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USAID/NAMIBIA: HIV PREVENTION, CARE AND SUPPORT PROJECT

MID-TERM EVALUATION OF INTRAHEALTH PERFORMANCE

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Backing us up at the dTS for the GHTech Bridge Project, Ashley Mills was always, "on time, on target."

—*Stephen C. Joseph and Regan Whitworth*

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AMS	Anglican Medical Services
ART	Antiretroviral treatment
ARV	Antiretroviral drugs
CAA	Catholic AIDS Action
CDC	U.S. Centers for Disease Control and Prevention
CHS	Catholic Health Services
CMS	Central medical stores
COP	Country Operational Plan
DAPP	Development AID from People to People
DSP	Directorate of Special Programs
ePMS	Electronic Patient Monitoring System
FBO	Faith-based organization
FP	Family planning
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRN	Government of the Republic of Namibia
HCMS	Human capital management system
HCS	HIV Clinicians Society
HCT	HIV counseling and testing
HDI	Human Development Index
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
HR	Human resources
HRH	Human resources for health
HRIMS	Human resources information management system
IT	Information technology
LL/CL	LifeLine/ChildLine
LMS	Lutheran Medical Services
MC	Male circumcision
MoHSS	Namibia Ministry of Health and Social Services
MSH	Management Sciences for Health
NGO	Non-governmental organization

NHA	National Health Accounts
OCA	Organizational capacity assessment
OHSS	Other Health Systems Strengthening
OPM	Office of the Prime Minister
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission
QA	Quality assurance
RMT	Regional management team
TA	Technical assistance
TB	Tuberculosis
UNDP	United Nations Development Program
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary counseling and testing
VCTC	Voluntary counseling and testing center
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

At the turn of the 21st century, Namibia found itself nearly overwhelmed by the tide of the HIV epidemic. The semi-arid country in Southern Africa, twice the size of California but with a population of approximately 2 million people, had a population in which nearly one in five Namibians (estimates up to 20%) was infected. The medical care system was severely over-taxed with the ill and dying. Fear and discrimination, and lack of knowledge concerning HIV and its consequences, was widespread.

Now, a mere decade later, a vigorous and effective national HIV program, assisted by major donors, including the United States (through the President's Emergency Plan for AIDS Relief [PEPFAR] funding via both USAID and U.S. Centers for Disease Control [CDC] mechanisms) and the Global Fund, has made what can only be described as enormous progress towards reversing the trends of the epidemic. Infection prevalence is now closer to 13%; annual incidence of new cases has fallen from nearly 25,000 in 1999 to less than 6,000 in 2010; and nationwide effective programs of counseling and testing, early diagnosis, prophylactic medication, clinical care of the sick, and widespread preventive, public health, and social support measures are in place. Namibia's statistics in the World AIDS Annual Report are among the best in Africa.

Still, critical issues remain, there is much progress to be made and new hazards are ever-present (such as reaching those hardest to reach and the challenge of resurgent drug-resistant tuberculosis [TB]). With Namibia's classification as an Upper Middle-Income Country (despite severe income inequality), many donors are reducing or withdrawing financial and technical assistance (TA). The Government of the Republic of Namibia (GRN) itself is embarking on major restructuring of its health system, moving towards a more 'horizontal' system of integrated primary health care (rather than the current "vertical" emphasis based on categorical disease approaches), and "absorbing" large numbers of crucial health care personnel (doctors, nurses and pharmacy assistants) from the missionary (faith-based organizations [FBO]) health systems to direct government employment in the Ministry of Health and Social Services (MoHSS).

These three elements—continuing challenges of the epidemic, reduced availability of donor assistance and restructuring of the Namibian health care system—are all converging in time, resource availability and organization. They form the backdrop to this mid-term assessment of the IntraHealth "Namibia HIV Prevention, Care and Support Project."

In November 2008, USAID awarded IntraHealth International a bilateral Cooperative Agreement, for five years and nearly USD $50 million. This was followed an earlier project. The stated goal of the project was to "build the capacity of indigenous organizations to respond to and implement HIV/AIDS programs leading to increased numbers of Namibians who know their HIV status, and to improved access to high quality HIV/AIDS prevention, care, and support and treatment services."

IntraHealth was to work primarily with FBOs, other non-governmental organizations (NGOs) and the MoHSS in pursuit of these objectives, emphasizing building the capacity and availability of managers and staff within the FBO health care and MoHSS systems through training and TA to clinical and administrative personnel, and development of e-data systems for management of patients' records, human resources and project data. Work was focused on voluntary counseling and testing centers (VCTCs), clinics at FBOs, and the development of, and training in the use of,

the HRIMS (Human Resources Information Management System). These clinical and non-clinical activities have both direct and indirect impacts on the wide spectrum of HIV prevention and care, is such areas as availability and adherence to early diagnosis, appropriate antiretroviral treatment (ART), prevention of mother-to-child transmission (PMTCT), and linkages of diagnosis and treatment of HIV and TB, etc.

Now past mid-term and approaching the expected end of project in September 2013, and in the context of extraordinary success of the overall Namibian HIV Program, it is the opinion of the assessment team that the IntraHealth project has been a major success in meeting its objectives, though not without attendant current and future problems.

As detailed in the following sections of this report, ambitious targets of training have been met or exceeded, and training is reported by all observers to be of high quality. Widespread VCT by FBOs and NGOs was supported, with crucial work in outreach, mobile and social/behavioral services. Training and support of nurses and other personnel in FBO clinics have been accomplished. A very successful logistics system of counseling and testing supplies and commodities has been put in place in collaboration with Supply Chain Management System. Training and installation of HRIMS at FBO facilities and GRN Regional Management Teams have also been carried out (see below for major problems with the HRIMS itself). IntraHealth's FBO and NGO sub-grantees have undertaken effective training in fiscal and administrative management. Important linkages between the MoHSS and the FBO health institutions (a linkage that is in the process of becoming even more direct, with the absorption of FBO health care personnel into direct employment as MoHSS staff [see discussion later in this report]) has resulted in successful IntraHealth activities providing an unusually strong contribution to the overall Namibian health care system.

On the less-positive side—and with the understanding that these problems and short-comings are not primarily a result of IntraHealth action or lack of action—significant problems have been encountered and remain. While IntraHealth supported the completion of an accurate electronic record of MoHSS staff, the HRIMS has proven to be an outdated system that has virtually collapsed. Causes of collapse include the inadequate capacity of the central server in the offices of the Prime Minister; poor connectivity in the regions; and staffing capacity gaps for IT support. HRIMS is currently being replaced by a new Oracle-based system, with the downsides and costs of this transition yet to be fully understood. The closure of the majority of the standalone VCTCs in 2010 was poorly coordinated and was a service and communications disaster that has left echoes of anxiety and loss of trust to this day.

The two most important and far-reaching problems experienced by IntraHealth activities are far beyond the organization's control and depend more upon other major actors—both GRN and the U.S. Government (USG). These problems relate directly to the three elements of change described earlier in this summary, and are expressed by 1) less-than adequate communication and collaboration among all the various players; and 2) widespread uncertainty concerning the shape and extent of both USG and GRN funding and program in the years ahead.

This report details the strengths and weaknesses, with the team's conclusions expressed in a strengths, weaknesses, opportunities and threats (SWOT) analysis, lessons learned and best practices. A series of recommendations for future action concludes the report.

In summary, recommendations include:

1. IntraHealth and USAID should prepare and exchange monthly reports documenting developments and appropriate action on the transition of pharmacy and nursing staff from IntraHealth employment to GRN.
2. IntraHealth and USAID should prepare and exchange monthly reports documenting developments and appropriate action on HRIMS usability in the regions, and planning for transition to a human capital management system (HCMS).
3. USAID should provide IntraHealth with monthly updates on developments on transition of USG funded activities to GRN.
4. Interagency budget planning should reflect the distinction between capacity building efforts and service provision.
5. To further support IntraHealth and USAID efforts, the PEPFAR coordinator should continue ongoing efforts to strengthen interagency function for improved coordination of program implementation.

I. INTRODUCTION AND BACKGROUND

Namibia is a sparsely settled country on the south-western edge of Africa, with 60% of land comprising desert and semi-desert. It has no perennial rivers or other permanent bodies of water. Due to the low and erratic rainfall and scarce ground and surface water, less than 5% of the country is arable, including through irrigation. It is twice the size of California, with a population slightly over 2 million people, 250,000 of whom live in the capital city of Windhoek. There are perhaps an additional dozen small towns, an agglomeration of population in the extreme north of the country, and the rest of the population is scattered across landscapes of bush, grass, uplands, desert and a desert coast.

Namibia achieved independence in 1990, after more than a century of colonial and mandate rule, and a long and bloody war of independence. It has since made strides as a constitutional democracy, with a high literacy rate, including female literacy, and a stable elected government. Namibia is classified as an Upper-Middle Income Country, although this obscures extreme income inequality. The 2011 Human Development Report rated Namibia's Human Development Index at 120 out of 187 countries and territories.

Access to basic education has become more equitable and primary health care coverage has become more widespread in recent years. Namibia is currently among the top 10 countries worldwide in share of GDP spent on education and second only to South Africa on the African continent in per capita expenditure on health. According to a 2003–04 national household survey, Namibia experienced a significant decline in the share of poor and extremely poor households compared to a decade prior. Some 28 percent of households were classified as poor and 4 percent as extremely poor, compared to 37.1 and 8.2 percent 10 years earlier.

The HIV epidemic exploded in Namibia in the first years of the 21st century, with infection prevalence estimated at up to 20% of the population, rapidly-rising death rates, and extensive adult and child morbidity.

There is no question that the vigorous response of the GRN, aided by major contributions by the Global Fund, USAID and CDC (both using PEPFAR funds) had a highly effective and rapid impact on the course of the epidemic. The prevention and treatment statistics achieved in Namibia are among the best in Africa.

Table 1. Selected HIV Achievement Indicators: Namibia

	Namibia	Mid- Lower-income Countries
%HIV positives on Antiretroviral Treatment	>95	36
% HIV+ aged under 15 on ART	89	25
% HIV+ pregnant women on ART	88	53
% Pregnant women counseled and tested	88	26

Source: UNAIDS/WHO/UNICEF Progress Report, 2010—all Figures for Year 2009

Table 2: Selected Health and Economic Indicators: Namibia, Africa, Upper-Middle Income Countries			
	Namibia	**Sub-saharan Africa**	**Upper- middle Income Countries**
GNI per capita (2010, Atlas method)	$4,510	$1,188	$5,886
Life expectancy at birth (years, 2010)	62	54	73
Life expectancy at birth, female (yrs, 2010)	63	55	75
Life expectancy at birth, male (yrs, 2010)	62	53	71
Gross primary enrollment (2009)	107%	100%	109%
Net bilateral aid, US (million, 2010)	$117.1	$7,637	$2,549
Net bilateral aid (DAC), total (million, 2010)	$222.1	$32,342	$10,377
Net ODA per capita (2010)	$113	$53	$5
Health expenditure per capita (2010)	$361	$85	$382
Health expenditure, 5 of Gov. budget	12		

Source: World Bank

In view of Namibia's progress in combating the HIV/AIDS epidemic, its status as an Upper-Middle Income Country and the strength of its government institutions, most major donors to the HIV effort are reducing their financial contributions to the effort. PEPFAR in Namibia is reportedly planning to substantially reduce funding over the next several years. Further, two other developments of importance and relevance are taking place:

1. The GRN Ministry of Health (MOH) is assuming greater responsibility for directly funding HIV-related care at the FBO missionary hospitals (Catholic, Lutheran and Anglican) who own their own facilities and properties, but who until now have operated on block grants by the GRN to support operations and staff. The FBOs operate four of Namibia's 33 hospitals, and a significant number of health centers, clinics and VCTCs. The "absorption" of physicians working in the FBO institutions to a new status as direct government employees has already taken place (a high proportion of physicians working in all Namibian hospitals are expatriates from other African countries). Similar absorption of nurses and pharmacy assistants into MoHSS employment is currently under negotiation, with a September 2012

2. USAID is also in the process of a transition. It's moving from a mechanism of support for its sub-grantees via IntraHealth to direct funding by the GRN's Ministry of Health and Social Services (MoHSS). The transition is expected to be completed by September 2013.

