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ASSESSMENT OF THE PRIVATE SECTOR'S ROLE IN EL SALVADOR'S HIV RESPONSE

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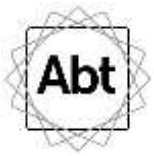

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CONTENTS

ACRONYMS

ANEP	National Association of the Private Enterprise
ART	Anti-retroviral treatment
ARV	Anti-retrovirals
CCM	Country Coordinating Mechanism-El Salvador of the fight against HIV/AIDS, tuberculosis, and malaria.
CONAVIH	National Committee for HIV/AIDS Prevention and Monitoring
COSAM	Military Forces Health Regime *(Comando de Sanidad Militar)*
CSR	Corporate Social Responsibility
CSSP	Superior Council of Public Health
CSW	Commercial Sex Workers
DNM	National Directorate of Medicaments
HFG	Health Finance & Governance
INSAFORP	Institute for Vocational Training
ISBM	Teacher's Welfare *(Instituto Salvadoreño de Bienestar Magisterial)*
ISSS	Social Security Institute *(Instituto Salvadoreño de Seguridad Social)*
JVPLC	Supervisory Board of the Clinical Laboratory Profession *(Junta de Vigilancia de la Profesión en Laboratorio Clínico)*
MOH	Ministry of Health
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment
NGO	Non-Governmental Organization
NRL	National Reference Laboratory
OOP	Out-of-pocket payments
PASMO	Pan American Social Marketing Organization
PEPFAR	United States President's Emergency Plan for Aids Relief
PHC	Primary Health Care
PLHIV	People living with HIV
PENM	National HIV/AIDS Multisector Strategic Plan 2016-2021 (*Plan Estratégico Nacional Multisectorial de VIH e ITS)*
POCT	Point of Care Testing
PPP	Public-Private Partnership
SBCC	Social and behavioral change communication
SID	Sustainability Index and Dashboard assessment of PEPFAR
SNS	National Health System
SUMEVE	Single System for Monitoring and Evaluation of Epidemiological Surveillance of HIV/AIDS from the MOH *(Sistema Único de Monitoreo, Evaluación y Vigilancia Epidemiológica del VIH-Sida del MOH)*
USAID	United States Agency for International Development
VL	Viral Load
WHO	World Health Organization

EXECUTIVE SUMMARY

In El Salvador, the HIV landscape is marked by a low national prevalence that is concentrated in key populations such as men who have sex with men and commercial sex workers. Among the 15 elements deemed critical to the HIV Response in El Salvador, the PEPFAR Sustainability Index and Dashboard (SID) exercise of 2016 ranked private sector engagement the lowest by far. To address this, HFG worked in consultation with the Ministry of Health (MOH) to assess El Salvador's progress in implementing effective partnerships between national programs and the private for-profit sector (henceforth referred to as private sector), focusing on how these partnerships impact the program's ability to sustain itself in the long term.

Through interviews with key stakeholders, this assessment summarizes the current role of the private sector in the HIV response, and identifies opportunity areas to further enhance the private sector's support in the efficient delivery of HIV services. It focuses on areas for private health sector providers to increase their involvement, as the National HIV/AIDS Multisector Strategic Plan 2016-2021 (PENM) has provided a specific scope of action for Corporates (HIV policies at the workplace) while private providers are not as visible.

First, the assessment highlights three key partnerships that exist: the Corporate Sector-ISSS-INSAFORP partnership, which aligns business associations with El Salvador's Social Security Institute *(Instituto Salvadoreño de Seguridad Social* or ISSS*)* to adopt HIV policies at the workplace; a partnership between the Pan American Social Marketing Organization (PASMO) and commercial laboratories to supply diagnostic HIV tests to PASMO beneficiaries; and a pilot partnership between commercial laboratories and the MOH's HIV Program in which data is more easily shared between actors into the Single System for Monitoring and Evaluation of Epidemiological Surveillance of HIV/AIDS of the MOH (SUMEVE) to more accurately understand dynamics of the HIV epidemic.

It then highlights factors found in El Salvador that constrain further growth of for-profit private sector involvement, grouped into structural barriers and program gaps. Biggest structural barriers included political polarization, fragmentation of service delivery and financing, the gratuity principle instituted by the free provision of HIV goods and services by the Government of El Salvador, and religious affiliations of corporate representatives that make HIV-related initiatives a delicate topic. Program gaps focused on needed elements that were conspicuously absent from the private sector partnerships: data sharing, standardized laboratory guidelines, and effective stewardship of national HIV program principles.

The assessment concludes by suggesting areas for potential further action to enhance public-private partnerships. These are to integrate the public and private sector capacities into the country's response, and enable private provision of ART and potentially self-testing services for population with payment capacity. The suggested initiatives are intended to strengthen the national response to HIV and support, and be framed by, the PENM.

