

Leveraging the Private Health Sector to Expand the HIV/AIDS Workforce





Executive summary

As countries work to expand access to HIV/AIDS care, national HIV responses in numerous countries have been impeded by human resources for health (HRH) shortages, often caused by public sector fiscal constraints and wage freezes. To make headway in the fight against HIV/AIDS, many countries have received donor support for health worker staffing and remuneration for the immediate delivery of HIV services. In particular, this support has been integral in supporting mid- and lower-level cadres that have been key to HIV services scale-up. However, as donor support declines, few governments are prepared to absorb these additional health workers and related costs to support the sustainability and long-term maintenance of epidemic control.

Many of these same countries have an active private health sector, which is already a key player in primary health care, family planning, and maternal and child health, and, increasingly, various HIV services. However, the private sector is not consistently tapped for service delivery across the HIV clinical cascade, and has largely not been explored as an avenue for an expanded HIV

health workforce. The Sustaining Health Outcomes through Private Sector (SHOPS) Plus project, with PEPFAR funding through USAID, interviewed representatives from 17 private sector organizations in India and South Africa to identify ways to use and expand the private sector health workforce for HIV/AIDS services.

The study sought to answer four key questions:

1. Are there specific points along the HIV clinical cascade for which private providers might be better leveraged?
2. What conditions are needed for the private sector to invest in staff to support the scale-up of HIV-related service delivery?
3. How can community-based HRH be better integrated with and financed by private organizations to sustain their operations?
4. What is the role of the public sector in strengthening the ability of the private sector to finance growth and improvements in private sector HRH to support a strengthened HIV response?

The study found that private providers are already active along the entire HIV clinical cascade to varying degrees. Their involvement depends upon having an enabling environment that makes room and creates a market for the private sector in HIV service delivery. In South Africa and India, the private sector's large networks of health workers in the community, clinics, pharmacies, and laboratories are well positioned for scaling up HIV services to increase testing, initiate people living with HIV (PLHIV) on antiretroviral therapy (ART), and support those already on ART to achieve viral suppression. Private service delivery organizations' large community health workforce have the potential to help increase HIV awareness and testing through demand generation activities; integration of provider-initiated testing and counseling into primary health care services; availability of testing services outside of clinic-based settings; and provision of tools to community health workers

(CHWs) to enhance patient education. Private providers in both countries have also capitalized on task-sharing policies, differentiated care models, and efficiencies offered by new technology to expand access to ART initiation, management, and distribution. Finally, the private sector, through public-private partnerships (PPPs) to leverage private laboratories and engagement of their community-based staff, has helped expand access to viral load processing and supported clients to adhere to treatment.

The study found that the private sector in South Africa and India makes decisions about investing in the expansion of service offerings based primarily on perceived demand for those services and the ability to meet that demand at a cost that is affordable to the purchaser—either the client directly or through a public or private financing program.



Private service delivery organizations in South Africa and India such as India's Mediclinic International have already integrated low- to mid-level health worker cadres into their business models.

Photo: Mediclinic International

Private service delivery organizations often think outside the box about whom, and how, they hire to keep costs down. Effective strategies for staffing facilities can include hiring seasonal employees; hiring locally and training employees in required skills; employing staff outside the prime age group, either at the beginning or end of their careers; and creatively using staff to the full extent allowable within the scopes of practice. In cases where these strategies are insufficient to make services affordable, private service delivery organizations have leveraged technology such as artificial intelligence, tele-health, and decision-support tools that increase staff efficiency and allow them to scale-up services without sacrificing quality of care. Regardless of the cost-reduction strategy, these organizations have used an organic process to design incentives tailored to attract and retain health workers rather than trying to compete with the public sector on wages. Examples include innovating within the fringe benefits package; exposing staff to new and innovative service delivery models; providing clear and explicit pathways for career growth; and developing benefits and working conditions tailored to address specific gender, cultural, and other considerations.

Private service delivery organizations in South Africa and India have already integrated low- to mid-level health worker cadres, such as CHWs, into their business models, mainly as their primary outreach staff. Many organizations view these CHWs as effective marketing assets that are part of the cost of doing business. They are considered part of the organizations' main operations, and their salaries are integrated into the general operations budget. Several other factors support the use of CHWs, including task-sharing guidelines that allow them to deliver more clinical services, the development of integrated clinical care teams that link community-based staff to health facilities, the emergence of new technologies that facilitate supportive supervision, and regular check-ins with clinical staff.



The private sector is innovating in both its service delivery models and how it employs health workers.



The public sector has a large impact on the private sector through policies, regulations, and taxation practices that create or constrain business opportunities. Specific practices that promote private sector investments in HRH to deliver HIV services include the use of public-private service delivery contracts and contracting private providers under national health insurance to provide new revenue sources; promoting a banking sector that facilitates access to finance for start-ups and the scaling up of proven models; and creating financial incentives for corporates to purchase health care services on behalf of their employees. Governments can also design regulations that help lower input costs and simplify taxes that help private providers offer better value to their clients. Across all of these efforts, governments need to strike the right balance. Regulations can help improve clarity of the types of services private providers are authorized to provide, but too much or poorly designed regulation can hinder innovation in service delivery models or handicap small start-ups.

Based on the study findings, there are four recommendations that policy makers, donors, and implementing partners across countries should keep in mind as they seek to leverage the private sector to employ HRH for a stronger HIV response:

1. **Recognize a role for the private sector in HIV service delivery—the private sector won't introduce services unless it sees a market opportunity, such as high demand or low barriers to entry.** Making room for the private sector in HIV service delivery requires policy makers to enact policies that incentivize entry, such as corporate social responsibility programs and tax incentives. Ministries of health can include the private sector in HIV strategic plans and ensure that the private sector is able to access needed resources, such as the antiretroviral drug (ARV) supply chain. Donors and implementing partners should include the private sector in HIV service delivery both through technical assistance related to HIV program design and demand generation, and financially through grants or identifying capital financing opportunities. This can be critical for capital-intensive expansion, such as procuring equipment to begin viral load testing. Health management companies can be used to ease the administrative burden that providing HIV services imposes on private health providers.
2. **Leverage the private sector's diversity to provide differentiated care across the HIV clinical cascade to clients of all income tiers.** The private sector extends far beyond individual doctors' private practices or corporate in-house HIV programs. Nurse-owned and operated rural clinics, artificial intelligence-enabled kiosks, mobile clinics, CHWs, pharmacies, and laboratories are all present and active in the private sector. Private providers have established sustainable models that are ready for scale-up, and that can absorb additional health workers to deliver HIV services. CHWs can provide

HIV testing and patient follow-up, pharmacies can be leveraged for expanded access to ARVs, and private laboratories have the potential to expand capacity for viral load and other tests. As governments, donors, and implementing partners look for ways to accelerate and sustain their HIV responses, they need to give greater consideration to how they can engage these cadres to support HIV goals, whether through distribution of public health messaging through private CHWs, PPPs that refer stable ART clients to private pharmacies for drug pick-up, contracts with private laboratories to utilize their existing capacity, or some other model. Doing so can free up public financial and human resources to focus on more complex cases or populations with a more limited ability to pay for a private sector HIV option.

3. **Determine how to pay the private sector.** Models can include the public sector wholly paying for private sector services, clients with the ability and willingness to pay entirely for the cost of their care, or a combination of payment mechanisms. The payer arrangements will shape how service delivery organizations utilize and plan for required HRH. If selecting public sector financing, ministries of health can directly contract the private sector for all aspects of the HIV clinical continuum, from community-based outreach to ARV distribution, or contract the private sector to hire health workers. Donors and implementing partners can also contract directly with private providers for services. If seeking to encourage private or out-of-pocket financing for services, donors can support the private sector to begin HIV service delivery through technical assistance, training private health workers, and making capital investments in required equipment and supplies. Private providers can make HIV services affordable for their out-of-pocket clients by leveraging technology and task sharing. However,



The private sector is one potential employer for the additional health workforce needed to continue expanding and sustaining HIV services.

Photo: Lorne Liebenberg of PPO Serve.

regardless of the mode of financing, private providers must have greater access to capital in order to transition into HIV service delivery and scale-up. Financing from corporate investors, social impact investors, and donors is currently easier to access than bank loans for most private providers. Easing access to bank loans is a key step in scaling the size of the private health workforce.

4. **Support regulation that allows the private sector to innovate in service delivery.** The ability to innovate is one of the private sector's greatest strengths. Access to technology, equipment and supplies, and flexibility about where and when and by whom services are delivered opens possibilities for the private sector to help reach clients that the public sector might not be able to. Policy makers can put in place regulations that allow innovative or flexible business practices, such as task sharing, community-based or lay-diagnostic testing, and mobile medical unit- and employer-provided HIV treatment programs. This can also assure

quality and encourage the private sector to find ways to make HIV service delivery feasible for their companies. Policy makers should also be mindful of policies that might inadvertently discourage start-ups and small companies, such as putting regulations on access to key equipment or excluding the private sector from national health insurance. Too many of such regulations may discourage private sector growth.

With the support of governments and donors, the private sector is well positioned to expand its health workforce. The organizations surveyed show that private providers are using a wide array of strategies to finance and manage their health workforce in order to profitably deliver services and enter into HIV service delivery. Strategies like relying on lower-cost cadres, hiring locally, and using a variety of contracting mechanisms (including short-term contracts and consultancies) support an agile and cost-effective workforce that can adapt to the requirements of HIV differentiated care. The organizations are experienced in gender-sensitive employment practices and employing junior-level staff, effectively drawing at-risk youth into the health workforce and thereby supporting youth employment. A proactive and organic approach to developing incentive packages is helping the private sector identify exactly what works for retaining and motivating their workforce. Demonstrated strong human resource management practices may be leveraged for expanding the private sector.

With coordinated and intentional encouragement and investment from all stakeholders, the private sector is a potential employer for the additional health workforce needed to continue expanding and then sustaining HIV services. The lessons contained in this brief offer a starting point for better engaging the private sector in overcoming country HRH constraints to achieve the 95-95-95 target and maintenance of epidemic control.



