

# Preliminary Review of Community- Based Health Financing Schemes and Their Potential for Addressing HIV/AIDS Needs in Sub-Saharan Africa

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- ▲ *Generation of new financing for health care, as well as more effective use of existing funds.*
- ▲ *Design and implementation of health information systems for disease surveillance.*
- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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# Abstract

The HIV/AIDS epidemic is present in many of the countries in Africa where Community-Based Health Financing (CBHF) schemes have taken hold, and it poses many problems for these communities and schemes due to the dynamic nature and pattern of transmission, the complexity of treatment regimens, the challenges of prevention, and the costs of delivering HIV/AIDS services. The Partners for Health Reform *plus* project (PHR *plus*) has been providing technical assistance to a number of CBHF schemes in sub-Saharan Africa over the past several years in areas such as financial management, social mobilization, and risk management. This paper examines what these existing CBHF schemes in sub-Saharan Africa have done to address HIV/AIDS in terms of providing prevention and/or care and support services in the benefits package through either implicit or explicit mechanisms.

The findings reveal that CBHF schemes know very little about the prevalence of HIV in their membership pool due to a lack of voluntary testing and counseling; nor are they aware of the impact that HIV/AIDS is having on their members. Some schemes cover HIV-positive patients implicitly because scheme benefits include coverage for specific diseases and conditions that may be HIV-related. Other schemes do not cover HIV-related diseases but refer those perceived as having HIV/AIDS to national AIDS control programs. HIV/AIDS poses problems both to the financial sustainability of a CBHF scheme and to the scheme's capacity to provide quality health services for HIV-related health problems.

Based on the dearth of knowledge on the subject and the limited findings, this paper recommends two areas for further research and investigation: 1) examine whether it is feasible or desirable for international donors and governments to contract with CBHF schemes in order to provide HIV/AIDS services; 2) explore various aspects of incorporating HIV prevention and care and support services into existing benefits packages of CBHF schemes, or how they can link with existing non-governmental organizations that provide HIV/AIDS services.

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# Acronyms

<b>ARV</b>	Antiretroviral
<b>CBHF</b>	Community-Based Health Financing
<b>CRHCS</b>	Commonwealth Regional Health Community Secretariat
<b>DALY</b>	Daily Adjusted Life Year
<b>DOTS</b>	Directly Observed Therapy, Short-course
<b>ESA</b>	East and Southern Africa
<b>IEC</b>	Information, Education, and Communication
<b>FAO</b>	Food and Agriculture Organization
<b>GDP</b>	Gross Domestic Product
<b>HIV/AIDS</b>	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
<b>MTCT</b>	Mother-to-Child Transmission
<b>MHO</b>	Mutual Health Organization
<b>NGO</b>	Non-Governmental Organization
<b>PHR</b>	Partnerships for Health Reform Project
<b>PHR<i>plus</i></b>	Partners for Health Reform <i>plus</i> Project
<b>PLWA</b>	Persons Living with AIDS
<b>STI</b>	Sexually Transmitted Infections
<b>TB</b>	Tuberculosis
<b>UNAIDS</b>	Joint United Nations Programme on AIDS
<b>UNGASS</b>	United Nations General Assembly Special Session
<b>USAID</b>	U.S. Agency for International Development
<b>VCT</b>	Voluntary Counseling and Testing
<b>WCA</b>	West and Central Africa
<b>WHO</b>	World Health Organization



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# Executive Summary

This paper is designed to serve as a “thought piece” to stimulate discussion of the role of Community-Based Health Financing (CBHF) in meeting critical HIV/AIDS needs in sub-Saharan Africa and to suggest potential topics for further investigation. The paper provides a preliminary, descriptive, limited review of existing information concerning what CBHF schemes in sub-Saharan Africa have done to date to address HIV/AIDS, based on the experience and information gleaned by the Partners for Health Reform*plus* (PHR*plus*) project. The current trend in emerging alternative health care financing organizations or movements across many countries in sub-Saharan African countries has shown that communities are interested and ready to take on responsibility for meeting critical health care services. With varying degrees of “success,” CBHF schemes (or Mutual Health Organizations, MHOs) have taken hold in sub-Saharan Africa and are operating to meet community needs. The HIV/AIDS epidemic poses many particular problems for these communities and schemes due to the dynamic nature and pattern of the transmission, the complexity of treatment regimens, the challenges of prevention, and the costs of delivering HIV/AIDS services.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), HIV/AIDS is the leading infectious disease in the world, with 40 million people infected at end of 2001. Of this number, 28.1 million live in sub-Saharan Africa (UNAIDS December 2001). While the average adult prevalence rate in sub-Saharan Africa is 8.4 percent, there is a wide range between countries and within countries. Within sub-Saharan Africa, HIV/AIDS adult prevalence rates tend to be lower in West and Central Africa (WCA) than in East and Southern Africa (ESA). “In West Africa, at least five countries (Burkina Faso, Ivory Coast, Nigeria, Togo, Cameroon) are experiencing serious epidemics, with adult HIV prevalence exceeding five percent.” The countries in ESA are experiencing even higher prevalence rates and therefore a greater urgency for action in terms of prevention and treatment programs. For example, Kenya (13.95 percent), Uganda (8.3 percent) and Zambia (19.95 percent) (UNAIDS June 2000) are countries where a rapid scale-up by the U.S. Agency for International Development (USAID) will significantly increase resources to combat HIV/AIDS in the next five years. USAID has committed to “help local institutions to provide basic care and psychosocial support services to at least 25 percent of HIV-infected persons” by 2007 (USAID November 2000).

Given the epidemic of HIV/AIDS in sub-Saharan Africa and the growing number of CBHF schemes, this paper investigates how existing schemes have addressed HIV/AIDS either implicitly or explicitly. The findings reveal that CBHF schemes know very little about the prevalence of HIV in their membership pools due to a lack of voluntary testing and counseling. They also lack information on the impact that HIV/AIDS is having on their members. Some schemes cover HIV-positive patients implicitly in that scheme benefits include coverage for specific diseases and conditions that may be HIV-related. Other schemes do not cover HIV-related diseases but refer those perceived as having HIV/AIDS to national AIDS control programs. In general, CBHF schemes do not currently offer HIV/AIDS services other than prevention services, such as information, education, and communication sessions and health education and outreach. Those schemes that do offer some coverage for HIV/AIDS services, such as Chogoria Hospital in Kenya, cap the benefits thus limiting the services available. In Ghana and Senegal, according to PHR*plus* WCA field staff, many MHOs do work in collaboration with non-governmental organizations (NGOs) and providers supported by the

national AIDS control programs, referring patients to the NGOs, encouraging HIV testing, and providing health education and AIDS prevention information at the provider and or scheme level. Based on what existing CBHF schemes are currently providing and what they could provide, this paper analyses where CBHF schemes are best positioned to finance or deliver HIV/AIDS services and recommends potential areas for further investigation.

HIV/AIDS poses problems both to the financial sustainability of a CBHF scheme and to its capacity to provide quality health services. Based on these experiences, this paper recommends two areas for further research and investigation: (1) conduct more research to examine whether it is feasible or desirable for international donors and governments to contract with CBHF schemes in order to provide HIV/AIDS services; (2) explore various aspects of incorporating HIV prevention and care and support services into existing benefits packages of CBHF schemes, or how they can link with existing NGOS providing HIV/AIDS services.

