BU School of Social Work
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Policy Brief

Financing the Transition: Health Insurance as a Bridge from Donor-Funded to Domestic HIV Programs

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Summary

As PEPFAR and other donors accelerate the transition of HIV programs to domestic ownership, countries face mounting pressure to mobilize sustainable financing while protecting hard-won health gains. This brief examines health insurance – both public and private – as a mechanism for absorbing donor-funded HIV services into general health systems, drawing on lessons from USAID's Sustainable Financing Initiative, the Ryan White AIDS Drug Assistance Program, and family planning graduation experiences in Latin America.

A review of insurance coverage, faith-based facility market share, and HIV burden across fourteen countries finds wide variation in financing capacity and coverage, and shows that faith-based organizations already deliver a substantial share of health services in many of the highest-burden countries.

The brief concludes that deliberately integrating insurance financing with faith-based service delivery – paired with the public financial management and claims systems needed to sustain it – offers one of the more immediately actionable paths for countries preparing to finance and deliver HIV services domestically. This integration requires time and investment to build out, however, and should be understood as a lever to support the transition of HIV, TB, Malaria, and other donor-supported health services rather than a near term or standalone solution.

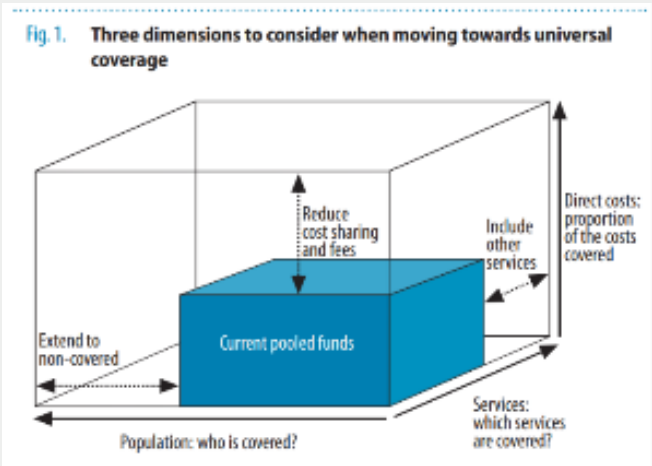
Introduction

Recent reductions in global health spending have increased pressure on countries to absorb donor-funded programs into their general health system. Donor funding for HIV, in particular, has faced significant shocks in recent years including a stop-work order from the U.S. State Department, subsequent funding cuts, and new co-financing requirements for recipient nations.[1–3] Historically, almost half of the global HIV response has been donor funded, yet major donors aim to transition most of the HIV response to countries by 2030.[4] At the same time, health spending among low- and middle-income countries (LMIC) has stayed the same or declined in many countries, remaining well below the 15% of expenditure estimated as necessary to sustain their health systems.[5,6]

Together, these compounding pressures leave countries facing a growing challenge: mobilizing domestic financing for health programs and embedding previously donor-funded programs into the general health system, all while ensuring that hard-won health gains are not lost.

Increasingly, LMICs are considering health insurance schemes – both public and private – to address this gap. The present brief outlines core components of health insurance, key considerations for countries choosing to adopt these approaches, explores examples to illustrate successes and limitations in health insurance adoption, and provides recommendations for assessing country capacity for insurance scheme adoption.

Considerations for Health Insurance Adoption



Source: *The World Health Report: Health Systems Financing; the Path to Universal Coverage*. (2010). World Health Organization.

As countries consider adopting insurance models, the World Health Organization's (WHO) Universal Health Coverage model poses three critical questions for establishing and expanding coverage over time:

1. Who is covered by the insurance plan?
2. Which services are covered?
3. What portion of service costs are covered? [7]

These questions form a foundation for establishing an insurance market, whether financed through public, private, or individual contributions – or some combination of the three. Adopting health insurance schemes has the potential to pool resources while expanding access to essential healthcare services; however, feasibility depends strongly on country context.[8] Strong health insurance systems require several supporting conditions: robust domestic revenue generation, sound public financial management systems, sustained investment in the healthcare system, a large formal sector, and political commitment to universal health coverage. Countries may also need capacity building and technical assistance to design, implement, and fully operationalize these schemes, along with monitoring to adjust rollout and ensure that systems function as intended[9].

