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SHOPS
Strengthening Health Outcomes *through* the Private Sector

Namibia Program Profile

PROFILE

Summary: In 2010, the Strengthening Health Outcomes through the Private Sector (SHOPS) project implemented a five-year program in Namibia funded by USAID that had three objectives: (1) Support the creation of an enabling environment for public-private partnerships; (2) Strengthen the role of private health providers to finance and provide voluntary medical male circumcision; and (3) Increase commercialization of selected NGOs to promote financial sustainability. This profile presents the goals, components, results, and the following lessons learned from the SHOPS program in Namibia:

- Creating an enabling environment for collaboration is critical to supporting a partnership with the private sector.
- Corporate-NGO pilots in Namibia demonstrate potential for commercializing NGO offerings, but additional investments in technical assistance are needed.
- Mobile clinics offer an important opportunity to expand access to testing, care, and treatment, but targeted demand creation in identified priority regions is necessary.
- Using existing systems and incentives can provide needed private sector data routinely and reliably.
- Working with private sector peer-supported networks provides opportunities to understand doctor-patient relationships and how they impact the demand for HIV services.

Keywords: Africa, AIDS, communicable diseases, commercialization, financial sustainability, health financing, HIV/AIDS, male circumcision, Namibia, NGO sustainability, private health providers, public-private partnerships

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Project Description: The SHOPS project is USAID's flagship initiative in private sector health. 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, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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Namibia
Program Profile

Jessica Scranton

CONTEXT

With a population of approximately 2.3 million and a landmass of 318,259 square miles, Namibia is one of Africa's largest and least densely populated nations. The population is distributed unevenly, with approximately 60 percent living in the northern regions along the border with Angola and the rest in a few urban centers like Windhoek, the capital (MoHSS and ICF International, 2014).

Economics and Financing for Health

With a relatively stable economy, Namibia has experienced significant economic growth since it achieved independence from South Africa in 1990. This growth is due to increased production in the diamond and uranium industries, improved macroeconomic policies, and revenues from the South Africa Customs Union.[1] Approximately 30 percent of the Namibian government's budget is supported by revenues from the Customs Union, making the government's fiscal situation sensitive to potential changes in the revenue-sharing arrangement. Although Namibia is an upper middle-income country based on its per capita income ($5,870), it has one of the highest income inequalities in the world with a Gini coefficient of 0.42 (MoHSS and ICF International, 2014). Approximately 28.4 percent of the population live in poverty, and unemployment is 29 percent and increasing (Namibia Statistics Agency, 2013). This economic disparity is reflected in the geographic locations and differential access to high quality health care of several population groups.

In general, Namibia has a well-funded health system. In 2010, total health expenditures equaled approximately 6.8 percent of the country's economy. These expenditures came largely from domestic sources, including the Namibian government (54 percent), private companies (12 percent), and households (12 percent); international donors provided the remaining 22 percent (MoHSS, 2010). In recent years, government expenditure on health has ranged between 14 and 15 percent of its annual budget, which is in line with its commitment to the Abuja Declaration.

In recent years, the government has increasingly financed and led the country's HIV response. The Namibian Ministry of Health and Social Services (MoHSS) manages more than 50 different accounts for donor funding; the two largest donors for health are the President's Emergency Fund for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, both primarily providing funding for HIV and AIDS. As of 2014, the government allocates approximately 27 percent of health expenditures for HIV, which represents about 60 percent of total funding to HIV. This is a substantial increase in government funding over 2009, when it financed approximately 45 percent of the response to HIV (MoHSS, 2010) and important in light of decreasing donor funding. In 2014, PEPFAR was estimated to contribute about 25 percent and the Global Fund about 13 percent of national HIV

[1] The South African Customs union is a regional partnership of five southern African countries (Botswana, Lesotho, Namibia, South Africa, and Swaziland) that share revenue collected from joint customs taxes.

expenditures. The government currently finances public sector HIV commodities, doctors, nurses, pharmacists, and community health workers, which were previously supported by PEPFAR's investment. This represents a significant accomplishment in country ownership for Namibia.

With strong authority and economic growth, the government has made significant progress in providing health care for all Namibians. However, the country faces many health challenges similar to other nations in sub-Saharan Africa, particularly concerning HIV and AIDS.

Health Care

Namibia's health care system is served by public and private health care sectors. The public sector, coordinated by the MoHSS, consists of hospitals, health centers, clinics, and outreach posts. It serves approximately 82 percent of the population, and clients generally pay a user fee that is subsidized by the government. Although its services are considered to be of much higher quality than those in the public health sectors of other sub-Saharan countries, the system is overburdened.

Namibia has a significant shortage of skilled health workers, notably in the public sector. Approximately 75 percent of doctors are in the private sector (SHOPS, 2012). The shortage is in part due to limited availability of medical training until the opening of Namibia's first medical school in 2010. Consequently, many health practitioners are third-country nationals detailed from countries including Cuba and Zimbabwe, a situation that makes Namibia vulnerable to political changes in the clinicians' countries of origin. As recognized during the 2013 National Strategic Framework Review, with rapidly declining donor funds and increasing demand for health services, it is critical to partner with the private sector to address ongoing human resource challenges, expand access to services, and increase domestic resources.

Crystal Beukes

The private health sector in Namibia serves approximately 18 percent of the population (SHOPS, 2012), and most of the financing in the private sector is through employer-subsidized health insurance. The private health sector consists of consultation rooms, clinics and medical centers, hospitals, and pharmacies. While the public sector has more hospitals and clinics than the private sector, the latter has more consulting rooms and pharmacies.

Health-seeking behavior by sector in Namibia is affected by wealth and geography and is representative of Namibia's income disparity. For example, approximately 87 percent of all women who gave birth in the five years preceding the 2013 Demographic and Health Survey did so at a facility with a skilled birth attendant (MoHSS and ICF International, 2014). However, there was significant variation based on wealth: while 98 percent of women in the highest quintile gave birth at a facility, only 71 percent of women in the lowest wealth quintile did. Furthermore, women in the highest wealth quintile were over seven times more likely to give birth at a private facility than the other four quintiles combined. This example highlights one of the inequalities of accessing quality care based on economic status as well as the need to expand access to care in the private sector for populations in lower wealth quintiles.

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HIV and AIDS

The HIV and AIDS epidemic in Namibia is mature, generalized, and driven by heterosexual sex and mother-to-child transmission. Prevalence of HIV among females aged 15 to 49 is estimated to be 16.9 percent and for males in the same age group to be 10.9 percent. Women in Namibia, as in many countries of sub-Saharan Africa, are at particular risk of contracting HIV, with certain regions indicating much higher rates of transmission, particularly rural areas: 19.3 percent in rural areas and 15.0 percent in urban areas (MoHSS and ICF International, 2014). Contributions from international donors, most notably PEPFAR, led to a scale-up in Namibia's HIV response beginning in 2004. Namibia has shown tremendous success, covering approximately 88 percent of individuals in need of antiretroviral therapy (ART) based on a CD4 threshold of 350.

