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USAID/NAMIBIA: MID-TERM EVALUATION OF THE APCA PROJECT

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ACRONYMS

| | |
|---------|---|
| AIDS | Acquired immunodeficiency syndrome |
| ANC | Antenatal Care |
| APCA | African Palliative Care Association |
| ART | Antiretroviral Therapy |
| ARV | Antiretrovirals |
| CAA | Catholic AIDS Action |
| CBO | Community-based organization |
| CHBC | Community home-based care |
| COP | Country Operational Plan |
| DSP | Directorate of Special Programs |
| GH Tech | Global Health Technical Assistance Project |
| HBC | Home-based care |
| HBHC | Home-based health care |
| HIV | Human immunodeficiency virus |
| IMAI | Integrated management of adolescent and adult illness |
| IR | Intermediate Result |
| I-TECH | International Training & Education Center for Health |
| KII | Key informant interview |
| MER | Monitoring, evaluation, and reporting |
| M&E | Monitoring and evaluation |
| MOHSS | Ministry of Health and Social Services |
| MTE | Mid-term evaluation |
| NGO | Non-governmental organization |
| NHTC | National Health Training Center |
| NSF | National Strategic Framework |
| OD | Organizational development |
| OI | Opportunistic infection |
| PC | Palliative care |
| PDCS | Pediatric care and support |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PHC | Primary health care |
| PHE | Public Health Evaluation |
| PLHIV | People Living with HIV |

| | |
|---------|---|
| PLWHA | People Living with HIV and AIDS |
| PMP | Performance Monitoring Plan |
| RHAP | Regional HIV/AIDS Program |
| SOP | Standard of practice |
| TA | Technical assistance |
| TB | Tuberculosis |
| TKMOAMS | Tate Kalunga Mweneka Omukithi wo “AIDS” Moshilongo Shetu (“Our Mighty Father Protect Our Nation from the Deadly Disease ‘AIDS’ ”) |
| TOT | Training of trainers |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNAM | University of Namibia |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

EXECUTIVE SUMMARY

A mid-term evaluation (MTE) of the African Palliative Care Association (APCA) Project was conducted in Namibia between April 21 and May 10, 2012, to inform and strengthen activities currently implemented by APCA, as well as future USAID programming in basic care and support for adults and children living with HIV/AIDS, by determining the progress, efficiency, and effectiveness of APCA toward achieving the project's intermediate results.

BACKGROUND

Over the past several years, the HIV/AIDS epidemic has remained the greatest development challenge for Namibia, with an estimated 13.1% prevalence among the general population. According to 2010 data from UNAIDS, 6,663 AIDS deaths occur per annum. People living with HIV/AIDS ultimately develop chronic or progressive life-limiting illnesses for which culturally appropriate holistic palliative care (including effective pain management) is needed.

In 2009, USAID's Regional HIV/AIDS Program awarded APCA a bilateral Cooperative Agreement (674-A-00-09-001 12-00) for "Scaling up Palliative Care (PC) for People Living with HIV/AIDS (PLHIV)." The aim of this project was to support the provision of palliative care in selected countries through a public health approach that balances quality and coverage. USAID/Namibia pledged a total amount of US\$2,598,280 to this project in support of Namibia's effort to integrate PC into home-based care. To date, USAID/Namibia has obligated \$971,562.

The specific program objectives are:

- To identify and build a consensus on the needs and priorities of palliative care services at multiple levels of the health system in Namibia by 2009.
- To enhance participation in policy dialogue and advocacy for palliative care priorities by the Namibia task force nationally by 2009.
- To provide technical assistance to increase the capacity of key stakeholders in the implementation of palliative care by 2009.
- To support the development of a functional national palliative care association.

The response of APCA through this project is primarily facilitative, working in close collaboration with the Ministry of Health and Social Services (MOHSS) through local partners such as Catholic AIDS Action (CAA), Tate Kalunga Mweneka Omukithi wo "AIDS" Moshilongo Shetu (TKMOAMS), and other organizations providing community home-based care services in Namibia.

GOAL AND OBJECTIVES OF THE MTE

Goal of the evaluation: This mid-term evaluation seeks to inform and strengthen activities currently implemented by APCA, as well as future USAID programming in basic care and support for adults and children living with HIV/AIDS, by determining the progress, efficiency, and effectiveness of APCA toward achieving the project's intermediate results.

Specific objectives of the evaluation

- To examine the progress of APCA toward achieving results as mandated by APCA's agreement and outlined in the Performance Monitoring Plan (PMP).
- To assess the sustainability of APCA's activities and establish whether capacity-building activities of local organizations in PC have had a measurable impact on local organizations.
- To determine if APCA investments in Namibia are having a long-term impact on human resources for health.
- To explore how APCA's work in PC aligns with the current realities of the HIV response in light of extensive roll-out of antiretrovirals (ARVs) in Namibia, as well as the push for positive health, dignity, and prevention for PLHIV.
- To make recommendations for future directions of APCA support.

METHODOLOGY

GH Tech, with funding from USAID, commissioned two external consultants to conduct this mid-term evaluation in order to assess APCA's progress toward achieving the project's goals, APCA's effectiveness in supporting the MOHSS, and whether APCA's capacity-building and skills transfer will ensure long-term impact and sustainability.

Different approaches were used during the evaluation, with mainly qualitative information gathered and analyzed to address the evaluation objectives. Methods used included document review; in-brief planning meetings; key informant interviews (KIIs); group discussion; field site visits; review of data collected; mission debrief; partner debrief; and submission of reviewable draft reports.

Groups and individuals met included USAID/Namibia Activity Managers and other staff members; MOHSS and government structures (Community-based Health Division; PHC Directorate, Pharmaceutical Division, Tertiary Care Directorate, Directorate of Special Programs, the University of Namibia's Social Work Department and Nursing and Public Health Department); partners such as APCA and I-Tech; local NGOs and palliative care providers and structures (CAA, Tonata, TKMOAMS, volunteers); and beneficiaries (PLWHA) (See Appendix B). The data collection tools and discussion guide developed for this evaluation can be found in Appendix F.

EVALUATION FINDINGS

The findings are regrouped under each of the four evaluation questions and address (1) progress achieved toward the project's results; (2) effectiveness in supporting the MOHSS and local organizations; (3) capacity-building and skills transfer of local organizations; and (4) palliative care's fit into the current context of Namibia's response to HIV/AIDS.

Objective One: *To examine the progress of APCA toward achieving results as mandated by APCA's agreement and outlined in the Performance Monitoring Plan (PMP).*

The evaluation team found that significant progress was made toward achieving the project's results. A review of the APCA Monitoring Evaluation and Reporting (MER) plan shows that 26 out of 36 key activities included in the initial workplan are completed, and the outstanding 10

are in progress (See Appendix E). All persons interviewed stated that they found the training received from APCA beneficial. All the current implementing partners are reliable channels through which PC can be provided and promoted. From available data, CAA is providing care to 5,936 clients (1,671 males and 4,265 females) in the regions where they are providing services, and TKMOAMS has 800 clients under its care. Although Tonata is not a service delivery organization, it connects its 8000 members from 300 support groups to community-based organizations offering palliative care.

Selected accomplishments include: situational analysis of palliative care in Namibia; piloting of PC integration to HBC in two CAA sites (Rehoboth & Anamulenge); scaling-up of PC to an additional seven CAA sites, for a total of nine out of 11 planned; training of health professionals (PC nurses); PC training provided to volunteers already trained in HBC; ongoing mentoring, supervision, and support to sites/staff; facilitated clinical placement for trained health professionals at Island Hospice; ongoing support for training curricula development; policy documents, guidelines, and standards of practice (SOP) in development; support to the PC country taskforce and technical reference group on home-based care; and street surveys on end-of-life priorities and preferences conducted.

Objective Two: *To assess the sustainability of APCA's activities and establish whether capacity-building activities of local organizations in PC have had a measurable impact on local organizations.*

From a qualitative perspective, it appears that appreciable progress is being made on institutional sustainability of PC provision based on the number of trainings conducted, ongoing mentoring, biannual meetings, and the palliative care conference. However, a sustainable expansion of activities and impact on local organizations will require more managerial and leadership training and support for palliative care nurses, and the leadership of volunteers and support groups, as well as a stronger leadership and advocacy between health facilities, clinics, and NGOs.

At this midpoint of the implementation of its five-year project, APCA needs to develop an overall exit strategy and transition plan, beginning in Year 4, as the Year 3 Workplan currently in execution is already well advanced. Such a strategy can include sourcing funds from other donors beyond USAID (currently the sole donor), expanding fundraising capacity, transitioning functions to the National PC Association that needs to be created, and strengthening the capacity of local organizations to carry out PC implementation activities in the field.

Objective Three: *To determine if APCA investments in Namibia are having a long-term impact on human resources for health.*

To date, APCA, in close collaboration with the MOHSS and CAA, has ensured that all CAA palliative care nurses and health workers from the different regions have undergone palliative care training. (The training breakdown per category and per sex is provided in Appendix F). It is expected that the trainings will translate to improved quality of care for clients, based on a better understanding of palliative care by the service providers.

Training of Trainers (TOT) courses were provided to 24 nationals, including 14 female and 10 males, so that the need for external trainers will be limited. Efforts are also in progress to ensure integration of palliative care into pre-service curricula for nurses and social services students. This will ensure that graduating service providers will be equipped with the knowledge and skills to provide palliative care. While this mid-term evaluation is a performance evaluation, it is expected that all the cumulative efforts of the project will lead to long-term impact. With

the specialist-level training being provided to five CAA nurses who were enrolled to study for a diploma in palliative care at Hospice Africa Uganda and Makerere University in Uganda through a distance learning program, it is hoped that these nurses will develop a commitment to remaining and promoting palliative care services. However, this does not address the shortage of human resources for health in Namibia. Furthermore, the uncertainty of donor funding and the attractive wages offered by the MOHSS often tempt CAA nurses to resign even after training. Yet it remains important for the future of the program to develop human resources for health that can demonstrate personal and professional management and leadership, in addition to the necessary academic knowledge and technical skills.

Objective Four: *To explore how APCA's work in PC aligns with the current realities of the HIV response in light of extensive roll-out of antiretrovirals (ARV) in Namibia, as well as the push for positive health, dignity, and prevention for PLHIV.*

With the extensive roll-out of antiretroviral therapy (ART) and the increased availability of medications for PLHIV, the physical condition of patients has dramatically improved, which gives a false impression that the need for PC is decreasing. Because there remains no cure for the disease, or vaccine to prevent the infection, HIV infection may ultimately result in a range of serious physical/medical, spiritual, psychological, emotional, social, and economic stresses and challenges for the affected individual and family. ART may improve patients' physical/medical conditions, yet comprehensive treatment, care, and support, including palliative care with equitable access to non-discriminatory health care and other services which promote wellness and positive living for PLHIV, will still be needed. The initiation of ART does not preclude the need for palliative care. Clients suffering from AIDS-related cancers or the side effects of ART also require skilled palliative management. The policy on palliative care when finally developed is expected to outline how Namibia will address palliative care issues in patients with HIV in light of the ART roll-out. While ARVs are available in the country, access continues to be a challenge, particularly in remote communities, since the decentralization process of ART has yet to cover the entire country.

APCA is working closely with the MOHSS and all stakeholders for greater buy-in to the PC program, with a special attention to contextual issues. APCA's approach of supporting the MOHSS is based on the World Health Organization (WHO) Framework for Palliative Care. The framework requires that the following are in place:

- A government policy to ensure the integration of palliative care services into the structure and financing of the national health care system.
- An educational policy to provide support for the training of health care professionals, volunteers, and the public.
- A drug policy to ensure the availability of essential drugs—in particular, opioid analgesics for pain relief—for the management of pain, psychological distress, and other symptoms.

All of the above three measures are necessary, along with committed leadership, to achieve an effective palliative care program.

Another important aspect for APCA is adhering to the WHO definition for PC which describes palliative care as an approach that improves the quality of life for patients and their families facing the problems associated with life-threatening illnesses, through the prevention and relief

of suffering by means of early identification, impeccable assessment, and treatment of pain and other physical, psychological, and spiritual problems.

Other Evaluation Questions: *In addition to the four evaluation objectives, the team assessed a selected set of illustrative questions and made the following findings.*

1. Regarding performance against the stated project intermediate results, APCA's approved MER plan outlines the project's workplan with set targets that are revised yearly. At mid-course, monitoring and evaluation (M&E) documents reviewed show that more than 70% of planned activities have been completed and the remaining activities are making good progress (See Appendix E).
2. As part of plans to address human capacity needs, APCA is working to ensure that a training program incorporating PC is in place. APCA is also supporting the Polytechnic of Namibia to develop a modular training program in PC starting either at a certificate or diploma level. Staff from all local organizations which were visited have been trained. All of this continues to build capacity within the indigenous partners and the host government. However, there are gaps in the areas of management, leadership, coordination, and resource mobilization. APCA plans to support the MOHSS to develop palliative care centers of excellence in Windhoek and Oshakati Hospitals—centers which will be used for placements for students that are trained in palliative care. Currently, APCA will conduct training for UNAM lecturers, and it is expected that nurse managers/supervisors will be trained at the same time, too. An advocacy plan to be led by the task force was developed which will address several issues, including nurse prescribers, policy development, and decentralization of PC in district hospitals; strengthening mentorship to the regions; clinical placement for clinical mentorship; continuous education; and funding.
3. APCA has national coverage with the MOHSS. Challenges regarding pain management remain within MOHSS facilities; plans are under way to conduct pain sensitization meetings for regions. With community home-based care (CHBC) organizations, APCA's coverage is in 11 of the 13 regions. Three of the regions are new additions. There is no duplication with other partners' activities.
4. Regarding environmental compliance, the APCA program's impact on the environment is negative determination with considerations. In health facilities, the safe disposal requirements of the MOHSS for injections and other services are followed, and the CAA nurses and CHBC volunteers do not handle needles. However, a session on universal precautions and hygiene, which reviews the importance of such precautions in caring for ill persons—specifically, the proper disposal of body fluids, including sputum, and the importance of washing hands—was discussed and emphasized during the palliative care trainings.
5. The evaluation team believes that data provided by APCA is reliable. APCA uses and maintains a database in Microsoft Excel that captures information on the indicators in the MER plan and those on which APCA is required to report.
6. Regarding the relevance of current activities, palliative care is an important part of HIV/AIDS care, throughout the course of illness and at the end of life. It can be easily integrated with disease-modifying therapies such as ART. It offers both an interdisciplinary and a patient-centered approach, with a focus on the quality of life of the patients. HIV/AIDS palliative care looks at the physical, emotional, social, and spiritual aspects of the patient's life and tries to address each one in collaboration with the patient and his or her family. Palliative care also has much to offer in the psychosocial realm. Treatment of depression, psychosocial support for patients and families, and advance care planning all fall under

palliative care. Finally, palliative care has much to offer patients at the end of life. AIDS is still a significant cause of death. Some patients lack the support system to adhere to a complicated medication regimen.