INTRODUCTION

In El Salvador, the HIV landscape is marked by a low national prevalence (of less than 1%) that is concentrated in key populations such as men who have sex with men and commercial sex workers. Though El Salvador's economy is the fourth-largest in the region, it still depends on donors for financing some aspects of its HIV response. According to the most recent HIV/AIDS Sustainability Index and Dashboard (SID) assessment, conducted by the United States President's Emergency Plan for Aids Relief (PEPFAR) in 2016, 71% of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources). Moreover, it found that among 15 critical elements to the sustainability of the El Salvador HIV/AIDS response, private sector engagement was, by far, the lowest rated and the only one falling in the "unsustainable and require significant investment" category.

The Health Finance and Governance (HFG) Project, funded by the United States Agency for International Development (USAID) was requested to provide technical assistance to the Ministry of Health of El Salvador to strengthen its HIV/AIDS response. This request falls under the USAID and Global Fund (GF) collaboration to support select countries in areas of financial management and analysis/costing. For the technical assistance, HFG conducted an assessment of the efficiency of the HIV/AIDS program in areas selected in consultation with the El Salvadoran Ministry of Health (MOH) to identify improvements in efficiency and determine how such improvements would impact the financing of the program. One key element of the analysis is the assessment of El Salvador's progress in implementing effective partnerships between national programs, civil society organizations, and the private for profit sector, focusing on how these partnerships impact the program's ability to sustain itself in the long term.

To achieve this, HFG performed a scoping visit in May 2018 to address the not-for-profit private sector role in the HIV response. In order to build on the previous visit[1] and assess the current and potential for-profit private sector role to increase efficiency in the HIV response, HFG conducted multiple interviews with key private sector stakeholders and officials of the MOH-HIV National Program from August 27 to August 31, 2018. Additional interviews were conducted via Skype the first two weeks in September. This brief summarizes the main findings of the interviews and resulting recommendations on how to enhance the role of the private sector to increase efficiency of the HIV response.

Section 1 describes, from the perspective of the interviewed for-profit private sector stakeholders[2], the current private sector role in the national HIV response, including existing partnerships with the public sector. It synthesizes barriers that have prevented private sector participation and, more importantly,

[1] During HFG's May scoping visit, several Civil Society Organizations (CSOs) were interviewed and inefficiencies identified there are in a separate report.

[2] HFG defined four stakeholders groups to be interviewed: (i) Private Health Sector Providers, (ii) Business Representatives; (iii) Experts/Researchers, (iv) Insurance Companies. During the mission and first two weeks in September stakeholders from target groups i-iii were interviewed and a questionnaire was sent on September 03/2018 to 3 insurance companies (MAPFRE, ASESUISA and SISA) with no available reply at the moment of writing this report. Therefore, this brief mainly comprises the private health sector providers and business representatives perspective.

the opportunity areas identified by stakeholders to further support the efficient delivery of HIV services as well as to allocate additional funding to the National HIV response.

Addressing these opportunity areas, section 2 (i) recommends two specific exploratory Public-Private Partnerships (PPP) and maps a general operational framework and financial/funding mechanism, and (ii) outlines the next steps needed to support their implementation.

Meaningful progress cannot be achieved without real and effective partnerships and commitment from the public and private sector but also from the donor community, at least in initial stages. Therefore, this brief intends to provide concrete proposals for action to boost efficiency and sustainability in the HIV response through PPPs that enhance the for-profit private sector role.

1. LANDSCAPE ANALYSIS OF THE PRIVATE SECTOR

1.1 The National HIV/AIDS Multisector Strategic Plan

The National HIV/AIDS Multisector Strategic Plan 2016-2021 (PENM) is the coordinating framework for the multisector response to HIV/AIDS in El Salvador. The plan maps key actions to address four strategic axes: financing for sustainability, continuum of HIV prevention and care services, monitoring and evaluation management, and enabling framework and synergies.

In the plan, many aspects of the private sector are detailed. The institutional framework of PENM highlights the *National Committee for the Prevention and Monitoring of HIV* (CONAVIH[3]) as being responsible for executing the national HIV response, and recommending strategies to enhance the interinstitutional and multisector coordination to tackle the HIV epidemic. It also describes the health sector to include both the National Health System (SNS) and the private health sector. Nevertheless, certain elements and stakeholders of the private sector remain absent: Private laboratories are the only private health sector stakeholders explicitly mentioned in PENM's operational matrix[4], for example, while the *National Association of the Private Enterprise* (ANEP) is the more frequently mentioned private sector stakeholder and supports activities in the first three strategic axes. The findings below elaborate on the PENM to provide a landscape analysis of the private sector's role in El Salvador's HIV response.