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Introduction

Achieving ambitious global health goals is contingent upon the availability, accessibility, and quality of human resources for health (HRH) (WHO 2016b). As countries work to expand access to HIV/AIDS care and other priority health services, national HIV responses in numerous countries have been constrained by HRH shortages, often caused by public sector fiscal constraints and wage freezes. To make headway in the fight against HIV/AIDS, many countries have received donor support for health worker staffing and remuneration for the immediate delivery of HIV services. This support has been integral in supporting mid- and lower-level cadres that have been key to HIV services scale-up.

However, few governments are prepared to absorb these additional health workers and related costs to support the sustainability and long-term maintenance of epidemic control (Figure 1).

Many of these same countries have an active private health sector, which is already a key player in primary health care, family planning, and maternal and child health, and, increasingly, various HIV services, for clients of all income levels. However, the private sector is not consistently tapped for service delivery across the HIV clinical cascade, and has largely not been explored as an avenue for an expanded HIV health workforce.

Figure 1. Sustainability of donor-supported health workers for HIV is uncertain

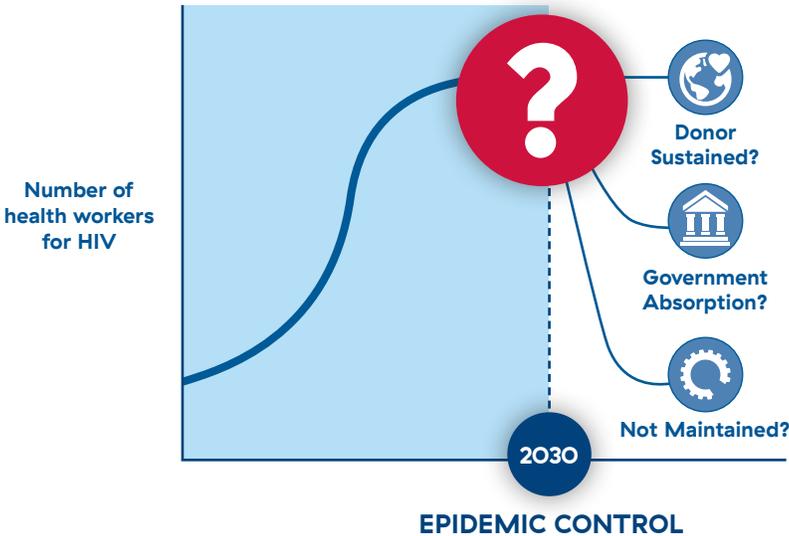
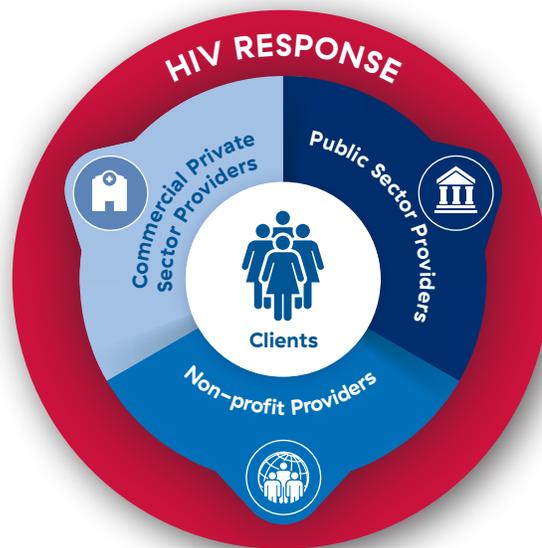


Photo: Rural Health Care Foundation

As donors and governments seek to address HRH gaps and transition responsibility for HRH investments to in-country partners, it is important to consider a total market approach which incorporates commercial private sector providers alongside the public sector and non-profit providers (Figure 2). There are opportunities to leverage both types of private providers to recruit health care workers and maintain their employment outside of donor funding.

Funded by PEPFAR through USAID, the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project conducted qualitative interviews with representatives from 17 private health care organizations in two PEPFAR countries—one in sub-Saharan Africa and one in Southeast Asia. This study examined four research questions intended to inform donor and government strategies to leverage the private sector to employ HRH to support national HIV responses.

Figure 2. Total Market Approach to HIV Response



Research questions

1. Are there specific points along the HIV clinical cascade for which private providers might be better leveraged?
2. What conditions are needed for the private sector to invest in staff to support the scale-up of HIV-related service delivery?
3. How can community-based HRH be better integrated with and financed by private organizations to sustain their operations?
4. What is the role of the public sector in strengthening the ability of the private sector to finance growth and improvements in private sector HRH to support a strengthened HIV response?

Methodology

Country selection

The researchers selected South Africa and India for the study from a pool of eight countries in Asia and sub-Saharan Africa due to their large, diverse, and innovative private sectors.

South Africa has a robust, diverse, innovative private health sector that is a recognized partner in the HIV response. As of 2008, approximately 37 percent of South Africans relied on private sources for primary health care (Econex 2010). Approximately half of national health expenditure is spent in the private sector (Econex 2013). The sector includes the entire range of service delivery models, from community-based programs to pharmacies, clinics, small hospitals, and large specialty hospitals (CDE 2011). It offers a wide range of provider types,

including approximately 7,500 general practitioners, 6,700 specialists, and 77,500 nurses (Econex 2013). It also comprises innovative social entrepreneurs who are developing new models for linking underserved communities to health care providers. Together, South Africa's public and private sectors have developed an effective country-owned HIV response. Public-private partnerships (PPPs) have been used in several cases to increase access to HIV services (Cooper et al. 2014). South Africa's HRH experience is relevant at a global level because it reflects challenges faced worldwide and approaches undertaken to address them (van Rensburg 2014).

India's private health sector is an important source of health care for the nation's 1.3 billion citizens. It is diverse, innovative, and evolving rapidly. There is a wide variety of private sector facilities, including



In India, private sector organizations such as Rural Health Care Foundation are an important source of health care for the nation's 1.3 billion citizens.

Photo: Rural Health Care Foundation

hospitals, ambulatory clinics, and pharmacies. Sixty-three percent of India's hospital beds are in private hospitals, and 70 percent of its \$96.3 billion health expenditures in 2013 were from private sources, mainly in the form of out-of-pocket payments (Gudwani et al. 2012, Dhawan 2015). In 2009, India had 761,806 doctors and 1,650,180 nurses and midwives, of which 70 percent were employed in the private sector (Hazarika 2013, Rao et al. 2012). Its private sector is currently not highly engaged in HIV service delivery but it is exploring innovative primary care service delivery models.

The research team selected a range of private sector organizations in each country to participate in the study, including hospitals, health centers, pharmacies, laboratories, and community-based programs. A total of 17 organizations, nine from India and eight from South Africa, participated in the study.

Organization selection criteria

In each country, SHOPS Plus used the following criteria to select private health service delivery organizations for inclusion in the study. Each organization must have:

- Large-scale operations and be successfully scaled in size
- Achieved, or are close to achieving, sustainability and financial viability
- Demonstrated ability to attract and retain staff
- A community-based component

SHOPS Plus also ensured that the final sample included a mix of:

- Urban and rural facilities
- Large, medium, and small hospitals, health centers, pharmacies, and laboratories as well as chains

Private sector providers that met the above criteria were approached with a description of the study and a request to participate. Those that agreed to participate were interviewed by SHOPS Plus researchers using a standardized key informant interview protocol. The researchers analyzed data by country and across countries for common themes.

Business models: South Africa

The eight organizations interviewed ranged from national chains with over 500 facilities to community health programs with no brick-and-mortar facilities. The organizations serve all income strata and range from South Africa's biggest pharmacy chain to asset-light start-ups.

In South Africa, SHOPS Plus interviewed eight private sector service delivery organizations located across all nine provinces (Table 1). Two of the eight organizations operated only in one province each (Gauteng and KwaZulu-Natal), while the other seven had sites in multiple provinces, ranging from two to all nine provinces. The organizations were located in both urban and rural areas.

The organizations surveyed ran the gamut from locally oriented nonprofit organizations spearheading community-based health initiatives with no bricks-and-mortar facilities (Expectra Health Solutions) to South Africa's leading corporate pharmacy chain (Clicks Group Ltd.), which has over 500 facilities nationwide and is one of the country's top employers. The providers include Unjani Clinic Network/Non-Profit Company (NPC), a social franchise of primary health care clinics owned and operated by nurses; and the Centre for HIV and AIDS Prevention Studies (CHAPS), the leader of one of the largest voluntary medical male circumcision (VMMC) scale-up programs in Africa.

Table 1. Organizational business models, South Africa

Organization	Model
CareWorks (Pty) Ltd	Contracts with corporate employers to offer employer-based HIV/AIDS services
Centre for HIV and AIDS Prevention Studies (CHAPS)	Public-benefit organization that expanded from VMMC-related research, service delivery, and training to primary health care
Clicks Group Ltd.	Corporate-owned retail pharmacies that expanded in recent years to include in-house clinics
Expectra Health Solutions	Nonprofit that provides community-based health care, supports service delivery improvement in government clinics, and runs a community health worker training program in KwaZulu-Natal province
Hospice Palliative Care Association of South Africa	Membership organization for South African hospices
Professional Provider Organization (PPO) Serve — Integrated Clinical Consortia (ICC)	Health management company that manages and oversees customized teams of HRH that are formed based on the specific needs of the population they serve
Unjani Clinic Network/Non-Profit Company (NPC)	Community-based social franchise of nurse-owned and -led health care facilities offering primary health care
Witkoppen Health and Welfare Centre	Standalone community-based nonprofit health center offering primary health care

Business models: India

The Indian organizations surveyed employ a high-volume low-cost model and serve large numbers of clientele in the lowest two wealth quintiles. The organizations were built to require minimal capital at start-up and to scale-up efficiently. More than half are profitable or nearing profitability.

