HIV/AIDS workplace programmes and Public-Private-Partnerships (PPP) through co-investment - extension of treatment and care into the community

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1. PPP and co-investment: definition and origins

(i) Definition

The ‘co-investment’ model is a mechanism for joint investment of public and private sector resources to provide access to HIV/AIDS prevention, testing and treatment at the workplace and in the surrounding community.

Public-Private Partnership (PPP) is defined as an “institutional relationship between the state and the private profit and/or the private non-profit sector, where the different public and private actors jointly participate in defining the objectives, methods and implementation of an agreement of cooperation”\(^1\).

PPP represents a joint approach between the private and the public sector. Co-investment requires involvement of various stakeholders – including donors and the international community, host government, the private sector, workers’ organizations and NGOs. The co-investment model can be seen as a specific form of PPP with the objective of strengthening and scaling-up the HIV/AIDS response beyond company premises.

(ii) Origins

The origins of the co-investment model can be found in a joint ILO-GFATM paper\(^2\), in the framework of the ILO partnership with GFATM the also drew on GTZ’s longstanding experience with PPP and WPP, and experience in promoting equal access for all to ARVs and development of health systems.

The ILO/GFATM paper was originally designed as a strategic working paper for a meeting of French enterprises preceding the G8 summit in Evian (July 2003). It stimulated discussions and encouraged the private sector to position itself more strongly as a major player in implementing HIV/AIDS programmes. Until then, private sector efforts had been seen as being mainly a provision of in-kind products/services to HIV/AIDS programmes. Subsequently, the ILO embarked on discussions with GTZ who strongly supported co-investment in their PPP department and technical assistance to companies for WPPs.

During this time the Global Business Coalition on HIV/AIDS (GBC) strengthened its activities to support the private sector in establishing innovative forms of WPP. The co-investment model provided an ideal mechanism to attract funds for promoting CSR with regard to fighting HIV/AIDS at the workplace. It was found that companies had already invested heavily in infrastructure for health delivery and AIDS care for employees, which resulted in “islands of excellence” within the private sector. However, these efforts disproportionately favoured those employed and neglected most of the population in the local community. Community health services in many countries were under government responsibility, but often run down and under-resourced. These companies expressed concerns that the effectiveness of their efforts would be diluted if the continuum of the AIDS response was not sustained between the workplace and the community. GBC’s efforts to assist partners in countries to submit proposals to the Global Fund on co-investment unfortunately did not lead to any proposals being accepted. Nevertheless, the GFATM staff and board were getting more sensitized on issues concerning private sector and co-investment, and possibilities were developed within the grant approval for co-investment: the first agreement being of Anglo-American with the NGO and GF sub-recipient Love-Life.

GTZ organized a meeting in Berlin in April 2004 along with the award ceremony for the best corporate WPP on HIV/AIDS. Multinational member companies of GBC and other enterprises, as well as GFATM, the ILO, the World Bank, GTZ and other bilateral agencies, were present. This provided a platform for exchange of experiences on GBC’s work and led to reflection and subsequent agreement concerning the model of co-investment and its expansion.

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2 See Bibliography 1.
In Maastricht, an initiative by the Dutch Ministry of Foreign Affairs brought together some of the same participants. It discussed definitions of co-investment and mechanisms for implementation.

At present, GTZ is working on a strategic document on co-investment. GTZ and GBC organised a strategic meeting on co-investment in June 2005 in New York where the ILO, WHO, companies and NGOs agreed on further collaboration, documentation and expansion of co-investment schemes, as well as the needs to involve other players such as PEPFAR.

(iii) Co-investment: a win-win situation for all

The development of the co-investment model was an outcome of business activities and partnerships happening on the ground in several countries. Historically the experience of WPP in enterprises first aimed at prevention and treatment for workers, and then expanded it to dependants and the local community. This has taken a big burden on the employers leading them to welcome co-investment, as in the case of Lafarge, BMW and many others. In the beginning also some worker organizations questioned the validity of this form of PPP, but in a later stage many positive reactions brought forward the recognition of the advantages of the co-investment model for workers and their families, as well as their communities (as documented during a tripartite seminar on ‘HIV/AIDS in the World of Work for 14 Anglophone African countries’, Stellenbosch 2004).

From the private sector viewpoint, supplementing corporate programmes with external funding ensured that a larger community than the employees only can be reached. Designed to extend sustainable prevention, care and treatment programmes from workplaces into communities, it creates increased access to health services, builds local capacity and implements health programmes efficiently. On the other hand, the public sector can contribute towards policy development and regulation; political leadership; financing; quality assurance, surveillance, and monitoring and evaluation.

The co-investment model aims to improve accountability and absorptive capacity of allocated funds, through collaboration of various sectors, avoiding duplication or development of parallel services. 3 PPP through co-investment can be thus seen as combining top-down and bottom-up policy and relationship building at various levels.

