POLICY FRAMEWORKS FOR SUSTAINABLE HIV AND HEALTHCARE FINANCING

Enabling Legislation, National Strategy Alignment, Continental Policy Coherence, and Legal Environments for Vulnerable Populations

Webinar 2 of 3 | 27 May 2026 | Virtual

Convened by the African-led HIV Control Working Group (AHCWG)

Secretariat Services provided by Policy Strategy Group (PSG), Nairobi

SESSION PARTICIPANTS

Moderator

Dr. Magda Robalo

Moderator | Co-Chair, UHC 2030 Steering Committee

Speakers

Hon. Commissioner Dr. Litha Musyimi-Ogana

Member, African Commission on Human and Peoples' Rights | Chairperson, Working Group on Indigenous Populations/Communities and Minorities in Africa | Chairperson, Committee on the Protection of the Rights of People Living with HIV and those at Risk, Vulnerable to and Affected by HIV in Africa

Mr. Petrus Khoza

Acting Chief Director, HIV/AIDS Conditional Grant and NGO Funding | National Department of Health, South Africa

Dr. Benjamin Djoudalbaye

Ag. Director, External Relations and Strategic Engagement | Africa CDC

Mr. Nelson Otwoma

Executive Director, National Empowerment Network of People and Families Affected by HIV/AIDS in Kenya (NEPHAK)

EXECUTIVE SUMMARY

This report documents the substantive discussions, speaker presentations, and policy outputs of the second webinar in the African-led HIV Control Working Group (AHCWG) 2026 Webinar Series, titled "Policy Frameworks for Sustainable HIV and Healthcare Financing," convened virtually on 27 May 2026. The session was moderated by Dr. Magda Robalo, Co-Chair of the UHC 2030 Steering Committee, and brought together four speakers representing African Union institutional authority, continental public health governance, national programme implementation, and the lived experience of communities most affected by HIV.

Building directly on the domestic financing architecture examined in Webinar 1, this session interrogated the policy and legal infrastructure that determines whether financing commitments are durable across political transitions and fiscal consolidation cycles. The central analytical position that emerged across all four presentations was consistent and reinforcing: Africa does not face a shortage of legal instruments or continental frameworks. What it faces is a structural failure to translate those instruments into enforceable national obligations, costed implementation strategies, and legal environments that allow the populations carrying the highest HIV burden to access the services those frameworks are designed to provide.

Hon. Commissioner Dr. Litha Musyimi-Ogana, a Member of the African Commission on Human and Peoples' Rights, grounded the session in the continent's three decades of legislative and policy development, tracing the legal architecture from the Abuja Declaration through the AU Catalytic Framework, the Maputo Reproductive Health Strategy, and the AU Roadmap to 2030 and Beyond. Her central argument was that HIV financing sustainability is not merely a fiscal or technical question; it is fundamentally a human rights question, and the failure to embed financing commitments in enforceable legislation is a failure of accountability to the people those commitments are designed to protect.

Mr. Petrus Khoza, Acting Chief Director at South Africa's National Department of Health, grounded the discussion in the implementation realities of one of the continent's largest HIV treatment programmes, with an emphasis on the necessity of a single, costed national strategic plan, integration into primary health care as a condition for long-term sustainability, and the role of domestic financing instruments including South Africa's conditional grant in sustaining a programme that has progressively reduced its dependence on external resources.

Dr. Benjamin Djoudalbaye, Acting Director of External Relations at Africa CDC, examined the gap between the political ambition of continental frameworks and their reflection in national laws, budgets, and contracts. He provided a four-level analysis of the risks created by poorly negotiated bilateral transition agreements and articulated the Africa CDC's advisory posture on the principles that member states should not depart from in those negotiations.

Mr. Nelson Otwoma, Executive Director of NEPHAK Kenya, brought the session's analysis from institutional governance to lived community reality, documenting the structural exclusion produced when HIV is treated as a biomedical issue in isolation from the social, legal, and political conditions that shape who can access services. He argued for a multi-sectoral response architecture that addresses inequality, stigma, punitive laws, harmful social norms, and poverty as the structural drivers of HIV vulnerability, and raised the specific governance challenge created by the integration of HIV into primary health care at a moment when the multi-sectoral accountability architecture for the response is not yet embedded in the mainstream health system.

