



*A community of practice of Director Generals of National AIDS  
Coordinating Authorities of Africa, Asia and Latin America*

# **LEVERAGING COUNTRY LEADERSHIP TO ADVANCE RESILIENCE FOR A SUSTAINABLE HIV RESPONSE PRE AND POST 2030**

**A Country Transition Readiness Report, of the HIV Leadership Forum, May  
2025**

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## EXECUTIVE SUMMARY

Following the abrupt halt of U.S. government HIV funding in January 2025, the HIV Leadership Forum—comprising Director Generals of 40 national AIDS commissions—conducted a rapid transition readiness survey across its membership of 38 countries to gauge service continuity, systems resilience and available transition assets. Eighteen countries from Africa and Latin America responded by mid-April, providing data on service delivery; data, laboratory and supply-chain systems; workforce; and prevention, via a 46-indicator Microsoft Forms assessment, analyzed descriptively in Excel. This report outlines the status of transition readiness in countries, identifies country actions and priorities for the medium and long-term.

### Transition Readiness Status

**HIV service continuity:** All countries reported that public health services that were offered through government facilities and health workers remained operational. Governments adapted rapidly and issued service-continuity directives within weeks. ART clients were re-directed to outpatient services and HIV clinics were repurposed to provide additional services such as becoming chronic care management units. Thus, all 100% countries continued offering ARVs to persons living with HIV, albeit with operational challenges. Prevention of mother-to-child transmission (PMTCT) remained functional in 83% countries.

Seventy-five percent (75%) of reporting countries indicated that NGO and community sites were non-functional and operations were full disrupted. In particular, 90% countries in sub-Saharan Africa indicated full disruption of adolescent-girls-and-young-women and key-population prevention programs.

**Systems:** All countries reported data interruptions in different functions: health reporting; data for supply chain decision making; patient data and facility level electronic medical records and national reporting mechanisms. In extreme cases, this meant that in some cases ART client transfers occasionally occurred without prior medical records. Laboratory networks faced similar vulnerabilities with closure of laboratory platforms, diagnostics reporting systems. The highest disruptions were cited in systems that relied on NGO-managed servers, licenses, or subscriptions. Countries with partial control over procurement, logistics, and data systems experienced milder disruptions.

**Commodities:** While 65% of countries had nine-month ARV and testing commodity stocks, half held fewer than six months of prevention-specific ARVs or condoms. All countries experienced Supply chain function (forecasting, procurement, tracking, warehousing, in-country distribution and overall management) disruptions, and these were different based on the level of reliance on PEPFAR supported mechanisms for any function. Eight (8) countries indicated internal commodity distribution breakdowns that had not been fully resolved by May 2025. **IMPORTANTLY, these reported commodity stocks are residual from pre-January shipments,** thus, urgent domestic investments are needed and may include global fund reprogramming negotiations to streamline the functionality of supply chain and initiate procurements.

**Human Resources:** Donor-funded staff losses totaled 123,668 across 12 countries only, including 55% frontline clinical workers (nurses, doctors, lab staff) and 44,502 community volunteers. The loss of large numbers of frontline health workers- nurses, doctors, clinical officers and community health

workers - will stretch the capacity of general health care provision with increased workloads for remaining staff, longer wait-times for all patients seeking care and reduced quality of care. 56,416 personnel, comprising technical, administrative, and logistics staff from local NGOs and CBOs exited health sector. As countries grapple with staffing shortages, limited visibility and access on these staff hindered rapid retention efforts. The impact on programme quality and lost contributions to domestic tax revenues and local economies remains unquantified.

**Governance:** Government leaders and institutions ranging from Presidencies, Parliaments, Ministries of finance were sensitized and domestic funding initiated. While the political momentum to safeguard HIV treatment has been retained, HIV prevention continues to be neglected in prioritization and budgeting plans.

### **Country assets and opportunities**

In the position paper on *Leveraging Country Leadership for Advancing Resilience and a Sustainable HIV Response Pre- and Post-2030*, the Forum proposed an evolved design and HIV delivery architecture that would progressively create coherence across programmes and support systems. This proposal remains valid. **DGs note that in addition to 'knowing your epidemic' countries must now invest in 'knowing your response'.**

While **integration** is happening organically in response to service needs, the definitions and practice differ in-country and globally. Structured integration frameworks that also include system level enablers and weave essential elements of the HIV response into health, social and financial systems operations of countries are urgent. Integration is not '*adding HIV to overburdened clinics*'.

HIV prevention and treatment service packages and commodities ought to be costed within insurance and Universal Health Coverage (UHC) schemes for sustained resourcing and financial cushioning.

Networks of people living with HIV (PLHIV) and communities' expertise can be applied in national health or social services infrastructure to strengthen task-shifting, enhance differentiated care in broader chronic disease management and bridge HR gaps. Robust trust-building dialogues between communities and government are important.

Private and faith facilities (outpatient clinics, nursing homes, local hospitals and pharmacies) present underutilized options as HIV prevention platforms, including delivery of condoms or new PrEP products. They can also implement co-pay models to relieve stretched public sector facilities and bolster supply chain resilience with their additional and diversified distribution channels.

HIV has been elevated back into national political agendas offering space to translate this attention into enduring policy prioritization and financing commitments.

There is scope for new models of HIV leadership and response that are government-led, country-managed, cost-effective and sustainable. In particular, HIV prevention needs to be re-imagined and rebuilt on multi-sector platforms; and coordination frameworks that enforce donor harmonization and alignment with national systems are essential.

## Country priorities and recommendations

Strategic ecosystem audits are imminent in countries to identify critical gaps and urgent challenges in supply chains, data ecosystems, laboratory networks, cross-sector and community delivery platforms in order to resolve operational bottlenecks in rebuilding the response. DGs also identified:

### HIV prevention:

- (i) Rebuilding the country HIV primary prevention: service delivery, data and supply chain systems; national condoms programmes; sustainable long-acting prevention technologies
- (ii) Promote access to options and choices leveraging private, digital tools and technologies
- (iii) Refine the HIV prevention message and equip national champions with tools to make the investment case

### Safeguarding the HIV Response

- (i) Know your epidemic: to include sub-national analysis of HIV, comorbidities and syndemics
- (ii) Know your response: programme decision-making guided by configuration of optimal interventions based on national needs, sub-epidemics, existing systems, and available resources; know the actual *price tag of services* in the new models
- (iii) Define localized integration frameworks
- (iv) Rebuilding community programs in partnership with PLHIV networks and social contracting

### Political Capital Mobilization

- (i) Implement donor alignment and coordination frameworks
- (ii) Deploying strategic advocacy for domestic and global HIV response resourcing

### Key HLF Secretariat support functions will include:

- (i) **Galvanize political momentum and rebuild HIV prevention:** Establish a *HIV Prevention Thought Leadership Group* to guide countries and the global community; *Coordinate with the Global HIV Prevention Coalition* to enhance HIV prevention visibility
- (ii) **Strengthen ‘Know your Epidemic, Know your Response’** in countries: Support ecosystem audits, design, prioritization and costing of integrated, multisector and community responses; promote *knowledge exchange* and showcasing country leadership and adaptation
- (iii) Advocate for **domestic and global HIV response resourcing**, including support for Global Fund replenishment

## An important observation

Decades of billions of dollar investments in HIV systems fractured instantaneously. In their position paper ‘*Leveraging Country Leadership for Advancing Resilience and a Sustainable HIV Response Pre- and Post-2030*’, Director Generals—drawing on their contextual understanding of national realities, epidemic dynamics, and institutional systems—collectively identified the HIV delivery ecosystem as the primary vulnerability to long-term sustainability. This assessment has since proven accurate, underscoring the importance of leveraging country knowledge and expertise in redesigning future health responses. The emerging HIV response must be rooted in country infrastructure and informed by the institutional, technical, and political systems.