Achieving an AIDS-free generation will require addressing specific challenges in certain geographies. Scaling up high quality core interventions, inclusive of adult and pediatric ART, retention and adherence support, prevention of mother-to-child transmission, and voluntary medical male circumcision (VMMC) in areas with large numbers of people living with HIV (PLHIV), is essential to control the epidemic. Currently, UNAIDS estimates ART coverage for 120,000 patients. Using UNAIDS data and assuming stable incidence, for Namibia to achieve the UNAIDS 2020 goal of 90-90-90 (90 percent of all PLHIV knowing their HIV status, 90 percent of all people diagnosed with HIV receiving sustained ART, and 90 percent of all people receiving ART having viral suppression) the country will need to expand treatment coverage to approximately 180,000 people, an increase of 150 percent. With declining donor funding, engaging the private sector in the HIV response is needed to protect the investments already made.

GOALS

In 2010, USAID/Namibia asked the Strengthening Health Outcomes through the Private Sector (SHOPS) project to complete a private sector assessment (PSA) to gain an understanding of opportunities to partner with the private sector to expand access to HIV services and to understand the role the private sector can play in providing essential health services to sustain PEPFAR's investment. Increasing domestic resources for HIV prevention, care, and treatment is a top priority for the Namibian government and its donors to ensure that achievements made in the fight against HIV are not lost as donor funding declines. The PSA, therefore, aimed to uncover the potential contribution of the private sector and recommend ways to access this potential.

The PSA highlighted Namibia's vibrant private health sector and showed that it has the capacity to take on a greater role in ensuring sustainable provision of essential health services, including those for HIV and AIDS. However, private investments were not adequately leveraged, and the private sector was not fully utilized. The PSA also identified key challenges in maximizing the contribution of the private sector, including lack of coordination between the public and the private health sectors and lack of a policy framework to guide such coordination, untapped capacity of health professionals in the private sector who could support national programs, and lack of information and knowledge about the private sector.

Based on the findings and recommendations of the PSA, the SHOPS team in Namibia—in partnership with USAID/Namibia—designed a program aimed toward leveraging private investment to increase efficiencies and prospects for sustainability, improve access to care for underserved populations, and achieve national health goals.

The program had three main goals:

- Support the creation of an enabling environment for public-private partnerships (PPPs)
- Strengthen the role of private health providers to finance and provide VMMC
- Increase commercialization of selected NGOs to promote financial sustainability

Timeline

September 2010: Complete a private sector assessment.

July 2011: Submit an application to the NAMAF that includes a clinical justification and a proposed tariff for VMMC as an HIV preventive benefit; application accepted.

April 2012: Begin providing technical assistance and temporary operational subsidy to the Mister Sister mobile primary health care clinics.

June 2013: Complete a study on commercial prospects for donor-funded NGOs.

August 2013–January 2014: Conduct a national private health provider and services mapping exercise.

June 2014: Partner with HIV Clinicians Society to conduct the first private sector VMMC training.

August 2014: Design two NGO commercialization pilots.

November 2014: Establish a network of private male circumcision providers in Oshakati and Windhoek.

March 2015: Conduct a business seminar for private health practitioners to stimulate demand for VMMC.

September 2015: Program ends.

COMPONENTS

Creating an Enabling Environment for Public-Private Partnerships

Public-private partnerships can leverage private sector resources and expertise to expand access to and improve the quality of public sector HIV and AIDS services. In the PSA, SHOPS noted that Namibia's public and private health sectors had communicated little and lacked experience working with each other. This lack of communication, combined with the legacy of South Africa's apartheid-era governance, created an environment of mistrust and tension in which each sector operated in parallel. During the course of the PSA, stakeholders on both sides indicated a potential interest in partnering, but neither possessed the opportunity to engage in productive dialogue. Therefore, the SHOPS team set out to create an enabling environment for partnership between the public and private sectors. The project conducted a series of activities to create new institutions, gather and share private sector data that would build trust and identify partnership opportunities, and develop innovative partnership models that expanded access to critical health services.

Developing a public-private partnership framework

The SHOPS PSA identified limited capacity in the MoHSS and a weak policy environment as key obstacles to a health system seeking to support engaging the private health sector and building effective partnerships. Given the stated interest expressed by public and private sector stakeholders during the assessment, SHOPS—in partnership with the MoHSS and USAID—sought to establish a PPP unit within the MoHSS that would be a focal point for private sector activities and encourage more strategic private sector engagement.

Beginning in 2011, SHOPS engaged with the MoHSS to develop an overall strategic framework for PPPs in the health sector. Project staff drafted multiple supporting documents, including a rationale for the creation of a PPP unit, a PPP concept note that outlined potential benefits, and a health PPP discussion paper that advocated for private sector engagement. Included in these documents were terms of reference, staff profiles, and job descriptions for the PPP unit. After presenting these resources, the MoHSS received cabinet approval to develop a health sector PPP framework that outlined the roles and responsibilities of a PPP unit under the MoHSS Directorate of Policy, Planning, and Human Resources Development and provided strategic guidance for implementing the Namibian government's PPP policy. SHOPS supported the formation of the framework with technical inputs and guidance. The final framework was launched at Namibia's first PPP conference in December 2014.

Collaboration and learning across sub-Saharan Africa

To build a foundation for the new MoHSS PPP unit, SHOPS supported efforts to gain insights from similar organizations in other countries. For example, the project financed the attendance of a delegation of key public and private sector players, led by the MoHSS permanent secretary, at a regional PPP conference in Tanzania. At the conference, the delegates met with practitioners from across the continent to discuss their experiences, lessons learned, and recommendations on building PPPs for health. This regional dialogue helped pave the way toward institutionalizing public-private cooperation in Namibia.

Strengthening private sector reporting to the ministry

As part of its efforts to improve knowledge of the private sector, SHOPS, in partnership with USAID and the Namibian Association of Medial Aid Funds (NAMAF), implemented activities to improve the availability of information about services offered in the private sector. This work was motivated by the belief that improved availability of private sector epidemiological and cost data would help address misconceptions about the private sector within the MoHSS. Also, these data could be used to quantify the private sector's contribution of delivering essential health services and provide the government with information for planning and understanding HIV and AIDS epidemic control.

