PERFORMANCE EVALUATION OF NAMIBIA’S DREAMS PROGRAM

November 2019

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Cover Photo: Implementing partner showing her safe space members how to correctly use a female condom. Credit: Project HOPE Namibia
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November 2019

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DISCLAIMER

The authors’ views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
ABSTRACT

The purpose of this qualitative performance evaluation of the Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) Namibia project was to understand the performance, capacity, and effectiveness of project start-up in meeting the intended results in project year (PY) 1; highlight gaps and opportunities that can be acted upon by project staff and USAID in the first 18 months of implementation; and identify areas that need modification/improvement to increase the likelihood of project success.

Changes in the early U.S. Department of State/Office of the U.S. Global AIDS Coordinator (S/GAC) guidance, along with high targets, created challenges in PY1. Nonetheless, Project HOPE Namibia and the DREAMS Namibia consortium sub-partners have made adjustments to outreach strategies as implementation has evolved. Project stakeholders and beneficiaries have been overwhelmingly positive about project benefits.

Key recommendations include:

- Strengthen community-based pre-exposure prophylaxis (PrEP) and antiretroviral therapy (ART) adherence strategies.
- Consider moving economic strengthening from secondary to primary intervention and dedicate more resources to economic strengthening activities.
- Incorporate beneficiary feedback opportunities into and throughout services.
- Share the plan for transition of orphans and vulnerable children services in Khomas and Zambezi regions with affected regional staff.
- Introduce psychosocial support and a personal safety policy for regional and district teams.
- Make use of existing communication channels to keep relevant ministries informed about DREAMS at the national and regional levels; develop short memoranda of understanding with ministries that commit to using these channels.
- Consider more frequent communication with a representative from each sub-partner if needed to maintain positive relationships—the success of the DREAMS Namibia consortium depends on healthy partner relationships.
ACKNOWLEDGMENTS

The evaluation team wishes to acknowledge the guidance and support of USAID/Namibia colleagues Johanna Mufeti, Molisa Manyando, Dr. Abeje Zegeye, and Daniel Lee as well as GH Pro staff in Washington, DC. The team thanks respondents within the Government of the Republic of Namibia Ministries of Education, Arts and Culture; Gender Equality and Child Welfare; Health and Social Services; Safety and Security; and Youth, Sports and National Service for their contributions. The team also extends its thanks to the DREAMS Namibia consortium staff and beneficiaries who contributed their time and experience to this evaluation. A special, resounding thanks goes to Charlene Urakuamenua from Project HOPE Namibia for her outstanding assistance throughout the evaluation site visits.
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AGYW</td>
<td>Adolescent girls and young women</td>
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<tr>
<td>AMELP</td>
<td>Activity Monitoring, Evaluation, and Learning Plan</td>
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<td>ANC</td>
<td>Antenatal care</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>CATS</td>
<td>Community Adolescent Treatment Supporters</td>
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<tr>
<td>CCW</td>
<td>Community care worker</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>COP</td>
<td>Chief of party</td>
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<td>CPO</td>
<td>Child protection officer</td>
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<td>CQI</td>
<td>Continuous quality improvement</td>
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<td>CSE</td>
<td>Comprehensive sexuality education</td>
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<td>DHIS</td>
<td>District Health Information Software</td>
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<td>DMO</td>
<td>Data management officer</td>
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<td>DQA</td>
<td>Data quality assessment</td>
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<tr>
<td>DREAMS</td>
<td>Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe</td>
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<tr>
<td>eCC</td>
<td>Electronic country clearance</td>
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<tr>
<td>EQ</td>
<td>Evaluation question</td>
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<td>ES</td>
<td>Economic strengthening</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>FMP</td>
<td>Families Matter Program</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FY</td>
<td>Fiscal year</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GH Pro</td>
<td>Global Health Program Cycle Improvement Project</td>
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<td>GRN</td>
<td>Government of the Republic of Namibia</td>
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<tr>
<td>HF</td>
<td>Health facility</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HR</td>
<td>Human resources</td>
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<td>HTS</td>
<td>HIV testing services</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>IEC</td>
<td>Information, education, and communication</td>
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<td>IHI</td>
<td>IntraHealth International, Inc.</td>
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<td>IP</td>
<td>Implementing partner</td>
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<td>IR</td>
<td>Intermediate result</td>
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<td>ISME</td>
<td>Interagency Subject Matter Expert</td>
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<td>ITECH</td>
<td>International Training and Education Center for Health (University of Washington)</td>
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<td>KII</td>
<td>Key informant interview</td>
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<td>KP</td>
<td>Key population</td>
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<tr>
<td>LCN</td>
<td>LifeLine/ChildLine Namibia</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MC</td>
<td>Male champion</td>
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<tr>
<td>MFMC</td>
<td>My Future is My Choice</td>
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<tr>
<td>MoEAC</td>
<td>Ministry of Education, Arts and Culture</td>
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<tr>
<td>MGECW</td>
<td>Ministry of Gender Equality and Child Welfare</td>
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<td>MoHAI</td>
<td>Ministry of Home Affairs and Immigration</td>
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<td>MoHSS</td>
<td>Ministry of Health and Social Services</td>
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<tr>
<td>MoSS</td>
<td>Ministry of Safety and Security</td>
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<tr>
<td>MoYSNS</td>
<td>Ministry of Youth, Sports and National Service</td>
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<tr>
<td>MTCT</td>
<td>Mother-to-child-transmission</td>
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<tr>
<td>NAPPA</td>
<td>Namibia Planned Parenthood Association</td>
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<tr>
<td>NARP</td>
<td>Namibia Adherence and Retention Project</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>NUST</td>
<td>Namibia University of Science and Technology</td>
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<tr>
<td>OHA</td>
<td>Office of HIV/AIDS</td>
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<td>OGAC</td>
<td>Office of the Global AIDS Coordinator</td>
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<td>OOS</td>
<td>Out-of-school</td>
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<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<tr>
<td>PCV</td>
<td>Peace Corps Volunteer</td>
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<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
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<tr>
<td>PEPFAR</td>
<td>U.S. President's Emergency Plan for AIDS Relief</td>
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<td>PHN</td>
<td>Project HOPE Namibia</td>
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<td>PHUS</td>
<td>Project HOPE US</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
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<td>PSS</td>
<td>Psychosocial support</td>
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<tr>
<td>PY</td>
<td>Project year</td>
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<tr>
<td>S/GAC</td>
<td>U.S. Department of State/Office of the U.S. Global AIDS Coordinator</td>
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<tr>
<td>SEM</td>
<td>Social-Ecological Model</td>
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<tr>
<td>SFL</td>
<td>Star for Life</td>
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<tr>
<td>SI</td>
<td>Strategic information</td>
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<tr>
<td>SOP</td>
<td>Standard operating procedure</td>
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<tr>
<td>SP</td>
<td>Sub-partner</td>
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<td>SRH</td>
<td>Sexual and reproductive health</td>
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<tr>
<td>SS</td>
<td>Safe spaces</td>
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<tr>
<td>STEM</td>
<td>Science, technology, engineering, and math</td>
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<tr>
<td>TWG</td>
<td>Technical Working group</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>USG</td>
<td>U.S. government</td>
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<tr>
<td>VMMC</td>
<td>Voluntary medical male circumcision</td>
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<tr>
<td>VSL</td>
<td>Village Savings and Loans</td>
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<tr>
<td>WASH</td>
<td>Water, sanitation, and hygiene</td>
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<tr>
<td>WoH</td>
<td>Windows of Hope</td>
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<tr>
<td>YFS</td>
<td>Youth-friendly services (clinics for AGYW and male sexual partners)</td>
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</table>
EXECUTIVE SUMMARY

PROJECT BACKGROUND

Namibia has a high-prevalence, high-incidence, generalized human immunodeficiency virus (HIV) epidemic, with 14.8 percent prevalence among women aged 15–49 years.¹ (The 2016 Spectrum model estimates 13.3 percent among women aged 15–49 years.)

Social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, gender-based violence (GBV), and school dropout rates all contribute to girls’ risk profiles and vulnerability to contracting HIV.² The Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) initiative, funded by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), addresses these factors to help reach the UN Sustainable Development Goal of ending AIDS by 2030.

The DREAMS Namibia/Twagamenwa (which means “We are safe”) project seeks to avert and reduce new HIV infections among adolescent girls and young women (AGYW) 10–24 years old and lessen the impact of HIV on vulnerable children. Preventing HIV in AGYW means empowering them with social protection and safe spaces (SS), education and economic skills, and access to family planning (FP) and sexual and reproductive health (SRH) services. During the evaluation period, DREAMS Namibia offered a package of layered services in Oshikoto region and HIV impact mitigation services for orphans and vulnerable children in Khomas and Zambezi regions. AGYW ages 10–24 are the DREAMS project’s primary target population of interest. Male sexual partners of AGYW and household members of vulnerable children are secondary target populations.

During fiscal year (FY) 2020 budget planning, the U.S. Department of State/Office of the U.S. Global AIDS Coordinator (S/GAC) provided policy and programmatic recommendations to Namibia to consolidate aspects of the country program to individual agencies (i.e., all DREAMS assistance in Namibia to be administered by USAID), as well as program-specific recommendations to expand or contract technical assistance where necessary to achieve population-level HIV epidemic control. As a result, the DREAMS project is expected to expand its work in Khomas and Zambezi regions to include a fuller package of layered services in PY2. Awarded through PEPFAR/USAID on June 4, 2018, the project is expected to run until July 3, 2023. DREAMS is implemented by Project HOPE Namibia (PHN) in partnership with IntraHealth International Inc. (IHI), Namibia University of Science and Technology (NUST), Star for Life (SFL), LifeLine/ChildLine Namibia (LCN), and Project HOPE US.

EVALUATION PURPOSE AND EVALUATION QUESTIONS

Evaluation Purpose

- Understand the performance, capacity, and effectiveness of project start-up in meeting the intended results in one year.


• Provide specific information about project gaps and opportunities that can be acted upon by project and USAID management staff in the first 18 months of implementation.

• Identify areas that need modification/improvement to increase the likelihood of success in existing and potential new health districts.

**Evaluation Questions**

1. Since project start-up, to what extent has PHN implemented the technical approach, service delivery approach, implementation plan, outputs, and beneficiary targets included in the initial technical narrative?

2. What are the strengths and challenges of the program inputs, the implementation of interventions/activities and processes, and the quality of outputs and outcomes at each age category of AGYW?

3. What systems are in place to identify and remedy challenges to program management and structure (i.e., planning, human resources, financial, operations, and communications)?

4. What is the capacity (i.e., planning, human resources, financial, operations, and communications) of PHN and sub-partners to effectively implement the DREAMS program?

**EVALUATION DESIGN, METHODS, AND LIMITATIONS**

**Design**

Qualitative performance evaluation

**Methods**

• Document and data review of documents provided by USAID/Namibia and PHN prior to evaluation, as well as additional documents and data reports provided by PHN and DREAMS consortium sub-partners (SPs) during site visits

• Semi-structured key informant interviews at the national, regional, and district levels

• Observational visits in three regions, Oshikoto, Khomas, and Zambezi, including three districts in Oshikoto (Tsumeb, Omuthiya, and Onandjokwe)

• Focus group discussions and informal conversations with beneficiaries over 18 years of age

**Limitations**

The team was unable to secure national-level interviews with the Ministry of Youth, Sports and National Service or the Ministry of Safety and Security.

**FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS**

**Findings for Evaluation Question 1**

The technical approach is outlined in the DREAMS revised Year 1 Implementation Work Plan and refers to the Social-Ecological Model (SEM), which “links the actions of individual target sub-populations (children, adolescents, and young women) to the actions of families and communities, availability of
services, the societal norms, policies and social structures that govern them.” Theoretically, the SEM concept is in good alignment with the PEPFAR DREAMS model of layered services. Different versions of the DREAMS Namibia results framework are found in the Year 1 Implementation Work Plan, the Activity Monitoring, Evaluation, and Learning Plan (AMELP), and the evaluation Scope of Work.

Funding delays,3 changes in early US Office of the Global AIDS Coordinator (OGAC) guidance, and high targets, especially for out-of-school (OOS) young women ages 19–24, presented challenges for PHN in implementing DREAMS Namibia in FY 2019. Funding delays hampered hiring of staff, changing guidance resulted in differing results framework models, and the rush to achieve high targets compromised planning and preparation.

DREAMS is, for the most part, getting services to AGYW. Household visits and case management allow for ongoing follow-up. School-based activities are well-received by school administrators, teachers, and students enrolled in DREAMS. DREAMS nurses at youth-friendly services (YFS) clinics have created trust and had success enrolling AGYW on pre-exposure prophylaxis (PrEP). Overall, the project is well-received by ministries, schools, parents, and caregivers, health facility (HF) campuses with DREAMS YFS clinics, and community leaders.

DREAMS Namibia aligns with several Government of the Republic of Namibia (GRN) ministries’ mandates: the Ministry of Education, Arts and Culture (MoEAC)’s comprehensive sexuality education (CSE) program, the Ministry of Health and Social Service (MoHSS)’s National AGYW and HIV frameworks, and the Ministry of Gender Equality and Child Welfare (MGECW)’s mandate to support GBV victims.

DREAMS staff and GRN representatives described an intense focus on reaching targets quickly in PY1. Some GRN ministry staff expressed concern about a commitment to quantity rather than quality. The phrase “numbers rather than lives” came up more than once in interviews with GRN representatives. All ministry stakeholders (see above paragraph) interviewed at the national and regional levels expressed a strong wish to be kept better informed through existing meeting and communication channels at the national and regional levels.

Village Savings and Loans (VSL) provide an avenue for AGYW and parents/caregivers to begin to build economic resilience. However, economic strengthening (ES) needs to extend beyond VSL to job training and job opportunities to have a long-term impact on the lives of vulnerable 20- to 24-year-old AGYW. It would be useful to identify possible ES public-private partnerships and interventions and that lead to job training and opportunities across the five DREAMS districts. A research opportunity exists to compare outcomes of various ES strategies.

**Findings for Evaluation Question 2**

The project has recruited dedicated, passionate staff. Overall, technical staff demonstrate competencies in their areas. District teams appear to be working well together, especially the school-based teams and YFS nurses with both school-based teams and male champions (MCs). All nurses have been recently trained on PrEP. (The evaluation team did not learn whether nurses are certified for HIV testing services.) More social workers are being hired, which is expected to strengthen support for community care workers and child protection officers.

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3 A cooperative agreement was signed in June 2018 but funding was not received until October 2018.
Some staff reported regularly working overtime hours and suggested that salaries do not adequately compensate for this. Field staff identified a need for additional training and suggested that district teams could receive group refresher trainings to ensure consistency in their knowledge. Field staff who deal with difficult situations such as child rape as part of gender-based violence (GBV) case identification identified a need for psychosocial support (PSS) to help them cope with the traumas they hear about and witness. Staff also identified their own vulnerabilities when traveling to homes where GBV incidents have occurred or to remote areas.

Sub-partners (SPs) appear to be well-chosen to carry out DREAMS activities, with demonstrated experience, technical capacity, and good longstanding relationships with government ministries. At the district level, staff from the various SPs are working well as a team. There are promising anecdotal reports that DREAMS is improving quality of life for beneficiaries, both DREAMS girls and parents/caregivers.

Training curricula used by DREAMS are well-received by 10- to 14-year-olds, 15- to 19-year-olds, 20- to 24-year-olds, and parents/caregivers. Families Matter Program (FMP) materials have been translated into some local languages in the Oshikoto region, but workbooks given to parents in particular need to be translated into additional local languages for parents to be able to use them without assistance. Reportedly, PrEP has been introduced into the My Future is My Choice curriculum for 15- to 19-year-olds by Peace Corps Volunteers. It is not yet a part of the FMP curriculum, though reportedly it has been included in a revised manual to be used in near future; it is not considered age-appropriate for the 10–14-year-old Windows of Hope curriculum.

Gauging client satisfaction is a useful strategy for helping to measure quality of services. As yet, no opportunities for beneficiary feedback have been included in the DREAMS Namibia model.

**Findings for Evaluation Question 3**

PHN’s Implementation Work Plan for FY 2019, an information booklet that provides a detailed project overview, and the AMELP, which describes in detail what data is to be collected and how it will be managed, analyzed, and reported, together reflect a good understanding of expectations and requirements for project implementation. Staff reported a need for long-term planning that goes beyond responding to challenges as they arise.