3. The MoHSS is currently engaged in planning a major restructuring of the health services system, which will most likely bring the organization of health services, including HIV services, into a more integrated form under a primary health care umbrella. Until now, health services, especially for HIV, TB and malaria, have operated in a much more vertical fashion. The completion of planning and implementation of this restructuring is probably two or more years away.

The concordance of these three developments in timing and function places critical importance on effective planning, coordination and implementation for USAID and other donor entities, as well as the GRN and especially the MoHSS.

This report is a mid-term assessment of the IntraHealth Project, first funded by USAID as a cooperative agreement in 2008, modified in 2011, and scheduled to terminate in September, 2013 (see Annex 1 for a Scope of Work).

II. METHODOLOGY

The purpose of this evaluation was to assess progress and achievements of the USAID-funded IntraHealth "Namibia HIV Prevention, Care, and Support Project, 2008-2013," at mid-term, from March–May 2012 (see Annex 1 for the Scope of Work). This report focuses on:

1. Progress to date within the larger context of HIV efforts by the GRN.
2. Analysis of capacity building, costs and the potential for transferring sustainable activities to the GRN.
3. Efficacy of the IntraHealth sub-grantee mechanism in regards to the above.
4. The potential and recommendations for the remaining project period (September 30, 2013) and possibly beyond.

The intermediate results of the original agreement were employed as a framework for this evaluation. The four major components of the methodology include 1) a document review; 2) key informant interviews; 3) site visits; and 4) data analysis. Components were not chronologically isolated. For example, some documents were made available only after the team arrived in Namibia and some key informants were present only at sites visited. Data analysis continued during the entire evaluation process.

The evaluation began with a review of documents provided by USAID/Namibia, in addition to selected published papers and reports, unpublished technical papers and selected web sites (see Annex 3 for a List of Documents and References). During three weeks in Namibia, the two-person evaluation team collected and review additional documentation.

Key informant interviews were conducted with a structured questionnaire (see Annex 2 for a List of Persons and Organizations Interviewed and Annex 5 for the Structured Questionnaire).

The following is an outline of the evaluation team's schedule while in Namibia (see Annex 1 for a more detailed work schedule).

Week One (March 23–31): After initial briefing with USAID Mission, the team presented its workplan to the Mission**.** The team then met with and interviewed relevant stakeholders, including IntraHealth, its sub-grantee partners, officials at the GRN and MoHSS, and other relevant entities in Windhoek. As mentioned, the team used a structured questionnaire during these interviews. The team presented an outline for this report to the USAID Mission by March 31**.**

Week Two (April 2–April 7): The team traveled in Northern and Central Namibia, interviewing and assessing relevant project activities at sites selected by USAID.

Week Three (April 9–April 14): Back in Windhoek, the team completed stakeholder interviews. The team presented a draft of this report to USAID, in the form of an annotated PowerPoint presentation. The team debriefed with USAID on April 13, and departed Namibia on April 15.

III. FINDINGS AND DISCUSSION

THE NAMIBIA HEALTH SYSTEM IS ORGANIZATIONALLY COMPLEX

Namibia's MoHSS oversees a mixed system of facilities and programs. Public-sector facilities (hospitals, clinics and health centers) include facilities owned *and* operated by the GRN as well as facilities funded by GRN, but owned and operated by religious groups, such as Anglican Medical Services (AMS), Catholic Health Services (CHS) and Lutheran Medical Services (LMS). Namibia also has private facilities that serve approximately 15% of the population, generally the employed and those with relatively high incomes.

The GRN facilities are staffed by GRN employees and personnel employed through donor-supported entities. Health facilities operated by FBOs include staff that are direct GRN employees in Primary Health Care (PHC) clinics; staff that are FBO employees funded through a GRN subsidy to the facility; and staff employed through donor-funded entities.

This complex system delivers health programs funded through (in addition to private spending for the private facilities) the GRN budget and multiple donors. Donor funding varies in its specificity, but most funding is targeted to HIV programs.

In addition to clinical facilities, Namibia has standalone VCTCs operated by NGOs, as well as mobile testing centers mainly operated also by NGOs with donor funding.

FAITH-BASED ORGANIZATIONS PLAY AN IMPORTANT ROLE IN NAMIBIA'S HEALTH SYSTEM

IntraHealth Support in Namibia has focused on FBOs and Community Service Organizations

The FBO hospitals and clinics are an integral part of Namibia's public health care system, and include approximately 25% of Namibia's population in their catchment areas. The FBO hospitals and clinics have consistently reached VCT, ART and PMTCT targets. Non-clinical FBOs and NGOs provide important community-based services, including VCT, support services and prevention programs.

NON-CLINICAL OUTREACH IS IMPORTANT FOR ACCESS, ADHERENCE AND PREVENTION

Even with Namibia's broad public health system, there are significant restrictions on access. In rural areas, households are an average of 114 minutes away from a facility, and even urban households are 25 minutes away, according to the WHO Namibia Country Cooperation Strategy for 2010–2015. Beyond this, chronic staffing shortages generate a significant wait time at facilities. Counseling and testing at non-clinical sites allows patients to avoid travel to and waiting at health facilities. VCT outreach efforts include temporary VCT sites (whether mobile vans or tent sites) in underserved communities, as well as mobilization programs to attract clients to fixed sites.

Namibia's extreme inequality in income and educational opportunities translates into a large portion of the population who do not have basic knowledge of medical care. Outreach programs that include home visits increase adherence to treatment regimens and provide psycho-social support, as well as reducing strain on clinical facilities. FBOs are, of course, a

natural vehicle for the provision of spiritual counseling, valued by a significant portion of Namibians. Social and behavioral change campaigns, including youth-focused prevention efforts, can also be implemented by NGOs without burdening clinical site staff.

FINDINGS: IR1. INCREASED CAPACITY OF INDIGENOUS ORGANIZATIONS TO RESPOND TO EPIDEMIC AND IMPLEMENT HIV/AIDS-RELATED PROGRAMS

Namibia Has Had Impressive Response

Namibia has achieved 90% ART coverage for a population with HIV prevalence of 13.1%. Reduced mortality has, necessarily, increased the number of people living with HIV even as the number of new infections has dropped dramatically. AIDS deaths peaked in 2004, at over 10,000, and have decreased steadily to the 2009 rate of approximately 6,600. Namibia now has nearly 180,000 people living with HIV. New HIV infections peaked at nearly 25,000 in 1999 and decreased to fewer than 6,000 in 2010.

Two IntraHealth Sub-grantees Now Receive Direct Funding from USAID

IntraHealth's Year Two workplan identified three main partners targeted for graduation: CHS, LifeLine ChildLine (LL/CL), and Catholic Aids Action (CAA). After significant capacity building work with IntraHealth, LL/CL and CAA developed internal financial and management controls to successfully apply for direct funding from USAID/Namibia. CAA and LL/CL both receive continuing TA from IntraHealth. In addition to these three main partners, two other partners, LMS and Development AID from People to People (DAPP), were also targeted for graduation; DAPP is now funded by CDC.

IntraHealth's clinical partners, CHS and LMS, are discussed below as part of the transition of clinical services to MoHSS support, rather than direct USAID funding. This movement towards direct USAID funding was overtaken by events (e.g., the movement towards transitioning to direct funding by GRN). IntraHealth also assisted with an organizational capacity assessment (OCA) for the HIV Clinicians Society (HCS), a professional organization that receives capacity building TA from IntraHealth.

IntraHealth-supported Physician Staff of Three IntraHealth Sub-grantees Has Transitioned to MoHSS

To augment staff and provide HIV-related clinical services, IntraHealth was influential, through agreements with the sub-grantees, in the hiring of (often excellent) staff by the respective FBOs at facilities operated by AMS, CHS and LMS. As part of a USG-wide strategy of transition toward greater GRN ownership, physicians employed by IntraHealth were accepted onto the MoHSS staff for the FBO facilities to which they were seconded by IntraHealth. For example, in the CHS facilities, all four medical officers transitioned to MoHSS employment. Completion of this transition illustrates the organizational complexity of the Namibian system even as it demonstrates successful capacity building.

IntraHealth-supported Pharmacy and Nursing Staffs are Planned for MoHSS Transition

To facilitate HIV services, IntraHealth supported a variety of staff in addition to the physicians accepted as MoHSS employees. Nursing and pharmacy staffs are planned for transition to MoHSS support, although the planned dates are not consistent for all affected parties. At CHS,

in addition to four (of five) nurses planned for transition, IntraHealth supports 50 staff, including 16 counselors and a social worker, in addition to others as varied as prevention officers, community organizers, receptionists, drivers and cleaners.

Regional Management Teams and Sub-grantee Officials Expressed Concerns Regarding Pharmacy and Nursing Staffs Transition

With USAID/Namibia instruction, IntraHealth plans to support nursing and other staffing positions through September 2012. Discussions with regional management teams (RMTs), which are tasked with the management of health facilities at the regional level, and include AMS, CHS and LMS, reveal a consistent unease with this end of funding. And while the MoHSS has agreed, in principle, to fund the nursing and pharmacy staff (either as MoHSS employees or through a subsidy to the FBO hospitals), the budget does not include funds for the nursing and pharmacy staff in the GRN fiscal year beginning April 2012. Funding for non-clinical staff, covering functions as varied as M&E, finance, and drivers is still uncertain. While staffing for clinical services is obviously essential, it is equally as obvious that without non-clinical support, patients will not be scheduled, records will not be maintained and the facility will not be serviceable.

FINDINGS: IR2. STRENGTHENED CAPACITY OF LOCAL ORGANIZATIONS TO PROVIDE HIGH QUALITY, AGE-APPROPRIATE HIV/AIDS PREVENTION PROGRAMS AND REFERRALS AT HEALTH FACILITIES AND AT COMMUNITY LEVELS

Faith-based Organization Hospitals Substantially Increased PMTCT Results

With IntraHealth support, more FBO clinical sites are providing PMTCT services. Through December 2012, FBO sites provided antiretroviral drugs (ARVs) for 5,391 pregnant women who were HIV positive, 43% above the target. Further, PMTCT has been integrated with cervical cancer screening at sites in Oshikuku, Odibo and Onandjokwe.

Challenges remain, of course. Male involvement in PMTCT programs is very low at less than 5%. Many clinics have chronic staff shortages, particularly nurses. This situation is not unusual across the country, as are difficulties in mother and infant follow-up care. The MoHSS has not implemented mother-to-mother support groups for HIV positive mothers.

IntraHealth-supported Clinical Sub-grantees Provide Community Outreach

The FBO clinical facilities have implemented social behavior change communication programs, including broad outreach and targeted programs to increase women's access to information and decision-making while others focused on increasing male involvement. Outreach services also introduced new prevention efforts such as male circumcision (MC), increasing communities' knowledge on new evidence on HIV prevention. IntraHealth also supported partners to implement outreach counseling and testing in collaboration with PHC/MoHSS, including at mines (Rosh Pinah and Arandis). With IntraHealth support, New Start centers teamed with the Bicycle Empowerment Network to create demand for HIV counseling and testing (HCT) services at all of the northern centers. A significant impediment to outreach was tasking of prevention personnel with other clinic-related duties. Implementation was improved with agreement that prevention staff should focus on HIV prevention activities, rather than to clinical support.

IntraHealth Provides Continuing Support for Technical and Managerial Capacity

While CAA and LL/CL are funded directly by USAID/Namibia, IntraHealth provides continuing support in finance and administrative capacity building. Leadership in these organizations recognizes persistent gaps in essential skills. To address those gaps, IntraHealth assisted with OCAs for LL/CL and CHS, and is working with AMS and LMS on OCAs. In addition to organizational TA, IntraHealth also provides quality assurance (QA) support for VCT programs and clinical sites.

