Monitoring the Outcomes of Orphans and Vulnerable Children Programs in Namibia

Findings from 2016–2018 Panel Data, Project HOPE Namibia

April 2019

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation

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Cover: Beneficiary child in Ohausholo village in Eenhana district, Ohangwena Region, Namibia.
Photo: Robert Mswia, MEASURE Evaluation, Palladium

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CONTENTS

Abbreviations 8

Executive Summary 9

Introduction 13

OVC Program Areas that USAID/Namibia Supports 14

Project HOPE Namibia (PHN) and Catholic AIDS Action (CAA) 14

PEPFAR MER OVC ESI 15

Study Objectives 17

Study Design, Data Collection Methods, and Analysis 18

Design of the Study and Sample Size 18

Household Listing Verification and Community Trace and Verify 18

Field Implementation 20

Data Collection Challenges 21

Sample Realization (Response Rate) 24

Survey Limitations 24

Panel Data Construction and Data Analysis 27

Results 30

Characteristics of the Study Population 30

Support and Services Received by Beneficiaries from Project HOPE/CAA 31

PEPFAR MER OVC ESI 33

Indicator OVC_HIVST: Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status 33

Indicator OVC_NUT: Percent of children (aged 6–59 months) who are undernourished 35

Indicator OVC_SICK: Percent of children (aged 0–17 years) too sick to participate in daily activities 35

Indicator OVC_BCERT: Percent of children (aged 0–17 years) who have a birth certificate 37

Indicator OVC_SCHATT: Percent of children (aged 5–17 years) regularly attending school 39

Indicator OVC_PRGS: Percent of children (aged 5–17 years) who progressed in school during the last year 41

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 43

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 44

Indicator OVC_MONEY: Percent of households able to access money to pay for unexpected household expenses 45

Discussion and Recommendations 47

References 50

Appendix 1. Namibia MER OVC Essential Survey Indicators Questionnaire 51

Appendix 2. Namibia MER OVC Essential Survey Indicators Field Teams 64

Appendix 3. Additonal Table(s) 66
Appendix 4. Map of Namibia Showing Study Areas and Data Collection Sites 67

TABLES

Table 1. Namibia MER OVC ESI, comparing the 2016 and 2018 MER survey rounds 10
Table 2. PEPFAR MER ESI for OVC programs 16
Table 3. Outcomes of the CTV exercise, by region 20
Table 4. Outcome of the follow-up visit of households during the 2018 round 2 MER ESI survey for the households that were included in the 2016 round 1 survey 24
Table 5. Types of services/support received by beneficiary households from CAA during the six months prior to the September 2018 round 2 survey 26
Table 6. A scenario demonstrating inclusion or exclusion in the panel data for specific age (and sex) of a child between the two survey rounds 28
Table 7. Number of households included in each of panel for various MER ESI by age and sex 29
Table 8. Demographic characteristics of children ages 0–17 under the care of primary caregiver in the study population, by survey round 31
Table 9. Items and/or program services provided by CAA that had been received or accessed by the household (primary caregiver or any other member of household) in the six months prior to the MER surveys (includes only households in the panel—comparing round 1 and round 2 surveys) 32
Table 10. OVC_HIVSTAT: Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status 34
Table 11. OVC_NUT: Percent of children (aged 6–59 months) in the panel who are undernourished, by sex 35
Table 12. OVC_SICK: Percent of children (aged 0–17 years) too sick to participate in daily activities, by sex and age 36
Table 13. OVC_BCERT: Percent of children (aged 0–17 years) who have a birth certificate (and verified) 38
Table 14. OVC_SCHATT: Percent of children (aged 5–17 years) regularly attending school, by age and sex 40
Table 15. OVC_PRGS: Percent of children (aged 5–17 years) who progressed in school year during the last year, by age and sex 42
Table 16. OVC_STIM: Percentage of children <5 years of age who recently engage in stimulating activities with any household member over 15 years 44
Table 17. OVC_CP - Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control children in the home or at school, by sex 45
Table 19: OVC_CERT: Percent of children (aged 0–17 years) who have a birth certificate as reported by caregiver, including those that were verified and not verified by interviewer 66

ABBREVIATIONS

ART	antiretroviral therapy
CAA	Catholic AIDS Action
CHBCP	community home-based care provider
CHW	community health worker
CI	confidence interval
CLHIV	children living with HIV
COP	country operational plan
ESI	essential survey indicators
ID	identification
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
NAMPHIA	Namibia Population-Based HIV Impact Assessment
NARP	Namibia Adherence and Retention Program
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHN	Project HOPE Namibia
PLHIV	people living with HIV
SPSS	Statistical Package for Social Sciences
USAID	United States Agency for International Development
Project HOPE	Project (Health Opportunities to People Everywhere)
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

This report presents panel data on outcomes of a program implemented by Project Health Opportunities to People Everywhere (HOPE) Namibia (PHN) and its partners to improve the well-being of orphans and vulnerable children (OVC) and beneficiary households in Namibia. These findings will support evidence-informed strategy, programming, and resource allocation by Namibian stakeholders: the United States President's Emergency Plan for AIDS Relief (PEPFAR)/Namibia, the Namibian government (Ministry of Health and Social Services [MOHSS] and Ministry of Gender and Child Welfare [MGECW]), implementing partners, and others. They will also contribute to PEPFAR's global evidence base on the effectiveness of PEPFAR's OVC programming.

In 2014, PEPFAR introduced a set of outcome indicators for OVC programs, referred to as monitoring, evaluation, and reporting (MER) essential survey indicators (ESI), with the requirement that these indicators be collected every two years by a research organization external to the OVC program. These outcome indicators reflect internationally-accepted developmental milestones and collectively measure the holistic well-being of children over time. A standardized survey methodology and tools have been developed to collect these data in countries where PEPFAR is supporting OVC programs.

MEASURE Evaluation conducted the first round of the MER OVC ESI in November 2016 and the second round in September 2018 for PHN.

Objectives of the Study

The survey is designed to answer the overall question: *What is the well-being of child participants in the Project HOPE PEPFAR-funded OVC project in the six health districts of Namibia, and have there have been any improvements over time?* The survey assessed the well-being of child beneficiaries enrolled in PHN in November 2016 (round 1) and the same households were followed up again in September 2018 (round 2). OVC well-being is measured by eight dimensions through the nine MER essential indicators. PEPFAR requires that data for the MER essential indicator survey be collected at two points in time over a two-year period so that progress can be tracked over time. This report covers panel data collected at two points in time and includes only households that were successfully interviewed during both rounds of the survey for these MER OVC ESI in Namibia.

Survey Design and Methods

MEASURE Evaluation, in partnership with Survey Warehouse of Namibia, conducted the round 2 household survey using a sampling frame generated during the round 1 survey from among beneficiaries enrolled in PHN at that time. In preparation for the round 2 survey, a household listing from the baseline survey was verified by comparison with current records at PHN and by a community trace and verify exercise involving PHN and Catholic AIDS Action (CAA) community volunteers. Primary caregivers of OVC were interviewed (one caregiver per household) about the program services received or accessed and/or activities offered by the project aimed at improving the general health and well-being of the children in the household. Data collection used a standardized questionnaire programmed for tablets, using the SurveyToGo data capture system.

Primary caregivers of children ages 0–17 years were asked questions about themselves, their respective households, and all children in the household under the age of 18 years for whom they were responsible. In addition to questions relating to the MER OVC essential indicators, mid-upper arm circumference

(MUAC) measurements were taken for all the children ages 6–59 months who were present at home during the survey period.

To facilitate data exploration, data cleaning, editing, construction of panel data, and data analysis, survey data from the SurveyToGo platform were exported to Statistical Package for Social Sciences (SPSS) and Stata software. To assess changes over time, a t-test for statistical significance was employed to test the difference between indicator estimates at round 1 and round 2 time points. The t-test results indicate whether any differences observed between the two time periods (by sex, residential location, and/or age categories) are due to chance alone, or indicate a real change, based on a pre-determined level of statistical significance.

Overall Findings

Table 1 summarizes major findings for the nine MER OVC ESI, based on a comparison of survey findings at round 1 and round 2 for the same households in Namibia. Table 1 presents the overall findings by relevant age range for the child indicators, and for both sexes combined. Details can be found in the indicator-specific tables (Tables 9–17).

Table 1. Namibia MER OVC ESI, comparing the 2016 and 2018 MER survey rounds

MER OVC essential survey indicators	Round 1 (2016) percentage (95% CI)	Round 2 (2018) percentage (95% CI)	Significance test: *P-value**
OVC_HIVST: Percent of children (aged 0-17 years) whose primary caregiver knows the child's HIV status	55.1 (51.7 – 58.6)	64.1 (60.8 – 67.5)	<0.001**
OVC_NUT: Percent of children (aged 6-59 months) who are undernourished	11.2 (8.7 – 14.3)	11.8 (9.1 – 15.2)	0.765
OVC_SICK: Percent of children (aged 0-17 years) too sick to participate in daily activities	24.3 (21.7 – 26.9)	12.8 (11.0 – 14.6)	<0.001**
OVC_BCERT: Percent of children (aged 0-17 years) who have a birth certificate (*and verified*)	57.0 (53.6 – 60.5)	60.1 (56.9 – 63.3)	0.212
OVC_SCHATT: Percent of children (aged 5-17 years) regularly attending school	67.9 (64.7 – 71.1)	76.9 (74.2 – 79.6)	<0.001**
OVC_PRGS: Percent of children (aged 5-17 years) who progressed in school during the last year	73.2 (70.0 – 76.4)	75.2 (72.3 – 78.0)	0.366
OVC_STIM: Percent of children< 5 years of age who recently engage in stimulating activities with any household member over 15 years	59.3 (53.6 – 64.9)	87.1 (83.6 – 90.6)	<0.001**
OVC_CP: Percent of Caregivers who agree that harsh physical punishment is an appropriate means of discipline or control children in the home or at school	61.8 (57.7 – 65.9)	42.0 (37.9 – 46.2)	<0.001**
OVC_MONEY: Percent of households able to access money to pay for unexpected household expenses	56.0 (49.7 – 62.2)	48.8 (42.0 – 55.6)	0.129

* Testing the difference between two proportions, comparing round 1and round 2 estimates using paired T-test

** Difference between two survey rounds is statistically significant at 5 percent level

Discussion

Overall findings indicate that PHN beneficiary households showed improvement over time, with findings attaining a high level of statistical significance, for at least five of the nine MER indicators: OVC_HIVST, OVC_SICK, OVC_SCHATT, OVC_STIM, and OVC_CP. The size of the observed differences further indicates that these changes are socially meaningful, as well as statistically significant.

OVC_HIVST: Overall, within the same households that were followed up during the two surveys, there was a nine percent increase from the round 1 survey (55 percent) to the round 2 survey (64 percent) among caregivers who reported that the children under their care had been tested for HIV and that the caregiver knew the results of the HIV test.

OVC_SICK: Approximately 50 percent reduction was observed during the round 2 survey for the children ages 0–17 years who were reported to be too sick to participate in daily activities. At round 1, the proportion was 24 percent, whereas the proportion from the same households among children who were reported to be too sick to participate in daily activities during round 2 survey was 13 percent.

OVC_SHATT: The proportion of children (ages 5–17 years) regularly attending school increased from 68 percent during round 1 to about 78 percent during the round 2 survey.

OVC_STIM: The percentage of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years increased by 28 percent during the round 2 survey compared to what was reported during the round 1 survey.

OVC_CP: The percentage of caregivers who agreed that harsh physical punishment is an appropriate means of discipline or to control children in the home or at school decreased by about 20 percentage point at the round 2 survey compared to the round 1 survey, indicating significant improvement within the same households.

Possible improvement was shown for three additional indicators: OVC_NUT, OVC_BCERT, and OVC_PRGS. Measurement showed movement in the desired direction, but these changes did not attain statistical significance.

The findings indicated a possible decline for only one indicator, OVC_MONEY, but the negative difference did not attain statistical significance. Caregivers' participation in economic strengthening activities, such as PHN village savings and loans groups, allow households to meet basic needs. However, the prevailing economic recession makes it increasingly difficult to budget for unexpected expenses. In addition to this, social grants act as a safety net to many OVC households, and often these grants are the only sources of income for these households. However, access to these grants is hampered by the lack of national documents, such as birth certificates.

Overall, these findings indicate that PHN OVC programs have a positive impact on the health and well-being of the household and children served in Namibia, and furthermore, that the overall benefits extend beyond the life of the program. While we cannot directly attribute 100 percent of these improvements to the households' participation in the PHN or CAA's OVC programs, it is evident that these OVC programs have contributed greatly to empower the caregivers in seeking the good health and welfare of children under their care, and as explained below, even beyond the life of their participation in the program.

Caveats

(See the section on Survey Limitations for a full discussion.)

During preparatory stages and while implementing the round 2 survey in Namibia, we were informed by PHN and CAA that a number of households that we had visited during the baseline in 2016 were no longer part of their program. PHN was successfully able to match the household identification number of 519 (88%) households out of 591 households visited in the baseline survey. However, based on the documentation in the database, a large proportion of these matched households (66%) were no longer served by CAA, the PHN's implementing partner in Ohangwena, Zambezi, and Kavango regions. Of this 66 percent, 148 clients graduated from the programme, 116 were lost to follow-up or exited the program without any reason, 70 clients transitioned out of the program, eight relocated to other areas, and three clients passed away.

The reason for this is that there has been a change in focus on enrolling children living with HIV (CLHIV). This affected a shift in focus with regard to the eligibility criteria for households and beneficiary children to be part of the program and receive OVC services to include households that had at least one HIV-positive child age 0–17 years. The implementation of this focus started towards the middle of 2018, when the Namibia Adherence and Retention Program (NARP) got an extension for another 2 years. This meant that the majority of the households that were included during round 1 and the ones we were following for interview during the round 2 survey had not received services from PHN or CAA from mid-2018 onward, and hence they had been graduated. However, for the purpose of the MER survey, we visited and interviewed all the households that were interviewed during round 1 and were located during the round 2 survey, regardless of their current eligibility and graduation status.

In addition to ESI questions asked during interviews, each caregiver was asked three questions related to graduation of the households or beneficiary children under their care. The three questions did not yield any useful information for analysis since almost all these households that were supposed to have been graduated were not aware of the changes in their participation to the program. As a result, we could not conduct separate assessments for those who were still in the program and those who had graduated. PHN informed us that they have also noted that community home-based care providers find it difficult to severe ties with clients and in many instances do not inform clients that they have been graduated.

