



Going private to grow public

Pioneering Public Private Partnerships
in the Health Sector in Namibia

A history of PharmAccess'
work in Namibia 2004-2016



*Joep Lange
presenting at
HIVREF launch*

Dedication to the memory of Prof. Dr. Joep Lange

On 17 July 2014, Prof. Dr. Joep Lange passed away, together with his partner Jacqueline van Tongeren, on board Malaysian Airlines flight MH17, en route to the International AIDS conference in Melbourne. Joep Lange was the founder of PharmAccess and an architect of many of the organizations interventions. He was a respected activist for anti-retroviral therapy globally and especially in Africa. He emphasized the need for rigorous scientific evaluations of health programs in Africa and initiated operational research within PharmAccess. It is impossible to overestimate the contribution Joep Lange has made to the legacy of PharmAccess in Namibia both in terms of health care program interventions and the related scientific articles, which are dedicated to his memory.

Preface

This booklet describes the journey of PharmAccess and its partners in Namibia, in improving access to healthcare in Namibia over a period of 12 years. This journey includes the development of low-income medical aid (health insurance) and a risk equalization fund for HIV, the implementation of anonymous workplace HIV prevalence screening, the design and roll out of mobile wellness screening vehicles and the establishment of mobile primary health care services. PharmAccess Namibia was established in 2004 and for 12 years pioneered innovative healthcare services. By the end of 2016, PharmAccess had successfully and sustainably transitioned all programmes to Namibian partners. The key contributor to the success of all these programs and their sustainable domestic funding has been in the strategic partnerships that were formed over the years, between private and public sector stakeholders both nationally and internationally. The continuous development of programs was based on evidence collected through both operational and original research, to specifically identify the gaps in the healthcare system and develop appropriate solutions.

One of the great achievements of the programs of PharmAccess in Namibia have been that all initiatives of PharmAccess, which were initially catalysed and developed with donor funding, were fully integrated into the Namibian healthcare landscape and continue to exist today and into the future, sustainably funded from domestic resources.

In many ways PharmAccess Namibia served as the ground zero country to design concepts and tools beneficial to other countries with PharmAccess operations, especially in the development of health insurance, quality improvement, impact assessments and public private partnerships.

PharmAccess

When Professor Dr. Joep Lange founded PharmAccess in 2001, he was determined to turn his groundbreaking scientific research on triple-combination drug therapy into action. His drive brought this life-saving AIDS treatment to those who needed it most. Joep's vision of increasing access to affordable and better healthcare for people in sub-Saharan Africa is still at the heart of what we do.

Building on this work on the front lines of HIV/AIDS, our focus has broadened to making healthcare finance and delivery more effective and more inclusive. Currently, the PharmAccess Group has developed into a dynamic international organization with a digital agenda dedicated to connecting more people to better healthcare in sub-Saharan Africa. The PharmAccess Group believes that digitalization has the potential to revolutionize healthcare in Africa. Our integrated approach mobilizes public and private resources for the benefit of doctors and patients through a combination of loans for healthcare providers (through the Medical Credit Fund www.medicalcreditfund.org), clinical standards for quality improvement (using the SafeCare methodology www.safecare.org), (mobile) health insurance and impact research. More and more, we are using digital technology to accelerate this approach.

We work closely with leading local and international partners to leverage donor contributions to increase trust throughout the health system, reduce risks, and pave the way for investments. Their specific approach to development has won prestigious international recognitions, including a G20 prize for innovative financing presented by U.S. President Obama and two Financial Times/IFC awards.



Timeline

PharmAccess Namibia high level timeline

- 2001 • PharmAccess Foundation founded in Netherlands
- 2002 • Namibia Business Coalition on Aids (NABCOA) launched
- 2003 • Proposal written to Dutch Postcode Loterij
- 2004 • PharmAccess start-up in Namibia commenced. DHS product developed
- 2005 • Okambilimbili launched. DHS product marketed
- 2006 • HIV Risk Equalization Fund (HIVREF) developed
 - Launch of Vitality and Vitality Day Care
 - DHS incorporated into NHP Blue Diamond
- 2006 • Oral fluid tests validated
 - 1st Windhoek household survey conducted
 - First HIV prevalence surveillance pilot conducted
- 2007 • Commence prevalence and on-site screening program,
 - Marketing of HIVREF & products through workplace programs
- 2008 • 2nd Windhoek household survey
- 2009 • Okambilimbili project ended
 - 3rd Windhoek household survey
 - HIVREF benefits incorporated into individual medical aid fund schemes
 - Launch of Bophelo! mobile wellness screening clinics
- 2010 • Pilot of Mister Sister mobile primary health care clinics in Otjozondjupa region (rural areas only)
- 2011 • Signing of 1st mobile primary health care provision public private partnership (PPP) agreement in Namibia between MoHSS and PharmAccess for the Mister Sister clinics in the Otjozondjupa and Omaheke regions
 - Transition Bopelhol! Mobile wellness screening program from PharmAccess to NABCOA
- 2012 • Mister Sister PPP agreement signed for Khomas region and all regional PPP agreements expanded to include service provision in semi urban area
 - Corporate Social Responsibility agreement concluded with Namibia Medical Care (NMC) for 3 years funding for Mister Sister and the donation of two mobile clinics
- 2013 • PPP agreements expanded to include urban areas
- 2014 • PPP agreement expanded to Erongo region
- 2015 • Funding agreement for Mister Sister with NMC extended to 2018
 - Funding agreement with B2Gold concluded for Mister Sister
- 2016 • Mister Sister program domestically financially sustainable
 - Transition Mister Sister to Healthworks