The session's Mentimeter polls produced live participant data confirming that weak accountability for financing commitments and limited legal protections for key populations are the two most-cited structural gaps in national HIV financing architecture, and that the failure of financing commitments to translate into actual budget allocations is the most frequently identified obstacle to sustained national strategic plan implementation.

SERIES ARCHITECTURE AND CONTINUITY

The AHCWG 2026 Webinar Series is designed as a sequenced policy architecture in which each session builds the analytical layer that the next requires. Webinar 1, convened on 22 April 2026 under the title "Protecting Core Services with Domestic Investments," established the continent's financing baseline. It examined Zimbabwe's AIDS Levy, Kenya's dedicated ARV budget line, Tanzania's domestic ARV allocation, Nigeria's National Domestic Resource Mobilisation Strategy, and South Africa's risk-adjusted conditional grant as the principal examples of domestic financing instruments that have demonstrated results. Its central conclusion was structural: the question confronting the continent is no longer whether domestic financing is necessary but whether governments will design budget architectures robust enough to protect the populations with the highest HIV burden and the greatest risk of exclusion when financing contracts.

Webinar 2 takes up the deeper architectural question that Webinar 1 identified but could not fully address: what gives those budget mechanisms institutional durability beyond a single administration or a single budget round? The session developed a three-part answer across its presentations and panel discussion. Durability comes from enabling legislation that converts policy aspiration into legal obligation; from national HIV strategies that are integrated with broader health and development frameworks rather than managed as vertically financed parallel systems; and from legal environments that extend access to the populations most affected by HIV rather than structurally excluding them through criminalisation, discrimination, and service denial.

Webinar 3, scheduled for June 2026, will close the series with an examination of regulatory environments and resilience partnership models, including local manufacturing, procurement reform, supply chain sovereignty, and the terms on which Africa engages international health partnerships.

SESSION DISCUSSIONS

Welcome and Framing

Dr. Magda Robalo | Moderator

Dr. Magda Robalo opened the session by welcoming participants across time zones and providing orientation on the session's bilingual English and French captioning, the Mentimeter interactive polls, and the structure of the programme. She framed the thematic agenda directly, noting that across the African continent countries are being asked to sustain HIV and broader health responses while managing fiscal constraints, transition negotiations, and growing pressure on national health systems, yet many financing commitments remain insufficiently protected within legislation, national planning frameworks, and broader governance systems.

As co-chair of the UHC 2030 Steering Committee, Dr. Robalo situated the session's stakes in the global access deficit, observing that 4.6 billion people around the world currently lack access to basic health care services. She set out the four interconnected dimensions that would structure the session's discussion: enabling legislation for sustainable financing; alignment between national strategic plans and broader health and development frameworks; continental policy coherence and transition governance; and the legal environments that affect populations most impacted by HIV. She emphasised that the session's goal was not only to reflect on challenges but to identify practical, solution-oriented legislative and governance actions that countries can advance within their own national contexts.

Before opening the floor to the first speaker, Dr. Robalo invited participants to respond to the first Mentimeter poll, asking them to identify the most binding constraint to strengthening domestic HIV financing in their country. The poll results established the analytical tone for the session: the most frequently cited constraints were weak political commitment and limited political will, followed by inadequate domestic resource mobilisation, and reliance on external financing. Participants from several countries noted that their governments had made formal commitments to increase domestic health allocations but that those commitments had not survived budget negotiations. The emphasis throughout was on political and structural constraints rather than technical or data limitations.

National Implementation Realities: Strategic Plan Alignment, Integration, and Financing

Mr. Petrus Khoza | Acting Chief Director, HIV/AIDS Conditional Grant and NGO Funding, National Department of Health, South Africa

Mr. Petrus Khoza opened by locating his perspective within South Africa's position as the operator of one of the largest HIV treatment programmes in the world. He identified four main areas of focus: strategic plan alignment, programme integration into primary health care, health economics and efficiency, and the financing architecture question.