With regard to these issues, current activities help ensure that health care providers receive education, training, and skills that not only help patients manage their illnesses, but also provide support for health professionals. The task-shifting agenda is also an important aspect that APCA promotes by encouraging the task force to learn from other experiences like in Uganda.

CHALLENGES

Some of the challenges facing APCA that may have delayed the implementation of some activities are listed below and should be addressed as the project unfolds.

- Inadequate understanding of palliative care. Findings from the situation analysis revealed that some health workers perceived palliative care as end-of-life care or care for terminally ill persons, while some referred to it as pain management. Varying definitions of palliative care were also made by interviewees during the study. There is still a lot of unresolved debate in Namibia on what palliative care means.
- Funding delays from the USAID/Southern Africa Office have slowed initiation of some of the project's activities. Additionally, APCA does not receive funds directly in country as it must wait for transfers from its headquarters in Kampala. All of these factors sometimes lead to delay in program implementation, and even to outright cancellation of planned activities.
- APCA's Technical Officer resigned, which has impeded the progress of some activities, especially those involving HBC organizations like the CAA biannual meetings. To date, APCA has engaged consultants for the short term to support the Namibia office where possible. Interviews are now in process to fill this position.
- Referral systems are weak. According to findings from the situation analysis, referral systems (that are sometimes formal and sometimes informal) exist in the overwhelming majority of the regions; however, there is no consistent referral process or criteria. Bi-directional referral forms have been developed by the MOHSS, but have yet to be disseminated, and the referral forms in the HBC standards have not been used effectively. There is typically a lack of feedback post-referral, and the quarterly CHBC regional forum at which some of these issues can be addressed and resolved is not regularly held in some regions. Another challenge with the referral system is that of transportation to the place referred, which is often too costly for clients to use.
- The limitation on nurses' prescription of opioids, as well as physicians' limited awareness of available options of stronger pain management medications, have become serious issues.
- Alcohol abuse among clients was mentioned as a barrier to care at all the places visited, since such abuse leads to missed clinic appointments and non-adherence. A review, "Behavioral and Contextual Factors Driving the Epidemic HIV/AIDS in Namibia," carried out by Measure Evaluation and Macro International, mentions numerous surveys conducted in Namibia that have consistently shown significant positive correlations between the frequency of alcohol consumption and having multiple or concurrent

partners.¹ This association between alcohol consumption and multiple partners is high among young women. The team was informed that some clients consume alcohol as a means of suppressing hunger. Also, the locally brewed drinks are reasonably cheap (50 Namibian cents per liter), so a client may not necessarily buy the alcohol, but will be offered it by friends.

- Non-replenishment of HBC kits (MOHSS circular exists which authorizes community health volunteers to come to health facilities to replenish their HBC kits but not all nurses and health workers adhere to the circular. Some facilities are still not cooperating and are not working in close collaboration with volunteers and palliative care nurses from the NGOs. Although APCA is not directly involved in service delivery, lack of HBC kits makes the work of the trained community volunteers and palliative care nurses difficult.
- Restructuring by the MOHSS is affecting the pace of progress and coordination of some planned activities with APCA, as it is uncertain into which department palliative care will eventually be incorporated. APCA has had to re-engage with new staff in the MOHSS many times in order to convince them of the importance of palliative care. Administrative procedures at the MOHSS level can be more complex and take longer than anticipated. In addition, competing priorities could become a challenge, as limited human resources in the MOHSS will need to respond to different partners and meet their targets and deadlines.
- Conflict with older belief systems (*Katima*) regarding illness and death can influence care and adherence. The team gathered that a majority of people within the community believe that whatever illness they have—including a diagnosis of HIV—is the result of a curse or witchcraft. The influence of such beliefs on health-seeking behavior and adherence to care and medication, particularly for those on ART, should be studied.

RECOMMENDATIONS

Based on the findings of the mid-term evaluation, the team proposes the following recommendations:

- Ensure that greater efforts are made within the MOHSS to improve the understanding of PC as defined by WHO and to promote its integration within Namibia's overall health system.
- Recruit competent technical staff to fill vacant positions at APCA. The recruitment of a competent technical staff by APCA is critical so that appropriate technical assistance can be offered to the MOHSS and other implementing partners.
- Improve funds release processes between the USAID/Southern Africa Office and APCA headquarters, as well as from APCA headquarters to the Namibia office, to avoid delay or cancellation of planned activities.

¹ Rimal, R. N., and R. A. Smith. 2006. Namibia HIV/AIDS Strategic Information Report: A baseline household analysis of residents from Gobabis, Grootfontein, Omaruru, and Otjiwarango. And a midterm household analysis of residents from Oshikuku, Oniipa, and Rehoboth. Baltimore, MD: Johns Hopkins Bloomberg School of public Health/Center for Communication Programs.

- Continue to work and collaborate with the MOHSS and other partners for full integration of palliative care at all levels (pre-service, NHTC, HBC). As highlighted in the National Strategic Framework (NSF), efforts should continue toward integration of palliative care within existing structures. It is important to promote synergy between the Directorate of Special Programs (DSP) and Primary Health Care (PHC) to ensure smooth integration of the services.
- Ensure that necessary training at all levels is provided and that required policy and regulation changes are made in order to address nurses' SOP regarding opioids, as well as to increase physician awareness of stronger pain management options.
- Advocate with the MOHSS to ensure speedy and timely finalization and implementation of planned activities. This is critical toward ensuring that time line and planned activities are undertaken as and when due.
- Work with the MOHSS to review composition of the PC task force to include key line ministries (gender, local government education, tertiary institutions, and operational staff working in oncology services and hospices).
- Continue to work with partners to ensure efficient referral mechanisms, supervision, monitoring, record-keeping, and reporting. The referral system should be fully supported and enforced by the MOHSS and all stakeholders involved at the different levels.
- Integrate PC into in-service training and pre-service training in order to ensure that health workers have the necessary PC skills, which will also strengthen the referral systems between community and health facilities.
- Continue collaboration with relevant partners and other stakeholders to address the issue of alcohol abuse as it affects adherence to ART and behavior change.
- Improve reporting mechanisms so that implementing partners regularly report not only to APCA, but also to the MOHSS, which will help the ministry track palliative care progress in Namibia.
- Undertake a study with partners and stakeholders to examine how cultural and religious beliefs influence adherence and care.
- Continue to work with the MOHSS to create a national PC association for Namibia. This association should develop appropriate structures to advocate for PC as it becomes a strong, sustainable organization capable of championing PC in the country for years to come.
- The shortage of human resources for health in Namibia is a serious matter that requires coordinated efforts from the MOHSS and key partners at all levels. One solution could be to increase the number of health professionals trained in task-shifting and multitasking.
- Technical assistance should go beyond technical training to include management and leadership. A sustainable expansion of activities and their impact on local organizations will require more managerial and leadership training and support for palliative care

nurses. Leadership training for volunteers and support groups, as well as stronger leadership and advocacy between health facilities, clinics, and NGOs, is also important.

- CAA services sites rely heavily on volunteers for implementation of their activities. Coordinating, supervising, and monitoring volunteers is thus a priority. Incentives for volunteers could take the form of T-shirts, umbrellas, and other items outlined in the plan.
- Recommendations to USAID for future programming could include:
 - Support APCA within this project in order to conduct a palliative care situation analysis in Namibia, since there still is little awareness and consensus about the definition and nature of palliative care among both health care workers and the general public. Also, the needs of individuals requiring palliative care in Namibia are evolving with the extensive roll-out of ART. Such a study should assess and inform all the variables that influence the understanding and definition of palliative care in Namibia. This will require mapping the roles and responsibilities of all the actors and stakeholders involved directly or indirectly in palliative care in Namibia.
 - Ensure that a program evaluation is conducted to assess the long-term impact of APCA's work. Factors to focus on should include improvements in patient care and increased access to palliative care services, with appropriate medicines available where trained health workers practice. Such an evaluation should include population or household-based surveys combined with health facility or service provider assessments.

CONCLUSION

The mid-term evaluation team was impressed both by APCA's progress toward achieving its goals in the very short period of time that has elapsed since the project started, and by the staff and volunteers the team met who were involved in the project. The APCA project is making a valuable contribution toward advancing PC services provision in Namibia. Technical assistance (TA) is being provided to key stakeholders, and significant progress is being made toward the achievement of each of the project's objectives. A survey conducted by APCA on public priorities and preferences for end-of-life care in Namibia shows high preferences for home and hospital. Therefore, as APCA strengthens the referral systems between communities and facilities, it may be useful to promote day care and hospice services, as well. The recommendations made in this report are meant to help APCA better focus its efforts in achieving long-lasting impact on Namibian PLHIV lives. Palliative care remains a collaborative effort that requires greater partnership and networking to be integrated into the overall response to HIV/AIDS in Namibia. Such integration will ensure a better quality of life for PLHIV and others with chronic life-limiting illnesses.

I. INTRODUCTION

BACKGROUND

HIV/AIDS and Palliative Care in Namibia

Namibia is one of the southern African countries greatly affected by the HIV/AIDS epidemic since it was first reported in the country in 1986. According to the 2010 HIV sero-sentinel survey, HIV prevalence among pregnant women attending antenatal care (ANC) was reported to be 18.8% with an estimated 13.1% prevalence among the general population. The epidemic appears to be unevenly distributed—varying from 4.2% in the lowest-infected regions, up to 35.6% in the more densely populated areas such as Katima Mulilo, Oshakati, and Engela along the northern borders with Angola, Botswana, and Zambia.² These are tourist and commercial areas as well as border entry and exit points where a huge migratory labor population takes temporary residence. There is a higher risk in this population of engaging in multiple and concurrent sexual partners, and in drinking heavily. Also, polygamy and low circumcision rates are common in these northern areas.

| HIV/AIDS in Namibia (2009–2011) | |
|--|-----------|
| Population, 2011 | 2,100,000 |
| People living with HIV/AIDS | 180,000 |
| Adults (aged 15+) with HIV/AIDS | 160,000 |
| Women (aged 15+) with HIV/AIDS | 95,000 |
| Children (aged 15-) with HIV/AIDS | 20,000 |
| Children with HIV/AIDS, 2009 | 16,000 |
| Adult HIV prevalence (%), 2009 | 13.1 |
| Orphans due to AIDS (aged 17-) | 70,000 |
| AIDS deaths, 2010 | 6,663 |
| Source: Population Reference Bureau & UNAIDS (2009–2010) | |

In 2009, an estimated 180,000 Namibians were living with HIV/AIDS, among whom 20,000 were children aged less than 15. The same year, 6,700 people lost their lives and 70,000 were orphaned due to HIV/AIDS. This situation requires a greater and sustained attention to prevention, treatment, care, and support. Most of the individuals affected/infected are likely to suffer from chronic life-limiting illnesses and long-term psychosocial stresses.

In the earlier years of the epidemic when antiretroviral drugs were not available, most clients were supported through home-based care services to relieve suffering and provide care and support. Palliative care for people living with HIV/AIDS and other chronic life-limiting illnesses commenced in 2007 in Namibia. The concept is still evolving and has yet to be fully integrated into existing services. Namibia's population of 2.1 million is highly dispersed, creating challenges in accessing services and reaching remote populations.

National Policy Framework

Since the beginning of the epidemic in 1986, several efforts have been made by government and non-governmental organizations to address prevention of new infections, as well as the treatment, care, and support of those infected and affected by the epidemic. Palliative care is one of the efforts initiated to support people living with HIV/AIDS, including those with other chronic illnesses such as cancer.

² Namibian Ministry of Health and Social Services. *Report on the 2010 National HIV Sentinel Survey*. November 2010.

The first National AIDS Control Program was established in 1990 just after independence, and was followed by three Medium-Term Plans that have guided the country's expanded multisectoral and multilevel response to the HIV/AIDS epidemic. More recently, a National Strategic Framework (NSF) for HIV/AIDS 2010/2011 to 2015/2016 was developed, with a paradigm shift on planning that went from the previous focus on services delivery to a more holistic approach seeking to understand how service delivery efforts can lead to positive changes in the lives of affected populations. This NSF identifies national priorities, highlights holistic and integrated approaches, and sets agreed-upon targets that all stakeholders will collectively contribute to achieve. Strategic interventions cover areas such as prevention; treatment; care and support, including palliative care; impact mitigation; and resources management.

The National AIDS Policy³ recognizes the importance of palliative care as part of a comprehensive response to the epidemic. The document states that quality palliative care is a right of all, with an accompanying need for the appropriate drugs to meet the clinical requirements of clients. The Namibian Ministry of Health and Social Services (MOHSS) also appointed a Senior Health Administrator for Palliative Care and Opportunistic Infections to take the lead in the development and inclusion of palliative care in the recently revised National Policy on HIV/AIDS.

AFRICAN PALLIATIVE CARE ASSOCIATION'S RESPONSE

In 2009, USAID's Regional HIV/AIDS Program awarded the African Palliative Care Association (APCA) a bilateral Cooperative Agreement (674-A-00-09-001 12-00) for "scaling up palliative care (PC) for people living with HIV/AIDS (PLHIV)."

The aim of this project was to support the provision of palliative care in six countries—Lesotho, Malawi, Namibia, Swaziland, Tanzania, and Uganda. The award focused on the PEPFAR technical areas of adult care and support (HBHC) and pediatric care and support (PDCS). USAID/Namibia pledged a total amount of US\$2,598,280 to this project in support of Namibia's effort to integrate PC into home-based care. To date, USAID/Namibia has obligated \$971,562. This five-year project with a start date of October 1, 2009, and an end date of September 30, 2014, is a follow-on award to a sub-award with APCA under a regional award with Partnership Collaborating Together (PACT).

In Namibia, it is expected that this five-year program will provide a mechanism for sustained development, including an ongoing sustainability plan that seeks to enable the country to build the structures and technical ability to continue scaling up palliative care with minimal support from APCA after the five years. At that time, it is expected that support from APCA will shift from direct technical support and capacity-building to more of a coordination role, as befits a regional umbrella organization. Throughout the five years of project implementation, APCA will be working closely with the MOHSS, as well as community-based organizations such as Catholic AIDS Action (CAA) and other key palliative care providers and organizations to ensure on-the-ground capacity development for future sustainability.

Project Goals and Objectives

The overall aim of the APCA agreement is to contribute to Namibia's response to the HIV/AIDS epidemic by scaling up provision of palliative care services through a public health approach that strives to balance quality and coverage. The specific program objectives are:

³ Namibian Ministry of Health and Social Services. *National Policy on HIV/AIDS*. March 2007.

- To identify and build a consensus on the needs and priorities of palliative care services at multiple levels of the health system in Namibia by 2014
- To enhance participation in policy dialogue and advocacy for palliative care priorities by the Namibia task force nationally by 2014
- To provide technical assistance to increase the capacity of key stakeholders in the implementation of palliative care by 2014
- To support the development of a functional national palliative care association.

