

A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society



5-6 October 2017

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CONVENED BY THE OPEN SOCIETY FOUNDATIONS, THE UNITED NATIONS DEVELOPMENT PROGRAMME, AND THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

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Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	anti-retroviral therapy
CBO	community-based organization
CCM	country coordinating mechanism
CSO	civil society organization
CSS	community system strengthening
EECA	Eastern Europe and Central Asia
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
LAC	Latin America and the Caribbean
M&E	monitoring and evaluation
MSM	men who have sex with men

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NGO	non-governmental organization
OSF	Open Society Foundations
PEPFAR	US President’s Emergency Plan for AIDS Relief
SCDT	social contracting diagnostic tool
SDGs	Sustainable Development Goals
STC	sustainability, transition and co-financing
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme

Executive Summary

With the ambitious relevant target of Sustainable Development Goal 3 the United Nations Member States aim, among other, to end the AIDS, tuberculosis, and malaria epidemics by 2030. The 2030 Agenda for Sustainable Development pledges to leave no one behind and to strive to address the need of those left furthest behind first. Countries everywhere are being urged to scale up their HIV, TB and malaria responses. While significant progress has been made in moving towards targets such as 90-90-90¹ in many countries, more extensive and comprehensive efforts are required in most places to reach all affected by and at risk for HIV, TB and malaria—and particularly the most vulnerable, isolated and ignored. Social contracting is a financing option by which **governments finance programmes, interventions and other activities implemented by civil society actors**. This option could help prevent reductions and disruptions in targeted services for key and vulnerable populations (in particular) and ideally contribute to more rapidly expanding effective HIV, tuberculosis (TB) and malaria responses. This report presents the background, findings, and next steps that were the result of a 5-6 October 2017 consultation convened in New York by the Open Society Foundations (OSF), the United Nations Development Programme (UNDP) and the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) to discuss social contracting.

External donors, including the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR), have historically been a main source of funding for prevention and treatment programming focused on key and vulnerable populations. As external financing becomes more limited in certain contexts, a greater share of funding responsibility will need to come from domestic sources, primarily governments. Whether and how domestic financing will enable such critical work to continue, expand and be sustained is a priority consideration for members of key populations and all others living with or otherwise vulnerable to the three diseases wherever they reside. Social contracting could be an advantageous option in any country that is seeking to build and improve its health system. The sustainability of vital services offered by civil society groups depends on them having access to alternative funding sources. Governments and other domestic sources are the most logical, and sometimes the only options. Social contracting has been shown to be an effective way to formally link the two sectors.

This consultation brought together an inclusive body of more than 60 people representing national governments, civil society groups, multilateral organizations and donors from Eastern Europe and Central Asia, Latin America and the Caribbean, Eastern and Southern Africa, and Asia-Pacific. This offered an opportunity for dialogue and discussion from both sides of the social contracting relationship in a range of contexts.

Input from these participants included observations from their own perspectives as to initiatives and approaches relevant to social contracting that are going on already in their

¹ UNAIDS, On the Fast Track to End AIDS, 2016-2021 Strategy, http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

countries. The consultation also included reflections from donors and technical partners about their experiences to date with social contracting as well as how they might be able to support such efforts in the future.

This report provides a summary of several of the main discussion areas and topics, including some practical elements and principles that could guide the design and implementation of social contracting mechanisms. More detailed information about the consultation, including many of the country-specific models presented, is available upon request from the co-conveners.

Defining Social Contracting

A background paper prepared for this consultation defined social contracting as: “The process by which government resources are used to fund entities which are not part of government (called here civil society organizations, or CSOs) to provide health services which the government has a responsibility to provide, in order to assure the health of its citizenry.”²

Finding consensus on a common definition for social contracting proves challenging, due to differences in opinions and contexts for the wide variety of actors involved. Despite these differences, consultation participants acknowledged that terms other than the one proposed at the meeting could be used to describe the same basic concept.

Conditions and Principles for Social Contracting

Participants determined a core set of seven conditions and principles for social contracting, including goals-oriented arrangements; free and fair competition; transparency; equal treatment of applications; accountability; independence; and proportionate supervision and oversight – all of which are described in detail on page 9 of this report.

Among the most pressing enabling environment issues were those of the legal, policy and regulatory nature. Participants described experiences of the legal framework for social contracting being shaped by a range of laws, policies, and implementation practices related to CSOs, including those governing their legal formation and oversight, licensing, the permissibility and taxation of CSOs, and regulation of foreign funding of domestic entities, among others. Other priority areas mentioned in regard to an enabling environment included the capacity of civil society to serve as implementers; accountability mechanisms for all involved parties; high-quality planning and communication by government actors on contracting processes; robust assessment and monitoring systems; and trust between government and non-government actors.

Existing Models and Practice of Social Contracting

The consultation provided an opportunity for showcasing experiences from nine countries: Belarus, Croatia, Former Yugoslav Republic of Macedonia, Guyana, Kazakhstan,

2 OSF, UNDP, GFATM, Social Contracting: working toward sustainable responses to HIV, TB and Malaria through government financing of programs implemented by civil society. Background Paper (2017)

Kyrgyzstan, Mexico, Montenegro, and Ukraine. Brief case studies for each country are included in this report, highlighting notable features and components of each country's social contracting mechanism, as well as key background information and context which is valuable for understanding the case.

The overarching impression from these country cases was that social contracting has already proved to be a promising opportunity or is anticipated to be so once it is implemented. Similar impressions emerged from comments by meeting respondents from countries whose social contracting structures and history were not formally presented, including Mauritius, Panama and Viet Nam.

Ultimately, it is noted that some of the approaches summarized in the case studies, or components of them, might be replicable or adaptable in other contexts. However, the forms of social contracting that take root in different countries are likely to have distinct features based on factors such as culture, history, legal structures, the strength and prominence of the civil society sector, financing and funding traditions, social expectations, and political priorities.

Concerns about Social Contracting

The concept and experience of social contracting is accompanied by a range of concerns which can be instructive for developing social contracting systems for service delivery related to HIV, TB and malaria.

Most concerns raised focused on the impact on civil society groups' independence and effectiveness and the resulting possible consequences for their clients. At various points in the meeting, government representatives from different countries also referred to concerns related to civil society groups' ability and capacity to successfully fulfil contractual requirements and provide valid, comprehensive reporting of activities and impact. These concerns are presented in further detail in the full report, but include:

- Lack of government willingness to invest in **sufficient core funding** for CSOs;
- Inability or restriction of CSOs to **fulfil essential advocacy roles** when dependent on government funding;
- Issues with measuring outputs and outcomes of **some of the most important activities** performed by CBOs and other civil society groups, which **cannot be measured in standard ways**;
- **The quality and extent of services** provided to the most 'controversial' people, including criminalized groups;
- Potential **loss of autonomy** for CSOs, limiting their creativity, innovation, and flexibility to respond to new and sudden priorities;
- **Changes in government** which lead to changes in the interest in or desire to engage in social contracting with civil society;
- Question of whether CBOs and other groups in the civil society sector that **provide the most acceptable and best services** are most likely to be engaged by governments;

- Difficulty of implementing in places where **independent CSOs find it hard to thrive and exist**; and
- Restrictive and prohibitive competition between **smaller CSOs who find it difficult to compete** with larger ones or private sector entities.

Many of the concerns mentioned above are not solely or even primarily about social contracting. Participants were generally enthusiastic about exploring ways to use social contracting in context-relevant ways to benefit both those receiving critical HIV, TB and malaria services and the governments that want to reach them. The concerns instead more directly reflect apprehension and frustration about ongoing and seemingly intractable barriers to access for many key and vulnerable populations, and the worry that current political, funding and human rights landscapes offer limited hope for improvement.

Lessons Learned

Several lessons learned were identified from country cases and from the consultation discussion at large. These, presented in further detail in the full report, include:

- (a) Existing mechanisms for contracting can work - but do not always. Countries must carefully examine any frameworks or mechanisms in place to determine whether they meet the specific needs of sustaining HIV, TB and malaria services through domestic financing, and should remain flexible to adapt as needed.
- (b) External donor financing, structures and partnerships can be used to build viable, efficient environments for social contracting and promote sustainability overall.
- (c) Advance planning can help to make social contracting arrangements more efficient, convenient and effective.
- (d) Diversification in financing is important for civil society groups.
- (e) Examples exist of contexts where civil society groups have largely maintained their independence, autonomy and voice while engaged in social contracting.
- (f) Accountability matters for all: contracting arrangements between governments and civil society are a two-way street.
- (g) Feasibility studies make sense in contexts with little or no history of government contracting with civil society groups to provide HIV, TB or malaria services.

Next Steps: Moving Forward on Social Contracting

The consultation resulted in broad agreement that some system of government support will be required in most countries as external financing decreases. Social contracting therefore represents an important way to ensure sustainability of services for key and vulnerable populations.

Suggestions were made throughout the consultation as to priority action steps or options that could help improve understanding and uptake of governments contracting with civil society groups to provide HIV, TB and malaria services—regardless of whether a model or mechanism is referred to as social contracting. An overarching principle noted by many

participants is that civil society should be involved in each step of any analysis or action associated with financial or other arrangements that could affect the sector.

