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NAMIBIA
PRIVATE SECTOR ASSESSMENT

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SHOPS
Strengthening Health Outcomes *through* the Private Sector

The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship project in private sector health. It works to involve nongovernmental organizations and for-profit entities in addressing the many health needs of people in developing countries. SHOPS 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, and HIV/AIDS, and other health areas through the private sector.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretrovirals
CAA	Catholic AIDS Action
CAFO	Church Alliance for Orphans
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHS	Catholic Health Services
CSO	Civil society organization
DED	German Development Service
DHS	Demographic and Health Survey
ELCAP	Evangelical Lutheran Church AIDS Program
FBO	Faith-based organization
FENETA	Federation of Namibian Tourism Association
FP	Family planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross national income
GP	General practitioner
GRN	Government of the Republic of Namibia
GTZ	German Agency for Technical Cooperation
HIV	Human immunodeficiency virus
HMIS	Health management information system
HSS	Health Systems Strengthening
IFC	International Finance Corporation
KfW	German Development Bank
LHS	Lutheran Health Services
LIMS	Low-income medical scheme
MCH	Maternal and child health
MoF	Ministry of Finance
MoGECW	Ministry of Gender Equality and Child Welfare
MoHSS	Ministry of Health and Social Services

MOU	Memorandum of understanding
MSH	Management Sciences for Health
MTP	Medium Term Plan for HIV/AIDS (2004-2009)
NABCOA	Namibia Business Coalition on HIV/AIDS
NaCCATuM	Namibia Coordination Committee on HIV/AIDS, TB and Malaria
NAMACOC	National Multi-sectoral AIDS Coordination Committee
NAMAF	Namibian Association of Medical Aid Funds
NAMFISA	Namibia Financial Institutions Supervisory Authority
NANASO	Namibian Network of AIDS Organizations
NAPOTEL	Namibian Post and Telecommunications
NGO	Non-governmental organization
NHA	National Health Accounts
NHP	Namibia Health Plan
NIP	Namibia Institute of Pathology
NMC	Namibia Medical Care
NPC	National Planning Commission
O&L	Ohlthaver and List Group of Companies
OOP	Out-of-pocket
OVC	Orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PPP	Public-private partnership
PPWG	Public-private working group
PSA	Private sector assessment
PSEMAS	Public Service Employees Medical Aid Scheme
RCC	Rolling Continuation Channel
SADC	Southern African Development Community
SHOPS	Strengthening Health Outcomes through the Private Sector Project
SSA	Sub-Saharan Africa
SSC	Social Security Commission
STI	Sexually transmitted infection
TB	Tuberculosis
THE	Total health expenditure
TPA	Third-party administrators
UNAIDS	United Nations Joint Program on HIV/AIDS
UNAM	University of Namibia

USAID	United States Agency for International Development
USG	United States Government
VAT	Value added tax
VCT	Voluntary counseling and testing
WHO	World Health Organization

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EXECUTIVE SUMMARY

BACKGROUND

Between 2004 and 2009, Namibia's HIV response was in scale-up mode, largely due to a dramatic increase in external aid in the form of the United States President's Emergency Plan for AIDS Relief (PEPFAR) and funding from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). As with other PEPFAR focus countries, the Namibia program focused on an aggressive pursuit of targets related to prevention, care, and treatment to demonstrate the effectiveness of the emergency response in mitigating the epidemic. However, scale-up was hindered by a dearth of health workers, a highly dispersed population, high rates of HIV/tuberculosis co-infection, limited in-country laboratory capacity, and a social context where gender-based violence and alcoholism are prevalent.

Despite these challenges, significant progress has been made in achieving treatment targets in Namibia. By 2009, over 80 percent of adults and 95 percent of children eligible for treatment were receiving it, and 58 percent of HIV-positive pregnant women received antiretrovirals (ARVs) to reduce the risk of mother-to-child transmission (MoHSS 2010b). The high rates of treatment coverage are based on current guidelines, yet the estimate for those in need of treatment is likely to double if the government adopts the recently revised World Health Organization (WHO) treatment guidelines (MoHSS 2010b).

Based on the new direction outlined in the PEPFAR Reauthorization, USAID/Namibia is shifting its emphasis from scale-up to long-term sustainability. Given Namibia's new classification as an upper-middle-income country, there is some expectation that country ownership in this context will also mean taking greater responsibility for the financial sustainability of the national HIV response. In particular, the United States Government (USG) plans to transition from implementing a program that focuses on prevention, care, and treatment targets to one addressing systemic issues that impact long-term sustainability, including operation of the national health care system human resources and financing.

In this current context of transition, there is considerable interest on the part of the USG and the Government of the Republic of Namibia (GRN) in exploring strategies to both decrease costs and improve efficiencies in the delivery of HIV/AIDS services and mobilize all potential sources of financing, including from the private sector. While there is some evidence that the commercial sector is involved in the HIV response, this role is not well defined, coordinated, or maximized to its fullest potential. The USAID Mission in Namibia therefore requested a private sector assessment (PSA) in early 2010 through the Strengthening Health Outcomes through the Private Sector (SHOPS) project, a USAID-funded five-year project. This assessment complements the recent and comprehensive review that the Namibian public health sector recently conducted (MoHSS 2008b).

METHODOLOGY

SHOPS conducted a review of available published and gray literature pertinent to the objectives of the assessment. The literature review informed the assessment, with a particular emphasis on better understanding of how the private sector could contribute to Namibia's national HIV response. Stakeholder interviews were deemed crucial to understanding prevailing attitudes of public and private sector actors, donors, and implementers and to identifying existing constraints and challenges as well as

potential solutions. The SHOPS team developed interview guides tailored to each stakeholder group and conducted key informant interviews between March and April 2010.

NAMIBIA'S HIV EPIDEMIC

Namibia's first reported case of HIV was in 1986. Since then, HIV prevalence has increased rapidly in Namibia, peaking in 2002 with 22 percent of pregnant women testing positive (MoHSS 2010b). Recent surveillance data indicate a slowing of the epidemic (MoHSS 2008a). Despite this progress, Namibia is facing a serious epidemic with adult prevalence estimated at 13.3 percent according to recent government figures (MoHSS 2010b). Approximately 175,000 adults and children are estimated to be living with HIV/AIDS and approximately 66,000 children aged 0 to 17 were orphaned by AIDS (UNAIDS, WHO 2008).

HIV/AIDS has caused significant economic and social repercussions in the country. Both the public and private sectors face direct and indirect costs, such as decreases in production due to absenteeism, increased costs of medical benefits, loss of morale, and loss of institutional memory.

Although the prevalence rate has stabilized, the public sector continues to face increasing numbers of people enrolling in antiretroviral therapy (ART). A recent modeling exercise underscored the potentially important role of the commercial sector in supporting HIV care and treatment costs. The model assumes that the number of ART cases will increase from 33,000 in 2007 to 144,000 in 2017.[1] Under the status quo scenario, public sector share burden rises from 76 percent in 2007 to 83 percent in 2017, while the private sector share decreases from nearly a quarter of HIV cases to 17 percent. Under a second scenario, which assumes that private companies would cover all their employees and their spouses in a medical aid scheme, the public sector burden would be reduced from 76 percent in 2007 to 64 percent by 2017, representing a fourfold decrease (PharmAccess Foundation and Boston University School of Public Health, 2007).

LANDSCAPE OF STAKEHOLDERS IN HIV/AIDS

International donors and the GRN. The principal donors in Namibia are GFATM, USG, and the German Republic. The challenges for development partners and donors focus on two areas:

- *Heavy donor reliance.* Key government documents underscore the GRN's continued reliance on donor funds and have a stated objective to reduce Namibia's reliance on external resource assistance for core recurrent costs of services, especially with regard to the delivery of ART (MoHSS 2009).
- *Missed opportunities for communication and coordination between key donors and the GRN.* At the moment, there are few concrete and direct discussions between the GRN and important donors, such as USG, about long-term, national solutions to address ongoing health needs in light of potential reductions in external aid.

Public sector. The primary implementer of Namibia's HIV response is the Ministry of Health and Social Services (MoHSS), with support from other government agencies such as the Ministry of Gender Equality and Child Welfare (MoGECW) and those of Agriculture, Finance, Labor,Trade, and Industry. The MoGECW oversees services for orphans and individuals with disabilities through its allowance

[1] It should be noted that this analysis was conducted prior to WHO recommendations promoting ART initiation at a CD4 threshold of 350, and the recent adoption of these recommendations by the GRN will unquestionably increase the number of eligible cases for ART.

program. Clearly there is strong GRN leadership and political commitment to a national response to HIV/AIDS. However, there are several challenges to the public sector response, including:

- *All sectors are not engaged to the fullest extent.* There is good intent on behalf of the government to engage all segments in the health sector—including the for-profit health sector—but the process is neither transparent nor fully coordinated.
- *The national response to HIV is not sustainable.* Key reasons include heavy reliance on donor funding to pay for ARVs and to finance the majority of faith-based organizations (FBOs) and non-governmental organizations (NGOs) delivering support and care to orphans and vulnerable children (OVC). The GRN needs to fully consider the cost implications of the recent adoption of WHO recommendations (e.g., to begin ART at a CD4 threshold of 350 cells/mm^3). Moreover, the MoHSS has difficulty attracting and retaining Namibian physicians in the public health system.

Private sector. There is a strong private sector response to HIV/AIDS and OVC in Namibia. The private sector comprises not-for-profit and for-profit entities. Within the not-for-profit sector, there are FBOs, NGOs, and community-based organizations (CBOs) that deliver prevention, care, and treatment for HIV/AIDS. There are also a substantial number of FBOs and NGOs that provide care and support for OVC. The biggest challenge for the not-for-profit sector is financial sustainability.

- *Heavy reliance on donor funds.* FBOs, NGOs, and CBOs alike responded to the need for providing HIV/AIDS services. Many of these organizations' HIV/AIDS programs are exclusively funded by external donors and, therefore, their long-term sustainability is uncertain.

The for-profit sector includes private health care providers, represented through a range of medical professional associations that deliver HIV/AIDS services as well as key industries—agricultural, finance, mining, tourism—that offer prevention and sometimes health services to their employees and surrounding communities. There is a medical insurance sector that sells health insurance covering HIV/AIDS benefits. In the area of OVC, businesses provide mostly in-kind contributions and limited funding through corporate social responsibility. Three critical issues confront the private sector's ability to realize its obligations to mitigate HIV/AIDS.

- *No formal platform for dialogue framework between the public and private sector.* The MoHSS occasionally sponsors consultation meetings that the private sector is invited to attend, but there is no forum—despite the myriad coordinating mechanisms—for the two sectors to share information and discuss roles and responsibilities.
- *Limited public sector capacity to effectively engage the private sector.* The National Planning Commission (NPC) and the MoHSS have neither the staff nor capacity to engage the private sector. Capacity building is needed in the evaluation of partnerships, negotiation, legal documentations, and oversight.
- *Uncertain policy and regulatory regime supporting private sector engagement.* By and large, the policy and regulatory environment is supportive of private provision of care, facilitating professional certification, and facility licensing. Moreover, the private sector regards the professional councils as fair, effective, and approachable when needed. But larger policy issues, such as the legal framework to form public-private partnerships (PPPs), remain a challenge.

Civil society. Namibia has a large number of NGOs delivering HIV/AIDS and related services. Some of the challenges confronting these organizations include:

- *A crowded field of small CBOs delivering questionable impact.* Hundreds of small CBOs deliver a narrow range of services, which results in a patchwork of organizations and services, and creates management and financial challenges in working with the sheer number, diversity, and size of existing CBOs.
- *Financial sustainability.* The recent influx of GFATM and PEPFAR funding has prompted a dramatic increase in NGOs wholly dependent on foreign and domestic donations. While the GRN has traditionally provided funds to mission hospitals, GRN funds have generally not been used to contract for the expanded prevention and treatment services provided by NGOs under PEPFAR, and there is relatively little experience within the GRN in writing and enforcing contracts for health and social services. Local funds from the private sector are scarce, given uncertainty about the rules allowing high-income individuals and/or local businesses to deduct NGO donations from taxable income.

DESCRIPTION OF THE PRIVATE HEALTH SECTOR

Financial size of the private health sector. The value of the private sector market was around N$1,296,802,073 (Namibian dollars) in 2008/09, equivalent to US $144 million (MoHSS 2010a). Nearly one-third of private funds are spent in private for-profit hospitals, followed by one-fourth at private dispensing chemists and 11.1 percent at private for-profit clinics. A significant amount (17.4 percent) of out-of-pocket and health insurance premiums are paid to a range of private providers at hospitals, clinics, and individual consultation rooms. Moreover, 4.1 percent of mission hospitals receive private funding, also through individuals and private insurance.

The public sector and donors are the core funders of HIV/AIDS services in Namibia (45 percent and 51 percent respectively). The private sector contribution is negligible at less than 1 percent. Unlike in other African countries, household spending is extremely low at 3.4 percent. The majority of HIV funds—nearly 96 percent—is spent in the public sector, while 4 percent is spent in the private sector (MoHSS, 2010a).

Health infrastructure. Recent MoHSS statistics show that the public/FBO sectors have almost three times the number of hospitals and three and one-half times the number of clinics as the private sector. Possible resources for the HIV/AIDS programs are private consulting rooms and pharmacies.

Health workforce. The scarcity of qualified health care professionals is a critical challenge in the health sector. As of 2008, there were 7,697 health workers nationwide. While the public sector continues to be the primary employer of health care workers (53 percent), the private sector attracts a large percentage of health care workers as well (47 percent). The private sector employs the majority of physicians—three-quarters of all doctors. The other two professional groups that work predominantly in the private sector are pharmacists and social workers: nine out of 10 pharmacists and seven out of 10 social workers practice in this sector.

Distribution of private sector. The distribution of private health facilities is uneven, with a small number of large, successful private providers who own hospitals and clinics that offer high-quality services concentrated in Windhoek and Swakopmund. These providers are competing for a small high-income clientele who either can afford to pay OOP or, more commonly, are covered by a medical aid scheme. Below the level of these high-end private providers are a large number of small-scale providers in private consulting rooms that struggle to remain financially viable and whose quality varies. They are

located in both the urban and peri-urban areas as well as throughout the country. These providers, typically nurses, serve a lower-to-middle income clientele.

Private sector contribution to health. Although the private health sector is relatively small compared to that of other countries in sub-Saharan Africa, it still plays an important role in key public areas, such as HIV testing and treatment for sexually transmitted infections, childhood illnesses, and maternal health.

- *HIV testing.* More women are tested for HIV than men: more than half of women (55.4 percent) compared to one-third of men (34.7 percent). Of the women who were tested, 15 percent went to the private sector, and 25 percent of men used the private sector. The men and women getting tested in the private sector were in the higher and highest income groups.
- *Childhood illnesses. A*pproximately 14 percent of mothers take their children to the private sector to treat diarrhea and 22 percent seek private sector care for fever or cough symptoms.
- *Deliveries. A* high percentage of Namibian women (82 percent) deliver in an institutional setting with a qualified health professional. Of these women, approximately 5 percent deliver in a private facility.

PUBLIC-PRIVATE ENGAGEMENT IN HIV/AIDS

Health care in Namibia is clearly a complex mix of public and private elements. Although formal communication and collaboration between the public and private health sectors has been limited, there is some experience with arrangements that would ordinarily be classified as PPPs.

The roles played by the public and private sector vary across the continuum of care in HIV/AIDS.

- *Workplace prevention and education.* The largest companies in Namibia (both private and parastatal) have well-developed workplace programs, usually with a designated HIV/AIDS or wellness coordinator within the Human Resources Department. For smaller companies, however, such programs are not common. Nationally, NABCOA (Namibian Business Coalition on AIDS) provides a forum for employer efforts to combat AIDS. Together with PharmAccess, NABCOA helped to start the Bopehlo! wellness screening initiative and offered informational sessions on low-cost health insurance plans. It supports employer HIV/AIDS education efforts and has received support from the GFTAM.
- *Screening (voluntary counseling and testing [VCT]).* The private sector is active in this vital activity. USAID has funded a chain of VCT clinics called New Start, although funding for this effort is now being reduced. HIV tests are widely available in private hospitals and physician offices, and are generally covered by medical schemes, which employ disease management organizations to monitor the care of identified HIV-positive beneficiaries.
- *Treatment of AIDS and opportunistic infections.* The first patients to receive ART in Namibia were private patients, supported by their employers or medical schemes and receiving care from company clinics or private providers. Namdeb, the diamond mining company, has provided ART for its employees for over a decade. In 2007, the number of ART patients in the private sector (including public employees covered by the Public Service Employees Medical Aid Scheme [PSEMAS]) was on the order of 7,000. By September 2008, the number of ART patients treated in the public sector was 58,000. Although the public and private sectors both treat AIDS, they tend to work unilaterally rather than in partnership.

Funding of care and treatment in the private sector. Private sector providers are generally paid fee-for-service by medical schemes according to a price list updated annually by the Namibian Association of Medical Aid Funds (NAMAF). ARVs (and most prescription drugs) are covered by medical schemes, and the prevailing rate paid to pharmacists is essentially the South African wholesale or production price plus a 50 percent retail markup. A reference pricing scheme is used so that the schemes pay only the rate for the lowest-cost products in the reference group.

- *Traditional medical schemes.* At the end of 2004, some 132,000 Namibians were enrolled in private medical schemes, both closed (limited to a particular company or industry) and open to any employer or individual. A further 118,000 civil servants and their dependents were enrolled in PSEMAS. Combined, PSEMAS and the private medical aid schemes provided coverage for 12 percent of the Namibian population at the end of 2004.
- *Low-cost schemes.* In 2004, the first low-cost medical scheme—Diamond Health Service—was introduced. It used a limited network of primary care providers paid on a capitation basis. Other low-cost schemes followed Blue Diamond into the market. One scheme, Vitality, covers HIV care only, and was initially offered in 2006 at N$30 per worker per month. Growth has been slow in the low-cost plans, adding just less than 1 percent of the population to private insurance so that the total privately insured is now perhaps 13 percent.
- *Risk equalization fund.* One medical scheme tried to form a risk equalization fund to spread the HIV risk across a broader number of insured groups. An "HIV reinsurance premium" would be paid into a central fund for each insured, and this fund would be used to even out the cost of AIDS coverage between different groups. However, the risk equalization fund now operates only within the plans controlled by a single medical aid scheme.

Partnerships to provide care and treatment. There are three specific public-private initiatives for patient screening and treatment. Beyond the projects discussed and the existing mission hospital contracts, we did not identify any other public-private health partnerships, nor did we find a policy or mechanism to encourage new partnerships.

- *Oranjemund is a "company town" located in the restricted diamond area, which is off limits to those without the proper permit.* To serve its workers in this isolated location, the diamond mining company Namdeb runs its own hospital and clinic, Oranjemund. MoHSS runs a primary care clinic in the town for those who are not employed or insured by Namdeb. When these patients cannot be treated by the nurses at the public clinic they are referred to the Namdeb hospital and MoHSS pays for their care under a negotiated agreement.
- *Rosh Pinah.* The proposed partnership at Rosh Pinah is an attempt to give public patients access to mine-operated medical facilities. The fully equipped outpatient clinic created by the two mines at Rosh Pinah has two physicians and a full range of support personnel. It also has basic diagnostic equipment (X-ray, ultrasound) that is not available at the nurse-staffed public clinic. Agreements are close to completion. The rapidly expanding uranium mine at Rossing offers a similar opportunity for partnership.
- *Bophelo! is a "classic" PPP to facilitate the screening of the population for HIV and other diseases.* Two mobile testing vans are owned and operated by NABCOA and PharmAccess Namibia. The vans are licensed as screening clinics by the MoHSS. For follow-up, patients are referred to private providers if they have medical scheme coverage, or to public clinics if they do have insurance. A portion of the costs is paid by employer fees, the rest by donor funds. The Namibia Institute of Pathology has contributed the monitoring costs.

KEY RECOMMENDATIONS

The PSA demonstrates that the private sector is an important part of the health system in Namibia and is in fact poised to play a greater role in ensuring the sustainable provision of essential health services, such as HIV/AIDS, as donor funding is scaled back. Using the WHO health systems strengthening (HSS) framework, the following table presents recommendations for engaging the private sector.

HSS Building Block	Recommendations
Governance	• Foster dialogue between leaders and champions from the different sectors. The team recommends structuring a short process that brings together the respective leaders in HIV/AIDS and creates a "level playing field" between the sectors. • Create a policy framework for PPPs in HIV/AIDS and other key health areas. The team proposes pulling together a group to: draft a framework, vet it with all the sectors, and finalize it. • Build MoHSS capacity to engage the private health sector. The team proposes developing an institutional strategy to build its internal capacity to effectively engage the private sector.
Health Financing	• Support dialogue between the MoHSS and private health insurers to explore the expansion of low-cost health insurance for the uninsured employed population and their dependents. • Encourage the GRN to make health insurance mandatory—either through private health insurance or by covering the uninsured through the Social Security Commission. • Support dialogue between sectors to amend taxation regulations to incentivize the purchasing of health insurance.
Health Workforce	• Build the capacity of existing private providers by making donor-supported training available to private practitioners—physicians, nurses, pharmacists, social workers. • Equip private nurses and lower-level health workers with strengthened clinical skills, access to finance, and business skills so that they can increase their role in providing HIV/AIDS services in private practices. • Expand the supply of health workers through incentives for workers to stay in Namibia, make medical school more affordable, and harmonize pay scales in the public sector to be on par with other sub-Saharan African countries.
Service Delivery	• For the commercial sector, use different strategies to incentivize private providers to provide HIV/AIDS services according to geographic setting. A precondition for these strategies to work would be formulation of a workplace policy requiring all employers to provide a minimum package of health services. • FBOs are critical players and merit continued support for their services reaching rural and poor population groups. Work with FBO leadership to scale-up promising cost-recovery schemes and experiments that are underway. • As the marketplace is crowded, consolidate the number of NGOs and CSOs providing HIV/AIDS services through a certification and competitive grant process. Also, harness the private sector contribution by clarifying the law on taxable donations for NGOs.
Medical Products (ARVs)	• Promote dialogue between all supply chain stakeholders to discuss feasible strategies to reduce the cost of ARVs in both the public and private sectors. • Create a mechanism so that trained and qualified private providers can offer ARVs at a reduced price to their clients. • Encourage private insurers to procure generic ARVs—as recommended by MoHSS guidelines—thus reducing overall costs of HIV/AIDS care. Also establish a transparent system to monitor and regulate the prices of ARVs.
Information	• Through a consultative process, work with private provider associations, FBO/NGO groups, and medical aid funds to develop a short list of health indicators, design a simple reporting format and establish an easy reporting system. • Ensure that basic information gets to appropriate end users—public and private alike—thereby ensuring a two-way flow of information.

STRATEGIC INVESTMENTS FOR USAID

The SHOPS team also proposes areas in which USAID can make strategic investments to maximize private commercial sector contributions to address HIV/AIDS in Namibia. The key area for investment to harness the private sector would be extending medical aid and health services to low-income workers in the formal sector.

EXTEND HEALTH INSURANCE AND HEALTH SERVICES THROUGH THE PRIVATE SECTOR

Namibia has a vibrant public health sector supported by risk pooling operations that are largely private. The low level of OOP health expenditure indicates that the public sector has been able to meet the expressed demand for health services in the rest of the population while charging very low user fees. But the conditions underlying this arrangement are changing. The combination of HIV/AIDS with an aging population means that the burden of chronic disease is rising. At the same time, some Namibians, particularly those with little education or living in remote areas, are not receiving the medical services they will need if the country is to meet its health objectives. To date, donor funding has enabled the MoHSS to expand HIV/AIDS services to meet nearly all of the increased need for treatment. However, external funding will likely diminish in relation to Namibia's expanding economy and because of donor pressure to prioritize finite resources.

To meet Namibia's national health objectives and increased need for health care, the volume of services must expand. The GRN could increase spending on the public health system, to both replace donor dollars and permit service expansion. But that will require higher GRN revenues and obligation of a larger portion of GRN budgets to health at a time when many other sectors demand development funding. An alternative, seen historically as many Western countries developed, would be to expand the system of health insurance and private health provision to the remainder of those employed in the formal sector and their dependents. Using either public (national health insurance) or private (medical scheme) risk pools, funds collected from employers and currently uninsured employees would be used to purchase the basic benefit package that these Namibians currently receive from MoHSS. This would free up MoHSS resources to expand the services provided to the poor and those in informal employment.

The moment is opportune for expanding medical aid schemes and increasing access to health services in the private sector for the working poor. At a recent meeting, His Excellency President Hifikepunye Pohamba stressed the need to expand enrollment to cover all employed Namibians (Namibian Association of Medical Aid Funds Conference, 2009).

STRATEGIC APPROACH TO EXPAND MEDICAL AID AND HEALTH SERVICES THROUGH THE PRIVATE SECTOR

Increasing private health services to lower-wage workers will require a number of initiatives. The attainment of this goal will be realized through four pathways, which also correspond to health systems strengthening building blocks.

Goal	HSS Building Block	Pathways
Low-wage formal workers access quality health services in the private sector through private medical schemes	Governance and Policy	Improve MoHSS capacity to engage and interact with the private health sector
	Health Financing	Establish and/or expand low-cost medical insurance schemes that cover basic health and HIV/AIDS services
	Service Delivery	Increase the number of and expand the location of private providers delivering affordable health services, including HIV/AIDS services
	Health Products	Increase private providers' access to low-cost ARVs for low-income clients

These pathways address the major barriers to meeting the health needs of lower-income workers through the private sector. On the demand side, the medical schemes will help remove this target group's financial barrier to accessing health care offered in the private sector. Increasing access to subsidized and/or donated ARVs will also drive down the cost of private health care, which in turn will reduce the cost of medical schemes premiums, permitting a larger number of employers and low-wage employees to purchase them. On the supply side, the proposed strategies will ensure an adequate supply of private health care providers to deliver health services at an affordable price to this market segment. The strategy also suggests four different service delivery models to "organize" private providers responding to the geographic challenges present in Namibia. Lastly, the proposed policy initiatives will not only create the legal and regulatory framework required to expand medical aid and services to low-wage earners, but will also lay the foundation for greater public-private dialogue to support other recommendations for an expanded role for the private sector.

CONCLUSION

In support of national health objectives, the intent of this PSA is to foster a vibrant, mixed health care system that maximizes the unique capabilities of both the public and private health care sectors in Namibia. Building such a system may require initial donor investment and, in the longer run, will rely on public support. The key is leveraging private investment to increase efficiencies, improve access to care for underserved population groups, and achieve national health goals, including mitigating the HIV epidemic. The true measure of success for these efforts/initiatives is not whether they are "public" or "private," but whether they improve access to quality health care for all Namibians in an equitable and sustainable way.

1. BACKGROUND

1.1 INTRODUCTION

Located in southwestern Africa, Namibia has a highly dispersed population of 2.1 million, with the majority residing in rural areas (UNAIDS, WHO 2008). Namibia is a country of contrasts. On one hand, the nation faces a serious HIV epidemic, high unemployment rates, and one of the highest rates of income inequality in the world. Despite the high gross national income (GNI) per capita, Namibia has the largest income disparity in the world, with a Gini Coefficient of 0.6, and more than half the population living below the poverty line (WHO 2010). At the same time, the country boasts high antiretroviral therapy (ART) coverage rates and high literacy rates and has recently been classified as an "upper-middle-income" country, primarily due to a recent jump in GNI to $4,200 per capita (World Bank Group 2010a; 2010b). Likely drivers of the relatively high GNI are: significant rates of foreign investment, an economy closely linked to South Africa's, moderate inflation, and low indebtedness. It is against this backdrop that the private sector has flourished.