PHN has been adjusting staffing hires through PY1 to get the right balance of staff cadres, most recently hiring MCs to conduct outreach to male sexual partners of AGYW as well as additional qualified social workers, and enlisting community mobilizers to conduct household outreach to find and recruit OOS AGYW. At the time of this report’s development, PHN had hired an impressive 199 staff persons for DREAMS and will continue to hire staff as project activities in Khomas and Zambezi regions are transitioned.

Although the DREAMS strategic information (SI) advisor position is vacant, there is a strong monitoring and evaluation (M&E) team at the national level and strong commitment among SPs at the regional/district levels to ensure M&E system performance. There is a need to strengthen M&E coordination at the district level. For example, M&E officers in regional/district offices are IHI staff; other data staff belong to PHN. The data management officer has oversight for PHN data only, and the regional M&E staff person is responsible only for IHI clinical data. Some SPs have their own DREAMS databases and there are no linkages among different databases to ensure data consistency. Communication can be improved so that all M&E staff have a full picture of how data is being managed.
PHN plans to shift from REDCap to District Health Information Software 2 (DHIS2) in PY2. The plan is reportedly to incorporate all partners into this system and migrate historic data onto the new platform by the end of PY1, which seems ambitious. Currently the only data shared with GRN is clinical data collected by IHI at YFS clinics, where MoHSS registers are used.

The national AGYW Technical Working Group has not served as an adequate platform for DREAMS planning and information-sharing as expected. Government structures in place for HIV prevention from district to national level have not yet been well-engaged for DREAMS communication.

In July 2019, PHN adopted a USAID-endorsed continuous quality improvement (CQI). This tool will be used to develop both operational and program-related quality indicators and should help PHN define and measure operations capacity. The district-level external stakeholder engagement strategies being developed under the CQI initiative can help to link DREAMS activities with government structures, especially at the regional level.

Findings for Evaluation Question 4

Filling vacant DREAMS managerial positions is an urgent priority and should make a notable difference in terms of PHN’s capacity to effectively plan and implement DREAMS activities. Technical capacity is strong overall. (USAID informed the evaluators that the chief of party (COP) position has been filled since the report was drafted.)

Not sharing the transition plan to absorb new beneficiaries and some staff from the International Training and Education Center for Health (ITECH) in Khomas and Zambezi regions with field staff has created anxiety among affected staff. In some instances, the need for rapid hires has resulted in a “lower starting capacity” for some field staff, which could affect quality-of-service provision and how DREAMS is perceived. Overall, though, staff capacity is positively perceived.

Opportunities to strengthen communications with ministries, SPs, and regional/district staff have been identified. One good practice is the participation of DREAMS staff in district-level child care and protection fora and “A Team” meetings for MoHSS and MGECW social workers.

Cross-Cutting Findings

Evaluation respondents unanimously requested to find ways to include boys in DREAMS. Opportunities exist to emphasize key messages about how boys can protect themselves as well as their sexual partners from HIV through whole-class sessions, and these should be strategically used to full advantage. There are also opportunities in FMP trainings to prepare parents to talk with both female and male children about SRH. Information, education, and communication (IEC) materials like Engender Health’s Men As Partners (MAP) training materials⁴ offer boys relevant messages and visuals. These activities can occur without diverting resources away from AGYW.

Some GRN stakeholders have expressed concern about the sustainability of the DREAMS Namibia project, especially with regard to providing commodities and support to AGYW and families (i.e., transportation, stationery, school uniforms, sanitary pads, and an emergency cash fund). However, they expressed their overall satisfaction and appreciation for the positive differences DREAMS Namibia is making in the lives of AGYW and their families.

Conclusions

Overarching

- Funding delays,\(^5\) changes in early OGAC guidance, and high targets—especially for OOS AGYW, which OGAC reportedly now acknowledges were set too high and has agreed to modify\(^6\)—have created challenges for PHN in implementing DREAMS Namibia in PY1.

- Nonetheless, PHN and its consortium SPs have been adaptive and responsive to early learning, making adjustments across all areas as project implementation has evolved.

- Project stakeholders and beneficiaries have been overwhelmingly positive about the project’s benefit to the communities it serves.

Technical Approach

- The technical and service delivery approaches are not harmonized in relevant documents—the Year 1 Implementation Work Plan, the AMELP, and the evaluation Scope of Work.

Service Delivery

- An identified good practice that shifts DREAMS services from health facilities to communities is provision of PrEP refills in communities so AGYW do not have to come back to clinic.

- PrEP and antiretroviral therapy (ART) adherence are challenge areas for AGYW: patients do not always understand how to take PrEP correctly or find it difficult to return to YFS clinics for refills, and some are reluctant to remain on PrEP since the pills look like ART.

- Some at-risk AGYW and male sexual partners are not yet served.

Implementation

- VSL provides an avenue for AGYW and parents/caregivers to begin to build economic resilience, but ES needs to extend beyond VSL to job training and job opportunities to have a long-term impact on the lives of vulnerable 20- to 24-year-old AGYW.

- The voices of AGYW beneficiaries are not yet heard in DREAMS project planning, implementation, and reporting. A key aspect of empowering AGYW is preparing them to lead and to be heard.

Planning/Operations

- There is high anxiety among DREAMS staff in Khomas and Zambezi about the transition from ITECH to PHN’s full package of services. Sharing the transition plan with affected staff is urgently needed.

- The CQI tool introduced mid-year in PY1 should help to strengthen nascent planning/operations systems and better measure their effectiveness and quality over the life of the project. Measures developed through this tool will help to provide structure for the project’s midterm review.

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\(^5\) A cooperative agreement was signed in June 2018 but funding was not received until October 2018.

\(^6\) PHN shared this information during out-brief with the evaluation team.
Human Resources

- Filling vacant key personnel positions such as COP and SI advisor in the PHN DREAMS organizational chart is an urgent priority and should make a notable difference in terms of PHN’s capacity to effectively plan and implement DREAMS activities. (Per USAID, the COP position has now been filled.)

- District staff identify urgent needs for PSS and personal safety assurance.

- Staff also identify additional training needs; there is opportunity for brief “whole team” trainings to help ensure that various staff cadres have a consistent fundamental understanding of DREAMS, the various staff roles and services, and how all the pieces fit together.

Communications

- The success of the layered services model depends on positive and transparent communication and collaboration between consortium partners providing the packages of services.

- Ministries request regular communication related to DREAMS at all levels.

- Government structures and communication channels in place for HIV prevention from district to national level are not yet fully utilized for DREAMS communication and information-sharing. The new district-level external stakeholder engagement strategies being developed under the CQI initiative can help link DREAMS activities with these structures.

Cross-Cutting

- Opportunities exist within DREAMS activities to emphasize key messages about how boys can protect themselves as well as their sexual partners from HIV risk without diverting emphasis or resources away from AGYW.

- Good practices exist across other DREAMS countries that DREAMS Namibia can benefit from. USAID can help to bring this information to the DREAMS consortium.

Recommendations (Eight Priority Recommendations are bolded)

Technical Approach

- Harmonize the technical approach, service delivery package (layering table), and results framework in all key documents, and orient all staff on the most current models.

Service Delivery

- **Strengthen community-based PrEP and ART adherence strategies.**
  - Explore adherence support models from other DREAMS countries and adherence support groups on WhatsApp as possible strategies. (DREAMS South Africa uses WhatsApp.)
  - Consider putting PrEP in discrete, opaque packaging.
  - Develop brief aids for staff (e.g., community care workers/MCs) and beneficiaries to ensure that all parties understand what PrEP retention requires.
  - Ensure that PrEP and ART adherence and retention messages are harmonized across training curricula where age-appropriate, including messages for correct use and retention.
• Explore cost-effective ways to bring more DREAMS services into communities (e.g., community-based PrEP initiation as well as refills, rapid oral fluid tests, and starter packs), linking with health extension workers where possible for outreach.

• Develop referrals and linkages to projects and organizations that serve AGYW not yet being reached by DREAMS, including AGYW with disabilities.

• Consider the implications of MoEAC’s new inclusive education policy on future requirements for DREAMS in-school staff. When other recommendations have been addressed, begin to explore ways to serve AGYW with disabilities in PY3. Consider a possible SP that can address AGYW with special needs.

Implementation

• Consider moving economic strengthening from a secondary to a primary intervention and dedicate more financial and human resources to ES activities. Incorporate strategies that directly link older AGYW with job training and opportunities. Search for ES public-private partnerships in the five districts.
  o Consider a research partner to compare outcomes of various ES strategies if funding allows.
  o Consider proxy indicators that would help to demonstrate how vulnerable older AGYW and vulnerable households have been empowered and made less vulnerable (e.g., number of older AGYW linked with job training, internships, or jobs; number of participating households living above Namibia’s poverty level when they transition out of DREAMS).
  o Consider supporting caregivers to receive disability and old-age pensions, perhaps linked with OVC home visits, and perhaps after the Khomas and Zambezi region transitions have been completed (perhaps in PY3).

• Incorporate beneficiary feedback opportunities into and throughout services—include AGYW voices!

Planning/Operations

• Share the written OVC services transition plan in Khomas and Zambezi regions with relevant staff.

• Systemize planning at the district level for each layered service (e.g., school schedules, MC schedules, transportation priorities and schedules, supply re-ordering schedule).

• Make full use of the CQI tool in all DREAMS districts.

Human Resources

• Introduce psychosocial support (PSS) for regional/district teams. Consider expanding the Star for Life support model for whole district teams or engaging certified psychologists or experienced social workers to provide regularly scheduled support (perhaps linked with staff meetings).

• Introduce a personal safety policy for field teams that addresses traveling in pairs, navigating unsafe communities, conflict management, and safety protocols for home visits, especially related to GBV cases.
When the COP position has been filled and more resources are available for HR functions:
  • Develop a short, generalized training for district staff teams.
  • Review supervisory relationships to ensure that all field staff are receiving supervision from the staff best qualified to oversee their unique roles and tasks.
  • Ensure that job descriptions exist for all positions; review all job descriptions to ensure they match the tasks actually being performed and are as consistent as possible (e.g., for data/M&E positions).
  • Set clear parameters for all staff roles (e.g., overtime policy, transportation support).
  • Where possible, put longer-term contracts in place and implement staff performance reviews.

Communications

• Make time-efficient use of existing communication channels to keep relevant ministries informed about DREAMS at the national and regional levels and develop short memoranda of understanding with relevant ministries that commit to using these communication channels.

• Consider more frequent communication (between quarterly review meetings) with a representative from each SP if needed to maintain positive relationships—the success of the DREAMS Namibia consortium depends on healthy partner relationships.

• Put bidirectional communication processes in place between PHN national and district/regional offices so that staff queries receive timely responses.

Cross-Cutting

• Engage district CQI teams in strategic planning for how to maximally include boys in DREAMS activities and messaging already underway, without diverting financial resources or primary attention from AGYW.

• Look for opportunities to learn from the implementation of the DREAMS model across other Southern African Development Community (SADC) countries. This could include review of management best practices; how to move services away from a health facilities focus and into communities; how to retain DREAMS AGYW on ART and PrEP; and how to link older AGYW with successful ES opportunities. OGAC, the Interagency Subject Matter Expert, and/or USAID can play a role in facilitating these opportunities.
I. INTRODUCTION

EVALUATION PURPOSE

The purpose of this performance evaluation on the Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) project is to:

- Understand the performance, capacity, and effectiveness of project start-up in meeting the intended results in one year.
- Provide specific information about project gaps and opportunities that can be acted upon by project and USAID management staff in the first 18 months of implementation.
- Identify areas that need modification/improvement to increase the likelihood of success in existing and potential new health districts.

EVALUATION QUESTIONS

1. Since project start-up, to what extent has Project HOPE Namibia (PHN) implemented the technical approach, service delivery approach, implementation plan, outputs, and beneficiary targets included in the initial technical narrative?

2. What are the strengths and challenges of the program inputs, the implementation of interventions/activities and processes, and the quality of outputs and outcomes at each age category of adolescent girls and young women (AGYW)?

3. What systems are in place to identify and remedy challenges to program management and structure (i.e., planning, human resources, financial, operations, and communications)?

4. What is the capacity (i.e., planning, human resources, financial, operations, and communications) of PHN and sub-partners (SPs) to effectively implement the DREAMS program?
II. PROJECT BACKGROUND

Namibia has a high-prevalence, high-incidence, generalized human immunodeficiency virus (HIV) epidemic, with 14.8 percent prevalence among women aged 15–49 years.7 (The 2016 Spectrum model estimates 13.3 percent among women aged 15–49 years.)

While HIV prevalence in Namibia is among the highest worldwide, overall the country is making remarkable strides toward the 95/95/95 goals.8 By December 2017, an estimated 86 percent of people living with HIV (PLHIV) were diagnosed, 96.4 percent of those diagnosed were on antiretroviral therapy (ART), and an estimated 91.3 percent of all PLHIV in treatment had suppressed viral load.9

Namibia’s epidemic has created large numbers of children growing up without adult protection, nurturing, or financial support. Among the 150,589 orphans and vulnerable children (OVC) identified by the 2011 Census,10 an estimated 33 percent (50,000) are HIV-affected. The study by the United Nations Children’s Fund (UNICEF) study on out-of-school children found that one in five children of school-going age is not in school and another 15 percent are at risk of dropping out.11

Social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, gender-based violence (GBV), and school dropout rates all contribute to girls’ risk profiles and vulnerability to contracting HIV.12 The DREAMS initiative, funded by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), addresses these factors to help reach the UN Sustainable Development Goal of ending AIDS by 2030.

The USAID DREAMS program in Namibia is a five-year cooperative agreement with a $20 million ceiling under award number 72067318CA00002. The DREAMS Namibia/Twagamenwa (meaning “We are safe”) project seeks to avert and reduce new HIV infections among AGYW 10–24 years old and lessen the impact of HIV on vulnerable children. Preventing HIV in AGYW means empowering them with social protection and safe spaces (SS), education and economic skills, and access to family planning (FP) and sexual and reproductive health (SRH) services. During the evaluation period, DREAMS Namibia offered a package of layered services in Oshikoto region and HIV impact mitigation services for OVC in Khomas and Zambezi regions. AGYW ages 10–24 are the primary target population of interest. Male sexual partners of AGYW and household members of vulnerable children are secondary target populations.

During FY 2020 budget planning, the U.S. Department of State/Office of the U.S. Global AIDS Coordinator (S/GAC) provided policy and programmatic recommendations to Namibia to consolidate aspects of the country program to individual agencies (i.e., all DREAMS assistance in Namibia to be administered by USAID), as well as program-specific recommendations to expand or contract technical assistance where necessary to achieve population-level HIV epidemic control. As a result, the DREAMS project is expected to expand its work in Khomas and Zambezi regions to include a fuller package of

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7 NAMPHIA 2017.
8 “Fast Track: Ending the AIDS epidemic by 2030,” released by the Joint United Nations Programme on HIV/AIDS (UNAIDS) on November 18, 2014, calls for 95 percent of people living with HIV to know their HIV status; 95 percent of people who know their status to be on treatment; and 95 percent of people on treatment to have suppressed viral loads.
9 NAMPHIA 2017.
layered services in FY2. Awarded through PEPFAR/USAID on June 4, 2018, the project is expected to run until July 3, 2023. DREAMS is implemented by PHN in partnership with IntraHealth International Inc. (IHI), Namibia University of Science and Technology (NUST), Star for Life (SFL), LifeLine/ChildLine Namibia (LCN), and Project HOPE US (PHUS).
III. EVALUATION METHODS AND LIMITATIONS

METHODOLOGY

Document and Data Review: The evaluation team reviewed documents provided by USAID/Namibia and Project HOPE Namibia (PHN) prior to travel to the country, as well as additional documents gathered by the team and provided by PHN and DREAMS consortium sub-partners (SPs) during site visits. The team reviewed quarterly reports, the project’s Activity Monitoring, Evaluation, and Learning Plan (AMELP), an information booklet that lays out the project’s overall technical approach and the roles of consortium partners, a formative baseline assessment, and, during site visits, various program data reports, screening tools, beneficiary booklets, and other records. The team also looked at training curricula used by the project but did not review them in-depth, as they are endorsed by U.S. government Interagency Subject Matter Experts (ISMEs) that oversee DREAMS in Namibia and the Office of the Global AIDS Coordinator (OGAC).