Despite that some households had been graduated because of the change in eligibility criteria, we still saw improvements in the nine MER OVC ESI over time for the same households that were followed, with the difference between two survey rounds for five of the essential indicators being statistically significant. While we cannot directly attribute 100 percent of these improvements to the households' participation in PHN or CAA's OVC programs, it is evident that these OVC programs have contributed greatly to empower the caregivers in seeking the good health and welfare of children under their care even beyond the life of their participation in the program.

Recommendation for Future Studies

The MER OVC ESI and accompanying guidance are being revised, and PHN is now implementing OVC programs and services under the same eligibility criteria, with an increased focus on CLHIV. We recommend that a new set of outcome evaluation studies that include the revised MER OVC ESI be conducted for the new sites where PHN had started implementing OVC programs. This will yield true baseline indicators for program services that began in 2018 and allow a follow-up panel survey when the program ends to measure the outcome/impact of these new programs over time.

INTRODUCTION

This report presents panel data on outcomes of a program implemented by PHN and its partners to improve the well-being of OVC and beneficiary households in Namibia. These findings will support evidence-informed strategy, programming and resource allocation by Namibian stakeholders: PEPFAR/Namibia, the Namibian government (MOHSS and MGECW), implementing partners, and others. They will also contribute to PEPFAR's global evidence base on the effectiveness PEPFAR's OVC programming.

The Republic of Namibia is a large and sparsely populated country in southwest Africa, with an overall population of a little over 2.5 million as of 2018 projections. Namibia is marked by a very high number of HIV infections. According to the Namibia Population-Based Impact Assessment (NAMPHIA) report, prevalence of HIV among adults ages 15–64 years in the country is 12.6 percent (with 15.7% among females and 9.3% among males) (NAMPHIA, 2018). Apart from the social implications of HIV, the disease is becoming an economic problem, too: the most productive age group (25–44 years) also accounts for the highest number of HIV infections. The HIV epidemic has generated a large population of OVC in Namibia, as it has worldwide. Among the 129,920 national OVC (Namibia Statistics Agency, 2017), the status of nearly half of them is HIV-related (that is, children who are affected by HIV, whereby one or both parents are living with HIV or one or both parents died from AIDS, and children who are themselves HIV infected). The Government of Namibia is responding to this growing population by adopting the National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22, which emphasizes continuation of HIV services for OVC, premised on the combination prevention approach that supports, on the one hand, the implementation of biomedical, sociobehavioral, and structural interventions premised on human rights and gender sensitivity and that are evidence-informed, and on the other, linkages to OVC programs (Namibian Ministry of Health and Social Services, Directorate of Special Programmes, 2017). According to UNICEF, among adolescents tested for HIV in the last 12 months, 14 percent of males and 29 percent of females received results (Children of the World, 2017). The 2016 UNICEF report on out-of-school children found that one in five children of school-going age is not in school, and another 15 percent are at risk of dropping out. These children are from the most disadvantaged communities, which are also located in the regions with the highest HIV burden.

UNAIDS calls on countries to reach the following by 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 (ART), and 90 percent of all people receiving ART will have viral suppression (UNAIDS, 2014). PEPFAR/Namibia, collaborating across United States Government agencies, supports the Government of Namibia to attain the global 90-90-90 goals. The PEPFAR/Namibia Country Operational Plan (COP) for U.S. fiscal year 2018 (COP17) and U.S fiscal year 2019 (COP18) emphasizes the overall strategy to ensure progress toward achieving sustainable HIV epidemic control in Namibia by 2020. Strategies include scaling up HIV testing services through innovative case-finding strategies, linkage of PLHIV to quality treatment services, retention on treatment through tailored patient care management, prevention of new infections through targeted outreach to and medical interventions for those most at risk, increased partner capacity and expertise to deliver, and investing in systems to ensure that Namibian institutions can maintain and sustain epidemic control by 2020 and beyond. PEPFAR/Namibia also supports implementation of OVC programs in partnership with the MGECW, MOHSS, and Ministry of Education. The OVC programs provide a pathway through which OVCs receive comprehensive support, including knowing their HIV status and linkage to treatment, and programs and services are aligned to geographic areas of the highest HIV burden and greatest unmet ART needs for children and adult populations. The targeted activities ensure that OVC and their caregivers receive PEPFAR assistance, in addition to national strategies for support. PEPFAR/Namibia also supports MOHSS in the adoption and

adaptation of the World Health Organization's (WHO) guidelines on differentiated service delivery of HIV care to increase service efficiency 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). It also includes the phased implementation of the "treat all" approach, multi-month scripting, and community involvement in linkage to treatment and care, adherence, and retention (PEPFAR/Namibia, 2012).

OVC Program Areas that USAID/Namibia Supports

USAID's programs for OVC affected by HIV and AIDS in Namibia contribute to the achievement of an AIDS-free generation by responding to the social, economic, and emotional consequences of the disease on children, their families, and the communities that support them. The goal of USAID and PEPFAR's OVC Program in Namibia—implemented by PHN and partners—is to improve the health and well-being of children and families by mitigating the impact of HIV and AIDS and increasing children's resilience and reducing their risk to the disease. Key program areas and objectives include the following:

- **Education**: Support efforts to reduce educational disparities and barriers to access among school-age children through sustainable "systemic" interventions.
- **Psychosocial care and support**: Prioritize psychosocial interventions that build on existing resources; place and maintain children in stable and affectionate environments.
- **Household economic strengthening**: Reduce the economic vulnerability of families and empower them to provide for the essential needs of the children in their care.
- **Social protection**: Reduce vulnerability and risks, foster human capital development, and interrupt the transmission of poverty from one generation to the next.
- **Health and nutrition**: Improve children's and families' access to health and nutritional services.
- **Child protection**: Develop appropriate strategies for preventing and responding to child abuse, exploitation, violence, and family separation.
- **Legal protection**: Develop and implement strategies to ensure basic legal rights, birth registration, and inheritance rights to improve access to essential services and opportunities.
- **Capacity building**: Prioritize capacity-building and systems strengthening interventions according to the Namibia context.

Project HOPE Namibia (PHN) and Catholic AIDS Action (CAA)

PHN and its partners began implementing the five-year NARP in June 2013, funded by PEPFAR through USAID/Namibia. NARP is among many HIV-related programs that PHN is involved in implementing to strengthen adherence and retention to HIV care and treatment (including prevention of mother-to-child transmission), and to mitigate the impact of HIV on people living with HIV and those affected by it (OVC and caregivers). The project covers 14 health districts in eight regions. NARP provides community-based HIV prevention and care and treatment support services in line with global UNAIDS goals. NARP works in collaboration with the MOHSS to improve adherence to ART. Increasing adherence induces viral suppression, resulting in higher survival rates, decreased risk of transmission, and improved quality of life. Community-based HIV prevention, testing, and treatment programs in Namibia are aimed at working toward the UNAIDS 90-90-90 treatment target.

In communities largely burdened by the HIV pandemic, PHN is working in partnership with CAA, a faith-based organization, in following up the affected households, maintaining a database for beneficiary households and individuals, and delivering necessary services to affected communities, households, and

children. Among the many program services and activities in which CAA engages, it works to ensure that OVC receive love, care, and other services to which they are entitled and equips them with personal knowledge and skills. Their services and activities aim to enable OVC to live responsible lives and 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, together with beneficiary households. Interventions focused on OVC are delivered by CAA to all members of enrolled households in several regions of Namibia.

PEPFAR MER OVC ESI

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

The survey is designed to answer the overall question: *What is the well-being of child participants in the PHN PEPFAR-funded OVC project in the six health districts of Namibia, and have there been any improvements over time*? The survey assessed the well-being of child beneficiaries enrolled in PHN in November 2016 (round 1), and the same households were followed up again in September 2018 (round 2). OVC well-being is measured by eight dimensions through the nine MER OVC ESI (see Table 2). PEPFAR requires that data for the MER OVC ESI be collected at two points in time over a two-year period so that progress can be tracked over time. This report covers panel data collected at two points in time and includes only those households that were successfully interviewed during both rounds of the survey for these MER OVC ESI in Namibia.

Table 2. PEPFAR MER ESI 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_BSERT	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, 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 households' resilience to economic shocks, such as unexpected household expenses. Child well-being is assumed to be affected by the household's resilience to economic shocks.

Study Objectives

The MER OVC ESI surveys were designed to answer two key questions:

- What is the well-being of child participants in the PHN PEPFAR-funded OVC project in the six districts of Namibia?
- Has the well-being of children participating in the PHN PEPFAR-funded project improved over time?

Both the first and the second rounds of the MER OVC ESI survey were designed to provide an assessment and evidence for addressing the two key survey questions in a panel setting. The second survey followed up the same PHN beneficiary households that were visited and interviewed during the round 1 survey in 2016.

STUDY DESIGN, DATA COLLECTION METHODS, AND ANALYSIS

Design of the Study and Sample Size

The second round of the MER OVC ESI survey was conducted in the same six districts (Andara, Nyangana, Rundu, Eenhana, Engela, and Katima Mulilo) in the three regions (Kavango, Ohangwena, and Zambezi) that were included during the round 1 survey in 2016 (see Appendix 4 on the location of these regions in Namibia). With a focus on monitoring changes in MER outcome indicators for OVC beneficiary children and their respective households over the approximately two years between two survey rounds, the surveys were specifically designed as a longitudinal panel study.

The round 1 survey in 2016 developed the sampling frame and determined sample size requirements for estimates of the nine MER OVC essential indicators as baseline indicators in the six selected districts in three regions in Namibia. Details on sample size determination for the baseline survey in 2016 are documented elsewhere (MEASURE Evaluation, 2017). The round 2 survey was designed to assess the changes, if any, over time for households and beneficiary children for the baseline indicators.

During the round 1 MER OVC ESI data collection, 591 households in the six districts were visited and successfully interviewed. A total of 534 female and 57 male caregivers were interviewed, covering a total of 2,470 children ages 0–17 years in the baseline survey. Only those households visited and interviewed during round 1 in 2016 were followed up in the 2018 round 2 survey, regardless of the status of the beneficiary household/child (whether active or graduated). Primary caregivers of children ages 0–17 years living in the selected households were interviewed about themselves, the household, and the children residing in the household. All children under the care of the primary caregiver living in the household who were under age 18 years were considered eligible. In order to meet PEPFAR reporting requirements to include age group disaggregation (0–11 months, 1–4, 0–4, 5–9, 10–14, and 15–17 years) for the child indicators, field interviewers listed all children living in the household and sorted them into these age groups. Appropriate questionnaires were administered to the primary caregiver about all the children in the household for whom the caregiver is responsible. Thus, data were collected from the caregiver on all the children ages 0–17 years per household.

Household Listing Verification and Community Trace and Verify

In preparation for the MER OVC ESI second survey round in Namibia, we conducted two household verification exercises. The first one was undertaken at the national level, with PHN Headquarters. We compared the household listing from the 2016 MER OVC ESI survey round with the records that PHN keeps in their database. The PHN team assisted in the comparison with their current database in order to identify the households that match their database, and for the households that were identified, they provided additional information to help in locating the households in the community, including contact names and numbers of caregivers and the names of the CAA group leaders who are assigned to these households. Additionally, they provided information on the current beneficiary status of the household—whether the household was currently active, had graduated from the program, or was closed for another reason. PHN was successfully able to match the household identification number of 519 (88%) households out of 591 households visited in round 1 survey. However, based on the documentation in the database, a large proportion of these matched households (66%) were no longer served by CAA, PHN's implementing partner in Ohangwena, Zambezi, and Kavango. Two main factors have contributed to the large proportion of beneficiaries not receiving OVC services, as observed during the round 2 survey:

- PHN was expecting the program to come to an end at the end of June 2018, and budget provisions only provided for engaging volunteers until then. Some volunteers had left earlier than the end date to seek other work opportunities, and hence no replacements were made to ensure smooth operation of the service provision until the end. However, PHN later received a two-year extension and had to re-engage new volunteers for the areas that have eligible beneficiary households and children.
- Toward the end of 2017, PHN's mandate regarding criteria for eligibility was revised to include only children ages 0–17 years living with HIV. In addition, at the request of MGECW, they included selected beneficiary households and children who were in PHN's program before and were in the process of being transitioned to government care.

As early as January 2018, there has been an active drive by PHN and its partners to graduate from the program those households and children who did not meet the eligibility criteria or children who were age 18 years and above.

The second verification exercise, CTV, was conducted at the community level. For the exercise, a Survey Warehouse field manager visited the regional management teams for CAA in the three regions. The purpose of the meeting was to sensitize the regional management on the upcoming survey, inform the team of the assistance needed for the success of the round 2 survey, the survey timeline, and the districts where the survey would be undertaken in those regions. The field manager also met with available community volunteers to review their updated beneficiaries register with the household listing from the 2016 survey round. The community volunteers went through all records to identify households associated with their areas, and where possible, provided an updated status and details of the households including the name of the owner of the house, name of the caregiver of the children in the household, contact information and physical address of the location of the household. Essentially, this CTV activity had the aim of identifying households that would be able to be located and would be available for interviewing in the round 2 survey. In cases where the community volunteers were no longer active, the PHN and CAA regional management teams suggested that the field manager contact those same community volunteers to assist with the identification of the households and their location. The regional management teams offered to follow up with active volunteers as they called and visited the CAA offices. While the CTV was very helpful in getting some indication of available households and their locations, it was not without challenges. Some of the challenges included the following:

- Contact numbers not reachable—either the number no longer existed, or calls failed due to poor network availability.
- Some volunteers were not available to take calls.
- Others did not have records on hand to assist the field manager with queries at the time of the call.
- While this was not specifically a direct challenge, there were a few community volunteers who refused to assist in the CTV activity, which contributed to difficulties in the verification process since we needed to liaise with these volunteers and counter-check their registers. The majority of these volunteers were no longer working for the program, and their contracts had been suspended.
- At the time of the CTV, the head of CAA in Kavango was unable to assist with the request, as he was on leave. After numerous follow-ups, the field manager managed to obtain a list of 30 volunteer names and contact details. However, a large portion of additional data requested was not provided. In order to make headway, the field manager contacted the PHN data manager in the Kavango Region for assistance. At the time, however, the District Medical Officer did not have access to the RedCap System. The MEASURE Evaluation team lead shared the list from the PHN

headquarters database matched for the Kavango region. This helped in obtaining more information and additional details to help locate the households.

