EVALUATION OF THE NAMIBIAN COMMUNITY HEALTH WORKERS PROGRAMME

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PREFACE

The Ministry of Health and Social Services (MoHSS), through the Primary Health Care (PHC) Directorate embarked on the process of ensuring the provision of affordable, accessible, and equitable health care services to all the corners of Namibia immediately after the country's independence in 1990. Even though significant achievements have been made with regard to the distribution of PHC Clinics throughout the country, behavioural change has not been well observed, especially in the far remote areas, which could be attributed to lower education levels and unavailability of information on health related matters.

The MoHSS therefore established the Community Health Workers Programme (CHWP) in 2013, following a pilot project, which was conducted in Opuwo District, Kunene Region, in 2012. This programme was established with the main objective of bridging the gap, which existed between the health facilities and the communities/households, and therefore strengthen the continuum of care from the health facilities to the household levels. Prior to this, most of the community based health care activities have been conducted by the community volunteers who have been mostly funded by the non-governmental organisations, as a response to the HIV/AIDS pandemic, which occurred as from the mid-1990s. While the immense contribution received from the community health care providers has been instrumental in the fight against the epidemic, sustainability of their services in the communities was questionable, leading to the establishment of the CHWP.

It has now been five years since the commissioning of the CHWP, hence the need to conduct a national programme evaluation to ascertain its impact, successes, and challenges, which may further provide guidance on the way forward with its implementation. The Ministry therefore appreciates the support received from our development partners and stakeholders, namely; United Nations Children's Fund (UNICEF), and Maternal and Child Survival Program (MCSP), for their unwavering support to this program. The leadership and coordination role played by the PHC Directorate, Family Health Division is also commendable. Moreover, the contribution received from the different directorates, Ministries, development partners, stakeholders, health districts, facilities and community members during this evaluation process is highly appreciated.

I therefore urge all programme supervisors in the MoHSS as well as the relevant stakeholders to use the recommendations emanating from this report to make informed and evidence based planning of the activities related to the CHWP, in order to realize the desired outcome of quality health for all Namibians.

Ms. P. Masabane
Acting Permanent Secretary

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This evaluation study was undertaken on behalf of the Ministry of Health and Social Services (MoHSS), Primary Health Care Services Directorate, Family Health Division by a team of consultants, including Dr. Hailay Desta Teklehaimanot- lead consultant and Dr. Pandu Hailonga-van Dijk – Local consultant, and two research assistants, Mrs. Jacky Mukupi and Mr. Trevor Mwiya. The evaluation was conducted under the leadership of the CHWP national steering committee that include representatives from MoHSS, MNCH and Nutrition committee, NHTC, UNICEF, MCSP/USAID, and WHO. Overall, the committee prepared and approved the terms of reference, provided technical inputs to the evaluation design, monitored its implementation, reviewed findings and helped generate recommendations, and organized validation workshop.

From the MoHSS, Mrs. Maria Kavezembi – PHC Director, Mrs, S.H.D. Auala, former PHC Director, Dr. John Rutabanzibwa, Acting Deputy Director and Mr. Tuutaleni Shilyomunhu- Senior Health Programme Administrator and Community Home Based Care coordinator led the evaluation, defined the scope, provided data and documents including feedback on results and context. In addition, technical assistance and support received from UNICEF Namibia, Mrs. Gloria Siseho, Health Specialist, Child Health and Nutrition Section, Dr. Jean Kaseya, Chief, Child Survival and Development, and Mr. Marcus Betts, Deputy Representative, and from MCSP/USAID, Mr. Nortin Brendell, Programme Director, and Ms. Claudia Inghepa, Senior HEP Technical Advisor is highly acknowledged onco-development of the research design, research tools and instruments, provided documents and data, organized and facilitated logistics for fieldwork, and assisted in the interpretation of results, and reviewed and provided feedback on the draft of the report. Dr. Zeenat Patel, Senior Technical Advisor, MCSP head office, for providing technical inputs in the design of the evaluation methodology and data collection tools as well as reviewed and provided feedback on the draft of the report.

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ABBREVIATIONS AND ACRONYMS

CAFO	Church Alliance for Orphans
CBOs	Community-Based Organizations
CBHTC	Community-Based HIV Testing and Counselling
CDC	Centers for Disease Control and Prevention
CHWs	Community Health Workers
CHWP	Community Health Workers Programme
CBHC	Community-Based Health Care
CBMNC	Community-Based Maternal and Newborn Care
CFGD	Community Focus Group Discussions
EF	Evaluation Framework
GE	Gender Equality
HRBA	Human Rights-Based Approach
MCSP	Maternal and Child Survival Programme
MNCH	Maternal, Neonatal and Child Health
MoHSS	Ministry of Health and Social Services
MSH	Management Sciences for Health
MUAC	Mid-Upper Arm Circumference
NDHS	Namibian Demographic and Health Survey
NDP5	National Development Programme Five
NHPF	National Health Policy Framework
NHTC	National Health Training Centers
NHSP	National Health Strategic Plan
OECD/DAC	Organization for Economic Co-operation and Development / Development Assistance Committee
ORS	Oral Rehydration Solution
PHC	Primary Health Care
SDGs	Sustainable Development Goals
SOP	Standard Operating Procedures
ToC	Theory of Change
TOR	Terms of Reference
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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BACKGROUND

In 2008 the Ministry of Health and Social Services (MOHSS) commissioned a national health and social service system review which found that although some progress has been made in Primary Health Care (PHC), provision of health services did not go beyond the health facilities, irrespective of the fast distances between the Health facilities and community. The review then recommended that health services should be extended in a structured manner to communities through the establishment of paid health workers.

In 2012 the MoHSS with technical and financial support from UNICEF and other partners like USAID piloted Community Health Worker Programme (CHWP) in Opuwo district of Kunene region., The MoHSS expanded the programme to the rest of the country following the successful pilot project in Opuwo. Namibia has been implementing CHWP since 2012 with over 1600 Community Health Workers (CHWs). However, in the past five years the programme package expanded and advanced significantly, yet no comprehensive evaluation has been undertaken to assess the relevance, efficiency, effectiveness, impact and sustainability of the programme.

An evaluation is required to guide the MoHSS on how to use the CHWs most effectively to achieve national health goals, and contribute to the achievement of the post-2015 global Sustainable Development Goals (SDGs). Programmatic achievements and constraints need to be documented and analysed, informing new technical guidance to maximize the impact of CHWP. It is in this context that this comprehensive evaluation was commissioned by the MOHSS with the financial and technical support from UNICEF and USAID-MCSP.

PURPOSE AND OBJECTIVES OF EVALUATION

The purpose of this evaluation is to document the CHWP, assessing programmatic achievements and constraints by reviewing the existing conceptual framework and overall system, including financial support, management structure, supervision mechanism and governance. The aim is to gain an in-depth understanding of the progress and challenges, and to identify areas for improvement; to assess the alignment with, and appropriateness of, policies and guidelines for the community health programme; as well as to determine the extent and depth of coordination and collaboration for partnerships. The findings of the evaluation will mainly be used by MoHSS and partners, in their different capacities and functions, to inform policies and strategies and develop future plans and interventions to improve programme performance. It could also be used in academic settings, especially public health and teaching on community health.

The overall goal of this evaluation was to understand whether the intended objectives of the CHWP were met and whether it resonates with the objectives in the strategic plan. The main objectives of the evaluation are to i) assess the impact, relevance, effectiveness, efficiency, coherence, sustainability, coordination, and human-rights based approach of the programme; ii) document lessons and identify best practices in the implementation and management of the Programme; and iii) provide evidence to improve the programme design and implementation, and related policy change.

SCOPE AND FOCUS OF THE EVALUATION

Geographically, the evaluation covered all regions with five regions selected as study sample to ascertain its sphere of influence on the overall maternal, newborn and child health (MNCH) programme in Namibia. The evaluation focused and included the following beneficiaries and stakeholders in the process: i) final beneficiaries including newborn babies, children, mothers and other caregivers and community members; ii) service providers including health facility supervisors, PHC supervisors, and CHWs; iii) sub-national decision-making level including regions, district and health facility authorities; and iv) national decision-making

level including national authorities and key stakeholders (Ministry of Health, Public Service Commission, Development Partners, the UN System (UNICEF, WHO), USAID, MCSP, MSH, etc.).

EVALUATION METHODOLOGY

Due to the lack of baseline data and control group, the contribution of CHWP to maternal, neonatal and child health outcomes was evaluated using a theory based contribution analysis. The evaluation was guided by the norms and standards of the United Nations Evaluation Group (UNEG) given their systematically established relevance for evaluating initiatives and programmes. The evaluation examined the impact (to the extent possible), relevance, effectiveness, efficiency, sustainability, and coordination of CHWP. It also examined human rights, gender and equity dimensions of the programme. Evaluation framework (EF), which identified indicators for each question, was developed in a participatory approach with the involvement of key stakeholders.

The evaluation used a mixed-method (qualitative and quantitative methods). The quantitative component focused on existing retrospective health facility data to analyse the trends in maternal, newborn and child health outcomes. The qualitative component used desk review of documents and interviews. Semi-structured interviews were used around the questions through a wide representation of key informants. The data collection method comprised a mix of site visits and observations, key informant interviews using semi structured questionnaires, community Focus Group Discussions (cFGDs) using guiding questions, desk-based review of existing documents, reports and secondary health facility data.

For the purpose of the evaluation, 5 regions were purposively sampled. The regions include Zambezi (average performance), Kunene (poor performance and unique characteristics), Oshana (good performance), Omaheke (good performance) and Karas (poor performance). Data collection was conducted in October 2017. A total of 60 key informants and six FGDs were conducted.

Both quantitative and qualitative data were analysed. On the quantitative aspect, trend analyses on key MNCH outcome/impact indicators was undertaken to compare the pre- and post-programme implementation trends. The qualitative component drew on the understanding and perception of the main stakeholders involved in the project. In addressing the questions of the evaluation, findings from the different sources were triangulated to present the final findings.

KEY FINDINGS BY EVALUATION CRITERIA

CHWP has contributed to the improvement of maternal, newborn and child health indicators. Maternal and child deaths have reduced in the last 2 to 3 years. The decrease in maternal deaths was mainly attributed to CHWs activities including early identification of pregnancy, increased ANC, increased referral of mothers, and more women with birth plans leading to increased health facility delivery. The decrease in child deaths was attributed to improved maternal health, decreased illnesses as a result of immunisation, early health seeking behavior, and immediate management of diarrhea and referral of other childhood illnesses.

CHWP contributed to improved health awareness and knowledge among the community. As a result of the various activities undertaken by CHWs, the community understood the importance of ANC, immunization, institutional delivery, and the possible adverse negative effects of home delivery.

CHWP's contribution to increased access was limited to selected health services. CHWs manage diarrhea cases, which has improved access. CHWs have also contributed to increased access to immunization but in combination with the outreach programmes.

CHWP contributed to improved health seeking behavior and increased utilization of maternal, newborn and child health. CHWP has contributed to increased uptake of ANC, health facility deliveries, PNC, and immunization. It also contributed to early health seeking behavior, identification of defaulters, and referral of clients including mothers and children.

The Programme fits well to national priorities. CHWP fits well to one of the national priorities of addressing the gap in health service delivery. It is also embedded in the key government policy document programme, and addresses issues pertinent to communities in rural agrarian, urban, peri-urban and nomadic communities.

The programme's strategic documents and approaches were appropriate to achieve the set objectives but the design had some limitations. The programme supported evidence-based maternal, neonatal and child services including family planning and adolescent health; partial management of diarrheal cases and identification and referral of other childhood illnesses, immunization, nutrition and growth monitoring; prevention of HIV/AIDS, tuberculosis and malaria; behavioural change and WASH; as well as social welfare and disabilities with proven effects on maternal and child health outcomes.

CHWP has not yet contributed to major policy direction and decision making processes, but it has contributed to increased resource allocation for maternal, newborn and child health. The Ministry of Health currently funds CHWP, although development partners contributed funding at the onset of the programme for trainers, training materials and daily allowance. Because of the scale up of the programme, the funding allocation for MNCH has increased.

The development process, and the quality and content of the training curriculum were found to be appropriate for the programme. The MoHSS with the support of international donor organisations developed the curriculum and teaching materials with the involvement of national and international experts. The Curriculum included service areas that are important and appropriate to achieve the objectives of the programme.

The current operation of the training process was found to be inefficient. The training is a standalone programme, and has not been integrated in the National Health Training Center (NHTC) programme, which may affect its sustainability and quality.

Coordination mechanisms involving steering committees have been established but functionality was inconsistent. The PHC directorate established a national steering committee. Nonetheless, meetings of the steering committee have not been effective and conducted regularly due to changes in management and competing priorities. The availability and functionality of village health committee have also been unsatisfactory.

Programme supervision was not strong and differed between regions. Supervision was one of the weakest link of the programme and most CHWs were not supervised frequently and regularly. Limited human resource and competing priorities were among the factors affecting supervision.

There were no systematic cross-sectoral linkages. CHWs collaborated with different sectors; however, it was on a reactive basis and not formalized. The unstructured nature of cross-sectoral collaboration, with no clear referral mechanism have contributed to poor response from some sectors.

There was high political commitment and will at the highest level, however management capacity was not strengthened. Overall the programme has seen support from the highest office with high political commitment. However, management human capacity was not strengthened.

CHWP has contributed to improvements in the capacity of regions and districts to deliver CHWP services. The key factors include the training of a critical mass of CHWs, the availability of guidelines, standards and tools for CHWP implementation, and provision of orientation trainings that improved the capacity of the regions and districts.

CHWP contributed to a moderate increase in the participation of community members in CHWP. The role of the community in selection of candidate CHWs was prominent. The participation of the community was mainly in implementation of CHWP activities, however, their participation in planning and monitoring was not satisfactory.

CHWP has increased motivation of CHWs. CHWs were generally satisfied with their living conditions. The main motivation factors were serving their community and making a difference in the needs of their communities. However, lack of adequate supervision and refresher training, and uncertainty in their future due to lack of career paths affected their motivation.

CHWP has moderately improved coordination of community health services, but the inconsistent and non-systematic coordination resulted in duplication of efforts. The different types of CHWs direct and refer specific clients to the appropriate CHW. However, due to the lack of systematic coordination, there was duplication of efforts.

CHWP has established and strengthened community health facility bidirectional referral linkage. Most of the elements for a functional referral linkage have been achieved in most areas. The important elements include: CHWs' skills and screening tools; tracking defaulters; awareness and health seeking behavior; and availability of ambulance services.

The available resources were generally used efficiently; however there were gaps in human resources, finance and logistics. Although there was no costed CHWP activity plan to appropriately assess the adequacy and efficiency of resource use, the general assessment showed that the available resources were not adequate to implement CHWP and that there were inefficiencies in using resources.

The programme was cost efficient in delivering PHC services at community level. With 1,547 CHWs, the programme was cost efficient in delivering the package of preventive and promotive services to a total of 140,203 households (588,853 people). On average, each CHW served 91 households (381 people).

The CHWP data system has been integrated into the national health informatics system; however, there was no evidence on use of data for monitoring of progress to improve CHWP management and decision-making.

CHWP is institutionalized within the health care system. With high high political leadership and support, the government owns the programme and there is clear evidence that the government and the community can sustain the programme.

CHWs are well incorporated in the community with an overall low level of attrition rate. CHWs were recruited from their communities and participate in all community social events. The attrition rate was low with average annual attrition rate of 3.6% although it differed significantly among the regions.

CHWP has empowered local communities through awareness building. Community members have equal access to the CHWP services and there is high level of trust between CHWs and the community. With increased awareness and health seeking behaviour, the community has recognized the need for healthy lifestyle and increased demand and uptake of health services.

CHWP considers the equity approach with a focus on most deprived areas, areas with high prevalence of critical newborn and under 5 mortality, and low-income families. The government has made health equity, gender and human rights its core principles in achieving universal health coverage and has deployed CHWs among the most disadvantaged and marginalized communities.

BEST PRACTICES

Strong relationship between the community and CHWs with respect and trust, which was critical in ensuring CHWs' acceptance by the community, was important facilitating factor in the implementation of the programme.

Participation and ownership of programme by community including Village Health Committee who monitored CHWs' activities and Constituency Councilors who were advocating for CHWP in various media channels facilitated the appropriate implementation of the programme.

Maps of households: All CHWs mapped the houses assigned to them, which facilitated their day-to-day activities.

Support from health facilities: CHWs who were supported by the respective health facility nurses were encouraged to perform their duties better. Good relationship and respect between health facilities and CHWs was critical in strengthening the community-health facility bi-directional referral system.

Accessibility to referral health facilities: In some communities, the referral health facilities were easily accessible to the community, without which the contribution of CHWP in improving health service coverage would have been limited.

Using social media to share knowledge: Oshana and Kunene teams have identified the importance of communication between CHWs, PHC and the health facility and created a WhatsApp group, where they share knowledge and information, and get advice.

External supervision: Given the competing priorities of the health facility nurses, the PHC supervisors have taken on the responsibility of supervising CHWs.

Peer supervision: To support supervision process, staff in Luderitz, Zambezi and Omaheke devised mechanism to do so. In Luderitz, the PHC supervisor and the health facility nurse created a supervisory structure, where each CHW gets an opportunity to act as a supervisor every 3 months. CHWs get an opportunity to help one another and assess the quality of work performed by a fellow CHW. In Omaheke and Zambezi, the programme followed the SOP guidelines and appointed a senior CHW.

LESSONS LEARNED

Strengthen advocacy: One of the key lessons were that teams/Sectors that are supportive of the programme are those with an appreciation for PHC, and who are exposed to CHWP Resistance and lack of support were observed from people who have not been exposed to the programme e.g. financial and human resource staff, and health professionals whose focus is on curative care. Moreover, due to lack of awareness on the scope of CHWP, some community members have requested additional services outside its scope, which may derail the community's interest in the programme. To strengthen /revitalise the CHWP, there is a need to orient officers, communities and other governmental organizations on the role of CHWs and the importance of PHC. Moreover, provision of uniforms has given CHWs a sense of belonging and easy recognition improving their visibility.

The use of CHWs as role models, especially those with a history of alcohol abuse had a positive outcome in addressing alcohol and gender based violence, especially in areas where there is a high rate of alcohol abuse and gender based violence.

Diversify funding of CHWs' activities: CHWP addresses social determinants of health that are the responsibilities of different sectors, and the burden cannot be carried by one sector. One key lessons was

that is important for different sectors for example, Gender, Culture Education provide support be it financial, logistics and human resources that they enable CHW to do their work effectively.

Strengthen external and peer supervision: This is especially important given the current challenges of limited human resources and competing priorities at health facility level.

Adjusting number of households per CHW based on geographic proximity of households: There is a need to allocate adequate number of CHWs according to the regional needs. Some CHWs are experiencing challenges as they are expected to cover 100 households within month, despite the long distances between households.

Community participation: Despite the variability, community participation is well documented and contributed to programme performance. While it has been noted that CHWP thrives in communities where the community selected CHWs, it was not the case in some communities. There is a need to develop a policy or guideline outlining participation to standardize and strengthen community participation.

Critically review CHWP for urban areas: The CHWP had the purpose of addressing health needs in rural, informal settlement and communities that do not have access to health care. Thus a key lesson is to ensure that the deployment of CHWs is done following a thorough situation analysis. In some case there is no need to deploy community health workers in urban township that can be catered by the Primary Health Care unit from the respective region. It is important to strongly consider the deployment of CHWs in the informal settlements in the urban areas.

Critically review the capacity of a health facility in supporting CHWs: The success of effective CHWP depends on the support provided by the nearest health facility. Hence the need to train and orient facility health staff towards CHWP.

Galvanize cross-sectoral support for CHWP: CHWP provide opportunity for cross-sectoral collaboration, including possibility of funding from the private sector. Although unstructured multi-sectoral collaboration is visible at the community level, at national and regional level, it is limited to the participation of Governors or town counsels in meetings.

Identify Champions: Despite the fact that all community members appreciate CHWP, its momentum is somehow diminishing. Thus, it is critical that the programme identifies champions (e.g. Governors who have seen the impact of the programme in their regions) and let them advocate, promote and inspire others to join and support the programme technically and/or financially.

Integrate CHWP pre-service and refresher trainings into NHTC. Providing CHWs training as a standalone programme, using adhoc facilities and relying on facility nurses as facilitators is not sustainable.

CONCLUSIONS

The purpose of this evaluation was to assess to what extent the CHWP contributed to improved maternal, neonatal and child health outcomes in Namibia; to gain an in-depth understanding of the progress and challenges, and to identify areas for improvement; to assess the alignment with, and appropriateness of, policies and guidelines for the community health programme; as well as to determine the extent and depth of coordination and collaboration for partnerships. To achieve the objectives of the evaluation, a systematic study was conducted to address a number of questions designed to assess the relevance, efficiency, effectiveness, impact and sustainability of the programme.

The evaluation concludes that the programme has contributed to increased coverage of MNCH services and improved health status of individuals, families and communities. This was achieved through interpersonal communication especially behavioral change mobilization at home and community levels. CHWs play a critical role as distributor of preventive health care, promoter of health behavior and social welfare, provider of curative care and as community organizers. They were able to create awareness on the importance of healthy lifestyle, addressing issues of alcohol, poor diet and Gender based violence, and promoted early health seeking behavior. They were also responsible for early detection and referral of clients, promotion of health behavior and social welfare, which led to increased utilization of services and improved coverage.

While the programme strategic documents and approaches are appropriate to achieve the set objectives, there were some limitations with the design. For example, the training process was found to be inefficient, the coordination mechanism was inconsistent and there was no strong programme supervision and no systematic cross sectoral collaboration.

RECOMMENDATIONS

#1

The Government, cabinet through the MOHSS Minister, needs to further strengthen its political commitment and stewardship role.

The introduction and scale-up of CHWP to improve maternal and child health as well as the overall health status of the people demonstrates the political commitment of the government. There is a need to further strengthen the government's commitment to allocate more funding and deploy the already trained CHWs with priority to marginalized and hard to reach areas. It is critical to enhance government's stewardship role to address the supply side bottle necks through the expansion of the CHW scope of practice.

#2

The Primary Health Care Director – CHBC in collaboration with the Human and Financial resource unit to develop detailed costed plan with annual breakdown through bottom up approach and strengthen programme monitoring.

The evaluation findings showed that there was no detailed costed plan to evaluate the cost-efficiency of the programme, and M&E framework lacked baseline values for the indicators against which to judge the performance of the programme.

#3

The Primary Health Care Directorate -CHBC, and district and regional directors to strengthen supportive supervision.

Regular supportive supervision is critical to provide technical support through direct observation and mentoring. Thus, the MoHSS is advised to create a supervision structure with the appointment of dedicated person to provide supportive supervision to a group of CHWs. The MoHSS can use different alternative approaches including the use of senior CHWs who could be selected from the existing CHWs to serve as supervisors.

#4

The PHC director, regional director and head of district health facility should strengthen managerial capacity of districts to ensure regular planning and monitoring.

With the addition of 1,600 CHWs into the health workforce, there is a need to appoint a dedicated staff, particularly at district level to coordinate CHWP.

#5

Improve the motivation and satisfaction of CHWs.

The motivation and satisfaction of CHWs is critical for the success of the programme. The MoHSS- Primary Health Care director - CHBC and Human and Financial Department should consider the following measures to improve the motivation, satisfaction and

retention of CHWs:1) establish CHW career paths; 2) provide regular refresher trainings; 3) strengthen procurement and distribution system of CHW supplies; 4) ensure the availability of M&E tools, guidelines, and job aids; and 5) provide uniforms, ID cards, means of transportation in selected villages.

#6

Further strengthen behavioral change communications to empower local communities.

It is important to mitigate cultural beliefs and misconceptions, and develop awareness and positive attitude sufficient to create demand and increase health seeking behavior and service utilization. Primary Health Care Director in collaboration with other division such as Directorate of special programme, epidemiology unit and other related sectors should strengthen BCC.

#7

Strengthen community engagement and participation to ensure community ownership. Community participation in planning, implementation and monitoring of the programme needs to be strengthened.

The community could be involved in administrative support of the programme. Primary Health Care Directorate at national and regional levels in collaboration with the Governors of the regions should take the lead.

#8

Improve access to MNCH services to respond to the increased demand created by CHWP.

With a focus on hard to reach communities, the following approaches, where appropriate in combination, have a potential to improve access to MNCH services: improving the quality of health services; expand the geographic reach and regularity of outreach programmes; use of mobile clinics; improve the availability and functionality of ambulance services and communication systems; and add key and effective interventions such as HIV Testing and Counselling, and integrated community case management (ICCM). Primary Health Care Directorate at national and regional levels in collaboration with the Governors of the regions should take the lead.

#9

Strengthen the coordination mechanisms at all levels of the health system with clear ToR.

With the leadership of the MoHSS, there is a need to strengthen the coordination of the programme, preferably using existing steering committees with participation of partners that are involved in implementation of CHWP. This can be done under the leadership of the MOHSS Permanent secretary designated officer.

#10

Improve the quality of HIS data and use the information for tracking progress and decision making.

Further effort of the government, particularly the PHC and epidemiology units, and partners is required to improve the quality, timeliness and completeness of the data collected. Moreover, due to the lack of capacity in data analysis, the information has not been used for decision making and tracking progress. This is another area requiring immediate attention through training of key health managers including district staff in data use for decision-making.

#11

Institutionalise the training of CHWs and develop an integrated refresher training module.

Institutionalising the training of CHWs improves the cost-effectiveness of the programme by reducing the cost related with resource intensive start-up of individual training programmes. Regular refresher training courses should be provided to all CHWs as part of professional development. There is a need to standardise training materials and programme to maximize existing resources for training and improve training effectiveness and efficiency. Expedite the accreditation process, ensure that there are adequately trained and qualified facilitators and use the NHTC's regional/central facilities. This requires a coordinated effort of the Primary Health Care – Community Based Health Unit and Directorate of Policy Planning and NHTC.

#12

Strengthen advocacy:

Advocacy activities are needed to promote the programme and enhance policy initiatives to strengthen and evolve the programme in response to the health needs and changes in the population dynamics. Advocacy is also needed to mobilize relevant sectors for cross-sectoral collaboration. This is the responsibility of the Primary Health Care – Information and Communication Unit and MOHSS – public relations officer.

#13

Establish cross-sectoral collaboration, which is the responsibility of the MOHSS Directorate of Policy and Planning; National Health Training Center; Primary Health Care.

The MoHSS should take the lead and engage in intensive and sustained mobilization of policy makers of relevant sectors through advocacy. The establishment of strong cross-sectoral collaboration based on specified roles and responsibilities will contribute to the achievement of health outcomes in a more effective, efficient and sustainable way than could be achieved by the health sector acting alone. CHWP addresses social determinants of health that are the responsibilities of different sectors, and the burden cannot be carried by one sector. Consideration should be made to explore how different sectors can contribute to CHWP budget, more so now with the budget cuts in 2016/17, which had a negative impact on CHWP.

1. PROGRAMME DESCRIPTION

1.1. Programme background and key information

Over the last three decades and following the 1978 Alma Ata Declaration on Primary Health Care (PHC), Community Health Workers (CHWs) were promoted to become part of many developing countries' health systems[1]. While there was considerable variation in the types of CHWs and the forms taken by CHW programmes, CHWs' international experiences gave rise to debates on their role in health systems and highlighted the problems associated with their management. While successful experiments across a range of contexts provided inspiration for CHW programmes, numerous challenges arose in the process of shifting from effective and small-scale local programmes to national CHW systems. Common problems cited included lack of community integration, unrealistic expectations, unsupportive environments, poor supervision, lack of appropriate incentives, high turnover and ultimately poor quality and cost-effectiveness.

In 1990, soon after independence, Namibia adopted PHC approach as the principal strategy to addressing fragmented services inherited from the apartheid era. The implementation of this approach has been guided by the principles outlined in the Ministry of Health and Social Services (MOHSS) Policy Framework of 1998, namely: equity, availability, accessibility, affordability, and community involvement. The National PHC/ Community Based Health Care Guidelines published in 1992 stated that, in the implementation of PHC, greater recognition has been given to the role of individuals, families and communities in the promotion of their health status, while at the same time ensuring there is improvement in the quality of health care provided at various service delivery points, especially in clinics closer to communities.

Immediately after independence, the country was confronted with high prevalence and incidences of non-communicable and communicable diseases. Notably, there was high rate of HIV prevalence at 22% resulting in high mortality and morbidity. With limited human resource in health this situation tested and stretched health facilities beyond their capabilities. The HIV/AIDS situation was unbearable as people were dying at home and it was the community members who took up the challenge of caring for the sick family members and neighbours. Community volunteers became a valuable resource in the 90's , not only in terms of caring for the sick, but also educating communities about disease prevention and management. Thus, the burden of HIV/AIDS on the health system was reduced by the work of CHWs, who were mostly volunteers and who provided their services at no cost.

In March 2008, a national policy on Community Based Health Care (CBHC) was issued by the MOHSS following a national assessment of community volunteers and CBHC programmes, and a national conference on volunteers that was held in December 2006. The policy document describes the policy goal, principles, objectives and strategies that guide CBHC programmes in Namibia.

General approaches to implementing community-based activities are outlined in the Community Health Worker Programme (CHWP) strategy. The idea behind CHWP is mainly to improve access to health services by bringing services closer to the communities while also addressing the shortage of health work force. The training curriculum has seven modules on First Aids, Community Mapping, Community-Based Maternal and New-born Care (CBMNC), Community Based Childhood Illness, HIV/AIDS/TB & Malaria, Social Welfare and WASH. With this six-month training, the deployed CHWs provide services and health promotion on those areas in their designated villages. The basic package of health care and promotional services provided by CHWs and the number of CHWs have been increasing overtime. The programme operates in the context of a health system, which is partly decentralized to the district level.

The country is divided into 14 regions and 34 district hospitals. The MoHSS started the formalization of community health programme through the modelling of Health Extension Programme in 2012, in Opuwo district of Kunene region, through the technical and financial support of UNICEF. At that time, UNICEF, jointly

with other partners such as USAID/C-CHANGE, currently known as the Maternal Child Survival Programme (MCSP), supported the MoHSS develop CHWP Strategy, Standard Operating Procedures (SOPs) and training materials. This included formation of a national steering committee to oversee the programme.

In 2012/2013 when the MoHSS endorsed the programme, the initial number of CHWs was only 34 for Opuwo district where the programme was piloted. By mid-2013, the government of Namibia allocated an amount of 9 million USD for the scale up of the programme. The Community Health Worker's training package was extended in 2015 to include Water Sanitation and Hygiene, Adolescent health and monitoring component. The number of districts or regions with presence of CHWs increased by end of 2014 from 4 regions to 13 (92.86%), and the number of trained and deployed CHWs to 1,640 by end of 2016. This increase in the short span of time was possible with the high government commitment through absorption of CHWs into MoHSS' pay roll, and on-going advocacy and support from development partners such as UNICEF, USAID/MCSP and WHO.

In December 2016, the MoHSS decided to cease the training of CHWs due to government-wide budget constraints. This affected those who were in training and the scheduled new intake for 2017/2018. In February 2017, the senior management of the MoHSS decided to re-launch this programme and trainings for CHWs based on positive appreciation received from populations, partners and colleagues from the MoHSS about the impact of the CHWs on the behaviour change of communities.

Namibia's 2013 Demographic and Health Survey[2] findings show that Namibia has made sluggish progress in health-related behavioural indicators. At the impact level, from NDHS 2006/07 to NDHS 2013, maternal mortality reduced from 449 to 385 per 100,000 live births and the under-five mortality rate (U5MR) reduced from 69 to 54 per 1,000 live births. CHWs' contributions have been felt in various ways especially since the introduction of government paid CHWs by end of 2013. Their contribution is expected to be significant and contribute to improvement of some health indicators during the next NDHS 2018/2019. Generally, the government paid-CHWs have been commended for mobilizing the population and raising awareness on the advantages of immunization, importance of antenatal care and early seeking behaviour for maternal newborn and child health, and the utilization of family planning services that are currently free of charge and accessible to the majority of Namibians. However, the CHWP has not been formally evaluated making continued investment in the programme a challenge, due to lack of impact evidence.

Literature has shown that CHWs, when used appropriately and incentivized, can bring about significant positive changes in health at the community level. However, like many African countries, and despite current and potential health achievements, the CHWP in Namibia still faces significant challenges that hinder the delivery of a quality comprehensive package of services. These challenges range from capacity and resource gaps to sustain routine community health activities (such as lack of institutionalized training institution for paid up CHWs, and refresher training), attitude of health facility nurses towards the programme, the urgent need for standardised coordinated recruitment, training, supervision and monitoring and/ or accreditation of certificates, and reinforce supply systems. Effectively addressing these challenges will significantly contribute towards achieving the national health targets described in the implementation plan for National Development Programme five (NDP5) 2017-2021.

Access to health care is a key priority for improving a country's overall health status. Therefore, it is crucial to document perceived barriers to accessing health care, as well as initiatives undertaken to overcome those barriers. Documentation of community health activities will lay out the actions required to strengthen Namibia's health system, and enable replication of good community health practices. This will ultimately support the achievement of maternal and child health goals outlined in Namibia's NDP5, 2017-2021, and National Health Sector Strategic Plan (2017 - 2021), and provide lessons learnt to improve CHWP and similar programmes in other countries in the region and elsewhere.

