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The HIPS Project

Extending Health Care Through the Private Sector in Uganda

Courtesy of Meghan Majorowski, BroadReach Healthcare, 2010

This small pharmacy and laboratory in a private, for profit clinic in rural Uganda serves over 200 clients on antiretroviral therapy. Equipment and enhanced infrastructure were garnered through a cost-sharing mechanism between the clinic proprietor and HIPS.

By Cassandra Blazer and Meghan Majorowski

A winding road through the mountains of western Uganda opens up to a rolling emerald carpet of tea leaves as far as the eye can see. The lush fields of the McLeod Russel tea company, located on huge estates spread across six districts, have long been an economic mainstay in the region, providing income for more than 6,000 permanent and seasonal employees from the surrounding villages and towns.

But the company—the largest tea producer in the world—offers its workers more than steady wages. For decades, employees have received generous health benefits, including free health care, maternity facilities, and screening for common diseases. Health care has traditionally been a feature of the tea industry in Uganda, and in recent years, some estates have extended health benefits to workers' families and to members of local communities.

The contribution that McLeod Russel and other companies and organizations make to national health care is significant but not unusual. In Uganda, as in many resource-limited settings, the private sector[1] plays a significant role in providing health services. Up to 60 percent of Ugandans seek health care from the private sector (International Finance Corporation, World Bank Group 2007), and spending within the private health sector accounts for more than 70 percent of total expenditures on health (World Health Organization 2009).

[1] This term covers all nongovernment service providers, both for profit and not-for-profit.

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The Role of Uganda's Private Sector in Health Care

For many hard-to-reach populations in Uganda, the private sector is the primary point of care. A recent study of the health-seeking behaviors of rural and poor Ugandans found that the majority of those surveyed use private clinics most frequently when seeking health care (Pariyo et al. 2009). Individuals choose private sector facilities for many reasons, including proximity to home, the perception that private sector health workers have better attitudes and that confidentiality and privacy are respected, and the belief that commodities are more available at private facilities.

One key player in private sector health care provision in Uganda is the Health Initiatives for the Private Sector (HIPS) Project, funded by the U.S. Agency for International Development (USAID) and implemented by the U.S.-based Cardno Emerging Markets USA, Ltd. (formerly Emerging Markets Group). Since 2007, HIPS has supported private sector integration into larger public health systems to cost-effectively improve and expand health programs. In addition to using private sector resources to build the capacity of private sector health care providers, HIPS works to leverage public-private partnerships by supporting training, enhancing infrastructure, and facilitating Ministry accreditation of antiretroviral therapy (ART) services at company-based and independent private clinics. Initially, HIPS focused on the business community, but has since begun working with independent, private, for profit providers; nonprofit organizations (NPOs); and faith-based organizations.

Before ART became available in public facilities, companies in Africa were among the first to provide this life-saving treatment for workers living with HIV, and for profit providers offered ART to the few clients who could afford to pay. The role of the private sector in HIV treatment was less integral once government facilities in Uganda began offering free HIV treatment with medication accessed through national supply chains, as many more people could afford to access drugs in public facilities. However, even with expanded access in public facilities, current estimates report that Uganda is reaching at best 40 percent of its ART-eligible population with treatment (Government of Uganda 2010).

Expanding access to treatment by leveraging private sector resources has the potential to increase the number of clients served without further taxing already overburdened public health facilities. At the same time, reliance on donor funds decreases because companies, clients, and clinic workers often share the cost of services in private sector settings. Although the medications are free to the client, as they are in government clinics, either the patient in private, for profit clinics, or the business in company-sponsored clinics pays for a share of the services needed to support service delivery. Through these partnerships, HIPS has made significant progress in establishing a cost-sharing, cost-effective approach to health service delivery within the private sector.

Implementation

Most collaborations begin when HIPS advisors approach a company or organization with some level of existing health program in a region that

needs expanded health care.[2] Sometimes, though, HIPS receives a request for support from a group that wants to add, improve, or scale up services. In either case, the HIPS advisors assess the organization's resources, infrastructure, and staff capabilities to determine where improvements are required to reach specific goals. For example, facilities seeking to add an HIV prevention program may simply need more educational materials and condoms, plus a training workshop for staff; however, adding or upgrading laboratory services may require significant investment in new equipment and training for lab technicians. At that point, HIPS and its new partner discuss how to share costs—most cost-share arrangements are one-to-one matches—and draw up an initial Memorandum of Understanding (MOU) that spells out obligations.