Going private to grow public: Pioneering Public Private Partnerships in the Health Sector in Namibia

Introduction

A chance meeting at the residence of the Dutch ambassador to Namibia, back in 2002, was the beginning of some of the most successful public-private health initiatives Namibia has ever seen. Professor Tobias Rinke de Wit, a co-founder of the Netherlands-based PharmAccess Foundation (www.pharmaccess.org) had just arrived in Namibia to assess the possibility of starting an HIV/Aids workplace programme at local brewing company, Namibian Breweries Limited. ‘PharmAccess at that time had a partnership with Heineken to initiate HIV/Aids workplace programmes in their breweries across Africa. This was part of our early efforts to roll out antiretroviral treatment in Africa and halt the spread of HIV, which was seriously starting to affect the workforce. With Heineken taking up an equity stake in Namibia Breweries we were investigating the possibility of rolling this programme out to Namibia as well,’ says Rinke de Wit. His visit coincided with the launch of the Namibia Business Coalition on Aids (NABCOA) with the mission to mobilise a private sector response to address a rampant Aids epidemic among the workforce. Rinke de Wit spoke about at the launch of NABCOA about PharmAccess and its mission of mobilising public and private funding for a common cause.

‘Aids was real, but we didn’t know how to deal with it,’ recalls Ingrid de Beer, then Head of Human Resources at Ohlthaver & List, the parent company of Namibia Breweries and founding member of NABCOA. ‘As a business we were feeling the effects of the epidemic, the national adult HIV prevalence rate was estimated between 13-22% in the different regions of the country. Too many people were sick, for longer periods of time, and even when they returned to work many were placed on light duty by the doctors and were unable to perform their normal work functions. We realised that remedying this trend through the hiring of extra people would be expensive and ultimately detrimental to sick workers as their careers would come to a standstill. Sick and disability insurance claims were rising and in the absence of effective treatment the cost to the employer would be astronomical’ Rich Feeley, Chair at the Department of Global Health at Boston University recalls this episode vividly. ‘Through USAID, Boston University, commissioned a study for the Ohlthaver & List Group to assess the effects of non-treatment. The results were scary.

It soon became clear that we were looking at an attrition rate of 2.5% of the workforce per year if we did nothing.’ Given Heineken’s relatively small stake in Namibia Breweries a full workplace programme involving the hiring of doctors and the establishment of a clinic wasn’t a viable option, but as Rinke de Wit and de Beer started talking at a soiree at the residence of Dutch Ambassador, other options emerged. ‘Medical aid was an obvious solution,’ says de Beer. ‘But the reality was that most schemes at the time excluded HIV benefits, especially cheaper options aimed at the lower income workers.



Tobias Rinke de Wit and Peter van Rooijen receiving cheque from Postcode Loterij

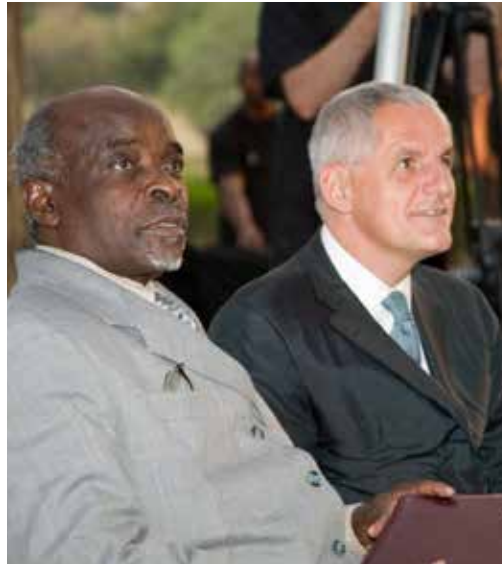
The schemes believed, that Aids patients were too risky to cover. They also lacked data on the scale of the problem, fearing that HIV benefits would open the floodgates for excessive medical costs.’ The PharmAccess Foundation, in the meantime had built significant experience with treatment programmes in Africa and Europe, working closely with corporate giants such as Heineken, Shell, KLM and Celltel, as well as with the Ministry of Foreign Affairs in The Hague. Rinke de Wit: ‘We were looking for ways in which public and private initiatives could strengthen each other because no one had all the answers. More and more we realised that the solution lay in comprehensive insurance products for the lower-middle income earners; people who would be able to pay some basic premiums, but didn’t have access to private anti-retroviral treatment which at that point hovered around a staggering US\$2,500 per patient.’

The transformation: Okambilimbili the 'Butterfly'

Taking this a step further Rinke de Wit and de Beer wrote a proposal to the Postcode Loterij, the Dutch private lottery that through the NGO Stop Aids Now! makes significant grants to Aids research and treatment. 'Surprisingly, or perhaps testifying to the strength of the idea, we received a grant of 3.3 million Euros a week later,' recalls Rinke de Wit.

The idea was that the innovative funding from the Postcode Loterij would support the development of innovate new products and provide a temporary subsidy to enable the private sector to reach the volumes that would allow HIV/AIDS treatment benefits to be commercially viable, and thus sustainable without subsidy. In 2005 PharmAccess established an office in Namibia and started working together with a local provider, Diamond Health Services (DHS), on a subsidised product that would allow the provider to offer capitation fees to health care professionals treating HIV.

