ESF support page (20).

Once EU priorities have been established for a country, it can be difficult for harm reduction stakeholders to influence those priorities and receive ESIF funds. Advocating and influencing the planning and priorities for the use of structural funds in a country should start at least two or three years ahead of the next funding period (2021-2027).

How to apply
If you are a public body, a private sector organization (especially a small business), a university, an NGO or an association, you can apply for ESIF funds. It is expected that each programme is developed through a collaborative process involving authorities at the European, regional and local levels, as well as social partners such as universities, foundations and civil society organizations.

As a potential beneficiary, you should do two things.

1. Consult the calls for proposals published by the managing authority or authorities in your country. You can find the national managing authorities here (21).
2. Send your application directly to the relevant managing authority.

Guidelines for ESIF investments in health, prepared by the Commission for the Member States and other interested stakeholders, can be found here (22), while an companion toolkit (23) offers technical advice for making sure these investments are sustainable and effective.

Finally, ESIF regulations and updated information on the ESIF funds are available here (24).

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Annex 5: Joint procurement – Tip Sheet #2

What is Joint Public Procurement?

Joint Public Procurement is when two or more contracting authorities agree to perform certain specific procurements jointly. Joint procurement (JP) can take several different forms. From coordinated procurement through the preparation of common technical specifications for works or supplies that will be procured by a number of contracting entities, each conducting a separate procurement procedure, to situations where the contracting entities jointly conduct one procurement procedure (1).

What are the benefits of joint procurement?

The intention of JP is to obtain lower prices, save on administrative costs and benefit from each other's procurement expertise and competences. This is a tool that is being considered as healthcare systems are under budgetary pressure.

How is joint procurement carried out?

Joint procurement actions may be performed among contracting authorities within the same country and as international/cross-border joint procurement among contracting authorities from different countries (i.e. where two or more contracting authorities from different Member States are jointly purchasing works, supplies or services through one tendering procedure):

- Permanent JP organization: Some countries have central purchasing bodies, which carry out activities in consulting, assistance, and support in procuring goods and services for the public sector (e.g. Italy: Consip (2); Croatia: State Office for the Central Public Procurement (3))
- Collaborative agreements (national or international): Groups or boards collaborating on coordination and joint action in purchasing and supply matters (e.g. London Contract and Supplies Group (4)-)
- Contracting authorities collaborating on a one-off procurement action.

Initiating joint procurement activity

- Internal/organizational actions – Involving all relevant actors and departments i.e. health, social services, procurement, legal departments – The benefits of JP must be promoted to convince the stakeholders – Importance of selecting the right product – Internal workflow/templates/responsibilities needs to be clarified.
- External actions – finding partners – approach other contracting authorities like public authorities networks, etc. – Set-up meetings between the partners: lead outlines the procedure, show some good examples, preliminary market research can be carried out – Contracting authorities may form a formal consortium (consortium agreement).

Joint procurement of medicine

Directive 2014/24 outlines the EU legislation on public procurement and it is intended to facilitate cooperation between contracting authorities, including between member states (5).[1] One main advantage of joint procurement groups within and across member states is improvement of the bargaining power position in price negotiations which can lead to lower prices. There are examples of European countries which have jointly negotiated lower prices for new patented medicines under this strategy (e.g. Belgium, the Netherlands and Luxembourg) (6, 7), and Bulgaria and Romania in another (8). As of 2016, Italy, Spain and Portugal potentially a few other countries are working on launching a joint hepatitis C drugs procurement group (94).

Box 15. Bulgaria and Romania agree on joint procurement of medicine

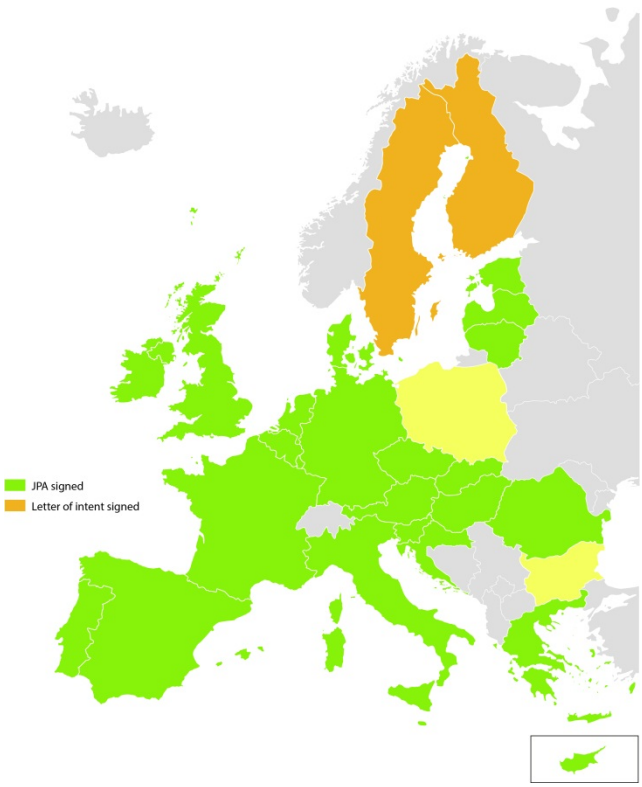
Bulgaria and Romania have agreed to jointly procure high-value pharmaceutical products. There have been exchanges between staff at health ministries to identify common areas of medicine procurement. The two countries have declared that the joint procurement provision is open to other EU states in the region in order to improve the bargaining position of the countries' respective healthcare systems. The agreement also involve exchanges of medicines that may be in short supply in either country; thus in the event that a particular drug becomes scarce in Bulgaria – and there are sufficient stocks in Romania – the Romanian authorities will provide their Bulgarian counterparts with supplies of the medicine concerned, and vice versa (10).