FINDINGS: IR3. IMPROVED OPPORTUNITIES FOR NAMIBIANS TO KNOW THEIR HIV STATUS BY IMPROVING LOCAL ORGANIZATIONS' ABILITY TO PROVIDE QUALITY HIV/AIDS COUNSELING AND TESTING SERVICES AT MEDICAL FACILITIES AND IN COMMUNITIES

Two IntraHealth-supported NGOs Now Provide VCT and Community Outreach with Direct Funding from USAID

After significant capacity building support from IntraHealth, LL/CL and CAA developed internal financial and management controls to successfully apply for direct funding from USAID/Namibia. (The CAA transition to direct funding was accomplished in conjunction with PACT, another USAID implementer, which also funded CAA.) Capacity building efforts embraced operational support (grants management, financial management, reporting and logistics, policies and procedures) and key institutional strengthening dimensions (strategic planning, leadership and management, human resource management, and monitoring and evaluation). More specifically, IntraHealth provided TA to CHS, LMS and LLCL to update their human resources policies, procedures and employment contracts, aligning them with changes in Namibian labor law. IntraHealth also provided TA to address the weaknesses identified in the financial/organizational capacity evaluation conducted by the Defense Contract Audit Agency. The TA included training in payroll processing; in accounting for program transactions using the Pastel accounting system; in the preparation and submission of monthly financial reports and quarterly financial and program reports; and in training program staff to update financial and grants management policies and procedures. CAA and LL/CL both receive continuing TA from IntraHealth.

LL/CL operates three New Start VCT sites and CAA operates one New Start VCT site. CAA has received direct USAID funding since November 2010. LL/CL received a two-year grant from USAID in December 2011.

Significant Accomplishments in VCT at FBO Hospitals and Standalone VCT Centers

Since fiscal year 2009, IntraHealth-supported sites have provided HIV test results to nearly 200,000 Namibians, exceeding targets in the aggregate. In the single year that the target was not reached, the result was 3% short. The accomplishments in testing are all the more impressive for the high proportion of couples counseling. At the Katatura/CCN site, nearly a quarter (23.4%) of individuals were counseled as part of a couple. The Central Business District, Oshikango and Oshikuku sites also had substantial success in couples counseling.

Collaboration with Management Sciences for Health (MSH) has ensured a consistent supply and efficient use of rapid test kits. The distribution and inventory management collaboration eliminated stock-outs at VCT sites while redirecting soon-to-expire supplies to sites with higher current use rates.

All the New Start sites implemented integrated HCT, with routine symptomatic screening for TB, sexually transmitted infections (STIs), information on risks associated with alcohol use, male circumcision education, information and referrals.

De-funding of Seven Stand-alone VCT Centers Raised Questions among NGOs about USAID Intentions

More than a year after seven VCT sites were closed toward the end of 2010, Namibian NGO staff reported the closures and broadly view the process as significantly flawed. Relevant to USAID and IntraHealth operations is the impact these closings have on the ability to conduct meaningful joint planning with Namibian NGOs. USAID/Namibia conducted a thorough after-action review, for which no supplement is necessary here, except to emphasize the importance of broad communication in anticipation of significant implementation changes.

RMT, NGO and Sub-grantee Officials Expressed Concerns Regarding GRN Funding of Outreach Staff

The organizational complexity has the potential to compromise HIV-related community outreach. RMT staff, NGO personnel and FBO clinical staff separately volunteered concerns that the GRN would not fund any non-clinical, HIV-related outreach services. The MoHSS is perceived as having little interest in non-clinical services related to HIV, and there is limited viability for alternative sources of support. The Ministry of Regional and Local Government and Housing ostensibly support community groups and regional committees, but enthusiasm and available funding both appear to be constrained.

FINDINGS: IR4. STRENGTHENED CAPACITY OF LOCAL ORGANIZATIONS TO PROVIDE HIV/AIDS CARE AND TREATMENT SERVICES FOR BOTH ADULTS AND CHILDREN

Faith-based Organization Hospitals Substantially Increased Provision of ART to Patients

The number of current ART patients at IntraHealth-supported clinical sites has increased by more than 5,000 since 2009. As of December 2011, the sites had over 20,000 patients receiving ART, of which 14% were under 15 years of age. The Onandjokwe site is the busiest ART clinic in Namibia, and is among several sites in which the number of patients has created a need for increased clinic space.

Increased capacity to provide care and treatment extends beyond the number of ART patients. Family Planning (FP) has been integrated with ART at the Odibo HC, and with PMTCT at Andara and Nyangana. Service integration is complicated by program separation—specifically with HIV-specific funding requiring financial separation of staff providing HIV services. Within funding constraints, CHS continues its tradition of integrated service delivery, with most services (ANC, PNC, EPI, EID, growth monitoring, FP, PMTCT) provided under one roof as one-stop access. Other service integration programs include cervical cancer screening and TB integration with HIV care.

Outreach is Important for Testing, Adherence and Support

The importance of outreach is well established in public health literature. At the most basic level, few people seek HIV testing in the absence of outreach efforts. Provider-initiated testing is unlikely to reach asymptomatic individuals who have been infected. Clients receiving post-exposure prophylaxis are not tracked, which precludes verification that the client remains uninfected. Low male involvement in prevention activities is unlikely to change without expanded, targeted outreach efforts. A significant number of patients are lost to follow-up, an recognizable area where outreach would be effective. Little information is available as to whether these patients have moved, are visiting a different clinic, have died or simply have not returned for treatment.

FINDINGS: IR5. INCREASED CAPACITY OF THE MOHSS TO MANAGE HUMAN RESOURCES FOR HEALTH THROUGH SUPPORT TO THE DEVELOPMENT AND IMPLEMENTATION OF A HUMAN RESOURCES INFORMATION SYSTEM

The Human Resources Information Management System Resides on the Office of the Prime Minister's Server

The Human Resources Information Management System (HRIMS) is a rather dated program intended to capture information for all GRN employees. The computer on which it is installed is under the authority of the Office of the Prime Minister (OPM). OPM authority over HRIMS requires exceptionally broad coordination, with a stakeholder leadership group including relevant MoHSS entities and representatives from OPM and the Ministry of Finance, among others.

The Office of the Prime Minister's Data Center Facilities Have Been Improved

IntraHealth provided improvements to the facility that houses HRIMS operations. These improvements addressed both physical security and data security. Physical site improvements included improved security doors, climate control and data backup to provide increased system availability, reliability and security.

The Regional Management Teams Have Terminals for HRIMS Connection

After an initial pilot test in six regions, HRIMS was rolled out to all 13 RMTs. With IntraHealth support, MoHSS provided data terminals and file servers at each region. Coordinating with MoHSS information technology (IT) staff, a wide area network (WAN) was contracted.

IntraHealth Provided Training and Technical Assistance for Regional Management Teams

IntraHealth provided training for HR staff at the regions for MoHSS. With an existing paper-based system, training began with computer literacy development before modules specific to HRIMS. IntraHealth also provided training for MoHSS IT staff. With this training, RMT HR staff has been able to enter all data into HRIMS. MoHSS and IntraHealth have conducted a series of data quality assessments comparing staffing data and payroll data. October 2011 reports on HRIM accuracy and consistency with payroll records are attached as Annexes 6 and 7.

Significant System Deficiencies Related to Server Capacity, Connection and/or Regional Management Team File Server Maintenance

The addition of 13 RMTs accessing HRIMS daily has strained system capacity. The RMT HR staff report extreme difficulties in system use during normal working hours. HRIMS is often completely unavailable multiple days each week. When access is possible, response is often so slow that data input or access is operationally unworkable. Access is apparently not problematic in Windhoek, or during non-working hours (before 08:00 and after 17:00).

IntraHealth anticipated many of these difficulties, although perhaps not to the extent to which they impede operations. HRIMS was intended as a transition from the pre-existing paper-based record system to a planned HCMS. IntraHealth's Year One workplan (December 2008–November 2009) noted that "many activities still remain to ensure a smooth transition from the MoHSS's paper-based HRIS to the existing computerized human resource information management system (HRIMS) and finally to the new human capital management system (HCMS)." At that time (December 2008), HCMS was to be functioning within 18 to 24 months. HCMS was delayed, and is now scheduled for deployment during the second half of 2012 with MoHSS as one of the pilot ministries.

FINDINGS: COST ANALYSIS

Crude Calculation of Cost would be Misleading

Example: Mechanism HTXS Budget Divided by APR ART Results

A review of PEPFAR budget codes quickly reveals some of the difficulties in developing useful estimates of cost. COP Guidance has consistently identified Adult Treatment (coded HTXS) as "including infrastructure, training clinicians and other providers, exams, clinical monitoring, related laboratory services, and community-adherence activities." From this, it is clear that a mechanism's "Adult Treatment" budget would not be a sensible measure of the cost of treating adults whose treatment is attributed to that mechanism. The expenses can all fairly be identified as costs for treatment broadly, but the budget code explicitly includes items that cannot reasonably be attributed to patients receiving ART under the mechanism.

Infrastructure improvements present multiple complications. The improved facility will certainly not be available during the entire budget year—and may not be available for any part of the year. It plainly would not be sensible to attribute the costs of infrastructure improvement to patients treated elsewhere while the improvements are under way. Even after the improvements are made, it would be sensible to pro-rate the cost of the facility over its expected life; the cost could not sensibly be attributed entirely to patients during the remainder of the year in which it was finished.

Training clinicians and other providers has difficulties analogous to infrastructure. It would not be sensible to attribute training costs to patients treated by other (already-trained) clinicians.

Cost estimates, whatever the item whose cost is estimated, are more likely to be helpful when developed carefully and used thoughtfully.

Indirect Costs (Overhead) Are Not Properly the Subject of Evaluation or Comparison

Some USG personnel in Namibia expressed concern regarding the significance of overhead costs of international partners. USAID guidance explicitly states that, "Indirect costs should not be

reviewed as part of any cost effective evaluation criteria." Further, "Indirect cost rates **should not** be considered in award decisions or negotiations…" (emphasis in the original). The guidance document "Best Practices Guide for Indirect Costing" reviews both the nature of indirect and some of the reasons for excluding it from evaluation of cost effectiveness and award decisions. "An indirect cost rate by itself has very little meaning." This observation precedes discussion of the fact that the base for indirect costs varies, making a rate comparison pointless. For example, a rate of 25%, levied against total costs, can result in a greater charge than a rate of 75% levied only against direct labor costs. USAID recognizes that "there are numerous differences in both workforce and accounting classifications as to direct or indirect costs, as well as other variables such as the extent to which subcontractors are used, the structure of an organization, the expanding and declining business base for individual organizations, and the differing accounting methodology of one organization verses that of another."

In the case of IntraHealth and its sub-grantees, it is especially important to be careful in considering any significance of indirect costs or overhead. The agreement between USAID and IntraHealth provides that the base for overhead charges excludes "overhead, donations and sub-awards/subcontracts in excess of $25,000 per sub-award/subcontract each year."

For identifying cost-effective interventions and support for cost effective services, though, the problems extend even deeper than the near-meaninglessness of indirect cost rates and the difficulty of producing comparable indirect cost amounts. Broadly, indirect costs or overhead are costs of support, administration, oversight and the like that are not directly attributed to specific activities. The analysis is especially difficult if funding is fragmented among related activities, some of which provide support, administration or oversight of other activities (not all of which are funded by the USG).

Appropriate Cost Estimation Requires Separation of Costs For Service Delivery And Capacity Building ("Investment" And "Operating" Costs)

Effective use of cost estimates requires a clear understanding of how cost components are identified and attributed. The task is more complex for undertakings that, like the IntraHealth Namibia project, include major components of capacity building as well as service delivery. Capacity building is conceptually analogous to physical investment, with a current expense that is expected to yield services well into the future. The analogy is illustrated by the common use of "human and institutional capital" as part of capacity building. Indeed, investment in "human and institutional capital" is sometimes used synonymously with capacity building. The GAO audit of health capacity building in Namibia notes that: "USAID/Namibia had spent about $39 million on **investments** in health workers" (emphasis supplied). Specification of technical units for infrastructure improvements can be difficult (square feet/meters added is not always a helpful measure), but it is even more challenging to measure human and institutional capacity building. The measurement challenge, as well as the investment nature of capacity building, was recognized in the GAO audit report, quoting a 2009 USAID report to Congress: "The lack of consensus surrounding a set of tested and accepted indicators related to health systems hinders efforts to track progress and demonstrate evidence-based results of investments in health systems."

The GAO audit report also noted that: "Despite the absence of mutually agreed-on indicators, USAID/Namibia needs to establish HRH baseline data and include indicators and targets in its PMPs to measure progress and achievement (outcomes) and to comply with ADS 203.3.3." These indicators, baseline measurements and targets, while not available to the evaluation team,

should enhance program effectiveness. If budgets reasonably attribute costs to indicator achievement, cost effectiveness will be more readily analyzed. Comparison would be greatly enhanced if indicators and budget attributions are used consistently across activities, USG agencies and relevant GRN entities.

