

HIV-related Public-Private Partnerships and Health Systems Strengthening



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Abbreviations

| | |
|--------|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| BD | Becton, Dickinson and Company |
| CDC | Center for Disease Control |
| GTZ | German Technical Cooperation |
| HIV | Human Immunodeficiency Virus |
| IFC | International Finance Corporation |
| ILO | International Labour Organization |
| MDR-TB | Multi-drug resistant tuberculosis |
| PPP | Public-private partnerships |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| TB | Tuberculosis |
| TBCA | Thai Business Coalition on AIDS |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session |
| WFP | World Food Programme |
| WHO | World Health Organization |
| ZBCA | Zambia Business Coalition on HIV and AIDS |

Executive summary

This document is a response to the UNAIDS Programme Coordinating Board's recommendation of December 2008 to compile "best practices and lessons learnt to support and facilitate Public-Private Partnerships with respect to their applicability for strengthening the public sector in low and middle income countries". In terms of the HIV response the most important locus of public-private partnerships is between companies and public health systems.

This report focuses on the contribution of AIDS-related public-private partnerships to the six building blocks of health systems:

- service delivery;
- human resources;
- information;
- medicines and technologies;
- financing; and
- leadership.

Based on a desk review and interviews conducted with representatives of private and public organization stakeholders as well as development partners, twelve public-private partnerships with a system-orientation more than only the response to HIV and strong collaborative relations with government institutions in the country of implementation were identified to present insider perspectives on catalysts and hurdles which may be encountered in developing collaborations.

A screening of private sector initiatives on AIDS has found that public-private partnerships with a health system orientation emerge in areas where the private partner can combine philanthropic investment with business strategy, expertise and resources and where this investment guarantees a surplus for the public partner in terms of enhanced health system structures or capacities. This can be well achieved when it comes to service delivery, health workforce support or access to modern technology including health information approaches. In contrast, public-private partnerships concerned with health financing and management support are rare, probably indicating the existence of barriers to the development of such partnerships that need to be addressed.

Despite growing international interest in a better integration of HIV programmes and health system strengthening, most private sector initiatives remain

focused on HIV interventions exclusively. The review of HIV-related public-private partnerships found that often, companies do not yet sufficiently apply a health system perspective to their activities. Both companies and health systems need specific support on developing such public-private partnerships. From the point of view of the private sector, partnerships would benefit from a clearer definition of the public sector's interest, expectations and commitment to such collaboration and mediating structures such as business coalitions would welcome guidance on public-private partnerships with respect to roles and responsibilities as well as the emerging perspective on health system strengthening.

Interviewees identified mutual understanding as an important precondition for the implementation of efficient and successful Partnerships. Diverse settings, procedures and ethics are often expressed as 'opposing' public and private "cultures" which have to be reconciled through patient and trustful negotiations. The private sector at times lacks profound knowledge of the complex stakeholder landscape in the HIV response and health care provision. To develop flourishing partnerships honest and wide-ranging dialogue to inform and secure agreement in joint planning is essential from the very earliest stages. Such planning will of course consider issue such as sustainability, follow-up, and monitoring, essential to flourishing partnerships. Health financing mechanisms, HIV and TB treatment and mobile health technology (mHealth) are areas which are of interest to the private sector and which require further technical expertise and promotion.

From the above lessons learnt, recommendations can be derived for UNAIDS and other organizations promoting HIV-related public-private partnerships with the motive of strengthening public health systems.

- **Carefully consider and define the partnership surplus for both partners**

The private partner wants to reconcile philanthropy with business strategy while the public partner seeks a benefit for the health system. Public-private partnerships work especially well for medical and communication technology companies, but require special promotional efforts concerning health financing or leadership support.

- **Define gaps, new topics and matching partnerships**

The UNAIDS Secretariat and its cosponsors should identify gaps in universal access provision, balance them with health system needs, advertise the demands and search for matching partnerships between companies and governments.

- **Promote a health system thinking in all HIV-related partnerships**

The private sector should be guided to apply a health system perspective to all HIV and health-related projects. This perspective may not lead to further action with respect to health system strengthening, but it will promote a better understanding of the project context and potential areas of cooperation.

- **Facilitate policy development for public-private partnerships**

National governments should be supported by the UNAIDS Secretariat and its cosponsors in developing a policy framework for public-private partnerships

- **Initiate early public-private dialogue**

The UNAIDS Secretariat and its cosponsors should support private sector partners in gaining a better understanding of the local health system, and an analysis of potential stakeholders and interfaces. In addition, an early exchange on promising project ideas should be enabled.

- **Support the integration of sustainable long-term follow-up within partnerships**

In the conception phase of a public-private partnership, UNAIDS cosponsors as well as other support agencies should promote and facilitate planning for sustainability and follow-up including the provision of resources and capacities.

- **Strengthen the reporting on public-private partnerships**

The UNAIDS Secretariat should provide further guidance to the private sector on monitoring in line with UNGASS indicators and as part of the national health monitoring.

Part 1: Introduction

The HIV epidemic demands exceptional endeavours from the public sector in middle- and low-income countries. National health systems are overburdened in working to scale up HIV prevention, treatment, care and support services to reach the goal of universal access by the end of 2010¹. If universal access targets are reached about 6.7 million people will be on treatment, 70 million pregnant women will be screened for HIV (and treated when necessary) and 2.6 million new infections will be averted cutting annual HIV incidence by 50 % and averting 1.3 million deaths². An estimated US\$ 17 billion for HIV-specific health services and US\$ 16.7 for general health system strengthening and cross cutting issues³ will be required to meet the 2010 targets on universal access.

Continuous multisectoral interventions—with a renewed focus on public health systems strengthening—with full and active participation of the private sector are needed. The main intersections between HIV programming and the public system involve the health sector. Public-private partnerships between governments and companies (in cooperation with additional partners such as donors, technical agencies and nongovernmental organizations) gain new importance in extending health services. If modern technology is adopted and coupled with visionary leadership, solutions to the human resource crisis may be found, and sustainable health financing and information systems promoted to pave the way for universal access.

Over the past decade recognition of the detrimental effects of the HIV pandemic increased among the business community⁴. Companies' contributions range from HIV workplace programmes to philanthropic and business-oriented systemic interventions that make use of companies' core competences and leadership influence. At the global, level many enterprises give money to international initiatives for research and programme implementation.

Many case studies of business projects responding to HIV have been published. However, the potential of the private sector for strengthening health systems

has not yet been sufficiently explored because the international discussion on HIV programming has only recently experienced a paradigm shift towards an additional health system orientation⁵. This publication *HIV-related Public Private Partnerships and Health Sector Strengthening* provides an overview of potential contributions that AIDS-related public-private partnerships can make in this respect. It looks specifically at intersections between the private and the public health sector and presents insider views of major actors.

The publication illustrates selected AIDS-related public private partnerships under each of the six building blocks of a health system as defined by the World Health Organization (WHO)⁶:

- service delivery;
- human resources;
- information;
- medicines and technologies;
- financing; and
- leadership and governance.

The analysis focuses on lessons learnt in the cooperation between the sectors and points out opportunities and recommendations for enhanced action. It is based on a thorough desk review and interviews with company representatives and corresponding partners from the public sector; in addition, key development partners as well as national and international institutions were consulted. More than 100 HIV-related public-private partnerships have been reviewed. About 20 of these initiatives showed (a) a health-system orientation in addition to objectives focused on HIV as well as (b) strong collaborative relations with public-sector institutions in the country of project implementation. Twelve of these partnerships were examined in more detail with a focus on institutional collaboration. The time frame for research, the envisaged report length and the availability of contact persons were the main drivers of this selection process. Sadly the selection process, a necessity in order to keep material to a manageable length, has meant that some examples of good practice are not mentioned in this publication.

¹ UNAIDS (2006) *The Road Towards Universal Access*, UNAIDS, Geneva.

² UNAIDS (2009) *Letter to partners by the Executive Director Michel Sidibé*, UNAIDS, Geneva.

³ UNAIDS (2009) *What countries need: Investments needed for 2010 targets*, UNAIDS, Geneva.

⁴ WEF (2006) *A Global Business Review of the Business Response to HIV/AIDS 2005-2006*, WEF, Geneva.

⁵ See for example the discussion between Roger England and Simon Collins et al, as well as articles and rapid responses of Fiona Godlee, Owen Dyer and Niyi Awofeso in the *British Medical Journal*, 2007, Vol. 334 and 335.

⁶ WHO (2007) *Everybody's business. Strengthening health systems to improve health outcomes*, WHO, Geneva.

The partnerships reflect country situations with high and moderate HIV prevalence and have been chosen from different continents. Since the African continent carries the highest HIV burden, the private sector runs more initiatives in response to HIV in this region. The investigation did not centre on the particularity of interventions since this information can be derived from other sources and case studies. It also did not set out to quantify the health-system impact of the partnerships described since the analytical framework for such national monitoring is in the process of development⁷. Instead, this publication intends to encourage the reader to develop creative partnership ideas, to learn from innovative concepts and to become aware of collaboration catalysts and hurdles that exist between the private and the public sector.

The understanding of “Public-Private Partnership”

The term “public-private partnership” has to date been applied to a wide range of interpretations and concepts⁸. It refers to global health initiatives of impressive magnitude⁹, to partnerships of private companies and development agencies¹⁰, to business relations of the private sector with public organizations¹¹ or the privatization of public services and the public-private mix of health care provision¹².

The following analysis focuses on public-private partnerships in an HIV-related development context. The term “partnership” stands for a formal collaboration between partners from the public and the private sector in the country where the partnership is implemented. The partnership must be characterized by a formal agreement, joint objectives, mutual contributions and an interaction in partnership management.