1.2 Current Role in the HIV response

The for-profit private sector has an active role mostly represented in companies and ANEP's participation to establish HIV policies at the workplace, but private health sector providers do not appear to systematically contribute to HIV service delivery. As part of a renewed partnership between the Social Security Institute (ISSS), the Institute for Vocational Training (INSAFORP), companies and ANEP to support the adoption of HIV policies at the workplace (see details in 1.3.1), the number of companies with an HIV policy has increased from 41 to 57 during the last year, which represents 4.2% of all medium-and large-sized companies in the country (1,357). These HIV policies are focused on anti-discrimination and on-site prevention and education. According to ANEP, under the frame of the HIV policies, services such as testing, mandatory medical referral to the public sector, prevention of mother to child transmission for specific cases, follow-up, and community-based outreach[5]/behavior change communication could be provided.

There are HIV related services provided by the private health sector but most of them are not reported to either the MOH-National Program or captured under the National AIDS Spending Assessment (NASA), hiding their impact and relative size. According to the interviews these services include HIV testing, blood sampling for CD4 and Viral Load (VL) analysis, medical consultation, and hospital treatment of opportunistic infections. HIV testing services reach the

[3] CONAVIH is a collegial body attached to the MOH
[4] Specifically supporting strategic axe 2 in activities related to access to diagnostic services.
[5] Through a partnership with an NGO: PASMO - Pan American Social Marketing Organization.

largest population. The resulting HIV-positive cases are supposed to be referred to the public sector, as ART is provided for free by the government.

However, not every HIV-positive case is referred to the public sector for ART. Some patients prefer to access ART through out-of-pocket payments (OOP) to preserve their privacy (avoiding the scrutiny process to officially enter the MOH National Program and be registered at the *Single System for Monitoring and Evaluation of Epidemiological Surveillance of HIV/AIDS from the MOH* (SUMEVE)). As a result, there are concerns about the reliability of the country's data on how many people are receiving ART from outside the MOH, how much are they paying for ART, and where they are receiving the treatment[6].

Although there is no official data, one infectious disease physician believes that approximately 1% of PLHIV patients are being treated in the private sector. He considers that HIV institutional coverages mirror those observed in the National Health System, with75% covered by the MOH, 20% by ISSS, and less than 5% by the *Teacher's Welfare*–ISBM and the *Military Forces Health Regime*-COSAM and the private sector serves only the very high-income population. These PLHIV are hiding from official statistics (not registered by SUMEVE).

According to the interviewed stakeholders, the payors of the HIV related services provided by the private health sector are patients (OOP payments), insurance companies, and NGOs. The most recent NASA reveals that only 5.5% of total expenditure of the HIV response in 2017 was financed with domestic private sector funding, with OOP payments being the main contributor (67%). Importantly though, the reported OOP payments are related to condoms purchases (56%) and laboratory services (11%) only, and therefore the remaining HIV related services that the private health sector is providing and delivering are not registered in the national response official data.

As exploratory estimations, PLHIV that prefer to access ART and remaining HIV-related services from outside the public sector could amount to 2.7% of the ART population registered in SUMEVE[7] (pillar number 5 of the continuum of HIV prevention and care services) and the resulting annual OOP payments for a basic package of HIV-related services from private health sector providers ($461,387), currently hidden from NASA, could be equivalent to 19.6% of all the OOP payments reported in 2017[8]. This is a very conservative scenario as few services were considered in the basic package, and for some, prices were assumed as equal to the unit costs estimated by the MOH under the HIV Program.

1.3 Identified Partnerships

This section summarizes existing partnerships (involving the for-profit private sector) that support the HIV response.

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[6] It was also out of the record commented that some go abroad (USA, Mexico, Panama, Costa Rica) to get ART.

[7] Assumptions for estimation: 1% of PLHIV are being treated in the private sector (source: Interviews) and PLHIV=23788 (source: PENM). The estimated PLHIV that is being treated in the private sector is 238 and it is also assumed that all of them are receiving ART, and therefor 238 equals 2.7% of people in pillar 5 in SUMEVE (8811, source: PENM).

[8] Assumptions for estimation: (i) The basic annual package comprises: annual ART, 2 annual CD4 and VL analysis (as the National Guideline for clinical care in HIV recommends once every six months), 2 medical consultations with infectologist as the National Guideline for clinical care in HIV recommends once every six months), hospital treatment of opportunistic infections. (ii) the unit prices were assumed as: annual ART: $435.93 (source: Investment Case – Scenario 4: Test and Immediate Treatment, PENM), CD4 and VL:$350 (source: interviews), consultation with infectologist: $45 (source: interviews); hospital treatment of opportunistic infections: $523.63 (source: Investment Case – Scenario 4: Test and Immediate Treatment, PENM),: The National Guideline for clinical care in HIV).

