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EVALUATION

ENDLINE PERFORMANCE EVALUATION OF THE STRENGTHENING HIV/AIDS RESPONSES IN PREVENTION AND PROTECTION PROJECT IN NAMIBIA

20 May 2015

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Cover Photo: A couple waits with their children for care at a Katatura Township sub-clinic in Windhoek, Namibia.

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ENDLINE PERFORMANCE EVALUATION OF THE STRENGTHENING HIV/AIDS RESPONSES IN PREVENTION AND PROTECTION PROJECT IN NAMIBIA

A four-year cooperative agreement funded by USAID Namibia focused on creating an enabling environment, HIV mitigation and prevention through high-impact, evidence-based programs.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
APR	Annual performance report
ARV	Antiretroviral drugs
BCC	Behavior change communication
CBF	Community-based facilitator
CSO	Civil society organization
DHS	Demographic and Health Survey
FGD	Focus group discussion
GCF	Gender Challenge Fund
GRN	Government of the Republic of Namibia
HCT ¹	HIV counseling and testing
HTC	HIV testing and counseling
HIV	Human Immunodeficiency Virus
GBV	Gender-based violence
KII	Key informant interview
LL/CL	LifeLine/Childline
M&E	Monitoring and evaluation
MGECW	Ministry of Gender Equality and Child Welfare
MoE	Ministry of Education
MoHSS	Ministry of Health and Social Services
MTC	Mobile Telecommunications Limited
NGO	Non-governmental organization
NIP	National Institute of Pathology
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Person (people) living with HIV/AIDS
QA	Quality assurance
SBCC	Social behavior change communication
SFH	Society for Family Health

¹ Initial USAID/Namibia SHARPP program-related documents used the term "HIV counseling and testing" (HCT). The implementing partner, LifeLine/Childline prefers an emphasis on testing and therefore uses an alternate term, "HIV testing and counseling (HTC)."

SHARPP	Strengthening HIV/AIDS Responses in Prevention and Protection
SOW	Scope of work
SSI	Semi-structured interview
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND QUESTIONS

USAID/Namibia commissioned an end-of-project process evaluation of the Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP) program, a 4-year cooperative agreement funded by USAID/Namibia that started on July 1, 2011. SHARPP has been implemented by LifeLine/Childline (LL/CL) in collaboration with the Ministry of Health and Social Services (MoHSS), the Ministry of Gender Equality and Child Welfare (MGECW) and the Ministry of Education (MoE).

The evaluation covers the period from July 2011 through May 2015 and was carried out within all five regions of program activity: Khomas, Oshana, Ohangwena, Kavango and Hardap. The main purposes are: (1) to assess the performance of activity implementers (LL/CL and its contracted implementers), (2) to determine whether intended results are likely to be achieved and (3) to inform the design of potential future activities. The intended audience consists of USAID/Namibia, the Government of the Republic of Namibia (GRN) and other stakeholders. Findings will be used to support the GRN in programming and investing in high-impact, evidence-based HIV prevention and mitigation programs. The findings will also be used to support USAID/Namibia in future program design for HIV prevention and mitigation.

The evaluation scope of work (SOW) specified a set of six evaluation questions:

1. To what extent and in what ways has LL/CL increased access to HIV counseling and testing (HCT) services for general populations?
2. Has SHARPP increased the involvement of male and female youth in practicing and promoting social behavior change for HIV prevention and gender-related norms? Why or why not?
3. In what ways has LL/CL increased capacity through technical assistance for families and communities in delivery of quality community-based interventions?
4. Is there evidence that SHARPP increased long-term financial viability and sustainability through improved program capacity and resource mobilization?
5. How do other stakeholders and clients perceive the quality of program interventions and capacity-building activities by LL/CL?
6. How was gender mainstreamed in SHARPP's activities?

PROJECT BACKGROUND

Although Namibia has performed well in many spheres of development since it gained independence 25 years ago, these gains have been reversed by the HIV/AIDS pandemic and its impacts on the people and the economy. It is commendable that the country has experienced a reduction in the estimated adult HIV prevalence among pregnant women attending antenatal care (ANC) from a peak of 22 percent in 2002 to 16.9 percent in 2014. While prevalence has been reduced, the impacts of HIV/AIDS continue to have far-reaching effects.

The SHARPP program² is aimed at creating an enabling environment for HIV mitigation and prevention in Namibia through targeted interventions that create a safe environment for the

² As shown in Attachment B of the July 2011 award document, the SHARPP is referred to as a "program" with multiple program areas. See CA No. 674-A-00-11-00062-00SHARPP page ii of 15.

population to access high-quality HIV services. SHARPP currently implements activities in six program areas.³

Program Area 1: Increasing access to and uptake of HCT services for at-risk, socially and geographically harder-to-reach clients.

Program Area 2: Greater involvement of male and female youth and communities in practicing social behavior change for HIV prevention and gender-related norms.

Program Area 3: Strengthened capacity of families and communities to enable delivery of quality interventions that provide protective and other social services to children in Khomas, Hardap, Kavango, Ohangwena and Oshana regions.

Program Area 4: Meeting the objectives of the Gender Challenge Fund in Hardap and Kavango.

Program Area 5: Meeting the emotional health and gender-based violence (GBV) prevention and mitigation needs of people living with HIV/AIDS (PLHIV) in order to promote access to and retention in care and treatment.

Program Area 6: Organizational Sustainability: Increased sustainability of LL/CL through improved programming capacity and resource mobilization.⁴

Results framework: The SHARPP results framework consists of key activities, intermediate results and major results for each of the program areas. All six major results contribute to the overarching goal of reducing the spread and mitigating the impact of HIV/AIDS through a comprehensive and integrated community-based response.

EVALUATION DESIGN, METHODS AND LIMITATIONS

The collection of evaluation data was carried out through (a) desk review of documents and program data; (b) site visits in the five regions where the program is active; (c) key informant interviews (KII) with national and regional stakeholders; (d) semi-structured interviews (SSI) with HTC clients, caregivers for orphans and vulnerable children (OVC), and older youth (18 to 24) in youth clubs/groups; and focus group discussions (FGD) with older male and female youth. The analysis triangulated information from stakeholders and beneficiaries with secondary data and documentation reviewed by the team.

The team visited national and regional implementing partners, selecting sites on the basis of consultation with stakeholders and with the intent of achieving a balanced review of project activity, key informants, clients and beneficiaries for all six program areas. The total number of respondents reached was 178.

Limitations: Limitations in the methods used include: non-representation, low response rates and selection bias. The evaluation is qualitative in nature due to the small non-random sample sizes. Due to constraints in access to certain categories of respondents, response rates for certain interview categories were lower than desired. Despite repeated attempts, it was not feasible to contact vitally important informants, such as counterparts at Positive Vibes. In addition, the SOW prioritized SSIs and FGDs with older youth participants in SBCC, and the team did not conduct qualitative interviews with PLHIV beneficiaries. There were possible biases

³ Per the final SOW, the main purpose of this evaluation is to assess the performance of activity implementers. In order to address the above mentioned evaluation questions, it is important to determine whether intended results of the six program areas have been achieved. The evaluation questions are closely aligned with the six program areas and are answered based on the findings from assessing the six program areas.

⁴ Program Area 6 Organizational Sustainability is not mentioned in the final draft of the evaluation SOW, but it is part of the results framework and was therefore added to the list of the six program areas.

in the selection of respondents due to the requirement to select locations on a purposive non-random basis.⁵ These limitations were addressed by developing a sampling plan balanced by program area, region and types of respondents, as well as by over-sampling and selecting respondents independently from participant lists.

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Program Area I: HCT

- **Findings:** The LL/CL SHARPP program has made important achievements providing HTC services at free-standing LL/CL NewStart Centers as well as through community outreach. These accomplishments include: reaching higher than average proportions of couples and men, reaching underserved populations in remote areas and linking HTC services with care and treatment facilities.
- **Conclusions:** Based on both quantitative and qualitative results, the LL/CL SHARPP HTC outreach strategy has been highly successful in reaching large numbers of new clients, both nearby and well outside the catchment areas of the LL/CL NewStart centers. The HTC program has developed a bi-directional referral system, with an emphasis on adherence counseling, which is being effectively monitored by the monitoring and evaluation (M&E) system. This is an important achievement that offers potential for guiding management decisions for prioritizing HTC efforts by region.
- **Recommendations:** Work with implementing partners (MoHSS and MoE) to build on the success of outreach efforts to develop enhanced outreach strategies. This should include emphasis on effective follow-up and after-care for outreach clients who test positive, especially learners during school-based outreach campaigns. The HTC program should invest additional staff and financial resources in both supportive supervision and M&E, to sustain and enhance the bi-directional referral system and its associated M&E data system.

Evaluation Question I: To what extent and in what ways has LL/CL increased access to HCT services for general populations?

- **Findings:** In four years, the SHARPP program almost doubled general population access to HTC services, from 16,700 to 31,200 clients. There was optimism that the LL/CL strategic proposal for NewStart HTC service sustainability through integration could be implemented with support from the GRN and donors. The SHARPP program staff at LL/CL NewStart sites have been trained to work with key populations and are willing to serve them.
- **Conclusions:** LL/CL's sustained increase in HTC services for general populations has been accomplished by expanding outreach programs in communities and schools and emphasizing high-quality counselling services for men and couples and youth-friendly services for adolescents. NewStart HTC services are not likely to be sustainable without integration of additional sexual and reproductive health services on a fee-for-service basis. There is potential to utilize most, if not all, of the NewStart centers (both walk-in and outreach) to increase access to HTC for key populations.
- **Recommendations:** Continue the focus on expanding outreach in communities and schools and emphasizing high-quality counseling for men and couples and youth-friendly services for adolescents. Donors and the GRN should support implementation of the LL/CL strategic proposal for NewStart HTC sustainability through integrated services for general populations. LL/CL should build on the existing capacity and willingness of NewStart centers

⁵ All interviews were conducted by the evaluation team in private without any USAID agency staff present.

to develop a new strategic approach to collaborate with Society for Family Health (SFH) and other agencies that work with key populations, such as Walvis Bay Corridor.

Program Area 2: Social Behavior Change Communication (SBCC)

- Findings: While small relative to the total population in need, all established PEPFAR quantitative milestones for SBCC programs for vulnerable adolescents and adults were met. Most respondents gave very favorable ratings to the quality of the SBCC interventions. Based on qualitative data, SBCC sessions were highly relevant for underserved hard-to-reach rural areas. Community-based facilitators reported a need for more capacity building.
- Conclusions: Facilitators require refresher training with up-to-date and relevant information. Access to SBCC sessions for hard-to-reach rural areas is a priority that warrants greater attention.
- Recommendations: LL/CL should ensure that quality assurance (QA) activities are carried out consistently. Facilitators should have more refresher and in-depth training to improve knowledge, facilitation skills and enhanced professionalism. Increase the focus on providing SBCC for hard-to-reach rural populations.

Evaluation Question 2. Has SHARPP increased the involvement of male and female youth in practicing and promoting SBC for HIV prevention and gender-related norms? Why or why not?

- Findings: Based on the output data from SBCC sessions, SHARPP reached its targets, and a substantial number of young people participated in multiple sessions. However, the number of youth reached is a small (less than 5 percent) portion of the total target population in the five regions. Qualitative findings from KIIs and FGDs with SBCC participants and facilitators provide some evidence, albeit limited to a small number of respondents, that the SHARPP program has increased the involvement of male and female youth in practicing and promoting SBC for HIV prevention and gender-related norms. The M&E system effectively measured client SBCC participation but did not measure changes in knowledge, attitudes and behaviors.
- Conclusions: Apart from output measures of the number of participants completing sessions, the SHARPP program did not establish systems to measure changes in knowledge, attitudes and behaviors of participants before and after the sessions. There were no available quantitative data to demonstrate an increased involvement of male and female youth in practicing and promoting behavior change. This lack of quantitative data is an important gap in the design of the M&E system. In the absence of definitive quantitative data, despite favorable qualitative findings, there is insufficient information to conclude that SHARPP has increased the involvement of male and female youth in practicing and promoting SBC for HIV prevention and gender-related norms.
- Recommendation: SHARPP's M&E system should collect and analyze measures of knowledge, attitudes and behaviors of participants before and at least six months after completing SBCC sessions.

Program Area 3: Family Strengthening

- Findings: The diverse portfolio of programs has met all established benchmarks. The quality of LL/CL family and child protection work, especially in counseling and positive parenting, is rated highly by most stakeholders and beneficiaries. There is a strong collaboration between LL/CL and the government, and the referral system between them is working well, although it varies from region to region. Examples of collaboration include active participation by

LL/CL on key national task forces, monthly placement of LL/CL staff at ministry offices, and bi-directional referrals for counseling interventions between LL/CL and ministries.

- **Conclusions:** Collaboration with government and other key agencies is crucial to effective implementation and sustainability of programs.
- **Recommendations:** LL/CL should continue to build partnerships with government and non-governmental organization (NGO) partners to leverage resources, especially for hotlines and positive parenting.

Evaluation Question 3. In what ways has LL/CL increased capacity through technical assistance for families and communities in delivery of quality community-based interventions?

- **Findings:** LL/CL has increased capacity through numerous types of technical assistance. It provides training in basic counselling, personal growth, positive parenting, child counselling and child participation methods. It also provides technical assistance at the national and regional levels on a wide range of initiatives for child protection, safe communities and safe schools (e.g., Child Rights Network, Parenting Network and National Forum for OVC). LL/CL has contributed to important innovations and trainings that have been effectively disseminated throughout GRN ministries (e.g., positive parenting and suicide prevention). Some respondents felt that there were too many initiatives and that mid-level staff managers were under stress to maintain adequate supervision to ensure quality. The SHARPP program did not develop population estimates for denominators to measure coverage for target populations in family strengthening and child protection interventions.
- **Conclusions:** LL/CL has a well-established record for increasing capacity for family strengthening and child protection through technical assistance for families and communities in delivery of quality community-based interventions. Mid-level managers need additional support to ensure adequate supportive supervision. The development of denominator estimates for target populations is needed to better inform allocation of LL/CL programming by regions.
- **Recommendations:** LL/CL should continue to focus on counselling as its core area, but provide more support for mid-level managers and consider reducing the number of initiatives. It should also develop regional estimates of target populations as denominators to measure program coverage.

Program Area 4: Gender Challenge Fund (GCF)

- **Findings:** The GCF program has been active at the national level, especially collaborating with the MGECW in support of the development of national policies to reduce GBV. Regionally, in Kavango and Hardap, the GCF has trained facilitators to roll out community sessions on harmful gender norms and GBV. Most PEPFAR benchmarks were achieved. Relative to some of the other SHARPP program areas, the GCF program did not implement very many training sessions, especially in the two target regions. The GCF has highly competent trainers in Windhoek but did not build sufficient capacity within the regional offices.
- **Conclusions:** The GCF program has helped LL/CL to develop close collaboration with the MGECW through LL/CL contributions to the National Plan of Action on GBV and national GBV events.

- Recommendations: The GCF should build on its constructive engagement with the GRN, especially the MGECW, to serve as a technical resource and catalyst for action on important GBV initiatives.

Program Area 5: PLHIV

- Findings: While this program represents less than 2 percent of the entire SHARPP budget and has failed to meet established targets, it has nonetheless developed promising methods to access LL/CL core competencies to promote client retention and adherence, especially in the implementation and monitoring of referrals for newly tested HIV-positive clients.
- Conclusions: The M&E systems for tracking referrals have made progress, but they are not implemented consistently across all regions. The program has suffered from a lack of full-time staffing and a failure to formally designate responsible regional staff. This has reduced the program's coverage and effectiveness. The indicator for the proportion of new HIV-positive clients followed up within one month is potentially a very powerful way to measure the performance of the care and support program and should be validated and included within the standard PEPFAR reporting.
- Recommendations: Invest in the validation and improvement of the M&E systems to ensure accurate data are available on the indicators for follow-up and support for retention and adherence. Improve staff management protocols to compensate for prolonged staff absences.

Program Area 6: Organizational Sustainability

- Findings: This area addresses LL/CL's medium- and long-term sustainability through five approaches: development of a business wing to provide training services (called ChangeAgent), diversification of the funding base through fundraising proposals, development of private-sector partnerships, improved organizational efficiency and public fundraising. Annual performance reports, financial reporting and KIIs have shown that all of these approaches have been implemented to varying degrees. KIIs with ChangeAgent clients demonstrated high satisfaction with trainings but raised concerns about turnover of training staff and the need to publicize ChangeAgent services.
- Conclusions: Staff turnover within the ChangeAgent training pool is a chronic challenge that requires intensive training to ensure adequate competence to provide high-quality services. ChangeAgent is still not well known to the private sector or among Namibian NGOs and multilateral agencies, and it lacks visibility in social media.
- Recommendations: ChangeAgent needs to investigate financial or other incentives to reduce staff turnover. ChangeAgent also needs aggressive marketing through social media and other methods for its corporate wellness programs and NGO training services.

Evaluation Question 4. Is there evidence that SHARPP increased long-term financial viability and sustainability through improved program capacity and resource mobilization?

- Findings: LL/CL's five approaches toward sustainability have been implemented with considerable success, improving capacity and resource mobilization. ChangeAgent has expanded its client base and invested in internal trainings to enhance its full-time senior training staff competencies in its core areas of expertise. Funding sources have been diversified and revenues are projected to increase.

- **Conclusion:** Annual performance reports, financial reporting and KIIs show that the major activities in this area (especially the development of ChangeAgent and diversification of the funding base) have been implemented effectively. The pace of ChangeAgent’s net revenue generation has exceeded the business plan’s projections. Despite current constraints on profit generated from donor-funded activities, much of USAID/Namibia’s initial investment in ChangeAgent has already been recovered.
- **Recommendations:** LL/CL should continue to invest in the expansion of its business arm.

Evaluation Question 5. How do other stakeholders and clients perceive the quality of program interventions and capacity-building activities by LL/CL?

- **Findings:** Stakeholders and clients perceived interventions and capacity-building activities in most of the program areas to be of good or very good quality.⁶ For example, one respondent commented, “They always solve cases, they always do follow-ups, and they keep social workers on their toes.”
- **Conclusions:** With very few exceptions, program interventions and capacity-building activities are perceived to be evidenced-based, informed by global and regional best practices and in-depth expertise, especially in counseling services. Some exceptions were concerns raised about the QA practices at some NewStart Centers, QA during HTC outreach sessions and the quality of SBCC sessions in one region.⁷
- **Recommendations:** As noted for certain program areas, improvements are needed to maintain QA. This requires changes in staffing patterns to ensure more supportive supervision at regular intervals and greater support for mid-level managers to allow more time for field supervision.

Evaluation Question 6. How was gender mainstreamed in SHARPP’s activities?

- **Findings:** As indicated by the findings for the above six program areas, gender has been mainstreamed into SHARPP by virtue of the fact that LL/CL has a long-held commitment to gender sensitization for all of its staff that preceded the SHARPP program. Gender has been mainstreamed into SHARPP activities in a consistent manner through a variety of trainings, curriculum development and management policies that address both gender and GBV.
- **Conclusion:** According to KIIs and SSIs with respondents from public and private sectors, LL/CL is recognized throughout Namibia as a well-established and strong resource for gender trainings and curriculum development, including GBV and male engagement expertise.
- **Recommendations:** LL/CL should continue to invest in maintaining its comparative advantage in Namibia as a resource on gender issues as part of its core focus on high-quality counseling services.

⁶ There were insufficient data to comment on the quality of the program or the capacity building activities for Program Area 5.

⁷ For purposes of respecting management confidentiality, the specific region is not mentioned explicitly; LL/CL is aware of the specific region concerned.

I. INTRODUCTION

EVALUATION PURPOSE

USAID/Namibia has requested an end-of-project process evaluation of the Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP) program, a 4-year cooperative agreement funded by USAID/Namibia that started on July 1, 2011. SHARPP has been implemented by LifeLine/Childline (LL/CL) in collaboration with the Ministry of Health and Social Services (MoHSS), the Ministry of Gender Equality and Child Welfare (MGECW) and the Ministry of Education (MoE).

The focus of this evaluation is on program implementation, including but not limited to access to services, whether services reached the intended population, how services are delivered, client satisfaction and perceptions about services provided, and management practices. The evaluation covers the period from July 2011 through May 2015 and was carried out within all five regions where the program has been implemented: Khomas, Oshana, Ohangwena, Kavango and Hardap.

The main purposes of this evaluation are: (1) to assess the performance of activity implementers (LL/CL and other implementers contracted by LL/CL), (2) to determine whether intended results are likely to be achieved and (3) to inform the design of potential future activities.

The intended audience for this analysis consists of USAID/Namibia, the Government of the Republic of Namibia (GRN) and other stakeholders. Findings will be used to support the GRN in programming and investing in high-impact HIV prevention and mitigation programs based on evidence generated on the efficacy of the SHARPP program. The findings will also be used to support USAID/Namibia in future program design for HIV prevention and mitigation.

EVALUATION QUESTIONS

The evaluation SOW recommended a set of six evaluation questions:

1. To what extent and in what ways has LL/CL increased access to HIV testing and counseling (HTC) services for general populations?
2. Has SHARPP increased the involvement of male and female youth in practicing and promoting social behavior change for HIV prevention and gender-related norms? Why or why not?
3. In what ways has LL/CL increased capacity through technical assistance of families and communities in delivery of quality community-based interventions?
4. Is there evidence that SHARPP increased long-term financial viability and sustainability through improved program capacity and resource mobilization?
5. How do other stakeholders and clients perceive the quality of program interventions and capacity-building activities by LL/CL?
6. How was gender mainstreamed in SHARPP's activities?

II. PROJECT BACKGROUND

COUNTRY CONTEXT

Namibia is a country with a relatively small population of 2.1 million, according to the 2011 National Housing and Population Census, spread across a surface area of 824,290 square kilometers. Although the country is sparsely populated, the regions in the northern part of the country are more densely populated. The urban population has grown quite significantly over the past years, from 28 percent in 1991 to 43 percent in 2011. Life expectancy for men was 59 years in 1991 and has gone down to 53 years in 2011; for women, life expectancy has experienced a more modest reduction from 63 years in 1991 to 61 years in 2011. The country has a strong economy, and it is classified as an upper middle income country by the World Bank. However, Namibia is characterized by an unequal distribution of resources as shown by its Gini Coefficient of 0.597.

Although Namibia has performed well in many spheres of development since it gained independence 25 years ago, these gains have been reversed by the HIV/AIDS pandemic and its impacts on the people and the economy. HIV/AIDS continues to erode well-being and the standard of living. Over the past years, various stakeholders have combined their efforts in the fight against HIV/AIDS, guided by national framework on HIV/AIDS and with the MoHSS taking a leading role. It is commendable that the country has experienced a reduction in the estimated adult HIV prevalence from a peak of 22 percent among pregnant women attending ANC in 2002 to 16.9 percent in 2014. From 2002 to 2014, HIV prevalence among younger pregnant women attending ANC, between the ages of 15-19 and 20-24 years, decreased from 11.0 percent to 5.8 percent and 22.0 percent to 9.8 percent, respectively. This decrease in HIV prevalence among younger women suggests new infections are decreasing.⁸ While prevalence is reduced, the impacts of HIV/AIDS continue to have far-reaching effects among the population.

Recent national data from the 2013 Namibia Demographic and Health Survey (DHS) show that among people age 15-49, 81.4 percent of women and 63.2 percent of men have ever been tested for HIV. There are important regional differences. For example, more than half (50.9 percent) of men age 15-49 in Kavango and 42 percent in Ohangwena have never been tested, compared to 36.8 percent nationally (Namibia DHS 2013, Tables 6.1.1 and 6.1.2). Data from 2010-2012 for more than 600,000 reported Namibian HTC clients show that stand-alone HTC centers account for 8 percent of all HTC tests (Pietersen, 2013). Based on the 2013 DHS, freestanding HIV testing sites may account for as much as 7.6 percent of HIV tests among females and 12.5 percent among males (DHS 2013). The percent HIV-positive among new clients of LL/CL NewStart centers ranges from 8.9 percent for females at the Rundu facility to a low of 1.4 percent for males from outreach in Ohangwena (FY14 SHARPP NewStart Data).

⁸ <http://www.nanaso.org/news/reduction-in-overall-hiv-prevalence> accessed 6 June 2015. Also see: National Strategic Framework Mid-term Review, Section 2 on page 16. 2013. NANASO 2015. Global AIDS Response Progress Reporting 2013: Monitoring the 2011 Political Declaration on HIV/AIDS Reporting Period: 2012 – 2013 Directorate of Special Programmes MoHSS. 2014. Report of the 2006 National HIV Sentinel Survey, MoHSS, 2006. Based on the recent 2013 DHS, 14.0 percent of adults age 15-49 and 16.4 percent of those age 50-64 are infected with HIV. HIV prevalence among respondents age 15-49 is 16.9 percent for women and 10.9 percent for men (MoHSS, NSA DHS 2013).

A significant portion of HIV/AIDS cases are among young women age 15-29. While there have been some favorable trends since 2000, for example a decline in reported age of first intercourse and increased condom use between the 2000 and 2013 DHS surveys, Namibian youths' sexual and behavioral practices continue to put them at risk of HIV and unplanned pregnancy. Gaps remain in their knowledge and behaviors. Less than two-thirds (62 percent) of young women and only half (51 percent) of young men have a comprehensive knowledge of HIV/AIDS. Almost one-third (32 percent) of young women who reported multiple partners in the past 12 months indicated that they did not use a condom at last intercourse.⁹

While it is difficult to get reliable data for orphans and vulnerable children (OVC), based on the 2011 National Census there were 130,589 children who have lost one (124,320) or both (6,269) parents; the 2006-2007 DHS estimated a total of 155,000 orphans.¹⁰ The 2013 DHS estimated that 35 percent of households in Namibia care for foster or orphaned children.¹¹ In 2015, more than 234,000 Namibians above the age of 15 are estimated to be living with HIV, with an estimated 8,960 new infections (of these, 1,047 are projected to be among males 15-24 and 1,828 among females 15-24).¹² It is anticipated that the continued reduction of AIDS-related deaths resulting from increases in antiretroviral therapy coverage will increase the number of people living with HIV/AIDS (PLHIV) in Namibia.¹³

Gender-based violence (GBV) is a major challenge to socio-economic and human development in Namibia and is a structural driver of the HIV epidemic (PEPFAR GCF Concept Note, June 2010). Nationally representative data from the 2013 DHS show high rates of GBV in LL/CL target regions, especially Kavango and Hardap, the two regions where the SHARPP program has focused on GBV. As shown in Table 1 below, these two regions have among the highest rates of sexual violence as reported by women respondents in the past 12 months.

Table 1. Regional and National GBV Data from DHS 2013

Percentage of women age 15-49 reporting sexual violence since age 15, ever sexual violence, and sexual violence in the past 12 months

Region	Physical violence since age 15	Sexual violence ever	Sexual violence in past 12 months	Number of respondents
Hardap	26.3	12.4	7.2	62
Kavango	49.3	11.8	10	174
Khomas	32.7	8.1	3.5	450
Ohangwena	30.5	4.3	1.5	207
Oshana	28.2	4.4	1.4	187
Total 15-49	31.5	7.2	3.7	2,226

⁹ See 2013 DHS, page 201; page 198, Figure 14.2; page 199; and page 195, Table 14.18.

¹⁰ See 2013 National Strategic Framework Mid-term Review, page 52.

¹¹ See 2013 DHS, page 20.

¹² See 2014 NAM Narrative Report. Table 1: Namibia HIV Epidemic update (Median Bound Estimates) for the Calendar Years year 2013, 2014 and 2015 based on Spectrum Policy Modelling System, Version 5.03 (2014); Namibia model 26 March 2014.

¹³ See National Strategic Framework Mid-term Review, page 16.

THE SHARPP PROGRAM

The SHARPP program has been implemented from July 2011 through June 2015, with a recent approval for continued activity through December 2015. To date, the total funding for SHARPP is US \$9.2 million, with program activities in the five regions of Khomas, Oshana, Ohangwena, Kavango and Hardap (See Figures 1¹⁴ and 2).

