Monitoring the Outcomes of Orphans and Vulnerable Children Programs in Namibia

Project Hope Namibia
2016 Survey Findings

August 2017

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MEASURE Evaluation

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Cover photo: A caretaker for orphans and vulnerable children (OVC) holds a child in Namibia.

All interior photos: Lizl Stoman

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ABBREVIATIONS

ART	antiretroviral treatment
CAA	Catholic AIDS Action
CHBCP	community home-based care provider
COP	country operations plan
DATIM	Data for Accountability, Transparency and Impact Monitoring
FP	family planning
MER	monitoring, evaluation, and reporting
MGECW	Ministry of Gender Equality and Child Welfare
MOHSS	Ministry of Health and Social Services
MUAC	mid-upper arm circumference
NARP	Namibia Adherence and Retention Program
NDHS	Namibia Demographic and Health Survey
NSA	Namibia Statistics Agency
NSF	National Strategic Framework for HIV/AIDS 2010/11-2016/17
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHN	Project HOPE Namibia
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
SDM	service delivery models
SOP	standard operating procedure
SPSS	Statistical Package for Social Sciences
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Study Background

In 2014, the United States President's Emergency Plan for AIDS Relief (PEPFAR) introduced a set of outcome indicators for programs serving orphans and vulnerable children (OVC), referred to as the Monitoring, Evaluation, and Reporting (MER) Essential Survey Indicators. PEPFAR requires these indicators to be collected every two years by a research organization external to the OVC program. These outcome indicators reflect internationally accepted developmental milestones; together, they measure the holistic well-being of children over time. A standard survey method and tools have been developed to collect these data in countries where PEPFAR is supporting OVC programs. PEPFAR/Namibia asked MEASURE Evaluation—funded by the United States Agency for International Development (USAID) and PEPFAR—to conduct a survey to collect these indicators for Project HOPE Namibia (PHN).

Objectives of the Study

The purpose of this survey was to collect the first round of indicators for enrolled active beneficiaries of PHN. PHN and other partners and stakeholders will use the findings from this survey to meet PEPFAR's national and global reporting requirements. The findings will also inform program planning by OVC policymakers and program managers in Namibia and across the region.

Survey Design and Methods

MEASURE Evaluation, in partnership with Survey Warehouse, a market research firm in Namibia, conducted a household survey using a two-stage cluster sampling approach from among currently enrolled beneficiaries PHN. The survey took place between November and December 2016. Forty clusters were randomly selected using probability proportional to size (PPS) methods. Within each cluster, 15 households were randomly selected to yield a total sample size of 600 households. Primary caregivers of OVC were interviewed (one caregiver per household) about the program services received or accessed and/or activities offered by the project, for the general health and well-being of the children in the household. The data were collected with a standard questionnaire programmed into smartphones using the Mobenzi Researcher mobile data capture system.

Primary caregivers of children ages 0–17 years were interviewed about themselves, their respective households, and all the children under the age of 18 years for whom they were responsible in the household. Besides asking questions necessary for specific OVC MER essential indicators, data collectors took mid-upper arm circumference (MUAC) measurements for all children between 6–59 months who were at home during the survey period.

Survey data from the Mobenzi Researcher platform were exported to Statistical Package for Social Sciences (SPSS) and Stata software to facilitate data exploration, cleaning, and analysis. Descriptive univariate and cross-tabulation analyses were carried out to generate the required OVC MER essential indicators and other characteristics of the study population. Where applicable, statistical significance tests

of proportions for the indicators were conducted to assess whether observed differences between sex, residential location, and/or age categories result from chance alone or are real differences based on a set level of statistical significance.

Major Findings

Table 1 summarizes the findings of the nine OVC MER Essential Survey Indicators for Namibia. These are overall findings for respective age ranges of the child indicator and both sexes combined.

Table 1. OVC MER Essential Survey Indicators for Namibia

MER Essential Survey Indicators	Percent	95% Confidence interval
OVC_HIVST: Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status	55.5	(53.5, 57.4)
OVC_NUT: Percent of children (aged 6–59 months) who are undernourished	11.3	(9.1, 14.0)
OVC_SICK: Percent of children (aged 0–17 years) too sick to participate in daily activities	22.3	(20.7, 24.0)
OVC_BCERT: Percent of children (aged 0–17 years) who have a birth certificate	56.8	(54.9, 58.8)
OVC_SCHATT: Percent of children (aged 5–17 years) regularly attending school	69.5	(67.3, 71.7)
OVC_PRGS: Percent of children (aged 5–17 years) who progressed in school during the last year*	73.7	(71.2, 76.0)
OVC_STIM: Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	59.0	(55.3, 62.5)
OVC_CP: Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or at school	61.8	(57.8, 65.6)
OVC_MONEY: Percent of households able to access money to pay for unexpected household expenses	55.3	(49.2, 1.1)

Discussion

Nine PEPFAR OVC MER Essential Survey Indicators were collected in this study. Except for Indicator CW 14 (primary caregivers who agree that harsh physical punishment is an appropriate means of discipline for a child), findings from this survey show that Namibia is making progress. Very few differences between males and females or across age groups were statistically significant. Six of the nine indicators (NC.1, CW.9, CW.11, CW.12, CW.13, and HW.2) were expected to have high percentages (over 55%), indicating progress. The remaining three were expected to have low percentages, indicating progress (CW.1, CW.4, and CW.14). In the absence of baseline or other data from Namibia for

comparison, the findings are considered consistent with those reported in other countries. A few differences emerged when disaggregating these indicators by age and sex, however. Approximately one in every 10 children ages 6–59 months were undernourished, and about one-fifth of the beneficiary children ages 0–17 years have had physical or mental health issues, as indicated by the percentage of children too sick to participate in daily activities during the last two weeks preceding the survey. This is somewhat alarming. More awareness and counseling on nutrition, childhood illnesses, and early detection of diseases should be promoted in the communities.

There were limitations and challenges during the implementation of the study, both with the sampling frame (list of beneficiaries provided by PHN) and field implementation (locating households and beneficiaries). The field teams struggled to identify adequate numbers of households that were registered by the program to receive services through Catholic AIDS Action (CAA). For one of the following reasons, not all originally sampled clusters had the required number of eligible households and beneficiaries:

- Those households did not exist.
- There were duplicate records in the list of beneficiaries.
- Households/beneficiaries had moved.
- Households/beneficiaries were no longer eligible to receive services (had been discharged).

Yet these households/beneficiaries appeared in the database as program beneficiaries. Alternative approaches had to be taken to replace communities that were no longer receiving services, to ensure that the sample size would be maintained.

This study was the first of its kind in Namibia and serves as a baseline for similar studies in the country, ongoing and planned. Lessons learned from the challenges encountered in this study's implementation will shape and improve follow-up studies on OVC MER Essential Survey Indicators. More important, findings from this survey will contribute to PEPFAR's Data for Accountability, Transparency and Impact Monitoring (DATIM) project, for which data on the nine indicators are required.

INTRODUCTION

This report presents data on outcomes of a program to improve the well-being of orphans and vulnerable children in Namibia. These findings will support evidence-informed strategy, programming, and resource allocation by Namibian stakeholders: PEPFAR/Namibia, the Namibian government, implementing partners, and others. They will also contribute to PEPFAR's global evidence base on the effectiveness of PEPFAR's OVC programming.

The HIV epidemic has increased the number of OVC in Namibia, as it has worldwide. The government of Namibia responded to this growing population by adopting the National Strategic Framework for HIV/AIDS 2010/11–2016/17, which makes support for OVC a key objective (Namibia Ministry of Women Affairs and Vulnerable Children, 2004). Support includes ensuring equitable access to emotional, social, material, and school-related support.

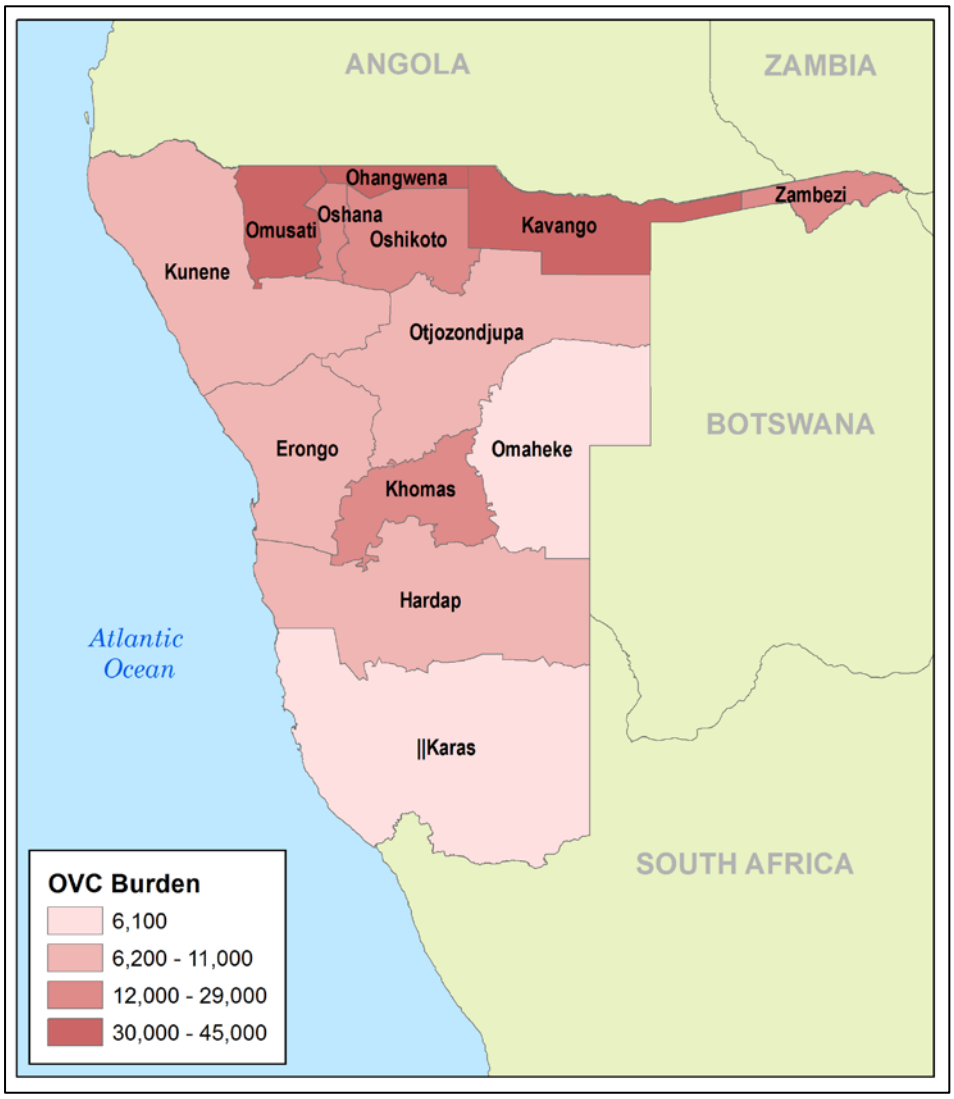
The Joint United Nations Programme on HIV/AIDS (UNAIDS) calls on countries to reach the following targets by year 2020: 90 percent of all people living with HIV (PLHIV) will know their HIV status, 90 percent of all people with diagnosed HIV will be on sustained antiretroviral therapy, and 90 percent of all people receiving antiretroviral therapy will have viral suppression (UNAIDS, 2014). PEPFAR/Namibia, collaborating across U.S. Government agencies, supports the Government of Namibia to attain the global 90-90-90 goals. It also supports the Namibian Ministry of Health and Social Services (MOHSS) to review, adopt, and adapt the new World Health Organization (WHO) guidelines, including differentiated service delivery of HIV care to increase service efficiencies and impact. Differentiated service delivery is a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of PLHIV while reducing unnecessary burdens on the health system (WHO, 2016), and the phased implementation of the "treat all" approach, multi-month scripting, and community involvement in linkage, adherence, and retention (PEPFAR/Namibia, 2012). PEPFAR/Namibia's Country Operational Plan for fiscal year 2017 (COP 16) reaffirms the focus on scaling up programs and services to reach over 80 percent antiretroviral therapy (ART) coverage among all PLHIV by 2017, and especially targeting areas with the highest HIV burden and unmet HIV treatment need (PEPFAR/Namibia, 2016).

As of June 2013, Namibia had a generalized HIV epidemic with a prevalence of 14 percent for people ages 15–44 (MOHSS & ICF International, 2013), making HIV one of the country's greatest public health challenges. As of 2013–2014, the number of PLHIV, ages 15 years and above, was estimated to be 260,000. The revised 2015 estimate projects the number of PLHIV to increase to more than 273,000 in 2017, and to more than 296,000 by 2020 (MOHSS, 2015). From 2010 to 2014, the number of new infections in Namibia remained relatively stable, at 11,000 per year; even so, HIV remains the leading cause of death in the country. There are an estimated 250,000 OVC, ages 18 or younger in Namibia (MOHSS & Macro International, Inc., 2008). Many of these children have been affected by HIV. According to the MOHSS, 45 percent of orphans have lost one or both parents to HIV-related illnesses. According to UNAIDS estimates, Namibia has approximately 45,000 orphans between the ages of 0 to 17 years because of HIV (UNAIDS, 2015). HIV is a considerable burden to the young residents of Namibia. Not only do OVC become vulnerable when their parents die. Often these children, especially girls, are tasked to take care of their ailing parents. Sometimes they earn income through activities that endanger their lives. These OVC often lack the guidance and protection of their parents, and they are exposed to poverty, disease, natural disasters, child trafficking, early work, and forced conscription. They

often experience abandonment, and some even lose their inheritance rights when their parents die. OVC are likely either to live in institutions or on the streets of major urban centers in Namibia. Often when they are placed in foster care, they are exposed to heightened vulnerabilities with new households' limited emotional, financial, and material resources.

