

MCHIP Namibia End-of-Project Report

October 1, 2012 – July 31, 2014



Photo: Chandrakant Ruparelia

Submitted on:
May 30, 2014

Submitted to:
United States Agency for International Development under
Cooperative Agreement # GHS-A-00-08-00002-000

Submitted by:

Jhpiego in collaboration with John Snow, Inc., Save the Children, ICFI/Macro, PATH, Institute of International Programs/Johns Hopkins University, Broad Branch Associates, and Population Services International.

The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00. The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

Published by:

Jhpiego

Brown's Wharf

1615 Thames Street

Baltimore, Maryland 21231-3492, USA

www.jhpiego.org

© Jhpiego Corporation, 2013. All rights reserved.

Country Summary: Namibia



Selected Health and Demographic Data for Namibia	
GDP per capita (USD)	5,293
Total population	2,113,077
Urban	43%
Rural	57%
Adult HIV prevalence (15–49)	13.3%
Maternal mortality ratio (deaths/100,000 live births)	210
Skilled birth attendant coverage (%)	81.4
Antenatal care, 4+ visits (%)	70.4
Neonatal mortality rate (deaths/1,000 live births)	18
Infant mortality rate (deaths/1,000 live births)	30
Under five mortality (deaths/1,000 live births)*	42 [63]
Oral rehydration therapy for treatment of diarrhea	63
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	82
Modern contraceptive prevalence rate	55.1
Total fertility rate	3
Total health expenditure per capita (USD)	283
Sources: World Bank; WHO; UNPAF; UNICEF; MOHSS; Population & Housing Census 2011.	
*UNICEF <5 mortality ranking (1=highest mortality rate)	

Major Activities by Program

- **Health Extension Program (HEP):** Finalized national HEP strategy, standard operating procedures, and monitoring and evaluation and supportive supervision materials. Participated in the review of HEP training curriculum to support scale-up; 34 trainers of trainers trained; 26 Health Extension Workers provided with refresher training
- **Teen Pregnancy (TP):** Built capacity of 26 Kavango Teen Pregnancy Task Force members to design prevention program and trained 33 health care providers on adolescent-friendly reproductive health services
- **HIV/PHC Integration:** Conducted gap assessment in Hardap Region, and used findings to craft action plan for integration activities
- **Health Information Systems (HIS):** Developed a draft national strategy to help guide implementation of an integrated HIS platform; assisted Ministry of Health and Social Services to define and adopt strategic hospital, primary health care and other strategic indicators; assisted in assembling and cleaning aggregate and outpatient data and prepared system to demonstrate web-based information presentation and analysis; and provided in-country and international training in information use
- **Voluntary Medical Male Circumcision (VMMC):** Supported local nongovernmental organization Nawalife and conducted needs assessment on attitudes and beliefs around VMMC

Program Dates	October 2012–August 2014					
Total Mission Funding to Date by Area	\$3,580,860					
Geographic Coverage	No. (%) of regions	14	No. of districts	35	No. of facilities	411
	HEP: 3 regions; 7 districts; 49 health facilities HIV Integration: 1 region; 2 districts; 9 facilities TP: 1 region; 3 districts; 5 facilities HIS: 14 regions; 35 districts; 411 health facilities VMMC: 2 regions; 2 districts; 48 health facilities					
Country and HQ Contacts	Styn Jamu (Chief of Party); Patricia Taylor (Country Support Team Leader); Jennifer Melgaard (Senior Program Officer)					

Table of Contents

Table of Contents.....	4
Acronyms and Abbreviations.....	5
Acknowledgments.....	6
Introduction	12
Country Context.....	12
Goals and Objectives.....	12
Interventions and Coverage.....	13
Major Accomplishments	16
Objective 1: Institutionalize the Health Extension Worker cadre and build capacity at all levels to take the HEP to scale	16
Objective 2: Provide the GRN with evidence informed strategic approaches and models for integration of HIV/AIDS services in Primary Health Care	16
Objective 3: Design and implement a pregnancy-prevention program in Kavango region with stakeholders.....	18
Objective 4: Strengthen and integrate Namibia’s Health Information System	20
Objective 5: Build capacity of local NGOs to plan for demand-side Voluntary Male Medical Circumcision activities.....	21
Cross-Cutting Themes	23
Recommendations and Way Forward	25
References	27
Annex 1: Indicator Matrix with Data.....	28
Annex 2: Success Stories.....	31
Annex 3: List of Presentations at International Conferences and Publications.....	32
Annex 4: List of Materials and Tools Developed or Adapted by the Program.....	33

Acronyms and Abbreviations

CM	Community Mobilization
FP	Family Planning
GHI	Global Health Initiative
GIS	Geographic Information Systems
GRN	Government of the Republic of Namibia
HEP	Health Extension Program
HEW	Health Extension Workers
HIS	Health Information System
HIV/AIDS	Human immunodeficiency virus infection/acquired immunodeficiency syndrome
HRIS	Human Resource Information System
IEC/BCC	Information Education Communication/Behavior Change Communication
iCCM	integrated Community Case Management
KTFS	Kavango Teen Fertility Survey
KTPTF	Kavango Teen Pregnancy Task Force
M&E	Monitoring and Evaluation
MCHIP	Maternal and Child Integrated Program
MDG	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MOHSS	Ministry of Health and Social Services
NAPPA	Namibian Planned Parenthood Association
NGO	Non-governmental organization
NTC	National Training Center
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PFIP	Partnership Framework Implementation Plan
PHC	Primary Health Care
PIs	Program Indicators
PMTCT	Prevention Mother-to-Child Transmission of HIV
PMTCT B+	Prevention Mother-to-Child Transmission of HIV, treatment (Triple ARVs) provided for life
PPHRD	Policy Planning and Health Resources Directorate
RH	Reproductive Health
SI	Strategic Information
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SS	Supportive Supervision
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TOT	Training of Trainers
TPTF	Teen Pregnancy Task Force
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Acknowledgments

The Maternal and Child Health Integrated Program (MCHIP), a global maternal and child health program funded by the United States Agency for International Development (USAID), implemented a program to support the Republic of Namibia (GRN) by providing technical support to strengthen human resource management and development, working closely with partners of the Ministry of Health and Social Services (MOHSS).

The MCHIP Namibia team would like to thank its national and MOHSS partners for their work to reach planned objectives. Specifically, MCHIP is grateful to the MOHSS and the representatives of the Primary Health Care Department (PHC) at national and regional levels, UNICEF, WHO, USAID partners (including C-Change, Synergos, IntraHealth, MSH), National Health Professional Council, National and Regional Training Centers and NawaLife Trust, a local non-governmental organization supporting health and development communication activities in Namibia.