Figure 1. Namibia Regions

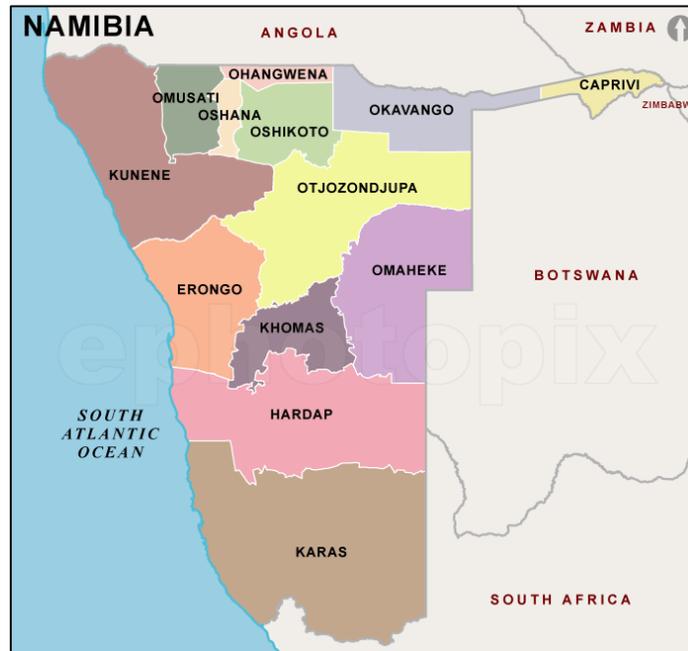
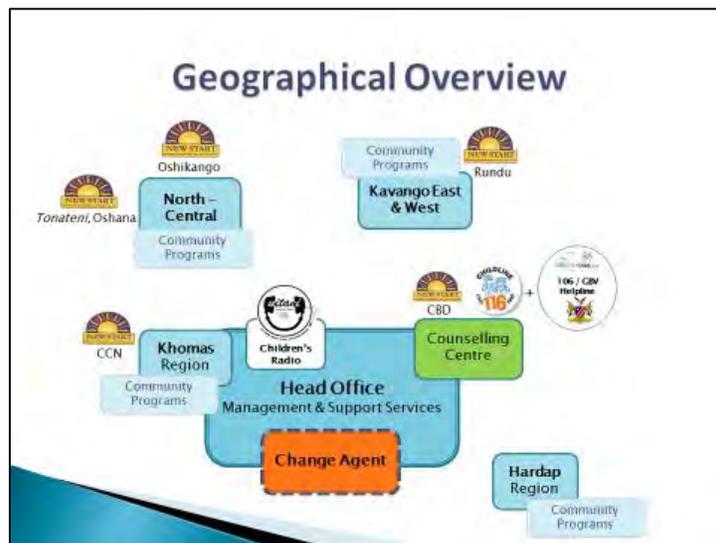


Figure 2. SHARPP Geographic Overview

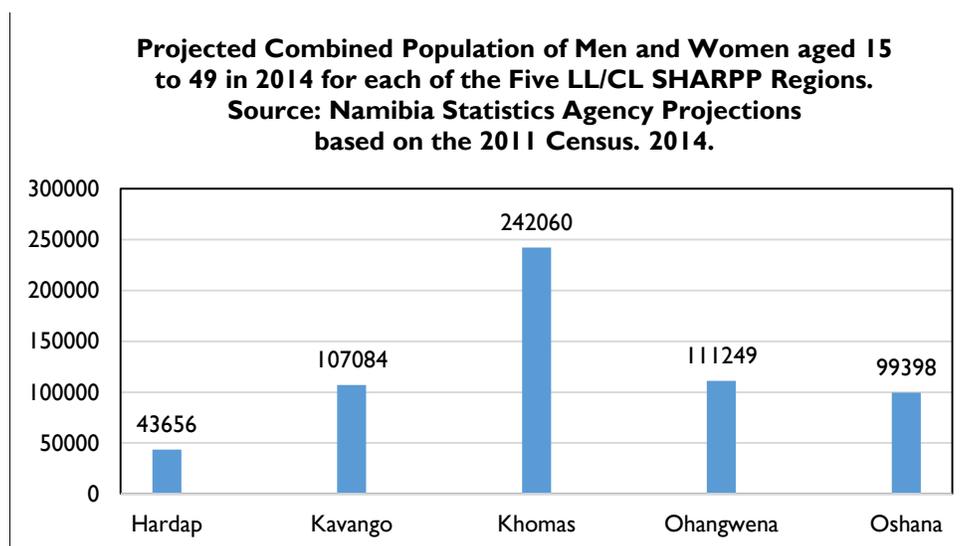


As shown in Figure 3 below, Namibia Statistics Agency projections based on the 2011 census, as of 2014, show that these five regions have a total of more than 603,000 men and women age 15

¹⁴ Sources: Figure 1. <http://www.emapsworld.com/images/namibia-regions-map.gif>. Figure 2. LL/CL ChangeAgent SHARPP PowerPoint Presentation 2014.

to 49, the equivalent of 29 percent of Namibia’s total population. The most populous of the five regions is Khomas, and the least is Hardap.

Figure 3. 2014 Regional Population Projections



The SHARPP program is aimed at creating an enabling environment to mitigate and prevent HIV/AIDS in Namibia. It provides targeted interventions to increase access to high-quality HIV services in six program areas:

- Program Area 1: Increasing access to and uptake of HIV counselling and testing (HCT) services for at-risk, socially and geographically harder-to-reach clients.
- Program Area 2: Greater involvement of male and female youth and communities in practicing social behavior change for HIV prevention and gender-related norms.
- Program Area 3: Strengthened capacity of families and communities to enable delivery of quality interventions that provide protective and other social services to children in Khomas, Hardap, Kavango, Ohangwena and Oshana regions.
- Program Area 4: Meeting the objectives of the Gender Challenge Fund in Hardap and Kavango.
- Program Area 5: Meeting the emotional health and GBV prevention and mitigation needs of PLHIV in order to promote access to and retention in care and treatment.
- Program Area 6: Organizational Sustainability: Increased sustainability of LL/CL through improved programming capacity and resource mobilization.

THEORY OF CHANGE AND RESULTS FRAMEWORK

The SHARPP program’s theory of change is that, through the above six interventions, it is possible to create a safe environment for the Namibian population to access high-quality HIV services, including HTC, OVC programs and psychosocial counseling focused on HIV-positive patients and victims of GBV. As shown in Annex 7, the SHARPP results framework consists of key activities, intermediate results and major results for each of the program areas. The major results contribute to an overarching goal of reducing the spread and mitigating the impact of HIV/AIDS through a comprehensive and integrated community-based response.

III. EVALUATION METHODS AND LIMITATIONS

EVALUATION OVERVIEW

The collection of evaluation data was carried out through a variety of techniques including site visits to LL/CL and its sub-grantee offices, direct observation of HTC outreach activities, informal and semi-structured interviews (SSIs) and focus group discussions (FGDs). The analysis is based on triangulating information obtained from stakeholders and beneficiaries as well as secondary data and documentation reviewed by the team. Quantitative data were tabulated using basic descriptive statistics in MS Excel spreadsheets to develop pre- and post-program comparisons of performance on key indicators. Qualitative data from interviews and FGDs were summarized using matrices in MS Word with a consistent set of criteria. The results were synthesized to identify patterns and themes, which were organized into key findings, conclusions and recommendations for each of the evaluation questions and program areas. The evaluation follows the principles of the USAID and PEPFAR guidance for evaluations with careful adherence to the protection of the privacy and confidentiality of respondents.

The evaluation is based on five key activities (see Annex 3 for the data collection instruments):

1. Desk review of documents and pertinent program data.
2. Site visits to program areas in the five regions where the program is active.
3. Key informant interviews (KII) with national and regional stakeholders (including national counterparts, implementing partners and development partners).¹⁵
4. SSIs with HTC clients, caregivers for OVC, and older youth (age 18 to 24) in youth clubs/groups.
5. FGDs with older male and female youth age 18 to 24: social behavior change communication (SBCC) promoters and clients participating in SBCC and gender norms transformation. Where feasible and desirable, the FGDs were kept as homogeneous as possible. For example, male-only and female-only groups were preferred. In instances where respondents have been trained on issues of gender awareness and there is little concern about inhibition of women in the presence of men, mixed focus groups were considered.

STAKEHOLDER INVOLVEMENT

The design of this evaluation was largely determined by the scope of work (SOW) (Annex 1) with relatively little input from non-USAID/Namibia stakeholders, such as LL/CL or the MoHSS. Both USAID and non-USAID stakeholders were consulted concerning the types of sites to be visited and types of respondents that might be considered, but the final selection of sites and respondents was made independently by the evaluation team with approval by USAID/Namibia. There was an opportunity for non-USAID stakeholders to comment on the initial findings of the evaluation at a stakeholder debriefing.

SITE VISIT SCHEDULE

Visits were made to implementation partners at the national and regional levels, selecting sites on the basis of consultation with stakeholders with the intent of achieving a balanced review of

¹⁵ The informed consent process did not obtain permission to list informants in this report. A list of the numbers and categories of key informant respondents interviewed is shown in Annex 8.

project activity, key informants and clients/beneficiaries for all six program areas. LL/CL provided a database of training events by each of the six program areas, which helped identify some of the beneficiaries of LL/CL program activities. (See the site visit schedule in Annex 4, and matrix of training and capacity building in Annex 5.)

SAMPLING PLAN VERSUS SAMPLE ACHIEVED

The SOW mandated three categories of data collection: KIIs, SIs and FGDs. KIIs were conducted with counterpart GRN ministries, such as the MoHSS and the MGECW, LL/CL SHARPP implementers, and community service organization staff who participate in SHARPP activities. The resulting sample achieved is shown in Tables 2-4. While it was difficult to obtain the number of respondents desired in certain categories (in particular older youth participants in SBCC sessions and caregivers for OVC), overall the total of 178 respondents exceeded the original target of 138.

LIMITATIONS

Limitations in the methods used include non-representation, low response rates, and selection bias. The evaluation is qualitative in nature due to the small non-random sample sizes. Due to constraints in access to certain categories of respondents, response rates for certain interview categories were lower than desired. Despite repeated attempts, it was not feasible to contact some vitally important informants, such as counterparts at Positive Vibes. In addition, the SOW prioritized SIs and FGDs with older youth participants in SBCC, and the team did not conduct qualitative interviews from PLHIV beneficiaries for this program. There were possible biases in the selection of respondents due to the requirement to select locations on a purposive, non-random basis. These limitations were addressed by developing a sampling plan balanced by program area, region and types of respondents, and by over-sampling some respondent categories and selecting respondents independently from participant lists. All interviews were conducted in private without any USAID staff present.

Table 2. Number of Key Informant Interviews

Region	Number of Respondents	Male	Female
Khomas	25	10	15
Kavango	15	10	5
Ohangwena and Oshana¹⁶	21	9	12
Hardap	9	2	7
Total	70	31	39

¹⁶ Ohangwena and Oshana are combined because, although they are two different regions in the North Central area, they are managed by just one North Central LL/CL office.

Table 3. Number of SSIs with SHARPP Beneficiaries

Region	Total SSI Respondents	HTC client exit interviews	Caregivers for OVC	Older youth in youth clubs/ groups
Khomas Week 2	5	5	0	0
Ohangwena Week 3	13	3	4	6
Oshana Week 4	20	9	4	7
Kavango Week 5	16	12	3	1
Hardap/Windhoek Week 6	4	0	4	0
Total	58	29	15	14

Table 4. Focus Groups by Type of Respondent by Region

FGD No	Region	Program	Respondent Type	Total	Male	Female
1	Khomas	SBCC	LL/CL Facilitators	8	4	4
2	Ondongwa	SBCC	LL/CL Facilitators	6	2	4
3	Oshana	SBCC	SBCC Beneficiaries	8	0	8
4	Rundu	GBV	GBV Beneficiaries	10	6	4
5	Rundu	SBCC	SBCC Beneficiaries	8	4	4
6	Hardap	SBCC	LL/CL Facilitators	2	1	1
7	Khomas	SBCC	SBCC Beneficiaries	8	0	8
			Total	50	17	33

IV. FINDINGS

PROGRAM AREA I. INCREASING ACCESS TO AND UPTAKE OF HTC SERVICES FOR AT-RISK, SOCIALLY AND GEOGRAPHICALLY HARDER-TO-REACH CLIENTS

Context: This program area aims to consolidate and increase access to HTC services through community mobilization, in-center and outreach testing, and new HTC modalities for harder-to-reach clients and areas.¹⁷ Per the SHARPP results framework, the overall approach is to implement three key activities: (1) provide HTC services, (2) provide initial screening and referrals, and implement and coordinate bi-directional referrals, and (3) coordinate services. The activities are intended to achieve three intermediate results: (1) increased number of individuals accessing counseling and testing services, (2) increased number of individuals screened and referred for HIV/AIDS care and treatment services and (3) referral links and services coordinated with relevant stakeholders. These activities and intermediate results in turn lead to an overall Program Area Result 1: Increasing access to and uptake of HTC¹⁸ services for at-risk, socially and geographically harder-to-reach clients. (See SOW in Annex I and SHARPP results framework in Annex 7¹⁹).

Implementation: Under the SHARPP program, LL/CL now operates three NewStart centers in Khomas, Rundu and Ohangwena and directly funds the Tonateni NewStart Center in the Oshana region through Catholic AIDS Action. For the purpose of this evaluation, data for all four of these sites are considered. Each of these centers provides HTC services for walk-in clients during normal business hours (some offer weekend hours) as well as outreach HTC services at field sites selected in cooperation with the MoHSS and other stakeholders. LL/CL outreach includes collaboration with the MoE to provide HTC services in schools in Khomas and Ohangwena regions. The number of outreach HTC clients exceeds walk-in clients in all regions. All SHARPP HTC services are required to adhere to Namibian guidelines and standards, and all sites are required to be assessed on a regular basis by the MoHSS and National Institute of Pathology (NIP).

As shown in Annex 2, Table 3, the SHARPP LL/CL HTC program has steadily increased the number of HTC clients who have received their results, from 16,712 in FY 2012 to 31,191 in FY 2014. These increases are due in large part to outreach efforts, which accounted for more than 70 percent of total HTC clients in FY 2014 (See Annex 2, Table 4). Outreach activities account for a higher number of HIV-positive client results than fixed sites in all regions (See Annex 2, Table 6). Based on SHARPP LL/CL data for FY 2012 through the first quarter of FY 2015, men account for 42.9 percent of clients seen (See Annex 2, Table 2).

¹⁷ Note that “harder-to-reach clients” and “harder-to-reach areas” refer to reaching men, couples and adolescents in areas that are difficult to reach, such as remote rural areas in northern regions, e.g., Ohangwena. These clients are not the same as key populations or most-at-risk populations (MARPs). Despite some references to MARPs and to key populations in some drafts of the results framework, the SHARPP HTC program was not mandated to reach key populations.

¹⁸ The wording in the SOW is “HIV counselling and testing” (HCT) services, but LL/CL currently puts the emphasis on testing and refers to “HIV testing and counselling” (HTC), which is consistent with the national strategy document.

¹⁹ The wording for Result 1 in the LL/CL SHARPP results framework is “Increased access (for most-at-risk-populations (MARPs) and other at-risk populations in high-prevalence areas) to voluntary counselling and testing services that meet Namibian guidelines and standards.” According to PEPFAR minutes from February 1, 2011 MARPs Working Group call, “PEPFAR’s definition includes injecting drug users (IDUs), men who have sex with men, and sex workers.” Accessed 17 May 2015. <http://www.pepfar.gov/sab/workinggroups/documents/160114.htm>

Quantitative Findings

Target Achievement: The HTC program has met most PEPFAR benchmarks. Based on SHARPP data from FY12 through the first quarter of FY15, the program has achieved all established PEPFAR targets except for two: youth under age 15 (2,022 reached versus a target of 4,402) and HIV-positive clients (1,936 reached versus a target of 2,194) (See Annex 2, Table 1). The overall achieved number of clients tested who received their results is 26 percent above target, and the overall achieved number of couples is more than 10 percent above the target. Using a different approach, looking at the proposed targets for percentages of clients in certain categories averaged over three fiscal years and one quarter, the program almost met the target for male clients (men were 42.9 percent of clients seen versus a target of 43.7 percent) and for couples (couples were 8.3 percent of clients seen versus target of 9.4 percent).

While it is a favorable finding that LL/CL has met most of its quantitative targets, it is more meaningful to assess the percentage of the target population reached. Unfortunately, the SHARPP program did not establish population denominators for target setting, only numerical targets. Based on 2014 population projections for the five SHARPP regions (Namibia 2011 Population Census Population Projections, Namibia Statistics Agency, September 2014), the total number of LL/CL NewStart HTC clients age 15 and above who received their results in FY14 represents only 5 percent of the total population age 15 to 49 in these regions (30,149/603,447=5.0%).

Referrals: A key selected indicator for the results framework is the percentage of HIV-positive clients who have been referred for HIV services and completed the referrals.²⁰ While no target was set for this indicator, the SHARPP LL/CL HTC program made strong efforts to develop a monitoring and evaluation (M&E) system to monitor this indicator, which is a major accomplishment. This system is based on the MoHSS bi-directional referral system with a common referral form, but it has been incorporated within LL/CL routine M&E reporting. Despite some significant limitations in the quality of the data for FY14 reported by the NewStart sites, the overall findings (for fixed and outreach efforts combined) suggest that: (a) 85 percent of all HIV-positive clients are referred, and (b) among those referred, 55 percent are documented to have completed their referral and reached their destination (See far left columns in Annex 2, Table 9). The proportions referred and completed are shown by quarter for FY14 Q1 through FY15 Q1 (See Annex 2, Table 8) and vary considerably from quarter to quarter. Overall the proportion of HIV-positive clients referred ranged from 85 percent to 100 percent,²¹ but for walk-in clients the reported completion rates for referrals are highly varied by site, ranging from only 32.6 percent for Windhoek Counselling Center to 71 percent for Rundu. This no doubt reflects a combination of actual performance and difficulties in collecting the monitoring data. These results reflect an M&E system that is a work in progress, with potential for improved quality over time.

Percentage of HIV-positive Clients among New Clients (Yield): As shown in Annex 2, Tables 5-7, there is a tremendous variation among HTC locations (both fixed and outreach) in the percentage of new clients in FY14 who tested positive. The highest yields are found at the Rundu and Oshakati (Ohangwena region) fixed sites, at 8.9 percent and 8.4 percent of female clients, respectively. The lowest yields are in the Oshakati (Ohangwena region) outreach (1.4

²⁰ In addition to referrals for treatment, referrals are made for social, psychosocial and other needs to MoHSS and other public GRN facilities as well as CSOs and other services.

²¹ Currently, Table 9 in Annex 2 shows a percentage referred of 146 percent for the Windhoek Counselling Center. This is due to the fact that a larger number of HIV-positive clients were referred than actually tested during the time period. This is an artefact of time lags in test results and referrals, as well as inaccurate reporting. On a month-to-month basis it is entirely plausible that the referral rate exceeds 100 percent due to lags in HIV-positive clients from previous months being referred in the current month. It is assumed that this indicator should not exceed 100 percent for a full fiscal year.

percent of males) and Windhoek walk-in center (1.6 percent of females). As a result of these different yield rates, the actual number of HIV-positive clients by site also varies dramatically, since it is a function of both the regional HIV prevalence among clients and the number of clients tested. The largest numbers of HIV-positive clients in FY14 were from Khomas and Rundu outreach at 268 and 172, respectively.²²

HTC Client Exit Interviews: A total of 29 exit interviews were conducted at the four NewStart centers and during three outreach sessions (14 respondents at fixed sites, 15 at outreach sessions). As shown in Table 5 below, the majority of fixed-site clients were making a first visit, while most of the outreach clients said it was not their first time. The results for both fixed sites and outreach were generally quite positive, with high percentages expressing satisfaction with services. With the caveat that sample sizes are very small and it is not a representative sample, one possible difference between the fixed sites and outreach sessions is the issue of confidentiality. While all of the fixed site respondents felt their services were confidential, one in five of the outreach respondents did not find the services confidential.

Confidentiality: Two HTC clients from outreach sessions made written comments about the issue of confidentiality. One wrote, “There was no confidentiality, when I went in I found someone and he said come in. They should make the testing as confidential as possible.” Another commented, “I was afraid of someone seeing me here.”

Table 5. Selected Results from Exit Interviews at Four NewStart Centers and Three Outreach Sessions

Visit Status	Fixed Site	Number of Cases	Outreach	Number of Cases	Total	Number of Cases
First visit	61.5%	8	20.0%	3	39.3%	11
Not first	38.5%	5	80.0%	12	60.7%	17
Total	100.0%	13	100.0%	15	100.0%	28
Do you find the services at this center confidential?	Fixed Site	Number of Cases	Outreach	Number of Cases	Total	Number of Cases
Yes	100.0%	14	80.0%	12	89.7%	26
No	0.0%	0	20.0%	3	10.3%	3
Total	100.0%	14	100.0%	15	100.0%	29

Training Activities: As shown in the summary of training activities in Annex 5, for the duration of the program there were only a limited number of trainings provided for HTC staff: one conducted for 18 staff on HIV rapid testing and two trainings conducted for couples HIV counseling (for 17 and 19 participants), all in August 2014.

Qualitative Findings

The following findings are based on KIIs with more than 22 respondents at the national and regional ministry levels as well as stakeholders within LL/CL, counterpart agencies and non-governmental organizations (NGOs).

Effectiveness: Most respondents strongly endorsed the effectiveness of the SHARPP LL/CL HTC program, making the point that, compared to MoHSS HTC service site data, LL/CL stands out

²² When the number of HIV-positive clients is adjusted by the percentage referred and by the percentage of referrals completed, it may be possible to do a yield analysis of the actual number of clients estimated to have reached their referral destination. Using these admittedly limited data, and making assumptions that may not be valid, the highest performing sites, with the largest number of HIV-positive clients estimated to have reached their referral point (fixed and outreach combined), were Rundu and Oshakati (Ohagwena Region).

for quality and confidential services, favorable client profiles and reaching higher proportions of couples (which has the advantage of assuring disclosure right away), men and other vulnerable populations such as adolescents. Compared to MoHSS HTC service sites, respondents reported that they prefer to visit LL/CL NewStart centers, which are generally well known. These perceptions align with the results from the quantitative data shown above. MoHSS respondents frequently cited the effectiveness of LL/CL referrals from NewStart centers and the benefits of LL/CL adherence counseling, preparing clients to start on antiretroviral drugs.

Capacity Building: Many respondents felt that LL/CL had contributed effectively to capacity building for HTC, on the basis of their participation in LL/CL-supported trainings for couples counseling and rapid testing, or having contracted with LL/CL to provide training for their outreach workers on HTC issues or useful generic counseling skills.²³

Sustainability: Respondents familiar with the transition of the NewStart centers from IntraHealth to LL/CL acknowledged that LL/CL has shown considerable leadership in efforts to ensure the continuation of NewStart centers through the development of a concise strategic proposal for the remaining stand-alone NewStart centers²⁴ and through its active participation on the National HTC Technical Working Group.²⁵ While there was a consensus that stand-alone centers are more expensive than integrated settings, there was appreciation for the efforts LL/CL has made to reduce costs and expand outreach service to generate more testing with less funds. While none of the respondents expressed confidence that there was a concrete pathway to sustainability, there was some optimism that the strategic proposal could in fact be implemented with support from the GRN and donors.

Findings from Site Visits: Interviews conducted during site visits to all four NewStart centers and observation of outreach in three regions largely confirmed the above findings. The SHARPP LL/CL NewStart staff are very experienced and, with few exceptions, were managing operations in a highly professional manner. There were frequent examples of high-quality referrals to counterpart agencies that were highly appreciated by MoHSS staff (based on reports from physicians and nurses at MoHSS antiretroviral (ARV) treatment clinics, who appreciated LL/CL's adherence counseling prior to referring clients for ARV services). There was some evidence of inadequate management at certain centers, with a lack of attention to maintenance, lack of funds for consumables, and lack of planning to ensure staff coverage during maternity leave. There were also instances where local and regional NewStart HTC procedures and policy may need to be reviewed. In particular, the policy of not writing test results in client health passports and only providing a referral letter for HIV-positive clients means that some HIV-positive clients must have a second confirmatory HIV test before starting ARVs.

Four main concerns applied to most of the four NewStart locations: (1) insufficient opportunities for refresher training on current technical information related to HTC and ARVs, (2) insufficient supportive supervisory visits from national LL/CL HTC staff, (3) lack of a staff nurse and (4) lack of sufficient counselor-testers on staff (in some instances a center had to be closed during outreach for lack of sufficient staff). All of the centers expressed interest in diversifying services beyond HTC toward integration; in particular, they supported obtaining access to CD4 test machines and participating in MoHSS training to use them. Based on interviews with LL/CL staff and MoHSS counterparts, respondents feel that HTC sites should be

²³ Respondents reported that LL/CL routinely used pre- and post-training tests to assess proficiency, but data from these tests were not assessed as part of this evaluation. Respondents from some NGOs pointed out that staff who participated in LL/CL HTC-related training fared better on MoHSS certification tests compared to staff who had not.

²⁴ See LL/CL et al. Meeting National Priorities through Community-based HTC: A strategic proposal for the sustainability of the remaining stand-alone NewStart Centers in Namibia. 2014.

²⁵ The former National Director, Mrs. Jane Shityuwete, was an active participant at the HTC TWG.

able to provide CD4 results for their clients, and CD4 machines offer significant advantages for integrating services and optimizing the referral process.

Evaluation Question 1. To what extent and in what ways has LL/CL increased access to HCT services for general populations?

Overview: LL/CL has significantly increased access to HTC services for youth, couples and men, primarily through outreach. Under the SHARPP program, LL/CL NewStart sites are mandated to provide services for general populations, with attention to hard-to-reach populations, such as youth, couples and men. The SHARPP program does not have a specific program objective to reach key populations (truck drivers, commercial sex workers, men who have sex with men, etc.).²⁶

Quantitative Findings: As demonstrated under Program Area I, the LL/CL SHARPP program has met or exceeded virtually all PEPFAR benchmarks for HTC services. This is largely due to the use of aggressive outreach programs in collaboration with the MoHSS and the MoE. While reaching these targets is an important accomplishment, the total number of HTC clients served represents a relatively small portion (5 percent) of the total population in need.

Qualitative Findings: KIIs with a wide range of knowledgeable respondents from the MoHSS, MoE, LL/CL and counterpart civil society organizations (CSOs) clearly showed that the SHARPP program has sustained an increased access to HTC services for general populations. In particular, compared to MoHSS service delivery sites, the SHARPP NewStart centers have reached a higher than average proportion of male clients, youth and couples. This sustained increase has been accomplished by expanding outreach programs in communities and within schools, combined with high-quality counseling services for men and couples and youth-friendly services for adolescents.²⁷ A key to sustained increased access has been attention to quality of care. Virtually all respondents felt LL/CL has been providing quality HTC services that were confidential without long delays, with high-quality counseling and referral as needed.

Apart from treating key populations in a non-judgmental way during normal hours, there has been no strategic effort to increase access for these groups. Based on KIIs with senior national experts on HTC, there were strong endorsements of LL/CL as an agency well suited to provide services for key populations. There was a clear perception that, compared to the MoHSS and other agencies, LL/CL is more enlightened about these populations, and, having been trained to deal with their needs, they have the expertise to work with them. Some respondents felt LL/CL has a comparative advantage in this area and there is an opportunity for LL/CL to expand services for them. This is particularly important given that the LL/CL strategic sustainability

²⁶ Nonetheless, LL/CL NewStart centers have a longstanding working relationship with SFH to provide services for key populations referred by SFH. While SFH tracks their referrals, NewStart centers do not have a tracking system and therefore have no data for the numbers of key populations served. Increasing access to and uptake of HTC by key populations is one of the six priority areas for the 2014 National Strategy and Action Plan for HTC (See LL/CL et al. Meeting National Priorities through Community-based HTC: A strategic proposal for the sustainability of the remaining stand-alone NewStart Centers in Namibia. 2014). Data for key populations are limited. Results from an Integrated Biological and Behavioural Surveillance Survey (IBBSS) of sex workers and men who have sex with men by the MoHSS and a Mapping Exercise by SFH were not available at the time of this evaluation (<http://esaro.unfpa.org/publications/sex-work-and-hiv-namibia-review-literature-and-current-programmes>).