Figure 1 shows the geographic distribution of OVC by region in Namibia as of 2007. The regions with the highest OVC burden are Ohangwena, Omusati, Kavango East and West, Oshikoto, Oshana, Zambezi, Otjozondjupa, and Khomas. These same regions also have the highest numbers of people living in poverty in Namibia. There is clear overlap in the geographic distribution of OVC burden and poverty, which also aligns closely with the geographic distribution of HIV prevalence in Namibia, suggesting prioritization options for USAID/Namibia programming.

Figure 1. Map of Namibia showing OVC burden (Source: USAID Report on Analysis of USAID/Namibia's OVC Landscape, November 2014)



BACKGROUND

Appropriate OVC programming and actions are key to improving the well-being of OVC. USAID/Namibia, in partnership with the government of Namibia, is supporting many initiatives to alleviate the HIV epidemic in the country.

Project HOPE Namibia (PHN) and Catholic AIDS Action

One of the initiatives funded by PEPFAR and supported by USAID/Namibia is the implementation of the Namibia Adherence and Retention Program (NARP) through a consortium of partners, of which PHN is a prime partner. NARP aims to strengthen adherence and retention in HIV care and treatment (including prevention of mother-to-child transmission) and to mitigate the impact of HIV on PLHIV and those affected (OVC and caregivers). Overall, the project covers 14 health districts in eight regions in the country. PHN has taken on the challenges of the AIDS epidemic by educating, training, empowering, strengthening, and motivating those who are HIV-positive, those affected by the virus, and all concerned individuals and groups at all levels. It focuses on several targets, including home-based care and counselling in communities through establishing networks; cooperating with traditional leaders to educate the communities about HIV/AIDS; engaging in education and awareness campaigns about HIV/AIDS through community participation and provision of care and support for people living with the pandemic, including OVC. In 2005, PHN specifically began implementing programs to address the increased economic needs of OVC households by providing economic strengthening opportunities, micro-credit loans or savings groups, and health and parenting education. The organization developed an OVC-targeted educational curriculum for caregivers, which addressed essential OVC care and support. PHN provides financial support (in the form of loans) to women taking care of OVC. These loans aim to help women to become self-sustainable to support their families, contributing to job creation and the Namibian economy.

In communities largely burdened by the HIV pandemic, PHN is working in partnership with Catholic AIDS Action (CAA), a nongovernmental, nonprofit, nonpolitical organization, in following up the affected households, maintaining a database for beneficiary households and individuals, and delivering the needed services to affected communities, households, and children. Among many program services and activities that CAA engages in, it works to ensure that OVC receive love, care, and other services that they are entitled to and equips them with personal knowledge and skills. Their services and activities aim to enable OVC to live responsible lives and to avoid the risks of acquiring HIV. CAA aims to ensure that those who are HIV-positive live longer, without discrimination, and that their lives are better emotionally, spiritually, and physically.

The interventions delivered by PHN are expected to lead to improved well-being of children under the age of 18. Interventions focused on OVC are delivered by CAA to all members of enrolled households in several regions of Namibia.

Phasing Out Districts, Communities, and Beneficiary Groups or Households by PHN

At the time of planning the OVC MER Essential Survey Indicators study, PHN was transitioning its record-keeping and archiving platform from the ACCESS database to the REDCAP database. (For more details about this transition from ACCESS to REDCAP, contact PHN.) This transition involved updating information on the beneficiary children and caregivers in the new database. PHN was also phasing out its involvement in some districts and expanding its activities in others. Districts and communities that PHN phased out are considered ***sustained.***

According to the standard operating procedures (SOPs) of the PHN and CAA, community home-based care providers (CHBCPs) across all program areas conduct household assessments and enroll (register) vulnerable households identified by the assessment tool. Once the needs for the household are identified, an intervention plan is developed in consultation with the household members, including an agreement to discharge the child or household once the needs are met and no new needs emerge. The SOPs document program interventions and specify the following roles for regional project staff:

- Maintaining a database of vulnerable households, children, and caregivers that is earmarked for specific interventions and forms of support
- Monitoring the implementation of program services and activities, including monitoring CHBCPs and the respective referral points
- Checking and validating forms and reports received from CHBCPs and others
- Submitting monthly reports to national office
- Following up with CHBCPs, referral points, and households, ensuring that support is being provided

Once the specific needs of a household have been met, visiting the household and providing the program services are no longer necessary. After the satisfactory intervention, the CHBCP is tasked to carry out a reassessment and discuss the outcome with the household members, the family, a treatment supporter, or a primary caregiver. All should agree that there is no longer a need for support or intervention, and that household members can cope by themselves. The household is considered discharged from the program from this point forth. The CHBCP completes a discharge form and files it with the regional office, where it is verified and captured. On the database, the household's status is changed, and the household is then hidden on the database. This household is then considered sustained.

PEPFAR MER OVC Essential Survey Indicators Study

The overall objective of the survey is to collect OVC MER essential indicators for enrolled active beneficiaries of PHN. The PEPFAR team requested the assistance of the USAID- and PEPFAR-funded MEASURE Evaluation to implement the survey in Namibia. MEASURE Evaluation, in partnership with its subcontractor, Survey Warehouse, conducted the survey, collecting the OVC MER outcome indicator data using a standard survey method and tools that MEASURE Evaluation previously developed on behalf of PEPFAR for these purposes (MEASURE Evaluation, 2014).

The survey is designed to answer the question: *What is the well-being of child participants in the Project HOPE PEPFAR-funded OVC projects in the seven health districts of Namibia?* The survey assessed the well-being of

child beneficiaries enrolled in PHN at the end of 2016. OVC well-being is measured by eight dimensions through the nine MER essential indicators. These are shown in Table 2. PEPFAR requires data for the MER essential indicator survey to be collected every two years so that progress can be tracked over time. This report, however, covers only data at one point in time: that is, the first round of data for these indicators in Namibia.

Table 2. PEPFAR MER Essential Survey Indicators for OVC programs

No.	Indicator	Rationale for inclusion
OVC_HIVST	Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status	If a child's HIV status is unknown to her/his caregiver, the child will not have access to life-saving care, treatment and support interventions.
OVC_NUT	Percent of children (aged 6–59 months) who are undernourished *For this indicator, the interviewer will obtain measurement of mid-upper arm circumference (MUAC) for children ages 6–59 months. It is the only indicator whose measurement requires direct interaction with a child.*	Nutrition is a critical factor in reducing infant mortality and builds a strong foundation for a child's health, growth and development.
OVC_SICK	Percent of children (aged 0–17 years) too sick to participate in daily activities	PEPFAR OVC programs support critical linkages to health services and treatment, aiming to reduce the number of sick children and improve functional well-being.
OVC_BCERT	Percent of children (aged 0–17 years) who have a birth certificate	Ensuring children access to basic legal rights, such as birth certificates, enables them to access other essential services and opportunities, including health, education, legal services, and legal employment when they grow older. Birth certificates are mandatory to receive social grants by OVC from the Ministry of Gender Equality and Child Welfare (MGECW)
OVC_SCHATT	Percent of children (aged 5–17 years) regularly attending school	In addition to being important in its own right, keeping children in school has positive impacts on HIV prevention.
OVC_PRGS	Percent of children (aged 5–17 years) who progressed in school during the last year*	Studies in many countries have linked higher education levels with increased AIDS awareness and knowledge, higher rates of contraceptive use, and greater communication regarding HIV prevention among partners.
OVC_STIM	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	Early childhood cognitive, social and physical stimulation is essential for promotion of long-term learning, growth, and health.
OVC_CP	Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school	Reducing harsh physical discipline, violence and abuse against children is a PEPFAR priority. Perceptions of physical discipline have been linked to actual use of physical discipline against children.
OVC_MONEY	Percent of households able to access money to pay for unexpected household expenses	The key goal of household economic strengthening programs is to improve household's resiliency to economic shocks, such as unexpected household expenses. Child well-being is assumed to be affected by the household's resiliency to economic shocks.

The survey was the first of its kind and serves as the first round of data collection for PHN. It covered seven health districts in Namibia (Andara, Nankudu,[1] Nyangana, Rundu, Eenhana, Engela, and Katima Mulilo) in three regions of Namibia (Kavango, Ohangwena, and Zambezi). Of these seven health districts, two were urban and seven were rural. Data were collected in November and December 2016 (see Appendix C for maps showing data collection regions and communities).

[1] Nankudu was eventually discarded from the sample, because it was considered sustained at the time of data collection, and CAA no longer provided services there. Therefore, the district did not contain any active households. Rundu district was oversampled to maintain the sample size. (See "Survey Limitations.")

STUDY DESIGN AND METHODS

Design of the Study and Sample Size

Many OVC-related studies interview only the beneficiary children in the household—usually one child in the age group 0–4 years and one child in the age group 5–17 years. Unlike other studies, this one asked primary caregivers some questions about all children ages 0–17 years for whom they are responsible, who resided in the beneficiary households.

The design for this study in Namibia was a cross-sectional survey, aimed at assessing the well-being of vulnerable households, primary caregivers, and children enrolled in the PHN program. For purposes of the survey, a representative sample of active beneficiaries and their respective households from three regions where PHN and its implementing OVC partner, CAA, operate was determined. For this study in Namibia, it was recommended to have about 40 clusters with about 15 households per cluster. With this in mind, we worked on the minimum number of households that will be required to meet the criteria using the following inputs: effect size (f) = 0.20, alpha error probability = 0.05, and power =0.95, stratified by sex, two age groups and rural-urban disaggregation using Excel. According to our calculations, a sample size of about 560 households would be sufficient for detection of small differences between groups and over time. This works out to be about 14 households per cluster in the 40 clusters. Our calculations aligned very well with the recommended 40 clusters and 15 households per cluster.

Therefore, for this baseline study, we maintained a total of 40 clusters and 15 households per cluster as recommended for the study. For the cluster allocation and selection of households within a cluster, we employed a two-stage cluster sampling approach whereby communities or clusters served by the project were first selected using probability proportional to size (PPS), and then the number of households within selected clusters were randomly selected.

Initially, it was proposed that the study should cover 10 districts in which PHN operates. However, three of the 10 districts (Walvis Bay, Swakopmund, and Okongo) were excluded from the sampling frame, because PHN transitioned out of these districts. These three districts were no longer active, and hence were considered sustained. Only active districts were included and can potentially be followed up in the next OVC MER survey—two years from the time of this survey. Hence, seven districts were maintained in the sampling frame from which clusters and sample households were selected.

Selection of the 40 clusters from the seven districts was based on a PPS approach, among all the communities in the three regions served by PHN. The larger the district's population, the bigger the chance or larger the number of clusters to be selected. A cluster was defined as a community or location in which PHN/CAA was operating within a district. To determine the number of clusters per district, we listed the total population in each of the seven health districts, obtained from the Namibia Statistics Agency (NSA). We then calculated the cumulative population across all seven districts and divided the grand total by 40 (the number of total clusters required) to get the sampling interval. Using a table of random numbers, we then selected a random number less than, or equal to the sampling interval—having the same number of digits. This formed the first cluster. To get the second cluster, we added the sampling interval to the initial random number. And we obtained the third cluster by adding the sampling interval to the second cluster, and so on, until the fortieth cluster was determined, by adding the sampling interval to the thirty-ninth cluster.

For each cluster, 15 households were required to get the 40 x 15 = 600 households required for our sample. In Namibia, given the challenges in terms of accuracy of the beneficiary list kept by the project, and in anticipation of the need to replace households, we decided to randomly select 25 households per cluster from the sampling frame (beneficiaries list) at one time, using a computer-based, random number-generator application. For each cluster, the first 15 households from the cluster sample served as the main sample that interviewers were required to visit. The additional 10 households in each cluster were selected in the event that a household in the first 15 needed to be replaced for some reason. See the section on "Survey Limitations" in this report for details on the challenges encountered with the sampling frame and field implementation. Table 3 shows the eventual survey location (region and district), number of clusters, and number of beneficiary households included in the survey. (Also see Appendix D for maps showing study sites.)

Table 3. OVC MER Essential Survey Indicators location and sample size, Namibia

Region	Health district	Total population size	# of beneficiary households from PHN	# of beneficiary children ages 0-17 years from PHN	# of clusters selected per district for MER OVC	# of beneficiary households per district
Kavango East/West	Andara	29,479	372	463	3	45
	Nankudu*	38,601	104	148	3	45
	Nyangana**	21,966	271	327	2	30
	Rundu	63,431	211	643	6	90
Ohangwena	Eenhana	82,519	116	354	5	75
	Engela	153,820	929	2,220	13	195
Zambezi	Katima Mulilo	98,849	426	688	8	120
Total		**488,665**	**2429**	**4,843**	**40**	**600**

*Note that during field data collection, when the teams reached Nankudu district, they found out that the entire district no longer received services from PHN or CAA; this district was also sustained. As a result, the three clusters from Nankudu had to be selected from the remaining districts in the Kavango region.

** In Nyangana, interviewers were informed that some beneficiary groups/communities overseen by community volunteers that were included in the original sample had been sustained. Replacement was done within the same district using information provided by the volunteers on households that are active beneficiaries.

Data Collection Tools, Training, and Field Implementation

Two population groups who were registered as active beneficiaries with PHN at the time of the survey were targeted:

- Primary caregivers ages 18 years or above
- Children ages 0–17 years (questions directed to the primary caregiver)

In early November 2016, a team of six project supervisors tested the standard method and tool in the Erongo Region, in the Walvis Bay health district. The Walvis Bay and Swakopmund health districts were not included in the study sample, because they were phased out at the time of the survey. Hence, they were good candidate districts for testing the questionnaires (in Walvis Bay) and to conduct pilot field practice (in Swakopmund). Testing confirmed that the tool had been adapted and translated properly for the Namibian context. The tools were translated into major local languages spoken in the study sites: Afrikaans, Oshikwanyama, Rukwangali, and Silozi.

