SUMMARY AND RECOMMENDATIONS

Market-driven Approaches to Advance the Financial Sustainability of Community-based HIV services

August 2022

Bangkok, Thailand

PEPFAR

USAID
FROM THE AMERICAN PEOPLE

EpiC
Meeting Targets and Maintaining Epidemic Control

Content

Acknowledgements

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Why talk about sustainable financing now?

Community-based organizations (CBOs) and Key Population-led Health Services (KPLHS) are critical to ending the HIV epidemic. Their contributions - from introducing innovations to reaching the under-served and most vulnerable - have been documented in numerous settings. However, their future sustainability and, therefore, our global progress in combatting the epidemic is endangered by a substantial reliance on international donor funding.

Sustainable financing for CBOs is a holistic approach to raising resources beyond traditional sources. Reducing dependence on a single source of funding is critical for many reasons:

- Diversified funding increases the stability of an organization, particularly amid economic downturns and shifting donor priorities.
- Multiple funding sources can increase the flexibility of organizations to adapt to changing community needs.
- Transitioning to new revenue models can lead to innovation in service delivery.
- Models that increase unrestricted funding support organizations to spend in line with organizational priorities.

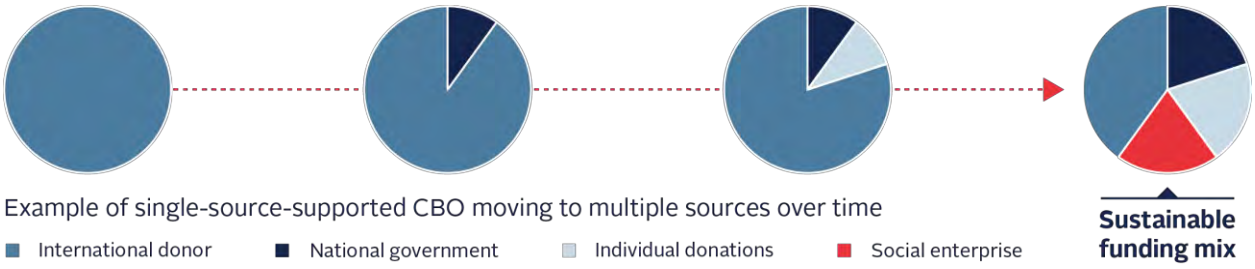
Themes We Heard

Health has a financing gap!

There are significant funding gaps for HIV, specifically, health generally, and a short window to bend the epidemic's trajectory.

Even before the COVID-19 pandemic and associated economic disruptions, the resources available for HIV in low- and middle-income countries had been leveling off. Despite rising in the previous decade, domestic HIV resources had declined before 2020, and limited investment in key populations has been holding back an equitable HIV response. As a result, the US$ 21.4 billion available globally for HIV in 2021 was well short of the US$ 29.3 billion needed in 2025 to end the AIDS epidemic by 2030. Generally, the largest gap in funding for HIV (about US$ 3.5 billion) is in lower-middle-income countries: resources available in those countries for 2021 fell 55% short of the projected near total needs for 2025. The economic impact of the COVID-19 pandemic in some countries is also likely to be severe, making it even more difficult for them to close their funding gaps with domestic resources alone. – *Iris Semini, UNAIDS.*

Sustainable Funding is not simply utilizing a single new source of funding. It is a diverse mix of funding sources.



On August 30th and 31st, 2022, over 100 participants from CBOs, Ministries of Health, NGOs, and the international donor community came together in Bangkok, Thailand to explore advancements in market-driven alternative and sustainable financing for community-based organizations and KPLHS from various countries, including:

- Social contracting and social health reimbursement schemes from host governments
- Social enterprise development
- Pay-for-performance approaches, with a spotlight on social impact bonds

> *"It's important to step back and understand the scope of the global deficit in funding available for Universal Health Coverage generally. Before the pandemic, there was an estimated gap of $134 billion, which was expected to triple by 2030. There is, simply put, no path to health for all without using multiple financing routes to get there.* – Whitney Adams, Senior Advisor for Innovative Finance"

The goal of the meeting was to launch a conversation about what's possible. We sought to spark ideas from donors, governments, and implementers with practical examples from around the region and aspirational achievements worldwide. In addition to sharing practical examples of blended financing strategies and celebrating successes, presenters were encouraged to share the barriers to implementing these financing strategies and the roadblocks they have hit along the way.

This workshop was only the start of our conversation. With support from USAID Regional Development Mission for Asia (RDMA), EpiC will support follow-up activities to ensure continued progress from CBOs and other stakeholders in sustainable financing strategies in Asia and globally. These may include the following:

- **Regional Social Enterprise Support:** Support four HIV-related social enterprises in Asia to launch new revenue generation strategies.
- **Launching the Sustainable Financing Primer:** Building on the Sustainable Financing Primer, a knowledge product EpiC created to support CBOs in developing a more diversified funding mix, provide technical assistance on key areas of interest for local partners.
- **Ongoing Support for Social Contracting:** Support learning exchanges between countries that want to improve their existing social contracting methods or those who need more advocacy and tools to start.
- **Continued Opportunities for Learning and Engagement:** Host webinars and in-person seminars on social enterprise development, impact bonds, and proposal development/writing.

On behalf of FHI 360 and the EpiC Project, we would like to extend our sincere thanks to all of the organizations that participated:

- **Cambodia:** Chhouk Sar; Ministry of Economic & Finance; National AIDS Authority; National Center for HIV/AIDS
- **India:** The Humsafar Trust; National AIDS Control Organisation (NACO); Population Services International; Sattva Consulting; Prayas Health Group; Network of Maharashtra by People Living with HIV/AIDS (NMP+)
- **Indonesia:** Angsamerah Clinic; West Java HIV/AIDS Community Care Forum; ACHIEVE; RHTSN; HASH; PAFPI; TLF Share; National Youth Association; DoH NCR; SHIP; Pinoy Plus; TDFI

- **Laos:** Department of Communicable Disease Control MOH; Center for HIV/AIDS and STIs; Community Health and Inclusion Association
- **Nepal:** Jagriti Mahila Mahasangh; Ministry of Health and Population; National Association of People Living with HIV; Blue Diamond Society; Ministry of Health and Population
- **Philippines:** LoveYourself; Philippines Department of Health; Family Planning Organization of the Philippines (FPOP); PhilHealth
- **Thailand:** Institute of HIV Research and Innovation; Pribta Clinic; Service Workers in Group (SWING); RSAT, MPLUS, ACTSE, MOPH
- **Vietnam:** Vietnam Authority of HIV/AIDS Control; Ministry of Health; Glink Vietnam; Blue Sky Social Enterprise
- **Global:** UNAIDS; USAID; South African Medical Research Council; Social Finance

The necessity of Key Population-Led Health Services (KPLHS) in ending HIV

Dr. Nittaya Phanuphak, Executive Director, the Institute of HIV Research and Innovation (IHRI) in Thailand, centered the discussion on the central role that KPLHS and CBOs are playing in ending HIV. In Thailand, a majority of current PrEP users receive PrEP from lay providers in key population-led clinics. These clinics, located in high-HIV prevalence provinces, are steadily expanding in number. Some of the innovative service delivery models that Thai CBOs have implemented now include same-day ART services, mental health screenings, and transgender-competent care.

With KP-led CBOs playing a central role in service delivery, we must move from community *engagement* to community *leadership*. In Thailand, this has meant moving to direct government funding of CBOs through reimbursements, aka "social contracting**".** Community leaders have cemented their role in policy and advocacy discussions at the national level in Thailand. A beneficial policy climate among a coalition of domestic and international stakeholders is crucial to success since the KPLHS model challenges the paternalistic and hierarchical healthcare system that hinders the advancement of innovative HIV service delivery models. Thailand has successfully turned yesterday's 'not feasible' into today's successful KPLHS programs. Even for governments with limited HIV budgets, reimbursing KP-led CBOs is a cost-effective and impact-oriented strategy.

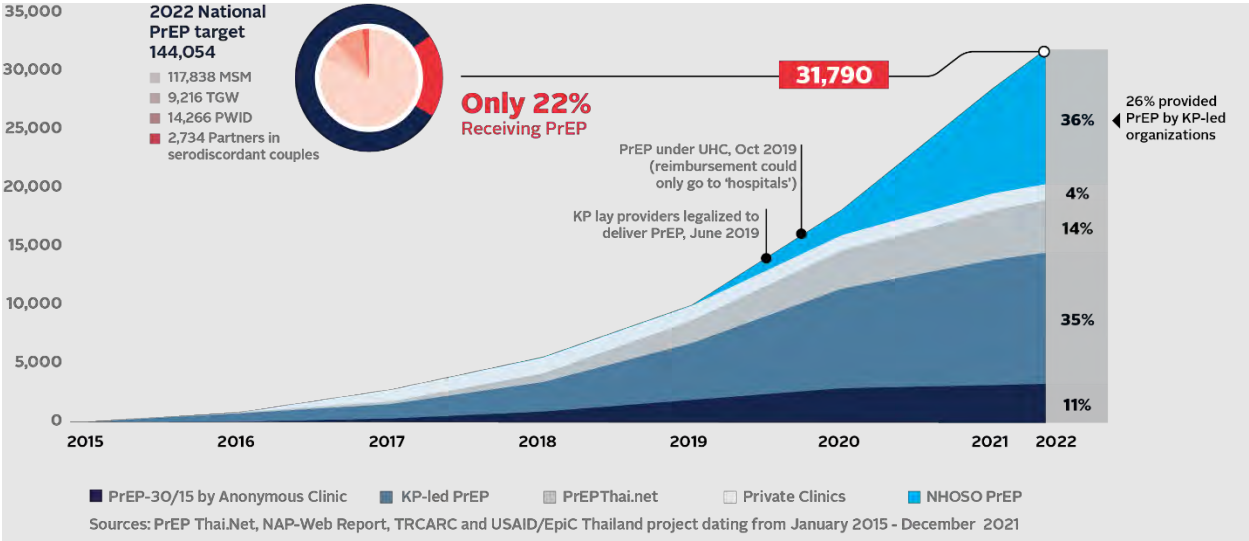
> *Let's rethink who gets to decide whether a program is feasible and how this is ultimately defined*
> — Dr. Nittaya Phanuphak

Themes We Heard **Get the data!**

International funding can and should be leveraged to generate data to facilitate high-level policy and advocacy discussions around KPLHs, including transitioning to domestic financing and sustainability.