Semi-Structured Key Informant Interviews (KIIs): The team conducted individual and group interviews at the national, regional, and district levels. At the national and regional levels, interviews were conducted with:

- U.S. government (USG)—U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), Centers for Disease Control and Prevention (CDC), and USAID staff
- Government of the Republic of Namibia (GRN) ministries—Education, Arts and Culture (MoEAC); Gender Equality and Child Welfare (MGECW); Health and Social Services (MoHSS); Safety and Security (MoSS); and Youth, Sports and National Service (MoYSNS)—at the national and/or regional levels, not always both.
- DREAMS consortium implementing partner (IP) managerial and technical staff
- International Training and Education Center for Health (ITECH) DREAMS coordinator (funded by CDC)
- External stakeholders working with marginalized and key populations

At the district level, interviews were carried out with:

- School administrators and teachers
- Various ministry representatives, as above
- DREAMS consortium field staff

See Annex VI for a complete list of interview respondents.

Observational Visits in Three Regions—Oshikoto, Khomas, and Zambezi—including Three Districts in Oshikoto (Tsumeb, Omuthiya, and Onandjokwe): The team visited various DREAMS activities and services—in-school safe space (SS) activities for 10–14 and 15–19 year-olds during Windows of Hope (WoH) and My Future is My Choice (MFMC) trainings; out-of-school (OOS) SS for 20–24 year-olds including Village Savings and Loans (VSL) activities for one group; Families Matter...
Program (FMP) trainings; VSL meetings for parents/caregivers; and youth-friendly services (YFS) clinics to observe how they fit within the larger MoHSS health facility (HF) structures and ascertain levels of patient comfort and confidentiality.

**Focus Group Discussions (FGDs) with Beneficiaries over 18 Years of Age:** Informal discussions were conducted with OOS AGYW and parents/caregivers where possible during observational visits to SS FMP trainings and VSL meetings. The full schedule, coupled with the evaluation team's wish not to interrupt activities, made conducting lengthier FGD conversations impossible.

The team triangulated quantitative data from PHN quarterly reports with qualitative field data to conduct a descriptive and thematic analysis of quantitative and qualitative data.

**ETHICAL CONSIDERATIONS**

In accordance with USG guidance, no OVC or AGYW under 18 years of age were interviewed during this evaluation. In accordance with USG human subjects guidance, KII respondents were informed of the evaluation purpose and of their rights related to participation and provided informed consent.

**LIMITATIONS**

The evaluation team was unable to determine which of three result matrix tables with varying intermediate results (IRs)—located in the project's AMELP, revised Year 1 Work Plan, and evaluation Scope of Work (SOW)—was the most current, and was therefore unable to match project key strengths and accomplishments to the IRs as envisioned. PHN clarified during the out-brief that various revisions to the results matrix reflected changes in early guidance from OGAC and that the matrix included in the evaluation SOW is the most recent. PHN also emphasized that the layered services table is a living document that continues to evolve as it undergoes review by the ISMEs (comprised of the CDC DREAMS focal person, the PEPFAR DREAMS coordinator, and USAID/Namibia representatives).

The team was unable to secure interviews with MoYSNS and MoSS at the national level but was able to reach representatives at the regional level.

Thanks to PHN's strong support scheduling site visits, evaluators believe they were able to observe an accurate picture of how DREAMS Namibia is currently being implemented.
IV. FINDINGS

The quarterly reports submitted by PHN contain detailed information about how well PEPFAR DREAMS indicator targets have been met. This evaluation report looks beyond the numbers to ascertain where project implementation has been most successful and why, where gaps and challenges remain, and what actions can best strengthen the project’s effectiveness going forward.

EVALUATION QUESTION 1. SINCE PROJECT START-UP, TO WHAT EXTENT HAS PHN IMPLEMENTED THE TECHNICAL APPROACH, SERVICE DELIVERY APPROACH, IMPLEMENTATION PLAN, OUTPUTS, AND BENEFICIARY TARGETS INCLUDED IN THE INITIAL TECHNICAL NARRATIVE?

TECHNICAL APPROACH

The technical approach outlined in the DREAMS revised Year 1 Implementation Work Plan refers to the Social-Ecological Model (SEM), which “links the actions of individual target sub-populations (children, adolescents, and young women) to the actions of families and communities, availability of services, the societal norms, policies and social structures that govern them.” The center of the model is the child with concentric circles showing the different layers that surround a child’s development. These circles include household/caregiver, community, and systems.13

Successes: Theoretically the SEM concept is in alignment with the PEPFAR DREAMS model of layered services (see Annex II for the Namibia minimum package of layered services). Evaluation respondents were familiar with the layering table’s primary, secondary, and contextual interventions.

Challenges: No one the team met during field visits made reference to the SEM. The team is unsure if this technical approach is still followed. There is a lack of harmonization across documents with the layering table as well, a result of changing guidance and evolving development of the table early in the project. The AMELP listed different interventions than the revised Year 1 Work Plan. And boys’ clubs are listed as a program in the SEM figure, whereas in the layered services table the contextual intervention “male engagement” has been implemented for potential male sexual partners of AGYW.

SERVICE DELIVERY APPROACH

Evaluators reviewed the revised Year 1 Work Plan and the results framework therein. The service delivery approach includes strategies for households, communities, schools, and health facilities (see Table 1). The evaluation team’s understanding is that the original DREAMS concept focused more on health facilities–based services such as adolescent friendly services, which would match PEPFAR clinical indicators; however, staff and AGYW beneficiaries reported that DREAMS seems to work better when services are taken to where the girls are located, especially given transportation challenges and perceived or experienced stigma and discrimination at government HFIs toward sexually active AGYW.

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13 Year 1 Implementation Work Plan, revised version, June 4, 2018 to September 30, 2019, p. 8.
Table 1. Service delivery approaches and interventions

<table>
<thead>
<tr>
<th>Service delivery approach</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households</td>
<td>Orphans and vulnerable children (OVC) services, including initial eligibility screening, support for national documents, psychosocial support (PSS), and water, sanitation, and hygiene (WASH); out-of-school (OOS) door-to-door outreach, gender-based violence (GBV) case home visits, case management</td>
</tr>
<tr>
<td>Communities</td>
<td>FMP/VSL, Male Champions outreach, community mobilization for OOS AGYW recruitment, OOS SS, care facilitators doing WASH (Tippy Taps); mobile outreach services that may include education, clinical services, and case management/follow-up services</td>
</tr>
<tr>
<td>Schools</td>
<td>Coaching; science, technology, engineering, and math (STEM) tutoring/mentoring and trunk libraries; SS; health services delivered to the SS sites; PSS for learners; referrals</td>
</tr>
<tr>
<td>Health facilities</td>
<td>Family planning (FP); HIV testing services; antiretroviral therapy (ART) initiation; pre-exposure prophylaxis (PrEP) initiation, care, and case management; counseling; primary health care; GBV screening; voluntary medical male circumcision (VMMC) referrals; antenatal care (ANC); well-child care/immunizations</td>
</tr>
</tbody>
</table>

**Successes:** DREAMS is, for the most part, providing services to AGYW. Each approach is well-received by beneficiaries. Household visits and case management allow for ongoing follow-up. School-based activities are well-received by school administrators, teachers, and students enrolled in DREAMS. AGYW seem to use YFS clinics primarily for SRH, family planning (FP), and antenatal care (ANC). AGYW also test for HIV and enroll on pre-exposure prophylaxis (PrEP) or antiretroviral therapy (ART). AGYW beneficiaries reported that other AGYW often feel reticent to come to these clinics. The DREAMS and youth-friendly nurses have created trust and good relationships and have had success enrolling AGYW on PrEP.

For OOS AGYW, home, community, and HF-based services are appropriate. The team spoke with beneficiaries who appreciated these service delivery approaches and also shared their challenges in accessing HF-based clinics.

**Challenges:** The team found three different results frameworks in the AMELP (p. 9), the revised Year 1 Work Plan (p. 7), and the GH Pro evaluation Scope of Work (p. 7). Both PHN and USAID confirmed during out-briefs that the GH Pro SOW contains the original results framework. PHN clarified during the out-brief that changing guidance from OGAC during project start-up necessitated these revisions to the results framework.

The PY1 service delivery approach has focused intensively on in-school youth; PHN reported having received informal guidance (perhaps from OGAC) to focus heavily on reaching targets for the 10- to 14-year age group because enrolling school-based youth might prove easier than out-of-school youth. And in fact, field staff did report difficulties reaching OOS AGYW and maintaining their use of services.

**IMPLEMENTATION APPROACH**

Overall, the DREAMS Namibia project is well-received by ministries, schools, parents, and caregivers, HF campuses with DREAMS YFS clinics, and community leaders. DREAMS Namibia aligns with several ministries’ mandates, including MoEAC’s comprehensive sexuality education (CSE) program, MoHSS’s
National AGYW and HIV frameworks, and MGECW’s mandate to support GBV victims. DREAMS fills important gaps in the country, as MGECW has no government-funded programs targeted for AGYW and MoHSS funding is limited to a Global Fund grant with a limited geographic focus.

However, all ministry stakeholders interviewed at national and regional levels with the exception of regional MoEAC respondents expressed the belief that PHN has not communicated well with them about DREAMS Namibia, and expressed a strong wish to be kept better informed through existing meeting and communication channels at national and regional levels.

DREAMS staff and GRN representatives described an intense focus on reaching targets quickly in PY1. Some GRN ministry staff expressed concern about a commitment to quantity rather than quality. The phrase “numbers rather than lives” came up more than once in interviews with GRN representatives.

**Identifying, Screening, Recruitment, and Retention**

In Khomas/Zambezi regions, ITECH is still responsible for identifying eligible AGYW and refers OVC beneficiaries to PHN. In Oshikoto, where the full package of services is implemented by PHN and DREAMS consortium partners, AGYW are identified through schools, HFs (with the help of community leaders), and more recently by community mobilizers. Community leaders also help identify men to participate in male sexual partner engagement activities.

The DREAMS bioID allows the project to track which beneficiary receives which interventions. The project does not follow enrolled girls as a cohort or longitudinally. Field staff reported high retention with in-school SS, with retention in OOS SS proving more difficult due to distances from beneficiaries’ homes, childcare constraints, and work schedules. The introduction of the VSL activities and childcare has improved retention in OOS SS.

**Successes:** DREAMS staff have established good relationships with community leaders, schoolteachers and administration officials, district and regional ministries, and HF staff.

FY 2019 Q3 data indicates that 66 percent (11,277/17,020) of AGYW screened were eligible and that 100 percent of those eligible were enrolled. By end of Q3, the highest number of AGYW who completed at least one primary service were among the 15–19 age group (n=5,611) followed by 10–14 (n=4,491). The 20–24 age group had the lowest number of AGYW who completed at least one primary service (n=1,175).14

DREAMS Namibia has focused on reaching in-school youth in FY 2019 to more quickly reach PP_PREV15 targets. PHN staff owed the doubling of PP_PREV results from Q2 to Q3 to intensified efforts to enroll in-school youth. Ages 10–14 appear to be the group most successfully reached, with 423 percent of the PP_PREV targets achieved. Though DREAMS has not fully reached its high targets for ages 15–19, the absolute number is higher than for the 10–14 age group.16 (See Annex IV for a complete list of PEPFAR indicators reported on by DREAMS Namibia.)

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15 PP_PREV is the number of priority populations (PP) reached with the required standardized, evidence-based intervention(s) designed to promote the adoption of HIV prevention behaviors and service uptake. (See Annex IV for PEPFAR indicators reported on by DREAMS Namibia.)
Challenges: Field staff in more than one district reported confusion on how to use the screening tools and which tools to use. Community care workers (CCWs) and data entry, data management, and monitoring and evaluation (M&E) staff reported insufficient training to use screening tools properly. Teams were not trained together. Some CCWs reported an added challenge of language ability: the tools are primarily written in English, and sometimes CCWs need assistance filling out the screening tool. There are cases of AGYW students correcting a CCW when the CCW marked an incorrect answer on the screening tool. These language and training challenges point to an underlying issue of data quality; missing data is easier to spot than incorrect data.

Beneficiaries screened as ineligible are not retained in the data management system. The girls who are immediately found to be eligible are entered into REDCap software, but there seems to be no system for retaining the ineligible ones who might be rescreened at a later time. During the out-brief, the PHN M&E team noted this as a concern they have already identified and are addressing.

For the OVC program in Zambezi and Khomas, more referrals have been received from ITECH than PHN staff can handle. In Khomas, about 50 percent of referrals received had been screened for eligibility. Less than 1 percent had been found ineligible in Khomas, though in Zambezi the proportion of ineligible participants for the OVC program was higher. In Zambezi, 24 additional CCW volunteers\(^{17}\) were recruited to support the paid staff given the high numbers of AGYW waiting for OVC eligibility confirmation.

According to KIIs with Zambezi PHN DREAMS staff, many OVC living in Zambezi have immigrated from bordering countries and often do not have national documents. Many OVC born in Namibia also do not have birth certificates. Lack of identification documents means that these OVC do not qualify for services like social grants or school uniforms.

For all districts, field staff identified a challenge of insufficient or incorrect contact information to enable follow-up with eligible beneficiaries after screening. This challenge may relate to the high mobility of AGYW, the lack of a dedicated phone or access to a phone, and/or information incorrectly entered.

OOS AGYW presented the most challenges in terms of identification, screening, recruitment, and retention. Finding them has required support from councilors and other leaders. Community-wide events were initially hosted, but older AGYW reached in this way were difficult to retain. This challenge was mitigated by focusing on smaller group SS in communities or central locations. OOS beneficiaries reported having to walk long distances to get to SS or YFS clinics, and staff reported difficulties in providing follow-up visits to AGYW who live in more rural or peri-urban areas.

**PRIMARY INTERVENTIONS**

**HIV Risk Assessments, HIV Testing, and ART and PrEP Referrals**

Successes: DREAMS Namibia is in alignment with the MoHSS test and treat policy. PHN reported high linkages to HIV testing and referrals to PrEP and ART (where eligible). By the end of FY 2019 Q3, 15,584 AGYW had attended a PP_PREV session, all were assessed for HIV risk, and 25 percent (3,963/15,584) were found to be at high risk for HIV and referred for HIV testing. Approximately 74 percent of these high risk AGYW tested for HIV, 24 were found to be HIV-positive, and 20 started treatment (83 percent). The majority of HIV case findings are among AGYW ages 20–24; this finding is

\(^{17}\) Evaluators saw no guidelines for volunteers as opposed to paid staff.
in alignment with national HIV prevalence data.\textsuperscript{18} PrEP\_NEW achievement is high at 92 percent of targets (616/667).\textsuperscript{19} Beneficiaries and staff reported that AGYW are interested in PrEP because their friends are taking it and it is something new. As one regional MoHSS respondent said, “DREAMS brought PrEP to Namibia.”

**Challenges:** PrEP retention remains a challenge for AGYW.\textsuperscript{20} Beneficiaries reported that partners and friends do not believe they are HIV-negative because the pills look like antiretrovirals (ARVs) and refute the idea that there is a pill that can prevent HIV. Refills have historically required a clinical visit, though this has been mitigated through community-based PrEP refills. Nurses reported that not all AGYW on PrEP have been properly informed on how to take it. For example, some AGYW thought that if they took PrEP for 20 days they would always be protected; they did not understand that PrEP effectiveness begins after 20 days and must be taken continuously thereafter. PHN confirmed during the out-brief that they are continuing to provide PrEP refills in communities to support retention.

ART retention remains a challenge among 15- to 19-year-old AGYW. Some reportedly do not know why they are taking medication and may not know they are HIV-positive. More adherence support is needed for AGYW on ART. Good practices exist in other DREAMS countries: in Zimbabwe’s Zandiri program, Community Adolescent Treatment Supporters (CATS) program, trained 18- to 24-year-old peer counselors provide adherence and psychosocial support to children and teens on ART who live in the same community. This model has worked well within a protective environment and with limited visibility of adolescent volunteers. The model has been highlighted by PEPFAR as a good practice.\textsuperscript{21}

**OVC Services in Khomas, Zambezi, and Oshikoto**

OVC have received full packages of DREAMS services in Oshikoto region and abbreviated services in Khomas and Zambezi. As DREAMS transitions from ITECH to PHN, Khomas and Zambezi will eventually implement the full-service package for AGYW, including PP\_PREV indicators. A transition plan has reportedly been in place since July 10, 2019 and is being discussed during weekly meetings of the DREAMS Re-alignment Committee, which includes both PHN and ITECH. However, field staff in both regions are not aware of this plan, what it includes, or what it implies for their future employment.