# 1. Introduction

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## 1.1 Purpose

The purpose of this paper is to examine how Community-Based Health Financing (CBHF) schemes<sup>1</sup> in sub-Saharan Africa that have worked with the Partnerships for Health Reform (PHR) and Partners for Health Reform (PHR*plus*) projects, currently address the critical health care needs posed by the HIV/AIDS epidemic. The paper is intended to serve as a “thought piece” to stimulate discussion of the role of CBHF in meeting critical HIV/AIDS needs in Africa and to suggest potential topics for further investigation. For the most part, the scope of the paper is limited to exploring what existing schemes are doing and what they could be doing for HIV-positive individuals. However, the paper does acknowledge several critical questions concerning barriers to enrollment, sustainability, and stigma concerning HIV-positive individuals in the community at large and suggests future research to explore these barriers. Based on this review, the paper analyses whether and how these alternative financing mechanisms can help to reduce the gap in existing service availability and needs at the community level.

This paper examines the potential for CBHF to help meet the call by the HIV/AIDS division of the U.S. Agency for International Development (USAID) for an “expanded response to the global HIV/AIDS pandemic,” particularly in several African countries, and to stem the increase in new infections. USAID has committed to “help local institutions to provide basic care and psychosocial support services to at least 25 percent of HIV infected persons” (USAID November 2000), by 2007. USAID is pursuing six interrelated strategies for fighting HIV/AIDS worldwide (USAID June 2001):

- ▲ Prevention
- ▲ Care, treatment, and support
- ▲ Orphans and vulnerable children
- ▲ Increasing surveillance capacity to track the epidemic
- ▲ Encouraging greater financial commitments by other donors
- ▲ Engaging national leaders and other sectors

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<sup>1</sup> For the purpose of this paper, the term Community-Based Health Financing scheme is defined as a voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity, and the collective pooling of health risks, in which members participate effectively in its management and functioning. This term includes references to various forms of alternative health care financing, such as Mutual Health Organizations (MHOs), prepayment schemes, and other mechanisms of financial risk sharing.

In the area of prevention, USAID promotes and supports Mother-to-Child Transmission (MTCT) programs and voluntary counseling and testing (VCT). In the areas of care, treatment, and support, USAID funds 25 care and treatment projects in 14 countries. USAID's primary objective in care, treatment, and support is to treat AIDS-related illnesses and to build the health infrastructure necessary for the future delivery of antiretroviral (ARV) therapies. Community-based health financing schemes have emerged in many countries in Africa which overlap with the countries where USAID will substantially increase resources within the next five years in order to reduce HIV prevalence rates and provide for basic care and psychosocial services to HIV-positive individuals, for example in Ghana, Kenya, Uganda, and Tanzania. In order to accomplish those goals, USAID will be looking for mechanisms to meet these pressing needs, and CBHF schemes might serve as potential vehicles to implement change.

HIV/AIDS prevention and treatment strategies fit with the mandate of CBHF in sub-Saharan Africa – meeting needs not filled by other entities, such as local, state, and national governments. “As already shown by successful local and community responses to HIV/AIDS, prevention and treatment are synergistic: access to HIV treatment enhances the effectiveness of prevention as well as VCT programs” (USAID June 2001).

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## 1.2 Structure of Paper

This paper reviews the existing HIV/AIDS epidemic in sub-Saharan Africa, highlighting the disparities in the nature, scope, and impact of the epidemic across East and Southern Africa (ESA) and West and Central Africa (WCA). The paper provides a definition of CBHF schemes, background information on the role of CBHF in African nations' health systems, and an overview of potential HIV/AIDS services to be provided. Following these background sections, this paper presents a limited review of what current CBHF schemes (those which the PHR projects have worked with in the past and is working with now) are currently doing about HIV/AIDS. Based on the basic functions of CBHF schemes, this paper explores which barriers might prevent CBHF schemes from providing those HIV/AIDS services and what kind of HIV/AIDS services CBHF schemes would likely be able to address. This is followed by an examination of the evidence of the strengths and weaknesses of community-based health financing schemes in the context of meeting critical HIV/AIDS prevention, and care and support needs. Finally, based on the analysis of how CBHF schemes can provide certain HIV/AIDS services, the existing body of literature, and PHR*plus* experience across Africa with alternative financing mechanisms, the paper makes recommendations for further inquiry and analysis.

## 2. Background on HIV/AIDS in Sub-Saharan Africa

### 2.1 State of the Epidemic

According to the Joint United Nations Programme on AIDS (UNAIDS), HIV/AIDS is the leading infectious disease in the world, with 40 million people infected at end of 2001. Of this number, 28.1 million are in sub-Saharan Africa (UNAIDS December 2001). In 2001, HIV/AIDS was the leading cause of death in Africa (World Health Organization [WHO] 2001), surpassing malaria, diarrhea, and acute respiratory diseases. In June 2001, a declaration of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS stated that "...Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV/AIDS is considered a state of emergency which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden" (UNGASS 2001).

While the average adult prevalence rate in sub-Saharan Africa is 8.4 percent, there is a wide range between countries and within countries. Within sub-Saharan Africa, HIV/AIDS adult prevalence rates tend to be lower in WCA than in ESA. "In West Africa, at least five countries (Burkina Faso, Ivory Coast, Nigeria, Togo, Cameroon) are experiencing serious epidemics, with adult HIV prevalence exceeding five percent." The countries in ESA are experiencing higher prevalence rates and therefore a greater urgency for action in terms of prevention and treatment programs. For example, Kenya (13.95 percent), Uganda (8.3 percent) and Zambia (19.95 percent) (UNAIDS June 2000) are countries where USAID's rapid scale-up effort will significantly increase resources to combat HIV/AIDS in the next five years.

While HIV/AIDS is present throughout the population, youths and young women of childbearing age are of particular concern. UNAIDS estimates that 10.3 million people age 15-24 are living with HIV/AIDS and half of all new infections, more than 7,000 daily, are occurring among young people. Seventy percent of youths with HIV/AIDS live in sub-Saharan Africa. According to a study sponsored by Family Health International, half of all new infections are among 16-23 year-olds, and three-quarters of them are young girls and women (Lamprey and Gayle 2001). In some of the worst affected countries, adolescent girls are being infected at a rate five to six times higher than adolescent boys (United Nations August 2001). In South Africa, pregnant women in their 20s are the most affected group. By 1998, 21 percent of pregnant women under 20 were infected. In the country's Hlabisa District, 35 percent of pregnant women age 20-24 were infected, as were 23 percent of those age 15-19 (U.S. Census Bureau June 2000). This is because, despite differences in the growth and stage of the epidemic across the continent, the predominant pattern of transmission is similar in ESA and WCA – older men infect younger women or girls. The implications of this call for strong prevention and treatment programs, especially aimed at young women of childbearing years and children.

**Table 1. HIV/AIDS Adult Prevalence Rates for Select Sub-Saharan African Countries**

<b>Countries where PHR<i>plus</i> has contacts for CBHF</b>	<b>Adult HIV/AIDS prevalence rates (in percent)</b>
<b>West and Central Africa</b>	
Burkina Faso	6.44
Cote d'Ivoire	10.76
Ghana	3.60
Mali	2.03
Senegal	1.77
Togo	5.98
<b>East and Southern Africa</b>	
Kenya	13.95
Malawi	15.96
Rwanda	11.21
Tanzania	8.09
Uganda	8.30

Source: UNAIDS June 2000

Despite these discouraging statistics, data from the year 2000 offers hope for reducing HIV/AIDS transmission. “The year 2000 was the first time Africa saw a decrease in new infections” since the onset of the epidemic, according to Dr. Antoine Kabore, Director of the Division for the Prevention and Control of Communicable Diseases at WHO’s Regional Office for Africa, at the International AIDS in Africa Conference in Burkina Faso in December 2001. Dr. Kabore attributed this decrease in new infections in part to the efficacy of prevention programs, and he urged that prevention strategies be maintained or increased.