## BACKGROUND

The advances made in the HIV response including increased life expectancy and higher quality of life for people living with HIV and reduced mother-to-child transmission are unprecedented global public health success. Key programmatic achievements have included: 29.8 million persons living with HIV being treated, attaining 71% viral load suppressions levels globally. There were over a third (38%) fewer new HIV infections in 2022 than in 2010. This progress was made possible by a focused approach that was characterized by dedicated systems for data management, human resources, diagnostics, surveillance, and supply chains.

Despite remarkable progress in the global HIV response over the past two decades, it was always known that country-led programs were essential to sustain gains made. For two decades, development partners introduced various frameworks—including guidance documents, indices, efficiency studies, transition policies, and co-financing requirements, emphasizing country ownership and domestic financing. However, the HIV delivery model remained parallel to government systems with high overhead costs and sustainability remained an elusive goal.

In 2024, *Directors General from National AIDS Commissions across Africa, Asia, and Latin America, organized as the HIV Leadership Forum (“the Forum”)* recognized that the HIV response was at a critical juncture. They determined the need to complement UNAIDS sustainability roadmap efforts with guidance informed by country realities and experience in the HIV response. The Forum conducted a structured strengths, opportunities, weaknesses and threats (SWOT) framework, triangulated peer-reviewed evidence, policy and programme data, and administrative data country experience to draft and iteratively refine a consensus position paper on HIV-response sustainability.

The highest vulnerability to sustainability was identified as the *globally driven HIV response design and funding architecture that was incompatible with government systems and services*. The vertical systems and off-budget financing had led to fragmented treatment and prevention programs in an ecosystem with multiple partners and diverse, overlapping and parallel data tools, electronic medical records, reporting and surveillance systems, diagnostic platforms, and supply chains that operated independently of the public health infrastructure. These findings and proposed solutions were articulated in a position paper of the Forum titled, ‘*Leveraging Country Leadership to Advance Resilience for a Sustainable HIV response pre and post 2030*’.

The highest vulnerability to sustainability was identified as the ***globally driven HIV response design and funding architecture that was incompatible with government systems and services***. The vertical structure and off-budget financing had led to fragmented treatment and prevention programs in an ecosystem with multiple partners and diverse, overlapping and parallel data tools, electronic medical records, reporting and surveillance systems, diagnostic platforms, and supply chains that operated independently of the public health infrastructure.

Additional critical threats to sustainability were identified as:

- (i) An *absence of unified vision* and understanding of "sustainability" among global health actors and within countries.
- (ii) *One-size-fits-all approach* that ignored the unique macroeconomic, political, legal, and social contexts influencing each country's public policy and health investments.

- (iii) *Narrow focus of epidemic analyses* that relied exclusively on HIV metrics only while failing to account for critical intersecting factors of other chronic diseases, shifting demographics and social determinants such as gender-based violence, substance use, educational attainment.
- (iv) *Neglect of primary prevention* that risked reversing progress in epidemic control.
- (v) Limited investments towards *resilience of local communities* with the roles and resources of communities un-defined in the future model.
- (vi) *Weak transition management arrangements* with limited investments made to advancing sustainability plans into execution, coupled with a lack of shared (between government and donors) accountability frameworks to track transition performance.

These findings and proposed solutions were articulated in a position paper of the Forum titled, ***'Leveraging Country Leadership to Advance Resilience for a Sustainable HIV response pre and post 2030'***.

### **January 2025**

In January 2025, the US Government issued a '90-day Stop Work Order' and various Presidential Executive Orders that had an impact on country HIV responses. On 30th January 2025, the Forum met and deliberated on the implications of the USG Policy Directives on the HIV response. They observed the following:

- (i) An urgency to pivot from long-term sustainability planning to immediate transition readiness and accelerated execution.
- (ii) A pressing need to understand the implications of emerging USG policy directives for the HIV and broader health response, at the time and post the 90-day stop-work-order
- (iii) A recognition that bilateral relations between countries and the US Government would continue and therefore DGs must take leadership to ensure HIV remains a priority in the bilateral discussions.

Subsequently DGs directed the Forum Secretariat to facilitate a rapid situational transition readiness assessment to support countries assess their transition readiness, challenges and priorities, as well as document assets available to mitigate country challenges. The transition readiness report would provide evidence for collective decision-making, regional coordination, and targeted advocacy.

### **Country transition readiness assessment methodology**

The design of the transition readiness assessment survey was informed by the HIV Leadership Forums position paper ***'Leveraging Country Leadership to Advance Resilience for a Sustainable HIV response pre and post 2030'***. It was designed for self-administration by technical officers within countries capturing information based on country realities at that point-in-time and was organized into three sections:

- (i) The first aimed to investigate the state of the response in the areas of HIV service delivery continuity covering government and non-government programmes; HIV response support systems- data, supply chains, laboratory diagnostics; human resources and prevention.
- (ii) The second identified assets and opportunities for country leverage in responding to transition priorities and mitigate the challenges

- (iii) The third was to uncover countries' most pressing needs and the strategic interventions necessary to safeguard and build upon the gains made in the HIV response, both during and beyond the transition period.

In addition to capturing cross-sectional data on the state of the response, it sought to elucidate the most pressing short- and medium-term vulnerabilities. Microsoft forms were used to develop a tool that comprised 46 closed-ended indicators which used a 3 or 4 level scoring rubric recorded directly in the form. Space was provided for narrative explanation and information. The Forum's sustainability thought leadership group reviewed and pilot-tested the draft, leading to clarifications and adjustments.

The form was sent to 38 countries. Countries from Asia Pacific indicated that their PEPFAR transition had happened years before and therefore the assessment was not relevant to them. Eighteen (18) countries responded, attaining a response rate of 56% (excluding 6 Asia Pacific members) by the end of March 2025. The data were returned via a secure SharePoint site. Simple domain means and medians were calculated. Clarification was sought as required from participating countries throughout the month of April. They received country specific feedback and proposed recommendations discussed. On May 6<sup>th</sup> 2025, the full Forum met again to deliberate the report and Director Generals provided further input. This report presents a summary of findings from 19 participating countries—15 from Africa, 3 from Latin America and 1 from Eastern Europe and captures the input of Director Generals in the period February to April 2025.

### **Responding Countries**

- |                                 |                  |
|---------------------------------|------------------|
| 1. Angola                       | 10. Mexico       |
| 2. Botswana                     | 11. Nigeria      |
| 3. Brazil                       | 12. Rwanda       |
| 4. Colombia                     | 13. Senegal      |
| 5. Democratic Republic of Congo | 14. South Africa |
| 6. Ghana                        | 15. Uganda       |
| 7. Kenya                        | 16. Ukraine      |
| 8. Lesotho                      | 17. Zambia       |
| 9. Malawi                       | 18. Zimbabwe     |