On strategic alignment, Khoza argued that the absence of a single, unified national strategic plan with a corresponding monitoring and evaluation framework is the primary structural obstacle to coordinated implementation. He described the advantage that South Africa has derived from its multi-sectoral National Strategic Plan, led from the President's Office and drawing in government, civil society, and the private sector. His argument was direct: without one plan and one M and E document against which all actors are accountable, it is structurally impossible to determine whether the national response is coordinated, whether targets are being met, or whether resources are flowing to the right places. He emphasised that detailed costing of activities is

essential and not optional; a strategic plan without a costed implementation breakdown is an aspirational document, not an operational one.

On integration, Khoza addressed the South African experience of managing the 2025 disruption caused by the US work stop orders and the subsequent USAID withdrawal. He described integration into primary health care not as a future aspiration but as an operational necessity given the contraction of external resources, and detailed the practical mechanisms through which it is being implemented in South Africa: lay counsellors who conduct HIV testing and simultaneously screen for non-communicable diseases, triage staff who collect vital signs for all patients, and facility-level arrangements that reduce the costs of running parallel systems. His position was that running vertical HIV programmes is not sustainable under current fiscal conditions, and that maximising efficiencies through integration is therefore a structural imperative rather than a policy preference.

On health economics, Khoza acknowledged the fiscal reality that donor funding is shrinking while economies are not growing at the rate needed to absorb the gap, and argued that programme sustainability requires governments to maximise impact from whatever resources are available. He identified strong supply chain systems, a properly capacitated workforce, and community structures that actively support implementation as the three operational pillars that make a costed strategic plan function in practice.

> *"The issue around programme financing will remain with us for as long as we remain as a continent funding our programmes mainly by relying on donor assistance. The challenge that sits with all of us is that we need to get to a situation where our own governments allocate resources to the programme. On our side, it is incumbent upon us to ensure that that one strategic plan translates into strategies for implementation broken down into costed activities, where we become cost efficient and ensure that we maximise all resources that we have." | Mr. Petrus Khoza*

Khoza also addressed the private sector and civil society dimensions of sustainable financing, emphasising that South Africa's programme reaches communities in part through domestically funded NGOs that run adherence clubs, medication pickup points, and community-based monitoring. He flagged the persistent gap in services for key populations, where the full package of services required cannot be delivered through public health facilities alone, and described South Africa's current approach of contracting NGOs to provide those services in community settings as an interim architecture while more permanent arrangements are developed.

Continental Governance, Policy Coherence, and Transition Arrangements

Dr. Benjamin Djoudalbaye | Ag. Director, External Relations and Strategic Engagement, Africa CDC

Dr. Benjamin Djoudalbaye opened by acknowledging the importance of an African-led conversation on sustainable HIV and health financing and framed his contribution around two core questions: how continental commitments translate into national laws and budgets, and how transition agreements can either reinforce or weaken sovereignty and sustainability.

He set out the current continental framework architecture: the AU Catalytic Framework, the AU Roadmap to 2030, the Lusaka Agenda, and the broader set of Africa-wide commitments on HIV, universal health coverage, domestic resource mobilisation, and health security. His assessment was direct. These frameworks are strong on political ambition but are not adequately reflected in national legislation, public financial

management rules, or social protections. He illustrated this with two concrete examples: the commitment to increase domestic health financing is present at the continental level, but HIV budget lines in most countries remain off-budget or heavily dependent on off-treasury project accounts; and the commitments on human rights and non-discrimination that most member states have subscribed to at the continental level coexist with persistent gaps in legal protection for key and vulnerable populations at the national level.

Dr. Benjamin defined policy coherence in operational terms: what heads of state sign at the AU level must be visible in budget laws, in procurement rules, in social health insurance frameworks, and in how services are purchased at facility level. The challenge is not the absence of frameworks; it is the distance between continental endorsement and domestic legal implementation. He argued that this distance is not bridged by good intentions but by deliberate legislative action at the national parliamentary level, supported by civil society monitoring and parliamentary oversight that holds governments accountable to the commitments they have endorsed.