Policy levers such as taxation policy, price negotiation for medication and commodities, and strong oversight mechanisms can further support long-term success.

Key Decision in Health Insurance Adoption

Outside of donor funding for health, out-of-pocket expenditures make up a large share of health spending in many low- and middle-income countries (LMICs). As external financing declines, countries will need to establish systems to sustainably finance the health sector, absorb donor-funded HIV services into the general health system, and minimize catastrophic health spending on individuals while sustaining broader health sector goals. Strong HIV treatment services play a dual role in supporting positive health outcomes among people living with HIV, while also lowering new infections - making them a vital component of strong population health.

As countries consider coverage, financing, and included services, the following factors may be useful to consider:

- **Core models & Coverage:** National insurance schemes, or government-run health insurance, are typically financed through payroll contributions and administrated through regional or national government offices. While these plans have the potential to provide widespread coverage, they can be difficult to implement in areas with large informal work sectors. Private insurance plans, often employer-subsidized, typically cover only employees and their family members. While these plans have limited reach, some countries pair these with smaller social health insurance schemes or direct coverage for specific services to widen health service coverage.

- **Covered Services:** A minimum benefits package specifies the core services that must be covered under a health insurance scheme, typically including standard prevention and health maintenance services. As donor-funding for HIV services declines, national governments will need to assess the financial viability of integrating HIV services into the general benefits package.
- **Costs & Market Segmentation:** A central challenge in HIV financing is ensuring that individuals who cannot afford to pay are still able to access care, while segmenting the market so that those who can pay do. Insurance schemes can be funded through levers such as taxes, premiums, and out-of-pocket spending. Taxes, typically collected through payroll contributions from the formal sector, fund or subsidize many social health insurance schemes. Premiums are fixed fees paid monthly or annually for coverage. Out-of-pocket spending covers additional costs related to service use, such as co-payments, co-insurance, or other fees. Effective schemes combine these levers rather than relying on one. Income-scaled premiums are a common approach with contributions rising based on income, and lower-income enrollees paying reduced fees. Many schemes go further, fully subsidizing care for those who are unable to afford it. This tiered structure – income-scaled premiums paired with full subsidies for the lowest-income enrollees – maximizes coverage while ensuring contributions align with ability to pay.
- **Service Availability/Location:** Insurance networks vary in where, and through whom, care is delivered. Coverage may route enrollees through public facilities, private clinics and hospitals, or faith-based providers, which in several PEPFAR-priority countries deliver 30–50% of all health services and are often concentrated in rural or underserved areas where public infrastructure is thin.10 Extending insurance accreditation to non-public providers, including faith-based facilities, can meaningfully widen geographic access to covered care, provided claims administration keeps pace with the added volume of accredited sites.

- **Payment Structures:** Fee-for-service structures typically cover a core set of services, with additional user fees varying by treatment type, the portion of the service covered, and whether the provider is in-network (i.e. approved to work with the insurance plan). This model generally allows policyholders to access care based on need, with referrals required only for highly specialized services. Managed care structures also cover a core set of services, but route care through a policyholder's primary care provider. Under this model, policyholders pay a set premium to enroll, and providers are reimbursed at a capitated (fixed) rate. Managed care typically emphasizes preventative services, with primary care providers referring patients to specialists as needed, and may operate through a defined network of hospitals or smaller group of community-based providers. Subscription-based managed care in India, for example, has increasingly expanded access to affordable, accessible healthcare nationwide.

Lessons Learned from Previous Attempts for Sustainable Financing

Sustainable Financing Initiative

Previous efforts illuminate core strategies, as well as successes and failures, for advancing health insurance initiatives. The Sustainable Financing Initiative (SFI), implemented by the U.S. Agency for International Development (USAID) through a $48 million PEPFAR investment, aimed to strengthen the sustainability of the HIV response by increasing shared responsibility and domestic contributions. From 2014 to 2021, this initiative emphasized measurable results, targeted investments, and greater efficiency to boost domestic resource mobilization, while also strengthening public financial management, financial protections, and private sector engagement.[11] Preliminary results showed that the initiative mobilized a minimum of $393 million in additional domestic resources across these three areas.