Objectives of the programme

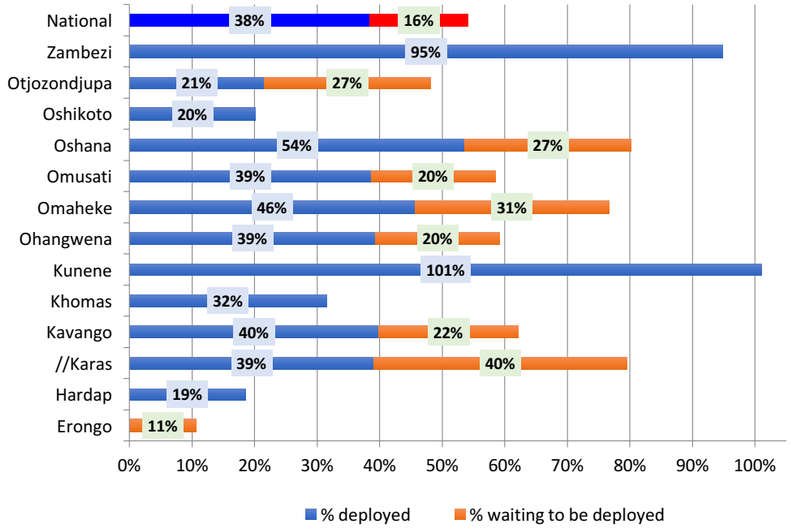
With the overall objective of improving the health and quality of life in households and communities in Namibia, CHWP aims to achieve the following specific objectives:

1. To increase access to and coverage of promotive and preventive health care services
2. To strengthen the continuum of care and bi-directional referral between the community and the health facility
3. To empower local communities through awareness building and training of Community Based Organizations (CBOs) to promote healthy lifestyles
4. To promote ownership and participation through the involvement of community members in planning, implementation and monitoring of the CHWP
5. To collect and analyze household level data for planning, reporting and decision-making.

1.2. Implementation status

Overall 38% of the targeted CHWs have been deployed. When the already trained CHWs (16% of the total) are deployed, the total coverage will be 54% of the targeted CHWs nationally. The implementation status and coverage differs by region with Zambezi and Kunene having achieved the target coverage (Figure 1.1).

Figure 1.1: Percent of targeted number of CHWs deployed and waiting to be deployed by region



1.3 Programme Theory of Change (ToC)

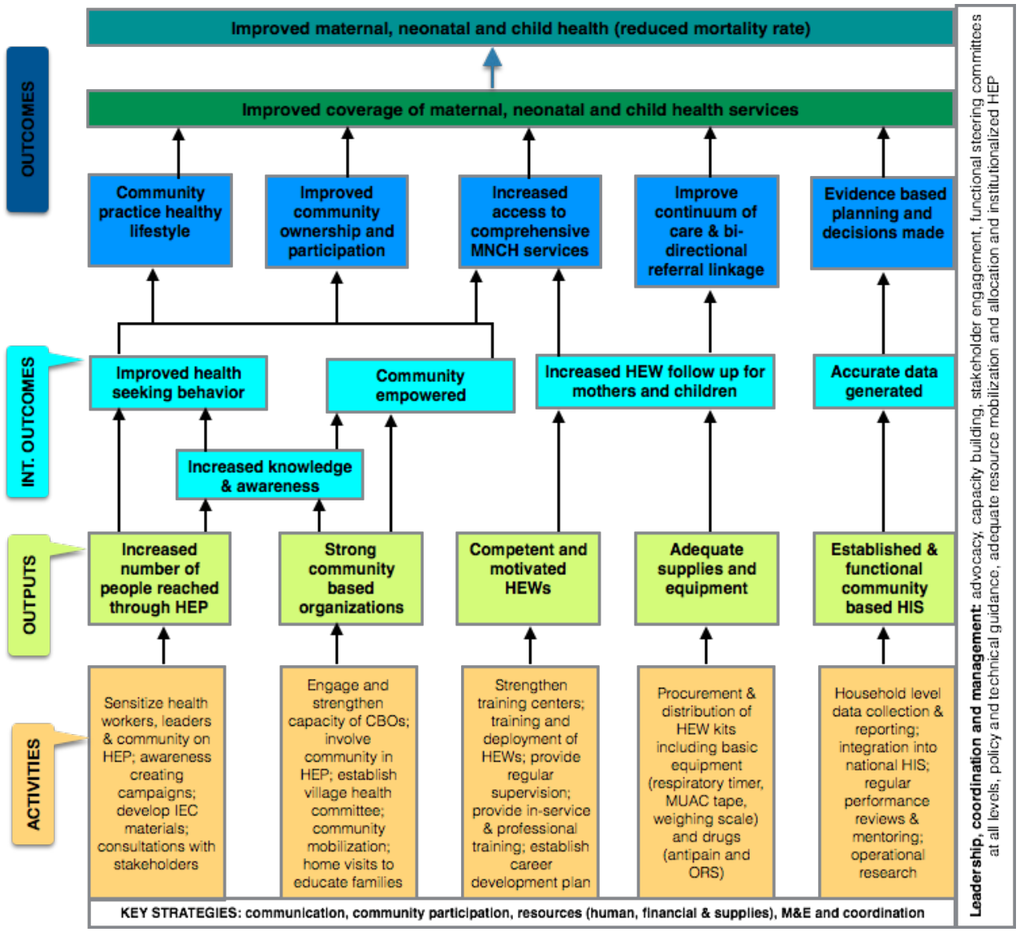
The Theory of Change (ToC) was reconstructed in a participatory approach based on the programme's intended impacts (objectives and strategies) and the evaluation framework (showing the outputs and outcomes). The reconstructed ToC sets clearly the causal chain that transforms the strategies into activities and activities into immediate, intermediate and long-term outcomes and then their contribution into impact (Figure 1.2).

The first step in the process of developing the ToC was problem analysis in relation with maternal, neonatal and child health, and identification of the underlying causes of the problems that are targeted by the programme (Annex A). The problems were organized into the following categories: lack of decision power to

seek care; lack of awareness and behaviour to seek care; poor referral system; lack of adequate, motivated and competent health workers; lack of service availability and quality; poor support and management system; and other contextual factors. The CHWP's key strategies and activities mainly target the first three categories (lack of decision power to seek care; lack of awareness and behaviour to seek care; and poor referral system). It also partially targets lack of health workers and poor support and management system categories.

The focus of CHWP is on preventive and promotive health services resulting in improved adoption of healthy family practices including better parenting skills, and ownership and participation of the community. These are achieved when awareness is created and community is empowered to make decisions. The increased access to service is generated through behavioural change and community empowerment to demand and utilize health care services in a timely manner as well as through the increased follow up of mothers and children by CHWs who identify risk factors and danger signs early and encouraging clients to seek service at referral health facilities.

Figure 1.2 Theory of Change for CHWP



1.4 Programme Activities

CHWP intended to achieve the objectives through the implementation of the following activities:

- Sensitization of health workers, leaders and community to create accurate understanding of CHWP
- Awareness raising community campaigns
- Engagement and consultations with stakeholders
- Develop and disseminate an integrated package of health promotion materials on maternal, newborn, child health and nutrition
- Engage and strengthen capacity of CBOs
- Involve CBOs and community members in planning, implementation and monitoring of CHWP
- Establish village health committees
- Conduct home visits to educate families
- Strengthen the capacity of training centers to improve quality of training
- Training and deployment of CHWs with the ratio of one CHW to about 100 households
- Motivation of CHWs through refresher training, career development and supportive supervision
- Develop and distribute guidelines, tools and manuals
- Procure and distribute CHW's kit, basic equipment (respiratory timer, MUAC tapes and weighing scale) and paracetamol, and Oral Rehydration Solution (ORS)
- Distribute M&E tools and forms

1.5 Programme Partners

Various partners were involved in the design, implementation and monitoring of the CHWP. Below are some of the key partners:

MoHSS

Ministerial Management provides continuous policy guidance and adequate resources to ensure the scale up and development of the CHWP. The PHC Directorate provides leadership and coordination to strengthen the management and administrative structures at national, regional, district, constituency and local levels.

UNICEF Namibia

UNICEF collaborates with the Government of Namibia, providing both financial and technical assistance to the CHWP initiatives. The support to date included piloting and payment of allowances in the pilot district, development and review of training materials, roll out trainings, supervision, review meetings, master plan development and review, orientation, procurement of supplies, equipment and consumables, and support for south to south cooperation and/ or study visits., among others. UNICEF intends to provide further support to review the Programme, including the planning and implementation processes, challenges, successes and lessons learnt during the implementation period, in order to improve the programme design and strengthen sustainability.

MCSP

MCSP provides technical assistance to the CHWP in seven regions and works with the MOHSS to increase access to an integrated package of PHC services, including community-based HIV testing and counselling (CBHTC). MCSP technical support is directed at increasing the quality of the package through strengthened supervision, mentoring, and knowledge sharing between health care workers and MOHSS staff in the districts and regions.

2. PURPOSE OF EVALUATION

The purpose of this evaluation was to document the Namibia CHWP, assessing programmatic achievements and constraints by reviewing the existing conceptual framework and overall system, including financial support, management structure, supervision mechanism and governance. The aim was to gain an in-depth understanding of the progress and challenges, and to identify areas for improvement; to assess the alignment with, and appropriateness of policies and guidelines for CHWP; as well as to determine the extent and depth of coordination and collaboration for partnerships. The evaluation will be conducted through a systematic assessment of the relevance, efficiency, effectiveness, impact and sustainability of the programme.

The findings of the evaluation will mainly be used by MoHSS and partners, in their different capacities and functions, to inform policies and strategies and develop future plans and interventions to improve programme performance. It could also be used in academic settings, especially public health and teaching on community health.

Namibia has been implementing CHWP since 2012. In the past five years the programme package expanded and advanced significantly, yet no comprehensive evaluation has been undertaken to assess the relevance, efficiency, effectiveness, impact and sustainability of the programme.

An evaluation is required to guide the MoHSS on how to use the CHWs most effectively to achieve national health goals, and contribute to the achievement of the post-2015 global SDGs. Programmatic achievements and constraints need to be documented and analysed, informing new technical guidance to maximize the impact of the CHWP.

3. EVALUATION CRITERIA AND QUESTIONS

The comprehensive external evaluation was guided by OECD/DAC evaluation criteria of relevance, effectiveness, efficiency, sustainability and impact. It also looked at criteria of interest to the Ministry of Health and UNICEF including coherence, human rights-based approach (HRBA), results-based approach to programming and equity. The evaluation was organized around the following evaluation criteria. The key evaluation questions are shown in Table 3.1, and the specific questions under each evaluation criteria are presented in the Evaluation Framework (Annex B).

- Objective 1 is to assess the programme impact
- Objective 2 is to assess the programme relevance
- Objective 3 is to assess the programme effectiveness
- Objective 4 is to assess the programme efficiency
- Objective 5 is to assess the programme sustainability
- Objective 6 is to assess programme coordination
- Objective 7 is to assess the application of a human rights-based approach (HRBA) in programming
- Objective 8 is to assess the training programme

Table 3.1: Evaluation Criteria and Key Evaluation Questions

Evaluation Criteria	Key Evaluation Questions
Impact	• To what extent did the programme contribute to the improvement of maternal, newborn and child health indicators? • To what extent did the programme contribute to increased access and utilization of maternal-newborn and child health, and improved health seeking behaviours? • To what extent has the programme contributed to making a real difference in the health status/Outcomes at household levels?
Context and Relevance	• National decision-making level: how well the programme fit to national priorities • To what extent has the programme contributed to the policy direction, decision-making processes and resource allocation for the maternal, newborn and child health at national, sub-national and partner levels? • To what extent are the programme`s activities and outputs aligned with the objectives of the CHWP strategy? • Community level: how well was initiative accepted by the communities? Did it fit to community priorities?
Effectiveness	• To what extent does the programme improve capacity of decentralized structures such as regions and districts to deliver CHWP services? • To what extent does the programme increase the participation of community members in the CHWP activities? • To what extent does the programme increase motivation of CHWs? • To what extent does the programme improve coordination of community health services at national, regional, district, health centres and community level? How strong are the community-facility linkages and referral networks?
Efficiency	• Were the available resources (financial, human, institutional and commodities) efficiently used to achieve the programme objectives? What gaps existed e.g. in remuneration, workload, supply chain? • Were resources at the community level effectively used to achieve the programme objectives? • How cost-efficient was the programme in delivering primary health care services at community level? • What are the current sources of funding for the programme? • What data system is used by the programme? To what extent is this integrated into the national health informatics system? To what extent is the data used to improve programme management and to inform investment?
Sustainability	• How well is the initiative incorporated into national and subnational legislation? • To what extent is the programme institutionalized within the health care system? • How well are CHW incorporated in the community? What is the attrition rate (and reasons for drop-out)? What are the main incentives for CHW to stay in the programme? • How well has the programme empowered local communities through awareness building and training of CBOs to promotive health lifestyles? • How has the programme promoted ownership and participation through the involvement of community members in planning, implementation and monitoring of the CHWP?
Coordination (implementation and management)	• What were the overall programme coordination mechanisms at national, sub-national and community levels? Was it functional? What can be improved? • What cross-sectoral linkages exist? What opportunities exist to strengthen these? • How adequate was the programme implementation and management capacity and system?
Gender and Human rights-based approach	• To what extent does the programme consider the equity approach (i.e. focus on most deprived areas, areas with high prevalence of critical newborn and under-5 mortality, low income families)? • To what extent are vulnerable groups involved in planning and utilization of the service?
Training, Supportive Supervision, Mentoring and coaching	• How was the training curriculum development process, adequacy and quality? • How is the current management and operation of the training facilities? • What are the training needs for CHWs?

4. OBJECTIVES

The overall goal of this evaluation was to understand whether the intended objectives of the CHWP were met and whether it resonates with the objectives in the strategic plan. Specifically, the evaluation determined to what extent the intervention had been able to meet its objective to create capacity, tools and structures to respond to the high levels of maternal, new-born and child morbidity and mortality rates in Namibia.

This involved a comprehensive system review, i.e. a critical review of the existing CHWP conceptual framework and overall system such as management structure, supervision mechanism, incentive/salary mechanism, financial allocation, governance and performance evaluation system. The evaluation assessed the CHWP performance in different dimensions of programme evaluation, including (i) impact, (ii) relevance, (iii) effectiveness, (iv) efficiency, (v) coherence, (vi) sustainability, (vii) coordination, (viii) human-rights based approach, ix) institutional capacity and (x) results-based approach.

Through detailed assessment, the evaluation documented lessons and identified best practices in the implementation and management of CHWP, and aimed to use the evidence to improve the programme design and implementation, and related policy change, if needed.

The evaluation did not attempt to quantitatively measure the behavioural change that occurred (due to lack of baseline information on this sphere) but used health facility data and results of surveys on child, newborn and maternal health indicators to determine improvements. Qualitative information from a large pool of stakeholders was used to triangulate the findings.

Scope and Focus

Geographically, the scope of the evaluation expanded beyond the national level to ascertain its sphere of influence on the overall maternal, newborn and child health (MNCH) programme in Namibia. There were no any programming elements related to the project that were not included in the scope of the evaluation, and there was no any change made to the original terms of reference. The evaluation focused and included the following beneficiaries and stakeholders in the process:

- Final beneficiaries: newborn babies, children, mothers and other caregivers and community members
- Service providers: health care professionals whose capacity has been built (including health facility supervisors, and sub district health professionals) and CHWs
- Sub-national decision-making level: regions, district and health facility authorities
- National decision-making level: national authorities and key stakeholders (Ministry of Health, Public Service Commission, Development Partners, the UN System (UNICEF, WHO), USAID, MCSP, Namibia Planned Parenthood Association, MSH, etc.)
- National Professional Societies and Academia: Namibia Paediatric Society, Midwifery Association of Namibia, School of Public Health, NHTC, Teaching Hospitals etc.

5. METHODOLOGY

Due to the lack of baseline data and control group, the evaluation determined the contribution of CHWP to maternal, neonatal and child health outcomes using a theory based contribution analysis. Thus, the approach was based on verifying the ToC (Figure 1.2) reconstructed for CHWP, while also taking into account the influence of other factors on the outcome indicators.

The evaluation was guided by the norms and standards of UNEG given their systematically established relevance for evaluating initiatives and programmes. The research considered the standard OECD criteria (relevance, effectiveness, efficiency, sustainability, coordination and impact) and integrated the criteria related to Human Rights (HR) and Gender Equity (GE) based approach. In order to be responsive to HR and GE aspects, special consideration was given to gender, sex, distance from service locations and wealth when stakeholders and beneficiaries' view were sought in data collection. As per the Terms of Reference (TOR) (Annex C), the evaluation examined the impact (to the extent possible), relevance, effectiveness, efficiency, sustainability, and coordination of CHWP. To achieve evaluation objectives, the EF (Annex B) has been developed in a participatory approach with the involvement of key stakeholders. The EF identified indicators for each question that was assessed during the evaluation. It also identified the sources of information each question.

The evaluation used a mixed-method (qualitative and quantitative methods). The quantitative component focused on existing retrospective health facility data to analyse the trends in maternal, newborn and child health outcomes.

During all stages of the evaluation process, the ET ensured the independence and impartiality, which contributes to the credibility of the evaluation and the avoidance of bias in findings, analyses and conclusions. The evaluators conducted the evaluation independently without any pressure from the MOHSS and commissioners of the evaluation. The ET followed a maximum level of objectivity distinguishing facts from opinions to support the findings, conclusions and recommendations with evidence. The evaluators do not have any conflicts of interest with the evaluation. Furthermore, evaluators ensured confidentiality of information, privacy and anonymity of study participants, and respected cultural sensitivities.

5.1 Evaluation framework (EF)

The EF is presented in a matrix organized based on the evaluation criteria with detailed evaluation questions, indicators and methods of data collection (Annex B). The key questions were taken from the ToR for this evaluation, which were revised and refined with the participation of the members of the steering committee. Follow-up questions were included to reflect the reconstructed ToC and ensure the required information was collected. Furthermore, the framework ensured gender and equal opportunity issues were considered.

All evaluation indicators were analysed using desk review of documents, interviews with programme staff, partners, beneficiaries and key stakeholders. In some cases, the rather subjective "perception" had to be used as an indicator. Semi-structured interviews were used around these questions through a wide representation of key informants. Findings (especially on perceptions) were crosschecked during different interviews and with available evidence from desk reviews and quantitative data.

5.2 Sampling method for field visits

Regional, district, health facility, and community level key informant interviews and cFGDs were undertaken in a sample of regions. The programme has been implemented nationally with the exception of one region. For the purpose of the evaluation, five regions were purposively sampled from the 13 regions that have been implementing CHWP. The parameters used for sampling comprised geographical location and perceived level of CHWP implementation.

Table 5.1: Characteristic of Sample Regions and Districts for Field Visit, Interviews and FGDs

Sites	Omaheke region	Oshana	Kunene	!//Kharas (Keetmanshoop)	//Kharas (Luderitz)	Zambezi
Geographic location	Central	North West	North East	South		North East
Geographic area (km2)	84,981	8,647	115,260	161,215		14, 785
Population	71,233	176,674	86,856	80,884 (as projected from the 2011 Population and Housing Census		90,596
Number of CHW	84	195	193	84		203
Districts	1 region and 1 district	1 region, 1 district	1 region, 1 district	1 region, Three (3) district		1 region, 1 district
Context	Urban informal settlement	Rural agrarian	Rural nomadic	Urban formal settlement	Urban informal settlement	Rural agrarian
Location	Kanaan community, Epako Gobabis	Oshana, Odjodjo	Omaepanga village	Lemoen Draai, Tseiblaagte	Area 7	Ikumwe Village
Mean distance to health facility	<5km	>5km	>5km	<5km	<5km	15 km

All regions were geographically grouped into clusters representing different geographic parts of the country: North West, North East, Central, and South. Then, the level of CHWP implementation was identified as poor, average and good, while one region was characterized as having unique characteristics and poor performance (Table 5.1). Based on this approach, the final sampled regions included Zambezi (average performance), Kunene (poor performance and unique characteristics), Oshana (good performance), Omaheke (good performance) and //Karas (poor performance).

5.3 Data collection methods

On the quantitative aspect, trend analyse was conducted on key MNCH outcome/impact indicators to compare the pre- and post-programme implementation trends. The qualitative component drew on the understanding and perception of the main stakeholders involved in the project. The evaluation methodology comprised a mix of site visits and observations, key informant interviews using semi structured questionnaires, community Focus Group Discussions (cFGDs) using guiding questions, desk-based review of existing documents, reports and secondary health facility data.

Desk Review (DR): Review of documents was a major part of the assignment. Some documents have been made available and the consultants obtained additional documents in consultation with UNICEF, MCSP/ USAID and other key stakeholders. The list of documents reviewed is provided (Annex D). The desk review studied available qualitative and quantitative secondary data around the themes of the evaluation. The key quantitative data constituted health facility data from the national health information system database. Data on key maternal, neonatal and child health indicators covering the period pre- and post-intervention was obtained from the database for all districts targeted for CHWP implementation whether they have or not implemented CHWP. Regions with at least 3-4 years of CHWP implementation were the main targets for the trend analysis.

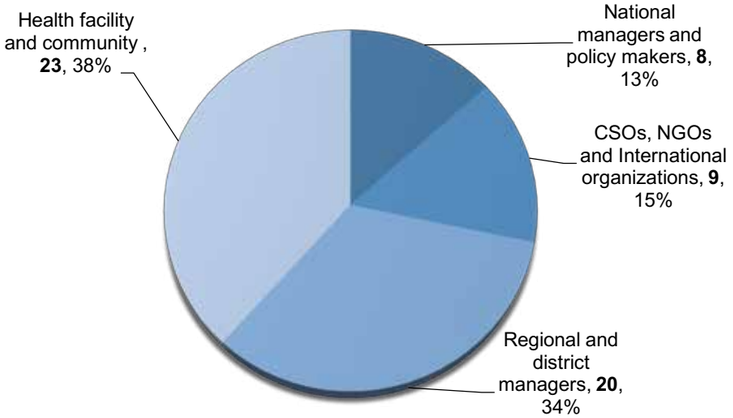
Site Visits (SV): While the team conducted key informant interviews and cFGDs, it also undertook observations at health facility and community levels to confirm some of the findings from key informant interviews. The team also obtained documents and reports available at the lower health system level.

Key informant interviews (KII): KIIs with various key stakeholders was an important source of evidence for many of the evaluation questions. The key informants comprised individuals who have substantial knowledge of CHWP through direct or indirect involvement in CHWP design, implementation and monitoring activities. They were selected from national health policy makers (MoHSS), managers and supervisors at regional and district levels, health workers and CHWs, and various key stakeholders (Table 5.2). In total 60 key informants representing the different health system levels were interviewed (Figure 1.1). Through in-depth interviews, the KII sought to obtain the perceptions and views of the key stakeholders on the evaluation questions. Moreover, documented evidence and data to support the overall analysis were obtained from the key stakeholders. The list of key informants is presented in Annex F.

Table 5.2: Number and Type of Key Informants

Level	Institution	Responsibility	Number
National	MoHSS	PHC Director/designate	1
		CHWP Coordinator	1
		Social Welfare Services Director/designate	1
		Planning & HR Development Director/designate	1
		NHTC director/designate	1
		HIRD director/designate	1
	UNICEF		1
	WHO		1
	USAID		1
	MCSP		1
	Project Hope		1
	MSH		1
	Synergos		1
	ITECH		1
	Red Cross		1
Region	Regional Government	Governor	5
	Health Department	Regional Health Director/designate	5
	Gender equality and child welfare	Regional Officer	5
District	Health Department	PHC supervisor/CHWP focal person	5
Health facility	Health facility	Health facility supervisor/designate	5
Community	Health (CHWP)	CHW	10
	Administration	Village headman	5
Total			**55**

Table 5.2: Number and Type of Key Informants



Focus Group Discussions: Community FGDs was one component of the data collection methods, and it aimed to obtain diverse perspectives from beneficiaries about the programme and the improvements in health outcomes. Participants of the cFGDs were selected from the community. The number of participants in each cFGD ranged between 8-10 members. The composition of the cFGDs depended on the availability of specific participants in the particular community, however, the following were part of the focus group: women with under five child, women who gave birth recently at a health facility, and women who were members of the village steering committee and village health committee. Overall, five cFGDs were conducted, one in each region.

All key informant interviews and cFGDs were digitally recorded upon verbal consent. The research assistants also took notes during the interview and cFGD. These notes were then summarized into bulleted points; and, every attempt was made to ensure that accurate statements were noted. The notes were comprehensive and tried to cover the full range of issues discussed during the key informant interviews and cFGDs. The research assistants typed the notes for each interview and FGD. A list of key informant interviews as well as cFGDs participants was submitted alongside the typed notes for each interview/FGD.

Data collection tools for key informants and FGDs as well as guiding questions for desk review were developed based on the EF to help ensure systematic coverage of questions and evaluation criteria. The interview topics were grouped according to the targeted key informants. General guiding procedures were followed during interviews and cFGDs (Annex E).

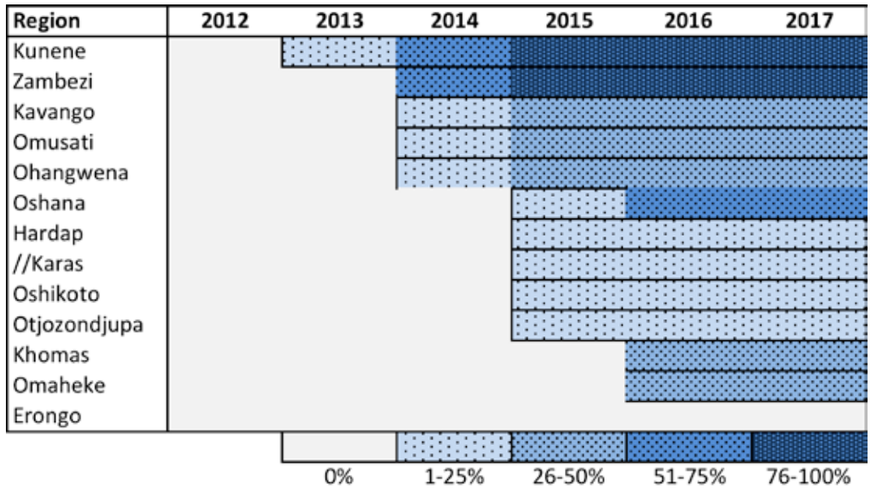
5.4 Data analysis methods

Quantitative data from the national health information system database was used for data analysis. The national health information system database comprises a comprehensive and integrated data reported by the standard health system and community based health care system. Data from health facilities and CHWs are compiled at the district level and entered into the DHIS web-based system. District level data on selected health outcome indicators with a focus on maternal and child health services was obtained for the years 2008 to 2016. In addition to conducting simple data analysis such as trend and annual change rate estimation for the outcome indicators, we had originally planned to conduct advanced statistical analysis including multivariate analysis to control confounding. However, the data was not suitable for multivariate analysis due to the small number of data points – with yearly data for about 30 districts. Thus, the focus of the quantitative analysis was based on retrospective health facility data to compare the pre- and post-intervention trend of the outcome indicators. The pre- and post-intervention period for the districts depended on when CHWs were deployed in the district and the level of coverage by CHWs (relative to the required number of CHWs or the size of the target population). Thus, data on how many CHWs were deployed in each district and when they were deployed was obtained to determine the district intervention years (It was also planned to use districts that had not yet deployed any CHWs as counterfactuals to control the effect of other external factors including in the health system, which might had affected the trend in outcome indicators. It was only in Erongo region where CHWs were not deployed, however, the districts in Erongo could not serve as counterfactuals since they couldn't match with other districts in terms of the socioeconomic and health outcome indicators.

Figure 5.2). A variable on intervention was generated to show the status of intervention for each "district-year" with either of the following values: "No", "Partial" and "Yes". The value "Partial" was given to a district-year if less than the targeted CHWs were deployed. We also factored the lagged effect of CHWs deployed in a specific year on the outcome indicators, and we assumed that the effect would be seen the following year. Considering these factors, adequate intervention exposure to bring about significant improvement of health outcome indicators is expected only in Kunene and Zambezi regions where the programme has been implemented for 3-4 years. Thus, the quantitative analysis and results presented in this report is mainly based on data obtained from Zambezi and Kunene (Opuwo district) regions.

It was also planned to use districts that had not yet deployed any CHWs as counterfactuals to control the effect of other external factors including in the health system, which might had affected the trend in outcome indicators. It was only in Erongo region where CHWs were not deployed, however, the districts in Erongo could not serve as counterfactuals since they couldn't match with other districts in terms of the socioeconomic and health outcome indicators.

Figure 5.2: Intensity of Coverage Relative to the Target by Region



The audio-recorded qualitative data was transcribed and translated into English for each interview and FGD. Qualitative data was analysed using a model of narrative analysis, interpretations and social /cultural norms. Data from the quantitative and qualitative data was triangulated. The contribution analysis involved triangulation using the various sources of data to assess the contribution story. The various data sources were used to answer the following questions: 1) which links (paths) in the ToC are strong (good evidence available and wide acceptance) and which are weak (little evidence and/or little agreement among stakeholders)? 2) Does the pattern of results and links validate the causal chain? 3) Do stakeholders agree that the programme has made an important contribution to the observed results? 4) What are the main weaknesses of the causal chain? Key preliminary findings were presented to the steering committee for review and consensus

on recommendations to prepare for ministerial committee presentation and approval. Finally, evaluation findings were presented in workshop represented by national and regional health managers and various stakeholders for validation of facts. About 50 people participated in the validation workshop (Annex G).

6. STAKEHOLDER PARTICIPATION

To ensure ownership of the evaluation findings and strengthen the involvement and interest of the stakeholders in continued support to the programme, the evaluation was conducted in a participatory under the leadership of the steering committee. The main stakeholders of the evaluation are the members of the CHWP Steering Committee: MoHSS, MNCH & Nutrition committee, UNICEF (Child Survival Development, Communication for Development and Monitoring & Evaluation), USAID/MCSP. The steering committee functioned as a reference group for the evaluation and assumed the following responsibilities: i) plan and design the evaluation through consultation with the main parties involved and final approval of the evaluation terms of reference; ii) provided technical inputs to the evaluation design; iii) provided guidelines to evaluators and monitored the implementation; iv) reviewed the evaluator's inception report (including proposals for desk review of documents, evaluation instruments, field visits, annotated outline of the report); v) reviewed preliminary findings for validation of facts and analyses and helped generate recommendations; vi) approved the preliminary reports; vii) by organizing validation workshop, reviewed and approved the final report, verify the findings and propose a management response on how to implement recommendations; and viii) ensure that evaluation findings are used for future planning and community health programme/MNCH programmatic interventions as well as advocacy purposes. The variety of stakeholders in the Steering Committee ensured that different opinions were represented and objectivity was achieved.

UNICEF Namibia and MCSP/USAID were responsible for selection of the consultants to conduct the evaluation, keeping the process separately from the CHWP Steering Committee, which would enrich transparency of the process and ensure neutrality/impartiality. Generally, both UNICEF and MCSP/USAID managed the evaluation. The management of the evaluation involved drafting the terms of reference, initiating the evaluation selection process, liaison between the evaluation team and other members of the Steering Committee, as well as quality assurance of the reports. MoHSS, UNICEF Namibia, and MCSP/USAID were responsible for providing relevant information at country level, providing access to relevant reports/statistics, providing inputs for data analysis, organizing field visits, logistical support, organizing meetings with different stakeholders.

7. ETHICAL ISSUES

Scientific and ethical clearance was sought from the Namibia MoHSS Research Unit. Adequate measures were taken to ensure that the process responds to quality and ethical requirements as per UNICEF Evaluation Standards. Also as per UNEG's standard and norms, the evaluation team handled the evaluation work with sensitivity to beliefs, manners and customs and acted with integrity and honesty in relationship with all stakeholders. Furthermore, the evaluation team protected the anonymity of individual information, and respected the confidentiality of all information, which were being handled during the assignment. The evaluation team used documents and information provided only for the tasks related to the terms of reference of this evaluation. Data was stored in a secure location, kept confidential with access restricted to principal investigators. The study data was used only for the purpose of this study. The evaluators conducted their work with impartiality and independence. The authors would also like to declare that there is no conflict of interest.

8. LIMITATIONS

There were a number of limitations related to this evaluation. Below are the limitations and approaches used by the researchers to mitigate their impact on the study results:

- Short intervention period: Length of intervention is short to bring about significant impact level improvements at national level. The quantitative data analysis focused in regions that have implemented the programme for at least 3 years. It is also important to note that the findings cannot be generalized to all regions in the country as some regions have the advantage of having started 3-4 years earlier, while others only have 12 months implementation.

- Low level of community penetration: Since all the targeted CHWs were not trained and deployed, the intensity of exposure of the community to the behavioral change communication interventions was not as planned to bring about a significant change in outcome measures.

- Availability of target participants: Among the identified key informants, one informant form a partner organization was not able to take part in the interview, which may limit the breadth of information available for the evaluation, however, a wide range of stakeholders were interviewed ensuring representativeness of the information. With regard to FGDs, there was difficulty in the availability of community members to participate in the FGDs in Luderitz due to a short notice, and the FGD was conducted with fewer than 8 members. However, the members represented different groups of the community ensuring their representation of the community.

- Generalizability of findings: Since the qualitative data was collected from 5 regions, the perceptions and opinions of participants may be different from the views in other regions. However, efforts were made when the five regions were selected to ensure a diverse type of regions was represented. Moreover, the inclusion of stakeholders involved in the programme at national level and key informants from different sections of the MoHSS at national level would improve the reliability and generalizability of the findings.

- Validity of qualitative data: the opinions of participants many not be based on evidence, which is a general limitation of such study. However, efforts were made to mitigate this challenge through the use of key quantitative data analysis findings during the interview. Moreover, the overall analysis involved triangulation of data obtained from different sources.

- Reliability of quantitative data: The quantitative data obtained from the national health information system has limitations in terms of quality and completeness. Some indicators in some regions and districts showed over 100% coverage, which could be due to data compilation and entry errors or the use of wrong denominators. Observations were also made that some CHWs may have not completed the data correctly which may have led to wrong data in the HIS.