In India, SHOPS Plus interviewed nine private sector organizations located across six states, primarily in the south, where the HIV burden is highest, plus one in West Bengal State and another in Mumbai (Table 2). Most of the organizations operate in rural areas, although two specialize in urban areas.

The organizations have a wide range of business models, operating hospitals, clinics, labs, and mobile medical units. While most models focus on providing primary health care, two provide specialized services: Aravind Eye Care System (ophthalmological care) and LifeSpring Hospitals (maternity services). One organization, Swasti Health Catalyst, provides a package of comprehensive services, including water and sanitation, to marginalized groups.

Although SHOPS Plus approached a wide variety of organizations to interview, the organizations that agreed to participate all focus on serving populations in the bottom two wealth quintiles. As a result, the study results don't reflect the large corporate entities of India's private sector, or entities serving the middle and top wealth quintiles. Despite being different types of clinics and offering a variety of services, the participating organizations all seek volume to make up for the very thin profit margins available from their poor target market. They differentiate themselves by offering high-quality services, safety, cleanliness, low costs, transparency, and accessibility. Many of them have been highly innovative, including using technology to increase efficiency, and are challenging the status quo.

Table 2. Organizational business models, India

Organization	Model
Aravind Eye Care System	Eye care: High-volume, high-quality ophthalmological care. Paying patients subsidize the majority of the patients, who pay no or low fees
Asian Health Alliance	Laboratories: Network of high-quality and low-cost diagnostic centers in profit-sharing agreement with doctors
Glocal Healthcare	Hospitals: Affordable emergency and critical care. Digital dispensaries: Automated primary health care in a nurse-staffed center, powered by artificial intelligence and virtual consultations
LifeSpring Hospitals	Maternity hospitals that provide high-quality maternal and child health care at affordable rates for low-income population
Rural Health Care Foundation	Asset-light, replicable, and sustainable service delivery model providing primary health care in rural areas
Sevamob	On-site pop-up clinics; tele-health consultations; artificial intelligence-enabled triage, consultation, and point-of-care diagnostics
Smile Foundation	Mobile medical units that provide curative, preventive, and promotive care in rural and urban areas for no or subsidized fees; funded by corporates
Swasth Foundation	Dense network of scalable and self-sustaining health centers with doctors, medicine, and pathology for primary-preventive care at half market rates
Swasti Health Catalyst	A health resource center that provides a comprehensive package of public health solutions for marginalized groups, including primary health care, sexual reproductive health, water and sanitation, and life skills

Photo: Smile Foundation

Findings



Findings

Across the organizations interviewed in South Africa and India, SHOPS Plus found that private providers are already active in many service areas, including HIV, and that there are many opportunities to further leverage the private sector for the 95-95-95 goals. The private sector is innovating in both its service delivery models and how it employs health workers. The private sector's involvement in HIV service delivery, however, depends largely upon having an enabling environment that creates a market for the private sector.

Leveraging private providers at different points along the HIV clinical cascade

The 95-95-95 target, an ambitious goal set by UNAIDS in 2014, states that by 2030, 95 percent of all people living with HIV will know their HIV status, 95 percent of all people with diagnosed HIV infection will receive antiretroviral therapy (ART), and 95 percent of all people receiving ART will be virally suppressed (UNAIDS 2014). In an environment of flat or declining donor resources, meeting this goal requires countries to more efficiently use existing resources along the HIV clinical cascade. The HIV/AIDS clinical response and corresponding HRH interventions have largely been focused on the public health sector. There has been less focus on leveraging the existing private sector HRH, nor attention paid to identifying ways to expand the private sector's employment of health workers for HIV service delivery as a means of overcoming HRH constraints.

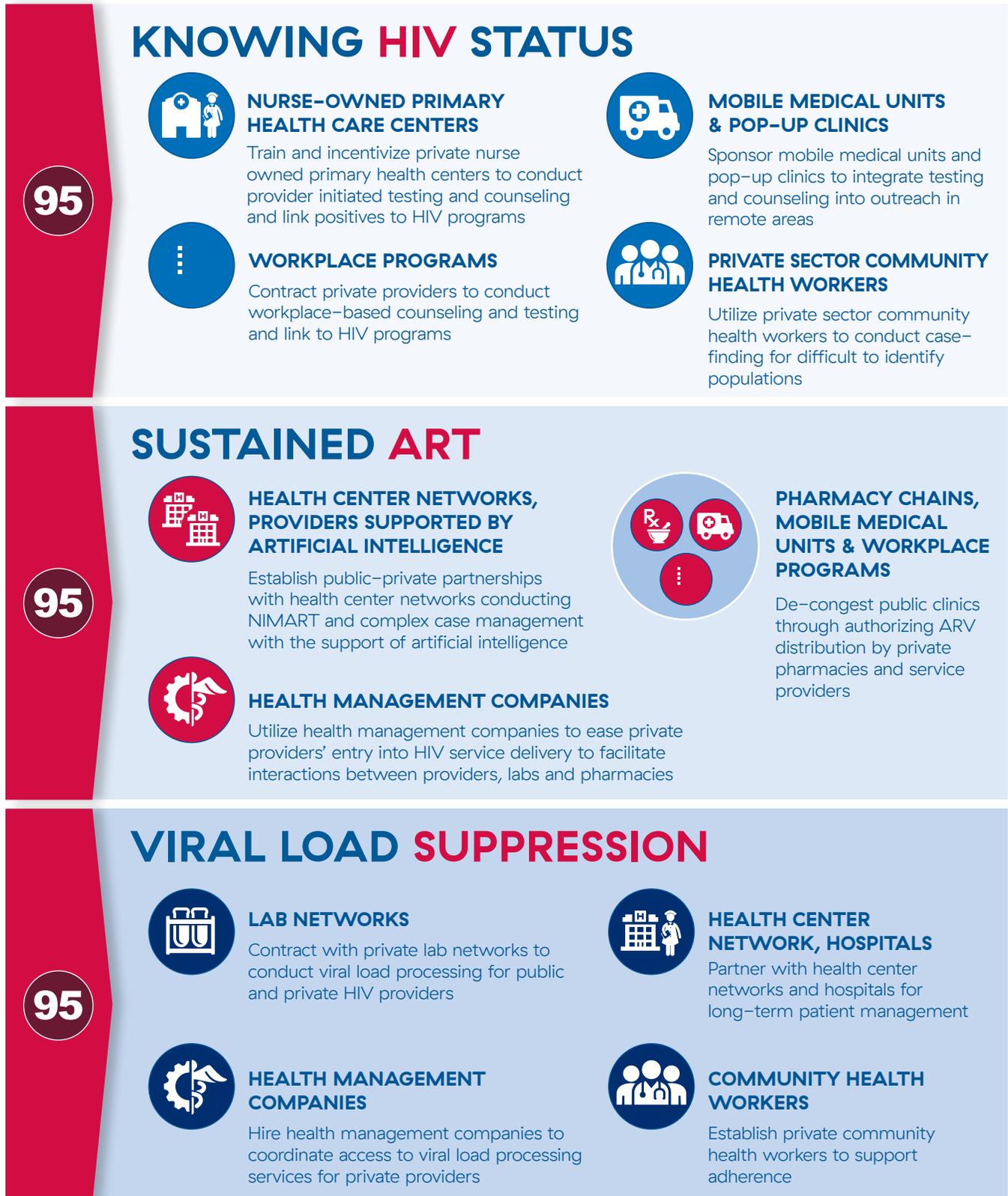
The South African and Indian participants in this study have widely different involvement and interest in HIV service delivery. In South Africa, respondents were involved in HIV testing, circumcision, treatment, and antiretroviral drug (ARV) distribution. They seized opportunities

to leverage their primary health care delivery models for HIV services. In contrast, in India, a few respondents included HIV testing among their standard tests and referred positives to government facilities for follow-up; the rest did not offer any type of HIV service. None of the Indian respondents envisioned an opportunity to expand their HIV services, stating that the response has been wholly owned by the public sector; nevertheless, their delivery models offer ideas for strengthening HIV service delivery. Both countries offered lessons on how to better leverage the private sector for the HIV clinical cascade.

The private sector's unique service delivery models could be—and in many cases are already—leveraged to provide differentiated care for patients along the entire clinical cascade (Figure 3). Differentiated care models are defined as “a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV, while reducing unnecessary burdens on the health system” (ARASA and ITPC 2016). Differentiated care models often move away from the standard facility-based model and bring HIV service delivery into the community. A 2017 study demonstrated that adopting differentiated care models can lead to improved health workforce efficiency (Barker et al.). The South African respondents are experimenting in differentiated care models by moving HIV testing and ARV delivery away from health care facilities. For example, CHWs in some programs, and Clicks Group Ltd. is expanding access to ARV drugs by filling prescriptions in its pharmacies nationwide as well as couriering drugs to miners and others working in remote areas. The private sector's agility in designing care delivery models makes it better suited to explore differentiated care models than the more structured public sector. Respondents in both South Africa and India provided examples of how the private sector could leverage these models to play a greater role across all three global targets.

Figure 3. Leveraging innovative private sector models of health worker employment across 95–95–95

The following infographic portrays various models of private sector engagement and how they might contribute to improving HIV cascade results as countries strive for 95–95–95.



95 Knowing HIV status

The private sector offers a large community health workforce that interacts closely with patients, which can be leveraged to increase HIV awareness and testing among populations that may not be well served by the public sector.

The private sector offers increased opportunities to connect with local populations to increase awareness, generate demand, and implement testing outside of a clinical setting. Nearly all of the organizations surveyed in South Africa and India incorporate CHWs into their business models. The CHWs have two significant roles: 1) deliver services

in the community, and 2) generate demand for the private health care providers. The CHWs are locally hired and provide education and/or basic services and testing, including for HIV. These CHWs offer an opportunity to expand access to basic HIV services. South Africa's CHAPS recruits unemployed people to do community-based demand generation for circumcision. By hiring locally, CHAPS leverages the CHWs' ability to speak the same language as the community and to increase awareness about HIV in culturally appropriate ways to reach key populations.