1.3.1 Corporate Sector-ISSS-INSAFORP Partnership to Adopt HIV Policies

Figure 1: Stakeholders in Corporate Sector-ISSS-INSAFORP Partnership

Under this partnership, ANEP and ISSS designed and performed training workshops to medium-and large-sized companies about the *Guidelines to Develop HIV Policies at the workplace* (CONAVIH, 2016). The intended outcome of the training workshop is to design and implement the HIV Policy of the participant company. In order to be beneficiary of the workshop, participating firms must have its own ISSS clinic, which is physically located at the workplace with staff and commodities provided and funded by the ISSS. Additionally, participant companies previously agreed to fund the training activities with the firm's contribution to the social security scheme allocated to INSAFORP.

During the past year, it has contributed to the adoption of HIV policies by 16 companies. This could be considered a successful case of resource mobilization to support the national response. Additionally, HIV policies help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies).

This partnership scheme is not formally backed by a signed agreement and ANEP is working on a draft version of the agreement to be initially signed by ANEP, the ISSS and INSAFORP.

1.3.2 Private Laboratories-NGO

Figure 2: Stakeholders in Laboratory Partnership

Under this partnership PASMO reviews bids submitted by private laboratories to supply diagnostic HIV tests used with key populations (PASMO beneficiaries of this project are men who have sex with men-MSM and commercial sex workers-CSW). This is a successful case of for-profit willingness to engage in the provision of HIV-related services at a low price, as they foresee and obtain economic benefits coming from the return of PASMO beneficiaries for other paid services and also PASMO beneficiaries bringing family members and friends for paid services.

Eligible laboratories must be located in PASMO target territories, have undergone proper training[9] to ensure laboratory capacity matches the quality of services delivery required for PLHIV (specifically meeting the needs of MSM and CSW), and preferably have branches. Under this scheme, PASMO pays

[9] Proper trainings in this context means trainings conducted by PASMO, the Superior Council of Public Health (CSSP), and the Supervisory Board of the Clinical Laboratory Profession (JVPLC).

between $10 and $15 per test while the market price for the selected laboratories ranges from $25 to $30. The chosen laboratories must perform the test for free to PASMO beneficiaries.

1.3.3 Pilot Project on Private Laboratories Certification and Standardization on Rapid HIV-Testing and Data Transmission to SUMEVE

Figure 3: Stakeholders in Pilot Rapid HIV-Testing and Data Transmission Partnership

Under strategic activity 1.2 in PNEM[10], the pilot project aims to strengthen the HIV national response with private providers of HIV-testing services and have more accurate and comprehensive information about the HIV epidemic. To do so, key PENM stakeholders (CSSP, JVPLC, NRL and MOH-HIV Program) jointly with PASMO, defined a certification process to private laboratories on rapid HIV testing and corresponding data transmission to SUMEVE. Specifically, the project defined training contents to certify the capacity of attendant laboratories to accomplish articles 25 (about Diagnostic), 27 (Results disclosures), 28 (Referral) and 30 (Epidemiological Surveillance) of the National HIV Law (*Decreto No. 562 - 2017. Ley de Prevención y Control de la Infección Provocada por el VIH*).

This pilot project started during the last quarter of 2017 and approximately 30 private laboratories have been trained. Nevertheless, the certification outcome to allow data transmission to SUMEVE has not been officially adopted and no users or passwords have been assigned to trained laboratories to access SUMEVE. The project needs to be taken up by the MOH Program to formally adopt it as part of the National response. According to PASMO, this would require strong advocacy by the MOH and also need to overcome two main challenges: (i) adapting and customizing SUMEVE structure, functionalities, permits, and security processes to guarantee confidentiality of PLHIV personal info at the same time that new category of users have to be allowed[11], and (ii) securing commitment and support of CSSP and JVPLC to scaling-up the pilot to a national level.

1.4 Underlying Constraining Factors to Private Sector Participation

The barriers that have prevented private sector participation to support the National HIV response can be grouped into two categories: structural barriers and program gaps. These are described below.

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[10] *"To stablish mechanisms and partnerships among the public sector, private sector and CSO to provide innovative and integral HIV-related services to key populations".*

[11] As an exploratory option, the MOH could permit private laboratories access only to report data but not to retrieve information from SUMEVE.

1.4.1 Structural Barriers

Political polarization has prevented corporate representatives and some right-wing private practitioners to support the HIV National Program of a left-wing government. By early 2017, ANEP was expelled as a member of CONAVIH[12]) and the recently adopted HIV policies (see 1.3.1) were enabled under the frame of the *Country Coordinating Mechanism-El Salvador of the fight against HIV/AIDS, tuberculosis, and malaria* (CCM[13]).