As we heard from presenters reflecting on what factors drove success in social contracting, one theme became clear: think about the data you need to make a case for funding KP-led CBOs and start collecting it now. This sentiment was echoed by presenters from Thailand, the Philippines, and UNAIDS. In addition to collecting data on impact to influence policy, cost data is also critical. Limited cost data hampers efforts to mobilize sufficient funding for impact. Accurate costs are needed to establish the basis of contracts and payments and generate evidence regarding comparative advantages. Very few countries fund advocacy activities from domestic government sources. Therefore, international donors play a crucial role in leading and funding data collection and evidenced-based advocacy or the scale-up of social contracting and reimbursement models.

KP-led PrEP service in Thailand: a majority of PrEP users



Financing Key-Population Led Health Services: What are the Options?

Though our forum focused on three specific options (social contracting, social enterprise development, and social impact bonds), Stephanie Turpin, Strategic Partnerships Advisor from FHI 360, presented the full range of options that CBOs might pursue, based on the forthcoming EpiC knowledge product, the Sustainable Financing Primer.

In addition to social contracting and social enterprise development, KP-led CBOs have diversified their funding through private foundations, corporate social responsibility, individual donations, crowdfunding, and impact investing.

With a range of options to consider, what factors should CBOs be thinking about? How should they get started?

EpiC will be launching a new toolkit to support CBOs on this journey, including full descriptions of each model plus:

- Business model adaptations
- A visual depicting resource flows in the model
- Short examples in practice
- CBO archetype for every model
- Key success factors
- Key questions to ask when considering each model

Themes We Heard

It's not either/or!

It's not social enterprise vs. social Contracting vs. other financing. Many sources are usually necessary.

Presenters highlighted not only diverse funding sources but also emphasized the diversity of funding *necessary* within each organization. Most organizations must pursue a range of diversified income sources from donor funding, earned income, and direct reimbursement from national governments.

In addition to risk mitigation, different funding sources are critical to diversifying activities. In most countries, social contracting reimburses for a narrow range of services. Earned income strategies can limit an organization's ability to reach the most vulnerable. CBOs must evaluate and strategically pursue multiple revenue streams.

Which models might work best in your country context?

Ranking

SOURCE : POLL OF MEETING PARTICIPANTS

Factors to consider for Funding Model Fit

Three Success Stories from the Region

A high point of the conference was spotlighting the extraordinary ingenuity and remarkable success that CBOs in the region have already achieved. We were grateful to have three seasoned CBOs join us to share their different paths to financial sustainability.

SUCCESS STORY 1

Success Through Social Contracting and High Net Worth Individuals: LoveYourself

Presented by: Lord-Art Lomarda, RN, with contributions from John Oliver Corciega, John Darwin Ruanto, RN, Danvic Rosadiño, DIH, and Dr. Ronivin Pagtakhan, Ph.D. Ed, MAN, RN

Themes We Heard **Where will the capital come from?**

While we normally think of seed funds and working capital as part of the social enterprise journey, they are also an important enabler of social contracting. As we heard in the LoveYourself example, seed funds were necessary to launch the CBO, and loans were necessary to sustain operations while waiting for government reimbursements. Low-interest loans and working capital to support partnerships with the public sector remain critical barriers to financial sustainability for small and medium-sized clinics worldwide.

In 2011, LoveYourself, a KP-led CBO in the Philippines, began as a project of a group of friends who envisioned establishing a wellness center for LGBT youth. The organization began by adapting a program from the U.S. called the Empowerment Program, a community-run program composed of volunteers sub-divided into committees (communications, events, partnerships, and HIV prevention). Initially, the founder supported the organization financially, and the team had to source and raise funds before each activity or event.

Soon after, LoveYourself entered a partnership with the Philippines Department of Health's Research Institute, where the institute trained LoveYourself volunteers, at no cost, to become HIV counselors. LoveYourself took over operations of a Department of Health (DoH) satellite clinic (which was not attracting many clients) and rebranded it as a community center run by the organization's volunteers and trained counselors. As they began their partnership with the government, they also began working with corporate foundations, which they continue to this day.

As LoveYourself increased the services they provided and became a “one-stop” HIV service model, diagnosing the third highest number of HIV cases nationwide, they began working with international donors. LoveYourself received a capacity-strengthening grant from Global Fund in 2014 to strengthen leadership, management, and finance.

In 2016 LoveYourself continued to expand the services they ran through grants from the national government. However, payments were continuously delayed (often by many years), requiring them to secure loans from high-net-worth individuals. In 2018, they received DoH and the Philippines Health Insurance Corporation (PhilHealth) accreditation to receive social health insurance reimbursements, first as a TB primary care facility, then HIV primary care facility, and finally for laboratory services in 2020.

During this time, loans from high-net-worth individuals were again required to provide working capital as they waited for reimbursement.

USAID, through the EpiC Project managed by FHI 360, also started to support LoveYourself in 2021 and expanded their number of sites in the country. LoveYourself is estimated to achieve debt-free status by 2024. While the journey has been long (2011 – 2024), LoveYourself believes others can follow an accelerated timeline, learning from their path.

SUCCESS STORY 2

Raising quality while raising revenue: Glink

Nguyen Tuong An, Head of Communications and Marketing Department

Themes We Heard **What are the gaps in customer service? Tailor your services there – and charge for them, where possible.**

What are patients and consumers missing in your current context? Are confidential services available? Are any services particularly inconvenient? How would patients rate the quality of various services they receive? In each country context, you can find gaps in quality and convenience, and patients who are able and willing to pay for better services.

A number of the clinics presenting were able to use their experience with grant and government funded projects to collect customer insights on what gaps exist for clients and where there is willingness to pay. While many continue to implement donor-funded or government-funded services, they were able to diversify revenue by adding a suite of fee-for-service offerings.

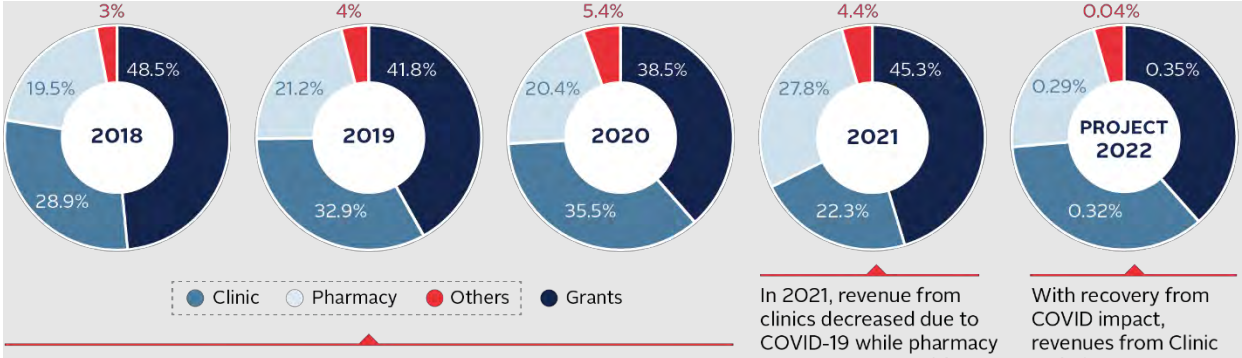
Glink was established in 2009 as a self-help group with only four volunteers from the men who have sex with men (MSM)community. In 2011, after receiving a small donation (just $400!) to promote HIV communication in the community, they began their journey as a community engagement organization. From 2011 through 2014, Glink grew its outreach to providing HIV prevention services to more than 5,000 MSM and transgender customers

In 2015, Glink began piloting an innovative lay provider HIV testing service with PEPFAR through the USAID Healthy Markets project managed by PATH. They also decided to transition to a social enterprise model to diversify services and revenue sources.

The first Glink clinic opened in Ho Chi Minh City in 2016; it would take one full year of advocacy before they were officially licensed to provide examinations and treatment. It was the first private HIV treatment license granted in Vietnam. Glink also became the first clinic to pilot PrEP. Glink has built a network of seven clinics across the country, with 80 full-time staff and more than 12,000 customers.

Proportion of revenue from commercial services increasing over time

Change in income sources over time, Glink clinics, 2018-2021



Increase in proportion of business income from 2018-2020 (from 51.5% to 61.45%); slight decrease in 2021 due to COVID-19.

In 2021, revenue from clinics decreased due to COVID-19 while pharmacy revenues increased from income from drug deliveries (for commercial cients) during lock down.

With recovery from COVID impact, revenues from Clinic and Pharmacy sources are expected to return to pre-COVID growth trends.

Glink continues to innovate and expand:

- At the end of 2021, Glink Foundation was launched, a source of capital for business projects owned by MSM.
- In early 2022, Glink Academy was launched as a training and capacity-strengthening space for community leaders of population groups who want to build a model of social enterprises and community clinics.
- In 2024, they hope to establish a Glink general hospital to provide various medical services that are friendly to the MSM, transgender, and LGBTQ communities.