MCHIP looks forward to continued work with our partners as together we can have an even greater impact on health and development in Namibia.

This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

Executive Summary: Namibia

The Government of the Republic of Namibia (GRN), with substantial foreign assistance and strong political commitment, was able to achieve a 35% decline in AIDS deaths and a 65% drop in HIV incidence (WHO 2012). The U.S. Agency for International Development (USAID) began providing assistance to Namibia at independence in 1990, and in 2003 increased support through the President's Emergency Plan for AIDS Relief (PEPFAR) for AIDS and TB prevention, care and treatment, and education (GHI 2012). Despite successes, Namibia still lacks sufficient human resources for health; rural communities are underserved; and vertical service delivery has resulted in a fragmented health information system.

Due in part to declines in HIV incidence and AIDS deaths, PEPFAR recently reclassified Namibia as a PEPFAR “transitioning country,” resulting in a reduction in the prevention, care and treatment budget. The GRN is thus faced with developing and managing a reform agenda to improve the coordination of health service delivery, especially in rural areas, and in integrating HIV/AIDS services into existing primary health care services (PHC)—including providing staff salaries and capacity building.

As part of this agenda, the GRN's Ministry of Health and Social Services (MOHSS) established a cadre of Health Extension Workers (HEWs) to strengthen access to health care. USAID provided technical assistance to the MOHSS, focusing on strengthening health and strategic information systems, and strategic coordination of partners and resources in the health sector (USAID 2012). The key partners supporting the MOHSS include: USAID, UNICEF, the World Health Organization (WHO), UNAIDS, the Namibia Planned Parenthood Association (NAPPA) and nongovernmental organizations (NGOs) such as LifeLine/ChildLine, C-Change, and IntraHealth International.

In September 2012, USAID/Namibia asked MCHIP to provide technical assistance to strengthen the quality of and access to health services. From October 2012–July 2014, MCHIP provided support to the GRN related to the HEW cadre; integration of HIV into PHC systems; the development of a Health Information System (HIS); a teen pregnancy prevention program in Kavango Region; and, a voluntary medical male circumcision (VMMC) program. Activities were implemented in Kunene, Osamuti, Ohangwena, Hardap, and Khomas regions, as defined in the table below.

MCHIP Interventions and Results

INSTITUTIONALIZATION OF THE HEATH EXTENSION PROGRAM (HEP): OCTOBER 2012–JULY 2014
<p>A total of 560 HEWs were trained in five regions. MCHIP trained trainers of trainers (TOTs), preparing training, monitoring, and supportive supervision materials, including adding integrated community case management (iCCM) to the training curriculum and supporting development of key, national-level guidance documents to support HEP scale-up.</p>
<ul style="list-style-type: none"> ▪ HEP strategy and standard operating procedures (SOPs) finalized and used to guide HEP scale-up. ▪ Supportive supervision training curriculum finalized and disseminated. ▪ 8 supportive supervision (SS) visits conducted in pilot sites. 34 TOTs trained with MCHIP support. ▪ 96 health facility staff oriented on supportive supervision. ▪ 26 HEWs provided with refresher training by MCHIP trainers. ▪ Technical assistance provided for further refinement of the HEW training methodology. ▪ The national HEP Steering Committee was supported to finalize implementation norms and guidelines.
HIV/AIDS INTEGRATION INTO PHC SYSTEMS: OCTOBER 2012–JUNE 2014
<p>MCHIP supported the development of strategic models for integrating HIV/AIDS into Namibia’s broader health care and PHC system by conducting a gap analysis in the Hardap Region and preparing an assessment and action plan based on findings.</p>
<ul style="list-style-type: none"> ▪ MCHIP supported the Technical Working Group (TWG) to develop and finalize national guidelines on the integration of services for the prevention of mother-to-child transmission of HIV (PMTCT/HIV). ▪ An HIV integration assessment to identify gaps in Hardap Region was finalized and an action plan based on assessment for strengthening HIV integration into PHC was developed.
TEEN PREGNANCY PREVENTION PROGRAM IN KAVANGO REGION: OCTOBER 2012–JUNE 2014
<p>The Kavango Region has the highest rate of teen pregnancy in the country. MCHIP worked to build the capacity of the Kavango Teen Pregnancy Task Force (KTPTF) to develop a teen pregnancy prevention program with stakeholders in the region.</p>
<ul style="list-style-type: none"> ▪ 26 KTPTF members were trained; capacity as a coordinating body, implementer, and advocate was built. ▪ Supported the KTPTF to develop the clinical components of their annual work plan by developing an “Adolescent-Friendly Reproductive Health Services” course and training 33 providers.
HEALTH INFORMATION SYSTEMS: OCTOBER 2012–JULY 2014
<p>MCHIP provided technical assistance to strengthen and integrate Namibia’s national HIS.</p>
<ul style="list-style-type: none"> ▪ Developed a five-year HIS strategy and framework for the integration of priority data management systems. ▪ Consensus built for a core set of essential hospital indicators; proposal prepared for program indicators. ▪ Review of health facility codes and recommendations for a Master Health Facility Standard shared with the MOHSS. ▪ Supported HIS TWG to develop job descriptions for a new health information research directorate. ▪ 56 MOHSS staff trained on information use and data quality. ▪ Data usage within the MOHSS strengthened through provision of software to demonstrate analysis and presentation of information. ▪ GIS maps developed and shared with the MOHSS/Policy, Planning and Human Resource Development Directorate.

VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC): OCTOBER 2012–AUGUST 2014

Supported local NGO NawaLife to plan and implement demand creation activities for VMMC.

- A formative assessment conducted on VMCC attitudes, beliefs, and practices.
- A community mobilization (CM) training conducted for CM trainers and community health volunteers/mobilizers to improve community approaches to interpersonal communication and peer-to-peer mobilization is being supported.
- Demand creation to identify and design VMMC generation activities among partners completed.
- Review and tailoring of NawaLife Trust information, education, and communication (IEC) materials completed.

INSTITUTIONALIZATION OF THE HEP

MCHIP/Namibia and partners supported the MOHSS to develop and finalize the HEP strategy and SOP, both of which are critical to implementation and scale-up of HEP and were approved by the National Steering Committee. MCHIP also provided technical support to strengthen the Regional Health Team for Kunene, Ohangwena, and Omusati, which will in turn support district teams with HEP implementation. MCHIP/Namibia supported the MOHSS to identify and refine a cost-effective HEW training methodology aimed at institutionalizing the Health Extension Worker cadre into the Namibia health system. MCHIP/Namibia also offered technical support in the development of a HEP supportive supervision package, which is used by the Regional and District Health Supervisory Teams to support HEWs in implementing and improving the quality of HEP services. Significantly, the HEP child health training module includes screening and treatment of malaria and pneumonia, and treatment of diarrheal disease with zinc.