PharmAccess for its part also realised that involving the wider medical aid fraternity was a prerequisite to access as many HIV patients as possible and optimize the quality of treatment in the private sector. However, it soon became obvious that the relatively small medical aid fund industry in Namibia was too risk averse to include the unknown financial risks of HIV into their existing structures, even if subsidised through the Dutch Postcode Loterij funds.



Joep Lange & Hon. Prime Minister Nahas Angula at HIVREF Launch



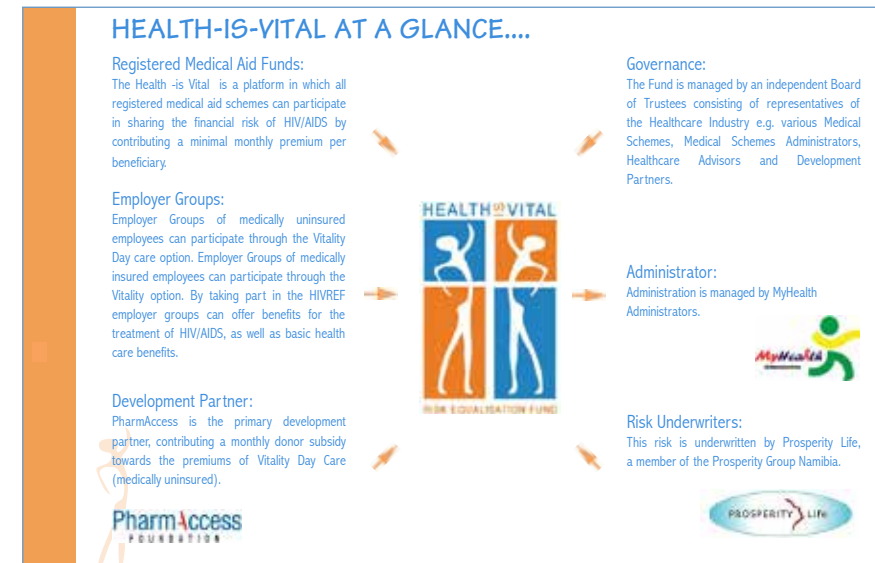
Prof Joep Lange providing training on ART to HIV Clinicians in Namibia in 2006

In the course of 2006, the realisation dawned that the HIV benefits should be taken out of the individual smaller risk pools of medical aid funds and shared in an industry fund backed by the Dutch lottery money. This would allow the medical aid providers to offer HIV benefits virtually risk-free. Together with the actuaries of local medical aid administrator Prosperity Health, the envisaged risk profile of the Namibian populations was calculated across the larger risk pool including all medical aid funds. This allowed for the development of a standard HIV benefit across different risk pools. Medical aid providers thus had a standard HIV-benefits that could be marketed to corporates in order for them to cover their workforce. The Health is Vital Risk Equalization Fund (HIVREF) was born. Prosperity Health Group Namibia, supported by the third party administrator Methhealth and the disease management organization MyHealth, administered the HIVREF.

The HIVREF initially offered two products:

- the Vitality option which was an insurance benefit for HIV and related conditions only and;
- the Vitality Day Care option, which included benefits for medical conditions other than HIV.

During the same time, with the support of PharmAccess, other medical aid funds, who did not participate in the HIVREF, started similar products. Namibia Health Plan (NHP), one of the largest funds, partnered with Diamond Health Services resulting in a new low-income product Blue Diamond. The subsidization of the HIV portion of medical risk through the HIVREF and individual schemes was the key to catalyse the changed perceptions of HIV risk in the Namibian healthcare industry.



‘But there were conditions,’ says de Beer. ‘The healthcare providers contracted by the medical aid schemes were required to adhere to the national treatment protocol and international quality standards for the management of HIV. The monitoring and improvement of quality of care was very important, especially at a time when the treatment of HIV/AIDS was very new and practitioners had limited experience in the field. The quality of care extended beyond just the relationship between the doctor and the patient, but also the capacity building of laboratory staff, pharmacists and treatment supporters/counsellors. Training and support to health care practitioners was a key part of the intervention to transform not only access to care but ensure the quality of care.’

There was significant uptake on the HIVREF and the new low income medical aid scheme products, and within 20 months over 34,000 people – almost 2% of the Namibian population at the time - were enrolled for the subsidized benefits. The temporary subsidy managed to raise exponential amounts of private sector funding of the HIV response in Namibia.

Fact Box 1 HIVREF

- Launched in 2006
- Established by Prosperity Health and Methealth
- Part of Okambilimbili project
- Enabled individual health insurance providers to share the risks for this disease
- Provides cross industry subsidy of N\$30 (€0.30) per (insured life) contribution to the participating medical aid funds
- Enrolled over 40,000 people between 2005-2009
- Led to medical aid funds retaining the new products that included HIV
- Up to 13,000 of the 200,000 HIV patients on treatment are treated by the private sector because of aid funds accepting the risk of HIV coverage
- First blueprint for PharmAccess of how to structure health insurance funds in Nigeria, Tanzania and Kenya

OP Schellekens, I de Beer, ME Lindner, M van Vugt, P Schellekens, TF Rinke de Wit. Innovation in Namibia: Preserving Private Health Insurance and HIV/AIDS treatment. Health Affairs. Volume 28, Number 6. November/December 2009.

From the beginning of the Okambilimbili project in 2004, it included a community focus. At a time when the Namibian public sector programme was bottlenecked by the high demand for HIV treatment amongst the poorest of the poor, over 500 community members, identified by the Namibia Red Cross Society and Lironga Eparu (the Namibian Association of People Living with HIV), as being in dire need of HIV treatment were treated by DHS, fully funded by the project. Thus critically ill people in the community had access to private treatment at any given time. Educating people on HIV, the availability of treatment and the importance of treatment adherence was key to the success of the program, thus efforts were made to increase awareness both in the community and in workplaces.