In a narrow sense “private sector” refers to for-profit business entities of all sizes or their philanthropic foundations excluding not-for-profit, nongovernmental and faith-based organizations. The term “public sector” refers to governments and government institutions¹³. All private-public partnerships described in this publication partner with a ministry or government institution in the respective country of operation of the partnership. They are formalized by some kind of contract such as a Memorandum of Understanding between the partners.

⁷ WHO (2008) Measuring health systems strengthening and trends: a toolkit for countries, WHO, Geneva. The new 2008 WHO Toolkit on monitoring health system strengthening provides a guideline to countries for future integration in national. Monitoring respective private sector contributions will have to become part of these monitoring efforts.

⁸ For a comprehensive discussion of various PPP types read: Nicolic IA, Maikisch H (2006) Public-Private Partnerships and collaboration in the health sector, World Bank, Washington.

⁹ For a discussion of Global Health Partnerships of private sector foundations and public partners refer to: Buse K, Harmer AM (2007) Seven habits of highly effective public-private partnership: Practice and potential, in: Soc Science and Med, Vol. 64:259-271.

¹⁰ For an understanding of PPPs as partnerships between for-profit corporations and donor agencies see: Beckmann S, Rai P, Alli BO, Lisk F, Mulanga C, Lavolley M, Girrba E (2005) HIV/AIDS workplace programmes and Public-Private Partnerships (PPP) through co-investment extension of treatment and cure into the community, ILO, Geneva.

Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung BMZ (2005) Public-private Partnerships in der deutschen Entwicklungszusammenarbeit, BMZ, Bonn. Nelson J (2001) Building Partnerships: Cooperation between the United Nations and the business community, United Nations Global Compact, New York.

World Economic Forum (2007) Public-Private Partnerships in health, Geneva.

¹¹ United Nations (2008) The United Nations and the private sector – A framework for collaboration, Global Compact Office, New York.

¹² The collaboration between national governments and local health care providers is an important influence on service delivery. Academic research on this type of collaboration is available but only to a surprisingly limited extent. From the available literature it becomes clear that the partnership character in these collaborations is hard to define. It is mostly a “contracting-out” process leading more towards privatization than partnership. Topics such as quality of public and private services, adherence to national guidelines or business interests would come to the fore.

Bulletin Vol. 84 of the World Health Organization is dedicated to a great extent to collaborations between governments and private health service providers: Evans D (2006) Using of contracting in public health, in: *Bulletin of the World Health Organization*, Vol. 84.

IFC (2007) The business of health in Africa, IFC Health and Education Department, Washington. This report provides recommendations how a better integration of private health care provision can be achieved. See also Sheikh K et al (2005) Public-private partnerships for equity of access to care for tuberculosis and HIV/AIDS: lessons from Pune, India in: *Transactions of the Royal Society of Tropical Medicine and Hygiene*, Vol. 100:312-320.

¹³ Barr DA (2007) A research protocol to evaluate the effectiveness of public-private partnerships as a means to improve health and welfare systems worldwide, in: *Health Policy and Ethics*; Vol. 97, No.1. For this research protokoll, Barr also included non-governmental organizations that have multilateral formal approval from state governments as public sector institutions.

Part 2: HIV-related public-private partnerships and their contribution to the six building blocks of health systems

Building block 1: contributing to effective, accessible service delivery

The health indicators of the Millennium Development Goals will only be achievable if populations gain access to high-quality health services. Access to health service delivery—as the desired objective—has three dimensions, services must be:

- physically available even in remote rural areas;
- financially affordable even to poor people; and
- sufficiently attractive to be acceptable to the public¹⁴.

In the past, HIV programmes contributed to infrastructure improvements such as building of new health facilities or promotion of primary health care services, especially through tuberculosis case-finding and treatment. On more general grounds, the provision of antiretroviral treatment has reduced the need for hospitalization of terminally ill patients and the incidence of opportunistic infections, thereby easing the load on health services¹⁵.

For most companies, the workplace is the most important access point for any kind of service delivery with respect to HIV because employees are the backbone of businesses and economies¹⁶. Workplace programmes often provide prevention, treatment, care and support for employees and potentially their dependents¹⁷. Bigger, often multinational, companies also support surrounding communities or suppliers and have a significant share in providing health information and other services¹⁸. The private sector widens the coverage of health information and nurtures treatment access, but rarely in a systematic partnership with the public system.

Companies often start planning and implementing workplace interventions internally, or with specific partners rather than with the public sector. Lakshmi

Sundaram, Associate Director of the World Economic Forum's Global Health Initiative says: "Employers are pragmatic. In terms of HIV action at the workplace they often expand programmes gradually according to their needs and those of their employees and dependents." But addressing gaps in the health systems is complex and complicated—the reason why many companies shy away from this task. But not all—as the following case studies show.



Miners knock off from their morning shift work on the mine.

Photo: UNAIDS/L.Gubb

¹⁴ WHO (2008) Toolkit on monitoring health systems strengthening: Service delivery, WHO, Geneva.

¹⁵ Yu D et al (2008) Investment in HIV/AIDS programmes: Does it help to strengthen health systems in developing countries? In: Globalization and Health, Vol. 4, No.8.

¹⁶ GTZ (2004) Challenging Partnerships: GTZ and Private Sector Commitment to the Fight Against HIV/AIDS at the Workplace in Africa, GTZ, Eschborn.

¹⁷ World Economic Forum (2006) Business and HIV: A Healthier Partnership? A Global Review of the Business Response to HIV/AIDS 2005-2006, WEF, Geneva.

¹⁸ GTZ/Global Business Coalition against AIDS, Tuberculosis and Malaria (2005) Making Co-Investment a Reality, GTZ, Eschborn.

Sierra Rutile Limited: expanding health education and HIV treatment in Sierra Leone

An efficient facilitator of public-private partnerships is the International Labour Organization, which generally works with a tripartite constituency consisting of government representatives, employers and union members. “Thus we secure from the beginning that workplace programmes are true public-private partnerships”, says Behrouz Shahandeh, the Senior Technical Advisor at the International Labour Organization on HIV and AIDS. He explains that action by the Organization is centered on enterprise-level interventions to reach workers to overcome discrimination, reduce risk behaviours and facilitate access to treatment, care and support. In collaboration with ministries of labour, and employers and workers’ organizations, enterprises are provided with technical advice, training and material support in developing policies and programmes. Within the framework of a public-private-partnership, enterprises, in turn, contribute work hours for HIV activities, venues for training, communication and training materials as well as strengthening their health facilities or establishing partnerships for referrals to community-based services. An HIV programme in the mining sector of Sierra Leone for example started with a Memorandum of Understanding between the mining company Sierra Rutile Limited as employer, the United Mine Workers’ Union and the National HIV/AIDS Secretariat as the coordinating body of the HIV response in the country.

In its post-conflict situation, Sierra Leone has recently developed a first strategic plan on HIV/AIDS for 2006–2010¹⁹. The International Labour Organization supported cooperation of Sierra Rutile Limited, the Union and the National HIV/AIDS Secretariat targeted objectives beyond the company scope, such as a mining-sector policy and health services reaching out to communities. Major components of the programme are development of understanding about HIV among mine workers, health care staff and community leaders as well as the establishment of testing and treatment services in the company clinic including prevention of mother-to-child transmission of HIV. While the company provides its clinic and staff, the government supplies condoms, antiretroviral drugs and test-kits and supports the clinic technically. The United Mine Workers’ Union educates and mobilizes the workers and the community. In

addition to health education and improved access to HIV testing and treatment in a remote area of Sierra Leone, the cooperation under International Labour Organization leadership has brought about a National Workplace Policy for the mining sector in the country.

Yunxi Mining Company: reaching out to at-risk workers in China

Setting up a sustainable public-private partnership was the goal of the first major workplace programme in the Peoples’ Republic of China which the International Labour Organization initiated and promoted with support of the Chinese Ministry of Human Resources and Social Security with seed funds from the United States Department of Labour. The workers of the Yunxi Mining Company face elevated risk of exposure to HIV since Yunnan Province in South West China sees 80 % of China’s drug traffic passing through, leading to high levels of drug use often associated with commercial sex work. This mix is reflected in rising prevalences of HIV and other sexually transmitted infections in the region²⁰. Qualitative research conducted by ILO showed extremely low levels of HIV awareness, knowledge of services and condom use among the miners.

To tackle HIV among the Gejiu mining population a range of partners joined hands in the partnership including the public institutions Gejiu Center for Disease Control, and the China Family Planning Association as well as a nongovernmental organization called Humana People to People. The international media company McCann Healthcare and the local media companies Gejiu TV and Gejiu Daily News contributed in-kind and financial resources to ensure a well integrated communication campaign to support the programme. The national and provincial labour departments were indispensable for advocating and coordinating the joint activities and contributions of the various partners.

On the policy front, the Ministry and its Department of Human Resources and Social Security were key stakeholders in enforcing the National Employment Promotion Law 2008 reducing discrimination for people living with HIV. A company policy at Yunxi ended mandatory testing and guarantees employment rights for HIV positive workers in line with the national law.

¹⁹ UNAIDS website (2009) AIDS responses in post-conflict Sierra Leone, available at www.unaids.org, accessed 16th April 2009.

²⁰ Guowei, D (2007). HIV-1 and STIs prevalence and risk factors among miners and female sex workers in the mining areas of Gejiu, Yunnan, China. *Programme and abstracts of the 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention*, July 22-25, 2007: Sydney, Australia. Abstract MOAC105.
Also see: Xu JJ, Wang N, Lu L, Pu Y, Zhang GL, Wong M, Wu ZL, Zheng & Xi Wen. (2008). HIV and STIs in clients and female sex workers in mining regions of Gejiu City, China. *Sexually Transmitted Diseases*, 35(6) June, 558-565.

