Policy brief

Implementing social contracting for HIV prevention

HIV Leadership Forum

Background

39M

People living with HIV globally

30M

People on anti-retroviral treatment (ARV)

77% of those living with HIV

70%

Living in Low-Income and Lower-Middle-Income Countries

Focus: Sub-Saharan Africa

1.3M

New HIV infections in 2023 - three times more than the target

2025 target

<370K

new infections per year

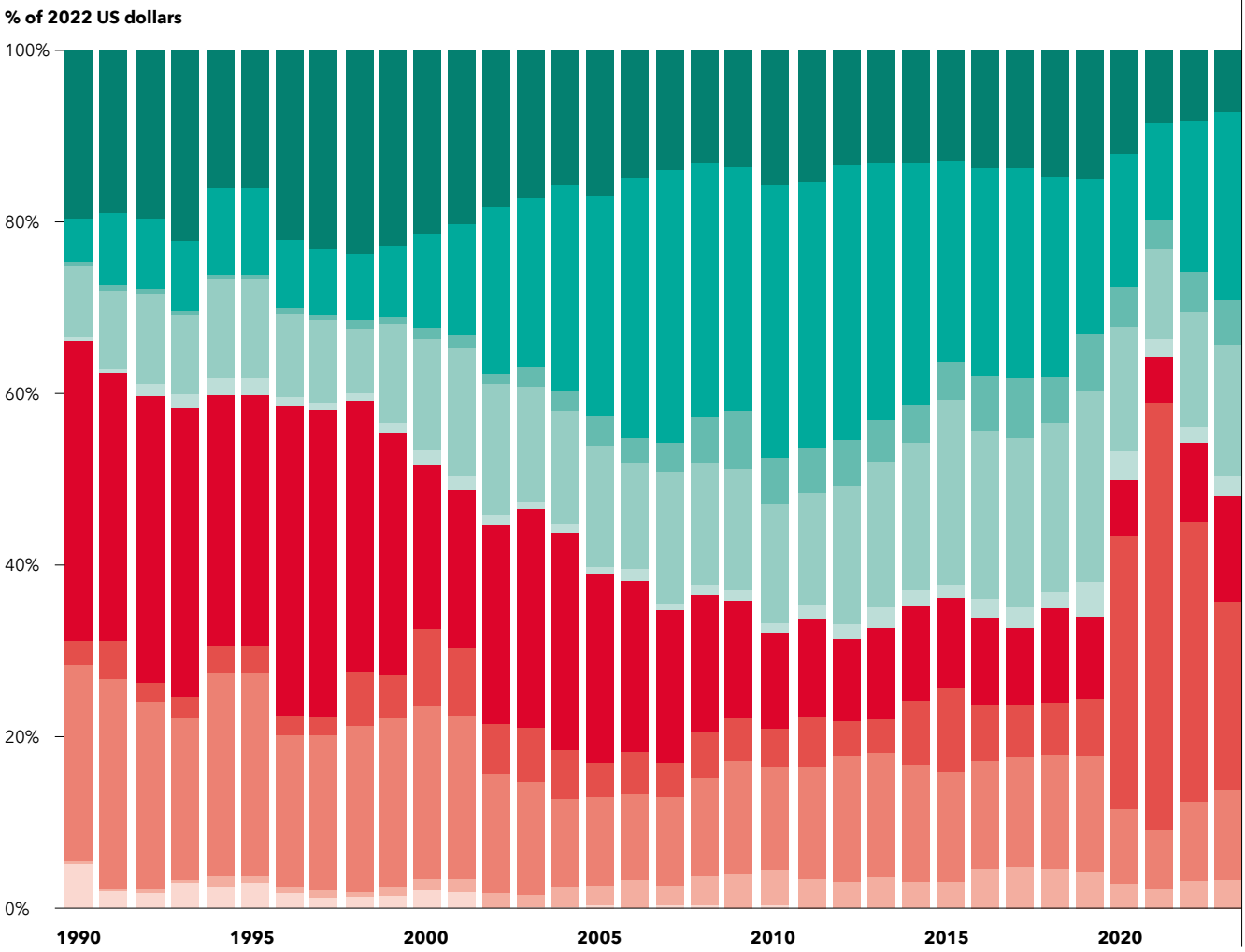
Globally, there were an estimated 39 million people living with HIV in 2023 of whom approximately 30 million were on antiretroviral treatment. Almost 70% live in low income countries (LICs) and lower middle income countries (LMICs), especially in sub-Saharan Africa. In the same year, there were 1.3 million new HIV infections, thus increasing these annual recurrent costs of ARV of medication and programmes *(1)*. The global community remains off track towards reaching less than 370 000 annual new infections globally by 2025. This necessitates accelerated implementation of the Global HIV Prevention Roadmap 2025 at the national and community levels to reach targets. Step 5 of the roadmap actions focuses on strengthening and expanding community-led HIV prevention services as well as setting up social contracting mechanisms.