2. Conditions for the establishment of a PPP

In the context of the provision of prevention, care and support to employees, the ILO OHS Convention, 1985 (No. 161) provides the framework for the establishment and functioning of medical service provision at the workplace. These services provide an infrastructure that can be harnessed to deliver ART, especially where community services are weak, as proposed in the ILO Code of Practice on HIV/AIDS and the world of work. This Convention covers all workplaces, public and private, formal and informal, and refers to health systems both on a local as well as national level.

The ILO encourages the actors identified in this form of PPP to undertake the role in which they have a comparative advantage and pool resources for the provision of health services to a larger community. The roles are quite flexible, as long as they are based on open dialogue among the tripartite partners. This is a pre-requisite for any PPP and ensures that the needs of the different parties are met. The most commonly seen task distributions are provision and financing of services and regulation of standards regarding price building and quality control (the latter often requiring government intervention).

At the local level, activities within companies and community outreach activities should feed into the district health system with regard to information sharing, planning, management and quality control. Local enterprises may not have the same financial backing as multinationals to contribute to infrastructure projects, however with their specific local knowledge and with their ties to the customer base they are essential participants in successful partnerships. Hence, they are an essential element of the local health system, which includes all actors and all initiatives aiming to preserve good health and to treat diseases irrespective of the provider’s institutional character or the scope of the services offered.

The role of the government is that of a coordinating and harmonizing mechanism. In situations where there are monopolies, and only a small number of providers, which is mostly the case in developing countries, government regulation is needed to address potential market failures, which would otherwise be determined by demand and market forces in a free market. The government can also ensure that the ‘3 Ones’ are adhered to and the various

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3 GBC Co-investment Report, April 2004
responses to the epidemic are coordinated and complementary in approach. Moreover, PPPs and co-investment strategies will be most effective if they are based on a multi-sectoral approach rather than vertical programmes.

3. Major players and their collaboration

With the establishment of the Global Fund, national coordination and participation of public and private sector stakeholders have become central issues for the allocation of global resources. CCMs form an essential structure of the Global Fund. They develop and submit grant proposals to the Fund and include representatives from both the public and private sectors, including governments, multi- or bilateral agencies, NGOs, academic institutions, private businesses and people living with the diseases. For each grant, the CCM nominates one or a few public or private organizations to serve as PR of the funds.

At the global level, the GBC, a rapidly expanding alliance of over 170 international companies, is dedicated to combating the AIDS epidemic through the business sector's unique skills and expertise. The GBC has the potential to act as a coordinating mechanism between the public and the private sector and has actively engaged in promoting co-investment.

At country level, more and more national business coalitions on HIV/AIDS are being established, frequently with the support of multi- and bilateral organizations. They can act as brokers for technical assistance, advocacy and for communicating good practices. As facilitators between companies, government agencies, CCMs and civil society, business coalitions can contribute substantially to the success of the co-investment concept.

International donors and organizations (e.g. GFATM, ILO, UNAIDS, the World Bank, WHO) can support improvement of a better enabling environment for co-investment, both at country and global levels. Apart from the provision of funding that allows expansion of programmes beyond companies’ immediate target groups, donors can support the identification of co-investment opportunities, contribute technical expertise, fund NGOs and other service providers – such as HMOs – interested in supporting co-investment, and provide a convening platform for other stakeholders at the country level.

The ILO recognizes HIV/AIDS as a workplace issue and raises awareness among companies that it is cost-effective to provide their employees with HIV/AIDS workplace programmes. The introduction of HIV/AIDS programmes is in most cases based on occupational safety and health services (OSH) already established in these enterprises. The ILO encourages and facilitates social dialogue between representatives of companies and workers, and helps provide prevention, care and treatment to workers and community members by means of PPP. This approach includes not only the provision of comprehensive treatment, care and support, but also the development of community health, procurement of drugs, capacity building and creation of a non-discriminatory environment. Ongoing access to ARV treatment remains a cornerstone of sustainability.

One of the core responsibilities of the ILO programme on HIV/AIDS is to strengthen the capacity of its constituents to reduce the spread and impact of AIDS in the world of work. Identifying what has and has not worked - and why, and then sharing those lessons, is how the good practice concept strengthens capacity and confidence. The ILO has an important role in helping the constituents identify, adapt and replicate useful practices. In addition, it brings together its tripartite constituents and other partners to develop networks useful in implementing partnership agreements.

Bilateral agencies are well positioned to contribute to co-investment. GTZ for instance maintains close partnerships with the ILO, UNAIDS, WHO and the Global Fund, supports CCMs at the country level, as well as through Global Fund regional meetings, and advises companies on the design and implementation of HIV/AIDS workplace and community outreach programmes (see section on practical examples). Similar PPP initiatives are being supported by other bilateral agencies, including USAID, DFID, and the Dutch Ministry of Foreign Affairs.