Glink's Growth:

From 4 volunteers in 2009 to 80 full-time staff in 2022

SUCCESS STORY 3

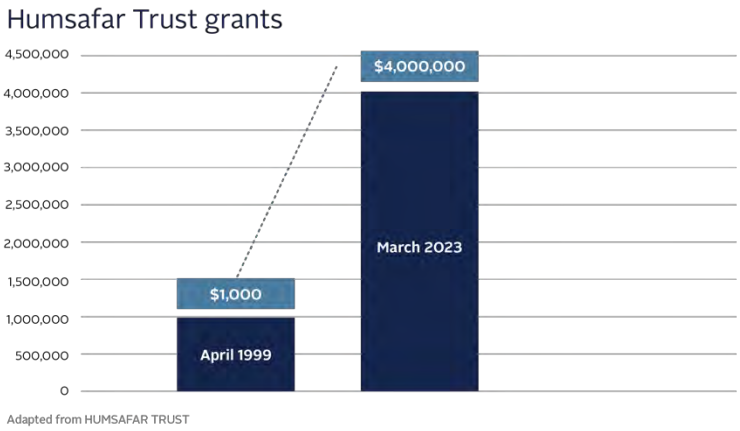
Success Through Partnerships: Humsafar Trust

Vivek Anand, CEO The Humsafar Trust

Humsafar translates to "Companions on a Journey, " a core insight into their values and visions. The Trust's public-private partnership model and central commitment to transparency, accountability, and dialog have allowed it to grow. While the Trust began through individual fundraising, it was the first community organization to obtain a social contract with the Government of India in 1990 (a pilot to reach MSM clients).

In 2001, they began expanding their partnerships with international donors, increasing the number of clients they were reaching while broadening their portfolio of programs.

While health services remained their core program, they expanded to other areas, including policy and advocacy, research, and capacity strengthening for other organizations. In 2009 a landmark legal ruling for the LGTBQ community opened the door for Humsafar to begin working with corporations, particularly for community events. They also started approaching consulates and introduced simple means testing (i.e., methods to categorize patients' income levels) to raise funds from higher-income clients. Since COVID-19, the Trust began working with high-net-worth individuals and increased individual fundraising from the community.



In 1994, a group of friends went to get an HIV test. When one tested positive, the group didn't know where to go from there. That year, the friends launched Humsafar Trust and began activities by inviting the LGBTQ community to HIV and human rights workshops. Twenty-seven years later, their annual budget was $4 million. In the last two decades, the outreach program has reached more than 110,000 members of the LGBTQ community. They've distributed over 700,000 condoms annually at more than 129 physical sites and performed 40,000 HIV tests and 70,000 STI screenings.

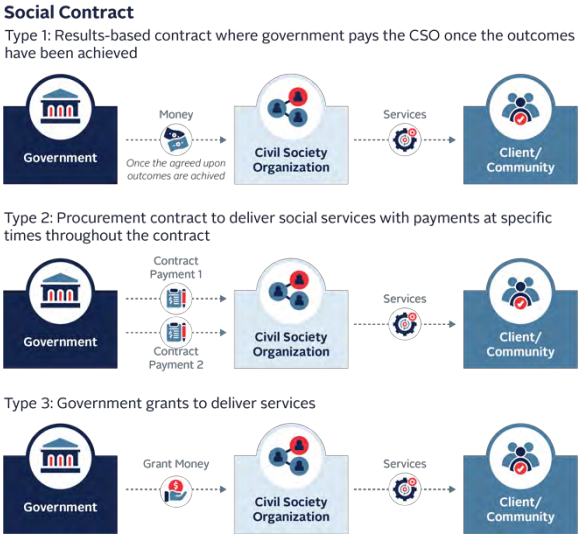
The Road to Social Contracting: Three Paths

The forum highlighted the progress of three distinct success stories in social contracting: Thailand, India, and the Philippines. While there were similarities in their journey to implementing social contracting, it's fascinating to see the variety of models leveraged and services covered.

Direct Reimbursement Model: Thailand National Health Security Office (NHSO)

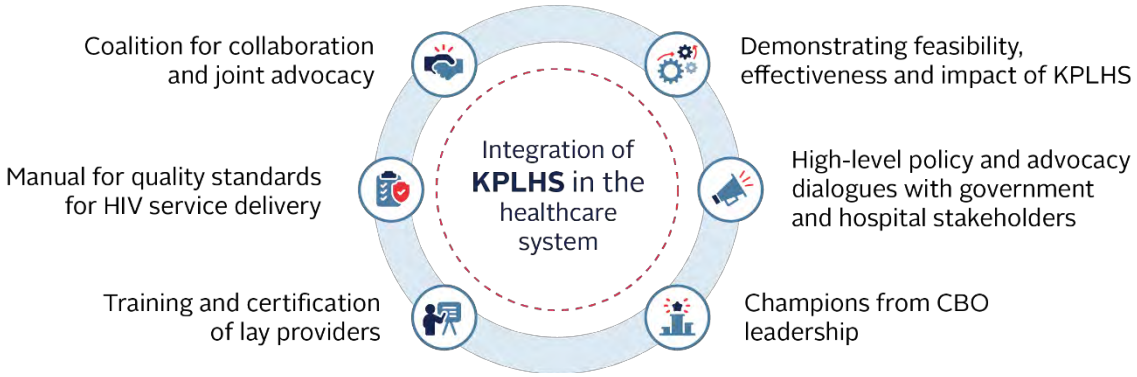
Dr. Nittaya Phanuphak, Executive Director, Institute of HIV Research and Innovation (IHRI) (Thailand)
Supabhorn Pengnonyang, Program Manager, Capacity Development and Advocacy, Institute of HIV Research and Innovation (Thailand)

Thailand follows a direct reimbursement model for services, including outreach and HIV testing. Investments by the National Health Security Office, the health funding arm of the Thai government, more than doubled to support recruit-to-test interventions from 2016-2020. KP-led organizations were reimbursed for testing 40,000 KP clients in 2020, substantially contributing to national HIV testing targets. KP-led organizations are increasingly supported by domestic financing, reaching almost half their operations budgets (on average) by 2021.

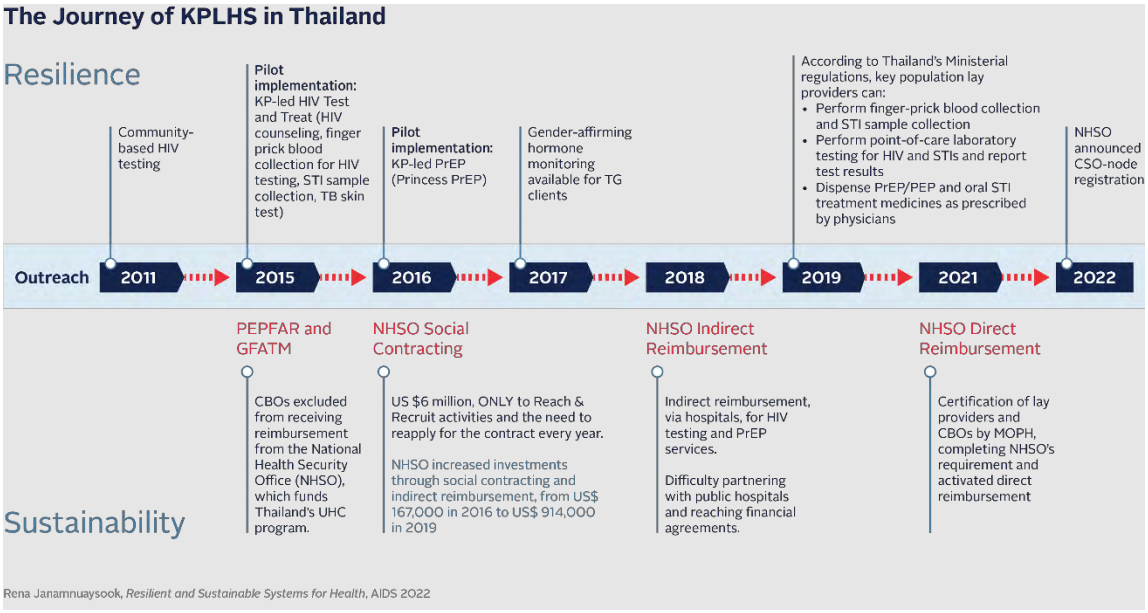


Policies and principles

- **Legal and political support:** Early efforts focused on building legal and political support for KP-led CBOs. It would not have been possible for KP-led organizations to provide the current services without policy changes.
- **Innovation:** Innovative approaches that were initially funded through international donors have been adopted by the National Health Security Office. The focus on innovation enabled rapid scale-up of HIV testing accompanied by same-day ART and PrEP access among both MSM and transgender people.
- **Demedicalization:** Task-shifting, finding less complex ways to deliver care, and embracing a client-centered approach were key policies that have enabled success. Task-shifting and de-medicalization of select services can increase access and efficiency while decreasing cost and maintaining quality. The move to support KP-led organizations to provide HIV services improves the client-centered approach and increases the availability of services within the community.



The Journey of KPLHS in Thailand



Social Insurance Reimbursement: PhilHealth

Sarah May Flores, Representative from the Department of Health (Philippines)

In the Philippines, social contracting is supported through the country's national health insurance system, PhilHealth. In 2018, PhilHealth began accrediting KP-led CBOs (with LoveYourself as the first) to provide ART services and receive reimbursement. To date, reimbursement to service providers is mostly limited to ART.

The Philippines' domestic spending for HIV rose by 286% between 2010 and 2015. However, this increase came as new HIV infections doubled in the same period. While the trend is moving toward greater domestic government support, most of that is for treatment costs.

Policies and principles they embraced on their journey

PhilHealth is one of the few government agencies in Asia that reimburses community clinics for ARV treatment. They now have five CBOs accredited to provide services in the regions with the highest prevalence estimates.

PhilHealth reimbursements are centered around the Outpatient HIV/AIDS Treatment Package. A core principle on the journey to social contracting has been to regularly and inclusively review the package of services offered, e.g. reach-test-treat-prevent-retain. Representatives from the PLHIV community, healthcare facilities, and development partners are consulted during package development and revisions to ensure responsiveness to their needs. In 2021, the latest package revision included a set of minimum of services to be provided to patients and the first approval of alternative modes of delivery of ARVs and other HIV-related services to be more responsive to community needs.