In-Country Comparison of Alternatives Requires Consistent Costing Methodology

PEPFAR II is not unique in seeking efficient provision of medical care. The legislative requirement for "comparison of the costs for equivalent services," implicitly and sensibly, encourages adoption of more efficient service models. Meaningful analysis, including comparison of alternatives, is only possible with a framework of consistent data.

Just as it would not be sensible to attribute the cost of construction to patients treated while the constructions is in progress, it would not be sensible to deny that support costs exist simply because they are funded through a different budget. The data challenges are significant in the context of PEPFAR, where the policy goal is increasing use of partner country systems for effective and efficient prevention, care and treatment services. It is not possible to conduct meaningful cost analysis of different delivery mechanisms without considering all the costs of each system, including costs for physical facilities and system administration.

In Namibia, comparison across districts or among facilities requires explicit consideration of the contributions of FBOs, GRN, PEPFAR and other donors. Careful thought should be given in attributing central expenses, including coordination and oversight, to provision of various services. Consistent measures of capacity building and service costs across mechanisms and service delivery modalities will allow identification of best practices, advancing the fight against the HIV epidemic and the health of the people of Namibia.

Existing Budget Records Do Not Permit Segregation of Service Delivery and Capacity Building Expenditures

PEPFAR budget codes are structured around program categories (prevention, care and treatment) and explicitly embrace capacity building and service provision expenses within budget codes. PEPFAR does include a budget code for Other Health Systems Strengthening (OHSS), but COP Guidance includes the admonition that "OGAC discourages reductions in HTXS, PDTX, HLAB, or HTXD funding from those budget codes into OHSS." In this context, with the already considerable reporting burdens of PEPFAR, it is not surprising that budget procedures largely reflect the PEPFAR budget structure and the operational needs of specific mechanisms.

Some of the difficulties in cost analysis are revealed in OGAC's February 2012 "Report on Costs of Treatment in the President's Emergency Plan for AIDS Relief." It estimates average costs to PEPFAR for ART as USD $335 per patient per year, USD $438 in lower-income countries, and USD $139 in higher-income countries. The lower cost **to PEPFAR** reflects, of course, the generally lower level of assistance to relatively rich countries. The total costs of treatment average USD $768 per patient per year. Of this, 5% is estimated as capital costs, and 20% for support above the facility level. The report noted that: "In terms of a comparison of PEPFAR's costs with those of other programs, there is not sufficient, comparable data to make a meaningful comparison possible." Even though there was a significant effort to compare costs between PEPFAR-supported treatment sites and those supported by other donors, "After working on this effort, those attempting it concluded that the comparison was no longer possible or useful."

Some sense of the cost-effectiveness of the IntraHealth project is shown by resource estimates prepared by the U.S. Centers for Disease Control (CDC). The 2009 "Estimation of Resource Needs Implications of Namibia's ART Treatment Guideline Changes" provides an average of 418 new ART patients per year per medical officer, or 1,045 patients per year for follow-up visits, with 1,463 patients per year per nurse for both new and follow-up patients. With IntraHealth support, CHS has 8,976 active patients on ART with four physicians, now transitioned to MoHSS, and five nurses. If all the ART patients were receiving follow-up treatment, it would justify eight medical officers and six nurses.

In the fiscal year () 2010 COP, IntraHealth had USD $1,599,262 in funding for Adult Care and Treatment (HTXS) and USD $310,421 in Pediatric Care and Treatment (PDTX). If these costs are attributed to the total number of IntraHealth-assisted ART patients for FY2010, the cost is USD $117 per patient per year, an amount well under the PEPFAR average, even excluding ARV costs. This estimate, of course, is a nearly meaningless estimate of the cost of treatment. It does not include the cost of ARVs, nor does it include a broad range of support costs, from facility operation to administrative support and quality assurance. Equally meaningless would be cost per patient for various mechanisms with HTXS funding that do not directly provide treatment for any for any patients.

FINDINGS: SUSTAINABILITY

Working Definition of Sustainability: Increased Ability of Country to Operate and Fund HIV Response

The PEPFAR II Reauthorization (the Lantos-Hyde Act) and the PEPFAR II Strategy use the words "sustainable" and "sustainability" in a variety of contexts, but do not offer a definition. However, there is consistent reference to a greater use of partner countries' institutions in fighting the HIV epidemic, and growing partner country responsibility for financing the effort.

Administrative Capacity Shown By "Graduated" NGOS Granted Direct USAID Funding

During implementation of the IntraHealth project, two Namibian NGOs (CAA and LL/CL) transitioned from receiving financial support and oversight by IntraHealth to receiving funding directly from USAID. This is unambiguous recognition of the strengthened management capacity of these organizations.

Namibian Private Donor Tradition Undeveloped

In the region, Namibia is not unusual for its absence of private giving to charities. However, the country has reasonable prospects for longer-term increases in charitable giving. The World Giving Index reports that half of Namibians reported helping a stranger in the previous year and 17% reported giving money. For most Namibians, the capacity for giving is limited by extreme income inequality. Substantial, local support for Namibian NGOs will require a continuing and significant shift in social norms.

GRN Budget Priorities Unclear with Respect to FBO Hospitals

FBO hospitals are an integral part of Namibia's public health system. There is, though, a remarkable asymmetry in discussion of FBO hospital funding by GRN officials and FBO health program officials. GRN officials consistently describe FBO hospitals as 100% subsidized by GRN, implicitly or explicitly putting the FBO hospitals on equal footing with GRN hospitals. But FBO

officials describe a funding procedure that lacks predictability, consistency and never "100%" as GRN states.

The mixed funding stream, with direct MoHSS employment of PHC physicians and a block subsidy for other operations, contributes to the differing perceptions. A recent GRN overture to completely absorb the FBO hospitals, including transfer of the land and buildings, also contributes to differing interpretations of funding discussions.

Little Interest by the MoHSS to Support Outreach through NGOs

HIV-related community outreach in Namibia is now accomplished through a number of entities, including mobile units based at MoHSS facilities and regional programs operated under the Ministry of Regional and Local Government and Housing, as well as the two NGOs now funded directly by USAID. MoHSS officials discussed an intention to expand clinical outreach with greater integration of HIV-related services and other health care. MoHSS officials expressed very little interest in funding VCT outreach through NGOs, and almost no interest in supporting non-clinical, social-services-related outreach.

IV. CONCLUSIONS

STRENGTHS

IntraHealth has significantly contributed to GRN's development and operation of an impressive national program for HIV prevention, treatment and related services. While directly servicing only five of the 34 district hospitals in Namibia, the quantity and quality of preventive counseling and testing and clinical service delivery of IntraHealth's sub-grantees is impressive. This has been especially so in the areas of salary support for ART, PMTCT, VCTS, training of clinical and non-clinical personnel, and training and TA in areas of financial management, administration, data management, quality assurance and infrastructure support.

Ambitious targets have been met in most project areas. The following illustrate key selected achievement indicators of the project, from fiscal year 2009 through the first quarter of fiscal year 2012:

Table 3. Key Project Indicators: FY 2009–March 2012

Indicator	Target	Achieved
Individuals completing training	2, 750	3,600
Pregnant women receiving ARV	3,765	5,391
Number of males circumcised	800	764
Number receiving risk prevention counseling	103,625	165,331
C/T clients receiving test results	190,675	196,238

There have been particularly noteworthy achievements in assisting sub-grantees with development of fiscal and administrative services and in the social/behavioral and outreach aspects of VCT services. Sub-grantees were unanimous in their praise and appreciation for the quality and availability of IntraHealth's training and technical support—in some cases describing it as "mentoring." Several of the sub-grantees appeared to be surpassing GRN VCT services by the extent and quality of outreach, mobile and social/behavioral aspects of VCT.

Working with MSH and the GRN, IntraHealth built a system of distribution and stocking of HIV testing commodities that sub-grantees describe as being absent of stock-outs and providing rapid and accurate delivery. This includes "just in time" features in which supplies at one VCT Center that have a near-expiration date, can be identified and moved to another center where utilization is higher or demand is more acute.

The project has made it possible for two sub-grantees to 'graduate' to direct USAID funding. This is likely to be a significant step to the future transition to direct GRN funding.

- **Substantial numbers of health care workers have completed in-service training (see Findings: IR1).**

- **FBO hospitals significantly increased the number of HIV positive pregnant women receiving ARV (see Table 3 and Findings IR3 and IR4).**
- **FBO hospitals significantly increased the number of HIV positive patients receiving ART (see Table 3 and Findings IR3 and IR4).**

WEAKNESSES

The history of the closure of the majority of stand-alone "New Start" VCT Centers has resulted in anxiety among sub-grantees facing uncertainties related to additional funding decline and transition to GRN direct funding. All observers (GRN, USAID, IntraHealth and sub-grantees) agree that the closure of these activities was handled with poor communication and lack of coordination. This led to confusion among clients and a decrease of confidence among partners—traces of which remain. The USAID After-Action Review of the closures noted that "USAID identified critical gaps during the closure of sites as follows: Lack of site closure guidelines[;] Lack of site specific transition plans[;] Lack of referral mechanism for potential clients[;] as well as Lack of an effective communication strategy between all relevant stakeholders." During meetings with implementing partners (including sub-grantees), discussants often spontaneously raised the closures and expressed concern about the future of unrelated programs.

It is unclear to what extent coordinated and adequate planning is proceeding for the transition of sub-grantees to direct GRN financing. More generally, there is a deficit in clear and specific communication between the parties, including GRN, USAID and IntraHealth, as to the specifics and timing of the proposed transitions and their financing.

In particular, NGOs are uncertain as to whether they will receive continued financing to provide the same range of funding post-transition. There are indications that GRN may not be as interested in financing the range of socio-behavioral and outreach/behavioral counseling as has been the case under IntraHealth with USAID funding.

In its current form, the MC activity is unlikely to be sustainable or reach scale. There are significant limitations in the long training period for physicians, the low continuance of physicians, the limited 'marketing' success, and other factors. This program needs a searching review and reformulation if it is to have a chance of large-scale and lasting success.

The IntraHealth project, as is the case with the overall National HIV Program, has had very limited focus on men who have sex with men or on commercial sex workers. Though there are significant legal and discrimination hurdles to be overcome, these two groups deserve more careful consideration and project activities as they will undoubtedly play a larger part in the HIV epidemic Namibia—as other routes of transmission become increasingly under control by the successful Namibian National HIV Program.

The HRIMS operation in the regions is significantly degraded, with access interrupted or unavailable, and with slow response time when access is achieved. In fact, the inadequate HRIMS server is soon to be entirely abandoned by GRN, in favor of a new Oracle-based system. It remains to be seen what downsides, added costs, and loss of prior effort will occur as current HRIMS data is migrated to the new system, and the new system implemented throughout Namibia.

PEPFAR mechanism budgets and workplans do not facilitate appropriate cost analysis. This creates undue difficulties in attempts to separate capacity building (investment) and service delivery (operating) expenses, and to make comparisons between various PEPFAR mechanisms.

OPPORTUNITIES

IntraHealth and USAID have an opportunity to develop a smooth and sufficiently-staged transition plan, working closely with the GRN, to move the sub-grantees directly under the GRN funding programmatic and personnel umbrella, where applicable and appropriate, and in such a way as to enhance both the work of the sub-grantees and also the quality and scope of the National HIV Program.

As part of the required transition to direct GRN project funding, enhanced working coordination can, and should, be engaged between IntraHealth and CDC/Namibia activities.

Interagency (CDC and USAID) discussion of budgeting to facilitate cost analysis would improve program coordination and effectiveness and program design, as well as permit improved analysis of operations. Identification of more cost-effective modes of service provision requires that cost information for alternative service modalities (whether prevention, care, treatment or capacity building) be available on a basis that permits meaningful comparison. Meaningful comparison of costs cannot be accomplished without cost estimates prepared with similar attributions of expenses.. Similarly, meaningful discussion of cost effectiveness requires that results (particularly capacity building results) be measured on a comparable basis and that costs be comparably attributed. If activity budgets for USAID and CDC were constructed to facilitate cost analysis on a comparable basis, it would be possible to identify interventions that are more cost effective, and would also encourage improved definition of intended results for proposed interventions. With improved definition of intended results (shared across agencies), presumably corresponding to the capacity building indicators promised in response to the GAO audit, and budgets reasonably attributing costs to achievements under those indicators, the implementation progress could be more readily tracked and analyzed.