²⁷ Based on KIIs with NewStart site managers, none of the sites reported increasing access to significant numbers of clients from key populations, including their collaboration with SFH in Oshikango, a border town near Angola reported to have significant commercial sex activity. In KIIs, the staff at LL/CL NewStart centers reported having received sensitization training on how provide service to key populations. The counseling staff are reported to be especially competent to deal with the needs of these populations. Given that LL/CL NewStart site staff have been trained for serving key populations, based on interviews with site managers, there was an expressed willingness to serve these populations. They reported having prior dialog with SFH in which they expressed willingness to collaborate, but for various reasons (such as security issues for moonlight hours), efforts to develop special hours or evening sessions were not implemented.

document points out that, “There is a good fit between the areas in which NewStart performs well,” and this priority area.²⁸

PROGRAM AREA 2. GREATER INVOLVEMENT OF VULNERABLE ADOLESCENTS, YOUTH AND ADULTS IN PRACTICING SBC FOR HIV PREVENTION AND GENDER-RELATED NORMS

Context: The strategic intent of this SHARPP program area is to provide tools that build the self-knowledge and self-esteem necessary to enable adolescents and adults to address issues and challenges facing them, including HIV prevention and encouraging help-seeking and reporting behaviors. The interventions under this program aim to deliver ongoing SBCC programs to children and adolescents in school and out-of-school settings and to adults in community and other settings for HIV risk reduction, HIV prevention and addressing barriers to these. This program was designed to address factors that are identified as the drivers for risk behaviors among adolescents and youth, for example, low self-esteem, low self-efficacy, limited understanding of rights and experience of harmful gender norms.

Midway through implementation of the program, LL/CL transitioned from the traditional stand-alone SBCC program to a stronger emphasis on a combination prevention approach, since it was recognized that for a SBCC program to yield the best results it cannot operate as a stand-alone program but has to be strongly linked to other SHARPP programs, such as HTC services. LL/CL reported an increased number of referrals to other programs, such as HTC, generic counselling and positive parenting, which were generated from the SBCC sessions.²⁹

Implementation: The program is implemented through three strategies³⁰ as follows:

1. *SBCC for vulnerable adolescents, primarily girls aged 15-18, in areas with high prevalence of teenage pregnancy, early marriage and other indicators of adolescent vulnerability to HIV:* This strategy is aimed at preventing and mitigating the impact of teenage pregnancy, early marriage and other factors that are likely to increase adolescent vulnerability, by taking them through a seven-session SBCC intervention for HIV prevention and behavior change. One of the sessions includes a self-risk assessment, which is an important tool to help adolescents realize and internalize their risk to HIV infection and design a plan to address identified risks.
2. *SBCC for vulnerable youth aged 19-24, primarily young women, including unemployed young people and young parents, with a focus on transition to safer and healthier adulthood:* This strategy is only implemented in three (Khomas, Oshana and Ohangwena) of the five LL/CL regions. Vulnerable youth have been reached through a seven-session HIV prevention intervention.
3. *SBCC for parents of vulnerable teenagers to enable them to promote open and supportive dialogue about challenges of parenting adolescents:* In an effort to achieve a systemic family approach, SBCC sessions on parenting are also offered to parents of vulnerable adolescents. Working with both parents and children assists in building healthy relationships and improves communication between them. LL/CL recognized that it is not sufficient to provide support to a child, but it is also important to deal with the child’s environment in a holistic manner that includes caretakers or parents.

²⁸ See LL/CL et al. Meeting National Priorities through Community-based HTC: A strategic proposal for the sustainability of the remaining stand-alone NewStart Centers in Namibia. 2014.

²⁹ The evaluation team was not able to obtain data to confirm this apart from reports in LL/CL APRs.

³⁰ Unfortunately, no baseline data or pre- and post-test SBCC data were collected to measure the impact of these strategies. There were no secondary data available to measure their impacts.

Quantitative Target Achievement

Male Norms and Behaviors: The program exceeded its target for the number of people reached by an individual, small-group or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS.³¹ The target for young people over 25 was exceeded by far; 641 were reached, compared to the target of 132. In the age group 15-24, 1,028 young people were reached, compared to the target of 75. The program reached 1,134 females and 544 males, exceeding the targets of 775 females and 525 males.

GBV and Coercion: The program exceeded its target for the number of people reached by an individual, small group or community-level intervention or service that explicitly addresses GBV and coercion related to HIV/AIDS, reaching 882 participants, compared to the target of 500.

SBCC Sessions: The program exceeded the targets set for the targeted population reached with individual or small-group (<25 people) preventive interventions that are based on evidence or meet the minimum standards required. The 10,673 youth over 15 reached through SBCC sessions were more than twice the target of 5,015. This is an impressive achievement, given that the minimum standard requires that all participants were documented to have attended a minimum of four out of the seven sessions to ensure a significant exposure to the SBCC program. The program targeted to reach 3,117 female and 3,426 male and these targets were exceeded; it reached 7,870 females and 5,425 males.

Referrals: According to LL/CL's annual performance review (APR) of 2014, since October 2013, 717 individuals were referred from SBCC program to other services offered by LL/CL and other stakeholders. The majority of clients were referred to psychosocial services such as counselling, and in FY14 about 65 percent (465 clients) have reached their referral destinations.

Lack of Measures of Coverage: While the above-mentioned targets were met, there were no established denominators to measure the coverage of these interventions in their respective regions. When looked at in aggregate, the numbers of youth reached is quite small relative to the overall target population in the five regions. For example, while 10,673 youth over 15 were reached during the course of the program, this is the equivalent of only 4.3 percent of the projected 2014 total population age 15 to 25 (248,776).

Lack of Measures of Change: Furthermore, beyond the output measure of number of participants completing sessions, there was no attempt to measure changes in knowledge, attitudes and behaviors of participants before and after completing the sessions. In the absence of behavioral indicators measuring changes in risk behavior and risk-reducing behavior, there is no basis for assessing the impact of the SBCC program.

Qualitative Findings

Usefulness of SBCC Sessions: Based on three FGDs with respondents who participated in the SBCC sessions, there was strong acknowledgement on how useful and beneficial the program is to them. Respondents explained how they learned how to protect themselves from HIV. "You need to know who you are dating, know your partner's status, you can't just look at the person and without being tested and conclude their status." They gave examples of how their behavior had changed as a result of the SBCC sessions. One participant claimed he now uses condoms and he never used condoms before. Another explained that they now get to know their partner and do not judge persons by appearance. Many participants felt the SBCC sessions facilitated

³¹ All data were provided by the LL/CL M&E department from the most current SHARPP database for the time period of FY12 through FY15Q1, a period of three years and three months.

their getting tested and encouraging others to do likewise, “I can go to other people and communicate and convince them to go get tested.”

Retention of Community-based Facilitators (CBFs): KII respondents raised a concern about the incentives given facilitators, which they feel are not sufficient to retain them, especially the best ones. One respondent stated, “Biggest problem is retention of facilitators, they move on, they are not paid well enough.”

Inadequate Screening of New CBFs and Provision of Refresher Courses: Some KII respondents are concerned that some CBFs are not properly screened, which has a negative implication regarding the quality of the work they deliver.

Inadequate Technical Information in the SBCC Manual: In KIIs and the three FGDs with SBCC facilitators, respondents felt that the manual has limited in-depth technical information. For example, one of the respondents said that there is a “need to revise the manual to include more current information,” and another one stated, “The manual gives guidance on facilitation but has no information.”

Lack of Supplementary Information, Education and Communication Materials for SBCC Sessions: Both KII respondents and SBCC facilitators indicated that there are inadequate materials. This was mentioned as both a local and a nationwide issue.

Little Evidence of Impact on Knowledge, Attitude and Behavior: Even though the program targets were reached, there are currently no tools to systematically detect if there is any change effected as result of the program. “They do not do a pre and post assessment, they might do that,” stated one respondent.

Gap in Reaching Hard-to-Access Rural Areas: KII respondents as well as SBCC facilitators identified a gap in reaching rural populations. One informant expressed the “need to target out of town schools,” and another one reported a “need to roll out to rural areas.”

Evidence of Occasional Referrals for Generic Counseling and HTC: Respondents in KIIs and FGDs (facilitators and participants) described how SBCC sessions generated referrals to other programs, for example HTC, generic counseling and positive parenting.

Lack of Reporting Mechanism to MoE Management on SBCC: MoE respondents expressed concern that they were not adequately briefed on diverse HIV prevention interventions underway at the regional and national levels (a concern not limited to just SHARPP programs). They indicated that they would like a feedback mechanism or a platform whereby the management of LL/CL and other NGOs can discuss and share: “There is a need to report back to MoE. We can help if there are challenges.”

Training or Capacity Building: The program has so far delivered training to 86 facilitators; training provided was on facilitation skills and personal growth. Refresher trainings were also offered throughout the implementation period.

Sustainability: Some KII respondents feel that the program can only be sustained if it is linked to other programs and it cannot survive as a stand-alone program. Others stated that there is “no way forward without funding,” when asked if the program has potential to sustain itself outside of external funding. Others feel that it can be sustainable if it is incorporated in the schools and if life skills teachers are trained on how to deliver it.

Evaluation Question 2. Has SHARPP increased the involvement of male and female youth in practicing and promoting social behavior change for HIV prevention and gender-related norms? Why or why not?

Quantitative Findings: As demonstrated above for Program Area 2, based on the output data for SBCC sessions, the LL/CL SHARPP reached its targets, and a substantial number of young people participated in multiple SBCC sessions. Unfortunately, there were no adequate measures of coverage for the SBCC sessions for the populations served (neither for the aggregate regional population, nor within the local school populations). In addition, there were no available quantitative data to demonstrate an increased involvement of male and female youth in practicing and promoting behavior change.

Qualitative Findings: The above qualitative findings for Program Area 2 from KIIs and FGDs with SBCC participants and facilitators provide some evidence, albeit limited to a small number of respondents, that the SHARPP program has increased the involvement of male and female youth in practicing and promoting social behavior for HIV prevention and gender-related norms. With few exceptions, respondents felt that there were changes in participant knowledge (e.g., how to use condoms, how HIV is transmitted), attitudes (e.g., greater tolerance of PLHIV, acceptance of women keeping condoms with them) and behaviors (e.g., more consistent condom use, ability to negotiate of HIV testing with partners) related to HIV as a result of the SBCC sessions. While anecdotal, there were many explicit examples where SBCC participants articulated how they felt better equipped to reduce their risk of HIV as well as to encourage their peers to do the same. One respondent stated, “Generally speaking it is effective, but they do lose out on some people because can’t reach everyone due to long distances. People in the region are hungry for info and there is high level of ignorance among people.” Another mentioned, “SBCC is doing a good job with raising awareness but you can’t expect that everyone will grasp the information and change immediately but the team is dedicated.”

PROGRAM AREA 3. STRENGTHENED CAPACITY OF FAMILIES AND COMMUNITIES TO DELIVER QUALITY INTERVENTIONS THAT PROVIDE PROTECTIVE AND OTHER SOCIAL SERVICES TO CHILDREN IN OSHANA, KAVANGO, OHANGWENA, HARDAP AND KHOMAS REGIONS

Context: The objective of this program is to give communities, primarily parents and caregivers of vulnerable children, parenting and communication skills to promote healthy relationships and improved safety and service delivery for children. Interventions include Positive Parenting, Safe Schools, Uitani radio and generic counseling. Under this program area, LL/CL has a dual approach: (1) to prevent harm through community activities that focus on building the capacity of individuals, families and communities to cope with the difficulties they face and to report violations of children’s rights; and (2) to offer a comprehensive portfolio of counselling services at the national and community levels. There is also a component under this program that supports the implementation of the Child Protection Bill.

Implementation: Family strengthening and child protection, especially counseling services, are LL/CL’s core area. This area entails a wide variety of programs, including Safe Plan Schools, Safe Plan for Communities, Positive Parenting, Child Protection Committees and the child-centered radio programming called Uitani Radio. Activities have included:

- Working with their parents and caregivers of vulnerable children
- Advocacy and support for the development of safety plans in schools, hostels and early childhood centers and activities

- Working with disabled learners, their teachers, caregivers and parents on child protection and harmful gender norms
- Working with community activists and community service providers to promote community advocacy and improved safety and service delivery for children
- Working with potential foster parents to ensure that they are able to provide a safe place for children
- Facilitating gender sessions for girls and boys on harmful gender norms

In addition, in FY14, *Safe Schools and Safe Communities* programs were introduced to help schools and communities identify and respond to HIV and violence risks. This program is highly valued by those who participate. In total, 140 people have participated in drawing up and implementing safety plans for their schools and communities. LL/CL is a member of the Safe School Task Force implemented by the MoE.

Uitani Childline Radio complements family strengthening and child protection programming through child-led media. According to the LL/CL 2014 APR, more than 150 radio programs on related issues, produced and presented by children and adolescents, have been broadcast. During the lifetime of SHARPP, increasing numbers of children from LL/CL regions have been involved in the making of programs, resulting in broadcasts in local languages on several community radio stations. Through the services of an external consultant in 2013-2014, significant improvements have been made to child participation and child communication in all of LL/CL's child-focused activities, especially in Uitani Childline Radio.

Counselling services: LL/CL maintains telephone counselling interventions through the 116, 106 and adult crisis lines, and SMS (116 and 106) and face-to-face counselling. LL/CL successfully implemented a new state-of-the-art database system that is able to track data on counseling services. This system shows that in February 2015, 358 text messages were received on the 116 SMS platform and 76 text messages were received on the new 106 SMS platform. Counseling services are also provided to private sector intuitions like Mobile Telecommunications Limited (MTC) through a hotline developed specifically for that purpose. Counselling is provided to MTC employees via telephone and SMS between the hours of 08:00 and 22:00.

The Child Rights Network was established with leadership from LL/CL in 2013 with the aim of supporting government objectives and serving as a critical watchdog in observance of children's rights. This has led, inter alia, to successful celebrations of the Day of the Namibian and African Child and the writing of the *Complimentary Report to the Second Periodic Report of the Government to the African Committee of Experts on the Rights and Welfare of the Child* in 2014. The Network also advocated for the passing of the Child Care and Protection Act.

A *parenting network* was established through the MoHSS with technical support from LL/CL. The MoHSS has since expressed interest to acquire LL/CL's parenting curriculum.

Partnerships: LL/CL is increasingly seen as a crucial partner for government. As a long-serving member of the national forum for OVC, LL/CL assisted the MGECW to develop the national protection flowchart in 2013, in which LL/CL's telephone services are identified as key entry points. LL/CL is also applauded for its good partnerships with other partner NGOs, and their services are highly appreciated, although some expressed the need to have a memorandum of understanding to formally define the terms of their collaboration.

Quantitative Target Achievement:

Umbrella Care (OVC): This program far exceeded the target for the indicator of “number of eligible adults and children provided with a minimum of one care service.”³² The program reached 3,512 females and 1,618 males over 18, as compared to the targets of 1,504 and 869 respectively. Among those under 18, 2,668 females and 2,016 males were reached, compared to the targets of 2,047 and 1,060, respectively.

Support Care: Targets for the indicator “number of eligible adults and children provided with protection and legal aid services” were exceeded by far. The program targeted to reach 2,211 females and 1,089 males and has reached 4,930 female and 4,069 male clients. The program also targeted to reach 2,013 people older than 18 and 1,287 younger than 18 and reached 5,411 over 18 and 3,791 under 18. The target for the indicator “number of eligible adults and children provided with psychological, social, or spiritual support” was also exceeded; the program reached 4,103 as compared to the target of 2,900.

Other Quantitative Findings: According to the 2014 annual program review, in December 2012, the 116 SMS line was launched, receiving up to 1,000 SMSs per month. In 2014 a state-of-the-art database and case management system was introduced. Though still in the final stages of installation, improved capacity of the system has seen an increase in the recording of incoming calls from approximately 3,000 per month to 11,000. On average, 15-20 percent of calls result in counselling or some other service being provided. Since inception of the parenting program in FY12, 1,043 parents completed parenting courses.

Qualitative Findings: According to a respondent, “The need for positive [parenting training] was identified through counseling sessions especially when counseling parents and children, that’s how LL/CL realized that there is a real problem with parenting styles of some parents.” The respondent reported that, as yet, there has been no follow-up after the training, and, “It would be a good idea to do an assessment and follow-up session.”

Based on KIs and interviews with a small number of participants in positive parenting workshops, SHARPP family strengthening activities were well received and considered effective. For example, positive parenting is rated effective by respondents: “It is effective because it brings a sense of responsibility to parents, they thought parenting responsibilities was for schools and through this workshop they were reminded of their parental responsibilities.” Respondents indicated that the parenting course was participatory and culturally sensitive. “We get favorable feedback. Parents say they never understood child development,” stated one respondent. Beneficiaries appreciate the program because it is not only aimed at improving communication between parents and children but also between spouses or couples. Innovation in child participation through the Uitani radio service is appreciated. There is a strong collaboration between LL/CL and the government, and the referral system between them is working well, although it varies from region to region. Mid-level managers expressed that a high workload limits their ability to provide supportive supervision.

Sustainability: Discussions with both government and the private sector on future funding of the Child Helpline have been initiated. Although there is currently no confirmed commitment, the government rates these services highly. MTC purchases counselling services from LL/CL; this cross-subsidizing of services has potential to be a reliable source of income if expanded to more corporate clients. Although some respondents are of the opinion that, even though the business wing is a good initiative, “It might not be a big money spinner; it might be enough to just break even.”

³² All data provided by LL/CL M&E Department from the most current SHARPP database for the time period of FY12 through FY14, a period of 3 years.

Training or Capacity Building: Through this program, 181 individuals were trained in basic counselling, personal growth, positive parenting and child counselling.

Evaluation Question 3. In what ways has LL/CL increased capacity through technical assistance of families and communities in delivery of quality community-based interventions?

Quantitative Findings: As shown above for Program Area 3, while virtually all established quantitative benchmark targets for outputs were reached, as with Program Areas 1 and 2, there were no SHARPP program population estimates for denominators to measure coverage for target populations. For example, although LL/CL has developed state-of-the-art monitoring systems for telephone counselling operations, there were no data on the estimated child listenership for the Uitani radio programs, no data on estimated target populations with need of telephone counselling, nor estimates of the number of parents in need of parenting workshops. The evaluation has only relied on quantitative output measures and did not develop quantitative capacity measures for counselors, parents, families or communities to better care for children.

Qualitative Findings: While the data are limited and anecdotal, based on the above qualitative findings for Program Area 3, LL/CL has increased capacity in numerous ways through technical assistance for families and communities in delivery of quality community-based interventions. Based on KIIs with counterpart ministry and CSO staff, LL/CL is seen as an evidence-based center of excellence for community-based psychosocial support services. There was a universally high regard for the contributions of senior LL/CL staff at the national and regional levels on a wide range of national GRN task forces for child protection, safe communities and safe schools (e.g., Child Rights Network, Parenting Network, National Forum for OVC). LL/CL has contributed to important innovations that have been effectively disseminated throughout GRN ministries (e.g., the recent national initiative to roll out positive parenting by the MoHSS using a curriculum developed by LL/CL). LL/CL trainings and technical assistance, such as for suicide prevention, were extremely well received. LL/CL's capacity for counseling services for child protection highly are appreciated by counterpart MoHSS and MGECW social workers. Some KII respondents felt that there were too many initiatives and that mid-level staff managers were under stress to maintain adequate supervision to ensure the quality of the programs.

PROGRAM AREA 4. MEETING THE OBJECTIVES OF THE GENDER CHALLENGE FUND IN KAVANGO AND HARDAP

The Gender Challenge Fund (GCF) program area has two main aims: to decrease tolerance for GBV and to increase access to and awareness of services in line with GRN policies. As outlined in the SHARPP results framework, the overall approach for this program area comprises four key activities: (1) Provide technical assistance to sub-grantees; (2) support national GBV-related events; (3) introduce a GBV helpline; and (4) provide networking. These activities are intended to achieve three intermediate results: (1) Increase the number of people with improved awareness of GBV and harmful gender norms; (2) increase the number of individuals receiving GBV preventative messages; and (3) increase the number of support groups formed and supported. These activities and intermediate results in turn lead to the overall Program Area Result 4: Meeting the objectives of the GCF in Kavango and Hardap.³³ (See SOW in Annex I and SHARPP Results Framework in Annex 7.)

³³ In the SOW, this Program Area/Result Four is described as: "Meeting the objectives of the Gender Challenge Fund in Kavango and Hardap," but in the results framework provided by LL/CL, Result Four is shown as, "Improved awareness of GBV by mobilizing communities to become proactive in recognizing and addressing GBV, and decrease community tolerance for GBV." For the purpose of the evaluation, the authors prefer to adhere to the SOW.

Implementation: The GCF program has been operational since FY12 for three of the above-mentioned key activities. The GBV work builds on previous capacity that LL/CL has acquired with male-engagement programming in collaboration with EngenderHealth. The sub-granting process, with awards to agencies in the two regions and associated technical assistance activities, only began in FY14. The GCF program is implemented at the national level by an 80 percent full-time equivalent gender programs manager and a 50 percent full-time equivalent national gender program manager, with assistance from regional GCF focal point staff in Hardap and Kavango. The program has been active at the national level, especially collaborating with the MGECW in support of the development of national policies to reduce GBV. At the regional level, the GCF has trained facilitators to roll out community sessions on harmful gender norms and GBV using a two-session approach to raise awareness and link community members to GBV services.³⁴ It has also conducted capacity building and sensitization workshops for stakeholders. The GCF has worked to secure GRN support to operationalize a toll-free GBV Helpline that is connected to the LL/CL Counselling Center, with advocacy to secure running costs from the ministry's budget. In FY14, the GCF program recruited a senior gender consultant to be seconded to the MGECW to support the implementation of the GBV Action Plan.³⁵

More recently, with the benefit of a one-day training on sub-granting from PACT, the GCF program conducted an ambitious request for proposals for GBV sub-grants in the two regions in May 2014. Following a lengthy process, the program reduced more than 60 proposals to seven awards in the two regions (three in Hardap and four in Kavango). While the awards were very different in approach and scope, they were all designed to have focus on zero tolerance for GBV and providing access to GBV services.

Quantitative Target Achievement: The GCF program has largely met its targets for key indicators, the exception being the number of support groups formed and supported.³⁶ For the past three fiscal years, it has met the target for the male norms and behaviors indicator (Figure 4). As shown below in in Table 6, for the most recent complete fiscal year (FY14) it almost met the target for the indicator for GBV and coercion. GCF also tracks indicators for gender-related referrals (30 made, 22 completed) and individuals reached with GBV awareness messages.³⁷

³⁴ A recent SIMS review concluded that the two-session approach had an insufficient number of hours to reach a minimum standard of ten hours for adequate dosage for behavior change. As a result a five-session version has been developed, with staff training. The new approach had not yet begun at the time of the evaluation.

³⁵ MGECW. National Plan of Action on Gender-Based Violence 2012-2016. 2012.

³⁶ No results for this indicator are found in the M&E data provided by LL/CL.

³⁷ At the time this was drafted, the targets for these additional indicators could not be located.

Figure 4. Male Norms and Behaviors

Number of people reached by an individual, small-group or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS: Target versus Achievement for FY 2012 through 2014 (combined results for Hardap and Kavango)

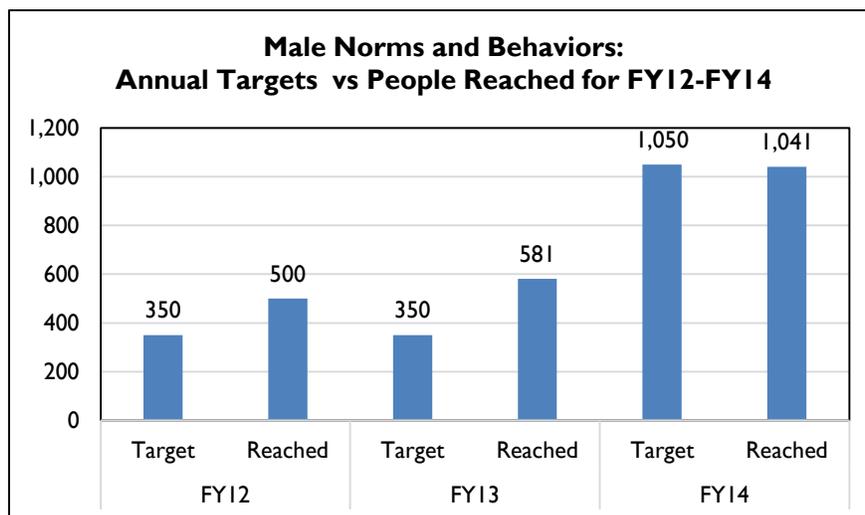


Table 6. GCF Program Indicators for FY 2014

Male Norms and Behaviors: Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS			
	Total	Targets	% Progress
	1,041	1,052	99.0
GBV and Coercion: Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses GBV and coercion related to HIV/AIDS			
	Total	Targets	% Progress
	1,003	1,052	95.3
Number of gender-related referrals made	30	NA	
Number individuals referred and received appropriate services	22	NA	
Percentage of individuals referred and received appropriate services	73.3%	NA	
Number of individuals reached with GBV awareness messages (including 16 days of activism)			
	Male	306	NA
	Female	409	NA
	Total	715	NA

Training: Relative to some of the other SHARPP programs areas, the GCF program did not implement very many training sessions, especially in the two target regions of Hardap and Kavango. Data provided from LL/CL showed that there were nine trainings from November 2011 to October 2014, but only four of these took place in the regions (a community leader training with 17 participants and an internal gender training with 25 participants in Rundu, and a community leader training for 20 participants and a GBV workshop for 14 participants in Hardap). KII with Hardap and Rundu sub-grantee staff found very positive feedback on the initial Windhoek-based sub-grantee capacity building workshop, but there was concern that there was not enough follow-up training to adequately capacitate the sub-grantee implementers.

Qualitative Findings: The qualitative findings are based on KIIs with respondents in Windhoek, Hardap and Kavango as well as a FGD with members of the Rundu Catalyst Youth Drama group in Kavango. Although limited in number, the respondents cover a range of stakeholders from LL/CL and the MGE CW to representatives of four of the seven sub-grantees.

Effectiveness: Respondents felt that the GCF was active in supporting national GBV events and had good visibility at the national level in collaboration with GBV policy and programs. While progress on the introduction of the GBV helpline was acknowledged to be slow, it was frequently pointed out that working with the GRN often requires perseverance and time. Respondents generally felt that the GCF was closely tied to GBV issues at the national level, but less so at the regional level. The placement of a gender consultant at the MGE CW helped the SHARPP GCF advocate for effective GBV policy implementation.

KIIs revealed that there were management issues with the sub-granting process both at the national and regional levels. Most of these seemed to stem for the lack of prior LL/CL experience in sub-granting and insufficient staff to manage the sub-grants. In addition to a lack of sufficient training on GBV issues, some sites reported they received few, and in one instance no, site visits during the entire course of their sub-grants. There were chronic problems and delays with fund disbursement; some projects were severely hampered by the delays and even by cancellation of planned procurement of equipment with no explanation offered. Despite the problems with the sub-grant process, there was strong enthusiasm on the part of the sub-granting agencies for the value of GCF support. While there was considerable variation in the sub-grants, with problems in design and implementation, most of the sub-grants had positive attributes that offered potential for continued support. The overall perception was that the GCF has raised awareness about GBV and access to services, but it was modest and not consistent across regions. A key issue was the raising of awareness without adequate follow-up to encourage constructive actions to increase access to services. The FGD with the participants in the youth GBV drama troupe, Rundu Catalyst Youth, showed clearly that they had gained in-depth understanding about harmful gender norms, the need to provide access to GBV services and how to access them.

Capacity Building: As discussed above, there was consensus among respondents that additional training was needed, especially for regional GBV coordinators and facilitators. It was acknowledged that it usually takes multiple trainings to acquire sufficient depth to be an effective GBV resource person and that not enough effort had been invested in capacity building. Despite this gap, respondents felt that the GCF has strong base of trainers in Windhoek and if time and resources are available, there could be effective capacity in the longer term.

Sustainability: Based on the KIIs with Windhoek-based respondents, there seems to be long-term potential for getting GRN support for the operating costs of the GBV Helpline. The close collaboration between the GCF and the MGE CW provides a basis for optimism that these costs may eventually be covered.

Findings from Site Visits: Based on site visits to the two regions, it was clear that there were significant differences between regions, not only in the management of the GCF program, but in the culturally defined roles of traditional leadership and in prevalence of GBV. A key constraint in Hardap was the total unavailability of the regional gender coordinator for eight months due to a car accident. There was no formal provision made to find a replacement for this staff person, which posed a major drain on other staff called on to help fill the vacuum. Failure to find a replacement for this coordinator appears to have reduced much needed oversight for sub-grants and cultivation of contacts with key local stakeholders. Based on KIIs in the two regions, there appeared to be missed opportunities, especially in Hardap, to provide mentoring and leadership for sub-grantees, to maintain rapport with key local stakeholders and to offer

guidance on next steps and follow-up. While the quality varies, some of the sub-grants appeared to have potential for making productive contributions to GBV awareness and access to services.

