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Feasibility of Private Sector Delivery of Pre-Exposure Prophylaxis in Windhoek, Namibia

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About SHOPS Plus: Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is USAID's flagship initiative in private sector health. The project seeks to harness the full potential of the private sector and catalyze public-private engagement to improve health outcomes in family planning, HIV/AIDS, maternal and child health, and other health areas. SHOPS Plus supports the achievement of US government health priorities and improves the equity and quality of the total health system.

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Feasibility of Private Sector Delivery of Pre-Exposure Prophylaxis in Windhoek, Namibia

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Acronyms

AGYW	Adolescent Girls and Young Women
ART	Antiretroviral Therapy
ARV	Antiretroviral
CMS	Central Medical Stores
DHS	Demographic and Health Survey
ELISA	Enzyme-linked Immunosorbent Assay
FSW	Female Sex Workers
FTC	Emtricitabine
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
I-TECH	International Training and Education Center for Health
MAS	Medical Aid Scheme
MOHSS	Ministry of Health and Social Services
MSM	Men Having Sex with Men
NAMAF	Namibian Association of Medical Aid Funds
NAPPI	National Pharmaceutical Product Index
NHP	Namibia Health Plan
NIP	Namibian Institute of Pathology
NMC	Namibia Medical Care
NMRC	Namibian Medicines Regulatory Council
NSF	National Strategic Framework
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PPP	Public-Private Partnership
PrEP	Pre-Exposure Prophylaxis
PSEMAS	Public Sector Employee Medical Aid Scheme
PSN	Pharmaceutical Society of Namibia
SDC	Sero-discordant Couple

SFH	Society for Family Health
SFI	Sustainable Financing Initiative
SHOPS Plus	Sustaining Health Outcomes through the Private Sector Plus
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TDF	Tenofovir
TG	Transgender
USAID	U.S. Agency for International Development
VCT	Voluntary Counseling and Testing
VMMC	Voluntary Male Medical Circumcision

Executive Summary

The government of Namibia, through its National Strategic Framework of HIV/AIDS Response in Namibia (2017/18–2021/22), has made reducing new HIV infections by 75 percent by 2020 a core feature of its national response. To reach this goal, the Ministry of Health and Social Services (MOHSS) expanded its priority groups to include all those at "substantial risk" of HIV infections, particularly men who have sex with men (MSM), female sex workers (FSW), and adolescent girls and young women (AGYW). In 2016, the ministry approved the use of pre-exposure prophylaxis (PrEP) as part of its comprehensive approach to HIV/AIDS prevention. The MOHSS now finances the procurement of a generic PrEP formulation in accordance with the 2019 National Guidelines for Antiretroviral Therapy (ART), as follows: 200 mg oral TDF (tenofovir) co-formulated with 300 mg FTC (emtricitabine). The MOHSS has made this product available to patients throughout the public sector health system.

While the MOHSS and donors have engaged some private NGOs to support these efforts, to date, they have not worked with the private commercial sector, and these actors do not have access to commodities procured through the Central Medical Stores (CMS). In order to support MOHSS efforts to expand access to and uptake of PrEP, USAID/Namibia is interested in examining opportunities and barriers to scaling up oral PrEP through the private sector. With funding from USAID/Washington under the Sustainable Financing Initiative, the USAID mission in Namibia engaged the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project to assess the feasibility of private sector delivery of PrEP in Windhoek, Namibia. The findings of this assessment are provided below and will inform the design of future USAID/Namibia and MOHSS efforts to engage private providers in making the oral PrEP formulation available.

President's Emergency Plan for AIDS Relief data indicate that use of PrEP has increased steadily since its introduction in 2016. By the second quarter of 2019, approximately 4,700 individuals utilizing public sector facilities or serviced by one of the USAID implementing partners were using PrEP; 1,333 of them live in the Khomas region, which includes Windhoek. In the 2019 ART guidelines, the Namibian government stated its commitment to increase access to PrEP for any sexually active HIV-negative person who is at high risk of acquiring HIV. To estimate the market sizes of three target groups—key populations at highest risk (MSM, FSW, and sero-discordant couples); AGYW in the general population who have higher risk of contracting HIV; and all men and women reporting risky sexual behaviors—SHOPS Plus used the 2013 Demographic and Health Survey to calculate potential future market size. These estimates range from approximately 7,800 individuals in key high-risk populations to 77,000 individuals in all three groups, with the bulk of the market coming from the general population groups.

All of the conditions are in place to support a purely private sector model. There are at least eight products in the commercial market in Windhoek that are being sold for PrEP, all manufactured by reputable firms and all conforming to the generic PrEP formula set forth in the 2019 ART guidelines. These products are currently imported by six major pharmaceutical distributors/wholesalers from a list of pharmaceuticals approved for sale in South Africa and have been tested for quality and registered for sale by the Namibian Medicines Regulatory Council. However, most of these products have been registered only for use as part of an ART treatment regimen and would require an updated registration for approved use for PrEP. Despite the registration gap, these eight products are currently available in pharmacies and are

being prescribed by providers and dispensed as PrEP treatments. All of these products are sold in bottles of 30 tablets.

Prices for the eight current PrEP products range from N$367 (US$24) for a one-month supply of a generic product to N$970 (US$65) for the Truvada non-generic. Consultations average N$360 (US$24), and follow-up consultation costs average N$243 (US$16). The costs of required laboratory tests range from N$355 to N$440 (US$24–29) every three months. The majority of medical aid schemes (MASs) now include PrEP treatments, consultations, and laboratory fees in their schedule of approved benefits, although some issues on payment for these benefits remain.

A survey of private sector facilities in Namibia, conducted in 2015, identified 428 private facilities in the Khomas region, including: 338 private consulting rooms, 4 mobile clinics, and 55 pharmacies. Any doctor who is licensed to practice medicine in Namibia may counsel and provide PrEP treatments to patients. There are no special circumstances, certifications, or specialized training required for a physician to prescribe PrEP. Doctors are already seeing patients and prescribing PrEP. New HIV guidelines were issued in 2019, after which both the Directorate of Special Programs at the MOHSS and professional associations sensitized a number of the private sector providers in the Khomas region. However, there has been no comprehensive training of private sector providers on the new PrEP protocols, although training materials and job aids have been developed for public sector training that could easily be adapted for a more in-depth training of private providers.

One of the MOHSS' main concerns is oversight of these services and assurance that profit-motivated shortcuts are not being taken. Monitoring quality of services, counseling, and follow-up remains a challenge.

In addition to the purely private sector model outlined above, the assessment team recommends consideration of two public-private partnership (PPP) models that would help alleviate cost issues for those paying out of pocket or exceeding MAS benefits.

1. *Partnering with the Pharmaceutical Society of Namibia (PSN)*. This PPP with the MOHSS is currently under consideration by the executive director of the ministry. Under this model, pharmacists operating in Windhoek would be trained by the PSN education unit on all aspects of PrEP risk assessment, counseling, testing, adverse effects, and prescribing practices. The pharmacists would then be allowed to dispense PrEP treatments without a clinician's prescription. PrEP products would be procured by CMS and sold to participating pharmacies at the much lower public sector base price, allowing clients to purchase them at one-quarter of the current market price. Prices for consultation and laboratory fees could be negotiated between the MOHSS and PSN at concessional rates.

2. *Dispensing through Designated Private Sector Clinics*. This PPP would build on existing models of franchised private sector clinics serving key populations—a network of 11 clinics currently providing voluntary medical male circumcision (VMMC) services in Khomas region and a network of clinics supported by the Society for Family Health serving key at-risk populations, two of which are in Khomas. The VMMC clinics would be canvassed to determine their interest in participating in a comprehensive PrEP training and becoming a designated provider of HIV prevention services. As their doctors are now able to both prescribe and dispense medicines from their clinics, they would be able also to procure PrEP products at the CMS base price and pass these savings on to their clientele. Prices for consultations and laboratory fees would be negotiated between the MOHSS and the participating providers as part of the PPP. MASs may cover the cost of these services and treatment products for their beneficiaries, and those without coverage will pay lower out-of-pocket costs. Key populations without access to MAS benefits

and/or reluctant to seek care in the public sector would be able to access services from one of the network clinics providing those services free of charge.

One advantage of a formal PPP, such as the two outlined above, is that reporting systems can be designed to collect information from participating clinical providers and pharmacies. Mystery client surveys can periodically be implemented to ensure that providers and/or pharmacists are conducting appropriate risk assessments, administering tests as required in the protocols, and providing appropriate counseling on adherence.