To support the provision of comprehensive prevention and care services, a professional communication strategy was developed to spread key messages about HIV-related services utilizing an overarching conceptual theme of migrant workers solidarity and mutual support. Comprehensive capacity was developed, and peer educators, with participation of the union, integrated HIV into routine occupational health and safety trainings. A company-funded drop-in centre run in partnership with a local nongovernmental organization provides resources on HIV, family planning, and drug dependence. A referral system links the miners up with voluntary counselling and testing, treatment of sexually transmitted infections, antiretroviral therapy, opioid substitution therapy and other services of the Geju Center for Disease Control. In 2009, an evaluation will assess the programme's success compared with base-line data collected in early 2007. "The partnership has helped us to scale up our response and work through company structures to prevent infections among an important risk population that had not previously been accessible", concludes Pu Yi, Director of the Geju Centre for Disease Control.

Companies' clinics as partners in rolling out HIV treatment

Provision of antiretroviral treatment as part of a workplace programme pushes the private sector closer into cooperation with government. This is the case especially for bigger companies operating in regions with high HIV prevalence²¹.

Small and medium-sized enterprises often do not have the financial means to provide antiretroviral therapy and rely—like companies in low prevalence countries—on the public health system for the provision of treatment.

In certain circumstances, the private sector is supplementing limited public capacities in health care provision with their own clinics. This is especially the case in remote areas and among industries operating in isolated sites such as mining or agrobusiness. Here, companies benefit from a clear partnership with government giving them access to free antiretroviral drugs and other medical products. Like Ok Tedi Mine Ltd. in Papua-New

Guinea numerous other companies now provide treatment for sexually transmitted diseases and antiretroviral therapy to keep HIV-infected staff and community members healthy, to promote confidence and to dry out the swamp of stigma and discrimination²². Many of them such as the tea growing branch of the multinational company Unilever in Tanzania and Kenya²³ or the cement producing daughter company of Lafarge, Hima Cement in Uganda²⁴ are part of country proposals to the Global Fund and have been accredited as care and treatment centres by their respective Ministries of Health making them part of the national treatment policy.

While considerable, sufficient progress has not yet been made in terms of access to first-line antiretroviral treatment, and the demand for second- and third-line drugs is rising globally. "Second-line antiretroviral treatment and treatment of multidrug resistant tuberculosis (MDR-TB) are new challenges lying ahead of companies and public health authorities in the near future", says Sabine Durier, Leader of the 'IFC Against AIDS Programme' of the International Finance Corporation. "Those treatments will come with greater costs for companies and ministries of health." In her perspective, insurance mechanisms must be created to respond to these rising costs or to potentially lower financial liabilities of the private sector induced by the current global economic crisis.

North Star Foundation: the workplace as a starting point for a transnational service provision in several African countries

Mobile populations have been identified as being at elevated risk of exposure to HIV since the late 1980s²⁵. In the last decade it has been observed that programme planners and implementers have made greater efforts to address the links between mobility and HIV. Many members of mobile populations are more vulnerable to health risks and less able to cope with infections given the difficulty of accessing medical support away from their homes. Although a growing number of mobile workers are travelling regularly to and fro across borders, high quality health service delivery remains a challenge that has not been met sufficiently.

²¹ World Economic Forum (2006) Business and HIV: A Healthier Partnership? A Global Review of the Business Response to HIV/AIDS 2005-2006, WEF, Geneva.

²² UNAIDS (2005) Access to treatment in the private sector workplace, UNAIDS, Geneva.

²³ World Economic Forum (2007) Case study: Unilever Kenya, WEF, Geneva.

²⁴ World Economic Forum (2007) Case study of Hima Cement in Uganda – Leveraging private sector resources for community AIDS treatment, WEF, Geneva. This case study nicely describes the process of accreditation and contributions of various partners in extending a company treatment programme to the surrounding communities.

²⁵ Carswell JW, Lloyd G, Howells J (1989) Prevalence of HIV-1 in East African lorry drivers, in: AIDS, 1989, Vol. 3 No. 11:759-761.

North Star Foundation is an industry platform of the transport sector responding to the impact of the AIDS epidemic. It was created in 2006 out of cooperation between the Dutch transport company TNT and the World Food Programme with support of the International Transport Workers' Federation and UNAIDS. North Star envisaged either strengthening existing health service providers or establishing new health service facilities in strategic points along the transport routes, which are often hotspots characterized by commercial sex work and high community interaction including occasional transactional sex.

“Now North Star Foundation has grown to be an alliance looking into HIV, TB, Malaria and other infectious diseases”, says Luke Disney, Director of North Star Foundation. The currently eight Wellness Centres created along transport routes in by now seven African countries provide all kinds of support to truck drivers, sex workers and community members, including hypertension control the most common disease condition affecting long-distance truckers.

With the establishment of Wellness Centres for long distance truck drivers, North Star Foundation left private sector ground to enter the public health sector in African countries. Many lessons were learned in taking this step. The scope of stakeholders in the provision of health and HIV-related services in low- and middle-income countries is huge and their influence on the national health system is substantial. Disney remembers: “In Zambia we had a situation in which we had the support of many key stakeholders, including the Ministry of Health, but we neglected to properly consult other nongovernmental organizations that were already operating in the area where we were going to open our new Wellness Centre.” An agreement with all partners under the leadership of the National AIDS Council was needed to resolve the issue of potentially overlapping service provision. “It would have helped us to have a better understanding of relevant stakeholders in the forefront”, concludes the North Star director.

Endurance is as important as a stakeholder analysis of the national public health arena. “Collaboration with the public sector and a good integration of an initiative into national plans require time,” is Disney’s second lesson. The usual fast speed of business transactions has to yield

to patience and thorough negotiations. “The private sector can benefit from the vast experience of our health specialists”, recommends Dr. Francis Otieno from the Kenyan National AIDS Control Programme, who is Medical Officer in Charge of Comprehensive Care Services in the Coast Province and North Star’s cooperating partner in setting up a Wellness Centre in the port of Mombasa. “We are very well trained and up-to-date on medical issues. In addition, we know all aspects of the system, are adept to improvising and can provide guidance on clinic set-up and patient management.”

From the point of view of North Star Foundation, the public sector can get the most out of public-private partnerships by having a clear and practical strategy for dealing with the private sector. “It works best when health officials are out-spoken about their expectations from the private sector and their own contributions to a partnership.” On the other hand, companies need to acknowledge the legitimate role of the government as the architect and manager of healthcare systems, and not simply regard them as just another stakeholder.

Too often the relationship is seen by both sides as a one-way-street to achieving their own ends. Dr. Otieno recommends: “A partnership with the private sector works best, if the private partner consults with government before he puts anything on the ground. We can discuss potential areas of conflict and find solutions before problems occur.” Long-term partnership is like a marriage—requiring continuous discourse, compromises at times and always the good will to stay together in a project. The most recent Wellness Centre opened in the port of Mombasa in



On the Zambia-Tanzania highway, peer education programmes have been set up for truckers. The sticker on this truck reads, Condoms prevent AIDS.

Photo: WHO/UNAIDS/L.Gubb

March 2009 is a good example. While the government supplies members of staff and medical products to the Centre, North Star provides a coordinator who integrates the Mombasa Centre into the remaining Wellness Centre network. “Clearly defined roles and responsibilities will remove room for friction”, is Dr. Otieno’s lesson learned after the first weeks of operation.

Business Coalitions: Facilitating and monitoring workplace activities

As much as company workplace programmes differ in scope, they very often have one thing in common: they are business-tailored, but more or less isolated interventions. As an example, 94% of African governments have reported on the UNGASS indicators in 2008²⁶, but none of the reports contain data reporting on the company contribution to treatment or prevention. In many countries, companies have created business coalitions as coordinating and mediating bodies. Many of the business coalitions against AIDS are actively involved in public-private partnerships helping companies permeating their programmes to their suppliers as in Nigeria or Kenya, establishing services in remote agricultural settings as in Tanzania or initiating mobile confidential voluntary counselling and testing and antiretroviral therapy provision as in Zambia to name just a few²⁷. The Global Business Coalition on HIV/AIDS, TB and Malaria has started to facilitate collective action projects, also known as Impact Initiatives which bring together several companies across different industries with key public stakeholders. In Kenya for example, the Coalition recently launched an initiative to bring home counselling and testing to two million Kenyans.

“PPPs are very useful in bridging gaps or reducing congestion in the provision of services”, says Esther Sakala, Executive Director of the Zambia Business Coalition on HIV and AIDS. Yet, she also identifies the need for relevant capacity building in the private and public sector. As supportive institutions pan-continental business coalitions have been created in the Asia-Pacific, Caribbean, Arab and African regions. “They are important bodies to sensitize

national business coalitions for the interface between the private and the public sector”, says Dr. Birgit Lampe who is heading a regional project on business and AIDS in German Technical Cooperation. As in the international discussion the trend is moving towards a stronger integration of AIDS into health systems, there is a need for the business sector to open



Home-based counselling and testing through the GBC-AMPATH Health at Home/Kenya Impact Initiative.
Photo: UNAIDS/Craig Bender.

up towards a health promotion model. According to Lampe, business coalitions need the skills to lead and direct the private sector accordingly in their respective countries.

Jane Wilson, UNAIDS Regional Advisor in Asia observes: “The role of the private sector needs to be more integrated into the national response and monitoring and evaluation.” The Thai Business Coalition on AIDS takes a leading role in filling this gap. As sub-recipient of two Global Fund grants, the Coalition promoted the development of an evaluation and accreditation scheme with minimum standards for HIV workplace programmes called the AIDS Response Standard Organization and is now in the process of developing a monitoring support structure for the private sector to oversee company treatment services for TB patients and those co-infected with HIV. Furthermore, an accreditation mechanism is being institutionalized that certifies businesses providing prevention, treatment and care services for TB and HIV.

²⁶ UNAIDS website (2009) Much progress to report: UNGASS 2008, available at <http://www.unaids.org>, accessed 17th April 2009. The indicators of the United Nations General Assembly (UNGASS indicators) were developed in compliance with the Declaration of Commitment on HIV/AIDS signed by UN member states in 2001.