The observations and suggestions mentioned about moving forward include the following, in brief:

- (a) **Raise awareness of civil society's crucial role.** The Global Fund, other donors and technical partners should assist governments to recognize the unique roles played by CBOs and other civil society groups in these disease responses.
- (b) **Know and use budgets.** To ensure robust and expanded public funding of civil society activities, civil society groups should prioritize building capacity to understand and utilize budget information for planning and advocacy activities.
- (c) **Know the territory before making decisions.** Responsive and responsible social contracting systems require extensive mapping to understand the needs and possibilities for service provision through social contracting. Comprehensive mapping of this sort ideally should focus on the following, among other things: the legal environment, baseline relationships (between government and civil society), extent and quality of services, and gaps in financing and other resources.
- (d) **Know the costs.** Detailed costing is useful for all social and other services that potentially could be provided by CSOs through social contracting arrangements. Costing can also be a good tool for civil society for both effectiveness and advocacy purposes.
- (e) **Prepare for the future.** More concentrated, serious steps should be taken now to introduce and consider the use of social contracting-type approaches in lower-income countries that do not yet face the challenges of transitions from external financing.
- (f) **Learn from what is already taking place.** As indicated throughout the consultation, there are many places with operational forms of financial arrangements that might be considered social contracting. The sharing of country experiences was a highly popular part of the meeting, and it was referred to positively in many immediate post-consultation evaluation forms.

Overall, representatives from both the government and civil society sectors indicated that they wanted to know more about similar arrangements, whether called social contracting or not, in additional countries and contexts. Many also signalled a desire for 'deeper dives' into the models discussed at the consultation and any other case studies that could be made available.

This strong level of interest in the social contracting concept in general is a notable outcome of the consultation. It suggests that the opportunities and potential benefits offered have wide appeal across a range of different contexts—although it is also evident that participants are not likely to commit to any sort of approach without careful, extensive consideration.

Following the consultation, the three co-conveners—the Global Fund, UNDP and OSF—outlined focus areas and (in some cases) specific activities at the centre of their institutions'

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follow-up work to support and expand social contracting models and opportunities. Inputs are listed in full detail at the end of the report.

1. Introduction: About the Consultation

Why social contracting? And why now? Summary rationale for the consultation

HIV, TB and malaria responses must be significantly scaled up to meet the Sustainable Development Goals (SDGs) and other targets countries have agreed to, such as the UNAIDS Fast-Track agenda to end the AIDS epidemic by 2030. Expansion of responses requires additional funds and more options for raising and allocating them, including - due to shifts in the external financing landscape - increasing contributions from national and local budgets, and in some cases, financing national responses entirely from domestic sources. Discussions such as those held at this October 2017 consultation are especially important and timely in the context of more limited external financing for middle income countries, particularly in Latin America and the Caribbean (LAC) and Eastern Europe and Central Asia (EECA).

Social contracting mechanisms are promising options for governments to fund their disease responses efficiently and effectively. Numerous examples of successful mechanisms, including Croatia and Mexico, already exist where civil society groups sign contracts with government entities to deliver critical HIV, TB and malaria services.

The value and importance of social contracting has taken on greater urgency as concerns grow over the sustainability of services for key and vulnerable populations.³ In many contexts, external financing has provided the majority, if not all, financial support for civil society groups working with and for these populations. National governments will need to take over this support if programmes and services targeting them are to be maintained and expand as part of overall efforts to meet the SDGs. Social contracting offers a proven way for governments to meet this need, and for civil society groups and their clients (especially those from key and vulnerable populations) to have their funding and services needs met as well.

The 5-6 October 2017 consultation in New York was convened to discuss social contracting, a financing option that could help prevent reductions and disruptions in targeted services for key and vulnerable populations (in particular) and ideally contribute to more rapidly expanding effective HIV, TB and malaria responses. Different definitions (see Section 2.2 below) are applied to the term, but at its core **social contracting refers to government financing of programmes, interventions and other activities implemented by civil society actors.**

3 Key populations in the context of HIV, TB and/or malaria typically include men who have sex with men (MSM), sexworkers, transgender individuals and people who inject drugs. Populations also highly vulnerable in various contexts include migrants, indigenous peoples, prisoners, and adolescent girls and young women. See Global Fund, Factsheet, Key Populations: A Definition (2015) https://www.theglobalfund.org/media/1289/core_keypopulationsdefinition_infonote_en.pdf?u=63648896442000000
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Common implementers in such arrangements are community-based organisations (CBOs) and other groups within the civil society sector. They have long formed the backbone of efforts to reach and support key and vulnerable populations. Social contracting therefore might be one viable option to ensure that responses continue to scale up among these and other vulnerable populations, and it could help improve the likelihood that all available services are of acceptable quality and accessibility.

Effective implementation and use of social contracting depends on trusting partnerships, which is why the consultation aimed to have a range of expertise and be broadly inclusive. It brought together more than 60 people representing national governments, civil society groups, multilateral organizations and donors. In the spirit of collaboration, organizers invited at least one representative from both government and civil society sectors in several countries from different global regions—including Eastern Europe and Central Asia, Latin America and the Caribbean, Eastern and Southern Africa, and Asia–Pacific—where forms of social contracting are already being used or could be started in the future.⁴ This offered an opportunity for dialogue and discussion from both sides of the social contracting relationship in a range of contexts.

Input from these participants included observations from their own perspectives as to initiatives and approaches relevant to social contracting that are going on already in their countries. The consultation also included reflections from donors and technical partners about their experiences to date with social contracting as well as how they might be able to support such efforts in the future.

This report provides a summary of several of the main discussion areas and topics, including some practical elements and principles that could guide the design and implementation of social contracting mechanisms. More detailed information about the consultation, including many of the country-specific models presented, is available upon request from the co-conveners.

2. Setting the Stage: Rationale for and Definition of Social Contracting

2.1 The global and local landscape: why social contracting is useful in some contexts

Countries everywhere need to expand and improve work against HIV, tuberculosis (TB) and malaria, in order to end epidemics which are fully preventable. Most have committed to achieving goals specifically associated with these infectious diseases, such as the 90-90-90 targets at the core of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Fast-

⁴ Countries represented in this manner included Botswana, Croatia, the Dominican Republic, the Former Yugoslav Republic of Macedonia, Guyana, Kyrgyzstan, Mauritius, Mexico, Montenegro, Namibia, Panama, Ukraine and Viet Nam.

Track initiative.⁵ All countries also have committed to meeting targets outlined in the 2030 Agenda for Sustainable Development, with positive impacts expected regarding all three diseases through actions taken to meet the wide-ranging SDGs. The UNAIDS 2016–2021 Strategy, the Global Fund 2017–2022 Strategy⁶ and the Strategy on HIV, Health and Development of UNDP are closely aligned to the SDGs.⁷

Significant progress in programmatic scale-up has been made in many countries, but more extensive and comprehensive efforts are required in most places to reach all affected by and at risk for HIV, TB and malaria—and particularly the most vulnerable, isolated and ignored, many of whom have been described as being ‘left behind’. Improved access to services and support for these populations is essential to the success of disease responses in any context.

External donors, including the Global Fund and the US President’s Emergency Plan for AIDS Relief (PEPFAR), have historically been a main source of funding for prevention and treatment programming focused on key and vulnerable populations. As external financing becomes more limited in certain contexts, a greater share of funding responsibility will need to come from domestic sources, primarily governments. Whether and how domestic financing will enable such critical work to continue, expand and be sustained is a priority consideration for people in key populations and other people affected by epidemics, wherever they reside.

In response to such fundamental changes in external financing landscape for the three diseases, governments, civil society groups at all levels, and technical partners are recognizing the need for changes in how they work together. Social contracting could be an advantageous option in any country that is seeking to build and improve its health system. It could also prove especially valuable for efforts in response to HIV, TB and malaria in countries facing funding and programming challenges, related to low domestic investment in key services and/or non-existent or declining donor support.

The social contracting concept is based on the premise that civil society groups often can provide certain essential services more effectively and efficiently than the government or other sectors, including in areas that have infrequently if ever received domestic support—such as HIV prevention among many key and vulnerable populations. In recent years, however, CBOs and other civil society groups in a growing number of countries report that

5 The UNAIDS Fast-Track agenda emphasizes the following targets for 2020: zero discrimination; 500,000 annual new infections among adults (which would be about one quarter of the number in recent years); and the so-called 90-90-90 targets in which 90 per cent of people (children, adolescents and adults) living with HIV know their HIV status; 90 per cent of people who know their HIV-positive status are accessing treatment; and 90 per cent of people on treatment have suppressed viral loads. For 2030, the targets include zero discrimination, 200,000 new infections among adults, and improvements in the treatment-related targets by five percentage points each, to 95-95-95.

6 GFATM, The Global Fund Strategy 2017-2022: Investing to End the Epidemics (2016), https://www.theglobalfund.org/media/1176/bm35_02-the-global-fund-strategy-2017-2022-investing-to-end-epidemics_report_en.pdf

7 UNDP Connecting the Dots, HIV, Health and Development Strategy 2016-2021 (2016), <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/hiv--health-and-development-strategy-2016-2021.html>

organizations have been forced to close, or are at heightened risk of taking that step soon, due to lack of funds.