During the past decade, African leaders were slow to recognize the problem of HIV/AIDS but now more countries are openly discussing the problem, encouraging public dialogue, and debating national policy formulation for treatment in particular. For example, the newly elected president of Zambia, Levy Mwanawasa, declared one week after his election that AIDS is a national disaster in his country, and he vowed to fight the epidemic and to look at securing cheaper drugs to help treat the disease (Cable News Network 2002).

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### **2.1.1 Economic Costs of the Epidemic**

The international community is just beginning to understand the true costs of the HIV/AIDS epidemic in economic, social, and political terms. “In just 20 years, nearly 58 million people have been infected with HIV. Countless other have become impoverished as a consequence: children have lost their parents; families have lost their property; communities have lost teachers, health workers, business and government leaders; nations have lost their investments in decades of human resource development; and societies have lost untold potential contributions to social, economic, political, cultural and spiritual life”(UNAIDS December 2001).

From a macroeconomic perspective, studies seem to agree that HIV/AIDS has a negative effect on the overall level of a nation’s gross domestic product (GDP) as well as on GDP growth. This effect may be small initially but increases over time. Studies disagree on the magnitude of the impact

because of factors such as excess labor supply and employee benefits. One study estimates that, in Tanzania, a relatively low-prevalence country, the economy with HIV/AIDS will be 16 percent smaller by 2010 than it would be in a no-AIDS scenario. However, the difference in GDP per capita by 2010 is much smaller (Cuddington 1993). The impact on GDP is larger in high-prevalence countries. In sub-Saharan countries with a prevalence rate of 20 percent or higher, the rate of growth of GDP is 2.6 percentage points lower each year (Bonnell 2000). The reductions in GDP growth are attributable to HIV/AIDS forcing governments to shift more spending to health care than would otherwise be the case and the crowding out of public and private investments in other areas.

The high financing costs of the disease may also worsen poverty levels. A July 2000 PHR study on household expenditures by HIV-positive individuals in Rwanda showed that “HIV seriously impairs the ability of the households to meet basic needs” (Nandakumar et al. July 2000). At the household level, HIV/AIDS will result in a loss of income from the HIV/AIDS patient, and a switch in household expenditures to health care costs as well as funeral and mourning costs. An earlier study (Leighton 1993) finds that households at each socioeconomic level will lose 49 percent to 78 percent of household income in the first year with the death of a sero-positive adult. With the death of a second adult and an infant in the following year, households will lose 95 percent to 167 percent of household income. To finance these expenses, individuals will reduce personal savings, remove children from school, and liquidate assets. Lower private savings and higher government expenditure on health lead to a drop in overall savings and capital accumulation. As a result, employment creation in the formal sector falls because it is capital intensive. With fewer jobs in the formal sector, workers are driven from the higher paying formal sector jobs to lower paying informal sector jobs.

Most sectors of the economy have been severely affected by HIV/AIDS. The disease has primarily impacted the agricultural sector in African countries because agriculture tends to be a large component of economic output and employment. The Food and Agriculture Organization (FAO) reports that 7 million agricultural workers have died in 27 African countries since 1985 (FAO May 2001). Certain rural areas have even experienced labor shortages. If the agricultural sector cannot adjust to labor shortages during planting and harvesting periods, output and income will fall, and food shortages may result. An FAO-sponsored study by Rugalema, Weigang, and Mkwiba (1999) illustrates this: as small-scale sugar farmers in Kenya withdrew labor and investments in sugar farming due to HIV/AIDS-related costs, the two agro-sugar estates surveyed, which depend on these out-growers, experienced decreased quantity and quality of cane for sale. Affected agricultural workers have coped with these labor shortages by switching to less labor-intensive crops, but these tend to be subsistence crops rather than more lucrative cash crops for export. In the village of Gwanda, in the Rakai district of Uganda, the labor shortage has forced agricultural producers to switch from producing coffee and bananas, both profitable exports but labor-intensive crops, to cassava and sweet potatoes, subsistence crops (FAO 2000). The shift in production to subsistence crops also has led to lower land utilization. Oxen owning households have been less affected by the epidemic because oxen can make up for labor shortages (FAO 1995).

The mining sector, which tends to be a key source of foreign exchange in these countries, also has been impacted by HIV/AIDS. Miners, who live far from home and population centers, have greater contact with sex workers. Konkola copper mines in Zambia reported that 18 percent of its workforce is HIV positive (U.N. Integrated Regional Information Network May 2001). Being higher-skilled workers, miners are costly to replace. HIV/AIDS has impacted the transportation sector in that truck drivers also tend to have high HIV/AIDS prevalence rates. Education also has suffered, as a result in the high number of infected teachers – in Zambia, teacher mortality rate is around 39 per 1,000, 70 percent higher than in the general population (Kelly 2000), and in Botswana, death rates among primary school teachers rose from 0.7 per 1,000 in 1994 to 7.1 per 1,000 in 1999 (Loewenson 2001) – as well as children staying at home to care for sero-positive relatives, to supplement family

income, or because household expenditures are reallocated from school tuition to health care. The health sector has been impacted by the high rate of infection among health care workers, the increased demand for HIV/AIDS-related care, and the high cost of this care, which together exceed the resources of the health care system. In Malawi and Zambia, health worker illness and death rates have increased five- to six-fold, reducing the number of personnel and increasing stress, overwork, and fear for personal safety among the remaining staff (Loewenson 2001). In Uganda, hospital occupancy due to HIV/AIDS cases is very high; interviews at the 200-bed Kitovu mission hospital serving Masaka and Rakai districts showed 40 percent to 50 percent of admissions due to HIV/AIDS, and 70 percent of patients in medical and tuberculosis (TB) wards are HIV positive (Armstrong 1995). Finally, the military is another area that has had high rates of infection, which threaten military preparedness as well as the health of the communities in which the military is posted. Rwanda is currently struggling with high rates of infection in its military; UNAIDS estimates that the prevalence rates for military personnel is two to five times higher than for civilians (UNAIDS May 1998).

At the microeconomic level, firms experience falling productivity and rising costs as a result of the effect of HIV/AIDS on the labor force. Because HIV/AIDS disproportionately affects workers in their most productive years, firms' overall productivity falls as higher skilled workers are replaced by younger, less experienced workers. Workers also must make up for the absenteeism of ill colleagues, which leads to lower quantity and quality of output. Costs rise due to higher health care and funeral expenses, and recruitment and training of replacement workers. Individual firms become less competitive, less profitable, and less attractive to investors. The economy as a whole also may suffer, if decreased economic output results in shortages in foreign exchange.

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## 2.2 Overview of HIV Responses: Prevention, Treatment, and Care and Support Services

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### 2.2.1 National Responses

In response to the HIV/AIDS epidemic and the associated costs discussed above, all countries in Africa have implemented or are in the process of designing national strategic plans to counter the HIV/AIDS epidemic. However, the extent of this response at the national level varies by country, depending on political commitment to fight the disease, recognition of the disease's impact, availability of resources and management capacity, as well as the stigmatization of the disease.

