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PROGRAM INSIGHTS

Expanding Coverage of Voluntary Medical Male Circumcision through the Private Sector in Namibia

In 2012, Namibia became the first country in the world to cover voluntary medical male circumcision through medical aid (private health insurance) as an HIV preventive benefit. This brief describes how the SHOPS project worked with the public and private sectors to standardize the fee for the procedure and train private providers so that more Namibian men and boys could access this benefit.

A generalized HIV epidemic impacts the quality of life of many Namibians, even though the country has waged an effective response with government leadership and donor support (PEPFAR, 2012a). The World Health Organization (WHO) and the United Nations Program on HIV and AIDS (UNAIDS) recommended the scale-up of voluntary medical male circumcision (VMMC) based on research that demonstrates the protective effect of the procedure in decreasing the incidence of female-to-male transmission of HIV (Auvert, 2005; Bailey, 2007; Gray, 2007). The recommendation is part of broader HIV prevention efforts in countries with low rates of male circumcision and a high prevalence of heterosexually transmitted HIV infections (WHO, 2007). Namibia has a high HIV prevalence at 13 percent (World Bank, 2011), a relatively low rate of adult male circumcision at 21 percent (Namibia MoHSS, 2008), and an active private health sector that employs 47 percent of the country's health care workers (O'Hanlon, 2010). If fully leveraged, this large private health sector[1] can be an active contributor to the national HIV response, and a particularly important partner in the scale-up of VMMC in Namibia.

In 2010, the Namibian Ministry of Health and Social Services (MoHSS) set a target to increase VMMC uptake to 80 percent of neonatal, adolescent, and adult males by 2015, which would require approximately 400,000 additional circumcisions (Namibia MoHSS, 2010). From 2009 to 2010, the scale-up effort resulted in 1,980 male circumcisions in the public sector (WHO, 2011). In addition to a large number of private health sector workers and facilities, Namibia has a robust private health insurance industry, regulated by the

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Private Sector Opportunities for VMMC in Namibia

- 13% HIV prevalence
- Low uptake of voluntary medical male circumcision in public sector
- 75% of doctors work in the private sector
- Approximately 190,000 males are covered by medical aid schemes

[1] Approximately 75 percent of doctors in Namibia are employed by the private health sector, which operates 66 percent of the total facilities in the country, including one-room clinics run by nurses (O'Hanlon, 2010).

SHOPS Strengthening Health Outcomes *through* the Private Sector

Namibia Association of Medical Aid Funds (NAMAF). The SHOPS project estimated that if 50 percent of men employed in the formal sector were covered by medical aid for preventive VMMC and there was 80 percent uptake of the procedure by covered men, then 93,600 men could be circumcised in the private health sector. This would represent 23 percent of the estimated total circumcisions required to reach 80 percent prevalence (see figure).

Prior to 2012, medical aid schemes (private health insurance plans) did not offer male circumcision as an explicit HIV preventive benefit, and only covered the procedure for medical reasons and mostly under costly general anesthesia. The fees charged for male circumcision services varied greatly among private providers.

With the approval of the MoHSS Male Circumcision Technical Working Group, USAID/Namibia funded the SHOPS project to work with actuaries from Deloitte and Touche in South Africa to provide an independent and credible cost analysis of VMMC. The actuaries used local anesthesia in their costing model, as it is the clinical procedure endorsed by both the MoHSS and WHO, and it increases the number of facilities that can perform the procedure while minimizing health risks to clients from general anesthesia. SHOPS submitted an application to NAMAF that included a clinical justification and a proposed rate for VMMC as an HIV preventive benefit in July 2011. In October 2011, the tariff (fee) was accepted by NAMAF. The tariff went into effect in January 2012 and Namibia became the first country in the world to systematically cover VMMC under medical aid as an HIV preventive benefit.