In 2012, SHOPS collaborated with the MoHSS response monitoring and evaluation team, USAID, the NAMAF, and actuaries to broker a new strategy to facilitate private sector reporting through the medical aid industry. This consortium collaborated to design specific data to be reported on by the private sector, most of which mirrored the MoHSS public facility reporting for HIV. The indicators included:

- HIV in pregnancy
- Male circumcision by age group, type of procedure, and associated cost
- Medicine utilization and possession, medicine collection statistics
- Number of people tested for HIV, type of test, and associated cost
- Number of people on HIV treatment, by age
- Number of people on second-line HIV treatment
- Number of tests done and associated costs for CD4 and viral load
- Number of tuberculosis patients on treatment
- Polymerase chain reaction coverage for babies

Using private sector reporting to understand HIV drug resistance

While the widespread availability and use of antiretroviral drugs (ARVs) has decreased HIV-related morbidity and mortality, ensuring appropriate adherence and retention is essential for viral suppression and preventing drug-resistant HIV. The consequences of HIV drug resistance include treatment and viral suppression failure, increased direct and indirect health costs associated with the patient's need for more costly second-line treatment, and the spread of resistant strains of HIV. As noted in the MoHSS 2014 HIV Drug Resistance Early Warning Indicator Report, retention in care and viral load suppression are challenging for Namibia, particularly in regions with large populations of PLHIV, including Kavango and Khomas. Preventing and monitoring HIV drug resistance in Namibia through both the private and public sectors is critical to achieving the UNAIDS 90-90-90 goals and an AIDS-free generation. In collaboration with the medical aid industry, SHOPS supported the MoHSS by identifying early warning indicators collectable from the private sector that can be used for the monitoring of HIV drug resistance. SHOPS partnered with actuaries to demonstrate how these data could be sourced from medical aid claims.

Mapping private providers

Even with an improving policy environment, the MoHSS lacked knowledge on where private health facilities were located and what services they were providing. Without this information, partnerships, as well as effective and efficient strategic planning, were not possible. In response to this challenge, SHOPS conducted a national private health provider and services mapping exercise to create a comprehensive list, database, and geographic representation of private health entities across the country. SHOPS used its expertise in private provider censuses and inputs from USAID, the NAMAF, and other associations to develop the mapping protocols. The team also met with the University of Namibia School of Medicine's Department of Pharmacy for input on the approach to the mapping activity from the perspective of the medical and pharmaceutical communities in Namibia.

Through the mapping, SHOPS intended to contribute to an enabling environment for PPPs. It sought to shed light on several private health providers and facility characteristics, including infrastructure, available services and equipment, staffing levels, patient volume, payment mechanisms, and training priorities. The team also used the exercise to gauge interest in service expansion and partnering with the public health sector to address health needs. The survey covered all regions of Namibia and the following categories of private health entities: ambulance services, medical suppliers, mobile clinics, pathology laboratories, pharmacies, private consulting rooms, private hospitals, and radiology laboratories.

Between August 2013 and January 2014, SHOPS collected data for the mapping in a multistep process. To begin, project staff accessed the NAMAF's registry to develop a master facility list. Data collectors then used a survey instrument tailored to the specific facility category (e.g., consulting room, hospitals) to conduct interviews. Once this initial list was completed, data collectors conducted an intensive search on foot in major cities, such as Windhoek, to identify facilities not included in the NAMAF registry. Additional facilities were identified by reviews of online medical listings and Telecom Namibia's *Telephone Directory 2013–2014*, as well as by a snowball methodology in which data collectors asked interviewees to identify all nearby private health facilities.

Jessica Scranton

Increasing access to services: Mister Sister

With an average of 2.5 people per square kilometer, Namibia has one of the lowest population densities in the world. One of the greatest challenges for rural communities is the distances to access health care—some estimates show an average of 43 miles to a clinic and 62 miles to a doctor. For the government to reach these remote populations through the public sector's existing structure, it would have to spend significant financial resources to build infrastructure and support new staff for a limited client base. As a result of advocacy efforts by SHOPS for PPPs in general, the MoHSS recognized the value of developing an innovative private sector model to reach these populations. Using the information that SHOPS provided, the ministry identified private mobile clinics as an effective and efficient strategy for increasing access to primary health care and HIV services in rural areas where HIV prevalence is higher, especially for women.

To that end, SHOPS partnered with PharmAccess Foundation Namibia, which manages the Mister Sister mobile clinics with additional financial support from the Heineken Africa Foundation. SHOPS chose PharmAccess and Mister Sister because of their existing partnership with the MoHSS and other successful experiences with USAID serving rural populations. The clinics, which are retrofitted vans and trucks, are generally staffed by a driver and two nurses who deliver a comprehensive set of primary health services. For more advanced care, the Mister Sister nurses refer patients to the nearest public health facility. Many of these services are paid for by employers along the clinics' routes. To keep costs low for rural and poorer populations, the MoHSS provides Mister Sister with necessary commodities.

With SHOPS support, Mister Sister began operating additional clinics in the Khomas, Omaheke, and Otjozondjupa regions in 2012. SHOPS contributed

Jessica Scranton

to this expansion by assisting with the contract development between the MoHSS and Mister Sister, planning the expansion, facilitating public-private dialogue, building demand for the services, and evaluating the program. SHOPS also provided a temporary operational subsidy for the expansion of the mobile clinics to ensure that services could be delivered to clients until sufficient private sector employers had subscribed to sustain service provision without donor subsidies. In 2013 and 2014, SHOPS helped Mister Sister expand its operations to cover the Erongo region. It also helped the clinics include HIV-specific services—HIV testing and counseling—and VMMC education and referral. Finally, SHOPS explored additional opportunities and barriers to provide ARVs and integrated HIV and tuberculosis services through mobile clinics.

Strengthening the Role of Private Health Providers to Finance and Provide VMMC

Namibia has a target of circumcising 80 percent of the male population. Recognizing the potential role for the private sector in scaling up VMMC, in 2011 SHOPS began supporting supply intervention with the delivery of male circumcision services by creating an enabling financial environment and building capacity for VMMC to be performed by private providers. To ensure quality of services and capacity in the private sector, the SHOPS team worked with the MoHSS Male Circumcision Technical Working Group to adapt the national male circumcision training curricula for private providers and related training, changing the mode of delivery to be private sector-friendly for the first time. Additionally, SHOPS explored working with on-site corporate programs to support VMMC campaigns to raise awareness in the workplace and increase uptake of VMMC services.

