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”

2-3 December 2019
Istanbul, Turkey

Participants in the global consultation on "social contracting", 2 December 2019, Istanbul, Turkey.

The Global Consultation explored successes, challenges, lessons and opportunities for "social contracting"

- *Exploring the experience of countries in all global regions*
- *Discussing dissemination of good practices and innovative models*
- *Identifying constraints and strategies to overcome them*

For more information visit the website of the global consultation at:
https://sites.google.com/view/socialcontracting

Cover images: The Global Fund / JB Russel and The Global Fund / Jiro Ose

Table of Contents

Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CSO	civil society organization
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
M&E	monitoring and evaluation
NGO	non-governmental organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme

Terminology

"social contracting"	Used throughout this document to refer to public financing of civil society service delivery.

Background

The achievement of the ambitious targets set by the 2030 Agenda for Sustainable Development (2030 Agenda) and Sustainable Development Goal 3 to end AIDS, tuberculosis (TB) and malaria as public health threats by 2030 will be possible only if effective, cost-efficient and sustainable national responses to the three diseases are designed and implemented with the meaningful involvement of affected people and communities, including people living with HIV, TB and malaria, as well as key and vulnerable populations, making sure that no one is left behind.[1]

Communities and civil society have been instrumental in driving the global HIV response from its earliest days. Community-based organizations have spearheaded advocacy efforts to expand access to prevention, treatment, care and support services for all in need, regardless of location and socio-economic status. Governments, multilateral organizations and donors have come to recognize the vital role of civil society and communities, not only in advocating for HIV services, but in providing the services themselves, reaching those who may otherwise be left behind. Drawing on lessons learned from the HIV response, civil society also plays a significant service delivery role in TB and malaria responses.[2]

Over the past decades, millions of dollars have been invested in community-based service delivery by various donors, including the United States President's Emergency Plan For AIDS Relief (PEPFAR)[3], the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and others, significantly expanding the effectiveness and reach of HIV, TB and malaria service delivery and improving health outcomes for those most in need. As external financing becomes more limited in certain contexts, and as countries continue to scale up national responses, a greater share of funding for HIV responses will need to come from domestic sources, primarily governments. Whether and how domestic financing will enable such essential work to continue, expand and be sustained is a priority consideration for all stakeholders involved in supporting national responses and particularly for key and vulnerable populations and all others living with or otherwise vulnerable to the three diseases.

Strengthening public financing of civil society organization (CSO) service delivery – often referred to as "social contracting" – is an important option for countries seeking to strengthen and improve their health systems and to continue to make progress addressing HIV, TB and malaria. The sustainability of critical services provided by civil society depends on CSOs accessing diversified funding sources. 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.

[1] United Nations General Assembly. "Transforming our world: the 2030 Agenda for Sustainable Development." 2015.

[2] In the 2016 Political Declaration on HIV and AIDS, United Nations Member States commended financing mechanisms, including the Global Fund, for their role in mobilizing funding for country and regional responses, including for civil society, and in improving the predictability of financing over the long term. The strategies of UNAIDS, the Global Fund, PEPFAR and the WHO Global Health Sector Strategy on HIV all note that civil society and communities must play a central role in the design, delivery and oversight of the HIV response, including community-based service delivery.

[3] In "PEPFAR 3.0: Controlling the Epidemic: Delivering on the Promise of an AIDS Free Generation" released in December 2014, PEPFAR identified a Sustainability Agenda as one of five key priority agendas. (www.state.gov/wp-content/uploads/2019/08/PEPFAR-3.0-%E2%80%93-Controlling-the-Epidemic-Delivering-on-the-Promise-of-an-AIDS-free-Generation.pdf). Since that time, PEPFAR has focused on sustainable financing, metrics for measuring sustainability and support for social contracting as a part of the broader goals for sustained epidemic control.

In mid-2016, the Global Fund approved a Sustainability, Transition and Co-financing Policy, which among other things envisioned increased domestic co-financing of responses to the three diseases. The ultimate objective of the policy is supporting national governments to move towards fully funding health programmes independent of Global Fund support, while continuing to sustain gains and scaling up as appropriate. The Global Fund's Sustainability, Transition and Co-financing Policy recognizes the fundamental importance of maintaining quality service provision for key and vulnerable populations. The policy highlights that one strategy to achieve this may involve government contracting of non-state actors, such as civil society organizations, which requires enabling laws and policies and strong relationships between governments and CSOs.[4] As part of its efforts to strengthen overall sustainability, the Global Fund recognizes the importance of, and actively supports, efforts to set up and strengthen "social contracting" mechanisms, whereby government financing is used to directly fund and contract civil society and community organizations for service provision, often to key and vulnerable populations. The Global Fund also recognizes that national governments must continue to invest – and scale up their investment – in programmes to remove human rights and gender-related barriers so key and vulnerable populations continue to have access to health programmes.[5]

In 2017, a global consultation on "social contracting" for service delivery in HIV, TB and malaria was organized by the United Nations Development Programme (UNDP)[6], the Global Fund and Open Society Foundations. The consultation explored opportunities to ensure continuity of sustainable, rights-based and community-led, effective and cost-efficient models for service delivery that leave no one behind. During the consultation, participants explored nine different country experiences of "social contracting", which are described in the report.[7]

Summary of the key messages of the 2017 Global Consultation

- Raise awareness of civil society's critical importance in service delivery well before external funding comes to an end.
- Know and use budgets. Ensure that social contracting mechanisms are institutionalized in national budgets.
- Know the country and epidemiological context before making decisions. Conduct extensive mapping and collect more and better data and context-relevant evidence.
- Know the costs. Learn how to carry out costing of services related to social contracting.
- Prepare for the future. Introduce social contracting early on and well before full transition from external financing support.
- Learn from what is already taking place: leverage good practices and lessons learned.

[4] The Global Fund. "The Global Fund Sustainability, Transition and Co-financing Policy." 2016. www.theglobalfund.org/media/4221/bm35_04-sustainabilitytransitionandcofinancing_policy_en.pdf.

[5] The Global Fund. "The Global Fund Focus on Sustainability, Transition and Co-financing." 2017. https://www.theglobalfund.org/media/8467/publication_sustainabilitytransitioncofinancing_focuson_en.pdf?u=637284230220000000

[6] As pointed out it its 2016-2021 HIV, Health and Development Strategy, UNDP supports countries in transition planning and sustainability support, including in areas such as social contracting and strengthening legal and policy frameworks, as well as health procurement services. See UNDP, Connecting the Dots: Strategic Note HIV, Health and Development, 2016. https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/hiv--health-and-development-strategy-2016-2021.html

[7] UNDP, The Global Fund, Open Society Foundations. "A global consultation on social contracting: working toward sustainable responses to HIV, TB and malaria through government financing of programmes implemented by civil society." 2017.

Following the consultation, UNDP conducted case studies in eight countries, Bosnia and Herzegovina, Brazil, Croatia, Guyana, Montenegro, Namibia, North Macedonia and Serbia.[8] The case studies analysed legal and policy frameworks to create an enabling environment for "social contracting", programme modalities, success stories, lessons learned and opportunities in these countries at different stages of developing and implementing "social contracting" modalities. Similar analyses have been carried out by the Global Fund, the Secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other stakeholders.

Since the global consultations on social contracting were completed, the COVID-19 pandemic has caused a catastrophic impact on vulnerable communities around the world. The pandemic also threatens the progress against HIV, TB and malaria. The UN Sustainable Development Goals Report (2020) notes that, if no action is taken, a six-month complete disruption in HIV services, including antiretroviral therapy, could lead to more than 500,000 additional deaths in 2020–2021 in sub-Saharan Africa only from AIDS-related illnesses, including TB.

