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# USAID/NAMIBIA: CORRIDORS OF HOPE PROJECT

## FINAL EVALUATION

**SEPTEMBER 2011**

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# ACRONYMS

| | |
|---|---|
| AIDS | Acquired immunodeficiency syndrome |
| ARV | Anti-retroviral drugs |
| ASO | AIDS service organization |
| BCC | Behavior change communication |
| CBO | Community-based organization |
| CDC | U.S. Centers for Disease Control and Prevention |
| CHC | Community health consultant |
| CMS | Central Medical Storage |
| CoH | Corridors of Hope |
| DCAA | Defense Contractors Audit Agency |
| DoD | (U.S.) Department of Defense |
| DSP | Directorate of Special Programmes |
| FBO | Faith-based organization |
| FSW | Female sex workers |
| GFATM | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GRN | Government of the Republic of Namibia |
| HBC | Home-based care |
| HCT | HIV counseling and testing |
| HIV | Human immunodeficiency virus |
| IEC | Information, education, and communication |
| IOM | International Organization for Migration |
| IPC | Interpersonal communication |
| IPPR | Institute for Public Policy Research |
| LGBTI | Lesbian/gay/bisexual/transgender/intersex |
| MARP | Most-at-risk population |
| MC | Male circumcision |
| MCP | Multiple concurrent partnership |
| M&E | Monitoring and evaluation |
| MIS | Management information system |
| MoHSS | Ministry of Health and Social Services |
| MRLGRD | Ministry of Regional and Local Government, Housing and Rural Development |
| MSM | Men who have sex with men |
| NAMFI | Namibian Maritime and Fisheries Institute |
| NANASO | Namibia Network of AIDS Service Organizations |

| | |
|---|---|
| NAPPA | Namibia Planned Parenthood Association |
| NASOMA | National Social Marketing Programme |
| NGO | Non-governmental organization |
| ORN | OutRight Namibia |
| OVC | Orphans and vulnerable children |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PEPP | Peer Education Plus Program |
| PLWHA | People living with HIV or AIDS |
| PMP | Performance monitoring plan |
| PMTCT | Prevention of mother-to-child transmission (of HIV) |
| PSI | Population Services International |
| PVO | Private voluntary organization |
| RNRT | Rights Not Rescue Trust |
| SFH | Society for Family Health |
| SMA | Social Marketing Association |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| ToT | Training of trainers |
| TRP | The Rainbow Project |
| USAID | United States Agency for International Development |
| USG | United States Government |
| WBCG | Walvis Bay Corridor Group |

# EXECUTIVE SUMMARY

## INTRODUCTION

In July 2005, the United States Agency for International Development (USAID) awarded Population Services International (PSI) a cooperative agreement to implement the Corridors of Hope (CoH) program in Namibia until September 2010. Practical implementation of the program was conducted by PSI's local affiliate, Social Marketing Association (SMA), which in 2009 transitioned into an independent Namibian organization and was renamed the Society for Family Health (SFH).

The CoH project was established in response to growing awareness that factors such as internal economic migration, unequal gender relations, and the low socio-economic status of women were all important drivers of the HIV epidemic in Namibia. The program sought to counteract these forces by using customized behavior change communication (BCC) among most-at-risk populations (MARPs), including sex workers, transport workers, border officials; seafarers, and vulnerable girls and young women. Initial HIV prevention objectives for the CoH program were to (1) reach mobile and border populations (sex workers, transport workers, informal traders, and border officials) through BCC work on Namibia's borders to reduce high-risk sexual behavior; (2) reach young women and girls and the communities in which they live through community activities and mass-media campaigns on cross-generational sex; and (3) social market condoms to these target groups during the project.

In December 2007, the CoH program's programmatic goals were updated to focus on increasing the organizational capacity of SMA. The program's revised objectives were to (4) strengthen the organization's capacity to provide high-quality, age-appropriate BCC for prevention, care, and treatment in HIV/AIDS and tuberculosis (TB) to MARPs, including the police, transit workers, border populations, and people engaged in informal sexual relationships; and (5) strengthen the organizational, financial management, contractual, and administrative capacity to implement and monitor HIV/AIDS and TB behavior change programs that comply with local and U.S. Government (USG) regulations, policies, and procedures via successful certification to receive direct U.S. funding.

This end-of-project evaluation sought to assist USAID in assessing the performance of the CoH program, as well as to inform the implementation of USAID's future competitive award to a follow-up project for MARPs.

## KEY FINDINGS

### Behavior Change Communication Interventions

During the period under review, SFH successfully expanded the scope and scale of the CoH program to a point where it became a well-recognized component of the national response to HIV. Considerable efforts were made to ensure program quality through a process of continual assessment and refinement of target groups and behavior change messages, with the program utilizing a diverse and contextually appropriate range of BCC interventions to convey key concepts. The CoH program documented impressive results and exceeded its targets for the majority of objectives. However, the numbers reported suggest that the quality of individual BCC contacts became inconsistent in the quest for quantity, and the majority of contacts appear to have been quite superficial.

A key component of SFH's mandate was to work with MARPs, and the organization made laudable efforts in identifying, defining, profiling, and measuring these target groups, and developing appropriate methods to reach them. The program achieved high visibility in target communities and SFH personnel were identified as a valued source of HIV-prevention information and support. However, despite the CoH program's focus on MARPs, the vast majority of those reached with BCC interventions appear to be members of the general population. This suggests that SFH was unable to maximize its comparative advantage as a specialist in MARP-focused BCC. However, strategic partnerships with organizations such as the Namibian Maritime and Fisheries Institute (NAMFI), Walvis Bay Corridor Group (WBCG) and the Namibian Police gave the CoH program excellent access to several of the program's target MARP groups, and SFH successfully capitalized on these opportunities.

Information, education, and communication (IEC) materials developed and used in conjunction with the CoH project were of consistently high quality, and were interesting and relevant to the needs of individual target groups. In response to community feedback and formal recommendations, SFH successfully introduced several interactive communication methods that actively engaged the audience in discussing and exploring key ideas. However, a reliance on English-language materials and lack of stakeholder or target group involvement in message development are factors that likely limited the usefulness of CoH materials among certain population groups.

Comprehensive referral to auxiliary services was supported by an extensive referral system providing linkages to both clinical and non-clinical services. However, the efficacy of the system was compromised by the fact that several services were not readily accessible to certain groups due to economic barriers (including cost of services); logistical constraints (stemming from an unwillingness to seek sensitive services within the local community, and concomitant challenges of accessing them externally); and the deterrent effect of health care workers who were not sensitive to the needs or rights of MARP populations. Adequate efforts were not made by SFH to address these barriers, or to consequently facilitate completion of referral. Limited advocacy on behalf of MARPs also constrained SFH's influence on the social and policy environment, and prevented the organization from assuming a natural role as a vocal advocate and mobilizing force on behalf of MARPs.

## Organizational Capacity

In line with stated objectives, SFH's organizational strength increased through extensive staff training and capacity-building exercises, although these were for the most part directed toward staff based in central and regional offices. The implementation of the program was primarily conducted by trained volunteers who were drawn from target communities. These individuals were highly skilled at providing culturally and linguistically appropriate behavior change messages to diverse target audiences. The program's reliance on un- or undercompensated individuals increased the financial sustainability of activities, but also brought with it high rates of volunteer attrition, which potentially compromised the consistency of interventions.

The decentralized nature of SFH operations was an important factor in the success of the CoH program, as it enhanced the coverage and quality of BCC interventions while simultaneously ensuring the local relevance of the message conveyed. Regional offices provided a natural, relatively accessible contact point for MARPs seeking information, support, or referral, and greatly enhanced the visibility of the program within target communities. Decentralized operations also enabled SFH to more effectively mobilize local community leaders, as well as establish or strengthen critical partnerships with key regional and national stakeholders. These

collaborative efforts effectively strengthened both SFH and its partners; enhanced the provision of MARP-related services and support; and leveraged resources between various organizations and programs.

### Research, Monitoring, and Evaluation

SFH invested considerable resources toward strengthening the organization's monitoring and evaluation (M&E) systems, including the development of an M&E plan and management information system (MIS) manual, and staff-specific training in data management and reporting. Data flow from the field functioned well, and relevant data of national interest were conveyed in a timely manner to pertinent government ministries. However, feedback to field-level staff was minimal, which deprived them of both the motivation derived from seeing progress toward stated targets, as well as the opportunity to participate in identifying specific areas for improvement.

The use of standard program data for planning was compromised by a lack of baseline data, as well as by a mid-program change of indicators and repeated revisions and refinements of target groups; this meant that nationally available data were frequently prioritized over project data in planning processes. Isolated studies were conducted by SFH's research department to profile certain populations or issues, which proved useful in enhancing understanding of issues related to specific target groups, and in modifying or refining BCC interventions accordingly.

A combination of financial and human resource constraints as well as inadequate prioritization of monitoring processes precluded routine programmatic evaluation, thus limiting SFH's ability to consistently ensure and maintain program quality. Nonetheless, results achieved by the CoH program were generally seen in a highly positive light by stakeholders and partners at all levels. The program was widely perceived as having played a crucial role in complementing the government's current programming for MARPs.

## RECOMMENDATIONS

#### 1. Increase access to specific at-risk populations through strategic partnerships

Existing strategic partnerships have greatly increased access to key target populations, and these collaborations should be scaled up through cooperative agreements and joint workplans. Partnerships with other relevant organizations working directly with specific at-risk populations should be formalized to increase understanding of, and access to, these groups. Strategic partnerships of this nature will be particularly valuable for reaching men who have sex with men (MSM), a group that was previously inadequately incorporated into the program. A mapping exercise of relevant organizations would identify future partners and could provide a valuable starting point for addressing gaps in the coordination of organizations working with MARPs.

#### 2. Focus on quality instead of quantity in BCC interventions

Current program approaches emphasize the quantity of BCC contacts achieved as opposed to the quality of each contact, thereby achieving high numbers but potentially limited impact. Stimulating sustained behavior change requires that key messages are communicated in intimate settings that are conducive to developing trust and generating active participation; such approaches are naturally time-intensive and are unlikely to generate high results figures, but instead have great potential to foster desired behavior changes. Focusing on achieving high-quality, contextually appropriate BCC contacts with defined target populations will enable SFH to capitalize on its comparative advantage as an expert in BCC for MARPs rather than overlapping with the community-based HIV awareness programs of other organizations. This would also entail that efforts are made to define a "quality" contact and develop tools to assess

this. Seeking an effective balance between single and multi-session HIV prevention sessions for individuals at varying risk levels is important.

### 3. Use a participatory approach in development of MARP-specific IEC

Using a participatory approach that involves both stakeholders and members of the intended target group in developing IEC materials will help ensure that messages are appropriate, relevant, and understandable, and will thus enhance uptake. This approach will also help standardize key behavior change messages for target groups and avoid unnecessary duplication of existing materials. To further enhance community access to IEC materials, SFH should consider translation of key items into major Namibian languages besides English, and should explore the possibility of developing materials for non- or semi-literate populations.

### 4. Strengthen and expand referral system

Given the CoH program's excellent access to individuals with elevated risk, it is critical that opportunities to provide holistic referral are maximized. Existing referral mechanisms should be strengthened through the development of a referral register and tracking form to enable follow-up and assessment of individual cases. Where possible, referrals should be directed to organizations that provide MARP-friendly services; where such "friendly" services do not exist, SFH should consider providing MARP-sensitive training to referral organizations.

### 5. Conduct MARP-oriented advocacy in community, regional and national fora

Structural-level factors that elevate risk of HIV infection include a legislative and social environment that marginalizes MARPs and greatly limits their access to prevention, treatment, and support services. As a specialist in MARP-oriented BCC, SFH has the potential to make a substantial contribution in advocating on behalf of these groups. Important components of such advocacy work include the sensitization and mobilization of relevant stakeholders at the community, regional, and national levels regarding the specific concerns and health needs experienced by MARPs. SFH should also consider assuming a leadership role in coordinating the advocacy efforts of MARP-focused organizations.

### 6. Invest in training and retaining implementation-level staff and volunteers

High levels of attrition among CoH volunteers compromises program consistency and necessitates time- and resource-intensive training of new staff. SFH should invest in providing (1) in-depth and repeated training for implementation-level staff and volunteers, and (2) ensuring that they are suitably compensated for their efforts. Where appropriate, volunteers should be offered employment contracts after a set period of service as an additional incentive.

### 7. Provide ongoing support and technical assistance to implementing partners

To ensure program sustainability, responsibility for implementing BCC interventions has largely been transferred to implementing partners. However, the success of this approach is dependent on these partners having sufficient technical competence and administrative capacity to carry out the required activities. All potential implementing partners should therefore be able to demonstrate adequate human resource and administrative capacity before agreements are finalized. In addition, all current partners should receive regular technical assistance and support in keys areas such as program planning, BCC methods, and M&E.

