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Bringing Primary Health Care to Remote Populations through Public-Private Partnerships: the SHOPS Mister Sister Experience

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Banyan Global
Jhpiego
Marie Stopes International
Monitor Group
O'Hanlon Health Consulting

Presentation Outline

- Introduction to SHOPS: Global and Namibia
- The Namibian context
- Mister Sister
 - The name
 - The beginnings
 - The goal
 - The partners
 - The services provided
 - The beneficiaries
 - The pricing structures
 - The clinic staff
 - Why mobile services
 - Contributions of the SHOPS team in Namibia
- Challenges and lessons learned
- Future plans

The SHOPS Global Project

- ❑ USAID flagship global project on private sector health
- ❑ Builds on previous USAID private sector projects: SOMARC, CMS, PSP-One
- ❑ **Goal:** *Strengthen the role of the private health sector in sustainable provision of family planning, HIV/AIDS, and child health services*

What we do

- Assessments
- Behavior Change Communication
- Health Financing
- mHealth
- NGO Sustainability
- Pharmaceutical Partnerships and Social Marketing
- Policy
- Provider Access to Finance
- Provider Networks
- Quality Improvement

Where we work

Africa

Benin
Ghana
Kenya
Madagascar
Malawi
Namibia
Nigeria
South Africa
Tanzania
Uganda
Zambia
Zimbabwe

Asia Middle East

Bangladesh
India
Jordan

Eastern Europe

Russia

Latin America and Caribbean

Bolivia
Caribbean
Paraguay
Peru

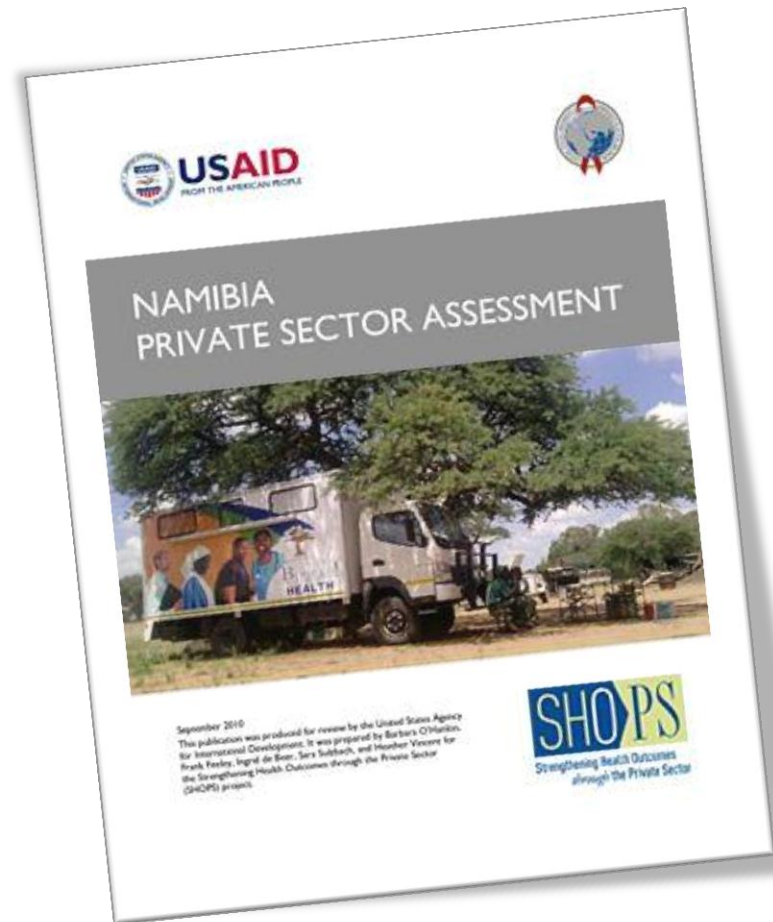
Our partners

The **Abt Associates**-led team includes five partners:

- Banyan Global
- Jhpiego
- Marie Stopes International
- Monitor Group
- O'Hanlon Health Consulting

