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PROTECTING CORE SERVICES WITH DOMESTIC INVESTMENTS: BUDGET ARCHITECTURE, TREASURY AND HEALTH ALIGNMENT, AND EQUITABLE SERVICE DELIVERY IN AFRICA'S HIV RESPONSE

Executive Summary

This report captures the substantive discussion, evidence, and advocacy outputs of the first webinar in the African-led HIV Control Working Group (AHCWG) 2026 Webinar Series, titled "Protecting Core Services with Domestic Investments," convened virtually on 22 April 2026. The session brought together finance and health officials, national programme managers, civil society leaders, and academic researchers from across the continent to interrogate the architecture of domestic HIV financing at a moment of profound fiscal and political turbulence, and to consolidate advocacy positions for immediate deployment at the ECOSOC Financing for Development (FfD) Forum and the 12th Africa Regional Forum on Sustainable Development (ARFSD-12).[1]

Africa carries approximately sixty-four percent of the global HIV burden, with 25.9 million people living with HIV, yet continues to finance its response through an architecture that is overwhelmingly externally sourced. Domestic government financing accounts for only nineteen percent of HIV resources across sub-Saharan Africa, with country-level realities significantly stark in most high-burden states.[2] The abrupt suspension of PEPFAR in January 2025 immediately jeopardized HIV care for an estimated 20.6 million people, including 550,000 children, and modelling projects between sixty and seventy-four thousand additional deaths across seven African countries in the absence of corrective action.[3] Alongside these disruptions, the continent now carries USD 89 billion in debt servicing obligations in 2025 alone, compressing the fiscal space within which domestic financing decisions must be made.[4]

Against this backdrop, the webinar's opening framing by Jaime Atienza Azcona of UNAIDS located the continent's HIV financing question within a shift from adequacy alone to questions of continuity, sovereignty, and transition. Roughly thirty to forty percent of external development assistance for health has been projected to fall in 2025 relative to 2023, and of the sixty countries reporting to UNAIDS, twenty-five have indicated an intention to increase domestic HIV budgets in 2026 despite the constrained environment. Professor Fareed Abdullah of the South African Medical Research Council offered a complementary perspective drawn from practical experience, cautioning that the moment does not call for

[1] UNAIDS (2026). *Africa united to end AIDS: 39th African Union Summit, Addis Ababa, Ethiopia, February 2026.* Available at https://www.unaids.org/en/resources/documents/2026/AU-summit-brochure. See also UNECA, ECOSOC Financing for Development Forum (April 2026) and ARFSD-12 (April 2026) convening documentation.
[2] Africa CDC (2025). *Africa's Health Financing in a New Era.* Available at https://africacdc.org/news-item/africas-health-financing-in-a-new-era-april-2025/.
[3] PMC (2025). *Partial waivers: PEPFAR's 2025 funding suspension and the impact on HIV care.* PLOS Medicine, 22(3). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC11959925/. See also PMC (2025). *The impact of the PEPFAR funding freeze on HIV deaths and new infections in sub-Saharan Africa.* PLOS Global Public Health, 5(4). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12230335/.
[4] PMC (2025). *HIV response financing challenges in Sub-Saharan Africa.* Frontiers in Public Health, 13. Available at https://pubmed.ncbi.nlm.nih.gov/40959624/.

the abandonment of the aid agenda so much as its honest re-engineering, and that the distortion of domestic prioritization caused by two decades of near-total external financing of commodities, laboratories, and workforce is itself a structural problem that budget architecture alone cannot resolve.

Dr Henry Zakumumpa of Makerere University grounded the conversation at the point where financing decisions meet service delivery, drawing on research conducted in Uganda shortly after the January 2025 funding announcement. His findings documented the loss of PEPFAR-contracted clinical staff in both public and mission facilities, the deep erosion of HIV prevention activities and community outreach, and the rushed nature of integration of HIV services into primary care which proceeded without the operational guidelines that have only recently been issued. Allan Maleche of KELIN provided the civil society and legal lens, analysing the emerging bilateral Memoranda of Understanding between African governments and the United States that are reshaping the terms of the HIV response, and setting out five risk criteria that governments and advocates should apply when assessing those agreements.