PROGRAM AREA 5. MEETING THE NEEDS OF PLHIV TO PROMOTE ACCESS TO AND RETENTION IN CARE AND TREATMENT

Context: This program represents only a small portion of the entire SHARPP budget (less than 2 percent) and was only started in FY14. It is, nonetheless, a very important program area because it has developed promising methods to access LL/CL core competencies (counseling to address mental health and support issues and GBV) for PLHIV to promote retention and adherence (See LL/CL FY15 Q1 report, section 2.5 Area 5). Per the SHARPP results framework, the overall approach for this program area is to implement three key activities: rolling out body mapping³⁸ for community support groups, providing psychological support to adolescents living with HIV and providing therapeutic counseling. These activities are intended to achieve one intermediate result: “Support groups supported and provided with psychological support.” These activities and intermediate results in turn lead to an overall Program Area Result 5: Meeting the emotional health and GBV prevention and mitigation needs of PLHIV in order to promote access to and retention in care and treatment (See SOW in Annex I and SHARPP results framework in Annex 7).

Implementation: At first, the primary focus of the HIV care and support was to provide assistance to PLHIV through the use of body mapping. Working in collaboration with key stakeholders, including Positive Vibes and TONATA, this roll-out has taken place in cooperation with PLHIV community support groups on a limited basis in four regions (Khomas, Ohangwena, Oshana and Kavango). In addition, attention has been focused on the needs of adolescents living with HIV at the Engela Hospital Pediatric ARV clinic. In FY14, adolescents (14 male and 15 female) participated in LL/CL’s child-centered training to provide psychological support.

More recently, in the later part of FY 2014, this program has successfully developed and implemented a set of important tools and strategies for systematic follow-up and support for newly tested PLHIV. Building on the MoHSS tools for bi-directional referrals, the care and support program developed an assessment tool to be used during follow-up calls and counseling sessions with newly tested HIV-positive people. They have also instituted procedures to make standard follow-up calls to all newly tested HIV-positive clients within four weeks of testing at the NewStart centers. These activities have been introduced through sensitization workshops for HTC and generic counselors on therapeutic and counseling interventions for newly tested HIV-positive clients (October 2013 and March 2014).

Quantitative Target Achievement: The primary PEPFAR indicator for this program, “Number of People Living with HIV/AIDS (PLHIV) reached with a package of PLHIV (PwP) interventions that meet the minimum standards required,” has not been achieved. The FY14 reporting data show a target of 218 and zero reached in each quarter. This probably reflects a reporting error, since it is certain the program did reach clients in FY14.³⁹ For FY15 Q1, substantial progress was made, with 144 persons reached, compared to a target of 220 (65 percent of target).⁴⁰ Although it appears the key PEPFAR indicator has not been achieved, by virtue of establishing a plausible and practical follow-up monitoring system (which admittedly still has limitations) that has been rolled out in all NewStart centers, this program has nonetheless demonstrated important quantitative achievements. These achievements in referrals have

³⁸ This participatory workshop format called “Body Mapping” has been found to be effective in helping newly tested PLHIV address the numerous challenges they face in coming to terms with being positive.

³⁹ Data provided by LL/CL. Q4 Updated reporting template V1 2013 (15/07/2014).

⁴⁰ Data provided by LL/CL. FY15-1st Quarter Report.

already been documented in the referral data described above for Program Area 1 (See Annex 2 Tables 8 and 9).

Other Quantitative Findings: In addition to the impressive efforts cited above to track the percentage of new HIV-positive clients referred and percentage of referrals completed, the APR narratives for FY14 and FY15 Q1 present data for the percentage of clients called within four weeks of being found to be HIV-positive.⁴¹ While these data are not presented very clearly or systematically,⁴² this indicator is potentially a very powerful way to measure the performance of the care and support program and deserves more attention to be validated and included within the standard PEPFAR reporting.

Training: Relative to the other SHARPP programs, the care and support program has succeeded in rolling out a substantial number of pertinent trainings. Since FY14, nine sensitization and body mapping trainings have been conducted with more than 100 participants, for a total of 28 days of training. This is another example of how this program area, with a small budget, has managed to make significant progress. Based on KIIs and a review of narrative reports, there is a need for refresher trainings both for body mapping and for sensitization on the needs of PLHIV and the associated follow-up procedures.

Qualitative Findings: Due to limitations in time and resources, only a small number of pertinent respondents were interviewed for this program (acting manager, interim manager, regional managers and respondents from counterpart agencies Tonateni and the MoHSS). Despite repeated attempts, it was not feasible to contact vitally important informants, such as counterparts at Positive Vibes. In addition, the SOW prioritized SSIs and FGDs with older youth participants in SBCC, and the team did not conduct qualitative interviews from PLHIV beneficiaries for this program. Nonetheless, some useful findings emerged.

Effectiveness: Due to staff limitations (the full-time lead staff resigned after six months and was never replaced), the program has had to rely on informal expectations of regional staff managers and facilitators to do the implementation when they could make time. During the first six months, there was substantial progress, with a slower subsequent pace. Based on KIIs and narrative reports, it appears that the activities implemented were appropriate for the target populations and well received. More importantly, the LL/CL innovations in introducing new tools and M&E systems (documented above) to track progress of newly tested positives show promise toward a rigorous basis for ensuring LL/CL's expertise in counselling is effectively applied to issues of retention and adherence.

Capacity Building: In addition to training staff to conduct body mapping work, this program has invested wisely in building capacity of facilitator and counselling staff in sensitization on how to meet the needs of PLHIV and how to use the monitoring tools and systems. Based on KIIs and narrative reports, refresher trainings are needed to consolidate the progress to date and increase the number of LL/CL staff competent to conduct body mapping workshops.

Sustainability: Based on KIIs, there was no evidence that this program can continue without external donor support. Given that much of Program Area 5 involves LL/CL priority core counseling and HTC staff at both NewStart and regional offices, it seems likely that LL/CL will find ways to continue these activities with future donor support.

⁴¹ Per the FY14 APR, this is part of, "Strategies undertaken included strengthening the test and treat approach (also referred to as same day <1 week enrollment) with a mandatory follow up within 4 weeks, targeting HIV positive persons in sero-discordant relationships and newly infected individuals." (Citation LL/CL FY14 APR).

⁴² Examples of this new indicator are: FY14 Q4 (July–September 2014) Of 197 HIV-positive clients referred, 68 percent were followed up within the bi-directional referral prescribed period of four weeks. FY15 Q1 (October–December 2014) Of 214 HIV-positive clients referred, 60 percent reached the referral points within the bi-directional referral prescribed period of four weeks.

Findings from Site Visits: While relatively little attention was given to this program during site visits, discussions with mid-level managers indicated that being assigned multiple additional activities by Windhoek-based staff, including for care and support, causes stress and is not conducive to consistent implementation. Apart from the full-time program manager, who resigned after six months, there were no officially designated full-time focal points for the care and support program.⁴³

PROGRAM AREA 6. ORGANIZATIONAL SUSTAINABILITY: INCREASED SUSTAINABILITY OF LL/CL THROUGH IMPROVED PROGRAMMING CAPACITY AND RESOURCE MOBILIZATION

Context: This SHARPP LL/CL program area reflects a strong spirit of innovation that mirrors USAID/Namibia's concern that practical responses be developed for the difficult Namibian funding environment. Sustainability is a key priority for LL/CL, anticipating the eventual completion of the SHARPP award. As outlined in the SHARPP results framework, the overall approach for this program area is to implement three key activities: develop a business model, reinforce resource mobilization strategies and offer limited trainings and technical assistance to partners. In turn, these activities are intended to increase the sustainability of LL/CL by achieving three intermediate results: a completed business model, a completed business plan and marketing strategy and resource mobilization. (See SOW in Annex I and SHARPP results framework in Annex 7.)

Implementation: This program area addresses LL/CL's medium- and longer-term sustainability through five approaches: development of a business wing to provide training services (called ChangeAgent), diversification of funding base through fundraising proposals, development of private sector partnerships, improved organizational efficiency, and public fundraising. (See LL/CL 2012 APR, ChangeAgent Business Plan 2013, and ChangeAgent Profile 2015). As evidenced by the SHARPP LL/CL APRs, financial reporting and KILs, all of the above-mentioned key activities have been implemented to varying degrees. The development of a business plan in 2012-2013 was based on the need to assess the viability of a business wing, set up efficient operations and develop a roadmap toward sustainable profitability. ChangeAgent was established in 2011 with full salary support from USAID/Namibia to provide professional training and counselling services (with an emphasis on emotional wellness) to the Namibian private and public sectors as well as to other national and international NGOs. In its early phase, ChangeAgent had a staff of ten. USAID salary support has been phased out as of 2013, and ChangeAgent is now self-supporting with a greatly reduced staff of four: a manager, a curriculum specialist and two full-time trainers with a pool of consultant associate trainers. The business wing now has a wide range of clients for wellness programs, training and curricula development, ranging from the MoHSS, MoE and MGECW to UNICEF, Catholic AIDS Action and Project Hope, as well as to private sector clients such as MTC, First National Bank and Gondwana. In FY2014, ChangeAgent reported having secured eleven new clients.

Quantitative Target Achievement: While it is not within the scope of the evaluation to present a financial analysis of the performance of ChangeAgent, it is important to note two benchmarks. First, when a comparison is made of the ChangeAgent business plan's projected net earnings versus actual net earnings for FY12 through FY14, actual net earnings were significantly above projections. Second, when a comparison of the funds awarded by USAID to ChangeAgent from FY12 through FY14 is made with estimated net earnings, it appears that as much as 50 percent of the USAID investment has already been recovered (data available on request). This is

⁴³ Following departure of the full-time program area manager, the care and support portfolio was assigned to the HTC program manager, who was only available part time to work on this and subsequently departed for a six-month maternity leave three months after the full-time program area manager resigned. In the interim, responsibility was assigned to the very competent but overburdened national program manager.

quite remarkable given that, under current donor restrictions on much of LL/CL's activities, there is a limit on recovery rates to be below a profit margin. Based on KII's, when these restrictions are lifted in FY16, it is anticipated that the level of cost recovery will increase.

Other Quantitative Findings: Efforts toward donor diversification have been successful, with several funding proposals awarded since 2011 (seven awards in FY2013 and three in in FY2014). As shown below in Table 7, a set of indicators were developed to present progress of the business wing in the FY13 APR. These indicators are no longer supplied as part of annual reporting, but provide useful evidence of the efforts made to document performance.

Table 7. Key ChangeAgent Performance Indicators April-Sept 2013

Indicator	Result
Revenue	N\$1,663,876
Gross profit	N\$853,095
Number of training hours sold	2,603 (against a target of 2,489)
Average facilitation fee per hour	N\$344 (against a target of N\$425)
Tenders applied for	N\$1,859,647
Tenders won	N\$1,510,408
Win ratio	81%
Pipeline (contracted)	N\$972,410
Pipeline (unconfirmed)	N\$66,778

Training: Based on the attached training data in Annex 5, relative to the other SHARPP programs, the business wing training has been very extensive. ChangeAgent has conducted more than 150 trainings with 3,092 trainees for the equivalent of two entire years of training days. The majority (about ¾) of this training is for the public sector, with the remainder in the private sector.

Qualitative Findings: The qualitative findings are based on a small sample of recent clients of ChangeAgent, experts in organizational sustainability and senior stakeholders at ChangeAgent. Respondents confirmed that the formal business plan had been developed with clearly stated objectives and projected net revenues. LL/CL has made very intensive efforts to seek new grants with a high success rate, and very extensive training programs have been implemented for the GRN and other entities.

Based on client interviews, ChangeAgent trainings have generated a highly positive response for meeting the training objectives. In some cases, however, the quality of training was offset by client perceptions that they needed more comprehensive reporting and feedback from ChangeAgent on how the training was conducted and how it was received by trainees. A majority of clients interviewed felt strongly that ChangeAgent had inadequate marketing to maintain high visibility in the private sector wellness sector as well as among NGOs. There was concern that, if it was seriously interested in expanding its private client market share, it did not have an adequate internet and social media presence and should do more outreach using these methods. Within LL/CL, concerns were raised about the tensions caused by introducing a for-profit wing within a traditional non-profit agency. This tension was due in part to changing of personnel contracts toward variable consulting arrangements from the more traditional method of salary remuneration.

Sustainability: While most respondents had serious reservations about ChangeAgent's ability to recover enough costs to significantly subsidize LL/CL, it was acknowledged that there is potential to improve sustainability and financial viability through the above-mentioned five approaches. Some respondents felt there has already been progress with cost recovery, despite

being constrained by donor restrictions on profit, and that there was potential for improvement in the future.

Evaluation Question 4. Is there evidence that SHARPP increased long-term financial viability and sustainability through improved program capacity and resource mobilization?

Overview: As shown by the above findings for Program Area 6, the major activities (especially the development of a business wing to provide training services and the diversification of its funding base) have improved LL/CL's program capacity and resource mobilization toward increased long-term financial viability and sustainability.

Quantitative Findings: The pace of ChangeAgent's net revenue generation has exceeded the business plan's projections. Despite current constraints on the level of profit generated from donor-funded activities, much of the initial USAID/Namibia investment in ChangeAgent has already been recovered. LL/CL has succeeded in diversifying its funding base through a concerted effort to attract new donors as well as clients paying for training and wellness services, with more than 150 trainings conducted through ChangeAgent. ChangeAgent has downsized its staffing from ten to four in order to be more efficient.

Qualitative Findings: Respondents acknowledged that ChangeAgent has succeeded in generating increased revenues, but most respondents had serious reservations about the ability of ChangeAgent to recover enough costs to significantly subsidize LL/CL. It was acknowledged that there is potential to improve sustainability and financial viability when donor restrictions on profit levels are lifted. Based on private sector and NGO client interviews, ChangeAgent trainings have generated a highly positive response for the quality of trainings and for meeting the training objectives. Concerns were raised that ChangeAgent needs to market its services more effectively, both to the private sector and among NGOs. ChangeAgent has invested in internal trainings to enhance its full-time senior training staff competencies in its core areas of expertise, especially counseling services, to remain competitive. Staff turnover for short-term consultant training staff is a challenge that requires ongoing capacity building to ensure quality.

Evaluation Question 5. How do other stakeholders and clients perceive the quality of program interventions and capacity building activities by LL/CL?

Overview: As supported by the findings for the above six program areas, a large majority of stakeholders and clients perceive LL/CL program interventions and capacity-building activities to be of good or very good quality. The most notable exceptions to this pattern were concerns raised about the quality assurance (QA) practices at some NewStart centers, QA issues during HTC outreach sessions, and the quality of SBCC sessions in one region. The following are detailed examples for each of the six program areas.

Program Area I (HTC Programs): Overall, the SHARPP LL/CL HTC services were rated as good or very good by most respondents. During KIIs, many respondents felt the HTC services (both the actual adherence to the MoHSS HTC testing protocols and counseling) were of excellent quality. They pointed out that, with few exceptions, this is substantiated by the NIP QA reports.⁴⁴ The ratings of high quality were based in part on perceptions that SHARPP LL/CL NewStart centers, compared to MoHSS services, provide greater confidentiality and higher quality of counseling, with shorter waiting times. Respondents stressed that the NewStart

⁴⁴ Due to the Easter Holiday season, a scheduled interview with the national NIP office had to be cancelled, and the evaluation team did not get access to the actual LL/CL NIP test results, but senior respondents from both national and regional levels were able to share their impressions based on their first-hand knowledge of the NIP test results for specific LL/CL NewStart centers.

centers were truly adolescent-friendly, due in part to high-quality counseling that MoHSS services could not rival. Overall, ratings for SHARPP LL/CL HTC capacity-building activities were quite positive, especially for couples counseling.

Despite the overall positive ratings, there were important exceptions raised by senior and line-staff MoHSS respondent as to the quality of the HTC services at NewStart centers. The main concerns (expressed emphatically by multiple respondents) were related to the lack of nursing staff, which is required to adhere to basic NIP QA testing.⁴⁵ There were also, to a lesser degree, concerns about the large numbers of clients served during outreach campaigns and whether or not adequate time was allotted per client, whether data collection procedures were sufficiently accurate and whether sufficient safeguards were in place for client privacy.⁴⁶ Finally, specific QA problems (related to record keeping and discrepancies in test results) were noted with one of the NewStart centers that were attributed to lack of sufficient supportive supervision and regular monthly sit-ins. Important concerns were also raised about the challenge of providing adequate follow-up for learners who test positive during school HTC outreach sessions.

Program Area 2 (SBCC): QA is not done consistently across all regions; some mid-level managers have reported that because of their heavy workload they have not been able to conduct QA activities as required, and this affects the quality of the program. One respondent rated the program as neutral simply because of the feeling that the CBFs need to be trained further and that they are not able to relate to school children well in terms of transferring information (the respondent felt that they were not able to connect with the students and did not make the material interesting enough through up-to-date teaching methods).

Program Area 3 (Family Strengthening): The quality of LL/CL family-strengthening work, especially in counseling, is rated very high by most stakeholders and beneficiaries: “They always solve cases, they always do follow-ups, they keep social workers on their toes.” However, one respondent felt that counselors need to be trained more in family counseling; they “need to learn more techniques on how to do effective counselling; they cannot do family therapy.”

Program Area 4 (GCF): The overall impression was that GCF has highly competent, quality trainers in Windhoek but did not build sufficient capacity within the regional offices. Respondents voiced strong support for the quality of GCF GBV activities and were open to further collaboration.

Program Area 5 (PLHIV): There are insufficient data to comment on the quality of the program or the capacity-building activities, except to point out that much of the work to implement these care and support activities is being done by the same staff that are rated highly for their activities in counselling and HTC.

Program Area 6 (Organizational Sustainability): Quality of training is perceived to be extremely high, as is capacity building. The key limitations cited were staff turnover (which requires constant rehiring and retraining with careful screening), the perceived need for better reporting and lack of marketing. There were also concerns that, while ChangeAgent adhered to the letter of their contracts, it was not providing any follow-up and mentoring to the trainees. This was cited as a limitation in a fee-for-training model, as training does not assure capacity is built without follow-up and monitoring.

⁴⁵ Namibian national guidelines require that 1 in 20 clients need blood draws for independent assessment for QA. Nursing staff are required to draw blood, and LL/CL NewStart centers currently do not have nurses on staff. This has required stop-gap, part-time arrangements with non-LL/CL sites that do have nurses for blood draws as needed. This can cause gaps in QA testing and delays for clients who are asked to wait while the part-time nurse is called.

⁴⁶ This was corroborated by some of the evaluation team’s direct observations of HTC outreach sessions as well as the results from HTC exit interviews presented above for Program Area 1.

Evaluation Question 6. How was gender mainstreamed in SHARPP's activities?

Overview: As shown in the findings for the above six program areas, by virtue of the fact that LL/CL has a long-held commitment to gender sensitization for all of its staff that preceded the SHARPP program, gender has been mainstreamed into SHARPP activities in a consistent manner through a variety of trainings, curricula and management policies that address gender and GBV. The following are specific examples for each of the six program areas.

Program Area 1 (HTC Services): Several respondents outlined strong examples of how the SHARPP program has mainstreamed gender into its HTC programming; e.g., concerted efforts have made to increase access for couples and men. LL/CL staff are clearly aware of gender issues in counseling. The program is felt to have assets in detecting GBV among HTC clients as part of staff training on GBV and transgender issues, and they do referrals accordingly.⁴⁷

Program Area 2 (SBCC): Most respondents feel that gender issues are mainstreamed within the SBCC program, especially gender roles and norms as well as GBV, which are part of the curriculum.⁴⁸ Some respondents expressed concerns about harmful gender practices still being practiced, especially in rural areas. One respondent cited how one facilitator turned out to be a good gender activist and established his own group of young men that deals with gender issues.

Program Area 3 (Family Strengthening): The beneficiaries of positive parenting confirmed that gender issues were included in the program: "Participants opened up on these issues and both men and women were able to discuss the linkages of gender roles and GBV and were also informed of where to go for help." A respondent mentioned, "There has been gender mainstreaming even before SHARPP."

Program Area 4 (GCF): Based on the KIIs, it appears that the SHARPP GCF-supported activities have bolstered LL/CL expertise in gender and GBV. LL/CL has been described as a "go-to" agency for gender training, GBV and male engagement expertise. Based on KIIs and a review of the LL/CL documents, it is abundantly clear that gender has been an integral part of the sub-granting content and training. KIIs with sub-grantees confirmed that their projects maintained a focus on sensitization regarding harmful gender norms and accessing services related to GBV.

Program Area 5 (PLHIV): It is clear that substantial efforts have been made to reach out to men for HTC services, and men make up a significant portion of HIV-positive clients. In addition, although the numbers are small, the pilot work with adolescents living with HIV has a good gender balance. As noted above, the innovative LL/CL care and support assessment tool for newly tested HIV-positive clients includes a section to flag and monitor GBV, which is consistent with gender mainstreaming.

Program Area 6 (Organizational Sustainability): LL/CL's expertise in gender and GBV clearly has been an asset for ChangeAgent, which has succeeded in getting substantial contracts for gender training. Private-sector clients in wellness programming appreciated ChangeAgent's gender expertise. Respondents stressed that LL/CL and its business wing have a special competence in culturally adapting curricula and staffing, which includes gender awareness and sensitivity training. ChangeAgent, as well as LL/CL, are recognized as a well-established and strong resource for gender trainings.

⁴⁷ As part of its initiative to improve the referral process, LL/CL included screening for GBV among recently tested HIV-positive clients. See Section E of the LL/CL care and support assessment tool for newly tested HIV-positive clients.

⁴⁸ There was an important exception to this overall finding. During a FGD with recent participants who had completed all seven sessions of the SHARPP SBCC program, despite repeated probing, none of the FGD respondents recalled any discussion of GBV during their sessions.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Program Area I. Increasing access to and uptake of HTC services for at-risk, socially and geographically harder-to-reach clients

Quality Assurance: Based on the findings above, it is clear that LL/CL has not devoted enough senior staff time to conducting the expected site visits to NewStart centers at three-month intervals. This is due in part to a lack of sufficient expert HTC staff at the national level to share the burden of this essential management function.

Staffing: Lack of essential staff was observed, especially qualified nurses and counselor-testers, with associated gaps in services and QA (closure of sites during outreach, inability to do one in 20 blood tests, etc.). Lack of staffing, especially a nurse, at the NewStart centers threatens the quality and efficiency of HTC services.

Site Management and Policies: There are instances of inadequate management to ensure proper maintenance, sufficient funds for consumables and adequate preparation and stand-in arrangements for prolonged senior staff absences. This includes burdensome local LL/CL NewStart policies in some regions that do not allow clients to have their HTC results to be written into their health passports.⁴⁹

Outreach: Based on both quantitative and qualitative results, outreach has been highly successful in reaching large numbers of clients, often in remote areas, but there are some quality implications associated with this success. A range of concerns have been raised about time allotted per client, client data recording methods, client privacy and follow-up of HIV-positive clients, especially for learners who test positive during outreach sessions in schools.

Referrals: The SHARPP LL/CL HTC program has developed a bi-directional referral system with a new emphasis on adherence counseling, which is being effectively monitored by the M&E system. The bi-directional referral system and the associated M&E data system, despite ongoing difficulties in record keeping and follow-up, is an important achievement. It offers potential for guiding management decisions for prioritizing HTC efforts by region.

Steps toward Future Integration: There is commitment and potential for the NewStart centers to augment their HTC program with additional services for income generation. Currently all HTC services are provided at no cost, and there is little likelihood of being able to charge for this service since HTC is offered for free at MoHSS sites. Augmenting HTC with reproductive health services for fees may be a viable option. The current labor market offers high salaries for nursing staff. Given the acute financial difficulty in supporting a full-time nurse for HTC services, it is essential to expand services that can be provided by nurses at NewStart centers in hopes of income generation.

⁴⁹ Respondents reported that as a result of this policy, clients have to be retested at the MoHSS ARV clinics before they are started on ARV treatment.

Evaluation Question 1. To what extent and in what ways has LL/CL increased access to HCT services for general populations?

General Populations: Compared to MoHSS service delivery sites, the SHARPP NewStart centers have reached a higher than average proportion of male clients, youth and couples. A sustained increase in HTC services has been accomplished by a focus on expanding outreach programs in communities and within schools, combined with an emphasis on high-quality counseling services for men and couples and youth-friendly services for adolescents.

Key Populations: LL/CL has a comparative advantage in providing HTC for key populations, and there is an opportunity for LL/CL to expand services for them. Staff at NewStart sites have been trained in serving key populations and are willing to serve them, but there has been no strategic effort to increase access for this group, in part because it was not viewed as part of the SHARPP mandate. There is potential to utilize most if not all of the NewStart centers (both walk-in and outreach) to increase access to HTC services for key populations.

Program Area 2. Greater involvement of male and female youth and communities in practicing social behavior change for HIV prevention and gender-related norms

Relevance of the Program to the Beneficiaries: Most beneficiaries appreciate the program and would like it to be rolled out to more beneficiaries.

Staffing: Facilitators that are not adequately trained and are not diligently screened have a serious implication on the quality of program delivery. Refresher training is required for facilitators so that they receive information that is up-to-date and relevant.

Quality Assurance: If QA activities are not consistently carried out, the quality of the program is likely to be negatively affected.

Referrals: A strong focus on combination prevention has a great potential for an effective referral system between the various programs and could yield great benefits.

Implementation Coverage: Implementation of the program is not adequately covering hard-to-reach areas, especially the rural areas where information is needed most.

Evaluation Question 2. Has SHARPP increased the involvement of male and female youth in practicing and promoting social behavior change for HIV prevention and gender-related norms? Why or why not?

Lack of pre- and post-SBCC Intervention Data to Measure Change: The lack of quantitative data pre- and post-SBCC intervention is an important gap in the overall design of the SHARPP M&E system. In the absence of definitive quantitative data, despite favorable qualitative findings, there is insufficient information to conclude that the SHARPP program has increased the involvement of male and female youth in practicing and promoting SBC for HIV prevention and gender-related norms.

Program Area 3. Strengthened capacity of families and communities to enable delivery of quality interventions that provide protective and other social services to children in Khomas, Hardap, Kavango, Ohangwena and Oshana regions

Program Relevance: Family strengthening and child protection are crucial to addressing protection issues in holistic manner. Therefore all components of this program are relevant and there is a call for scaling up, especially on the positive parenting component.

Staffing: LL/CL staff is highly praised for the quality of their work, especially in counselling and positive parenting training, and they are encouraged to have a bigger pool of trained positive parenting experts to benefit more caregivers.

Quality Assurance: Uitani Radio is a good platform to encourage child participation and builds the capacity of children. With regards to safe schools, even though LL/CL has done good work in creating a platform for safe schools, and plans of action are developed, there is a feeling that LL/CL does not have adequate personnel to follow up on the implementation of these plans.

Referrals and Follow-ups: The LL/CL referral system is highly praised for follow-ups, especially within the counselling program (although it is noted that follow-ups are not always easy, especially in rural areas), and they are also applauded for developing a referral flow chart.

Implementation Modality and Coverage: The national phone helplines are covering the whole country; however, counselling services are not offered in all the languages. This language barrier could limit certain individuals from receiving services. There is a need for a consistent and clear volunteer policy.

National Support: LL/CL has contributed greatly to national policies, especially the child care and protection bill, as well participation in national platforms. LL/CL is acknowledged for its national contributions to child protection; as stated by one respondent, “It is an organization that Namibia can be proud of.”

Partnership: Collaboration with government and other agencies is crucial to effective implementation and sustainability. The parenting network has gained momentum, and collaboration with MoHSS can ensure roll-out to more parents.

Evaluation Question 3. In what ways has LL/CL increased capacity through technical assistance to families and communities in delivery of quality community-based interventions?

LL/CL has a well-established record for increasing capacity for family strengthening and child protection through technical assistance for families and communities in delivery of quality community-based interventions. Mid-level managers need additional support to ensure adequate supportive supervision. The development of denominator estimates for target populations is needed to better inform allocation of LL/CL programming by regions.

Program Area 4. Meeting the objectives of the Gender Challenge Fund in Hardap and Kavango

Regional Variation in SHARPP GCF Activity: Significant regional differences were observed between Hardap and Kavango in the management and implementation of GBV programs, both overall and for GCF sub-grants in particular. This is attributed in part to gaps in adequate local staff and insufficient oversight by Windhoek-based staff.