²⁷ Data from interviews with the Executive Directors of various Business Coalitions against AIDS: Stephen Grant (Asia Pacific Business Coalition on AIDS), Helen Magutu (Kenyan HIV/AIDS Private Sector Business Council), Olusina Falana (Nigerian Business Coalition Against AIDS), Richard Kasesela (AIDS Business Coalition Tanzania), Anthony Pramualratana (Thai Business Coalition on AIDS), Esther Sakala (Zambian Business Coalition on HIV and AIDS).

This can only be realized in close collaboration with the Ministry of Labour and the Ministry of Public Health. “While TBCA assesses and monitors companies’ workplace programmes, the accreditation is the task of the Ministry”, explains Anthony Pramualratana, Executive Director of The Thai Business Coalition on AIDS. As a member of the Country Coordinating Mechanism of Global Fund and the National AIDS Commission, the Coalition is responsible for the UNGASS reporting on workplace issues. In the 2008 Progress Report, the AIDS Response Standard Organization tool received recognition as a best practice providing monitoring data on an improved protection of workers’ rights, increased number of workplace programmes, and reduction of stigma and discrimination in the workplace²⁸.

Building block 2: contributing to a responsive, competent and satisfied health work force

High-quality service delivery requires a responsive, competent health work force satisfied with its professional identity and workplace conditions. Human resources for health include clinical staff as well as management and support staff. Many countries have a severe shortage of health workers for reasons such as insufficient production of new staff, in-country, out-migration, inefficient and inappropriate deployment, poor mix of skills and demographic imbalances²⁹. WHO estimates that there is at least a total shortfall of 4 250 000 health workers who are currently needed in service delivery and management in African and Asian countries³⁰. Many health workers migrate first from rural areas to the cities, then to industrialized countries which offer better salaries and working conditions, more job satisfaction and career opportunities as well as good quality management³¹. Comprehensive, reliable and timely information on the health workforce situation is needed to enable



A Peer Health Education session in the Tea Plantation of Kibena, where the AIDS Business Coalition Tanzania is the implementer for a public-private partnership (Comprehensive HIV/Aids Control in the Tanzanian Tea Industry) between German technical Cooperation (GTZ), three Tea Companies and the Business Coalition.

Photo: UNAIDS/ AIDS Business Coalition Tanzania

targeted action, such as training of new and skill-building of experienced staff, incentives for workers in unattractive worksites, appropriate staff distribution accounting for cultural specifics of populations or human resource initiatives that create motivation and promote job satisfaction.

The private sector—specifically companies operating in the field of pharmaceuticals and medical technology—invests considerable resources and competences in leveraging know-how and standardized practices in low- and middle-income countries. To them efficient health systems and competent health personnel form the market for their products and create an environment for development. But also companies without a health focus benefit from competent health staff in their own production sites or in the public system. Selected examples of public-private partnerships range from training of professionals to fostering exhausted and overburdened staff as the following examples show.

SIDA-ENTREPRISES: joint public-private efforts for an educated health staff in Senegal and Burkina Faso

Since 2008 SIDA-ENTREPRISES, a coalition of mainly French businesses runs training programmes jointly with two national HIV programmes in Western Africa. Twenty companies with 43 health workers in Burkina Faso and 25 companies with 75

²⁸ National AIDS Prevention and Alleviation Committee (2008) UNGASS Country Progress Report Thailand, Bangkok.

²⁹ WHO (2008) Toolkit for monitoring health systems strengthening: human resources for health, WHO, Geneva.

³⁰ WHO (2006) The global shortage of health workers and its impact, Factsheet No. 302, WHO, Geneva.

³¹ WHO (2006) Migration of health workers, Factsheet No. 301, WHO, Geneva.

health workers in Senegal participate in the three year activity. The modules cover basic knowledge on HIV and prevention at the workplace, legal, discrimination and gender issues, practical trainings in health facilities, as well as modules on adherence to antiretroviral treatment and side-effects of drugs. After the three year training course doctors and nurses are equipped to link workers up with care and treatment specialists and to manage patients on antiretroviral drugs.

In Burkina Faso only 25% of the enrolled health workers are employees of a company, 75% work for the Office de Santé des Travailleurs, which also runs two public clinics providing services specifically for workers. The director of the Office is part of the steering group of the programme which is also supported by the International Labour Organization. The National AIDS Control Programmes of both countries contribute expertise to the initiative; the Senegalese Comité National de Lutte contre le sida even provides some additional funds. Sophie Stépanoff, Development Director of SIDA-ENTREPRISES, explains the strong involvement of the public sector in the training. “It was quite legitimate to ask the public sector for help for the training of health workers.” She sees a big advantage in running the training in close cooperation with government: “The private sector needs long-term support on health issues and the public sector has to guarantee this in a long-term perspective.”

Becton, Dickinson and Company: ‘Wellness Centres’ to relieve the pressure on nurses in sub-Saharan Africa

This innovative project initiated by the International Council of Nurses in 2006 and supported by Becton, Dickinson and Company in collaboration with various national governments and PEPFAR established Wellness Centres for health-care workers and their families as an incentive for African nurses to stay in their jobs and in their home countries.

Wellness Centres are a symbol and instrument of care for demoralized health workers. They offer confidential voluntary counselling and testing, treatment for HIV and tuberculosis, post-exposure prophylaxis and prevention of mother-to-child

transmission services. In addition, health workers can learn about stress management and occupational safety, take up training opportunities, and can find other resources for continuous professional development³². Says Renuka Gadde: “Healthcare workers are integral partners and customers for Becton, Dickinson and Company. For many years, the Company has been manufacturing products and providing services that help protect healthcare workers. Therefore, the idea of working on wellness initiatives for health workers was a natural fit for us. Through our collaboration on wellness centres, we hope to provide training and education and upgrade clinical practices in places where it is most needed”.

The first public partner in this project was the Government of Swaziland. Project outcomes in the Kingdom of Swaziland are impressive: 77 % of the Swazi health workforce has benefited from the Wellness Centre to date with a continuous increase of uptake of services. “The Ministry of Health has integrated wellness into the national personnel policy and provides the Centre with medical supplies as well as other support”, explains Renuka Gadde, Director of Global Health at Becton, Dickinson and Company. National buy-in and ownership is crucial with respect to sustainability of the wellness centres. A project which is part of a national approach has better chances for continuous funding from public and private sources.

The Swaziland Wellness Centre project has become a model in the region: Lesotho, Zambia, Malawi and Uganda have opened or are in the process of



Photo : UNAIDS/ Becton, Dickinson and Company

³² Baleta A (2008) Swaziland nurses the wellbeing of its health workers, in: Lancet, Vol. 371.

establishing similar centres. The Partnership facilitates peer visits as an instrument to create interest of other countries in this model. “It is much easier to cooperate with national governments if you have not only an idea to present but something practical to show as well,” Gadde concludes.

Building block 3: contributing to a well-functioning health information system

Sound decision-making in health care provision requires comprehensive information. Data must be generated and compiled, analysed and synthesized. Data analyses must be communicated and used as preconditions for planning and managing of the health system³³. This principle also extends to data generated by stakeholders other than the public system. It creates legitimate expectations to all other health services and activities operating in a country. Major information categories that are required for planning and decision-making include data on social determinants, inequalities and contextual environments of health in the system, quantitative and qualitative data on inputs to the system and outputs relating to services and other components as well as health outcome data. All this information has to be made available in a format that can be used by many different professionals.

The United Nations General Assembly Special Session on HIV/AIDS indicators are a groundbreaking achievement in providing comparable reporting on national AIDS situations. However, national health information systems are often burdened by parallel reporting requirements of major donor programmes responding to AIDS³⁴. Modern technology now opens new opportunities to facilitate health reporting including AIDS monitoring. The explosive growth of mobile networks globally has the potential to overcome the disadvantages of remote and resource-poor environments, relieve the shortage of health workers and support the management of service delivery and emergencies³⁵.

The private sector plays an important role as developer and promoter of information technology. The application of information technology in health is called “mHealth” and defined as the use of short-range, portable electronic devices for mobile data communication over a cellular network³⁶. For some specialists mHealth will lead to a review of health care financing and delivery, blurring the boundaries between professional medical help and do-it-yourself medicine³⁷. Others stress the usefulness of mHealth in the management of the double disease burden of communicable and non-communicable diseases, the cost containing effect of commodity purchases via internet with more competition and client empowerment, and the applicability in skills enhancement of health workers³⁸.

Voxiva, Motorola, MTN: regular reporting via “Phones for Health” in Kenya, Rwanda and Tanzania

Phones for Health is a partnership between the health-care software provider Voxiva, the phone producer Motorola, the telecom company MTN, the GSMA Development Fund, PEPFAR, CDC Foundation, Accenture Development Partnerships and various governments. Voxiva developed a software application that integrates with core health applications and that can be downloaded to a wide range of mobile phones. A health worker with this software on the phone can input health data and transfer them to a central data base where the data can be analysed. In addition, the health worker can order medicines, send alerts, download guidelines, or access training materials³⁹.

Phones for Health is a further development of the TRACnet system, which supports the monitoring of the National AIDS Control Programme of Rwanda since 2004. The system enables practitioners to monitor antiretroviral drug stocks in real time, and accelerates the return of results from CD4 molecule and viral load tests to remote facilities⁴⁰. After three years in operation, TRACnet now covers all health facilities offering antiretroviral therapy in Rwanda

³³ WHO (2008) Toolkit for monitoring health systems strengthening: health information systems, WHO, Geneva.

³⁴ Yu D et al (2008) Investment in HIV/AIDS programmes: Does it help to strengthen health systems in developing countries? In: *Globalization and Health*, Vol. 4, No.8.

³⁵ Vital Wave Consulting (2009) mHealth for development – The opportunity for mobile technology in health care in the developing world, UN Foundation-Vodafone Foundation Partnership, Washington and Berkshire.

