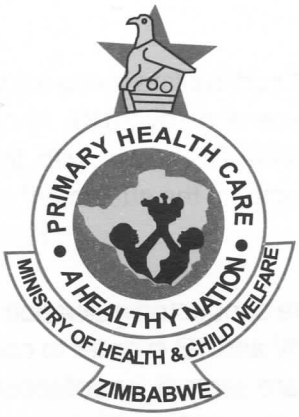
SITUATION ANALYSIS OF PUBLIC - PRIVATE PARTNERSHIPS FOR THE PROVISION OF HIV, AIDS AND TB SERVICES IN ZIMBABWE, 2010



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Foreword

The Zimbabwe Ministry of Health and Child Welfare made a commitment towards universal access to HIV prevention treatment and care services by 2015. All of this demands intensification of the multisectoral national response to HIV/AIDS. It is with this realisation that the Government recognises the critical role of private sector in the attainment of this goal as outlined in the National Health Strategy (2009 - 2013).

The Ministry of Health and Child Welfare conducted a situation analysis to assess the state of public private partnerships with respect to HIV and TB in order to come up with a strategic framework to guide actors from the public and private sectors for collaboration towards universal access. The ministry believes that under its guidance, partnerships are going to be further strengthened to achieve more results.

Brigadier General (Dr) G Gwinji
SECRETARY: HEALTH AND CHILD WELFARE

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Acknowledgements

The Ministry of Health and Child Welfare would like to extend its gratitude to all who participated in the assessment of the public-private partnerships for HIV and TB in Zimbabwe. This report would not have been complete without the full participation of all the different stake-holders in the country including those from the public and private sectors. The situation analysis was instrumental in informing the development of the Strategic Framework for PPPs in HIV and AIDS and TB. Special appreciation goes to Dr. G. Shambira and Dr. T. Bwakura for carrying out the assessment on behalf of the MOHCW.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Anti-retroviral
ASO	AIDS Service Organization
CME	Continuing Medical Education
HIV	Human Immunodeficiency Virus
HCT	HIV Counseling and Testing
ILO	International Labour Organization
M&E	Monitoring and Evaluation
NGO	Non-governmental Organization
OI	Opportunistic Infection
PLHIV	People Living with HIV
SADC	Southern Africa Development Community
STI	Sexually Transmitted Infection
UNAIDS	Joint UN Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZIMA	Zimbabwe Medical Association

Glossary of Terms

The definitions below have been derived from existing publications by the ILO, WHO, UNAIDS and National Policy Documents on HIV and AIDS.

AIDS: Acquired Immune Deficiency Syndrome. A cluster of medical conditions often referred to as opportunistic infections and cancers.

ARV: Anti Retroviral. Medicines used to treat HIV and AIDS.

ART: Anti Retroviral Therapy. A term used to describe the treatment of HIV and AIDS. ART is what is called a 'holistic' treatment, which not only involves taking ARV drugs, but understanding HIV, AIDS and ART, preparing for and adhering to ARV regimens, ensuring proper nutrition, psychosocial support, palliative care and caring for the carers of PLWHA.

Employer: A person or organization employing workers under a written or verbal contract of employment, which establishes the rights and duties of both parties, in accordance with national law and practice. Governments, public authorities, private enterprises and individuals may be employers.

Gender: Refers to difference in social roles and relations between men and women. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are affected by age, class, race, ethnicity and religion, and by geographical, economic, cultural and political environments.

Opportunistic Infections or OIs: Infections that take the 'opportunity' of the weakened immune system caused by HIV to make a person sick

Private Sector: The part of a nation's economy which is not controlled by the government which may be for or not for profit

Public Private Partnerships: collaborative endeavors that combine resources from the public sector with resources from the private sector to accomplish set goals

Screening: Measures to assess the HIV status of individuals, whether direct (HIV testing) or indirect (such as assessment of risk-taking behaviour, asking questions about medication).
Sexually Transmitted Infection (STI): Infections that are transmitted through sexual contact such as syphilis, cancroids, Chlamydia and gonorrhea. HIV is also classified as an STI.

Wellness programmes: Workplace wellness programs are recognized by more and more companies for their value in improving health and well-being of their employees. They are part of a company's health and safety program. Wellness programs are designed to improve employee morale, loyalty and productivity and can cover nutrition, weight or stress management training, health risk assessments, health screenings and HIV and AIDS prevention.

Workplace: All places where workers perform their activity

Executive Summary

Introduction

In order to meet demand for quality services and to achieve the Millennium Development Goals on health, there is need to identify opportunities for collaboration and sharing of the burden in a multi-sectoral approach. Public-private partnerships (PPPs) provide one such opportunity. Through innovative strategies, strategic partnerships can help to address the challenges of service provision, finding solutions to the human resource crisis, and sustainable health financing and information systems for universal access. It is within this context that a situation analysis was conducted.

Objectives

The purpose of the study was to assess the state of public-private partnerships with respect to HIV and TB. The analysis sought to identify existing strengths and opportunities for public-private collaboration and weaknesses and threats that could hinder effective partnerships.

Methodology

A descriptive cross sectional study was undertaken among purposively selected institutions and key informants in the various economic sectors as well as the public sector. The data collection process consisted of review of relevant documents including policy guidelines, frameworks, key operational documents, key informant and service provider interviews. A total of ninety informants from different sectors were interviewed. Two PPP Consultative stakeholder workshops provided an additional platform for input and validation of the findings.

Findings

- There are a number of governance and legislative structures that regulate the operations of the private sector with respect to HIV and TB. However of the seven institutions assessed, five operate mostly informally with no written agreements or Memorandum of Understanding (MOU) which poses a threat to sustainability and commitment.
- The Health Professions Authority has the mandate to uphold and promote high standards for the health care delivery system through various health professional bodies. However the authority faces constraints in effectively monitoring standards at health institutions.
- The Medicines Control Authority of Zimbabwe (MCAZ) and the National Drugs and Therapeutics Policy Advisory Council (NDTPAC) promote alignment to standardized treatment protocols, robust data and close monitoring of treatment outcomes.
- The analysis showed that Zimbabwe has a large private sector with over a 1000 registered health institutions that contribute significantly to health service delivery. Service providers range from large corporate entities in different economic sectors to sole traders such as general practitioners.
- Most private sector service providers sampled expressed their willingness to participate in a well structured PPP programme. However, minimal flow of information between the public and private sectors and lack of coordination in training activities threaten the establishment and sustainability of PPPs.
- Commitment to address HIV and AIDS as a critical workplace issue exists in the private sector. This is demonstrated through the existence of many policies, strategies and workplace programmes in existence.
- Zimbabwe has relatively well established and decentralized health insurance schemes, one

of which has strong public sector membership. This provides an opportunity for possible PPP fund administration in conjunction with the mooted National Health Insurance scheme in the long term.

Conclusion

The informal PPPs in Zimbabwe for both the TB and HIV programmes can form a basis from which to build a PPP framework. There are numerous documented cases of PPPs that Zimbabwe can learn from and further refine this framework. The private sector is willing to support efforts by the public sector in delivering care and treatment for TB/HIV patients. However, there are no clear guidelines on how these PPPs can mutually benefit all parties involved.

Recommendations

- There is need to develop a public-private partnership framework that will guide the implementation of PPPs in strengthening TB/HIV programmes.
- The MOHCW should lead the process in reconstituting the National PPP steering committee to spearhead the establishment, coordination, management and monitoring of PPPs with an initial focus on HIV and TB management.
- The PPP unit within MOHCW should be strengthened to lead dialogue with stakeholders in creating effective PPPs through adoption of standard MOUs.
- Training on ART, PMTCT, HTC and TB should be extended and well coordinated to include the private sector.
- It is important for the Health Information Unit and AIDS & TB Unit (MOHCW) to engage the private sector to develop mechanisms to strengthen reporting on HIV and TB data from the private sector e.g. adaptation of recording and reporting tools, training, feedback mechanisms.
- In the long term the scope of PPPs should be expanded to include components beyond HIV and TB such as non-communicable diseases.

1. INTRODUCTION

Zimbabwe is currently facing an HIV epidemic of enormous proportions. The national HIV and AIDS Estimates Working Group estimated HIV prevalence among persons aged 15-49 years at 13.6% (2009/2010).1 However it is expected that the rate of decline will decrease as more and more people survive as treatment programmes are scaled up. Following the revision of National ART guidelines in line with the revised 2010 WHO recommendations of commencement of ART at a CD4 count of ≤350, it is estimated that 593 168 people are now in need of ART. By December 2010, approximately 326 000 people were accessing treatment from mostly the public sector. It has been a challenge to have accurate ART data from the private sector primarily due to poor flow of data from most of the private HIV care providers to the national M&E system.