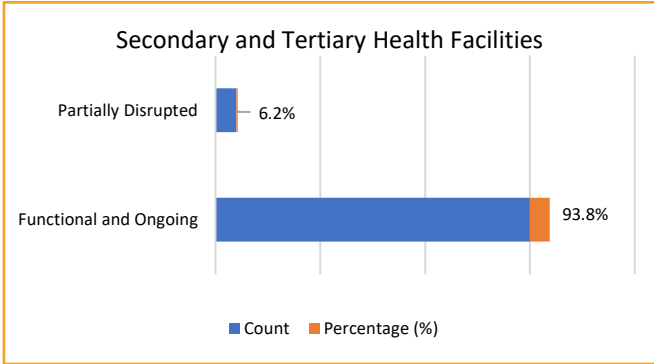
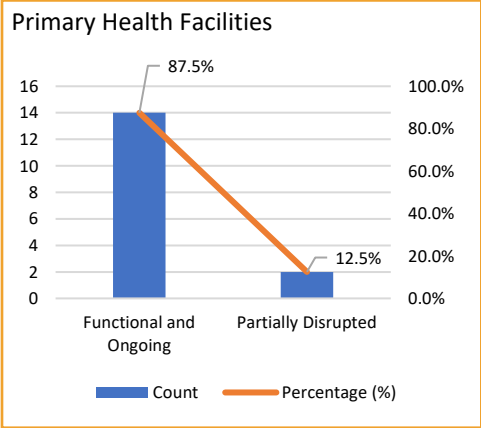
# TRANSITION READINESS STATUS OF COUNTRIES' HIV RESPONSE

As countries respond to the disruptions triggered by the stop-work order on US-funded HIV programs, the transition readiness assessment provides a clear snapshot of the current status of HIV responses across 16 countries in Africa and Latin America. This chapter unpacks the data from multiple pillars of the HIV ecosystem—revealing the fault lines in donor-dependent systems, the resilience of government-integrated platforms, and the emerging gaps that threaten continuity of care.

## HIV services continuity

### Service delivery sites

Public primary, secondary and tertiary health facilities that are managed by government remained operational. ART clinics that were co-located within government facilities, but not integrated or leveraging government health workers, electronic medical records, or pharmacies were immediately shut down and no longer functional.



Conversely, 75 % of NGO-run and community sites experienced varying levels of disruptions, ceasing various adolescent-girls-and-young-women and key population prevention activities in 90% of countries.

### HIV programmes

Governments issued service-continuity directives, re-directed all ART care clients to the operational government facilities and rapidly integrated antiretroviral care into outpatient departments. Where feasible, co-located HIV clinics and were re-purposed, some for chronic care. At the time of reporting 100% countries reported zero disruptions in issuance of ART services.

PMTCT remained the most resilient ancillary service and with zero reports of full disruption. All countries surveyed maintained the provision of antiretroviral therapy for both pregnant women and their infants, antenatal HIV testing, single-dose nevirapine (sdNVP) distribution, and early infant diagnosis (EID), with no more than 2 countries reporting partial disruption in any one service. However,

5 countries reported partial disruption in ANC viral load testing and this was attributed to staffing shortages.

VMMC programs, largely operated through NGO service points were shut down and 50% of the countries reported that the functional services were those offered through government facilities, but indicated that these were not an immediate priority.

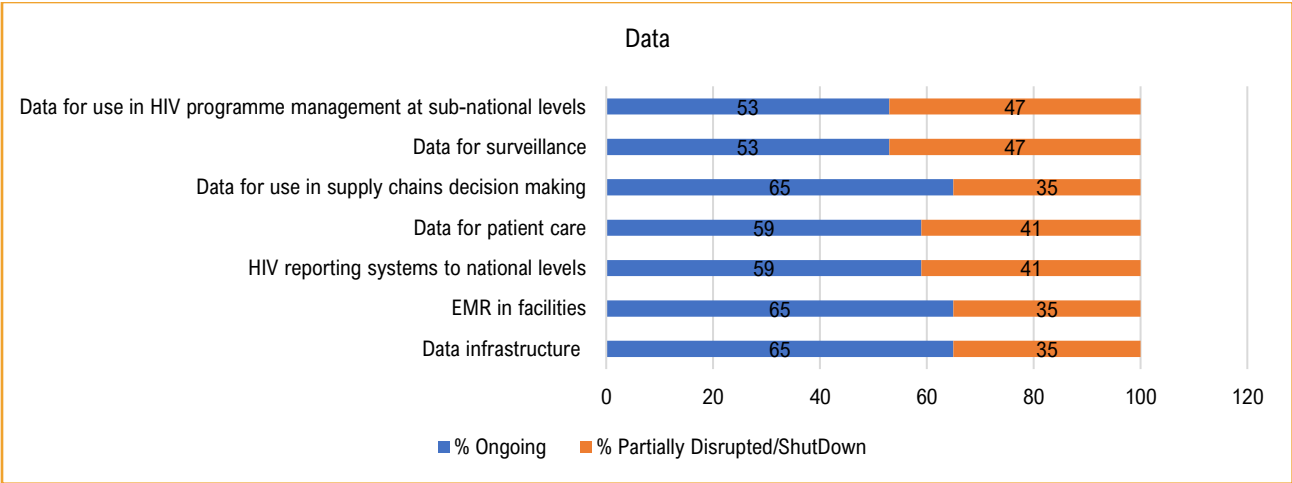
Continuity of HIV prevention programmes was premised on their delivery model. HIV testing services, including for adolescent girls and young women (AGYW) or key populations were identified as functional due to their availability within government facilities or the private sector. PrEP and PEP dispensing in facility pharmacies was reported as on-going in 33% and 67% of the countries respectively. However, all countries from the Africa region indicated that HIV prevention services especially needle and syringe programs and opioid substitution therapy (OST) of which majority were delivered through NGOs ceased. Countries in Latin America demonstrated greater resilience due to pre-existing integration of KP-focused services into public health systems.

**The HIV delivery ecosystem**

**Data systems**

Varying degrees and types of data system disruptions were recorded in all countries. 59% of countries reported that electronic medical records (EMR) were partially functional, and half reported that patient-level data and data infrastructure was not inaccessible. As patient data from NGO supported systems were initially rendered inaccessible, it forced transfers of ART clients without their medical records.

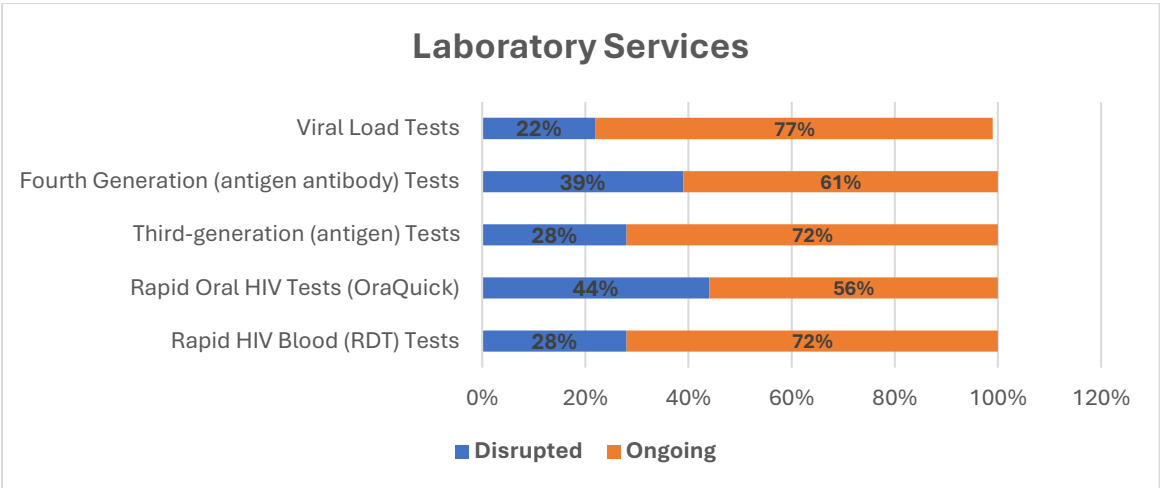
All African countries experienced different types of disruptions in planning and decision-making capacities for programme, surveillance and supply chain management as a result of non-functionality or inaccessibility of at least one of the key data systems. Qualitative reports indicated that data disruptions were most acute in high-burden subnational regions, where data platforms were heavily reliant on NGO managed infrastructure-servers, licenses, or subscriptions.