From the onset, NABCOA was a key partner in the program mobilising the private sector to make highly active antiretroviral therapy (HAART) available to employees through the newly established low-income products and the HIVREF. With financial support from the Okambilimbili program and technical assistance from PharmAccess, NABCOA supported workplace programs and promoted the ‘Health Workforce, Health Business’ campaign.

‘Companies need information to make decisions’ explains Peter van Wyk, CEO of NABCOA. ‘Selling medical aid products or health insurance to companies is difficult when the impact of the burden of disease is not quantified. We needed a way to show management of companies what the prevalence of HIV was not only the estimates in the country, but what the infection rates were in their own business. Thus with PharmAccess we started looking for a solution.’

PharmAccess started a process of validating non-invasive oral fluid based HIV tests in Namibia for prevalence surveillance in workplaces and communities. This was the first validation study for non-invasive HIV tests based on the collection of oral fluid in Namibia. Two types of test kits were validated for surveillance purposes, the OraQuick rapid HIV test which results become available within 20 minutes for surveillance in companies and the OraSure oral fluid test, which result requires analysis in a laboratory and is not immediately available, for use in household surveys. Both tests, based on a successful validation were approved by the MoHSS for surveillance purposes in 2006.



Ora-Quick rapid HIV screening tests 2007

Fact Box 2 ORASURE/ORQUICK VALIDATION STUDY

- Validation study conducted in 2006 in collaboration with the Namibia Institute of Pathology (NIP).
- The diagnostic accuracy of the OraQuick HIV-1/2 Rapid Antibody test and the Oral Fluid Vironostika HIV Uniform II micro ELISA were compared with the Namibian National Algorithm for HIV Testing
- 273 OraQuick specimens and 267 OraSure specimens were collected from ante-natal clinics in Windhoek
- This study was the first formal field evaluation of the OraQuick and OraSure devices, in a resource limited setting in Southern Africa.
- Finding 1: OraQuick test is 100% accurate (100 sensitivity and specificity)
- Finding 2: OraSure has a high specificity (99.5) and slightly lower sensitivity (97.1)
- Based on this validation the Namibian MoHSS approved the OraQuick and OraSure devices for surveillance purposes in Namibia

Hamers RL, de Beer IH, Kaura H, van Vugt M, Caparos L, Rinke de Wit TF: Diagnostic accuracy of 2 oral fluid-based tests for HIV surveillance in Namibia. J Acquir Immune Defic Syndr 2008,48:116-118.

The OraSure oral fluid tests were used in three rounds of panel household surveys in the City of Windhoek, conducted by PharmAccess, the Amsterdam Institute of International Development (AIID) and the University of Namibia, to evaluate the effect of the Okambilimbili programme on the household level. These surveys were undertaken between 2006-2009 and were the first household surveys in Namibia to include bio-medical markers and anonymous HIV testing. The results of these surveys not only provided extremely important evidence of the HIV epidemic and the related socio-economic factors – they provided the first ever HIV incidence data in Namibia! This contributed tremendously to the knowledge pool and resulted in numerous publications in international and national peer reviewed journals.

Fact box 3 Publications on household studies in City of Windhoek

1. Janssens W, Gustafsson-Wright E, de Beer I, van der Gaag J: A Unique Low-cost Private Health Insurance Program in Namibia: Protection from Health Shocks Including HIV/AIDS. *Development Issues*. Vol. 10/ Number 2/ November 2008.
2. OP Schellekens, I de Beer, ME Lindner, M van Vugt, P Schellekens, TF Rinke de Wit. *Innovation in Namibia: Preserving Private Health Insurance and HIV/AIDS treatment*. Health Affairs. Volume 28, Number 6. November/December 2009.
3. Janssens W, de Beer I, Coutinho HM, van Rooy G, van der Gaag J, Rinke de Wit TF. A cautious note on household survey HIV prevalence estimates in resource-poor settings. *BMJ* 2010. 341: c6323. www.bmj.com/content/341/bmj.
4. Marleen E. Hendriks, Ferdinand W. N. M. Wit, Marijke T. L. Roos, Lizzy M. Brewster, Tanimola M. Akande, Ingrid H. de Beer, Sayoki G. Mfinanga, Amos M. Kahwa, Peter Gatongi, Gert Van Rooy, Wendy Janssens, Judith Lammers, Berber Kramer, Igna Bonfrer, Eseguel Gaeb, Jacques van der Gaag, Tobias F. Rinke de Wit, Joep M. A. Lange, Constance Schultsz. Hypertension in Sub-Saharan Africa: Cross-Sectional Surveys in Four Rural and Urban Communities; *PlosOne*. March 2012, Volume 7, Issue 3, e3263f.
5. Aulagnier M, Janssens W, de Beer IH, van Rooy G, Gaeb E, Hesp C, van der Gaag J and Rinke de Wit, T.F. Incidence of HIV in Windhoek, Namibia: demographic and socio-economic associations. *PLOS One* 6, e25860, 2011.
6. Asfaw, A., Gustafsson-Wright, E. and van der Gaag, J. (2009). Willingness to pay for health insurance: An analysis of the potential market for new low cost health insurance products in Namibia. *Research Study* 08-01/2. Amsterdam: AIID.