Zimbabwe is one of the 22 Tuberculosis (TB) High Burdened Countries in the world. The HIV pandemic presents a particular challenge to the control of tuberculosis. In 2010, the country reported 47688 cases of tuberculosis with a case notification rate of 379 cases per 100 000 population for all TB cases. Sputum positive cases were 11 685 with a case notification rate of 93 cases per 100 000 population for sputum positive cases. 75% of all TB patients were dually infected with HIV. Treatment success rate for the 2009 cohort was 78% with a death rate of 8%.

Within the world of work, no sector is spared from the ravages of the dual epidemic. HIV and TB affect the most productive segment of the labour force and impose huge costs on economic development in all sectors through declining productivity. At the enterprise level, HIV and AIDS cause huge costs due to increased labour costs and loss of skills and experience as workers succumb to diseases and deaths due to AIDS. This results in businesses realizing reduced profit margins due to increased expenditure relating to health, disability, pension and death benefits. Effectively addressing HIV and TB is thus a business priority affecting the bottom line.

The public health sector is already overburdened despite increasing effort for an expanded response. Low coverage, limited capacity and poor access to services remain major challenges for the health sector. The rural populations, peri- urban and remote areas are often the most affected. Even in the urban areas with better proximity to services, the demand for services far exceeds the supply. This calls for strengthened public- private partnerships and collaboration to build on each other's comparative advantage to increase access to services and address the complex needs of people infected and affected by HIV and AIDS and Tuberculosis.

There is political commitment to provide Universal Access to an essential package of HIV and TB prevention, treatment, care and support services by 2015. However resources to achieve these targets are insufficient. A rapid scale up of health sector responses to HIV and AIDS is therefore required through public health approaches that can be replicated and decentralized to the primary care level for extending coverage. During the end-term review of the National OI/ART Programme in 2008 it was observed that there was little documented involvement of the private sector in the National ART programme with no policy or guidelines on PPPs. Practical strategies are therefore needed to engage and support non-state providers to participate more formally in health delivery in the country.

Public-Private Partnerships are voluntary and collaborative relationships among state and non-state actors normally characterized by a formalized agreement, (Memorandum of Understanding)

with mutual objectives and contributions (UNAIDS).3 The non-state actors include for-profit organizations, their representative bodies and foundations including:

- Large companies(local and multinational)
- Small and Medium Enterprises
- Business coalitions
- Employer organizations and private sector employee organizations
- Informal sector
- Charitable foundations established to provide donations and grants
- Private practitioners
- Private for-profit clinics/hospitals

Public-private partnerships help in various ways by developing innovative strategies in responding to the challenges of health service provision, finding solutions to the human resource crisis, contributing to sustainable health financing and information systems for Universal Access. According to UNAIDS best practice analysis (UNAIDS 2009), effective partnerships remain fundamental to successful and sustainable HIV responses. Partnerships give voice to those infected and affected by HIV, act as a catalytic force for a change agenda, and provide accountability for new and innovative ways of working within different kinds of partnerships. The analysis also showed that HIV-related public-private partnerships work best if they combine philanthropy with business strategy.

A key driver and motivation for private sector partnership with the public sector is the potential to share risks and rewards. Successful partnerships require support and sustained interest and motivation. Development partners have often helped to articulate expectations, sustainability issues, regulatory mechanisms, national standards and quality control issues, supervisory mechanisms and roles and responsibilities of partnerships.

2. OBJECTIVES AND METHODOLOGY

The purpose of the situation analysis was to document current status of HIV and TB services within the public and private sectors with the view to develop a long term strategic framework to guide the implementation and strengthening of partnerships for the national HIV and TB responses. This assessment also sought to identify scale up options for HIV and TB service provision.

2.1 OBJECTIVES

The broad objective of the situation analysis was to assess the state of public-private collaboration in HIV and TB prevention, care, and treatment and support services in Zimbabwe. The specific objectives were:

1. To assess the current regulatory framework governing public-private sector collaboration in the provision of HIVand TB services
2. To assess perceptions regarding usefulness and need for public-private partnerships for HIVand TB services among policy-makers and implementers in both public and private sectors
3. To assess the extent of implementation of HIVand TB workplace programmes in private sector organizations and document best practices
4. To understand the motivating factors (financial and/or non-financial) for private providers to provide HIVand TB services to the public
5. To identify private sector strengths and opportunities in HIVandTB services with respect to leadership, human resource, service delivery, health information, supply chain management, financing and technologies.
6. To identify possible threats to public-private sector collaboration in the provision of HIVandTB services in Zimbabwe
7. To make recommendations which will guide the development of a strategic framework for public-private partnerships in the provision of HIVand TB services in Zimbabwe

2.2 DESIGN, DATA COLLECTION AND ANALYSIS

A descriptive cross-sectional study was conducted to assess the extent and nature of collaborations between private, public and civil society sectors in the provision of HIV and AIDS and TB services in the country. The study was guided by the WHO six pillars of health systems strengthening:4

- Human resources
- Service delivery
- Supply chain management
- Health information systems
- Financing
- Governance and leadership

Purposive sampling methodology was used to identify the study population ensuring that all relevant sectors were represented and best practices documented. Snowballing methodology was used to identify additional key informants and critical case sampling was used to identify best practices in PPP. Attempts were made to ensure a representative nationwide sample. It should be noted that when purposive sampling is used findings may not be generalizable.

The survey was carried out in the cities of Harare, Bulawayo, Mutare, Masvingo and Gweru including the Provincial Medical Directorates of Manicaland, Matabeleland North and Masvingo. The Informants included policy makers, service providers and beneficiaries from different sectors which included MOHCW, Health Funders, Business, Multilateral Partners, Civil Society, PLHIV and Service providers. Consultations with groups of General Practitioners were held in Harare, Mutare, Bulawayo and Gweru. Retail pharmacies participated in this assessment.

The data collection process consisted of review of relevant documents including policy guidelines, frameworks and key operational documents. These were reviewed to provide background information, define policy direction rules and regulations as well as document best practices from Zimbabwe, the SADC region and internationally. Key informant and service providers were interviewed using structured questionnaires. A research team was trained for proficiency in using the tools. Consistency and quality in the use of the tools was assured by the three consultants who were the team leaders in the field. Two PPP Consultative stakeholder workshops provided an additional platform for input and validation of the findings.

Quantitative data was analyzed using EPI info software to generate proportions and means. Qualitative data was analyzed manually for content guided by the six pillars of health systems strengthening.

3. FINDINGS

A total of ninety informants from different sectors which included MOHCW, Health Funders, Business, Multilateral Partners, Civil Society, PLHIV and Service providers were interviewed. Consultations with groups of General Practitioners were held in Harare,Mutare, Bulawayo and Gweru. Fifty three retail pharmacies participated in this assessment. Two PPP Consultative stakeholder workshops provided an additional platform for input and validation of the findings

Table 1 summarizes the study participants by sector and location

Province/City	Health Funders	Policy Makers	Business	Service providers	Others(partners, civil society)
Harare	9	16	15	12	14
Bulawayo		1	1	4	
Matabeleland North		1	1	2	
Mutare		1		7	
Midlands			2	2	
Masvingo		1		5	

3.1 GOVERNANCE AND LEADERSHIP

3.1.1 Policy and Regulatory Environment

The MOHCW in consultation with relevant stakeholders is responsible for formulation, coordination and implementation of national health policy. One of the objectives under goal 33 of the National Health Strategy (2009-2013) is "To increase and strengthen private sector involvement in the health sector" which includes the development of a system to coordinate the operations of the public and private sectors. 5

The private sector is organized into groups of professions such as the Zimbabwe Medical Association, Pharmacist Council of Zimbabwe, and Laboratory Association etc. These organizations represent the interests of particular professional groups and have limited formal linkages between themselves and the public sector. These organizations however can provide an excellent platform for more coordinated formal engagement with the private sector. They provide an opportunity for provision of training on HIV and TB so that management is standardized according to national guidelines.