The report stresses the need for greater public health preparedness, including rapidly scaling up response capacities and increasing multisectoral and international collaboration. Under the leadership of the World Health Organization, the Global Fund, UNAIDS, and UNDP are partnering with all stakeholders, including governments and civil society organizations in many countries around the world, to coordinate responses to COVID-19. Engaging civil society and allocating public finances for civil society service delivery in the COVID-19 responses is instrumental for leaving no one behind and building forward better.

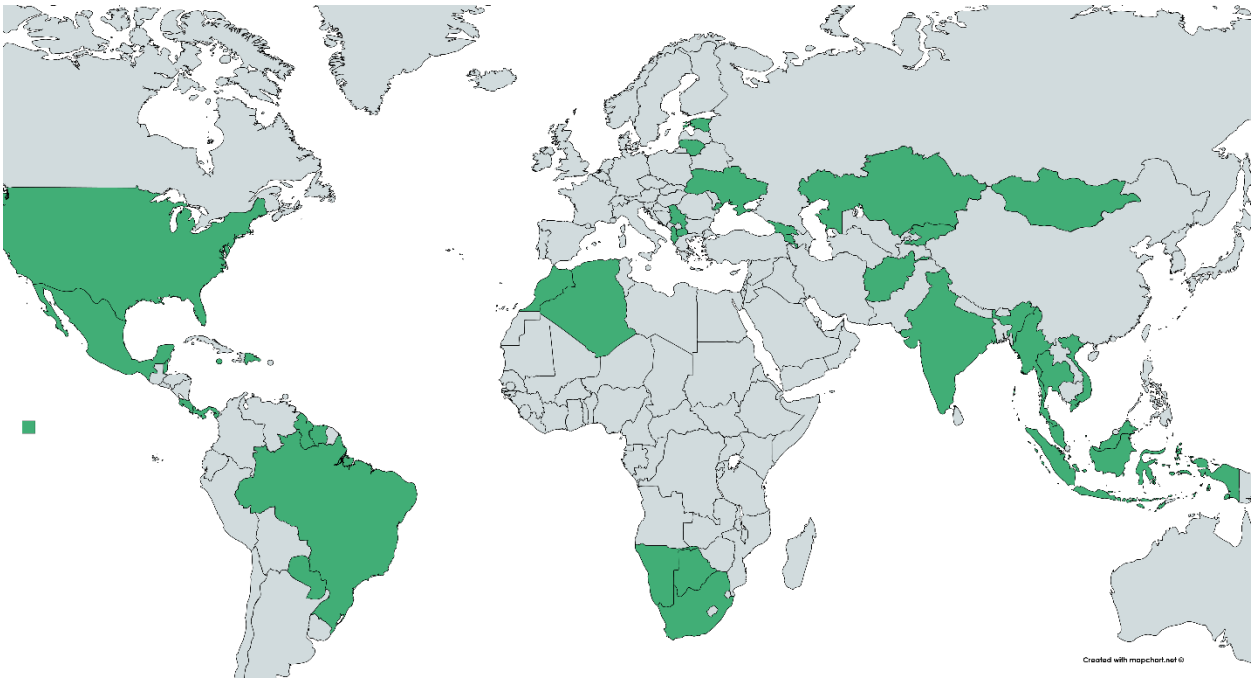
The Consultation

In December 2019, a global consultation entitled "Public financing of CSO service provision in national responses to HIV, TB and malaria" gathered 80 delegates from 34 countries in Istanbul, Turkey. The consultation was co-convened by UNDP, the Global Fund and the UNAIDS Secretariat. The objectives of the consultation were to:

(1) provide a forum for demonstrating the value of "social contracting" to expand services for key and vulnerable populations; and
(2) initiate and catalyse dialogue among countries at different stages of developing "social contracting" mechanisms to share good practices, lessons learned and practical strategies to improve these mechanisms.

[8] UNDP. "Using Social Contracting in National HIV Responses: Country case studies from Africa, the Caribbean, Eastern Europe and Latin America." 2019 (advanced draft). https://drive.google.com/file/d/1BZ6DFZMNPQjz_kwngGPObwXTaiN2tism/view.

Participants included government representatives, civil society, technical experts and representatives of multilateral organizations.



Countries represented at the 2019 global consultation.

The meeting was comprised of panel discussions, country presentations from various stakeholders, including government and civil society, and thematic workshops, in which participants rotated and were able to learn from the experiences of their counterparts in other countries and regions.[9] The workshops covered seven themes, which are discussed in the following sections of this report. Finally, this report provides a summary of the lessons learned as shared by participants and a summary of the conclusions and recommendations from the consultation.

Seven thematic workshops focusing on key issues related to "social contracting" were conducted. For each workshop, several framing questions were defined to guide the discussion and engagement of stakeholders. Different country experiences were shared by government and civil society representatives. This report captures the main messages shared during the workshops (based both on discussions and presentations), centred around the following topics:

- Defining service packages and costs;
- Paying for and contracting CSO services;
- Calls for proposals and selection of service providers;
- Mitigating political risks, promoting sustainability of CSO service delivery and CSO advocacy;
- Managing potential conflicts of interest as a CSO recipient of public funds; and
- Accountability, data, monitoring and quality of CSO services.

[9] Power Point presentations from the workshop are available on the consultation's website: https://sites.google.com/view/socialcontracting.

Workshop #1: Defining services

Topics of discussion

1. Which services can CSOs deliver under government contracts?
2. What approaches and considerations can be taken to define the service package?

Country examples: Georgia, India, Malaysia, Panama, Ukraine.

National disease programmes and related implementation plans outline the interventions that form the basis of national responses to HIV, TB and malaria. They might also specify which of these interventions are already implemented by CSOs and indicate areas in which the role of CSOs is more prominent even if they are not (primary) implementers. In practice, CSOs implement a range of critical interventions that vary across countries and change over time.

Examples of these services in the HIV, TB, malaria response include, but are not limited to:

- reaching beneficiaries outside the coverage of public health institutions with prevention commodities and health products (condoms, bed nets, clean syringes, etc.), health education and counselling;
- linking and helping beneficiaries to navigate or access services in public health institutions;
- conducting community-based testing, symptom screening and active case-finding for HIV, TB and malaria, outside health institution settings;
- initiating individuals to new services like pre-exposure prophylaxis of HIV;
- supporting treatment adherence and treatment education, including home visits;
- providing legal services to vulnerable groups to overcome barriers to health services;
- undertaking needs assessments; and
- capacity building of health workers to tailor non-stigmatizing services provided to underserved communities.

Below are the key messages from the discussions.

- **Social contracting is used to fund HIV prevention services and beyond**. Countries with experience in "social contracting" that were represented at the consultation use "social contracting" to implement HIV prevention programming for key and vulnerable populations, which are often at a disproportionally high risk of HIV and face legal and other barriers to accessing services. Examples beyond HIV prevention were also presented. For example, India uses "social contracting" to address all three diseases. Ukraine started funding CSOs to provide HIV treatment adherence and psychosocial support and is preparing to contract TB case finding services and treatment support. For these purposes, Ukraine uses and plans to increase the use of domestic funding. In Estonia, among other services, CSOs are paid to support the redirection of people who use drugs from law enforcement facilities to health and social services as part of Estonia's policy to support instead of punish people for minor drug-related offences. In South Africa, youth-led and gender organizations are funded to conduct school-based education to confront gender-based violence.
- **It is important HIV, TB and malaria service packages and interventions are clearly defined in national standards**. Regardless of which interventions are contracted to CSOs, their scope should be defined in sufficient detail in national technical standards and/or calls for proposals for delivery of services. Frequency and quantity of the services provided may also be part of the standards, in addition to the

types of services. With respect to standards, some flexibility should be allowed regarding the way in which CSOs could deliver these services.