The countries' first step in responding to HIV/AIDS, following the determination of the first HIV/AIDS cases in the 1980s, was development of a National AIDS Control Program (*Programme National de Lutte contre le SIDA*), implemented through ministries of health. These programs have been responsible for formulating and implementing the countries' first and second Medium Term Plans, which focus on issues such as information, education, and communication (IEC) strategies, HIV/AIDS case management, condom distribution, promotion of VCT, ensuring safe blood supply, epidemiological surveillance, and care and support for persons living with AIDS (PLWA). Following the implementation of these plans, national governments formulate national strategic plans and create committees to oversee their implementation.

The ability of national governments to implement these plans has varied significantly. Ethiopia, for example, implemented a National Task Force against HIV/AIDS in 1985, a year before country's first case of AIDS in the country was discovered. Certain African countries with high infection rates have moved quickly to respond to the epidemic from its beginning. USAID describes Uganda as having one of the most comprehensive HIV/AIDS programs in Africa, due partly to political

leadership (Synergy Project June 1999). Other countries were slower to respond but now acknowledge the seriousness and impact of the epidemic. In 1999, King Mswati III of Swaziland declared HIV/AIDS a national crisis and called on all sectors to take action. In Rwanda, HIV/AIDS is now considered a national priority. South Africa has renewed its commitment to fight the epidemic. Nonetheless, many of these countries lack the resources to support an adequate response. Other obstacles include civil violence, as in Rwanda, as well as the lack of clean water and housing.

Many of the national strategic plans have emphasized a multisectoral approach, involving multiple ministries at the national level. For example, Ghana's National Strategic Plan involves the adoption of policies by the Ministry of Employment, the Ministry of Agriculture, and the Ministry of Youth and Sports. In Botswana, 10 of the 23 districts have established multisectoral committees to implement the Medium Term Plan. Other African countries, such as South Africa, have not yet mounted a multisectoral response.

Strategic plans have also focused on decentralization of HIV/AIDS policies to the district level. Senegal has attempted to involve non-governmental organizations (NGOs), religious groups, and community organizations as well as district government. Ethiopia has also attempted to design a response at the regional level. However, despite the benefits of decentralization and community involvement, most African countries have not fully decentralized their HIV/AIDS programs because of a lack of political commitment and coordination (Synergy Project June 1999).

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## 2.2.2 Description of Services

In order to address how CBHF schemes might provide HIV services, it is necessary to define what constitutes HIV/AIDS services and examine the broad spectrum of services that could be possibly be provided. "The content of care delivered across a continuum contains a range of comprehensive services including counseling and testing, clinical management, nursing care, and community-based social support. The provision of care extends from the individual/home to the hospital, through various levels of care linked with discharge planning and referral networks and back to the individual home... the PWA [person with AIDS] must be able to move freely from one level of care to another" (Osborne 1996).

HIV/AIDS services can be broadly divided into two categories: prevention, and care and support activities (Table 2). Some of these services can be provided at a health center while others can be provided through home-based care. Services can be delivered by health care workers, volunteer community health workers, home-based caregivers, NGOs, or family members.

On the prevention side, HIV/AIDS experts agree that voluntary counseling should occur from the time that an individual is tested for HIV through the life of the persons found to be sero-positive. Counseling is particularly important if patients are asymptomatic and thus may not perceive themselves as being capable of transmitting the virus. When the patient receives counseling at this point in time, there is an opportunity for informing patients about how they can help themselves and prevent spreading the infection to other persons. By offering VCT and certain treatment options, CBHF schemes provide incentives for sero-positive members to enter the care continuum and can help link patients with other national and local programs supporting HIV/AIDS services.

**Table 2. HIV/AIDS Services**

Type of service	Examples of service
Prevention	Behavior change communication Condom promotion Management of sexually transmitted infections (STIs) Voluntary counseling and testing Blood safety precautions MTCT prevention Stigma reduction
Care and support	VCT Clinical management of opportunistic infections, such as TB and STIs ARV treatment, including MTCT interventions Home-based care Peer counseling groups Nutritional support Palliative care Psychological support

Source: Family Health International 2002.

One of the trickier aspects of treatment of HIV/AIDS is the occurrence of HIV-associated opportunistic infections. Tuberculosis is the most common opportunistic disease, with one-third of 32.9 million HIV-infected people being co-infected with *Mycobacterium tuberculosis* (U.S. Centers for Disease Control and Prevention 2002). Increasing numbers of TB cases in sub-Saharan Africa are attributed to the HIV epidemic, because sero-positive people who become infected rapidly progress to active disease. The WHO and UNAIDS issued guidance in 1998 recommending the use of isoniazid TB preventive therapy as a component of basic care for persons living with HIV infection in settings with TB prevalence (UNAIDS October 2000b). This indicates that it is important to treat HIV patients for TB and other opportunistic infections prior to treatment with other drug combinations, such as ARV. However such preventive therapy for TB in sub-Saharan Africa is difficult to provide.

Treatment for sero-positive people with active tuberculosis should begin with DOTS (Directly Observed Therapy, Short-course). There has been some experience in controlling multi-drug resistant tuberculosis using community-based approaches in resource-constrained environments (Farmer and Kim 1998). In rural Haiti and in an urban slum of Lima, Peru, the Partners for Health group has pioneered community-based approaches to controlling multi-drug resistant TB by combining DOTS with individualized aggressive regimens. Using the same approaches and principles, there is potential for further investigation of community-based approaches to HIV treatment (Farmer 2001). In Haiti, the HIV Equity Initiative is providing directly observed therapy with highly active ARV therapy (HAART) through community health workers and clinic staff at no cost to the patient.

Palliative care and support delivered by an interdisciplinary team could become an important part of a basic HIV/AIDS package of services. Palliative care for people with HIV/AIDS must balance the management of chronic symptoms and conditions with the treatment of acute symptoms (UNAIDS October 2000a). A comprehensive palliative care program includes pain relief, treatment of opportunistic infections, nutritional support, psychological support and counseling to both PLWAs and their caregivers. Pain relief is critical – mild pain can first be treated with acetaminophen, aspirin,

or paracetamol, more intense pain by codeine with or without non-steroidal anti-inflammatory drugs, and severe pain with morphine and other strong opioid analgesics. Access to these drugs is thus paramount to PLWAs. However, most African countries do not address the pain relief component of care due to lack of drugs and human resources to deliver controlled substances.



## 3. Role of CBHF in Addressing HIV/AIDS Health Needs

### 3.1 PHR Experience with CBHF

“CBHF schemes are a mechanism for mobilizing community resources to share in the financing of local health services” (Cripps, Edmond, and Killian 2000) and are often designed to improve access, quality, efficiency and equity in health services. The Partnerships for Health Reform project defined a CBHF scheme, or *Mutuelle* (Mutual Health Organization, MHO) as it is known in WCA, as “a voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity, and the collective pooling of health risks, in which members participate effectively in its management and functioning” (Atim 1998).

In response to shrinking government capacity to provide basic health services over the last decade, there has been a growing movement in Africa to develop alternative financing mechanisms for health care to distribute the financial burden across the population. CBHF schemes, often based on existing solidarity structures, were developed in Africa as mechanisms that would enable members to pool their health risks together.