**Successes:** DREAMS OVC support complements and enhances the MGECW OVC service support; ministry social workers at the regional level expressed appreciation for DREAMS support with their large caseloads in all three regions. DREAMS CCWs and child protection officers (CPOs) handle PSS,

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\textsuperscript{18} NAMPHIA 2017.
\textsuperscript{19} PHN FY 2019 Q3 report. PrEP\_NEW is the number of individuals who have been newly enrolled on ARV pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period. (See Annex IV for PEPFAR indicators reported on by DREAMS Namibia.)
\textsuperscript{20} Stakeholders reported that some health providers are reluctant to prescribe or resupply PrEP to AGYW and some nurses scold the girls because they are on PrEP and accuse them of being sex workers. Some AGYW have reported being turned away from the MoHSS clinic because they are young girls on PrEP. Khomas HFs are described as not adolescent-friendly. The I-TECH DREAMS project emphasized that community-based PrEP refills are the best way to ensure that AGYW are retained on PrEP, and PHN reports that it has taken up this practice.
case management, and follow-up while MGECW social workers address the statutory requirements, especially for GBV. Adherence support for OVC in Zambezi and Khomas seems to work well, because OVC are the sole focus of the program.22

**Challenges:** OVC in Oshikoto region were not receiving services every quarter as there was a misunderstanding from staff on what services to provide and when. The staff was also focusing on the PP_PREV indicator and achieving those targets as a priority. Misunderstandings have been addressed.

**GBV Screening**

GBV screening is part of the initial screening all AGYW receive to determine eligibility into the program. GBV cases are followed up on by DREAMS CPOs.

**Successes:** The DREAMS program is identifying GBV cases through eligibility screening, although most cases are beyond the 120-hour cutoff for the GEN_GBV indicators as reported to PEPFAR.23 A handful of more recent cases have been caught through the DREAMS screening, and CPOs have provided support for those cases. DREAMS CPOs have been well integrated into the GBV units at district hospitals, and representatives in different regions appreciate the support the CPOs provide. CPOs are also well-integrated with police units and support the case management process with all stakeholders.

**Challenges:** CPOs are responsible for follow-up home visits, even if perpetrators are still in the home with the AGYW. This places staff at potential risk and emphasizes the need for a personal safety policy for field staff. Staff also reported the urgent need for additional PSS for themselves when they are dealing with cases of child rape.

Most GBV cases are identified beyond the 120-hour limit and have not been able to be reported against targets. GBV units expressed frustration with what they perceive as an “artificial” age cutoff that does not capture most cases. PHN reported during the out-brief that this was discussed during the OGAC visit that coincided with this evaluation, and that agreement was reached to report older cases.

**Opportunity:** PHN may wish to explore the reasons for delays in reporting GBV incidents and seeking care. It might be straightforward to add a few questions to the screening form that identifies specific reasons why AGYW who experience GBV hesitate to report.

**In-School Programs**

In-school programs are the backbone of DREAMS programming in Namibia. This is where DREAMS partners work together closely: coaches (Star for Life), STEM tutors (NUST), CPOs, and CCWs (PHN).

**Successes:** The DREAMS program is well-received by the MoEAC, schools, administrators, teachers, students, and their caregivers, and has made an impact on the schools it operates in. Life skills teachers reported feeling supported by coaches, especially for sensitive topics, and science teachers by NUST and their mentors. Principals reported feeling well-supported by CPOs, mentors, coaches, and CCWs. Participating AGYW reported feeling well-supported by CPOs and CCWs. DREAMS influence appears to already be reducing teen pregnancies in two schools.

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22 PHN’s Namibia Adherence and Retention Project (NARP) and DREAMS projects align in reporting: DREAMS reports all-female AGYW including OVC and NARP reports all-male OVC.

23 GEN_GBV is the number of people receiving post-GBV clinical care based on the minimum package. (See Annex IV for PEPFAR indicators reported on by DREAMS Namibia.)
During evaluation visits, two schools anecdotally reported a decrease in teenage pregnancies and likened it to the DREAMS program that had been implemented for one year. One school reported that learners previously had an average of 16 pregnancies per year, and that since DREAMS was implemented, there have only been four pregnant students. Teachers and administrators reported that the “DREAMS messages” spread through AGYW social networks, both through word-of-mouth and online.

**Challenges:** The DREAMS staff highlighted moderate challenges in retaining AGYW in in-school SS. Learners are hungry and tired after school; some cannot attend sessions because they travel long distances to home and must leave immediately after school. A few learners did not receive permission to participate since parents thought “DREAMS is for poor girls.” DREAMS staff noted the challenge of promoting the activity without specifying the eligibility criteria.

At some but not all schools, administrators expressed scheduling concerns, reporting that they never know in advance when DREAMS staff will come and may get a notice the day before or same day of a visit. They also expressed concern that the intensity of involvement as DREAMS expands to more schools could be reduced. PHN reported during the out-brief that the schedule issue was being addressed and more CCWs were being hired to cover more schools.

Schoolteachers, administrators, and several ministry representatives unanimously emphasized that boys also need to be educated on the same topics as girls and that boys are “being left behind.” School staff and DREAMS field staff all would like to see the inclusion of boys so that the same or similar information can be shared and covered (see Cross-Cutting Findings).

**OOS Programs**

**Successes:** Overall, the older AGYW interviewed by evaluators found the SS valuable. The addition of the VSL component has increased attendance and retention. The VSL group dynamic creates a sense of trust among the girls and increases social and financial capital individually and as a group (e.g., through the establishment of an emergency fund). VSL integration in the OOS SS is a good practice to be expanded. OOS SS field staff provide childcare where needed so that AGYW who are mothers can participate. The evaluation team observed a coach taking care of an infant and a toddler while a CCW led a session.

**Challenges:** PHN reported that the initial targets were mistakenly set too high and that this was corrected during the recent OGAC site visit. AGYW are being supported to save small amounts through VSL, but there is not yet support in place that links them directly to job training or jobs.

**Opportunity:** ITECH has enjoyed a successful SP relationship with the Lidar Community Foundation in Khomas region to develop professional skills for OOS AGYW. Lidar is a community-based organization whose aim is to prepare AGYW to enter and succeed in the Namibian workforce. Girls are taught how to cook and bake in a professional kitchen, package their goods, and sell them for profit, practice hygiene and cleanliness in the workplace, navigate the workplace, develop their CVs, and other job skills needed. Lidar has successfully placed graduates in jobs in the tourism industry with kitchens and housekeeping. ITECH supported Lidar with ES activities for DREAMS AGYW, and PHN currently uses its space for FMP and VSL for parents and caregivers. PHN reported being in discussion with Lidar for continuing ES activities.

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24 In Omuthiya district, MoEAC has given approval for DREAMS to go to all primary schools.
Condoms

**Successes:** There is high demand for condoms from appropriate AGYW age groups and male partners.

**Challenges:** There is a national shortage of condoms across Namibia that has been described as a supply chain and financing issue. The evaluation team saw condoms in Tsumeb with CCWs and coaches at schools, but there are reported stockouts in other areas. Respondents reported that it is easier to get PrEP than condoms. There were frequent complaints from beneficiaries and staff that condoms break. DREAMS staff brought up a concern with storage of condoms across the supply chain to ensure that heat does not reduce their viability. In-school 15- to 19-year-olds complained that the female condom (Femdom) is too noisy and difficult to put in.

SRH Screening and Referrals for Family Planning

**Successes:** There is a high demand for SRH services, which can be an entry point for HIV prevention and testing and linkages to PrEP or ART. FP is in high demand, and many AGYW reportedly request implants as the contraceptive method of choice.

**Challenges:** There are FP commodity shortages; implants are unavailable or too expensive. Evaluators noted that the DREAMS model might strengthen its focus on preventing teen pregnancy as a strategy to empower AGYW and prevent mother-to-child transmission (MCTC) of HIV among HIV-positive AGYW.

Social Asset Building (Support for Social Grants and National ID Documents)

Social asset–building in DREAMS Namibia is not defined in the Year 1 Work Plan. DREAMS has outlined a list of interventions under this definition that include parenting skills development and FMP, increased learner performance and retention, procurement and provision of sanitary pads, in-school clinical service delivery, counseling, and supporting teachers and schools. Many of these areas have already been discussed or will be discussed under other evaluation questions. The remaining interventions cover social grants, national identification documents, and sanitary pads.

**Successes:** Support for social grants is happening as part of OVC support in Khomas and Zambezi. There is a robust national identity documents assistance program through DREAMS in collaboration with the ministries of Home Affairs and Immigration (MoHAI), MGECW, and MoHSS) in Khomas that is expected also to begin in Zambezi. PHN has procured sanitary pads that are distributed during in-school SS. PHN sees this as a potential income-generating opportunity to be explored for OOS AGYW.

**Challenges:** Zambezi region field staff described the most challenges with national identity documents and social grants and reported that social grants can take up to two years to be disbursed. Due to the high numbers of immigrants from other countries, Zambezi has a high number of OVC who cannot access social grants or national identity documents given the residency status of their parents.

Respondents reported that identity documents are also a key issue for further schooling for AGYW as well as securing employment. Even Namibian-born AGYW have challenges because they must track down their identity documents. This process is particularly difficult if they are born outside of the region they reside in or do not have the full names of their biological parents. Without these documents, AGYW, including eligible DREAMS girls, cannot enter into schools after grade 7 in Khomas. This is national policy and soon this will become the standard for all schools nationally.
SECONDARY INTERVENTIONS

FMP/VSL

Successes: Parents/caregivers have increased their savings and have started new businesses or have expanded their existing businesses, resulting in a reduction in food and financial insecurity for AGYW and their families. Parents/caregivers report an increase in the quality of communication between parent couples and between parents and children related to SRH matters. Emergency cash grants were cited multiple times as a much-needed resource in the VSL. The grants are generated over time through contributions by the members. The most common emergency described was illness.

Other reported results from VSL and increased income were that caregivers can provide transport for their children. Taxi drivers were listed by AGYW in the DREAMS baseline assessment as male sexual partners. The team heard reports that taxi drivers trade sex for rides to school. The VSL program could, in theory, lessen reliance on others for daily needs and lower AGYW’s risks.

Challenges: VSL and FMP groups include low male involvement; evaluators noted a majority of women in all observed sessions. Participants and facilitators reported a lack of local language resources. FMP includes long sessions (three to six hours) due to simultaneous translation and the group discussion. Coupled with a VSL meeting, participants can be in attendance for the whole day. Participants reported needing refreshments and food and suggested that the project hire the VSL participants to cater the sessions. This would further strengthen the savings of the VSL.

Male Champions

The DREAMS baseline assessment found that the main reported partners of AGYW are men in uniform, taxi drivers, and cattle herders. Targeting specific male sexual partners can be difficult given the hidden nature of sexual relationships with AGYW, especially transactional relationships. Additionally, there could be statutory implications if the AGYW is underage; MC facilitators reported men in uniform having this concern. Men in uniform are reportedly the most difficult to reach. Taxi drivers were identified as frequent partners of AGYW, exchanging sex for transportation.

Successes: MCs who lead male engagement sessions live in the communities they serve and have good relationships with the men they engage (who were observed to range in age from twenties to seventies), as well as local counselors who volunteer their offices for meetings. MCs use a manual developed by MGECW. They are part-time employees with LifeLine/ChildLine Namibia (LCN), have a monthly outreach schedule and are supervised by the DREAMS regional gender advisor. Male engagement sessions are generally held during weekends. A YFS nurse is available to provide clinical services and answer clinical questions. In an observed session in Onandjokwe, men talked comfortably about key messages from DREAMS.

Challenges: MCs reported that they know very little about the DREAMS project as a whole. They are not a part of the staff meetings, feel separate from other field staff, and perceive that they lack counseling and PSS skills. They do not receive feedback on their effectiveness. They did not know why there was a focus on these categories of men. MCs have no phone call or taxi allowance. One MC reported that he feels unprepared to address men who have both male and female sexual partners. MCs are not sure if they have responsibilities to reach boys as well as men.

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25 This represents overtime work hours for nurses.
Male partner session participants have been asking for VMMC, but there is a waiting list at public health facilities. There are opportunities to explore linkages to private clinics, particularly in Khomas.

**Linkages for Higher-Risk, Vulnerable AGYW**

Respondents identified the following populations of AGYW who are not yet being reached by DREAMS: AGYW with disabilities (e.g., who are visually or hearing impaired), AGYW in the San population, bisexual AGYW/male sexual partners, children of sex workers, street children, AGYW who are using drugs, and AGYW who sell sex. DREAMS could usefully consider strengthening linkages with organizations who work with these populations (e.g., Society for Family Health’s key populations program for children of sex workers or NGOs working with persons with disabilities). There was a resounding call from field staff to have referral information available and appropriate sensitization where needed. There is an opportunity for organizations who advocate for various marginalized populations to sensitize DREAMS staff.

**Outputs (Results) and Beneficiary Targets**

Overall, DREAMS is overachieving for AGYW ages 10–14 (423 percent), underachieving for ages 15–19 (58 percent), and deficient in reaching ages 20–24 (11 percent). DREAMS staff reported that targets were too high for the first year of implementation. PHN reported not having any input into how targets were set and district staff, likewise, have no input into how district targets were set.

Initially, many staff at the district level did not understand how to count results for an indicator and/or the interventions needed to count toward the indicator. To address this, PHN conducted a data audit and assessed staff understandings of their roles, responsibilities, and procedures for the DREAMS project. The process unveiled misconceptions and provided an opportunity for PHN to course-correct and improve results going forward. For example, some staff thought that to count for the PP_PREV indicator, all sessions had to be delivered when the minimum package calls for at least three. It is possible that the project will see greater improvements going forward. Additionally, PP_PREV requires condom promotion and distribution, but in a national stockout of condoms, it is yet unknown how staff can count this indicator if there are no condoms to provide.

AGYW_PREV\(^{26}\) is well-covered with achievement of targets within Q3. GEN_GBV is a challenging indicator to set targets for, particularly due to it being a primarily clinical intervention. In order to “reach” the targets, the AGYW who were screened needed to have had recent incidences of GBV that required clinical intervention. The MGECW GBV unit reported that most of the cases were from a “long time back” and that PSS and counseling were most needed.

For OVC_SERV, there is a backlog of AGYW waiting to be served.\(^{27}\) The backlog is due to low numbers of staff. At the time of the evaluation, there was also a backlog of data to be entered in Khomas because the data management officer (DMO) was also the data entry clerk. PHN was working to address these issues.

\(^{26}\) AGYW_PREV is the percentage of AGYW who completed the DREAMS primary package of evidence-based services/interventions. This indicator is reported on by the USG team rather than implementing partners. IPs collect the data and USG uses the layering data and service completion for its reporting. (See Annex IV for PEPFAR indicators reported on by DREAMS Namibia.)

\(^{27}\) OVC_SERV is the number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV. (See Annex IV for PEPFAR indicators reported on by DREAMS Namibia.)

In the absence of program inputs in the project’s results matrix, the evaluation team has referenced inputs in the DREAMS logic model, including SS, staff, supplies, transport, curriculum, M&E tools, and information, education, and communication (IEC). Findings are based on these inputs with the exception of SS (already addressed under evaluation question 1).

Finding 1: DREAMS Staff Strengths and Challenges

Strengths: The project has recruited dedicated, passionate staff. Overall, technical staff demonstrate competencies in their areas. District teams appear to be working well together, especially the school-based teams and YFS nurses, with both school-based teams and MCs. All nurses have been recently trained on PrEP. More social workers are being hired, which is expected to strengthen support for CCWs and CPOs.

Challenges: Vacancies in the DREAMS Chief of Party (COP) and senior M&E advisor positions, as well as a vacancy for a broader PHN HR and operations director position, have handicapped the project. Efforts are being made to recruit and hire well-qualified staff who are comfortable working on yearlong contracts. (USAID informed the evaluators that a COP had been hired after field work was completed and the report was drafted.)

Not all staff have seen their job descriptions and there appear to be inconsistencies across them, such as for M&E positions among SP. Some staff are working outside of what they understand to be their intended roles; some are working overtime and on weekends (e.g., YFS clinic nurses who participate in community outreach events on weekends). In these instances, staff feel that salaries are not commensurate with workloads.