Courtesy of Meghan Majorowski, BroadReach Healthcare, 2010

The proprietor and clinical officer at the People's Clinic, Kasanda, set out signs advertising HIV services.

As the collaboration with a new private sector partner takes form, HIPS uses a step-by-step process that incorporates the company or organization's current program and follows national guidelines for ART accreditation to develop a menu of services tailored for the partner. The HIPS Phased Approach includes the following steps:

- Create a policy: all private sector partners start by creating a formal HIV workplace policy that may include sections on HIV, tuberculosis (TB), discrimination, and other critical issues.
- Deliver wins with prevention: basic prevention activities, such as peer-based education and distribution of educational materials, have high impact yet are inexpensive to implement in the early stages of developing a workplace program.
- Promote treatment as a valuable contribution to workplace efficiency: HIPS uses data from studies conducted across the life of the project to demonstrate the cost-effectiveness of implementing an HIV treatment program for employees (Feeley et al. 2004; Bukuluki 2009).
- Expand the service population: once partners begin offering health services to employees and realize the benefits, many report that the program is not as expensive as anticipated. HIPS can then encourage the company or organization to extend services to dependents and the surrounding community. As HIPS continues its third year of implementation, over 60 percent of the 5,000 people on ART through HIPS-supported sites are community members, not employees.
- Offer a variable menu of services: HIPS encourages its partners to consider expanding services beyond HIV to other health services

[2] Hear about one company's motivation to provide HIV treatment and care services to their employees, their families, and the community at www.aidstar-one.com/case_study/HIPS.

such as prevention and treatment services for malaria, TB, and sexually transmitted infections; family planning; and reproductive health. This menu of services can change when the partner decides it is time to expand services.

- Appeal to the added value of partnerships: the companies and organizations interviewed saw the cost share—where the company pays part of the costs, the government provides some commodities, and HIPS covers other costs—as an opportunity to make their funds go further. Some companies reported being motivated to bring funds to the table when they can get more "bang for their buck" through a matching incentive from HIPS. Rob Jennings at Kasese invests in the program because the cost share is an easy sell to company stakeholders: "If you can do a lot with a little, you can sell it to anybody."

Throughout the process, HIPS encourages private sector partners to think beyond their initial projections for strengthening services by demonstrating the affordability—thanks to cost sharing—and the benefits of expanding into new areas of health care for employees, families, and communities.

Ken at Nile Breweries describes the phased approach his company took to providing HIV treatment and care:

> We started with a workplace HIV policy in 2002. It was a business decision. In order to sustain [ourselves] as a company, we needed to look after the health of our employees. If we are going to be successful, we have to secure talent. We started with our employees, then extended services to their dependents, then to [personnel in our broader] supply chain, then to the community. We went from offering prevention messages to employees to managing a community orphans and vulnerable children program and home-based counseling and testing pilot.

Companies reported initiating health programs to fulfill their Corporate Social Responsibility (CSR) obligations,[3] because it made good business sense, or because it was "the right thing to do." For many companies, providing care to workers is understood as either a traditional responsibility or a contractual agreement with labor organizations. Providing health care for staff is a company requirement for some employers, making accreditation and access to donor-funded ART through the Ugandan government a powerful bottom-line motivator for organizations with a considerable level of staff needing care.

Integration of private provider service within public systems: Upon accreditation, private facilities are linked into the national commodities management system for donor-funded antiretrovirals (ARVs) and given tools to report consumption and indicators. The commodities management design ensures a link with the public system; private providers are required to report to the central commodity supplier in order to receive ARVs. Private facilities under HIPS are integrated under the jurisdiction of their district health officer, who is responsible for all health service delivery in the district (both private and public). This relationship varies significantly by district, but in general, district health officers conduct

[3] Many African companies voluntarily participate in the global CSR movement, a set of principles for supporting social improvements as a way to give back to the community and the nation.

support-supervision, help to broker re-allocation of commodities when there are stockouts, and act as advocates for private providers at the national level. When functioning as designed, these partnerships improve sustainability, quality, and reporting at private facilities.

