



Expanding Community-Based HIV & TB Services for Key Populations through Social Contracting in Panama

CASE STUDY



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I. Introduction

Panama's National Health Policy 2016-2025 envisions a health system that

guarantees the rights of all people to receive quality care for optimal health throughout the life cycle. In the context of the national HIV and tuberculosis (TB) responses, achieving health for all people calls for **robust multi-stakeholder partnerships to tackle the interconnected social and economic determinants that drive the epidemics**. The effects of inequity can be seen in the concentrated nature of HIV in the country: while the prevalence is 0.9% in the general population from 15-49 years old, it stands at 9.3% among men who have sex with men, 29.5% among transgender people, and 1.4% among female sex workers.¹

The Government of Panama has recognized the **vital role that civil society organizations (CSOs) play in reaching key population groups most vulnerable to HIV and TB** by connecting them to prevention, treatment and care services, advocating for their rights, and addressing barriers associated with stigma and discrimination. Since 2003, Panama has received three grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to expand its national HIV and TB responses and reach those left furthest behind. One of the key contributions of these programmes has been to improve the involvement of civil society and key population-led groups in developing and implementing HIV and TB strategies, including through a community-based service delivery model.

In anticipation of the final Global Fund allocation for HIV/TB (2019-2021 grant), national stakeholders have worked with the Global Fund, UNDP, and other partners over the last few years to pave the way for a sustainable transition to domestically-financed programmes. This has included, in particular, identifying strategies to ensure the continuity and increased coverage of essential services for key and marginalized populations. To achieve this aim, the MoH, with the support of UNDP and the Global Fund, **established a mechanism to strengthen public financing of CSOs – also known as "social contracting"** – initially for the provision of HIV and TB services. In 2020, as a formal recognition of the need for this link with communities, the government launched the “National Strategy for the Extension of Health Services for Key Populations through Community Organizations.”

While a first step in a longer journey, the introduction of this strategy for social contracting marks an important milestone for Panama in its efforts to eliminate HIV and TB and further institutionalize an integrated community-based model of care in its public health response more broadly. **This case study describes the process, lessons learned, challenges, and outcomes thus far in the multi-stakeholder effort to develop and successfully launch a social contracting mechanism in Panama.**

¹ UNAIDS 2018; and Estimation of the size of the population of men who have sex with men, Trans women and sex workers aged 18 and over, characterization of this population, use of health services, condom use, discrimination and violence in the Republic of Panama for the year 2018

What is social contracting?

While there is no universally adopted definition, social contracting is broadly understood as non-governmental entities or civil society organizations, which include and serve key populations, receiving domestic funding to deliver social services. The mechanism typically involves a legally binding contract, based on a set of agreed deliverables. As a model applied in numerous countries, social contracting has 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.

II. Developing the strategy

Development of the social contracting strategy took place between 2018 and 2019 through a series of mapping activities and consultative processes. Multi-stakeholder discussions and analysis that laid the groundwork for the approach, however, started as early as 2016. The community systems strengthening component of the 2016-2018 Global Fund HIV/TB grant included an objective to strengthen public financing of CSOs to provide HIV and TB prevention and diagnosis services. As such, the Global Fund Country Coordinating Mechanism (CCM) created a commission to facilitate consultations on the topic starting in 2018. Building on these earlier discussions, an in-depth, participatory process was initiated in 2018 to design a strategy with a view to ensure its feasibility, acceptability and sustainability. **This section describes the key elements of this process, up to the launch of the strategy in 2020, including activities for evidence generation, advocacy, consensus building, and challenge mitigation.**



i. Understanding the landscape

An assessment of Panama's Global Fund grant transition preparedness in 2017 underlined the need for a scaled-up system of public financing of CSOs to ensure the continuity of critical services to key populations following the end of Global Fund funding. Building on the recommendations of this assessment, the Global Fund **contracted a third-party consultancy team in early 2018 to support Panama to define the framework.** The role of the advisory team was to assess the options for, and work with, government and civil society to jointly build the institutional and regulatory framework for public financing of CSOs for HIV and TB prevention, care and support activities for key populations, as well as to support the pilot phase of its implementation. The process unfolded over the course of a year, given the extensive stakeholder engagement, decision-making and capacity building efforts entailed. This timeframe was a critical element of the process that allowed for sustained engagement rather than one-off or minimal interactions.

