When Donors Walk Away: Can Social Contracting Save Malawi's HIV Gains?

An Analytical Perspective on Sustainable Pathways for Containing HIV in Malawi

By Nicholas Mwisama | July 2026

Malawi stands at a precarious crossroads. Just as the country celebrates hard-won victories against the Human Immunodeficiency Virus (HIV), having attained the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 targets ahead of schedule, the foundations of that success are cracking under donor fatigue. For instance, the United Kingdom's recent announcement of drastic bilateral aid cuts, projected to slash official development assistance to Malawi by up to 90 percent by 2028/29, is the sharpest edge of a broader retreat by traditional partners. In January 2025, the US government issued a broad pause on foreign assistance through USAID where, approximately awards amounting to US$176 million for Malawi were terminated. Meanwhile, the fights against HIV, tuberculosis (TB) and malaria rage on. Without decisive domestic action, the gains of two decades risk rapid reversal.

This article argues that **social contracting**, defined as the structured mechanism through which government entities provide financial support to non-state actors, particularly Civil Society Organisations (CSOs), to deliver essential health services, offers the most pragmatic, evidence-based pathway to sustain and deepen Malawi's HIV response. Drawing on Malawian policy frameworks and comparative lessons from South Africa, Zimbabwe and Tanzania, it shows why social contracting is not merely desirable but urgently necessary.

The Perfect Storm: Donor Retreat Meets Unfinished Business

According to the United Kingdom Foreign, Commonwealth and Development Office (FCDO) Annual Report and Accounts 2025–2026, bilateral aid to Malawi will fall from £50.2 million in 2025/26 to £20 million in 2026/27, £10 million in 2027/28, and just £5 million by 2028/29, a 90 percent cut. This coincides with a Global Fund to Fight AIDS, Tuberculosis and Malaria replenishment that secured only about US$11.3 billion of an US$18 billion target for 2026–2028. Malawi's HIV response remains heavily donor-dependent for antiretroviral therapy (ART) commodities and a large share of prevention and community programmes.

Epidemiologically, the picture is mixed and fragile. Adult HIV prevalence (ages 15–49) has declined to roughly 6.7–7 percent, and Malawi achieved the 95-95-95 cascade by late 2024: 95 percent of people living with HIV know their status, 95 percent of those diagnosed are on ART, and 95 percent of those on treatment are virally suppressed. New infections have fallen sharply, yet key populations and adolescent girls and young women continue to face elevated risk. TB incidence hovers around 119 per 100,000 and malaria remains a major killer. Any interruption in community outreach, testing, pre-exposure prophylaxis (PrEP) or adherence support could reverse viral suppression and reignite transmission. Domestic health financing has risen from about 8.8 percent to over 12 percent of the national budget. This is progressive but still short of the Abuja Declaration's 15 percent target. Prevention services are especially exposed.

The National Health Financing Strategy 2023–2030 and Health Sector Strategic Plan III (HSSP III) 2023–2030 correctly call for diversified financing and stronger public–civil society partnerships. What has been missing is a systematic, scaled mechanism to operationalise those partnerships for HIV.

What Social Contracting Offers

Social contracting is the process by which government provides financial support, through grants, service-level agreements or performance-based contracts to non-state actors to deliver health services for which the state retains ultimate responsibility. CSOs bring comparative advantages that public facilities often lack in terms of deep community reach, trust among key and vulnerable populations, agility, and the ability to deliver differentiated, rights-based services at lower unit cost.

In the HIV response this means contracting CSOs for targeted prevention (condom and PrEP distribution, peer education and behaviour-change communication), community-based testing and linkage to care, adherence support and differentiated service delivery, stigma reduction, and specialised packages for sex workers, men who have sex with men, people who inject drugs, and adolescent girls and young women. When properly designed, with transparent procurement, clear performance indicators and robust oversight, social contracting enhances effectiveness, responsiveness and efficiency, maximising impact from scarce resources.