- Lack of financial information on costs of CHWP: due to lack of information on costed activity plan and expenses of the programme intervention, it was not possible to estimate the cost-efficiency of the programme. The only known costs were in relation to training and salary of CHWs.

9. MAJOR FINDINGS

9.1 Context and Relevance

The Community Health Worker Programme fits well with national priorities

It is widely recognised that despite the 1978 Alma Ata Declaration, the PHC goal to achieve "Health for all by the year 2000", followed by the Millennium Development Goals (MDGs), which ended in 2015 and the SDGs, health remains unmet for many in poor and remote areas. The CHWP was introduced to address the gap in health service delivery, and the study confirmed that CHWs are the link between the community and key social sectors.

The study established that the programme fits well to national priorities. It is embedded in the key government policy document programme such as National Development Plans, Harambee Project, National Health Policy Framework (NHPF), 2010-2020 MoHSS Strategic Plan, Vision 2030 and SDGs with at least seven goals i.e. SDGs 1 (ending poverty), 2 (ending hunger and ensuring food security), 3 (health and wellbeing), 5 (gender equality), 6 (clean water and sanitation), 10 (reduce inequalities), and 17 (partnerships for global health). Challenged with unnecessary deaths due to preventable diseases, the Namibian government introduced the programme. Consequently, the National Health Strategic Plan (NHSP) identified CHWP as one of the key strategies towards ensuring access to health care for Namibians, and this is reflected in the cabinet decision No. 3rd/12.03.13/005.

This is well illustrated by the Governor of Omaheke region, political head of the region:

> *"As a former health worker health is a priority for me. Health is a priority, if you are a politician you lead people and you want them to be healthy. The programme is essential, and this programme has assisted, as you know Omaheke region is vast and it is not in every corner that you find health workers. I have realised that the queues/lines at the hospital have reduced; simple diseases have been reduced simply because of the education by CHW. I would have requested the Ministry to train more, they have made an impact."*

Other key informants made similar observations:

> *"It is a priority. We want to move away from curative services to preventive services. And that's the core function of the CHWs. They make sure that people prevent diseases. I think that there is a need for CHWs in this country". (Key informant, National level)*

> *'Yes, the objectives are in line with the government programme, as it is bridging the gap between health facilities and the community and the objective of PHC is for the status gap between health facilities and the community to be bridged. So, they are in line". (Key informant, National level)*

The cadre of CHWs is recognized and integrated into the national health system and human resources for health and policy plans. They are part of the Ministry of Health's structure and acknowledged as a key cadre in achieving the PHC objectives as stated by one of the key informants:

> *"In the past, we had CHWs who were useful in improving health situations in the community. CHWP was brought in to have employed community workers who could get paid and be committed to their work. It was created to have committed workers and to have access to information in areas that are far away. Where we started the intention of coming up with this programme was very very useful as we were dealing with maternal cases and they taught people to understand the implication of childbirths. This was possible because CHWs were trained to identify danger signs and refer on time. They also gave psychological support to mother and helped them to have birth plan so that they are fully prepared for the birth of the child in terms of money etc." (Senior Health Programme officer, //Kharas Keetmanshoop)*

The programme addresses issues pertinent to communities in rural agrarian, urban, peri-urban and nomadic communities, which has contributed to improvement in childhood illnesses and maternal health, and general health at individual, household and community level. For example, increased childhood immunization, reduction in childhood fever and diarrhoea, improved maternal health, increase pre-natal and post-natal care services, improved access to safe drinking water, improved sanitation and good practices.

Generally, the programme is bridging the gap between health facilities and the community and has reduced the burden on health facilities as most people who are not severely sick have else-where to consult first (now go to CHWs) instead of the health facility.

The programme's strategic documents and approaches were appropriate to achieve the set objectives but the design had some limitations.

Overall, the programme's design, strategy and approaches were appropriate to achieve the set objectives. The programme supported evidence-based interventions, such as maternal and neonatal care including family planning and adolescent health; identification and referral of childhood illnesses and partial management of diarrheal cases, immunization, nutrition and growth monitoring; prevention of HIV/AIDS, tuberculosis and malaria; behavioural change and WASH; as well as social welfare and disabilities with proven effects on maternal and child health outcomes.

However, the strategic document did not include a logic model linking activities to outputs and outcomes to objectives and goals. There were differences in content between the main strategic document and a separate M&E framework document. Activities and outputs required to achieve one of the strategic objectives on improving quality of service was clearly spelled out in the strategic document. Moreover, improving quality of MNCH services did not relate to the conceptualization of CHWP and its key strategic approaches that focus on promotive and prevention services. The M&E framework, which was clearer than the strategic document, presented Results Matrix with programme's activities and outputs aligned with outcomes of CHWP. However, baseline and target values for all indicators were not stated, which would have served as a benchmark for judging the programme impact. Moreover, the outcome indicators listed in the results framework included indicators related with service coverage only. The specific objectives were not specified in a SMART way and respective indicators have not been stated to measure the objectives.

The study noted that national level situation analysis was not conducted and the situation analysis conducted in Kunene region during the piloting phase would not provide a national picture given the diverse and contrast nature of Namibia. A situation analysis is important and critical as it can identify needs and challenges that are specific and provide a clear understanding of the local environment, which will enable the design of a programme that is specific to the region.[3]

The programme design did not include a practical supervision structure and long-term sustainability approaches. Although some considerations were made in determining the required number of CHWs at regional level, the programme design did not consider the diverse local situation within regions in determining the CHW to household ratio. For example, CHWs were expected to cover 50 - 70 households irrespective of whether they were working in urban, rural, peri-urban, agrarian or nomadic communities. The findings noted that in some areas of !Kharas, Oshana, Zambezi and Kunene, households assigned to CHWs were very scattered with more than 20km from the center to the furthest household, while in Omaheke – Kanaan, Lemoen Draai- Tseiblaagte-Keetmanshoop, and Area 7 Luderitz more than 100 households were located within a 5km radius.

CHWP activities and outputs are well aligned with the objectives of the CHWP strategy.

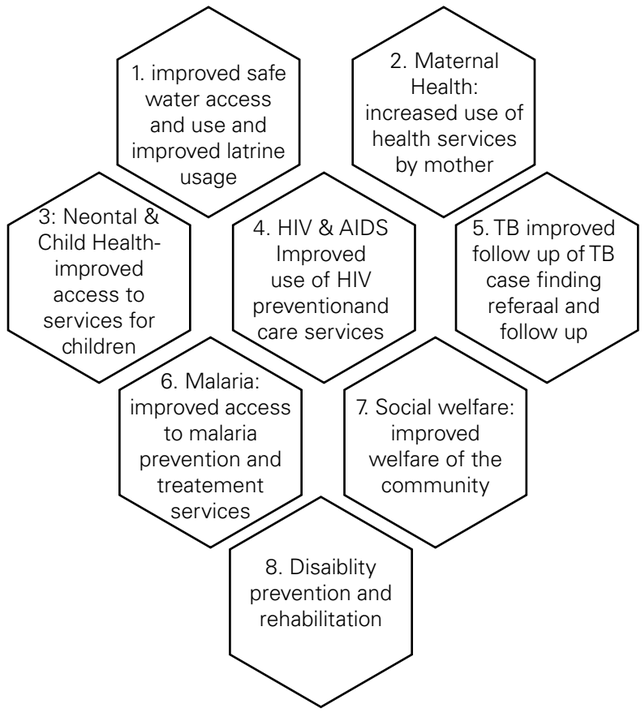
The evaluation found that the programme's activities and outputs are aligned with the objectives of the CHWP strategy. Respondents believed that CHWs are doing a superb job regarding the expected activities. As one of them expressed

> *"In their modules, they are taught how to screen for diseases such as malaria, pneumonia, diarrhoea, and malnutrition. They also refer clients that require medical assistants to health facility. They educate, they support, they give ORS and Panadol. They use the thermometer to detect high temperature then they give Panadol and refer."*

Sometimes the CHWs have been lucky to meet the demand of the community. "In !Kharas Luderitz district, Area 7, the CHW advocated and managed to have the town council build toilets for the community members. This may have implications for future programmes. For example, can the government afford to promote the importance of sanitation without making provision for that?

Generally, the programme has been able to address issues of knowledge and access, and in almost all the areas visited CHWs are appreciated, they are providing services with dedication and contributing to the improvement of health care services in the community. Their activities have been in relation to the key outcomes stipulated in the strategic document. CHWP includes nine outcomes as shown in Figure 9.1. The respondents believed that their work and value has been recognised and many sectors are now seeing the benefit of having CHW, which means their activities may expand. While the study noted that CHW are playing a critical role as advocates for social change including promoting the services of other sectors,, this has not yet been taken advantage by the different sectors.

Figure 9.1: Key Outcomes of CHWP



CHWP has not yet contributed to major policy direction and decision making processes, but it has contributed to increased resource allocation for the maternal, newborn and child health.

A limited number of key informants at least 10 respondents, agreed that the programme has contributed to some policy changes. While the majority were not able to provide a comprehensive response as how CHWP has contributed to policy changes, one of the changes noted is the provision of pre-and post-natal care by CHWs. Policy changes are expected in view of the possible expansion of the CHWs' job descriptions. As a key informant puts it:

> *"Follow up of mothers before and after delivery is made part of the policies now. Other programmes like EPI, and Nutrition are also trying to incorporate into their policies activities which can be conducted by CHWs at the community level to ensure that all these programmes are effectively implemented" (Key informant, National level)*

> "Am not really able to answer that, however everyo*ne needs to use CHWs in the ministry these days. The impact is that if CHWs start working for every division and organization, it will call for a policy change. We are currently piloting HIV counseling in Oshana, Ohangwena and Oshikoto" (Nurse, Oshana region)*

In all the study areas the community members expressed the need to expand the work of the CHWs. For example, community members requested the MOHSS to expand the job description of CHW to include the following areas i.e. measuring of Blood Pressure, Collecting Sputum, conducting emergency delivery, treat Malaria and pneumonia. These added responsibilities may lead to policy changes. As a key informant expressed below:

> "No policy changes so far, but we believe that after *this evaluation there will be some policy changes, as people in communities want CHWs to be performing all sort of activities, which are related to health in their communities. Now we are considering making a recommendation to the national level so that CHWs can be trained and be able to give vitamin A and albendazole (medicine that prevents worms) and it is given to under 5 after 1 year. So, we are going to give that recommendation that CHWs should be trained to give these medications." (Key informant Senior Programme Officer – Oshana)*

While CHWs provide critical services and serve as the link between the health facility and the community, the evaluation noted that CHWs do not have a contact person after hours, as they often must call the PHC nurse of the facility. It was then recommended that CHW especially in urban areas and who are close to the hospital be provided with the number of the Doctor on duty. However, some respondents expressed concern about policy changes and its implication on the budget. As expressed below:

> "Yes, it has led to some policy changes, as the government is very se*rious about maternal and child health care. The policies are there but the implementation of these policies comes with the available resources. So even if they say each HF should have an ambulance, they cannot maintain that. In our status the policy is there but they cannot full-fill them due to limited funding." (PHC supervisor, !Kharas)*

CHWP is currently funded by MoHSS, although development partners contributed at the onset of the programme for funding trainers, training materials and daily allowance. Because of the scale up of the programme, the funding allocation for MNCH has increased. Although the programme includes activities that cut across different sectors such as education, gender and agriculture, CHW programme activities are resourced only by the Ministry of Health.

9.2 Training of CHWs

The development process, and the quality and content of the training curriculum were found to be appropriate for the programme.

The training of CHW aimed at developing new knowledge and skills as they relate to the roles and responsibilities of CHWs, which strengthened their capacity to communicate and serve the respective communities they are helping.

The Ministry of Health with the support of international donor organisations notable, UNICEF, C-change and WHO developed the curriculum and teaching materials. Given the range of the modules, experts were brought in from both national and international organisations and from other non-health related sectors (Environment, Social and Gender).

Majority of respondents perceived that most of the service areas included under the modules were important and appropriate to achieve the objectives of the programme. Participants were asked to rate

the importance of each service area included in the training curriculum and being provided by CHWs to the successful implementation and performance of the programme. Participants rated the services with a 7-point likert scale (1=not important at all and 7=absolutely important). Generally almost all services received high importance score, and the average scores for each activity and modules is presented in Figure 9.3. The modules that were scored higher include: community-based child health care with an average score of 6.8, and monitoring and evaluation with a score of 6.6 out of a maximum expected score of 7 points. Social welfare and disabilities module was scored low with an average score of 5.7 points. The perceived importance of most of the various services was similar between the key informants at different levels of the health system. However, there was difference in the average perceived importance score of some services between national level key informants (government and partners) and key informants at sub-national (regional, district and community) level (Figure 9.4). National level key informants gave higher importance score than the sub-national key informants to adolescent sexual and reproductive health (6.5 vs. 5.8), gender awareness (5.9 vs. 5.5) and malaria (6.4 vs. 5.9). On the other hand, the sub-national key informants gave higher importance score than national level key informants to using CHW monitoring tools (6.7 vs. 5.9), monthly data summary and reporting (6.9 vs. 6.1), household census (6.7 vs. 6.1), social welfare (5.8 vs. 5.3) and disability prevention and rehabilitation (5.8 vs. 5.4).

Figure 9.2: Recruitment criteria and the CHW training modules

RECRUITMENT CRITERIA

The CHWs are selected and recommended by community members, headman or town counsellor in the office of the governor. Regions and district are required to establish a recruitment committee and the following recruitment criteria is required:

- Mature men and women, at least 23 years of age
- Citizen of Namibia
- Living in, and is from, the village
- Completed at least grade 10, with 25 points and D symbol in English
- Good English writing and communication skills
- Able to speak and understand local languages in deployment
- Willingness to work with people, able to make home visits and is physically fit
- Respected by the community and committed to community service
- Good organizational skills
- Prior experience with CBHC, or other volunteer experience is an advantage

CHW TRAINING

Six-month training courses that covers six modules including:

1. Introduction
2. Community mobilization, mapping and the household census, behaviors change and facilitation;
3. First AID
4. Community based maternal and Newborn care (CBMNC)
5. Community Based integrated Child health
6. HIV and AIDS, TB and Malaria
7. Social Welfare and disabilities

Figure 9.3: Average importance score of the various CHWP services based on perception of key informants

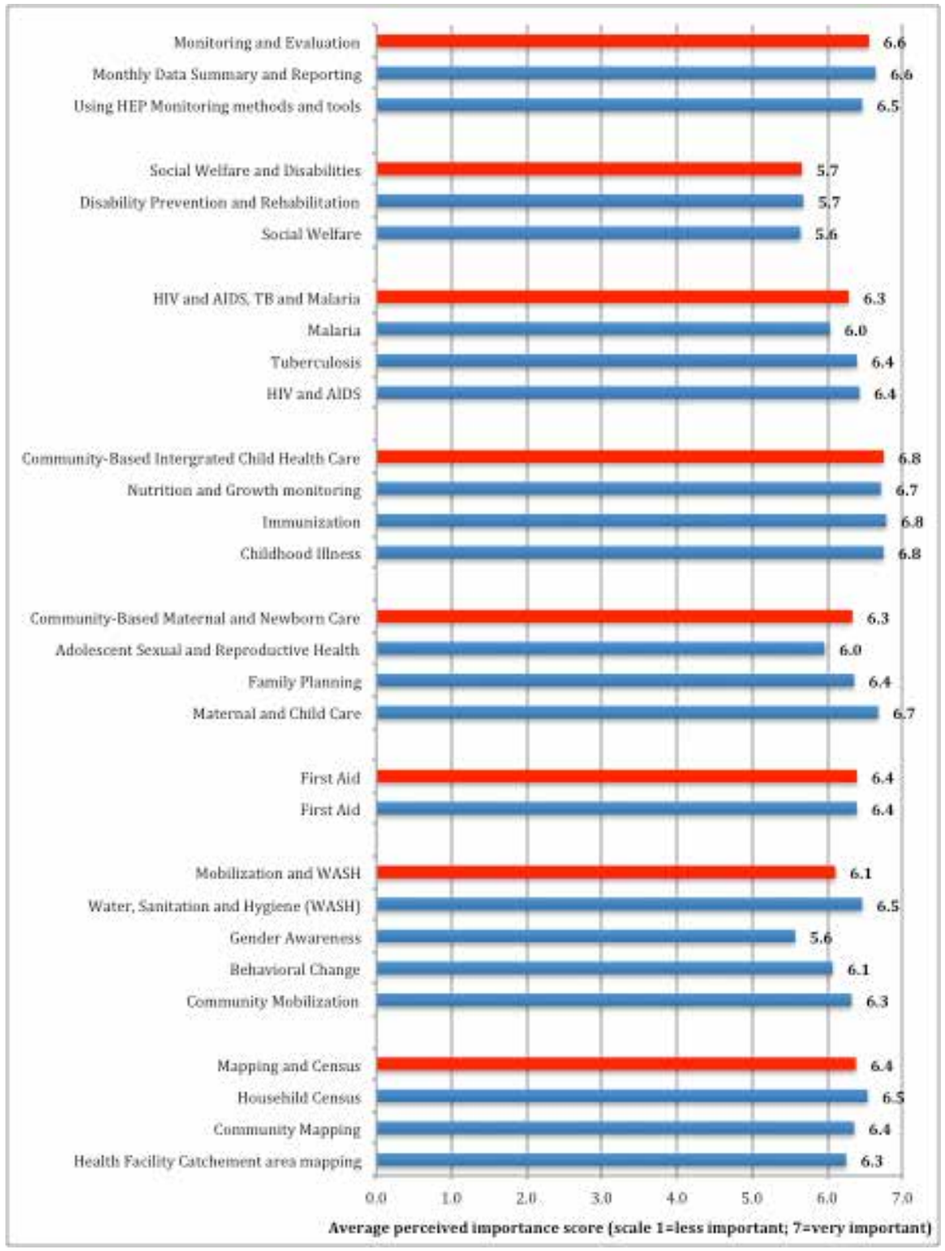
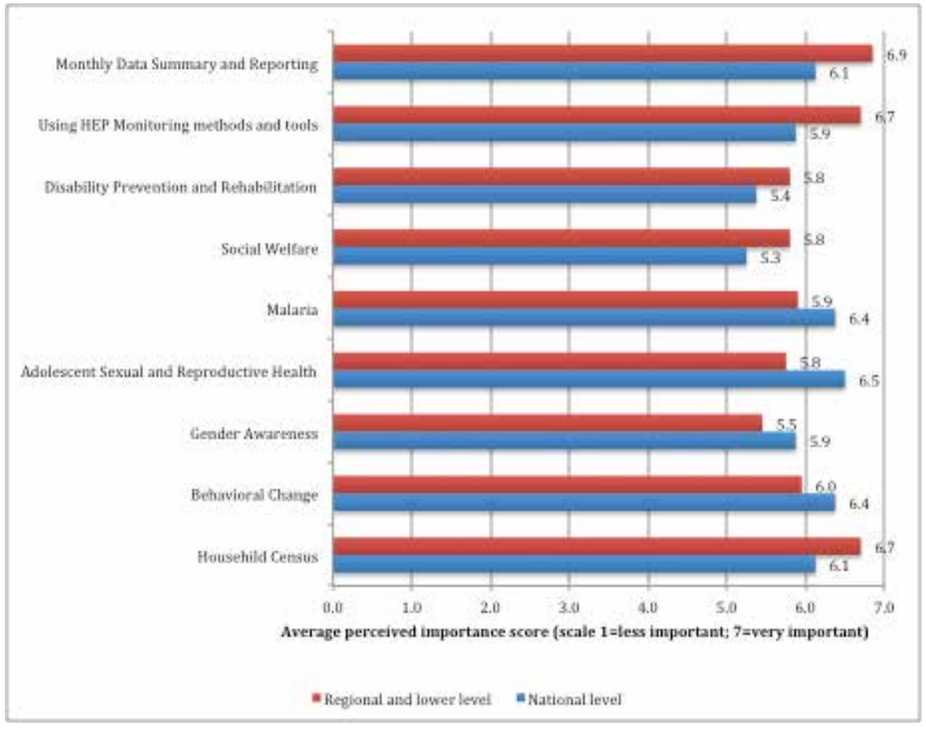


Figure 9.4: Average importance score of the various CHWP services based on perception of key informants by level of the health system



The current operation of the training process was found to be inefficient

The MOHSS - NHTC, which provides health-related in-service and pre-service training, is the designated institution facilitating the CHW training programme. NHTC has four training centers at regional level i.e; i) Otjiwaronga, Otjozondjupa region; ii) Onadjokwe, Oshikoto region; iii) Keetmanshoop, !kharas region; and iv) Rundu, Kavango region. NHTC facilitated the CHW trainings by appointing two Master trainers as CHWP training coordinators, and health facility nurses as trainers/instructors after receiving Training of Trainers for two weeks.

The CHWs are trained for a 6-month period covering 6 modules, using nationally developed materials. Four weeks are allocated per module divided into 2 weeks theory and 2 weeks practice. Upon completion of the training CHWs are then deployed in the respective communities under the leadership of PHC supervisor, health facility nurse and the area headman/woman. Almost all respondents believed that the 6 months training was sufficient, and the modules are relevant and appropriate, and that it has equipped CHWs with the necessary skills and knowledge to implement the activities of the programme. Once CHWs complete their training, they are then introduced by the PHC nurse or facility nurse to the community who has selected them.

Nonetheless, at least 60% of the respondents questioned the training approach of 2 weeks theory and 2 weeks practice. Respondents expressed concern and believed that this approach was not effective. In the same light concerns were raised about the number of participants in one class. According to the respondents the average class had at least 92 CHWs, which was too many and likely to compromise the quality of training. Trainee CHWs are not homogenous group and thus, they may have different training needs and learning style. In addition, the respondents expressed concern about the current assessment, which is module based and not continuous.

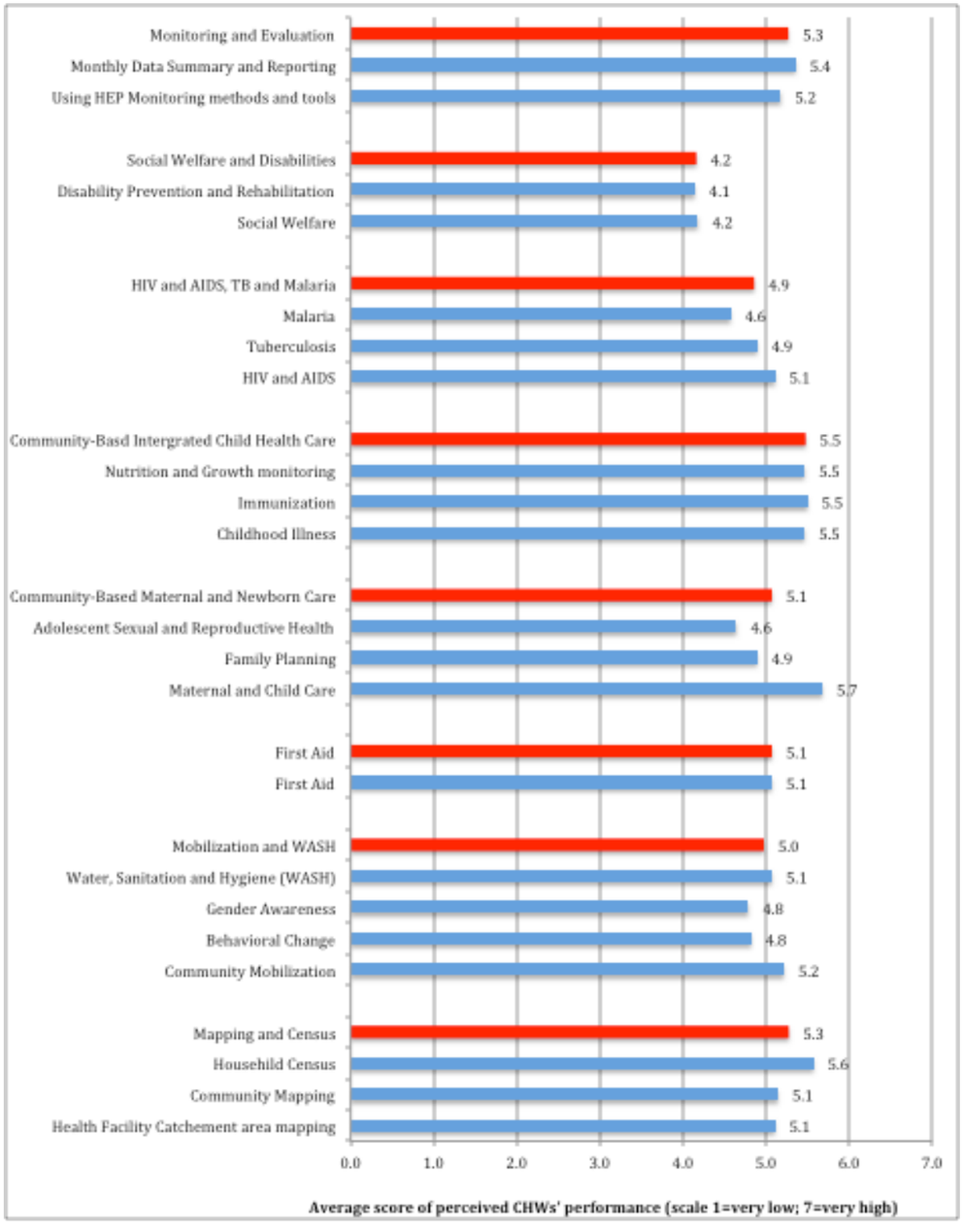
Although respondents were generally satisfied with the trainers from NHTC, some respondents expressed concern regarding the competence of the Trainers of Trainers and Trainers of implementers, who are selected by the regional management teams. The criteria for trainers selection include being a registered/enrolled nurse, social workers, rehabilitation officers. With competing priorities and with the aim of preventing the closer of clinics for 6 months, managers had often overlooked the criteria for a trainer and tended to nominate any nurse who was available. This is well expressed by a key informant below:

> *"It is cost effective but the issue of taking people from regions should be looked at. NHTC should be left to do the training. In case of regions where there are NHTC, the trainers in those facilities should be left to train CHWs and not bringing in nurses from clinics and living gaps in facilities." (National, Key informant)*

Respondents revealed that this is a standalone programme, and has not been integrated in the NHTC programme, which may affect its sustainability and quality. Many respondents reiterated the high cost related with allowance payment to both trainers and trainees. Moreover, the use of nurses selected from health facilities who do not have teaching skills and neither experience in community health may affect the quality of the training.

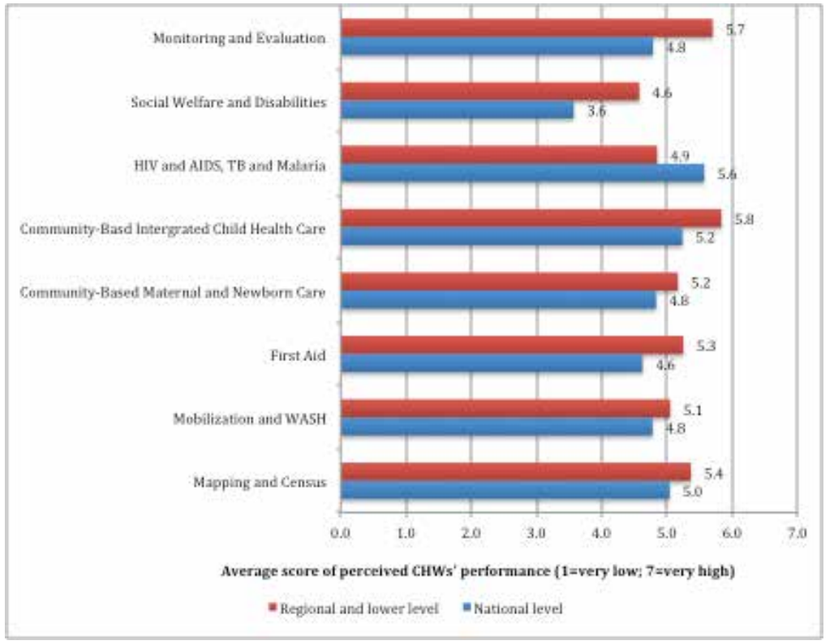
Participants were asked to rate the current performance of CHWs on each service area they were providing. Participants rated the performance with a 7-point likert scale (1=very poor and 7=exceptionally good). The perceived performance of CHWs on all service areas was not very high, and the average scores for each activity and modules is presented in Figure 9.5 on page 42. The modules that were scored relatively higher include: community-based child health care with an average score of 5.5, mapping and census with a score of 5.3 and monitoring and evaluation with a score of 5.3 out of a maximum expected score of 7 points. The modules with the lowest performance scores include social welfare and disabilities module with an average score of 4.2 points and HIV and AIDS, TB, and malaria with a score of 4.9 points. Some of the services under the major modules where the CHWs were rated as poorly performing include disability prevention and rehabilitation (4.1), social welfare (4.2), adolescent sexual and reproductive health (4.6), behavioural change (4.8), and family planning (4.9).

Figure 9.5: Average performance score of CHWs on the various services based on perception of key informants



There was difference in the perceived performance of CHWs on the various modules between the key informants at different levels of the health system (Figure 9.6). Generally, the performance of CHWs was scored lower by the national level key informants than the key informants at sub-national level except for HIV and AIDS, TB and malaria module.

Figure 9.6: Average perceived performance score of CHWs on the various CHWP services by type of key informants



The evaluation revealed that while refresher trainings where conducted, they were not formalized, and the refresher trainings were provided as per the need of a programme e.g. nutrition. As illustrated by a key informant below:

> *"Yes, they (CHWs) were refreshed when we realised that they were lacking some knowledge. We have TOT, somebody who trains them, and they are also trained on the spot to assess their work".*

Majority, almost all, respondents believed that there is a need to train CHW in the following additional technical areas:

1. Non-communicable diseases - monitoring Blood Pressure and diabetes testing
2. Integrated case management including pneumonia and malaria,
3. HIV Testing and Counselling
4. Skill to conduct emergency normal delivery

9.3 Management and Coordination

Coordination mechanisms involving steering committees have been established but functionality was inconsistent

a) National level

The CHWP is situated within the PHC Directorate, under the family health unit - Community Based Health Care – outreach. As part of the CHWP coordination, the PHC directorate established a national steering committee/technical working group. The committee is chaired by a PHC designated officer and consist of members representing government, international organisations and NGOs including: MoHSS/ PHC (Chairperson), NHTC, MoHSS/DSP, MoHSS/Social Welfare, UNICEF, C-Change, MCSP, USAID, WHO,

Project Hope, CAFO, Synergos and Centers for Disease Control and Prevention (CDC). The objective of the committee is to provide leadership, strategic guidance and technical inputs – by supporting the ministry in the development of policy frameworks, strategic planning and guidelines, financial and technical assistance, advocate for policy adaptation, resource allocation and provide periodic reports to the ministerial management committee. The multi-sectoral composition of the committee was very much appreciated and respondents believed that different ideas and inputs are brought to the table, which has enriched the CHWP programme. This was further confirmed when the researchers reviewed minutes of 2010/2011/2012.

> *"At the national level, we are responsible for policy and guideline issues and for training materials. Regions are responsible for coordinating the selection and training, and we work together to support each other. The steering committee is inclusive and is chaired by the PHC. It comes together every twice a year and see to it that human resource provides employments." (National level, Key Informant)*

Nonetheless, the majority of respondents believed until recently meetings of the steering committee have not been effective and have not been conducted regularly due to changes in management and competing priorities.

"It hasn't acted as a steering committee for a long time. It may just be a working group or planning group". (National, Key informant)

"I am aware of the national and regional steering committees, but I don't know if we really have somebody dedicated to build up a national one so that steering committee becomes sustainable institutional." (National, Key informant)

b) Regional and district levels

At the regional level CHWP activities are coordinated through the Family Health Division of PHC, which assists with planning, coordinating, programme monitoring, budgeting and conducting regular supervisory visits, and facilitates the establishment of a regional multi sectoral steering committee. Respondents believed the inclusion of the diverse sectors has been helpful given the issues that confront CHW in the community, as a key informant stated:

> *"The CHW steering committee is drawn from all the sectors in the region, including political office bearers and traditional office barbers. When we talk about sectors it is the ministry of agriculture, ministry of education, ministry of health, Red Cross, and gender. This is very helpful in a way that CHWs know to which sector to refer if they have a problem. In terms of disability, CHWs go to households with disabled persons and they find out if they are registered and then if not, they refer them to the organisation that can help them, so that they can register." (Key informant, Kunene region)*

The study revealed that many regions have functional steering committees at the regional level. Majority of the participants believed the effectiveness of the steering committee in coordination was dependent on the set up and the leadership of PHC. At district level, quarterly review meetings were held, and senior management come together to discuss, share data and challenges within the health facility and try to solve these challenges.

The meetings at both regional and district level has several challenges from initial setup, structure, composition, and financial challenges.

> *"At the regional level, we have stakeholders who coordinate with us. We established a steering committee but it's not active. The last steering committee meeting was in July this year. The reason why it is not functional is due to lack of funds to support the meetings, as members demand to be given sitting allowances when they attend the meetings." (JNG1-Omaheke)*

Political interference

All most all respondents believed that the recruitment process is fair and there is minimal political interference. However, in some regions 1 or 2 politicians may have used the programme to promote their own political agenda. Majority of the informants alleged that the interference only came to the surface when there were issues with the CHW performance. This situation was more prominent in areas where there are high unemployment rate and where the CHW may be one of the few people employed in the area. For example, if the CHW is not working, no one will report her/him, because reporting her/him means that he will lose his job. As expressed by a key informant in !Kharas

> *"Sometimes you will find that the CHW in rural areas do not work, but if you go to the community and ask people around they always say the CHW is working very well because they know they are benefitting from those CHWs." (Key informant - !Kharas)*

Concern has been raised for future recruitment and health professionals are fearful for the mere fact that CHW programme gives job opportunities and some traditional leaders may push their family members.