> *"Our challenge is not the lack of commitment. It is ensuring that continental decisions are embedded in national laws, budgets, and contracts. I encourage all of us, especially policy makers, partners, and civil society, to systematically review how African Union and regional commitments are reflected in national legal and financial instruments. The policies are defined at the continental level, but at the grassroots, civil society and different partners should look at it, including the parliamentarians." | Dr. Benjamin Djoudalbaye*

On transition agreements, Dr. Benjamin argued that Africa CDC has been advocating for a gradual, predictable financing trajectory that combines domestic resources, innovative financing, and efficiency measures, and that investment in laboratories, supply chains, health workforce, and digital systems must be consistent with the continental vision rather than defined by external programme priorities. He called for transition MoUs to be scrutinised through a sovereignty, rights, and sustainability lens before signature, and indicated that Africa CDC stands ready to work with member states, regional economic communities, and partners to develop model clauses, peer learning frameworks, and technical support mechanisms so that transition agreements truly serve African priorities.

Legal Environments, Community Reality, and the Structural Drivers of HIV Vulnerability

Mr. Nelson Otwoma | Executive Director, NEPHAK Kenya

Mr. Nelson Otwoma opened by acknowledging the changing global health and HIV financing landscape and the imperative of innovation to sustain the work that has been built, noting that much of Africa, including Kenya, witnessed the 2025 disruptions from the US government funding freeze. Otwoma offered three framing observations: that sovereignty does not mean stopping partnerships but requires countries to be more vigilant about the terms of those partnerships; that much external support flows to what is easiest to fund, namely biomedical treatment, while leaving a significant gap in prevention; and that the move toward integration of HIV into primary health care, while necessary, creates a specific governance challenge around how the multi-sectoral response architecture fits into mainstream public health systems.

Otwoma drew a sharp analytical distinction between HIV as a biomedical issue and HIV as a deeply social, structural, legal, and political challenge. He argued that treating HIV solely as a matter of medicines and clinical services, while leaving unaddressed the cross-cutting issues that fuel transmission and worsen the impact of AIDS, produces a

response that cannot control the epidemic. The cross-cutting issues he identified as non-negotiable within any serious HIV response architecture include inequality, stigma and discrimination, punitive laws, disregard for human rights, harmful socio-cultural norms and gender-based violence, and poverty and other economic factors.

On legal environments and key populations, Otwoma addressed the structural exclusion produced when HIV service delivery is integrated into primary health care systems staffed by providers who do not have the competencies to serve key populations. He argued that the announcement that countries are taking HIV back into the health sector and into mainstream public health simultaneously removes the question of how multi-sectoral accountability for the response works from the governance architecture of the health system, since that architecture was historically maintained through dedicated HIV programme structures. The challenge of how the multi-sectoral response fits into public health at the time of integration is, in his framing, the governance question that needs urgent deliberate resolution.

For adolescent girls and young women, Otwoma described Kenya's multi-sectoral response as a useful model, comprising biomedical (oral PrEP, new technologies including vaginal ring and injectables, ARVs framed through the principle that treatment is prevention), structural (cash transfers, free schooling, social vaccines), and behavioural (comprehensive sexuality education, peer mentoring) components. He argued that scaling up this model requires a deliberate design decision about how to anchor multi-sectoral accountability within the integration process, and that this design decision has not yet been made in most countries.

> *"Responding to the vulnerability of young people and their susceptibility to AIDS calls upon countries in sub-Saharan Africa to address HIV for what it is: not solely a biomedical issue, but a deeply social, structural, legal, and political challenge. Countries need to identify the cross-cutting issues that fuel the spread of HIV and worsen the impact of AIDS. This agenda includes inequality, stigma, discrimination, punitive laws, disregard for human rights, harmful socio-cultural norms and traditions including where gender-based violence is sanctioned, and poverty and other economic factors." | Mr. Nelson Otwoma*

Legislation as the Foundation for Durable Financing: The African Union Institutional Architecture

Hon. Commissioner Dr. Litha Musyimi-Ogana | Member, African Commission on Human and Peoples' Rights

