



# **THE COMMUNITY COUNSELLOR PROGRAMME EVALUATION IN NAMIBIA**

**JULY 2015**



*Integrated research solutions*

**REPORT**

**THE COMMUNITY COUNSELOR PROGRAMME EVALUATION IN NAMIBIA**

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## ACRONYMS

HCT	HIV counselling and testing
CC	Community Counsellor
MOHSS	Ministry of Health and Social Services
CCs	Community Counsellors
ART	Anti-retroviral Treatment
PEPFAR	President's Emergency Plan for AIDS Relief
CDC	Centres for Disease Control and Prevention
US	United States of America
NIP	Namibia Institute of Pathology
RT	Rapid testing
PMTCT	Prevention of Mother to Child Transmission
ANC	Antenatal care
VCT	Voluntary counselling and testing
PLWHA	People living with HIV and AIDS
HIV	Human immunodeficiency virus
AIDS	Acquired immune deficiency syndrome
PITC	Provider-initiated testing and counselling
TaSP	Treatment as Prevention
RMT	Regional Management Team
KII	Key Informant Interview
DH	District Hospital
HC	Health Centre
IQC	Internal quality control
EQC	External quality control
PT	Panel testing
IC	Incomplete
ND	No data
SOW	Scope of Work

## EXECUTIVE SUMMARY

### Introduction:

The CC programme was implemented by the Namibian MOHSS in 2004 in response to a need for the scale up of HCT services, as well as to address the critical shortage of health care providers in facilities across Namibia. This lay cadre was intended to complement regular health facility staff in order to increase capacity to provide HCT and to provide supportive counselling for PLWHA. The programme was also intended to enhance the effectiveness of PMTCT and ART services.

The MOHSS started the CC Programme in collaboration with various stakeholders. MOHSS owned the programme and was responsible for policy development and supervision. The US Government provided funding and technical assistance from PEPFAR through CDC. NIP provided HIV rapid testing training and conducted RT quality assurance activities.

Regional selection committees were responsible for the selection of CCs. Standardised selection criteria were used to identify qualified candidates for training. At minimum, candidates had to have a Grade 10 certificate, and good references from the community. However, there were candidates that were recruited that did not meet the Grade 10 requirement. These candidates were recruited because they had provided longstanding services in the community, especially in the areas of HIV and TB.

A standard curriculum was used to train CCs. CCs attended a 12-week initial training course, comprising of six weeks of theory and six weeks of practical training. During the training, CCs were trained to perform HCT services in health facilities, by combining counselling skills and competencies in HIV RT. CCs were trained to provide pre- and post-test counselling to patients who need or request HIV testing, they were certified to conduct RT and they were trained to provide on-going counselling and support to HIV-infected patients. This included conducting adherence counselling for patients both prior to the initiation of ART and while the patient receives ART.

Before final certification, CCs were required to conduct ten rapid HIV tests with 100% concordance on re-testing by the NIP. Throughout their services, CCs were also required to attend annual refresher training. On completion of training, CCs received a certificate of competence and they were assigned to health facilities in communities from which they were selected. Training was conducted centrally and was subcontracted to different local training agencies. Some health care workers were also trained in counselling and RT to enable them to provide the services themselves, especially at sites where no CCs were assigned. Additionally, their training also enabled them to play a supervisory role, monitoring CCs placed in their facilities.

It should be noted that at the time of the commencement of the evaluation, the MOHSS received recommendation from the Public Service Commission on the transitioning of the CCs (to be known as Health Assistants), effective 1 November 2014. On recommendation from the commission, the process-outline indicated that only those CCs meeting the Grade 10 requirements (24 points over seven subjects, with an E-symbol in English) were approved for the transition at the time. These CC's received "Ministerial Appointment Letters". Those who did not meet these requirements received a contract extension letter from MOHSS/CDC Project and continued to operate as usual, with retention of their then current benefits. MOHSS is currently awaiting feedback on the transitioning status of the final 136 CCs from the commission.

## **Design:**

The process evaluation took place across nine of the 14 regions of Namibia. The goal of this process evaluation was to evaluate the CC Programme, which had been in operation in Namibia since 2004, including its role in the implementation of PITC. The evaluation will document lessons learned from the deployment and training of CCs and will inform discussions about the future programme.

The objectives of the evaluation were to:

- Describe the human resource profiles of the CCs employed at the time of data collection including: demographic profiles; length, types, and quality of training; length of service; daily work assignments; work satisfaction; retention issues; professional growth; and availability of technical supervision and psycho-social support systems.
- Describe how CCs affected the workload of health care providers between 2007 and 2013 in the uptake of HCT, PMTCT, TB, and ART services.
- Describe the role of CCs in the implementation of PITC in Namibia, including how PITC is defined as well as where and how PITC was being implemented in facilities where CCs were based.
- Assess the quality of HCT services provided by CCs.
- Assess the level of client satisfaction with services provided by CCs.

The following evaluation questions were outlined in the final evaluation protocol.

### **CC PROFILES**

- What is the demographic profile of the currently employed cadre of CCs?
- Are CCs utilized by health facilities to carry out tasks that are outside of their official job description?
- How many and what types of trainings are offered to CCs?

### **ROLE OF CCs IN HCT UPTAKE AND IMPLEMENTATION OF PITC**

- What health facility activities rely on the services provided by CCs and what role should CCs play in health facilities and in the health care system in the future?
- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
- What are the current barriers to proper implementation and documentation of PITC?

### **QUALITY OF SERVICES PROVIDED BY CCs**

- Are CCs able to deliver high quality HCT services?
- Are clients generally satisfied with HCT services?

This evaluation targeted various aspects of the CC Programme implementation. There were four study populations, selected largely based on patient load at facilities. The study utilised multiple study tools and data collection methods to increase validity. It is impossible to capture all of the information related to this project with one single tool, as there are multiple factors to consider and numerous data sources that needed to be taken into account.

The evaluation comprised of the following components:

- A Human Resources Document Review;
- A Document Review of the NIP Quality Assurance Reports for HIV Counselling and Testing;
- An HCT Register Review at each of the evaluation sites;
- Self-administered Questionnaires among CCs;
- Client Exit Interviews among clients who had received HCT services offered by CCs;

- Key Informant Interviews (KIIs) with the RMTs of the nine regions included for the evaluation;
- FGDs with health care staff at facilities in the nine regions included for the evaluation.

The HR Document Review and NIP QA Reports for HIV Counselling and Testing were carried out at national level only. The HCT Register Reviews and Client Exit Interviews were undertaken at the identified evaluation sites. Both the KIIs and FGDs were undertaken at regional level and included all regions that were identified for the evaluation. All CCs that made themselves available were included in the evaluation. These included CCs from all regions in Namibia and not only the regions identified for the evaluation.

The evaluation protocol contained standard evaluation tools. Survey Warehouse modified these in consultation with MOHSS and CDC.

A training workshop was conducted from 24 to 26 September 2014 with the data collection staff. The training workshop was led by the Survey Warehouse Project Manager, Data Manager, and Field Manager in collaboration with representatives from MOHSS and CDC. Data collection teams deployed on 26 October 2014 and the final data collection activities concluded early in 2015. Data processing staff was trained on the evaluation instruments at the Survey Warehouse offices prior to the start of data processing. The training was led by the Project and Data Managers. Quantitative data was checked, categorised, coded, and captured in SPSS. The Field and Data Managers supervised this process. The Data Manager cleaned the data. Data was analysed in SPSS as well. Qualitative data was transcribed using Microsoft Word and coded for themes relevant to the evaluation questions.

## **Findings:**

### HR Data Review:

Human Resource data was abstracted from Payroll data files as provided by MOHSS, Directorate of Special Programmes in early March 2015. Upon examination of the initial data abstracted, Survey Warehouse in consultation with MOHSS and CDC realised that the data did not correspond with the number of CCs that were reported by the respective RMTs at the start of the evaluation.

A subsequent request to MOHSS for revised HR data yielded the following for the total numbers for CCs and facilities, from 2012 to 2015. At the time, data by gender, age profile, and length of service was not available. It is important to note that the data below does not capture any CCs that were transitioned from the Namibia Red Cross Society to the CDC payroll. Also note the significant drop in number of CCs between 2014 and 2015, attributable to the transitioning process of CCs to Health Assistants.

This part of the evaluation specifically addressed the demographic profile of the CCs employed at the time of data collection. At first, HR data retrieved appeared to be incomplete and inaccurate. Pre-transition data appears accurate and corresponds well with the data obtained through the self-administered questionnaires that were completed by the CCs themselves.

The majority of CCs were females, with only 30% male CCs. Only 12% of CCs were younger than 31, and 7% were older than 45. Only 13% of CCs worked less than three years as CCs at the time just before the transitioning process of CCs.



#### NIP Quality Assurance Reports Document Review:

All HIV RT sites must be certified by the NIP, who is mandated by the MOHSS to ensure that Quality Assurance standards are maintained and that staff meet the competencies required. All sites must enrol with the NIP QA programme to be included in the regular QA assessments. In order for a site to open, health workers need to be trained in HIV RT to be able to supervise the testing site organisation and activities, since testing is mainly performed by CCs. It is the responsibility of the testing site supervisors to ensure that HIV RT test staff strictly adhere to and follow all relevant protocols and standard operation procedures.

The objective addressed through this component of the survey was to assess the quality of HCT services provided by CCs. The specific evaluation question that was answered is whether CCs are able to deliver high quality HCT services.

From the EQA reviews presented in this chapter, it is clear that the quality and accuracy of HIV testing in Namibia is high. The one shortfall, however, is that these figures represent testing done by health care staff as well as CCs at facilities, and the data extraction did not allow for the presentation of these statistics for CCs only.

#### HCT Register Reviews:

This chapter will highlight findings from the HCT Register Reviews conducted at the 38 sites included in the evaluation. Data was mainly abstracted from the HCT Register. The objective of this evaluation component was to describe how CCs have affected the workload of health care providers between 2007 and 2013 in the uptake of HCT. The data shows that CCs are just about solely responsible for the HCT services provided at facilities.

#### Self-Administered Questionnaire Among CCs:

The objective addressed in this component of the evaluation was to describe the human resource profiles of the CCs employed at the time of data collection. This included demographic profiles, length, types and quality of training, length of service, daily work assignments, work satisfaction, retention issues, professional growth, and availability of technical supervision and psycho-social support systems. This component of the evaluation was also aimed at describing the role of CCs in the implementation of PITC in Namibia, including how PITC is defined, and where and how PITC is being implemented in facilities where CCs are based.

The following evaluation questions were specifically addressed in this component:

- What is the demographic profile of the currently employed cadre of CCs?
  - Around 70% of CCs are female, and only 2% have only completed up to Grade 7.
  - Almost all CCs speak, read, and write English.
  - The youngest CC who participated in this part of the evaluation was 23 and the oldest was 59. The majority of CCs were between 31 and 40 years old.
- Are CCs utilized by health facilities to carry out tasks that are outside of their official job description?
  - CCs are of the opinion that they do more than what is expected of them - more than what is defined in their SOWs. In general, they noted that they perform duties such as patient intake, translations and filing, but also pharmacy assistance and cleaning; and they reported that these are not tasks that are defined in their job descriptions. Although these duties are not stipulated in their job descriptions it can be safely assumed that they could be categorized as 'Any other duties assigned by the Supervisor'.

- How many and what types of trainings are offered to CCs?
  - Just about all CCs indicated that they were satisfied with their initial training and they were of the opinion that it provided them with enough skills and knowledge to perform quality HCT.
  - Close to 90% have attended refresher trainings.
  - Seventy-seven percent indicated that there is a need for more frequent refresher trainings.
- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
  - Data shows that around 56% of CCs provide HCT to up to ten patients per day.
  - Eighty-seven percent of CCs felt that patients come to the health facility for another issue and are referred for testing by a nurse or doctor, while 58% felt that they come to the health facility for another issue and are referred for testing by themselves or another CC. Both of these options constitute PITC.
  - CCs have indicated that they can provide HCT to more clients than to whom they are currently delivering these services.
- What are the current barriers to proper implementation and documentation of PITC?
  - According to CCs about 66% of those referred for HCT by doctors and nurses do not end up getting tested.
  - The main reasons for not getting tested after being referred are cited as client choice; waiting time for HCT services, and infrastructure (HCT rooms too far from the screening rooms).
- Other
  - 2007 and 2010 reported higher intake of CCs compared to other years.
  - The vast majority reports supervision at facility, regional, district, and national level. They also reported high levels of satisfaction with these supervisors.
  - CCs reported satisfactory psycho-social support in the form of guidance and discussions (e.g. with a supervisor); peer support and case conferences to deal with job-related stress.
  - Seventy-five percent of CCs reported being either satisfied or very satisfied with their jobs. Sources of dissatisfaction were remuneration and excessive workload.

#### Client Exit Interviews:

The objectives of this evaluation component were to describe the role of CCs in the implementation of PITC in Namibia, including how PITC is defined, and where and how PITC is being implemented in facilities where CCs are based, as well as to assess the level of client satisfaction with services provided by CCs.

The following evaluation questions were addressed specifically:

- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
  - Fifty-three percent of respondents indicated that the reason for their visit to the facility on the day of the interview was for HIV testing. Another 21% visited the facility for ANC.
  - Seventy-five percent of respondents indicated that a CC spoke to them about HIV on the day that they got tested.
  - When asked who the first person was to suggest that they get tested on the day, 35% reported that it was a CC and 20% said that it was a nurse. The remainder indicated that they asked for the test themselves.
  - When asked why they got tested, 36% indicated that they wanted to know their status, 33% indicated that the provider suggested the test or that it was part of the visit and another 11% indicated that it was a three-month window period test.

- What are the current barriers to proper implementation and documentation of PITC?
  - Although the majority of respondents felt that HIV testing should be recommended to all patients who visit a facility, irrespective of the reason for their visit, around a third of respondents were opposed to this. They were of the opinion that patients should have a choice, and that not all patients or clients are ready to know their HIV status.
- Are clients generally satisfied with HCT services?
  - The majority of respondents felt that the time spent with the CC was sufficient. Just about all respondents felt that the CC conducted him/herself in a respectable manner, put them at ease, explained the results adequately, and listened to them.
  - Ninety-seven percent of respondents felt that the CC provided them with enough information, 93% felt they were able to ask questions, and 93% believed that their information would be kept confidential.
  - Ninety-five percent of respondents rated their overall experience with the CC as either good or very good and 96% of respondents indicated that they would recommend the facility to family and friends for testing.
- Other
  - Respondents suggested that more CCs be enrolled for the provision of HCT; others suggested that programmes and interventions be developed that disseminate information and increase awareness and encourage testing and also indicated that more space is required for HCT service provision.

#### RMT KIIs:

Eight KIIs were carried out with key individuals from the RMTs to assess their opinions as stakeholders on the service gap filled by CCs, how PITC is implemented, and the future roles of CCs in HIV services. These key informants occupied posts such as Chief Medical Officer; Senior Health Programme Administrator; Acting Director; Programme Officer for Family Health; Programme Officer for HIV, TB and Malaria; and Head of Division for Special Programs for HIV, TB and Malaria.

The discussions began with talking about how the RMT defines and addresses the needs concerning CCs. Most described their role in recruitment as one of making recommendations to the national MOHSS office or one of identifying their needs and passing those along to the national office or CDC. They reported sending the CCs for training as requested by the Ministry.

RMTs perceived that CCs have enabled the provision of effective HCT services -- the entry point to PMTCT, TB, and ART services -- and have taken over some of the workload from overburdened nurses. CCs are now considered indispensable for both of these reasons. Particularly because of CCs' role in relieving some of the nurses' workload, all other patient services are understood to be impacted by the CCs' responsibility for HCT services. With their inclusion in MOHSS and the salary increase that will accompany that transition, many RMTs would like to see the CC role expanded somewhat to allow more relief for nurses and to better link facilities with their surrounding communities.

RMTs are concerned that CCs should be trained for PITC and that the demand on CCs will increase with effective PITC such that more CCs will be required. CCs did not commonly feature in the RMTs' definitions of PITC but were identified as important to the implementation of PITC.

More specifically, this component addressed the following evaluation questions:

- Are CCs utilized by health facilities to carry out tasks that are outside of their official job description?
  - CCs are reportedly working almost entirely within their existing job description. Several RMTs commented that CC duties had been intentionally restricted in this way because CCs' remuneration was so low.
- How many and what types of trainings are offered to CCs?
  - Training of CCs appears inconsistent and irregular across regions. Beyond the initial national-level training, RMTs reported that training largely takes the form of on-the-spot training when they do annual supervisory visits. Some refresher trainings are reported, but funding problems sometimes interfered with training.
- What health facility activities rely on the services provided by CCs and what role should CCs play in health facilities and in the health care system in the future?
  - CCs have effectively helped to alleviate some of the workload from nurses and that impacts all service provision at facilities.
  - HCT is deemed to be almost entirely dependent on CCs. Far fewer clients would access these services were it not for CCs and the quality of service provision would be inferior in their absence, according to all RMTs.
- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
  - The RMTs describe PITC as though it is only in its early stages of roll out so the role of CCs is discussed as though imagined rather than observed.
- What are the current barriers to proper implementation and documentation of PITC?
  - Human resources limitations (numbers and training), infrastructure constraints on space in which to provide HCT services, and community resistance were identified as the greatest barriers to the successful implementation of PITC.
- Other:
  - Retention and replacement problems have reportedly created many unfilled posts.
  - Supervision of CCs has been incomplete and irregular
  - To date, RMTs have largely felt distanced from the management of the CCs. They described decisions to which they believed they should have contributed being made at the national level or by the donor.
  - RMTs' assessments of the CC Programme are surely impacted by the timing of the evaluation. CCs were in the early stages of transitioning into the MOHSS and so RMTs could only speculate about changes anticipated with this transition. For example, the problems with retention of CCs that have been experienced have been blamed on an insufficient salary that RMTs imagine will be rectified once CCs are absorbed into MOHSS and salaries are consequently increased. Some also hoped that introducing a hierarchy of CC posts will provide a further incentive for CCs to remain in their positions and fulfil their duties.

#### FGDs with Health Care Staff:

Eight focus group discussions were carried out with supervisors at health facilities in a given region to determine their level of satisfaction with CCs, including their knowledge and skills, as well as to assess their opinions on CCs' future roles in HIV/AIDS and other public health programs in Namibia. Individuals were conveniently sampled based on their supervisory roles with CCs, and they occupied posts such as Nurse, Special Programme Manager, Registered Nurse for the Special Program, and Medical Officer.

The specific evaluation questions that were addressed are discussed hereafter:

- Are CCs utilized by health facilities to carry out tasks that are outside of their official job description?
  - CCs are widely assigned duties outside of their job description. Most respondents recognized this problem, but explained that staff shortages compel them to do so. They stated that they ask CCs if they are able and willing to do other tasks. When they do so, respondents interpreted it as a sign that CCs are willing to work as a team in which everyone helps one another as needed rather than as an abuse of CCs.
  - Duties related to patient files were most frequently mentioned.
  - Respondents did not agree about whether the inclusion of these additional duties meant that CCs were over worked or that they were working to their potential.
- What health facility activities rely on the services provided by CCs and what role should CCs play in health facilities and in the health care system in the future?
  - Daily duties were described as including official duties such as HCT, PTMTC testing and counselling, adherence counselling, health education about HIV/AIDS, referring clients to other services, tracing defaulters, following up with clients in treatment, keeping statistics, and completing monthly reports. They described an array of outside duties such as filing, registering and weighing patients, driving staff to workshops, translating for doctors or pharmacists, taking pill counts and packing medicine, and filling in forms for blood samples as well as maintaining the correct temperatures for the testing room and refrigerator. Respondents in these focus groups repeatedly emphasized that CCs have significantly reduced nurses' workload.
  - All respondents asserted that CCs have a great impact on HCT services and HIV/AIDS services more broadly.
  - Counselling, in particular, would be very difficult or impossible to accomplish in the absence of CCs, primarily because nurses do not have time to counsel patients properly.
  - The impact was frequently perceived to extend beyond HCT services because CCs have relieved some work from the nurses, allowing them more time to focus on other duties.
  - Many suggested that, in the future, the CC job description should allow them to do more to relieve nurses' workloads.
  - All focus groups suggested that CCs should be provided with opportunities to grow in their career within the Ministry. Many emphasized that the MOHSS should support and encourage CC career growth as a means of increasing retention and not losing the significant experience that CCs have already gained.
- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
  - Many respondents included the referral of patients to CCs as a component of their definition of PITC.
  - Most respondents described CCs as an integral part of PITC, as the health care workers to whom patients are referred for HCT. If a patient is in a hospital, the CC comes to the patient to perform HCT.
- What are the current barriers to proper implementation of PITC?
  - Space at facilities and staff shortages were widely identified as barriers to full PITC implementation. Other reported barriers include: long queues, lack of HCT supplies, and lack of cooperation by some nurses.
  - Most respondents were concerned that the full implementation of PITC would place an increased demand on HCT services beyond what current CCs could manage, necessitating the recruitment of more CCs.
- Are CCs able to deliver high quality HCT services?
  - Respondents assessed the quality of HCT services provided by CCs to be generally quite good. They noted both results of quality assurance tests and their perceptions of patient satisfaction in making this assessment.
  - That respondents perceived the HCT to be so dependent on CCs also suggests that the quality of their work is sufficient to successfully maintain the program.