In order to define the bounds of the strategy, the assessment looked at the structure of the country's legal system, existing policies and financing mechanisms of non-state actors, financing options, the scope of services to be contracted, and mechanisms for monitoring and evaluation, among other aspects. **Most critical to this process was the fact that it was highly participatory.** It particularly leveraged the participation of civil society organizations, representatives of key population communities, different departments within the Ministry of Health (MoH), including the National STD/HIV/AIDS Programme, National Programme for Tuberculosis Control, the Directorate of Health Services Provision, the Directorate-General for Health, and the Administrative and Financial Health Management Unit among others, the Directorate of Finance, and other key ministries including the Ministry of Social Development, the Ministry of Economy and Finance, and the Technical Secretariat of the Social Cabinet.



ii. Building consensus

Beyond articulating the legal and financial landscape to inform decision-making, a key outcome of the consultancy was to **generate buy-in from the stakeholders critical to the strategy's implementation**. In particular, valuable dimensions of the process included:

A coordinating body to facilitate access to all key stakeholders

The consultant team **relied heavily on the networks and dialogue channels already in place through the CCM**. This included a commission, comprised of the heads of different government units and representatives of CSOs and communities, with support from UNDP and other partners, that provided a mechanism for consultation at all stages of the assessment and strategy development process. Moreover, the longstanding presence of the CCM in Panama meant that it had a broad mapping of and established relationships with a range of stakeholders and organizations engaged in the HIV and TB response, beyond those implementing the Global Fund grant.

Use of external consultants to promote neutrality

The engagement of a **neutral third-party consultancy helped to generate trust** in the results of the assessment and process for defining the framework itself. The consultancy team represented expertise from across the region, including in finance and legal issues, as well as extensive experience in Panama itself. In this, the team was effective at obtaining inputs from all relevant players and presenting a collective proposal and solid set of evidence to high-level authorities for feedback. Stakeholders noted that it was valuable to have the analysis coordinated and presented by an external player, as it meant that the strategy was not biased by a single viewpoint or agenda.

Persistent follow-up and multiple communication channels

A defining feature of the process, from the consultancy in 2018-19 through the initiation of the strategy and contracting of the first CSOs in 2020, was **dedicated mechanisms for follow up on commitments, bottlenecks, and issues requiring consensus**. Overall, this meant a wide range of issue-based meetings, workshops, and ad hoc meetings convened through the CCM and the MoH. Many aspects of the strategy required significant back and forth between government authorities and civil society, with the technical assistance of neutral partners like UNDP and UNAIDS, to facilitate decisions on matters such as the budget and scope of services. While time intensive, these deliberations were necessary to reach agreements on priorities and feasibility amidst constraints. The CCM also helped to play an intermediary role, supporting CSOs to liaise with relevant government authorities, present written communications for follow-up and solicit letters of signed agreement.



Making the case

Achieving necessary commitments from various departments and levels of government was a multi-faceted process. While the assessment helped to build the evidence base for social contracting, **strong negotiation skills and a range of targeted approaches were necessary to galvanize the political will, resources, and support required from all parts of the house.** Some approaches that helped to make the case among diverse stakeholders included:

Demonstrating the unique capacities and experiences of CSOs to reach where the health system cannot : The most important arguments that influenced investment in the strategy was showcasing the unique role played by civil society and other community-based organizations in reaching key populations with essential prevention and care services. As groups comprised of key populations themselves, many have an intimate understanding of the forces of exclusion that impede access to services. They are likewise uniquely positioned to reach those pushed to the margins. Having built long-term relationships within communities, they are able to conduct outreach by going directly to the target populations, beyond the formal operating hours of the health system.

“The advantage of CSOs is that these are peer organizations for key populations. This makes it easier to overcome discrimination-based barriers and create greater openings for key populations to access health care services.” – *Dr. Jairo Osorio, Medical Technician, Monitoring & Evaluation Department of the Directorate of Health Services Provision, MoH*

Reinforcing the value of government-civil society partnerships : An important framing for uptake of the social contracting model was to emphasize both the complementarities and limitations of each stakeholder in the fight against HIV and TB. While the MoH instituted "Friendly Clinics" in 2016 as a means to care for the populations at highest risk of HIV and STIs, it recognized that it still required the support of community organizations to connect the populations to the clinics. A CSO could reach sex workers directly where they congregated, for instance, and help them navigate the health services available to them. This recognition that neither government nor civil society alone could serve these populations helped to reinforce the necessity of a mechanism like social contracting to institutionalize the joint approach.

