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PRIVATE SECTOR INVOLVEMENT IN HIV SERVICE PROVISION

TECHNICAL BRIEF

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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INTRODUCTION AND BACKGROUND

Demand for HIV prevention, treatment, and care services in developing countries continues to increase, putting additional stress on an already overburdened public health sector. To meet the need for these services within communities and ensure service quality and sustainability, it is useful to consider a renewed focus on identifying new models that incorporate capacity and resources from other parts of the health sector. The private health sector, including private providers and insurance schemes, is often overlooked in health systems strengthening (HSS) initiatives, yet has the potential to ease the increasing burden on public health resources and strengthen the health sector in developing countries. Health systems strengthening initiatives can engage the private sector to expand access to quality care to underserved populations and create linkages between the public and private sectors to build an integrated, sustainable health system.

Better integration of the commercial health sector into the health system improves the efficiency of resources and may be preferable to some clients. Private facilities can alleviate the patient load on public facilities, have shorter wait times, reduce stigmatization, and provide more flexible scheduling. Some patients also perceive private facilities as having more respect for confidentiality and sensitivity toward patient needs (Sandiford, Gorter, and Salvetto 2002). Patients may be geographically closer to a private provider, enabling them to access services closer to their homes or work. According to data collected by the World Health Organization (WHO) in 2006, approximately 21 percent of patients receiving antiretroviral therapy (ART) in six African nations (Botswana, Kenya, Namibia, Nigeria, South Africa, and Uganda) were receiving treatment in the private sector (Feeley, Connelly, and Rosen 2007).

Despite these potential benefits, including private sector involvement in the national strategy for meeting HIV needs has been overlooked in some regions due to quality concerns about provider training, prescribing standards, regular testing and monitoring of HIV patients, adequate counseling on prevention, and appropriate management of opportunistic infections, among other things (Over 2009). In some countries where the private sector is heavily involved in HIV treatment but also largely unregulated, clinical mismanagement may exacerbate the epidemic's impact and cost. Donor and government concerns about quality and affordability may have limited the role the private sector currently plays in HIV care and treatment but there are successful models that attempt to address these concerns. This brief presents a sampling of those models.

This technical brief will describe effective or promising practices that leverage the private health care sector in developing countries, taking advantage of existing infrastructure, financial resources, and expertise to better integrate HIV services and reduce the burden on public health facilities. The authors undertook a review of published literature describing existing models of private health sector integration into HIV service delivery in developing countries, as well as interviews with program managers. It is intended to be a tool for program planners and implementers of HSS initiatives. The introductory table and section titled "Implementation Considerations" should prove universally valuable, while the details of different programmatic examples will be useful to individual program planners, depending on their needs.

EXAMPLES OF PRIVATE HEALTH SECTOR ENGAGEMENT IN HIV SERVICE DELIVERY: OPPORTUNITIES AND CHALLENGES

Approaches to private sector involvement in the health system vary by country, program, and community. Many private sector providers pioneered the provision of HIV-related care in developing countries, but they have largely been overlooked by the public sector and donor agencies seeking to create a large-scale, fully integrated system of health delivery. The next step in HSS is to build a health sector that systematically integrates the private sector, resulting in improved financial viability, efficiency, and equitability.

The private sector can be leveraged to provide HIV prevention, education, counseling and testing, care and support, and treatment services. Also, private sector prevention and treatment efforts for other STIs can directly support HIV services. While there is ample room for innovation and improvement, a number of promising programs aim to improve integration between private sector providers and the public health system and expand access to quality care for people living with HIV (PLWH) and their families. The examples provided in Table 1 offer some combination of services; most provide ART and a selection of other services, while some provide prevention, advocacy, and/or training, but do not distribute antiretrovirals (ARVs).

A. FEE FOR SERVICE

Service provision in the private sector is traditionally based on a fee-for-service model, where individuals or employers pay private providers a fee for services rendered. This model has the advantage of being simple to understand and implement, and it offers a cost savings to the public system. This model has different considerations for different HIV services. Some individuals can afford to pay

out-of-pocket for some tests, treatments, and service fees. However, while individuals in developing countries may be able to afford medication for treatment of an opportunistic infection (OI) or an HIV test, a lifelong commitment to an ARV regimen has a significant cost for an individual without any type of subsidy, and is therefore less sustainable in resource-limited settings.

Under a basic fee-for-service model, providers work independently and potentially without accountability to any regulatory body. This makes it difficult to monitor or ensure quality of care. Because they are not part of a network or necessarily linked to government initiatives, private providers may struggle with supply chain management. They may also have a limited ability to refer patients to support or wrap-around services that might be more established in a public facility. Coordination of care, data management, quality, cost, monitoring and evaluation, and provider accountability could be improved by moving toward a comprehensive approach to better integrate the private sector in HIV service delivery. Most private sector delivery models are a variation of the fee-for-service model, with mechanisms for financing and service delivery that go beyond the clinician and the patient. Options in which individuals directly pay for or subsidize specific services could improve the long-term financial viability of public health support for HIV services.

B. LEVERAGED PROVIDER NETWORKS

An emerging model of private sector engagement leverages donor sponsorship for ARV treatment, counseling and testing, clinician training, community education, and/or other services for PLWH delivered by an organized network of private providers. Donor-sponsored provider networks can vary in methodology, delivery of care, partnering, funding approach, target population, and services offered.