Lessons Learned Include:

- Continuous engagement with health facilities, government ministries, and other partners is a necessary foundation to scale up the HEP.
- Continuous supportive supervision must be a part of the HEP scale-up plan.
- High-quality training for HEWs, including refresher training, is necessary to ensure that HEWs have the skills and knowledge to perform, especially when new concepts, such as iCCM, are introduced.
- Introducing and implementing new interventions in selected districts prior to scaling up is important because it provides an opportunity to evaluate what works before scale-up to the entire HEP.

HIV/AIDS INTEGRATION INTO PHC SERVICES

MCHIP supported the Hardap Regional Health Team to identify HIV integration gaps in service delivery, and use the information to develop an action plan for strengthening integrated, essential health care service at the primary care level. In collaboration with the MOHSS, the Hardap Regional Health Team led a facility gap analysis. The methodology and tools used for the assessment were based upon the current evidence related to patient-centered primary care and integration of vertical services. MCHIP maintained an element of standardization with the assessment by expanding upon the previously used UNFPA assessment tools, broadening the scope of integration to HIV and PHC services from HIV and sexual and reproductive health services.

MCHIP developed a technical report to document results and findings from the facility assessment, action planning with the regional managers and health facility staff, and results dissemination to inform the development of a “framework” for HIV integration with primary health services.

Lessons Learned Include:

- Define the minimum package of care and offer comprehensive services regularly at primary care facilities for full integration within facilities.

TEEN PREGNANCY PREVENTION IN KAVANGO REGION

Addressing the high rates of teenage pregnancy in Kavango required a multi-pronged and sustainable approach. Recognizing the complexity of the problem, MCHIP supported “activation” of a regional task force, the KTPTF, drawn from government ministries, community leaders, and development partners, to leverage resources through a sector-wide approach. The key components of the program included planning for an intervention to prevent teen pregnancy, behavior change communication, and training of health service providers in youth-friendly sexual and reproductive health services. MCHIP also took into consideration the need to integrate the teen pregnancy prevention approach into other HIV prevention programs, particularly focusing on HIV infection among sexually active teens and school drop-out when pregnancy occurs. During the same period, MCHIP guided the KTPTF to develop and incorporate clinical components into the teen pregnancy prevention annual work plans.

Lessons Learned Include:

- Strengthen adolescent-friendly services. Parent and community sensitization is required as a means of strengthening services in this arena.

HEALTH INFORMATION SYSTEMS

MCHIP supported the development of a five-year health information system strategy (2013–2017), which was approved by USAID in February 2014 and submitted to the MOHSS (Permanent Secretary’s Office) for review. MCHIP also supported development of the Namibia essential hospital and primary health care indicators, and provided capacity building for government officers to strengthen competencies in data analysis, use, and dissemination.

Lessons Learned Include:

- Link programs with essential indicators to monitor the effects of implementation over time.
- Health information systems should be integrated with all levels of service provision.

VOLUNTARY MALE MEDICAL CIRCUMCISION

MCHIP supported NawaLife Trust to manage, develop, and disseminate information on VMMC. A formative assessment was conducted to explore attitudes, beliefs, and practices surrounding VMMC, which resulted in a strategy for future VMMC demand creation, advocacy, and service delivery activities.

The completion of the formative assessment had a positive impact on achieving immediate results. These results included completing training materials for community mobilization; identifying and designing VMMC activities among partners; reviewing and tailoring the MOHSS/Nawalife IEC materials; establishing regional trainers for VMMC community mobilization; training community mobilizers using the developed training manuals; and mass printing IEC materials for use in districts scaling up VMMC.

Lessons Learned Include:

- Demand creation is a key component to increasing the number of VMMCs. The demand and supply sides must be interrelated for any future success in this program area.

FUTURE DIRECTIONS

MCHIP technical support contributed significantly to each of the five technical components described above. However, future efforts will need to focus on greater coordination between the MOHSS and other government ministries, regional agencies, and other partners including USAID and other development partners. As Namibia is a highly consultative environment, this collaboration is and must remain a key priority in order for the consortium of partners to attain the desired outcomes.

Expanding coverage can be done using integrated approaches. MCHIP experienced that integration approaches must be sector-wide to expand service coverage. The integration approach can focus on the health information system, HIV and primary health care services, and establishment of a strong link between the formal health system and the community.



Introduction

Country Context

Namibia is the 34th largest country in the world with a land area of 824,292 kilometers. It is located in the south west of Africa and bordered by the Republic of South Africa in the South; Angola and Zambia in the North, Botswana and Zimbabwe in the east and the Atlantic Ocean in the west. Namibia has thirteen administrative regions including Zambezi, Kavango, Kunene, Omusati, Ohangwena, Oshana and Oshikoto in the north, Erongo in the west, Omaheke in the east; Otjozondjupa and Khomas regions in the central and Hardap and Karas in the south (Housing and Population Census, 2011). During the reporting period MCHIP/Namibia had interventions in Kunene, Osamuti, Ohangwena, Hardap and Khomas regions.

The Government of Namibia has enjoyed many health successes over the last several decades. For example, there has been a 35 percent decline of AIDS deaths and HIV incidence has dropped by 65 percent over a 12 year period (Republic of Namibia, 2008)ⁱ. Despite impressive progress made in many health areas, Namibia faces many challenges, including: 1) insufficient human resources for health; 2) fragmented health information system; 3) inadequate service delivery related to too few health workers; lack of access to health facilities; and health services unresponsive to the needs of youth (UNPAF, 2013).

Namibia gained independence in 1990, resulting in the U.S. Agency for International Development (USAID) to begin providing assistance to Namibia. In 2003, Namibia was named one of The United States President's Emergency Plan for AIDS Relief (PEPFAR) countries in the early 2000's. Between 2004 and 2012, Namibia received USD \$637.5 million for the development of an effective health care and prevention response until recently when Namibia became reclassified as a PEPFAR "transitioning country" due to impressive progress with HIV/AIDS achievements. The reclassification resulted in a reduction in PEPFAR funding over the course of the current Partnership Framework Implementation Plan (PFIP), which ends in 2016. In 2012, PEPFAR funding for salaries was reduced and the GRN started to add personnel who had been funded by PEPFAR to the MOHSS payroll.

