



Namibia Centership Project

Case Study Report

September 2013



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Cover photo: Community health volunteers in Rosh Pinah giving health training to community members. Photo courtesy of Teri Brezner.

ABBREVIATIONS LIST

1mCHW	One Million Community Health Worker Campaign
CHC	Clinic Health Committee
CHV	Community Health Volunteer
CHW	Community Health Worker
HEW	Health Extension Worker
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IGA	Income Generating Activity
MDG	Millennium Development Goal
MOHSS	Ministry of Health and Social Services
MSH	Management Sciences for Health
NGO	Nongovernment Organization
PCRV	Peace Corps Response Volunteer
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

The concept for a community-based health information initiative, Centership, began in the Office of HIV/AIDs and Health Information System Technical Working Group and U.S. Agency for International Development (USAID)/Washington, in collaboration with the USAID mission in Namibia, in early 2010. The goal was to create community hubs to provide health- and HIV-related information, promote healthy behaviors, and collect community-based health data. The Centership project design was to provide training to community health volunteers (CHV) who offer needed HIV/AIDS and other health information and education to community residents and serve as referral links between the community and public health facilities. The Centership design called for project offices to house a community organization, the Centership Board or committee, to help CHVs promote health by sharing resources, generating income to fund ongoing Centership activities, and assisting CHVs in community outreach, health data collection, and joint problem solving. The Centership concept was to build knowledge and skills in organizational management and business planning to support resource generation and develop a microenterprise to ensure sustainability. The intention was that income generated would provide incentives to CHVs and cover operating costs of the Centership offices.

In March 2011, USAID asked AIDSTAR-Two, managed by Management Sciences for Health (MSH), to coordinate and manage Centership and provide business planning training. USAID/Washington, USAID/Namibia, the Namibia Ministry of Health and Social Services (MOHSS), the Peace Corps, local nongovernment organizations (NGO), MSH, and ICF International formed a collaborative partnership that divided project roles and funding. After consultation with MOHSS, two communities were selected to test the concept: (1) *Onderombapa*, a cattle-farming community of approximately 3,000 people in widely scattered villages in east central Namibia, approximately 20 kilometers from Botswana; and (2) *Tutungeni*, a settlement of approximately 14,000 people outside the town of Rosh Pinah in southwestern Namibia close to South Africa.

These propositions were tested during implementation:

1. Linking CHVs to a community structure, such as a Centership committee, will result in community members taking responsibility for the health issues in their community.
2. Combining CHV health promotion and HIV/AIDS awareness and community health information system reporting with business training to establish a community owned-and-operated business will provide funding to sustain the community-based approach to health information and awareness.
3. Differences likely will result from the Centership project being implemented in two communities with different levels of social cohesion.

Centership was introduced to both communities in 2010 by a team from USAID/Washington and Namibia and MOHSS. A Centership Board and committee members were identified at that time; however, activities on the ground did not begin until March 2011 when MSH was asked to take over the project. A local coordinator, hired by MSH/Arlington and based in Windhoek, provided support and coordination to both sites. Each community had a Peace Corps Response Volunteer (PCRV) assigned through the Namibia Peace Corps office. MOHSS identified and trained 10 CHV candidates in October 2011 in Onderombapa and 13 CHV candidates in December 2011 in Tutungeni. The training focused on CHV roles and responsibilities and accurate completion of the MOHSS monthly reporting form for community-based data.

Onderombapa: At the midline assessment, the Centership Board reported challenges in Onderombapa with drafting and submitting a workable business proposal to AIDSTAR-Two. The

Centership Board's focus was on the business proposal, with minimal attention to community-based data collection, HIV awareness, and health promotion. The Centership activity as initially designed was disintegrating. USAID and AIDSTAR-Two discussed possible alternatives: to continue funding the activity another year to find a workable solution or end funding and declare the activity a lesson learned on what did not work. They decided to continue another year under the management of a local NGO, CoHeNa, which was already in the area and had experience implementing and managing community-based health promotion and data collection for TB and HIV, and it had an established Clinic Health Committee (CHC) at the Onderombapa clinic. This NGO was known to and recommended by USAID. The Centership Board and committee were disbanded and one combined CHC was established under the oversight of CoHeNa and the clinic head nurse. CoHeNa, which started implementation in May 2013, identified and retrained 15 CHVs on the MOHSS community-based reporting form. Many already were active in their communities promoting TB and HIV awareness, and the training added to their knowledge of maternal and child health and sanitation. CoHeNa followed up with onsite mentoring and supportive supervision to demonstrate specific tasks. At the final evaluation visit, the clinic nurse reported that she had received monthly reports from all the CHVs since the retraining. She meets with CHVs monthly to review their data, answer questions, and problem solve. CoHeNa also initiated a goat-rearing project, with the CHVs as an income-generating activity.

Rosh Pinah and Tutungeni: Just before the midline evaluation visit, AIDSTAR-Two decided not to fund a business project because a workable proposal had not been submitted, and the Centership Board and committee were disbanded. Activity refocused on the CHVs, and a new local coordinator was hired. This was perceived as a positive decision because the emphasis on the business aspect had taken priority, and CHV activities had been neglected, with little connection between the Centership Board and the CHVs. In the ensuing year, several changes occurred. AIDSTAR-Two redesigned the project to incorporate a public-private partnership agreement between MOHSS, AIDSTAR-Two, the CHVs, and RoshSkor (a management board for the town of Rosh Pinah), which included small financial incentives to the CHVs for providing health promotion messages to the community. A vegetable-growing project using veggie tunnel greenhouses acquired through a horticultural NGO in Windhoek was established as an income generation activity (IGA) to provide small incentives to the CHVs after the stipends from RoshSkor end. The clinic head nurse trained several CHVs to register patients in the clinic and take blood pressures so that community members would recognize and accept them on home visits. The clinic head nurse met with the CHVs weekly to review their data, problem solve, plan monthly health promotion activities, and collate reporting. RoshSkor provided secure land for the greenhouse project. The CHVs received two weeks of training in managing and growing vegetables. At the final evaluation in August, six types of vegetables had been planted and many had sprouted. The CHVs organized to water the plants twice daily and planned for 60% of the harvest to go to patients and malnourished children and be shared among the CHVs, with the remaining 40% to be sold to local restaurants and guest houses, with profits to be used to replant and extend the garden.