Hon. Commissioner Dr. Litha Musyimi-Ogana joined the session from the Democratic Republic of Congo, where she was on a mission, and contributed after the other three speakers, having listened to their presentations through earphones. She opened by situating her personal history with HIV advocacy, noting her involvement since 1986 in Kenya, when HIV was still widely misunderstood and the work of destigmatisation was central to the public health response. Her framing was direct: sustainability of HIV and AIDS and health financing in Africa is not merely a financial or technical issue. It is fundamentally a human rights issue. Financing determines whether people living with HIV have access to life-saving treatment, whether vulnerable populations are protected from discrimination, whether women and girls can access sexual and reproductive health services, and whether health systems can equitably serve all people.

Dr. Musyimi-Ogana walked the session through the key continental legislative and policy instruments that have defined Africa's approach to HIV financing over the past three decades, framing them as a cumulative architecture that successive generations

of African leaders and advocates have built, and which now requires national-level implementation to be meaningful.

On the Abuja Declaration, she recalled the historical moment of its adoption and articulated its six core principles as they remain relevant today: the importance of domestic resource mobilisation; sustainable and diversified financing; recognition of health financing as an integral part of development; strengthened health systems; promotion of affordable medicines and treatment access; and accountability in health infrastructure and expenditure. She noted that Africa still monitors implementation of the 15 percent health budget target, and that this continuing accountability function is itself evidence that Africa has not been passive in the face of the financing challenge.

Dr. Musyimi-Ogana also addressed the 2006 Abuja Call for Accelerated Action on Universal Access, describing it as a landmark political commitment that established universal access to comprehensive HIV, TB, and malaria services as a continental objective, with key elements including increased domestic financing, strengthened partnerships, rights-based HIV programming, and health system strengthening. She described the Maputo Reproductive Health Strategy, in its original form adopted during the OAU to AU transition and in its current 2016-2030 iteration, as groundbreaking in translating the Maputo Women's Protocol into a concrete health strategy for women, and noted the particular significance of that strategy for the intersection of sexual and reproductive health rights with HIV financing and access.

In closing, Dr. Musyimi-Ogana connected the historical arc of the response to the current moment, tracing the progression from destigmatisation and behaviour change through the condom era, the ARV era, and the COVID-19 disruption, which for two years eclipsed attention to HIV and other established diseases. She closed by signalling that the continent is now entering an era of serious thinking about HIV vaccines and domestic resource mobilisation, and that the legal and financing architecture must be built to sustain a response that will need to absorb these new developments.

> *"Sustainability of HIV and AIDS and health financing in Africa is not merely a financial or technical issue. It is fundamentally a human rights issue. Financing determines whether people living with HIV have access to life-saving treatment, whether vulnerable populations are protected from discrimination, whether women and girls can access sexual and reproductive health services, and whether health systems can equitably serve all people without leaving anyone behind." | Hon. Commissioner Dr. Litha Musyimi-Ogana*

PANEL DISCUSSION

Following the four presentations, Dr. Robalo convened a structured panel discussion with all four speakers, posing a set of focused questions on the legal, legislative, and governance dimensions of sustainable HIV financing.

What Legal Protections Survive Political Transition and Fiscal Consolidation?

Dr. Robalo directed this question first to Hon. Commissioner Dr. Litha Musyimi-Ogana, who indicated from the DRC that her field assignment required her to withdraw at this point, though she committed to responding in writing. Dr. Robalo then addressed the question to Mr. Nelson Otwoma.

Otwoma offered a candid and historically grounded response. He observed that across African countries and drawing specifically on Kenya's experience, the only commitments that have consistently survived changes in political administration are debt obligations, particularly debt to the IMF, World Bank, and bilateral creditors. By contrast, many

progressive policy commitments including free primary education to keep girls in school and maternal and child health policies such as Kenya's Linda Mama scheme have been significantly altered or reversed by successive administrations. His reading of the evidence was that in the HIV space, legislatively protected mechanisms have the strongest survival record: the Zimbabwe AIDS Levy, embedded in law, has demonstrated greater durability than administrative commitments in most comparable contexts. He also noted, with candour, that in Kenya a previous administration had funded HIV services when Global Fund support was not available, but that a subsequent administration returned to dependence on external partners, illustrating precisely the vulnerability of unlegislated financing commitments to political transition.