The most striking disruption relates to the collapse of HIV prevention data systems. As at the time of writing this report, few countries have any prevention data available. Those that had PEP or PrEP captured in national reporting systems note that this data may be available, only if offered within government facilities.

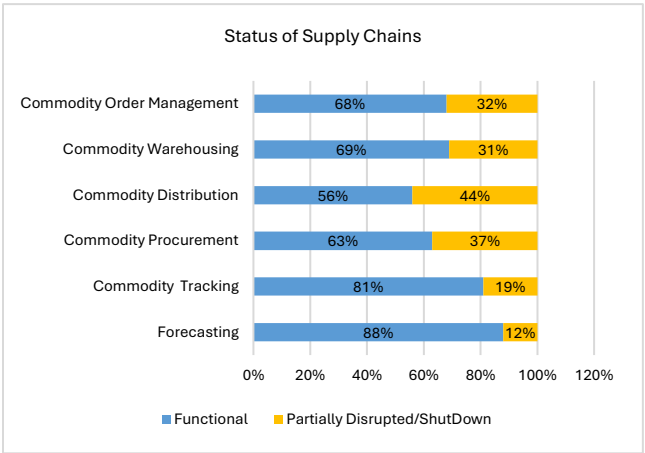
**Laboratory Services**

Averagely, 64% countries continued basic HIV testing as delivered within government run and managed facilities. 39% countries reported disruptions in 4<sup>th</sup> generation anti-gen tests, 22% in viral load testing and in rapid test kits testing. Highest resilience was observed in viral load and rapid HIV blood tests (only one country reported full disruption) and this may be attributable to its use of private sector platforms. In the 75% countries where national laboratory systems were reported as functional and supporting critical HIV testing, the sudden withdrawal of technical support and human resources had disrupted services.



**Supply Chain Systems**

The supply chain status of Africa and Latin America differed. 67% African countries reported functional supply chain systems, though various functions had been disrupted. Levels of functionality of supply chain elements differed depending on their reliance on NGOs for management. 44% countries reported in-country commodity distribution disruption with one country having lost visibility of its supply chain. F & Q and order management and warehousing experienced least disruptions. LAC countries supply chains remained resilient.



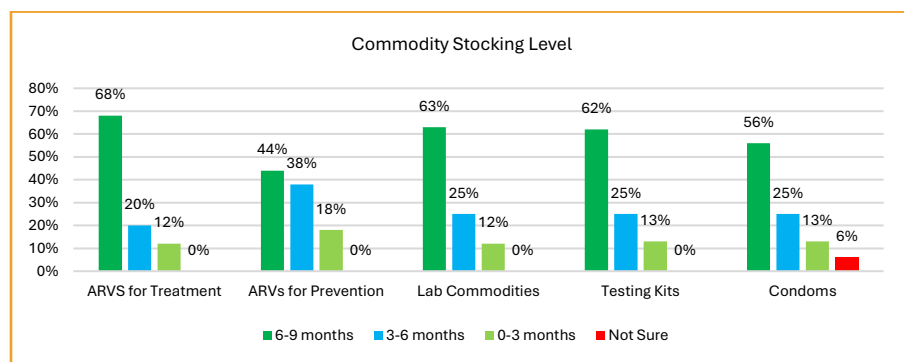
100% countries reported established medical supplies agencies. However, in 13% countries, these agencies do not manage HIV commodities, and it was observed that these countries experienced the disruptions across most of the supply chain functions. Further, no country national agency managed

all the functions of the HIV supply chain including: forecasting and quantification, procurement, order management, tracking, warehousing and in-country distribution. Varied aspects were managed through donor mechanisms, either pooled at global level or outsourced to international NGOs.

### Commodity security

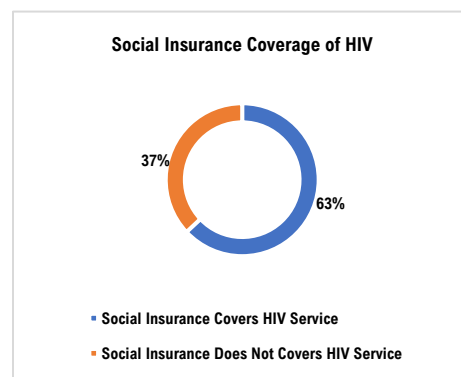
68% countries reported up to a 9-month forecast for antiretrovirals for treatment, testing and laboratory commodities. Half of the countries had <6 months of antiretrovirals for prevention or condoms and 25% countries did not have visibility of their condoms stock levels. 8 countries reported initial internal distribution failures and while Governments took action to address them, some were still unresolved by May 2025.

The HLF Secretariat sought to understand country supply chains during data clarification exercise. Countries reported that their procurement and supply pipelines comprised of an inter-connected tripartite partnership of Government, PEPFAR and the Global Fund. With the withdrawal of PEPFAR, the impact on the functionality of the system was unclear in most countries and needed auditing to resolve emerging challenges. It was observed from the data that countries whose HIV procurement and supply chain relied on national systems reported less disruption.



### Country social insurance and universal health care schemes:

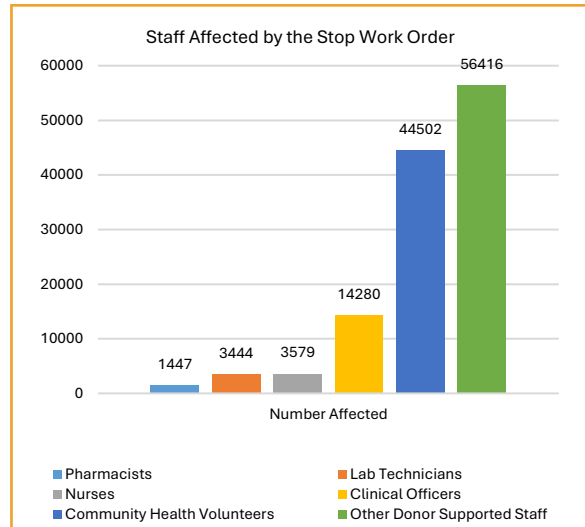
All countries indicated the existence of (100%) national social health insurance schemes. However, while 63% currently include HIV services and commodities within these benefit packages, qualitative reports noted that these services and commodities were traditionally not funded within these schemes as they were funded off-budget.



## Human Resources

12 countries in SSA indicated an attrition of 123,668 donor funded HRH, while 5 did not have the data.

Almost 55% (67,252) were frontline health workers (nurses-3,579, clinical officers- 14,280, pharmacists-1,447, lab techs- 3,444). 44,502 community health workers such as out-reach workers, mentor mothers, treatment adherence support staff became instantaneously unavailable for service continuity. 56,416 personnel, comprising technical, administrative, and logistics staff from local NGOs and CBOs exited health service functions. Countries identified both contractual and financial challenges to retaining this donor-funded HIV workforce as the numbers, terms and conditions were locked with NGOs.



## Sustainability Roadmaps

The assessment found that 75% of participating countries had developed HIV sustainability roadmaps prior to the current crisis with support from international partners like UNAIDS. These documents were intended to guide gradual transitions toward greater domestic ownership and financing of HIV programs. However, countries reported varied utility following the abrupt funding withdrawal with 50% revealing strengths in pre-identified milestones that enabled rapid decision-making. For instance, Namibia credited its roadmap for preventing ART interruptions during the critical first months

However, another half of those with roadmaps noted their limitations due to their long-term planning design and long-term goals on clinical cascades and systems integration, they contained no provision for rapid systems migration during crisis and thus presented limited utility.