In 2012, for example, Vietnam set out to expand universal health coverage (UHC) through the adoption of social health insurance (SHI). SFI supported this effort through technical assistance aimed at increasing domestic resource mobilization. By 2017, social health insurance covered 80% of the population, creating a strong platform for HIV services to be integrated into the system. By 2019, 90% of people living with HIV were covered through SHI, and by 2020, 98% of HIV clinics were incorporated into the SHI reimbursement structure. As a result, Vietnam's domestic investment in HIV services rose from 34% of total funding in 2015 to 53% in 2020 – more than half. [9,11]

Findings from SFI show that targeted interventions to strengthen financing systems work best in countries with strong political will and favorable economic conditions; countries lacking either may have limited capacity to expand existing financing systems. Service efficiencies and effective clinical guidance – such as multi-month dispensing for clients who are virally suppressed – can also reduce service costs. Additionally, revenue generation efforts must be matched with strong public financial management systems to ensure that increased revenues translate directly to expanded service coverage.[9] Finally, building strong financing models requires time for development and implementation, and to demonstrate the return on investment – SFI in Nigeria, for example, yielded a 45% ROI after three years of implementation.[11]

The Sustainable Financing Initiative represents one example of how donors can support innovative approaches to increase domestic HIV financing, leveraging domestic and private sector resources to expand coverage of health spending, including for vital HIV services. Sustained efforts of this kind can build a durable platform for mobilizing domestic resources, strengthening health systems, and advancing long-term health goals. As donors consider this type of support, they should carefully weigh each country's economic context, political will, and financing sustainability.

AIDS Drug Assistance Program (ADAP)

The Ryan White HIV/AIDS program – a U.S. domestic grant program that leverages federal and state grant funding - provides safety-net services for individuals living with HIV who are uninsured or underinsured. A 2007 policy directive expanded Part B of the program, including the AIDS Drug Assistance Program (ADAP), to allow programmatic funds to purchase health insurance plans, rather than direct medication coverage alone, leading to improved health outcomes and cost savings.[12] A 2016 study in Virginia found that keeping a client insured for a year cost roughly half as much ($5,399) as covering medications directly for an uninsured ADAP client ($10,224). Beyond cost savings, insurance coverage was associated with better health outcomes: viral suppression rates for clients enrolled in a qualifying health plan reached 84.6%, compared to 78.6% for uninsured clients receiving medications directly through ADAP. Similarly, lab costs for insured clients were 75% lower than for those covered directly by ADAP. Part of these savings stems from rebates ADAP receives from pharmaceutical companies, which lower effective medication costs when purchases are routed through insurance plans. [12]

While early insurance enrollment efforts showed success, implementation faced several challenges. States encountered difficulties integrating the new model into existing systems, and some faced resistance to expanding insurance coverage where political buy-in was limited.[13] Financial investment in the program also varied by state, with some states able to subsidize costs beyond insurance premiums and others unable to do so. In states without additional cost-sharing support, implementers worried that out-of-pocket costs would create a financial burden for beneficiaries, potentially lowering enrollment rates.

Family Planning Service Graduation in Latin America

The absorption of family planning services into health insurance schemes in Latin America offers another framework for embedding donor-funded services into the general health system.[14] USAID's graduation strategy, established in 2006, laid a course to help countries absorb family planning services as funding for this service declined.[15] Amid this transition, many Latin American countries sought to expand access to family planning services, while advancing progress toward Universal Health Coverage (UHC) through one of three coverage models: social health insurance, private health insurance, or public tax-funded service provision.[14]

Social health insurance has been the most widespread avenue for increasing health insurance coverage in the region. This model is government-supported and financed through payroll contributions from the formal sector. In some middle- and upper-income countries, these schemes are paired with subsidized schemes for low-income individuals or informal-sector workers. Private insurance schemes typically cover high-income individuals and represent a small share of overall coverage. Integrating family planning into health insurance schemes has been one way the region has sustained high-quality family planning services despite declining donor contributions – countries worked to shift previously donor-funded family planning services into insurance coverage or to provide them free of charge at government facilities.