Table 1: Models of Private Sector Involvement in HIV Service Provision (adapted from Feeley, Connelly, and Rosen 2007)						
Model	Description	Funding Source	Funding Direction	Implementation Considerations	Example	Country
A. Fee for Service	Fees are paid for services rendered.	Individual	Individual pays private providers or clinics.	Assumes a patient population that can pay. Quality control requires regulatory agency.	N/A	
B. Leveraged Provider Networks	Donor sponsors HIV services delivered by network of providers.	Donor Government Individual	Donor funding can subsidize health services/products, administrative costs, provider training, member hotlines. Individual may pay negotiated rate for health services/products.	Complex implementation requires a fairly sophisticated health system. Dedicated manager is needed to facilitate players, funding and quality control. Must consider funding sustainability.	BroadReach Healthcare	South Africa
C. Decentralized National ARV Program	Government decentralizes ARV program and supplies "free" ARVs to private providers.	Donor Government	Donors supply drugs. Government procures drugs for private providers.	Requires an established health system. Dedicated management is needed to coordinate partners, medicines, and supply systems. Consider financing sustainability. Must have human resources and data management system for forecasting and quality control.	Gold Star Network	Kenya
D. Output-Based Aid	Donors purchase outputs for patients delivered by public and private providers.	Donor	Donor funding purchases health services/products, and covers administrative costs.	Consider sustainability due to high administrative cost. Useful to partner with community organizations when focusing on high-risk populations. Must have quality control mechanism.	Decentralization of ARV program	Uganda
E. Insurance	Insurance policies pool the health risks and costs of a group of people subscribing to the policy.	Individual Company	Individual and/or employer pays a periodic fee to the insurer for health coverage at the time of an event.	Difficult to reach individuals not in the formal employment sector. Employers may see an increase in spending on fringe benefits, though may also see an increase in productivity.	Instituto Centroamericano de la Salud (ICAS) voucher program	Nicaragua
F. Company-Sponsored Clinics	Donor aids company in expanding services to community.	Donor Company Individual	Donor provides technical assistance, training, medical supplies, equipment, health products and communication materials. Company provides services at workplace clinic.	Funding sustainability. Leverages existing health care infrastructure and business organizations. Cost to companies must be reasonable. Assumes existing accreditation body.	Diamond Health Services	Namibia
G. Workplace Initiatives	Company develops HIV prevention, treatment, education, and support program.	Company	Company contributes human and financial resources to HIV intervention program at the workplace.	Consider funding sustainability. Ensure monitoring and evaluation (M&E) program is in place to provide feedback. Keep senior-level players involved. Useful to partner with other companies to share ideas and pool resources.	Health Initiatives for the Private Sector (HIPS) program	Uganda
H. Regional Business Coalition	Nonprofit coalition of dues-paying businesses works with companies, other nongovernmental organizations (NGOs), and the public sector to create or expand workplace interventions.	Company Donor Government	Company dedicates human and financial resources to program. Donor contributes commodities or funding. Government provides expertise.	Cost to companies must be reasonable. Possible subsidies for small businesses. May require grant for start-up costs, with short-term goal of self-sufficiency. Useful to partner with other NGOs and business groups for expertise.	Mercedes-Benz South Africa (MBSA)	South Africa
					Thailand Business Coalition against AIDS	Thailand

Two examples of this model are offered below.

The efficacy of these examples is predicated on the sophistication of the pre-existing health care system in South Africa and Kenya. These approaches are complicated to implement and require dedicated management to coordinate players, funds, data collection, and commodities. Because providers are part

of a network, a coordinating body facilitates supply chain management, quality control, financing, program management, and government support. Implementers interested in applying one of these models in their community must consider existing health care infrastructure, leveraging a dedicated intermediary, and funding sustainability.

Down Referral Model (North West Province, South Africa)

BroadReach Healthcare's North West Province Down Referral Model in South Africa reduces overburdened public health resources by leveraging the private sector in treatment delivery for PLWH. Patients start treatment at a public health care facility, the Wellness Centre, where they are stabilized for six months, and then down-referred to a private general practice (GP) or clinic for continued government-funded treatment. (Down referral is the process of referring a patient from the secondary hospital level to a local primary health clinic.) Should a patient acquire an opportunistic infection or require treatment for another condition, they are referred back to the Wellness Centre, and down-referred again to the private GP/clinic once stabilized.

Funding for health services, training, doctors' fees, patient education, and other health products comes from South Africa's Ministry of Health (MOH) and PEPFAR, while the North West Provincial Department of Health funds the provision of medication and labs. Private clinicians provide care for these patients at a capitated (per person) rate and receive training, mentoring, and a monitoring system for patient outcomes, in addition to free ARVs. Quality of care is monitored by Aid for AIDS, the largest disease management organization (DMO) in South Africa.

This program has proven highly effective, with a patient retention rate of 97.3 percent and a viral load suppression rate of 96 percent (Sargent 2008). In a recent study of a subset of patients in the North West program (n=170), 73 percent reported perfect ART adherence over the last month, and 98 percent reported not missing a pill in the last week (Hirschhorn et al. 2009). The specialized computer-based monitoring program disseminated to participating private GPs enables exceptional quality control, which contributes to program efficacy.

Gold Star Network

The Gold Star Network is a donor-sponsored branded network of private providers in Kenya, organized by Family Health International and the Kenya Medical Association. This model has sometimes been referred to as "franchising." Providers receiving the Gold Star seal of approval meet minimum training requirements and adhere to national treatment protocols. Through a USAID grant, PEPFAR funding covers operational and administrative costs and training. PEPFAR funds also make donor-funded ARVs available to patients identified as unable to afford ART, distributed by a few private providers.

Network member providers benefit from access to a nationally recognized laboratory providing viral load tests at negotiated rates, a reliable client base, and mentorship and training. Private providers receive training on the weekend so they can maintain normal business hours. Each is assigned a mentor—a provider in the public sector—with whom they train and correspond for aid in clinical decision-making. They also have the advantage of access to low negotiated prices for HIV test kits and other commodities and can pass on these lower rates to their patients.