Collaboration with GRN: The SHARPP GCF program has helped LL/CL to develop close collaborative ties with the MGECW through LL/CL contributions to National Plan of Action on GBV, as well as national GBV events.

SHARPP GCF GBV Capacity: Despite a perceived lack of depth at the regional level, the SHARPP GCF program has contributed to the overall development of LL/CL gender and GBV capabilities, especially at the national level, where LL/CL is seen as an important resource on gender issues.

Sub-grant Management: The Windhoek-based GCF team deserves credit for managing the entire GCF request for applications with only one day of training, and for developing its own

procedures from scratch. Despite hiring a part-time manager, however, the GCF sub-grants process was flawed, with cumbersome financial procedures and inadequate oversight.

Potential Follow-on GCF Activities: Despite problems with the sub-grant process, some of the programs in the two regions appear to hold potential for useful follow-up activity where awareness has been raised and stakeholders have expressed interest in taking actions to improve access to GBV-related services.

Program Area 5. Meeting the emotional health and GBV prevention and mitigation needs of PLHIV in order to promote access to and retention in care and treatment

Staffing: The program as suffered from a lack of full-time staffing and a failure to formally designate regional staff with responsibility to implement the program. This has significantly reduced the coverage and effectiveness of the program.

Quality Assurance: According to KIs and narrative reports, in the absence of a full-time program area manager, currently the responsibility for regional oversight has been informally delegated to regional managers without regular national oversight. With only one set of initial trainings, there is a need for additional refresher training for facilitators and counselling staff for adherence counselling and to implement the care and support follow-up activities.

Referrals: The development of new tools and M&E systems to ensure follow-up and support for retention and adherence are major accomplishments but need more work to be validated and routinized uniformly in all regions. These systems offer LL/CL a valuable new management tool to document its progress toward ensuring all HIV-positive clients are reaching their referral points within one month of testing positive.

Implementation Coverage: All three of the proposed key activities (rolling out body mapping for community support groups, providing psychological support to adolescents living with HIV, and providing therapeutic counselling) have been implemented, but the first two have only been implemented at very modest levels.⁵⁰ For example, at most, only a small portion (100, or 9 percent) of the 1,107 SHARPP LL/CL newly tested positive clients in FY14 have participated in body mapping, and less than 30 adolescents living with HIV have benefited from youth-oriented workshops.

Program Area 6. Organizational Sustainability: Increased sustainability of LL/CL through improved programming capacity and resource mobilization

Staff Turnover: Staff turnover within the ChangeAgent training pool is a chronic challenge that requires intensive training to ensure adequate competence to provide high-quality services.

Additional Client Needs: While clients acknowledge that ChangeAgent has fulfilled its contractual obligations for trainings, some clients would prefer better or more detailed reporting, while others would prefer more follow-up and mentoring for trainees.

Market Visibility: ChangeAgent is still not well known to the private sector, Namibian NGOs or multilateral agencies and lacks visibility in social media.

Organizational Transition: The introduction of the ChangeAgent business arm within LL/CL has not been without organizational stress and has human resource implications.

⁵⁰ Therapeutic counselling is already part of the HTC services infrastructure with high levels of coverage during post-test counseling.

Evaluation Question 4. Is there evidence that SHARPP increased long-term financial viability and sustainability through improved program capacity and resource mobilization?

As seen in the SHARPP LL/CL APRs, financial reporting and KIs, the major activities toward sustainability (especially development of a business wing to provide training services and diversification of funding base) have been implemented with substantial effectiveness. The pace of ChangeAgent's net revenue generation has exceeded the business plan's projections. Despite current constraints on the level of profit generated from donor-funded activities, much of the initial USAID/Namibia investment in ChangeAgent has already been recovered.

Evaluation Question 5. How do other stakeholders and clients perceive the quality of program interventions and capacity-building activities by LL/CL?

With very few exceptions, LL/CL program interventions and capacity-building activities are perceived to be evidence-based, informed by global and regional best practices and in-depth expertise, especially in counseling services. Some exceptions to the high ratings for quality were concerns raised about the QA practices at some NewStart centers, QA during HTC outreach sessions and the quality of SBCC sessions in one region.⁵¹

Evaluation Question 6. How was gender mainstreamed in SHARPP's activities?

Based on KIs and SSIs of respondents from both public and private sectors, LL/CL is recognized throughout Namibia as a well-established and strong resource for gender trainings and curriculum development, including GBV and male engagement expertise.

RECOMMENDATIONS

Program Area I. Increasing access to and uptake of HTC services for at-risk, socially and geographically harder-to-reach clients

Quality Assurance: Strengthen and deepen the SHARPP LL/CL HTC QA cadre to ensure regular site visits at three-month intervals. This will require either designating or hiring one additional senior HTC staff member to be accountable for QA for both fixed-site and outreach services. Refresher training should be provided for HTC staff on HIV and ARVs.

Staffing: While it is acknowledged that nurses are costly, it is essential that all NewStart centers have a full-time nurse. This can only be envisioned as part of the strategic proposal for the sustainability of stand-alone NewStart centers in Namibia (LL/CL et al. 2014). It is also essential to increase HTC staff at all sites to permit aggressive outreach without closing the NewStart centers.

Site Management and Policies: Provide in-depth management training for site managers to ensure optimal site maintenance and to ensure personnel management and budgeting are implemented at high standards.

Outreach: Work with the MoHSS and NIP to ensure that a complete review of outreach procedures is done to ensure that all activities are consistent with national HTC service delivery standards (in particular, to review issues of minimum time per client, precautions to ensure accurate record keeping, and privacy). Work with implementing partners (MoHSS and MoE) to develop enhanced strategies for effective follow-up and after-care for outreach clients who test positive, especially learners during school-based outreach campaigns.

⁵¹ For purposes of respecting management confidentiality, the specific region is not mentioned explicitly; LL/CL is aware of the specific region concerned.

Referrals: The HTC program should invest additional staff and financial resources in both supportive supervision and M&E to sustain and enhance the bi-directional referral system and its associated M&E data system.

Steps toward Future Integration: HTC program staff and senior counterpart agencies should update the strategic proposal for sustainability of the remaining NewStart centers (LL/CL et al. 2014). USAID/Namibia should advocate for the implementation of this updated strategic proposal with GRN support toward the transition to integrated services, if feasible with Medical Aid, for sexual and reproductive health for couples and youth.

Evaluation Question 1. To what extent and in what ways has LL/CL increased access to HCT services for general populations?

Continue the focus on expanding outreach programs in communities and schools, combined with an emphasis on high-quality counseling services for men and couples and youth-friendly services for adolescents. Build on the existing capacity and willingness of LL/CL NewStart centers to develop a new strategic approach to collaboration with SFH and other agencies, such as Walvis Bay Corridor, to reach key populations. This would include both moonlight sessions at fixed sites as well as outreach sessions to mutually agreed-upon locations that accommodate key population preferences.

Program Area 2. Greater involvement of male and female youth and communities in practicing social behavior change for HIV prevention and gender-related norms

Relevance of the Program: The program is very relevant and should be continued.

Staffing: Explore improvement of incentives for facilitators to ensure retention and also to ensure that quality screening is done.

Quality Assurance: Ensure that QA activities are carried out consistently. Include more refresher training with up-to-date information, and in-depth training for CBFs to improve knowledge, facilitation skills and professionalism. Revise the SBCC manual periodically to ensure that it contains up-to-date and relevant information.

Referrals: Consolidate experience with referrals to enhance the process, paying attention to tracking follow-up. Referrals from SBCC to other service points should be encouraged and continued.

Implementation Coverage: Increase the focus on hard-to-reach rural populations and increase stakeholder involvement.

Evaluation Question 2. Has SHARPP increased the involvement of male and female youth in practicing and promoting social behavior change for HIV prevention and gender-related norms? Why or why not?

Lack of pre- and post-SBCC Intervention Data to Measure Change: The lack of quantitative data from before and after SBCC interventions is an important gap in the overall SHARPP M&E system. The system should collect and analyze measures of knowledge, attitudes and behaviors of participants before and after completing the SBCC sessions. Ideally, data should be collected at three time intervals: immediately before the SBCC sessions, immediately after and at least six months following completion (to assess retention of information, trends in attitudes and reported behaviors).

Program Area 3. Strengthened capacity of families and communities to enable delivery of quality interventions that provide protective and other social services to children in Khomas, Hardap, Kavango, Ohangwena and Oshana regions

Program Relevance: Family strengthening and child protection initiatives are relevant to addressing child protection issues and should be continued. The interventions should be revised periodically to ensure that they remain relevant to the current situation.

Staffing: LL/CL should establish clear and consistent CBF payment policies, provide greater acknowledgement and incentives for CBFs and improve human resources policy.

Quality Assurance: The program needs more staff to provide supportive supervision.

Referrals: LL/CL should explore innovative approaches to ensuring referrals, especially in hard-to-reach rural areas.

Implementation Modality and Coverage: Continue with positive parenting initiatives and find innovative ways to expand coverage for positive parenting.

Partnership: Continue to strengthen and forge partnerships and collaboration, especially with government and other critical NGO partners, for leveraging of resources, especially for hotlines and positive parenting.

Evaluation Question 3. In what ways has LL/CL increased capacity through technical assistance of families and communities in delivery of quality community-based interventions?

LL/CL should continue to focus on counselling as its core area, but it should provide more support for mid-level managers and consider reducing the number of initiatives it currently implements. Regional estimates of target populations should be developed as denominators to measure program coverage.

Program Area 4: Meeting the objectives of the Gender Challenge Fund in Hardap and Kavango

Regional Variation SHARPP GCF Activity: In addition to providing gender and GBV training to bolster staff capacity in both regions, the GCF should immediately identify and appoint a competent replacement for the gender coordinator in Hardap.

Collaboration with GRN: The SHARPP GCF should build on its constructive engagement with the GRN, especially the MGECW, to serve both as a technical resource and a catalyst for action on important GBV program initiatives.

Sub-grant Management: While the GCF staff gained much useful experience through the GCF in sub-granting, additional capacity building is needed for LL/CL management and finance staff before LL/CL embarks on any future sub-granting activities.

Potential Follow-on GCF Activities: LL/CL and USAID/Namibia should seriously consider an extension of GCF activities to permit follow-up with the more promising sub-grantee agencies to consolidate and extend the initiatives begun with GCF sub-grants in both regions.

Program Area 5. Meeting the emotional health and GBV prevention and mitigation needs of PLHIV in order to promote access to and retention in care and treatment

Staffing: A full-time care and support manager should be hired and regional staff formally delegated responsibility for program implementation, with adjustment in their responsibilities to ensure they have adequate time to implement the program.

Quality Assurance: Formally assign responsibility for regular supportive supervision and provide ongoing capacity building for adherence counselling and implementation of care and support follow-up.

Referrals: Invest in validating and improving M&E systems to ensure accurate data are available on indicators for follow-up and support for retention and adherence. This should include developing accurate routine reporting on follow-up phone data to monitor the proportion of newly HIV-positive clients that are on treatment within one month of testing positive.

Implementation Coverage: Develop a more ambitious but realistic strategy to increase coverage for the core care and support activities.

Program Area 6. Organizational Sustainability: Increased sustainability of LL/CL through improved programming capacity and resource mobilization

Staff Turnover: ChangeAgent needs to find ways to reduce staff turnover through financial or other types of incentives.

Additional Client Needs: ChangeAgent should develop strategies to respond to private sector and NGO client needs for more in-depth reporting and follow-up for mentoring trainees.

Market Visibility: ChangeAgent needs aggressive marketing for corporate wellness programs for NGO training services, using social media and other appropriate methodologies.

Organizational Transition: LL/CL and its business wing ChangeAgent should consider obtaining external experts to provide organizational development support to address ongoing stress associated with the transition from an NGO to a mixed-model agency with a business wing. This should include development of more transparent human resources policies for both ChangeAgent and LL/CL.

Evaluation Question 4. Is there evidence of SHARPP increased long-term financial viability and sustainability through improved program capacity and resource mobilization?

LL/CL should continue to invest in the expansion of its business arm.

Evaluation Question 5. How do other stakeholders and clients perceive the quality of program interventions and capacity building activities by LifeLine/Childline?

As noted above for certain program areas, improvements are needed to maintain quality assurance by modifying staffing patterns to ensure more supportive supervision at regular intervals and greater support for mid-level managers to allow more time for field supervision.

Evaluation Question 6. How was gender mainstreamed in SHARPP's activities?

LL/CL should continue to invest in maintaining its comparative advantage in Namibia as a resource on gender issues as part of its core focus area of high-quality counseling services.

ANNEX I. SCOPE OF WORK

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067
EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
March 10, 2015

TITLE: Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP) Project in Namibia (067)

Requester / Client

USAID/Washington
Office/Division: /

USAID Country or Regional Mission
Mission/Division: Namibia / HIV & Health Office

Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

- | | |
|--|---|
| <input checked="" type="checkbox"/> 3.1.1 HIV | <input type="checkbox"/> 3.1.6 MCH |
| <input type="checkbox"/> 3.1.2 TB | <input type="checkbox"/> 3.1.7 FP/RH |
| <input type="checkbox"/> 3.1.3 Malaria | <input type="checkbox"/> 3.1.8 WSSH |
| <input type="checkbox"/> 3.1.4 PIOET | <input type="checkbox"/> 3.1.9 Nutrition |
| <input type="checkbox"/> 3.1.5 Other public health threats | <input type="checkbox"/> 3.2.0 Other (specify): |

Cost Estimate: Note: *GH Pro will provide a final budget based on this SOW.*

Performance Period

Expected Start Date (on or about): March 16, 2015
Anticipated End Date (on or about): July 17, 2015

Location(s) of Assignment: (Indicate where work will be performed)

Namibia – in Kavango, Khomas, Oshana and Ohangwena regions

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

Performance Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact

evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)

Midterm Endline Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

BACKGROUND

Background of project/program/intervention:

SHARPP is a 4-year cooperative agreement funded by USAID Namibia, which started on July 1, 2011. As indicated in the project title, the goal of SHARPP is to strengthen HIV/AIDS responses in prevention and protection.

Describe the theory of change of the project/program/intervention.

The SHARPP program focused on creating an enabling environment, HIV mitigation and prevention in Namibia through its high-impact evidence based programs. The concept of the SHARPP program is that through its interventions it creates a safe environment for the Namibian population to access high quality HIV services, including HIV testing and counseling, OVC programs and psychosocial counseling focused on HIV-positive patients and victims of gender-based violence.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

- Program Area/Result 1: Increasing access to and uptake of HIV counselling and testing (HCT) services for at-risk, socially and geographically harder-to-reach clients
 - Select indicators
 - Number of individuals who received testing and counseling (T&C) services for HIV and received their test results
 - Percentage of HIV-positive clients who have been referred for HIV services and completed the referrals
- Program Area/Result 2: Greater involvement of male and female youth and communities in practicing social behavior change for HIV prevention and gender-related norms.
 - o Select indicators
 - Male norms and behaviors: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS
 - Gender-based violence and coercion: Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS
- Program Area / Result 3: Strengthened capacity of families and communities to enable delivery of quality interventions that provide protective and other social services to children in Khomas, Hardap, Kavango, Ohangwena and Oshana regions
 - o Select indicators
 - Number of eligible adults and children provided with a minimum of one care service
 - Number of eligible adults and children provided with protection and legal aid services
 - Number of eligible adults and children provided with psychological, social or spiritual support
- Program Area/Result 4: Meeting the objectives of the gender challenge fund in Kavango and Hardap region
 - o Select indicators
 - # of individuals reached with harmful gender norms messages
 - # of individuals reached with GBV preventative messages
 - # of support groups formed and supported

- Gender-based violence and coercion: Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS

Program Area / Result 5: Meeting the emotional health and GBV prevention and mitigation needs of PLHIV in order to promote access to and retention in care and treatment

•Select Indicators:

- Number of PLHIV reached with a package of PLHIV (PwP) interventions that meet the minimum standards required

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

The project covers a few regions in Namibia, namely, Khomas, Kavango, Ohangwena and Oshana regions.

SCOPE OF WORK

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

USAID Namibia seeks a mid-term, performance evaluation of its project, “Strengthening HIV/AIDS Responses in Prevention and Protection” (SHARPP). The main purposes of this evaluation are to assess the performance of activity implementers (LL/CL and USAID), to determine whether intended results are likely to be achieved and to inform the design of potential future activities or modification of the current project.

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID Namibia, Government of the Republic of Namibia (GRN) and other key stakeholders

C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

These findings will be used to support the Government of Namibia in programming and investing in high-impact HIV prevention and mitigation programs based on evidence generated on the efficacy of the LL/CL SHARPP program. In addition, findings will be used to support USAID Namibia in future program design for HIV prevention and mitigation programming.

D. **Evaluation questions:** Evaluation questions should be: (a) aligned with the evaluation purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.); they must be incorporated into the evaluation questions. **USAID policy suggests 3 to 5 evaluation questions.**

Evaluation Questions	
1.	To what extent and in what ways has LifeLine/Childline increased access to HCT services for key populations?
2.	Has SHARPP increased the involvement of male and female youth in practicing and promoting social behavior change for HIV prevention and gender related norms? Why or why not?
3.	In what ways has LifeLine/Childline increased capacity through technical assistance of families and communities in delivery or quality community-based interventions
4.	Is there evidence of SHARPP increased long-term financial viability and sustainability through improved program capacity and resource mobilization
5.	How do other stakeholders and clients perceive the quality of program interventions and capacity building activities by LifeLine/Childline?

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation.)

6. How was gender mainstreamed in SHARPP's activities?
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- E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

Document Review (list of documents recommended for review)

SHARPP Annual Progress Reports SHARPP Quarterly reports Program Registers SHARPP Performance Management Plans, including performance indicator data and results C&T Policy Child Protection Documents Namibia DHS Namibia HIV/MCH SPA
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Secondary analysis of existing data (list the data source and recommended analyses)

Data Source (existing dataset)	Description of data	Recommended analysis

Key Informant Interviews (list categories of key informants, and purpose of inquiry)

<ul style="list-style-type: none"> • Ministry of Health – C&T quality standards adherence • Ministry of Gender and Child Welfare – OVC and protection policies; regulatory framework and needs; and gender issues • LifeLine/Childline – SHARPP project implementer • CSO staff – participant of SHARPP activities
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Focus Group Discussions (list categories of groups, and purpose of inquiry)

Focus group discussions held among older youth (non-minors) to explore: (1) youth as promoters of BCC; (2) behavior change among youth; and (3) gender norms transformation. [**Note:** minors cannot be primary respondents in FGDs, KIIs or surveys.]

Group Interviews (*list categories of groups, and purpose of inquiry*)

Client/Participant Satisfaction or Exit Interviews (*list who is to be interviewed, and purpose of inquiry*)

- Exit interviews with voluntary beneficiaries of C&T
- Client satisfaction survey with caregivers of OVC who received support through SHARPP
- Participant survey with older youth through Youth Clubs/Groups involved with SHARPP [**Note:** minors cannot be primary respondents in FGDs, KIIs or surveys.]

Facility or Service Assessment/Survey (*list type of facility or service of interest, and purpose of inquiry*)

Verbal Autopsy (*list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population*)

Survey (*describe content of the survey and target responders, and purpose of inquiry*)

Observations (*list types of sites or activities to be observed, and purpose of inquiry*)

Data Abstraction (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

Case Study (*describe the case, and issue of interest to be explored*)

Rapid Appraisal Methods (ethnographic / participatory) (*list and describe methods, target participants, and purpose of inquiry*)

Other (*list and describe other methods recommended for this evaluation, and purpose of inquiry*)

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

Yes No

List or describe case and counterfactual.

Case	Counterfactual

ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to SHARPP’s achievements in relation to the project’s objectives and targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age and location. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate. In the report, the evaluators will describe the statistical tests used.

Thematic reviews of qualitative data will be performed. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project performance indicator data and DHS) will allow the team to triangulate findings to produce more robust evaluation results.

ACTIVITIES

List the expected activities, such as team planning meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and deliverables may overlap. Give as much detail as possible.

Background reading and document review – Several documents are available for review for this evaluation. These include SHARPP’s annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data. There are also national surveys that provide useful information, including the Namibia’s DHS and HIV/MCH SPA surveys. This desk review will provide background information for the evaluation team, and will also be used as data input and evidence for the evaluation.

Team planning meeting (TPM) in Namibia – A three-day team planning meeting (TPM) will be held in Namibia before the evaluation begins. The TPM will:

- Review and clarify any questions on the evaluation SOW;
- Clarify team members’ roles and responsibilities;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Review and finalize evaluation questions;
- Review and finalize the assignment timeline and share with other units;
- Develop data collection methods, instruments, tools and guidelines;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a data collection plan;
- Draft the evaluation work plan for USAID’s approval;

- Develop a preliminary draft outline of the team’s report; and
- Assign drafting/writing responsibilities for the final report.

Briefing and Debriefing Meetings – Throughout the evaluation the team leader will provide briefings to USAID. The in-briefing and debriefing are likely to include the all evaluation team experts, but will be determined in consultation with the mission. These briefings are:

- Evaluation **launch**, a call among the USAID/Namibia, GH Pro and the team leader to initiate the evaluation activity and review expectations. The mission will review the purpose, expectations and agenda of the assignment. GH Pro will introduce the team leader and review the travel schedule and other management issues.
- **In-briefing with USAID/Namibia**, as part of the TPM. This briefing will include the evaluation team, USAID/Namibia Health Office and M&E team representatives. This briefing may be broken into two meetings: (a) at the beginning of the TPM, so the evaluation team and USAID can discuss expectations and intended plans; and (b) at the end of the TPM when the evaluation team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-briefing will be the format and content of the evaluation report(s). The time and place for this in-briefing will be determined between the team leader and USAID/Namibia prior to the TPM.
- **In-briefing with GRN and SHARPP**. USAID/Namibia will assist the evaluation team to set up meetings with GRN and SHARPP staff to inform them about the evaluation. These two in-briefings are likely to be scheduled immediately following the TPM, but the timing should be discussed and finalized with USAID/Namibia.
- The team leader will brief the mission **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing and by email.
- A **final debriefing** will be held approximately three days before departure, between USAID/Namibia and the evaluation team. During this meeting, a summary of the data will be presented, along with high-level findings and draft recommendations. For the debriefing, the evaluation team will prepare a **PowerPoint Presentation** of the key findings, issues and recommendations. The evaluation team shall incorporate comments received from USAID during the debriefing into the evaluation report. *(Note: preliminary findings are not final, and as more data sources are developed and analyzed these finding may change.)*
- **Stakeholders’ debrief/workshop** will be held following the final debrief with the mission, and will include SHARPP staff and GRN. The mission will discuss with the evaluation team who should participate and will assist with the invitations and logistics as needed.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID/Namibia. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable/Product	Timelines and Deadlines (approx.)
<input checked="" type="checkbox"/> Launch briefing	March 16, 2015
<input checked="" type="checkbox"/> Work plan with timeline	March 30, 2015
<input checked="" type="checkbox"/> Analytic protocol with data collection tools	March 30, 2015
<input checked="" type="checkbox"/> In-briefing with mission or organizing business unit	March 23-27, 2015
<input checked="" type="checkbox"/> In-briefing with target project/program	March 31, 2015
<input checked="" type="checkbox"/> Routine briefings	weekly
<input checked="" type="checkbox"/> Field work (data collection)	April 6-24, 2015
<input checked="" type="checkbox"/> Out-briefing with mission or organizing business unit with PowerPoint presentation	May 5, 2015
<input checked="" type="checkbox"/> Stakeholders debriefing workshop	May 7, 2015
<input checked="" type="checkbox"/> Draft report	May 27, 2015
<input checked="" type="checkbox"/> Final report	June 17, 2015
<input type="checkbox"/> Raw data	
<input type="checkbox"/> Dissemination activity	
<input type="checkbox"/> Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 business days

TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with relevant methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities

Experience implementing program evaluations including: U.S. Government and USAID project evaluations, public health program evaluations, counselling and testing, child protection, monitoring and evaluation; research.

Overall, the evaluation team should have skills in: HIV, family planning (FP), SBCC, social marketing, organizational development (OD), and evaluation.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, or for the individual team members.

Key Staff 1 Title: Team leader (International) (*Note: This person should have strong technical skills that may duplicate other key staff positions; therefore, the team leader will be recruited to fill both roles.*)

Roles and Responsibilities: The team leader will be responsible for (1) managing the team's activities, (2) ensuring that all deliverables are met in a timely manner, including the final report, (3) serving as a liaison between the mission and the evaluation team and (4) leading briefings and presentations. The team leader will facilitate the TPM and ensure evaluation methods are designed to elicit data and information needed to address the evaluation questions. S/He will oversee the development of all data collection instruments, data collection, data, analysis and report writing.

Qualifications: Master's Degree in public health or related degree; eight years in public health and working in a PEPFAR environment in Africa; demonstrated professional experience in program evaluation and technical oversight over HIV/AIDS programs in Africa or a similar environment.

Key Staff 2 Title: Evaluation specialist

Roles and Responsibilities: Serve as a member of the evaluation team, providing quality assurance in the field on issues related to evaluation protocols, standards and implementation, including methods, development of data collection instruments, protocols for data collection, data management, data analysis and data reporting.

Qualifications:

- At least five years of experience in evaluation and/or research, and in USAID M&E procedures
- Strong knowledge, skills and experience in qualitative and quantitative evaluation tools
- Experience in design and implementation of evaluations
- Experience developing effective data collection tools
- Experience training data collectors to ensure highest quality of validity and reliability, and adherence to protocols
- Experience analyzing quantitative and qualitative data
- Experience developing data visualization, such as charts, graphs, tables

Key Staff 3 Title: HIV specialist

Roles and Responsibilities: Serve as a member of the evaluation team, and provide technical expertise on quality HIV services, including HTC, OVC programs, counseling for HIV-positive patients and victims of GBV.

Qualifications:

- Minimum of 10 years of experience in public health, with technical knowledge and experience of HIV, including HTC, OVC, services for PLHIV, and GBV
- Knowledge and experience with PEPFAR policies and guidance
- Experience conducting project evaluations

Number of consultants with this expertise needed: 1

Other Staff Titles, with Roles and Responsibilities (include number of individuals needed):

Research Assistant/Logistics (local) will be hired to assist with qualitative and quantitative data collection, data entry, data analyses and transcription of qualitative data. This person will also assist the team with arrangements for transportation, lodging, venues (as needed), setting appointments and other assistance as needed.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

- Yes – If yes, specify who: **Robert Festus**
 No

Staffing Level of Effort (LOE) Matrix (Optional):

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- Immediately below each staff title enter the anticipated number of people for each titled position.
- Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of effort in **days** for each evaluation/analytic team member

Activity / Deliverable		Evaluation/Analytic Team		
		Team Leader/HIV Specialist	Evaluation Specialist	Research Assistant/Logistics
Number of persons →		1	1	1
1	Launch briefing	.5		
2	Desk review and data synthesis	5	5	5
3	Preparation for team convening in-country			
4	Travel to country	2		
5	Team planning meeting	3	3	3
6	In-brief with mission	1	1	1
7	Training data collectors	2	2	2
8	Preparation and logistics for site visits			1.5
9	Data collection and site visits	18	18	18
10	Data analysis	4	4	4
11	Debriefing with mission including preparation	2	2	2
12	Stakeholder debriefing workshop with preparation	2	2	2
13	Depart country	2		
14	Draft report(s)	8	6	5
15	GH Pro report QC review and formatting			
16	Submission of draft report(s) to mission			
17	USAID report review			
18	Revise report(s) per USAID comments	4	2	.5
19	Finalization and submission of report(s)			
20	508 compliance review			
21	Upload evaluation report(s) to the DEC			
Total LOE		53.5	45	44

If overseas, is a 6-day workweek permitted Yes No

Travel anticipated: List international and local travel anticipated by which team members.

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LOGISTICS

Note: Most evaluation or analytic teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

- USAID Facility Access
Specify who will require Facility Access:
- Electronic County Clearance (ECC) (international travelers only)
- GH Pro workspace
Specify who will require workspace at GH Pro:
- Travel other than posting (specify):
- Other (specify):

GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production: If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities
<p>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</p> <p>Before Field Work</p> <ul style="list-style-type: none">• <u>SOW</u>.<ul style="list-style-type: none">○ Develop SOW.○ Peer Review SOW○ Respond to queries about the SOW and/or the assignment at large.

- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team, as needed, in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

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

ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See *How-To Note: Preparing Evaluation Reports*)

The analytic report should be developed in a final word document and given to USAID/Namibia by the date set in the SOW. The report should include the following sections: executive summary; introduction and background; evaluation project and audience; project background; evaluation design and methods; evaluation questions; methods, respondents and limitations of the assessment; findings including sub-sections for general findings and question specific findings; recommendations; issues; future directions; and annexes (including data review, tools used, etc.)

USAID CONTACTS

	Primary Contact	Alternate Contact
Name:	Robert Festus	Matthew Rosenthal
Title:	SI Program Specialist	SI Advisor
USAID Office/Mission	USAID/Namibia	USAID/Namibia
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Cell Phone (optional)		

List other contacts [OPTIONAL]

Abeje Zegeye – Activity Manager for LifeLine/Childline

REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

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ANNEX II. PROGRAM AREA TABLES

1. Number of individuals who received testing and counseling services for HIV and received their test results⁵²

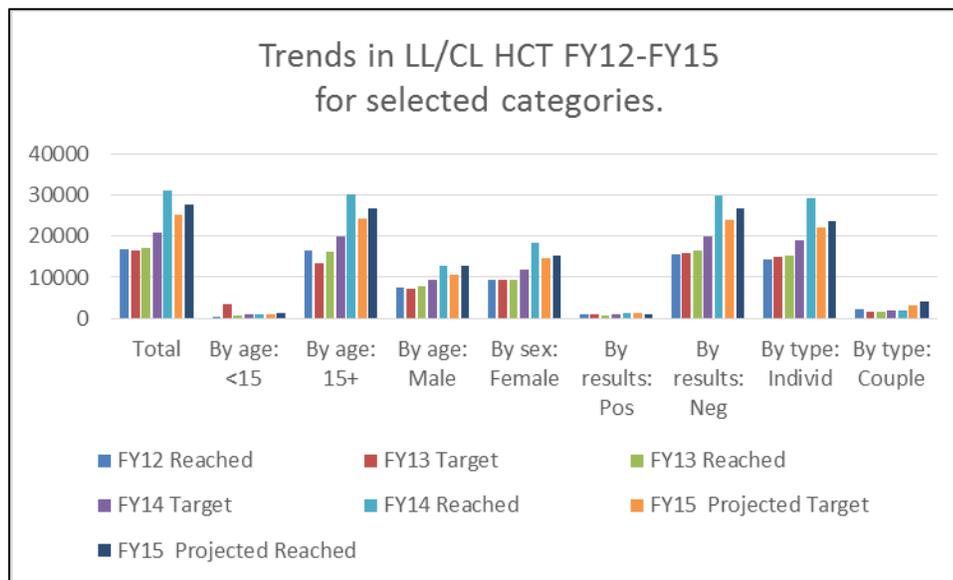


2. Individuals who received testing and counseling services for HIV and received their test results, continued: Percentage of target reached and target percentage versus actual percentage for key indicators

Percent of Numeric Target Reached		Comparison of Percentage Targets with Actual Percentage Results for Key Client Attributes		
By age: <15	45.8%	Attribute	Target	Actual
By age: 15+	134.9%	% < 15	10.1%	3.7%
By age: Male	123.7%	% Male	43.7%	42.9%
By sex: Female	127.7%	% Positive	5.0%	3.5%
By results: Positive	88.2%	% Couple	9.4%	8.3%
By results: Negative	127.9%			
By type: Individual	127.4%			
By type: Couple	111.4%			
Total	125.9%			

⁵² All data provided by LL/CL M&E Department from the most current SHARPP database for the time period of FY12 through FY15Q1, a period of 3 years and 3 months.

3. Number of individuals who received testing and counseling services for HIV and received their test results, continued: Trends in LL/CL HCT from FY2012-FY2015⁵³

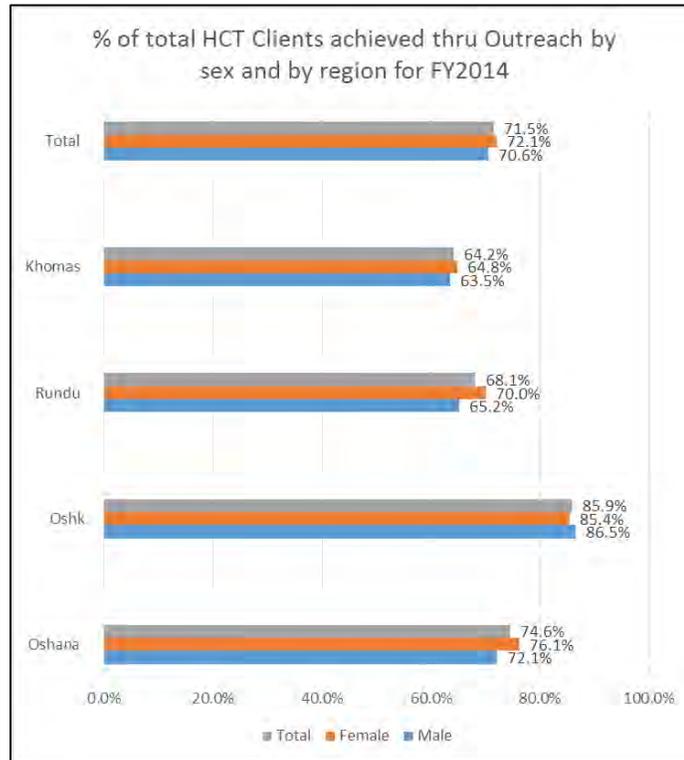


Trends in LL/CL HCT by Key indicators from FY12 through FY15*							
	FY12	FY13	FY13	FY14	FY14	FY15	FY15
	Reached	Target	Reached	Target	Reached	Target	Reached
Total	16,712	16,600	17,072	20,950	31,191	25,280	27,912
By age: <15	261	3,320	682	840	1,042	1,008	1,192
By age: 15+	16,451	13,280	16,390	20,110	30,149	24,272	26,720
By age: Male	7,350	7,304	7,696	9,220	12,854	10,616	12,660
By sex: Female	9,362	9,296	9,376	11,730	18,337	14,664	15,252
By results: Positive	971	830	576	1,048	1,107	1,264	1,012
By results: Negative	15,741	15,770	16,496	19,902	30,084	24,016	26,900
By type: Individual	14,411	15,106	15,414	19,064	29,273	22,248	23,784
By type: Couple	2,301	1,494	1,658	1,886	1,918	3,032	4,128

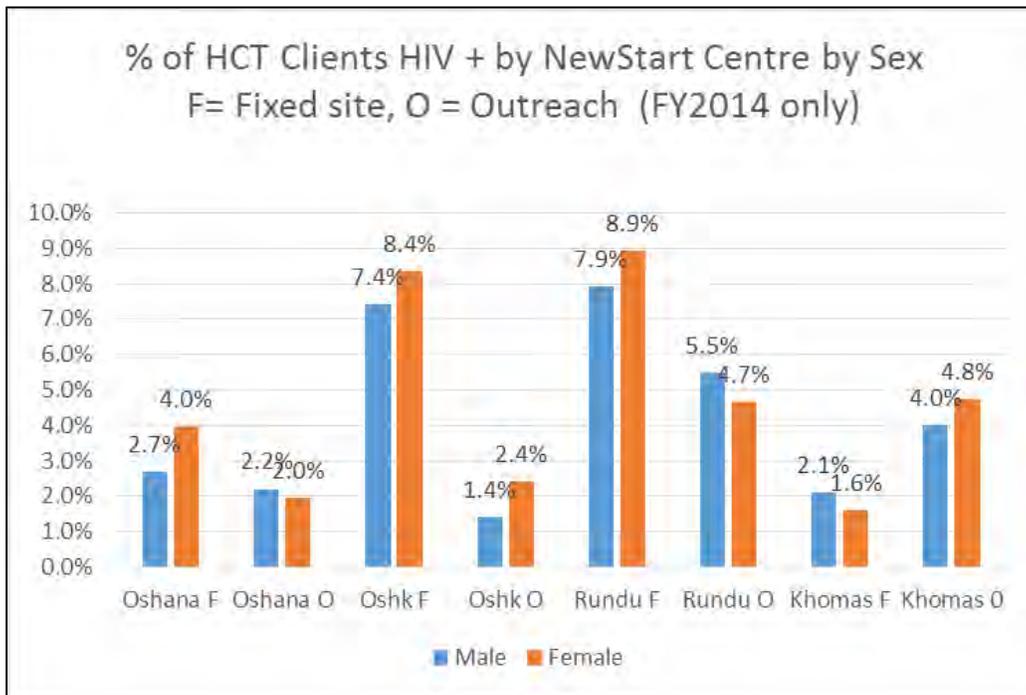
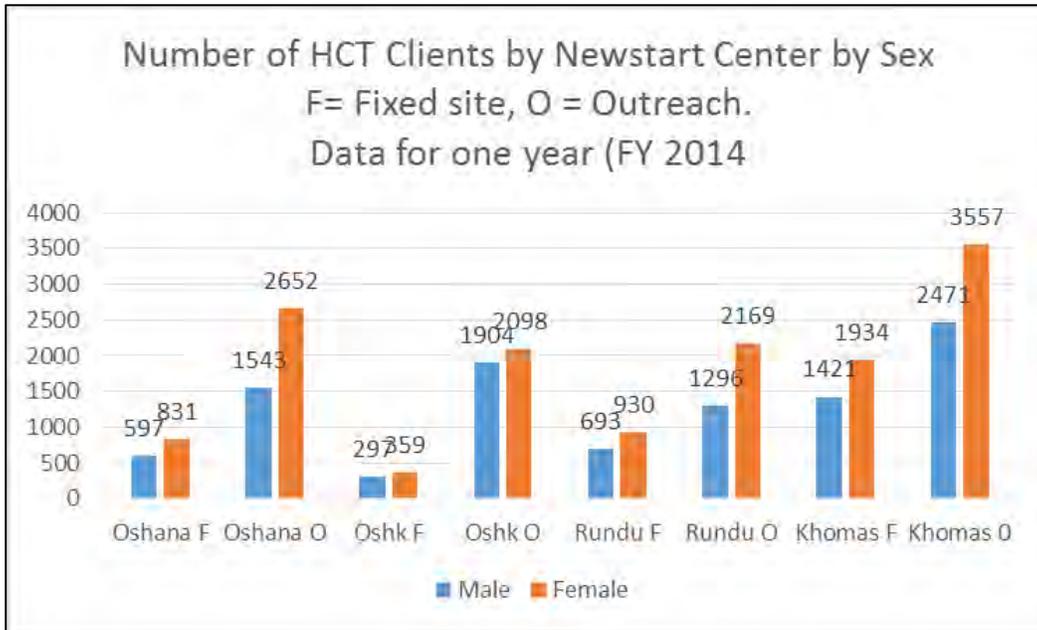
***FY15 projected on basis of FYQ1 target and number reached.**

⁵³ NB: The FY15 data are projected on the basis of just the data from FY15 Q1 on the assumption that the achievements for Q1 continue at the same level for Q2 through Q4.

4. Percent of total individuals who received testing and counseling services for HIV and received their test results achieved through outreach in FY2014

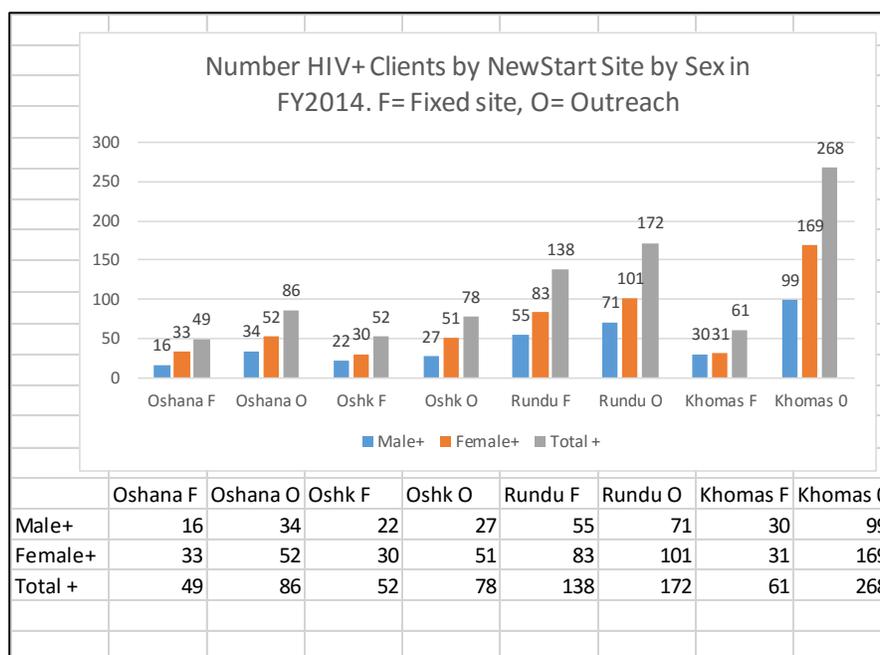


5. Number of individuals who received testing and counseling services for HIV and received their test results, continued: Figure and data showing number of tests and percent positive by NewStart location



Number Tested	Oshana F	Oshana O	Oshk F	Oshk O	Rundu F	Rundu O	Khomas F	Khomas O
Male	597	1543	297	1904	693	1296	1421	2471
Female	831	2652	359	2098	930	2169	1934	3557

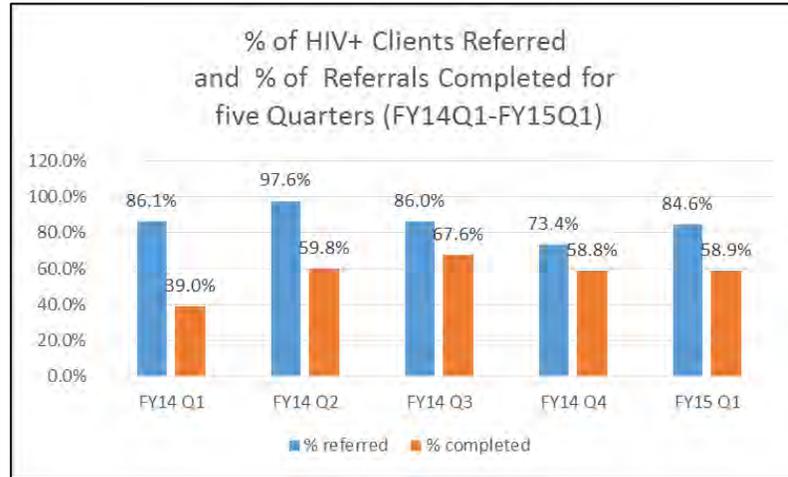
6. Number of individuals who test positive for HIV and received their test results, continued: Figure and data showing number of positive tests by sex by NewStart location



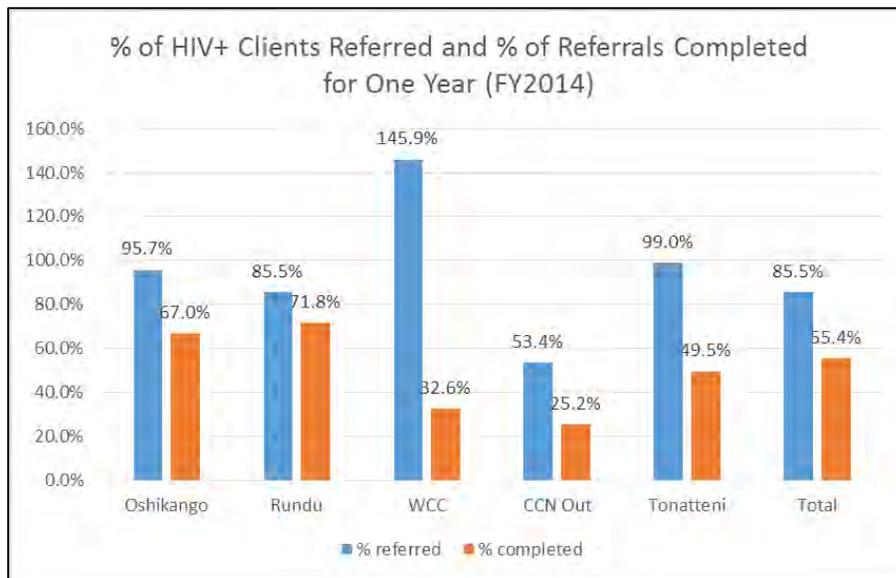
7. Number of individuals who received testing and counseling services for HIV and received their test results, continued: Figure and data showing yields by NewStart location in LL/CL HCT

Percent Positive HIV Test by Facility and Outreach						Period: October 2013 - September 2014 (FY2014)					
Tonateni New start Centre			Oshikango New start			Rundu New Start			CCN Outreach and WCC (combined)		
Oshana			Ohangwena			Kavango			Khomas		
Total	New Clients Only		Total	New Clients Only		Total	New Clients Only		Total	New Clients Only	
2140	3483	5623	2201	2457	4658	1989	3099	5088	3892	5491	9383
Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
2.3%	2.4%	2.4%	2.2%	3.3%	2.8%	6.3%	5.9%	6.1%	3.3%	3.6%	3.5%
Facility	New Clients Only		Facility	New Clients Only		Facility	New Clients Only		Facility	New Clients Only	
597	831	1428	297	359	656	693	930	1623	1421	1934	3355
Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
2.7%	4.0%	3.4%	7.4%	8.4%	7.9%	7.9%	8.9%	8.5%	2.1%	1.6%	1.8%
Outreach	New Clients Only		Outreach	New Clients Only		Outreach	New Clients Only		Outreach	New Clients Only	
1543	2652	4195	1904	2098	4002	1296	2169	3465	2471	3557	6028
Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
2.2%	2.0%	2.1%	1.4%	2.4%	1.9%	5.5%	4.7%	5.0%	4.0%	4.8%	4.4%

8. Percent of HIV-positive clients who have been referred for HIV services and completed the referrals (percent of HIV-positive clients who have been referred to other services, and the percent of referred clients who completed the referral (reaching the referral point))



9. Percent of HIV-positive clients who have been referred for HIV services and completed the referrals by NewStart Sites:⁵⁴ (percent of HIV-positive clients who have been referred to other services, and the percent of referred HIV-positive clients who completed the referral (reaching the referral point))



⁵⁴ These data are for just FY2014 and include the data for the LL/CL-supported CCN outreach based at the CCN Katatura location. Despite being an outreach site, the CCN outreach data show significant referrals are being made and being completed.

ANNEX III. DATA COLLECTION TOOLS

Key Informant Interview (KII) Questionnaire

Introduction: Thank you for meeting with us today. Our names are [Sam Clark, Ndeu Amulungu and Nelao Haimbodi.] We are evaluation consultants conducting an end-of-project evaluation of the USAID-funded program called “Strengthening HIV/AIDS Responses in Prevention and Protection.” It is also called the “SHARPP” program. The SHARPP program in Namibia has been implemented since 2011 by LifeLine/Childline (LL/CL) in collaboration with the Ministry of Health and Social Services, Ministry of Gender Equality and Child Welfare and other agencies. This SHARPP program consists of six program areas. In this interview we would like to ask you questions about the program area you are most familiar with. The six program areas are:

- 1) HIV testing and counseling
- 2) Sexual risk reduction for HIV prevention (HVOP) [other sexual prevention]
- 3) Family strengthening and child protection (HKID) [orphans and vulnerable children]
- 4) Gender Challenge Fund grant activities on GBV prevention in Hardap and Kavango
- 5) Care and support for PLHIV to promote access to and retention in care and treatment (HBHC) [Adult care and support]
- 6) Organizational sustainability

Goals and objectives of the evaluation: It is now almost four years since SHARP program began in July 2011. The main purposes of this evaluation are:

- 1) to assess the performance of (LL/CL and other implementers contracted by LL/CL
- 2) to determine whether intended results are likely to be achieved
- 3) to inform the design of potential future activities

Our questions are based on five main criteria: how programs are implemented, how effective they are, how sustainable they are, what are some key lessons learned and what are the key recommendations.

The evaluation findings will be used to support the Government of Namibia in HIV programming and inform USAID Namibia in future program design.

Informed Consent: This interview is confidential and voluntary. Your name will not be linked to any of the findings. If you are willing to be quoted, this is appreciated. But no information will be associated with your name unless cleared with you in advance. There will be no risks or direct benefits to you as a result of your participation in this interview. You can end the interview at any time and have no obligation to answer any questions asked. However we appreciate your collaboration in this important exercise.

Are you willing to be interviewed on this basis? **Circle One:** Yes No

1. a. Unique Identification Number: (Two column var): ___/ ___/
1. **Date of interview:** __Day__Month__Year
2. **Name of interviewer**_____
3. **Name of person(s) taking notes:** _____
4. **Location of interview:**_____
5. **Name of respondent:** _____
6. **Position/job title and organization of respondent: Title:** _____
Organization: _____
7. **Question for Interviewer: Position with respect to policy:** Does the respondent work at a senior enough level where he/she has an understanding of national donor policy issues? **Circle one:** Yes No
8. **Number of years respondent has worked in this position:** _____years
9. **Which of the following above mentioned six SHARP program areas are you familiar with?**

9.1 **Are you familiar with all six? Yes or No. Circle one.** If yes, ask respondent which of the six they would prefer to discuss? Circle respondent's preference below in 9.2. Only ask questions on this one program area.

9.2 If you are not familiar with all of them, which ones can you answer questions about? In particular, please indicate the program area you are best able to discuss. **Circle respondent preference below.**

1) HIV Testing and Counseling. Yes, can answer questions. No, not familiar enough. Circle one
2) Sexual Prevention (HVOP), Greater Involvement of vulnerable adolescents, youth and adults in practicing social behavior change for HIV prevention and gender-related norms. Yes or No. Circle one.
3) Family strengthening and child protection Yes or No. Circle one.
4) Meeting the objectives of the Gender Challenge Fund in Hardap and Kavango Yes or No. Circle one.
5) Meeting the emotional health and GBV prevention/mitigation needs of PLHIV in order to promote access to and retention in care and treatment Yes or No. Circle one.
6) Organizational Sustainability Yes or No. Circle one.

NB: If respondent says they cannot answer questions about any of the program areas, thank them for their participation and end the interview.

Instruction to interviewer: When we ask questions about the program area, if the respondent feels the questions are too general or are at a policy level they are not comfortable with, this is not a problem. Simply skip to the next question.

Section 10. Program Area I: HIV Testing and Counseling

Evaluation Questions	
6.	<p>Based on your knowledge, can you briefly describe how has the SHARPP LL/CL HCT program been implemented?</p> <p>In your opinion, how effective has the SHARPP LL/CL HCT program been?</p> <p>To what extent and in what ways has LL/CL increased access to HCT services for key populations? Probe: What are the remaining gaps in providing HCT services to key populations?</p>
7.	<p>In what ways has SHARPP LL/CL increased capacity for HCT services? Probe: If respondent wants clarification, provide examples, such as HCT capacity building for its services at NewStart Centers, but also capacity for other stakeholders, such as HCT training for MOHSS counseling staff.</p>
8.	<p>Is there evidence that SHARPP LL/CL increased long-term financial viability and sustainability of HCT services? Probe: If not clear, explain that “long-term financial viability and sustainability” refers to achievement of a firm financial footing for HCT services so they can function without independent external donor support in the years to come. Probe: What would it take to increase long-term financial viability and sustainability of HCT?</p>
9.	<p>In your opinion, how do you perceive the quality of SHARPP LL/CL HCT program interventions in (a) counseling and testing and (b) capacity-building activities?</p> <p>a) How would you rate LL/CL in this program area? Circle one: Very poor Poor Neutral Good Very Good</p> <p>b) How would you rate LL/CL capacity-building activities in this program area? Circle one: Very poor Poor Neutral Good Very Good</p>
0.	<p>In your opinion, would you say gender was mainstreamed into the SHARPP LL/CL HCT activities? If so, how?</p> <p>Probe if needed: Would you say SHARPP reaches out and engages men and women in the same way in their HCT activities? Can you provide examples of how they do this, or when it differs for men and women?</p> <p>If needed, provide definition: Gender mainstreaming is the process of creating knowledge and responsibility for the problems caused by inequality between men and women among all health professionals (Definition adapted from WHO).</p>
1.	<p>What would you say are some key lessons learned from SHARPP HCT activities?</p> <p>Probe: Please comment on the key challenges and problems as well as achievements.</p>
2.	<p>What recommendations do you have for SHARPP HCT activities for future programming?</p>

Section II. Program Area 2: Sexual Risk Reduction for HIV Prevention (HVOP), Greater Involvement of vulnerable adolescents, youth and adults in practicing social behavior change for HIV prevention and gender-related norms

Evaluation Questions	
	<p>Based on your knowledge, can you briefly describe how the SHARPP LL/CL sexual risk reduction program for HIV prevention has been implemented?</p> <p>In your opinion, how effective has the SHARPP LL/CL Sexual Risk Reduction Program for HIV Prevention been?</p>
2.	<p>Has this SHARPP LL/CL program increased the involvement of male and female youth in practicing and promoting social behavior change for HIV prevention and gender-related norms? Why or why not?</p> <p>Probe: Is there a difference in male and female involvement? If so, describe the difference.</p>
3.	<p>In what ways has this SHARPP LL/CL program increased capacity for sexual risk reduction for HIV prevention? Probe: If respondent wants clarification, provide examples, such as capacity building for institutions, or counseling staff or youth workers.</p>
4.	<p>Is there evidence that this SHARPP LL/CL program increased long-term financial viability and sustainability for programs for sexual risk reduction for HIV prevention?</p> <p>Probe: If not clear, explain that “long-term financial viability and sustainability” refers to achievement of a firm financial footing for these programs so they can function without independent external donor support in the years to come.</p> <p>Probe: What would it take to increase long-term financial viability and sustainability of these types of programs?</p>
5.	<p>In your opinion, how do you perceive the quality of LL/CL’s program for sexual risk reduction for HIV prevention? Probe: Please comment on (a) actual programs and (b) capacity-building activities.</p> <p>a) How would you rate LL/CL in this program area? Circle one: Very poor Poor Neutral Good Very Good</p> <p>b) How would you rate LL/CL capacity building activities in this program area? Circle one: Very poor Poor Neutral Good Very Good</p>
6.	<p>In your opinion, would you say gender was mainstreamed into the LL/CL program for sexual risk reduction for HIV prevention? If so, how? Probe if needed: Would you say SHARPP reaches out and engages men and women in the same way in these risk reduction activities? Can you provide examples of how they do this, or when it differs for men and women?</p> <p>If needed, provide definition: Gender mainstreaming is the process of creating knowledge and responsibility for the problems caused by inequality between men and women among all health professionals (Definition adapted from WHO).</p>
7.	<p>What would you say are some key lessons learned from this SHARPP LL/CL’s program for sexual risk reduction for HIV preventions? Probe: Please comment on the key challenges and problems as well as achievements.</p>
8.	<p>What recommendations do you have for the SHARPP LL/CL program for sexual risk reduction for HIV prevention?</p>

Section 12. Program Area 3: Family strengthening and child protection (HKID)

Evaluation Questions	
	<p>Based on your knowledge, can you briefly describe how LL/CL's family strengthening and child protection program been implemented?</p> <p>In your opinion, how effective has the LL/CL family strengthening and child protection program been?</p>
	<p>In what ways has LL / CL increased capacity for family strengthening and child protection programs? Probe: If respondent wants clarification, provide examples.</p>
	<p>Is there evidence that SHARPP increased long-term financial viability and sustainability for family strengthening and child protection programs? Probe: If not clear, explain that "long-term financial viability and sustainability" refers to achievement of a firm financial footing for these programs so they can function without independent external donor support in the years to come. Probe: What would it take to increase long-term financial viability and sustainability of these types of programs?</p>
	<p>In your opinion, how do you perceive the quality of LL/CL family strengthening and child protection programs? Probe to cover quality of (a) actual programs and (b) related capacity building.</p> <p>a) How would you rate LL/CL in this program area? Circle one: Very poor Poor Neutral Good Very Good</p> <p>b) How would you rate LL/CL capacity-building activities in this program area? Circle one: Very poor Poor Neutral Good Very Good</p>
	<p>In your opinion, would you say gender was mainstreamed into the LL/CL family strengthening and child protection program activities? If so, how? Probe if needed: Would you say SHARPP reaches out and engages men and women in the same way in these activities? Can you provide examples of how they do this, or when it differs for men and women?</p> <p>If needed, provide definition: Gender mainstreaming is the process of creating knowledge and responsibility for the problems caused by inequality between men and women among all health professionals (Definition adapted from WHO).</p>
	<p>What would you say are some key lessons learned from LL/CL family strengthening and child protection program activities? Probe: Please comment on the key challenges and problems as well as achievements.</p>
	<p>What recommendations do you have for LL/CL family strengthening and child protection program activities?</p>