Likewise, for all three of the private sector or PPP models outlined above, demand creation and community awareness campaigns will be critical tools in bringing potential at-risk populations to private sector outlets. Both informants currently working with key populations and provider survey participants strongly encouraged the development of a community awareness campaign in order to educate the community and even health care providers and public officials about PrEP and its uses in order to dispel misunderstandings and work to reduce stigma. In addition, demand generation campaigns to bring potential PrEP users into clinics and pharmacies for risk assessment and counseling, especially if the services are available at a reduced cost, will be critical to any of the above private sector or PPP models.

Introduction

The government of Namibia has made significant progress in the fight against HIV/AIDS over the past 18 years, successfully reducing human immunodeficiency virus (HIV) prevalence among adults from 14.3 percent in 2002 to 11.8 percent in 2018 (UNAIDS 2019). HIV prevalence peaks in the 45–49 age group for women (30.0%) and the 50–54 age group for men (26.4%), according to the Namibia Population-based HIV Impact Assessment (NAMPHIA) Final Report (MOHSS 2019). Part of the country's success derives from the effective expansion of efforts to identify and initiate people living with HIV (PLHIV) on antiretroviral therapy (ART). Still, Namibia has the sixth-highest adult prevalence rate in the world and HIV remains the leading cause of death in the country.

The country is meeting UNAIDS' 90/90/90 goals, with 91 percent of PLHIV aware of their status, 96.4 percent of PLHIV who know their status are on ART, and 95 percent of those on treatment virally suppressed as of 2018 (UNAIDS 2019). This translates into an estimated 184,000 out of 200,000 PLHIV on ART. With this success in hand, the country is now focusing on how to sustain these achievements over the long term, including ensuring retention of ART patients on treatment, decentralizing ART service to primary health care clinics and health centers, and giving top priority to the reduction of new HIV infections by 75 percent by 2020 as another core feature of its national response. In 2018, the Ministry of Health and Human Services (MOHSS) expanded its priority groups to include all those at "substantial risk" of HIV infections, particularly men having sex with men (MSM), female sex workers (FSW), transgender individuals (TG), and adolescent girls and young women (AGYW) and emphasized greater male involvement.

As set forth in the National Strategic Framework of HIV/AIDS Response in Namibia (2017/18–2021/22) (MOHSS 2017), the MOHSS' prevention approach encompasses a mix of behavioral, structural, and biomedical interventions that include promotion of the use of pre-exposure prophylaxis (PrEP), prevention of mother-to-child transmission, community engagement and mobilization, stigma reduction, and use of mass media.

Namibia approved the use of PrEP as part of this comprehensive approach to HIV/AIDS prevention in 2016 and now finances the procurement of generic PrEP medication through the Central Medical Stores (CMS). CMS is responsible for overseeing all MOHSS procurements for public sector health facilities and special programs, based on the generic formulations of medicines identified in treatment guidelines and added to the Namibian Essential Medicines List (NEMLIST). CMS procures about 600 drugs annually and uses its own quality assurance department to ensure quality of all imported medicines. Additionally, all drugs are tested by the Namibian Medicines Regulatory Council (NMRC) when the product is registered. In accordance with the National Guidelines for Antiretroviral Therapy, Sixth edition in August 2019 ("the 2019 national ART guidelines"), CMS is now in the process of procuring the generic formulation of 200 mg oral tenofovir (TDF) co-formulated with 300 mg emtricitabine (FTC) by ordering the branded product Ricovir EM from Mylan Pharmaceuticals for the MOHSS' 2020 needs.

While the MOHSS and donors have engaged some private NGOs to support these efforts, to date it has not worked with the private commercial sector, and these actors do not have access to commodities procured through CMS. In order to support MOHSS efforts to expand access to and uptake of PrEP, USAID/Namibia is interested in examining opportunities and barriers to scaling up oral PrEP through the private sector. Such efforts would build on previous investments by the government of Namibia and its donors and partners to encourage private sector participation in the country's HIV response. To date, MOHSS has partnered with private mobile clinics to expand access to HIV counseling and testing and with 16 private clinics to

provide voluntary male medical circumcision (VMMC) at a reduced price. There are more than 3,200 registered private health care providers in Namibia. These are key potential partners that the government can leverage to make the country's HIV response more sustainable.

With funding from USAID/Washington under the Sustainable Financing Initiative (SFI), the USAID mission in Namibia engaged the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project to assess the feasibility of private sector delivery of PrEP in Windhoek, Namibia. This assessment informs the design of future USAID/Namibia and MOHSS efforts to engage private providers in this area. Through the feasibility assessment, SHOPS Plus set out to document the current scope of PrEP services in the private sector, as well as the potential demand for PrEP, the ability of private providers to reach this market, the feasibility and willingness of the government to partner with the private sector to deliver PrEP, and any other opportunities or bottlenecks that USAID/Namibia and the MOHSS would need to address in order to move forward with a pilot effort. This effort is aligned with SFI's objective of mobilizing domestic resources for HIV by engaging the private sector to encourage private markets that increase options and facilitate greater private sector participation to increase access and deliver sustained health outcomes.

Methodology

The SHOPS Plus assessment focused on answering the following three main questions:

1. **What is the size and composition of the potential PrEP market?** Using secondary data from Demographic and Health Surveys (DHS), population figures, service delivery statistics, and other data, the project describes the potential market for PrEP. The analysis looked at three possible groups that would be interested in PrEP and possibly interested in private sector sources: individuals at the highest risk of infection (primarily FSW, MSM, and members of sero-discordant couples (SDCs)); individuals who have sought an HIV or sexually transmitted infection (STI) test at a private health facility; and individuals who engage in risky sexual behavior.

2. **What is the ability of the private sector to serve this market?** Through a desk-based literature review, semi-structured interviews with public and private sector stakeholders, and a rapid survey of 27 private providers and pharmacies, SHOPS Plus examined and documented the five A's of the current and potential private market for PrEP in Windhoek: availability, affordability, assured quality, appropriate design, and awareness of PrEP as a service. This analysis considered how a focus on a more limited or expansive client base (Question #1) would influence these factors.

3. **How feasible is it to engage the private sector to deliver PrEP?** Through a document review of relevant government policies and strategies—as well as stakeholder interviews with public, private, and donor stakeholders—SHOPS Plus sought to document the willingness of different actors to make investments that would support an expanded role for the private sector to deliver PrEP.

The remainder of this document presents the findings from this effort organized around these three questions. It concludes with a discussion of several potential models that USAID/Namibia and the MOHSS could support to increase access to PrEP through the private sector.

Findings

With strong evidence for the efficacy and effectiveness of daily oral PrEP across multiple studies, the World Health Organization issued guidance on PrEP use in high HIV incidence settings to people having substantial risk of HIV acquisition. Oral PrEP is to be offered as part of a "Combination Prevention" package that includes HIV testing services, male and female condoms, lubricants, ART for HIV-positive partners in SDCs, VMMC, and STI prevention and management.[1] Before initiating a client on PrEP, health care providers must assess HIV risk and determine clinical eligibility by taking a thorough sexual, medical, and social history. In addition to conducting a full risk assessment and providing appropriate counseling, the provider initiates a number of baseline tests, including an enzyme-linked immunosorbent assay (ELISA) test to ensure that the individual is HIV negative. If the provider deems the client eligible to initiate PrEP, the client can begin taking the tablet once daily. Thereafter, the client returns for routine maintenance visits to check HIV status (every three months) and kidney function (creatinine clearance baseline, month six, and annually thereafter). Clients also receive a Hepatitis B surface antigen test at baseline and at six months thereafter, if initially positive.

The branded TDF product, Truvada, manufactured by Gilead Pharmaceuticals, was introduced in Namibia through an MOHSS tender and the public sector in 2016, although the MOHSS reported introducing PrEP for SDCs as early as 2014 (Republic of Namibia, 2016). In 2017, the President's Emergency Plan for AIDS Relief (PEPFAR) supported the registration of a generic version of the medicine tenofovir disoproxil fumarate (Ricovir EM) (PEPFAR 2018). A new tender was recently issued for 2020 supplies of the generic version and procurement of Ricovir EM for the public sector is underway.