Closing reflections by Dr Nyaradzo Mgodi, co-chair of the AHCWG, distilled three imperatives for the continent in the period ahead. The first is to protect continuity of care by preventing abrupt disruption to treatment, prevention, community delivery, laboratories, and data systems. The second is to strengthen country-led financing architecture as well as funding levels, with emphasis on central budget lines, execution discipline, improved public financial management, procurement reform, and community contracting. The third is to place equity at the centre of the response, ensuring that adolescent girls and young women, children, and key populations remain explicitly named within domestic budgets because where they are unnamed, they are unfunded in practice.

The session surfaced a set of priority financing instruments already operating on the continent that participants identified for country-level follow-up, notably Zimbabwe's AIDS Levy generating approximately USD 30 million annually, Kenya's dedicated ARV budget line which has sustained six consecutive years of increasing domestic treatment financing, Tanzania's continental first domestic ARV line item of USD 4.5 million, Nigeria's National Domestic Resource Mobilisation and Sustainability Strategy for HIV targeting USD 662 million across five financing pillars, and South Africa's domestic financing of approximately seventy-five percent of its HIV response through provincial conditional grants and the Treasury's risk-adjustment instruments.[5] The discussion confirmed that the question confronting the continent is no longer whether domestic financing is necessary, but whether governments will design budget architectures that are robust enough to protect the populations who have historically borne the greatest HIV burden and the greatest risk of exclusion when financing contracts.

DISCUSSIONS

[5] Aidsmap News (2023). *African countries are making the transition from donor-funded HIV programmes to government-led initiatives.* Available at https://www.aidsmap.com/news/may-2023/african-countries-are-making-transition-donor-funded-hiv-programmes-government-led. See also Health Policy Plus (2021). *Nigeria Launches a National Domestic Resource Mobilization and Sustainability Strategy for HIV (2021-2025).* Available at https://www.healthpolicyplus.com/nigeriahivstrategy.html.

Welcome and Opening Remarks

Ina Kafunda, Health Policy and Law Lead at the AHCWG Secretariat, opened the session by welcoming participants and situating the webinar within the broader architecture of the 2026 AHCWG Series. She framed the convening's central question directly: given that approximately eighty percent of HIV financing in most African countries currently originates from external sources and that sixty-three percent of new infections on the continent occur among women and young girls, the question before the session was not whether domestic financing was needed, but how it should be structured, protected, and distributed such that the services most vulnerable to transition shocks remain operational.

Before proceeding to the substantive presentations, Kafunda invited participants to respond to a Menti meter poll asking for the single most binding constraint to strengthening domestic HIV financing in their own country's context. Responses from attendees centred on political will and prioritisation, government commitment, continuing reliance on the Global Fund and other external financiers, budget reliability, and corruption, themes that would recur across the subsequent presentations and which the panel returned to in discussion. These audience responses set the analytical tone for the session and reinforced the premise that the challenge before the continent is fundamentally political and structural rather than narrowly technical.

1. Strategic Framing: The Financing Landscape and the Risks of Transition

Jaime Atienza Azcona, Director of Equitable Financing at UNAIDS, delivered the opening strategic framing, drawing on UNAIDS data, the National AIDS Spending Assessments conducted by member states, and the agency's recent equity analysis with PEPFAR to map the terrain within which African governments must now operate.

Azcona began by reframing the financing conversation itself, observing that the debate has moved decisively away from questions of adequacy alone and toward questions of continuity, sovereignty, and transition. The HIV response is no longer in a replenishment-style funding cycle but in a structural redesign, one that is unfolding under the pressure of an ongoing financing shock that is forcing countries to stabilise core services while simultaneously planning for a longer-term shift toward domestic financing. Across low- and middle-income countries, fifty-nine percent of HIV funding in 2024 came from domestic resources, though the proportion in Africa is considerably lower, and external development assistance for health is projected to fall by thirty to forty percent in 2025 relative to 2023. Despite these compressions, twenty-five of the sixty countries reporting to UNAIDS have indicated they intend to increase domestic HIV allocations in 2026, which Azcona characterised as an expression of both political priority and continuing hope in the face of deteriorating external conditions.