- Better supervision and regular refresher trainings were widely suggested as means of improving the services CCs provide.

### **Limitations of the Process Evaluation:**

There were some limitations to how well some evaluation objectives and questions could be addressed based on either study design or data availability.

#### CC Profiles:

*What is the demographic profile of the currently employed cadre of CCs?*

HR data was found to have gaps. For the evaluation, HR data was compared with the results of the CC self-administered questionnaire to estimate the CC HR profile.

*Are CCs utilised by health facilities to carry out tasks that are outside of their official job description?*

Because there was no follow-up available with those CCs completing the self-administered questionnaire, it is not possible to better understand how respondents interpreted some concepts that they reported on, especially 'refresher training' (i.e., does it include on-the-spot training by visiting RMTs), 'supervision' (i.e., what constitutes sufficient supervision), 'cleaning' (i.e., own workspace or a clinic floor, for example) and "support" for job-related stress.

A precise assessment of tasks performed outside the official job description is not possible because the official job description is not well defined. Specifically, it includes a clause that states 'Any other duties assigned by the Supervisor'. As such, the evaluation could only address perceptions of extraneous tasks and did so according to the perspectives of CCs, RMTs and facility-level supervisors.

*How many and what types of trainings are offered to CCs?*

In the CC self-administered questionnaire, CCs were asked to report on skills and knowledge gained from their initial training and then asked to report on the number and quality of 'refresher trainings' they had attended. There was no definition of 'refresher trainings' in the questionnaire and so the CCs would have responded according to their perceptions of what constituted this sort of training. For example, some may have interpreted 'training' to constitute something like their initial training – transported to a training site, formal instruction, and so forth. The tool did not allow for follow-up questions to clarify how CCs defined training in answering questions about attending trainings. The discussion guidelines for RMT KIIs asked specifically about 'in-service training'. Each tool addressing this question asked specifically about only one type of training and did not precisely define these trainings. CCs did not report on "in-service training" received and RMTs did not report on whether and how many 'refresher trainings' CCs attended. Thus, triangulation is not possible in addressing this question.

#### Roles of CCs in HCT Uptake and Implementation of PITC:

*What are the current barriers to proper implementation and documentation of PITC?*

No tool addressed the documentation of PITC. However, in the course of reviewing records, it was found that the HCT register does not reflect whether a client's test resulted of VCT or PITC.

## Quality of Services Provided by CCs:

### *Are CCs able to deliver high quality HCT services?*

The NIP QA reports do not record whether the tester is a CC or another health care worker. It is therefore not possible to report on the number of tests or proficiency panels carried out by CCs specifically. Additionally, it is unknown whether the results of proficiency panels reported match the number of panels required by the NIP guidelines. NIP QA reports and records for 2007 to 2009 were unavailable electronically. These had to be retrieved from the archives and data was abstracted from hard copy records. Where quarterly reports were not available, monthly reports were aggregated to establish the quarterly figures for each of the years of interest. HCT registers also do not record the post of the tester so it is not possible to check the number of clients a CC sees daily according to their reports against any other data source. One way in which this data might be used would be to check whether CCs see the number of clients outlined in the guideline for high quality HCT service. Some HCT registers were missing at particular facilities so that a complete data set was not obtainable.

Other:

### *Timing of evaluation*

The evaluation took place during the time of CCs being transitioned into the MOHSS although the decisions about all CCs had not yet been made. Consequently, it is possible that some respondents in the qualitative sections and the CC self-administered questionnaire approached the questions with this context in mind: concerns such as about how many CCs would be transitioned, whether there would be changes to the post, that a reduction in the number of CCs would increase work burdens on nurses, and so forth, as well as assumptions about challenges that some might hope would be rectified simply via the integration of CCs into MOHSS structures and policies (e.g., critiques of CCs were directed towards the donor and may have overlooked other causes). For instance, their responses may have attempted to provide evidence for a need for CCs at their current or greater numbers or may have underestimated performance problems.

## **Conclusions and Recommendations:**

The conclusions and recommendations of the process evaluation is shown in the matrix that follows.

EVALUATION QUESTIONS	HR RECORDS REVIEW	NIP QA REPORTS DOCUMENT REVIEW	HCT REGISTERS REVIEW	SAQs AMONG CCs	CLIENT EXIT INTERVIEWS	RMT KIIs	FGDs WITH HEALTH CARE STAFF	RECOMMENDATIONS
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CC PROFILES								
What is the demographic profile of the currently* employed cadre of CCs?	550 CCs (31 Oct 2014) 70% female Majority 31-45 Majority worked 3 years or more			Speak, read and write English. 70% female Majority 31-40 2007 and 2010 shows higher uptake.				
Are CCs utilized by health facilities to carry out tasks that are outside of their current job description?				Patient intake; translations, filing, pharmacy assistance, cleaning.		Within job description.	Ask CCs to help with other tasks if willing and able to do so. Mostly assistance with patient files.	<ul style="list-style-type: none"> <li>- Clearly defined job descriptions.</li> <li>- Strengthen psycho-social support.</li> <li>- More frequent refresher trainings.</li> </ul>
How many and what types of trainings are offered to CCs?				Satisfied with initial training. 90% attended refresher training. 77% want more refresher training.		Inconsistent and irregular. On-the-spot training during annual supervisory visits. Some refresher trainings, but impacted by funding.		



ROLE OF CCs IN HCT UPTAKE AND IMPLEMENTATION OF PITC

<p>What health facility activities rely on the services provided by CCs and what role should CCs play in health facilities and in the health care system in the future?</p>			<p>CCs solely responsible for HCT at facilities. Some also do ANC/PMTCT and TB.</p>			<p>HCT services = entry point to TB, PMTCT and ART services. Relieve workload for nurses. Take over more duties; link better with community in future. Position within MOHSS in order "to grow". CC Supervisor/Senior Health Assistant.</p>	<p>HCT services, PMTCT testing and counselling, adherence counselling; health education; client referrals; defaulter tracing; keeping statistics; monthly reports; filing; registering patients; weighting patients; drivers; translation; taking pill counts; packing medicine; filling in blood sample forms; maintaining correct temperatures for testing rooms and refrigerators. Relieve workload for nurses. HCT relies on CCs, especially counselling. Position within MOHSS in order "to grow". Take over more duties.</p>	<p>- Prioritise monitoring and evaluation.</p>
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<p>How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?</p>				<p>60% provide HCT to up to 10 clients per day. 87% referred by nurses and doctors 58% referred by CCs Can provide HCT to more clients per day.</p>	<p>53% came to facility for HIV testing. 21% for ANC. 75% said CC spoke to them about HIV testing on the day. Who suggested testing: 35% = CC; 20% nurse (the rest wanted the test themselves. 36% wanted to know their status; 33% provider suggested or part of visit; 11% 3-month window period.</p>	<p>Only 1 RMT included CCs in definition of PITC = referral to CCs.</p>	<p>Patients are referred to CCs by HCWs. CCs are described as an integral part of PITC.</p>	
<p>What are the current barriers to proper implementation and documentation of PITC?</p>				<p>66% of the referred do not end up getting tested. Main reasons: client choice; waiting time; lack of infrastructure.</p>	<p>30% felt that clients should have a choice to get tested and that not all patients are ready to know their status.</p>	<p>Space and facilities and staff shortages.</p>	<p>Space, staff shortages, long queues, lack of HCT supplies; lack of cooperation by some nurses, higher demand on CCs for HCT.</p>	

QUALITY OF SERVICES PROVIDED BY CCs

<p>Are CCs able to deliver high quality HCT services?</p>		<p>1st 50/10 samples = less than 1% discordance 1/20 samples = less than 1% discordance PPT = above 95%</p>					<p>CCs provide high quality HCT services. Noted NIP QA and perceptions of patient satisfaction. Service could be improved with better supervision, regular refresher trainings and better remuneration. Opportunities for career growth was also mentioned.</p>	
<p>Are clients generally satisfied with HCT services?</p>					<p>Sufficient time spent with CC. CC conducted him/herself in respectable manner. Put clients at ease. Explained results. Listened to clients. 93% felt that they could ask questions. 93% believe info would be kept confidential. 97% = felt CC provided enough information. 95% rated overall experience as good/very good. 96% would recommend services to family member/friend.</p>		<p>Felt patients are satisfied. Did not receive complaints. Interpreted the increasing number of clients coming for testing as a reflection of client satisfaction.</p>	<ul style="list-style-type: none"> <li>- Performance monitoring</li> <li>- Performance criteria should include those of NIP QA guidelines after initial certification.</li> <li>- Enforce NIP QA control and corrective action.</li> <li>- Improve supervision</li> <li>- Develop standard for service delivery where it does not exist.</li> </ul>

# 1 INTRODUCTION

## 3.3. PROCESS EVALUATION BACKGROUND

The Community Counsellor (CC) programme was implemented by the Namibian Ministry of Health and Social Services (MOHSS) in 2004 in response to a need for the scale up of HIV counselling and testing (HCT) as entry to care and support services, as well as to address the critical shortage of health care providers in facilities across Namibia. Community Counsellors (CCs), a lay cadre, were intended to complement regular health facility staff in order to increase capacity to provide HCT and to provide supportive counselling for people living with HIV and AIDS (PLWHA). The programme was also intended to enhance the effectiveness of prevention of mother-to-child transmission (PMTCT) and antiretroviral treatment (ART) services.

During the initial implementation of the PMTCT programme at the Katutura and Oshakati District Hospitals in 2004, challenges in providing the necessary HCT services were identified. Of pregnant women attending antenatal care (ANC), only 10% received voluntary counselling and testing (VCT). In an effort to scale up PMTCT and ART services, MOHSS identified the need for strengthening HCT services through the use of volunteers to conduct the counselling and testing and provider-initiated testing and counselling (PITC)<sup>1</sup>. Subsequently, the CC model was developed.

The MOHSS started the CC Programme in collaboration with various stakeholders. MOHSS owned the programme and was responsible for policy development and supervision. The US Government provided funding and technical assistance through the President's Emergency Plan for AIDS Relief (PEPFAR) through the US Centres for Disease Control and Prevention (CDC). The Namibia Institute of Pathology (NIP) provided HIV rapid testing (RT) training and conducted RT quality assurance activities.

Regional selection committees, chaired by the MOHSS, were responsible for the selection of CCs. Standardised selection criteria were used to identify qualified candidates for training<sup>2</sup>. At minimum, candidates had to have a Grade 10 certificate, and good references from the community. However, there were candidates that were recruited that did not meet the Grade 10 requirement. These candidates were recruited because they had provided longstanding services in the community, especially in the areas of HIV and tuberculosis (TB).

A standard curriculum was used to train CCs. CCs attended a 12-week initial training course, comprised of six weeks of theoretical training and six weeks of practical training. During the training course, CCs were trained to perform HCT services in health facilities, by combining counselling skills and competencies in HIV RT. More specifically, CCs were trained to provide pre-test and post-test counselling to patients who need or request HIV testing, they were certified to conduct RT and they were trained to provide on-going counselling and support to HIV-infected patients<sup>3</sup>. This included conducting adherence counselling for patients both prior to the initiation of ART and while the patient receives ART.

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<sup>1</sup> PITC refers to HCT recommended by health care providers to persons attending health care facilities as a standard component of medical care. HCT should be recommended by health care providers as part of the normal standard of care provided to the patient, regardless of whether or not the patient shows signs and symptoms of underlying HIV.

<sup>2</sup> Ministry of Health and Social Services, Directorate of Special Programmes, 2006

<sup>3</sup> Ministry of Health and Social Services, Directorate of Special Programmes, 2006

Before final certification, CCs were required to conduct ten rapid HIV tests with 100% concordance on re-testing by the NIP. Throughout their services, CCs were also required to attend annual refresher training<sup>4</sup>. On completion of training, CCs received a certificate of competence and they were assigned to health facilities in communities from which they were selected. Training was conducted centrally and was subcontracted to different local training agencies. Some health care workers were also trained in counselling and RT to enable them to provide the services themselves, especially at sites where no CCs were assigned. Additionally, their training also enabled them to play a supervisory role, monitoring CCs placed in their facilities.

It should be noted that at the time of the commencement of the evaluation, the MOHSS received recommendation from the Public Service Commission on the transitioning of the CCs, effective 1 November 2014. See Annexure 1 for the Transition Motivation Summary of CCs. On recommendation from the commission, the process-outline indicated that only those CCs meeting the Grade 10 requirements (24 points over seven subjects, with an E-symbol in English) were approved for the transition at the time. These CC's received "Ministerial Appointment Letters". Those who did not meet these requirements received a contract extension letter from MOHSS/CDC Project and continued to operate as usual, with retention of their then current benefits. MOHSS is currently awaiting feedback on the transitioning status of the final 136 CCs from the commission.

The transitioning status of CCs – now known as Health Assistants – looked as follows at the end of February 2015. Note the decline in the total workforce at November 2014, indicating the start of the transitioning process of CCs to Health Assistants.

**TABLE 1: COMMUNITY COUNSELOR TRANSITIONING STATUS**

	<b>Sept 2014</b>	<b>Oct 2014</b>	<b>Nov 2014</b>	<b>Dec 2014</b>	<b>Jan 2015</b>	<b>Feb 2015</b>
Total Workforce as per the Payroll Inputs	547	535	302	301	299	136
Terminations	12	1	1	2	-	-
Transitions	-	232	-	-	163	-
Total workforce for the new month	535	302	301	299	136	136

## **1.2 JUSTIFICATION FOR THE STUDY**

MOHSS, with the support of CDC, commissioned a mixed method process evaluation to assess the quality, impact and outcomes of the integration of CCs in the health care setting. The process evaluation intended to document and learn from the experiences of deploying and implementing CCs to improve HIV services.

## **1.3 INTENDED/POTENTIAL USE OF STUDY FINDINGS**

The process evaluation was intended to guide the future of the CC Programme in Namibia. Findings will, amongst other applications, also inform the roles of the newly transitioned Health Assistants. Findings will further be used to inform decisions around quality HIV care and treatment services. In particular, the outcomes of the evaluation will inform decisions about the role of Health Assistants/CCs to implement Option B+<sup>5</sup>, Treatment as Prevention (TaSP)<sup>6</sup>, and scale-up of the national male circumcision programme.

<sup>4</sup> Ministry of Health and Social Services, Directorate of Special Programmes, 2011

<sup>5</sup> Initiation of life-long triple ARV treatment for all pregnant and lactating women irrespective of their CD4 count or clinical staging, and that newborn children be given nevirapine from birth to six weeks of age.

<sup>6</sup> HIV treatment (ARV) for prevention purposes to reduce the risk of HIV transmission.

## 1.4 DESIGN/LOCATIONS

The process evaluation took place across nine of the 14 regions of Namibia. The following regions and health facilities were included in this evaluation:

**TABLE 2: EVALUATION SITES**

ZONE	REGION	HOSPITAL	HEALTH CENTRE	CLINIC
1.	Erongo		Kuisebmond HC	1. Henties Bay Clinic 2. Tamariskia Clinic 3. Karibib Clinic <sup>7</sup> 4. Costal Health Clinic
	Otjozondjupa	Grootfontein Hospital		1. Nau Aib Clinic (Okahandja) 2. Okakarara Clinic 3. Orwetoveni Clinic 4. Otavi Clinic
2.	Khomas	Katutura Hospital		1. Groot Aub Clinic <sup>8</sup> 2. Donkerhoek Clinic 3. Wanaheda Clinic
	!Karas		Bethanie HC	1. Aussenkehr Clinic 2. Noordoewer Clinic <sup>9</sup> 3. Daan Viljoen Clinic 4. Lüderitz Clinic
3.	Kavango East and West		Sambyu HC	1. Mayara Clinic 2. Nankudu Clinic 3. Kayengona Clinic 4. Nkarapamwe Clinic
	Zambezi	Katima Mulilo Hospital		1. Ngoma Clinic 2. Ngwezi Clinic 3. Mavuluma Clinic 4. Sesheke Clinic
4.	Kunene	Outjo Hospital		1. Khorixas Clinic 2. Okangwati Clinic <sup>10</sup> 3. Opuwo Clinic 4. Kamanjab Clinic <sup>11</sup>
	Ohangwena		Odibo HC	1. Eenhana Clinic 2. Ongha Clinic 3. Ekoka Clinic

<sup>7</sup> Identified as Sam Nujoma Health Centre.

<sup>8</sup> Groot Aub Clinic replaced Robert Mugabe Clinic in the Khomas region. During data collection no CCs were stationed at the Robert Mugabe Clinic.

<sup>9</sup> Identified as Noordoewer Health Centre.

<sup>10</sup> Identified as Okangwati Health Centre.

<sup>11</sup> Identified as Kamanjab Health Centre.

## 1.5 GOALS AND OBJECTIVES OF THE EVALUATION

### 1.5.1 EVALUATION GOAL

The goal of this process evaluation was to evaluate the CC Programme, which had been in operation in Namibia since 2004, including its role in the implementation of PITC. The evaluation will document lessons learned from the deployment and training of CCs and will inform discussions about the future programme.

### 1.5.2 EVALUATION OBJECTIVES

The objectives of the evaluation were to:

- Describe the human resource profiles of the CCs employed at the time of data collection including: demographic profiles; length, types, and quality of training; length of service; daily work assignments; work satisfaction; retention issues; professional growth; and availability of technical supervision and psycho-social support systems.
- Describe how CCs affected the workload of health care providers between 2007 and 2013 in the uptake of HCT, PMTCT, TB, and ART services.
- Describe the role of CCs in the implementation of PITC in Namibia, including how PITC is defined as well as where and how PITC was being implemented in facilities where CCs were based.
- Assess the quality of HCT services provided by CCs.
- Assess the level of client satisfaction with services provided by CCs.

## 1.6 EVALUATION QUESTIONS

The following evaluation questions were outlined in the final evaluation protocol.

**TABLE 3: EVALUATION QUESTIONS**

<b>CC PROFILES</b>
What is the demographic profile of the currently employed cadre of CCs?
Are CCs utilized by health facilities to carry out tasks that are outside of their official job description?
How many and what types of trainings are offered to CCs?
<b>ROLE OF CCs IN HCT UPTAKE AND IMPLEMENTATION OF PITC</b>
What health facility activities rely on the services provided by CCs and what role should CCs play in health facilities and in the health care system in the future?
How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
What are the current barriers to proper implementation and documentation of PITC?
<b>QUALITY OF SERVICES PROVIDED BY CCs</b>
Are CCs able to deliver high quality HCT services?
Are clients generally satisfied with HCT services?

## **2 METHODS AND PROCEDURES**

### **2.1 STUDY POPULATION**

This evaluation targeted various aspects of the CC Programme implementation. The information gathered is considered to be nationally representative. There were four study populations:

- **CCs**
  - CCs were studied in areas including their skills, knowledge, work environment, supervision, and training. All CCs employed at the time of data collection were targeted for the evaluation. Quantitative, self-administered questionnaires were used to collect data from this population.
- **Clients/patients accessing HCT services**
  - Those who had received counselling and testing services from CCs were interviewed to gather information on the level of satisfaction with the CC HCT services and issues surrounding PITC. Quantitative, face-to-face, exit interviews were used to collect data from this population.
- **Key informants**
  - The Regional Management Team (RMT) and Health Facility supervisors of CCs participated in qualitative in-depth interviews (IDIs) to complement the above documentation as well as advise on the future role of CCs in HIV/AIDS programmes in Namibia.
- **Other health care workers**
  - HCT supervisors, facility managers, and other health workers with a role in HCT were invited to participate in qualitative focus group discussions (FGDs).

### **2.2 DESIGN**

The evaluation comprised of various components. These were:

- A Human Resources Document Review;
- A Document Review of the NIP Quality Assurance Reports for HIV Counselling and Testing;
- An HCT Register Review at each of the evaluation sites;
- Self-administered Questionnaires among CCs;
- Client Exit Interviews among clients who had received HCT services offered by CCs;
- Key Informant Interviews (KIIs) with the RMTs of the nine regions included for the evaluation;
- FGDs with health care staff at facilities in the nine regions included for the evaluation.