- **Countries use a combination of inputs to define their service packages and determine which could be contracted to CSOs.** These inputs include disease-strategic objectives, epidemiological and programmatic data, international guidance, needs mapping, community and CSO perspectives, capacity of CSOs and state health institutions to provide services and reach certain populations, affordability, lessons learned from Global Fund grants, etc.
- **Adjust services based on evolving needs**. The composition of service packages should be revisited and adjusted depending on the evolving needs of the target populations and capacities of CSOs. For instance, India uses needs mapping along with data on service coverage, population size estimations, etc. Mapping is contracted to CSOs and paid from domestic resources and CSOs are tasked to identify needs, locations, to determine and prioritize underserved populations in communities and to assess health providers for possible service implementation partnerships. Malaysia considers how CSOs and government services are complementary in each location to define which services to be contracted to CSOs.

Workshop #2: Costing of services

Topics of discussion

1. How is costing conducted for the services to be contracted?
2. What are the lessons learned from costing and how do they apply to contracting services?

Country examples: Estonia, Georgia, India, Malaysia, Panama, Ukraine.

Costing of services is critical for estimating budget needs of national responses and for dialogue with policymakers about domestic investments. While there is no universal costing methodology to assess the cost of CSO-led service delivery, during the consultations several principles were highlighted, as described below.

- **Differentiation.** Different types of services might benefit from different approaches to costing. Various parameters, particularly volume of services, affect costs. Differentiated models of service delivery might require separate costing.
- **Involvement and planning.** Costing methodologies should be agreed upon among stakeholders before costing is undertaken. Methodologies may change depending on the purpose for which data will be used. Finance specialists representing the organisations financing the CSO services should be included in the costing discussions, along with programme managers and practitioners to ensure that the proposed methodologies are compatible with internal systems - for example, of the Ministry of Health, local authorities, health insurance funds, etc.
- **Standards and quality.** Service standards provide the basis for costing. Costing should accommodate the provision of high-quality services, i.e. compliant with World Health Organization guidelines for comprehensive packages of services.
- **Including all indirect costs, i.e. administrative and shared and subsidized costs.** The total costs of services provided by CSOs should ideally include administrative costs, as well as materials, labour and cost of premises (e.g. rent, furniture), even when these services are paid for from other sources and/or are donated. This approach makes it possible to know the actual costs of services, regardless of subsidies. The approach also allows a comparison of CSO costs with public sector costs and

analyses where there could be savings to guide future contracting. This approach can often help build political support to argue for the expansion of "social contracting" and may also help to advocate for government and donors to cover overhead costs, without which services may not be sustainable. In addition, some institutional funding is important for increasing capacity of the sector and investing in its viability and long-term sustainability.

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- **Including the indirect costs of organizations**. Indirect costs (staff, commodities, etc.) for CSO management should be considered along with direct costs of services. Some institutional funding is important for increasing capacity of the sector and investing in its viability and long-term sustainability.
- **Cost updates.** Costs are dynamic and should be updated, for example, to reflect changes in salary scales in the country, exchange rate fluctuations, inflation, etc.
- **Cost of addressing stigma and discrimination.** Higher stigma and discrimination against beneficiary groups may make services more expensive. In such cases adding legal and case-management services and other programming costs may be needed to address these barriers.
- **Factoring in capacity development.** CSOs, particularly those working at the community level, need support to develop their own capacity to plan and manage their costs, including the costs of services that will be provided under government contracts. CSOs need to strengthen their understanding of how to plan for depreciation of value over time, factor in fixed and variable costs, manage administrative and capacity building costs under their programme operations, etc.

As highlighted in the workshop, countries like Georgia, Panama and Ukraine have had positive experiences in devising unit cost analyses for HIV community-based services through consultative bottom-up processes that included consideration of the historical costs paid by international donors. As there is no universally accepted appropriate costing methodology, different cost concepts and costing methodologies can be used, depending on the purpose for which cost data will be used. During the consultation, countries shared tools (e.g. Excel spreadsheets) that were devised to support costing.

The unit costing process can produce powerful arguments for dialogue with public health and financing decision makers on "social contracting", CSO engagement and domestic investment. Unit costing can demonstrate how changes in some costs could help achieve savings and strengthen efficiency of national responses. Unit costing can also demonstrate the cost effectiveness of those interventions, for instance by comparing costs of services delivered by CSOs to cost of services delivered through the public and private sectors and can point to the impact and quality of those services. The process of arriving at unit cost estimates can help demonstrate changes in unit costs and overall cost estimates for the programme in case, for example, testing is conducted by non-medical providers.

In some countries, governments offer the contract to the bidder with the highest quality proposal based on the selection criteria and a pre-determined budget based on the unit cost. In others, price competition is allowed and considered the main factor in the evaluation. Participants identified the long-term risk of 'dumping[10]' if price competition is the only decisive factor in the contracting of services.

[10] Dumping is, in general, a situation of international price discrimination, where the price of a product when sold in the importing country is less than the price of that product in the market of the exporting country. Many governments take action against dumping in order to defend their domestic industries.

Workshop #3: Selection of service providers

Topics of discussion

1. Which selection approach to choose?
2. What are considerations for selection criteria and panels?
3. How to overcome possible challenges, such as contracting unregistered community groups?

Country examples: Brazil, Estonia, Serbia and a set of countries in Asia analysed by FHI 360.

The approach to the selection of service providers is largely governed by the legal framework for contracting of CSO services – e.g. general public procurement laws, civil society and special "social contracting" legislation, health, social care or specialized HIV laws and government regulations. Social contracting mechanisms might follow a procurement model which allows for government funding of CSO managed health and social services or can be based on grants and subsidies. In most countries, the experience of contracting CSO services is rather new and, no matter the selection mechanism, requires adaptation and continuous improvement.

The selection process consists of defining the selection approach, creating a call for proposals with set criteria for selection, followed by the review of received proposals by a selection panel.

The below considerations were discussed.

- **Differentiation.** Methodologies used for selection and review of proposals will depend on the setting, country and other specific issues. Approaches taken depend on multiple factors, including the CSO service provider landscape, the overall goals of the disease programme and interventions, disease epidemiology, institutions involved and their capacity, size of the country, capacity of the contractor(s), etc.
- **Selection method.** The selection of service providers could be done through open calls for proposals, calls among pre-selected CSOs and/or direct negotiations. An open call for proposals encourages competition and may help achieve economies of scale if the pool of CSOs able to provide services is large and the CSOs have strong capacities. Calls for piloting of certain interventions at current service levels may be announced among existing service providers. Direct negotiations might be the most appropriate fit in countries with a small pool of service providers who have been operating good quality programmes over time, without major changes to the pool.
- **Programmatic purpose.** Selection criteria depend on the programmatic purpose. For example, do selection criteria aim to maintain the same access to existing services or do they aim to establish and/or foster change? In the case of sustaining the existing level of access, the selection criteria might emphasize specific experiences of previous service provision. Setting up a new service, new approach, expanding client cohorts and responding to a new context may benefit from broader selection criteria and from investing in capacity building of providers.
- **Minimum requirements.** Selection criteria should include minimum qualification requirements to demonstrate ability to deliver services, in addition to other selection criteria. That helps to screen out applicants that are unfit to provide the services and save the selection panel's time.
- **Defining qualifications.** The criteria on qualifications could be defined in different ways allowing new CSOs to join the service provider pool. Countries often ask for demonstrated experience of CSOs in the field for a certain number of years. Alternatively, selection criteria could be set on staff qualifications (e.g., in the case of outreach services, requiring proof that outreach workers have been

trained and have experience; in the case of psycho-social support, requiring proof of certification and a certain number of years of practice), facilities (in the case of maintaining services in a drop-in centre, requiring availability of space to receive clients in a convenient location for beneficiaries; for mobile services, requiring availability or rental of mobile units), etc.