In health, this sector comprises three levels: as financiers, risk-pooling agents, and providers of care. Company and household contributions (largely to insurance premiums) contribute to health financing, accounting for 24.4 percent of all health expenditures in 2008/09—second only to contributions from the Government of the Republic of Namibia (GRN), which accounted for 53.8 percent of health spending. In addition to financing health services for employees, companies contribute to various community-related health activities as part of their corporate social responsibility mandates. As risk-pooling agents, Namibia's private commercial sector absorbed approximately 22 percent of national health expenditures in 2006/07 through its insurance industry (World Bank Group 2010c). The private insurance contribution declined to 14.1 percent in 2008/09 (MoHSS 2010a). As a source of health care, the private for-profit sector is sizeable, comprising 844 facilities. Although the majority of these are private consulting rooms, by comparison, the public sector comprises 343 facilities (MoHSS 2008b).

Beyond general health services, the commercial sector contributes specifically to the HIV response. For example, companies have contributed to HIV awareness campaigns, provided bursaries to orphans and vulnerable children (OVC), supported soup kitchens for OVC, financed mobile counseling and testing units, and implemented workplace programs. However, these efforts have not been taken to scale (NABCOA 2008). In addition, some Namibian medical aid schemes offer low-cost health plans that include coverage of HIV/AIDS treatment—Namibia is one of the first countries in sub-Saharan Africa (SSA) to offer this. Lastly, it should be noted that the private sector began providing antiretrovirals (ARVs) even before they were available in the public sector. According to the latest data available from the US President's Emergency Plan for AIDS Relief (PEPFAR), 56,100 individuals (adults and children) were receiving ART through the end of 2008/09. Of this amount, the private sector accounts for approximately 8,000 cases, or about 14 percent (PEPFAR 2010).

While there is thus some evidence that the commercial sector is involved in the HIV response in Namibia, this role is not well defined, coordinated, or maximized to its fullest potential. The need to do so is critical given finite donor resources and escalating costs for financing the national response. While the United States Government (USG) is one of the largest financiers of the national response in Namibia, its contributions will likely decrease in coming years as the focus shifts from an emergency response towards developing long-term sustainable strategies (GRN, USG 2009).

1.2 NAMIBIA'S HIV RESPONSE

Namibia's first case of HIV infection was reported in 1986. Since then, the epidemic grew rapidly until it peaked in 2002 with 22 percent of pregnant women testing positive (MoHSS 2010b). Recent surveillance data indicate a slowing of the epidemic (MoHSS 2008d). Despite this progress, Namibia is facing a serious HIV/AIDS epidemic, with adult prevalence estimated at 13.3 percent (MoHSS 2010b). Approximately 175,000 adults and children are estimated to be living with HIV/AIDS, and approximately 66,000 children aged 0 to 17 were orphaned by AIDS (UNAIDS, WHO 2008).

Between 2004 and 2009, Namibia's HIV response could be characterized as in scale-up mode, largely due to a dramatic increase in external aid in the form of PEPFAR and funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). PEPFAR funding increased fourfold during this period, from $24.5 million in 2004/05 to about $109.4 million in 2009/10 and has remained relatively steady since then. The GFATM has approved grants worth $255 million, of which $213 million are devoted to HIV/AIDS programs. To date, $97 million has been disbursed for HIV/AIDS. As with other PEPFAR focus countries, the Namibia program was focused on an aggressive pursuit of targets related to prevention, care, and treatment to demonstrate the effectiveness of the emergency response in mitigating the epidemic. However, scale-up was hindered by a dearth of health workers, a highly dispersed population, high rates of HIV/tuberculosis (TB) co-infection, limited in-country laboratory capacity, and a social context where gender-based violence and alcoholism are prevalent.

Despite these challenges, significant progress has been made in achieving treatment targets in Namibia, and external aid from PEPFAR and other donors has helped to overcome some of the health system's constraints to financing and service delivery. Namibia receives support from the GFATM and the Clinton Foundation for the procurement of ARVs, with the government funding roughly a quarter of the total cost of ARV procurement. Through PEPFAR, the USG has supported the contracting in of health care workers from outside Namibia (a large proportion of workers come from Zimbabwe) to alleviate the clinical capacity constraints within the public health system.

By 2009, over 80 percent of adults and 95 percent of children eligible for treatment were receiving it, and 58 percent of HIV-positive pregnant women received ARVs to reduce the risk of mother-to-child transmission (MoHSS 2010b). Treatment rates fare comparably to that of the region as a whole—in SSA, on average, only 44 percent of adults and children in need of ART have access to treatment (UNAIDS, WHO 2008).

While these short-term successes are noteworthy, Namibia is facing serious health system constraints as it prepares to sustain its HIV response for the longer term. These challenges include:

- **Financing.** Domestic funding sources, including the GRN and the private sector, contribute significant resources to the HIV response, accounting for just half of the total spending, while the balance comes from development partners such as the USG and GFATM.
- **Human resources.** The public health system continues to be plagued by a shortage of qualified health personnel, and the continued reliance on foreign health workers, financed through donor funds, is risky and unsustainable. Only 34 percent of doctors and 39 percent of nurses practice in rural areas, while over 65 percent of Namibia's population lives in these areas. The public sector loses approximately 5 percent of its health workforce staff to attrition each year (MoHSS 2008b).
- **Laboratory capacity.** Laboratory support is provided through the Namibia Institute of Pathology (NIP), a parastatal organization with a national network of labs that has been challenged by a lack of qualified technicians, management issues, high costs, and insufficient coverage of rural areas.

- **Prevention and treatment.** The high rates of treatment coverage noted above are based on outdated guidelines, which recommended ART for patients with a CD4 count of less than 200. However, the GRN has adopted new World Health Organization (WHO) guidelines, which recommend initiation of treatment when CD4 counts drop to 350 (WHO 2009). Adopting the WHO recommendations will likely double the number of HIV-positive individuals requiring treatment, with obvious budget and service delivery implications. There are some recent indications that behavior change prevention programs are having some impact; these include decreased prevalence among pregnant women (20 to 18 percent) and a decrease in sexual debut among young men aged 15-19 (27 to 17 percent). Nonetheless, HIV prevalence and corresponding demand for ART is likely to remain high (MoHSS 2010b).

1.3 EVOLVING USG HIV/AIDS STRATEGY IN NAMIBIA

Based on the new direction outlined in the PEPFAR Reauthorization, USAID/Namibia is shifting its emphasis from scale-up to long-term sustainability (see Box 1). Given Namibia's status as an upper-middle-income country, there is some expectation that country ownership in this context will also mean taking greater responsibility for the financial sustainability of the HIV response. In particular, the USG plans to transition from implementing a program that focuses on prevention, care, and treatment targets to one addressing systemic issues that impact long-term sustainability, including human resources and financing and operation of the national health care system.

In July 2010, USAID/Namibia and the GRN began the process of finalizing a partnership framework (PF), outlining the respective roles and commitments governing the bilateral relationship between the two nations with respect to PEPFAR implementation. The framework will likely address increasing public financial contributions to the overall HIV response, from the already substantial current level (48 percent of total expenditures). As the GFATM support for ARVs is scheduled to decrease from 42 percent in 2010 to 38 percent in 2015, the GRN will also need to allocate greater national resources to ARV procurement.

In this current context of transition, there is considerable interest on the part of the USG and the GRN in exploring strategies to both decrease costs and improve efficiencies in the delivery of HIV/AIDS services and to mobilize all potential sources of financing, including from the private sector. Management Sciences for Health (MSH) has worked with the medical aid schemes to analyze the costs of private sector ART and also has data on the costs of procuring ARVs for public facilities. These analyses could be building blocks to project the long-term costs of AIDS care in the public and private sectors, as well as the extent to which private sector costs would be reduced if the sector had access to publicly procured ARVs. The USG and GRN are currently engaged in a variety of strategic analyses related to resource mobilization and sustainability planning, including a financial strategy assessment to guide the GRN through this process. The results of the private health sector assessment will inform the USG/GRN strategy.

Box 1: PEPFAR reauthorization

The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act (PEPFAR Reauthorization) was approved in early 2008. The reauthorization seeks to move the global HIV/AIDS program beyond the "emergency" phase of implementation of the first five years of PEPFAR. The PEPFAR Reauthorization goes beyond immediate goals related to prevention, care, and treatment and seeks to transition the programs that it has supported to greater sustainability. It thus broadens the thematic focus of the program to include such priorities as health systems strengthening; training new health care workers; and integrating with other health programs, food and nutrition programs, and education efforts. The PEPFAR Reauthorization also included a new focus on strengthening programming related to women and girls and a particular focus on gender-sensitive programming and gender-based violence.

The new mandate of the PEPFAR Reauthorization was operationalized in a strategy document released in December 2009. The document outlines five major goals for the next phase of the program:

1. Transition from an emergency response to promotion of sustainable country programs.
2. Strengthen partner government capacity to lead the response to this epidemic and other health demands.
3. Expand prevention, care, and treatment in both concentrated and generalized epidemics.
4. Integrate and coordinate HIV/AIDS programs with broader global health and development programs to maximize impact on health systems.
5. Invest in innovation and operations research to evaluate impact, improve service delivery, and maximize outcomes.

Source: PEPFAR 2009

1.4 SCOPE OF ASSESSMENT

As one of the first countries poised to "graduate" from PEPFAR, Namibia faces the difficulty of balancing paradoxical economic indicators. While certain aspects of the country's economy have flourished—high rates of investment, moderate inflation, and strong external surpluses—other factors have hindered the country's response to crippling health issues, such as persistently high maternal mortality rates. These other, constraining factors include Namibia's HIV prevalence rate of 13.3 percent (MoHSS 2010b) and an unemployment rate of 37 percent (NPC 2008). Additionally, although Namibia was recently classified as an upper-middle-income country, economic well-being is extremely variable for the populace.

As Namibia's national HIV response faces a funding threshold, the future direction of this response requires an in-depth study of certain crucial yet often misunderstood actors from the private commercial sector. The USAID Mission in Namibia therefore commissioned a private sector assessment (PSA) through the Strengthening Health Outcomes through the Private Sector (SHOPS) project, USAID's global initiative to increase the role of the private sector in the sustainable provision of essential health services. This assessment complements the recent and comprehensive review that the MoHSS recently conducted (MoHSS 2008b). Armed with a better understanding of the private sector's current role in HIV/AIDS, the GRN will be in the position to better integrate and maximize contributions of this sector in the national HIV response.

To this end the scope of the PSA included:

1. Reviewing the impact on Namibia's current policy environment of stakeholders' perceptions regarding private sector involvement in the HIV response and health system.

2. Analyzing and mapping out the private commercial sector's involvement in the HIV response and health system.

3. Examining the degree to which partnerships addressing HIV needs do/could exist between the commercial and public sectors as well as civil society.
4. Identifying opportunities to create and strengthen partnerships with the commercial sector that could contribute to sustainable goals concerning HIV/AIDS and health systems.
5. Identifying partnering opportunities for the commercial sector to help sustain the USAID program post-PEPFAR graduation.

(Refer to Annex A for the complete scope of work.)

1.5 OVERVIEW OF REPORT

The report is divided into eight sections, covering a wide range of technical areas. Following the introduction, this report presents the methodology used to conduct the PSA in Section 2. Section 3 provides an overview of the evolution of the HIV/AIDS epidemic in Namibia. Sections 4 through 7 synthesize and present information from three sources: the literature review; secondary analysis of key data sources such as the National Health Accounts (NHA), Demographic and Health Surveys (DHS), and key-informant interviews. Section 4 provides a landscape and brief description of all major stakeholders involved in HIV/AIDS in Namibia to orient the reader. Section 5 describes the private health market in Namibia, focusing on private provision of HIV/AIDS services and OVC services and programs. Section 6 offers an overview of Namibian experience in public-private partnerships (PPPs) in health. The PSA concludes with key findings and suggestions on how to mobilize the private health sector in Section 7. Recommendations for strategic investments to engage the private sector in the HIV response in Namibia are in Section 8.

2. METHODOLOGY

The assessment began with a scan of available published and gray literature pertinent to the objectives of the assessment and proceeded with a literature review. The literature review helped inform the assessment, with a particular emphasis on better understanding how the private sector could contribute to the national HIV response within a health systems strengthening framework. To understand the political, economic, and social landscape of Namibia, the topics reviewed included health policy and legislation, DHS, the health care system, health insurance, and employer-sponsored services. The literature review revealed several potential opportunities for increased stewardship of the public sector and involvement of the private sector.

Stakeholder interviews were deemed crucial to understanding salient/prevailing attitudes of public and private sector actors, and of donors and implementers, and to identifying existing constraints and challenges as well as potential solutions. The SHOPS team developed interview guides tailored to each stakeholder group and conducted key informant interviews between March and April 2010. Stakeholders included government officials, financiers, private health providers, faith-based organizations/non-governmental organizations/community-based organizations (FBOs/NGOs/CBOs), industry representatives, and others. Specific objectives for each group are shown in Table 1.

TABLE 1: TARGETED STAKEHOLDERS AND OBJECTIVES OF INTERVIEWS

Stakeholder Group	Objective
Ministry of Health and Social Services (MoHSS)	• Get perspective on the long-term strategies to address HIV/AIDS challenges and sustainability issues • Learn about MoHSS policy/plans to work with the private sector • Measure openness toward the private sector • Identify current partnerships with private sector in HIV/AIDS and/or other health areas • Identify possible barriers for public sector to engage/transact with the private sector
Other ministries	• Get perspective on the long-term strategies to address HIV/AIDS challenges and sustainability issues • Learn the extent to which the ministries engage with the private sector (NGO, mission, and for-profit) • Measure openness toward the private sector • Identify any barriers for public sector to engage/transact with the private sector
Other government officials/donors	• Get perspective on the long-term strategies to address HIV/AIDS challenges and sustainability issues • Learn about government policies/plans to work with the private sector (NGO, mission, and for-profit) • Measure openness toward the private sector
Health insurance	• Ascertain the current status of the health insurance market • Understand why uptake has been marginal on low-cost private insurance programs and identify strategies for improving uptake • Explore prospects for expanding coverage to low- and middle-income populations

Stakeholder Group	Objective
Industry	• Provide an update on industry practices and policies related to HIV/AIDS services • Identify current partnerships with NGO/mission or public sector to address HIV/AIDS, as well as best practices • Identify possible barriers to private sector partnering with the public sector, and/or obstacles to a greater role for understanding in HIV/AIDS prevention and care • Measure openness to working with the public sector
Private health sector	• Learn whether the private sector is aware of government HIV/AIDS strategies and long-term plan to address HIV/AIDS challenges and sustainability issues • Measure willingness to work on HIV/AIDS and what could be their potential contribution • Identify possible barriers to partnering with public sector, and/or barriers to the greater role for the commercial sector in HIV/AIDS • Measure openness to working with the public sector
NGO/mission	• Learn the extent to which they are aware of government HIV/AIDS strategies and long-term plan to address HIV/AIDS challenges and sustainability issues • Identify current partnerships with private sector or public sector to address HIV/AIDS • Gauge receptivity to partnering with the private commercial sector

It is important to note that the PSA team was not able to schedule interviews with as many government officials as planned during the assessment trip given the lack of availability of some MoHSS employees.

To meet the desired objectives of the assessment, the SHOPS project assembled a dynamic team of professionals with complementary technical expertise and familiarity with the health sector in Namibia. Barbara O'Hanlon, SHOPS Senior Policy Advisor, served as the Team Leader for the assessment. Ms. O'Hanlon conducted interviews with both for-profit and not-for-private health sector stakeholders and is the lead author on this report. Drawing from extensive experience in Namibia, SHOPS consultant Rich Feeley took the lead in the areas of private industry and health insurance, conducting interviews with stakeholders from financial, clinical, farmers' and miners' organizations, and other private associations. As the primary contact in Namibia, Ms. Ingrid de Beer was instrumental in identifying stakeholders and held interviews with members of the MoHSS and health investment branches of banks and trade unions. Ms. Shyami de Silva, Private Sector Technical Advisor (USAID/OHA), participated in selective interviews and site visits with health insurers and private health sector stakeholders. Ms. Chantelle Reid (independent consultant) participated in interviews with NGOs and FBOs and assisted with logistics. Sara Sulzbach, Private Sector HIV/AIDS Advisor for SHOPS, provided technical coordination and wrote sections of the report, while Heather Vincent provided administrative support and also contributed to the report.

3. NAMIBIA'S HIV EPIDEMIC: PAST, PRESENT, AND FUTURE

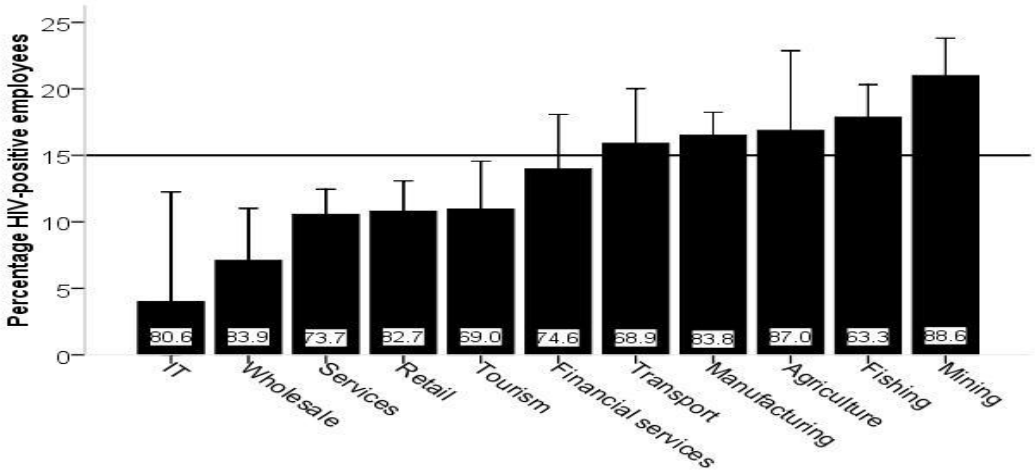
Much has been written about the trends and factors contributing to the HIV/AIDS epidemic in Namibia. This section offers a succinct synopsis of HIV/AIDS in Namibia to provide the context for understanding the private sector role in the national response. Moving from an understanding of the current situation, this section projects future trends in HIV/AIDS based on a modeling exercise to frame the discussion on a possible public-private mix in addressing HIV/AIDS needs into the future.

3.1 EVOLUTION OF THE HIV EPIDEMIC

Prior to gaining independence, Namibia witnessed its first reported case of HIV in 1986. Despite the fact that Namibia is the second most sparsely populated country in the world, the virus rapidly spread throughout the country. Since 1986, the number of people living with HIV (PLHIV) has grown exponentially, reaching approximately 204,000 in 2007-2008 (MoHSS 2008d). In 2007 alone, 14,100 people (approximately 39 people per day) were infected with HIV. As the leading cause of death in Namibia— accounting for a quarter of all deaths in 2007—HIV has affected nearly every Namibian (MoHSS 2008a). Recently released figures estimate a slightly lower estimate of PLHIV—175,000 (MoHSS 2010b).

Figure 1, on the next page, reveals the results of an anonymous workplace survey conducted in 2007-2008. The numbers at the bottom of the bars represent mean participation rates per industry category. Error bars represent 95 percent confidence intervals. The horizontal line represents mean percentage of HIV-positive employees in the entire cohort. Results are shown for 6,251 out of 8,500 participants. Figure 1 illustrates that HIV is present among employees in all key sectors of the economy, with a higher concentration in transport, manufacturing, agriculture, fishing, and mining. The diversity and geographic location of these industries underscore the challenge in HIV response.

FIGURE 1: ANONYMOUS HIV WORKPLACE SURVEYS, 2007-2008



Source: de Beer et al. 2009

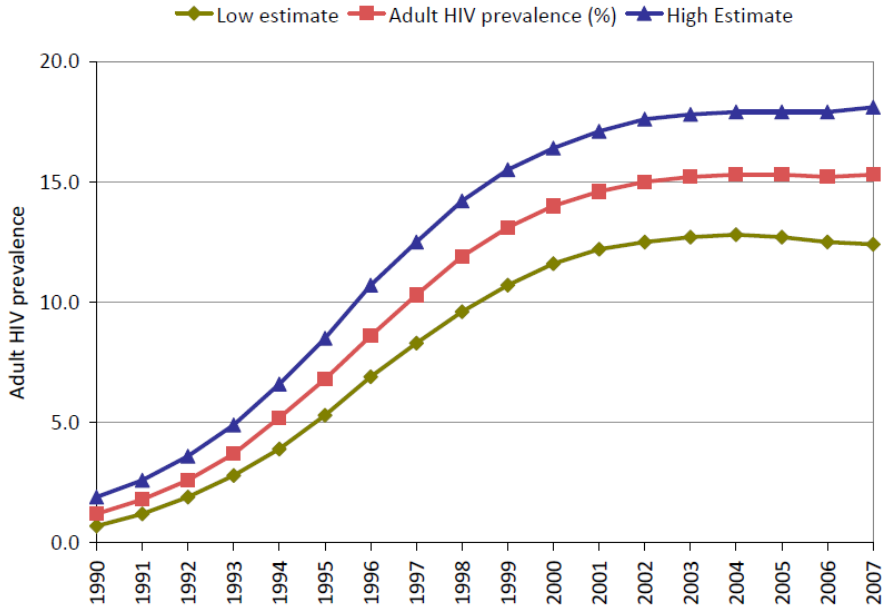
A prevalence rate of 13.3 percent carries with it significant economic and social repercussions. Both the public and private sectors face direct and indirect costs such as decreases in production due to absenteeism, increased costs of medical benefits, loss of morale, and loss of institutional memory. In terms of treatment services, the public sector has faced an incredible burden—prior to donor funding and private sector engagement, the MoHSS used GRN funds to purchase all ARVs for the ART program. As the ART program expanded to different districts, the public sector found the funding of the program too much to take on by itself (MoHSS 2008a).

Significant barriers that need to be addressed include HIV/AIDS knowledge, attitudes, and behavior. Data from the 2006 DHS reveal serious gaps in knowledge about HIV. Despite the omnipresence of the virus, men and women still harbor common misperceptions—25 percent of women and 40 percent of men did not know that HIV can be transmitted through breastfeeding nor that drugs can taken to prevent mother-to-child transmission. Only 71 percent of men knew that the virus cannot be spread by mosquito bites. Along with the knowledge gaps, stigma surrounding HIV still impacts peoples' attitudes: only 55 percent of those surveyed said that they would not want to keep a family member's status a secret, and only 75 percent would purchase fresh produce from a person known to be HIV-positive (MoHSS, Macro International 2008a).

Another underlying issue within the epidemic concerns gender. The HIV prevalence rate among pregnant women decreased from 22 percent in 2002 to 17.8 percent in 2008 (MoHSS 2008d); however, 17.8 percent was still higher than the 13.3 percent general population prevalence rate for 2007-2008. Especially vulnerable are young women aged 15-24. Of the 14,100 new infections in 2007-2008, 44 percent were among young people aged 15-24, 77 percent of whom were young women (MoHSS 2008b). The MoHSS hypothesizes that women's choice of partner is riskier than their other behaviors: multiple partnerships are not a risk factor for women aged 15-49, as only 27 percent reported more than two partners in their lifetime (MoHSS 2008a). Thus, the common practice among men of maintaining multiple or concurrent relationships appears to contribute to HIV infection rates among women.

Based on data collected from sentinel surveillances and subsequent projection calculations run by the MoHSS, the high adult prevalence rate shows signs of stabilizing (see Figure 2).

FIGURE 2: ESTIMATED ADULT HIV PREVALENCE RATE



Source: UNAIDS, WHO 2008

An important factor to consider is that these projections assume that the level of prevention efforts will remain constant throughout time. A substantial, multi-sectoral response to the national epidemic is essential to significantly decrease the prevalence rates that remain high.

3.2 FUTURE NEEDS FOR HIV/AIDS CARE AND TREATMENT

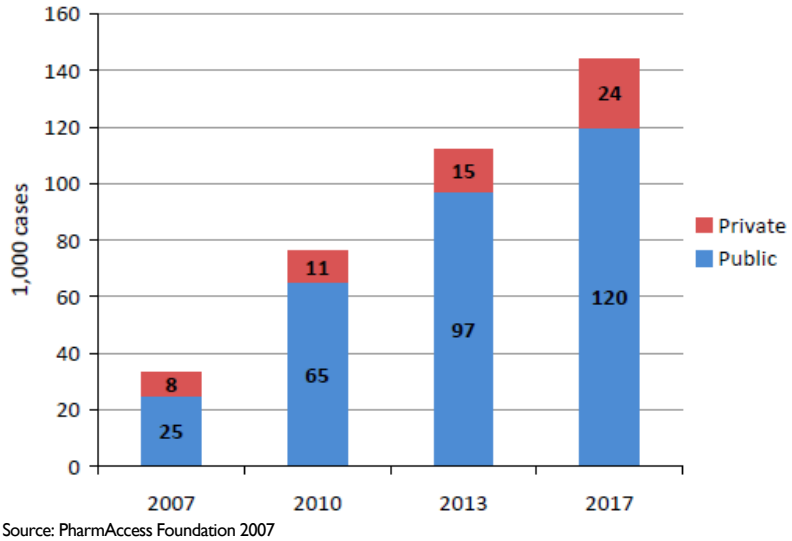
Projecting needs for HIV treatment and care is a useful exercise that can inform policy making and strategic planning. PharmAccess Namibia and Boston University conducted such a modeling exercise in 2007, which highlights the public-private burden in HIV/AIDS treatment according to two scenarios. While some of the assumptions used in the models may have changed slightly—for example, the model assumes an adult prevalence rate of 16 percent, whereas the current estimate is 13.3 percent (see Box 2)—these findings are highly relevant to better understanding current and potential contributions of the private sector to the Namibian HIV response.

Box 2: Assumptions informing the models

Workforce
Namibia Adult Population: 1,000,000
Workforce Participation: 85%
Formal Sector Workforce: 250,000
Adult Population Growth Rate: 2%
Formal Sector Employment Growth: 3% per year
Insurance
% Formal Sector Workforce Insured: 40%
Adults Covered Per Insured Worker: 1.3
AIDS Epidemic
National Adult Prevalence: 16%
Annual HIV Infection Rate: 1.6%
HIV Prevalence, Formal Sector Workers: 14%
HIV Prevalence, Informal Sector: 16.7%
% of HIV-Infected Starting ART: 12% per year
On ART: Private 8,000 - Public 25,000
Annual Mortality on ART: 10%

The first model (Figure 3) projects ART cases to 2017, assuming that baseline characteristics remain unchanged. According to this model, the number of ART cases increases from 33,000 in 2007 to 144,000 by 2017. In this scenario, the burden on the public sector to provide ART increases from 76 percent in 2007 to 83 percent 10 years later. In contrast, the private sector share decreases from nearly a quarter of HIV cases to 17 percent.