The Human Resources Document Review and NIP Quality Assurance Reports for HIV Counselling and Testing were carried out at national level only. The HCT Register Reviews and Client Exit Interviews were undertaken at the identified evaluation sites. Both the KIIs and FGDs were undertaken at regional level and included all regions that were identified for the evaluation. All CCs that made themselves available were included in the evaluation. These included CCs from all regions in Namibia and not only the regions identified for the evaluation.



Prior to the start of data collection, MOHSS, CDC, and Survey Warehouse conducted sensitization meetings with the RMTs of the regions selected for the evaluation. In these meetings, Information Packs were presented to the RMTs and the RMTs were taken through a presentation highlighting the study, its components, and the roles and responsibilities of the individual stakeholders. The following RMT teams were visited:

- Khomas RMT (8 September 2014)
- Otjozondjupa RMT (9 September 2014)
- Erongo RMT (11 September 2014)
- Zambezi RMT (7 October 2014)
- Kunene RMT (7 October 2014)
- !Karas RMT (9 October 2014)

### **2.3 EVALUATION TOOLS**

The evaluation protocol contained standard evaluation tools. Survey Warehouse modified these in consultation with MOHSS and CDC in two evaluation tools workshops. All instruments were prepared in English. Client Exit Interview questionnaires were translated into Afrikaans, Oshikwanyama, Otjiherero, Rukwangali, and Silozi. The English evaluation tools can be found in Annexures 2 to 8 of this report.

All participants signed consent forms to indicate their willingness to participate in the evaluation voluntarily. The consent forms for all components of the study were in English. Client Exit Interview consent forms were translated into Afrikaans, Oshikwanyama, Otjiherero, Rukwangali and Silozi. It explained the objective of the evaluation and the voluntary nature of participation. The English consent forms can be found in Annexures 9 to 12 of this report.

### **2.4 TRAINING AND PILOTING**

A training workshop was conducted from 24 to 26 September 2014 with the data collection staff. The training workshop was led by the Survey Warehouse Project Manager, Data Manager, and Field Manager in collaboration with representatives from MOHSS and CDC.

Topics and activities covered in training were:

- Background and introduction to the evaluation
- Overview of the evaluation methods
- Research ethics and informed consent
- Overview of the evaluation design and sampling procedures
- Overview of fieldwork supervision and management
- Familiarisation with the evaluation instruments
- In-house practice with the evaluation instruments
- In-field practice
- Debriefing session

Additional training with supervisors covered the following topics:

- Introduction of the team and the evaluation to RMTs and the Facility-in-Charge at the sites
- Sampling responsibilities of the Field Supervisors
- Data collection responsibilities of the Field Supervisors
- Data control mechanisms: data quality monitoring and daily debriefing
- Compilation of technical notes
- Safekeeping of evaluation materials

Piloting activities were undertaken from 29 September to 3 October 2014. The HCT Register Review pilot was undertaken at Windhoek Central Hospital, Katutura Health Centre, and Otjomuise Clinic. Pilot Client Exit Interviews were conducted at the same sites. Both the KII and FGD were piloted in the Khomas Region. Pilot activities yielded very few recommendations for changes to the evaluation methods and instruments. A detailed feedback session was held with MOHSS and CDC, in which a few changes were developed. The Report on Pilot Testing is attached in Annexure 13.

The HR and NIP Records review instruments were tested and amended as data was collected in February and March 2015.

## **2.5 DATA COLLECTION**

### **2.5.1 AN OVERVIEW**

Data collection teams deployed to the field on 26 October 2014. By Saturday, 15 November 2014, all four teams were called back to Windhoek. By this date, three weeks of data collection was completed successfully. During the second week of data collection, Survey Warehouse learned that the week of 17 to 21 November would be Maternal and Child Health Week and was informed that many of the sites would not operate as they would normally, and that many of the staff would need to participate in activities surrounding the health week. Survey Warehouse consulted with the project team at MOHSS and CDC, and a joint decision was made to halt data collection for the week of 17 to 21 November 2014.

Teams re-deployed on Sunday, 23 November 2014. Three teams travelled back to Windhoek on 13 December 2014 and the fourth team returned on 16 December 2014. At the end of data collection in 2014, a couple of evaluation activities remained. These were:

- Client Exit Interviews at the Okangwati Health Centre in the Kunene Region.
  - The CC was not present at the time the team was scheduled to collect data in December 2014. MOHSS, CDC, and Survey Warehouse concluded that data collection would be rescheduled. This activity was concluded in early 2015.
- FGD with Facility Staff in the Kunene Region.
  - Challenges arose with regards to the transport of staff to the FGD venue, a responsibility of MOHSS. This activity was concluded in early 2015.

- FGD with Facility Staff in the Ohangwena Region.
  - The majority of the staff that was invited to attend the FGD could not commit themselves to any possible date in December 2014. This activity was concluded in early 2015.
- The CC Session in the Ohangwena region was very poorly attended in December 2014 and it was decided to do a supplementary session. This supplementary session was conducted in early 2015.

### **2.5.2 HUMAN RESOURCES RECORDS REVIEW**

Survey Warehouse requested Human Resources records from MOHSS. MOHSS provided Survey Warehouse with Payroll data. Initial data made available proved to have significant gaps. Efforts to supplement the data at a later stage were made in consultation with MOHSS. Data abstraction was carried out by the Survey Warehouse Field Manager.

### **2.5.3 NIP QUALITY ASSURANCE REPORTS DOCUMENT REVIEW**

Survey Warehouse requested HCT Quality Assurance data for the years 2007 to 2013. Data for 2010 to 2013 was abstracted from hard copy Quarterly Reports stored at the NIP offices in Windhoek. Reports and records for 2007 to 2009 were retrieved from the archives and data was abstracted from hard copy records. Where quarterly reports were not available, monthly reports were aggregated to establish the quarterly figures for each of the years of interest.

Records only indicated the name of the person who conducted the test and name of facility at which the test was conducted. As a result, one of the challenges was to identify the percentage of tests conducted by CCs. Reporting on this component of the data can therefore not be done.

Data abstraction was carried out by the Survey Warehouse Field Manager, assisted by one of the field team members on the project.

### **2.5.4 HCT REGISTER REVIEWS**

Field Supervisors completed one review per site, for all sites included in the evaluation. A total of 38 sites were included for the evaluation.

At each facility selected for participation in the evaluation, Survey Warehouse extracted data from the following sources:

- HCT Registers,
- ANC/PMTCT Registers, and
- TB registers.

Data was extracted for the years 2007 to 2013. Survey Warehouse requested that facilities prepare all registers in advance for the years in question. The specific months that were examined were February, May, August, and November for each year. The Supervisor also needed to access current registers at the HCT, ANC/PMTCT, and TB Service Points. Upon arrival at each facility, the Survey Warehouse Supervisor reported to the Facility-in-Charge to announce their arrival and enquired about additional ways in which he could assist the facility team to prepare the data sources for the data abstraction exercise. There was a short section of the questionnaire that had to be answered by the Facility-in-Charge. These questions related mostly to the staff that is employed at the facility. At some bigger facilities, the Supervisor had to speak to the in-charge at the ANC and TB Service Points as well.

During the course of data collection, Survey Warehouse informed MOHSS and CDC of some missing health facility records at specific facilities. MOHSS investigated the matter and attempted to locate the missing records. Unfortunately these missing records could not be retrieved.

### 2.5.5 SELF-ADMINISTERED QUESTIONNAIRE AMONG CCs

The initial evaluation protocol assumed that there were 580 CCs in the country. At data collection, the RMTs of the respective regions reported a total of 558 CCs. A total of 491 CCs completed the self-administered questionnaires.

Survey Warehouse shared route plans with the RMTs; and in consultation with the RMTs, self-administered questionnaire sessions were scheduled with CCs at district level. RMTs supplied Survey Warehouse with lists of CCs in their regions. CCs from across the country were invited by their respective RMTs to sessions at district level where they were guided through the self-administered questionnaire.

All CCs that attended the sessions were reimbursed for their transport costs to and from the venue. Survey Warehouse provided copies of the self-administered questionnaires and stationery. A Survey Warehouse supervisor, who was assisted by Survey Warehouse data collectors, led the sessions. These data collectors were available during the session to assist CCs with the administration of the questionnaire, if required. Informed consent was administered prior to the start of the questionnaire administration. At the end of each session, the supervisor who led the session asked CCs to check their completed questionnaire before they placed it in an envelope and sealed it. Team members collected all the sealed envelopes and a tea break was announced. Light refreshments were served before the group sessions were closed.

The table hereafter shows how many CCs attended each of the self-administered questionnaire sessions, and the respective response rates for each region. The table shows, for each region, how many CCs were identified and invited by the RMT to attend the session as well as how many attended the session held for that region.

**TABLE 4: CC SELF-ADMINISTERED QUESTIONNAIRE SAMPLE REALIZATION BY REGION**

REGION	TOTAL CCs PER REGION	TOTAL CCs SURVEYED	RESPONSE RATE
Erongo	46	40	87%
Kunene	35	32	94%
Omusati	64	63	95%
Oshana	64	45	73%
Khomas	39	27	69%
!Karas	31	27	87%
Hardap	24	20	79%
Omaheke	27	27	96%
Kavango	53	51	91%
Zambezi	52	48	96%
Otjozondjupa	31	28	94%
Ohangwena	51	49	96%
Oshikoto	41	34	85%
<b>TOTAL</b>	<b>558</b>	<b>491</b>	<b>88%</b>

## 2.5.6 CLIENT EXIT INTERVIEWS

The protocol set out a sample size of 792 for the client exit interviews. This sample was obtained using the following formula:

$$N = Z^2 [(P) (1-P)]/E^2$$
$$N = 1.96^2 [(0.7) (1-0.7)]/4\%^2$$
$$N = 720$$

(Where N = estimated sample size; Z = standard normal distribution of response reflecting confidence level; P = Percentage estimate of HCT clients who are tested by CCs; E = level of sampling error).

In addition, the following assumptions were made:

- About 20,000 HCT clients will be served during one month of data collection;
- 70% of these clients are expected to indicate satisfaction; with 4% sampling error; 80% study power; 95% confidence limit and 10% non-response.
- With 10% assumed for non-response rate among the 720 clients, the final sample size for client exit interview is 792.

The 792 clients were to be sampled from the nine selected regions and, within these regions, from sites that were selected for the evaluation. Furthermore, 118<sup>12</sup> clients were to be sampled from four district hospitals (DHs) (approximately 30 per DH); 594<sup>13</sup> from 30 clinics, (approximately 20 clients per clinic) and 80<sup>14</sup> clients from the four health centres (HCs) (approximately 20 clients per HC). At the time of the evaluation and during the health facility records reviews, health care staff indicated that the status of four of the 30 clinics had changed to health centres. These were Dr Sam Nujoma HC (Karibib Clinic); Noordoewer HC; Okangwati HC; and Kamanjab HC. The final sample was, therefore, distributed among four DHs, 26 clinics, and eight HCs. This redistribution of type of facility also influenced the number of interviews conducted at each site.

Upon arrival at each of the facilities, the supervisor asked to speak to the Facility-in-Charge to make the necessary arrangements for this component of the evaluation. Survey Warehouse had to interview 20 to 30 patients who (a) had received HCT services from a CC on the day the interview was conducted, and (b) who were 18 years or older on the day, at each of the facilities. When patients exited the office or room of the CC after receiving HCT services, they were approached by a Survey Warehouse data collector and they were screened for eligibility to participate in the exit interview. If they were eligible (that is, if they just received HCT services from a CC and if they were 18 years or older), they were asked whether they would like to participate in the evaluation. If they agreed, they were asked to accompany the data collector to a private space where they administered informed consent and conducted the interview. Clients were selected sequentially until the required number of interviews for that facility was reached. Survey Warehouse sampled for each facility: 20 clients per clinic, 20 clients per HC, and 30 clients per DH. After many attempts to fill the sample of 20 at the Dr Sam Nujoma HC, it was decided that patient flow did not allow for the full sample realization<sup>15</sup>. The remainder of the sample (nine interviews) was filled at Tamariskia Clinic, with a total of 29 interviews. The table hereafter shows the final sample realization for this component of the evaluation, by region.

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<sup>12</sup> 120 clients were interviewed at DHs.

<sup>13</sup> 529 clients were interviewed at clinics.

<sup>14</sup> 151 clients were interviewed at HCs.

<sup>15</sup> Only 11 interviews were conducted at Dr Sam Nujoma HC.

**TABLE 5: CLIENT EXIT INTERVIEW SAMPLE REALISATION BY REGION**

REGION	FREQUENCY	PERCENT
Zambezi	110	13.8
Erongo	100	12.5
!Karas	100	12.5
Kavango West	20	2.5
Kavango East	80	10.0
Khomas	90	11.3
Kunene	110	13.8
Ohangwena	80	10.0
Otjozondjupa	110	13.8
<b>TOTAL</b>	<b>800</b>	<b>100.0</b>

### 2.5.7 RMT KIIs

Approximately three senior technical managers from each of the eight RMTs (for example, the PHC supervisor, senior health programme administrator, chief health programme administrator) were selected through purposive sampling. MOHSS requested RMTs to identify three members to attend the KII session in each of the nine<sup>16</sup> regions. Sessions were scheduled in consultation with the RMTs and were led by a trained Survey Warehouse facilitator, assisted by a note-taker, using a semi-structured interview guide. The sessions were audio-recorded and informed consent was administered with each of the attendees prior to the start of the session. The sessions lasted for about 1-½ hours. The final attendance realized was as follows:

**TABLE 6: RMT KII ATTENDANTS BY REGION**

REGION	NUMBER OF RMT MEMBERS
Erongo	2
Kunene	3
Khomas	2
!Karas	3
Kavango	4
Zambezi	3
Otjozondjupa	2
Ohangwena	2
<b>TOTAL</b>	<b>21</b>

### 2.5.8 FGDs WITH HEALTH CARE STAFF

Health facility staff FGDs were held with facility managers and health workers who were responsible for supervising or providing technical support to CCs. There was one FGD per selected region, totalling eight FGDs each with eight to ten participants per FGD. Sessions were booked in consultation with the RMTs, who also arranged for transport of the health facility staff to the venues arranged by them. FGD participants were identified and invited to attend by the RMT of each region, and were employed in facilities in the region itself. It was, therefore, not only limited to facilities included in the evaluation. Sessions were audio-recorded and informed consent was administered with each of the attendees prior to the start of the session. Light refreshments were served during the course of the discussions, and the sessions lasted for about 1-½ hours. The sample realisation per region is shown in the table hereafter.

<sup>16</sup> For the purposes of the RMT KIIs and FGDs, Kavango East and West were grouped together for sampling purposes.

**TABLE 7: FGD ATTENDANTS BY REGION**

<b>REGION</b>	<b>NUMBER OF RMT MEMBERS</b>
Erongo	7
Kunene	4
Khomas	9
!Karas	6
Kavango	11
Zambezi	10
Otjozondjupa	7
Ohangwena	9
<b>TOTAL</b>	<b>63</b>

## **2.6 DATA PROCESSING**

Data processing staff was trained on the evaluation instruments at the Survey Warehouse offices prior to the start of data processing. The training was lead by the Project and Data Managers.

Quantitative data was checked, categorised, coded, and captured in SPSS<sup>17</sup>. The Field and Data Managers supervised this process. The Data Manager cleaned the data. Data was analysed in SPSS as well.

Qualitative data was transcribed using Microsoft Word and coded for themes relevant to the evaluation questions.

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<sup>17</sup> Statistical Package for Social Sciences.

### 3 EVALUATION FINDINGS

#### 3.1 HUMAN RESOURCES RECORDS REVIEW

##### 3.1.1 FINDINGS

Human Resource data was abstracted from Payroll data files as provided by MOHSS, Directorate of Special Programmes in early March 2015. Upon examination of the initial data abstracted, Survey Warehouse in consultation with MOHSS and CDC realised that the data did not correspond with the number of CCs that were reported by the respective RMTs at the start of the evaluation.

A subsequent request to MOHSS for revised HR data yielded the following for the total numbers for CCs and facilities, from 2012 to 2015. At the time, data by gender, age profile, and length of service was not available. It is important to note that the data below does not capture any CCs that were transitioned from the Namibia Red Cross Society to the CDC payroll. Also note the significant drop in number of CCs between 2014 and 2015, attributable to the transitioning process of CCs to Health Assistants.

**TABLE 8: CCS BY YEAR AND FACILITY AT MARCH 2015**

YEAR	NUMBER OF CCs	NUMBER OF FACILITIES
2012	578	178
2013	572	326
2014	540	308
2015	170	131

A request for data pertaining to the demographic profile of CCs as at 31 October 2014, the month prior to the start of the transitioning process of CCs yielded the data presented in the table below.

**TABLE 9: DEMOGRAPHIC PROFILE OF CCs AT 31 OCTOBER 2014**

DEMOGRAPHIC INDICATOR			
		n	%
Total CCs at March 2015		550	
Gender	Male	165	30
	Female	385	70
Age	Youngest	23	
	Oldest	60	
	Less than 20 years old	0	0
	21 to 25 years old	12	2
	26 to 30 years old	53	10
	31 to 35 years old	148	27
	36 to 40 years old	189	34
	41 to 45 years old	108	20
Length of service	46 and older	40	7
	Less than one year	0	0
	Up to one year	10	2
	Up to two years	5	1
	Up to three years	55	10
	Up to four years	112	20
	Up to five years	136	25
Six years and longer	232	42	



### **3.1.2 OBJECTIVES AND EVALUATION QUESTIONS ADDRESSED AND KEY FINDINGS OF THE CHAPTER**

This part of the evaluation specifically addressed the demographic profile of the CCs employed at the time of data collection. At first, HR data retrieved appeared to be incomplete and inaccurate. Pre-transition data appears accurate and corresponds well with the data obtained through the self-administered questionnaires that were completed by the CCs themselves.

The majority of CCs were females, with only 30% male CCs. Only 12% of CCs were younger than 31, and 7% were older than 45. Only 13% of CCs worked less than three years as CCs at the time just before the transitioning process of CCs.

### 3.2 NIP QUALITY ASSURANCE REPORTS DOCUMENT REVIEW

All HIV RT sites must be certified by the NIP, who is mandated by the MOHSS to ensure that Quality Assurance (QA) standards are maintained and staff meet the competencies required. All sites must enrol with the NIP QA programme to be included in the regular QA assessments. In order for a site to open, health workers need to be trained in HIV RT to be able to supervise the testing site organisation and activities, since testing is mainly performed by CCs. It is the responsibility of the testing site supervisors to ensure that HIV RT test staff strictly adhere to and follow all relevant protocols and standard operation procedures (SOPs)<sup>18</sup>.

Data was abstracted from the HCT QA Reports 2007 to 2013. NIP stipulates two main groups of quality assurance. These are:

- The internal quality control (IQC)
  - Known positive and negative specimens
- The external quality control (EQA)
  - Re-testing of ten first samples of a new tester or new site
  - Re-testing of 5% of client samples
  - Proficiency panel testing (PT)
- Site assessments.

This component of the evaluation specifically addressed EQA.

(a) Re-testing of ten first samples of a new tester or new site:

The first ten samples tested by a new tester and new sites are re-tested by NIP. A venous blood draw must be sent from each client to NIP for testing. Results are crosschecked to ensure accurate testing. A 100% concordance is expected. This procedure forms part of the certification of CCs.

Prior to the review of the *National Guidelines for HIV Counselling and Testing in Namibia* (2011), CCs were required to have their first 50 samples re-tested by NIP. The revision to the guidelines prompted the revision of the programme activities including the change from 50 to ten samples for the RT training certification process. The data at the time showed less than one percent error rates. Additionally, many could not complete 50 samples in a timely fashion. The change accommodated a faster turnaround on the first samples required for RT certification.

Only after this is done, is a tester is certified and is allowed to issue test results to clients. If a tester does not achieve 100% concordance, the error or problem should be investigated to determine the cause thereof. This is conducted by the site supervisor. Action should be taken to address the cause of the problem or error.

The following table shows the number of first 50 or first 10 samples submitted for EQA review during each of the specified periods as well as the number of tests found to be discordant. The change from 50 samples to ten would have occurred around 2011. Table 10 shows a 100% concordance for 2011 for all samples that were re-tested by NIP. Other years show very high concordance – less than 1% discordance.

