

# C-CHANGE NAMIBIA

## FINAL REPORT

September 2014



**USAID**  
FROM THE AMERICAN PEOPLE



NAMIBIANS AND AMERICANS  
IN PARTNERSHIP TO FIGHT HIV/AIDS  
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THE SCIENCE OF IMPROVING LIVES





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This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Associate Award No. AID-673-LA-12-00002 and the Leader with Associate Award Agreement No. GPO-A-00-07-00004-00. The contents are the responsibility of FHI 360, and do not necessarily reflect the view of USAID or the United States Government.



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## ACKNOWLEDGMENTS

C-Change Namibia worked with the following governmental and non-governmental partners to support the project's objective to bring about social and behavior change using communication programs for HIV prevention and for increased uptake of Antenatal Care, Prevention of Mother-to-Child Transmission of HIV, and Maternal, Neonatal and Child Health practices.

### *Government Partners*

MOHSS/Health Promotion Directorate  
MOHSS/Primary Health Care Directorate  
MOHSS/Directorate of Special Programs  
Ministry of Health and Social Services/National Health Training Centre  
Regional Health Directorates: Kunene, Zambezi, Kavango East and Kavango West

### *Development partners*

World Health Organization (WHO)  
United Nations Children's Fund (UNICEF)  
Maternal and Child Health Integrated Program (MCHIP)

### *NGO Partners*

NawaLife Trust  
Namibia Networks of AIDS Service Organizations (NANASO)  
Christian Alliance for Orphans (CAFO)  
Ombetya Yehinga Organization (OYO)  
LifeLine/ChildLine  
Catholic AIDS Action (CAA)  
Development Aid from People to People (DAPP)

C-Change Namibia was funded by USAID. FHI 360 provided technical support.

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### RECOMMENDED CITATION

C-Change. 2014. C-Change Namibia Final Report. Washington DC: FHI 360.  
[www.c-changeprogram.org/resources/c-change-namibia-final-report](http://www.c-changeprogram.org/resources/c-change-namibia-final-report)



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## ACRONYMS

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>BCC</b>	Behavior change communication
<b>CAA</b>	Catholic AIDS Action
<b>CAFO</b>	Christian Alliance for Orphans
<b>CSO</b>	Civil Society Organization
<b>DSP</b>	Directorate of Special Programs
<b>DAPP</b>	Development Aid from People to People
<b>FBO</b>	Faith-based organization
<b>GRN</b>	Government of the Republic of Namibia
<b>HCT</b>	HIV Counseling and Testing
<b>HEP</b>	Health Extension Program
<b>HEW</b>	Health Extension Workers
<b>HIV</b>	Human immunodeficiency virus
<b>HPD</b>	Health Promotion Division
<b>IEC</b>	Information, education, and communication
<b>IPC</b>	Interpersonal communication
<b>IT</b>	Information technology
<b>MCHIP</b>	Maternal and Child Health Integrated Program
<b>M&amp;E</b>	Monitoring and evaluation
<b>MOHS</b>	Ministry of Health and Social Services
<b>NANASO</b>	Namibia Networks of AIDS Service Organizations
<b>NGO</b>	Non-governmental organization
<b>NHTC</b>	National Health Training Centre
<b>NOP</b>	National Operational Plan
<b>OGAC</b>	Office of the Global AIDS Coordinator
<b>OP</b>	Condoms and other prevention
<b>OVC</b>	Orphans and vulnerable children
<b>PAN</b>	Prevention Alliance Namibia
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PHC</b>	Primary Health Care
<b>PHCD</b>	Primary Health Care Directorate
<b>PLHIV</b>	Person living with HIV
<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>QI</b>	Quality Improvement
<b>RMT</b>	Regional Management Team
<b>RSC</b>	Regional Steering Committee
<b>SBCC</b>	Social Behavior Change and Communication
<b>SI</b>	Strategic Information
<b>STI</b>	Sexually transmitted infection
<b>TA</b>	Technical Assistance
<b>TAC</b>	Technical Advisory Committee
<b>TB</b>	Tuberculosis
<b>TOT</b>	Training of Trainers
<b>TWG</b>	Technical Working Group
<b>USAID</b>	United States Agency for International Development
<b>VMMC</b>	Voluntary Medical Male Circumcision

# INTRODUCTION

## Background

C-Change implemented a field support multi-level social and behavior change communication (SBCC) capacity strengthening program from July 2008 to September 2012, following a 2008 rapid assessment of SBCC for HIV prevention. That assessment had shown that while over 90% of the population had high rates of knowledge about HIV prevention, there were high levels of risky behaviors (concurrent sexual partnerships, inconsistent condom use, inter-generational and transactional sex) and low levels of HIV testing and male circumcision. This combination continued to fuel an HIV epidemic. It was also found that NGOs and government institutions were weak in their SBCC coordination and programming for behavioral and normative change.

Following launch in mid-2008, C-Change Namibia field support focused its efforts on strengthening SBCC in HIV prevention projects and other health areas among PEPFAR-funded civil society organizations (CSOs) and line ministries at the national and district levels. This included designing and establishing coordinating structures, policies and quality standards. C-Change Namibia also developed SBCC campaigns and interpersonal communication materials to strengthen HIV prevention. In 2010, C-Change was requested to expand its support to include developing and implementing a community-based primary health care program with the Ministry of Health and Social Services (MOHSS).

That initial effort was successful and led to a request to C-Change from the MOHSS/Primary Health Care Directorate (PHCD) to assist with the design and implementation of a new community-based health program pilot in collaboration with UNICEF called the Health Extension Program (HEP). The HEP had begun as a pilot intervention in Opuwo Health District in Kunene Region with technical support from C-Change to the MOHSS PHCD, the Opuwo District Health Office, and the National Health Training Centre (NHTC).

USAID recognized that critical gaps remained in the MOHSS's capacity and that C-Change was well positioned to build and enhance technical leadership on health extension and the integration of HIV into primary health care, M&E support, and professional training to institutionalize the HEP in the district health offices in Kunene Region and in five additional regions: Kavango East, Kavango West, Zambezi, Ohangwena, and Omusati.

The Associate Award also noted C-Change's quality improvement partnership with USAID-supported local civil society organizations (CSOs). The aim of the QIs was to continually enhance the performance and/or effectiveness of interventions as well as the processes involved in delivering the interventions.

## Host Country Involvement

The MOHSS/Directorate of Special Programs, MOHSS/Primary Health Care Directorate and MOHSS/National Health Training Centre was involved in the joint planning and implementation and

performance review of the C-Change Associate Award, including the specific SBC capacity building and service delivery interventions of the HEP.

## Goal of the AA

The goal of the AA was: To decrease morbidity and mortality with an emphasis on women, children and underserved populations.

The AA also contributed to the two cross-cutting areas of the Namibia Global Health Initiative: *transitioning* and *access*. Specifically, C-Change Namibia supported the *transition* to country ownership through TA to the MOHSS Directorate for Special Programs (DSP), the HIV Prevention TAC and PEPFAR-funded CSOs. The project also strengthened capacity to design and implement quality SBCC projects and to coordinate SBCC efforts in the health sector with the aim to help reduce maternal and child mortality, decrease HIV incidence and prevalence, and prolong the survival of persons living with HIV and AIDS.

Support to improved *access* was accomplished through technical support to the MOHSS Primary Care Directorate's HEP, which integrated maternal, neonatal, child health and reproductive health services, promoted HIV prevention and ART adherence, promoted awareness of gender-based violence and related services to hard-to-reach high risk rural areas in Namibia. Improved *access* was also supported with TA to PEPFAR-funded CSOs, the MOHSS DSP HIV Prevention TAC and its TWGs to strengthen HIV prevention programming.

Recommendations from the USAID Report No. 11-01-581-2 *Assessment of Capacity Strengthening in the C-Change Project* and the USG Operating Principles were applied to the design of the approaches presented under each IR, and significant involvement of the MOHSS was built into project planning, monitoring and performance assessment.

## Expected Results

Under the AA, C-Change built on the achievements of the previous four years of the C-Change Namibia project implementation to achieve the project goal through the following Intermediate Results (IR):

- IR 1: Increased coverage of communities receiving integrated primary health care programming at the community and household level through Health Extension
- IR2: Improved quality of HIV prevention-focused social and behavior change interventions
- IR3: Strengthening the enabling environment for social and behavior change



OshiHerero (Kunene region), OshiWambo (Omusati and Ohangwena), SiLozi (Zambezi)) and RuKwangwali (Kavango East and Kavango West).

This AA also supported activities under IR2, which focused on technical assistance to the MOHSS National HIV Prevention Technical Advisory Forum and its technical working groups (TWG) at national level, and regional/local projects that were implemented by CSOs. Activities under IR3 aimed to strengthen the enabling environment under the MOHSS/Health Promotions Division and regional/local projects focused on social and behavior change communication.