Grants: India National AIDS Control Organisation (NACO)

Dr. Shobini Rajan, Deputy Director General, National AIDS Control Organisation (India)

India began social contracting programs in 1996, primarily with the distribution of condoms, and has been evolving for the past 25 years. Social contracting is done primarily through grants, with each state publishing an expression of interest and CBOs submitting proposals. The award process also follows a more traditional grants approach, with the assessment of organizational capacity as part of the selection process.

Policies and principles they embraced on their journey?

India's program is based on a long-standing commitment to capacity strengthening. CBOs are mentored and monitored by the State AIDS Control Society (SACS) and government Technical Support Units (TSU). The program has robust standard guidelines – programmatic, operational & costing – and monitoring indicators.

The government continuously builds capacity for community and locally-led implementation and oversight. While the government originally performed evaluations, now regional institutions have taken over this role. Community score-card methods and community-led monitoring of services are also being rolled out to ensure services are tailored to community needs.

The government's role is now focused on a few critical elements. First, supporting the scale-up of innovations that began with international donor funding. For example, a key focus now is to provide domestic funding that supports better linkages from testing to ART and counseling. Capacity strengthening also remains a key activity, with the government continuing regular monitoring through the Technical Support units and providing regular site visits and formal feedback every six months.

The CBO Experience

Mona Liza Diones, Chapter Program Manager, FPOP, Lord-Art Florenz Lomarda, Program Manager, Internal Grants, LoveYourself (Philippines) and Surang Janyam, Director, Service Workers in Group Foundation (Thailand)

After presentations from national governments, we heard from SWING (Thailand), LoveYourself (Philippines), Family Planning Organization of the Philippines (Philippines), and Humsafar Trust (India). These CBOs discussed their experience as early adopters and implementers of social contracting.

Top five takeaways:

1. International donor funding for capacity strengthening for CBOs was critical to the current success seen in these countries.
2. Countries must be prepared to continuously revise the package of services and costs. What is the feedback process or platform that would support that process? How can collective HIV stakeholders move quickly to stay responsive to community needs and shifting costs while taking the time for stakeholder input?
3. CBOs faced challenges in covering their full operational costs from the reimbursements and grants available from governments. How might CBOs advocate with the government to obtain higher – and more accurate - levels of reimbursements? Costs related to management, operations, and capacity strengthening are often left out. The use of volunteers posed another challenge. Since many organizations started with a heavy reliance on volunteers, their labor is often not included in cost studies but is necessary for success. Future iterations of social contract programs must include fair pay for both volunteers and lower-paid CBO staff.

Themes We Heard

Regardless of the model, costing was an issue for everyone

Whether cost data is the basis for reimbursements from government or a financial model for a social enterprise, all CBOs mentioned struggling to produce and use accurate cost data. CBOs continually highlighted the need for building capacity in this area and using grant funding to collect cost data to inform future models. International donor support and technical assistance in this area would help build a stronger foundation for CBOs in the future.

4. Diversification from international donor funding to government funds is not enough. CBOs still need other funding sources (e.g., earned income, grants, corporate donations, etc.). What governments cover is still limited and is subject to the instability of government funding from year to year.
5. While international funding has been instrumental to innovation, donor-funded projects come with an end date. The focus of the government and CBO relationships is the long-term commitment to growth and improvement.

Spotlight on the Next Country Ready to Launch: Vietnam

Dr. Duong Thuy Anh, Deputy Head of the Office of VAAC (Vietnam)

In 2021, the government began working with international and local partners to develop Vietnam's social contracting model, service packages, and cost standards. Under the new model, provincial centers for disease control (under provincial departments of health) will have the choice of running an open bidding process or selecting partners directly based on articulated needs. Provinces and partners can choose from four packages with standardized costs. Community partners will be able to assist with harm reduction and referral to methadone maintenance treatment, HIV screening, and referral to treatment or PrEP.

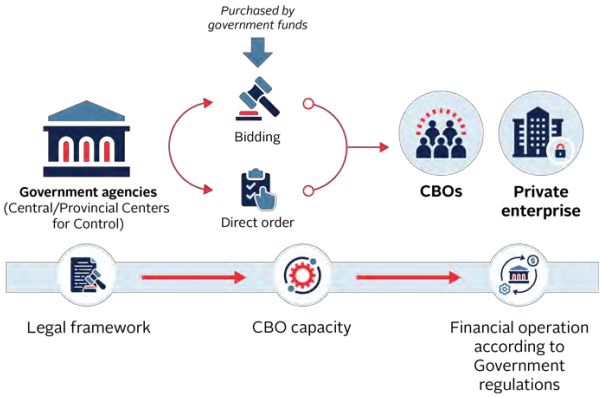
Themes We Heard

It's a long road

Whether it's social contracting or social enterprise strategies, there is significant legal and regulatory work, mindset shift and capacity building that needs to happen to make these paths feasible.

Pilot implementation began this year, and partners plan to document lessons learned to scale beyond the pilot in 2024. Presently, implementation at the provincial level is supported by donor funding, and the government will gradually take on the cost of the pilot.

Social Contracting HIV/AIDS Services in Vietnam



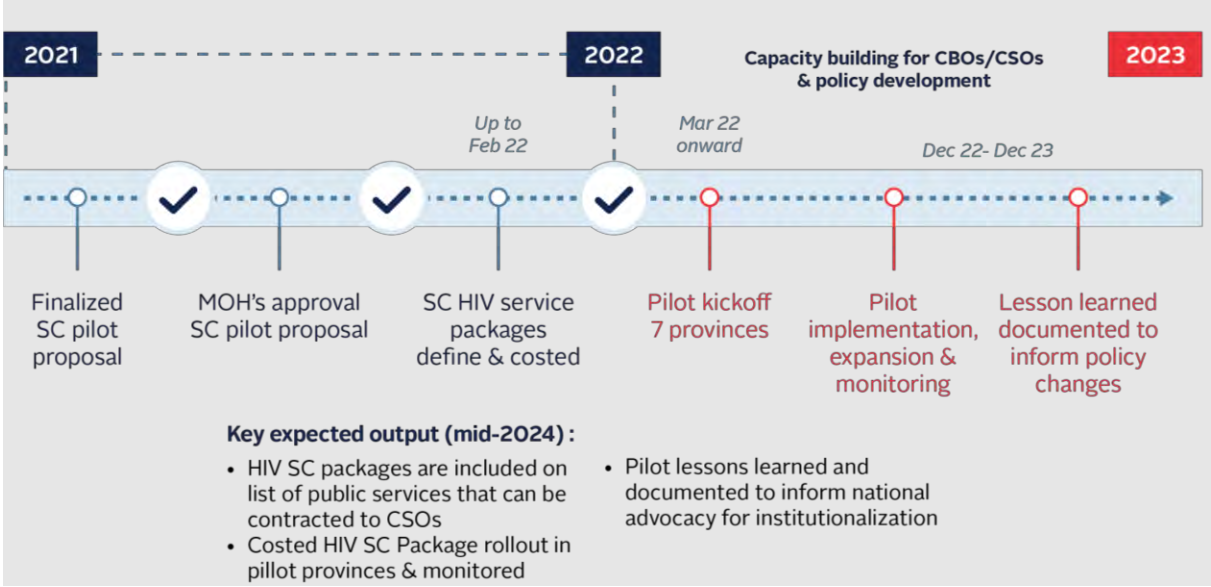
Several documents and tools guide the social contracting work, which were developed with partners' contributions. These include:

- national guidelines on service packages and contracting
- tools for assessing the readiness of both government and community partner
- national monitoring and evaluation framework
- a national social contracting dashboard that will monitor implementation

Social Contracting Milestone, Next Steps and Key Expected Outputs

Several tools were created to ensure partners are prepared for implementation, including provincial authorities and community partners. The Vietnam Government Readiness Checklist looks at capacity across several domains: financial management, legal awareness, and gender and inclusiveness. Scores are determined based on interviews using a standardized questionnaire with stakeholders from departments of health and centers for disease control. Using the findings, social contracting technical support providers work collaboratively with provincial leadership to develop capacity-strengthening action plans.

Example: Vietnam Government Readiness Checklist



SC=social contracting

Challenges as we advance

- There are legal barriers to the implementation of HIV services by community partners with government funding under the current bidding laws
- At the local level, provinces have limited funding and several priorities beyond HIV, including COVID response and other health interventions.
- Community partners, especially in provinces with limited international support, also lack basic planning and financial management skills and may not have the legal status to receive funds.

DIBs and SIBs: How HIV programs can embrace new innovative finance tools

To close out Day 1, the forum heard from two organizations on the cutting edge of new innovative finance tools. While there are no social impact bonds (SIB) for HIV in Asia, Population Services International (PSI) shared their experience with health impact bonds in India. South Africa Medical Research Council (SAMRC) shared their progress in launching an HIV impact bond in South Africa.

An impact bond is a variant of a pay-for-performance contract. The mechanism is pre-financed, and program implementers are paid directly by private investors. Either public sector agencies (Social Impact Bonds) or donor agencies (Development Impact Bonds) will pay back investors. Investors are paid the principal plus a return if, *and only if*, the programs succeed in delivering the agreed-upon social outcomes.

When might a Social Impact Bond make sense?

Government would like to pursue more innovative models, but cannot take the risk that they fail.

The costs of the proposed model plus interest together is cheaper than the solution the government is currently supporting.

Implementing organizations need to be paid more regularly for pre-determined outcomes and milestones.

If a funder has to pay interest, is this a smart mechanism? Doesn't that mean the intervention ultimately costs more? Yes! With a SIB, the government will likely pay more for successful outcomes. However, the benefit of the mechanism is that it eliminates *risk*. If the initiative fails, the government doesn't pay anything. Since the risk of failure is often a political barrier to innovation, paying more for guaranteed results can be a smart trade-off.

To date, many examples of impact bonds worldwide have been paid for by donors to pilot the model. Now that we have case studies of successful impact bonds, will we see governments will become the outcome payers for impact bonds?