The sustainability of vital services offered by civil society groups depends on them having access to alternative funding sources. Governments and other domestic sources are the most logical, and sometimes the only options. Social contracting has been shown to be an effective way to formally link the two sectors.

2.2 Defining social contracting: context matters

A background paper prepared collaboratively in advance by the consultation cosponsors—and distributed to all participants before the meeting—included the following working definition of social contracting: “The process by which government resources are used to fund entities which are not part of government (called here civil society organizations, or CSOs) to provide health services which the government has a responsibility to provide, in order to assure the health of its citizenry.”⁸

Following that definition’s introduction early in the meeting, some participants expressed example, the term ‘public financing of CSO service delivery’ is a term preferred by some stakeholders. Regarding the term ‘social contracting’ itself, some participants proposed other options for the overall concept that emphasized collaboration, including ‘social participation’ and phrases that highlighted ‘planning and coordination’. Some also called for more careful consideration and consistency in how the term is translated into other languages, including those spoken and interpreted at the consultation (Russian and Spanish).

Despite these differences, it was acknowledged by participants that terms other than the one proposed at the meeting could be used to describe the same basic concept. **A main takeaway message was that the approach would always be highly context-specific, whatever it is called and regardless of how it might be structured—but that social contracting should be understood as an important tool to enable public funding for CSOs.**

Embedded within this message is the important idea that although no one definition of social contracting is likely to suffice for all country contexts, it should be possible to describe some basic and generally accepted parameters that are applicable in most places worldwide. In each context, too, there will almost certainly be unique term(s) used to describe these types of arrangements between the public and civil society sectors to provide HIV, TB, malaria and other health and development services such as those required for progress on all SDGs.

The summaries presented below provide examples of some differences in opinion or interpretation regarding social contracting that were cited and described at various points during the consultation. Participants did not attempt to reach consensus on any of these issues.

⁸ This definition is intended to cover what is broadly acceptable and expected in most countries. Some governments take a more expansive view than suggested by the word ‘citizenry’ as they also provide access to essential health services also to people on their territory who are not citizens.

Who or what can be funded?

- ***One opinion:*** A mechanism can only be considered social contracting if a government is funding non-profit CSOs. No other organizations or institutions (e.g., for-profit ones, including those in the private sector) are eligible.
- ***Contrasting opinion:*** The private sector and any other for-profit entities should also be allowed to participate in such arrangements with government.
- ***One opinion:*** Social contracting is a financial arrangement setting out terms for an exchange of money for services rendered.
- ***Contrasting opinion:*** A wider interpretation is preferable, and it should include situations in which a government provides non-financial support (e.g., commodities such as condoms) for CSOs providing services.
- ***One opinion:*** Social contracting does not include financial arrangements between a government and any other entity, civil society or not, that does not have legal status, does not pay wages or salaries, or does not have any financing structures or mechanisms.
- ***Contrasting opinion:*** A more expansive interpretation is necessary to avoid excluding CBOs in many countries, especially those that work with and for criminalized and highly stigmatized populations such as MSM, sex workers and people who use drugs. Many of them cannot get legally recognized even if they have credible structures in place and can demonstrate the reach and impact of their services.
- ***One opinion:*** A government hiring individuals, such as peer educators, to work in public-sector clinics would not constitute social contracting. The reason is that in such cases, there is no contract with a CSO, only with an individual, and therefore those hired are more properly considered government employees.
- ***Contrasting opinion:*** This interpretation could limit a government's ability to allocate resources in more targeted, precise manners to meet specific needs. Social contracting should instead accommodate using government funds to hire individuals from the civil society sector as needed to provide unique and vital support and other services such as peer education.

How can financial arrangements be structured?

- ***One opinion:*** Contracts are at the heart of the concept, including all the relevant targets, indicators, financial-dispensation schedules, and reporting expectations.

- **Contrasting opinion:** Funding arrangements could include grants, for example, and still be considered part of the overall social contracting mechanism.⁹

How widely should social contracting be used?

- **One opinion:** Social contracting should only be used when governments cannot or will not provide specific services. This means that each sector has strict, divergent areas of work: the government provides all medical services, for example, while CSOs receive government funding only for non-biomedical prevention and other services targeting key populations.
- **Contrasting opinion:** Social contracting should be an ‘open bidding’ system, in which CSOs can compete with private sector and government to be funded for any services within one or more disease responses. Decision-making criteria should be based on whatever institution or organization can provide specific services most efficiently, cost-effectively, quickly and sustainably.

2.3 Creating an enabling environment: conditions and principles

Several conditions and principles were discussed as being important for the establishment of an enabling environment for arrangements that could be categorized as social contracting. Box 1 at the end of this sub-section includes a list of core principles proposed at the consultation.

The legal, policy and regulatory environments are of great importance. There should be a legal basis for social contracting in general, but having a specific favourable law on social contracting is not necessary, nor is it sufficient on its own. The legal environment for social contracting is shaped by a range of laws, policies, and implementation practices related to CSOs, including those governing their legal formation and oversight, licensing, the permissibility and taxation of CSOs, and regulation of foreign funding of domestic entities, among others. These various norms may be enabling or obstructive.

One example of an excessively onerous legal condition in one country in Latin America was cited at the consultation: current regulations impose a 5 per cent cap on civil society groups’ spending on administrative expenses if they are certified as able to receive tax-deductible donations. That policy sets a significant burden when taking into account extensive administrative responsibilities associated with social contracting, including reporting and oversight.

⁹ Grants often include targets, schedules and expectations of the sort that are specified in contracts. Typically, though, grants are financed differently (often through a lump initial sum, for example); cover a more limited scope; and in the case of many civil society groups providing HIV, TB and malaria services are for relatively small amounts of funding. Another important difference is that contractors (including CSOs) are legally bound to deliver, and could be found in breach of default if they do not do so. There are no such legal consequences if objectives specified in a grant are not met.

Other priority areas mentioned in regard to an enabling environment include the following:

- Sufficient capacity for CBOs and other contracting CSOs to manage and report, as per conditions specified in a contract
- Clear accountability mechanisms for both government and civil society recipients
- High-quality planning and clarity by government as to what it is funding, why and its expectations for each arrangement, among other things. This is part of a broader need for governments to have sufficient capacity to manage all components of social contracting processes, from development of calls to evaluation
- Clear assessment and monitoring procedures
- Trust between government and civil society partners
- The need to invest in enabling environment and in improving enabling environment

Some other important factors likely include the following, among others:

- Removal or at least sufficient reduction of barriers for key and vulnerable populations to access services, and for CSOs or other groups to reach out to them and provide services. This would include, for example, policies that enable the delivery of services in contexts where needle and syringe exchange is illegal and governments cannot fund drop-in centres through social contracting.
- Removal or at least sufficient reduction of legal and other barriers on registration for CBOs and other CSOs, including those led by or focused on key and vulnerable populations.

Basic, common principles for social contracting

Some common principles were proposed for frameworks and regulations governing public funding for CSOs delivering services in general as well as HIV, TB and malaria services specifically. They include:

- Arrangements should be **goals oriented**: public funding should be allocated for clearly defined goals and priorities in line with the government policies and public health needs. Evaluation should be driven by indicators to measure the achievement of these goals.
- **Free and fair competition** should be ensured: Information about contract opportunities should be advertised as widely as possible to encourage competition among all potential applicants.
- Application and selection procedures should be clear and **transparent**, and provide for maximum clarity and openness of the process (e.g., requirements to publish the tender announcement in official and local media, allowing appropriate time for submission of proposal, publicizing the selection criteria and names of selected applicants).
- **Equal treatment of applications** should be a main priority. This would mean, for example, a set of pre-established clear and objective criteria, which ensure non-discrimination and selection of the most qualified applicant based on the merit of the proposal.
- The principle of **accountability** refers to, among other things, spending the allocated funds in an agreed way and with clear reporting obligations.
- The **independence** of all CSOs should be recognized and supported. This includes their right within the law to comment on and to challenge government policy and to determine and manage their own affairs. CSOs and communities also should be engaged in shaping and reviewing social contracting policies and structures.
- Procedures for application, documentation, reporting requirements, oversight and supervision should be **proportionate** to the programme activities and funding provided.

3. Models of Contracting in Practice: Country Examples

Listed below in alphabetical order by country name are summaries of some examples presented at the consultation of different approaches being undertaken or considered in various countries for providing public funds to CSOs to deliver services associated with HIV, TB and malaria. The overarching impression from the country presentations is that social contracting has already proved to be a promising opportunity or is anticipated to be so once it is implemented. Similar impressions emerged from comments by meeting respondents from

countries whose social contracting structures and history were not formally presented, including Mauritius, Panama and Viet Nam.

Some of the approaches summarized, or components of them, might be replicable or adaptable in other contexts. However, the forms of social contracting that take root in different countries are likely to have distinct features based on factors such as culture, history, legal structures, the strength and prominence of the civil society sector, financing and funding traditions, social expectations, and political priorities.

Belarus¹⁰

Background and other observations: Until recently, Belarus had no legislation that specifically allowed for the funding of independent CSOs. In October 2017, changes were adopted to the law on the prevention of communicable diseases that allow the use of a social contracting mechanism to support CSOs providing services associated with such diseases (including HIV prevention).