Goals and Objectives

In September 2012, USAID/Namibia requested MCHIP to provide technical support to GRN in five key areas: the health extension program (HEP); HIV/AIDS integration into primary health care; strengthening the national health information system (HIS); teen pregnancy prevention program in Kavango region; and supporting Nawalife Trust to design and implement demand creation activities for voluntary medical male circumcision (VMMC).

MCHIP/Namibia's work plan (October 2012 – July 2014) was developed following three assessments and planning missions to Namibia, with the following objectives:

1. To institutionalize the health extension worker cadre and build capacity at all levels to take the Health Extension Program to scale
2. To provide the GRN with evidence informed strategic approaches and models for integration of HIV/AIDS services in primary health care
3. To design and implement a pregnancy prevention program in Kavango region with stakeholders
4. To design and implement a national HIS strategy
5. Build capacity of local NGOs/CSOs to plan for demand-side VMMC activities

Interventions and Coverage

1) Institutionalization of the Health Extension Worker cadre

The HEP was introduced to ensure health services reach remote communities. HEWs provide case detection, essential direct care and treatment, and health promotion in MCH, HIV/AIDS, sexual reproductive health and other communicable diseases. MCHIP's technical support to GRN helped expand the PHC model by institutionalizing the HEW cadre into the broader health system. Implementation was conducted through the leadership of the MOHSS HEP National Steering Committee. Based on lessons learned from the Opuwa pilot, MCHIP supported the GRN in expanding the HEP in Omusati, Ohangwena and continued to support the Kunene region. With MCHIP support, iCCM was included in HEP.

2) Integration of HIV/AIDS services in Primary Health Care

HIV/PHC integration interventions were implemented through the HIV/PMTCT technical working group by supporting approaches that enhance facility-centered, integrated models for HIV integration in Hardap Region. MCHIP/Namibia also supported facility assessments in the Hardap Region, and worked alongside relevant government ministries at national and regional levels; donors; and international and local implementing partners involved in integration interventions.

3) Pregnancy-prevention program in Kavango Region

The Kavango Teen Fertility Survey (KTFS) in 2011 found a 36.7 percent prevalence of teen pregnancies in the Kavango region. MCHIP built the capacity of the Kavango Teen Pregnancy Task Force (KTPTF) to reduce the incidence of teen pregnancies in the region by facilitating the development of a strategic plan aimed at leveraging local resources. MCHIP supported KTPTF to operationalize its annual work plan, specifically by increasing the availability of adolescent friendly reproductive health services through clinical trainings for health services providers and establishing strong referral linkages with the communities.

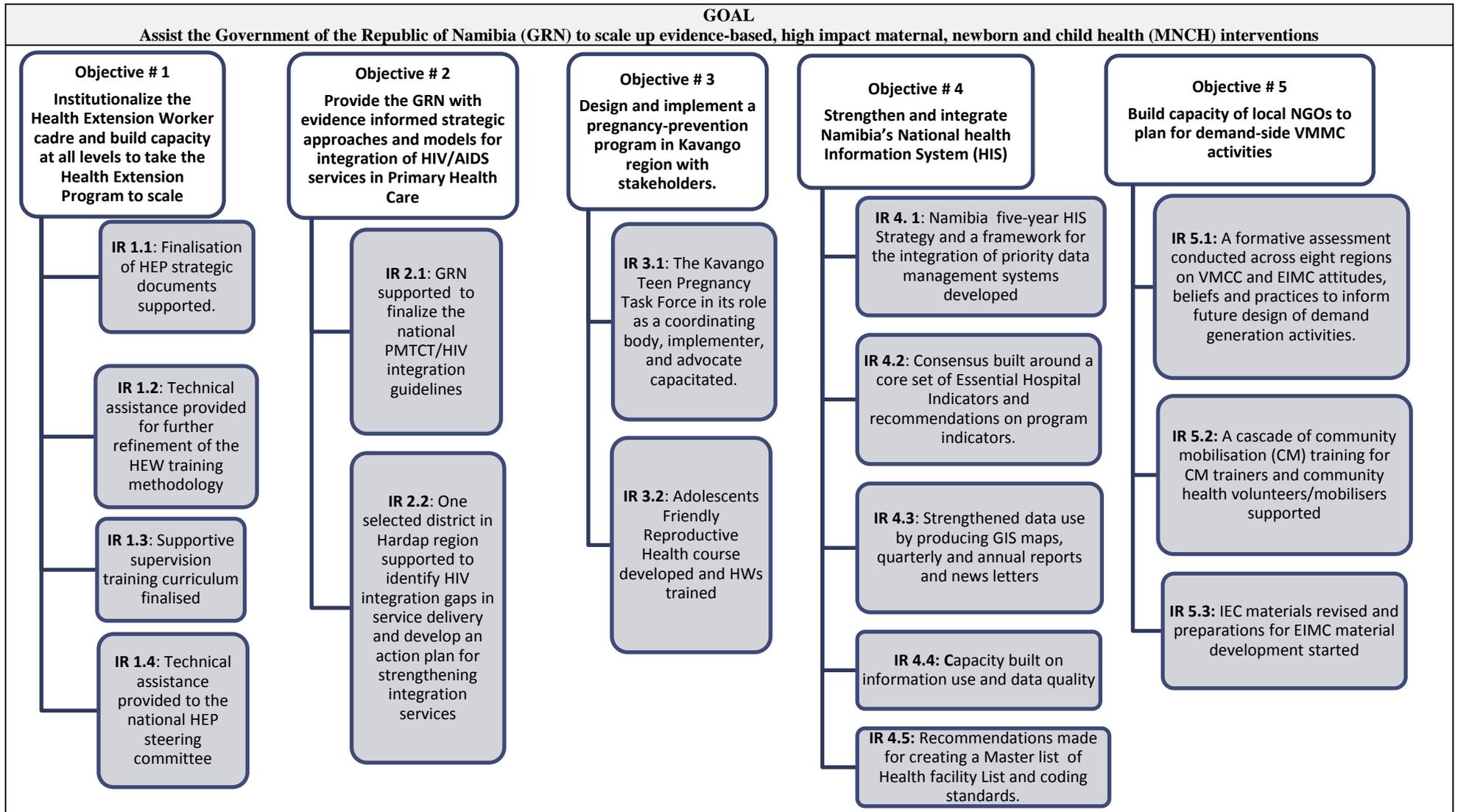
4) Health Information System

The MOHSS health information system is highly fragmented in Namibia, consisting of more than 60 data collection and reporting systems introduced by various vertical programs and donors. MCHIP/Namibia provided technical support to integrate vertical health information systems; and to develop an integrated national health information system, working with stakeholders to identify key essential indicators and develop Geographic Information System (GIS) tools and maps.