In addition to their desire for the GRN to adopt the best features of the stand-alone VCT centers (in particular mobile/outreach and the social-behavioral services), the sub-grantees themselves should explore how best they can 'reinvent' their own programs to be increasingly broadly-effective and cost-effective.

THREATS AND CHALLENGES

The major threat facing USAID/IntraHealth accomplishments is the possible delay or failure of the GRN projected absorption of FBO nurses into direct employment as MoHSS personnel, by the projected date of September 2012. It seems near-certain that the GRN self-imposed timeline will not be met. Employment uncertainty for FBO staff could induce departures and service degradation, well before the projected closure of the IntraHealth Project in September 2013

A poorly-implemented HRIMS impedes effective transition to GRN implementation and funding of HIV activities, including IntraHealth. If full implementation or successful

operation of the new Oracle-based system is compromised or delayed, this problem, and its costs, will be magnified.

Community and mobile outreach for counseling, testing and support are threatened if these services are de-funded or inadequately funded through NGOs without replacement programs and funding by GRN. Community and mobile outreach activities will become even more integral to the effective reach of the National HIV Program as the more accessible population reaches its peak.

LESSONS LEARNED

The outcry generated in the process of the closure of the majority of the stand-alone VCT centers underline the importance of coordinated planning and open and clear communication between all partners concerned.

Despite significant and successful efforts in e-system investment in the HRIMS at facility and regional office levels, the inadequacy of the system server (housed in the OPM) has created significant inadequacies in the functional usefulness of the system. An entirely new and different, Oracle-based, HR e-system (HCMS) is now being developed and installed by GRN, with the same server location, and a projected start-up within the next few months. Server adequacy, migration of HRIMS data, and prior HRIMS training, may all pose problems for smooth HR data effectiveness during the transition period between IntraHealth and MoHSS activities.

Coordination among USAID/IntraHealth mechanisms and MoHSS offices poses a continuing challenge and merits additional attention. The organizational structure addressed by the IntraHealth mechanism is inherently complex as well as fluid. USAID funds multiple mechanisms that impact the organizations directly assisted by IntraHealth, while the MoHSS has its own complex structure that includes multiple central functions and regional functions that embrace government-owned facilities and the FBO facilities directly assisted by IntraHealth. The CDC assistance directly to MoHSS unavoidably adds to the complexity of relationships, at times obscuring the integrated USG approach anticipated by PEPFAR. Some senior MoHSS officials spoke unfavorably of USAID assistance, both on its own terms and in comparison to CDC assistance. The comments included an explicit statement that USAID does not encourage cooperation with other donors. The expressed sense of disharmony reveals the desirability of increased effort to communicate, to both MoHSS and within the USG, the shared strategy of USG assistance in Namibia.

Cost analysis is constrained by budget practices; appropriate (interagency) budget planning can facilitate cost analysis among PEPFAR mechanisms.

BEST PRACTICES

- **Development and operation, in cooperation with MSH, of a smoothly-functioning and highly-effective counseling and testing supply chain.**
- **The quality of IntraHealth TA and training, especially in finance and administration.**

RECOMMENDATIONS

As part of the PEPFAR Namibia effort, the process of transitioning IntraHealth's activities and funding to the responsibility of the GRN requires recommendations that address both near term events and longer-view considerations.

Preserving the gains in prevention, care and treatment requires attentive monitoring of the transition from USG funding (through USAID to IntraHealth and the FBO hospitals and clinics to GRN funding). Thus:

IntraHealth and USAID should prepare and exchange monthly reports documenting developments and appropriate action on the transition of pharmacy and nursing staff from IntraHealth employment to GRN.

IntraHealth and USAID should prepare and exchange monthly reports documenting developments and appropriate action on HRIMS usability in the regions and on planning for transition to HCMS.

USAID should provide IntraHealth with monthly updates on developments of transition of USG funded activities to GRN. Effective transition planning, for the NGOs and FBO clinical service providers, as well as for IntraHealth's provision of TA will require timely information on such issues as potential GRN funding; the GRN entity through which services will be provided; and GRN policy on the interaction of NGOs with clinical facilities. Although expected, information sharing as a routine management process has been notably lacking. Implementation of the three recommendations above should not place an undue burden on either USAID personnel or IntraHealth. It seems likely that IntraHealth would welcome the information, and USAID would benefit both from the compilation and review of information sent to IntraHealth and from the information sent by IntraHealth.

Equally important, but perhaps less urgently, analysis as well as implementation could be improved by revised budget procedures and more explicit efforts to improve coordination. Mechanisms funded through PEPFAR Namibia should include budget-planning categories that reflect the distinction between capacity building efforts and service provision. Even though funding to deliver services may, in some sense, increase capacity, it has a significantly different emphasis than creating a local entity that can provide the services without external TA or financial assistance.

Increased formal recognition of the distinction between capacity building and service delivery, in both budgets and operations description, would facilitate assessment of success and cost effectiveness in capacity building as well as in service provision. Thus:

Interagency budget planning should reflect the distinction between capacity building efforts and service provision.

The PEPFAR transition from emergency to sustainability, combined with staff turnover and distinct agency cultures (USAID and CDC), increases the need for explicit effort to improve team function and increase program effectiveness. Thus**:**

To further support IntraHealth and USAID efforts, the PEPFAR Coordinator should continue ongoing efforts to strengthen Interagency function for improved coordination of program implementation.

ANNEX 1: SCOPE OF WORK

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

I. TITLE: USAID/NAMIBIA MID-TERM EVALUATION FOR INTRAHEALTH INTERNATIONAL "NAMIBIA HIV PREVENTION, CARE, AND SUPPORT PROJECT".

II. PERFORMANCE PERIOD: NOT INCLUDING TIME FOR PREPARATION AND COMPLETION OF REPORT, AND PENDING CONSULTANT AVAILABILITY, FOUR WEEKS IN-COUNTRY DURING ON/ABOUT FEBRUARY TO MARCH, 2012. FULL TIMEFRAME OF ACTIVITY WILL BE O/A LATE FEBRUARY 2012 THROUGH EARLY MAY 2012.

III. III. FUNDING SOURCE: THIS ASSIGNMENT WILL BE FUNDED BY USAID/NAMIBIA

IV. IV. PURPOSE AND OBJECTIVES:

Goal of the evaluation: The goal of this evaluation is to assess progress made towards achieving intermediate result under the original agreement as well as determine the cost effectiveness of IntraHealth model/approach. Findings and recommendations will be used to inform USAID/Namibia and relevant stakeholders in adjusting workplans and approaches to achieve award objectives.

Objectives of the Evaluation:

- To determine the sustainability of IntraHealth activities (including sub-grantees) and establish if capacity building activities have had measurable impact on local organizations.
- To determine if investments in human resources are achieving a long-term impact and are sustainable.
- To conduct a cost analysis of IntraHealth International's activities and determine the unit cost or the service package cost.
- To provide USAID/Namibia and relevant stakeholders with data to inform potential adjustments to workplans and program approaches with the goal of achieving maximum results.

Period under review for the evaluation: From the start of the award (November 26, 2008) to the end of the First Quarter of FY11 (December 31, 2011).

V. BACKGROUND

Namibia is one of the Sub-Saharan African countries at the epicenter of the HIV epidemic. According to the 2010 National HIV Sentinel Sero Survey, HIV national prevalence was 17.8% with estimated national prevalence of 13.3%. To help reduce the spread and impact of

HIV/AIDS, USAID funded projects have supported capacity building of the Government of the Republic of Namibia (GRN) and indigenous organizations with the overall goal of increasing Namibians' access to HIV/AIDS prevention, treatment, and care and support services.

On 26 November 2008, USAID awarded IntraHealth International a bilateral Cooperative Agreement (674-A-00-09-00003-00) for "Namibia HIV Prevention, Care, and Support Project." This five-year project has an original ceiling of $48,917,696 and an end date of November 25, 2013. The current award is a follow-on to the centrally funded Capacity Project. The award focuses on the following PEPFAR technical areas: Prevention (HVAB), PMTCT, Condom and Other Prevention (HVOP), Male Circumcision (CIRC), Palliative Care (HBHC), TB/HIV (HVTB), HIV/AIDS Adult and Pediatric Treatment (HTXS, PDTXS), Counseling and Testing (HVCT), Strategic Information (HVSI), as well as Other Health Policy and System Strengthening (OHSS).

As per the original agreement, the goal of the IntraHealth International Project was to "build the capacity of indigenous organizations to respond to and implement HIV/AIDS programs leading to increased numbers of Namibians who know their HIV status, and to improved access to high quality HIV/AIDS prevention, care and support and treatment services".

To achieve this goal, the original agreement focused on the following five intermediate results:

IR1. Increased capacity of indigenous organizations to respond to epidemic and implement HIV/AIDS-related programs.

IR2. Strengthened capacity of local organizations to provide high quality, age-appropriate HIV/AIDS prevention programs and referrals at health facility and community levels.

IR3. Improved opportunities for Namibians to know their HIV status by improving local organizations' ability to provide quality HIV/AIDS counseling and testing services at medical facilities and in communities.

IR4. Strengthened capacity of local organizations to provide HIV/AIDS care and treatment services for both adults and children.

IR5. Increased capacity of Ministry of Health and Social Services (MoHSS) to manage human resources for health (HRH) through support to the development and implementation of a human resources information system.

To achieve the above intermediate results, IntraHealth worked in collaboration with the Ministry of Health and Social Services (MoHSS), two professional organizations (HIV Clinician's Society and Pharmaceutical Society of Namibia) and several local partners (sub-grantees). At the project start-up, sub-grantees agreements included: Catholic AIDS Action, Catholic Health Services, Democratic Resettlement Community Project, Development Aid from People to People, Evangelical Lutheran Church AIDS Program, LifeLine/ChildLine (LL/CL), Lutheran Medical Services, Namibia Red Cross and the Walvis Bay Multi-Purpose Center.

In order to align IntraHealth Project activities with PEPFAR-II principles, the Namibian National Strategic Framework (2010/11-2015/16), and the Partnership Framework, the agreement was modified in August 2011. The goal of the modified agreement is to provide technical assistance to Namibian faith-based organizations and the Ministry of Health and Social Services to sustain comprehensive HIV and AIDS programs aligned to Namibia's National Strategic Framework for HIV and AIDS 2010/11 – 2015/16.

The expected results of the modified agreement are as follows:

Expected Result 1: Capacity Building: Strengthened capacity of Namibian faith-based and non-governmental organizations to deliver high quality, comprehensive HIV and AIDS prevention, care and treatment services with emphasis on maternal, neonatal and child health.

Expected Result 2: Quality assurance: Improved quality assurance, efficiency and sustainability of Namibian faith-based and non-governmental organizations through specialized technical assistance.

Expected Result 3: Country Ownership: Increased technical, management and financial capacity of Namibian faith-based and non-governmental organizations to sustain the HIV/AIDS response.

VI. SCOPE OF WORK

Illustrative Key Questions to be Addressed by the Team:

1. What is the progress of IntraHealth towards achieving the Project IRs?
2. To what extent has IntraHealth strengthened the capacity of its sub-grantees (indigenous partners) and the host government in the following areas:
    a. Human resources for health (HRH).
    b. Financial management.
    c. Service delivery (in the areas of prevention, treatment and care and support)
    d. Technical areas relevant to the sub-grantees' activities, e.g. monitoring and evaluation.
3. Describe cost effectiveness of IntraHealth technical approach/model
4. Describe the challenges and success in each technical area – prevention, care, treatment, systems strengthening and strategic information.
    a. Describe the coverage, the reach and the quality of services provided by IntraHealth International to sub-grantees.
    b. Identify potential duplication of activities with other USAID/USG projects or other partners supported by other partners.
5. Are there best practices, innovations, clinical excellence documented within IntraHealth International's activities?
6. What is the quality of data provided by IntraHealth International's project programs?

Evaluation questions will be finalized during the team planning meeting and will be provided to USAID/Namibia for review and approval.