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<sup>18</sup> Ministry of Health and Social Services, Directorate of Special Programmes, 2012

**TABLE 10: QUALITY ASSURANCE/QUALITY CONTROL: FIRST 50 OR FIRST 10 SAMPLES**

	2007	2008	2009	2010	2011	2012	2013
Number of first 50/10 samples (total) submitted for QA/QC review	18693	15931	13722	13833	1245	3081	3606
Number of first 50/10 samples reported as discordant	37	18	11	12	0	3	8
Percentage of first 50/10 samples reported as discordant	0.20%	0.11%	0.08%	0.09%	0.00%	0.10%	0.22%

(b) Re-testing of 5% of client samples:

NIP also re-tests 5% of all client samples. A correlation of 95% is expected for a site to continue testing. CCs are required to submit a venous blood sample to NIP for every 20<sup>th</sup> client that they test. These samples are then re-tested by NIP. NIP sends a report to CCs indicating whether the CCs' tests are (a) under 80% concordant; (b) between 80% and 100% concordant, and (c) 100% concordant. If concordance is found to be fewer than 95%, the site supervisor should investigate to determine the cause or error. Action should be taken to address the cause of the problem or error.

The table below shows the number of 1 in 20 samples<sup>19</sup> submitted for EQA review during each of the specified periods and the number of these tests found to be discordant. Again, all years show less than 1% discordance of re-tests. It should however be noted that not all sites comply with the submission requirements and that oftentimes, quarterly reports by NIP indicate low submission rates. Challenges with the transport of samples also result in haemolysed samples that are not viable for re-testing.

**TABLE 11: QUALITY ASSURANCE/QUALITY CONTROL: 1 IN 20 SAMPLES**

	2007	2008	2009	2010	2011	2012	2013
Number of 1 in 20 samples (total) submitted for QA/QC review	6091	5852	5365	6046	5330	9397	11957
Number of 1 in 20 samples reported as discordant <sup>20</sup>	14	13	14	09	05	14	36
Percentage of 1 in 20 samples reported as discordant	0.23%	0.22%	0.26%	0.15%	0.09%	0.15%	0.30%

c) Proficiency panel testing (PT):

NIP also sends a panel of blind samples to rapid testing sites for testing. After testing is done by CCs, results are returned to NIP and checked against the known results. Results of this component of EQA specifically provide information on the general testing process and management of the testing environment. A 90% conformance of proficiency panels is expected.

The following table shows the number of proficiency panel tests submitted for EQA review during each of the specified periods, and how many of these tests were found discordant. Across all years, concordance is shown as above 95%.

**TABLE 12: QUALITY ASSURANCE/QUALITY CONTROL: PROFICIENCY PANEL TESTS**

	2007	2008	2009	2010	2011	2012	2013
Number of proficiency panel tests (total) submitted for QA/QC review	897	1495	1374	2340	2751	3024	2547
Number of proficiency panel tests reported as discordant	17	62	10	53	61	17	53
Percentage of proficiency panel tests reported as discordant	1.90%	4.15%	0.73%	2.26%	2.22%	0.56%	2.08%

Unfortunately the data sources for the above components of EQA do not indicate whether the tester is a CC or another health care worker. It is therefore not possible to report on the number of tests carried out by CCs specifically.

<sup>19</sup> At first only 1 in 10 samples were submitted. In the last quarter of 2008, these were increased to 1 in 20 samples.

<sup>20</sup> NIP records show whether or not the NIP test and the test conducted by the health care provider have the same result and report it as concordant or discordant.

### **3.2.2 OBJECTIVES AND EVALUATION QUESTIONS ADDRESSED AND KEY FINDINGS OF THE CHAPTER**

The objective addressed through this component of the survey was to assess the quality of HCT services provided by CCs. The specific evaluation question that was answered is whether CCs are able to deliver high quality HCT services.

From the EQA reviews presented in this chapter, it is clear that the quality and accuracy of HIV testing in Namibia is high. The one shortfall, however, is that these figures represent testing done by health care staff as well as CCs at facilities, and the data extraction did not allow for the presentation of these statistics for CCs only.

### **3.3 HCT REGISTER REVIEWS**

#### **3.3.1 FINDINGS**

This chapter will highlight findings from the HCT Register Reviews conducted at the 38 sites included in the evaluation.

The MOHSS, Directorate of Special Programmes provided the following testing data for total number of patients tested nationally since 2010:

- 2010: 57,749 (June to December 2010)
- 2011: 202,886
- 2012: 221,068
- 2013: 243,961
- 2014: 317,862

It should however be noted that this includes all HCT testing from all testing facilities, and not only those of the MOHSS.

Data was mainly abstracted from the HCT Register. Table 13 shows four-month totals that were calculated as follows. For each year, the four selected months' (February, May, August, and November) testing figures were totalled – for number of tests conducted as well as number of tests conducted by a CC. If any one or more of the months were not reported, incomplete (IC) is reported. When data for an entire year is missing, no data (ND) is reported. Table 14 shows the portion of clients tested by CCs for all sites with complete data.

HCT data clearly shows the impact of CCs on the specific service, where almost 100% of testing for HCT is done by CCs.

**TABLE 13: HCT REGISTER DATA ABSTRACTION**

Facility	2007		2008		2009		2010		2011		2012		2013	
	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC
Dr Sam Nujoma HC	159	159	125	125	172	172	190	189	290	290	320	320	311	308
Okangwati HC	137	137	155	155	110	110	100	100	127	127	94	94	131	131
Bethanie HC	89	89	72	72	116	116	115	115	80	80	95	95	123	123
Aussenkehr C	ND <sup>21</sup>	ND	ND	ND	ND	ND	IC <sup>22</sup>	IC	234	234	251	251	285	285
Katutura H	835	835	150	150	1011	1011	615	615	930	930	959	959	991	991
Noordoewer HC	116	116	180	180	260	260	233	233	162	162	245	245	189	189
Donkerhoek C <sup>23</sup>	85	0	69	0	65	0	72	0	74	0	334	334	535	535
Wanaheda C <sup>24</sup>	40	9	168	168	143	143	272	272	435	435	564	564	1046	1046
Groot Aub C <sup>25</sup>	33	0	46	0	66	0	73	0	81	81	74	74	59	59
Daan Viljoen C	147	147	162	162	225	225	IC	IC	404	404	IC	IC	425	425
Tamariskia C	ND	ND	ND	ND	ND	ND	IC	IC	1264	1264	1368	1366	1040	1040
Lüderitz C	479	479	1571	1571	2085	2085	1737	1737	1157	1357	1098	1098	1068	1068
Nkarapamwe C	ND	ND	ND	ND	ND	ND	IC	IC	IC	IC	875	875	IC	IC
Nankudu C	ND	ND	ND	ND	ND	ND	ND	ND	IC	IC	760	760	IC	IC
Kayengona C	ND	ND	ND	ND	ND	ND	IC	IC	203	203	197	197	234	234
Sambyu HC	112	112	295	295	300	300	412	412	306	306	373	373	309	309
Ngweze C	ND	ND	121	121	IC	IC	449	449	524	524	493	493	469	469
Ngoma C	31	31	106	106	IC	IC	138	138	183	183	159	159	191	191
Mavuluma C	93	93	65	65	62	62	380	380	430	430	406	406	442	442
Sesheke C	ND	ND	IC	IC	IC	IC	193	193	182	182	214	214	238	238
Kuisebmond HC	ND	ND	ND	ND	IC	IC	299	299	1093	1093	1133	1133	744	744
Katima Mulilo H	489	489	682	682	490	490	551	551	638	638	540	540	454	454
Mayara C	ND	ND	ND	ND	ND	ND	IC	IC	51	51	54	54	147	147
Grootfontein H	ND	ND	ND	ND	ND	ND	314	314	684	684	473	473	610	588
Nau Aib C	733	733	709	709	434	434	609	609	508	508	577	577	663	663
Okakarara C	479	479	655	655	668	668	506	506	573	573	513	507	674	674
Eenhana C	1176	1176	856	856	876	876	869	869	1125	1125	738	738	689	689
Odibo C	484	484	481	481	467	467	496	496	739	739	565	565	706	706
Ongha C	406	406	546	546	283	283	550	550	781	781	733	733	772	764
Otavi C	209	209	298	298	263	263	299	299	329	329	379	379	303	303
Coastal C	385	385	IC	IC	360	360	903	903	1241	1241	IC	IC	IC	IC
Orwetoveni C	ND	ND	ND	ND	ND	ND	IC	IC	646	635	625	625	724	724
Ekoka C	ND	ND	18	18	61	61	146	146	199	199	183	183	173	173
Henties Bay C	102	102	537	537	204	204	220	220	248	248	243	243	228	228
Khorixas C	208	208	476	476	452	452	343	343	308	308	178	178	197	197
Outjo H	298	298	239	239	110	110	725	725	984	984	1092	1092	1009	1009
Kamanjab HC	60	60	IC	IC	121	121	IC	IC	333	333	320	320	275	275
Opuwo C	304	304	321	321	225	225	254	254	622	622	690	690	767	767

<sup>21</sup> No Data (no records found for the specific year)

<sup>22</sup> Incomplete (one or more of the data points not available – one or more of the required months' data not recorded)

<sup>23</sup> From 2007 to 2011, Nurses conducted HIV testing using ELISA.

<sup>24</sup> CCs were only introduced later in 2007, and before their introduction, nurses conducted the testing.

<sup>25</sup> CCs were only responsible for HIV testing from 2011.

**TABLE 14: HCT REGISTER DATA ABSTRACTION – PROPORTION TESTED BY CCs FOR SITES WITH COMPLETE DATA**

	2007		2008		2009		2010		2011		2012		2013	
	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC	HCT	Tested by CC
<b>TOTAL</b>	7066	6917	8696	8581	8862	8731	9621	9475	10927	10853	10810	10804	11666	11655
<b>% TESTED BY CCs</b>	98%		99%		99%		98%		99%		100%		100%	

### **3.3.2 OBJECTIVES AND EVALUATION QUESTIONS ADDRESSED AND KEY FINDINGS OF THE CHAPTER**

The objective of this evaluation component was to describe how CCs have affected the workload of health care providers between 2007 and 2013 in the uptake of HCT.

The data shows that CCs are just about solely responsible for the HCT services provided at facilities.



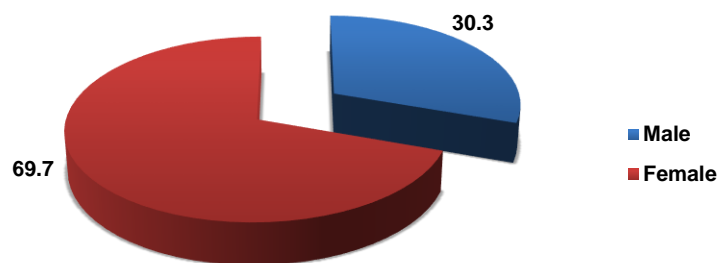
### 3.4 SELF-ADMINISTERED QUESTIONNAIRE AMONG CCs

#### 3.4.1 FINDINGS

Of the reported 558 CCs, as indicated by the RMTs of the eight evaluation regions, 491 CCs attended the self-administered questionnaire sessions. See Table 4 for a detailed breakdown of the sample realisation. All variables were analysed by biographic variables. These analyses however did not produce any meaningful differences across strata.

Chart 1 hereafter shows the gender distribution of the sample. It is heavily favoured towards women, with nearly 70% of respondents being female.

**CHART 1: GENDER**



The age profile of CCs ranged from 23 to 59. The majority of CCs reported being between 31 and 40 years old. Chart 2 below shows the age distribution of CCs.

**CHART 2: AGE**

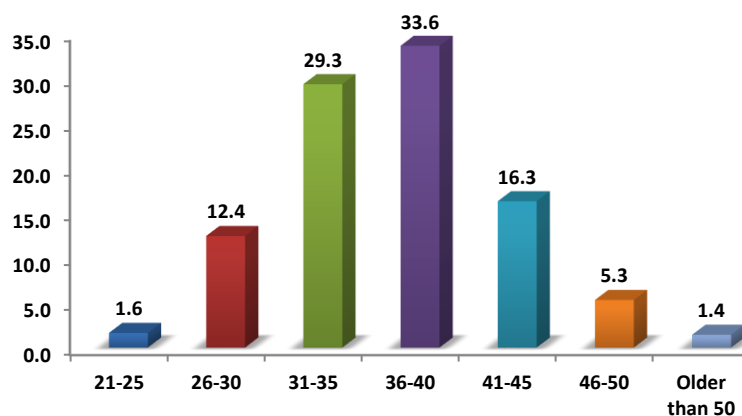
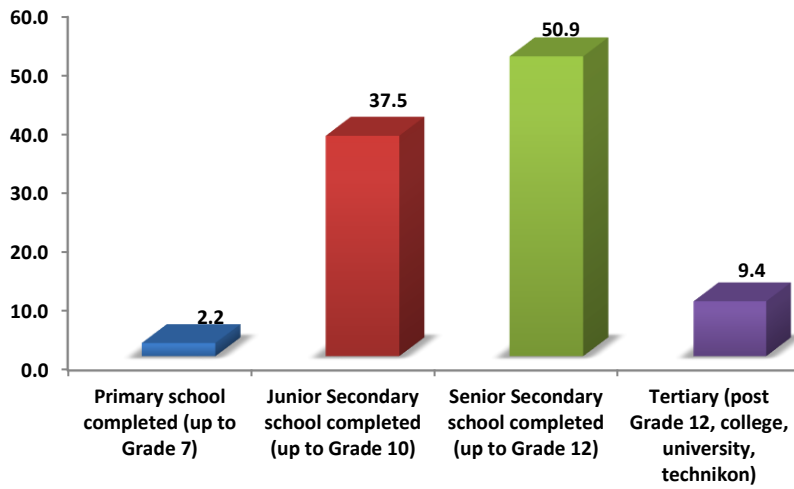


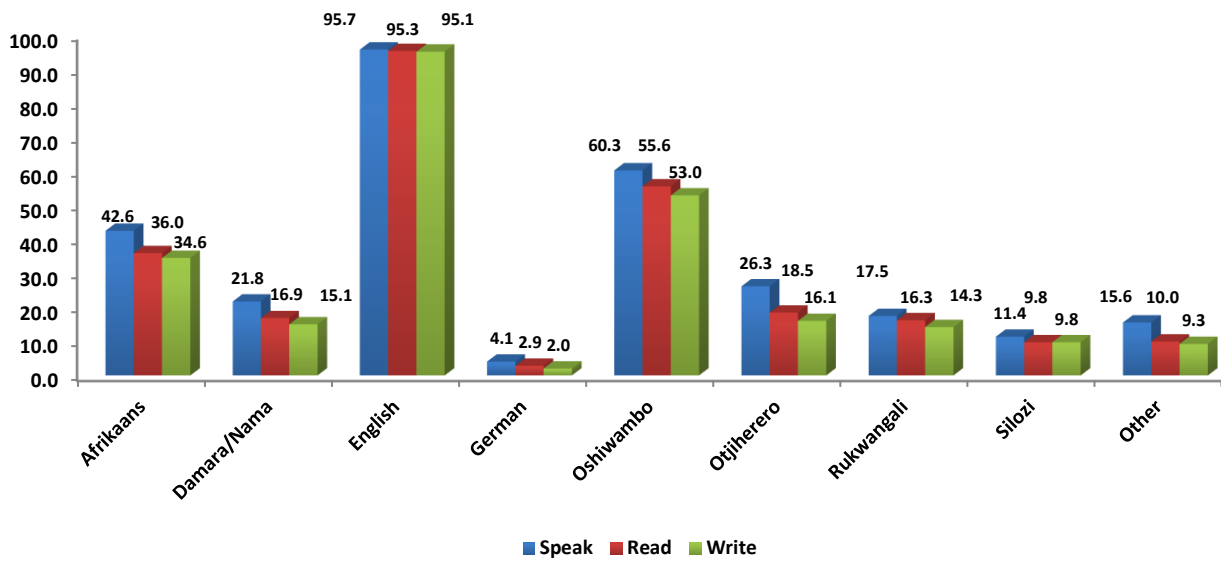
Chart 3 hereafter shows the highest level of education completed successfully by CCs. Around 2% (11 CCs) of CCs only completed primary school (up to Grade 7). Almost all CCs completed at least Grade 10 - nearly 40% having only completed Grade 10 and slightly more than half of the sample having completed high school (Grade 12). Only around 9% of CCs have any kind of post Grade 12 tertiary education.

**CHART 3: HIGHEST LEVEL OF EDUCATION**



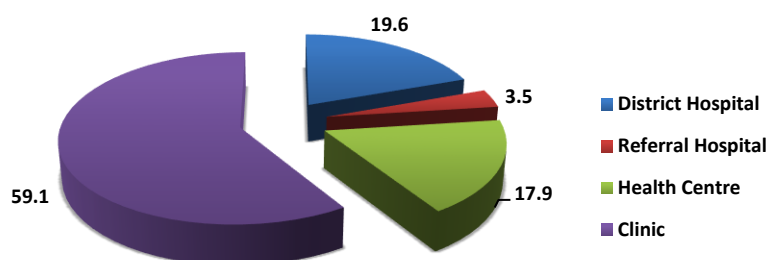
In terms of language proficiency and literacy, nearly all of the CCs spoke, read and wrote English. Other languages and their respective proficiencies and literacy are shown in the chart hereafter.

**CHART 4: LANGUAGE PROFICIENCY AND LITERACY**



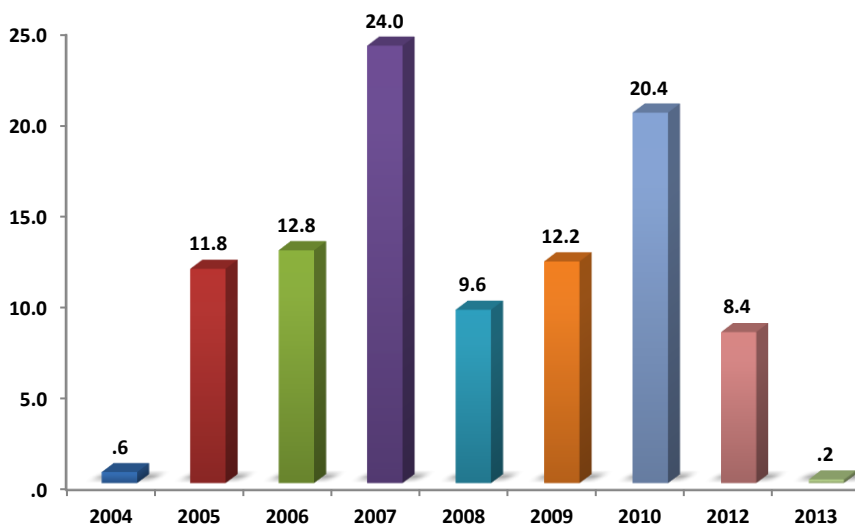
Around 60% of facilities represented by the sample were clinics, with DHs and HCs at around 20% representation each. Only 3.5% of total responses came from CCs stationed at referral hospitals.

**CHART 5: FACILITY TYPE**



The earliest year in which respondents started working as CCs was in 2004, while the latest was 2013. Chart 6 below shows a significantly higher intake of CCs for the years 2007 and 2010. The data indicates that there was no intake of CCs in 2011.

**CHART 6: YEAR STARTED WORKING AS A CC**



Nearly all of the respondents (99%) indicated that the initial training received provided them with the skills and knowledge to perform quality HCT.

Since their initial training, close to 90% of respondents have subsequently attended refresher trainings. Nearly 40% of the sample population has only ever attended one refresher training, while 25% have attended two and 15% three refresher trainings since they started working as a CC. The remaining CCs reported having attended more than this.

Almost all CCs (98%) felt that the refresher trainings were useful in providing them with the knowledge and skills to provide HCT services. Ninety-seven percent of CCs rated the overall quality of the refresher trainings as good.

Seventy-seven percent of CCs indicated that there were not enough refresher trainings. Detailed responses are shown in the chart hereafter.