Following the test exercise and finalization of data collection tools, a training workshop for data collectors and supervisors was held in Swakopmund, in the Erongo Region, from November 7–11, 2016. MEASURE Evaluation and Survey Warehouse facilitated the workshop. Twenty-four data collectors "|present during the workshop's introductory sessions. Training included both in-class sessions and practical sessions (both drama scenarios and pilot field work). Topics were an introduction to PEPFAR's OVC MER Essential Indicators, background on PHN and CAA activities in Namibia, and the goal and objectives of the data collectors' training, with specific learning objectives. Participants were introduced to definitions of terms related to household well-being and the OVC MER Essential Survey Indicators. They were also introduced to general and applied ethics of data collection and to child protection policy in general and specifically for Namibia. Moreover, the training covered issues related to measurement of the MUAC for children ages 6–59 months, questionnaire administration, both paper-based and electronic data capture, location of beneficiary households while in the field, how data collectors should introduce themselves in the communities and households where they would conduct the interviews, how to identify the appropriate caregiver who would be responsible for responding to questions in the questionnaires, and how to obtain that person's consent to participate in the study. In addition, participants were trained to use mobile phones installed with Mobenzi Researcher data capture software during interviews and data collection. One day of the training was set aside for pilot testing of the standard method and tool. (See Appendix B for a list of study team members.)

Field teams and supervisors preparing for a pilot field visit in Erongo Region, Swakopmund Health District, Swakopmund

The week immediately following the training was set aside for finalizing questionnaires (including correcting the translations in the local languages), sorting out issues found with the Mobenzi Researcher data capture system during the pilot test, and planning field execution and deployment of teams in the field. Interviewers were grouped into four teams, with each team having one supervisor. Field teams were deployed to the regions in the north of Namibia from November 18, and data collection officially began on November 21, 2016. Two teams were deployed in Ohangwena region, one team in Kavango region, and one team in Zambezi region. As stated earlier, the survey was conducted among households that had been registered to receive services from CAA.

The survey originally used cluster sampling of 40 project sites located in the seven districts. In each cluster, 15 households were earmarked for interviews in order to render a total sample size of 600 households. With the sustained status of the entire Nankudu district, as well as some sustained households/communities in Nyangana and Andara districts, teams had to oversample in some of the clusters in an attempt to reach the final sample size of 600.

Very soon, teams depleted their initial sample lists prepared by MEASURE Evaluation and Survey Warehouse. Teams were directed to consult with local CAA representatives and volunteers to obtain additional lists with active households within each cluster. The lists received from volunteers during data collection were matched to the original lists that were prepared initially, for removal of duplicates. From the short list of new households obtained from volunteers, a random sample of households required to meet the quota was selected and interviewers visited these households to get the required 15 households per cluster/community. During fieldwork, data collection teams managed to conduct between eight and nine interviews per day on average, with each interviewer averaging about two interviews per day.

Identifying and locating households in Kavango Region, Nyangana Health District

Three types of questionnaires were used during data collection, all consolidated in a single questionnaire separated into sections for the three target population groups. The first questionnaire was for the primary caregivers of children 0–17 years of age, who were interviewed about themselves, the household, and the children they are responsible for in the household. The second (for children 0–4 years of age) and third (for children 5–17 years of age) questionnaires were for all children under the care of the primary caregiver who slept in the household on the night before the survey. Primary caregivers of these children were interviewed on behalf of the children and responded to all the questions in all three sets of questionnaires (see Appendix A for questionnaires used).

Field teams worked with CAA regional representatives and CAA volunteers to locate selected households in the respective health districts. CAA volunteers were asked to accompany the field supervisor during the household identification stage of data collection. Once identified, the field supervisor assigned the households to interviewers. Interviewers visited the households and interviewed eligible primary caregivers. When the caregiver was not at home, the interviewer was required to return to the household at least two more times in an attempt to conduct the interview. Similarly, if a child 6–59 months of age whose MUAC had to be taken was not at home, the interviewer had to return to the household at least two more times to attempt to take the measurement, if the child was expected back during the period of data collection.

After identifying the caregiver, the interviewer explained the purpose and nature of the survey and its expected risks and benefits. Caregivers were informed that their participation was voluntary and interviewers explained that a caregiver's decision to participate in the survey would not affect their eligibility to receive or continue services. Caregivers were given an opportunity to ask questions. Once convinced that the caregiver understood what was expected of him or her, the interviewer continued with the consent process.

A field supervisor helping to rescue a stuck field vehicle during data collection in Kavango region

Data were collected using smartphones. The electronic data collection platform was provided by Mobenzi via a mobile data collection application called Mobenzi Researcher. Data were hosted on a Mobenzi database that was accessible by senior researchers from Survey Warehouse and MEASURE Evaluation

for monitoring field work and checking the quality of data being collected. The eventual database was exported to Statistical Package for Social Sciences (SPSS) and Stata (v13.1) software for editing, cleaning, and analysis.

Data Quality Assurance

All data collectors involved in the field participated in the training for this specific activity to ensure that all would conduct interviews and collect information in a standard way. Additional data collectors participated in the training as back-ups, in the event that an interviewer needed to be replaced. Additionally, the customized Mobenzi Researcher software incorporated built-in skip patterns, consistency, and logical checks in the program to help ensure that quality of the data collected would be high. If the interviewer made an error in the entry, an error message would pop up on the screen to alert the interviewer to double-check the entry and correct it, if necessary. In instances where the Mobenzi software was not operational, interviewers used traditional paper-based questionnaires. The research assistants had to conduct 18 interviews using paper questionnaires, because the Mobenzi software failed. The data from the paper questionnaires were then captured in the electronic data application using spare phones with the Mobenzi application that the supervisors kept. These completed questionnaires were checked by the interviewer for logic and completeness before they were entered in Mobenzi Researcher at a later stage (usually in the evening, when supervisors and data collectors met to share their feedback and plan for the next day).

As part of ensuring that interviews and data were high-quality, team supervisors were required to identify households ahead of time, take the interviewers to the households, and ensure that the correct caregivers were identified for the interviews. This process ensured that the households visited were the ones selected in the sample. In addition, supervisors of the teams were required to select at least one household per cluster for re-interviews. Supervisors had to ensure to rotate re-interviews per interviewer. About 40 re-interviews were conducted by the supervisors in all. Households for validation interviews were selected randomly from the completed interviews. Interviewers were instructed to submit electronic entries only after they had checked in with the supervisor after each interview. If a specific household had been selected for re-interview, the supervisor informed the interviewer of this. In those cases, the electronic entries from the interviewer were left pending, until after the re-interview was conducted.

The supervisor visited selected households after the interviewer had conducted the initial interview, and asked the same questions using a paper-based re-interview questionnaire (see Appendix B). Afterward, the supervisor and interviewer compared answers to these questions. If a different answer to the same question was found, the pair re-visited the household and corrected the electronic entry accordingly. Only then did interviewers submit the entry electronically.

According to field reports, almost no edits had to be made to electronic entries. This can be ascribed to validation interviews being conducted only a short time after the initial interview. Generally, caregivers'

recall of the original answers was good: supervisors obtained consistent answers. The only edits made were for data entry errors (mistyping). These were also infrequent, because interviewers were required to review their entries before submitting them electronically. Most errors of this type were picked up by interviewers themselves and corrected before submission of electronic entries. In general, logic checks and skip patterns programmed for the electronic data application facilitated accurate data entry. Because errors were corrected on the spot, when detected, the electronic data and the paper questionnaires matched completely, even when additional verifications were carried out by the office.

Survey Limitations

Assuring the high quality of data and records is important and a responsibility that all stakeholders share. Data quality may be affected by many factors and activities from the point of data collection through reporting. In this study, we experienced challenges both with the sampling frame (list of beneficiaries provided by PHN) and field implementation (locating households/beneficiaries).

Even before data collection started, during the pretesting and pilot-testing phase of the survey, it was found that many of the listed households in the sampling frame had one or more of the following issues:

- Contact number for the caregiver was not listed
- Incorrect contact number was listed for the caregiver
- Incorrect ages were listed for child beneficiaries
- Outdated household details: some caregivers had passed away, some households had moved away, and some children were no longer in the care of the caregiver
- Duplicate households on the list received from PHN
- Correct caregiver data were listed but child beneficiary data were incorrect on the sampling frame

MEASURE Evaluation and Survey Warehouse, in consultation with PHN and CAA, cleaned the sampling frame before data collection, and as far as possible tried to remove duplicate households. During data collection, teams found that the sampling frame contained similar issues that presented some barriers to effective data collection. Additional limitations, mostly concerned with the sampling frame, are discussed hereafter.

In Kavango region, some households in Andara and Nyangana districts were said to be sustained. This information was made available to field supervisors during the household identification process. Nankudu district was sustained in its entirety, and the team could not conduct any interviews in this health district. Rundu district—the only remaining district—was oversampled to compensate for the lower sample realization in the other three districts.

When meeting with the CAA representative and volunteers in this region, the team learned of some groups that were sustained.

In Engela district, 195 households were selected for interviews and had a replacement sample list of 130 households. Of the 195 selected sampled households, 119 households reported that CAA activities regarding OVC had phased out, and such activities and services were no longer provided to these households, leaving only 76 households eligible for interviews. Of the 130 replacements, 44 households belonged to sustained groups, leaving only 86 households for replacements.

In Eenhana district, the team interviewed two households before learning that this group was sustained in its entirety. The field manager informed the group of this and asked that these two households be replaced.

In Zambezi, the sampled and replacement households were depleted before the required sample size was met. Many caregivers were reported to have moved away and some were listed more than once, under different household identification numbers. Among the replacement households, the team also encountered some households that were no longer receiving services and support from CAA. These households belonged to groups that were not entirely sustained, but that contained a couple of households that were sustained within the groups.

From the above, it became evident that the sample approach was affected significantly. It was decided that teams should work with volunteers in the regions and districts where there was a shortfall of households to get to additional active households and use these as replacements. It was further decided that the households would be kept to 15 per cluster, and an overall total sample of 600. In the districts and communities where CAA is implementing OVC activities and services, but where some of the households or smaller groups have been sustained, the field teams replaced those sustained households with active households from the beneficiary household listings that were provided by the CAA representative and volunteers who worked in that area. In areas where groups made up a large part of the district, Survey Warehouse replaced households with active households in sites as close to the original site as possible. Teams focused on households that were currently active. CAA representatives assisted teams with lists of active households that were not included in the sample. Even so, it was found that some of these households were sustained.

One of the measures taken was to increase the sample of households from within the clusters that had more beneficiaries in order to replace discharged/sustained households or communities. This was done in consultation with volunteers working with beneficiary households who were present in the communities during field work. With this approach (oversampling in clusters where we had more households participating in the CAA program), we managed to reach about 98 percent of the targeted number of households required for the study.

Response Rates

Table 4 summarizes response rates for households visited and interviewed in the original sample, and the eventual sample that was realized after oversampling in some health districts. Prior to oversampling, the overall response rate was 69 percent. We managed to locate 411 out of 600 households in the original sample. Of the caregivers in the 411 households in the original sample who were interviewed, about eight children younger than five years of age under their care were temporarily away from the households, so MUAC measurements could not be taken for those children. The original sample included Nankudu health district, which had three clusters (45 households), and Nyangana health district, which had two clusters, with 30 households earmarked for interviews. However, as indicated earlier in this report, the interviewers found out that the entire Nankudu health district was sustained, which was confirmed by CAA volunteers and the CAA regional representative. The information was not obtained until halfway through the data collection process, when the field team was already in the field, and at the time they were visiting the district. As a result, all households in the five selected clusters had to be re-selected from the Rundu health district, with assistance from CAA community volunteers in the area.

The Kavango team who were working in Andara and Nyangana health districts were also informed of some households that were now considered sustained within certain communities in these areas. They faced similar challenges in terms of reaching the required sample size, because fewer households were eligible for the survey. The chairmen of the groups of volunteers assigned individual volunteers to the team. They were then asked to locate households listed on the sample. However, these volunteers were not familiar with the listed households, and could only show the team households that they had been working with. These households were not part of the original sample, however. To reach the target number of households for these two districts, the interviewers randomly selected households from the volunteers' beneficiary list to conduct interviews. In some districts, it was necessary to select more households than were in the original sample, to compensate for the other districts where either the entire district, or some community or some households within the community, had been sustained from the program.

With oversampling done in the Rundu health district and in other clusters in order to compensate for sustained districts/communities or sustained groups of beneficiaries, we managed to interview 591 households of the targeted 600 households, which increased the response rate to about 99 percent. With the need to oversample in Rundu district to compensate for sustained communities from other areas, the original sampling approach was slightly affected. However, given the situation, and the fact that the field teams were already more than halfway into data collection when this issue was discovered, this was the only feasible solution to make sure we would obtain the required sample. Some of the beneficiaries' characteristics from the sustained communities were compared to the beneficiaries' characteristics in Rundu, and they seemed to be similar. This was reassuring, because if bias was introduced in the process of oversampling, then it was more likely to be minimal.

Of the original sample of 600 households interviewed, interviews with about 7 percent were not completed at all or only partially completed, for any of the following reasons: community volunteers could not recognize the household in the list (13 households); the primary caregiver refused to be interviewed (8 households); the household had no children 0–17 years of age (7 households); the caregiver or the child was away during the data collection period (12 households); the members of the household had moved away (4 households). This breakdown does not include households or communities that were found to be sustained at the time of field work. (See Tables 3 and 4 for an explanation of sustained households.) The sustained communities were replaced with other communities and households that the program serves.

Table 4. Response rates from the original sample list and response rates after oversampling to compensate for Nankudu and Nyangana districts

Description	Kavango				Ohangwena		Zambezi	Total
	Andara	Nankudu[1]	Nyangana[2]	Rundu	Eenhana	Engela	Katima Mulilo	
# of clusters selected from original sampling frame	3	3	2	6	5	13	8	40
# of households selected for interview from beneficiary database (original sample)	45	45	30	90	75	195	120	600
# of households interviewed from the list	24	0	4	90	48	137	108	411
Response rate from the original sample of households	53%	0%	13%	100%	64%	70%	90%	69%
# of clusters after oversample	3	0	2	9	5	13	8	40
# of households oversampled – from CAA volunteer list	24	0	20	42	34	46	14	180
# of households interviewed from oversampled areas	24	0	20	42	34	46	14	180
Percent of households interviewed after oversampling	107%	0%	80%	147%	109%	94%	102%	99%
Eventual sample realization	48	0	24	132	82	183	122	591

1. The entire Nankudu district was sustained. This was discovered during data collection, while the teams were in the field visiting the districts.