FIGURE 3: PROJECTED GROWTH IN ART CASES (ASSUMES BASELINE CHARACTERISTICS REMAIN UNCHANGED)

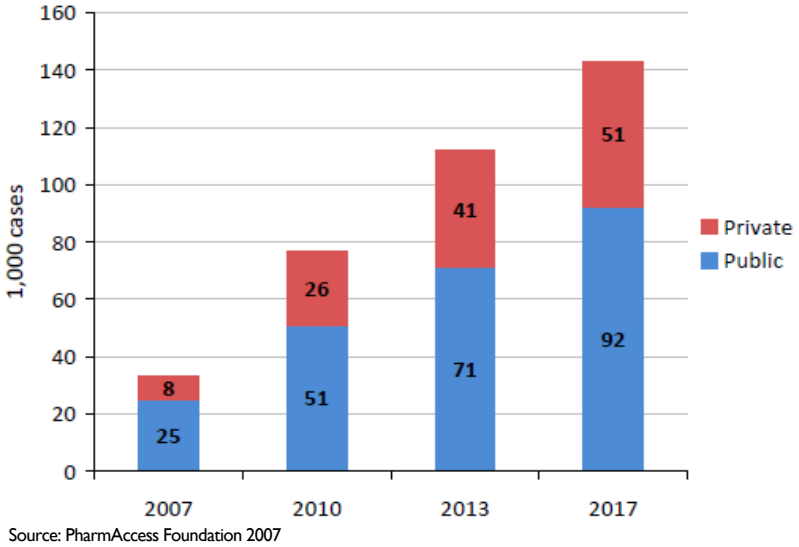


Source: PharmAccess Foundation 2007

However, another scenario is possible. If private companies were to cover all their employees and spouses in a medical aid scheme, the public sector burden would be reduced. While the projected total

number of patients on ART remains the same for 2017 (144,000), the private share would rise from 24 percent in 2007 to 36 percent by 2017, resulting in a sixfold increase (Figure 4). Conversely, the public sector share would fall from 76 percent in 2007 to 64 percent in 2017, representing a fourfold decrease.

FIGURE 4: PROJECTED GROWTH IN ART CASES (ASSUMES ALL FORMAL SECTOR EMPLOYEES AND SPOUSES COVERED BY MEDICAL SCHEME)



Source: PharmAccess Foundation 2007

The projections presented in Figure 4 assume that economic growth is 4 percent per year, that 100 percent of formal sector workers are covered, and that 1.7 adults are covered per worker. Both models assume that Namibia meets the target of getting 100 percent of those who need treatment into care.

4.LANDSCAPE OF HIV/AIDS STAKEHOLDERS IN NAMIBIA

This section provides an overview of the different stakeholders engaged in the national response to HIV/AIDS. The landscape of actors (see Figure 5 and Table 2) provides a "snapshot" of who's who in HIV/AIDS in Namibia. The following sections provide further details on the HIV/AIDS stakeholders as well as the challenges they confront. A companion table (see Annex B) offers a comprehensive description of the roles and responsibilities of various stakeholders.

4.1 OVERVIEW OF NAMIBIAN STAKEHOLDERS ENGAGED IN THE HIV RESPONSE

Figure 5 presents a visual overview of the complex landscape of actors engaged in HIV/AIDS in Namibia, organized by sector—e.g., international donors, public sector, private sector, civil society. See Table 2 for a complete list of acronyms used in this figure.

FIGURE 5: LANDSCAPE OF THE NAMIBIAN HEALTH SECTOR IN HIV/AIDS

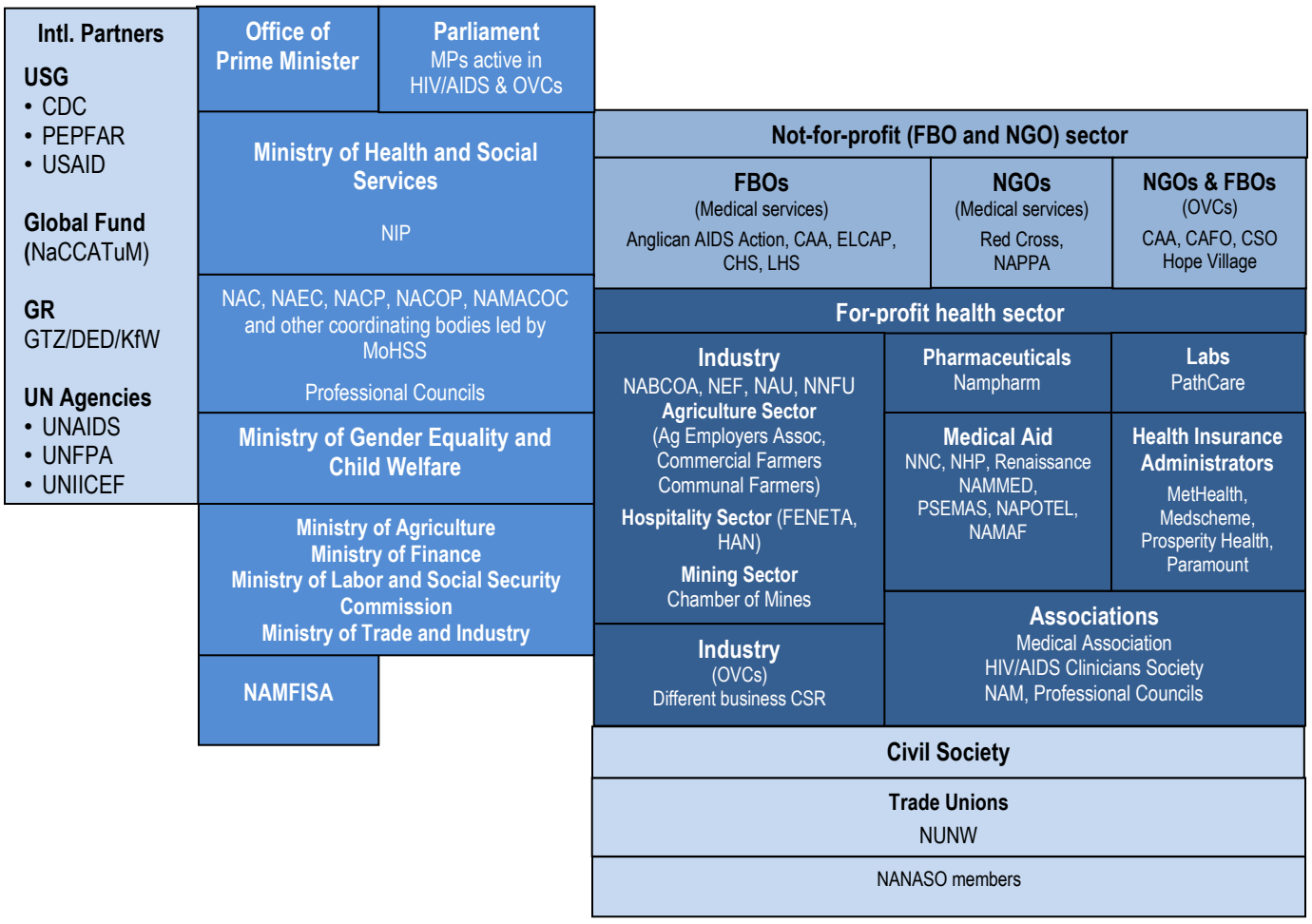


TABLE 2: LEGEND OF ACRONYMS FOR KEY ACTORS

Government Sector		Private, Not-For-Profit Sector	
MoGECW	Ministry of Gender Equality and Child Welfare	CAA	Catholic AIDS Action
MoHSS	Ministry of Health and Social Services	CAFO	Church Alliance for Orphans
MP	Member of Parliament		
NAC	National AIDS Committee	CHS	Catholic Health Services
NAEC	National AIDS Executive Committee	CSO Trust	Christina Swart Oppermann AIDS Orphan Trust
NACP	National AIDS Control Program	ELCAP	Evangelical Lutheran Church AIDS Program
NACOP	National AIDS Coordination Program	LHS	Lutheran Health Services
NAMACOC	National Multi-sectoral AIDS Coordination Committee	NABCOA	Namibia Business Coalition on HIV/AIDS
NAMFISA	Namibia Financial Institutions Supervisory Authority	NAPPA	National Association of Planned Parenthood
NIP	Namibia Institute of Pathology	NAPOTEL	Namibian Post and Telecommunications
		NMC	Namibia Medical Care
		PSEMAS	Public Service Employees Medical Aid Scheme
Development Partners		**Private For-Profit Sector**	
CDC	Centers for Disease Control and Prevention	FENETA	Federation of Namibian Tourism Association
DED	German Development Service	HAN	Hotel Association of Namibia
GR	German Republic	Nampharm	Namibian Pharm Wholesale Distributor
GTZ	German Agency for Technical Cooperation	NAU	Namibian Agricultural Union
NaCCATuM	Namibia Coordination Committee on HIV/AIDS, TB, and Malaria	NEF	Namibian Employers Federation
PEPFAR	President's Emergency Plan for AIDS Relief	NNFU	Namibian National Farmers Union
UNAIDS	United Nations Joint Program on HIV/AIDS	NUNW	National Union of Namibian Workers
UNFPA	United Nations Population Fund	PSN	Pharmaceutical Society of Namibia
UNICEF	United Nations Children's Fund		
USAID	United States Agency for International Development		
USG	United States Government	**Civil Society**	
		NANASO	Namibian Network for AIDS Organizations

International donors. Unlike in other African countries, such as Kenya, there are a relatively small number of international donors playing a strategic role in HIV/AIDS by funding Namibian programs, providing critical inputs such as technical assistance and donating ARVs. The principal donors are the GFATM, USG, and the Republic of Germany.

Public sector. The leading group in the field of HIV/AIDS is the public sector, with stakeholders in the executive and legislative branches of government—Prime Minister and Parliament respectively—and in line agencies. The primary actor in the public sector, by far, is the MoHSS, with support from other government agencies such as the Ministry of Gender Equality and Child Welfare (MoGECW), and those

of Agriculture, Finance, Labor and Trade and Industry. The public sector also has a financing function in HIV/AIDS services, through the Social Security Commission (SSC), and Public Service Employees Medical Aid Schemes (PSEMAS), and a regulatory function through the Namibia Financial Institutions Supervisory Authority (NAMFISA). The MoGECW also provides finance services for orphans and individuals with disabilities through its allowance program.

Private sector. There is a strong private sector response to HIV/AIDS and OVC in Namibia. The private sector comprises not-for-profit and for-profit entities. Within the not-for-profit sector, there are FBOs and NGOs that deliver prevention, care, and treatment of HIV/AIDS. There are also a substantial number of FBOs and NGOs that provide care and support for OVC.

The for-profit sector includes private health care providers, represented through a range of medical professional associations, that deliver HIV/AIDS services, as well as key industries—agricultural, finance, mining, tourism—that offer prevention and sometimes health services to their employees and surrounding communities. There is a medical insurance sector that sells health insurance covering HIV/AIDS benefits. In the area of OVC, businesses provide mostly in-kind contributions and limited funds through corporate social responsibility.

Civil society. Civil society plays an important role in advocating for government commitment and response to the HIV/AIDS crisis and in ensuring that the rights and perspective of PLHIV are respected through policy and law. Namibia has a large number of NGOs in the areas of both PLHIV and OVC. The Namibian Network of AIDS Organizations (NANASO) is an umbrella organization that represents many of the important non-government and civil society organizations (CSOs) dealing with HIV/AIDS and OVC. It is important to note that the recent influx of GFATM and PEPFAR funding has prompted a dramatic increase of NGOs wholly dependent on foreign and domestic donations. A recent 2009 guide to civil society in Namibia lists 74 HIV/AIDS and health organizations, and eight gender and OVC organizations. The GRN generally does not contract with these NGOs using public resources.

4.2 INTERNATIONAL DONOR SUPPORT FOR NAMIBIA'S HIV RESPONSE

As in many African countries, international donors play an important role in ensuring access to HIV/AIDS services though provision of funding, drugs, and other essential supplies, as well as technical assistance. The primary development partners supporting the GRN HIV response are the USG through PEPFAR, the GFTAM, and the German Republic (MoHSS 2008b).

The GFTAM grants are overseen through the Namibia Coordination Committee on HIV/AIDS, TB and Malaria (NaCCATuM), the Country Coordinating Mechanism (CCM), and implemented through a Program Management Unit (PMU). Namibia has received five grants of which the largest, under Round 2, is dedicated to HIV/AIDS. The other four are equally divided among malaria and TB. A key component of GFATM support is the purchase of ARVs: one-third of the cost of the drugs in Namibia is covered through the GFATM grant. Namibia was invited to apply for a Rolling Continuation Channel (RCC) grant in 2009 due to its high performance rating on its Round 2 grant. Namibia's RCC grant was approved in November 2009 and is expected to begin in July 2010. Namibia is currently developing two proposals for Round 10, including one focused on TB and another aiming to increase private sector involvement in the HIV response.

NaCCATuM has approximately 25 members including international donors such as PEPFAR, UN agencies, and the European Union, and public sector entities including the MoHSS, MoGECW, Office of the Prime Minister (OPM), National Planning Commission (NPC), Ministry of Agriculture, and representatives from civil society. Civil society covers a wide range of representatives from the private sector (Namibia Business Coalition on AIDS [NABCOA], Namibian Employers Federation [NEF],

Namibia Chamber of Commerce and Industry), NGO sector (NANASO, Namibian Association of Planned Parenthood [NAPPA], Society for Family Health), and FBO sector (Council of Churches in Namibia). NANASO is a Principal Recipient of the recently awarded RCC grant and is ramping up staff and activities. Some key informants interviewed indicated that the private sector—particularly the private health sector—is not adequately represented on NaCCATuM. Although NABCOA is an active member and the primary private sector voice in NaCCATuM, its mandate is too narrow to represent the diversity of the private health sector in Namibia.

NaCCATuM partners have begun the discussion on sustainability, but there is no strategy in place to address declining funding levels. Although the GFATM has not directly told the Namibian partners that funds will eventually be reduced, the signals are there. The GFATM has asked the Namibian government to reduce the Round Two "rolling continuation budgets" by 10 percent. It has indicated there will be a next phase of funding covering six years, but the Namibian organizations recognize that these funds cannot support them indefinitely. At a recent NaCCATuM meeting the members debated the topic of sustainability and the fact that the next round of GFATM (Round 10) would likely be Namibia's last opportunity to apply for a grant. The key concerns among NaCCATuM members were how to pay for ARVs and for NGO staff salaries.

The German development agencies involved in Namibia are the German Development Bank (KfW), German Agency for Technical Cooperation (GTZ), and German Development Service (DED). German donor support focuses on:

- Funds to hire MoHSS staff to work in different capacities of HIV/AIDS programming.
- Support to expand workplace programs in partnership with different Namibian organizations such as Namibia Development Foundation (NAMDEF), National Union of Namibian Workers (NUNW), and NABCOA.
- Technical assistance to mainstream HIV/AIDS in key sectors such as transport, environment, and natural resource management.

USG support is funded through PEPFAR and is carried out through multiple agencies as well (Table 3). The funds are administered primarily through USAID and the Centers for Disease Control and Prevention (CDC), but the State Department and Peace Corps also have roles. Implementing partners are primarily Namibian organizations such as the MoHSS, MoGECW, regional governments, NIP in the public sector, Church Alliance for Orphans (CAFO), and many NGOs in the not-for-profit private sector. PACT, a USAID implementing partner, funds 16 Namibian FBOs, NGOs, and CSOs. As illustrated, the USG's support is substantial in terms of dollar amount (approximately $77 million in 2008/09 dollars—or approximately US$38 for every HIV-positive person in Namibia) and breadth and scope of areas.

TABLE 3: OVERVIEW OF USG SUPPORT IN HIV/AIDS

Category	Components	Primary partners
Health system strengthening	Policy analysis Health system strengthening Strategic information Supply chain management	Abt Associates, Macro International MoHSS Management Sciences for Health Partnership for Supply Chain Management
Prevention	Prevention Condom and other prevention Abstinence/Be faithful Counseling and testing	Academy for Educational Development Development Aid People to People MoHSS PACT Intl (through its partners) Potentia Namibia University Research Corporation Population Services International
Basic health care and support	ARV services and drugs Basic health care and support Blood safety Laboratory infrastructure Prevention of mother-to-child transmission (PMTCT) Palliative Care: TB/HIV	IntraHealth Management Science for Health MoHSS NIP PACT, International Potentia Namibia University of Washington
OVC	Shelter and care Psychosocial support Food and nutrition Education Vocational training	Academy for Educational Development Church Alliance for Orphans Family Health International Ministry of Gender Equality and Social Welfare PACT, International Project Hope

4.2.1 CHALLENGES CONFRONTING DEVELOPMENT PARTNERS

The challenges for development partners, donors, and their interactions with the GRN focus on two areas:

- **Heavy donor reliance.** The MoHSS Strategic Plan 2009-2013 states that one of the main weaknesses challenging the national response to HIV is the GRN's continued reliance on donor funds (MoHSS 2009). In fact, the 2009 National AIDS policy clearly states that "the government will endeavor to reduce Namibia's reliance on external resource assistance for core recurrent costs of services, especially with regard to the delivery of ARTs" (MoHSS 2009). Most government and other officials who were interviewed recognize that a time will come when development partners will pull out of Namibia, given its ranking as a middle-income country.

  Donor spending on health as a percentage of total health expenditure (THE) in Namibia is on par with the average for SSA, at approximately 22 percent. Donor reliance is a recent phenomenon in Namibia: until 2003 donor spending was below 5 percent of THE. Beginning in 2004, Namibia experienced a dramatic influx of donor funds, with external aid increasing from 4 percent to 22 percent of THE by 2006, and remaining at that level in 2008/09. This striking increase in funding corresponds to the introduction of PEPFAR funds. This rapid and sharp increase of donor funding coincides with a decrease in GRN government health expenditures as a percentage of total governmental expenditures. In just a two-year span, the percentage went from 14.7 percent in 2007/08 to 12.2 percent in 2008/09 (MoHSS 2010a).

- **Nascent relationship between donors and the GRN.** While the GRN and donors recognize the importance of public-private relations, talks need to be concrete and direct about long-term, national solutions to reductions in PEPFAR funding.

4.3 PUBLIC SECTOR

4.3.1 CONTRIBUTIONS TO HIV/AIDS

The MoHSS is the lead protagonist in the GRN's effort to combat HIV/AIDS. The MoHSS, in coordination with other important government entities, such as the Cabinet, Namibian Parliament, National AIDS Committee (NAC), and National Multi-sectoral AIDS Coordination Committee (NAMACOC), sets the direction and focus of the national response. The MoHSS has spearheaded the design of the National AIDS Policy and development of the National Strategic Plan on HIV/AIDS (Medium Term Plans [MTP] II and III). The MoHSS also chairs, from time to time, multi-sectoral consultations involving all the actors working in HIV/AIDS.

The MoHSS is also the primary provider of HIV/AIDS services. The MoHSS has made remarkable progress in combating the infection: since 2007, the infection rate has stabilized at 13.3 percent, and in 2008, 72 percent of HIV-infected individuals received ART (totaling approximately 50,600 individuals, of whom 7,000 to 8,000 receive ARV in the private sector). The MoHSS delivers comprehensive services, ranging from prevention, care, and treatment including PMTCT, and ensures adequate laboratory infrastructure. These services are delivered almost exclusively by foreign (primarily from Zimbabwe) physicians and Namibian nurses. Main sources of funding for the GRN HIV/AIDS program are donors (51 percent), public (45 percent), and out-of-pocket (OOP; 3.4 percent) (MoHSS 2010a). Currently, the MoHSS is covering one-third of the costs of ARVs with public funds.

4.3.2 CHALLENGES CONFRONTING THE MOHSS

Clearly there is strong GRN leadership and political commitment to a national response to HIV/AIDS. Review of national plans and key informant interviews, however, reveals several challenges to the public sector response.

- **All actors are not engaged to the fullest extent of their capabilities.** There is good intent on behalf of the government to engage all segments in the health sector—including the for-profit health sector—as demonstrated by the statements in the National AIDS Policy and the various strategic plans. In fact, the MTP III states that "addressing problems of poor communication and coordination" is one of its goals. The interviews with public and private sector key informants also confirmed that communication is irregular. Moreover, the GRN has created a complicated coordination system that is confusing to key stakeholders (see LaFond et al. 2007 for the Organogram of National AIDS Coordination Program) and many of the entities are not active and rarely meet.

- **National response to HIV/AIDS is not sustainable.** Despite the HIV/AIDS program's remarkable achievements, it is not sustainable for a variety of reasons; key among them is the heavy reliance on donor funds to pay for ARVs, and MoHSS and FBO staff and to finance the majority of FBOs and NGOs delivering OVC support and care. Moreover, the MoHSS has difficulty attracting and retaining Namibian physicians not only for its HIV/AIDS programs but for others as well. As a first step towardustainability, the MoHSS has asked all 34 district hospitals, including FBO ones, to review staffing patterns so the MoHSS can rationalize staffing and absorb the cost of paying for staff.

4.4 PRIVATE SECTOR

4.4.1 NOT-FOR-PROFIT CONTRIBUTIONS TO HIV/AIDS

- **Faith-based organizations:** FBOs enjoy a close working relationship with the MoHSS. The major players are Catholic Health Services (CHS), Catholic AIDS Action (CAA), Lutheran Health Services, and Evangelical Lutheran Church Aids Program. Of the three, CHS is the dominant FBO health provider for HIV/AIDS. CAA also delivers some HIV/AIDS-related programs and is the leader in programs for OVC.

  In response to the HIV/AIDS epidemic in Namibia, the FBOs entered into a Cooperative Agreement in 1994 to ramp up HIV/AIDS services. The Cooperative Agreement specified that FBO staff are to comply with MoHSS guidelines and protocols. In response, FBOs quickly hired staff to put into place needed HIV/AIDS services, focusing on increased access to prevention, counseling and testing, and care and treatment. The FBO response has been impressive. FBOs exclusively operate all HIV/AIDS services and programs in five of the 34 districts in Namibia. And FBOs cover approximately 25 percent of 80,000 patients on ART.

- **Non-government organizations:** There are a few NGOs that provide HIV/AIDS services but they focus mostly in the area of prevention. They include Population Services International and the Red Cross. Moreover, there are a large number of organizations providing support group activities for PLHIV in the areas of treatment literacy and treatment buddy support, treatment and adherence counseling, home-based care, and community education. Others provide income generation for PLHIV.

4.4.2 COMMERCIAL SECTOR CONTRIBUTIONS TO HIV/AIDS

The for-profit, commercial sector is complex and comprises a variety of private entities involved in different aspects of HIV/AIDS prevention and treatment. In the area of health services, a range of private health care providers deliver HIV/AIDS services; they are represented by their respective professional associations. Key among them are: Medical Association (physicians), Nurses Association, HIV/AIDS Clinicians Society (range of for-profit providers including physicians, nurses, laboratory technicians, and pharmacists), and Hospital Associations. (For more discussion of these organizations, see Section 6.)

Private entities also distribute and retail products in Namibia's pharmaceutical sector. The Pharmaceutical Society of Namibia (PSN) is a powerful entity in the Namibian health sector, representing pharmacists and their interests in licensing, pricing of drugs, and other related issues. NamPharm Ltd is a full-line pharmaceutical wholesaler and distributor of ethical, generic, and consumer products to hospitals, doctors, and pharmacies in Namibia. The company started in 1997 and has become one of Namibia's leading pharmaceutical distributors.

Laboratories are an important component of HIV/AIDS services, and in Namibia there is one for-profit company, PATHCARE, that exclusively serves private health care providers and hospitals, while the parastatal NIP primarily supports MoHSS needs with a limited number of private sector clients.

There are four medical aid schemes that finance HIV/AIDS care and treatment: MetHealth, Medscheme, Paramount, and Prosperity Health. Medical aid schemes are not-for-profits, while the administrators are for-profits. Also, the GRN offers a medical aid scheme for its employees through PSEMAS. Although trade unions are usually part of civil society, representing the interests of their union members, they are included as part of the private sector financing because they have recently created an entity called Endombo, with the purpose of offering health insurance, which would include HIV/AIDS services and drugs.

FIGURE 6: BILLBOARD FOR METHEALTH NAMIBIA

Finally, important industries in Namibia, such as agriculture, finance, mining, and tourism, actively provide prevention and, in some cases, HIV/AIDS services. These industries are organized through an umbrella organization, such as NABCOA, or through their respective trade associations.

4.4.3 CHALLENGES CONFRONTING PRIVATE HEALTH STAKEHOLDERS

The biggest challenge for FBOs and NGOs delivering HIV/AIDS programs is financial sustainability.

- **Heavy reliance on donor funds.** In an effort to scale up HIV/AIDS and OVC services, the GFATM and PEPFAR pumped lots of money into the country. Many organizations—FBOs, NGOs, and CBOs alike—responded to the need and the increased funding and ramped up HIV/AIDS services. FBOs recognize that a decrease in PEPFAR funding will negatively impact their ability to continue to provide needed HIV/AIDS services. For example, PEPFAR covers 60 percent to 80 percent of salaries for CHS's staff working in HIV/AIDS programs and services. In the last year, the MoHSS and FBOs have started the conversation on what to do with reduced PEPFAR funds, but they have not come up with a clear strategy. FBOs are also concerned about the stability of MoHSS funding. The MoHSS has never met its financial commitment of 100 percent funding to cover FBOs' operating costs, in fact, MoHSS funding has declined in recent years. To address the MoHSS funding shortfall, FBO management are closing facilities, creating private wings, and considering asking for reimbursements from PSEMAS or other medical aid schemes. With respect to NGOs and CBOs, the GRN pays for treatment and testing but offers almost no direct funding for these organizations.

Three critical issues confront the private sector's ability to realize its HIV/AIDS obligations:

- **No formal dialogue forum to engage the public and private sector.** The private sector has access to the MoHSS, but there is little dialogue between the sectors. The MoHSS occasionally sponsors consultation meetings that the private sector is invited to attend or asks the private sector to help with ad hoc requests for specific issues or emergencies. But there is no forum—despite the myriad coordinating mechanisms—for the two sectors to share information and discuss roles and responsibilities. Key private sector informants state they are unaware of the government's expectations of private sector's role in HIV/AIDS prevention as well as the treatment of government priorities and strategies to address the epidemic.
- **To address the lack of dialogue, the Minister of Trade and Industry was developing a PPP Framework and policy for all ministries in late 2009.** The initial proposal was modeled on the South African PPP policy. In late 2009, the GRN agreed to hire a consultant to develop a draft that the Task Committee would review and finalize.
- **Limited public sector capacity to effectively engage the private sector.** Although the NPC is well positioned to facilitate public-private dialogue and to form PPPs, the NPC—as is the case with other state departments, like the MoHSS—does not have the staff and capacity to engage the private sector. For example, the MoHSS has expressed an interest in establishing more PPPs like Ornajemund and Rosh Pinah (described in Section 6) but has limited ability to develop them. There is good will from both the public and private sector, but the process cannot get started in the absence of a policy framework to guide and structure the partnerships. Missing skill areas noted during interviews include: evaluation of partnerships, negotiation, legal documentations, and oversight.
- **Uncertain policy and regulatory regime supporting private sector engagement.** By and large, the policy and regulatory environment is supportive of private provision of care, facilitating professional certification and facility licensing. Moreover, the private sector regards the professional councils as fair, effective, and approachable when needed. But conflicts involving larger policy issues, such as work permits, are not easily resolved. Moreover, the legal framework to form PPPs may not exist.