The CHWs in South Africa and India have extensive reach into underserved areas. Community- and home-based testing can be leveraged for the index-patient model, in which CHWs offer HIV testing



Some private providers have already integrated provider-initiated HIV testing and counseling into their primary health care services.

Photo: Witkoppen Health and Welfare Centre

and counseling to the family and sexual partners of persons diagnosed with HIV. South Africa's Expectra Health Solutions' CHWs conduct home visits in low-income districts in KwaZulu-Natal province. In some of its programs, Expectra's CHWs provide HIV testing. Often, there are large numbers of people living together in one household, and Expectra's CHWs offer testing to all household members.

Private pharmacies are also increasing access to HIV testing for populations that do not want to go to the public sector. Clicks Group Ltd. has increased access to HIV testing and counseling by introducing the service at "Clicks Clinics," which now exist in 190 of the Clicks' pharmacy stores. The clinics use nurses to provide primary health care and HIV testing and counseling. Opening the clinics within the pharmacies increased foot traffic for the company, and since September 2014 Clicks Group Ltd. has tested and counseled over 18,000 people for HIV. Clicks also sells HIV self-test kits for customers who prefer to do the test on their own. Clients who test positive for HIV are referred for treatment initiation, and then can return to Clicks to pick up ARVs.

Some private providers have already integrated provider-initiated HIV testing and counseling (PITC) into their primary health care services. One organization that does PITC is South Africa's Witkoppen Health and Welfare Centre. Witkoppen uses lower-level facility staff to provide pre-test counseling and to encourage patients to get tested for HIV. Patients can still opt out or request a referral to public points of care. By employing lower-level cadres, this model is low cost and reaches patients who may not otherwise access HIV testing through the public sector. However, on the whole, only a small proportion of the respondents in South Africa and India indicated that they utilize PITC, meaning that many patient-provider interactions are missing an opportunity to offer HIV tests.

95 Sustained ART

The private sector can expand access to ART initiation, management, and distribution using its existing CHWs, pharmacies, and nurses to expand coverage.

Private sector service delivery organizations are leveraging regulations that allow nurse-initiated and managed ART (NIMART) to expand affordable access to ART: NIMART is a task-sharing method that shifts the initiation and management of ART from specialized facilities and personnel to primary care nurses. Over the past decade, research has demonstrated that NIMART is a cost-effective way to improve access to and early initiation of ART, improve retention in care, reduce mortality rates, and reduce the burden on referral hospitals, among other benefits (Jones and Cameron 2017). It is particularly promising for the private sector, where there is pressure to keep HIV service delivery at an affordable price. India does not have a scope of practice for nurses that specifically lists any HIV-related tasks (Elison et al. 2015). South Africa approved a NIMART policy in 2010. However, many private sector nurses are not certified to perform NIMART and those that are, lack the knowledge or are reluctant to practice their full scope.

The majority of South Africa's Unjani Clinics are owned and operated by nurses who are either trained in NIMART or are undergoing training. Unjani Clinics' standardized list of affordable primary health care services includes services from across the HIV clinical cascade: counseling, testing, and the treatment and management of patients on ARVs, all delivered by nurses.

Private sector organizations are leveraging existing non-health care facility-based structures to distribute ARVs. South Africa allows ARVs to be distributed outside of public health facilities, freeing private providers to identify the most effective

ways to get the drugs to patients. CareWorks (Pty) Ltd negotiated a treatment program with some employers, in which CareWorks CHWs deliver ARVs to employees at the contracted companies. CareWorks has also entered into an agreement with Clicks Group to courier ARVs to miners working far from urban centers. Clicks is also conducting a National Health Insurance (NHI) pilot with the South African government in which some stores are serving as ARV pick-up points for state patients. Since Clicks' stores are conveniently located and have little or no wait times, this model improves access to ARVs.

95 Viral load suppression

Private sector laboratories, health management companies, and private CHWs can help expand access to viral load processing, support private providers to take on HIV services, and follow up with patients to ensure adherence.

PPPs leverage private laboratories to expand access to viral load processing. Accessing viral load processing can be challenging for both private and public HIV service providers. In India, Asian Health Alliance (AHA) is a network of high-quality, low-cost diagnostic centers in profit-sharing agreements with doctors. AHA already has a memorandum of understanding with the Government of Karnataka whereby AHA-affiliated private doctors can treat government patients; AHA has the potential to expand its contribution to HIV-related service delivery by contracting with the government to process state patients' viral loads. Making such a shift would require a significant capital outlay to purchase viral load processing equipment; therefore, access to investors, loans, or donations is essential to ensuring the private sector can capitalize on this opportunity.

With training, private CHWs and service providers can provide effective HIV care management and adherence counseling for patients within their communities as an integral part of their duties.

Private health management companies or other organizations can interface with laboratory and pharmacy services to reduce the management burden of HIV service delivery for private providers. Despite the private sector's greater involvement in HIV service delivery in South Africa, as compared to India, most private physicians in South Africa are still reluctant to engage in HIV service delivery because it is widely seen as too much work for too little money, particularly for uninsured patients. Professional Provider Organization (PPO) Serve, a health management company, tackles this issue in partnership with the Foundation for Professional Development by interacting with the laboratories and drug suppliers on behalf of the private physicians to streamline the inputs and lower the costs of delivering HIV services. By alleviating the management burden of private health care providers, PPO Serve encourages their entry into HIV service delivery.

With training, private CHWs and service providers can provide effective HIV care management and adherence counseling for patients within their communities as an integral part of their duties. South African organizations emphasized the importance of "closing the loop"—ensuring patients stay in care to achieve viral suppression—by actively managing their care using facilities and CHWs located in the community.



Private health management companies such as PPO Serve can interface with laboratory and pharmacy services to reduce the management burden of HIV service delivery for private providers.

Photo: Lwazi Mashiyi of PPO Serve

For example:

- Patients at Unjani Clinics who seek HIV services from the public sector may, where the clinics have memorandums in place with the government, retrieve their ARVs and have their care managed at Unjani. This leads to improved retention in care, since the clinics are relatively easier to access for their patients than government facilities, have shorter waiting times, a reliable supply of stock, and a trusted counselor (the clinic nurse).
- CareWorks' adherence rates are very high—approximately 92 percent. It attributes this to an active approach to adherence. CareWorks' counselors stay in regular touch with patients to encourage them and troubleshoot problems as they arise.

Case study: The Unjani Clinic Network/Non-Profit Company

The Unjani Clinic Network/NPC offers best practices in strengthening and sustainably growing the health workforce for global application. The objective of this social franchise is three-fold: 1) to empower its professional nurses, who are all black women, by providing them with infrastructure, entrepreneurial opportunities, and skills to establish and grow businesses; 2) to create permanent jobs for the nurses, who are the owners and operators of the individual clinics, and the staff they employ; and 3) to create a sustainable model for primary health care.

Founded in 2010, the Unjani Clinic Network has expanded to include 49 clinics across five provinces. The only nurse-led initiative of its kind in South Africa, the social franchise shifts primary health care tasks to professional nurses, who are the owners and operators of the individual clinics. The nurses are residents of their community, and with their community-level service delivery, build trust and their reputation.

The Unjani Clinic Network is overseen by the Unjani NPC. Corporate social investments and enterprise development funding, which support small and medium-size black-owned businesses in South Africa, cover the low cost of establishing clinics, which are made from converted secondhand shipping containers. The nurse owner-operators receive supportive funding administered by the NPC until they hit a preset monthly patient volume (250 patients per month) that ensures their sustainability. The network average is now over two times the sustainability mark, signaling that the majority of the clinics are financially self-sufficient (and those that are not yet self-sufficient are largely those that were more recently founded). Once 70 clinics are sustainably operating, the Unjani NPC will also be fully self-sustaining. Unjani NPC provides support structures and professional development trainings to enhance the nurses' business and financial skills.

Clinics are strategically located in low-income areas where need is high and access to other options for care is limited. Before the clinic is established, each nurse must conduct a household survey that shows that at least 200 people will seek care from the clinic and be able to pay for it. As word about a new clinic spreads in the community and the clinic attracts more patients, the nurse hires more health workers, mainly support staff (clinic assistants) and other nurses in accordance with a predetermined ratio of 30 patients a day per nurse. The nurse's salary grows, from a starting rate below that of government nurses to one that is higher, and, in a few cases, double. Patients are generally employed but uninsured, so many earn government stipends. They primarily pay with cash.

All clinics provide a standardized list of affordable primary health care services, including basic ultrasound and laboratory services. Each clinic has a storeroom that contains a supply of medicines. Unjani provides services across the HIV clinical cascade: counseling, testing, and ART. The majority of nurses have been trained or are receiving training in nurse-initiated and managed ART (NIMART). For any services they do not provide, Unjani nurses refer patients to government clinics. Unjani NPC supports the nurses to monitor their progress in order to ensure the clinics are on the path to achieving financial profitability and sustainability while delivering high-quality

services. Expenses are assessed, clinic stock levels are overseen, and operational and financial audits are held quarterly.

The network aims to become a national service provider under South Africa’s National Health Insurance (NHI) Policy, which focuses on re-engineering primary health care to improve outcomes and lower costs. Unjani plans to expand to 300+ clinics treating millions of South Africans nationwide.

The Unjani Clinic Network offers tested strategies for empowering health workers, equipping them with the tools needed to provide high-quality care, and expanding priority health services to communities in need. Unjani demonstrates that private providers can be leveraged to deliver services across the HIV clinical cascade, from outreach and testing to NIMART, and demonstrates innovative solutions to overcoming country’s public sector HRH constraints. Lynda Toussaint, CEO of Unjani Clinics NPC, emphasizes that Unjani puts people first: “The Unjani Clinic Network has provided in excess of 500,000 consultations since its inception, which has not only relieved the government structures of this workload, but has shown that if you provide patients with affordable alternatives, they will choose the service that best suits their needs.”



Unjani demonstrated that private providers can be leveraged to deliver services across the HIV clinical cascade and offers innovative solutions to overcoming South Africa’s public sector HRH constraints. Pictured here: Mpumi Moremi of Kanyamanzane Clinic, part of the Unjani Network.