SHOPS team in Namibia

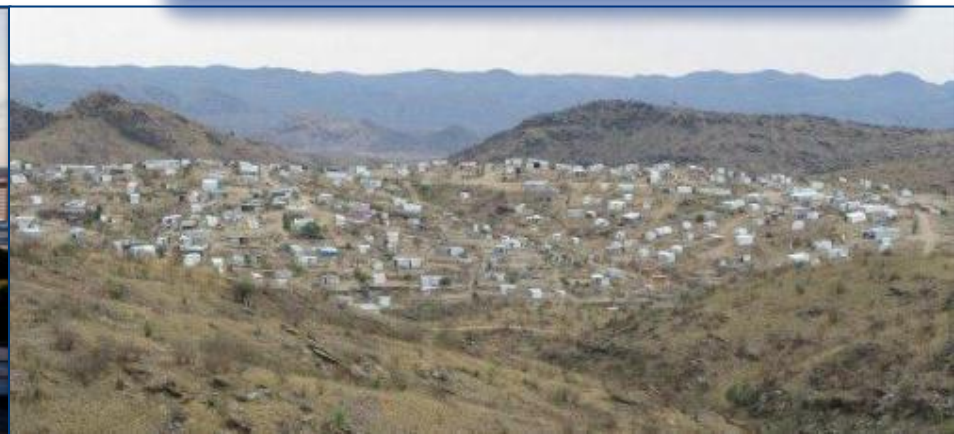
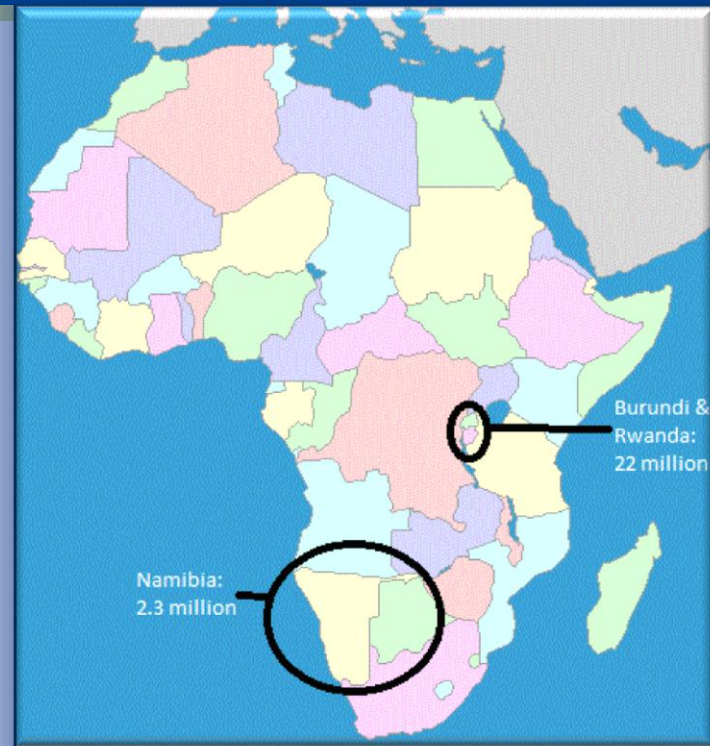
- ❑ **Overall goal:** To leverage private investments to increase efficiencies and prospects for sustainability, improve access to care, and achieve national health goals
- ❑ SHOPS involvement in Namibia began with a core-funded Private Sector Assessment (PSA) in 2010 to synthesize and quantify the degree to which private sector engagement could help sustain the national HIV/AIDS response
- ❑ Implementation of field-support activities started in April 2011
- ❑ Technical assistance and operational subsidy to Mister Sister began in April 2012



Namibia context:

Rich and poor, large and small, and unequal

- Population: 2.3 million
- Sparsely populated
- Upper middle-income status
- Gini-Coefficient: 70.7%
- Declining donor funding
- Robust private health sector



Mister Sister: the name

It's a male nurse!



