



A European Foundation Centre  
(EFC) Special Interest Group

**New Models to Improve HIV/AIDS Healthcare Coverage**

**European Foundation Centre, Annual General Assembly**

**Wednesday 13 May 2009**

**Conference Hotel Rome Cavalieri, Rome**

## **CONTENTS**

Introduction and background	3
Session One: Opportunities for European Foundations to Help Share Financial Risk of Ill Health	3 - 6
Session Two: New Models to Financing Healthcare in Poor Communities	6- 9

## **ANNEXES:**

Annex I:	Speakers Contacts
Annex II:	Participants List
Annex III:	Programme

## **PROCEEDINGS**

## **New Models to Improve HIV/AIDS Healthcare Coverage**

On May 13 the European HIV/AIDS Funders Group (EFG) convened a meeting attended by 30 participants from European and US based Foundations, NGOs and other global stakeholders working in the field of HIV/AIDS.

The meeting was entitled “New Models to Improve HIV/AIDS Healthcare Coverage” and the purpose of the discussions was to explore effective and equitable ways of sharing the financial risk of ill health, in particular related to HIV/AIDS. The meeting was formed of two sets of presentations followed by plenary discussion.

The meeting took place at the 20<sup>th</sup> European Foundation Centre (EFC)’s Annual General Assembly in Rome.

### **SESSION ONE PRESENTATIONS**

#### **OPPORTUNITIES FOR EUROPEAN FOUNDATIONS TO HELP SHARE FINANCIAL RISK OF ILL HEALTH**

The first session was opened by **Karen Hoehn**, *Vice Executive Director, Director of International Affairs at German Foundation for World Population (DSW) and Co-chair of European HIV/AIDS Funders Group*, who gave an introduction to the European HIV/AIDS Funders Group and outlined the theme of the meeting.

After 25 years of the epidemic, organisations are looking for new ways to achieve better impact. Given the difficulty of accessing care and the current financial constraints, the session was designed to explore some of the new models of how to provide and ensure care in low income countries.

#### ***European HIV/AIDS Funders Group: From Vision to Reality***

**Dr. Joerg F. Maas**, *Senior Programme Officer - Global Health Policy and Advocacy – Europe, The Bill and Melinda Gates Foundation* addressed participants as one of the founders of the EFG, giving a brief history of the EFG and the current international health funding trends.

The EFG was initiated by a few foundations that wanted to create a pressure group to coordinate activities among foundations by combining foundations’ voices and mobilising other stakeholders around HIV/AIDS.

The amount of money available for HIV has doubled as has the funds available for health. The Gates Foundation has learnt that to influence political agendas and mobilise political and financial support, engagement and advocacy is needed, through

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European HIV/AIDS Funders Group

New Models to Improve HIV/AIDS Healthcare Coverage

European Foundation Centre, Annual General Assembly, May 13, 2009, Rome

Page 3

stakeholders such as UNAIDS, who can convene policy-makers to change their positions and make new commitments.

EFC and the EFG play a crucial role to mobilise other stakeholders to come forward with new ideas to increase the percentage of much-needed health funding.

### **African Private Health Care: International Finance Corporation (IFC)'s Approach in Partnership with Philanthropy and Other Donors/Investors**

*Dan Runde, Head of Partnership Development, International Financial Corporation (IFC).*

A recent study by IFC and Bill and Melinda Gates Foundation on African Private Healthcare found that the private health sector in Sub-Saharan Africa is surprisingly large and constitutes a growing component of the region's healthcare systems.

Sharing some of the findings of the study, Dan Runde added that from 15.7 billion US dollars spent on health in Africa, 60% is “out-of-pocket” out of which 50% is spent on private providers – social enterprises, NGOs and for-profit institutions. Figures like these show that it is essential that these actors participate in discussions on any healthcare access, as well as for building joint cross-sector partnerships in order to give the appropriate repose to healthcare obstacles faced by low income countries.

However, accessing financial resources is a significant barrier to market entry in Africa.