The Gold Star Network was not designed as a vehicle for subsidy, with the exception of donor-funded ARVs. Instead, payments come from patients, insurance, or employers based on the payment option determined by the patient and clinician. The Gold Star Network also provides training, clinical support, technical assistance to providers, and a member hotline for patients.

C. DECENTRALIZED NATIONAL ARV PROGRAM

Decentralization is an opportunity to strengthen health systems by leveraging all qualified partners, establishing regulations and standards, sharing resources, establishing referral systems and linkages between the public and private sector, and mutually benefitting from best practices and lessons learned. Generically, the MOH develops and enforces treatment guidelines and accredits private sites for ARV delivery. This broad program requires dedicated human resources for drug procurement planning, coordination, patient and provider education, inventory management, and quality control. Private providers must not only be trained to deliver quality care at their facilities but must also be able to provide referrals and linkages for services they may not provide. An example is shown below.

The most important lesson learned from countries currently implementing large-scale ARV decentralization

initiatives is that the private sector can and should be involved during the planning stages. This example and others demonstrate that private-for-profit providers (PFPPs) want to be part of decentralization efforts. Private providers should be integrated into training, monitoring and evaluation, health management information systems, supply chain management systems, and mentorship programs from the beginning of implementation. It is reasonable to expect cost-sharing between government and PFPPs for private sector integration, as it provides a mutual benefit. In most national decentralization efforts to date, building capacity in the public sector to facilitate accreditation has been challenging but benefits from the employment of an intermediary between the MOH and PFPPs.

D. OUTPUT-BASED AID

Output-based aid is a strategy for using government or donor funding to purchase a specified package of products and services, such as a clinic visit, a lab test,

Uganda's ARV Decentralization

Uganda's decentralization process serves as an example of a sustainable, locally owned, large-scale ARV program. ARV decentralization occurred within a larger context of decentralization of delivery, accountability, and responsibility for a wide range of public services to local government. In Uganda, PFPPs are often primary HIV service providers, so decentralization, beginning in 2004, was an opportunity to establish standards of quality, create procedures for health system integration, and engage the private sector in monitoring and evaluation efforts. The MOH set standards for accreditation of private providers, including requirements for personnel, drug dispensing, storage facilities, laboratory capacity, records and data management, and linkages to social support mechanisms in the community. Private providers may request accreditation from the MOH, and if they meet the criteria, they are accredited to prescribe ARVs to their patients, as long as those drugs are dispensed free of charge.

The government does not proactively offer training to providers seeking accreditation, but they also do not limit it (Rich Feeley, personal communication, 2009). The assessment process ensures that private facilities meet the initial criteria for accreditation, and the MOH states it may assess the facility two to three times per year. However, local implementers report that in practice the government does not regularly assess quality of ongoing care provided by PFPPs, nor are their patient's clinical data being incorporated into the nation's health management information system (HMIS) (Kyayise et al. 2008). Currently, the MOH is working with USAID and implementation partners to initiate assessment and quality improvement of HIV care in select for-profit clinics. Through these collaborations, private providers are trained in HIV service delivery and receive mentorship from clinicians at NGOs. Once a for-profit facility is accredited, the MOH requires regular reporting on a number of indicators (Barbara Addy, personal communication, 2009).

Private providers are required to distribute ARVs at no cost to the patient. However, they may charge for consultations, tests, commodities, and services. These fees are paid by patients, employers, and insurance companies, displacing some of the financial burden typically sustained by the public sector.

or a treatment for patients, rather than a subsidy to providers based on the ongoing costs of providing services. This model allows donors to purchase clinical products and services for underserved populations. The ICAS Voucher Program provides an example.

Voucher programs are an opportunity to build capacity among PFPPs and develop community linkages. Such programs improve the quality of monitoring, care for high-risk populations, and provider relationships with most-at-risk populations (MARPs); they also promote popular acceptance of private sector health options. Training for PFPPs should not only teach them how to deliver services and refer clients to public or commu-

nity services but also improve their sensitivity to high-risk populations. The administrative costs of voucher programs are high, with funding coming from multiple and varied sources, making this model less likely to be sustainable without donor funding and less feasible to take to scale in generalized epidemics. Nonetheless, voucher schemes effectively target MARPs, which can result in reduced HIV transmission overall.

E. INSURANCE

Health insurance products that target previously uninsured, low-wage workers are emerging, as are products that cover HIV services. Insurance policies pool the health risks and costs of a group of people subscrib-

ICAS Voucher Program

The donor-sponsored ICAS voucher scheme in Nicaragua is an example of effective employment of output-based aid for HIV prevention services and supportive care, rather than direct services for ART or OIs. ICAS uses donor funding to purchase a predetermined suite of health services, which are distributed in the form of vouchers to such high-risk populations as sex workers (Sandiford, Gorter, and Salvetto 2002). Vouchers entitle patients to a consultation, follow-up visit, counseling and testing for HIV and other STIs, labs, and follow-up care for PLWH, including pregnant women. When patients test positive for HIV, ICAS assigns a care coordinator to accompany them to a referral hospital and arranges for provision of treatment. This system adheres to the protocols of the MOH, the only entity in Nicaragua that can provide ARVs, drugs for prevention of mother-to-child HIV transmission (PMTCT), or OI treatment. If a patient is referred to psychosocial support, the care coordinator accompanies the patient to the referral site.