The Global Fund and ILO have identified several promising areas of partnership. Similar co-operation can be envisaged for co-investment schemes with other donors:

- Establishment of voluntary counselling and testing services
- Extension of prevention initiatives/services
- Development of community health services: providing infrastructure for public health
- Capacity building and training
- Procurement of drugs
- Information management and other private sector efficiencies.
In this context, the important question of sustainability also needs to be addressed, especially since the co-invested funds are available for a limited time period only.

4. PPP and HIV/AIDS in the health care sector: key challenges

For most governments in developing countries, working with the private sector is still a new concept. Not only are there challenges between the private and the public sector, but also the relationship among private sector actors themselves affect the success of co-investment.

Donors are also confronted with different types of challenges. A reluctance to engage with the private sector for development in general and to fund private sector initiatives in particular is quite common. This can be due to a lack of familiarity with these procedures and the lack of an enabling environment, such as appropriate channels for communication with the private sector.

Bottlenecks for greater corporate activities include lack of familiarity with running community-based health programmes, fear of financial liabilities (particularly given the limited time horizons of donor support), a paucity of good country- and sector-specific case examples, and a lack of appropriate partners or tools.

Since NGOs are often being involved in programmes directly on site, their contribution to co-investment mainly consists of the provision of technical assistance and implementation support (including the training of service providers). NGOs could also have a particularly important role acting as intermediaries or bridges between the public and private sectors.

The GBC summarized key challenges for implementing PPPs in its pilot projects in Cameroon, India and Nigeria (2003). Some of the relevant ones are listed below:

1. The highest-level political commitment is the critical starting point in a national response.
2. To promote multi-sectoral collaboration, relevant platforms are required for cross-sectoral information sharing and coordinating implementation.
3. Without clear methodologies for interacting and defined responsibilities, public-private partnerships are rendered futile, despite the willingness of stakeholders.
4. Bureaucratic processes and local politics within countries have paralyzed the rollout of programmes. Even Global Fund CCMs, if not formulated in a functional or appropriately managed structure, can act as yet another bureaucratic hurdle at national level.
5. Current thinking on business contributions and participation on HIV/AIDS is limited to drugs, diagnostics and health service delivery but based on its core competencies, the business sector has highlighted a vast range of in-kind contributions.
6. There is little experience on integrated approaches to addressing HIV/AIDS, TB and Malaria. Most programmes involve a vertical approach to each of these three diseases, and current funding initiatives propagate this view. Integrated approaches through strengthening of health systems and forming successful PPP potentially offer greater benefits for efficiency and sustainability.
7. Small and medium enterprises are a neglected segment of the business sectors' AIDS response, and yet remain potentially more vulnerable to the impact of AIDS. SMEs could profit from the expansion of HIV/AIDS workplace programmes through the supply chain of larger companies, as well as from the services offered by national business coalitions on HIV/AIDS.

To overcome these challenges, sharing of information on programmes and on good practices is required. The development of a joint approach with delineating clear roles and responsibilities would also help achieve the agreed objectives. The UNAIDS ’3 Ones’ initiative addresses the need to harmonize all efforts supported by donors and the private sector. Large and multinational companies have a special role to play in terms of sharing best practices from a wide variety of settings and supporting the efforts of smaller companies. Needless to say, it will take time and persistence to build the necessary trust among the different partners.

5. PPP examples

There are many examples of successful partnerships undertaken to mitigate the impact of HIV/AIDS. This section provides a variety of diverse initiatives of successful PPP to establish WPPs for HIV/AIDS. To start with, well-
known corporations like GlaxoSmithKline now offer its non-profit prices to all projects financed by the Global Fund. This has significantly expanded the availability of these prices which were previously limited to 63 countries. Novartis, the primary manufacturer of ACT, is preparing to ramp up production based on the GFATM’s establishment of a transparent mechanism (signalling future purchasing volumes of ACT expected to result from funded malaria grants) which would provide critical information to accurately forecast demand for this treatment which is in short supply.

In terms of increasing in-country effectiveness, the Glaser Progress Foundation has provided funding for the Access Project at Columbia University, which works with GFATM proposal applicants as well as grantees to assist in the management and implementation of funded programmes.

Coca Cola has formulated its WPP Charter for HIV/AIDS with reference to the ILO Code of Practice. The program creates awareness on the issue of HIV/AIDS by educating staff, and by providing confidential counselling and advice to ensure that affected employees are treated without discrimination. It also offers guidance on such issues as testing, screening, confidentiality and non-discrimination in employment.