The Health Professions Authority of Zimbabwe, which was established by the Health Professions Act (Chapter 27:19) has the mandate to uphold and promote high standards for the health care delivery system in Zimbabwe including ethical and professional services by members in the public, private and civil society sectors. However the authority currently has limited capacity in terms of

human and material resources to carry out this role effectively. There is also overlap and duplication of regulatory roles with local authorities which practitioners reported as an additional financial burden.6

Government has enacted legislation that governs the conduct of employers with respect to HIV and AIDS creates a platform whereby the public and private sector can collaborate in ensuring compliance. Statutory instrument 202 of 1998 directs employers to provide workplace education on HIV and AIDS. HIV policies have been developed for the different sectors with differing levels in terms of implementation. While the public sector remains the overseer of the entire health system its operational role in public-private collaboration lacks comprehensive guidelines. The Plan for the Nationwide Provision of ART 2008-2012 has a clear strategic objective to strengthen PPPs to facilitate OI/ART services. The objective includes among others advocacy, encouraging incorporation of ART in all medical aid insurance benefits, strengthening and expanding workplace AIDS treatment programs, and creating mechanisms for continued M&E.

Although policy makers are unanimous on the need for the private sector to report on HIV/AIDS and TB to the MOHCW, mechanisms for facilitating this are lacking on the ground. Reporting is generally left to the initiative of individual service providers. This means that information on HIV and TB from the private sector is unrepresentative of the situation prevailing. This undermines the planning process with respect to the needs and challenges of the private sector. There is therefore need to review and establish mechanisms that facilitate reporting. The scope of practice, of health workers need reviewing in line with current disease burden. For example the current scope of practice for nurses does not have provision for ART initiation. This has limited decentralization efforts to make ART accessible to patients. This has also affected those private companies that only employ nurses who cannot initiate ART at these workplaces and refer to the public sector. This leads to further congestion at the already overburdened facilities. Efforts have been made to review the scope of work. Findings from a feasibility assessment of Nurse–led ART recommended the MOHCW to adopt this approach.7

The Public Health Act (Chapter 15:09s19) has provisions which allows the Minister to make regulations/prescriptions on notification of notifiable diseases (TB included). However HIV is not a notifiable disease according to the Public Health Act and there are no strict requirements for practitioners to report on it. It is envisaged that revision of the Public health Act will enable the private sector to report on a regular basis on priority public health problems which include HIV and TB

The National TB policy espouses a strategy of engaging all care providers though public-public and public-private mix approaches. The four key guiding principles of the TB policy are:

- Sputum microscopy for diagnosis and follow up provided free of charge.
- Short-course chemotherapy provided free of charge in the public health sector.
- TB services available at all levels of the health delivery system, being integrated into the primary health care system to ensure efficient case finding, particularly for sputum smear positive patients.
- Collaborative TB/HIV activities at all levels

The National TB policy document mentions the need to explore ways of collaborating with the private sector with roles ranging from referral of suspects, shared patient management and to implementation of DOTS by both sole practitioners and institutional private providers. The policy

also spells out the role of the public sector in diagnosis and treatment of TB. The treatment role is outlined mainly for the larger private institutions who may obtain TB medicines from the National Pharmaceutical Company of Zimbabwe (Natpharm). The role of private for profit hospitals in TB treatment is minimally elucidated in that these institutions should only be provided a limited supply of drugs from a public facility. Reporting requirements are mentioned but not elaborated. While the policy does not address the issue of involvement of the private sector in TB detection and treatment, it encourages the private sector to be involved in HIV/TB collaborative activities at Community, primary care, secondary and tertiary levels. 8

The integration of HIV and AIDS and TB services will, if implemented at central level and replicated up to facility level, help push the agenda of universal access. Guidelines for integrating these services are expected to increase access to these services in the private sector as well.
The National TB guidelines highlight the need for training health workers from the private sector and the certification of some of these facilities for TB treatment. However there are no indicators to measure the implementation of this part of the strategy.7 The challenge therefore is to balance regulations and policies aimed at quality control while simultaneously creating market conditions conducive to private sector participation.

3.1.2 Medicines Control

The mandate of the Medicines Control Authority of Zimbabwe (MCAZ) is to ensure the availability of safe, effective and good quality medicines and medical equipment and supplies on the Zimbabwean market. MCAZ has managed to regulate the manufacture, importation, distribution, storage, and sale and to some extent post marketing surveillance of medicines. Operations have been negatively affected by high staff turnover, inadequate funding and shortage of equipment. The issue of regulating quality and safety use of TB and ARVs is also paramount in these partnerships to prevent use of poor quality medicines, emergence of drug resistance and inappropriate prescribing and dispensing practices. Activities of the MCAZ and the National Drugs and Therapeutics Policy Advisory Council(NDTPAC) has promoted alignment to standardized treatment protocols in both public and private sectors.A robust MCAZ presents an opportunity for increasing the local manufacture of ARVs, antibiotics, TB drugs and other commodities under closely regulated conditions. This will in the long term reduce costs associated with the importation of these commodities and ensure that ART and TB programmes remain viable.

3.1.3 The National Strategic Framework for the Private Sector

The development of the Zimbabwe National Strategic Framework for the Private Sector Response to HIV and AIDS (2007- 2010) is an indicator of the private sector and organized labour's appreciation of the gravity of the situation and willingness to take a proactive response within the national multi-sectoral approach. The framework followed a situation analysis and stakeholder consultations led by the key stakeholders, employers' and workers' representatives, government, civil society NAC, UNAIDS and the ILO. It was recommended that the private sector response needed to be scaled up, and coordination strengthened. 10As a response, several sectors, sub-sectors and private sector organizations have developed and started implementing HIV workplace policies and programmes. Sector wide policies have been developed for agriculture, textile, mining, transport, energy, motor industry and Small and Medium Enterprises (SMEs).

The strategy however lacks clear guidelines on how to increase engagement with the public sector. Limited capacity to coordinate the private sector response to HIV and AIDS remains evident. While the strategic document spells out the formation of the Private Sector HIV and AIDS partnership

forum this has not taken place. This forum was envisaged to be representative of various stakeholders including labour, employers, civil society and specific sector interests. While the Employers' Confederation of Zimbabwe (EMCOZ) and the Zimbabwe Congress of Trade Unions (ZCTU) have the largest membership of the constituents and are implementing HIV/AIDS programmes, they still have to work closely with other private sector stakeholders to come up with a coordinating mechanism that brings all world of work together nationally.

The lack of a single coordinating body has hindered effective implementation of the national private sector strategic framework leading to limited visibility and participation of the private sector in the national response to HIV and AIDS. This may be due to competing interests and duplication of efforts. It was reported that if reconstituted, given resources and mandated to play a coordinating role, the Zimbabwe Business Council on HIV and AIDS (ZBCA) could take on the coordination role for the private sector response. Currently ZBCA coordinates a membership of thirty, mostly the large business corporates in the country.

However, despite these weaknesses the private sector continues to contribute significantly to the national HIV/AIDS TB response. The existence of a strategic framework presents an opportunity for the MOHCW to engage the private sector more effectively.

3.1.4. Role of Civil Society

Civil society has recently been more actively involved in the formulation of national strategies for HIV and AIDS including collaboration with the TB programme. Civil society plays a critical role in advocating for Universal Access to services through community mobilization and increasing demand for services and actual service provision. While the role of civil society in public- private partnerships needs to be clearly defined, partnerships already exist. A number of private companies are already collaborating with the NGO members of Zimbabwe AIDS Network (ZAN) for technical support in training and peer education. However significant gaps in linkages with ZAN membership and service providers in both public and private sector means that there are missed opportunities for delivery of services on HIV and AIDS.11 Limited linkages between some civil society organizations and public institutions exist but are mostly informal with no official agreements. The formalization of these arrangements and improved coordination will strengthen resource mobilization complementing government efforts towards Universal Access and help ensure equity in terms of national coverage.

Zimbabwe National Network of People Living with HIV and AIDS (ZNPP+) was founded in 1992 and officially registered as a non-governmental organization in 1999. The current membership is 50, 000 people. ZNPP+ represents and coordinates the interests and activities of support groups and PLHIV throughout the country. It promotes empowerment of PLHIV through skills development, counseling and education by lobbying for the rights of PLHIV.The major strength of this organization is the structure which starts from village level and extends up to national level. This means that the organization has capacity to participate in follow up of patients, resource mobilization and to effect widespread behavior change. PLHIV still face barriers to care which include unaffordable user fees at point of care, drug shortages, and stigmatization at workplaces and society at large. While policies to counter discrimination exist, advocacy, education and awareness remains a critical strategy. The inclusion of ZNPP+ as a recipient of funding under Global Fund Round 8 has increased the capacity of the organization to reach the grassroots. The MOHCW is likely to benefit by continuing to engage this organization especially in patient tracking and identifying those who need services.

3.2 SERVICE DELIVERY

Strong public partnerships have emerged with examples of Hippo Valley/ Triangle Hospital, Hwange Colliery and many church related hospitals that currently act as de facto district and rural hospitals. Together the key stakeholders had participated in the Global Fund processes that secured Global Fund Round 8 resources for private sector responses.

