

Namibia HIV Prevention, Care and Support

Program Progress Report: Quarter 4 (JULY – SEPTEMBER 2011) ANNUAL (OCTOBER 2010 – SEPTEMBER 2011)

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List of Acronyms

AB	Abstinence and/or Being Faithful	IMAI	Integrated Management of Adolescent and Adult Illness
ACTS	Assess Counsel Test and Support		
AIDS	Acquired Immunodeficiency Syndrome	IPT	INH Preventive Therapy
AMS	Anglican Medical Services	IT	Information Technology
ANC	Antenatal Care	LL/CL	LifeLine/ChildLine
ART	Antiretroviral Therapy	LMS	Lutheran Medical Services
ARV	Antiretroviral Drugs	MCP	Multiple Concurrent Partnership
BCC	Behavior Change Communication	M&E	Monitoring and Evaluation
BEN	Bicycle Empowerment Network	MIS	Management Information System
BMI	Brief Motivational Intervention	MoHSS	Ministry of Health and Social Services
C&T	Care and Treatment	MOU	Memorandum of Understanding
CAA	Catholic Aids Action	NDF	National Defense Forces
CBD	Central Business District	NIP	Namibia Institute of Pathology
CBO	Community-Based Organization	NLT	NawaLife Trust
CCN	Council of Churches in Namibia	NRCS	Namibia Red Cross Society
CDC	Centers for Disease Control and Prevention	NS	New Start
CHS	Catholic Health Services	OPD	Out Patient Department
CM	Community Mobilizers	OVC	Orphans and Vulnerable Children
CT	Counseling and Testing (for HIV)	PEP	Post-Exposure Prophylaxis
CTP	Cotrimoxazole Prophylaxis	PEPFAR	President's Emergency Plan for AIDS Relief
DAPP	Development AID from People to People	PITC	Provider-Initiated Testing and Counseling
ELCAP	Evangelical Lutheran Church AIDS Program	PLHIV	Person Living with HIV and AIDS
ELISA	Enzyme-Linked Immunosorbent Assay	PMTCT	Prevention of Mother-to-Child Transmission
EMIS	Education Management Information System	PO	HIV Prevention Officer
ePMS	Electronic Patient Management System (FileMaker Data System)	PwP	Prevention with Positives
		RMT	Regional Management Team
EQA	External Quality Assurance	RT	Rapid Testing
FBO	Faith-Based Organization	RTK	Rapid Test Kit
FP	Family Planning	SCMS	Supply Chain Management Systems
HAART	Highly Active Antiretroviral Therapy	STI	Sexually Transmitted Infection
HIV	Human Immunodeficiency Virus	TB	Tuberculosis
HRMIS	Human Resource Management Information Systems (MoHSS Sub Division)	USAID	United States Agency for International Development
HRIMS	Human Resource Information Management System (Office of the Prime Minister)	VCT	Voluntary Counseling and Testing (for HIV)
HRIS	Human Resources Information System		
HVCT	HIV Counseling and Testing		

PROGRAM RESULTS (REQUIRED)

See Excel spreadsheet ("INTRAHEALTH FY11Q3 July2011") and complete worksheet ("1. Program results.Q3") on table of program results.

PROGRAM-AREA NARRATIVES FOR OCTOBER 2010 – SEPTEMBER 2011

During FY2011, IntraHealth and its partners, Anglican Medical Services, Catholic Health Services, Lifeline/Childline and Lutheran Medical Services engaged in a variety of key activities to continue combating the HIV epidemic in Namibia. IntraHealth also continued to support Catholic AIDS Action with ongoing technical assistance for their HIV Counseling and Testing (HCT) program.

During the first quarter of FY11, IntraHealth submitted a revised Program Description to USAID/Namibia. The purpose of this modification is to increase emphasis on capacity building, quality and country ownership, reflecting greater alignment with GRN and USG priorities. The goal of the program modification is to focus technical assistance in the remaining years of the project on systematic capacity building of select Namibian faith-based organizations (AMS, LL/CL, CHS, and LMS) and the Ministry of Health and Social Services, the HIV Clinician's Society, and the Nursing Council of Namibia, among others to sustain comprehensive HIV programs aligned to Namibia's National Strategic Framework (NSF) for HIV and AIDS 2010/11–2015/16.

Following review of IntraHealth's initial submission, USAID and IntraHealth have maintained an ongoing dialogue in order to refine the program modification so that it ensures an ambitious but achievable program scope of work and budget that will result in efficient use of USAID resources and measurable gains in health for all Namibians. This dialogue began in the second quarter and has continued through June 2011. IntraHealth has worked to thoroughly comply with all USAID requests and revise the document so that it reflected the vision of USAID and its Namibian partners. During this time, as instructed by USAID/Namibia, IntraHealth maintained a baseline level of activity and service delivery, but did not initiate any new activities or take on significant expenses unless specifically requested to do so.

The program modification was approved in early August 2011. During the next quarter, IntraHealth will work on submitting a work plan based on the modification.

Beginning fourth quarter of FY2011, the LLCL Prevention program was funded directly from USAID while IntraHealth continued supporting the VCT and M&E activities in LLCL until the end of FY2011. IntraHealth will continue to provide technical assistance to LLCL as the need arises. Due to these changes in programming, the IntraHealth Prevention and SBCC Director, and the Regional Community Mobiliser were transitioned out at the end of the third quarter. IntraHealth acknowledges and appreciates these staff members for their sterling work in the past years and wishes them the best in their future endeavours. The other two Prevention Officers were re-assigned to other duties; one as PMTCT/MNCH Officer and the other as Prevention Officer providing technical assistance to the Society for Family Health (SFH) most at risk populations (MARPs) program in addition to the IntraHealth HIV prevention duties. This collaboration with SFH is expected to bring synergies to the two programs.

The IntraHealth North West office was re-opened during the fourth quarter. Additionally, the HCT TA, began operating from CCN during the same quarter. These changes are meant to facilitate the HCT QA skills transfer to local partner staff as well as transitioning of HCT QA to the MoHSS/ RMT.

At the beginning of the fourth quarter of FY2011, IntraHealth received the Deputy Chief of Party who is expected to spearhead organization development and HRH activities.

Program Area 1: Prevention of Mother-to-Child Transmission of HIV (PMTCT)

The prevention of mother-to-child transmission (PMTCT) component is aimed at reducing the HIV incidence related to vertical transmission by increasing the proportion of HIV-positive women and their exposed babies provided with antiretroviral (ARV) prophylaxis. Ensuring availability of ARV drugs to mothers and their newborns, safe childbirth, infant feeding counseling, family planning (FP) counseling and referral, and continuity of care are the key components of the IntraHealth-supported PMTCT program. These interventions are accessed through antenatal clinics and labor and delivery wards in six mission facilities (five faith-based hospitals and one health center).

By the end of the reporting period, 56 outlets in and around mission facilities were supported in providing PMTCT services. These sites include the 5 IntraHealth supported district hospitals, 1 health centre, and the surrounding facilities which fall under our partners, though are not necessarily faith-based facilities. At present, only 7 facilities within the catchment areas of the Mission district hospitals are not yet providing PMTCT services.

2.1 Program Area 1: Prevention of Mother-to-Child Transmission (PMTCT) of HIV

The prevention of mother-to-child transmission (PMTCT) component is aimed at reducing the HIV incidence related to vertical transmission by increasing the proportion of HIV-positive women and their exposed babies provided with antiretroviral (ARV) prophylaxis. Key components of the IH supported PMTCT program include ensuring availability of ARV drugs to mothers and their newborns, safe childbirth, infant feeding counseling, family planning (FP) counseling and referral, and continuity of care. These interventions are accessed through antenatal clinics and labor and delivery wards in six mission facilities (five faith-based hospitals (FBH) and one health center).

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Accomplishments & Successes

Antenatal Care: During the fourth quarter, a total of 2,675 women attended their first antenatal care (ANC) visit, of which 269 (10%) had a known HIV-positive status, and 2,406 (90%) with unknown status. Of those mothers with unknown HIV status, 2,317 (96%) were newly tested in the first quarter and received their HIV test results. The total number of ANC women with known HIV status is 2,586 (see *Figure 1* below).

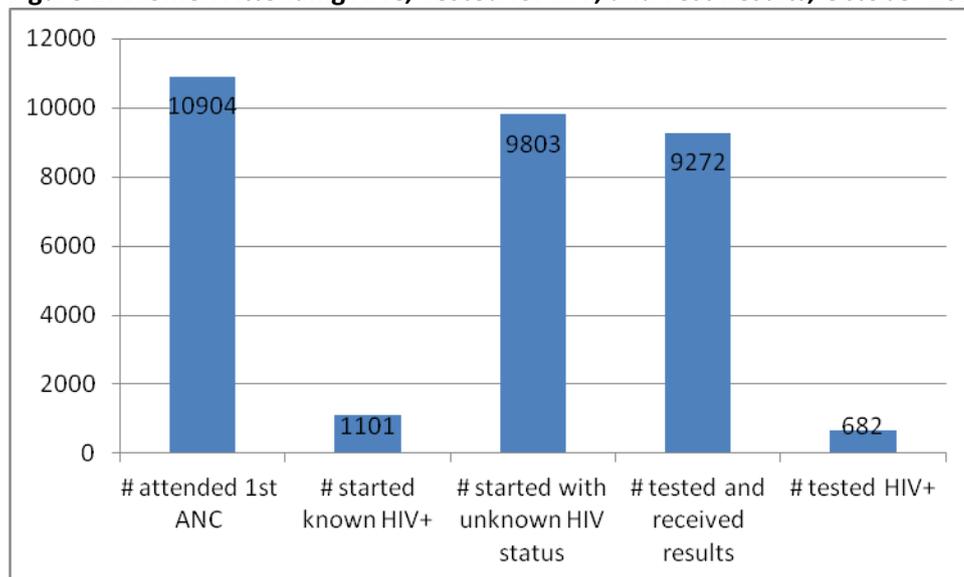
During FY2011, a total of 10,904 women attended their first ANC visit, of which 1,101 (10%) had a known HIV positive status, and 9,803 (90%) with unknown status. Of those mothers with unknown HIV status, 9,272 (95%) were newly tested and received their results during FY2011. The total number of pregnant women with known HIV status is 10,373.

For the pregnant women counseled and tested in the fourth quarter, 180 (7.8%) tested HIV-positive, bringing the total for FY2011 to 682 (7.3%). These numbers include women attending ANC at peripheral clinics within mission-supported districts that are receiving indirect support from IH.

The FY2011 target of 6,500 pregnant women who know their HIV status through ANC, comprised of those known to be HIV-positive at entry and those tested through at their first ANC visit, been exceeded by approximately 60%.

As part of the couple counseling program within PMTCT, among the 2,317 women counseled and tested, 100 (4.3%) were tested along with their partners during the fourth quarter of FY2011. In addition, 43 male partners had a known HIV-positive status. During FY2011, the total number of women counseled, tested and who received results was 9,272 with 444 (4.8%) being tested along with male partners. Of the 100 men tested during the fourth quarter, 7 (7%) tested HIV-positive. For FY2011, this number increased to 36. All the women testing HIV- positive were referred for enrollment into HIV care and assessment for treatment. Those women testing HIV-negative before the third trimester were counseled to stay negative, and a repeat test was recommended during the third trimester.

Figure 1: Women Attending ANC, Tested for HIV, and Test Results, October 2010 – September 2011



Labor & Delivery: During the fourth quarter, 2,816 women delivered in IH supported health facilities and 2,777 (99%) knew their HIV status. During the same period, 476 HIV-positive women delivered in these facilities, of which 293 (63%) received ART and 171 (37%) received ARV prophylaxis. Most (99%) HIV-positive women chose exclusive breastfeeding as their preferred infant feeding option.

During FY2011, 10,470 women delivered in at IH supported health facilities, of which 10,202 (97%) knew their HIV status. During this same period, 1,796 HIV-positive women delivered in these facilities, of which 887 (53%) received ART and 783 (47%) received ARV prophylaxis. 1,799 infants received ARV prophylaxis during this time. Most (98%) HIV-positive women chose exclusive breastfeeding as their preferred infant feeding option

Postnatal Care: 513 exposed infants were tested with DNA polymerase chain reaction (PCR) during the fourth quarter, of which 28 (5.5%) tested HIV-positive. Of the total number of HIV exposed infants tested, 270 (52.6%) were tested within the first 2 months of birth. 325 HIV exposed babies were enrolled for follow up during the fourth quarter, and 319 of them were initiated on cotrimoxazole prophylaxis.. The FY2011 figures show that 2,188 exposed infants were tested, of which 97 (4.4%) tested HIV-positive. Of the 2,188 babies tested during FY2011, 984 (45%) were tested within 2 months of birth.

HIV & FP Integration: Of the 449 positive women enrolled in to postnatal care during the fourth quarter, 345 (77%) were referred for family planning (FP) services. 243 (71%) of these women reached and enrolled in FP. During FY2011, 1,452 women received postnatal care services. Of those receiving postnatal care, 1,301 (90%) were referred for FP, of which 944 (73%) reached and enrolled for family planning.

Additional Accomplishments and Highlights

- An additional clinic, Shamaturu, was opened in Andara district during the first quarter and has continued providing PMTCT services, bringing the number of clinics in this district to nine.
- About 96% of mothers tested in ANC in CHS received their test results, an increase from 87% recorded in FY2010. This can be attributed to the success of the Performance Improvement (PI) approach used which had identified lack of Rapid Testing (RT) sites as a root cause. Sending specimens for RT in the local Namibia Institute of Pathology (NIP) as well as an increase in the outreach HCT were successful interventions identified.
- 97% of mothers delivering in the faith-based districts came to deliver with known HIV status.
- Almost all the HIV exposed infants received ARV prophylaxis at birth.
- Almost all of HIV exposed babies enrolled for follow up were started on cotrimoxazole prophylaxis.
- The PMTCT committee started in Onandjokwe has been meeting regularly and it is anticipated this committee will tackle the PMTCT issues including reporting from the peripheral clinics.
- Reports from Odibo indicate that mothers do appreciate the new guidelines as they now can breastfeed freely and for longer periods without necessarily having to wean their infants early. This reduces stigma

associated with early cessation of breastfeeding according to previous guidelines. However, the longer duration providing prophylaxis to the baby has been noted as a challenge.

- All facilities continue to be vigilant to check HIV status for mothers coming to deliver. All mothers who came to deliver without known HIV status were tested in all the facilities.
- Implementation of the new PMTCT guidelines that have been incorporated in the ART guidelines going on well though with minor challenges. The recent support visits to all the facilities during the third quarter attest to this. There is need to determine the adherence to nevirapine by the babies as the treatment covers a longer period.
- The MoHSS circular clarifying which codes to use in the ANC and maternity registers with regards to the new regimens was a relief for many staff in the facilities. The monthly summary reporting forms still need to be updated though.
- As a short term measure to staff shortages due to resignations, IH has assisted partners to get approvals from USAID to recruit replacements for MOs and Nurses. In the long term though, IH continues to actively participate in the Human Resources for Health (HRH) Technical Working Group (TWG) and Taskforce to transition staff to the Government of the Republic of Namibia (GRN) which currently has more favorable packages for MOs. Regional visit of HRH TWG to Kavango occurred in June and the next regional visit will occur in October. IH is an active participant in the TWG and recommendations from the visit are being used to absorb USG supported physicians by December 2011.
- Support, supervision and mentorship visits were conducted to all facilities with the respective Program Managers to facilitate skills transfer.
- Rehoboth established PMTCT support groups and are collaborating closely with PharmaAccess Orange Baby project and refer mothers there for nutritional assistance.

Challenges, Constraints & Plans to overcome them

- Tracking and retesting of mothers initially testing negative in earlier trimesters. Using the PI approach, IntraHealth will work with the respective partners to improve retesting during the third trimester as well as the reporting of the outcomes.
- Staff resignations and the disparities in salaries between project staff and GRN/subsidy are likely to worsen the situation. IH continues to actively participate in the HRH TWG in pursuit of lasting solutions.
- Overall, only 45% of HIV exposed babies tested for HIV received the DNA PCR test within 2 months of birth. Early infant diagnosis is critical to ensure HIV-positive babies are linked to ART early and improve their survival. IH will continue to work with the relevant partners to improve the follow up of these babies. IH will work with partners to roll out the tracking system which was piloted in a few districts including Onandjokwe by UNICEF.