Financing VMMC through private medical aid schemes

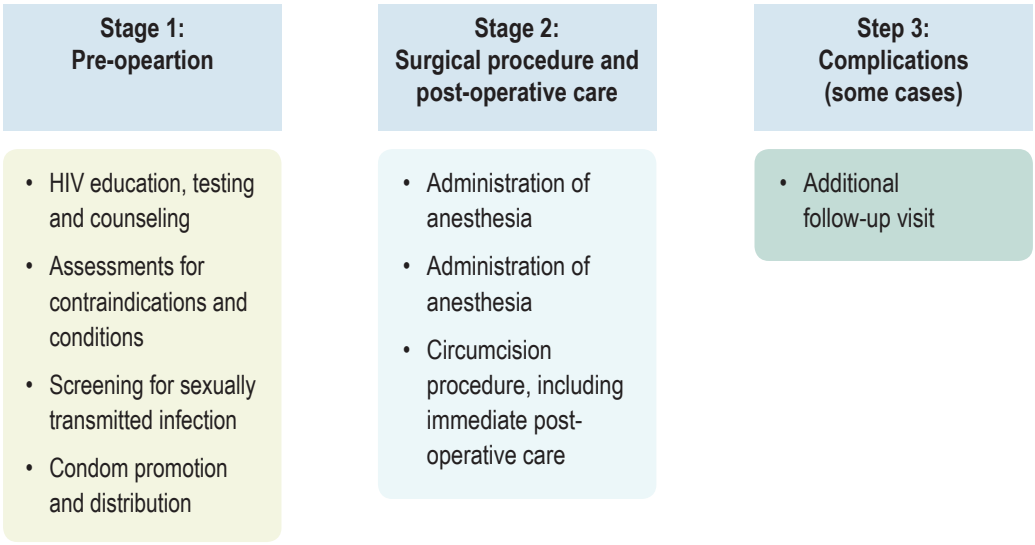
Prior to the SHOPS program, Namibian men who subscribed to medical aid and wanted to undergo male circumcision as an HIV preventive measure could not receive any reimbursement from their scheme. These men either paid out of pocket or sought VMMC from a public or nonprofit service delivery point.

Given the private sector's resources and untapped potential, USAID/Namibia looked to SHOPS to consider ways to increase private provision of VMMC. SHOPS estimated that if 50 percent of medical aid schemes covered VMMC as an HIV preventive benefit, and if 100 percent of insured men had the procedure, 93,600 men could be circumcised in the private health sector. These men would represent 28 percent of the total required to reach the MoHSS circumcision rate goal of 80 percent across all age groups.[2] In Namibia, the NAMAF sets standard reimbursement fees (or tariffs) for medical procedures, such as VMMC, that are covered by Namibian medical aid schemes. Accordingly, in partnership, the NAMAF, USAID/Namibia, and SHOPS identified a VMMC tariff as a potential method to increase the number of Namibians accessing this benefit.

The SHOPS team supported actuarial work with Deloitte to identify an accurate cost and reimbursement rate for male circumcision in the Namibian setting. For the analysis, the actuaries employed an activity-based costing method, which allowed for accurate accounting of direct and indirect costs of the medical procedure. Considering three different types of non-device male circumcision methods—clamp, dorsal slit, and surgical excision—SHOPS divided these procedures into separate components (as shown in Figure 1) and computed the cost of performing each. The costing exercise looked at the three stages of the male circumcision procedure, including all associated activities.

[2] This model was developed in 2011 by SHOPS resource partner Professor Frank F. Feeley (Boston University School of Public Health) using conservative estimates for future workforce growth and medical aid coverage levels.

Figure 1. Stages of the VMMC procedure considered in costing analysis



After aggregating all costs associated with the three stages of the procedures, SHOPS included a 3 percent margin to account for any unforeseen costs or wasted medical materials. SHOPS completed a proposal with the tariff calculations, along with an explanation of the costing analysis to the NAMAF.

Expanding provision of VMMC through the private sector

To expand the provision of high quality VMMC services through the private sector, the SHOPS team worked to develop a private sector-friendly VMMC training that follows MoHSS guidelines. Through its partner Jphiego, the team worked with the MoHSS Male Circumcision Technical Working Group to assess private provider training needs. Based on the findings from this assessment, the project adapted the public sector training curriculum for male circumcision, developed by the World Health Organization, to create a course specific to private sector providers in Namibia for the first time.

With this curriculum, SHOPS partnered with the HIV Clinicians Society in June 2014 to conduct the first private sector VMMC training. The HIV Clinicians Society is the only association in Namibia with a specific HIV mandate and encompasses many types of clinicians, including doctors, nurses, and pharmacists. The trainings were conducted in a PPP approach with Oshakati State Hospital, the largest public hospital in northern Namibia, providing facilities for training as well as clients, and ErongoMed, a private wholesaler, providing male circumcision kits. During the practical session of the training, 10 doctors were trained and 50 males were circumcised. SHOPS continued to collaborate with the HIV Clinicians Society to train private providers in Katima Mulilo, Oshakati, Rundu, and Windhoek.

In 2013, SHOPS supported the City of Windhoek's, campaign to promote VMMC in the workplace. This HIV prevention and awareness campaign focused on the benefit of male circumcision. Ten campaign sessions took place over a two-week period, during which 300 City of Windhoek employees attended the VMMC information sessions.

The SHOPS team also coordinated between the MoHSS and the City of Windhoek and assisted the city in negotiations with medical aid schemes to finance VMMC during this campaign. SHOPS identified 12 private medical doctors who agreed to participate in the campaign as VMMC referral doctors for city employees. As a partner in the campaign, LifeLine/Childline, a local Namibian NGO, also conducted HIV counseling and testing.

Increasing Commercialization of Selected NGOs to Promote Financial Sustainability

Since 2004, PEPFAR has invested heavily in Namibia's HIV response. Much of this funding was allocated to local nonprofits, resulting in a dramatic increase in the number of registered NGOs in the country. As of 2011, SHOPS estimated that there were approximately 235–270 NGOs actively providing HIV and AIDS-related services. These organizations have made significant contributions to scaling up access to a range of HIV services, from testing and counseling to ART. Many of the organizations are primarily (up to 90 percent) dependent on PEPFAR for their funding. As PEPFAR transitions its financial commitments in Namibia, these partners face significant challenges to sustaining their operations. USAID actively sought out new strategies and opportunities to sustain its PEPFAR partners by identifying new funding sources. To assist this effort, the SHOPS team sought to gain an improved understanding of how corporate demand for health and wellness services could contribute to the NGOs' financial sustainability.

Evaluating commercialization opportunities

In July 2012, SHOPS Namibia began a process to define, quantify, and analyze the potential for Namibia-based NGOs to partially commercialize their operations by catering to corporate clients. The SHOPS team completed an assessment of major corporations who financed HIV and AIDS-related programs to determine their purchasing criteria and propensity to use NGOs versus other service providers. Based on this assessment, SHOPS determined that disease management, wellness services, and low cost health clinics were the most significant opportunities. In parallel, the team evaluated leading NGOs that had received significant PEPFAR funding to assess their readiness to provide services that corporations demanded and to measure their attitudes toward working for these types of partners. Based on these analyses, project staff identified how PEPFAR partners could offer potential solutions that spoke to corporations' interests in each of the three opportunity areas identified by SHOPS (Figure 2).