Zimbabwe has a relatively vibrant private sector providing essential services which include HIV and TB. Clinical health service providers range from individual practitioners, group practices, workplace clinics/hospitals and private hospitals. The other providers such as pharmacies and laboratories are either sole traders or part of health insurance schemes with units that provide specific services in addition to their medical insurance core business.

3.2.1 Private Health Institutions in Zimbabwe

Zimbabwe has a large private sector which contributes significantly to health service delivery. The Health Professions Authority maintains a register of both public and private health institutions in the country. Table 1 shows the numbers of registered health institutions of relevance to HIV and TB by category as at December 2010. The number of health facilities in table 1 is probably an underestimate as there are more facilities which may not be currently registered. The special clinics comprise mostly New Start Centres that offer HIV counseling and testing (they have more recently expanded their services to include point of care CD4 testing, TB diagnosis and clinical services); family planning clinics and those that offer palliative care. There is potential to incorporate these institutions in PPPs in order to provide Universal Access in a holistic manner.

Table 1. Number of private medical institutions by category, 2010

Category	Number
Medical practitioner consulting rooms	400
Pharmacies	225
Mine clinics	57
Industrial Clinics	112
Medical Laboratories	90
Nursing Homes	35
Agricultural Estate Clinics	10
Radiology Services	43
Special Clinics	51

Most PPPs identified operate informally without written agreements or Memorandum of Understanding (MOU). The partnership arrangements tended to be reached at a local level on the basis of a "gentleman's agreement". However, although these arrangements can be effective with mutual benefits in the short term, they are not usually sustainable owing to staff mobility and lack of a legal framework.

The following examples illustrate the existence of these collaborations.

- **At Mutare General Hospital the hospital executive has entered into an informal agreement which allows the hospital pharmacy to dispense anti-retroviral drugs to patients presenting prescriptions given by private practitioners within the city. This was described as helping to decongest the OI clinic at the hospital as patients receive ART preparation with their service providers from the private sector. This method should be considered for expansion to other centres in the country as it seems to be operating smoothly.**
- **Zimasco in Shurugwi was accredited as an ART Clinic in July 2010 and is involved in the District AIDS Action Committee (DAAC) activities. They managed to access test kits for HIV and malaria from the public health system; however, they had not secured ARVs yet from the national pool. The company management expressed willingness to extend their services to the surrounding communities provided they received ARVs from Natpharm. A similar arrangement also exists at Zimplats clinic in Selous collaborating with Chegutu district hospital.**

All private sector providers surveyed expressed willingness to participate in PPPs in one form or another and explore ways to extend services to surrounding communities provided support is provided e.g. in the form of medicines, IEC materials and training. Experiences from Botswana where a partnership comprising government, private practitioners and an established health insurance firm managed to transfer 4500 patients to the private sector within two years provides a learning opportunity. It is estimated that this cooperation reduced the immediate need for recruiting up to 40 medically qualified staff into the public sector. 12There is need to exploit and leverage opportunities; formalize existing and future partnership arrangements in order to improve HIV and TB service provision.

3.2.2 Medical Laboratories

Zimbabwe has approximately 120 registered medical laboratories of which more than half are situated in Harare and Chitungwiza. These consist of large laboratories which are independent, operated by large medical aid societies, research institutions and small individual laboratory practices. The Medical Laboratory and Clinical Scientists council of Zimbabwe has the mandate to regulate, control and supervise the training, registration and issuance of practicing certificates. It collaborates with stakeholders from the public and private sectors to ensure adherence to acceptable standards. The Zimbabwe National Quality Assurance Programme (ZINQAP) provides comprehensive proficiency testing to assist medical laboratories assess and improve performance in all major laboratory disciplines. ZINQAP has also developed a program to support HIV and AIDS testing in medical laboratories and non-traditional testing sites such as VCT, PITC and PMTCT. One major challenge faced by this programme is limited financial resources by laboratories to participate in proficiency testing. It is also not mandatory for laboratories to participate in external quality assurance practices. However, ZINQAP remains vital in quality assurance especially for private laboratories which will be engaged in PPPs.

Private medical laboratories complement the public sector in the provision of HIV diagnostics as well as sputum microscopy for TB Diagnostic capacity limitations within the public sector has seen private laboratories playing a greater role. For example the city of Harare reported that 40% of the TB cases are diagnosed in the private sector. There was an interest for partnerships at agreed tariffs, and expanding collaboration in areas such as mentoring laboratory scientists, provision of

advanced diagnostics while reporting to the MOHCW. Private laboratories face challenges of shortages of qualified staff and lack of working capital to procure modern equipment and laboratory reagents. There is potential to increase capacity utilization in this sector and further collaboration with the public sector towards enhancing HIV and TB diagnostics.

3.2.3 Faith Based Organizations

The Zimbabwe Association of Church related Hospitals (ZACH) which was founded in 1974 caters for approximately 68% of the bed-occupancy in rural areas and 35% of bed occupancy in the country. It therefore plays a significant role in the provision of health care services. The association has a comprehensive HIV and TB programme which is aligned to the national policies and strategies and supports member institutions to develop strategies for mitigating the pandemic especially in rural and marginalized communities. Although mission hospitals are privately owned, in essence they function as public sector facilities with some of them designated as district hospitals. They receive support from the central government e.g. staff salaries, equipment, medicines, training and mentorship. This demonstrates a successful partnership model between public and private (not-for profit) organizations.

3.2.4 TB Case Management in the Private Sector

Most private medical care is available on a fee for service basis, either out of pocket or with the support of medical insurance companies. The private health sector supports the NTP mainly in the diagnosis of TB and referral of diagnosed cases to government or designated health facilities for notification and treatment. The private not-for profit organizations (e.g. ZAN affiliated organizations) work mainly in the community on advocacy, treatment literacy and support. Some large corporations such as Triangle, Hwange, Zimasco and Zimplats have developed company-based TB control programmes using the DOTS strategy in accordance with the national guidelines and are benefiting from the medicines and diagnostics provided by the national programme. These however remain ad hoc arrangements and exclude a number of other workplace medical facilities with the potential to provide DOTS.

Some challenges were noted in the provision of TB services in the private sector:

- Following diagnosis the private patients who seek to continue care with their practitioners cannot do so as they have to obtain TB medicines from the public sector
- Reluctance by private patients, who can afford paying for service, to be referred to public institutions as these are often congested and perceived as lacking privacy
- Stock outs of TB medicines
- Lack of involvement for participation in TB case management training workshops
- Private sector is often perceived to be self-sufficient and overlooked in the allocation of resources for TB

3.3 HUMAN RESOURCES

According to the Human Resources Department (MOHCW) report in December 2008 the vacancy levels in the public health sector were 69 percent for doctors, 80 percent for nursing midwives, 61 percent for environmental health technicians and 63 percent for medical school lecturers. By end of 2010 the staffing situation had improved with vacancy levels for doctors at 52% and that of nurses in general at 8%.13This may be partially attributed to adoption of the multi-currency system,

improved economic performance and introduction of the human resource retention scheme for the health sector. Of note is that there has been no review of staff establishment since 2000 in line with population growth and changing disease burden. The staffing levels in the bigger private sector service providers such as Hippo Valley, Hwange Colliery and Zimasco are now satisfactory with most hospitals currently having a full complement of medical doctors and nurses.

3.3.1 Opportunistic Infections Clinics in the public sector

The ART programme in Zimbabwe has been expanding rapidly since its inception in 2004. This has happened despite major resource constraints. The eight health institutions visited demonstrated considerable progress in HIV care and ART service provision including decentralization of care and patient follow up. There were no reported stock outs of ARVs and HIV-related commodities at the visited sites. However, sites continued to experience challenges including increasing work load, shortage of staff; congestion with limited space for counseling and consultation; frequent break down of equipment and limited laboratory supplies and consumables. This compromises quality of services, infection control particularly TB and confidentiality for clients. It was noted that programmes such as the Expanded Support programme (ESP), Vital Health Services Support programme (VHSSP) and GFTAM had significantly improved service delivery and staff retention particularly in the rural areas. Allowing patients to receive HIV care from accredited private medical practitioners, workplace clinics and private health facilities including accredited private pharmacies may reduce workload at public clinics, improve access and help reduce the defaulter rate.