2. Some beneficiary households in the two clusters selected in the sample in Nyangana district were found to have been sustained from the program; hence interviewers had to randomly select additional active beneficiary households in other communities within the district with guidance from CAA volunteers.

RESULTS

Characteristics of the Study Population

Households in the Sample

A total of 591 out of the 600 households selected were successfully interviewed. These households came from six districts in three regions where PHN's and CAA's services and programs are being implemented. By residential location, 450 households (76.1%) were from rural areas.

Basic Demographic Characteristics of the Primary Caregivers in the Households Surveyed and Participation in PHN

One primary caregiver from each of the households selected was identified and interviewed. Table 5 provides a distribution of primary caregivers by sex and residential location. Most primary caregivers were female (90.4%). The age of primary caregivers ranged from 19 years to 96 years among women; the median age was 46. Among male primary caregivers, the age range was from 21 to 72 years; the median age was 45.

Table 5. Distribution of primary caregivers, by sex and residential location

Primary Caregiver Sex	Type of Location		Total
	Urban n (%)	Rural n (%)	n (%)
Female	128 (90.8)	406 (90.2)	534 (90.4)
Male	13 (9.2)	44 (9.8)	57 (9.6)
All	**141**	**450**	**591**

Primary caregivers were asked if they had personally ever participated in program services or activities that offered by PHN and/or CAA. About 370 of the 591 (65%) reported that they had personally received services or participated in program activities. Of those who personally received services or participated in program activities, 240 (65%) reported that they had done so within the past six months. On average, one primary caregiver in the urban areas was responsible for about four children under his or her care (one child under five years of age, and three from 5–17 years of age), whereas primary caregivers in the rural areas were responsible for about six children (two under five years of age, and four from 5–17 years of age).

With regard to social welfare grants from the government, currently 253 (56%) primary caregivers in rural areas had registered to receive social welfare grants from the government, and of these, 200 (79%) received all three monthly social welfare grant payments within the three months prior to survey. In urban settings, 65 (46%) primary caregivers were registered to receive social welfare grants from the government, and of these, 45 (69%) had received all three monthly payments within the three months prior to the survey.

During the survey, primary caregivers were asked whether they or anyone else in their households had received or accessed any of the items or services provided by CAA in the six months prior to the survey. Table 6 shows program items or services listed and the responses from primary caregivers who said they or someone in their households received items or accessed program services.

Table 6. Items and/or program services provided by Catholic AIDS Action (CAA) that have been received or accessed by the primary caregiver or any other household member in the six months prior to the survey, by residence

Items and/or program services received or accessed by caregiver or any other member of household	Total N = 591		Rural N=450		Urban N=141	
	N	%	N	%	N	%
HIV testing and counseling	364	61.6	277	61.6	87	61.7
ART adherence counseling	355	60.1	270	60.0	85	60.3
Nutritional screening and counseling	365	61.8	305	67.8	60	42.6
TB screening	282	47.8	237	52.7	45	31.9
OVC care and support services (psychosocial, legal, or visits from community/CAA volunteer)	361	61.1	307	68.2	54	38.3
Referral support or services (on access to social grants, school fees exemption, mother-to-mother support groups, educational support, woman and child protection support)	212	35.9	178	39.6	34	24.1
Referral services to clinics (either ART, prevention of mother-to-child transmission of HIV, tuberculosis, family planning, or general healthcare)	340	57.5	283	62.9	57	40.4
Provision of temporary school fees/grants to promote school enrollment or progression	62	10.5	55	12.2	7	5.0
Provision of educational materials	86	14.6	78	17.3	8	5.7
Livelihood training/income generation	100	16.9	79	17.6	21	14.9
Community savings/lending groups/village savings and loan groups	74	12.5	58	12.9	16	11.4
Life skills training	221	37.4	184	40.9	37	26.2
Vocational training scholarships	17	2.9	8	1.8	9	6.4

As Table 6 shows, overall, HIV testing and counseling, ART adherence counseling, nutritional screening and counseling, OVC care and support services (psychosocial, legal, or visits from community/CAA volunteer), and referral services to clinics (either ART, prevention of mother-to-child transmission of HIV [PMTCT], tuberculosis [TB], family planning [FP], or general healthcare) were the most-received items or most-accessed program services (>50%) in the six months prior to the survey. However, there was an observable difference between rural and urban beneficiaries when it came to accessing items or services provided by CAA. Beneficiaries from rural areas tended to access or receive items and services provided by the program more

than beneficiaries from urban areas, with the exception of HIV testing and counseling, ART adherence, and vocational training scholarships.

As indicated earlier, 318 primary caregivers (both from rural and urban areas) mentioned that they were registered to receive social grants, but only 245 primary caregivers received all three monthly payments. Moreover, only 212 primary caregivers out of 591 (35.9%) reported that either they themselves or any other member of their household had received or accessed items or services provided by CAA programs in the past six months.

Children Ages 0–17 Years Cared for by Primary Caregiver

Table 7 provides the age and sex distribution by residential location of all the children under the care of primary caregivers in the study population. A total of 2,470 children ages 0–17 years cared for by primary caregivers were included in the survey. About half of them were girls (50.2%). There was no difference between age or sex distributions and area of residence (rural-urban).

Table 7. Demographic characteristics of children ages 0–17 years in the study population who have a primary caregiver, by residence

Variable	All children ages 0–17 years N = 2,470	Children ages 0–17 years, rural N = 1,929	Children ages 0–17 years, urban N = 541
	n (%)	n (%)	n (%)
Age Group			
0–4 years	724 (29.3)	570 (29.6)	154 (28.5)
5–9 years	734 (29.7)	570 (29.5)	164 (30.3)
10–14 years	645 (26.1)	499 (25.9)	146 (27.0)
15–17 years	367 (14.9)	290 (15.0)	77 (14.2)
Sex			
Female	1,241 (50.2)	970 (50.3)	271 (50.1)
Male	1,229 (49.8)	959 (49.7)	270 (49.9)
Residence			
Urban	541 (21.9)	-	-
Rural	1,929 (78.1)	-	-

At the time of survey, 772 (87.2%) out of 885 girls, and 740 (86.9%) out of 861 boys between the ages of 5–17 years were enrolled in school. By residential location, 314 (81.1%) of the 387 children ages 5–17 years under the care of primary caregivers living in urban areas were enrolled in school, whereas in rural areas, 1,198 (88.1%) of the 1,359 children ages 5–17 years under the care of primary caregivers were enrolled in school at the time of survey.

Given HIV-affected children's elevated risk of acquiring HIV, the first step for HIV prevention and treatment critical to OVC programs is to link supported children to HIV-testing services. In this survey, primary

caregivers reported that 1,431 (57.9%) of all children 0–17 years of age under their care had ever been tested for HIV—with approximately equal proportions across age groups. However, caregivers reported that more female children (59.9%) than male children (56.0%) under their care were tested for HIV. The sex differential regarding HIV testing of children was significant (p-value=0.05).

Primary caregivers reported that, overall, a small number of children—350 out of 2,470 (14.2%)—had ever received services or participated in CAA activities. This small proportion could be because not all children in the household under the care of the primary caregiver were registered with CAA to receive services. Of the children who had been reported as ever having received services, 263 (75.1%) had received these services in the six months prior to the survey, according to primary caregivers' reporting.

PEPFAR OVC MER Essential Survey Indicators

PEPFAR's outcome indicators for OVC programs are part of its MER guidance. These outcome indicators are designated "essential," and are required to be collected in PEPFAR countries biennially. They will support improved, evidence-informed strategic portfolio development, programming, and resource allocation decisions at country level, as well as at the headquarters level. This section provides the results of the nine OVC MER Essential Survey Indicators for Namibia.

Indicator OVC_HIVST: Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status

Table 8 presents the percentage of children whose primary caregiver knows the child's HIV status, disaggregated by age and sex. Overall, about 56 percent of caregivers surveyed knew that their children were tested for HIV, and knew their children's HIV status. The results show that the primary caregiver was more likely to know the child's HIV status if the child was a girl, than if the child was a boy, across all ages. Overall, the difference in proportions between boys (53%) and girls (58%) was statistically significant at a 5 percent level (p-value = 0.025).

Table 8. Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status

	All children 0–17 years of age N=2,470			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–4 years	724	381 (52.6)	49.0	56.2
5–9 years	734	418 (56.9)	53.5	60.5
10–14 years	645	367 (56.9)	53.0	60.7
15–17 years	367	204 (367)	50.4	60.6
All ages (0–17 years)	**2,470**	**1,370 (55.5)**	**53.5**	**57.4**
	All male children 0–17 years of age N=1,229			
			95% Confidence interval	
	N	**n (%)**	**L**	**U**
Age group				
0–4 years	368	190 (51.6)	46.5	56.7
5–9 years	377	205 (54.4)	49.3	59.3
10–14 years	300	163 (54.3)	48.6	59.9
15–17 years	184	96 (52.2)	44.9	59.3
All ages (0–17 years)	**1,229**	**654 (53.2)**	**50.4**	**56.0**
	All female children 0–17 years of age N=1,241			
			95% Confidence interval	
	N	**n (%)**	**L**	**U**
Age group				
0–4 years	356	191 (53.7)	48.4	58.8
5–9 years	357	213 (59.7)	54.5	64.6
10–14 years	345	204 (59.1)	53.8	64.2
15–17 years	183	108 (59.0)	51.7	65.9
All ages (0–17 years)	**1,241**	**716 (57.7)**	**54.9**	**60.4**

Indicator OVC_NUT: Percent of children (aged 6–59 months) who are undernourished

Nutrition is a critical factor in reducing infant mortality and builds a strong foundation for a child's health, growth, and development. MUAC is recommended by the World Health Organization (WHO) as a method of assessing severe, acute malnutrition among children ages 6–59 months. For reporting of this indicator in Namibia, children whose MUAC measurements were below 12.5 cm were considered undernourished.

Table 9 presents the percentage of children 6–59 months whose MUAC measurements were below 12.5 centimeters in the study areas. Overall, about 11 percent of children in the study areas were undernourished, with no difference between boys and girls (p-value = 0.948).

Table 9. Percent of children (ages 6–59 months) who are undernourished

	All children ages 6–59 months N=653			
			95% Confidence interval	
	N	n (%)	L	U
Sex				
Male	333	38 (11.4)	8.4	15.3
Female	320	36 (11.3)	8.2	15.2
All	**653**	**74 (11.3)**	**9.1**	**14.0**

We also compared MUAC measurements in children under five years of age for urban and rural differences in the study sites. A total of 31 (21.5%) out of 144 children ages 6–59 months who live in urban areas were considered undernourished, whereas only 43 (8.4%) out of 466 children in rural areas were undernourished. Surprisingly, the difference between undernourished children in urban compared to rural settings was statistically significant at a 5 percent level (p-value <0.001), with children in urban areas fairing worse compared to children in rural areas.

Indicator OVC_SICK: Percent of children (aged 0–17 years) too sick to participate in daily activities

This is an indicator of a child's well-being. It measures the impact of sickness, impairment, and mental health issues on a child's daily life. Children who are unable to participate in daily activities may need immediate medical care and could be in an especially vulnerable state. For each child between 0–17 years of age in this study, their primary caregivers were asked if the child had been too sick to participate in daily activities within the past two weeks prior to the survey. Table 10 presents findings for this indicator, by age and sex of the child.

Table 10. Percent of children ages 0–17 years who had been too sick to participate in daily activities within the 2 weeks prior to the survey

	All children 0–17 years of age N=2,470			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–4 years	724	236 (32.6)	29.3	36.1
5–9 years	734	154 (21.0)	18.2	24.1
10–14 years	645	102 (15.8)	13.2	18.8
15–17 years	367	60 (16.3)	12.9	20.5
All ages (0-17 years)	**2,470**	**552 (22.3)**	**20.7**	**24.0**
	All male children 0–17 years of age N=1,229			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–4 years	368	123 (33.4)	28.8	38.4
5–9 years	377	77 (20.4)	16.7	24.8
10–14 years	300	44 (14.7)	11.1	19.1
15–17 years	184	28 (15.2)	10.7	21.2
All ages (0–17 years)	**1,229**	**272 (22.1)**	**19.9**	**24.5**
	All female children 0–17 years of age N=1,241			
			95% Confidence Interval	
	N	n (%)	L	U
Age group				
0–4 years	356	113 (31.7)	27.1	36.8
5–9 years	357	77 (21.6)	17.6	26.1
10–14 years	345	58 (16.8)	13.2	21.1
15–17 years	183	32 (17.5)	12.6	23.7
All ages (0–17 years)	**1,241**	**280 (22.6)**	**20.3**	**25.0**

Overall, about 22 percent of male children, and about 23 percent of female children were reported as having been too sick to participate in daily activities. There was no statistical difference between male and female children (p-value = 0.797) in terms of proportions of children who were too sick to participate in daily activities.

Indicator OVC_BCERT: Percent of children (aged 0_17 years) who have a birth certificate

This is an indicator of the child's access to legal protection, because it is often considered the starting point for protecting the child's right to national- and subnational-level support. In Namibia, a child must have a birth certificate to attain government social and protection services, including school enrollment and access to social grants. In this study, primary caregivers were asked if the children under their care had birth certificates, and if the caregivers said yes, they were asked to show these birth certificates. Table 11 presents results of these two questions. Only after the interviewer had seen and verified the presence of a birth certificate for the child was it counted as available.