> *"After traditional leaders realized that CHWs were getting paid, they decided that the next time they select new recruitment they would have to select their family members so that they benefit from them". (Key informant, Oshana).*

c) Community level

CHWP programme at community level is supported by the village/community health committee, which is chaired by the village headman/woman. Respondents perceived that the health committees have been effective particularly in Kunene, Omaheke and Oshana. The team observed that there was equal participation of both men and women in the health committees, however, very little involvement of young people. The village health committee provided opportunity to discuss issues affecting the community. While issues were brought to the committee and discussed, participants felt that no actions were taken. For example, in Kunene the members of the village had on several occasions reported the condition of their water, which they felt was dangerous for human consumption, but committee members discussed it and no action was taken. Similarly, in Oshana, committee members discussed elder abuse and alcohol abuse among HIV patients and no action was taken. Likewise, in Omaheke the committee had on several occasions discussed the need for an ambulance, and no action was taken.

In some communities, the committee met regularly and CHWs reported daily to the village headman (for example in Omaheke), and in some villages the committee members keep track of the whereabouts of the CHW, as reported in Kunene and Oshana. In most communities, the committee meetings were irregular, and respondents revealed that the committees were not functional, due to lack of incentives where some members of the committees have been reluctant of attending meetings as they believed the CHW was getting a salary and they were supervising their work at no cost.

> *"The reason why it's not functional is due to lack of funds to support the meetings as members demand to be given sitting allowances when they attend the meetings". (Key informant, Kunene)*

It was noted that there were no health committees in some communities, especially where there was no community involvement in the recruitment of the CHWs. For example, the CHWs in Keetmanshoop were

not selected by and neither introduced to the community. CHWs responded to the advert, applied for the course, received training and presented themselves in the community and have never established a committee.

> *"Although the people appreciate us, they were not part of people who brought us to the communities. When we were in training the community did not know about us, we were not properly introduced by the councillor. During practical that was the first time when the community heard of us, so we had to introduce ourselves during practical training". (CHW-!Kharas-Keetmanshoop)*

According to the structure, facility nurses are expected to provide supportive supervision to CHWs in their respective catchment areas. In some areas, participants recognized the benefit of this linkage not only in supervision but also in keeping track of the where abouts of CHWs. Unfortunately, not all facility nurses have accepted CHWs, and some considered them as a burden and were of the opinion that it was a waste of money and funds should have been used to train more nurses. It also came to light that few health facility nurses were not properly introduced to the programme.

Programme supervision was not strong and differed between regions

Majority of the respondents highlighted that supervision was one of the weakest link of the programme and most CHWs were not supervised frequently and regularly. Quantitative data from the HIS also confirmed that the number of supervisory visits received per CHW per year was low (Figure 9.7). The PHC supervisors/ programme administrators have taken a key role in supervising CHWs although they were not able to provide frequent and regular supervision given the large number of CHWs per region. About half of the CHWs interviewed were not supervised during the 3 months prior to the survey, while the other half were supervised by the regional PHC staff. CHWs who received supervision expressed their satisfaction with the way supervision was conducted that included observation, job review, and provision of guidance.

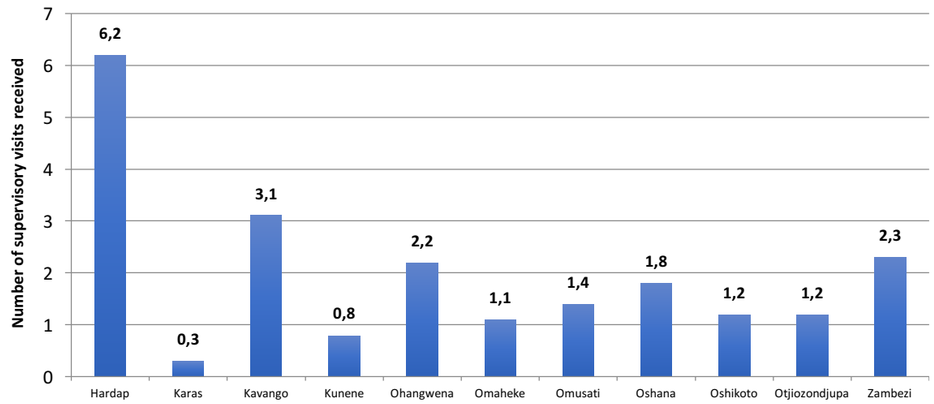
> *"Supervision, inputs and processes are very poor. If we do not have human resource to cover the programme, that's the biggest issue". (Key informant, National)*

Several factors that affect supervision were stated including limited human resource and competing priorities. The design of CHWP stipulated that health facility nurses would be the immediate supervisors of CHWs. While this might be ideal, it was not realistic as majority of clinics were manned by one nurse, compromising the quality of the programme. Majority of the respondents believed that the design of CHWP might not have been well thought out, although it looks good on paper and appears to be following a logical framework. The findings noted that CHWP was designed when the MoHSS was finalising its restructuring progamme which made provision for increasing human resources at the health facility level. One of the key challenges has been the design of CHWP in anticipation of future restructuring, which has not been operationalized.

> "Funding, restructuring, reporting, and hierarchy o*f CHWs were not well thought out. Who takes care of them, provide them with support. This was loose. We should have done more on that. They live far away in isolated areas and could not communicate or get in touch, we never resolve this when we started. Some regions did well others not so well" (Key informant, National level).*

In some areas, support and supervision responsibilities were taken over by the village headmen and village health committee. Such arrangements would have been detrimental for the success of the programme, however it was not clearly and systematically defined, and the village health committee were not given proper training and checklist. Moreover, it was noted that not all areas have functional village health committees. Some regions have adopted strategies to address the supervision issues. In Luderitz the health facility has appointed a senior CHW as a supervisor and each 3rd month a new CHW act as a supervisor. Likewise,

Figure 9.7: Average number of supervisory visits received per CHW per year by region



Omaheke and Zambezi, followed the SOP guidelines of appointing a senior CHW who became the link between headman, community and health facility.

"Supervision wasn't as better as it is now because we were short staff. But now that we have a senior CHW it is much better. We can now reach the community easily than before. Every week we go for supervision because we have a senior CHW. He goes with the nurse and ambulance driver, to nearby houses he goes alone. But he was not given training on supervision". (PHC supervisor – Omaheke region)

There was no systematic cross-sectoral linkages

Collaboration between different sectors enhances the quality of service provision. The evaluation revealed that CHWs deal with variety of issues that require interaction with various sectors. It was observed that CHWs collaborated with diverse sectors such as education, gender, agriculture, water and police. For example, in Omaheke (Kanaan) and !Kharas – Keetmanshoop, CHWs collaborated with the police and the Ministry of Gender to address issues of alcohol, gender based violence, and abuse of social grants. In Luderitz-Area 7, the CHW worked with the town counsel and advocated for the provision of toilets, which resulted in town counsel providing 1 toilet per 5-7 households.

> *"Yes, I work in connections with different organization as I can refer anyone anywhere if the problem at hand requires for that programme's attention. E.g. I found a 12-year-old in a house who was kicked out of school. That kid was not able to read and write, so I took the kid to the disability affair at the rehabilitative center, and they asked me to get a letter from the principal why the kid was kicked out of school, and finally the kid ended up into special school." (CHW, Oshana)*

The cross-sectoral collaboration was on a reactive basis and not formalized. The unstructured nature of cross sectoral collaboration, with no clear referral mechanism have contributed to poor response from some sectors.

> *"Looking on the social problems in the country, the staff indicated that there are. They once reported two cases of child neglect to the office of the social worker in January this year, through the social worker* promised to come, he has not." (Key informant, Omaheke)

Overall CHWP provided a unique opportunity for cross-sectoral collaboration, and participants expressed the need for strong and systematic cross-sectoral partnership.

There was high political commitment and will at the highest level, however management capacity was not strengthened

Overall the programme has seen support from the highest office and there was high political commitment. CHWs are integrated into the MoHSS structure, recognised cadre contributing to overall care of the society. Government has made provision of budget for salary and equipment of CHWs, however management human capacity was not strengthened.

According to participants, the government is going through economic recession and there was a need to cut the budget, which affected some critical programmes. CHWP was one of the affected programmes, with its trainings suspended in 2016 and no recruitment or deployment was done in 2017, even though CHWs have been trained and ready for deployment.

> *"The Ministry had suspended the programme. They have tried to rename the programme. They tried to re-orientate the programme. One of the challenges was the speed at which the government wanted to implement the programme. We can't expect a new programme to have higher impact. The barrier is the oversight of the CHWs. Another barrier is the utilization of that data to inform action." (Key informant, National level)*

Despite the challenges, the CHWP was and continues to be appreciated by all sectors. Town councilors, regional governors, politicians and partners, in general, were supportive of the programme and expressed willingness to support with resource mobilization.

9.4 Impact

CHWP has contributed to the improvement of maternal, newborn and child health indicators

Most participants perceived that maternal and child deaths have reduced in the 2-3 years mainly due to CHWs activities in the villages. According to participants, the decrease in maternal deaths was attributable to the following: CHWs identify pregnancy at early stage and register all pregnant mothers; CHWs visit pregnant women and provide health promotion and advice that resulted in increased ANC coverage, especially during the first trimester; increased referral of mothers with complications for timely management at referral facilities; availability of ambulance; and having more women with birth plans leading to increased health facility delivery. It was also perceived by most of the participants that child deaths have decreased due to improved maternal health, decreased diarrhea and malnutrition, decreased illnesses as a result of immunization, early health seeking behavior, and immediate management of diarrhea cases by CHWs and referral and management of other childhood illnesses.

> "Since the deployment *of CHWs in the community, outbreaks of cholera and measles have ceased to occur." (Nurse, Kunene region)*

Quantitative assessment of MNCH impact indicators (such as child and maternal mortality) is not possible as the latest national data is from 2013 and there are no other population based surveys conducted after the implementation of CHWP. Moreover, the duration of CHWP implementation is short to result in a significant improvement of maternal and child mortality. However, given that CHWP was able to strengthen the community-based health delivery capacity at all levels of the health system, established a system where each and every pregnant woman and child is identified and linked to health facilities, strengthened referral system, improved health seeking behavior, and improved service coverage, which are all key requirements for achievement of the impact level results, it is likely that CHWP contributed to the improvement of impact indicators. As a proxy of mortality rate assessment, we used data on number of deaths documented in the HIS from 2008 to 2016 to determine the trend over time. The number of maternal and neonatal deaths decreased overtime in both Kunene and Zambezi regions (Figure 9.8). The significant reduction in number of maternal and neonatal deaths was observed starting in 2013-2014, which coincides with the introduction of CHWP in both regions.

Figure 9.8: Number of maternal and neonatal deaths reported in Opuwo, Kunene and Zambezi, 2008-2016

However, it was noted that there were still home deliveries that resulted in maternal deaths where CHWP was not able to address. The challenges stated by participants for home deliveries included deeply rooted cultural beliefs, particularly in Kunene and among families coming across the border, distance and cost of transportation to health facilities, unexpected timing of labor, and low level of CHW capacity and support. Similarly, participants also noted that all child deaths could not be averted due to distance and cost of transportation in remote villages and non-compliance to go to referral health facilities. According to some CHWs, there were some clients that delayed or did not take their sick children to referral health facilities when the children felt better after receiving paracetamol, which is a non-intended negative effect of antipyretic provision.

CHWP contributed to improved health awareness and knowledge among the community

According to participants in all study areas, the activities undertaken by CHWs in relation to MNCH services included educating and creating awareness about MNCH, mobilizing mothers for immunization during outreach sessions, visiting and encouraging pregnant mothers for ANC, motivating and encouraging pregnant women to have birth plans for institutional delivery, and follow-up of mothers after birth. They also educated mothers about child health including breastfeeding, immunization, growth monitoring, and danger signs of childhood illness. CHWs referred children and mothers with danger signs and complications. They also identified defaulters not only on immunization but also patients on anti-retroviral and tuberculosis treatment. Participants noted that the community was making use of CHWP services.

"We are using the services, as CHWs come to our houses to ensure that we are living health life styles. They move around in houses asking how people are preparing their food, and they also ask in other area of everyday health activities, some people show them in their kitchens and they show them how they do their activities and then the CHW correct them if they do it wrongly. They also show them on how to use the hand washing materials." (Mother, FGD)

"Our daughter has assisted us: educating us, getting medicines and referring us to the hospital." (Mother, Kunene)

The focus group participant stated that, through CHWs, they had understood about the importance of ANC, immunization, institutional delivery, and the possible adverse negative effects of home delivery. CHWs as the link between the community and the health facility have been able to break the language barrier. According to participants, majority avoided the health facilities, as the health professionals were not able to speak their language, with the arrival of CHW they were able to do so with their support.

"Before the programme came to our village, we didn't have knowledge about health."

"The programme improved the education of women especially when it comes to sickness of their kids, to the extent where they can identify danger signs."

"We were afraid of going to the hospitals or even to take our children there when they are sick because of the language barrier between us and the doctors at the facility."

The quantitative data obtained from the health information system confirmed the various services provided by CHWs. Table 9.1 shows the number of mothers who received different types of maternal health services 2016 by region in comparison to the expected number of pregnant women. The expected number of women (22,821 women) was estimated based on the total number of households covered by the 1547 CHWs. In 2016, 1,453 CHWs submitted their activity report and their data was available in the HIS. These CHWs supported a total of 11,900 (52% of the expected pregnancy) pregnant women to have birth plan for institutional delivery and they visited 2,538 (11%) of the pregnant women four times during their pregnancy.

The CHWs also visited 1,570 (7%) women within 24-48 hours of giving birth. Given the large number of pregnant women reached through CHWs, it is expected that these activities contributed to significant improvement in health facility delivery. There was a significant difference between regions in the percent of expected number of pregnant women receiving the maternal health services. Figure 9.9 shows the percent of pregnant women with birth plan ranging from 100% in Kunene to 19% in Oshana. This difference may not be related to difference in performance of CHWs by region but it could be due to the difference in the number of households (and thus number of expected pregnant women) assigned to each CHW. For example, the average number of households assigned per CHW was 42 in Kunene while it was 92 in Oshana.

The CHWs performance by region is shown in Figure 9.10, which shows a significant difference in the number of pregnant women who received different maternal health services per CHW. On average, each CHW in Oshikoto and Otjiozondjupa helped 14 pregnant women to have birth plan, while each CHW in Oshana and Zambezi regions helped an average of 3 and 5 pregnant women, respectively.

Table 9.1: Number of mothers who received maternal health service from CHWs by region

Region	Expected no. of pregnant mothers	Mothers with birth plan		Mothers visited 4 times during pregnancy		Mothers visited within 24-48 hours of birth	
		Number	Percent	Number	Percent	Number	Percent
Hardap	864	470	54	42	5	39	5
Karas	2,053	570	28	249	12	118	6
Kavango	1,633	1267	78	426	26	346	21
Kunene	1,182	1181	100	276	23	139	12
Ohang.	2,944	2310	78	492	17	247	8
Omaheke	1,420	946	67	144	10	56	4
Omusati	3,326	1391	42	210	6	123	4
Oshana	3,166	607	19	22	1	27	1
Oshikoto	1,618	1133	70	200	12	105	6
Otjiozon.	1,653	1081	65	234	14	145	9
Zambezi	2,960	944	32	243	8	225	8
National	**22,821**	**11900**	**52**	**2538**	**11**	**1570**	**7**

Figure 9.9: Percent of expected number of pregnant women who had birth plan by region

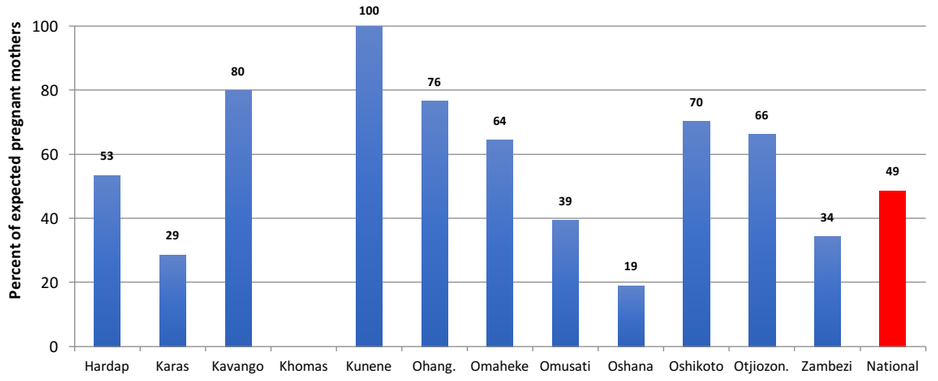
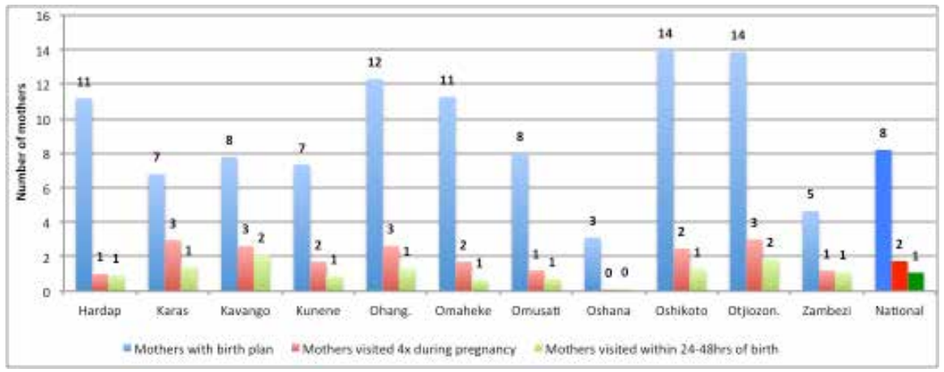


Figure 9.10: Average number of pregnant women per CHW who received maternal health services by region

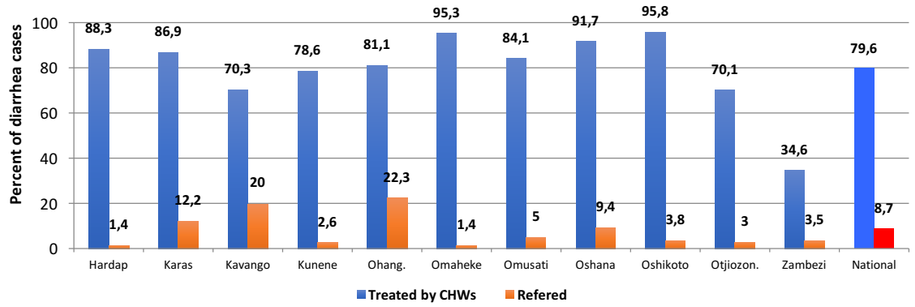


CHWP's contribution to increased access was limited to selected health services

CHWP focuses on preventive and promotive health services. The only curative service provided by CHWs is provision of ORS and homemade fluids at household level to manage diarrheal cases as well as the provision of paracetamol to reduce fever and for headache among adults. Although it is partial management (without Zinc), the programme has improved access to management of diarrhea. Based on the quantitative data on diarrhea cases detected, treated and referred by CHWs, overall about 80% of diarrhea cases were treated by CHWs at home (Figure 9.11). The treatment rate was high (over 90%) in Oshikoto, Omaheke and Oshana regions, while it was low in Zambezi region (34.6%). Participants noted that the home management of diarrhea cases has contributed to decrease in number of severe diarrhea cases and the workload in health facilities. Since majority of diarrhea cases were promptly managed by CHWs at community level, only a small proportion of diarrhea cases (8.7%) were referred to health facilities (Figure 9.11).

> *"People don't come to the hospitals in critical situations anymore because they know what to do, they have the knowledge about health. The workload at the health facilities has been lifted off. Health facilities are no longer overcrowded." (Nurse, Oshana)*

Figure 9.11: Percent of diarrhea cases treated by CHWs and percent referred to health facilities by region



Although CHWs do not provide immunization services, they have contributed to increased access to immunization in combination with the outreach programmes. The findings revealed that there was strong collaboration between district PHC office and CHWs in all study areas, where outreach programmes were conducted with the involvement of CHWs. CHWs played a key role in mobilising the community members and preparing the groundwork and having the place ready when the PHC team arrived. Respondents believed that this approach has contributed to increased access and uptake of immunization services.

CHWP contributed to improved health seeking behavior and increased utilization of maternal, newborn and child health

As a result of the range of preventive and promotive services delivered by CHWs, CHWP has contributed to increased uptake of ANC, health facility deliveries, PNC, and immunization. It also contributed to early health seeking behavior, identification of defaulters, and referral of clients including mothers and children.

Maternal health care

All participants thought that the number of women who attend antenatal care has increased following the deployment of CHWs in the villages. In particular, CHWs contribution has been in early identification of pregnant women and referral, which resulted in increased number of women attending antenatal care at first trimester. The communities have seen a reduction in home deliveries and this was made possible by CHWP and the policy of the ministry, which discouraged traditional birth attendance. The communities in both Omaheke and Kunene revealed that prior to CHWP, there was a high rate of home delivery due to lack of awareness and cultural beliefs combined with access barriers, which in many cases led to child and maternal mortality. The education by the CHWs, which included teaching people about the importance of antenatal care and the importance of a birth plan including saving money for transportation and related costs, has contributed to majority of women now delivering in a health facility. However, there are still some women who deliver at home due to geographic, cultural and health system factors including distance to health facilities and unavailability and cost of transportation.

Quantitative data from HIS supports the participants' perception that there was improvement in coverage of maternal health services. Quantitative data on ANC and health facility delivery was used to compare the trend in coverage between pre- and post-intervention periods and determine the contribution of the programme. Behavioral change communication interventions require at least few years to bring about significant change in service utilization and coverage. Among the five study regions, it was only Kunene and Zambezi regions that had been implementing the programme for about 3-4 years prior to the study. The rate of increase in number of pregnant women who received their first ANC during the first trimester was higher after the programme was implemented compared to the pre-intervention period in both Kunene and Zambezi regions (Figure 9.12 and Figure 9.13). Similar trend was observed when data on the percent of pregnant women who received their first ANC during the first trimester from all regions was plotted over time as shown in Figure 9.14 on page 54.

Figure 9.12: Number of pregnant women who received their first ANC by trimester in Opuwo, Kunene region

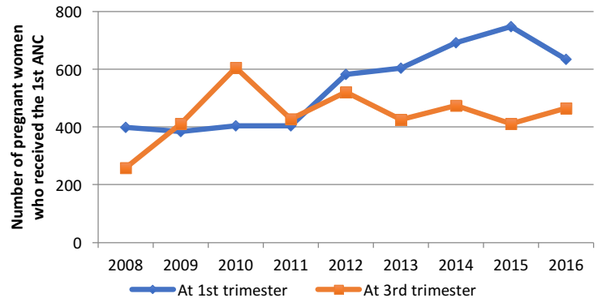


Figure 9.13: Number of pregnant women who received their first ANC by trimester in Zambezi region

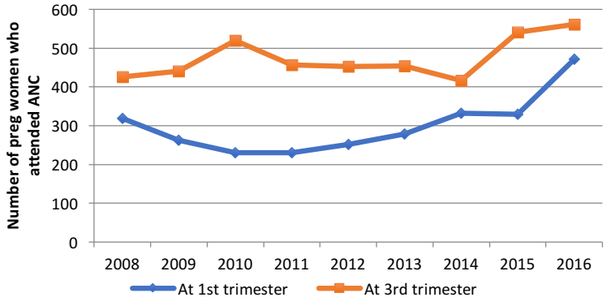
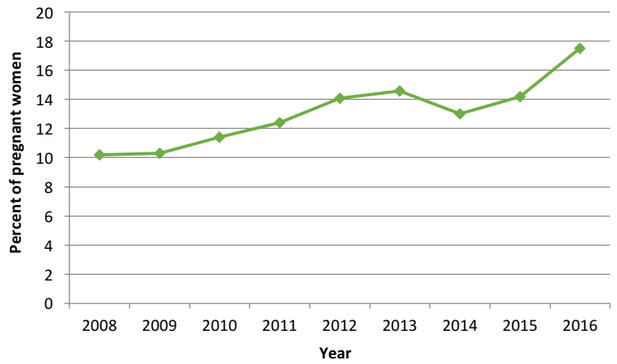


Figure 9.14: Number of pregnant women who received their first ANC by trimester, Namibia



Quantitative data on the percent of pregnant women who delivered in health facilities in the two regions showed a trend with higher rate of improvement post-intervention than pre-intervention (Figure 9.15). The trend in the coverage of ANC, health facility delivery and PNC using national level data also confirmed the participants' claim that the programme contributed to improvement in maternal health service coverage (Figure 9.16).

Figure 9.15: Percent of pregnant women who delivered in health facilities in Opuwo, Kunene and Zambezi regions

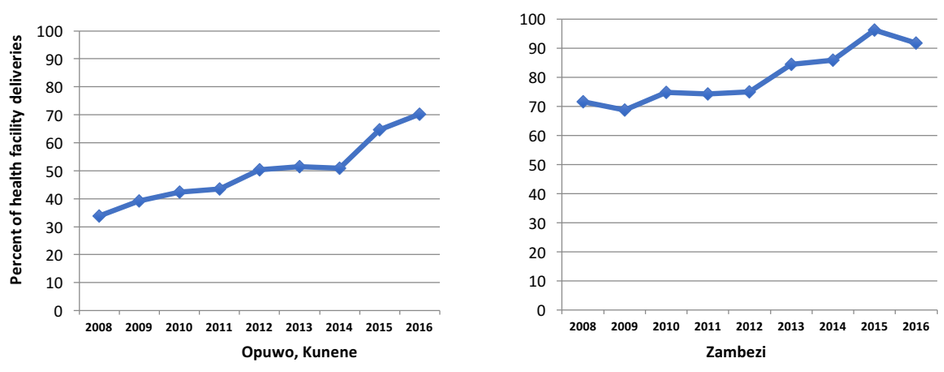
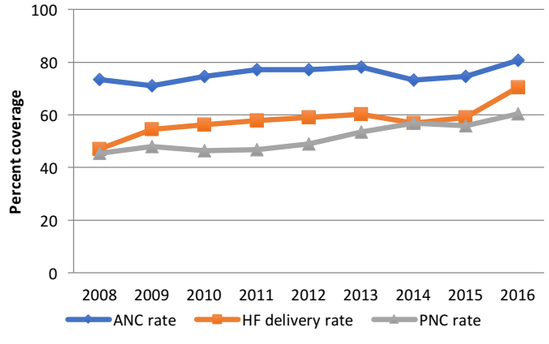
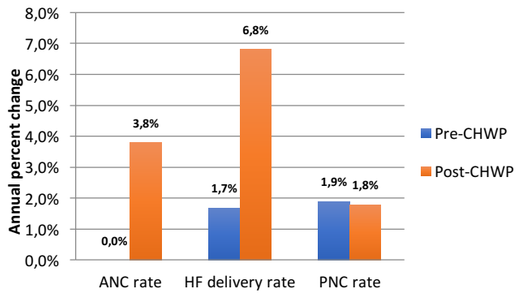


Figure 9.16: Percent of mothers who received ANC, delivered at health facilities and received PNC, Namibia



The annual percent change in coverage of ANC, health facility delivery and PNC was determined for the pre- and post-intervention periods. The post-intervention annual change for ANC (3.8%) and health facility delivery (6.8%) were higher than the pre-intervention rates for ANC (0%) and health facility delivery (1.75), while there was no difference between the pre- and post-intervention annual precent change for PNC (Figure 9.17).

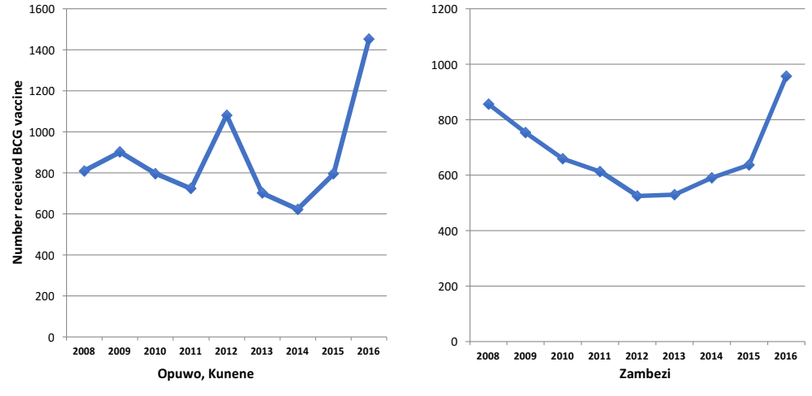
Figure 9.17: Annual rate of increase in maternal health indicators comparing pre-and post-CHWP period, Namibia



Child health

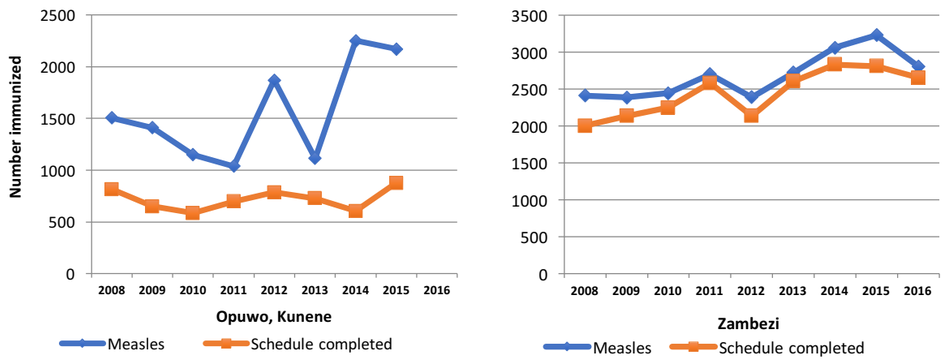
Many key informants stated that immunization coverage has improved and defaulter rate has decreased as a result of CHWs activities, and mothers reported that they get themselves and their children immunized. This improvement was achieved through behavioral change communication, identifications of dropouts, and mobilization of pregnant mothers and children during outreach sessions. In particular, CHWs have addressed miss opportunities through home visits where they review clients' health passport and advice accordingly. The participants' perception that immunization uptake has improved as a result of the programme is supported by quantitative data obtained from HIS. The number of one-year-old children who received BCG increased significantly following the implementation of CHWP in both Kunene and Zambezi regions (Figure 9.18).

Figure 9.18: Number of one-year-old children who received BCG in Kunene and Zambezi regions



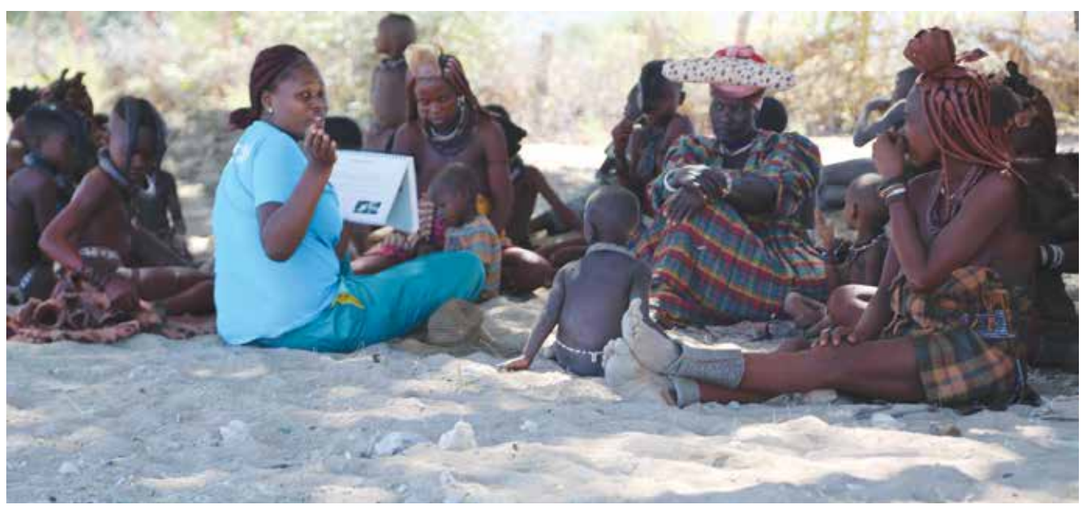
Similarly, the number of children who received measles and all scheduled vaccines increased following the implementation of the programme (Figure 9.19). The rate of improvement for the different vaccines varried in both regions, in particular, the number of children who completed the schedule vaccines in Kunene did not show much improvement. Participants expressed a number of barriers for immunization including distance to health facilities, cultural beliefs, and fear for injections and side effects. The availability of outreach sessions as alternative delivery service has been critical in addressing distance barrier, however the frequency was not adequate to provide the schedule vaccines, especially in Kunene where the frequecny was reduced due to shoratge of human resources and transportation.

Figure 9.19: Number of one-year-old children who received measles and all scheduled vaccines in Kunene and Zambezi regions



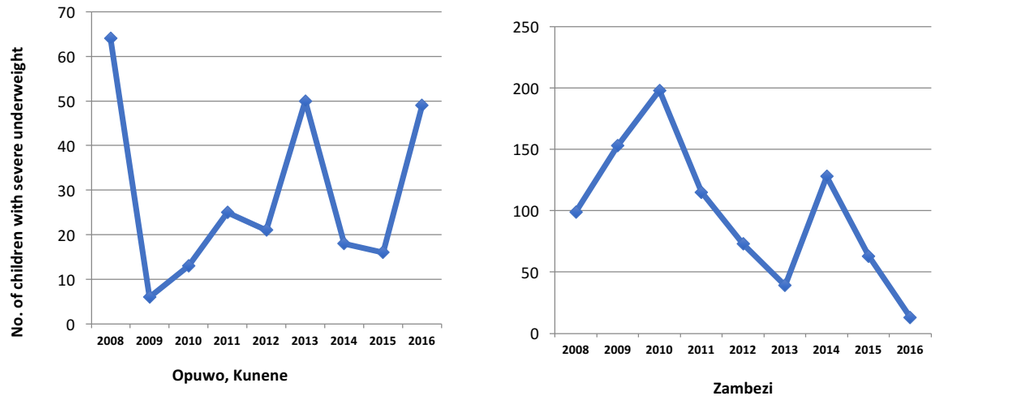
Participants perceived that malnutrition has decreased and they stated a number of reasons including health promotion and nutritional counseling, decreased in diarrheal episodes from improved hand-washing practices and latrine use, and improved prompt management of diarrhea cases. In Kunene, the community members indicated that they used to have many children with malnutrition, but with the arrival of CHWs, it is no longer the case.