4.4.4 CIVIL SOCIETY CONTRIBUTIONS TO HIV/AIDS

Finally, civil society is represented through a myriad of NGOs speaking on behalf of PLHIV and OVC, ensuring sufficient government response to the HIV/AIDS crisis through political, policy and financial support. NANASO, an umbrella organization, is the stated leader of the NGO sector in HIV/AIDS in MTP III. NANASO's network consists of 174 NGOs, 191 CBOs, and 51 FBOs. In addition, there are over 15,000 volunteers. NANASO's role as a network organization is to act as a conduit between its members and other key stakeholders, such as the public and private sector in Namibia and international partners. NANASO performs several functions for its members, including 1) providing information and sharing knowledge; 2) building its members' organizational capacity; 3) raising capital and funds; 4) representing and advocating on behalf of its members with the government, public, and private sectors; and 5) monitoring the sector's performance.

Some of the issues NANASO is currently working on with its members include:

- **Financial support from the government.** They have argued that the government should create a budget for CSOs, but the government is resisting. NANASO tried to get a bill through Parliament to allocate government funds to NGOs, but it did not pass.

- **Financial regulations governing NGOs.** Some of NANASO's members fear that the government is trying to control the NGO sector, while others are aware of the concerns about "briefcase NGOs" and would welcome some form of financial regulations.
- **Modifying NGO registration requirements.** All NGOs are required to register with the NPC, but many of the smaller CBOs have difficulty complying with the registration requirements.

NANASO recently became the second largest principal recipient for the GFATM (after the MoHSS) under the RCC grant. It is in the process of rapidly staffing up to meet its new institutional demands. Several informants raised concerns about NANASO's ability to manage the RCC grant given the demanding requirements of managing such a large grant. Since its inception in 1991, NANASO has experienced difficulties in becoming a sustainable organization, facing serious financial constraints in 2002.

4.4.5 CHALLENGES CONFRONTING CIVIL SOCIETY

Some of challenges confronting the organizations representing civil society include:

- **Crowded field of small CBOs delivering questionable impact.** There are hundreds upon hundreds of small CBOs delivering a narrow range of services, resulting in a patchwork of organizations and services. Some key informants who were interviewed raised several questions regarding management and financial challenges in working with the sheer number, diversity, and size of existing CBOs: 1) how to manage and fund so many small CBOs while ensuring quality services; 2) how such a large number of small CBOs can deliver impact; and 3) how can these small organizations go to scale without donor funding.
- **Financial sustainability.** The dramatic influx of PEPFAR funds has created a multitude of small NGOs and CBOs with limited organizational capacity to grow and to become financially independent of donor funding to stay in operation. And local funds from the private sector are scarce given the confusion among NGOs and FBOs on which organizations are qualified to be legally classified as welfare organizations. Being a welfare organization means that high-income individuals and/or local businesses can deduct their donations to the organization from their taxes.

5.DESCRIPTION OF THE PRIVATE HEALTH SECTOR IN NAMIBIA

Much is known about the public and not-for-profit health sectors in Namibia. This section attempts to describe and quantify the size, scope, and use of the private health sector in Namibia, drawing on a variety of data sources, including the NHA, DHS, and MoHSS statistics.

Historically, FBOs are an important segment of the private health sector, particularly in SSA countries. Arrangements with hospitals owned by FBOs (mission hospitals) would ordinarily fit into this definition of the private health sector but, in the case of Namibia, most mission hospitals operate as an extension of the public hospital system. Nonetheless, we have included them in this section because mission-based health services are increasingly exploring "for-profit" strategies to address gaps in funding from the MoHSS. Also, this section offers a description of the health insurance sector because it can play an increasingly important role in facilitating a greater private health sector response to HIV/AIDS.

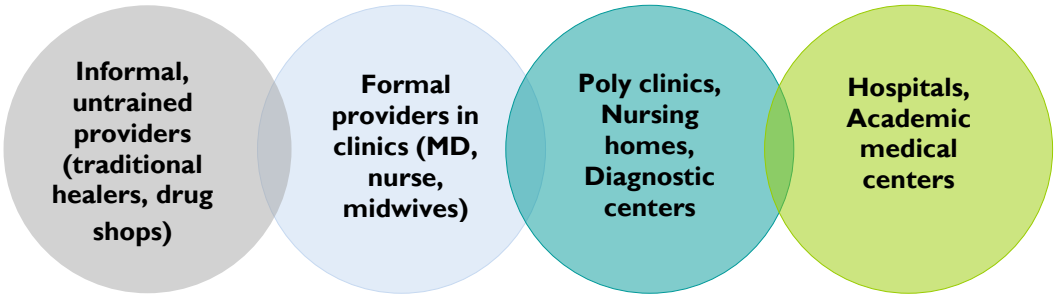
5.1 RANGE OF PRIVATE HEALTH PROVIDERS

Private sector care is often defined to include all the providers and facilities outside of the public sector Natasha Palmer describes the private, or non-state actors, as:

> [They] are all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease. They include large and small commercial companies, groups of professionals such as doctors, national and international nongovernmental organizations, and individual providers and shopkeepers. The services they provide include hospitals, nursing and maternity homes, clinics run by doctors, nurses, midwives and paramedical workers, diagnostic facilities e.g. laboratories and radiology units, and the sale of drugs from pharmacies and unqualified static and itinerant drug sellers, including general stores (2006).

Figure 7 illustrates the make-up of the private health care sector, reflecting the fact that segments of the private sector can sometimes overlap and that the lines are often blurred. This is particularly true among private providers that have a dual practice, working in the public sector in the morning and in their private clinics in the afternoon. Or in the case of the FBOs, where in Namibia their facilities and providers are extensions of the public health system.

FIGURE 7: PRIVATE HEALTH CARE PROVIDERS

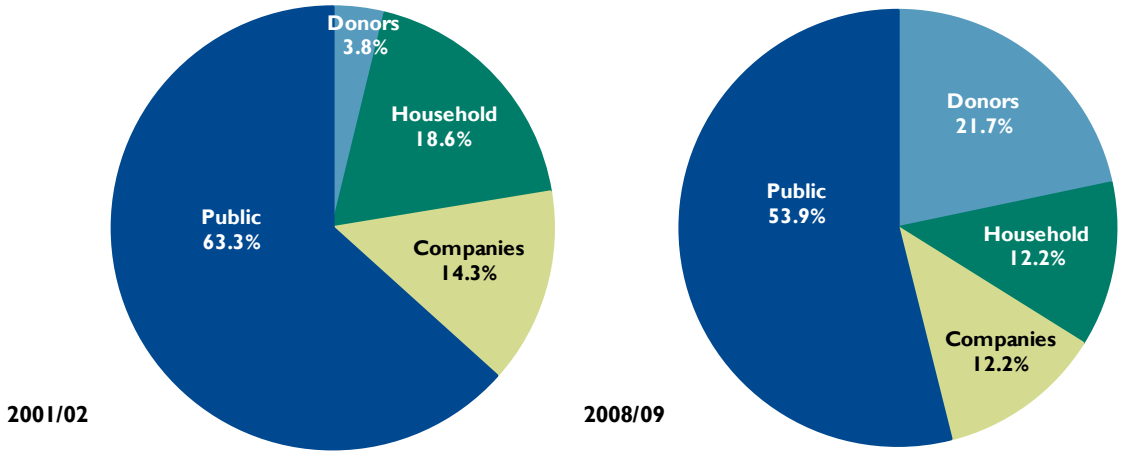


5.2 PRIVATE FINANCING FOR HIV/AIDS

Namibia has conducted several NHA analyses in the last decade (2001/02, 2002/03; 2003/04; 2004/05; 2005/06; 2006/07, and 2008/09). The NHA analyses provide important data that document the evolution of financing sources in health and how the health funds are spent in the health sector. Figure 8 illustrates the funding sources as a percentage of THE in the health sector for the years 2001/02 and 2008/09. In both years, the public sector financed the majority of health care in Namibia: 63.3 percent and 53.8 percent, respectively. During this same time period, the private sector share—comprising companies and individual households—declined from one-third of THE (32.9 percent) in 2001/02 to one quarter (24.5 percent) in 2008/09.

The funding source that experienced the most growth was donors, rising from 3.8 percent in 2001/02 to 21.7 percent in 2008/09. The dramatic rise in donor funds is attributed to the influx of GFATM and PEPFAR funds in 2005 to 2007. Increased donor funds impacted both the public and private sectors. In the case of the public sector, the government reduced its spending by almost 10 percent, using donor funds to make up the difference. Private company expenditures in health experienced a decline from 14.3 percent to 12.2 percent during this period. Household spending also declined from 18.6 percent to 12.2 percent.

FIGURE 8: FINANCING SOURCES AS % OF THE, 2001/02 AND 2008/09

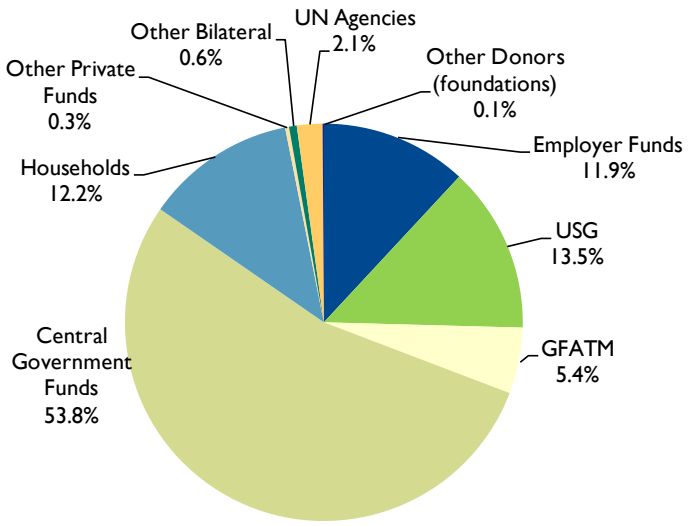


Source: MoHSS 2010a

Namibia is not unique in reducing its domestic expenditures for health in the face of dramatically increased donor funding. A study published in The Lancet showed that SSA governments have pulled anywhere from $0.43 to $1.14 from their own domestic spending on health for every dollar in health aid they received from foreign donors (Lu et al. 2010). This phenomenon was also found in a study of health expenditure, where two of five SSA countries witnessed a decrease in absolute public sector financing for HIV/AIDS (Sulzbach et al. 2009).

Figure 9 provides a more detailed breakout of the different funding sources for all health expenditures. The public sector is the major source of funds for health at 53.8 percent, followed by the donors at 21.7 percent. Among the donors, USG contributes the largest amount (13.5 percent), followed by the GFATM (5.4 percent), other UN agencies (2.1 percent), and bilateral (0.6 percent). Employer funds and households contribute almost equally at 11.9 percent and 12.2 percent respectively.

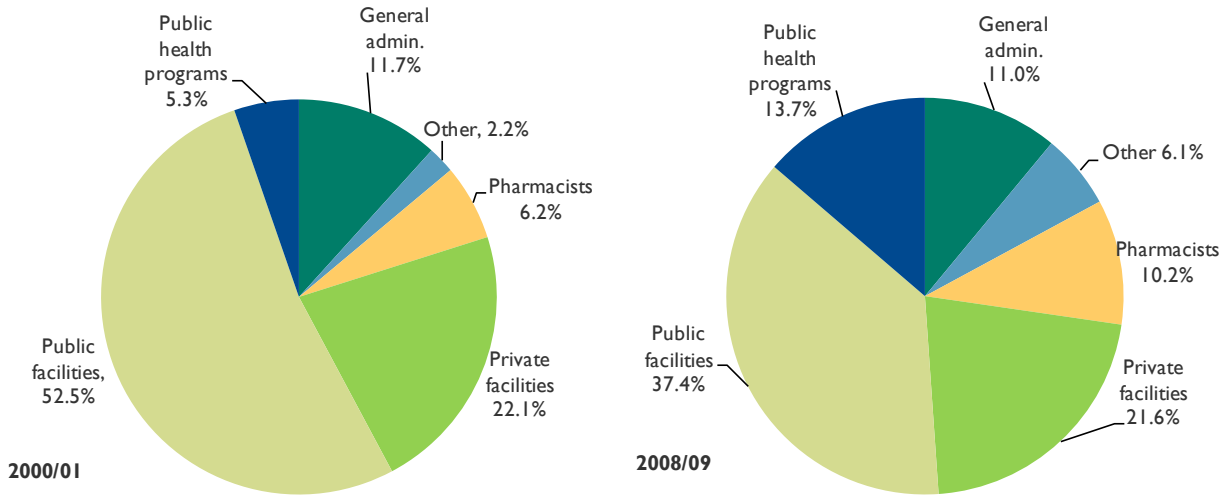
FIGURE 9: FINANCING SOURCES OF THE, 2008/09



Source: MoHSS 2010a

The NHA also demonstrates how general health funds are spent in the health sector. Figure 10 shows that the majority of funds in both 2001/02 and 2008/09—approximately two-thirds—are spent at public sector facilities, public health programs, and general administration. During this same time period, there is a modest increase in the funds spent in the private health sector—at both private facilities and chemists. Spending in private health facilities stayed relatively the same—22.1 percent for 2001/02 and 21.6 percent for 2008/09. Simultaneously, spending at dispensing chemists grew from 6.2 percent to 10.2 percent, where most of the private sector increase occurred.

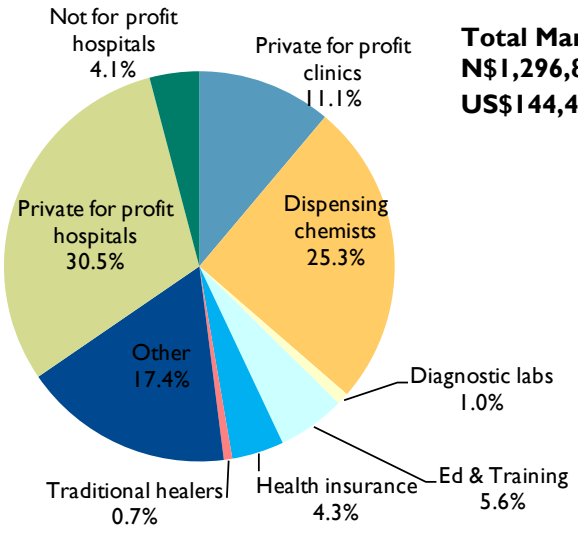
FIGURE 10: PROVIDER DISTRIBUTION AS % OF THE THE, 2001/02 AND 2008/09



Source: MoHSS 2010a

Figure 11 provides a closer look the total size of the private health market in Namibia. The value of the private sector market is around N$1,296,802,073 in 2008/09, equivalent to US$144,410,030.

FIGURE 11: DISTRIBUTION OF PRIVATE HEALTH SECTOR EXPENDITURES, 2008/09

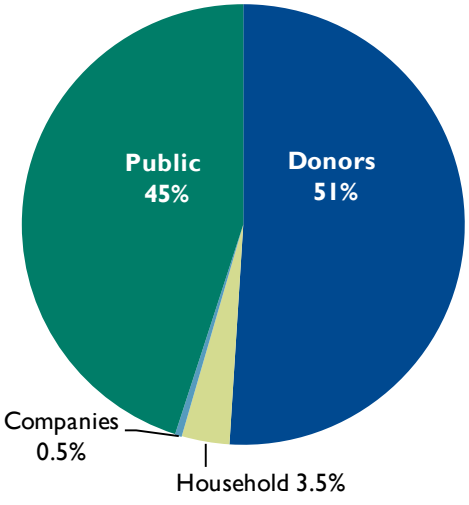


Source: MoHSS 2010a

Almost one-third (30.4 percent) of private funds are spent in private for-profit hospitals, followed by one-fourth (25.2 percent) at private dispensing chemists, and 11.1 percent at private for-profit clinics. A significant amount (17.4 percent) of OOP and health insurance premiums are paid to a range of private providers at hospitals, clinics, and individual consultation rooms. Moreover, 4.1 percent of mission hospitals receive private funding, also through individuals and private insurance.

5.3 SIZE OF THE TOTAL HIV/AIDS MARKET

FIGURE 12: FINANCING SOURCES AS % OF THE$_{HIV}$ 2008/09

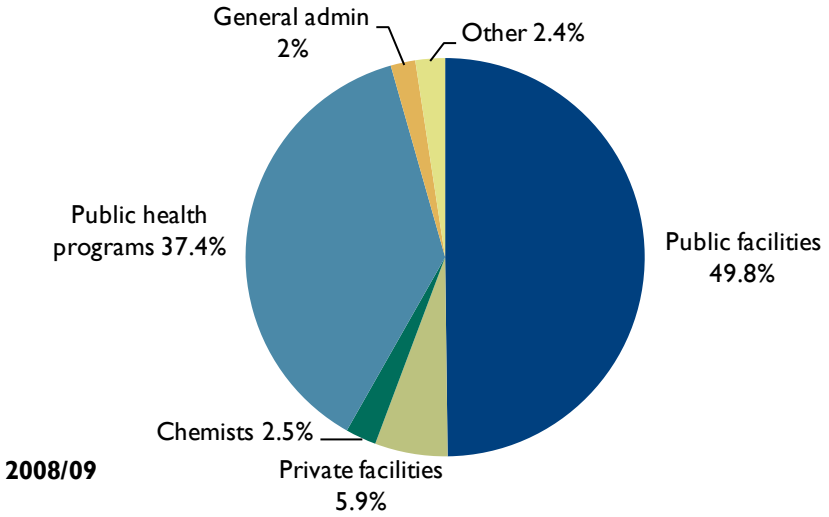


Source: MoHSS 2010a

In addition, the 2008/09 NHA examined health expenditures specific to HIV/AIDS (Figure 12). The public sector and donors are the core funders of HIV in Namibia (45 percent and 51.1 percent respectively). The private sector contribution is negligible at less than 1 percent. Unlike in other African countries, household spending is extremely low, at 3.4 percent.

Figure 13 shows where the HIV funds are spent. As can be expected, the clear majority of HIV funds—nearly 90 percent—is spent in the public sector, distributed between public facilities (49.8 percent), public health programs (37.4 percent), and general administration (2 percent). A much smaller proportion of HIV funds is spent in the private sector, with 5.9 percent going to private facilities, 2.5 percent to dispensing chemists, and 2.4 percent to other types of providers.

FIGURE 13: PROVIDER DISTRIBUTION AS A % OF THE$_{HIV}$ 2008/09



Source: MoHSS 2010a

5.4 SIZE AND SCOPE OF THE PRIVATE HEALTH SECTOR

5.4.1 HEALTH FACILITIES

A 2008 review of the Namibian health system provides statistics on the numbers of private health sector facilities and staff. For comparison, we have included public sector data as well. Table 4 shows that the public sector (including mission facilities) has approximately three times the number of hospitals and clinics as the private sector. However, there are over 550 private provider consulting rooms and 75 private pharmacies, both of which could potentially play a role in contributing to Namibia's HIV response. Note that private sector clinics include nurse-run clinics and mobile testing vans.

TABLE 4: DISTRIBUTION OF HEALTH FACILITIES BY OWNERSHIP

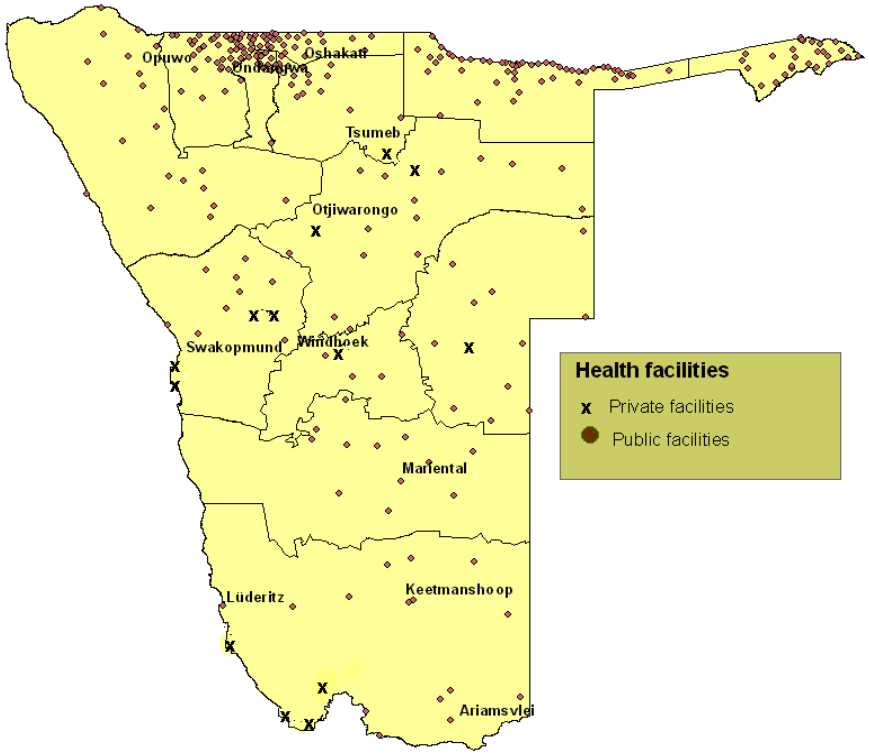
Facility type	Public	Private
Hospitals	35	13
Primary care clinics	256	75
Health centers	42	8
Private provider consulting room	N/A	557
Pharmacies	N/A	75
Total	333	844

Source: MoHSS, 2008b

5.4.2 REGIONAL VARIATION

One of the salient characteristics of the HIV/AIDS epidemic in Namibia is its significant regional variation. There is similar variation in the distribution of private health facilities in the country, unfortunately not proportionate to the epidemic or the population of the country. The map shown in Figure 14 depicts areas that have private health clinics, facilities, and hospitals (private doctors and pharmacies are not mapped). As the map illustrates, the majority of private health sector facilities and practitioners are concentrated in Windhoek and Swakopmund/Walvis Bay. The remaining private facilities are sprinkled in the south and north and are closely linked to the extractive industries or larger urban areas.

FIGURE 14: DISTRIBUTION OF PUBLIC AND PRIVATE CLINICS, FACILITIES AND HOSPITALS IN NAMIBIA, 2008



Source: Central Bureau of Statistics 2001

5.4.3 HUMAN RESOURCES

Scarcity of qualified health care professionals was a common issue emerging from the key informant interviews and the literature review. Table 5 shows the ratio of health care professionals to the Namibian population. Although the overall Namibian ratio of health care workers per population—3.0 per 1,000 inhabitants—is higher than the WHO benchmark of 2.5, there are disparities in this ratio between the public and private sector.

The dearth in health care workers is compounded by the chronic shortage of MoHSS frontline workers —doctors, nurses, and social workers—forcing the MoHSS to import workers primarily from Zimbabwe and neighboring countries. The lack of medical training institutions in Namibia further exacerbates the human resource shortage. The University of Namibia (UNAM) trains nurses and has recently begun training laboratory technicians. Although UNAM has started a medical school this year

with plans to start a pharmacy school as well, it will take years for these programs to become established and begin graduating medical professionals.

TABLE 5: RATIO OF HEALTH CARE PROFESSIONALS TO POPULATION

Category	Ratio per national population
Doctors	1:2,952
Registered nurses	1:704
Pharmacists	1:10,039
Dentists	1:20,078
Social workers	1:13,519

Source: MoHSS 2008b

As of 2008, there were 7,697 health workers nationwide. While the public sector employs a slight majority of health care workers (53 percent), the private sector attracts nearly as many health care workers (47 percent). Table 6 shows the distribution of workers by selected number of categories important to HIV/AIDS services and programs. The private sector employs the majority of physicians—three-quarters of all doctors. The other two professional groups that work predominantly in the private sector are pharmacists and social workers: nine out of 10 pharmacists and seven out of 10 social workers.

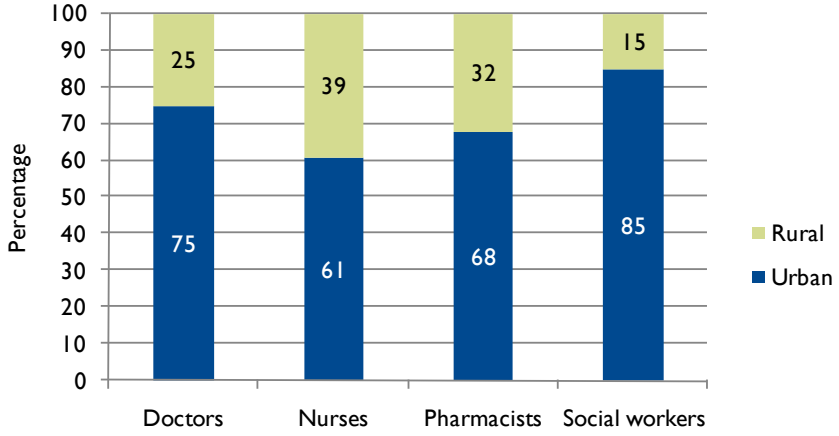
TABLE 6: DISTRIBUTION OF HEALTH WORKERS BY SECTOR

Category	# Registered 2006/07	Public Sector		Private Sector	
		#	%	#	%
Doctors	774	216	28	558	72
Registered nurses	2989	1626	54	1363	46
Enrolled nurses	2761	1884	68	877	32
Pharmacists	239	27	11	212	89
Pharmacist assistants	137	65	47	72	53
Social workers	250	76	30	174	70

Sources: MoHSS 2008b, MoHSS website, 2010

Another characteristic of the health workforce is geographic disparity. Not surprisingly, the majority of doctors, pharmacists, and social workers are employed in the private sector and are located in urban areas (see Figure 15).

FIGURE 15: GEOGRAPHIC DISTRIBUTION OF HEALTH PROFESSIONALS



Source: MoHss2008b

Registered nurses in the private sector, as in many other SSA countries, can play an important role in addressing general health and HIV/AIDS. Box 3 illustrates one such example.

Box 3: Human resources in action

Located in central Windhoek, the Health Care 4 You primary care clinic is run under the supervision of two nursing sisters. For cash charges ranging from N$150 to N$180 (including available medications that can be prescribed and are in stock), the clinic consults on a variety of primary care issues—flu, gastrointestinal distress, sexually transmitted infections (STIs), family planning advice and contraceptives, etc. For the past 15 years, the clinic has been resourcefully assisting the community with a number of health services. The clinic does not stock childhood vaccines but will procure vaccines when the GRN sponsors vaccine campaigns; in return Health Care 4 You does not charge for the vaccination. If patients wish to have a Pap smear, the sample is sent to NIP or other labs. The clinical staff also refers patients to other clinics for HIV tests and to the public sector or private providers for TB tests (depending on whether or not the patient has medical aid). The clinic is required to report to the MoHSS only on "reportable" diseases such as yellow fever, meningitis, leprosy, and polio.