³⁶ Kahn JG, Yang J, Kahn JS (2008) The relationship among economic development, health, and the potential roles of mHealth. Presentation at the conference series *Making the eHealth Connection: Global Partnerships, Local Solutions, conducted* at the Rockefeller Foundation’s Bellagio Center in Bellagio, Italy from July 13 to August 8, 2008, available at <http://ehealth-connection.org> (Accessed 30th March 09).

³⁷ Mishra S, Singh IP (2008) mHealth: A developing country perspective. Presentation at the conference series *Making the eHealth Connection: Global Partnerships, Local Solutions, conducted* at the Rockefeller Foundation’s Bellagio Center in Bellagio, Italy from July 13 to August 8, 2008, available at <http://ehealth-connection.org> (Accessed 30th March 09).

³⁸ Kahn JG, Yang J, Kahn JS (2008).

³⁹ GSMA (2007) Phones for Health – Case study, GSMA, London, available at www.gsmworld.com (Accessed 30th March 2009).

⁴⁰ United Nations (2008) Innovation for sustainable development – local case studies from Africa, UN Dept. Of Economics and Social Affairs, New York.

and all patients on antiretroviral therapy. Health workers submit monthly indicator reports and weekly consumables reports via a toll-free number. Since most individuals own a phone they are also used to using text messaging features⁴¹.

“With Phones for Health we are replicating and improving our experiences with TRACnet”, says Will Warshauer, Executive Vice President of Voxiva. “We build systems which are owned and operated by the partner governments.” The partnership has contractual arrangements with the governments of Kenya, Tanzania and Ruanda. Local steering committees chaired by senior officers of the Ministries of Health define the priorities and prepare existing processes for mHealth application. Kenya wants a listing and regular basic reporting of all public and private health facilities. In addition, national vaccination and disease outbreak reporting will be done via mobile technology. The Kenyan Ministry consolidated down 52 reporting forms to one for mobile reporting of basic indicators to 80 % concerned with HIV of all public and private health facilities in the country. Tanzania intends to monitor and advertise blood donation via mobile phones. Rwanda aims at a better reporting of its 50 000 community health workers and an improved knowledge transfer.

The specific needs and wishes of individual governments complicate the development of mHealth applications for open source utilization. “Governments insist on customized solutions suiting their processes and existing instruments”, says Warshauer. Part of the project funds have therefore to be spent on software licenses. Continuous need for IT-support is another threat to sustainability. The Voxiva Executive Vice President acknowledges the justified resentments of governments towards short-term public-private partnerships which may cut the support too early. He assures: “The Phones for Health partnership provides a national system. There is evidence that over time governments take on more and more parts of the system.”

In the various countries, the partnership has support from offices of CDC to liaise with the national governments, explains Dhevi Kumar from the CDC Foundation. To Will Warshauer further support would be welcome, especially with respect to promoting mHealth among sceptical Ministries of Health. Many government officials do not yet see the benefits of using mobile phones for reporting in real time.

DataDyne.org and Vodaphone Foundation: health surveys with EpiSurveyor

Apart from regular reporting, surveys are an additional tool of national health monitoring. For conducting health surveys the non-profit software provider DataDyne.org developed EpiSurveyor, an open-source software application available to every internet user at no cost. Surveys with data collection on paper even with computer analysis are cumbersome; supportive internet and mobile phone technology exists but requires the support of experts. “Specialists and consultants who have to be hired for surveys are a bottle neck for progress in resource-limited settings”, says Dr. Joel Selanikio, Director of DataDyne.

Until recently, EpiSurveyor ran solely on Personal Digital Assistants (PDAs): the EpiSurveyor software had to be downloaded to a computer to create the forms for a survey. The form was then transferred to the Personal Digital Assistant and used for data collection, and the data sent back to the computer for analysis. A new beta-version is now available allowing the creation of forms on an internet platform which can then be downloaded to standard mobile phones running Java. Data collected will directly be sent to the internet platform for analysis. No installation of software is needed on the desktop or laptop computers—a great advantage in countries with slow internet connection.



Phones for Health.
Photo: PEPFAR

Dr. Selanikio underlines another advantage of the web-based EpiSurveyor: “We want to promote simple sharing of survey forms and technical expertise.” Experts who have done HIV-related investigations can share their surveys used for knowledge screening, behaviour change monitoring or treatment supervision.

With support of the mHealth Alliance, formed by the Rockefeller Foundation, the United Nations Foundation and Vodaphone Foundation, the Personal Digital Assistant-based EpiSurveyor was piloted in

⁴¹ Voxiva (2008) Rwanda TRACnet – Case study, Voxiva, Washington.



Doctors and clinic workers use mobile phones to collect and record vital health data and monitor patients' status.

Photo: UNAIDS/ Joel Selanikio/DataDyne.org

Burkina Faso, Kenya and Zambia in cooperation with the respective Ministries of Health and subsequently rolled out to 13 sub-Saharan African countries. That rollout is now being switched over to the web- and mobile-phone-based version, which has just been tested in a nationwide child health week campaign in Kenya. The World Health Organization acts as a door-opener to the public sector. The Foundations now support the roll-out to further 20 countries in Africa, including training and support⁴². Anyone wishing to try the beta software on their own can access it at www.episurveyor.org.

Building block 4: contributing to equitable access to essential medical products, vaccines and technologies

Medical products, vaccines and technologies are basic requirements of high quality health services. Access to these commodities must be regulated by policies, standards and guidelines which lie in the responsibility of the public system. Health systems require sufficient funds to equip technology hubs such as laboratories with modern machinery. In-country manufacturing sites require specialized staff and controlled quality processes. Health staff including

management personnel need skills to use medical commodities appropriately; rational use of essential medicines is as essential as a sound induction to new laboratory machines or technical maintenance. Medical products require comprehensive quality control to stop the distribution of counterfeit drugs or prevent adverse effects of ineffective or overdosed drugs. Processes such as procurement, supply, storage and distribution have to be established, monitored and optimized. Providing access to essential medical products, vaccines and technologies is a challenge to many public health systems in low- and middle-income countries.

On the private sector side, access to modern technology and pharmaceuticals is the natural domain of support from pharmacological and medical technology companies. Corporations operating in the health sector have an inherent self-interest in efficient service delivery flanked by potent medical technology. Supplementary philanthropic ambitions lead to engagements that exceed efforts based on business interests only; they unleash investments in capacity development that are not focused on specific products. Thereby, significant added-value can be achieved as the following two case studies demonstrate.

⁴² Vital Wave Consulting (2009) mHealth for development – The opportunity for mobile technology in health care in the developing world, UN Foundation-Vodafone Foundation Partnership, Washington and Berkshire.

Abbott Fund: laboratory support from national to regional level in Tanzania

The Abbott Fund, the philanthropic foundation of the global health care company Abbott, saw that its project of strengthening laboratories in Tanzania developed in steps. Christy Wistar, divisional vice president who runs the Abbott Fund office in Tanzania, explains: “Our original programmes were in support of orphans and vulnerable children. The need was critical and we knew we could help make a difference.” In 2002, Abbott Chief Executive Officer Miles White visited Tanzania, and it was his experience that led the Abbott Fund to focus its growing support on strengthening health systems. White saw first hand that Abbott Fund financial support and Abbott volunteers could help address some of the underlying problems at Muhimbili National Hospital, especially in the areas of infrastructure and staff training. The construction of an outpatient facility to treat 500 patients per day and a clinical laboratory as well as staff training programmes became the focus of the succeeding project.

The Abbott Fund’s support in Tanzania is an example of a project going from the specific to the

general. Wistar explains: “The impact of our work at Muhimbili National Hospital convinced us that health system strengthening was an unmet need that Abbott could help address. Today, we are constructing or modernizing 23 regional-level laboratories to ensure patients across Tanzania have access to quality laboratory results.”

Modern laboratories are a key to quality health care. “Without them [laboratories], doctors practice blindly”, says Wistar. “We are working in partnership to deliver 23 laboratories that are standardized to meet national and international standards.” The laboratory standard design was developed with the Government of Tanzania, the US Centers for Disease Control, the Association of Public Health Laboratories and international laboratory design experts. The Abbott Fund is providing safety cabinets and fume hoods, to ensure the safety of laboratory personnel.

The Government of Tanzania has procured automated equipment from various diagnostic companies to meet their clinical needs. In Wistar’s perspective providing the laboratory equipment is only the first step: “The greater challenge is keeping the laboratory operational day-to-day due to challenges such as too few



Abbott Fund Training Programme.
Photo: UNAIDS/ Abbott Fund

trained laboratory personnel, lack of reagents, and few maintenance personnel when an equipment problem is encountered. That's why the Abbott Fund helps to monitor laboratory performance to make sure that the automation is operational and reagents are available.”

According to the Government of Tanzania, there are not enough trained laboratory technicians in the country; even at the regional level hospitals, many professionals are not sufficiently conversant in using modern technology and require further managerial skills of demand definition, forecasting and procurement. To help address the laboratory personnel shortage, the Abbott Fund provides 100 Medical Technologist Scholarships each year so that Tanzanians can enrol in a three-year laboratory technology programme. In addition to scholarships, as part of its training and implementation programme, Abbott laboratory professionals act as mentors to the newly modernized regional-level laboratories during the first two months of operation.

Maintenance of equipment is another challenging issue in a country the size of Tanzania. All donated Abbott laboratory equipment is maintained by field-service engineers supported by the Abbott Fund. To help with maintenance of other companies' equipment, the Abbott Fund has been trying to gain traction on a “Crash Cart” programme. The concept is that each laboratory would have a locked cart of parts, tools, and instructions to be used by on-site personnel in case of a broken instrument, minimizing downtime and travel expense related to instrument

service. So far, cooperation of manufacturers has been very limited due to a reluctance to give out equipment information.