Crystal Beukes

A training session for private doctors in VMMC.

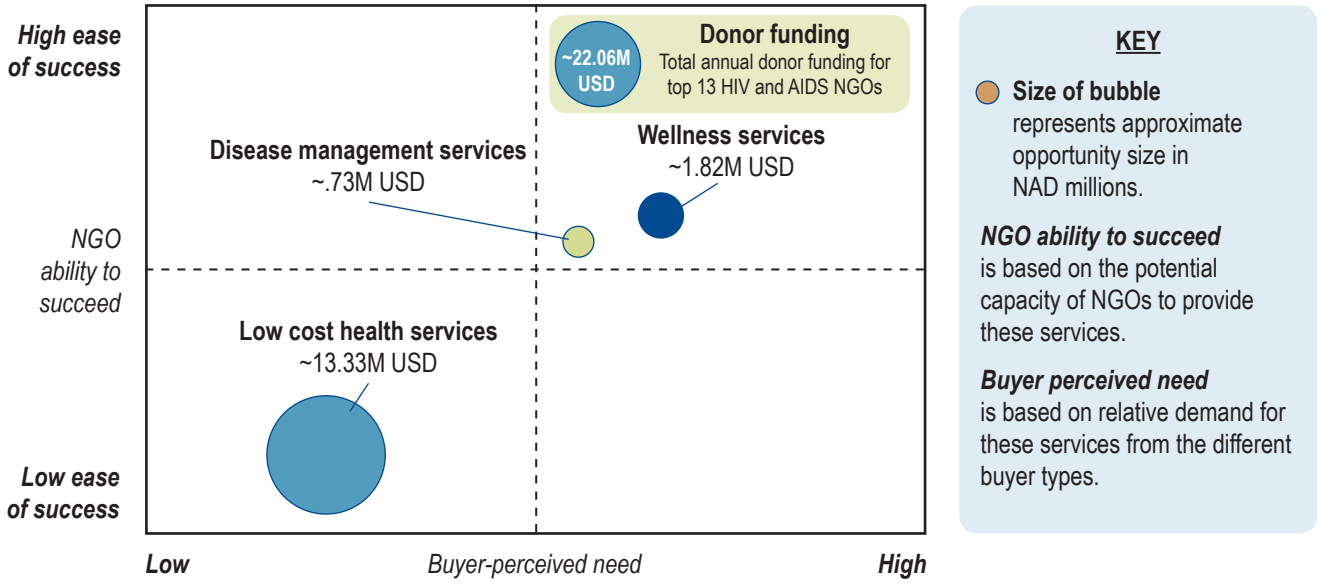
Figure 2. Opportunities for corporate-NGO partnerships

	Disease management	Wellness services	Low cost health clinics
Buyer	Medical aid and insurance providers	Private companies	Individuals employed by companies that do not provide access to health care services; and those who are unemployed with buying power
Rationale for purchase	Improving patient behavior can potentially cut the cost of coverage for medical aid for chronic diseases	Wellness services are becoming increasingly popular, and there appear to be insufficient affordable and reliable service providers	There is a service provision gap between private providers and government provision, particularly for the employed but uninsured population
Potential solution	Provide disease management and counseling services to medical aid and insurance members	Provide wellness services to company employees	Provide primary health care services, through either fixed or mobile clinics
Potential benefit	Affordability, service quality, scope of offering, reliability, familiarity, up-to-date medical knowledge, monitoring systems	Affordability, service quality, scope of offering, experience, reliability, certification	Affordability, accessibility, service quality

Each opportunity had market potential, yet none of the opportunities alone or combined was considered large enough to replace declining donor funding. To identify a focus area for pilot programs, the SHOPS team compared the three major opportunities in relation to their revenue potential as well as their perceived need and potential ability to succeed (Figure 3). Wellness services were determined to be the most promising opportunity for developing market linkages due to high demand from corporations and existing NGO capacity in this area. With these findings, SHOPS recommended technical assistance to improve the internal capacity of NGOs offering wellness services to provide high quality services to corporations, to design improved packages to meet the needs of the employed, and to better market themselves to create awareness among those who would purchase services.

For years, HIV and AIDS services have been a strong employee health provision component of Namibian companies. However, with HIV and AIDS viewed as increasingly under control, firms are now turning their attention to providing more holistic wellness services to their employees including, but not limited to, HIV and AIDS. Such services are viewed as beneficial to companies and employees alike, as they help to mitigate workplace issues, such as absenteeism and low productivity. Some NGOs in Namibia have the capacity and experience to provide wellness services. NGO readiness combined with a sizeable potential market made wellness service provision the most likely opportunity to succeed.

Figure 3: Commercial prospects market sizing



Note: Exchange rate used = average bid rate for third quarter of 2012 (July 1, 2012–September 30, 2012) to align with period of original calculation: 1 USD = 8.2491 NAD

Source: Oanda.com; NGO Interviews; Monitor Analysis

Piloting partnerships

To test wellness commercialization prospects for NGOs, in July 2013 SHOPS facilitated the launch of two six-month pilots that partnered two NGOs with two private companies to provide general wellness services. The primary objective of the pilot was to assess whether NGOs can be effective as commercial service providers. The intervention's broader intention was to explore how the revenue-generating opportunities that SHOPS identified could enable NGOs to continue to fulfill their primary mission of providing key health and HIV services to vulnerable populations using non-donor funding.

SHOPS conducted an assessment to identify corporations that would be well suited for the pilots. The assessment considered business organizations' size, growth, and potential match to NGO service providers based on similar needs, preferences, and purchasing behaviors. SHOPS team interviews with potential commercial partners resulted in a short list of corporations that expressed a willingness to pay for NGO services and previously did not have ties to current wellness providers.

In addition to identifying corporations to participate, SHOPS assessed 13 NGOs that deliver 80 percent of HIV and AIDS services in Namibia to identify partners for the pilot. SHOPS considered the following characteristics as most relevant to commercialization prospects:

- External relationships with other NGOs and private sector partners that leverage resources to address challenges in health
- Financial management systems
- Organizational commitment to growth while continuing to maintain a social mission
- An administrative infrastructure that supported the organization in fulfilling its social mission

Based on the overall organizational capacity and service provision assessment of NGOs and the private sector, the SHOPS team identified two NGOs for six-month pilot projects aimed at developing alternative income sources. Throughout the pilot, the team provided the NGOs with technical assistance to price their service offerings, build monitoring and evaluation systems, and market their services to stimulate demand among potential corporate partners. The NGOs successfully developed value propositions to meet private sector needs and—with SHOPS support—negotiated contracts to provide general employee counseling for the six-month pilot period. In conjunction with the aforementioned technical assistance, SHOPS conducted an extensive legal analysis of Namibia's common law and international best practices to identify the legal implications of commercializing services while remaining an NGO.