- **Collaboration with local institutions.** Some countries require candidate providers to demonstrate proof of cooperation with local authorities or local health facilities as part of the requirements or additional selection criteria. Such criteria could be beneficial for greater linkages between contracted interventions with existing local service networks, securing local political support and particularly in cases in which local funding is expected to support complementary services. However, too stringent or specific criteria may create additional barriers for CSOs - especially when local politics come into play.
- **Community groups.** Contracting unregistered community-based groups is a challenge for most governments, as CSO registration is a core requirement in most calls for proposals. One option to secure community engagement would be defining specific requirements for service providers to include community representatives among its staff or volunteers. Alternatively, registered CSOs could take on the 'fiscal agent' or 'umbrella organization' role for unregistered community groups to be involved in service provision.
- **Quality of services versus quality of proposals.** The selection process should consider the risk that assessments are completed purely based on the quality of proposals. Many organizations hire proposal writers, but the organization may not be capable of delivering quality services. The opposite is also true: some CSOs who deliver great services might have difficulties submitting good proposals. Calls for proposals could go hand-in-hand with training or information sessions for service providers to understand the requirements and processes.
- **Preventing interruptions between contracts.** Operating in annual state budget cycles means that countries may face challenges in ensuring continuity of services at the beginning of the budget year. Calls for proposals can only be announced after the approval of the state budgets and at the beginning of the current budget year, leaving nine months or less for service implementation. Some options to decrease the interruption period include: (1) introducing legislation that allows contracting services that go beyond the end year (for example up to 31 January, giving an additional month for the selection of contracting in the new year); (2) starting the selection process with the first draft budget (for example in September) and adding a clause that the funding is contingent on the approval of the state budget; and (3) introducing legislation allowing three-year contracts when certain conditions are met, etc.
- **Review and selection.** The review and selection of service providers is normally a two-tier process. The first tier ensures the requirements set in the call for proposals are met and overall compliance of documentation; this creates a shortlist of candidates. The second tier assesses the technical merits in line with targets envisaged, geographic area, conformity with service quality standards, etc. Sufficient time should be allowed for both tiers and could include a possibility for candidates to provide additional clarifications and documentation.
- **Composition of selection committees.** Membership of the selection committee should be different from the team that ensures programme implementation and monitoring, if feasible. Members from non-affiliated NGOs, other government institutions and academia, for example, could be considered for the committee. Involvement of international institutions (including on a non-vote, observer basis) active in the country or some other formal decision structure are other options. Such arrangements may be a challenge in smaller countries with a limited pool of providers and programme staff. Therefore, while taking into account the benefits of using unbiased experts, selection teams must first be based on the necessary knowledge and experience.

- **Managing conflicts of interest.** Forming a selection committee that balances potential conflicts of interest with 'lack of interest,' is often challenging, especially when the committee requires considerable time commitments without remuneration. This is a serious concern and significant differences in how to manage conflicts of interest between countries are proof of its complexity. Nevertheless, this is an important point and as such countries can request guidance from health donors, technical agencies and relevant governments and CSOs to tailor an appropriate COI policy.

Workshop #4: Payment mechanisms

Topics of discussion
1. How to design payment mechanisms, specifically identifying on what basis contractors are paid? 2. How to support implementation of the payment mechanisms? Country examples: Armenia, Brazil, Estonia, Georgia.

Payment mechanisms used in social contracting need to be carefully designed to align incentives appropriately with outcomes, account for planning and financial needs of both the government and individual providers and consider the operational realities of service delivery.

Governments may choose to pay service providers using different methods or a combination of methods: input-based, output-based and/or performance-based. The payment method chosen should be connected to the desired result, as all forms of payments for health services have advantages, drawbacks and the possibility for perverse incentives. E

It is important to note that countries may use different names for similar payment method concepts. Thus, it is important to understand what is meant when referring to these terms and match the terms to the names used nationally by ministries of finance and health authorities.

Input-based payment
This type of payment involves the transfer of funds from the government to a provider based on the resources deployed and inputs. These usually include salaries, health products, equipment and use of facilities. Payments are often made in the following sequence: 1) initial instalment before starting services; then a 2) second instalment based on the submission of financial and/or programmatic reports. Input-based payment does not take into account whether outputs are achieved. Input-based payment was the option most commonly used among countries participating in the meeting.

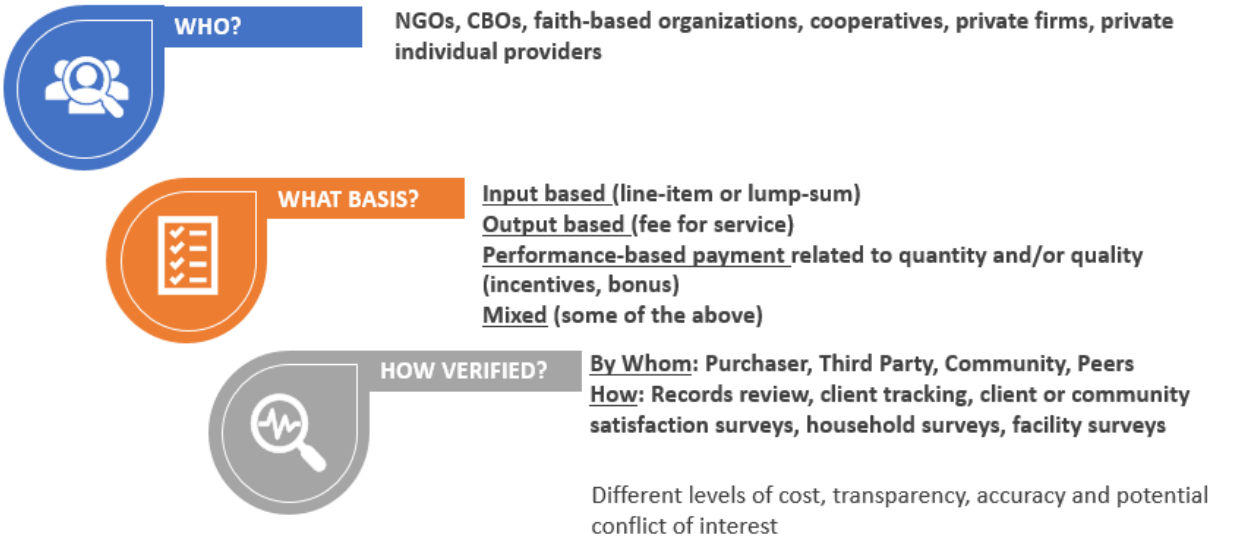
Output-based payment (fee for service)
Payment is based on the number of services, tasks or procedures provided to patients, with the unit cost defined by the purchaser. Units of service are quantifiable and verifiable. Usually, this is based on number of clients reached with a specific package of service or the number of specific referrals.

Performance-based payment (incentives, bonus)

Payment for services is linked to outcomes, such as coverage or quality of interventions. As in the output-based payment, a significant part of the payment is based on the results, whether the estimated number of services provided or by the percentage coverage multiplied by an agreed tariff. However, this amount

is then subject to adjustment if agreed criteria are (or are not) met, which means that 'good' performers will be rewarded with extra payment while 'bad' performers may be penalized. The selection of the right indicators is therefore crucial and should be suitable to the local context.

Examples	
Input-based payment	Brazil National HIV/STI/Hepatitis Programme: • CSOs contracted yearly for the provision of specific HIV services. • Costing of activities with a budget for each activity, breaking up the sub-activities and related costs. • Funds released in half-yearly instalments, subject to receipt and approval of financial and progress reports. • The first release is the sum of the total intervention budget for the first six months.
Output-based payment	Armenia NGO 'New Generation,' implementing HIV prevention activities, contracted by the Ministry of Health/National AIDS Center: • Output-based payments used in contracting outreach workers. • Remuneration of outreach workers based on the unit cost per each administered rapid test. • As a result of the change in payment mechanism from input- to output-based, the number of tested clients increased almost eight times in less than three years. The number of detected HIV-positive people also increased over five times.
Performance-based payment	India National TB Control Programme: • Payment is linked to numbers of notified TB patients recorded in an online TB monitoring system, Nikshay, in the geographic areas within a defined time period. • A deduction of 20 percent is applied for those notified patients whose microbiological confirmation/Drug Susceptibility Test (DST) are not documented in Nikshay. • A 30 percent deduction is applied for those notified patients whose treatment outcome are not recorded in Nikshay within nine months of treatment start.
Combined approach	Estonia combines the three types of approaches. The country uses the input-based model (budget-based model) to fund certain staff positions and other budget lines so that low-threshold HIV prevention remains accessible. For HIV testing, Estonia provides funds based on unit cost (output-based model) and applies a mixed model for some other services. Even in cases of input-based funding, outputs and outcomes are monitored.