The response of APCA through this project is primarily facilitative, working in close collaboration with the MOHSS, through local partners such as CAA, TKMOAMS, and other organizations providing community home-based care services in Namibia. APCA provides technical assistance and support to the MOHSS and CAA as well as other partners to advance the implementation of palliative care in the country.

MID-TERM EVALUATION OBJECTIVES

This mid-term evaluation is a performance evaluation of palliative care for people living with HIV/AIDS for the African Palliative Care Association's (APCA) project. The evaluation, which is descriptive, identifies the progress made with regards to program performance, accountability, lessons learned, challenges, and best practices, as well as the extent to which the intermediate results (IRs) were achieved.

Goal of the Evaluation

This mid-term evaluation seeks to inform and strengthen activities currently implemented by APCA, as well as future USAID programming in basic care and support for adults and children living with HIV/AIDS, by determining the progress, efficiency, and effectiveness of APCA toward achieving the project's intermediate results.

Objectives of the Evaluation

- To examine the progress of APCA toward achieving results as mandated by APCA's agreement and outlined in the Performance Monitoring Plan (PMP).
- To assess the sustainability of APCA's activities and establish whether capacity-building activities of local organizations in PC have had a measurable impact on local organizations.
- To determine if APCA investments in Namibia are having a long-term impact on human resources for health.
- To explore how APCA's work in PC aligns with the current realities of the HIV response in light of extensive roll-out of antiretrovirals (ARVs) in Namibia, as well as the push for positive health, dignity, and prevention for PLHIV.
- To make recommendations for future directions of APCA support.

Illustrative Key Questions to be Addressed by the Team

1. How has APCA performed against the stated project IRs? If not, why and what remedies are recommended? If so, why, and are there best practices?
2. Has APCA strengthened the capacity of local partners to implement palliative care in the context of HIV/AIDS? Review the programmatic benchmarks and standards used for each organization. Were they successful?
3. What is the progress of capacity-building within the indigenous partners and the host government? What human capacity needs remain? Is there a transition plan to host country ownership or an exit strategy? Has APCA made progress toward facilitating the creation of a National Palliative Care Association?
4. Describe the challenges and successes of each technical area—adult care and support and pediatric care and support.
5. Is there duplication of activities with other partners?
6. Assess the coverage, reach, and quality of services provided by APCA and its partners.
7. Are there best practices or innovations documented from APCA's activities?
8. To what extent does APCA maintain and monitor its environmental compliance requirements as stipulated in the agreement?
9. What is the quality of data provided by APCA's programs?
10. What is the relevance of current activities?

Period under Review for the Evaluation

The period covered in the mid-term evaluation is the start of the award (October 1, 2009) to the end of the first quarter of FY 2012 (December 31, 2011).

II. METHODOLOGY

GH Tech, with funding from USAID, commissioned two external consultants to conduct this mid-term evaluation in order to assess APCA's progress toward achieving the project's goals, APCA's effectiveness in supporting the MOHSS, and whether APCA's capacity-building and skills transfer will ensure long-term impact and sustainability (See Appendix A).

Different approaches were used in conducting the evaluation with mainly qualitative information gathered and analyzed to address the evaluation objectives. Methods used are listed as follows.

PREPARATION PHASE

- *Document review.* Documents related to the project were reviewed to obtain insight into the program's goals, objectives, key indicators, progress year by year, management and managerial processes, and program strategies and approaches.
- *In-brief planning meetings.* The team held planning meetings with USAID/Namibia in order to share background, experiences, and expectations for the assignment, and to formulate a common understanding of the assignment, as well as to clarify roles and responsibilities.
- *Tool development and revision of evaluation schedule.* Semi-structured interview guides were developed, and the evaluation agenda was discussed and amended.

FIELD WORK PHASE

- *Key informant interviews (KII).* KIIs were held with project staff and key stakeholders, including the MOHSS. A semi-structured interview guide was developed to explore variables and ensure that comparable information would be obtained from the stakeholders.
- *Group discussion.* Group discussions were held with some volunteers, who were asked about the usefulness of the program to them, and to identify the challenges and priorities that they felt need attention.
- *Field site visits.* The team visited different implementation sites to observe and to elicit information regarding program relevance, efficiency and sustainability, as well as the benefits, challenges, and limitations experienced in the course of program implementation. The sites visited were selected using criteria for good geographical, epidemiological, and technical coverage of the project.

REPORTING PHASE

- *Review of data collected.* The qualitative data collected were analyzed.
- *Report outline/Preparation of draft report.* The report outline was developed and submitted for approval by USAID/Namibia for review and approval, while the report was prepared based on the findings of the evaluation.

- *Mission debrief.* A PowerPoint presentation was made to the mission to highlight key findings, challenges, and recommendations. Comments from the mission were incorporated into the report.
- *Partner debrief.* A PowerPoint presentation was also made to key partners in order to highlight key findings and validate information presented, challenges, and recommendations. Comments from the partners were incorporated into the final report.
- *Submission of reviewable draft report.* Prior to departing Namibia, the consultants submitted a reviewable draft report to USAID/Namibia addressing key findings, conclusions, recommendations, and other items outlined in the draft report outline.

SAMPLE SELECTION

The evaluation targeted key stakeholders and palliative care structures and providers at central, regional, and peripheral (district and community) levels. Categories of people met included:

- *USAID/Namibia* (Activity Manager)
- *MOHSS and government structures* (community-based health PHC Directorate, Tertiary Care, Pharmaceutical, Directorate of Special Programs, the University of Namibia's Social Work Department and Nursing and Public Health Department)
- *Partners* (APCA, I-Tech)
- *Local NGOs and palliative care providers and structures* (CAA, Tonata, TKMOAMS, volunteers)
- *Beneficiaries* (See Appendix B for a list of persons contacted.)

Data Collection Tools

Data collection tools were developed. Among these was a *semi-structured interview guide* for different target groups:

- *MOHSS officials* and government structures
- *APCA*
- *CAA* and other NGOs
- *PLHIV* support group

Places Visited

The team visited the following sites for key informant interviews, group discussions, and site observations:

| Places | Regions |
|----------------------|----------------|
| Windhoek | Khomas |
| Rehoboth | Hardap |
| Oshakati | Oshana |
| Ongwediva | Oshana |
| Oshikuku | Omusati |
| Anamulenge | Omusati |
| Rundu | Kavango |
| Katima Mulilo/Bukalo | Caprivi |

III. FINDINGS

This section addresses the mid-term evaluation objectives and questions as stated in the scope of work. The section first presents the findings regarding progress toward achieving the APCA project goals as listed in the workplan. It assesses APCA's effectiveness in supporting the MOHSS and local organizations for the implementation of PC in Namibia. Then the section examines local organizations' capacity-building and skills transfer to ensure long-term impact and sustainability. Lastly, the section explores how PC continues to fit into the Namibian response to HIV/AIDS in the context of an extensive roll-out of ART and drug availability for opportunistic infections (OI).

EVALUATION OBJECTIVE I

To examine the progress of APCA toward achieving results as mandated by APCA's agreement and outlined in the Performance Monitoring Plan (PMP).

At mid-course, a review of the Monitoring, Evaluation, and Reporting (MER) plan as outlined in Appendix E shows that more than 70% of planned activities are completed, and that those outstanding are making good progress.

I.1. Project Objective One: To identify and build a consensus on the needs and priorities of palliative care services at multiple levels of the health system in Namibia by June 2014.

The MOHSS and key partners in Namibia's response to HIV/AIDS have identified a significant need for palliative care while recognizing at the same time the current limitation in availability of those services. The first objective of the project builds on the work that APCA has been doing since its establishment in Namibia in 2006, and is addressed through activities that support the scaling-up of palliative care in Namibia. This objective focuses on APCA's technical assistance to key stakeholders in training and education, advocacy and organizational development, and in support of the development of a functional national palliative care task force.

Findings

Support to CAA: Until last year, CAA was the main implementing partner of the APCA project in the provision of PC at community levels. During the period covered in this evaluation, APCA continued to provide supervision and mentorship support to CAA and facilitated the scale-up of CAA sites implementing PC from its two pilot sites to an additional nine, out of the eleven sites targeted. It has not been possible so far to cover all eleven sites due to an inability to recruit the PC nurses required by the team. The entire field staff interviewed during the evaluation expressed appreciation for the support provided by APCA, which had helped them better understand palliative care. These staff has initially understood PC as end-of-life care or care for the terminally ill person. They have now come to understand that palliative care involves holistic care, not just for physical needs, but for spiritual and psychosocial needs, bereavement counseling, and pain management. This has led to an improved quality of care and services for their clients.

| Clients Served in Palliative Care to Date (May 2012) | | | |
|---|----------------|---------------|--------------|
| Office | Clients | | |
| | Male | Female | Total |
| Anamulenge | 274 | 802 | 1,076 |
| Caprivi | 288 | 608 | 896 |
| Keetmanshoop | 152 | 242 | 394 |
| Mariental | 64 | 168 | 232 |
| Okatana | 314 | 774 | 1,088 |
| Omaheke | 61 | 187 | 248 |
| Oshikuku | 214 | 654 | 868 |
| Rehoboth | 65 | 139 | 204 |
| Rundu | 239 | 691 | 930 |
| Total | 1,671 | 4,265 | 5,936 |

Planned biannual meetings of all those involved in service delivery could not be held during the period October 2010–September 2011 due to delayed release of funds from the USAID/Southern Africa Office to APCA. These meetings offer an opportunity to palliative care providers to share their experiences and challenges, and to reach consensus on how to address them.

The development and piloting of a model for referrals from health facilities to community-based organizations providing home-based care was planned as part of the activities in the October 2009–September 2010 action plan, and was to be led by the Primary Health Care (PHC) Division within the MOHSS.

To date, it has yet to be completed and be fully functional. The model was to be developed in such a way that community volunteers and caregivers would recognize and refer cases beyond their capacity to trained health professionals in health centers/clinics with better capacity to handle palliative care cases. In situations where the case is beyond professionals at the health center/clinic level, further referral would be made to hospitals with specialists or to more specialist palliative care services such as hospices. It is also expected that referrals could be made either by community volunteers or health professionals to spiritual leaders, social workers, or even psychologists when a client has spiritual or psychosocial problems that cannot be managed clinically.

Bi-directional referral forms have been developed but have yet to be disseminated and put to use, while health care providers have not yet received orientation to ensure the effective use of such forms when they become available. In some of the sites visited, there is no mechanism for feedback, so there is no way of knowing if a referral was actually completed. It appears that IntraHealth is helping the Directorate of Special Programs develop another referral form, while the Directorate of PHC has completed one that is more focused on home-based care standards. It is important to promote dialogue between these departments within the MOHSS so that the forms can be consistent with each other.

Training has been conducted for the two new CAA districts in collaboration with the MOHSS and other service providers as planned. The trainings were conducted using the new draft national PC curriculum. In addition, training has also been conducted for all CAA regional coordinators and senior administrative staff. To date, all PC nurses and regional coordinators have thus received training in PC. In addition to CAA personnel, all regional managers in the DSP and PHC Directorates have been trained. The National Health Training Centre was also part of the training as some participants were trained and sent to Island Hospice. Two trainers received training of trainers (TOT) in palliative care.

The review of the palliative care training to integrate it into a standardized national training has yet to be finalized. This is due to staff changes both in CAA and APCA. The trainings for community workers that have been held to date have used the generic APCA training curriculum and handbook on introduction to palliative care.

Support to the MOHSS: A meeting was held in July 2010 with stakeholders to share lessons learned from the CAA program. The meeting brought together palliative care providers (organizations and individuals). Participants decided that the MOHSS should support the implementation of palliative care and should train personnel to offer PC services, as well as provide mentorship and ongoing supervision to ensure quality service delivery. The issue of scope of practice of nurses with regard to opioids was a major issue that will require policy and regulation changes to address. Promising steps are being taken in advocating for the reclassification of palliative care medicines in order to make them more accessible, along with influencing the necessary policy and legal framework to allow nurses to prescribe palliative care medicines.

I.2 Project Objective Two: To enhance participation in policy dialogue and advocacy for key identified palliative care priorities by the Namibia task force nationally and regionally by 2014.

The focus of this objective is to establish and strengthen a national PC task force with committed and influential members that can champion the implementation of the national palliative care advocacy strategy. When the project was designed, it was felt that special attention should be given to the production of core palliative care documents (policies and guidelines) that set the standards for all levels of care and that can be used as a national reference document for palliative care. It is important that palliative care be integrated into standards of care in settings such as home-based care, antiretroviral therapy, and prevention of mother-to-child transmission.

Findings

Regarding advocacy and technical assistance to support the national task force and strategy, the evaluation team found that a PC national task force chaired by the MOHSS was established in 2007 with membership drawn from different units and institutions engaged in PC. An action plan has been developed which includes approval for nurse prescribers, particularly those trained in palliative care, to be able to prescribe and administer morphine for their clients in severe pain. However, the team was informed that this is currently not within their scope of practice and will therefore require changes in policy and regulation. The palliative care task force has been functional to date. Discussions with some members indicate that so far representation has been more Windhoek-based and as such needs to be reviewed in order to include key line ministries such as gender, local government, tertiary institutions, and some operational people from the oncology unit and hospice, as well as regional representation.

The APCA conference held in 2010 was held with high-level representation at the opening and closing ceremonies. The conference provided an excellent opportunity for palliative care advocacy in Namibia and helped to bring issues of palliative care to the forefront, as well as stimulate interest among health care workers and other service providers in the subject. It also led to better understanding of palliative care through the presentations made during the conference. Some of the key outcomes from the conference are as follows.

- Many in-country partners from Namibia became re-energized in their work, and other people have become involved in palliative care either through training or service delivery.
- The conference provided an opportunity to all the PC stakeholders from Namibia and beyond to come together and discuss palliative care, make presentations on their work, and learn from their colleagues about palliative care developments in their respective countries.

In addition, a media briefing has been held for correspondents. Observance of the annual World Health Palliative Care Day every October 14th has not yet been held in Namibia even though it is outlined in the APCA workplan as a forum to be used for advocacy and awareness of PC.

For the review and development of national policies and guidelines on palliative care in Namibia, the team found that while the National Policy on HIV/AIDS contains three statements promoting drug availability in palliative care as a right for all, they are not detailed enough. Efforts to develop a national palliative care policy were in progress but stalled when the government issued a directive that additional policies should not be developed. This directive was reversed in 2011, and renewed efforts are ongoing to have a PC policy in place. Draft guidelines and a standard operating procedure (SOP) have been developed, but must go through several stages before being approved and becoming operational. APCA is committed to continued support of the MOHSS to move the national palliative care policy and guidelines through the process until their final ratification and approval.

The country adaptation of palliative care standards initially planned for Year 2 of the project has been placed on hold because, according to the MOHSS, it was more appropriate first to develop the policy before proceeding to the country adaptation of palliative care standards. One critical issue here is whether palliative care should be part of the Directorate of Community-Based Health and Primary Health Care under which the community home-based care program is coordinated, or if it should remain in the Directorate of Special Programs (DSP), which is HIV/AIDS-specific. The team was informed that they are hopeful that the ongoing restructuring by the MOHSS will address this issue and allow expedited implementation of activities.

