GNP+
GLOBAL NETWORK OF PEOPLE LIVING WITH HIV

Comparative analysis of the engagement of people living with HIV in the process of developing fit-for-purpose HIV Response Sustainability Roadmap Part A East and Southern Africa- 9 Countries

2025

1. Background

Over forty million people are living with HIV globally, 630,000 of our peers died in 2024 among them 120,000 children. 1.3 million people acquired HIV in the same period, and approximately one in four people living with HIV are not accessing ARV while over 30 million people are dependent on lifelong access treatment, including the services that sustain this.

UNAIDS has been working with partners and over 30 countries to develop country-led roadmaps for the sustainability of HIV prevention, treatment and care services far into the future (**Annex 1. HIV Response Sustainability Roadmaps Background**). The Global Network of People Living with HIV (GNP+) has undertaken a comparative analysis of process and content of the HIV Response Sustainability Roadmaps Part A of nine East and Southern Africa countries: Eswatini, Kenya, Lesotho, Malawi, Namibia, Tanzania, Uganda, Zambia and Zimbabwe. Its purpose is to develop the advocacy space and supporting information base to ensure that country HIV Response Sustainability Roadmaps Part A being developed are fit-for-purpose from the perspective of people living with HIV. The analysis focuses on critical areas of concern to people living with HIV rather than being a comprehensive one.

2. Methodology

Data collection involved:

- **Desk review** which included the UNAIDS Sustainability Technical Guidance, UNAIDS HIV Response Sustainability Roadmaps Peer-Learning Workshop Report 28–31 October 2024, PLHIV Leadership Summit 2025 Report along with the HIV Sustainability Roadmaps Part A for the nine countries and Botswana, Ghana and Togo.
- **Dialogue** with UNAIDS Equitable Financing Practice department.
- **Interviews**: Based on the desk review and UNAIDS input, an interview protocol was developed with the input of GNP+ (**Annex 2, interview protocol**) followed by nine 30-minute semi-structured interviews with people living with HIV representatives from the nine countries with clarifications subsequently by email (**Annex 3 List of Participants**).

Country selection criteria evolved as information became available through data collection with the final criteria requiring Government's endorsement of the country's Roadmap Part A; level of reliance on United States PEPFAR funding; total number of people living with HIV; and is a country of East or Southern Africa (**Table 1**). Uganda was included as its experience as one of two countries to implement the **Rapid AIDS Response Financing Tool (RAFT)** to date will be informative to countries engaged in the HIV Response Sustainability Roadmap process.

Table 1: Country selection criteria

Countries	No. PLHIV all ages	% total HIV budget funded by United States PEPFAR Program
Eswatini	230 000	30-49%
Kenya	1 400 000	
Lesotho	270 000	50-89%
Malawi	980 000	50-89%
Namibia	230 000	30-49%
Tanzania	1 700 000	90%+
Uganda	1 500 000	50-89%
Zambia	1 300 000	50-89%
Zimbabwe	1 300 000	50-89%

Analysis

The comparative analysis has two arms. The **process analysis** informs countries, in particular people living with HIV networks, which are still in the process of developing Roadmap Part A and for all countries when developing Roadmap Part B; while the **content analysis** identifies areas of paramount concern issues and insights from people living with and impacted by HIV, on three of the HIV Sustainability Roadmap Part A Domains: 1. community engagement; 2. financing of the HIV response - specifically funding (i.e. social contracting) of people living with and impacted by HIV community health workers/ service providers within the MoH-recognized cadre of community health workers (CHWs) to ensure that funding to meet the needs of people living with and impacted by HIV for people-centred programmes and service delivery; and 3. enabling laws and policies with a

focus on social enablers to address stigma, gender, violence and laws to inform countries, in particular health, finance and other ministries, along with UNAIDS, Global Fund, donor and development partners, and other stakeholders as the Roadmap development and implementation process evolves. For more information on the specific areas of analysis, **Annex 4: Roadmap Part A Process and Content Areas for Analysis**

3. Process Findings

HIV Sustainability Technical Working Group
In all countries, people living with HIV were involved in the development of the Roadmap Part A, including membership of the **Technical Working Group** (TWG) or equivalent overseeing the process with many people living with HIV representatives reporting that the process went relatively well with caveats. However, the scope of people living with HIV involvement remains an issue.

Technical Working Groups sought technical input from people from people living with and impacted by HIV with capacities i.e. community experts and similar, which resulted in the engagement of people living with HIV dependent on the availability of the limited representation invited. This bias is reinforced by community self-selection. For example, in **Malawi,** TWG members were chosen from those who were interested in topic and who had experience in such processes – a coalition of the willing – which limits the diversity of lived experience informing the process.

Further, given time constraints, financial means and the approach taken to developing the Roadmap, community level consultation with people living with HIV were often not undertaken by the community members involved or community members from these communities were not invited into the process.

Recommend: Broad-based community engagement, including membership of the TWG or equivalent in the HIV Sustainability Roadmap development processes (Roadmap Parts A and B, RAFT), needs to be addressed to improve outcomes, increase transparency and accountability, along with community trust and buy into the process and outcomes.