**CHART 7: SUFFICIENCY OF THE NUMBER OF REFRESHER TRAININGS**

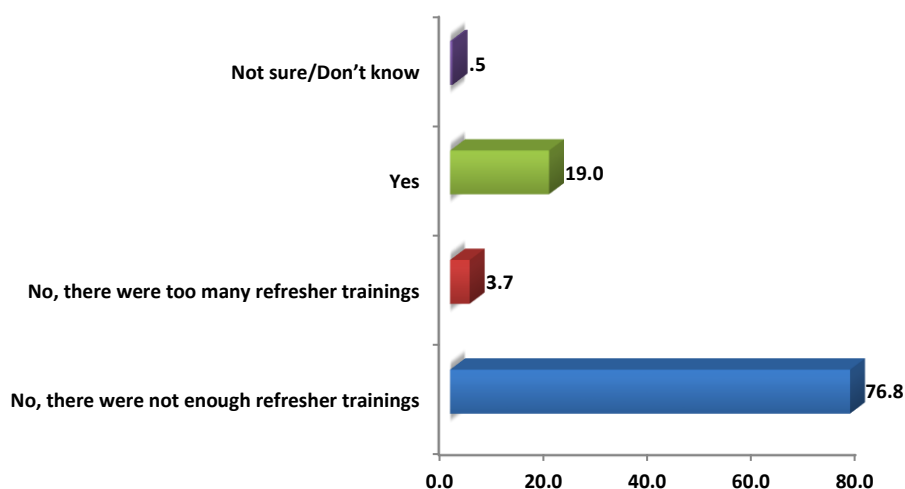
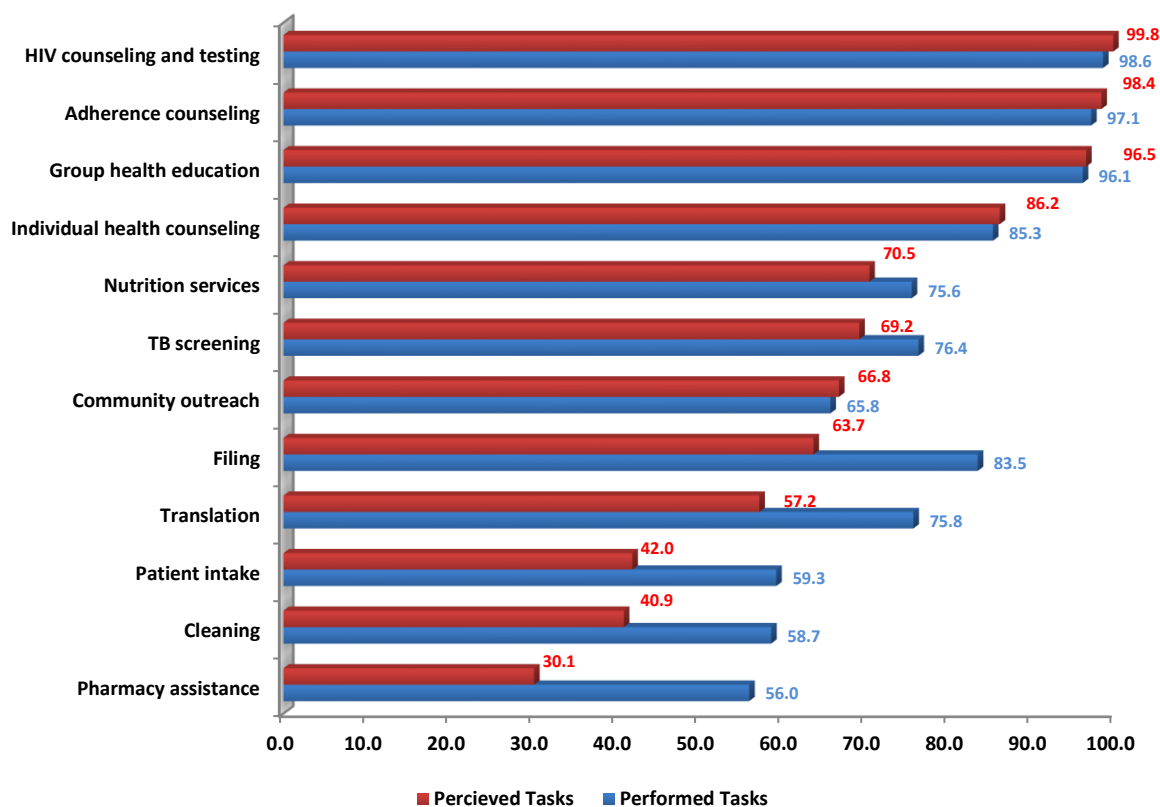


Chart 8 hereafter shows CCs perceptions of those tasks included in their current Scope of Work (SOW) against the tasks currently performed by them.

**CHART 8: TASKS OF COMMUNITY COUNSELLORS – PERCEIVED AS PART OF SOW VS CURRENTLY PERFORMED**



Most notably, administrative duties such as patient intake, translations, and filing, but also pharmacy assistance and cleaning were currently performed tasks not perceived by them as part of their SOW.

According to the *National Guidelines for HIV Counselling and Testing in Namibia*<sup>26</sup>, VCT counsellors should ideally perform pre- and post-test counselling on no more than ten VCT clients per day. This data shows that around 56% of CCs provide HCT to up to ten patients per day, of which 24% provide HCT to ten patients specifically. Furthermore, 11% claim to offer HCT to an average of 15 patients per day, 8% to 20 patients, 3% to 25 patients and 4% to 30 patients. This clearly shows a trend of CCs administrating HCT to more patients than the recommended daily limit.

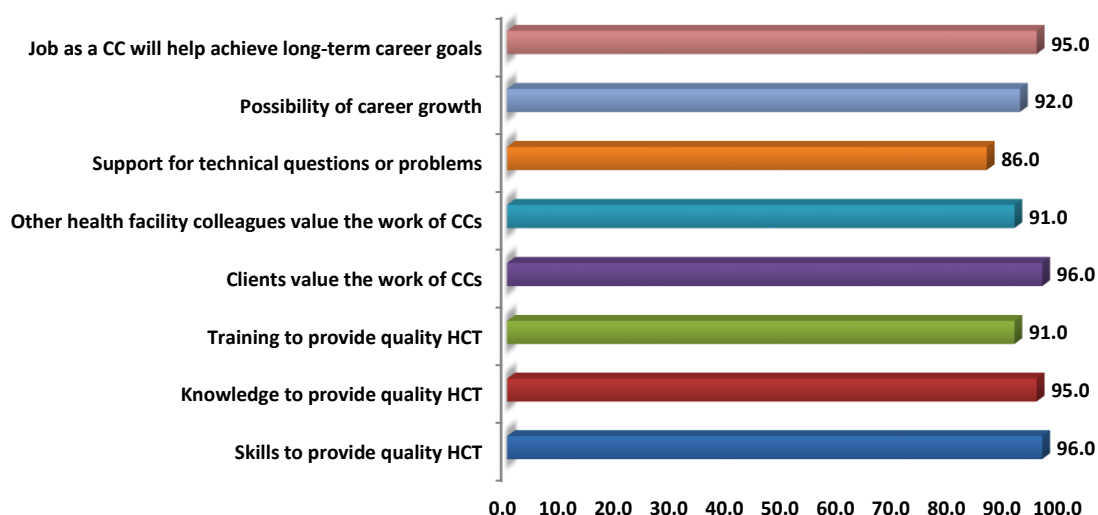
When considering supervision, 98% of CCs reported that there was a supervisor assigned to their facility. Satisfaction with the facility supervisor was 80%. Furthermore, 76% reported that they had a regional supervisor, with satisfaction just more than 80%. For district level supervision, 77% reported a district supervisor and satisfaction was again slightly more than 80%. National level supervision was again higher, with 80% reporting a national supervisor. Satisfaction with the national supervisor was around 82%.

When considering the support services for job-related stress that exist for CCs, CCs reported guidance and discussions (e.g. with a supervisor) (54%); peer support (30%) and case conferences (14%). Nearly 80% of respondents indicated that they were either satisfied or very satisfied with the psycho-social support that they receive to deal with work related stress.

Overall job satisfaction was rated, with around 35% of CCs indicating that they were very satisfied, just over 40% said that they were satisfied, and around 10% were indifferent. The main reasons for dissatisfaction were *Poor Remuneration* (30%) and *Excessive Workload* (22%).

In general, CCs were very positive about their jobs and felt that they were well equipped to perform the tasks that they were required to do. When asked about specific job skills and their ability and preparation for these skills, the vast majority of CCs answered with a positive response (Agree/Strongly Agree). These job skill items were asked individually and rated on a 5-point Lickert scale, where 1 = Strongly Disagree; 2 = Disagree; 3 = Neither Agree, Nor Disagree; 4 = Agree; and 5 = Strongly Agree. Chart 9 aggregates the positive responses contained in this section.

**CHART 9: JOB SKILLS SATISFACTION**



<sup>26</sup> Ministry of Health and Social Services, Directorate of Special Programmes, 2011

CCs were asked how they receive HCT clients. They could report multiple ways of receiving HCT clients. Ninety-four percent of CCs felt that HCT clients come to the health facility with the goal to get tested. Another 87% felt that they come to the health facility for another issue and are referred for testing by a nurse or doctor, while 58% felt that they come to the health facility for another issue and are referred for testing by themselves or another CC. Eighty-three percent were of the opinion that HCT clients attend a Group Health Education Session led by a CC or nurse, and then they choose to get tested, while 5% thought that HCT clients may have been referred to testing by an external facility or provider. Being referred for HCT by a nurse or doctor, or by a CC would constitute PITC.

The table below shows the distribution of types of clients referred for HCT by a doctor or nurse. It would seem that there are no specific types of patients that are getting referred above others and that referral is done by blanket approach.

**TABLE 15: CLIENTS REFERRED FOR HCT BY A DOCTOR OR NURSE**

TYPE OF CLIENT	PERCENT
Pregnant women	98
TB Patients	95
Patients who have HIV related symptoms	92
Men who are interested in getting circumcised	87
Patients who engage in high risk activities	84
Male partners of pregnant women	81
Patients who are sick with non-HIV related symptoms (outpatients)	73
Patients admitted to the hospital (inpatients)	57

CCs were of the opinion that 66% of those referred by nurses or doctors do not get tested. The main reason (nearly 50%) cited for referred patients not being tested is that the person did not want to receive a test. Twenty percent of CCs felt that the waiting time for HCT is too long; 18% were of the opinion that patients can get lost on their way to the HCT room and 14% of CCs felt that the HCT room is too far from where the patients was initially seen.

Although just over half of the CCs adhere to the guidelines on the number of patients to be tested per day, nearly 85% of CCs indicated that they would be able to see more patients if nurses and doctors referred more patients for HCT.

When considering the integration of health service providers and the referrals between them, there seems to be good unison between groups. Nearly 70% of CCs indicated that they personally refer patients to community based health workers<sup>27</sup>. Reasons for these referrals are mainly for TB screening and/or treatment (48%), adherence counselling (48%), and mother-baby pair follow-ups (38%). Around 70% of CCs indicated that it was possible to confirm whether a referred patient received the specific health service, and this was mainly through the confirmation from referral (19%); from their Health Passport (16%) and by phoning the department the patient was referred to (11%). Ten percent indicated that confirmation could be obtained through follow-ups.

Nearly 74% of CCs felt that their work as facility based CCs adds value to health work done by community based health workers. This was mainly because of the communication and information sharing (31%); contributing quality health education and HCT services (16%) and providing patients with necessary skills (12%).

When probed on further comments only two things stood out: nearly 45% of CCs expressed a need for more refresher trainings and 11% would like to see all CCs transitioned to Government.

<sup>27</sup> Community Health Workers, DAPP TCE Field Officers; Health Extension Workers.

### 3.4.2 OBJECTIVES AND EVALUATION QUESTIONS ADDRESSED AND KEY FINDINGS OF THE CHAPTER

The objective addressed in this component of the evaluation was to describe the human resource profiles of the CCs employed at the time of data collection. This included demographic profiles, length, types and quality of training, length of service, daily work assignments, work satisfaction, retention issues, professional growth, and availability of technical supervision and psycho-social support systems. This component of the evaluation was also aimed at describing the role of CCs in the implementation of PITC in Namibia, including how PITC is defined, and where and how PITC is being implemented in facilities where CCs are based.

The following evaluation questions were specifically addressed in this component:

- What is the demographic profile of the currently employed cadre of CCs?
  - Around 70% of CCs are female, and only 2% have only completed up to Grade 7.
  - Almost all CCs speak, read, and write English.
  - The youngest CC who participated in this part of the evaluation was 23 and the oldest was 59. The majority of CCs were between 31 and 40 years old.
- Are CCs utilized by health facilities to carry out tasks that are outside of their official job description?
  - CCs are of the opinion that they do more than what is expected of them - more than what is defined in their SOWs. In general, they noted that they perform duties such as patient intake, translations and filing, but also pharmacy assistance and cleaning; and they reported that these are not tasks that are defined in their job descriptions. Although these duties are not stipulated in their job descriptions (see Annexure 14) it can be safely assumed that they could be categorized as *'Any other duties assigned by the Supervisor'*.
- How many and what types of trainings are offered to CCs?
  - Just about all CCs indicated that they were satisfied with their initial training and they were of the opinion that it provided them with enough skills and knowledge to perform quality HCT.
  - Close to 90% have attended refresher trainings.
  - Seventy-seven percent indicated that there is a need for more frequent refresher trainings.
- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
  - Data shows that around 56% of CCs provide HCT to up to ten patients per day.
  - Eighty-seven percent of CCs felt that patients come to the health facility for another issue and are referred for testing by a nurse or doctor, while 58% felt that they come to the health facility for another issue and are referred for testing by themselves or another CC. Both of these options constitute PITC.
  - CCs have indicated that they can provide HCT to more clients than to whom they are currently delivering these services.
- What are the current barriers to proper implementation and documentation of PITC?
  - According to CCs about 66% of those referred for HCT by doctors and nurses do not end up getting tested.
  - The main reasons for not getting tested after being referred are cited as client choice; waiting time for HCT services, and infrastructure (HCT rooms too far from the screening rooms).
- Other
  - 2007 and 2010 reported higher intake of CCs compared to other years.
  - The vast majority reports supervision at facility, regional, district, and national level. They also reported high levels of satisfaction with these supervisors.
  - CCs reported satisfactory psycho-social support in the form of guidance and discussions (e.g. with a supervisor); peer support and case conferences to deal with job-related stress.

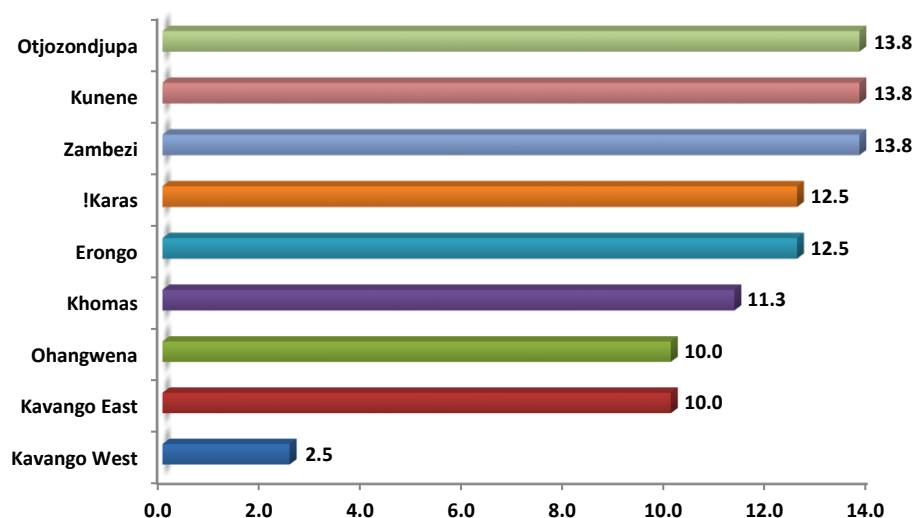
- Seventy-five percent of CCs reported being either satisfied or very satisfied with their jobs. Sources of dissatisfaction were remuneration and excessive workload.



### 3.5 CLIENT EXIT INTERVIEWS

Chart 10 below shows the regional distribution of the completed sample population.

**CHART 10: REGIONAL SAMPLE DISTRIBUTION**



Furthermore, the majority of the interviews (66%) were conducted at clinics, 19% at HCs, and 15% at DHs. Table 19 below shows the total distribution of interviews across health facilities.

**TABLE 16: FACILITY SAMPLE DISTRIBUTION**

FACILITY	FREQUENCY
Aussenkehr Clinic	20
Bethanie HC	20
Coastal Clinic	20
Daan Vijoen Clinic	20
Donkerhoek Clinic	20
Dr Sam Nujoma HC (Karibib Clinic)	11
Eenhana Clinic	20
Ekoka Clinic	20
Groot Aub Clinic	20
Grootfontein Hospital	30
Henties Bay Clinic	20
Kamanjab HC (Kamanjab Clinic)	20
Katima Mulilo State Hospital	30
Katutura State Hospital	30
Kayengona Clinic	20
Khorixas Clinic	20
Kuisebmond HC	20
Lüderitz Clinic	20
Mavuluma Clinic	20
Mayara Clinic	20
Nankudu Clinic	20
Nau-Aib Clinic	20
Ngoma Clinic	20
Ngweze Clinic	20
Nkarapamwe Clinic	20
Noordoewer HC (Noordoewer Clinic)	20
Odibo HC	20
Okakarara Clinic	20
Okangwati HC (Okangwati Clinic)	20
Ongha Clinic	20
Opuwo Clinic	20
Orwetoveni Clinic	20
Otavi Clinic	20
Outjo Hospital	30
Sambyu HC	20
Sesheke Clinic	20
Tamariskia Clinic	29
Wanaheda Clinic	20
<b>TOTAL</b>	<b>800</b>

Nearly 76% of respondents who participated in the exit interviews were female. Almost 90% of respondents were between 18 and 40 years old, with 38% of respondents between 18 and 25 and 46% between 26 and 40.

Chart 11 below indicates the highest level of education that respondents had completed. Although the majority of respondents only completed up to junior-level secondary schooling, nearly 30% of respondents attained a senior secondary school diploma or better.

**CHART 11: HIGHEST LEVEL OF EDUCATION COMPLETED**

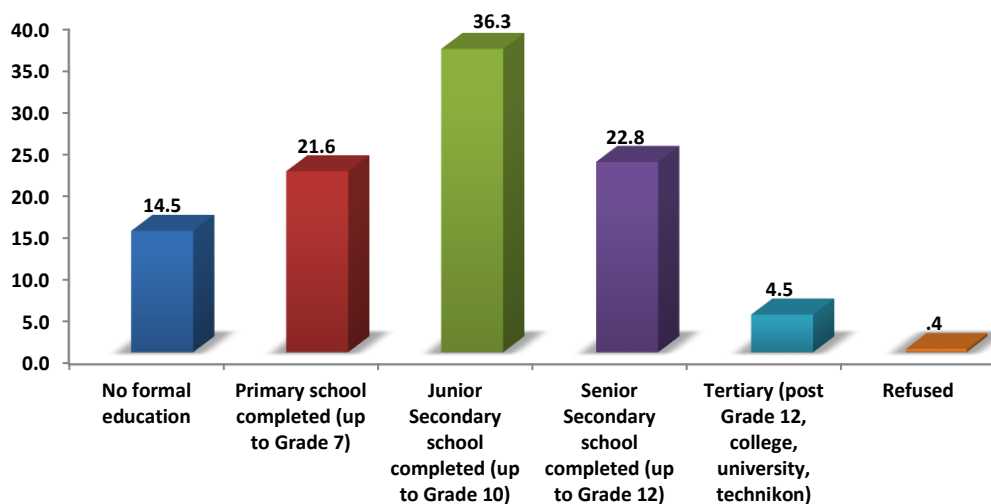


Chart 12 shows the main (home) languages spoken by the sample. This was mainly influenced by where interviews were completed.