Section 13. Program Area 4: Meeting the objectives of the Gender Challenge Fund grant activities for GBV prevention in Hardap and Kavango

Evaluation Questions	
1	<p>Based on your knowledge, how can you briefly describe how LL/CL's Gender Challenge Fund activities to reduce GBV been implemented in Hardap and Kavango?</p> <p>In your opinion, how effective have LL/CL's Gender Challenge Fund GBV prevention activities been in Hardap and Kavango?</p>
2	<p>In what ways has LifeLine/Childline increased capacity for gender and gender-based violence prevention activities through the Gender Challenge Fund in Hardap and Kavango? Probe: If respondent wants clarification, provide examples.</p>
3	<p>Is there evidence that SHARPP LL/CL increased long-term financial viability and sustainability for gender and gender-based violence prevention activities in Hardap and Kavango through the Gender Challenge Fund? Probe: If not clear, explain that "long-term financial viability and sustainability" refers to achievement of a firm financial footing for these programs so they can function without independent external donor support in the years to come. Probe: What would it take to increase long-term financial viability and sustainability of these types of programs?</p>
4	<p>In your opinion, how do you perceive the quality of LL/CL's activities to reduce GBV with the Gender Challenge Fund in Hardap and Kavango? Probe: comment on both (a) the program and (b) capacity building.</p> <p>a) How would you rate LL/CL in this program area? Circle one: Very poor Poor Neutral Good Very Good</p> <p>b) How would you rate LL/CL capacity-building activities in this program area? Circle one: Very poor Poor Neutral Good Very Good</p>
5	<p>In your opinion, was gender mainstreamed into the LL/CL Gender Challenge Fund activities for GBV prevention in Hardap and Kavango? If so, how?</p> <p>Probe if needed: Would you say SHARPP reaches out and engages men and women in the same way in these activities? Can you provide examples of how they do this, or when it differs for men and women?</p> <p>If needed, provide definition: Gender mainstreaming is the process of creating knowledge and responsibility for the problems caused by inequality between men and women among all health professionals (Definition adapted from WHO).</p> <p>Alternate Probe: Have women and men been equally engaged? Do they have similar roles on the project and throughout the activities? How are men's and women's roles the same or different throughout the Gender Challenge Fund activities in Hardap and Kavango?</p>
6	<p>What would you say are some key lessons learned from SHARPP LL/CL activities to meet the objectives of the Gender Challenge Fund for GBV prevention in Hardap and Kavango? Probe: Please comment on the key challenges and problems as well as achievements.</p>
7	<p>What recommendations do you have for SHARPP LL/CL Gender Challenge Fund activities in Hardap and Kavango?</p>

Section 14. Program Area 5: Care and Support for PLHIV in order to promote access to and retention in care and treatment

Evaluation Questions	
	<p>Based on your knowledge, can you briefly describe how LL/CL's care and support program for PLHIV been implemented?</p> <p>In your opinion, how effective has the LL/CL HCT emotional health and GBV prevention program for PLHIV been (especially in promoting access to and retention in care and treatment)?</p>
	<p>In what ways has LL/CC increased capacity for care and support for PLHIV in order to promote access to and retention in care and treatment? Probe: If respondent wants clarification, provide examples. For example, tracking referrals or body mapping.</p>
3.	<p>Is there evidence that SHARPP increased long-term financial viability and sustainability for its care and support program for PLHIV? Probe: If not clear, explain that "long-term financial viability and sustainability" refers to achievement of a firm financial footing for these programs so they can function without independent external donor support in the years to come. Probe: What would it take to increase long-term financial viability and sustainability of these types of programs?</p>
	<p>In your opinion, how do you perceive the quality of LL/CL's care and support program for PLHIV? Probe: Please comment on both (a) the program and (b) capacity building.</p> <p>a)How would you rate LL/CL in this program area? Circle one: Very poor Poor Neutral Good Very Good</p> <p>b)How would you rate LL/CL capacity-building activities in this program area? Circle one: Very poor Poor Neutral Good Very Good</p>
	<p>In your opinion, was gender mainstreamed into the LL/CL care and support program for PLHIV? If so, how? If needed, provide definition: Gender mainstreaming is the process of creating knowledge and responsibility for the problems caused by inequality between men and women among all health professionals (Definition adapted from WHO).</p> <p>Probe: Have women and men been equally engaged? Do they have similar roles on the project and throughout the activities? How are men's and women's roles the same or different?</p>
	<p>What would you say are some key lessons learned from LL/CL care and support program for PLHIV? Probe: Please comment on both the key challenges and problems as well as achievements.</p>
	<p>What recommendations do you have for LL/CL's care and support programs for PLHIV?</p>

Section 15. Program Area 6: Organizational Sustainability

Evaluation Questions	
1.	<p>Based on your knowledge, can you briefly describe SHARPP LL/CL's efforts to implement organizational sustainability? Probe: Make sure that it is clear that this refers to LL/CL's efforts to increase its own sustainability.</p> <p>In your opinion, how effective has the SHARPP LL/CL organizational sustainability effort been?</p>
2.	<p>Is there evidence that SHARPP LL/CL efforts for organizational sustainability have increased its long-term financial viability and sustainability through improved program capacity and resource mobilization? Probe: If respondent wants clarification, provide examples. Probe: If not clear, explain that "long-term financial viability and sustainability" refers to achievement of a firm financial footing for these programs so they can function without independent external donor support in the years to come. Probe: What would it take to increase long-term financial viability and sustainability of these types of programs?</p>
3.	<p>In your opinion, how do you perceive the quality of SHARPP LL/CL efforts for organizational sustainability?</p> <p>Probe: This refers to the quality of LL/CL efforts to increase its own organizational sustainability. It can refer to quality of its service delivery, but only as part of its attempts to increase its sustainability.</p> <p>a) How would you rate LL/CL in this program area? Circle one: Very poor Poor Neutral Good Very Good</p> <p>b) How would you rate LL/CL capacity-building activities in this program area? Circle one: Very poor Poor Neutral Good Very Good</p>
4.	<p>In your opinion, would you say gender has been mainstreamed into the SHARPP LL/CL efforts for organizational sustainability? If so, how? Probe: If needed, provide definition: Gender mainstreaming is the process of creating knowledge and responsibility for the problems caused by inequality between men and women among all health professionals (Definition adapted from WHO).</p> <p>Probe: Have women and men been equally engaged in this effort? Do they have similar roles on the project and throughout the activities? How are men's and women's roles the same or different in this effort?</p>
5.	<p>What would you say are some key lessons learned from SHARPP LL/CL efforts for organizational sustainability? Probe: Please comment on the key challenges and problems as well as achievements.</p>
6.	<p>What recommendations do you have for SHARPP LL/CL efforts for organizational sustainability?</p> <p style="text-align: center;">Thanks for your help in this evaluation</p>

**Focus Group Discussion Guide for use with older male youth (18 to 24)
LL/CL GBV program participants in Hardap or Kavango**

Unique FGD ID Number	____ _ <i>To be filled by evaluation team</i>
Interviewer/Facilitator Name(s)	
Notes on this form taken by (name)	
Date of FGD	Day: ____ Month: ____ Year: 2014
Location: Name of Region	
Location: Specific Site/Facility	

Participant Information						
Number of participant	Gender male or female	Age	Participant participated in LL/CL GBV program? Yes/No	Participant completed how many sessions? (number of sessions completed)	When completed last session? (month and year)	Verbal informed consent completed?
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Introduction: Hello and thank you for agreeing to meet with us today. Our names are and ... and ... We are evaluation consultants and have been hired to conduct an evaluation of the USAID-supported LL/CL programs for youth that have been in your community on the past year or so. We would like to ask you questions about the [insert preferred locally used name of the sub-grantee or other] program you completed related to gender norms and gender-based violence (GBV). We would like to discuss this program with you, as well as your knowledge, beliefs, attitudes and practices related to gender norms and gender-based violence (GBV). Participation in this discussion today is voluntary and you may decline to answer any individual question. You may also discontinue participation at any time. The information you provide will be kept strictly confidential and will not be disclosed to others. One of us will be asking the questions, while the others will take notes based on what you say. For purposes of not losing any information we need to take notes. Does anyone object? Before beginning, we would like to recommend some ground rules for our discussion.

1. This conversation should be treated as confidential. Whatever is discussed here should not be shared outside of this group after the discussion has finished.
2. Please respect each other's opinions.
3. There is no right or wrong answer.
4. The information you provide will not be linked to you in any way. Our notes will not contain your names so you can say whatever you want without anyone knowing what you said. Your honest responses to our questions will be highly appreciated.

We hope today's discussion will be balanced. This is an open discussion and everyone is entitled to his or her own opinions so please feel free to express what you think and feel. You are the experts about this (preferred name of sub-grantee or other LL/CL program), and we are here to learn from you and ensure that we keep the discussion to a reasonable time. We hope it will not take more than an hour and a half. We will be serving refreshments afterwards. If any of you would prefer not to participate you can leave any time. Can we begin? Thank you.

Themes	NB: Do not read out the themes to the participants All probes are optional but all questions should be asked.
Theme I / Participation, perceived benefits and challenges in being in the GBV program	
<p>1. Why did you decide to participate in this GBV program? Probe: How did you get involved with these sessions? Probe: Where do the sessions take place?</p> <p>2. Were there any advantages of participating in this program? If so, what were they?</p> <p>3. Did you experience any challenges or difficulties in participating in this program? If so, what were they?</p>	

Theme II / Participant assessment of the Gender Norms GBV program	
<p>1. Tell us about the program you participated in. What was the program about?</p> <p>2. How do you as participants, feel about the program sessions (the different parts of the program)? Probe: Which sessions worked best for you (the participants)? Probe: Which sessions are the easiest for you to do? Probe: Which sessions were the most difficult for you to do?</p> <p>3. Did you learn any new information? Did you learn any new skills?</p>	

Theme II Continued / Participant assessment of the Gender Norms GBV program	
<p>4. Can you tell us how some gender roles/norms can be harmful to young women?</p> <p>5. Can you tell us how some gender roles/norms can be harmful to young men?</p> <p>6. Did any of the sessions change your behavior? If so, how?</p>	

Theme III / Perceived impact on locality/local community or neighbourhood	
<p>1. Did this program change anything in your community or schools?</p> <p>2. If so, what changed?</p> <p>Probe: How did it change?</p>	

Theme IV / Degree of satisfaction with LL/CL training and/or sub-grantee facilitators they have worked with

1. What do you think of the quality of the program provided by the LL/CL facilitators in your community or school? How was the quality? Give examples (well organized, useful, and interesting)?

Probe: Does your facilitator/trainer have the right kind of skills, knowledge and experience to help you?

2. Did you have any say in how this GBV program is done?

a) For example, did you have a say in how the program was designed (how it was set up)?

b) For example, did you have a say about what was presented and how?

c) Would have liked to have a say and be involved in designing this program?

3. What recommendations would you have to improve this GBV program?

Probe: What would you do differently?

Probe: What does not need to be changed?

Validation:

1. Note takers briefly present the key findings to participants for each of the theme areas.
2. They then ask participants for feedback to validate the notes.
3. If there are discrepancies, they resolve them in the notes.

Thank them for their assistance.

Focus Group Discussion guide for use with SHARPP LL/CL Older Youth (18-24) Participants in LL/CL 7-session HIV prevention intervention: SBCC and Sexual Risk Reduction (SRR)

Unique FGD ID Number	<u> </u> <u> </u> <u> </u> <u> </u> <i>To be filled by evaluation team</i>
Interviewer/Facilitator Name(s)	
Notes on this form taken by (name)	
Date of FGD	Day: <u> </u> <u> </u> Month: <u> </u> <u> </u> Year: 2015
Location: Name of Region	
Location: Specific Site/Facility	

See the sign up list.

Number of participant	Participant Information				
	Male or Female	Age	Participated in all seven sessions of the SBCC SRR program Yes/No	When completed the last session? Month and Year	Verbal informed consent completed?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Introduction: Hello and thank you for agreeing to meet with us today. Our names are [... and ... and ...]. We are consultants hired to conduct an evaluation of the USAID-supported LifeLine/Childline (LL/CL) programs for youth that have been carried out in your community for the past few years. We would like to ask you questions about your experience as participants in [NB: We will verify the preferred local name for program: LL/CL's seven-session SBCC SRR program]. We would like to discuss your reactions to these sessions. We would like to learn about your knowledge, beliefs, attitudes and activities related to your participation in the sessions.

One of us will be asking discussion questions, while the others will take notes based on what you say. For purposes of not losing any information we need to take notes. Does anyone object?

Informed Consent: Participation in this discussion today is voluntary and you may decline to answer any individual question. You may also discontinue participation at any time. The information you provide will be kept strictly confidential and will not be disclosed to others.

Before beginning, we would like to recommend some ground rules for our discussion.

1. This conversation should be treated as confidential. Whatever is discussed here should not be shared outside of this group after the discussion has finished.
2. Please respect each other's opinions.
3. There is no right or wrong answer.
4. The information you provide will not be linked to you in any way. Our notes will not contain your names so you can say whatever you want without anyone knowing what you said. Your honest responses to our questions will be highly appreciated.
5. There will be no risks or direct benefits to you as a result of your participation in this interview.

We hope today's discussion will be balanced. This is an open discussion and everyone is entitled to his or her own opinions, so please feel free to express what you think and feel.

We value your opinions about the [preferred local name for the LL/CL youth program]. We are here to learn from you and we will keep the discussion to a reasonable time. We hope it will not take more than an hour. We will be serving refreshments afterwards.

It is my understanding that you have all agreed to participate on the basis of these ground rules. But please keep in mind that if any of you would prefer not to participate you can leave any time. Can we begin? Thank you.

Themes **NB: Do not read out the themes to the participants**
All probes are optional but all questions should be asked.

Theme I / Participation, perceived benefits and challenges of being in the seven sessions

1. Why did you decide to participate?
Probe: How did you get involved with these sessions?
Probe: Where do the sessions take place?
2. What were the advantages of participating?
3. What were the challenges/difficulties of participating?

Theme II / Participant assessment of the seven sessions

3. Tell us about the seven sessions that you participated in. What were they about?
4. How do you, as participants, feel about the sessions?
Probe: Which sessions find worked the best for you (the participants)?
Probe: Which sessions are the easiest for you to do?
Probe: Which sessions are the most difficult to do?

Theme II Continued / Participant assessment of the seven sessions

5. Did you gain new information? If so, what?
6. Did you gain any new skills? If so, what?
7. Did any of the sessions change your behavior? If so, which sessions and how?

Theme III / Perceived impact on area or school

1. What do you think of the activities and programs provided by the LL/CL in your area or school?
2. What kind of changes have you seen in your area or school since the LL/CL facilitators started this program in the last year? Positive? Negative? No change?

Theme IV / Degree of satisfaction with LL/CL training and facilitators they have worked with

1. What do you think of the quality of the sessions provided by the LL/CL facilitators in your area or school?

Probe: Do your facilitators/trainers have the right kind of skills, knowledge and experience to help you?

2. What recommendations would you have to improve the seven sessions?

Probe: What would you do differently? Would you do anything differently?

Probe: What does not need to be changed? What should stay the same?

Validation:

4. Note takers briefly present the key findings to participants for each of the theme areas.
5. They then ask participants for feedback to validate the notes.
6. If there are discrepancies, they resolve them in the notes.

Thank them for their assistance.

Focus Group Discussion guide for use with SHARPP LL/CL older youth (18-24) facilitators for LL/CL 7-session HIV prevention intervention for SBCC and SRR

Unique FGD ID Number	____ _ <i>To be filled by evaluation team</i>
Interviewer/Facilitator Name(s)	
Notes on this form taken by (name)	
Date of FGD	Day: Month: Year: 2015
Location: Name of Region	
Location: Specific Site/Facility	

See the list.

Number of participant	Participant Information				
	Male or Female	Age	Trained as SBCC SRR facilitator? Yes/No	When started as facilitator? Month and Year	Verbal informed consent completed?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Introduction: Hello and thank you for agreeing to meet with us today. Our names are [... and ... and ...] We are consultants hired to conduct an evaluation of the USAID-supported LifeLine/Childline (LL/CL) programs for youth that have been carried out in your community for the past few years. We would like to ask you questions about your experience as facilitators in [NB: We will verify the preferred local name for program: LL/CL's seven-session SBCC SRR program]. We would like to discuss your work with this program. We would like to learn about your knowledge, beliefs, attitudes and activities related to your work as facilitators.

One of us will be asking discussion questions, while the others will take notes based on what you say. For purposes of not losing any information we need to take notes. Does anyone object?

Informed Consent: Participation in this discussion today is voluntary and you may decline to answer any individual question. You may also discontinue participation at any time. The information you provide will be kept strictly confidential and will not be disclosed to others.

Before beginning, we would like to recommend some ground rules for our discussion.

1. This conversation should be treated as confidential. Whatever is discussed here should not be shared outside of this group after the discussion has finished.
2. Please respect each other's opinions.
3. The information you provide will not be linked to you in any way. It will only be used as content for our report. Our notes will not contain your names so you can say whatever you want without anyone knowing what you said. Your honest responses to our questions will be highly appreciated.
4. There will be no risks or direct benefits to you as a result of your participation in this interview.

We hope today's discussion will be balanced. There is no right or wrong answer. This is an open discussion and everyone is entitled to his or her own opinions, so please feel free to express what you think and feel.

You are the experts about your role as facilitators in the [preferred local name for the LL/CL youth program]. We are here to learn from you, and we will keep the discussion to a reasonable time. We hope it will not take more than an hour. We will be serving refreshments afterwards.

It is my understanding that you have all agreed to participate on the basis of these ground rules. But please keep in mind that if any of you would prefer not to participate you can leave any time. Can we begin? Thank you.

Themes **NB: Do not read out the themes to the participants**
All probes are optional but all questions should be asked.

Theme I / Skills development to become a facilitator and level of effort

1. How often do you work as facilitators?

Probe: Do you currently work as a facilitator? Yes/No
If yes, how many days in the last month? ___days per week___

Probe: On average, how many hours do you work per day?

Probe: On average, how many youth do you work with on a given day?

Probe: How is a normal day organized?

We would like to learn what kind of training you have had in order become a facilitator.

2. Can you tell us about the training you have received before becoming facilitators?

Probe: How long did it take before you were able to be a facilitator? What kind of person does it take to become a facilitator?

Follow-up question: Why would you use the word “brief” knowledge required to be a facilitator?

Do women facilitate in the same way as men?

3. Did this training provide you with all the skills you need to do all seven sessions?

Probe: What additional training would you like to get in order to do all seven sessions?

Probe: Do your trainers have the right kind of skills, knowledge and experience to help you? How frequently do you prefer training?

Probe: How, in your opinion, should a facilitator be trained? Do the trainers have the right skills and knowledge?

Theme II / Benefits and challenges of being a facilitator

4. Why did you decide to become a facilitator?
Probe: How did you come to learn about this program?

5. What does being a facilitator mean to you?
Probe: How have you benefited? Has it changed your life in any way?

6. Do you face challenges in your work as a facilitator? If so, what are they?

7. What do you find most rewarding about being a facilitator?

Theme III / Facilitator assessment of the seven sessions

8. Tell us about the seven session that you do. What are they?

Probe: Which sessions find work the best? Which sessions are the easiest for you to do? Which sessions are the most difficult to do?

Would help to get training on this?

9. Which sessions do you feel are most beneficial to participants?

10. Do the sessions change the behavior of your participants? If so, how?

Probe: If appropriate, ask about the Sexual Risk Assessment Exercise and how it works)

Why the problem with SBCC in schools?

Theme IV / Level of youth participation in the seven sessions

1. What do you think of the way youth participate in this program?

NB: This should refer to the youth participants, not the facilitators.

2. Do you have any role in designing the sessions?

Probe: Do you have a say in how things are done?

Probe: How are you involved in developing the seven sessions?

Theme V / Perception of impact and recommendations for future

3. What do you think of the activities and programs provided by the LL/CL in your area?

One issue emerged based on comment from the evaluation team: Are the children in the seven sessions by choice, or are the children are assigned to the classes?

4. What kind of changes have you seen in your community since the LL/CL facilitators started this program in the last year? Positive? Negative? No change?

5. If you could change things about this program, what would you recommend?

6. Recommendations for improving the trainings and the seven sessions?

Probe: How to you feel when you have to go into the schools to do the SBCC?

Validation:

1. Note takers briefly present key findings to participants for each of the theme areas.
2. They then ask participants ask for feedback to validate the notes.
3. If there are discrepancies, they resolve them in the notes.

Thank participants for their assistance.

Semi-Structured Interview (SII) Questionnaire for Older Youth in Youth Clubs or Groups

Introduction: Thank you for meeting with us today. Our names are [Sam Clark, Ndeu Amulungu and Nelao Haimbodi]. We are evaluation consultants conducting an end-of-project evaluation of the USAID-funded program called “Strengthening HIV/AIDS Responses in Prevention and Protection.” It is also called the “SHARPP” program.

The SHARPP program in Namibia has been implemented since 2011 by LifeLine/Childline (LL/CL) in collaboration with the Ministry of Health and Social Services, Ministry of Gender Equality and Child Welfare and other agencies. This SHARPP program consists of six program areas. In this interview we would like to ask you questions about one of the program areas, which we believe you are familiar with: the LL/CL programs for young people in the area of social and behavior change communication (SBCC), especially LL/CL’s programs for sexual risk reduction (SRR) for the prevention of HIV/AIDS and the prevention of gender-based violence.

Goals and objectives of the evaluation: It is now almost four years since SHARPP program began in July 2011. The main purposes of this evaluation are:

- 1) to assess the performance of SHARPP LL/CL and other implementers contracted by LL/CL
- 2) to determine whether intended results are likely to be achieved
- 3) to inform the design of potential future activities

Our questions are based on five main criteria: how the SHARPP LL/CL programs for youth are implemented, how effective they are, how sustainable they are, what are some key lessons learned and what are the key recommendations.

The evaluation findings will be used to support the Government of Namibia in HIV programming and inform USAID/Namibia in future program design.

Informed Consent: This interview is confidential and voluntary. Your name will not be linked to any of the findings. If you are willing to be quoted, this is appreciated. But no information will be associated with your name unless cleared with you in advance by you. There will be no risks or direct benefits to you as a result of your participation in this interview. You can end the interview at any time and have no obligation to answer any questions asked. However we appreciate your collaboration in this important exercise.

Are you willing to be interviewed on this basis? **Circle One:** Yes No.

1. a. Unique Identification Number: (Two column var): ___/ ___/
1. **Date of Interview:** __Day__Month__Year
2. **Name of interviewer**_____
3. **Name of person(s) taking notes:** _____
4. **Location of interview:**_____
5. **Name of respondent:** _____
6. **Age of respondent:**_____
7. **Sex of respondent:**_____
8. **Confirm respondent participated in one or more LL/CL programs for youth. Yes No Circle one.**
9. **In what type of LL/CL program has the respondent been involved? Check/circle any that apply:**
- Seven Sessions of SBCC SRR
 - Workshop/Training on Gender Awareness/Male Gender Norms
 - Parenting Training Course
 - Other _____
10. **Month and year respondent last participated in LL/CL program for youth.**
Month___ **Yr**_____

Instruction to Interviewer: When we ask questions about the program area, if the respondent feels the questions are too general or are at a policy level they are not comfortable with, this is not a problem. Simply skip to the next question.

Evaluation Questions
<p>I 1. Can you briefly describe the LL/CL program for youth and how you were/are involved with it?</p> <p>Probe: How did you become part of the program?</p> <p>Probe for older male youth who participated in Gender Norms Training: What do “male gender norms” mean to you?</p>
<p>I 2. Has this program made a difference for you? If so, how?</p> <p>Probe: In your opinion, how effective has this LL/CL program been for you and other youth?</p> <p>Probe: Has participating in this program changed you in any way? If so, how?</p>
<p>I 3. A: If the respondent participated in Sexual Risk Reduction Sessions, has the LL/CL program changed your behavior? If so, how?</p> <p>B: If respondent participated in Male Gender Norms/GBV, has the program changed your views about GBV? If so, how?</p> <p>B.1: Did the training change the way you feel about being a man? If so how?</p> <p>B.2: Did the training change how you relate to women? If so, how?</p>
<p>I 4. In your opinion, how do you perceive the quality of LL/CL program for you and other youth?</p> <p>Probe: For example, were the youth SRR sessions well organized, stimulating, useful, participatory, etc.?</p>
<p>I 5. Would you say the LL/CL program engages young men and women in the same way?</p> <p>If respondent participated in Sexual Risk Reduction Sessions, probe: Did the LL/CL program address gender roles of young men and women? Can you provide examples of how they do this, or when roles differ for young men and women?</p> <p>If respondent participated in Male Gender Norms/GBV, probe: Did the LL/CL program explain how male and female gender norms are related to gender-based violence? If so, what does this mean to you?</p>
<p>I 6. What would you say are some key lessons learned from your participation in the LL/CL program in support for youth?</p> <p>Probe: What are the key challenges of this program?</p> <p>Probe: Please comment on the key challenges and problems.</p> <p>Probe: Please comment on the key benefits and achievements from the youth program.</p> <p>Lessons Learned:</p>
<p>I 7. What recommendations do you have for LL/CL’s programs for youth?</p> <p>If respondent participated in Sexual Risk Reduction Sessions, probe: In particular, what do you recommend for the reduction of risk for HIV/AIDS?</p> <p>If respondent participate in Male Gender Norms/GBV, probe: In particular, what do you recommend for the reduction of gender-based violence?</p>

Thank you for your participation in this evaluation.

Semi-Structured Interview Questionnaire for OVC Caregivers

Introduction: Thank you for meeting with us today. Our names are [Sam Clark, Ndeu Amulungu and Nelao Haimbodi]. We are evaluation consultants conducting an end-of-project evaluation of the USAID-funded program called “Strengthening HIV/AIDS Responses in Prevention and Protection.” It is also called the “SHARPP” program.

The SHARPP program in Namibia has been implemented since 2011 by LifeLine/Childline (LL/CL) in collaboration with the Ministry of Health and Social Services, Ministry of Gender Equality and Child Welfare and other agencies. This SHARPP program consists of six program areas. In this interview we would like to ask you questions about one of the program areas, which we believe you are familiar with: the LL/CL programs in the area of Child Protection and Parenting especially for caregivers for orphans and vulnerable children affected by HIV/AIDS.

Goals and objectives of the evaluation: It is now almost four years since SHARPP program began in July 2011. The main purposes of this evaluation are:

- 1) to assess the performance of SHARPP LL/CL and other implementers contracted by LL/CL
- 2) to determine whether intended results are likely to be achieved
- 3) to inform the design of potential future activities

Our questions are based on five main criteria: how the SHARPP LL/CL programs for caregivers of OVC are implemented, how effective they are, how sustainable they are, what are some key lessons learned and what are the key recommendations.

The evaluation findings will be used to support the Government of Namibia in HIV programming and inform USAID/Namibia in future program design.

Informed Consent: This interview is confidential and voluntary. Your name will not be linked to any of the findings. If you are willing to be quoted, this is appreciated. But no information will be associated with your name unless cleared with you in advance by you. There will be no risks or direct benefits to you as a result of your participation in this interview. You can end the interview at any time and have no obligation to answer any questions asked. However, we appreciate your collaboration in this important exercise.

NB: Confirm respondent is 18 or over. Circle One: Yes No

Are you willing to be interviewed on this basis? Circle One: Yes No.

I. a. Unique Identification Number: (Two column var): ___/ ___/

1. **Date of interview:** __Day__Month__Year

2. **Name of interviewer**_____

3. **Name of person(s) taking notes:** _____

4. **Location of interview:**_____ (**Oonte or SOS or other agency providing support for caregivers**)

5. **Name of respondent:** _____

6. **What type of caregiver are you?** _____

Probe: This can be as parent, guardian, sibling, social worker, auxiliary social worker, etc.

7. **How many children do you currently care for? Number of children**_____.

8. **Number of months/years respondent has received support from Oonte or SOS or Other:** __Months/Years

Instruction to Interviewer: When we ask questions about the program area, if the respondent feels the questions are too general or are at a policy level they are not comfortable with, this is not a problem. Simply skip to the next question.

Evaluation Questions

9. We understand that you are a caregiver and that you have benefited from the LifeLine/Childline (LL/CL) program for caregivers of OVC through [Oonte / SOS/ or other]. Can you tell us about the program?