HIV Sustainability Dialogue
For the **HIV sustainability dialogues**, in general CSOs were invited as participants with most of the leading roles allocated to MoH and NAC staff. This imbalance needs to be addressed so that the needs and voice of people living with HIV inform, guide and lead such dialogues. In **Zambia**, country dialogues were held leveraging PEPFAR Zambia COP 23 planning, Global Fund Country Team missions, the CCM provincial dialogues culminating in a joint steering committee and TWG inception meeting in which ToRs were ratified paving the way for engagements by the TWG

Recommend: Address the imbalance in the leadership of the HIV sustainability dialogue process by including people living with HIV in the leadership and planning group so that their needs and voices inform, guide and lead such dialogues. These voices can be strengthened through a process that allows for PLHIV leaders to gather input from communities before dialogue and to give feedback post dialogue- a model used for community engagement with CCMs.

HIV Sustainability Tools

Countries have adapted the Roadmap to meet their needs, and overall this has worked well. However, **data must be disaggregated by people living with and populations impacted by HIV**. In the Excel Sustainability Assessment tool, under the domain services and solutions: HIV testing cascade does not disaggregate key populations; and HIV treatment cascade does not disaggregate people living with HIV. Countries have recognized these gaps and included the relevant data in their processes.

Recommend: It is essential to ensure that country realities and data inform processes and plans as part of a broader adaptive process to funding realities, guided by tools developed for these purposes. Specifically, the UNAIDS Roadmaps Part B tool needs to ensure that all data collected is disaggregated by people living with HIV, and other categories as appropriate. While WHO has developed operational guidance for sustaining priority HIV, viral hepatitis and STI services in a changing funding landscape.

Overall:
In **Uganda**, the community have consistently demanded that a **separate domain for Community Systems Strengthening (CSS) and Leadership** be included in the Roadmap but to date this has not been realized. This call for a CSS Domain reflects communities' commitment to community engagement, the need for a sustainable funding modality, and the centrality of CSS in providing people-centred, accessible services to people living with and impacted by HIV.

Finally, **resources for the HIV response** are the point of all this work. Kenya developed its Roadmap plan without commitment on domestic resources i.e. it was developed by a technical team without political authority to commit resources. This raises the question of whether it will be implemented, and the level of effort to invest in the process.

Recommend: Engagement and participation of people living with and impacted by HIV in a country's HIV Sustainability Roadmap development process and implementation must be part of a broader collaborative community resource mobilization and advocacy strategy to secure domestic financing through the national resource and budget planning process.

4. Content Findings

4.1 Services and Solutions, and Systems

Community Engagement

Community-led organizations and networks of people living with HIV are the heart of the HIV response. For more than 40 years, our - people living with and impacted by HIV - activism, knowledge and inventiveness have shaped and powered HIV programmes across the world, saving countless lives. **Community-led services and support** are often lifelines for people neglected by standard health systems. They are also best placed to respond as the age profile of people living with HIV and vulnerable evolves with the majority aging with comorbidities especially non-communicable diseases becoming more prevalent. From advocacy to peer-led services, monitoring and research, community-led interventions continue to fill service gaps, monitor and register deficiencies, identify solutions and help ensure HIV responses are grounded in human rights. Community-led services extend beyond health to advocacy for legal and policy reforms, monitoring of and seeking redress for human rights violations, and actions to support communities with violence mitigation, legal literacy and livelihood assistance.

Programmes for people living with and impacted by HIV must be evidence- and human rights-based, driven by People living with HIV leadership and empowerment, and they must ensure stigma- and discrimination-free access to services. That requires removing structural, policy and legal barriers, including, addressing and ending stigma and discrimination by community, health workers, law enforcement, justice sector, employers, education providers and others. Trusted service platforms require robust outreach systems that are peer-led and clinical services that are nonjudgmental, accessible and competent in addressing key populations' needs on the continuum of prevention, testing and treatment services. Universal health coverage systems need to be structured in ways that make these services accessible to all people living with and impacted by HIV.

In recognition of these vital roles, the 2021 Political Declaration on HIV and AIDS committed countries to increase the proportion of HIV services delivered by community-led organizations to 30% for HIV testing and treatment services, 80% for HIV prevention services, and 60% for programmes supporting the achievement of societal enablers by 2025. However, many of these services have closed in recent months and many more remain at risk.

All nine country Roadmaps acknowledge that the success of the HIV response has been significantly driven by community engagement and that community empowerment and social change remain critical elements of a comprehensive response. As noted above, people living with HIV interviewees are united on the centrality of people-centred, sustainably funded community systems and services as best practice for service delivery i.e. providing services by communities to meet the needs of communities where they live and work.

Recommend: Advocate for ongoing financial and government commitment to strong and capacitated community systems to ensure people living with HIV-led networks and organizations can provide treatment and prevention services,

conduct community- led research, monitoring and advocacy (including on stigma and discrimination and other human rights barriers) and engage in national and local planning mechanisms.

Community Health Workers
For people living with and impacted by HIV, there is a link between the quality of services and the people who provide those services.

Their role includes but is not limited to community mobilization linkages to health care and community health education. However, Community Engagement requires a structured, supported, meaningful and accountable process that ensures that people living with HIV have a seat and a voice in decision-making, planning, implementation, monitoring and evaluation to achieve access to quality HIV care for all. The CHW programme does not necessarily put the involvement of PLHIV at its centre while communities and people living with HIV do.