Conveying the sense of not starting from scratch : The assessment of the legal and policy environment in Panama revealed that relevant experiences could be leveraged from within and outside the country. While a new legal structure and provisions would need to be developed, they could build on the experiences and address the identified limitations of pre-existing mechanisms used in different sectors to finance community organizations. Likewise, the lessons from effective social contracting structures in other countries in the region revealed viable entry points for Panama.

“One thing that got our attention was that we already had established mechanisms do it.”
– *Dr. Lissette Chang, Coordinator, National STD/HIV/AIDS Programme, MoH*

Drawing on the momentum of the Global Fund grant transition : While discussions on social contracting had been ongoing for years, the anticipated Global Fund grant closures in 2021 incentivized stakeholders to accelerate efforts. Given the grants' strong focus on key populations and the reliance by many community organizations on Global Fund funding to serve these populations, the need to institutionalize mechanisms to secure the continuation of such services and survival of the organizations that provide them assumed newfound urgency.

Appealing to existing commitments : Amidst limited public resources and competing priorities, it was critical to ground the rationale for the social contracting strategy in existing national commitments and policy priorities. In particular, a core argument was to reiterate the country's commitment to the HIV and TB response, invoke relevant existing strategies, and articulate the gaps in prevention efforts, with attention to the specific needs of key populations. The establishment of the social contracting mechanism was likewise an opportunity for the government to optimize the use of existing funds, given the cost-effectiveness of the approach.

Galvanizing momentum from cross-country exchange : Representatives from the MoH and civil society had the opportunity to participate in two global workshops on social contracting: one in 2017 organized by UNDP, the Open Society Foundation and the Global Fund, and another in 2019 convened by UNDP, the Global Fund and UNAIDS that brought together delegates from 34 countries. Beyond offering practical insights based on other countries' experiences implementing social contracting for HIV, TB and malaria, the meetings helped to increase the sense of national ownership of the process. They also underlined the opportunity for Panama to generate learning from its own model to eventually support other countries in the region.

"The global social contracting workshop held in 2019 was of great importance as it allowed me to learn about the various experiences that the countries of the world carry out with key populations. Once back in Panama, I was better able to establish strategies to advance social contracting."
– Dr. Maria Victoria Crespo, Director of Health Services, MoH



iii. Overcoming hurdles to secure commitments

The work of generating consensus and translating political will into budgetary commitments was far from linear. Adaptability and persistence were crucial to overcome both inevitable and unanticipated hurdles to move from evidence generation and strategy development to the successful implementation of the social contracting strategy. This included overcoming the inherent **resistance that comes with the introduction of something new**. For the MoH, the strategy meant embracing a different funding structure and level of responsibility in its engagement with CSOs. For CSOs, it meant adapting to new timelines and bureaucratic processes to comply with government requirements to receive public funding.

While a plethora of evidence was available to make the case for social contracting, it was sometimes difficult to translate the importance of the work to stakeholders not directly working on health-related issues, such as the Ministry of Economy and Finance. Additionally, without ensuring the integration of social contracting within the annual budget lines of a ministry, **funding commitments remained subject to fluctuations**. One of the major hurdles affecting the sustainability of initial commitments was a **change in government** that occurred in the midst of the consensus-building process. This turnover of key government personnel that had been sensitized on social contracting in 2019 stalled the process by several months. As a result, an adjusted approach was required to identify and sensitize new champions across the relevant government departments and adapt the proposal to the priorities set by the new authorities. The **COVID-19 pandemic** in 2020 further derailed the trajectory of efforts, as government funding had to be redirected towards the pandemic response. While the government initially committed to US\$600,000 for the strategy in Panama based on the identified needs, these resources subsequently became unavailable.