> *"In most of Africa, the only thing that has transitioned beyond political regime change is debt. Other regimes had very good policies, but when another regime comes up, they are turned upside down. In the space of HIV, the only example I can give is where governments put in an AIDS levy like Zimbabwe. When you put a law protecting HIV money, then it will survive." | Mr. Nelson Otwoma*

How Can Countries Legislate Financing?

Mr. Petrus Khoza took the floor first on this question, and offered a direct affirmative: it is possible, and the Mentimeter data showing political will as the primary success factor was, in his reading, the most important finding of the session. His argument was that political will must move from being a statement made in large meetings to being a lived reality embedded in government decision-making processes. He cited Zimbabwe's AIDS Levy and the legal mechanism through which it is collected, South Africa's act of parliament underpinning its HIV financing architecture, South Africa's sugar tax levy as a comparable instrument for health promotion financing, and Tanzania's and Uganda's emerging levy discussions as evidence of a continental pattern in which legislative action is achievable where government-led commitment is sustained. His caution was equally pointed: legislation that emerges only in response to advocacy pressure and is not rooted in genuine political commitment tends to be legislated through one administration and reversed or hollowed out by the next.

> *"It is possible to legislate financing. What comes up as the main success factor is political will, and that needs to come through not as a political statement in big meetings but as a lived reality. Countries such as Zimbabwe, Kenya, South Africa, and now Tanzania are coming up with levies of some kind. In South Africa it is an act of parliament. In Zimbabwe it is the same for the AIDS levy. It is actually possible where there is a government-led strategy." | Mr. Petrus Khoza*

Dr. Benjamin Djoudalbaye reinforced this from the continental governance perspective, emphasising that the issue is not the absence of legal instruments but the absence of alignment between the legal instruments that exist and the domestic constitutional frameworks, budget laws, and public financial management rules through which they must operate. His position was that Africa has all the legal provisions it needs; what it lacks is the ownership, transparency, accountability, and clear governance provisions that turn legal frameworks into enforceable obligations.

What Risks Do Poorly Negotiated Bilateral Transition Agreements Create?

Dr. Benjamin Djoudalbaye addressed this question directly, identifying four levels of risk with precision.

Risk 1: Bypassing national planning and budgeting systems, producing a situation in which money is committed but not properly planned or budgeted within national public

financial management processes, making it structurally vulnerable to misuse and impossible to account for against national development objectives.

Risk 2: Introducing procurement or programme conditions that disturb national priorities, requiring procurement outside the national cycle in ways that distort the entire supply chain architecture and create parallel systems that erode the national procurement infrastructure.

Risk 3: Shifting accountability upward to funders rather than outward to citizens and institutions, which is the structural inversion of the accountability relationship that sovereign health governance requires.

Risk 4: Exposing vulnerable populations to service disruptions during the transition period, because the communities most dependent on the services being transitioned are precisely those least able to absorb gaps in care.

In the subsequent Q and A, when asked about early lessons from new government-to-government agreements and how they have been framed to support sovereignty and sustainability, Dr. Benjamin noted that Africa CDC was not initially associated with these negotiations, as national sovereignty prevails in government-to-government arrangements. He described Africa CDC's advisory posture as one of drawing member states' attention to critical areas from which they should not depart: data ownership must remain with the country; conditionalities must not override domestic laws or national priorities; any exceptional arrangement must be transparent, time-bound, and linked to a clear transition back into the national system; and governments must negotiate from a whole-system perspective rather than from the perspective of a single programme. He specifically referenced Kenya and Zimbabwe as countries where legislative and constitutional review processes had identified significant misalignments between proposed MoU terms and domestic legal frameworks, and noted that several African countries had paused or stopped agreement processes on those grounds.

Which Legal Reforms Are Realistic, Actionable, and Politically Feasible?