The program partners with community-based organizations that work with high-risk populations to distribute vouchers, or program implementers hand out vouchers directly to clients. The voucher program gives patients a choice of private providers, encouraging competition and potentially driving down price. Contracts with private clinics stipulate pricing for the set of health services and require staff to receive training and follow STI protocols. Clinic enrollment in the program is thus based on price, location, and quality of services.

ICAS builds capacity at private clinics by training providers in STI management and sensitivity training for most at-risk populations, and ensures adherence to the STI treatment protocol by reviewing data collection sheets providers are required to complete for each voucher patient. ICAS tracks quality of service provision by reviewing medical records and data collection sheets, quantifying follow-up visits, and conducting satisfaction questionnaires with 10 percent of patients. ICAS compensates clinics according to the vouchers and data collection sheets returned. The program reduced the prevalence of gonorrhea, syphilis, and trichomonas in the lowest strata of sex workers from 1996 to 2005 (Gorter et al. 2006). Because the presence of STIs increases the transmission of HIV, a decrease in STIs can reduce the transmission of HIV.

Various funding agencies have contributed to the ICAS voucher program over its history, including the Dutch, British, and U.S. governments and multiple NGOs. Some funding is channeled through the Nicaraguan government to ICAS; however, the government has no direct involvement in the management of the program. ICAS negotiates regularly with providers to maintain competition and ensure the lowest cost and highest quality for the program. Consequently, the clinics providing care are regularly subject to change, possibly disrupting continuity of care for patients, or posing hardships for patients who rely on local providers serving particular locations.

ing to the policy. An individual (or an employer on the individual's behalf) pays a periodic fee to the insurer for health coverage when health care is necessary.

Risk pooling is a key element of insurance coverage, with the inputs of a healthy population essentially subsidizing the pay-outs for those in need of care. Models of health insurance involve the private and public sectors, and many pool the risk between PLWH and people who are not living with HIV. In the case of PLWH, the cost of services can be quite expensive, and many countries allow private insurers to drop a patient from all private coverage when he or she tests positive for HIV. This leads to several adverse outcomes by:

- Discouraging people from getting tested for HIV.
- Encouraging private providers to provide care without testing their patients for HIV.
- Creating a dual-care dynamic where a patient receives unlinked care for HIV in the public sector and non-HIV-related care in the private sector, with no information shared between the two.

All of these lead to poor patient outcomes and increased costs to the system due to incomplete or conflicting care.

Several insurers are looking at ways to cover HIV care and treatment, possibly through select service models (e.g., providing services excluding ART medication), or low-cost options targeted to low-income populations. Pressure from employers or government may motivate insurers to cover HIV care; insurance companies may also see an avenue for market growth among potential new members previously unable to afford coverage. Alternatively, insurers may respond to the incentive of subsidies, such as PharmAccess grants, for medical aid products targeting low-wage employees and PLWH. To date, there has been no assessment of the viability of providing health insurance products for PLWH without continuous donor subsidy. However, there are examples of pre-paid, risk-equalized health insurance mechanisms working in low-income countries with generalized epidemics that may survive after donor subsidy has ceased. An example from Namibia, Diamond Health Services, is provided below.

Diamond Health Services

In 2004 in Namibia, PharmAccess, a Dutch nonprofit organization, teamed up with Diamond Health Services, a private network provider, to offer low-cost insurance products that include an HIV benefit. PharmAccess pays N\$20/month for each new member on the Blue Diamond Option for low-wage employees until the end of 2007 (three years of subsidy) (Feeley et al. 2006). Diamond Health offers policies with varying levels of coverage, with a corresponding level of cost for out-of-hospital primary care and outpatient care for HIV, including ART and treatment for OIs. Diamond Health transferred to the providers some of the risk of providing these benefits through a capitated service arrangement. The emphasis is on selling policies through employers, who must enroll all of their employees if they want to offer the AIDS benefit to avoid adverse selection. Employers and employees pay a monthly fee, subsidized by PharmAccess, for annual benefits to Diamond Health. They are then able to receive benefits, up to a level determined by their insurance plan, over the course of the year.

Diamond Health and other low-cost health insurance products that offer HIV coverage are reinsured for their members living with HIV through a risk equalization fund (REF) established in 2006. The REF pools differences in HIV prevalence across different low-cost medical schemes (Schellekens et al. 2009), and may have encouraged other medical schemes to create their own low-cost products that provide coverage for some HIV services. The REF developed a database for patient monitoring and assigned case managers to network providers, improving quality of care and monitoring (Schellekens et al. 2009).

For employers, the costs of fringe benefits could increase with participation in insurance coverage; however, they may also experience improved attendance and productivity due to better treatment and employees' ability to schedule appointments in private clinics around working hours. Over the long term, it is difficult to predict whether the initial low-cost premiums will be sufficient as more patients receive treatment, live longer on medication, and require more expensive second-line therapy over the course of their lives, and as donor subsidy is discontinued. Although the subsidized premiums were too high for some low-wage employees, scaling up these innovative products without subsidy will likely require higher premiums or products that are tailored to different income levels, so that low-income workers pay less for less coverage (Pauly, Blavin, and Meghan 2009). Medical insurance schemes present numerous opportunities for improving service delivery, as they can establish and require adherence to standards for network providers, standardize treatment protocols, and develop criteria for data management. As all parties struggle toward large-scale fiscal sustainability in supporting PLWH, insurance options for PLWH will certainly be explored and deserve more study.