Rapid recruitment of personnel to fill gaps and increase service delivery capacity has resulted in some CCW hires who are not yet fully trained or qualified; these staff have a heavy workload and lower pay. There is concern that CCWs are trained by one partner (LCN) but supervised by another (PHN), and have a key role in capturing initial data but are not supervised by data staff. Many field staff identify the need for additional training and suggest that entire district teams could receive refresher trainings as a group to ensure consistency in their knowledge. In the DREAMS consortium model, different SPs hire and train various staff, according to their roles, which is why staff have not received identical trainings.

Opportunity: There is an opportunity for a generalized, one-day training for entire districts teams about the purpose of DREAMS and the layered package of services; this would help to ensure that all staff have a basic understanding of the purpose of DREAMS; HIV risks to AGYW in the context of social norms; services provided through DREAMS; how HIV tests, ART, PrEP, post-exposure prophylaxis

28 The team has seen more than one version of the logic model in various PowerPoint presentations. This model was referenced in the ITECH regional overview prepared for the recent OGAC visit.
(PEP), and VMMC work; and differences between staff roles and how they all fit together to form a DREAMS team.

Following is an illustrative but not exhaustive list of examples of training requests identified during site visits:

- **CCWs**: use of screening tools; better understanding of GBV; how to serve young OVC; how to set up and facilitate VSL; how to facilitate Aflateen curriculum; more facilitation skills overall
- **Coaches**: how to do one-on-one counseling
- **MCs**: purpose of DREAMS; how they fit within the team; clinical information about PrEP, HTS, VMMC, ART; whether they are expected to work with boys and, if so, how
- **All**: more GBV training; how to deal with their own personal issues that arise from this work; how to better understand each other’s roles to work well as a team
- **For Khomas and Zambezi regions**: orientation on package of services PHN DREAMS will provide in Khomas/Zambezi regions; timetable for phasing in new services

Field staff who are dealing with difficult situations—such as child rape as part of GBV case identification and, in some cases, extreme life challenges faced by vulnerable AGYW who are poor—identify a need for PSS to help them cope emotionally with the traumas they hear about and witness. (The oldest adolescent girl among the rape cases being seen by DREAMS field staff in Omuthiya district is reportedly 17 years old.) SFL coaches describe having PSS built into their regular monthly meetings in Windhoek, which includes support from a certified psychologist.

Staff also identified their own vulnerabilities when traveling to homes where GBV incidents have occurred or when traveling to remote areas. Staff do not always travel in pairs. There are reportedly so many urgent transportation needs that drivers cannot always accompany staff for house visits; at times they are dropped off and make their way thereafter by taxi or by walking.

**Finding 2: SP Technical Packages and Relationships**

**Strengths**: SPs appear to be well-chosen to carry out DREAMS activities, with demonstrated experience, technical capacity, and good longstanding relationships with government ministries. At the district level, staff from the various SPs are working well as a team.

The U.S. Peace Corps Volunteers (PCVs) based in Omuthiya district have provided some degree of training for CCWs on revised curricula and offer ongoing CCW mentoring to strengthen facilitation skills.29 It is unclear how this is integrated with LCN’s role to train CCWs as facilitators or PHN’s role to supervise them; nonetheless, the support is viewed by all parties as helpful.

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29 Reportedly, Peace Corps Namibia has produced a short video on the ITECH DREAMS project in Zambezi. There is potential to further promote DREAMS through the partnership with Peace Corps Namibia.
Challenges: PHN is perceived as relying to some degree on SP’s GRN relationships rather than establishing its own DREAMS-related relationships and regular communication with relevant ministries. The PY1 Q3 report identified weak coordination and collaboration with SPs as a challenge. Some SPs have reportedly struggled with the request to remove components of their standard technical packages that do not relate directly to DREAMS objectives and targets, and reported that at times these decisions have not been mutually negotiated. PHN reported that all SPs have reached negotiated agreements for PY2. The evaluation team was surprised that SPs were not invited to the out-brief at the PHN office.

As an example of where role confusion might arise, the DREAMS information booklet (p. 34) defines LCN’s overall responsibility as follows: “Lead psychological support services as well as technical training on evidence-based DREAMS curriculum.” Activities listed under this heading include: “Community mobilization: Conducting sessions with CATS”; “Men engagement (Reaching sexual partners of AGYW): Education (Norms change, and GBV, and HIV prevention) and linking men with biomedical prevention services (HTS, VMMC, condom, and ART)”; and “Capacity building (training of staff).”

It is not clear when LCN is directly responsible for an activity through its hired staff and when it is expected to provide capacity-building or supervisory support for an activity. It is also not clear whether in some instances LCN is meant to provide a training of trainers that positions other SPs to cascade skills thereafter. Language may be clearer in PY2 agreements, which evaluators did not see.

Finding 3: Resources (Supplies, Transportation)

Strengths: PHN has developed a financial spending acceleration plan, intended to be completed by the end of PY1, which includes rapid procurement of supplies and transport (e.g., purchase of six new vehicles and rental of 12 additional vehicles). This should help to address pressing district-level transportation challenges, although it is unclear how transportation resources will be prioritized and how SPs will collaborate for transport and supply needs (see later in this report for more acceleration plan details.) Focus areas in the acceleration plan include gender and social norms, M&E, OVC, cross-cutting activities and sub-grants, prevention and clinical services, and ES; the acceleration plan appears to be an effort to spend down the PY1 pipeline in the most useful ways.

As part of its evolving teaming approach with Ministries of Gender Equality and Child Welfare and Home Affairs and Immigrations in Khomas and Zambezi districts, DREAMS has supported ministries’ transport needs for collaborative field visits related to helping immigrant children obtain national documents to qualify for OVC and social grants support.

Challenges: District staff reported that at times, requests from district/regional offices to HQ for procurement of supplies (furniture, stationery) meet with slow response and that they are not well-informed about reasons for procurement delays. There are differences in supply levels between districts: Zambezi seems to face the most supply challenges, and it is unclear why this is the case.

Finding 4: Training Curricula

The evaluation team was able to observe MFMC, WoH, and FMP sessions, but not Afla-teen. The team heard different explanations for how these curricula were chosen. One explanation was that ITECH

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30 Two acceleration plan documents were shared with evaluation team. Evaluators did not see the original FY1 budget.

31 Evaluators are aware that this curriculum extends across 33 weeks, beyond the six-month reassessment schedule for DREAMS girls; it is unclear how these timelines will be merged.
suggested using these materials at the beginning of its DREAMS services implementation in 2017, since curricula have been used through the years in Namibia and are accepted by GRN. Another was that it was a USG decision to use the FMP materials and a MoEAC decision to use MFMC and WoH.

PHN worked in collaboration with ITECH and with the assistance of two PCVs—one linked with PHN and one with ITECH—to revise and update two DREAMS curricula (WoH and MFMC) to address comments and recommendations received from ISMEs by the country team. Reportedly, revisions include adding more energizers and games to strengthen messages. It is unclear whether these revised curricula are now in use or, if not, when they will be introduced. Evaluators were informed that the revised training materials have been reviewed and approved by OGAC and the USG ISMEs.

**Strengths:** Curricula are well-received by DREAMS AGYW key beneficiaries (10–14 years, 15–19 years, 20–24 years) and parents/caregivers. (No training is provided as part of outreach to male sexual partners; this is not part of the services package.) Most observed facilitators seem to be well-trained and comfortable in the role; some newer hires mostly just read the materials, but this will likely change as they become more familiar with curriculum content. FMP materials have been translated into some local languages in the Oshikoto region (but need to be translated into more).

**Challenges:** FMP materials—especially workbooks given to parents—need to be translated from English into additional local languages for parents to be able to use them without assistance. Reportedly, PrEP has been introduced into the MFMC curriculum for 15- to 19-year-olds by the PCVs; PrEP is not yet part of the FMP curriculum, though a draft revised FMP manual provided by ITECH is reportedly intended for near-future use. PrEP is not considered an age-appropriate topic for the 10- to 14-year-old WoH curriculum.32

**Finding 5: M&E Tools**

**Strength:** M&E tools are well-defined in the AMELP. M&E national staff continue to review and revise tools as needed. As an example, district-level staff found it challenging to export data from REDCap, so national-level M&E staff designed trackers for OVC, PP_PREV, and weekly progress data; this innovative solution seems to be working well. (See evaluation question 3 for more M&E details.)

**Finding 6: IEC**

**Strengths:** Evaluators saw many visual materials displayed at YFS clinics, in classrooms, at FMP session locations, and in DREAMS district/regional offices. The only observed material clearly developed by DREAMS Namibia is a WASH handout; however, all materials contained relevant messages.

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32 The current MoHSS guideline indicates that PrEP is to be offered to people from the age of 15 upwards.
**Challenges:** FMP facilitators requested promotional materials in more local languages. District staff reported that DREAMS could make better use of media—radio\(^{33}\) and social media—to promote key messages and market the DREAMS package of services.\(^{34,35}\)

**Finding 7: Quality of Outputs and Outcomes**

Outcomes in the DREAMS logic model include increased AGYW empowerment and agency, better health-related behaviors, improved GBV care, and better family support of SRH.\(^{36}\) The DREAMS Namibia results matrix does not have outputs for “increased AGYW empowerment and agency” or “better family support of SRH.” Better health-related behaviors can be inferred by the DREAMS clinical indicators as well as by reduced teen pregnancies (which are not now being documented by the project, but might usefully be, even anecdotally); increased use of condoms and other FP methods; and increased attendance at YFS clinics. Improved GBV care relates to the GEN_GBV indicator.

**Strengths:** In July 2019, PHN adopted a USAID-endorsed continuous quality improvement (CQI) tool that focuses on four core areas at the district level: (1) leadership, mentorship, and sustainability, (2) management, staffing, and mentorship, (3) M&E, and (4) environment, supplies, and commodities.\(^{37}\) The tool contains domains and standards that provide measures of quality improvement for internal operations; PHN reported that it is using this tool to develop quality measures for project inputs, outputs, and outcomes. District CQI teams have been formed and are intended to include at least one of each of the following staff cadres: CCWs, coaches, STEM tutors, nurses, DMOs, and MCs. Teams are expected to meet regularly with district team coordinators to advise on their progress. The Onandjokwe CQI team has put together a stakeholder engagement strategies document that includes the formation of an external stakeholders advisory committee to be convened quarterly; this appears to be a practical strategy for engaging relevant ministries at the district level.

There are promising anecdotal reports that DREAMS is improving quality of life for beneficiaries, including girls and parents/caregivers. Parents have said they can now talk with their children about sexuality and SRH matters. Two schools reported a reduction in teen pregnancy since the prior year, before the DREAMS program began in these schools—in one school, a reported decrease from an average of 16 pregnancies per school year to four pregnancies over the past year.

\(^{33}\) As an example, in South Africa, Soul Buddy is an award-winning multimedia “edutainment” experience equipping 8- to 12-year-olds with potentially life-saving messages before they become sexually active. Every week, young actors encounter, explore, and solve the kinds of issues and problems that face young South Africans in real life, from bullying, racism, and abuse to smoking, love, sex, and HIV/AIDS. Initial research suggests that Soul Buddy and similar interventions might be helping to delay the age at which young South Africans first have sex. Starting as a weekly nationwide television show, Soul Buddy has been expanded into a radio show in nine different local languages and a growing network of 1,300 youth clubs where children meet to take part in activities based on the themes of the program.

\(^{34}\) World Education Inc. conducted a WhatsApp focus group discussion with more than 2,000 adolescents across 65 districts in Zimbabwe, including rural hard-to-reach districts, to ask what participants want in terms of SRH services and how they want them to be provided. Respondents voiced a preference to receive education through SMS messaging and media apps rather than face-to-face from adults.

\(^{35}\) The evaluation team notes that opportunities also exist for OGAC to use media platforms to enable the sharing of DREAMS experiences and good practices across the Southern African Development Community (SADC) region. During the evaluation, in-school DREAMS girls expressed interest in sharing their stories with DREAMS girls in other participating countries.

\(^{36}\) Taken from the logic model slide from the ITECH PowerPoint presentation for a recent OGAC regional visit.

\(^{37}\) Taken from a PHN Namibia PowerPoint presentation, Ondangwa district, August 19, 2019.
Challenges: The evaluation team saw no output or outcome quality indicators for the layered services across age categories; outputs are rather defined as numbers of tools, numbers served, etc. Quality cannot be assessed without measures in place. Through PHN’s current work with the new CQI tool, quality indicators should be in place in time for the project’s midterm review.

Opportunity: Client satisfaction is a useful strategy to measure quality of services. As yet, no opportunities for beneficiary feedback have been included in the DREAMS Namibia model. An essential strategy for empowering AGYW is to include their voices in planning interventions intended to benefit their lives and providing feedback for how well the layered services model is meeting their needs. As a first step, feedback can fairly easily be built into OVC, in-school, OOS, HF-based, and community-based parent/caregiver services, not just as part of exit interviews but as part of regular sessions (e.g., as part of quarterly visits with OVC).

EVALUATION QUESTION 3. WHAT SYSTEMS ARE IN PLACE TO IDENTIFY AND REMEDY CHALLENGES TO PROGRAM MANAGEMENT AND STRUCTURE (i.e., PLANNING, HUMAN RESOURCES, FINANCIAL, OPERATIONS, AND COMMUNICATIONS)?

Planning Systems

Finding 1: PHN developed a work plan for FY1 that describes the layered services table and roles of each consortium partner as well as an information booklet that provides a detailed project overview—with PEPFAR indicators and targets, the layered services table for Namibia, mandatory components of packages of services, and an AMELP that describes in detail what data is to be collected and how it will be managed, analyzed, and reported. These documents reflect an overall understanding of expectations and requirements for project implementation.

However, project activities and decisions appear to be based more on responses, as problems and needs arise, rather than on longer-term planning. PHN recognizes that it needs to revisit planning based on learning in PY1 and reported an intention to do so after end-of-year reporting. It would serve the project well to take time to bring regional/district staff together, visit lessons learned, and systematically plan for modifications to implementation approaches. The filling of the COP position should help to strengthen the project’s planning overall.

Finding 2: The evaluation team was informed that the ISMEs have been reviewing the layered services table and considering revisions. PHN confirmed this and advised the team that revisions are to be introduced in July. Evaluators do not know what changes are being made or if they have been negotiated with PHN and SPs. At some point, the layering table and results matrix must stabilize in order for inputs and outputs to be defined and clearly linked with IRs that do not continue to fluctuate. This is the underlying structure for the project; efforts to stabilize, systematize, and more effectively implement the project rely on a stable, well-defined model.

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38 In Zimbabwe, the World Education Inc. Bantwana OVC services model centers around a child advisory board comprised of adolescents from every participating district, trained to participate and lead quarterly meetings. Board members report on program interventions in their communities and what is and is not working, and they take their responsibility seriously. Membership includes deaf children and representatives of all key populations. The Zimbabwe DREAMS programming includes teenage advisory groups who play a similar role.

39 Staff at the national, regional, and district levels have unanimously identified the need to strengthen the planning process at all levels.
HR Systems

**Finding 3:** PHN appears to have initially underestimated the number of staff that would be necessary to implement multiple services across three regions (and five districts) and continues to hire more staff as more layered services are added. The project has been adjusting staffing hires through PY1 to get the right balance of staff cadres, most recently hiring MCs to conduct outreach to male sexual partners of AGYW and additional qualified social workers to support (and hopefully mentor) less qualified CCWs, and enlisting community mobilizers to conduct household outreach to find and recruit OOS AGYW. At the time of this report’s development, PHN had hired an impressive 199 staff for DREAMS (see Annex III for number of staff by position) and will continue to hire staff as project activities in Khomas and Zambezi region are transitioned from ITECH to PHN. (PHUS key managerial positions are filled, there is an opportunity to assess type and level of trainings received by all staff to date and make a plan to address remaining training needs in a time- and resource-efficient way.

**Finding 4:** The lack of transparency with which some recruitment has taken place has raised concerns by SPs whose staff were interviewed and hired into PHN positions without managers having been informed in advance. There is room for improved communication and transparency about staff recruitment plans.

**Finding 5:** A number of staff confided in evaluators that they were unhappy with salary levels. While this may be a national issue that extends beyond the DREAMS Namibia project, it seems important to adjust salaries or working expectations where staff are putting in overtime hours on a regular basis.

Financial Systems

**Finding 6:** The evaluation team saw the acceleration plan spreadsheet for prioritization of activities with prominent budget levels where results can be achieved quickly (particularly for PP_PREV and OVC_SERV) by end of PY1. No additional information about PHN’s financial systems was shared with the evaluation team other than acknowledgement that PHN receives some financial management support from PHUS, which is a common practice between an international “parent” and local nongovernmental organization (NGOs).