The dependence of HIV financing on international actors is, Azcona emphasised, structural in character rather than fiscal alone, and its consequences are unevenly distributed across the continuum of care. Prevention, testing services for key populations, paediatric antiretroviral therapy, laboratory systems, community delivery, and data infrastructure are all significantly more exposed to external funding reductions than adult first-line treatment. In both Western and Central Africa and Eastern and Southern Africa, PEPFAR and the Global Fund together account for over three quarters of HIV prevention financing, a figure drawn from analysis of National AIDS Spending Assessments across twenty-two reporting countries. The implication

is that in the absence of deliberate protective measures, the retreat from external financing will produce a response that is narrower in scope and more unequal in reach, with prevention, community-led delivery, laboratories, and data systems bearing disproportionate cuts while treatment continuity is preserved.

Against this backdrop, Azcona argued that sustainability requires financial architecture as well as additional resources. He rejected the proposition, advanced in some recent analyses, that efficiencies alone can generate sufficient fiscal space for the HIV response in the absence of new revenue. Proper architecture, in his framing, includes a fully costed national response calibrated to national standards in place of the international standards that parallel donor systems have historically imposed, protected line items for essential commodities, improved budget execution and sub-national release, integration of HIV into primary health care and health insurance instruments in a manner that preserves the HIV-specific gains of the past two decades from being dissolved, financing for community-led delivery and social contracting, and sustained alignment between ministries of finance, ministries of health, and partners around a country-led roadmap.

On equity, Azcona was unequivocal that the populations most exposed to financing transition risks are those whose inclusion has historically been most hard-won: adolescent girls and young women, particularly in contexts where prevention gains remain fragile; children requiring paediatric diagnostics and treatment; key populations who rely on stigma-free, community-proximate prevention and testing services; and community-led organisations whose funding channels are rarely secured within domestic public financial management systems. He closed by setting out an indicative menu of diversified financing options for the continent to pursue, including earmarking within government budgets, more effective action against tax evasion, expanded leverage of international financial institutions and development banks, pro-health taxes, and deeper public-private partnerships, all operating within a country-led framework in which communities participate meaningfully in design and accountability.

2. Budget Protection Mechanisms: Design, Architecture, and Political Realism

Professor Fareed Abdullah, Director of the Office of AIDS and TB Research at the South African Medical Research Council (SAMRC), offered a more granular and politically candid assessment of what domestic financing architecture can and cannot achieve in current conditions.

Abdullah opened with a warning against the temptation to treat domestic financing as a ready-made solution to the present funding shock, observing that the conversation has in recent months become a kind of fashion across international HIV platforms and that it risks obscuring the fiscal realities within which African treasuries actually operate. He noted that most low- and middle-income countries remain in severely constrained fiscal positions in the wake of the COVID-19 pandemic, with debt servicing costs having grown to levels that crowd out health expenditure in numerous jurisdictions. In South Africa, debt servicing has for the first time become the single largest expenditure item on the national budget, exceeding both health and education allocations. These are difficult conditions in which to ask treasuries to absorb the cost of a response that has been donor-financed for over two decades, and any serious advocacy strategy must acknowledge this reality rather than work around it.

Abdullah also registered a dissent from what he described as the premature abandonment of the aid agenda. While the shift in United States policy has been dramatic and destabilising, it does not follow that all traditional donor relationships should be dissolved or that African governments should accept the loss of international solidarity as a settled fact. The principle that those with more resources should assist those with fewer remains legitimate, and distinctions between donor jurisdictions matter, with several European and Scandinavian partners continuing to maintain commitments that should be engaged rather than written off.

Turning to the question of why governments have historically not placed more domestic resources into HIV, Abdullah offered a structural explanation grounded in the political economy of budget-making. When external financing has been abundant, the incentive for ministries of finance and ministries of health to negotiate domestic allocations for commodities, laboratories, and workforce has been systematically weakened. The very generosity of PEPFAR and the Global Fund, in his analysis, removed HIV from the local conversation about prioritisation in countries where the disease accounts for twenty, thirty, or forty percent of the overall disease burden. The present moment, difficult as it is, restores that conversation to its proper place and forces governments to make choices that were previously obscured.

Drawing on South Africa's experience of financing approximately seventy-five percent of its HIV response domestically, Abdullah described the mechanisms that have enabled this result. The Treasury developed an instrument to adjust provincial health allocations for the additional burden imposed by HIV, recognising that the epidemic had distorted the standard allocation formula both at national level and between provinces with significantly different prevalence rates. A dedicated conditional grant, informed by modelled estimates of national patient volumes, unit costs, and expected uptake, provided an annual increase in allocated resources that could be defended across political cycles. The current debate within South Africa over whether that conditional grant should now be integrated into the general primary health care budget was, he noted, an important one, with implications for the continent as it considers how to balance HIV-specific protection against broader integration.