Even so, OOP expenditures for family planning services remained high in many countries, reflecting both the higher costs of services in the private sector and, in some cases, a mismatch between covered methods and demand. Private health insurance coverage remained below 10% in six of nine countries examined in one study, meaning that low-income individuals largely relied on free government services where available, or paid out of pocket at private facilities. Notably, women enrolled in government insurance schemes showed higher uptake of modern family planning methods than those who relied solely on free government services. This gap was even more pronounced among the lowest-income women: modern contraceptive use was 16.5 percentage points higher among insured women than among those who were uninsured.[14,15]

Country Data: Insurance, Faith-Based Care, and HIV Burden Across 14 Countries

Table 1, below, profiles fourteen countries – thirteen in sub-Saharan Africa plus Haiti – across health insurance coverage, the market share of faith-based health facilities, formal-sector employment, tax revenue, government health spending, out-of-pocket (OOP) expenditure, and the number of people living with HIV (PLHIV) broken out by wealth quintile. Read together, these indicators tell a story about how differently these health systems are financed, who bears the direct cost of care, and how HIV burden is distributed across the income spectrum – a distribution that turns out to vary far more than a single regional narrative would suggest.

Country	Insurance Coverage (%)	Faith-based health facility market share [16]	% Formal Sector [17]	Tax Rev. as % of GDP [18]	Health Spend (% GDP, 2023)* [19]	OOP per Capita (2023) [20]	Lowest quintile - PLHIV (#)	Second quintile - PLHIV (#)	Middle quintile - PLHIV (#)	Fourth Quintile - PLHIV (#)	Highest Quintile - PLHIV (#)
Botswana	12% (2024) [21]	18%	26% (2023)	22% (2023)	6.3%	$20.85	75,607	73,006	72,210	68,385	37,855
Cameroon	7.9% (2024) [22]	NA	15% (2014)	11% (2021)	4.6%	$53.51	73,340	152,274	127,850	132,976	133,345
Cote d'Ivoire	13% (2022) [23]	NA	9% (2022)	13% (2023)	3.4%	$28.05	141,808	144,972	101,610	88,881	55,365
Haiti	6% (2021) [24]	NA	9% (2012)	12% (2024)	3.2% 25	$28.52	26,845	30,442	41,664	21,837	18,815
Kenya	26% overall; 90% are covered through public insurance. (2014) [26]	40%	15% (2019)	14% (2023)	4.4%	$20.60	352,838	398,078	421,449	306,550	227,633

Country	Insurance Coverage (%)	Faith-based health facility market share [16]	% Formal Sector [17]	Tax Rev. as % of GDP [18]	Health Spend (% GDP, 2023)* [19]	OOP per Capita (2023) [20]	Lowest quintile - PLHIV (#)	Second quintile - PLHIV (#)	Middle quintile - PLHIV (#)	Fourth Quintile - PLHIV (#)	Highest Quintile - PLHIV (#)
Lesotho	2% (2024) [27]	40%	13% (2024)	35% (2024)	12.6%	$16.18	61,277	70,047	75,699	68,699	57,314
Malawi	1% (2019-2020) [28]	37%	16% (2013)	16% (2024)	6.5%	$4.95	158,572	166,590	233,658	289,973	276,496
Mozambique	2.7% (in 2011) [29]	NA	5% (2015)	22% (2024)	8.5%	$5.49	282,355	300,726	491,776	645,686	637,627
Namibia	17.5% overall (2013). 8% private health insurance (2022-2023) [30,31]	NA	47% (2018)	34% (2024)	9.5%	$29.75	62,271	55,882	55,314	40,892	15,255
Rwanda	91% (in 2019) [32]	40%	18% (2024)	13% (2023)	5.1%	$2.16	43,601	37,931	48,102	64,319	65,865
Tanzania	32% overall, 3% private insurance, 29% public insurance (2018) [33]	42%	8% (2020)	13% (2024)	3.1%	$10.13	329,822	369,431	336,603	374,671	275,262
Uganda	1.4% (2016) [34]	50%	7% (2021)	13% (2024)	4.2%	$14.55	293,146	293,651	376,143	377,267	298,117

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Zambia	10% Private (2022); 3% of men, 2% of women had private (2018) [35,36]	40%	19% (2023)	19% (2024)	6.0%	$8.18	152,966	187,909	305,283	409,497	441,228
Zimbabwe	11.6% total; 3% public, 10.2% private or employer-provided, 1% community-based (2015) [29]	35%	14% (2023)	7% (2018)	2.9%	$6.69	274,234	269,265	253,150	225,403	207,089