Operations Systems

**Finding 7:** The CQI tool introduced in July 2019 provides useful measures for internal quality of operations, and reportedly will help PHN to better monitor SP activities as well as internal operations. The tool was piloted in Ondangwa district; PHN has trained staff and introduced the CQI tool in all five districts. PHN has also developed several standard operating procedures (SOPs) for various DREAMS protocols and services, including M&E. Overall, good structures are in place for operations.

**Finding 8:** Evaluators saw no inventory management system in the district offices. A number of supply needs were identified (e.g., for penile models, furniture, and stationery supplies). Establishing an inventory system to inform a supply re-ordering system would be helpful.

**Finding 9:** Regarding M&E as part of operations, although the DREAMS Strategic Information (SI) Advisor position is vacant, there is a strong M&E team at the national level and strong commitment among SPS at the regional/district levels to ensure M&E system performance.

The AMELP contains clearly defined data management (collection, transfer, storage, analysis, and reporting) mechanisms, including collaboration and coordination among different SPs. However, this plan
is not well-known at the district level and evaluators saw no copies of it in district offices. District-level staff are more familiar with the PEPFAR Indicator Guidance document and have copies of it.

There is a need to strengthen district-level M&E coordination. For example, job descriptions for M&E staff exist across the SPs, but some roles, responsibilities, and channels of reporting overlap.40 M&E officers in regional/district offices are IHI staff; other data staff belong to PHN. The DMO has oversight for PHN data only, and the regional M&E staff person is responsible only for IHI clinical data. Some SPs have their own DREAMS databases, and there are no linkages between different databases to ensure data consistency. At a minimum, all M&E staff should understand one another’s roles and how each SP is managing and reporting data.

PHN has guidelines for supervising routine data at the district level, including supervisory visits and data quality assessments (DQAs). Several supervisory and DQA visits have been conducted and reports are available at the national level. PHN has not historically reported on % error or % agreement as requested by USAID as part of the DQA. District-level M&E staff apparently do not have access to any of these national-level DQA reports. SP IHI conducts independent DQA on its clinical data. District PHN teams reportedly conduct some DQA for bio IDs, but most data analysis and DQA takes place at the national level.

A formal definition of “lost to follow up” would be helpful; currently, the project is counting people who move out of DREAMS districts as “lost to follow up”; this does not capture AGYW who stop attending DREAMS activities for other reasons (e.g., those who miss repeated appointments at YFS clinics).

PHN plans to shift from REDCap to District Health Information Software 2 (DHIS2) in PY2. Reportedly, the plan is to incorporate all partners into this system and migrate historic data onto the platform by the end of PY1. This seems ambitious and evaluators imagine this task could easily take until the end of the 2019 calendar year, and perhaps beyond. The strategy is to initially roll out the new data entry system in one district, then gradually extend it to all five DREAMS Namibia districts and replace REDCap. It is unclear if the new platform will enable district/regional teams to conduct any data analysis directly or if they will continue to rely on the national office for this.

Evaluators note one data confidentiality concern. Many in-school DREAMS girls’ booklets are kept in lockers at schools due to long distances between schools and DREAMS district office. If increased transportation resources are directed to in-school activities that will enable CCWs to travel more easily from the office to school sites, it seems safer to keep files in the office. The team realizes this may not be feasible and encourages the project to ensure that the records containers are always well-locked.

Regional/district DREAMS teams have important experience that can help USAID and PEPFAR understand challenges in terms of how targets were reached, whether targets are accurate, and realities of girls’ lives and what makes it difficult to reach, enroll, and retain them. However, these details are not typically reflected in quarterly reports as they lie outside of quantitative indicator/target templates. It would be useful to the ISMEs and to OGAC for PHN and SPs to document more of this “behind the data” information or to share it proactively during quarterly performance report meetings, and for USAID to proactively ask questions about factors that hinder or facilitate expected project performance.

40 There is an overlap with the job descriptions for DMO, data clerk, and M&E officer at the district level. All district-level M&E staff/M&E designates report to the M&E person at their SP organization; there is no one in charge of M&E at the district level. The M&E officer at the regional level also serves as M&E officer for clinical data at Onandjokwe district.
It is not clear if any DREAMS Namibia data is currently being shared with ministries; if the shift to the DHIS2 platform will include new data-sharing with GRN, evaluators assume this plan will be incorporated into a DHIS2 training for all regional/district–level M&E staff. (No GRN stakeholders interviewed described any data-sharing with ministries.)

Communications Systems

**Finding 10:** Key mechanisms for project coordination and communication include quarterly performance reports with USAID/Namibia, followed by quarterly review meetings with consortium SPs. Weekly staff meetings and data review meetings are scheduled at the regional and district levels. PHN reported that less formal discussions take place more frequently between all project partners. The need to strengthen planning and regular communication with ministry stakeholders at the national/regional/district levels is addressed under evaluation question 1; the request from regional/district offices for timely communication and responses from the PHN central office is addressed under evaluation question 2.

**Finding 11:** For reasons that are unclear, the national AGYW Technical Working Group (TWG) has not served as an adequate platform for DREAMS planning and information-sharing as expected. Reportedly, this group comprises large membership and addresses many topics. DREAMS reporting has been included in some meeting agendas, but there has apparently been no engagement with planning. Typically, DREAMS countries form a DREAMS Advisory Group that comprises relevant ministry and other external stakeholders. Apparently the expectation was that the Namibia AGYW TWG would serve this purpose, but that has not happened. This may be a key reason why ministry respondents have felt somewhat out of the loop about what DREAMS is doing.

Government structures in place for HIV prevention from district to national level have not yet been well-engaged for DREAMS communication (e.g., the national school health task force, constituency AIDS coordinating committees, regional AIDS coordinating committees, the national prevention and treatment TWG, technical advisory committees for all HIV TWGs). The new district-level external stakeholder engagement strategies being developed under the CQI initiative can help to link DREAMS activities with these structures.

**EVALUATION QUESTION 4. WHAT IS THE CAPACITY (i.e., PLANNING, HUMAN RESOURCES, FINANCIAL, OPERATIONS, AND COMMUNICATIONS) OF PHN AND SUB-PARTNERS TO EFFECTIVELY IMPLEMENT THE DREAMS PROGRAM?**

**Planning Capacity**

**Finding 1:** Filling vacant managerial positions in the PHN DREAMS organizational chart is an urgent priority and should make a notable difference in terms of PHN’s capacity to effectively plan and implement DREAMS activities. This finding relates to all categories below as well.

**Finding 2:** The lack of communication about the transition plan to absorb new beneficiaries and some staff from ITECH in Khomas and Zambezi regions has created anxiety among affected staff. Sharing such a plan is a priority.

**Human Resources Capacity**

**Finding 3:** The need for rapid hires has resulted in some instances in a “lower starting capacity” for some field staff (this may refer primarily to the recent addition of volunteer CCWs); this has the
potential to affect the quality of service provision and how DREAMS is perceived. Overall, though, staff capacity is positively perceived. As one MoEAC respondent reported, “DREAMS is using people with knowledge. I came across various facilitators and officials and they are competent with the credentials to make us happy.”

**Finding 4:** Some SPs expressed concern about PHN’s certifications or qualifications to directly provide counseling services originally meant to be provided by SPs, as they understood the agreements. Evaluators are unclear whether this concern relates to the functions of CCWs, CPOs, or coaches, all of whom provide informal counseling. It may be that having these staff cadres mentored by certified social workers when sufficient numbers of district-level social workers have been hired can help to provide some quality assurance for how counseling is conducted.

**Financial Capacity**

(The team received no information from which to assess financial capacity, other than to note that the acceleration plan appears to be an effort to spend down the FY1 pipeline in useful ways.)

**Operations Capacity**

**Finding 5:** Use of the CQI tool introduced mid-year in PY1 should help to strengthen nascent operations systems and improve effectiveness and quality over the life of the project. Measures developed through this tool will help to provide structure for the project’s midterm review.

**Finding 6:** Providing adequate transportation resources—vehicles, drivers, schedules, and schedule managers—should help to address the operations challenges of long distances for community outreach, participation by OOS AGYW and parents/caregivers, and finding GBV cases in the Oshikoto region.

**Communications Capacity**

**Finding 7:** Opportunities to strengthen communications with ministries, SPs, and regional/district staff have been identified above. Filling key staff vacancies is expected to improve PHN’s capacity to strengthen communication at all levels. The evaluation team notes that district-level child care and protection fora and “A Team” meetings for MoHSS and MGECW social workers are excellent venues for information-sharing about DREAMS and case management details, and that DREAMS staff actively participate in these meetings.

**CROSS-CUTTING FINDINGS**

**Finding 1: Inclusion of Boys in DREAMS**

With full recognition that the DREAMS model focuses on AGYW and mostly older male sexual partners, the evaluation team notes that gender social and sexual norms cannot change if teenage boys—who will, in a few years, become the next wave of sexual partners for AGYW—are not somehow included in DREAMS messaging and interventions.

Reports from Omuthiya district of boys experiencing rape and sexual assaults that do not get reported suggest that the HIV risk to adolescent boys and young men may not be fully documented, regardless of HIV prevalence statistics.

In-school boys benefit from PP_PREV educational sessions given by DREAMS coaches to whole classes. Coaches, CCWs, and CPOs offer counseling sessions to boys based on private requests.
There are opportunities to emphasize key messages about how boys can protect themselves as well as their sexual partners from HIV risk through counseling and in whole-class sessions, and these should be strategically used to full advantage. There are opportunities in FMP trainings to prepare parents to talk with both female and male children about SRH. And IEC materials exist that reference boys with relevant messages and visuals.  

Finding 2: Sustainability

Some government stakeholders have expressed concern over the sustainability of the DREAMS Namibia project, especially with regard to the provision of commodities and support to AGYW and OVC (e.g., transport, stationery, school uniforms, sanitary pads) and families (emergency support fund). However, they expressed their overall satisfaction and appreciation for the positive differences DREAMS Namibia is making in the lives of AGYW and their families.

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V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Overarching

• Changes in early OGAC guidance and high targets—especially for OOS AGYW—have created challenges for PHN in implementing DREAMS Namibia in PY1.

• Nonetheless, PHN and its consortium SPs have been adaptive and responsive to early learning, making adjustments across all areas as project implementation has evolved.

• Project stakeholders and beneficiaries have been overwhelmingly positive about the project’s benefit to the communities it serves.

Technical Approach

• The technical and service delivery approaches are not harmonized in relevant documents. (Per PHN, the layering table submitted as part of the latest version of the DREAMS modification approved by USAID has addressed the discrepancy in the AMELP and PY2 work plan.)

Service Delivery

• An identified good practice that shifts DREAMS services from HFs to communities is the provision of PrEP refills in communities so girls do not have to return to clinics.

• PrEP and ART adherence are challenge areas for AGYW.

• Some at-risk AGYW and male sexual partners are not yet served.

Implementation

• VSL provides an avenue for AGYW and parents/caregivers to begin to build economic resilience; however, economic strengthening needs to extend beyond VSL to job training and job opportunities to make a long-term impact in the lives of vulnerable 20- to 24-year-old AGYW.

• The voices of AGYW beneficiaries are not yet heard in the DREAMS project planning, implementation, and reporting. Preparing AGYW to lead and be heard is a key aspect of empowering AGYW.

Planning/Operations

• There is high anxiety among DREAMS staff in Khomas/Zambezi about the transition from ITECH to PHN’s full package of services. Communication of planning that is underway is urgently needed with affected field staff.

• The CQI tool introduced mid-year in PY1 should help to strengthen nascent planning/operations systems and better measure their effectiveness and quality over the life of the project. Measures developed through this tool will help to provide structure for the project’s midterm review.

HR

• Filling vacant key managerial positions in the PHN DREAMS organizational chart is an urgent priority and should make a notable difference in terms of PHN’s capacity to effectively plan and implement DREAMS activities. (Per USAID, the COP position was filled after this report was written.)

• District staff should identify urgent needs for psychosocial support and personal safety assurance.
• Staff have identified additional training needs; there is opportunity for brief “whole team” trainings to help ensure that various staff cadres have a consistent fundamental understanding of DREAMS, the various staff roles and services, and how all the pieces fit together.

Communications
• The success of the layered services model depends on positive and transparent communication and collaboration between consortium partners providing the packages of services.
• Ministries request regular communication related to DREAMS at all levels.
• Government structures and communication channels in place for HIV prevention from district to national level have not yet been fully engaged for DREAMS communication and information-sharing. The new district-level external stakeholder engagement strategies being developed under the CQI initiative can help to link DREAMS activities with these structures.

Cross-Cutting:
• Opportunities exist within DREAMS activities to emphasize key messages about how boys can protect themselves as well as their sexual partners from HIV risk without diverting emphasis or resources away from AGYW.
• Good practices exist across other DREAMS countries that DREAMS Namibia can benefit from. USAID can help to bring this information to the DREAMS consortium.

RECOMMENDATIONS (EIGHT PRIORITY RECOMMENDATIONS ARE BOLDED)

Technical Approach
• Orient all staff on the most current layering table and results framework (perhaps as part of one-day, whole team refresher trainings).

Service Delivery
• **Strengthen Community-Based PrEP and ART Adherence Strategies.**
  o Explore adherence support models from other DREAMS countries and adherence support groups on WhatsApp as possible strategies. (DREAMS South Africa uses WhatsApp.)
  o Consider putting PrEP in discrete, opaque packaging.
  o Develop brief aids for staff (e.g., CCWs/MSc) and beneficiaries to ensure that all parties understand what PrEP retention requires.
  o Ensure that PrEP and ART adherence and retention messages are harmonized across training curricula where age-appropriate, including messages for correct use and retention.
• Explore cost-effective ways to bring more DREAMS services into communities (e.g., community-based PrEP initiation as well as refills, rapid oral fluid tests, and starter packs), linking with health extension workers where possible for outreach.
• Develop referrals and linkages to projects and organizations that serve AGYW not yet being reached by DREAMS, including AGYW with disabilities.
• Consider implications of the Ministry of Education, Arts and Culture’s new inclusive education policy on future requirements for DREAMS in-school staff. When other recommendations have been addressed, begin exploring ways to serve AGYW with disabilities in PY3. Consider a possible SP that can address AGYW with special needs.
 Implementation

- Consider moving economic strengthening from a secondary to a primary intervention and dedicate more financial and human resources to ES activities. Incorporate strategies that directly link older AGYW with job training and opportunities. Search for ES public-private partners in the five districts.
  - Consider a research partner to compare outcomes of various ES strategies if funding allows.
  - Consider proxy indicators that would help to demonstrate how vulnerable older AGYW and vulnerable households have been empowered and made less vulnerable (e.g., number of older AGYW linked with job training, internships, or jobs; number of participating households living above Namibia’s poverty level when they transition out of DREAMS).
  - Consider supporting caregivers to receive disability and old-age pensions, perhaps linked with OVC home visits, and perhaps after the Khomas and Zambezi region transitions have been completed (perhaps in FY3).

- Incorporate beneficiary feedback opportunities into and throughout services—include voices of AGYW!

 Planning/Operations

- Share the written OVC services transition plan in Khomas and Zambezi regions with relevant field staff.

- Systemize planning at the district level for each layered service (e.g., school schedules, MC schedules, transportation priorities and schedules, supply re-ordering schedule).

- Make full use of the CQI tool in all DREAMS districts.

 HR

- Introduce PSS for regional/district teams. Consider expanding the Star for Life PSS model for whole district teams or engaging certified psychologists or experienced social workers to provide regularly scheduled support (perhaps linked with staff meetings).

- Introduce a personal safety policy for field teams that addresses traveling in pairs, navigating unsafe communities, conflict management, and safety protocols for home visits, especially related to GBV cases.

- When the COP position has been filled and more resources are available for HR functions:
  - Develop a short, generalized training for district staff teams (see report for suggested content).
  - Review supervisory relationships to ensure that all field staff are receiving supervision from the staff best qualified to oversee their unique roles and tasks.
  - Ensure that job descriptions exist for all positions; review all job descriptions to ensure that they match the tasks actually being performed and are as consistent as possible (e.g., for data/M&E positions).
  - Set clear parameters for all staff roles (e.g., overtime policy, transportation support).
  - Where possible, put longer-term contracts in place and implement staff performance reviews.