# STRATEGIC APPROACH TO SBCC

## C-Change and SBCC

C-Change’s SBCC approach refers to the systematic application of interactive, theory-based, and research-driven communication processes and strategies to address change at the individual, community and social levels. C-Change’s planning model follows well-known steps in applied communication. (See detailed information on the C-Modules at: <https://www.c-changeprogram.org/focus-areas/capacity-strengthening/sbcc-modules>.) The steps are:

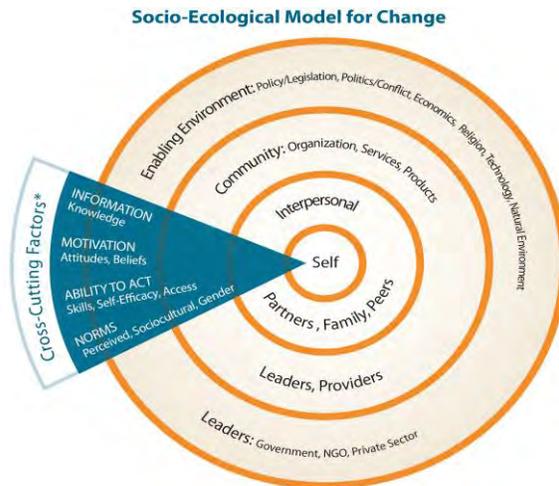
- 1) Understanding the situation;
- 2) Focusing and designing projects;
- 3) Creating materials and strategies;
- 4) Implementation monitoring; and
- 5) Evaluating and re-planning.



SOURCE: Adapted from Health Communication Partnership, CCP at: 9/11 (2001) the P-Process; McKee et al (2001) the ACADA Model; Parker, Darbyshire, and Dudson (1998) The Integrated Strategy Wheel; Roberts et al (1995) the Tool Box for Building Health Communication Capacity; and National Cancer Institute (1996) Health Communication Program Cycle.

C-Planning in 5 steps

At the heart of the C-Change approach is the socio-ecological model for change used in both analysis and planning, which offers a way to analyze barriers and opportunities, sources of influence, audiences, partners, and possible allies at the national, community, family and peer levels. Under the C-Modules link, there is information about the various theories of social and behavior change, readily available to practitioners to apply theoretical concepts in their designs and evaluations.



\*These concepts apply to all levels (people, organizations, and institutions). They were originally developed for the individual level.

SOURCE: Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

Socio-Ecological Model for Change

C-Change works through *three key strategies*: behavior change communication (BCC), using interpersonal, group approaches, mass media and new information technologies, including mobile technologies for specific behavior and social norm changes; social and community mobilization for involvement of a broader coalition and capacity strengthening of partners and allies from the international to the community level; and advocacy for policy change and resource mobilization. These three strategies are essential for sustained behavior and social change. Often projects only focus on BCC, working to change individual behaviors without addressing the overall influencing environment. The social milieu must be addressed as well through advocacy for change on issues such as accessible and friendly service delivery, or by engaging partners and allies who may bring additional resources to the cause. (It is not essential that any single project address all three strategies, but rather recognize that all three are important components).



SOURCE: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

Three Key Strategies for SBCC

This approach was deemed particularly effective for Namibia, because C-Change had previously implemented the SBCC approach with the MOHSS and CSOs during the four preceding years of field support. The SBCC approach, with its addition of advocacy and social mobilization to individual behavior change, required practitioners to acquire new sets of skills. This made capacity strengthening (CS) activities very relevant to the Associate Award. C-Change also increased the time taken with each CSO during and after training to help the organization transfer, apply, and institutionalize new SBCC capacities outlined in their SBCC strategies. To accomplish this, C-Change incorporated a continuing Quality Improvement (QI) process among all participating CSO that allowed teams of CSO and C-Change staff to follow each CSO as it implemented its SBCC strategy and identify continuing gaps and needs for support. Depending upon periodic QI findings, actionable recommendations were implemented by the CSO itself, with additional support from C-Change or another source.

### Cross-Cutting Principles Underlying our Strategic Approach

In order to frame and place the C-Change approach within USG priorities, a set of key operating USG principles were applied as cross-cutting basic principles underlying the Associate Award as follows:

#### Country Ownership and Sustainability

Given the future of external funding for the health sector in Namibia, C-Change recognized the importance of guiding the Namibian government and local CSO partners to sustain appropriate HIV prevention interventions using local and limited external resources.

C-Change provided TA to build country ownership and sustainability of SBCC within the MOHSS/PHCD and the regions/districts implementing the HEP, the MOHSS/DSP National Prevention TAC, the MOHSS/Health Promotion Division (HPD), and local CSOs and by stressing appropriate high impact interventions that could be implemented using local resources or limited external resources.

## **Substantial Involvement of Persons Living with HIV and Community-Based Advocacy and Support Groups**

As an underlying principle of the Award, PLHIV were encouraged to apply for key management and technical positions in the project, the MOHSS/Primary Health Care, the Directorate for Special Programs, the HPD and CSOs were encouraged to engage and empower PLHIV at all levels, work with PLHIV support groups for advocacy and project implementation.

This was mainly realized through the HEP, which has a large cadre of PLHIV currently working as HEWs in the various regions. C-Change also actively ensured that they build the capacity of organizations which focus on PLHIV in SBCC.

## **Coordination and Leveraging**

C-Change coordinated with national, regional, community, CSO and other development partners to leverage costs in order to broaden the coverage and intensity of interventions. Specifically, C-Change coordinated with the MOHSS national level, HEP implementing regions, the MOHSS National HIV Prevention TAC and development partners in the implementation of national SBCC efforts receiving assistance from the project, the MOHSS HPD, and with CSOs working in HIV prevention.

## **Combination Approach**

A mix of evidence-based behavioral, biomedical and structural interventions will result in greater impact on HIV prevention than separate interventions. For this reason, C-Change focused efforts on delivering higher-impact interventions centered not only on primary health care but also on strengthening health promotion and linking SBCC efforts to biomedical and structural interventions.

## **Scale and Efficiency**

C-Change prioritized those public health programs that operated at sufficient scale to achieve measurable population-level impacts. Specifically, project support assisted the MOHSS/Primary Health Care Directorate to implement and extend the Health Extension Program, assisted the MOHSS/Directorate for Special Programs National HIV Prevention TAC and its TWGs to implement and coordinate HIV prevention activities nationwide, assisted the MOHSS/HPD to strengthen SBCC across technical directorates, and supported participating CSOs working in HIV prevention in Namibia to strengthen their projects and unify approaches with the Government of the Republic of Namibia (GRN).

## **Epidemiological Relevance and Flexibility to Respond**

The Associate Award required that partners utilize current data to ensure the relevance and prioritization of their interventions. Specifically, evidence was to inform assistance to the MOHSS/Primary Health Care Directorate for the HEP, support to the MOHSS/Directorate for Special Programs National HIV Prevention TAC and its TWGs in planning, strategy development and implementation; support to the MOHSS HPD to provide SBCC support to technical directorates, and support to CSOs to inform the development of SBCC strategies and approaches, including the use of behavioral M&E.

## **Gender**

C-Change recognized the important role that gender dynamics and norms play in health-related behavior, and ensured gender-sensitive approaches within all interventions, taking vulnerability to HIV infection for both men and women into account. Specifically, the project ensured that all strategy development and programming incorporated gender analysis and gender-sensitive approaches including

those related to the MOHSS HEP; the MOHSS National HIV Prevention TAC and its TWGs, the MOHSS/HPD, and those related to CSO.

### **Host Country Involvement**

It was only through GRN active involvement that C-Change could ensure national ownership, buy-in and sustainability of the projects and approaches supported by USAID through the project. C-Change welcomed the active involvement of the GRN in the design, planning, implementation and review of the C-Change activities.

Since 2009, C-Change worked closely with the MOHSS/Directorate for Special Programs to strengthen HIV prevention coordination and implementation; and since 2010/11 there has been a growing collaboration between the MOHSS/Primary Health Care Directorate, and MOHSS/HPD and C-Change on specific SBCC capacity building and service delivery interventions such as the HEP.

Under the Associate Award, C-Change strengthened its relationship with the MOHSS/Primary Health Care Directorate and Directorate for Special Programs through joint project design, planning, monitoring, and final performance evaluation.

# C-CHANGE NAMIBIA RESULTS FRAMEWORK

**Goal: Decreased morbidity and mortality with an emphasis on women, children and underserved populations**



# IR1: INCREASED COVERAGE OF COMMUNITIES RECEIVING INTEGRATED PRIMARY HEALTH CARE PROGRAMMING AT THE COMMUNITY AND HOUSEHOLD LEVEL THROUGH HEALTH EXTENSION PROGRAM

## Background

Namibia's MOHSS adopted 'The Primary Health Care' (PHC) approach at Independence in 1990 to guide the restructuring of Namibia's health sector, with the objective of *Health for All Namibians*. Efforts have since been geared to shift resources to the most disadvantaged regions, focusing on preventive services and basic care provided by clinics, mobile health teams and community volunteers in order to provide care that is more equitable.

A national health and social services system review conducted in 2008 found that despite the great strides Namibia had taken in the implementation of PHC services, such services did not extend beyond facility level, leaving the marginalized majority still without equitable access to these essential services.

One of the ways the MOHSS has addressed inequitable access is through the Health Extension Program (HEP), designed to reach households in remote rural communities with basic services in first aid, maternal and neonatal health, child health, Nutrition, HIV/AIDS, malaria, TB, social welfare and disabilities. The program uses an extensive network of Health Extension Workers (HEWs), currently based in six Namibian regions.