3.3.2 Private Medical Practitioners

Most private medical practitioners offer HIV treatment and care services which include direct provision or referral for VCT, PITC, Cotrimoxazole prophylaxis, ART and treatment for opportunistic infections, and PMTCT. They reported a steady increase in clients seeking care and being initiated on ART thus complementing government efforts towards Universal Access. On site testing for HIV was generally not provided by most individual practitioners. However most practitioners indicated that they can readily provide onsite counseling and testing if they are provided with training and test kits. Their role in TB case management is limited to diagnosis and referral to public sector facilities for treatment and follow up. Capacity utilization among sampled private general practitioners ranged from 25-50%. One private practitioner reported that "Doctors have lots of free-time and can do work in the public sector if things are organized well". This presents an opportunity for a structured involvement of private practitioners to offer their services at public health institutions.

Major challenges faced in providing the services were noted to be:

- Lack of adequate knowledge and confidence in the management of HIV and AIDS in infants and children hence most practitioners referred these patients to the already congested public sector facilities. The practitioners are unable to benefit from training and mentorship in pediatric care offered to public sector health care workers.
- Lack of a platform to share experiences and interact with colleagues in the public sector as well as participation in workshops to update knowledge, regular access to IEC materials and current guidelines/policies in HIV and TB.
- Failure by patients to access affordable CD4 and other laboratory services from the public sector particularly in rural settings due to lack of mechanisms for collaboration.
- Negative attitudes by health workers at some public institutions towards patients referred by private practitioners.

- Lack of feedback from the public sector on referred clients
- Unaffordable user fees leading to delays in initiating treatment, defaulting and lost to follow up

3.3.3 Workplace Programmes

The workplace is one of the most important and effective points for tackling the HIV and TB epidemics. There are many workplace programmes in Zimbabwe where employers and employees support prevention through education programmes and also provide varying levels of care and treatment. Where these programmes are in place they have contributed to the well-being of employees, keeping them at work and maintaining productivity and morale. There is anecdotal evidence that these programmes are actually having an impact in reducing new infections at workplaces.

The International Labour Organization provides the link between the UN and the broader private sector for the world of work responses to HIV and AIDS operating through a tripartite structure comprising Ministry of Labour and Social Welfare, employers represented by Employers Confederation of Zimbabwe (EMCOZ) and employees represented by Zimbabwe Congress of Trade Unions (ZCTU). In HIV this tripartite structure focuses mainly on capacity building of the employers and workers organizations, developing workplace policies and programmes and use of standardized protocols and tools for policy development and programme implementation. They also have linkages with MOHCW in training, information sharing and facilitation of treatment for workplace programmes. Efforts have also been made to integrate HIV and TB within workplace programmes.

While there is evidence of increasing cooperation from the private sector in terms of resource leveraging, poor economic performance remains a major challenge as most companies are operating at suboptimal capacity. The ILO continues to work closely with the constituents to strengthen coordination and ensure comprehensive representation of the private sector. Sector-wide and enterprise level policies including the transport sector, mining sector, energy sector, commercial and motor industry, SME and informal sector have been developed. The focus on the transport sector led to relatively vibrant programmes in the Railways, Air Zimbabwe and the road transport sector through the National Employment Council of Transport Operating Industries.

Commitment to address HIV and AIDS as a critical workplace issue exists in the private sector. This is demonstrated through the existence of many policies, strategies and workplace programmes in existence. Business has also invested significant resources in the provision of prevention, care, treatment and support services to employees and their families. Training for management and workers focusing on HIV and AIDS awareness, VCT, treatment and nutrition has increased awareness in the workplace. While there is encouragement for companies to form support groups this has been a major challenge that has been attributed to stigma in the workplace. The wellness approach where VCT is integrated with monitoring of non-communicable diseases such as hypertension and diabetes has been adopted by some businesses. There is anecdotal evidence that this approach has helped reduce stigmatization.

However the level of commitment of resources has been significantly affected by the hyperinflationary environment which peaked in 2008, the current low capacity utilization and lack of access to financing in the market. A positive indicator of the sustainability is the inclusion of HIV and AIDS within the operating budgets of some companies which can act as a springboard for PPPs.

The critical role the SMEs play in the livelihoods of Zimbabweans has been increasing significantly as more people find employment in the informal sector. HIV and AIDS have been noted to lower productivity at the workplace owing to absenteeism, disability and death. This is more pronounced for SMEs as they usually operate with very few key personnel. A study on the impact of HIV and AIDS on the SME sector in Zimbabwe, 2006(ILO) found that on average over 40% of SMEs had lost productive time owing to absenteeism from illness or attendance at funerals. Other costs were incurred owing to direct funeral costs which were often absorbed by the SMEs. Approximately 70% of SMEs did not have a workplace programme in place. Only 24% of SMEs distributed condoms at the workplace. However employers (84%) in the SME sector expressed willingness to fund workplace programmes if they are provided with the necessary technical skills and support.14 Recommendations have been made to facilitate networking and more meaningful participation of SMEs in policy formulation, implementation and evaluation HIV and AIDS services including TB. The situation of SMEs has changed little since this survey was conducted meaning that a significant proportion of the working population in Zimbabwe may not be accessing HIV and AIDS services. Although the sector has a workplace policy limited capacity and lack of resources has delayed implementation of any meaningful programmes.

A number of gaps were noted with respect to workplace programmes:

- Difficulties in reaching SMEs and informal sector including domestic workers
- Reproductive health and PMTCT programmes not adequately addressed in the workplace
- Lack of adequate information on TB management in the private sector
- Lack of an M and E framework to capture workplace programmes information and other institutional capacity and sustainability information

3.4 HEALTH FINANCING

3.4.1 Health Expenditure

While in the past, the Government of Zimbabwe funded the majority of health related activities with partners filling in the gaps; in recent years funding from donors – including bilateral agencies and the United Nations Family - has been critical in the provision of Health Services in Zimbabwe. The country also submitted successful Round 5 and Round 8 funding applications to the Global Fund. According to the World Health Report of 2009, Zimbabwe's total health expenditure for 2006 was 9.3% of the gross domestic product.

In a costing analysis done in South Africa comparing sole public provision: public-private workplace (PWP) and public-private non-government (PNP) it was concluded that government financing would require $609-690 per new patient treated in the purely public model. This was in contrast to PNP sites which would only need to $130-139 per patient and $36-46 with the PWP model.16 This presents a strong economic case for expanding PPP involvement in TB treatment. The cost to the government per new patient treated could be reduced by enhanced partnership between the private and public sectors.

3.4.2 Resource Mobilization

Domestic resources have been mobilized through the National AIDS Trust Fund (NATF)/AIDS levy, which was introduced in 1999 and collects 3% of taxable income from companies and all formally

salaried employees to increase resources for the HIV prevention, treatment, care and support components. Following the introduction of the multi-currency system in 2009, there has been a significant improvement of inflows into the NATF. In 2009, the AIDS levy collection was US$5.7 million. Although companies are willing and investing in HIV and AIDS programmes there is a perception that they are paying twice through the AIDS levy and their own direct investment. With improved economic performance this fund is likely to grow and should also act as a catalyst for initiating and expanding PPPs towards Universal Access.

There are a number of private sector initiatives which are currently supported by Global Fund with these organizations as Sub-sub Recipients (SSR) of funds e.g.

- Management capacity building of funding recipients in collaboration with Stanbic Bank
- College of Primary Care Physicians of Zimbabwe
- Behaviour change programme in Mashonaland Central Province, ZAPSO
- The EMCOZ/ ZCTU Consortium for workplace programmes
- SAFAIDS and PSI-Z are also recipients of the global fund for workplace related programme responses

Workshops are held for grantees on financial management and maintenance of good internal controls. This also presents an opportunity for public institutions to leverage on this resource to increase governance and financial management systems in government.

3.4.3 Medical Insurance

There has been a significant increase in the number of medical insurance schemes in Zimbabwe since 2009. The high prevalence of HIV in Zimbabwe challenges the medical insurance firms to complement government efforts at primary prevention of HIV and providing more access to care and treatment. At present all medical aid societies cover the cost for diagnosis of both TB and HIV as well as baseline pre-ART investigations. However only a few extend coverage for ART and advanced tests such as viral load and HIV drug resistance testing. Collaboration in this area can leverage capacity in the public national reference laboratories which provides TB drug sensitivity testing, viral load and HIV resistance testing, and other private specialist laboratories while utilizing medical aid financing models.

Medical aid societies expressed willingness to participate in PPP through accessing the public sector medicines and other services at an agreed fee and thereby be able to extend services to their general membership. This model may also be replicated when the National Health Insurance Scheme, which is currently in the planning stage, comes to fruition.

Some medical aid firms are now also providing medical services thus creating a sense of unfair competition between private care providers and health insurers. This has also impacted negatively on patients' access and choice of health care providers. This is an area which policy makers should address as they engage these stakeholders in public-private partnerships.