Dr. Benjamin Djoudalbaye again engaged this question, this time with a distinctive framing: the answer to what is politically feasible is not more legislation but better alignment, ownership, and accountability for the legal frameworks that already exist. His core observation was that Africa has a substantial body of legal texts in each country, but what is missing is the alignment of those instruments with domestic constitutional obligations, transparency and accountability provisions, and the governance structures that make implementation possible. He argued that the priority is not drafting new laws but ensuring that existing frameworks are owned by governments, that implementation is transparent and accountable, and that the institutional strengthening necessary for long-term sustainability is pursued deliberately.

> *"We don't need more laws. We have all that it takes for countries to align their constitutional prescriptions and provisions with continental legislative frameworks, own them, account on them, be transparent about them, but most importantly, implement them." | Dr. Magda Robalo, synthesising the panel discussion*

AUDIENCE ENGAGEMENT: Q AND A AND MENTIMETER POLL RESULTS

Questions from Participants

Participant questions during the Q and A session addressed three principal areas.

On government-to-government agreement design: A participant asked whether there are early lessons from new G2G agreements on how they have been framed to support continental and national sovereignty and sustainability while promoting equitable access and quality of care. Dr. Benjamin Djoudalbaye responded as described above, noting Africa CDC's advisory principles and the experience of Kenya, Zimbabwe, and other countries where constitutional review processes had identified alignment issues with proposed MoU terms.

On integration and human resources: A participant from rural Tanzania noted that 3,200 clients are under care in their area and that integrating HIV services will be extremely difficult for staff to cover, reflecting the human resources challenge that integration creates at the point of service delivery. This comment was complemented by another participant's observation that integration offers opportunities for sustainability and efficiency but also creates real risks to quality, equity, and community-led approaches.

On what is being integrated: Dr. Robalo posed to Mr. Khoza the direct question of whether countries are integrating people, diseases, or services. Khoza's answer was unambiguous: it is services that are being integrated, not diseases, and not people as abstract categories. He described South Africa's approach of embedding HIV and TB services within the primary health care platform, with outreach teams linking facilities to communities, and with domestically funded NGOs running community-based services including adherence clubs and medication pickup points. He reiterated the persistent gap in key population services, where the full package required cannot be delivered through public facilities, and described the current approach of contracting community-based NGOs as a bridge to a more permanent architecture.

Dr. Robalo synthesised the integration discussion with a complementary observation: that as people living with HIV live longer, they are developing non-communicable diseases including diabetes and cancer, and that a people-centred integration approach must ensure that they receive care for the full range of conditions they carry, not only HIV treatment.

Mentimeter Poll Results

Four Mentimeter polls were conducted throughout the session. The results provided live participant data that reinforced and complemented the analytical positions developed in the presentations and panel discussion.

MENTIMETER POLL: What is the single most binding constraint to strengthening domestic HIV financing in your country?	
Weak political commitment and limited political will	**Highest rated**
Inadequate domestic resource mobilisation	**Second**
Continued reliance on external financing (Global Fund, bilateral)	**Third**

MENTIMETER POLL: What is the single biggest policy or legal gap affecting sustainable HIV financing in your country?	
Weak accountability for financing commitments	**Highest rated**
Limited legal protections for vulnerable and key populations	**Second**

MENTIMETER POLL: What is the main challenge with translating national HIV strategic plans into sustained implementation?	
Financing commitments do not translate into budget allocations	**Highest rated**
Weak implementation capacity at subnational level	**Second**

MENTIMETER POLL: What principle should be non-negotiable in HIV transition agreements or G2G MOUs?	
Equitable access is non-negotiable	**Highest rated**
People-centred care and equity	**Second**
Data sovereignty and ownership	**Also prominent**

The poll results carry significant analytical weight. The fact that participants across the continent independently identified weak accountability for financing commitments and limited legal protections for key populations as the two principal structural gaps confirms the session's core finding: the challenge is not the absence of policy commitments but the absence of enforcement, accountability, and legal protection mechanisms that make those commitments durable and equitable.

POLICY OUTPUTS AND ADVOCACY POSITIONS

On Enabling Legislation

Continental health financing targets must be embedded in domestic legislation rather than maintained as declarations. Legislative instruments that have demonstrated durability, including dedicated fund laws, earmarking statutes, and parliamentary acts underpinning conditional grants, should be studied as replicable models rather than treated as exceptional cases. Governments preparing Voluntary National Reviews should include the legislative status of health financing commitments as a reporting indicator.