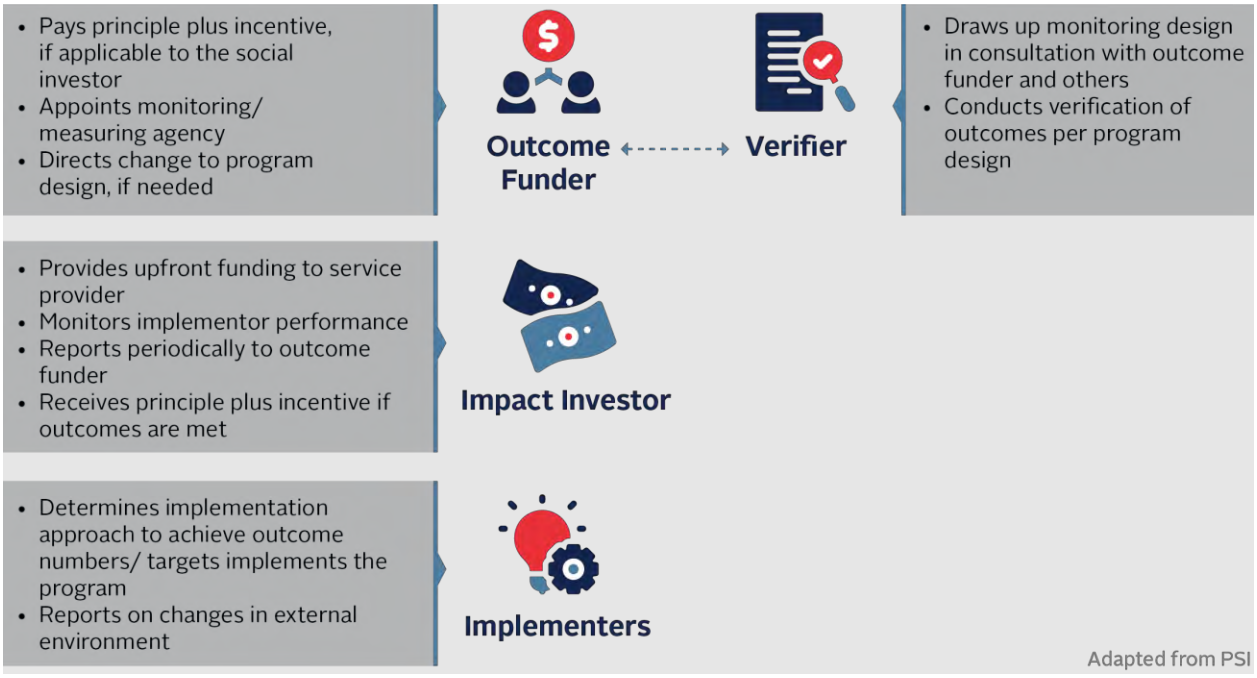
Transitioning from DIBs to SIBs: What has PSI learned about transitioning from a donor-funded DIB to a government-funded SIB

Suma Pathy, Lead, Innovations, Health Systems Accelerator, Population Services International**,** took the forum through key points from PSI's experience:

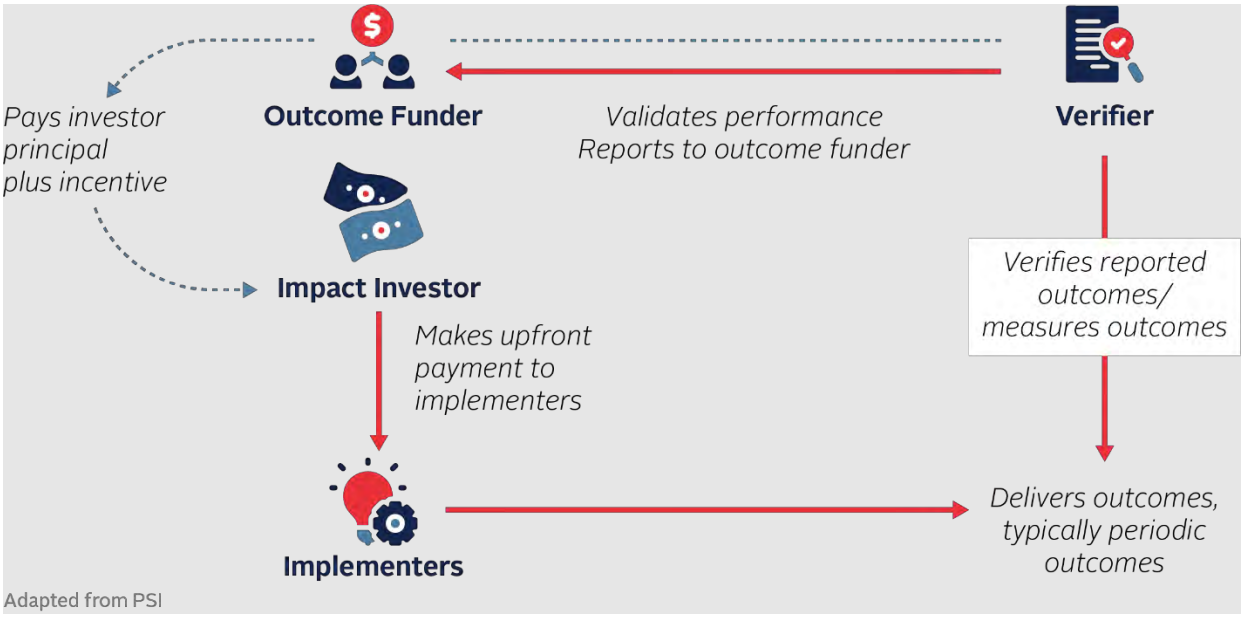
- One of the goals of the PSI DIB in India, which was ultimately not achieved as originally envisioned, was to encourage government uptake of the program interventions. To increase the likelihood of government adoption, it is critical to align the outcomes of the DIB with the government metrics and goals. Donors piloting DIBs should consider aligning outcomes during the pilot phase to ease learning and eventual scale-up.

- Donors should ensure government participation not only during the design phase but throughout the journey of implementation.
- All stakeholders must identify appropriate government departments and levels of government where decisions can be made.
- Advocate the instrument, not necessarily the sector-specific impact bond, for future investment. While the current DIB in India is focused on maternal health, other government departments are interested in leveraging the impact bond mechanisms for different sectors. Therefore, it's important to advocate with and involve a diverse set of government partners.
- Currently, the design of an impact bond mechanism with funders, investment, investors, measurement, and service providers is time and resource-intensive and can take between 3-5 years. Many express a need to shorten this time if the mechanism is to become a viable future strategy.
- It is critical to agree not only on the outcomes but also on the methodology and the metrics for verification.

Participants in a DIB



Mechanics of a DIB



South Africa's First Social Impact Bond for HIV Prevention

Dr. Nevilene Slingers (Executive Manager, Social Impact Bond at South African Medical Research Council (SAMRC)) and Jonathan Flory (Director, Social Finance) joined the forum remotely from London and South Africa to present their progress on designing and launching the first social impact bond for HIV prevention in South Africa.

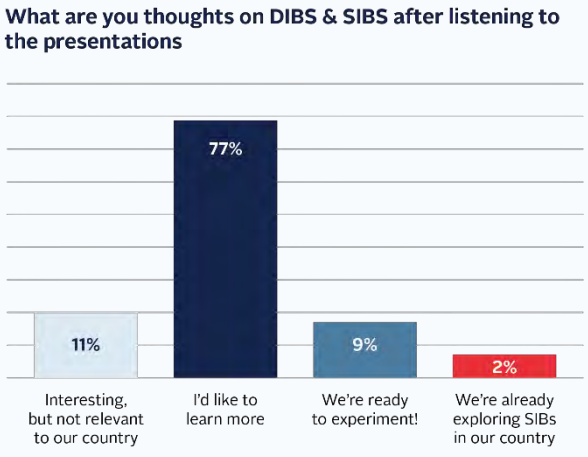
The South African National AIDS Council (SANC) identified a need for innovative finance solutions to:

- Drive focus on outcomes and more effective and efficient use of funding.
- Bring in new sources of funding.
- Build sustainability of investments by external donors.

They applied to the Global Fund to support the development of a SIB focusing on sex workers. While the Global Fund approved the application, individual government departments refused to focus on sex workers. The impact area then pivoted to prevention in adolescent girls and young women. At that stage, SAMRC became a managing partner.

When this SIB is launched, it will be the first one in South Africa focusing on health and the first with the government providing the outcome funds. SAMRC, with support from their partner Social Finance, has made the following progress:

- Identified an investor and implementing partner.
- Completed the program design, including outcome targets for payment and metrics that include incentives for the implementer if the targets are exceeded.
- Identified an independent verification agent and performance manager.
- Provided technical support to develop the package of services.
- Developed the financial model that demonstrates the financial flow of funds, determines the cost per outcome achieved, return on investment for the investor under different conditions, and cash flow.
- Developed the payment metrics: a combination of output and outcomes payment metrics to manage the risk to investor and outcomes funder.
- Provide ongoing support in engagement with national treasury to enhance understanding of performance-based contracting.



SOURCE: POLL OF MEETING PARTICIPANTS

Global Policies and approaches to financing community-led responses

As Day 2 was launched, Iris Semini, Manager, Country, and Regional Impact, Equitable Financing Practice from UNAIDS Global Center, summarized the global efforts shaping financing for CBOs.

International donors and UN Member states are highly committed to expanding sustained CBO-led delivery. The Global AIDS Strategy and UN Member States have committed that by 2025 community-led organizations will deliver:

- 30% of HIV testing and treatment services
- 60% of programs to achieve societally enabling environments – removing barriers and increasing equity
- 80% of HIV prevention services for high-risk populations

Themes We Heard

Agility matters

While social enterprise and social contracting models operate differently, many of the initial steps are the same, including developing new capacities and staff skillsets, building new partnerships, advocating for new policies. Increasing organizational agility to experiment and iterate will support developing a more sustainable financing model, whatever mix of financing mechanisms the organization chooses.