Probe: Can you briefly describe the LL/CL program for caregivers and how you are involved with it?

Probe: What kind of support did you receive as a caregiver?

- Parenting training course
- Counseling services
- Social support
- Material support
- Vocational training
- Micro-financing/financial support
- Other _____

10. How did you feel about the LL/CL program support for caregivers received through [Oonte / SOS/ or other]?

Probe: What did you like best, what did you like the least about the program?

11. Has the LL/CL program support through [Oonte / SOS/ or other] changed the way you care for your children? If so, how?

Probe: Have you use any of the skills you learned from the program? If so, how?

12. How do you feel about the quality of the LL/CL training program you received through [Oonte / SOS/ or other]?

Probe: For example, was the parenting course well-organized, practical and informative?

13. Would you say the LL/CL program received through [Oonte / SOS/ or other] involves men and women caregivers in the same way?

Probe: Please explain your answer.

Probe: Did the parenting course address gender roles of men and women OVC caregivers? Can you provide examples of how they do this?

Probe: When do the roles of caregivers for OVC differ for men and women?

Probe: Are men involved in caregiving the same as women?

14. What would you say are some key lessons learned from your participation in the LL/CL program received through [Oonte / SOS/ or other] in support for caregivers of OVC?

Probe: Please comment on the key challenges and problems as well as benefits and achievements from the program.

Key challenges/problems:

Key benefits:

Lessons Learned:

15. What recommendations do you have for LL/CL's programs to support caregivers for OVC?

Thank you for your participation in this evaluation.

HCT Exit Interview Questionnaire

Introduction: Thank you for agreeing to meet with us today. Our names are [Sam Clark, Ndeu Amulungu and Nelao Haimbodi]. We are consultants hired to evaluate the USAID-supported program called “Strengthening HIV/AIDS Responses in Prevention and Protection,” which is also called the “SHARPP” program. The SHARPP program here in Namibia has been implemented by LifeLine/Childline (LL/CL) in collaboration with the Ministry of Health and Social Services and other ministries since 2011.

This SHARPP program includes the HIV counseling and testing services provided by this NewStart center. We would like to ask you questions about the HCT testing services you received today.

The main purpose of our evaluation is to learn about how HCT services are provided and identify ways to improve them.

Informed Consent: This interview is confidential and voluntary. Your name will not be linked to anything you wish to say. If you are willing to be quoted, this is appreciated. But no information will be associated with your name. There will be no risks or direct benefits to you as a result of your participation in this interview. You can end the interview at any time and have no obligation to answer any questions asked. However, we would appreciate your collaboration in sharing your opinions.

Are you willing to be interviewed on this basis? Circle One: Yes No

**Draft GH Pro 067 SHARPP LL/CL Exit Interview for HCT Clients
(Designed to be either self- or interviewer-administered)
Draft 0.3 29 Mar 2015
Preliminary Draft Only: Not for Distribution**

THIS SURVEY IS CONFIDENTIAL. PLEASE DO NOT WRITE YOUR NAME ON THIS FORM.

Please share your honest opinions with us. We need your comments to improve services.

I. Questionnaire ID Number: _____
[Kindly tick (✓) or circle one option for each question]

2. Is this your first visit to this NewStart Centre? 1. Yes 2. No

3. What services did you come for today? 1. HIV Test and Counseling 2. Other

Questions on your access and your rights

What is your opinion?

Kindly tick (✓) or circle one option for each question

<p>4. Do you feel comfortable coming to this centre?</p>	<p>1. Very comfortable 2. Comfortable 3. Neither comfortable nor uncomfortable 4. Uncomfortable 5. Extremely uncomfortable</p>
<p>5. Are the centre hours convenient?</p>	<p>1. Very convenient 2. Convenient 3. Neither convenient nor inconvenient 4. Inconvenient 5. Extremely inconvenient</p>
<p>6. Do you feel comfortable asking for information about this centre's services?</p>	<p>1. Very comfortable 2. Comfortable 3. Neither comfortable nor uncomfortable 4. Uncomfortable 5. Extremely uncomfortable</p>
<p>7. How long did you wait for services at the centre today?</p>	<p>1. 10 minutes and below 2. 11 – 25 minutes 3. 26 – 40 minutes 4. 41 – 60 minutes 5. More than 1 hour</p>
<p>8. Was the waiting time reasonable?</p>	<p>1. Very reasonable 2. Reasonable 3. Neither reasonable nor unreasonable 4. Unreasonable 5. Extremely unreasonable</p>
<p>9. Did you find the centre staff friendly?</p>	<p>1. Very friendly 2. Friendly 3. Neither Friendly nor unfriendly 4. Not friendly 5. Extremely unfriendly</p>

Kindly Tick (✓) or circle one option for each question	
10. Do you find the services at this centre confidential?	1. Yes 2. No
11. Did you feel like the services were private?	1. Yes 2. No

NB: This instrument has been adapted from an exit interview instrument developed for NAPPA with USAID/Namibia support in 2013.

Kindly Tick (✓) or circle one option for each question	
12. Did the centre have posters and leaflets on the services you needed?	1. Yes 2. No
13. Were you provided with sufficient information to meet your needs?	1. Yes 2. No
14. Did you understand the information provided?	1. Yes, fully. 2. Yes, a little bit. 3. No

How do you feel about this NewStart Centre? The following questions ask about your satisfaction with the services provided at this centre and the staff. Kindly tick (✓) or circle one option for each question to indicate your satisfaction level.	
15. How do you feel about the way you are treated?	1. = Very happy 2. = Happy 3. = Neither happy nor unhappy 4. = Unhappy 5. = Very unhappy
16. How do you feel about NewStart's services?	1. = Very happy 2. = Happy 3. = Neither happy nor unhappy 4. = Unhappy 5. = Very unhappy

What are your suggestions?
Suggestions
17. Kindly state the things you liked most about your visit today.
18. Kindly state things that you did not like about your visit today.
19. Do you have any suggestions for how we might improve your visit?

Thank you for participating in this evaluation!

ANNEX IV. SOURCES OF INFORMATION

LL/CL SHARPP Evaluation Documents Reviewed

Project-specific Documents
LifeLine/Childline SHARPP Cooperative Agreement #674-A-00-00062-00 Work-plan Description (1 July 2011- 30 September 2012).
LifeLine/Childline Namibia Annual Progress Report for FY12 (October 2011-September 2012).
LifeLine/Childline Progress Report for FY13 Semiannual Report (October 2012-March 2013).
LifeLine/Childline Progress Report for FY13 Quarter 3 (April 2013-June 2013).
LifeLine/Childline Progress Report for FY13 Annual Report (October 2012-September 2013).
LifeLine/Childline Progress Report for FY14 Quarter 1 (October 2013-December 2013).
LifeLine/Childline Progress Report for FY14 Semiannual Report (October 2013-March 2014).
LifeLine/Childline Progress Report for FY14 Quarter 3 (April-June 2014).
LifeLine/Childline Progress Report Annual Program Results (October 2013-September 2014).
LifeLine/Childline Namibia. Overview of the Main Achievements of the SHARPP Award to Date (July 2011-September 2014).
LifeLine/Childline Progress Report for FY15 Quarterly Progress Report (October 2014-December 2014).
LifeLine/Childline SHARPP Program Performance Monitoring Cooperative Agreement #674-A-00-11-00062-00. January 2013.
Komu, P. Assessment Report of Project effectiveness, planning and implementation the Strengthening HIV/AIDS Responses in Prevention and Protection (SHARPP) Project in Namibia.
Namibia Statistics Agency, Windhoek, Namibia. Namibia Demographic Health Survey 2013. September 2014.
Program Area 1
LifeLine/Childline. Meeting National Priorities through Community-based HTC: A strategic proposal for the sustainability of the remaining stand-alone NewStart Centres in Namibia.
National Guidelines for HIV Testing and Counselling in Namibia. 2011.
National Strategy and Action Plan for HIV Testing and Counselling 2014/15-2016/17.
Program Area 2
C-CHANGE Social and Behaviour Change Communication (SBCC) Quality Assessment Tool.
C-CHANGE Childline HIV and AIDS Program HIV and AIDS Behaviour Change Communication Baseline Assessment and Recommendations for COP08. February 2009.
LifeLine/Childline Social Behaviour Change Communication: Integrated Session Guide Focusing on the Drivers of HIV/AIDS Epidemic 15-24 Years Old.
LifeLine/Childline Social Behaviour Change Communication: Integrated Session Guide Focusing on the Drivers of HIV/AIDS Epidemic 25-49 Years Old.
Quality Improvement Team Report, Community-led Action Against HIV and AIDS (LL/CL).

Program Area 3
Complimentary Report to the African Committee of Experts on the Rights and Welfare of Children. 2014.
UNICEF. Uitani Childline Radio Evaluation. 2009.
Urgoiti, G. Review of Child Participation Approaches and Practices of Life Line Child Line, Namibia: Proposed Principles and Guidelines. 2013.
Program Area 4
LifeLine/Childline. Addressing Harmful Gender Norms and Gender Based Violence Session Guide
LifeLine/Childline. Stepping up in Support of LifeLine/Childline Project to Address GBV in the Hardap Region.
National Action Plan of Gender-based Violence (2012-2016)
PEPFAR. Addressing Gender-based Violence in Namibia: A Multifaceted Approach. 2010.
Program Area 5
LifeLine/Childline Care and Support Assessment Tool for Newly Tested HIV-positive Clients.
Program Area 6
LifeLine/Childline Sustainability Strategies. 2014. PowerPoint Presentation.
Putting Employee Wellness into Perspective. 2014. PowerPoint Presentation.

Preliminary Evaluation Agenda

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<p>Mar 23</p> <p>Full Team Windhoek Submission of Draft Work Plan Team Lunch 13-14:00 PM 14:30 In-brief with USAID/Namibia</p>	<p>Mar 24</p> <p>Full Team Windhoek TPM In-brief LL/CL and Key Stakeholders MoH and MoG Team Lunch 13-14:00</p>	<p>Mar 25</p> <p>Full Team Windhoek TPM Team Lunch 13-14:00 TPM</p>	<p>Mar 26</p> <p>Full Team Windhoek Pre-test Instruments Team Lunch 13-14:00 TPM</p>	<p>Mar 27</p> <p>Full team Windhoek Appt: Bernadette Harases TBD Team Lunch 13-14:00 KII/SSIs/LL/CL Data Pre-test Instruments</p>	<p>Mar 28</p> <p>Full team Windhoek Document review Revision of Instruments</p>	<p>Mar 29</p> <p>Full team Windhoek Rest/Synthesis Submit Weekly Progress Report</p>
<p>Mar 30</p> <p>Full team Windhoek KII/SSIs/LL/CL Data Team Lunch 13-14:00 Final Work Plan, Timeline, analysis protocol and data collection instruments.</p>	<p>Mar 31</p> <p>Full team Windhoek KII/SSIs/LL/CL Data Team Lunch 13-14:00 KII/SSIs/LL/CL Data</p>	<p>Apr 1</p> <p>Full Team Windhoek KII/SSIs/LL/CL Data Team Lunch 13-14:00 KII/SSIs/LL/CL Data</p>	<p>Apr 2</p> <p>Full team Windhoek FGD with LL/CL SBCC SRR Older youth Facilitators Team Lunch 13-14:00 KII/SSIs/LL/CL Data</p>	<p>Apr 3</p> <p>Full team Windhoek GOOD FRIDAY Public Holiday</p>	<p>Apr 4</p> <p>Full team Windhoek Public Holiday</p>	<p>Apr 5</p> <p>Submit Weekly Progress Report Public Holiday</p>
<p>Apr 6</p> <p>13:15 AM Travel by Sw103 Team to Ondangwa EASTER MONDAY Public Holiday</p>	<p>Apr 7</p> <p>Team Ohangwena KII/SSIs/LL/CL Data Team Lunch 13-14:00 KII/SSIs/LL/CL Data</p>	<p>Apr 8</p> <p>Team Ohangwena KII/SSIs/LL/CL Data Team Lunch 13-14:00 KII/SSIs/LL/CL Data</p>	<p>Apr 9</p> <p>Team Ohangwena FGD with LL/CL SBCC SRR Older Youth Facilitators Team Lunch 13-14:00 KII/SSIs/LL/CL Data</p>	<p>Apr 10</p> <p>Team Ohangwena KII/SSIs/LL/CL Data Team Lunch 13-14:00 Travel by Car to to Oshana</p>	<p>Apr 11</p> <p>Oshana Data capture and Synthesis Team Lunch 13:00-14:00 Data Capture and Synthesis</p>	<p>Apr 12</p> <p>Oshana Rest and data Synthesis Submit Weekly Progress Report</p>
<p>Apr 13</p> <p>Team Oshana KII/SSIs/LL/CL Data Team Lunch 13-14:00</p>	<p>Apr 14</p> <p>Team Oshana KII/SSI/LL/CL Data Team Lunch 13-14:00</p>	<p>Apr 15</p> <p>Team Oshana FGD w LL/CL SBCC SRR older youth clients female Team Lunch 13-14:00</p>	<p>Apr 16</p> <p>Team Oshana KII/SSIs/LL/CL Data Team Lunch 13-14:00</p>	<p>Apr 17</p> <p>8:30 Team travel SW102 Back to Windhoek Team Lunch 13:00-14:00</p>	<p>Apr 18</p>	<p>Apr 19</p> <p>Rest and data Synthesis Fight 127 Travel to Rundu via Katima Submit Weekly Progress Report</p>

Apr 20 Team Kavango KII/SSIs/LL/CL Data Team Lunch 13-14:00	Apr 21 Team Kavango KII/SSIs/LL/CL Data Team Lunch 13-14:00	Apr 22 Team Kavango Team Lunch 13-14:00	Apr 23 Team Kavango FGD with LL/CL GBV norms <u>male</u> older youth clients Team Lunch 13-14:00 KII/SSIs/LL/CL Data	Apr 24 Team 14:50 SW125 travel back from Rundu via Katima to Windhoek KII/SSIs/LL/CL Data Team Lunch 13-14:00 KII/SSIs/LL/CL Data	Apr 25 Full Team Windhoek Data Capture and Synthesis	Apr 26 Full Team Windhoek Submit Weekly Progress Report
Apr 27 Full Team Travel by car to Hardap Full Team Hardap KII/SSIs/LL/CL Data Team Lunch 13-14:00 Full Team by car return to Windhoek before dark.	Apr 28 Full Team Travel by car to Hardap KII/SSIs/LL/CL Data Team Lunch 13-14:00 Full Team by car return to Windhoek before	Apr 29 Full Team Windhoek Data Capture and Synthesis Data Analysis	Apr 30 Full Team Windhoek FGD with LL/CL SRR older youth clients female Data Capture and Synthesis Data Analysis	May 1 Full Team Windhoek Prep for Outbrief WORKERS DAY Public Holiday	May 2 Full Team Windhoek	May 3 Full Team Windhoek Submit Weekly Progress Report
May 4 Full Team Windhoek Preparation for Outbrief Team Lunch 13-14:00 CASSINGA DAY Public Holiday	May 5 Full Team Windhoek Team Lunch 13-14:00 Outbrief with Mission	May 6 Full Team Windhoek Prep for Stakeholder Debrief Workshop Team Lunch 13-14:00	May 7 Full Team Windhoek Team Lunch 13-14:00 Stakeholder debrief Workshop	May 8 Full Team Windhoek Team Lunch 13-14:00 Draft Report	May 9	May 10 Submit Weekly Progress Report
May 11 Team Lunch 13-14:00	May 12 Full Team Windhoek Team Lunch 13-14:00 Draft Report	May 13 Full Team Windhoek Team Lunch 13-14:00 Draft Report	May 14 Full Team Windhoek Team Lunch 13-14:00 Draft Report ASCENSION DAY Public Holiday	May 15 Full Team Windhoek Team Lunch 13-14:00 Draft Report	May 16	May 17 Submit Weekly Progress Report
May 18 Full Team Windhoek Team Lunch 13-14:00 Draft Report	May 19 Full Team Windhoek Team Lunch 13-14:00 Draft Report	May 20 Full Team Windhoek <u>Submission of Draft Report</u> Team Lunch 13-14:00 20:35 Sam Clark Depart SW285	May 21 Sam Clark on Leave	May 22 Sam Clark on Leave	May 23 Sam Clark on Leave	May 24 Sam Clark on Leave Submit Weekly Progress Report

May 25 Sam Clark on Leave	May 26 Sam Clark on Leave	May 27 Sam Clark on Leave <u>Actual Deadline for Draft Report</u>	May 28 Sam Clark on Leave USAID/Namibia Review Draft Report	May 29 Sam Clark on Leave USAID/Namibia Review Draft Report	May 30 Sam Clark on Leave USAID/Namibia Review Draft Report	May 31 Sam Clark on Leave USAID/Namibia Review Draft Report
June 1	June 2	June 3	June 4	June 6 USAID/Namibia Comments due in 7 working days.	June 7	June 8 June 17, 2015 Final Report

ANNEX V. MATRIX OF TRAINING AND CAPACITY-BUILDING ACTIVITIES

HTC

Type of Training (Topic area)	Number of Trainers	Number of Trainees in each training	Number of Trainings	Total Number of Trainees	Location(s) of Training	Days of Training	Dates Completed
HIV rapid testing	3	18	1	18	Windhoek	5	
Couple HIV testing-counseling	2	17 and 19	2	36	Windhoek and Ondangwa	5 days each 2 trainings	

Sexual Prevention

Type of Training (Topic area)	Number of Trainers	Number of Trainees in each training	Number of Trainings	Total Number of Trainees	Location(s) of Training	Days of Training	Dates Completed
Personal growth	2	13	1	15	Rundu	5	01/16/2015
Refresher training (Facilitation skills)	2	11	1	13	Khomas	3	04/16/2014
Refresher training (SBCC curriculum)	4	20	1	24	Khomas	5	01/30/2015
Refresher training (SBCC curriculum)	4	18	1	22	Kavango	4	02/12/2015
Refresher training (SBCC curriculum)	4	8	1	12	North Central	5	20/03/2015

Family Strengthening

Type of Training (Topic area)	Number of Trainers	Number of Trainees in each training	Number of Trainings	Total Number of Trainees	Location(s) of Training	Days of Training	Dates Completed
Exploration and counseling management training	1	10	1	10	Rundu	3	04/10/13
Child counseling refresher	1	18	1	18	Ondangwa	3	04/17/13
Personal growth and basic counseling	3	20	2	40	Ondangwa	10	05/31/13
Personal Growth	2	12	1	12	Windhoek	6	08/03/13
Basic counseling	1	7	1	7	Windhoek	6	10/13/13
Personal growth (internal)	2	20	1	20	Windhoek	6	04/12/14
Basic counseling	1	20	1	20	Windhoek	6	05/24/14
Personal growth and basic counseling sign language	2	11	1	11	Windhoek	5	06/06/14
Parenting training of trainers	2	25	1	25	Rehoboth	5	09/12/14
Child counseling	3	18	1	18	Windhoek	5	08/02/13

GCF

Type of Training (Topic area)	Number of Trainers	Number of Trainees in each training	Number of Trainings	Total Number of Trainees	Location(s) of Training	Days of Training	Dates Completed
Engaging men and boys	2	18	1	18	Swakopmund	10	11/04/11
Engaging men and boys	2	25	1	25	Ongwediva	5	11/18/11
GBV training for LL/CL Counselors	2	10	1	10	Windhoek	2	01/31/13
GBV workshop	2	14	1	14	Mariental	2	05/17/13
Internal gender training	2	18	1	18	Windhoek	2	03/05/14
Community leaders training on GBV	2	17	1	17	Rundu	3	03/13/14
Internal gender training	2	25	1	25	Rundu	2	03/18/14
Community leaders training on GBV	2	20	1	20	Rehoboth	3	03/27/14
Sub-grantees capacity-building workshop	2	24	1	24	Windhoek	4	10/07/14

PLHIV

Type of Training (Topic area)	Number of Trainers	Number of Trainees in each training	Number of Trainings	Total Number of Trainees	Location(s) of Training	Days of Training	Dates Completed
Body Mapping	2	22	1	22	Windhoek	4	4
Sensitization Workshop	1	6	2	12	Oshikango and Oshakati	1	1
Body Mapping	2	18	1	18	Ondangwa	4	4
Body Mapping	1	7	1	7	Windhoek	4	4
Sensitization Workshop	1	4	1	4	Rundu	1	1
Body Mapping	2	20	1	20	Rundu	4	4
Body Mapping	1	11	1	11	Windhoek	9	9
Sensitization Workshop	1	10	1	10	Windhoek	1	1

ANNEX VI: EVALUATION TEAM INFORMATION AND DISCLOSURE OF CONFLICTS OF INTEREST

Sam Clark, team leader (International), works as a consultant to design and implement public health program evaluations, mostly on maternal and child health, family planning and reproductive health. He has a Doctorate (Sc.D.) and Masters (Sc.M.) degree from the Johns Hopkins University School of Hygiene and Public Health in Population Dynamics. He has experience in public health program implementation and management (nine years at PATH as a program officer, and three years at the Maryland State Health Department as community health educator for the state's Title 10 family planning program). Since 1985, he has participated in research and M&E activities in more than twenty countries, working with multinational teams for agencies such as UNFPA, UNICEF, USAID and the WHO.

Ndeutalala Amulungu, evaluation specialist, currently works as an independent consultant in M&E. For the past seven years she has worked in M&E at various levels, most recently as an M&E manager before becoming an independent consultant. She has a background in economic and public policy research. She has worked in the fields of HIV/AIDS, development planning and child rights advocacy. She has experience in working with both national and international institutions, such as UNICEF and Millennium Challenge Account Namibia. She holds a Post-graduate Diploma in Monitoring and Evaluation from the University of Stellenbosch, South Africa and a Bachelor's Degree in Economics from the University of Namibia.

Nelao Sheila Haimbodi, research assistant, works as a consultant in the area of communications for development, designing and implementing SBCC campaigns for various government ministries and non-profit organizations in the sectors of public health and sustainable development. Most recently, she worked on developing a demand-creation strategy for voluntary male medical circumcision and also developed a communication campaign for Option B+ in the prevention of mother-to-child transmission for the MoHSS. She has in-depth experience in facilitation, working with rural communities to create awareness for development initiatives, conducting needs assessments and training. Nelao has a MA in Communication Management from Emerson College and a BA in Media Studies and Industrial Psychology from the University of Namibia.

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USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature

Samuel D. Clark, Jr.

Date

20 Feb 2015

Name

SAMUEL D. CLARK, Jr.

Title

*Consultant
Public Health*

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

27-02-2015

Name Ndettalala Amulungu

Title Private Consultant
Monitoring & Evaluation

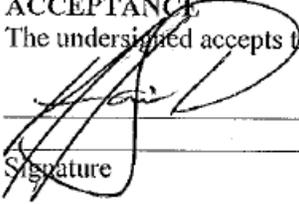
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.



Signature

23/02/2015

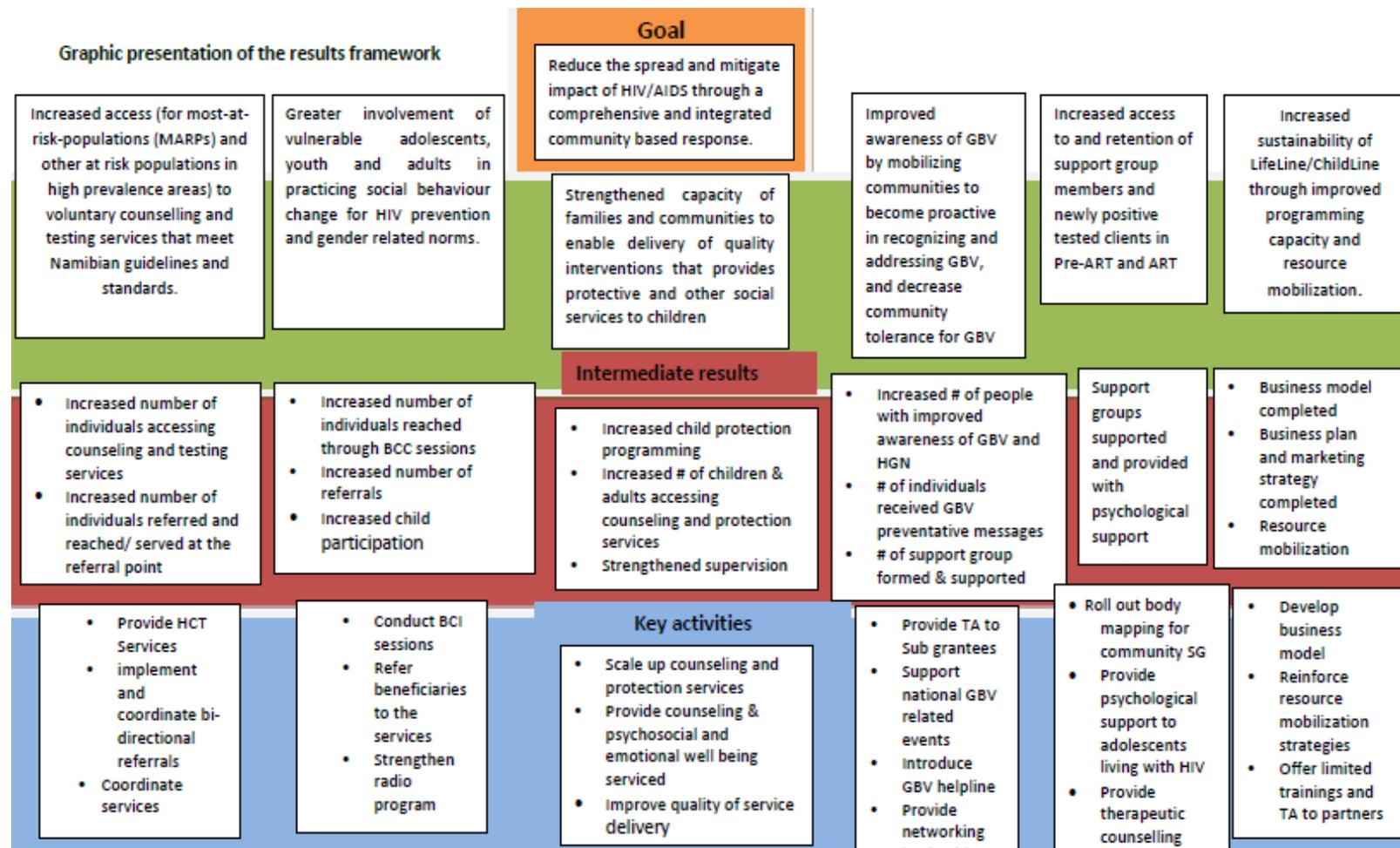
Date

NEAHO HAIMBODI

Name

Title

ANNEX VII: GRAPHIC PRESENTATION OF SHARPP LL/CL RESULTS FRAMEWORK



ANNEX VIII: LIST OF CATEGORIES OF RESPONDENTS WITHOUT NAMES

Summary Table⁵⁵ of Respondents by Region, Respondent Type and Program Area⁵⁶

Region	Respondent Type	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Total
Khomas	CSO, Donors, etc.	3	1	3	1	0	5	13
	GRN Ministries	2	1	1	1	0	0	5
	LL/CL	0	1	1	2	1	2	7
	Total	5	3	5	4	1	7	25
North Central	CSO, Donors, etc.	1	1	2	0	1	0	5
	GRN Ministries	4	1	3	0	1	0	9
	LL/CL	3	2	1	1	0	0	7
	Total	8	4	6	1	2	0	21
Kavango	CSO, Donors, etc.	0	0	0	2	0	0	2
	GRN Ministries	4	0	4	0	0	0	8
	LL/CL	1	2	0	1	1	0	5
	Total	5	2	4	3	1	0	15
Hardap	CSO, Donors, etc.	0	0	1	2	0	0	3
	GRN Ministries	0	0	2	1	0	0	3
	LL/CL	0	2	1	0	0	0	3
	Total	0	2	4	3	0	0	9
Total	CSO, Donors, etc.	4	2	6	5	1	5	23
	GRN Ministries	10	2	10	2	1	0	25
	LL/CL	4	7	3	4	2	2	22
	Total	18	11	19	11	4	7	70

⁵⁵ A detailed list of key informants interviewed is archived with USAID/Namibia. It is not included within the annex, because the informed consent process did not include permission to list the respondents' names.

⁵⁶ Ohangwena and Oshana are combined because, although they are two different regions in the North Central area, they are managed by just one North Central LL/CL office.

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