The Centership model in Namibia was envisioned as an innovative answer to the recognized need for community members to reach their own communities with health promotion, HIV/AIDS awareness, referrals, data collection, and provision of limited services. The Centership model did not work in either community as originally designed, but it evolved to specific local solutions for the two communities. At midline, the activities in both locations were floundering and would have ended; however, both USAID and AIDSTAR-Two were willing to adapt the approach. The willingness to be flexible and adapt the response based on local learning supports USAID's collaboration, learning, and adaptation approach, which promotes monitoring, review of data, and learning from the implementation process to promote a living strategy and course correction to adapt projects to the local situation.

ICF International evaluated the project over three years, with a focus on documenting the implementation process, challenges, and learning. Key informant interviews, data collection, and process documentation occurred during a series of three site visits to each location: close to baseline (December 2011), midline (July 2012), and endline (August 2013). Key informants included MOHSS national-, regional-, and district-level representatives; clinic nurses; PCRVs; Centership Board and committee members; CHVs; community leadership and community members; and RoshSkor management and CoHeNa leadership.

Recommendations

1. As modeled in this project, involve MOHSS Regional Director and Regional Health Management team and community leaders from inception to foster ownership. When the IGA involves sectors beyond health, include the Regional Councilor of the Ministry of Regional Local Government and Housing, and Rural Development to create and enable links to other sectors.
2. Use a community capacity-enhancement approach and facilitation process to stimulate community awareness of its own strengths to foster ownership and lead to sustainability.
3. Start with network and partner mapping to ensure informed decisions and understanding of the environmental context and presence of other potential partners.
4. From the CHVs: Be clear about the role and expectations of volunteers from the beginning. Small nonfinancial incentives are acceptable, as well as recognition at community, district, and regional events.
5. From the CHVs: Foster a team sense of working together for the community.
6. Seek opportunities to integrate or build on existing platforms; don't duplicate structures unnecessarily.
7. Review and use data collected by CHVs to solve problems in the community; to help improve data reliability, make sure CHVs understand the usefulness of the information they collect.
8. Design IGAs in cooperation with the community and ensure it is relevant to the community's context, knowledge, and experience.
9. Be prepared to provide ongoing mentorship and support to an IGA to achieve success and additional training, when needed.
10. Acknowledge that the roles of local coordinator and supervisor are essential. These could be the same person if the individual has the clinical knowledge to provide supervisory support.
11. Provide an opportunity for trained CHVs to become health extension workers as the national program expands.

INTRODUCTION

In early 2010, the Office of HIV/AIDS and Health Information System Technical Working Group and U.S. Agency for International Development (USAID)/Washington, in collaboration with the USAID mission in Namibia, began planning a community-based health information initiative, Centership. The goal of Centership was to create community information hubs to provide access to health and HIV-related information, promote healthy behaviors, and collect community-based health data. A November 2010 concept note by USAID/Namibia provided a rationale and objectives for the Centership project, stating “community hubs are designed to address a gap in HIV/AIDS education and information and the lack of routinely collected community-based health information to identify urgent health problems, risks, or service gaps and to plan more appropriately for needed services in vulnerable communities.”¹ In the concept note, USAID also stated:

“... the focus on country ownership and sustainability underscores the mandate for community level investment. This is particularly applicable to the fight against HIV/AIDS whose success relies heavily on a community level response to address needs around care, support and prevention. To facilitate that response, investments must be made at the community level now to support, sustain and build capacity in its volunteers and civil society organizations.”

The Centership project design called for training community health volunteers (CHV), who then would offer needed HIV/AIDS and other health information and education to community residents and serve as referral links between the community and public health facilities. Centership offices would house a community organization, the Centership Board or committee, to enable CHVs to promote health by sharing resources, generating income to fund Centership activities, and assisting CHVs in community outreach, health data collection, and joint problem solving. The concept included building knowledge and skills in organizational management and business planning to support resource generation and developing a microenterprise to ensure sustainability. The intention was to generate income to provide incentives for CHVs and cover operating costs of Centership offices.



CHVs at end-of-project results meeting in Onderombapa. Photo courtesy Sharon Arscott-Mills.

¹ November 2010 concept note by USAID Namibia referenced in AIDSTAR Two concept paper, “Community-Based HIV AIDS and Health Information Hubs in two Pilot Areas of Namibia,” January 2011.

USAID put a hold on the project until March 2011 to further define and clarify the concept of Centership. Then USAID asked AIDSTAR-Two, managed by Management Sciences for Health (MSH), to coordinate and manage the activity and provide business planning training.

Partnerships

USAID/Washington, USAID/Namibia, the Namibia Ministry of Health and Social Services (MOHSS), Peace Corps, local nongovernment organizations (NGO), MSH, and ICF International formed a collaborative partnership, with the roles as summarized in Table 1.

Table 1. Initial Centership partners and roles

Partner	Role
USAID/Washington	Provide initial project funding
USAID/Namibia	Provide ongoing project funding
MOHSS	Train CHVs, provide standards and data collection forms, supervise and collect data monthly through clinic nurses, and provide general program oversight
Peace Corps	Provide a Peace Corps Response Volunteer (PCRV) to coordinate activities in each community
Local NGOs	Sponsor PCRVs by providing accommodation
MSH	Provide oversight and coordination at implementation sites under AIDSTAR-Two funding
ICF International	Conduct a case study evaluation of the process and outcomes at implementation sites

Community Selection

After consultation with MOHSS, the two communities were selected to test the Centership concept:

1. *Onderombapa* lies east of Windhoek, an hour south of Gobabis in east central Namibia, approximately 20 kilometers (km) from Botswana. Onderombapa is a cattle-farming community of approximately 3,000 people in widely scattered villages and difficult access to health care; however, village leadership and communal structures are in place. A single health center serves 45 villages, some of which are 40 km from the clinic. Public transportation is minimal and most people travel on foot.
2. *Tutungeni* is an informal settlement of approximately 14,000 people outside the town of Rosh Pinah in southwestern Namibia close to South Africa. Rosh Pinah is managed by the two large zinc mines in the area through an organization, RoshSkor. Tutungeni has few formal services or developed infrastructure. Many migrant laborers representing multiple languages and tribal groups from across Namibia have settled in the area to look for employment. Many traditional community structures do not function, and it is not a cohesive community.