Patients

The patient flow fluctuates depending upon the season—around 40 patients per day in the summer and up to 90 patients per day in the winter. About 25-50 percent of the patients are medical aid scheme members. Low-cost plans do negotiate sub-Namibian Association of Medical Aid Funds (NAMAF) fees. But the sisters could not make it work at the Blue Diamond fee of N$90, so the sisters negotiated a higher (but still discounted) fee. Some of their patients do not know how to use their medical scheme coverage or how to get an MD appointment, which is why the walk-in nature of this clinic is appealing. Health Care 4 You has a good reputation, not only because it is a convenient location, but also the waiting time is usually less than 30 minutes, and the public sector does not always have the common medications that the clinic stocks. They are allowed to advertise in the newspaper, and do so. They think they are getting some additional patients this way.

Clinical staff and management

Told by banks that they were too old for loans, the two founding partners, Sister Parkhouse and Sister Marais, took a second mortgage on their houses for start-up expenses. The rest of the staff consists of one manager and five clinical staff. The manager is a young woman who handles business aspects, including selecting an electronic data processing system for medical scheme claims. Three of the five clinical staff are 22A trained nurses. The clinic has regular nurses do some routine procedures and even paid for one to take the 22A training course. Only one drug wholesaler (Erongo Medical Supplies) was willing to give them trade credit, so they use this when they can.

Regulation

Health Care 4 You holds a clinic license from the MoHSS, with start-up and annual inspections. In addition, the clinic is required to hold a municipal occupancy permit and Nursing Council license, and register with NAMAF as a provider. Obtaining such licenses is not difficult, but the costs can be high.

Competition

The clinic does not face many competitors in Windhoek. Similar clinics can be found in Khomasdal, Otjimuise, Okahandja, and Rehoboth, but they are few and far between. When interviewed, Sr. Marais stated that there is a need for more primary health care clinics in the north due to increased population and new awareness of private health care. There is no "industry" association, but the clinic has an informal network. Nurses considering starting a clinic frequently approach Sister Parkhouse for advice, as she is the founder of this kind of clinic in Namibia.

Note: Sadly, Sister Parkhouse died shortly after the assessment.

5.4.4 STRUCTURE OF PRIVATE HEALTH CARE IN NAMIBIA

The distribution of private health providers in Namibia is uneven, with a small number of large, successful private providers who own hospitals and clinics that offer high-quality services, concentrated in Windhoek and Swakopmund. These providers are competing for a small high-income clientele who can afford to either pay OOP or, more commonly, are covered by a medical aid scheme. Also in this provider group are several specialists in Windhoek and Swakopmund with private consulting rooms and hospital privileges, who run a profitable business. Box 4 categorizes the types of private providers prevalent in Namibia.

Private health care providers and medical aid schemes are exploring how to deliver a basic package of services at a lower cost—a strategy called moving "down market"—to capture more middle-income groups, who may have sufficient income to pay OOP and/or have limited medical aid scheme coverage, but are willing to "top up" the benefits to remain with their provider of choice and/or to seek care at a particular private hospital. The challenge is how to capture the lower-wage earner who still does not understand the purpose of health insurance and who would rather keep the funds and use the public health system for expensive illnesses.

Below the level of high-end private providers are a large number of small-scale providers in private consulting rooms that struggle to remain financially viable and whose quality varies. They are located both in the urban and peri-urban areas, as well as throughout the country. These providers, typically nurses, serve lower-to-middle income clientele. As the interviews revealed, nurses with the right qualifications can own and operate a licensed primary care clinic. There are, however, relatively few of these nurse-owned facilities.

FIGURE 16 : IMAGE OF A PRIVATE MEDICAL CENTER IN NAMIBIA

Box 4: Categories of private providers prevalent in Namibia

Primary health care clinics

The first level of care is delivered by trained nurses offering immunization, and screening services (e.g., Pap smears, family planning, etc). Clients presenting disease symptoms are referred to a public health facility, private doctor or hospital.

Medical clinics

These clinics are operated by qualified individual physicians. These solo practitioners manage all conditions ordinarily managed in a general practice, with referral to higher levels as required. There are also several specialists, including those who specialize in HIV/AIDS treatment, with consulting rooms. These private doctors use private hospitals for their patients.

Medical centers

Medical centers—or polyclinics—are group practices where diverse services are offered in one site. These group practices are owned by the practicing physicians or jointly with business partners. These group practices are often medical facilities with the most modern outpatient services and amenities. Many of these facilities receive public service employees in addition to those with private health insurance.

Private hospitals

Private hospitals provide inpatient services, intensive-care units, and surgical facilities for general practitioners (GPs) and specialists. These hospitals are generally managed by nurses, with few or no full-time medical doctors. Most of the private hospitals are struggling and would consider a contractual relationship with MOHSS or low-cost health insurers to increase occupancy. However, the private hospitals in Windhoek have enough high-end business driven by the presence of specialists (surgeons, diagnostics). In the rural areas, medical care is more driven by GPs, with less surgery. Moreover, there are fewer patients with good medical aid. Costs are high in rural areas, and it is harder for these small hospitals to achieve economies of scale.

Pharmacies

There are a growing number of pharmacies in Namibia, of which almost all are private. All private pharmacies are run and owned by a qualified pharmacist. These pharmacies are highly sophisticated, using IT and other forms of technology. Drug prices in the private sector are a barrier to access. Value added tax (VAT) on all drugs, even essentials, is 14 percent. And the NAMAF tariff is wholesale cost plus 50 percent (higher than in South Africa, where it is 15 percent). Even when using generics, the price is set at the average of the two lowest prices plus the 50 percent markup. A few pharmacies sell below the normal NAMAF tariff. There is no movement for reducing drug prices, even for ARVs.

Industry

Depending on size and capacity, several private companies provide health services to their employees, and, in some cases, the communities where the business operates. Services vary, ranging from workplace programs on education and prevention, to nurse-managed primary care, to comprehensive health services including tertiary care.

Source: NABCOA 2008

5.5 PRIVATE SECTOR CONTRIBUTION IN KEY HEALTH AREAS

The private health sector plays a role in delivering key public health areas, such as HIV testing and STI treatment, family planning, childhood illnesses, and maternal health. The following section relies on data from the 2006/07 DHS.

5.5.1 HIV TESTING AND STI TREATMENT

As Table 7 and Table 8 reveal, more women are tested for HIV than men: more than half of women (55.4 percent) compared with one-third of men (34.7 percent). Of the women who were tested in the last 12 months, clearly the majority (84 percent) received their test in the public sector, while only 16 percent did so in the private sector. The majority of men also went to the public sector for their HIV test (73 percent). More men, however, used the private sector than women: 25 percent compared with 16 percent.

TABLE 7: PERCENTAGE OF MEN AND WOMEN EVER TESTED FOR HIV

Ever tested for HIV	Gender	
	Women	Men
Yes	55.4	34.7
No	44.6	65.4

Source: MoHSS, Macro International, 2008a

TABLE 8: SOURCE OF LAST HIV TEST AMONG MEN AND WOMEN

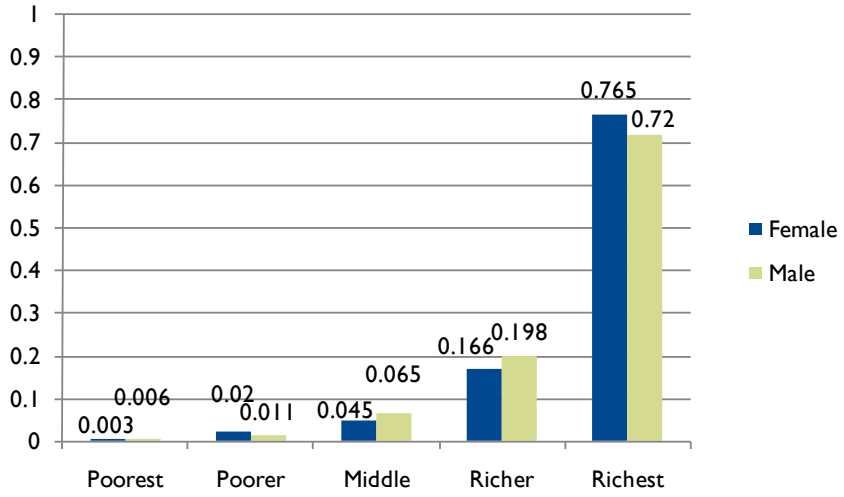
Source of last HIV test	Source of service		
	Public	Private for-profit	Other
Female	83.8	15.5	0.7
Male	72.8	25.3	2.0

Source: MoHSS, Macro International, 2008a

Note: No observations for private non-profit sector.

Figure 17 illustrates the income levels of the men and women who went to the private sector for their last HIV test. As can be expected, almost no men or women in the lowest two wealth quintiles used the private sector to get a HIV test. Women and men from the highest wealth quintile are most likely to use a private sector source for HIV testing.

FIGURE 17: PERCENTAGE OF MEN AND WOMEN WHO RECEIVED HIV TEST AT A PRIVATE SOURCE BY INCOME GROUP



Source: MoHSS, Macro International 2008a.

5.5.2 CHILD CURATIVE CARE

In other SSA countries, many mothers take their children for treatment of common illnesses to for-profit doctors, pharmacists, and traditional healers. In Namibia, however, the majority take their children to the public sector to treat diarrhea (85 percent), or a fever or cough (77 percent).

TABLE 9: LAST SOURCE OF CHILD'S TREATMENT FOR SELECTED ILLNESSES BY SECTOR (%)

Illness	Source of service		
	Public	Private for-profit	Other
Child's diarrhea	84.5	14.4	1.1
Child's fever/cough	76.8	22.4	0.8

Source: MoHSS, Macro International, 2008a

Note: No observations for private non-profit sector

5.5.3 DELIVERY

Table 10 shows what type of facility women choose to deliver their babies. A high percentage of Namibian women (82 percent) deliver in an institutional setting with a qualified health professional. Of these women, the clear majority (77 percent) seek maternity services in a public facility, while only 5 percent use a private facility. Nearly one in five women (17 percent) deliver their children at home, likely due to transport issues, which is one of the reasons for the high maternal mortality in a country

with relatively high levels of per capita health spending. The heavy reliance on the public sector for deliveries is not surprising, given that PSEMAS requires public facilities to provide inpatient services, including deliveries. PSEMAS also allows the beneficiary to have her private physician deliver at the public hospital. Private health insurance, on the other hand, covers only the 6 -7 percent of the population that has a lower total fertility rate (TFR), explaining the lower use of private sector hospitals for births.

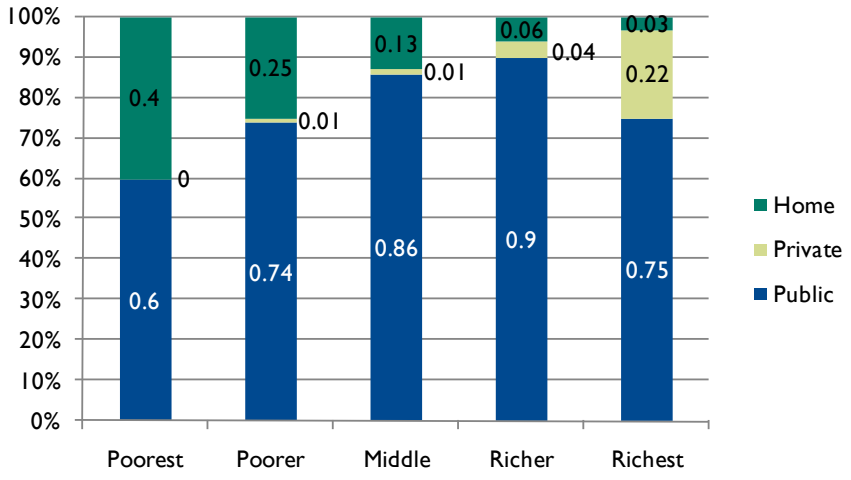
TABLE 10: PLACE OF LAST CHILD'S DELIVERY BY SECTOR (%)

	Source of service			
	Public	**Private for-profit**	**Home**	**Other**
Place of last child's delivery	77.3	5.1	17.4	0.2

Source: MoHSS, Macro International, 2008a

Figure 18 illustrates the income levels of women who have their babies delivered in the public and private sector respectively. The highest percentages of women who deliver at home are from the poorer and poorest income groups (40 percent and 25 percent). Similarly, the highest percentages of babies delivered in private facilities are born women in the wealthiest income groups. What is unexpected, however, is that more rich women deliver in the public sector than poor women (75 percent and 60 percent respectively).

FIGURE 18: PLACE OF DELIVERY BY SECTOR AND INCOME GROUP



Source: MoHSS, Macro International 2008a

6. CURRENT PUBLIC-PRIVATE PARTNERSHIPS IN HIV/AIDS

Health care in Namibia clearly comprises both public and private sector elements. Although formal communication and collaboration between the public and private health sectors has been limited, there is some experience with arrangements that would ordinarily be classified as PPPs. In this section, we discuss these developments and the potential for more extensive collaborations in the future.

6.1 DEFINITION OF PUBLIC-PRIVATE PARTNERSHIP

In general, the partnerships described here, or sought in the future, are collaborative ventures in which resources from public (GRN-owned) and private (for-profit or not-for-profit) entities are combined in order to achieve a health objective. This can include special contracts by which GRN entities obtain selected services from the private sector, or vice versa, but excludes traditional contracts for the purchase of drugs, supplies and equipment, or facility construction. Arrangements with hospitals owned by FBOs (mission hospitals) would ordinarily fit into this definition, but are excluded in this discussion because most mission hospitals in Namibia operate as an extension of the public hospital system. They are heavily dependent on GRN funding, although they retain some management autonomy when compared to hospitals owned directly by the MoHSS.

The health insurance system (i.e., medical schemes) in Namibia, which is described below, would not be considered as a PPP. Traditionally, health insurance policies in Namibia have been operated by regulated not-for-profit medical schemes, administered by for-profit companies, with the larger being related to South African health administrators and funded by premiums paid by individuals and employers. The medical schemes pay claims for medical services obtained from private providers, most of which are "for-profit" entities or individual practices. However, the biggest single medical scheme in the country, PSEMAS, covers public employees and is funded by GRN payments plus modest employee premium contributions. It uses public hospitals for inpatient care but pays private providers and pharmacies for physician care and drugs. Administrative services are provided under contract by a for-profit administrator. Thus, it may be considered a complex PPP. As medical schemes have begun to seek a market among lower-wage formal sector workers, they are paying for some services that this population has traditionally sought from public sector providers. Expansion of "low-cost" medical schemes is, potentially, a form of PPP because it would address the medical needs of a population traditionally served with public sector funds.

6.2 HIV/AIDS CARE CONTINUUM

Addressing the HIV/AIDS epidemic requires a variety of policies and services, from basic education through testing, treatment, palliative care, and support for orphans left behind by parents who die of AIDS. The roles played by the public and private sector vary across this spectrum.

6.2.1 WORKPLACE PREVENTION AND EDUCATION

The largest companies in Namibia (private and parastatal) have well-developed workplace programs, usually with a designated HIV/AIDS or wellness coordinator within the Human Resources Department. The firms offer employee education, provide condoms, and often sponsor periodic voluntary counseling and testing (VCT). For smaller companies, however, such effort is unusual. Within the GRN, AIDS education programs for public employees are variable. Nationally, NABCOA provides a forum for employer efforts to combat AIDS. NABCOA helped to start the Bopehlo! screening initiative (see section 6.4.3) and offered informational sessions on low-cost health insurance plans. It supports employer AIDS education efforts, has received support from the GFATM, and hopes to receive more. Although aware of the "supply chain" approach to making AIDS services available at smaller companies, so far NABCOA has not been particularly successful in reaching these smaller firms.

In broader public education about AIDS, the GRN (generally with donor funding) has worked with private sector advertising and media firms to design and broadcast educational messages. The current campaign to limit multiple concurrent sexual partnerships is direct, explicit, and widely disseminated.

6.2.2 SCREENING (VCT)

Public and private sectors are active in this vital activity, with a notable partnership for the operation of the Bophelo! mobile screening program (see section 6.4.3). A chain of VCT clinics called New Start has been funded by USAID and operated by a U.S.-based contractor, although funds for this effort are now being reduced. HIV tests are widely available in MoHSS and mission health facilities, as well as in private hospitals and physician offices. In the public sector and New Start, HIV tests are free. In the private sector, tests are generally covered by medical schemes, which employ disease management organizations to monitor the care of identified HIV-positive insureds.

Large Namibian employers have contracted for both anonymous seroprevalence testing and VCT. The Bophelo! initiative now brings multi-disease screening to employers, with a sharing of cost between employers and donors. A Namibian who wants to know his HIV status will have no trouble obtaining a test—if he can get to a facility, or has an employer who brings testing to the work site. The biggest problem in identifying new HIV cases is the isolation and travel cost for remote populations, as well as the stigma that still keeps some Namibians from learning their status.

6.2.3 TREATMENT OF AIDS AND OPPORTUNISTIC INFECTIONS

The first patients to receive ART in Namibia were private patients supported by their employers or medical schemes and receiving care from company clinics or private providers. Namdeb has provided ART for its employees for over a decade. But with PEPFAR funding reaching $50 million per year, the public sector treatment program has rapidly outstripped the private sector. In 2007, the number of ART patients in the private sector (including public employees covered by PSEMAS) was probably on the order of 7,000. By September 2008, the number of ART patients treated in the public sector was 58,000, and it has continued to rise.

Although the public and private sectors both treat AIDS, there has been relatively little collaboration between the two. Private patients obtain their drugs from private pharmacists without benefit of the Government's buying power. There is no arrangement to accredit private sector ART providers, such as Gold Star in Kenya, and no program to provide donor-funded ARVs to qualified private patients who receive their care through private providers (as in Uganda and Ethiopia). Private providers can choose between NIP (parastatal) and PATHCARE (private) for laboratory tests. Donor-sponsored training for ART is available to private sector providers, but generally not on a schedule that is tailored to the demands of private practice.

6.2.4 CARE AND SUPPORT

Faith-based and other non-for-profit organizations provide a variety of services to OVC: nutrition, education, and economic and psychosocial support. AIDS support organizations such as Lirongu Eparu offer support for the HIV-positive. Some of these organizations provide palliative care in the community. NANASO, an umbrella NGO Organization, attempts to support and coordinate these efforts. Funds come from a variety of foreign donors and from charitable donations within Namibia.[2] Significantly, the GRN is generally not contracting with these organizations for care and support services. Attempts to create a budget for non-governmental care and support organizations have been unsuccessful.

6.3 FUNDING OF CARE AND TREATMENT

The public sector provides medical care with only modest user fees, and ART patients are not charged for drugs or tests. Private sector providers are generally paid fee-for-service by medical schemes according to a price list updated annually by NAMAF. ARVs (and most prescription drugs) are covered by medical schemes, and the prevailing rate paid to pharmacists is essentially the South African wholesale or production price plus a 50 percent retail markup. A reference pricing scheme is used so that the schemes pay the rate for only the lowest-cost products in the reference group.

6.3.1 TRADITIONAL MEDICAL SCHEMES/HEALTH INSURANCE

Traditionally, private sector medical schemes have been offered through employers, who pay a percentage (often 50 percent) of the premium for the plans. Employees pay the rest of the premium. Benefits are generally extensive, with the lower-cost schemes having lower annual benefit caps. With this benefit structure, the employee share of the premium was sufficiently high that most lower-wage employees elected not to join a scheme even when eligible. Casual and contract employees are not eligible for employee-sponsored coverage. Uninsured workers have paid for some modest private sector medical costs OOP but fall back on the public sector for expensive care.

At the end of 2004, some 132,000 Namibian were enrolled in private medical schemes, both closed (limited to a particular company or industry) or open to any employer or individual. A further 118,000 civil servants and their dependents were enrolled in PSEMAS (Feeley et al. 2010). PSEMAS provides a full package of outpatient benefits in the private sector plus inpatient care in private beds in public hospitals. This is technically not a medical aid scheme, as the Ministry of Finance (MoF) funds all costs not covered by employee contributions; PSEMAS is not subject to the solvency requirements governing regular medical aid schemes. Like private medical schemes, PSEMAS pays claims fee-for-service and employs a for-profit administrator to do so. Combined, PSEMAS and the private medical aid schemes provided coverage for 12 percent of the Namibian population at the end of 2004.

6.3.2 LOW-COST SCHEMES

With stable enrollment, medical schemes began to look at offering lower-cost health insurance options as a source of growth. Some large employers encouraged them to do so, and the GRN said a few encouraging words. However, unions did not press for health insurance coverage in collective bargaining, instead emphasizing wage increases, pensions, and job security.

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[2] For purposes of both individual and corporate income tax, a donation to an approved "welfare" organization is deductible from gross income in determining taxable income. However, contributions to religious organizations and non-profit organizations in general do not qualify for such deductions. Both the MoHSS and the Ministry of Finance must approve the application of a non-profit to be recognized as a "welfare" organization so that donors can receive a tax benefit.

In 2004, the first low-cost medical scheme, Diamond Health Services, was introduced. It used a limited network of primary care providers paid on a capitation basis. The providers were obligated to provide both primary care and necessary pharmaceuticals. The scheme encountered regulatory obstacles, because it was not licensed as a medical aid fund. Over time, these problems were resolved by integration with an existing medical aid fund, Namibia Health Plan (NHP), thus creating the Blue Diamond health plan. The mode of payment was modified to an inclusive fee per visit, covering both drugs and professional services. AIDS care is paid for separately on the standard NAMAF fee schedule.

Other low-cost schemes followed Blue Diamond into the market. One scheme, Vitality, covers HIV care only and was initially offered in 2006 at N$30 per worker per month. To avoid adverse selection, the employer is required to purchase coverage for all its uninsured workers. In pursuit of its objective to expand access to AIDS care through the private sector, PharmAccess partially subsidized premiums for the low-cost policies.[3] All of the policies offered full coverage for first-line ART as a standard benefit, with various additions for broader outpatient care or limited inpatient services.

The PharmAccess subsidies ended in 2008, with some 16,000 Namibians covered by the low-cost policies. A number of large companies purchased the Vitality product at the end of 2006, but growth since then has been slow. The first low-cost plan, Blue Diamond, reports 7,500 members and continuing slow growth in enrollment in 2010. The low-cost plans have added just less than 1 percent of the population to private insurance, so that the total privately insured is now perhaps 13 percent. Growth has been slower than desired for two reasons: the policies (other than Vitality) that have a reasonably broad benefit are still too expensive for most lower-wage workers when the employer pays only 50 percent of the premium; and, the unions have still not pushed hard for expanded insurance coverage. There are indications that some unions may soon back a new low-cost plan in which they have an interest. If this happens, Namibia might see a surge in enrollment long sought by the advocates for low-cost health insurance.

6.3.3 RISK EQUALIZATION FUND

Recognizing that the risk of HIV infection varies widely across different employment groups, one medical scheme tried to form a risk equalization fund to spread the HIV risk across a broader number of insured groups. An "HIV reinsurance premium" would be paid into a central fund for each insured, and this fund would be used to level out the cost of AIDS coverage between different groups. This seemed a reasonable way to share risk and reduce the cost of providing insurance for AIDS services for high-risk groups. PharmAccess provided support for the establishment of this risk equalization fund. However, other players in the insurance industry were suspicious of the motives of the insurer that initiated the idea, and the risk equalization fund now operates only within the plans controlled by one medical aid scheme.

6.4 PARTNERSHIPS TO PROVIDE CARE AND TREATMENT

Described below are three specific public/private initiatives for patient screening and treatment. Beyond the projects discussed, and the existing mission hospital contracts, the PSA team did not identify any other PPPs, nor did it find a policy or mechanism to encourage new partnerships. The MoHSS has been approached by the International Finance Corporation (IFC), which has described the PPP for construction and operation of the apex hospital in Lesotho (now under construction), but no specific proposals are currently in discussion.

[3] Except Vitality, because it did not provide a general primary care benefit.

6.4.1 ORANJEMUND

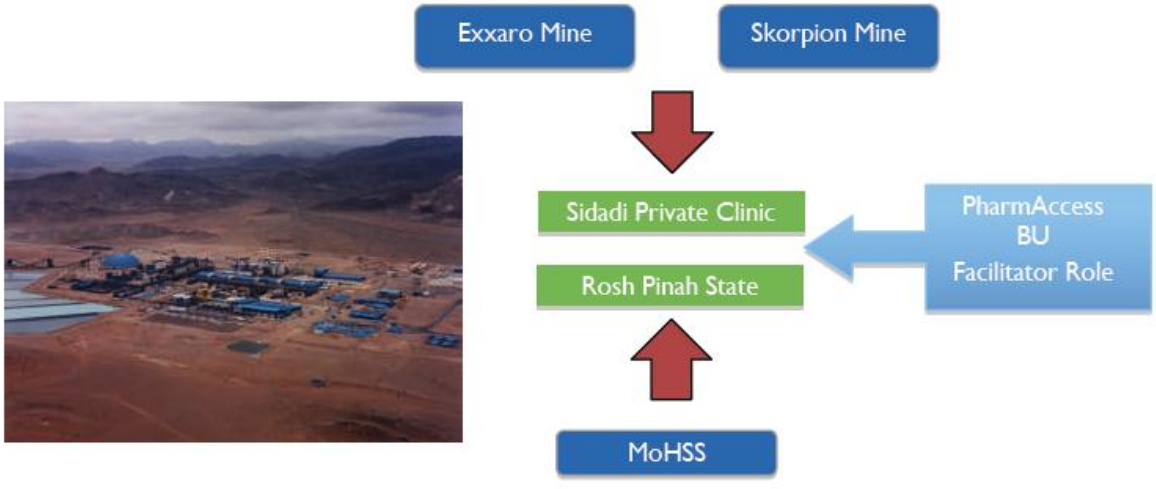
Oranjemund is a "company town" located in the Sperrgebiet—the restricted diamond area, which is off limits to those without the proper permit. To serve its workers in this isolated location, Namdeb, the diamond mining company that is a joint venture between DeBeers and the Namibian Government, runs its own hospital and clinic, Oranjemund. MoHSS runs a primary care clinic in the town for those who are not employed or insured by Namdeb. When these patients cannot be treated by the nurses at the public clinic, they are referred to the Namdeb hospital, and MoHSS pays for their care under a negotiated agreement. Patients are being seen at the Namdeb facility, but MoHSS worries about the costs and is concerned that gate keeping may not be effective.

6.4.2 ROSH PINAH

As with Oranjemund, the proposed partnership at Rosh Pinah is an attempt to give public patients access to mine-based medical facilities, rather than forcing the patients to travel long distances to a public facility or imposing high costs on MoHSS to bring additional services to an isolated mining town. The fully equipped outpatient clinic created by the two mines at Rosh Pinah has two physicians and a full range of support personnel. It also has basic diagnostic equipment (X-ray, ultrasound) that is not available at the nurse-staffed public clinic, which provides only primary care and uncomplicated deliveries. Chronic patients who require physician care (including all AIDS patients) are seen by MoHSS doctors, who must travel 250 kilometers from Luderitz twice a month. After an accident or in an emergency, public patients must be transported by ambulance to Luderitz for tests or physician treatment.

Representatives from MoHSS, the Skorpion Mine, and the mine clinic have been meeting regularly for six months to identify and develop service-sharing arrangements. Agreements for sharing of waste disposal and autoclaving services are close to completion, and discussions of costs and referral procedures for shared clinical services continue. PharmAccess Namibia, with support from Boston University, plays a key role in convening these discussions and staffing the follow-up activities. Perhaps in the long run, a successful partnership at Rosh Pinah could operate a facility serving both public and private populations, rather than MoHSS investing in an expansion of public facilities in a community whose life span will be limited by the economic viability of the ore body.