The legal reform effort was driven by advocacy undertaken by local and region civil society groups. Their influence and success point to the importance of such groups having sufficient funding for critical advocacy work.

Croatia

Notable features or components: Longstanding, continually evolving, institutionalized social contracting structure and tradition. Clearly defined and communicated thematic areas and activities guiding how and what can be funded through public funds.

One underlying principle is that there should always be a possibility to publicly fund CSOs, as long as quality and effectiveness are assured. Both government and civil society partners in these financing arrangements for social services consider mutual trust, understanding, partnership and coordination to be core values for success.

Numerous positive impacts of this longstanding structure are evident. CSOs supporting key and vulnerable populations have benefited from this comprehensive structure and its clearly defined and transparent elements. A total of US\$850,000 was made available for HIV prevention activities in 2016–2017, for example, including for prevention among MSM.¹¹

Background and other observations: The formal Croatian structure for social contracting has been built up over the past 20 years. It is based on four pillars that support effective government–civil society cooperation: *strategy* and normative frame of creating an enabling

¹⁰ Belarus was not represented at the consultation by either government or civil society. The summary information is based on comments made by other meeting participants and presentations discussing research undertaken by the Eurasian Harm Reduction Association, a regional network working on sustainability.

¹¹ More detailed information about public funding of HIV services in the country, including after Global Fund financing stopped, may be found in a UNDP case study published in 2015: 'Towards Domestic Financing of National HIV Responses: Lessons Learned from Croatia'. The publication is available at www.hr.undp.org/content/croatia/en/home/library/poverty/towards-domestic-financing-of-national-hiv-responses.html.

environment for civil society; *structures* promoting cooperation between government and CSOs; *funding* schemes ensuring sustainable CSO programmes and projects; and *consultation* standards allow timely involvement of CSOs in policy making.

The normative framework for public funding of associations and non-profit organizations has evolved over time through four key laws, the first of which (a law allocating revenues from the national lottery to CSOs working in eight areas) was passed in 2002. More recently, a law from 2014 provided more structure and guidance for the financial activities and accounting of non-profit groups.¹²

Three main government offices and advisory groups collectively seek to strengthen and raise awareness of the civil society sector and promote sustainability of civil society groups themselves and the specific services they provide. The oldest and most important is the Government Office for Cooperation with NGOs, which was created in 1998 and has led the government's efforts to devise effective financing arrangements and other partnerships with eligible CSOs.¹³ That office has its own annual budget and full-time staff.

The Croatian structure includes both centralized and decentralized elements. For example, to be eligible for public funding, CSOs must be listed on a national register of non-profit organizations. That register contains CSOs' annual financial reports, which can be reviewed by all potential decentralized sources of public funding for social services, including the national and subnational budgets and European Union funds.

Former Yugoslav Republic of Macedonia

Notable features or components: The core of the structure, which had not been launched as of October 2017, is public procurement (tender) for CSOs. The revised 2017 national budget includes specific budget lines for HIV prevention and other services targeting key populations, including people who inject drugs and MSM. That step suggests that such funding has been institutionalized, which greatly increases the likelihood that it will be sustained. Civil society advocacy with the government played a major role in these crucial developments.

Background and other observations: The new Prime Minister in September 2017 agreed to add about US\$2 million to the 2018 budget to help sustain HIV prevention programmes for key populations, which formerly had been financed primarily by the Global Fund. The new budget funds also will cover antiretroviral therapy (ART) services for people living with HIV. This amount is nearly four times larger than the amount budgeted by the previous government.

¹² As described in a presentation by Croatia participants at the consultation, the four laws are titled as follows (and are listed chronologically): Law on Games of Chance (2002), Law on Fiscal Responsibility (2010), Law on Associations (2014), and Law on financial activities and accounting of non-profit organizations (2014).

¹³ The other two entities are the Council for Civil Society Development (2002) and the National Foundation for Civil Society Development (2003).

Details have yet to be finalized for how the new funding mechanism for CSOs will operate in practice. One issue which needs to be addressed is important from the trust and capacity perspectives: the Ministry of Health, which will oversee the social contracting mechanism, has never before worked directly with CSOs; likewise, CSOs have never worked directly with the government on a contract basis.

Guyana

Notable features or components: Discussions on social contracting have started with the implementation of a social contracting diagnostic tool (SCDT) that explores opportunities, barriers and priorities for public funding of CSO service delivery to key and vulnerable populations.

Background and other observations: The SCDT results have strengthened evidence that key population groups and other CSOs are legally allowed to incorporate, and that existing legal and administrative structures exist to direct government funding to them. Some gaps and potential restrictions identified are related to training and licensing regulations.

Next steps include costing of the services and defining and developing specific mechanisms. This work is being led by a Sustainability Steering Committee that includes representatives from various government ministries as well as civil society and private sector representatives.

Kazakhstan¹⁴

Notable features or components: Two mechanisms are now used. One, adopted in 2015, is based on contractual arrangements and therefore is considered closely aligned with core assumptions regarding social contracting. Another, adopted in 2016, is used to provide grants to CSOs.

Background and other observations: According to input at the consultation, the grants option seems to be easier and more useful for CSOs to date. The social contracting mechanism has numerous regulations that are time-consuming to fulfil, including for filling out forms for compliance. Long delays have been reported for promised funds to be delivered, which means that CSOs have few if any resources available to initiate programmes on a timely basis.

Another concern noted about the social contracting mechanism is that because funding decisions are based on price/cost competition, there is often a “race to the bottom” that puts the quality of the services and financial stability of implementing CSOs at risk.

Kyrgyzstan

Notable features or components: Social contracting for HIV services appears likely to be focused somewhat narrowly, with CSOs primarily being funded for certain prevention and

¹⁴ Kazakhstan was not represented at the consultation by either government or civil society. The summary information is based on comments made by other meeting participants and presentations discussing research undertaken by the Eurasian Harm Reduction Association, a regional network working on sustainability.

support activities. As in some other contexts where social contracting has been or will soon be implemented, the government likely will retain oversight and control of ‘medical’ services.

Background and other observations: Social contracting for health services, including HIV programming, is now legal. It has not been introduced in a systematic way because standardized rules and regulations do not yet exist. A technical working group within the Ministry of Health is developing a clearer and stronger mechanism for contracting as well as a system of standards for licensing the provision of selected services. Civil society representatives are on the consultative body.

Civil society groups are hoping that funding for social contracting for HIV programming might also be provided from the budgets of agencies other than the health ministry.

Mexico

Notable features or components: Government funding for targeted HIV services delivered by CSOs has been provided continuously for more than 11 years, including throughout the Global Fund programme and after it ended in 2014. The government planned and implemented social contracting while Mexico was still receiving Global Fund support, a decision that helped ensure a relatively seamless transition and continuance of services after the Global Fund programme ended in 2014. The comprehensive process is highly streamlined.

From 2013–2017, an amount equivalent to about US\$31 million was publicly financed for 645 HIV-related projects. The Global Fund’s departure in 2014 did not result in significant changes overall regarding these metrics. The number of projects fell from 184 in 2013 to 123 in 2017, but not due to reductions in funding. In fact, the total amount allocated annually in Mexican pesos remained about the same: nearly 101 million pesos in 2014, and slightly more than 102 million pesos in 2017; however, reorganizations in program design and configuration resulted in fewer projects funded. One long-term measure of impact of the country’s HIV response overall—of which social contracting is one important part—is that an estimated 45,000 infections have been averted since universal access to antiretroviral therapy (ART) was achieved in 2003.

Background and other observations: The federal government early on recognized and responded to the unique and valuable role of civil society groups in the HIV response. Creating a legal environment has been a critical part of the process. Provisions in several laws specifically allow and promote the participation of CSOs, including the general law on health and the law on public administration.¹⁵

Transparency is another longstanding priority principle. Relevant government entities, including the health and finance ministries, prepare budgets indicating funding amounts potentially available for civil society contracting. Drafters of these budgets recognize the

15 The official names of the three main laws in Spanish are: Ley de la Administración Pública Federal, Ley General de Salud, and Ley Federal de Fomento a las Actividades realizadas por las Organizaciones de la Sociedad Civil. In English, these are the Federal Public Administration Law, the General Law of health, and the Federal Law for the Promotion of Activities carried out by Civil Society Organizations.

importance to the success of the HIV response of targeted services for key and vulnerable populations. Years of civil society advocacy have also made them aware that CBOs and other civil society groups tend to be best-placed to reach those populations.

Tenders are awarded based on responses to public calls for proposals. For HIV, the cascade of care is the benchmark for public policy, with other guiding principles being human rights, supportive legislation (e.g., affecting people living with and at risk for HIV), and zero tolerance for violence. These top-level issues are reflected in the predetermined categories for funding that help to guide the process for HIV programming: they include, for example, prevention areas around vertical transmission, people who use drugs, and young MSM. Specific interventions to be funded are associated with these categories.

Some limitations were noted at the consultation, both regarding the Mexico social contracting system overall and more specifically for HIV services. The contracting and operating system is electronic, which although convenient for the government can cause complications among civil society groups that do not have the capacity or time to engage regularly. Compliance and reporting requirements reportedly can be extensive. To some observers, this suggests that the government did not adequately plan for how best to integrate and support CBOs that need to transition from Global Fund support. Such observations are reinforced by the number of civil society groups providing HIV prevention, support and other services that closed due to lack of funding after the Global Fund left. One consultation participant said that some CSOs had ‘disappeared’ since then. These closures do not necessarily minimize the overall positive effect of Mexico’s social contracting process, but they underscore the complexities inherent in domestic financing of HIV responses in large, diverse settings in particular.