E Gustafsson Wright; I de Beer, E Gaeb, G van Rooy, J van der Gaag, T Rinke de Wit; The Okambilimbili Health Insurance Project in Namibia: Lessons Learnt. PharmAccess International, Amsterdam Institute of Global Health and Development, The Netherlands, October 2011.

'Once the Ora-Quick rapid tests were approved for use in Namibia, we used these tests to offer subsidized anonymous and non-invasive prevalence HIV screening to companies. We presented companies with this information based on which they could assess the impact on their workforce and weigh the benefits of signing up for the new insurance products. Based on anonymous screening results at 24 large companies it was clear there certainly was a potential market for products which included HIV benefits. It further became clear that knowing the HIV prevalence of their workforce motivated employers to buy the HIVREF Vitality product for their employees' De Beer explained.

Fact Box 4 ANONYMOUS HIV SCREENING

- Anonymous HIV prevalence surveillances were conducted by PharmAccess in 24 Namibian private companies, from 11 different industries, between November 2006 and December 2007.
- Participation rates amongst the 8,500 employees ranged from 61.3-97.3% with a mean participation rate of 78.6%.
- The prevalence rate of 15.0% revealed that the overall HIV prevalence rate in these companies was in line with the national prevalence estimates in Namibia at the time.
- HIV prevalence varied widely between industries, ranging from 4% in the information technology sector to 21% in the mining sector.
- Following the HIV prevalence surveillance, 61% of the previously uninsured employees had been enrolled in health insurance, the majority of these insurances (78%) covering HIV only.

De Beer I, Coutinho H, van Vugt M, Rinke de Wit TF. Anonymous HIV workplace surveys as an advocacy tool for affordable private health insurance in Namibia Journal of the International AIDS Society. 2009, 2:7



The Minister of Health, Honourable Dr. Richard Kamwi leading the way participating in oral fluid HIV screening at the University of Namibia main campus 2007

The oral fluid based tests were also used for surveillance amongst tertiary education students in Namibia following huge HIV awareness raising campaigns in 2007. 'Tertiary education students are the future skilled workforce of our country. We needed to understand the HIV prevalence rate to engage with University management on treatment and care options for students. The HIV prevalence rates amongst the student population was found to be quite low 1.8-2.8% respectively. Despite this students should be considered for inclusion in non-HIV exclusive health insurance.' said Peter van Wyk

Fact Box 5 STUDENT HIV PREVALENCE SURVEY

- HIV prevalence surveillance at University of Namibia (UNAM) and Polytechnic conducted in 2007 amongst 5,568 and 6,302 students respectively.
- HIV prevalence rate was relatively low (1.8% at UNAM and 2.8% at Polytechnic) compared to the estimated national adult average of 15.3%.
- HIV/AIDS knowledge amongst students was reasonable, except for some misperceptions about transmission.
- Awareness of own HIV status was low, motivating a need for HIV counselling and testing services.
- Namibian campus health facilities were found to be underused, mostly due to privacy reasons.
- The findings motivated an intensification of prevention and education initiatives through the institutional HIV awareness programs and better marketing the use of the existing campus health facilities.
- It was concluded that this group would not be the most viable target group for insurances covering HIV without significant and long-term subsidy.

De Beer I, Gelderblom H, McNally A, Van Rooy G, Schellekens O, Rinke de Wit T. HIV matters for University Students. Journal of the International AIDS Society 2012, 15:9.

The Okambilimbili program made good headways mobilizing private sector investment into health and increasing enrolment on private insurance for HIV. During the same period starting in 2004 the big donors such as the President's Emergency Plan for AIDS Relief (PEPFAR) and Global Fund for HIV, TB and Malaria (GFATM) started to move into Namibia in seriousness, working with Ministries of Health to roll-out free universal anti-retroviral treatment. This intervention began reaching critical mass around 2006/7.

'By 2008 it was clear that the donors were crowding out our private sector initiative,' remarks Rinke de Wit. 'This wasn't necessarily a good thing in the longer term. When donor funds eventually dwindle, the call for sustainable private sector solutions grows louder. It's important to keep the private sector on board from the start and ensure commercial sustainability. This didn't happen.'

'However,' he adds, 'the low-cost insurance packages including HIV/AIDS benefits are there to stay even if the donors leave. That is a direct result of the Okambilimbili project.'

De Beer agrees. 'During its lifespan the HIV Risk Equalisation Fund made a significant impact. Not only did the HIVREF enrol over 40 000 people between 2005 and 2009 when the programme ended, the fund was also essential in charting the burden of HIV on medical aid funds. The risk of HIV was monitored, costed and ultimately placed back into the funds.'

While a low income scheme for HIV was eventually not needed due to free provision of ART services in the public sector, medical aid funds retained the new products that included

HIV care and today up to 13 000 of the 200 000 HIV patients on treatment in Namibia are treated by the private sector.

The HIVREF showed medical aid funds that the risk of HIV coverage was acceptable and a business case could be made for private sector products including HIV benefits. As a result, by 2009 the medical aid funds decided to bring the HIV risk back into their own funds, eliminating the need for the HIVREF. The highly innovative approach of Okambilimbili mainstreamed the necessity of having low-cost HIV/AIDS benefits available. The programme was so successful that in 2009 the subsidy could be withdrawn as insurers started covering the risks of HIV/AIDS benefits within their own schemes as they saw the business case for doing so and were convinced the risk were manageable. The HIVREF did not grow and expand in the Namibian market as anticipated due to the temporary gains made being crowded out by donor funded free public treatment programs, but the inclusion of an HIV treatment benefit in all medical aid funds remains to date, directly as a result of this intervention.