Method

The Centership evaluation focused on documenting the implementation process, challenges, and learning in both communities. Table 2 identifies key features of the two communities.

Table 2. Key features of Onderombapa and Tutungeni communities

Features	Onderombapa	Rosh Pinah/Tutungeni
Type of community	Population of 3,000 scattered over 10,000 sq. km in 45 widely distributed villages, the farthest of which are 40 km from the clinic at Onderombapa	Tutungeni is a squatter community of approximately 14,000 migrant workers outside Rosh Pinah, a mining town
Location in Namibia	Eastern Namibia, near Botswana border	Southern Namibia, near South Africa border
Main community income-generating activities	Cattle and small livestock farming	Contract work for zinc mines and other local contractors, such as cafeteria services
Clinic	1 clinic; head nurse was on Centership committee initially	1 clinic; head nurse was on Centership committee initially
Community health volunteers	10 CHVs trained by MOHSS in October 2011; 15 more trained by CoHeNa in May 2013	16 CHVs trained by MOHSS in December 2011; ongoing monthly health education sessions conducted by nurse
Centership Board and committee	Centership Board established with additional committee members; later disbanded	Centership Board established with additional committee members; later disbanded
Centership meeting space	Centership meeting room is in community center building, renovated through AIDSTAR-Two with USAID funding	Centership meeting space is provided by RoshSkor, as outlined in a Memorandum of Understanding
Peace Corps	2 female PCRVs with varying lengths of stay	1 male PCRv for several months; local coordinator hired after PCRv left
Private sector engagement	CoHeNa, local NGO engaged by MSH in 2013	RoshSkor, private management company for Rosh Pinah
Local coordination	MSH coordinator based in Windhoek for 1 year; followed by CoHeNa	MSH consultant based in Windhoek for 1 year; followed by a local coordinator hired in the community for several months; followed by MSH Namibia Operations Specialist
Management	Overall management from MSH Arlington office	Overall management from MSH Arlington office

These propositions were tested during implementation:

1. Linking CHVs to a community structure, such as a Centership committee, will result in community members taking responsibility for the health issues in their community.
2. Combining CHV health promotion and HIV/AIDS awareness and community health information system reporting with business training to establish a community owned-and-operated business will provide funding to sustain the community-based approach to health information and awareness.
3. Differences may result from the Centership project being implemented in two communities with different levels of social cohesion.

Following are some of the questions the evaluation sought to answer: Does the model as originally conceived work? Does success of the model vary with local circumstances? If so, what are the factors that contribute to or affect success? How would success be defined? Did the model change in either site? If so, how? Does the presence of social cohesion and strong community structures, accountability, and leadership improve community decision making and data use? Does the

presence of the Centership Committee enhance the use of community health data and community awareness of HIV/AIDS and other health issues?

During a series of three site visits to each location (close to baseline, in December 2011; midline, in July 2012; and endline, in August 2013), ICF interviewed key informants, collected data, and documented processes. ICF also conducted phone interviews with MSH staff members after their field visits. Key informants included MOHSS national-, regional-, and district-level representatives, clinic nurses, PCRVs, Centership Board and committee members, CHVs, community leadership and community members, RoshSkor management, and CoHeNa leadership. The evaluators also attended the end-of-project results meetings in both communities.

Results

The Centership concept was introduced to both communities in 2010 by a team from USAID/Washington and Namibia and MOHSS; however, activities did not begin until March 2011, when the AIDSTAR Two Project managed by MSH was asked to take over activity management and implementation. Centership Board and committee members were selected, a meeting place identified, and required renovations initiated. AIDSTAR Two hired a local coordinator based in Windhoek to provide support and coordination to both sites. Each community had a PCRv assigned through the Namibia Peace Corps office. The PCRv's role was to coordinate with the Centership Board, communicate with AIDSTAR Two, and generally provide support to the local process. A teacher from the local primary school in Onderombapa provided accommodation for the PCRv in his home. The PCRv in Rosh Pinah was provided a small apartment near the clinic, which was approximately three kilometers from the Centership office. MOHSS identified and trained 10 CHVs candidates for Onderombapa in October 2011 and 13 CHV candidates for Tutungeni in December 2011. The training focused on CHV roles and responsibilities and accurate completion of the MOHSS monthly reporting form for community-based data. The Annex shows an example of the data collection form.

Over four successive visits, AIDSTAR-Two staff conducted training in business principles and management to address the microenterprise aspect of the project. The training also included brainstorming on potential microenterprise ideas and a group prioritization process. The Centership Boards were then tasked with conducting a simple market analysis to understand demand for the service, product, or business idea suggested.

The clinic nurse's role was to collect and validate the monthly data received from CHVs and provide ongoing support and supervision to CHVs. After CHVs were trained, data collection was expected to involve community mapping and routine community health data collection, using the MOHSS reporting forms. Members of the Centership committees, some CHVs, and the clinic staff also were trained in the use of data for decision making.

CHALLENGES AND CHANGES: WHAT HAPPENED?

USAID's Collaboration, Learning, and Adaptation approach² promotes monitoring, review of data, and learning from the implementation process to promote a living strategy and course correction to adapt projects to the local situation. The Centership project evolved over time in each site and became an example of this approach. This evolution and findings from the final evaluation follow.

² <http://usaidlearninglab.org/faq/collaborating-learning-and-adapting-cla>

Onderombapa

At the time of the midline assessment in Onderombapa, the Centership Board had problems drafting and submitting a workable business proposal to AIDSTAR-Two. Although the Centership chairperson was motivated, she had little concrete support from other members, and a series of discouraging events slowed progress. During the first year, two CHVs were dismissed following the theft of office materials. Planned renovations that included construction of a water tank and flushing toilet stalled when the committee had difficulty obtaining quotes and following up on the construction, and the selected contractor failed to install the tank and plumbing properly.