5) Voluntary Medical Male Circumcision

Namibia has an adult HIV prevalence of 13.1%. With several studies suggesting that VMMC is an effective strategy for preventing HIV and STI transmission, the Namibia Government has adopted VMMC as a key component of its HIV prevention strategy (WHO and UNAIDS 2007). MCHIP/Namibia formative research covered Oshana, Ohangwena, Zambezi, Khomas, Omusati, Kavango East, Kavango West and Oshikoto regions. MCHIP strengthened the capacity of NawaLife Trust, a local non-profit organization, to increase awareness of SRH issues through community mobilization, advocacy, and public awareness campaigns.

Table 2: Results Framework



Major Accomplishments

Objective 1: Institutionalize the Health Extension Worker cadre and build capacity at all levels to take the HEP to scale

Namibia is confronted with lack of adequate resources to address the burden of communicable as well non-communicable diseases. One of the major barriers, especially in rural areas, is the lack of human resources, and the costs, for patients, to reach facilities. To address this, the GRN through MOHSS introduced the HEW cadre to improve the quality of and access to health services. MCHIP/Namibia provided technical support to take HEP to scale by contributing to the development of the HEP strategy, standard operating procedures and other supportive documents, such as supportive supervision and training curriculum. These key scale-up documents are now used by the MOHSS, development partners, health service delivery points, and HEWs themselves.

Intermediate Results Achieved (October 2012 – July 2014)
IR 1.1: Finalisation of HEP strategic documents supported
IR 1.2: Technical assistance provided for further refinement of the HEW training methodology
IR 1.3: Supportive supervision training curriculum finalised
IR 1.4: Technical assistance provided to the national HEP steering committee

Proposed Next Steps:

- Continue strengthening regional and district HEP implementation approach
- Strengthen regional and district supportive supervision of HEW and monitor the quality and usefulness of the community data
- Review and revise HEW training curriculum every two or three years
- Support MOHSS with identification and implementation of cost-effective pre-service model of training of HEW before the next in-take
- Incorporate operations/implementation science research to inform future HEP programming

Objective 2: Provide the GRN with evidence informed strategic approaches and models for integration of HIV/AIDS services in Primary Health Care

The adult HIV/AIDS prevalence rate in Namibia is 13.3 percent; HIV/AIDS is the leading cause of death among women of reproductive age and a significant contributor to maternal mortality in high prevalence settings, equating to approximately 200,000 people aged 15 years and above living with HIV (AIDS), 60% of whom are women. In addition, there are 18,000 children under the age of 14

living with HIV in Namibia (UNAIDS, 2012). HIV/AIDS is leading cause of death among women of reproductive age and a significant contributor to maternal mortality in high prevalence settings. According to recent estimates, HIV-infected pregnant or postpartum women have about eight times higher mortality than their HIV-uninfected counterparts.

MCHIP was asked by MoHSS through the HIV/AIDS integration committee to develop learning laboratories for HIV integration models into primary health care. MCHIP does not consider services to be integrated in situations where a client who sought health services is not offered other related services at the same time, but forced to return to the same or alternate clinic for the other service. MCHIP used its global leadership in technical assistance to build on existing integration work to help MoHSS delineate a minimum package of care that should be afforded every client accessing services at PHC clinics, crossing technical areas/programs, and therefore ‘integrating’ services from the service-delivery perspective and providing patient-centered care from the client perspective.

In Namibia, MCHIP supported the development of a framework for HIV integration in PHC. Since 2011, UNFPA, UNAIDS and MoHSS have supported integration of HIV and SRH. MCHIP’s technical support built upon work done in HIV and SRH integration initiatives to include integration of HIV into essential PHC services. To advance collaborative support to MoHSS, MCHIP expanded upon the integration tools from other partners (i.e. UNFPA) based on MCHIP/Jhpiego’s global experience and literature reviews, under the leadership of the national HIV integration committee.

Lessons from the assessment strengthened HIV integration at three selected facilities in Mariental District: Mariental clinic, Mariental ART clinic, and Gibeon clinic. In Rehoboth District, facility assessments for HIV were conducted in six facilities including Rehoboth health center, Rehoboth clinic, Rehoboth HAART clinic, Rietoog clinic, Klein-Aub clinic and Schlip clinic.

MCHIP developed a detailed technical report to document results and findings from the facility assessments and outlined a recommended framework for PHC-level integration to inform future scale-up. MCHIP recognized that for integration to be successful there was a need to:

- Regionally define a minimum package of integrated PHC services to be offered to clients accessing services at the facility, adhering to national norms and standards while taking into consideration the regional priorities and burden of disease
- Ensure essential medications and commodities are available at PHC level, supported by legislation and supportive health systems for procurement and distribution
- Ensure appropriately trained and skilled staff are available to provide integrated services (i.e. through onsite teaching and mentorship)

- Conduct facility-specific assessments to evaluate patient flow in order to make site-specific recommendations related to service delivery
- Confirm robust yet flexible monitoring and evaluation systems that allow for alternative ways of functioning in order to return focus of care to the client rather than data recording and reporting

Intermediate Results Achieved (October 2012 – June 2014)

IR 2.1: GRN supported to finalize the national PMTCT/HIV integration guidelines
--

IR 2.2: One selected district in Hardap region supported to identify HIV integration gaps in service delivery and develop an action plan for strengthening integration services
--

Next steps:

- Develop “learning laboratories” in PHC clinic catchment areas in different regions of the country with different burdens of disease to test different patient flow and M&E systems to provide minimum package of integrated care to adults and children, from community (utilizing HEWs) to clinic
- Pilot testing integrated outreach services based upon the HIV-outreach model, affording equitable access to medical services to individuals living with other chronic diseases or requiring specialized care
- Support GRN to assess policy barriers to equitable access to essential integrated services and to develop an action plan to overcome these barriers (i.e. restrictions on types of drugs distributed to primary care facilities, restrictions on dispensing medications in the community, scope of practice issues impeding service delivery, etc)
- Support GRN to redefine staff establishment requirements at PHC and district hospital levels based upon comprehensive integrated primary health care, taking into consideration healthcare worker skills, training, and performance as well as the heavy burden of recording and reporting, a non-clinical task
- Support GRN at national, regional, and district levels to develop a supervisory framework and standard operating procedures for service delivery based upon scope of practice policy discussion outcomes
- Replicate the models that work to scale up HIV integration in the whole district and eventually in the region

Objective 3: Design and implement a pregnancy-prevention program in Kavango region with stakeholders

Studies indicate the high prevalence of teen pregnancies in Namibia, especially in Kavango region. Teen pregnancy is driven by poverty and entrenched social norms, and addressing teen pregnancy requires a multi-pronged approach. At the onset, MCHIP supported the KTPTF in August 2013 with a technical workshop aimed at

effectively preparing the task force to implement teen pregnancy prevention activities. A total of 26 participants attended the workshop from various ministry departments, town and regional councils, CBOs, and NGOs. The workshop ultimately highlighted the need for contraceptive technology as well as the lack of sexual and reproductive health needs of adolescent and adolescent friendly health services including counseling adolescents. For instance, emergency contraceptives, implants, and IUCD's are not easily accessible within the public sector while most of these methods are available in the private sector. Workshop participants also mentioned that providers be trained to offer these contraceptives at the time of visit rather than at a proposed later visit. Some of the effects of this initial workshop can be found below.