Photo: Capital Land Projects

Necessary conditions for the private sector to invest in staff to support the scale-up of HIV-related service delivery

Increasing and maintaining staff levels among the respondents was predicated upon two factors: proven demand and low-cost opportunities to meet that demand. For example, South Africa's Unjani Clinics bring on more staff in accordance with predetermined nurse-to-patient ratios: once a nurse is seeing 30+ patients consistently per day, she hires another nurse. While increased demand is the product of many factors, respondent organizations differed in how they responded to that demand, in large part based on who was paying for the service. In instances where government, private corporates, or another third party paid on behalf of the client, they tended to look for opportunities to scale up by using a mix of health worker cadres so as to ensure clinical quality. When workers so as to ensure clinical quality. When clients paid out of pocket, organizations used lower-cost cadres, but also often relied on technology to increase the efficiency of their health workers to take on more patients without hiring more staff. Both of these models offer lessons on how to effectively recruit, maintain, and utilize private sector staff effectively.

Private sector leverages expansive scopes of practice to develop innovative approaches to staffing

Employing differentiated care models for a client-centered approach requires thinking beyond higher-level cadres and facility-based service delivery. Task sharing, or using lower-level cadres to deliver health services traditionally done by higher cadres, is particularly important for delivering differentiated care. Lower-level cadres are well suited to providing services in the community, enhancing accessibility for clients.

South Africa and India's provider scopes of practice allow some degree of task sharing, and many of the respondent organizations have taken advantage of this by using nurses and CHWs to deliver aspects of the HIV clinical cascade. For example, South Africa's Unjani Clinics recognized a relative surplus of professional nurses in South Africa and built their service delivery model around using nurses to deliver HIV and other primary care services. In India, Glocal Healthcare's dispensaries are staffed by nurses who rely on artificial intelligence and tele-consultations with doctors to support their service delivery, and Aravind Eye Care System uses nurses to do all tasks in the operating room that don't require a surgeon's skill, and who are trained and certified as eye care technicians. Lay persons were recruited for CHW roles in both South Africa and India.

The differentiated care models are particularly advantageous for the private sector as task sharing supports competitive prices for high quality services. Given that the private sector is "competing" with the public sector's free HIV services, being able to provide consistently high-quality services at an affordable price is critical to successfully scaling services. Task sharing, particularly when coupled with technology, has allowed the organizations to lower staffing costs and recruit cadres that were more readily available. In South Africa, task sharing to nurses was particularly helpful for maintaining continuity at organizations because the law does not allow most private sector hospitals to directly hire doctors (they must employ them on a contractual basis). To maintain service quality, the organizations put in place standard processes and protocols, provided training, and introduced support tools, such as artificial intelligence-powered decision-support tools.

Private service delivery organizations invest in technology to keep staffing costs low and improve quality of service delivery

The South African and Indian organizations leveraged technology differently. The South African organizations primarily used technology to improve service quality, whereas the Indian organizations used it to reduce staffing requirements—number or cadre of staff—without compromising quality.

South Africa's CareWorks found that CHWs needed support in order to accurately and efficiently capture data on the patients they were testing. They developed the InterACTive KAPture Tool for data capture, training, and communication in order to automate, regulate, and record activities conducted at the service delivery level. The system comprises:

- InterACTive: an administrative point-of-care tool designed to capture all important data during voluntary counseling and testing (VCT) for HIV
- KAPture: a training and communication tool designed to educate and survey participants on HIV/AIDS
- A central database and back-office system

Technology helps health workers be more efficient and keep costs down without sacrificing quality. For instance, as CareWorks conducts VCT, data are quickly uploaded into the system (entered manually or through Voice over Internet Protocol) and are available within minutes of the session's end, facilitating rapid follow-up and ART initiation. Artificial intelligence ensures that data are captured correctly—where data are entered incorrectly, the program generates an error report, and staff are retrained or provided additional support. The tool also helps CareWorks staff gain a thorough understanding of the environments they are working in: cumulative, longitudinal studies can be conducted with survey data and test results.

South Africa's Unjani Clinics' nurses originally used paper forms to gather clinical data. However, the paper forms contributed to errors in both capture and transcribing. Unjani introduced Bluetooth-enabled tablets that guide the nurses in data capture, providing real-time quality control as they interview the patient and allowing the nurses to convey the data via WiFi into their clinical records. This has both reduced errors and enhanced efficiency. South Africa's PPO Serve developed an Intelligent Care System to manage clinical workflow based on patient-centric care plans, which has increased their efficiency and patient satisfaction.

Artificial intelligence, such as decision-support tools, helped organizations minimize health worker errors in order to achieve better results. In India, organizations' business models rely on efficiency to achieve profitability. Many of them use technology to increase efficiency in their use of health workers. Glocal Healthcare and Sevamob both use artificial intelligence and tele-health to do this. Glocal uses artificial intelligence to guide nurses in conducting clinical examinations and video consultations to enable doctors to support multiple digital dispensaries at once. Similarly, Sevamob's model incorporates video consultation and artificial intelligence into triage, consultation, and point-of-care diagnostics. By using these technologies, the organizations have achieved efficiency in two ways: 1) they hire fewer staff, because technology allows them to share skilled staff between multiple facilities (i.e., one doctor doing remote video consultations with multiple health facilities), and 2) extensive task sharing has allowed them to use lower-cost staff to deliver most services.

Case study: Glocal Healthcare

Glocal Healthcare provides high-quality and affordable health services with a commitment to transparency and equality in health care. It runs two lines of business, hospitals and digital dispensaries. To launch the business, Glocal took on three different investors, and also obtained a loan. Currently their hospitals are breaking even, and next year Glocal expects to be profitable at the company level.

Glocal's 10 hospitals are in second- and third-tier towns, which typically have access only to small nursing homes. The 100-bed hospitals provide emergency and critical care, with their intensive care units providing an important back-up service for the local nursing homes. Glocal operates its hospitals using a lean and efficient model that allows it to charge much lower prices and break even at an occupancy rate of just 20 percent. This has allowed Glocal's hospitals to thrive even in towns where other private hospitals have failed. To drive efficiency, the hospitals are built in a modular design, using open layouts that are simpler and use only 30,000 square feet, whereas other 100-bed hospitals would need 70,000 square feet. Glocal uses protocols for their services, allowing a lower number of staff-per-patient ratio while also ensuring quality.

Recently, Glocal started a primary care model of digital dispensaries. It currently has 120 dispensaries, and the number is rapidly increasing. The dispensaries use a unique automated model. They are run by a nurse who has access to a machine equipped with artificial intelligence. The nurse takes symptoms from the patient and enters the symptoms into the machine. The machine asks questions until it can recommend what test should be done. Blood and urine tests are done within the facility, and the results are available within 15 minutes. Once results are available, a doctor (a generalist or specialist) is connected by video conference. The doctor can conduct a virtual exam using an electronic stethoscope or other tools, and is backed up by an artificial-intelligence clinical support system. The doctor makes the final diagnosis and recommends treatment. Within the dispensary is a machine that automatically dispenses the required medication once it receives the doctor's order. The entire process takes 30 minutes, and patients receive a follow-up visit after one week. Glocal charges clients a flat rate that is less than half the market rate for the tests, diagnosis, and medication.

Glocal's commitment to quality through detailed protocols and use of technology has earned a 98 percent satisfaction rate from their clients.



Glocal's commitment to quality through detailed protocols and sensible use of technology has earned a 98 percent satisfaction rate from their clients.

Photo: Glocal Healthcare

The private sector uses innovative strategies such as short-term contracts, hiring locally, and expanding the age range of the labor pool to staff facilities

The private sector competes with the public sector for staff. However, while the public sector is largely bound by establishment registers, formalized cadre scopes of practice, and centralized hiring and deployment, the private sector is free to be innovative with whom and how they hire. Both South Africa and India provided good examples of thinking outside the box in hiring staff, ultimately expanding the pool of health workers available to the labor market.

Some services can be supported through seasonal hiring of otherwise unemployed staff. South Africa's CHAPS provides VMMC. CHAPS conducts seasonal hiring drives for workers because demand for circumcisions is substantially higher in the winter months than the rest of the year. CHAPS typically recruits people who were previously unemployed to do community-based demand generation work using short-term contracts. This strategy allows CHAPS to surge staffing levels as needed without long-term commitments, and avoids competing with other health facilities for staff.

It is sometimes more affordable to hire locally and train employees in the required skills. South African and Indian organizations praised the virtues of hiring facility-based staff locally, even for rural clinics. One organization, South Africa's CareWorks, noted that their local workers were less tired because they were traveling shorter distances, and happier because they were able to stay with their families. Local hires tend to remain at the organizations longer, although they sometimes leave if they find something nearby with the government or for higher pay.

Several organizations noted that, while local hiring is the most effective, sustainable model, some local staff lack critical skills. To counterbalance this, the organizations build training, mentorship, and performance feedback into their systems to ensure the local workers are able to provide services at the level required.

Hiring outside the prime age group can ease recruiting problems. Staff at the beginning or end of their careers offer distinct advantages. In India, organizations, particularly those recruiting for remote rural areas, found that hiring health workers at the very beginning or end of their careers expanded the labor pool willing to work in undesirable locations. Young health workers are less likely to have families that might be unwilling to move with them to the location. They are also eager for experience, and therefore are more willing to live in inconvenient locations in order to gain that experience.

Organizations promised innovative service delivery models and on-the-job training to attract young workers. However, turnover can be high among younger workers, because they look to leverage the experience for higher-paying or better-located jobs. Many organizations also recruit health workers past the government retirement age, an especially effective way to expand the pool of health workers. Older health workers are more likely to be recruited locally and stay on the job for many years. They bring experience to their positions, and some organizations invest in continuing professional development for them to ensure their skills are up to date.