 Communications

- Make time-efficient use of existing communication channels to keep relevant ministries informed about DREAMS at the national and regional levels and develop short
memoranda of understanding with relevant ministries that commit to using these communication channels.

* Consider more frequent communication (between quarterly review meetings) with a representative from each SP if needed to maintain positive relationships—the success of the DREAMS Namibia consortium depends on healthy partner relationships.

* Put bidirectional communication processes in place between PHN national and district/regional offices so that staff queries receive timely responses.

**Cross-Cutting**

* Engage district CQI teams in strategic planning for how to maximally include boys in DREAMS activities and messaging already underway, without diverting financial resources or primary attention from AGYW.

* Look for opportunities to learn from the implementation of the DREAMS model across other Southern African Development Community (SADC) countries. This could include review of management best practices; how to move services away from an HF focus and into communities; how to retain DREAMS AGYW on ART and PrEP; and how to link older AGYW with successful ES opportunities. OGAC, the ISME, and/or USAID can play a role in facilitating these opportunities.
ANNEX I. SCOPE OF WORK

Assignment #: 757 [assigned by GH Pro]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: May 28, 2019
Last update: 09-06-19

I. TITLE: Performance Evaluation of Namibia’s DREAMS program

II. Requester / Client
☐ USAID Country or Regional Mission
Mission/Division: Namibia / __________________________

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
☐ 3.1.1 HIV
☐ 3.1.2 TB
☐ 3.1.3 Malaria
☐ 3.1.4 PIOET
☐ 3.1.5 Other public health threats
☐ 3.1.6 WSSH
☐ 3.1.7 FP/RH
☐ 3.1.8 MCH
☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. Cost Estimate: Note: GH Pro will provide a cost estimate based on this SOW

V. Performance Period
Expected Start Date (on or about): July 30, 2019
Anticipated End Date (on or about): November 29, 2019

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

| Namibia: |
| Oshikoto Region DREAMS Districts (3 districts), Project HOPE Namibia, |
| Windhoek Project Hope National Office and Sub-National Office |
| Katima Mulilo (1 district), Zambezi Project Hope Sub-National Office |

VII. 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): 1-year implementation

Performance evaluations encompass a broad range of evaluation methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making.

☐ 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. They 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)

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**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): **1-year implementation**

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?

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**VIII. BACKGROUND**

If an evaluation, Project/Program being evaluated:

<table>
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<tr>
<th>Project Title</th>
<th>DREAMS Program</th>
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PERFORMANCE EVALUATION OF NAMIBIA’S DREAMS PROGRAM / 32
A. Description of the Problem

HIV/AIDS response to Adolescent Girls and Young Women (AGYW)

Namibia has a high prevalence, high incidence, generalized, and mature HIV epidemic. The majority of new HIV infections are transmitted through unprotected heterosexual sex and mother-to-child transmission. HIV prevalence in adults aged 15-49 is 13.4% with women representing approximately six in 10 of those infected. Young women aged 15-24 also account for roughly one-third of new infections.

According to the new Spectrum projections, there are 6,152 new HIV infections [2,646 male and 3,506 female] in Namibia per year, and over 237,000 persons living with HIV. For the new HIV infections, 40 percent occur in women aged 15-24 - a very high rate of new infections. Girls and young women account for over 70 percent of new HIV infections among adolescents in sub-Saharan Africa, and nearly 1,000 adolescent girls and young women (AGYW) are infected with HIV every day. Each week in Namibia, approximately 42 AGYW are newly infected which represents a population at substantial risk.

Social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, gender-based violence, and school dropout rates all contribute to girls’ risk profiles and vulnerability to contracting HIV. The DREAMS initiative goes beyond health to address these factors – a key to reaching the Sustainable Development Goal of ending AIDS by 2030. The HIV response still remains overwhelmingly health facility-based, yet barriers to care exist (e.g. distance, transport costs, child care, etc.) which offer opportunities for implementers and partners to innovate an

B. Program Goal, Strategy and Expected Results

The DREAMS-Like Initiative builds on an existing foundation of HIV prevention, treatment and impact mitigation activities implemented by the Government of the Republic of Namibia. In collaboration with local organizations, the National HIV Response seeks to achieve HIV epidemic control among adult female populations to increase the number of girls enrolled and graduating from all levels of education. The national response also focuses on implementation of broad social protection programs to support vulnerable children given that Namibia experiences a large number of new HIV infections among 15 - 24-year-old females. The country has a generalized epidemic, where HIV is primarily transmitted through heterosexual and mother-to-child transmission (MTCT). Furthermore, HIV diagnosis and ART coverage rates indicate a significant unmet need for HIV testing and treatment among 15 - 24-year-old females and males.

The goal of the DREAMS Project is to help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) women. DREAMS initiatives aim to empower adolescent girls and young women to remain HIV free and achieve their full potential. The primary focus populations are adolescent girls who are in and out of school, orphans and vulnerable children, aged 10-18, and young women aged 19 - 24. The secondary focus population includes their male sexual partners, aged 20-49.
The DREAMS Project’s goal is to avert an estimated 504 new HIV infections among AGYW by 2021. This will be achieved by meeting the following intermediate results (IRs):

- IR1: Avert new HIV infections and decrease teenage pregnancy among adolescent girls and young women;
- IR2: Decrease gender-based violence rates among adolescent girls and young women;
- IR3: Link AGYW and their sexual partners to a continuum of services that include HIV prevention, treatment and post-GBV care;
- IR4: Improve educational status and economic empowerment among AGYW; and
- IR5: Strengthen the enabling environment for HIV prevention and mitigation activities focused on AGYW.

C. Description of DREAMS Project in Namibia

DREAMS program is implemented by a consortium led by Project HOPE Namibia (PHN). Consortium members include: Project HOPE US, IntraHealth International Inc., Star for Life Namibia (SLN), LifeLine/ChildLine Namibia (LCN), and Namibia University of Science and Technology (NUST).

PHN is the prime partner and program’s administrative secretariat, leading responses to mission requests, overseeing partners and implementation of agreements, and serving as the primary contact for USAID.

PEPFAR/Namibia DREAMS project seeks to avert new HIV infections among Adolescents and Young Women (AGYW) aged 10-24 years as the primary population of interest, with their male sexual partners of AGYW as secondary focus. The project offers the full package of services in Oshikoto Region and HIV mitigation only activities to orphans and vulnerable children (OVC) in Khomas and Zambezi regions respectively.

The overall technical approach for DREAMS is rooted in the Socio-Ecological Model (SEM) of change that acknowledges both individual agency and the impact of family/friends, community, and society on HIV-related behavior and outcomes. The model links the actions of individual target sub-populations (children, adolescents and young women) to the actions of families and communities, availability of services, the societal norms, policies, and social structures that govern them.

This mechanism implements adaptive management techniques and continually reviews its approach in light of program data, PEPFAR technical considerations, technical inputs from USAID and local and international bodies of literature. PEPFAR Namibia defined an enrollment criteria and a layering package that is implemented by all partners. The risk factors below are used to determine enrollment into the PEPFAR Namibia DREAMS project. AGYW meeting any one of the criteria below are deemed at risk of being or going “off-track” and eligible for enrolment into the DREAMS program.

- AGYW aged 9-14 who are or have been sexually active
- AGYW aged 15 and older who are sexually active and had or currently have multiple concurrent partners, or report inconsistent condom use.
- AGYW in school but not attending regularly (missed more than 2 days in the last month self-reported) or 2 or more years behind— screening further for reasons why school was missed such as illness, caring for ill family member, menstruation, partaking in economic activity, nutrition, marriage etc.
- AGYW <18 who have dropped out of school.
- AGYW disclosed engagement in commercial, transactional or intergenerational sex
- AGYW who are currently or have ever been pregnant
- AGYW exposed to violence including sexual violence, child abuse, physical threats, physical violence or emotional violence at home or from romantic partner/boyfriend
- AGYW experiencing neglect e.g. living without the emotional and financial support of adult caregiver
- AGYW who disclose alcohol and/or substance abuse of self or caregiver
- AGYW who has qualified as an OVC

Main entry points to recruit AGYW and OVC households include:

a) **Facility based:** The PEPFAR/Namibia DREAMS project works closely with health facilities to identify AGYW beneficiaries and it has also expanded on PHN’s highly successful model of index client recruitment—refined in USAID’s Namibia HIV Adherence and Retention Project (NARP)—to include new entry points. Strengthened Provider-Initiated Counseling and Testing (PITC) is used to identify and recruit beneficiaries in public and youth friendly health facilities. Facility points of recruitment include outpatient department (OPD) and primary health care centers (PHC), ART clinic, Pediatric Ward, ANC, PrEP, and Index testing points. The Community Care Workers (CCWs) cadre are responsible for working closely with health care workers in facilities to identify beneficiaries. The DREAMS project also collaborates with another PHN Project Namibia Adherence and Retention Project (NARP) to seek consent from beneficiaries to recruit eligible clients in the target regions.

b) **Household:** A census is conducted on households identified through the indexing client model or other means allowing identification of AGYW and other family members. Through this model, those who qualify as vulnerable AGYW will be recruited as index clients, followed by family members and others around them.

c) **School-based:** The project currently works with 32 schools to implement in school HIV and GBV education and prevention. Star for Life is responsible for leading the implementation of in-school activities. The Ministry of Education has been instrumental in identifying these schools and is further engaged to identify satellite schools from where AGYW can be recruited into safe spaces.

d) **Community-based:** Community Engagement: Community engagement is critical to the success of program activities. Entry into the community involves gatekeepers and consultations with stakeholders at various levels of national line ministries, regional and district government structures, community leaders, school principals, and the general community. Through these meetings, DREAMS seek input from the stakeholders on district and local priorities related to meeting the needs of AGYW, OVC and their caregivers.

Child Welfare/MGECW intervention-based: The DREAMS project works to strengthen collaboration with the MGECW to enroll AGYW vulnerable grant recipients, GBV survivors and other eligible clients identified in the ministry’s case management system. Furthermore, where CLHIV are identified, they are referred to and reported under NARP for OVC.

D. **Summary of the Project/Activity Monitoring, Evaluation, and Learning (MEL) Plan**
The project has a variety of data sources which includes:

a. Cooperative Agreement
b. Annual and Quarterly Reports and performance reviews
c. Project M&E Plan or Performance Monitoring Plan (PMP)
d. Result Framework/Technical Approach
e. Annual work plans
f. Activity deliverables (tools, training curricula)
g. Financial data
h. Program data (IP databases)
i. Formative baseline assessment
In addition to the above-mentioned data sources, the evaluators should utilize DREAMS Guidance, DREAMS layering by age groups (10-14, 15-19, and 20-24), DREAMS Completion table and other qualitative and quantitative data sources, including PEPFAR DATIM, to conduct a performance evaluation of the implementation of the package of DREAMS services provided to AGYWs.

Theory of Change of target project/program/intervention

[Diagram showing the Theory of Change model with steps for supply, demand, and uptake of the package, including core package, mediators of change, and outcomes such as safer sexual relationships, social protection, and biological protection from HIV.]
What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Oshikoto Region: Omuthiya, Onandjokwe, Tsumeb
Zambezi region: Katima Mulilo (OVC only)
Khomas region: Windhoek (OVC only)

IX. Purpose, Audience & Application

A. Purpose: Why is this evaluation/assessment 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.

The purpose of this DREAMS performance evaluation is to:
Understand the performance, capacity and effectiveness of the start-up of the project in meeting the intended results in one year;

Provide specific information about the gaps and opportunities for the project that can be acted upon by project and USAID management staff in the implementation of the first 18 months of the project;

To identify areas that need to be modified/improved to increase the likelihood of success in existing and potential new health districts.

USAID Namibia technical and management teams will utilize the findings from the evaluation to understand the gaps in implementation and to make decisions and take necessary actions accordingly.

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

The main audience for the analysis is USAID Namibia and the USAID Regional Office in Pretoria, Secondly, it is USG and implementing partners. Major finding and recommendations will be shared to local government, and OHA and OGAC DREAMS teams.

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

Findings are expected to inform USAID Namibia on how to plan, improve the implementation and scale-up of the DREAMS program based on detailed findings and recommendations (USG specific). In addition, USAID will share recommendations with local government, OHA/OGAC DREAMS team and other relevant stakeholders.

D. **Evaluation/Analytic Questions & Matrix:**

- Questions should be: a) aligned with the evaluation/assessment 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, age, geographic locale, age, etc.), they must be incorporated into the evaluation/assessment questions.

  **USAID Evaluation Policy** recommends 1 to 5 evaluation questions.

- State the method and/or data source and describe the data elements needed to answer the evaluation questions

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Suggested Data Sources</th>
<th>Suggested Data Collection Methods</th>
<th>Data Analysis Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Since project start-up, to what extent has PHN implemented in the technical approach, service delivery approach, implementation plan, outputs and beneficiary targets included in the initial technical narrative? Include information on: a) Efforts made to mitigate barriers or constraints limiting program implementation</td>
<td>Program Description (PD) with goals and results, work plans, PMP, quarterly reports, key informant interviews, site level record reviews, formative assessment of DREAMS intervention areas.</td>
<td>Key informant interviews, site visits, desk review</td>
<td>Pre- and post-baseline data and targets vs. achievements, progress to date and anticipated achievement of goals/milestones; descriptive statistics Qualitative analysis of key informant interviews targeting both beneficiaries, implementing staff, and key stakeholders</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Suggested Data Sources</td>
<td>Suggested Data Collection Methods</td>
<td>Data Analysis Methods</td>
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<td>-------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>b) Factors that facilitated successful program implementation</td>
<td>Selection of three or more interventions / activities, and tools used across each age group.</td>
<td>Content technical review of quality of product, compared to DREAMS packages of services and PEPFAR standards.</td>
<td>Rating of training curriculum, tools using checklist against standards. (Checklist to be developed by Evaluation Team.)</td>
</tr>
<tr>
<td>2 What are the strengths and challenges to the program inputs, implementation of interventions/activities and processes, and the quality of outputs and outcomes at each age category of AGYW?</td>
<td>Project documents (organogram, management functions, financial records, HR records, process documents, meeting minutes and notes, etc.)</td>
<td>Desk reviews Key informant interviews (project and USAID staff in DC and Namibia)</td>
<td>Content analysis Qualitative analysis of key informant interviews</td>
</tr>
<tr>
<td>3 What systems are in place to identify and remedy challenges on program management and structure (i.e., planning, human resources, financial, operations, and communications)?</td>
<td>Project documents (organogram, management functions, financial records, HR records, process documents, meeting minutes and notes, etc.)</td>
<td>Desk reviews Key informant interviews (project and USAID staff in DC and Namibia)</td>
<td>Content analysis Qualitative analysis of key informant interviews</td>
</tr>
<tr>
<td>4 What is the capacity (i.e., planning, human resources, financial, operations, and communications) of PHN and sub partners to effectively implement the DREAMS program?</td>
<td>Project documents (organogram, management functions, financial records, HR records, process documents, meeting minutes and notes, etc.)</td>
<td>Desk reviews Key informant interviews (project and USAID staff in DC and Namibia)</td>
<td>Content analysis Qualitative analysis of key informant interviews</td>
</tr>
</tbody>
</table>

**Other Questions [OPTIONAL]**
(***Note**: Use this space only if necessary. Too many questions lead to an ineffective evaluation or analysis.)

**X. Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/assessment 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.

**General Comments related to Methods:**
USAID/Namibia would like the evaluation team to observe how DREAMS packages of services have been implemented at each age category for AGYW, their male partner, families and communities and whether it is with fidelity as required by PEPFAR.
As required by USAID policy, all evaluations must be gender-sensitive, meaning that all stages of the evaluation should reflect: 1) an awareness that the degree and meaning of program participation, program results, and potential sustainability are shaped by gender; 2) a recognition that explicit attention to gender issues must be integrated into the evaluation if gender equality objectives are to be addressed; and 3) a commitment to examining the extent to which gender equality was achieved as a result of the program or project that was implemented.

In addition to answering the above evaluation questions, USAID expects that the evaluation team develops specific recommendations for the remainder of the DREAMS project period of performance and scaling-up to any additional regions/districts. Recommendations should be based on scientific evidence and pragmatic experiences from other development programs. If any specific DREAMS’s methodology, approach, or tool is considered inappropriate, the evaluation team should be able to provide alternatives based on existing methodologies, approaches, or tools. In addition, while the primary purpose of this performance evaluation is to inform and course correct the current project, USAID would appreciate recommendations for the scale-up of DREAMS services package to an additional 7 districts in the next 2 years, including technical and management recommendations that can inform any future procurements.