How are "social contracting" services paid?

Considerations for design and implementation of payment systems are described below.

- **Evaluation and verification**. Monitoring and evaluation systems should collect information and include verification and supervision to support the payment approach. In the case of output-based payments, the systems should enable the purchaser to collect information on the volume of services reported and compare the result with the volume of services from other providers (public, private and NGO). Moreover, these comparisons should be used to develop national projections of service volume for given targeted populations or areas and, ultimately, to control costs and assist with overall costing of services. Further considerations are outlined in the next section on monitoring and evaluation, including accountability, data, monitoring and quality of CSO services.
- **Capacity building.** Capacity building is needed for countries to strengthen the understanding of the different types of payment mechanisms that could be used for "social contracting", including their advantages and disadvantages,.
- **Payment structure.** When defining payment mechanisms, countries should consider the amount of time that dealing with certain technical and financial reporting requirements will imply, consequent implementation delays and the risk of attention being drawn away from technical concerns of contract implementation. The capacity of the public sector to monitor performance-based contracting also needs to be considered.
- **Payment schedule.** As most CSOs cannot advance payments, long delays in receiving funds may mean that CSOs have few if any resources available to initiate programmes on a timely basis; this is a consideration that should be explored during the development of payment mechanisms.
- **Adaptation to change.** A CSO working for the first time under a fee-for-service or performance-based contract may face the challenge of having to fulfil conditions in order to receive payment, while continuing to function as an organization using their systems and patterns already in place. It is important to allow time for and provide support for learning and adaptation to change.

Workshop #5: Monitoring and evaluation for accountability and quality

Topics of discussion

1. How can assurances of impact and quality be balanced with flexibility, confidentiality and CSO needs?
2. How can possible challenges be overcome?

Country examples: Estonia, Georgia, India, Mexico.

Transitioning from external to domestic funding for service provision by CSOs may require changes in the organization of monitoring and evaluation (M&E) systems. The participants discussed how updated M&E systems should balance assurances of impact and quality of services with the flexibility, confidentiality and support CSOs need to effectively provide services.

What to consider when planning a "social contracting" M&E framework

- What do we need to monitor?
- Who should do the monitoring and the evaluation? Which institutions should be involved? What competencies are required?
- What should be the flow of data? How should results be validated?
- What should be the type and frequency of programmatic and financial reporting? Should these occur separately?
- How can we ensure that implementers have the capacity for reporting?
- How can we ensure confidentiality of data collected and processed?
- What mechanisms should be put in place for dealing with under-performance and/or fraud? What types of issues may be encountered and what are some risk mitigation options?

Several factors to consider were outlined during the consultation, as described below.

- **Methods of monitoring of services.** Governments could use different methods of monitoring the services contracted to CSOs, including: monitoring and verification by the contracting institution (purchaser monitoring and verification); outsourced monitoring and verification by a third party; community-based monitoring and verification; or peer monitoring and verification. Each of these methods involves different levels of cost, transparency, accuracy and potential conflicts of interest. The choice of method should balance these considerations with the payment approach and objectives of the M&E system and plan. Monitoring of services and providing support for quality assurance could be done by government institutions that contract the services, as in Estonia, or outsourced to other bodies with relevant technical expertise. For example, in the case of India's national HIV response, the National AIDS Control Organisation supports Technical Support Units in each state that monitor, evaluate and provide technical support to CSOs in those states. Consolidated strategic information and national data from services are used by the National AIDS Control Organisation to assess and validate progress and make policy decisions. Additionally, the National AIDS Control Organisation conducts staff visits to service sites and makes external evaluation. The system assesses and supports the programmatic level and also the systems in place – financial, human resources, organizational capacity and overall management.

- **Proportionality and balancing data needs.** Consideration of service outputs, outcomes and impact to monitor services should use the principle of balancing data needs, i.e. as much as needed but as little as possible. Procedures for oversight and supervision should be proportionate to the programme activities and funding provided.
- **Confidentiality.** Programmes should find ways to verify results without breaking the anonymity required by some clients as a precondition to use services. In some countries, the accountability mechanisms for state funds require collecting identifier data for all beneficiaries, which might not be possible for anonymous services for criminalized, marginalized and discriminated populations. Unique Identifier Codes used with donor funded systems may not always align with the reporting requirements of national funding and may require significant legislative and regulatory changes and adaptation of M&E systems to be allowed to continue. Often, one challenge of transition to domestic funding for "social contracting" has been setting up safeguards for governments to cross-check the reliability of reported beneficiaries receiving services.
- **Quality assurance, training and needs assessment.** Developing strong indicators and quality assurance should be an equally important part of monitoring, evaluation and learning systems. One of the approaches is collecting perspectives of clients and conducting community-based monitoring to provide inputs on how to improve services. Additionally, contracts should include funds for human resources related capacity building and/or CSOs should be provided training on regular basis, particularly on new evidence and new approaches. In both Estonia and India, assessing the needs and situation before contracting services is one element of the M&E system that helps ensure quality, acceptability and accessibility of services. Training and assessments should be budgeted together with "social contracting" for service delivery.

Workshop #6: Mitigating political risks and promoting sustainability of "social contracting"

Topics of discussion

1. What approaches are effective in mitigating political challenges and in keeping public financing for services and CSOs high on the government agenda?
2. Which funding sources and modalities could support a sustainable response?
3. Which strategies are effective to ensure sustainable and diverse funding streams?

Country examples: Albania, Jamaica, Mexico, North Macedonia.

Securing and maintaining political support for civil society engagement in HIV, TB and malaria programmes is equally important at the initial and more advanced stages of development of contracting mechanisms. Several principles and approaches, described below, can help keep the issues high on the political agenda despite and throughout political transformations and changes.

- **Early start and long-term view.** Fostering political recognition of HIV, TB and malaria work across partisan lines and in operational management in ministries takes time and consistent efforts. Therefore, efforts to strengthen sustainability should start early, and well before the departure of the donor, positioning work in these areas as being in the country's interest and not as a donor requirement. Building sustainability and political dialogue needs to continue after the end of international funding for services delivered by CSOs.

- **Health as a political priority.** When health is under-addressed and underfunded in general, it can be more challenging to strengthen the financing of specific interventions within national responses. CSOs are particularly well positioned to advocate for health as a political priority and the need for critical investments in health sector development across the political spectrum, using evidence-based arguments as part of these advocacy efforts.
- **Multi-layer and multi-stakeholder dialogue.** Securing commitments to HIV, TB and/or malaria work, and particularly investments for key and vulnerable populations, needs to reach parties in power and those in opposition, as majorities may change with elections. Dialogue should attempt to engage parliamentarians, the executive branch and party leadership, as well as senior and mid-level officials in various ministries, the latter of whom are less likely to change during political shifts. Examples were presented on how this can result in pre-election written declarations and multi-party leadership groups, Memorandums of Understanding with ministries of health and partnerships between CSOs and health experts which can be leveraged for sustained political will.
- **Evidence base.** As highlighted in the workshops, arguments based on public health, value-for-money and modelling scenarios of impact with and without services have resonated with political leadership and officials in several countries. Good data on costed needs, transparency and accountability of existing services is critical.
- **Local authorities.** Alliances (and funding opportunities) at local government levels may be more effective than national ones to maintain sustained support for social causes, including provision of services to key and vulnerable populations.
- **Capacities.** CSOs and governments require capacity strengthening in such functional areas as financial management, monitoring and evaluation, understanding local laws and policies and advocacy strategies. CSOs that do not understand public financing strategies and modalities face a real credibility risk with national partners.
- **Diversification of funding.** The discussions also covered ways to reduce funding risks and diversify funding sources. Changes in governments, a country's financial situation and other developments may result in a reduction or a cut in domestic public funding. Furthermore, public sources might not be willing to support certain activities that are a core part of a CSO's mission, such as advocacy or research. For both reasons, diversification of the sources of funding is recommended. Local governments, private sector partners and private foundations can be potential good sources of funding for CSOs. Devising and launching resource mobilization strategies while donors are still supporting the delivery of critical services and the CSOs themselves is encouraged.