F. COMPANY-SPONSORED CLINICS

Many businesses have realized the financial and non-financial benefits of implementing workplace HIV prevention and treatment programs for employees. By partnering with other NGOs and public agencies, company-sponsored clinics can expand access to HIV prevention, treatment, and care beyond their employees, to employees' families and the surrounding community. Company clinics can be well integrated into the health system, providing referrals and linkages to community support and public services. While the scale is limited, there is an opportunity to leverage private resources to integrate private facilities into the health system. The example below, Health Initiatives for the Private Sector (HIPS), illustrates this model.

Company-sponsored clinics must address a number of issues, including capacity for effective referrals, linkages, quality, confidentiality, and sustainability. A lesson learned from the HIPS model involves building relationships with local and national health authorities to create an integrated system of referrals and linkages between the private and public health sectors. Better integrating company-sponsored facilities, whether a company site or a for-profit community clinic, has resulted in enhanced training and mentorship, improved private sector adherence to government standards, and increased data sharing. Quality of care should be monitored at each site, ensuring accountability with regular reporting to the coordinating body or governmental regulator. To ensure sustainable, high-quality service delivery, company-sponsored clinics must be linked to the national supply chain management system for medication forecasting and procurement, which has been a considerable challenge for Uganda (Barbara Addy, personal communication, 2009).

Confidentiality is an important issue for employees visiting company-sponsored clinics. To overcome the hesitation workers express about loss of confidentiality at company-sponsored clinics, management must be openly supportive of voluntary counseling and testing (VCT) and treatment programs, and confidentiality practices must be monitored and enforced.

Whether company-sponsored programs are going to survive in the absence of donor assistance depends on transitioning the financial burden to government, investment from employers, and cost-sharing by individual patients. Any attempt to integrate company-sponsored clinics in the health system is strengthened by employing a broker who can help players understand each other and foster relationship building for sustainable partnerships.

Health Initiatives for the Private Sector

HIPS acts as a broker between Uganda's MOH and private clinics by building capacity at private clinics and facilitating MOH accreditation, which allows providers to distribute Global Fund ARVs. Once a clinic is accredited for the company's workers, it is required to open its doors to the broader community. While for-profit providers must provide ARVs free of charge to patients, they are permitted to charge for consultations, tests, labs, and services. Most company clinics act like NGOs, offering all services free of charge to community patients once the site is accredited. However, company clinics may also choose to operate like for-profit facilities and recover some of their operating costs by charging fees for non-ART services.

Through a contract with USAID, the Emerging Markets Group uses PEPFAR funding to help private facilities meet accreditation criteria by providing technical support, training, and lab equipment. HIPS transfers knowledge to private sector providers through training programs that build capacity for ART provision. Though the company is the entry point for assistance from HIPS, if a company does not have a health facility, HIPS reaches out to local private for-profit clinics to act as the service point for employees and the surrounding community.

The companies cover the costs associated with running the clinic, including staff salaries and medications (Addy 2008). Because each clinic differs in its capacity to implement a comprehensive program, HIPS provides companies with a range of services from which to choose, helping companies tailor their program to their capabilities and budget. In 2008, HIPS member companies contributed over half of project costs (Rich Feeley, personal communication, 2009).

To make activities sustainable, HIPS works closely with the Federation of Uganda Employers (FUE) and Uganda Manufacturer's Association (UMA) to build capacity at these two employers' groups. HIPS is currently transitioning many of the training, accreditation, and prevention activities to FUE/UMA, while membership dues will help to sustain activities. HIPS members are required to complete quarterly reports for HIPS and the MOH, and to host two to three MOH support supervision visits per year to ensure quality.

G. WORKPLACE INITIATIVES

Many companies have developed workplace HIV prevention and treatment programs for their employees independent of public or donor support. These workplace clinics offer HIV prevention, treatment, and/or care to their employees, sometimes scaling the program up to include employees' families and the surrounding community. Although multinational companies affected by HIV are most able to offer comprehensive programs, many local and small- and medium-size companies have taken steps to at least provide information and education on HIV. Although workplace programs are inherently small scale, they are also financially self-contained. If company initiatives can be better integrated into the health system, they are a viable way of leveraging private resources without subsidy from donors. The example below illustrates this model.

Mercedes-Benz South Africa (MBSA) is a large, multinational corporation with thousands of employees and extensive resources, but other smaller, local enterprises are interested in developing some level of HIV workplace program. Toolkits can help these companies decide whether or not an HIV program makes sense in their environment and how extensive that program should be (see Resources). Once a company has some level of HIV workplace program, it is imperative to establish linkages and referrals to treatment, care, and support services if they are not provided at the workplace. For example, if a company develops a VCT program at their company clinic, it must be prepared to make referrals for individuals who test positive for HIV to care and support services nearby.

One notable challenge is ensuring quality in the workplace program; company-wide policies that adhere to

national guidelines and include a monitoring and evaluation system can encourage quality of services and confidentiality. Large-scale policies, such as corporate social responsibility (CSR) requirements, tax credits, and standards for information and service delivery can encourage expansion of workplace HIV policies. Earlier work on the subject suggests that the following may increase demand for workplace HIV: providing data on treatment costs to employers; encouraging the use of health maintenance organization arrange-

Mercedes-Benz South Africa HIV Workplace Programme

The MBSA HIV Workplace Programme in South Africa continues to be a successful example of workplace HIV programming that does not rely on external funding. The program began in 1991 with an education and awareness campaign and the development of a policy to protect employees from discrimination associated with HIV status. Over the next 10 years, MBSA developed an information, education, and communication program, led by trained peer educators.