- In the Zambezi Region it was challenging to get all the necessary information about the households to help with the verification and location of these households, and hence the exercise was not as successful as in the other two regions. The regional manager in the Zambezi Region was very helpful in providing the contact details for volunteers who serve households in the regions. Efforts to contact volunteers and households for which telephone contacts were available proved challenging; many of the contact numbers were not reachable during the CTV exercise, and contact could not be established with volunteers and some households.

Table 3 provides the outcome of the CTV exercise leading to fieldwork implementation. Note that despite the CTV's outcomes suggesting some challenges in trying to locate these households during the actual survey round, the field teams made every effort to locate the households from the 2016 household listings for the area they were visiting. The efforts by the field teams as described later in this report helped locate more households in addition to those verified during the CTV exercise and increased the sample size for the round 2 survey in 2018.

Table 3. Outcomes of the CTV exercise, by region

Region	Number of households visited during round 1 survey in 2016	Number of households verified during CTV exercise in 2018 in preparation for round 2 survey	Percentage of households verified for round 2 survey
Ohangwena	265	188	71%
Kavango	204	145	71%
Zambezi	122	59	48%
Total	**591**	**389**	**66%**

Field Implementation

Training of Field Data Collectors and Field Practicum

Prior to field implementation, data collection teams were trained for four days on survey methods and data collection tools and techniques. The training workshop took place both in a classroom and the field September 5–8, 2018 in Windhoek. Thirty-four data collectors attended the training. Additionally, in-country representatives from USAID, PHN, and CAA attended the introductory sessions.

The training workshop was led by the MEASURE Evaluation activity lead, assisted by Survey Warehouse senior staff. The chief of party for PHN introduced PHN's NARP and OVC programs in Namibia and provided recent updates on these programs. Participants were trained on MER OVC ESI, research ethics, survey questionnaires, use of tablets for data collection, considerations and policies related to child protection, and how to successfully locate households and conduct successful interviews in the communities. Participants were also trained on how to take the MUAC measurements of children in the household ages 6–59 months.

The third day of the training was the field practicum. For the practicum, PHN supplied a beneficiary list of 40 households located in the Katutura area in Windhoek. PHN's community health workers assisted the field teams in locating these households. The tablets for electronic data capture and the SurveyToGo program were tested during the field practicum, and necessary changes were subsequently made to the program.

The last day of the training was set aside for feedback on the field practicum and more in-class practice interviews, while the supervisors underwent training specifically focused around the roles and responsibilities of supervisors and how to ensure high-quality data from the field. At the end of the training workshop, both the trained participants and the data collection tools were deemed ready for deployment.

Field Deployment

Six field teams, each consisting of one supervisor and four enumerators, were deployed to the field on Sunday, September 9, 2018. Teams were accompanied by Robert Mswia, the MEASURE Evaluation activity lead, and Petrus Shikongo, Survey Warehouse field manager. All teams returned from the field on Monday, September 24, 2018.

The MEASURE Evaluation activity lead and Survey Warehouse field manager were present in the field during the entire period of data collection to ensure high quality of data by observing teams as they collected the data. Data uploaded into SurveyToGo were monitored on a daily basis. Each day, newly uploaded cases were downloaded, and each case was reviewed. Any issues that were identified were communicated to the teams in the field, and the teams were requested to rectify any errors or omissions. During data cleaning and editing, the data were further checked against the round 1 sample list and the supervisor and interviewer control sheets to confirm their accuracy, and where necessary, to make revisions.

Field site in Eenhana health district, Ohangwena Region. Photo: Robert Mswia, MEASURE Evaluation, Palladium.

Data Collection Challenges

Despite efforts to verify the household list during the CTV activity prior to data collection, the field implementation had both successes and challenges. All households included in the 2016 round 1 survey were successfully tracked and outcome data documented (see next section on response rate). With this success came a number of challenges encountered by the data collection teams in trying to locate and reach some of the households interviewed in 2016. However, as detailed below, with guidance from the MEASURE Evaluation activity lead and the Survey Warehouse field manager, most of these challenges were successfully addressed.

- Teams discovered that in some cases, household identification (ID) numbers for households that had since graduated from the OVC program had been reassigned to households that were newly

signed up. In an effort to trace 2016 households and caregivers, interviewers were directed to the newly recruited households instead of the baseline households. Teams verified confirmed with the new households that neither the children nor the caregiver from the 2016 baseline interview were known to those households. When contacted for clarification, PHN informed us that household IDs still resided in the database, so the ID for graduated beneficiaries should not change in the event that they are ever approached again. They were not sure how our field teams had been directed to new households with the same ID.

- Teams also found different households sharing the same household ID and that were registered under different volunteers. When arriving at one of these households, interviewers then found that household members did not recognize the names of the listed child beneficiaries. PHN informed us that it is not possible for different volunteers to have the same household IDs, given the functionality of ID generation for household ID. However, this was nonetheless what was found in the field for some households.
- In the baseline survey, additional households were identified for interviews when the sample size could not be reached from the selected sample list for a number of reasons. These households were verified as registered with CAA, but they did not yet have an assigned household ID at the time the baseline survey was conducted. In such cases, field teams assigned a random household ID, and these were identified as starting with zero. During the second round of the survey, it proved difficult in some instances to match these 2016 households with their correct allocated household IDs.
- In some areas, volunteers were not available to assist teams in locating the listed households. As with the round 1 survey, contact numbers of some listed caregivers were either unavailable or the caregivers were not reachable.
- Some areas were inaccessible. One such area was a village in Kavango Region where a household interviewed in 2016 had relocated. This village was only accessible by foot or donkey cart, and the road leading to the village was between 10 and 15 kilometers long. The team was unable to travel to this village for the one interview.
- In Zambezi Region specifically, a few urban households that were on the baseline list could not be traced. Local communities did not have any knowledge of the whereabouts of these households or the caregivers or children. Even when talking to institutions such as schools and churches, children were not known by these community members.
- Where children were listed by first name only in the baseline survey, field staff had difficulty in locating some of the listed households. A similar challenge was experienced with households that were not listed with a specific village name.
- Since 2016, some households had also changed their composition. In some instances two households had joined to become one household, and in other cases some households had split and moved into smaller units. A strategy for correctly identifying these households in the electronic data collection platform was devised and communicated to all teams.
- A large portion of households that had since become inactive were unknown to the volunteers who now work in these areas. PHN explained that this situation may be related to staff turnover. The list that we received from PHN included the name of the community health worker (CHW)/CHBCP associated with the household to be visited, so it should be known to the CHW/CHBCP who provided the services to the household.

MEASURE Evaluation and Survey Warehouse, in consultation with the PHN and CAA district offices, devised strategies to overcome the challenges reported above.

- Any challenges or instances where interviewers could not follow the standard operating procedure directly were reported to MEASURE Evaluation activity lead and the Survey Warehouse management team for further follow-up and action.
- Additionally, teams spoke to caregivers who were found at the households identified but who were not part of the round 1 survey and confirmed that neither the caregiver of the 2016 survey nor the children listed in 2016 were known to the household that was located.
- Shared household IDs were cross-referenced to the PHN's electronic RedCap data source for clarification.
- Randomly assigned household IDs were checked against lists from CAA in the regions, in an effort to match households listed in the baseline survey with households currently in their system. In most instances, child names were used as a reference for matching these cases.
- With the aim of locating the graduated households and their residents, teams visited local community sources and asked around to find out if anyone knew the caregiver of children from the 2016 household. Typical sources included community leaders, churches, health facilities, markets, *cuca* shops and local *shebeens*, and in some instances, schools. (Cuca shops and shebeens are places in Namibia where unlicensed alcoholic beverages are sold.) Teams made sure to observe all ethical protocols.

The following issues pertaining to completing interviews capturing data using tablets (especially during the first few days of data collection) were noted:

- In some instances, the MUAC measurements for children 6–59 months old could not be taken at the time of the interview (for example, the child was not at home at the time of interview, the child was sleeping). Interviewers returned to these households in order to get these MUAC measurements at a later agreed-upon time.
- Many caregivers reported not knowing when their households or the members of their households had graduated from the program and could therefore not provide a specific date for graduation. When the issue was discussed with volunteers working in these households, it was reported that volunteers had found it difficult to communicate to a caregiver or household members when they were graduated.
- In a few instances, social events (such as weddings, funerals, and burials) in the survey locations delayed data collection, because households were unavailable for interviews at the time of the event. However, teams navigated around these issues and found ways to return to these households when they were available.
- Some caregivers did not honor the appointments they set up with the teams and the respective interviewers. This caused delays, and when an interview was not secured after the third visit, interviewers followed the standard operating procedure and moved to their next assigned household for interview.
- An entry rule in the electronic data capture system prevented interviewers from capturing when a child was not enrolled in school in the previous year as a result of pregnancy but then was enrolled in the current year. At the time, teams captured the case the best they could and noted these instances in the comments section of the application. The few cases that occurred before a correction was implemented in the data capture system were later edited during the data cleaning phase. The application was revised, and the entry rule was removed.
- The application did not allow capturing data for children older than 17. However, in order to trace children from the round 1 survey in 2016, it was important to capture data for children who had

graduated from the program as a result of turning 18. Interviewers were instructed to capture data for these children by entering their age as 17, and then making detailed comments for the specific child and his or her age in the comments section of the instrument. These cases were addressed and corrected during the data cleaning phase.

- Interviewers had difficulty in capturing data for more than 10 children per age group 0–4 years and 5–17 years initially. This limitation was immediately communicated to Survey Warehouse, and the limit was removed to allow for capture of children that exceeded this limit.

Sample Realization (Response Rate)

During the round 1 survey in 2016, a total of 591 beneficiary households were successfully visited, and an interview with the primary caregivers and beneficiary children was completed. The aim of the round 2 survey in 2018 was to visit the same households that were surveyed in 2016. Table 4 provides information regarding follow-up of the 2016 households during the 2018 round of the MER ESI survey. The CTV team managed to verify the availability of 66 percent of the households surveyed during baseline (Table 3). Given the challenges encountered during the CTV exercise, additional time and strategies were used to further locate these households during fieldwork, and these strategies were successful. As a result of the additional efforts made to locate the households during fieldwork, a total of 545 out of 591 (92 percent) households included during round 1 were successfully visited and interviews with primary caregiver conducted during round 2.

Table 4. Outcome of the follow-up visit of households during the 2018 round 2 MER ESI survey for the households that were included in the 2016 round 1 survey

Category	N	Percentage
Number of households visited and interviewed during the round 1 survey in November 2016 to be followed up for round 2 survey	591	
Number of households that were in round 1 survey but could not be traced at round 2 survey	45	7.6
Households in the round 1 survey that were located at round 2 (*Note: a total of 13 households in round 1 survey were found to have split into two households at the round 2 survey.*)	559	94.6
Number of households confirmed to have moved from the study area at time of the round 2 survey	8	1.4
Number of households visited and interviewed during round 2 but later found to be duplicate households (two separate interviews done at round 2 to the same household by two different field interviewers)	4	0.7
Number of households with no appropriate respondent during round 2 survey (caregiver not available after three callback attempts)	2	0.3
Number of households in round 1 survey that were visited and successful interviews conducted during round 2 survey	545	92.2

Survey Limitations

In this second round of the MER OVC ESI, it was important to ensure that all households visited during the round 1 survey were accounted for and followed in order to maintain high quality of data and records for panel data construction for comparative purposes. While there were some challenges, as documented in previous sections, during the household listing verification and CTV exercises, as well as during the actual field implementation, many of these challenges in locating the households and conducting interviews were resolved as they were encountered.

While it was expected that there would be some beneficiary households and children that had since graduated (that is, they were no longer eligible to be part of the program because the beneficiary children had aged out) and households that had moved out of the program areas for some reason, we did not expect to learn that the majority of existing beneficiary households that we were able to locate were actually no longer eligible for participation in the program. As indicated earlier in the report, PHN's OVC program was expected to come to an end at the end of June 2018, and budget provisions only provided for engaging beneficiaries and volunteers to that date. However, we were informed that PHN had another two-year extension since that time, and with this extension, the eligibility criteria for participation in the OVC program changed its focus to identifying households with CLHIV.

In 2018, PHN's mandate regarding criteria for eligibility was revised to include more of a focus on children ages 0–17 years living with HIV. This means that beneficiary households that have at least one HIV-positive child age 0–17 years were included to continue with the program and services and support. As a result, a number of the beneficiary households that were part of the round 1 survey in 2016 were considered "graduated" from the program if they did not meet the new criteria. However, before they were officially graduated, the PHN and CAA program officers and volunteers were supposed to have provided support or services on the following:

- Ensuring that all children between 0–17 years in ineligible households had received their birth certificates already or the process to get a birth certificate had been initiated
- Primary caregivers of the children or other adult member in the beneficiary households had been introduced and linked to some type of savings group to help the caregivers in these households join the savings groups in order to reduce the economic vulnerability of their families and empower them to provide for the essential needs of the children in their care.

Additionally, at the request and recommendation of the MGECW, in the extension phase PHN is continuing to serve some beneficiary households and children who were in the program but did not necessarily meet the new eligibility criteria.

CAA has been working in Ohangwena, Kavango, and Zambezi Regions. With the revised eligibility criteria focusing on CLHIV, some districts in these regions transitioned out of the program as requested by PEPFAR/USAID. PHN established additional sites in Khomas region and Oshikoto, Oshana, and Omusati in the Northern region as part of donor requirements under the beneficiary eligibility criteria focusing on CLHIV. They are directly managing these sites and provide services directly to the beneficiaries (and not through the CAA project, as was the case in the other sites in the Northern region).

In order to try capture when these households stopped receiving services from PHN or through CAA, we added another question in the questionnaire for primary caregivers on whether they had received any services since the beginning of 2018. This was in addition to the question already included in the questionnaire on whether the primary caregiver or anyone in the household has received any items or services provided by CAA in the six months prior to the survey visit. Of the households that had ever received services, about 33 percent said they had received some services from CAA in 2018. The overall low percentage reported suggests that, indeed, these households were no longer receiving services as of the beginning of 2018.

It is also possible that the proportion of those who reported receiving services was even lower if graduation were factored in. This is because some of these 33 percent households who reported receiving services may have actually been graduated but were still receiving visits because some volunteers/CHBCPs were struggling to close cases, as they had become attached to the households. In the round 2 survey, we added three questions in the questionnaire to help determine whether and when the household/child had graduated, or if the household/child had left the program without officially graduating. (See questions

5.16a, 5.16b, and 5.16c for children below five years, and questions 7.19a, 7.19b, and 7.19c for children between 5-17 years in the MER OVC ESI questionnaire in Appendix 1.)