Elsewhere within the region there are a variety of schemes which offer benefits for ART17. For example patients are attended to by their usual practitioners who have received training on ART and access their medicines through network pharmacies for a small dispensing fee. Patients also access CD4 counts and viral load tests for monitoring treatment and response. Financial and

actuarial reports have validated the success of this scheme.

These examples are an indicator for potential public private or private- private partnerships where collaborations can work leveraging on the capacities of different medical insurance firms in administering funds and paying providers for services rendered.

3.4.4 User Fees

User fees in both the public and private sectors remain a barrier to accessing care and treatment. There is variation in the administration of user fees in the public sector. Levels of fees range from $5 to $50 (to cover consultations, radiology and laboratory tests). This amount was found to be beyond the reach of most clients who sought services. Limited access to investigations and the costs have created an environment whereby it was reported that some health workers solicit for bribes from clients in order to access services. The PPP model should therefore put in place affordable and sustainable financing mechanisms to ensure smooth service provision at both the public sector and collaborating private sector facilities.

3.5 MEDICINES AND TECHNOLOGIES

3.5.1 Retail Pharmacies

The 53 retail pharmacies visited dispensed ARVs and provided counseling associated with ART services. None of the retail pharmacies visited neither stocked nor dispensed anti-TB medicines. This is due mainly to the regulatory provisions which restrict the handling of TB medicines to the public institutions and local authority health facilities. Pharmacists reported willingness to provide TB medicines in the retail settings. Reasons for the willingness to take part in such a partnership included perceived potential for improved business performance and recognition associated with social responsibility. Provision of training on HIV and TB was cited by 92 per cent of the respondents as an incentive to engage more formally in partnerships with e private sector. Other perceived incentives highlighted included access to free or subsidized medicines, tax subsidy, retention scheme for pre-registration pharmacist.

Majority of retail pharmacists (77%) reported willingness to attend to clients referred through the PPPs. All respondents expected to be financially compensated for services rendered at an agreed tariff with 90% of the respondents preferring fee for service while the remainder preferred capitation whereby fees are paid for being available to provide services.

Lack of information sharing was highlighted as a gap to collaborating with the public sector. Most of the retail pharmacists (60%) reported that they did not regularly receive Information, Education and communication (IEC) material on HIV from the public sector and neither are they routinely invited to participate in workshops. This further highlighted the need for effective sharing of information between government and this sector for partnerships to work.

3.5.2 Pharmaceutical Manufacturers

Four major local pharmaceutical manufacturers were interviewed in the situation analysis. Two are involved in the manufacturing of ARV medicines with one of them also producing TB medicines. Of note is that one of the manufacturers are at an advanced stage of achieving WHO pre-qualification for ARVs. Challenges faced in the sector include the high research & development costs, human resource expenses and low capacity due to "unfair" competition from imports and customs duty on raw materials. Concerns were raised about government commitment to promoting local

pharmaceutical production, as most tenders are won by the import products distributors. Informants reported willingness to collaborate with the public sector on research and development for specific ARVs or TB combinations, batch production earmarked for public consumption. This presents an opportunity for long term partnerships which will reduce dependence on imports and also enabling the local pharmaceutical industry to develop. This is in line with the National Health Strategy for Zimbabwe (2009-13) which seeks to promote local manufacture of ARVs. Given adequate support these manufacturers have the potential to supply the region.

3.6 HEALTH INFORMATION

Sound decision making in health should be based on evidence gathered through data collection, analysis and dissemination. Only the bigger corporate institutions are reporting to the MOHCW on a regular basis on HIV and TB. This applies mostly to those institutions that are receiving ARVs and TB medicines from government through the National Pharmaceutical Company (Natpharm). The other corporate institutions reported collecting data on HIV and TB for internal use but have not been engaged by the government and neither do they have data collection tools used in the public sector. Most respondents expressed willingness to report on HIV, TB and other conditions to the MOHCW. More positively, the National Health Information System (HMIS) Technical Committee has private representatives such as medical insurance firms and medical practitioners. This committee has provided a platform for increasing information sharing between the public and private sectors.

Feedback on information reported as well as non direct monetary incentives such as access to IEC material, regular updates and participation in training and workshops as well as access to HIV and TB commodities was cited as incentives for continued participation in reporting data. Some key informants would want the Monitoring and Evaluation unit in the MOHCW to be capacitated to actively involve the private sector.

Reporting of data on key indicators from the private sector has been poorly coordinated resulting in lack of important information on the contribution of the private sector to the HIV and TB response. For example it has been estimated for years that 10 000 people are accessing ART from the private sector. This figure has remained static as there is no reliable data on the actual number accessing ART.

One of the key outputs for the private sector strategic framework is evidence based strategies and the use of documented best practices to guide programme responses. The framework thus motivates for research in collaboration with development partners and other key stake holders in the world of work. More could be done if the linkages with the public sector in carrying out operational research on HIV and TB were strengthened. This has been a lost opportunity as the MOHCW does have a comparative advantage to carry out research with partners.

The Zimbabwe Business Council on HIV and AIDS and its stakeholders have developed an M&E plan within the context of a broader Wellness Programme. The plan describes the key indicators, data collection methods, and data flow channels and data quality assessment measures to be employed. This plan aims to improve the monitoring, evaluation and documentation of the private sector's Wellness and HIV and AIDS Programmes in Zimbabwe. This is in line with the national strategic plan and provides opportunities for synergies that will provide information of the contribution of the private sector to the HIV and AIDS response. Data collected include routine monitoring data, annual baseline data and survey data which ultimately feed into the reporting structures within National AIDS Council. The involvement of private sector in the national health

information system will result in a more representative picture of the status of HIV and TB in Zimbabwe. However the ZBCA does not represent the entirety of the private corporate, therefore there is need to put in place mechanisms for the rest of the private sector to report to the Ministry.

3.7 BEST PRACTICES

There are many examples of good practice in HIV and AIDS programming in the private sector as well as PPPs. The examples in Annex B are not exhaustive but illustrate the existence of such best practices in Zimbabwe.

3.8 PERSPECTIVES ON PPPs

3.8.1 Public Sector Perspective: Challenges on working with the private sector

In general MOHCW and Local Authorities are comfortable and look forward to engaging the private sector formally. However a number of challenges were noted.

- Lack of broad based representation of the private sector at national, provincial and district structures
- Lack of a framework to engage with the private sector to complement service provision in light of the changing disease burden
- Perception of the private sector priorities as being driven by profit thereby not being aligned with the public sector
- Inadequate resources in government to meaningfully contribute to the promotion and establishment of effective partnerships
- Non-adherence by some practitioners to national protocols in particular TB case management.
- Negative attitude toward the private sector; lack of trust; lack of recognition of private sector value
- Ineffective defaulter tracing mechanisms for both HIV and TB,
- Failure to keep essential records for HIV and TB by some private practitioners

3.8.2 Private Sector Perspective: Challenges on working with the public sector

- Lack of trust and a desire to control the private sector
- Public sector underestimates the value of the potential contribution of the private sector in addressing public health objectives.
- Perception that the public sector system is too bureaucratic
- Public sector does not widely disseminate information that the private sector providers need to improve their quality of services;
- The public sector has a negative attitude toward the private sector e.g. patients reportedly being literally discriminated against and criticized for consulting private practitioners
- Perception by the private sector that public sector employees expect incentives when partnering with them.

3.9 SWOT ANALYSIS

The following section highlights major strengths and weaknesses of the public and private sectors as well as opportunities and threats towards the establishment of formal partnerships for HIV and TB responses in Zimbabwe.

3.9.1 Strengths

- Existence of regulatory structures for health professionals and health facilities that can be utilized to monitor compliance to standards in the provision of services
- Legislation that governs the conduct of employers with respect to HIV and AIDS under various instruments which encourages employers to provide certain services allows for potential PPPs within a legal framework
- Availability of a large and diversified private sector which contributes significantly to health service delivery in terms of capital expenditure, human and other material resources which can be tapped into.
- The existence of budget line items for health programmes by some companies e.g. workplace programmes provides an opportunity of further investment in this area in the context of PPPs
- Zimbabwe has a relatively robust, decentralized public health infrastructure which can be utilized by the private sector to increase access to HIV and TB services
- Well established health insurance schemes.

3.9.2 Weaknesses

- Weak PPP coordination structures from central to local level
- Limited involvement of the private sector in trainings
- Poorly coordinated flow of information on key indicators from the private sector and vice versa.
- Weak referral systems between public to public and public to private providers as well as negative perceptions between the two compromises the quality of service provided to clients.