Apart from regional laboratories, the Abbott Fund programme also upgrades local health facilities. At 90 sites throughout the country testing and counselling rooms have been built, outpatient clinics have been created, laboratories were renovated, staff trained and equipment and test kits provided. Thus, voluntary counselling and testing services run by local hospital HIV management teams have been strengthened to supplement the care and treatment programmes which are rolled out in every district.

Monthly meetings with the Minister of Health and Social Welfare or the Chief Medical Officer develop strong relations and programme oversight. At Muhimbili National Hospital, the partnership is steered by a committee consisting of officials from the hospital and the Abbott Fund. In addition, the Abbott Fund participates in the Donor Partners Group on AIDS to harmonize approaches and avoid duplication. Wistar also regards it as important to employ local companies for infrastructure development to provide local investment and build local capacity.

According to Wistar, many challenges remain in upgrading local health care systems, and while it is necessary to help meet unmet needs, it is also important to prioritize: “We find ourselves drilling wells, installing transformers, developing procurement tools, and much more. Unfortunately, sometimes we have to say ‘no’ or sometimes “not now” when we reach the limits of our support potential.”

The Abbott Fund appreciates the cooperative and trustful working relations with the Tanzanian government. According to Wistar, the secret for this positive relation can be found in the history of meeting commitments and delivering on promises. “Our relationship with the government is built on mutual trust that has grown over the years we have been in Tanzania and continues to flourish.”



Tanzania clinical laboratory supported by the Abbott Fund.
Photo: UNAIDS/Abbott Fund

Becton, Dickinson and Company: knowledge transfer and supply solutions in Uganda

Becton, Dickinson and Company is also a US -based medical technology company with a strong engagement in global health. The rationale for Becton Dickinson's global health initiative is no different than the company's purpose of helping all people live healthy lives, says Krista Thompson, Vice President and General Manager for Global Health in Becton, Dickinson and Company: "We cannot grow our business unless markets develop. For functioning health markets we need a health systems strengthening strategy."

The Partnership on country-specific laboratory strengthening that the Company, PEPFAR and the Center for Disease Control collaborate on, responds to this demand. As part of national plans developed by the Ministries of Health of the partnering countries, the laboratory strengthening support shall bring about better diagnostics for AIDS and TB, continuous quality control and national TB reference and training sites⁴³. The programme has started in Uganda, South Africa, and Mozambique, with plans to work in additional African countries.

The foundation of a functioning partnership between Becton, Dickinson and Company, national governments and other stakeholders is a work plan with defined roles and responsibilities. According to the Company Global Health Manager the first negotiations on laboratory strengthening partnerships have taken a long time because it required mutual trust to sign a partnership agreement. She adds: "Now with existing examples and experiences, these processes can be accelerated in new partner countries."

The Company contributes expertise, financial resources and short-term technical assistance through the deployment of employee volunteers to the partnerships. The latter sometimes creates potential for tensions between the private and public partners. For example, the Company proposed to second short-term consultants for three-week intervals to the Ugandan National TB Laboratory. The Director of the Laboratory Dr. Moses Joloba recalls his reaction: "Initially we were sceptical how someone could be helpful who was only there for such a short time." Jointly, the company and Dr. Joloba defined clear tasks that could be done in a three-week-period such as training of staff, the mapping of TB treatment sites

or the setting up of a data-base for TB specimen. This task definition worked very well. Dr. Joloba sees the benefit of an outsider coming with strong energy and a clear three-week objective: "A system sometimes needs an outside impulse to get things done in a specific period of time."

Governments are often critical of short-term technical assistance rightly pointing towards the long-term perspective needed for sustainable capacity development. Training provision is only one side of the coin. Members of staff have to be followed-up by on-the-job advice and supervision over longer periods of time. The partnership with Becton, Dickinson and Company has been integrated into the operational processes of the national laboratory. The team of Dr. Joloba monitors the work in the nine TB zones of the country quarterly: "If we do not follow up on the trainings, all that has been learned will be lost."

Becton, Dickinson and Company acknowledges government reluctance to accept short-term consultancies, but faces its own constraints with respect to long-term secondment of staff. "We are trying to find solutions to these concerns," stresses Thompson. In Uganda, the partnership also involves the nongovernmental Infectious Disease Institute which can now duplicate the trainings with Becton, Dickinson materials.

The public-private partnership for laboratory strengthening started in March 2008 in Uganda. Technicians of 95 laboratories have been trained in Quality Management so far and are beginning to implement an external quality assurance programme. Numerous TB treatment sites have been mapped with GIS/GPS⁴⁴ and a TB Specimen Referral mechanism has been put in place using the Uganda Post Company for the transport of sputum samples from the periphery to Kampala. "We first feared that samples would be contaminated when transported by a post vehicle. But the contamination rates were not higher than with an exclusive health transport", says Dr. Joloba.

HIV programmes have been criticized for establishing additional supply chains⁴⁵. But Dr. Joloba as a public health officer is optimistic concerning the sustainability of the partnership of his institution with the Post Company. "We were surprised that the cooperation with the Ugandan Post company works so well." He underlines that colleagues from other fields have shown interest in the transport model.

⁴³ PEPFAR (2007) New public-private partnership to strengthen laboratory systems, PEPFAR, Washington, available at www.pepfar.gov

⁴⁴ Houtz B (2009) BD/PEPFAR Lab Strengthening Programme, Presentation to the Stop TB Partners' Forum, March 23 – 25, 2009 in Rio de Janeiro.

⁴⁵ Yu D et al (2008) Investment in HIV/AIDS programmes: Does it help to strengthen health systems in developing countries? In: *Globalization and Health*, Vol. 4, No.8.



Photo: UNAIDS/Becton, Dickinson and Company

Building block 5: contributing to sustainable health financing

The financing mechanism of any health system has to fulfil three basic functions:

- to generate sufficient funds;
- to protect the population from financial health risks; and
- to purchase or deliver services cost effectively.

Universal access to HIV prevention and treatment, care and support also greatly depends on efficient and equitable health financing. HIV funding contributed to an immense increase of funds from the donor side as well as from international governments and the private sector⁴⁶. Innovative fund-raising approaches in the private sector such as the Product RED Campaign contribute to numerous AIDS initiatives as well as to the Global Fund⁴⁷. However, despite this financial influx needs for health systems strengthening still persist.

Establishing a good financing system to provide healthcare services is a serious challenge to many low- and middle-income countries. About one third of WHO member countries cannot afford a core health package of US\$ 40 per person per year. Without sufficient funds health systems cannot run their

services, pay health workers and buy commodities. Without pooling of funds and risks, citizens have to make out-of-pocket payments for medical services when they become sick potentially leading to their impoverishment. Without efficient use of funds, services may not respond to needs, funds may get lost in non-transparent administrative processes or synergies between private and public health service providers may not be used⁴⁸.

Ideally, no one should be denied access to needed services because of poverty and inability to pay. Prepayment, risk pooling, subsidy of the poor and strategic purchasing of service delivery are mechanisms for fair and responsive health financing⁴⁹. Insurance schemes are required to ease the pressure on the individual, but also to sustain and co-finance services provided by the private sector. Public-private partnerships addressing this need are very rare.

Mars: promotion and support of the National Health Insurance Scheme of Ghana

The public-private partnership of Mars Inc. in Ghana is a very comprehensive public-private partnership integrating aspects such as farmer productivity improvements, education and child labour. With respect to HIV and TB, Mars Inc. cooperates with

⁴⁶ Yu D et al (2008) Investment in HIV/AIDS programmes: Does it help to strengthen health systems in developing countries? In: *Globalization and Health*, Vol. 4, No.8.

⁴⁷ Product Red partners channel a percentage of profits from their products to the Global Fund. So far, more than a 120 million dollars have been raised making Product Red the largest private sector contributor to the Global Fund.

⁴⁸ WHO (2008) Toolkit for monitoring health systems strengthening: health systems financing, WHO, Geneva.

⁴⁹ WHO (2000) Who pays for health, WHO, Geneva.

various stakeholders of Ghana's health system and the German Technical Cooperation (GTZ). The Partnership is based on collaboration agreements with the National AIDS and Tuberculosis Control Programmes, with the Ghana Health Services and selected district health facilities. It has started to work with approximately 12 000 cacao farmers in 19 communities in two districts in January 2009.

Apart from education and prevention, the Partnership targets to increase the enrolment of HIV and TB infected farmers in the national care and treatment programme and to raise the membership of farmers in the national health insurance scheme.

The support of the national health insurance scheme will build on the company's communication and business channels to the cacao farmers. In addition, special Partnership activities to achieve a greater uptake of HIV and TB treatment in rural communities will also provide a platform for insurance promotion. By using mobile units, for example, the public-private partnership will encourage uptake of HIV testing and counselling as well as general health check-ups. Explaining the advantages of the national health insurance will be part of the campaigning.

The insurance managers of the district health office cooperate closely with the Partnership to educate the farmers on the scheme and to promote the underlying idea of solidarity and pooled risk. The District Health Insurance Officers identify communities with low enrolment rates and high education needs. In cooperation with the community leaders they also identify which community members require premium waivers. As an incentive to join the national health insurance scheme at district level, the Partnership will cover the insurance registration costs of the individual farmer.

"The PPP subsidies are intended to lower the bars to insurance enrollment", says Holger Till who is leading the Regional Coordination Unit for HIV & TB of GTZ. "Convincing farmers of the benefit of treatment will be easy compared to convincing them to pay for health insurance when they are not sick." The Partnership time frame of three years is short for such an endeavor. But Ernest Asante, Public Relations Officer for the District Health Insurance Scheme of Assin North District sees this in a positive light: "The government of Ghana targets to achieve a significant enrolment into the national health insurance scheme within the next five to ten years. A project time



Ghana farmers.
Photo: UNAIDS/P.Virot

frame of three years covers a good part of this.” He expects the Partnership to make a visible contribution to the enrolment percentage in the communities addressed.