### 8. Provide regular program updates to all interested and involved parties

Program updates and results should be shared with key stakeholders as well as with all staff and volunteers on a routine basis, with structures put in place to ensure that this occurs. In particular, program staff should receive regular feedback on their performance, as well as information placing their efforts within the context of the program in general.

### 9. Monitor both qualitative and quantitative program performance

There is a need for program monitoring to move from the current relatively simplistic method of data collection and analysis, where the primary focus is on the number of people reached with BCC, to a comprehensive assessment system that captures both the quality and quantity of individual BCC contacts. Such a system should establish continuous monitoring and feedback mechanisms to both assess intervention output and outcome, and inform message content and delivery channel. This would necessitate the development of additional data-capturing systems, as well as more effective use of existing assessment tools.

### 10. Invest in research capacity

Namibia lacks sufficient data on the majority of MARP groups to support strategic planning and advocacy work. SFH is well positioned to help address this dearth of data, while simultaneously becoming a respected repository of MARP-related research. However, conducting rigorous, relevant research requires individuals who have considerably more experience and education than that which can be acquired through isolated workshops and trainings. SFH should therefore invest in specialized, in-depth research training for selected individuals, with the goal of becoming a national center of excellence in MARP- and HIV-related research. This would not only greatly enhance any future implementation of the CoH program, but would also strengthen the organization's advocacy efforts and support national MARP-focused policy and planning processes.

# BACKGROUND AND INTRODUCTION

## HIV IN NAMIBIA

Namibia has one of the highest HIV infection rates in the world, with an estimated national prevalence of 18.8% in 2010.[1] However, this number masks great regional variation, and there is strong evidence of concentrated sub-epidemics in specific geographic hot-spots and among certain groups whose behaviors are conducive to elevated risk of infection. Although the epidemic appears to have already peaked within the general population, there are now an estimated 200,000 people living with HIV or AIDS (PLWHA). Women and girls are disproportionately at risk of contracting HIV due to a range of social, economic, and biological issues that make them more vulnerable to infection. The weak social and economic position which many women experience often prevents them from avoiding sex with an infected partner or demanding condom use, while economic desperation may force them to engage in transactional sex to ensure their survival or that of their children. Consequently, women constitute the majority of new cases in Namibia.

Namibia's HIV epidemic is driven by numerous social and contextual factors, including poverty; gender inequality; low levels of consistent condom use; low levels of male circumcision; and social norms that exacerbate risk behaviors such as early sexual debut, culturally defined male roles, and alcohol misuse. Additionally, high levels of new infections are sustained by extensive population migration and complex sexual networks defined by multiple concurrent partnerships (MCP) and cross-generational and transactional sexual encounters.

## CORRIDORS OF HOPE PROGRAM

The Corridors of Hope (CoH) project was initially established in 2002 in response to growing awareness that factors such as internal economic migration, unequal gender relations, and the low socio-economic status of women were all important drivers of the HIV epidemic in Namibia. The program sought to address these factors through the promotion of targeted messages related to abstinence; mutual fidelity; correct and consistent use of condoms; partner reduction; stigma reduction; access to and use of counseling and testing services; and early diagnosis and treatment of sexually transmitted infections (STIs) and tuberculosis (TB). The program also actively discouraged coercive and cross-generational sex, and operated specifically in towns with documented high incidences of transactional sex and along Namibia's most high-risk transport corridors. Within the program's general HIV prevention framework, particular attention was directed toward the provision of comprehensive behavioral change activities targeting most-at-risk populations (MARPs), including sex workers; transport workers; border officials; seafarers; and vulnerable girls and young women. Behavior change communication (BCC) efforts were thus targeted at known hot-spots such as bars, border posts, and truck stops, and were based on the peer education framework for eliciting sustained behavior change at both an individual and community level.

In July 2005, the United States Agency for International Development (USAID) awarded Population Services International (PSI) a cooperative agreement to implement the CoH program in Namibia until September 2010. Practical implementation of the program was conducted by PSI's local affiliate, Social Marketing Association (SMA), which in 2009 transitioned into an

[1] MoHSS 2010, Report on the 2010 National HIV Sentinel Survey, Ministry of Health and Social Services, Windhoek, Namibia.

independent Namibian organization and was renamed the Society for Family Health (SFH). The program focused on the following activities:

- Reaching mobile and border populations (sex workers, transport workers, informal traders, and border officials) through BCC work on Namibia's border
- Reaching young women and girls and the communities in which they live through community activities and mass-media campaigns on cross-generational sex
- Carrying out social marketing of condoms to these target groups during the project

Following a program modification in December 2007, the goal of the CoH program was updated to focus on increasing the capacity of SMA to provide high-quality HIV prevention programs to populations at risk through well-designed, targeted BCC interventions. The program's revised objectives were:

- Strengthen the organization's capacity to provide high-quality, age-appropriate BCC for prevention, care, and treatment of HIV/AIDS and TB for MARPs, including the police, transit workers, border populations, and people engaged in informal sexual relationships
- Strengthen the organizational, financial management, contractual, and administrative capacity to implement and monitor HIV/AIDS and TB behavior change programs that comply with local and U.S. Government (USG) regulations, policies, and procedures via successful certification to receive direct U.S. funding

To achieve these objectives, USAID/Namibia supported SMA in conducting CoH activities in nine regions (Kavango, Caprivi, Ohangwena, Oshana, Omusati, Oshikoto, Omaheke, Karas, and Erongo). Project activities have included: working with commanding officers of the police at the regional level; working with peer education programs for mobile MARPs (truckers and fishermen) at hot spots through a variety of outreach interventions such as presentations, drama, and video facilitation; and training peer educators working at community-based organizations (CBOs).

## THE SOCIETY FOR FAMILY HEALTH

SFH (formerly SMA), is a non-governmental organization (NGO) that has operated in Namibia since 1997. SFH is a member of the PSI global network of organizations, and has health promotion programs focused within two key areas: HIV and AIDS (including projects on prevention, care, and support)[2] and maternal and childcare (including projects on malaria, safe water, and pneumonia).

Specific projects in the area of HIV prevention include the CoH program targeting MARPs, as described above, and the HIV Workplace Program, which targets members of the uniformed services such as military and police officials. One component of the latter program is the PolAction project, which was introduced in 2005 to provide workplace-based BCC to police officers as a way to reduce the incidence of HIV among members of this profession. SFH's PolAction is estimated to have reached more than 5,000 members of Namibia's Police Force – approximately one-third of the total force – through training and peer education in areas such as basic facts about HIV and STIs; correct and consistent condom usage; and interpersonal communication (IPC). Police personnel have been trained as peer educators in the majority of regions, and are themselves now responsible for implementing PolAction training and outreach

[2] As a complementary measure to SFH's HIV prevention projects, the organization's TUSANO program seeks to provide practical care and psycho-social support to individuals who test positive for HIV, and for anyone adversely affected by the disease.

sessions, with limited technical assistance (TA) from SFH. Although this is a separate program from CoH, the methodological approach and message content of both programs are so similar that they are typically reported together. Thus, data and observations related to PolAction will be presented in this document where appropriate.

A fundamental concept underlying all of SFH's work is that BCC messages must be appropriately customized and targeted to address the needs and concerns of specific audiences. Within the realm of HIV prevention and the CoH project, key messages for MARPs have emphasized the risks associated with multiple concurrent sexual partnerships; cross-generational or transactional sexual relationships; alcohol misuse; and unhealthy male cultural norms. Messages have also promoted the importance of correct and consistent condom use, and for specific target audiences – primarily young girls and vulnerable women – have emphasized the benefits of abstinence, delayed sexual activity, and fidelity within relationships.

## EVALUATION GOAL AND OBJECTIVES

USAID/Namibia contracted the Global Health Technical Assistance (GH Tech) Project to conduct an end-of-project evaluation of the Corridors of Hope Project implemented by SFH. The purpose of the evaluation was to assist USAID in determining the performance and effectiveness of Corridors of Hope, as well as informing the design of USAID's future competitive award to a follow-on project for MARPs.

The period under review for this evaluation was from the start of the project (July 2007) to the Semi-Annual Progress Report for 2010 (March 31, 2010). The evaluation's primary objectives included the following:

- Assess why progress toward planned results has been positive or negative
- Assess how well the needs of different customer groups (mobile versus border populations) were served
- Assess how Corridors of Hope used project and nationally available data that were collected over the course of the project
- Assess how quality assurance/control was maintained at the regional level; analyse the implications of the Corridors of Hope decentralized regional organizational structure for reaching MARPs.

The evaluation took place from September 20, 2010, to October 7, 2010, and was performed by two GH Tech consultants, Lia Kropsch and Tsitsi-Stella Dangarembizi. The full scope of work for the evaluation is attached as Appendix A. Subsequently, a revision of the initial evaluation was conducted in August 2011.

## METHODOLOGICAL APPROACH

### Desk Review

The evaluators reviewed all relevant SFH project documentation, including performance monitoring plans; work plans; project reports; training materials; evaluation reports; and data collection instruments. Appropriate background material, including Ministry of Health and Social Services (MoHSS) strategy and policy documents, was also reviewed to obtain a comprehensive, holistic understanding of the economic, legal, social, and health situation in Namibia, as well as a clear picture of the environment in which USAID and its Namibian partner organizations operate.

## Team Meetings

Meetings were held with both USAID officials and SFH personnel to ensure that the evaluation exercise was a collaborative and transparent process. Input was sought from both USAID and SFH regarding the agenda for the evaluation as well as the content of evaluation instruments.

## Field Assessment

Field visits were conducted at project sites in five regions (Khomas, Erongo, Oshana, Ohangwena, and Caprivi). In each region, the evaluators visited local SFH offices; regional MoHSS directorates; community leaders and groups; CBOs; private voluntary organizations (PVOs); and NGOs. Contact was also made with SFH-affiliated community health consultants (CHCs), and various BCC sessions and approaches were observed.

## Key Informant Interviews

Semi-structured interviews with key informants were the primary method of eliciting information and perspectives regarding the implementation of the CoH project. Although the evaluators had initially envisaged using a form of group interviews, logistical constraints entailed that most interviews involved only one or two respondents. Individuals targeted in this exercise included SFH personnel at central and regional offices; MoHSS officers at the central and regional levels; community leaders; and selected staff members from relevant partner and stakeholder organisations such as CBOs, PVOs, and NGOs. Interviews were conducted in nine cities and border towns, including Windhoek, Swakopmund, Walvis Bay, Ongwediva, Oshakati, Oshikango, Ondangwa, Okatope, and Katima. Contact was made with a total of 69 people from 37 public and private organizations.

## Analysis and Interpretation of Findings

Data collection methods used during the evaluation were primarily qualitative, as these methods enabled the evaluators to explore complex questions; allowed respondents to put forth their own opinions; and elicited more detailed responses than would be possible using quantitative tools. The resultant data were analyzed and interpreted through triangulation of input from interviews, reviewed documents, and evaluator observations. Where necessary, additional information was requested from project staff to support findings or assess the reliability of specific data.

## Submission of Evaluation Report

A debriefing meeting was held at the conclusion of the evaluation period to inform the USAID/Namibia team of the evaluation's key findings and recommendations, and to solicit feedback on the draft report. The final report was completed after the evaluators left Namibia.

# KEY FINDINGS: BEHAVIOR CHANGE COMMUNICATION INTERVENTIONS

## COH TARGET GROUPS

When the CoH project originally commenced in 2002, its primary focus was to reach all vulnerable individuals living in border towns in four regions with high HIV risk profiles: Kavango, Caprivi, Ohangwena, and Erongo. Such individuals included female sex workers, truck drivers, vulnerable women and girls, out-of-school youth, informal traders, market women, uniformed personnel, migrant workers, and PLWHA. All BCC activities were designed to be conducted by trained health educators and SFH volunteers with supervision from SFH regional staff.

During the period under review, SFH gradually expanded the CoH program to target MARPs in high HIV-risk settings in a total of nine regions of the country (Kavango, Caprivi, Ohangwena, Oshana, Omusati, Oshikoto, Omaheke, Karas, and Erongo), and simultaneously narrowed and defined its target groups. In 2008, SFH revised the CoH target populations such that the program ceased its work with informal traders and market women, and started focusing on fishermen (both those working along the rivers in Caprivi and those on seafaring vessels). Additionally, the out-of-school youth category was subdivided into males and females to both improve program targeting and allow for disaggregated data reporting and analysis. Project target groups resulting from this process were defined as follows:

- **Female sex workers (FSW)**, defined as women who openly trade sex for money and who operate in hot spots such as bars, night clubs, and specific streets. These women are frequently open about their work and willing to self-identify as sex workers.
- **Vulnerable girls**, defined as young girls who may engage in transactional sex for food, clothing, alcohol, or similar items. These sexual relationships are often cross-generational (with so-called "sugar daddies"), but the girls involved rarely self-identify as sex workers.
- **Transport workers**, defined as Namibian and foreign men who operate trucks along the country's transport corridors, and who frequently make brief or extended stops at border towns.
- **Fishermen**, initially defined as Namibian and foreign men working for fishing companies who typically enter Namibia through the port of Walvis Bay in the Erongo Region, and local (river) fishermen in the Caprivi Region; subsequently this target group was revised to include only seafaring individuals.
- **Out-of-school youth**, defined as young males and females between the ages of 15-24 who are currently not attending school, due to either personal choice or socio-economic limitations.
- **Uniformed/border personnel**, defined as members of the Namibian Police Force and consequently primarily targeted by PolAction interventions.