The PrEP program in Namibia is still very new and public sector training, primarily focused on sensitization of doctors, is still underway. The PrEP program has been supported by PEPFAR, assisted by both IntraHealth and the International Training and Education Center for Health (I-TECH), which have developed training materials and job aids. The MOHSS also works with local Namibian organizations (both faith-based and NGOs) and a number of PEPFAR implementing partners, such as the Society for Family Health (SFH), IntraHealth, I-TECH, and Positive Vibes to reach high-risk groups at STI clinics, antenatal clinics, and sexual and reproductive health (SRH) clinics (PEPFAR 2018). To date, three regions have completed training of providers on the PrEP protocols and the rollout continues. By the third quarter of 2019, MOHSS had successfully provided PrEP through its health clinics to more than 4,700 clients, almost double its goal of reaching 2,500 individuals.

Private health sector resources in Windhoek

In 2015, the USAID-funded Strengthening Health Outcomes through the Private Sector (SHOPS) project conducted a private sector assessment in Namibia to identify key private sector actors and activities and to develop strategies of leveraging the resources of the private sector to increase and sustain access to priority health services (O'Hanlon et al. 2010). This survey identified 428 private facilities in the Khomas region of the country, which includes Windhoek, including: 338 private consulting rooms, 5 workplace clinics, 5 private hospitals, 9 pathology labs, 6 radiology labs, 3 ambulance services, 3 medical suppliers, and 4 mobile clinics.

[1] MOHSS, National ART Guidelines, Fifth Edition, 2016.

There are also approximately 55 pharmacies in Windhoek (Khomas region) with about 150 registered pharmacists. Pharmacists are not allowed to dispense medicines/controlled substances without a prescription. Private sector pharmacies have their own computerized stock management system that keeps track of stocks, expiration dates, and adverse effects. Pharmacists are currently dispensing a wide range of antiretroviral medicines (ARVs), including Ricovir EM (the product labelled for PrEP) and products with a similar formulation as Ricovir EM, though not currently labelled for PrEP, to clients for PrEP purposes. Our survey of 15 pharmacies indicated that on average, each pharmacy carries eight different ARVs[2] and six branded products with similar formulation as PrEP products. Pharmacists are interacting regularly with Medical Aid Schemes (MASs) on payment for these treatments. These products dispensed through the private sector are procured from manufacturers and sold to pharmacies by distributors and wholesalers. Physicians are also allowed to dispense controlled medicines from their clinics, although many still prefer to write prescriptions to be filled by the local pharmacies.

When new treatment guidelines are issued by the MOHSS, they are made available to private sector providers through their professional associations: the Namibian Medical Society, Medical Association of Namibia, HIV Clinicians Society, Pharmaceutical Society of Namibia (PSN), and others. There are also several online sources such as the Namibian Doctors What'sApp Group and MedScape. Several associations mentioned obtaining information from medical representatives and continuing professional development programs. These associations also post information and sponsor trainings and workshops, some of which are co-sponsored by pharmaceutical companies.

Laboratories are an important component of HIV/AIDS services, and in Namibia there are nine private and one public pathology laboratory. There are two major labs in the Khomas region to which a doctor can send lab tests: the parastatal Namibian Institute of Pathology (NIP) is the partially donor-supported laboratory to which public health clinics and hospitals send tests and PATHCARE, a large private sector facility serving private practices. There are several private labs attached to large private medical practices or smaller private labs, such as MediLink, NamPath, and High Care, that service private practices and do so at lower costs than PATHCARE.

In addition, Namibia has a well-established (albeit small-scale) private health financing sector. As of 2014, 10 private medical aid funds covered about 181,000 members (Ohadi, Jones, and Avila 2016). According to the Namibian Association of Medical Aid Funds (NAMAF), 82 percent of the population relies on the public sector, 8 percent have health insurance coverage through the Public Sector Employee Medical Aid Scheme (PSEMAS), and 7 percent have coverage through one of the private MASs. We assume that the remaining 3 percent pay out of pocket in the private sector. A SHOPS Plus rapid survey of private providers in Windhoek reinforces the finding that the majority of private sector clients rely on medical aid coverage to finance the costs of their care.

The private sector MASs are offered primarily through employers who pay a percentage of the premium for the plans, although private individuals may also enroll. Employees pay the remainder of the premium. Uninsured workers may pay some modest private sector medical costs out of pocket but fall back on the public sector for expensive care. There are also now several low-cost medical schemes that cover, at minimum, general outpatient services and pharmaceuticals. Private sector providers are generally paid via fee-for-service by medical

[2] SHOPS Plus provided a list of 14 potential ARVs. In the 15 pharmacies surveyed, the number of ARVs in stock ranged from 2 to 14, with an average of 8. From the list of 8 potential branded PrEP products, survey pharmacies carried from 2 to 8 with an average of 6 products available for dispensing.

schemes according to a price list updated annually by NAMAF.[3] Most prescription drugs, consultation fees, and laboratory tests are covered by the medical schemes. A reference pricing scheme is used so that a MAS reimburses at a rate that covers the lowest-cost products in the reference group.

The majority of MASs now at least claim to finance HIV/AIDS care and treatment. These include Namibia Health Plan (NHP); PSEMAS; Namibia Medical Care (NMC), BankMed, Paramount, and Prosperity Health. NHP is the insurer of 34,000 enrollees in Namibia, 1,300 of whom are on ARVs. NHP monitors compliance and does not charge administrative fees for services provided under the AID for AIDS program, as this program covers low-income beneficiaries. NHP has the following two benefit options to provide affordable primary health care services to the lower-income groups who previously had no access to subsidized private health care: Blue Diamond and Litunga. NHP focuses on prevention services in general and can promote PrEP to its members. All members are allowed one HIV test annually under the scheme. MyHealth manages three schemes: PSEMAS, NMC, and BankMed. MyHealth currently follows more than 1,700 HIV-related cases; 1,400 are on ART and 300 are accessing post-exposure prophylactics, PrEP, or baby formula for HIV-positive mothers. PrEP has been on MyHealth's schedule of payments for several years but is primarily focused on SDCs and pregnant women; however, last year, the MOHSS asked MyHealth to service a broader group of clients. MyHealth reports covering 100 percent of the costs of HIV consultative services, testing, and treatment and paying for the two lowest-cost generic products, the ELISA blood test every three months and the kidney function test every six months. Despite claims by MAS respondents during the assessment, pharmacists participating in the rapid survey reported multiple issues collecting benefits from the schemes for PrEP-related treatments and services, with additional justifications, explanations, and paperwork often required.

SHOPS Plus rapid surveys of clinicians and pharmacists asked respondents to estimate what proportion of their clients use three major methods for payment. Among the clinics, respondents estimated that on average, 6 percent pay out of pocket, 24 percent are members of a commercial MAS, and 70 percent are members of PSEMAS. For pharmacies, respondents estimated that on average, 9 percent pay out of pocket, while 26 percent are supported by a MAS and 65 percent by PSEMAS.[4] These data indicate that a good portion of clients of private sector services in Khomas region are public sector employees or their dependents and that nearly all those using the private sector are insured.

Current and potential market size for PrEP

PEPFAR data indicate that use of PrEP has increased steadily since its introduction. In 2017, only 14 individuals were taking PrEP treatments. By the second quarter of 2019, almost 4,500 individuals, 1,333 of whom live in Khomas, were using PrEP. In the 2019 National ART guidelines, the Namibian government has a stated commitment to increase access to PrEP for any sexually active HIV-negative person who is at risk of acquiring HIV, especially those at high risk. These include the following:

- HIV-negative people in sero-discordant relationships, especially those with a partner who is not confirmed as virologically suppressed, those who want to conceive, or those who are pregnant/breastfeeding

[3] Providers are not limited by the NAMAF reimbursement rates and may charge whatever they feel is appropriate for their services.

[4] Anecdotally, we heard during interviews that public sector employees preferred using private sector clinics due to issues of confidentiality.

- Those with partners(s) of unknown HIV status
- Those who engage in risky sexual behaviors, such as multiple and/or concurrent sexual partners, inconsistent or no condom use, recurrent use of post-exposure prophylaxis, or recent/recurrent STIs
- Those who strongly feel at substantial risk of HIV infection

The number of PrEP users will directly impact both the ability of the public sector to serve the total market and the ability of private providers to generate revenue from these services, either directly (through medical aid payments or contracts with the government) or indirectly (through revenue from other services that these patients access). SHOPS Plus therefore considered several different actionable market segments that could potentially affect the public sector's strategy for rolling out PrEP through the private sector, as well as private providers' interest in offering it. The first set of actionable segments includes groups that are already prioritized by the Namibian government and who are most at risk of contracting HIV, namely members of SDCs, MSM, and FSW. Based on stated priorities by the Government of Namibia, it is assumed that these groups would be targeted for free public sector PrEP services. In an environment where these populations have easy access to free products and services, the actionable opportunities for a fee-bearing private sector strategy are more limited. The estimations therefore assume that these populations would be entirely served by the public sector, although there are likely some key populations with an ability and willingness to pay for PrEP in the private sector. In the second scenario, SHOPS Plus considered another highly prioritized group with a high risk of HIV infection, sexually active AGYW. While the first group is likely small in scale, this second group expands to the general population and would likely be larger, with implications for the resources that the public and private sectors would need to mobilize to serve them. Finally, SHOPS Plus included people in the general population who engage in risky sexual practices, such as multiple concurrent sexual partners or paying for sex, or have expressed care-seeking behavior that would make them a potentially likely PrEP user (i.e., treatment for a STI). Within this group, SHOPS Plus considered the likelihood that these clients would be a likely match for private providers based on ability to pay and previous sourcing of HIV testing and STI treatment.