1.3. Project Objective Three: To provide technical assistance to increase the capacity of key stakeholders in the implementation of palliative care.

A critical component of this project is to increase the technical and managerial capacities of key stakeholders in the implementation of palliative care services through education and training.

It was anticipated that APCA will continue to work with I-Tech and the national training committee to integrate palliative care into ongoing educational strategies. Moreover, it was planned that the project will integrate palliative care into all relevant pre-service training curricula, including physicians, nurses, social workers, and religious leaders. In addition, APCA was gradually to build the capacity of local organizations in providing palliative care, and to undertake placements as part of their training. The project was also supposed to increase the capacity of the training staff faculty of nursing at the University of Namibia (UNAM) for in-service training provision.

Findings

Training of a core group. APCA had planned to train a core group of health workers and MOHSS personnel. This was done, and all the health professionals identified for this activity have undergone the two-week palliative care training using the APCA generic training curriculum since the national curriculum has not yet been developed.

For clinical placement, all the CAA nurses (old and new) except one have undergone the clinical placement at Island Hospice in Zimbabwe. Island Hospice is a center of excellence and offers the nurses an opportunity to gain practical exposure in palliative care. All the nurses who met with the team had gone for the clinical placement. They found the experience to be beneficial and expressed satisfaction for what they had observed and learned in practice.

| Health Workers and Volunteers Trained in Palliative Care to Date (May 2012) | | | |
|--|-------------|---------------|--------------|
| | Male | Female | Total |
| Health workers trained in palliative care | 112 | 598 | 710 |
| Volunteers trained in palliative care | 254 | 1,358 | 1,612 |

The biannual meetings are used as a forum for follow-up/refresher training for nurses. Usually, nurses are requested to identify areas needing update prior to the meeting, and experts in those areas then make presentations during the meeting. However, as stated earlier, these meetings were not held regularly during the period under evaluation due to delayed funds release by USAID to APCA.

Integration of palliative care into pre-service training curriculum. It was scheduled that APCA would provide technical assistance with regard to integration of palliative care into pre-service training curricula and the integrated management of adolescent and adult illness (IMAI) palliative care module for the University of Namibia (UNAM), the National Health Training Centre (NHTC), the International University of Management, and the Polytechnic. So far, APCA is collaborating with I-Tech and the MOHSS on this activity, which is ongoing. Progress was delayed in developing the curriculum due to hiccups on the APCA end in terms of the materials required for input in relation to what Namibia wanted as a country. After the initial delays, the Island Hospice approach had to be adapted, and for now the content and methodology are ready with a first pilot of the curriculum held in June 2011 and a review meeting held in November 2011. Based on comments from the participants at the first pilot, job aids are being developed to complement the document. It is expected that a second pilot will take place probably in June 2012. APCA has also worked with the Social Work Department within the Faculty of Humanities at UNAM to integrate palliative care in their teaching to third-year social work students. The department is currently teaching palliative care using the draft national PC curriculum and other palliative care materials provided by APCA.

The palliative care training for the Faculty of Nursing at UNAM and for NHTC personnel has been postponed due to staff scheduling conflicts. So far, one staff member from the UNAM and two from NHTC have attended the TOT workshop on palliative care.

With regard to the training of two health professionals to attain a specialist level in palliative care, six persons were identified and paid to complete the course. One individual died in a traffic accident; two graduated; and three are attending the course. APCA was expected to provide

resources in the APCA office to the students. However, while the palliative care standards have been made available to them, other materials have been provided only based upon request. APCA has continued to provide support for the students engaged in distance learning while in-country mentorship remains ongoing.

I.4. Project Objective Four: To support the development of a functional palliative care country task force or national association by 2014.

Under this objective, APCA was expected to support the development of a functional palliative care country task force or national palliative care association in Namibia. This was to be done by providing TA for organizational development (OD) and training to current national task force members so that they could become champions of PC. Activities under this sub-objective included: (a) a review of the recommendations from previous OD and the strategic plan for the task force/national palliative care association, with wider stakeholders; (b) identification of training needs with regard to OD and training of the task force; (c) implementation of the strategic plan and workplan for the task force/national palliative care association; and (d) registration of the national association.

Findings

APCA is a member of the palliative care task force as well as the Community Home-Based Care Reference Group. These are coordinated by the MOHSS and have continued to function as the most appropriate venue to share experience and coordinate the collaborative effort to advance PC and HBC integration in Namibia. A small committee has been established to define terms for the setting up of a national association on palliative care. APCA then plans to help the association develop an infrastructure in order to undertake PC advocacy. APCA sees the association as a source for PC funding both locally and internationally, as well as becoming a strong sustainable organization capable of championing palliative care in Namibia.

APCA is also considering an option of transitioning the local APCA office into a national association. This idea was partly discussed at an advocacy follow-up training for task force members, but will be further discussed at the wider task force meeting. It is hoped that before the terminal date of this award the national association will be in place with the registration process completed.

I.5. Project Objective Five: To conduct a palliative care public health/program evaluation in Namibia by 2014.

There is little awareness of and consensus on the nature and definition of palliative care among both health care workers and the general public. Also, the needs of individuals requiring PC in Namibia are evolving with the extensive roll-out of ART. It is therefore important for APCA to undertake a palliative care public health evaluation (PHE) in Namibia.

Although the palliative care PHE in Namibia was included in the workplan for APCA, it was not approved. According to APCA, this was due to the inadequate number of PC providers in Namibia to replicate the PHE that had been done in Uganda and Kenya. A decision thus was made to concentrate on the situation analysis as a substitute for the public health evaluation. The funds for the PHE, according to APCA, were reprogrammed by USAID/RHAP. In addition to the situation analysis, APCA also conducted a street survey on public priorities and preferences for end-of-life care in Namibia.

Findings

A street survey to explore the priorities and preferences of the Namibian public with regard to end-of-life care, death, and dying was conducted during the last quarter of 2010. Approximately 200 people were interviewed in Windhoek's central business district, and also in Katutura township. The latter was chosen because of the diversity of its inhabitants, which would allow preferences to be recorded based on cultural differences. The results of the survey were shared with the MOHSS and USAID.

Survey respondents reported pain to be their greatest concern; hence the need to ensure proper pain management. The hospital (48%) and respondents' own homes (32%) were their preferred places to die, while only 11% of the respondents expressed a desire to die in a hospice. The implications of these preferences require strengthening linkages/referrals between health facilities/clinics and the community/home through the community-based organizations such as CAA that are working through volunteers to provide care within communities.

Conclusion of Evaluation Objective One

The evaluation team found that significant progress was being made toward achieving the project's goals. All the individuals met by the team said that they found their APCA training to be helpful because it improved their knowledge of PC and their skill in administering it, resulting in better care of their clients. All the current implementing partners are viable channels through which palliative care can be provided and promoted. The work started with the MOHSS (policy, guidelines, and standards development and review), the University of Namibia (pre-service training), and I-Tech (training curriculum development and in-service training) is making good progress.

Selected accomplishments include:

- Situational analysis of palliative care in Namibia.
- Piloting of PC integration to HBC in two CAA sites (Rehoboth & Anamulenge).
- Scaling-up of PC to an additional seven CAA sites, leading to a total of nine out of 11 planned.
- Training of health professionals (PC nurses).
- PC training provided to volunteers already trained in HBC.
- Ongoing mentoring, supervision, and support to sites/staff (tools are available for this purpose).
- Facilitating clinical placement for health professionals at Island Hospice.
- Ongoing support for training curricula development.
- Policy document, guidelines, and standards of practice (SOP) in development.
- Support to the PC country task force and Technical Reference Group.
- Street survey on end-of-life priorities and preferences.

EVALUATION OBJECTIVE II

To assess the sustainability of APCA's activities and establish whether capacity building activities of local organizations in PC have had a measurable impact on local organizations.

Because this is the mid-term evaluation of a five-year project, it is difficult to ascertain the sustainability and long-term impact of activities carried out by the project so far. The evaluation assessed the project's sustainability by examining the technical and institutional capacity of local organizations or implementing partners to continue PC activities beyond the life of the APCA program. From a qualitative perspective, it appears that appreciable progress is being made in institutional sustainability based on the number of trainings conducted, ongoing mentoring, biannual meetings, and the palliative care conference. Meeting the social needs of the community volunteers and PC clients is critical to their care since government and the NGOs cannot meet all of their needs. During the trainings, community volunteers and nurses were encouraged to promote the creation of income-generating activities for their patients and caregivers.

APCA expects to develop institutional sustainability by creating a cadre of well-trained PC human resources at all levels of the Namibian health system. Palliative care training has been provided to almost all implementing partners or local organizations' nurses and volunteers. Refresher courses are being provided on schedule. All the individuals met by the team said that the training provided was appropriate and useful since it had broadened their technical skills and improved their confidence and ability to effectively provide needed services to their clients. Support is being provided for in-service and pre-service training, which will increase the awareness, skills, and availability of future qualified health workers.

Another way APCA expects to develop institutional sustainability is by contributing to the development, review, and implementation of policies, guidelines, and standards, as well as helping develop curricula and other training materials and job aids. APCA has also developed good working relationships with all key public and private stakeholders involved in palliative care within the Namibian health system. Close collaboration with the MOHSS and partnerships with multiple institutions are strengthening the sustainability of APCA's activities and increasing its impact.

In spite of the progress made by APCA to date, the organizational development plan for the partners is not yet in place, and the pre-service training has yet to commence. In addition, the referral model is not fully functional, while the national PC association remains an unreach goal. All these are critical for sustainability.

Conclusion of the Evaluation Objective Two

At this midpoint of the implementation of its five-year project, APCA needs to develop an overall exit strategy and transition plan, beginning with its Year 4 Workplan for September 2012–October 2013. Such a strategy could include broadening funding sources to include other donors; expanding fundraising capacity; transitioning functions to the national PC association that will be created; and strengthening local organizations' capacity to carry out palliative care activities in the field, as well as ensuring adequate numbers of national trainers.

EVALUATION OBJECTIVE III

To determine if APCA investments in Namibia are having a long-term impact on human resources for health.

The main areas of focus for APCA include building capacity of the MOHSS and local partners for integrating palliative care into HBC programs; educating service providers and local advocates on palliative care; creating awareness of PC among different stakeholders, including policymakers and the media; and developing a PC curriculum.

To date, APCA in close collaboration with the MOHSS and CAA has ensured that all CAA palliative care nurses and health workers from the different regions have undergone PC training. Training support from APCA was considered by interviewees to be useful as it has helped PC nurses and other health workers to gain a better understanding of the palliative care concept, as well as to build self-confidence in their work. Clinic nurses and managers from all the regions have been trained. However, this training was done before the curriculum was developed using the Island Hospice training curriculum. Following development of the curriculum, public-sector health workers will be trained through NHTC, UNAM, and MOHSS in-service trainings. APCA has also trained health workers and other stakeholders from the MOHSS in palliative care, advocacy skills, and data collection.

Some nationals have attended a TOT course, so the need for external trainers will be limited, and the long-term impact increased. Many CAA volunteers and staff from the sites of Caprivi, Mariental, Okatana, and Rundu were mentored and supervised in providing palliative care. These mentorships were designed to empower local teams to undertake future supervision roles, and were conducted by a team from APCA, CAA, and Island Hospice in Zimbabwe.

Specialist-level training was also provided to five CAA nurses who enrolled to study for a diploma in palliative care at Hospice Africa Uganda and Makerere University in Uganda through a distance learning program. During the past year, three nurses sat for their exams in Windhoek. The nurses also attended clinical placement sessions under the supervision of specialists with the Oncology Units in Windhoek and Oshakati. These placements gave the nurses a period of hands-on practical involvement in holistic patient care during which they were part of a multi-disciplinary palliative care team, and actively participated in patient care. The nurses stated that the experience was extremely positive and allowed them to move from purely book knowledge to application in a very practical manner. The experience also gave them an opportunity to reflect on the importance of patient referrals for pain management.

In addition, APCA organized a study visit to Uganda for senior pharmaceutical services in order for the team to observe the delivery of palliative care in practice, as well as to experience firsthand the handling and prescription of opioids by nurses in Uganda. One Health Council staff member was supported by APCA. Later, APCA conducted a one-day advocacy training for 12 task force members during Quarter I to build upon their palliative care knowledge and to equip them with better skills to drive PC at the national level.

Efforts are ongoing to integrate PC into pre-service training curricula and the NHTC program, which will have positive impacts on human resources in this aspect of care.

Conclusion of the Evaluation Objective Three

The long-term impact of APCA’s work in Namibia is and will be demonstrated in the improvements in patient care and increased access to palliative care services, including medicines within sites where the trained health workers practice. For instance, this information can be obtained from the different CAA sites where the trained nurses and community volunteers practice after having received training and support supervision by APCA. Even though the tools used to collect information at this level did not allow an understanding on a scale of 1 to 10 of the level of improvement of practitioners’ skills, most nurses and volunteers interviewed stated that their caregiving skills improved thanks to the PC training they received through APCA.

The numbers of trained health workers (nurses and community volunteers) have increased the pool of health professionals with the knowledge and skills to provide quality palliative care services in a wider area of the country—which means that more people with life-threatening illnesses are accessing better PC services.

Technical assistance from APCA is still needed at the national level since the TOT will continue to be necessary even after the project concludes. However, it is important for the future of the program to develop human resources for health that, in addition to the necessary academic and technical preparation, demonstrate personal and professional management and leadership skills. This requires capacity-building in management, planning, and leadership, as well as in the technical specialty area of palliative care and home-based care.

EVALUATION OBJECTIVE IV

To explore how APCA’s work in PC aligns with the current realities of the HIV response in light of extensive roll-out of antiretrovirals (ARVs) in Namibia, as well as the push for positive health, dignity, and prevention for PLHIV.

The availability of ART in Namibia has led to great improvements in the health of many PLHIV, which has led in some cases to the false notion that palliative care is no longer required. Although the ART medications are available, access to this therapy in some hard-to-reach areas and remote communities is still a major challenge. The ongoing decentralization of ART services does not yet cover the entire country. Because there remains no cure for HIV or vaccine to prevent HIV infection, HIV-infected people will ultimately develop a range of serious physical/medical, spiritual, psychological, emotional, social, and economic stresses and challenges that will require palliative care. ART may improve patients’ physical/medical conditions. But comprehensive treatment, care, and support, with equitable access to non-discriminatory health care and other services promoting wellness and positive living for people living with HIV, will still be needed.

| Service Providers and People on ART | |
|--|--|
| Total number of service providers, excluding volunteers trained by APCA on different aspects of palliative care, is 710 (598 females and 112 males). | |
| Number of people on ART is 88,841, with more females than males. Number of pediatrics accessing ART is 18,266. | |
| <i>Sources: APCA program report & MOHSS electronic patient monitoring system</i> | |

The Government of the Republic of Namibia recognizes the importance of palliative care for PLHIV and other chronic and life-limiting illnesses. This recognition and support is clearly stated in the Government's recent National Policy on HIV/AIDS, as follows:

- All patients shall be provided with adequate and effective palliative care at all times.
- Appropriate training and resources shall be made available to care providers.
- Appropriate pain medication shall be made available at the appropriate level in the health system and community, and personnel shall be trained in a step-wise approach to pain management which will include relevant narcotic medication when indicated.