Religious affiliations of the ANEP Chair and Executive Committee make it difficult to tackle key populations of PLHIV such as MSM and CSW. Many members of the executive committee belong to the Opus Dei, affecting ANEP´s stewardship for HIV policies at the workplace as ANEP itself removed its HIV policy from their website. This illustrates how corporate sector support to the HIV response relies more on individual willingness than systemic commitment.

Fragmentation of service delivery and financing among the public institutions of the National Health System (MOH, ISSS, ISBM, and COSAM) has been documented as one of the main sources of inefficiencies in El Salvador[14]. Fragmentation is even more severe between public and private health sectors as the National Health System Law[15] does not apply to private institutions or coordinating mechanisms between the two sub-systems. Likewise, the PENM 2016-2021 introduces the concept of Health Sector as comprised of the National Health System and the private health sector, but the service delivery response relies almost exclusively on public health sector, except for the private laboratories.

Lastly but perhaps most influentially, the **gratuity principle** that governs the national health system service delivery system, including the national HIV program, removes any incentive for private health sector providers to support or otherwise participate in national HIV program. The market opportunities for private health sector providers under the National HIV Program are very constrained as: (i) PLHIV do not pay a service fee or even a copayment in the public sector; and (ii) the MOH provides all treatment and care services through the public network neglecting the possibility of a more effective (more providers and service delivery) and timely response through the private sector. To promote private health sector providers participation in the National response should, to some degree, ease MOH financial burden that has prevented the adoption of the new World Health Organization (WHO 2015) guidelines[16] to test and start ART. As clarified in PENM, current budget is insufficient to implement the WHO recommended approach *Test and Start for all populations*[17]. Instead, the country is performing the technical and financial assessment to gradually adopt the approach, starting with key populations. Therefore, ART is not immediately started once positive testing is confirmed[18] and,

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[12] Decree 562 12-01-2017.

[13] CCM is a national committee, with multisectoral public-private composition, responsible for a coordinating submission of requests for funding on behalf of the entire country to the Global Fund (or any other international funding body of the HIV/AIDS response) and to oversee implementation once the request has become a signed grant.

[14] Bossert T. and Hill E. (2013). ***Análisis de la política pública de salud en el Salvador***. Ed. FUSADES and Harvard School of Public Health. Junio 2013.

[15] Decree 442 12-11-2007. Ley de creación del sistema nacional de salud.

[16] WHO. Consolidated Strategic Information Guidelines for HIV in the Health Sector. May 2015.
WHO. Consolidated Guidelines on the use of Antiretroviral Drugs for Treating and Preventing HIV Infection. Policy Brief. What's New. November 2015.
WHO. Consolidated Guidelines on HIV Testing Services. 5cs: Consent, Confidentiality, Counselling, Correct Results and Connection. July 2015

[17] According to this approach, patients begin on ART immediately after an HIV-positive diagnosis in an effort to improve health outcomes.

[18] Except for the conditions detailed in table 3 of the *National Guideline for clinical care in HIV (2014)*.

according to some interviews, sometimes it is not available where the patient is located but in the central/regional facility.

1.4.2 HIV Program Gaps

No procedures currently exist for reporting and sharing data across public and private sectors. This fact, combined with the desire of patients for anonymity, results in very little information sharing from the private sector to the national HIV program. As a result, the scope of the private health sector support to the HIV response remains unmeasured, and, consequently, the national HIV program lacks accurate figures on both PLHIV (through the cascade of continuous HIV care) and on the complete picture of domestic resource mobilization, financing, and expenditure data.

Standardized guidelines for all laboratories are not applicable to private labs. There are no standardized guidelines for service delivery officially adopted by private laboratories and despite recent attempts (see section 1.3.3) the public facilities guidelines have not been shared with private laboratories. Moreover, many question the quality of care provided, as they believe that small private laboratories declare false positives to minimize liability. As a result, when patients with a positive test result are referred to a public facility from a private practitioner, the receiving facility will perform a second diagnostic test to confirm the results. Although the confirmatory test is in the MOH guidelines and is a best practice to prevent false positives, performing it on all patients coming from the private sector is duplicitous and risks sending a message that private practitioners are not trustworthy. Like in a "vicious circle", private practitioners do not necessarily refer an HIV-positive patient directly to the MOH but to an NGO. This is inefficient as ART is only provided by the MOH and without a direct referral more time is needed to start treatment.

Governance and stewardship of the national HIV program does not deeply penetrate the private sector. Business representatives and experts perceive CCM as the effective coordinating body to implement actions and initiatives supporting the national HIV response and not CONAVIH. Nevertheless, according to PENM, CONAVIH is the leading coordinating body and limits CCM role to advocacy and civil control around human rights defense. This demonstrates that CONAVIH's leadership and capacity for influence is still a challenge, as it was identified in an evaluation of the previous PENM (2011-2015) performed in 2016.