The proposed business concept was a feed, veterinary medicines, and farm supplies store; however, no adequate building was available and renovating or constructing one was beyond the financial scope of the project. In addition, obtaining the required estimates proved difficult. Other potential options for storage space were blocked by community members who controlled the space. The Centership Board found proposal writing difficult and became discouraged when it appeared that their proposed business idea would not be accepted. The assigned PCRv tried to motivate the Centership Board to move the process forward, but the effort resulted in repeated frustration.

At the midline assessment, the focus of the Centership Board's efforts appeared to be on the business proposal, with minimal emphasis on community-based data collection, HIV awareness, and health promotion. The CHVs complained about the distance they had to travel to deliver their reports, cost of getting to meetings, and cost of cell phone usage. Most of the trained CHVs were not submitting monthly reports, and only three had mapped their villages. The clinic nurse felt pressured and overworked and said she did not have time to follow up with CHVs to review their data. AIDSTAR-Two extended the deadline for submission of a business proposal, but the group was unable to submit it within the extended time. The Centership activity as initially designed was disintegrating. The first PCRv left when her contract was complete in March 2012. Another PCRv was assigned but stayed only seven months. The MOHSS Regional Director was discouraged with the lack of progress.

At that point, USAID and AIDSTAR-Two discussed possible alternatives. The question was whether to continue funding the activity another year to find a workable solution or end funding and declare the activity a lesson learned about what did not work. At this point, AIDSTAR-Two explored the possibility of subcontracting to SME Compete (<http://www.smecompetite.com/>) but this proved difficult due to the time required to contract them. They also did not have the health technical knowledge to support the CHVs. USAID then suggested CoHeNa, a local NGO. CoHeNa was already present in the area and had experience implementing and managing community-based health promotion and data collection specifically for TB and HIV, and it had established a CHC at the Onderombapa clinic. In fact, some misunderstandings had occurred between the CHC and the Centership Board because of some overlap in responsibility and membership but without clarity about roles. The Centership Board and committee were disbanded and one combined CHC was established under the oversight of CoHeNa and the clinic head nurse.

We want to work together "so that Omaheke region does not have any diseases."

"The very important thing is that people in our community are dying and we are able to help our community."

"I like my community, and I want my community to be healthy. That's why I volunteer today."

CHVs in Onderombapa

CoHeNa: When CoHeNa started implementation in May 2013, it identified and retrained 15 CHVs on the MOHSS community-based reporting form. Several of these volunteers already were active in their

communities promoting TB and HIV awareness, and the training added to their knowledge about maternal and child health, as well as sanitation. CoHeNa followed up with onsite mentoring and supportive supervision to demonstrate specific tasks, such as home visits, community mapping, and completion of the monthly reporting form. At the final evaluation visit, the clinic nurse reported she had received monthly reports from all CHVs since the retraining three months earlier. She also reported that she meets with CHVs monthly to review their data, answer questions, and solve problems noted in the community. She stated that the CHVs are her “eyes and ears in the community.” A simple referral form was developed for CHVs to refer cases identified during their home visits to the clinic.

Clinic Head Nurse: The nurse reported 49 referrals by CHVs in the last three months. She also reported that CHVs are now submitting monthly reporting forms on time. CHVs collate the monthly data and report to CoHeNa. The nurse reviews and collates the same data for her monthly reports to the national health information system.

The nurse recounted several cases of CHVs making a difference in their communities. One example was of a child that the CHVs identified during a home visit who had never been immunized. The parents did not bring the child to the clinic on the first referral, but the CHV persisted and eventually the family brought the child in for immunization. Another volunteer collects TB medicines from the clinic for a nine-year-old child and takes them to a treatment support volunteer in a remote village. In another example, a CHV identified a pregnant woman in her village who was experiencing delivery complications. She immediately referred the patient by phone to the nurse, who examined the patient and arranged an ambulance to a facility because the client needed an emergency C-section. The nurse also commented that the number of diarrhea cases had dropped since the CHV retraining, and she attributed this to increased community awareness of the causes of diarrhea and the need for hand-washing and proper sanitation, although no direct evidence supports this. She added that

the CHVs distribute oral rehydration packets to families during their home visits.



Photo: CHVs in Onderombapa take delivery of goats provided by CoHeNa for IGA.

supervision and mentoring needed to sustain CHVs’ interest and involvement. She mentioned the need for ongoing refresher training, training for new recruits, and supervision of CHVs. She said that if MOHSS could provide another nurse to staff the clinic, she would have more time to follow up with CHVs.

The clinic head nurse reported that the CHVs appeared to be motivated to report regularly on their data collection and health promotion activities. She stated that, in the beginning, the interest of the Centership Committee “seemed to be more on the business idea and not on health promotion.” She felt that the supervision and mentoring CoHeNa provided was important to refocusing on health. Looking forward, she commented that the role of a local NGO, such as CoHeNa, was important to provide the

CoHeNa also has experience in forming community income generating activities (IGA). It proposed a goat-rearing project as the income-generating activity because it was in line with the knowledge and expertise of community members. Project funds were used to purchase 20 goats with from another project, and one CHV offered to accommodate the goats in an enclosure on her land. The group jointly decided to contribute funds to buy fuel to pump water for the goats, and the project funds provided feed during the drought period. The group under CoHeNa's leadership also discussed how they would manage the eventual profits from the goat project.

The local CoHeNa coordinator reported that CHVs in Onderombapa would “sustain themselves if given the chance.” She also said they would “persevere even without external funds.” CoHeNa leadership noted the important role of the nurse in sustaining the activities of CHVs. Another suggestion was that trained and active CHVs be considered as candidates for the health extension worker (HEW) training and positions as that national program is rolled out, which would provide additional motivation to CHVs.



CHVs share the pride in Onderombapa at results meeting with USAID, CoHeNa, and MSH. Photo courtesy of Teri Brezner.