When the data collection teams were in the field for data collection, they discovered that households that should have been graduated were unfortunately not even aware that they were no longer in the program. All these households knew was that suddenly they had not been getting regular services or support from their community volunteers, apart from the volunteers sometimes passing through, visiting households to greet them and maybe pray with them. The field teams asked the community volunteers if they were aware that the households were no longer eligible for continuation with the services. *Some volunteers mentioned that they were aware of the new eligibility criteria but had found it difficult to inform the caregivers of these children because they had already established good relationships and were close friends with these families.* In most cases they continued to visit them, just to talk to them or even give them advice to seek medical care if someone in the household was sick.

Unfortunately, the three questions added on graduation status did not work very well for the Namibia round 2 MER ESI survey, because responses to these questions did not provide any useful information. *None of the households could say if they had officially graduated from the program. For those who were unsure, they could not provide the graduation date if they thought they might have graduated.* During fieldwork, the data collectors entered the date of visit to the household as date of graduation to some of these households who might have indicated that they thought they had been graduated. Even when the caregivers were asked differently, to get some idea on graduation—the caregivers were asked to cite the last time they received services from CAA—they could not recall the last time they had received the services. Because of this limitation, we could not analyze data by graduation status.

Table 5 provides a breakdown on the number of households by the types of services the beneficiary households had received during the past six months before the second survey round. With the exception of psychosocial support and health services, less than 100 households received the remaining other categories of service/support type. This tallies with what we were informed by the volunteers—that they sometimes visit the supposedly graduated households just to offer social support and advice in the event of sickness in the family. It also confirms what we were told at the PHN headquarters when we went to verify our 2016 household listing with their current records in the database—that most of the households that were part of the 2016 round 1 survey were no longer participating in the program because of the new eligibility criteria implemented toward the end of 2017 and early 2018. The few households (out of 545 households) that said they had received support and/or services probably met the new eligibility criteria.

Table 5. Types of services/support received by beneficiary households from CAA during the six months prior to the September 2018 round 2 survey

Type of service or support received within the last six months prior to round 2 survey data collection	Total number of households in the panel (N) = 545	
	N	%
Educational goods, support, or services	50	9.2
Household economic strengthening support or services	65	11.9
Food or nutritional services support or services	63	11.6
Psychosocial support or services	134	24.6
Health goods or services	111	20.4
Legal or protection services	97	17.8
Shelter-related support or services	12	2.2

In our analyses for the nine MER OVC ESI and other additional indicators, we include all households that had successfully been merged into the panel dataset, regardless of the household status at the time of the second round of the survey. This was the case unless it was clear to us that the household had graduated given that there was only one child in the household and that that child was over 17 years of age at the time of the second survey. This was the only time a household was excluded in the panel analysis for child related indicators, since the matching for panel construction was based on household marching and age of the child (0–17 years).

Panel Data Construction and Data Analysis

Panel data at the household level (using Household ID variables) was created to assess whether there had been any improvements to OVC beneficiary households or OVC children over time for the nine MER OVC ESI and other indicators for the households that were visited during the round 1 and round 2 surveys. In this case, a beneficiary household was the unit of analysis. The panel data were used to produce the following statistics:

- Calculate the point estimates for the each of the MER indicators for the two rounds (proportions)
- Calculate the confidence intervals around point estimates for each round
- Conduct statistical tests for the difference of estimates between the two survey rounds. The null hypothesis was that there was no difference between the two proportions.

To achieve this, the following approaches were employed to construct several panel datasets for various age and sex combinations for analyses of both household-level and child-level MER indicators, including significance testing for the difference between round 1 and round 2 surveys for each of the indicators:

Constructing Panel Data for Household or Caregiver-Level MER OVC ESI

Panel data were created at the household level by merging households visited and interviewed during the round 1 survey with the same households that were visited and interviewed during the round 2 survey. The households that could be successfully merged from the two surveys into a single dataset were then used to obtain estimates for OVC_CP and OVC_MONEY indicators and to conduct significance testing for the difference in proportions using a paired T-test. For analysis, see the next section on steps for conducting analysis of MER OVC ESI from panel data.

Constructing Panel Data for Analysis of Child-Level MER OVC ESI

For child-level indicators, panel data were created at the household level rather than the individual level, since all children under the care of the primary caregiver were included in the study and the number of children per household was different between the two survey rounds. The steps to create the panel data, which is a merger of round 1 and round 2 surveys for child-level indicators, and to conduct the appropriate statistical analyses were as follows:

Steps for Panel Data Construction

- **Step 1:** The outcome variables of interest (the variables that feed into the indicators) were first coded to 0-1 codes where 0 represented no and 1 represented yes responses for yes/no questions. This was done because some statistical software like Stata requires this coding for commands to work and produce results as intended. For example, the question on whether a child had a birth certificate or not was initially coded 1=Yes, 2=No in the data coming from the field. During data preparation, these categorical responses were changed to 1=Yes, 0=No.

- **Step 2:** Summary data for child indicators within each household were created separately for each survey round. The number of records became the number of households visited and interviews successfully conducted for each survey round, and not the number of children.
    - The **collapse** command in Stata software was used to create a new dataset containing summary statistics of the original data for each survey round.
- **Step 3:** Rounds 1 and 2 surveys were then merged using unique household ID variables. Records that were successfully merged at the household-level between the two survey rounds formed the dataset for analysis.
- **Step 4:** Estimates of child-level indicators were then calculated from the merged panel dataset for each survey round for the following seven indicators: OVC_HIVST, OVC_NUT, OVC_SICK, OVC_BCERT, OVC_SCHATT, OVC_PRGS, and OVC_STIM. A test for overall difference in the two proportions for each indicator was conducted using the paired T-test.
- **Step 5:** For analysis of the indicators by sex and/or age disaggregation, the above three steps were repeated to create panel data for each sex and/or age combination, by first creating subsets of each dataset from the two surveys using the desired disaggregation.
    - For example, if indicators were required for males and females separately for beneficiary children ages 0–4 years, then a subset of data was created for rounds 1 and 2 surveys separately for all males ages 0–4 years. Then panel data were created by merging the two subsets of datasets together (round 1 and round 2 datasets) at household level. The resulting panel data for analysis would contain only male children ages 0–4 years from the two datasets that successfully merged. Note that if a household had more than one child (two or more children) in this age group and some responses were yes and some were no, this record would become a proportion, i.e., an average between 0 and 1, of the responses within that household. The two datasets were merged by Household ID to create the panel data. If during the round 2 survey a household did not have a male child age 0–4, then this household would drop out of the male 0–4 years panel data. The same applied to other age groups and to sex disaggregation. It is therefore important to be aware that specific counts for age and sex for each age group (0–4, 5–9, 10–14, and 15–17) in the respective rows in the tables are independent based on the way the data panels were constructed, and these specific age group counts should not add up to the overall totals for all ages 0–17 years combined, as demonstrated in Table 6.

Table 6. A scenario demonstrating inclusion or exclusion in the panel data for specific age (and sex) of a child between the two survey rounds

Round 1	Round 2	Included in children ages 0–4 years panel?	Included in children ages 0–17 years panel?
A child 3 or 4 years old in 2016	Same child now 5 or 6 years old in 2018	No	Yes
A child 0–2 years old in 2016	Same child, now 2–4 years old in 2018	Yes	Yes
A child 0–4 years old present in 2016	Child no longer present in the household (died or out-migrated) in 2018	No	No
A child 0–4 years old present in 2016	Not same child, but a different child 0–4 years old present in 2018 (born or in-migrated)	Yes	Yes
No child 0–4 years present in 2016	Child 0–4 present in 2018 (born or in-migrated)	No	Yes

In this scenario, we consider children ages 0–4, whether included or excluded in the panel data for 0–4-year- old children, in comparison with panel data for children 0–17 years old. In Table 6, it is observed that there will be fewer children counted in the 0–4-year-old panel (two out of five) as compared to children counted in the 0–17-year-old panel (four out of five).

Table 7 presents the number of households that successfully merged to create panel datasets for all ages and sex combined, and for each age and sex disaggregation included in the statistical analyses.

Table 7. Number of households included in each of panel for various MER ESI by age and sex

Age	Male children only in the panel	Female children only in the panel	All children in the panel
0–1 years	21	23	65
2–4 years	66	63	173
0–4 years	120	113	262
5–6 years	32	23	94
5–7 years	66	61	172
5–9 years	143	124	294
7–9 years	60	54	156
8–9 years	29	25	90
10–14 years	95	106	254
15–17 years	36	46	129
5–17 years	331	338	489
0–17 years	433	424	532

Steps for Conducting Analysis of MER OVC ESI from Panel Data

- **Step 1:** The appropriate panel dataset was used for data analysis to produce the required overall indicators, and for age- and sex-specific indicators or a combination of both where required. See step 5 on panel data creation for how age- and sex-specific panel data were created for various indicators.
- **Step 2:** Where applicable and required, appropriate commands were applied to take into account stratification, clustering, and weights in the analysis to correctly calculate point estimates (proportions), together with 95% confidence intervals (CIs) of the indicators for each survey round for data in the panel. Namibia data were designed to be self-weighted, and hence adjustments were only made to place of residence stratification.
- **Step 3:** For testing the difference in the proportions observed for each of the outcome indicators between the two survey rounds, a **paired T-test** was employed.
- **Step 4:** It was important to consider subgroups of data in the analysis for correct presentation and interpretation, for example, the household's ability to pay unexpected expenses. It is possible that there could be improvement in urban areas and regression in the rural areas. There may be significant differences in those subgroups, but the opposite trends cancel out when looking at the difference overall, showing no significant change over time. This is misleading if the subgroup analysis is not presented.

RESULTS

Characteristics of the Study Population

A total of 545 of the 591 households interviewed during the round 1 survey in 2016 were successfully located and interviewed during the second round of the survey in 2018. Of these 545 households, 428 (78.5%) households had the same caregiver interviewed during both the round 1 and round 2 surveys. These households came from the six districts in three regions where PHN and CAA services and programs were being implemented in 2016. In 2018, some of those households no longer received services from CAA or PHN due to eligibility criteria discussed in earlier sections of this report.

Caregiver Receipt of Social Welfare Grants

The design and implementation of social protection programs, including social welfare grants from the government, particularly in the form of cash transfers, are considered to be an effective social policy tool and an intervention for responding to the challenges of chronic poverty and child vulnerability. The MGECW is the lead government ministry tasked with ensuring that OVC are protected. Four types of child welfare grants are provided for OVC in Namibia, namely the Maintenance Grant, the Foster Care Grant, the Special Maintenance Grant for children younger than 16 years with disabilities, and the Place of Safety Allowance.

About 64 percent of the caregivers/households during the round 2 survey reported that they were registered to receive social welfare grants from the government, which is about 11 percentage points higher compared to what was reported during round 1 (53%, p-value < 0.001). This level of increase is statistically significant at a high level. Among caregivers who received social welfare grants at the time of the 2016 round 1 survey, about 76 percent reported receiving all three monthly payments in the three months prior to the survey, compared to 94 percent of caregivers from the same households at round 2.

Children and Parental Status

From the panel data, 2,276 children ages 0–17 years were included from the first round of the survey, and 2,607 children of the same age group were included from the second round. Of these children, as reported during the round 2 survey, about 92 percent reported that their biological mother was still alive (of these, 57 percent reported that the mother was living with the child). Six percent reported that the mother had died, and about 1 percent reported that they did not know whether the mother was alive or dead. For the status of the father, 85 percent reported that their biological father was alive (of these, only 23 percent reported that the father was living with the child). Twelve percent reported that the father had died, and about 3 percent of children reported that they did not know whether the father was alive or dead. The questions on survival of biological parents were added and asked during round 2 survey but were not included during the round 1 survey.

Table 8 provides the basic demographic characteristics of these children by survey round. Overall, the age, sex and residence distribution of the children between the two surveys are similar, although for each survey round, a caregiver was interviewed about all the children under his/her care at the time of survey, and the total number of children 0–17 years per household between the two survey rounds was not the same.

Table 8. Demographic characteristics of children ages 0–17 under the care of primary caregiver in the study population, by survey round

Characteristic	Round 1 (2016) All children ages 0–17 years in panel N = 2,276	Round 2 (2018) All children ages 0–17 years in panel N = 2,607
	n (%)	n (%)
Age group		
0–4 years	682 (30.0)	747 (28.7)
5–9 years	669 (29.4)	797 (30.6)
10–14 years	597 (26.2)	650 (24.9)
15–17 years	328 (14.4)	413 (15.8)
Sex*		
Female	1,128 (49.6)	1,283 (49.2)
Male	1,148 (50.4)	1,323 (50.8)
Residence		
Urban	466 (20.5)	529 (20.3)
Rural	1,810 (79.5)	2,076 (79.7)

* One child in round 2 survey is missing information on sex

Support and Services Received by Beneficiaries from Project HOPE/CAA

During both round 1 and round 2 surveys, primary caregivers were asked whether they themselves 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. During round 1, a limited list of items showing types of goods and services (13 items) were included, and each of those items/services was read to the caregiver, who was to provide a *yes* or *no* response. For the round 2 survey, the list of goods, support, and services was increased to 49 items, grouped into seven broad support/service pillars (education, household economic strengthening, psychosocial, food/nutrition, health, legal/child protection, and shelter). Each item, support, or service was read to the respondent caregiver for him/her to provide a *yes* or *no* answer.

Table 9 shows program items or services listed and the responses from primary caregivers who said they or someone in their households had received items or accessed program services. The types of goods and services included in Table 8 are based on what was asked during round 1. For distribution of goods and services based on the seven pillars as collected during round 2, see Table 5.