## Country actions to safeguard the HIV response

Across the 17 reporting countries, governments demonstrated rapid adaptation and leadership in response to funding transitions. Ministries of Health and National AIDS Commissions (NACs) convened emergency coordination meetings, issued policy directives, and pivoted toward a more sustainable HIV response model.

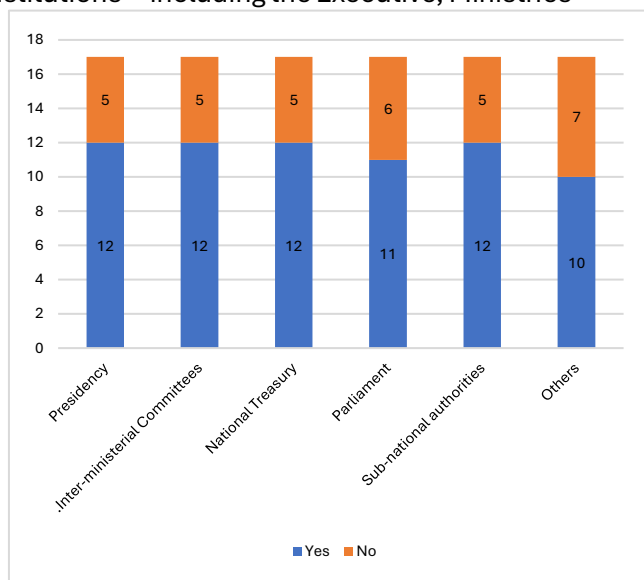
### Political capital mobilization

National AIDS Commissions engaged key government institutions—including the Executive, Ministries of Health, Finance, Parliaments and Foreign Affairs—to address the implications of funding transitions. They developed policy advisories, high-level briefings, and facilitated interagency meetings to safeguard program gains, enhance political capital, and mobilize domestic resources.

Governments adapted by issuing national circulars and memos aimed at providing continuity of care. They re-directed persons living the HIV to ART clinics in facilities. They implemented administrative reassignments to backstop the human resource shortage. They adopted task-shifting strategies innovative approaches to maintain supply chains.

These efforts were informed by an understanding of respective national decision-making systems and power structures, yielding varied outcomes:

- **Angola:** The NAC’s swift engagement with the presidency led to the establishment of a high-level, multi-sectoral commission chaired by the Vice President to oversee the transition of previously donor-funded health programs. Supplementary budgets have since been secured to plug in to the funding gaps, prioritizing testing, treatment and laboratory commodities.
- **Uganda:** The NAC developed a strategic policy brief for decision-makers, outlining immediate funding needs and recommending reforms for better HIV integration into public systems. This was presented to the presidency and execution of these proposals has been initiated. Clients from NGO run facilities have also been redirected to public facilities.
- **Kenya:** Parliament convened special sessions to review HIV financing options, resulting in temporary budget reallocations to maintain essential services. Public statements from Kenya’s NSDCC served to reinforce public trust during uncertainty, especially among persons living with HIV.
- **Ghana:** The President directed the Minister of Finance to assess HIV funding gaps and implement fiscal mitigation strategies, elevating HIV from a sectoral issue to a national budgetary priority. The ministry of health and the Ghana AIDS Commission (GAC) are leading transition efforts to address



inventory management, reporting, and distribution challenges for ARVs and laboratory commodities.

- **Zambia:** Reorganized its laboratory network by remapping sample courier routes, recruiting lab personnel, and redeploying staff to restore PCR and viral load testing. The government also prioritized migrating data from donor-controlled platforms to national systems and securing funding for data systems licenses. Governments initiated action to integrate HIV services within primary healthcare and capacity building community health workers and task-shifted staff at public facilities to fill in gaps created by exit of NGO supported staff
- **Botswana:** Began absorbing portions of HIV services costs and redirection of clients to public facilities, signaling a shift from external dependence to domestic accountability. The Ministry of Health is working with a Joint Oversight Committee to ensure continuity of services through targeted funding to NGOs providing HIV services.
- **Nigeria:** Conducted audits of donor-supported health workers, mapping roles, locations, and funding structures to explore regularization and retention strategies. A Ministerial Task Team has proposed state-level interventions, including task-shifting government staff to address human resource gaps.

Government and communities collaborated to sustain services:

- **Malawi:** Local NGOs adapted outreach strategies, repurposing grants to maintain HIV testing, PrEP delivery, and peer support. The government has issued press releases assuring the public that HIV services will continue uninterrupted. A country-level task team – including representatives from people living with HIV and key population networks - convened to assess the impact on service delivery and identify immediate and long-term mitigation actions including developing a plan for HIV commodities warehousing and distribution to transition from the current service provider to the Central Medical Stores Trust.
- **Zambia:** Partnered with Centre for Infectious Disease Research in Zambia (CIDRZ) to operationalize the CIDRZ Life App to track ARV and diagnostic availability, reactivating real-time stock monitoring systems. The Ministry of Health has also allocated funds for renewal of licenses for data systems and training of local human resources, towards institutionalizing domestic data governance.
- **Latin America and the Caribbean:** Governments preserved services for key populations through their social contracting mechanisms, reinforcing the need to invest in community structures as frontline delivery agents. In Colombia, government has engaged temporarily engaged two NGOs to facilitate continuity of HIV services for irregular migrants pending full integration of the services under public health facilities.

## **Implications of these findings**

Despite decades and billions in investments in resilience and sustainability, HIV systems built in parallel to public systems fractured instantaneously. Data for planning, patient management, commodity security and decision making became inaccessible. Community-based HIV prevention and support functions collapsed.

During the May 5<sup>th</sup> feedback meeting, DGs noted the effect of the US Government policies across health systems beyond HIV. US government investments in-country included TB, Malaria, family planning and all with multiple implementing partners, data ecosystems, laboratory platforms and supply chains. The funds invested in these different programmes differed by amounts and mechanisms in each country. Malawi's MNCH investments from USAID surpassed HIV services, and thus the country priority is a comprehensive health sector review. These systems were also disrupted simultaneously and the implications for the health system and countries are not yet quantified.

### **HIV delivery services and systems**

The abrupt withdrawal of funding exposed critical vulnerabilities in HIV service delivery, particularly in systems that operated in parallel to national health infrastructures. Countries reported that services integrated into government platforms—such as ART and PMTCT—demonstrated greater resilience, experiencing fewer disruptions compared to vertically funded programs. This suggests that deeper integration with public health systems provides a buffer against external shocks.

While Governments demonstrated rapid adaptive capacity, the sudden influx of ART patients into public facilities is straining already overburdened systems, raising concerns about long-term care quality. Many public clinics now face concurrent disruptions in data systems, laboratory networks, and supply chains, further complicating service continuity. Notably, private-sector-funded initiatives, such as oral HIV testing, remained relatively stable, highlighting the potential for diversified financing models.

A critical challenge emerged with the loss of access to NGO-managed data systems, including electronic medical records (EMRs), laboratory information systems (LIS), and prevention databases—many of which operated in public facilities alongside national systems. The inability to retrieve patient histories occasioned patient transfers without medical records in facilities and this poses a significant barrier to effective HIV management, given the longitudinal nature of treatment. Additionally, the loss of survey and surveillance data such as bio-behavioral studies, stigma indices, and AIDS impact evaluations, as well as future unavailability of biomarker samples and data collected from these surveys amounts to losses of these investments and will impair short and long-term strategic planning, denying countries an available evidence base needed to guide interventions.