Jessica Scranton

Results

Jessica Scranton

RESULTS

Creating an Enabling Environment for Public-Private Partnerships

Building trust through improved reporting

The lack of knowledge of private sector activities and contributions caused a barrier to effective engagement between the sectors. Through its work with the NAMAF and MoHSS, SHOPS helped crack the "black box" of private sector service data, building trust and increasing knowledge of and respect for the private health sector's role.

Starting with male circumcision data, SHOPS successfully brokered systematized annual reporting of private sector data on key HIV indicators to the MoHSS. In addition to reporting statistics, SHOPS analyzed the data to build knowledge and understanding of HIV management in the private sector. SHOPS presented its findings to several medical aid administrators and funds to share new opportunities and identify areas for improvement. For example, 30 percent of private sector ARV patients collected their medication more than 30 days late, indicating compromised adherence to treatment protocols. By highlighting these issues and working with partners, SHOPS helped strengthen the private health sector's contributions to Namibia's HIV response.

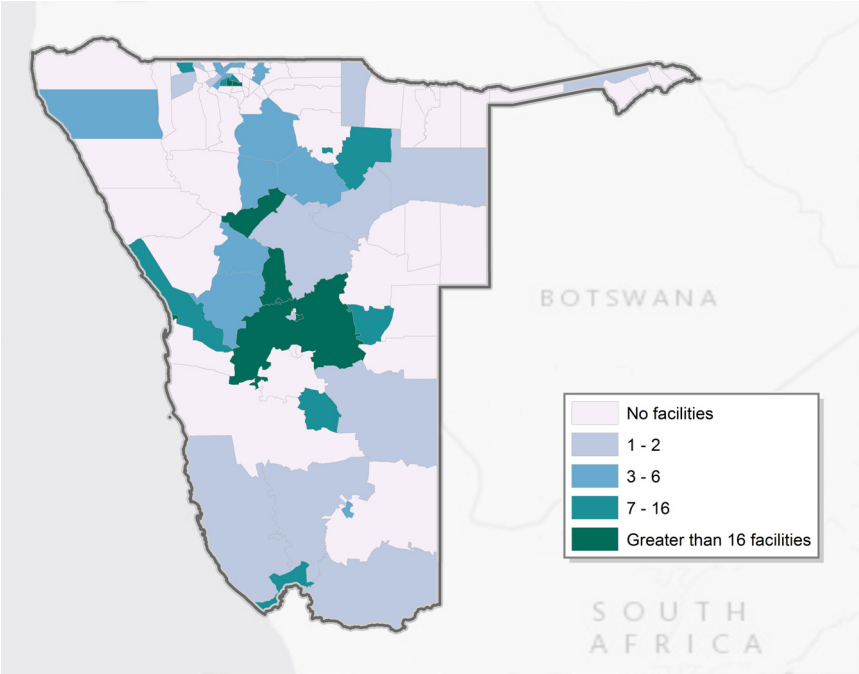
Mapping the private health sector to identify new public-private partnership opportunities

By mapping the private health sector, SHOPS developed the first consolidated, comprehensive database on the country's 890 private health facilities. The exercise gathered information on the facilities' geographic location, staffing, specialized equipment and services, and payment mechanisms and fees. This information provides evidence to support the government and other stakeholders as they seek to maximize the contributions of the private health sector. This goal is particularly important as the country takes increasing ownership for sustaining the national HIV response and exploring PPPs. Based on the mapping, 662 (74 percent) of private facilities are within PEPFAR priority regions. Of these, 428 (64 percent) are concentrated in Khomas and 87 (13 percent) in Oshana (Figure 4). The survey identified the presence of viral load testing in several private hospitals, which could present opportunities for future training partnerships between the public and private sector and for cross-referrals.

SMS reminders to support drug adherence

Tracking ARV adherence is important for successful viral suppression and reducing HIV incidence. Currently, there are limited data on adherence rates in the Namibian private sector. In response to learning that 30 percent of private sector patients collect their medication late, SHOPS collaborated with partners to implement an SMS reminder for patients. SHOPS initiated meetings with telecommunications companies, including Computerkit Namibia, a software company that designed a system used by private pharmacies to write a script that will introduce automated SMS reminders to patients. Working in partnership with the Pharmaceutical Society of Namibia, SHOPS tested the first script and suggested changes to improve the automated reminders.

Figure 4. Density of private providers in Namibia



Supporting innovative public-private partnerships to improve sustainability of HIV response

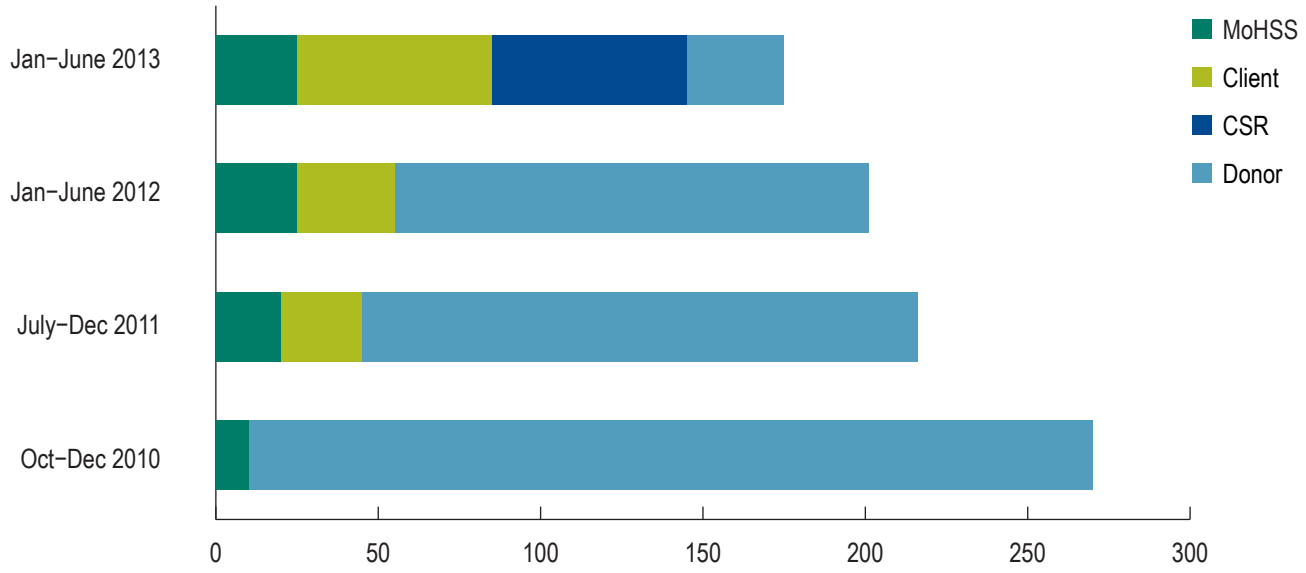
Through the PPP with Mister Sister, the SHOPS team helped demonstrate that innovative PPPs could expand the reach of primary health care services and sustain the national HIV response. As one of the first PPPs for health in the country, Mister Sister represented a significant opportunity to provide a proof of concept to support further public-private engagement. Over the course of the team's support, the clinics expanded their range to provide 12,276 health care visits—the majority of which were for women—in 4 out of 14 political regions. Services included primary health care, sexually transmitted infection treatment, vaccinations, and HIV services. More than 1,808 people received HIV testing and counseling, and 122 men were counseled on and 54 men received male circumcision services. As the Namibia Demographic and Health Survey recently found that men were twice as likely to access testing and counseling through mobile services as women (MoHSS and ICF International, 2014), it is of note that Mister Sister demonstrated the opposite: 57 percent of Mister Sister's HIV counseling and testing clients were women. This poses a significant opportunity to further HIV outreach to women, who are more likely to be living with the disease. During this activity, Mister Sister was not provisioned to provide ART; in the future, the clinics' recurring visits and ability to attract female patients could be an effective way to reach and support adherence for more women on ART if the clinics are able to stock and prescribe ARVs. As stakeholders consider interventions to reach women and vulnerable populations with HIV services, the Mister Sister experience demonstrates that mobile clinics may provide an effective and efficient option for service delivery.