These groups are appropriate target populations for PrEP for several reasons. AGYW have relatively low rates of comprehensive knowledge about HIV and AIDS, yet higher rates of STIs compared with their male counterparts. Challenges include early sexual debut, intergenerational and transactional sex, high teen pregnancy rates, school dropouts due to pregnancies, gender inequality, limited engagement of parents and caregivers, and inadequate reach of vulnerable girls with social protection services. Among MSM, low use of condoms, multiple sexual partners, and intergenerational sex also contribute to high prevalence. Approximately 50 percent of MSM reported to have four or more sexual partners, with nearly two-thirds of HIV-positive MSM unaware of their status. Providing services to MSM remains a challenge as societal attitudes, norms, and values do not support people of non-heterosexual identities or behaviors. FSW are often physically or sexually abused and are unable to negotiate for safe sex due to gender inequality. Sexual abuse cases are underreported for fear of facing criminal charges themselves. In addition, groups such as those who have accessed an HIV test or been treated for an STI in a private outlet demonstrate a potential relevance as well as a potential preference for private sector care based on their care-seeking behavior (Republic of Namibia MOHSS 2017: 14–16).

To estimate the market sizes of these groups, SHOPS Plus used data from the 2017 NAMPHIA (Republic of Namibia, MOHSS 2017), the 2013 DHS (Republic of Namibia, MOHSS, and ICF International 2014), and the 2013 Integrated Biological and Behavioral Surveillance Studies.

The results of these estimates are presented in Table 1. To generate these results, SHOPS Plus used the following assumptions:

- Group 1: Key populations. 2013 Integrated Biological and Behavioral Surveillance Studies data indicate that in Khomas, there are an estimated 3,000 FSW with an HIV prevalence of 37.5 percent, and 2,400 MSM with an HIV prevalence of 21.0 percent; all HIV-negative FSW and MSM are included as target groups. In addition, 12.9 percent of PLHIV in Windhoek belong to an SDC. All HIV-negative members of these couples would be priority target groups for PrEP.
- Group 2: AGYW. Based on UN population data, there are approximately 80,000 AGYW in Khomas. National HIV prevalence figures for ages15–19 and 20–24 from NAMPHIA 2017 are 5.4 percent and 6.0 percent, respectively. DHS data indicate that approximately 38 percent of adolescent girls (15–19) and 79 percent of young women (20–24) have been sexually active within the past year. Given the factors described above, all HIV-negative AGYW who have been sexually active within the past year are considered priority targets for PrEP, with those AGYW in the highest two wealth quintiles assumed to be actionable segments for the private sector.
- Group 3: General population men and women with risky sexual behavior. All men and women who report risky sexual behavior would be interested in PrEP. Those who are in the highest two wealth quintiles are assumed to be appropriate targets for the private sector, while those belonging to lower wealth quintiles would likely need to be served by the public sector. To avoid double counting, SHOPS Plus discounted estimates of the number of potential PrEP users from prioritized groups (AGYW, MSM, FSW, and SDCs). While men and women who reported accessing an HIV test or treatment for an STI could be possible target segments for PrEP, SHOPS Plus did not include them in these estimates, since uptake of testing is so widespread in Khomas that that cohort would include significant numbers of people whose risk profiles are not substantial enough to warrant initiating PrEP. Those cohort members who sought HIV/STI services due to risky behaviors are assumed to be captured in Group 3 based on their other reported behaviors. SHOPS Plus notes that HIV/STI clinics may be one of the appropriate channels for reaching this group efficiently.
- For AGYW and general population, these estimates use 2019 population figures. For key populations, the estimates assume that the populations grew at rates equal to the general population in order to update them to 2019 figures.

Table 1. Potential actionable market segments for PrEP in Khomas

Market segment	Estimated total	Public sector targets	Private sector targets
Group 1: Key Populations	7,882	7,882	
FSW	*2,056*	*2,056*	
MSM	*2,082*	*2,082*	
SDC	*3,743*	*3,743*	
Group 2: AGYW	39,925	9,702	30,223
Group 3: General Population, Risky Sexual Behavior	29,272	8,790	20,483
Total	**77,079**	**26,373**	**50,706**

These assumptions yield a potential market of as many as 77,000 PrEP users in Windhoek and the surrounding Khomas region—larger by a factor of 56 than the 1,333 individuals currently accessing it.

The size of the potential total market highlights the need to expand the number of access points as much as possible for clients seeking PrEP and the need for a multisectoral approach, since it may not be feasible for the public sector alone to finance and deliver services to all potential PrEP users in Windhoek. Notably, significant proportions of the general population groups come from higher wealth segments due to Windhoek's relative wealth compared with the rest of the country. In Khomas, an estimated 71 percent of men and women engaging in risky sexual behavior are from the top two wealth quintiles. Furthermore, the majority of upper-income men and women accessing HIV and STI services in Khomas do so in the public sector, indicating an opportunity for the government to better target its resources and for the private sector to increase its contributions. If the private sector were to serve all the people in the potential market with a presumed ability to pay, it could contribute to 66 percent of the PrEP market in Khomas, specifically AGYW and general population men and women in the upper two wealth quintiles. Subsequent sections of the report focus on these two segments.

While there is a lot of potential, there are also some possible constraints. Many of the private providers interviewed as part of this assessment expressed concerns about offering PrEP to anyone outside of an SDC. They voiced concerns ranging from the cost of PrEP compared with other prevention strategies to how being on PrEP could affect clients' willingness to engage in risky sexual behavior. It is therefore important to identify the best strategies to optimize the contribution of private providers to the PrEP market. The remainder of this report examines other potential supportive or constraining factors in the market, as well as strategies and recommendations for responding to them.

Supply and demand considerations

Availability

There are at least eight high-quality products available in pharmacies with formulations suitable for use as and currently being sold as PrEP. All of these products in the market are manufactured by reputable pharmaceutical companies. Pharmacies visited carried at least two of the branded products listed below and the majority carried six of these products. All contain 300 mg oral TDF co-formulated with 200 mg FTC or 300 mg lamuvidine. They all fulfill the PrEP formulation requirements set forth in the ART guidelines (MOHSS 2019), although only Ricovir EM is registered with the government specifically for PrEP. While the remaining drugs are currently registered with the NMRC as ARVs, there is a need to amend their registrations so that they can be officially labeled as available for PrEP. These changes could promote commodity security, competition in the marketplace, and consumer choice.

All of the products listed have in the past been imported as ARVs for inclusion in the ART cocktail. TDF is one of the main components of the cocktail, to which other substances (lamuvidine, efavorins, dolutergravis) are added to complete the approved treatment regimen. Given that MASs will cover only one of the two lowest-price generics, all pharmacists we visited knew that the generic formula of these eight products was the one to be used for PrEP, and many of the pharmacists are actively collaborating with prescribing doctors and MASs to ensure that clients obtain a generic PrEP that can be covered by the scheme.

There are six major pharmaceutical distributors/wholesalers (Gecka, NamPharm, ErongoMed, CosPharm, Shipanga Medical Services, and FabuPharm) that purchase pharmaceuticals from manufacturers and make them available for sale through the private sector. All private pharmacies order their drugs and supplies directly from one of these distributors, some of which

also act as wholesalers. Currently, Mylan is working with ErongoMed to import and distribute Ricovir EM—its generic PrEP formulation—on a small scale in the private sector.

Importers must ensure that the drugs have a National Pharmaceutical Product Index (NAPPI) code. This is a comprehensive database of pharmaceutical codes for medical product classification used in South Africa. Each product has a unique NAPPI code, which enables electronic data interchange throughout the health care delivery chain. These codes cover all products approved for commercial sale in South Africa—and, by extension, Namibia.