Only Malawi includes people living with HIV and key populations providing community health services within the Government's definition of community health workers. Other countries, including Namibia, Tanzania, Uganda, Zambia and Zimbabwe do not. However, definitions do matter. In the case of CHW, if a cadre of workers is included within the health sector, this means that positions are paid and come with terms and conditions, including workforce development, attraction, recruitment and retention. In Eswatini, advocating for people living with HIV to be included as CHW faces another impediment in that:

> **With regards to communities here in my country we have a big problem because the word community itself is not understood, by community they mean the general population. We have tried to explain but no one is willing to use it to mean communities as defined by Global Fund and PLHIV.** PLHIV interviewee, Eswatini

In Tanzania, while the language included in the Roadmap is supportive and there is understanding of the potential for communities to provide services, in the end, communities have been defined solely in terms of beneficiaries[1] leaving the private sector or NGOs to provide the actual services.

The designation of who is a CHW has other outcomes. In Kenya, there is Division of Community Health under the Ministry of Health with policies that define the lower-level cadre staffing under the government. Currently, the policy provides for Community Health Promoters (CHPs) (formerly Community Health Volunteers) who are not paid rather provided stipends. Going forward and with integration of HIV care into routine health service delivery points, the CHPs will be expected to take up community-based roles, including Peer Educators, Adherence Counsellors, Mentor Mothers etc. The fear is that CHPs may not have the skills to deal with stigma, discrimination, privacy and confidentiality (key aspects of HIV

[1] **Community-based HIV services** These are services that are often community-based delivered by the community or an external service provider. In the case of Tanzania, the services are either provided by MOH, or other NGOs funded to work with communities. Communities are in most cases beneficiary.

programming) as to date HIV has been externally funded through GFATM/PEPFAR, with programmes not strongly linked to the national Community Health Strategy. This gap provides an opportunity for PLHIV networks to train CHPs including in scientific progress, in particular, what Undetectable=Untransmittable is. It also an opportunity to ensure a percentage of CHWs/ CHPs are PLHIV to meet the unique needs of HIV programming.

HIV Sustainability Roadmaps need to recognize people living with HIV community health workers and others providing services to their communities are provided with pay and conditions reflecting their status as a cadre or adjunct to the health sector, in effect, status and pay akin to Community Health Workers (CHWs), the cadre of health care workers engaged and recognized by the MoH to support and expand community service delivery.

Recommend: Advocate to ensure that people living with HIV providing community health services are included in the Government's definition of community health workers or equivalent (and harmonized across laws and regulations). Further, that PLHIV networks are supported to train CHPs; and a designated percentage of CHWs/ CHPs employed are PLHIV to meet the unique needs of HIV programming.

4.2. Finance

The recent cuts in United States funding have had a seismic impact on HIV responses across East and Southern Africa. They have led to immediate disruptions in HIV prevention, treatment and care services. While a waiver was introduced to allow implementing partners to continue providing certain services, including lifesaving HIV treatment, it did not prevent widespread service gaps. The US funding cuts have already resulted in thousands of health workers being retrenched, programs halted, reduced access to HIV prevention, unavailability of data system and other related services and the dismantling of community health systems.

The total HIV budget funded by United States PEPFAR Program was 90%+ in Tanzania; 50-89% in Lesotho, Malawi, Uganda, Zambia and Zimbabwe; and 30-49% in Botswana, Eswatini and Namibia.

With the fear and uncertainty surrounding funding and the fact that Roadmaps were developed prior to these changes; whether implementing even the most coherent HIV sustainability finance plan remains feasible is in question. In this context, one universal message from respondents is that it is imperative that Government, in particular, the Ministry of Health, clarifies the scope of **social contracting** as a way of providing the necessary and predictable funding required for community service providers to deliver services in communities.

Social contracting is a form of result-based financing (RBF), which is one alternative Government can use to ensure that public funds are allocated most effectively towards the populations in need.

> **Results-based financing** is a financing arrangement between a funder and agent in which part of the payments are contingent upon the achievement of predefined and verified results[2].
>
> **Social contracting** refers to the strengthening of public financing of civil society organizations (CSO) for service delivery. It provides an important option for countries seeking to strengthen and improve their health systems and to continue to make progress addressing HIV, TB and malaria. Government and other domestic sources are often the most logical and sometimes the only options. Social contracting has been shown to be an effective way to formally reinforce the link between civil society and government and to provide services that can strengthen national disease responses and health systems[3].

East and Southern Africa countries that participated in the UNAIDS Regional Consultation on Social Contracting in Johannesburg, South Africa, September 2023, committed to developing a social contracting policy framework to guide the country in establishing structures for social contracting implementation. Countries are taking up this challenge with all Roadmaps including social contracting except for **Malawi** while Lesotho. A number of countries have integrated social contracting

[2] World Bank (2018). A Guide for Effective Results-Based Financing Strategies.
[3] UNDP (2019). Public financing of service provision by civil society organisations in national responses to HIV, TB and malaria: Report of the Global Consultation on "social contracting. 2019, UNDP.

across their respective HIV Sustainability Roadmaps Part A: **Namibia** (sustainable health financing systems, community systems capacity and resilience, and equitable healthcare delivery systems), **Tanzania** (leadership and governance, sustainable financing, community, and enabling policies and laws domains) and **Zambia** (financing, services and solutions- HIV prevention, and community systems domains)

In developing the **Namibia** Roadmap, one sustainability lesson learnt is that beyond the HIV response across other health contexts reducing reliance on donor finance by adopting innovative domestic financing solutions, such as public health funds or social contracts with civil society, is critical. Further, adapting and expanding social contracting widely across the health sector will strengthen the HIV response and the health sector more broadly by deepening the evidence base at all levels - policy, programme and service delivery.