What it will take to secure sustainable financing for CBOs and networks

As 2025 approaches, UNAIDS has identified three key areas where countries must progress to meet these targets:

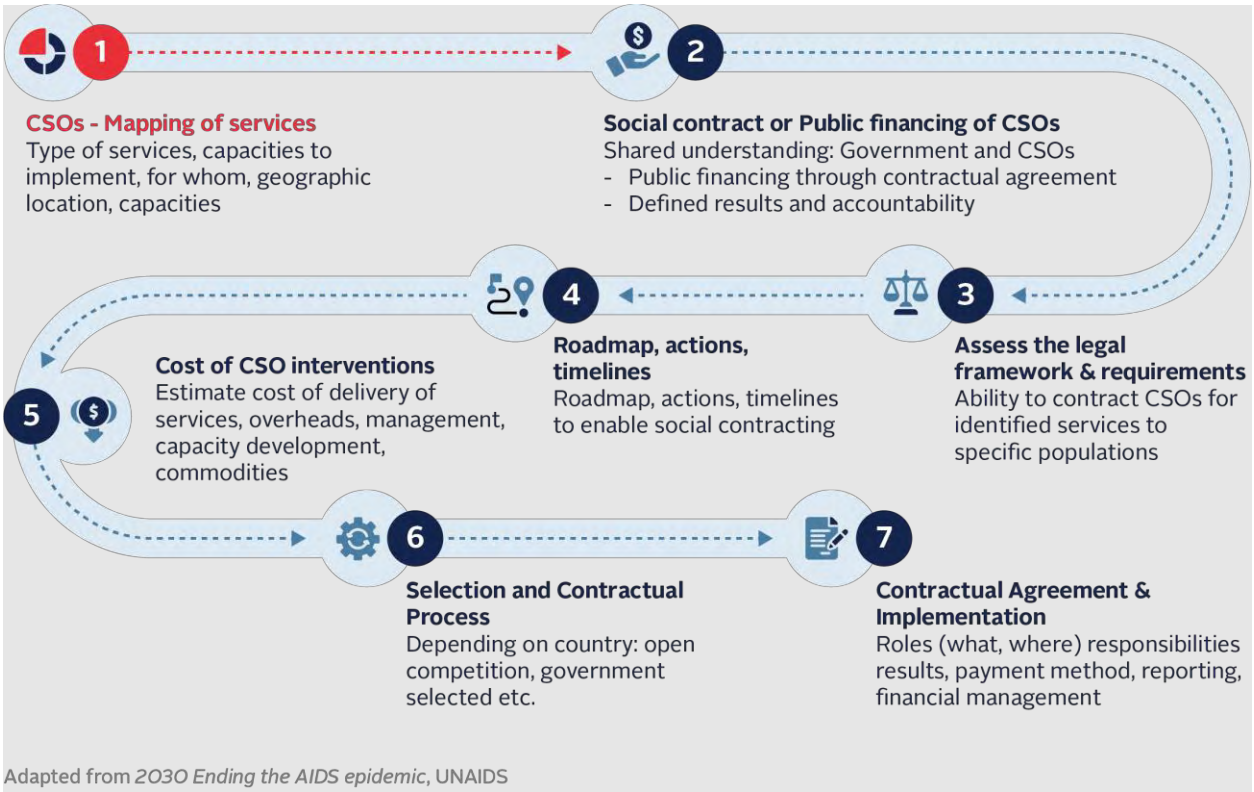
1. Integrate CBOs in the national health care systems, policies, budgets, and financing instruments (e.g., health insurance).
2. Create the necessary legal and regulatory environment for CBOs to access public financing, grants, and other funding sources without discrimination or limitations
3. Empower CBOs to diversify financing sources to sustain their role in policy, advocacy, decision-making, service delivery, community-led monitoring, and accountability.

Barriers to Funding CBOs and KPLHS

Legal	Cost
• Public-private partnerships – which provide the legal umbrella for inclusion of CBOs in health care policies and their ability to receive funding – might be limited for key population services. • Key-population-led CBOs face challenges related to laws, policies, and implementation practices related to governing their legal	• Accurate cost estimates are needed to establish the basis for contracts and payments and to generate evidence regarding cost effectiveness • Standardized costing of service packages is the exception and is only available in a few countries

Legal	Cost
formation and oversight, licensing, the permissibility and taxation of the CBOs, and regulation of foreign funding of domestic entities. • There is often a lack of legal status to apply for the provision of public services and a mechanism that allows it to take place. • Regulations pertaining to decentralized budgets and other sector resources are dispersed and not easily accessible to localities to support implementation. • There are significant barriers in environments in which sex workers and the LGBTQ community are criminalized	• It is necessary to perform a unit cost analysis for HIV community-based services through a consultative, bottom-up process that considers the historical costs paid by international donors. • There is a risk of competitive prices but false economies – the last mile costs more.

Pathway and Milestones: Establish and Implement Public Financing – Social Contracting



Adapted from *2030 Ending the AIDS epidemic*, UNAIDS

Archetypal Models for health and social enterprise

As we transitioned to speaking about social enterprise models for earned income, we had presentations from Whitney Adams, an independent advisor on innovative finance for global health, and Rathish Balakrishnan, Co-Founder and Managing Partner, Sattva Consulting.

While we've seen an explosion of social enterprise activity in global development, health has often lagged behind other social sectors. Currently, the health sectors in LMICs receive a negligible percentage of private sector investments.

Why is health a challenging sector for the social enterprise model?

Health is a particularly challenging sector for social enterprise and private investment. We examined a few of the current barriers:

- It's complex. There are longer R&D times for innovation, and the sector is far more regulated than others.
- There are very few proven business models for startups to replicate.
- Blended finance will almost certainly be necessary for the majority of health social enterprises, yet our knowledge of how to implement and scale these models is still in its infancy.
- There are significant barriers to the most impactful type of capital, particularly for small and medium-sized clinics and enterprises.
- When social enterprises access capital, there are significant challenges in managing a blend of finances and business models. Staff training and capacity are limited in this area.
- As a sector, we have not yet cracked the code on profitability for service delivery models in health, particularly in LMIC.

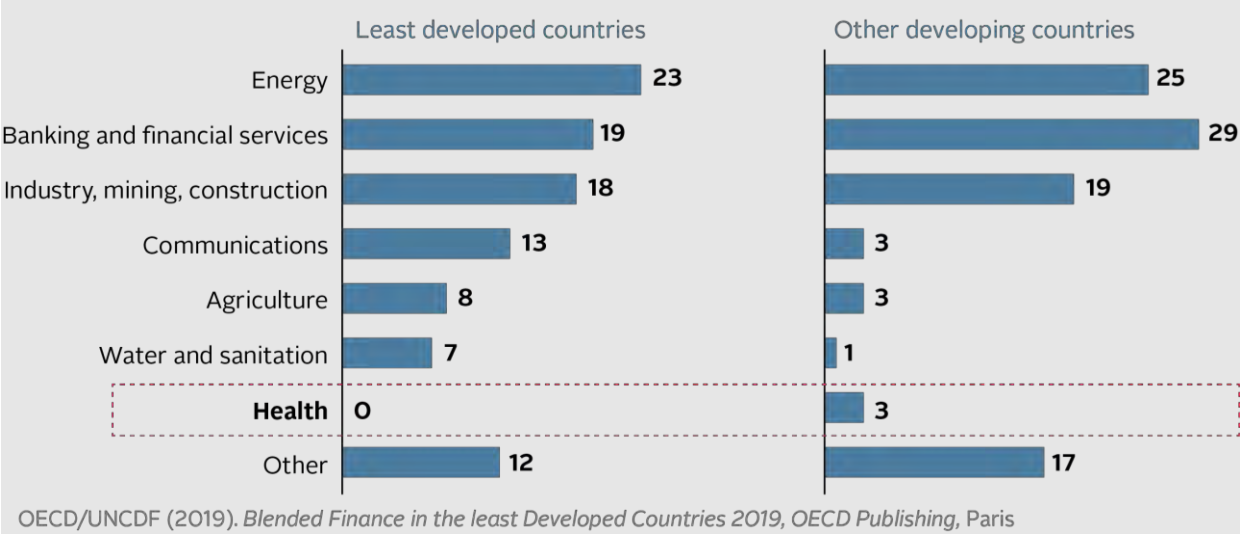
Themes We Heard

Let's rethink who does what

Task shifting and de-medicalization of certain procedures are important strategies for both social enterprise and social contracting. Transitioning activities to non-medical bstaff can reduce costs and increase availability of services in communities. Part of the preparation for a shift to sustainable financing should include evidenced-informed policy changes and business models that include task shifting.

It's important to set the expectation that full profitability may not be the end goal for most health social enterprises. Yet the inclusion of private sector models and strategies *can* improve sustainability and quality of care.

Mobilizing Private Sector Capital for Universal Health Coverage (Private capital distribution across sectors % of total**)**



OECD/UNCDF (2019). *Blended Finance in the least Developed Countries 2019, OECD Publishing,* Paris

What are the most promising models?

Model #1: Fee-for-service Clinics using blended finance and cross-subsidy models to sustain service delivery

Model #2: Service Subsidization Small and medium-sized non-health enterprises that generate revenue for health services through adjacent businesses

Model #3: **Business Model Innovation** Health Innovators that transform gaps in health systems into value propositions for new business models

What strategies do successful fee-for-service models use to generate revenue?

- Cross-subsidies from high-income patients
- High-volume, low-cost procedures where specializing can drive down costs
- Profitable bundles of products and services
- Leveraging innovation to cut costs and reach economies of scale

Incubating social enterprises in HIV: what do we know

Sattva Consulting is supporting EpiC partners in India on their social enterprise journey. Sattva Co-Founder Ratish Balakrishnan gave an overview of what they've learned about incubating early-stage health social enterprises. What key factors are essential for CBOs to move towards market-based models?