CSOs carried out advocacy in response, to ensure the government kept its commitment to key populations. Ultimately, the amount was reduced to US\$100,000, to cover the first 6 months of implementation. This meant that the initial plans had to be reprioritized through additional rounds of meetings between civil society and health authorities. The MoH additionally had to identify alternative funding sources in the interim to ensure the availability of this funding for a timely start to implementation. As the MoH Directorate of Health Services

Provision already had a relevant budget line in place to serve hard-to-reach populations, it was able to borrow existing funding from the Inter-American Development Bank to facilitate the first phase of the social contracting mechanism. Over the next several months, and in order to achieve greater coverage in reducing new cases of HIV, the MoH will work in coordination with the HIV Care and Treatment Project, executed with the Emergency Funds of the President's Emergency Plan for AIDS Relief (PEPFAR).

Key lessons from these experiences include the importance of:

- Communicating that social contracting and the provision of services for key populations is the **responsibility of the country**, rather than a commitment of a sitting government.
- Grounding political will in the **commitments of government institutions, not individuals**: While helpful to leverage champions within government, it is equally critical to institutionalize commitments in a way that can survive staff turnover, such as in budget lines and longer-term strategies. This is also key to mitigate against potential biases and complex social dynamics that influence the support from individuals.
- Support from neutral partners such as UNDP, UNAIDS, external consultants and the CCM to facilitate **persistent, targeted advocacy at the highest levels of government** as well as among the public, to ensure that the issues stay on the radar of key decision-makers and budget holders.



III. Implementing the strategy

The social contracting strategy was officially launched in November 2020 and resulted in three organizations receiving funding in the first half of 2021 to carry out the first round of HIV and TB service delivery. This section describes the core elements entailed in **laying the groundwork and kicking off the initial phase of the strategy's implementation**, from contracting the first CSOs to sensitizing key players and building implementation capacities.



Contracting the CSOs

While a competitive bidding process was deemed a priority for the sustainability and effectiveness of the social contracting strategy in the long-term, the delays and constraints created by the change of government and COVID-19 pandemic called for an alternative approach in the short-term. In order to avoid interruptions in essential services for key populations through a timely start to implementation, the MoH determined to reward contracts for the first round of funding to the three CSOs already implementing these

activities in their role as Sub-recipients (SRs) of the Global Fund HIV/TB grant: *Asociación Panamena de Personas Trans (APPT)*, *Asociación Viviendo Positivamente (AVP)* and *Asociación de Hombres y Mujeres Nuevos de Panamá (AHMNP)*. Given that these CSOs had already been working over the last several years, with the support of UNDP and the Global Fund, to achieve legal status and sufficient formalization to receive government funds, they were best positioned to be the pioneers for the first phase of the strategy. Likewise, each had longstanding experience serving the priority communities, along with existing relationships with relevant government counterparts.

In the longer-term, the MoH will develop a selection process for CSOs that is 1) competitive and 2) designed in a way to promote inclusivity among a variety of applicants. As the MoH is most accustomed to contractors with specialized experience applying to bids for state funding, it will work in consultation with CSOs to strike the right balance between accessibility for those unfamiliar with such bidding processes, while not compromising on standard operating procedures and state requirements. In addition, given the distinct purpose of the social contracting strategy, a priority is to ensure the process does not simply favor those organizations with the greatest legal expertise or formalization, but rather, identifies those with strong track records working with marginalized communities and demonstrating clear commitments to the populations they serve.



Prioritizing the scope of services

With the reduced budget from US\$600,000 to US\$100,000, the strategic prioritization of interventions became all the more vital to balance immediate needs and resource availability with long-term goals. The MoH and partners ultimately decided on a **multi-phased approach**, with a focus in the first phase on continuing a significant part of the CSO-led services funded at the time by the Global Fund to address the social and systemic barriers affecting key populations' access to HIV and TB prevention and care. The first call for proposals accordingly covered interventions to 1) contact and identify people belonging to key populations; 2) deliver information and implement behavior change strategies that help prevent and control diseases; 3) refer people from key populations to the relevant health services for diagnosis and, where appropriate, treatment; and 4) encourage the search for new positive cases for the health system.

The strategy additionally prioritized the scope geographically, focusing on 6 of the 16 health regions in the country for the first two years of implementation. **Subsequent phases will expand the reach and integrate additional services** deemed important for the fulfilment of national HIV, TB, and broader health goals. Even within the initial focus on disease-specific activities, the support offered by the CSOs is intended to provide holistic care to key populations, such as by connecting them to mental health and other essential services beyond those for HIV or TB alone.