In April 2012, the MOHSS, with the assistance of USAID, UNICEF, MCHIP and C-Change Namibia, piloted the HEP in Opuwo District, Kunene Region. Following the success of the pilot, the HEP was rolled out in Omusati, Ohangwena, Kavango East, Kavango West, and Zambezi region. The purpose of the program was to bridge the gap between the community and the health facilities and improve equity of health care by extending a standardized set of basic primary care services into underserved rural communities located more than five kilometers from a health facility through HEWs.

The minimum requirements for HEWs as developed under the C-Change pilot, are: a) 10th grade education qualification with basic English; b) live in and be from the community they serve; c) selected by their community; and d) speak the local language. Each HEW is expected to cater to approximately 100 households or 450 individuals (due to geographical and cultural constraints, this number was decreased to 70 households or 315 individuals per HEW in the pilot area of Opuwo District).

HEWs were tasked with mapping and conducting an annual household census in their catchment areas, detecting and managing common health conditions, and providing health promotion to households and community groups to improve health-related knowledge, attitudes, and behaviors.

HEWs received training on the following core modules:

- Module 1: INTRODUCTION, COMMUNITY MOBILIZATION, MAPPING AND THE HOUSEHOLD CENSUS, BEHAVIOR CHANGE AND FACILITATION
- Module 2: FIRST AID
- Module 3: COMMUNITY-BASED MATERNAL AND NEWBORN CARE
- Module 4: COMMUNITY-BASED INTEGRATED CHILD HEALTH
- Module 5: HIV AND AIDS, TB AND MALARIA
- Module 6: SOCIAL WELFARE AND DISABILITIES

These modules, initially drafted, tested and revised by C-Change in collaboration with various partners, were then taken on by the MOHSS to lead their finalization with continued technical and operational support by C-Change.

C-Change Namibia has played a key role in the development and implementation of the HEP, leading the pilot alongside the MOHSS and UNICEF in the Kunene region, and also providing technical and financial assistance to the rollout of the program in the five additional regions.

Specifically, C-Change guided and supported the MOHSS National HEP Steering Committee and NHTC as follows:

- Spearheaded the design of the final HEP supervision structure, including human resources needs from the clinic level to the district to the region, which was pilot tested in Opuwo District prior to expansion to new areas;
- Drafted and facilitated partners in determining the final content of the service package and the final HEW kits prior to HEP expansion;
- Finalized the edited HEW materials (Facilitator's Guide, Handbook, Screening Tools, Health Promotion materials and M&E tools) including facilitation and technical guidance for final MOHSS/PHC and NHTC review and approval prior to reproduction and HEP expansion;
- Continued technical and operational support to the MOHSS and NHTC to review and report on the pilot project, including selection of communities and HEW candidates, training on implementation and determination of outcomes, thorough costing of the pilot, documentation of outcomes, and recommendations for institutionalization and expansion;
- Spearheaded the development and annual reviews of the HEP curriculum
- Acted in the capacity of master trainers in three regions, namely Kavango East, Kavango West and Zambezi region. This included assisting NHTC in the training of HEWs, both in the theoretical and practical assessments for three weeks per month for six months.
- Professional capacity development and training to the MOHSS designed to assist decision makers in their plans for the institutionalization and expansion of the HEP.

## Implementation

### HEP development and implementation

During the HEP pilot in Kunene region and the rollout of HEP in the additional regions (Kavango East, Kavango West, Zambezi, Ohangwena and Omusati), C-Change assisted the MOHSS/NHTC with financial assistance and TA in the core areas of joint planning and implementation, HEP training, TA and financial support and SBCC capacity strengthening. The target audience for these programs is children under 5, pregnant women, newborns, postnatal women, people with TB, HIV, or malaria, and people with social welfare needs and disabilities. The table below provides details:

JOINT PLANNING AND IMPLEMENTATION	HEP TRAINING	TA AND FINANCIAL SUPPORT	SBCC CAPACITY STRENGTHENING
<ul style="list-style-type: none"> <li>• Active Participation in the HEP steering Committee</li> <li>• Regional Programming</li> <li>• Annual Program and Curriculum Reviews</li> <li>• Periodic field supervisory visits with NHTC and regional/district program coordinators to clinic-based supervisors</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic-based HEW supervisors, district and regional coordinators and HEWs, with a</li> <li>• Focus on:               <ul style="list-style-type: none"> <li>○ HEP and its purpose</li> <li>○ The role of the HEW</li> <li>○ The role of the clinic-based supervisor, district and regional coordinators</li> <li>○ Supportive supervision, methodologies, schedules and supervisory tools</li> <li>○ M&amp;E</li> </ul> </li> <li>• In-service training to HEWs to strengthen service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• TA to selected expansion region/districts (Based on MOHSS expansion plans for HEW selection and training)</li> <li>• Assistance to the MOHSS and NHTC in meetings with the expansion Region/Districts to present the HEP</li> <li>• Support to the expansion during the selection of communities at high risk, and community nomination and selection of HEW candidates for training</li> <li>• Support to district and regional reporting, monitoring and evaluation and conducting annual program reviews</li> </ul>	<ul style="list-style-type: none"> <li>• CS to implement effective interventions</li> <li>• Ensure evidence-based programming</li> <li>• Training of C-Change SBCC methodologies and theory to NHTC, health care managers and health care workers</li> <li>• Technical assistance to the MOHSS and NHTC on the integration of SBCC methodologies to the HEP curriculum and field materials, practicum sessions and training methodologies that support the integration HIV and AIDS into the HEP</li> </ul>



HEW examines a child while the mother listens.



HEW delivers a health promotion session with a family in their compound.

## HEWs field work

As of June 2014, 550 HEWs had successfully completed the HEP training and were implementing the HEP in the regions. Focused on six core modules (see IR 1: Background), C-Change Namibia and MOHSS/NHTC ensured that the HEP stayed current to the needs of their communities through the annual review and revision of the HEP curriculum. Following the graduation of HEWs in the five regions, C-Change and MOHSS/NHTC embarked on an intensive program of training skills application and curriculum review. C-Change conducted 15 focus group discussions (FGD) in the five implementing regions with two groups of HEWs and one group of regional facilitators per region. In total 96 HEWs and 22 facilitators took part in the discussions. The FGDs focused on the following areas: curriculum content, delivery of the content, transferability, accomplishments in the field, challenges, and recommendations.

Following are some of the key findings from the FGDs:

- **Most used module:** Across the regions, all participants agreed that *Module 3: COMMUNITY-BASED MATERNAL AND NEWBORN CARE* was the module most often used in their communities. *Module 5: HIV AND AIDS, TB AND MALARIA* was also an important module in the regions, with malaria of particular importance in the Kunene, Zambezi and Omusati regions. This module was closely followed by *Module 4: COMMUNITY-BASED INTEGRATED CHILD HEALTH*. Although *MODULE 6: SOCIAL WELFARE AND DISABILITIES* was a difficult module to address (according to both HEWs and facilitators), it was essential because many communities are strife with gender-based violence, suicide, and substance abuse. Many communities also have large populations of orphans and vulnerable children and the elderly. This module was of particularly relevant to addressing the needs of these groups.
- **Information needs:** The greatest need voiced by the HEWs was for capacity building on *Module 5: HIV/AIDS, MALARIA & TB*, particularly for HIV counseling, testing and treatment, and treatment adherence monitoring. This need arose due to the frequent requests HEWs received from community members about testing and treatment. *Module 6: SOCIAL WELFARE AND DISABILITIES* was difficult for the regions to implement due to lack in skills training for both HEWs and facilitators during the training of trainers (TOT), particularly in the areas of social welfare (social grant referral mechanisms for the elderly and OVC); disability (identification, referral mechanisms, and rights of the person living with a disability); household violence, substance abuse and suicide (counseling and referral mechanisms). Facilitators also found this module the most difficult to facilitate during HEW training and relied on the support of colleagues working in this field, especially rehabilitation officers.
- **Difficult topics/health concerns to address:** HEWs felt that issues relating to disclosure on HIV status, mental health, suicide, substance abuse, and violence were difficult to address in their communities. This was due to fear of repercussions (especially for cases related to social welfare), issues of confidentiality, and general unease by HEWs based on their experience of screening members in their community with whom they were well acquainted. Screening for suicide was especially difficult for HEWs in all regions. Facilitators,

who are in many cases nurses, also indicated this module was the most difficult to facilitate as they felt many of the issues were outside their area of professional expertise.

Other topics that the HEWs found difficult to address were:

- Maternal and neonatal health (for male HEWs)
  - Safer sexual practices, e.g., cultural beliefs, condom use, and voluntary medical male circumcision
  - Malnutrition (HEWs were accused of unfairness if cases of malnutrition were reported)
- **Observed successes:** To date, HEWs have greatly contributed to the extension of the public health response among remote and marginalized communities. Successful application of new HEW technical skills was particularly notable for community-based maternal and newborn care, which was part of Module 3: *COMMUNITY-BASED MATERNAL AND NEWBORN CARE*. Both the HEWs and facilitators stated that as a result of this module they were starting to observe the following improvements in their communities' health seeking behaviors: Early and maintained uptake of antenatal care, early identification of danger signs during pregnancy, decrease in home deliveries, decrease in morbidity and mortality, increased postnatal care, and increased partner support during ANC/prenatal care.