> *"Our health has improved. For example, we had a child who was malnourished and about to die and she [CHW] weighed the child, and referred her to the clinic. The child was helped and today she is healthy." (Woman, Kunene region)*



Quantitative data on number of under five children with severe underweight in Zambezi region, which showed a decreasing trend, confirmed the participants` perception of decreasing malnutrition as a result of the programme (Figure 9.20). However, in contrast to the perception of participants, the quantitative data on the number of under five children with severe underweight showed an increasing trend over time in Kunene region.

Figure 9.20: Number of under five children with severe underweight in Zambezi and Kunene regions



The participants agreed that the awareness on danger signs such as dehydration and difficulty in breathing created among the community resulted in early health seeking behavior, referral and appropriate management, while the use of traditional and herbal medicine decreased. Unlike suspected pneumonia and malaria cases, which are referred to health facilities, CHWP has increased access to prompt management of diarrhea cases at household level using ORS or homemade solutions.

> *"CHWP is helping in pneumonia. In the olden days when a baby gets sick the community would think that baby was bewitched and they would give the baby herbs. But now ever since I started working as CHW, it has changed.... If the baby shows symptoms of pneumonia, I quickly make a referral and the child is treated in health facility." (CHW, Zambezi)*

9.5 Effectiveness

CHWP has contributed to improvements in the capacity of regions and districts to deliver CHWs services

Respondents recognized the improvements in delivering community based health services at regional, district, and community levels. In particular, the improvement has been in producing a critical mass of CHWs (over 1,600) over a short period. The training of CHWs was conducted through the involvement of health workers working at different levels of the health system including in the health facilities that directly supervise the CHWs. This process has improved the capacity of health professionals working at the regional, district and health facility levels. The availability of guidelines, standards and tools for CHWP implementation and some orientation trainings has improved the capacity of the regions and districts. Despite the non-consistency and weaknesses in some regions, CHWP improved regional capacity through the involvement of regional steering committees. However, the human resource capacity that provides oversight over CHWP implementation was not adequate to properly plan, manage, supervise and monitor the programme. District PHC supervisor has responsibility not only for CHWs but also for all clinics and health centers within the district. There were some initiatives observed in some regions to build the district capacity, for example, in Zambezi region, a nurse has been assigned to help the CHWP supervisor.

"Government's vision is 100% but the people on the ground are causing the vision not to work. Poor planning is the problem, especially in some areas. The Government is dishing out resources but the planning is supposed to come from us. We can't wait for the Government to plan for us." (Councillor, Zambezi)

CHWP contributed to a moderate increase in the participation of community members in CHWP

According to most respondents, the role of the community in selection of candidate CHWs was prominent. In all study sites except in Keetmanshoop, CHWs were selected by the community and received the blessings of the town/regional councillor/headman/headman.

Generally, the people have accepted CHWs in their community. This was partly made easy by the fact that CHWs were selected from their respective communities. CHWs have gained respect from the community, and the community expressed appreciation of CHWP and the change CHWs have made in the community not only in health but also in other social services.

"We used to cry day in and out to the Government to bring services closer to the people. And now that we have these CHWs, we are really grateful. We have taken ownership of the programme." (Councilor, Oshana)

However, in some areas such as Keetmanshoop district the programme might have been perceived as a job creation, where anyone was able to apply in response to an advertisement, and the community was not involved in the selection process of candidate CHWs. This might have been one of the key reasons for the little community ownership noted in the district. The CHWs were viewed as the provider and saviour; they bring medicine and provide E-pap. This begs the question that if the community members had introduced the CHWs, would they have been perceived differently.

The participation of the community members, village headmen and councillors was mainly in supporting CHWs in the implementation of CHWP activities. Participants noted that participation of the community in the planning and monitoring of CHWP was not satisfactory.

"As a community we feel responsible. We support, we inform CHW about anyone who is sick. Sometimes when the CHW has left and is far way and when someone is sick behind the mountains, we take it upon ourselves to inform her and to accompanied her to the house of the sick person." (Discussant in Kunene region)

In some villages, village headmen and councillors ensured that CHWs performed their duties and addressed challenges they encountered within the community.

"If a CHW visits a house and the owner of the house chase her away, she takes the issue to the village headman to solve the problem, if a person does not corporate with the headman, then the headman reports that person to the councillor as he is a hindrance to the provision of health services."

Village health committee were not involved in CHWP activities, although these were constituted in many villages at the introduction of the programme. They were participating until CHWs started getting salary (for example in Zambezi, they were functional in 2014 and 2015).

"The headmen and the village health committee members demand to be paid. They don't come up for meetings. They say I am paid and they are not."

Few individuals who were members of the village health committee still support the work of CHWs in some villages.

"We do and we are committed to supporting our nurse, especially in identifying who is sick, as she cannot be at all places at the same time."

"I myself volunteer and look out for those who are sick in the community and inform her if there is any situation /sick person"

CHWP has increased motivation of CHWs

CHWs were generally satisfied with their living conditions since they were living within their communities. The main motivation factors that kept them engaged include: serving their community and making a difference not only in health but also other social needs of their communities. In particular, the immediate care they provide for people with pain, fever and injury is the most satisfying, which contributed to their acceptance by community. Most also reported that they are satisfied when they see the result of their efforts.

"I work in my own village, staying in my own house and I am familiar with the community. I know where to find my people season in and out."

"There was a kid I referred to the health facility because she had malnutrition. She couldn't walk all she did was just crawl but now the child can walk."

However, CHWs expressed grievances regarding the working conditions, which affected their performance and motivation. The factors stated by most informants were: stock-outs of supplies, lack of uniforms, ID badges, M&E registers, bags and refresher trainings, and long walking distance. The most important factors that affect their motivation were lack of adequate supervision and uncertainty in their future due to lack of carreer paths. Most CHWs felt that they were left out and that their efforts were less important leading into intentions of leaving their job for more attractive opportunities. Only one CHW raised an issue related with remuneration.

"Most of the CHWs are young and we are losing them because they tend to go for greener pasture." (Health manager, Oshana)

Most stated that it would be more satisfying and encouraging if they would be trained in HIV, malaria, pregnancy and diabetes testing, and management of malaria and pneumonia in children. According to CHWs, health workers at health facilities, managers at district and regional level, and community members, management of malaria and pneumonia by CHWs would ensure prompt and immediate treatment of childhood illnesses, avoid long distance travel to health facilities, increase community acceptance and motivate CHWs.

"From the ministry side, I am not satisfied. We don't even do minimum intervention. People get tired of just being given health promotions and paracetamols all the time." (CHW, Kunene)

CHWP has moderately improved coordination of community health services, but the inconsistent and non-systematic coordination resulted in duplication of efforts.

CHWP has improved to some extent the coordination of community health services at all levels of the health system. Although not systematic, there was some coordination between community volunteers and CHWs. The different types of CHWs direct and refer specific clients to the appropriate CHW. For example, if a client requires first-aid service, a volunteer would refer the client to CHW or call him/her to inform about the case. Similarly, CHW worker refers a client who demands an HIV test to a volunteer who does HIV testing. However, due to the lack of systematic coordination between the various CHWs, there was duplication of efforts.

"Sometimes when I visit a household to educate on HIV/AIDS counselling, they tell me they had already received such education earlier. It is not a problem because they tell us." (CHW, Kunene)

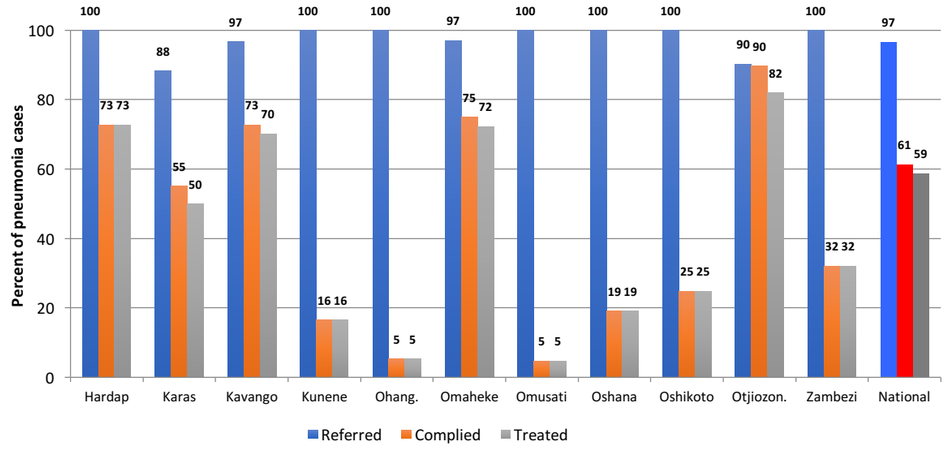
Outreach services conducted from health facilities are coordinated with CHWs. All participants recognized the impact of CHWs in mobilizing community members during outreach sessions. Prior to CHWP, only few people were receiving outreach services due to lack of prior mobilization, while recently the number of mothers and children mobilized has increased. In particular, CHWs identify defaulters of immunization and ensure they received the service during outreach sessions if they were not able to go to health facility.

CHWP has established and strengthened community health facility bidirectional referral linkage.

Almost all participants recognized the importance of CHWP in strengthening the community-health facility linkage. There is an established referral system between CHWs and the health facility and most of the elements for a functional referral linkage have been achieved in most areas. The important elements stated by informants and discussants include: CHWs have adequate skills, and with the support of the screening tools, they were able to detect cases that require referral; tracking patients and clients who missed their medication or immunizations has improved; awareness and health seeking behavior among the community members has improved and most clients comply to go to referral health facilities; and availability of ambulance services.

However, distance to referral health facilities, availability and cost of transport, lack of prompt attention at referral health facilities, and inconsistent feedback by health facilities were among the key challenges affecting referral linkage. Some facility nurses have not always responded or completed the form as they felt it was unnecessary. CHWs also experienced challenges when CHWs referred clients to health facilities at night. In Omaheke one CHW was confronted with a woman who gave birth in the middle of the night, with no ambulance, the only option she had was to call the PHC Supervisor, who provided guidance on how to assist the delivery, which fortunately went very well. In most cases CHWs just referred clients with the hope that they have the transport to reach the hospital. Participants of cFGDs suggested that CHWs should be introduced to the medical officers, especially to those on night duty. Quantitative data on suspected pneumonia cases who were referred to health facilities and who attended and received treatment showed the challenges that exist in some of the regions. Figure 9.21 shows lower percent of pneumonia cases who were treated in some regions (such as Kunene, Ohangwena, and Zambezi) with difficult geographic terrains, long distance to referral health facilities and challenges in transportation.

Figure 9.21: Percent of suspected pneumonia cases detected by CHWs who were referred, who went to health facility (complied) and who received services at health facilities by region



9.6 Efficiency

The available resources were generally used efficiently; however there were gaps in human resources, finance and logistics.

Although there was no plan with detail costs for CHWP activities that enable appropriate assessment of adequacy and efficiency of resource use, the overall assessment showed that the available resources were not adequate to implement CHWP and there was inefficiencies in using resources.

Shortage of funding has been the key challenge limiting CHWP from reaching to all hard to reach communities. The country was able to train and deploy over 1,600 CHWs over short period of time, however, given the dispersed settlement pattern of the people, all people who don't have access to health services were not reached. Given the high political commitment of the government and partners, training of CHWs continued and 647 CHWs have been trained to ensure increased reach to hard to reach communities (Table 9.2). However, due to the economic challenges in the country, budget has not been allocated to deploy the new graduates.

Human resources that provide management, support and supervision to CHWs have been the most critical challenge that affected the performance of CHWP. The health managers at regional and district levels and the nurses in charge of the health facilities were given the additional task of supporting and managing CHWs on top of their main responsibilities. Some health facilities are manned by one nurse and the nurses weren't able to leave the clinic to provide supportive supervision to CHWs. Thus, there is a need to have a structure at all levels of the health system that provides support and oversight of CHWP.

"We need dedicated teams at regional and district, as well as heath facilities because CHWs are supposed to be reporting to health facilities, and health facilities are supposed to be supervising CHWs, which is not happening." (Partner, National level)

Table 9.2: Number of CHWs deployed, currently active and new graduates waiting for deployment

Region	Number of CHWS Trained	Number of CHWs deployed	Number of CHWs currently active	New graduates waiting for deployment
Erongo	0	0	0	34
Hardap	53	48	42	0
//Karas	95	92	84	87
Kavango	190	167	163	91
Khomas	98	94	94	0
Kunene	198	198	161	0
Ohangwena	200	200	188	95
Omaheke	92	90	84	57
Omusati	199	182	174	89
Oshana	198	198	195	97
Oshikoto	94	86	81	0
Otjozondjupa	95	89	78	97
Zambezi	214	212	203	0
National	**1726**	**1656**	**1547**	**647**

Effective coordination and partnership with partners and existing interventions has not been achieved, particularly at regional and community level. At national level, the partners coordinated their resources with MOH through the National CHWP steering committee, however the participation of the steering committee members has been declining overtime. There is an effective coordination between MOH and the actively participating key partners including UNICEF, MCSP/USAID and WHO. This coordination has been critical in ensuring that there was no duplication of efforts. However, as some of the participants stated, the lack of detailed budget plan for CHWP was a challenge for effective coordination of efforts.

In majority of villages, the deployed CHWs were efficiently used - providing the required volume and range of services although there was variation between and within regions.

The design of the programme, which build upon existing community based health program improved its efficiency but there was weakness in effectively coordinating resources at the community level.

CHWP was designed building upon existing community health programme and CBOs to ensure high efficiency in the programme implementation. There are a number of Civil Society Organizations (CSOs) that have volunteers at village level providing a range of health services including TB field promoters, malaria officers, and HIV/AIDS. The community based volunteers and CHWs all contribute to the preventive and promotive community-based health services. However, there was no systematic and effective coordination mechanism in place that ensured efficient use of human resources at community level.

The programme was cost efficient in delivering primary health care services at community level.

Although, the CHWP strategic document included three year estimated budget for CHWP showing the incremental budget estimate for salary, training, supply and other costs, documentation on annual plan with detailed activities, quantification and budget specific for CHWP are not available. At national level, CHWP is under the PHC Directorate and only lumped budget for the directorate was available. A document with comprehensive quantification and budget for CHWP that allows the estimation of resources needed to implement CHWP was not available. This limited the ability to assess allocation against a costed plan for CHWP. Moreover, participants from partners stated that lack of detailed budget plan prevented them to plan and implement activities inline with the CHWP strategy.

The CHWP strategic model was fit to reach the most marginalized communities where there was lack of access to formal health delivery system. The key cost related with the programme included training cost and salary of CHWs. The programme was cost efficient in delivering the preventive and promotive service package to a large number of people. The programme reached a total of 140,203 households (588,853 people) through 1,547 CHWs with an overall average of 91 households (381 people) per CHW (Table 9.3). The average number of households per CHW varied between regions with 42 households per CHW in Kunene region and 139 households in! Karas region.

Table 9.3: Total number of households and people reached by CHWP and average number of households and people per CHW by region

Region	Number of CHWs	Number of HHs reached	No. of people reached	Average no. of HHs per CHW	Average no. of people per CHW
Hardap	42	4,899	20,576	117	490
!Karas	84	11,641	48,892	139	582
Kavango	163	9,260	38,892	57	239
Khomas	94	10,835	45,507	115	484
Kunene	161	6,698	28,132	42	175
Ohang.	188	16,687	70,085	89	373
Omaheke	84	8,050	33,810	96	403
Omusati	174	18,856	79,195	108	455
Oshana	195	17,948	75,382	92	387
Oshikoto	81	9,175	38,535	113	476
Otjiozon.	78	9,372	39,362	120	505
Zambezi	203	16,782	70,484	83	347
National	**1547**	**140,203**	**588,853**	**91**	**381**

The following areas were identified as leading inefficiencies: 1) CHWs were trained in temporarily set up training facilities with higher cost related to daily allowance for trainees and trainers; 2) there are CHWs who have completed training and have not yet been deployed; 3) due to the lack of supervision and monitoring, CHWs in some areas are not present at all, have additional work, or not providing services as per the standard resulting in inefficiency of the human resources; 4) although the health information reported by CHWs is used in monthly review meetings at health facilities, the large amount of data being collected has not been used for tracking progress or in decision making; 5) there is unnecessary duplication of efforts due to lack of effective coordination of various community-based health workers supported by different partners; 6) in some villages, the walking distance from village to village and house to house takes much of CHWs' time resulting in inefficient use of human resources.

The CHWP data system has been integrated into the national health informatics system; however, while there was greater emphasis on data collection, there was no evidence on use of data for monitoring of progress to improve CHWP management and decision-making.

The CHWP M&E system has been integrated into the national HIS. CHWs tally their activities and complete monthly report for submission to the respective health facility at the end of each month. At the health facility, data from all CHWs under the catchment area of the health facility are aggregated to report to the district. Finally, the districts enter the data into web based DHIS2 platform. There is data for a range of services that can be extracted at different organizational levels for the year from 2014-2017 depending on the introduction of CHWP to each region. The quality and reliability of the data reported by CHWs is not known due to lack of systematic supervision to verify the data. Moreover, delay in submission and backlogs in data entry affected the completeness of the data.

"Sometimes they create reports. Through the records I am able to see what they are doing on the ground and what is in the reports. I am able to see when the ANC are not coming, also when immunization is going down." (Nurse, Kunene)

While there was greater emphasis on data collection, there was no evidence on use of data for monitoring of progress to improve CHWP management and to inform investment. At health facility level, key respondents stated that CHWs' data is used in monthly and quarterly review meetings to evaluate CHWs performance, track defaulters, and identification of abnormally increased number of cases.

"We use the data. We check if CHWs are doing their work properly. In this catchment area they are supposed to visit 4-5 households per day." (Nurse, Oshana)

"Regarding malnutrition, we try to see where the cases come from, then we follow up on the CHWs. That's when we find out that some don't want to come to health facilities. But the information is not used that much." (District manager, Zambezi)

9.7 Sustainability

CHWP is institutionalized within the health care system.

The PHC directorate at the MOHSS has ownership and overall leadership of CHWP. It is responsible for national planning and coordination of CHWP, coordination of partners, development of the guidelines for implementation and a Monitoring & Evaluation framework for CHWP. There is high political leadership and support, without which it would not have been possible to train and deploy over 1,600 salaried community-based CHWs. However, the human resource capacity in support of CHWP as stipulated in the operational strategy with organizational structure including CHWP coordinator at national level and similar positions at regional and district levels has not been established. This issue is mainly due to lack of proper organizational planning but the level of political will and commitment in the provision of funding for such positions was lacking.

"There is a planned organizational structure, which incorporates CHWP where we want to have at the National level - a National Coordinator, that applies to Regional and District levels. All these structures at this moment are not established; so CHWP is currently still an addition activity." (Key informant, National level)

The MOH is supported by a core group of partners that include, but not limited to UNICEF, MCSP/USAID, WHO. The strategic document of CHWP spelled the roles and responsibilities of the different levels of the health system and partners only in general terms and not in a way that shows division of roles and responsibilities between the different partners. The key partners are part of the National Steering Committee who frequently meet and discuss about CHWP. However, there is no evidence that shows coordinated planning to develop annual planning describing who does what. The commitment of some partners that make up the steering committee has been declining as evidenced by low attendance of members during steering committee meeting for this evaluation.

Desk review and interviews suggest that the core group partners have invested substantial resources over the last five years for provision of technical support, training and procurement of medical equipment and supplies. However, due to lack of coordinated planning with role division, the support of the partners has been limited to some regions and technical areas. For example, if a specific region requests budget to undertake refresher training, then the partners would provide the support to the specific region and such refresher training may not be conducted in other regions that did not take the initiative to conduct refresher training.

Although there was variability between regions, regions have taken ownership and established regional steering committee that supports the coordination of CHWP. For example in Oshana, government budget was used to undertake various activities in support of CHWP and there was a strong support from the steering committee that meets regularly, while such coordination was weak in Zambezi region.

"Possibility for sustainability is there. Because mostly in our region we manage our daily activities with our own budget. We only ask for funds when we are doing extra things." (Key informant, Oshana)

In general, all participants agreed that the government owns the programme and there is clear evidence that if the gaps and challenges are addressed with the support of partners, the government and the community can sustain the programme.

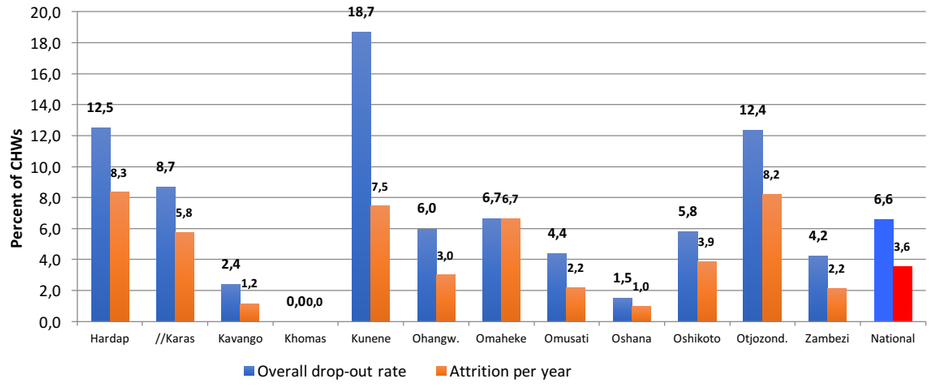
"They are already sustaining it. They only need our support in terms of skills and how to maximise their resources." (Partner, National level)

CHWs are well incorporated in the community with an overall low level of attrition rate.

Participation in community events is critical to build community trust, which overcomes delays in care seeking. Most CHWs were recruited from the community they are currently deployed, and all consider themselves as part of the community and participate in all community social events. Some CHWs, particularly in Kunene, noted that they still practice their respective culture ensuring continued acceptance and trust within the community.

Retention of human resources is critical for sustainability of a programme. The attrition rate was not very high although it differed significantly among the regions. The overall average annual attrition rate was 3.6%. The annual attrition rates by region are presented in Figure 9.22. The figure also shows the overall attrition since deployment of CHWs, which was 6.6% nationally.

Figure 9.22: Percent of CHWs dropped since deployment and the annual attrition rate by region



The key reason expressed by key informants for attrition of CHWs include 1) level of remuneration (looking for greener pastures, low salary); 2) lack of clear career paths (enrollment in nursing or other fields, uncertainty); 3) difficult working environment (hot weather, difficult topography, long walking distance carrying heavy bags, fear of attack by men and wild animals when girls walk in the bushes); 4) low recognition and institutional support (poor relationship and acceptance by community, inadequate support from supervisors and health facilities); 5) perceived unsatisfactory performance (feeling inadequate in their capacity, high expectation of the community, lack of supervision and refresher training, inadequate supplies); and 6) workload being

too much or too low. Majority of CHWs did not express strong views on level of remuneration in relation to motivation and retention, and the main issues raised were recognition, perceived unsatisfactory performance and working environment. Most CHWs felt that they were left out and that their efforts were less important leading into intentions of leaving their job for more attractive opportunities.

> *"Most of the CHWs are young and we are losing them because they tend to go for greener pasture."*

> *"Community not using the services. When people don't want to participate like taking part in meetings." (CHW, Kunene)*

> *"Lack of skills and knowledge may cause CHWs to leave due to lack of refresher training. Lack of uniforms for identification can be discouraging." (CHW, Zambezi)*

> *"From the ministry side, I am not satisfied. We don't even do minimum intervention. People get tired of just being given health promotions and paracetamols all the time."*

Key informants suggested the following mechanisms should be used to improve motivation and retention of CHWs: provide full package of benefits similar to other government employees, build career path, strengthen supervision, provide refresher trainings, additional skills to satisfy the community needs.

> *"We need to be given identification tags or uniforms so that the nurses can identify us because sometimes they are very mean to us when we go ask for tablets for instance. They reject us. They should give us training on HIV testing and TB Testing." (CHW, Kunene)*

> *"Increase the salaries. The cost of living is too high. Build carrier paths for CHWs. Train CHWs and other community members to enroll in nursing." (CHW, Zambezi)*

CHWP has empowered local communities through awareness building.

The participants stated that, through home visits and mobilization activities of CHWs, the community has understood about the importance of ANC, immunization, institutional delivery, and the possible adverse negative effects of home delivery. The programme has promoted ownership and participation of the community starting from the selection of CHW candidates. Community was involved in the recruitment of CHW candidates. All community members in the villages have equal access to the CHWP services, and despite some social and system barriers; they have also access to referral facilities. In most communities, there is high level of trust between CHWs and the community, which reflects increased community capacity. Community members and community leaders have the confidence to achieve improved health status at household and community level. Community has been educated with trained community members, and as a result the level of health awareness and health seeking behaviour has improved. Community members have recognized the need for healthy lifestyle. The uptake of health services has improved. The community is practicing healthy lifestyle including cleaning their environment, hand washing, and use of latrines. The fact that the community is demanding for more shows that awareness has been created and knowledge on alternative health services has been created.

> *"Women ask for condoms at the health facility, which is a sign that they can convince their partners into using protection." (Key informant, Kunene)*

Although, in most areas, councillors and village headmen are actively involved providing effective leadership and support, which is critical to create strong community, the involvement of community members and community organizations such as village health committee varied between and within regions.

In general, community participation was limited to supporting CHWP implementation but participation in planning and monitoring was low. There were still dependency attitudes where people expect everything from the government and payment for their involvement in the CHWP activities. There were also challenges due to cultural barriers, distrust between traditional healers and CHWs, and the skill and knowledge of CHWs.

> *"Women are not yet empowered. The husbands are the ones to make all the decisions. […] Women seek health family planning in secret at the health facility without the consent of their husbands. Many of them prefer injection because no one can see them taking the tablets." (Nurse, Kunene")*

9.8 Gender and Human rights based approach

CHWP considers the equity approach with a focus on most deprived areas, areas with high prevalence of critical newborn and under 5 mortality, and low-income families

> *"If I go to a household and discover that the person is not receiving any grants, I refer to ministry of gender, we refer to relevant offices so that the person can receive the services that he doesn't have access to." (CHW, Omaheke)*

The country has one of the biggest gaps between the rich and poor with gini-coefficeint reported at 0.572. Confronting the nation are underlying issues of poverty and economic inequality, with the majority of the citizens living in poverty, overcrowded housing, poor nutrition, poor water, sanitation and inadequate infrastructure and suffering from hunger and ill health. Consequently, the government has made health equity, gender and human rights its core principles in achieving universal health coverage and has deployed CHWs among the most disadvantaged and marginalized communities.

The evaluation revealed that CHWs addressed social determinants of health, which are strongly linked to human rights. They provided services with a high degree of humility and respect for diversity, and ensured gender equality and equity, promoting active participation of both males and females and collectively identify solutions.

CHWs are the cultural brokers, the communicator and the link between the community and different sectors. In all regions, strong interpersonal relationship between the community and CHWs was observed that CHWs are valued, respected and seen as the link or eye of the community. The expressions "Our Child, Our daughter, Our son, Our nurse" were mentioned several times. Majority of the community members felt valued and part of the Namibian house as one woman put it in !Kharas region.

> *" We feel that as people, although poor, we are valued and now have someone to whom we can express our concern and who in turn address them." (Woman ,!Kharas region – Lemoen Draai)*

Community members were comforted by the fact that they knew someone who accompanied them to a health facility and provided the necessary support in a time of need. This was the case in both !Kharas and Omaheke region which is urban centred. To facilitate this process CHWs are aiding health professionals and act as interpreters for community members/patients, a task which CHWs carry out with respect and without using medical jargon. This is illustrated in the quotation below:

> *"It is now easier to go to the hospital because there is someone who speaks our language." (Mother FGD- Kanaan, Omaheke region)*

Majority/all programme beneficiaries are very poor and destitute, which have implications on the action they are expected to take. This situation was observed in !Kharas region- Keetmanshoop an area with a 90% unemployment rate. As one discussant put it.:

> *"Sometimes a CHW come at a house and there is no money to go to hospital, the person is hungry, cannot take medicine on an empty stomach, ambulance refuse to come because it is during the day" (Discussant -Lemoen Draai Keetmanshoop)*

CHWs have devise mechanism to assist community members in need. For example, in Keetmanshoop the CHWs managed to secure E-pap for an unemployed woman on ART.

Socio economic challenges are rampant, issues of poor /unaffordable water, hunger, alcohol abuse and poverty were found to be some key issues affecting the programme and a right to health. Majority people that were referred to a health facility were not able to receive treatment due to lack of transport money or hunger. According to a discussant

> *"The problem is that sometimes people do not have money to go to the hospital, sometimes people go to the tombo house and drink alcohol just to have something in the stomach."*

In Kunene, community members found that the water was not good for human consumption - it was salty, bitter and made them sick. They have been demanding for safe and potable water. Similarly, in Omaheke, the communities were of the opinion that although water was available, members were required to procure them at a price.

Social issues that were confronting the community became the responsibility of the CHWs. For example, when community members are referred to the health facility but do not have money – they turned to the CHW for assistance. Almost in all regions studied, CHWs have gone the extra mile such as providing transport money, food and taking the clients to the health facility, or collecting medication on behalf of a client without any expectation. Discussants in both Omaheke and !Kharas recommended that provision be made for a community soup kitchen. They acknowledged that although government has made provision for drought relief food, some clients sell the food to buy alcohol.

CHWs used a human right based approach, which aimed at realizing the right to health and other health-related human rights as well as the key underlying causes of health and ill health i.e. food, housing, water, sanitation and information.

The majority of CHWs interviewed, close to 80%, were women with an average age of 30 years. The study observed that in Keetmanshoop where both CHWs were men, focused on alcohol and gender based violence. In Kunene, male community members took it upon themselves to protect the female CHW and accompanied her during the night when she had to attend a patient.

9.9 Unexpected results

There were no much unexpected results generated by the programme. However, it is important to mention that some key informants stated that when a child with a febrile illness is referred by CHWs after receiving paracetamol, some care givers did not take their children to the referral health facilities or delayed seeking the referral treatment. This was as a result of the temporary effect of the paracetamol on fever, where care givers though their children were cured from the illness. Despite the benefit on majority of cases, the provision of paracetamol alone by CHWs may have a negative effect on the treatment of febrile illness such as pneumonia. This could be addressed by empowering the CHWs with the mandate to treat pneumonia and malaria, and/or improving the counselling of care givers on the importance of the referral treatment.

10. ANALYSIS OF RESULTS

10.1 Context and Relevance

The integration of CHWP in the NHSP as well as its being reflected in the cabinet decision of No. 3rd/12.03.13/005, reiterate the importance of CHWP. CHWs have been recognized to be a critical cadre in community development and most specifically as it relates to health. This is well illustrated by a quotation from Kahssay below:

> *CHW programmes have a role to play that can be fulfilled neither by formal health services nor by communities alone. Ideally, the CHW combines service functions and developmental/ promotional functions that are, also ideally, not just in the field of health. The relatives importance of these two functions varies according to the socio-economic situation and the availability and accessibility of the health services.....Perhaps the most important developmental or promotional role of the CHW is to act as a bridge between the community and the formal health services in all aspects of health development. However, the importance of this link has often not been realized in national programmes....the bridging activities of CHWs may provide opportunities to increase both the effectiveness of curative and preventive services and, perhaps more importantly, community management and ownership of health-related programmes... CHWs may be the only feasible and acceptable link between the health sector and the community that can be developed to meet the goal of improved health in the near term (Kahssay, Taylor & Berman, 1998:4).4*

The existence of policy guidelines, training packages, and presentation tools for CHW have enabled CHWs to perform their work effectively. The activities and outputs are well aligned with the objectives of the CHWP strategy; however, community members are demanding additional services to be performed by

CHWs, which may have policy implications. Therefore, policy makers should be cognizant and carefully consider the request and try their utmost best to avoid creating unrealistic expectations.

However, the hierarchical nature and the limited involvement of the medical professionals at district level, in CHWP especially doctors on night duty have left CHWs in a difficult situation. For example, a CHW in Omaheke reported that she was confronted with an emergency situation, which she could not address and the only phone number she had was the one of the facility health nurse and PHC nurse who do not work during the night. On the other hand, she did not have the contact of the medical officer on night duty, as she was never introduced to the medical team at the health facility.

Similar to other studies, this evaluation found that CHWs were the agent of change in their communities and that the success of health and a healthy neighborhood is determined by the decision taken by policy makers outside the health sectors (Commission on Social Determinants of Health, 2008).

10.2 Training of CHWs

Like other studies conducted elsewhere,[5] this study found that pre-service training is a key vehicle providing CHWs with the necessary knowledge, skills, and abilities to perform their work. Although pre-service training is mandatory for all the CHWs prior to being deployed in the community, refresher trainings were not regularly conducted and dependent on the need and availability of financial and human resources. Ashwell and Freeman 1995[6] noted the importance of continuous refresher training, and that, if refresher training is not provided there is a likelihood that CHWs will lose the skills and knowledge acquired during the training.