Sensitizing partners

Among the most vital elements to prepare the way for the success of the social contracting strategy was **sensitization at the sub-national level**. In particular, the MoH central office, with support from the CCM, carried out site visits in all regions where the strategy would be first implemented, as the regional personnel would ultimately be responsible for monitoring activities, resolving issues, and ensuring that services were made available to key populations referred through CSOs. Given the importance of an integrated response that addresses the interconnected health needs of key populations, the MoH did not only consult those in the HIV and TB programmes. It also spoke to regional personnel providing services in areas like mental health and gender-based violence, for instance, to facilitate synergies with the HIV and TB response and ensure key populations receive access to holistic care.

The sensitization process was also unique in that it **put the MoH regional departments in the driver's seat**. It was important for the strategy to not be viewed as one owned and overseen by the MoH centrally, as was often the case for donor-funded initiatives, but for the regional actors to see the value of the strategy to their existing efforts and thereby feel invested in the success of its implementation. Consultations were also held with donors and other organizations supporting key populations in these regions to ensure coordination and align strategies for service delivery. In addition, UNDP reallocated grant funds to hire a consultant to continue this work at the sub-national level.



Capacity development

While the value of social contracting lies in the existing capacities of CSOs to reach key populations with HIV-related services, there is often a need to build the capacity of organizations to meet the eligibility requirements to receive government funding. Beyond the initial requirements, additional capacities may be needed to comply with the procedures entailed in implementing the strategy, such as having the necessary human resources to perform ongoing project coordination, monitoring and financial management functions, and knowing the administrative processes of the MoH, among others. At the same time, the transition to working with CSOs through social contracting, as a mechanism distinct from other funding streams for non-government organizations, can require additional capacities within the MoH at both the national and sub-national levels to effectively work with, oversee, and support the contracted CSOs. **Capacity development is therefore an ongoing and multi-directional process central to the implementation of the strategy in Panama.**

Some of the channels for capacity development thus far have included:



The application process

While participation in the call for proposals proved tedious for organizations unaccustomed to the new procedures, it also served as a learning experience and capacity development process in and of itself. As Dayra Garcia, Executive Director of AVP, notes, **“This process is something that strengthens organizations. A lot is required to have a contract with a government entity.”** In the case of the three CSOs contracted for the initial call, the capacity development process had in fact begun years ago, as part of their role as SRs under the Global Fund programme, to acquire the necessary institutional, administrative, and legal capacities for recognition as formalized entities.



Monitoring and evaluation (M&E)

Among the gaps identified through the initial assessment of pre-existing mechanisms for government funding of CSOs was the issue of weak provisions for monitoring. Accordingly, one of the important features for the new mechanism was to ensure a systematic process for the

MoH to monitor the implementation of the funded CSO interventions, as a means to facilitate additional support and mitigate challenges where needed. As part of the social contracting strategy, the MoH Directorate of Health Services Provision leads the M&E of CSO annual monitoring plans, in coordination with regional health authorities and a multisectoral body for additional technical support. Additionally, the strategy brought a shift in focus for the measurement itself, bringing increased attention to the number of people who know their HIV status as a way to reinforce goals linked to prevention.



Technical support from multilateral partners

A primary role for partners like UNDP and the Global Fund has been to offer technical assistance where needed, building on existing relationships with different programmes and CSOs. This has included, for example, offering trainings, inviting focal points to regional exchange opportunities, and sharing resources and examples of social contracting from other country contexts. For example, the consultancy for technical assistance to support the design and implementation of the social contracting mechanism in Panama resulted in the development of a [Resource Guide](#) of key documents, tools and examples to facilitate improvements in some of the core competencies needed for a government to effectively implement social contracting. Additionally, UNDP and the Global Fund have worked with the MoH and other partners to identify additional sources of funding and in some cases provide physical (e.g. computers to regional health authorities) and human (e.g. M&E personnel inside the ministry) resources.



Capacity building through local networks

The MoH Directorate of Health Services Provision reached out to a range of actors, tapping into an existing multi-stakeholder network of institutions working on HIV, to promote sustainable avenues for continuous capacity building. It connected with other donors and implementors, other MoH departments and national programmes, and private sector players, for instance, to identify opportunities for the CSOs to benefit from the expertise, guidance, and resources of those already mandated to support capacity development in the HIV and health response. Beyond direct HIV-related support, it also sought out expertise from institutions skilled in communications or business development, or those who could provide guidance tied to integrating mental health into HIV services. It likewise encouraged the CSOs to leverage and build their own networks of partners to address capacity needs.