Note:
Asterisked (*) column headings denote the primary source for that column; country-level figures drawn from a different source are cited next to the value itself. Estimates of the number of people living with HIV by income quintile were calculated by multiplying HIV prevalence within each quintile by the estimated population of that quintile (the percentage of people in each quintile times total population). Prevalence by quintile and the percentage of the population in each household level income-quintile are drawn from Population-based HIV Impact Assessment (PHIA) data.

Insurance coverage is extremely uneven, and Rwanda is an outlier

Rwanda's insurance coverage stands at 91%, built on its community-based mutuelle de santé scheme, and dwarfs every other country in the table. The next-highest figures are Tanzania (32%) and Kenya (26%), while Uganda (1.1%), Malawi (1%), and Lesotho (2%) report almost no insured population. Coverage does not track neatly with formal employment either: Tanzania has 32% insurance coverage but only 8% formal-sector employment, implying that much of that coverage is reaching people outside formal jobs, while Namibia has the highest formal employment share in the table (47%) but only moderate insurance coverage (17.5%).

Faith-based facilities are a major, and often undocumented, part of these systems

Where the data exists, faith-based providers hold between 35% and 50% of the health facility market – highest in Uganda (50%) and Tanzania (42%), and consistently around 35–40% in Kenya, Lesotho, Malawi, Rwanda, and Zambia. But the figure is simply "not available" for six of the fourteen countries – Cameroon, Cote d'Ivoire, Haiti, Mozambique, Namibia, and Zimbabwe – which is itself notable: faith-based providers appear to be a structurally important part of health delivery across the region, yet their footprint goes unmeasured in nearly half the countries profiled.

Out-of-pocket spending does not move in lockstep with insurance coverage

Rwanda's OOP spending per capita is the lowest in the table at $2.16, consistent with its near-universal insurance coverage. But Cameroon combines low insurance coverage (7.9%) with the highest OOP spending in the table at $53.51 – more than 20 times Rwanda's figure – suggesting Cameroonian patients are shouldering a heavy direct-payment burden with little insurance cushion. Uganda is a partial exception: despite near-zero insurance coverage, its OOP figure ($14.55) is mid-range rather than extreme, which points to other mechanisms – subsidized public care, informal cost-sharing – absorbing part of the burden that insurance would otherwise cover.

Fiscal capacity correlates loosely with health investment

Lesotho and Namibia post both the highest tax-revenue-to-GDP ratios in the table (35% and 34%) and the highest government health spending as a share of GDP (12.6% and 9.5%), suggesting stronger state fiscal capacity translates into greater health investment in these settings. Zimbabwe sits at the opposite end on both measures (7% tax revenue, 2.9% health spending), and Cote d'Ivoire and Haiti are similarly low on health spending (3.4% and 3.2%) despite average-to-moderate tax bases – indicating that tax capacity alone does not guarantee health investment follows.

HIV burden is concentrated in a handful of countries

Across the fourteen countries, roughly 13.68 million people are living with HIV. Mozambique carries the largest absolute burden (2.36 million), followed by Kenya (1.71 million), Tanzania (1.69 million), Uganda (1.64 million), and Zambia (1.50 million). These five countries alone account for over 60% of the combined total. Haiti (140,000) and Namibia (230,000) report the smallest burdens in the table.

The wealth-quintile distribution of HIV burden is genuinely mixed

Perhaps the most striking finding is that HIV burden does not uniformly skew toward the poorest quintile. In several countries it actually skews toward wealthier quintiles: Zambia shows the sharpest reversal, with the richest quintile carrying nearly three times the caseload of the poorest, and Mozambique, Cameroon, Malawi, and Rwanda show the same pattern to varying degrees. Other countries show the more commonly assumed pattern of poverty-concentrated burden – most sharply in Namibia, where the poorest quintile's caseload is more than four times the richest quintile's, followed by Cote d'Ivoire, Botswana, and Kenya. This split suggests HIV burden in this region is not simply "a disease of poverty" as a single regional rule; the equity picture likely depends on country-specific epidemic dynamics – urban versus rural spread, key population dynamics, and treatment access – rather than one shared pattern.