As a result of the study's findings, IFC and other partners have established an investment fund to invest in for-profit health care providers in Africa with an emphasis on companies providing products and services to the most poor.

In addition, IFC and the Gates Foundation have developed a technical assistance fund to support private healthcare providers' business performance and, finally, IFC and other parts of the World Bank have set aside resources to provide policy advice to governments in the region to support the development of the private health care sector.

### **Global Fund Support to Health Financing: Example of a Social Protection Programme in Rwanda.**

*Dr. Kirsi Viisainen, Manager, Program Effectiveness Team, the Global Fund to fight AIDS, Tuberculosis and Malaria*

Dr Viisainen said that, The Global Fund to fight AIDS Tuberculosis and Malaria (GFATM) has played a major role in the increase of health financing in developing countries. Although the three diseases (HIV, Tuberculosis, Malaria) remain the principal focus of GFATM, strengthening health systems is part of the Framework Document.

Concerning the Social Protection Programme in Rwanda, Dr Viisainen highlighted that the application was part of the first call for proposals in 2005, which allowed health system strengthening (HHS) in the grants. The project was requesting \$34 million over 5 years, for a social insurance scheme which was a small proportion of the overall Rwanda funding (\$300 million). The Rwandan example of the social protection programme is a success story about Community Based Health Insurance involving both government and communities in healthcare coverage.

The Global Fund has sought ways of expanding the HSS portfolio. There is demand at country level for HSS beyond the 3 diseases and the Global Fund can steer this demand through better guidance. No single funder can entirely meet this demand but pilot activities can help to develop good approaches.

### **Session One - Group Discussion**

Participants raised questions and were actively engaged in the discussion focusing on the importance of strengthening communities and ensuring long term sustainability of the health systems.

In this, John Tomaro (Aga Khan Foundation) underlined the importance of supporting systems in order to make them operational. He pointed that funding is often concentrated on the diseases only, living systems aside and without support. The role of foundations, as a development organisation it to focus on assisting development by addressing HIV in the context of sustainable systems and mechanisms, such as financing, so that dependence on outside funders is reduced and ongoing delivery of care and services is continued.

Other interventions echoed the importance of long term funding commitment. Such initiatives often yield results in 5-10 years and this can be challenging for funders but is the only way to make communities sustainable.

Vincent McGee (The Atlantic Philanthropy) emphasised also the lack of investment in human resources. By training local paramedics, nurses and doctors who are happy to live in the community, resources will be generated to provide services.

## **SESSION TWO PRESENTATIONS**

### **NEW MODELS TO FINANCING HEALTHCARE IN POOR COMMUNITIES**

*Kate Harrison, HIV Coordinator at Comic Relief and Co-chair of European HIV/AIDS Funders Group* opened the second session, highlighting that the second session will focus on financing models of healthcare for poor communities.

#### **How “Vouchers for Health” can help poor people**

*Dr Claus P. Janisch M.D, Medical Advisor, KfW Banking Group*

Voucher schemes are a simple form of pre-payment scheme that involves the purchase of a voucher against which the holder is entitled to a pre-agreed package of health services at a number of accredited health facilities in his/her area. A key feature of voucher scheme is that they are a demand-side financing approach that is directly subsidizing the consumer of health care. As the scheme targets the very poor or especially vulnerable groups of the society, the price of a voucher is highly subsidized. The accredited provider, in turn, gives the holder of the voucher the treatment at no extra charge. Any accredited service provider can cash the vouchers as soon as they have provided the healthcare services. They will be reimbursed at rates which have been set in advance and which are geared to average real costs of service provision. The gap between the voucher price paid by the client and the reimbursement claimed by the service provider is filled by donor funds, government subsidies, and/or contributions from health insurance schemes.

In low income countries people in need of medical care often do not go to local service providers because those services may lack basic medical material and the staff may be irregular. This situation pushes poor communities to scrape together their funds and go to a traditional healer where they feel they will get good services.