On the question of efficiency, Abdullah struck a different note from Azcona, arguing that there remains substantial scope for gains within domestic systems. He pointed to the HIV programme's accumulated efficiencies over the past three decades, including the rapid diagnostic test, task shifting to pharmacists and nurses, rationalised laboratory algorithms, and the single-pill three-active-ingredient regimen now available at roughly USD 60 per person per year, all of which are now embedded in World Health Organization guidelines. The next frontier, in his view, is system-level efficiency rather than commodity-level efficiency, and he highlighted results-based financing, national health insurance reforms underway in several African countries, and emerging social impact fund structures that mobilise domestic risk capital from private sources as instruments worthy of serious consideration. Loan instruments, he cautioned, come with conditionalities and technical assistance arrangements that can erode domestic authority if not carefully negotiated, a point that would be echoed later in the session.

Abdullah closed with a pointed observation about the locus of the current conversation. Of the five domestic financing webinars he had participated in over the preceding three weeks, the agenda-setting had in each case been driven by international NGOs, United Nations

agencies, and multilateral bodies. The AHCWG convening, by contrast, represented an African-led initiative in which the framing, speakers, and conclusions were set by practitioners and researchers based on the continent, and he urged that this form of leadership be sustained and expanded.

3. From Allocation to Execution: Sub-National Realities in Uganda

Dr Henry Zakumumpa, health systems researcher at Makerere University, brought the discussion from continental framing to district-level implementation, drawing on fieldwork conducted in Uganda in March 2025 immediately following the PEPFAR announcement.

Zakumumpa located Uganda's experience within a broader set of shifts in bilateral aid, noting that several traditional European partners, including the United Kingdom, have contracted their HIV allocations in parallel with the United States, and that Kenya has similarly moved into a new bilateral framework. The research his team undertook was conducted in a Ugandan district with HIV prevalence significantly above the national average and was designed to document the immediate service delivery consequences of the funding announcement.

The most acute early impact fell on the health workforce. PEPFAR-contracted staff, including data officers, counsellors, laboratory personnel, and in some mission hospitals as much as sixty percent of clinical staff, were lost almost immediately. These workers had not been provided for in the Uganda government staffing norms, despite their centrality to HIV service delivery, and the skills and institutional memory they carried were lost to the health system as a consequence. Private and faith-based facilities were, in the research team's assessment, more deeply affected than public facilities, because their dependence on PEPFAR-funded workforce was proportionally greater. At the time of the webinar, more than a year after the funding announcement, Uganda had not yet replaced the majority of these personnel.

HIV prevention activities, Zakumumpa reported, were among the most profoundly disrupted arms of the response. Although injectable long-acting prevention has since received some new funding, the broader prevention agenda including condom distribution and community outreach has largely ceased in the absence of financing. This finding underscored Azcona's earlier observation that prevention is disproportionately externally financed and therefore disproportionately exposed to transition shocks.

The integration of HIV services into primary care and chronic disease clinics proceeded in Uganda, in Zakumumpa's characterisation, as something closer to a reflexive response to the funding shock than a deliberately designed policy shift. Government guidelines on how to implement integration were only issued after the integration had already begun in many facilities, and the research team documented important gaps in health worker capacity to deliver the expanded service package that integration now requires of individual clinicians. The commonly cited benefit of integration in the form of reduced provider stigma was, in the emerging findings, less consistently realised than advocates had anticipated, with mixed results across facilities. Waiting times at the point of care, the loss of the intensive adherence counselling and viral load monitoring that vertical HIV programmes had sustained, and the disruption of patient tracking systems were all surfacing as areas of concern with implications for drug resistance and mortality that would need to be closely monitored.

On the financing response, Zakumumpa reported that the Uganda government had passed a supplementary budget in 2025 to absorb the costs of PEPFAR-contracted country drivers, a move that demonstrated that fiscal space could be expanded in moments of acute need. A transition agreement was also under negotiation to absorb a portion of the demobilised PEPFAR workforce into the government staffing norms. Efforts were underway to revive the AIDS Trust Fund originally proposed in 2014, which had envisaged earmarked levies on soda and other consumption categories, though political constraints had so far prevented its activation. Taken together, these measures indicated a government moving toward increased domestic responsibility, albeit under duress and without the preparatory period that a well-designed transition would ordinarily require.