Table 11. Percent of children [ages 0–17 years] who have a birth certificate

	All children 0–17 years of age N=2,470			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–4 years	724	343 (47.4)	43.8	51.0
5–9 years	734	430 (58.6)	55.0	62.1
10–14 years	645	395 (61.2)	57.4	64.9
15–17 years	367	236 (64.3)	59.3	69.0
All ages (0–17 years)	**2,470**	**1,404 (56.8)**	**54.9**	**58.8**
	All male children 0–17 years of age N=1,229			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–4 years	368	177 (48.1)	43.0	53.2
5–9 years	377	229 (60.7)	55.7	65.6
10–14 years	300	186 (62.0)	56.4	67.3
15–17 years	184	115 (62.5)	55.3	69.2
All ages (0–17 years)	**1,229**	**707 (57.5)**	**54.7**	**60.3**

	All female children 0–17 years of age N=1,241			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–4 years	356	166 (46.6)	41.5	51.8
5–9 years	357	201 (56.3)	51.1	61.4
10–14 years	345	209 (60.6)	55.3	65.6
15–17 years	183	121 (66.1)	58.9	72.6
All ages (0–17 years)	**1,241**	**697 (56.2)**	**53.4**	**58.9**

Note: Numerator for birth certificate is as reported by caregiver AND verified by interviewer by observation.

Overall, about 58 percent of male children had verified birth certificates, and about 56 percent of female children had birth certificates. This difference between male and female children having birth certificates was not statistically significant (p-value = 0.494). With place of residence, 296 children out of 541 (54.7%) living in urban areas, and 1,108 out of 1,929 (57.4%) living in rural areas had birth certificates seen and verified by interviewers during household visits. The difference between rural and urban children having verified birth certificates was not statistically significant (p-value = 0.258). The caregivers reported that 65.5 percent of children below the age of five years had a birth certificate. However, when asked to produce the birth certificate to be verified by interviewer, only 47.4 percent of children under five years had birth certificates that were seen and verified by the survey interviewer.

Indicator OVC_SCHATT: Percent of children (aged 5–17 years) regularly attending school

School attendance is an important correlate of educational progress and protection for children. There are many reasons why a child might have missed school. In Namibia, children usually begin grade school at seven years of age. However, the indicator requires the questions to be asked for all children ages 5–17 years. In this study in Namibia, primary caregivers were asked two questions regarding school attendance of the children ages 5–17 years under their care in order to generate this indicator. First, caregivers were asked if the child was currently enrolled in school. Second, for those children who were enrolled in school, caregivers were asked if there had been any day in the past school week that a child had missed school for any reason. Table 12 presents the results of the combination of the two questions related to school attendance that primary caregivers were asked about the children under their care. We further disaggregated the age range 5–17 years into smaller age groups, especially to reflect the usual age at which children start grade school in Namibia.

Table 12. Percent of children (aged 5–17 years) regularly attending school

	All children 5–17 years of age N=1,746			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
5–6 years	297	112 (37.7)	32.4	43.4
7–9 years	437	322 (73.7)	69.3	77.6
10–14 years	645	495 (76.7)	73.3	79.9
15–17 years	367	285 (77.7)	73.1	81.6
All ages (5–17 years)	**1,746**	**1,214 (69.5)**	**67.3**	**71.7**
	All male children 5–17 years of age N=861			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
5–6 years	148	56 (37.8)	30.4	45.9
7–9 years	229	168 (73.4)	67.2	78.7
10–14 years	300	224 (74.7)	69.4	79.3
15–17 years	184	145 (78.8)	72.3	84.1
All ages (5–17 years)	**861**	**593 (68.9)**	**65.7**	**71.9**
	All female children 5–17 years of age N=885			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
5–6 years	149	56 (37.6)	30.1	45.7
7–9 years	208	154 (74.0)	67.6	79.6
10–14 years	345	271 (78.5)	73.9	82.6
15–17 years	183	140 (76.5)	69.8	82.1
All ages (5–17 years)	**885**	**621 (70.2)**	**67.1**	**73.1**

Overall, 69.5 percent of children ages 5–17 years who were enrolled in school regularly attended school, as measured by children who did not miss any school days in the week before the survey. There was no difference in school attendance between male and female children (p-value = 0.556). If we consider only children ages 7–17 years who regularly attend school (excluding the 5–6 years age group in the analysis), 1,102 (76.1%) out of 1,449 children ages 7–17 years regularly attended school in the study areas in Namibia. The percentage among male children ages 7–17 years increased to 75.3 percent, and for female children it increased to 76.8 percent.

Indicator OVC_PRGS: Percent of children (aged 5–17 years) who progressed in school during the last year

This is a direct outcome measure of educational progress. The educational progress of children can be jeopardized by a household's financial vulnerability, which could render families unable to afford school fees, or other school-related expenses. Additionally, children's educational progress could be slowed by the need for a child to drop out of school completely or miss some school days in order to work to support their household financially or to shoulder an increased burden of household responsibilities.

This indicator is a composite indicator, measured by four questions related to school enrollment and grade in school at the time of the survey. These questions include school enrollment and grade attended at the time of the survey, and school enrollment and the child's grade in the previous school year. The indicator requires looking at all children ages 5–17 years who report being in a more advanced grade level at the time of the survey than they were in the previous school year, with the denominator being 5- to 17-year-old children surveyed who report being enrolled in school during the academic year previous to the current/most recent academic year. Table 13 below presents the results of this composite indicator, disaggregated by the age and sex of the child.

Table 13. Percent of children (aged 5–17 years) who progressed in school year during the last year

	All children 5–17 years of age N=1,303			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
5–7 years	108	34 (31.5)	23.4	40.9
8–9 years	262	198 (75.6)	70.0	80.4
10–14 years	600	477 (79.5)	76.1	82.6
15–17 years	333	251 (75.4)	70.4	79.7
All ages (5–17 years)	**1,303**	**960 (73.7)**	**71.2**	**76.0**
	All male children 5–17 years of age N=637			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
5–7 years	60	17 (28.3)	18.3	41.1
8–9 years	136	95 (69.9)	61.6	77.0
10–14 years	275	210 (76.4)	71.0	81.0
15–17 years	166	122 (73.5)	66.2	79.7
All ages (5–17 years)	**637**	**444 (69.7)**	**66.0**	**73.2**

	All female children 5–17 years of age N=666			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
5–7 years	48	17 (35.4)	23.1	50.0
8–9 years	126	103 (81.7)	74.0	87.6
10–14 years	325	267 (82.1)	77.6	86.0
15–17 years	167	129 (77.2)	70.2	83.0
All ages (5–17 years)	**666**	**516 (77.5)**	**74.1**	**80.5**

Overall, school progression among male children ages 5–17 years was about 70 percent, and this proportion was much higher among female children (about 78%) ages 5–17 years. The observed difference in school progression between male and female children was statistically significant (p-value = 0.001).

Because Namibian children usually begin grade school at the age of seven years, to assess children who progressed in school during the past year, it is more reliable to focus on children who are currently between the ages of 8–17 years, because they are expected to have been one school grade/year lower in the past school year than in the current school year. Out of 577 male children between the ages of 8–17 years, 427 (74.0%) had progressed in school during the past year. Among female children, 499 (80.7%) out of 618 between the ages of 8–17 years had progressed in school during the past year. The difference in proportion of school progression between males and females was statistically significant at a 5 percent level (p-value = 0.005), with female children doing better than male children.

Indicator OVC_STIM: Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age

Stimulation of children younger than five years of age, through individual attention from primary caregivers or any other adult member in the household, is among the most vital needs of children in this age group. Stimulating children during early childhood is essential for the promotion of long-term learning, growth, and health. Stimulation has been shown to have a significant effect even on the development of undernourished children in the absence of other interventions. In this OVC MER indicator survey in Namibia, primary caregivers were asked if in the past three days they themselves or any other household member over 15 years of age had engaged in any activities with a child ages 0–4 years in the household such as reading books, looking at the pictures in the books, telling stories, singing songs or lullabies, playing with the child, or naming, counting, or drawing things.

Table 14. Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age

	All children 0–4 years of age N=724			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–1 years	236	109 (46.2)	40.0	52.6
2–4 years	488	318 (65.2)	60.8	69.3
All ages (0–4 years)	**724**	**427 (59.0)**	**55.3**	**62.5**
	All male children 0–4 years of age N=368			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–1 years	113	51 (45.1)	36.1	54.4
2–4 years	255	165 (64.7)	58.6	70.4
All ages (0–4 years)	**368**	**216 (58.7)**	**53.6**	**63.6**
	All female children 0–4 years N=356			
			95% Confidence interval	
	N	n (%)	L	U
Age group				
0–1 years	123	58 (47.2)	38.4	56.0
2–4 years	233	153 (65.7)	59.3	71.5
All ages (0–4 years)	**356**	**211 (59.3)**	**54.1**	**64.3**

Table 14 presents results to the question on engagement of children under five in stimulating activities for early childhood development. Overall, 216 (58.7%) of 368 male children, and 211 (59.3%) of 356 female children ages 0–4 years were reported to have engaged in stimulating activities with the primary caregiver or any other adult member in the household during the three days preceding the survey. The difference in stimulating activities among boys and girls was not statistically significant (p-value = 0.875).

However, if you further disaggregate children under five into 0–1 years and 2–4 years, the proportion among children between 0–1 years of age who recently were engaged in stimulating activities was 46.2 percent, whereas this proportion among children ages 2–4 years was 65.2 percent. The difference between the age groups of children were statistically significant at a 5 percent level (p-value <0.001), with older children (2–4 years) being more engaged in stimulating activities than infants (0–1 years).

Indicator OVC_CP: Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or at school

This indicator is related to child protection. Research indicates that most perpetrators of violence against children are family members or others close to a family. Children frequently experience violence in the form of harsh punishment as a form of discipline or control by caregivers or those close to the family. Harsh punishment is, in this case, defined as hitting or beating a child as a means of discipline. Perceptions of physical discipline have been linked to actual use of physical discipline against children and changing perceptions of discipline can reduce violence against children. The distinction between home and school is important, because caregivers might think teachers and caregivers have different boundaries on what constitutes harsh punishment. Table 15 presents findings from the survey.

Overall, 62.5 percent of female primary caregivers, and 54.4 percent of male primary caregivers agreed that hitting or beating a child at home or at school is an appropriate means of disciplining a child. The observed difference in proportions between male and female caregivers was not statistically significant (p-value = 0.228).

Table 15. Percent of primary caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or at school

	All primary caregivers N=591			
			95% Confidence interval	
	N	n (%)	L	U
Sex				
Male	57	31 (54.4)	41.3	66.9
Female	534	334 (62.5)	58.3	66.6
All	**591**	**365 (61.8)**	**57.8**	**65.6**

Indicator OVC_MONEY: Percent of households able to access money to pay for unexpected household expenses

The HIV pandemic affects the economic stability of families and children in their care by interrupting income streams, depleting assets, and introducing other constraints that in turn affect the food security, health, and well-being of primary caregivers, children, and other household members. In the study, the question about the ability to access money for unexpected household expenses in the past 12 months was asked of primary caregivers who mentioned that they or their households incurred unexpected household expenses in the 12 months preceding the survey. The combination of these two questions asked in the survey allows for the generation of the indicator, which measures households' financial stability and resilience in the face of economic shocks. Results from the survey are presented in Table 16.

Table 16. Percent of households able to access money to pay for unexpected household expenses

	All sampled households N=266			
			95% Confidence interval	
	N	n (%)	L	U
Residence				
Urban	69	34 (49.3)	37.6	61.0
Rural	197	113 (57.4)	50.3	64.1
All	**266**	**147 (55.3)**	**49.2**	**61.1**

Overall, about 55 percent of households reported that they were able to access money to pay for unexpected household expenses in the 12 months preceding the survey. About 49 percent of households in urban areas and 57 percent of households in rural areas reported that they were able to access money to pay for unexpected household expenses. However, the observed difference between rural and urban households was by chance alone (p-value = 0.245).

DISCUSSION AND RECOMMENDATIONS

Namibia continues to face an enormous burden of OVC, despite its relatively small population. The HIV pandemic is among the main contributing factors in the increase in the number of OVC in the country. Government and international efforts and initiatives have been introduced in Namibia to alleviate the burden of HIV/AIDS in general and among OVC, in particular. In our study areas—mostly the rural areas—a large proportion of community members live in poverty and have insufficient opportunities for employment and limited access to social welfare. Most of the primary caregivers in the households that were followed up for this particular study are older women. This is not a surprising finding, because in HIV-affected households, parents are either too sick to take care of their children or have died, and the children are taken care of by the grandmothers or older relatives in the households.

During the survey, all primary caregivers in the sampled households were asked whether they or any other member of their household had received items or accessed program services that were provided by CAA in the six months preceding the survey. The responses of the primary caregivers were not encouraging. It is not certain if this is a true reflection of the challenges these communities are facing in accessing these services or if it is the result of respondent bias: either recall bias or purposely giving incorrect responses in the hope of getting more services (see Table 8, which reports the results of this question). From what we learned from PHN's experience in the field, a significant number of caregivers expect material handouts from the program. This could be another factor to consider. It may also depend on how caregivers perceive "service." In this study, the interviewers asked the question exactly as written in the questionnaire. (See Appendix A questions numbered 4.18 to 4.31 for list of program items or services received.) Further follow-up on these findings was not part of the scope of this survey. However, service providers should follow up on these issues to verify our

findings and to address the gaps in channeling provision of their services, if indeed these items and services are not being fully accessed by or provided to the program beneficiaries.

On average, an equal number of male and female children were reported for the sampled households. At the time of the survey, about 87 percent of children ages 5–17 years were reported to be enrolled in school. This is welcome news, and shows that efforts to support education for children, especially OVC, are achieving the expected outcome.

One of the survey questions was to find out from the primary caregivers how many children under their care had ever been tested for HIV. Primary caregivers reported that about 58 percent of children ages 0–17 years under their care had been tested. About 55 percent of primary caregivers reported that they knew the results of the child's HIV test. Although this finding is encouraging and a step in the right direction, it should be noted that the goal is for all primary caregivers to know their child's status. A lot more could be done by the programs to improve the situation.