Also often cited by HEWs as relevant were Module 4: *COMMUNITY-BASED INTEGRATED CHILD HEALTH*, Module 5: *HIV, MALARIA AND TB* and Module 6: *SOCIAL WELFARE AND DISABILITY*. HEWs and regional facilitators observed increased childhood immunizations, better nutrition, early identification of danger signs during pregnancy, and successful referrals to the health facility.

### **Selected Quotes from HEW and Facilitators on their Observations of Improvements in Communities' Health-Seeking Practices and Behaviors**

#### **Maternal and Neonatal Health**

- "Maternal & Neonatal is better now, before most clients were not going for ANC and delivered at home and did not take their children for immunization." – *Kunene HEW, group 2 female*
- "They used traditional things to clean the cord of baby, but we teach them how to clean. Now we reduce deaths of the baby." – *Ohangwena HEW, group 1 female*
- "ANC - I found one lady during the health promotion field assessments who refused to deliver at a facility. I persevered; she decided to go for ANC and hospital delivery. This lady ended up having a caesarean."  
- *Kavango East HEW, group 2 female*
- "A good opportunity was created for the HEW during the strategic phase from pregnancy up to when the baby was born, especially as pregnant women are now starting ANC early; there are no more home deliveries and neonatal deaths – this is a change, the nation is changing and the community also. Pregnant women are now starting ANC early and are taken care of at the health facility until the baby is born." -

*Ohangwena HEW, group 1 female*

- “Nurses don’t weigh babies, HEWs do. HEW also take the breathing of the baby (count breathing).” – *Zambezi HEW, group 2 male*
- “Maternal & neonatal facilitators see that pregnant women now start ANC earlier than before the HEP.” - *Omusati Facilitator*

#### **Child Health**

- “Some kids did not have health passport and did not go for especially Vitamin A. We explain why they need vitamins. In our village, all children now have child health passports.” – *Ohangwena HEW, group 1 male*
- “Previously a lot of children were not immunized but now the community takes their children to hospital for immunization” – *Kunene HEW, group 1 male*
- “Child health, we learn to recognize danger signs in children under five years. We teach communities to also identify danger signs and when to send children to clinic.” – *Ohangwena HEW, group 1 female*”

#### **Social Welfare and Disabilities**

- “HEW learned how to handle people with disabilities” - *Kunene HEW, group 2 male*
- “Social Welfare and Rehabilitation. Now we have skills to change people’s behavior. We now have information and skills on how to help them” – *Zambezi HEW, group 1 male*

- **Challenges:** The biggest challenge HEWs face was the delay in their allowance from the MOHSS. Some reported going hungry during their training and lack of funds available for transport. In addition, HEWs faced a lack of materials and inability to replenish stock, e.g., medications and disinfectants; inequitable distribution of materials; and poor quality, small storage bags supplied to the HEWs.

M&E was challenging according to some HEWs and facilitators, especially for referral mechanisms regarding social welfare and disability. Difficulties included too little time to prepare for HEW M&E training and its placement at the end of the curriculum. Facilitators also noted that due to the extension of their professional mandate, which involved other line ministries and directorates within MOHSS, they had little control regarding referrals.

Other challenges included lack of cooperation from nurses at health facilities, community expectations of HEW vs. HEW scope of work, availability of mosquito nets, mobile populations and unavailable clients, lack of transport to health facility, and long travel distances.

To address these challenges, HEWs suggested solution to their facilitators: conduct sensitization meetings with headmen and community health committee in the villages, ask other HEWs in the area for assistance/advice if uptake of services is poor, and increase health promotion.

## Key Recommendations

HEWs and facilitators made the following recommendations during the FGDs:

HEP in general	HEP Facilitators
<ul style="list-style-type: none"> <li>• Regional sensitization of MOHSS, preferably by national level authorities</li> <li>• Orientation of nurses on HEP</li> <li>• MOHSS introduces HEP and HEWs to the communities</li> <li>• Training of additional HEWs for larger villages</li> <li>• Larger and more durable kits</li> <li>• HEW identification and uniform (including bicycles and umbrellas)</li> <li>• Equitable distribution of materials and medication</li> <li>• Refill of medication</li> <li>• Receive materials on time</li> <li>• Receive allowances on time</li> <li>• Storage for medicine and confidential materials</li> <li>• Annual refresher training</li> <li>• Improved feedback mechanisms, especially relating to scores per module in assessment</li> <li>• Assessment questions be sent from the region and collated at national level</li> <li>• Adequate training venues with appropriate chairs and materials</li> <li>• Review of transport mechanisms available to the HEW</li> </ul>	<ul style="list-style-type: none"> <li>• Increase supervision</li> <li>• Maintain mild temper in class</li> <li>• Give opportunity to ask questions</li> <li>• Prepare well in advance and not on day of training</li> <li>• Refresher training focused on facilitation skills</li> <li>• Content training and skills transfer on social welfare and rehabilitation</li> <li>• Trainers have nursing background</li> <li>• Expert trainers to give specialized training on some topics</li> <li>• Increased time especially for practical sessions</li> <li>• Do not critique in front of the client</li> <li>• Must be innovative</li> <li>• Must have observation skills</li> <li>• Use as simple language as possible</li> <li>• M&amp;E understanding and skills</li> </ul>

The findings from the FGDs further informed the curriculum revision workshop led by MOHSS/NHTC, along with C-Change's technical and financial support and the regional facilitators and technical advisors from MCHIP and WHO, who ensured all gaps identified in the curriculum review were addressed for the new regions' TOT. In August 2014, C-Change and NHTC conducted the new implementing regions' TOT based on this revised curriculum.



New implementing regions' HEP facilitators with Acting COP Nortin Brendell in the middle

## Results

To date, 550 HEWs have successfully completed the HEP training and are currently working in the regions. From January 2013–April 2014, HEWs in the Kunene region (the region C-Change was responsible for reporting on), the HEWs reached 9215 individuals (5393 females, 3822 males); delivered HIV, TB, and malaria health promotion services to 2967 individuals (1639 females, 1327 males); and provided 1020 children under 5 with health care referrals (553 females, 467 male).

In October 2012, representatives from USAID, the C-Change Namibia office, UNICEF and five journalists visited a community and witnessed the work of one of the HEWs in the community. A video of the visit can be viewed at [http://www.unicef.org/infobycountry/namibia\\_66212.html](http://www.unicef.org/infobycountry/namibia_66212.html).

*“Establishment of the health extension workers initiative in Kunene will accelerate the promotion of health awareness and build local communities’ capacity for greater access, involvement and participation in primary health care interventions.” – Dr. Richard Kamwi, Namibia’s Minister of Health and Social Services, who also noted that the HEW would serve as a link between health*

facilities and communities, thereby increasing the number of qualified health workers in the community.”



An HEW educates Himba women about health care for their infants and children to prevent or treat malaria, diarrhea, HIV/AIDS, tuberculosis and other infectious diseases. *USAID/E Mbekele*



C-Change Namibia COP Stephanie van der Walt with newborn exhibiting danger signs she and trained HEW brought to hospital.

## IR2: IMPROVED QUALITY OF HIV PREVENTION-FOCUSED SOCIAL AND BEHAVIOR CHANGE INTERVENTIONS

### Background and Implementation

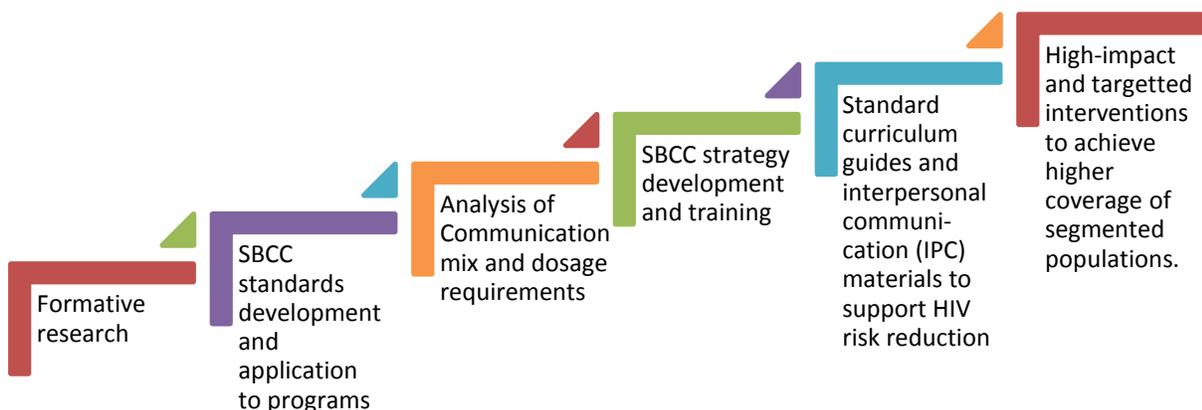
Under IR 2, C-Change Namibia provided tailored SBCC TA to MOHSS and CSOs to help improve SBCC HIV prevention programs. This included SBCC Quality Improvement (QI) visits and active participation in TWG meetings.

Namibia’s transition from BCC to SBCC in late 2009 called for the alignment of partner strategies, mutually reinforcing and focused messaging and continuous quality assessments of SBCC interventions. Through its capacity building initiatives, provision of quality assessments to partners and technical contributions during TWG deliberations, C-Change helped transform SBCC within the HIV response.