4. Memoranda of Understanding, Risk, and Equitable Partnership Terms

Allan Maleche, Executive Director of the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), addressed the legal and civil society dimensions of the bilateral frameworks that are now reshaping the HIV response across more than twenty African countries.

Maleche opened with the proposition that as governments shift toward greater domestic financing, the question before African publics is not only how much money is available but on what terms the HIV response will operate, because even expanded domestic investment can be undermined by poorly negotiated partnership arrangements that sustain the dependencies of the donor era under new contractual forms. A strong bilateral agreement, in his formulation, supports the national system and adds value to procurement, data, and service delivery while leaving governments at the front foot of decision-making. A high-risk agreement, by contrast, maintains external control over those same functions even as nominal responsibility transfers to government.

He set out five categories of risk that governments and advocates should apply in assessing any emerging bilateral MoU. The first concerns procurement, where requirements to purchase through externally designated systems or specific third-party channels, rather than through the national procurement infrastructure or the African Medicines Agency, erode supply chain sovereignty and limit the cost efficiencies that domestic pooled procurement can achieve. Maleche referenced Kenya's earlier experience of a Global Fund-supported initiative to strengthen the national procurement system, noting that although the investments were substantial and the design was sound, the subsequent unwinding of the initiative meant that the gains did not endure. The lesson is that procurement sovereignty requires continuous defense and cannot be secured by a single reform cycle.

The second category concerns data. Where agreements require that programme data flow through external platforms or remain subject to external government access, countries generate data locally but lose control over its analytical use and its implications for planning and decision-making. Several of the current United States bilateral agreements include provisions under which technical assistance for surveillance is offered in exchange for data transfer to Washington for what is described as the receiving government's planning requirements, an arrangement that replicates in contractual form a dependence that the transition was nominally intended to resolve.

The third category concerns service delivery and equity. Agreements that restrict or exclude services for particular populations, whether by explicit conditionality or by defunding community-led organisations that have historically reached those populations, reintroduce

inequity into the response. Maleche noted that in the Kenyan case the agreement specifies which services will be supported, with commodities and workforce allocations tied to that specification, which creates practical constraints on integration and on the ability of government to reach communities the agreement treats as outside its scope.

The fourth category concerns timelines, where transition periods that do not align with national budget cycles, legislative processes, or the realistic pace at which workforce capacity and procurement systems can shift produce commitments that are structurally impossible to meet. The fifth category concerns financial control, where concerns about leakage and corruption have in several recent agreements generated parallel audit and oversight architectures that duplicate domestic systems, add compliance cost, and in some cases introduce inefficiencies of their own.

Maleche closed with a set of non-negotiables for African governments in the period ahead. Governments must retain control over programme design and delivery, must refuse conditions that exclude key populations and that violate the constitutional right to health, must insist on data ownership and procurement sovereignty as items on which no compromise is acceptable, and must invest in the domestic financial controls that create the credibility from which stronger negotiating positions can be built. He observed that Zimbabwe had, in his reading, held its ground on certain aspects of these negotiations in ways that should be studied rather than criticised, and that the overall posture of African governments in this period must be one of clear positions held with discipline.

5. Panel Discussion and Audience Questions

The panel discussion that followed was moderated by Ina Kafunda and engaged audience questions submitted through the chat.

A question from a senior participant asked how the substantive analysis produced in convenings such as this might be translated into formats that ministers of finance and offices of the president could act upon. Professor Abdullah responded that African governments have more technical and institutional capacity than international interlocutors often credit them with, and that the priority must be to move external resources onto budget so that they are integrated into standard public financial management processes rather than maintained in parallel accounting structures. He argued that civil society's time would be more productively spent engaging local ministries and treasuries than focused on Global Fund replenishment dynamics, and drew on the experience of the Treatment Action Campaign in South Africa in the early 2000s to illustrate the role of sustained domestic pressure in shifting political will at the highest levels. Azcona added that the investment case matters in the competition for resources among sectors, and that articulating the cost of inaction alongside the investment case is essential, as is sustained attention to the legal, parliamentary, and sub-national reforms through which any financing architecture must be implemented.