Planned Events for the Next Quarter

- Continue follow up on the implementation of PI in all the facilities.
- Implement the revised support and supervision tool.
- Conduct support and supervision with partner management staff in order to develop their capacity to provide support and supervision with IH.
- Strengthen current efforts to integrate PMTCT and MCH programs.

2.2 Program Area 2: Male Circumcision

As part of a comprehensive HIV prevention strategy, IntraHealth (IH) works to improve access to high quality HIV prevention services, and strives to make men aware of, and have access to, voluntary medical male circumcision (MC) services. Activities are aimed at ensuring a minimum MC package is provided, including screening and management of sexually transmitted infections (STI), behavioral change counseling including risk reduction, provider initiated counseling and testing (PICT), and condom promotion and distribution. Currently, five (5) IH supported sites - Onandjokwe, supported by LMS and Andara, Nyangana, Rehoboth and Odibo Health Centre supported by CHS - are implementing MC as a HIV prevention strategy.

IH is an active member of the Namibian MC task force, and will continue to contribute to the development and implementation of the national MC strategy, supporting policies and technical recommendations. In addition, IH is actively involved in advocacy and communication efforts to ensure safe male circumcision is available throughout the country.

Accomplishments & Successes

During quarter four of FY2011, 235 men (56 in Onandjokwe, 90 in Nyangana, 46 in Andara, 40 in Oshikuku and 3 in Rehoboth) were circumcised as part of minimum package of MC for prevention services. For FY2011, a total of 565 men (161 in Onandjokwe, 214 in Nyangana, 102 in Andara, 8 in Rehoboth and 20 in Odibo) were circumcised and a total of 667 men have been circumcised since the inception of the program (please note that other implementing sites are reported via CDC.) With the exception of one moderate adverse event (swelling and bleeding) that was reported by Odibo and where the patient was attended to immediately, there have been no other reports of adverse events associated with MC.

A doctor, a nurse and one community counselor from Oshikuku were trained in MC, making a total of 6 IH supported sites trained. IH also continues to actively participate in the national MC training by conducting Quality Assurance (QA) visits in collaboration with I-Tech and the MoHSS as well as performing MC at Windhoek Central Hospital at least twice a month. A total of 3 trainings were conducted this year where 48 clinicians (doctors and nurses) and 32 community counselors were trained according to WHO standards. IH participated in two out of three national QA visits conducted during the reporting period that were held at Swakopmund and Gobabis.

Additional Accomplishments:

- Procurement of 32 diathermy machines on behalf of the MoHSS. The machines were handed over to the Deputy Minister of Health and Social Services by the US Ambassador to Namibia during the third quarter. The machines will facilitate the scale up of MC in Namibia as they will be distributed to 32 of the 34 public hospitals.
- Continuation as an active member of the MC task force.
- Hiring of the consultant who will develop the national MC strategy and implementation plan.
- Printing and distribution of the MC toolkits was finalized.
- Task shifting - Currently trained nurses from Andara, Nyangana and Onandjokwe are performing MC under the supervision of a Medical Officer and the MoHSS is advocating for task shifting in general and in particular for MC.
- Participation in the first meeting with the Nursing Council to advocate for task shifting in general and for MC.

Challenges, Constraints and Plans to Overcome Them

- The Odibo Medical Officer trained in MC has since resigned leaving the program with no trained staff. Efforts will be made to train Odibo staff in the next MC training.
- The trained nurse in Rehoboth has resigned leaving the facility with no trained clinician. IH will provide necessary support to help replace or train another nurse for this position.
- The number of men circumcised in Rehoboth is low due to low demand. Culturally, people believe that the right period for MC is in winter. Community workshops and community mobilization will help address this misconception.
- The shortage of medical officers in Rehoboth continues to hamper efforts to train doctors in Rehoboth. To date only a nurse and counselors were trained. IH will continue to collaborate with the NC to ensure that the scope of practice is adjusted for MC related activities.

Planned Events for the Next Quarter

- Through the Performance Improvement approach, continue strengthening referral of clients from HIV counseling and testing services to MC.
- Continue strengthening community mobilization around MC, and involve community leaders to address cultural barriers within communities.
- Continue to perform MC at Windhoek Central Hospital at least two days per month to minimize the back log of clients needing the services.
- Continue active support and facilitation of training in collaboration with I-TECH and MOHSS.
- Continue active participation on the MC task force.
- Procurement of MC kits, extra diathermy pencils and printing of IEC materials as requested by the MoHSS
- Continue with the MC consultant activities by initially focusing on stakeholder interviews

2.3 Program Area 3: Post Exposure Prophylaxis (PEP)

According to the national guidelines which contain protocols for effective implementation of post exposure prophylaxis (PEP), it is to be provided within 72 hours following occupational or sexual exposure. IH continues to work towards strengthening the implementation of PEP guidelines, with a focus on data collection and reporting systems, while supporting training and skill updates, in order to improve awareness and close the gaps on missed opportunities for PEP within Namibian health facilities.

Accomplishments & Successes

All staff members working at IH supported sites have been oriented in PEP. During the fourth quarter of FY2011, a total of 29 individuals received PEP at these sites. The 29 include 5 for occupational exposure, 20 victims of rape, and 4 non-occupational exposures including condom failure. All recipients of rape tested negative initially. The total number of individuals who received PEP by the end of FY2011 is 119, including 25 for occupational exposure, 75 victims of rape and 19 non-occupational exposures. The Community Mobilizers and Prevention Officers have also incorporated PEP information in their sessions in the community and at work places.

Three facilities (Rehoboth, Nyangana and Oshikuku) are conducting follow ups for occupational exposure according to the national guidelines. However, during our last support visit only two clients from Oshikuku graduated from the programme with HIV negative status. The other three are still in the process.

The revised supportive supervision tool was piloted in June 2011 in all IH supported sites and supervision is conducted in all the facilities.

Challenges, Constraints and Plans to Overcome Them

- Still some victims of rape occasionally report to the hospital after the 72 hour window, in spite of the community awareness by Prevention Officers and Community Mobilizers. IH will continue to work to intensify the community awareness efforts of PEP through the prevention program.
- Despite improved reporting on PEP at the facilities, there is still incomplete reporting of outcomes. Of those who received PEP, it is not known exactly how many seroconvert, and how many remained HIV negative. IH will continue to work with the partners to address this issue and ensure accurate reporting of PEP outcomes.

Planned Events for the Next Quarter

- Continue strengthening awareness of PEP in the community and at work places by Prevention Officers and Community Mobilizers.
- Strengthen follow-up of PEP clients until discharge.

2.4 Program Area 4: Sexual and Other Behavioral Risk Prevention

Preventing new HIV infections represents the only long-term, sustainable solution to turn the tide of the HIV epidemic. Successful strategies for fostering effective behavior change require comprehensive, multi-sectoral, complex prevention interventions that address prevailing norms associated with the spread of HIV, while still meeting the needs of people who face elevated risk exposure. Behavior change will be required at both the personal and community level. This can be encouraged by creating an environment that enables individuals to make safer choices and sustain healthy behaviors and lifestyles.

Life Line/Child Line (LLCL), a key partner in the provision of sexual and other behavioral risk prevention programming in Namibia, transitioned to direct United States Government (USG) funding in July FY2011. Given LLCL's graduation, IH's prevention portfolio is now restricted to a more limited role working solely with the FBH's as indigenous groups begin to assume responsibility for the prevention efforts in Namibia.

Accomplishments and Successes

According to the National Strategic Framework (NSF) the strategic priority for prevention is to reduce HIV incidence by 50% by 2015. This will be achieved by implementing interventions that reduce exposure to HIV, reduce the probability of transmission if exposure has occurred, and influence change in social norms, values and practices that prevent adoption of key prevention behaviors. The NSF has prioritized programs that will be used to deliver the appropriate services to achieve 50% reduction in HIV incidence. Social behavior change communications (SBCC) is chief amongst the 10 identified programs.

- **Facility- based HIV Prevention Officers**

IH is tasked to build the capacity of six faith-based health organizations to provide high quality HIV prevention services. This capacity building involves increasing, improving, and standardizing prevention activities at the Mission hospitals and under their stewardship. Activities include providing training, QA, oversight, mentorship and supervision and teaching partners to use accurate monitoring, evaluation and reporting on the activities. IntraHealth assists partners to strengthen, focus and improve existing delivery methods ensuring a greater impact of the intervention while increasing the sustainability of the hospital's HIV/AIDS response.

- **Mentorship**

Mentorship visits to the sites were provided in the second and fourth quarters this year and emphasis was placed on increasing activities particularly on gender equity and reaching more men.

- **Technical Assistance**

Beginning third quarter of FY2011, IntraHealth has been providing technical assistance to Society for Family Health (SFH) for the most at risk populations (MARPS) program.

- **Sexual and Other Behavior Risk Prevention**

Catholic Health Service (CHS):

Ongoing HIV Prevention Program Evaluation: HIV prevention and SBCC activities are based on the recommendations from the baseline survey results that were collected during the HIV prevention Program Evaluation in 2010. The ongoing activities focus on alcohol abuse, male engagement, MC and multiple concurrent partnerships (MCP).

Sexual and other behavior risk prevention activities in the fourth quarter increased compared to the previous three quarters. During this quarter, 449 people (253 females and 196 males) completed 8 HIV prevention sessions in three of the four CHS facilities. Andara had the highest figures of 192 (42%), followed by Oshikuku with 182 (41%) and Rehoboth with 75 (17%). This brings the total for FY2011 to 842 people who completed 8 HIV prevention sessions.. A total of 738 people (385 males and 353 females) were reached by at least one prevention message in and around the CHS facilities, with Oshikuku reporting the highest number of people reached of 353 (48%), followed by Andara with 220 (30%), Rehoboth 128 (17%), and Nyangana 39 (5%).

Lutheran Medical Services (LMS)

LMS conducted SBCC sessions on sexual and behavior change with individuals, small groups and large groups in the communities around the hospital. The staff and patients also attended the sessions focusing on multiple concurrent partnerships (MCP) using the flannel gram, correct and consistent condom use, and HIV testing. MCP is now

understood as a driver of the HIV epidemic by the community. The HIV Prevention Officer, in partnership with a Peace Corps volunteer, jointly organizes and conducted the sessions.

- **Gender**

A total of 380 people (284 males and 96 females) were reported as having been reached with gender messages focusing on male norms and gender based violence in and around CHS facilities in the fourth quarter. There has been an increase in the number of males reached with gender messages which can be attributed to the now popular male conferences strategy that draws men to come together and participate as men only in large and small groups. A total of 154 sessions were conducted at LMS reaching a total of 2,585 people (1,604 females and 981 males) through small and large group sessions with messages focusing on behavior change and male norms.

Group of men who completed their sessions at Transnamib



- **Information, Education, Communication (IEC) and Condoms**

In LMS, 2,884 male condoms, 250 female condoms and 2,279 leaflets were distributed during the behavior change sessions and designated condom outlets where communities collect condoms within the health district. The prevention officer carried out a number of small and large group sessions on HIV prevention as summarized below.

The number of session, Condoms and number of people reached by Onandjokwe

	Session	IEC	Condoms	Male	Female
October	10	110	0	129	50
November	13	137	0	51	22
December	9	279	1440	118	416
January	9	195	194	11	55
February	10	163	864	139	146
March	18	150	260	74	79
April	17	212	200	20	52
May	0	0	0	0	0
June	17	250	400	91	101
July	16	230	144	87	159
August	22	330	2050	149	349
September	21	223	332	112	175
Total	162	2279	5884	981	1604

- **Alcohol**

The majority of community members, in and around Onandjokwe (LMS), felt that they encourage each other to drink through peer pressure within the community. One community member who also runs a local shop confessed to having started drinking because of pressure from her customers saying that she can't sell them alcohol if she herself doesn't drink and she feared losing business as a result. Alcohol abuse is a major problem in all of the sites that IH supports. Young people are stealing money from family members and even to the extent of physically abusing them, and those with pensions are using their money to buy alcohol. The Coalition on Responsible Alcohol Drinking (COORD) officers, in partnership with the HIV PO and social workers in the region, conducted a one-day meeting at three different sites, including Omuntele, Onayena and Oniipa. These meetings were well attended by headmen, chiefs, shebeen owners, bar owners, bartenders, community activists and community members. During the meeting, COORD raised awareness about alcohol abuse and provided recommendations on alcohol legislation. The COORD also was invited to create smaller committees to tackle the problem of alcohol abuse. Police officers were invited to make presentations on the Namibia Liquor Licensing Act.

CHS facilities continued to implement alcohol programs including brief motivational interviewing (BMI). In addition, CHS' abstract on "The Catholic Health Services: responding to alcohol abuse in Namibia" was accepted for poster presentation at the ICASA conference in December 2011.



COORD meeting at Omuthiya.

Other Accomplishments & Successes

- Male conferences continue to be a way to reach man with gender norms related messages, encouraging men to take responsibility as responsible men should in relationships and encouraging health seeking behaviors. They also encourage gender equity in relationships.
- The gender activity of the HVOP program managed to reach 129 men at their workplace. Pupkewitz and Transnamib participated in the sessions during this last quarter. At least 4 sessions were conducted with information on MCP, Alcohol, antiretroviral therapy (ART), gender-based violence (GBV), and MC. Men were actively participating in the sessions and they are willing to participate anytime.

Challenges, Constraints & Plans to overcome them

- Activities related to SBCC including gender have decreased amongst CHS sites during the fourth quarter. CHS will network more with other stakeholders like the MoGECW, the WCPU and the Police to co-facilitate these sessions and bring in expertise from their varied angles.
- **The positive health dignity and prevention (PHDP, formerly PwP which targets** people living with HIV (PLHIV) in the ART sites got off to a slow start this year. The MoHSS joint National Health Training Center, along with I-TECH, delivered trainings first in the Khomas region and then in the Kavango region, after having piloted the training in Omaheke. The regional training in the Kavango region, where CHS' Andara and

Nyangana sites are located, managed to accommodate the nurse, pharmacy assistant and two counselors from Nyangana only. The training needs to be delivered to the whole team attending to the clients since one ART clinic visit for the intervention needs to be completed by a team and then counted as having attended to one client. Nyangana introduced the intervention with the three cadres mentioned above, and will have a complete team once a doctor is trained. The cadres will be trained in teams during the first quarter of FY2012 and the training will then be rolled out to the remaining FBHs. Onandjokwe is in the final stage participating as a comparison site in the ongoing pilot study on PwP, and thus they will receive training with the other sites.

- AMS St Mary's Odibo's HIV prevention officer has been underperforming and this is being attended to with management both at IntraHealth and AMS levels, as the cadre needs more hands on supervision and accompaniment to increase and improve on the number of groups that are graduating or attaining at least five to eight sessions of SBCC sessions.

LifeLine/ChildLine (LLCL) Namibia

Schools program

LifeLine/ChildLine (LL/CL) Namibia is at the forefront of national efforts to improve communications skills among youth, to enhance emotional intelligence and self-esteem and thereby to increase positive decision making especially with regards to sexuality.

The ChildLine Schools Outreach intervention consists of two components: (1) Primary Schools, aged 10 – 14 and (2) Secondary Schools, aged 15 - 24. The ChildLine team works with students from grades 5 to 7 and grades 8 to 12 and covers topics of self-esteem, gender, alcohol and drugs, cross-generational sexual relationships, multiple concurrent partnerships for the older learners and HIV/AIDS. These topics cut across both programs. The facilitation methods and the depth in which the topics are covered vary according to the age group. The interactive process used by the ChildLine team stimulates the children to challenge one another through interactive discussions.

The ChildLine program focus on 4 schools each in 3 high prevalence regions, Khomas, Oshana and Kavango. The team together with the Ministry of Education and other relevant partners identify underserved schools or schools with identified social problems such as high teen pregnancy rates. Multiple groups with a minimum of 15 and a maximum of 25 students go through a series of 8 HIV prevention sessions focusing on the drivers of the epidemic. With the support of IntraHealth and C-Change, LLCL has carried out a program evaluation of the ChildLine intervention through surveys and data analysis. Results of the program evaluation (baseline done before the start of intervention) have informed the COP 10 program interventions.