Table 9. Items and/or program services provided by CAA that had been received or accessed by the household (primary caregiver or any other member of household) in the six months prior to the MER surveys (includes only households in the panel—comparing round 1 and round 2 surveys)

Types of goods, support, and services received or accessed by the beneficiary household* *Caregivers responded with a **Yes/No** response for each type of service asked, indicating whether received or did not receive in the last six months*	**Round 1 Households in panel = 545**		**Round 2 Households in panel = 545**	
	n	**%**	**N**	**%**
HIV testing and counseling	340	62.4	98	18.0
ART adherence counseling	331	60.7	69	12.7
Nutritional screening and counseling	345	63.3	46	8.4
TB screening	266	48.8	65	11.9
OVC care and support services (psychosocial, legal, or visits from community/CAA volunteer)	341	62.6	151	27.7
Referral support or services (on access to social grants, school fees exemption, mother-to-mother support groups, educational support, woman and child protection support)	199	36.5	91	16.7
Referral services to clinics (either ART, prevention of mother-to-child transmission of HIV, tuberculosis, family planning, or general healthcare)	318	58.4	53	9.7
Provision of temporary school fees/grants to promote school enrollment or progression	57	10.5	31	5.7
Provision of educational materials	81	14.9	14	2.6
Livelihood training/income generation	98	18.0	16	2.9
Community savings/lending groups/village savings and loan groups	71	13.0	29	5.3
Life skills training	207	38.0	72	13.2
Vocational training scholarships	15	2.7	10	1.8

* Categorization of types of goods, services, or support as asked during round 1 Namibia MER ESI in November 2016

As shown in Table 9, with the exception of the "OVC care and support services…" category, less than 20 percent of the households in the panel indicated that they had received services in the six month prior to the survey for the other 12 items in the list, as compared to only 5 items with less than 20 percent of households during round 1 who said they had received those services. Across all 13 items on the list, a significant decline in the uptake of goods and services from CAA in the last six months was observed during the round 2 survey compared to the round 1 survey.

These findings were in line with what we were informed by PHN and CAA—that the majority of the households that were part of the round 1 survey were no longer eligible to participate in the OVC program under PHN and CAA as a result of the change in the eligibility criteria, and not just because children in the households had aged out (reached age 18 and above), which is one of the criteria for households or children to graduate.

PEPFAR MER OVC ESI

This section provides the results of the nine MER OVC ESI for Namibia, presented in Tables 10–19 by selected demographic characteristics from the analysis of panel data. 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 at two points in time within two years. They will support improved, evidence-informed strategic portfolio development, programming, and resource allocation decisions at the country level, as well as at the headquarters level. Recall that for all child-level ESI, it is important to refer to the section on constructing panel data for analysis of child-level MER OVC ESI, in particular to Step 5, "Steps for Panel Data Construction." This will help clarify the connection between the total number of children for all ages combined, and the counts for the age bands in each of these tables. The overall total is not the sum of all counts of children within each age band; this is not due to the missing data, but rather because of the way the panel was constructed for each age band and sex disaggregation.

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

Table 10 presents the percentage of children whose primary caregiver knew the child's HIV status, disaggregated by age and sex for each survey round for all children whose households were in the panel. Overall, about 55 percent of caregivers surveyed during round one for the households that were also followed in round two knew that their children had been tested for HIV and knew their children's HIV status. This proportion was higher during the second survey round for the same households, at 64 percent. The increase in percentage documented from round 1 to round 2 shows that participation in the program for longer may have had some benefits, and indeed the primary caregivers were more likely to know the child's HIV status, especially for older children ages 10 and above if they continued participating in the program.

Overall, the difference in proportions between the round 1 survey (55%) and round 2 survey (64%) was statistically significant at a 5 percent level (p-value <0.001). While the proportions were higher during the second survey across all age groups, the difference in estimates in the survey rounds for age groups 0–4 years and 5–9 years was not statistically significant at 5 percent.

When disaggregated by sex of the children, the percentage of primary caregivers who knew their children's status was higher during the round 2 survey compared to the round 1 survey for male children across all age groups. Overall, for male children ages 0–17 years, the difference in proportion between round 1 (54%) and round 2 (63%) was statistically significant at 5 percent (p-value = 0.002).

Among female children whose caregiver knew their HIV status, the difference between the two survey rounds was largely driven by the status of female children ages 10–17 years. For female children ages 0–4 years and 5–9 years, the percentage of caregivers who knew their children's HIV status seemed lower in round 2 compared to round 1. However, the observed differences were not statistically significant. Overall, for female children ages 0–17 years, the difference in proportion between round 1 (56%) and round 2 (65%) was statistically significant, at 5 percent (p-value = 0.006).

Table 10. OVC_HIVSTAT: Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status

	Round 1 survey (2016)		Round 2 survey (2018)		
	All children 0–17 years in panel				
BOTH SEXES	**N**	**Percent (95% CI)**	**N**	**Percent (95% CI)**	**P-value for Difference: *Round 1 vs. Round 2***
Age group					
0–4 years	458	52.9 (47.4 – 58.5)	520	57.4 (52.0 – 62.7)	0.269
5–9 years	504	57.1 (51.7 – 62.4)	554	60.0 (54.7 – 65.3)	0.448
10–14 years	412	53.0 (47.2 – 58.8)	436	67.2 (61.6 – 72.7)	<0.001**
15–17 years	166	55.6 (47.2 – 64.1)	193	69.1 (61.3 – 76.8)	0.015**
All ages (0–17 years)	**2,175**	**55.1 (51.7 – 58.6)**	**2,623**	**64.1 (60.8 – 67.5)**	**<0.001****
MALES	All male children 0–17 years in panel				
	N	**% (95% CI)**	**N**	**% (95% CI)**	**P-value for Difference: *Round 1 vs. Round 2***
Age group					
0–4 years	157	49.6 (41.0 – 58.2)	192	54.5 (46.1 – 63.0)	0.425
5–9 years	179	52.3 (44.2 – 60.4)	205	63.8 (56.1 – 71.6)	0.035**
10–14 years	112	51.6 (41.6 – 61.6)	128	64.4 (54.7 – 74.1)	0.065
15–17 years	39	50.0 (32.8 – 67.2)	44	69.4 (53.6 – 85.2)	0.070
All male children (0–17 years)	**991**	**53.6 (49.4 – 57.8)**	**1,183**	**62.8 (58.8 – 66.8)**	**0.002****
FEMALES	All female children 0–17 years in panel				
	N	**% (95% CI)**	**N**	**% (95% CI)**	**P-value for Difference: *Round 1 vs. Round 2***
Age group					
0–4 years	142	54.0 (44.9 – 63.1)	168	53.1 (44.5 – 61.8)	0.893
5–9 years	164	60.8 (52.6 – 68.9)	179	54.0 (45.5 – 62.5)	0.263
10–14 years	144	49.8 (40.5 – 59.2)	144	71.5 63.0 – 80.1)	0.002**
15–17 years	57	62.0 (47.5 – 76.4)	55	77.5 (65.6 – 89.5)	0.099
All female children (0–17 years)	**1,006**	**56.3 (52.1 – 60.5)**	**1,134**	**64.6 (60.7 – 68.6)**	**0.006****

** Difference between round 1 and round 2 surveys is statistically significant at 5 percent

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 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 11 presents the percentage of children ages 6–59 months whose MUAC measurements were below 12.5 centimeters in the study areas, comparing round 1 and round 2 surveys for the same households. Overall, the percentage of children who were undernourished was slightly higher at round 2 (12%) compared to round 1 (11%). However, the two overall estimates were not significantly different (p-value = 0.765).

Even when analyzing boys and girls separately between survey rounds, similar observations were noted for boys and girls. About 12 percent of boys were undernourished in both survey rounds; hence, no difference was observed between the survey rounds (p-value = 0.780). For girls, 11 percent were undernourished in the round 1 survey, and 12 percent were undernourished during round 2. However, the difference in undernourishment among girls between the two survey rounds was by chance alone (p-value = 0.695).

Table 11. OVC_NUT: Percent of children (aged 6–59 months) in the panel who are undernourished, by sex

	Round 1 survey (2016)		Round 2 survey (2018)		
Sex	**n/N**	**Percentage (95% CI)**	**n/N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Male	37/316	11.7 (8.4 – 16.2)	39/327	11.9 (8.7 – 16.2)	0.780
Female	32/300	10.7 (7.6 – 14.8)	34/291	11.7 (8.1 – 16.7)	0.695
All	**69/616**	**11.2 (8.7 – 14.3)**	**73/618**	**11.8 (9.1 – 15.2)**	**0.765**

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

OVC_SICK 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 the two rounds of the survey, their primary caregivers were asked if the child had been too sick to participate in daily activities within the two weeks prior to the survey. Table 12 presents findings for this indicator, for overall estimates, and by age and sex of the child, comparing the two survey rounds.

Overall, about 24 percent of all children ages 0–17 years in round 1, and about 13 percent of children 0–17 years from the same households in the panel visited during round 2 were reported as having been too sick to participate in daily activities for the same households. The reduction in percentage was about half at round 2, indicating that fewer children were reported to be too sick to participate in daily activities. The observed difference between the two survey rounds was highly significant (p-value < 0.01) in terms of proportion of children who were too sick to participate in daily activities. Similar findings were observed when analysis was disaggregated by broad age categories, as well as by sex and age categories.

Table 12. OVC_SICK: Percent of children (aged 0–17 years) too sick to participate in daily activities, by sex and age

	Round 1 survey (2016)		Round 2 survey (2018)		
	All children 0–17 years in panel				
BOTH SEXES	**N**	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
0–4 years	458	34.2 (28.8 – 39.6)	520	23.5 (19.0 – 28.1)	0.002**
5–9 years	504	22.0 (17.8 – 26.3)	554	11.8 (8.6 – 14.9)	<0.001**
10–14 years	412	18.1 (13.6 – 22.6)	436	7.4 (4.6 – 10.3)	<0.001**
15–17 years	166	17.5 (11.0 – 24.0)	193	7.7 (3.3 – 12.2)	0.018**
All ages (0–17 years)	**2,175**	**24.3 (21.7 – 26.9)**	**2,623**	**12.8 (11.0 – 14.6)**	**<0.001****
MALES	All male children 0–17 years in panel				
	N	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
0–4 years	157	38.1 (29.4 – 46.7)	192	22.0 (15.1 – 28.9)	0.003**
5–9 years	179	17.8 (11.7 – 23.9)	205	13.0 (7.7 – 18.2)	0.246
10–14 years	112	16.3 (8.8 – 23.8)	128	7.7 (2.3 – 13.1)	0.056**
15–17 years	39	15.3 (3.3 – 27.3)	44	9.7 (0.8 – 18.6)	0.487
All male children (0–17 years)	**991**	**22.3 (19.0 – 25.6)**	**1,183**	**12.7 (10.2 – 15.1)**	**<0.001****
FEMALES	All Female Children 0–17 Years in Panel				
	N	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
0–4 years	142	32.4 (24.0 – 40.8)	168	23.3 (15.9 – 30.7)	0.096
5–9 years	164	25.8 (18.5 – 33.1)	179	11.8 (6.6 – 16.9)	0.002**
10–14 years	144	15.6 (8.9 – 22.3)	144	9.6 (4.3 – 14.9)	0.150
15–17 years	57	14.1 (3.9 – 24.3)	55	8.7 (0.2 – 17.2)	0.441
All female children (0–17 years)	**1,006**	**24.5 (21.0 – 28.0)**	**1,134**	**13.6 (11.1 – 16.1)**	**<0.001****

** Difference in proportion between round 1 and round 2 surveys statistically significant at 5 percent

Indicator OVC_BCERT: Percent of children (aged 0–17 years) who have a birth certificate

OVC_BCERT 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 both round 1 and round 2 surveys, primary caregivers were asked if the children under their care had birth certificates. If the caregivers said yes, they were asked to show these birth certificates. Table 13 presents results of these two questions, comparing the two survey rounds. Only after the interviewer had seen and verified the presence of a birth certificate for the child was it counted as available for the reporting of this indicator.

Overall, there seems to have been a slight increase among children 0–17 years who had a birth certificate seen by the interviewers during the round 2 survey (60%) compared to the round 1 survey (at 58%). However, the difference between the two surveys was not statistically significant (p-value = 0.212). Slight increases were also observed at round 2 for male children ages 0–17 years who had birth certificates (62% at round 2 vs. 58% at round 1, p-value = 0.193), as well as for female children ages 0–17 years (58% at round 2 vs. 57% at round 1, p-value = 0.726); however, the observed differences for male and female children between the two survey rounds were not statistically significant at 5 percent. Age-specific differences between male and female children were not statistically different, as indicated in Table 13.

We also looked at the response from caregivers alone when they were asked if the children in their care had a birth certificate, regardless of whether the certificates were seen by the interviewer. These percentages were much higher but nonetheless not significantly different when comparing the two rounds. These data are presented in Table 19 in Appendix 3.

Table 13. OVC_BCERT: Percent of children (aged 0–17 years) who have a birth certificate (and verified)

	Round 1 survey (2016)		Round 2 survey (2018)		
	All children 0–17 years in panel				
BOTH SEXES	**N**	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
0–4 years	458	47.0 (41.1 – 52.6)	520	52.1 (46.8 – 57.4)	0.201
5–9 years	504	61.7 (56.5 – 67.0)	554	59.7 (54.5 – 64.8)	0.572
10–14 years	412	60.6 (54.8 – 66.3)	436	62.0 (56.4 – 67.6)	0.742
15–17 years	166	70.7 (62.9 – 78.4)	193	66.3 (58.4 – 74.2)	0.474
All ages (0–17 years)	**2,175**	**57.0 (53.6 – 60.5)**	**2,623**	**60.1 (56.9 – 63.3)**	**0.212**
MALES	All male children 0–17 years in panel				
	N	**Percent (95% CI)**	**N**	**Percent (95% CI)**	**P-value for Difference: *Round 1 vs. Round 2***
Age group					
0–4 years	157	48.7 (40.0 – 57.5)	192	57.4 (49.3 – 65.5)	0.166
5–9 years	179	65.7 (58.0 – 73.5)	205	61.7 (54.2 – 69.1	0.438
10–14 years	112	70.1 (60.9 – 79.4)	128	62.4 (52.8 – 71.9)	0.286
15–17 years	39	72.2 (56.8 – 87.6)	44	72.2 (57.4 – 87.0)	1.000
All male children (0–17 years)	**991**	**58.1 (54.0 – 62.2)**	**1,183**	**61.9 (58.1 – 65.6)**	**0.193**
FEMALES	All female children 0–17 years in panel				
	N	**Percent (95% CI)**	**N**	**Percent (95% CI)**	**P-value for Difference: *Round 1 vs. Round 2***
Age group					
0–4 years	142	51.0 (41.9 – 60.0)	168	48.3 (39.7 – 56.9)	0.691
5–9 years	164	61.0 (52.6 – 69.4)	179	54.4 (45.8 – 62.9)	0.289
10–14 years	144	55.6 (46.4 – 64.8)	144	66.1 (57.1 – 75.1)	0.088
15–17 years	57	76.1 (63.7 – 88.5)	55	64.1 (49.9 – 78.4)	0.264
All female children (0–17 years)	**1,006**	**57.2 (53.0 – 61.4)**	**1,134**	**58.3 (54.3 – 62.3)**	**0.726**

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 both the round 1 and round 2 studies 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 14 presents results for the percentage of children who are enrolled in school and who did not miss a day of school in the past week for any reason, as reported by the primary caregiver. We further disaggregated the 5–17-year age range into smaller age groups to reflect the usual age at which children start grade school in Namibia.