VII. 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. Data will be segregated and presented by site and by gender. 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. Prior reports will be reviewed; as part of the in-country evaluation work, the centrally reported data from the quarterly facility reports may be checked against primary source documents. A list of key documents may include, but will not be limited to, the following:

1. Baseline program data on leader with associate award and predecessor project
2. Associate award agreement
3. Country Operational Plan FY08, FY09 and FY10 and FY11 narratives
4. Workplans and PMP
5. Quarterly, semi-annual and annual progress reports
6. Financial report and pipelines
7. Namibia's resource needs estimate and ART costing reports
8. Interagency portfolio reviews (ART, HCT)
9. Any signed agreements with local partners
10. Namibia Global Health Initiative Strategy (2011-2015/16)
11. Namibia Health Policy Framework 2010-2020
12. Namibia Strategic Framework for HIV/AIDS 2010/11-2015/16
13. Namibia Health and the Social Service Systems Review, 2008
14. Namibia Counseling & Testing Guidelines
15. QA report from Liverpool SOM, if report reflects time period that IntraHealth was working on HCT
16. Other documents, per the discretion of USAID/Namibia.

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

- Share background, experience, and expectations for the assignment;
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities;
- 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 and finalize data collection methods, instruments, tools and guidelines, and methodology and develop an assessment timeline and strategy for achieving deliverables; and
- Develop a draft report outline for Mission review and approval.

Key Informant Interviews

The team will conduct structured interviews with the project staff from IntraHealth Central Office in Windhoek as well as frontline staff in regions selected with input from USAID/Namibia (The activity manager and USAID/Namibia Evaluation Point of Contact), service beneficiaries and key partners including the MoHSS and NGOs, other donors, multilateral agencies, implementing partners, and other key USG funded and non-USG funded stakeholders. To ensure that comparable information is collected during interviews, the team will develop standard guides focused on different stakeholders (participants) reflecting the questions posed by the evaluation scope of work. Using snowball technique, the team will identify additional stakeholders and information sources to gain in-depth understanding of the evaluation questions as well as other unexpected findings or issues should they arise.

Field Site Visits

The evaluation team will coordinate with USAID/Namibia to prepare for and conduct field visits for structured observations while in-country, and to interview key informants at these sites. Field visits will cover the Windhoek area and three to four other regions determined by USAID/Namibia in consultation with partners. The team will be composed of two consultants, with the possibility of adding two members from USAID/Washington and USAID/Namibia. USAID/Namibia is to inform GH Tech as soon as possible if you plan to include two members of USAID/W in this activity. Note that the Team Leader can notify the USAID/W team members when to limit participation in key informant interviews/site visits, as appropriate.

USAID/Namibia may, based on technical as well as logistical considerations, elect to split the team and conduct field site visits simultaneously.

USAID/Namibia will provide a detailed contact list of key informants and key points of contact to the consultants during the document review period, so planning can begin for appointments, interviews, and site visits can be set up for the team's arrival in-country. USAID/Namibia will also provide a draft schedule for field visits including duration of stay at various sites to inform the team's time in-country.

Quantitative Data:

The consultants are expected to use in their methodology quantitative resources to triangulate the data with qualitative findings. Sources of quantitative data may include monitoring data, progress reports, databases and other project records.

VIII. TEAM COMPOSITION, SKILLS AND ROLES

USAID anticipates that the evaluation team will consist of the following individuals:

Profile of Evaluation Team (see description below for a **<u>two person</u>** team):

- Should be external evaluators, at least one being an international consultant.
- Should have expertise in comprehensive HIV/AIDS programming

- Should have expertise in costing, financial management, and organizational development—ideally with respect to civil society as well as government institutions.

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

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

Estimated Level of Effort (LOE):

A six-day work week will be approved when the consultants are working in country. This is a preliminary timetable and USAID/Namibia may choose to make changes to it during the course of the project based on technical and logistical considerations:

Task/Deliverable	Team Leader LOE (days)	Team Member	Est. Timeline (pending consultant availability)
Read Background Documents.	3	3	o/a February 29
Travel to Namibia	2	2	o/a March 3
Team Planning Meeting	2	2	o/a March 5-6
Assessment work			
Begin stakeholders interviews and site visits (including in-country travel)	15	15	o/a March 7-24
Discussion, analysis and draft report preparation	6	6	o/a March 26-30
Presentation of findings to Mission and partners	1	1	o/a April 2-3
Complete report draft – revise report & incorporate debriefing comments into draft report	1	1	o/a April 4
Return travel	2	2	o/a April 5
USAID/Namibia sends technical feedback/comments on draft report to GH Tech (within 10 working days of submission)	0	0	o/a April 19
Consultants revise/finalize report	3	3	o/a April 25

Task/Deliverable	Team Leader LOE (days)	Team Member	Est. Timeline (pending consultant availability)
USAID/Namibia reviews/signs off on final report (within 5 days of receipt)	0	0	o/a May 3
Only if GH Tech receives the unedited approved draft by April 16, can it edit and finalize report – approx. 30 days after committee approval	0	0	
Total LOE	35	35	

A six day work week in country is authorized.

IX. LOGISTICS

GH Tech will provide:

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

USAID/Namibia will provide:

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

X. DELIVERABLES

1. **Work plan**: Written methodology and work plan submitted to USAID/Namibia for review and approval before field work and key informant interviews begin.
2. **Draft outline:** A draft report outline prepared and submitted during the first two weeks of the field work.

3. **Presentation slides:** A Mission debrief meeting to be followed by a partner debrief meeting that will be held before the team's departure from Namibia and prior to the submission of the draft report. The team will prepare a PowerPoint presentation for this event. The PowerPoint presentations will be shared with GH Tech prior to the USAID and stakeholder debriefings.

4. **Draft Report:** Prior to departing Namibia, a reviewable draft report addressing key findings, conclusions, recommendations and other items as outlined in the draft report outline will be submitted. USAID/Namibia mission will have 10 days following the submission of the draft report to respond and provide written comments and feedback to GH Tech.

5. **Final Report:** The team will incorporate all feedback provided by USAID/Namibia reviewing team. A final unedited draft report will be submitted 5 days from the date of receipt of USAID/Namibia's feedback on the draft report. The report should conform to USAID Evaluation Policy "Criteria to Ensure the Quality of The Evaluation Report" (please see Appendix 1).

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

Only if the final draft is approved by USAID/Namibia prior to April 16, 2012, will GH Tech provide the edited and formatted final document approximately 30 days after USAID provides final approval of the content. Otherwise, USAID/Namibia will need to go through another mechanism to finalize the report. Procurement sensitive information will be removed from the final report and incorporated into an internal USAID Memo. The remaining report will then be released by GH Tech as a public document on the USAID Development Experience Clearinghouse (DEC) (http://dec.usaid.gov) and the GH Tech project web site (www.ghtechproject.com).

XI. ROLES AND RESPONSIBILITIES

GH Tech will coordinate and manage the assessment team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team.
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.

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

Before In-Country Work

- SOW. Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide

additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

- Documents. Identify and prioritize background materials for the consultants and provide them to GH Tech, preferably in electronic form, at least one week prior to the inception of the assignment.

- Local Consultants. Assist with identification of potential local consultants, including contact information.

- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.

- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and if necessary, identify a person to assist with logistics (i.e., visa letters of invitation etc.).

During In-country Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.

- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).

- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.

- Facilitate Contact with Implementing Partners. Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After In-country Work

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

XII. MISSION POINT OF CONTACT

Dr. Didier Mbayi Kangudie MD, MPH

HIV/AIDS Treatment Technical Adviser

USAID/Namibia

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Fax +264 61 227006
Cell + 264 81 127 8236
e-mail nalsoufi@usaid.gov

XIII. COST ESTIMATE—TO BE PROVIDED BY GH TECH FOR THIS ACTIVITY.

XIV. REFERENCES—TO BE PROVIDED TO GH TECH AS SOON AS POSSIBLE.

APPENDIX 1 (OF SOW)

Criteria to Ensure the Quality of the Evaluation Report

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the technical officer.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex in the final report.
- Evaluation findings will assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).

- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

ANNEX 2: INDIVIDUALS AND ORGANIZATIONS MET

(In chronologic order of schedule)

NAMIBIA

USAID Namibia

Ms. Melissa Jones, Director, Health Office

Dr. Mbayi Kangudie, HIV/AIDS Treatment Technical Advisor

Dr. Nabil Alsoufi, Health Officer

Mr. Brad Corner, HIV Prevention Advisor

Ms. Susna De, Systems Strengthening and Capacity Development Advisor

Dr. Ichiawunma Ibe, Senior Technical Advisor, HIV/AIDS Care and Nutrition

Mr. Robert Festus, Strategic Information Assistant

IntraHealth Namibia

Dr. Pamela McQuide, Chief of Party

Dr. K. Chani, Technical Director

Ms. Rosaline Hendricks, HRIS Technical Advisor

Ms. Sandra Owoses, M&E Technical Advisor

Mr. Alex Ntumba

Mr. Donald Matzuri, Financial Director

Mr. Malakia Inungu, M&E Technical Advisor

Management Sciences for Health Namibia

Dr. David Mabirizi, Country Director

Mr. Benjamin Ongeri, Senior Program Associate

GRN National Health Training Center

Sister Ottilie Kutenda, Deputy Director

LifeLine/ChildLine

Ms. Jane Shityuweke, Director

Catholic Aids Action

Mr. Godwin Chisenga, Director of Operations

I-TECH International

Deqa Ali, Country Director

CDC Namibia

Dr. David Lowrance, Country Director

Stand-alone VCT Sites, Windhoek

Katura: Karl Naimhwaka, Site Manager; Agatha Kuthedze (IntraHealth HIV Technical Advisor)

Central Business District: Patricia Komu, VCT Program Manager; Matthew Kashadi, Community Mobilizer and Acting Site Manager

Anglican Medical Services

Fr. Lucas Katenda, Secretary-Treasurer, Anglican Diocese of Namibia

Onandjokwe Hospital (Lutheran Medical Services)

Dr. I. Petrov, Medical Superintendent

Dr. Njuki, HIV Service Director

Tonateni VCT

Mr. Ephraim Aipinge, Site Manager

Mr. David Nghikerwa, Community Mobilizer

Ms. Lucia Hangola, Senior HIV Counselor

Omusati Regional Management Team

Ms. Haipinge, Director

Dr. Ananias, Chief Medical Officer

Oshikuku Hospital (Catholic Health Services)

Dr. Samuel Awe, Chief Medical Officer

Okalongo Health Center

Dr. Luckaj, Medical Officer

Oshana Catholic AIDS ActionVCT

Lucia Hangola, David Lunghikrwe, Ephriam Ilpigue

Engala District Hospital (MoH)

Dr. Katende Kashaiga, Principal Medical Officer

Dr. N. M. Benhura, HIV Medical Officer

Dr. Christian Tshibambe

Odibo Health Center (Anglican Medical Services)

Sr. Anna Nghifitikako, Matron

Oshikango VCT Center

Dr. Lucky Ogbeiwi

Ms. Sabina David

Oshikoto Regional Management Team (Tsumeb)

Ms. Maria Kavezembi, Regional Manager

Ms. Kauna Haimkodei, Chief Human Resources Practitioner

Dr. N. Siame, Chief Medical Officer

Ms. V. S. Kambuta

MoH, Human Resources, Directorate of Special Programs, VCT

Ms. Sarah Fuller, National VCT Coordinator.

Ms. Ismelda Pietersen, Deputy Coordinator

MoH, Directorate of Special Programs

Ms. Ella Shihepo, Director

Ms. Alexinah Muadinohamba, Deputy Director

Dr. Justice Gweshe, Chief Medical Officer

MoH, Division of Human Resources Management

Ms. Celine Uusiku, Director, Human Resources Management

Catholic Health Services, Namibia

Sr. Angela Bock, Director

Dr. E. H. Sidile, Chief Medical Officer

Mr. Alex Mumba, Finance Chief

HIV Clinicians' Society

Dr. Mugala, Past President

Sr. Ndahafa, President

MoH, Directorate of Primary Health Care

Ms. Magdalena Nghatanga, Director

ANNEX 3: DOCUMENTS REVIEWED FOR THE NAMIBIA INTRAHEALTH MID-TERM ASSESSMENT

After-action Review Report-Stand-alone VCT Closures, USAID/Namibia 2011.

Audit of USAID/Namibia's HIV/AIDS Efforts to Build Health Workforce Capacity, 2011.

Best Practices Guide For Indirect Costing, USAID 2004.

Capacity Development: A UNDP Primer, UNDP 2009.

Capacity Project Annual Report FY07.