Workshop #7: Addressing potential conflicts of interest and maintaining independence

Topics of discussion

1. How can CSOs be enabled to preserve their monitoring and advocacy roles, while receiving government contracts?
2. Are changes needed in governance of HIV, TB and malaria responses once "social contracting" is implemented?

Country examples: Brazil, Guyana, India, Malaysia, South Africa, Ukraine.

Public funding, particularly being dependent on a single source, may limit CSO independence and restrict the ability of some CSOs to conduct advocacy. This concern was confirmed by CSOs and governments in several countries with considerate experience in "social contracting", such as Estonia and Mexico. The

below reflections were shared on how to preserve CSO roles as an advocate, a watchdog and an effective party to governance efforts, as well as how to prevent and manage potential disputes during implementation of "social contracting".

- **Legislative frameworks for social participation**. Foundations can be laid for social participation and civil society development either in general laws on public participation, civil society and access to information, and/or in specific legislation on health, social policy and particular diseases. The legal framework could establish mechanisms and safeguards, such as inclusive governance models with self-elected civil society representatives and a supportive environment for CSO income generation including from public and private sectors. CSOs working on the HIV, TB and malaria may need to strengthen their capacity to engage in the establishment of these legislative foundations and to understand and leverage existing legal opportunities.
- **Diversified funding beyond HIV, TB and malaria**. Diversification of funding sources gives more independence to civil society groups, even if all their funding comes from some aspect of the state budget. It is important to create general opportunities for civil society funding, while CSOs should seek to raise funds from sources outside the specific disease areas, for example, from broad civil society funds or from justice, youth, gender and social policy programmes (if possible). Some of these funding opportunities might not exist at the national level but within regions, cities and municipalities. In addition, new ways of thinking among civil society groups should be encouraged to raise financial and other support from local authorities, businesses, society at large and through social entrepreneurship.
- **Strategic alliances**. Expanding CSO partnerships beyond the contracting authority, such as the ministry of health, could serve as a safeguard and increase the impact of advocacy. Strategic alliances could be built, for instance, with the presidential administration, parliamentarians, ministries of finance, education, interior and local authorities, academia, the private sector and broader civil society movements. Additionally, strengthening relationships with the leadership of the contracting authority, such as the minister of health, could improve communication of "social contracting" results and programmatic and policy needs with a possibility to turn to the leadership in case of pressure placed on CSOs.
- **Coordination**. Building civil society coalitions on HIV, TB, malaria and health can enable dialogue with authorities, without singling out service providers. In addition to service providers, such coalitions could accommodate other diverse civil society groups, community groups and human rights defenders. Coalitions could pool resources for building CSO visibility and public communication.
- **Sustainability of services versus sustainability of CSOs**. Budget advocacy for "social contracting" should be distinct from advocacy for sustaining specific CSOs. Individual CSOs are rightly increasingly concerned with their own sustainability. Moreover, "social contracting", particularly if resources become scarcer, might increase competition among CSOs to receive public contracts. Open dialogue facilitated by independent civil society groups, mediation among specific providers and support for CSOs to undertake strategic planning about their future and sustainability have proven helpful, as experienced for example in Ukraine.
- **Mutual accountability**. M&E and contractual arrangements should provide an agreed upon, objective basis to track inputs and outputs of "social contracting" and keep both contractor (government) and provider (CSOs) accountable for the success of services. Once health ministries start investing their budgets in needed but not fully supported interventions for vulnerable groups, the ministries become more keen to join CSO advocates for the full recognition of and the removal of legal and other barriers to these services.
- **Complaints and monitoring**. Prevention and management of possible undue pressures related to "social contracting" could be enhanced through oversight by national oversight mechanisms. For example, oversight bodies could have a system for complaints and technical working groups could

provide operational oversight of the implementation of "social contracting". Similarly, contracting authorities and civil society boards should have frameworks in place for complaints from CSOs.

- **Feedback**. Service providers might have valuable feedback on how to improve "social contracting" and programmes. If the governance does not foresee collecting such feedback, leadership of HIV, TB and malaria programmes should initiate systemic consultations with service providers.
- **Inclusive, multi-sectoral governance**. With donor support, coordinating mechanisms have been built on a foundation of inclusion and participation of different sectors, with a strong role for community representatives and civil society groups. Coordinating mechanisms operate with a different degree of success. These principles and good practices need to be sustained beyond donor support.

Conclusions

The need to ensure public financing of CSO service provision in national responses to HIV, TB and malaria is of critical importance for saving lives, reducing infections, promoting health and wellbeing and ultimately delivering on the relevant targets of Sustainable Development Goal 3 and Agenda 2030. Public financing of services provided by CSOs is among the many tools that can be used as a vehicle for sustainable financing and service delivery, particularly for key and vulnerable, hard to reach populations.

More countries recognize the need for public contracting and financing of services provided by CSOs. This is particularly noticeable in the field of HIV work, and increasingly with TB work, especially when providing services to key and vulnerable populations. Many countries supported by the Global Fund and PEPFAR have included "social contracting" in their plans addressing transition from donor financing. At present, a limited number of countries have extensive experience of developing and practicing "social contracting". Several countries have started piloting their contracting in recent years, and a growing number of countries are increasingly recognizing the importance and principles of such an approach.

"Social contracting" requires trust and mutual accountability among both government and civil society. Authorities and CSOs need to agree on the mechanisms of "social contracting" and seek endorsement for greater institutionalization across the various branches of government. Both sectors must work together to learn from piloting and proactively search for solutions needed to make "social contracting" work. Fostering that trust may entail making changes in the relationship between authorities and CSOs at conceptual and practical levels.

The development of "social contracting" mechanisms is an evolving process. The process does not end when the contracting mechanisms are initiated or when a transition is made from external financing. Even countries with years of experience continue to amend and evolve their approaches. Hence, piloting should start early, even when there are no immediate plans for a reduction in external financing, and ongoing learning is essential to strengthen mechanisms over time. The practice of "social contracting" might expose the need for legislative changes that would require time, particularly if external financing enjoys simplified or special procurement procedures for contracting. Additionally, piloting helps with creating systems and capacities for defining and costing services, selecting service providers, identify financing, initiating contracting and putting in place M&E systems and plans.

As more countries pilot and expand "social contracting", opportunities arise for cross-country communities of practice and learning, which can help strengthen progress. While solutions must be contextualized and tailored to specific country contexts, learning from other's experiences can strengthen

capacity, help avoid pitfalls and accelerate implementation. For example, existing documents from countries with experience in contracting CSOs could be used for drafting national documentation in places where these mechanisms are being piloted. Participants noted the importance of continued global dialogue on this topic, including recommending a potential third global consultation on "social contracting" to keep pace with a topic that is advancing quickly and to enable increased sharing and learning between countries.