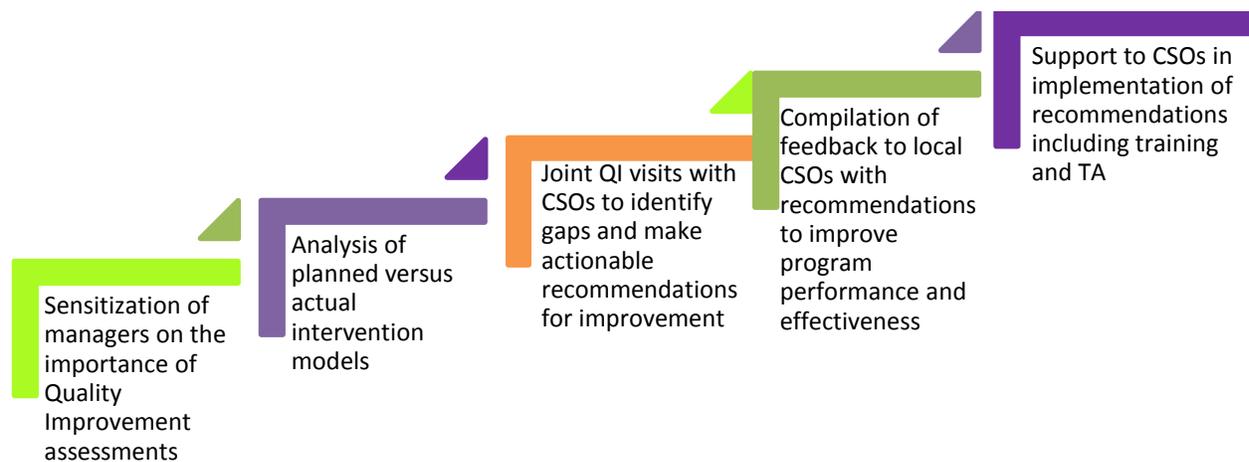
Indeed, the C-Change methodology for SBCC capacity strengthening in national and local health organizations was highly regarded by participating partners and by USAID Namibia. One partner in Namibia rated her workshop “double A plus” for its utility and practical approach. Participants appreciated the flexible format and ability to focus on their own projects. C-Change facilitation and material were rated of good quality. Importantly, almost all participants reported they successfully learned the SBCC approach and applied it in their work.

An expatriate advisor who provided organizational development services and sub-grants to a number of local NGOs in Namibia commented that attempts to conduct health communication were ‘uncoordinated’ before the introduction of C-Change capacity strengthening. Following the C-Change capacity strengthening process, this advisor reported that NGO health communication interventions had “improved dramatically.”

Technical support from C-Change to the MOHSS and CSOs also institutionalized SBCC standards among USAID-supported local organizations across the following areas:



In 2011, C-Change initiated a QI partnership with USAID-supported local CSOs to provide ongoing support to the performance, effectiveness and delivery of interventions. This included:



This partnership approach has been well received and was expanded to additional CSOs including those in the Prevention Alliance Namibia (PAN), which provided SBCC advocacy trainings. Activities with local organizations were tightly linked to efforts by the National HIV Prevention Coordinator to improve the performance of the national HIV prevention response, which was based at the DSP of the MOHSS.

Activities included TA to assist:

- Coordination and quality of the national HIV prevention response through the active participation in the HIV Prevention TAC;
- The national TWGs to ensure quality SBCC, particularly related to the national promotion of high-impact prevention measures including MC, HIV testing, and ART adherence among PLHIV;
- The TAC and TWGs in ensuring that local CSOs continue to be involved in national strategy development and planning, and have the training and interpersonal communication materials necessary to play an important role in SBCC campaign implementation in their communities;
- The TAC and its partners in the documentation of the outcome SBCC campaigns; and
- Support to multiple stakeholders in civil society including participants in the PAN.

## Results

Under IR2, C-Change worked with the MOHSS, the Global Fund, and CSOs and also assisted various organizations in the development of strategies. Results for each of these partners are detailed below.

### MOHSS/Directorate of Special Programs

A notable contribution that C-Change made to the national HIV SBCC response was the TA that C-Change provided to the MOHSS/DSP in drafting the minimum package for SBCC in HIV prevention, based on the SBCC quality standards assessment tool and the HIV prevention session guides developed by the SBCC TWGs for various age groups.

### Global Fund, NANASO

In 2014, C-Change assisted Global Fund, Namibia Networks of AIDS Service Organizations (NANASO) and its Sub-Recipients (including Philippi Trust, Ombetya Yehinga, Namibian Planned Parenthood Association and Development from People to People), to review their current SBCC interventions, with specific emphasis on program objective(s), target audiences, activities and targets.

### Civil Society Organizations

C-Change conducted 10 QI visits to 3 CSOs—LifeLine/ChildLine, Society for Family Health and Churches Alliance for Orphans—and assessed several SBCC interventions including IPC sessions, and provided feedback and recommendations for improvement to the CSOs, using the Participatory Improvement Process for SBCC.

### Document Development

Through audience segmentation, identification of key messages, identification of communication channels and activities, identification of indicators, C-Change's assisted the MOHSS and various CSOs in the development of the following documents:

- Risk Reduction strategy
- National HCT Strategy
- Constitution of the Child Rights Movement
- Key Populations advocacy strategy (draft), and
- Draft Nutrition Strategy
- National Combination [HIV] prevention strategy (draft)



Combination Prevention Strategy (Draft)

*“The capacity building and follow-up feedback we received from C Change had a huge influence on how we operate. It forms an integral part of our strategy.” – Jane Shityuwete, National Director, LifeLine/ChildLine*

## IR3: STRENGTHENING THE ENABLING ENVIRONMENT FOR SOCIAL AND BEHAVIOR CHANGE

### Background

C-Change recognized the important role of the enabling environment in both organizational and individual behavior change as well as long lasting social norm change with regard to establishing SBCC as integral and effective part of HIV prevention and care programming. Factors that needed to be addressed to effect change at the organizational level e.g., at MOHSS levels, included: the lack of understanding of SBCC among decision makers, the lack of functioning coordinating structures, the lack of guiding policies and strategies, and the lack of agreed upon quality standards. On the individual level of staff as well as audiences addressed with prevention interventions, factors that needed to be better addressed with SBCC included: social and cultural norms, gender norms, the role communication plays to help focus on structural access issues to services and poverty affecting risk behaviors, and overall prioritization and decision making with regard to health.

C-Change worked with the GRN and CSOs to advocate for and train decision makers and staff in SBCC to develop the necessary structures for coordination and quality program implementation, to develop guiding SBCC policies and strategies, to develop the necessary tools, and to develop quality standards. Throughout this process, C-Change worked with implementing partners to identify the underlying factors related to the targeted behaviors and audiences and to develop policies, strategies, approaches and materials.

### Implementation

Under the AA, C-Change Namibia continued to assist the MOHSS and CSOs to address continuing gaps in the enabling environment that negatively impacted the ability to implement quality SBCC programs. Support is described below and is divided by strategic partners: the MOHSS/HPD and selected CSOs, including participants in PAN.

#### Support to the MOHSS/Health Promotion Division

The MOHSS/HPD is responsible for providing SBCC guidance and TA to all technical directorates throughout the Ministry. It is important that Division staff be well trained in state-of-the art SBCC theories and approaches, and able to apply them to support their work through the MOHSS.



PAN participant detailing their Advocacy plan during the PAN advocacy workshop



Participatory QI Process for SBCC Programs developed by C-Change to strengthen SBCC capacity in Namibia.

SBCC training for the HPD took place in February 2013 in Otjiwarongo and was attended by 16 participants from HPD from various regions. The training focused on creating an understanding of SBCC strategies, exploring different effective communication channels, using appropriate tools (e.g., the problem tree) to analyze issues, and developing action plans for implementation. Participants were also trained on gender norms and stigma and discrimination and each of the participants developed specific communication objectives.

After the training, C-Change continued to provide support to strengthen HPD through the following:

#### **TA to the MOHSS/PHC and DSP**

- TA to the directorates to tailor the quality standards and tools for SBCC program planning, implementation, and M&E, and for the supervision of group SBCC sessions for the MOHSS
- TA to the Division in the use of the new national SBCC QI tools through implementation of a QI visit
- Handing over of the SBCC Quality Standards tool to the MOHSS/HPD to ensure that the standard of high quality SBCC interventions are maintained in the future. Institutions that plan to measure the standard of their SBCC responses will liaise with MOHSS

#### **TA to the MOHSS/HPD**

- TA in the development of the Health Promotion Strategic Framework in a process initiated through a meeting held with the Deputy Director of Primary Health and the Health Promotion team in February 2014.
- Strategies, objectives and activities were outlined during the meeting and further refined during a second meeting in March 2014.
- The document is currently being finalized by the MOHSS/HPD directorate.

#### **Support to select CSOs including PAN**

- CSOs faced significant barriers to their ability to change their targeted behaviors. Underlying factors varied according to the behavior as well as the target audience. C-Change provided training and technical assistance in advocacy, identification of underlying factors, and development of CSO plans to address underlying factors in the enabling environment that were negatively affecting their ability to change individual behaviors and social norms. This involved applying the new facilitation guides developed by C-Change.