Some important lessons were learned through the implementation emphasises Rinke de Wit. 'The risk equalisation fund in Namibia provided us with the first blueprint of how to structure health insurance funds in Nigeria, Tanzania and Kenya. Namibia was our 'phase zero' country. Because of the relatively small size and the existence of a middle class it enabled us to simulate a health insurance pilot on the ground with the grant from the lottery. It also provided us the opportunity to focus on improvement of quality of treatment and care, laying the foundations of what would later become the SafeCare program.

Secondly, the project yielded important scientific research through three in-depth household socio-economic and bio-medical surveys in 2006, 2008 and 2009 in the City of Windhoek, the capital of Namibia. These surveys, conducted using the new oral fluid test kits, confirmed the impact of Okambilimbili in making cost-effective treatment accessible on a wider scale. Okambilimbili yielded important insight in Namibian public health.'

Rinke de Wit: 'Our research unearthed data outside the realm of HIV/AIDS. We found out for instance that the prevalence of non-communicable diseases (NCDs) such as diabetes and cardiac diseases was much higher than expected. These findings were important for the government in order to start planning for the advent of NCDs. This research also provided the first ever HIV household prevalence and incidence data for the City of Windhoek (Namibia's capital).'

The Okambilimbili project also catalysed several spin-off programmes specifically dealing with the needs of people living with HIV. These included a PCMTTC programme for HIV positive mothers, a nutritional programme for HIV positive children and a support programme for HIV orphans and vulnerable children, which was implemented in partnership with Dutch charity Orange Babies. 'The Okambilimbili program highlighted the need for PMTCT and OVC services, which resulted in Orange Babies opening an office in Namibia in 2009, upon the conclusion of the Okambilimbili program. 'We assist over 1,600 beneficiaries annually' says Cecile Thieme, Country Director of Orange Babies Namibia.

And the wheels begin to roll - Bophelo! mobile wellness screening

'Early in the Okambilimbili program, as a result of the anonymous surveillance conducted in companies, we had a good idea of what the HIV prevalence rate was in companies. However, we realised that, while employees had access to the benefits, we didn't get the uptake in HIV treatment that we were expecting,' says de Beer. 'It was evident that people who worked daily and were not sick would not visit health facilities or testing sites, which were only open during working hours, for routine testing. We needed to find an innovative solution to close this gap, to achieve our expected program impact.'

With this knowledge, PharmAccess Namibia embarked on a new endeavour. 'The obvious solution to getting people tested was to bring screening to the workplace, explains de Beer. 'However, this meant companies needed to have certified testing sites, which wasn't a realistic option. The solution lay in mobile testing services, that could move easily even to the most remote workplaces to test employees and refer them into care.'

This realization led to the introduction of mobile testing clinics, another first for Namibia and the region. In 2008 PharmAccess started with the Bophelo! Project as a direct spin-off of Okambilimbili. Bophelo means Life in Tswana, one of the eleven official Namibian languages. The Bophelo! program intensified the 'Health Workforce, Healthy Business campaign' of Okambilimbili and became the brand.

Bophelo! was structured as a unique public-private partnership between PharmAccess, the Ministry of Health and Social Services (MoHSS), NABCOA and the Namibia Institute of Pathology (NIP).

'Since HIV/AIDS carries a stigma, we knew that offering HIV testing only at our clinics may deter people from attending, thus we offered a wellness screening package, which included screening of blood pressure, the calculation of BMI, and rapid blood testing for glucose, cholesterol, Hepatitis B, and HIV,' de Beer explained.

The programme soon proved to be not only very successful in providing screening services and accessing hard to reach populations, the costs were competitive, says Prof. Rich Feeley of Boston University. 'Taking into account the additional screening services that were offered, the cost per patient tested for HIV was significantly lower than in comparative stand-alone HIV testing sites.'

Persons who tested positive for any condition or whose screening results were outside the normal range, who were insured were referred to the private provider and those who did not have insurance coverage were referred to public health facilities under a PPP referral agreement with the Ministry of Health and Social Services.

The purchase of the first Bophelo! mobile clinic was made possible through forex gains and the lower than planned subsidy costs for HIV benefits, as a result of higher private sector



contributions on the original Okambilimbili program. The running costs of the Bophelo! program were facilitated through contracting for service delivery with companies and subsidization from the GFATM.

The findings of the Bophelo! surveys conducted during the period 2007-2011 gave rise to numerous publications and contributed largely to the knowledge of HIV and NCD in the Namibian working population.

Fact Box 6

BOPHELO! MOBILE WELLNESS

- Started in 2008 as a direct spin-off of Okambilimbili.
- A unique public-private partnership between PharmAccess, the Ministry of Health and Social Services (MoHSS), NABCOA and the Namibia Institute of Pathology (NIP).
- Offers a wellness screening package which included screening of blood pressure, calculation of BMI, rapid blood testing for glucose, cholesterol, Hep B, and HIV.
- The cost per patient tested for HIV was significantly lower than in comparative stand-alone HIV testing sites.
- First clinic purchased by Okambilimbili program.
- Successfully conducted screenings from 2008-2011 by PharmAccess and transitioned to NABCOA in 2011.
- Bophelo! still operating under NABCOA with GEATM subsidy in 2016.