FIGURE 19: ROSH PINAH PARTNERSHIP MODEL



The rapidly expanding uranium mine at Rossing offers a similar opportunity for partnership. The Rossing mine is building a hospital/clinic at the site; there is no public hospital closer than Swakopmund. The

current expectation is that this hospital will serve public as well as mine patients when completed, but no formal partnership agreement appears to be signed as yet. Private hospitals outside Windhoek have expressed an interest in serving public patients, and might grant discounted rates for such care, but the MoHSS has generally not been interested in such arrangements and has restricted agreements to the mission hospitals in which MoHSS remains the dominant partner.

6.4.3 BOPHELO!

Bophelo! is a "classic" PPP to facilitate the screening of the population for HIV and other diseases. Two mobile testing vans are owned and operated by NABCOA and PharmAccess Namibia, which manages the venture. The vans are licensed as screening clinics by the MoHSS. Patients are screened for a variety of conditions—hypertension, high blood sugar, high cholesterol, syphilis, hepatitis B—as well as HIV. TB risk questions are included in the medical screening. This helps to reduce stigma because a patient is not visibly identifying himself or herself as at risk of HIV infection.

FIGURE 20: BOPHELO! MOBILE CLINIC AT A RURAL SITE

For follow-up, patients are referred to private providers, if they have medical scheme coverage, or to public clinics. NIP provides quality control testing and monitoring. Since early 2009, the vans have travelled to work sites and remote agricultural locations, screening over 6,000 patients. A portion of the costs is paid by employer fees, the rest by donor funds—mostly from a GFATM grant. NIP has contributed the monitoring costs. A memorandum of understanding (MOU) between NIP, NABCOA, and PharmAccess Namibia documents the partnership. USAID commissioned an evaluation of Bophelo!'s cost per patient compared to a fixed-site program, New Start, that is entirely donor (USAID)-funded. The evaluation found that the mobile testing program was only slightly more expensive for each person tested ($ 60.57) than the fixed-site testing program ($58.22). This difference is largely explained by a difference in price for VCT testing kits, which were available at lower cost to New Start through the USAID-sponsored Supply Chain Management System. Employers paid for over one-third of Bophelo! costs, so the per capita donor costs were substantially lower for Bophelo! ($37.73) than those at New Start ($58.22). In addition, clients incurred no costs at Bophelo!, whereas New Start clients had to pay for transport and/or take time off from work.

6.5 DISCUSSION ON PPPS IN HEALTH

The MoHSS has had some experience with PPPs in health care, such as arrangements with mission hospitals or contracting out support services for its facilities, such as catering. Beyond the mission hospital relationships, there are few formal partnerships for provision of clinical services, and these examples are described above. When short of staff with the necessary skills occasionally, the parastatal NIP turns to private pathologists. Arrangements to use a machine or service in one sector for a patient from the other sector are occasionally made, but these are generally not documented in formal agreements. An exception is the only oncology service in the country at this time, located at the Central Hospital in Windhoek.

For financing of health services, the split between the public and private sectors is still quite clear, although blurred by the structure of PSEMAS. To date, the GRN has played no role in the development of the low-cost health plans, and it provides no incentives for their expansion. The SSC is investigating the possibility of a national health insurance plan, but as yet there have been no discussions of such an initiative with industry or the medical schemes. There was no representative from the MoHSS at a recent national conference on micro-insurance, which is part of a national strategy to expand health services for the poor in other countries. Yet senior officials continue to speak of the need for private employers to do more to provide health care for their workers.

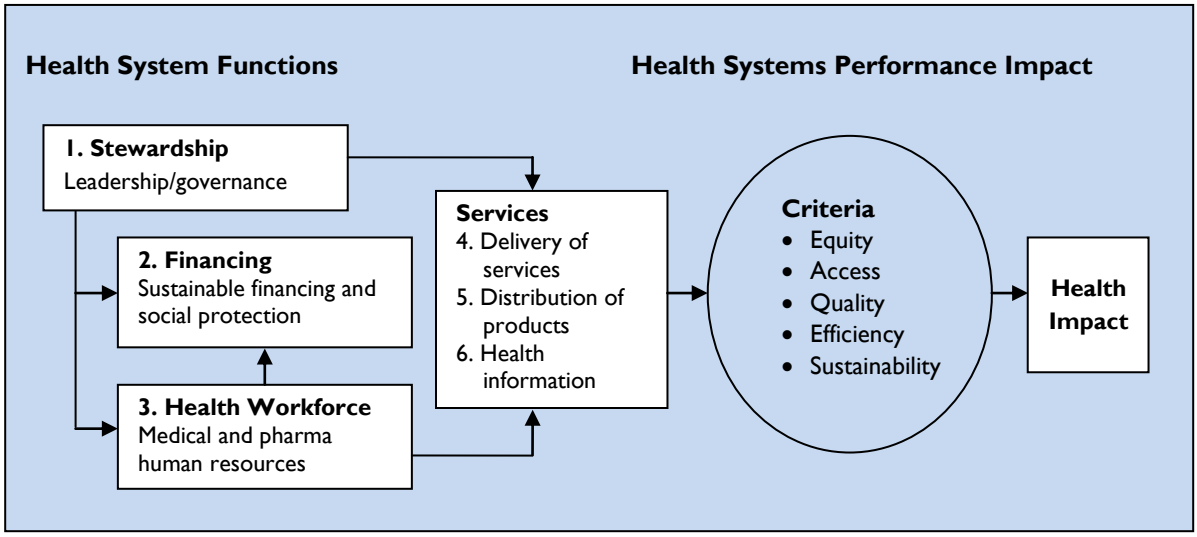
While supportive of partnerships in general pronouncements, and in occasional specific arrangements (Rosh Pinah, Oranjemund), the GRN has not mobilized the staff support or leadership to create a PPP policy or forum. The regulatory regime controlling the private health sector functions quite well—better than in many developing countries—and has not attracted great attention or pressure for reform. Despite occasional statements of concern about private sector providers who do not follow national AIDS treatment guidelines, the GRN continues to focus its efforts on expanding ART through public facilities, rather than through PPPs or more-effective regulation of the private sector. Perhaps this is understandable. Namibia has an enviably low rate of OOP health spending, and the proportion of AIDS patients requiring treatment and actually receiving ARVs is very high. Moving toward an expansion of true partnerships may be a diversion from the GRN focus on public facilities and public services.

Though never explicitly stated, the general impression emerging from stakeholder interviews was that the GRN views the private health sector as having a secondary role, serving a small and privileged portion of the population, whereas the public sector is the primary provider of health services. However, the 1998 Policy Framework established that the sectors are in fact equals, and current national policy continues to assert that the sectors shall co-exist in accordance with the mixed economy policy of government.

7. KEY FINDINGS AND RECOMMENDATIONS

The PEPFAR Reauthorization emphasizes the importance of health systems strengthening in achieving and sustaining HIV/AIDS prevention, treatment and care objectives. This assessment has demonstrated that the private sector is an important part of the health system in Namibia, and is in fact poised to play a greater role in ensuring the sustainable provision of essential services, such as HIV/AIDS services, as donor funding is scaled back. It is within this context of health systems strengthening that we present findings and recommendations according to the WHO health systems building blocks (Figure 21). These findings and recommendations were further refined to inform the following section on strategic investments on the part of USAID to maximize the contributions of the private commercial sector in Namibia.

FIGURE 21: ADAPTED WHO HEALTH SYSTEMS STRENGTHENING FRAMEWORK



7.1 STEWARDSHIP (DIALOGUE, POLICY AND REGULATIONS)

Key findings

- The policy environment supports private sector provision of health care.
- The policy environment does not present major barriers to entry or continued presence in the HIV/AIDS marketplace.
- However, the public and private sectors appear to operate in two parallel universes rather than in tandem in support of the national response to HIV/AIDS.
- This absence of coordination poses a challenge to fostering greater private sector engagement, and collaboration between the sectors.

- While there is openness among key individuals within the MoHSS, obstacles exist:
    - Unlike in other African countries (Nigeria, Uganda, Ghana, and more recently, Kenya) there is no existing policy framework, so guidance is lacking on how the public and private sectors could work together.
    - No clear agenda prioritizes areas for PPPs.
    - The MoHSS lacks the capacity to identify, establish, and monitor PPPs that bring "best value" (e.g., cost-effectiveness and health impact).

Recommendations

The team proposes a three-pronged approach to foster integration of and better coordination between the public and private sectors:

1. Foster dialogue between leaders and champions from the different sectors.
    - There are several African examples of successful dialogue processes between the public and private sectors, including Kenya, Ghana, Mali, and Tanzania.
    - The team recommends structuring a short process that brings together the respective leaders in HIV/AIDS and creates a "level playing field" between the sectors.
    - The process can be used to identify mechanisms to foster meaningful dialogue and to develop an agenda of priorities to help foster continued collaboration.
2. Create a policy framework for PPPs in HIV/AIDS and other key health areas.
    - There are a growing number of PPP policies and frameworks emerging from the developing world that can serve as the basis of a joint activity between the two sectors. Examples include Ethiopia, Kenya, Uganda, Nigeria, South Africa, and India (Uttar Pradesh), to name a few. Ghana, Mali, and Malawi are in the process of developing their own PPP frameworks.
    - The team proposes pulling together a group to: draft a framework, vet it with all the sectors, and finalize it.
3. Build MoHSS capacity to engage the private health sector.

Public sector interest in working with the private sector underscores the need to: i) create a regulatory framework permitting the government to transact with the private sector, ii) hire different staff profiles (e.g., economists, lawyers, MBAs) to create the capacity to work with the private health system, and iii) establish new policies and procedures.

- The MoHSS also needs to build skills in these new areas, as well as raise awareness among national- and district-level staff of the benefits and opportunities involved in partnering with the private health sector.
- The team proposes developing an institutional strategy to build the internal capacity to effectively engage the private sector—one that will: a) build commitment and support for working with the private health sector, b) create organizational structure, c) develop the policies and procedures, and d) train staff in PPPs.

7.2 FINANCING (SOCIAL SECURITY AND INSURANCE)

Key findings

- Although there is a well-established private sector health insurance industry, over 50 percent of the formally employed do not have health insurance. It is estimated that this is even higher in the informal sector. Health insurance for employees is neither mandatory nor required for tenders/concessions/ trade licenses, etc. The voluntary nature of enrollment is not conducive to large-scale health insurance coverage.
- Recent surveys have suggested that willingness to pay for health insurance is moderate (e.g., household surveys/farmer surveys and formal sector employer/ee surveys). However, what respondents are willing to pay is lower than the cost of the most affordable health insurance, which means there is a gap.
- A previous experiment in Namibia on health insurance for low-income wage earners achieved moderate success and proved the principle that temporary subsidy of health insurance premiums increases employers' and employees' willingness to pay for health insurance over time.
- The private health insurance industry is willing to develop low-cost health insurance options.
- However, there are certain market factors that deter the private health insurance industry from growing. Between the years 2006 and 2008, the private sector offered a successful HIV-only health insurance product (Vitality) for approximately US$2.40 per month. Free public sector treatment, however, decreased the demand for such an insurance product. Employees/employers do not receive a tax benefit for the provision of health insurance. Employees are taxed as part of the benefits tax.
- The SSC has tabled national health insurance as a priority for a few years, but little progress has been made in finding a suitable health insurance model. The private sector has had minimal involvement in these discussions. The SSC has demonstrated the ability to collect premiums and handle claims for death, maternity, and sick leave benefits, from over 480,000 beneficiaries. No health insurance is offered. This could be an opportunity for a national health insurance scheme.

Recommendations

1. Support dialogue between the MoHSS and private health insurers to explore expansion of Vitality and/or other low-cost health insurance for the uninsured employed population and their dependents to reduce the cost of public sector treatment. As part of this approach USAID and/or other donors may want to explore the possibility of time-limited donor subsidies (3-5 years) to scale up access to affordable health insurance.
2. Support dialogue between the private health insurance industry, the MoHSS, MoF, and SSC to explore the possibility of starting a health insurance component within the SSC—initially covering HIV and opportunistic infections and later expanding to include primary care and eventually including secondary (inpatient) care. Encourage the GRN to make health insurance mandatory—either through private health insurance or by covering the uninsured through the SSC (this could be a precursor to national health insurance).
3. Support dialogue between the MoF, employer federations and the MoHSS to amend taxation regulations to incentivize employers/employees to acquire health insurance; and explore other incentives.

4. As an alternative to the SSC as a basis for national health insurance, the GRN could consider a tax levy similar to the VAT levy (2.5 percent) for health insurance in Ghana.
5. Support MSH and the MoHSS in analyzing a possible shift in the treatment burden between public and private sectors, with expanded health insurance in the formal sector.
6. Negotiate to get ARVs at zero cost or at the GRN procurement price to beneficiaries in low-cost systems (including the new union plan, if this is moving). Existing disease management programs could play a role here.

7.3 HEALTH WORKFORCE

Key findings

- The private sector accounts for 47 percent of the health care workforce in Namibia. The public-private mix of health care professional varies by cadre.
- There are twice as many doctors working in the private sector as in the public sector.
- Almost all—90 percent—of the pharmacists are in the private sector.
- There are a high proportion of foreign nationals working in the public sector. These health professionals are almost exclusively doctors and pharmacists and are supported with PEPFAR funding.
- There is a severe shortage of social workers in the public sector. The few social workers in Namibia work in the not-for-profit sector.
- The private health care providers represent an untapped resource, which could be mobilized.
- Namibia recently opened a public medical school and will complete its first year of physician training this year. UNAM also plans to open a pharmacy school. Many Namibians will continue to seek medical education in South Africa and other countries, risking further loss of Namibian health professionals to other countries. Moreover, it will be years before the UNAM will produce adequate levels of physicians and other health professionals to address the human resource crisis.

Recommendations

While the GRN ramps up to produce sufficient numbers of health professionals to staff its health market, there are a few short-term strategies to address the human resource shortage.

1. Build capacity of existing private providers. Make donor-supported training available to a wide range of private practitioners: physicians, nurses, pharmacists, social workers.
2. Equip private nurses and other lower-level health workers to do more in HIV/AIDS in their private practices, through task shifting. Steps include:
    - Revising the laws to increase nurse and health professional cadres to expand their scope.
    - Strengthening nurses' and other health professionals' clinical skills.
    - Improving these private providers' business skills so they stay in private practice.
    - Facilitating access to finance so they can invest in quality improvements and expand their practices.

3. Expand supply of health workers by:

    - Working with other SSA countries to harmonize pay scales in the public sector, thereby decreasing emigration of Namibian health workers to Botswana, South Africa, and other countries in the region.
    - Creating incentives for trained workers to return to/stay in Namibia.
    - Making medical school more affordable, by developing appropriate loan products with better terms, such as a longer repayment period (SHOPS activity in Uganda is a potential model).
    - Exploring feasibility of loan forgiveness if graduates stay in the public sector, particularly if they serve in rural areas.

7.4 SERVICE DELIVERY

There are three non-state sectors engaged in service delivery: the FBO, NGO, and commercial sectors. Key findings and preliminary recommendations are presented for each group.

Commercial Health Sector

Key findings

- The private sector is small but sizable. The recent 2008/09 NHA shows that the Namibian private health sector represents one-third (32 percent) of THE.
- However, only 9 percent of THE_{HIV} goes to the private health sector.
- There are more private than public facilities (844 compared to 333). However, the majority of these private facilities are consultation rooms for solo practitioners.
- The private sector providers account for 47 percent of the health care workforce in Namibia. When looking at the different health professions, there are twice as many physicians in the private sector as in the public sector. Almost all—90 percent—of the pharmacists are in the private sector. The majority of private health care facilities and providers are concentrated in urban areas.
- In addition to private providers, there are a number of private employers that deliver health care services to their workers, and, in some cases, the communities where they operate. Some larger workplaces have company clinics that serve employees on site but do not offer these same services to dependents or the community. Other large employers, such as many mines, have private health facilities that are available to employees and their dependents but not the community. Most companies that provide health care benefits to their employees do so not through health insurance/ medical aid funding. A large majority of businesses do not offer health services and/or provide health care benefits to employees (and/or employee dependents).

Recommendations for Commercial Health Sector Services

Namibia has a unique geographic setting that in effect, creates four different countries in one. Given the geographic diversity, the team proposes different strategies by zones to strengthening a private sector response. Table 11 maps out the four different zones and the strategy needed to mobilize the private sector. These approaches take into consideration the socioeconomic conditions, public and FBO facilities, and private sector presence.

A precondition for these strategies to succeed would be formulation of a workplace policy, in concert with the private health sector and industry, requiring all employers to provide a minimum package of health services to their employees.

TABLE 11: RECOMMENDED STRATEGIES BY ZONE TO HARNESS THE PRIVATE SECTOR

Zones	Private Sector Strategy
Urban areas/densely populated, affluent income groups/high concentration of private sector	For the most part leave it as it is: the private commercial sector is reaching its intended segments, i.e., upper- and middle-income groups that have access to health insurance and medical aid. There is a need, however, to create an affordable private health service for lower-income groups—mostly through developing primary care providers (qualified nurses) and supporting worker-accessible clinics.
Remote, isolated areas/highly concentrated population, working-poor income groups/limited access to health services in the public or private health sector	Foster PPPs based on the Rosh Pinah model, which leverages both public and private sector resources to deliver needed health services to workers and the surrounding communities. Offering a minimum package of health services should be a requirement for all leases with extractive industries entering Namibia.
Remote, rural areas/dispersed population, poor and poorer income groups/limited access to public or private health services	Promote and scale up mobile clinics like the Bophelo! model, in which these health services are funded by employer contributions and/or government contracting.
Northern rural areas /moderately dense population, poor income groups /negligible private sector presence	Establish low-cost private health worker models (nurses, health technicians) by creating incentives for retired nurses in rural areas and/or encouraging nurses and other health care professionals from urban areas to relocate.

FBO Sector

Key findings

- FBOs in Namibia are not considered private sector (i.e. not-for-profit) entities, because of their heavy reliance on public funding and close alignment with MoHSS policies and procedures. With the introduction of PEPFAR funds, FBOS have become an important provider of HIV/AIDS-related services including prevention, care, and treatment, and palliative care.
- Increasingly, the financial sustainability of FBOs is in question. While public funds have covered FBO operating expenses as outlined in MOUs, these funds may be declining. FBOs are highly dependent on PEPFAR funds to carry out HIV/AIDS services. There is minimal recognition from FBO leadership on the need to diversify funding sources, resulting in no strategy and/or plan in place to increase financial sustainability.

Recommendations for FBO Sector

FBOs are a critical player in the service delivery landscape and merit support to continue their high-quality services that reach rural and poor population groups. It is unrealistic, however, for the FBOs to plan on receiving increased MoHSS resources to cover 100 percent of their operating expenses, including the newly established HIV/AIDS services and programs.

Moreover, even if the FBOs did receive 100 percent of the funds promised in the MOUs, this still would not address the structural issue, which is that MoHSS District Management teams still make all funding and other resource allocation decisions. FBOs still have to compete with MoHSS facilities for their share of the resources.

In light of decreased levels of PEPFAR funds in Namibia, the team recommends working with FBO leadership to explore scaling up promising cost-recovery schemes and pilots underway. Examples include:

- Subsidizing mission services with profits earned at the private Catholic hospital in Windhoek; subsidizing hospital costs with revenues from patients in the private wing.
- Offering concessions and/or leasing arrangements with private providers to use FBO hospital facilities.
- Negotiating with PSEMAS to get reimbursed for public sector employees who receive care in an FBO facility.

NGO/CBO Sector

Key findings

- The rapid influx of and large size of PEPFAR funds have created a plethora of CBOs and NGOs working on a wide range of HIV/AIDS-related issues and programs. Clearly, the majority rely heavily on PEPFAR funds for their existence. A small percentage of these NGOs, particularly those working with OVC, do receive limited financial support from the public sector (MoGECW and/or local governments). Others receive in-kind support from the commercial sector, but it tends to be informal contributions and ad hoc in nature.
- The bottom line is that many of these NGOs/CBOs are at financial risk of going under because of limited financial resources from either government or private sources, and eventually, decreasing international donor support from GFATM and PEPFAR.

Recommendations for NGO/CBO Sector

There are two challenges to address regarding the NGO/CBO sector: 1) the myriad of small NGOs/CBOs have difficulty reaching scale and therefore, ultimately, impact; and 2) NGOs/CBOs need to decrease their reliance on international funding sources.

1. Consolidate the marketplace of NGOs/CBOs through certification and competition.
    - The MoGECW has established certain criteria that certify an NGO's authenticity. The team recommends building on the MoGECW system to create a certificate that could guide commercial donations to legitimate NGOs with need. The certification suggested for OVC NGOs could also be applied to NGOs who provide HIV education, support groups, condom distribution, peer education training, etc. These NGOs could have a defined "professional" service offering, which could be marketed to organizations for a fee.
    - Using a competitive grant process, consolidate NGOs based on their key competencies and their ability to go to scale. Supplement the grants with technical assistance to professionalize services, especially for prevention, education, and treatment, and offer these services at a fee to both the public and private sector, to reduce reliance on donor funding.

2. Formalize private sector contributions to NGOs delivering care to OVC

    - The GRN will continue to fund certain aspects of OVC programs, but it is highly unlikely that they will contract out and/or increase funding for NGOs to deliver critical services needed in both OVC and HIV/AIDS. Therefore it is important is to harness private sector contributions.

3. The team recommends structuring and formalizing ad hoc donations to NGOs.

    - As referenced above, extend the MoGECW "Certification program" of NGOs. Many private businesses hesitate to donate to NGOs because they are unsure whether the NGOs are legitimate enterprises; or businesses tend to give to the few "known" ones because of personal relations. A certification process that guarantees an NGO's institutional integrity and competency will help address Namibian industry's concern about whom to donate to and whom to avoid. In addition, the certification can give added weight and/or points to those NGOs based on need. For example, a legitimate OVC NGO in a rural area would earn more points than one in an urban area.

    - Another key area requiring "structure" is in-kind donations. Many NGOs/CBOs state that they get "one-off" types of donations, such as food, or school supplies. The team recommends creating central warehouses and distribution centers, similar to those in the US such as "food banks," where a wide range of businesses no longer have to search for a worthy cause but can instead drop off on a regular basis excess food, office supplies, school materials, etc. The warehouse could in turn distribute these supplies among certified NGOs/CBOs according to need, eliminating the oversupply of a few NGOS and undersupply of others.

4. The team also recommends building an understanding among industry and NGOs of laws governing tax contributions, to encourage cash donations by businesses and/or business contributions to fundraising initiatives. Currently, organizations can register as welfare organizations and any contribution by a company to a welfare organization is tax-deductible. However, not all NGOs are registered as welfare organizations. Helping the consolidated NGOs, or "mega" NGOs, register as a welfare organization will help increase contributions, since these will be tax-deductible. Registering a selective number of NGOs as welfare organizations will also help reduce the number of NGOs. The clearinghouses and food banks referred to above should also have a welfare organization status to ensure that the donors receive the tax benefit.

7.5 MEDICAL PRODUCTS (ARVS)

Key findings

- A recent study by MSH presented the key cost drivers to private sector provision of HIV/AIDS care. Affordability of ARVs was the major driver. There are many reasons why ARVs are so costly in the private sector:

    - Heavy reliance on physicians: a doctor needs to initiate ART and dispense drugs.
    - Not enough service providers are located in rural areas, creating barriers to access.
    - Lack of subsidized or free ARVs available to private providers to offer to their patients.
    - The 50 percent mark-up and special packaging requirements further drive up the cost of brand-name ARVs.

Recommendations

1. Set up a forum involving all stakeholders in the supply chain—research and development manufacturers, pharmaceutical wholesalers, distributors, and retail pharmacies and health care providers—to discuss feasible strategies to reduce the cost of ARVs in both the public and private sectors. Topics would include: pricing, procurement, distribution, retailing, and regulation.
2. Create mechanisms by which the private sector providers can buy ARVs at a reduced price. Possible strategies to help private sector providers get a better purchase price for ARVs include:
    - Private sector providers buy as a group through bulk purchasing.
    - Allow the private sector to tender with the public sector to access advantageous prices offered to the public sector only.
    - Permit the private sector to draw stock at cost from the central medical store that has been procured at international tender prices.
    - Cap wholesale and retail mark-ups on ARVs.
3. The GRN could also allow private providers—who have received training and are certified to be qualified to dispense ARVs—to access donated ARVs in exchange for a greatly reduced price to their clients. This model has been successful in Uganda and Kenya.
4. Encourage private insurers to procure generic ARVs, as recommended by MoHSS, thus reducing overall costs of HIV/AIDS care. The reduction in drug costs would make premiums more affordable for employees. Costs could be further reduced if insurers buy as a group and procure in bulk. However, they would have to set up a distribution network and dispense the ARVs through the pharmacists.
5. Establish a transparent system to monitor and regulate prices of ARVs. Pharmacists and medical aid funds have a system in place to monitor prices. This same mechanism could monitor ARV prices and report to the GRN regularly. An independent body, however, will need to supplement the private sector system to regulate pharmaceutical pricing of the private sector, especially on ARVs and the use of generic ARVs (as per national guidelines).

7.6 INFORMATION

Key findings

- Asymmetry of information and knowledge is one of the greatest barriers to public sector understanding of the private sector. Private providers are not currently reporting service statistics to the national health management information system (HMIS); therefore, national statistics underreport the true size and complexity of the health system. In fact, the MoHSS has not requested private providers to supply information to the HMIS. Interviews with provider associations suggest that private providers are willing to cooperate and report out on key health statistics, providing it is not too labor intensive or time consuming, and that the reporting requirements are clear.
- Information is a two-way street. Many private providers and other health-related businesses stated that they are not included in strategic health planning and policy discussions. As a result, they do not have a good understanding of MoHSS priorities and strategies. This lack of information prevents the private sector from understanding its potential role and contribution to government priorities.

Recommendations

1. Build the evidence base for public-private policy dialogue.

- The PSA is a first step to better understand and document the private health sector. However, the GRN needs basic information to better partner with the private sector, such as:
    - Number, type, location, and services offered by private providers.
    - Number, type, capacity, and location of private facilities.
    - Consumer preferences of providers and their ability to pay for services and/or for health insurance.
    - Inventory of existing PPPs in health, including listing of partners, type of services offered, for what target population groups, at what cost, and under what type of partnership arrangement.
    - The GRN, through a consultative process, also needs to work with private provider associations, FBO/NGO groups and health insurer/medical aid funds to develop a short list of the key health indicators, design a simple reporting format, and establish an easy reporting mechanism. mHealth applications, such as the use of mobile phones for reporting, should be explored. Involving the private sector in this process will encourage them to provide data on a regular basis to the MoHSS.
    - In addition to collecting the basic information, the GRN should ensure the information gets to the appropriate end users, including public sector policymakers as well as private providers. Incorporating the private sector into the national data dissemination process will foster a two-way flow of information.