Strengthening the provision of critical services provided by CSOs is often needed not only for programmes that respond to HIV, TB and malaria, but also in other areas. While legal frameworks are being created that support "social contracting" for HIV, TB and/or malaria services, it is important to also consider how these legal frameworks could be adjusted to apply to services provided outside of the three diseases. In addition, lessons from the HIV, TB and malaria fields should be shared with stakeholders in other sectors to contribute to ongoing fostering of sustainable CSO service provision.

Strengthening CSO contracting should go hand-in-hand with efforts to increase health investments and enhance efficiencies and effectiveness, as well as political commitment to reform policies and perceptions towards key and vulnerable populations, and underserved and marginalized groups. The Second Global Consultation did not discuss this area in detail but acknowledged the need to examine progress related to strengthening political support in the future. Building a country's willingness and ability to address challenges and access issues related to key and vulnerable populations will be a continuous process that will take consolidated efforts and persistence (particularly in the event of political changes), even when strong "social contracting" mechanisms are in place.

Based on the consultation, a number of specific suggestions and considerations were highlighted that may help strengthen "social contracting" mechanisms and sustainable service provision within and beyond HIV, TB and malaria responses. These include:

For CSOs

- Build and further develop professional capacity to provide services in HIV, TB and malaria programs, including with government funding.
- Strengthen capacity to develop proposals and participate in calls for proposals.
- Engage in definition of service packages, including how to cost, deliver and measure performance.
- Strengthen data collection while maintaining privacy, confidentiality, safety and security of beneficiaries.
- Develop systems and processes for maintaining independence – internal, by the organization itself, as well as external, through the community of civil society organizations.
- Develop plans and alliances to mitigate political risks that may result from increased service delivery financed by public sources of funding.
- Engage in partnerships with governments, the private sector, multilaterals and donors to strengthen public financing of CSO service delivery.

For governments

- Remove regulatory, fiscal, organizational and other obstacles and/or enhance the overall environment for "social contracting" by CSOs in national HIV, TB and malaria responses and health and social protection systems.
- Develop transparent, timely, fast, consistent and efficient mechanisms and processes for "social contracting".

- Engage CSOs and communities in programme development and decision-making.
- Partner in the development of service packages and engage CSOs in data collection that measures impact and identifies further needs while ensuring confidentiality of that data.
- Ensure continuity and support efforts to strengthen sustainability of services provided by CSOs, as a key strategy of overall efforts to strengthen sustainability of national responses.
- Strengthen capacity to work with CSOs and undertake and use cost and efficiency analysis.
- Respect CSO independence and support mechanisms to preserve that independence even as CSOs increase the delivery of services with public financing.

For donors

- Encourage "social contracting" to be considered in discussions of co-financing and domestic commitments, the development of funding requests and the development and implementation of grants (if and when applicable).
- Support efforts to design and pilot systems for "social contracting" well before external financing comes to an end, including by considering providing specific funding earmarked for contracting CSO-led health services.
- Support capacity development of CSOs and governments, for instance by providing policy advice and technical support, such as training, good practice exchange and development of knowledge and lessons learned and tools.
- Explore opportunities to support innovative payment mechanisms or other novel approaches to "social contracting", when applicable.
- When possible, leverage available technical assistance or other support to support the design, development and implementation of "social contracting" mechanisms at the country level.
- Support international exchanges of good practices and lessons learned, as well as South-South learning, particularly country to country exchanges of practice and documentation.

For multilateral partners

- Multilateral partners should encourage countries to consider "social contracting" modalities for service delivery in response to the three diseases and beyond.
- Multilateral partners can provide policy advice and technical support to develop "social contracting" mechanisms at the country level.
- Support technical assistance needs, including capacity development.
- Foster continued South-South dialogues, learning and exchange.
- Develop and support online and other platforms for ongoing sharing of documents and experiences.

Annexes

Annex 1: Consultation agenda

2 December 2019

8.30 – 9.00	**Registration**
Session 1: Opening and setting the scene *Chair: Mark Dibiase, UNDP*	
9.00- 9.45	**Opening session** Welcome on behalf of conveners: Gerd Trogemann, UNDP Introduction of participants Overview of agenda Security briefing
9.45 – 10.30	**Joint presentation: Public financing of CSO services in the HIV, TB and malaria fields** ➢ Nertila Tavanxhi, UNAIDS ➢ Carmen Gonzalez, Global Fund ➢ Boyan Konstantinov, UNDP
10.30 – 11.00	**Comments from participants**
11.00 – 11.30	*Tea/Coffee*
Session 2: Learning from countries *Chair: Matthew Macgregor, Global Fund*	
11.30 – 12.45	**Panel: Country experiences and Q&A** - Estonia: Aljona Kurbatova, Head of Drug Abuse and Infectious Diseases Prevention Centre, National Institute for Health Development, Ministry of Social Affairs - South Africa: Dr Linda Ncube-Nkomo, CEO, LoveLife
Session 3: Practical workshops (group work)	
12.45 - 13.00	**Introduction to workshops** – Raminta Stuikyte
13.00 – 14.00	*Lunch*
14.00 – 15.30	**Workshops A in parallel*** 1. Defining the service package and costs Translation: ENG + ESP moderator: Carmen Gonzalez, Global Fund 2. Mitigating political risks and promoting sustainability of CSO service delivery and advocacy Translation ENG + RUS moderators: Boyan Konstantinov & Mark DiBiase, UNDP
	3. Call for proposals and selection of service providers Translation ENG + FRA moderator: Corina Maxim, Global Fund
15.30 – 16.00	*Tea/Coffee*

16.00 – 17.30	**Workshops B in parallel*** 1. Accountability, data, monitoring and quality of CSO services Translation: ENG + ESP moderator: (*TBC)* 2. Paying for and contracting of CSO services Translation ENG + RUS moderator: Benjamin Loevinsohn & Carmen Gonzalez, Global Fund 3. Managing potential conflicts of interest as a CSO recipient of public funds Translation ENG + FRA moderators: Rosemary Kumwenda & John Macauley, UNDP
17.30 – 18.30	Reflection of Day 1 and networking with coffee and tea (*TBC*)

3 December 2019

8.30 – 8.45	Day 2 Overview
Session 4: Learning from piloting and developing "social contracting" mechanisms *Chair: Nertila Tavanxhi, UNAIDS*	
8.45 – 9.45	**Panel: Country experiences and Q&A** - Guyana: Sonia Roberts, Finance Director, Health Sector Development Unit, Ministry of Health - Kazakhstan: Bahyt Tumenova, President, Foundation "Aman-Saulyk"
Session 5: Practical workshops	
9.45 – 11.15	**Workshops C in parallel*** 1. Call for proposals and selection of service providers Translation ENG + ESP moderator: Corina Maxim, Global Fund 2. Defining the CSO service package and costs Translation: ENG + RUS moderator: Carmen Gonzalez, Global Fund 3. Mitigating political risks and promoting sustainability of CSO service delivery and advocacy Translation ENG + FRA moderators: Boyan Konstantinov & Mark DiBiase, UNDP
11.15 – 11.45	*Tea/coffee*

11.45 – 13.15	**Workshops D in parallel*** 1. Paying for and contracting of CSO services Translation ENG + ESP moderator: Benjamin Loevinsohn & Carmen Gonzalez, Global Fund 2. Managing potential conflicts of interest as a CSO recipient of public funds Translation ENG + RUS moderators: Rosemary Kumwenda & John Macauley, UNDP 3. Accountability, data, monitoring and quality of CSO services Translation: ENG + FRA moderator: (*TBC)*
13.15 - 14.15	*Lunch*
Session 6: Conclusions and way forward *Chair: Raminta Stuikyte*	
14.15 – 15.15	**Reporting from Workshops** Rapporteurs from 6 thematic workshops (7 min presentations)
15.15 – 15.30	*Tea/Coffee*
15.30 – 16.00	**Final thoughts from the participants** - What are key learnings? - What other issues need to be addressed? - What could be practical follow-up?
16.00 - 16.30	**Next steps. Closure** Support available from the organizers and other technical partners: Global Fund, UNAIDS, UNDP and others Thanks-yous. Evaluation forms. Closure