Table 14. OVC_SCHATT: Percent of children (aged 5–17 years) regularly attending school, by age and sex

	Round 1 survey (2016)		Round 2 survey (2018)		
	All children 5–17 years in panel				
BOTH SEXES	**N**	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
5–6 years	121	39.4 (29.5 – 49.2)	128	64.5 (55.0 – 74.1)	<0.001**
7–9 years	220	73.9 (67.2 – 80.5)	223	79.9 (74.1 – 85.7)	0.171
10–14 years	412	74.0 (69.0 – 79.0)	436	84.4 (80.4 – 88.4)	0.002**
15–17 years	166	75.3 (68.0 – 82.5)	193	78.7 (72.0 – 85.4)	0.483
All ages (5–17 years)	**1,482**	**67.9 (64.7 – 71.1)**	**1,766**	**76.9 (74.2 – 79.6)**	**<0.001****
MALES	All male children 5–17 years in panel				
	N	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
5–6 years	36	35.9 (18.7 – 53.2)	41	59.4 (41.4 – 77.4)	0.045**
7–9 years	70	75.0 (63.7 – 86.3)	72	82.8 (73.4 – 92.2)	0.241
10–14 years	112	76.0 (67.3 – 84.6)	128	88.1 (81.7 – 94.5)	0.023**
15–17 years	39	77.8 (63.5 – 92.0)	44	83.3 (70.5 – 96.1)	0.571
All male children (5–17 years)	**619**	**69.6 (65.3 – 74.0)**	**706**	**77.6 (73.7 – 81.5)**	**0.006****
FEMALES	All female children 5–17 years in panel				
	N	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
5–6 years	25	34.8 (13.7 – 55.8)	26	52.2 (30.1 – 74.3)	0.213
7–9 years	66	71.9 (59.8 – 84.0)	63	79.6 (68.8 – 90.4)	0.340
10–14 years	144	77.4 (69.7 – 85.0)	144	83.3 (76.6 – 60.1)	0.264
15–17 years	57	73.9 (61.1 – 86.7)	55	77.2 (64.8 – 89.6)	0.726
All female children (5–17 years)	**651**	**68.5 (64.0 – 73.0)**	**724**	**76.5 (72.7 – 80.4)**	**0.008****

** Difference between round 1 and round 2 surveys statistically significant at 5 percent

Overall, for panel data of the same households that were both round 1 and round 2, the percentage of children who regularly attended school increased from 68 percent in 2016 to 77 percent in 2018. This increase was highly statistically significant (p-value < 0.001). When further disaggregated by age, the proportions statistically significant were larger for round 2 survey age groups 5–6 years (p-value < 0.001) and 10–14 years (p-value = 0.002). The proportion regularly attending school also increased for children ages 7–9 years and 15–17 years in the round 2 survey, the differences between the two survey rounds were not statistically significant.

For male children ages 5–17 years, there is also a significant increase in the proportion of children regularly attending school (78% in 2018 vs. 70% in 2016, p-value = 0.006). Similarly, for female children ages 5–17, the proportion of those who regularly attended school was higher during the round 2 survey (77%) compared to the round 1 survey (68%), and this difference was statistically significant at 5 percent level (p-value = 0.008).

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

OVC_PRGS 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 reported 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 reported being enrolled in school during the academic year prior to the current/most recent academic year. Table 15 below presents the results of this composite indicator from panel data, disaggregated by the age and sex of the child, and comparing rounds 1 and 2 surveys.

Overall, following the same households over time, the percentage of children 5–17 years who progressed in school was slightly higher during the round 2 survey (75%) compared to school progression rates during the round 1 survey (73%). However, the difference between the two rounds was not significantly different (p-value = 0.366). Even when disaggregated by age, it is observed that across all age groups, the proportion of school-going children who progressed in school was higher during the round 2 survey in 2018 than the round 1 survey in 2016, and differences were statistically significant for children ages 5–7 years (p-value < 0.001) and for children ages 8–9 years (p-value = 0.019). While proportions were higher for school-going children of older age groups during round 2 survey as compared to the round 1 survey, the differences in percentages observed between the two survey rounds were not statistically significant for these older age groups.

Similar observations were seen when analysis of this indicator was disaggregated by sex for the age groups. Among male children ages 5–17 years, overall, school progression was higher during round 2 survey (75%) compared to the round 1 survey (at 70%). However, the observed difference was not statistically significant (p-value = 0.137). Among female children ages 5–17 years overall, the proportion of school progression between the two survey rounds was about the same (at 76% during round 1 and round 2 surveys, p-value = 0.890).

Table 15. OVC_PRGS: Percent of children (aged 5–17 years) who progressed in school year during the last year, by age and sex

	Round 1 survey (2016)		Round 2 survey (2018)		
	All children 5–17 years in panel				
BOTH SEXES	**N**	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
5–7 years	243	33.3 (20.6 – 46.0)	268	60.5 (51.6 – 69.5)	<0.001**
8–9 years	112	74.0 (64.7 – 83.3)	110	87.6 (80.0 – 94.2)	0.019**
10–14 years	412	79.8 (75.2 – 84.3)	436	78.3 (73.6 – 82.9)	0.948
15–17 years	166	76.2 (69.2 – 83.3)	193	77.7 (70.7 – 84.6)	0.778
All ages (5–17 years)	**1.482**	**73.2 (70.0 – 76.4)**	**1,766**	**75.2 (72.3 – 78.0)**	**0.366**
MALES	All male children 5–17 years in panel				
	N	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
5–7 years	78	42.1 (17.7 – 66.6)	90	54.3 (38.2 – 70.5)	0.380
8–9 years	33	60.0 (39.4 – 80.6)	29	89.3 (77.1 – 100.0)	0.013**
10–14 years	112	75.7 (67.2 – 84.2)	128	76.8 (68.3 – 85.2)	0.861
15–17 years	39	75.7 (61.1 – 90.4)	44	81.9 (69.7 – 94.2)	0.508
All male children (5–17 years)	**619**	**70.0 (65.3 – 74.6)**	**706**	**74.6 (70.6 – 78.7)**	**0.137**
FEMALES	All female children 5–17 years in panel				
	N	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
5–7 years	75	16.7 (0.0 – 36.7)	74	74.8 (60.2 – 89.3)	<0.001**
8–9 years	30	84.8 (69.6 – 100.0)	28	81.1 (65.7 – 97.9)	0.782
10–14 years	144	79.1 (71.6 – 86.7)	144	82.8 (75.8 – 89.8)	0.475
15–17 years	57	77.0 (64.8 – 89.1)	55	75.6 (61.8 – 89.5)	0.883
All female children (5–17 years)	**651**	**75.8 (71.4 – 80.2)**	**724**	**76.2 (72.2 – 80.3)**	**0.890**

** Difference between round 1 and round 2 surveys statistically significant at 5 percent

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 both rounds of the MER OVC ESI 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. With the panel data, we compared the percentages observed between the two survey rounds for any differences, disaggregated by sex and age of the under-five child.

Table 16 presents results to the question on engagement of children under five in stimulating activities for early childhood development, comparing round 1 and round 2 surveys for the same households in the panel data. Overall, 87 percent of 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 during round 2 survey, whereas only 59 percent were reported to have done so during the round 1 survey. The difference between the two survey rounds was highly significant (p-value < 0.001). When disaggregated by sex and age, similar differences between the two rounds were observed.

Among male children ages 0–4 years, 87 percent were reported during round 2 to have been engaged in stimulating activities as compared to 58 percent during the round 1 survey, and the difference between the two survey rounds for this indicator was statistically significant (p-value < 0.001). Similarly, among female children ages 0–4 years, 88 percent were reported to have been engaged in stimulating activities during the round 2 survey versus 63 percent during round 1, and the difference between the two survey rounds for this indicator was statistically significant (p-value < 0.001).

Table 16. OVC_STIM: Percentage of children <5 years of age who recently engage in stimulating activities with any household member over 15 years

	Round 1 survey (2016)		Round 2 survey (2018)		
	All children 0–4 years in panel				
BOTH SEXES	**N**	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
0–1 years	78	45.4 (33.0 – 57.7)	80	80.8 (71.0 – 90.5)	<0.001**
2–4 years	258	64.3 (57.3 – 71.4)	278	90.7 (86.7 – 94.8)	<0.001**
All ages (0–4 years)	**458**	**59.3 (53.6 – 64.9)**	**520**	**87.1 (83.6 – 90.6)**	**<0.001****
MALES	All male children 0–4 years in panel				
	N	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
0–1 years	23	42.9 (19.8 – 65.9)	23	78.6 (60.1 – 97.0)	0.010**
2–4 years	78	63.6 (51.7 – 75.6)	85	90.5 (83.7 – 97.3)	<0.001**
All ages (0–4 years)	**157**	**57.6 (48.9 – 66.3)**	**192**	**87.1 (81.8 – 92.4)**	**<0.001****
FEMALES	All female children 0–4 years in panel				
	N	**Percentage (95% CI)**	**N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Age group					
0–1 years	24	60.9 (39.3 – 82.4)	27	82.6 (65.8 – 99.4)	0.170
2–4 years	71	62.7 (50.5 – 74.9)	78	92.9 (86.5 – 99.2)	<0.001**
All ages (0–4 years)	**142**	**63.5 (54.8 – 72.2)**	**168**	**87.6 (81.8 – 93.4)**	**<0.001****

** Difference between round 1 and round 2 surveys statistically significant at 5 percent

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

OVC_CP 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 these perpetrators. 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. 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 17 presents findings from the panel data, comparing the same households visited during the round 1 and round 2 surveys.

From Table 17, it is evident that, overall, perceptions of harsh physical punishment as an appropriate means of discipline or control of children in the home or at school has significantly declined from round 1 (62%) to round 2 (42%). The difference between the two is highly statistically significant at the 5 percent (p-value < 0.001). Even when disaggregating the findings by sex of the caregiver, the overall decline still holds. Among male caregivers, 27 percent during the round 2 survey agreed that harsh punishment was an appropriate means to discipline a child in the home or at school, compared to 47 percent during round 1, with the difference being statistically significant (p-value = 0.053). Similarly, among female caregivers, 44 percent of caregivers during round 2 agreed that physical punishment was an appropriate means for discipling a child compared to 63 percent during round 1. The difference between the two survey rounds on perception of harsh punishment among female caregivers was highly significant (p-value < 0.001).

Table 17. OVC_CP - Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control children in the home or at school, by sex

	Round 1 survey (2016)		Round 2 survey (2018)		
Sex	**n/N**	**Percentage (95% CI)**	**n/N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Male	23/49	46.9 (32.8 – 61.1)	16/56	28.6 (16.6 – 40.5)	0.053**
Female	314/496	63.3 (59.0 – 67.6)	212/485	43.7 (39.3 – 48.1)	<0.001**
All∞	**337/545**	**61.8 (57.7 – 65.9)**	**229/545**	**42.0 (37.9 – 46.2)**	**<0.001****

** The difference between round 1 and round 2 surveys was statistically significant at 5 percent

∞There were four caregivers during the round 2 survey whose sex information was not recorded. They are included in the row for the total. A paired T-test was used to test the difference between the two surveys (round 1 vs. round 2) for the same households in the panel.

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 allows for the generation of the OVC_MONEY indicator, which measures a household's financial stability and resilience in the face of economic shocks. Results are presented in Table 18, comparing round 1 and round 2 surveys in the panel data for the same households visited during the survey rounds, and disaggregated by residence (rural or urban).

Overall, at round 1 and for the households that are included in the panel, about 56 percent of households reported that they were able to access money to pay for unexpected household expenses in the 12 months

preceding the survey compared to 49 percent at round 2. The difference between these two proportions was not statistically significant. When disaggregated by residency, similar findings were observed. Comparing round 1 and round 2 results for households in urban settings, 50 percent at both round 1 and round 2 reported that they were able to access money to pay for unexpected household expenses in the 12 months preceding the survey. For rural households, 58 percent reported that they were able to access money to pay for unexpected household expenses during round 1, whereas this proportion of rural households in the panel was 48 percent at round 2. There was a difference of about 10 percentage points between the round 1 and round 2 surveys. Households at round 1 seemed to be faring better than the same households when asked two years later. However, the difference was not statistically significant (p-value = 0.073).

Table 18. OVC_MONEY: Percent of households able to access money to pay for unexpected household expenses, by residency

	Round 1 survey (2016)		Round 2 survey (2018)		
	Among all households that have incurred unexpected household expenses such as household repairs, urgent medical treatment, etc., in the last 12 months				
Residency	**n/N**	**Percentage (95% CI)**	**n/N**	**Percentage (95% CI)**	**P-value for difference: *Round 1 vs. Round 2***
Urban	34/68	50.0 (37.8 – 62.2)	28/56	50.0 (36.5 – 63.5)	1.000
Rural	102/175	58.3 (50.9 – 65.7)	74/153	48.4 (40.4 – 56.4)	0.073
All	**136/243**	**56.0 (49.7 – 62.2)**	**102/209**	**48.8 (42.0 – 55.6)**	**0.129**

DISCUSSION AND RECOMMENDATIONS

The purpose of conducting the MER OVC ESI was to obtain a snapshot of program outcomes at one point in time (round 1 survey) and to assess changes in outcomes over a two-year period (round 2 survey). In Namibia, this was conducted through a panel design where beneficiary households enlisted and interviewed during round 1 data collection in 2016 were followed up again in 2018, and data were analyzed to assess if there had been any improvements in the nine MER OVC ESI.

It is important to note that during preparatory stages and over the course of implementing the round 2 survey in Namibia, we were informed by PHN and CAA that a number of households that were visited during round 1 in 2016 were no longer eligible for participation in the program in 2018. The eligibility criteria for households and beneficiary children to be included in the program and therefore receive OVC services in the seven strategic areas had since been revised to focus more on CLHIV. In 2018, eligibility criteria included only households that had at least one HIV-positive child age 0–17 years, or if for specific reasons, the government through the MGECW had recommended that the households should continue to receive support and services from the program. For the purpose of these MER OVC ESI surveys, all households that were part of round 1 and successfully located at round 2 were interviewed, and their information was included in the panel data for analysis and assessment of the nine MER OVC ESI over time, regardless of their eligibility or graduation status. Due to challenges in the data collected from the field, we could not conduct a separate assessment for those who were still in the program, as opposed to those who had graduated. Despite that some households had graduated because of the revision to the eligibility criteria, in addition to the usual graduation process, improvements were still observed in some of the MER OVC ESI over time for the same households that were followed.