A further question, submitted by a senior expert representing a multilateral agency, asked whether the funding cuts affecting United Nations entities working on HIV, including UNAIDS itself, would be reversed. Azcona acknowledged that seventy-three percent of all money committed to the HIV response through 2024 came from the United States, which means that the shock has propagated across every country programme, every partner organisation, and every multilateral agency including UNAIDS. An agreement has been

reached to resume a portion of UNAIDS financing, though final confirmation was still pending at the time of the webinar. Independent of that arrangement, UNAIDS itself is the subject of a member-state working group that is examining which core functions the joint programme should continue to carry and which might be redistributed across other United Nations entities or regional institutions. The posture of the agency during this period has been to support country leadership in the design of sustainability roadmaps, to enable the space within which the dialogue between governments and large funders can proceed with national leadership intact.

An implementation question directed to Dr Zakumumpa asked how the Uganda government had absorbed the expensive delivery models that had operated under PEPFAR as it moved toward integration. He responded that Uganda has consolidated HIV services with hypertension, diabetes, and other chronic conditions under a single facility footprint, with commodities, workforce, and pharmacy services operating under one roof, an arrangement that offers operational efficiencies even where the clinical implications of integration remain under evaluation.

6. Audience Engagement: Mentimeter Poll Results

Two Mentimeter polls were conducted during the session. The opening poll asked participants to identify the single most binding constraint to strengthening domestic HIV financing in their own country context. Responses clustered around political will and prioritisation, government commitment, reliance on external financing including the Global Fund, budget reliability, and corruption. The emphasis on political and structural factors rather than on technical or data limitations reinforced the session's central analytical position that domestic HIV financing is fundamentally a question of political economy.

A second poll asked participants to characterise their country's current HIV financing structure. Approximately sixty percent of respondents identified their country as predominantly externally financed with limited domestic contribution, confirming the structural dependency set out in Azcona's opening framing. Smaller proportions of respondents identified mixed financing structures or predominantly domestic structures, with the distribution consistent with UNAIDS data indicating that only a small number of African countries, led by South Africa, have moved to majority domestic financing of the HIV response.

Closing Reflections: Dr Nyaradzo Mgodi

Dr Nyaradzo Mgodi, co-chair of the AHCWG, delivered the session's closing reflections, synthesising the discussion into three imperatives for continental advocacy and action.

The first imperative is that dependence on external financing constitutes a structural condition rather than a purely fiscal one, and that sustainability therefore requires the construction of resilient financing architecture alongside the mobilisation of incremental resources. A programme that excludes the most vulnerable is, in her formulation, a narrow programme rather than a sustainable one, and equity must be understood as constitutive of sustainability, not treated as an ancillary consideration.

The second imperative concerns the macroeconomic environment within which domestic financing decisions are made. The debt servicing burdens that constrain national budgets

across the continent are not a backdrop to the HIV financing conversation but a central determinant of its outcomes, and the transition away from donor financing will require deliberate fiscal policy measures alongside the shift to insurance mechanisms, earmarked levies, and other domestic instruments. The Uganda experience, documented by Dr Zakumumpa, illustrates with force that transition without adequate preparation can reverse hard-won gains in treatment coverage, prevention, and community engagement.

The third imperative is that the coming phase of the response will require bold, coordinated action to translate analysis into sustained impact. Equity requires the active protection of community systems and the deliberate addressing of the macroeconomic constraints that limit the fiscal space within which governments operate. Efficiency and accountability must be maximised across the response, with accountability understood not as an external audit function imposed by donors but as a domestic civic function exercised by communities, civil society, parliaments, and the courts.

Dr Mgodi closed by inviting participants to the second webinar in the AHCWG 2026 Series, scheduled for 19 May 2026 and focused on policy frameworks for sustainable HIV and healthcare financing, and by expressing the AHCWG's gratitude to the speakers, panellists, and participants for their engagement.

Advocacy Messages for the FfD Forum, ARFSD-12, and National Budget Processes

Drawing on the evidence and discussion from the session, participants identified a set of advocacy messages for deployment at the ECOSOC Financing for Development Forum (20 to 24 April 2026), the 12th Africa Regional Forum on Sustainable Development (28 to 30 April 2026), Voluntary National Reviews during 2026, and national budget processes through the remainder of the year.