The insurance scheme will only satisfy its members if the health care services convince with respect to responsiveness and quality. A baseline survey was done in the partnership to record the farmers’ attitudes towards the health systems as well as their needs and complaints. Logistics support and various trainings e.g. on quality assurance and financial management shall improve the services leading to a better cost-benefit ratio for the insured farmers in the next monitoring rounds. The logic of this intervention is charming. The Public Relations Officer Assante appreciates the contribution of the Partnership in selected communities of the District. However, the District Health Insurance Office is responsible for all communities—similar support would be needed for the whole district.

PharmAccess Foundation: group insurance and risk equalization funds as models for the private sector

In economic settings characterized by low income levels, it is not easy to sell the concept of prepaid risk pooling to a low income population says Hans-Peter Wiebing, Senior Process Manager from the Dutch PharmAccess Foundation: “Health insurance is a totally new concept for these groups of people, not because the idea of solidarity is new but because solidarity is not applied in terms of pre-paid risk-pooling for health care.”

However, Wiebing sees an urgent need for high level support of subsidized health insurance programmes. Private health insurances are not always interested in covering AIDS-related care and treatment. Risks involved are often perceived as high. One way this can be addressed is through setting up a risk equalization fund for AIDS, as has been tested in Namibia by PharmAccess. Through this fund the lower- and middle-income target groups share the risk of the high medical costs related to HIV treatment with more wealthy groups.

The fund is accompanied by an administration and disease management system shared by several private insurance companies. Relieved of the financial burden for HIV-related diseases, the private insurer can offer low-cost insurance products. This insurance concept is strongly based on group enrolment with at least

50% premium coverage paid by the employer⁵⁰.

Initiatives as the Namibian one benefit from a public-private partnership, since in the end the public side is responsible for regulating the overall system and for integrating the private health care providers in the distribution of resources such as antiretroviral drugs for low prices.



Pharmaccess: Members of the community in Kwara State are showing their insurance card.

Photo: UNAIDS/Pharmaccess.

Based on the experiences in Namibia PharmAccess Foundation and the Health Insurance Fund developed the idea to promote and support a subsidised health insurance scheme for low-income worker groups. Health insurance premiums are being subsidised for individuals (demand side), increasing the accessibility of good quality healthcare. At the ‘supply side’, health insurance organizations or health care provider networks are being contracted to deliver health care, with agreed quality standards and fixed pricing for health provision. In order to achieve the agreed quality levels, investments in the supply side take place through upgrading plans for contracted health care providers. If a health care provider does not meet the targets in the upgrading plan, the provider cannot remain in the insurance network. The idea is to increase the use of private health care capacity for public health goals, while introducing transparent, performance-based health care delivery

The idea has been introduced in Nigeria with success. Since the Health Insurance Fund started its subsidized insurance programme, a quality health care system has been created for two targeted groups: market women in Lagos and farmers in Kwara State. More than 50 000 people now have access to high quality

⁵⁰ Janssens W, Gustafsson-Wright E, Beer I. de, Gaag J. van der (2008) A unique low-cost private health insurance programme in Namibia: protection from health shocks including HIV/AIDS, in: *Development ISSUES*, Volume 10, Number 2, November 2008, available at <http://www.pharmaccess.org> (Accessed 28th April 2008).

basic health care including HIV treatment provided by upgraded clinics. The success of the insurance mechanism has attracted the attention of policy makers in Nigeria. The Governor of Kwara State believes the programme is a blueprint for providing quality health care for the whole state. He agreed to co-fund a new programme in his state, that has been launched in June. This programme will grant another 70 000 farmers and their families access to quality care.

Building block 6: contributing to good governance and competent leadership

Increased external health system funding has created a great interest in governance of health systems, especially in the areas of accountability and results orientation. A good understanding of the services involved, finance mechanisms, health data, performance indicators and enforcement options are main preconditions for proper accountability⁵¹.

In addition, complex health systems require highly collaborative leadership, fostering dialogue with multiple stakeholders to influence health care policy and provision⁵². These include private and faith-based health care providers, professional associations, multi-lateral and bilateral organizations, development banks, civil society and many more. Accordingly, indicators measuring governance examine the availability of policies and guidelines, financial and administrative performance reviews, data collection mechanism and health system outcomes.

The multisectoral approach to HIV prevention, treatment, care and support has been an unprecedented expansion of health-related collaboration. The heterogeneity of partners in the national HIV responses including the private sector as an important contributor has opened the gateway for exchange on very diverse governance and leadership practices. The private sector enjoys a high reputation with respect to many management competences needed for good governance and leadership in health. Still, this competence is seldom deployed in a public-private partnership. The following case study is an exception.

Fondation Sogebank: managing Global Fund grants as Principal Recipient in Haiti

Fondation Sogebank, the philanthropic foundation of the biggest banking group in Haiti, became Principal Recipient of a Global Fund HIV and AIDS grant in

2002 under funding Round 1. Fondation Sogebank managed this grant together with the United Nations Development Programme (UNDP). From Round 3 onwards Fondation Sogebank was selected as the sole Principal Recipient and administrator of Global Fund grants which now includes support for programmes fighting tuberculosis and malaria. “In every round we were selected by the Country Coordinating Mechanism after having gone through a competitive process with other applicants,” explains Dr. Emile Herald Charles, Chairman of Fondation Sogebank. “The Global Fund supports the engagement of companies as Principal Recipients,” says Patrik Silborn, Senior Partnership Officer of the Global Fund. “To date, Fondation Sogebank in Haiti and Shell Foundation in the Philippines are among the few private sector institutions who act as Principal Recipient of Global Fund resources. Depending on grant negotiations, more private sector institutions are anticipated to become Principal Recipient under funding Round 8: Anglogold Ashanti in Ghana, the Ghana Employer’s Federation and Access bank in Nigeria.”

The recent history of Haiti has been one of political instability creating conditions unfavourable to providing a strong system of public health care. The health infrastructure is insufficiently equipped to provide primary health care services to a population of approximately 9.5 million people. In response to this severe situation, financial commitments from the Global Fund in Rounds 1, 3, 5, 7 and 8 were used to provide prevention and treatment services for the three diseases HIV, TB and malaria; but funds were also spent on better salaries for health care providers, training, essential medicines and other measures needed to improve basic health care⁵³.

As a Principal Recipient, Fondation Sogebank carries a number of responsibilities. It supports sub-recipients in setting up their projects and action plans, pays out their fund allotments, procures drugs, commodities and products, monitors performance, validates data received from sub-recipients and compiles the reports for the Local Fund Agent and the Global Fund Secretariat. “The programmatic and financial monitoring as well as procurement are the biggest chunks in our work as Principal Recipient,” says Dr. Charles. He underlines that these are managerial functions. “The strategic orientation and regulation of the programmes are completely driven by the Ministry of Health, the AIDS Control Commission and the Country Coordinating Mechanism.”

⁵¹ WHO (2008) Toolkit for monitoring health systems strengthening: health systems governance, WHO, Geneva.

⁵² WHO (2008) Primary health care including health system strengthening – Report by the Secretariat to the Executive Board, 4th December 2008.

⁵³ Mukherjee JS (2003) HIV-1 care in resource-poor settings: a view from Haiti, in: *The Lancet*, Vol 362.



A health worker examines an HIV-infected child at a health centre in Port-Au-Prince, Haiti. Photo: PAHO/A. Waak

The various successful proposals submitted by Haiti to the Global Fund are being implemented by both nongovernmental organizations and government institutions, who act as sub-recipients. Innovative approaches are pursued in the country, such as adherence support by community members for patients on antiretroviral drugs⁵⁴ or integration of reproductive health services including family planning in centres for confidential voluntary HIV counselling and testing⁵⁵.

Representatives from the private sector in Haiti have welcomed the Global Fund funding model as it demonstrates that a private institution can assist and complement the government in the efficient

and rapid provision of services⁵⁶. But in a long-term perspective, such assistance has to be combined with increased capacity development of the public partner. Acknowledging this, Fondation Sogebank and the Ministry of Health have entered into an agreement on sharing knowledge and best practices. As the Chairman points out: “We are passing on all that we have learned in our role as Principal Recipient which allows us to create a progressive transfer of capacities to our public partner.” Equipped with sufficient skills and an experienced private partner on its side, the Ministry of Health will take up the role as Principal Recipient in August 2009 for a new Global Fund malaria grant approved under funding Round 8.

⁵⁴ Global Fund (2002) Summary of Haiti Global Fund proposal, Round 1, Global Fund, Geneva.

⁵⁵ UNAIDS (2008) Gateways to integration – a case study from Haiti, UNAIDS, Geneva.

⁵⁶ Inter-American Development Bank and Canadian International Development Agency (2005) The role of the private sector in rebuilding Haiti, Dialogue document from a roundtable, 9 – 10 Sept 2005 in Québec, Canada.

Part 3: Lessons learned and recommendations⁵⁷

Lessons learned from HIV-related Public-Private Partnerships and their efforts for health-system strengthening

The examples of HIV-related public-private partnerships cited/grouped under the six building blocks of a health system present several approaches to health-system strengthening. The experiences of private and public sector stakeholders sketch a picture of mutual appreciation; collaborations of both can enhance the role each of them plays in the health system. Public-private partnerships also enjoy a good reputation among bilateral and multilateral donors and support agencies. The question remains, how best such partnerships can be leveraged, which lessons can be learnt and which mistakes can be eluded.

Priority fields

While this document presents examples of HIV-related public-private partnerships from all building blocks of a health system, analysis of partnerships indicated that the greatest number of projects can be found in the area of service delivery due to a business interest of improving the health of employees through more and better services. Large and often cost-intensive public-private partnerships are also implemented in the building blocks concerning human resources and access to medical products and technologies because pharmaceutical and medical technology companies have an inherent interest in strong health markets and relevant expertise and resources to contribute to health system strengthening. The strongly emerging corporate social responsibility investment in mHealth projects also reflects the fertile marriage between social action and the core business of mobile technology companies. This coincides with a scientific finding that corporate social responsibility activities work best if they reinforce corporate strategy⁵⁸.