In general, the schemes in WCA (MHOs) are community- and employment-driven groups formed to meet gaps in health care financing needs. MHOs have ranged from small to medium size in membership and have for the most part been community initiated, where the community has engaged a health service provider to deliver services included in a mutually agreed upon benefits package. Health care providers range from village health posts to district health centers and in many cases include regional- or district-level hospitals. In Senegal and Ghana, MHOs have grown exponentially over the past three years, and this growing movement has caught the attention of national governments trying to craft health care financing policy and legislation. In contrast, the schemes in ESA have tended to be initiated by NGOs, in many cases church mission hospitals, and offered to the community as an outreach activity. These schemes tend to be provider-based, with the mission hospital or clinic serving as the central point of service and contact. In both regions, MHOs and CBHF schemes have received external donor support in terms of technical assistance and funds to underwrite scheme operations. These funds and assistance have played a role in the continuity of the schemes over time.

In 1996, the PHR project began analyzing the design and operations of CBHF schemes in Africa. In West and Central Africa, PHR provided technical assistance to MHOs to improve their accessibility and financial sustainability. Similarly in East and Southern Africa, PHR conducted an extensive review of CBHF schemes in the region. Both efforts resulted in the production of an operations manual for building the management and organizational capacity of those working with CBHF schemes. The *PHRplus* project continues to build on the successes of CBHF schemes in ESA, and on the rapid development and growth of MHOs in WCA. The projects have highlighted the critical role of these community-level mechanisms in filling health financing gaps, and project staff

provides technical assistance and advice to encourage the schemes' success in various aspects of operation – from organization and design of emerging schemes, to day-to-day management, quality improvements, and evaluation of scheme performance. With this report, *PHRplus* examines the potential for CBHF schemes to meet the community's needs for prevention, treatment, and care and support services to combat the omnipresent AIDS crisis across the continent of Africa.

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## 3.2 Rationale for CBHF to Help Address HIV/AIDS Needs

There are four important challenges to mitigating the HIV/AIDS epidemic in ESA, according to Dr. Bamet Ndyabangi, the HIV/AIDS advisor at the Commonwealth Regional Health Community Secretariat (CRHCS) in Arusha, Tanzania (Ndyabangi 2001). These are:

- ▲ Increasing financing options. ESA communities need more resources: to address the resource gap; to encourage public-private partnerships; and to advocate with governments for access to new resources.
- ▲ Scaling up activities from pilot programs to broad-based interventions.
- ▲ Networking and developing partnerships.
- ▲ Increasing community participation. ESA governments need to develop strategies to help implement effective interventions at the local level. These interventions could help to address the existing gap between service providers and community members, health care workers, and health extension workers.

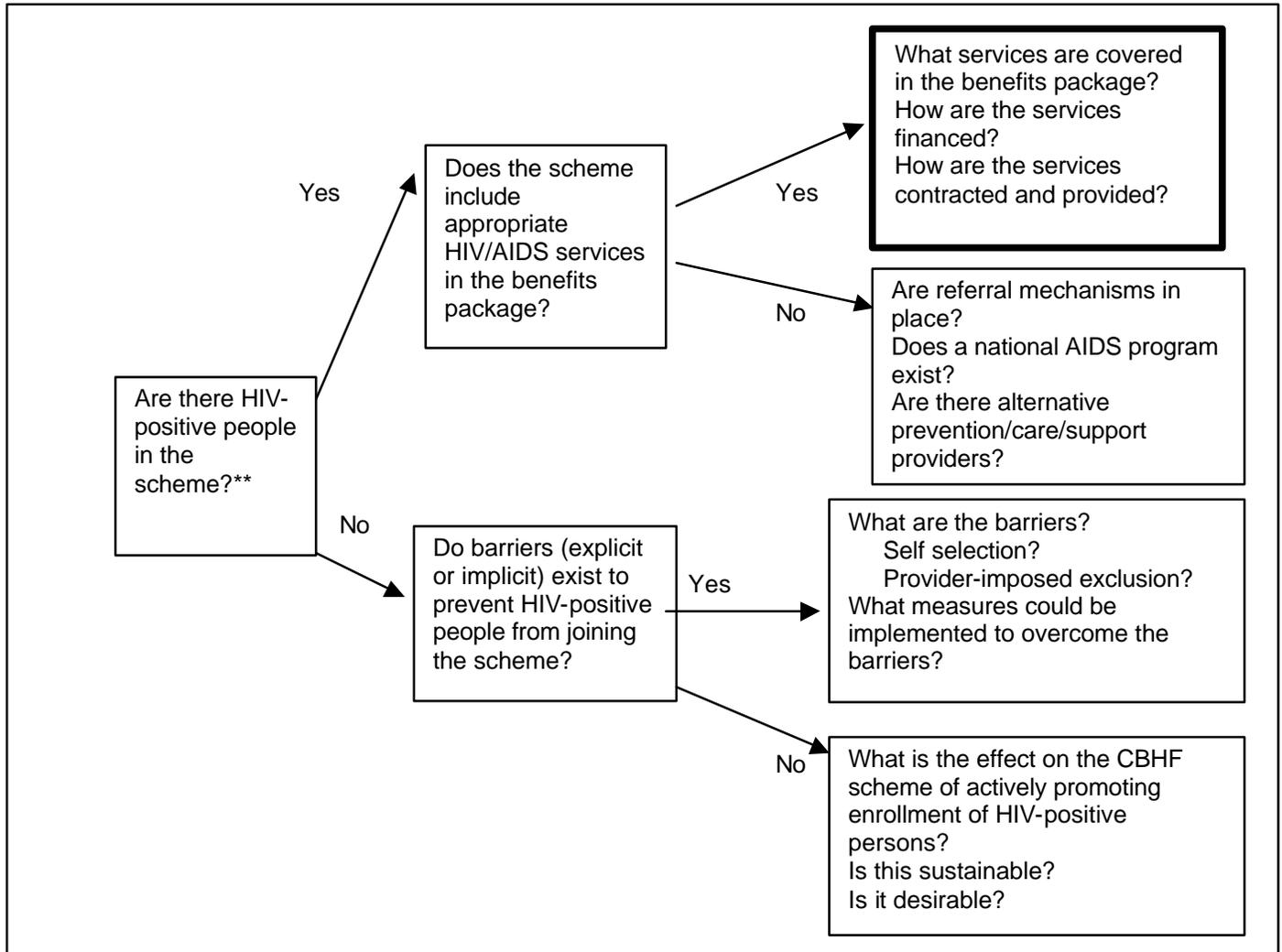
In order to meet these critical challenges, national and local governments have begun to look at innovative approaches to financing pressing health care needs. The examination of CBHF as a potential mechanism for meeting HIV needs is in line with recent trends in increasing information and advocacy for community-based organizations to play a more active role because, as the World Bank Macroeconomic Commission on Health reported, “community financing is effective in reaching a large number of low-income populations who would otherwise have no financial protection against the cost of illness” (Jakab and Krishnan 2001).

The Macroeconomic Commission's analysis of community financing schemes also found that “community financing arrangements contribute significantly to the resources available for the local health care systems, be it primary care, drugs, or hospital care” (Jakab and Krishnan 2001). The June 2001 UNGASS declaration calls for partnerships of civil organizations, business groups, and community-based organizations to strengthen and finance effective HIV/AIDS initiatives. NGOs and other local organization have already implemented community-based care and support initiatives, developed peer support networks, disseminated basic information on prevention and care, and, in some cases, even delivered HIV/AIDS treatment and care services. These existing organizations may be attractive partners for CBHF schemes in the HIV/AIDS health financing context.