Primary caregivers reported that fewer than 15 percent of children under their care had ever received services or participated in CAA activities. This finding is much lower than we expected, and flies in the face of a recent NARP recruitment model. PHN/NARP started family-centered household recruitment in October 2015, whereby all children below the age of 18 belonging to the beneficiary households would be registered. The new approach replaced the existing CAA recruitment approach of registering only one child per household. We are not sure why caregivers reported low numbers in this survey, and it is unclear if this is an accurate reflection of the situation on the ground. A possible explanation is that participants can identify services received but cannot always tie the services back to the organization that provided them. In this survey, each caregiver was asked whether each child in the household under his or her care ever received services or participated in activities from CAA, and the response was either "Yes" or "No." Either caregivers could not recall each of their children having received services or participated in activities (maybe because services had not been provided recently), or they could not identify the specific provider (in this case, CAA). It may be helpful for program implementers to follow up on this, to understand the reasons for this low reporting despite all the efforts to reach out to the beneficiaries.

Nine PEPFAR OVC MER Essential Survey Indicators were collected in this study. This is the first time in Namibia that these indicators have been collected in a special survey. With the exception of one essential survey indicator, the findings from this survey show progress. Few differences between males and females and across age groups were statistically significant. Six of the nine indicators (NC.1, CW.9, CW.11, CW.12, CW.13, and HW.2) were expected to have high percentages, indicating progress. The remaining three were expected to have low figures, also indicating progress (CW.1, CW.4, and CW.14). The six indicators expected to have high percentages all reported over 55 percent overall. There were a few differences when disaggregating these indicators by age and sex, however. Considering that children in Namibia start school in the year that they turn seven, school attendance and progression indicators have high coverage for children ages 7–17 years. The overall coverage (all ages, both sexes) for these two indicators was over 76 percent. This finding is encouraging, given these children's orphan or vulnerable in status. It will be informative to know how the findings from this survey in Namibia compare with other surveys using these indicators. To our knowledge, similar studies have been carried out in Nigeria and Kenya, and data are being analyzed. Once the findings from these other surveys are available, it will give some indication on how Namibia is performing compared to other counties with PEPFAR OVC programs.

In responding to Namibia's OVC crisis, the country has adopted a National Plan of Action on children orphaned and made vulnerable by HIV. Birth registration (including issuance of birth certificates) is included in the action plan. In this survey, primary caregivers reported that about 76 percent of children ages 0–17 years under their care have birth certificates. However, this indicator requires that the interviewer sees the birth certificate of the child for verification purposes. With verification, the proportion decreased to about 57 percent overall. Upon disaggregating by age, the findings from this survey indicated that only 47.4 percent of children below five years of age had birth certificates that were seen and verified by interviewers. However, caregivers reported that 65.5 percent of children below five years of age had birth certificates. The 2013 Namibian Demographic and Health Survey (NDHS) reported that 87 percent of children under five years of age have been registered with civil authorities, and 63 percent have birth certificates (MOHSS & ICF International, 2014). However, the question in the NDHS survey did not require interviewers to verify the presence of the birth certificate in the household (MOHSS & ICF International, 2014).

There is significant improvement in school attendance and school progression for children ages 7–17 years in this study. Regarding school attendance, on average three out four children currently enrolled in school regularly attend school. Slightly more girls than boys regularly attend school. According to the 2013 NDHS, more than three quarters of primary school age children in Namibia attend school (MOHSS & ICF International, 2014). Regarding school progression, this study focused on children who were currently enrolled in school, and between the ages of 8–17 years in the current school year. These children were expected to have been one school grade or year lower in the previous school year than in the current school year. Among boys, about 74 percent progressed in school during the past year, whereas 80.7 percent of females between the ages of 8–17 years progressed in school during the past year. Thus, female children tend to progress more in school than do male children in the same age range.

Nongovernmental organizations, church groups, and development partners are contributing to OVC care and support through the mobilization of funds, the provision of technical support to child welfare, the development of community-based projects, and direct assistance to OVC. Despite all efforts by these organizations, many orphans are not yet receiving the grants to which they are entitled, because caregivers are required to provide birth certificates of the children, death certificates of the parents, and other documentation confirming that they are supporting the orphans, before they receive these grants. Some people, particularly in poor, rural areas, do not have this documentation, and elderly caregivers often do not have the energy or resources to go back and forth to obtain the documentation required. Considering that more than half of all OVC in our study areas live with elderly women as their caregivers, these issues need attention and assistance from social and other community development agencies concerned.

One of the many grave impacts of the HIV epidemic is the weakening of the quality of public service delivery and the capacity of families and communities to care for children. Protection systems in Namibia are considered fragmented, making it difficult to access good-quality services in an integrated manner. One of the proxy indicators for violence against children is harsh physical punishment, including hitting and beating children in the name of disciplining or controlling child behavior. In this study, a large proportion (over 60%) of primary caregivers agreed that harsh physical punishment (hitting or beating a child) is an appropriate means of disciplining or controlling a child in the home or at school. This finding is concerning. To our knowledge, the United States Centers for Disease Control and Prevention has not yet conducted a Violence Against Children Survey (VACS) in Namibia. However, according to UNICEF, 73 percent of young people surveyed in four regions in Namibia reported that they had suffered corporal punishment at school (UNICEF, n.d.). Moreover,

VACS data from other African countries indicate that the prevalence of physical violence inflicted on children younger than 18 years of age by parents, adult caregivers, or other authority figures is high: 51 percent in Nigeria, 54 percent in Malawi and Tanzania, and 70 percent in Kenya and Zimbabwe. There is a need to improve public awareness of violence and exploitation of children and the devastating toll it takes on children and families.

In this study, about 45 percent of households reported having incurred unexpected household expenses, such as a house repair or urgent medical treatment in the year preceding the survey. Of those households, just about half said they were able to access money to pay for the unexpected household expenses. This is somewhat lower than expected in the surveyed households, considering that PHN and CAA have programs that are geared toward empowering or supporting beneficiary families. Perhaps household members who were interviewed purposefully reported that they were not able to pay for these unexpected expenses in hopes that they would be given more support following the survey. We recommend that PHN and CAA develop mechanisms for follow-up and feedback (if these are not already in place) to assess these households' challenges, and how best to improve service provision and support for effective interventions.

Our findings suggest that about one-fifth of the beneficiary children ages 0–17 years have had physical or mental health issues, as indicated by the percentage of children too sick to participate in daily activities during the two weeks preceding the survey. This is alarming. Caregivers should be encouraged to take their children for medical care as soon as signs of ill health are detected. Community awareness and home visit programs should also be routinely undertaken, to help caregivers improve the health and well-being of the children under their care.

According to the 2013 NDHS, malnutrition in children in Namibia is a major challenge (MOHSS & ICF International, 2014). The report documents that approximately 26 percent of children under the age of five are stunted and 8 percent are severely stunted; 13 percent are underweight; and 6 percent are wasted. In this survey, we found that at least one in every 10 children between the ages 6–59 months were undernourished (using the MUAC measurement cutoff point of 12.5 centimeters). The findings from this study with regard to malnutrition in children in Namibia seem to be in line with the NDHS and other nutritional studies conducted in the country. Program-level data from PHN and CAA also support these findings in malnutrition. NARP is working with other stakeholders and the MOHSS in the drought response.

As discussed in the section on the study's limitations, we encountered challenges with the sampling frame on which the sample of clusters and households was based, even after review and making corrections to the sampling frame and confirming with PHN prior to the start of field work. During data collection, the field teams struggled to identify adequate numbers of households that were registered by the program to receive services through CAA. Not all originally sampled clusters had the required number of eligible households/beneficiaries, either because those households never existed, or because there were duplicate records in the list of beneficiaries, or because households/beneficiaries moved, or because they were no longer eligible to receive services, and had been discharged. But these households/beneficiaries remained in the database as active beneficiaries. These challenges with the list of beneficiaries in the sampling frame and other field issues led to a reduced sample of households that could be followed and interviewed, from our initial target households in the sample. Measures to address the situation had to be taken while teams were in the field collecting data.

The delay between households being discharged and reporting of discharged household status to the national office suggests that SOPs are not always followed. We recommend that additional quality control reviews be

undertaken to contextualize the findings of the MER Essential Indicator Survey. If the SOPs for interventions and support are followed, findings of the MER Essential Indicator Survey could be triangulated with additional data sources, such as the monthly reports filed by the regional CAA offices to the national office. Additionally, the accuracy of the beneficiary database should be reviewed regularly, to ensure that only active beneficiaries—those who are still receiving support from the CAA's OVC program—are listed.

This study of PEPFAR's OVC MER Essential Survey Indicators is the first of its kind in Namibia. Therefore, it serves as a baseline for future, similar studies in the country and across the region from which data can be compared, to assess progress over time and across aggregates. Because this study was the first, of course, there were challenges and lessons to be learned in the course of its implementation. This experience will help to shape and improve follow-up studies on OVC MER Essential Survey Indicators. More important, findings from this survey will contribute greatly to PEPFAR's DATIM data collection system, which requires data on the nine indicators.

Key Recommendations

- PHN should review and update its database to accurately reflect active beneficiaries of the program, to make it easier to identify which communities and households have been sustained. To facilitate follow-up with active beneficiaries, PHN should update contact information of beneficiary households and children.
- PHN should investigate the quality of the program data to validate what this survey reports. It should then take relevant action to ensure that the program activities and services reach their intended beneficiaries: the primary caregivers and the children under their care.
- Despite considerable progress made by the government and relevant institutions in terms of accessibility to birth registration and issuance of birth certificates, especially for OVC, many OVC are still without a birth certificate. This prevents them from accessing healthcare, education, and social grants. Registration is also crucial for preventing abuse, child trafficking, violence, and exploitation, and it facilitates the rights to adoption. The government, through its agencies and partners, needs to review the structure and administrative systems and procedures for issuing birth certificates. Relevant agencies should be more proactive in meeting the people where they live, especially those in remote rural areas. They should also explore the use of mobile technology for birth registration, and ways to improve information campaigns about the usefulness of birth registration and acquiring a birth certificate.
- Harsh physical punishment of children is associated with psychological trauma and abuse. There is a need to improve public awareness of violence and exploitation of children and the devastating toll they take on children and families. Institutions responsible for the health and well-being of children need to strengthen their efforts to prevent and manage violence against children at home and in schools and other child care institutions in Namibia.
- HIV testing among OVC was low. The government, PHN, CAA, and other partners in Namibia need to facilitate the referral of known HIV-exposed children and children whose serostatus is unknown for HIV testing and access to program services, medical care, and—when required—treatment.
- Households with hardships are not fully using governmental and nongovernmental social welfare grants, either for lack of awareness or because access to the grants is challenging. Communities and households in need would benefit from public information campaigns letting them know that the grants are available and from streamlined bureaucratic processes that make the grants easier to access.

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APPENDIX A. NAMIBIA OVC MER ESSENTIAL SURVEY INDICATOR QUESTIONNAIRE

SECTION 2: INTRODUCTION AND CONSENT

2.1 Hello. My name is _____ and I am working with Survey Warehouse. We are conducting a survey about child and caregiver well-being so that we can improve the impact of Government's and Catholic AIDS Action's (CAA) services and programs. To gather this information we are interviewing caregivers in some households. We have randomly chosen to visit your household. We would very much appreciate your participation in this survey. Participation involves answering a few easy questions about ALL children under your care who are between 0 and 17 years of age. If you care for a child between the ages of 0 and 4 years, I will also measure that child's mid-upper arm circumference.

2.2 The interview with you will take less than 30 minutes to complete. If you agree to participate, we will ask you questions using a cellular phone and we will note your answers on this password protected phone. The risks to you as a participant in this survey are minimal. Some of the questions are personal and some people may find them difficult to answer. You do not need to answer any questions that you do not want to. Your participation in this survey is voluntary. If you don't want to answer my questions, it is OK. If you agree to participate, you can decide not to answer certain questions and can stop the interview at any time. Your decision about whether to participate in this survey or to answer any specific questions will in no way affect any services that you receive. Other people will not know if you participated in this survey. We will put things we learn about you together with things we learn about other people from your community, so no one can tell what answers came from you. We will never use your name, so no one will ever know what answers you gave me.

2.3 Only a few data collectors will have access to this information, and all information will be stored on a password protected data base in the care of Survey Warehouse until it is destroyed in 2019. Your participation in this survey will not benefit you directly, but it may benefit others in the future, as your responses will improve our understanding of ways to provide better services to people in communities like yours. Before you say **yes or no** to participating, we will answer any questions you have. You can also ask me questions later. Do you have any questions now? **[Pause & answer all questions.]** If you have any questions later, you may contact the survey coordinator at +264 61 246 830.

CONSENT STATEMENT

2.4 I have had this entire consent form read to me, and any questions have been answered to my satisfaction. I agree to participate in this survey. **[Confirms by ticking the box below.]**

2.5 Data Collector confirmation:

Respondent Agrees to be interviewed	1	Continue with interviews
Respondent does not agree to be interviewed	2	Complete details on Cover Sheet and END

2.6 Interviewer Code

2.7 Interviewer Name

2.8 Date

SECTION 3: IDENTIFICATION DATA

3.1	Type of location	Urban 1 Rural 2
3.2	Region	
3.3 – 3.6	District	
3.8	Constituency [If applicable]	
3.9	Town/Village [If applicable]	
3.10	Neighbourhood [If applicable]	
3.11	Household Number [Record first 10 digits of the Unique ID Number from the sampling list.]	

SECTION 4: OVC MER INDICATOR QUESTIONNAIRE FOR CAREGIVERS

First, I have a few questions about you and the children under your care.