Private sector models: Approximately half of the private facilities supported by HIPS are run by medium or large companies or organizations; the others are independent, for profit facilities based in the community. At company clinics, services are funded by the sponsoring businesses and operate like NPOs. For profit clinics receive some patient payment for services rendered, although ARVs are provided free in all HIPS clinics. Some provide care for individuals who can afford and pay for the services involved in their HIV care (i.e., consultations, tests, consumables), but cannot pay for ARVs.

These different kinds of facilities appear to fill an unmet need for people living with HIV in Uganda. In some instances, clinics serve areas where government facilities are located far from the

HIGHER VALUE, LOWER COSTS

One private clinic in Kampala, Sim's Medical Centre, is experimenting with providing a suite of high-quality services for HIV-positive clients for an annual fee that is lower than the case rate (the standard amount of money it costs per client) for HIV treatment and care in a Ugandan private clinic. SIM's is now able to offer a higher level of care at a lower average cost than do most company clinics, which procure for a much larger employee patient base. Table 1 is a cost comparison.

TABLE 1. COMPARISON OF COSTS FOR ART PATIENTS AT SIM'S MEDICAL CENTRE AND OTHER CERTIFIED PRIVATE CLINICS

	Sim's MEDICaid		Other Certified Private Clinics*	
Monthly ARVs	☺	Provided by MOH	☺	Provided by MOH
Cotrimoxazole prophylaxis	☺	Included in plan	😐	At additional cash rates
Other drugs	😐	Not included in plan (est. U.S.$51/yr)	😐	At additional cash rates (est. U.S.$51/yr)
Laboratory tests	☺	Included in plan: 2x/yr monitoring of 1) CD4/CD8 counts, 2) viral load, 3) kidney and liver function	😐	1x/yr lab testing (+U.S.$167)
Physician/specialist visit fee	☺	Included in plan: Routine monthly specialist consultations by HIV physician	😐	At additional professional service rates (+U.S.$165 annually)
Counseling and adherence	☺	Included in plan (including voluntary counseling and testing, prevention of mother-to-child transmission, adherence, nutrition, and general counseling)	☹	Not included
TOTAL	☺	U.S.$200/yr plus cost of other drugs (est. at U.S.$251)	😐	U.S.$362/yr plus cost of cotrimoxazole

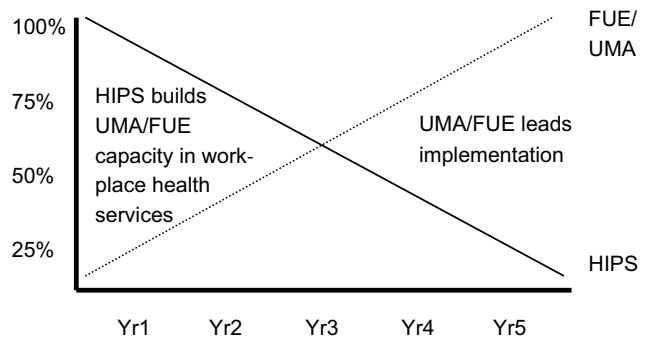
**Source: Emerging Markets Group 2009*

community or where the public sector cannot meet the burden of disease within district facilities alone.[4] By acting as a replacement for public care or by taking patients off otherwise overburdened government registers, these facilities serve the health system as a whole.

Planning for sustainability: HIPS's programmatic approach includes a sustainability plan to help create long-term relationships between companies, communities, and public health agencies that endure after HIPS funding ends. In year one, HIPS identified two membership-based service organizations—the Federation of Uganda Employers (FUE) and the Uganda Manufacturers Association (UMA)—that could integrate health programming into their existing service offerings to their company members. The next year, HIPS worked with them to develop institutional, programmatic, and financial capacity to help them become leaders in health workplace programming during the second half of the project and continue to implement the activities after HIPS ends (see Figure 1). By providing HIV training, and advising companies on workplace HIV prevention activities, FUE and UMA have realized additional revenue from increased membership and from opportunities to provide additional (non-HIV) follow-on services to their member companies.