3.9.3 Opportunities

- Global recognition of the potential for private sector co-investment in HIV and TB responses as one of the key strategies for the attainment of Universal Access targets.
- Existence of a business council on HIV and AIDS presents an opportunity for creating a broad based coalition which will coordinate the entire private sector in the context of PPPs
- Availability of international and local funding mechanisms to support private sector initiatives e.g. The Global Fund.
- Existing linkages between some private sector companies and NGOs presents an opportunity for significant scale up in prevention, treatment and care.
- Established network for People Living with HIV and AIDS can be utilized in reaching potential beneficiaries of programmes and in patient defaulter tracking and promoting adherence.
- Potential for increased capacity utilization by private providers
- Willingness among both private and public service providers to participate in PPPs

3.9.4 Threats

- Unavailability of workplace programmes in 70% of SMEs.
- Involvement of informal sector in HIV and AIDS remains minimal
- Brain drain in both the public and private sector.

4. Conclusion And Recommendations

4.1 CONCLUSION

The private sector constitutes an important, diverse component of Zimbabwe's health care system with the potential for complementary solutions. There are human and material resources which PPPs can leverage from the private sector. There is willingness by the private providers to engage with the government and other partners in a mutually beneficial way. While the political will is evident there is need for clear delineation of roles and responsibilities and involvement of partners at all levels.

4.2 RECOMMENDATIONS

4.2.1 Short-Term

1. Review and reconstitute the National PPP steering committee to spearhead the establishment, coordination, management and monitoring of PPPs with an initial focus on HIV and TB management.
2. The national PPP steering committee to advocate for the establishment of a broad based private sector coordinating body for effective engagement.
3. Strengthen capacity of the PPP Unit within MOHCW to lead dialogue with all stakeholders in creating effective PPPs.
4. Develop standard MOUs for adaptation to formalize PPPs in various settings. Meanwhile HIV and TB programmes should facilitate and expedite site assessments and accreditation for HIV and TB service provision (Laboratory, radiology, clinical services, pharmacy e.t.c) in the private sector.
5. Training on ART, PMTCT, HTC and TB should be extended and well coordinated to include the private sector.
6. The Health Information Unit and AIDS & TB Unit, MOHCW to engage private sector to develop mechanisms to strengthen reporting on HIV and TB data from the private sector e.g. adaptation of recording and reporting tools, training, feedback mechanisms
7. Expedite the policy review of the "the scope of practice" of health workers to enable them to take on responsibilities in line with evolving disease patterns e.g. nurse-run doctor-led ART services.
8. The MOHCW should engage the Association of Health Funders of Zimbabwe (AHFoZ) to ensure that access to HIV (including ART) and TB services are a minimum package in all health insurance schemes. Mechanisms to enforce this should be put in place.
9. The MOHCW and the private sector to create pooled funding mechanisms to support PPP activities.

4.2.2 Long Term

1. Create decentralized structures for PPPs for HIV and TB services.
2. Expand the scope of PPPs to include other health components beyond HIV and TB.
3. Government should consider removal of VAT and taxes on imported packaging and raw materials as an incentive to enable local pharmaceutical manufacturers to be competitive and run sustainable operations.
4. The Government to expedite the establishment of the National Health Insurance Scheme as it has the potential to significantly increase access to services for the population and also growth of the private sector.

5. Appropriate internal mechanisms should be developed for research and development together with the private sector

6. Create a supportive environment that encourages medical professionals to stay in the country thus reducing brain drain and strengthening PPPs. One way would be to establish wellness centers for health care workers and their families.

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Annex A. Best Practices

Newlands Clinic

Newlands clinic which was established in 2003 in Harare with a family centered approach is one example of public private collaboration in integrated provision of HIV and TB services. The clinic provides a comprehensive treatment and care programme with most of the services being initiated by the registered general nurse. This model of nurse-led care is being used to train health workers from public sector and other private clinics. In addition to providing Anti-retroviral therapy and treatment of opportunistic infections the clinic is offering TB treatment in collaboration with Harare City Health Department. TB services have been decentralized using static and mobile outreach approaches in close collaboration with the City of Harare. Public private partnership has been further demonstrated with the government providing anti-retroviral and TB medicines and the clinic reporting data to MOHCW.

Newlands clinic is actively collaborating with MOHCW in training health workers in HIV and AIDS including TB since 2009. Presently a 2 week joint training course is being offered to nurses and doctors from both the public and private sectors thus enhancing knowledge and capacity particularly in managing paediatric cases. Approximately 150 nurses and doctors have been trained so far. All trainers are locals who have been employed by Newlands clinic.

Hippo Valley Estates

Hippo Valley Estates and Triangle Limited are members of the Tongaat-Hulett Group of companies, together forming part of the Triangle Sugar Corporation. The Core business of the company is to grow sugar cane and produce sugar.

The company recognized HIV/AIDS as a threat to their business and employee welfare hence introduced VCT in 2004. Hippo Valley was one of the five pilot OI learning sites as a PPP model accredited by MOH&CW to provide comprehensive HIV/AIDS services including ART.

Successful public-private partnerships are demonstrated in the funding mechanisms for HIV and TB programmes in the following ways:

- A significant proportion of funding comes from the Company. This includes staff costs, training, transport, consumables and OI drugs
- MOHCW through Global Fund funding provides most of the ARVs and has supported some infrastructural development and additional training of staff . TB drugs, HIV test kits, drugs for PMTCT are provided by MOHCW
- Fluconazole for cryptococcal meningitis treatment is provided by Pfizer international through MOHCW under the "Diflucan partnership programme"

The Swedish Workplace HIV and AIDS Programme (SWHAP)

The Swedish Workplace HIV and AIDS Programme (SWHAP) presents a model workplace programme that could be replicated in many settings in the spirit of public private partnerships. SWHAP was jointly initiated by the International Council of Swedish Industry (NIR) and the Industrial

and Metal Workers' Union of Sweden (IF Metall) in 2004. A key factor in SWHAP's success is that management and employees are jointly responsible for needs assessment, formulation of policy and programme implementation. In order to receive co-funding from SWHAP workplaces must have an HIV/AIDS policy that ensures confidentiality of employee HIV status doesn't discriminate against HIV infected employees and is gender sensitive.

One strategy which has had major impact in these programmes is the hosting of family wellness days. There is anecdotal evidence that this initiative has been an entry point to HIV testing and eventual ART. Some of the companies have also integrated TB screening in their workplace programmes. An innovation of SWHAP is the supply-chain and union mentorship programme where mentor company coordinators provide the logistics, monitoring, evaluation and training for the supply chain company.

Partnerships with Populations Services International Zimbabwe (PSI/Z)

Populations Services International Zimbabwe. (PSI/Z) accounts for 50 per cent of the population that has been tested in the country with an average of about 360 000 clients per year. Expansion of services to include "point of care CD4 testing" and TB screening has facilitated patient care.. PSI/Z is in partnership with MOHCW on the Male Circumcision programme using the national MC strategy as the roadmap. Within this strategy there are opportunities for health systems strengthening. Staff retention in both the public and private sectors has been demonstrated. Partnerships have been created by providing counseling services at public sector OI clinics eg Harare Central Hospital.

Partnerships have been established between PSI/Z and some private institutions through the New Start network. They have MOUs with these institutions where they provide VCT, human and material support. One institution where this has worked well is at the Collin Saunders hospital, Triangle. The New Start Network is also reaching many workplaces including surrounding communities through outreach activities.

Annexe B: PPP Informants

Policy Makers

MOHCW: Head Office: Dr D Dhlakama, Mrs. C Chasokela, Mrs. Gerede
AIDS and TB Unit: Dr O Mugurungi, Dr C Sandy, Dr T Apollo, Dr T Murimwa, Muhlwa B, F Gwenzi, ,Mr Ncube, Dr M Ngwenya, Dr A Mushavi, MOHCW- PMD Manicaland; Dr M Chemhuru; MOHCW-PMD Masvingo .Dr R Mudyiradima; **Masvingo Provincial Hospital OI Clinic:** Sr Dube;

City of Harare: Dr P Chonzi, Dr C Duri

NAC: Dr T Magure, Mr. A Mpofu, Ms Mdege Mrs. R Kona

Health Funders: GFATM-CCM, Mr. Chiteure : **PSMAS:** E Chitekedza : **NSSA:** Dr Mapuranga; **CIMAS- Harare:** N. Shayachimwe, Dr Mupanguri, Sr Ndudzo, M Mutambirwa: **HMMAS:** A Zerere, A Puzo