2. Create a health market research clearinghouse.

- To address the current information gaps in Namibia, and to better disseminate current and future health research efforts, the team recommends that the GRN, or a partnership between GRN and the private sector, create a website that would serve as a clearinghouse of information on the health sector.
- The website would serve multiple functions:
    - Announce planned research studies.
    - Solicit sponsorship of research studies.
    - Share findings and data sets.
    - Create opportunity for cost-sharing and more efficient funding of future studies.

8. STRATEGIC INVESTMENTS TOWARD A GREATER PRIVATE SECTOR ROLE IN NAMIBIA'S HIV RESPONSE

The previous section summarized the key findings that emerged from the PSA, and presented a variety of options organized along the lines of the WHO health systems building blocks tailored to the Namibian context. The GRN and its development partners could pursue many of these recommendations to strengthen the participation of the private sector in the HIV response. This section prioritizes the recommendations, outlining a strategic approach to optimally engage the commercial sector in the HIV response.

8.1 THE CASE FOR EXTENDING HEALTH INSURANCE AND PRIVATE HEALTH SERVICES TO LOW-WAGE FORMAL WORKERS

Namibia has a vibrant health sector that comprises a mix of public and private elements. The health sector is supported by risk pooling operations that are largely private.[4] The low level of OOP health expenditure indicates that the public sector has been able to meet the expressed demand for health services in the rest of the population while charging very low user fees.

But the conditions that underlie this arrangement are changing. The combination of HIV/AIDS with an aging population means that the burden of chronic disease is rising. At the same time, some Namibians, particularly those with little education or living in remote areas, are not receiving the medical services they need if the country is to meet its health objectives. Donor funding has enabled the MoHSS to expand HIV/AIDS services to meet nearly all of the increased need for treatment. But these funds will almost certainly decrease just as Namibia grows into middle-income status and the number of people requiring ART continues to expand.

To meet Namibia's national health objectives and increased need for health care, the volume of services must expand. The GRN could increase spending on the public health system, both to replace donor dollars and permit service expansion. But that will require higher GRN revenues and obligation of a larger portion of GRN budgets to health at a time when many other sectors demand development funding.

An alternative, seen historically as many Western countries developed, would be to expand the system of health insurance and private health provision to the remainder of those employed in the formal

[4] Although funded by the MoF, PSEMAS is generally operated like a private medical scheme.

sector and their dependents. Using either public (national health insurance) or private (medical scheme) risk pools, funds collected from employers and currently uninsured employees would be used to purchase the basic benefit package that these Namibians currently receive from MoHSS. This would free up MoHSS resources to expand the services provided to the poor and those in informal employment.

The moment is opportune for expanding medical aid schemes and increasing access to health services in the private sector for the working poor. At a recent conference, His Excellency President Hifikepunye Pohamba asserted, "The challenge to the private medical aid funding industry is to reach out to a larger constituency of the employed and entice them to membership with greater innovativeness. Every Namibian that is gainfully employed should be able to have access to medical aid cover. As an industry you cannot be content with your current membership. Similarly, it cannot be in our interest to maintain aspects of cherry picking or cream skimming, where those with higher risks get priced out of access to private medical aid coverage. We need benefits, designs, and packages that appeal to all our employed" (Speech at Namibian Association of Medical Aid Funds Conference, 2009).

8.2 STRATEGIC APPROACH FOR EXPANDING PRIVATE HEALTH SECTOR ROLE IN HIV/AIDS

The SHOPS team therefore recommends focusing the USG's efforts on covering low-wage formal sector workers through private medical schemes, while ensuring at the same time that quality, affordable health care services are offered by the private sector. Focusing on extending health insurance to those working in the formal sector is regarded as an achievable goal within a 3-5- year timeframe.

To expand private health services to lower-wage workers will require a number of initiatives. As outlined in Table 12, the attainment of this goal will be realized through four pathways, which also correspond to health systems strengthening building blocks. The four pathways are:

1. Improving MoHSS governance capacity to engage and interact with the private health sector.
2. Establishing and/or expanding low-cost medical insurance schemes that cover basic health and HIV/AIDS services.
3. Increasing the number of and range of private providers delivering quality, affordable health services.
4. Making available low-cost ARVS for private providers to use when delivering services to low-wage workers.

TABLE 12: STRATEGIC INVESTMENT PLAN

Goal	HSS Building Block	Pathways
Low-wage formal workers access quality health services in the private sector through private medical schemes	Governance and Policy	Improve MoHSS capacity to engage and interact with the private health sector.
	Health Financing	Establish and/or expand low-cost medical insurance schemes that cover basic health and HIV/AIDS services.
	Service Delivery	Increase the number of and expand the location of private providers delivering affordable health services, including HIV/AIDS services.
	Health Products	Increase private providers' access to low-cost ARVs for low-income clients.

These pathways address the major barriers to meeting the health needs of lower-income workers through the private sector. On the demand side, the medical schemes will help remove this target group's financial barrier to accessing health care offered in the private sector. Increasing access to subsidized and/or donated ARVs will also drive down the cost of private health care which, in turn, will reduce the cost of medical schemes premiums, permitting a larger number of employers and low-wage employees to purchase them. On the supply side, the proposed strategies will ensure adequate supply of private health care providers to deliver health services at an affordable price to this market segment. The strategy also suggests four different service delivery models to "organize" private providers responding to the geographic challenges present in Namibia. Lastly, the proposed policy initiatives will not only create the legal and regulatory framework required to expand medical aide and services to low-wage earners, but will also lay the foundation for greater public-private dialogue to support other recommendations proposed in the previous section that encourage an expanded role for the private sector.

8.3 ACTION STEPS

Critical to any private sector initiative is demonstrating success quickly. Given the mutual wariness between the public and private health sectors, a "quick win" showing how the two sectors can work together to address a common purpose goes a long way toward building the trust needed for more complicated—and politically sensitive—partnerships. The SHOPS team has therefore divided the activities into near-term (6-12 months) and longer-term (2-5 years) tasks to help build the confidence needed between the different stakeholders.

8.3.1 POLICY

Objective

To create a favorable policy environment supporting greater private sector participation in addressing HIV/AIDS, SHOPS proposes working in three core areas: 1) establish an enduring public-private dialogue process, 2) establish a favorable policy environment through policy reform, and 3) build MoHSS capacity to interact and engage with the private sector.

Near-term policy activities:

Initiate public-private dialogue.

- Identify champions from across the sectors to engage in a public-private dialogue initiative.
- Convene first-ever policy seminar to discuss and prioritize areas for public-private collaboration.
- Convene a committee to organize the policy seminar, identify key stakeholders to attend, and plan the event.
- Present findings from PSA to foster discussion and dialogue on types of PPPs.
- Prioritize policy areas for reform.
- Establish a multi-sectoral Public-Private Working Group (PPWG) to lead the dialogue process emerging from policy seminar.
- Contract a neutral party to lead the PPWG.
- Foster support for public-private dialogue process among leaders and influentials in the different sectors.

- Introduce a charter signed by all the sector leadership.
- Reach agreement on a common definition for PPPs in the Namibian context.

Put into place and reform key policies.

- Create a PPP policy framework that involves widespread participation by all sectors.

Strengthen MoHSS capacity.

- Identify key stakeholders in MoHSS and other relevant ministries interested in learning more on how to interact and engage the private sector.
- Provide opportunities for Namibian public officials to participate in upcoming events on private sector themes (e.g., a SHOPS and Health Systems 20/20 Regional Technical Exchange)
- Link key MoHSS staff to counterparts/PPP units in other countries (e.g., through the SHOPS Network for Africa virtual network).

Longer-term policy activities:

Initiate public-private dialogue.

- Appoint a neutral party (or representatives from both sectors) to lead the process, convene meetings, and work with both parties.
- Build PPWG capacity to work together on range of concrete activities (e.g., reforming policy obstacles, implementing PPPs).
- Provide targeted technical assistance supporting the PPWG's technical activities (e.g., designing a PPP, drafting a proposal for new legislation, analyzing the market to identify PPP opportunities).

Put into place and reform key policies.

- The report identifies several policy areas requiring reform and/or an update, such as decreasing the cost of ARVs, clarifying the laws on charitable organizations, accreditation mechanisms for NGOs, worker/community health services as a condition for extractive industry concessions, and taxation of health insurance as a fringe benefit for employees.
- Work with the PPWG to prioritize, through consensus, which policies require change.
- Provide technical assistance to analyze and propose strategies to reform the priority policies.

Build MoHSS capacity to engage the private health sector.

- Define terms of reference and first-year work plan for a PPP unit to be embedded in the MoHSS or MOF. Establish a PPP desk or unit within MoHSS.
- Create the operational policies and systems to permit MoHSS to transact with private sector (e.g., contracting, vouchers).
- Build staff capacity to implement new operational policies (e.g., training in new skills areas such as contract negotiation and monitoring, PPP design, market analysis).
- Assist the PPP unit to carry out the first-year work plan activities, such as documenting existing PPPs and, designing and implementing new PPPs. (Examples include accrediting private providers to deliver ARVs, expanding mobile clinics, and contracting private practice nurses in underserved areas.)

Build private sector capacity to work with the public sector.

- In similar fashion, it will be necessary to build the private sector's capacity to engage with the public sector.
- Identify key stakeholders in the private sector interested in learning more about how to interact and engage with the public sector.
- Private sector stakeholders need to learn to understand public priorities and "speak the language."
- Link private sector to counterparts in other countries (such as through the SHOPS and Health Systems 20/20 Public-Private Technical Exchange)
- The private sector should not be seen as one entity but as a group of often competing entities, whose interest in PPPs will have to be continuously motivated.

Critical assumption: The success of the policy initiatives depends on open and candid communication between all key stakeholders. As part of this transparency, it will be critical that donors open a full and frank dialogue with the GRN regarding their expectations for financing and implementing the HIV response.

8.3.2 FINANCING

Objective

Establish and/or expand low-cost medical insurance schemes that cover basic health and HIV/AIDS services.

Near-term financing activities:

Negotiate a pilot for subsidized ARVs linked to a low-cost medical scheme.

- A medical aid scheme such as Vitality (which currently has no competitors) could develop a system for distributing GRN-provided ARVs to its providers (i.e., negotiate a lower premium for lower-priced ARVs).
- Providers would need to comply with existing treatment protocols. Vitality or its disease manager would monitor the distribution of the drugs and compliance with protocols.
- In return, Vitality would lower the monthly premium for the policy.

Rebrand and promote existing low-cost scheme.

- This must include marketing to employers (the advantages of prompt private sector treatment/reduced absenteeism) and to employees.
- Many employees need to be taught how to use medical scheme coverage since they have never experienced it.

Develop and price a basic service package for a low-cost plan that all medical schemes would offer.

- The premium estimates should reflect both current ARV/drug prices and prices that could be achieved with pharmaceutical market reforms or provision of certain GRN-purchased drugs (ARVs).
- Encourage integration of nurse-run primary facilities and mobile clinics into low-cost medical schemes.

Longer-term financing activities:

- Consider a national policy to require that employers purchase defined low-cost primary health insurance policies for their workers. This will require definition of a required minimum benefit package (including ART) and establishment of a price point that does not reduce the growth in formal sector employment.
- Consider exempting from the employee's taxable income any employer premium contributions for approved low-cost schemes.
- If the initial experiment is successful, develop a policy, accreditation standards, and a verification mechanism for issuing GRN-purchased ARVs to all accredited providers in low-cost medical schemes.
- Assist faith-based hospitals in developing revenue-generating services (private wards, after-hours clinics), while maintaining public funding and contractual obligations to provide services to the general population.

Ideally one would like to see a minimum benefits package, defined, and costed equally across all medical aid funds as an entry package. This package should include subsidized or low-cost ARVs. All medical schemes should have the benefit of adding this "product" to their selection of health plans. In this way, the playing field would be leveled and all industries/sectors could be reached. It would also allow standardized treatment protocols to be applied across various medical schemes, requiring standard adherence of providers to treatment protocols, drug formularies, and requirements for data collection and reporting. This could in essence be a low-income medical scheme (LIMS). Alternatively, if the private medical aid funds were not interested in this, such an LIMS could be provided through the SSC. In order to make an LIMS attractive, the benefits would have to extend beyond HIV care and treatment and include primary care. This would encourage greater interest from employees and organized labor. The support of the latter would be critical to mass enrollment of private sector employees in a low-income medical scheme.

Critical assumptions: Trade unions must actively support these initiatives. Unless expansion of medical scheme coverage for low-wage workers becomes a priority for the labor movement, there will be little movement. Some employers will resist, and it may be necessary to legislate a requirement for purchase of low-cost scheme coverage.

8.3.3 SERVICE DELIVERY

Objective

Increase the number and broaden the location of private providers delivering affordable health services, including HIV/AIDS services. SHOPS proposes a three-pronged approach that focuses on 1) expanding service delivery models responding to different geographic and/or underserved population groups, 2) strengthening both clinical and business skills of private health care providers, and 3) creating an enabling environment that supports the different private sector delivery models. As first introduced in Section 7, in light of geographic and socio-economic realities in Namibia, we propose a "zonal" approach to increasing access to affordable private health services.

Near-term service delivery activities (following a zonal approach):

- Invest in mobile clinics for rural and underserved areas.
- Establish system for accredited private providers to establish and supervise ART.

Build private provider capacity.

- Make government-sponsored training available to private providers.
- Establish "entrepreneurship" training for private providers.
- Link business training to the UNAM NGO training curriculum.
- Conduct the first round of business training.

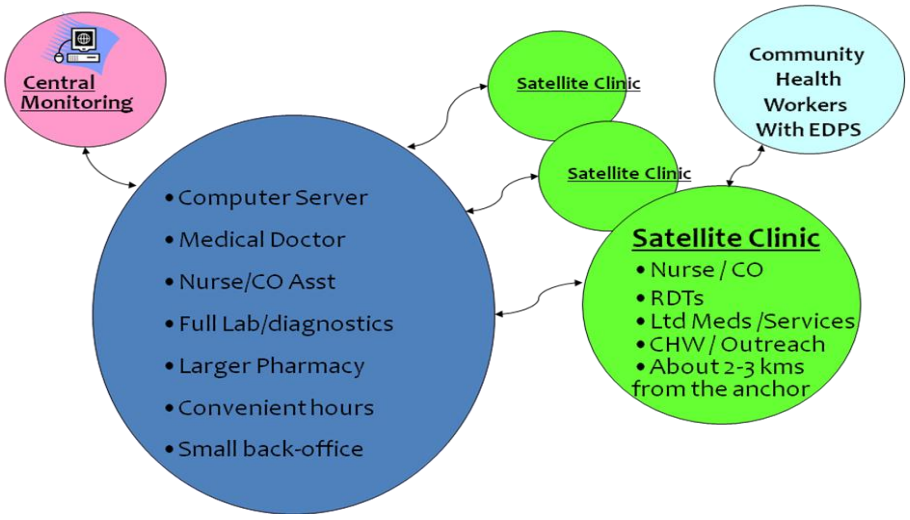
Stimulating investment in health insurance creates demand for health services. The fact that health insurance will be able to pay for services should also boost supply, thus stimulating more private investment into health service infrastructure. However, the reality is that as long as all services are available free of charge, people won't pay for them. And to the extent that people don't pay for services, the private sector will not invest in them.

Longer-term service delivery activities (following a zonal approach)

For rural zones (both densely and sparsely populated):

- Invest in mobile clinics for rural and underserved areas.
- The model is dependent on trained nurse counselor with referrals.
- Explore the feasibility of expanding the mobile model to a fixed clinic staffed with registered nurses and/or physicians. Possible examples to build on include: 1) North Star Alliance, located in northern border areas funded by Canadian and Swedish international development agencies and 2) LiveWell hub and spoke model in Kenya (see Figure 22).

FIGURE 22: LIVEWELL SERVICE DELIVERY MODEL



- Initially provide subsidies to scale up models.
- Link mobile clinic model to medical aid schemes.

For urban, peri-urban, and working poor/low-income zones:

- Invest in nurse-run clinics with off-site services as model for peri-urban centers.
- Explore strategies to network with and organize individual practitioners.
- Build capacity (see below).
- Link to medical aid schemes.

For rural remote/concentrated zones (e.g., mining towns):

- Support and document the Rosh Pinah partnership model.
- Replicate the partnership model as part of concession agreement for new mines.
- Build operational policies within the MoHSS to facilitate partnerships with mining companies.

Build private provider capacity:

- Strengthen HIV/AIDS Clinicians Society capacity to spearhead capacity-building activities.
- Map out and identify private providers interested in expanding health services to low-income wage earners.
- Building on donor-sponsored curriculum, adapt training to meet the needs of private providers.
- Link training to continuing medical education requirements.
- Establish "entrepreneurship" training for private providers.
- Conduct a business training needs assessment.
- Adapt the existing business training curriculum conducted in Uganda, Zambia, and Nigeria to the Namibian context.
- Work with medical and nursing societies and UNAM/Polytech to conduct entrepreneurship training.

Create an enabling environment supporting new private providers:

- Increase access to affordable loans to aspiring doctors, pharmacists, and nurses.
- Establish a strategic relationship with key Namibian banks to provide access to loans.
- Work with banks to create loan products targeted to private health care providers.
- Provide initial training to banks to issue loans.
- Work with private providers to help them with loan process.
- Link loan programs to USAID's Development Credit Authority and/or the IFC's new debt programs.
- Help private providers make market linkages to local government, banks, and medical suppliers.
- Conduct trade fairs in key geographic areas (peri-urban and remote densely populated) to connect private providers with local government, medical supplies, medical aid schemes, and private distributors of drugs.
- Help private providers access favorable leasing terms for needed medical equipment and supplies.

- Market and promote private providers as viable source of health care.
- Carry out consumer awareness campaigns on benefits of medical aid schemes.
- Carry out consumer awareness campaigns on availability of new services through certified private providers.
- Carry out consumer awareness to promote nurses as a good source of health care to consumers.

Foster policy reforms that:

- Ensure standards and regulations that permit nurses and other para-skilled health care cadres (clinical officers, pharmacists assistants, etc.) to provide basic health care services, including key aspects of HIV/AIDS care.
- Develop model contracts for local/national government to purchase services from qualified private primary care providers where public facilities are nonexistent.
- Facilitate entry into private practices.
- Create incentives to deliver care to low-income earners (e.g., certificate of need, tax breaks).

8.3.4 PRODUCTS

Objective

According to the MSH cost analysis of HIV/AIDS services in the private sector, the price of ARVs is the major driver of cost of services in the private sector. Therefore, the SHOPS project recommends different strategies to help drive down the cost of ARVs.

Near-term health products activities

- Explore with private sector leaders the most politically feasible approach to reducing price of ARVs.
- Conduct a series of small workshops presenting international experience in lowering costs.
- Propose South Africa approach to pricing—15 percent mark-up plus a modest dispensing fee.
- Explore strategies to encourage greater use of generic ARVs.

Long-term health products activities

- Educate health care providers and consumers on the value of generic products.
- Consider issuing government-purchased ARVs at discounted or no cost to accredited private providers for use with patients who would otherwise access treatment through public facilities. Link these services to low-cost insurance programs.
- Task an NGO with providing ARVs at low-cost to create competition with private providers, motivating them to decrease prices.

8.4 CONCLUSION

The goal of these recommendations is to build a vibrant mixed health care system that highlights the unique capabilities of both the public and private health care sectors. This would mobilize new funding for health care from low-wage workers (a modest monthly insurance contribution) and their employers. Building such a system may require initial donor investment. In the longer run, the optimal system may also require some contributions of public funding. For example, mobile clinics serving remote populations are probably not fully supportable from the contributions of farmers/lodge owners and their employees. But with partial government subsidies, these facilities could improve access for the rural poor while lowering the government cost of treating those currently residing in these rural sites. The true test of success for these innovations is not whether they are nominally "public" or "private" but whether they improve access to quality health care for all Namibians in an efficient and equitable way.

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ANNEX A: SCOPE OF WORK

Scoping Assessment for Greater Private Commercial Sector Involvement in Namibia's HIV Response and Health System

Scope of Work

Background

Namibia is a country of contrasts. While the nation faces a severe HIV/AIDS epidemic (15 percent adult prevalence[5]), one of the highest degrees of income inequality in the world (Gini co-efficient of 0.6[6]), and high unemployment rates (37 percent[7]), Namibia has also been upgraded to "upper middle income country" status.[8] In this respect, Namibia has experienced high rates of investment (averaging 29 percent gross domestic product [GDP] growth between 2003 and 2007[9]), an open economy closely linked to South Africa, moderate inflation, and strong external surpluses. It has low indebtedness as a result of prudent fiscal policies, a stable political environment, a strong legal and regulatory environment, and a fairly developed infrastructure. It is against this backdrop that the private commercial or for-profit sector has flourished.

In health, this sector is featured at three levels: as financiers, as risk-pooling agents, and as providers of care. As financiers, this sector, comprising company and household contributions (largely to insurance premiums), accounts for 34 percent of all health expenditures in 2006/7.[10] This is second only to Government contributions, which account for 44 percent of health spending. In addition to financing occupational health activities, companies contribute to various community-related health activities as part of corporate social responsibility mandates. As risk pooling agents, Namibia's private commercial sector absorbs approximately 22 percent of national health expenditures (in 2006/07) through its insurance industry.[11] Findings from the latest NHA report show that the amount of funds managed by private insurance schemes doubled between 2001/02 and 2006/07. As health providers, the for-profit sector is sizeable, comprising 844 facilities (currently registered with MoHSS), of which 13 are hospitals, 75 are primary care clinics, 8 are health centers, and 75 are pharmacies. By comparison, the public sector comprises 333 facilities.[12]

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[5] UNAIDS 2006 estimate

[6] National Planning Commission. 2008.2nd Millennium Development goals report; Namibia 2008

[7] National Planning Commission. 2008.2nd Millennium Development goals report; Namibia 2008

[8] http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20421402~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html#Upper_middle_income

[9] www.afdb.org/

[10] MoHSS. 2008. Namibia National Health Accounts 2001/02-2006/07.

[11] ibid

[12] ibid

In addition to health care provision, the commercial sector contributes to the HIV response. For example, companies have contributed to HIV awareness campaigns, provided bursaries to orphans and vulnerable children, supported OVC soup kitchens, financed mobile counseling and testing units, and implemented workplace programs (but this represents only 0.22 percent of Namibian businesses[13]). In addition, some Namibian medical schemes offer low-cost health plans that include AIDS coverage—Namibia is one of the first countries in sub-Saharan Africa to do so. Lastly, at the delivery level, the private sector began providing ARVs even before these were available in the public sector. Currently, the private sector accounts for 24 percent of ARV cases (in 2007), with the remainder treated in the public sector. [14]

While it is clear that commercial sector initiatives are involved in the HIV response, this role is not well defined, coordinated, or necessarily maximized to its fullest potential. The need to do so is critical given the recent waning of donor support for health and HIV/AIDS services in the country, and escalating costs for financing the national response. While the USG is one of the largest financiers of the national response, its contributions will likely decrease in coming years as it shifts from a rapid emergency response approach to one focused on developing long-term sustainable strategies. [15]

To achieve a sustainable effective national response and health system, it is unlikely that the public sector will be able to absorb all costs and deliver the services that are currently donor-funded. To what extent can the private commercial sector cover some of these costs and responsibilities? How can its involvement be more strategic and coordinated with GRN efforts to achieve national HIV/AIDS goals? To help answer these questions, USAID is commissioning a "scoping assessment" to explore the potential roles of the private commercial sector in the national HIV response and health system. Such roles may include partnerships between for-profit entities and the public sector as well as civil society. Findings and recommendations from this assessment will inform USAID's strategy for strengthening private sector involvement to help achieve HIV/AIDS and health sustainability goals.

It should be noted that while the not-for-profit sector also plays an important role in service delivery and community-based care, this effort is largely supported by external donors; thus, strategies will need to be developed to ensure this sector's sustainability using domestic resources. Given the potential role of the private commercial sector as one such domestic resource for HIV/AIDS activities, the focus of the proposed assessment will be on the potential for increased involvement by the commercial sector.

Goal

The overarching goal of this assessment is to determine how the private commercial sector can play a larger role in the national HIV response, contributing to a more sustainable health system in preparation for USAID's eventual withdrawal.

Objectives

To achieve this goal, the private sector assessment will:

1. Offer a review of the current policy environment and stakeholder perceptions regarding private sector involvement in Namibia's HIV response and health system.

[13] National Business Coalition on HIV/AIDS Strategic Plan 2008-2012

[14] Feeley F, de Beer I, Rinke de Wit T, van der Gaag J. 2006. The Health Insurance Industry in Namibia Baseline report. Boston University Center for International Health, Amsterdam Institute for International Development, PharmAccess Foundation.

[15] Government of the Republic of Namibia and Government of USA. 4th draft September 23, 2009. HIV and AIDS Partnership Framework Agreement 2009-2013; a five-year strategy.

2. Provide an overview of the current level of involvement by the private commercial sector (at the level of financier, risk-pooling, and provider) in the HIV response and health system.

3. Understand the degree to which partnerships to address HIV/AIDS needs exist between the commercial sector and the public sector as well as civil society.

4. Identify ways in which partnerships with the for-profit sector could be strengthened and/or created to contribute to HIV/AIDS and health sustainability goals—also taking into consideration risks and market volatilities that may affect private sector involvement.

5. Identify opportunities in which the for-profit sector could help sustain USAID programs (e.g., Supply Chain Management Services, Strengthening Pharmaceutical Systems, Project Hope, CAFO) beyond PEPFAR financing.

Ideally, recommendations from the assessment should be "scaleable" and articulate ways in which USAID can support a dialogue and/or help broker linkages between the for-profit sector and the public sector as well as civil society.

Approach and Activities

The assessment will be conducted by a multidisciplinary team familiar with private sector policy; small, medium and large enterprises; private sector insurance; and for-profit provider workforces in developing countries. The assessment process will entail a review of secondary data, targeted stakeholder meetings (including public and private sector representatives), key informant interviews, and field visits to private sector initiatives as well as USAID financed programs. The assessment will require primary data collection by the entire team over a two-week period, followed by a one-week visit to disseminate the findings and facilitate their uptake by key stakeholders.

Specific tasks include:

1. Reviewing the current status and environment for private sector involvement in Namibia's HIV response and the health system (national and community levels), including:

    a. Market segmentation, range (including consumer targets), and distribution of private sector activities.

    b. The quality of private sector products and services (including insurance) and the degree to which these are standardized and meet national protocols and guidelines.

2. Analyzing health care reform or other government-led initiatives that may impact the involvement of the private for-profit sector.

3. Identifying ways to link, or strengthen links between, the commercial sector and public sector, civil society, and relevant USAID programs.

4. Assessing the comparative roles and advantages of the public sector, civil society and the for-profit sector to finance, manage, and deliver services.

5. Exploring opportunities to strengthen private for-profit sector involvement in the national response and health system, and the demand for such involvement. For example:

    a. Despite availability of low-cost insurance products with HIV/AIDS coverage, employers are not participating in these schemes; why not? How could enrollment be increased?

    b. How can private training institutions play a larger role in strengthening the human resource workforce for HIV/AIDS and health care?

6. How can private sector involvement strengthen both national- and community-level health systems?
7. Developing supporting arguments for partnerships with the commercial sector. Questions to address include:
    a. What can the public sector and civil society gain from partnerships with the commercial sector (e.g., amount saved by the GRN if private sector involvement increases)?
    b. What can the private sector gain from partnership with the public sector? With civil society?