**CHART 12: MAIN LANGUAGE**

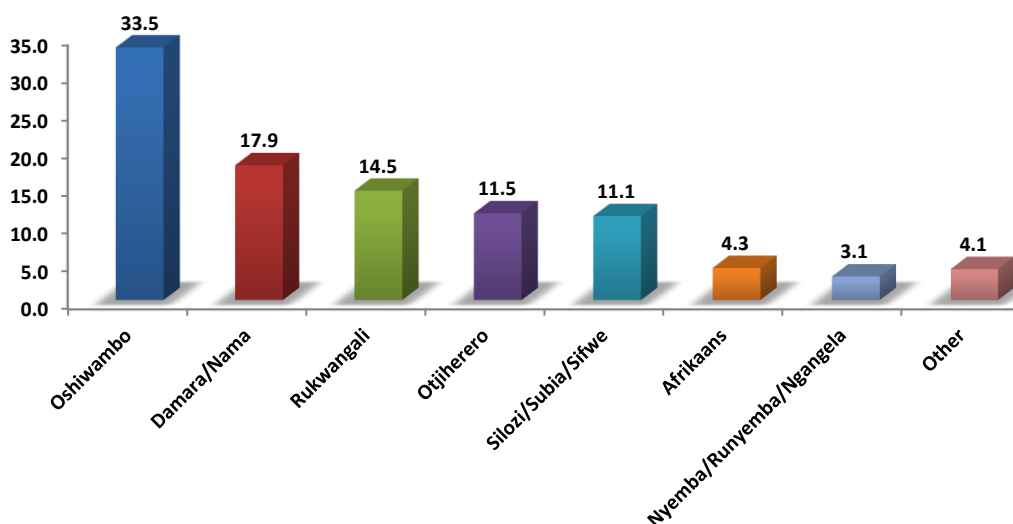
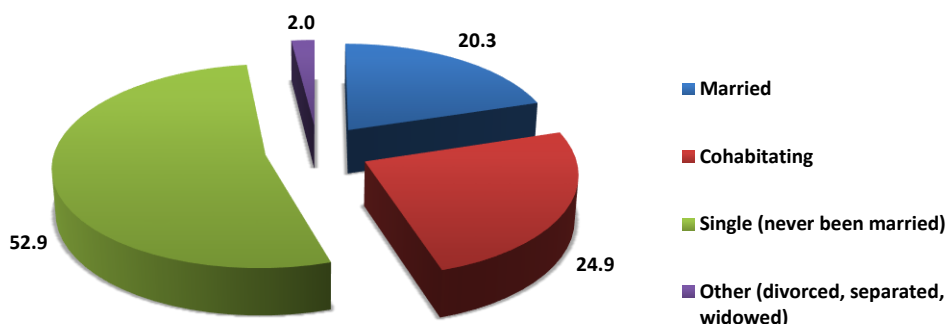


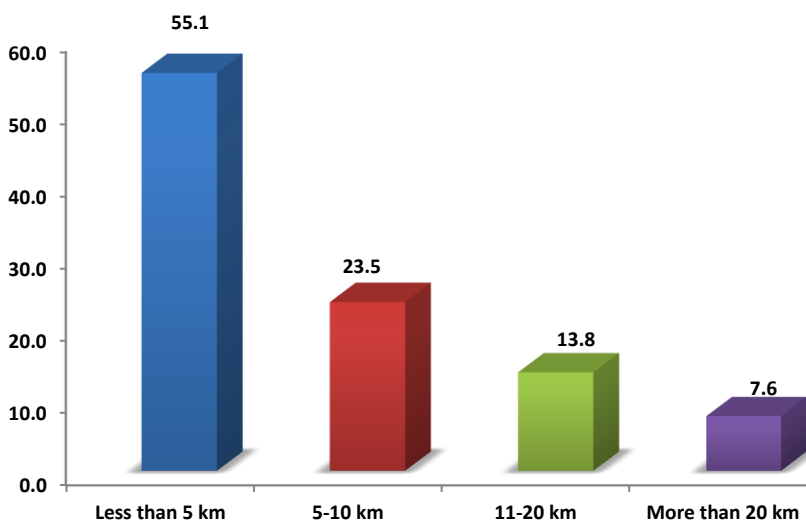
Chart 13 below details respondents' marital status. About half of the respondents interviewed indicated that they were single and never married.

**CHART 13: MARITAL STATUS**



When considering the distance that respondents had to travel to the facility where they were interviewed, more than half lived within a five kilometre range. A total of around 65% of respondents walked to the facility, nearly 20% took a taxi and 12% were driven there by a family member or friend. Chart 14 highlights the distances that respondents had to travel to get to the facility.

**CHART 14: DISTANCE TO FACILITY**



The primary reasons for respondents visiting the facility on the day of their interviews were to receive an HIV test (53%), for antenatal care (21%), and because they were feeling sick (13%). The majority (75%) of the sample indicated that a CC spoke to them about HIV on the day. Eighteen percent indicated that a nurse spoke to them, 2% reported that the doctor spoke to them about HIV and another 2% indicated that a friend or family member spoke to them about HIV.

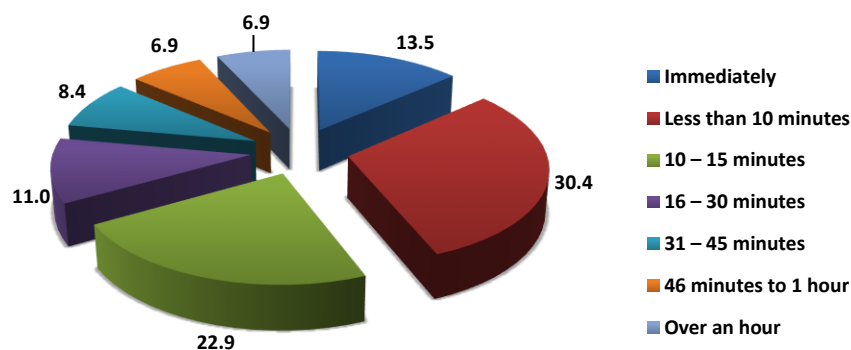
When asked who the first person was at the facility that suggested the HIV test on the day of the interview, 35% indicated that it was the CC and another 18% indicated that it was the nurse. Forty-five percent of respondents asked for the HIV test before it was offered to them.

The main reasons cited for getting tested on the day of the interview were because respondents wanted to know their status (36%); it was part of the clinic visit or the provider recommended it (33%); and 11% reported that they were there for a three-month window period test.

Just fewer than 70% of the sample indicated that they thought HIV testing should be recommended to everyone that visits a facility, irrespective of the reason for their visit. The main reason for being in favour of PITC was that everyone should know his or her HIV status (59%). Reasons against PITC included that people should have a choice to get tested (16%) and that not everyone is ready to find out their HIV status, at 16% respectively

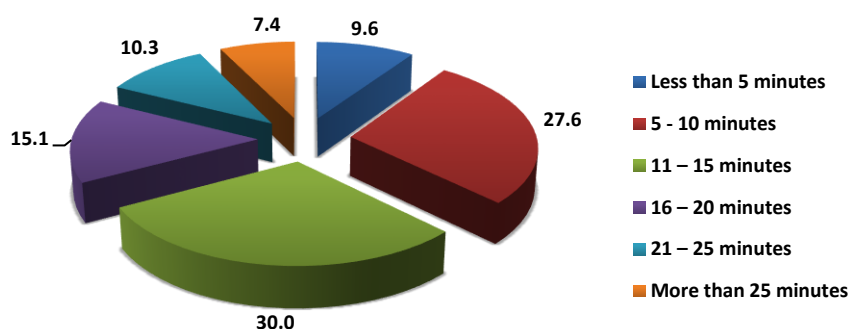
The charts below highlight how long a visit to a CC took. Chart 15 shows the waiting time for the CC; while Chart 16 shows the amount of time that was spent with the CC. Nearly 70% of clients waited 15 minutes or less to see the CC.

**CHART 15: WAITING TIME FOR CC**



Sixty-seven percent of clients spent up to 15 minutes with the CC, as shown in Chart 16 hereafter.

**CHART 16: TIME SPENT WITH CC**



The majority of clients (78%) felt that they spent just the right amount of time with the CC, while 15% felt the time they spent was too short and 7% felt it was too long.

When looking at the total client experience:

- Ninety-seven percent of respondents felt that they received enough information prior to the test.
- Ninety-eight percent felt that the CC conducted him/herself in a respectable manner.
- Ninety-three percent of respondents indicated that they felt that they were given the opportunity to ask questions.
  - Ninety-two percent of these indicated that their questions were answered to their satisfaction, while a further 7% said that they did not have any questions. 8% did not know if their questions were answered or not, and less than 1% indicated that their questions were not answered.
- Ninety-three percent of the sample believed their information will be kept confidential, while a further 6% indicated that they do not know if it will. Only 1% felt it would not.
- Nearly 99% of respondents indicated that the CC helped them to feel at ease.
- Ninety-seven percent said that the CC adequately explained their results to them.
- Those 97% also felt that the CC listened to them.
- Around 95% of the overall CC rating was either good or very good, with 5% being rated as being neither good, nor bad.
- Ninety-six percent of the sample would recommend the facility they went to for testing to a friend or family member.

With regards to suggestions to improve testing and counselling, 26% of respondents said that there is a need for more CCs. A further 24% indicated a need for more space for HCT services and 14% suggested a need to create greater awareness around testing and counselling services offered by CCs.

When probed on suggestions to improve the work done by CCs, 36% of respondents suggested that more CCs be employed, while a further 19% thought that current CC efficiency could be improved in some way.

Other significant comments made by respondents were that CCs provide mobile testing during outreach (23%) and that the number of CCs be increased at sites (14%). Eleven percent suggested that programmes and interventions be developed that disseminate information and increase awareness and encourage testing. Ten percent indicated that more space is required for HCT service provision.

### **3.5.2 OBJECTIVES AND EVALUATION QUESTIONS ADDRESSED AND KEY FINDINGS OF THE CHAPTER**

The objectives of this evaluation component were to describe the role of CCs in the implementation of PITC in Namibia, including how PITC is defined, and where and how PITC is being implemented in facilities where CCs are based, as well as to assess the level of client satisfaction with services provided by CCs.

The following evaluation questions were addressed specifically:

- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
  - Fifty-three percent of respondents indicated that the reason for their visit to the facility on the day of the interview was for HIV testing. Another 21% visited the facility for ANC.
  - Seventy-five percent of respondents indicated that a CC spoke to them about HIV on the day that they got tested.

- When asked who the first person was to suggest that they get tested on the day, 35% reported that it was a CC and 20% said that it was a nurse. The remainder indicated that they asked for the test themselves.
- When asked why they got tested, 36% indicated that they wanted to know their status, 33% indicated that the provider suggested the test or that it was part of the visit and another 11% indicated that it was a three-month window period test.
- What are the current barriers to proper implementation and documentation of PITC?
  - Although the majority of respondents felt that HIV testing should be recommended to all patients who visit a facility, irrespective of the reason for their visit, around a third of respondents were opposed to this. They were of the opinion that patients should have a choice, and that not all patients or clients are ready to know their HIV status.
- Are clients generally satisfied with HCT services?
  - The majority of respondents felt that the time spent with the CC was sufficient. Just about all respondents felt that the CC conducted him/herself in a respectable manner, put them at ease, explained the results adequately, and listened to them.
  - Ninety-seven percent of respondents felt that the CC provided them with enough information, 93% felt they were able to ask questions, and 93% believed that their information would be kept confidential.
  - Ninety-five percent of respondents rated their overall experience with the CC as either good or very good and 96% of respondents indicated that they would recommend the facility to family and friends for testing.
- Other
  - Respondents suggested that more CCs be enrolled for the provision of HCT; others suggested that programmes and interventions be developed that disseminate information and increase awareness and encourage testing and also indicated that more space is required for HCT service provision.

## 3.6 RMT KIIs

### 3.6.1 FINDINGS

Eight KIIs were carried out with key individuals from the RMTs to assess their opinions as stakeholders on the service gap filled by CCs, how PITC is implemented, and the future roles of CCs in HIV services. These key informants occupied posts such as Chief Medical Officer; Senior Health Programme Administrator; Acting Director; Programme Officer for Family Health; Programme Officer for HIV, TB and Malaria; and Head of Division for Special Programs for HIV, TB and Malaria.

The discussions began with talking about how the RMT defines and addresses the needs concerning CCs. Most described their role in recruitment as one of making recommendations to the national MOHSS office or one of identifying their needs and passing those along to the national office or CDC. They reported sending the CCs for training as requested by the Ministry.

Most RMTs had little to say about remuneration as they stated that everything pertaining to remuneration happened outside of MOHSS. However, it was an issue that most identified as a challenge to CC job satisfaction and retention. Several RMTs reported problems with CCs being paid in a timely fashion due to communication problems with the national office or a mismatch between remuneration processes and the technological capabilities of facilities, especially those in rural areas. One informant explained: *“The donor wants things to arrive today in Windhoek from Community Counsellors. But most facilities do not have fax machines or email and Internet at the clinics. So how can they expect things to be on time? They sometimes have to travel somewhere to send things to Windhoek. And even in Windhoek, sometimes the Internet does not work. So many times things do not arrive on time. And then this hampers the good flow of submissions.”* One RMT reported that CCs have sometimes not been paid for up to two months as a result of processes relying on technologies that are not available at their facilities. Many RMTs deemed the CC salaries insufficient. As one informant explained, *“We cannot call it a salary. It is just an incentive. A remuneration. For what they are doing. It is not enough.”* In one discussion, insufficient remuneration was directly linked with retention challenges: *“I know that there is the challenge of shortage of CC’s. It is at all of the health facilities. It is because of the low salary and that there are no benefits. Some of them look for another job that has a better salary and benefits.”* Another informant described the same problem with remuneration: *“There is also a high staff turnover of Community Counsellors. We see a lot of it. They go in search of greener pastures. I do not think the donor is paying them enough. Especially when one of the Community Counsellors passes away. Their families come to us. They ask for a lot of things and we cannot provide them with anything. The families expect a lot of things. But we cannot provide it. I think they only have life insurance.”*

In discussions about recruitment, it was issues of CC needs not being met, replacements for posts and the requirements for CCs being transitioned into the MOHSS that were most frequently highlighted. The causes of the first and second issues were attributed to recruitment and placement responsibilities lying with the donor and the RMTs’ inability to influence the involved processes. One RMT explained that CC shortages were a result of the RMT not being permitted to move CCs as they saw fit as others left their posts. A sense of a lack of influence on the recruitment and placement processes was echoed by several other RMTs. Some suggested that replacement was a *“cumbersome”* process, while others claimed there was no provision for replacement. One informant described frustration at not being able to replace CCs who had left for further training or other jobs: *“Our hands were tied. We could not replace these ones that we lost.”* Indeed, several RMTs claimed that CCs who left their posts were not replaced. The requirements for CCs were also highlighted as challenges to successful HCT programs, particularly the mismatch between the donor’s and the government’s requirements for the position. One was frustrated about the requirement that CCs be identified in the communities they will service such that professionally trained counsellors could not be recruited. Several other RMTs were concerned about some existing CCs failing to meet the requirements to be transitioned into the new government positions. One RMT pointed to the possible skills or psycho-social

gaps that will result of the MOHSS requirements. They explained that they had recruited to meet the needs of particular communities such that they targeted candidates who could speak all languages, men, and PLWHA. The latter they saw as particularly important for motivating others to adhere to treatment. One informant described this concern: *“We can also not afford to discharge those who do not have Grade 10. Especially those who are living positive. It is in the policy of MOHSS to involve those who are positive. We have already invested in their knowledge. And where will they now go with that knowledge? They are really the best to talk to others about adherence.”*

Most RMTs reported that refresher trainings are infrequent due to funding constraints and that most training occurs in an ad hoc manner during the RMT supervisor support visits at facilities. When they do these visits -- approximately once a year due to funding constraints -- they assess CCs and provided on-the-spot training if they see needs. Several RMTs stated that refresher trainings were organized by the donor, but that these were sometimes cancelled at short notice due to a lack of funding. CCs were also invited to some relevant clinical workshops for nurses at some facilities, but, as many explained, MOHSS did not have a budget to provide transportation for CCs to attend trainings. Lastly, two RMTs noted that training had been more regular when there were regional community coordinator positions (when the Red Cross owned the CC Programme).

Most of the RMTs identified such ad hoc or on-the-spot training as a component of their supervisory role, albeit only usually an annual occurrence. These visits also included hearing grievances and encouraging CCs to further their studies. A more regular component of the RMTs' supervisory role was reviewing monthly reports that concerned the CCs' performance. Several also highlighted the role of facility (nurses) or district supervisors in providing regular or day-to-day supervision. One RMT reported that this system of nurses supervising CCs had not worked because the nurses' workload did not permit them time to complete the required forms.

The RMTs responded to questions about their mentoring role in much the same way. Indeed, it appears that “supervising” and “mentoring” held similar meanings for all informants. They described mentoring that happened during annual supervisory visits, but explained that nurses in the same facility were expected to do day-to-day mentoring. Several RMTs highlighted their role in encouraging CCs to study further (i.e., to become nurses).

With one exception, this supervisory role reportedly did not extend to doing performance reviews for CCs. One RMT described several ways in which they assessed the performance of CCs: from checking on the accuracy of their testing to observation to exit interviews with clients. Similarly, RMTs were not directly involved in firing CCs either. Most said they have “no role” in firing CCs. The RMTs could track attendance via monthly reports, but could then only make a recommendation to the national level concerning a CC's poor performance. According to one RMT, their very limited purview in addressing disciplinary issues and a perceived lack of action or feedback from the head office reportedly resulted in problems among CC peer groups -- others are burdened by those not doing their jobs -- and, seemingly, a sense of disempowerment among the RMT. Respondents described these issues: *“You will find a CC with disciplinary issues, but then the direct supervisor does not do anything about it. And if it is not documented, you cannot do anything about it. And even if it is written down, you can write a recommendation and submit it, but nothing gets done.... Sometimes we also request that they get unpaid leave. Because some go without permission. Then we request that they take unpaid leave. But we never really know if it is deducted. But then they do not change their actions.”*

As they described needs, processes, and challenges with recruitment, placement, in-service trainings and remuneration, the informants expressed a range of different degrees of ownership over the programme across regions. For example, the RMT of one region described being actively involved in the processes of recruitment and supervision and depicted a close relationship with the CCs: *“We consider them as part of the health system – the MOHSS. So the way that we handle nurses, is also the way we handle them. Apart from the fact that HR and Finance does not sit with us.”* At the same time, another



RMT respondent claimed, *"We do not really know about all of this stuff... The stuff about recruitment, remuneration, training and those things. We are not the ones doing this. We just recommend to the supervisor."*

All RMTs made it clear that they see CCs as a vital cadre that has a significant impact on service provision. One respondent summarized the CCs' contribution towards successful service provision: *"They are improving the quality of life for the patients. The Community Counsellors do their jobs very well with very little supervision. They know what they are doing. It is a very good, supportive unit. And they are helping to reduce HIV."* Foremost, they were seen as filling a significant human resources gap. More specifically, RMTs asserted that CCs relieved nurses of some of their excessive workload. One informant described the probable outcome of the elimination of the CC Programme: *"At the moment they are sharing the responsibilities. There is division of labour. So it is easier at the moment. And there is no over-burden. And the client is receiving the sufficient package. The nurses will be overloaded and it would affect the quality of services being delivered."* CCs were described as an *"extension of the nurses"* and as staff who helped the nurses. One RMT claimed that nurses, in fact, rely on CCs to contend with the patient load.

Secondly, they were recognized as keys to a successful HIV/AIDS program. *"When it comes to HIV,"* explained one informant, *"I think they have become like the first... line of defence. We rely on them so much. If they are not there, there is a delay in people knowing their status. They are quite vital."* This assessment was echoed by all the other RMTs, particularly as they were asked to imagine the impact of a reduction in the number of CCs. *"Without the Community Counsellors, the HCT programme would not be there. We cannot do the HCT without the CCs,"* explained one informant. This RMT also predicted that ART services, PMTCT, and TB services would be of lower quality in the absence of CCs *"... [B]ecause HCT is the entry to these three services. If we do not do HIV testing we would not be able to prevent unborn babies to get HIV. Or people would not be offered ARVs to prolong their lives. TB patients would die quickly."* Another respondent estimated the change in service provision were the CC Programme to be discontinued: *"Let us say that they can now counsel a hundred patients a day. Then you would only counsel ten patients a day if they were no longer there."* Another RMT imagined how service provision might be negatively impacted without CCs: *"The service will be compromised. I might find that rapid testing is done, without counselling. Or people would not want to come because my attitude might not be nice. It will not be because I do not want to do my work, but I might just be overworked... The queues will be very long. At the moment it may take about one hour to go through the whole system. But it will take longer then."*

All RMTs described CCs as responsible for duties listed in the job description and little, if anything, beyond these. Duties that RMTs listed included: pre- and post-test counselling, administration of tests, adherence counselling, nutritional assessment, alcohol assessment and counselling, referrals to social workers and maintaining records. Several RMTs identified the CC position as flexible, particularly in terms of CCs assisting nurses with basic tasks, such as taking some vital signs, doing stock takes or ordering testing kits.

The RMTs' visions for how the CC role could change in the future varied widely, however, with several suggesting that no duties be added or removed. As such, several felt that the new name for the cadre - Health Assistants - more aptly described the CCs' responsibilities than a title connected with "community". That the absorption of CCs into MOHSS would bring an increased salary and regularized supervisory structures and rules, some RMTs thought the position could be expanded to better address staffing and service gaps. Several did suggest that a community component be incorporated into the position -- if a sufficient number of CCs were available -- such as doing door-to-door testing, following up with clients who default on their treatment, or broadly serving as a link between the community and the facility. One informant described what this might look like: *"I would really like for our Community Counsellors to go to houses and do testing. And be in the community. And be the link between the community and the health facility. But not only knowledge on rapid testing. But maybe to also have knowledge on first aid. Maybe to recognize signs and symptoms and refer community members to facilities."* A few RMTs also suggested that the role should include basic nursing practices and health education.