NAMAF is a juristic body established to control, promote, encourage, and co-ordinate the establishment, development, and functioning of medical aid funds in Namibia. NAMAF ensures that the MASs pay only for medicines and supplies that have a NAPPI code. This code is obtained from MediKredit, a South African-based company responsible for the management and maintenance of the NAPPI product file.

In addition, every medicine, including all of the PrEP products currently available in the private sector pharmacies, have been tested for quality, registered by the NMRC, and approved for sale in Namibia.

Affordability

There is a standard markup on all pharmaceutical products. A “single exit price” is established for every product sold at wholesale. Retail then sells the product at 1.5 times the wholesale price plus 15 percent VAT. The VAT is returned to the government and the pharmacist’s profit and overhead come out of the 50 percent markup. The larger retail pharmacies can bargain with distributors for somewhat better deals, discounts, bonus packs, and so forth, depending on the quantity purchased, which may allow these larger pharmacies more profit. However, the sales prices, in essence, are set by this government formula.

The brands that interviewed pharmacists reported as being sold for PrEP currently in the commercial market and their prices are provided in Table 2. The prices for the products in different pharmacies visited by the assessment team varied only slightly, so all are basically following the single exit price rule. These prices may vary slightly over time as new batches are imported and an exit price is established for that batch.

Table 2. PrEP brands and prices available at private pharmacies

Brand name (manufacturer)	Retail price at private pharmacies	US$ equivalent (US$1=N$15)
Adco Emtivir (Adcock generic)	N$ 367	US$ 24.47
Ricovir EM (Mylan generic)	N$ 474–476	US$ 31.60–31.73
Tenohope E (McLoed generic)	N$ 386–465	US$ 25.73–31.00
Tenofovir EM (Gilead generic)	N$ 465–469	US$ 31.00–31.27
Tenof EM (Hetero labs generic)	N$ 465–476	US$ 31.00–31.73
Truvada (Gilead generic)	N$ 578	US$ 38.53
Didivir (Cipla non-generic)	N$ 710–712	US$ 47.33–47.47
Truvada (Gilead non-generic)	N$ 932–970	US$ 62.13–64.67

According to discussions with stakeholders and the survey of private sector providers, the costs of medical consultations range from N$200 and N$500 (US$13–33) for an initial consultation and from N$160 to N$300 (US$11–20) for a follow-up consultation. MASs cover N$411 for the initial visit to a general practitioner and N$617 for the initial visit to a specialist. MAS coverage for a follow-up visit for the same condition ranges from N$331 for a general practitioner to

N$412 for a specialist. The costs of the required laboratory tests in the private sector are as follows: ELISA = N$300–370 (US$20–25), and serum creatinine[5] = N$55–70 (US$3.65–4.67). The Hepatitis B antigen test is required at baseline (cost = N$229–265 (US$15–18)) but is only required at six-month intervals thereafter if the individual tests positive.[6] These costs are covered by the majority of MASs. According to the MAS NHP, the rate for coverage of the ELISA test is N$389 and for the Creatinine test it is N$66. These are clearly within ranges noted above and are within rates set by NAMAF.

Assured quality

All medications available for sale in either health clinics or pharmacies are imported into Namibia. All pharmaceuticals imported by the private sector are tested for quality by the NMRC prior to registration. All products purchased by the CMS are subject to additional batch testing upon receipt.

Any doctor who is licensed to practice medicine in Namibia may counsel and provide PrEP treatments to patients. There are no special circumstances, special certifications, or prior training required for a doctor to prescribe PrEP; however, in line with general restrictions on task sharing in the private sector, there are limits on the ability of private nurses to offer PrEP without special training and certification. New HIV guidelines were issued in 2019, after which both the Directorate of Special Programs at the MOHSS and the HIV Clinicians Society and other professional associations sensitized a number of the private sector doctors in the Khomas region. However, there has been no comprehensive training of private sector providers on the new PrEP protocols. The majority of clinicians in the rapid survey had received some training on PrEP. All indicated their interest in receiving additional training and all indicated that they supported the use of PrEP in general. The MOHSS, with the technical assistance of PEPFAR implementing partners has been training public sector doctors on PrEP protocols since 2016.

Private sector providers are already seeing patients and prescribing PrEP. Of the 12 general practitioners surveyed, all were aware of PrEP and 8 (77%) knew at least one PrEP drug and are currently prescribing PrEP. All of the 13 clinicians surveyed provide HIV counseling and testing, STI care and treatment, and referral services. Only eight provide ART-related services. On average, these clinicians see 20 HIV counseling and testing patients in a month (range 3–56), 35 ART patients (range 1–100), and 55 STI patients (range 2–500). Those who are treating PrEP clients have 1 to 10 clients per month (average = 4) but did see opportunity for expansion of their current services. It is difficult to determine the number who actually follow all of the protocols. Most knew that the pill must be taken daily, but fewer than half knew more than one or two eligibility requirements or contraindications. Two of the respondents mentioned that they use a Rapid HIV Test kit in order to enable the HIV-negative client to quickly access PrEP.

Appropriate design

There was considerable concern expressed by implementing partners that private providers are not conducting a thorough risk analysis of all patients coming into antenatal, family planning, VMMC, or voluntary counseling and testing clinics and in particular are not using opportunities to discuss prevention with those who come to the clinic for STI diagnosis and treatment. These doctor/patient encounters could be used more effectively to ask questions about potentially risky

[5] The cost of the creatinine clearance/urea test ranges from N$311 to N$346 at the two major labs, but it appears from data collected from NHP that NHP is covering primarily the serum creatinine test as the standard.

[6] We did not ask the cost of this test on our rapid survey. The cost range was developed from information provided by one of the private clinics and the NHP MAS.

behaviors and direct patients toward prevention solutions. Specifically, pharmacist surveys conducted as part of this assessment revealed low levels of adequate knowledge about appropriate uses and contraindications for PrEP. Additionally, provider interviews revealed some evidence of provider biases against providing PrEP to non-SDCs, due to beliefs that it will encourage riskier behavior. Providers need to be trained on appropriate methods for conducting risk assessments, including which questions to ask (STI, multiple or concurrent partners, AGYW with more than one partner, etc.), so that patients can be counseled and prevention messages transmitted. Providers also need to educate potential users about side effects. HIV risk at university level is high; therefore, providers need to be asking all AGYW passing through their clinics about STI, family planning, and sexual activity. Providers need to be well grounded through training to know who really needs PrEP and to counsel clients that using PrEP is a commitment, not a casual-use product.

Given that the public sector has been supporting SDCs with PrEP since 2016, USAID implementing partners supporting service delivery in the public sector, IntraHealth, and I-TECH have already developed training curricula/slides and training manuals for teaching public sector doctors about delivery, adherence to protocols, testing, and counseling. This training has been completed in several regions and is continuing. I-TECH has also developed and printed standard operating procedures as a tool for doctors. These materials are available for training providers working in private sector clinics.

Awareness

Almost all surveyed providers, pharmacists, and PEPFAR partners implementing HIV treatment and prevention programs at government units, as well as those currently working with key populations, encouraged the development of a community awareness campaign to educate the community—including health care providers and public officials—about PrEP and its uses in order to dispel misunderstandings and work to reduce stigma. Implementing partners feel that this is as important as demand generation to bring potential PrEP users into clinics and pharmacies. PrEP drugs are ARVs and are known as such. Friends/family may know what these drugs look like and, although the drugs are preventive, they may think the individual has HIV. Partners may think the individual is taking PrEP to enable him/her to engage in risky behaviors. Educational materials need to address power dynamics in relationships. More information is needed as well to sensitize target key populations at risk.

Anecdotally, providers reported that a newspaper article last year caused an upsurge in demand, which led the team to conclude that a mass media campaign through radio, TV, and social media channels to encourage at-risk individuals to seek care in either sector should be considered. Partners felt that efforts to reach youth of either sex should be through social media. SFH has a Facebook page that is accessed by key populations using their clinical services. This would not be “brand” advertising, but rather “social marketing” or transmitting the idea that taking PrEP could prevent HIV infection.

Under the national PrEP program, MOHSS printed information, education, and communication (IEC) materials and developed a strategy for radio and television ads. However, when the MOHSS coordinator resigned to take a position with another organization, all planning came to a halt. At the same time, the program ran out of funds from both U.S. Centers for Disease Control and Prevention and PEPFAR. Both I-TECH and Project Hope have developed basic print materials—flyers mostly for the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) Project—that can be adapted for broader dissemination.