Specifically through the support of MCHIP over 50 school management members and boards at five schools in Rundu were sensitized on teen pregnancy and provided with recommendations based on the findings of a teenage pregnancy survey. Over 300 teens and parents were also sensitized on teen pregnancy and child rights at Leevi Senior Secondary School and Sarusugu School. Furthermore, teachers were provided with life skills training while health care workers were trained on adolescent friendly reproductive health services. Ultimately, this training for service providers resulted in an increase in adolescent friendly reproductive health services available in Kavango and an increase in the number of adolescents reached. From the period January-June 2014 alone, 5,813 condoms were distributed to teens and there were 4,830 adolescent acceptors. Through MCHIP's additional support, a study on the contributing factors and project recommendations on teen pregnancy was conducted through the Global Health Technical Assistance project funded by USAID, further highlighting the need for adolescent friendly services.

From October 2012-July 2014, MCHIP built the capacity of the KTPTF, helping them to create and implement an annual workplan. During the same period, MCHIP guided the KTPTF to develop and incorporate clinical components into the teen pregnancy prevention annual work plans by developing the "Adolescent Friendly Reproductive Health Services" course in which 33 providers were trained in this aspect of health service delivery.

Intermediate Results Achieved (October 2012 – June 2014)
IR 3.1: The Kavango Teen Pregnancy Task Force in its role as a coordinating body, implementer, and advocate capacitated.
IR 3.2: Adolescents Friendly Reproductive Health course developed and HWs trained

Next steps:

- Continue to support KTPTF, to ensure it can manage teen pregnancy prevention activities independently
- Incorporate operations research into the teen pregnancy prevention programs

- Build the capacity of local organizations to sustain gains already achieved during the two years of implementation

Objective 4: Strengthen and integrate Namibia's Health Information System

Developing and strengthening an integrated health information system is critical for improving the efficiency and effectiveness of health service delivery and improving patient management. Namibian health information system is constrained by institutional and technical fragmentation, lack of HIS policy guidelines or a strategic framework, limited use of health information to inform decision-making, and inadequate human resources. MCHIP provided technical assistance to MOHSS in preparing a strategy to address these issues. MCHIP supported the development of job descriptions for the Health Information and Research Directorate (HIRD), a new directorate proposed by the MOHSS to facilitate institutional integration. MCHIP also provided assistance to strengthen specific areas of the health information system: by facilitating consensus building among partners within and outside government departments to develop a core set of essential hospital indicators and by proposing primary health care and other program indicators. MCHIP also provided capacity building for government officers to strengthen their competencies in data analysis and dissemination and supported the assembling and cleaning of PHC-HIS data for inclusion in a demonstration of data analysis and information presentation in DHIS2, the software that has been proposed for installation to support PHC-HIS.

One key lesson: capacity building of data producers and users is necessary for the development of robust information systems that result in the collection of high quality data that can be used at all levels of the health system.

Intermediate Results Achieved (October 2012 – July 2014)
IR 4. 1: Namibia five-year HIS Strategy and a framework for the integration of priority data management systems developed
IR 4.2: Consensus built around a core set of Essential Hospital Indicators and recommendations on program indicators
IR 4.3: Strengthened data use by producing GIS maps, quarterly and annual reports and news letters
IR 4.4: Capacity built on information use and data quality
IR 4.5: Recommendations made for creating a Master list of Health facility List and coding standards

Next steps:

- Support MOHSS' use of the Strategic Plan in future HMIS planning
- Ensure that the core set of indicators are used with program monitoring

- Provide on-going technical support to strengthen the use of data

Objective 5: Build capacity of local NGOs to plan for demand-side Voluntary Male Medical Circumcision activities

Male circumcision is one of the most effective measures for reducing the risk of female-to-male HIV transmission, which is why the GRN endorsed voluntary medical male circumcision as part of its HIV prevention response in 2010 (Republic of Namibia, 2010). Despite the increased numbers of trained health service providers, an active national working group, and a supportive policy and implementation plan, the scope of VMMC service delivery has remained limited. To help close the gap, MCHIP supported NawaLife Trust, a local non-governmental organization specializing in health communications, in strengthening their communication strategies to increase demand for VMMC. MCHIP provided sustainable high-level technical assistance through capacity building of NawaLife Trust to manage, develop and implement evidence-based communication platforms that promote and disseminate information on VMMC in Namibia. The technical assistance involved some of MCHIP’s renowned VMMC leaders that will shape NawaLife in its health communication and create a solid platform for increasing awareness on VMMC, sexual and reproductive health (SRH) issues through community mobilization, advocacy, and public awareness campaigns. A formative assessment to explore attitudes, beliefs and practices among Namibians was also conducted which produced a recommended strategy for future VMMC demand creation, advocacy and service delivery. The study also explored client/potential client preferences related to service delivery elements. The results of the assessment were prepared in a report to guide program design. This impacted the design of VMMC activities among partners particularly NawaLife Trust training materials for community mobilization. In collaboration with NawaLife, MCHIP supported TOTs for community mobilization trainers, developed a community mobilization manual, and conducted participatory workshops for community mobilizers to further assist with demand generation of VMMC services.

Intermediate Results Achieved (October 2012 – July 2014)
IR 5.1: A formative assessment conducted across eight regions on VMCC attitudes, beliefs and practices to inform future design of demand generation activities.
IR5.2: A cascade of community mobilisation (CM) training for CM trainers and community health volunteers/mobilisers supported
IR 5.3: IEC materials revised and preparations for EIMC material development started

Next steps:

- Refine VMMC implementation based on lessons learned while providing guidance to local organizations and MOHSS

- Ensure that demand created through communication matches the supply of high quality services
- Document and disseminate lessons from field experiences
- Invest in operations research to assess/evaluate uptake of VMMC and trends of medical male circumcision in the country/region of operation
- Continuation of demand generation from NawaLife based on their increased capacity

Cross-Cutting Themes

MCHIP incorporated cross cutting strategies into Namibia programming, including health equity, community approaches, integration, and scale-up of evidence-based interventions.