## Results

- 2 National SBCC quality standard documents and QI tools were developed with the MOHSS
- 7 QI visits were conducted with the MOHSS to measure the quality of their SBCC programs
  - 5 Advocacy Plans were developed by CSOs to address underlying factors negatively affecting the SBCC programs

*“C-Change was very detailed in the advocacy training that they provided for PAN. Using the VIPP methodology, they allowed us to look at advocacy in a more comprehensive manner.” – Nahum Gorelick, Director, NawaLife Trust, Director*

## LESSONS LEARNED

The overarching lessons learned during implementation of the C-Change Namibia AA are detailed below by IR.

### IR1: Increased Coverage of Communities Receiving Integrated Primary Health Care Programming at the Community and Household Level through Health Extension Program

- **Ensuring HEP sustainability through collaboration at both national and regional level:** The biggest strength of C-Change Namibia has been its ability to work collaboratively with the MOHSS to help it realize its commitment to the most marginalized and remote populations in Namibia through the HEP. While leading the pilot of the HEP in the Kunene, C-Change Namibia ensured the sustainability of the HEP in all regions of Namibia by prioritizing and maintaining effective communication mechanisms at both national and regional level. This enabled C-Change Namibia to not only provide comprehensive and responsive TA, ensure regions were appraised of the HEP progress, and ensure a respectful partnership where all contributions were considered, but also ensured that at national and regional level, the MOHSS took ownership of the HEP and could sustain the program without the major input of civil society.
- **Establishing close ties between the Regional Management Teams (RMTs) and the HEWs facilitated a closer working relationship between the community and RMTs:** Most of the HEP facilitators are regional staff with intimate knowledge of their communities, including needs and cultural dynamics as well as understanding of the intricacies of their regional directorate. This comprehension has enabled community-specific responses (e.g., the establishment of tippy taps during the recent cholera outbreak in Kunene region through the HEWs) and also allowed the various regions to foster strong relationships with partners working in the regions, but also with the HEWs themselves. Engaging local and traditional leaders at the inception of the program, has also led to widespread and easy acceptance of the program in many communities and results in faster, more informed responses to community needs, based on data generated through the work of the HEW.
- **The need for a dedicated HEP focal person within the regions:** C-Change's supportive supervision and placement of its Technical Advisor in two regions demonstrated the importance of establishing ministry-based focal persons within the regions to facilitate sustainable supervision and coordination of the program and avoid activities being stalled and M&E not taking place in a timely manner.
- **Documenting best practices and lessons learned is critical to showcasing HEP successes:** A communication strategy that describes how to engage the local media and community leaders to publicize the accomplishments of this program and distribute lessons learned is vital to increase the visibility of the program and showcase program successes. To ensure effective documentation, regional facilitators and HEWs need additional training to advance their skills in both quantitative and qualitative documentation.

## IR2: Improved Quality of HIV Prevention-Focused Social and Behavior Change Interventions

- **SBCC quality improvement needs to be institutionalized to ensure sustainable quality SBCC programs in CSO's:** The SBCC QI tool has allowed Global Fund CSOs to realign their programs to meet the requirements for quality SBCC interventions. C-Change's participatory QI assessment enabled managers and directors to critically reflect on their programs and improve in areas where they identified gaps. C-Change-supported CSOs have also been able to develop and sustain their SBCC program and integrate SBCC into their Standards of Operation. The tool has allowed these CSOs to maintain the quality of their interventions
- **M&E for SBCC needs strengthening:** Large strides have been made in the development and coordination of national and regional SBCC interventions, yet the documentation of the outcomes for these interventions beyond the 'number of people reached' has not been as strong. To capture the outcomes of SBCC programming, there is a need for skills strengthening and the application of a mixed-model and participatory M&E systems.

## IR3: Strengthening the enabling environment for social and behavior change

- **Appreciation for the role of SBCC has increased in Ministry and CSOs:** Through the comprehensive TA that C-Change has provided, the MOHSS and CSOs have recognized the critical role of evidence-based and targeted SBCC to better health for Namibians. C-Change support to the 'National SBCC Strategic Framework' has embedded SBCC thinking into health promotion. The HPD's shift from IEC to SBCC has meant that SBCC is regarded as a priority at national levels.

## C-CHANGE NAMIBIA FORMAL EXIT AND HANDOVER

Partners gathered during C-Change Namibia's end-of-project dissemination meeting in Windhoek, Namibia on September 5, 2014. Twenty-four participants from donor, civil society and partner community were in attendance.

Salen Engelbrecht from NawaLife Trust echoed the sentiments of many, when she observed "It feels as if we are losing a great pioneer and advocate for SBCC in Namibia." This reaction was reiterated by partners, who not only commended C-Change for their inclusive mode of operating in Namibia, but also for the quality technical assistance they provided in strengthening SBCC responses in Namibia.

Desderius Haufiku, focal person for the HEP within the MOHSS/PHC directorate acknowledged: "It is with mixed feelings that I stand before you here today. C-Change has been of great assistance to the development and implementation of the Health Extension Program and were it not for their technical and financial assistance, we would not have progressed as far as we have in such a short amount of time."

Ismelda Pietersen, the MOHSS/DSP's National HIV Counselling and Testing Coordinator, highlighted the important contributions C-Change made from strengthening of SBCC interventions in Namibia, their work within the TWGs, capacity building interventions, and valuable insight in document development, such as the National HCT Strategy and draft Combination Prevention Strategy, stating, "An organization is made up of its employees, and I would like to thank Stephanie, Nortin, Abigail and the rest of the team for their professionalism and comprehensive TA. Their loss will be felt in the Ministry." USAID representative Robert Festus reiterated this and was optimistic that other CSOs would absorb the capacity that was built by C-Change Namibia.

To conclude the event, C-Change shared some of the remarks made by other partners who were unable to participate in the event. Below are selected quotes:

*"It is sad to see the program is finishing, because of the relationship that has been built. I think it is very critical, because sometimes it is not necessarily just money, it is the hands on work, for C-Change to be there, for C-Change to be part of the team. That was very, very important for us... If it was in my control, in my power, I would have said, let's find money for C-Change to continue."* – Maggie Nghatanga, Director, MOHSS/PHC

*"When the successes of the Health Extension Program are being broadcast, C-Change's banner will fly high alongside it."* – Nahason Katjangua, Training Officer, MOHSS/NHTC

*"Their approaches were participatory, we worked together. They did not dictate to us what we had to do, rather they used their knowledge of adult learning to integrate and utilize our strengths and expertise in the development of our program ... SBCC is interesting, we have adopted it in everything we do, whether it be gender-based Violence, child protection, HCT etc. The capacity building and follow-up feedback we received from C-Change had a huge influence on how we operate. It forms an integral part of our strategy."* – Jane Shityuwete, National Director, LifeLine/ChildLine

*“After the training we received, we were able to not only transfer the skills to our regional implementers and volunteers, but we now have an established SBCC program.” – Macci Boois, Project Coordinator, CAFO,*



Highlights from the C-Change end-of-project meeting

# APPENDIX 1

## PERFORMANCE MONITORING PLAN

FY 13 (October 2012-September 2013)

C-CHANGE Namibia Project

## INTRODUCTION

The purpose of any PMP is to provide a framework for the set of indicators to be used by a program to monitor that program's progress and results. The C-Change Namibia PMP for FY13 includes the PEPFAR and HRH indicators required by the Mission and optional indicators tailored to the Associate Award.

Because the program results are key to measuring success, the C-Change Namibia PMP is organized by intermediate results. In FY13, C-Change Namibia will continue to provide SBCC strengthening from national to local levels in HIV prevention and other technical health areas within the context of the GHI. The three intermediate results are as follows:

- IR 1: Increased coverage of communities receiving integrated primary health care programming at the community and household level through Health Extension**
- IR2: Improved quality of HIV prevention-focused social and behavior change interventions**
- IR3: Strengthening the enabling environment for social and behavior change**

### **Performance Indicators and Programmatic Benchmarks**

The C-Change Namibia PMP includes benchmarks for each expected result and program indicators that will allow for monitoring of program progress. Indicators and benchmarks are limited to activities within C-Change's direct manageable interest.

The PMP includes both output and outcome level indicators designed to assess progress and results. Indicator data will be collected by tools designed to be analyzed by organization, gender and region and other relevant variables related to that indicator. Progress towards achieving indicator targets and benchmarks will be monitored and reported to USAID on a quarterly basis.