The SBCC program is aimed at grades 5 to 12 learners (ages 10 to 24 years) and is described as:

- About 45 minutes in length, presented in a classroom or hall
- Consisting of 8 sessions, with facilitated discussions in between, and including 2 facilitators
- Covering the following topics:
 - Self-esteem
 - Gender
 - Delayed sexual debut & abstinence
 - Risky sexual behavior
 - Sexuality and relationships
 - Multiple and concurrent sexual partnerships
 - Cross-generational and transactional sex
 - Alcohol abuse & HIV, including the consequences of such risky behavior.

Uitani ChildLine Radio is a participatory radio program run by and for children. The Uitani team is currently made up of 39 children aged between 8-15 (12 boys and 29 girls) and 8 students from the Polytechnic of Namibia and MATS, the media department of the College of the Arts. We have four radio presenters and the rest of the children are reporters. The students support the children in teams with their research, understanding and production. The presenters and reporters are trained in radio production and interview techniques and record programs every week for Uitani ChildLine Radio. In April they will receive personalized voice training.

In 2011, 14 children graduated from Uitani ChildLine Radio and moved over to the 'Lets Realize' child protection committees which runs under the Child Protection Program that is funded by USAID through PACT. The committees

meets weekly And some of the graduates have indicated their interest in becoming buddy counselors for Child helpline.

Accomplishments & Successes

Quarter 1 (Oct 2010 to Dec 2010)

School program

For the school program, quarter 1 activities ended by mid November 2010 before the start of the final exams and the Christmas holidays. All teams completed the compulsory 8 sessions with their schools in the regions before closing off quarter 1. The teams focused on only two schools per region which made it possible for them to be able to complete their sessions before the commencement of the end of year examinations (December 2010).

Below is the table presenting the number of learners reached by the end of quarter one.

Region, town	Age	Male	Female	Total
Khomas, Windhoek	10 - 14 years	46	36	82
	15 - 24 years	74	56	130
North-Central, Ondangwa	10 - 14 years	29	43	72
	15 - 24 years	2	2	4
North-East, Rundu	10 - 14 years	50	61	111
	15 - 24 years	12	9	21
	Total	213	207	420

Schools covered during quarter one

The teams covered the following schools in quarter 1 with SBCC sessions.

- Dordabis Primary School
- Groot-Aub Junior Secondary School
- Uvhungu-Vhungu Combined School
- Kehemu Primary School
- Heroes Primary School
- Etambo Primary School

In addition to the SBCC sessions that are facilitated in schools, the Windhoek based team visited the following places and facilitated life skills sessions.

Klein-Aub Special School Intervention

- Conducted self-esteem and motivational activities with all learners and teachers present.
- Children coming forward to report rape and attempted rape as well as other types of sexual advances by teachers, molestation and other types of sexual harassment.
- The openness and willingness of the learners has made it easier for us to complete our tasks successfully.
- Learners had an opportunity to vent out issues which they are dealing with in a very confidential set-up.
- The intervention has enhanced the level of self-disclosure in the group and some of the learners opted for counseling, resulting in the reporting of rape cases which LifeLine/ChildLine helped them to pursue.

Osire Refugee Settlement

The ChildLine team was invited by the Sexual and Reproductive Health and Rights (SRH) Unit under the Osire Health Project in Osire Refugee Settlement to conduct Life skills sessions at Osire Pre-Primary and Primary School.

Uitani Children's Radio

Uitani ChildLine Radio continued to air 65 one hour shows on four different radio stations (NBC, Omulunga, BASE FM and Fresh FM). The topics related to issues children may be faced with (i.e. Child Trafficking, STI's, Saying No to sex, Partying, Rape, Drug & Alcohol abuse, HIV & Myths, Money, Christmas, Food, Fear, Suicide, Bullying, Sibling rivalry, Death and bereavement, Domestic violence, Talking to our parents about sex, Love languages – receiving and showing love, Child Labor, Bullying and Peer pressure, Emotional abuse, Death and bereavement, Puberty, Stress management, HIV & ARV's, HIV & Disclosure and How to study). These programs are co-produced and presented by children (ages 8-14 years).

Regional Community Outreach Programs

Introduction

Community outreach program

According to the DHS 2006/7, the level of comprehensive knowledge of HIV and AIDS in Namibia is estimated at 63% for men and 67% for women. Despite this, people have continued to engage in risky sexual behaviors that expose them to HIV or increase the opportunities for HIV transmission. Moreover, the NSF refers to an analysis of a study in Namibia which indicated that the greatest challenge in social and behavior change was associated with inadequate personal HIV risk perception and societal tolerance of practices that fuel the epidemic such as MCP, alcohol use, inter-generational and transactional sex. Thus the NSF argues that in order to address the behavioral drivers of the epidemic more meaningfully, there is a need to employ strategies that target both at risk individuals and the societies they live in.

LL/CL outreach program consists of the social behaviour change communication as well as the provision of counselling services. As stated above, the NSF proposes that an outcome result of prevention intervention programs should be to reduce risk of exposure to possible HIV infection in the general population by reducing risky behavior.

Consequently, by the end of these SBCC interventions we hope to improve HIV risk taking behaviors of our population. We hope that our population will be able to say no to sex with more than one sexual partner therefore reducing multiple concurrent sexual partnerships and also saying no to all modes of transactional sex. In addition, we hope that the population will adopt a culture of correct and consistent use of condoms. Consequently, we anticipate that our population will be able to negotiate condom use in difficult situations such as when under the influence of alcohol or in long term sexual relationships where HIV infection is a risk. We further hope that our population will reduce the abuse of alcohol which can be linked to multiple concurrent sexual partnerships, inconsistent condom use and transactional sex.

The community program targets group level interventions whereby group sessions are held based on a curriculum targeting the drivers of the epidemic. However, providing information on the drivers is not enough thus the curricula also addresses underlying issues like gender and cultural values, attitudes and beliefs that influence behavior. Also incorporated in the sessions is the availability of counseling services for the individual in order to improve their problem solving, decision making and negotiating skills. The sessions are based on the curricula is based that was developed by C- Change.

Session	Topic
Session	Introduction to SBCC.
Session	Value clarification and Gender issues
Session	Self disclosure and Johari's window
Session	Personal Risk assessment and Multiple concurrent partners
Session	Cross generational sex and transactional sex.
Session	Male circumcision
Session	Alcohol abuse and condom use
Session	VCT and PLWHA

Sessions are conducted twice a week for a period of four weeks with each session being one and half hours long. Consequently, a maximum number of twenty five participants per group are taken through a one month programme. The sessions are interactive whereby the facilitators engage the participants in the discussions by using national materials like Picture Code and Flannel gram. The interaction is critical as the participants need to explore their behaviour in relation to themselves and their communities. In order to effectively address behaviour, it is imperative to target different age bands to increase the relevance and provide life skills to vulnerable youth.

The sessions are conducted by volunteer facilitators who are also trained lay counsellors. Thus each community is covered by a pair of volunteer facilitators. Accordingly, a pair works in the same community providing both facilitation and counselling service as outlined in the sessions programme. This is meant to foster trust and ownership between the community and the facilitators who in most cases are also part of the particular community. In addition using volunteer from the same communities that are targeted also ensures a level of sustainability as there is capacity building within members of a particular community.

North East: Community outreach (SBCC)

In order to improve the quality of the SBCC program and especially to incorporate lessons learnt from the two SBCC cohorts, a training and review session of SBCC was conducted with the volunteer facilitators in October 2010, prior to commencement of the third cohort of SBCC sessions.

The objectives of the training were as follows:

- For volunteer facilitators and SBCC staff to internalize behavior change by reflecting on what behavior they personally need to address
- Volunteer facilitators to understand the session objectives in order to a) use them to facilitate the sessions effectively and b) link the sessions topics to HIV prevention and bring out this link in the sessions
- Volunteer facilitators to understand how to plan their sessions so as to address quality of the sessions provided
- Volunteer facilitators to understand the activity report template and how to use it in order to produce comprehensive reports. Thus reports should reflect the actual events activity, provide insight on the participants' reception of the sessions while also outlining challenges faced, lessons learnt and future plans.
- Volunteer facilitators to understand the importance of the attendance list and explore how to fill it correctly throughout the eight sessions. Thus the attendance list should allow for identification and monitoring of new and old participants, while also ensuring that the participants were from the correct age group.
- Map out a way forward for future SBCC activities

SBCC Follow – up Data Collection

Prior to the commencement of the third cohort, a follow up (post intervention) data collection was conducted in October 2010. The communities involved in this exercise were Ndama, Tuhingireni, Kehemu, Sauyemwa, Muhopi and Mururani 1 and 2. Thus the communities comprised of 4 urban and 3 rural areas. A total of 103 participants comprising of 50 participants in the 15 – 24 age groups and 53 participants in the 25+ age category were interviewed for this exercise.

In the same quarter, the third cohort has started and a total of 110 participants completed at least five sessions by the end of the quarter. It comprised of six communities four of which had participants in the 15-24 age category while the other two had participants in the 25+ age category.

The table below shows the number of participants per location those who have completed at least 5 sessions

Community	Age group	No. completed at least 5 of the 8 sessions		
		Male	Female	Total
Rundu – Ndama	15-24	2	10	12
Rundu -Kehemu	15-24	3	11	14
Nkurenkuru- Siudiva	25+	15	4	19
Nkurenkuru- Kakuro	15-24	16	4	20
Mururani – Mururani1	25+	4	18	22
Mururani- Mururani 2	15-24	10	13	23
Total		50	60	110

In October 2010, 28 clients received generic counseling in various sites. The highest problem category received was physical health with 35% of the cases. Relationship issues composed 14% while education, addiction and material needs each comprised 10% of the cases received this month. Half of the clients were in the 15-24 age categories while 10% and 49% were in the 0-14 and 25+ age categories respectively. About 57% of the clients received the services in Rundu, while 25% were provided services in Nkurenkuru.

In November 2010, 43 new and 6 follow up clients received generic counseling at the various sites. The highest category problem was relationships with 34% of the cases followed by physical health with 30% and Educational related cases with 13% of the cases. About 43% of the clients were in the 25+ age category while 53% of the clients were female. By site, Rundu had the most clients (43%) followed by Mururani with 29% of cases.

Due to festive season, the month of December 2010 did not have a lot of clients requiring counseling services but nevertheless the counseling numbers picked up in quarter two.

Khomas: Community outreach (SBCC)

SBCC Follow – up Data Collection

The objective of this exercise was to collect data from participants who have been involved in SBCC discussion groups in order to gauge whether the program implemented has had an effect on the community members.

Each pair had to interview 25 participants were a total of 50 people had to be interviewed. The Volunteers selected the participants randomly from the list of participants who have attended the SBCC sessions. The volunteers arranged the venues where interviews were conducted. It was noted that these venues were in the areas where the Volunteers actually live and where sessions has been conducted.

SBCC Sessions

In October 2010, two pairs of volunteer facilitators have been conducting the sessions. A total of 45 participants all above 25 years have been registered and have completed all 8 sessions. General remarks from the reports state that participants would like to receive certificates and that they wish for this program to continue.

Quarter one has recorded a total of 172 counseling cases in Khomas. The cases came from the Windhoek counseling centre and Okuryangava outreach centre in Windhoek. The most presenting categories are the alcohol and drug abuse as well as domestic violence and multiple concurrent partnerships. Other counseling categories presented were death/bereavement, education and intimate relationship.

North Central: Community Outreach (SBCC)

Due to the fact that SBCC was a new approach, all volunteers' facilitators were again brought together in October 2010 for a refresher to broaden their facilitation skills as well as creating a common understanding on what type of information should be discussed during the sessions. This process was done with the guidance of the acting regional manager, regional coordinator and the two activators.

In addition to the preparations, quarter one saw the establishment of new outreach points at Ohakweenyanga, Onamungundo, Okahao, Ondangwa Security Company and Okatope. Only three outreach points have completed their eight sessions so far namely, Okatope, Okahao and Ondangwa. Due to the interest shown by the participants, it is expected that more people will be reached through these outreach points as the team leader and the headman are happy with the program. Most of the participants were open to discussions especially on sexual network and the virus chart. One on one counseling sessions were provided to individuals as necessary.

Generic counseling continued at all outreach points and centers such as Engela Hospital, Ondobe, Oshikango, Ondangwa, Ongwediva, Ondangwa health centre, Onankali and Oshakati. A total of 231 clients were counseled during quarter one. The most presenting age category is the adults of 25 years and above of which the majority are women. The counseling category with number is HIV/AIDS under relationship problems, condom use and MCP

Quarter 2 (Jan 2011 to Mar 2011)

School program

The ChildLine school program continued with the SBCC sessions during quarter 2. This quarter, the sessions commenced after the schools reopened in January 2011. So far a total of 79 individuals (28 males and 49 females) has gone through and completed 8 sessions in Windhoek were as 129 individuals (69 females and 60 males) all completed 8 sessions at Rundu during quarter 2. However more individuals were still participating in the sessions and were expected to complete the 8 sessions within the first month of the third quarter in all 3 locations, namely; Windhoek, Ondangwa and Rundu.

Windhoek

A total of 441 (196 males, 245 females) learners were enrolled in the program and attended sessions at the following schools:

- St Joseph High School
- Peoples Primary School
- Bet-El Primary School
- Highline High School

Ondangwa

A total of 136 (61 males, 75 females) learners were enrolled in the program and attended sessions at the following schools:

- Oluno Primary School
- Heroes Private School
- Ondangwa Secondary School
- Wendy Primary School

Rundu

A total of 187 (89 males, 98 females) learners were enrolled in the program and attended sessions at the following schools:

- Sarusungu Combined School
- Kehemu Primary school
- Rundu Secondary School
- Kasote Combined School

Klein-Aub

The Klein-Aub Special School intervention has been an ongoing activity of LifeLine/ChildLine since the school requested urgent visit late 2010. Continuous counseling sessions have been happening at the school with learners that have been sexually assaulted. The ChildLine team this time around went to do a TREE OF LIFE activity with the learners of the Special School and the Feeling YES Feeling NO program with the learners from Klein-Aub Primary School. It was decided on the Tree of Life program because it is a counseling tool. We thought it was necessary after the traumatic experiences the children went through. At the same time it will equip the participants with the necessary skills to deal with similar situations in future, especially where to look for help.

Uitani Radio

Radio programs:

Uitani ChildLine Radio continued to air the child participatory programs every week. Approximately 20 one hour shows on 4 different radio stations were broadcasted every month. The shows were played on NBC National Radio every Saturday from 9h to 10h. They re-broadcast sometimes on Sundays but always during the holiday season. The community radio station BASE FM played the shows from 7h to 9h every Saturday morning. The commercial radio station Omulunga, Radio airs the programs on Sundays from 12h to 13h. Until February 2011 the highly popular commercial radio station Fresh FM aired the programs on various times. All the topics discussed are themes that are relevant to the daily lives of children and are established through SMS as received from listeners, listener clubs in three regions and the participating children themselves. If partner organizations request us to focus on a theme then we try to accommodate them if we feel they are relevant to our target audience e.g. healthy lifestyle from World Health Organization. Some of the themes that we covered this year are: New Year, New Beginnings, Peer pressure, teen pregnancies cliques and gangs in school, parenting, bullying, corporal Punishment, Friendship and recognizing real friends, pets and animal rights, HIV and AIDS in general, HIV and ARV's.

Production of public service announcements with BASE FM:

We wrote and recorded 10 public service announcements with some of the Uitani children and BASE FM. The themes are: tolerance and understanding, having multiple concurrent partners, underage drinking, Intergenerational relationships, HIV and Stigma, bullying, peer pressure, suicide, self esteem and speaking out about your problems.

In February LL/CL held three afternoons of auditions to give children in Windhoek the opportunity to join. We have 20 places for this year and 80 children came to audition. We were thrilled to have more boys auditioning this year. The standard of reading and general interest and knowledge was remarkably higher with the boys this year's intake than compared to previous years' intakes.