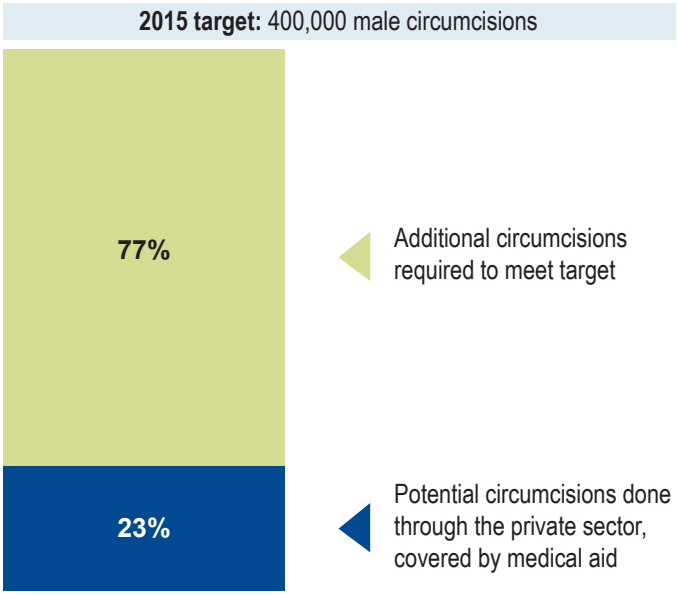
Methods

To determine an appropriate tariff, the actuaries used the activity-based costing method, a two-stage service costing technique that divides a service into specific activities and then allows for the costs associated with the resources performing the activities. Deloitte actuaries divided the circumcision procedure into three stages: (1) activities that should take place before the procedure, per the Namibian government's male circumcision policy; (2) activities associated with the actual procedure and post-operative care; and (3) activities associated with potential follow-up for any complications. The costing included a margin for error to account for unpredicted costs or wasted medical materials. SHOPS experts provided input into service delivery assumptions and the pricing of various medical supplies in Namibia. The MoHSS provided input into the development of the tariff and reviewed the work done by the actuaries.

Initial Outcomes of the Tariff

Starting in 2012, NAMAF recommended that medical aid schemes include the tariff for male circumcision as an HIV preventive benefit. Although NAMAF cannot mandate the specific benefits that medical aid schemes cover, by January 2013, nine out of ten medical aid schemes in the country chose to include the tariff for male circumcision as an HIV preventive benefit.

Potential of the Private Sector to Assist in Meeting 2015 Target



Note: This model was developed by Frank F. Feeley, Boston University School of Public Health, using conservative estimates for future workforce growth and insurance coverage levels.

The primary health outcome associated with the tariff is measured in the number of insured men who choose to undergo the procedure through their medical aid scheme. SHOPS received preliminary data from NAMAF that 1,074 male circumcisions were done by private providers prior to the acceptance of the standard fee structure. This data confirms the assumption that private providers conducted male circumcision procedures before 2012, although not all may have been provided for the purpose of preventing HIV.

To ensure quality and standardize provision of the procedure across the country, the MoHSS, in partnership with SHOPS, invested in ensuring private providers have access to VMMC training that follows WHO and MoHSS guidelines and meets the needs of private providers. SHOPS partner Jhpiego worked with the MoHSS Male Circumcision Technical Working Group to conduct an assessment of private provider training needs. Jhpiego then adapted the public sector male circumcision training curriculum developed by WHO for private sector providers. For instance, Jhpiego made the timing of the training more flexible for providers, recognizing that time away from their clinics translates to lost income. Once approved, the MoHSS, in partnership with SHOPS, plans to conduct a pilot training. SHOPS will hand over the curriculum to local training partners to ensure that private providers are consistently offered training in male circumcision.

Since the private health sector is not organized under a central authority in Namibia, uniformity of quality standards and adherence to reporting essential service statistics is often a concern. SHOPS created linkages between NAMAF and the MoHSS to help create a system for annually reporting the number of male circumcisions performed in the private sector. These statistics will assist the Namibian government in better understanding the availability and use of HIV services throughout the health system, and can help establish the profitability of male circumcision for private providers and medical aid schemes.

Challenges and Recommendations

NAMAF's approval of the male circumcision tariff and its acceptance by the vast majority of medical aid schemes in Namibia has been an important step in increasing the private sector role in VMMC scale-up. However, while the financing is now in place for more people to access the service, further efforts to create demand may be required to complement the supply-side financing effort. A demand creation campaign should be sector-neutral and allow potential clients to understand that both public and private service delivery points exist for the procedure.

Efforts to ensure quality through reporting and training have met some challenges. There is a discrepancy between the frequency of NAMAF and MoHSS reporting periods. Additionally, not all of the private sector statistics that the MoHSS wishes to collect are easily available from NAMAF, since the association only collects statistics related to processing insurance claims. Regarding the training of private providers, it has taken a long time for stakeholders to agree on a format that is sensitive to providers' needs and a curriculum that meets quality standards. Given that the formal relationship between the public and private health sectors is nascent, these issues may take time to address as trust is built between stakeholders. However, the success of standardizing the male circumcision tariff in Namibia illustrates the potential of the private sector to contribute to high-impact HIV prevention services and the relative speed in which private sector domestic resources can be leveraged to help sustain donor-funded efforts.

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The Strengthening Health Outcomes through the Private Sector (SHOPS) project is a five-year cooperative agreement (No. GPO-A-00-09-00007-00) funded by the U.S. Agency for International Development (USAID). The project focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. To access the capabilities of SHOPS, USAID missions and bureaus can buy into the leader agreement or issue their own associate awards. SHOPS is led by Abt Associates Inc., in collaboration with Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting. The views expressed in this material do not necessarily reflect the views of USAID or the United States government.

For more information about the SHOPS project, visit: www.shopsproject.org

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