[1] Specific rules apply to the procurement of services in social, health and cultural services and to some other services that are exhaustively listed in Annex XIV of the directive 2014/24/EU on public procurement.

European Union Joint Procurement Agreement on medical countermeasures

This is a relatively new mechanism of EU health system collaboration. It is a framework agreement laying down common rules for the practical organization of joint procurement procedures with a view to the advance purchase of medical countermeasures for serious cross-border threats to health such as communicable diseases (11).

By April 2016, 24 EU countries had signed the Joint Procurement Agreement (JPA) - see Figure 2.



18 April 2016	Germany
19 February 2016	Austria
22 September 2015	France
19 June 2015	Ireland
1 December 2014	Denmark Lithuania
12 November 2014	Hungary
16 October 2014	Italy
23 September 2014	Romania
26 June 2014	Luxembourg
20 June 2014	Belgium Croatia Czech Republic Cyprus Estonia Greece Latvia Malta Netherlands Portugal Slovakia Slovenia Spain United Kingdom

Figure 1: Map of EU countries that have signed the Joint Procurement Agreement

Source: European Commission, Joint Procurement Agreement Map (12)

What can be purchased?

The Joint Procurement Agreement permits the purchase of any medical countermeasures aimed to prevent or control the spread of communicable diseases that can be considered as serious cross-border threats to health. Therefore, all potential medicines, medical devices, services and goods that could be used to mitigate/treat a life-threatening or otherwise serious hazard to health of biological, chemical, environmental or unknown origin which spreads, or entails a significant risk of spreading across the national borders of Member States, and which may necessitate coordination at the EU level in order to ensure a high level of human health protection, can be procured in common under the Joint Procurement Agreement (11).

The JPA is directed to pandemic outbreaks, such as seasonal influenza. The products that could be procured in common under the Agreement are the following: diagnostic tools/kits, laboratory tests

and services, vaccines, antivirals, other medicines, ancillary products and protective equipment for healthcare workers. So far only Belgium, Croatia, Cyprus, Italy and Malta have tried to use the process, with plans to buy protective clothing for contact with infectious patients (11).

How to start a procurement procedure

Any Joint Procurement Agreement Steering Committee (JPASC) member may propose the launch of a procurement procedure. This proposal shall identify the medical countermeasures to be procured. A procurement procedure shall be initiated if at least four Member States plus the European Commission vote in favour of starting such a procedure and have notified this intention to the Chair of the JPASC. Involvement in a procedure is voluntary and open to all states that have signed up to use of the mechanism. A Contracting Party may decide to donate the medical countermeasures acquired under the joint procurement procedure to other states and international organizations (11).

The potential of JPAs

Procurement of supplies for harm reduction services (needles, etc.) may be possible, but to date no concrete examples exist. There is an ongoing debate on whether the JPA may be extended to cover the purchase of medical countermeasures for other infectious diseases, such as HIV, hepatitis B and C, or human papillomavirus (HPV) (13).

In response to Petition No 0058/2015 to the European Parliament by Carmen Hinojar (of Spain) on behalf of the Platform for People Affected by Hepatitis C, on the creation of a European plan to eradicate hepatitis C, the Committee on Petitions responded:

“Regarding calls to coordinate Member States' drug purchases or to set up an EU fund for hepatitis C treatments, the Commission is not in a position to provide direct funding for PE576.836v01-00 2/4 CM\1085857EN.doc EN medical treatments, nor to set up funds for that purpose. The Commission is also not in a position to coordinate or impose on Member States which drugs to buy for specific diseases. Under current EU legislation on serious cross-border threats to health, the Joint Procurement Agreement (JPA), signed so far by 22 Member States, is an instrument available at EU level envisaged by Article 5 of Decision 1082/2013 that can potentially help Member States improve access to new drugs against hepatitis C at more favourable conditions. This option can be used by Member States and a specific procurement procedure (e.g. for hepatitis C treatments) can be organized in line with the conditions set out in the Decision and in the JPA by the Commission if at least four Member States and the Commission are in favour.” (14)

Thus indicating that the EU Commission sees a potential in the Joint Procurement Agreement for Member States improve access to new drugs against hepatitis C at more favourable conditions.

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