Recommend: Advocate to include social contracting in country Roadmaps as an assured way of ensuring PLHIV networks and community-led organizations are funded sustainably.

4.3 Social enablers to address stigma, gender, violence and laws

Funding by the United States for projects and programmes focused on addressing stigma and discrimination and enabling legal environments has been largely halted.

Most of the Interviewees share that this work has been undertaken for decades, it is a work in progress, and that responsibility for policies, laws and regulations along with creating an enabling environment sits with the Government. There are commonalities of experience in relation to Enabling Laws and Policies: Societal Enablers (i.e. Human rights and legal environment). Overall, the current situation in countries is exemplified by:

- **Weak integration of HIV programs into broader national health systems and Universal Health Coverage agenda**
- **Fragmented coordination mechanisms leading to duplication of interventions across implementing partners**
- **Persistent legal (including criminalization of HIV transmission, same-sex relations, sex work, drug use as well as age of consent laws and restrictions on sexual and reproductive health rights) and policy barriers limiting access to services for key and vulnerable populations**
- **Inadequate frameworks for government funding of community-led interventions**

The actions for the **Enabling Laws and Policies** domain outlined in country roadmaps are reported, overall, to be appropriate for each country. For example, **Lesotho** and **Malawi** have the most detailed approach, outlining short term actions which focus on protection measures to protect from the harmful effects of existing laws and practices criminalizing populations and behaviours; while the long-term activities focus on the reform and removal of such laws – an approach employed since the earliest days of the pandemic. This approach is consistent with that of the other countries with their less detailed outline of activities.

Further, what needs to be done is not new, it is 'simply' a matter of implementing what needs to be done. For example, the Pathways for Change and Major **Strategies outlined in the Tanzania HIV Sustainability Roadmap** Part A are quite clear:

- **Review and update policy, laws, and related instruments to address policy, barriers to access and utilization**
- **Strengthen strategies to monitor and enforce adherence and compliance with existing policies and laws**
- **Strengthen capacity of law enforcers and decision makers to use health-rights-based approaches in planning and implementation of activities in service delivery**
- **Implement the Report on the Legal Environment Assessment in Response to HIV and AIDS (2016) recommendations**
- **Strengthen policy and legal support to address root causes for gender inequality and violence**
- **Institutionalize social contracting to support and facilitate community efforts in service delivery.**

Recommend: Advocate for enabling laws and policies to strengthen the capacity of communities and service providers to address stigma and discrimination, gender and violence and increasing their reach to support people living with HIV to claim, protect and enforce their rights, in particular access to treatment under the umbrella of social contract funding.

Overall assessment and recommendations

Global health is undergoing unprecedented change and with this, a persistent uncertainty at a time when progress in science affirms Undetectable=Untransmittable, underscoring the impact of HIV treatment not only in securing healthy lives for PLHIV but also for HIV prevention. Through this time of change PLHIV networks and organizations must work to ensure people living with HIV have access to treatment and build trust with governments to work together strategically. Engaging with Government on the HIV Sustainability Roadmap process is an important step to ensuring that the HIV response going forward is calibrated to meet the needs of all people living with HIVand vulnerable populations. To date, the process and outcomes are overall good with the following recommendations for the process going forward.

Process Recommendations

- **HIV Sustainability Technical Working Group**: Broad-based community engagement, including membership of the TWG or equivalent in the HIV Sustainability Roadmap development processes (Roadmap Parts A and B, RAFT), needs to be addressed to improve outcomes, increase transparency and accountability, along with community trust and buy into the process and outcomes.
- **HIV Sustainability Dialogue**: Address the imbalance in the leadership of the HIV sustainability dialogue process by including people living with and impacted by HIV in the leadership and planning group so that their needs and voices inform, guide and lead such dialogues. These voices can be strengthened through a process that allows for PLHIV leaders to gather input from communities before dialogue and to give feedback post dialogue- a model used for community engagement with CCMs.
- **HIV Sustainability Tools:** It is essential to ensure that country realities and data inform processes and plans as part of a broader adaptive process to funding realities, guided by tools developed for these purposes. Specifically, the UNAIDS Roadmaps Part B tool needs to ensure that all data collected is disaggregated by people living with and populations impacted by HIV, and other categories as appropriate. While WHO has developed operational guidance for sustaining priority HIV, viral hepatitis and STI services in a changing funding landscape.