A portfolio review conducted by USAID in 2009 recommended further modifications to CoH target groups. These included phasing out BCC work with out-of-school youth and instead focusing more intensively on FSW and their clients, vulnerable girls, sector workers (such as uniformed personnel, transport workers, and fishermen), and a previously unaddressed target, men who have sex with men (MSM).

## BEHAVIOR CHANGE COMMUNICATION METHODS

SFH's BCC implementation strategy sought to move beyond awareness-raising and HIV education to promote an internalization of personal risk and subsequent sustained behavior change at both an individual and community level. At the core of the strategy was customized peer education and mentoring. In addition, a variety of additional BCC activities were used within the framework of the CoH program, including the following:

- Health Awareness Days, which were in-depth activities organized in collaboration with local or traditional authorities, and which typically cover several different HIV-related topics
- Promotional/ informational events that address one key message and are held at hot spots such as bars, truck stops, harbors, border posts, and open markets
- Trainings and workshops that provided structured, in-depth information on a range of topics to build confidence and capacity in the target audience
- Monthly group meetings that were organized for FSW and vulnerable girls to provide a platform for reinforcement of key messages and peer support
- Distribution of information, education, and communication (IEC) materials

Additional BCC interventions specific to the PolAction program included the use of training and expert speaker seminars to sensitize high-ranking police officials to key issues surrounding HIV in their work force; and "edutainment" sessions at police stations, camps, and bases covering a broad range of HIV-related topics.

During 2008, the CoH program developed and introduced the Peer Education Plus Program (PEPP) to more actively engage MARPs and promote the assimilation of safer sexual behaviors. Based on the concept of community volunteerism for peer education, the PEPP model was designed to be implemented by CHCs under supervision of BCC officers from SFH's regional offices. The program aimed to gradually build subject knowledge and self-risk identification through a series of linked educational modules that were held on a weekly basis. Only one key message was presented per PEPP session, and concepts were reinforced through interactive discussions using specially designed flipcharts and manuals. In its original form, PEPP consisted of 13 modules and required three months to complete. The program experienced high attrition due to its length, and thus the April 2009 USAID Portfolio Review recommended reducing the number of sessions to eight. An outline of these eight modules is attached as Appendix C.

Part of SFH's long-term work plan for the CoH project was the gradual devolution of BCC activities to selected partners at the community level. This process was based on SFH's vision to transform its organizational approach from one focused on direct implementation to one characterized by facilitation and leadership of partners and networks engaging in large-scale BCC interventions. The concept was initially tested with independent volunteers and then expanded to include training of peer educators attached to suitable CBOs.

## PROGRAMMATIC PERFORMANCE

During the period under review, SFH documented impressive quantitative results for the CoH program and actually exceeded key quantitative result targets for 2008-2010 by a factor of four.3 Program indictors were changed from the original performance monitoring plan (PMP) to PEPFAR (President's Emergency Plan for AIDS Relief)-defined indicators during this period,

[3] For PEPFAR indicator "Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/ or being faithful," CoH's two-year combined target was 18,500, and total contacts reported was 74,291, while for "Number of individuals reached through community outreach that promotes HIV/AIDS and TB prevention through other behavior change beyond abstinence and/or being faithful," CoH's two-year target was 24,000, and reported contacts was 91,135.

which limited indicator-based comparison across the program. However, SFH's internal disaggregation of data per target group and intervention type suggest a sustained trend of increasing community contact with target groups, and conforms with expectations of a program that was designed – through the peer education and community mobilization model – to experience continual growth and expansion.

However, despite the program's successes in achieving and surpassing results targets, the quality of individual BCC contacts is frequently unclear due to the sheer number of contacts involved.[4] Reports also indicate that significant numbers of contacts were derived from BCC sessions that targeted large groups of people, such as a Health Awareness Day or video screening events. While such interventions can be valuable as part of a complete behavior change promotion package, by their very nature such public interactions preclude full audience participation and prevent the type of carefully targeted BCC needed to reach vulnerable MARP groups. There is therefore a concern that the quality of individual BCC contacts and interventions was neglected in the quest to achieve and report a high quantity of contacts.

## Message Targeting and Coverage

Both project documentation and stakeholder input suggest that SFH successfully developed and shared expertise in profiling and understanding their target groups, and modified BCC interventions accordingly. Indeed, SFH's CoH project reports show a wide variety of customized activities taking place to reach specific target populations, including abstinence training sessions for socio-marginalized youth; condom use and negotiation workshops for FSW; training-of-trainers (ToT) sessions for HIV Unit Coordinators in the Police Force; support group discussion sessions for vulnerable girls; and peer education on HIV prevention modified to meet the time constraints experienced by seafaring fishermen. Specific BCC messages were targeted according to the risk profile and needs of each MARP group, as outlined below.

### Sex Workers

Sex workers in Namibia are concentrated in coastal towns, in the capital city, and in border towns along major transit routes. SFH estimated the presence of 8,500 FSW within CoH target regions, based on extrapolation of World Bank national-level data. Due to a combination current legislation that criminalizes sex work, prevailing cultural prejudices, and religious dogma, sex workers are frequently socially marginalized[5] and therefore difficult to reach with conventional BCC approaches. FSW are highly vulnerable to HIV infection due to their high rates of partner change and inconsistent condom use, particularly with regular clients and boyfriends/partners. Primary CoH interventions for this group included PEPP, BCC role-play, workshops, and IPC, all of which focused on the need for consistent condom use and consequently emphasized condom negotiation skills. In some regions, SFH successfully established ongoing weekly PEPP sessions and monthly IPC sessions for FSW, while in a few communities FSW themselves became peer educators. This latter factor clearly enhanced the relevance of BCC messages and increased the likelihood of assimilation by other FSW.

Both CoH reports and input from SFH field workers underscored the fact that many FSW had no opportunity to generate an income besides sex work and there was consequently a need to create alternative routes to economic independence for these individuals. Furthermore, many FSW reported that clients refused to use condoms, but they had no economic choice but to

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[4] By way of illustration, in a single quarter (July 2009-September 2009) SFH narrative reports indicated that the CoH program made 113, 225 BCC contacts. Given the fact that this result was achieved by fewer than 100 peer educators, CHCs, and BCC officers, the figure suggests limited opportunity for genuinely individualized and targeted BCC.

[5] See LaFont, S. 2008, *Help Wanted: Sex Workers in Katutura, Namibia*, Monograph No. 2: Gender Research and Advocacy Project, Legal Assistance Centre, Windhoek, Namibia.

concede to high-risk sex. However, this information does not appear to have been used to modify behavior change messages, and the program continued to prescribe a potentially impossible action to FSW, i.e., consistent condom use. Given the fact that the CoH program focused on FSW in border and harbor towns, and that clients of these FSW included foreign tourists, fishermen, and transport workers who are known to be unwilling to accept condom use,[6] the program appears to have displayed unnecessary rigidity and lack of responsiveness in addressing the needs of this particular at-risk group.

### Vulnerable Girls

SFH estimates that there are 53,000 vulnerable girls living in CoH target regions. Many of these girls either are unemployed, or have only part-time or sporadic employment; a large proportion of them are single mothers. Members of this group are frequently economically vulnerable, and approximately half of them are believed to engage in transactional and/or cross-generational sex in exchange for food, gifts, or money. Girls in this category rarely consider themselves to be sex workers, and they require BCC messages that encompass both existing and potential high-risk behaviors. Initial BCC interventions for this group in the CoH program initially focused on training on abstinence and fidelity, but shifted toward a combination of abstinence, fidelity, and consistent condom use in response to program review recommendations. As with FSW, it is clear from reports and interviews that SFH workers are sympathetic to the fact that sourcing a monthly income remains a persistent problem for this group; engaging in high-risk sexual behavior is consequently seen as unavoidable. However, there is little indication that this awareness has informed program actions or BCC message content in any noticeable manner. Furthermore, there is no acknowledgement that vulnerable girls in transactional relationships typically have less power to negotiate consistent condom use than FSW: it is quite simply not possible for these girls to demand condom use (or monogamy) from the men who ensure their economic survival.[7]

### Transport Workers/ Truck Drivers

Major transport corridors run through Namibia from its primary port in Walvis Bay, Erongo Region, across the borders in the north with Angola and Zambia, and to the south with South Africa. Border crossings and their associated truck stops have become HIV hot spots as truck drivers wait for extended periods of time for goods to clear customs, and in the process attracting FSW and informal traders. SFH estimates that there are 2,000 truck drivers operating in Namibia, and the organization aimed to reach 80% of these through CoH interventions. Such interventions included information/promotional events at bars; video shows; and IPC and distribution of condoms and IEC materials, including CDs with key BCC messages. Efforts to reach this mobile population were strengthened in 2008 when SFH entered into a partnership with the Walvis Bay Corridor Group (WBCG) – a public-private partnership that manages all commercial routes in Namibia – to develop and distribute customized IEC. Field reports suggest that CoH activities not only reached this MARP segment, but also the touts who loaded and unloaded trucks, as this latter group were frequently observed at hot spots listening to CoH presentations. Anecdotal data suggest that CoH interventions are successfully raising awareness regarding HIV and high-risk sexual behavior among this MARP, as it has been noted that transport companies are now contacting the MoHSS's Central Medical Stores (CMS) to source condoms. Furthermore, HIV counseling and testing (HCT) sites are reporting that increasing numbers of transport workers are seeking HIV testing.

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[6] *Ibid*; also see LeBeau, D. 2006*, From Corridors of Mobility to Corridors of Hope: Mapping the Link between Mobility and HIV Vulnerability in Namibia*, International Organization for Migration (IOM) and Institute for Public Policy Research (IPPR), Johannesburg, RSA.

[7] *Ibid*.

### Seafarers/Fishermen

Of nearly 13,000 people employed in the fishing industry, approximately 2,000 are seafarers, of which the CoH program had a target to reach 80%. An initial mapping exercise identified seafarers' primary land-based residential quarters as well as the bars and other hot spots that were frequented; HIV-focused IPC was subsequently conducted at these sites. An agreement between SFH and the Namibian Maritime and Fisheries Institute (NAMFI) – whose mandate is to provide maritime training for seafarers – enabled SFH to directly access this group with CoH BCC messaging through a variety of media, including the provision of formal HIV-related training as an integrated component of the seafarers' security courses; modified PEPP for fishermen going to sea; IPC in bars and club houses; placement of IEC posters in workplaces and on board ships (in partnership with the Namibian Port Authority); and distribution of HIV-related IEC materials. The SFH office in Walvis Bay was well placed to target this MARP due to its close proximity to the entrance to Namport harbour; thus, as men came from ships and passed the SFH office, staff members were able to hand IEC materials and condoms directly to them.

### Uniformed Officials

During the period under review, there were an estimated 17,000 people working in the Namibian Police Force many of whom were posted away from their homes and families for extended periods of time. The officers also consequently engaged in high-risk behaviors including MCP; sexual relationships with FSW; and alcohol misuse. SFH established a target to reach 60% of the Police Force with BCC, primarily through CoH's sister program PolAction. Key BCC messages for this target group focused on a broad range of issues, including abstinence, fidelity, the dangers of MCP, alcohol misuse, and testing/treatment of HIV and other STIs. Toward the end-of-project period, messages related to male circumcision (MC) were also incorporated.

In the PolAction implementation model, two police officers from each station were trained as peer educators under a specially customized PEPP program; these individuals subsequently facilitated BCC sessions at their respective stations and trained additional peer educators. During the course of the project, ownership of the PolAction program – and consequently responsibility for implementation – was transferred to the Police Force, with SFH's input being limited to technical assistance. However, this implementation model also entailed that the program's success showed considerable variance from region to region; in areas where there was no dedicated PEPP officer, or where he or she was overloaded with other duties, the program yielded limited results. Overall, there is evidence that the PolAction program was well received by police personnel, and PEPP was frequently conducted as a recreation activity (through "edutainment" sessions). A study[8] conducted by SFH suggested increasing condom use and HIV testing and decreasing stigma among the target group, although it is not clear which baseline or earlier study was used as the foundation for this comparative analysis. However, anecdotal reports from police appear to support these findings, with (casual) observations of reduced high-risk behavior, stigma, and infections as well as increased demand for condoms and HCT services.