The Omaheke Regional Management team of the MOHSS was involved from inception of the project. During the final evaluation interview, the regional representative recommended that this was a very important aspect of the approach used in the Centership Project. Her additional recommendation was to involve the Ministry for advice and input, even if they don't have time to manage the project. She added that it is important not to sideline key leadership from MOHSS and the community. The Regional MOHSS representative also stated that the “activity will be more sustainable when community leadership owns the activity and takes leadership. It is also important to think through

the implications of the process being initiated. This activity has demanded time of the clinic nurse, but the nurses are overwhelmed with their current work load.”

The Regional MOHSS representative said expectations were high and probably unrealistic in the beginning, but she pointed out that proposal writing expertise was lacking in the group and more guidance and support were needed. The project lost momentum when the chairperson left, creating a gap in leadership; however, CoHeNa recently was able to revitalize the project and CHVs feel they own the project now. The Regional MOHSS representative stated, “They are empowered. They are helping their communities by bringing them health information and messages.”

When asked about the possibility of replication in Namibia, her opinion was that an NGO is needed to facilitate and start a CHV activity. After a CHV program is established, the facilitating organization can move on. The Regional MOHSS representative’s opinion was that the NGO should not have a long-term role because eventually it will withdraw when the funding ends. She addressed motivational factors, saying that recognition of CHVs and their contribution to the community and MOHSS is most important, but giving CHVs money is not sustainable. She mentioned the need for leadership and financial management training as important aspects of sustaining both an IGA and a CHV activity.

On the Peace Corps partnership, the regional MOHSS representative recognized the difficulties and reasons for discouragement. She felt that success depends on the personality of a volunteer, and she was unwilling to draw conclusions generally about the value of having the Peace Corps as part of the partnership.

Community Health Volunteers: During the final evaluation interviews, CHVs described feeling motivated to help their communities. They said that CoHeNa’s training and supervision helped them understand the importance of the role of CHVs. The CHVs made the following points:

- *“Teamwork is one of the most important things.”* The Clinic Health Committee has a structure with clear roles and responsibilities.
- *“The idea of volunteerism must be clear from the beginning. Don’t make any promises that cannot be kept. If you promise people money and then it’s not provided, people will become frustrated. Small nonfinancial incentives are okay.”*
- CHVs serve as the nurse’s outreach into the community. If a nurse identifies a TB patient, the CHV can follow up in the community.
- The number of referral slips has become a bit of a competition among CHVs.
- *“Do and Document.”* Notebooks and pens are provided in the trainings.
- The Centership room is very important for CHVs as a place to meet, problem solve, and compile monthly data and reports.

Rosh Pinah and Tutungeni

Just before the midline evaluation visit, AIDSTAR-Two decided not to fund a business project because a workable proposal had not been submitted, and the Centership Board and committee were disbanded. The

“Rosh Pinah is a different clinic now; there used to be endless queues...the cases of diarrhea have gone down... One of our nurses was even sent to another community to help at their clinic.”

Head Nurse, Rosh Pinah clinic

activity was refocused on CHVs, and a new local coordinator was hired. Several key informants felt that refocusing on the CHV activity was a positive decision because the emphasis on developing a workable business proposal previously had taken priority and CHV activities had been neglected. In fact, several key informants noted they had not seen much real connection between the Centership Board and CHVs. One key informant stated that the Centership project “tried to mix two things that are not mixable, a community-based health project with a private business.”

Other issues were identified during the midline evaluation, such as mistrust between the Centership Board and the private management organization for the town of Rosh Pinah, RoshSkor. It was also mentioned that the Centership Board was seen as politically and personally motivated, but not motivated to improve the health conditions of the community.

“I’m very happy to share information with my community. I have learned a lot and am still learning...how to work with the people...how to solve their problems. I wanted to help them to help themselves. “

CHV, Tutungeni

Over the ensuing year, a number of changes occurred. AIDSTAR-Two redesigned the project to incorporate a public-private partnership agreement between MOHSS, AIDSTAR-Two, the CHVs, and RoshSkor. This arrangement included small financial incentives to CHVs for providing health promotion messages to the community, paid for in the first year by AIDSTAR-Two. The clinic head nurse trained several CHVs to register patients in the clinic and take blood pressures so that community members would recognize and accept them on home visits. The clinic head nurse also met with CHVs weekly to review their data, problem solve, plan monthly health promotion activities, and collate reporting. This has become a regular venue to coordinate and address needs in the Tutungeni community. Some information is then reported to RoshSkor and the Rosh Pinah Community Forum for resolution. In addition, the CHVs received training on a variety of health topics, including data collection and effective communication and counseling for people affected by HIV/AIDS.

The clinic head nurse repeatedly voiced her concern about the nutrition needs of TB and HIV patients in treatment and malnourished children. In response, AIDSTAR-Two explored local options to address this. Although the newly appointed coordinator lasted only a few months, before his departure he initiated arrangements to set up a vegetable-growing project that uses veggie tunnel greenhouses acquired through a horticultural NGO in Windhoek. RoshSkor provided secure land for the greenhouse project, and all CHVs received two weeks of training in managing and growing vegetables. At the final evaluation, six types of vegetables had been planted in 4,000 black plastic bags, and many seeds had sprouted. CHVs organized themselves to water the plants twice daily, and they planned that 60% of the harvest would go to patients and malnourished children and be shared among CHVs, and the remaining 40% would be sold to local restaurants and guest houses, with the profits used to replant and extend the garden.

“Initially, the idea was to only collect information, but I am very impressed that they (CHVs) got to the point of educating the community...they now do health promotion workshops in the community... They will address a specific topic in each workshop – several times within the community... What I love about the model as it evolved is that the people in the community are making decisions about and for themselves.”

RoshSkor Director

Clinic Head Nurse: The nurse acknowledged challenges in managing the CHVs, such as the amount of personal time and effort demanded of her, but overall she was positive about the changes she has seen in the community through the efforts of the CHVs. She spoke of the need to increase the

number of volunteers to 20 to enable full coverage of every home in Tutungeni. She added that many people have asked to become CHVs. She advised that selection criteria should be clear and that MOHSS should be involved in the selection process. She believes one reason for the strength of the program is the weekly meetings to review data, problem solve, and plan health promotion activities. She said it is important to ensure that accurate health information messages are disseminated, especially because all CHVs are not fluent in English. She hopes that the frequency of these meetings can be reduced as CHVs become more confident in their knowledge and role.