HIPS requires cost-sharing from all participating private providers, which contributes to a sense of continued ownership and responsibility for sustainable service delivery. Although HIPS has provided much of the support necessary for private facilities to meet accreditation criteria, once they are accredited, private facilities offer

Figure 1: HIPS Vision for the Evolution of Support Role vs. Lead Role*



*From: HIPS Q4 and Annual Report FY 2009

[4] Watch a brief interview with Andrew, human resources manager at Kasese Company Cobalt Ltd (KCCL), talking about how his program reaches underserved populations at www.aidstar-one.com/case_study/HIPS.

BUILDING FOR THE FUTURE

FUE, UMA, and HIPS view their collaboration as a win-win: FUE and UMA benefit from increased revenue and membership, broader service offerings, and an enhanced reputation, which build their roster of paying members, while HIPS lends credibility for health-related activities and helps with marketing to the organizations.

HIPS benefits from a close collaboration with two organizations that can continue to provide support after project completion. HIPS is able to monitor the quality of the services provided by FUE and UMA for the second half of the project, to ensure they are qualified to carry on activities post-HIPS.

George of FUE described one of the benefits the organization receives from the partnership: "Before the [HIPS] program, our membership was really concentrated in Kampala. We are now truly a national program with a broader base of active members across Uganda."

treatment with minimal HIPS support, because the cost of the drugs is supported by donors and the cost of care is subsidized by either the sponsoring companies or the patients themselves. As in the public system in Uganda, provision of treatment depends on donor-sponsored ART; however, HIPS and providers anticipate that as long as there are subsidized medications available through government channels, accredited facilities will continue to provide HIV treatment.

What Works Well

Securing high-level management buy-in and stakeholder commitment: HIPS aims to sign an MOU with each partner that receives its support.[5] Those who have signed an MOU with HIPS report that it is central to the success of their program. The MOU clearly defines roles, responsibilities, cost-sharing agreements, time commitments, expectations, and other key aspects of implementing a health initiative.

Managers reported that it was clear when to expect support, and they could forecast health budget needs in alignment with normal business planning cycles. Company health program managers confirmed that the MOU engaged company leadership, easing decision making for health initiatives. At some companies, management buy-in impacts workers' behaviors. For example, the human resources director at Nile Breweries noted that when the boss is seen making a priority of HIV prevention, employees care more and are more likely to talk about it at home.

Creating clear HIV workplace policies: Once an MOU is signed, HIPS works with company or organizational stakeholders to develop a workplace HIV policy. While signing an MOU may seem pro forma, as Matsiko, human resources manager at McLeod Russel Tea Estates, put it, the workplace policy "brings clarity around how and where to begin and end the workplace HIV program, in terms of responsibility. Clearly stating company obligations on what is and what is not company responsibility helps in company willingness to participate. Start with policy." Delivering on the obligations laid out in the MOU is key, as it builds confidence in the policy and in the partnership, clearing the way for a company to be comfortable about ramping up services and responsibilities, and advancing local ownership. Workplace HIV policies also create a document that outlast the tenure of the managers who put it in place, providing continuity to the program and empowering employees to hold management accountable for service delivery. With each increase in service level, a new, detailed MOU is created.

Planning for a phased engagement and implementation approach: HIPS successfully engages companies in HIV prevention activities as a low-cost, high-impact mechanism to keep their employees healthy. All of the business leaders interviewed for this report said that when HIPS ends, prevention activities will continue at their site. As private providers become comfortable with providing health services and accustomed to delivering more diversified health services, HIPS encourages service expansion to larger numbers of clients for HIV, and to services beyond HIV. Although HIPS enters into partnerships based on an HIV platform, by the end of the second year, 50 percent of clinics had integrated services, including TB, malaria, and family planning/reproductive health. By the end of the third year, 75 percent of clinics added services, particularly long term family planning methods, medical male circumcision, and intermittent preventive treatment of malaria in pregnancy. While the end goal might

[5] A sample MOU is available at www.aidstar-one.com/case_study/HIPS.

be HIV treatment on a large scale to the community, HIPS demonstrates that a step-by-step program with an extended lifespan is the road to achieving it. These slowly increasing levels of services are integral to the success of the HIPS model.