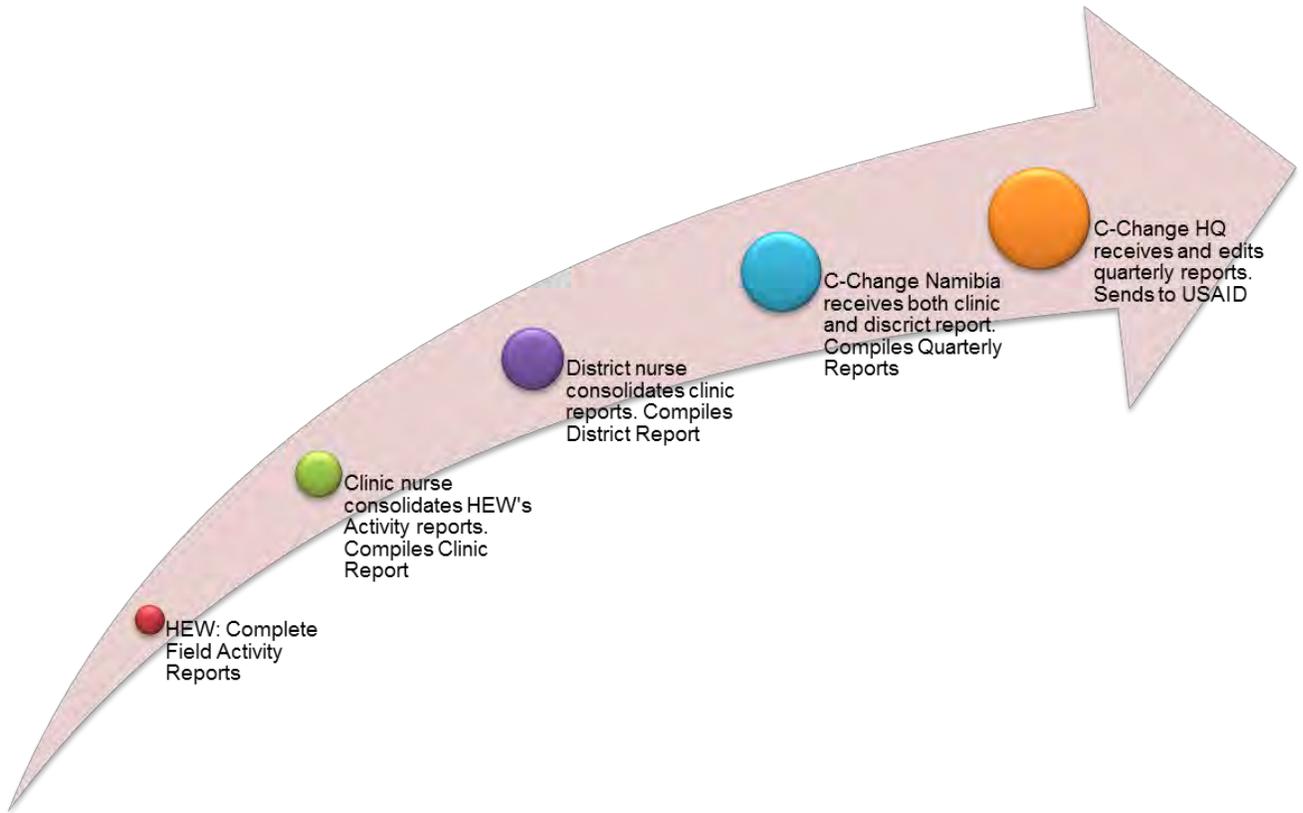
Performance indicators and programmatic benchmarks for each expected result are presented below. Each performance indicator includes the indicator target, the definition and unit of measurement, and the data collection methods/approaches to be used. Each programmatic benchmark includes the target date for that benchmark and the measurable result. Indicators and benchmarks reflect the breadth and complexity of C-Change's activities included in the project's work plan.

# RESULTS FRAMEWORK FOR C-CHANGE NAMIBIA

**Goal: Decreased morbidity and mortality with an emphasis on women, children and underserved populations**



# DATA FLOW CHART



## PERFORMANCE OVER THE AWARD PERIOD

PERFORMANCE INDICATORS, DEFINITION AND UNIT OF MEASUREMENT	DATA COLLECTION METHOD AND APPROACH	PROJECT TARGET AND RESULT
IR 1: Increased coverage of communities receiving integrated primary health care programming at the community and household level through Health Extension		
Namibia HRH Custom Indicators		
<p>1. % of health workers receiving USAID-supported capacity building assistance who have applied this acquired knowledge or skill(s) to their jobs.</p> <p><i>(Outcome level Indicator)</i></p> <p><i>Definition:</i> Health workers who participated in USAID-supported capacity building activities who self-report (and/or whose managers' report) that they changed their behavior or used the new skill or knowledge on the job after the capacity building activity (within 6 months). Capacity building may include pre-service and in-service trainings, workshops, one-on-one technical assistance, and mentoring.</p> <p>Unit: Percentage of Health Workers</p>	<p>A six-month follow up interview will be conducted with both managers (to report of overall application of skills and knowledge) and individuals (self-report) who have gone through capacity building exercises. The results of quality improvement visits and field visits will supplement the information gathered.</p>	<p>Target: 40%</p> <p>Result: 100%</p> <p><i>Comments:</i> All HEWs that were part of the HEP training are implementing the HEP. 550/550 of graduates currently implementing</p>
<p>2. # of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required</p> <p><i>(Outcome level indicator)</i></p> <p><i>Definition:</i> This indicator will measure the reach of HEP through the # of clients reached by the HEW. Interventions are defined as: Individual level interventions (ILI): Interventions that are provided to one individual at a time (e.g., individual counselling). The intervention assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Counselling associated</p>	<p>Information included in quarterly reports</p>	<p>Target: 4250</p> <p>Result: Total: 2967 Male: 1321 Female: 1639</p> <p><i>Comments:</i> Data for Kunene Region<sup>1</sup> from January 2013 to April 2014.</p>

<sup>1</sup> In the original PMP submission, C-Change was required to collect data pertaining to training, supportive supervision and other TA activities for IR1 because C-Change's function was in a supportive capacity and not as a direct implementer of the HEP. As it became increasingly clear that C-Change would increase their level of effort on IR 1, it was important to collect data pertaining to reach to program beneficiaries. C-Change made considerable efforts to collect the data, and was more successful in the pilot region as they were the key implementers (together with MOHSS) in this region. As of April 2014, C-Change Namibia had difficulty obtaining data as the MOHSS were in the process of finalizing their Annual Report and data from newly implementing districts were being collated at regional level. In other regions where C-Change was providing TA for the HEP, the databases were not consistent with that of Kunene and only highlighted the cumulative Health Promotions activities conducted. These were not disaggregated by gender or health topic. (C-Change only considers Health Promotion conducted on HIV, Malaria and TB for its monitoring of program reach.)

PERFORMANCE INDICATORS, DEFINITION AND UNIT OF MEASUREMENT	DATA COLLECTION METHOD AND APPROACH	PROJECT TARGET AND RESULT
<p>with testing and counselling should not be counted here.</p> <p>Small group level interventions (GLI): Interventions that are delivered in small group setting (less than 25 people) and that assist clients in making plans for behavior change and appraisals of their own behavior. Small group can include a family or couple.</p> <p>Unit: # of individuals Disaggregated by gender and region</p>		
<p>3. # of eligible children provided with health care referral</p> <p><i>(Outcome level indicator)</i></p> <p>Definition: This indicator will measure the # of children referred to health services, primarily through the HEP.</p> <p>Unit: # of children Disaggregated by gender</p>	Information included in quarterly reports	<p>Target: 1063</p> <p>Result: Total: 1020 Male: 467 Female: 553</p> <p><i>Comments:</i> Data for Kunene Region from January 2013 to April 2014.<sup>2</sup></p>
PEPFAR Indicators: Health System Strengthening Sub Area 2: Human Resources for Health		
<p>4. # of community health and para-social workers who successfully completed a pre-service training program</p> <p>PEPFAR H.2.2.D <i>(Output level indicator)</i></p> <p>Definition: For this indicator the focus is on Community health and para-social workers (CHSW) (e.g., caregivers, peer educators, link workers, and lay counsellors) who complete pre-service training prior to entering the health workforce in his or her new position.</p> <p>Unit: # of community-health and para-social workers</p>	Program training data base	<p>Target: 350</p> <p>Result: 550</p> <p><i>Comments:</i></p> <ul style="list-style-type: none"> <li>• 5 regions, approximately 100 persons per region trained.</li> <li>• Gender data exists at NHTC</li> </ul>
<p>5. # of health workers who successfully completed an in-service training program</p> <p>PEPFAR H.2.3.D <i>(Output level indicator)</i></p> <p>Definition: This indicator focuses on health workers who complete an in-service training. In-service training programs are for practicing</p>	Program training data base	<p>Target: 40</p> <p>Total: 42</p>

<sup>2</sup> See Footnote 1.