The transitioning of CCs into MOHSS that was in progress at the time of the evaluation was envisioned by all RMTs as having a positive impact on the CCs and their service provision. Thus, all RMTs wanted to see all current CCs absorbed as rapidly as possible. Making the CCs part of the MOHSS was expected to mitigate existing supervisory problems, as CCs would be included in present structures. One informant described potential psycho-social benefits of this transition: *“If they receive the training and they are well equipped and skilled, they will feel accepted in the health team. I think they will also change their previous bad behaviours. And they will receive the same incentives. I think it will help them to change their conduct. And they will be better informed. And they will be part of an organization.”* With the transitioning of CCs, some RMTs suggested that the position be situated into MOHSS categories such that there would be opportunities for CCs to be promoted or to *“grow in the position”*, such as creating a CC supervisor position or a senior Health Assistant position. RMTs had a number of suggestions regarding the location of CCs in the MOHSS structure in terms of management and supervision: within management, under enrolled nurses, or under primary care.

When RMTs described PITC, they generally spoke of the provider, health care workers, or nurses initiating HCT and the benefits such nearly universal testing offers for early diagnosis and treatment. Only one RMT included referral to the CC as part of their description of PITC. However, concerns about higher demands on CCs were mentioned by three RMTs as challenges with PITC. The other barriers with PITC that nearly every RMT identified were staff shortages or HCT training needs, insufficient infrastructure/space, and community resistance. It was then steps towards addressing these barriers, including the training of CCs, that RMTs said would help to make PITC possible in the region with the MOHSS’ assistance. For example, one informant suggested a MOHSS public awareness campaign: *“MOHSS should inform the nation of what they want to do. Just to inform all people about PITC and how it will work. So that people can get used to the idea. So that when we implement it, people know why we are doing it. Awareness goes hand-in-hand with advocacy and sensitization. We should use the community activists. We need a multi-sector approach.”* Another informant described the challenge that insufficient infrastructure poses for PITC: *“If you really want to do proper PITC, we need to look at the infrastructure and make sure that there is space and privacy. Making sure that the rooms have adequate space, not just a small cramped space where you are screening. The room must be big enough that you can keep the test kits there too. At least that you have a space where you can work and do the testing in the same area.”* Increased human resources, especially CCs, and training for nurses and CCs were also highlighted as needs by RMTs.

### **3.6.2 OBJECTIVES AND EVALUATION QUESTIONS ADDRESSED AND KEY FINDINGS OF THE CHAPTER**

The following objectives were addressed in this component of the evaluation:

- Describe how CCs have affected the workload of health care providers between 2007 and 2013 in the uptake of HCT, PMTCT, TB, and ART services.
- Describe the role of CCs in the implementation of PITC in Namibia, including how PITC is defined, and where and how PITC is being implemented in facilities where CCs are based.

RMTs perceived that CCs have enabled the provision of effective HCT services -- the entry point to PMTCT, TB, and ART services -- and have taken over some of the workload from overburdened nurses. CCs are now considered indispensable for both of these reasons. Particularly because of CCs’ role in relieving some of the nurses’ workload, all other patient services are understood to be impacted by the CCs’ responsibility for HCT services. With their inclusion in MOHSS and the salary increase that will accompany that transition, many RMTs would like to see the CC role expanded somewhat to allow more relief for nurses and to better link facilities with their surrounding communities.

RMTs are concerned that CCs should be trained for PITC and that the demand on CCs will increase with effective PITC such that more CCs will be required. CCs did not commonly feature in the RMTs' definitions of PITC but were identified as important to the implementation of PITC.

More specifically, this component addressed the following evaluation questions:

- Are CCs utilized by health facilities to carry out tasks that are outside of their official job description?
  - CCs are reportedly working almost entirely within their existing job description. Several RMTs commented that CC duties had been intentionally restricted in this way because CCs' remuneration was so low.
- How many and what types of trainings are offered to CCs?
  - Training of CCs appears inconsistent and irregular across regions. Beyond the initial national-level training, RMTs reported that training largely takes the form of on-the-spot training when they do annual supervisory visits. Some refresher trainings are reported, but funding problems sometimes interfered with training.
- What health facility activities rely on the services provided by CCs and what role should CCs play in health facilities and in the health care system in the future?
  - CCs have effectively helped to alleviate some of the workload from nurses and that impacts all service provision at facilities.
  - HCT is deemed to be almost entirely dependent on CCs. Far fewer clients would access these services were it not for CCs and the quality of service provision would be inferior in their absence, according to all RMTs.
- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
  - The RMTs describe PITC as though it is only in its early stages of roll out so the role of CCs is discussed as though imagined rather than observed.
- What are the current barriers to proper implementation and documentation of PITC?
  - Human resources limitations (numbers and training), infrastructure constraints on space in which to provide HCT services, and community resistance were identified as the greatest barriers to the successful implementation of PITC.
- Other:
  - Retention and replacement problems have reportedly created many unfilled posts.
  - Supervision of CCs has been incomplete and irregular
  - To date, RMTs have largely felt distanced from the management of the CCs. They described decisions to which they believed they should have contributed being made at the national level or by the donor.
  - RMTs' assessments of the CC Programme are surely impacted by the timing of the evaluation. CCs were in the early stages of transitioning into the MOHSS and so RMTs could only speculate about changes anticipated with this transition. For example, the problems with retention of CCs that have been experienced have been blamed on an insufficient salary that RMTs imagine will be rectified once CCs are absorbed into MOHSS and salaries are consequently increased. Some also hoped that introducing a hierarchy of CC posts will provide a further incentive for CCs to remain in their positions and fulfil their duties.

## 3.7 FGDs WITH HEALTH CARE STAFF

### 3.7.1 FINDINGS

Eight focus group discussions were carried out with supervisors at health facilities in a given region to determine their level of satisfaction with CCs, including their knowledge and skills, as well as to assess their opinions on CCs' future roles in HIV/AIDS and other public health programs in Namibia. Individuals were conveniently sampled based on their supervisory roles with CCs, and they occupied posts such as Nurse, Special Programme Manager, Registered Nurse for the Special Program, and Medical Officer.

These groups began by discussing their relationships with the CCs. Both their job responsibilities in relation to the CCs and the quality of their working relationships were outlined. These respondents reported responsibilities that included checking that CCs complete their duties and abide by appropriate guidelines, observing the CCs' interactions with clients, assigning other tasks (i.e., beyond regular duties), being available should CCs have any problems and helping to solve problems as needed, offer psycho-social support at times, ensure that the CCs attend trainings and workshops, and ensure there are sufficient testing supplies. Several focus groups described CCs as part of an HIV/AIDS programme team, while respondents described themselves as both supervisors and co-workers of the CCs. Most asserted that working relationships were good, which referred to CCs being willing to help as needed and others reciprocating, reporting to supervisors as expected, and maintaining good interpersonal relationships.

Respondents readily listed an array of duties for which CCs are either solely responsible or with which they assist others. Duties they reported included: HCT, PTMTC testing and counselling, adherence counselling, health education about HIV/AIDS, referring clients to other services, tracing defaulters, following up with clients in treatment, keeping statistics, and completing monthly reports. As they listed duties, respondents frequently highlighted duties that were outside the scope of the CCs' job description. They qualified these duties by describing staffing shortages that prompted the need for help from CCs. For example, one explained *"They help us to collect files from the cabinet. We do not have a receptionist. So they assist us with that."* In addition, that these respondents provided such extensive lists of CC duties suggests that they are in close contact with CCs daily.

All focus groups were quick to acknowledge that CCs were doing duties not explicitly outlined in their job description. *"I do not want to say we abuse them, but they do over and above what is in their job description,"* acknowledged one respondent. The extra duties most often reported pertained to taking out, adding to, or organizing patient files. Other extra duties, which were recognized as such, included registering and weighing patients, driving staff to workshops, translating for doctors or pharmacists, taking pill counts and packing medicine, and filling in forms for blood samples as well as maintaining the correct temperatures for the testing room and refrigerator. Some were unfamiliar with the CC job description or believed that such duties were permissible given that a clause in the job description reads "Any other job assigned by the supervisor". Most, however, understood that these duties were outside the scope of CC work, but explained that such duties were only assigned when the CC did not have any clients and that the requests were only a result of nurses being overburdened with work. *"We just ask them if they are free,"* explained one respondent. *"We are not always busy. Some days are quiet. And when they are free, we ask them to help us. We work together as a team here. The doctor, me, the nurse and the Community Counsellors."* Calling upon the CCs to help was, in their eyes, merely a feature of working as a team such that everyone helped each other. *"So it is not really us abusing them. It is just integrating the program,"* this respondent concluded. Another respondent similarly explained how CCs come to perform other duties: *"We communicate with the individual. We tell the counsellor our situation. We explain our staff shortage. And then we ask that all available staff should help out. So we help each other. So sometimes the nurses also take on extra duties. It is done by everybody."* Each individual CC reportedly

decided whether or not to assist in other duties, but the respondents described most as willing because *“they see us suffering.”*

As respondents discussed whether CCs were used to their full potential they largely focused on how the CCs used their time, whether CCs were busy throughout the day, or whether CCs were well used for HCT and helping nurses. Responses were framed in terms of whether CCs were being over used – opinions about which were very mixed – or whether they were doing all the duties outlined in their job description – with which almost all universally agreed. *“We use them usually beyond what we believe is their job description. So they are over-used,”* remarked one respondent. Also, implicit to this discussion was the assumption that CCs could indeed be trained to take on more diverse tasks, despite their educational level or qualifications. At other points in the focus group discussions, respondents talked about assigning CCs extra duties based on their individual capacities. For example, some had enough computer experience to enter data, others had driver’s licenses, which allowed them to help transport nurses, and others knew enough about wound care to do dressings. In other words, managers have been informally assessing CCs’ individual capacities and assigning additional duties accordingly towards the goal of effective service provision while managing excessive work demands.

All respondents asserted that CCs have a great impact on HCT services and HIV/AIDS services more broadly. Counselling, in particular, would be very difficult or impossible to accomplish in the absence of CCs. The primary reason given for this impact was one of nurses’ time, in that CCs have proven very helpful in reducing some of the work burden for nurses. Like many others, one respondent predicted severe problems for HIV/AIDS services in the absence of CCs: *“If you take [CCs] away the load on the nursing personnel will be so heavy and the backlog on HIV counselling and testing and treatment will be huge. And the follow-up of patients, interrupters, and defaulters... the whole system, the whole HIV programme will just collapse.”* In this aspect, several respondents imagined that every aspect of a facility’s health services would be negatively affected by the absence of CCs, as nurses would be forced to absorb the HCT duties. Counselling was deemed to be particularly time consuming, if done well, and, thus, particularly difficult to provide in the absence of CCs. One respondent described an inevitable negative impact on counselling if left to nurses: *“I try to do it. But to consult and to do this... I will do it in a Chinese way. And I will not cover all the topics.”* Another respondent described the special need for timeliness in HCT service provision: *“Without counsellors it will be a disaster. We will be overloaded and we will not give our attention to the client 100 percent. We would have to show patients away, and tell them to come back the next day. And then the person would not come again. It is not easy to decide to come for testing. So if you miss that opportunity, the person might not come again.”* It was also repeatedly noted that CCs had been trained for duties that most others had not, such as running quality assurance tests or even HCT, and so other health workers would immediately have to be trained if the CC programme were eliminated.

Nearly all focus groups deemed the overall quality of HCT and other HIV/AIDS services provided by CCs to be *“good”*, *“high”*, or *“excellent”*. These assessments were primarily based on regular quality assurance test results from the NIP and perceived patient satisfaction. One respondent explained this assessment: *“The quality can be measured through your satisfied patients. We do not have complaints from the patients. So that is a sign of the quality and the satisfaction of the patients. And the increasing number of people from the community. They are coming and they know about the services. So they are coming here. And the number of people that are getting HIV counselling and testing is increasing every day.”* One respondent enthusiastically attributed broader trends to the CCs’ work quality: *“Excellent. If you look at the Sentinel Survey, and you look at the graph... If you look at the enrolment, our indicator is declining. It is because of the services that they are providing. They give information and they encourage the patients to tell others where they come from. It is excellent.”* Another respondent in this focus group added another means of quality assessment: *“I am not only looking at prevalence. But I am also looking at stigma and discrimination attached to HIV testing and counselling. If we look back, client intake in 2004 were very low. None of the pregnant women opted in for counselling and testing. But nowadays it is very different. If you go to the maternity ward, and a woman is very far from the clinic, they get tested immediately. Even when they come for labour.”*

A few respondents described particular concerns with their CCs such as that the CC was lacking in empathy or communication skills. Many respondents thought that CCs could improve the quality of service provision if they were given more training and better supervision. Both regular refresher training, especially when new guidelines come out, and inclusion in training for nurses were suggested. Supervision, many imagined, could be improved with a dedicated supervisor since the nurses were too busy to adequately do so. Many also suggested that service provision would improve if CCs were better remunerated and motivational incentives were offered (e.g., opportunities to advance in their career) and if there were more CCs. Respondents also suggested a need for relief CCs or shift schedules to ensure a CC is always available as well as dedicated rooms for HCT.

For the future, most focus groups discussed a desire to have CCs integrated better with other programs, meaning that the scope of work and training should be expanded to permit CCs to assist nurses more extensively. Most respondents wanted CCs to be trained in basic nursing skills like taking parameters, doing dressings and drawing blood, and some suggested they should be trained on and included in related disease programs like TB and STI management. A few respondents also pointed to a need for CCs to “*go into the communities*” to do HCT.

All focus groups suggested that CCs should be provided with opportunities to grow in their career within the Ministry. Although low levels of education or qualifications were cited by all as barriers to career growth, many respondents suggested that CCs should train to become enrolled nurses. A few also suggested that there should be different tiers within the CC cadre that would allow career growth. Many emphasized that the MOHSS should support and encourage CC career growth as a means of increasing retention and not losing the significant experience that CCs have already gained.

Many respondents were concerned about the lack of benefits that CCs received. Increasing salaries as well as providing housing assistance and medical aid were widely suggested in the focus groups. Several also suggested that the CCs should have uniforms provided by the MOHSS and that motivational awards be introduced. In line with these suggestions, several respondents also emphasized the need to quickly absorb all existing CCs in the MOHSS to retain their experience and to combat the demoralized feelings of those not transitioned.

PITC had been implemented at most facilities and respondents defined PITC variously as the practice of referring patients that enter a facility for any treatment or as the practice of nurses identifying patients to refer for testing on the basis of symptoms or diseases with which they present. One focus group expressed a lack of familiarity with PITC. Many respondents included the referral of patients specifically to CCs as a component of their definition of PITC. This description is typical of how several respondents defined PITC: *“When a patient comes in, he is seen by a nurse. The nurse might think that the person should have an HIV test in order to manage the symptoms that made the patient come to the clinic. And then the nurse refers the patient to the Community Counsellor for HIV testing. After that the person will know their status and it will enable me as a health care worker to determine the correct treatment. So the provider initiates it. The patient does not ask for the test.”* One respondent described a typical patient flow in more detail: *“With us, it might be a client who is there for follow-up. We already know who is positive and who is negative. The nurse who sees the couple will initiate the counselling and testing. So from the nurse’s room they will send them to the Community Counsellor for testing and counselling. If the result is positive, the patient will be sent to a nurse or counsellor for CD4. And from the counsellor [if the counsellor did the CD4], the same counsellor will open the file. And then the counsellor will send the client to the nurse to initiate treatment. And from there the client will go to another nurse for blood collection. From there the nurse will send the client back to the counsellor for adherence counselling. And from there they will go to the pharmacy and exit.”* If the patient is instead in a hospital, the CC reportedly goes to the patient to do HCT. One respondent claimed that the CCs also circulate through the hospital wards to look for potential clients. All focus groups discussed fairly similar barriers and supports for PITC. They recognized that some clients may become upset or refuse if they are referred to HCT, but emphasized the importance of clients knowing their status, either to start treatment as early as possible or to be counselled about how to remain negative. A shortage of CCs was consistently identified as a barrier to full PITC implementation. Other barriers discussed included:

long queues, lack of HCT supplies, and lack of cooperation by some nurses. Consequently, willingness of health care providers to inform clients about HCT and the availability of rapid testing were identified as key components to facilitating PITC.

Nearly every focus group highlighted the same needs as the most significant factors influencing PITC implementation: space and trained staff. They all described out-dated infrastructure that did not accommodate the growing number of programs for which facilities were responsible. Several focus groups were concerned that insufficient space resulted in a lack of privacy for those being tested and counselled. *“We need proper space, especially at clinics,”* explained one respondent. *“This is a confidential matter and the space is not there. Two nurses cannot work in one space. It is unacceptable – not just for HIV testing. But also for general care. These issues should be addressed immediately.”* Many others described constraints on patient numbers that resulted of inadequate space for HCT. In addition, most respondents were concerned that the full implementation of PITC would place an increased demand on HCT services beyond what current CCs could manage. Thus, many suggested that more CCs should be recruited and that nurses should also be trained. In addition, some pointed to a need for more community awareness about HCT, both so that clients would come for testing and so that when a nurse refers a client for testing (i.e., PITC) the client isn’t alarmed and is more willing to be tested. Within discussions about this question, animosity surfaced about relationships between facilities delivering services and the national office, which, respondents believed, planned and implemented programs without adequately understanding infrastructure and staffing conditions at facilities. One respondent remarked, *“They must come to each facility before they implement all these programs. They must first see if there is enough space to implement all these programs. They just want us to implement programs and programs and programs... We keep piling up these programs on the same number of nurses. And we cannot do all of this. They are proud of these results, but it is us who are suffering. They need us.”*

### **3.7.2 OBJECTIVES AND EVALUATION QUESTIONS ADDRESSED AND KEY FINDINGS OF THE CHAPTER**

The following objectives were addressed in this component of the evaluation:

- Describe the human resource profiles of the currently employed CCs, including: daily work assignments.
- Describe how CCs have affected the workload of health care providers between 2007 and 2012 in the uptake of HCT, PMTCT, TB, and ART services.
- Describe the role of CCs in the implementation of PITC in Namibia, including how PITC is defined, where and how PITC is being implemented in facilities where CCs are based.
- Assess the quality of HCT services provided by CCs.

The specific evaluation questions that were addressed are discussed hereafter:

- Are CCs utilized by health facilities to carry out tasks that are outside of their official job description?
  - CCs are widely assigned duties outside of their job description. Most respondents recognized this problem, but explained that staff shortages compel them to do so. They stated that they ask CCs if they are able and willing to do other tasks. When they do so, respondents interpreted it as a sign that CCs are willing to work as a team in which everyone helps one another as needed rather than as an abuse of CCs.
  - Duties related to patient files were most frequently mentioned.
  - Respondents did not agree about whether the inclusion of these additional duties meant that CCs were over worked or that they were working to their potential.
- What health facility activities rely on the services provided by CCs and what role should CCs play in health facilities and in the health care system in the future?
  - Daily duties were described as including official duties such as HCT, PTMTC testing and counselling,

adherence counselling, health education about HIV/AIDS, referring clients to other services, tracing defaulters, following up with clients in treatment, keeping statistics, and completing monthly reports. They described an array of outside duties such as filing, registering and weighing patients, driving staff to workshops, translating for doctors or pharmacists, taking pill counts and packing medicine, and filling in forms for blood samples as well as maintaining the correct temperatures for the testing room and refrigerator. Respondents in these focus groups repeatedly emphasized that CCs have significantly reduced nurses' workload.