Integrating health into normal business operations: For workplace programs, HIPS starts with the partner's existing capacities and integrates additional activities into their business operations, leveraging the company's core capabilities. The business leaders interviewed stated they felt they were able to get more results for the program by offering their expertise in logistics, supply chain management, or knowledge of their community. One example of this came from the manager of a mining company who allocated some of his contract officer's and procurements officer's time to their company clinic; with improved negotiations and logistics, the company secured transport and equipment for the health program at lower prices, enabling them to invest the savings back into the health program. Making use of companies' expertise can lower the cost of CSR efforts, making them more palatable to management concerned about the bottom line, and integrates health initiatives with normal operations.

Creating a sustainable approach: HIPS successfully presents its project as a platform for partnership and acts as coordinator rather than the central implementing figure. HIPS secures partner buy-in, formalizes MOUs with partner companies, and brings different organizations with varied expertise on board, then facilitates coordination of the different players. Since HIPS acts more like a broker than an implementer, activities are implemented primarily by local players, which increases sustainability. As the relationship matures and local capacity is built, HIPS works to transfer more responsibility to the local level. While HIPS funding supplies approximately half of the program cost, companies provide a substantial human resource investment. Once companies can access government-sponsored ARVs, the capacity built has the potential to support service provision after HIPS ends.[6]

Leveraging private partners as testing grounds for innovation: Compared to the vast public sector, private facilities are small-scale, face less bureaucracy, and benefit from localized decision making, which contributes to private facilities' ability to quickly introduce certain innovations. The private sector players working with the HIPS Project—company facilities and standalone for profit clinics—are able to act as a testing ground for innovative approaches to health service delivery. According to its district health officer, McLeod Russel is the only facility in Kyenjojo District performing medical male circumcision. Beyond piloting clinical procedures or the roll-out of new guidelines, private sector locations are also helpful for testing new technologies and insurance approaches, as well as patient willingness to pay, as seen in the Sim's Medical Centre example. Similarly, HIPS recently partnered with International Air Ambulance (IAA), a Ugandan health insurance company, to launch a managed care product for HIV care and treatment for private employers; companies can pay U.S.$200 a year for employees and U.S.$150 for dependents for full outpatient and inpatient services related to HIV.[7] Wagagai Ltd., a medium-size enterprise in Uganda, boasts a fully electronic medical records

[6] Hear what Marion, the director of Wagagai Ltd, says about her program's long term sustainability at www.aidstar-one.com/case_study/HIPS.

[7] A brochure describing the IAA managed care product is available at www.aidstar-one.com/case_study/HIPS.

system that every clinician can access in real time via personal computer, promising better reporting and increased efficiency.

> HIPS has provided an opportunity to experiment. We wanted to try to roll out medical male circumcision, but the public sector was not an option. We used private providers working with HIPS as test sites to model the approach for USAID—test the acceptability of the initiative while providing medical male circumcision at low to no cost.
>
> *—USAID/Uganda representative*

Challenges

Gaps in treatment program ownership: Many business owners and private clinicians were hesitant to begin provision of ARVs because of concerns about depending on donor-funded drugs. They worried about initiating clients on ART and then having to discontinue care due to stockouts or government discontinuation of private sector support; all clinicians noted that few of their clients could afford the cost of ARV medication. Private, for profit providers stated that in the event that they could no longer access government drugs, they would offer ARVs at cost to those who could afford it, which would leave most of their clients without treatment or dependent on the public sector for treatment. Some companies opted to cap their HIV treatment programs at a level that would allow them to continue to provide treatment without government support, purchasing ARVs in the private sector and offering them free to existing clients indefinitely. For example, Nile Breweries is committed to long term HIV treatment for anyone they initiate on drugs, including past employees, dependents, and community members, even in the absence of government support. In order to maintain this commitment, they capped their program so that in the event that they have to pay for ARVs they are able to absorb the cost. Most companies interviewed claim ownership only of HIV prevention activities; from their perspective, they are "contracting out" their services as extensions of the government's ARV program by treating with government drugs.[8] They are clear that they could or would not continue to treat clients with company-paid ARVs in the absence of government support. As one business leader put it:

> If we can't access free ARVs, we stop delivering that service today. On all other things, we can handle it on our own, but on ARVs we can't. We could fill the gap for a short time, but in the long term we definitely can't.