Engela Communicable Disease Clinic Overview, 2012.

Estimation of Resource Needs Implications of Namibia's ART Treatment Guideline Changes, 2009.

Final Namibia National Operational Plan Costing, 2010.

GRN-USG HIV & AIDS Partnership Framework, 2010/11-2015/16.

HIV/AIDS Treatment in Practice, Issue 188, 23 March 2012.

HRIMS Accuracy Completeness Consolidated October 2011.

Human Capacity Development Assessment for Public Sector Pharmaceutical Services in Namibia, USAID 2006.

Human Development Report, Namibia, UNDP 2011.

Implementation Completion and Results Report, Education and Training Sector Improvement Program, Namibia World Bank 2012.

IntraHealth Capacity Project Financial Report FY08.

IntraHealth Capacity Project Financial Report FY09.

IntraHealth Capacity Project Progress Report Q4 FY08 & APR.

IntraHealth Namibia HIV Prevention, Care and Support Review, March 26, 2012.

IntraHealth Namibia PMP Baseline 2008.

IntraHealth Namibia Workplan Narrative Year 1.

IntraHealth Namibia Workplan Narrative Year 2.

IntraHealth Project Progress Report Q4 FY09 & APR.

IntraHealth Project Progress Report Q4 FY10 & APR.

IntraHealth Sub-Agreement with Catholic Health Services.

IntraHealth Sub-Agreement with Lifeline.

IntraHealth Sub-Agreement with Lutheran Medical Services.

LLCL Comprehensive Institutional Strengthening Plan, IntraHealth 2010.

Measuring Capacity, UNDP 2010.

Mobile Wellness Screening in Namibia Unit Costs and Comparison to Fixed Site VCT, 2010.

MoHSS Annual Report 2007-2008.

MoHSS Health and Social Services System Review 2008.

MoHSS Hospital Efficiency Report (September 2004).

MoHSS HRIMS Project Risks Status Update April 2010.

MoHSS HRIMS Rollout to 6 Regions Project Lessons Learned April 2010.

Namibia COP 2007.

Namibia COP 2008.

Namibia COP 2009.

Namibia COP 2010.

Namibia COP 2011 Executive Summary.

Namibia Country Brief, World Bank 2009.

Namibia Country Cooperation Strategy 2010-2015, WHO 2010.

Namibia Health and HIV/AIDS Resource Tracking: 2007/08 & 2008/09.

Namibia Health Facilities Directory.

Namibia HIV Counseling and Testing Portfolio Review, 2009.

Namibia MoHSS "Guidelines for Implementing National Policy on Community-Based Health Care," 2010.

Namibia MoHSS "National Policy on Community Based Health Care," 2008.

National Strategic Framework for HIV and AIDS Response in Namibia 2010/11–2015/16; 2010.

OPM Payroll HRIMS Audit, October 2011.

Organizational Capacity Assessment- Catholic Health Services 2011.

Organizational Capacity Assessment- Catholic Health Services-Most Important.

Organizational Capacity Assessment- Lutheran Medical Services 2012.

Organizational Capacity Assessment- Lutheran Medical Services-Most Important.

Report on Costs of Treatment in the President's Emergency Plan for AIDS Relief, OGAC 2012.

Report from the US President's Emergency Plan for AIDS Relief HIV Treatment Consultation in Namibia, 2009.

Resource Needs Estimation: A Tool for Enhancing Sustainability, 2009.

Summary Notes on Computer Literacy Training, 2009.

Sustainable Financing For HIV/AIDS In Namibia, UNAIDS 2011.

"Technical efficiency of district hospitals: Evidence from Namibia Using Data Envelopment Analysis," Cost Eff Resour Alloc. 2006; 4: 5; PMCID: PMC1524815.

USAID-IntraHealth Associate Cooperative Agreement No. 674-A-00-09-00003-00.

ANNEX 4: DRAFT SCHEDULE

INTRAHEALTH MID-TERM EVALUATION SCHEDULE

March 22–April 15 2012

Date and time	Activity	Venue/Contact person	Comment
Thursday 22/03/12	GH Tech Consultants arrive.	HKA	Airport pick up and hotel reservation made by GH Tech
Friday 23/03/12			
11h–12h00	In-Brief with Namibia Health Office	USAID Namibia 5th Floor	Include discussions on methodology, workplan, visit schedule, logistics e.g. cell phones, working space
Saturday 24/03/12	Team planning meeting		Methodology/workplan to be submitted to USAID
Monday 26/03/12			
9h00–13h0	Initial visit with IntraHealth team in Windhoek	IntraHealth Office (Dr. Pam, Dr. Chani)	Include adjusting site visits and KII IntraHealth Technical approaches Data quality assessment Preliminary budget analysis and unit cost estimates
14h30–16h30	Visit MSH office	MSH office (Dr. Mabirizi)	Confirmed
Tuesday 27/03/12			
8h00	NHTC		IntraHealth to arrange Confirmed
12h00–13h00			Include KII, data validation Assess impact of capacity building and HR support
14h30–16h30	Meet LL/CL Head office	LL/CL office (Ms. Jane)	Assess progress on IR 1,2,3,4 as appropriate LL/CL confirmed
Wednesday 28/03/12			Visits include mainly KII:
8h00–9h30	Meet CAA Head Office	CAA Head Office (Mr. Godwin)	Confirmed
10h45–11h45	Meet ITECH in Windhoek	ITECH Office (Ms. Dequa Ali/Dr. L. Brandt)	Confirmed

12h00–12h45 14h30–16h00	Meet w CDC, Dr. Lowrence	MoH	Confirmed
Thursday 29/03/12			
9h00–0h30	Visit Stand-alone VCT sites: CCN, CBD	Windhoek based stand-alone VCT: Katutura and Town center	Renee to confirm
11h00–13h00	PS/ or Deputy PS		As comparative state facility site, ePMS support (IntraHealth to arrange)
14h30–15h15 15h30–17h00	Visit Katutura State Hospital ART site		
Friday 30/03/12			
0900	AMS Review data collected to date, define IntraHealth service package, preliminary cost per unit Draft report outline to USAID Namibia	Anglican Church Offices (Fr. Katenda)	Fr. Katenda confirmed
2:30	USAID	Susan De	Confirmed
Monday 02/04/12			
6h00–8h30	Fly North West (800 Km): Arrival Ondangwa 8h30	Ondangwa	Renee to arrange logistics with GH Tech: flights and hotel reservations, Driver up North IntraHealth to inform sites.
9h30–14h30	Onandjokwe Hospital	Onandjokwe Hosp (Dr. Petrov)	Visits include KII, with data validation, Assess capacity building and HR support, Confirmed LMS
15h30–17h00	Tonateni VCT	Oshakati (Mr. Aipinge)	Assess IR 1,2,3,4 as appropriate
Tuesday 03/04/12			IntraHealth to confirm
9h30–11h00	Omusati RMT	Outapi (Ms. Haipinge, Dr. Ananias)	For Omusati RMT visit in Outapi: plan minimum 1h drive. RMT are the interface between the GRN and the church facilities
12h00–17h00	Oshikuku Hospital (to include Okalongo Health center as appropriate)	Oshikuku (Dr. Awe)CONFIRMED	

Wednesday 04/04/12			IntraHealth to confirm
9h30–10h30	Engela District Coordinating Committee	Engela Hospital	Visits include KII, with data validation, Assess capacity building and HR support, assess IR 1,2,3,4 as appropriate
11h00–13h00	Odibo Health Center	Odibo	
14h30–16h00	Oshikango VCT center		
Thursday 05/04/12			
8h00–12h00	Drive to Tsumeb to meet Oshikoto RMT	Tsumeb (Ms. Maria Kavezembi)	IntraHealth to confirm
12h00–13h30	Meeting in Tsumeb		
14h00–18h00	Drive back to WHK		
Friday 06/04/12	Review data collected to date		
Monday 09/04/12	Easter		
Tuesday 10/04/12			
9h30–10h30	Meet MoHSS DSP (VCT)	DSP office (Sarah Fuller/ Ismelda Pietersen)	Confirmed
14h30–15h30	Meet MoHSS DSP (RME)	DSP office (Ms. Anna Jonas)	Confirmed (assessment of SI support including ePMs)
16h00-17h00	Meet MoHSS HRM – Ms. Celine Usiku	HRM Office Meet	IntraHealth to arrange. Visits include KII and structured observations, visits HRIS confirmed—check with evaluators if they want to see HRIS in region
Wednesday 11/04/12			
8h30–11h30	CHS National Office	Sister Angela and Dr. Sidile	Include KII, data validation Assess impact of capacity building and HR support Assess progress on IR 1,2,3,4 as appropriate
14h00–17h00	Rehoboth–CHS and ELCAP	PMO Rehoboth ELCAP (TBC as per evaluation needs)	

Thursday 12/04/12	Draft report		
Friday 13/04/12 11h–12h30	Out- brief with USAID Namibia Health Office	USAID Namibia 5th Floor	Skype with P. McQuide for out-brief in addition to IH team in-country
Saturday 14/04/12	Incorporate mission comments and submit draft report		
Sunday 15/04/12	Team departs Namibia		

ANNEX 5: NAMIBIA INTRAHEALTH EVALUATION: KEY INFORMANT INTERVIEW QUESTIONNAIRE

USAID/NAMIBIA QUESTIONS

1. What have been the major IntraHealth achievements in Namibia since November 2008? (IR 1, IR 2, IR 3, IR 4, IR 5)

   Do you recognize any outstanding methods ("best practice") or results?

2. What have been the major challenges, barriers and constraints encountered with the IntraHealth project since November 2008? (IR 1, IR 2, IR 3, IR 4, IR 5)

   How have these affected the project and how have you responded?

   Have there been legal and policy barriers and how have you addressed these?

3. What are the structures and procedures for coordination with other donors and with the Government of Namibia? (IR 1, IR 2, IR 3, IR 4, IR 5)

   How does USAID participate in these structures and procedures?

   Do you see any issues re duplication of effort among donors?

4. What data do you use to manage implementation of the IntraHealth project? (IR 1, IR 2, IR 3, IR 4, IR 5)

   Technical performance

   Financial

5. GRN seems to have done a relatively good job with respect to HIV (e.g. stats re access, CNT, rx and dx, etc.). How (if at all) has IntraHealth contributed to this performance? (IR 5)

6. What progress has been made in implementing the RIG audit recommendations? (IR 1, IR 2, IR 3, IR 4, IR 5)

   What challenges have arisen in implementation?

   What plans do you have to complete implementation?

Recommendation 1. The Mission agreed with the recommendation to establish and implement a plan to transfer strategic and financial responsibilities for HRH investments to the Namibian Government or civil society. To accomplish this objective, USAID/Namibia indicated it would work with the U.S. Government team in Namibia to develop a strategy for transferring PEPFAR-supported staff to the host country. By March 2011 the Mission planned to complete an inventory of U.S. Government-supported positions that could be potentially transferred. USAID/Namibia anticipated that the first phase of the HRH transition would be submitted to the Namibia Government for approval in April 2011. As for civil society, USAID/Namibia pointed to a lack of sufficient funding as a hindrance to transferring HRH investments. To address this, the Mission was working with civil society partners on strategies to mobilize resources through partnerships with the private sector and involvement of other donors. The Mission will detail all actions for the HRH transition in the upcoming Partnership Framework Implementation Plan, to be drafted by October 31, 2011. The Mission gave this date as the target date for completion of

planned corrective action. On the basis of the Mission's described actions, we consider that a management decision has been reached on Recommendation 1.

Recommendation 2. The Mission agreed with the recommendation to establish baselines and develop indicators and targets to measure the progress and achievement of its HRH activities. The Mission said it would revise its PMP to include HRH indicators and targets and would tailor HRH indicators for implementing partners' PMPs and evaluations; the data obtained from partners' PMPs will be used to develop baselines for the mission's PMP. The target date for completion of the planned corrective action for this recommendation is January 2012. On the basis of the Mission's described actions, we consider that a management decision has been reached on Recommendation 2.

INTRAHEALTH QUESTIONS

1. What have been the major IntraHealth achievements in Namibia since November 2008? (IR 1, IR 2, IR 3, IR 4, IR 5)

   (Follow up to get responses for each technical area: Prevention, Care, Treatment, Systems Strengthening and Strategic Information)

2. What have been the major challenges, barriers and constraints encountered since November 2008? (IR 1, IR 2, IR 3, IR 4, IR 5)

   How have these affected your projects and how have you responded?