Mister Sister: the beginnings

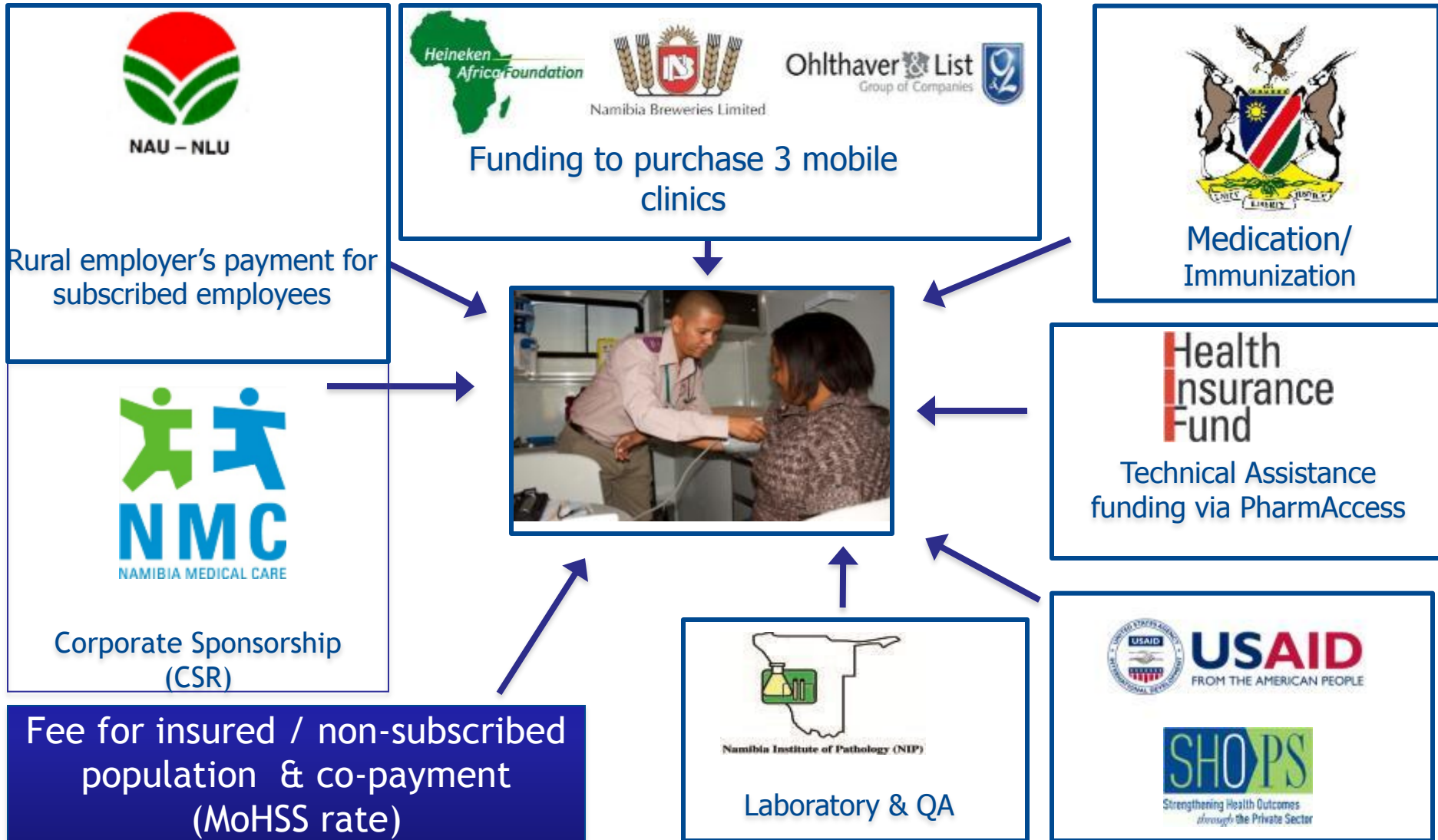
- First PPP agreement between PharmAccess Foundation Namibia and the MoHSS signed in June 2011
 - MoHSS would provide free medicines
 - Mister Sister would refer its patients to public facilities
 - Mister Sister would collect and deliver medication for chronic conditions and ensure follow-up
- Heineken Foundation Africa donated the first mobile clinic
- Implementation in Otjozondjupa region began in July 2011

Mister Sister: the goal

To provide sustainable, unified mobile primary health care services to rural, remote, and underserved populations through a unique public-private partnership, financed in part by rural employers, employees, the Ministry of Health and Social Services, donors, and corporate social investment.