Duration, Timing, and Schedule

It is anticipated that the period of performance of this assessment will be approximately seven months, including preparation time in Washington, two in-country visits, and report writing and dissemination. It is proposed that the bulk of in-country work will take place between March and April 2010, although individual Team Members will have varying schedules within this timeframe. The following chart proposes a schedule of key activities to be undertaken for this scope of work.

Activity	Jan. 2010	Feb. 2010	Mar. 2010	Apr. 2010	May 2010	June 2010	July 2010
Step 1 – Finalize Detailed Plan of Action							
Finalize SOW	X						
Recruit team members	X						
Identify key research questions	X						
Identify key stakeholders		X					
Schedule meetings with key stakeholders		X	X				
Step 2 – General Background Research & Document Review							
Conduct background research & document review	X	X					
Develop draft assessment tools		X	X				
Step 3 – Conduct Country Assessment							
Conduct stakeholder interviews			X				
Conduct field visits			X				
Debrief with USAID/Namibia				X			
Step 4 – Report Writing and Dissemination							
Develop outline for report			X				
Vet preliminary findings and recommendations with in-country stakeholders				X			
Finalize analysis and draft report				X	X		
Submit report to USAID for comment					X		
Receive comments from USAID						X	
Disseminate findings to USAID and key stakeholders in Namibia						X	
Finalize report							X

ASSESSMENT TEAM COMPOSITION, ROLES & RESPONSIBILITIES

Assessment Team:

Barbara O'Hanlon – (SHOPS Senior Policy Advisor) will serve as Team Leader and will conduct interviews with MoHSS officials, parliamentarians, and private health sector stakeholders. Ms. O'Hanlon will also return to Namibia to disseminate findings. [Proposed TDY March 15-26]

Rich Feeley – (Boston University) will take the lead in the areas of private industry and health insurance and will interview stakeholders from MoGECW, MoF, and MoTI. Dr. Feeley will write sections of the report and will also participate in dissemination efforts. [Proposed TDY March 20 – April 2]

Ingrid de Beer – (Consultant from PharmAccess) will orient team members to the Namibian context, identify key stakeholders to interview and sites to visit, and participate in interviews with private industry and government officials. Ms. de Beer will also review and provide input on the report and recommendations. It is anticipated that Ms. de Beer will also participate in dissemination events.

Chantelle Reid – (Local consultant) will coordinate logistics and scheduling for the assessment, will participate in interviews with and site visits and will review the assessment report. Ms. Reid will also serve as the lead on OVC programs and will conduct interviews and site visits to NGOs and FBOs.

Shyami de Silva – (Private Sector Technical Advisor, USAID/OHA) will participate in selected interviews and site visits to health insurers and private health sector stakeholders. [Proposed TDY March 20-27]

Technical Coordination:

Sara Sulzbach – (SHOPS Private Sector HIV/AIDS Advisor) will provide oversight, coordinate technical activities, and contribute to the assessment report.

Heather Vincent – (SHOPS Task Manager) will coordinate administrative activities and help synthesize existing reports and information.

Deliverables

1. Final expanded scope of work developed in consultation with USAID/Namibia and USAID/Washington that includes
    a. Team composition, roles, and responsibilities
    b. Budget
    c. Relationships and responsibilities (regarding key points of contact, logistical arrangements, scheduling of meetings and appointments, etc.) of assessment team and USAID/Namibia
    d. Timeline and level of effort
2. Detailed plan of action to include:
    a. Key research questions and how they will be addressed
    b. Timeline for key activities, including product due dates
    c. Schedule of interviews both internal and external

d. Schedule of debriefing to USAID

e. Proposed timing of report dissemination

3. Draft outline of assessment report

4. Presentation of major findings and recommendations to USAID/Namibia and USAID/Washington (may be virtual presentation, given that not all team members will be present the final week of the assessment)

5. Final assessment report

6. Presentation(s) of findings to key stakeholders including the National Planning Council, MoHSS, MoGECW, companies, insurance, private providers (TBD if these will be one-off meetings vs. joint stakeholder meetings)

Budget Considerations

Primary financing for assessment will be covered from USAID/Office of HIV/AIDS core funding through its Strengthening Health Outcomes through Private Sector (SHOPS) project. Specific budget considerations that were taken into account are listed in the table below.

Budget considerations	Unit	Number of Units
Estimated Level of Effort:*		
Team Leader (BOH)	Day	40
Technical team member (FF)	Day	25
Technical team member(IdB)	Day	15
Technical team member(CR)	Day	25
International Travel to and from Namibia:		
Visit 1 (BOH and RF)	Week	2
Visit 2 (BOH and RF)	Week	1
Domestic Travel*:		
Travel to Northern Namibia (USG programs) (partial team)	Day	2
Travel to Walvis Bay/Swakopmund (visit small and medium enterprises) (partial team)	Day	2
Travel to Walvis Bay/Swakopmund to present findings to stakeholders (e.g., firms) (2rd country visit)	Day	1

*Note: We propose that travel to the South may not be necessary, given the familiarity of the team with companies and issues specific to this area. Instead, we will draw upon team members' existing knowledge, meetings with company offices in Windhoek, and discussions by phone as necessary.

Proposed Stakeholder List

Ministry of Health and Social Services (MoHSS)	**Objective** • to get perspective on the long-term strategies to address HIV/AIDS challenges and sustainability issues • to learn about MoHSS policy/plans to work with the private (NGO, Mission, and for-profit) sectors • to measure openness towards private sector • to identify current partnerships with private sector in HIV/AIDS and/or other health areas • to identify possible barriers for public sector to engage/transact with the private sector

Entity	**Team Member/s**
• MoHSS leadership: PS, Deputy PS	O'Hanlon, de Beer
• Director of Special Programs (responsible for HIV/AIDS, TB and malaria)	O'Hanlon, de Beer
• Director of Policy, Planning and HRD (strategic plan and/or policy guidance on working with the private health sector)	O'Hanlon, de Beer
• Director of HRM and General Services (focus on human resources for health), or whatever regulatory body internal to the MoHSS can give me policies, health acts, laws related to private health sector	O'Hanlon, de Beer
• Director of Tertiary Health Care & Clinical Support Services (pharmaceutical services; medical laboratory services)	O'Hanlon, de Beer
• Director of Primary Health Care Services (potential linkages between HIV/AIDS and MCH, FP; also IEC)	O'Hanlon, de Beer
• Councils responsible for regulating doctors, nurses, pharmacists and labs	O'Hanlon, Feeley

Other Ministries	**Objective** • to get perspective on the long-term strategies to address HIV/AIDS challenges and sustainability issues • to learn the extent to which the Ministries engage with the private (NGO, Mission, and for-profit) sector • to measure openness towards private sector • to identify any barriers for public sector to engage/transact with the private sector

Entity	**Team Member/s**
• Ministry of Gender Equality and Child Welfare: Director of Child Welfare Services (OVC programs and issues)	Feeley, Reid
• Ministry of Labor	Feeley, Reid
• Ministry of Finance (runs social security system, funds PSEMAS)	Feeley, de Beer
• Ministry of Trade and Industry	Feeley, de Beer

Other government officials/donors	**Objective** • to get perspective on the long-term strategies to address HIV/AIDS challenges and sustainability issues • to learn about government policies/plans to work with the private (NGO, Mission, and for-profit) sectors • to measure openness towards private sector

Entity	**Team Member/s**
• Parliamentarians or government officials who are active in and familiar with HIV/AIDS issues and have a vision on long-term sustainability (time permitting)	O'Hanlon, de Silva
• Southern African Development Community (SADC) Parliamentary Forum on	O'Hanlon, Reid

HIV/AIDS	
• Global Fund CCM	O'Hanlon, de Silva

Health insurance	**Objective** • to ascertain the current status of the health insurance market • to understand why uptake has been marginal on low-cost private insurance programs, and identify strategies for improving uptake • to explore prospects for expanding coverage to low- and middle-income populations

Entity	**Team Member/s**
• Private insurers (2 or 3)	Feeley, de Silva
• NAMAF (Association of Medical Aids Funds)	Feeley, de Silva
• NAMFISA (regulates medical schemes)	Feeley, de Silva

Industry	**Objective** • to provide an update on industry practices and policies related to HIV/AIDS services • to identify current partnerships with NGO/Mission or public sector to address HIV/AIDS as well as best practices • to identify possible barriers to private sector partnering with public sector and/or barriers to greater role in HIV/AIDS • to measure openness to working with public sector

Entity	**Team Member/s**
• Namibian Employers Federation (NEF)	Feeley, de Beer
• NABCOA (Business Coalition on AIDS)	Feeley, de Beer
• Chamber of Mines	Feeley, de Beer
• National Union of Namibian Workers (NUNW) (Equivalent of AFL/CIO)	Feeley, de Beer
• Bankers Association	Feeley, de Beer
• Tourist Industry (Namibian Hospitality Association)	Feeley, de Beer
• Agriculture sector	Feeley
• Commercial farmers (ranchers)	
• Small farmers (mostly in north)	

Private Health Sector	**Objective** • to learn if private sector is aware of government HIV/AIDS strategies and long-term plan to address HIV/AIDS challenges and sustainability issues • to measure willingness to work on HIV/AIDS and what could be their potential contribution • to identify possible barriers to partnering with public sector and/or barriers to a greater role in HIV/AIDS • to measure openness to working with public sector

Entity	**Team Member/s**
• Directors of physician, pharmacist, nurse, and labs professional associations	O'Hanlon, de Silva
• Key private sector practitioners	O'Hanlon, de Silva
• Key private sector hospital and/or clinic owners	O'Hanlon, de Silva
• Key lab owners	O'Hanlon, de Silva
• Owners of pharmacy chains	O'Hanlon, de Silva
• Key leaders in the pharmaceutical sector	O'Hanlon, de Silva

NGO/Mission	Objective
	• to learn the extent they are aware of government HIV/AIDS strategies and long-term plan to address HIV/AIDS challenges and sustainability issues • to identify current partnerships with private sector or public sector to address HIV/AIDS • to gauge receptivity to partnering with the private commercial sector

Entity	Team Member/s
• Catholic and Lutheran Hospital Associations (and maybe individual hospitals)	Reid, O'Hanlon
• Catholic AIDS Action	Reid
• CARE	Reid
• Network of Namibian AIDS Service Organization (NANASO)	Feeley, Reid

SHOPS ASSESSMENT TEAM MEMBER BIOS

Barbara O'Hanlon, MPP (Team Leader), is a recognized leader in international health policy and implementation, with over 24 years' experience in advocacy and strategic communication to create favorable policy environments for key health issues. She has developed and applied new policy tools and methodologies and written and trained extensively in policy-related areas such as strategic planning, stakeholder analysis, advocacy, strategic communication, and change management. Ms. O'Hanlon works with federal and provincial-level MoHSS officials to reform policy governing the private sector and helps strengthen their policy design and advocacy skills. Additionally, she provides technical assistance to foster Ministry of Health stewardship of the private health sector, using policy instruments such as policy dialogue, stakeholder assessments, and financial mechanisms to forge public-private alliance building. Ms. O'Hanlon has an M.P.P. from the John F. Kennedy School of Public Policy at Harvard University.

Frank (Rich) Feeley, JD, has over 40 years of experience in health care in the US and developing countries. Trained as a lawyer, he joined the faculty of Boston University School of Public Health in 1991. He teaches public health writing, health systems organization and finance, and consulting skills. His particular interests include insurance, the role of private health providers, and the economics of HIV/AIDS and its treatment. He has consulted on or directed research projects in over 20 countries, including 10 in sub-Saharan Africa. He has worked in Namibia since 1994, collaborating with PharmAccess since 2003. He is currently completing a study of the impact of low-cost health insurance policies on the attrition-related costs incurred by Namibian firms, beginning a study of the comparative costs of fixed-site and mobile HIV/AIDS screening in the country and working with multiple parties in establishing a public-private partnership for health care in a remote mining community.

Ingrid de Beer, MA, is General Manager for the PharmAccess Foundation in Namibia. Ms. de Beer oversees the management of projects aimed at strengthening health systems in Namibia. In this position she coordinated the Okambilimbili program, which aimed to develop health insurance for previously uninsured low-income workers. She also manages the Bopehlo! mobile testing vans that provide on-site wellness screening at workplaces. (Over 6,000 people have been tested for a variety of medical conditions and illnesses since March 2009.) In addition to her management duties, she has participated in comprehensive research studies, such as a study of 2,000 households in Windhoek measuring both socio-economic and bio-medical indicators, a survey of 1,800 commercial farmers in the Namibian Agriculture Employers Federation to assess both the implementation of HIV workplace programs and willingness of members to join and pay for health insurance, and an HIV prevalence survey in 38 formal sector organizations in Namibia. She has written extensively on health insurance and HIV/AIDS treatment, and has given presentations on the subject at many international conferences. Ms. de Beer has a M.A. in Development Studies from the Rand Afrikaans University/University of Johannesburg, and speaks English, Afrikaans, and German.

Chantélle Reid, BA, is a social work professional with seven years of experience in the coordination, management, and provision of psychosocial therapy and employee wellness programs involving HIV/AIDS. In previously held positions with Catholic AIDS Action and the Ohlthaver and List Group of Companies (O&L), she helped establish and maintain information exchange networks between public and private (commercial- and NGO-based) entities to implement health education and awareness programs. Additionally, Ms. Reid has conducted in-depth research and made recommendations regarding the financial impact of HIV/AIDS on productivity and absenteeism and conducted an extensive study spanning 10 African countries to assess the implications of the global economic crisis for sustaining and improving HIV/AIDS programs. An innovative and determined professional, she effectively lobbied for free ARV provision for all O&L employees and designed, coordinated, and executed a successful VCT campaign for 4,100 employees within 6 weeks and with 91 percent participation. Ms. Reid holds an honors BA in Social Work and Community Development/Industrial and Clinical Psychology from the

University of Namibia, and has completed other psychology, health service, and AIDS control trainings. She speaks both English and Afrikaans fluently.

ANNEX B: SUMMARY OF KEY STAKEHOLDERS BY SECTOR

Sector	Name	Summary of relation to HIV/AIDS and/or OVC response
International Sector Actors engaged in HIV/AIDS and OVC	GFATM NaCCATuM	Namibia has five GFATM grants—1) in HIV/AIDS; 2) in TB and malaria. Does not fund programs directly but instead funds organizations at the national level. NANASO and NABCOA are major recipients. Also reaching OVC through funds allocated to NANASO and MoHSS programs. Namibia applied for a Round 10 grant in August 2010 to increase engagement of the private sector in the HIV response. Proposal still pending.
	Republic of Germany KfW/GTZ/DED	German Republic funds support MoHSS staff, workplace programs in private sector, and initiatives to mainstream HIV/AIDS in sectors other than health (environment, natural resource management).
	USG CDC PEPFAR/USAID	Funds over $77 million per year to support Namibian and international partners in the areas of health system strengthening and policy support, prevention, basic health care and support, and OVC.
Public Sector Actors engaged in HIV/AIDS Public sector actors engaged in OVC	**HIV/AIDS**	
	Parliament	Southern African Development Community (SADC) project supports Members of Parliament who draft and promote HIV/AIDS and OVC legislation. National Policy on HIV/AIDS (2007) lays out the framework and approach to address HIV/AIDS in Namibia.
	President Office of Prime Minister	Developed national response to HIV/AIDS and OVC that calls for a multi-stakeholder involvement (MTP II and III). Additionally, 3 years ago developed overarching policies and strategies targeted to public sector agencies to address HIV/AIDS and OVC, and monitors line agencies' implementation. Currently drafting a National PPP Policy, which will include health sector.
	Ministry of Health and Social Services (MoHSS)	Sets direction and priorities of National AIDS Program for country through policy framework and strategic plans. Responsible for coordinating all actors in HIV/AIDS. Primary service provider of HIV/AIDS services as well. Provides technical support to partners in all sectors engaged in HIV response. Implements expanded workplace programs in health sector.
	Other agencies Ministry of Agriculture, Fisheries, Defense, Finance, Labor, Trade and Industry	Other line agencies support the national response by: disseminating information to key actors in sector; increasing awareness among workers in sector; and coordinating and planning prevention activities in sector. Certain agencies have specific functions. The MoF investigates the impact of and adequacy of funding for HIV/AIDS activities; the Defense Ministry tracks # of new infections.
	Health Professionals Councils of Namibia	Councils responsible for certifying all medical professions (physicians, nurses, radiologists, lab technicians, pharmacists, social workers, and psychologists) and ensuring compliance.

	Namibia Financial Institutions Supervisory Authority (NAMFISA)	Regulatory agencies governs the financial sector more generally and health insurance industry specifically.
	OVC	
	Ministry of Gender Equality and Child Welfare (MoGECW)	Sets direction and priorities for OVC through policy and strategic plans. Also coordinates all development partners and Namibian entities working with OVC. Disburses all allowances for children under the age of 18; manages all residential child care facilities, which, if registered with the Ministry, receive subsidies for operating costs; and supports other programs such as school feeding, education, and vocational training. Has tabled new Children's Bill, which is expected to be enacted before the end of 2010.
	Ministry of Education	Reduces transmission and mitigate impact on education system; ensures OVC not deterred from attending school; provides holistic care and support; and expands vocational training.
	Regional and municipal governments	Local governments, with help from AMICAALL, form PPPs with local businesses to cover the costs and materials for OVC programs while municipalities provide location, staff and funding for other operating expenses.
Private Sector Not-for-profit actors engaged in HIV/AIDS	**HIV/AIDS Services and Programs**	
	Catholic Health Services (CHS)	Second largest health provider in Namibia, with 16 health facilities, including 4 district hospitals, 5 health centers, and 7 clinics located throughout country. Delivers HIV/AIDS treatment and partners with CAA for prevention (VCT) and home-based care and services for OVC.
	Catholic AIDS Action (CAA)	Improves knowledge including youth education programs (YAP), offers VCT in partnership with New Start, provides support services (soup kitchen, income-generation projects, and food distribution), and delivers home-based care.
	Evangelical Lutheran Church Aids Program (ELCAP)	Two hospitals located in the North deliver HIV/AIDS treatment but on smaller scale. ELCAP programs include improving knowledge, distributing condoms, and partnering with New Start, to offer VCT, and support of OVC and home-based care.
	Lutheran Health Services (LHS)	Provides youth education programs and works in conjunction with the New Start centers for VCT services. Also trains home-based care volunteers as well as community counselors. Delivers care and support to OVC in the form of havens, soup kitchens, and food parcels.
	Namibian Red Cross	Improves knowledge through occasional training and youth education programs. Supports PLHIV through distribution of food parcels and limited home-based care.
	Namibian Network of AIDS Organizations (NANASO)	Operates as a not-for-profit umbrella organization for NGOs and CBOs providing services in HIV/AIDS. Key functions for members include:1) providing information and sharing knowledge; 2) building members' organizational capacity; 3) raising capital and funds; 4) representing and advocating on behalf of its members; 5) and monitoring the sector's performance. Major recipient of GFATM.
	Health Financing of HIV/AIDS Services	

	Medical Aid Schemes Namibia Medical Care (NMC) Namibia Health Plan (NHP) Renaissance (NAMMED)	Multiple medical aid schemes financing health care that are not-for-profit risk pools including four open medical aid funds: NMC (administered by MetHealth), NHP (administered by Medscheme, Renaissance (administered by Prosperity Health), and NAMMED (administered by Paramount). Three for-profit closed medical aid funds run for selected employee groups: PSEMAS and NAPOTEL that provide HIV treatment to their members and dependents on the same basis as the open funds. PSEMAS is the exception since GRN covers its risks.
	Namibian Medical Aids Federation (NAMAF)	Umbrella body for these medical aid funds. Responsible for the annual negotiation and setting of tariffs with the private health providers.
	Public Sector Employees Medical Aid (PSEMAS)	Health insurance scheme for government employees offering a spectrum of AIDS care, including ART. Outpatient benefits are generous and can be obtained through private providers. Inpatient benefits are unlimited, but available only in private units of MoHSS and FBO hospitals.
Not-for-profit actors working with OVC	**OVC Care and Treatment**	
	Catholic AIDS Action (CAA)	Largest NGO provider of care and care support of OVC, supports youth education and prevention programs, soup kitchens, and multi-purpose centers. Provides home-based care and psychosocial support training. Believed to be the only organization providing palliative care in Namibia. Currently serves over 8,000 people infected/affected by HIV/AIDS and has over 17,000 OVC registered. Has income-generating activities for older OVC, as well as bursary scheme for secondary and tertiary economic for OVCs.
	Hope Village (HV)	Charity organization cares for destitute terminally ill adults and children with HIV/AIDS. Currently only has 3 homes for children (24 per home). Hospice and community centers are planned, but funds are not available yet. Has a small clinic, which serves the children's homes and community, but has not received a license from the MoHSS Receives no state aid and survives on partnerships and donations.
	Christina Swart Oppermann AIDS Orphan Trust	Successfully raises funds through international and mostly local philanthropy. Uses funds to provide needed supplies to support OVC schooling.
Private Sector	**Private Health Care Sector – HIV/AIDS**	
	HIV/AIDS Clinician Society	Professional association for health care providers—physicians, nurses, pharmacist, lab technicians. Objectives include: provide updated info on and guidelines for HIV/AIDS treatment; offer training in latest technologies; and accredit providers. Membership includes 300 physicians—250 are private and 125 pharmacists (all private). Growing number of nurses and lab technicians.
For-profit third party administrators (TPAs) engaged in HIV/AIDS	**Health Insurance Sector – HIV/AIDS**	
	MetHealth Medscheme Paramount Prosperity	Manage the not-for-profit medical aid schemes. Functions include: adminstration, marketing, claims, and premium collection.
	Pharmaceutical Sector – HIV/AIDS	

	NamPharm	Largest private sector distributor and manufacturer of medicines and medical supplies. Local representative of research and development firms that manufacture ARVs and other HIV/AIDS-related medicines.
	Pharmaceutical Society of Namibia (PSN)	Professional associaton with135 out of some 200 pharmacists as members.
	Industry and Business Sector – HIV/AIDS	
	Namibia Business Coalition on AIDS (NABCOA)	A business coalition that encourages its members-around 50 companies and institution- to provide HIV/AIDS services. Provides training for business leadership and HIV/AIDs implementers within companies, advocates among business community, particularly small and medium enterprises to establish HIV/AIDs workplace programs.
	Namibian Employers Federation (NEF)	Employer's organization representing all industries. Represents wide range of sectors in business. Performs government relations on behalf of industry. Recently appointed staff person to address HIV/AIDS and other worker safety issues.
	Namibian Agriculture Union (NAU)	A membership-based association of commercial farmers in Namibia.
	Namibian National Farmers Union (NNFU)	A membership-based association of communal farmers in Namibia.
	Industry and Business Sector – OVC	
For-profit sector entities engaged with OVC	Multiple: Ohlthaver & List Group of Companies, Standard Bank Namibia, Kalahari Sands Hotel, Windhoek Country Club, Namdeb	Active business community donating in-kind inputs for OVC programs that deliver care and support. Examples include the Namibia Dairies Oshikandela Program for OVC, Kalahari Sands, and Windhoek Country Club support to build the HV clinic, and Standard Bank sponsored funding of the home for girls at Hope Village. Usually one-off based on relations and opportunities.
Civil society actors engaged in HIV/AIDS	Namibian Network of AIDS Organizations (NANASO)	Operates as a non-profit umbrella organization for NGOs and CBOs providing services in HIV/AIDS. Key functions for members include: 1) providing information and sharing knowledge; 2) building members' organizational capacity; 3) raising capital and funds; 4) representing and advocating on behalf of its members; 5) monitoring the sector's performance. Major recipient of GFATM funds.

ANNEX C: CONTACTS

Sector	Organization	Interviewee/Title
International Donors	DED	Dr. Henning Austmann, Program Manager – SME Development
	GFTAM	Jeannette De Putter, Manager – Operations Vera Bronkhorst., Senior Program Officer
	USAID	Dr. Kangudi, FBO sector
Public Sector	Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level	Rachel Basirika, Country Director
	MoGECW	Helena Andjamba, Director – Child Welfare Veronica de Klerk, Chief Social Worker
	MoHSS	Kahijoro Kahuure, Permanent Secretary Thomas Mbeeli, Deputy Director – Policy & Planning
	NIP	Harold Kaura, GM – Technical Operations Johannes Klemens
	NPC	Susan-Marie Lewis, Director – Development Cooperation
	Southern African Development Community (SADC) Parliamentary Forum	Sabelo Mbokazi, HIV/AIDS Capacity Development and Support Officer
Private For-profit Sector	Bank Windhoek	Hans Sauer, Manager – Emerging Small and Medium Enterprises
	BCI	Jacob Nghifindaka, CEO
	Chamber of Mines	Theo Machako, Program Coordinator Ronnie Mutjavikua, Assistant Program Coordinator
	De Beers Marine	Elsabe Grotzinger, Employee Wellness Coordinator
	Endombo Investment Holdings	Deon Gerber, Business Coordinator
	Erongo Medical Services	Matthias Braune, Managing Director
	Family Primary Health Care	Sister Tuti, Owner Sister Parkhouse, Owner
	Health Care 4 You	Sister Marais, Owner
	Medscheme	Tiaan Serfontein, Medical Doctor

Sector	Organization	Interviewee/Title
	Methealth	Theo Oppermann, Medical Doctor
	MTC Namibia	Raymond Cloete, Wellness & OHS Practitioner
	NAMFISA	Utarera Williams Kamburona, Financial Analyst – Medical Aid
	Ohlthaver & List Group of Companies	Berthold Mukuahima, Director – Human Capital
	PATHCARE	Ebert Oosthuysen, Regional Manager
	Uranium Institute	Dr. Wotan Swiegers, Director
Private Not-for-profit Sector	Catholic AIDS Action	Father Rick Bauer, Executive Director
	Catholic Health Services	Eric Sidile, Medical Program Manager
	Katutura Youth Enterprise Centre Trust	Mike Yates, Director
	Namibia Medical Care Clinics	Hardie Van Wyk, Principal Officer
	Synergos	Len LeRoux, Director – Partnerships
Professional Associations and Councils	Agricultural Employers Association	Derek Wright, President and Board Member
	Communal Farmers Organization	Isabel Moroff, Technical Advisor
	Health Professionals Council of Namibia	Ena Barlow, Registrar
	HIV/AIDS Clinicians' Society	Dr. Flavia Mugala, Chair
	Hospitality Association of Namibia	Gitta Paetzold, CEO
	Namibia Medical Association	Dr. Estie Maritz, CEO
	Namibian Business Council on HIV/AIDS	Peter Van Wyk, CEO
	Namibian Employers Federation	Tim Parkhouse, Secretary General
	Pharmaceutical Society of Namibia	Karin Brockman, CEO
Implementing Partners	IntraHealth (The Capacity Project)	Dr. Emad Aziz, Chief of Party Dr. Chani
	MSH	Jacob Kawonga, Senior Program Associate Dr. David Mabirizi, Senior Technical Advisor Dawn Pereko, Senior Program Associate
	PACT	Stephanie Posner, Chief of Party
	University of Washington (I-TECH project)	Dr. Laura Brandt, Deputy Director of Clinical Programs
Civil Society	NANASO	Micahel Mulonga, Executive Director