The nurse said “the community needs health information more than medicine since good health practices can prevent the need for medicine.” She said, “Rosh Pinah is a different clinic now; there used to be endless queues...the cases of diarrhea have gone down. Now there are only five to seven cases each month. There used to be 20+ cases per week. One of our nurses was even sent to another community to help at their clinic.” The Rosh Pinah clinic also scored the highest in the region in TB health education.

The CHVs have been receiving a small stipend from AIDSTAR-Two of \$250 Namibian dollars for each health presentation made, and during the initial phase, each CHV was allowed up to four sessions per month. The original plan was for one session per month, which is more financially feasible. Of each payment, \$50 is put into a joint account for CHVs. The incentive has motivated CHVs; however, the challenge is how to sustain this payment because MOHSS cannot continue this expense. Under the public-private partnership agreement, RoshSkor has committed to covering these incentives for a year.

The nurse believes CHVs will continue to have an important role, even after the HEWs program is implemented in the region in 2015 because the number of planned HEWs will not be sufficient to reach all communities and households.

The RoshSkor director was positive about the role and effect of CHVs in the Tutungeni community. He said that initially the volunteers collected health data from the community, which RoshSkor was interested in, but they also began to conduct health promotion workshops in the community. He added that the CHVs now serve their community in other ways by providing information to RoshSkor so that RoshSkor can address problems and improve conditions. He said he had always wanted a way to interact with the Tutungeni community, to be aware of their problems, and the CHVs have provided that. He stated, “Their [CHVs’] feedback and RoshSkor’s actions are now synergized. There

has been collaboration, opening up of channels. My expectations have been exceeded in the end.” The director was not surprised that the business idea did not work. He explained that he did not see how “volunteerism and a business concept could be mixed.” He does not see the greenhouse vegetable growing project as a business, but as a

community garden. In conclusion he stated, “The people... they are also the boss. What I like about it [CHV program] is community involvement and empowerment. They are pulled into the decision making. They don’t make decisions about others—but about themselves. And I like that concept. And it works here; it works very well... What I love about the model as it evolved is that the people in the community are making decisions about and for themselves.”

“The one thing that has impressed me from this project is the concept of unemployed or low income individuals who see their way open to work as volunteers to uplift the community. This project proves to us that it is possible to have a sustainable project where the guarantee of sustainability is founded in the hearts of people. This project proves to us that there is a force stronger than money...caring.”

From RoshSkor Director’s speech at the end-of-project results meeting

When asked to identify success factors, he mentioned the involvement of MOHSS and the town council from the beginning. He also said, “Don’t come with the structure. They will develop a structure that allows it to grow because they’ve taken ownership.” The approach of anyone who wants to help should be, “We are here to support you, not to tell you how to do it...We are here to give you the tools if you would like.”

RoshSkor and other partners signed the Public-Private Partnership arrangement, which commits RoshSkor to providing stipends to CHVs for health promotion sessions for a year. The director believes the added value of the Peace Corps depends on the particular personality and skills of an individual. He did not believe that general conclusions about the role of the Peace Corps in the project could be drawn based on this experience.



Community Health volunteers in Onderombapa demonstrating community maps. Photo courtesy of Sharon Arscott-Mills.

MOHSS district director stated that the presence of CHVs is desirable because they provide MOHSS with a “hands on the ground and a more immediate sense of outbreaks and health problems at the community level.” He said the success of this activity was due largely to the exceptional personal qualities of the nurse at the Rosh Pinah clinic who had invested her time and energy and her clinical training to meet regularly with CHVs, problem solve, train, and supervise them. His opinion was that the role of supervisor and coordinator will be important if the model is to be replicated in Namibia. He felt that it is possible to combine an IGA with a community-based health program, but he also believes it is important to identify an activity that is familiar to or needed by the local community. He

also stated that it is important to involve all levels of the health system in discussions and design from the beginning.

Community Health Volunteers were positive about the opportunity to learn about health and share this information with their community. Several said they initially faced resistance from community members who would not allow entry into their homes or answer questions about health, but now the CHVs are accepted and sought out by community members. A recent example was of a young woman who was discovered on a home visit “looking quite sick.” She resisted going to the clinic at the urging of the CHV. A few days later the mother of the young woman called the CHV and asked for help to get her daughter to the clinic. The CHV responded immediately, hired a taxi, and accompanied the patient to the clinic, where she was immediately seen and referred to the district hospital.

“...what motivates me is that there have been challenges that have not been addressed, that no one has been doing anything about, and I thought I could contribute to the development of my community.”

CHV, Tutungeni

CHVs recounted their routine data collection, health promotion planning, and home visits schedule. Some of the health promotion sessions are conducted in the clinic while patients are waiting to be seen; others occur in Tutungeni. A nurse is present at each health promotion session to ensure accuracy of messages disseminated. One CHV stated, “Normally after each group goes into the community, we come together and look at the data. If we find common problems, we note that in the book. We discuss these with the nurse. Sometimes, if it is a big problem, it will be passed on to authorities like RoshSkor.” A specific example of problem solving was identification of a shortage of toilets and dirty toilets. The problem was raised with RoshSkor, which erected new toilets and increased the frequency of cleaning the toilets to twice per day.

CHVs have organized themselves and appointed a chairperson, secretary, and treasurer. They have a bank account. Business management was included in the training for setting up the garden. CHVs have organized a twice daily watering schedule, but they also recognize the need for a subcommittee to manage the garden.

Community testimonials: During a home visit, a CHV identified a child with a physical disability. After bringing this to the attention of the clinic nurse, the nurse contacted a local NGO, which donated a pediatric wheelchair. She also contacted social services so that the family would receive the monthly government stipend for children with disabilities.