Organizational Readiness Checklist:

- Market Understanding: The CBO should have a monetizable product/service with a basic understanding of the target customer segment and the market size, anchored in research and prior experience.
- Human Resources: There should be a dedicated person to be the strategic lead of the enterprise, along with well-defined roles and responsibilities for each position.
- Financial Resources: Preferably, 5-10% of the total funding should be available to invest in the enterprise.
- Infrastructure and other physical resources: Basic resources like space, equipment, etc., should be available or identified.

USAID EpiC Project Asia Regional Social Enterprise Initiative

With support from USAID RDMA, EpiC will incubate four social enterprises in Asia during 2022-23, including one each from Cambodia, India, the Philippines, and Nepal. EpiC will work with the host organizations to chart their path to success, documenting the barriers and facilitating factors which help move these ideas from birth to functioning enterprises.

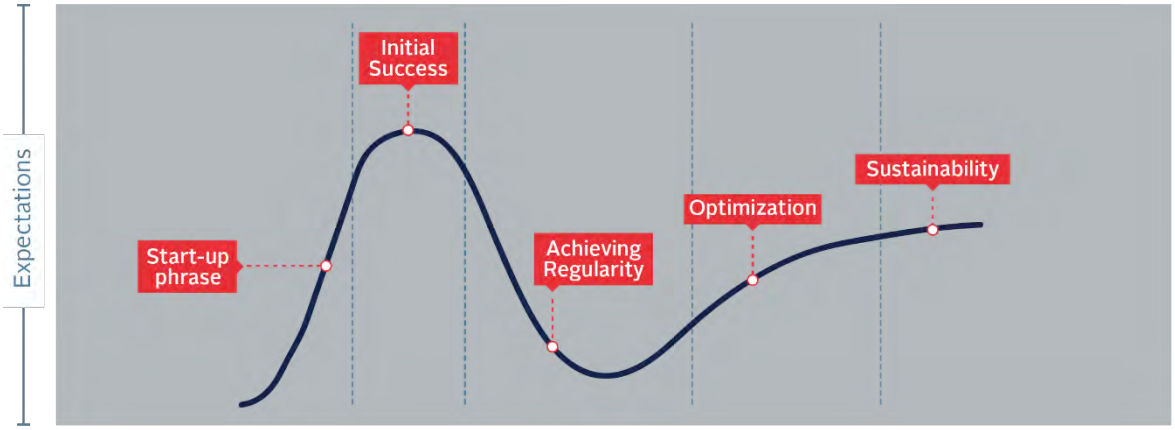
- Legal: Compliance and certificates necessary to facilitate a shift towards revenue-generating models should be in place (or at least applied for).
- Enabling partnerships: The organization should be able to identify resourceful partnerships that can support the enterprise through monetary or non-monetary assistance.

People Capabilities

- **Intent:** The leadership should have a strong vision for the enterprise and should be able to drive buy-in from key stakeholders.
- **Financial Management:** The organization should have staff with experience in managing financial resources and skills in financial forecasting.
- **Resource Mobilization and Fundraising:** The leadership should be proficient in mobilizing resources from the community to drive sales and raise funds.

- **Digital know-how:** The people associated with the enterprise should have a basic understanding of digital processes (such as organization management software, social media, etc.) to simplify internal processes and establish credibility online.

Achieving sustainability in any enterprise can take between 3-5 years



(This can range between 3-5 years)

It is critical for CBOs to be aware of the time and investment that can be required to establish a successful, sustainable enterprise.

Charging Clients for Service: Caveats from the Global Evidence

Matt Avery, Chief of Party for the USAID Strengthening Communities and Accelerating Local Engagement (SCALE) Project in China

Proponents of user fees tend to promote two key benefits:

- Increasing service coverage and quality by reducing frivolous use of services
- Improved efficiency and equity through the generation of additional revenue and expanded service availability

We now have decades of evidence demonstrating the potential downside of charging fees. So what caveats should we consider?

Coverage, Service, and Uptake

A Cochrane review from 2008[1] found that the introduction of user fees usually resulted in immediate, large decreases in service uptake – the authors concluded that the findings broadly demonstrated that user fees are a barrier to health services for those eligible to pay. The review also found an increase in service uptake when fees were reduced or removed.

What about HIV?

A meta-analysis on the efficacy of 15 ART programs in low-income countries found that receiving treatment in a fee-for-service program was associated with an increased probability of receiving no post-initiation follow-up and increased mortality.[2] Another meta-analysis of 10 studies in resource-poor settings determined that fees for all or part of ART services accounted for the largest variability in viral load suppression rates at 6 and 12 months after ART initiation.[3]

What happens to quality?

Can the revenue generated through user fees enhance the quality of service delivered? There are examples of programs using fees to improve service quality. However, for this to happen, several conditions must be met:[4]

- Fees must be high enough to raise substantial revenue but low enough to remain affordable.
- Funds must be retained by the facilities and appropriately reinvested to improve service quality.

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[1] Lagarde M, Palmer N. The impact of user fees on health service utilization in low- and middle-income countries: how strong is the evidence? Bull World Health Organ. 2008; 86(11):839–48. https://doi.org/ 10.2471/blt.07.049197 PMID: 19030689; PubMed Central PMCID: PMC2649541.

[2] Brinkhof MW, Dabis F, Myer L, Bangsberg DR, Boulle A, Nash D, Schechter M, Laurent C, Keiser O, May M, Sprinz E, Egger M, Anglaret X; ART-LINC, IeDEA. Early loss of HIV-infected patients on potent antiretroviral therapy programmes in lower-income countries. Bull World Health Organ. 2008 Jul;86(7):559-67. doi: 10.2471/blt.07.044248.

[3] Ivers LC, Kendrick D, Doucette K. Efficacy of antiretroviral therapy programs in resource-poor settings: a meta-analysis of the published literature. Clin Infect Dis. 2005 Jul 15;41(2):217-24. doi: 10.1086/431199. Epub 2005 May 27. PMID: 15983918.

[4] Witter S. An unnecessary evil? User fees for healthcare in low-income countries. 2005. https:// eresearch.qmu.ac.uk/handle/20.500.12289/3376.

- New revenue cannot be offset by funding cuts from other sources.

Equity

If user fees are a barrier to health services, they are a barrier that disproportionately affects vulnerable groups. Waivers or exemptions are often used to ensure continued access among the poorest and most vulnerable. These exemptions can fail for several reasons:[5]

1. Means testing is difficult, and health systems or facilities must choose between broad categories (and therefore more "leakage") or narrow definitions (which reduce access and equity)
2. Whatever approach is chosen, clients sometimes refuse to be stigmatized and therefore decline exemptions
3. Providers are often reluctant to offer exemptions if user fees are an important source of clinic revenue –particularly where user fees go to support human resource costs

It's not all bad news - there have been programs that successfully implemented fee exemptions to mitigate the impact of user fees. However, to be successful, several criteria need to be met – exemptions must be adequately funded (they cannot simply reflect a loss of operating revenue). They need to be managed appropriately.[6] They must clearly define what medicines and services will be covered by the exemption. They must have clear criteria for eligibility and who is responsible for determining eligibility. It is also important to remember that waivers won't solve everything. Programs need to account for other costs to accessing health services – beyond clinical fees – that may not be covered under a typical waiver scheme but may disproportionately impact vulnerable groups. Finally, some studies have suggested that – because of the stigmas associated with waivers and exemptions – programs may have more success with voluntary programs that encourage those with the ability to pay to self-select in exchange for higher-tier services or other perks.

[5] Bitran, R. and Giedion, U. (2003) Waivers and Exemptions for Health Services in Developing Countries. World Bank Institute: 87. Washington, D.C
Nicole Atchessi, Valéry Ridde, Maria-Victoria Zunzunegui, User fees exemptions alone are not enough to increase indigent use of healthcare services, Health Policy and Planning, Volume 31, Issue 5, June 2016, Pages 674–681, https://doi.org/10.1093/heapol/czv135

[6] Bitran, R. and Giedion, U. (2003) Waivers and Exemptions for Health Services in Developing Countries. World Bank Institute: 87. Washington, D.C

Fee-for-Service Models Meet New Demands

Tran Thi Tham, Deputy Chief of Party, USAID/PATH-STEPS project. (Vietnam), Dr. Vinay Vaman Kulkarni, Coordinator Prayas Health Group Founder Trustee Prayas (India), Krittaporn Termvanich, Pribta Clinic Manager, Institute of HIV Research and Innovation (IHRI) (Thailand), Inlicia Cutami, Medical Doctor, Angsamerah Clinic (Indonesia) and Yun Phearun, Executive Director, Chhouk Sar (Cambodia)

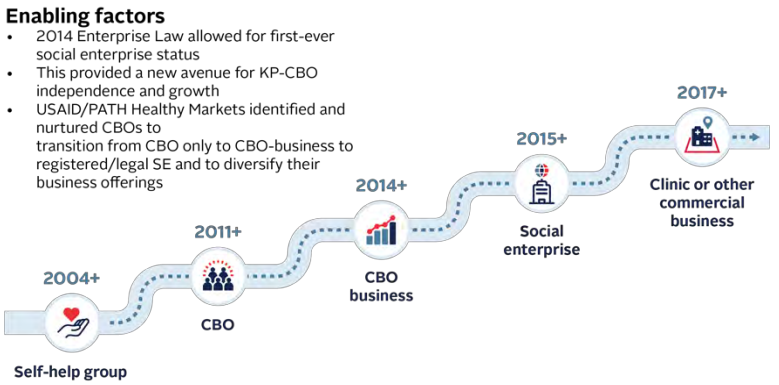
In 2014, the USAID STEPS program in Vietnam identified a fundamental mismatch between supply and demand. Public sector HIV services were the norm. However, with increasing HIV incidence among MSM and TG, limited uptake of HIV testing services among KP, and demand for KP-led services, new service models were needed.

In 2014 a new law allowed for the first-ever social enterprise status in Vietnam

This provided a new avenue for KP-CBO independence and growth. The USAID/PATH Healthy Markets Project identified and nurtured CBOs to transition to legal social enterprises and diversify their business offerings.