Capacity building:

We had our first radio production meeting where the older and new kids met and mingled. We did some team building activities and then a brain storm session on their topics for the year. Additionally we did some production

exercises to remind them about how to produce a slot: research, questions, interview techniques and non verbal communication while interviewing.

We had a 14 year old learner from Windhoek International School do a one week internship at Uitani ChildLine Radio. She aided in the transcribing of some of the recordings for the youth pages and assisted the children with their productions in the afternoon.

Public relations and marketing:

Birthday event Uitani ChildLine Radio. For six years children have been striving to empower their peers through a weekly radio program. We opted to celebrate this together with children that don't often have cause to celebrate. We partnered with CAA/ Bernhard Nordkamp Centre and hosted a birthday party with the 140 orphans and vulnerable children that attend the centre. Our graduates, current team and 'Let's Realize' committee joined in the fun too. We had clowns and performances and some of our children gave touching testimonies. At the request of the Uitani ChildLine Radio children the local artist DeeJay was selected to judge the talent competitions and perform a couple of his latest hits. We were very happy to see that some of the Uitani parents also attended the event and helped with the logistics.

OBI: We had a live outside broadcast for two hours with FRESH FM. This happened from the birthday event. It was co-presented by the Uitani presenters and our reporters were interviewed about their experienced live on air. Children got to meet and greet their favorite radio DJ's such as Morris and Che. Local artist DeeJay was also interviewed.

Regional community outreach program

North Central: Community Outreach (SBCC)

Generic counseling continued at all 9 centers in the region during the second quarter. At Oluno Clinic volunteers received cases of Alcohol abuse and gambling, child neglect as well as problems with ARV adherence. Referrals were made to the clinic.

Ongwediva Centre handled a case of a child with disciplinary problem. This has been a continuous problem so the child was referred to Oshakati Hospital ward 16 for a psychiatric evaluation.

Learners at Erundu School expressed their gratefulness at the opportunity to come to counseling. They felt fortunate at the chance to talk to a counselor as they do not have anyone with which to share their concerns and problems.

Supervision

There were 11 volunteers at Ondobe and 8 cases were discussed. Most of the cases involved alcohol abuse.

6 Staff members at Oshikango received individual supervision and also had the opportunity to discuss personal issues and problems counselors were experiencing.

At Ondangwa 10 volunteers were supervised and 8 cases were presented.

In service training

In service training was done at Ondobe with 11 volunteers. The topic was "counseling people who are abusing alcohol". Volunteers did role plays after the training to reinforce the knowledge and techniques learned. They were also encouraged to role play some of their cases that they presented at the supervision session.

Khomas : Community outreach (SBCC)

In the Khomas region, a total of 53 adults above the age of 25 have completed at least five out of eight sessions of the SBCC program. Several challenges were recorded during the sessions such as the lack of male involvement in HIV prevention activities, when the topic of *Living Positively with HIV / AIDS* was discussed; men said that they "are not free to go to New Start Centre". This is an indication that many males are still reluctant to get tested. Other challenges include people not fully understanding HIV disclosure and some participants pointed out that condoms are not always available in some areas.

Lifeline/ChildLine continued to provide counselling services through face to face as well as telephone counselling through the Khomas regional office and Okuryangava outreach centre. There has been a marked increase in the

numbers in March 2011 compared to January and February where 60 and 45 cases respectively were handled; the numbers for March 2011 were the highest in the quarter with a total of 101 clients being served. Children and adults were counseled with their major problem categories being rape, divorce and sexual behavior.

North East: Community outreach (SBCC)

The following communities have participated in SBCC sessions in Kavango region in quarter two.

Sauyemwa, Tuhingireni, Sun City 2/Sikanduko, Kehemu, Kakuro, Siudiva, Muhopi, Mururani 1, Mururani 2, Sun City 2 (Ndama), Utokota. The groups covered are 15 to 24 and 25 and above age groups.

Most of the participants were very delighted and excited to start the program after the festive season. The participants received the sessions very well and were asking: what does PEPFAR stand for? Where Lifeline office is allocated? Why the HIV prevalence is increasing in Namibia? What will be next when we are done with all eight sessions?

It became clear that basic information on HIV, its transmission and prevention is still lacking based on the questions asked for example, 'If I do not know my status, why should I use a condom?', 'What happens if both a man and woman are HIV positive, do they still use a condom?', 'If I am found to be HIV positive, do I start medication right away?'. Another confusing factor was the term locally used to describe HIV virus = 'kambumburu' literally meaning 'a small insect' where one participant asked: 'If I give my 'kambumburu' to someone else during unprotected sex, does it get out of my body?' implying that there is one virus that can be handed over to another person. Another challenging perspective was in the following question: 'Where is the risk if I am HIV positive, have many partners and am always using a condom.

This quarter 39% of clients referred to counseling came as a result of SBCC interventions in the community with more men receiving counseling in the last two months. Former Tusano counselors were instrumental in receiving clients referred from the VCT who require positive living counseling in that they have the knowledge and experience to accommodate such clients. This reinforces the organization's commitment in involving people living with HIV in the programs. Volunteer counselors continued to attend monthly meetings in which both counseling and SBCC aspects are covered, these meetings provides feedback and support to better the program. In addition, role plays were held once a month at respective counseling point and difficult cases were discussed in the meeting.

In this second quarter, a total of 76 new and 8 repeat clients received generic counseling at all counseling points. An increase has been noticed each month from 12 clients seen in January, 28 in February and 36 in March. The highest problem categories this quarter is being health problems, relationship problems, educational and violence and abuse related cases. By site Rundu-based volunteers saw most clients, followed by Mururani and Nkurenkuru. Male and females share an equal number of clients seen this quarter, 38 each.

In total 76 new clients and 8 follow up clients were served during this quarter.

Quarter 3 (April 2011 to May 2011)

School program

The ChildLine school program continued with the SBCC sessions during quarter 3. This quarter, the sessions continued after being interrupted by the floods in some of the areas. The teams in various regions managed to reach 1142 children in total during the reporting quarter.

Windhoek

SBCC sessions completed during the 3rd quarter

School	Age	Male	Female	Total
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St. Joseph High School	10 - 14 years	18	31	49
	15 - 24 years	19	22	41
People's Primary School	10 - 14 years	29	49	78
	15 - 24 years	0	1	1
Bet-el Primary School	10 - 14 years	39	50	89
	15 - 24 years	18	31	49
Highline Secondary School	10 - 14 years	0	0	0
	15 - 24 years	57	58	115
Theo Katjimune Primary School	10 - 14 years	50	60	110
	15 - 24 years	16	11	27
	Total	246	313	559

Ondangwa

The activities in the North which were disrupted by the floods continued in quarter 3 and were completed.

SBCC sessions completed during the 3rd quarter

School	Age	Male	Female	Total
Oluno Primary School	10 - 14 years	23	47	70
	15 - 24 years	5	0	5
Wendy Primary School	10 - 14 years	35	38	73
	15 - 24 years	2	1	3
Ondangwa Secondary School	10 - 14 years	23	33	56
	15 - 24 years	8	6	14
Heroes Private School	10 - 14 years	6	13	19
	15 - 24 years	6	9	15
	Total	108	147	255

Rundu

SBCC sessions completed during the 3rd quarter

School	Age	Male	Female	Total
Sarungu Combined School	10 - 14 years	19	22	41
	15 - 24 years	4	2	6
Kehemu Primary School (Group1)	10 - 14 years	28	45	73
	15 - 24 years	3	3	6
Rundu Secondary School(Group1)	10 - 14 years	6	10	16
	15 - 24 years	14	18	32
Kasote Combined School	10 - 14 years	2	0	2
	15 - 24 years	32	22	54
Kehemu Primary School (Group2)	10 - 14 years	20	25	45
	15 - 24 years	6	2	8
Rundu Secondary School(Group2)	10 - 14 years	2	4	6
	15 - 24 years	16	23	39
	Total	152	176	328

Tree of Life Workshops

The Tree of Life is a psychosocial support tool based on Narrative Practices. It is a tool that uses different parts of a tree as metaphors to represent the different aspects of our lives. The use of metaphors and carefully formulated questions invites children and others to tell stories about their lives in ways that make them stronger and more hopeful about the future. While it was not designed as a "bereavement tool" it opens up space and has been used extensively with children in different contexts to facilitate conversations about loss and bereavement. The tool allows children severely affected by HIV & AIDS, poverty and conflict to tell, hear and explore stories of loss without

remaining trapped in expressions of grief and bereavement. It simultaneously opens up spaces and opportunities to tell, hear and explore stories of hope, shared values, connection to those around them as well as to those who have died.

One of the particularly appealing aspects of this intervention is that it links children back to their families and communities. Structured counseling processes are often, by nature, separate from the daily lives of the people who access the services. The Tree of Life exercise deliberately invites children to reflect honor and acknowledge the precious relationships they have with their caregivers, families, peers and community members.

Tree of Life workshops were conducted during the school holidays with 15 participants from Hope Village in Windhoek and with 15 participants from Rundu town. The workshops covered the following main themes;

1. The Roots of my Family
2. What I want to become in my life.
3. How HIV works in the Body
4. HIV Myths and facts
5. MY tree of life

The workshops achieved the following outcomes:

- Awareness about **Lifeline/ChildLine** including the **child help line number (116), 232221** as well as the SMS line - **0811400222**
- Awareness of **broadcasting times** of Uitani ChildLine radio on **Base FM, Fresh FM, Omulunga Radio and NBC National Radio.**
- Disclosure from the children about their past life experiences which were very emotional, but which they have improved and overcame through counseling.
- The children recognizing the few people that are playing a very big role in their lives and who are always motivating them to finish school and go for further studies and to become someone in life.

Uitani ChildLine radio

Production:

1. The radio team block produced a number of programs with the eye on the exams and holidays in August.
2. Individual feedback and evaluation sessions with the students and children on the production team were ongoing.
3. Also the team produced specific shows for (16 June) Day of the African Child and the UN International Day against drug and alcohol abuse (campaign from 16th June to the 2nd July), a show on child labour (18 June) in the week that the ILO and UNICEF had their campaign highlighting the plight of children in child labour networks.

Broadcast:

Shows were aired on four radio stations on a weekly basis (NBC National Radio, BASE FM, Omulunga Radio and Fresh FM). Some of the topics were: drugs and alcohol abuse, child trafficking, day of the African Child, child labour, emotional abuse and bullying and peer pressure.

Events and live broadcast:

For the day of the African child we invited 97 children from two orphanages, betel 'let's realize' child protection committee and some of the Uitani kids and students to the Lifeline/ChildLine headquarters. We hosted a children's rights event with games, interviews on radio, a puppet show and an information session given by ChildLine and two of the Uitani kids. Simultaneously we hosted a live broadcast for two hours on Base FM. The show was co-presented by Cecilia Uitani ChildLine Radio presenter and Mufaro Base FM presenter. Children were interviewed, aired their opinions about their rights and responsibilities and had fun all around.

Other media/PR:

1. Drafting of an advertorial and the subsequent publication in the Namibian youth pages for the day of the African Child
2. Radio drama produced with the NBC national radio service and Uitani for the day of the African Child
3. Interview on good morning Namibia with two of the Uitani kids on the day of the African Child
4. Interview on NBC National Radio's drive time news program about child helpline and ChildLine services by Natasha and Hildegard

5. Back page of the youth pages on the 21st of July was dedicated to children speaking out about education and the page was adorned with Uitani and 'let's realize' children from our event on the 16th of June 2011.

Community Outreach Program

Rundu SBCC Sessions

In quarter 3, 222 people were reached with SBCC program in various communities. The region managed to complete its sixth cohort since the start of the program in 2010. Although females made up 65% of the total number reached in this quarter, more males were reached in the last cohort, which shows greater involvement of males in community programming resulting from the male engagement initiatives by LL/CL.

In June, the sixth cohort was completed with 5 groups; six Rundu-based facilitators volunteered their time to complete these groups together with the community activator who conducted the Mazana sessions. One of the groups reached in June was a group situated at a flood relocation camp. The inclusion of the flood camp in this cohort was based on the following considerations to cover a community in the Sambyu catchment area and to be proactive, ensuring that flood affected people have access to information and services.

Rundu Generic counseling

In this third quarter, a total of 175 new and 18 repeat clients received generic counseling at all counseling points. The highest problem category this quarter is being health problems (94), relationship problems (28), and educational (15). People who turned up for counseling were mostly referred through SBCC, community meetings, friends and family, radio and posters, schools and the VCT outreach this quarter.

The integrated approach to outreach proved to be successful as all teams involved had a good understanding of their particular role and thus generated good numbers of clients while delivering appropriate services to respond to community needs. This integrated response strategy worked equally well at the flood camp a number of clients were reached and it proves that the communities in this kind of environment have greater need for counseling to help them deal with their trauma.

North central SBCC sessions

In quarter three, SBCC intervention continued at Eembidi village, Epatululo number 1, Omunyekadi village (Okatope centre) in Ohangwena region and Okahao in the Omusati region reaching a total of 42 participants.

Omunyekadi, Eembidi and Epatululo communities form part of Okatope Centre. Social issues around rape, child sexual abuse, MCP among learners and adults, lack of discipline, teenage pregnancies, alcohol abuse, and transactional sex and cross generational sex (learners/adults) were reported as prevalent in these communities

Participants of the above communities were particularly interested in the MCP FG topic. They confirmed that this is a reality at Omunyekadi as those involved sometimes fight each other because they share man/woman. One of the participants thanked the facilitators for the intervention and said that it was an eye opener as people are sometimes ignorant about the consequences of MCP and transactional sex.

North central generic counseling

Generic counseling continued at all centers. At Ongwediva the volunteers spent their time at flood centers in Ekuku and at Oshoopala where they met with children and adults and provided counseling. They also used the PSS tool that was developed by LLCL (A Psycho-Social Framework for Working with Children Affected by Floods) to help children deal with their own experience of trauma. The total number reached with generic counseling over the reporting quarter is 182 clients.

Khomas region SBCC

A total number of 95 participants completed the 8 SBCC discussion sessions during the reporting quarter. These consists of people from Havanna #1, Nalitungwe, Gabriel Shihepo and Goreangab dam settlement areas. Although there has been low number of males participating in the groups, those that have participated have shown interest in the program and were fully participating in the discussions.

Khomas region generic counseling

The total number of cases reported this quarter is 212. April reported cases 81, May reported 84 cases and 47 cases were reported in June. The major problem categories were Destitution, Child Abuse and Maintenance. Due to funding difficulties, the number of volunteers providing generic counseling at various centers was reduced for the meantime and this has resulted in lower number being reported in June.

The SMS line received a total number of 502 text messages this month. The major problem categories identified were Intimate Relationships and Family Relationships. The types of issues raised in these two problem areas are mainly to do with communication either between partners or family members. A common theme which occurs in Intimate Relationship issue is that either one of the partners has started to change – they are not the same as they used to be in the past. Partners are finding it difficult to adjust to the various changes which occur within a relationship.

Challenges & constraints & plans to overcome them

- Life skills periods are no longer an option. There is a need to move sessions to after school. If we use Life Skills period the school expects us to assess the children for the subject. We would rather move the sessions to after school so that we do not interfere with the normal school program. It would allow us more time with the children (1 hour instead of 30-45 minutes). Thirty minutes or less are not enough to conduct an effective session.
- Flooding in the northern regions has affected both the community SBCC program as well as the school's program

Planned events for next quarter

- Continue with the activities under the new award

2.5 Program Area 5: HIV Counseling and Testing (HCT)

The IH-supported HCT program continues to run successfully and has experienced success in scaling up outreach testing services in conjunction with the MoHSS. During the fourth quarter, 14,065 individuals received counseling, testing and received their test results, bringing the total for FY2011 to 51,468. Of those who received counseling and testing in the fourth quarter 13,183 (93.7 %) were first time testers, making the total number of first time testers for FY2011 to 45,211 individuals which represents 97% of the FY2011 target of 46,600. The number of couples receiving counseling during the fourth quarter was 1,625 (12.3 %), and 7,710 (54.8 %) females and 5,473 (38.9 %) men were tested. The number of HIV-positive clients in the quarter was 1,015 which represent 7.7% of the total number of clients who tested HIV-positive. The number of males that tested HIV positive was 408 (7.5%) compared to 607 (7.9%) women.