Despite the availability of ART, as well as opportunistic infection and palliative care medicine for PLHIV, access remains a problem both from the clients' and the providers' perspectives.

On the one hand, clients' access problems may include the distance to the health facility; the cost of transportation; getting to areas that are hard to reach during flooding; and alcohol abuse, which can cause clients not to adhere to their medication and/or fail to show up for treatment and appointments. All the people met during the field visits mentioned alcohol abuse as an issue of concern. Another area of concern expressed by those whom the team met was non-adherence among some young HIV-positive clients (OVC), particularly those without a guardian, who live with elderly grandparents, or whose parent(s) have yet to disclose their status.

On the other hand, the primary access problem for providers occurs when the client comes to a health facility for a refill of medication but does not meet the health worker, either because of competing priorities, since one staff person in the facility is usually responsible for other programs, and/or a shortage of staff, which leads to long waiting hours and large patient turnover. Additionally, outreach services do not yet cover all PHC facilities, which can impede access to services for clients in remote communities.

All the individuals interviewed confirmed that the palliative care program remains highly relevant despite the availability of ART, since clients on ART still need the following services:

- Adherence counseling in order to reduce the number of clients who will fail and then need to be on a second-line regime. [Although previous studies⁴ have concluded that adherence to ART is high in Africa (68%–99% of patients took at least 95% of their medicines), the need for adherence counseling remains⁵].
- Addressing disclosure issues, particularly for young HIV-positive clients who either refuse outright to take their medication or who default. It is often difficult for parents of HIV-positive children and adolescents who are on medication to disclose their status and openly discuss the whole HIV/AIDS issue with them.
- Behavior change communication (some clients abandon their medications once they feel better, only to fall sick again shortly thereafter).

⁴ World Health Organization. 2007. Palliative Care. Cancer Control Knowledge into Action: WHO Guide for Effective Programmes.

⁵ Gill, C.J., D.H. Hamer, J.L. Simon, D.M. Thea, and L.L. Sabin. "No Room for Complacency about Adherence to Antiretroviral Therapy in Sub-Saharan Africa." *AIDS*, 19(12): 1243–1249 (2005).

- Addressing family planning issues with HIV-positive clients and promoting linkages for such services.
- Nutritional supplements (in some cases). Poverty remains prevalent in Namibia, and some PLWHA and others with chronic life-limiting illnesses have lost their sources of livelihood. These clients will need disability support and linkages with such services with the assistance of volunteers/NGOs.
- Addressing alcohol misuse and abuse. This was mentioned as a barrier to care in all the places visited because it leads clients not to adhere to their medications and to default on their treatment and appointments.
- General monitoring of the client's health condition.

During this evaluation, access to pain medication was noted as an important issue to be monitored. APCA supported the MOHSS to organize a pain management sensitization workshop in Windhoek last year. The workshop aimed at increasing awareness of the need for and appropriate administration of opioids by health workers to control pain, and was attended by 48 health workers, including doctors, nurses, social workers, and pharmacists. Doctors at regional levels have not yet been trained to assess pain adequately or to prescribe the proper medication to alleviate it. The importance of this training cannot be overemphasized. Clients need stronger medications for their pain, and access to it is a challenge caused by the policy regarding its prescription. Even the availability of morphine tablets is not widely known by all doctors. There is also the issue of "opiophobia," which makes physicians reluctant to prescribe opioids. Currently, opioids are inaccessible at units below the district hospitals, and strict control of morphine sometimes results in the prescription of weaker, less controlled analgesics.

Workshops for the other 12 regions are expected to be held in 2012. The MOHSS has since continued its effort to increase availability and access to pain medication, mainly opioids. Now the MOHSS and other relevant government structures are pushing for an amendment to Regulation No. 36 of the Medicines and Control Act of 2003, which would authorize registered nurses who have undergone one year of PC specialist training as part of task-shifting to handle and prescribe oral liquid morphine and slow-release morphine tablets.

Conclusion of the Evaluation Objective Four

Palliative care provides physical, psychological, social, emotional, and spiritual care during incurable illness and is integral to a comprehensive care strategy for people living with HIV/AIDS. The initiation of ART does not preclude the need for palliative care. AIDS-related cancers and side effects of antiretrovirals also require skilled palliative management.

It is important for a sustainable palliative care program to be established in Namibia in order to empower local partners to engage in national decision-making processes, especially when it comes to drug legislation. Based on the needs identified with regard to the continued relevance of palliative care, APCA must ensure that (1) it redesigns its programs in the remaining period of the award to integrate PC where necessary; and (2) it addresses PC in its trainings and during advocacy with policymakers. APCA will also need to leverage resources and create synergies, as well as more closely collaborate with multiple stakeholders in areas not within APCA's core competence. APCA must also continue to work closely with the MOHSS and all stakeholders for greater buy-in to the palliative care program, paying special attention to contextual issues. APCA should build upon the broad partnerships it has established with all key players and

continue the approach it has used for training curricula and methods, as well as policy or guideline standards development. The National Policy on HIV/AIDS currently being developed will outline how Namibia will address PC issues in patients with HIV in light of the ART roll-out, but this does not mean that palliative care has become irrelevant.

ENVIRONMENTAL ISSUES

Environmental issues do not apply to APCA as the project is not involved directly in service delivery. However, a session on universal precautions and hygiene, which reviews the importance of hygienic precautions in caring for ill persons—more specifically, the proper disposal of body fluids, including sputum, and the importance of hand-washing—is included in the PC trainings.

CHALLENGES

Some of the challenges facing APCA that may have delayed implementation of various activities are listed below and should be addressed as the project unfolds.

- *Inadequate understanding of palliative care.* Findings from the situation analysis revealed that some health workers perceived palliative care as end-of-life care or care for terminally ill persons, while some referred to it as pain management. Varying definitions of palliative care were also made by interviewees during the study. There is still a lot of unresolved debate in Namibia on what palliative care means.

| Useful Definitions |
|---|
| Community Home-Based Care: The holistic, comprehensive care of clients that extends from the health facility to the client’s home through family participation and community involvement, using available resources and in collaboration with the health worker. It encompasses clinical care, nursing care, palliative care, counseling and psycho-spiritual care, and social support. |
| Community-Based Health Care: A strategy to operationalize and ensure effective community participation in primary health care. It addresses all aspects of health care (preventive, promotive, curative, and rehabilitative) at the community level, and it may address issues such as environmental health, reproductive health, training of community members, and income-generating activities. |
| Palliative Care: An approach that “improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment of treatment of pain and other problems, physical, psychological, and spiritual.” ⁶ |
| <i>(Taken from the MOHSS, National Community Home-Based Care Standards, March 2010 & APCA Standards for providing quality palliative care across Africa)</i> |

- The Technical Officer of APCA resigned, which has delayed the progress of some activities, especially those involving HBC organizations, such as the CAA biannual meetings, and the training of volunteers. APCA has engaged consultants for the short term to support the Namibia office where possible. Interviews are now in process to fill the Technical Officer position.

⁶ WHO 2002. <http://www.who.int/cancer/palliative/definition/en/>. Accessed May 2012.

- Referral systems are weak. According to findings from the situation analysis, referral systems (that are sometimes formal and sometimes informal) exist in the overwhelming majority of the regions; however, there is no consistent referral process or criteria. Bi-directional referral forms have been developed by the MOHSS, but have yet to be disseminated, and the referral forms in the HBC standards have not been used effectively. There is typically a lack of feedback post-referral, and the quarterly CHBC regional forum at which some of these issues can be addressed and resolved is not regularly held in some regions. Another challenge with the referral system is that of transportation to the place referred, which is often too costly for clients to use.
- APCA claims to have continued to advocate for a proper, functional referral system. When community volunteers are trained, they are always encouraged to send cases requiring referral to health professionals in facilities with greater capacity. Nurses and other health workers are given the same instruction, and the importance of the referral system has been emphasized through the trainings. According to APCA, the challenge is that the referral system has not been fully supported and enforced by the MOHSS and stakeholders. APCA staff believe that once the referral system is supported by the MOHSS, it will cease being weak and become effective.
- The restriction on nurses' prescription of opioids, as well as physicians' limited awareness of available options of stronger pain management medications, has become a serious issue requiring both further training and policy and regulation changes.
- Alcohol abuse among clients was mentioned as a barrier to care at all the places visited, since such abuse leads to missed clinic appointments and non-adherence. A review, "Behavioral and Contextual Factors Driving the Epidemic HIV/AIDS in Namibia," carried out by Measure Evaluation and Macro International, mentions numerous surveys conducted in Namibia that have consistently shown significant positive correlations between the frequency of alcohol consumption and having multiple or concurrent partners.⁷ This association between alcohol consumption and multiple partners is high among young women. The team was informed that some clients consume alcohol as a means of suppressing hunger. Also, the locally brewed drinks are reasonably cheap (50 Namibian cents per liter), so a client may not necessarily buy the alcohol, but will be offered it by friends.
- Non-replenishment of HBC kits (circular exists but not adhered to in all regions). Some facilities are still not cooperating and are not working in close collaboration with volunteers and palliative care nurses from the NGOs.
- Funding delays from RHAP have temporarily halted some project activities. Additionally, APCA does not receive funds directly in-country as it must wait for transfers from its headquarters in Kampala. These factors sometimes lead to delay in program implementation, or even cancellation.

⁷ Rimal, R. N., and R. A. Smith. 2006. Namibia HIV/AIDS Strategic Information Report: A baseline social network analysis of residents from Gobabis, Grootfontein, Omaruru, and Otjiwarango And a midterm analysis from Oshikuku, Oniipa, and Rehoboth. Baltimore, MD: Center for Communications Programs, Johns Hopkins Bloomberg School of Public Health.

- Restructuring by the MOHSS is affecting the pace of progress and coordination of some planned activities with APCA, as it is uncertain into which department palliative care will eventually be incorporated. APCA has had to re-engage with new staff in the MOHSS many times in order to convince them of the importance of palliative care. Administrative procedures at the MOHSS level can be more complex and take longer than anticipated. In addition, competing priorities could become a challenge, as limited human resources in the MOHSS will need to respond to different partners and meet their targets and deadlines, as well as APCA's.
- Conflict with older belief systems (*Katima*) regarding illness and death can influence care and adherence. The team gathered that a majority of people within the community believe that whatever illness they have—including a diagnosis of HIV—is the result of a curse or witchcraft. The influence of such beliefs on health-seeking behavior and adherence to care and medication, particularly for those on ART, should be studied.

IV. RECOMMENDATIONS

Based on the findings of the mid-term evaluation, the team proposes the following recommendations:

- Ensure that greater efforts are made within the MOHSS to improve the understanding of PC as defined by WHO and to promote its integration within Namibia's overall health system.
- Recruit competent technical staff to fill vacant positions at APCA. The recruitment of a competent technical staff by APCA is critical so that appropriate technical assistance can be offered to the MOHSS and other implementing partners.
- Improve the funds release processes between the USAID/Southern Africa Office and APCA headquarters, as well as from APCA headquarters to the Namibia office, to avoid delay or cancellation of planned activities.
- Continue to work and collaborate with the MOHSS and other partners for full integration of palliative care at all levels (pre-service, NHTC, HBC). As highlighted in the National Strategic Framework, efforts should continue toward integration of palliative care within existing structures. It is important to promote synergy between the Directorate of Special Programs and PHC to ensure smooth integration of the services.
- Ensure that necessary training at all levels is provided and that required policy and regulation changes are made to address nurses' SOP regarding opioids, as well as to increase physician awareness of stronger pain management options.
- Advocate with the MOHSS to ensure speedy and timely finalization and implementation of planned activities. This is critical toward ensuring that time line and planned activities are undertaken as and when due.
- Work with the MOHSS to review composition of the PC task force to include key line ministries (gender, local government education, tertiary institutions, and operational staff working in oncology services or hospices).
- Continue to work with partners to ensure efficient referral mechanisms, supervision, monitoring, record-keeping, and reporting. The referral system should be fully supported and enforced by the MOHSS and all stakeholders involved at the different levels.
- Integrate PC into in-service training and pre-service training in order to ensure that health workers have the necessary PC skills, which will also strengthen the referral systems between community and health facilities.
- Continue collaboration with relevant partners and other stakeholders to address the issue of alcohol abuse as it affects adherence to ART and behavior change.
- Improve reporting mechanisms so that implementing partners regularly report not only to APCA, but also to the MOHSS, which will help the ministry track palliative care progress in Namibia.

- Undertake a study with relevant partners and stakeholders to examine how cultural and religious beliefs influence adherence and care.
- Continue to work with the MOHSS to create a national PC association for Namibia. This association should develop appropriate structures to advocate for PC as it becomes a strong, sustainable organization capable of championing PC in the country for years to come.
- The shortage of human resources for health in Namibia is a serious matter that requires coordinated efforts from the MOHSS and key partners at all levels. One solution could be to increase the number of health professionals trained in task-shifting and multitasking.
- Technical assistance should go beyond technical training to include management and leadership. A sustainable expansion of activities and their impact on local organizations will require more managerial and leadership training and support for palliative care nurses. Leadership training for volunteers and support groups, as well as stronger leadership and advocacy between health facilities, clinics, and NGOs, is also important.
- CAA services sites rely heavily on volunteers for implementation of their activities. Coordinating, supervising, and monitoring volunteers is thus a priority. Incentives for volunteers could take the form of T-shirts, umbrellas, and other items outlined in the plan.
- Recommendations to USAID for future programming could include:
 - Support APCA within this project in order to undertake a palliative care public health evaluation in Namibia, since there still is little awareness and consensus about the definition and nature of palliative care among both health care workers and the general public. Also, the needs of individuals requiring palliative care in Namibia are evolving with the extensive roll-out of ART.
 - Ensure that a program evaluation is conducted to assess the long-term impact of APCA's work. Factors to focus on should include improvements in patient care and increased access to palliative care services, with appropriate medicines available where trained health workers practice.

V. CONCLUSIONS

The mid-term evaluation team was impressed both by APCA's progress toward achieving its goals in the very short period of time that has elapsed since the project began, and by the staff and volunteers the team met who were involved in the project. The APCA project is making a valuable contribution toward advancing PC services provision in Namibia. Technical assistance is being provided to key stakeholders, and significant progress is being made toward the achievement of each of the project's objectives. The recommendations made in this report are meant to help APCA better focus its efforts in achieving long-lasting impact on Namibian people living with HIV and AIDS and the systems that support them.

Sustainable expansion of APCA activities in Namibia will require:

- More advocacy with the MOHSS to ensure speedy and timely implementation of planned activities.
- Greater technical assistance support (both technical and managerial) to implementing partners by undertaking the Organizational Development Plan.