### MSM

The introduction of MSM as a CoH target group occurred in response to recommendations made in an April 2009 USAID Portfolio Review. However, due to a combination of current legislation that criminalizes homosexuality, entrenched cultural prejudices toward sexual minorities, and a very real risk of social ostracism, these are hidden populations of men and

[8] SMA, 2009, Sexual behaviour and HIV risk reduction practices among the Namibian Police, 2008/2009, Research Report; SMA, Windhoek, Namibia.

typically accessible only through the social and sexual networks of other MSM. Thus, to effectively reach MSM, SFH entered into a collaborative agreement with The Rainbow Project (TRP) – an organization that worked to promote the rights of members of the lesbian, gay, bisexual, transgender, and intersex community – to map MSM in the country and develop an HIV-prevention program and customized BCC materials to meet their needs. However, the subsequent dissolution of TRP prevented this collaborative effort. While SFH independently conducted the MSM mapping exercise, no MSM-specific BCC messages or IEC materials were developed. Evidence suggests that the needs of MSM were never addressed by the CoH program.

## Coverage and Quality of BCC Interventions

Despite evidence that SFH successfully profiled the needs of CoH target groups and developed customized BCC messages and interventions accordingly, it is unclear what coverage the program actually achieved among MARPs. Indeed, despite the program's stated objectives – and SFH's own mandate – to focus HIV prevention primarily on MARPs, project documentation indicate that the vast majority of CoH BCC contacts involved members of the general population.[9] Although this shows that the CoH program was achieving an important part of the project's second objective – i.e., to reach young women and girls *and the communities in which they live* – it also suggests that MARP-focused BCC actually comprised a relatively small component within the program. Comparing a simply tally of MARPs reached with estimated target group size does not yield information about program coverage, as the implementation methodology (in which peer educators and CHCs often visited the same site several times in the same month/quarter) and lack of unique identifiers for individual BCC contacts created a significant risk of double counting. A simple comparative analysis of project data suggests that such double counting has indeed been commonplace.[10]

Beyond this, project narrative reports also raise questions regarding the quality of individual CoH BCC contacts, not only due to the large numbers involved, as noted earlier in this report, but due to the settings in which BCC occurred. Non-interactive settings – such as road shows and video screenings – generated large numbers of contacts, but suggest that the BCC contacts were quite superficial. Similarly, bar promotions appear to have been a popular method of reaching vulnerable women and girls (although how members of this group were identified as such is not clear), but many of these promotions focused primarily or extensively on abstinence-related messages.[11] The suitability of crowded bars for sharing intimate behavior change messages related to sexual abstinence or partner fidelity is not immediately clear.

Nonetheless, the results achieved by the CoH program were generally seen in a very positive light by stakeholders and partners at both the regional and national level, and the program was widely perceived to play a crucial role in complementing the government's programming for MARPs. The professionalism displayed by SFH personnel was also frequently noted, and was highly regarded and appreciated by partners at community and regional levels.

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[9] For example, in the 4th quarter of 2008, 92% of all BCC contacts were either categorized as "youth" or "general population," and only 8% as CoH-defined MARPs; see *SMA Progress Report FY09 Quarter 1 (Oct 2008- Dec 2008)*. Similar distributions were a feature of all CoH project process reports.

[10] For example, CoH progress reports note that CHCs reached 4,193 FSW during a single quarter of 2009; given that SFH had previously estimated the total number of FSW in Namibia as 6,100, this achievement would have entailed that the project reached nearly 70% of all FSW in the country. While such results would certainly be laudable, the report also shows that nearly 1,800 of these FSW contacts were made in a single mid-sized town which – while on a major transport corridor – is unlikely to claim nearly 30% of the country's total population of FSW.

[11] For example, see SMA Progress Reports for FY 08 Quarter 4 and FY09 Quarter 1.

## INFORMATION, EDUCATION, AND COMMUNICATION MATERIALS

IEC materials used in conjunction with the CoH project were observed to be interesting, of good quality, and highly relevant to messages conveyed during BCC sessions. In particular, flipcharts were noted to be popular among both CHCs and members of the target audience, as they encouraged active participation by group members. However, all written materials observed were in English, which limited their relevance for several segments of the target populations. This fact also entailed that many CHCs and peer educators found themselves constantly changing between languages as they were required to read materials in English and then attempt to stimulate discussions in the audience's local language. The need for local language and audio-visual IEC materials was emphasized by stakeholders, as well as the importance of involving partners in revising IEC materials and standardizing HIV prevention messages.

In response to recommendations in a 2007 Program Assessment that called for greater use of participatory approaches, SFH made plans to develop additional interactive communication channels during the project's second half. These methods included interactive IEC such as flannelograms and board games, designed to stimulate discussions that promote positive behavior change; a "listening group device" which would enable CHCs to moderate discussions in response to pre-recorded BCC messages; community outreach in form of singing, drama, competitions, and video shows; and "community branding," which made use of imagery such as wall paintings to reinforce HIV-prevention messages conveyed through IPC sessions. Flannelograms were successfully introduced in the second year of the program period, and rapidly proved to be a popular BCC method. However, other interactive materials had not been finalized or fully implemented at the time of this report.

Although the creativity evident in the development of CoH IEC materials and communication channels is laudable, there were important concerns expressed by stakeholders and partners that target groups were not adequately involved in developing key messages. Project documentation contains a single, isolated reference to the use of focus group discussions when pre-testing one piece of IEC material. SFH's failure to include MARPs in identifying key issues and appropriate behavior change messages is a cause for concern, as this automatically limits the relevance – and subsequent uptake – of messages conveyed.

## HOLISTIC APPROACH TO HIV PREVENTION

SFH outlined a comprehensive system to ensure that all individuals targeted by CoH received appropriate advice and, where necessary, referral to auxiliary services. Referral was provided both for clinical services – such as HCT, STI diagnosis and treatment, anti-retroviral (ARV) treatment, and prevention of mother-to-child infection (PMTCT) – and for non clinical support, including legal advice, help for orphans and vulnerable children (OVC), and home-based care (HBC) for PLWHA. Referrals were made to an extensive network of CBOs and government agencies to create linkages to resources that people otherwise might not have known existed. However, despite the existence of an excellent theoretical framework and well-written guidance document, implementation of the CoH referral system was uneven and follow-up was generally poor. Referral cards that were dutifully collected each month by SFH staff do not appear to have been used to evaluate or inform the process, and follow-up of individual clients was sporadic and appears to have been wholly dependent on the individual motivation of the referring CHC or PolAction peer educator.

Functional follow-up of the referral system was documented in (only) one CoH region, and resultant data indicated that two-thirds of referred individuals had sought services from the institutions where they had been referred. SFH staff acknowledged that referral to local services was potentially a deterrent to the remaining third, who may have preferred to seek sensitive services (such as those related to HIV testing or treatment) outside of their own community. The cost of auxiliary services was also noted as a barrier to access, as well as the fact that certain socially stigmatized MARPs – such as FSW and MSM – are frequently met by judgmental or abusive attitudes from health care workers, and may be denied services. These observations, which are borne out by both numerous studies[12] and widely cited anecdotal data, highlight the challenges of implementing isolated interventions (e.g., referral to auxiliary services) in the absence of structural change. Project documentation alludes to SFH's plans to enhance the referral system by adding incentives (such as discounted fees or IEC materials) for people who present their referral card at designated sites, and by training workers at referral partners in MARP-friendly approaches; however, there was no evidence of concrete action on this matter at the time of this evaluation.

In addition to proving referral to auxiliary services, there was clear evidence that SFH was implementing or exploring initiatives that would expand the scope of its HIV-prevention work. One such complementary intervention was the social marketing of condoms (an initial objective of the CoH program), which greatly increased access and enhanced the government's efforts to scale up distribution. Through the CoH program, SFH also provided technical assistance to WBCG to help establish the North Star Alliance Roadside Wellness Center, which offered HIV-related services and advice from its strategic position on a major transport corridor. During the CoH program's second year, SFH senior management explored the possibility of integrating male circumcision as a component of the organization's HIV prevention work, as well as providing testing and treatment for TB as an auxiliary service. In this conjunction, senior SFH staff visited PSI Zambia to incorporate ideas from their MC strategy into an SFH MC pilot program, and SFH staff and affiliates at national, regional, and implementation levels received basic training in TB in order to facilitate integration of TB activities in SFH operational regions.

Although the CoH program demonstrated considerable competence in addressing individual-level risk factors for HIV through BCC, there is virtually no evidence of policy or advocacy work to address the environmental and structural forces the increase MARPs' vulnerability to HIV. Project reports are devoid of reference to specific advocacy efforts, and key partners indicated that SFH had failed to make noteworthy contributions to MARP-related policy or advocacy efforts. Indeed, partner organizations noted that SFH failed to attend the National Prevention Technical Advisory Committee formed by the MoHSS's Directorate of Special Programmes (DSP), which in turn prevented them from providing input to, or receiving guidance from, the Committee's National MARPs Technical Working Group. However, this shortcoming in terms of advocacy efforts appears to have been acknowledged by SFH senior management following the conclusion of the CoH program period, and there are tentative plans to develop and host an advocacy forum for organizations working with MARPs.

[12] See LaFont, S. 2008, *Help Wanted: Sex Workers in Katutura, Namibia*, Monograph No. 2: Gender Research and Advocacy Project, Legal Assistance Centre, Windhoek, Namibia; Baral, S. et al. 2009, HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana, *PLoS ONE*, 4(3): e4997.

# KEY FINDINGS: ORGANIZATIONAL CAPACITY

## STAFF CAPACITY AND COMPETENCE

During the period under review, SFH developed a new, streamlined staffing structure to improve the organization's efficacy and improve anchoring of BCC programs within their target communities. Administrative staff at national and regional levels received extensive organizational development training to strengthen their capacity within the general areas of operations, finance, human resources/administration, and logistics, as well as within specialized topics such as management information systems (MIS), gender mainstreaming, and research. (Much of this training was conducted to bring all financial reporting and MIS protocols in compliance with requirements so SFH could be certified to receive direct funding from the U.S. Government; however, ascertaining the full extent to which this was achieved is beyond the scope of this evaluation.[13]) Although there was high turnover of key staff members during the project period, the regular nature of capacity building trainings appears to have ensured that acquired knowledge and skill sets remained within the organization.

At the implementation level, BCC officers received ToT instruction in CoH methodology and messaging, and in turn trained CHCs, peer educators, and other volunteers. Field staff does not appear to have benefited from any subsequent or follow-up training in BCC and interventions, but during the latter part of the program were able to access relevant information through newly developed PEPP manuals and a Peer Educators' Handbook. Although SFH officers intermittently attended CHC-conducted BCC sessions and provided mentoring as deemed necessary, there was widespread concern among both field-level implementers and key community members that the lack of regular refresher trainings on key messages and BCC interventions compromised program quality. A requirement for all BCC officers was that they were to have at minimum a grade 12 education, as they were also responsible for collecting or supervising the collection of data from CHCs. There was no indication of any minimum educational requirements or suitability testing for volunteers.

Supervisory activities were conducted routinely either by SFH staff alone or in teams with key stakeholders such as MoHSS. In this connection, SFH established a Field Visit Quality Assurance Check List to ensure a useful and uniform procedure; however, SFH was not able to produce a completed check list for the evaluators to review, nor could they document any written evaluation or set of recommendations resulting from these supervisory visits. That these visits were of limited value in terms of providing useful input to field-level workers or informing program actions was evident from CHC and volunteer comments, who claimed that they rarely, if ever, received feedback on their performance from SFH staff. Furthermore, the supervisory visits were perceived to primarily serve as fault-finding missions, as opposed to providing motivational support and helpful guidance.

Nonetheless, despite the limited scope of training and supervision received, CHCs and peer educators working within the CoH program were observed to be highly skilled at their task, and readily able to address sensitive or taboo topics in a culturally appropriate, clear manner. Field visits made to BCC sessions in conjunction with this evaluation highlighted the value of CHCs working directly with their own community, as they were known and welcomed at all sites (even in the absence of a pre-existing appointment), were readily able to communicate in local languages, and rapidly established good rapport with their audiences. Difficult questions and

[13] Specific actions relate to the findings of the Defense Contractors Audit Agency (DCAA) audit conducted in April 2007, as well as overall strengthening of internal financial, information management, and human resources procedures.

challenging situations were noted to be dealt with in a calm and capable manner, and CHCs appeared able to engage their audiences regardless of the BCC setting.

However, despite reports from CHCs and volunteers that they valued the sense of empowerment that they felt as a result of their training and role as educators, the CoH program's reliance on these uncompensated volunteers jeopardized the program's sustainability – and the consistency of BCC messaging – due to high levels of volunteer attrition. The possibility of addressing attrition through incentives such as stipends, t-shirts, and certificates was pro-actively reviewed by SFH, although no definitive compensation policy was evident at the time of the evaluation. It should nonetheless be noted that this process was complicated by the fact that any such incentive was required to be in keeping with national guidelines on volunteer compensation, and that this policy document was still under development at the conclusion of the period under review.