Javanparast et al 2012,[7] found that an effective CHW's trainer need to have the tertiary qualifications in public health related field with work experience in a PHC set up. The findings revealed that the master trainers are full-time employees with the necessary qualifications and providing quality training. Concerns were raised about the interest and the qualifications of trainers recruited at regional and district levels, who are usually facility health nurses. Furthermore, the trainers may not have the necessary experience in teaching and public health with a likelihood of compromising the training. The current situation is that the CHWs training is a standalone programme, not yet accredited by the Health Professional Council (HPC), and its training relies on facility' nurses instead of using the NHTC regional staff, as well its facilities.

It has been recognized that when training is integrated into an existing programme, such as the NHTC, it is much easier to finance, and it ensures programme sustainability. This arrangement is likely to secure adequate financial and resource support for pre-and in-service training, supervision, and certification. The study found that the CHWs training is not integrated in the NHTC curriculum. Consequently, the 2017 financial challenges facing the government contributed to CHWs related training being suspended.

Integrating the CHWP into NHTC may create room and make it possible to add additional subjects as requested by beneficiaries to the current curriculum and possible extend the training and facilitate the accreditation by HPC.

10.3 Management and coordination

Coordination

It is widely acknowledged that how a programme is conceived, introduced and rolled out has implications for its implementation. Studies suggest that CHWs programmes are sometimes advocated by enthusiasts, who persuade politicians and policy makers in scaling up and implement programmes at a large scale, with the implementation directed from the centre with limited involvement of health personnel, at the district level.[8] Unlike the situation described above, this evaluation found that CHWP was well thought-out, well researched and provision made for technical and financial support.

The study noted that national level situation analysis was not conducted, and the situation analysis conducted in Kunene region would not provide a national picture given the diverse and contrast nature of Namibia. According to Jergen et al,[9] a situation analysis is important and critical as it can identify needs and challenges that are specific and provide a clear understanding of the local environment, which will enable the design of a programme that is specific to the region. It was also noted that the programme may have been rolled out in a haste and in the process overlooked some key elements. Consequently, the programme was implemented with limited evidence and without the full participation of health personnel at the district/ community level, which led to limited support from the personnel at the health facility.

This situation led to challenges with the management and implementation of the programme. For example, the evaluation noted that irrespective of the region, context, geographical size and different terrains, all CHWs were required to service between 70- 100 households. The different country context requires that allocation of households be done accordingly. In some regions such as !Kharas, Oshana, Zambezi and Kunene, households assigned to CHWs were scattered with the nearest home 20km away, while in Omaheke – Kanaan, Lemoen Draai- Tseiblaagte-Keetmanshoop, and Area 7 Luderitz more than 100 households were located within 5km radius.

Lack of comprehensive national situation analysis may have compromised some aspects of the programme especially at the district level. The district level is the key framework that will enable CHWs to conduct their work effectively and efficiently. It is the district that is required to provide support in all spheres, be it in training, technical, providing a reliable referral system and information.

CHWs are selected by their own communities, accountable to the community, supported by the village headman or village health committee and health facility nurse. Paradoxically, it was noted that in some districts, CHWs were not selected by their communities, but they responded to an advert that required applicants to be from the (listed) communities. Challenges were identified when the CHWs were expected to take responsibility for mobilizing communities by themselves without the leadership of the community members, resulting in the non-existence of a health committee, as was the case in Keetmanship.

Regular and reliable support and supervision has been found to reduce the sense of isolation and assist in sustaining the interest and motivation of CHWs and a key to successful performance of the CHWs, and the vehicle to increase access to health services with the greatest need in remote areas, geographical challenged terrains.[10]

The study found that supervision has not received the needed time, human nor financial support to carry out supervision activities and sustain them. However, several regions have identified mechanism to provide supervision such as appointing a senior CHWs and rotating CHWs to act as supervisors.

Several practices that contribute to poor quality supervision have been identified i.e. cost not taken into consideration; need and importance of supervision overlooked; inadequately planned supervision; Ill-defined responsibilities of supervisors and when supervision left to the staff in health facility (health facility nurse) with competing for priorities.[11,12]

These findings are similar to studies that found that lack of supervision and support of CHWs deployed in challenging geographical areas was a key barrier to performing their work.[13,14,15]

Geographical barriers, with limited transportation, have made conducting home visits and supervision challenging. For example, CHWs in some districts in !Kharas, where the nearest household may be 30 km away, have not been able to conduct home visits and to follow up.

Resentment among some health facility staffs and village health committees were observed. The health facility staff felt overwhelmed as they viewed CHWs supervision as an added responsibility, while the village health committee expressed unhappiness for supervising paid CHWs and not being compensated for it.

Lack of orientation programmes for the finance and human resource managers, medical professionals at facility level made it difficult to gather support for the programme. It should be noted that majority of health professionals at the health facility levels are socialised and trained in "curative care" and that the curriculum of nurses and medical doctors tend to neglect community health, thus leading to their failure in appreciating PHC, and in the process failing to support and supervise CHWs.

Not helping the situation is the limited human resources and competing priorities. Consequently, some health facilities are diverting from the job description of the CHW and deploying CHWs as assistants within the clinics, where CHWs measure vital signs, translate for health professionals, cleaning/dressing wounds and provide necessary support to the patients/clients in a clinic. This setup may compromise the health promoting activities within the communities.

Community participation is a key ingredient for the success of a CHW programme.[16] Community participation can be divided into two i.e. community participation as the mobilization of community resources (people, money, materials to carry out health programmes and community participation as increasing people control over social political, economic, environmental factors determining their health.[17] The study found that the participation is referred to in terms of participating in meetings and in the selection of CHWs with the aim of increasing control and determine people's health, promote immunization, maternal health, general hygiene and sanitation.

In some cases, community participation is institutionalised through the village/area health committee, as was the case in Oshana and Omaheke. They took the responsibility of managing and overseeing the work of CHWs.

One of the most important conditions for sustainability of the programme is the capacity of the community members owning the process and organizing themselves. Globally village health committees are a source of inspiration and support for the CHWs and that strong health committees are associated with superior performance.[18] The evaluation noted similar findings that when the community is strong and organised, it can implement effective and high-quality programmes as was the case in Omaheke and Oshana. The community leaders appreciate and own the process and have also developed a mechanism to address transport challenges. For example, in Omaheke community committee created a saving where members contribute monthly, which enabled members to have emergency transport funds.

Cross sectoral collaboration

Health is a state of complete physical, mental and social wellbeing.[19] It is well recognized that health be it at individual, household, community or at the national level cannot be handle by the health sector alone. Collaboration between different government sectors, public and the private sector, bilateral and multilateral institutions is a key strategy in reducing mortality, morbidity, and disability.

The evaluation noted that CHWs were dealing with diverse issues, outside the health sector such as poor water and sanitation, food insecurity, elder, child social grant abuses, school dropout, alcohol and gender based violence which require input from different sectors like Ministries of Water and agriculture: Local Government; Poverty; Gender & Child-Welfare; Education, Ministry of Gender and Education.

The importance of sector collaboration is well illustrated in the Alma Ata declaration article VII and further reiterated in subsequent agreements notable MDGs and now SDGs.

> *According to article VII (4)[20]*
> *(PHC) involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;*

The findings revealed that there was no systematic relationship between the different sectors. Ndumbe et al[21] identified four patterns of relationships, which they characterized as i) information sharing, ii) cooperation, iii) coordination, and iv) integration. This evaluation noted the existence of political commitment, a buy-in from several sectors and good informal collaboration between the different sectors. The relationship between sectors was limited to information-sharing, as was the case with the CHWs and the Ministry of Gender. For example, the CHWs in Omaheke and Oshana, reported cases of Child, social grant, and elder abuse, as well as Gender based violence. The CHWs reported and were dependent on the goodwill of the officer representing Ministry of Gender and whether they will act.

The relationship in !Kharas region, Keetmanshoop and Luderitz district, focused on cooperation which led to social change. For example, in Keetmanshoop, the collaboration between CHW and the police led to control of alcohol outlets and led to a decrease in violence. In Luderitz, the CHW advocated the need for additional toilets in the informal settlement, resulting in the town-counsel making provision for additional toilets. As other studies have found, this study also found that the health sector's PHC tends to benefit from other sectors largely by coincidence.[22]

Cross-sectoral collaboration is key and continuing the current status quo of informal relationship between the key sectors may not enable the country to attain the nation's health. For example, CHWs may promote hygiene and sanitation, but unless toilets are provided and or materials to built toilets are made available, people are likely to continue with old habits. Likewise, CHWs may refer clients to the hospital, and if there are no roads or transport funds, then the exercise is set up to fail. Similarly, the community members in Omaepanga- Kunene have been complaining about the water, which causes diarrhoeal, and while the MOHSS may promote the importance of drinking water and unless safe and potable water is provided – the MOHSS will continue to be confronted with patients suffering from diarrhoeal diseases.

10.4 Impact

An important precondition to achieve the CHWP's goal of reduction in child and maternal mortalities was that mothers would have access to health facilities providing quality MNCH services including the delivery by skilled birth attendants. The primary causal pathway, as identified in the TOC for CHWP is sensitization and education to create awareness and knowledge leading to increased health seeking behavior and demand, which combined with detection and referral of clients (pregnant women, mothers with risk factors, children with danger signs and children who missed immunization) contribute to increased utilization of services and improved coverage. For example, the pathway for increased health facility deliveries is the availability of CHWs who did behavior change communication with mothers, which empowered the pregnant women to take decisions regarding institutional delivery. CHWs acted as a bridge between the community and health facilities. The ToC constructed for CHWP can be supported by various other studies. A study reported that building health promotion capacities of community-level cadres to promote maternity care seeking by women in their villages has been shown to increase utilization of maternal health services.[23] In another study, health promotion messages by CHWs in rural Kenya have been shown to increase knowledge of maternal and newborn care among women and encourage institutional deliveries.[24] However, it is critical to combine health promotion activities with interventions that tackle barriers in health care access.[25]

In addition to the health promotion activities by CHWs, the government supported the programme with the provision of ambulance services, which benefitted pregnant women and children residing in remote areas to access MNCH services. A study reported that if the mothers are properly educated and counseled and given the enabling environment, such as ambulance, they would go to health facility.[26] CHWP's contribution to increased service access was not identified in the TOC. However, based on the findings of this evaluation, CHWP improved access to institutional delivery, immunization and management of diarrhea cases. The improved access to institutional delivery was achieved in combination with the ambulance service, while the improved access to immunization was achieved with increased mobilization combined with outreach services. Since CHWs manage diarrhea, which is one of the leading causes of child morbidity and mortality, the improved access to diarrhea management is directly linked to CHWP.[27] In line with the evaluation

findings, a systematic review showed that interventions that were effective in reducing inequity included the improvement of health care delivery by outreach methods, using human resources in local areas, using services in the community nearest to the residents, and providing knowledge support to the demand side.[28]

In this study,the preconditions in the ToC, however, were not fully met in Kunene and Karas regions. This was due to geographic and health system barriers, like the inadequate number of CHWs given the scattered settlement patterns, distance to health facilities, and inadequate ambulance service to improve access. This was compounded by the presence of cultural barriers for accessing MNCH services in Kunene. Interventions, that are otherwise well designed, therefore, might not have work. An enabling environment at the structural, political and cultural level is an important precondition. Similar results as in this evaluation are reported in some studies done on the effective role of CHWs in improving MNCH,[29] and on the poor functional status of village health committees.[30]

10.5 Gender and Human rights-based approach

CHWP takes a HRBA and by virtue of their work, CHWs address issues of inequalities. A HRBA emphasizes key elements i.e. availability, accessibility, acceptability and good quality health-related services and facilities, and human rights standards and principles, such as participation, equality, nondiscrimination and accountability, which should guide programme implementation.[31]

- This study found that HRBA is integrated into the national policies and programmes, which aim at addressing underlying determinants of health such as gender equality, safe and potable water, sanitation and health related information. The evaluation found that the programme focused on the most deprived areas whether it is in the rural or urban areas, and also areas with the high prevalence of child morbidity and mortality, low-income families and areas where there is a high rate of alcohol and gender based violence. In addition, it was also found that both men and women participated equally in both the programme implementation and to a lesser extend in the planning of the services. The CHWs expressed concern about the socio economic status of their clients, in some cases, they had to address issues of Gender based Violence. For example, in Keetmanshoop, the CHWs revealed that they had to intervene in a case of domestic violence, and according to him it was easier to address a male member issue as the CHW was male and was able to draw from his own experience.

- The socio-economic challenges of the community members made it difficult to promote and realise their clients' right to health, and towards equitable service delivery, participation of the communities and local ownership. In addition, CHWs have to address and assist community members. In all study areas, CHWs used their own resources for food and transport to enable their clients to access health services. Other studies have found a difference between the issues that are dealt with by men or women CHWs. For example, in Uganda male CHWs were found to perform better in certain roles such as mobilizing communities for public health interventions e.g. clearing drainage of water sources. In Zambia, community members prefer to receive services especially sexual and reproductive health services from the same sex provider, while in Tanzania male and female CHWs performed equally in the provision of MNCH promotion, which is similar to the findings in this study. Similar to a study in Brazil, which found that domestic violence was best addressed with male engagement, this study found that male CHWs in Keetmanshoop where comfortable in dealing with Alcohol and Gender Based violence.[32]

11. BEST PRACTICES AND LESSONS LEARNED

11.1 Best Practices

- **Strong relationship between the community and CHWs** with respect and trust, which was critical in ensuring CHWs' acceptance by the community, was important facilitating factor in the implementation of the programme.

- **Participation and ownership of programme by community** including Village Health Committee who monitored CHWs' activities and Constituency Councillors who were advocating for CHWP in various media channels facilitated the appropriate implementation of the programme.

- **Maps of households:** All CHWs mapped the houses assigned to them, which facilitated their day-to-day activities.

- **Support from health facilities:** CHWs who were supported by the respective health facility nurses were encouraged to perform their duties better. Good relationship and respect between health facilities and CHWs was critical in strengthening the community-health facility bi-directional referral system.

- **Accessibility to referral health facilities:** In some communities, the referral health facilities were easily accessible to the community, without which the contribution of CHWP in improving health service coverage would have been limited.

- **Using social media to share knowledge:** Oshana and Kunene teams have identified the importance of communication between CHWs, PHC and the health facility and created a WhatsApp group, where they share knowledge and information, and get advice.

- **External supervision:** Given the competing priorities of the health facility nurses, the PHC supervisors have taken on the responsibility of supervising CHWs.

- **Peer supervision:** To support supervision process, staff in Luderitz, Zambezi and Omaheke devised mechanism to do so. In Luderitz, the PHC supervisor and the health facility nurse created a supervisory structure, where each CHW gets an opportunity to act as a supervisor every 3 months. CHWs get an opportunity to help one another and assess the quality of work performed by a fellow CHW. In Omaheke and Zambezi, the programme followed the SOP guidelines and appointed a senior CHW.

11.2 Lessons Learned

- **Strengthen advocacy:** One of the key lessons were that teams/sectors that are supportive of the programme are those with an appreciation for PHC, and who are exposed to CHWP. Resistance and lack of support were observed from people who have not been exposed to the programme e.g. financial and human resource staff, and health professionals whose focus is on curative care. Moreover, due to lack of awareness on the scope of CHWP, some community members have requested additional services outside its scope, which may derail the community's interest in the programme. To strengthen /revitalise the CHWP, there is a need to orient officers, communities and other governmental organizations on the role of CHWs and the importance of PHC. Moreover, provision of uniforms has given CHWs a sense of belonging and easy recognition improving their visibility.

- **The use of CHWs as role models,** especially those with a history of alcohol abuse had a positive outcome in addressing alcohol and gender based violence, especially in areas where there is a high rate of alcohol abuse and gender based violence.

- **Diversify funding of CHWs' activities:** CHWP addresses social determinants of health that are the responsibilities of different sectors, and the burden cannot be carried by one sector. One key lessons was that is important for different sectors for example, Gender, Culture Education provide support be it financial, logistics and human resources that they enable CHW to do their work effectively.

- S**trengthen external and peer supervision:** This is especially important given the current challenges of limited human resources and competing priorities at health facility level.

- **Adjusting number of households per CHW based on geographic proximity of households:** There is a need to allocate adequate number of CHWs according to the regional needs. Some CHWs are experiencing challenges as they are expected to cover 100 households within month, despite the long distances between households.

- **Community participation:** Despite the variability, community participation is well documented and contributed to programme performance. While it has been noted that CHWP thrives in communities where the community selected CHWs, it was not the case in some communities. There is a need to develop a policy or guideline outlining participation to standardize and strengthen community participation.

- **Critically review CHWP for urban areas:** The CHWP had the purpose of addressing health needs in rural, informal settlement and communities that do not have access to health care. Thus a key lesson is to ensure that the deployment of CHWs is done following a thorough situation analysis. In some case there is no need to deploy community health workers in urban township that can be catered by the Primary Health Care unit from the respective region. It is important to strongly consider the deployment of CHWs in the informal settlements in the urban areas.

- C**ritically review the capacity of a health facility in supporting CHWs:** The success of effective CHWP depends on the support provided by the nearest health facility. Hence the need to train and orient facility health staff towards CHWP.

- **Galvanize cross-sectoral support for CHWP:** CHWP provide opportunity for cross-sectoral collaboration, including possibility of funding from the private sector. Although unstructured multi-sectoral collaboration is visible at the community level, at national and regional level, it is limited to the participation of Governors or town councils in meetings.

- **Identify Champions:** Despite the fact that all community members appreciate CHWP, its momentum is somehow diminishing. Thus, it is critical that the programme identifies champions (e.g. Governors who have seen the impact of the programme in their regions) and let them advocate, promote and inspire others to join and support the programme technically and/or financially.

- **Integrate CHWP pre-service and refresher trainings into NHTC.** Providing CHWs training as a standalone programme, using adhoc facilities and relying on facility nurses as facilitators is not sustainable.

12. KEY CONSTRAINTS

Policy direction and commitment: Demand of the community may not be addressed by supply side of the health system. "In !Kharas Luderitz district, Area 7, the CHW advocated and managed to have the town council build toilets for the community members. This may have implications for future programmes. For example, can the government afford to promote the importance of sanitation without making provision for that? The community has also demanded for additional community health services such as HIV counselling and testing as well as management of childhood illness. Based on the quantitative data, many pneumonia cases detected and referred to health facilities did not go to the referral health facilities due to distance, transportation and other factors, in particular in some of the hard to reach areas. The programme has created high level of health service demand, and it is critical that it evolves over time and address the supply side bottle necks. However, it is important that the expansion of the CHW scope of practice be accepted by management, policy makers and health professional council.

Weak coordination mechanism at all levels of the health system: Respondents were of the opinion that steering committee meetings have not been effective, and have not been conducted regularly, this is partly due to the changes in management, financial reasons and competing priorities. Weak coordination mechanism affects the coordination of resources leading to inefficiency of the programme.

> *"It hasn't acted as a steering committee for a long time. It may just be a working group or planning group".*

> *"I am aware of the national and regional steering committees but I don't know if we really have somebody dedicated to build up a national one so that steering committee becomes sustainable institutional"*

There was also weak coordination of the different types of CHWs leading to duplication of efforts and inefficiency.

> *"Sometimes when I visit a household to educate on HIV/AIDS counselling, they tell me they had already received such education earlier. It is not a problem because they tell us." (CHW, Kunene)*

Inadequate management capacity: Inadequate human resources for management, support and supervision at all levels of the health system has been one of the key constraints that limited the programme from maximizing its achievement. Due to the inadequate staffing, evidence based planning, implementation and monitoring of the programme has not been strong.

> *"Government's vision is 100% but the people on the ground are causing the vision not to work. Poor planning is the problem, especially in some areas. The Government is dishing out resources but the planning is supposed to come from us. We can't wait for the Government to plan for us." (Councilor, Zambezi)*

The training of CHWP has not been institutionalized and the current approach of training in temporarily setup training facilities has been costy due to allowance payments to both trainers and trainees. Moreover, respondents questioned the following key areas of the training approach: 1) Majority of the respondent felt that the approach of 2 weeks theory and 2 weeks practice was not effective and rather they recommended to finish all theoretical aspect of the training in three months and then, do the practice in the remaining three months enabling them to practice the whole package at the same time. 2) About 100 CHW students in a session affects the quality of training and suggested to enrol about 25 students for theory, while another 25 students are doing practice. 3) The capacity and teaching experience of trainers might have affected the learning process because trainers are often selected from the region/district and health facilities and due to competing priorities, the regions are forced to send anyone who is available. Thus the selection of trainers is ineffective and with the limited human resources meant that the region or the district has to release an officer for more than 6 months. This also have financial implications on the programme. The programme should consider having trainers of facilitators, and trainers of trainers. Facilitators could be attached to an academic institute e.g. University of Namibia Nursing/school of medicine/public Health and national Heatlh training. The trainers could be based in the region or district and supported by the regional National Health Training center. This means that trainers do not need to travel and be away for more than 6 months, and this will reduce the financial cost as a result of travelling and need for accommodation.

A range of demand and supply side barriers still affect access and utilization of services. The following are some of the factors:

- Distance, and availability and cost of transportation to health facilities,
- Unexpected timing of labor,
- People who live on farms, in particular in Omaheke and !Kharas regions, have not been reached by CHWs, and are likely to miss ANC and deliver at home,
- Fear of injections and side effects of immunization, and deeply rooted cultural beliefs, particularly in Kunene and among families coming across the border;
- Non-compliance to go to referral health facilities due to cultural beliefs, distance to referral health facilities, availability and cost of transport, lack of prompt attention at referral health facilities, and inconsistent feedback by health facilities, and
- Although the availability of outreach sessions as alternative delivery service addressed the distance barrier, the frequency was not adequate to provide the scheduled vaccines, especially in Kunene where the frequecny was reduced due to shoratge of human resources.

Community participation was not strong: There was no strong community participation, specifically in planning and monitoring of the programme.

Working condition related factors affected CHWs' motivation: CHW motivation is critical for the success of the programme; however, despite the overall satisfaction, CHWs stated a number of working condition factors that affect their motivation. These included lack of adequate supervision and refresher trainings; uncertainty in their future due to lack of carrier paths; long walking distance, and shortage of supplies, M&E registers, uniforms and ID badges; and higher expectation and demand from the community for more services, which are not provided by CHWs affected their acceptance by the community and their motivation.

> *"From the ministry side, I am not satisfied. We don't even do minimum interventions. People get tired of just being given health promotions and paracetamol all the time." (CHW, Kunene)*

Inadequate human and financial resources: Although a detailed costed plan for CHWP implementation was not available to undertake appropriate assessment of adequacy and efficiency of resource use; based on general assessment, available resources were not adequate to implement CHWP. Shortage of funding and human resources has been one of the key challenges limiting CHWP from reaching to all hard to reach communities.

Although most of the sustainability elements have been encouraging, one key informant expressed concern whether the government would be able to sustain the programme with 4,113 CHWs in the salary payrolle.

Weakness in the use of data for decision-making: While there was greater emphasis on data collection, there was no evidence on use of data for monitoring of progress to improve CHWP management and to inform investment. There was limited use of data for monitoring CHW activities. At health facility level, key respondents stated that CHWs' data was used in monthly and quarterly review meetings to evaluate CHWs performance, track defaulters, and identify abnormally increased number of cases.

"Sometimes they create reports. Through the records I am able to see what they are doing on the ground and what is in the reports. I am able to see when the ANC are not coming, also when immunization is going down." (Nurse, Kunene)

> *"We use the data. We check if CHWs are doing their work properly. In this catchment area they are supposed to visit 4-5 households per day." (Nurse, Oshana)*

Weak cross-sectorial collaboration: There was no systematic multisectoral collaboration at all levels of the health system. However, there is a great potential to establish cross sectoral collaboration among differernt sectors as it was seen at community level where CHWs collaborate with different sectors on an adhoc and case bases. Due to the lack of systematic and structured collaboration with other sectors, CHWs expressed the challenges related to non-responsiveness of some key sectors as such the social work.

> *"I once reported two cases of child neglect to the office of the social worker in January this year, though the social worker promised to come, he has not. (CHW, Omaheke region)*

Human rights based approach: The socio-economic challenges makes it difficult to promote and realise their clients' right to health, and towards equitable service delivery, participation of the communities and local ownership. In all study areas CHWs used their own resources be it food, transport funds to enable their clients to access health services. This is partly due to the fact that majority of the community members are poor and likely to be destitute.

13. GENERAL CONCLUSIONS

The purpose of this evaluation was to assess to what extent the CHWP contributed to improved maternal, neonatal and child health outcomes in Namibia; to gain an in-depth understanding of the progress and challenges, and to identify areas for improvement; to assess the alignment with, and appropriateness of, policies and guidelines for the community health programme; as well as to determine the extent and depth of coordination and collaboration for partnerships. To achieve the objectives of the evaluation, a systematic study was conducted to address a number of questions designed to assess the relevance, efficiency, effectiveness, impact and sustainability of the programme.

The evaluation concludes that the programme has contributed to increased coverage of MNCH services and improved health status of individuals, families and communities. This was achieved through interpersonal communication especially behavioral change mobilization at home and community levels. CHWs play a critical role as distributor of preventive health care, promoter of health behavior and social welfare, provider of curative care and as community organizers. They were able to create awareness on the importance of healthy lifestyle, addressing issues of alcohol, poor diet and Gender based violence, and promoted early health seeking behavior. They were also responsible for early detection and referral of clients, promotion of health behavior and social welfare, which led to increased utilization of services and improved coverage.

The positive impact of the Namibian CHWP is a result of several factors i.e. i) political commitment; ii) financial support from both Government and development partners; iii) community participation and support; iii) CHWs' motivation and interest; iv) human resource management; and v) training and well defined job description.

It was however noted that the programme faces a number of challenges ranging from financial, human resources and technical capacity. Other factors include i) limited buy in and involvement of key stakeholders (nurses at health facility and other sectors); ii) limited integration of CHW into existing health system; iii) the lack of costing CHWP including cost of supervision; iv) poor monitoring systems; v) limited supervisory support; and vi) long distances and challenging terrains.

This evaluation confirms findings found earlier and that community health workers are the link between the community and health system, in all regions they provided these services with respect and empathy and this was also made possible by the fact that they understand the language and culture. However lack of governing structure, limited involvement of key stakeholders (sectors) water, sanitation, social welfare at district, local and national levels means that the CHWs are forced to address social determinants of health such as poor sanitation and hygiene, alcohol and gender based violence without the participation of key partners.

While the programme strategic documents and approaches are appropriate to achieve the set objectives, there were some limitations with the design. For example, the training process was found to be inefficient, the coordination mechanism was inconsistent and there was no strong programme supervision and no systematic cross-sectoral collaboration.

To assure that CHWs will continue to positively impact health, it is important that the Government in particular MOHSS take these evidence-based recommendations into account in the redesign of the policy, guidelines and strategic documents including funding for CHW services in consideration. It is important to urgently address issues that relate to certification, accreditation, quality control and supervising process and governance structure. The findings can also be used to reformulate some contents of programme design, training, supervision, monitoring and evaluation. Not forgetting the importance of orientating health staff/ staff from related non-health sectors to the role of CHWs.

It is hoped that these findings will be used by MoHSS and partners, in their different capacities and functions, to inform policies and strategies and develop future plans and interventions to improve programme performance. It could also be used in academic settings, especially public health and teaching on community health.

14. RECOMMENDATIONS

#1 The Government needs to further strengthen its political commitment and stewardship role.

The introduction and scale-up of CHWP to improve maternal and child health as well as the overall health status of the people demonstrates the political commitment of the government. Although the training of CHWs was suspended due to the economic recession in the country, the government showed its commitment by providing the necessary resources to complete the training. There is a need to further strengthen the government's commitment to ensure that the programme reaches the marginalized communities through allocation of more funding and the deployment of the already trained CHWs with priority to marginalized and hard to reach areas. While the programme creates health service demand, it is critical to enhance government's stewardship role to address the supply side bottle necks through the expansion of the CHW scope of practice. This requires government commitment and leadership to bring together policy makers, steering committee and partners, health professional council, and other key stakeholders to design appropriate policy directions. It is critical under this recommendation to identify a high level champion in the recommendation on political leadership and commitment

#2 Develop detailed costed plan with annual breakdown through bottom up approach and strengthen programme monitoring.

The evaluation findings showed that there was no detailed costed plan to evaluate the cost-efficiency of the programme, and M&E framework lacked baseline values for the indicators against which to judge the performance of the programme. The strategic plan should be revised with accompanying costed annual activities, while optimizing the use of existing resources from different stakeholders. There is a need to consider and strengthen MoHSS regional budgeting process, training, transport, materials and supplies (uniforms, bags, hats, shoes), and supportive supervision issues. The findings also showed variation in the performance (productivity) of CHWs. For example, among the estimated number of pregnant women within households covered by the programme, the percent of mothers with birth plan varried from 19% in Oshana to 100% in Kunene. Since the M&E framework has not stated the target coverage that should be achieved by each CHW, district, region or at national level, it was not possible to judge the achievement against a target.

Table 14.1 shows an example for monitoring the activities of a CHW who is responsible to cover 100 households. The assumptions and targets given are to show case the exercise and not based on objective sources, and if such tool is adopted, there is a need to use reliable source for each assumption. The CHW level data can then be aggregated at health facility, district, region and national levels to monitor the performance.

Total population: will be captured during annual census (or estimation based on average household size). Example – 100 households X 4.2 = 420 people

Household visit: with the assumption that a CHW will visit 5 households per day, the 100 HHs will be visited within a month. Thus, each HH will be visited 12 times per year.

Total population and women 15-49 years: will be captured during annual census (or estimation based on percent of women 15-49 years in the population).

Estimated number of pregnant women: about 4.2% of total population in catchment area.
Estimated number of one-year old children: about 2.9% of total population in catchment area.
Estimated number of under five children: about 13.8% of total population in catchment area.

Table 14.1: Example with assumptions for detailed plan with indicators and targets

Service	Target group	No. of target subjects	Indicator	Baseline level	Annual target plan	Annual achievement
Household visit	All households	100	% of HHs visited every month		100%	
Women 15-49 years	Women 15-49 years					
Family planning	Expected no. of women for family planning		% of women who received counselling	20%	90%	
ANC	Estimated no. of pregnant women	18	% of pregnant women visited 4 times	11% (taken from Table 9.1)	100%	
Delivery	Estimated no. of pregnant women	18	% of pregnant women with birth plan	52% (taken from Table 9.1)	100%	
PNC	Estimated no. of pregnant women	18	% of births visited within 24-48 hours	7% (taken from Table 9.1)	100%	
Child immunisation	Estimated no. of one-year old children	13	% of one-year old children fully vaccinated	80%	90%	
Latrine	All households	100	% of HHs with latrine facility	20%	80%	

#3 Strengthen supportive supervision

One of the key challenges in the implementation of the programme has been lack of supportive supervision, which has limited the programme from maximazing its impact. Regular supportive supervision is critical to provide technical support through direct observation and mentoring, which improves the quality of services. It also increases motivation of CHWs and contributes to monitoring their day to day activities ensuring their availability in their respective villages, which increases their productivity. Supervisors will also strengthen the linkage between the community including the village headmen/women and the health facilities. Thus, the MoHSS is advised to create a supervision structure and appoint a dedicated person to provide supportive supervision to CHWs. The MoHSS can use different alternative approaches. The first approach is to use senior CHWs who are selected among the existing CHWs to serve as supervisors. This approach can be immediately implemented with the provision of training to the selected senior CHWs on supervision technics and basic data management to ensure that the CHWs receive quality supportive supervision and get feedback on their performance. Some regions including Omaheke, Zambezi and !Karas have assigned senior CHWs as supervisors although it was implemented only recently and without training to on supervision skills. It is also important that the selection process of senior CHWs should be undertaken through transparent process preferably using a committee. The second approach is to use community health nurse who will be deployed in the community to provide supportive supervision to a group of CHWs. This approach is a long-term solution as it requires training of community health nusers. Since the community health nurses can provide curative services as well as some MNCH services, this approach can also address

challenges related to access to MNCH services. This approach is especially appropriate for hard to reach communities.

While the supervision structure is being established, the PHC staff at the regional and district levels should continue to provide supportive supervision. There is a need to strengthen district health capacity and advocate for PHC to ensure that the health professionals in curative care understand the social determinants of health, which may contribute to the appreciation for PHC and supporting the CHWP. Thus, the MoHSS and partners should provide financial and logistic support to continue the regional and district support provided to CHWs. There is a need to integrate and coordinate supervision with outreach programme and partners such as red cross. There is also a need to revise the current MoHSS transport policy to include CHWP services.

#4 Strengthen managerial capacity of districts to ensure regular planning and monitoring.

The evaluation findings showed that it was only the PHC supervisors that were providing support to CHWs. With proper integration into PHC, all technical PHC staff at different levels of the health system should provide technical support. Moreover, with the addition of 1,600 CHWs (and more in the future) into the health workforce, there is a need to appoint a dedicated staff, particularly at district level to coordinate CHWP. The availability of a district coordinator with skills in basic data analysis and the involvement of the PHC technical staff will strengthen the districts' evidence based managerial decision-making capacity. The SOP needs to be revized to ensure it responds to the regional variation and ensure standardization and systematic implementation of CHWP.

#5 Improve the motivation and satisfaction of CHWs.

The motivation and satisfaction of CHWs is crucial for the success of the programme. Thus, there is a need to further improve their motivation and satisfaction. Based on the findings of the evaluation, the MoHSS should consider the following critical measures to improve the motivation, satisfaction and retention of CHWs: 1) establish CHW career paths to address the uncertainty in their future; 2) provide regular refresher trainings; 3) strengthen procurement and distribution system of CHW supplies; 4) ensure availability of M&E tools, guidelines, and job aids; and 5) provide uniforms, ID cards, means of transportation (eg. Bycle) in selected villages.

#6 Further strengthen behavioral change communications to empower local communities.