The team would like to conclude its report by emphasizing that palliative care remains a collaborative effort requiring strong partnerships and networks to advocate for PC and improve the Namibian response to HIV/AIDS. In addition to integrating PC with home-based care services, APCA should strengthen referral systems between communities and facilities, and promote day care and hospices services. This will ensure a better quality of life for people living with HIV/AIDS and others with chronic life-limiting illnesses.

APPENDIX A. SCOPE OF WORK

GH Tech Bridge Project Contract No. AID-OAA-C-12-00004 SCOPE OF WORK

(Revised April 14, 2012)

- I. **TITLE:** USAID/Namibia Mid-term Evaluation for African Palliative Care Association's (APCA) Project "Palliative Care for People Living with HIV/AIDS."
- II. **PERFORMANCE PERIOD:** Not including time for preparation and completion of report, two to three weeks in-country during on/about April 16 to o/a May 22, 2012.
- III. **FUNDING SOURCE:** This assignment will be funded by USAID/Namibia.
- IV. **PURPOSE AND OBJECTIVES:**

Namibia is one of the Sub-Saharan African countries at the epicenter of the HIV epidemic. According to the 2010 National HIV Sentinel Sero-Survey, HIV prevalence was 18.7% with an estimated national of 13.4%. To help reduce the spread and impact of HIV/AIDS, USAID/Namibia has supported capacity building of the Government of the Republic of Namibia (GRN) and local non-governmental organizations to increase access to HIV/AIDS prevention, treatment, care, and support services.

In 2009, the USAID Regional HIV/AIDS Program awarded APCA a bilateral Cooperative Agreement (674-A-00-09-00112-00) for "Scaling Up Palliative Care (PC) for People Living with HIV/AIDS (PLHIV)," to which USAID/Namibia has made some investments to provide support to Namibia. This five-year project has a start date of October 1, 2009, and an end date of September 2014 with USAID/Namibia contributing US\$2,598,280. The project is a follow-on award to a sub-award with APCA under a regional award with Partnership Collaborating Together (PACT).

The current award focuses on the following PEPFAR technical areas: Adult Care and Support (HBHC) and Pediatric Care and Support (PDCS).

The goal of the APCA award is to "contribute to the response to the HIV/AIDS epidemic by scaling-up PC provision through a public health approach that strives to balance quality and coverage in each target country".

To achieve the immediate results in Namibia, APCA had the following sub-objectives:

Sub-Objectives:

1. To identify and build a consensus on the needs and priorities of PC services at multiple levels of the health system in Namibia by June 2014.
2. To enhance participation in policy dialogue and advocacy for key identified PC priorities by the Namibia task force nationally and regionally by 2014.
3. To provide technical assistance to increase the capacity of key stakeholders in the implementation of PC by 2014.

4. To support the development of a functional PC country task force or national association by 2014.
5. To conduct a PC public health evaluation in Namibia by 2014.

APCA has been working with the Ministry of Health and Social Services (MOHSS), through local partners such as Catholic AIDS Action, Tonata, and other organizations providing community home-based care services in Namibia.

Goal of the Evaluation

This mid-term evaluation seeks to inform and strengthen activities currently implemented by APCA, as well as future USAID programming in basic care and support for adults and children living with HIV/AIDS, by determining the progress, efficiency, and effectiveness of APCA toward achieving the project's intermediate results.

Objectives of the Evaluation:

- To determine the progress of APCA toward achieving results as mandated by APCA's agreement and outlined in the Performance Monitoring Plan (PMP).
- To determine the sustainability of APCA's activities and establish if capacity-building activities of local organizations in PC have had measurable impact on local organizations.
- To determine if APCA investments in Namibia are achieving a long-term impact and the impact of those investments on human resources for health.
- To probe how APCA's work in PC aligns with the current realities of the HIV response in the light of extensive roll-out of anti-retrovirals (ARVs) in Namibia as well as the push for positive health dignity and prevention for PLHIV.
- To make recommendations for future directions of APCA support.

Key Implementation Issues:

The evaluation will include visits to activities and/or facilities or interviews with personnel that require GRN concurrence. USAID/Namibia will work with the respective Ministries to obtain such concurrence.

Period Under Review for the Evaluation:

From the start of the award (October 1, 2009) to the end of the first quarter of FY 2012 (December 31, 2011).

V. SCOPE OF WORK

Illustrative key questions to be addressed by the team:

1. How has APCA performed against the stated project intermediate results? If not, why and what remedies are recommended? If so, why and are there best practices?
2. Has APCA strengthened the capacity of the local partners to implement palliative care in the context of HIV/AIDS? Review the programmatic benchmarks and standards used for each organization. Were they successful?
3. What is the progress of capacity-building within the indigenous partners and the host government? What human capacity needs remain? Is there a transition plan to host country

ownership or an exit strategy? Has APCA made progress toward facilitating the creation of a National Palliative Care Association?

4. Describe the challenges and success made in each technical area—adult care and support and pediatric care and support.
5. Is there duplication of activities with other partners?
6. Assess the coverage, reach, and quality of services provided by APCA and its partners.
7. Are there best practices or innovations documented by APCA's activities?
8. To what extent does APCA maintain and monitor its environmental compliance requirements as stipulated in the agreement?
9. What is the quality of data provided by APCA's programs?
10. What is the relevance of current activities?

Methodology

USAID/Namibia will hold team planning meetings (TPM) with the evaluation team during the first days of the team's in-country field work. The timing and length of the meetings will be determined by USAID/Namibia in consultation with the evaluation team. This time will be used to clarify team roles and responsibilities, deliverables, development and finalization of tools and the approach to the evaluation, and refinement of agenda. In the TPM, the team will:

- Share background, experience, and expectations for the assignment.
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities.
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion.
- Develop and finalize data collection methods, instruments, tools and guidelines, and methodology and develop an assessment timeline and strategy for achieving deliverables.
- Develop a draft report outline for Mission review and approval.

The evaluation team will use a variety of methods for collecting and analyzing qualitative and quantitative information and data. The following essential elements should be included in the methodology as well as any additional methods proposed by the team:

Document Review

Prior to arriving in country and conducting field work, the team will review various project documents and reports. A list of key documents will be provided by USAID/Namibia prior to consultants' in-country work. The list may include, but will not be limited to, the following:

1. Baseline program data on APCA cooperative agreement and predecessor sub-award under PACT regional award
2. Cooperative agreement award
3. Country Operational Plan FY 2008, FY 2009, and FY2010, FY 2011 narratives
4. Workplans and PMP

5. Quarterly, semi-annual, and annual progress reports
6. Financial report and pipelines
7. Any signed agreements with local partners

Key Informant Interviews

The team will conduct structured interviews with the project staff, and key partners including the MOHSS and NGOs, other donors, implementing partners, and other key U.S. Government-funded and non-U.S. Government-funded stakeholders. To ensure that comparable information is collected during interviews, the team will develop standard guides reflecting the questions posed by the evaluation scope of work.

Field Site Visits

The evaluation team will coordinate with USAID/Namibia to prepare for and conduct field visits for structured observations while in-country, and to interview key informants at these sites. Field visits will cover the Windhoek area and four other regions, namely Hardap, Kavango, Omusati, and Oshana. Assuming a two-person team, USAID/Namibia may, based on technical as well as logistical considerations, elect to split the team and conduct field site visits simultaneously.

VI. TEAM COMPOSITION, SKILLS AND ROLES

Profile of Evaluation Team (See description below for a **two-person** team):

- Should be external evaluators, at least one being an international consultant.
- Should have expertise in comprehensive HIV/AIDS programming, including facility- and community-based care.
- Should have expertise in advocacy, organizational development, and local capacity-building—ideally with respect to civil society as well as government institutions.

Team Leader should have the following qualifications: extensive expertise in the mid- and end-of-project evaluation of PEPFAR-funded HIV/AIDS programs designed to build government, ministry, NGO, and civil society agency capacity for sustainability; minimum Masters, preferably a medical doctor with HIV/AIDS experience or a postgraduate degree in public health or related field; and proven track records leading both qualitative and quantitative evaluations with ability to synthesize findings into a high-quality final report within a short time frame.

Team member should have the following qualifications: in-depth expertise and experience in organizational development, with an emphasis on strengthening the capacity of both civil society as well as government agencies in human and financial resources; minimum Masters, preferably a financial management, budgeting, and program costing (e.g., MBA) related area; and proven track record participating in evaluations with cost analysis, and ability to synthesize findings within a short time frame. Experience with PEPFAR-funded programs is a plus.

Local team: The local team members (could include USAID/RHAP AOTR Ms. Faith Xulu; USAID/Namibia Activity Manager, Dr. Ibe, and possibly staff from CDC) will participate with the two external evaluators (as needed and feasible) to accompany them on site visits, where appropriate introduce them to national and local informants and collect data, but they will not be responsible for the drafting of the evaluation report.

| Task/Deliverable | Team Leader LOE | Second Team Member LOE |
|---|------------------------|-------------------------------|
| Read Background Documents | 3 days | 3 days |
| Travel to Namibia | 2 | 2 |
| Assessment Work | 13 days | 13 days |
| In-briefing with USAID HIV/AIDS team (and partner(s) as needed) | (1 day) | (1 day) |
| Conduct site visits and key informant interviews (includes in-country travel days) | 10 | 10 |
| Discussion, analysis, and draft report preparation and Mission (and partner debriefing) | 4 | 4 |
| Return travel | 2 days | 2 days |
| Mission sends technical feedback/comments on draft report to GH Tech (within five days of submission) | 0 | 0 |
| Consultants revise/finalize report | 3 days | 3 days |
| Mission reviews/signs off on final report (within five days of receipt) | 0 | 0 |
| GH Tech edits and finalizes report—approx. 30 days after mission approval | 0 | 0 |
| Total LOE | 25 | 25 |

A six-day work week in country is approved.

VII. DELIVERABLES

1. Written methodology and workplan submitted to USAID/Namibia for review and approval before field work and key informant interviews begin.
2. A draft report outline prepared and submitted during the first two weeks of the field work.
3. A Mission debrief meeting to be followed by a partner debrief meeting that will be held before the team's departure from Namibia and prior to the submission of the draft report. The team will prepare a PowerPoint presentation for this event.
4. Prior to departing Namibia, a reviewable draft report addressing key findings, conclusions, recommendations, and other items as outlined in the draft report outline will be submitted. USAID/Namibia will have 20 days following the submission of the draft report to respond and provide written comments and feedback to GH Tech.
5. The team will incorporate all feedback provided by USAID/Namibia reviewing team. A final unedited draft report will be submitted 14 days from the date of receipt of USAID/Namibia's feedback on the draft report.
6. If USAID/Namibia determines that there are still content issues to be addressed or that previous feedback has not been satisfactorily addressed, the final unedited report will be

considered second draft and further feedback will be given to the team no later than 10 days of receipt of the second draft. If USAID/Namibia determines that there is no need for further changes, the report will be considered final unedited draft and no further feedback will be given. The report shall not exceed 30 pages, excluding the annexes.

7. Once the unedited draft report is approved by USAID/Namibia, GH Tech will have 30 (thirty) days to edit/format and print the final document. This will be a public document and will be posted on the USAID/DEC and the GH Tech websites.

VIII. LOGISTICS

GH Tech will provide:

- Economy tickets for international travel to and from the consultants' point of origin and Namibia.
- GH Tech consultant per diem and lodging expenses as well as all local costs and travel expenses.
- Country cable clearance. Please note: a formal electronic country clearance (eCC) request is not necessary; instead, an informal email request directly to Karla Fossand, Deputy Director of HIV/AIDS and Health Office, USAID/Namibia will suffice. Ms. Fossand will provide an e-mail concurrence upon receipt of this request.
- Reserve hotel and guest house accommodations in country.
- Arrange transportation for the team in Windhoek as well as other regions

USAID/Namibia will provide:

- Mission Point of Contact: Ensure constant availability of the Mission Point of Contact person(s) to provide technical leadership and direction for the consultant team's work.
- Visitors will not have an EA (security clearance) and therefore will need to work out of their hotel/lodging or a designated work space (TBD). They will need prior approval to bring any laptop into the USAID office for any meetings or briefings.
- USAID/Namibia will provide a USAID/Namibia car and driver for use by GH Tech Consultants **only** when other U.S. Government staff members accompany them. When no U.S. Government staff members accompany consultants, GH Tech will arrange the team's transportation.
- All assignment-related costs for local team members.

USAID/Namibia will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before In-Country Work

- SOW. Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

- Documents. Identify and prioritize background materials for the consultants and provide them to GH Tech, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel-line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and if necessary, identify a person to assist with logistics (i.e., visa, letters of invitation, etc.).

During In-Country Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After In-Country Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

Key Contacts Include:

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APPENDIX B. PERSONS CONTACTED

NAMIBIA

USAID

Elzadia Washington-Danax, Mission Director

Karla Fossand, Deputy Director

Ochi Ibe, HIV/AIDS Senior Care and Nutrition Technical Advisor

Nabil Alsoufi, Health Officer

Brad Corner, Prevention Technical Advisor

Shireen Strauss, Program Officer

Robert Festus, Strategic Information Specialist

Mathew Rosenthal, Strategic Information

Rosalia Indongo, TB/HIV Advisor

Ministry of Health & Social Services (MOHSS)

Wilhemina Kafitha, Senior Program Administrator for OIs & PC, Directorate of Special Programs

Salomo Natanael, Senior Program Administrator for ART, Directorate of Special Programs

Kennedy Kambyamba, Chief Pharmacist, Tertiary Care Pharmaceutical

Qamar Niaz, Principal Pharmacist, Tertiary Care Pharmaceutical

Anthony Shapumba, National HBC Coordinator, Primary Health Care Directorate

University of Namibia

Majorie Katijre, Lecturer, Nursing & Public Health

Hardap Region

Sr. Bonifatia Serogwe, Palliative Care Nurse, CAA, Rehoboth

Joey Joseph Heita, Child/Youth Development Coordinator, CAA, Rehoboth

I I Women, Volunteers, CAA, Rehoboth

Khomas Region

Molisa Manyando, Regional Manager, APCA, Windhoek

Rosalia Paavo, Administrative Assistant, APCA, Windhoek

Yvonne Konjore Stephanus, Director of Institutional Development, I-Tech

Godwin Chisenga, Acting Executive Director, CAA HQ, Windhoek

Veronika Kadhimo, Monitoring & Evaluation Officer, CAA HQ, Windhoek

Uatoororua Marenga, Clinical Support Manager, CAA HQ, Windhoek

Oshana Region

Paulus Nehemia, Coordinator, Tonata

Silas Shoolongela, Assistant Coordinator, Tonata
Herenius Kamati, Member Tonata Management Committee/Trainer, Tonata
Rebekka Shikongo, Chairperson, Tonata
Leonard Shikololo, Program Manager, TKMOAMS
Paulus Shikambe, HBC/PC Coordinator, TKMOAMS
Johanna Ilishidimbwa, Monitoring & Evaluation Officer, TKMOAMS