### **Health workforce and human resources**

The attrition of approximately 125,000 health workers from only 12 countries points to an under-examined area of the impact of relying on parallel funded workforce. In the case of PEPFAR funded health workforce the impact of this significant human resource attrition is unclear in the short and long-term.

The loss of large numbers of frontline health workers- nurses, doctors, clinical officers and community health workers - will stretch the capacity of general health care provision with increased workloads for remaining staff, longer wait-times for all patients seeking care and reduced quality of care. The likely outcome is disruptions in the HIV clinical cascades and viral load suppression rates, thus clawing back gains made. Countries reported that while these staff were recruited as HIV workforce and worked in parallel programmes, those within working in ART clinics that were co-located to health facilities were often called up to supplemented government funded health providers. In particular, laboratory, data and pharmacy staff were integral to the functioning of health facilities, as their functions supported routine services. For instance, the laboratories would provide diagnostic services for HIV, TB and malaria testing, COVID diagnosis and support PCR testing requests for general health care. .

In only 12 countries, more than 56,000 administrative, technical, and logistics staff—mostly from NGOs and CBOs—were released from service. While not all were directly involved in patient care and other frontline services, their roles in supply chain management, data coordination, surveillance and program quality assurance were critical to the HIV operational ecosystem and health sector. Additionally, the economic ripple effects of this mass attrition remain unquantified, including lost contributions to domestic tax revenues and local economies.

As countries grapple with staffing shortages, their ability to develop legal pathways to retaining these trained and experienced personnel is hampered because they had limited visibility and access to data relating to their employment- numbers, contractual terms, training.

## **Community Systems**

Community-led HIV prevention and support structures—task-shifting cadres, peer networks, and stigma reduction programs—collapsed in many countries, particularly in sub-Saharan Africa, where they were never fully integrated into national health frameworks. Historically, they have operated in parallel to government health and social systems, often funded vertically by external donors. Over time, this created tension between community actors and state institutions.

The reported loss of 44,709 community health workers across 13 countries, including outreach workers and peer educators, has compromised critical services such as defaulter tracing, adherence support, and youth-focused interventions.

Yet, examples of resilience emerged. In Malawi, local NGOs repurposed residual grants to sustain targeted testing and adherence programs. Zambia’s CIDRZ Life App, originally designed for community ART monitoring, was adapted to track medication stocks and service availability. In Latin America, more mature social contracting models—such as those in Brazil and Mexico—allowed for sustained service delivery through community-based organizations, underscoring the importance of institutionalized financing mechanisms.

The role of networks of people living with HIV (PLHIV) deserves particular attention. Other than those community services already receiving funds under the Global Fund programme or other donors, HIV related community services have ceased. However, the assessment documented some innovations in organizing by persons living with HIV to mitigate disruptions. In Uganda, peer support groups

developed rotating drug pickup systems to compensate for reduced clinic staffing. Zimbabwe's community ART distribution networks reduced interruptions in treatment for thousands. These innovations highlight the need for formalized integration of community-led models into national health systems to enhance sustainability.

### **Commodity Security**

While countries reported 9-month forecasts for ARVs for treatment, prevention and laboratory commodities, it is important to note that these stocks were residual from pre-January 20<sup>th</sup> shipments. The US government policy actions resulted in a breakdown of coordinated procurement mechanisms between PEPFAR, Global Fund. Although PEPFAR's supply chain was partially restored for the 2024/25 fiscal year, uncertainty remains.

First, countries reported lack of full visibility to track and plan with regard to commodities delivered through NGO funded procurement mechanisms- forecasting status, ordering and timelines, thus hindering government effective decision-making. Additionally, because countries are mid-stream of their fiscal years, the ability to re-program already stretched national budgets is sub-optimal. At the time of reporting, the potential to re-programme Global Fund resources as a stop-gap measure to secure the supply chain was not clear. Some countries, especially West African nations further highlighted challenges with Country Coordinating Mechanisms (CCMs) operating outside government structures, complicated government led response efforts. It was also noted that the global mechanisms do not facilitate supply chain localization, which was described as 'more urgent than ever'.

A deeper structural issue is the absence of HIV commodities- for both HIV treatment and prevention- from national essential medicines lists and Universal Health Coverage (UHC) packages, which shape health budget priorities. Because these items have historically been donor-funded, their true costs when delivered through government systems remain unpublished. Thus, governments will need to undertake localized costing as a basis to defend domestic budget allocations.

HIV prevention commodities- condoms, PrEP, and PEP are short-stocked (at generally between 3-6 months), in a context where prevention is not priority. Cost considerations further alienate potential for PrEP programmes, as governments grapple with budget requirements for ART for treatment. Even where stocks are available, lack of trained staff to deliver services remains a barrier.

### **HIV Prevention**

While unquantified, Director Generals noted that most of HIV prevention programmes were PEPFAR funded and largely delivered through NGOs and communities and these ceased operations. Few remaining Global Fund supported interventions remain operational. Unlike treatment programs, these PEPFAR funded programmes were established as parallel services to country community health infrastructure and lacked pre-existing pathways for integration into national systems due to prior under investments for sustainability.

Countries rightfully focused on securing treatment in the immediate aftermath of the stop-work-order. However by May 2025, HIV prevention was still not prioritized in national planning and resourcing deliberations.

little remains of prevention programmes and support systems against which to re-programme. Their data systems, already traditionally de-linked from national platforms became no longer accessible, compromising planning and straining possible options to accessing domestic funding, which require reporting into the national system. In addition, Ministries of Health are not designed to deliver prevention to healthy at-risk individuals outside of the health system, but limited investments were made into building strong resilient multi-sector platforms.

DGs noted the urgent need to make a case for HIV prevention. The question *-What is the HIV Prevention Message?-* must drive the NACAs approach to prevention. The cost of non-action and the potential impact of neglecting HIV prevention interventions on domestic budgets ought to be articulated. While modelling data indicates that without robust and continuous HIV prevention efforts, the progress made to date could be reversed, education that every new infection will translate into an additional lifetime treatment cost that will be loaded onto health budgets is essential for Government decision makers in the executive and legislature.

Countries must re-imagine and define new HIV prevention models. DGs emphasized willingness to take tough decisions in prioritizing cost-effective interventions that leverage existing delivery channels across multiple sectors—such as through youth programs, pharmacies, or social media platforms. Countries that continued to build multi-sector NAC managed models alongside donor funded services such as Zimbabwe and Uganda now demonstrate advantage of pre-existing infrastructure essential for rebuilding and deploying prevention models. Their pre-existing infrastructure provides a foundation for developing new, domestically funded prevention strategies—a critical lesson for other nations navigating the transition.

### **Prioritization of interventions**

While this transition readiness assessment focused on the HIV response ecosystem, Director Generals are aware that safeguarding programme performance is an essential part of transition. In this regard, prioritization approaches that result in optimal configurations of interventions based on national needs, sub-epidemics, existing systems, and available resources are urgently needed. These will differ by sub-national epidemics and systems capacities. Various considerations may include: HIV epidemiological impact (ART coverage, viral suppression rates, treatment gaps and patient re-distributions); present and future confluence with co-morbidities and disease burden (NCDs, TB, STIs, maternal health) and syndemics (drug use, sexual violence); Geographic (urban slums, high-burden locations); shifting demographics of PLHIV; cost effectiveness (per patient retention and viral suppression); emerging transmission dynamics and epidemics (populations, sub-national geographies); health systems integration (laboratory, data and surveillance) and multi-sector opportunities. A challenge to realistic prioritization is the inaccessibility of sufficient epidemiological, programmatic and systems data that were rendered inaccessible. DGs proposed that country learnings in this journey are continuously shared.