### 3.3 Conceptual Model

Figure 1 is a conceptual model that shows the relationship between HIV-positive people and CBHF schemes. The issue of whether or not CBHF schemes currently cover HIV-positive individuals is complicated by the fact that the HIV status of many individuals is not known. This may be due to lack of access to testing services, to people's reluctance to be tested because of the stigma associated with HIV testing and treatment, and to the lack of education about the epidemic.

**Figure 1. Conceptual Model of Relationships between CBHF Schemes and HIV-positive Individuals**



\*\* HIV/AIDS diagnostic testing is unavailable in many sub-Saharan African countries and therefore individual HIV status is often unknown.

Even though many schemes do not specify benefits for HIV-related health problems, they are in fact providing benefits for some of these problems, including services for a range of symptoms and opportunistic infections that may be HIV-related, such as TB and pneumonias.

For example, the benefits packages of many schemes do not cover HIV/AIDS services but do cover inpatient care. HIV-positive members thus can take advantage of inpatient care eligibility to treat an opportunistic infection, say, TB. Even if scheme policy were to exclude HIV-positive individuals, in reality, without testing to confirm HIV infection, it would be impossible to identify HIV-positive persons. Thus, assuming the scheme covers TB, all members with TB would be covered and receive treatment.

Assuming that diagnosis and testing services are available at the local level, HIV-positive individuals may be excluded from joining or maintaining membership either directly or indirectly: Schemes' membership criteria may explicitly prohibit HIV-positive individuals from joining; schemes may not offer HIV/AIDS services, therefore discouraging HIV-positive individuals from enrolling; or, more implicitly, schemes may discourage enrollment of HIV-positive individuals through unaffordable premiums and other membership fees. This report recognizes that these barriers exist and affect the search for ways to meet HIV needs in the community. The report does not directly address these issues, although it recommends research into these questions (see Annex A, Additional Research Questions). Rather, the paper focuses on the questions in the highlighted box in Figure 1.

## 4. Findings

### 4.1 Inventory of Existing Schemes and HIV/AIDS Benefits

The selected inventory of CBHF schemes in Table 3 is gleaned from PHR and PHR*plus* work with schemes in sub-Saharan Africa. The table lists the essential components of scheme operations – location, membership size, basic benefits, and HIV/AIDS provisions and/or exclusions. It highlights the schemes that have addressed HIV/AIDS services or are in the process of designing interventions.

**Table 3. HIV/AIDS Services Currently Financed or Provided by CBHF Schemes**

Scheme	Country	Basic benefits	HIV/AIDS provisions	As of August 1999, # of members/ percent of population covered
Kisiizi Hospital Health Society Est. 1996	Uganda	Outpatient care Inpatient care at general ward bed No annual limits	None explicitly mentioning HIV/AIDS, however could in fact cover outpatient and inpatient care for HIV/AIDS patients	6,580 individuals or 6.5 percent of population (100,000 people)
Chogoria Hospital Insurance Scheme Est. 1991	Kenya	Outpatient care and Inpatient care subject to annual limits	Explicitly excludes AIDS treatment costs over Ksh 2000 per policy year no matter which benefits package chosen	1,494 individuals or 0.3 percent of the population (450,000)
Community Health Fund Est. 1996	Tanzania	Unlimited access to outpatient care at participating health centers	If a client is HIV positive through test results, clients are referred to national HIV clinics.	2.8 percent of population in Hanang district in 2001
Atiman Health Insurance Scheme Est. 1995	Tanzania	Outpatient care No annual limits	Does not cover AIDS, TB, cancer, hospitalization	At peak, 13 percent of parish population
Mburahati Coop Society Est. 1992	Tanzania	Covers outpatient clinics, 10 percent of hospitalization at government clinics	Explicitly excludes chronic diseases, AIDS, TB, diabetes	23 out of 27 cooperative members (85 percent) or 78 beneficiaries
Nkoranza Community Health Insurance Scheme Est. 1992	Ghana	Covers 100 percent of hospitalization and referrals to other hospitals for specialty care. Does not cover outpatient visits other than snake bites	None stated in benefits package	Estimated at 30 percent of population (131,941 people)
Prepayment schemes Est. 1999	Rwanda	Outpatient care at health center Inpatient care with referral at district hospital	Church paid for 50 sero-positive members	88,303 people or 8 percent of the population in 3 districts

Sources: Musau 1999, Atim et al. 2001, Atim personal communication, ILO materials

In general, CBHF schemes do not currently offer HIV/AIDS services other than prevention services such as IEC sessions and health education and outreach. Those schemes that do offer some coverage for HIV/AIDS services, such as Chogoria Hospital in Kenya, cap the benefits cover, therefore limiting the amount of services available.

In addition, PHR*plus* recently surveyed several MHOs in Ghana and Senegal to determine which types of health services are included in benefits packages and to what extent the schemes offer HIV/AIDS services. The findings show that, in Ghana, six of eight MHOs surveyed cover HIV services in their benefits packages. The services included prevention, treatment, and support, but primarily prevention (Anie 2001). In contrast, none of the 10 MHOs surveyed in Senegal covers HIV services. However, according to PHR*plus* WCA field staff, many MHOs do collaborate with NGOs and providers supported by the national AIDS control programs in Ghana, Mali, and Senegal, referring patients to the NGOs, encouraging HIV testing, and providing health education and AIDS prevention information at the provider and/or scheme level.

While these results may be non-representative of the country as a whole, they indicate that schemes that offer or address HIV/AIDS services concentrate on prevention services. In addition, while the schemes may not identify HIV services in their benefits packages, in reality the likelihood that the scheme is treating HIV/AIDS patients is high, given existing prevalence rates especially in ESA and the frequency of opportunistic infections such as TB.

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## 4.2 Role of CBHF in Meeting HIV Needs

While CBHF mechanisms do not appear to be the ultimate answer or “quick fix” for getting needed services to the community-level, it does appear from PHR’s “lessons learned” and experiences in sub-Saharan Africa that CBHF schemes are beginning to play a larger role in the health care financing picture of national governments. The PHR*plus* survey of health financing schemes in Ghana found that “their proliferation in the country has been concentrated within the last two years with as many as 80 percent of them being formed during this period” (Atim 2001). In Tanzania, government started the Community Health Fund in 1996 to increase the availability of quality health services at affordable prices and increase community participation in generating and controlling financial resources for health care. The scheme targeted the informal sector and was aimed at generating revenue from the community to increase the quality of health services. PHR*plus* is currently providing technical assistance to the Community Health Fund as it expands to all districts of the country and begins to play a greater role in the nation’s health financing plan.

Based on what existing CBHF schemes currently provide and what they could provide (Table 4), the following sections show where CBHF schemes are best positioned to finance or deliver HIV/AIDS services.