Additionally, the Mister Sister experience demonstrated that with donor investments, responsible management, and demand for services, organizations can achieve sustained service provision. Over the three years from October 2010 through June 2013, Mister Sister transformed from an organization largely dependent on donors to one funded by the MoHSS, corporations, and clients who had the ability and willingness to pay (Figure 5). This establishes an important precedent for domestic resource mobilization in support of health services.

Mister Sister HIV testing and counseling

	Male	Female	Unspecified	Total
Total tested	744	1029	35	1808
Positive	53	25	6	84
Negative	805	853	29	1687

Figure 5. Mister Sister's sources of funding



Note: CSR = corporate social responsibility

Strengthening the Role of Private Health Providers to Finance and Provide VMMC

Expanding universal private medical aid coverage of VMMC

In July 2011, the SHOPS team submitted an application to the NAMAF that included a clinical justification and a proposed tariff for VMMC as an HIV preventive benefit. The tariff was accepted by the NAMAF in October 2011 and went into effect in January 2013, making Namibia the first country to systematically cover VMMC under medical aid as an HIV preventive benefit. By January 2012, 9 out of 10 medical aid schemes in the country also had included the tariff in their packages. This quick and positive uptake surpassed SHOPS's expectations and indicated a strong desire by the medical aid industry to expand access to VMMC for HIV prevention. As the project trained more providers to deliver this service, medical aid schemes became an important and sustainable domestic source of funding for HIV prevention efforts.

Cost of covering VMMC for HIV prevention

The SHOPS tariff costing analysis estimated the cost of a single male circumcision procedure to be $276.28,* as detailed in the table at right. Namibia also has a public sector program supported by PEPFAR. With a budget of $6.6 million, the program provided 12,509 circumcisions over the course of three years, for a unit cost of $527. Accordingly, SHOPS costing analysis demonstrated that a cost savings for male circumcision of approximately $251 can potentially be achieved by targeting males with medical aid seeking private sector services. Furthermore, PEPFAR's investment in the private sector program during the same period was $327,000, or $112 per male circumcision.

Pre-operation activities	$46.22
Surgical procedure and post-operative care	$220.76
Potential complications	$31.25
Margin for waste (3%)	$8.05
Total Tariff	**$276.28**

** Exchange rate of Namibian dollars to U.S. dollars of 0.1449 from May 1 to July 19, 2011, when the tariff costing analysis was completed.*

Expanding the provision of VMMC through the private sector

SHOPS's work with private providers resulted in a network of trained doctors who had access to male circumcision kits as an incentive to standardize care across sectors and increase provision of male circumcision. Facilities in the SHOPS network received site readiness assessments, business model training, access to and guided use of a quality assurance tool, and technical assistance. In return, the clinicians provided regular male circumcision reports to SHOPS for submission to the MoHSS. In collaboration with USAID, SHOPS also identified and established four VMMC model sites. These sites received additional technical assistance to establish a business model for VMMC and related reporting systems. In total, SHOPS distributed 405 disposable male circumcision kits to the 25 doctors in the SHOPS network. These facilities performed 302 circumcisions as of December 31, 2014.

Building partnerships for private sector HIV services in Windhoek

The City of Windhoek campaign was successful through collaboration among the city government, MoHSS, SHOPS, Lifeline/Childline, medical aid schemes, and support from private sector clinicians. The MOHSS welcomed this private sector initiative, their contribution toward national HIV counseling and testing, and VMMC goals. During the campaign, 159 men and 39 women were tested and counseled for HIV with their results provided on site. Also, 51 VMMC procedures were scheduled, 50 of which were provided by the private sector. An additional 51 males were circumcised after the campaign.

Through these initiatives, SHOPS has made considerable progress in increasing private sector participation in national VMMC programs in a short time period. The project's efforts demonstrated that high quality VMMC procedures could be sustainably financed and delivered through the private sector. Based on a 2009 pilot program that had the goal of reaching 80 percent of adult males (ages 18–49) through the expansion of VMMC services in district hospitals throughout the country, stakeholders developed a larger regional program to avert new HIV infections. When the new regional program was launched in July 2014, only 5 percent of males (16,341) had been circumcised (*New Era*, 2014), but the private sector was fully recognized as an important partner in achieving the national goals.

Increasing Commercialization of Selected NGOs to Promote Financial Sustainability

Generating revenue sources

The two commercialization pilots successfully generated alternative revenue sources for the NGOs. One notable effect of the pilots was the enhanced capacity of local NGOs in organizational management and their success in incorporating commercialization into their long-term revenue and sustainability strategies. Although it is important to note that while both NGOs and corporations felt the pilots were a success, additional service agreements were needed to generate the level of revenue received by donors through commercialization.