Anglo-American contributed $4m to leverage the GF’s $12 m grant allocation to Love-Life (South Africa) in 2003, helping to expand the scope of implementation - a good, example of in-country co-investment. Another unique example is seen in Ivory Coast, where a joint partnership is being developed with the National Agriculture Development Agency, the Ministry and the GFATM - this negotiation is conducted by a private sector partner at country level.

The private sector can offer direct contributions in support of regional or country CCM processes to increase effectiveness and efficiency of programmes, as seen in Swaziland with the Royal Swazi Corporation (RSCC). Its efforts at controlling HIV/AIDS are being supported by NERCHA. NERCHA is a Global Fund principal recipient of $29 m. In addition to funding NGOs, government programmes, community orphan rehabilitation organizations and others, NERCHA provides prevention activities to smaller businesses through the Swazi Business Coalition on HIV/AIDS and directly funding the RSCC through a co-investment scheme.

Co-investing with GFATM financing can trigger an opportunity to partner with companies to use existing business infrastructures staff and management skills to support programme implementation, thus increasing and expanding the impact of proposed funding. Examples of this kind of financing can be seen in the case studies in Zambia, South Africa and Mozambique. The Lubombo Spatial Development Initiative is a collaborative project of the governments of Zambia, South Africa and Mozambique to develop the cross-border region into a competitive economic area. The initiative is an expansion of a programme that was developed by Mozel, a large aluminium company in the region, when they approached the Medical Research Council to help them fight opportunistic infections (malaria).

Unilever Tea Kenya runs a successful HIV/AIDS workplace programme for its 18, 000 employees and their families (approximately 100, 000 people) and plans to extend these activities to the community and to its small-scale out-grower farms, thereby diminishing inequity in a community that is highly dependent on the company. Unilever Tea Kenya Ltd, the Kenya Tea Growers Association and GTZ have signed a cooperation agreement for the implementation of a two-year project geared at supporting the extension of existing HIV/AIDS interventions at the workplace into the neighbouring community of Kericho, and the promotion of HIV/AIDS workplace interventions in the tea sector. The financial commitment from the public (GTZ) and the private sector is close to a 50-50 basis with GTZ providing not only financial but also technical support.

Ashaka Cement (Lafarge Group) and GTZ have signed an agreement for co-investment with the goal of complementing the existing public health system by extending HIV/AIDS and health services to the surrounding rural communities. The company has a very significant impact on the economy of these states. The total workforce is 800, and with dependants amounts to 3,000. Lafarge’s strategy aims at setting up clear and practical projects with local partners before applying for GFATM funding. Using its GBC and other contacts Lafarge identifies partners and ensures sustainability through further global funding and local government participation.

6. Conclusions

There is increasing recognition of the potential contributions the world of work can make in responding to public health challenges, and notably HIV/AIDS. While the onus of public health lies with the public sector, companies can maximize the impact of corporate experience, resources and technical capacities, by merging their activities to complement and support the efforts, roles and responsibilities of others – including international organizations, the public sector, trade unions and NGOs.
Individual companies have been able to demonstrate that HIV/AIDS WPP, including access to treatment and care based on occupational health services, are of high quality and cost effective. Sharing the burden of the provision of these services to communities through PPP and co-investment schemes requires partners to take responsibility and ensure that these commitments are long term. The application of PPP and co-investment schemes are encouraged by the Global Fund, the ILO, the Global Business Coalition and the World Economic Forum as potentially successful strategies in providing access to prevention, treatment and care to the HIV/AIDS affected population.

Nevertheless, there are still many unresolved questions about how these programmes can fit into the larger community. From the ILO perspective, PPP through co-investment schemes will ensure that company investments in the health of their employees will be protected in the long term and that these WPP are sustainable. The co-investment experiences so far are promising and prove that the concept works if all partners agree on their roles, responsibilities and the desired outcome. Sharing the burden through partnership must be seen as a long-term commitment in which private and public employers, governments, workers’ organizations, NGOs and development partners each take a fair share of responsibility.

References

1. ILO/Global Fund (July 2003), Co-investment: a central mechanism for establishing PPPs at country level.
2. GTZ (May 2005), Making Co-Investment a Reality - Strategies and Experiences (draft).

Acronyms

ARV: Antiretroviral treatment
CCM: Country Coordinating Mechanisms
CSR: Corporate Social Responsibility
GBC: Global Business Coalition on HIV/AIDS
GFATM: Global Fund to Fight AIDS, Malaria and TB
GTZ: German Technical Cooperation
HMO: Health maintenance organization
ILO: International Labour Organization
NERCHA: National Emergency Response Council on HIV/AIDS in Swaziland
NGO: Non governmental organization
OHS Convention: Occupational Health Services Convention
OSH: occupational safety and health services
PEPFAR: President’s Emergency Fund to Fight HIV/AIDS
PPP: Public-Private Partnerships
PR: Principal Recipient
WPP: HIV/AIDS workplace programmes