## **The impact on health systems**

The spillover effects of losing decades of programmatic data, medical records and support systems information, compromised surveillance, health workforce attrition, sub-optimal laboratory and diagnostics platforms, medical records and community support on the broader health sector has not yet been investigated and quantified globally and at country level. The implications on non-HIV health priorities such as immunization, family planning and reproductive health require monitoring. In addition, specificities, such as the implications of the inevitable scale back of HIV testing on other health areas such as blood safety, TB, Hepatitis B and C testing are unknown. Rebuilding stronger health systems demands that data be based country realities and systems. For instance, programme costing or cost-effectiveness data that are currently based on prior donor funded infrastructure may not be relevant, or eligible for consideration in domestic budgeting processes.

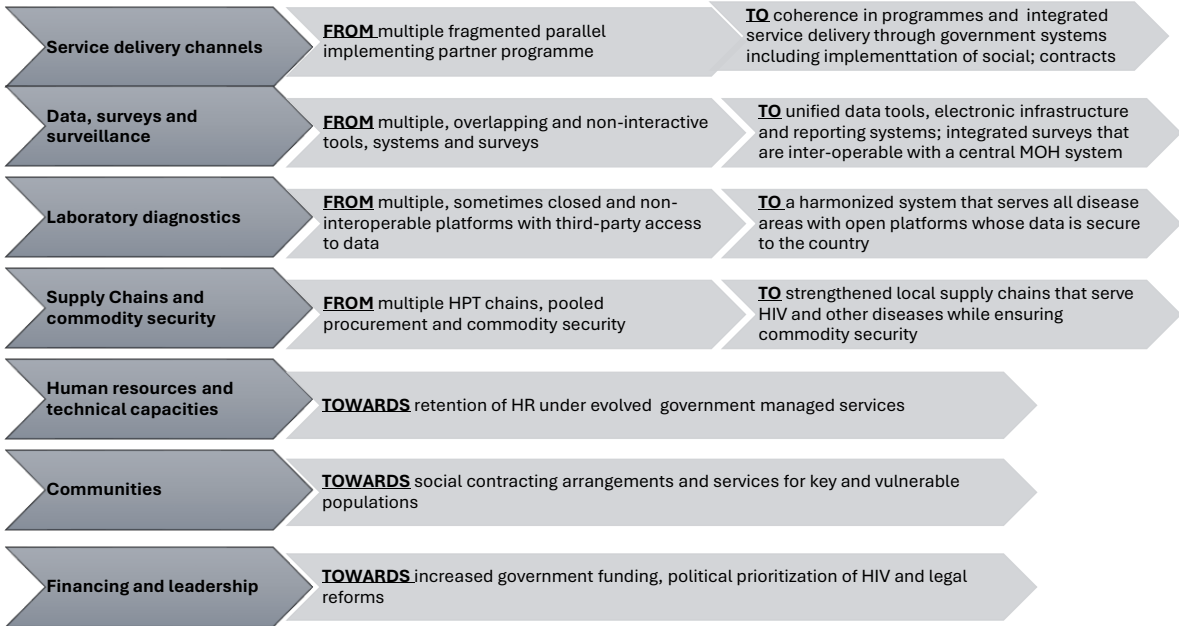
# OPPORTUNITIES FOR NEW DELIVERY MODELS

While the abrupt donor transition has presented complex challenges to HIV responses in aid-recipient countries, it has also uncovered assets and untapped opportunities that the countries can harness to advance sustainable, domestically driven responses. Through a nuanced understanding of both the constraints and the emerging prospects, countries are actively designing and implementing country-specific strategies to not only mitigate the immediate disruptions but also to institutionalize resilient HIV responses that are aligned with countries national health programs and universal health coverage goals.

## Integration

The funding crisis has created an imperative to fundamentally rethink HIV program design and delivery models. In the position paper on *Leveraging Country Leadership for Advancing Resilience and a Sustainable HIV Response Pre- and Post-2030*, the Forum had proposed an evolved design and HIV delivery architecture that would be designed in the country's UHC configuration with regard to service packages and that it would progressively create coherence across programmes and support systems. This proposal remains valid.

Figure 1: An illustration for an evolved HIV design and delivery architecture



**Considerations for integration:** From this assessment, integration with national systems emerges as the foundational principle for sustainability and was cited consistently in the qualitative data. However, the definitions and practice of integration have, and continue to differ across and within global and country actors. At the time of writing this report, integration is largely being undertaken as an emergency response of localized action to provide examination and ARVs within clinical care services of public facilities. Countries have the opportunity to develop structured integration frameworks for services and system level enablers.

## HIV Treatment service level integration

- Comprehensive care models that [deliver holistic care to individuals, including PLHIV, with minimal separation of service quality](#) and merge services coherently - Develop frameworks and packages of care for integration of HIV within chronic care management services at primary and tertiary facilities, aligned with country public health systems and structures
- Differentiated service delivery that is designed to include community health worker systems, task-shifting models, private and faith facilities and pharmacies, social service and welfare infrastructure
- Multi-disease screening as part of routine care- HIV testing, TB, hepatitis, hypertension, diabetes.

## HIV Prevention integration

- private Sector Platforms to mainstream access through retail and pharmacy networks
- Education Ecosystems to reach youth at scale and institutionalization through enhancing prevention literacy models
- Digital infusions that promote self care for prevention such as self risk assessments
- Social protection and welfare synergies to reach those at risk
- Leverage faith and cultural institutions to promote prevention uptake

## Systems level enablers of integration

- Policy and governance alignment where HIV strategies are harmonized with national health policies, UHC roadmaps, and SDG frameworks
- Nationally controlled data systems:
  - Prioritize indicators and metrics essential for performance management in cognizance of sub-national data collection capacities
  - Leverage broader health indicators that can act as proxies for HIV epidemics e.g, early pregnancy indicators
  - Institute the use of local surveillance mechanisms such as sentinel surveillance of MNCH clinics for epidemics monitoring
  - Fund and manage the national health system, being the DHIS2 in many countries
- Embed HIV training into medical/nursing curricula and continuous professional development
- Strengthen localized supply chain capacities
- Create links across multiple sectors for HIV prevention interventions, psychosocial support, legal aid, and economic empowerment programs.

**In considering integration, DGs recognized that health facilities cannot become all things to all people, a common pitfall of integration noting that integration is not “adding HIV to overburdened clinics’, but finding ways to weave essential elements of the HIV response into health, social and financial systems operations at country level!”**

## **Social health insurance/universal health coverage**

The presence of social insurance schemes and funded universal health coverage packages presents a substantial opportunity for financial cushioning for people living with HIV- for ART and other health conditions. Their full potential will be realized where there are no health cover policy restrictions to chronic care management or exclusions for HIV service packages.

There also exist an opportunity to understand the true cost of HIV programmes in the current operating reality of countries. Existing cost data that includes NGO and other donor negotiated indirect cost overheads are generally in-eligible in government medium term expenditure frameworks, unless allowed via social contracting mechanisms. Such detailed actuarial data would facilitate design of appropriate benefit packages and reimbursement rates.

## **Community systems**

Latin America reported more mature social contracting mechanisms in countries like Brazil and Mexico and their HIV prevention and support services not severely disrupted. The HIV leadership forum developed a policy brief in 2023 that outline pathways towards social contracting, whose recommendations remain valid today.

Networks of people living with HIV (PLHIV) offer opportunities to leverage their expertise in community mobilization for testing, adherence, viral suppression and prevention uptake lie in integrating these HIV community systems and providers with national health or social services infrastructure. Such integration would expand the community health workforce in-country to strengthen task-shifting and task-sharing with community health workers, bridge HR gaps in overstretched public systems, enhance community level differentiated chronic disease management, strengthen real-time community intelligence on service status and , link PLHIV action into country reporting. This may require policy reforms to situate PLHIV networks in national and subnational HIV governance, priority-setting platforms, budget making process and funding decisions. Robust trust building dialogues between local and global networks of persons living with HIV and Governments, including National AIDS Commissions are urgently required as part of realizing these goals.