> "We never would want the corporate work to be so dominant to take over the core business of providing services to the vulnerable people of Namibia."
>
> *– NGO representative*

Strengthening the financial management infrastructure of NGOs

The revenue-generating pilots had a positive impact on the financial management infrastructure of NGOs. Fundamental to the SHOPS approach was the market-led focus to better understand and respond to the needs of the private sector. Nevertheless, interviews with NGO representatives following the pilot program highlighted their continued commitment to their social mission of serving vulnerable populations in Namibia. With the help of SHOPS pricing strategies, the commercial service agreements generated approximately 25 percent and 11 percent, respectively, of average annual revenue for the two NGOs. This impressive return depended on both the commitment of private sector partners to the service contracts and the ability of the NGOs to raise awareness of counseling services by adapting their employee engagement strategies. Both commercial partners extended their service agreements beyond the pilot period.

Jessica Scranton

Lessons Learned

Jessica Scranton

LESSONS LEARNED

Partnership with the private sector is critical for Namibia to reach the UNAIDS goal of 90-90-90. Assuming stable incidence and using current coverage estimates, Namibia will need to expand treatment coverage by 150 percent to reach an additional 180,000 Namibians, while continuing to sustain the 120,000 PLHIV currently on ART. Lessons learned in Namibia will inform future private sector partnerships and domestic resource mobilization to facilitate the achievement of this goal.

Creating an enabling environment for collaboration is critical to supporting a partnership with the private sector.
Governments in many sub-Saharan African countries are hesitant to work with the private health sector, either because they are unaware of potential opportunities or because they are opposed to such engagement on principle. The SHOPS experience in Namibia demonstrated that such reluctance can be overcome and an enabling environment built through targeted advocacy. Several activities supported this success. As a neutral broker, SHOPS was able to engage both government and private sector stakeholders to begin dialogue and build trust between the two sectors. This dialogue was supported by high quality information, both on regional PPP experiences and potential opportunities specific to Namibia. These efforts helped show both sectors how PPPs can be mutually beneficial and support the achievement of priority health goals. By identifying and supporting a pilot PPP opportunity with a high chance of success (Mister Sister), SHOPS built momentum and expertise in the health system to manage and implement PPPs.

Corporate-NGO pilots demonstrate potential for commercializing NGO offerings, but additional investments in technical assistance are needed.
Donors interested in stewarding successful NGO commercialization may need to encourage NGOs to consider revenue diversification strategies as PEPFAR transitions because they will require technical assistance related to these types of strategies. The SHOPS pilot found that NGOs require marketing capacity, pricing support, negotiation skills, and support for the development of monitoring and evaluation systems that meet the needs of both corporations and donors. Without the additional technical assistance, the pilots would not have been as successful and revenues would not have exceeded NGO services.

Mobile clinics offer an important opportunity to expand access to testing, care, and treatment, but targeted demand creation in priority regions is necessary.
With the majority of PLHIV living in remote areas, Namibia can benefit from innovative and cost-effective methods to reach these populations. Mobile clinics are strategically positioned to provide efficient and low cost health services on behalf of both government and private sector partners. However, expanding access to services through mobile clinics will require geographic targeting to reach vulnerable populations and behavior change campaigns to encourage health-seeking decisions and build demand for HIV services. While SHOPS's experience with Mister Sister was a successful PPP offering some needed low cost health services (such as immunization, antenatal care, and treatment of acute illnesses) in hard-to-reach areas, it did not achieve high rates of HIV testing. This was likely due to the selection of regions for Mister Sister outreach. While the regions selected in partnership with the MoHSS were critical to expand access to services for the general population, they were not necessarily regions with the largest populations of PLHIV.

Using existing systems and incentives can provide needed private sector data routinely and reliably.
Before the SHOPS program, Namibia's public and private sector systems operated completely independently of one another and, consequently, the private sector's contribution to the national HIV response was not well known or fully integrated in national reports. To understand the impact of HIV services in the private sector, it is critical for clinicians to report on the types of services provided for patients and identified HIV indicators while protecting patient confidentiality. SHOPS supported activities that leveraged existing mechanisms to ensure sustainability of reporting. For example, working in partnership with the NAMAF provided SHOPS with access to data from all medical aid funds operating in Namibia. Through this partnership, SHOPS was able to access data on HIV service coverage such as testing, CD4 counts, viral

load testing, male circumcisions, and ARV coverage through the private sector. While medical aid funds were unwilling to share data because of concerns about the use of those data, the NAMAF's role in the industry and its commitment to assuring anonymity of shared data allowed SHOPS—and therefore, key partners such as the MoHSS and USAID—to have access to private sector data for key indicators. Moreover, by incorporating VMMC reporting requirements with resupply of male circumcision kits, SHOPS was able to regularly collect these data from private health providers participating in VMMC delivery. Ultimately, the inclusion of the private sector data into national reporting provides a broader understanding of the HIV response and progress toward an AIDS-free generation.

Working with private sector peer-supported networks provides opportunities to understand doctor-patient relationships and how they impact the demand for HIV services.
Through the coordination of a network of private clinicians providing VMMC, SHOPS supported the sharing of lessons learned among providers relating to patient engagement. In particular for HIV services with limited demand—like VMMC—it was helpful for providers to share strategies about how to engage and educate patients on the benefits of services. The opportunity for these doctors to work together improved their approach to patients and supported the scale-up of VMMC.

CONCLUSION

Access to health care in Namibia is complicated by the country's large size, uneven population distribution, and high rate of HIV and AIDS, especially among women. The well-funded public health system serves approximately 82 percent of the population, yet 75 percent of doctors practice in the private sector. Based on findings of a PSA, SHOPS partnered with USAID/Namibia to design a program to support an enabling environment for PPPs, strengthen the role of private providers to finance and provide VMMC, and increase commercialization of two NGOs to promote financial sustainability.

SHOPS submitted an application to the NAMAF that included a clinical justification and a proposed tariff (standard medical reimbursement fee) for VMMC as an HIV preventive benefit. The NAMAF accepted the proposal effective January 2012, making Namibia the first country to systematically cover VMMC under medical aid as an HIV preventive benefit. Within a year, 9 out of 10 medical aid schemes in the country had included the tariff in their packages.

In preparation for reduced donor funding, SHOPS carried out two six-month commercialization pilots aimed at promoting NGO sustainability. The pilots showed the potential for commercializing NGO offerings, but additional investments in technical assistance are needed. The program found that mobile clinics presented an opportunity to increase access and found ways to improve data reporting from the private sector, a necessary step to gaining a better understanding of the HIV response and achieving an AIDS-free generation.

Through these efforts, SHOPS helped to improve access to affordable health care and create linkages with the public sector to support expansion of care for the Namibian people.

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

Abt Associates Inc.
4550 Montgomery Avenue, Suite 800 North
Bethesda, MD 20814 USA
Telephone: 301.347.5000 • Fax: 301.913.6019
www.abtassociates.com