Equity

Inequalities in health systematically place the most vulnerable—mothers, children, and youth—at risk of diseases because they are socially disadvantaged by virtue of being poor, female, young, or members of disenfranchised group. As part of its PHC strategy, the Namibian MOHSS considers equity one of its foremost goals, as seen in the MOHSS's health policy, which states:

"All Namibians shall have equal access to basic health care & social services provided by the Ministry. Particular emphasis shall be paid to resource distribution patterns in Namibia to identify and accelerate the correction of disparities".

MCHIP's support on the HEP contributes to MOHSS efforts to reducing health inequalities by increasing access to health services among socially disadvantaged segments of the population. The presence of HEWs in communities is meant to ensure access to basic services. The HEP not only brings services to the community, it also links the community to the health system.

Many of the recommendations made in the integration of HIV and PHC service delivery assessment address issues of health inequities by making concrete recommendations to improving care. HIV testing will no longer be offered to only those individuals accessing specific services (i.e. TB or ANC, but to anyone attending the facility – as provider initiated testing and counseling. Another example is that of delivery of standardized comprehensive package of services, including provision of essential drugs for chronic illness at the point of contact rather than referral.

Community-based approaches

In many developing countries, community-based approaches and community health workers serve as the backbone of the health system, responsible for bringing health services to underserved communities. Since September 2012, MCHIP has supporting the MOHSS to develop sustainable community-based approaches for improving health equity. MCHIP recognizes that MCH services are a core component of population health, which encompasses a broad range of services targeting infants, children, adolescents and women.

Integration

HIV prevention, care and treatment interventions in Namibia have resulted in fragmented implementation of health services at services delivery points.

Fragmented health information systems are evident in the MOHSS where there are over 61 vertical HIS systems. Fragmentation of services has left some critical interventions such as maternal and child health inadequately served.

MCHIP has supported MOHSS in integrating not only HIV into primary healthcare but also integrating health information system at all levels of service provision. MCHIP believes that co-locating health services within the same delivery points - even if the specific services have separate staff - maximizes use of limited resources. Integrated provision of services is extended to the community level through prevention and promotion of community-based HIV testing and counseling, and basic treatment of acute childhood diseases. In addition, MCHIP's approach to integration extended to supporting the national integration of multiple vertical health information systems that operate independently and not linked in any effective manner. MCHIP's support is intended to develop an integrated and sustainable national health information system.

Scale-up

MCHIP's support in scaling up activities, specifically the HEP, will not only bring services to the community, it will also promote healthy home practices and care seeking for illnesses and preventive services. MCHIP/Namibia supported scale-up of the HEP prior to the first expansion stage by revising training materials and data collection tools. MCHIP/Namibia also developed the SOP and national strategy to ensure that once full scale-up occurred, organizational structures were in place to support the newly deployed HEWs in April 2014. MCHIP/Namibia provided support to the MoHSS to train, supervise, support and monitor these HEWs. Currently, MCHIP/Namibia is supporting scale-up of the HEP by developing a supportive supervision package that includes supportive supervision guidelines, toolkits and training manuals.

For all technical areas, MCHIP/Namibia developed enabling policies and tools and supported capacity development to support future scale-up. MCHIP/Namibia engaged in a highly participatory manner, working closely with all program partners, to strengthen on-going activities, avoid duplication of effort and add technical value to the different development processes.

Recommendations and Way Forward

MCHIP team recommends an **integrated approach** among the various components of the future projects. As HEPs are scaled-up availability of routine data on a regular basis will be necessary to monitor performance and planning. Linking HIS integration efforts and development of community level information system with scale-up of HEP provide a natural platform for integration and development of these two major health system interventions. HIS integration also links with the HIV integration in primary health care. An integrated HIV & primary health care platform requires routine data on monitoring referrals and provision of treatment across different health services. As Namibia looks to scale-up in the five technical areas covered, MCHIP recommends that expanding coverage can be done using **integrated approaches**, including incorporating program learning tools in the implementation process.

MCHIP/Namibia lessons learned highlight the need for **continued coordination** between the MoHSS and other government ministries, regional agencies, and other partners including USAID, C-Change, and IntraHealth. Following are recommendations unique to each technical area implemented by MCHIP/Namibia:

HEP

- Continuous engagement with healthcare providers, government ministries, and other partners will build ownership and is a necessary foundation for scaling up the HEP
- Continuous, structured supportive supervision must be a part of the HEP scale up plan. HEP in Namibia is in its infancy and requires regular follow up and support, including coaching HEWs to build their confidence to interact with families and communities in their catchment village
- Quality training, including refresher training, is necessary to ensure that HEWs have the skills and knowledge to perform their roles, especially when new concepts, such as home-based care, and newborn health, are introduced
- Test interventions in select districts prior to scale up; learn and revise from pilots prior to scale-up

HIV/Integration

- Define the minimum package of care. Offer comprehensive services regularly at primary care facilities for full integration within facilities

Teen Pregnancy

- Strengthen adolescent friendly services. Parent and community sensitization is required as a means of strengthening services in this arena

HIS

- Link national, regional, district, facility, and program performance monitoring with essential, hospital, and program indicators to monitor the effects of implementation over time

- Integrate community-based health information systems, including HEP IS, with PHC-HIS
- Support development of DHIS2 software to include health facility and community information system, including enhancement of report interface and support its national roll-out
- Capacity building in data quality and data use at all levels of the health system
- Support development of a comprehensive HIS enterprise architecture including HMIS, and Human Resource Information System (HRIS)
- Invest in operations research to learn and improve approaches to data use

VMMC

- Demand creation is key component to increasing MCs; demand and supply side must be interrelated for any future success in this program area