Written agreements between private and public stakeholders guaranteeing sustainable access to government-supplied ARVs for a specified period of time would advance the long-term cost-share potential of businesses and patients in the private sector.

Contending with unstable political commitment ("The Kampala Issue"): Uganda is not the only country with supply chain management challenges, but it is well known that Uganda has experienced significant challenges procuring ARVs through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (GFATM 2005). The challenges and interruptions felt in early- to mid-2010 in procurement and delivery processes occurring in Uganda seem different in nature from procurement difficulties in other low-resource settings. Procurement instability,

[8] Hear Matsiko, the human resources manager at McLeod Russel, discuss his perspective on treatment program ownership at www.aidstar-one.com/case_study/HIPS.

transitions in the delivery mechanism, and other issues have caused major disruptions in national HIV treatment. Many districts in Uganda have experienced stockouts of ARVs and other health commodities lasting months, and have informally put caps on patients allowed in treatment programs, preventing new patients from accessing treatment until someone else dies. The director of a large HIV treatment program, now forced to limit the number of new patients, said:

> It's quite sad, really. In Uganda, HIV is becoming a slimming disease again as more and more patients receive treatment in much later stages of the disease progression.

Private providers and program implementers are concerned that the possible long-term effects of the political issues around ARV procurement pose a substantial threat to the ability of the private sector to assist with Ugandan HIV treatment delivery. One district health officer revealed that the Ministry of Health was no longer accrediting newly qualified private facilities for ARV distribution due to uncertainty about the future of ARV availability in the private sector. Rumors about the government retracting private sector access to GFATM ARVs prompt private providers to put artificial caps on the number of clients they will treat. Many fear that the government is using the private sector as a scapegoat for the drug availability crisis. Public and private sector stakeholders agree that it does not look good for the private sector to continue treating HIV clients while the public sector runs out of stock; however, they also agree that discontinuing private sector supply of ARVs will have little to no effect on the supply shortages experienced across Uganda, as these patients will still need treatment and will seek to procure the same (unavailable) medications in the public sector. As the trend toward flat or decreasing donor resources for HIV treatment continues, the issue of how best to leverage the private sector will be a key concern for decision makers globally, particularly if cost sharing of services continues.

Unreliable commodity management exacerbates the challenges of integrating private sector treatment programs into the national system. Many program leaders at private clinics noted that when there are stockouts, they contact the HIPS deputy director rather than following normal channels and communicating directly with the Ministry of Health or the Joint Medical Store, the drug supplier, as they might do if the programs were truly integrated. This is due to a perception that the HIPS deputy director is more effective at resolving logistics issues, thus perpetuating a gap in communication between private clinics and public health officials. Because the private sector is persistent and proactive and may have other channels to pursue, it appears more able than the public sector to work around stockouts and to secure buffer ARVs for patients. This may exacerbate distrust between the public and private sectors.

Variability in public-private partnerships: As participants in HIPS, private facilities and district health offices (DHOs) are introduced to one another. DHOs are mandated to oversee all the health services in their jurisdiction, both public and private. In practice however, the partnership between HIPS-supported private facilities and public health offices varies by district. Many private facilities report regularly to the district office, and receive training and support supervision from the district team. Others interviewed indicated they did not report to the district office at all, never having been asked to

do so by the district. As the Kyenjojo DHO said, "I don't get [to McLeod Russel Tea Estate] for support-supervision very often, but I don't worry about them. They are providing high-quality services—better than in the public facilities here—so I spend my time [with the public facilities]."