IV. Early outcomes & lessons

While the social contracting strategy is still in the early phases, the strategy development and initial implementation process has already yielded a number of positive outcomes. These have included:

Ensuring that essential services continue to reach key populations affected by HIV

"It has been proven globally that no state or government can accomplish health objectives on its own, and that the engagement of communities is required to improve the health situation for the population. We did not have [a mechanism like this] before and it has reinforced the engagement of CSOs to address health issues at the community level." – Dr. Jairo Osorio, Medical Technician, Directorate of Health Services Provision, MoH



Mutual trust for effective collaboration

Numerous stakeholders have noted how the participatory processes and collaboration required to develop the social contracting mechanism has positively influenced the working relationship between CSOs and government.

"At the beginning, there was a lack of trust and confusion in how to best work with civil society, but now with the practice we have, the state is seeing that civil society is their ally."
– Diego Postigo, UNDP Consultant.

For those in CSOs, the opening of more consistent lines of communication with government counterparts has likewise been important for establishing trust in the process and having their voices heard, as crucial for sustainability.

Breaking down silos in the national health response

The collaboration required between the MoH and other ministries at the national and sub-national levels to set the stage for the social contracting strategy helped to create new patterns of engagement across government. While these new ways of working were likewise propelled by the change in administration during this period, the social contracting strategy helped to reinforce the importance of working with all parts of the house – beyond departments directly implicated in HIV and TB – to have a sustainable mechanism that supports the multi-faceted needs of key populations and the CSOs that serve them.

"I have never seen us working with so many people before. Now every time I [need to move a decision forward], I talk to the different departments to make sure everyone is on board."
– Dr. Lissette Chang, Coordinator, National STD/HIV/AIDS Programme, MoH



Enhanced capacity of CSOs to receive government funding

"There is great opportunity for CSOs to be enriched by engaging in these processes. From the moment there is a call to participate in a programme [for social contracting], that in itself helps them to build capacity."
– Javier Arellano, Youth Officer, UNAIDS



Formation of new alliances

"Something positive has been identifying our allies within the health system through the social contracting process," notes Dayra Garcia, ED, AVP, explaining how the work has led to the identification of strategic partners across the MoH as well as in the departments for social welfare, economy and finance, and others. It has likewise increased awareness of the role of HIV/TB prevention and treatment for key populations within broader national development goals. "Now that we are involved with [these allies], they better understand the work done by civil society and the role they have that goes above and beyond the health system."

Establishing a social contracting mechanism: Lessons learned

While more work and investments are required to achieve the long-term goals of the social contracting strategy, the work to date to develop and launch the mechanism has established a strong foundation from which to build on. Key lessons raised through the process thus far include :

Ground commitments in institutions, not individuals

Long-term, formalized commitments to the mechanism must be established in ways that can withstand changes in government. "It is important to really understand the dynamics of the country and who you need on your side. If it is possible, some agreements should be established between the ministries or other stakeholders that need to be involved so that when those in charge change, the commitment is with the ministry and not the person." – Dr. Lissette Chang, MoH

Find the right allies

Responsibility for showcasing the importance of the social contracting strategy and bringing key players on board was a collaborative effort among the MoH and CSOs, through the support of the CCM. The process revealed the importance of finding the right allies who could carry the messages forward in smaller spaces and reach those responsible for decision-taking, working with organizations and people with influential voices on the issues. This includes having a strategic understanding of the places where support could be counted on in the future, and places where further awareness raising might be needed.

Establish strong coordination mechanisms

For social contracting to work in practice, a broad network of actors must be aligned in their understanding of the goals and sensitized in their individual roles to contribute to its success. In Panama, this particularly called for strong coordination across MoH departments at the regional level, and between the central and regional offices. It likewise required extensive outreach to donors and partners in the regions to avoid duplication of activities to target populations. One good practice for coordination, starting from the development of the strategy itself, was in setting up small working groups comprised of representatives from different sectors and organizations to facilitate follow-up on issues and ensure communication with the right people, including high-level decision-makers in government.