The *Let Communities Lead 2023* report *(2)* highlighted the critical role of communities and community-based organizations in the HIV response; uptake and adherence to HIV treatment for people living with HIV; improving their quality of life; and reducing viral load, which are key in preventing HIV transmission. Communities are at the centre of advocacy on stigma and discrimination as well as promoting uptake of HIV prevention methods. They have led in innovating and implementing strategies tailored to specific contexts and populations, often serving those who are most marginalized and with limited access to formal and government health, social and economic services. Access to care and policy changes all have strengthened the HIV response.

Funding for communities in the HIV response has been predominantly external through bilateral agreements and social contracting of global North governments with large international nongovernmental organizations (NGOs). These resources are declining. The 2023 report of the Organisation for Economic Co-operation and Development on global official development assistance highlighted a shift in donor priorities, with a notable decrease in allocations for HIV/AIDS (Figure 1). *(3)*

To safeguard community responses, the notion of social contracting between government and communities in LICs and LMICs has been proposed: community-based organizations and non-government organizations. However, implementation remains challenged by insufficient resources.

Figure 1: Shows the Heath focus areas of development assistance for Heath



The imperative for social contracting between governments and communities for HIV prevention

This policy brief makes a case for social contracting. Continued investment in communities for HIV prevention services is critical to enhance uptake of prevention methods. While the incidence is declining due to prevention and treatment programmes, gaps still exist in the identification of new infections, reaching men for antiretroviral uptake and low risk perception among high-risk young people and key populations that could stagnate progress.

This brief recognizes that social contracting is the exercise of availing taxpayer (i.e. public) funds to the private non-profit sector for delivery of public goods and services. It underscores the value that communities contribute through their reach and services, while recognizing some inherent complexities of social contracting.

For instance, there can be tensions between government and NGOs, particularly regarding politically sensitive issues, questions about allocation of government funds for NGO salaries over health-care workers' compensation, especially for high overhead budget organizations, or difficulties in measuring value for money from services delivered. It posits that challenges can be addressed through thoughtful social contracting scheme designs that maximize benefits for countries with limited budgets while minimizing potential conflicts and inefficiencies.

Globally, the application of public funds is governed by public finance management regulations. Therefore, successful social contracting must be premised on national financing systems. A designated Ministry or Development Agency (MDA) of Government that is accountable for these funds is required and the principle of equitable access is prioritized, usually through bidding processes. It is proposed to adopt the private public partnership (PPP) approach to design social contracting for HIV prevention.

This policy brief is developed by the HIV Leadership Forum (a community of practice of Director Generals of National AIDS Coordinating Authorities of the Global HIV Prevention Coalition countries), and benefits from an in-depth understanding of government operations and thus, offers a viable pathway for social contracting to countries with limited resources. It is intended for government policy-makers, civil society and other health stakeholders. Its utility is in its actionable insights on navigating complexities of advocating and implementing social contracting, as well as offering the National AIDS Coordinating Authorities (NACAs) as an opportunity for stewardship and a platform to leverage in implementing social contracting for HIV services.

The value of PPPs for health care delivery

In LMICs, PPPs have evolved from simple outsourcing models to more sophisticated, collaborative arrangements between governments and private entities.

They initially focused on infrastructure development, and with time expanded their scope to management, service delivery, capacity building and technical assistance in health. They are intended to address challenges of limited resources and system overhead costs. Through PPPs, the government can leverage the private sector's expertise, innovation and agility, leading to more efficient and effective. For health care, the risk-sharing between public and private entities can result in more consistent and reliable health services. For ministries of finance, it means a more predictable and manageable fiscal commitment to drive long-term service delivery.

Why adopt social contracting as a PPP model for HIV prevention services delivery

In the context of reduced health and HIV funding, HIV prevention, which already suffers resource limitations, faces the highest funding cutbacks, potentially slowing down declines in incidence. This is not an affordable option as it leads to increased lifetime antiretroviral therapy costs into the future for countries with the least ability to pay.

The benefits of adopting a PPP approach, in which national governments contract civil society organizations to fast -track HIV prevention interventions include:

- *Savings in national budgets.* Costs saved from avoiding new HIV infections significantly outweigh the initial investment in prevention. Returns in LMICs are potentially up to nine times their investment in economic and social benefits by 2035 *(4)*.
- *Value for money.* Leveraging the agility, innovation, adaptability and reach of national civil society organizations will allow government to optimize and focus on areas of public sector competence and comparative advantage, thus leading to overall budget efficiency and cost savings for HIV and health care.
- *Reduce current overhead costs of HIV prevention services.* These usually include administrative and transaction costs of international NGOs. Reducing these costs will strengthen national capacity for locally designed programmes in the long-term.
- *Provide alternative pathways.* These facilitate the delivery of prevention products and commodities, including those for which there is population willingness to pay, such as condoms. The ripple effects would be reduced incidence of syphilis and hepatitis B and C.