As Bophelo! grew in popularity amongst Namibian employers and employees, it highlighted further challenges and gaps in the Namibian healthcare system. 'We found that access to healthcare services, especially for rural and remote employers and their employees was a real challenge, said de Beer. 'Employers were keen to contract us to provide screening services, which we could easily do with our mobile clinics. However when we referred individuals, especially those who were quite far from health facilities, we found that they did not seek medical care. We also found that a number of rural and remote employers would have been very keen to contract for low income health insurance, but the distance to the nearest health facility posed a barrier. If we wanted to close that gap, we would have to find an alternative form of health service provision that could bring services closer to these groups.'

By 2011, the Bophelo! program was running like a well-oiled machine and PharmAccess handed the program over to NABCOA, whilst PharmAccess took on the next challenge – how to bring health services closer to rural, remote and underserved populations in Namibia?

And more wheels roll, down a road less travelled - Mister Sister

According to de Beer the survey amongst commercial farmers conducted in 2007, the findings of the Bophelo! surveys, as well as the original Okambilimbili household survey data from informal settlements in Windhoek, indicated a demand and willingness to pay for mobile primary care services, especially in more remote areas. 'Here the government clinics are far and it didn't make sense for rural employers such as lodges and farms to spend money on medical aid without primary care services in the proximity. Employers, however, showed willingness to pay for basic services including outpatient care. In an attempt to fill this gap we designed the Mister Sister mobile clinic pilot program in 2010, expanding the public-private partnership agreement with the MoHSS for our mobile clinics to offer primary healthcare services to rural areas'

Fact Box 7

Agricultural employers as a target group for health insurance

- In 2007 a cross-sectional study was conducted amongst 1414 commercial farmers nationwide in Namibia to assess the feasibility of introducing health insurance, including HIV treatment benefits.

- The findings were as follows:
 - 1404 farm owners participated in the survey each having an average of 10.2 employees
 - 95% had access to at least one health facility
 - Employers were more likely to use private health facilities and have health insurance while employees did not have health insurance and used public health facilities.
 - Average one way distance to the nearest health facility was 68km and transport costs to healthcare facilities were largely borne by the employer
 - 78% of employers were willing to contribute towards the costs of health insurance for their employees.
- It was concluded that commercial farm workers have inadequate access to healthcare facilities and particularly HIV treatment. Access could be improved by providing on-site services and leveraging the willingness of the employer to contribute to health insurance to deliver prepaid services to farms.
- This resulted in the Mister Sister clinics program.

De Beer I, Coutinho HM, Guariguata L, Fortsch HHT, Hough R, Rinke de Wit TF. Health care options for commercial farm workers in Namibia. Rural and Remote Health 11 (online), 2011: 1384. <http://www.rrh.org.au>.



The name Mister Sister came as a result of a male nurse leading the initial pilot of the mobile clinics. In Namibia nurses are mostly female and traditionally referred to as 'Sister'. When the community at Otjizondju, where the initial pilot was conducted asked the male nurse, George, what they should call him, he jokingly said – call me 'Mister Sister'. The word spread and the mobile clinics soon became known as Mister Sister.

The first PPP agreement to provide mobile primary health care services was concluded between PharmAccess and the MoHSS in 2011 after a successful pilot in December 2010 in the Otjozondjupa region of Namibia. Within two years three further PPP agreements were concluded and the services were expanded to four regions. With funding from Heineken Africa Foundation, supported by Namibia Breweries two mobile clinics were purchased for the program and funding to operationalise the clinics was provided by both Heineken Africa Foundation and the Dutch Health Insurance Fund. The Ministry of Health and Social Services provides the program all medication and consumables required to perform the services at no cost, while costs of staff and transport are charged to corporate clients and corporate social responsibility contracts.



Mister Sister – funded by the Heineken Africa Foundation



Fact Box 8 MISTER SISTER CLINICS

- Launched in 2010 in Otjozondjupa region
- Provides mobile primary healthcare services.
- Services were expanded to 4 regions within 2 years
- 2 mobile clinics were purchased for the program with funding from Heineken supported by Namibia Breweries
- In 2012, Namibia Medical Care (NMC) donates 2 mobile clinics and commits to a 3-year funding agreement
- In 2015, the good performance of the NMC sponsorship was extended with a further 3 years
- The mobile primary care service improved the health outcomes of children in rural areas especially orphans and vulnerable children
- Achieved 100% domestic funding level for sustainability in 2016
- Over 16,000 registered and receiving services from Mister Sister clinics in 2016
- In 2016 transitioned to and included into the portfolio of Healthworks Business Coalition

In 2012, Namibia Medical Care (NMC), one of the medical schemes which supported the Okambilimbili program in earlier years donated a further two mobile clinics to the program and committed to a three year funding agreement, which in 2015 based on the good performance of the program was extended with a further 3 years.



Alison Begley, Principal Officer of Namibia Medical Care (NMC) cutting the ribbon at the hand-over of two mobile clinics from NMC to the Mister Sister team

Fact Box 9 EFFECT OF MOBILE CLINICS SERVICES ON HEALTH OUTCOMES OF ORPHANS AND VULNERABLE CHILDREN

- A longitudinal study was conducted in 2011 to evaluate the effect of the Mister Sister mobile clinics services on health outcomes of children.
- 853 children were evaluated at baseline and 635 followed up 5-6 months later, in the Otjozondjupa region.
- The study found that the health outcomes of the Orphan and Vulnerable Children. (OVC) was worse than those of non-OVC. For example: at baseline only 81.3% of OVC had up to date immunizations compared to 93.8% among non-OVC. The following improvements were noted over the six month evaluation period:

1. Up-date immunization in orphans increased by about 21%, from 75.0% to 95.5%.
2. The corresponding increase in this same indicator was modest among all other children, from 94.2% to 96.2%.
3. improvements in nutritional status.
4. Near eradication of parasitic worms.
5. A decline in children with anaemia.
 - The improvements suggest that the intervention contributed to safeguarding the health of these children from infectious disease.