Only one private health care provider mentioned CONAVIH during the interview, reflecting a lack of sense of belonging to the HIV program or the PENM. Likewise, as previously stated (see section 1.1), private laboratories are the only private health sector stakeholders explicitly in PENM's operational matrix in one strategic axis, while ANEP is in 3 strategic axes.

All the above leaves much of the measurable private sector input in the hands of corporates leaving service delivery issues practically uncovered and unmeasured by the PENM.As a consequence of these issues (particularly the structural barriers) there is a disconnect between public and private sector agendas to address a Country/National HIV response. The private sector agenda seems to be more individual (firm/facility/private individual practitioner level) than institutional or systemic.

1.5 Opportunity Areas

Aligned with the findings reported in previous sections of this report, the most recent SID noted that although the private sector has the capability to support HIV/AIDS services, it does not currently engage in many opportunities to support the national HIV/AIDS response. This section shares opportunities to trigger for-profit private sector engagement in the national response. Enabling conditions were structured accordingly to the analysis of the conducted interviews and focused on identifying possible opening points of potential revenue for the for-profit private sector.

1.5.1 Revenue from Increased Demand for Services

As shown in section 1.3.2, for-profit private health sector providers (laboratories) are able to engage in the provision of HIV-related services at a low price[19], as they foresee economic benefits coming from both the return of HIV clients for other paid services (regular price), and HIV services clients bringing family members and friends for paid services.

Thus, it is essential to identify the drivers for creating and increasing service demand among the population in accessing HIV services from the private sector. The table below lists strategies to achieve this and shares how effective each strategy would be based on stakeholder responses[20]:

Strategy to boost demand for HIV-related services	Stakeholder appraisals
Scale-up insurance coverage for HIV specifically	Perceived as potentially efficient when the added coverage is not specifically for HIV but for a broader set of chronic conditions, as the pooling effect might reduce the extra premium to be jointly payed by the insured person, the employer (if apply) and the PPP.
Reduce costs of consultation	Perceived as non-effective due to the for-profit nature of stakeholders and reinforces the notion that gratuity for HIV services is not a plausible scenario to engage private sector providers.
Provide packaged PHC/HIV care at set price	Perceived as highly efficient. Also, a successful initiative of this sort was mentioned by PASMO: For those beneficiaries with willingness to pay, PASMO has successfully offered a $10 package of three services: HIV test, syphilis test, and nutritional consultation. (That is the free service described in 1.3.2 plus two added services for a total of $10.)

[19] Given that the public system provides services under a gratuity principle, it is not feasible to consider the current private sector market prices to boost HIV-services demand. Likewise, the cero cost scenario for HIV related services was not considered as feasible to attract private providers. Therefore, the low cost (below the current private market price) scenario is the one that meet a window of opportunity.

[20] The question was: *How do you think private providers, government, or donor agencies can increase interest among the public in accessing HIV services from the private sector? (Rank from 1-5, with one being the most optimal and five being the least optimal).* The answer options were the five strategies listed in the table.

Establish additional PPPs	The PPP is perceived as an enabling operational framework and resource mobilization mechanism to implement any of the other strategies. The PPP is not perceived at the project level but as a program level intervention, and many stakeholders believe that the most effective PPP scheme must include donors – especially to support it until it has been established.
Establish tiered-payment mechanisms that redistribute funds for low income HIV care	Perceived as most efficient if established as a progressive copayment mechanism that cross subsidizes with clients who can afford to pay more. Also perceived as an enabling financing mechanism for resource mobilization that needs to be complemented by PPP funding in order to implement any of the other strategies.

PPPs as a framework and source of financing complemented by co-payments from the population with payment capacity seems to be imperative conditions to effectively boost services demand from private healthcare sector providers. Thus, to identify not only PLHIV payment capacity but also willingness to pay emerge as critical aspects. The interviews revealed some points that can be perceived as window of opportunity:

- A recent research project conducted by PASMO found that average income of MSM is more than twice the average salary and 1,7 times the minimum salary in the country. This is an actual opportunity as a key population appears to have payment capacity.
- Stigma and discrimination are realities that boost the willingness to pay for accessing HIV-related services from the private sector.
- PASMO sales of condoms (which are purchased entirely through OOP spending) are increasing even though other NGOs provide them for free.

1.5.2 Market Opportunities – Self-diagnosis test

HIV self-diagnosis methods are not currently offered or licensed in El Salvador, and consequently there are no policies that permit HIV self-testing. However, one interviewed stakeholder foresees market opportunities to private health sector provision of self-testing because there is a clear potential demand and willingness to pay from a population that highly values privacy and fears stigma and discrimination. Moreover, the international price (approximately $15 in the United States) is well below the market price of HIV-testing currently offered by private providers in El Salvador (from $25 to $60, according to two stakeholders). It was also mentioned that there was an unsuccessful previous attempt for self-tests licensing process in El Salvador.