Further strengthen the behavioral change communication activities of CHWs to mitigate cultural beliefs and misconceptions (such as fear of injections and side effects of immunization), and develop awareness and positive attitude sufficient to create demand and increase health seeking behavior and service utilization. This requires training of CHWs in counseling technics and standardization of home visits with increased frequency and number of households visited per day per CHW. Moreover, the behavioral communication activities should be supported with locally appropriate IEC materials.

#7 Strengthen community engagement and participation to ensure community ownership.

Community participation in planning, implementation and monitoring of the programme needs to be strengthened with the involvement of the community, village headmen/women, councillors and village health committees. Community participation and ownership help to address community and cultural preferences, and determines the success of the programme. With community empowerment and strong participation, the community could be involved in administrative support of the programme. While district PHC and health facility staff provide technical support, the community could share the responsibility of administrative support and monitor the day-to-day activities of CHWs. Although a dedicated supervisor, senior CHW, or health facility nurse could provide regular supportive supervision, a supervisor couldn't provide appropriate administrative support. The community was involved in selection of CHW candidates, however programme officer, several community members and HR committee should be involved during the selection process at community level.

#7 Improve access to MNCH services to respond to the increased demand created by CHWP.

CHWP's contribution has been in creating demand and utilization of services through preventive and promotive interventions. Its contribution in improving access has been limited to management of diarrheal diseases and, in combination with outreach programmes, to immunization services, while access to other MNCH services remains unchanged. To improve access to other MNCH service, there is a need to address the supply side barriers, particularly in hard to reach communities. The following approaches, where appropriate in combination, have a potential to improve access to MNCH services:

1. xWhile improving the quality of health services in health centers and clinics, it is important to make the health facilities culturally sensitive and ensure the availability of maternity waiting homes. Provision of culturally sensitive health care through training or deploying health workers from the same ethnic groups can improve acceptability and access.

2. Expand the geographic reach and range of services provided during outreach programmes, and improve its regularity. Although the range of health services that could be provided during outreach programme is limited, integrating other MNCH services with outreach immunization services addresses the issue of geographic accessibility and increases service availability.

3. Use of mobile clinics, particularly in hard to reach areas and nomadic communities

4. Improve the availability and functionality of ambulance services (or other alternative means of transportation) and communication systems. There is also a need to strengthen the feedback from health centers to CHWs.

5. Deploy community nurses who can provide such services, while also providing supportive supervision

6. Add selected key and effective interventions to the CHWP package with a focus on hard to reach areas. Majority of respondents believed that there is a need to provide the following services (in order of priority) through CHWP: i) HIV Testing and Counselling; ii) integrated community case management including pneumonia and malaria,; iii) non-communicable diseases - monitoring blood pressure and diabetes testing; and iv) ability to conduct emergency normal delivery. The addition of these services to the CHWP service package has the following benefits: shifting some of the health facility workload into CHWs, and increase efficiency of CHWs (delivered services commensurate with the level of their salary);

increase acceptability and motivation of CHWs; and increase access to services, which contributes to improved health outcomes. However, such policy decision requires careful review of cost, source of funding, and sustainability mechanisms, and approval by health professional council.

7. Adoption of the 'life course' approach in the revision of the intervention package

#9 Strengthen the coordination mechanisms at all levels of the health system with clear ToR.

The evaluation revealed that the CHWP steering committee was not strong enough to coordinate the planning, implementation and monitoring of the programme. Only few partners were participating in the meetings of the steering committee. With the leadership of MoHSS, there is a need to strengthen the coordination of the programme, preferably using existing steering committees with participation of partners that are involved in implementation of CHWP. It is critical to consider integrating CHWP into platforms that are functional specific to each regional setting (government/traditional), for example, at regional level - HBC/ stakeholders, RACOC, Regional Development Committee (RDC), District Development Committee (DDC); at constituency level – Constituency Development Committee, CACOC; and at village level –VHC. A strong coordination mechanism will be important:

- To avoid duplication of efforts, there is a need to coordinate all partners involved in community based health care and develop a joint action plan with detailed activities, targeted regions/districts and time period.
- To efficiently coordinate funding and technical support, particularly at national and regional levels, which improves efficiency and transparency and timely reporting
- To efficiently use CHWs supported by different partners through mapping the geographic distribution of the various community volunteers and reprogramming of efforts
- With a regular meeting to plan, review activities and achievements and address implementation challenges, the coordination mechanism will also be critical to identify funding and technical gaps to address them accordingly.
- Given the shortage of human resources at the national, regional and district levels of the MOHSS, the coordinating mechanism will fill the gap in management and coordination of the programme.

There is also a need to coordinate communication among different sectors at all levels by strengthening and adhering to the existing channels of communication (from national, regional, district, health facility, to community).

#10 Improve the quality of HIS data and use the information for tracking progress and decision-making.

The MoHSS has established a comprehensive web based district health information system, which is essential for evidence-based decision-making at all levels of the health system. The CHWP information system has been integrated with the national health information system. However, the evaluation revealed that the HIS data has gaps in quality and completeness, thus further effort of the government and partners is required to improve the quality, timeliness and completeness of the data collected. One of the approaches could be to extend the district level HIS to the level of CHWs through the use of mobile data. It could be expensive to procure and distribute smart phones or tablets to each of the CHWs, however most of the CHWs have smart phone for their personal use. Thus, it would be a cost-effective approach to use their phones for data collection. They could be supported with limited data service credit to submit and send their report.

Moreover, due to the lack of capacity in data analysis, the information has not been used for decision making and tracking progress. This is another area requiring immediate attention through training of key health managers including district staff in data use for decision-making.

#11 Institutionalize the training of CHWs and develop an integrated refresher training module.

Institutionalizing the training of CHWs improves the cost-effectiveness of the programme by reducing the cost related with resource intensive start-up of individual training programmes. Institutionalization facilitates coordination of different courses, trainers and materials. It also ensures the use of experienced trainers over the long time rather than bringing inexperienced trainers each time. There is also a need to review and make adjustments to the size of trainees enrolled in one classroom and the approach in relation to scheduling the theoretical and practical training. For example, it may be more appropriate to complete the theoretical training followed by practical training on all aspects of the programme, which mimics to what the CHWs do when they are deployed.
Establish and strengthen bottom up mutual social accountability mechanisms that are institutionalized. Regular refresher training courses should be provided to all CHWs as part of professional development. There is a need to standardize training materials and programme to maximize existing resources for training and improve training effectiveness and efficiency. There is a need to coordinate the refresher training for tracking training courses and participants not only to improve the efficiency, effectiveness and sustainability of training, but also to ensure equitable access to training by all CHWs. Continuous evaluation of the outcome of the training is important to improve the refresher courses.

Below are specific recommendations and alternative approaches to consider with the aim of improving the CHWs training:

- **Integrate the CHW training into the NHTC programme:** The programme is currently a standalone programme, using adhoc facilities, and nurses who are expected to provide crucial service, and the programme has not yet been accredited by the HPC. For cost effectiveness and sustainability of the programme should be integrated into the NHTC's programmes
- **Accreditation of the CHWP:** In view of future plans to ensure a career path for CHWs, the MOHSS should consider getting accreditation as a matter of urgency.
- **Block training:** Instead of having 92 participants in one class consider having a limit of 25 people per training. For example, while the one group is in class getting theory the other could be doing practice.
- **Assessment:** Implement a continuous assessment: Module 1 and mid-way include assessment 50% of the modules and at the end assess 100%
- **Training CHWs in additional technical areas:** This issue should be researched thoroughly as it will have implications on the training curriculum as well as policy implications
- **Trainers:** Develop a pool of trainers (facilitators and training of trainers) who could be called upon anytime when training is conducted.
- **Review the criteria of Trainers of Trainers:** The criteria should include degree in nursing, with working experience in community and PHC, Master in public health will be an added advantage.
- **Collaborate with other training institutions** such as the University of Namibia; Welwitchia University and the International University of Management. The aim of the collaboration is to make use of their staff as trainers.
- **Refresher training:** Provision should be made to ensure that the CHWs receive refresher trainings every two years. This would create opportunity to bring CHWs back to class, where they can be refreshed, share knowledge and learn from one another.

#12 Strengthen advocacy.

Advocacy activities are needed to promote the programme and improve community health, and enhance policy initiatives to strengthen and evolve the programme in response to the health needs and changes in the population dynamics. Advocacy to strengthen partnership between community, CHWs and health facilities to ensure that decisions to address community needs and preferences are made. This requires promoting the community empowerment and participation in planning, implementation and monitoring of the programme. Advocacy is also needed to mobilize relevant sectors for cross-sectoral collaboration. In general there is a need to develop advocacy strategy at all levels of the health system.

#13 Establish cross-sectoral collaboration.

Although not systematic and structured, CHWs in various villages have shown the feasibility and usefulness of collaborating with other sectors such as education, police, water, sanitation, agriculture, gender and child-welfare, and social protection. CHWs have shown that the health sector can play broader roles with strong cross-sectoral collaborations. To improve the health status of individuals, families and communities, CHWP should involve not only the health sector but also other related sectors, which demands their coordinated efforts. Establishing cross-sectoral collaboration is one of the strategic challenges impending success of PHC. The MoHSS should take the lead and engage in intensive and sustained mobilization of policy makers of relevant sectors through advocacy. The establishment of strong cross-sectoral collaboration based on specified roles and responsibilities will contribute to the achievement of health outcomes in a more effective, efficient and sustainable way than could be achieved by the health sector acting alone. Specific recommendations are listed below:

- **Formalize the partnership between different sectors:** Develop a framework document or a memorandum of understanding, with different sectors that clearly spells out key responsibilities of each sector.
- **Intersectoral committee or sectoral representation in the steering regional/village committees:** Improve cross sectoral collaboration at the district/community level, and provide opportunity for the different sectors to critically review how their policies and programmes may promote or hamper health
- **Collaborative work:** Create opportunities for the different sectors to work together – develop stronger linkages between sectors. Thus, there is a need to strengthen cross sectoral planning, budgeting, implementation and monitoring.
- **Promote CHWP:** Increase knowledge about the role of CHWP and its contribution to different sectors using information, education and communication materials. Thus, there is a need to demonstrate the impact of CHWP and create understanding on its impact and cost saving to ensure that others can support CHWP.
- **Experiential learning about other sectors:** Provide exposure to one another's work. For example, create opportunities for CHWs to accompany other sectors e.g. water, sanitation and social worker and vice versa.
- **Cross-sectoral resource mobilization:** Explore opportunities to collectively mobilize resources, or share financial responsibilities. For example, supervision could be funded by other sectors or by the private sector.
- **Knowledge sharing and high staff turnover:** Ensure a proper handover in view of the high staff turnover.

#14 Improve Human Rights Based approach (HRBA).

- **Support CHWs** in dealing with socio economic challenges
- **Civil society:** there is a need to have strong civil society to promote further participation.
- **Sectoral collaboration:** HRBA requires a multi sectoral approach. There is a need to engage sectors such as the Ministry of Gender to ensure that members who are eligible for grants be it social/ pension/vulnerable grant are taken care of.

#15 The development of an investment case for community health as one of the recommendations within either the recommendation on costing or on advocacy, especially given that the costing and CE questions were not completely addressed due to lack of data.

#16 Development of a strong learning and research agenda for community health moving forward.

#17 The development of inclusive and effective partnerships including private public partnerships.

15. ANNEXES

Annex A. Key problems for low maternal, neonatal and child health coverage

Problem	Lack of decision power to seek care	Lack of awareness and behavior to seek care	Poor referral system	Lack of adequate, motivated & competent health workers	Lack of service availability and quality	Poor support and management system	Contextual issue
Possible causes	Gender inequalities	Societal acceptance of child and maternal deaths	Lack of awareness of existing services	Shortage of healthcare personnel	Inadequate and unequal distribution of health facilities	Poor health information system (quality, validation, utilization)	Political will & support
	Cultural/religious beliefs and practices	Poor understanding of pregnancy complications & risk factors	Lack of awareness when and where to refer	Inadequately trained healthcare personnel	Shortages & stock-outs of essential medicines and supplies	Inadequate regional and district leadership & management capacity	Environmental factors (drought,
	Women preoccupied taking care of domestic responsibilities	Poor understanding of danger signs in children	Poor feed back and counter referral	Inadequate sup-portive supervision and mentoring	Lack of comprehensive services	Weak continuum of care with poor service integration	Socio-economic inequities
	Lack of social and financial support in going to health facility	High prevalence of harmful traditional practices	Lack of local community support system	High turn-over	Sparsely distributed population	Lack of community ownership and participation	Programme ownership at all levels
	Early marriage and pregnancy	Previous experience of low quality health care or mistreatment	Distance to health facilities	Lack of guidelines, reference & work aid materials	Inaccessibility of health facilities	Inadequate financial resources	
	Domestic violence	Poor understanding of when medical interventions are needed	Availability of transportation for referral	Poorly motivated healthcare personnel	Lack of formal quality improvement mechanisms		
		Poor parenting practices	Lack of money for medical expenses & transport		Lack of respect and ineffective communication	Poor performance management system	
		Poor communication strategies			Rehabilitation for the disabled		
		Education level			Mental health and addictions		
					Lack of privacy and confidentiality		
					Social protection		

Evaluation criteria	**Detailed questions**	**Judgment and indicators**	**Data collection methods**			
IMPACT			DR	KII	FGD	SV
A.1. To what extent did the programme contribute to the improvement of maternal, newborn and child health indicators?	A.1.1. To what extent did the programme contribute to the improvement of maternal, newborn and child health indicators?	Contribution analysis based on ToC	X	X	X	X
A.2. To what extent did the programme contribute to increased access and utilization of maternal-newborn and child health, and improved health seeking behaviours?	A.2.1. To what extent did the programme contribute to increased access and utilization of maternal-newborn and child health, and improved health seeking behaviours? On which services was the improvement higher/lower? What were the major factors influencing the achievement or non-achievement of objectives?	Evidence of improved maternal and child care and health seeking practices	X	X	X	X
A.3. To what extent has the programme contributed to making a real difference in the health status/Outcomes at household levels?	A.3.1. To what extent has the programme contributed to a perceived improvement in health status at household levels?	Evidence of perceived improved health status at household level	X	X	X	
CONTEXT AND RELEVANCE						
B.1. National decision-making level: how well the programme fit to national priorities.	B.1.1. To what extent do the interventions as planned target the leading causes of MNCH mortality and morbidity?	Extent to which the programme interventions as planned target the leading causes of MCH mortality and morbidity	X	X		
	B.1.2. Are its objectives consistent with national priorities for the health sector?		X	X		
	B.1.3. Is CHWP a priority delivery platform in Namibia?		X	X		
	B.1.4. Are there budgetary commitments for CHWP?		X	X		
	B.1.5. To what extent do the interventions address the key barriers/bottlenecks of MNCH services?	Extent to which the programme interventions as planned target the key barriers/bottlenecks of the MCH services	X	X		
B.2. To what extent has the programme contributed to the policy direction, decision making processes and resource allocation for the maternal, newborn and child health at national, sub-national and partner levels?	B.2.1. Is CHWP contributing to reinforcing MNCH services? Could you bring examples of policy change and/or decision made as a result of programme implementation?	Evidence of policy change and/or decision made based on the results and lessons learned from programme interventions	X	X		
	B.2.2. Could you bring examples of resource allocation for MNCH as a result of the programme implementation?	Evidence of increased resource allocation for MNCH as the result of the programme	X	X		

Evaluation criteria	Detailed questions	Judgment and indicators	Data collection methods			
CONTEXT AND RELEVANCE			DR	KII	FGD	SV
	B.3.2. Was situation analysis/needs assessment conducted for the programme identification?	Evidence of increased resource allocation for MNCH as the result of the programme	X	X		
B.4. Community level: how well was initiative accepted by the communities? Did it fit to community priorities?	B.4.1. Do you think that the intervention is pertinent to your needs? What additional service would you like to receive through CHWP? What services are not essential? Why?	Assessment by end users of relevance of the intervention package and delivery strategy		X	X	X
	B.4.2. In your opinion, please explain how the intervention provided through CHWs addressed the community's needs?	Programme addresses the priority health needs of the community		X	X	
	B.4.3. How is the community supporting the programme?	Community support of the programme	X	X	X	
	B.4.4. Are you and other people in the community using the service? Which services? If not, Why?	Community using the services	X		X	
EFFECTIVENESS						
C.1. To what extent does the programme improve capacity of decentralized structures such as regions and districts to deliver community health workers services?	C.1.1. What improvements in capacity to deliver community health workers services do you observe following the implementation of CHWP?	Regions and districts implementing community based health services	X	X		X
	C.1.2. Are your capacity development needs in delivering community based services being address? What should be done to sustain the changes?	The programme benefits received as identified by regions and districts	X	X		
	C.1.3. What are the challenges for further improving of regional and district capacity?	Challenges	X	X		
C.2. To what extent does the programme increase the participation of community members in the CHWP activities?	C.2.1. What is the level of community participation in CHWP activities?	Level of community involvement in planning, implementation and monitoring	X	X	X	X
	C.2.2. How do you describe community contribution to CHWP implementation (eg. provision of working space to CHWs)?	Level of community contribution	X	X	X	X
	C.2.3. Do community members promote healthy behavior in the community?	Community members involvement in promotion of healthcare	X	X	X	X
	C.2.4. Is there a functional village health committee? What role does it play? What are the challenges and how do you think they can be addressed?	Availability of functional village health committees	X	X	X	X

C.3. To what extent does the programme increase motivation of CHWs?	C.3.1. Are you satisfied with the working and living conditions? What are the key factors that increase your motivation? Was the programme providing or supporting these factors to improve your motivation?	Level of motivation of CHWs		X		
	C.3.2. What is your intention to stay in your work?	Intention to stay		X		
	C.3.3. How difficult it is to find CHWs whenever you want their service?	Attendance in work place		X	X	X
	C.3.4. Do you think CHWs have the skill and knowledge to provide the CHWP services? For which services do CHWs have adequate skill and knowledge, and for which do they lack the required skill and knowledge? Why?	Level of skills and knowledge of practices		X	X	X
	C.3.5. Did CHWs receive refresher trainings? How many? On what area?	Number (percent) of CHWs trained by region	X	X		
	C.3.6. How do you describe the availability of equipment and supplies? Which ones are in shortage?	Availability of equipment and supplies	X	X	X	X
C.4. To what extent does the programme improve coordination of community health services at national, regional, district, health centres and community level? How strong are the community-facility linkages and referral networks?	C.4.1. How do you describe the change in coordination of community health services?	Improvement in coordination of community health services	X	X	X	X
	C.4.2. What is CHWs' capacity to identify danger signs and risk factors for referral of cases?	CHWs identify and refer patients		X	X	X
	C.4.3. What Is the level of compliance when mothers and children are referred?	Compliance to go to referral		X	X	X
	C.4.4. What proportion of referral cases received services at referral health facilities?	% of referral cases who received services at referral health facilities	X	X	X	X
	C.4.5. Do referral health facilities send referral cases back to CHWs with feedback?	Level of bi-directional referral linkage	X	X	X	X
	C.4.6. Are the referral facilities accessible (in terms of distance, transport, cost)?	Access to referral health facility (distance, transport, cost)	X	X	X	X
	C.4.7. What is the capacity of the referral facilities to provide quality service?	Referral facilities provide quality service	X	X	X	X

Evaluation criteria	Detailed questions	Judgment and indicators	Data collection methods			
EFFICIENCY			DR	KII	FGD	SV
D.1. Were the available resources (financial, human, institutional and commodities) efficiently used to achieve the programme objectives? What gaps existed e.g. in remuneration, workload, supply chain?	D.1.1. Were the available resources (financial, human, institutional and commodities) efficiently used to achieve the programme objectives?	Level of efficiency in resource use	X	X		
	D.1.2. To what extent has effective coordination and collaboration with existing interventions and partners been addressed and achieved?	Level of resource harmonization (wastage & duplication)	X	X		
	D.1.3. What are the leading causes of inefficiency and what strategies do you propose to reduce them?	Causes of inefficiency	X	X		
	D.1.4. Are CHWs providing the expected volume and range of services? If no, why?	Volume of tasks performed per CHW	X	X		
	D.1.5. Are you satisfied by the service you get from CHWs? For which services are you satisfied, and for which not satisfied?	Community satisfaction level			X	
	D.1.6. What gaps existed e.g. in remuneration, workload, supply chain?	Specific resource gaps affecting service delivery	X	X	X	X
D.2. Were resources at the community level effectively used to achieve the programme objectives?	D.2.1. Are there other CHWs outside from CHWs working in the communities? If yes, can you describe the type/role of these CHWs and who supports them?	Type of community-based workers	X	X		
	D.2.2. Was there effective coordination between these CHWs and CHWs?	Level of coordination between CHWs and other CHWs		X		
	D.2.3. What were the challenges and how do you think these could be addressed?	List of challenges and solutions		X		
	D.2.4. There is an intention to change the name "CHWP" to "CHW programme". What do you think about giving it a name, which has not been associated with success in past? Can you suggest a distinctive name that helps to brand it and remain in the minds of the people? What about a name for CHWs?	List of potential names for CHWP		X	X	
D.3. How cost-efficient was the programme in delivering primary health care services at community level?	D.3.1. How cost-efficient was the programme in delivering primary health care services at community level? Has the intervention been shown to be as efficient or more efficient than appropriate alternative approaches in the same context? Are there other feasible ways to implement the intervention that would be more economical?	Level of compliance with project financial planning / annual plans	X	X		
	D.3.2. Are the services affordable to the community?	Affordability of service by community		X	X	X
	D.3.3. What was the total cost for CHWP in 2016? How many people received service in 2016? How many people have been reached through CHWP?	Total project cost/people served	X	X		
	D.3.4. How many CHWs have been deployed and how many dropped-out?	CHW drop-out rate (or CHW satisfaction level)	X	X		X
D.4. What are the current sources of funding for the programme?	D.4.1. What are the current sources of funding for the programme?	Source of funding	X	X		
	D.4.1. Were the available resources adequate to meet programme needs? Probe for: all planned activities implemented within available budget; all planned activities implemented were adequately financed.	Resources were adequate/non-adequate	X	X		
D.5. What data system is used by the programme? To what extent is this integrated into the national health informatics system? To what extent is the data used to improve programme management and to inform investment?	D.5.1. Could you describe the health information system developed for the programme? Is it integrated into national health system? If no, why?	Integrated CHWP data system	X	X		X
	D.5.2. Has the M&E system been effective in tracking progress and decision-making? Could you describe any changes/corrections/ improvement in programme implementation, management and/or investment based on M&E data?	Evidence of data used for decision making in management and resource allocation	X	X		
	D.5.3. How do you describe the completeness, accuracy, and timely submission of CHWP routine reports?	Level of completeness, accuracy and timely submission of reports	X	X		X
	D.5.4. To what extent are the monthly health facility and quarterly district level review meetings conducted? Any challenges?	Regularity of review meetings	X	X		X

Evaluation criteria	Detailed questions	Judgment and indicators	Data collection methods			
SUSTAINABILITY			DR	KII	FGD	SV
E.1. How well is the initiative incorporated into national and subnational legislation?	E.1.1. How well is the initiative incorporated into national and subnational legislation?	Evidence of programme alignment with national and subnational strategies	X	X		
E.2. To what extent is the programme institutionalized within the health care system?	E.2.1. To what extent is the programme institutionalized within the health care system? Is there a clear organizational structure?	Evidence of organizational structure with career ladder and delegation	X	X		
	E.2.1. Is there budget line for CHWP at national and regional levels?	Availability of budget line for CHWP (? % of regions with budget line for CHWP)	X	X		
E.3. How well are CHW incorporated in the community? What is the attrition rate (and reasons for drop-out)? What are the main incentives for CHW to stay in the programme?	E.3.1. Do CHWs participate in social events of the community?	Evidence of social integration	X	X	X	X
	E.3.2. How many CHWs have been deployed and how many dropped-out?	Attrition rate of CHWs	X	X	X	
	E.3.3. What do you think are the reasons for CHWs leaving their work?	Reasons for drop-out	X	X	X	
	E.3.4. What mechanisms are being used to improve retention? What do you suggest should be done to motivate and keep them in the village?	Approaches to improve retention	X	X	X	
E.4. How well has the programme empowered local communities through awareness building and training of CBOs to promotive health lifestyles?	E.4.1. How well has the programme empowered local communities through awareness building and training of CBOs to promotive health lifestyles? (# of CBOs trained or oriented if available)	Evidence of community capabilities to participate and influence decision making; Number of CBOs trained	X	X	X	
	E.4.2. How do you describe the awareness of maternal, neonatal and child health issues in the community?	Extent of awareness of MNCH issues	X	X	X	
	E.4.3. Has the community developed capacity to make effective choices?	Evidence of community capacity to make effective choices		X	X	
	E.4.4. Do the community members have access to their choices and make use of them?	Evidence of availability and use of choices		X	X	
E.5. How has the programme promoted ownership and participation through the involvement of community members in planning, implementation and monitoring of the CHWP?	E.5.1. How has the programme promoted ownership and participation through the involvement of community members in planning, implementation and monitoring of the CHWP?	Perception of ownership and evidence of involvement of local structures (such as community heads man and CBOs)	X	X	X	

Evaluation criteria	Detailed questions	Judgment and indicators	Data collection methods			
IMPLEMENTATION, MANAGEMENT AND COORDINATION			DR	KII	FGD	SV
F.1. What were the overall programme coordination mechanisms at national, sub-national and community levels? Was it functional? What can be improved?	F.1.1. How is CHWP coordinated at national, sub-national and community levels? Are there functional steering committees at national, regional, district and clinic levels?	Programme coordination mechanisms	X	X		
	F.1.2. What role do they play in coordination of CHWP?	Evidence of activities of the coordination mechanisms	X	X		
	F.1.3. What are the challenges? What can be improved?	Challenges and approaches to improve coordination	X	X		
F.2. What cross-sectoral linkages exist? What opportunities exist to strengthen these?	F.2.1. Is there any cross-sectorial linkage in coordinating CHWP? Which sectors?	Evidence of cross-sectoral collaboration; List of collaborating sectors	X	X		
	F.2.2. What opportunities exist to establish or strengthen these?	Opportunities for strengthening collaborations		X		
F.3. How adequate was the programme implementation and management capacity and system?	F.3.1. To what extent have the programme implementation mechanisms outlined in the strategic document been followed? Were pertinent adaptations made to the original approaches?	Level of implementation of mechanisms outlined in programme document	X	X		
	F.3.2. Was the programme management (at national and sub-national levels) adequate, effective and efficient (skills, leadership, coordination, adaptive capacity)?	Level of satisfaction of overall management	X	X		
	F.3.3. Where there any operational and political / institutional problems and constraints that influenced the effective implementation of the programme, and how did the programme tried to overcome these problems?	Number of identified problems/constraints	X	X		
	F.3.4. How adequate were programme supervision, inputs and processes?	Degree to which plans were followed up by programme management	X	X		
	F.3.5. Did you receive any supportive supervision during the last 3 months?	Number (proportion) of CHWs who received supervision during the last quarter	X	X		
	F.3.6. How well did technical support play its role? What were the strengths and limiting factors?	Perception of effectiveness and documented technical support	X	X		
	F.3.7. Were annual national and regional quarterly reviews conducted? Were reports developed and disseminated?	Number of review meetings and reports developed; quality of reports	X	X		

Evaluation criteria	Detailed questions	Judgment and indicators	Data collection methods			
THE APPLICATION OF A HUMAN RIGHTS-BASED APPROACH (HRBA) IN PROGRAMMING			KII	FGD	SV	DR
G.1. To what extent does the programme consider the equity approach (i.e. focus on most deprived areas, areas with high prevalence of critical newborn and under-5 mortality, low income families)?	G.1.1. To what extent does the programme focus on most deprived areas, areas with high prevalence of critical newborn and under-5 mortality, low-income families?	HR & GE are clearly reflected in the CHWP intervention design (log frame, indicators, activities, M&E systems, reporting mechanisms)	X	X		
	G.1.2. Is gender disaggregated data generated in M&E reports?	Gender disaggregated M&E and statistical data	X	X		
		Evaluation team gender composition	X	X		
G.2. To what extent are vulnerable groups involved in planning and utilization of the service?	G.2.1. To what extent are vulnerable groups involved in planning and utilization of the service?	Perception of empowerment among vulnerable groups		X	X	
	G.2.2. Are the needs of the vulnerable groups addressed by CHWP?	Evidence of services addressing the needs of vulnerable groups	X	X	X	
	G.2.3. Do the CSOs advocate for the needs of vulnerable groups?	CSOs advocating for the needs of vulnerable groups		X	X	
	G.2.4. To what extent are the vulnerable group using the services?	Evidence of improved access to/satisfaction with services by vulnerable groups	X	X	X	
TRAINING, SUPPORTIVE SUPERVISION, MENTORING AND CHOACHING						
H.1. How was the training curriculum development process, adequacy and quality?	H.1.1. What was the process in the development of the CHW's training curriculum?	Curriculum development process	X	X		
	H.1.2. Who was involved in the process?	List of participants	X	X		
	H.1.3. Do you think the 6 months training duration of CHWs is adequate to equip them with the necessary skills and knowledge to perform their tasks well? What do you suggest about the duration?	Suggested duration of training		X		
	H.1.4. To what degree does the training contents match with the tasks CHWs are performing?	Level of matching between training and tasks	X	X		
	H.1.5. Which modules are not important considering their current tasks?	List of less important modules		X		
	H.1.6. For which module do you think the duration of training should be increased?	List of modules requiring increased duration of training		X		
	H.1.7. Are there additional technical areas that should be included in the CHWs scope of work?	List of technical areas that should be included in the training		X		

Evaluation criteria	Detailed questions	Judgment and indicators	Data collection methods			
TRAINING, SUPPORTIVE SUPERVISION, MENTORING AND CHOACHING			KII	FGD	SV	DR
H.2. How is the current management and operation of the training facilities?	H.2.1. Who is currently running the training of CHWs?	Responsible organization	X	X		
	H.2.2. How well are the training institutions institutionalized within the government structures?	Level of institutionalization	X	X		
	H.2.3. Do you think the current approach is appropriate and cost-effective?	Appropriateness and cost-effectiveness		X		
	H.2.4. What do you think should be changed or improved? Why?	Improvement approaches		X		
H.3. What are the training needs for CHWs? (See for details in worksheet "Training need")	How do you rate the degree of importance and performance of each of the tasks you perform?	Rating of importance and performance		X		
	What would be the best approach to improve performance of the tasks?	Approaches to improve performance		X		

Annex C. Terms of Reference for the Evaluation

UNICEF Namibia
Terms of Reference for International Consultant for the comprehensive
External evaluation of the community health programme in Namibia

Location: Windhoek with field travels in Namibia
Period: 6 weeks (3 July 2017 – 11 August 2017)
Supervisor: Chief Child Survival and Development, UNICEF Namibia

1. Purpose and Background

Background

Over the last three decades and following the 1978 Alma Ata Declaration on Primary Health Care (PHC), Community Health Workers (CHWs) were promoted to become part of many developing countries' health systems (Walt 1988). While there was considerable variation in the types of CHWs and the forms taken by CHW programs, CHWs' international experiences gave rise to debates on their role in health systems and highlighted the problems associated with their management. While successful experiments across a range of contexts provided inspiration for CHW programmes, numerous challenges arose in the process of shifting from effective and small-scale local programs to national CHW systems. Common problems cited included lack of community integration, unrealistic expectations, unsupportive environments, poor supervision, lack of appropriate incentives, high turnover and ultimately poor quality and cost-effectiveness (Berman et al. 1987; Walt 1988; Walt 1990; Gilson et al. 1989).

In 1990, soon after independence, Namibia adopted the Primary Health Care (PHC) approach as the principal strategy to addressing fragmented services inherited from the apartheid era. The implementation of this approach has been guided by the principles outlined in the Ministry of Health and Social Services (MOHSS) Policy Framework of 1998, namely: equity, availability, accessibility, affordability, and community involvement. The National Primary Health Care/ Community Based Health Care Guidelines published in 1992 stated that, in the implementation of PHC, greater recognition has been given to the role of individuals, families and communities in the promotion of their health status, while at the same time ensuring there is improvement in the quality of health care provided at various service delivery points, especially in clinics closer to communities.

In March 2008, a national policy on Community-Based Health Care (CBHC) was issued by the MOHSS following a national assessment of community volunteers and CBHC programmes, and a national conference on volunteers that was held in December 2006. The policy document describes the policy goal, principles, objectives and strategies that guide CBHC programs in Namibia.

General approaches to implementing community-based activities are outlined in the CHWP strategy. The idea behind CHWP is mainly to improve access to health services by bringing services closer to the communities while also addressing the shortage of health work force. The training curriculum has seven modules on First Aids, Community Mapping, Community Based Maternal and New-born Care (CBMNC), Community Based Childhood Illness, HIV/AIDS/TB & Malaria, Social Welfare and WASH. With this six month training, the deployed CHWs provide services and health promotion on those areas in their designated villages. The basic package of health care and promotional services provided by CHWs and the number of CHWs have been increasing overtime. The programme operates in the context of a health system which is partly decentralized to the district level.

The country is divided into 14 regions and 34 district hospitals. The MoHSS started the formalization of community health programme through the modelling of Health Extension Programme in 2012, in Opuwo district of Kunene region, through the technical and financial support of UNICEF. At that time, UNICEF, jointly with other partners such as USAID/C-CHANGE, currently known as the Maternal Child Survival Programme (MCSP), supported the Ministry of Health and Social Services develop CHWP Strategy, Standard Operating Procedures (SOPs) and training materials. This included formation of a national steering committee to oversee the programme.