- All respondents asserted that CCs have a great impact on HCT services and HIV/AIDS services more broadly.
- Counselling, in particular, would be very difficult or impossible to accomplish in the absence of CCs, primarily because nurses do not have time to counsel patients properly.
- The impact was frequently perceived to extend beyond HCT services because CCs have relieved some work from the nurses, allowing them more time to focus on other duties.
- Many suggested that, in the future, the CC job description should allow them to do more to relieve nurses' workloads.
- All focus groups suggested that CCs should be provided with opportunities to grow in their career within the Ministry. Many emphasized that the MOHSS should support and encourage CC career growth as a means of increasing retention and not losing the significant experience that CCs have already gained.
- How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?
  - Many respondents included the referral of patients to CCs as a component of their definition of PITC.
  - Most respondents described CCs as an integral part of PITC, as the health care workers to whom patients are referred for HCT. If a patient is in a hospital, the CC comes to the patient to perform HCT.
- What are the current barriers to proper implementation of PITC?
  - Space at facilities and staff shortages were widely identified as barriers to full PITC implementation. Other reported barriers include: long queues, lack of HCT supplies, and lack of cooperation by some nurses.
  - Most respondents were concerned that the full implementation of PITC would place an increased demand on HCT services beyond what current CCs could manage, necessitating the recruitment of more CCs.
- Are CCs able to deliver high quality HCT services?
  - Respondents assessed the quality of HCT services provided by CCs to be generally quite good. They noted both results of quality assurance tests and their perceptions of patient satisfaction in making this assessment.
  - That respondents perceived the HCT to be so dependent on CCs also suggests that the quality of their work is sufficient to successfully maintain the program.
  - Better supervision and regular refresher trainings were widely suggested as means of improving the services CCs provide.



## 4. LIMITATIONS OF THE PROCESS EVALUATION

There were some limitations to how well some evaluation objectives and questions could be addressed based on either study design or data availability.

### 4.1 CC PROFILES

- (a) What is the demographic profile of the currently employed cadre of CCs?

HR data was found to have gaps. For the evaluation, HR data was compared with the results of the CC self-administered questionnaire to estimate the CC HR profile.

- (b) Are CCs utilised by health facilities to carry out tasks that are outside of their official job description?

Because there was no follow-up available with those CCs completing the self-administered questionnaire, it is not possible to better understand how respondents interpreted some concepts that they reported on, especially *'refresher training'* (i.e., does it include on-the-spot training by visiting RMTs), *'supervision'* (i.e., what constitutes sufficient supervision), *'cleaning'* (i.e., own workspace or a clinic floor, for example) and "support" for job-related stress.

A precise assessment of tasks performed outside the official job description is not possible because the official job description is not well defined. Specifically, it includes a clause that states *'Any other duties assigned by the Supervisor'*. As such, the evaluation could only address perceptions of extraneous tasks and did so according to the perspectives of CCs, RMTs and facility-level supervisors.

- (c) How many and what types of trainings are offered to CCs?

In the CC self-administered questionnaire, CCs were asked to report on skills and knowledge gained from their initial training and then asked to report on the number and quality of *'refresher trainings'* they had attended. There was no definition of *'refresher trainings'* in the questionnaire and so the CCs would have responded according to their perceptions of what constituted this sort of training. For example, some may have interpreted *'training'* to constitute something like their initial training – transported to a training site, formal instruction, and so forth. The tool did not allow for follow-up questions to clarify how CCs defined training in answering questions about attending trainings.

The discussion guidelines for RMT KIIs asked specifically about *'in-service training'*. Each tool addressing this question asked specifically about only one type of training and did not precisely define these trainings. CCs did not report on *'in-service training'* received and RMTs did not report on whether and how many *'refresher trainings'* CCs attended. Thus, triangulation is not possible in addressing this question.

### 4.2 ROLES OF CCs IN HCT UPTAKE AND IMPLEMENTATION OF PITC

- (a) What are the current barriers to proper implementation and documentation of PITC?

No tool addressed the documentation of PITC. However, in the course of reviewing records, it was found that the HCT register does not reflect whether a client's test resulted of VCT or PITC.

### **4.3 QUALITY OF SERVICES PROVIDED BY CCs**

- (a) Are CCs able to deliver high quality HCT services?

The NIP QA reports do not record whether the tester is a CC or another health care worker. It is therefore not possible to report on the number of tests or proficiency panels carried out by CCs specifically. Additionally, it is unknown whether the results of proficiency panels reported match the number of panels required by the NIP guidelines.

NIP QA reports and records for 2007 to 2009 were unavailable electronically. These had to be retrieved from the archives and data was abstracted from hard copy records. Where quarterly reports were not available, monthly reports were aggregated to establish the quarterly figures for each of the years of interest.

HCT registers also do not record the post of the tester so it is not possible to check the number of clients a CC sees daily according to their reports against any other data source. One way in which this data might be used would be to check whether CCs see the number of clients outlined in the guidelines for high quality HCT service.

Some HCT registers were missing at particular facilities so that a complete data set was not obtainable.

### **4.4 OTHER**

- (a) Timing of evaluation

The evaluation took place during the time of CCs being transitioned into the MOHSS although the decisions about all CCs had not yet been made. Consequently, it is possible that some respondents in the qualitative sections and the CC self-administered questionnaire approached the questions with this context in mind: concerns such as about how many CCs would be transitioned, whether there would be changes to the post, that a reduction in the number of CCs would increase work burdens on nurses, and so forth, as well as assumptions about challenges that some might hope would be rectified simply via the integration of CCs into MOHSS structures and policies (e.g., critiques of CCs were directed towards the donor and may have overlooked other causes). For instance, their responses may have attempted to provide evidence for a need for CCs at their current or greater numbers or may have underestimated performance problems.

## 5. CONCLUSIONS AND RECOMMENDATIONS

### 5.1 GENERAL OBSERVATIONS

The CCs set out to improve the MOHSS's capacity to provide HCT as an entry point to care and support services in the context of a shortage of health care workers. The CC Programme was implemented in 2004 as a strategy for scaling up HCT, easing some of the burden on overworked nurses and addressing significant HR gaps. The programme trained lay community members, who began as volunteers, on specific tasks related to HCT to allow for some task shifting and scale up of services. This lay cadre remained external to MOHSS structures and processes prior to a transition that began in November 2014. Supervisors and regional managers hope that some existing challenges -- such as discipline, irregular training and insufficient supervision -- with the cadre will be addressed by the transition of all CCs into the MOHSS.

The CC Programme stands as a successful example of training a lay cadre to become effective health care workers. Clients reported satisfaction with the services received from CCs, a finding that was also supported by supervisors' observations and further substantiated by available QA results from the NIP. Supervisors and regional managers reported that CCs had made a significant impact on the provision of HCT (and other) services, helped to provide some relief to nurses via task shifting, and projected that CCs would be ever more necessary with the implementation of PITC.

### 5.2 CC PROFILES

#### 5.2.1 KEY OBSERVATIONS

The 550 CCs at the time of the evaluation were largely females aged 31-40 who spoke, wrote, and read English and who had worked as a CC for at least three years. CCs are reportedly doing many tasks beyond their core HCT duties. However, because the CC job description includes a vague clause -- *'Any other duties assigned by the Supervisor'* -- it is unclear whether CCs are being asked to fulfil inappropriate duties. While CCs believed that their initial training was very helpful to their ability to do their job, CCs, supervisors and managers all saw need for regular refresher trainings that they do not currently have.

- (a) What is the demographic profile of the currently employed cadre of CCs?

According to a review of HR documents, the majority of the 550 CCs were females, with only 30% male. Only 12% of CCs were younger than 31, and 7% were older than 45. Only 13% of CCs worked less than three years as CCs at the time just before the transitioning process of CCs.

A self-administered questionnaire among CCs largely matched HR records. Around 70% of CCs were female, and only 2% have only completed up to Grade 7. Almost all CCs speak, read, and write English. The youngest CC who participated in this part of the evaluation was 23 and the oldest was 59. The majority of CCs were between 31 and 40 years old.

- (b) Are CCs utilized by health facilities to carry out tasks that are outside of their current job description?

CCs are of the opinion that they do more than what is expected of them -- more than what is defined in their job descriptions. In general, they noted that they perform duties such as patient intake, translations and filing, but also pharmacy assistance and cleaning; and they reported that these are not tasks that are defined in their job descriptions. Although these duties are not stipulated in their job descriptions (see Annexure 14) it can be safely assumed that they could be categorized as *'Any other duties assigned by the Supervisor'*.

According to RMTs, CCs are reportedly working almost entirely within their existing job description. Several RMTs commented that CC duties had, in fact, been intentionally restricted in this way because CCs' remuneration was so low.

CCs are widely assigned duties outside of their job description, according to facility-level supervisors. Most respondents recognised this problem, but explained that staff shortages compel them to do so. They stated that they ask CCs if they are able and willing to do other tasks. When they do so, respondents interpreted it as a sign that CCs are willing to work as a team in which everyone helps one another as needed rather than as an abuse of CCs. Duties related to patient files were most frequently mentioned. Respondents did not agree about whether the inclusion of these additional duties meant that CCs were over worked or that they were working to their potential.

(c) How many and what types of trainings are offered to CCs?

Just about all CCs indicated that they were satisfied with their initial training and they were of the opinion that it provided them with enough skills and knowledge to perform quality HCT. Close to 90% have attended refresher trainings. 77% indicated that there is a need for more frequent refresher trainings.

Training of CCs appears inconsistent and irregular across regions. Beyond the initial national-level training, RMTs reported that training largely takes the form of on-the-spot training when they do annual supervisory visits. Some refresher trainings are reported, but funding problems sometimes interfered with training.

## 5.2.2 RECOMMENDATIONS

*Clearly define job description:* At the time of the evaluation, CCs and supervisors expressed uncertainty about the tasks that CCs were being asked to do outside of HCT tasks or even what precisely CCs should and should not do. While some of this uncertainty stemmed from supervisors' lack of familiarity with the CC job description, the imprecise scope of the official job description -- including the clause '*Any other duties assigned by the Supervisor*' -- makes it virtually impossible to define any tasks as lying beyond the work of CCs. The quality of HCT services that CCs provide is compromised by a lack of focus on these services. Thus, with the transition of CCs in the MOHSS and the cadre's new designation as Health Assistants, the new job description should be precisely worded and should clearly prioritise HCT services. Subsequently, CCs and their supervisors should be trained on the scope of this post.

*Strengthen psycho-social support:* While nearly 80% of CCs reported having access to sufficient psycho-social support, there was actually no provision for such support for CCs. Particularly for the kind of work they do and because some are PLWHA, this support is crucial for CCs to be able to counsel others effectively. One component of strengthening this support is to formalise peer support and train CCs to do so. Additionally, they should be included in burnout prevention that is required for certified HCT counsellors<sup>28</sup>.

*Regularise trainings:* CCs, supervisors and regional managers all recognized that irregular trainings left CCs with potential gaps in their knowledge and practice with little means of remedying these gaps. Regional managers reported challenges with transportation for training as one hurdle in the past that would be alleviated if trainings were to be decentralized.

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<sup>28</sup> Ministry of Health and Social Services, Directorate of Special Programmes, 2011

## **5.3 ROLE OF CCs IN HCT UPTAKE AND IMPLEMENTATION OF PITC**

### **5.3.1 KEY OBSERVATIONS**

HCT is almost entirely dependent on CCs, according to both HCT register data and reporting by supervisors and regional managers. Their impact is reported to extend beyond HCT services due to task shifting away from nurses. Many supervisors included the referral of patients to CCs as a component of their definition of PITC and described CCs as an integral part of PITC. Infrastructure and HR shortages were identified by CCs, supervisors and regional managers as the greatest barriers to PITC along with client choice. Regional managers and supervisors were concerned that full implementation of PITC would over burden human resources, especially CCs at their current number.

- (a) What health facility activities rely on the services provided by CCs and what role should CCs play in health facilities and in the health care system in the future?

The available HCT register data shows that CCs are solely responsible for the HCT services provided at facilities. At some sites, CCs are also responsible for HCT at ANC/PMTCT and TB service points. The evaluation team found significant gaps in HCT register data; and the ANC/PMTCT and TB registers likely reflect significant transcription errors.

According to regional managers, CCs have effectively helped to alleviate some of the workload from nurses and that impacts all service provision at facilities. HCT is deemed to be almost entirely dependent on CCs. Far fewer clients would access these services were it not for CCs and the quality of service provision would be inferior in their absence, according to all RMTs.

Facility supervisors described CCs' daily duties as including official duties such as HCT, PMTCT testing and counselling, adherence counselling, health education about HIV/AIDS, referring clients to other services, tracing defaulters, following up with clients in treatment, keeping statistics, and completing monthly reports. They described an array of outside duties such as filing, registering and weighing patients, driving staff to workshops, translating for doctors or pharmacists, taking pill counts and packing medicine, and filling in forms for blood samples as well as maintaining the correct temperatures for the testing room and refrigerator. Respondents in these FGDs repeatedly emphasized that CCs have significantly reduced nurses' workload. All respondents asserted that CCs have a great impact on HCT services and HIV/AIDS services more broadly. Counselling, in particular, would be very difficult or impossible to accomplish in the absence of CCs, primarily because nurses do not have time to counsel patients properly. The impact was frequently perceived to extend beyond HCT services because CCs have relieved some work from the nurses, allowing them more time to focus on other duties. Many suggested that, in the future, the CC job description should allow them to do more to relieve nurses' workloads. All FGDs suggested that CCs should be provided with opportunities to grow in their career within the Ministry. Many emphasised that the MOHSS should support and encourage CC career growth as a means of increasing retention and benefitting from the significant experience that CCs have already gained.

(b) How have CCs contributed to the uptake of HCT services and the provision of PITC in health facilities?

According to estimations by CCs, almost 60% of CCs provide HCT to up to ten clients per day, on average. Eighty-seven percent of CCs felt that patients come to the health facility for another issue and are referred for testing by a nurse or doctor, while 58% felt that clients come to the health facility for another issue and are referred for testing by themselves or another CC. Both of these options constitute PITC. CCs have indicated that they can provide HCT to more clients than those to whom they are currently delivering these services.

Fifty-three percent of clients exiting the CC's office or area indicated that the reason for their visit to the facility on the day of the interview was for HIV testing. Another 21% visited the facility for ANC. Seventy-five percent of respondents indicated that a CC spoke to them about HIV on the day that they got tested. When asked who the first person was to suggest that they get tested on the day, 35% reported that it was a CC and 20% said that it was a nurse. The remainder indicated that they asked for the test themselves. When asked why they got tested, 36% indicated that they wanted to know their status, 33% indicated that the provider suggested the test or that it was part of the visit and another 11% indicated that it was a three-month window period test.

Many facility-level supervisors included the referral of patients to CCs as a component of their definition of PITC. Most respondents described CCs as an integral part of PITC, as the health care workers to whom patients are referred for HCT. If a patient is in a hospital, the CC comes to the patient to perform HCT.

(c) What are the current barriers to proper implementation and documentation of PITC?

According to CCs about 66% of those referred for HCT by doctors and nurses do not end up getting tested. The main reasons for not getting tested after being referred are cited as client choice; waiting time for HCT services, and lack of infrastructure (HCT rooms too far from the screening rooms).

Although the majority of clients felt that HIV testing should be recommended to all patients who visit a facility, irrespective of the reason for their visit, around a third of respondents were opposed to this. They were of the opinion that patients should have a choice, and that not all patients or clients are ready to know their HIV status.

HR limitations (numbers and training), infrastructure constraints on space in which to provide HCT services, and community resistance were identified by RMTs as the greatest barriers to the successful implementation of PITC.

Space at facilities and staff shortages were widely identified by facility-level supervisors as barriers to full PITC implementation. Other reported barriers include: long queues, lack of HCT supplies, and lack of cooperation by some nurses. Most respondents were concerned that the full implementation of PITC would place an increased demand on HCT services beyond what current CCs could manage, necessitating the recruitment of more CCs.

No component of the study protocol evaluated the documentation of PITC.

### **5.3.2 RECOMMENDATIONS**

*Prioritise Monitoring and Evaluation:* Accurate data regarding HCT is necessary to track its effectiveness and to understand the impact of PITC implementation. The significant gaps in HCT data found in the course of this evaluation thus pose a challenge to successful HCT and PITC planning and financing. Monitoring and evaluation should be prioritised and motivated from the facility to the national-levels. Specific improvements might include training CCs to enter their own data,

ensuring data clerk posts are sufficient in number and filled or digitalising data capture. In addition, the registers should be redesigned to effectively capture all data points of interest to monitor and evaluate activities. An external dashboard study of one particularly important domain of data capture may assist in identifying and finding solutions for some of the challenges with existing data collection processes.

## **5.4 QUALITY OF SERVICES PROVIDED BY CCs**

CCs were found to provide HCT services of satisfactory quality. Based on available data, they were found to be technically proficient in conducting tests and to be knowledgeable, trustworthy and respectful in their interactions with clients.

### **5.4.1 KEY OBSERVATIONS**

#### **(a) Are CCs able to deliver high quality HCT services?**

According to the NIP EQA reviews from 2007 to 2013, it is clear that the quality and accuracy of HIV testing in Namibia is high. Retesting of CCs or a new site's first 50 or 10 samples found less than 1% discordance in any given year. The same degree of discordance was found for re-tests of 1 in 20 client tests. Proficiency Panel Tests were found to be less than 5% discordant for all years. However, these figures represent testing done by both health care staff and CCs at facilities and it was not possible to disaggregate CC data. Additionally, it is not known whether the expected number of Proficiency Panel Tests was conducted and there is uncertainty as to whether this gap results of NIP not sending out panels or facilities not returning them.

FGDs with facility supervisors also reported that CCs provide high quality HCT services. Respondents described the quality of CCs' service provision as "good", "high", or "excellent". They noted both results of NIP quality assurance tests and their perceptions of patient satisfaction in making this assessment. One respondent suggested that the perceived waning stigma of getting tested reflected positively on the level of service that CCs provide. Factors that could improve services included: better supervision, regular refresher training, better remuneration, and opportunities for career growth.

#### **(b) Are clients generally satisfied with HCT services?**

Facility supervisors assessed clients to be satisfied with HCT services provided by CCs. They had not received complaints; and they interpreted the increasing number of clients coming for testing as a further reflection of client satisfaction.

Client exit interviews also found a high level of satisfaction with CC service provision. The majority of those who participated in these interviews felt that the time spent with the CC was sufficient. Just about all respondents felt that the CC conducted him/herself in a respectable manner, put them at ease, explained the results adequately, and listened to them. Ninety-seven percent of respondents felt that the CC provided them with enough information, 93% felt they were able to ask questions and 93% believed that their information would be kept confidential. Ninety-five percent of respondents rated their overall experience with the CC as either good or very good and 96% of respondents indicated that they would recommend the facility to family and friends for testing.

## 5.4.2 RECOMMENDATIONS

*Performance monitoring:* With the transition of CCs to the Ministry, MOHSS took in CCs who did not meet minimal requirements, a policy supported by RMTs. While this takes advantage of the skills and experience gained by current CCs, it also means that previously unresolved performance issues remain. Using the new Health Assistant job description and MOHSS guidelines, there should be improved monitoring and enforcement of CCs' performance, with disciplinary action taken as needed.

*Performance criteria should include those of NIP QA guidelines after initial certification:* internal quality controls on a rotational basis and per Annexure E of the *Guidelines and Standard Operating Procedures for HIV Rapid Testing*, 95% conformance of 1 in 20 (5%) retesting samples (per site, one month per year) and 90% conformance of proficiency panels on a rotational basis. It would also prove helpful if QA procedures and results could be correlated with individual testers to more accurately monitor performance.

*Enforce NIP QA controls and corrective action:* Ensure NIP sends internal quality control samples (beginning of every second month) and proficiency panel samples (approximately once every three months). Site must return samples and results to NIP Windhoek or nearest NIP laboratory. The site supervisor is responsible for detecting, documenting and resolving problems with the testing process at each site. NIP will issue quarterly QA reports by site to the MOHSS via the National VCT coordinator, DSP office and make recommendations for corrective action as needed. NIP will communicate with designated rapid testing site supervisors, who should then provide feedback to CCs. Unskilled testers must be replaced by competent testers or at least while they are retrained. Failure to take corrective action, as assessed by NIP, can result in closure of a testing site by the inspecting body of the MOHSS.

*Improve Supervision:* Locate CCs within the MOHSS HR structure such that adequate supervision is possible. According to regional managers and supervisors, using nurses to supervise CCs has proven ineffective due to nurses' existing workload. Developing a tiered structure for the new Health Assistant cadre would be one means of improving supervision<sup>29</sup>. Currently, site supervisors are expected to do daily supervision, regional and district supervisors are expected to visit facilities on a quarterly basis, depending on their workplans. Site visit reports are specified as a deliverable to these site visits. The national office may visit regions quarterly or every six months.

*Develop standards for service delivery where they do not exist:* A standard for client waiting times for HCT services should be developed along with means of monitoring compliance. Section 4.3.2 of the National Guidelines for HIV Counselling and Testing in Namibia state that waiting time should be minimized to no more than two hours.

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<sup>29</sup> Note that as per the Guidelines and Standard Operating Procedures for HIV Rapid Testing, MOHSS 2012, CCs must be supervised by a health care worker trained in RT.



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