Content Recommendations

- **Community Engagement:**
    - Advocate for ongoing financial and government commitment to strong and capacitated community systems to ensure people living with HIV-led networks and organizations can provide prevention and treatment services, conduct community- led research, monitoring and advocacy (including on stigma and discrimination and other human rights barriers) and engage in national and local planning mechanisms.
    - Advocate to ensure that people living with and impacted by HIV providing community health services are included in the Government's definition of community health workers or equivalent (and harmonized across laws and regulations). Further, that PLHIV networks are supported to train CHPs; and a designated percentage

of CHWs/ CHPs employed are PLHIV to meet the unique needs of HIV programming

- **Finance:** Advocate to include social contracting in country Roadmaps as an assured way of ensuring PLHIV networks and community-led organizations are funded sustainably.
- **Social enablers to address stigma, gender, violence and law**s: Advocate for enabling laws and policies to strengthen the capacity of communities and service providers to address stigma and discrimination, gender and violence and increasing their reach to support people living with HIV to claim, protect and enforce their rights, in particular access to treatment under the umbrella of social contract funding.

Annex 1. HIV Response Sustainability Roadmaps Background

UNAIDS has proposed a new approach to ensure the sustainability of the HIV response beyond 2030. The goal of the new sustainability approach is to use a transformative lens, articulating the shifts needed for the long-term sustainability and lasting impact of the HIV response. The new approach calls for a country driven and owned processes that leverage country data and information, that will chart the pathways for country level strategies and actions to achieve and sustain impact and leave no one behind.

The process for developing the HIV Response Sustainability Roadmaps is aligned with the principles, goals and targets set out in the Global AIDS Strategy 2021–2026 and in the 2021 Political Declaration on Ending AIDS, therefore countries should prioritize the strategies and actions most urgently needed to achieve the 2025 targets and end AIDS by 2030. This holistic approach cuts across five sustainability domains: political leadership and commitment, enabling laws and policies, sustainable and equitable financing, science-driven, effective and high-impact HIV services and solutions, and systems built to deliver.

UNAIDS proposed definition of HIV response sustainability: a country's ability to have and use, in an enabling environment, people centred systems for health and equity, empowered and capable institutions and community led organizations, and adequate, equitably distributed, resources to reach and sustain the end of AIDS as a public health threat by 2030 and beyond, upholding the right to health for all.

UNAIDS has been working with partners and over 30 countries to develop country-led roadmaps for the sustainability of HIV prevention, treatment and care services far into the future. On World AIDS Day 2024, ten countries launched their sustainability roadmaps, and more will follow over the course of 2025.

Overview of Country progress on the development of Sustainability Roadmaps Part A

Countries which launched Roadmap Part A in 2024	**Countries expected to launch Roadmap Part A by end of the 1st Quarter 2025**	**Countries Expected to have a Draft Roadmap Part A by end of the 1st Quarter 2025**
1. Botswana 2. Eswatini 3. Kenya 4. Lesotho 5. Namibia 6. South Africa 7. Tajikistan 8. Tanzania 9. Zambia 10. Zimbabwe	1. Benin 2. Cameroon 3. Democratic Republic of Congo 4. Ghana 5. Malawi 6. Moldova 7. Mozambique 8. Rwanda 9. Senegal 10. Togo 11. Uganda 12. Viet Nam	1. Angola 2. Belarus 3. Burkina Faso 4. Burundi 5. Côte d'Ivoire 6. Dominican Republic 7. Ecuador 8. Ethiopia 9. Liberia 10. Mali 11. Nepal 12. Sierra Leon

HIV Response Sustainability Roadmap

An HIV Response Sustainability Roadmap outlines a country-led path for achieving the global AIDS targets for 2025, ending AIDS by 2030 and sustaining the impact of those achievements beyond 2030. It lays out the steps that can transform both health- and HIV-related political leadership, policies, finances, systems and services. The Roadmap should be aligned to existing sectoral strategies and plans, including for HIV, health and related social and multisectoral development strategies. The transformations proposed in the Roadmap should also inform future revisions in national strategies, including HIV and other health-sector and multisectoral strategies.

The HIV Sustainability Roadmap comprises two sections:

- Part A covers Phases 1–3, including: country engagement, the Sustainability Assessment, the tailored country approach, and the design of the plan.
- Part B covers the development of the transformation plan.

Rapid AIDS Response Financing Tool (RAFT)

UNAIDS has developed a Rapid AIDS Response Financing Tool (RAFT) to help countries navigate the current crisis caused by the 90-day pause for all United States foreign assistance, including activities funded by the United States President's Emergency Plan for AIDS Relief (PEPFAR).

RAFT provides a structured, data-driven participatory approach to inform strategic financial and programmatic decisions, to support country teams develop and implement a HIV financing emergency plan to pursue in a very short time resources and urgent reforms required to safeguard the continuation and the future of the life-saving programme. These emergency plans will be nested within the broader HIV Response Sustainability Roadmaps.

Annex 2 Interview Protocol

1.. Questions/ Areas of Inquiry regarding process for developing Roadmap Part A in 9 countries

Q1. Were you or other people living with HIV involved in the development of the Roadmap Part A?