Political and regulatory feasibility

There are no policy barriers to delivery of PrEP through the private sector. The public sector is encouraging private sector participation in this effort and has prioritized strengthening partnerships with the private sector. Treatment guidelines have been developed and made available to the private sector. Doctors are already licensed to provide the full range of medical services. Providers are already seeing patients and treating them. Payment for PrEP has recently been included in the MAS benefits. Pharmacies carry quality products and work closely with MASs to ensure that these services are covered under the schemes.

As yet, there are no provisions for pharmacists to dispense controlled substances without a prescription. In order for the suggested public-private partnership (PPP) model with the PSN to be operational, the PSN must itself decide that it wants to move forward and the executive director of the MOHSS must sanction this pilot and make an exception to the drug dispensing regulations to allow this model to be piloted.

Options for Supporting the Expansion of PrEP Delivery through the Private Sector

Purely Private Model: Private sector procurement and delivery of PrEP treatment and services

Background

Implementing partners and MOHSS officials felt that if properly regulated by the MOHSS, the private sector would be an excellent provider of PrEP. Patients prefer going to the private sector (less time invested, privacy, confidentiality, etc.) to using public sector facilities. The MOHSS supports expansion of these services in the private sector if regular reporting can be provided and protocols followed. Availability of PrEP in the private sector would take strain off the public sector during periods of stockout and permit public sector clients to continue to adhere to the protocol for full protection, although the costs will be higher.

How it would work

A purely private sector model would allow market forces to work unimpeded. Products would be imported into Namibia under their current NMRC registration by one of the six distributors and wholesalers. Standard markups on the products would apply. Pharmacies, based on guidelines for dispensing drugs provided by the MOHSS, would obtain quality medicines, manufactured by reputable pharmaceutical companies, from one of the six wholesalers. This is already happening in Namibia. There are currently eight PrEP products in the commercial market. It is highly unlikely that all of these products would be out of stock at any one time. Not one of the pharmacists or distributors visited mentioned that drug stockouts were a problem. According to stakeholders and the rapid surveys, the system for importation, registration, and distribution of drugs in the current commercial climate works very well. If demand exists, current distributors will be in touch with their suppliers to ensure that supplies of these products are available.

Private sector providers working in one of the 338 private consulting rooms, clinics, or hospitals would be comprehensively trained to provide an appropriate risk assessment and follow the protocols outlined in the current ART guidelines issued by the MOHSS. All doctors in Namibia, once licensed to provide medical services, are authorized by the government to provide these services. While training will improve the quality of services provided, there is no requirement that this training take place in order for the provider to counsel a client or prescribe the drugs. Current prices for provider consultation, test kits, and laboratory tests would be at the full market prices described above. Again, increased demand for PrEP will mean that provider incomes will rise correspondingly.

Although doctors and clinics may now procure and stock drugs in their clinics, most still prefer not to invest in a wide range of products but rather to write a prescription and refer clients to nearby pharmacies with which many have a close working relationship. As noted above, prices are relatively fixed and there is little percentage in “shopping” for a better price at a different pharmacy.

In terms of having the costs of these services covered, most MASs now include these services in their benefit packages, most of which pay 100 percent of the costs up to the maximum benefit allowed.

Due to the fact that some of the PrEP formulations can be part of the ARV cocktail, and some have also been used to treat Hepatitis B, it has been very difficult for pharmacies, distributors, or medical aid funds to estimate the market demand for PrEP as an HIV preventive in the commercial private sector. The MAS NHP provided information on their PrEP-related payments, which grew from an average of 530 per month in 2017 to 890 per month in 2018 and 1,560 per month during the first nine months of 2019. These data cover their membership of about 34,000 beneficiaries nationwide. Given a maximum demand estimate of 51,000 potential clients, as noted above, there is ample room for private sector involvement in addressing the needs of individuals seeking PrEP treatment.

Manufacturers' interest in partnering in market development

Currently, Mylan Pharmaceuticals, by virtue of having won the CMS tender to provide PrEP treatments (Ricovir EM) to the public sector and their long-term local distribution partnership with ErongoMED to place its products throughout the private sector, clearly leads the market in Namibia. In September, Mylan launched an HIV self-test kit into the private market in Namibia. They are considering building co-packs of three-month supplies of PrEP plus an HIV self-test kit, which could eliminate two of the four annual visits to the providers for testing, bringing down costs for PrEP in private sector. Product awareness is their key challenge and they would be interested in partnering with USAID or MOHSS to raise awareness, sponsor training workshops, or produce detailing materials, depending upon the ultimate size of the market and sales revenue that would allow them to do this. They are very interested in seeing the market for PrEP products grow and would be willing to make contributions in terms of training and demand generation if sales are strong.

Recommendation

USAID/Namibia can support the commercial sector model by:

1. Partnering with the professional associations (HIV Clinicians Society, Medical Association, and Pharmacy Society) to train private sector providers in the new protocols. In-depth training on appropriate risk assessment, counseling on adherence and side effects, and requirements for follow-up will improve the quality of clinical services provided and help to identify additional at-risk individuals. Pharmaceutical companies that offer PrEP products can be tapped to co-sponsor these trainings.
2. Improving both community and potential user awareness. These efforts should be supported by PEPFAR, although conversations should be initiated with the pharmaceutical manufacturers' representatives on their support for generic ads, detailing to pharmaceutical companies, and other promotions. MAS prevention units can be tapped to sponsor wellness days and send information to their members.

Opportunities	Challenges
General	
• High-quality products are available throughout the region and there is an excellent distribution system with few stockouts. • There are many providers in the region, all of whom have been licensed to practice medicine in the country. • Appropriately trained providers will be able to conduct thorough risk assessments and provide appropriate counseling on side effects and the need for adherence to the protocols. • This option addresses MOHSS challenges of work overload and privacy/confidentiality as public sector users and key at-risk populations shift to seeking more efficient and confidential services in the private sector. • Providers who deliver PrEP can increase their revenues by establishing long-term relationships with patients who will return for repeat visits over time.	• Most private clinics do not report to the government and they have no incentives to do so. This makes it difficult to catch adverse events early. • The MOHSS has concerns about the pace at which private providers adopt policy and guidelines. It fears that private providers are slow to change practices and follow new guidelines. • Many physicians fail to take full advantage of opportunities to conduct a thorough risk assessment of clients who come to them for STIs or other complaints. • Conducting a thorough risk assessment is time consuming and some private providers are reluctant to spend the extra time with PrEP patients. • Practitioners do not always offer an integrated package of either SRH or HIV services.
Key populations (MSM, FSW, TG, AGYW) with ability to pay	
• Key populations, including AGYW, prefer the convenience, quality, and confidentiality available in the private sector and the ability to consistently see a single provider. • Most MASs will cover the costs. • Private providers are located throughout the city including areas of high HIV incidence. • Trained providers with key populations as regular clientele can better address issues of adherence with consistent follow-up. • AGYW are often willing to spend money out of pocket and travel further to private outlets if they perceive reduced stigma (FHI360 2017).	• Some providers are worried that PrEP: 1) encourages risky behaviors and 2) will contribute to an upsurge in STIs. • There is still stigma associated with homosexuality and prostitution that may inhibit appropriate care delivery and care seeking behaviors.
Other at-risk populations (including SDCs) with ability to pay	
• Private sector services are more efficient and confidential. • Many patients would rather pay for quality services than put up with the wait times and lack of privacy at public clinics. • Both clinicians and pharmacists are positive about treating SDCs. • Most MASs will cover the costs.	• Many providers expressed concerns about serving populations other than SDCs.

To move forward with this opportunity, USAID/Namibia should:

- Consult with professional associations on a partnership to adapt training materials and job aids for private providers and to develop a program to train as many private sector providers as possible on the new guidelines.
- Review current IEC and demand generation materials. Consult with advertising professionals on the quality of current materials and develop a plan to implement both community awareness and demand generation media campaigns.

- Consult with private sector pharmaceutical representatives on their willingness to sponsor training and generic demand generation advertising.
- Discuss with the MOHSS options for monitoring and/or increasing oversight of private providers' delivery of services, possibly through a partnership with the professional associations (shared monitoring systems).