As is evident from the Results section of this report, the findings indicate that beneficiary households have significantly improved over time in at least five of the nine MER ESI. These include OVC_HIVST, OVC_SICK, OVC_SCHATT, OVC_STIM, and OVC_CP. The size of the observed differences further indicates that these changes are socially meaningful, as well as statistically significant.

- OVC_HIVST: Overall, within the same households that were followed up during the two surveys, there is a 9 percent increase from the round 1 survey (55%) to the round 2 survey (64%) among caregivers who reported that the children under their care had been tested for HIV and that the caregiver knew the results of the HIV test.
- OVC_SICK: A reduction of approximately 50 percent was observed during the round 2 survey for the children ages 0–17 years who were reported to be too sick to participate in daily activities. At round 1, the proportion was 24 percent, whereas the proportion from the same households among children who were reported to be too sick to participate in daily activities during round 2 was 13 percent.
- OVC_SHATT: Overall, the proportion of children (ages 5–17 years) regularly attending school increased from 68 percent during round 1 to about 78 percent during round 2. Similar observations were seen when disaggregated by sex of the child. One interesting observation is that for children ages 5–6 years, there was a significant increase among children regularly attending school, and this increase was observed especially among male children of that age range. In theory at that age, many children are not yet attending school. Recently, there has been a big drive for early childhood development in Namibia. There are a couple of early childhood development centers and many kindergarten/preschools. We believe that more and more parents are enrolling their children for kindergarten. Generally, at age 6, children are enrolled into grade 0 or grade R. A number of the private schools require that the child be enrolled in grade 0/R at the same school where they will

be enrolled for grade 1. Grade 0/R is then considered the final year of preprimary, in preparation for grade 1.

- OVC_STIM: The percentage of children < 5 years of age who had recently engaged in stimulating activities with any household member over 15 years increased by 28 percent during the round 2 survey compared to what was reported during the round 1 survey.
- OVC_CP: The percentage of caregivers who agreed that harsh physical punishment is an appropriate means of discipline or to control children in the home or at school decreased by about 20 percentage points at the round 2 survey compared to round 1, indicating significant improvement within the same households.

There was also indication of possible improvements in three other indicators (OVC_NUT, OVC_BCERT, and OVC_PRGS). Measurement showed movement in the desired direction, but these changes did not attain statistical significance. The findings from OVC_MONEY, however, suggest that there was no improvement over time for this indicator.

Overall, this panel study in Namibia indicates that the strategic OVC programs have had a positive impact on the health and well-being of the households and children being served, and the overall benefits could extend beyond the life of the program.

As noted, we were able to locate about 92 percent of households visited during round 1 (2016) and round 2 (2018). This was made possible by cooperation between the field teams and the implementing partners/service providers in the areas visited, as well as some extra steps added at the time of the round 2 field-data collection. For example, for round 1 beneficiary children and/or caregivers where the home address or the name of the community volunteer was missing, interviewers attempted to locate these respondents at schools (children) or health facilities (caregivers). The reason why some of the households could not be located in round 2 was because they could not be traced in the area. The current CHBCP or CHW did not recognize any member of these households, and field teams were not able to locate previous CAA volunteers who could help identify and locate the households. There were also cases where the entire household had migrated out of the area. For the households that were not visited during round 2, we looked for evidence of selection bias, to see if they were different from other households with regard to sociodemographic and other selected characteristics. We found that these households were not very different from the households that we visited, and hence found no evidence of selection bias.

As seen in summary Table 1, a substantial and statistically significant ($p < .001$) decrease in the OVC_SICK indicator is observed from round 1 (24.3%) to round 2 (12.8%). In addition to the potential impact of ongoing interventions supported by the OVC programs, it is possible that the observed decrease was also influenced by seasonal differences in timing of the round 1 and round 2 data collection periods. As previously noted, round 1 data collection was conducted in November/December 2016 (towards beginning of rainy season) and round 2 data collection in September 2018 (towards end of dry season). Children are more likely to become sick during rainy/wet season than during dry season, and this may explain some of the variation in this indicator between the two survey rounds.

Seasonality may also have influenced the substantial and statistically significant ($p < .001$) increase in the OVC_STIM indicator in round 2 (87.1%) compared to round 1 (59.3%). This indicator is based on the caregiver's response at the time of the survey, and it can get very hot outside during the dry season (i.e., near the time of round 2 data collection). This could lead adults in the household to spend more time inside, away from the sun, with possibly more opportunities to interact and spend time with the household's child under five years, and for stimulating activities such as playing, singing, reading books, or telling stories.

An interesting finding from the round 2 survey was the absence of the biological father in the child's life in the study areas. During the round 2 survey, we added questions on parental survivorship (that were not asked during round 1). While 85 percent of children reported that their biological father was alive, 62 percent of these fathers did not live with the child. There could be a number of reasons for this high proportion (e.g., father not married to mother, father based in another place for employment, separated from mother, divorced), but we did not ask about the reasons during the round 2 survey. What might be interesting would be to learn what effect, if any, the "missing" biological fathers had on the child's welfare and protection. Examples of potentials effects include poor household economy and poor social development of a child, health, and lack of protection from exploitation. Fathers are often the main breadwinners in Namibia, and this can affect the economic situation of these households. It is also known that there are situations in Namibia where fathers often do not honor the maintenance agreement for children. Mothers are often left without any economic support from fathers who leave the home.

While we cannot directly attribute 100 percent of these improvements to the households' participation in the PHN or CAA's OVC programs, it is evident that these OVC programs have contributed greatly to empowering the caregivers to seek the good health and welfare of children under their care even beyond the life of their participation in the program.

It is important to note that for the round 1 survey, figures shown here do not necessarily match those figures presented in the final report for round 1 that MEASURE Evaluation published in 2018 (https://www.measureevaluation.org/resources/publications/tr-17-192). This is because the data in this panel report are limited to households that were visited and interviewed in both round 1 and round 2, matched by age and sex of the beneficiary children, whereas the report produced earlier is based on all households and children included in the cross-sectional survey. As a result, comparison of the round 1 estimates from the present report with the round 1 MER ESI estimates from the 2018 report will not yield matching figures.

The MER OVC ESI and accompanying guidance are currently being revised, and PHN is now implementing OVC programs and services under the new eligibility criteria. We recommend that a new set of outcome evaluation studies that include the revised MER OVC ESI be conducted to obtain true round 1 indicators for program services that began in 2018, with a follow-up panel survey when the program ends to measure the outcome/impact of these new programs over time.

REFERENCES

MEASURE Evaluation. (2014). Collecting PEPFAR essential survey indicators: A supplement to the OVC survey tools. Chapel Hill, NC, USA: MEASURE Evaluation. Retrieved from https://www.measureevaluation.org/resources/publications/ms-14-90

MEASURE Evaluation. (2017). Monitoring the outcomes of orphans and vulnerable children programs in Namibia. Project Hope Namibia 2016 survey findings. Retrieved from https://www.measureevaluation.org/resources/publications/tr-17-192

Namibia Ministry of Health and Social Services (MOHSS). (2010). United Nations General Assembly Special Session (UNGASS) country report (reporting period 2008–2009). [Online]. Retrieved from http://data.unaids.org/pub/Report/2010/namibia_2010_country_progress_report_en.pdf

Namibia Ministry of Health and Social Services (MOHSS). (2015). The Namibia AIDS response progress report 2015. Reporting period: 2013–2014. Retrieved from https://www.medbox.org/namibia/the-namibia-aids-response-progress-report-2015-reporting-period-2013-2014/preview?q=

Namibia Ministry of Health and Social Services, Directorate of Special Programmes. (2017). Retrieved from http://www.unaids.org/sites/default/files/country/documents/NAM_2018_countryreport.pdf

Namibia Ministry of Health and Social Services (MOHSS) & Macro International, Inc. (2008). Namibia demographic and health survey 2006–2007. Windhoek, Namibia and Calverton, Maryland, USA: MOHSS & Macro International Inc. Retrieved from https://dhsprogram.com/pubs/pdf/FR204/FR204c.pdf

Namibia Ministry of Women Affairs and Vulnerable Children. (2004). National policy on orphans and vulnerable children. Windhoek, Namibia: Government Printers. Retrieved from https://extranet.who.int/nutrition/gina/en/node/11584

Namibia Population-based HIV Impact Assessment (NAMPHIA) 2017. (2018). Summary sheet: Preliminary findings. Retrieved from https://phia.icap.columbia.edu/wp-content/uploads/2018/10/33462%E2%80%A2NAMPHIA-SS_A4_B.v41.pdf

Namibia Statistics Agency. (2017). Namibia Inter-censal Demographic Survey 2016 report. Windhoek, Namibia: Namibia Statistics Agency. Retrieved from https://cms.my.na/assets/documents/NIDS_2016.pdf

UNAIDS. (2014). 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Geneva, Switzerland: UNAIDS. Retrieved from http://www.unaids.org/en/resources/documents/2017/90-90-90

UNAIDS. (2015). Namibia: HIV and AIDS estimates. [Online.] Retrieved from http://www.unaids.org/en/regionscountries/countries/namibia

UNICEF. (n.d.). A Namibia fit for children: Prevention of violence against women and children. Retrieved from https: www.unicef.org/mamibia/Violence_fact_sheet_print.pdf

United States President's Emergency Plan for AIDS Relief (PEPFAR)/Namibia. (2012). PEPFAR's Namibia operational plan report FY 2012. [Online]. Retrieved from https://2009-2017.pepfar.gov/documents/organization/212152.pdf

World Health Organization (WHO). (2016). Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach. 2nd Edition. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/hiv/pub/arv/arv-2016/en/

APPENDIX 1. NAMIBIA MER OVC ESSENTIAL SURVEY INDICATORS QUESTIONNAIRE

MER INDICATOR QUESTIONNAIRE
FINAL
7 SEPTEMBER 2018

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. According to our records, your household was interviewed in 2016. We would like to interview you again. 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 tablet and we will note your answers on this password protected tablet. 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		
3.10	Neighbourhood [IF APPLICABLE]		
3.11a	Household Number [RECORD FIRST 10 DIGITS OF THE UNIQUE ID NUMBER FROM THE SAMPLING LIST.]		
3.11b	Household Number [RECORD FROM VERIFIED CAA/PROJECT HOPE LIST]		

SECTION 4: MER OVC 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	
4.1a	Are you the same Caregiver who was interviewed during Round 1 OVC MER EIS in 2016?	Yes 1 No 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 or anyone in your household 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: 4.6**
4.4	How long ago did you or member of household start receiving services or participating in activities from Catholic AIDS Action (CAA)?	[__ __] months	
4.4b	Have you received services from Catholic AIDS Action (CAA) in 2018?	Yes 1 No 2	**If No: 4.6**
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 0-11 months are you responsible for?	[__ __] children	
4.11	How many children aged 1-4 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				
	What specific EDUCATIONAL GOODS or SERVICES were you provided by the Catholic AIDS Action (CAA) in the last 6 months? [MULTIPLE RESPONSE POSSIBLE]	**Yes**	**No**	**DK**	**Refused**	
	4.19 Facilitation of Child enrollment	1	2	8	9	
	4.20 Waiver/Payment of school fees	1	2	8	9	
	4.21 Provision of school materials and uniform	1	2	8	9	
	4.22 Grants to promote school enrolment or progression	1	2	8	9	
	4.23 School visit by Project HOPE or CAA staff	1	2	8	9	
	4.24 Vocational training scholarships	1	2	8	9	
	4.25 Others: Specify _____					
	4.26 Not Applicable – Did not receive education support	1				
	What specific HOUSEHOLD ECONOMIC STRENGTHENING SERVICES were you provided by the Catholic AIDS Action (CAA) in the last 6 months? [MULTIPLE RESPONSE POSSIBLE]	**Yes**	**No**	**DK**	**Refused**	
	4.28 Savings Group	1	2	8	9	
	4.29 Vocational training	1	2	8	9	
	4.30 Enterprise start-up capital	1	2	8	9	
	4.31 Cash transfers	1	2	8	9	
	4.32 Financial education	1	2	8	9	
	4.33 Access to social grants	1	2	8	9	
	4.34 Agricultural inputs	1	2	8	9	
	4.35 Market linkages	1	2	8	9	
	4.36 Value chain development	1	2	8	9	
	4.37 Livelihood training/income generation	1	2	8	9	
	4.38 Others: Specify _____					
	4.39 Not Applicable – Not received economic strengthening services	1				
	What specific PSYCHOSOCIAL SUPPORT OR SERVICES were you provided by the Catholic AIDS Action (CAA) in the last 6 months? [MULTIPLE RESPONSE POSSIBLE]	**Yes**	**No**	**DK**	**Refused**	

	4.41 Home visit and counseling	1	2	8	9	
	4.42 Recreational activities (e.g. kids club)	1	2	8	9	
	4.43 Life skills education	1	2	8	9	
	4.44 Parenting skills session	1	2	8	9	
	4.45 mother-to-mother support groups	1	2	8	9	
	4.46 Others: Specify _____					
	4.47 Not Applicable – Not received psychosocial support/services	1				
	What specific FOOD OR NUTRITIONAL SUPPORT OR SERVICES were you provided by the Catholic AIDS Action (CAA) in the last 6 months? [MULTIPLE RESPONSE POSSIBLE]	**Yes**	**No**	**DK**	**Refused**	
	4.49 Nutritional screening/education/counseling	1	2	8	9	
	4.50 Food/Nutritional supplements	1	2	8	9	
	4.51 Nutritional assessment	1	2	8	9	
	4.52 Growth Monitoring	1	2	8	9	
	4.53 Nutritional referral (for malnutrition)	1	2	8	9	
	4.54 Others: Specify _____					
	4.55 Not Applicable – Not received food/nutritional support	1				
	What specific HEALTH GOODS OR SERVICES did you receive from the Catholic AIDS Action (CAA) in the last 6 months? [MULTIPLE RESPONSE POSSIBLE]	**Yes**	**No**	**DK**	**Refused**	
	4.57 Immunization	1	2	8	9	
	4.58 Health education	1	2	8	9	
	4.59 Treatment of common childhood ailment	1	2	8	9	
	4.60 De-worming	1	2	8	9	
	4.61 Insecticide Treated Bed net [LLIN]	1	2	8	9	
	4.62 Point of use water treatment	1	2	8	9	
	4.63 Water, Sanitation and Hygiene [WASH]	1	2	8	9	
	4.64 HIV Counseling, Testing and Referral	1	2	8	9	
	4.65 ART Adherence support and counseling	1	2	8	9	
	4.66 TB symptoms screening/referral/DOTS	1	2	8	9	
	4.67 Family Planning or general health care	1	2	8	9	
	4.68 Pay User fees	1	2	8	9	
	4.69 Others: Specify _____					
	4.70 Not Applicable – Did not receive health support/services	1				

	What specific LEGAL OR PROTECTION SERVICES did you receive from the Catholic AIDS Action (CAA) in the last 6 months? [MULTIPLE RESPONSE POSSIBLE]	**Yes**	**No**	**DK**	**Refused**	
	4.72 Legal services	1	2	8	9	
	4.73 Succession planning	1	2	8	9	
	4.74 Birth registration	1	2	8	9	
	4.75 Awareness on gender issues/norms	1	2	8	9	
	4.76 Foster parenting	1	2	8	9	
	4.77 Post-rape care	1	2	8	9	
	4.78 Physical/emotional violence prevention	1	2	8	9	
	4.79 Woman and child protection support	1	2	8	9	
	4.80 Others: Specify _____					
	4.81 Not Applicable – Did not receive legal/protection services	1				
	What specific SUPPORT OR SERVICES RELATED TO SHELTER did you receive from the Catholic AIDS Action (CAA) in the last 6 months? [MULTIPLE RESPONSE POSSIBLE]	**Yes**	**No**	**DK**	**Refused**	
	4.83 Re-integration into family	1	2	8	9	
	4.84 Clothing support	1	2	8	9	
	4.85 Renovation of shelter	1	2	8	9	
	4.86 Others: Specify _____					
	4.87 Not Applicable –Not received support/services related to shelter	1				

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 AND Q4.11 - 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.]