- No, why not? What were the circumstances? Is it a one off or structural problem for PLHIV engagement
- Response Yes, please provide details regarding:

1. **HIV sustainability technical working group**:
    - Inclusion of communities, including but not limited to networks of people living with HIV, civil society organizations and community-led organizations working on health and HIV. Included? How was engagement? Suggestions as to what could be improved.
    - Whether a technical implementation team that can be delegated responsibility for developing the technical work required for the sustainability roadmap development process was established, including inclusion of communities and level of engagement and level of engagement.
    - Whether sub-working groups were established and how they related to the larger group, including inclusion of communities.
2. **HIV sustainability dialogue:** Inclusion and role as attendee, participant, presenter, session leader, not invited? How was engagement? Suggestions as to what could be improved
3. **HIV Response Sustainability Roadmap Part A development:**
    - Inclusion in the writing and/or review process. At what level?
    - Are there any Issues with Excel Sustainability Assessment tool. For example, under the domain services and solutions: HIV testing cascade does not disaggregate key populations; and HIV treatment cascade does not disaggregate people living with HIV. Have such omissions been overcome during the Roadmap development process, and these populations reflected in the Roadmap?
    - Are there any issues with country Roadmaps? For example, Kenya's Operational Plan for Enhancing Country Readiness to Sustain a Resilient HIV Response Beyond 2030 collapses the two domains of political commitment and enabling policies into Governance, Leadership, Accountability, Legal and Policy Framework. What impact, particularly for people living with HIV? What was the purpose? What is the cost? Are there positive aspects of collapsing the two domains?

Q2. What worked well?

Q3. What could be done better?

Q4. Are there any red flags from the process?

Q5. Suggestions to improve the overall process from the perspective of people living HIV/ community-led organizations i.e. What would you want done differently? Why? How and Other concerns.

2.. Questions/ Areas of Inquiry regarding the content of the Roadmap Part A of 9 countries in 3 domains:

- Services and Solutions, and Systems: Community Engagement.

- Finance (i.e. Funding sources and PLHIV engagement, including funding for community health workers. Does the government define: community health workers? Are PLHIV providing community health services included in the government's definition of community health workers?).
- Enabling Laws and Policies: Societal Enablers (i.e. Human rights and legal environment).

Qn1. Is the Roadmap Par A fit for purpose from the perspective / lens of people living with HIV.

Qn2. If not, what are the issues that need to be addressed/ included?

Annex 3 People Living with HIV Networks Interviewees

Eswatini Albertina Nyatsi Director, Positive Women Together in Action, Manzini, Swaziland Mob: +26876364366 albertina2001@hotmail.com	Kenya Nelson Otwoma Director, National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK) notwoma@nephak.or.ke
Lesotho Boshepha Ranthithi Executive Director, Lesotho National Empowerment and Prevention of HIV/AIDS (LENEPWA), Maseru, Lesotho Mob: branthithi@lenepwha.org.ls	Malawi Edna Tembo Executive Director, Coalition of Women and Girls Living with HIV and AIDS (COWLHA), Lilongwe, Malawi Mob: +265888309917 tembo.edna@cowlha.org
Namibia Vicky Kamule Executive Director, Tonata PLHIV Network, Windhoek, Namibia Mob: +264 65-231979 vkamule@gmail.com	Tanzania Cyprian Komba, Network of Young People Living with HIV and AIDS in Tanzania (NYP+), Dar es Salaam, Tanzania cypkomba@gmail.com
Uganda Flavia Kyomukama Movement of Women Living with HIV in Uganda (MOWHA) Mob: +256 772 602138 +256 702 602138 flaviakyomukama@gmail.com flaviakyomukama@yahoo.co.uk	Zambia Samuel Nyoni Community Youth Engagement Officer Network of Zambian People Living With HIV/AIDS (NZP+), Lusaka, Zambia PHI 23236// +260971-511-507 samuelnyoni24@gmail.com
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Annex 4: Roadmap Part A Process and Content Areas for Analysis

Process Areas for Analysis

HIV sustainability technical working group:

- Inclusion of communities, including but not limited to networks of people living with HIV, civil society organizations and community-led organizations working on health and HIV. Included? How was engagement? Suggestions as to what could be improved.
- Whether a technical implementation team that can be delegated responsibility for developing the technical work required for the sustainability roadmap development process was established, including inclusion of communities and level of engagement and level of engagement.
- Whether sub-working groups were established and how they related to the larger group, including inclusion of communities.

HIV sustainability dialogue: Inclusion and role as attendee, participant, presenter, session leader, not invited? How was engagement? Suggestions as to what could be improved

HIV Response Sustainability Roadmap Part A:

- Inclusion in the writing and/or review process. At what level?
- Are there any Issues with Excel Sustainability Assessment tool. For example, under the domain services and solutions: HIV testing cascade does not disaggregate key populations; and HIV treatment cascade does not disaggregate people living with HIV. Have such omissions been overcome during the Roadmap development process, and these populations reflected in the Roadmap?
- Are there any issues with country Roadmaps? For example, Kenya's Operational Plan for Enhancing Country Readiness to Sustain a Resilient HIV Response Beyond 2030 collapses the two domains of political commitment and enabling policies into Governance, Leadership, Accountability, Legal and Policy Framework. What impact, particularly for people living with HIV? What was the purpose? What is the cost? Are there positive aspects of collapsing the two domains?

Content Areas of Analysis

Analysis of the roadmap of each country, in the first instance, to ensure that they fit for purpose from the perspective / lens of people living with HIV. While the analysis addresses all five (5) domains; focused analysis is on the paramount issues for people living with HIV, under the domains:

- Enabling Laws and Policies: Societal Enablers (legal environment)
- Finance (i.e. funding sources and PLHIV engagement, including funding for community health workers).
- Services and Solutions, and Systems: Community Engagement.