Other cited limitations refer to difficulty in validating information provided by CSOs on measures such as the effectiveness of activities provided, number of people served, and costs of inputs. Government stakeholders reportedly aim for improved technical efficiency by, for example, more effectively linking interventions with specific populations. They also want to encourage the most qualified CSOs to implement new and innovative interventions.

Montenegro

Notable features or components: Core Global Fund structures and systems, including the country coordinating mechanism (CCM), are being retained as part of the governance and management architecture for social contracting.

Background and other observations: The Global Fund exited Montenegro before the adoption of its Sustainability, Transition and Co-Financing (STC) policy. Advocates considered it an ‘unplanned exit’, and as a result many services for key and vulnerable populations collapsed and the country saw an increase in HIV infections.

Advocacy by local CSOs led to the adoption of a law, in 2015, that for the first time allowed the allocation of funding specifically for ‘non-governmental organizations who provide services for support to people living with HIV/AIDS and affected populations’. No mechanism was yet in place to allow such funding to place, however.

With the support of policy makers and civil society advocates, the Global Fund provided a grant to support the CCM Secretariat even though the Global Fund HIV programme had ended. That step is intended to make the transition smoother and to limit the reduction in funding for civil society groups that provide essential HIV prevention and support services. In the meantime, a long-term mechanism is being developed collaboratively, with technical support from both OSF and UNDP, to meet both the stipulations of new domestic legislation and the needs of key and vulnerable populations on the ground. Additional transition funding from the Global Fund from the 2017–2019 allocation period is being used to strengthen this mechanism during its start-up.

Ukraine

Notable features or components: Financing of CSOs through subnational (regional) government budgets. Encouraging regional budgets to have a ‘boosting’ effect by taking over responsibility for some interventions is considered an important way to ensure sustainability.

Background and other observations: The Ukrainian model allows CSOs to receive funding through different channels at the regional level to provide a wide range of services, including some traditionally offered only by the government. This includes mechanisms for financing of core HIV prevention interventions through regional health administrations, as well as financing of community strengthening and social support work through structures of the Ministry of Social Policy. The stated goal is to award contracts to organizations or institutions that can provide the highest-quality services in the most cost-effective and efficient manner. The resulting competition for government funding reportedly has helped push providers from both sectors (government and civil society) to be more innovative and improve their services.

Ukraine’s recently submitted HIV/TB proposal to the Global Fund, to cover a three-year cycle through 2019, prioritizes this decentralization. Global Fund programme implementation in 2018 will shift to having grants from the Global Fund passing through a national principal recipient, the Public Health Center, and then flowing directly to regional administrations for allocation based on local needs and priorities. Ideally, regional governments will contribute budget funds to boost the total amount available for procurement and contracting. At national level, the Public Health Center has piloted procurement of services from two NGOs (principle recipients of the current Global Fund grant) using funds from that three-year grant. This pilot along with the decentralized financing of services and a gradual increase in the percentage of prevention services financed by the government sector is part of the transition plan to domestic financing of HIV response.

4. Concerns about Social Contracting

This section summarizes several concerns—about social contracting more generally and in specific situations—that were raised throughout the consultation, both during plenary discussions and in presentations. They are among the issues that deserve consideration when developing social contracting systems for service delivery related to HIV, TB and malaria.

As indicated by the contents of the list below, most concerns raised at the meeting focused on the impact on civil society groups' independence and effectiveness and the resulting possible consequences for their clients. At various points in the meeting, government representatives from different countries also referred to concerns related to civil society groups' ability and capacity to successfully fulfil contractual requirements and provide valid, comprehensive reporting of activities and impact.

- Governments are likely to be unwilling to contract for core funding for CSOs, preferring instead to focus only on project funding. Yet CSOs cannot implement effective projects without having **sufficient core funding** behind them. If other sources are not available for such essential funding, they will be unable to meet their contractual requirements.
- If communities become reliant on government funding, they might feel constrained or **unable to fulfil essential advocacy roles** that include close monitoring and criticism of the government if warranted. Programmes for key and vulnerable populations in particular could regress if civil society groups cannot and do not have sufficient advocacy capacity.
- Governments tend to be interested in funding specific services for which reasonable indicators can be set and impact quantified and monitored. The value and usefulness of **some of the most important activities performed by CBOs and other civil society groups cannot be measured in such ways**. A related yet different challenge is that existing information and monitoring and evaluation (M&E) systems in many countries do not adequately capture or reflect the disease-response work undertaken by many CSOs. How then can the sustainability of activities focused on social and legal support, advocacy, human rights and community systems strengthening (CSS) be ensured?
- The **quality and extent of services** provided to the most 'controversial' people, including criminalized groups, **could be reduced** overall because governments refuse to allocate funding for such services or believe they cannot do so for risk of violating laws. For example, how could a government contract a sex worker coalition through social contracting if sex work is illegal?
- CSOs risk **losing their autonomy**, which could also limit their creativity, innovation, and flexibility to respond to new and sudden priorities. Particularly problematic could be a **lessening of trust** between clients and civil society groups because of suspicions about CSOs' formal, close arrangements with governments.
- **Changes in government** could lead to changes in the interest in or desire to engage in social contracting with civil society. Abrupt or sudden financing decisions could have disastrous consequences for CSOs and the populations they are serving.
- With social contracting, governments are responsible for evaluating the CSOs they engage with. They may not have the ability or inclination to identify CBOs and other groups in the civil society sector that **provide the most acceptable and best services** from the perspective of expected clients.

- Social contracting will be difficult to implement, or must be highly adaptable, in places where **independent CSOs find it hard to thrive and exist**. For example, CBOs deemed ‘difficult’ because they are critical of the government could be shut out for reasons unrelated to their ability to provide the intended services properly and effectively. For such reasons, some CSOs will reasonably fear being co-opted or silenced politically.
- **Smaller CSOs may find it difficult to compete** with larger ones, due to factors such as limited capacity for meeting rigorous contract requirements (such as reporting and impact measurement). **Competition could also be a challenge for all CSOs, regardless of size, when private-sector entities are eligible** for social contracting participation. Many CBOs and other civil society groups could be pushed to the margins, which could result in less effective services for key and vulnerable populations that trust and rely on their support and advocacy.

Many of the concerns mentioned above are not solely or even primarily about social contracting. Participants were generally enthusiastic about exploring ways to use social contracting in context-relevant ways to benefit both those receiving critical HIV, TB and malaria services and the governments that want to reach them. The concerns instead more directly reflect apprehension and frustration about ongoing and seemingly intractable barriers to access for many key and vulnerable populations, and the worry that current political, funding and human rights landscapes offer limited hope for improvement.

5. Lessons Learned

Some lessons learned can be noted from the country examples and overall consultation discussions about social contracting, including those associated with the numerous concerns.

Several are summarized below.

- (a) ***Existing mechanisms for contracting can work (but not always)***. The Mexico situation is instructive from the positive side. Social contracting existed before the Global Fund arrived and has continued after it left. It was not donor-driven or donor-dependent. In such contexts, mechanisms exist at the national level because they are important to ensuring that services get to those who need them most. Designing and implementing new mechanisms might not be useful or constructive.

Existing mechanisms are likely to have the best chance of succeeding in contexts with adequate political will and acceptable regulatory frameworks. Yet even when such an environment exists, not all existing mechanisms are right or good for both partners. Civil society groups could find their impact, effectiveness and independent nature greatly reduced unless changes are made to mechanisms guiding social contracting. Governments might wish to alter mechanisms if they find it more difficult than anticipated to maintain sufficient oversight and confidently guarantee quality services.

Such possibilities point to the *importance of regular dialogue about all relevant mechanisms already in place or being developed or considered*. All partners recognize the opportunities offered by social contracting, and therefore the will and interest to explore ways to improve them tend to be strong and constant. Expansive, regular dialogue also can help to raise awareness about social contracting opportunities across a broader range of CBOs and other civil society groups, thereby increasing options for the provision of efficient, quality and sustainable services.

- (b) ***External donor financing, structures and partnerships can be used to build viable, efficient environments for social contracting and promote sustainability overall.*** The Global Fund's role in supporting the Montenegro CCM for additional years and its partnership with OSF to support community engagement in the development of the social contracting mechanism is a good example that could be considered for adaptation in other contexts.
- (c) ***Advance planning can help to make social contracting arrangements more efficient, convenient and effective.*** Montenegro's decision to maintain and adapt the CCM prior to the Global Fund's departure offers a good example. A mechanism for social contracting has been put in place that is valued and supported by government and civil society partners.

On the other hand, according to some respondents, the end of Global Fund financing in Mexico has had negative consequences for many CBOs even though social contracting of a sort had existed since before the Global Fund provided Mexico with financing. One negative impact cited was the end of centralized purchasing when the Global Fund grant finished. Now, each organization must purchase its own supplies and has fewer opportunities to buy in bulk, thereby increasing costs for commodities such as condoms. Such challenges might have been avoided through more careful, in-depth advance planning prior to the end of Global Fund financing.