In 2012/2013 when the MoHSS endorsed the programme, the initial number of CHWs was only 34 for Opuwo district where the programme was piloted. By mid-2013, the government of Namibia endorsed the programme and allocated an amount of 9 million USD for the scale up of the programme. The Community Health Worker's training package was extended in 2015 to include Water Sanitation and Hygiene, Adolescent health and monitoring component. The number of districts or regions with presence of CHWs increased by end of 2014 from 4 regions to 13 (92.86%), and the number of trained and deployed CHWs is 1,640 by end of 2016. This increase in the short span of time was possible with the high government commitment through MoHSS, absorption of the CHWs into government MoHSS pay roll is highly commendable and this was possible with complimented by ongoing advocacy and support from development partners such as UNICEF, USAID/MCSP and WHO. The CHWs are MoHSS cadre and receive full monthly salary.

In December 2016, the MoHSS decided to cease the training of CHWs due to government-wide budget constraints. This affected those who were currently in training and the scheduled new intake for 2017/2018. In February 2017, the senior management of the MoHSS decided to re-launch this programme and trainings for CHWs based on positive appreciation received from populations, partners and colleagues from the MoHSS about the impact of the CHWs on the behaviour change of communities.

Namibia's 2013 Demographic and Health Survey (NDHS2013) findings show that Namibia has made sluggish progress in health-related behavioural indicators. At the impact level, from NDHS 2006/07 to NDHS 2013, maternal mortality reduced from 449 to 385 per 100,000 live births and the under-five mortality rate (U5MR) reduced from 69 to 54 per 1,000 live births. CHWs' contributions have been felt in various ways especially since the introduction of government paid CHWs by end of 2013. Their contribution is expected to be significant and contribute to improvement of some health indicators come the next NDHS 2018/2019. Generally, the government paid-CHWs have been commended for mobilizing the population and raising awareness on the advantages of immunization, importance of Antenatal care and early seeking behaviour for maternal newborn and child health, and the utilization of family planning services that are currently free of charge and accessible to the majority of Namibians. However, the CHWP has not been formally evaluated making continued investment in the programme a challenge, due to lack of impact evidence.

Literature has shown that CHWs, when used appropriately and incentivized, can bring about significant positive changes in health at the community level. However, like many African countries, and despite current and potential health achievements, the Health Extension Programme in Namibia still faces significant challenges that hinder the delivery of a quality comprehensive package of services. These challenges range from capacity and resource gaps to sustain routine community health activities (such as lack of institutionalized training institution for paid up CHWs, and refresher training), the urgent need for standardised coordinated recruitment, training, supervision and monitoring and/ or accreditation of certificates, and reinforce supply systems. Effectively addressing these challenges will significantly contribute towards achieving the national health targets described in the implementation plan for NDP5 2017-2021.

Access to health care is a key priority for improving a country's overall health status. Therefore, it is crucial to document perceived barriers to accessing health care, as well as initiatives undertaken to overcome those barriers. Documentation of community health activities will lay out the actions required to strengthen Namibia's health system, and enable replication of good community health practices. This will ultimately support the achievement of maternal and child health goals outlined in Namibia's National Development Programme five (NDP5, 2017-2021), national Health Sector Strategic Plan (2017 - 2021), and provide lessons learnt to improve the CHWP and will also be helpful for other countries in the region and elsewhere.

UNICEF collaborates with the Government of Namibia, providing both financial and technical assistance to the Health Extension Programme initiatives. The support to date included piloting and payment of allowances in the pilot district, development and review of training materials, roll out trainings, supervision, review meetings, master plan development and review, procurement of supplies, orientation and equipment and consumables, and health infrastructure improvement, among others. UNICEF intends to provide further support to review the Health Extension Programme, including the planning and implementation processes, challenges, successes and lessons learnt during the implementation period, in order to improve the programme design and strengthen sustainability.

Purpose

The purpose of this Evaluation is to document the Namibia Health Extension Programme, assessing programmatic achievements and constraints by reviewing the existing conceptual framework and overall system, including financial support, management structure, supervision mechanism and governance.

The aim is to gain an in-depth understanding of the progress and challenges, and to identify areas for improvement; to assess the alignment with, and appropriateness of, policies and guidelines for the community health programme; as well as to determine the extent and depth of coordination and collaboration for partnerships. The evaluation will be conducted through a systematic assessment of the relevance, efficiency, effectiveness, impact and sustainability of the program.

The findings of the evaluation will mainly be used by MoHSS and partners, in their different capacities and functions, to inform policies and strategies and develop future plans and interventions to improve programme performance.

2. Justification

Namibia has been implementing the Health Extension Programme since 2012. In the past five years the programme package expanded and advanced significantly, yet no comprehensive evaluation has been undertaken to assess the relevance, efficiency, effectiveness, impact and sustainability of the programme.

An evaluation is required to guide the MoHSS on how to use the CHWs most effectively to achieve national health goals, and contribute to the achievement of the post-2015 global Sustainable Development Goals. Programmatic achievements and constraints need to be documented and analysed, informing new technical guidance to maximize the impact of the Health Extension Programme (HEP).

3. Objectives

The overall objective of this evaluation is to understand whether the intended objectives of the HEP are met and resonate with the objectives in the strategic plan. Specifically, the evaluation will determine to what extent the intervention has been able to meet its objective to create capacity, tools and structures to respond to the high levels of maternal, new-born and child morbidity and mortality rates in Namibia.

This involves a comprehensive system review, i.e. a critical review of the existing HEP conceptual framework and overall system such as management structure, supervision mechanism, incentive/salary mechanism, financial allocation, governance and performance evaluation system. The evaluation will assess the HEP performance in different dimensions of programme evaluation, including (i) impact, (ii) relevance, (iii) effectiveness, (iv) efficiency, (v) coherence, (vi) sustainability, (vii) coordination, (viii) human-rights based approach, ix) institutional capacity and (x) results-based approach.

Specific questions for each objective are listed in the next section 'scope, focus and evaluation criteria'.
Through the detailed assessment, the evaluation will also document lessons and identify best practices in the implementation and management of the Health Extension Programme. This will provide evidence to improve the programme design and implementation, and related policy change, if needed.

The evaluation will not attempt to quantitatively measure the behavioural change that occurred (due to lack of baseline information on this sphere) but will use results of surveys on child, newborn and maternal health indicators to determine improvements. Qualitative information from a large pool of stakeholders will triangulate the findings.

Scope, Focus and Evaluation Criteria

Geographically, the scope of the evaluation should expand to the national level to ascertain its sphere of influence on the overall maternal, newborn and child health (MNCH) programme in Namibia.

The evaluation should focus on and include the following beneficiaries and stakeholders in the process:

- Final beneficiaries: newborn babies, children, mothers and other caregivers and community members
- Service providers: health care professionals whose capacity has been built (including doctors, midwives, community health nurses and sub district health professionals) and CHWs
- Sub-national decision-making level: regions, district and health facility authorities
- National decision-making level: national authorities and key stakeholders (Ministry of Health, Public Service Commission, Development Partners, the UN System (UNICEF, WHO, UNFPA), USAID, MCSP, Namibia Planned Parenthood Association, Namibia Red Cross Society, etc.)
- National Professional Societies and Academia: Namibia Paediatric Society, Midwifery Association of Namibia, School of Public Health, National Health Training Center, Teaching Hospitals etc.

The time period covered by this evaluation will be 2012 to 2016. However, due to the period covered, the evaluators may find some aspects of the programme will be difficult to document, or data will be difficult to collect/analyse for certain time periods. In addition, the absence of a programme theory of change and baseline data will pose challenges in establishing the causality relations, but in spite of this, the evaluation should reasonably address these elements.

Evaluation Criteria

The comprehensive external evaluation will be guided by OECD/DAC evaluation criteria of relevance, effectiveness, efficiency, sustainability and impact. It will also look at criteria of interest to the Ministry of Health and UNICEF including coherence, human rights-based approach, results-based approach to programming and equity.

Objective 1 is to assess the programme impact

- To what extent did the programme contribute to the improvement of maternal, newborn and child health indicators?
- To what extent did the programme contribute to increased access and utilization of maternal-newborn and child health, and improved health seeking behaviours?
- To what extent has the programme contributed to making a real difference in the health status/Outcomes at household levels?

Objective 2 is to assess the programme relevance

- National decision-making level: how well the programme fit to national priorities. To what extent has the programme contributed to the policy direction, decision making processes and resource allocation for the maternal, newborn and child health at national, sub-national and partner levels?
- To what extent are the programme`s activities and outputs aligned with the objectives of the HEP strategy?
- Community level: how well was initiative accepted by the communities? Did it fit to community priorities?

Objective 3 is to assess the programme effectiveness

To what extent does the programme:

- Improve capacity of decentralized structures such as regions and districts to deliver community health workers services?

- Increase the participation of community members in the Health Extension Programme activities?
- Increase motivation of community health workers?
- Improve coordination of community health services at national, regional, district, health centres and community level? How strong are the community-facility linkages and referral networks?

Objective 4 is to assess the programme efficiency
- Were the available resources (financial, human, institutional and commodities) efficiently used to achieve the programme objectives? What gaps existed e.g. in remuneration, workload, supply chain?
- How cost-efficient was the programme in delivering primary health care services at community level?
- What are the current sources of funding for the programme? Are the available resources adequate to meet programme needs?
- What data system is used by the programme? To what extent is this integrated into the national health informatics system? To what extent is the data used to improve programme management and to inform investment?

Objective 5 is to assess the programme sustainability
- How well is the initiative incorporated into national and subnational legislation?
- To what extent is the program institutionalized within the health care system?
- How well are CHW incorporated in the community? What is the attrition rate (and reasons for drop-out)? What are the main incentives for CHW to stay in the programme?
- How well has the programme empowered local communities through awareness building and training of CBOs to promotive health lifestyles?
- How has the programme promoted ownership and participation through the involvement of community members in planning, implementation and monitoring of the HEP?

Objective 6 is to assess programme coordination
- What were the overall programme coordination mechanisms at national, sub-national and community levels? Was it functional? What can be improved?
- What cross-sectoral linkages exist? What opportunities exist to strengthen these?

Objective 7 is to assess the application of a human rights-based approach (HRBA) in programming
- To what extent does the programme consider the equity approach (i.e. focus on most deprived areas, areas with high prevalence of critical newborn and under-5 mortality, low income families)? To what extent are vulnerable groups involved in planning and utilization of the service?

The key policies and performance standards to be referenced in evaluating the programme are described in the United Nations Evaluation Group (UNEG) "Standards for Evaluation in the UN System" and "UNICEF's Evaluation Policies and Principles". Basics of human rights-based approach and results-based approach to programming are described, for example, in the UNICEF Programme Policy and Procedure Manual.

4. Methodological Approach & Expected Output

Type of Study: The comprehensive evaluation is expected to be a mixed-method (qualitative and quantitative), cross-sectional study including a retrospective longitudinal study to analyse the trends in maternal, newborn and child health access to care, as well as maternal, newborn and child health outcomes.

D**ata Source:** On the quantitative aspect, the consultant will collect relevant primary data from the field at all levels including households (i.e. districts, health facilities, CHWs and communities or households). In addition, trend analyses will be done on key MNCH outcome/impact indicators and will be compare with available survey data results. The consultant will further be expected to analyse any other secondary sources of relevant information. The qualitative component will draw on the understanding and perception of the main stakeholders involved in the project, e.g. based on interviews with relevant stakeholders and cFGDs on the selected topics with communities. As well as a desk review on published literature on the CBHC program and/ or its related elements drawing comparisons from other relevant country contexts.

The evaluation methodology, being guided by the norms and standards of the United Nations Evaluation Group (UNEG), will use the UNEG guidelines on integrating Human Rights (HR), Gender Equity (GE) in Evaluation. In order to be responsive to HR and GE aspects, special consideration will be given to gender, sex, distance from service locations and wealth when stakeholders and beneficiaries' view are sought in data collection. In the design phase of the evaluation framework, careful considerations will be given to such inclusion aspects. In the analysis phase, appropriate disaggregation will be attempted to shed light on HR and GE elements. For example, the evaluation will see if different health needs for men and women were considered by CHWs in providing services, if any effort was made to empower female and/or male CHWs to address certain issues, if there is any evidence of CHWs potentially improving intra-household gender dynamics at the time of household visits, and whether this in turn has led to improved gender equality in health care service outreach in general.

The evaluation methodology will be further defined with support from the international consultant. The international consultant will work with the MoHSS/FHD, UNICEF, and other MNCH partners to finalize the design and conduct the evaluation under the leadership of the steering committee. The international consultant will work to provide assistance for the situation analysis in line with the country context and quantitative assessment of the intervention by collecting and using the service delivery data. The international consultant will share the responsibilities for field visit, data compilation, data analysis and drafting of the report. The international consultant will further work with the steering committee and other stakeholders to coordinate the work, conduct interviews/focus group discussion, conduct the data collection and analysis, and disseminate the findings of the evaluation.

Given the time period and within reasonable cost, the consultant is expected to propose a sampling methodology that is suitable to achieve the desired results of the evaluation. Quantitative data will be analysed using standard statistical techniques, including multivariate analysis. Qualitative data will be analysed using a model of narrative analysis, interpretations and social /cultural norms. Data from the quantitative and qualitative data will be compared to triangulate the findings.

The evaluation process and methodology will include three phases:

Phase 1. Inception:
- Develop an evaluation work plan, to be submitted to the HEP Steering Committee for approval.
- In-depth desk review of available documents related to MNCH and HEP, data on MNCH from other surveys and HMIS, national/regional/district reviews and other literature related to Namibia's community health extension programme.
- Preliminary discussions with the Namibia MoHSS Primary Health Care Director, MoHSS/FH Division Deputy Director, HEP National Coordinator, members of the National Maternal Newborn, Child Health and Nutrition Technical Working Group, HEP steering committees and UNICEF. This will facilitate a common in-depth understanding of the conceptual framework, refining the evaluation questions and adjusting data collection methods, tools and sources.
- Drafting of Inception report (deliverable 1), including the details of the methodology, an evaluation matrix for each agreed evaluation question and a detailed analysis plan, to be presented to and approved by the members of the steering committee. The proposed methodology needs to be appropriate to capture all agreed indicators.

Phase 2. Data collection:
- In-depth interviews with national level MoHSS management, national level health managers and providers, Maternal Newborn, Child Health and Nutrition Technical Working Group members, donors, UN System and development partners. The consultant will submit a report with the key information and findings of interviews (deliverable 2).

- Field visits to selected districts to conduct data collection and interview/focus group discussion. Interviewees/focus group discussion participants will include key health care providers, health facility staff, sector officials, CHWs, community leaders, community volunteers, households, mother support groups and caregivers. A field report summing up the findings will constitute deliverable 3.

Phase 3. Analysis and reporting phase:

- Following the completion of the fact-finding phase, the evaluation team will conduct a detailed analysis of the data collected at all levels and compare with other survey results. A presentation of the key findings (deliverable 4) will be given to MoHSS, Maternal Newborn, Child Health and Nutrition Technical Working Group and other key stakeholders working on MNCH. Once the findings are discussed and validated by the Maternal Child and Community Health Technical Working Group, a final report will be shared with key partners for a final review and validation. The final evaluation report and the selected topics for publication as end products, are subject to approval by the Steering Committee (deliverable 5). Lastly, the consultants will produce two academic articles for peer-reviewed publications (deliverable 6).

5. Major Tasks, Deliverables & Timeframe

Deliverables:

Tasks	Expected Deliverables	Timeframe
1. Desk review of available documents, coverage data of core MNCH indicators and literature related to the community health programme	Feedback meeting on findings from desk review	Week 1
2. Reconstruct theory of change, and establish an evaluation framework in a participatory manner	Theory of change and evaluation framework	Week 1
3. Design of the data collection phase and relative tools and preparation of inception report	Inception report (deliverable 1) including work plan, presentation of methodological approach, instruments to be used, interview/focus group and country visit protocols, annotated outline of final report), to be presented and approved by the Steering Committee.	Week 1-2 1st payment: 30%
4. Obtaining, cleaning and analysing quantitative data	Quantitative data analysis progress report	Week 2
5. National level stakeholders (MoH/FHD, UN System, MNCH & Nutrition TWG) meetings and interviews	Brief report of the national in-depth interviews (deliverable 2)	Week 2
6. Field work (selected districts) including interviews with RHMT, DHMT & HC/Clinics, service providers, communities or households, sampled facilities visits and interviews with primary beneficiaries	Field visit, observation and interview report (deliverable 3)	Week 3-4
4. Analysis of findings and draft report preparation, presentation for validation		
	PPT presentation (deliverable 4) or presentation in other format on the preliminary draft of the analytical report, and at least four draft selected topics for publication	Week 5 2nd payment: 40%
5. Debriefing on findings with the National MNCH& Nutrition TWG and other stakeholders	Written feedback on meetings with stakeholders.	Week 5
6. Incorporate comments from key stakeholders and finalization of the formative/summative evaluation report; identify four topics for publication.	Final evaluation report, and summary of four final selected topics for publication (deliverable 5) as end products, subject to approval by the Steering Committee	Week 6 3rd payment: 20%
7. Writing and submission of two articles to peer-reviewed publication (to be submitted to UNICEF, as MoHSS and UNICEF C-authors)	Academic articles (deliverable 6)	Week 6 4th payment: 10%

The end products are specifically deliverables 4, 5 and 6 (set of Power Point slides with key salient features of the report, validated final report of the external evaluation with key recommendations, and two academic articles). The final report should be in line with the UNICEF evaluation standard and very focused on practical and implementable recommendations.

Specifically, the report should include at least the following sections: executive summary, description of the evaluation methodology (as per agreed inception report), assessment of the methodology (including limitations), findings, analysis, conclusions, lessons learned and recommendations for improvement. The Annexes to the report should contain: the TOR, the approved data collection instruments, and any other relevant information.

The final evaluation report should follow UNICEF Evaluation report standards. The report template should include:

- Title page and opening pages
- Executive summary
- Programme description
- Role of MoHSS, UNICEF and other stakeholders in programme implementation
- Purpose of evaluation
- Evaluation criteria
- Objectives
- Evaluation design
- Methodology
- Stakeholder participation
- Ethical issues
- Major findings
- Analysis of results
- Case studies/good practices
- Key Constraints
- General Conclusions
- Recommendations
- Lessons learned
- Annexes TOR, tools of data collection used

The report should be provided in both hard copy and electronic version in English. Complete data sets (database, filled out questionnaires, records of interviews and focus group discussions etc.) should also be provided to MoHSS and UNICEF at the end of the evaluation.

Potential uses of the evaluation findings: This study will serve (1) to inform policymakers on the impact of the HEP on maternal Newborn and child health (2) to make policymakers and developers aware of areas in which the HEP can be strengthened to support maternal newborn and child health (3) to inform external stockholders/the academic community of the impact and lessons learned of the HEP (4) to develop an evaluation management response that is going to tract the implementation of the recommendation from the study, and (5) inform the investment case for the HEP .

Dissemination of Results: Findings of the evaluation will be summarized and discussed with the MoHSS. Findings will also be made available to individual health care providers, health care facilities, and other relevant organizations through scientific meetings, presentations, and publications.

6. Stakeholder Participation

The main stakeholders are the HEP Steering Committee: MoHSS, MNCH & Nutrition committee, UNICEF (Child Survival Development, Communication for Development and Monitoring & Evaluation), which will

function as a reference group for the evaluation and assume the following responsibilities:

- Plan and design the evaluation through consultation with the main parties involved and final approval of the evaluation terms of reference;
- Provide technical inputs to the evaluation design;
- Provide guidelines to evaluators and monitor the implementation;
- Review the evaluator's inception report (including proposals for desk review of documents, evaluation instruments, field visits, annotated outline of the report);
- Review preliminary findings for validation of facts and analyses and help generate recommendations;
- Approve the preliminary reports;
- Review and approve the final report, verify the findings and propose a management response on how to implement recommendations;
- Ensure that evaluation findings are used for future planning and community health programme/MNCH programmatic interventions as well as advocacy purposes.

UNICEF Namibia will be responsible for selection of the international consultant to conduct the evaluation: keeping this process separately from the HEP Steering Committee will enrich transparency of the process and ensure neutrality/impartiality.

The evaluation will be managed by UNICEF Namibia. The management of the evaluation will involve drafting the terms of reference, initiating the evaluation selection process, liaison between the evaluation team and other members of the Steering Committee, as well as quality assurance of the reports.

MoHSS and UNICEF Namibia CO will be responsible for providing relevant information at country level, providing access to relevant reports/statistics, providing inputs for data analysis, organizing field visits, logistical support, organizing meetings with different stakeholders.

The variety of stakeholders in the Steering Committee will ensure that different opinions are represented and objectivity is achieved.

7. Ethical Consideration/confidentiality

Scientific and ethical clearance will be sought from the Namibia MoHSS Research Unit. The MoHSS directorate Primary Health Care and UNICEF will support the consultant obtain ethical clearance. Adequate measures should be taken to ensure that the process responds to quality and ethical requirements as per UNICEF Evaluation Standards. Also as per United Nations Evaluation Group (UNEG) Standard and Norms, the consultant should be sensitive to beliefs, manners and customs and act with integrity and honesty in relationship with all stakeholders. Furthermore, the consultant should protect the anonymity of individual information, and respect the confidentiality of all information which is being handled during the assignment. Consultants are allowed to use documents and information provided only for the tasks related to the terms of reference of this evaluation. Data will be stored in a secure location, kept confidential with access restricted to principal investigators. The study data will be used only for the purpose of this study.

8. Qualifications and Requirements

The qualifications and skill areas required for the international consultant include:

Consultancy qualifications:

- Minimum of 5 years' experience as a consultant in similar health evaluation assignments.
- Experience working in different countries amongst which at least one should be in Africa
- Experience in working with UN agencies (desired).
- Experience in evaluations/research: knowledgeable on UN evaluation policy, skilled in performing structured interviews and facilitating focus group discussions

Technical expert:

- Extensive quantitative research and impact evaluation expertise and experience
- Academic background in health / strong knowledge of epidemiological approaches
- Minimum of 5 years' experience in evaluation assignments or related similar assignments.
- Familiarity with technical aspects related to community health programming, maternal, child and new-born health
- Knowledgeable on institutional issues related to the provision of global public goods (including funding, administration, the role of the UN system, partnerships, sustainability of activities)
- Knowledge of the areas of intervention

Qualitative research expert:

- Extensive qualitative evaluation expertise and experience, including data collection skills; demonstrated skills in similar evaluations
- Knowledge of technical aspects of similar programmes
- Knowledge of the areas of intervention
- Indicate minimum qualification

Other skills:

- Language proficiency: excellent oral and writing skills in English
- Minimum three years working field evaluation experience
- Advanced university degree in related field or social science
- Analytical skills: demonstrated analytical skills related to the use of quantitative and qualitative data for decision-making
- Process management skills: Demonstrated skills and experience in conducting and presenting evaluations
- Good communication and advocacy skills: Ability to communicate with various stakeholders, and to express ideas and concepts concisely and clearly in written and oral form

Evaluation and selection criteria of the consultancy institution:

Applications shall therefore contain the following required documentation:

a. Technical Proposal: The consultant should prepare a proposal on the basis of the tasks and deliverables (as per the ToR). The proposal should include the approach and methodology with a detailed breakdown of inception phase, proposed scope and data collection methodology. The proposal shall also include a brief explanation of the data analysis, report writing and possible dissemination plan, and importantly, a draft work plan and timeline for the formative/summative evaluation. The Technical Proposal shall also include updated CVs and copies of two reports of previous MNCH programme and/or community health programme evaluated by the consultant.

b. Financial Proposal: this consists of an expected financial offer with cost breakdown of consultancy fees and daily subsistence allowance (DSA) and operational costs for the field work in Namibia. The financial proposal shall be submitted in a separate file, clearly named financial proposal. No financial information should be contained in the technical proposal as this will lead to proposal cancellation. Financial Proposals should be filled as per table below:

Deliverable	Number of person days	Delivery date	Costs
Inception report (Deliverable 1)			
Draft Report (Deliverable 2,3 and 4)			
Final reports and four academic articles for publication including a presentation (Deliverable 5 & 6)			
Operational Costs (a detailed addendum budget required)			
Total			

9. Supervision

The evaluation will be supervised by UNICEF CSD-Health section and PME jointly with MoH/FHD. The HEP Steering Committee will provide technical inputs to the design of the evaluation, provide guidance to the consultant, and monitor the evaluation implementation process.

10. Terms and conditions:

Procedures and logistics
The consultant is to use his/her own computer. UNICEF will provide office space and will pay some of the field operational costs related to this consultancy and these should not be included into the proposed financial proposal.

Terms of payment

The payment will be in three (3) instalments as follows:

- 30% of the total payment upon completion of the desk review, submission of inception report with work plan and methodology, theory of change and research instruments and protocols.
- 40% of the total payment upon completion quantitative and qualitative data collection and analysis, including field visits and submission of the draft final report of the evaluation;
- The remaining 30% will be paid upon completion of all deliverables, as per the above schedule (validated final report of the evaluation; a set of Power Point slides (25-30 slides) with key salient features of the evaluation; and four selected topics for publication in the form of academic articles for submission to peer-reviewed journals).

Payment will only made for work satisfactorily completed and accepted by UNICEF. UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs is incomplete, not delivered or for failure to meet deadlines

All materials developed by the firm will remain the copyright of MoH/UNICEF, who will be free to adapt and modify the materials for future use.

11. How to apply:

Qualified institutions are requested to submit a full proposal, consisting of two parts (technical and financial) to lshatipamba@unicef.org

Annex D. Documents consulted for this inception phase

1 Namibia's 5th National Development Plan (NDP5)
2 National Health Policy Framework (2010-2020)
3 National Health Act 2015
4 Community Based Health Care Policy - 2007
5 Child Survival Strategy 2014-2016
6 National Strategy for Community Based Health Extension Programme in Namibia
7 Standard Operating Procedures - Health Extension Programme
8 Health Extension Programme - Screening and Management Tools
9 Health Extension Workers Training Manuals
10 Namibia Demographic and Health Survey 2013
11 Guidelines for Implementing National Referral Policy - 2015
12 National department of health, I-tech and CDC South Africa study tour to Namibia strengthening facility-community linkages
13 Joint Review of Maternal, Newborn, Child and Adolescent Health and Nutrition Programmes in Namibia - 2016
14 Baseline Survey for Health Extension Pilot Programme, Opuwo Health District, Kunene Region

Annex E: Data collection procedures during key informant interviews and FGDs

Key informant interview

Preparatory Steps:

- Identify the key informants
- Schedule interview times that are long enough to gather all pertinent information.
- Review the questionnaire prior to the interview.
- Allow at least 1 hour for each key informant interview.
- If the interview is interrupted, schedule a follow up meeting to finish the interview and note the dates of the interviews into the TALLY SHEET.

Interviewing Procedures – ALL INTERVIEWS MUST BE RECORDED.

- Begin the interview with obtaining a verbal informed consent. Read statement to participant and record approval or declined on informed consent.
- Complete the details of the Interviewee Roster titled, TALLY SHEET.
- Prepare digital recorder and notebook.
- Begin recording after consent has been given.
- Use the questionnaires as a general guide.
- Insert probing questions as relevant. The interviewer can develop these questions as the interview progresses.

Duration of Key Informant Interviews

- Each key informant interview should take about an hour. All interviews must be audio recorded after obtaining verbal informed consent. An assistant will assist the interview by taking notes alongside. Scheduling follow up interviews may be necessary, especially in the event that interviews are cut short or interrupted.

Terminating the Interview

- Verify that all relevant questions have been asked.
- If any probing questions have been asked, ensure that the Research Assistant has noted those questions. It is not necessary to add them to the questionnaire template. However, they should appear in the typed transcription.
- Thank interviewees for their time. Schedule any follow up interview as necessary.

Community Focus Group Discussion

Preparatory Steps:

- Examine the summary of available data from desk review and key informant interviews. If information is available prior to CFGDs, results will help to understand what areas are going well and what areas have been challenging at the community level. Also review health facility data to understand, from a data perspective, how the community interacts with the health system and CHWs. For example, examine whether there are changes in attendance or whether health facility visits for certain issues have increased or fallen over time.
- Identify the focus group participants.
- Schedule interview times that are long enough to gather all pertinent information.
- Review the questionnaire and data results prior to the interview.

Scheduling Community Focus Groups:

- Allow at least 2 hours for each community focus group.
- Have ready the interview questions as well as the summary of health facility data to refer to as necessary during the interview.

Facilitating a Community Focus Group – ALL FOCUS GROUPS MUST BE RECORDED:

- Begin the focus group discussion with sharing the aim of the evaluation and obtaining a verbal informed consent. Read statement to participants and record approval or declined on informed consent.
- Complete the details of the Interviewee Roster in the worksheet titled, TALLY SHEET.
- Let participants introduce themselves and where they come from to one another.
- Prepare digital recorder and notebook.
- Begin recording after consent has been given.
- Use the questionnaires as a general guide.
- Insert probing questions as relevant. The interviewer can develop these questions as the interview progresses.
- Some people will be very talkative while others will be quiet. For each question, the interviewer should encourage as much participation and input as possible from everyone. The aim is to capture as many opinions as possible so reach out to those who are quiet or not saying as much and encourage them to share their experiences and opinions.

Duration of Community FGDs

- Community FGDs require at least 2 hours per discussion, allowing for maximum participation from everyone. The interviewer/facilitator is required to actively engage participants to express their opinions, offer guidance, discuss their experience, and reactions to the data.

Terminating the focus group discussion:

- Verify that all questions have been asked.
- If any probing questions have been asked, ensure that the Research Assistant has noted those questions. It is not necessary to add them to the questionnaire template. However, they should appear in the typed transcription.
- Thank interviewees for their time. Schedule any follow up interview as necessary.

Annex F: List of key Informant Participants

Dr. Rutabanzibwa	Acting Deputy Director, Primary Health Care PHC Director-MOHSS	
Ms Petronella Aimes & Ms Denk (Chief and social worker)	Social Welfare Services Director	bdenk@mhss.gov.na
Anna Isaaks - Human resources	Planning & HR Development Director	
	Dupty Minister (MoHSS)	
Mr. Tuutaleni Shilyomunhu	CHWP coordinator (MoHSS)	
Mrs. Maria Helao	HIRD (MoHSS)	
Dr. Gloria Siseho	UNICEF	
Dr. Marry Nana Ama Brantuo	WHO	
Ms. Claudia Inghepa	MCSP	
Dr. Brad Corner	USAID	
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Mrs. Naomi Heita- Secretary General , Mrs. L Onesmus-National Coordinator, Organisational Development: .	Namibia Red cross society	naemi.heita@redcross.org.na
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Intra health	C/o Ria Bock	
Mrs. Hilma Auala	Former PHC Director	
OMAHEKE REGION		
Mr. Jeremia Shikulo	Director Omaheke region	jeremia.shikulo@mhss.gov.na;
Sr. Emgard Kaune	Chief Health Programme Administrator Family Health	
Hon. Festus Ueitele	Governor: Omaheke region	fuietele@omahekeog.gov.na
Sr. F.E. Zariro	Primary Health Care supervisor - Epako clinic	
Mrs. Christiana van Wijk	Health Extension worker - Kanaan	
Daniel Matsuib	Primary Health Care Nurse - Epako clinic Pandu & Jacky	vanwykchristiana@gmail.com
Siegfried Kauahuma	Kanaan Community Leader	
Kanaan Community members (FGD)	Beneficiaries	Focus group discussion
OSHANA		
Mrs. Ipawa Shikulo	Chief Health Programme administrator	ipawash@gmail.com>
Omutanga village community members	Beneficiaries	Focus group discussion
Mr. Natinda	Senior Health Program Officer (HIS)	
Mrs. Ipawa Shikulo	Chief Health Program Administrator	
Ms. Johannes	Director, Regional Health	
Sr. Prinus	HCP supervisor	
Sr. Katangolo	Head, Okatana Health Center	
Mrs Susan Ashipala	HEW (Omutanga village)	
Mrs. Esther Angula	HEW (Oshakati District)	
Honn. Gerson Kapenda	Senior Advisor of Governor	
Mrs.Angula	HEW	Observation
Mrs. Rauna Mutota	HEW (Omusheshe village)	Observation
Mrs. Albertus Shilamba-Epanga ; Gotlieb Martin - Emanya; Eufemia Odjodjo; Frans - Ohailulu village	Village Headmen and woman	
Ms. Laina	HEW	
KUNENE		
Omaepange community members	Beneficiaries	Focus group discussion
Mr. Tomas Shapumba	Director Opuwo health regional director	tshapumba@yahoo.com
Mr. Tjiumbua Liaondjeako	HEW	
Honourable Katuutire Kaura	Senior advisor of the Governor	
Ms. Nghuumbwa Ndeshihafela	HEW (Alpha)	
Mr. Ngaakise Mbembe	Village Headman	
Mrs. Martha Johannes	member of village health committee	Discussion
Mr. Ndahepele	Regional FH	
Mr. Kiarie	Head of Entanga Clinic	
Mr. Collin Ngumbi	HEW (Okamanga)	
Ms. Rukuma Rukireeko	HEW (otjiwarongo)	Observation
!KHARAS		
Mr. Barth Muntenda	Director, Regional Health	Barth.muntenda@gmail.com
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Lemoen Draai (Tseiblaagte	Beneficiaries	Focus group discussion
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Mrs. Albertian Manya	Health Extnesion worker	
Area 7	Focus group discussion	
ZAMBEZI		
Heritha Kambinda	Chief Health Program Officer	
Agnes Mwilima	Director	
Kelly	PHC Supervisor	
Sr Grace		
Cosmus	HEW and supervisor	
Sr Kasona	Nurse	
Community members	Beneficiaries	Focus group discussion
Sharon Mabuku	HEW	

Annex G: Participants of Validation meting

NAME	DESIGNATION	ORGANIZATION	TEL/MOBILE	E-MAIL
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End Notes

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