MBSA distributes condoms as part of their prevention program, and offers confidential TB, STI, ARV, and OI treatment through MBMed, MBSA's medical aid scheme through Aid for AIDS. MBMed is linked to other community, public, and private resources for referrals and linkages to support and care services. The MBSA program has been scaled up to reach many small and medium partners in South Africa, implementing an HIV treatment strategy that follows national guidelines for treatment and is monitored by MBSA's health promotion team.

ments instead of direct reimbursement for medical costs; developing low-cost, lower-benefit insurance policies; providing cost/benefit information on treatment to employers; and including HIV coverage in insurance products (Feeley, Bukuluki, and Cowley 2004).

H. REGIONAL BUSINESS COALITION

Regional business coalitions are operating in many

countries and regions, offering different types of benefits and models for their members. In this context, business coalitions are nonprofit organizations made up entirely of for-profit businesses interested in leveraging their capabilities and human and financial resources in the fight against HIV. The coalition serves as a facilitator between the public and private sectors, providing resources, training, and education to help companies develop and implement workplace HIV programs. The coalition may also facilitate information-sharing between businesses or offer quality control or data management support. Also, a donor may provide commodities or funding, and the government may provide expertise and assist with funding. An example of this model, the Thailand Business Coalition on AIDS, appears below.

The business coalition model may require a grant for start-up costs, with a short-term goal of self-sufficiency. The cost to companies must be reasonable; if possible, grants or subsidies should be available for small businesses. Larger companies may be able to share resources with or provide mentorship to smaller companies. Finally, partnerships between businesses, other NGOs, and the private sector are valuable not only for facilitating financing and pooling resources, but also for sharing information, monitoring quality, and reinforcing the value of the work being done.

IMPLEMENTATION CONSIDERATIONS

Whether implementers seek to emulate one of the programs highlighted above or create a new approach to private sector engagement, the same considerations form the foundation of the planning process. To design a program, planners must identify the specific problem(s) they are trying to solve, determine a model for private sector engagement that best solves these problems, identify stake-

Thailand Business Coalition on AIDS

In 1993, the Thailand Business Coalition on AIDS (TBCA) was the first recognized business coalition of this kind established to address HIV. Its goal was to assist with information and resource sharing between companies and the public sector to reduce HIV incidence in the workplace and the surrounding community. The TBCA identifies private sector businesses to become part of the program. The coalition then assesses companies for readiness to implement an HIV program, requires that member companies create HIV-related policies and an HIV program work plan, and monitors adherence to the work plan. Workplace health care providers and peer educators are trained by private sector providers trained by TBCA.

Working with the MOH and the Ministry of Public Health (MOPH), TBCA developed a high-quality certification program on effective workplace HIV programs, called the AIDS-response Standard Organization (ASO). ASO awards are given to companies that establish effective HIV prevention and/or treatment programs. TBCA is responsible for evaluating each company's programs. In 2008, 1,528 companies received an ASO award. Other TBCA services include a training program targeting management and employees and a condom distribution program, both supported by the Global Fund.

holders and develop program goals and objectives, examine essential components of effectively engaging the private sector, and determine a course for delivery, implementation, and sustainability. Each of these factors is outlined below, along with some key questions program planners can use to inform their approach.

DUE DILIGENCE AND GOAL SETTING

- What problems will the program be designed to solve? (For example, there is no access to ARVs through the government sector in rural settings, or government ART facilities in urban areas have long wait lists and cannot meet future demand for services, etc.)
- Given these problems, which model for private sector involvement would best solve them?
- What are the goals and objectives of the proposed program?
- Have stakeholders and partners been identified based on the problems, the proposed model, program goals and objectives, and the local environment?
- Is the government prepared to work with the private sector?

- Has consensus been reached on setting priorities for health outcomes and goals?
- Is there clear alignment among partners on their roles, objectives, and responsibilities?
- Have partners agreed upon a memorandum of understanding (MOU) or other legal document finalizing roles, objectives, and responsibilities for all players?
- Has a mechanism been established for holding partners accountable for their responsibilities?

The first step in involving the private sector in HIV service provision is to identify stakeholders and partners and define program goals with representatives of the public and private sectors. Program goals and components should take into account the HIV epidemic in the area to be served, relevant barriers facing the health system, health-seeking behaviors, and sociocultural factors affecting the target population. Once players have been identified, it is imperative to develop a legal document outlining each partner's responsibilities and implement a mechanism for holding partners accountable.

UNDERSTANDING THE FOUR MAJOR COMPONENTS OF PRIVATE SECTOR ENGAGEMENT IN HIV SERVICE DELIVERY

Successful models of private sector engagement that provide care, support, and treatment services for PLWH have four major components:

- Supply side (e.g., the health care delivery system, including personnel, pharmacies, laboratories, and so on)
- Demand side (e.g., the patients and their families, friends, supporters, and community)
- Financing
- Leadership and management

Once the most appropriate model for private sector involvement is chosen (see Due Diligence and Goal Setting above), the next step is to determine the specific issues and solutions for each of the four components as they relate to the model. This provides the customization necessary to ensure that the model meets the specific needs and challenges for a particular country.

Each of these components has unique considerations and potential issues that need to be considered before implementing a private sector approach. For example, on the supply side, how does a program ensure quality of care from its doctors, labs, and pharmacies? It is essential to identify and then address the key issues within each component during the design phase. Below is an outline of some of the key considerations in each of the four components.

SUPPLY SIDE

- What comprises the existing private health sector? Has it been evaluated for geographic dispersion, complexity, utilization, capabilities, and preparedness

for private sector integration?