AIDSTAR-TWO RESPONSE AND LESSONS LEARNED IN BOTH COMMUNITIES

Initially AIDSTAR-Two/Arlington was asked to address the business component of the Centerships project after it had been designed and introduced to the communities. AIDSTAR-Two's role was limited and unclear, and it was difficult to manage a community-based activity from the United States. When AIDSTAR-Two took over management of the Centership activity, the communities had already been selected and the AIDSTAR-Two team did not know what the communities had been told. It proved difficult to train the two communities to develop and manage full-fledged livelihood programs. In hindsight, it would have been better to begin with network mapping and do an assessment of strengths, opportunities, and challenges in the communities at the point at which AIDSTAR-Two took over. This might have identified resources, such as CoHeNa and RoshSkor, earlier.

The AIDSTAR-Two representative said during the final evaluation interview: “The project in both communities adapted over time into something that appears to be workable for the local context; however, we only learned to be adaptable toward the end. We tried to make the original design that was handed to us work. Most of the changes resulted from discovering resources in the communities themselves. One advantage was that USAID and MSH were open to changes in the scope if they were needed. If individuals had been rigid, nothing would have been accomplished.”

Income generation: The business aspect created interest, but it would have been better to have one primary focus, whether it was the business aspect or the health component. It would have been better to start with small income-generating activities relevant to local knowledge and experience. The expectation that the Centership Board and committee could draft a business plan was challenged by volunteer turnover after the business trainings had been conducted, particularly in Onderombapa. In the beginning, when the business aspect was the priority, the health component suffered. The project, as initially conceived, also involved computer and internet access as a source for health and HIV/AIDS information, but the lack of capacity for computer use and insufficient time for computer training resulted in this aspect of the project becoming secondary. The primary priority was to help the CHVs understand data collection and use. If the project were longer, the CHVs, nurses, and possibly MOHSS staff could benefit from computer training now that data collection is becoming more reliable. CHVs also could make use of online tools, such as those available through CHW Central (<http://www.chwcentral.org/>). Training the community could be a longer-term goal.

Incentives and motivation: The incentives provided during the past year to CHVs in Rosh Pinah have been motivating, but the problem is how to sustain this expense over the long term. Interestingly, CHVs in Onderombapa do not receive financial incentives, although they face greater distances and challenging transportation. Other methods of motivation, such as recognition of CHVs in the district, region, and nation, are important.

Ongoing challenges: Onderombapa CHVs face the ongoing challenges of lack of transportation and great distances to attend meetings and report data.

They encourage patients to attend the clinic for treatment, but know that patients also face the transportation problem. In Tutungeni, challenges include maintaining the incentive program after the first year. Both communities will face challenges of ongoing management of the newly established IGAs.

Community health information and data reliability: Considering the oversight and mentoring provided by CoHeNa in Onderombapa, the data now seem reliable; however, for this trend to continue, CoHeNa will need to continue to be involved. CHVs cannot yet collate the data reliably on their own. It is important that MOHSS use the data or the data collection will stop. CHVs have requested and received additional training on various health topics. Ongoing training and support through clinic nurses from MOHSS will be required.

Sustainability: Both communities will need ongoing supervision and coordination for data collection, health promotion, and data-use activities to continue.

Role of the Centership Board: In Tutungeni, several Centership Board members had political leanings and connections that affected the group. Most CHVs were not board members and functioned apart

“Both communities are at a tipping point. They have been jumpstarted, motivated, are moving forward, but they probably need two years of support and management to continue the IGA projects. The CHVs have commitment and motivation, so it’s promising if they can get the support they need.”

AIDSTAR-Two

from the board. During the last year, CHVs organized themselves to manage their community activities and the garden. In Onderombapa, the CHC provided this structure. In both cases, the Centership Boards were not helpful or a necessary structure, and were dissolved around midline.

Partnerships: It is important to initiate and maintain constant contact with MOHSS key stakeholders during implementation of a health-related activity. The partnerships with a local NGO in Onderombapa and the private sector in Rosh Pinah were part of the success of this project. Working with local partners was a positive step, but it took a long time to establish the partnerships. The activity should have started with network mapping to identify existing local organizations. It is necessary to select communities strategically and do more research initially. The partnership with Peace Corps was not necessary to the success of the project; however, it was important to have someone at the community level coordinate and stimulate action. Using PCRVs was probably not a workable approach because they lacked sufficient local or technical knowledge.



Community Health Workers in Rosh Pinah check plants in the community garden greenhouse. Photo courtesy of Teri Brezner.

CONCLUSIONS AND RECOMMENDATIONS

The Community Health Worker (CHW) Central website states, “Meeting the [Millennium Development Goals] MDGs and addressing the dearth of health workers in developing countries is critical for the improved health of communities. The goal of the One Million CHW Campaign (1mCHW) is to deploy 1 million trained and equipped CHWs by 2015. In September 2013, the campaign discusses its strategy for helping African countries create national CHW strategies, and a collaborative scale up plan.”³ The Centership model in Namibia was envisioned as an innovative answer to the recognized need for community members to reach their own communities with health promotion, HIV/AIDS awareness, referrals, data collection, and provision of limited services.

The Centership model did not work in either community as originally designed, but it evolved over time to specific local solutions for the two communities. At midline, the activities in both locations were floundering and would have ended; however, both USAID and AIDSTAR-Two were willing to adapt the approach. The willingness to be flexible and adapt the response based on local learning supports USAID’s collaboration, learning, and adaptation approach.

³ <http://www.chwcentral.org/blog/building-relationships-effective-chw-scale-one-million-chw-campaign>

If the Centership Project had closed in mid 2012 as intended, few positive outcomes would have resulted. Most of the turnaround at both sites occurred in the last few months. It is too soon to be sure the activities will be sustainable, but both sites have a better chance now than a year ago.

Lessons Learned

The leadership and commitment of a few key people (e.g., clinic head nurse, RoshSkor director, CoHeNa local coordinator) were important in turning the situation around. It is important to also note that several of the problems, as well as successes, during implementation were specific to individuals and, therefore, do not lend themselves to generalization. An example of this is the strength of commitment and leadership qualities of the head nurse at the Rosh Pinah clinic, who gave her personal time and energy to provide support, training, and oversight to the CHVs. Without her leadership and commitment, it is unlikely that the Tutungeni CHVs would have continued.