Omusati Region

Kornelia Alweendo, Palliative Care Nurse, CAA, Oshikuku
Sr. Petronella Shetunyenga, Regional Coordinator, CAA, Oshikuku
13 Volunteers, Omampira Home-Based Palliative Care Group, CAA, Oshikuku
Efraim Ilpinge, Regional Manager, CAA, North West
Hellena Munghono, Regional Coordinator, CAA, Anamulenge
Toini Aluvilu, Palliative Care Nurse, CAA, Anamulenge
14 Women, Volunteers, CAA, Anamulenge

Kavango Region

Sherpard Moyo, Regional Manager, CAA, Rundu
Sr. Margaret Mary Shintango, Regional Coordinator, CAA, Rundu
Hilde Neromba, Palliative Care Nurse, CAA, Rundu
Joseph Pillemon, Chairperson Compassion Volunteer Group, CAA, Rundu
8 Women, Volunteers, Compassion Group, CAA, Rundu

Caprivi Region

Christina Liomba, Palliative Care Nurse, CAA, Katima Mulilo
Jane Wachila, Regional Coordinator, CAA, Katima Mulilo
Moses Musukubili M., Coordinator, Hardworking Men's Group, CAA, Katima Mulilo
6 Men, Volunteers, Hardworking Men's Group, CAA, Katima Mulilo

APPENDIX C. REFERENCES

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APPENDIX D. IN-COUNTRY EVALUATION SCHEDULE

African Palliative Care Association—Scaling Up Palliative Care for People Living with HIV/AIDS Mid-term Evaluation April 21– May 10, 2012

| Date and Time | Activity | Venue/Contact person | Comment |
|--------------------|--|---|--|
| Saturday 21/04/12 | GH Tech Consultants arrive | HKA | Airport pick up and hotel reservation made by GH Tech |
| Monday 23/04/12 | | | |
| 12:00–13:00 | <u>In-Brief</u> with Namibia Health Office | USAID Namibia 6 th Floor | Include discussions on methodology, workplan, visit schedule, logistics |
| Tuesday 24/04/12 | Team planning meeting | | Methodology/workplan to be submitted to USAID |
| Wednesday 25/04/12 | | | |
| 08:30–10:30 | APCA Office Molisa Manyando (413330) | | |
| 15:30–17:30 | Meet with Activity Manager | | KII, Assess all sub-objectives |
| Thursday 26/04/12 | | | |
| 08:00–09:30 | Community-Based Health PHC Directorate | Mr. Haufiku and Anthony Shapumba (203-2733/081-2707205) | KII (USAID to make contacts) |
| 10:00–11:30 | Tertiary Care Pharmaceutical | Ms Jenny Lates and Kennedy Kambyambya (2032344/081-2707205) | Include KII, data validation Assess impact of capacity building of Health workers and advocacy for availability of medicines and progress on sub-objectives 1, 2, 3, 4 as appropriate |
| 12:00–13:00 | Meet with Directorate of Special Programs | Dr. Justice Gweshe (2032864/081-1493373) and Ms. Wilhemina Kafitha Senior Programme Administrator (2032858) | KII, Assess sub-objectives 1,2,4 |
| 14:15–15:30 | University of Namibia Social Work Department | Mrs. Marietha Maree (081-2337907) | |
| 15:45–17:00 | University of Namibia Nursing and Public Health Department | Marjorie Katjire (081-2540309) | |
| Friday 27/04/12 | | | |
| 07:00–11:00 | Meet with CAA at | Same day travel to Rehoboth | KII, Assess sub-objectives 3 |

| Date and Time | Activity | Venue/Contact person | Comment |
|-----------------------------------|---|---|--|
| | Rehoboth | Sr. Bonifatia Serogwe | |
| 12:00–13:00 | Meet I-TECH in Windhoek | I-TECH Office Ms. Yvonne, Konjore, Stephanus Director of Institutional Development (310200) | KII, Assess sub-objectives 2 and 3 |
| 14:00–16:00 | CAA Office Godwin Chisenga, Sister Uatorua (276350) | | Assess sub-objective 3. Assess impact of capacity-building of CAA palliative care nurses |
| Sunday 29/04/12 | Travel to Ondangwa For interviews in OSHANA and OMUSATI regions | Fly North West (800 Km) to Ondangwa | Flights, airport pick up and hotel reservation made by GH Tech |
| Monday 30/04/12 | | | |
| 08:30–10:00 | Meet with Tonata | Paulus Nehemia 065-231979 Silas Shoolongela (065-231979/081-4416860) | Renee to confirm |
| 10:30–11:30 | Meet with TKMOAMS | Mr. Leonard Shikololo 065-231979/2220384/ 081-2696146 | KII, Assess sub-objectives 3 |
| 12:00–13:00 | Meet with HBC volunteers in Okatana | | Distance from Okatana to Anamulenge is more than 100km—needs more than 1 hour travel time. |
| 15:00–16:30 | CAA Anamulenge Omusati | Sister Toini Aluvilu Anamulenge | Renee to confirm these appointments with APCA |
| Tuesday 1/05/12 Public Holiday | Travel to Rundu (500+ km) | | GH Tech to make travel arrangements |
| Wednesday 2/05/12 | | | |
| 08:30–10:00 | Meet with CAA Rundu | Hilde Neromba | Renee to confirm appointment with APCA support |
| 10:30–12:00 | Meet with CAA volunteers | Sauyemwa HBC volunteers | KII to assess capacity-building and advocacy efforts Assess IR 2, 3 as appropriate |
| 12:30–17:30 | Travel to Katima Mulilo | | GH Tech to arrange travel and hotel reservations |
| Thursday 3/05/12 | | | |
| 08:30–10:30 | Meet CAA Katima Mulilo office | Christine Liomba | Renee to confirm appointment with APCA support |

| Date and Time | Activity | Venue/Contact person | Comment |
|----------------------------------|--|---|--|
| 11:00–12:30 | Meet the Men-only HBC volunteer group in Katima | CAA Katima to arrange | KII to assess capacity-building and advocacy efforts assess IR 2,3 as appropriate |
| Friday 4/05/12 Public Holiday | Review data collected/ Any TBD interviews Fly back to Windhoek from Mpacha aerodrome | | GH Tech to make travel arrangements |
| Saturday 5/05/12 | Start to draft report | | |
| Monday 7/05/12 | | | |
| 12:00–13:00 | Finalize draft report | Office Director Activity Manager/Alternate | |
| 14:30–16:00 | Out-brief to Mission Incorporate comments from Mission | Treatment Advisor | Renee set up appointment |
| Tuesday 8/05/12 | Out-brief with Implementing Partners | | Renee set up appointment |
| Wednesday 9/05/12 | Incorporate comments from Partners and fine-tune reviewable draft report | | |
| Thursday 10/05/12 | Team departs Namibia | | |

APPENDIX E. PLANNED ACTIVITIES VS. ACHIEVED

Overall Program Aim: To contribute to the national HIV/AIDS response by supporting the scale-up of palliative care services in Namibia.

| OBJECTIVES/ACTIVITIES | Expected Results | Met | Unmet | Comments |
|--|--|---|-------|---|
| Objective One: To identify and build a consensus on the needs and priorities of palliative care services at multiple levels of the health system in Namibia by June 2014. | | | | |
| Sub-objective 1.1: To support Catholic AIDS Action to integrate palliative care into home-based care in more districts following the lessons learned by the pilot program by 2014. | | | | |
| 1 | Ongoing supervision, support and mentoring | Ongoing supervision, of seven CAA sites with PC | X | Ongoing in 9/11 sites |
| 2 | Semi-annual meetings of personnel from the different sites across the country for ongoing support | Staff from the seven CAA sites meet twice a year | X | For FY 2012, one has taken place; the second is for July. |
| 3 | Development and piloting of a model for referrals in some of the sites | Referral model developed and piloted | | Forms developed but not used |
| 4 | Training of nurses from two new districts on palliative care on a two-week introductory course followed by clinical placements at Island Hospice | Two nurses from CAA attend the introduction to PC & placed for clinical | X | This took place in March 2012. |
| 5 | Training of CAA regional co-ordinators and administrative staff on a one-week program for non-health care professionals | CAA regional coordinators and administrator trained in PC | X | This took place in March 2012. |
| 6 | Development of national palliative care training for community health workers. | Training for CV integrated into MOHSS training | | Not yet finalized |
| 7 | Training of a further 150 community health workers at the two new CAA sites, utilizing the above curriculum | Community volunteers trained in PC | | 55 volunteers trained |
| Sub-objective 1.2: To support the MOHSS to integrate some of the lessons learned from the CAA program into their programs by 2014. | | | | |
| 8 | Identification of the key lessons learned that could be applied to other programs | Lessons learned, identified, and shared | X | Stakeholders' meeting in July 2010 |
| 9 | Discussions with regards to how lessons learned can be integrated into the MOHSS model of HBC | Lessons learned are integrated into the MOHSS HBC model | X | Stakeholders' meeting in July 2010 |

| OBJECTIVES/ACTIVITIES | Expected Results | Met | Unmet | Comments |
|--|---|--|-------|--|
| Objective Two: To enhance participation in policy dialogue and advocacy for key identified palliative care priorities by the Namibia task force nationally and regionally by 2014. | | | | |
| Sub-objective 2.1: To work with the MOHSS re: the availability of palliative care drugs and an advocacy strategy for palliative care in Namibia. | | | | |
| 10 | Advocacy technical assistance to support the PC task force and advocacy strategy | Technical assistance on advocacy for the PC task force | X | Task force in place and functional |
| 11 | Advocacy for PC around specific events such as World Hospice and Palliative Care Day and the APCA conference | Advocacy for PC conducted at key times throughout the year | X | Conference, media, radio, and breakfast meeting |
| Sub-objective 2.2: To review development of national policies and guidelines re palliative care in Namibia. | | | | |
| 12 | Provision of TA to support the development of national policies, guidelines, and documents | TA for national policies, guidelines development | | X Draft SOP & guideline developed |
| 13 | Support to the MOHSS re getting palliative care documents approved and ratified | Documents for PC approved | | X Work in progress pending approvals |
| 14 | Review and country adaptation of the generic APCA palliative care standards for Namibia | Palliative care standards for Namibia developed | | X Work in progress pending approvals |
| Objective three: To provide technical assistance to increase the capacity of key stakeholders in the implementation of palliative care by 2014. | | | | |
| Sub-objective 3.1: To train a core group of health workers and MOHSS personnel by September 2014. | | | | |
| 15 | Conduct a two-week training program for health care professionals | 25 health professionals trained | | X Curriculum not finalized |
| 16 | Provision of clinical placements for two CAA nurses to Island Hospice Zimbabwe | The two CAA nurses trained | X | Trained in March 2012 |
| 17 | Follow-up training for 25 nurses who have been trained over the past two years | 25 health workers follow-up training | | X Curriculum not finalized |
| Sub-objective 3.2: To provide technical assistance with regard to the integration of palliative care into pre-service training curricula and the IMAI palliative care module by end of 2014. | | | | |
| 18 | Provision of training on palliative care for UNAM and ITECH personnel | Palliative training given to UNAM and ITECH personnel | X | One lecturer trained at UNAM, two at NHTC, and one from I-Tech |
| 19 | Provision of technical assistance to UNAM with regards to integrating palliative care into the curricula for the new medical school | Palliative care integrated into the curriculum | | X Ongoing discussions |

| | OBJECTIVES/ACTIVITIES | Expected Results | Met | Unmet | Comments |
|----|--|--|-----|-------|--|
| | Sub-objective 3.3: To train two health professionals to a specialist level in palliative care by the end of 2014. | | | | |
| 20 | Identification of two health professionals to undergo specialist training | Two health professionals identified | X | | Six identified and enrolled |
| 21 | Enrollment of the two health professionals on the appropriate distance learning course | Two health professionals accepted | X | | Two graduated; three ongoing; one deceased |
| 22 | Provision of resources for palliative care within the APCA Namibia office for use by the students on their courses and by others interested in palliative care | Palliative care resources are available | X | | Made available in local offices |
| 23 | Financial support for the first year of the distance learning program | Two students accepted and the fees paid | X | | All fees were paid |
| 24 | Provision of in-country mentorship and support for the students on the course | In-country mentorship for the students | X | | APCA, Island Hospice and CAA |
| | Sub-objective 3.4: To support the APCA conference in Namibia in September 2010. | | | | |
| 25 | Support for 30 local personnel from Namibia to attend the conference | Thirty supported to attend conference | X | | Done September 2010 |
| 26 | Support for the local coordination and advertising for the conference | APCA conference is well coordinated | X | | Coordinators hired |
| 27 | Support for a high-level reception at the conference for the Namibia MOHSS and other stakeholders | High-level reception held at the conference | X | | High-level reception held |
| | Sub-objective 3.5: To add technical assistance for the promotion of palliative care in Namibia by the end of 2014. | | | | |
| 28 | Provision of technical assistance to the MOHSS for M&E for palliative care | TA provided to the MOHSS with regards to M&E in PC | X | | Support provided on demand |
| 29 | Provision of miscellaneous technical assistance as required | Miscellaneous PC TA provided | X | | TA provided as requested |
| 30 | Capacity-building and support supervision to the APCA team in Namibia | To APCA team in Namibia | X | | Done as needed |
| | Objective four: To support the development of a functional palliative care country task force of national association by 2014. | | | | |
| 31 | Review of the recommendations from previous organizational development (OD) and the strategic plan for the task force | Strategic plan and OD recommendations | X | | Done but needs further development |

| OBJECTIVES/ACTIVITIES | | Expected Results | Met | Unmet | Comments |
|--|--|--|-----|-------|----------------------------|
| 32 | Identification of training needs with regard to OD and training of the task force | Training needs identified provided | X | | With the task force |
| 33 | Implementation of the strategic plan and workplan for the task force/national association | Strategic plan and subsequent workplan implemented | X | | With the task force |
| 34 | Registration of the national association | Registration for national association | | X | In process |
| Objective five: To conduct a palliative care public health/program evaluation in Namibia by 2014. | | | | | |
| 35 | Finalization of the protocol, ethical approval, and implementation of the evaluation | Protocol finalized and evaluation begun | X | | Protocol developed |
| 36 | An initial assessment will be undertaken of priorities and preferences in end-of-life care in Namibia. | Assessment undertaken and results shared | X | | Conducted in December 2010 |