All DHOs interviewed mentioned sustainability of support-supervision for private facilities as a challenge. DHOs, business leaders, and private clinicians in stand-alone clinics admitted that increased interaction was critical for sustainability planning, but noted human and financial resource limitations; the reality for all public health officials interviewed is that in a resource-limited area, the public sector is the priority.[9]

Inconsistent reporting and monitoring of service quality: HIPS clinics use government reporting tools that are in sync with existing management information systems. However, the inconsistency in private sector reporting makes it difficult to participate in the broader health system and impedes national decision makers from formally allocating a substantive role to the private sector in health strategies. Incentives for reporting or consequences for not reporting would greatly benefit the system.

Lack of patient tracking: An absence of patient tracking, especially in the for profit stand-alone clinics, poses a challenge to treatment adherence. The company clinics interviewed seemed better positioned to leverage community resources to follow up on patients who missed appointments. Private, for profit clinics would benefit from connections with community groups that conduct follow-up. Asa, the proprietor of a for profit clinic with high loss to follow-up, described the situation at his clinic, where clients fall ill at home and do not have the funds for transport to the clinic or consultation fees. He notes that support for home-based follow-up, including extra staff or an ambulance, would enhance their ability to follow the poorest clients.

Courtesy of Meghan Majorowski, BroadReach Healthcare, 2010

In some hard-to-reach communities the public clinic is a shared resource for public and private health service delivery through partnerships between the district health office and private companies. In this instance, KCCL sends its health care staff into surrounding hard-to-reach communities several times a month to provide HIV-related and other health services, and to follow up with existing clients who cannot travel to the clinic.

Limits to scaling up: HIPS-supported private clinics provide relief to the overall system by allowing businesses or patients to cost share the price of services for their HIV care, but are inherently small in scale. However, the government does not consistently show support of the private sector, and does not drive comprehensive private sector integration with components of the health system. Without the government's sustained commitment to the private sector as a mechanism for the distribution of their subsidized ARVs, private clinics are likely to remain on the periphery of HIV service delivery.

[9] Watch a brief interview with Dr. Simon, the proprietor of Sim's Medical Centre, as he describes his thoughts on the public health officials' perception of private providers in Uganda at www.aidstar-one.com/case_study/HIPS.

Recommendations for Program Planners

Invest in creating broad private sector linkages: One of the strengths of the HIPS Project is its ongoing focus on sustainability. HIPS is a facilitator, rather than an activities implementer or commodities supplier, bringing together private facilities and implementing partners. HIPS also troubleshoots and streamlines commodities management, training, support-supervision, and administration. As a result, although program managers at private organizations are generally aware of key players (they know they receive subsidized family planning products and mosquito nets from Uganda Health Marketing Group; TB reagents from the district; training from FUE, UMA, and Mildmay; accreditation from the Ministry of Health; and ARVs from the Joint Medical Store), they have not always developed working relationships with these organizations, nor do they necessarily understand the procurement or delivery processes. To promote private facilities' ownership of continuing activities, programs should begin to develop linkages between private facilities and partners.

As part of its planned life cycle, HIPS is currently undergoing a transition phase where MOUs with private providers are signed over to the FUE and UMA, the local partners, to continue to support prevention activities and training. Companies interviewed were generally aware of the transition and, though they expressed some concerns about the expertise of these organizations in health-related topics, accept the change. This is a step in the right direction and should serve as an example of local sustainability of donor-funded projects. Implementers should regularly assess their succession plan partners to ensure their capacities are growing to meet future needs.

Creating linkages between stand-alone private clinics and community support groups could possibly improve loss to follow-up and treatment adherence. Because private, for profit providers charge fees for consultation and some (non-ARV) treatments, providers report that it is difficult for clients to afford travel to the clinic and then pay clinic fees. Shifting this responsibility to home-based care providers would cut down on transport costs. Furthermore, since some for profit clinics are the only facilities providing ARVs in an area, the district might consider offering home-based health workers free of charge to the private facilities as a way to provide broader care in their catchment area.

Facilitate private sector forums: Further facilitating private sector information-sharing sessions on a regular basis can improve programs and hold program managers accountable by:

- Offering an opportunity to share innovations.
- Providing an occasion to discuss challenges and solutions.
- Introducing implementing partners and ideas.
- Creating linkages between private providers who can support each other with advice and possibly commodities during shortages.
- Applying pressure to business leaders to reach and exceed CSR goals attained by their peers.