In a district of Uganda a voucher scheme for Sexually Transmitted Infection (STI) diagnosis and treatment was initiated. 29 private providers willing to join the scheme identified what is meant by the steps in the diagnosis, tests and treatment and came up

with a full cost payment for these steps of about 30 Euros. The cost of the voucher was set at an affordable rate for even the poorest people, who then use the voucher with a service provider whose quality is verified.

The experience of Kenya where a network of 57 service providers was set up produced very interesting outcomes. A private clinic had existed for 30 years that had not flourished, but with a voucher system, the number of births in the clinic went from 7-8 deliveries per month to 30 deliveries per month. The income generated is then invested in staff training and equipment. Moreover, with sufficient volumes of clients, service providers could pay better wages, invest in staff etc. This helps retention of trained healthcare providers. Doctors are now looking to invest in new clinics in these voucher areas because they can see that there will be sufficient business for profit. The quality of the providers is verified every few months and the system is becoming more cost-effective.

### **Microcredit for Woman living with HIV in Haiti**

*Martina Gliber, Project Manager, Fondation Mérieux*

Martina Gliber underlined the importance of micro-credits in helping vulnerable people to support their families, empower women and reduce stigma and exclusion. Furthermore, this type of assistance has an impact on identity change, the individual from being an aid recipient, becomes a borrower.

Presenting the programme which the Fondation Mérieux (FM) is funding in Haiti, Martina Gliber described that the FM works with the GHESKIO centre, an NGO dedicated to clinical service, research and training in HIV. The project gave 1,600 particularly vulnerable HIV positive women access to 300 Euros, given training and support as well as access to healthcare services. The results of the evaluation showed 90% of those that received the microcredit could buy food for their family, buy clothes, pay school fees, felt less stigmatised and developed a greater sense of belonging compared to 68% in the control group (without micro credits).. Only 6% of women said they need to sell sex to survive, compared to 20% of the control group.

The rate of woman that are able to reimburse the loan is extremely high (95%), but the FM has set a guarantee fund to assist those women who are unable to reimburse the loan.

Martina Gliber concluded that this approach has been highly positively evaluated in the way that it has shown very positive impact on women's lives and their families.

## **Community Based Health Insurance Schemes in India**

*Prof. Dr. David Dror, Chairman of the Micro Insurance Academy, New Delhi & Professor at Erasmus University Rotterdam, Inst. of Health Policy and Management, Netherlands*

Prof. Dr. Dror stated that the experience shows that for people from very base of the income “pyramid”, communities are often their own support, social services and health. The Micro Insurance Academy (MIA)’s approach is inclusion, MIA works with communities and not individual people. It is notable, that all decisions about curative services are made collectively

Where communities rather than institutions act, change, plan and develop, solidarity and sharing are fundamental for survival in such difficult situations.

Relating these predispositions to the HIV, Prof. Dr. David Dror suggested that according to the data, morbidity due to acute illnesses is higher in the poorest communities and there is a huge denial over exclusion because exclusion is a death sentence. People go first to the traditional healer as illness is seen as a malediction, before they have the social permission to get ‘health’ care. Decisions are often taken in public, and they set joint priorities.

In order to overcome stigma on HIV, testing should not be offered in isolation for the HIV only. By screening for diabetes as well as hypertension, HIV and malaria, everyone knows who seeks care, but not exactly what they get care for.

Prof. Dr. Dror stressed that accountability is very important for this group, on their own terms, not necessarily in the same way that a funder measures impact. The worst risk for this group is not to be ill or HIV positive or poor, it is to be excluded. This risk cannot be taken by people living with HIV and this type of approach is not picking up at the government level, but at the base of the pyramid.

### **Second Session – Group Discussion**

The presentations of the second panel triggered discussions around achievements as well as the challenges when implementing Community Based Health Insurance models.

In this, foundations were encouraged to get involved in a Community Based Approaches through similar models by adopting an inclusive approach which will integrate chronic diseases that drag populations in the poor countries beyond the limits of poverty.

Erik Lamontagne (UNAIDS), emphasised that this is an opportunity for foundations to act, helping CBHI to scale up for chronic diseases to increase the resilience of community.