In contrast, the promotion of sustainable health financing via insurance models is a step-child of HIV-related public-private partnerships. With respect to health insurance, companies rather call for a broader range of options than putting efforts into creating them. External prompts are needed to evaluate the best role(s) of the private sector in this

respect and to define models of cooperation with the public system which could meet business interest.

At the same time the potential of the private sector for strengthening leadership, management and governance of the public sector is lying dormant, despite the often shared understanding that these competences are a special domain of company managers. Peer support may be an instrument that can be applied in a sensitive and diplomatic manner taking into account that public sector managers underlie very specific constraints and responsibilities. However, the benefit of such collaboration is difficult to translate into a business case.

The private sector sees the need for strengthening the public sector, but getting involved appears to be complex especially to those companies whose core competencies do not lie in health-related products. Managers are often pragmatic and interested in the business case. Often they prefer to look for discrete actions that can be managed internally and deliberately avoid becoming involved with the national health system.

Workplace programmes are the most common private sector HIV projects. Prevention activities and HIV education for workers supplement national prevention efforts. As soon as components of workplace programmes such as education or medical treatment reach out to community members, the contribution to the national system becomes obvious though not necessarily quantifiable. Yet, only few company managers think of their programmes in these terms. The perspective on health system strengthening is missing in many HIV-related activities. Adding this perspective would automatically lead to public-private partnerships because it calls for a dialogue with the national system at local or at national level.

Support needs

Development partners such as the International Labour Organization have taken the role of a broker and mediator between the public and private sectors, promoting dialogue and best utilization of mutual strengths. Other facilitators are national business coalitions and their supporting bodies on regional level such as the Asia-Pacific, the Caribbean, the

⁵⁷ These recommendations are derived from the consultations with government stakeholders, companies and development partners as well as from the research done by the consultants.

⁵⁸ Porter ME, and Kramer MR (2006) The link between competitive advantage and corporate social responsibility, in: Harvard Business Review, Dec 2006.

Arab and the Pan-African business coalitions. They have the mandate to advise businesses on the best responses to HIV. They are also the ones participating jointly with big multinational corporations in the international discussion on health system strengthening educating companies on options, opportunities and the relevant know-how. An exchange of good practices is as much needed as skills building of business coalitions.

According to private sector representatives the private partners would welcome a clear policy of the public sector towards collaboration with companies. Such a policy should include priority areas, expectations of the private contribution and a definition of the public contribution. Learning from earlier lessons, it should in addition look at sustainability issues, adherence to national standards, quality control, and supervision.

Similar to such a strategy, the private sector would appreciate guidance for setting up public-private partnerships. All stakeholders need more information on system-strengthening public-private partnerships and a definition of roles and responsibilities of the partners in such a partnership.

Mutual understanding

The interaction between the private and the public sector is often encumbered by the need for both parties to work in an environment of very different settings, procedures and ethics from those with which they are familiar. While the public sector is driven by slow bureaucratic procedures, politics and a long-term responsibility for the public good, the private sector can act more flexibly, faster and in a targeted manner. Often these diverse “cultures” stand like barriers in-between a fertile collaboration. They must be removed in close negotiation processes which require time and openness towards the partner. Almost all partners in public-private partnerships mentioned the slow start-up phase of their respective project.

In addition to patience and goodwill, the private sector also needs a better understanding of the stakeholders in a national system. Especially with respect to HIV numerous public and private service providers, nongovernmental organizations, donors and technical agencies form the ground on which a public-private partnership has to settle. Without a good introduction into this system, a business may not pursue a good idea for a partnership or may not partner as efficiently as possible.

For many of the bigger partnership projects it has been helpful to start with a small project to gain confidence of the partnering government. Starting

small also provides the opportunity to learn jointly while the project develops. Successful partnerships are an ideal tool to convince new governments of the value of project ideas. Peer visits are one way of promoting mutual learning.

Efficient partnership

Especially the public sector voted for an earlier collaboration between the private and the public partners in setting up a joint partnership. This seems central for tailoring a project according to private and public needs and for making use of respective strengths of both partners. They underlined the government insight into the system, the well trained specialists and the experiences with resource-limited settings.

The public sector naturally has a long-term perspective on all issues relating to national health but the private sector cannot guarantee a life-long involvement in an HIV or health programme. Possibilities and limitations concerning the duration of a partnership have to be transparently discussed among all partners. However, it is important to remember that time-limited partnerships such as a three-year project can make a meaningful contribution to a national response in an appropriate framework.

In other partnerships, mechanisms must be created that regulate the transfer of knowledge to local institutions and the follow-up of project achievements by national partners. Public institutions are predestinated to provide this kind of support. Public sector representatives pointed out that the public sector needs resources and capacities to ensure quality control and supervision.

Most private sector activities responding to HIV are isolated interventions which are monitored at company level without input in the national monitoring system. The UNGASS indicators cover private sector involvement. However, country reports mainly provide national achievements. A partnership framework makes it easier to integrate monitoring according to national procedures. Furthermore, businesses need technical support in this respect.

New topics

From the interviews several topics emerged requiring further promotion and technical backstopping.

- For strengthening health information systems the concept of mHealth is not yet widely known to government officials. mHealth applications are often met with suspicion and resentment despite their potential for facilitating national reporting.

- Insurance schemes are vital for financial sustainability of HIV and health projects. Successful approaches must be encouraged and supported.
- An upcoming challenge in universal access are second- and third-line therapy as well as treatment of multidrug resistant TB which creates technical demands and additional costs to companies. Technical support and financial solutions for companies providing treatment for employees, dependents and community members have to be provided.

Recommendations

Define the partnership surplus

Experiences presented in this report have shown that HIV-related public-private partnerships work best if they reconcile philanthropy with business strategy for the private partner and effort and systemic surplus for the public partner. In areas such as health financing or leadership support, these mutual benefits still have to be defined if stronger partnership action is to be achieved. Models must be developed that encourage private sector involvement and investment.

Identify gaps, new topics and matching partnerships

The UNAIDS Secretariat and its cosponsors can play a vital role in defining gaps that delay the achievement of universal access. If these gaps can be filled by a company's core competences, the headstone for a successful partnership is laid. UNAIDS cosponsors as well as other multinational organizations supporting the private sector should become active in advertising the demand for specific action and searching for matching partnerships between companies and governments. Medical and communication technology companies inhibit important potential for future public-private partnerships that should be revealed through systematic screening at country level. Corporations such as the mining or agricultural businesses operating in remote areas may be in a position to fill pressing health system gaps through their services.

Progress and development open up new opportunities and challenges for public-private partnerships in responding to HIV. UNAIDS should develop technical expertise on mHealth applications for HIV programmes taking into account risks and benefits requiring attention and advocacy. Furthermore, UNAIDS should provide guidance to companies

facing the financial challenge of MDR-TB and second- and third-line antiretroviral treatment. This also includes the pro-active search for and facilitation of potential partnerships targeting insurance solutions.

Integrate health system thinking in HIV-related partnerships

The private sector should be guided to apply a health system perspective to all HIV and health-related projects. This perspective may not lead to further action with respect to health system strengthening, but it will promote a better understanding of the project context and potential areas of cooperation. The UNAIDS Secretariat and its cosponsors should sensitize national and regional business coalitions as well as multinational and bilateral technical support agencies and enable them to provide this guidance. As mediators, supportive institutions should nurture the public-private information exchange at country level with support of UNAIDS.

Facilitate policy development for public-private partnerships

It is helpful for emerging public-private partnerships if both partners can transparently define their expectations and contributions. Companies proposing a partnership usually have their concept clear. The UNAIDS Secretariat and its cosponsors should support national governments in setting parameters and cornerstones for HIV-related collaboration with businesses. This should involve national business coalitions as brokers and promoters of public-private partnerships in the private sector.

Initiate early public-private dialogue

Companies willing to commit themselves to a system strengthening HIV-project should actively seek the discussion with the public partner. Support may be needed with respect to a better understanding of the national system and an analysis of potential stakeholders and interfaces. With several activities at country level the UNAIDS Secretariat and its cosponsors can strengthen this process:

- workshops for the private sector at national level about the HIV- and health-related landscape in a respective country;
- exchange forums between the private and the public sector;
- publication of good practices; and
- peer learning of exemplary system-strengthening public-private partnerships

Promote supervision and long-term support

In a public-private partnership, in a long-term perspective public institutions are likely to be the more permanent partners. The follow-up of a project therefore often falls under their domain unless nongovernmental organizations can take over some of these tasks. Planning for sustainability and follow-up must be part of the conception phase including the provision of resources and capacities. UNAIDS' cosponsors as well as other support agencies should promote and facilitate this process in a partnership. In addition, they should facilitate the networking between national stakeholders for an optimal staging of long-term support.

Enhance private sector monitoring

Sound systems have been set up at country level for monitoring HIV- and health-related progress. The private sector contribution is still insufficiently presented in these monitoring processes. The UNAIDS Secretariat should provide further guidance to the private sector on monitoring according to UNGASS. In this respect, it will also be helpful to strengthen the respective capacities of national and regional business coalitions as well as other supportive agencies.

UNAIDS is an innovative joint venture of the United Nations, bringing together the efforts and resources of the UNAIDS Secretariat and ten UN system organizations in the AIDS response. The Secretariat headquarters is in Geneva, Switzerland—with staff on the ground in more than 80 countries. The Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Contributing to achieving global commitments to universal access to comprehensive interventions for HIV prevention, treatment, care and support is the number one priority for UNAIDS. Visit the UNAIDS website at www.unaids.org



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