Figure 6: Individuals (First Time Testers) Receiving HIV Counseling and Testing, October 2010 -September 2011

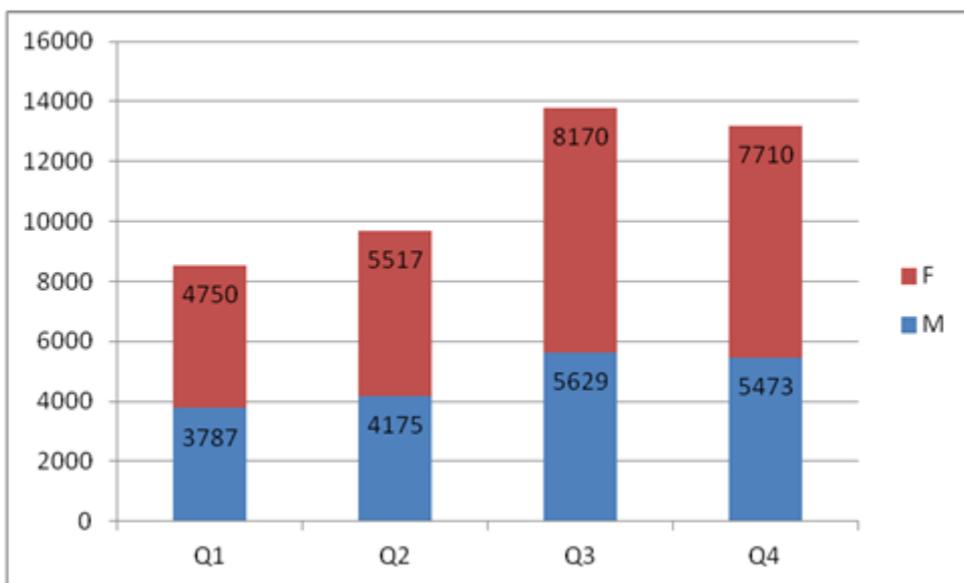
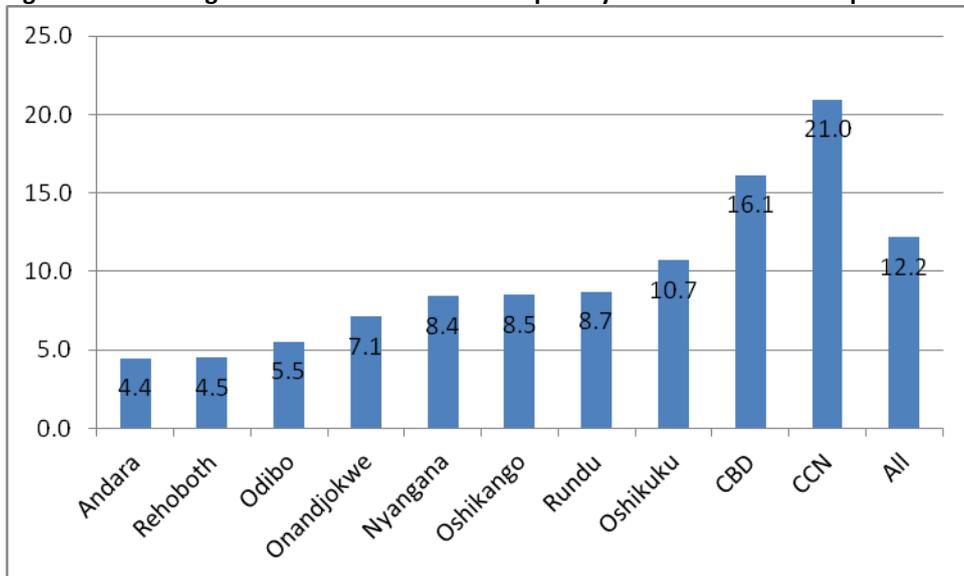


Figure 7: Percentage of clients counseled as couples by site October 2010-September 2011



Transition of HCT Partners: At the outset of the award, with support from USAID/Namibia through the President’s Emergency Plan for Aids Relief (PEPFAR), IH entered into sub-award partnerships with nine local organizations, five of which were stand-alone Voluntary Counseling and Testing (VCT) sites. Based on guidance from the Mission technical staff, reductions in the year three USAID obligation to IH in the area of

HCT were made and as a result funding was discontinued to the seven New Start VCT centers. In all locations, HCT sites supported by the GRN now provide access to individuals and couples wishing to receive HCT services, although those services were not available when the New Start VCT Centers began. During the fourth quarter, IH resources were directed towards scaling up, expanding upon and improving services and outreach testing in the remaining sites as well as in hard to reach areas which were identified in collaboration with the MoHSS and stakeholders. IH currently provides support to 10 remaining New Start centers operating under the following partners (including CCN New Start center under IH):

- Anglican Medical Services – 1 site
- Lutheran Medical Services – 1 site
- Catholic Health Services – 4 sites
- LifeLine/ChildLine – 3 sites
- IntraHealth – 1 site (CCN)

Community Mobilization: The focus of Community Mobilization activities during this quarter focused on the following topics: modes of HIV transmission, dangers of Multiple Concurrent Partnerships, transactional sex, benefits of MC and intensive VCT demand creation. In the fourth quarter, the Windhoek based sites mobilized individuals for testing from organizations such as the International University of Management (IUM), KAYEC, the Electoral Commission of Namibia (ECN), and the Roof of Africa employees. The turnout was satisfactory.

Accomplishments & Successes

- All clients who were confirmed to be HIV-positive were referred to their preferred sites for enrollment in HIV care and other support services.
- The CCN New Start Center attended to more males (51%) than females (49%) during FY2011. This could be attributed to intensive mobilization efforts targeting men. The same trends have also been noted in Rehoboth as a result of mobilization activities through media such as the radio.
- CCN and CBD continue to record high numbers and proportion of clients counseled and tested as couples, 21% and 16% respectively during FY2011 (see Figure 7 above). Other centers are encouraged to follow this example to increase their reach to couples.
- Extension of outreach activities with a third outreach site being opened in Oshikuku district.
- All the sites experience high acceptance rates for HIV counseling and testing.
- Counselors debriefing sessions occurring in almost all the sites.
- IH continues to conduct HCT QA and supervision all the centers. In general, all the sites were found to be providing high quality services according to national guidelines and protocols.
- The IH North West office was re-opened during the third quarter. The move is aimed to facilitate intensified skills transfer for HCT QA to the partner staff as well as transitioning of HCT QA to the MoHSS/ RMT. In a similar move, the HCT TA is now operating from CCN.
- IH submitted an abstract for the ICASA conference to be held in December in Addis Ethiopia titled **“Strengthening Couple HIV Counseling and Testing: A Namibia Best Practice”**. The abstract was accepted for a poster presentation.
- IH has started the procurement process of HCT mobile vans which will be used to intensify HCT in hard to reach areas. The placement of these vans will be done in consultation with MoHSS and the Mission. The Oshikango New Start center relocated next to SFH offices in Oshikango town. Their former location had become unsuitable for HCT activities especially during the rainy season. It is anticipated that this move will improve access to VCT for most at risk populations (MARPS) receiving services at SFH in addition to improved quality services.
- IH participated in the review and finalization of the HCT service providers’ curriculum for the counselors in partnership with Namibian Institute of Pathology (NIP), MoHSS and I-TECH. Plans are finalized to commence with the refresher training and new training of counselors by MOHSS.

- IH filled a position of a Community Mobilizer/Counselor at CCN New Start Centers to scale up the mobilization activities of clients.
- All the IH supported New Start centers successfully participated in the National HIV Testing Day during the fourth quarter.
- IH also participated in the annual joint support and supervisory visits with the MoHSS and other stakeholders. The IH staff included the Technical Director, HCT TA and the Regional HCT Coordinators.
- IH was chosen to be co-chair of the HCT TWG.

Challenges & constraints & plans to overcome them

- Men still lag behind in HCT in most of the centers: community mobilization activities will be intensified during the next quarter.
- Transport for outreach counseling and testing activities is a challenge in most sites. IntraHealth will continue to encourage partners to combine trips with Primary Health Care (PHC) visits.
- An analysis of HCT data from most hospital based facilities indicates only about 30% of HCT clients are Provider Initiated (PICT). IntraHealth is developing a work plan and strategies to increase PICT activities in the hospital based sites.

Planned Events for the Next Quarter

- Intensify community mobilizations and campaigns for couple HIV counseling and testing and counseling and testing for men. Continue with outreach counseling and testing activities. In addition establish new outreach sites to improve access to distant communities.
- Participate in the pilot of the bi-directional referral system.
- Attend RACOC meetings with stakeholders in the regions to plan HCT activities in their respective regions.
- Finalize procurement of the vans for mobile HCT.
- Continue playing an active role in the national HCT TWG.
- Conduct QA visits to all the sites with an emphasis on skills transfer to the partner staff such as Site Managers and Senior Counselors.
- Graduation of LLCL to direct funding with USAID. Three LLCL New Start centers namely, CBD, Rundu and Oshikango will no longer be funded through IH. IH will continue to provide TA and QA to LLCL as needed.

2.6 Program Area 6: TB/HIV

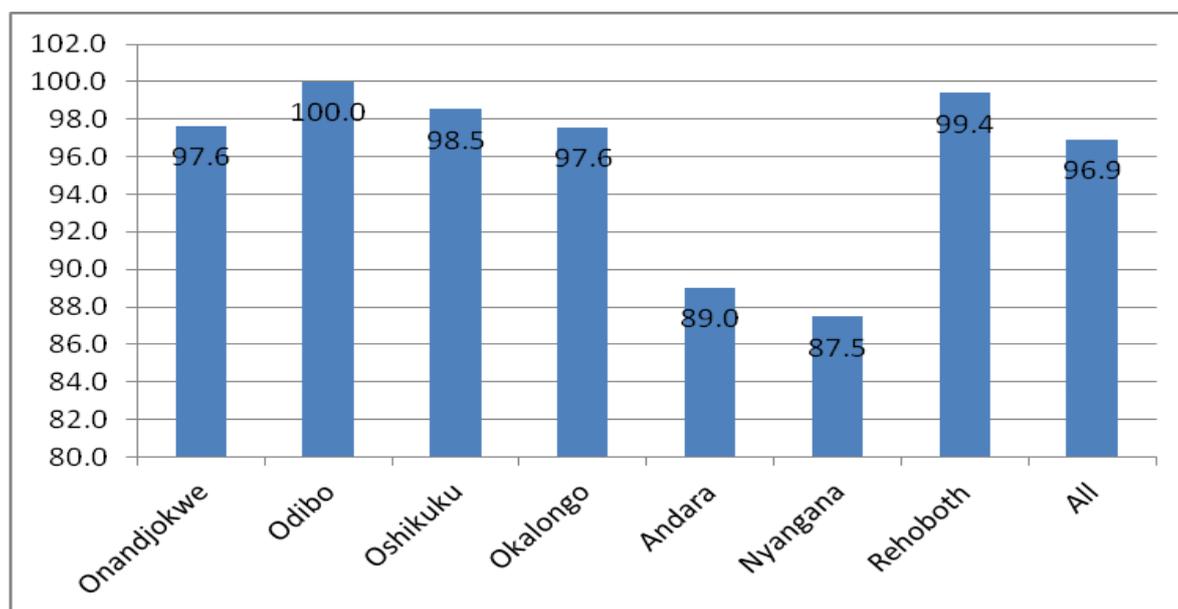
During the reporting period, IH has continued its support to the TB/HIV collaborative activities. These activities are aimed at strengthening linkages between the TB clinics managed under MoHSS at IH supported sites. Currently, 28 outlets are supported by IH to provide TB/HIV integrated services.

Accomplishments & Successes

In order to decrease the burden of TB among People Living with HIV (PLHIV), all sites are engaged in the implementation of the WHO-recommended 3I's: intensive case finding, infection control, and isoniazid INH prophylaxis. To decrease the burden of HIV in TB patients, a successful collaboration and referral system between TB clinics and HIV services facilitates the routine availability of HIV counseling and testing to all TB patients presenting with unknown HIV status. Similarly, patients accessing services from other hospital departments, both inpatients and outpatients, are evaluated for TB if/when they are symptomatic, and offered HCT using the PITC approach.

At the end of the fourth quarter, 481 (91%) of the 531 TB clients registered were tested for HIV and received their test results in the supported sites. Of those who had TB and were tested for HIV, 273 (57%) tested HIV-positive. For FY2011, 1,462 (85%) of 1,715 TB clients registered were tested for HIV and received their test results and 839 (57%) TB infected individuals tested HIV-positive. The prevalence of HIV among TB patients remains between 50-60% in most sites, indicating that the TB/HIV co-infection is still a crippling dual burden. All TB patients testing HIV-positive were transferred for enrollment in HIV treatment and for clinical and laboratory evaluation, according to national eligibility guidelines. All sites have been synchronizing clinic visits for those co-treated to receive their follow-up care on the same day and reduce additional visits for each condition.

Figure 8: Percentage of HIV Patients Screened for TB at Last Visit, by Facility, July – September 2011



By the end of the reporting period, 19,581 (97%) of 20,202 patients enrolled in HIV care and who visited the facility during the reporting period were actively screened for TB at their last visit. Figure 8 shows the percentage of HIV-positive patients screened for TB during the fourth quarter of FY2011, by facility. Four of the six main supported sites reported 97% or more screenings of their HIV-positive clients for TB during the last visit, with the exception of Nyangana, and Andara which screened approximately 90% of HIV-positive patients (an improvement for Nyangana from 81% during the first quarter). IH will continue to work with Nyangana and Andara to improve screening and record keeping for TB at each visit for all HIV-positive patients enrolled in care. During the fourth quarter, 104 patients enrolled in care were initiated on TB treatment, bringing the total for FY2011 to 376. A total of 2,494 PLHIV were initiated intermittent preventative therapy (IPT) at the main IH supported sites during FY2011. Odibo initiated the highest number of patients on IPT with 680.

Other Accomplishments:

- Administrative measures to improve infection control continued to be enforced in most hospitals especially moving waiting clients into well ventilated waiting areas in Onandjokwe, Odibo, Andara and Nyangana.
- Implementation of new TB/HIV guidelines incorporated in the new ART guidelines started in all hospitals.
- Increased utilization of HIVQUAL and the PIA has resulted in improvement in the proportion of patients screened for TB at each visit in Nyangana as well as IPT uptake in all facilities.
- Multi-disciplinary ward rounds conducted on a weekly basis in Rehoboth have continued to provide a platform for better coordination of care for PLHIV. The team includes the medical officer, District TB Coordinator, ART Site Manager, Nurses, Counselors and a Social Worker. In the other sites, such coordination is enhanced through monthly TB/HIV collaborative meetings.
- Triaging of coughing patients has been implemented in Andara, Nyangana and Onandjokwe.
- Onandjokwe recruited two MOs to replace those who had resigned. This has alleviated the workload challenges experienced during FY2011.

Challenges, Constraints and Plans to Overcome Them

- Lack of space in most ART clinics, especially in CHS facilities, continues to hamper infection control efforts. IH will continue to work with the relevant partners to implement innovative ways of decongesting the clinics and improving infection control. Prefabricated units will be procured for all the partners during the next quarter.
- Staff movement, particularly MOs' and nurses' resignations in Oshikuku and Rehoboth, have put a strain on the remaining doctors. This may compromise the quality of some TB/HIV activities, such as screening TB patients at each visit and provision of IPT. IH will continue to work with the partners to implement task shifting strategies where possible.
- There is still a low uptake of IPT in pediatric patients and in PMTCT. IH will continue to work with the partners to ensure the guidelines are fully implemented including active screening for TB in PMTCT clients as well as among pediatric patients.

Planned Events for the Next Quarter

- Implement a revised support and supervision tool with the TB/HIV module.
- Continue to work with CHS to improve the missed opportunities for provision of IPT particularly in Oshikuku.
- Continue promoting the open window policy to promote TB infection control in all departments particularly OPDs, patient/ client waiting rooms, TB wards and IPD in general. In addition, IH will continue to work with partners to ensure multi-drug resistant (MDR) and extremely drug-resistant (XDR) TB patients are separated from the rest of the TB patients. Staff working with TB patients must wear appropriate masks at all times.
- Procurement of prefabricated units to alleviate space challenges.