Partners: ILO: Mrs. I Chimedza. UNAIDS: G Billy: UNICEF: Dr F Kitabire, Dr Alemach: **WHO:** Dr C Chakanyuka, Dr S Banda: **ZACH :** V Chitimbire: **PSI/Z:** Dr K Hatzold: **Elizabeth Glasier Foundation:** Dr Nyamundaya: **Zimbabwe AIDS Network:** L Jangira, M Mharadze, J Siveregi, W Tapfumaneyi: **MSF-Spain:** Dr Saint-Sauveur; **MSF-Belgium:** S Simons; **MSF-Holland:** P Jaravaza

Business: ZBCA: Mr. D Mutambara: **ZCTU:** Mr. Banda: **MCOZ; ZNCC; CZI ; Chamber of Mines:** Mr. V Gapare ; **Stanbic Bank; Swedish Workplace Programme:** E Maziofa; **Pioneer Transport Company:** E Chinhamo; **Delta Beverages:** S Maseko; **Portland Holdings:** S Nkomo; **Bata Shoe Company, Gweru; Africa Sun, Harare; Zimplats:** Dr S Gavi; Bindura Nickel: Dr E Nyazika; Varichem : Mr. Dzangare; **ZAPSO :** Mrs. F Mwashita; ZAPSO : Mrs. Gwanzura

Consumers: ZNPP+: Prof Shoko, P Magaya, A Chiwara;

Private Hospitals Association: Dr B Rigava ; **Avenues Clinic, Harare:** Mrs. Tavaziva; **Newlands Clinic, Harare :** Prof R Luethy: **Hwange Colliery :** Dr C Nylander, Mrs. Rakabopa,Mrs. Mbanje Mr. Shonai; **Claybank Clinic, Gweru; Murambi Gardens, Mutare;** V Vosloo; **Collin Saunders Hospital, Triangle:** Dr A Morar; **Hippo Valley, Chiredzi :** Dr T Mukwewa; **ZIMASCO:** Dr A Nyahwa;

CPCPZ: GPs: GP_- Masvingo ;Dr Huwa; GP-Chiredzi : Dr Mungwadzi GP-Chiredzi , Dr W Phiri; GP-Nyanga: Dr Dambanemweya

ZIMA/CPCPZ : Dr S Zichawo; Harare Physicians; :Dr C Muronda Dr M Odwee, Dr C Pasi, Dr Musasiwa , Dr Mubwandarikwa , Dr Ngwende:

Multi-tech laboratories: H Mudoni; **Lancet Clinical Laboratories**

Annexe C Tools

Questionnaire - Service Providers

My name is..... I am here on behalf of the MOHCW. We are assessing the state of private public collaboration in HIV/AIDS and TB prevention, care, treatment and support services in Zimbabwe. Your responses to these questions will assist us in drafting a framework for public private partnerships in the provision of HIV/AIDS/TB services in the country. All information gathered will be treated with strict confidentiality.

Name of respondent/s ----------

Organization: ----------

Location: ----------

Contact Details: ----------

Telephone numbers ----------

Email address ----------

Date of interview ----------

Medical Practitioners (Company Clinics, NGO clinics, General Practitioners, Physicians/Paediatricians)

Service Provision

1. Do you offer the following Services

		Yes	No
A	Prevention programme incl. HIV VCT, PITC		
B	Male Circumcision		
B	Co-trimoxazole as preventive therapy		
C	Screening for TB		
D	DOTS		
E	Treatment of opportunistic infections		
E	PMTCT		
F	Post-exposure prophylaxis		
G	Anti-retroviral therapy and ongoing monitoring of patients		
H	Other, specify		

2. Do you face any challenges in providing any of these services? Yes/ No

2.1. If yes highlight the main challenges----------

2.2. What are the top 3 challenges do you currently face in providing these services? -----
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3. Are you participating in any Public/Private Partnership? Yes/No

3.1. If Yes Please explain ----------

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4. Would you require any additional resources to optimize your contribution to PPP Yes/No

5. What extra resources would you require to optimize your contribution to PPP

5.1. Human resources(specify) ----------

5.2. Material resources(specify) ----------

5.3. Financial(specify) ----------

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6. If no are you willing to participate in Public/Private Partnership? Yes/No

7. Would the following be incentives to participate in public/private collaboration in providing these services?

		Strongly agree	Agree	Disagree
1	More access to public facilities(such as diagnostics, etc)			
2	Financial Reimbursement			
3	Fee for service			
4	Capitation(fixed fee for defined cohort)			
5	Training and Continuing Medical Education (CME)			
6	Access to free/subsidized medicines/consumables			
7	Enhanced image			
8	Increased profitability			
9	Other(specify)			

8. Do you use national guidelines Yes/No (verify)

9. If not, describe the guidelines you use and why ----------

10. At what capacity utilization are you currently operating on a scale of 1-10

11. Are there any policies or regulations that hinder your provision of HIV/AIDS/TB services Yes/No

11.1. If yes explain how. ----------

12. Do you dispense ARV drugs Yes/No

12.1. If not why not ----------

13. Do you dispense TB drugs Yes/No

13.1. If not, why ----------

14. Do you refer HIV/AIDS patients to the public sector Yes/No

14.1. If not, explain ----------

15. Do you face any challenges when you refer to the public sector Yes/No

15.1. If yes, explain ----------

16. Do you refer TB patients to the public sector Yes/No

17. Do you face any challenges when you refer to the public sector Yes/No

17.1. If yes, explain ----------

18. Do you regularly receive updates, treatment guidelines IEC material for TB/HIV etc from the public sector Yes/No

	TB	HIV/AIDS
Guidelines		
Updates		
IEC Material		

19. Do you have any suggestions on how you could further collaborate with the public sector in providing HIV/AIDS/TB services

Monitoring and Evaluation

20. Do you regularly collect data on HIV /AIDS services you provide (Yes/No)

21. Where do you report this information

	Yes	No
Internal		
NAC		
Partners(specify)		
MOHCW		
Other (Specify)		

22. Would you be willing to report on your work on HIV/AIDS/ to the MOHCW/NAC Yes/No

23. Do you regularly collect data on TB services you provide (Yes/No)

24. Where do you report this information

	Yes	No
Internal		
NAC		
Partners(specify)		
MOHCW		
Other (Specify)		

25. Would you be willing to report on your work on TB to the MOHCW Yes/No

Interview -Guide Health Insurers

Key Informant Questionnaire

My name is..... I am here on behalf of the MOH/CW. We are assessing the state of private public collaboration in HIV/AIDS and TB prevention, care, treatment and support services in Zimbabwe. Your responses to these questions will assist us in drafting a framework for public private partnerships in the provision of HIV/AIDS/TB services in the country. All information gathered will be treated with strict confidentiality.

Name of respondent/s ----------

Organization: ----------

Location: ----------

Contact Details: ----------

Telephone numbers ----------

Email address ----------

Date of interview ----------

Financing

1. Is your organization funding any HIV/AIDS services Yes/No

1.1. If yes, which services are funded ----------

2. If not, are you in a position to fund these services in the future Yes/No

2.1. Is your organization funding any TB services Yes/No

2.2. If yes, which services are funded

3. Do you reimburse practitioners for TB services Yes/No

3.1. If no, why not? ----------

Partnerships

4. Do you work in partnership with any organization in HIV/AIDS services Yes/No

4.1. If yes, describe this partnership ----------

4.2. Are there any challenges? Yes /No

4.3. If yes, describe the challenges ----------

4.4. What suggestions do you have to counter these challenges? ----------

5. Do you work in partnership with any organizations that provide TB services? Yes/No

5.1. If yes describe the nature of this partnership ----------

5.2. Are there any challenges? Yes /No

5.3. If yes describe the challenges ----------

6. In HIV/AIDS/TB service delivery, do you work in collaboration with the public sector? Yes/No

7. If yes explain ----------

8. Do you have any partnering agreement or MOU? Yes/No (Collect a copy)

9. Do you face any barriers to public private collaboration? Yes/No

9.1. If yes, specify----------

10. Do you have any reporting mechanisms with the public sector? Yes/No

10.1. If yes explain ----------

11. Do you face any difficulties in reporting on your work to the MOHCW Yes/No

11.1. If yes/why ----------

12. How can your organization assist in increasing access to HIV/AIDS/TB services

13. Are there any benefits to your organization anticipated/associated by collaborating with public sector Yes/No

Operational efficiency	
Financial incentives	
Increased access to services	
Better access to information	
Enhanced credibility/ improved cooperate image	
Other(specify)	

14. Do you have any concerns regarding your collaboration with the public sector? Yes/No

14.1. If yes explain

Reputation of organization may be affected	
Loss of autonomy	
Conflicts of interest	
Drain on resources	
Accountability	
Other (specify)	

15. What mechanisms do you have to monitor and uphold standards by service providers?

Notes

Notes