Annex: Social Contracting by country

	Social Contracting
Eswatini	Commitment is there but modalities unclear. GF is funding social contracting currently. In what form this progresses is unclear. The Global Fund (GF) funds and GF recipients implement and direct and strength capacity for: • Strengthening community systems to ensure community-led networks and organizations can provide prevention and treatment services, conduct community- led research, monitoring and advocacy (including on stigma and discrimination and other human rights barriers) and engage in national and local planning mechanisms? • Social contracting (or other mechanisms by which the government finances CSOs to provide health services The next phase of Eswatini's HIV response will focus on building resilient systems that can withstand emerging challenges while meeting the needs of people living with HIV. Integrating HIV services into broader health systems, enhancing supply chain efficiency, and improving service quality will ensure continuity and equity in care. Community-driven approaches remain critical, with increased emphasis on empowering local actors to lead in service delivery, advocacy, and program monitoring. Communities will be empowered to play a central role in the HIV response by strengthening community-based organizations, networks and in addressing social determinants of health. By building capacity, providing resources and fostering collaboration, the ability of communities will be enhanced to deliver services, advocate for their needs, and contribute to the overall sustainability of the HIV response.
Kenya	**Financing** Current Status: • Despite evolving public-private partnership frameworks and potential for social contracting, Kenya has yet to establish mechanisms that would enable sustainable domestic financing for community-led responses. • Limited mechanisms for **social contracting** with local organizations Desired Future: Legally established **social contracting** mechanisms that: • Support sustainable community-led interventions • Enable direct government funding to community organization • Strengthen community health systems and service delivery • Ensure meaningful engagement of affected populations

	Action Point: Secure sustainable funding mechanisms and optimize resource utilization by: • Develop **social contracting** models to ensure sustainable funding for community-led initiatives and grassroots programs **Interviewee** The National Syndemic Diseases Control Council (NSDCC - formerly the National AIDS Control Council) and the National AIDS and STIs Control Programme (NASCOP) were working on the Transition and Sustainability Roadmap, the Ministry of Health (Kenya) was working on the Social Contracting Framework with funding from GFATM and USAID (consultant). There was weakness in how the Social Contracting Framework would fit within the Sustainability plans. Regrettably, the US government funding pause came before the work was finalized and consultant could be contracted and the work seem to have stalled. Anyway, civil society including PLHIV and KPs networks believe Social Contracting Framework will guide how the government can support non-state actors, including their networks. Without the Social Contracting Framework, Kenya lacks the mechanism through which the government can fund PLHIV networks. See also: • Kenya the Total War Against HIV and AIDS (TOWA) Project 2007-2014 which implemented a social contracting model. • UNAIDS Implementing social contracting for HIV prevention.
Lesotho	**Financing** Limited financial systems and access to funding: Absence of an interoperable tracking system for fund allocation and disbursement, along with restricted CBO resource mobilisation and social contracting, reduces transparency and access to financing, especially for TB programmes. **Community Services** Current Situation: The Government of Lesotho, through the MOH, has limited social contracting with select organisations but lacks a formal policy, legal framework and private sector involvement in the HIV and TB response. Pathways For Change Short-term 2024- 2027 • Develop a comprehensive social contracting policy, supported by legal frameworks, policies, and guidelines, to facilitate government funding for community-led organisations in HIV and TB services. • Strengthen the capacity of community led organisations to effectively manage donor and social contracting funds by incorporating digital financial

	tracking tools for transparency, and ensure the inclusion of dedicated budget lines or allocations for social contracting activities to enable predictable funding and transparent resource utilization Long-2028- 2030 • Advocate for sustained, long- term health financing to support community-led interventions, focusing on social contracting.
Malawi	**Interviewee:** community systems are underfunded and lack government support for social contracting mechanisms to effectively contribute to the HIV response. Comment: Not mentioned in roadmap
Namibia	**Lessons Learnt** The development of a sustainability roadmap, beyond just HIV, has highlighted several important lessons that can be applied across various health contexts: • Reducing reliance on donor finance by adopting innovative domestic financing solutions, such as public health funds or social contracts with civil society, is critical for sustainability. **Sustainable Health Financing Systems, capacity and resilience** High level outcome: Strengthened financing and resource mobilization for health to expand affordable access to the comprehensive Essential Health Service Package (EHSP) and ensure financial protection for all Namibians when seeking health and social services. Strategies: Expand use of social contracting to provide interventions to high risk and vulnerable populations. Interventions: • Simplify and streamline the social contracting process to encourage more organizations to participate. This could involve providing technical assistance to organizations unfamiliar with government contracting procedures, or offering flexible contracts tailored to the specific needs of different organizations and target populations. • Ensure that the contracting process is transparent and open, with clear criteria for selection and funding, allowing for fair competition and engagement from a broad range of non-state actors. • Advocate for sustained government funding for social contracting, ensuring that these