No.	Question	Coding Category	Skip
4.1	[Record caregiver sex.]	Female 1 Male 2	
4.2	How old were you at your last birthday? [Do not leave blank. If unknown, ask respondent to estimate.]	[__ __] years	
4.3	Have you personally ever received services or participated in activities from Catholic AIDS Action (CAA)? By this I mean, have you ever been visited by a community worker (community homebased care provider – CHBCP), or have you ever received services organized by the program?	Yes 1 No 2	**If No, Go to: 4.6**
4.4	How long ago did you start receiving services or participating in activities from Catholic AIDS Action (CAA)?	[__ __] months	
4.5	Have you personally received services or participated in activities from Catholic AIDS Action (CAA) in the last six months?	Yes 1 No 2	

4.6	Did your household incur any unexpected household expenses, such as a house repair or urgent medical treatment, in the last 12 months?	Yes 1 No 2	**If No, Go to: 4.8**
4.7	Was your household able to pay for these expenses?	Yes 1 No 2	
4.8	Do you think that hitting or beating a child is an appropriate means of discipline or control in the home?	Yes 1 No 2	
4.9	Do you think that hitting or beating a child is an appropriate means of discipline or control at school?	Yes 1 No 2	
4.10	How many children aged 0-4 years are you responsible for?	[__ __] children	
4.12	How many children aged 5-17 years are you responsible for?	[__ __] children	
4.15	[Record total number of children that caregiver cared for who are between 0-17.]	[__ __] children	
4.16	Are you currently registered to receive a social welfare grant from the government?	Yes 1 No 2	**If No, Go to: 4.18**
4.17	In the last 3 months, have you received all three monthly payments?	Yes 1 No 2	
4.18	I am going to read out a list of items and services. Please tell me if you, or anyone else in your household has received or accessed any of these items or services provided by Catholic AIDS Action (CAA) in the last 6 months.		

	Yes	**No**	**DK**	**Refused**
4.19 HIV testing and counseling	1	2	8	9
4.20 ART Adherence counseling	1	2	8	9
4.21 Nutritional screening and counseling	1	2	8	9
4.22 TB screening	1	2	8	9
4.23 OVC care and support services (psychosocial, legal, visits from community volunteer/CAA volunteer)	1	2	8	9
4.24 Referral support / services (on access to social grants, school fees exemption, mother-to-mother support groups, educational support, woman and child protection support)	1	2	8	9
4.25 Referral services to clinics (ART, PMTCT, TB, FP or general health care)	1	2	8	9

	4.26 Provision of temporary school fees / grants to promote school enrolment or progression	1	2	8	9	
	4.27 Provision of educational materials	1	2	8	9	
	4.28 Livelihood training/income generation	1	2	8	9	
	4.29 Community savings/lending group/ Village Savings and Loan Groups (VSL)	1	2	8	9	
	4.30 Life skills training	1	2	8	9	
	4.31 Vocational training scholarships	1	2	8	9	

SECTION 5: OVC MER INDICATOR QUESTIONNAIRE FOR CHILD AGED 0-4

4.32 I have a few questions about the children 0-4 years that you are responsible for. **[Refer to Q4.10. You must complete this section for each child aged between 0-4 years under the care of Caregiver in the household. All qualified children will have this section completed. Check to make sure the children are present, especially those between six months and 4 years. You will need to take the child's mid-upper arm circumference for all children aged between 6-59 months. Reconfirm to be sure if all children 0-4 years have been asked for.]**

No.	Question	Coding Category	Skip
5.2	Child's [NAME].		
5.3	Is [NAME] female or male?	Female 1 Male 2	
5.4	How old was [NAME] at her/his last birthday? [Do not leave blank. If unknown, ask caregiver to estimate.]	[__ __] years	
5.5	Does [NAME] have a birth certificate?	Yes 1 No 2	
5.6	[IF YES, ASK:] Can I see [NAME's] birth certificate? [MARK APPROPRIATE RESPONSE.]	Caregiver could not show me the birth certificate 1 Caregiver could show me the birth certificate 2	
5.7	In the past 3 days, did you or any household member over 15 years of age engage in any of the following activities with [NAME]: [Read out one at a time.]	Read books to or looked at picture books with [NAME]? Told stories to [NAME]?	

		Sang songs to [NAME] or with [NAME] including lullabies? Played with [NAME]? Named, counted, or drew things with [NAME]? None	
5.8	In the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2	
5.9	I don't want to know the results, but has [NAME] ever been tested to see if he/she has the HIV virus?	Yes 1 No 2	**If No, Go to: 5.11**
5.10	I don't want to know the results but do you know the results of [NAME's] HIV test?	Yes 1 No 2	
5.11	May I measure your child's mid-upper arm circumference?	Yes 1 No 2	**If No, Go to: 5.13**
5.12	[Measure the child's mid-upper arm circumference using the MUAC tape and document measurements.]	[__|__].[__|__] Cm	
5.13	Has [NAME] ever received services or participated in activities from Catholic AIDS Action (CAA)?	Yes 1 No 2	**If No: GO TO NEXT CHILD**
5.14	How long ago did [NAME] start receiving services or participating in activities from Catholic AIDS Action (CAA)?	[__ __] months	
5.15	Has [NAME] received services or participated in activities from Catholic AIDS Action (CAA) in the last six months?	Yes 1 No 2	

SECTION 6 AND 7: MER INDICATOR QUESTIONNAIRE FOR CHILD AGED 5-17

6.1 I have a few questions about children aged 5-17 that you are responsible for. **[Refer to 4.12. You must complete this section for each child aged between 5-17 years under the care of Caregiver in the household. All qualified children will have this section completed. Children are grouped in the following ages 5-9, 10-14, and 15-17 if the household has these children in different age groups. These children are assumed to be in school. Reconfirm to be sure all children between 5-17 years under the Caregiver have been reported.]**

No.	Question	Coding Category	SKIP
7.3	Child's [NAME].		
7.4	Is [NAME] female or male?	Female 1 Male 2	
7.5	How old was [NAME] at their last birthday? [Do not leave blank. If unknown, ask caregiver to estimate.]	[__|__] years	
7.6	Does [NAME] have a birth certificate?	Yes 1 No 2	
7.7	[IF YES, ASK:] Can I see [NAME's] birth certificate? [MARK APPROPRIATE RESPONSE.]	Caregiver could not show me the birth certificate 1 Caregiver could show me the birth certificate 2	
7.8	Is [NAME] currently enrolled in school?	Yes 1 No 2	**If No, Go to: 7.11**
7.9	During the last school week, did [NAME] miss any school days for any reason?	Yes 1 No 2	
7.10	What grade is [NAME] in now?	[__|__]	
7.11	Was [NAME] enrolled in school during the previous school year?	Yes 1 No 2	**If No, Go to: 7.13**
7.12	What grade was [NAME] during the previous school year?	[__|__]	
7.13	At any point in the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2	
7.14	I don't want to know the results, but has [NAME] ever been tested to see if he/she has the HIV virus?	Yes 1 No 2	**If No, Go to: 7.16**
7.15	I don't want to know the results but do you know the results of [NAME's] HIV test?	Yes 1 No 2	
7.16	Has [NAME] ever received services or participated in activities from Catholic AIDS Action (CAA)?	Yes 1 No 2	**If No: NEXT CHILD/END**

7.17	How long ago did [NAME] start receiving services or participating in activities from Catholic AIDS Action (CAA)?	[__ __] months	
7.18	Has [NAME] received services or participated in activities from Catholic AIDS Action (CAA) in the last six months?	Yes 1 No 2	

SECTION 8: INTERVIEW LOG

Thank you. We have reached the end of the interview. Thank you very much for participating in this survey.

8.1	Which visit was this?	Visit 1 Visit 2 Visit 3	1 2 3	
8.2	[Record date of the visit]			
8.3	What was the outcome of this visit?	Completed	1	
		Appointment made for the same day	2	**Only if First or Second visit**
		Appointment made for another day	3	
		Refused to continue, and no appointment made	4	
		Other	5	**Go to 8.4**
8.4	If OTHER in 8.3 above, please specify:			
8.5	Record any other comments that you might have.			

APPENDIX B. SUPERVISORS DQA QUESTIONNAIRE FOR RE-INTERVIEWS: NAMIBIA OVC MER ESI SURVEY

SECTION 2: INTRODUCTION AND CONSENT

2.1 Hello. My name is _____ and I am working with Survey Warehouse. We are conducting a survey about child and caregiver well-being so that we can improve the impact of Government's and Catholic AIDS Action's (CAA) services and programs. To gather this information we are interviewing caregivers in some households. We have randomly chosen to visit your household. We would very much appreciate your participation in this survey. Participation involves answering a few easy questions about ALL children under your care who are between 0 and 17 years of age. If you care for a child between the ages of 0 and 4 years, I will also measure that child's mid-upper arm circumference.

2.2 The interview with you will take less than 30 minutes to complete. If you agree to participate, we will ask you questions using a cellular phone and we will note your answers on this password protected phone. The risks to you as a participant in this survey are minimal. Some of the questions are personal and some people may find them difficult to answer. You do not need to answer any questions that you do not want to. Your participation in this survey is voluntary. If you don't want to answer my questions, it is OK. If you agree to participate, you can decide not to answer certain questions and can stop the interview at any time. Your decision about whether to participate in this survey or to answer any specific questions will in no way affect any services that you receive. Other people will not know if you participated in this survey. We will put things we learn about you together with things we learn about other people from your community, so no one can tell what answers came from you. We will never use your name, so no one will ever know what answers you gave me.

2.3 Only a few data collectors will have access to this information, and all information will be stored on a password protected data base in the care of Survey Warehouse until it is destroyed in 2019. Your participation in this survey will not benefit you directly, but it may benefit others in the future, as your responses will improve our understanding of ways to provide better services to people in communities like yours. Before you say **yes or no** to participating, we will answer any questions you have. You can also ask me questions later. Do you have any questions now? **[Pause & answer all questions.]** If you have any questions later, you may contact the survey coordinator at +264 61 246 830.

CONSENT STATEMENT

2.4 I have had this entire consent form read to me, and any questions have been answered to my satisfaction. I agree to participate in this survey. **[Confirms by ticking the box below.]**

2.5 Data Collector confirmation:

Respondent Agrees to be interviewed	1	Continue with interviews

Respondent does not agree to be interviewed	2	Complete details on Cover Sheet and END

2.6 Interviewer Code

2.7 Interviewer Name

2.8 Date

SECTION 3: IDENTIFICATION DATA

3.1	Type of location	Urban Rural	1 2
3.2	Region		
3.3 – 3.6	District		
3.8	Constituency [If applicable]		
3.9	Town/Village [If applicable]		
3.10	Neighbourhood [If applicable]		
3.11	Household Number [Record first 10 digits of the Unique ID Number from the sampling list.]		

SECTION 4: OVC MER INDICATOR QUESTIONNAIRE FOR CAREGIVERS

First, I have a few questions about you and the children under your care.

No.	Question	Coding Category	Skip
4.1	[Record caregiver sex.]	Female 1 Male 2	
4.2	How old were you at your last birthday? [Do not leave blank. If unknown, ask respondent to estimate.]	[__ __] years	
4.3	Have you personally ever received services or participated in activities from Catholic AIDS Action (CAA)? By this I mean, have you ever been visited by a community worker (community homebased care provider – CHBCP), or have you ever received services organized by the program?	Yes 1 No 2	**If No: GO TO 4.6**
4.4	How long ago did you start receiving services or participating in activities from Catholic AIDS Action (CAA)?	[__ __] months	
4.5	Have you personally received services or participated in activities from Catholic AIDS Action (CAA) in the last six months?	Yes 1 No 2	
4.6	Did your household incur any unexpected household expenses, such as a house repair or urgent medical treatment, in the last 12 months?	Yes 1 No 2	**If No: 4.8**
4.7	Was your household able to pay for these expenses?	Yes 1 No 2	
4.8	Do you think that hitting or beating a child is an appropriate means of discipline or control in the home?	Yes 1 No 2	
4.9	Do you think that hitting or beating a child is an appropriate means of discipline or control at school?	Yes 1 No 2	
4.10	How many children aged 0-4 years are you responsible for?	[__ __] children	
4.12	How many children aged 5-17 years are you responsible for?	[__ __] children	
4.15	[Record total number of children that caregiver cared for who are between 0-17.]		
4.16	Are you currently registered to receive a social welfare grant from the government?	Yes 1 No 2	**If No: 4.18**

4.17	In the last 3 months, have you received all three monthly payments?	Yes 1 No 2				
4.18	I am going to read out a list of items and services. Please tell me if you, or anyone else in your household has received or accessed any of these items or services provided by Catholic AIDS Action (CAA) in the last 6 months.					
		Yes	**No**	**DK**	**Refused**	
	4.19 HIV testing and counseling	1	2	8	9	
	4.20 ART Adherence counseling	1	2	8	9	
	4.21 Nutritional screening and counseling	1	2	8	9	
	4.22 TB screening	1	2	8	9	
	4.23 OVC care and support services (psychosocial, legal, visits from community volunteer/CAA volunteer)	1	2	8	9	
	4.24 Referral support / services (on access to social grants, school fees exemption, mother-to-mother support groups, educational support, woman and child protection support)	1	2	8	9	
	4.25 Referral services to clinics (ART, PMTCT, TB, FP or general health care)	1	2	8	9	
	4.26 Provision of temporary school fees / grants to promote school enrolment or progression	1	2	8	9	
	4.27 Provision of educational materials	1	2	8	9	
	4.28 Livelihood training/income generation	1	2	8	9	
	4.29 Community savings/lending group/ Village Savings and Loan Groups (VSL)	1	2	8	9	
	4.30 Life skills training	1	2	8	9	
	4.31 Vocational training scholarships	1	2	8	9	

SECTION 5: OVC MER INDICATOR QUESTIONNAIRE FOR CHILD AGED 0-4

4.32 I have a few questions about the children 0-4 years that you are responsible for. **[Refer to Q4.10. You must complete this section for each child aged between 0-4 years under the care of Caregiver in the household. All qualified children will have this section completed. Check to make sure the children are present, especially those between six months and 4 years. You will need to take the child's mid-upper arm circumference for all children aged between 6-59 months. Reconfirm to be sure if all children 0-4 years have been asked for.]**