References

- Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R. et al. (2005). Randomized controlled intervention trial of male circumcision for reducing of HIV infection risk: The ANRS 1265 trial. *Plos Med* 2(11), e298.
- Bailey, R.C., Moses, S., Parker, C.B., Agot, K., Maclean, I. et al. (2007). Male circumcision for HIV prevention in young men in Lisumu, Kenya: A randomized controlled trial. *Lancet*, 369, 643-656.
- Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, 57, 254-258.
- Chang, W.C. (2002). The meaning and goals of equity in health. *Journal of Epidemiology and Community Health*, 56, 488-491.
- Government of the Republic of Namibia. (2008). Second Millennium Development Goals report/Namibia. National Planning Commission: Windhoek, Namibia.
- Gray, R.H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S. et al. (2007). Male circumcision in men in Rakai, Uganda: A randomized trial. *Lancet*, 369, 657-666.
- Legido-Quigley H, Montgomery CM, Khan P, et al. Integrating tuberculosis and HIV services in low- and middle-income countries: a systematic review. *Trop Med & Int Health* Feb 2013; 18(2) pp. 199-211.
- Ministry of Health and Social Services (2008). Namibia demographic and health survey 2006/2007. Windhoek, Namibia: Ministry of Health and Social Services.
- Petti C, Polage C, Quinn T, et al. Laboratory medicine in Africa: a barrier to effective health care. *Clin Infect Dis* 2006; 42: 377–382.
- Republic of Namibia (2008). 2nd Millennium Development Goals Report/Namibia. Windhoek, Namibia: national Planning Commission
- Republic of Namibia (2010). National strategic framework of for HIV and AIDS response in Namibia 2010/2011-2015/2016. Windhoek, Namibia: Government of the Republic of Namibia.
- Stender SC & Christensen A. Patient-centered primary health care: synergy potential for health systems strengthening. *Int J Tuberc Lung Dis* 2013; 17(10):S15-S21.
- United Nations Country Team/Namibia. (2013). Partnership Framework (UNPAF) 2014-2018: A partnership for growth, job creation and equity. Office of the United Nations Resident Coordinator: Windhoek, Namibia.
- World Health Organization. The pursuit of responsible use of medicines: sharing and learning from country experiences. WHO/EMP/MAR/2012.3. Geneva, Switzerland: WHO, 2012.
- Zere, E., Mandlhate, C., Mbeeli, T., Shangula, K., Mutirua, K., & Kapenambili, W. (2007). Equity in healthcare in Namibia: Developing a needs-based resource allocation formula using practical components analysis. *International Journal for Equity in Health* 2007, 6:3 doi:10.1186/1475-9276-6-3.

Annex 1: Indicator Matrix with Data

Strategic Objective	Indicator	Unit Measure	Disaggregation	Baseline Year	Base line value	2014 target	2014 Actual
Institutionalize the Health Extension Worker cadre and build capacity at all levels to take the HEP to scale.	HEP strategic documents (SOP, strategy, M&E framework) finalized	Milestones	n/a	2013	nil	Framework finalized	Framework finalized^
	Supportive supervision package for HEP developed	Milestones	n/a	2013	nil	Package finalized	Package finalized
	Number of health facility staff oriented on supportive supervision.	Number	sex	2013	0	96	96 42 Male 54 Female
	Number of HEP supervisors trained in supportive supervision	Number	sex	2013	0	60	Training not conducted- MOHSS yet to appoint HEP supervisors
	Number of supportive supervision visits conducted with MCHIP's support in pilot intervention site	Number	n/a	2013	0	8	8
	Number of participants in the National HEW TOT trained with MCHIP support in preparation for the first expansion phase	Number	sex	2013	0	30	34 10 Male 24 Female
	Number of health extension workers provided with refresher training with MCHIP's support	Number	sex	2013	0	26	26 Males: 15 Females: 11

Strategic Objective	Indicator	Unit Measure	Disaggregation	Baseline Year	Base line value	2014 target	2014 Actual
Provide the GRN with evidence informed strategic approaches and models for integration of HIV/AIDS services in Primary Health Care	Assessment conducted to identify operational/functional areas to support integration of HIV into PHC.	Milestones	n/a	2013	nil	Assessment finalized	In progress
Design and implement a pregnancy prevention program in Kavango Region	Training manual and course on adolescent friendly reproductive health services developed	Milestones	n/a	2013	Nil	Training course and manual developed	Training course developed
	Number of people trained on adolescents friendly reproductive health services	Number	sex	2013	0	40	33 14 Male 19 Female
	Number of KPPTF members trained during skills building workshop	Number	sex	2013	0	25	26 Male: 11 Female: 15
Strengthen and integrate Namibia's national health information systems	HIS strategy drafted	Milestones	n/a	2013	nil	Strategy drafted	Strategy drafted *
	Essential Hospital Indicators developed with definitions submitted to the PPHRD, MOHSS	Milestones	n/a	2013	nil	Indicators developed	Indicators developed
	Report produced with recommendations on coding standards and master health facility list	Milestones	n/a	2013	nil	Report produced	Report produced

Strategic Objective	Indicator	Unit Measure	Disaggregation	Baseline Year	Base line value	2014 target	2014 Actual
	GIS maps developed and shared with PPHRD, MOHSS	Milestones	n/a	2013	nil	GIS maps developed	GIS maps developed
	Quarterly and annual reports and newsletters produced	Milestones	n/a	2013	nil	Reports produced	In progress
	Number of MOHSS trained on information use and data quality	Number	sex	2013	nil	56	56 25 Male 31 Female
Build capacity of local NGOs to plan for demand-side VMMC activities	Conduct a national assessment of VMMC in 8 regions of Namibia	Milestones	n/a	2013	nil	Assessment finalized	Assessment finalized
	IEC material on VMMC and EIMC revised	Milestones	n/a	2013	nil	IEC material revised	IEC material revised
	Number of people trained in community mobilization	Number	sex	2013	0	25	In progress

*draft strategy submitted to MOHSS

^ Submitted to the Ministerial Management Committee for approval.

Annex 2: Success Stories

Due to a delay in implementation of key activities, there was not enough time to capture success stories.

Annex 3: List of Presentations at International Conferences and Publications

Nothing to include in this report.

Annex 4: List of Materials and Tools Developed or Adapted by the Program

Standards and Guidelines

National Health Information Systems (HIS) Strategy
National Health Extension Program (HEP) Strategy
National Health Extension Program (HEP) Standard Operating Procedures

Technical Reports

Teen Pregnancy Assessment
VMMC Technical Assessment
HIV/PHC Health Facility Assessment

Training Materials and Tools

Health Extension Program (HEP) Training Manual
Health Extension Program (HEP) Facilitator's Guide
Health Extension Program (HEP) M&E Tools
Health Extension Program (HEP) Supportive Supervision Manual
Institutionalization of HEW Training Program

Service Delivery Registers

Health Extension Worker Registers

IEC/BCC Materials

Teen Pregnancy Brochure

Other

VMMC Study Questionnaire (Men)
VMMC Study Questionnaire (Women)
VMMC EIMC Assessment FGD Guide (Traditional Council OR Older Women)
VMMC EIMC Assessment FGD Guide (Comm Mobilizers)
VMMC EIMC Assessment FGD Guide (Circumcised Men)
VMMC EIMC Assessment FGD Guide (Uncircumcised Men)
VMMC EIMC Assessment FGD Guide (Females)
VMMC EIMC Assessment Key Informant Interview (HCWs)
VMMC Screening Script