Private organizations use an organic process to design a mix of incentives tailored to attract and retain priority health workers, rather than trying to compete with the public sector

Respondent organizations in both South Africa and India offer salaries at the market rate. In South Africa, high public sector wages were difficult for the organizations to outcompete. In India, the organizations found market rates sufficient to attract health workers generally, but they have difficulty hiring for their most rural locations. Rather than compete on wages, the organizations offer a mix of incentives to attract health workers. The mix of incentives are developed organically over time through experimentation and responding to health worker requests.

Private organizations have the flexibility to experiment within the fringe benefits package to attract health workers. In South Africa, the corporate organizations offer generous packages of benefits such as an employee stock ownership program, health and wellness services, and customized retirement plans. They reported that this helps them compete with the public sector's high wages in a cost-effective manner. In contrast, in India none of the organizations innovated on benefits, offering only the standard package required by the government. This was considered adequate to attract and retain staff.

Health workers are attracted to the unique aspects of innovative business and service delivery models. Many respondent organizations had unique business and service delivery models that attracted candidates eager for exposure to new models and training in the skills required. In South Africa, corporate hospitals have invested in state-of-the-art equipment to help attract doctors. In India, organizations tout their technology, task sharing, and efficient systems to attract health workers. The organizations that recruit locally have found that it is advantageous to be perceived as a “big fish in a small pond.”

Giving health workers opportunities to grow through career pathways and training opportunities are effective retention strategies. Supporting health workers' professional growth is a strong retention theme in both South Africa and India. In South Africa, organizations that provide employees a clear pathway to more senior and/or management roles see higher retention rates. In India, five of the organizations interviewed offer clearly defined career pathways for their clinical staff, which they said helped with retention. The other four, however, felt that getting a fair salary, being recognized in the community, and being exposed to innovation was sufficient to attract and retain staff, without the need for career pathways.

Case study: Sevamob

At Sevamob in India, most health workers remain in the organization for long periods of time. Sevamob attracts employees with the promise of having a significant social impact through their work, having a flexible schedule, and being exposed to a unique service delivery model. To encourage health workers to stay, Sevamob uses a variety of incentives. Health workers receive training in standardized service delivery and in skills such as patient handling. The health workers are given a stake in the business, receiving a percentage of revenue for new deals and service delivery. They also receive non-financial incentives, such as employee of the month awards. Sevamob also works hard to accommodate the personal lives of health workers. Many of their nurses have to move due to marriage, and Sevamob works with them to transfer their position to a Sevamob clinic near their new home. This attention to the well-being of the health worker builds loyalty among the staff. Over the past three years, Sevamob's attrition rate was 10–20 percent, with most health workers leaving only when their contract expired.

Organizations in both countries offer training opportunities (both external and in-house) as an incentive for staff. India's Aravind Eye Care System has an extreme training model—they allow no lateral entries for health workers. Rather, they recruit doctors directly after graduation to do fellowships at Aravind; potential nurses are recruited after grade 12, and they attend nursing school at Aravind. This allows Aravind to control every aspect of the quality of their health workforce, while making sure their health workers are trained to perform under Aravind's demanding service delivery model. It also engenders loyalty in their staff and provides a strong draw to ambitious young workers.

The organizations surveyed also use a variety of other benefits to attract and retain staff. Most offer one or two additional items that they had found, through trial and error, work for their staff. These are:

- Performance-based financial incentives, such as annual bonuses tied to key performance ratings or indicators
- Flexible shifts and working hours to match employees' lifestyles
- Generous role-specific hiring bonuses
- Recognition, such as awards to outstanding workers
- A safe work environment and trust between the organization and health worker
- Food and housing in rural areas



Ensuring female health workers are safe, empowered and have flexible working conditions promotes their retention.

Photo: Aravind Eye Care System

For example, in South Africa, Clicks Group Ltd. offers long-term financial incentives to black employees and staff with scarce and important skills. Other organizations differentiated incentives based on cadre (e.g., to attract doctors only) or location, with hardest-to-reach postings receiving the largest incentives.

Ensuring female health workers are safe, empowered and have flexible working conditions promotes their retention. Both South Africa and India have a high ratio of female health workers. In South Africa, approximately two-thirds of medical school graduates are women, and in both countries the vast majority of nurses are female. India's LifeSpring Hospitals is 99 percent female staffed and credits this staffing profile to their success as maternity service providers, but nearly all facilities surveyed rely heavily upon female health workers.

Gender-specific retention strategies are powerful for organizations in both countries. Organizations in both noted that many women on their staff are at the marrying and child-bearing stage in life, which causes them to leave the workforce. The organizations, therefore, found it essential to find ways to support female staff to work through these life changes.

The organizations that have been most successful at retaining female staff worked hard to give them flexible employment options. They assign the women a manageable workload, and allow them flexible working hours so they have time to attend to family responsibilities. Indian organizations found that female staff were leaving when they married because they moved to their husband's home region, and so the organizations began offering transfers to one of their other facilities if there was one near the health worker's new home. To reduce loss of pregnant health workers, organizations allow women to take as much unpaid maternity leave as they desire with a guarantee of returning to the same position and salary when they are ready. LifeSpring Hospitals emphasizes a work environment that is safe for women. South African organizations have gone further and tailored benefits packages to better suit women (such as female-friendly health insurance or retirement plans). Others explicitly emphasize women's empowerment. In fact, the 11th Annual Standard Bank Top Women Awards named Clicks Group the country's Top Gender Empowered Company in the retail sector.

Case study: India's female-staffed LifeSpring Hospitals

LifeSpring Hospitals has an unusual characteristic that attracts both clients and staff to their hospitals: nearly 100 percent of the staff is female. LifeSpring actively recruits female doctors, nurses, cleaners, and administrators to staff their hospitals—only the security guards (who remain outside the hospital) are male. This policy promotes a safe and supportive environment for women in labor, and is also an incentive for staff, who like working in an environment that is safe and free from harassment. LifeSpring's women-friendly policies have made their median retention rate for nurses five years and for obstetricians seven years. They attribute some of their success in retention to their recruitment process—candidates are recruited directly out of college, and in the second stage of recruitment they are placed in the hospital for one week. Recruits are narrowed down over the first week of employment based on their ability to internalize LifeSpring's core values and handle heavy client loads. LifeSpring promptly invests in building their skills. They provide clinical and non-clinical training, both in the classroom and on the job. New nurses work in different areas of the hospital for eight months, getting the larger picture of the hospital, and then can take on more advanced roles, such as working in the operating room. This type of exposure and opportunity for advancement doesn't typically happen in other hospitals, and is something of which the nurses are proud. LifeSpring also has leave policies that support workers who need to travel home to family—they are allowed to aggregate their leave for a month and take it all at once. Obstetricians, who work on contract, are supported to work hours that make sense for their personal lives. And, when LifeSpring noted that many of their health workers were lost to marriage and maternity, they made a policy that health workers could take as much unpaid time off as they needed after these events, and return to protected positions and salary.

Sustaining community-based HRH operations by integrating them with private organizations

Although CHWs are typically seen as a public sector cadre, nearly every respondent organization in South Africa and India actively leverages its own CHW cadres to expand demand creation for their services. Further mobilizing private sector CHWs is a cost-effective way to generate demand and promote uptake of HIV services. As seen throughout the previous section, CHWs are integral to the organizations' business models and HIV service delivery. The providers have integrated community-based staff into their organizations to expand their reach and sustain their operations. Having a community-based service component is largely understood as the cost of doing business in both countries.

Local hiring facilitates retention and better performance of CHWs. Both South African and Indian organizations noted the importance of hiring CHWs locally. CHWs have a vested interest in making a difference in their communities and they are familiar with the area so they know things such as communities and they are familiar with the area. Local workers do not need to travel as far as mobile workers, and are therefore more available on a day-to-day basis. Hiring locally helps ensure that the CHWs can effectively communicate in the local language and deliver care in culturally appropriate ways. The organizations found that hiring locally promotes greater retention and therefore sustainability—turnover was higher among CHWs hired from elsewhere, particularly among CHWs from urban areas working in rural and/or underserved areas. Moreover, hiring lower-skilled workers and/or the unemployed has the potential to reduce unemployment, especially in underserved areas. Respondent organizations incorporated training for CHWs into their model to ensure quality.

Forming integrated clinical care teams with other health professionals improves outcomes of CHWs. Integrated care is a potential way to improve the patient experience and health outcomes by coordinating multiple services, providers, and settings in order to streamline the patient experience, enhance quality of care and quality of life, and increase customer satisfaction (WHO 2016a, WHO 2016b). South Africa's PPO Serve's Integrated Clinical Consortia's (ICC) primary health care and HIV response uses CHWs to streamline services for patients and provide continuity of care to the home level. For patients who require intensive or specialized home-based care or other services that are beyond the CHW skill level, higher-skilled personnel such as physicians and nurses conduct community health work in concert with the CHW, including care from mobile units and home visits. When faced with these scenarios, other organizations designed teams that leveraged CHWs for tasks such as outreach and patient education, saving higher-level cadres for more complex health service delivery.

- Where home-based care is required, South Africa's PPO Serve's ICCs send the appropriate health care worker from the team or subcontract home-based care agencies to attend to the patient. In some cases, this may be the CHW; in others, it may be a nurse, specialized physician, or other personnel depending on the need.
- India's LifeSpring Hospitals rely heavily on outreach workers to do community-based work, but send nurses to accompany CHWs when needed.
- At South Africa's Unjani Clinics, the nurses, CHWs and clinical assistants do community-based work. CHWs do most of the home visits for patients whose conditions render them unable to attend the clinic, but nurses directly provide care when needed.

CHWs receive supportive supervision and regular check-ins from clinical providers. Quality supervision strategies can increase CHWs' motivation and retention and lead to better performance. In both South Africa and India, the organizations with large community-based components implemented supervisory systems to support the CHWs and ensured that the CHWs regularly reported back to the facility or main organization. In India, LifeSpring required that health workers report daily to the facility to ensure that they were fully integrated into the clinic.