CHILD NUMBER X in AGE GROUP 0-4 YEARS

No.	Question	Coding Category	Skip
5.2	Please mention the full names and surname of the [FIRST/SECOND/THIRD etc.] child, 0-4 years old, that you care for.		
5.3	Is [NAME] female or male?	Female 1 Male 2	
5.3a	What is your relationship to [NAME]. I am…….	Mother/Father 1 Grandmother/Grandfather 2 Auntie/Uncle 3 Older Sister/brother 4 Cousin 5 Other relative 6 Neighbor/No relation 7	
5.4	How old was [NAME] at her/his last birthday? [IF THE BABY IS BELOW 12 MONTHS, WRITE AGE IN COMPLETED MONTHS. DO NOT LEAVE BLANK. IF UNKNOWN, ASK CAREGIVER TO ESTIMATE.]	[__ __] months [__ __] years	
5.4a	Is [NAME]'s biological mother still alive?	Yes – living with child 1 Yes – not living with child 2 No 3 Don't know 9	
5.4b	Is [NAME]'s biological father still alive?	Yes – living with child 1 Yes – not living with child 2 No 3 Don't know 9	
5.5	Does [NAME] have a birth certificate?	Yes 1 No 2	**If No: 5.7**

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]? 1 Told stories to [NAME]? 2 Sang songs to [NAME] or with [NAME] including lullabies? 3 Played with [NAME]? 4 Named, counted, or drew things with [NAME]? 5 None 6	
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 AIDS 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 [NAME]'s mid-upper arm circumference? [ONLY ASK FOR CHILDREN 6-59 MONTHS OLD.]	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: 5.16**
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	

5.16a	Since the last time we interviewed your household in November or December 2016, has [NAME] officially graduated from the program? [IF YES – PLEASE PROVIDE DATE]	(Y / N) Date:_____
5.16b	Since the last time we interviewed your household in November or December 2016, has [NAME] been transferred to another OVC program [IF YES – PLEASE STATE NAME]	(Y / N) Name:_____
5.16c	Since the last time we interviewed your household in November or December 2016, has [NAME] left the program without officially graduating [IF YES – PLEASE GIVE REASON]	(Y / N) Reason:_____

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.]

CHILD NUMBER XX in AGE GROUP 5-17 YEARS

No.	Question	Coding Category	SKIP
7.3	Please mention the full names and surname of the [FIRST/SECOND/THIRD etc.] child, 5-17 years old, that you care for.		
7.4	Is [NAME] female or male?	Female 1 Male 2	
7.4a	What is your relationship to [NAME]. I am…….	Mother/Father 1 Grandmother/Grandfather 2 Auntie/Uncle 3 Older Sister/brother 4 Cousin 5 Other relative 6 Neighbor/No relation 7	
7.5	How old was [NAME] at their last birthday? [DO NOT LEAVE BLANK. IF UNKNOWN, ASK CAREGIVER TO ESTIMATE.]	[__|__] years	
7.5a	Is [NAME]'s biological mother still alive?	Yes – living with child 1 Yes – not living with child 2 No 3 Don't know 9	
7.5b	Is [NAME]'s biological father still alive?	Yes – living with child 1 Yes – not living with child 2 No 3 Don't know 9	
7.6	Does [NAME] have a birth certificate?	Yes 1 No 2	**If No: 7.8**

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 AIDS 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: 7.19**
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	

7.19a	Since the last time we interviewed your household in November or December 2016, has [NAME] officially graduated from the program? [IF YES – PLEASE PROVIDE DATE]	(Y / N) Date:_____
7.19b	Since the last time we interviewed your household in November or December 2016, has [NAME] been transferred to another OVC program [IF YES – PLEASE STATE NAME]	(Y / N) Name:_____
7.19c	Since the last time we interviewed your household in November or December 2016, has [NAME] left the program without officially graduating [IF YES – PLEASE GIVE REASON]	(Y / N) Reason:_____

SECTION 8: INTERVIEW LOG

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

[INTERVIEWER COMPLETE.]

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 Appointment made for another day	2 3	**Only if First or Second visit**
		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 2. NAMIBIA MER OVC ESSENTIAL SURVEY INDICATORS FIELD TEAMS

MEASURE Evaluation	Robert Mswia (MER OVC ESI Activity Lead)

Survey Warehouse Project Team

Project Manager	Lizl Stoman
Field Manager	Petrus Shikongo
Data Manager	Pieter Stoman
Project Accountant	Benita Blaauw
Research Assistant	Luciano Siluka

Data Collection Teams

Kavango Region (Team 1)	Zebulon Unanisa (Supervisor) Leonard Kandundu (Interviewer) Petrus Kalipa (Interviewer) Jacobine Elifas (Interviewer) Eusebius Shipoya (Interviewer)
Kavango Region (Team 2)	Marlyn Nguvauva (Supervisor) Freddie Muyamba (Interviewer) Basiliuis Mkuwe (Interviewer) Memory Ntesa Ntesa (Interviewer) Alma Uapeua (Interviewer)
Ohangwena Region (Team 1)	David Amundjembo (Supervisor) Henock Nuuyoma (Interviewer) Gertrude Aindongo (Interviewer) Nelson Nagenda (Interviewer) Petrus Itembu (Interviewer)
Ohangwena Region (Team 2)	Brumilda Daniels (Supervisor) Leonard Mweshihange (Interviewer) Justina Iipinge (Interviewer) Selma Kuuvilwa (Interviewer) Paulina Amutenya (Interviewer)
Ohangwena Region (Team 3)	Elise Mwatanhele (Supervisor) Filippus Shaningwa (Interviewer) Ester Namene (Interviewer) Alina Kambonde (Interviewer) Hilde Mwalya (Interviewer)

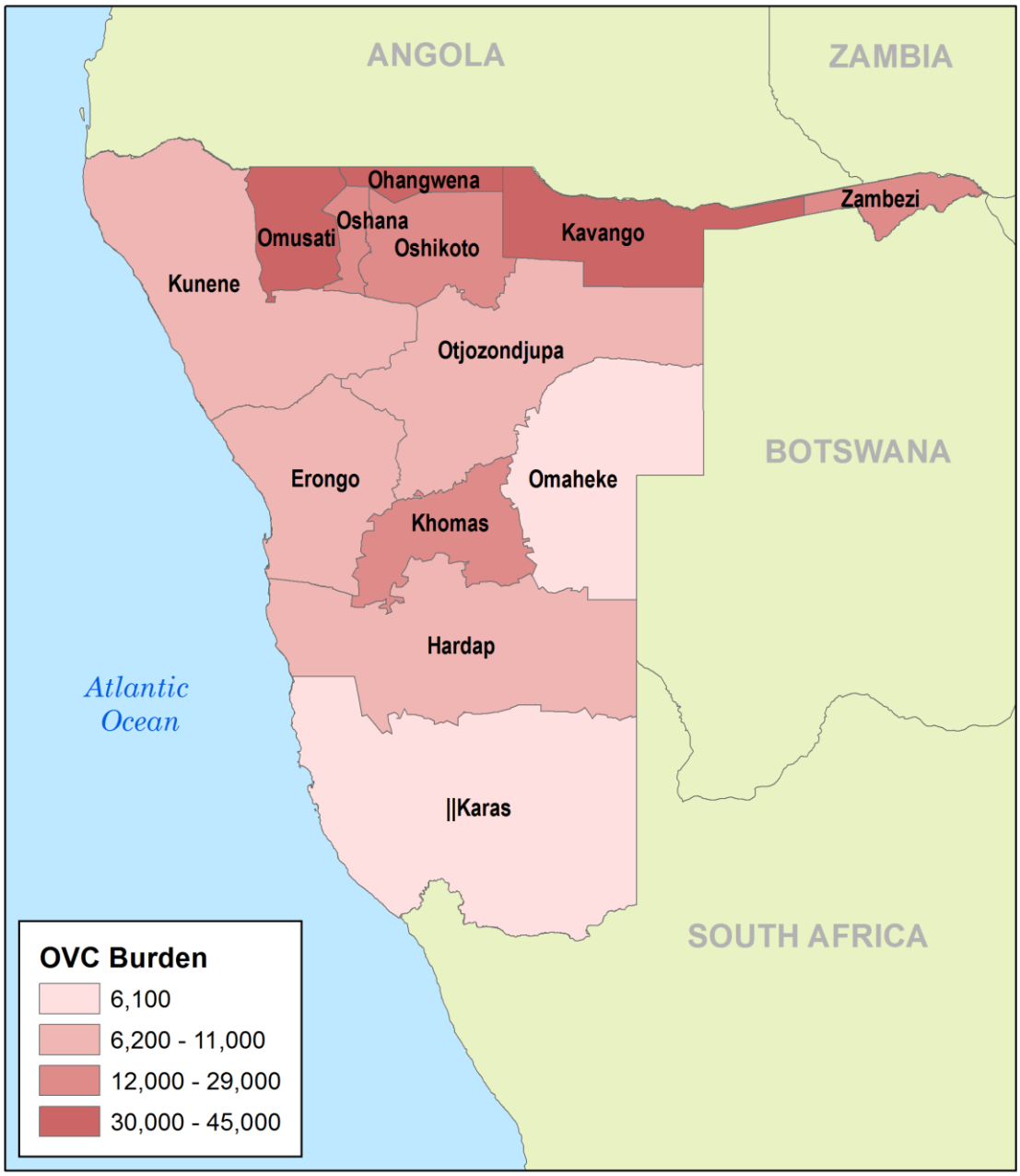
Zambezi Region	Joseph Theodor (Supervisor) Minsonzi Sanimombo (Interviewer) Jane Siseho (Interviewer) Davis Kwenane (Interviewer) Elvis Muyenga (Interviewer)

APPENDIX 3. ADDITONAL TABLE(S)

Table 19: OVC_CERT: Percent of children (aged 0–17 years) who have a birth certificate as reported by caregiver, including those that were verified and not verified by interviewer

	Round 1 survey (2016)		Round 2 survey (2018)		
	All children 0–17 years in panel				
BOTH SEXES	**N**	**% (95% CI)**	**N**	**% (95% CI)**	**Test for Difference: *Comparing Round 1 vs. Round 2 P-value***
Age group					
0–4 years	458	63.8 (58.4 – 69.1)	520	69.4 (64.5 – 74.3)	0.128
5–9 years	504	76.9 (72.4 – 81.3)	554	77.2 (72.9 – 81.5)	0.920
10–14 years	412	80.2 (75.5 – 84.8)	436	81.7 (77.3 – 86.1)	0.648
15–17 years	166	84.6 (78.5 – 90.7)	193	86.4 (80.8 – 92.1)	0.675
All ages (0–17 years)	**2,175**	**74.7 (71.9 – 77.5)**	**2,623**	**77.0 (74.4 – 79.6)**	**0.207**
	All male children 0–17 years in panel				
MALES	**N**	**% (95% CI)**	**N**	**% (95% CI)**	**Test for Difference: *Comparing Round 1 vs. Round 2 P-value***
Age group					
0–4 years	157	64.7 (56.4 – 73.0)	192	73.1 (65.8 – 80.4)	0.146
5–9 years	179	77.7 (70.9 – 84.5)	205	81.5 (75.6 – 87.4)	0.378
10–14 years	112	86.5 (79.6 – 93.3)	128	82.1 (74.7 – 89.5)	0.397
15–17 years	39	86.1 (74.2 – 98.0)	44	86.1 (74.2 – 98.0)	1.000
All male children (0–17 years)	**991**	**76.1 (72.6 – 79.5)**	**1,183**	**78.8 (75.7 – 82.0)**	**0.222**
	All female children 0–17 years in panel				
FEMALES	**N**	**% (95% CI)**	**N**	**% (95% CI)**	**Test for Difference: *Comparing Round 1 vs. Round 2 P-value***
Age group					
0–4 years	142	70.8 (62.6 – 79.0)	168	66.8 (58.7 – 74.9)	0.490
5–9 years	164	79.6 (72.7 – 86.5)	179	73.1 (65.4 – 80.8)	0.195
10–14 years	144	77.5 (69.8 – 85.2)	144	84.7 (77.9 – 91.5)	0.177
15–17 years	57	83.7 (72.8 – 94.6)	55	80.4 (68.9 – 91.9)	0.690
All female children (0–17 years)	**1,006**	**75.0 (71.5 – 78.5)**	**1,134**	**76.6 (73.2 – 80.0)**	**0.516**

APPENDIX 4. MAP OF NAMIBIA SHOWING STUDY AREAS AND DATA COLLECTION SITES



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