1.5.3 Economies of Scale from innovative mechanisms to integrate the private health-service provider into the National HIV Response.

Stakeholders mentioned that private providers' willingness to further engage will be boosted if they are able to benefit from the economies of scale provided by more integrated private service delivery and referral into the Program/National Response. From interviewed inputs, the following innovative integration mechanisms can be envisaged:

- **A National referral/counter-referral system**, connecting the current MOH healthcare network[21] and the private health-service provider sector (i.e., private practitioner infectologist referring the patient for ART to the MOH and subsequently, after counter-referral, continue providing patient follow-up) and establishing enabling conditions for the MOH to validate and accept private laboratory test results without confirmatory (duplicate) testing. The definition of these enabling conditions[22] could save resources and could be a first step to a more integrated service delivery and referral system.

- **Allow transactions of HIV related services between public and private providers**. Specifically, allowing the MOH (VICITS, Public Hospitals) to sell services for which it is almost the monopolistic/oligopolistic provider (i.e. ART, Genotypic Antiretroviral Resistance Test, processing of CD4 and LV) to private health sector providers for them to be able to offer a more integrated healthcare service to the patient that prefers to be treated in the private sector and pay for it. An **electronic prescriptions system** was mentioned as a desirable complementary initiative to a more efficient transactional process.

[21] RIISS: *Redes Integrales e Integradas de Servicios de Salud* and more specific for HIV/AIDS: VICITS: *Clínica de Vigilancia Centinela de las Infecciones de Transmisión Sexual.*

[22] For example, avoid the confirmatory test when the result comes from certified private laboratories, which means that a certification process needs to be implemented.

2. PROPOSAL FOR ACTION

As an exploratory starting point, this section outlines the proposal of two PPP initiatives intended to harness opportunity areas for the private sector to further support the efficient delivery of HIV services as well as to allocate additional funding to the National HIV response. The proposals focus on private healthcare providers' engagement, as corporate sector has already a specific scope of action by promoting HIV policies at the workplace while private providers are not as visible in PENM. The two initiatives also support specific strategic axes of PENM and contribute to addressing challenges identified in the evaluation of the previous Multisector Plan.

2.1 PPP to Integrate and Harmonize the National Response

This initiative is a PPP aimed at strengthening and enlarging the national response to HIV by integrating the public and private sector capacities into the country's response. The Public sector agrees to share, adapt if necessary, and train private sector providers in the National Guidelines for HIV care and the private sector commits to adhere to the Guidelines, ensuring the harmonization processes that might be needed. Once standardized and harmonized provision and service delivery is formally stablished, both sub-sectors commit to refer and counter-refer patients in a more efficient and timely manner.

The following table summarizes the exploratory elements to consider for this PPP recommendation:

Stakeholders	General Operational Framework and Main lines of Action	Financial Mechanism/Resource Mobilization	Expected Efficiency Gains	Critical Next Steps
MOH-National HIV Program **ISSS** **JVPLC** **Representatives of Private Providers (RPP)** **CSSP** **ANEP** **Donors**	All stakeholders jointly define the strategy to ensure that private providers receive, understand, and adhere to: • National Program guidelines/ protocols for HIV-related service delivery • Appropriate quality standards and certifications Accordingly, MOH-HIV Program, CSSP and JVPLC stablish a process for granting certification to private providers (critically, but not exclusively, for private laboratories and for testing and counselling services) Certified private providers are allowed to the National referral/counter-referral system (connecting the current Public healthcare network -MOH, ISSS - and the certified private health-service provider sector) Led by the MOH, the National referral /counter-referral system ideally must develop/expand its Information System in order to implement: • Data Transmission to SUMEVE (especially data transmission from private providers about PLHIV)	The proposed initiative requires relatively high initial resource mobilization to fund the Granting Certification Process and all the adjustments/ developments of the Information System. Once both are implemented, financing needs stabilize at a moderate level Initial Resource Mobilization from: -Corporate Social Responsibility (CSR). Resources (mainly from companies in economic sectors more likely linked to risk factors such as maquila, transport, business travelers-sales) -Donor financing Once the financial need stabilizes at a relatively low level, funding must be domestic and sustainable, coming from: -Public Budget Allocations -CSR funding	More accurate statistics (PLHIV, services demand, etc) for better planning on the HIV response Increased service delivery from private providers benefited by economies of scale coming from a more integrated national response system More timely response to HIV-related service demand, supported by the expanded network of providers (now including the	Validate/adjust current National Program guidelines/ protocols for HIV-related service delivery, foreseeing that there are harmonization challenges among MOH and ISSS. To achieve gradual progress, it is recommended to start approaching JVPLC and CSSP to address the Surveillance and Regulations Framework to Monitor Quality of Laboratories and Point of Care Testing (POCT) To assure Confidentiality in data transmission from private providers to SUMEVE (entitle certified private providers to report data but not to retrieve information from SUMEVE) Advocacy to the public budget allocation needed to co-finance the project.