During the latter part of the CoH program period, SFH started to phase out the use of SFH-affiliated volunteers, and instead contracted with local CBOs to conduct CoH BCC activities. Not only was this process intended to ensure program sustainability, but it was also directly aligned with SFH's organizational vision to replace its existing focus on direct implementation with one characterized by facilitation and leadership of strategic partners conducting HIV-prevention BCC. Once suitable CBOs were identified and agreed to participate in the program, SFH provided technical training in the PEPP program to selected individuals within the CBO, who in turn assumed responsibility for providing BCC to identified target groups within their community. Representatives from CBOs reported that their organizations had not received any formal follow-up training from SFH, but that mentoring, training, and demonstrations had occasionally been provided during and after outreach sessions.

The use of CBOs for BCC interventions appears to be successful insofar that CBOs were observed to cooperate well with local authorities and were familiar with informal structures and key issues relevant in their own communities. However, CBOs also relied heavily on un- or under-compensated volunteers to conduct their work, and thus experienced the same high rates of volunteer attrition as the SFH regional offices. Furthermore, the technical competence and capacity of CBOs selected as SFH implementing partners was often minimal, and several were found to have extremely limited knowledge on programmatically important issues such as participatory approaches to BCC or community-led development.

## DECENTRALIZED OPERATIONS

An operational strength that was noted by virtually all SFH partners and stakeholders was the organization's decision to implement projects through a decentralized structure in which regional offices assumed a significant degree of managerial responsibility for their program activities. Under this organizational model, each CoH regional manager was responsible for creating work plans for his or her region, based on programmatic decisions made by SFH senior management. Regional managers were entitled to adjust implementation plans, work schedules, and specific financial and human resource allocations, but did not have authority to alter the CoH technical implementation model. Financial decentralization was not operational at the time of this report, although plans were in place to pilot this in select regions.

The decentralization of CoH activities was repeatedly identified by stakeholders as a crucial factor in the program's success, as it enhanced the consistency, coverage, and quality of BCC interventions, and helped ensure the local relevance of specific messages. SFH's regional operations were also perceived to increase access to key services by MARPs, as they provided a natural contact point for information, support, and referral within targeted communities. In certain areas the CoH project was believed to be the only one offering HIV prevention services

to MARPs; although there were in fact other MARP-focused HIV-prevention organizations operating in all but one CoH implementation regions,[14] the perception is still valuable, as it illustrates the program's visibility within the community. That CoH activities were visible and well-known in the communities is further reinforced by an independent study (conducted immediately prior to this latter program period), which noted that FSW in several hot-spot communities identified hospitals, clinics, and SMA/SFH offices as key service points.[15]

The CoH program's decentralized operations also enabled SFH to establish or strengthen relationships with key stakeholders at the community and regional levels, and to enter into partnerships with relevant organizations working on similar or complementary issues. SFH entered into formal partnerships with several organizations – such NAMFI, WBCG, and the Namibian Police – all of whom reported that their partnerships with SFH had been productive and beneficial, and that they were consequently interested in scaling up existing joint activities or exploring possibilities for additional collaboration, In addition to these formal relationships, SFH also worked with a large and diverse range of NGOs and international agencies on a variety of joint implementation, experience-sharing, or resource-pooling activities.[16] Both oral reports and project documentation suggest that these collaborative efforts effectively strengthened both SFH and its partners, and enhanced the provision of MARP-related services and support. However, it was also noted that despite SFH's widespread network of implementing and strategic partners, overall coordination among organizations working with MARPs was extremely weak, which meant there remained substantial gaps in the national response for MARPs.

## RESOURCE LEVERAGING

While the CoH program (during the period under review) was fully funded by USAID, SFH received funding for other projects from a range of different donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the U.S. Department of Defense (DoD), and Procter & Gamble. The PolAction program was jointly funded (50/50) by USAID and GFATM, which enabled SFH to increase the scope and impact of its HIV-prevention BCC program through non-USAID resources. Many of SFH's implementing partners also received funding through GFATM, thus effectively leveraging each others' programs. SFH also successfully capitalized on PSI regional resources by accessing expert training and technical assistance in areas such as BCC, IPC, prevention programming, research, and monitoring and evaluation (M&E), all of which helped to enhance the quality and impact of CoH BCC interventions.

[14] See Namibia Network of AIDS Service Organizations (NANASO) 2008, *Directory of AIDS Service Organizations (ASOs)*, Windhoek, Namibia.

[15] See LeBeau, D. 2006, *From Corridors of Mobility to Corridors of Hope: Mapping the Link between Mobility and HIV Vulnerability in Namibia*, IOM and IPPR, Johannesburg, RSA.

[16] Examples include an SFH-hosted ToT workshop on IPC that was attended by partners from Nawa Life Trust, The Rainbow Project, and the National Social Marketing Program (NASOMA), and a 2008 Literacy Survey that was conducted as a joint effort by SFH, Nawa Life Trust, TRP, Positive Vibes, and Family Health International.

# KEY FINDINGS: RESEARCH, MONITORING, AND EVALUATION

## DATA COLLECTION AND USE

Substantial resources were dedicated to the provision of training and support in M&E during the period under review, with the intention of ensuring that implementation of the CoH program was informed by accurate data and strengthening SFH's capacity and competence in data collection and use. A CoH-specific M&E plan was developed in collaboration with USAID that listed all program objectives and indicators, as well as a relatively unspecific summary of steps for data collection and reporting, and quality assurance. An SFH-specific MIS manual was developed to improve data collection, reporting, storage, and use; all staff working with M&E and MIS received annual training in these topics. Data flow followed a simple structure in which CHCs collected pertinent data as part of all BCC activities and reported these to the appropriate regional officer. Data were then submitted in both electronic and hard copy format to SFH's head office on a monthly basis, where they were verified and captured in appropriate templates. Certain data sets were subsequently reported to the appropriate government ministries in accordance with Namibia's national framework for data collection and coordination, with relevant ministries noting that SFH consistently reported required data in a timely and professional manner. However, at this point the flow of data appears to have terminated, and both regional staff and implementing CBOs noted that they received little or no feedback from the head office regarding either their performance at the regional level or the overall achievements of the CoH program. Similarly, key stakeholders at all levels noted that SFH had failed to routinely share CoH data and progress reports, and that such data were typically only disseminated through occasional presentations at high-level meetings.

At an organizational level, the use of CoH data to evaluate and improve program implementation was limited by a lack of baseline data, which prevented quantitative assessment of programmatic achievements and challenges. Furthermore, program indicators were changed from those defined on the original PMP to standardized PEPFAR indicators during the program, which not only created difficulties for staff involved in data collection and analysis but also limited the comparability of data across the life of the program. This challenge was compounded by the repeated revision and refinement of target groups, which meant that very few data sets were defined and counted in the same way throughout the program's duration. It is important to note that these limitations can all be attributed to changing donor requirements and expectations, and were thus essentially beyond SFH's control. Thus, instead of reflecting negatively on SFH, they instead attest to the tenacity and dedication of CHCs and volunteers who readily accommodated frequent programmatic adjustments.

As previously noted, the quality of data reported from the CoH program is likely to have been compromised by the relatively informal, unstructured schedule for BCC interventions in which CHCs and peer educators tended to visit the same sites on several occasions during a given month or quarter; this tendency – in combination with the lack of unique identifiers for BCC recipients – automatically created a situation conducive to double or triple counting of contacts. While data thus reflected the total number of BCC contacts within a given period, they provided no information on the degree of BCC coverage achieved within a target group.[17] Consequently, SFH's intention to establish the size of individual CoH target groups for "each

[17] By way of illustration, during a single quarter the CoH program reported reaching 2,033 trucker drivers with HIV-prevention BCC. Given that SFH had previously established that the size of this target group was 2,000, the program (erroneously) appears to have achieved nearly 102% coverage; see *SMA Progress Report for FY10 Quarter 1 (Oct 2009-Dec 2009)*.

region to be allocated specific targets to be reached per target group"[18] could not be realized; as a result, the mapping exercises understandably made a minimal contribution to program planning. Indeed, there is little evidence of instances where project data have been used to inform specific program direction, and instead nationally available data appear to have guided planning processes. One clear exception to this is the PolAction program, where data appear to been regularly transformed into pertinent information that was in turn used to modify and improve the program. This is most likely attributable to the concise implementation format and schedule of the PolAction program, in which individual peer educators could be expected to have good oversight of the degree of BCC coverage achieved among their colleagues.

## RESEARCH, EVALUATION, AND QUALITY ASSURANCE

Applied research is an important and integral component in the process of developing BCC interventions and messages, and permits the internal evaluation of program quality and achievements. Recognizing this, SFH has made ongoing investments in the development of research capacity within key staff since its establishment. Research has consequently been conducted into several highly relevant areas to generate useful information and data to support sound programmatic decision-making. Examples of such studies include a report profiling *shebeens* (informal bars) to enable effective targeting of BCC at *shebeen*-based promotional events, and a mapping exercise of the lesbian/gay/bisexual/transgender/intersex (LGBTI) community to establish sizes of individual groups in the country. Another highly important study conducted during the second year of the program was a PSI-designed Tracking Results Continuously (TRaC) survey among police officers; using a large sample size and rigorous methodological approach, the researchers were able to identify key high-risk activities among this population, allowing for refinement of specific BCC within the PolAction program. However, the quality of research conducted was uneven, and while several studies were technically sound, others appear to have been based on an opaque hypothesis and inappropriate methodological approach. By way of illustration, the mapping exercise noted above was based on interviewing small population samples in select towns and requesting their opinion on the number of individuals with a specified sexual orientation living in the area; this yielded highly unspecific estimates, with, for example, the "number of gay men in Windhoek" being reported as ranging from a minimum of 7 to a maximum of 30,000.[19] The value of such "data" for program planning purposes is unclear.

The importance of regular programmatic evaluation through qualitative and quantitative methods is emphasized in the CoH program's M&E Plan, and appropriate data collection tools have been developed. There is evidence of several such evaluations having been planned, but it appears that limited financial and human resources dedicated to this purpose – in combination with inadequate prioritization of monitoring activities – have compromised SFH's ability to conduct such activities. Nonetheless, those evaluations that have been performed were highly relevant and appear to have informed CoH programming.

Regular organizational evaluations are also crucial to ensuring consistent program quality and performance. In this conjunction SFH developed a Field Visit Quality Assurance Check List to be

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[18] PSI/SMA, 2008, Technical Program Proposal for Modification of Cooperative Agreement No. 690-A-00-05-00126-00/ USAID: HIV/AIDS Prevention and Care Program in Namibia, April 1, 2008 – March 31, 2009, Washington, DC, p.10.

[19] It should also be noted that the researchers involved did not appear to fully understand the issue being investigated, as populations of lesbians, gays, bisexuals, MSM, and women who have sex with women (WSW) were all presented as mutually exclusive categories; see SFH2009, LGBTI, WSW and MSM Mapping Report, SFH and TRP, Windhoek, Namibia.

completed during supervisory visits. It was not possible to assess the use and impact of this checklist, as SFH was unable to produce a completed check-list for the evaluators to review or to document a written evaluation or set of recommendations resulting from the use of these checklists.

# LESSONS LEARNED AND RECOMMENDATIONS

## KEY ACHIEVEMENTS, CHALLENGES, AND LESSONS LEARNED

### Behavior Change Communication

During the program period under review, SFH successfully expanded the scope and scale of the CoH program to a point where it became a well-recognized and highly respected component of Namibia's national response to HIV. Considerable efforts were made to ensure program quality through a process of continual assessment and refinement of target groups and behavior change messages, with the program making use of a diverse and contextually appropriate range of BCC interventions to convey key concepts. The CoH program documented impressive quantitative results and exceeded its targets for the majority of objectives. However, the numbers reported suggest that the quality of individual BCC contacts was sacrificed in the quest for quantity, and the majority of contacts appear to have been quite superficial. This raises questions regarding the expected impact of the program, as BCC on sensitive issues such as HIV is typically only effective in small group sessions wherein individuals become cognitively engaged through active participation and feedback. In the absence of such intimate settings, the messages are more likely to serve an awareness-raising function, as opposed to one designed to stimulate sustained behavior change.