Private organizations employ CHWs as staff members or contractors, as part of their marketing or service delivery budget. Most organizations noted that CHWs are integral to their marketing and service delivery, and therefore should not be treated as a separate program or expense. They fund their community-based HRH as part of their regular facility or program costs, often as a marketing expense. Most hire CHWs as staff members, although a few brought them on through contracts or with a stipend.

Case study: South Africa's Professional Provider Organization Serve Integrated Clinical Consortia

PPO Serve — Integrated Clinical Consortia offers best practices in organizing, compensating, and motivating HRH for HIV and other priority health services. PPO Serve is a health care management company that manages and oversees ICCs—local business units owned by the participating clinicians.

The ICCs are customized teams of HRH that are formed based on the specific needs of the population they serve. Most focus on population medicine or HIV-related services. PPO Serve helps clinicians to launch the ICC and helps to hire the health workers. Most ICCs include and task share with mid- and lower-level health workers, such as nurses and CHWs. Many are women. PPO Serve teaches all staff the methodology behind working as a team. ICCs do not hire for all of their needs; for some, they work with local organizations. All ICCs include care coordinators. These are nurses or clinical associates who manage the transition of care among the different HRH on the team. PPO Serve developed its Intelligent Care System to help ICCs manage patient care and clinical workflow. This system allows the team to assign tasks and alert ICC members to ensure patients are well cared for and monitored. The ICC holds regular meetings to review care plans.

Several ICCs currently work in pilot projects across South Africa, funded by the government, international donors such as PEPFAR, private companies, and some by consumers paying with cash. The first ICC, the Alberton Pioneer ICC, was launched in July 2016 in Gauteng. It focuses on population medicine. Alberton was initially based on a contract with the Discovery Health Medical Scheme and linked to about 6,000 Discovery members. The Alberton ICC consists of an internal medicine specialist, a pediatrician, seven general practitioners, a clinical director, a social worker, an occupational therapist, and others. The Government Employee Medical Scheme recently joined this project and is supporting several new projects. In the long-term, PPO Serve aims to run 100 ICCs nationwide that are primarily focused on population medicine.



PPO Serve is a healthcare management company that manages and oversees ICCs, which are local business units owned by the participating clinicians.

Photo: Lorne Liebenberg

In PPO Serve's model, the HRH in each ICC are paid for their services through the value contract, a capitated alternative to the fee-for-service payment mechanism. In the private for-profit health sector in South Africa, fee-for-service is the dominant payment mechanism. Currently, individual doctors, nurses, and practices compete against each other due to the oversupply of clinicians in the private sector relative to the market of privately insured clients. This competition leads to inefficient, fragmented care that produces sub-optimal health outcomes and is unaffordable for the majority of South Africans. Many HRH prefer to work in teams and share earnings rather than to compete individually for clients. PPO Serve uses a payment mechanism called the value contract, which has two components: 1) a capitated payment given to the ICC based on the number and health risks of the patients being treated, and 2) the value-added component, based on the ICC's score against specific quality and production outcomes (determined by national benchmarks). By bringing HRH together in a team and splitting the income among them, ICCs enable each health worker to focus on the role they were trained to perform. The value contract fosters care that is patient centered and lower cost.

The ICC model offers the benefits that come with being supported by peer health workers, including more flexible working hours, efficient transitions between care, clearer communication between HRH, and quality oversight. The flexible hours and support are especially important considering the large role women of reproductive age play in the health workforce in South Africa—the ICC model allows female health workers to work and raise a family at the same time.

Case study: South Africa’s Expectra Health Solutions

Expectra Health Solutions is a nonprofit organization that provides community-based health care, supports service delivery improvement in government clinics, and runs a CHW training program in the province of KwaZulu-Natal. It is the only organization of its kind operating in that province. Expectra works primarily in uMzinyathi District, one of the poorest districts in the country. Its objectives are to improve the quality of care delivered in the region and to reduce the burden on the public health system by promoting preventive practices among the local population.

Expectra provides primary health care services and supports government clinics to improve their primary health care service quality. This includes chronic disease management such as HIV testing and care as well as the treatment of non-communicable diseases such as diabetes and hypertension.

The organization is engaged in a variety of community health activities, including door-to-door profiling, in which Expectra’s CHWs identify the community’s needs, hold health education campaigns and medical camps, and deliver door-to-door medical interventions. In partnership with the Department of Health, Expectra visits schools in poor areas to improve children’s health.



Expectra Health Solutions conducts door-to-door profiling, in which CHWs identify the community’s needs, hold health education campaigns and medical camps, and deliver door-to-door medical interventions.

Photo: Expectra Health Solutions

Expectra launched a year-long training program (accredited by the Health and Welfare Sector Education and Training Authority) in community health work in order to generate revenue and train more CHWs. Expectra views this training of CHWs as a long-term investment in its own financial sustainability and in the development of South Africa's health system. Its approach tackles two HRH challenges: the shortage of CHWs in South Africa and the widespread lack of education and important skills among the existing CHWs. Expectra emphasized the need at the local and national levels for more trained CHWs, especially in light of the NHI reforms. Under NHI, public sector CHWs are to be responsible for the needs of their community, but many lack the skills or capacity to fulfill this role. Not only do many CHWs not possess the community health qualification provided by Expectra; many lack any formal education in community health, having attended only a two-week introductory course on community health work and other infrequent programs. Many additional CHWs will have to be well trained in order for the NHI system to work.

The CHW training program easily attracts the 60 students Expectra recruits annually. Expectra creates a platform for the students to practice what they are learning by playing a supervisory role in the organization's programs. This training has proven to be a significant professional development opportunity with the potential to advance students. Some graduates of the program continue their education; some go to work for NGOs; and many obtain employment in the public sector—close to 900 in uMzinyathi District.

Expectra employs a core staff of about 25, although this number varies at any given time depending on the size of the organization's grants. Many core staff members are graduates of the CHW training program. In addition, the organization employs staff under short-term contracts, generally six months to one year, to work on specific programs. For many short-term programs, Expectra recruits CHWs in the respective local communities, targeting those who had experience volunteering or working in the local clinic. Most are women. Expectra trains them and pays their salaries for the duration of the program. The organization provides a tailored training program for these CHWs so that, although the programs are brief, the CHWs come away from them with useful skills.

Role of the public sector in strengthening the ability of the private sector to finance growth and improvements in their HRH to support a strengthened HIV response

The public sector in South Africa and India strengthens the ability of the private sector to finance growth through three mechanisms—an enabling policy environment, service delivery contracts, and national health insurance—and through policies.

Carefully designed policies and regulations are needed to support private sector growth, especially for HIV.

As noted, the South African and Indian private health sectors have very different roles in their respective national HIV responses. The difference between the South African and Indian respondents' willingness to be involved in the HIV clinical cascade stemmed from the two governments' current willingness and potential future openness to engage with the private sector in the HIV response, and the type of epidemic the country is facing. In India, where the epidemic is concentrated in key populations, the government is the undisputed provider of HIV services, which are offered for free and are seen as good quality. Therefore, the organizations saw no opportunity in HIV service provision. In contrast, in South Africa's generalized epidemic, organizations saw opportunities to complement the government's service delivery with HIV services tailored to the varying needs of different population segments, such as convenient ARV pick-up locations, workplace HIV testing, and NIMART services in the community.

Regulatory requirements and tax incentives for private companies to offer HIV counseling, testing, and treatment to their employees create opportunities for private sector. Both South Africa and India have corporate social responsibility (CSR) regulations that encourage corporations to invest in private sector health. South Africa's Broad-Based Black Economic Empowerment (B-BBEE) Act of 2003 promotes CSR investments in skill building, enterprise development, and management opportunities. B-BBEE and other policies motivate businesses to contribute to community development, which has had a substantial impact on many organizations surveyed. In India, a two percent CSR bill has created incentives for corporations to put aside money for health, and many of the respondents tapped into the funds in order to offer additional or alternative services.

Recognizing the benefits of employee well-being, South Africa's CSR regulations encourage private employers to provide the full spectrum of HIV service delivery at their workplaces. For example, the Johannesburg Stock Exchange SRI Index mandates that listed companies offer their employees programs on HIV and AIDS prevention, education, and awareness and access to VCT, and that they sponsor and support prevention, education, and awareness programs for the communities in which they operate. South Africa's guidelines for the governance structures and operation of companies encourages public reporting on companies' strategies for promoting employee health and risk mitigation. Thus, companies in the country's large-scale mining, manufacturing, and agriculture sectors are incentivized to invest in health care for their staff. Many companies contract with private sector providers to deliver care to their employees. One South African respondent, CareWorks, partners with mining companies to provide services to their employees. CareWorks leverages lay counselors (employed by CareWorks) and trains mine workers (employed by



Regulatory requirements and tax incentives for private companies, such as Swasth Foundation, to offer HIV counseling, testing, and treatment to their employees create opportunities for the private sector.

Photo: Swasth Foundation

the mining companies) as peer educators to promote awareness and do HIV outreach. CareWorks also offers ART for some companies; for others, it refers all positive cases to the government.

Similarly, Clicks Group Ltd. has an Employee Wellness Programme that provides comprehensive services, including HIV care and treatment, to its permanent employees. The company also offers professional counseling and advisory services to employees and their household dependents who are affected by HIV, as well as preventive care (VCT, post-exposure prophylaxis, etc.). The program was introduced to promote a supportive organizational culture and ensure that permanent employees who are affected by HIV receive the care they need to remain productive employees. In the last employee survey, the Wellness Programme was rated the company's top program.

Case study: Smile Foundation

Smile Foundation uses mobile medical units to deliver services in rural areas and poor urban areas. The foundation interacts with local district government officials in the areas in which the mobile medical units provide services. The Smile Foundation aligned their work in accordance with the National Health Policy, which specifically addresses and permits mobile medical units. Having a written policy has helped Smile Foundation in negotiating with local government officials. There are still differences between policy and implementation, and Smile Foundation actively manages the differences through promoting active participation by civil society.