Public-Private Partnership Model: Partnership with Pharmaceutical Society of Namibia

Background

The PSN recently submitted a PPP proposal to the MOHSS executive director that would allow potential clients to by-pass clinics and obtain PrEP directly from pharmacies. Pharmacists would themselves conduct the risk assessment, initiate and evaluate the appropriate blood and urine tests, provide counseling, and dispense PrEP to clients. The PSN has an education department that currently offers training workshops for which pharmacists receive Continuing Professional Development credits required for renewing their licenses. The team discussed options for using the PSN as a training partner, development of curricula and job aids, obtaining lower-priced PrEP products from CMS for trained pharmacists, and quality assurance. PSN leadership is in the process of putting together a concept note to flesh out how this partnership could work.

Pharmacists reported seeing a pattern of requests from young patients, for morning-after pills, contraceptives, pregnancy test kits, and HIV test kits. The pharmacists have already identified these young patients as higher-risk clients who should receive counseling about HIV prevention and PrEP. Several of the pharmacies already have private consulting areas or plans for expanding those areas and hiring counseling staff. About 40 percent of the pharmacies surveyed already provide HIV counseling, all sell test kits and ARVs, and all were aware of PrEP and carried at least two PrEP products.

The CMS director believes that there are great opportunities for reducing the cost of health care in Namibia by allowing CMS to order first-line treatments for key public health illnesses (HIV, tuberculosis, malaria). CMS can buy larger quantities at better prices and make them available to the entire population at the public sector price.

Clients prefer the privacy and confidentiality of the pharmacy to the ARV clinic, where they may meet others in their community or where health providers may not be discrete. This option would allow key at-risk populations to seek services in an anonymous and confidential manner at an affordable out-of-pocket cost. Pharmacies are historically key delivery points for family planning services and advice for health-related issues, offering convenient, low-cost services.

Moreover, this approach would benefit all of the MASs and their beneficiaries. PSEMAS clients who cannot obtain needed treatment at a public ARV clinic may be sent to the private sector, where the scheme must pay the full market cost of the treatment. This option would allow government employees and individuals under the various MASs, as well as individuals operating outside of the medical schemes, to access the product at a much lower price. It would allow those who have surpassed their MAS benefit limit to continue to procure treatments at an affordable cost.

While this approach would be a departure from current prescribing practice, it is worth the consideration of a pilot effort and discussion among several parties: PSN, the MOHSS Directorate of Special Programs, the HIV Clinicians Society, CMS, and PEPFAR to determine

whether allowing pharmacists to dispense this single prevention product will work. Stakeholders interviewed as part of this assessment agreed that better monitoring of the private sector is needed if the pharmacists were allowed to dispense drugs without a doctor's prescription.

How it would work

According to the PSN, there are approximately150 pharmacists in 55 pharmacies throughout the Khomas region. A high-quality product, Ricovir EM, would be purchased from CMS by participating pharmacists who have completed the PSN specialized training. With standard markups and the 15 percent VAT, this product could be made available to clients at a retail price in the $105–$110 (US$6–7) range. The price for the consultation would be negotiated under the PPP. Test kits could also be provided by CMS at their procured price plus standard markups. Laboratory testing could be negotiated with NIP or one of the private sector laboratories at a concessional rate. The cost of these services and products should still be covered for MAS members.

Quality of services provided would be enhanced through a partnership with the PSN, which would train all participating pharmacists in the protocols for treatment, compliance, and testing, as well as counseling and risk assessment skills.

One of the main concerns of both the MOHSS and clinicians is oversight of these services and assurance that pharmacists are not taking shortcuts, motivated by profit. The advantage of a formal PPP is that reporting systems can be designed to collect information from participating pharmacies. Mystery client surveys can periodically be implemented to ensure that pharmacists are conducting appropriate risk assessments, administering tests as required in the protocols, and providing appropriate counseling on adherence.

Almost all pharmacists in the survey mentioned the need for community awareness campaigns. Specific demand generation campaigns informing potential clients and high-risk groups that these services and products are available at all/designated pharmacies at reduced prices need to be developed and broadcast.

Opportunities	Challenges
General	
• There is excellent coverage of pharmacies in Khomas, including high HIV incidence areas. • A quality product can be made available through CMS at one-quarter of the current retail price. • Clients view pharmacists as knowledgeable professionals from whom they can seek confidential advice. • Pharmacists are already providing ad hoc counseling to PrEP clients. • Demand generation efforts can inform potential clients and drive them to the pharmacies for quality services and products. • Training partners are already available and committed to providing appropriate training, leadership, and monitoring. • Adding the additional quantities for the private pharmaceutical sector to the CMS tender would allow CMS to procure larger amounts at better prices.	• Pharmacists may be more motivated by profit or see this as an "easy fix" and not provide adequate follow-up (testing and/or counseling) to ensure adherence. • Monitoring quality of services, counseling, and follow-up remain a challenge. • There are limited patient testing and tracking mechanisms. • Pharmacists may not be sufficiently trained to identify co-morbidities or contraindications that might preclude PrEP. • The expectation that NIP will provide testing at a reduced rate, given that their resources are stretched, may be unrealistic. • Pharmacists have encountered issues with unwillingness of MASs to pay for PrEP-related products and services. • Sourcing products from CMS may impact the market for local/regional distributors.

Opportunities	Challenges
• The majority of pharmacies are located near private clinics and/or have linkages to clinics to whom clients can be referred for additional or related services.	
Key populations (MSM, FSW, TG, AGYW) with ability to pay	
• The anonymity and confidentiality provided by pharmacists encourage the participation of key populations. • Pharmacies are highly utilized by young women for pills and condoms and health information due to their convenience and acceptability.* • MAS will pay for services and, at lower rates for product and services, may have fewer objections to paying.	• Some pharmacists are worried that PrEP: 1) encourages risky behaviors and 2) will contribute to an upsurge in STIs. • Pharmacists may not take the time to ask about related risky behaviors that impact on STIs. • FSW and AGYW have a hard time adhering to protocols. Pharmacists may not provide consistent follow-up to ensure compliance. • Key populations, in order to maximize confidentiality, may access PrEP from various pharmacies and not receive the necessary follow-up that can be provided by a single practitioner.
Other at-risk populations (including SDC) with ability to pay	
• Pharmacies are quick and efficient and provide more confidential services than public sector or even private clinicians. • MASs will pay for services and, at lower rates for product and services, may have fewer objections to paying. • Pharmacists seem very willing to serve SDC.	• Pharmacists may not take the time to ask about related risky behaviors that impact on STIs.

*Note: The Children's Investment Fund Foundation is doing research into co-packaging PrEP with oral contraceptive pills as a dual prevention pack targeted specifically for this at-risk group of AGYW.

To move forward with this opportunity, USAID/Namibia should:

- Consult with the PSN and obtain the concept note on their proposal to adapt training materials and job aids for private pharmacists and to develop a program to train as many private sector pharmacists as possible on the new guidelines.
- Provide advice to the MOHSS on the development of the PPP.
- Consult with CMS on adding appropriate quantities of Ricovir EM to their tender to cover the private sector; discuss options for providing test kits.
- Explore the possibility of using NIP or another laboratory as a referral laboratory to cover costs of tests at a concessional rate.
- Review current IEC and demand generation materials. Consult with communication professionals on the quality of current materials and develop a plan to implement both community awareness and demand generation media campaigns.
- Discuss with both the PSN and MOHSS options for monitoring and/or increasing oversight of private pharmacists' delivery of services. Consider options for ensuring quality of services, including mystery client surveys.

Public-Private Partnership Model: Dispense through designated private sector clinics

Background

There are existing models upon which to build a network of private sector clinics to service high-risk groups without adequate health insurance with an integrated program of health care and HIV prevention services. This model has two approaches. The first is a social franchise model of self-selected HIV specialists who are willing to provide the range of HIV services at a reduced price using lower-cost PrEP products. The second is the NGO clinic model, which offers free services to high-risk key populations, with costs subsidized by either donors or MOHSS.

- PEPFAR, through the AIDSFree project, is supporting the MOHSS through a network of 16 clinics that provide VMMC services. These contracted clinic services could be expanded to provide high-risk groups with both integrated HIV treatment and prevention services, including PrEP, and adequate medical care for other conditions. USAID, through the AIDSFree project, provides the surgical kits; consultation and surgery are covered by the MAS. The program equally welcomes clients who do not have medical aid. Their circumcisions are covered by a subsidy PEPFAR provides to the private providers.
- With USAID funding, SFH reaches high-risk groups in eight districts within seven regions of Namibia. This community-centered program targets FSW, MSM, TG, and other high-risk populations (mostly male, truck drivers, sailors, etc.) in low-income areas. SFH's early work focused on prevention activities and messages and linking group members to services provided by Namibia Planned Parenthood Association. They have since transitioned to directly providing testing and prevention services through 11 key population-friendly facilities, two of which are located in Khomas region. The MOHSS conducted the initial training of facility staff. They partner with community organizations that provide mobilization and outreach, find and follow up with individuals who may need testing and treatment, and provide counseling. All services are provided free of charge to these target groups.