Foster an equal partnership between CSOs and government

"It is very important to have a strong bond with the CSOs and to work hand in hand with them in order to benefit key populations. These are populations that for a long time have felt discriminated, isolated and stigmatized. With this strategy, we are closing gaps so they can have the same rights as the rest of the population." – Dr. Jairo Osorio, MoH. To ensure full representation of civil society voices, it is likewise important to strengthen coalitions among those who represent different key population groups and interconnected issues. As the first legally recognized LGBTI organization in Panama, AHMNP has fought to protect the human rights of men who have sex with men, sex workers, transgender populations, and other groups facing social and structural barriers to accessing HIV services. As its president Ricardo Beteta, notes, "It is not easy for one or two organizations to be a spokesperson on these issues. We need to come together as one voice."



V. Looking ahead

Risks and priorities for sustainability

With 2021 being the first year of implementation, the MoH and partners will continue to build on the evidence and experiences from the current round of service provision by the three contracted CSOs to further refine the social contracting mechanism and garner the necessary support for subsequent years. Against the ambitions to **expand the strategy** to gradually encompass all regions of the country and ensure an integrated approach to ensuring access to health for marginalized groups, mobilizing additional resources is among the most pressing needs for the sustainability of the mechanism. The effects of the COVID-19 pandemic on the economy and increased **challenge to secure consistent and predictable budget** availability poses one of the biggest risks to the process. Likewise, it has been a long-term process for CSOs to enable the populations they serve to trust the health system and access friendly health care. Gaps in funding and the potential disruptions in services could reverse some of this important progress made to date.

The MoH, in collaboration with the CSOs and CCM, continues to advocate for HIV, particularly prevention activities for key populations, to be prioritized within the national response such that funding for social contracting is increased and reflected in regular budget lines of relevant government agencies. There should likewise be a budget line within the MoH for work to strengthen civil society capacities, given the long-term investments needed. **Areas requiring further capacity development**, for instance, include raising awareness among CSOs on the process and eligibility requirements to be able to receive government resources; providing institutional, administrative, and legal support to assist more organizations to become formalized; and reinforcing advocacy activities to ensure that organizations can generate evidence and communicate the unique value of their work under the social contracting strategy.

Investments in **capacity building for community-based organizations beyond those currently receiving government funding** is also important to ensure that future funding rounds are characterized by an equitable competitive process among a range of eligible organizations. At the same time, the MoH has recognized the importance of working with CSOs to ensure their access to a diversity of funding sources, such that they are not fully dependent on government funding to sustain their activities, leaving them susceptible to budget fluctuations in the case of a crisis for example. Given that social contracting is a competitive process, there is likewise no guarantee that an organization would consistently receive resources from it. Accordingly, an important area for continued capacity development is strengthening CSOs' business models, including strategies to secure grants through private sector donors.

Another risk lies in the **insecurity of the existing coordinating mechanism** for the social contracting strategy. The CCM has played a central role as a network for consistent and robust communication channels between community organizations, public institutions and other stakeholders throughout the process. As funding for the CCM ends with closure of the Global Fund grant in Panama, alternative options are being explored for the continuation of a coordination mechanism to ensure sustained engagement between civil society actors and national authorities as well as participatory oversight and monitoring of the strategy. Multilateral partners like UNDP, UNAIDS and the Global Fund will continue to have an important role as well to support coordination efforts, advocacy, and capacity development, including via regional learning platforms.

Finally, **regular monitoring and evaluation** of the social contracting mechanism is essential to allow for stock taking of results achieved, the bottlenecks and necessary areas of improvement. A multi-stakeholder approach should be employed to allow for maximum, sustained engagement as this process evolves and grows over time.

While work lies ahead to ensure the sustainability of social contracting, the work thus far underlines the immense potential of the investment.



"This will really help our country. There are so many limitations to what a government can provide [for key populations]. If you empower the community, they can support the people who otherwise don't have access – who have lost hope. I truly believe in social contracting as a tool to reach the people who cannot reach the system."
– Dr. Amador Goodridge, President, CCM

This case study was prepared by the UNDP HIV, Health and Development Group, Bureau for Policy and Programme Support. It is based on interviews with stakeholders from UNDP Panama, the Ministry of Health of Panama, AHMP, AVP, UNAIDS, the Global Fund and Panama Country Coordinating Mechanism and a desk review conducted in March 2021.
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