   Have there been legal and policy barriers and how have you addressed these?

3. How do you determine programming priorities and capacity building needs? (IR 1, IR 2, IR 4, IR 5)

   Do you explicitly consider gender in your planning?

   What would help achieve a better alignment between priorities, programs and local organization capacity gaps?

4. How do you and your grantees collaborate with other CAs, other NGOs and the programs of other donors? (IR 1, IR 2, IR 3, IR 4, IR 5)

   What evidence is there of effective collaboration?

   How has collaboration improved your outcomes?

   How could collaboration be improved?

5. Are there any noteworthy areas of synergy or duplication across USAID funded and other donor funded capacity building activities? (IR 1, IR 2, IR 3, IR 4, IR 5)

6. How well are existing service linkage and referral systems working? (IR 1, IR 2, IR 3, IR 4, IR 5)

   Do they work equally well for men and women, or are there some differences?

   To what extent have TB/HIV and PMTCT outcomes been improved?

   How do you do program planning in these areas?

   What specific objectives have been established?

   How do you measure results?

(WHO documents show Namibia among highest co-infection countries.)

To what extent is there a true continuum of prevention to care and treatment?

Can you give some examples of how USAID support has facilitated the development of a true continuum of prevention to care and treatment?

What improvements would be most helpful?

7. How do you promote and measure quality in your work, including technical assistance and the delivery of service? (IR 1, IR 2, IR 3, IR 4, IR 5)

   How do you respond to concerns regarding quality?

   How do you address the tension between quality and extension of service with limited funding?

8. What strategies have you adopted to reduce the unit cost of interventions or to increase their cost effectiveness? (IR 1, IR 2, IR 3, IR 4, IR 5)

   What records do you have of unit cost by intervention?

   How do you measure cost effectiveness?

   Are there any negative consequences?

   How can these be minimized?

9. What evidence do you have to demonstrate how your work has contributed to capacity building (in the GRN HS, NGOs, or community)? (IR 1, IR 2, IR 3, IR 4, IR 5)

   What indicators do you use for progress in capacity building?

   Technical

   Financial

   Management

   What indicators do you use for progress in sustainability?

   What do you think is a reasonable definition of 'sustainability' in the Namibian context?

   What do you see as the key priorities areas for system strengthening over the next 5 years?

10. Under PEPFAR II, USG programs are meant to shift from direct program implementation to an increased technical assistance focus. Can you outline what you think this means and how you are going about implementing this shift? (IR 1, IR 2, IR 4, IR 5)

    How are you doing things differently?

11. What are the key factors for improving HIV prevention programs in Namibia? (IR 1, IR 2, IR 3)

12. How would you describe USAID's management of your project? What changes would make USAID management more effective? (IR 1, IR 2, IR 3, IR 4, IR 5)

INTRAHEALTH GRANTEE QUESTIONS

1. Thinking about the HIV work you have been doing with USAID funding, what have been your major achievements since November 2008? (IR 1, IR 2, IR 3, IR 4, I)

2. What have been the major challenges, barriers and constraints encountered since November 2008? (IR 1, IR 2, IR 3, IR 4)

   How have these affected your projects and how have you responded?

   Have there been legal and policy barriers and how have you addressed these?

3. How do you determine programming priorities and capacity building needs? (IR 1, IR 2, IR 3, IR 4)

   Do you explicitly consider gender in your planning?

   What would help achieve a better alignment between priorities, programs and local organization capacity gaps?

4. Do you collaborate with other health-related programs? (IR 1, IR 2, IR 3, IR 4, IR 5)

   What evidence is there of effective collaboration?

   How has collaboration improved your outcomes?

   How could collaboration be improved?

   Are there effective service linkages and referral systems, with a continuum from prevention through care and treatment?

5. Are there any areas where the work of IntraHealth conflicts with or is duplicated by other activities? (IR 1, IR 2, IR 3, IR 4, IR 5)

   Specifics; US-funded, or other-donor-funded?

6. What types of support do you receive from IntraHealth? (Follow-up: Technical, financial, management) (IR 1, IR 2, IR 3, IR 4)

   How effectively does IntraHealth support your organization?

   Are there areas where their support could be improved?

   Are there types of support you would like to get but which are not available?

7. How do you know what standards your activities and interventions should meet to be considered good quality and effective? (IR 1, IR 2, IR 3, IR 4)

   How do you improve the quality of your work?

   What assistance do you get from IntraHealth in showing you how to measure quality and how to improve quality?

8. How has your organization improved since November 2008? (IR 1, IR 2, IR 3, IR 4)

   Technical

   Specifics: Access, C/T, Px, Rx

   Financial management

   Operational management

9. Thinking of the needs of your target groups, are there any significant unmet needs or gaps in services? These gaps or unmet needs might be HIV-related or for broader health needs. (IR 1, IR 2, IR 3, IR 4)

How could you or other agencies go about meeting these needs?

10. Are there areas where you now operate with less or no support as a result of IntraHealth activities? (IR 1, IR 2, IR 4)

    What are your organization's two greatest:

    Strengths

    Weaknesses

    Opportunities

    Threats?

Government Agencies, Multilaterals and Other Donors Questions

1. What have been the major achievements since November 2008 of the USAID-funded IntraHealth project in Namibia? (IR 1, IR 2, IR 3, IR 4, IR 5)
2. What have been the major challenges, barriers and constraints encountered since November 2008 in your work with IntraHealth? (IR 1, IR 2, IR 3, IR 4, IR 5)

    How effectively has IntraHealth responded to these challenges, barriers and constraints?

3. In what ways does IntraHealth collaborate with your agency and others? (IR 1, IR 2, IR 3, IR 4, IR 5)

    How effective is this collaboration?

    Do you share data with USAID or IntraHealth?

    How could collaboration be improved?

4. Do you see any noteworthy areas of synergy and/or duplication with IntraHealth and other USAID funded and other donor funded HIV activities? (IR 1, IR 2, IR 3, IR 4, IR 5)
5. How well are existing service linkage and referral systems working? (IR 1, IR 2, IR 3, IR 4, IR 5)

    Is there an effective continuum from prevention to care and treatment?

    How could service linkages be improved?

6. In what ways has IntraHealth contributed to systems strengthening? (IR 1, IR 2, IR 4, IR 5)
7. What are the key factors for building health care capacity in Namibia? (IR 1, IR 2, IR 3, IR 4, IR 5)

    Has IntraHealth been addressing those factors?

8. What do you think should be the IntraHealth project priorities over the next 5 years? (IR 1, IR 2, IR 3, IR 4, IR 5)

    What should IntraHealth, or USAID, be doing more of, less of and differently?

9. Have you seen any change in capacity as the result of IntraHealth's work? (IR 1, IR 2, IR 3, IR 4, IR 5)

    Namibia NGOs

    GRN agencies

10. Have you seen any progress toward sustainability as the result of IntraHealth's work? (IR 1, IR 2, IR 3, IR 4, IR 5)

11. What do you expect over the next five years in Namibia's HIV epidemic? (IR 1, IR 2, IR 3, IR 4, IR 5)

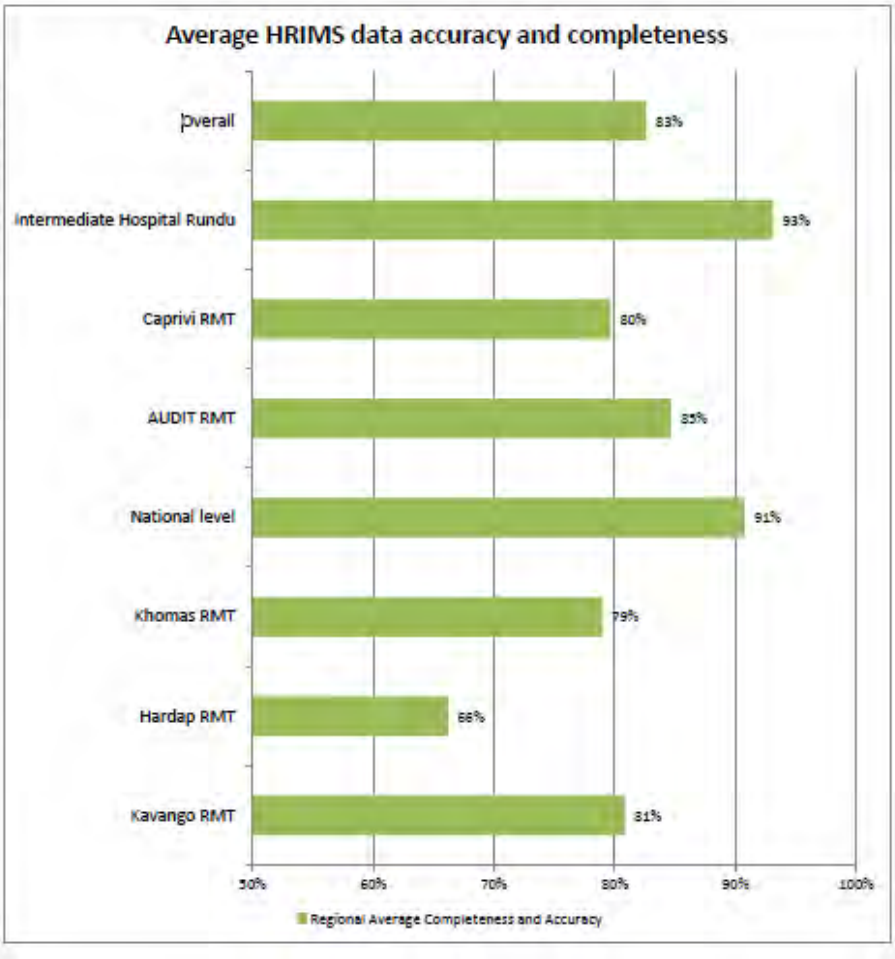
12. What do you expect will be the response to that development in the epidemic?

    If not offered, ask about impending funding problems, changing priorities of health programs, capacity development issues.

ANNEX 6: HRIMS ACCURACY AND COMPLETENESS REPORT, OCTOBER 2011

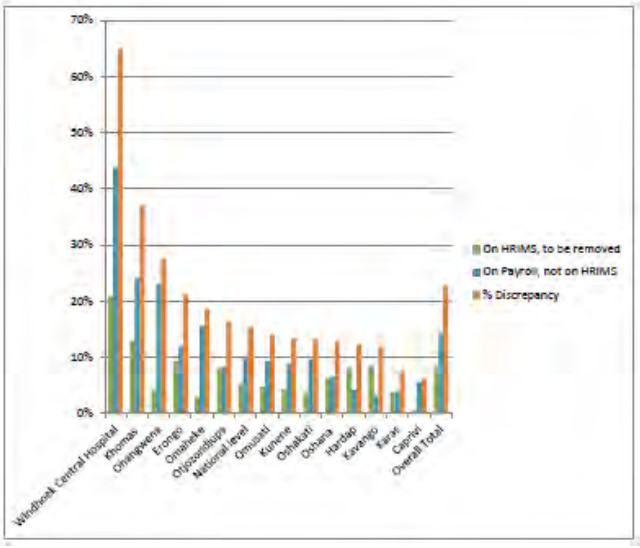
Summary

	Regional Average Completeness and Accuracy
Kavango RMT	81%
Hardap RMT	66%
Khomas RMT	79%
National level	91%
AUDIT RMT	85%
Caprivi RMT	80%
Intermediate Hospital Rundu	93%
Overall	83%



ANNEX 7: HRIMS OPM PAYROLL AUDIT REPORT OCTOBER 2011

Region	On HRIMS, to be removed	On Payroll, not on HRIMS	% Discrepancy
Windhoek Central Hospital	21%	44%	65%
Khomas	13%	24%	37%
Ohangwena	4%	23%	27%
Erongo	9%	12%	21%
Omaheke	3%	16%	19%
Otjozondjupa	8%	8%	16%
National level	5%	10%	15%
Omusati	5%	9%	14%
Kunene	4%	9%	13%
Oshakati	4%	10%	13%
Oshana	6%	7%	13%
Hardap	8%	4%	12%
Kavango	9%	3%	12%
Karas	4%	4%	8%
Caprivi	1%	6%	6%
Overall Total	**8%**	**15%**	**23%**



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