2.7 Program Area 7: Care – Adults

In order to reduce morbidity and mortality among PLHIV, IH is supporting the implementation of the facility-based clinical component of the minimum package of basic health care in six faith-based health facilities and their satellites. In the fourth quarter of FY2011, 28 service outlets were providing the integrated palliative care package.

The following elements of clinical care are provided: prevention and treatment of OIs, including cotrimoxazole prophylaxis for eligible HIV-positive patients; TB screening; Isoniazid (INH) prophylaxis, based on eligibility criteria; pain and symptom management, including the use of opioids; nutritional assessment and food promotion, including hygiene and food demonstration through kitchen corner; and, micronutrient supplementation in the form of multivitamins, iron and folic acid. Patients are also provided with psychosocial support, including spiritual counseling, and linked with other palliative care providers, such as the Red Cross and other community-based organizations. The Integrated Management of Adolescent and Adult illness (IMAI) has been rolled out and is currently being implemented by local partners.

Accomplishments & Successes

A total of 27,565 eligible adults were provided with a minimum of one clinical care service at the end of this reporting period. Additionally, 24,614 HIV-positive adults are receiving cotrimoxazole prophylaxis, 92% of 26,665 of all adults and children on prophylaxis.

Spiritual counseling is being conducted in four facilities: Onandjokwe, Oshikuku, Nyangana and Rehoboth. During this reporting period, 1,896 clients/patients received spiritual counseling (93 from Onandjokwe, 1,167 from Oshikuku, , and 636 from Andara and Nyangana).

During this reporting period, 115 caregivers at Onandjokwe and 104 PMTCT women from Oshikuku attended kitchen corner sessions. The revised supportive supervision tool was piloted in June 2011 in all IH supported sites and supervision conducted in all the facilities. The major findings were incomplete nutritional assessments done in most facilities (except Nyangana with more 70%) recording less than 40% of patients having height measured (to facilitate BMI calculations). The HIVQUAL will be intensified to improve. A total of 656 clients/patients receive services from Rehoboth Social Worker in form of psycho-social support.

Challenges, Constraints and Plans to Overcome Them

- During the last two quarters, no Kitchen Corner sessions were conducted in Onandjokwe. In Onandjokwe, the structure in which these sessions were conducted is no longer sound. IH will provide the site with a prefabricated room in the next year.
- Andara hospital did not conduct any Kitchen Corner activities since the hospital did not have foodstuffs for demonstration. IH will discuss with the CHS at the national level on the importance of providing health education regarding nutrition even if foodstuff for demonstration is not available.
- Nyangana hospital did not start the kitchen corner activities due to lack of necessary equipment. IH will discuss with CHS at the national level to provide Nyangana with necessary resources for Kitchen Corner Activities.
- Body Mass Index has not been calculated in most facilities. IH will provide guidance to facilities on the best way to measure BMI and will encourage consistent measurement.

Planned Events for the Next Quarter

- Strengthen Kitchen Corner activities in Andara
- Start Kitchen Corner activities in Nyangana in the next quarter.
- IH will ensure that all IH supported facilities measure patients heights as appropriate and facilitate calculation of BMI and provide nutritional counseling and referral for food support where applicable
- Pilot the bi-directional referral system with the MoHSS

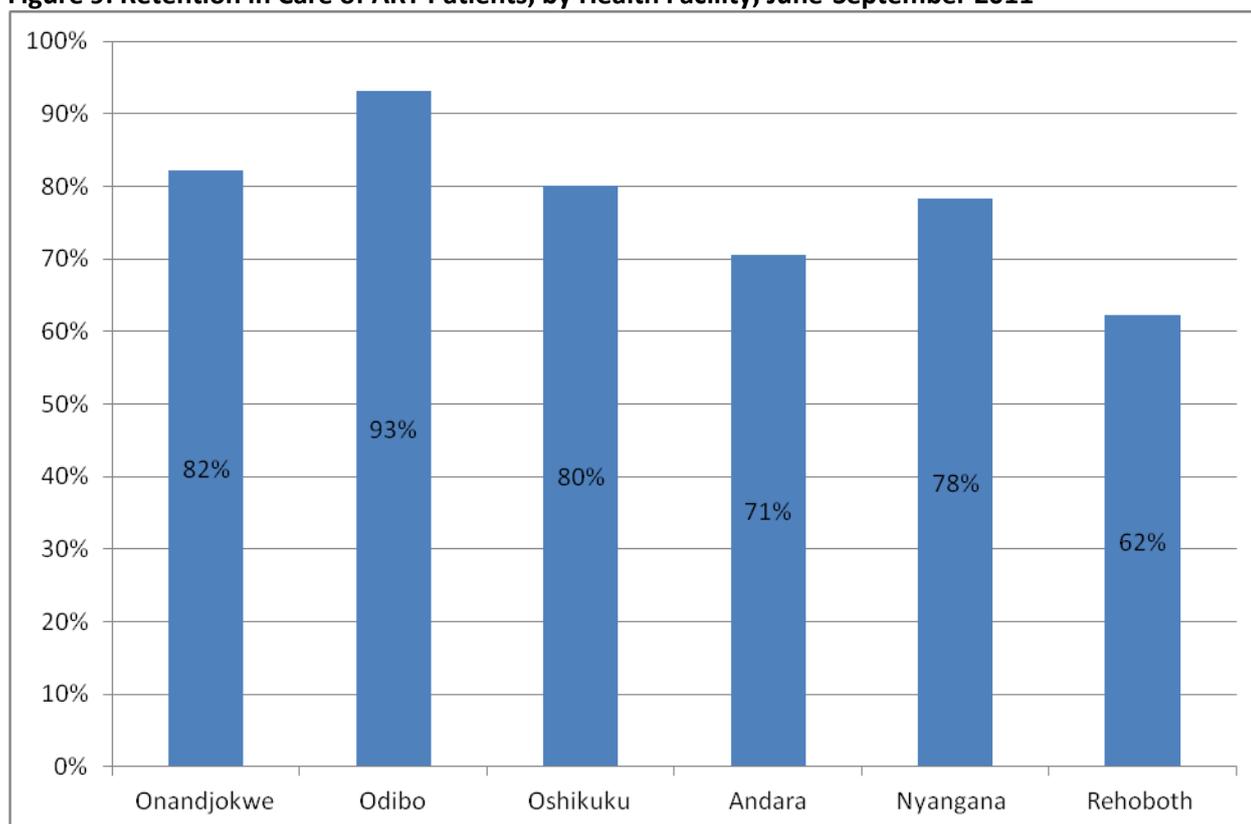
2.8 Program Area 8: Treatment: ARV Services – Adults

IH is supporting an integrated and comprehensive HIV and AIDS care and treatment program for adults in six mission facilities, comprised of five district hospitals and one health center. This program is also extended to their satellite facilities through outreach services and IMAI. During the reporting period, IH supported 28 outlets in the provision of HIV and AIDS clinical care.

Accomplishments & Successes

Overall, 17,073 adults living with HIV are currently receiving antiretroviral therapy (ART). During the reporting period, 4,138 adults PLHIV have been newly initiated on ART which represents 39% more than the FY2011 target of 3,300 new patients. This increase can be attributed to the revision of the ART eligibility criteria at the end of FY2010 which increased the CD4 threshold to 350cells/ul. Out of 943 adults and children started on ART in the third quarter of FY2010, 757 (80.3%) are still alive and on treatment 12 months later. This positive trend of retention is a result of significant and continued efforts in adherence counseling, support group activities and active defaulter tracing. Figure 9 below shows retention in care by facility during the reporting period.

Figure 9: Retention in Care of ART Patients, by Health Facility, June-September 2011

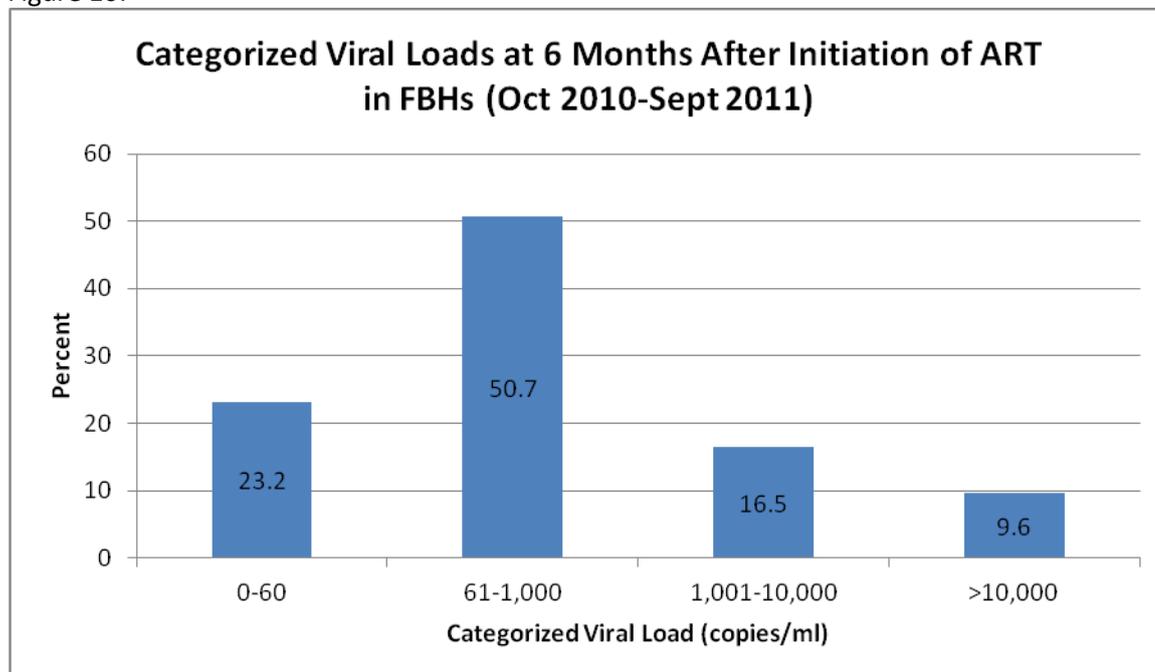


Additional Accomplishments

IH attended the annual Care and Treatment Technical Advisory Committee (TAC) retreat in Swakopmund and made a presentation on “ART guidelines implementation: experiences from the field”. The recommendation taken up by the TAC was the need to provide more guidance on how new guidelines should be implemented by facilities. In addition, MoHSS will also conduct an ART program review in the next fiscal year, and the IH presentation will also be referenced.

Figure 10, below, is an excerpt from the presentation showing the categorized results of viral loads done at 6 months for adult patients initiated on ART in Faith Based Hospitals between October 2009 and December 2010. It shows that only 20% of all viral loads were reasonably suppressed. The recommendation was for TAC to review the guidelines with regards to the usefulness of the 6 month viral load.

Figure 10:



Challenges, Constraints and Plans to Overcome Them

- The number of patients receiving services at ART clinics has overloaded the available space in most of the facilities. Partners are being encouraged to source alternative funding for expanding their existing infrastructure. Increase in the outreach activities is also expected to decongest the main facilities. IH will seek approval to procure prefabricated units for all facilities to address the space challenges.
- All IH supported sites are conducting tracing of ART patient defaulters. However, the availability and cost of transport cost remains a major challenge, especially in Onandjokwe. To bridge the gap, Onandjokwe has managed to conduct outreach services in eight facilities of which two are health centers and six are clinics.
- Workloads have increased due to implementation of updated guidelines in CHS facilities. IH will continue to liaise with CHS to ensure that hospital management teams be more involved in the program and allocate staff accordingly.
- Following GRN gazettement of new salaries and remuneration packages for medical officers and the instruction from PEPFAR prohibiting matching of these increments by PEPFAR funded programs, a gap now exists between program and GRN funded medical officers. CHS medical officers are the most affected since historically they have strived to match GRN salaries even when other programs were paying more. This disparity in remuneration between program and subsidy medical officers could begin to affect the quality of service if medical officers dissatisfied with their salary begin to leave. IH will continue to liaise with CHS management to engage Principal Medical Officers to take ownership of the program and ensure that patients in need receive medical services. On the other hand, ongoing discussions between PEPFAR, MoHSS and stakeholders continue to resolve some of these issues.

Planned Events for the Next Quarter

- Continue providing care and treatment to all HIV-positive individuals in all IH supported sites.
- Conduct support and supervision to all the sites with the respective partner management staff with the aim of transferring supervision skills to them.
- Establish an additional outreach point in Odibo to address the increased number of defaulters.

2.9 Program Area 9: Care – Children

In order to reduce morbidity and mortality among PLHIV, IH is providing support for the provision of HIV care to children infected, or suspected to be infected, with HIV. The following elements of clinical care are provided: prevention and treatment of OIs, including cotrimoxazole prophylaxis for HIV-exposed infants, TB screening; isoniazid (INH) prophylaxis, based on eligibility criteria; pain and symptom management, including the use of opioids; nutritional assessment and food promotion, including hygiene and food demonstration through kitchen corner; and, micronutrient supplementation in the form of multivitamins, iron and folic acid. Patients are also provided with psychosocial support, including spiritual counseling, and linked with other palliative care providers, such as the Red Cross and other community-based organizations. The Integrated Management of Childhood illness (IMCI) has been rolled out and is currently being implemented by local partners.

Accomplishments & Successes

As a result of the wide use of DNA PCR testing for HIV exposed infants, more infants and young children are enrolled in care. By the end of this reporting period, 3,916 children under the age of 15 were provided with at least one HIV clinical care service. This represents 12.4% of the 31,481 individuals currently receiving care, including adults. A total of 3,020 HIV-positive children were provided with co-trimoxazole prophylaxis. This represents 12% of the 24,614 children and adults receiving co-trimoxazole prophylaxis.

In all IH supported sites, pediatric care also includes the diagnosis and treatment of malaria, and referral for routine and timely immunization programs and campaigns. Routine provision of CTX at 6 weeks of age is given, according to the national guidelines for HIV exposed infants. For HIV-positive children, CTX is continued, as well as IPT, TB screening, nutritional assessment, and pain management. All IH supported facilities offer diagnosis and management for OIs and co-morbidities, including diarrhea and pneumonia. As with adults, all children in care are screened routinely for TB in every follow up visit, and referrals are made for suspected cases to the TB clinic for further evaluation (clinical, radiological and other investigations). Referral for confirmed cases is included in health registries and treatment is prescribed. Likewise, HIV testing is conducted for all children diagnosed with TB. Infants initially testing HIV-negative, but who remain at risk due to ongoing exposure from breastfeeding, are also retested.

Additional Accomplishments:

- During this reporting period, 2,100 children attended pediatric friendly services. These services assist children in increased adherence to treatment. In the next quarter, these services will include the process of disclosure according to the national guidelines.
- In Onandjokwe, two nurses and one counselor were trained in HIV disclosure process. At the end of the fourth quarter, 262 children from the age of 7 years have been registered in the disclosure process. This tool will help children understand why they are on treatment and therefore improve their adherence and behavior.
- The adolescent friendly services in Onandjokwe provide HIV disclosure process. By the end of this quarter, 120 children know their HIV status of which 70 are adolescents.
- Two teen clubs meetings occurred in Onandjokwe in May and June of 2011. Adolescents were the focus of these meetings and were given opportunity to write any questions and concerns they wished to address during the sessions.

Challenges, Constraints and Plans to Overcome Them

- During the second quarter, no kitchen corner sessions were conducted in Onandjokwe due to logistics constraints: the tent is dilapidated and heavy rains occurred. A prefabricated room is under consideration.

Planned Events for the Next Quarter

- Start Kitchen corner activities in Nyangana in the next quarter.
- Conduct a support and supervision visit to every site
- Procure prefab for Onandjokwe kitchen corner activities

2.10 Program Area 10: Treatment: ARV Services – Children

Under the Associate Agreement, IH is supporting an integrated and comprehensive HIV and AIDS care and treatment program for children in six mission facilities, comprised of five district hospitals and one health center. This program is also extended to their satellite facilities through outreach services and IMAI. During the reporting period, IH supported 28 outlets in the provision of HIV and AIDS clinical care and ARV services for children.