- (d) ***Diversification in financing is important for civil society groups.*** Many CBOs and other groups are seeing funding dry up as the Global Fund and other funding is reduced. They will find it difficult to maintain their independence if they have only one or a small number of funding sources moving forward, government or not. All stakeholders interested in ensuring strong, committed, independent civil society voices should recognize the need for such diversity of financing and work to support it.
- (e) ***Examples exist of contexts where civil society groups have largely maintained their independence, autonomy and voice while engaged in social contracting.*** The situation in Ukraine illustrates how it is possible for this to be done. Many Ukrainian CSOs that have contracted with government entities to provide a wide range of HIV and TB services, and not just in prevention, have not lost their ability or inclination to advocate. Even though contexts differ widely—with Ukraine being a more or less open democracy with a strong civil society sector—the successes there offer models and hope elsewhere.

- (f) ***Accountability matters for all: contracting arrangements between governments and civil society are a two-way street.*** Civil society groups are as responsible for meeting the terms of contracts as are governments, as long as neither side faces undue burdens. Joint accountability should be clarified at the very beginning of any arrangement.
- (g) ***Feasibility studies make sense in contexts with little or no history of government contracting with civil society groups to provide HIV, TB or malaria services.*** Would a social contracting mechanism make sense from legal, social, economic or political perspectives? The energy and time needed to establish an acceptable mechanism might not be worthwhile if the potential barriers seem too high or insurmountable. Assessing and reforming relevant laws, policies and regulations would need to come first.

6. Moving Forward on Social Contracting

6.1 Suggestions for focus and priorities

The consultation did not conclude with any consensus recommendations. There was broad agreement that some system of government support will be required in most countries as external financing decreases. Social contracting therefore represents an important way to ensure sustainability of services for key and vulnerable populations. Not all CSOs will want to receive government funding for HIV, TB or malaria services. But many will seize the opportunity, especially as local civil society groups increasingly rely on domestic funding sources.

Suggestions were made throughout the consultation as to priority action steps or options that could help improve understanding and uptake of governments contracting with civil society groups to provide HIV, TB and malaria services—regardless of whether a model or mechanism is referred to as social contracting. An overarching principle noted by many participants is that civil society should be involved in each step of any analysis or action associated with financial or other arrangements that could affect the sector.

The observations and suggestions mentioned about moving forward include the following, among others:

- (a) ***Raise awareness of civil society's crucial role.*** The Global Fund, other donors and technical partners¹⁶ should assist governments to recognize the unique roles played by CBOs and other civil society groups in these disease responses. They should also emphasize that due in part to donor programmes, these groups have the necessary capacity in place to boost and improve epidemic responses. Governments should

¹⁶ Shortly after this meeting took place, on 10 October 2017, UNAIDS and UNFPA released a joint HIV Prevention 2020 Roadmap, which calls for at least 30% of service delivery to be community-led, via social contracting mechanisms (point #7 of the 10-point plan). http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf

utilize this opportunity because CBOs and CSOs are often the only way to reach vulnerable groups with many essential interventions.

(b) **Know and use budgets.** To ensure robust and expanded public funding of civil society activities, civil society groups should prioritize **budget advocacy**. This means they need to understand how public budgets are made at national and local levels; be able to analyse them effectively; understand the wide-ranging political sphere (e.g., beyond just the health ministry) that determines where and with whom they should advocate; and understand the role of relevant parliaments in budget-making processes. Such steps are important to help achieve an important and valuable objective: **ensuring that social contracting services are institutionalized in budgets** (as has occurred to different extents in Macedonia and Mexico). Once this happens, the likelihood of sustainable financing and services is far greater.

(c) **Know the territory before making decisions.**

- **Extensive mapping** is needed to ensure the most effective and useful social contracting arrangements are designed. In most contexts mapping should take into account not just HIV, TB and malaria services, but also services delivered in the broader health and development spheres. Among the many reasons this wider scope is important is that in certain contexts, responses covering numerous steps along a range of health responses—including design, planning and implementation of non-communicable diseases programmes—are integrated within the same health department.

Comprehensive mapping of this sort ideally should focus on the following, among other things: the legal environment, baseline relationships (between government and civil society), extent and quality of services, and gaps in financing and other resources. Support for such mapping already exists. For example, as noted Annex 1, the Global Fund recently has finalized a diagnostic tool on public financing of CSOs. It offers specific guidance on what kind of questions to ask, whose opinions and input is important, and how to assess situations with little or no history of these kind of arrangements. Civil society groups, in particular, would benefit as well if **mapping also aims to provide a greater understanding of the full range of domestic funding opportunities** at national and subnational levels. In many contexts, they have not had the need to explore widely and deeply because significant shares of their funding have been provided by external donors such as the Global Fund.

- **More and better data**, in addition to costing information, should be generated to influence improved decision-making by governments when prioritizing interventions to be funded. **Context-relevant evidence** often is the best way to make a case for supporting prevention interventions among key and vulnerable populations, for example.

(d) **Know the costs.** Detailed costing is useful for all social and other services that potentially could be provided by CSOs through social contracting arrangements.

The results can help CSOs and governments have a clearer idea of how much money is realistically needed to deliver specific services.

- **Costing** can also be a good tool for civil society for both effectiveness and advocacy purposes. In terms of the former, it can help to ensure CSOs have the necessary internal processes and systems to provide high-quality services in the most efficient and effective manner. In regard to advocacy, costing information can help CSOs make the case for why such services are cost-effective in overall epidemic responses.
- (e) ***Prepare for the future.*** More concentrated, serious steps should be taken now to **introduce and consider the use of social contracting-type approaches in lower-income countries** that do not yet face the challenges of transitions from external financing. Defining preliminary mechanism frameworks can make it much easier and quicker to finalize and put in place when needed. Additional time also allows for greater contemplation of options and revisions as needed.
- (f) ***Learn from what is already taking place.*** As indicated throughout the consultation, there are many places with operational forms of financial arrangements that might be considered social contracting. Comprehensive, systematic **analysis and monitoring** should be undertaken to provide detailed evidence as to how well they function and levels of satisfaction among both government and civil society contractual partners. What seems to be working? Why or why not? What is the impact of such mechanisms? Analysis of this sort should also seek to evaluate disease-response impacts, such as contracted interventions' impact on HIV incidence, prevalence, etc.

The learning referenced above echoes a frequent comment by consultation participants. **The sharing of country experiences was a highly popular part of the meeting, and it was referred to positively in many immediate post-consultation evaluation forms.** More extensive sharing could magnify the benefits, and both donors and domestic actors can play central roles in expediting. Opportunities for South-South learning exist, with stakeholders from Mexico among those able and willing to discuss their experiences with social contracting. In another region, Montenegrin government and civil society representatives have learned from Croatia and continue to learn through visits to Estonia, for example.

Representatives from both the government and civil society sectors indicated that they wanted to know more about similar arrangements, whether called social contracting or not, in additional countries and contexts. Many also signalled a desire for 'deeper dives' into the models discussed at the consultation and any other case studies that could be made available. Among other things, the additional detail and analysis might include (1) technical information from country-level implementers; (2) support options (e.g., tools and plans) from technical partners; and (3) candid assessments from in-country contracting partners as to successes and challenges.

This strong level of interest in the social contracting concept in general is a notable outcome of the consultation. It suggests that the opportunities and potential

benefits offered have wide appeal across a range of different contexts—although it is also evident that participants are not likely to commit to any sort of approach without careful, extensive consideration.

The additional, and deeper, sharing of experiences also includes two other relatively common requests, according to participants' observations during the consultation and in evaluation forms:

- Many stressed the need for more contributions in the future from sectors and multi-lateral institutions that either were not represented at the consultation. For example, **greater government input and engagement**—including by finance ministry officials—in discussions around social contracting was seen as essential, as was greater engagement by multi-lateral institutions.
- HIV dominated the discussion, even though the consultation was presented as being about financing for TB and malaria as well. Several participants called for more equal balance, with many also suggesting that the use of social contracting-type mechanisms for broader health areas also be a priority topic.

6.2 Commitments by consultation co-conveners to advance social contracting opportunities

After the meeting ended, representatives from each of the three consultation cosponsors outlined focus areas and (in some cases) specific activities at the centre of their institutions' follow-up work to support and expand social contracting models and opportunities. That input is listed below, in alphabetical order by institution.

Global Fund

Representatives from The Global Fund highlighted the following envisaged steps:

- Engage in dialogue with country stakeholders and partners about strategies to ensuring key and vulnerable populations have sustainable access to services. Public financing for CSO-led service delivery is one of the potential strategies to maintain and scale up effective interventions for key and vulnerable populations.
- Fund technical assistance to: a) conduct analysis of the context for public financing of CSO service delivery; b) support the design and implementation of mechanisms, including legal frameworks, tendering processes, M&E plans, etc.; c) document / collect best practices and lessons learned from different countries and regions; d) support costing of the services provided by CSOs; and e) support efforts to advocate for increasing public financing for key interventions currently funded by Global Fund and implemented by civil society organizations; etc.
- Support capacity building of governments and civil society organizations to develop adequate public financing mechanisms and to implement them effectively.
- Support and foster experience sharing and technical support among countries (i.e., South-South collaboration).