A key component of SFH's mandate was to work with MARPs, and the organization made laudable efforts in identifying, defining, profiling, and measuring its MARP target groups, and developing appropriate methods with which to reach them. It is clear that SFH developed considerable expertise in understanding the specific needs of individual at-risk populations, and successfully reached both mobile and stationary/border populations with innovative and cleverly customized BCC approaches. The program achieved high visibility in target communities and SFH personnel were identified as a valued source of HIV-prevention information and support. Program implementation was enhanced in some regions where certain CHCs and peer educators were themselves MARPs; this naturally increased their understanding of issues and challenges involved, and permitted behavior change messages to be further refined. However, despite the CoH program's focus on MARPs, the vast majority of those reached with BCC interventions were members of the general population. Since these individuals were likely to already be benefiting from a broad range of similar HIV-prevention programming conducted by other NGOs, CBOs, and faith-based organizations (FBOs), this fact suggests that SFH failed to maximize its comparative advantage as a specialist in MARP-focused BCC.[20]

Despite the CoH program's strong focus on achieving a specified degree of BCC coverage within a target group (typically 60 or 80% of a given MARP), the manner in which the program is implemented – via repeated visits to the same sites and infrequent use of participant logs – automatically precludes an accurate estimate of coverage. Changing the program's relatively casual implementation model is not viable without compromising both community access and participant privacy, which suggests that the overarching emphasis on coverage is not compatible with the program's structure. Furthermore, many of these targets appear to have been set quite arbitrarily, with no clear basis in previous results or organizational capacity, which raises further

[20] There is nonetheless inherent value in educating the community at large in border and/ transport corridor communities, as partners of mobile workers represent a frequently overlooked high-risk group. Research suggests that in HIV-discordant couples where the man has a migrant or mobile occupation, one-third of the time it is the woman who is infected with HIV while her partner is negative; see Lurie, M., et al. 2003. Who infects whom? HIV-1 concordance and discordance among migrant and non-migrant couples in South Africa, *AIDS*, 17: 2245-52.

concerns regarding their relevance. Any follow-on project specifically targeting MARPs should therefore consider whether to prioritize degree of coverage by encouraging high numbers of BCC contacts, or instead focus on message impact through the use of small-scale intensive IPC approaches.

IEC materials developed and used in conjunction with the CoH project were of consistently high quality as well as interesting and relevant to the needs of individual target groups. In response to community feedback and formal recommendations, SFH successfully introduced several interactive communication methods that actively engaged the audience in discussing and exploring key ideas. However, a reliance on English-language materials limited the usefulness of CoH materials among certain age and ethnic groups. Similarly, a failure to actively involve target MARP groups in identifying key issues and suitable behavior change messages is likely to have compromised the MARP-specific relevance – and consequent uptake – of the message.

Behavior change messages can only generate sustained changes if the desired behavior is actually viable. It is therefore critical to ensure that individual BCC messages are appropriate for a particular audience. Thus, promoting consistent condom use to an FSW may achieve little if the individuals in her clientele refuse to pay for sex with a condom; encouraging abstinence among vulnerable young girls is futile if they have no economic alternative for survival than to engage in transactional sex. Volunteers and CHCs working with the CoH program demonstrated sensitivity to these issues, and empathized with the challenges that many of the program's participants faced. However, this issue also highlights the fact that BCC cannot function in isolation, but should instead be viewed as a single component of a holistic system that creates an enabling, supportive environment conducive to personal risk reduction.

An important aspect of this type of holistic approach is the provision of comprehensive referral to relevant auxiliary services; SFH worked toward this by establishing a sound theoretical and logistical foundation for a strong referral system that includes both clinical and non-clinical services. However, the referral structure was operationally sub-par, as poor follow-up by SFH staff prevented the formation of a dynamic and responsive system. Furthermore, referred services were frequently not accessible due to barriers created by cost or staff that were insensitive to the specific needs of MARPs; this is a relevant issue, and the fact that stigmatized and socially marginalized groups such as FSW and MSM are often afraid to seek services has been well documented.[21] Given the CoH program's excellent access to individuals with elevated risk and consequent vast potential to enhance community access to crucial services, an absolute priority in any future CoH activity would be to strengthen and refine SFH's referral system. This would include ensuring that referral points were MARP-friendly, which could be readily accomplished through strategic partnerships with organizations that already provide MARP- and adolescent-friendly services, such as Namibia Planned Parenthood Association (NAPPA), or with specific organizations working directly with stigmatized groups, such as OutRight Namibia (ORN) for members of the LGBTI community and Rights Not Rescue Trust (RNRT) or Red Umbrella for sex workers who can provide customized training for workers in relevant services. Collaboration with organizations providing opportunities for income generation would also enable some individuals to avoid the high-risk behavior inherent in transactional sex.

A major weakness in the manner in which the CoH program was implemented was the lack of advocacy work addressing structural-level factors that elevate HIV risk. Given the parallel forces

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[21] See LaFont, S. 2008, *Help Wanted: Sex Workers in Katutura, Namibia*, Monograph No. 2: Gender Research and Advocacy Project, Legal Assistance Centre, Windhoek, Namibia; Baral, S., et al. 2009, HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana, *PLoS ONE*, 4(3): e4997.

of legislation which criminalizes the behavior of sex workers and MSM, and cultural attitudes which stigmatize and isolate these same individuals (while paradoxically tolerating statutory rape, incest, and sexual exploitation), there is clearly a great need for community- and national-level advocacy on behalf of MARPs. At a national level, coordination among organizations working with MARPs is poor, leading to substantial gaps in the county's HIV response for these individuals. This suggests the potential for SFH to make substantial contributions on the advocacy front, and potentially even to take a leadership or coordination role to unify and strengthen the efforts of MARP-focused organizations.

## Organizational Capacity

In line with stated objectives, SFH's organizational strength increased through extensive staff training and capacity-building exercises, although these were primarily directed toward staff based in central and regional offices. While CHCs and other field-level volunteers received initial training in BCC messaging and methods, they did not benefit from regular follow-up trainings or supportive supervision, both of which potentially compromised the quality of interventions. Despite these hindrances, CHCs and volunteers were widely observed to be skilled at providing culturally and linguistically appropriate behavior change messages to diverse target audiences. Indeed, CoH volunteers were renowned and appreciated for their professionalism and technical competence.

Since implementation of the CoH program relied heavily on the efforts of under-compensated individuals, it suffered from high levels of volunteer attrition; this in turn jeopardized both the sustainability and consistency of community-level interventions. Given the fact that field-level implementers were the foundation of the program, it seems inappropriate that they received so little training, support, and compensation. Instead, their skills should have been developed and retained through regularly scheduled training and supportive supervision, as well as suitable incentives such as financial compensation or possibilities for professional growth and advancement. Similarly, regional BCC officers responsible for overseeing program implementation and data collection needed opportunities to develop their skills and capacity, particularly in light of the increasing number of managerial tasks they were required to perform in conjunction with decentralization of operations. Weaknesses in the technical competence and administrative capacity of CBO implementing partners suggest that they too would benefit greatly from targeted capacity-building exercises and ongoing technical assistance from SFH.

The decentralized nature of SFH operations was an important factor in the success of the CoH program, as it enhanced the consistency, coverage, and quality of BCC interventions while simultaneously ensuring the local relevance of the conveyed messages. Regional offices also provided a natural and relatively accessible contact point for MARPs seeking information, support, or referral, and greatly enhanced the visibility of the program within target communities. Decentralized operations also enabled SFH to more effectively mobilize local community leaders as well as establish or strengthen partnerships with key regional and national stakeholders. These collaborative efforts effectively strengthened both SFH and its partners, enhanced the provision of MARP-related services and support, and leveraged resources between organizations and programs. Given the large number of organizations working with HIV-related issues in all SFH operational regions, it is probable that certain opportunities for collaboration and cooperation have not yet been explored. A mapping exercise of all relevant organizations and their implementation foci would facilitate future partnerships, avoid unnecessary duplication of interventions, and potentially yield greater impact from available resources. It would also provide a valuable starting point for addressing gaps in the coordination of organizations working with MARPs.

### Research, Monitoring, and Evaluation

SFH invested considerable resources toward strengthening the organization's M&E systems, including the development of an MIS manual and staff-specific training in data management and reporting, all of which enhanced program monitoring. A functional CoH-specific M&E plan was developed, but while it represented a good checklist for M&E personnel, it did not make provision for documentation of the program's achievements beyond the indicators listed or for placing them in the context of SFH's programming as a whole. Since the success of behavior change interventions is equally dependent on the quality of messaging and the population coverage achieved, it would seem beneficial to move beyond the existing simplistic system of data collection – wherein the primary focus is on the number of people reached – to a structure that captures intervention content and quality.

Data flow from the field functioned well, and relevant data of national interest were conveyed in a timely manner to pertinent government ministries. However, feedback to field-level staff was minimal, which was unfortunate, as this gap deprived staff of the motivation derived from seeing progress toward stated targets as well as the opportunity to participate in identifying specific areas for improvement. Additionally, such one-way movement of data prevents reporting staff from understanding the true purpose of data collection and can thus erode interest in ensuring reporting accuracy and completeness. Communication of program results to partners and stakeholders was also weak, which precluded SFH from effectively showcasing achievements and fostering support at community, regional, and national levels. Ensuring regular feedback to all interested or involved parties should therefore be a central component of any future intervention.

The use of standard program data for planning was compromised by the lack of baseline data, as well as by a mid-program change of indicators and repeated revisions and refinements of target groups; as a result, nationally available data were frequently prioritized in planning processes. Isolated studies were conducted by SFH's research department to profile certain populations or issues. Some of these studies were useful in enhancing understanding of issues related to specific target groups, allowing BCC interventions to be modified or refined accordingly. The studies also provided evidence of inherent weaknesses in the organization's capacity to design and conduct relevant research, suggesting that isolated workshops and training sessions are insufficient for instilling rigorous research skills.

A combination of financial and human resource constraints as well as inadequate prioritization of monitoring processes precluded routine programmatic evaluation, thus limiting SFH's ability to consistently ensure and maintain program quality. Nonetheless, results achieved by the CoH program were generally seen in a strongly positive light by stakeholders and partners at all levels, with the program widely perceived as having played a crucial role in complementing the government's current programming for MARPs.

## RECOMMENDATIONS

### 1. Increase access to specific at-risk populations through strategic partnerships

Existing partnerships with organizations such as NAMFI and WBCG have greatly increased access to specific target populations such as seafarers and transport workers; these collaborations should be scaled up through cooperative agreements and joint work plans. Partnerships with other relevant organizations working directly with stigmatized groups – such as ORN for members of the LGBTI community and RNRT or Red Umbrella for sex workers – should be formalized. This will permit greater understanding of the specific needs and challenges of each group while facilitating access to them. Strategic partnerships of this nature will be particularly valuable for reaching MSM, a group that was previously inadequately incorporated

into the program. A mapping exercise of relevant organizations would identify future partners and could also provide a valuable starting point to address gaps in the coordination of organizations working with MARPs.

**2. Focus on quality instead of quantity in BCC interventions**

Current program approaches emphasize the quantity of BCC contacts achieved as opposed to the quality of each contact, and thus achieve high numbers but potentially limited impact. Stimulating sustained behavior change requires that key messages are communicated in intimate settings that are conducive to developing trust and generating active participation. Such approaches are naturally time-intensive and are unlikely to generate high results figures; at the same time, they have great potential to foster desired behavior changes. Focusing on achieving high-quality, contextually appropriate BCC contacts with defined target populations will enable SFH to capitalize on its comparative advantage as an expert in BCC for MARPs rather than overlapping with the community-based HIV awareness programs of other organizations. This would also entail that effort is made to define a "quality" contact and developing tools to assess this. Seeking an effective balance between single and multi-session HIV prevention sessions for individuals at varying risk levels is also important.

**3. Use a participatory approach in development of MARP-specific IEC**

Using a participatory approach that involves both stakeholders and members of the intended target group in developing IEC materials will help ensure that messages are appropriate, relevant, and understandable, and will thus enhance uptake. This approach will also help standardize key behavior change messages for target groups, and avoid unnecessary duplication of existing materials. To further enhance community access to IEC materials, SFH should consider translation of key items into major Namibian languages besides English and explore the possibility of developing materials for non- or semi-literate populations.

**4. Strengthen and expand referral system**

Given the CoH program's excellent access to individuals with elevated risk, it is critical that opportunities to provide holistic referral are maximized. Existing referral mechanisms should be strengthened through the development of a referral register and tracking form to enable follow-up and assessment of individual cases. Where possible, referrals should be directed to organizations that provide MARP-friendly services – e.g., NAPPA for sexual and reproductive health services such as HCT, diagnosis and management of STIs, ARVs, and PMTCT; and Positive Vibes for specialized psychosocial support – and in other cases SFH should provide MARP-sensitive training to staff at referral points. Collaboration with organizations providing opportunities for income generation would also enable some individuals to avoid the high-risk behavior inherent in transactional sex.

**5. Conduct MARP-oriented advocacy in community, regional and national fora**

Structural-level factors that elevate the risk of HIV infection include a legislative and social environment that marginalizes MARPs and greatly limits their access to prevention, treatment, and support services. As a specialist in MARP-oriented BCC, SFH has the potential to make a substantial contribution in advocating on behalf of these groups to create an environment that is supportive and potentially conducive to positive behavior change. Important components of such advocacy work include the sensitization and mobilization of relevant stakeholders at the community, regional, and national levels regarding MARPs' specific concerns and health needs. SFH should also consider assuming a leadership role in coordinating the efforts of MARP-focused organizations. Furthermore, it should seek active involvement in policy-making processes through participation on relevant bodies such as the National MARPs Technical Working Group hosted by the MoHSS's DSP, and the Technical Working Group for the Removal of Discriminatory HIV and AIDS related Laws, Regulations, Polices and Practices, hosted by UNAIDS.