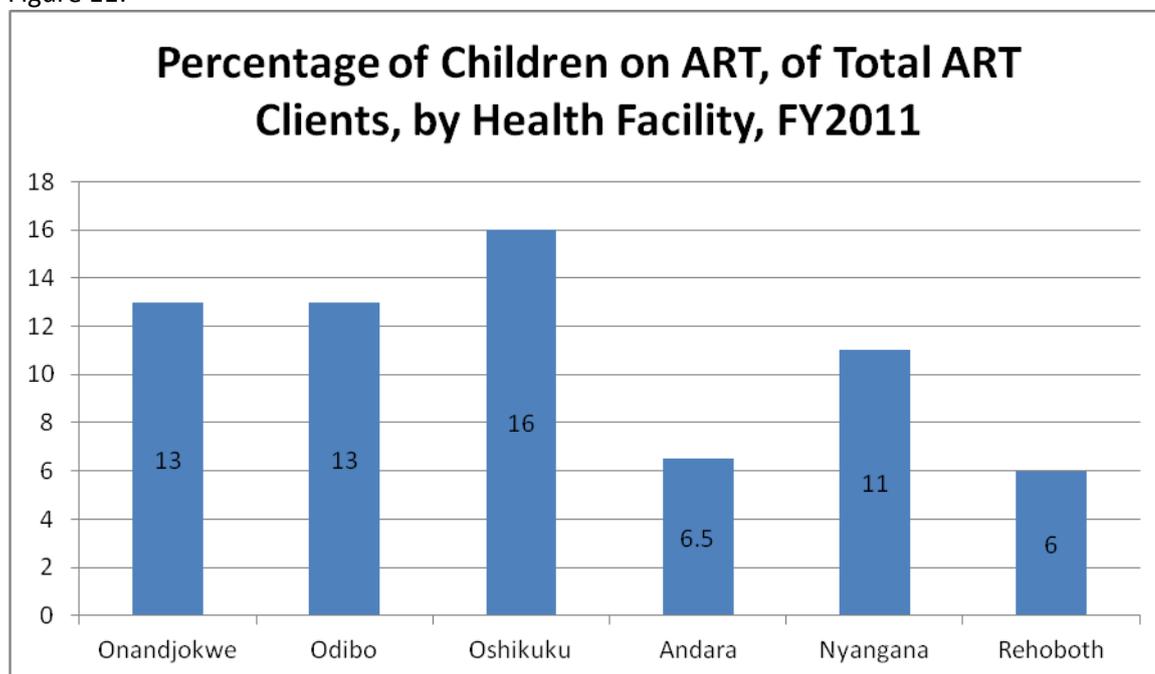
Accomplishments & Successes

Overall, 2,610 children on HIV care are currently receiving ART, which represents 13% of all patients. In the fourth quarter of FY2011, IH-supported sites enrolled 99 children onto ART, bringing the total for FY11 to 445. Figure 11, below, shows the percentage of children out of the total number of patients on ART, by facility, at the end FY2011.

Partner facilities have been continually sensitized to active screening and earlier identification and recruitment of HIV-exposed children in order to expedite entry into care and treatment. Early infant diagnosis and the recommended Namibian ART approach of commencing ART earlier for children has been rolled out in all IH supported sites. This change in treatment protocol is expected to have a significant increase in the ART initiation among children younger than 24 months of age.

The Onandjokwe and Nyangana clinics have continued with the pediatric ART clinics with Nyangana holding a quarterly event involving the care givers as well. These clinics have ensured that pediatric patients receive the specialized care they need. Disclosure issues for children and adolescents living with HIV are being managed in Onandjokwe. The Onandjokwe experience will be replicated to other facilities in the next quarter.

Figure 11:



The Andara and Rehoboth clinics have been admitted to the PATA network, which aims to improve the management of pediatric patients in Africa through cross fertilization of clinics in different regions of Africa. This admission is bringing the number of CHS member hospitals to four.

Challenges, Constraints and Plans to Overcome Them

- Some mothers do not have cell phones or give wrong phone numbers leading to difficulty in infant tracing.
- Staff shortages in most facilities in Onandjokwe limit IH's ability to trace exposed infants at home. IH will encourage partners to leverage the community based organizations such as CAA and Project Hope, to assist with follow up and tracing of defaulters.

- The majority of the ART nurses are not trained in the new guidelines. IH will liaise with NHTC, RHTC and I-TECH to assist partners in the development of their training needs through relevant channels.

Planned Events for the Next Quarter

- Continue implementation of the new ART guidelines of starting all children less than 2 years on treatment regardless of CD4 count and clinical staging in all IH supported sites.
- Strengthen tracing of defaulters.

2.11 Program Area 11: Health Systems Strengthening (HSS)

The ability of IH's Namibian partners to operate as vibrant, autonomous organizations contributing to the national HIV response is a key indicator of project success. An additional critical success factor for these organizations is the ability to access non-USG sources of funding through the GRN, corporate sponsors within Namibia, international donors and foundations. Since June 2006, IH has been working to strengthen the organizational capacity of indigenous Namibian organizations to deliver effective and efficient HIV prevention, care and treatment programs. In addition to providing clinical and programmatic oversight, technical assistance and support, an important strategy has been to undertake a capacity building process among the partner organizations. Initially the goal was to prepare some of these organizations to eventually move to direct USAID funding (graduation). However, with the recent program modification, the objective changed and IH is now working with our Faith Based Organizations (FBO) to transition their staff to non-USG funding and to improve their organizational sustainability and capacity.

During the fourth quarter of FY2011, IH continued to provide organizational strengthening technical assistance to CHS and LLCL in order to conclude earlier work begun with these organizations. Starting on September 1, 2011, LLCL graduated to direct funding with the USG. IH also met with the Human Resources Management Director at the MoHSS to discuss the type of HRH support they would like to receive from IH, such as support for their human resources information system, workload assessment, and retention strategies. These efforts also support the efforts underway for the MoHSS to absorb and retain donor funded health workers.

In addition, IH joined the Human Resources for Health (HRH) TWG for a field visit to the Kavango Region. The team visited the Kavango Regional Management Team RMT, Rundu Hospital, Nankudu District Hospital, Nkurenkuru Health Center and Nyangana Hospital. The purpose of the visit was to assess the potential for the government to absorb donor supported positions in Kavango. Facilities completed questionnaires aimed at gathering updated demographic information and differences and similarities between program and hospital staff's work patterns. The findings of the assessment was that no updated staffing norms were in place to estimate workforce requirements and most of the proposed staff establishments lists were done without these staffing norms. Findings and recommendations from this visit have been presented to the HRH Taskforce and the Deputy Permanent Secretary for the MoHSS. Several recommendations include: requesting an additional budget allocation from the Ministry of Finance to support the absorption of donor funded staff to GRN over the next three years; integrating services for HIV into primary health care and other clinical services; and clear communication with the regions in order to avoid unnecessary staff resignations due to inaccurate information. It appears that the GRN is taking these requests seriously and may start to absorb medical officers beginning in December 2011.

Note: Draft capacity building plans were submitted as part of the proposed revised Program Description. These documents will be updated based on feedback from USAID and the participatory organizational assessments described above.

Accomplishments & Successes

Ministry of Health and Social Services: IH continued to attend meetings with the HRH TWG during the fourth quarter. Pamela McQuide, our Deputy Chief of Party (DCOP), also joined the team in August 2011 and has attended various meetings with the TWG and USAID to assess the status of the HRH activities and to provide TA to the HRH TWG and the MoHSS HRM and HRD Divisions. These activities will be included in the workplan for the 2011-2012 financial year.

Regarding Human Resources for Health Information System (HRIS) activities, IH conducted a requirements definition workshop with the Health Facilities subdivision. The purpose of this workshop was to define requirements for the database of health workers in private health facilities and to begin developing the database.

LifeLine/ChildLine (LLCL): IH continued providing technical assistance to complete the activities on the comprehensive institutional strengthening plan (CISP). IH also assisted LLCL to retrieve counseling data from the counseling database which was developed by LLCL South Africa. Previously LLCL was unable to obtain additional

reports in order to complete their monthly indicators. This helped reduce the time spent to recapture counseling data for their reports.

As of September 30, 2011, 92% of the activities planned for the period on the CISP for LLCL were begun. 8% of these have not yet started and will be completed by LLCL with assistance from KPMG Netherlands, who have offered in-kind support to LLCL.

Table 4: Progress of CISP activities for LLCL

Color Key	# of Activities	
1 Planned	0	0%
2 On track	14	15%
3 In progress	2	0%
4 Not yet started / rescheduled	8	8%
5 Completed	44	77%
Total Number of OD Activities	68	

Catholic Health Services(CHS): IH continued to support CHS with the strengthening of their financial and human resources management systems as well as aligning Financial and Administration Policies and Procedures with those of MoHSS. The Organizational Capacity Assessment (OCA) was scheduled and conducted from the 4th – 6th of October. The Institutional Strengthening Plan (ISP) is still being drafted by the facilitators, but the feedback from the participants about the value of the OCA was positive. The following capacity areas were assessed:

Figure 12:



- Purpose & Planning (PP),
- Programs and Services (PS),
- Governance and Leadership (G),
- Organizational Sustainability (OS),
- Financial and Operational Management (FO),
- Human Resources (HR),
- Monitoring & Evaluation (ME), and
- Networking (NW)

The group results are shown in Figure 12 and indicate that there is little consensus amongst the attendants about the capacity of CHS in the areas assessed. This can be attributed to the vertical silos that exist between the various operational areas in CHS and seem to suggest that improved communication will improve the group consensus. However, in the group discussions there was consensus about the need to identify additional revenue streams by developing a fund development plan as well as a

marketing plan. There was also considerable discussion about identifying and promoting the added value of being a faith based institution for both the health workers and clients.

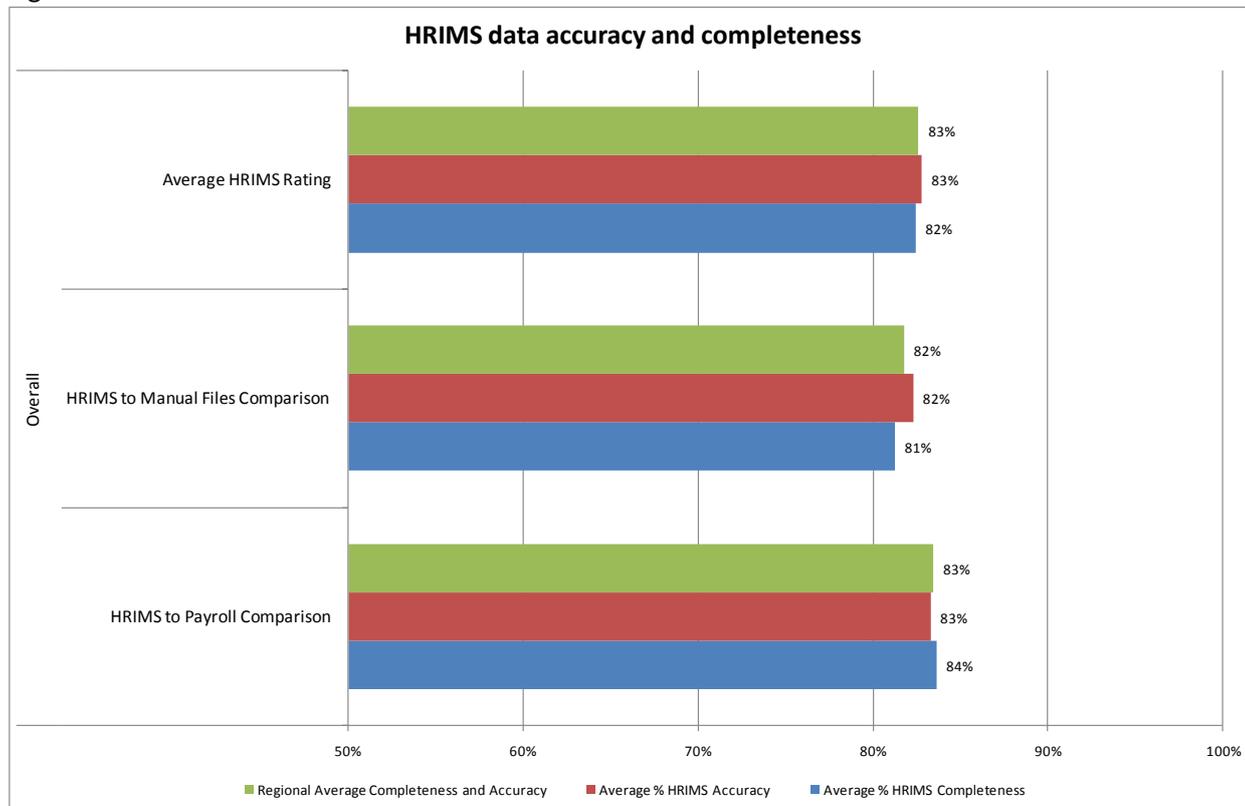
Lutheran Medical Services (LMS): IH scheduled a capacity building kick off meeting with LMS and Shanumatango management staff which unfortunately was rescheduled due to a visit from their Bishop. The team conducted the meeting with a larger target audience which did not provide the opportunity for the LMS management team to ask questions and share their concerns with our team. A brief presentation was made to discuss the USAID Global Health Initiative goals and how that will affect the IH program as well as an overview of the organizational strengthening approach. As a result, we need to reschedule the kick off meeting to allow for a collaborative process and to agree on the areas to be assessed.

Anglican Medical Services (AMS): IH conducted a capacity building kick off meeting with the AMS head office staff and travelled to Odibo Health Center to meet with the management and staff on site and to explain the changes in our capacity building approach. A key staff member from AMS' head office was on leave and therefore the OCA could not be scheduled. We expect to secure a date for the OCA in FY2012.

HIV Clinicians' Society (HCS): HCS has conducted their annual HIV/AIDS conference as well as conducted their Annual General Meeting in August 2011 with IH support. A new chairperson has been elected and IH will work with the chairperson to define the direction for HCS and identify what capacity building activities are appropriate based on these goals in FY2012.

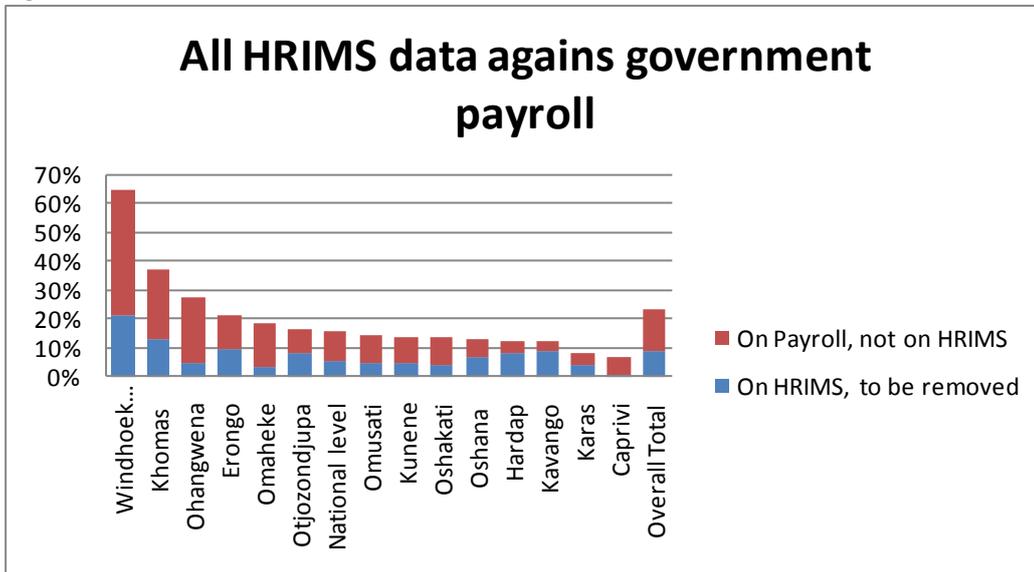
Human Resources for Health Information Systems: Continuous technical assistance has been provided to the HRIMS project manager of MoHSS to ensure data accuracy and that complete assessments are being carried out. However, progress on HRIS activities has been delayed due to lack of availability of key MoHSS Staff. However, the HRIMS team leader continued to conduct data accuracy and complete assessments for five offices with the results showing in Figure 13. On average the HRIMS data compared to the manual HR files, and are 82% accurate and 81% complete. HRIMS compared to the government payroll files, and are 83% accurate and 84% complete.