UNDP

UNDP's commitments for social contracting and opportunities for follow-up include the following:

- Continuing global, regional and country efforts for improving legal, policy and regulatory environments for the response to the three diseases
- Developing a case study compendium of good practices (with the Global Fund, also OSF, UNAIDS). (*pending available funding*)
- Exploring regional initiatives on social contracting, particularly in the Eastern Europe and Central Asia, Latin America and the Caribbean, and Asia-Pacific regions. Ensuring that Global Fund priority countries are considered in the process, as well as countries where the other partners have invested (e.g., OSF in Ukraine, Kyrgyzstan and the former Yugoslav Republic of Macedonia). Support to ongoing social contracting initiatives.
- Developing regional guidelines how to develop country factsheets and assess the opportunities for social contracting. (Global guidelines are not a viable solution due to the various legal and regulatory systems.) (*pending available funding*)
- Currently UNDP is the principal recipient for 35 Global Fund grants in 18 countries, several of which are in or nearing transition from Global Fund funding. UNDP is committed to developing national capacities and to leveraging this role through facilitation of South-South cooperation to share experience and tools/resources from these processes.

OSF

OSF's commitment to social contracting:

- OSF's focus on social contracting is part of its broader work on ensuring responsible transition from donor to domestic financing of HIV prevention programs for key population groups. OSF will continue to support civil society engagement in transition planning and oversight, including advocacy for development and implementation of social contracting mechanisms and making sure that sustainability plans developed by the state are explicit about key population needs, with a specific focus on harm reduction programming in such countries as Kyrgyzstan, Ukraine and the former Yugoslav Republic of Macedonia.
- OSF will also support piloting and documentation of elements required for successful transition to domestic financing of harm reduction in selected countries in Southeast Europe where Global Fund financing is ending.
- OSF will also continue to support civil society groups to advocate for allocation of resources at national and provincial level and making sure that governments are living up to their commitments to support the prevention and treatment needs of key populations by monitoring domestic spending and highlighting gaps between political commitments and actual allocations.

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- Finally, OSF will continue to play its role as a convener bringing together civil society groups, donors and governments to ensure that transition and sustainability stays on the agenda and providing space for exchange of advocacy strategies and knowledge sharing in this area.

Annex 1. Background Paper to the Consultation: Social Contracting Obstacles and Opportunities Highlighted

A background paper was prepared specifically for the consultation and distributed in advance to all participants. Many of the paper's research findings and observations were reflected in discussions, directly or indirectly. Based on the discussions and potential future actions suggested, the following information from the paper is expected to be particularly worthy of close consideration:

Some notable obstacles to social contracting include:

- The need to build trust between CSOs and government
- Non-existent or weak legal or policy framework to allow social contracting
- Regulatory systems (licensing, accreditation and permits) that could impede CSOs from delivering services, including under social contracts
- Fragmented data systems and reporting that make it difficult to demonstrate the effectiveness and value of CSO involvement

How have these challenges been addressed?

- Building the case for civil society involvement—e.g., a 2013 World Bank overview of community responses (15 studies including 11 evaluations carried out in 8 countries) set out in detail some of the evidence for positive outcomes from civil society involvement in HIV programmes.
- Development of handbooks on social contracting mechanisms—e.g., UNDP and the European Center for Not-for-Profit Law have produced a Handbook on Non-State Service Delivery Models for the Commonwealth of Independent States (CIS).
- Development of tools and guidance for assessing preparedness for domestically-funded social contracting—e.g., the Global Fund has been conducting national assessments to determine the readiness of countries to either take over or scale up social contracting in HIV, TB and malaria.
- Specific country analysis. For example:
 - a Global Fund tool, the Diagnostic Tool on Public Financing of CSOs for Health Service Delivery, has been piloted in Latin America and the Caribbean (Dominican Republic, Panama and Paraguay) and Namibia, and also used by HP+ in Guyana and Kyrgyzstan.
 - UNDP Europe and Central Asia Regional Office has produced lessons learned documents on domestic financing of HIV response in two countries (Croatia and Serbia); NGO social contracting country fact sheets in 10 other countries in the region; and two NGO social contracting case reports to date. These documents are available online at <http://www.eurasia.undp.org/content/rbec/en/home/ourwork/democratic-governance-and-peacebuilding/hiv-and-health/sustainable-financing-of-hiv-responses.html>.

Annex 2. Agenda

TIME	TOPIC
8:15–8:45	Registration and Breakfast
8:45–9:15	<p>Welcome and Opening Remarks The importance of sustaining community responses to HIV</p> <ul style="list-style-type: none"> • Welcome from Julia Greenberg, OSF, on behalf of co-conveners • Community representative: Raoul Fransen (Communities delegation) • Video presentation • Logistical announcements
9:15–9:50	<p>Session 1: State of Play: International Commitments to Scale up National Responses to AIDS, TB, and Malaria. Review of relevant commitments: Agenda 2030 and SDG3, GF Strategy, UNAIDS Strategy. The importance to leave no one behind</p> <p>Chair: Vivek Anand, HUMSAFAR Trust, India</p> <ul style="list-style-type: none"> • <i>Mandeep Dhaliwal</i>, UNDP • <i>Dr. Viorel Soltan</i>, Stop TB • <i>Nertila Tavanxhi</i>, UNAIDS • <i>Matt MacGregor</i>, Global Fund to Fight AIDS, TB and Malaria
9:50–10:10	Break
10:10–10:45	<p>Session 2: Overview of social contracting: What is it and how can it be used to scale up responses to the three diseases?</p> <p>Chair: Boyan Konstantinov, UNDP</p> <ul style="list-style-type: none"> • <i>Dave Burrows</i>, APMG Health: What is social contracting? • Respondents: <i>Vesna Lendic Kasalo</i>, Croatia and <i>Kunal Naik</i>, Mauritius
10:45–11:15	<p>Moderated Discussion</p> <p>Facilitators: Raminta Stuikyte/Melania Trejo</p>
11:15–11:45	<p>Session 3: Cases of successful support by government to civil society through social contracting. How was contracting initiated? How has it contributed to effective responses? What are the lessons learned?</p> <p>Chair: Carmen Gonzalez, Global Fund</p> <ul style="list-style-type: none"> • Ukraine: <i>Oleh Pruglo</i> and <i>Maxim Demchenko</i> • India: <i>Vivek Anand</i>
11:45–12:30	<p>Moderated Discussion</p> <p>Facilitators: Raminta Stuikyte/Melania Trejo</p> <p>Suggested Questions:</p> <ul style="list-style-type: none"> • What does success look like from government and CSO perspectives? • What can we take away to replicate in other geographies?
12:30–13:30	Lunch

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<p>13:30–14:10</p>	<p>Session 4: Barriers and challenges in developing mechanisms for government support of NGOs and community led services and how to overcome them</p> <p>Chair: Ron MacInnis, HP+</p> <ul style="list-style-type: none"> • <i>Batma Estebesova</i>, Kyrgyzstan: Obstacles and barriers to allocating funding to CSOs for service delivery • <i>Dr. Morris Edwards</i>, Guyana: Piloting social contracting in Guyana • <i>Dr. Ketevan Gogvadze</i>, Curatio: Challenges across the social contracting management system • <i>Ivan Varentsov</i>, Eurasian Harm Reduction Association: Autonomy and preserving space for CSO advocacy: good practices and common challenges
<p>14:10–15:00</p>	<p>Moderated Discussion</p> <p>Facilitators: Raminta Stuikyte/Melania Trejo</p> <p>Suggested Questions:</p> <ul style="list-style-type: none"> • How can permit/licensing systems be revised to allow CSO staff to take on more functions? • What new tasks are CSOs performing? What's on the horizon? What will be required to allow them to do these? • What political support is needed?
<p>15:00–15:20</p>	<p>Break</p>
<p>15:20–16:00</p>	<p>Session 5: Creating an enabling environment for social contracting: How to implement and support these efforts</p> <p>Chair: John Macauley, UNDP</p> <ul style="list-style-type: none"> • <i>Jocelyn Nieva</i>, ICNL: What is considered an enabling environment for social contracting? • <i>Vladan Golubovic</i>, Chair CCM Montenegro: Country experience in developing enabling environment for social contracting • <i>Giselle Scanlon</i>, Insalud, Dominican Republic: Nothing about us without us: civil society engagement in developing/protecting enabling policies for social contracting
<p>16:00–17:00</p>	<p>Moderated Discussion</p> <p>Facilitators: Raminta Stuikyte/Melania Trejo</p> <p>Suggested Questions:</p> <ul style="list-style-type: none"> • What is the best way to support countries to amend existing laws and policies or put new supportive ones in place? • What's the most effective way of continuously sharing information between countries on these issues including model policies, templates, etc.? • How do CSOs make the shift from external advocate to implementation partner – are there sample 'rules of engagement' or Memoranda of Understanding available? • What about in situations where CSOs have been leading (as PR for example)? What needs to happen for a smooth transition back to government leadership whilst preserving a role for CSOs?
<p>17:30–19:00</p>	<p>Cocktail Reception at OSF</p>