- How will a program ensure quality from its doctors, pharmacies, and laboratories?
- Is the cost of participating in the program reasonable for providers, patients, and other stakeholders?
- Are there growth and opportunities to scale up across the geographic locations covered by the program?
- Are there established referral and support networks, or will networks require development?
- Have gaps in the continuum of care been identified?
- How is the supply chain managed? (For example, how does the program ensure patients receive their medication? How does the program account for forecasting?)
- How are data collected and managed? (For example, are medical records accurate? Is patient information collected and stored to facilitate treatment adherence and program monitoring and evaluation?)
- What are the needs of private providers for training and material support?
- What is the appropriate level of dependence on donor and public funding? Is funding sustainable?
- Where can the private sector take the leading role?

Supply-side considerations include quality, cost, support, and sustainability. Effective programs use donor or government resources to enforce clinical and ethical standards of care. This can include accreditation,

initial and ongoing training, and establishing standards where they do not already exist. The costs associated with any program must be reasonable for providers, patients, and other stakeholders. Support needed for most programs includes technical assistance—for supply chain management and forecasting, for example—and linkages to high-quality ancillary support services, including pharmacy and laboratory.

Sustainability should be assessed before implementing any program to ensure continuity of care for patients over time. Implementers should determine an appropriate level of dependence on donor, public, and/or commercial funding, and establish an ongoing mechanism to ensure supply of commodities and services over time.

Other supply considerations include geographic distribution of providers and the capacity of providers to deliver intended services. To inform the program's long-term vision, implementers might evaluate whether provider capabilities can be scaled up by region or service. Finally, partnerships within the private sector can ensure appropriate entry points for care and referral networks for treatment and support.

DEMAND SIDE

- How will the program increase demand for services?
- Does the program include a plan for increasing access to underserved areas?
- How will the program incorporate treatment literacy to ensure patients are prepared for treatment?
- Which support systems are needed to ensure patients remain on treatment?
- Are program components in line with cultural norms and health-seeking behavior in each region?
- Is the program aligned with community-based organizations and support structures?

Demand-side program design should include an understanding of patients, their support networks, and the community. Demand generation requires patient buy-in, which may include marketing of services, community mobilization, and increasing access to care in underserved areas. Once demand is generated, it is imperative that mechanisms be in place for treatment literacy and ongoing adherence support. Consider psychosocial and cultural factors that may pose challenges to service use, such as regional cultural norms and health-seeking behavior of the target population. Partnering with community-based organizations and support structures can aid in marketing appropriate services and generating a reliable patient flow, especially among stigmatized groups. Developing treatment literacy networks may also stimulate demand. If structures for enhancing patient literacy, adherence, and awareness already exist within a community, they may be leveraged to increase demand for prevention, care, support, and treatment services.

FINANCING

- Have potential sources of funding that can either be leveraged or established been identified?
- Are funding sources secure and sustainable?
- What is the role of out-of-pocket costs for individuals receiving treatment?
- How should private providers go about setting fees?
- What is the role of means testing in the private sector? How is means testing regulated?
- Is there an opportunity in your context for using the standards set by private insurance companies as quality control?

- Are mechanisms in place to ensure correct and timely fund allocation as well as the tracking and reporting needed by donors?
- Does the program offer financial and non-financial incentives to participating public and private providers?

While pursuing private sector integration, consider funding mechanisms. Funding considerations include whether the program will be adequately financed over the long term, what role out-of-pocket expenses play, how to ensure timely and reliable payments for providers, and how to provide incentives for private sector facilities. Financial and non-financial benefits to private health care providers, including ongoing training, access to networks, output-based or capitated payments, or subsidized commodities, can function to continually engage the private sector.

Planning for funding sustainability also includes considerations about program continuation in the absence of donor support. Programs that incorporate long-term planning for building local capacity, enhanced integration, and self-contained management will prove more sustainable when donor funding ceases. Though circumstances would vary by country, in the absence of international donor funding a rapid transition to local host country ownership of support provision would be necessary, along with a cost-benefit analysis of services previously funded by international donors.

LEADERSHIP AND MANAGEMENT

- Is a coordinating body or mechanism in place to lead the overall process?
- Are coordinating mechanisms for administration and management of program components and partnerships in place?
- How will the program ensure accountability?

- Are there clear roles for all players within the program? Has documentation outlining responsibilities for each role been disseminated?
- Are systems in place to support data collection and management?
- Does the program have government support?
- Are processes in place to ensure ongoing program review and assess stakeholder alignment?

For all of the models mentioned here, government involvement is assumed and paramount to program success. Government buy-in and clearly delineated roles and expectations are essential, necessitating stakeholder alignment across all players and ongoing review of agreed-upon methodology. Ideally, the government will participate in regulation, monitoring and evaluation, policy implications, finance, and linkages between existing HIV service networks and the selected program. Different programs will require varying degrees of coordination; however, all will require some level of administration and management of partners.

While experiences can vary, the defining characteristic of successful private sector integration is the efficient sharing of resources, including funding, commodities, or personnel, across the public and private sectors; success often requires a skilled “broker” to negotiate the arrangement. The broker, who will often be project-funded, must be highly motivated and also committed to creating the best conditions for the public and private partners, as well as capable of managing the complex relationships that evolve from so many diverse stakeholders. Successful involvement of the private sector is greatly improved by leveraging a skilled intermediary.

IMPLEMENTATION, DELIVERY, AND SUSTAINABILITY

- What is the program's operational model of implementation?
- Which activities and costs will be borne by whom?
- What is the protocol for quality assurance and quality improvement?
- What is the plan for sustainability?

The program's operational model of implementation, including all functional and reporting roles, as well as clinical, technical, managerial, logistical, and financial considerations, should be clearly defined and documented. All partners must agree on resource responsibilities, and once those decisions have been made, they can develop a mechanism for ensuring accountability. Having a plan for quality assurance, including monitoring, evaluation, and reporting systems in place at program commencement, will help support quality assurance practices. Data management is vital and must include systems and processes to support data collection on predefined, measureable outcomes and resource utilization, as well as patient data for quality assurance and decision-making. Program planners should begin thinking about sustainability at the outset of program design, including mechanisms for ongoing funding, quality control, management, and ongoing engagement of partners and stakeholders.