Aneni, EC, De Beer IH, Hanson L, Brennan A, Rijnen B, Feeley FG Mobile Primary Health Care Services and Health Outcomes of Children in Rural Namibia. Accepted for publication in the Rural and Remote Health Journal 2013. Rural and Remote Health (online), 2013: 2380. <http://www.rrh.org.au>.

An added benefit of the mobile primary care service, says Feeley, was that vaccination programmes were far more successful as outreach services were brought to the people's doorstep, rather than children having to travel a long distance to get their injections. It soon turned out that the mobile clinics improved the health situation of children in rural areas, especially orphans and vulnerable children.

Feeley lauds the PharmAccess approach, saying there are very few organisations in Africa that can pull off public-private partnerships like this. 'PharmAccess Namibia is a credible partner to both Government and the private sector and they have the ability to manage programmes effectively. In doing so they are one of the more extraordinary organisations in Africa that can effectively and innovatively implement public health programmes. It is an extraordinary operation, unprecedented on the continent.'

Feeley feels that the Mister/Sister programme is well-suited for rural areas in Africa where there is a strong private sector. 'It is an opportunity for private healthcare providers, but unfortunately Africa lacks health entrepreneurs that can bring together public and private sector forces in addressing public health issues.



'Namibia has in many ways functioned as our laboratory where we invented public health interventions that stood the test of reality,' also notes Rinke de Wit. 'Especially the concept of private leverage and public implementation was unique. To just rely on donors means there is no exit strategy.'

De Beer and Rinke de Wit don't see taking on public health challenges as shouldering the responsibility of the Government. 'PharmAccess as an organisation has always combined scientific research, pragmatism and action,' says de Beer. 'We were ideally placed to signal gaps, identify risks and then pull public and private partners together in offering innovative solutions.'

By 2016, the Mister Sister programme had demonstrated that the provision of good quality mobile primary health care services in a public private partnership with the Ministry of Health and Social Services was possible.

'We had established all the systems and processes needed to not only run the operations smoothly, but also expand the model to semi-mobile and fixed sites' says de Beer. 'We were able to demonstrate the principles of the innovation. By late 2014 the program became fully funded from domestic contributions in Namibia and became financially sustainable through the employer contributions and generous CSR contributions of our private sector partners. We are extremely grateful for the donor funding which made it possible for us to start this innovation and grow it to the point where it can be sustained through domestic funding.'

And the road continues

'PharmAccess identifies gaps in the healthcare system, develops innovative solutions in partnership, pilots these innovations and demonstrates proof of principle. Once this is done and the innovation works well, we find local partners to continue and grow the operations. The Mister Sister program has reached this stage and PharmAccess is proud to transition the program to our long-time partner - Healthworks.' Says de Beer

With effect end December 2016, the Mister Sister primary health care clinics were fully transitioned from PharmAccess Namibia to Healthworks Business Coalition Namibia. Healthworks, previously known as the Namibia Business Coalition on HIV/AIDS, provides wellness services and workplace program solutions to Namibian workplaces in both the public and private sector. Healthworks provides these wellness services and the TB extension program in partnership with the Ministry of Health, thus the inclusion of the Mister Sister mobile primary health care services into this portfolio is a logical next step to expand the portfolio and offer a more comprehensive service to workplaces and the community. Peter van Wyk, CEO of Healthworks said: 'We are delighted to have been given this opportunity to continue the excellent work done from inception to date by the Mister Sister program under the tutelage of PharmAccess. We are looking forward to fully engage with the support companies and partners of the Mister Sister Programme and hope for meaningful dialogue with all partners involved to strive for that excellent benchmark already set.'

With the transition of the Mister Sister program to Healthworks the role of PharmAccess in Namibia will come to completion having supported the development of low income health insurance, improving the quality of care in the private sector, developing innovative public private partnerships for health service delivery and conducting operational and original research to contribute towards knowledge pool. In cooperation with Boston University and the University of Amsterdam ground-breaking research was conducted into HIV, primary health care and program evaluation in Namibia.'

Partners and funders

The programs of PharmAccess in Namibia were made possible through the continuous collaborative efforts of public and private stakeholders, including:

International funders and partners

Postcode Loterij
The Dutch AIDSfondS
STOP AIDS NOW
HIVOS
The Dutch Foreign Ministry
Heineken Africa Foundation
USAID
UNAIDS
GIZ/Global Compact
Orange Babies

Namibian government and para-statal organizations

Ministry of Health and Social Services
Namibia Institute of Pathology

Namibia implementing partners

Namibia Red Cross Society
Lironga Eparu (Namibian Network of People Living with HIV)
IBIS / Positive Vibes
Namibia Medical Aid Federation (NAMAf)

Prosperity Health Group
Methealth Administrators / My Health
Medscheme
Namibia Health Plan
Diamond Health Services

Namibian private sector partners

Ohlthaver & List Group of Companies
Namibia Medical Care
Meatco Foundation
Namibia Agricultural Union
Namibian Agricultural Employers Federation
Namibia Employers Federation

Academic institutions

Amsterdam Institute for International Development
Amsterdam Institute for Global Health and Development
Boston University School of Public Health (Centre for Global Health and Development)
University of Namibia
Namibia University of Science and Technology

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