PERFORMANCE INDICATORS, DEFINITION AND UNIT OF MEASUREMENT	DATA COLLECTION METHOD AND APPROACH	PROJECT TARGET AND RESULT
<p>providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfil their current job responsibilities. In-service training may update existing knowledge and skills, or add new ones. It requires a shorter, more focused period of time than pre-service education, and is often more hands-on. It can be a workplace activity (led by staff, peers or guest lecturers) or an external event.</p> <p>For the purposes of this indicator, health workers include the following:</p> <p>1) Clinical health workers – Clinical health workers play clinical roles in direct service delivery and patient care:</p> <p>a) Clinical professionals, including doctors, nurses, midwives, laboratory scientists, pharmacists, social workers, medical technologists, and psychologists; They usually have a tertiary education and most countries have a formal method of certifying their qualifications.</p> <p>b) Clinical officers, medical and nursing assistants, lab and pharmacy technicians, auxiliary nurses, auxiliary midwives, T&amp;C counsellors. They usually have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals.</p> <p>2) Non-clinical health workers - Non-clinical workers do not play clinical roles in a health care setting but rather include workers in a health ministry, hospital and facility administrators, human managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support.</p> <p>Unit: Number of health workers</p>		

PERFORMANCE INDICATORS, DEFINITION AND UNIT OF MEASUREMENT	DATA COLLECTION METHOD AND APPROACH	PROJECT TARGET AND RESULT
C-Change Custom Indicators		
<p>6. # of collaborating organizations that received technical support in the development, implementation, expansion and M&amp;E of the Namibia Global Health Initiative - Health Extension Program (HEP)</p> <p><i>(Output level indicator)</i></p> <p>Definition: Collaborating organizations (which include gov't, entities or sub-entities, NGO/CBO/FBOs or organizations within networks) that received technical assistance and/or training from C-Change to develop, implement, expand, and monitor and evaluate the HEP.</p> <p>Unit: # of collaborating organizations</p>	<p>Information included in training and technical support reports</p>	<p>Target: 4</p> <p>Result: 4</p> <p><i>Comments:</i></p> <ul style="list-style-type: none"> <li>• MOHSS/PHC</li> <li>• MOHSS/NHTC</li> <li>• MCHIP</li> <li>• UNICEF</li> </ul>
<p>7. # of finalized HEP training and field materials edited following the pilot training and submitted to the MOHSS for approval</p> <p><i>(Output level indicator)</i></p> <p>Definition: # of HEP training and field materials edited by C-Change following the pilot training and submitted to the MOHSS for approval</p> <p>Unit: # of HEP training and field materials</p>	<p>Information included in quarterly reports</p>	<p>Target: 6</p> <p>Result: 6</p> <p><i>Comments:</i></p> <p>HEP curriculum comprises of 6 Key documents:</p> <ul style="list-style-type: none"> <li>• Facilitators Guide</li> <li>• Handbook</li> <li>• Screening tool</li> <li>• M and Tool tools</li> <li>• Flipchart</li> <li>• Standards of Operation</li> </ul>
<p>8. # of HEP training and field materials review conducted</p> <p><i>(Output level indicator)</i></p> <p>Definition: This indicator measures the # of reviews conducted in collaboration with MOHSS and other partners regarding the HEP training and field materials currently employed.</p> <p>Unit: # of reviews</p>	<p>Information included in quarterly reports</p>	<p>Target: 1</p> <p>Result: 2</p> <p><i>Comments:</i></p> <p>Y1: Curriculum review following the Pilot in the Kunene region Y2: Curriculum review following initial HEP training in 6 regions.</p>

PERFORMANCE INDICATORS, DEFINITION AND UNIT OF MEASUREMENT	DATA COLLECTION METHOD AND APPROACH	PROJECT TARGET AND RESULT
<p>9. # of trainings conducted</p> <p><i>(Output level indicator)</i></p> <p>Definition: This indicator measures the # of training activities conducted by C-Change Namibia such as HEW refresher trainings, training of new HEW on HEP.</p> <p>Unit: # of Trainings</p>	<p>Program Training database</p>	<p>Target: 7</p> <p>Result: 11</p> <p>Comments:  Y1: HEP TOT (1 region - Kunene Regions)  Y2: HEP TOT (3 regions - Kunene, Kavango East and West, Zambezi regions)  HEW training (3 regions - Kunene, Kavango East and West, Zambezi regions)  M&amp;E refresher training (1 event – All regions)  Opuwo Refresher training – 1 NEW regions HEP Facilitator Training (2 events-Otjiwarongo and Ondangwa)</p>
<p>10. # of supervisory visits conducted to clinic and community sites</p> <p><i>(Output level indicator)</i></p> <p>Definition: # of field supervisory visits to clinics and communities in HEP intervention areas to strengthen HEW and supervisor performance</p> <p>Unit: # of supervisory visits conducted</p>	<p>Information included in quarterly reports</p>	<p>Target 12</p> <p>Result: 32</p> <p>Comments:  Increase in the supervisory visits during HEW assessments</p>
IR2: Improved quality of HIV prevention-focused social and behavior change interventions		
<p>11. # of collaborating national entities that received technical support to strengthen SBCC in national HIV prevention programs</p> <p><i>(Output level indicator)</i></p> <p>Definition: Collaborating national entities ( government, TWGs) that received technical assistance in SBCC program development, implementation, expansion and M&amp;E from C-Change to contribute to national SBCC programming in HIV prevention, such as national campaigns on VMMC, ART, SRH, HCT, key populations and PLHIV and on-going Health Promotion</p> <p>Unit: # of collaborating entities.</p>	<p>Information included in technical reports</p>	<p>Target: 5</p> <p>Result: 5</p> <p>Comments:  <ul style="list-style-type: none"> <li>• All MOHSS directorates count as a single entity</li> <li>• TWGs: SBCC, PHDP, HCT, Key Populations</li> </ul> </p>

PERFORMANCE INDICATORS, DEFINITION AND UNIT OF MEASUREMENT	DATA COLLECTION METHOD AND APPROACH	PROJECT TARGET AND RESULT
<p>12. # of SBCC program strategies developed with CSO partners</p> <p><i>(Output level indicator)</i></p> <p>Definition: SBCC program strategies that were developed by CSO with C-Change assistance.</p> <p>Unit: # of SBCC Strategies</p>	<p>Information included in technical reports</p>	<p>Target: 1</p> <p>Result: 1</p>
<p>13. # of Quality Improvement visits conducted with CSO partners and QI reports completed</p> <p><i>(Output level indicator)</i></p> <p>Definition: Quality Improvement visits that were conducted with CSO partners and reports completed</p> <p>Unit: # of QI visits and reports</p>	<p>Information included in technical reports</p>	<p>Target: 10</p> <p>Result:10</p> <p>Comment: In Y1 of AA, C-Change conducted 10 QI visits conducted with 3 partners: LL/CL, SFH, CAFO</p>
<p>14. % of collaborating entities that received technical support who have applied this acquired knowledge or skills in their organization</p> <p><i>(Outcome level indicator)</i></p> <p>Definition: Collaborating entities that received technical support and have applied this acquired knowledge or skills in their organization. Application would consist of updated program strategies, new organizational plans relating to advocacy, social mobilization and BCC in HIV programs, programs implemented and/or expanded and M&amp;E activities conducted as a direct result of C-Change TA.</p> <p>Unit: % of collaborating entities</p>	<p>Will be collected semi-annually through key informant interviews e.g. Manager, M&amp;E staff and program staff. Program documentation will be collected during this process.</p>	<p>Target:60%</p> <p>Result: 80%</p> <p>Comments:</p> <ul style="list-style-type: none"> <li>• All MOHSS directorates were counted as a single entity.</li> <li>• CSOs assisted include LL/CL, SFH, and CAFO.</li> <li>• PAN counts as a single entity</li> <li>• NANASO and its sub-recipients count as a single entity</li> </ul> <p>NANANSO and its SR are still in the process of revising their programs, so they have not been counted.</p>
<p>IR3: Strengthening the enabling environment for social and behavior change</p>		
<p>15. # of national SBCC quality standard documents and QI tools developed with the MOHSS</p> <p><i>(Output level indicator)</i></p> <p>Definition: SBCC quality standard documents and QI tools that were developed with the MOHSS for determining the quality of SBCC programs.</p>	<p>Information included in technical reports</p>	<p>Target: 2</p> <p>Result: 1</p> <p>Comments: National SBCC quality Improvement tool for MOHSS IEC division</p>

PERFORMANCE INDICATORS, DEFINITION AND UNIT OF MEASUREMENT	DATA COLLECTION METHOD AND APPROACH	PROJECT TARGET AND RESULT
Unit: # of documents and tools		
<p>16. # of QI visits conducted with the MOHSS to measure the quality of SBCC programs</p> <p><i>(Output level indicator)</i></p> <p>Definition: SBCC QI visits that were conducted with Health Promotion</p> <p>Unit: # of QI visits)</p>	Information included in technical reports	<p>Target: 1</p> <p>Result: 7</p> <p><i>Comments:</i> Based on demand by MOHSS/IEC</p>
<p>17. # of plans developed by CSO for advocacy and to address underlying factors negatively affecting SBCC program implementation</p> <p><i>(Output level indicator)</i></p> <p>Definition: Plans developed by CSO for advocacy and to address underlying factors negatively affecting program implementation</p> <p>Unit: # of plans</p>	Information included in technical reports	<p>Target: 4</p> <p>Result: 6</p> <p><i>Comments:</i> Y1 – 1 SBCC advocacy document for Key populations</p> <p>Y2 – 5 advocacy plans for PAN participants, including NLT, LL/CL, SFH, CAA, PV</p>
<p>18.% of collaborating entities who report an improvement in the quality of SBCC interventions following C-Change Technical Assistance</p> <p><i>(Outcome level indicator)</i></p> <p>Definition: % of collaborating entities that received technical assistance from C-Change and have reported an improvement in advocacy, social mobilization and/or BCC components in their HIV programs, as a direct result of C-Change TA.</p> <p>Unit: % of collaborating entities</p>	Will be collected semi-annually through key informant interviews e.g. Manager, M&E staff and program staff. Program documentation will be collected during this process.	<p>Target: 5</p> <p>Result: N/A</p> <p><i>Comments:</i> This data was not collected by C-Change, as C-Change scaled down activities related to IR2 and 3. In their program review, USAID's overall finding for IR2 and IR3 was that C-Change effectively built the capacity of local CSOs to create more targeted, evidence-based SBCC interventions but did not adequately meet M&amp;E needs for SBCC.</p>



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