On National Strategic Plan Implementation

A national HIV strategic plan that is not costed, not integrated with broader health and development frameworks, and not supported by a single monitoring and evaluation system cannot produce a coordinated response. The continental standard should be a single national plan with costed activities, unified M and E, and governance structures that extend beyond the health sector to include finance, justice, and community accountability.

On Continental Policy Coherence

The legislative transposition gap between continental commitments and national law is not a communication failure; it is a structural problem requiring deliberate parliamentary action. Parliamentarians, civil society organisations, and communities should systematically audit how AU and regional commitments are reflected in their national legal and financial instruments. The AHCWG calls on African governments to establish parliamentary working groups on health financing legislation as a practical, immediately actionable step.

On Bilateral Transition Agreements

Any bilateral HIV transition agreement must be assessed against five non-negotiable principles drawn from the session discussion: conditionalities must not override domestic laws or national priorities; data ownership must remain with the country; procurement conditions must not distort the national supply chain cycle; accountability must run outward to citizens rather than upward to funders; and equitable access for all populations, including key populations, must be explicitly protected rather than left to interpretation. Any exceptional arrangement must be time-bound and linked to a clear transition back into the national system.

On Legal Environments for Vulnerable Populations

A national HIV response architecture that does not address the social, structural, legal, and political drivers of HIV vulnerability will not control the epidemic regardless of the financing it mobilises. Legal reforms that remove criminalisation of key populations, expand adolescent access to services without parental consent barriers, and enforce existing gender-based violence protections are both health policy imperatives and prerequisites for the equity that makes any financing architecture legitimate.

CONCLUSION

The second webinar of the AHCWG 2026 Series established with clarity and practical grounding that the continent has the legal instruments, the continental frameworks, and the institutional architecture it needs. What it requires is the political will to align those instruments with constitutional obligations, the governance capacity to translate strategic plans into costed and implemented reality, and the legal courage to build environments in which every person the epidemic affects can access the services their governments have committed to provide.

Mr. Petrus Khoza demonstrated from South Africa's implementation experience that the distance between a national strategic plan and a sustainable, domestically financed programme is bridged by costed activities, supply chain discipline, and an integration strategy that does not sacrifice equity for efficiency. Dr. Benjamin Djoudalbaye showed from Africa CDC's continental governance vantage point that the risks of poorly negotiated bilateral agreements are not abstract; they cascade through national planning systems, procurement cycles, accountability structures, and ultimately through the communities that depend on service continuity during transition. Mr. Nelson Otwoma made the most direct case of the session: that HIV is not only a biomedical challenge, and that a response architecture that treats it as such will continue to leave the most affected populations unreached regardless of the resources allocated. Hon. Commissioner Dr. Litha Musyimi-Ogana placed all four dimensions in their historical and institutional context, reminding the session that Africa has been building this architecture for over three decades and that the present moment calls not for new frameworks but for implementation.

The Mentimeter data from across the session's participant community confirmed what the speakers said from their institutional positions: weak accountability for financing commitments and limited legal protections for key populations are the most cited structural failures in national HIV architecture. These are not technical problems with technical solutions. They are political problems that require political leadership at the parliamentary, executive, and community accountability levels simultaneously.

The AHCWG will carry the advocacy positions generated in this session into the spaces where they have immediate operational relevance, including the World Health Assembly, national budget processes through the remainder of 2026, and the bilateral negotiations that continue in parallel with continental and multilateral forums. Country-

level follow-through on the legislative and policy commitments made in this session will be reported at Webinar 3 in June 2026.

WEBINAR 2 | EVENT DETAILS			
Date	27 May 2026	**Series**	Webinar 2 of 3 | AHCWG 2026 Financing and Resilience Series
Format	Virtual, bilingual (English and French)	**Duration**	90 minutes
Convener	African-led HIV Control Working Group (AHCWG)	**Secretariat**	Policy/Strategy Group (PSG), Nairobi