Discussion

As countries graduate from PEPFAR support, additional analysis is needed on current government contributions to health financing, existing insurance coverage and resources, and political buy-in for establishing or expanding insurance schemes. Drawing on lessons learned elsewhere, specific criteria should be developed to assess each country's readiness to adopt insurance schemes in the near or longer term. As schemes are developed, a mix of insurance types may be needed to cover the full population - for example, private employer plans for higher-income quintiles, paired with public plans for those who cannot afford private coverage and lack an employer-sponsored option.

Leveraging Insurance and Faith-Based Organizations to Finance and Deliver Care

This brief's own country data point to a concrete, underused option for sustaining HIV services as donor funding recedes: integrating faith-based providers into insurance-financed systems. Several considerations follow:

- **Insurance is feasible in a few countries:** While most countries have made leveraging insurance a key pillar to deal with reductions in donor spending, the analysis shows that this is feasible in only a few countries such as Rwanda, Kenya, Tanzania and potentially Zambia. However, the distribution of the HIV burden shows that there is the potential to include HIV services for those already insured and the possibility of using the amount spent on HIV services to subsidize premiums for a broader range of services. More analysis is needed and it is important to note that, in the majority of countries, insurance-based solutions will likely not be viable over a five year period.

- **Faith-based organizations are a resource that is under-leveraged:** Faith-based providers already deliver 35–50% of health services in several of the countries profiled above – Kenya, Lesotho, Malawi, Rwanda, Tanzania, Uganda, and Zambia – and PEPFAR itself has long channeled roughly 3–4% of its funding annually through faith-based partners concentrated in six countries: Cameroon, Kenya, Malawi, Uganda, Zambia, and Zimbabwe.[37] Governments and donors planning for PEPFAR transition have a logical foundation already in place, rather than needing to build parallel public capacity from scratch. GHSD has recently announced a $2 billion funding to faith based organizations.[38] A portion of that can be used as development assistance that will enable faith-based organizations to establish Managed Care Organizations providing a comprehensive set of services and/or become providers that the government and insurance can contract with.

- **System deficiencies must be addressed to claims systems must keep pace with expanded accreditation:** CHAG reports waiting 6 to 12 months for insurance claims to be reimbursed, which constrains its ability to procure medicines.[10] In Kenya, faith-based facilities organized under the Christian Health Association of Kenya (CHAK) were owed an estimated KSh 13 billion in pending claims as of late 2025, with some facilities receiving as little as 38% of approved amounts – delays severe enough to bring surgical operations at some hospitals to a near standstill.[39]

- **Financing alone will not replace what donor programs provided:** In Uganda, private not-for-profit facilities – predominantly faith-based – sustained HIV service provision better than private for-profit facilities after PEPFAR funding declined, but were significantly more likely than public facilities to lose the clinical supervision they had previously received through PEPFAR (odds ratio 2.27).[40] Countries will need to plan for the training, supervision, and laboratory networks that donor programs carried alongside their funding.

- **Insurance and Faith Based Organizations can be Mutually Reinforcing:** The Christian Health Association of Ghana (CHAG), a consortium of 326 facilities across 34 denominations, delivers an estimated 30–40% of health services nationwide and piloted the mutual health insurance model that the government later adopted as the basis for its National Health Insurance Scheme (NHIS) in 2003–2004. Today, an estimated 84–90% of patients accessing CHAG facilities are covered through NHIS, showing that national insurance and faith-based delivery can be mutually reinforcing rather than competing for the same resources.[10]

- **Three considerations follow for countries and donors:** (1) formally accrediting faith-based facilities as insurance providers can extend coverage into underserved areas more quickly than building new public infrastructure, though this brief's own country data shows how little this role is currently tracked, with six of fourteen countries reporting no data on faith-based facility market share; (2) expanding accreditation must be paired with public financial management strong enough to process claims promptly, since revenue mobilization without reliable disbursement can destabilize the providers a scheme depends on; and (3) governments and donors should plan explicitly for the continuity of clinical supervision and technical support that donor programs previously provided directly, so that transition does not simply trade one fragility for another.

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