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8:15–8:45	Registration and Breakfast
8:45–9:15	Recap 1st Day Facilitators: Raminta Stuikyte/Melania Trejo
9:15–10:00	Session 6: Operationalizing social contracting Mechanisms: How is it done? Government and CSO perspectives: <i>Carmen Gonzalez</i> , Global Fund: Principles of effective social contracting <i>Vesna Lendic Kasalo</i> and <i>Dr. Iva Jovovic</i> : Social Contracting in Croatia: the mechanisms, how they were set up and how they operate Respondents: <i>Dr. Do Huu Thuy</i> , Vietnam and <i>Jaime Luna</i> , Panama
10:00–10:20	Break
10:20–11:00	Session 7: Operationalizing social contracting mechanisms: How is it done? (cont.) Government and CSO perspectives: <ul style="list-style-type: none"> • <i>Agustin Lopez</i> and <i>Carlos Leon de Garcia</i>: Social Contracting in Mexico: the mechanisms, how they were set up and how they operate • Respondents: <i>Nikola Antovic</i>, Montenegro and <i>Anara Eskhodzhaeva</i>, Kyrgyzstan
11:00–12:00	Moderated Discussion Facilitators: Raminta Stuikyte/Melania Trejo Questions: <ul style="list-style-type: none"> • What safeguards are needed for government and for CSOs in social contracting? • What role can results-based financing/performance-based contracting play in improving the accountability of CSO engagement?
12:00–13:00	Lunch
13:00–14:00	Session 8: From External to Domestic Support of HIV, TB and malaria Services: What might we gain and what might we lose? Facilitated discussion with civil society about the challenges related to future quality of services, ongoing civil society engagement, probable lack of support for advocacy, etc. Chair: <i>Julia Greenberg</i> , OSF Panellists: <i>Cindy Kelemi</i> , Botswana; <i>Kunal Naik</i> , Mauritius; <i>Jaime Luna</i> , Panama; <i>Simone Sills</i> , Guyana
14:00–15:00	Session 9: Next Steps: What is needed at international, regional and country level in order to scale up social contracting? What are stakeholder responsibilities? (civil society, government, donors, and partners) Facilitators: Raminta Stuikyte/Melania Trejo Small group discussion divided by regions
15:00–15:15	Break
15:15–16:00	Report back from small groups and discussion Facilitators: Raminta Stuikyte/Melania Trejo

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16:00–17:00	<p>Session 10. Next Steps: Commitments</p> <p>Representatives of donor and partner agencies will describe future plans for support for social contracting (5 mins each):</p> <ul style="list-style-type: none">• <i>Julia Greenberg</i>, OSF• <i>Boyan Konstantinov</i> and <i>Mark DiBiase</i>, UNDP• <i>Carmen Gonzalez</i>, Global Fund to Fight AIDS, TB and Malaria• <i>Nertila Tavanxhi</i>, UNAIDS• <i>Viorel Soltan</i>, Stop TB• <i>Serge Votyagov</i>, RCN• <i>Deborah Kaliel</i>, USAID <p>Moderated discussion. Questions:</p> <ul style="list-style-type: none">• What commitments can participants make?• Apart from the donors present at the meeting, who else can be approached for support? How can linkages be created with potential partners?
17:00–17:30	<p>Evaluation and Closure</p> <p>Facilitators: Raminta Stuikyte/Melania Trejo</p>

Annex 3. List of Participants

1	Mr.	Agustin Lopez	CENSIDA (Centro Nacional para la prevención y el control del VIH y el Sida) (Mexico)	Team Director
2	Ms.	Alysa Remtulla	STOPAIDS	Policy Officer
3	Ms.	Ana Filipovska	Global Fund Board	Board Member, EECA
4	Ms.	Anara Eskhodzhaeva	Social Development Unit of the Executive Office of the President (Kyrgyzstan)	Healthcare Expert
5	Mr.	Ashis Kumar Hoolass	Ministry of Social Integration and Economic Empowerment (Mauritius)	Permanent Secretary
6	Dr.	Aurelio Nuñez	National HIV, STI and Hepatitis Program (Panama)	Director
7	Ms.	Batma Estebesova	Sotsium (Kyrgyzstan)	Director
8	Mr.	Boyan Konstantinov	UNDP	Policy Specialist, Key Populations, LGBTI and Rights
9	Mr.	Carlos Garcia de Leon	Mexico	Civil society representative
10	Ms.	Carmen Gonzalez	Global Fund	Specialist on Sustainability and Transition, GF focal point on social contracting
11	Ms.	Celeste Silie de Castellanos	Centro Nacional de Fomento y Promocion de las Asociaciones sin Fines de Lucro (Dominican Republic)	Directora Ejecutiva
12	Ms.	Cindy Kelemi	BONELA (Botswana)	Executive Director
13	Ms.	Danielle Parsons	APMG Health	Managing Director
14	Mr.	Dave Burrows	APMG Health	Director
15	Ms.	Deborah KalieI	PEPFAR/USAID	Lead Technical Advisor, HIV/AIDS
16	Dr.	Do Huu Thuy	Administration on HIV/AIDS Prevention and Control (VAAC), Ministry of Health	Chief of Communication Department

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			(Vietnam)	
17	Mr.	Dong Do Dang	Vietnam Network of People Living with HIV and AIDS (VNP+)	Chairperson
18	Ms.	Dorothy Tlagae	PCI Botswana; Botswana CCM	Country Director; Vice Chair
19	Mr.	Edmund Settle	UNDP	Policy Advisor, UNDP Bangkok Regional Hub
20	Mr.	Elfatih Abdelraheem	UNDP	Team leader for UNDP HHD work in the Arab States
21	Mr.	George Sakvarelidze	Global Fund	Senior Fund Portfolio Manager, Eastern Europe and Central Asia Team
22	Ms.	Giselle Scanlon	INSALUD (Dominican Republic)	Director
23	Ms.	Haley Falkenberry	APMG Health	Consultant
24	Dr.	Iva Jovovic	LET (Croatia)	Director
25	Mr.	Ivan Varentsov	Eurasian Harm Reduction Association (EHRA)	Advisor
26	Ms.	Ivana Vujovic	Juventas (Montenegro)	Executive Director
27	Mr.	Jaime Luna	Grupo Génesis Panamá Positivo (Panama)	Executive Director
28	Mr.	Jeff Hoover	APMG Health	Consultant
29	Ms.	Jocelyn Nieva	International Center for Not-for-Profit Law (ICNL)	Senior Legal Advisor - Latin America and the Caribbean
30	Mr.	John Macauley	UNDP	Programme Specialist, UNDP Istanbul Regional Hub
31	Ms.	Julia Greenberg	Open Society Foundations (OSF)	Director, Governance & Financing
32	Ms.	Julieth Karirao	Ministry of Health and Social Services (Namibia)	Chief Health Program Administrator
33	Ms.	Karin Santi	UNDP	Team Leader, HIV, Health and Development Group (UNDP Regional Service Center, Panama)

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34	Dr.	Ketevan Gogvadze	Curatio International Foundation	Business Development Unit Director
35	Mr.	Kunal Naik	Mauritius Country Coordinating Mechanism	Chair
36	Ms.	Mamka Anyona	Open Society Foundations (OSF)	Program Specialist
37	Dr.	Mandeep Dhaliwal	UNDP	Director: HIV, Health & Development Group
38	Mr.	Mark DiBiase	UNDP	Policy Specialist
39	Mr.	Matthew MacGregor	Global Fund	Senior Project Lead, Sustainability, Transition, and Co-Financing
40	Mr.	Maxim Demchenko	Light of Hope (Ukraine)	Executive Director
41	Ms.	Melania Trejo		Consultant
42	Mr.	Michael Chaitkin	Results for Development	Senior Program Officer
43	Dr.	Morris Edwards	Health Sector Development Unit, Ministry of Public Health (Guyana)	Executive Director
44	Mr.	Mykola Povoroznyk	Kyiv City Administration (Ukraine)	Deputy Head
45	Ms.	Nertila Tavanxhi	UNAIDS	Technical Advisor, Health Economics
46	Ms.	Nikola Antovic	Ministry of Health (Montenegro)	Secretary
47	Mr.	Oleh Pruglo	Poltava (Ukraine)	Deputy Governor
48	Ms.	Raminta Stuikyte	Office of the UN Special Envoy for AIDS In EECA	
49	Mr.	Raoul Fransen-dos Santos	Communities Delegation to the Global Fund Board	Administrative Working Group Member
50	Mr.	Ronald MacInnis	Health Policy Plus (HP+)	Senior Technical Advisor
51	Mr.	Sandie Tjaronda	NANASO (Namibia)	Executive Director
52	Mr.	Sergey Votyagov	Robert Carr Networks Fund (RCNF)	Director
53	Ms.	Simone Sills	Guyana Global Fund CCM	Civil Society Representative

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54	Ms.	Vesna Lendic Kasalo	Office for Cooperation with NGOs of the Government of Croatia	Head
55	Dr.	Viorel Soltan	Stop TB Partnership	Team Leader, Country and Community Support for Impact
56	Mr.	Vitaliy Karanda	Public Health Center (Ukraine)	Head of Department for Projects Management and International Cooperation
57	Mr.	Vivek Anand	Humsafar Trust (India)	Director
58	Mr.	Vladan Golubovic	CCM Secretariat, Montenegro	Secretary General