### 6. Invest in training and retaining implementation-level staff and volunteers

High levels of attrition among CoH volunteers compromises program consistency and necessitates time- and resource-intensive training of new staff. While this program model may reduce staffing costs, it is not sustainable; it is also inappropriate that the program's entire implementation at the community level depends on undercompensated individuals who are relatively untrained and unqualified. Instead, SFH should invest in providing (1) in-depth, repeated training on a variety of health and HIV-related issues for implementation-level staff and volunteers, and (2) ensuring that implementation-level staff are suitably compensated for their efforts. Where appropriate, volunteers should be offered employment contracts after a set period of service. This can be expected to greatly reduce volunteer attrition and improve program quality.

### 7. Provide ongoing support and technical assistance to implementing partners

The responsibility for implementing BCC interventions has largely been transferred to implementing partners, including select CBOs and the Namibian Police (through the PolAction program). Although this implementation model is designed to ensure program sustainability, it also requires that implementing partners have sufficient technical competence and administrative capacity to carry out required activities. In the absence of this, the program will fail. All potential implementing partners should therefore be able to demonstrate adequate human resource and administrative capacity before agreements are finalized, and all current partners (including the Namibian Police) should complete regular capacity/needs assessments and receive appropriate technical assistance and support within keys areas such as program planning, BCC methods, and M&E.

### 8. Provide regular program updates to all interested and involved parties

Program updates and results should be shared with key stakeholders as well as with all staff and volunteers on a routine basis, with structures put in place to ensure that this occurs. In particular, program staff should receive regular feedback on their performance, as well as information placing their efforts within the context of the program in general.

### 9. Monitor both qualitative and quantitative program performance

There is a need for program monitoring to move away from the current relatively simplistic method of data collection and analysis, where the primary focus is on the number of people reached with BCC. Instead, the program should move to a comprehensive assessment system that captures both the quality and quantity of individual BCC contacts, and uses continuous monitoring and feedback mechanisms to assess intervention output/outcome and inform message content and delivery channel. This would entail the development of additional data-capturing tools as well as more effective use of existing assessment tools, such as the Field Visit Quality Assurance Checklist.

### 10. Invest in research capacity

With Namibia lacking sufficient data on the majority of MARP groups to support strategic planning and advocacy work, SFH is well positioned to become a respected repository of MARP-related research. However, conducting rigorous, relevant research requires individuals who have considerably more experience and education than can be acquired through isolated workshops and trainings. SFH should therefore invest in specialized, in-depth research training for select individuals, with the goal of becoming a national center of excellence in MARP- and HIV-related research. This would not only greatly enhance any future implementation of the CoH program, but would also strengthen the organization's advocacy efforts and support national MARP-focused policy and planning processes.

# APPENDIX 1. SCOPE OF WORK

**Global Health Technical Assistance Project**
**GH Tech**
**Contract No. GHS-I-00-05-00005-00**

## I. TITLE: USAID/NAMIBIA END OF PROJECT EVALUATION FOR CORRIDORS OF HOPE PROJECT.

Contract: GH Tech GHS-I-00-05-00005-00.

## II. PERFORMANCE PERIOD:

Not including time for preparation and completion of report, two to three weeks in-country at some time during September, 2010.

## III. FUNDING SOURCE:

This assignment will be funded by USAID/Namibia.

## IV. PURPOSE AND OBJECTIVES:

The US Agency for International development (USAID) awarded the local affiliate of Population Services International (PSI), the Social Marketing Association (SMA), a five-year Local Cooperative Agreement Corridors of Hope (Number: 690-A-00-05-00126-00) in July 2005 with an end date of September 31, 2010. SMA was subsequently renamed in 2009 to be called the Society for Family Health (SFH). This agreement had a planned life of project of $10,962,171. The project focused on HIV prevention in Namibia's most high-risk transport corridors with attention to comprehensive behavioral prevention activities to reach Most at Risk Populations (MARPs).

The initial prevention objectives for the Corridors of Hope Program were to:

- Reach mobile and border populations (sex workers, truckers, informal traders, and border officials) through BCC work on Namibia's borders;
- Reach young women and girls and the communities in which they live through community activities and mass media campaigns on cross-generational sex and,
- Social market condoms to these target groups during the project.

Following a program modification in December 2007, the goal of the Corridors of Hope Program was updated. The goal was to increase the capacity of the local PSI affiliate organization to provide high quality HIV prevention programs to populations at risk through well designed and targeted behavior change communication programs. The revised objectives for Corridor of Hope were as follows:

- To strengthen the capacity to provide high quality, age-appropriate behavior change communications (BCC) for prevention, care and treatment in HIV/AIDS and TB to most at risk populations, including the police, transit workers, border populations, and people engaged in informal sexual relationships.
- To strengthen the organizational, financial management, contractual and administrative capacity to implement and monitor HIV/AIDS and TB behavior change programs that

comply with local and USG regulations, policies and procedures via successful certification to receive direct US funding.

To achieve these objectives, USAID/Namibia supported Corridors of Hope activities in nine regions (Kavango, Caprivi, Ohangwena, Oshana, Omusati, Oshikoto, Omaheke, Karas and Erongo). Project activities have included, working with commanding officers of the police at the regional level, working with peer education programs for mobile MARPs (truckers and fishermen) at hot spots with outreach including presentations, drama, video facilitation, and the training of peer educators working at community CBOs.

**Goal of the evaluation:** This evaluation seeks to assist USAID to determine the performance and effectiveness of Corridors of Hope, as well as inform the implementation of USAID's future competitive award to a follow-on project for MARPs.

Objectives of the evaluation include:

1. To assess why progress toward planned results has been positive or negative.
2. To assess how well the needs of different customer groups (mobile versus border populations) were served.
3. To assess how Corridors of Hope used project and nationally available data that were collected over the course of the project.
4. To assess how quality assurance/control was maintained by at the regional level; analyze the implications of the Corridors of Hope decentralized regional organizational structure of Corridors of Hope for reaching MARPs.

**Key implementation issues:** The evaluation may require concurrence of Government of Namibia counterpart Ministries (Health and Social Services, Regional and Local Government, Safety and Security) to facilitate meetings with regional health offices, the Namibian Police force and Regional AIDS Coordinating Committees in Caprivi, Erongo, Khomas and Ohangwena. In addition, per a recent audit by the Office of Inspector General, (See "Audit of USAID/Namibia's efforts to address crucial shortages of trained HIV/AIDS Health Workers," Audit Report No. 9-000-10-00X-P, July 1, 2010), this evaluation will be required to define the SFH project's contribution to health systems strengthening through human resources for health (HRH) investments, as well as identify SFH's contribution to sub-partners or to the Government of Namibia in the area of organizational capacity.

**Period under review for the evaluation:** From start of project (July 2007) to the Semi-Annual Progress Report for 2010 (March 31, 2010).

## V. SCOPE OF WORK

Illustrative Key Questions to be addressed by the team:

### Guiding evaluation questions (illustrative)

1. What was the performance and effectiveness of SFH Corridors of Hope as measured against stated objectives?
2. How has the SFH program achieved greater impact through leveraging of non-USAID resources (e.g. GFATM)
3. Why has SFH progress toward planned results been positive or negative?
4. How well has SFH served the needs of different customer groups (mobile versus border populations)?

5. Has there been adequate combination of HIV prevention interventions including behavioral, biomedical and structural?
6. Are referral services impacting customer's access to HIV and ancillary services?
7. How has Corridors of Hope used project data and nationally available data that were collected over the course of the project?
8. Was SFH able to maintain quality assurance/control at the regional level, and if so, how was this accomplished?
9. What are the implications of the decentralized regional organizational structure of Corridors of Hope for reaching MARPs? Did this result in improved collaboration between SFH with other HIV prevention programs at local and regional level?
10. What are key lessons learned that can inform the implementation of USAID's future competitive award to a follow-on project for MARPs?
11. Specific to human resources for health, have Corridors of Hope interventions adequately addressed recruitment, training, supervision and attrition of technical specialists and community health volunteers?
12. What has been SPS-SCMS's contribution to health systems strengthening through investments in human resources for health?
13. What has been SPS-SCMS's contribution to sub-partners and/or to the Government of Namibia in the area of organizational capacity?

### Performance Information Sources

1. Baseline assessments for program implementation (if any)
2. Country Operational Plan FY07, FY08 and FY09 narratives
3. Workplans and PMP
4. Quarterly, semi-annual and annual progress reports
5. Financial report and pipelines
6. MoHSS reports on SFH activities
7. Any signed agreement with local partners
8. Key informants interviews
9. Field visits and direct observations

## VI. METHODOLOGY

The evaluation team will use a variety of methods for collecting and analyzing qualitative and quantitative information and data. The methods to be used in completing this evaluation will include, but not be limited to: reviewing documentation, interviews, site visits, stakeholder meetings, etc. Drawing on experiences in other PEPFAR countries, USG Namibia will seek the assistance of external consultants, headquarters, host country and local USG counterparts to conduct the assessment. The following essential elements should be included in the methodology as well as any additional methods proposed by the team:

### Document Review

Prior to arriving in country and conducting field work, the team will review various project documents and reports. A list of key documents is included in Section XIII. The USAID/Namibia team will provide the relevant documents for review as soon as possible.

### Team Planning Meeting

A two-day planning meeting (TPM) will be held during the evaluation team's first two days in-country with USAID staff. This time will be used to clarify team roles and responsibilities, deliverables, development of tools and approach to the evaluation, and refinement of agenda. In the TPM the team will:

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

### In-depth Discussions with USAID/Namibia and project staff

#### Key Informant Interviews

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

#### Field Site Visits

The team will coordinate with USAID/Namibia to prepare for and conduct site visits while in-country, and to interview key informants at these sites. Assuming a two person team, over a period of 9 days, one member of the team will conduct site-visits in two northern regions (three days in Oshikango, Ohangwena Region; three days in Katima Mulilo, Caprivi Region; three days travel). During the 9 days when one team member is making site visits in the two Northern regions, the other team member will conduct site visits (3 days) in Walvis Bay, Erongo Region as well as three days of site-visits in the Windhoek area, with two days travel. If there is a one person team, the total number of days will be increased to allow for site visits to three regions, or the number of regions to visit will be reduced. USAID/Namibia will arrange for all required in-country transport from Windhoek to Oshikango, Katima Mulilo and Walvis Bay. USAID/Namibia will make arrangements for accommodations as needed.

## VII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

USAID anticipates that the evaluation team will consist of the following individuals and groups (TBD):

- Most likely one, possibly two external evaluators, based on availability.
- **Team Leader:** Expert in social behavior change communication campaigns (SBCCs) for HIV prevention among Most at Risk Populations (MARPs) preferably including high risk transport workers, commercial sex workers and men in uniform. Should have expertise in community based interpersonal communication campaigns (IPCCs) for HIV Prevention. Must have proven track record conducting high quality mid-term and end-of-project evaluations of comprehensive SBCC and IPC Programs for prevention of HIV transmission. Must have

excellent writing skills to synthesize findings and recommendations into a high quality evaluation report within a short time period.

- **Team Member:** Similar to Team Leader, with less overall experience, but able to work well independently. Expert in social behavior change communication campaigns (SBCCs) for HIV prevention among Most at Risk Populations (MARPs) preferably including high risk transport workers, commercial sex workers and men in uniform. Should have expertise in community based interpersonal communication campaigns (IPCCs) for HIV Prevention. Must have proven track record participating in high quality mid-term and end-of-project evaluations of comprehensive SBCC and IPC Programs for prevention of HIV transmission. Must have excellent writing skills to help synthesize findings and recommendations into a high quality evaluation report within a short time period.
- Local team: Host country representative (MITC), USAID Namibia (Brad Corner; Robert Festus), USG counterparts in Namibia (i.e. Nick DeLuka, CDC). The local team members will participate with the two external evaluators as needed to accompany them on site visits, introduce them to national and local informants and collect data, but they will not be responsible for the drafting of the evaluation report. The roles of the local team will be determined in collaboration with the Team Leader during the TPM.

Key contacts include: Mrs. Lavinia Shikongo (SFH), Mr. Zacch Akinyemi (SFH), Brad Corner (USAID), and Freida Katuta (MOHSS)

## VIII. ESTIMATED LEVEL OF EFFORT (LOE):

A six-day workweek will be approved when the consultants are working in country.

| Task/Deliverable | Team Leader LOE | Second team member LOE |
|---|---|---|
| Read Background Documents | 3 days | 3 days |
| Travel to Namibia | 2 days | 2 days |
| Team Planning Meeting | 2 days | 2 days |
| Assessment work | 15 days | 15 days |
| • In-briefing with USAID HIV/AIDS team (and partner(s) as needed) | (1 day) | (1 day) |
| • Conduct site visits and key informant interviews (includes in-country travel days) | (9 days) | (9 days) |
| • Discussion, analysis and draft report preparation | (3 day) | (3 day) |
| • Mission (and partner debriefing) | (1 day) | (1 day) |
| • Complete report draft – revise report & incorporate debriefing comments into draft report | (1 day) | (1 day) |
| Return travel | 2 days | 2 days |

| Task/Deliverable | Team Leader LOE | Second team member LOE |
|---|---|---|
| Mission sends technical feedback/comments on draft report to GH Tech (within 10 days of submission) | 0 | 0 |
| Consultants revise/finalize report | 5 days | 3 days |
| Mission reviews/signs off on final report (within 5 days of receipt) | 0 | 0 |
| GH Tech edits and finalizes report – approx. 30 days after mission approval | 0 | 0 |
| Total LOE | 29 Days | 27 Days |

## IX. LOGISTICS

GH Tech will provide:

- International travel to and from the consultant's point of origin and Namibia. GH Tech will provide full-fare economy.
- GH Tech consultant per diem and lodging expenses.
- Country cable clearance.