Over the last decade, similar dynamics have emerged across Asia, leading to a new crop of social enterprise and commercial clinics.

On day two, we heard from several clinics on their way to sustainable financing through fee-for-service models: Angsamerah Clinic (Indonesia), Pribta Clinic (Thailand), Prayas (India), and Chhouk Sar Association (Cambodia). Though each was at a very different place in their journey, a few commonalities stood out.



Successful social enterprises experiment with business models

The Angsamerah Clinic in Indonesia shared how they experimented with seven different business models to find an operational model, including a clinic, pharmacy, foundation, and educational platform. Currently, the clinic serves middle- and upper-income patients. The profits from the clinic are owned by the foundation, which distributes the funding for operations, creating new programs, and providing free testing and treatment for the community. Specifically, the funding supports the HIV Health Checkpoint model, which includes fast, inexpensive HIV testing services and rapid diagnostic services such as blood

sugar, cholesterol, and uric acid checks (reduces the stigma in the community regarding HIV testing). Some partners have even joined to expand the coverage of the model. The strategy responds to the variety of market needs in the country.

Similarly, Prayas Clinic in India has evolved its business model over two decades of changing contexts. In 2000 (before the widespread public sector provision of ARVs), Prayas began procuring ARVs from pharmaceutical companies to dispense at cost. In 2005, they were approached to participate in a Global Fund program to create a graduated cost recovery model. This model categorized patients based on socioeconomic status; costs were recovered on a sliding scale. When the infrastructure support for the Global Fund program stopped after a few years, Prayas was left in a difficult position as patients had come to rely on care under the model. By this time, the national free ART program had launched. Understanding that in India's complex healthcare structure, there is a need for the private sector, they decided to continue the graduated cost recovery model by tweaking it to make it sustainable. The medicines are procured from the pharmaceutical manufacturers directly. They are then dispensed at or below the procurement cost as per the patient's ability to pay. Necessary tests are provided in their in-house laboratory at cost. While clients are informed of free services (including ART) elsewhere, most choose the convenience and quality service associated with Prayas.

Chhouk Sar Association in Cambodia, while just beginning its journey, has identified elements of social contracting, fee-for-service, CSR, grants, and crowdfunding that they will be testing.

Successful social enterprises never stop testing new services and platforms

Once clinics established their core operational models, they could expand programmatically and test demand and impact for new services. Prayas, for example, now has a diverse programmatic platform that includes clinical and socio-behavioral research, advocacy, innovative online communications resources (websites and web series), mental health services, and preventive oncology screenings. Chhouk Sar Association is looking to integrate potential products and services for additional income generation while retaining free products and services for KP. They recently conducted a market analysis, realizing potential unmet needs in reproductive health services, pharmacies, and mental health services. Angsamerah is diversifying further and hopes to establish a practical educational program for health professionals on sustainable social business models in healthcare. One organization is even considering a dating app!

Themes We Heard:
There are many methods for recollecting revenue

There was no clear winning method for structuring and collecting fees. The Angsamerah Clinic has embraced a cross-subsidization model, while Prayas has a graduated cost recovery model. Other clinics that spoke at the forum, such as LINK and Blue Sky, favored fully commercial models with prices set to ensure a sustainable business model and meet customer willingness to pay. One clinic, Pribta, is experimenting with a "pay it forward" model. Rather than charging higher-income clients more, Pribta allows clients to pay more voluntarily to subsidize services for others.

Transforming gaps in the health system into business opportunities

Aphiwat Chawilai, Managing Director, ACTSE/CAREMAT (Thailand), Nguyen Anh Phong, Deputy Director, Blue Sky Social Enterprise, Vice-chair of Ho Chi Minh City HIV/AIDS Prevention Association (Vietnam) and Manoj Pardesi, General Secretary, Network of Maharashtra by People Living with HIV/AIDS (NMP+) (India)

Besides fee-for-service models, health innovators identify gaps in health systems and transform those gaps into value propositions for new business models. Often, the weakest point of a health system is the best place to innovate! Globally and throughout Asia, we see new healthcare companies launching competing models to traditionally expensive and inefficient products, services, and infrastructure, including:

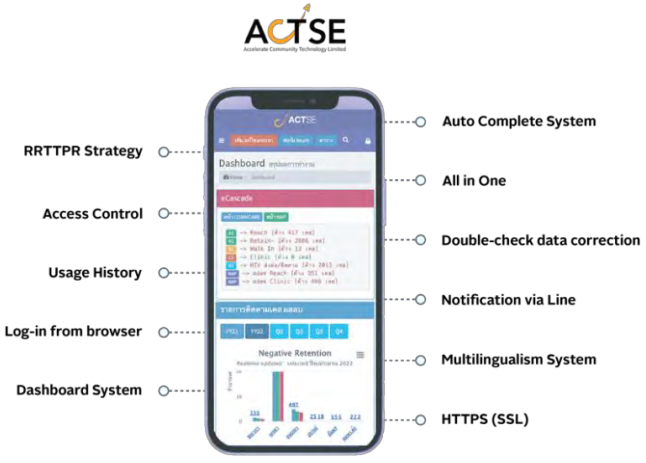
- Diagnostics and laboratory services
- Health Information Technology/Software
- Emergency transportation services
- Supply chains and logistics
- Rural health networks

These health innovators often identify revenue models through:

- Serving client demographics that have been ignored.
- Working to drive down costs of services (laboratory, diagnostics, medical transport) or drugs and sell to government health systems or other providers.
- Creating and selling software and health information technology or expertise to government systems or other providers.

One such health innovator (Accelerating Community Technology, Social Enterprise – or ACTSE) arose from the EpiC Project. Former M&E staff from an EpiC CBO partner realized the substantial human resources dedicated to highly inefficient health information and data systems. They developed a new business model and social enterprise to develop data management systems for CBOs. The systems move CBOs from paper and Excel-based tracking systems to health information software designed for their needs to track and support clients.

ACTSE is an example of market-based strategies driving improvements in system efficiencies, quality care, and patient satisfaction. Innovations such as these could be the links that ensure social contracting and shifting to key-population-led services works with CBOs in partnership with public sector services.



Following the strategy of innovating in the gap, NMP+ has a Community Pharmacy that provides HIV/AIDS medicines at highly subsidized prices to those who prefer private providers over government services. The

pharmacy has a regular clientele of over 700 customers and plans to expand across India through digital interventions. Astonishingly, they have been able to support the public sector clinics in times of stock out. The enterprise is exploring leveraging its long-standing relationship with pharmaceutical companies to sponsor and develop a website and e-commerce platform for the pharmacy, which will lead to increased brand credibility and higher sales.

Next Steps

As our final activity, each country delegation met together to brainstorm next steps about how they could take learning from the Forum forward and to describe support they could benefit from to accelerate their sustainable financing journey. Across the groups, there was a recognition that they needed to understand more about their own country context's impact on their options for financial sustainability, as many of the mechanisms and strategies discussed would look different in different parts of the region. There were also discussion about the two mechanisms discussed most: social enterprise and social contracting.

With social enterprise, the delegations took a learning posture, with many emphasizing that they were eager to hear more about business opportunities their CSO was well-placed to capitalize on, including exploring subsidized or sliding scale fee-for-service models. Several groups requested additional assessments and trainings to support them in that exploration. Those that were already operating social enterprises expressed that they felt encouraged and invigorated to grow that aspect of their work.

In discussions regarding social contracting, the emphasis was on advocacy and capacity. Many delegations discussed the need to advocate for the government to endorse social contracting, approve an inclusive package of services, and include KP-led organizations. Additionally, it is important for governments to understand the limitations of social contracting, the financial delays and bottlenecks it can cause, and its impact on CBOs. Groups also acknowledged the need to increase the capabilities of KP-led organizations to meet the requirements of social contracting work, including legal registration for CBOs and ensuring accountability to manage government funds.

Participant Perspectives: What support do you need?

ADVOCACY	• Regional support on social contracting and advocacy to national governments. • Support on lobbying, advocating for and analyzing the different sustainable financing mechanisms. • Policy change to support and enhance CBOs to deliver health services through public-private partnerships.
PEER LEARNING	• Exchange visits to see a flourishing social enterprise, catch the vision, and assess if it is feasible for us would be helpful before moving forward with an idea. • Technical assistance and sharing of successful experiences from countries with similar socio-political contexts.
COSTING	• Cost-benefit analysis of investing in prevention and cases averted.
CAPACITY-STRENGHTENING	• Connecting with corporations and understanding how to use CSR funds appropriately. • A training module or course on developing our business model and business skills (accredited course on social enterprise where there are reputable instructors and CBO staff are paid to attend and then get certified). • TA and capacity strengthening on organizational development (financial management, planning, human resources, etc.). • Guidance on how to prepare CBOs to find investors. • Capacity strengthening on organizational development (e.g., HRH, systems improvement, financial management, etc.). • Capacity strengthening to identify marketable opportunities and development of a business plan
TARGETED FUNDING	• Seed funding for social contracting and social enterprises tailored to different business models.

Participant Perspective: Where should we take this conversation next?

WHAT TOPICS SHOULD WE INCLUDE IN A FUTURE FORUM

- Who are we missing (and why) in our delivery of services as new financing models are adopted?
- How do these models contribute to the 95-95-95?
- How can we bring innovative finance/DIBs/SIBs into HIV/AIDS? Where are there unmet needs where an investor might be interested?
- How are organizations with social enterprise models using the revenue/profit they are generating? Are there controls/accountability around that? Are those uses increasing the impact of the organization?
- What are the key considerations in designing a legal framework for social enterprise? What are the relevant laws and legislation on social enterprise?
- What are donors' perspectives on social enterprise?
- What advocacy strategies work best with government and policymakers?
- How can we use the new primer tool to develop our sustainable financing strategy? How do financing strategies differ between countries and regions?
- Key champions for change and new models: How to find the right persons and moments to move things forward?
- What *hasn't* worked in organizations' sustainable financing journeys? Let's share failure experiences!