Social contracting in LMICs is not new and has been used to make significant progress in different areas of development (5, 6) and in the HIV response. Countries adopt different social contracting models suitable to their local context.

The case of India

Social contracting for basic education services. Pratham, an NGO, partnered with the government to improve primary education. Initially, Pratham started by holding pre-education classes ('balwadis') for children in Mumbai's slums. The organization's mission is to improve literacy levels among India's poor, and its Read India programme, launched in 2007, has reached approximately 34 million children, leading to significant improvements in literacy across several Indian States. *(5,6)*

Social contracting for HIV services. India's social contracting model for HIV services involves government through the National AIDS Control Organization (NACO) funding civil society to provide targeted intervention programmes of behaviour change, communication, outreach, service delivery, counselling and testing, and ensuring linkages to HIV care. Between 2012 and 2017, INR 143 million (approximately US$ 1.9 billion) was allocated. It involves joint planning between the NACO, Ministry of Health and stakeholders to jointly identify priorities and targets. The programme has contributed to:

- Increased access to antiretrovirals, especially by the most vulnerable populations that the government may not reach as easily.
- Community-based screening and HIV testing and follow-up to attain up to 90% retention in care.

Key lessons include: the need for strong political leadership to set up and implement social contracting measures, community involvement in planning and need for customized programmes for unique needs of different populations. Diminishing resources are threatening sustainability or programmes, and monitoring and evaluation have not been adapted to focus on impact.

The case of Kenya

Kenya, through the World Bank, initiated a social contracting programme from 2008 to 2014 called the Support Total War Against HIV and AIDS (TOWA), implemented through the Kenya National AIDS Council (NACC). *(7)* The budget of $165 million complemented sector investments made within the medium-term expenditure framework (MTF). Budgets and annual work plans were part of the national budgeting cycle and results evaluated via government performance contracting. The resources were in the form of grant awards: 40% to national civil society organizations; 20% to public sector MDAs; 25% was used to collect essential commodities for HIV, TB and malaria. Funds were disbursed through a competitive process of calls for proposals that were evaluated by independent teams and priority was given to sectors identified in the Kenya National AIDS Strategic Plan III and service marginalized communities; 15% of the resources were used to improve institutional performance of the NACC for stronger governance and management of HIV response.

- A total of 5 559 540 people were mobilized and provided HIV counselling and testing (HTC), contributing to the increased coverage of HTC by up to 72% (KAIS).
- Over 22 million people were reached through community mobilization and advocacy with increased HIV prevention awareness and services evidenced in subsequent demographic surveys.
- A total of 322 848,000 million condoms were procured and distributed.

In terms of capacity building, 9464 PSIs (92%) civil society organizations fully accounted for the disbursed funds in line with Ministry of Finance regulations and audits by the Office of the Auditor General of Kenya showed project compliance.

Requirements for social contracting frameworks for HIV prevention services

These requirements are informed by normative guidance (for example, the IMF methodologies for monitoring financial operations, applicable in the context of social contract) *(8)* and the experience of NACAs as government agencies.

- Enabling regulatory framework. This will authorize the use of public funds through social contracts; provide a framework for appropriation and monitoring; align civil society regulation in-country with national budgeting processes; and outline oversight and audit requirements.
- A responsible Ministry or Development Agency (MDA) of government. National treasuries appropriate resources to MDAs, which are responsible and accountable. In this case, the NACA is the proposed agency. It would require approved mechanisms for funds disbursement and oversight and contracts management capacities. A multisector, multistakeholder prevention advisory team to guide technical aspects is essential.
- Investment. A compelling investment case for social contracting, with clear justifications for civil society organization contributions, public benefits and expected impact, must be made to national treasuries and captured in budgeting instruments.
- Capacitated civil society. Civil society must be prepared to engage in social contracting design, and receive, administer, implement and report in compliance with public finance regulations.
- Realistic HIV prevention costs. These can be captured in a country's performance-based budgeting processes and are competitive enough to justify resource allocation.

Country specific determination will need to be made in the design of social contracting models. Areas to consider will include:

- Funding mechanisms. countries may adopt grant making approaches or contract payments based on service delivery or performance.
- Pay for results. Performance/results-based financing models as opposed to activity-based funding may be considered. They have demonstrated efficient use of funds and better outcomes. They, however, face the challenge of appropriately designed attributable evaluation metrics.