Summary of Targets for Namibia for October 2009–September 2010

| Indicators | Target | Achieved | Comments |
|--|--------|------------|--|
| 1. Total number of individuals (palliative care providers) trained by APCA to provide HIV-related palliative care | 214 | 710 | |
| 2. Number of palliative care provider organizations brought together to share lessons learned and best practices in HIV-related palliative care | 50 | 158 | MOHSS, CAA, TONATA, TKMOAMS, Hope Hospice, COHENA, and AIDS Care Trust |
| 3. Number of local organizations provided with technical assistance for HIV-related institutional capacity building | 1 | 7 | |
| 4. Number of local organizations provided with technical assistance for strategic information activities (includes M&E, surveillance, and/or health management information systems). | 1 | 5 | Number of individuals who are fully supported to pursue a diploma in palliative care |
| 5. Number of national palliative care associations formed in project countries | 1 | 0 | Initial discussions have been held. |
| 6. Number of project countries with palliative care standards developed | 1 | 0 | PC standards are not developed pending the completion of the policy. |
| 7. National palliative care training curriculum developed for in-service training | 2 | 1 | A standardized PC curriculum is currently being developed, led by MOHSS. |
| 8. Number of organizations supported in relation to HIV palliative care advocacy and policy development | 1 | 1 | |
| 9. Number of individuals trained in HIV-related institutional capacity-building | 62 | 82 | |
| 10. Number of policies/guidelines for the promotion/integration of PC into the public health approach of Namibia | 1 | 1 | APCA is providing support to MOHSS to develop a PC Policy currently in draft form. |
| 11. MER plan and tools developed, approved by RHAP/AOTR, and used for data collection and dissemination | 1 | 1 | |

APPENDIX F. TRAINING BREAKDOWN PER CATEGORY AND SEX

AFRICAN PALLIATIVE CARE ASSOCIATION

Implementing Mechanism: 674-A-00-09-00112-00

| Activity Description | Dates of Activity | # of Females | # of Males | Total | Participants |
|-------------------------|----------------------|--------------|------------|-------|---|
| Pilot Training | June 20-24 2011 | 24 | 5 | 29 | All nurses |
| Media Breakfast Meeting | July 8 2011 | 18 | 9 | 27 | Non-health participants |
| CHBC PC TOT Training | March 5-7 2012 | 14 | 10 | 24 | Three nurses and 21 allied health participants (HBC coordinators and supervisors) |
| PC Training Mariental | Sept 5 2010 | 14 | 1 | 15 | Community-based care providers |
| PC Training Mariental | May 31 – June 6 2010 | 35 | 4 | 39 | Community-based care providers |
| PC Training | June 7-11 2010 | 31 | 3 | 34 | Community-based care providers |
| Stakeholders' Meeting | July 13 2010 | 42 | 11 | 53 | Thirty-four nurses, one doctor, two pharmacists |
| PC Review Workshop | Nov 1-4 2011 | 16 | 5 | 21 | |
| Katima Mentorship Visit | Feb 14 2011 | 4 | 1 | 5 | Community-based care providers |
| Mentorship Katima | Feb 14-15 2011 | 1 | 4 | 5 | Community-based care providers |
| Mentorship Rundu | Feb 17 2011 | 1 | 1 | 2 | Community-based care providers |
| Mentorship Rundu | Feb 17 2011 | 4 | | 4 | Community-based care providers |

| Activity Description | Dates of Activity | # of Females | # of Males | Total | Participants |
|---|-----------------------|--------------|------------|------------|--------------------------------|
| Mentorship Rundu | Feb 18 2011 | 5 | 1 | 6 | Community-based care providers |
| Mentorship Rundu | Feb 18 2011 | 3 | 1 | 4 | |
| Advocacy Skills Training for Task Force Members | | 7 | 6 | 13 | |
| Tonata AGM | Dec 2010 | 34 | 8 | 42 | |
| Nurse Meeting | April 13 2012 | 8 | 1 | 9 | Nine nurses |
| PC Volunteer Training (Tonata) | June 27 – July 1 2011 | 23 | 3 | 26 | Community-based care providers |
| PC Training (Okatana) | June 28 – July 2 2010 | 37 | 5 | 42 | Community-based care providers |
| PC Volunteer Training | June 21–25 2010 | 38 | 4 | 42 | Community-based care providers |
| PC Volunteer Training | June 28 2010 | 44 | 3 | 47 | Community-based care providers |
| PC Volunteer Training | June 21-25 2010 | 36 | 1 | 37 | Community-based care providers |
| PC Volunteer Training | June 14-18 2010 | 16 | | 16 | Community-based care providers |
| PC Volunteer Training | June 14-18 2010 | 36 | 2 | 38 | Community-based care providers |
| PC Volunteer Training | June 14-18 2010 | 19 | 2 | 21 | Community-based care providers |
| Total | | 510 | 91 | 601 | |
| | | | | | |
| Biannual Meeting | Feb 7 2012 | 9 | 5 | | |
| Refresher PC Training | Feb 8 2012 | 9 | 5 | | |

| Activity Description | Dates of Activity | # of Females | # of Males | Total | Participants |
|-------------------------------------|--------------------------|---------------------|-------------------|--------------|---------------------|
| Khorixas PC Training for Volunteers | March 2012 | 26 | 2 | | |
| Outjo PC Training for Volunteers | March 2012 | 24 | 3 | | |
| Sensitization Meeting | February 15 2012 | 20 | 6 | | |
| Total | | 88 | 21 | | |

APPENDIX F. INTERVIEW GUIDES

**USAID/Namibia Mid-term Evaluation for
African Palliative Care Association's (APCA)
Semi-structured interview guide for MOHSS**

This questionnaire targets CBHPHC Directorate, Tertiary Care, Pharmaceutical, Directorate of Special Programs, and Universities.

Introduce yourself, explain the APCA project's MTE purpose and the interview process, and seek the respondent's consent before starting the interview.

Introduction & Identification

1. Interview date: _____
2. Name and address of the institution: _____
3. Name of the respondent: _____ Position: Manager__ Provider__

Level of Program Performance

This section explores progress in program implementation (process) and changes in access (quantity, quality), coverage (demand and use), and overall management (leadership, coordination). Please request relevant documents to support findings (digital or hard).

1. What is the role of your unit with regard to Namibia's response to HIV/AIDS in general and PC in particular?
2. How did your unit (directorate) participate in identifying PC needs and priorities in the country?
3. One important need was the integration of PC to HBC with a strong referral and counter-referral system between communities or local NGOs and health facilities or providers. Was a model for referral developed, and how is it being implemented?
4. Are PC policies, guidelines, and standards in place in the country? Yes__ No__
If no, what progress is being made on those?
5. Is there a PC training curricula in place, and if not, why?
6. PC medicine availability is key to PC programs' success. How available are ART (adult and pediatric), OI drugs, and HBC kits in the country? What is the supply mechanism? Is morphine allowed for PC use (country policy)? Do people pay for investigation and testing?

Capacity Building

This section determines the sustainability of APCA's activities and establishes if capacity-building activities of local organizations in PC have had measurable impact on local organizations. Please request relevant documents to support findings (digital or hard).

1. APCA has been collaborating with the Ministry in advancing PC capacity-building of health workers and local NGOs. How would you assess their performance?
2. How does your unit relate to NGOs implementing PC (CAA, TONATA...)?
3. What mechanism is in place to insure country ownership and sustainability of the PC program? What human capacity needs remain?
4. What type of TA have you received or provided for PC integration into pre- and in-service training?
5. Is there a focal person for PC in the directorate?
6. Is a national PC task force in place, when was it created, and how does it work?
7. Do you have a national M&E frame in place with agreed-upon indicators and data collection tools? How do APCA and CAA align with it?
8. Is there any research planned for PC in the country?

Relevance of APCA Activities

This section probes how APCA's work in PC aligns with the current realities of the HIV response in the light of extensive roll-out of antiretrovirals (ARVs) in Namibia, as well as the push for positive health, dignity, and prevention for PLHA.

1. Describe the challenges and success made in each technical area—adult and pediatric care and support and PC support.
2. In the light of ARV extensive roll-out, do you consider PC activities still relevant, and if so, how?
3. How would you assess the coverage and quality of services provided by APCA and PC implementing partners?
4. Are there best practices, innovations, or documented activities available on PC?
5. Does the government have a budget that supports PC implementation? If not, why not?
6. Any recommendations for future directions of PC in the country?

Thank you for your time.

USAID/Namibia Mid-term Evaluation for African Palliative Care Association (APCA)

Semi-structured interview guide for APCA

This questionnaire targets APCA project managers.

Introduce yourself, explain the APCA project's MTE purpose and the interview process, and seek the respondent's consent before starting the interview.

Introduction & Identification

1. Interview date: _____

2. Name and address of the institution: _____

3. Name of the respondent: _____ Position: Manager__ Provider__

Level of Program Performance

This section explores progress in program implementation (process) and changes in access (quantity, quality), coverage (demand and use), and overall management (leadership, coordination). Please request relevant documents to support findings (digital or hard).

1. What is the work of APCA with regard to Namibia's response to HIV/AIDS in general and to the APCA project in particular?

2. How did APCA participate in identifying the needs and setting priorities for PC in the country?

3. Have policy, guidelines and standards been developed? Yes__ No__
If Yes, cite copy. If No, what progress is being made on those?

4. PC medicine availability is key to PC programs' success. How available are ART (adult and pediatric), OI drugs, and HBC kits in the country? What is the supply mechanism? Is morphine allowed for PC use (country policy)? Do people pay for investigation and testing?

5. Which type of TA have you provided for PC integration into pre- and in-service training?

Capacity Building

This section determines the sustainability of APCA's activities and establishes if capacity-building activities of local organizations in PC have had measurable impact on local organizations. Please request relevant documents to support findings (digital or hard).

1. Has APCA strengthened the capacity of the local partners to implement palliative care in the context of HIV/AIDS? Review the programmatic benchmarks and standards used for each organization. Were they successful?
2. Has APCA made progress toward facilitating the creation of a National Palliative Care Association?
3. How were the trainings organized? Do you consider the duration, content, and quality adequate? Were your targets met?
4. Is there a national M&E framework in place with agreed-upon indicators and data collection tools? How do you align with it?
5. What indicators and data collection tools does APCA use? To whom do you really report?
6. How is supervision organized, and how is support provided?
7. Is a national PC task force in place, when was it created, and how does it work?

Relevance of APCA's Activities

This section probes how APCA's work in PC aligns with the current realities of the HIV response in the light of extensive roll-out of anti-retrovirals (ARVs) in Namibia, as well as the push for positive health, dignity, and prevention for PLHIV.

1. Describe the challenges and success made in each technical area—adult and pediatric care and support. How relevant are activities in those areas?
2. Is there duplication of activities with other partners?
3. Are there best practices, innovations, and documented PC activities?
4. Any recommendations for future directions of APCA support?

Thank you for your time.

USAID/Namibia Mid-term Evaluation for African Palliative Care Association (APCA)

Semi-structured interview guide for CAA/implementing partners

This questionnaire targets CAA strictures and palliative care providers.

Introduce yourself, explain the APCA project's MTE purpose and the interview process, and seek the respondent's consent before starting the interview.

Introduction & Identification

1. Interview date: _____

2. Name and address of the institution: _____

3. Name of the respondent: _____ Position: Manager__ Provider__

Level of Program Performance

This section explores progress in program implementation (process) and changes in access (quantity, quality), coverage (demand and use), and overall management (leadership, coordination). Please request relevant documents to support findings (digital or hard).

1. What is the work of your organization with regard to Namibia's response to HIV/AIDS in general and to the APCA project in particular?

2. At how many sites is your organization implementing PC? What is the number of people being reached and the sex distribution?

3. How did your organization participate in identifying needs and setting priorities for PC in the country?

4. Tell us about your efforts in integrating PC into HBC. How did the pilot program go, and what were some of the key lessons learned?

5. What were some of the lessons learned from your PC program, and how did you communicate or disseminate them? Did the MOHSS integrate some of those lessons learned, and what did you do to facilitate that process?

6. PC medicine availability is key to PC programs' success. How available are ART (adult and pediatric), OI drugs, and HBC kits in the country? What is the supply mechanism? Is morphine allowed for PC use (country policy)? Do people pay for investigation and testing?

Capacity Building

This section determines the sustainability of APCA's activities and establishes if capacity-building activities of local organizations in PC have had measurable impact on local organizations. Please request relevant documents to support findings (digital or hard).

1. How has the training support from APCA strengthened the capacity of your organization to implement palliative care in the context of HIV/AIDS?
2. How were the trainings organized? Do you consider the duration, content, and quality adequate? Were your targets met?
3. What supervision and mentoring support do you receive, and from whom?
4. What indicators and data collection tools does your organization use? To whom do you really report?
5. Is your organization represented on the PC task force? What role do you think the task force can play to promote PC in the country?

Relevance of APCA Activities

This section probes how APCA's work in PC aligns with the current realities of the HIV response in the light of extensive roll-out of anti-retrovirals (ARVs) in Namibia, as well as the push for positive health, dignity, and prevention for PLHA.

1. Describe the challenges and success made in each technical area—adult and pediatric care and support and PC support.
2. In the light of the extensive ARV roll-out, do you consider that PC activities remain relevant, and if so, how?
3. How would you assess the coverage and quality of services provided by APCA and PC implementing partners?
4. Are there best practices, innovations, or documented activities available on PC?
5. What are the sources of funding for your PC activities?
6. Any recommendations for future directions of PC in the country?

Thank you for your time.

**USAID/Namibia Mid-term Evaluation for African Palliative Care Association
(APCA)**

Semi-structured interview guide for PLWHA

This questionnaire targets organizations and structures of PLWHA.

Introduce yourself, explain the APCA project's MTE purpose and the interview process, and seek the respondent's consent before starting the interview.

Introduction & Identification

1. Interview date: _____
2. Name and address of the institution: _____
3. Name of the respondent: _____ Position: Manager__ Provider__

Level of Program Performance

This section explores progress in program implementation (process) and changes in access (quantity, quality), coverage (demand and use), and overall management (leadership, coordination). Please ask relevant documents to support your findings (digital or hard).

1. What is the work of your organization with regard to Namibia's response to HIV/AIDS in general?
2. What is the relationship of your organization to APCA?
3. How did your organization participate in identifying needs and setting priorities for PC in the country?
4. What are some of those critical needs and priorities for PC in Namibia?
5. What are some of the critical needs of PLWHA in your community?
6. What efforts are being made to advocate for PC in Namibia? Is your organization involved?
7. Which type of support have you received from APCA, or CAA and other organizations?
8. What else is needed that is critical?
9. What are the changes you've seen in the availability of HBC kits and PC medicine?

Training and Other

This section determines the sustainability of APCA's activities and establishes if capacity-building activities of CBO in PC have had measurable impact, as well as how APCA's work in PC aligns with the current

realities of the HIV response in the light of extensive roll-out of anti-retrovirals (ARVs) in Namibia, as well as the push for positive health, dignity, and prevention for PLHA.

1. How has APCA supported training with your organization? What is the number of people trained and the sex ratio?
2. How would you assess HBC, kits, ART, and PC medicine availability?
3. Describe the challenges and success made in each technical area—adult and pediatric care and support and PC support?
4. How would you assess the coverage and quality of services provided by APCA and PC implementing partners?
5. Are there best practices, innovations, or documented activities available on PC?
6. Any recommendations for future directions of PC in the country?

Thank you for your time.

For more information, please visit
<http://www.ghtechproject.com/resources>

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