USAID/Namibia will provide:

- Visitors will not have an EA and therefore will need to work out of their hotel/lodging or a designated work space (tbd). They will need prior approval to bring any laptop into the USAID office for any meetings or briefings.
- Cell phone, but consultant(s) will purchase air time
- SFH will submit a list of all stakeholders and beneficiaries for field visits and USAID will provide logistical support for the team in country assessment.
- Arrangements/logistics for in-country site visits.
- Reserve hotel and guest house accommodations in country.
- Most local costs and travel expenses, but not per diem and lodging for GH Tech consultants.
- USAID/Namibia will provide a USAID/Namibia car and driver for use by GH Tech Consultants only when other USG staff members accompany them. When no USG staff members accompany consultants, they will use taxis.

## X. RELATIONSHIPS AND RESPONSIBILITIES

**Prior to In-country Work:**

- Consultant Conflict of Interest. To avoid conflicts of interest (COI) or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding any potential COI.
- Background Documents: Identify and prioritize background materials for consultants and provide them to GH Tech as early as possible prior to team work.

- Key Informant and Site Visit Preparations: Provide a list of key informants, site visit locations, and suggested length of field visits for use in planning for in-country travel and accurate estimation of country travel line items costs (i.e. number of in-country travel days required to reach each destination, and number of days allocated for interviews at each site).
- Lodging and Travel: Provide information as early as possible on allowable lodging and per diem rates for stakeholders that will travel/participate in activities with the evaluation team. Also, provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics.

**During In-country Work:**

USAID/Namibia will undertake the following while the team is in country:

- Mission Point of Contact: Ensure constant availability of the Mission Point of Contact person(s) to provide technical leadership and direction for the consultant team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. While consultants typically will arrange meetings for contacts outside the Mission, support the consultants in coordinating meetings with stakeholders,
- Formal and Official Meetings. Arrange key appointments with national and local government officials and accompany the team on these introductory interviews (especially important in high-level meetings).
- Other Meetings. If appropriate, assist in identifying and helping to set up meetings with local professionals relevant to the assignment.
- Facilitate Contacts with Partners. Introduce the team to project partners, local government officials, and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

**Following in-country work:**

USAID/Namibia will undertake the following once the in-country work is completed:

- Timely reviews: Provide timely review of draft/final draft reports and approval of the deliverables.

## XI. DELIVERABLES AND PRODUCTS

1. A written methodology/work plan (Evaluation design/operational work plan) prepared during the TPM and submitted to the Mission for review and approval before field work and key informant interviews begin.
2. A draft report outline prepared during the TPM.
3. A Mission and partner debrief meeting that will be held before the team's departure and prior to the submission of the draft report. The team will prepare a PowerPoint presentation for this event.
4. Prior to departing Namibia, a draft report addressing key performance findings, conclusions, recommendations and lessons learned will be submitted. The mission will have 10 days following the submission of the draft report to respond and provide written comments and feedback to GH Tech.

5. Conditional on receipt of comments from USAID/Namibia five days beforehand, the final report will be due on October 1, 2010. It will be the property of USAID. Dissemination of relevant findings will occur through official channels at local (Mission, USG and stakeholders) as well as Washington level. Some of the findings may be used for country operational planning. The report shall not exceed 30 pages, excluding the annexes.
6. The revised final unedited report will be provided to the mission 5 days after the comments are received.
7. Once the mission signs off on the final unedited report, GH Tech will have the documents edited and formatted and will provide the final report to USAID/Namibia for distribution (5 hard copies and CD ROM). It will take approximately 30 days for GH Tech to edit/format and print the final document. This will be a public document and will be posted on the USAID/DEC and the GH Tech websites.

# APPENDIX 2. PERSONS CONTACTED

## NAMIBIA

### U.S. Agency for International Development

Melissa Jones, Director, HIV/AIDS and Health Office

Brad Corner, HIV/AIDS Preventions Adviser

Sam Clark, Strategic Information, HIV/AIDS and Health Office

Nabil Alsoufi, Health Officer

### Ministry of Health and Social Services

Ms. Ella Shihepoe, DSP Director

Frieda Katuta

Mr. Tjaronda, Condom Logistic Manager

C. Thataoni, Regional Health Director, Swakopmund

Meriam Valombola, Senior Health Program Administrator, DSP, Swakopmund

Dr Katende Kashija, District Medical Officer, Ohangwena Region

Mrs. Irene Mabuku, DSP, Caprivi

### SFH – Society for Family Health

Lavinia Shicongo, Incumbent Director

Zacch Akinyeme, Out-going Director

Johannes Haufik, CoH Project Manager

Manuel Ngaringombe, Regional Manager for Khomas and Erongo

Liz Biermann, MCH Program Coordinator

Walfried Paulinus, CHC (Community Health Consultants) Katutura Office

Ndeshipewa Hamupito, CHC (Community Health Consultants) Katutura Office

Mike Haidula, Regional Manager, Ongwediva Office

Peingondjabi, Ongwediva Regional Office

Maria Nepolo, Senior Workplace Officer, Walvis Bay Office

Marco Peichl, Technical Advisor WB Office

Henry Ngandi, BCC Community Officer, Walvis Bay Office

Johanes Paulus, CHC Walvis Bay Office

Jake Lockwood, Regional Coordinator, Katima Office

Braster Kakula, Workplace Officer, Katima Office

Albert Kasokonya, TUSANO Project Coordinator, Katima

**IntraHealth**

Liberte Malone, Director

**Okahanja Park Community**

Moses Ndara, Community Leader

**UNAIDS / UNDP**

Henk Van Renterghem, UNAIDS Country Coordinator

Sara Mutona

Koech arap Rotich, UNAIDS Partnership & Society Mobilization Advisor

**Ministry of Regional and Local Government, Housing and Rural Development**

Connie Podewitz

Ndeshi Nambinga

Saima Shicongo

Peter Iita, Oshana Region

Renate Shoombe, Oshana Region

Ms Ekaku, RACOC , Khomas

Ben Philep, Committee Technical Advisor WB District Aids Committee

Phillip Bue, Ministry of Finances WB District Aids Committee

Kleria Autanga, Regional Aids Coordinator, Swakopmund, Erongo

**Namibian Police**

Commissioner Tweya, Police Director for Health and Welfare

WO Shicongo, HIV Coordinator

Sgt. Shivela, HIV Coordinator

M. Maritshane, Deputy Commisionary,Erongo

V. Geigos, Sgt. for Regional HIV/AIDS Coordination, Erongo

Constable Uusikum, PE Okatope, Oshana

**King's Daughters Organization**

Esme Kisting, Executive Director

Desiree, Training Facilitator (volunteer)

**CDC**

Nick DeLuca, CDC Prevention Advisor

**Nasoma**

Theopolina Kueyo

**Nawa Life Trust**

Nahum Gorelick, Director

Salen Engelbreacht, Deputy Director

**C-Change**

Ellie Burleight, Director

**WBCG – Walvis Bay Corridor Group**

Edward Mwahafa Shivute, HIV/AIDS Coordinator

Kirsti Hamunime, Coordinator

**NAMFI – Namibian Maritime and Fisheries Institute, Walvis Bay**

Tobias N. Nambala, Safety Department Head

**Caprivi Hope for Life (CHL)**

Victor Munsu, MD

Jane Mushwena, Project Supervisor

**North Star Alliance Roadside Wellness Centre, Katima**

Mr. Rassen Muzibe, Peer Educator

Mr. Sylvester Mahoto, State Register Nurse (SRN)

**Project Hope**

Steven Neri, Director

Wilfred Luyanga, Regional Supervisor for Katima (telephonic interview)

**The Community Development Committee, Oneshila, Oshana Region**

Meeting with five members

# APPENDIX 3. PEPP MANUAL – TABLE OF CONTENTS

## TABLE OF CONTENTS

### or Partner Reduction/MCP

**(a)** Trusted partner myth

**(b)** Multiple partnering

**(c)** Multiple concurrent partnering

### Module 7: Alcohol Abuse and Risky Behavior

**(a)** Alcohol abuse

**(b)** Alcohol and risky behavior

### Module 8: Voluntary Confidential Counseling and Testing

**(a)** HIV counseling and testing

**(b)** Benefits of counseling and testing for HIV

**(c)** Results

# APPENDIX 4. MATERIALS CONSULTED

## SFH/ SMA DOCUMENTS:


SFH 2010, *Report on Shebeens*. March 2010.

SFH 2010, *Background and Update on the USAID Funded COH Project: Handout at a Presentation to the USAID Evaluation Team, 21st September 2010*. Windhoek, Namibia.

SFH 2009, *LGBTI, WSW and MSM Mapping Report,* SFH and TRP, Windhoek, Namibia.

SMA 2009, *How to Guides for HIV at the Community Level.*

SMA, 2009, *Sexual Behaviour and HIV Risk Reduction Practices among the Namibian Police*, 2008/2009, Research Report; Windhoek, Namibia

SMA 2008/2009, *Research Report: Sexual Behaviour and HIV Risk Reduction Practices among the Namibian Police.*

SMA (Date unknown) *Peer Educators Handbook*.

SMA (Date unknown) *Report of Attrition Study Carried out among Participants in the SMA's Peer Education Plus (PEPP) amongst Uniformed Service Men and Women and the Vulnerable Girls/Female out of School Youth*.

SMA Quarterly Financial and Narrative Reports, 2007-2010.


## OTHER DOCUMENTS:


Baral, S., et al. 2009, HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana, *PLoS ONE*, 4(3): e4997.

C-Change 2009, *Social Marketing Association Peer Educator Plus Program: HIV and AIDS Behavior Change Communication Baseline Assessment and Recommendations for COP08*, March 2009.

LaFont, S. 2008, *Help Wanted: Sex Workers in Katutura, Namibia*, Monograph No. 2: Gender Research and Advocacy Project, Legal Assistance Centre, Windhoek, Namibia.

LeBeau, D. 2006*, From Corridors of Mobility to Corridors of Hope: Mapping the Link between Mobility and HIV Vulnerability in Namibia*, International Organization for Migration (IOM) and Institute for Public Policy Research (IPPR), Johannesburg, RSA.

Lurie, M., et al. 2003. Who infects whom? HIV-1 concordance and discordance among migrant and non-migrant couples in South Africa, *AIDS*, 17: 2245-52.

MoHSS 2010, *Report on the 2010 National HIV Sentinel Survey*, Ministry of Health and Social Services, Windhoek, Namibia.

MoHSS 2009, *HIV/AIDS in Namibia: Behavioral and Contextual Factors Driving the Epidemic*, Ministry of Health and Social Services, Windhoek, Namibia.

MoHSS 2009, *Results of the 2008 HIV Sentinel Survey*, Ministry of Health and Social Services, Windhoek, Namibia. Available at: http://www.healthnet.org.na/statistics/2008%20HIV%20Sentinel%20brochure.pdf

MoHSS 2006, *Progress Report on the Third Medium Term Plan on HIV/AIDS: April 2004 – March 2006,* Ministry of Health and Social Services, Windhoek, Namibia.

NANASO 2008, *Directory of AIDS Service Organizations (ASOs)*, Namibia Network of AIDS Service Organizations, Windhoek, Namibia.

PSI 2008, *Technical Program Proposal for Modification of Cooperative Agreement No. 690-A-00-05-00126-00/ USAID: HIV/AIDS Prevention and Care Program in Namibia, April 1, 2008 – March 31, 2009*, Population Services International, Washington, D.C.

Republic of Namibia 2007, *National Policy on HIV/AIDS*, Windhoek, Namibia.

Republic of Namibia 2003, *The National Strategic Plan on HIV/AIDS , MTP 3: 2004-2009,* Windhoek, Namibia.

USAID 2009, *DHS Qualitative Research Studies 16: Alcohol Consumption, Sexual Partners and HIV Transmission in Namibia*, Windhoek, Namibia.

USAID 2009, *Prevention Portfolio Review USAID Namibia: Handout at Debriefing, 3rd April 2009*. Windhoek, Namibia.

USAID (Undated) *Handout: Major Factors Driving the HIV Epidemic in Namibia – A review of the current evidence,* Joint USAID and MEASURE Evaluation Report.

For more information, please visit
http://resources.ghtechproject.net

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