No.	Question	Coding Category	Skip
5.2	Child's [NAME].		
5.3	Is [NAME] female or male?	Female 1 Male 2	
5.4	How old was [NAME] at her/his last birthday? [Do not leave blank. If unknown, ask caregiver to estimate.]	[__ __] years	
5.5	Does [NAME] have a birth certificate?	Yes 1 No 2	
5.6	[IF YES, ASK:] Can I see [NAME's] birth certificate? [MARK APPROPRIATE RESPONSE.]	Caregiver could not show me the birth certificate 1 Caregiver could show me the birth certificate 2	
5.7	In the past 3 days, did you or any household member over 15 years of age engage in any of the following activities with [NAME]: [Read out one at a time.]	Read books to or looked at picture books with [NAME]? Told stories to [NAME]? Sang songs to [NAME] or with [NAME] including lullabies? Played with [NAME]? Named, counted, or drew things with [NAME]? None	
5.8	In the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2	
5.9	I don't want to know the results, but has [NAME] ever been tested to see if he/she has the HIV virus?	Yes 1 No 2	**If No: 5.11**

5.10	I don't want to know the results but do you know the results of [NAME's] HIV test?	Yes 1 No 2	
5.11	May I measure your child's mid-upper arm circumference?	Yes 1 No 2	**If No: 5.13**
5.12	[Measure the child's mid-upper arm circumference using the MUAC tape and document measurements.]	[__|__].[__|__] Cm	
5.13	Has [NAME] ever received services or participated in activities from Catholic AIDS Action (CAA)?	Yes 1 No 2	**If No: GO TO NEXT CHILD**
5.14	How long ago did [NAME] start receiving services or participating in activities from Catholic AIDS Action (CAA)?	[__ __] months	
5.15	Has [NAME] received services or participated in activities from Catholic AIDS Action (CAA) in the last six months?	Yes 1 No 2	

SECTION 6 AND 7: MER INDICATOR QUESTIONNAIRE FOR CHILD AGED 5-17

6.1 I have a few questions about children aged 5-17 that you are responsible for. **[Refer to 4.12. You must complete this section for each child aged between 5-17 years under the care of Caregiver in the household. All qualified children will have this section completed. Children are grouped in the following ages 5-9, 10-14, and 15-17 if the household has these children in different age groups. These children are assumed to be in school. Reconfirm to be sure all children between 5-17 years under the Caregiver have been reported.]**

No.	Question	Coding Category	SKIP
7.3	Child's [NAME].		
7.4	Is [NAME] female or male?	Female 1 Male 2	
7.5	How old was [NAME] at their last birthday? [Do not leave blank. If unknown, ask caregiver to estimate.]	[__|__] years	
7.6	Does [NAME] have a birth certificate?	Yes 1 No 2	
7.7	[IF YES, ASK:] Can I see [NAME's] birth certificate? [MARK APPROPRIATE RESPONSE.]	Caregiver could not show me the birth certificate 1	

		Caregiver could show me the birth certificate 2	
7.8	Is [NAME] currently enrolled in school?	Yes 1 No 2	**If No: 7.11**
7.9	During the last school week, did [NAME] miss any school days for any reason?	Yes 1 No 2	
7.10	What grade is [NAME] in now?	[__|__]	
7.11	Was [NAME] enrolled in school during the previous school year?	Yes 1 No 2	**If No: 7.13**
7.12	What grade was [NAME] during the previous school year?	[__|__]	
7.13	At any point in the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2	
7.14	I don't want to know the results, but has [NAME] ever been tested to see if he/she has the HIV virus?	Yes 1 No 2	**If No: 7.16**
7.15	I don't want to know the results but do you know the results of [NAME's] HIV test?	Yes 1 No 2	
7.16	Has [NAME] ever received services or participated in activities from Catholic AIDS Action (CAA)?	Yes 1 No 2	**If No: NEXT CHILD/END**
7.17	How long ago did [NAME] start receiving services or participating in activities from Catholic AIDS Action (CAA)?	[__ __] months	
7.18	Has [NAME] received services or participated in activities from Catholic AIDS Action (CAA) in the last six months?	Yes 1 No 2	

SECTION 8: INTERVIEW LOG

Thank you. We have reached the end of the interview. Thank you very much for participating in this survey.

8.1	Which visit was this?	Visit 1 1 Visit 2 2 Visit 3 3	
8.2	[Record date of the visit]		
8.3	What was the outcome of this visit?	Completed 1	

		Appointment made for the same day	2	**Only if First or Second visit**
		Appointment made for another day	3	
		Refused to continue, and no appointment made	4	
		Other	5	**Go to 8.4**
8.4	If OTHER in 6.3 above, please specify:			
8.5	Record any other comments that you might have.			

APPENDIX C. NAMIBIA OVC MER ESSENTIAL INDICATOR SURVEY TEAM MEMBERS

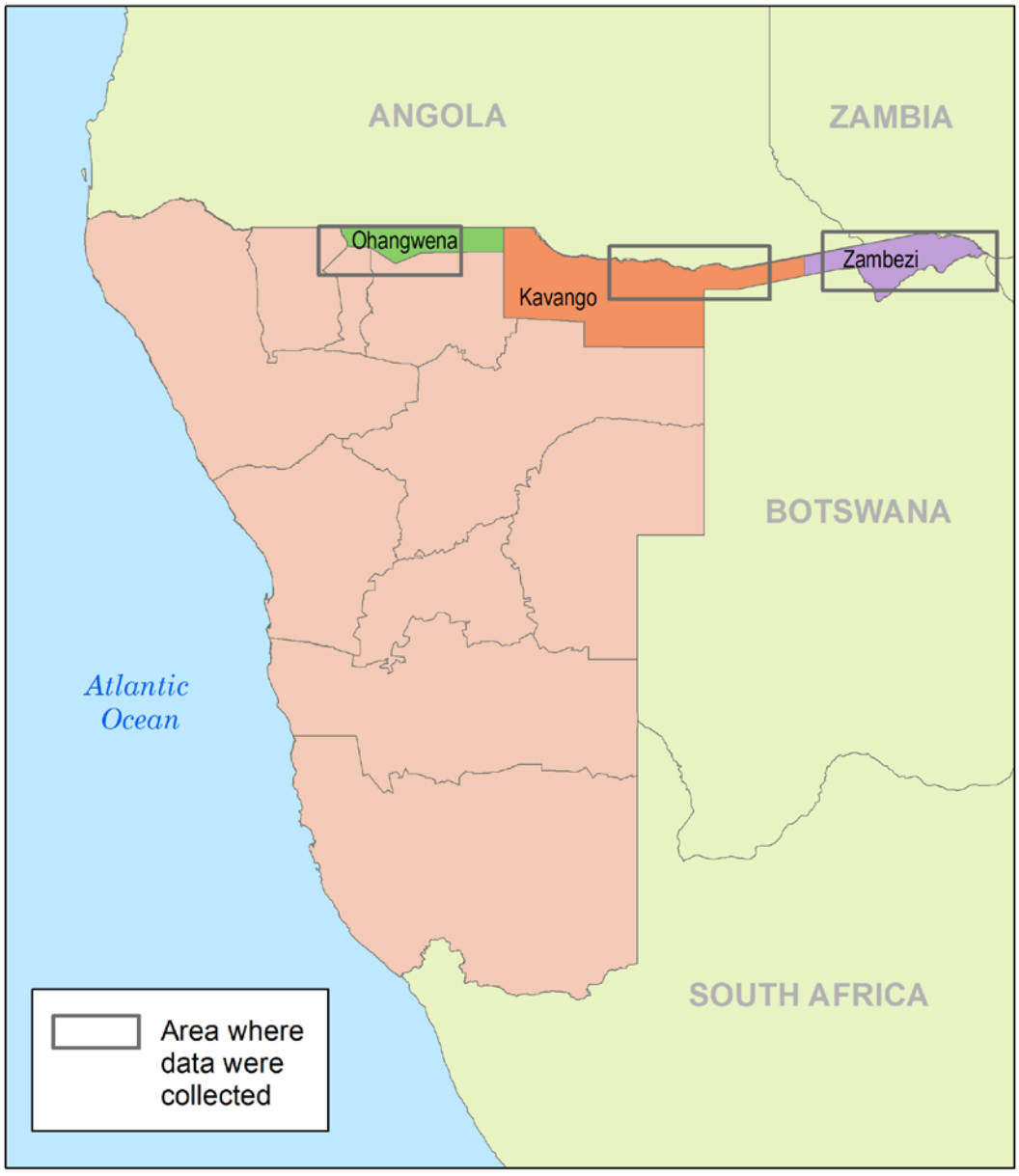
MEASURE Evaluation

	Robert Mswia
	Walter Obiero

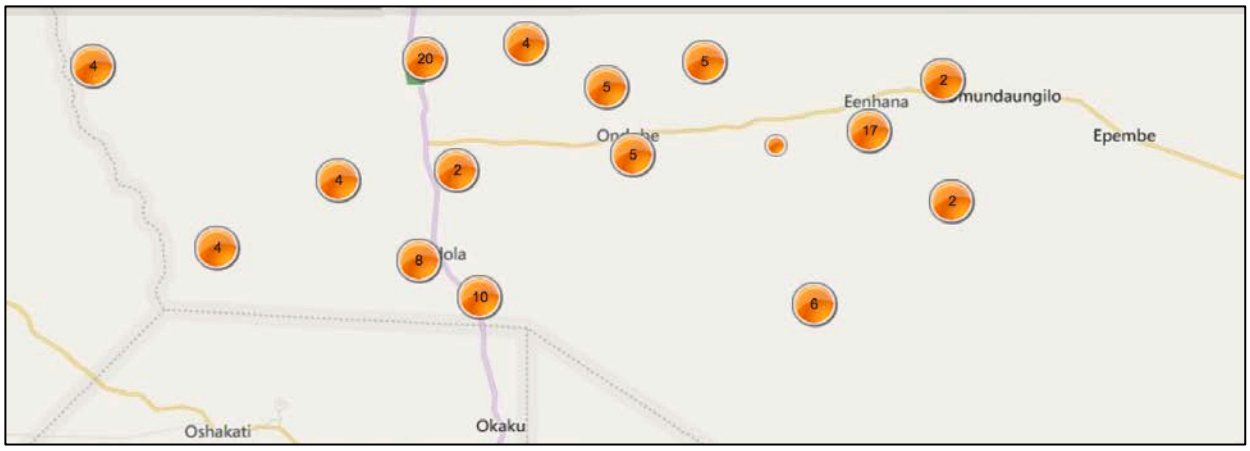
Survey Warehouse Project Team

Project Manager	Lizl Stoman
Field Manager	Petrus Shikongo
Data Manager	Pieter Stoman
Project Accountant	Benita Blaauw
Research Assistant	Luciano Siluka
Field Supervisors	Freddie Muyamba
	Joseph Theodor
	Elton Imene
	Petrus Mwashekuna
Field Interviewers	Elise Mwatanhele
	Raukinen Katshuna
	Justina Iipinge
	Selma Kuuvilwa
	Leonard Mweshihange
	Victoria Nghilondo
	Gertrude Aindongo
	Josefina Endjala
	Desdelius Mashonde
	Elvis Siyamba
	Petrus Kalipa
	Siegberth Kahare
	Rodrick Samwele
	Elvis Muyenga
	Gloria Simataa
	Mukowa Lilungwe

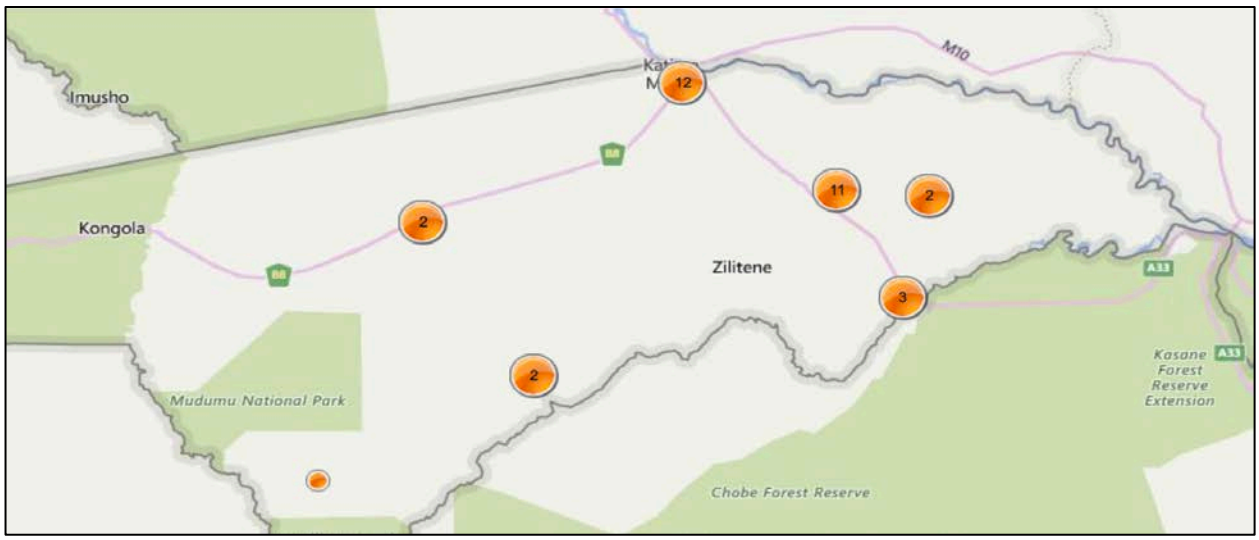
APPENDIX D. MAP OF NAMIBIA SHOWING STUDY AREAS AND DATA COLLECTION SITES



Data collection sites in Zambezi



Data collection Sites in Kavango



Data collection sites in Ohangwena

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