Some of the challenges raised for implementation of those models were the difficulty to mobilise savings in order to pay premiums. For those models to be successful, the joint work of governments, major donors and foundations is necessary in order to assist communities to pay for premiums in countries where savings are minimal if existing at all.

Models like micro-finance and the Vouchers scheme can be complementary, with micro-finance raising the money, while vouchers insuring access to best quality services.

Kate Harrison closed the meeting thanking participants for their attendance and contribution to the stimulating two panel discussions session. She informed participants that the EFG's Resource Tracking Survey has been launched and that Funders are encouraged to respond to the survey. Kate Harrison also extended a warm invitation to join EFG at its next event in Autumn 2009.

## ANNEX I

### SPEAKERS CONTACTS

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**Karen Hoehn**

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**EFG – Co-chair**

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European HIV/AIDS Funders Group

New Models to Improve HIV/AIDS Healthcare Coverage

European Foundation Centre, Annual General Assembly, May 13, 2009, Rome

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## **ANNEX II:**

### **PARTICIPANTS' LIST:**

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## ANNEX III

### PROGRAMME

#### **“NEW MODELS TO IMPROVE HIV/AIDS HEALTHCARE COVERAGE”**

**Rome, 13 May 2009, 14.30h - 17.30h**

Conference Hotel Rome Cavalieri, Via Alberto Cadlolo 101, 00136 Rome, Italy

*Venue: Sala Leonardo*

### SESSION ONE

#### ***Opportunities for European Foundations to Help Share Financial Risks of Ill Health***

- 14.30-14.40 Introduction & Opening Session One  
**Karen Hoehn**, *Vice Executive Director, Director of International Affairs, German Foundation for World Population (DSW)*  
*Co-chair, European HIV/AIDS Funders Group*
- 14.40-14.50 European HIV/AIDS Funders Group: From Vision to Reality  
**Dr. Joerg F. Maas**, *Senior Programme Officer - Global Health Policy and Advocacy – Europe, The Bill and Melinda Gates Foundation*  
*European HIV/AIDS Funders Group*
- 14.50-15.05 African Private Health Care: IFC's Approach in Partnership with Philanthropy and Other Donors/Investors  
**Dan Runde**, *Head of Partnership Development, International Financial Corporation*
- 15.05-15.20 Global Fund Support to Health Financing: Example of a Social Protection Programme in Rwanda.  
**Dr. Kirsi Viisainen**, *Manager, Program Effectiveness Team, The Global Fund to fight AIDS, Tuberculosis and Malaria*
- 15.20-15.45 Group Discussion
- 15.45-16.00 Coffee Breaks

### SESSION TWO

#### ***New Models to Financing Healthcare in Poor Communities***

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European HIV/AIDS Funders Group

New Models to Improve HIV/AIDS Healthcare Coverage

European Foundation Centre, Annual General Assembly, May 13, 2009, Rome

Page 15

- 16.00-16.05      Opening Session Two  
**Kate Harrison**, HIV Coordinator, Comic Relief  
*Co-chair, European HIV/AIDS Funders Group*
- 16.05-16.20      How “Vouchers for Health” can help poor people?  
**Dr Claus P. Janisch M.D**, Medical Advisor, KfW Banking Group
- 16.20-16.35      Microcredit for Woman living with HIV in Haiti  
**Martina Gliber**, Project Manager, Fondation Mérieux
- 16.35-16.50      Community Based Health Insurance Schemes in India  
**Prof. Dr. David Dror**, Chairman of the Micro Insurance Academy,  
New Delhi & Professor at Erasmus University Rotterdam, Inst. of  
Health Policy and Management, Netherlands
- 16.50-17.15      Group Discussion
- 17.15-17.30      Closing Remarks  
EFG Resource Tracking Exercise 2009  
EFG Convening Fall 2009  
**Karen Hoehn & Kate Harrison**  
*Co-Chairs, European HIV/AIDS Funders Group*

**The purpose of this meeting is exchange and dialogue and SHOULD NOT be used for purpose of grant-seeking.**