## **Expanding private and faith-based sector models**

In many regions across Africa, private health facilities provide primary and secondary health care, sometimes up to 70% of all services. They comprise numerous outpatient clinics, nursing homes, local hospitals and pharmacies, yet they have not traditionally been actively involved in HIV delivery. These facilities now offer an opportunity to backstop public facilities and absorb ART patients who are willing and able to co-pay. Expanding private and faith facilities co-pay models can be meaningfully and rapidly scaled up to support countries' transition, offer relief to public sector facilities while harnessing the potential of existing long-term infrastructure.

Such an approach will relieve public-sector stretch by shifting stable ART clients and those willing and able to co-pay to private pharmacies/GPs thus shortening queues and freeing public-sector staff. ([Differentiated service delivery](#)); improve patient access and retention as it offers choice options while mobilizing local resources preferred dispensing point and trade a small copay for saved transport costs and lost wages from all-day public-clinic visits ([FHI 360](#)); leverage under-used private capacity

to absorb HIV clients, maintain viral load suppression and also serve other health care needs for aging HIV positive populations ([BioMed Central](#)). It will also bolster system resilience & supply chains by providing additional distribution channels to diversify “last-mile” delivery and lessen the impact of single-pipeline failures ([theafricalogistics.com](#))

## **Political capital**

The funding crisis unexpectedly elevated HIV back to national political agendas across affected countries, creating a critical window of opportunity for sustainable policy reforms. This assessment has documented examples of how heightened political attention translated into concrete and multi-ministerial actions to safeguard HIV programs during the transition period. This top-level endorsement can be leveraged through on-going strategy policy and political advocacy by NACAs to reframe HIV as a national budgetary priority rather than a sectoral health issue.

To institutionalize this political attention beyond the current crisis, countries should consider several structural reforms. Mandating regular HIV updates in cabinet meetings and parliamentary health committee hearings would maintain visibility of the issue. Linking HIV outcomes to broader development goals - such as economic productivity, broader health outcomes, and social stability - could engage non-health sectors in the response. Establishing permanent legislative caucuses on health sustainability would provide ongoing oversight of transition processes.

As countries navigate the current transition, maintaining and building upon this political attention will be crucial. The challenge now is to translate this awareness into enduring policy and financing reforms that will sustain the response for years to come.

## **Transition stewardship and management**

Ensuring a successful transition that safeguards program performance gains in the long term requires deliberate leadership, management, and oversight. Transition stewardship is a strategic imperative as countries prioritize interventions and implement new resourcing and delivery models. National AIDS Coordinating Authorities (NACAs) are uniquely positioned to lead these transformations, which demand collaboration across multidisciplinary stakeholders and Ministries, Departments, and Agencies (MDAs). Leveraging their statutory authority, NACAs can broker difficult compromises in prioritization efforts, establish accountability mechanisms with stakeholders, and utilize their multisectoral mandate to enhance coordination and expand delivery platforms for sustainability.

Opportunities for transition stewardship will vary by country context and may include:

- Conducting strategic ecosystem audits to identify critical gaps and urgent challenges requiring intervention. These audits may involve supply chain assessments to forecast commodity security or optimize in-country distribution networks, particularly in light of patient transfers across health facilities. Data systems audits can also address treatment gaps, facilitate the transfer of essential data to national systems, and resolve operational inefficiencies—ensuring a data-driven approach to system strengthening.

- Facilitating prioritization exercises aligned with national economic, social, and financial priorities, while coordinating across government agencies and institutions (e.g., Parliament, Ministries of Finance) to execute strategic action.
- Engaging public service management authorities and national treasuries to mediate pathways for rationalizing, resourcing, and recalling the health workforce.
- Implementing service delivery models that leverage private and faith-based facilities and pharmacies for differentiated services.
- Establishing harmonized coordination frameworks to enforce donor alignment with country priorities and systems, preventing service fragmentation.
- Developing country-managed, cost-effective, and sustainable multi-sector HIV prevention models.

## **The HIV Leadership Forum**

### **Responding to country needs and priorities**

Decades of investments in HIV systems fractured instantaneously, underscoring the need to strengthen existing, functional systems within countries rather than replicate parallel structures. The sudden withdrawal of donor support necessitates a reconstruction of the HIV response—one that is rooted in country infrastructure and informed by the institutional, technical, and political systems.

Director Generals (DGs) identified the following priorities:

#### **General Area 1: HIV Prevention**

1. Rebuilding the country HIV primary prevention response:
  - Multi-sector HIV prevention delivery platforms
  - National condom programs
  - Prevention data systems (indicators, data tools, reporting mechanisms) and surveillance
  - Prevention supply chains and workforce
2. Promoting access to prevention options and choices:
  - Models leveraging private-sector primary health providers for prevention service delivery
  - Digital tools and technologies for self-risk assessment and intervention uptake
  - Sustainable implementation of long-acting prevention technologies
3. Refining the HIV prevention message:
  - Investment cases to equip national HIV prevention champions

## **General Area 2: Safeguarding the HIV Response**

1. Know your epidemic:
  - Sub-national HIV epidemic analysis
  - Analysis of HIV comorbidities and syndemics
2. Know your response:
  - Defining functional delivery systems through ecosystem audits
  - Determining the actual cost *-price tag-* of services (vs. donor-funded expenditures)
  - Identifying multi-sector levers, infrastructure, and platforms
3. Effective integration:
  - Weaving essential HIV response elements into health, social, and financial systems—guided by principles, benchmarks, and contextual considerations
4. Country prioritization approaches:
  - Configuring optimal interventions based on national needs, sub-epidemics, existing systems, and available resources
5. Rebuilding community HIV programs:
  - Partnerships with PLHIV networks and communities
  - Integration of HIV programs into national social and community health infrastructure
  - Social contracting

## **General Area 3: Political Capital Mobilization**

1. Developing investment cases:
  - Articulating the necessity of Ministry of Finance allocations for HIV prevention
  - Making the case for cross-sector investments in HIV prevention
2. Implementing donor alignment and coordination frameworks
3. Deploying strategic advocacy for domestic and global HIV response resourcing

### **The HLF Secretariat's Support to DGs**

In their position paper '*Leveraging Country Leadership for Advancing Resilience and a Sustainable HIV Response Pre- and Post-2030*', Director Generals—drawing on their contextual understanding of national realities, epidemic dynamics, and institutional systems—collectively identified the HIV delivery ecosystem as the primary vulnerability to long-term sustainability. This assessment has since

proven accurate, underscoring the importance of leveraging country knowledge and expertise in redesigning future health responses.

Key HLF Secretariat support functions will include:

- (i) **Galvanize political momentum and rebuild HIV prevention**
  - a. Establish an **HIV Prevention Thought Leadership Group** to guide countries and the global community
  - b. Support countries to implement **sustainable, country-led HIV prevention**
  - c. Coordinate with the Global HIV Prevention Coalition to enhance **HIV prevention visibility**
- (ii) Strengthen 'Know your Epidemic, Know your Response' efforts in countries
  - a. Facilitate targeted eco-systems audits
  - b. Support design, prioritization and costing of integrated, multisector and community responses
  - c. Promote **knowledge exchange** and showcasing country leadership and adaptation
- (iii) Advocating for **domestic and global HIV response resourcing**, including support for Global Fund replenishment