Malawi already possesses enabling legal and policy hooks. The HIV and AIDS (Prevention and Management) Act establishes structures with clear multi-sectoral coordination mandate. The Public Procurement and Disposal of Public Assets framework, the Public-Private Partnership Act, the Local Government Act (supporting decentralised service delivery) and the National Health Financing Strategy all create space for government-to-CSO financing. What is required is deliberate operationalisation: national social contracting guidelines, standardised contracting instruments, ring-fenced domestic budget allocations, and capacity strengthening for both government entities and CSOs. This operationalisation should be accompanied by transparent procurement processes, meaningful participation of CSOs in oversight.

Comparative Lessons: South Africa, Zimbabwe and Tanzania

South Africa: Institutionalised Domestic Financing of Civil Society

South Africa funds the bulk of its national HIV response from domestic resources. The National Department of Health and the Department of Social Development channel funds to non-profit organisations through competitive tenders and business-plan processes, underpinned by legal agreements with the National Treasury. Approximately 1 percent of the National Department of Health budget flows to non-profit organisations, with additional and variable provincial allocations. The South African National AIDS Council (SANAC) structures 18 civil society sectors, fostering coordination and capacity. Concrete examples include provincial HIV and AIDS conditional grants that finance community-based organisations for prevention, orphan and vulnerable children support, and adherence clubs. While challenges such as delayed payments, preference for larger organisations, and uneven provincial performance remain, the system demonstrates that a government can sustain CSO-delivered HIV prevention and social support through public budgets. The clear lesson for Malawi is the value of embedding CSO financing within the Medium-Term Expenditure Framework and using transparent, results-linked instruments.

Zimbabwe: AIDS Levy-Powered Social Contracting in Action

Zimbabwe's National AIDS Council has operationalised social contracting as a deliberate strategic shift under the Zimbabwe National HIV and AIDS Strategic Plan V (ZNASP V), using domestic resources, primarily the AIDS Levy to fund CSOs in a resource-constrained environment. Clear principles guide the process: goal-orientation, transparency, equal treatment, mutual accountability, proportionality, beneficiary participation and trust. Priority populations (adolescent girls and young

women, key populations, people living with HIV, and young men) are explicitly targeted. Concrete implementing examples include ZiCHIRE and Dot Youth delivering the Brotha2Brotha peer-led model for young men; Tariro Development Trust and Insiza Godhlwayo AIDS Council running Sista2Sista and related programmes for young women; Jointed Hands Welfare Organization reaching miners; and Katswe Sistahood implementing SASA! community mobilisation. Sector coordination bodies such as the Zimbabwe National Network of People Living with HIV (ZNNP+) and the Zimbabwe AIDS Network (ZAN) also receive support. The model shows that even lower-resource settings can build functional government–CSO financing pipelines when political will, a dedicated financing stream and structured guidelines exist. Malawi's National AIDS Commission is well-positioned to adapt this blueprint. Malawi can build on these lessons by ensuring that social contracting mechanisms are inclusive. Competitive contracting should prioritize transparency and value for money.

Tanzania: The Concrete Cost of Delay

Tanzania offers the clearest cautionary tale of what happens when social contracting remains aspirational rather than operational. The country's HIV Sustainability Roadmap and related investment-case explicitly identify the absence of a defined social contracting mechanism as a critical structural gap. Community-based and community-led interventions continue to rely on ad-hoc, largely donor-driven arrangements. As a result:

1. **Financing fragility:** Domestic public funding for CSO- and community-led HIV prevention remains minimal and unpredictable. When external grants fluctuate or end, services for key and vulnerable populations are the first to contract.
2. **Coverage gaps:** Key populations and adolescent girls and young women, groups that CSOs reach most effectively, experience inconsistent access to combination prevention, PrEP, and differentiated support. This undermines national progress toward epidemic control.
3. **Lost institutional capacity:** Without multi-year domestic contracts, local CSOs struggle to retain trained peer educators, maintain data systems, or invest in quality improvement. The very community infrastructure needed for a sustainable response atrophies.
4. **Higher long-term costs:** Interrupted prevention leads to preventable new infections and higher future treatment and care liabilities, precisely the opposite of value-for-money in a constrained fiscal environment.
5. **Policy inertia:** Despite repeated recommendations to institutionalise social contracting, the absence of guidelines, budget lines and clear institutional ownership has left the community response permanently vulnerable to donor transitions.