	Note: The MOHSS has managed to get its social contracting policy approved by Cabinet and is now moving to implement the social contracting pilot, which will allow the MoHSS to contract CSOs to provide health services (including HIV, malaria and TB services) at community level. This not only allows the MoHSS to ensure the sustainability of these critical services, but also allows them to expand access to health services at community level, thereby making progress towards the Ministry's broader objectives towards UHC. Through the work on social contracting and Program-based Budgeting there has been some strengthened engagement between Ministry of Health and Social Services and Ministry of Finance and Public Enterprises, but this honestly still needs more work **Community Systems capacity and resilience** High level outcome: A resilient and responsive Community Based Health Care System. Strategies: Implement the **social contracting** policy to deliver essential health services. Interventions • Ensure that the TWG remains active and proactive in absorbing and adapting to lessons learned in piloting and implementation. • Launch awareness campaigns to inform communities, local governments, and stakeholders about the **social contracting** policy, its objectives, and the role of CSOs in delivering health services. This fosters transparency and encourages community participation in health programs. • Ensure that the **social contracting** system is financially sustainable by developing long-term financing plans that reduce dependency on external funding and secure government and donor commitments. **Equitable healthcare delivery systems** Strategy: Ensure HIV sustainability is done under the umbrella of UHC and sustainability for health Intervention: Ensure the effective implementation and institutionalization of the Social Contracting for Health Policy, which involves formalizing partnerships between the government and civil society organizations (CSOs) to deliver health services. This requires establishing clear guidelines, transparent processes, and strong monitoring mechanisms to enable CSOs to access public funding and contribute to health service delivery. Successful institutionalization will ensure

	sustainability, accountability, and increased involvement of non-governmental actors in achieving health goals.
Tanzania	**Leadership and Governance** Current Situation: Inadequate resources to fully implement policy and strategies Pathways for Change: Institutionalize **social contracting** to support and facilitate community efforts in service delivery. **Sustainable Financing** Current Situation: There is no defined mechanism for social contracting to fund/support CSOs/NGOs Pathways for Change: Institutionalise and operationalize **social contracting** mechanisms to support CSO/CBOs/ FBOs (including KVP and PLHIV led) implement community-based and community led initiatives. **Community Role** Current Situation: Ad hoc and inadequate funding of community-based and community- led HIV response interventions Pathways for Change: Institutionalise **social contracting** to support CBOs **Enabling Policies and Laws** Current Situation: Inadequate resources to fully implement policy and strategies Pathways for Change: Institutionalize **social contracting** to support and facilitate community efforts in service delivery For resilient and sustainable community systems, communities will need to be strategically **empowered** to initiate and successfully implement **community- based and community-led HIV prevention and treatment services** in line with the 2021 United Nations Declaration of Commitment and the Global AIDS strategy.
Uganda	**3.3.1: Political Leadership** High Level Outcomes: Increased involvement of CSOs in the HIV response decision making structures and processes by 2030: Benchmarks / Tracking Indicators: **Social contracting** of CSOs established by 2025 and beyond Interviewee: Strengthened community systems for CL Orgs to provide community-based services, create demand for services, research, advocacy against S&D and engage in national and local planning in 70% of CL organizations.
Zambia	Government will further consider a shift to a total market approach (TMA) to provision of HIV products and technologies, with financial protection for the vulnerable. There will be further consideration for social contracting and enterprise mechanisms to sustain

	community led HIV responses - key for maximizing access and improving outcomes among key and vulnerable populations. In addition, Zambia will explore innovative financing such as debt swaps for health and philanthropy. **3.3. Sustainable and Equitable Financing** High Level Outcome: Efficient and effective HIV response Strategies/Actions: Establish modalities for social contracting for community responses **3.4 Services and Solutions 3.4.1 HIV Prevention** High Level Outcome: People-centred HIV and STI combination prevention and services for key and vulnerable population Strategies/Actions: Social Contracting and enterprise mechanisms **3.5 Systems 3.5.5 Community Systems** High Level Outcome: National HIV program service delivery expanded to include community led organizations (PLHIV, key and vulnerable populations) Strategies/Actions: Review/develop frameworks for community service delivery and CLM through social contracting
Zimbabwe	**Budget planning and spending** The concept of social contracting by government with CSOs in Zimbabwe is driven by multiple factors which include the need for community-based services to key and priority populations and the emerging role of CSOs as an important actor in community health service delivery, promoting social development and human rights. The adoption of new social contracting protocols by the GoZ is currently underway, with implementation involving the contracting of up to two organizations per province. While the guidelines have been disseminated, their use has not been extensive. Desired high-level outcomes: Resources for HIV services are optimally allocated and expended including optimal allocations to CBOs/NGOs. Risk: Sub-optimal social contract management and late disbursements to NGO providers. Transformation approach Enable NGOs to deliver agreed HIV services and functions, at an appropriate scale, in a community setting. on behalf of and financed by MOHCC and other government agencies. Actions:

	• Creating the polices, financing mechanism and partnership models to capacitate NGOs at national and sub national levels. • Assess feasibility of integrating relevant and feasible donor funded community service delivery activities into existing public platforms. • Implementation description: Address policy, legal and PFM barriers to social contracting. • Undertake budget impact assessment of government funding community-led service delivery through local NGOs. **Community engagement and Social Contracting** Desired long-term outcomes • Improved service delivery through community led initiatives. • Effective community engagement (capacity building, involvement) for a sustainable HIV response in Zimbabwe. • Communities provide input into government policy, programming and budget decisions related to the HIV programme and exercise ongoing feedback to responsible authorities

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