Mister Sister: the partners



Mister Sister: the services provided

- Confirmation of pregnancy and routine ante- and post-natal care
- Family planning advice and supplies (including oral and injectable contraception)
- Routine immunizations which are part of the MoHSS vaccination program
- Well-child care and monitoring
- Screening for TB symptoms
- Voluntary counselling and testing for HIV
- Diagnosis and treatment of routine communicable diseases
- Testing, referral, and follow-up on chronic diseases
- Treatment (including suturing) for minor trauma
- Information, education, and communication on health matters
- Chronic medication drop-outs tracing and referral



Mister Sister: the beneficiaries

- Farmers
- Rural employees and dependents
- Vulnerable populations on mobile clinics' routes
- Residents of informal settlements



Mister Sister: pricing structures

Rural Payment Structure					
	Once a month visits 10+ employees Proximity to an outreach site	Once a month visits 10+ employees	Once a month visits 20+ employees	Per visit for PHC services	FP services and any other service provided for free by the MoHSS
Employer's contribution	\$40.23	\$57.47	\$114.94		
Employee's contribution				\$0.57	Free
Non-participating employees and dependents				\$4.02	Free
Vulnerable populations (orphans, elderly, etc.)				Free	Free

Employers' contributions cover employees and their dependents

Semi-rural Payment Structure (for non-farmers around Windhoek)				
	Once a month visits	Twice a month visits	Per visit for PHC services	FP services and any other service provided for free by the MoHSS
Employer's contribution per employee	\$4.02	\$5.75		
Employee's contribution			\$0.57	Free
Non-participating employees and dependents			\$4.02	Free
Vulnerable populations (orphans, elderly, etc.)			Free	Free

Mister Sister: the mobile clinic staff



A registered nurse



An enrolled nurse



A driver (admin tasks)

Mister Sister: Why mobile services matter

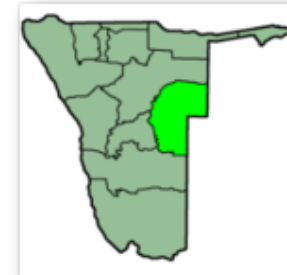
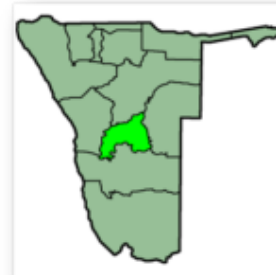
- Namibia: 3 people/km²; 2nd lowest population density in the world; 62 miles one way to see a doctor
- Transportation challenges
- Need for regular health services (ANC, family planning, vaccinations, etc.)
- Preventative benefits
- Reaching low-income, remote, and vulnerable populations with quality health services



"It is very important to have a mobile clinic in informal settlements because without it, children and vulnerable people would definitely not have access to medical help." Patricia Sola (Founder of Hope Initiative)

Mister Sister: Why SHOPS matters

- Technical assistance:
 - Contracting, expansion planning, public-private dialogue, demand creation, evaluation, pharmaceutical management, etc.
- Operational subsidy to expand and deepen services
 - From 1 to 3 regions: Otjozondjupa (2011) to Khomas and Omaheke (August 2012)



- Reaching more people and sites

SHOPS supported services: August – December 2012	
Employers served	78
Outreach sites	59
Patient visits	3726
Informal settlements	5
New enrollment as potential users	2206
HIV testing	675*

**Of the 675 tested, 61 were found HIV+ and referred to treatment and care*

Mister Sister: challenges

- Creating sufficient demand for the services
- Getting sufficient CSR contributions
- Database/IT-infrastructure: separate databases
- Political/regional boundaries between the regional directorates of the MoHSS
- Notification of schedules to patients in the field (end-user doesn't receive information and is not able to access services)
- Needs for ARVs in the field but not part of current service agreement

Mister Sister: lessons learned

- Quality primary health care service provision in remote areas can be done without a full-time doctor
- Leveraging local private sector resources through in-kind donations reduces operational costs
- Targeting bigger companies/employers and clustering farms improves patient time/travel ratio and decreases cost per patient
- Employers/farmers tend to be conservative. It takes time to convince them of the usefulness of the mobile clinic services. However, once convinced, re-enrollment rates are high
- Cost per patient decreases as services expand

Mister Sister: future plans

- Expansion to Erongo Region (mining sector)
- Use of mHealth to improve operation (SMS for attendance and follow-up, payment of fees by mobile phones, telemedicine linking a nurse to a doctor)
- Include ART on mobile clinics
- Streamlining HIV counseling and testing on all mobile clinics
- Operational excellence (quality improvement in systems, services, and staff)
- Explore possibilities of continuing service provision in the informal settlements through outsourcing from MOHSS and/or external funding
- Continuously strengthen the PPP
- Mister Sister services as a low-cost health insurance package offered by private medical insurers

Questions?



Comments?



Thoughts?





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through the Private Sector



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