Many patients using the private sector and paying through one of the insurance schemes visit the private clinic for 9 or 10 months out of the year. But when the insurance payout ceilings are met, they either stop taking the drugs or must go to the public sector. This provides an opportunity for a PPP with providers within this proposed franchise. Private clinicians could partner with the public sector, either referring patients to the public sector when their insurance funds are depleted or the public sector can provide the drugs and kits to the private clinic for use during those periods with appropriate reporting from private providers to the MOHSS.

How it would work

There are currently 11 VMMC clinics and two SFH clinics in the Khomas region. Other providers in the region, interested in offering these services, could be identified, thus expanding the number of outlets in the region that focus on providing both HIV prevention services as well as other medical care needed by high-risk groups.

The MOHSS has voiced some concern as to the quality of service provided by the private sector and the sector's ability to follow the government-issued protocols. Although many clinicians have already received some sensitization training, partnering with the HIV Clinicians Society or the Medical Association to provide comprehensive training, with training curricula and job aids already prepared by implementing partners for the public sector, will ensure that the selected providers have

the in-depth training needed to conduct risk assessments and provide the appropriate counseling to ensure continuing compliance and adherence to the protocols for an integrated system of HIV care, treatment, and prevention services.

Trained providers in the social franchise model would be able to access PrEP products at the CMS procured price for Ricovir EM of approximately N$61 and quality test kits from CMS and dispense them from their clinics at a retail price of $105–$110 (US$6–7) range. The price for the consultation would be negotiated under the PPP with the self-selected providers. Laboratory testing could be negotiated with NIP or another private laboratory at a concessional rate. These services and products should still be covered for MAS members, while those paying out of pocket can access these services at affordable prices.

Under the NGO model, all services would be provided free of charge to high-risk key populations as they are currently under the SFH project. One possible option for expanding the services for high-risk individuals would be to work through community partners, such as Positive Vibe, to issue vouchers to high-risk group members (particularly AGYW). The key populations could take the vouchers to members of the selected (and perhaps branded) NGO clinics for counseling, testing, and PrEP treatment, as well as for other medical services. All providers in the system would be trained and have to agree to honor the vouchers and provide services. Additional clinics should be established in key high-risk areas in the capital city.

With a small number of participating clinical facilities, a PPP could be developed, which would establish a system for reporting to the government. These clinics could also serve as referral facilities for clinics that do not wish to or cannot provide HIV-related services.

Surveyed clinicians agreed that community awareness campaigns need to be developed and broadcast. Specific demand generation campaigns informing potential clients and high-risk groups that these services and products are available at designated clinics (similar to the VMMC campaign) at reduced prices need to be developed and communicated to potential users. This campaign can drive new clients to the selected clinics.

Opportunities	Challenges
General	
• Selected clinics would provide integrated HIV care, treatment, and prevention services as well as other medical services. These clinics already provide HIV counseling and testing and are accustomed to providing services to key populations at risk. • Clinics are located in areas of the city with high HIV incidence and are accessible to the populations to be served. • High-risk groups prefer to seek services in the private sector as they think quality is better. • Working-class patients may be more likely to seek care from one of the franchised clinics. • Providers will benefit through enhanced/expanded skills and up-to-date information on HIV care and treatment and additional clients. • Many patients themselves initiate discussions with doctors about PrEP, indicating that the demand exists.	• The key population-friendly service centers are not necessarily stigma free, but efforts are continuing to better sensitize health care providers. • Doctors may not follow the prescribed protocols or counsel effectively. • Reporting on services rendered is inherently weak, as there is no MOHSS oversight or monitoring of private practice. Systems would need to be put in place to address this issue. • Some providers may think that they need extra incentives themselves to provide these reduced-priced services. • Conducting a thorough risk assessment is time consuming and some private providers are reluctant to spend the extra time with PrEP patients. • Focus on key populations may deter AGYW from using the same facilities due to stigma.

Opportunities	Challenges
• Providers who deliver PrEP can increase their revenues by establishing long-term relationships with patients who will return for repeat visits over time.**	• Sourcing products from CMS may impact the market for local/regional distributors.
Key populations (MSM, FSW, TG, AGYW) with ability to pay	
• Key populations, including AGYW, prefer the convenience, quality, and confidentiality available in the private sector and the ability to consistently see a single provider. • AGYM are currently comfortable accessing family planning/SRH services through these channels. • For formal sector workers, MASs may cover the majority of costs. • Clinicians will be self-selected and willing to provide comprehensive HIV services without prejudice. • Appropriately trained providers will be able to conduct thorough risk assessments and provide appropriate counseling on side effects and the need for adherence to the protocols. • Franchised clinic services are usually affordable for low- and middle-income patients.	• Some private providers are worried that encouraging the use of PrEP encourages risky sexual practices and that PrEP should be confined to SDCs.
Other at-risk populations (including SDC) with ability to pay	
• Patients would be able to receive comprehensive HIV services at a reduced price. • Private clinics are preferred over public sector ARV clinics for time efficiency and confidentiality. • MAS will cover the majority of costs.	

**Note: Assuming 15,000 clients and an average income of N$1500 (US$100) per year, each clinician could on average expect to make up to US$4000 additional income.

To move forward with this opportunity, USAID/Namibia should:

- Consult with VMMC network providers to ascertain their interest in becoming a designated HIV prevention clinic.
- Consult with SFH on options for expanding the number of clinics in their network.
- Consult with the HIV Clinicians Society or the medical associations on their interest in adapting training materials and job aids for private providers and developing a program to train private sector providers in the network on the new guidelines.
- Consult with CMS on adding appropriate quantities of Ricovir EM to their tender to cover the private sector; discuss options for providing test kits.
- Explore the possibility of using NIP or a private sector laboratory as a referral laboratory to cover costs of tests at a concessional rate.
- Review current IEC and demand generation materials. Consult with advertising professionals on the quality of current materials and develop a plan to implement both community awareness and demand generation media campaigns.
- Discuss with the MOHSS options for monitoring and/or increasing oversight of private providers' delivery of services. Consider options for ensuring quality of services, including mystery client surveys.

Conclusion

There are no regulatory or policy barriers to delivery of PrEP through the private sector. The most recent treatment guidelines have been made available to the private sector through their professional associations. Doctors are already licensed to provide the full range of medical services, including PrEP, although not all have had training on appropriate risk assessment, counseling, and adherence requirements. Doctors are already counseling patients and treating them by prescribing PrEP products. Payment for PrEP has recently been included in most MAS benefits and the larger schemes are covering the majority of these costs; however, several of the pharmacists interviewed stated that these payments often engender additional administration, justification, and documentation, which can be a barrier to effective implementation of these initiatives.

There are eight quality imported PrEP products in the commercial market that have been tested for quality, registered, and approved for sale by the NMRC. Pharmacies currently carry at least two of the available products and are working closely with medical aid societies to ensure that these services are covered under the schemes. The CMS is currently procuring the Ricovir EM PrEP treatment for the public sector at a wholesale price of N$61, which could be made available to selectively trained providers at a retail price of about N$105 (US$7), making the product much more affordable for both MAS beneficiaries and those required to pay out of pocket for these services.

Each of the models discussed above can provide private sector PrEP products and services to at-risk populations:

- Individuals with MAS coverage or who can afford to pay out of pocket have at their disposal a private sector with an array of high-quality PrEP products procured from private sector providers that provide convenient, confidential, quality services and can follow up each individual's progress over time and provide counseling on potential risks and the need to adhere to the protocols.
- Low- to middle-income individuals with or without MAS coverage can access subsidized services and much lower priced PrEP products from pharmacists or franchised clinics where providers have been trained to conduct risk assessments and provide follow-up counseling and adherence monitoring.
- Low-income individuals without MAS coverage who do not have the funds to seek care from the formal health system or are reluctant, for reasons of confidentiality, to use the public sector ARV clinics, can seek care at one of the designated NGO clinics that provides free product and services. These individuals can be referred from civil society organizations that support high-risk key populations, especially AGYW, MSM, and FSW.

USAID/Namibia can support all of these models by supporting the training of clinic- or pharmacy-based providers, encouraging the airing of community awareness and demand generation campaigns, supporting the NGO clinics that provide free services to key populations without the ability to pay, and assisting the MOHSS in the development of the PPPs.

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