These messages include

- The explicit protection of dedicated budget lines for antiretroviral commodities, prevention, paediatric treatment, and community-led services across national health budgets, with named line items for women, adolescent girls, children, and key populations.
- The insistence within bilateral negotiations on the retention of national procurement authority, national data ownership, and programme design authority, consistent with the risk framework set out by KELIN.
- The pursuit of pro-health taxes and earmarked levies in jurisdictions where the fiscal and political environment permits, drawing on the Zimbabwe AIDS Levy as a demonstrated instrument.[6]
- Improved public financial management and budget execution at sub-national level, with particular attention to the execution gap that limits the translation of allocated resources into delivered services.
- Sustained investment in community systems and community-led monitoring as constitutive of the response rather than peripheral to it.

Conclusion

[6] Aidsmap (2025). *The funding scramble: countries desperately seek HIV finance solutions.* Available at https://www.aidsmap.com/news/jul-2025/funding-scramble-countries-desperately-seek-hiv-finance-solutions.

The first webinar of the AHCWG 2026 Series made clear that the architecture of domestic HIV financing in Africa is now the principal determinant of whether the gains of the past two decades will be preserved through a period of profound transition. Africa carries sixty-four percent of the global HIV burden and nineteen percent of its financing comes from domestic government sources, with most high-burden countries below ten percent, and this structural position cannot be addressed by incremental allocation adjustments alone.[7] The continent requires architectural change that protects commodities, laboratories, workforce, prevention, community systems, and data infrastructure through dedicated budget lines, earmarked revenue streams, improved public financial management, procurement sovereignty, and sustained alignment between ministries of finance and ministries of health.

The evidence presented during the session demonstrates that such architecture is achievable. Zimbabwe's AIDS Levy, Kenya's dedicated ARV budget line, Tanzania's domestic ARV allocation, Nigeria's National Domestic Resource Mobilisation and Sustainability Strategy, and South Africa's conditional grant with risk-adjusted provincial allocations together constitute a continental portfolio of instruments that have delivered results in their national contexts. These instruments are available for adaptation now and should be understood as replicable architecture rather than aspirational models. Execution capacity and the translation of allocation into delivered services remain the next frontier, as Dr Zakumumpa's Uganda findings and Professor Abdullah's South African experience together demonstrate, and the AHCWG series will address these implementation questions across its subsequent convenings.

At the same time, the bilateral frameworks now being negotiated between African governments and external partners, particularly the United States, will shape the operating terms of the HIV response for years to come. The risk framework set out by KELIN, covering procurement conditions, data ownership, service delivery conditionalities, timelines, and financial control, provides a practical instrument for governments and civil society to apply in the period ahead. Agreements that meet these criteria can advance sovereignty. Agreements that fail them will perpetuate the dependencies they nominally intend to resolve.

Equity remains the test against which every element of this work will ultimately be assessed. Women and girls account for sixty-three percent of new infections on the continent, adolescent girls and young women in parts of Eastern and Southern Africa face HIV acquisition rates up to eight times higher than their male peers, and key populations bear a disease burden that is consistently underestimated in national data systems.[8] Any domestic financing architecture that fails to name and fund these populations explicitly will fail to protect the HIV response as such. The AHCWG Position, affirmed at continental level, holds that a sovereign and total HIV response finances treatment, prevention, and community

[7] PMC (2025). *Addressing the HIV/AIDS investment gap through stronger public financial management.* Global Health: Science and Practice, 13(2). Available at https://pubmed.ncbi.nlm.nih.gov/40437478/.
[8] UNAIDS Global AIDS Update and UNAIDS regional data for Eastern and Southern Africa, as cited in AHCWG Webinar 1 Concept Note, March 2026.

systems for the full epidemic including those whom criminalisation, stigma, and political discomfort have historically excluded from domestic budgets.[9]

The broader policy corridor of 2026, the UNECA Conference of African Ministers of Finance, the ECOSOC Financing for Development Forum, ARFSD-12, and the Voluntary National Reviews of nineteen African countries, provides the platforms through which the positions generated in this webinar can be consolidated into continental and global commitments. The AHCWG will continue to carry these positions into those forums, and will track the country-level follow-through to which participants committed during the session. The work of Webinar 1 is therefore not concluded but is now in motion across finance ministries, health ministries, parliaments, and civil society spaces where the architecture of the response will be decided.

[9] Section27 (2025). *The African-led HIV Control Working Group response to abrupt cuts in HIV support.* Available at https://section27.org.za/2025/02/the-african-led-hiv-control-working-group-response-to-abrupt-cuts-in-hiv-support/.