Prioritize research on private sector contributions: The HIPS Project has been documented in studies assessing the business case for providing HIV treatment to employees (Feeley et al. 2004; Bukuluki 2009). In the current political climate in Uganda, other research considerations might include assessment of private sector impact on commodities procurement and delivery, client satisfaction with the private versus

the public sector, effectiveness or quality of private sector HIV service delivery, and the value of cost share on service provision. This type of research may motivate policy and government support.

Pursue commitment and accountability from national-level decision makers: An example must be set for all health workers by national-level decision makers about commitment to delivering high-quality treatment to all in need, leveraging all resources available. Transparency about and commitment to improving health systems should start with policy and stewardship at the national level. A formal contract between high-level officials and the private sector with an explicit time horizon for providing donor-funded ARVs would contribute to private sector willingness to take ownership of HIV treatment programming. A reliable supply system and systematic oversight from district health officials are missing pieces for HIPS sustainability, and are essential for continuing or scaling up HIV treatment in the private sector.

Future Programming

Costing considerations: Future programming in private sector provision of ART must be realistic about expectations of private sector stewardship. While programmers would like private companies to shoulder more or all the expense of providing treatment, there is rarely a realistic business case for it. Cost sharing is the practical expectation for business involvement.

Directions for future programming in the private sector depend on the availability of donor-funded or highly subsidized ARVs. Even with the reduction in prices of first-line therapy, company clinics cannot be expected to provide all of the human resources, capacity, infrastructure, and consumables, as well as disburse ARVs on a large scale to clients for free, especially to non-employees or community members. The independent, private, for profit providers interviewed reported they would expect to see most of their clients drop out of treatment if they had to charge them the full cost of drugs. When exploring inventive costing or service packaging schemes, programmers should recognize the significant contribution the private sector offers by covering the cost of services.

Courtesy of Meghan Majorowski, BroadReach Healthcare, 2010

Employee peer educators are tasked with educating other employees and community members about how to prevent HIV transmission and accessing counseling and testing services. Some companies reward peer educators for their successes as part of his/her regular employee performance review.

Prevention versus treatment in the workplace: The workplace is a key venue for delivering prevention messages. Companies are keen to pursue prevention activities as a low-cost strategy for keeping their workforce healthy over the long term and for fulfilling CSR requirements; however, they are more hesitant to commit to supporting long-term treatment programs. Also, including an employee's successes as a peer educator in his performance review, or encouraging supervisors to model interpersonal communication

about HIV prevention may be powerful incentives for behavior change.

Scale versus sustainability: As long as programmers are expecting businesses to make substantial cost-sharing contributions, it may be necessary to choose between scale and sustainability. Particularly in the context of unstable access to government drugs, some companies interviewed said they were likely to restrict the clients on ART to a number that they felt they could sustain on treatment for free if they had to purchase ARVs in the private market. On the other hand, if a long-term cost-sharing mechanism was developed to ensure reliable access to subsidized commodities, the private sector can be a trusted partner in delivery of high-quality HIV treatment. When asked why she thought private providers were perceived to deliver quality services, one business owner said:

> We own the place. We have a responsibility to do it right, to do it within budget. At the end of the day, we are accountable to ourselves. When you have a feeling of ownership, you watch closely what's happening.

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Video available online at www.aidstar-one.com/case_study/HIPS

- One company's motivation to provide HIV treatment and care services to their employees, their families, and the community.
- Andrew, human resources manager at KCCL, is interviewed about how his program reaches underserved populations.
- Brief interview with Dr. Simon, the proprietor of Sim's Medical Centre, as he describes his thoughts on public health officials' perception of private providers in Uganda.
- Marion, the director of Wagagai Ltd, talks about her program's long term sustainability.
- Matsiko, the human resources manager at McLeod Russel, discusses his perspective on treatment program ownership.

Resources available online at www.aidstar-one.com/case_study/HIPS

- HIPS Cost-Share Table
- International Air Ambulance Health Care, Managed care product brochure
- Map of Uganda, HIPS Locations
- Memorandum of Understanding Between Tea Factory and The Health Initiatives for the Private Sector Project/Uganda Manufacturers Association

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