The role of local coordinator is important to success. Two models emerged to fill the coordination role:

1. Local NGO with presence and experience in the community
2. Clinic nurse with support from MSH Windhoek office

A third option is to design the coordination role for a nurse or HEW who is directly connected to the health system. Another option is to hire a retired nurse or teacher. All these options require funding for this role.

In addition to the coordination role, maintaining motivation and involvement of CHVs will require providing supportive supervision, problem solving, ongoing training, and updates. Recognition of the CHVs contribution through MOHSS district or regional events also will be an important motivator. Funding through MOHSS or external resources will be required to provide this support.

CHVs almost unanimously mentioned that their motivation to be a volunteer was a desire to help their communities become better informed about health and how to live healthily. It was also clear from comments and interviews that being a CHV provides a measure of status in the community and a sense of empowerment. The small stipend for the health promotion activities in Tutungeni also provided motivation. Other informants mentioned the opportunity to participate in the IGA. Several also said that being a CHV gave them the prospect of future employment as a HEW or other worker, which was a motivating factor. Another motivating factor identified by CHVs was recognition events planned by MOHSS.

The Centership project included donations of three computers to each site, with a goal of promoting access to health and HIV/AIDS information through the Internet; however, problems, such as managing monthly Internet access payments, computer and antivirus maintenance, and controlling computer access proved difficult.

The original project, which was a top-down approach designed by USAID/Washington, included a range of partnerships. Although the Peace Corps was included in the design, several key informants felt that placing a PCRV in this role was not wise. It was a difficult assignment in a tough location. The coordination role that Peace Corps had, however, is important. Coordination and implementation would also have been simplified if responsibility resided in the MSH/Namibia office rather than in the AIDSTAR-Two/Arlington office. It is essential to start any future expansion with a local scan or mapping of community resources and build on those existing strengths. The central role of MOHSS in any scale up or expansion plans will be critical.

It is difficult to predict if CHV activities in both communities will be sustained. The answer involves deciphering and monitoring a complex mix of factors, including motivated local leadership, local ownership of problems and successes, ongoing interest and support from regional and district MOHSS to use community data and provide training and supervision, private sector and IGA funding for financial incentives, and perceived opportunities for CHVs to become HEWs or get a regular job.

Specific Recommendations

1. As modeled in this project, involve MOHSS Regional Director and Regional Health Management team and community leaders from inception to foster ownership. When the IGA involves sectors beyond health, include the Regional Councilor of the Ministry of Regional Local Government and Housing, and Rural Development to create and enable links to other sectors.
2. Use a community capacity enhancement approach and facilitation process to stimulate community awareness of its own strengths to foster ownership and lead to sustainability.
3. Begin with network and partner mapping to ensure informed decisions and understanding of the environmental context and presence of other potential partners.
4. From the CHVs: Be clear about the role and expectations of volunteers from the beginning. Small nonfinancial incentives are acceptable, as well as recognition at community, district, and regional events.
5. From the CHVs: Foster a team sense of working together for the community.
6. Seek opportunities to integrate or build on existing platforms; don't duplicate structures unnecessarily.
7. Review and use data collected by CHVs to solve problems in the community; to help improve data reliability, make sure CHVs understand the usefulness of the information they collect.
8. Design IGAs in cooperation with the community and ensure it is relevant to the community context, knowledge, and experience.
9. Be prepared to provide ongoing mentorship and support to an income-generating activity to achieve success and provide additional training, when needed.
10. Acknowledge that the roles of local coordinator and supervisor are essential. These could be the same person if the individual has the clinical knowledge to provide supervisory support.
11. Provide an opportunity for trained CHVs to become HEWs as the national program expands.

ANNEX

Community Health Volunteers use a standard Ministry of Health and Social Services form, shown on the following pages, to collect data from the community.



Republic of Namibia

Community Health Workers Activity Report

Location / Area of Community Own Resource Person


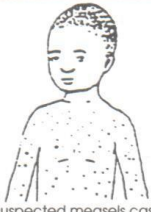


Village







Name of Community Health Worker

Number of households Month 20.....

Section: 1

Health problems attended to in a month? Please put a (x) for each case seen eg. ☒

	TOTAL	
	Treated	Refer
 1. Diarrhoea cases identified, 0-5 years, and ORS* given	<div>REFERRED</div>	
 2. Number of suspected measles cases identified and referred	<div>REFERRED</div>	
 3. TB cases suspected	<div>REFERRED</div>	
 4. Malnourished children identified	<div>REFERRED</div>	

		REFERRED												TOTAL	
														Treated	Refer
 <p>5. Persons with disabilities</p>															
 <p>6. Number of new home deliveries</p>															
 <p>7. Number of new pregnant women identified and referred</p>															
 <p>8. Common cold identified and referred</p>															
 <p>9. Number of children with suspected malaria identified and referred</p>															
 <p>10. Number of pregnant women with suspected malaria identified and referred</p>															



REFERRED


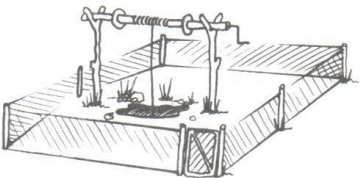

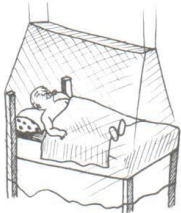

TOTAL

Treated

Refer


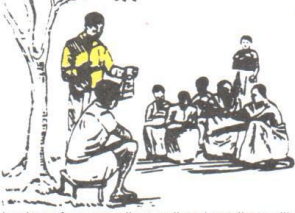
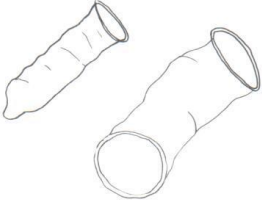
Section: 2

Community problems observed this month? Please put a (x) for each case seen eg. ☒

	TOTAL				
 <p>12. Pit latrine</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <p>13. Protected water point (well)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <p>14. Unprotected water points</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <p>15. Baby under mosquito net.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <p>16. Person under mosquito net.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section: 3

Community based activities implemented this month? Please put a (x) for each case seen eg. ☒

		TOTAL																																																																																																				
 <p>17. Number of home visits done</p>	<table border="1"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>																																																																																																					
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