**Table 4: HIV/AIDS Services that Could Be Financed or Provided by CBHF Schemes**

HIV/AIDS services	Financer of services	Provider of services	
		Community contracts provider (WCA)	Scheme is provider based (ESA)
<b>Prevention</b>			
<b>Voluntary Counseling and Testing</b>	Comprehensive VCT can be expensive to provide and could possibly require outside funding sources. In Kenya, the cost of VCT per DALY saved averaged between \$5.16 and \$27.36 (Sweat, 2000). Funding would be necessary for both the ongoing counseling and the initial testing.	CBHF schemes may contract with providers who can administer VCT.	Providers may already provide VCT services and include those services in the benefits package.
<b>Information, Education, and Communication/Sensitization</b>	IEC costs are relatively small compared to treatment costs. If CBHF schemes are already conducting IEC for other health topics, marginal costs for introducing HIV/AIDS IEC would be low.	Regular CBHF scheme management meetings provide venues for informing, educating, and communicating HIV/AIDS prevention messages to CBHF scheme members.	Providers may also include IEC services as part of the benefits package.
<b>Mother-to-Child Transmission</b>	Outside funding sources could potentially finance MTCT for CBHF scheme members. This could also serve as an incentive for more of the target population to become a member of the scheme and add to the risk-sharing pool.	CBHF schemes can refer HIV-positive pregnant women to national programs that can provide them with free or subsidized treatment.	If providers are already providing MTCT treatment, they may be able to offer those services to CBHF scheme members. If they do not provide those services, they may be able to refer members to national AIDS programs.
<b>Care and Support</b>			
<b>Opportunistic Infections</b>	Some CBHF schemes are already covering some treatment of opportunistic infection. Some schemes cap the amount that they will cover in order to avoid cost escalation.	CBHF can contract out to providers to provide treatment of opportunistic infections. Those services may already be covered by the scheme without explicit reference to AIDS.	Provider-based schemes may cover treatment of opportunistic infections the way they cover other problems, by placing an annual limit on the expenses that they will cover.
<b>Antiretroviral Treatment</b>	Providing ARV treatment would jeopardize the financial sustainability of CBHF schemes without outside funding sources. However, CBHF schemes have the potential to absorb outside funds to deliver ARV treatment if appropriate technical assistance is delivered to build local capacity.	In general, providers have limited capacity both in terms of human resources and facility availability to provide ARV treatment.	In general, providers have limited capacity both in terms of human resources and facility availability to provide ARV treatment.
<b>Home-based Care/Case Management</b>	Home-based care can be cheaper than paying for inpatient care, but not necessarily. For those CBHF schemes that already cover inpatient care, it might be cheaper to cover home-based care. Home-based care can also alleviate some of the pressure felt at the hospitals with the influx of HIV/AIDS patients. However, long-term home-based care can result in cost escalation for CBHF schemes if the service is included in the benefits package.	CBHF schemes can contract with home-based care agencies to provide care to PLWAs. Even if CBHF schemes do not cover home-based care, they should establish clear referral guidelines to refer HIV-positive members to other resources in the community.	Provider-based schemes can contract with home-based care agencies to provide care to PLWAs. Provider-based schemes that do not cover home-based care should establish clear guidelines to refer HIV-positive members to other resources in the community.

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### 4.3 Strengths

The CBHF movement in sub-Saharan Africa is growing and adapting to changing health challenges in the community, region, and continent. With their understanding of and advocacy for the family and individual, CBHF schemes are well positioned to respond to community health needs. In addition, many CBHF schemes represent public–private partnerships that the international HIV/AIDS community is encouraging “for delivery of care, mobilization of funding, and/or procurement of commodities for HIV/AIDS care” (AFRO-NETS).

As a financing mechanism, CBHF schemes allow donors to prepay for those who would normally not be financially capable of paying the membership premium. In Rwanda, the Church paid the premiums of 50 HIV-positive individuals, which enabled them to obtain the care that they needed without having to incur the cost of treatment at the time of illness. There is the potential for other donors to use CBHF schemes as a channel to fund palliative care for HIV-positive individuals. Premiums might have to be raised to respond to the increase in risk that the CBHF scheme has to bear, but a greater number of people would share that risk if more people were enrolled in the scheme.

As a provider of services, CBHF schemes in WCA are already contracting with providers to deliver health services to their members. The schemes can use this capacity to contract with home-based care agencies, especially to provide palliative care. Even if CBHF schemes chose not to include home-based care in their benefits packages, it is important the schemes have guidelines for referring people to the appropriate community-based organization that can assist them. Most CBHF schemes already conduct IEC sessions and could provide IEC on HIV/AIDS. CBHF can help target youth and families in HIV/AIDS prevention education programs as an additional membership benefit. This would be particularly attractive in schemes that encourage membership by families or groups.

CBHF schemes incorporating VCT and treatment options into the scheme benefits packages would serve as an incentive for people to enter the health system. With VCT benefits as an entry point to the care system, HIV services could become normal components of the health care package. This may increase health-seeking behavior, increase awareness of the impacts of HIV as a social disease, and decrease stigma.

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### 4.4 Weaknesses

As a financing mechanism for HIV/AIDS services, CBHF schemes are in a precarious position without outside sources of funding. However, although CBHF schemes may not be able to finance many HIV/AIDS treatment services, they can act as a mechanism to channel external funding sources along with the technical assistance needed for absorbing and monitoring external funds. A caveat to the suggestion of simply injecting external funds into the scheme is that most schemes do not know their members’ HIV prevalence rates. This prevents schemes from developing a realistic premium scale, i.e., one that will not endanger the financial sustainability of the scheme.

Including HIV-positive individuals as members also poses a financial risk to CBHF schemes because these individuals are more likely to use health services, again driving up costs. “... The vast majority of MHOs (in WCA) cap their insurance coverage for members so that no one can exceed a certain cost... This is a risk management strategy that means that MHOs do not have to concern themselves with anybody’s particular illness from the cost point of view”(Atim, personal

communication). “Generally, community-based health financing schemes are reported to reduce the out-of-pocket spending of their members while increasing their utilization of health care services” (Jakab and Krishnan 2001, p.19). A 2000 PHR study in Rwanda revealed that HIV-positive individuals had an annual per capita health service utilization rate of 10.92, compared to a rate of 0.29 for the rest of the population (Nandakumar et al. 2000)

Advocating for CBHF schemes to cover certain treatment options assumes that there are providers who offer those services. As noted above, many CBHF schemes already treat and cover opportunistic infections as part of the benefits package, without explicit reference to HIV/AIDS. Other schemes cap the amount that they will cover in relation to specific diseases. However, very few providers in sub-Saharan Africa provide ARV treatment, due to the lack of infrastructure and the cost of the drugs. “Barriers to the widespread implementation of ARV treatment in sub-Saharan Africa (SSA) include the price of the drugs, lack of technologies needed to monitor the ARV treatment, lack of trained staff with the knowledge to administer ARVs and weak facilities” (Bonnell 2001). This environment may change soon due to the drop in drug prices over the last couple years.

Finally, while some schemes are mature enough to have developed capacity to execute and monitor contracts with providers, many CBHF schemes are nascent organizations not ready to handle complex contracting arrangements and the monitoring and evaluation to ensure contract compliance.

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## 4.5 Conclusions

Despite the limited findings from this review of CBHF schemes, there seems to be potential for CBHF schemes to provide certain HIV/AIDS services, specifically in terms of the four CRHCS objectives of increasing financing options, scaling up activities, developing partnerships, and increasing community participation.

The UNAIDS Global Framework indicates that “it is at the community level that the outcome of the battle against AIDS will be decided. Containing and reversing the HIV/AIDS epidemic within this decade requires dramatically increased efforts in communities with increasing and/or high HIV prevalence, and in low-prevalence areas where the preconditions exist for rapid rise in HIV transmission. Local capacity for prevention, care, and support efforts need to be recognized, affirmed and strengthened (Bonnell 2001, p.6).