- Strong alignment to ministry of health priorities and targets. Ongoing rigorous monitoring and evaluation to determine value for money are needed.
- Co-financing. Co-financing allows for layering of complementary financing from the private sector and international donors to bridge the gap left by limited public funding.
- Transparency and ease of execution. These are needed to encourage smaller grassroots organizations, while maintaining integrity to public finance management practices.
- Risk management. This is essential to measures to mitigate mismanagement or misallocation of funds with in-built contingency plans in line with national practices for budget transparency

Policy recommendations

1. Establish a multisector working group on social contracting. This should have the capacity and authority to work across line ministries and institutions and, ideally, be hosted at the NACA. It will:

    - Develop the investment case and technical requirements for social contracting.
    - Inform the development of a regulatory framework and guidelines for social contracting.
    - Guide HIV prevention costing efforts and ensure integration in national budgeting processes.

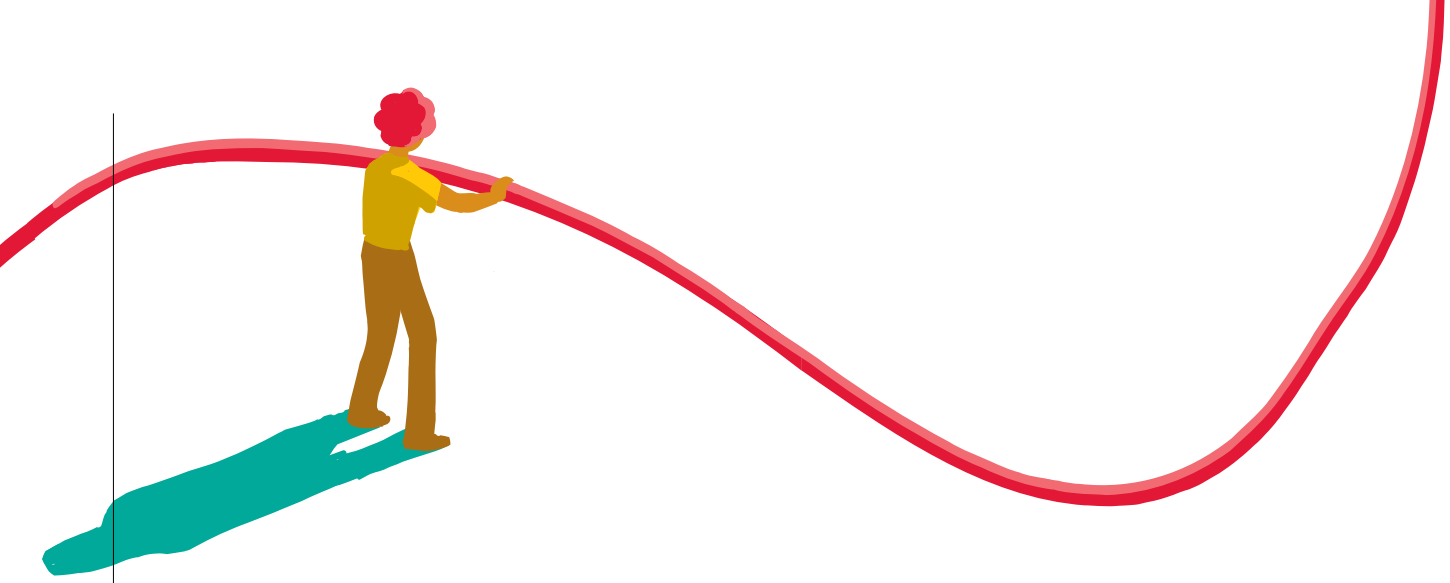
2. Develop a regulatory framework for social contracting

    - The Ministry of Finance, Ministry of Health and the attorneys general propose adjustments or changes to the finance management acts, if needed.
    - The relevant institution to approve changes to regulations, including appointment of the NACA or other MDA as the responsible agent for execution of the social contracts by receiving resources from the national treasury, administering them and submitting returns within regulations.
    - The regulator responsible for civil society organizations should make the necessary changes to licencing, oversight, permissibility, taxation and reporting requirements to align with national financing and budgeting requirements.
    - The relevant agency should publish guidelines for social contracting processes, including bidding processes, application requirements, selection, monitoring and evaluation.

3. Allocate budget to HIV programmes and approve expenditure for social contracting.

4. Develop the capacity of civil society organizations to access funds, implement and report in line with established financial and programme metrics.

5. Strengthen grant administration and oversight capacity at the NACA or responsible MDA



Conclusions

Public and private partnerships, such as social contracting, are a response to the challenge of new HIV infections that exert considerable pressure on future health budgets.

Channelling domestic resources through communities and civil society organizations to deliver tailored HIV prevention services can enhance coverage and quality while reducing government costs.

Social contracting must be accompanied by a robust framework that encompasses enabling regulatory frameworks, adherence to fiscal responsibility requirements for the management of public funds, rigorous monitoring and continuous learning.

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Policy brief

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