Tanzania's experience demonstrates that delay is not neutral: it actively erodes the community systems that have driven much of the region's HIV progress. Malawi still has the opportunity to choose a different path, but only if it moves from policy aspiration (already visible in United for Prevention advocacy and related forums) to concrete guidelines, pilot contracts and protected budget lines.

Why Social Contracting Is the Pathway Malawi Needs

Seven interlocking reasons make social contracting the superior strategic choice:

1. **Sustainability over substitution:** It replaces unpredictable donor grants with predictable domestic public financing, locking in community capacity rather than allowing it to atrophy when external funds dry up.

2. **Comparative advantage:** CSOs reach populations and deliver services that facility-based systems struggle with, multiplying the impact of every Kwacha spent on prevention and support.
3. **Policy coherence:** It operationalises existing commitments in the National Health Financing Strategy, HSSP III, the National HIV/AIDS Policy 2022–2027, and the multi-sectoral mandate of the HIV and AIDS (Prevention and Management) Act, without requiring entirely new legislation.
4. **Decentralisation synergy:** Aligned with the Local Government Act, it enables local councils and District Health Offices to contract local CSOs, improving responsiveness, ownership and last-mile delivery.
5. **Accountability and results:** Properly designed contracts introduce performance metrics, independent verification and mutual accountability, raising the bar beyond pure grant-making.
6. **Political and social legitimacy:** In a context of rising civic expectations and capable CSO networks (including the Zomba Civil Society Organizations Network and national coalitions), government-led contracting signals genuine partnership rather than competition or co-optation.
7. **Community systems strengthening:** Social contracting Should strengthen community systems by investing in government, financial management, digital reporting systems, peer educators, community health workers and community led monitoring as strong community systems will sustain outcomes.

Capacity constraints, fiduciary risks and potential competition with public facilities are real but manageable through phased pilots, capacity-building investments (as Zimbabwe and South Africa have done), clear delineation of roles, and robust monitoring. The greater risk is inaction: watching community systems collapse while waiting for an improbable return of large-scale donor funding.

Conclusion: From Analysis to Action

Donor fatigue is a structural shift, not a temporary inconvenience. The United Kingdom cuts are a signal, not an anomaly. Malawi's impressive progress toward ending AIDS as a public health threat by 2030 will evaporate if community prevention and support systems are allowed to wither. Social contracting is the most coherent, comparative-advantage-aligned and policy-ready instrument available to prevent that outcome.

The pathway is clear. The Ministry of Health and National AIDS Commission, working with the Ministry of Finance, should: (1) finalise and adopt national social contracting guidelines for HIV and broader health services; (2) ring-fence initial domestic allocations, starting with prevention and key-population packages, within the 2026/27 and subsequent budgets; (3) launch competitive pilot contracts in high-burden districts; (4) strengthen CSO readiness through targeted capacity support; (5) Institutionalize CSOs participation in governance and oversight and (6) embed learning and scale-up mechanisms linked to the Health Financing Technical Working Group.

South Africa shows that institutionalisation at scale is possible. Zimbabwe shows it can work with modest domestic resources and a dedicated levy. Tanzania shows in concrete terms, the high cost of delay in terms of fragile financing, coverage gaps, eroded community capacity, higher long treatment liabilities, and permanent vulnerability to donor transitions. Malawi still has the legal scaffolding, the epidemiological urgency and a vibrant civil society ready to partner. The missing ingredient is decisive political and budgetary action. Social contracting is not a silver bullet but it is the most sought-after, evidence-informed pathway to keep winning against HIV when donors walk away. The time for hesitation has passed.

About the Author

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Key sources: FCDO Annual Report and Accounts 2025–2026; Global Fund Results Report 2025 and replenishment updates; UNAIDS, CDC and MPHIA Malawi HIV statistics; Malawi National Health Financing Strategy 2023–2030; Health Sector Strategic Plan III; HIV and AIDS (Prevention and Management) Act; National HIV/AIDS Policy 2022–2027; Zimbabwe National AIDS Council Social Contracting framework and ZNASP V; South African National Department of Health and Department of Social Development NPO financing practices; Tanzania HIV Sustainability Roadmap and related analyses; UNAIDS, Health Policy Plus and United for Prevention documentation on social contracting.