There is potential for local capacity to be built within CBHF schemes through technical assistance or financial assistance from governments, the private sector, new international partnerships and funding sources. “Success in curbing the epidemic has come from government and civil society working together, ensuring the epidemic is visible while at the same time decreasing the stigma associated with HIV/AIDS. In an increasing number of countries, partnerships bring together government and international resources with those of the community of interested activists, people living with HIV/AIDS, NGOs, community-based organizations, religious and academic institutions and the commercial sector” (UNAIDS June 2001). CBHF schemes could serve as effective partners in the HIV/AIDS community, serving as a bridge for financing of services and linking community needs with community health priorities. One particular area worth exploring is whether CBHF schemes can effectively channel HIV/AIDS funding intended to reach people most affected by HIV/AIDS. As community-based organizations, CBHF schemes have a comparative advantage of addressing community-identified priorities.

Although it remains unclear which HIV/AIDS services CBHF schemes could finance or provide, it is clear that CBHF schemes will require technical assistance in mitigating the AIDS epidemic in

their communities. The appropriate role and capacity of CBHF to help meet the wide range of service needs should be addressed at the local and national levels. “Reducing the impact on individuals and families (includes) improved access to quality of care for people living with HIV including peer group support, voluntary counseling and testing, essential drugs and commodities, antiretrovirals and social support services, including appropriate supportive roles for traditional practitioners” (UNAIDS June 2001).

## 5. Recommendations

*There is a need to examine whether it is feasible or desirable for international donors and governments to contract with CBHF schemes in order to provide HIV/AIDS services.*

The international community is calling for efficient and quick response to the ever-growing problem of HIV/AIDS prevention, care, and treatment needs at the local level. The Global Trust Fund for AIDS, Malaria and TB has been set up to encourage nations to facilitate flow of funds. It stresses community involvement as PLWAs need resources on the ground as soon as possible. “NGO contracting for HIV/AIDS is of particular interest at this time because of its potential to funnel new funding quickly and effectively to “on-the-ground” interventions” (Barnett, Connor, and Putney 2001).

CBHF and MHO schemes in Africa are organizations “on-the-ground,” which are community driven or include significant community involvement. Many schemes already have in place working relationships with community health care providers, and they are currently working to meet basic primary health care needs through health promotion, service delivery, and follow-up. CBHF schemes may have a distinct and unique role to play in accepting HIV funding and providing or arranging for provision of appropriate services, given their experience in handling funding and contracting with providers. Contracting for service with CBHF schemes could be an efficient and simple initiative to increase the flow of resources where it is badly needed, at community levels. Contracting makes the purchaser and service delivery mechanism more accountable for how moneys are spent and how performance is measured. Speed, effectiveness, and cost-effectiveness are three criteria used to measure performance.

A PHR assessment of contracting NGOs to combat HIV/AIDS in Brazil and Guatemala showed promise for improving service delivery, and outreach. In many countries NGOs were providing basic prevention, education, and care for those infected with HIV/AIDS before the government acknowledged that HIV/AIDS was a national problem. NGOs have also emerged to fill the gap to provide services that governments are unable or reluctant to provide (Barnett, Connor, and Putney 2001).

There are many ways in which international donor and government funds could be used within CBHF schemes. One is to subsidize specific HIV/AIDS services such as VCT. Providing VCT as a prevention effort leads people to decrease their risk behavior for contracting HIV/AIDS. Family Health International reported “more than a 40 percent reduction in unprotected intercourse among individuals who received VCT compared to those who received only health information” (Family Health International 1998).

Another way is to use international donor and government funds for specified services. Although prevention and treatment services are often separated, CBHF schemes have the potential to integrate the two efforts. Introducing VCT into the benefits packages and providing an appropriate HIV basic care package that consists of opportunistic infection management, palliative care, and psychological support can serve as an incentive for people to get tested. VCT can also instruct HIV-positive persons to mitigate behavior that might spread infection. “[P]roper assessment of an individual’s HIV status

permits educational measures to help negative persons remain negative and positive persons to enter into care” (AFRO-NETS). For example, in Rwanda, the Church paid the premiums of HIV-positive patients, which enabled them to obtain health care.

One constraint in negotiating and setting up formal contracts with CBHF schemes is the various legal aspects to contracting with non-registered organizations. As Atim points out, “60 percent of 50 CBHF schemes reviewed in West and Central Africa were not registered with authorities” (Jakab and Krishnan 2001, p.20). For legal reasons, CBHF schemes may prefer to remain non-registered, which may pose challenges for establishing performance-based contracts and other formal mechanisms. If CBHF mechanisms are classified or registered as NGOs, there is potential for international donors, national programs, and other donors to establish contracts for providing HIV/AIDS services.

Another constraint is the absorptive capacity of CBHF schemes for international donor or government funds. While millions of dollars are being contributed to different funds such as the Global Trust Fund for AIDS, TB and Malaria, many NGOs can absorb those funds only at a measured rate. CBHF schemes are in that same position and more research needs to be done on how these organizations will use these funds to provide services to as many people as possible. Many schemes do not have the accounting or monitoring systems to account for such large sums of money. Technical assistance to these CBHF schemes would be crucial if they were to receive such funds.

***There is a need to explore various aspects of incorporating HIV prevention and care and support services into existing benefits packages of CBHF schemes, or how schemes can link with NGOs that provide HIV/AIDS services.***

The AIDS epidemic will continue to affect sub-Saharan Africa in the coming years, and there will be increasing numbers of people who are HIV positive (regardless of whether or not they know their status) who will join CBHF schemes to obtain health services. CBHF schemes already cover services for certain HIV/AIDS-related opportunistic infections in their benefits package regardless of whether or not they explicitly refer to them as HIV/AIDS services. Many schemes cover either inpatient or outpatient care without specifically excluding HIV/AIDS.

Community-based NGOs have been organizing to provide home and community care to PLWAs. UNAIDS reviewed six organizations as best practices in mobilizing family and community care for PLWAs (UNAIDS June 1999). Such examples show how community resources can be tapped for providing a variety of HIV/AIDS services, and that there is potential for CBHF schemes to fill the same kind of roles that these community-based NGOs have been providing.

If CBHF schemes wish to incorporate certain HIV/AIDS services into their current benefits packages, they will require technical assistance to assess how inclusion will impact their current premiums, risk pooling, relationships with providers, and financial sustainability. They should consider developing relationships between existing CBHF schemes and NGOs that are already providing home-based care to PLWAs.

Including HIV/AIDS services in the current benefits packages of CBHF schemes will affect premiums and the cost of providing health services to scheme members. Services that will be included in the benefits package will need to be costed to ensure that the scheme can cover those costs either through an increase in premiums or subsidies from outside sources. If the scheme starts including HIV/AIDS services in the benefits package, there could be an increase in the number of HIV-positive members.

Providers already contracted to provide health services to CBHF members may not have the capacity (personnel, lab, or drugs) to provide certain HIV/AIDS services. For example, if a CBHF scheme claims to cover certain drugs used to treat opportunistic infections, but the contracted providers do not have those drugs, the CBHF scheme is not in reality providing those services. Such issues must be anticipated and resolved before a contract is completed and benefits promised to members.



# Annex A: Additional Research Questions

1. What are the explicit and implicit barriers to access of services in CBHF schemes by HIV-positive individuals?
2. Can financial viability of schemes be maintained in cases where the majority of members have some chronic disease, such as HIV?
3. From the policy perspective, what is the government's role in trying to regulate schemes that are seen to discriminate against and impose barriers to HIV-positive people?
4. What is the effect upon CBHF schemes of including HIV-positive individuals as members?
5. To what extent do CBHF schemes reduce the financial vulnerability of HIV-positive members?



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