Figure 13:



The Office of the Prime Minister OPM, who is responsible for the HRIMS and other government information systems, conducted their own comparison of all HRIMS data to the government payroll and the results show that 8% of the staff on HRIMS are not on the payroll and should therefore be removed from HRIMS. This comparison also shows that 15% of the staff on the payroll are not on HRIMS.

Figure 14:



Challenges, Constraints & Plans to Overcome Them

Local Partner Capacity Building

- IH must work with each partner to develop a plan to transition staff off of USG funding. Four MOs at CHS have transitioned from the program to the health facility but have continued working on the program activities to avoid disruption of the services. This has resulted in a discrepancy between the workloads of MOs that needs to be addressed as part of the staff transitioning process. IH is not able to engage directly in a discussion with MoHSS representatives, as per the instructions issued by the PEPFAR Coordinator. However, we are talking directly with our FBO's and are jointly working on opportunities to transition staff. To date, four MOs at CHS have already transitioned to the government subsidy.
- Assembling the management team for an entire organization – not just those responsible for the PEPFAR program component supported by IH – remains a challenge. For the OCA to succeed, it is critical that the entire organization participate and own the results and actively support the comprehensive institutional strengthening plan developed from the results. We have successfully worked with CHS to identify a cross-section of staff that includes management, supervisory and clerical staff with whom to conduct the OCA. We've worked directly with two or three members of the top management team and also relied on them to involve the remaining members. We will use the same approach with LMS and AMS.

Human Resources for Health/Information Systems

- A key risk to the success of the HRIS Program remains the MoHSS IT staff. The current level and capacity of the MoHSS IT staff is inadequate and HRIMS users are still experiencing delays in IT support. This matter has been brought to the attention of the MoHSS Management, but informal feedback received indicates that this will only be addressed as part of the Ministry's restructuring project. Recommendations to the MoHSS include: education requirements for the regional administrators should be changed from a 4-year degree to a 3-year diploma with appropriate work experience. As an interim work-around, one of the three system administrators at national level has been transferred to Oshana region to alleviate the IT support challenges the Ministry is facing in the northern regions namely Kunene, Omusati, Oshana, Ohangwena, Oshikoto, Kavango and Caprivi.
- The future of HRIMS and the unavailability of a timeline for the Oracle based Human Capital Management System (HCMS) is still unknown. There is still no information available from OPM with respect to the timeline for the implementation of HCMS.
- As the HRIMS is increasingly being used within the MoHSS for decision making, some reports need to be changed and additional reports have been identified as critically important to HR practitioners in order to optimize the benefits from the HRIMS. Due to the prospects of HCMS, OPM is not keen on making changes to the HRIMS and also does not have sufficient resources to assist MoHSS in making these changes. However, since the unavailability of reports is seriously impacting on the usage of HRIMS for decision-making, this request will be escalated to the office of the Permanent Secretary (PS) of MoHSS to agree on a solution that

will enable MoHSS to use the HRIMS data. These data are essential to make accurate and informed human resources planning, management, and policy decision regarding the health workforce.

Planned Events for the Next Quarter

Local Partner Capacity Building

- Finalize the ISP for CHS, which will prioritize the capacity building activities for CHS.
- Conduct the OCA kick off meeting with LMS.
- Set a date to conduct the OCA with AMS.
- Meet with the newly elected chairperson of HIV Clinicians Society (HIVCS) and agree on a way forward for the OCA.

Human Resources for Health/HRIS

- Escalate the additional reports needed from HRIMS and request a meeting with OPM through the office of the PS to discuss options to make the HRIMS data available for decision-making.
- IH will continue providing technical assistance to the FBO's to automate their HR data and make it available to facility management for decision-making.
- IH will continue to provide technical guidance and support to the MoHSS to get access to the health worker data in the private sector to support a national HRIS.
- IH will support the MoHSS to gain access to accurate information about student health professionals who are in the pipeline.
- IH will encourage the multi-sectorial stakeholder leadership group for human resources information to convene again to advice on the next steps to develop an integrated HR information system.

FINANCIAL REPORT (REQUIRED)

See accompanying Excel spreadsheet and complete worksheet "FY11.3rd Quarter Report"

WRAP AROUNDS FOR FY2011

ENVIRONMENTAL ISSUES

During FY2011, in compliance with USAID environmental requirements and regulations as per the 22 CFR 216 integrated into ADS 204.5, IntraHealth and the project-supported sites conducted the following activities:

- Triaging of coughing patients to minimize risk of exposure to TB and other infectious respiratory conditions.
- Patients and staff in MDR-TB wards have been provided with N95 masks.
- Counseling of TB patients is also done in the special RT rooms located in or near the TB wards.
- Use of open areas, such as verandas, as patients waiting areas to improve infection control.
- Staff are supervised to adhere to appropriate waste disposal, including sharps, medical waste (including foreskins from MC) and condoms used for demonstrations in counseling and testing.
- Safety measures are observed while transporting waste generated from outreach services.
- Cleanliness and hygiene in all centers have continued to receive emphasis, and sites where food is prepared are made aware of the necessity of hand washing for both those who are cooking and for clients receiving food.
- Patients are continually provided with information on how to safely dispose items, and recycling bins are being maintained.

Additionally, the IntraHealth Technical Director attended a training organized and conducted by USAID on environmental compliance during the third quarter. The training focused on the content of the environmental compliance regulations (22 CFR 216). The training also discussed what is meant by “environmental compliance” and reasons for complying with these regulations.

6. Strategic Information & Issues with Data Quality

6.1 Strategic Information

During FY2011, IntraHealth has been supporting the national RM&E subdivision and partners to improve the quality of data, data collection, data use and report writing and strengthening the M&E system. The goal is to effectively and efficiently monitor and evaluate the response of IntraHealth and its partners for informed decision making. This will strengthen the capacity of IntraHealth and its partners to collect and use program data and measure its achievements and provide for accountability to the donor. IntraHealth also supported its partners in the use of information for effective program management. This was done through improving and harmonizing data collection tools, ensuring data coordination, data mining, analysis, dissemination and informing evidence-based program planning and improvement.

Accomplishments & Successes

As a result of program modification, the emphasis during the last two quarters of FY2011 was to provide necessary support to partner organizations in order to ensure reporting on indicators is accurate. IntraHealth also continued work on strengthening its supportive supervision tools.

During the fourth quarter, the M&E team has been focusing on providing feedback to the partners on Q1-Q3 programs results. IntraHealth has worked with CHS, LMS and AMS team on the reporting requirement (Indicators, narratives report as well as the indicator template) as per required by USAID. The analysis on key indicator data was also carried-out and shared with the partners during supervisory support visits. Table 1 below list the activities and progress to date with CHS.

Table 1: CHS M&E Capacity Strengthening

ACTIVITY	PROGRESS TO DATE
CHS needs an M&E framework for the organization's strategic objectives that demonstrates clear linkages to current programs	<ul style="list-style-type: none"> The M&E work plan and framework has been finalised.
CHS needs to build its capacity to measure program outcomes and support program evaluations	<ul style="list-style-type: none"> CHS has completed HIV/AIDS Behavioural survey in its regions and the final reports are available Needs support in implementing future evaluations.
CHS to continue building on its ability for data analysis and use data for planning	<ul style="list-style-type: none"> Updated version of the VCT and ePMS databases has been installed on all computers at the sites Training provided to staff on the VCT and ePMS databases.
CHS staff to update database during support visits	
CHS conducts quarterly data verification visits to their sites, data verification needs to be strengthened at National Office	<ul style="list-style-type: none"> CHS uses its data verification mechanism to ensure data quality. Use feedback to improve data collection. These include documentation of standard operating procedures, regular reviews of source documents, cross-checking of numbers against alternative data sources, separation of duties, review of discrepancies, etc.

Additional accomplishments:

- The M&E team continued working with partner organizations reporting requirement and indicators for the ART program. IntraHealth trained staff on ePMS, specifically how to clean data once reported from the health facilities, generate PEPFAR indicators, and to produce other care and treatment reports for program planning and evidence-based decision-making.
- During the reporting year, IH worked together with the MoHSS to improve on the reporting system for ART and to build the capacity of the RM&E subdivision to ensure sustainability and effectiveness of the system.
- The M&E team has been supporting the National M&E TWG as well as the Research and Surveillance TWG.
- During the reporting year, IH has strengthened the production of monthly and quarterly narrative reports and data and indicators templates by partners by providing onsite mentoring, supervision and support.

Challenges, Constraints & Plans to Overcome Them

- M&E activities remains a major challenge since program managers at partner organizations continue to be overloaded with other day-to-day responsibilities
- Some partners still have a challenge of technical skills, especially manipulating care and treatment data on ePMS for improving patient management, quality of data and reporting, among others.
- Reporting by field offices needs additional support from national office M&E staff of partner organizations, which will help to improve the quality of data collected and will enhance ownership, involvement and commitment.
- Reporting for the PMTCT program is also challenging as registers and forms have not been updated by the MoHSS since the inception of the program. IntraHealth will support this process, and in the meantime, will continue to use the updated monthly reporting template to make provision for the new indicators.
- Data Management and quality not well addressed by implementing partners
- The data infrastructure, M&E systems structures and strategic information flows, at all levels is not well understood and functional
- Poor compliance on reporting requirements among implementers.

Planned Events for the next quarter and year

- IntraHealth will support the MoHSS to develop the National ART database system and provide technical support to the RM&E staff.
- In order to strengthen the capacity of the partners to conduct supportive supervision, IntraHealth will conduct M&E mentorship visits to partner offices, and continue holding quarterly M&E partner meetings for feedback and discussion of M&E issues. At least one visit per quarter per partner is planned and more frequent visits may be conducted depending on identified needs. This includes site visits with partner staff to conduct data quality assessments and verification to all the sites.
- In collaboration with the MoHSS, IntraHealth will work with RM&E and partner organizations to update ePMS through trainings to ensure country ownership and capacity to manage the system.
- Continue to support the M&E officer at CHS Headquarters to strengthen their M&E system.
- Continue to strength the HCT and ePMS databases through trainings and supervisory support visits in collaboration with the partner organizations.
- Continue supporting the national M&E system including SPM.
- Continue to support the implementation of the National M&E Association.
- In collaboration with the MoHSS, IntraHealth will work with RM&E and partner organizations to integrate the New Start HCT M&E system into the MoHSS M&E system.
- Strengthen research and evaluation by developing an evaluation agenda and putting in place an effective strategy for dissemination and application of research findings.
- Coordinate and develop mapping and GIS work with partner organizations
- Assess and strengthen M&E systems of partner organisations.

6.2 Issues with Data Quality

The M&E team at IntraHealth provides partner organizations with coaching and mentoring on data collection and data quality, improving record-keeping, program reporting standards, HMIS systems, and other quality improvement initiatives. IntraHealth is implementing the QI/QO (quality in, quality out) model with all partners and investing much effort to ensure that the data gathered is valid, reliable, accurate, precise, and timely.

During the COP12 of FY2011, IntraHealth continued to institute measures to improve data quality, and continued with regular data quality checks to verify that appropriate data management systems are in place and to verify the quality of reported data for key indicators at sites.

What we are doing on a routine basis to ensure that our data is high quality:

- IH routinely provide technical support to partner organizations to ensure problems with data are adequately addressed.
- At the end of each month, discrepancies between the data entered in the electronic and the paper based systems are identified and addressed at facility level.
- The IntraHealth M&E Officer assists partner organizations to routinely verify data reported monthly, and provide feedback to the reporting sites.
- Data quality checks are conducted for HCT, prevention, PMTCT and ART at sites and partner organizations.
- PMTCT data entry into the registers is checked by district coordinators before submission.
- PMTCT, VCT & ART data is checked by the site manager before submission.
- The VCT & ART electronic systems have built-in data quality checks, which the data clerks and site managers use to check for quality and consistency.
- Ensure that both electronic systems can generate automated monthly reports.
- Data reported on a monthly basis are routinely verified and feedback is provided to the reporting sites.
- Staff that handle data are supported by the senior management to ensure that problems are adequately addressed.
- Reporting Period indicator templates submitted are checked and verified with the monthly reports submitted.
- For ART & VCT systems, data quality checks are done monthly at the national level.

Specific concerns we have with the quality of the data reported in this report:

- Minor inconsistencies with data especially for the ART program
- Late reporting of data which doesn't allow enough time for data verification

How we plan to address those concerns and improve the quality of our data:

- To be able to address all the data concerns and improve the quality of data, IntraHealth will continue to focus on the following areas, highlighted in Table 2.

Table 2: Data Quality Improvement

AREA	WHAT SHOULD BE DONE	COMPLETED TO DATE
M&E Capabilities, Roles and Responsibilities	<ul style="list-style-type: none"> • Support LMS and AMS to identify staff with clearly assigned M&E responsibilities • Ensure the completeness and consistency of ART data at Okalongo Health Centre • Continued technical support to partner organizations • Quarterly meetings with M&E staff at partner organizations and focal person 	<ul style="list-style-type: none"> • Partners encouraged to identify staff with clearly assigned M&E responsibilities • Data clerk for Okalongo H.C is appointed • Continued support and mentoring provided to partner organizations
Training	<ul style="list-style-type: none"> • Ensure partners train all their relevant staff in basic M&E • Build capacity of partners to conduct trainings on data quality, verification and use • With Partner organizations, provide training and refresher trainings on the data collection tools and systems for each program • Support the training of health workers and data clerks in the revised ART patient monitoring tools and ePMS in accordance with the new guideline. 	<ul style="list-style-type: none"> • Capacity strengthening in basic M&E continues • Quarterly meetings with partners were conducted • All partners are trained in evaluation • New guideline in use at all facilities offering ART
Data Reporting Requirements	<ul style="list-style-type: none"> • Document in writing to partner organizations the program reporting requirements (what is reported to who, and how and when reporting is required) 	<ul style="list-style-type: none"> • Document currently being developed, to be finalized with partner organizations during next quarters

AREA	WHAT SHOULD BE DONE	COMPLETED TO DATE
Indicator Definitions	<ul style="list-style-type: none"> • Continue with quarterly meetings with M&E staff at partner organizations to discuss indicators definitions and reporting requirements • Develop simple operational indicator definitions guides for partners 	<ul style="list-style-type: none"> • Quarterly meeting conducted with CHS, LMS and AMS • Partners oriented on the indicator definitions
Data-collection and Reporting Forms and Tools	<ul style="list-style-type: none"> • In collaboration with the MoHSS and CDC, update monthly reporting tools and systems for PMTCT and ART programs to accommodate IntraHealth and other partner reporting requirements • Regularly update data collection tools • Harmonize data collections tools with the MoHSS and other partners to ensure that all partners use standard data-collection and reporting forms • Develop source documents for all tools and make available to all partners • Strengthen the reporting system for the partners 	<ul style="list-style-type: none"> • PMTCT monthly reporting tool updated and circulated to all partners
Data Management Processes	<ul style="list-style-type: none"> • In collaboration with M&E persons at partner organizations, develop clear documentation on data collection, aggregation and manipulation 	<ul style="list-style-type: none"> • Part of Simple Indicator Definition guide (see above)
Data Quality Mechanism and Control	<ul style="list-style-type: none"> • During quarterly M&E meetings, identify data quality challenges and solutions for addressing them • In collaboration with M&E persons at partner organizations, develop procedures to identify, reconcile discrepancies in reports and verify source data • Through partner organization, provide feedback to the reporting sites on a monthly basis in order to motivate quality of data 	<ul style="list-style-type: none"> • To be discussed with partners during the quarterly meetings
Links with National Reporting System	<ul style="list-style-type: none"> • Align partner and IntraHealth data collection and reporting systems with the national reporting system • Support the development of the national M&E system • Integrate partner reporting into the reporting process for the System for Program Monitoring (SPM) and continuing strengthening the collaboration between the partners' organizations, the Regional Councils and the National M&E office. 	<ul style="list-style-type: none"> • Continued support to the development of the national M&E system • In process of integrating partner reporting into the reporting process for the System for Program Monitoring