Regulations that lower input costs and simplify taxes can help the private sector offer value to clients. In India, respondents were focused on providing affordable high-quality services to their clients. Therefore, the regulations they found most helpful were those that cut costs:

- The Essential Drug Policy reduced the cost of key drugs, making them more affordable for the low-income clientele.
- Preventive primary health care services are exempt from the Goods & Services Tax (GST), making prevention services more affordable to their clientele.

In contrast, the GST is levied against most health items other than preventive primary health care, and the rates are variable, placing an administrative burden on the organizations. Eliminating taxes on health inputs and services would relieve the burden on private sector providers and support their price-competitiveness. Alternatively, a low flat tax would ease the administrative burden.

Regulations need to strike the right balance. Overall, India has hundreds of laws pertaining to health, making it challenging for both private health care organizations and those responsible for enforcing the laws to comply. The organizations noted that the varying degrees of specificity in the laws were both a blessing and a curse. Since most of the interviewed organizations work in rural areas, they interact primarily with officials from local jurisdictions. In some instances, it was helpful to go to the officials with a specific regulation, particularly when the regulation clearly showed that the type of innovation the organization was introducing was legal, but at other times it was helpful to have no regulation so that the organizations could negotiate their own deal. Overall, however, the opaque regulations meant high levels of bureaucracy and a lot of interpretation from local officials.

Some specific regulations in both South Africa and India limited the organizations' ability to grow. For example:

- In most cases, South African hospitals are legally prohibited from directly employing doctors; instead, the hospitals must retain doctors as independent contractors.
- India's Public Health Insurance Scheme can reimburse only 50-bed or higher hospitals, cutting out small service providers.
- India strictly regulates access to some key equipment. LifeSpring Hospitals reported that regulations around licensing an ultrasound device have decreased the affordability of related services and increased inefficiency; for example, the ultrasound device cannot be moved from the room where it is kept, so patients must be brought there.

Public-private service delivery contracts give private providers a reliable revenue source.

Respondents in both South Africa and India contracted directly with the government to provide services. Most were reimbursed on a per procedure basis, and two had memoranda of understanding with parastatal organizations to deliver services. Although the organizations appreciated the reliable revenue source, government reimbursement made up 20 percent or less of total revenue for the organizations.

Including private providers in NHI schemes creates a significant opportunity for scaling up private services for HIV and moving toward universal health coverage.

South Africa is planning to implement a new NHI policy, posing major changes to the health financing landscape. NHI will be approved for use at accredited public and private providers, giving respondents an opportunity to scale-up their businesses by becoming National Health Service providers (DoH 2017), and thereby to help overcome public sector HRH constraints that could impede successful rollout of NHI. The proposed capitation model is similar to current government contracts, which pay a flat rate for services. Organizations raised concerns, however, about being able to maintain clinical and operational autonomy as NHI is rolled out. India's government also recently announced a plan to provide half a billion citizens free health insurance, which offers a similar opportunity to private providers. These changes present opportunities to design policies and regulations that support private sector growth.

Providers need regulatory regimes that facilitate access to financing for start-up capital and for scaling proven models.

Organizations in both South Africa and India had cobbled together financing for start-up and expansion through a wide variety of sources: the founders' own money, CSR funds, government or nonprofit grants, private investors, and bank loans. In both countries, access to financing was challenging, and for those that had to rely on bank loans, prohibitively expensive. Limited access to financing made it difficult to take advantage of new opportunities and to build upon proven models.

Photo: Rural Health Care Foundation

Looking toward 2030 and beyond



Looking toward 2030 and beyond

The organizations that SHOPS Plus interviewed in both South Africa and India provided diverse examples of good business and human resource management practices. Across the spectrum of organization sizes and types, private sector HRH were being carefully leveraged to efficiently deliver high-quality services. However, the project also found starkly different levels of willingness among the organizations to engage in HIV service delivery between the two countries. In India, where the HIV epidemic is concentrated in key populations, HIV service delivery was seen to be a responsibility of government, with no opportunity for the private sector to sustainably enter beyond occasional HIV testing. In contrast, in response to South Africa's generalized epidemic, the government fostered a more inclusive space for private providers, with incentives such as CSR policies, expanded scopes of practice such as NIMART, and policies that allow innovation on how and where HIV service delivery

occurs. This contrast shows that private sector involvement in HIV service delivery depends upon the type of epidemic the country faces, and the public sector making room for the private sector through policies that help HIV service delivery make good business sense.

In both countries, the private sector offers rich resources to leverage for HIV service delivery. It uses its agility in business models and utilization of the health workforce to develop profitable business models even within the lowest-income communities and in hard-to-reach rural areas. The private sector is using task sharing and technology to drive efficient and cost-effective service delivery. CHWs are already deeply and sustainably integrated into private sector business models, providing essential outreach and marketing to build demand for the providers. Private laboratories and pharmacies have capacity to take on PPPs to expand access points for HIV testing and ARV distribution. The private sector is well positioned to employ additional health workers in order to respond to new business opportunities in HIV/AIDS service delivery.



Leveraging the private sector's capacity for HIV service delivery to achieve the 95-95-95 goals requires input from policy makers, ministries of health, donors, implementing partners, and private providers such as Dr. Howard Manyonga from PPO Serve.

Photo: Lwazi Mashiya

Fully leveraging the private sector’s capacity for HIV service delivery to achieve 95-95-95 goals by 2030 requires input from policy makers, ministries of health, donors, implementing partners, and private providers. Based on the study findings, there are four recommendations that policy makers, donors, and implementing partners should keep in mind as they seek to leverage the private sector to employ HRH for a stronger HIV response:

- 1. Recognize a role for the private sector in HIV service delivery—the private sector won’t introduce services unless it sees a market opportunity, such as high demand or low barriers to entry.** Making room for the private sector in HIV service delivery requires policy makers to enact policies that incentivize entry. Ministries of health can include the private sector in HIV strategic plans and ensure that the private sector is able to access needed resources, such as the ARV supply chain. Donors and implementing partners should include the private sector in HIV service delivery both through technical assistance related to HIV program design and demand generation, and financially through grants or identifying capital financing opportunities. This can be important for capital-intensive expansion, such as procuring equipment to begin viral load testing. Health management companies can be used to ease the administrative burden that providing HIV services imposes on private health providers.
- 2. Leverage the private sector’s diversity to provide differentiated care across the HIV clinical cascade to clients of all income tiers.** The private sector extends far beyond individual doctors’ private practices or corporate in-house HIV programs. Nurse-owned and operated rural clinics, artificial intelligence-enabled kiosks, mobile clinics, CHWs, pharmacies, and laboratories are all present and active in the private sector. Private providers have established sustainable models that are ready for scale-up,

and that can absorb additional health workers to deliver HIV services. CHWs can provide HIV testing and patient follow-up, pharmacies can be leveraged for expanded access to ARVs, and private laboratories have the potential to expand capacity for viral load and other tests. As governments, donors, and implementing partners look for ways to accelerate and sustain their HIV responses, they need to give greater consideration to how they can engage these cadres to support HIV goals, whether through distribution of public health messaging through private CHWs, PPPs that refer stable ART clients to private pharmacies for drug pick-up, contracts with private laboratories to utilize their existing capacity, or some other model. Doing so can free up public financial and human resources to focus on more complex cases or populations with a more limited ability to pay for a private sector HIV option.

- 3. Determine how to pay the private sector.** Models can include the public sector wholly paying for private sector services, clients with the ability and willingness to pay entirely for the cost of their care, or a combination of payment mechanisms. The payer arrangements will shape how service delivery organizations utilize and plan for required HRH. If selecting public sector financing, ministries of health can directly contract the private sector for all aspects of the HIV clinical continuum, from community-based outreach to ARV distribution, or contract the private sector to hire health workers. Donors and implementing partners can also contract directly with private providers for services. If seeking to encourage private or out-of-pocket financing for services, donors can support the private sector to begin HIV service delivery through technical assistance, training private health workers, and making capital investments in required equipment and supplies. Private providers can make HIV services affordable for their out-of-

pocket clients by leveraging technology and task sharing. However, regardless of the mode of financing, private providers must have greater access to capital in order to transition into HIV service delivery and scale-up. Financing from corporate investors, social impact investors, and donors is currently easier to access than bank loans for most private providers. Easing access to bank loans is a key step in scaling the size of the private health workforce.

4. **Support regulation that allows the private sector to innovate in service delivery.** The ability to innovate is one of the private sector's greatest strengths. Access to technology and equipment and supplies, and flexibility about where and when and by whom services are delivered opens possibilities for the private sector to help reach clients that the public sector might not be able to. Policy makers can put in place regulations that allow innovative or flexible business practices, such as task sharing, community-based or lay-diagnostic testing, and mobile medical unit- and employer-provided HIV treatment programs, and that can also assure quality to encourage the private sector to find ways to make HIV service delivery feasible for their companies. Policy makers should also be mindful of policies that might inadvertently discourage start-ups and small companies, such as putting regulations on access to key equipment or excluding the private sector from national health insurance. Too many of such regulations may discourage private sector growth.

With the support of governments and donors, the private sector is well positioned to expand its health workforce. The organizations surveyed show that private providers are using a wide array of strategies to finance and manage their health workforce in order to profitably deliver services and expand into HIV service delivery. Relying on lower-cost cadres, hiring locally, and using a variety of contracting mechanisms (including short-term contracts and consultancies) support an agile and cost-effective workforce that can adapt to the requirements of differentiated care. The companies are experienced in gender-sensitive employment practices and employing junior-level staff, and effectively drawing at-risk youth into the health workforce and thereby supporting youth employment. A proactive and organic approach to developing incentive packages is helping the private sector identify exactly what works for retaining and motivating their workforce. These demonstrated strong human resource management practices may be leveraged for expanding the private sector.

With coordinated and intentional encouragement and investment from all stakeholders, the private sector is a potential employer for the additional health workforce needed to continue expanding and sustaining HIV services. The lessons contained in this report offer a starting point for better engaging the private sector in overcoming HRH constraints to achieve the 95-95-95 target, maintain epidemic control, and achieve other ambitious global health goals.

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