CONCLUSION

There is immense potential in leveraging the private sector to alleviate overstressed public sector resources. The questions posed here serve as a starting point for better integration of the private sector into the rest of the health system. To date, many organizations have found ways to share experiences,

lessons learned, and emerging best practices (see Resources section). Together, donors, governments, NGOs, and other stakeholders can support work with private providers by investing in linkages between the private and public sectors, subsidizing HIV services or ARVs to improve existing programs, increasing efforts to mobilize the private sector, investing in promising innovations in private sector provision of HIV services, and sharing their experiences with the global community. Host governments can create opportunities for both sectors to work together to maximize effectiveness, efficiency, and equity of health outcomes.

RESOURCES

TOOLS, GUIDES, AND CASE STUDIES

The Corporate Council on Africa, guides and toolkits:

- HIV/AIDS Workplace Tools & Guides
- Tools for National Business Coalitions against HIV/AIDS
- Industry-Specific Tools
- Access to Funding Resources
- Civil Society Tools
- Multisector Approaches

Available at www.africacncl.org/HIV_AIDS/initiative_activities/guides.asp.

The Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria, case studies:

Available at www.gbciimpact.org/hiv-aids.

USAID Doing Good Business: HIV/AIDS Public-Private Partnerships, program summary:

Available at www.usaid.gov/our_work/global_health/aids/Partnerships/partnerships_brief.html#motion.

PSP-One: Private Sector Partnerships for Better Health Online Resource Center includes such searchable publications as tools, case studies, handbooks, and information sheets:

Available at <http://www.psp-one.com/section/resource/>.

For more information on the programs highlighted in this brief—

Down Referral Model:

Sargent, J. 2008. "US-Africa Private Sector Health Forum: Presentation on Public Private Partnerships." Oral presentation at the Corporate Council on Africa Conference, BroadReach Healthcare, LLC, Washington, DC, November 21.

Gold Star Network:

- The Gold Star Network: Quality and Hope (newsletter). Accessed on May 27, 2009 at www.fhi.org/NR/rdonlyres/elosqfi4fcj6czatc6dzkcarrh-vghqrtp2iba3demx6m5lecgoy22iindzyfsjxqjmw-gcv456d5j/TheGSNNewsletter2.pdf.
- Family Health International (FHI) and Kenya Medical Association (KMA) (program profile). Available at www.fhi.org/en/CountryProfiles/Kenya/res_Kenya+Gold+Star+Network.htm.

Uganda ARV Decentralization:

Kidde, S. 2006. "Uganda: Experience with Decentralization of ARV Programme and Implication on Procurement Planning" (CRS Uganda Program). Presentation at the Technical Briefing Seminar for Francophone Consultants, Copenhagen, Denmark, Jan. 30 to Feb. 2. Available at www.who.int/hiv/amds/SupplyChainUganda.ppt.

ICAS Voucher Program:

Sandiford, P., A. Gorter, and M. Salvetto. 2002. "Vouchers for Health: Using Voucher Schemes for Output-based Aid." Viewpoint series, Vol. 1, Number 24276 (April). Washington: World Bank. Available at www.icas.net/new-icasweb/english/en_vih_sida.html.

Diamond Health Services:

Feeley, F., I. DeBeer, T. Rinke de Wit, and J. VanderGaag. 2006. The Health Insurance Industry in Namibia Baseline Report. CIHD Project Report. Boston: CIHD Project. Available at sph.bu.edu/images/stories/scfiles/cih/final_namibia_insurance_situation__june_2006.pdf.

HIPS Project:

Ellis, J. 2008. 'HIPS' Project Targets Health in Uganda; Developing a Sustainable Model to Support Businesses in the Fight Against AIDS, Tuberculosis and Malaria. *CardnoConnect* 1 (4): 24–25.

Mercedes-Benz South Africa:

For more information, see www.gbciimpact.org/itsc_node/0/0/member_profiles/391.

Thailand Business Coalition against AIDS:

For more information, visit www.tbca.or.th/aboutus/who_we_are.php.

Testing on Wheels—The Bophelo! Mobile Outreach Unit

Another promising new project is the Bophelo! mobile outreach unit, launched on April 1, 2009, by the Namibia Business Coalition on AIDS (NABCOA), with PharmAccess and the Namibia Institute of Pathology (NIP). NABCOA used a Global Fund grant to build two testing vehicles, which travel to remote employment sites to test employees and dependents for HIV and other diseases. Employers pay variable costs to bring the van to the worksite. For more information, access the NABCOA newsletter at www.pabcnetwork.org/images/stories/nabcoa_newsletter_-_april_2009_-_final_revised.pdf.

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- Gorter, A.C., Z.E. Segura, J.A. Medina, and J.E. McKay. 2006. “Effectiveness and Impact of a Long Running Competitive Voucher Program Providing Quality STI/HIV Care to Groups Most at Risk of HIV in Nicaragua.” Poster presentation at the XVI International Conference on AIDS, Toronto, Canada, August 13–18.
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- Kyayise, A.M., R. Kyeyagalire, N. Livesley, I. Kirunda, B. Tumwesigye, S. Kinoti, and D. Katungu. 2008. *Private-for-Profit HIV Care in Uganda: An Assessment*. Technical Report of the USAID Health Care Improvement Project. Bethesda, MD: University Research Co.
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