	• An electronic/on-line prescription module		private providers)	

The proposed PPP has potential contributions to PENM's strategic axis 1 (Financing to sustainability) and 2 (Continuum of HIV prevention and care services), specifically for the strategic actions:

1.1 Integrated management to implement cost-effective HIV prevention and care initiatives.
1.2 Stablishing mechanisms and partnerships between public sector, private sector and CSO to provide and deliver innovative and integral HIV care services to key populations.
2.2.7 Laboratory Quality control (diagnostic and follow-up testing, internal processes and procedures).
2.3.1 Strengthening recruitment of PLHIV to healthcare services
2.3.2 Promoting innovative strategies to assure adherence of PLHIV to healthcare services (to the continuum of HIV care services).

2.2 PPP to Support Pooled Procurement Process of ART and License Self-Testing Services

This initiative is a PPP aimed at strengthening and enlarging the national response to HIV by enabling the private provision market of ART and potentially Self-Testing for population with payment capacity. The Public sector agrees to conduct a pooled procurement process (incorporating the private sector demand planning) and the private health sector commits to buy from the MOH the planned units and to report to SUMEVE all the effective demand information.

The following table summarizes the exploratory elements to consider for this PPP recommendation:

Stakeholders	General Operational Framework and Main lines of Action	Financial Mechanism/Resource Mobilization	Expected Efficiency Gains	Critical Next Steps
MOH-National HIV Program **National Directorate of Medicaments (DNM)** **CSSP** **Donors** **Representatives of Private Providers (RPP)**	All stakeholders jointly define: (i) the framework to allow public sector to sell HIV related services (specially ART and potentially Self-Testing) to private health sector providers; and (ii) the framework for enabling policies to overcome the legislation/market gap about Self-Testing Services, considering that the licensing process must be jointly led by DNM, MOH-HIV Program and CSSP Potential ART procured had to be previously incorporated in a pooled demand planning for the	The financial needs of increasing procured ART could initially (only for the first annual pooled procurement process) be supported by Donors resources. From the second pooled procurement process on, the sustainable financing mechanism could be the pooled resources coming from: -Co-payments from OOP in accessing/buying the services from the private sector provider -Private providers funding (assuming that to boost demand, the selling price is lower than the buying price to the MOH, but also predicting economic benefits coming from both: (i) the return of HIV clients for other regular-price services; (ii) HIV services clients bringing family members and friends for paid services. -Donors funding to fill financing gaps if co-payments and private providers funding are not enough.	The pooled demand could lead to lower unit costs of the procured items and make the National response more cost-effective. Increased service delivery from private providers and affordable co-payment to boost demand from population with payment capacity. More timely response to ART demand, supported by the higher availability	To conduct a market analysis to calculate the additional ART to procure, and the feasible fee/financing scheme. Thus, the market analysis has to address: -Potential market population to private sector delivery (i.e. current clients of private sector, current ART population in the public sector with willingness to pay, PLHIV with willingness to pay but currently not accessing to services). -Potential market size (economic value), addressing proxies such as: the income levels of the potential market population and the specific willingness to pay. -A feasible fee/financial scheme to simultaneously meet: (i) a profitable selling price for private providers (including the demand boosting for other services), (ii) an affordable co-payment for patients with payment capacity, and (iii) a sustainable funding mobilization from donors. The market analysis on HIV Self-Testing services should be conducted

	MOH's procurement process (pooling public and private sector demand planning)	The feasibility and scope of the initiative to license Self-Tests depends on a market analysis that could be financed by the interested and potential private providers.		to inform stakeholders decision process on this potential new market. If approved, the procurement process funding will mirror the proposed for the pooled ART procurement process.

The proposed PPP has potential contributions to PENM's strategic axe 2 (Continuum of HIV prevention and care services), specifically for the strategic actions:

2.2.1 Stablishing a strategy to expand HIV testing to assure every HIV-positive person to recognize its condition.

2.3.1 Strengthening recruitment of PLHIV to healthcare services.

2.3.2 Promoting innovative strategies to assure adherence of PLHIV to healthcare services (to the continuum of HIV care services)

2.3.3 Ensuring ART to PLHIV.

Finally, the two proposal contribute to addressing the Management and Administration challenges identified in the evaluation of the previous Multisector Plan (PENM 2011-2015): the need for a more efficient management, more competitive procurement process, and more integrated information system.

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