Annex 2: List of participants

No	Country	Sector	Name	Institution
	COUNTRY PARTICIPANTS			
1	Afghanistan	CS	Dr. Yasamin Yousofzai	Agency for Assistance and Development of Afghanistan (AADA)
2	Albania	Gvt	Xhilda Papajani	Ministry of Health and Social Protection
3	Albania	CS	Albana Dhimitri	Institute of Public and Private Policies (IP3)
4	Algeria	Gvt	Dr. Zahia Cherfi	Ministry of Health, PR/PMU GF grant
5	Algeria	CS	Nadjla Traidia	ANISS NGO / SR GF grant
6	Armenia	Gvt	Naira Sergeeva	Ministry of Health, Global Fund PCT
7	Armenia	Gvt	Ruben Hovhannisyan	National Centre for AIDS Prevention Centre
8	Armenia	CS	Sergey Gabrielyan	New Generation
9	Belize	Gvt	Dr. Marvin Manzanero	Ministry of Health
10	Belize	CS	Eva Burgos	GOJoven Belize Alumni Association (GOBelize)
11	Botswana	Gvt	Moagi Kenosi	National AIDS and Health Promotion Agency (NAHPA)
12	Botswana	CS	Dr. Khumo Seipone	African Comprehensive HIV/AIDS Partnerships (ACHAP)
13	Brazil	CS	Nara Denilse de Araújo	Ministry of Health
14	Costa Rica	Gvt	Esmeralda Britton González	Junta de Proteccion Social (Social Protection Board)
15	Costa Rica	Gvt	Grettel Arias Alfaro	Junta de Proteccion Social (Social Protection Board)
16	Dominican Republic	Gvt	Ivelisse Sabbagh	National Council on HIV and AIDS - Consejo Nacional para el VIH y el SIDA (CONAVIHSIDA)
17	Dominican Republic	CS	Vicente Ruíz	Instituto Dermatológico y Cirugia de Piel (Institute of Dermatology and Skin Surgery)
18	Estonia	Gvt	Aljona Kurbatova	National Institute for Health Development, Ministry of Social Affairs
19	Georgia	Gvt	Irma Khonelidze	National Centre for Disease Control and Public Health
20	Georgia	CS	Lia Mamatsashvili	Centre for Information and Counseling on Reproductive Health TANADGOMA
21	Guyana	Gvt	Sonia Roberts	Ministry of Health
22	Guyana	CS	Simone Sills	National Coordinating Coalition Inc.
23	India	Gvt	Dr. Bhawani Singh Kushwaha	National AIDS Control Organisation, Ministry of Health & Family Welfare
24	India	CS	Rupika Dhillion	SPACE 'Society for People's Awareness, Care & Empowerment'
25	Indonesia	Gvt	Dr. Wiendra Waworuntu M.Kes	Ministry of Health
26	Indonesia	Gvt	Dr. Sri Pandam Pulungsih	Ministry of Health
27	Indonesia	CS	Meirinda Sebayang	Jaringan Indonesia Positif (JIP)

28	Jamaica	Gvt	Ms Rowena Palmer	Ministry of Health and Wellness
29	Jamaica	CS	Ms Mickel Jackson	Jamaica AIDS Support for Life
30	Kazakhstan	Gvt	Panagul Jazybekova	National Scientific Centre of Phtisiopulmonology
31	Kazakhstan	CS	Bakhyt Tumenova	"Aman-Saulyk"
32	Kyrgyzstan	CS	Aibar Sultangaziev	Partner Network Association
33	Kyrgyzstan	Gvt	Zamirbek Akaev	Republican AIDS Centre
34	Malaysia	Gvt	Dr. Anita Suleiman	HIV/STI/Hepatitis C Sector in Ministry of Health
35	Malaysia	CS	Yusral Hakim Yusoff	Malaysian AIDS Council (MAC)
36	Mexico	Gvt	Agustin Lopez Gonzalez	National HIV Programme (CENSIDA)
37	Mongolia	Gvt	Enkhjin Surenjav	Ministry of Health
38	Mongolia	CS	Dr. Naranbat Nyamdavaa	Mongolian Anti-Tuberculosis Association (MATA)
39	Morocco	Gvt	Dr. Mohamed Youbi	Ministry of Health
40	Morocco	SC	El Mostafa Lamqaddam	AMSED: association marocaine de solidarité et développement
41	Myanmar	Gvt	Dr Htun Nyunt Oo	Ministry of Health and Sports
42	Myanmar	Gvt	Pyae Soan	Ministry of Health and Sports
43	Namibia	Gvt	Petronella Masabane	Ministry of Health and Social Welfare
44	Namibia	CS	Sandi Tjaronda	NANASO
45	North Macedonia	CS	Andrej Senih	Stronger Together, Association for Support of People Living with HIV
46	Panama	Gvt	Dr. María Victoria de Crespo	Ministry of Health
47	Panama	CS	Juan Alonzo	New Horizons GLBTIO Association (Asociación Nuevos Horizontes GLBTIO)
48	Paraguay	Gvt	Dr. Tania Samudio	National Programme on HIV/AIDS and STI Prevention and Control
49	Paraguay	CS	Juan Domingo Centurión	CIES Ñepyru
50	Serbia	Gvt	Dr. Vladimir Cakarevic	Ministry of Health
51	Serbia	CS	Milos Peric	DUGA
	South Africa	CS	Dr. Linda Ncube-Nkomo	LoveLife
53	Suriname	Gvt	Dr. Georgian Singorawi	Ministry of Health
54	Suriname	CS	Tania Kambel - Codrington	Country Coordinating Mechanism Suriname
55	Thailand	Gvt	Dr. Rattaphon Triamwichanon	National Health Security Office, NHSO
56	Thailand	Gvt	Dr. Nareerut Pudpong	International Health Policy Program
57	Thailand	CS	Promboon Panitchpakdi	Raks Thai Foundation
58	Ukraine	CS	Sergii Dmytriiev	100% Life

59	Ukraine	CS	Maxim Demchenko	Budget Advocacy School, NGO Institute on Analysis and Advocacy
60	Vietnam	Gvt	Do Huu Thuy	Viet Nam Authority of HIV/AIDS Control (VAAC)
61	Vietnam	CS	Do Thi Bich Ngoc	Viet Nam Union of Science and Technology Associations
	ORGANIZERS, MULTILATERALS, OTHER PARTNERS			
62	Global Fund	partners	Carmen Gonzalez	Global Fund
63	Global Fund	partners	Matthew Macgregor	Global Fund
64	Global Fund	partners	Corina Maxim	Global Fund
65	Global Fund	partners	Benjamin Loevinsohn	Global Fund
66	Regional network	partners	Fatou Ndow	ENDA Sante
67	Regional network	partners	Karen Esquivel	HIVOS
68	UNAIDS	partners	Nertila Tavanxhi	UNAIDS
69	UNAIDS	partners	Dr. Kamal Alami	UNAIDS
70	UNAIDS	partners	Stuart Watson	UNAIDS
71	UNDP	partners	Boyan Konstantinov	UNDP
72	UNDP	partners	Mark DiBiase	UNDP
73	UNDP	partners	Dr. Rosemary Kumwenda	UNDP
74	UNDP	partners	John Macauley	UNDP
75	USAID	partners	Deborah Cook Kaliel	Office of HIV/AIDS, USAID
76	USAID	partners	Nicole Ross Judice	Health Policy Plus Project Palladium
77	USAID	partners	Stephen Mills	LINKAGES Thailand and Laos - Linkages Across the Continuum of HIV services for Key Populations
78	World Bank	partners	Dr. Sutayut Osornprasop	World Bank
79	Facilitator	partners	Raminta Stuikyte	UNDP