**Document and Data Review** *(list of documents and data recommended for review)*

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- 2017/2018 PEPFAR Country Operational Plan
- 2018/2019 PEPFAR HIV Country Operational Plan
- Namibia National Health Strategic Framework (2019-2024)
- NAMPHIA Data (2017/2018)
- Namibia Combination Prevention strategy
- Namibia DHS 2013
- USAID Quarterly Performance review slides
- PEPFAR Quarterly report in DATIM (PEPFAR reporting system)
- 2018-09-26 DREAMS Layering Guidance FY19 Update
- DREAMS Guidance
- 2018-02-01 DREAMS Efficiency Questions
- MER Indicator Reference Guide (Version 2.3 FY19)
- DREAMS Namibia Layering Table
- DREAMS Namibia Completion Table
- PEPFAR OVC Guidance
- GBV Guidance

**Secondary analysis of existing data** *(This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)*

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine health data: GRN and DREAMS</td>
<td></td>
<td>Re-analysis of existing data to see how it can be better used <em>(Note: USAID/Namibia will obtain access to these datasets for the Evaluation Team.)</em></td>
</tr>
<tr>
<td>Formative Assessment data for DREAMS from the partner</td>
<td></td>
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</tr>
</tbody>
</table>

PERFORMANCE EVALUATION OF NAMIBIA’S DREAMS PROGRAM / 40
### Key Informant Interviews
*List categories of key informants and purpose of inquiry*

The evaluation team will meet with implementing partner DREAMS POC in Washington DC and Namibia, as well as USAID staff in Namibia and some technical backstops in USAID/W, to gather input and feedback into the implementing partner performance.

DREAMS/HIV: national, facility-based government, and community counterparts (MOHSS, MGECW, Ministry of Education); USG Namibia DREAMS Team; DREAMS(AGYW)technical working group consortium members (expats and Namibians; using different questionnaires).

### Focus Group Discussions
*List categories of groups, and purpose of inquiry*

DREAMS AGYW (out of school) in Safe Spaces, Parents in the FMP groups

### Group Interviews
*List categories of groups, and purpose of inquiry*

Key informants may be interviewed in small groups of similar respondents, as long as all participants feel free to express their own opinions.

### Client/Participant Satisfaction or Exit Interviews
*List who is to be interviewed, and purpose of inquiry*

DEARMS: AGYW

### Survey
*Describe content of the survey and target responders, and purpose of inquiry*

### Facility or Service Assessment/Survey
*List type of facility or service of interest, and purpose of inquiry*

### Observations
*List types of sites or activities to be observed, and purpose of inquiry*

Direct observations to be discussed and decided upon with USAID/Namibia. This is DREAMS result specific (training, AGYW packages of services, coordination with sub-grantee). It'll depend on evaluation dates. Government of Republic of Namibia and its structures will be informed in advance.

### Cost Analysis
*List costing factors of interest, and type of costing assessment, if known*

### 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*

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

### 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/assessment, 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

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

XII. HUMAN SUBJECT PROTECTION
The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:
- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

No formal IRB approval will be requested from the MOHSS for this internal performance evaluation; however, by norm the ministry requires such approval if health care workers will be involved in a study or research activity. During any possible key informant interviews with health care workers employed by the MOHSS, the analytic team should therefore stress that this evaluation is for internal purposes only and the results will not be shared outside of USAID and the DREAMS project team.

XII. 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 interviews 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 the project/program’s achievements against its objectives and/or targets.
Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. 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/program performance indicator data, DHS, NAMPHIA data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe brief analytic methods s employed in this evaluation if any.

XIII. 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** – Several documents are available for review for this analytic activity. These include DREAMS initiatives and packages of services, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data available since project start up on 4 June 2018. 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)** – A two-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection 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
- 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
- Assign drafting/writing responsibilities for the final report

**Briefing and Debriefing Meetings** – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief 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/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID,** as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the
project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

- **Work plan and methodology review briefing.** At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.

- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

- The Team Lead (TL) will brief the USAID/ Namibia weekly to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

- **A final debrief** between the Evaluation Team and USAID/Namibia will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. Additionally, USAID/Southern Africa Regional Mission has requested a debrief. This will be discussed during the USAID in-brief and Team Planning Meeting. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.)

- **IP and Stakeholders’ debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be procurement deemed sensitive or not suitable by USAID.

**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. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

**Evaluation Report** – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. USAID will manage implementing partner(s)’s (IP) review of the report and compile and send their comments and edits to GH Pro. (Note: USAID will decide what draft they want the IP to review.)
5. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
6. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
7. Once the Evaluation Report is approved, GH Pro will reformat and edit it for 508-compliance and post it to the DEC.

The Evaluation Report excludes any procurement-sensitive and other sensitive but unclassified (SBU) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report.
**Data Submission** – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

**XIV. 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.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Launch briefing</td>
<td>August 5, 2019</td>
</tr>
<tr>
<td>☐ In-brief with USAID</td>
<td>August 27, 2019</td>
</tr>
<tr>
<td>☐ Workplan and methodology review briefing</td>
<td>August 30, 2019</td>
</tr>
<tr>
<td>☐ Workplan submitted to USAID (must include questions, methods, timeline, data analysis plan, and instruments)</td>
<td>August 30, 2019</td>
</tr>
<tr>
<td>☐ In-briefing with DREAMS/Namibia IP</td>
<td>August 28, 2019</td>
</tr>
<tr>
<td>☐ Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>☐ Debrief with USAID with Power Point presentation</td>
<td>September 26, 2019</td>
</tr>
<tr>
<td>☐ IP &amp; stakeholders’ findings review workshop with Power Point presentation</td>
<td>September 27, 2019</td>
</tr>
<tr>
<td>☐ Draft report</td>
<td>Submit to GH Pro: October 7, 2019&lt;br&gt;GH Pro submits to USAID: October 11, 2019&lt;br&gt;USAID shares feedback on report: October 20, 2019</td>
</tr>
<tr>
<td>☐ Final report</td>
<td>Submit to GH Pro: October 24, 2019&lt;br&gt;GH Pro submits to USAID: October 30, 2019</td>
</tr>
<tr>
<td>☐ Raw data (cleaned datasets in CSV or XML with codesheet)</td>
<td>October 15, 2019</td>
</tr>
<tr>
<td>☐ Report Posted to the DEC if needed</td>
<td>November 29, 2019</td>
</tr>
<tr>
<td>☐ Other (specify):</td>
<td></td>
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</tbody>
</table>

**Note:** USAID needs the report with the Findings and Recommendations as soon as possible. If the Team moves this timeline along quicker and submit a solid first draft of the report earlier, the Mission would appreciate this.

**Holidays:**
- August 26, 2019 ..........Heroes’ Day (Namibia)
- September 2, 2019..........Labor Day (US)
- October 14, 2019 ..........Columbus Day (US)
- November 11, 2019 ........Veterans Day (US)

**Estimated USAID review time**

Average number of business days USAID will need to review the Report? _____ 5 _____ Business days
XV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Assessment 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/assessments 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 methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI), or describing the conflict of interest if applicable.

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

- List desired qualifications for the team as a whole
- List the key staff needed for this analytic activity and their roles.
- Sample position descriptions are posted on USAID/GH Pro webpage
- Edit as needed GH Pro provided position descriptions

Overall Team requirements:
The evaluation team should include a team leader with 2 additional team members and an evaluation assistant/logistics coordinator. The positions include: Team Leader (1), Local Evaluation Specialist (1), Technical (HIV, AGYW Specialist and Evaluation Assistant/logistics (1). All key staff team members should have extensive experience conducting performance evaluations. All team members should have experience working in global public health (HIV/AIDS, and AGYW interventions. Among the key staff team members, the team will have expertise in HIV, DREAMS packages of services.

Key Staff 1 Title: Team Lead:
Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on analytic issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. The team leader will be responsible for (1) providing team leadership; (2) managing the team’s activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/assessment team, and (5) leading briefings and presentations.
Qualifications:
- Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations and/or assessments
- Experience in design and implementation of evaluations and/or assessments
- Demonstrated experience leading health sector project/program evaluation/assessments, utilizing both quantitative and qualitative s methods
- Excellent skills in planning, facilitation, and consensus building
• Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
• Excellent skills in project management
• Excellent organizational skills and ability to keep to a timeline
• Good writing skills, with extensive report writing experience
• Experience working in the region, and experience in Namibia is desirable
• Experience implementing and coordinating others to implement surveys, key informant interviews, focus groups, observations and other evaluation and assessment methods that assure reliability and validity of the data

**Key Staff 2 Title: Local Evaluation Specialist**

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing expertise in Evaluation methods, tools and data analysis. S/He will participate in planning and briefing meetings, data collection, and data

**Qualifications:**
• At least 6 years’ of experience in conducting evaluation of projects and programs with the same magnitude
• Experience in conducting USAID evaluations of health programs/activities
• Familiarity with USAID Evaluation policy, Results frameworks, Performance monitoring plans
• Strong knowledge, skills, and experience in qualitative and quantitative analytic tools
• Experience in data management
• Able to analyze quantitative data, which will be primarily descriptive statistics and cross-tabulations
• Able to analyze qualitative data
• Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
• Experience conducting secondary analysis of existing quantitative datasets
• Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
• Strong data interpretation and presentation skills

**Key Staff 3 Title: Technical (HIV, AGYW Specialist)**

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing expertise in HIV and AGYW interventions. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

**Qualifications:**
• At least 8 years’ experience with HIV prevention and AGYW programs projects; USAID project implementation experience preferred
• Expertise in HIV Prevention and AGYW activities
• Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
• Good writing skills, including experience writing evaluation and/or assessment reports
• Experience in conducting USAID evaluations of health programs/activities
Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

| Local Evaluation Assistant/Logistics | (1 consultant) will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation, as well as assist with data collection and data management. S/He may also be asked to assist with data analysis and report writing, as needed. The Evaluation Assistant will have a good command of English and one of the Namibian local language spoken in Oshikoto. S/He will have knowledge of key actors in the health sector and their locations including MOHSS, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and ensure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly, as well as assist with the conduct of the evaluation, as needed. S/He may also be asked to assist in translation of data collection tools and transcripts. |

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 assessment activity.

☐ Full member of the Evaluation Team (including planning, data collection, and analysis and report development) – If yes, specify who:

☐ Some Involvement anticipated – If yes, specify who:

☐ No

Staffing Level of Effort (LOE) Matrix:
This 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.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.

b) Immediately below each staff title enter the anticipated number of people for each titled position.

c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.

d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.

e) 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.

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation/Analytic Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team Lead</td>
</tr>
<tr>
<td>1 Launch Briefing</td>
<td>0.5</td>
</tr>
<tr>
<td>2 HTSOS</td>
<td>1</td>
</tr>
<tr>
<td>3 Desk review</td>
<td>4</td>
</tr>
<tr>
<td>4 Preparation for Team convening in-country</td>
<td>0.5</td>
</tr>
<tr>
<td>5 Travel to country</td>
<td>2</td>
</tr>
<tr>
<td>Activity / Deliverable</td>
<td>Evaluation/Analytic Team</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td>Team Lead</td>
</tr>
<tr>
<td>6 In-brief with Mission</td>
<td>0.5</td>
</tr>
<tr>
<td>7 Team Planning Meeting</td>
<td>3</td>
</tr>
<tr>
<td>8 Workplan and methodology briefing with USAID</td>
<td>0.5</td>
</tr>
<tr>
<td>9 Eval planning deliverables: 1) workplan with timeline, eval matrix, protocol (methods, sampling &amp; analytic plan); 2) data collection tools</td>
<td>1</td>
</tr>
<tr>
<td>10 Data Collection DQA Workshop (protocol orientation/training for all data collectors)</td>
<td>1.5</td>
</tr>
<tr>
<td>11 In-brief with project</td>
<td>0.5</td>
</tr>
<tr>
<td>12 Prep / Logistics for Site Visits</td>
<td>0.5</td>
</tr>
<tr>
<td>13 Data collection / Site Visits (including travel to sites)</td>
<td>14</td>
</tr>
<tr>
<td>14 Data analysis</td>
<td>4</td>
</tr>
<tr>
<td>15 Debrief with Mission with prep</td>
<td>1</td>
</tr>
<tr>
<td>16 IP &amp; Stakeholder debrief workshop with prep</td>
<td>1</td>
</tr>
<tr>
<td>17 Data management</td>
<td></td>
</tr>
<tr>
<td>18 Depart country</td>
<td>2</td>
</tr>
<tr>
<td>19 Draft report(s)</td>
<td>5</td>
</tr>
<tr>
<td>20 GH Pro Report QC Review &amp; Formatting</td>
<td></td>
</tr>
<tr>
<td>21 Submission of draft report(s) to Mission</td>
<td></td>
</tr>
<tr>
<td>22 USAID Report Review</td>
<td></td>
</tr>
<tr>
<td>23 Revise report(s) per USAID comments</td>
<td>3</td>
</tr>
<tr>
<td>24 Finalize and submit report to USAID</td>
<td>0.5</td>
</tr>
<tr>
<td>25 USAID approves report</td>
<td></td>
</tr>
<tr>
<td>26 Final copy editing and formatting</td>
<td></td>
</tr>
<tr>
<td>27 508 Compliance editing</td>
<td></td>
</tr>
<tr>
<td>28 Eval Report(s) to the DEC</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total LOE</strong></td>
</tr>
</tbody>
</table>
Billing up to seven (7) days in any consecutive seven (7)-day period is approved when traveling to or from the Consultant’s home of record:  
☐ No  ■ Yes

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

**Namibia**: Data collection will occur in 5 Districts (3 Regions) where DREAMS is implemented
- Oshikoto Region: 1) Omuthiya, 2) Onandjokwe, 3) Tsumeb Districts
- Zambezi region: 4) Katima Mulilo District
- Khomas region: 5) Windhoek

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**XVI. LOGISTICS**

**Visa Requirements**
List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

- Visa will be obtained in advance of travel to Namibia

List recommended/required type of Visa for entry into counties where consultant(s) will work

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Type of Visa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Namibia</td>
<td>☐ Tourist</td>
</tr>
</tbody>
</table>
Clearances & Other Requirements

*Note:* Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant’s behalf.

GH Pro can obtain **Facility Access (FA)** and transfer existing **Secret Security Clearance** for our consultants, but please note these requests, processed through AMS at USAID/GH (Washington, DC), can take 4-6 months to be granted. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. FAs for non-US citizens or Green Card holders must be obtained through the RSO. If FA or Security Clearance is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant’s travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**. HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. **[Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]**

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one-week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

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 (FA)
- [ ] Electronic Country Clearance (ECC) (International travelers only)
- [ ] High Threat Security Overseas Seminar (HTSOS) *(required in most countries with ECC)*
- [ ] Foreign Affairs Counter Threat (FACT) *(for consultants working on country more than 45 consecutive days)*
- [ ] GH Pro workspace
- [ ] Travel -other than posting *(specify):* Travel to sites for data collection
- [ ] Other *(specify):* Problems accessing cash from ATMs. Credit cards use is limited (big hotels accept credit cards, except American Express)

Specify any country-specific **security concerns and/or requirements**

**XVII. GH PRO ROLES AND RESPONSIBILITIES**
GH Pro will coordinate and manage the evaluation/assessment 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/assessment 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, workplan, 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.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
</tbody>
</table>

**Before Field Work**

- **SOW**
  - 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 with communications for 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.
XVIII. ANALYTIC REPORT

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

The Evaluation/Analytic Final Report must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

- The report should not exceed 30 pages (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found here or here.
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people’s opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/assessment report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.

The findings from the evaluation/assessment will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
• Table of Contents (1 page)
• Acronyms
• Evaluation/Analytic Purpose and Evaluation/Analytic Questions: state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)
• Project [or Program] Background: describe the project/program and the background, including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)
• Evaluation/Analytic Methods and Limitations: data collection, sampling, data analysis and limitations (1-3 pages)
• Findings (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data
• Conclusions
• Recommendations
• Annexes
  o Annex I: Evaluation/Analytic Statement of Work
  o Annex II: Evaluation/Analytic Methods and Limitations ((if not described in full in the main body of the evaluation report)
  o Annex III: Data Collection Instruments
  o Annex IV: Sources of Information
    ▪ List of Persons Interviews
    ▪ Bibliography of Documents Reviewed
    ▪ Databases
    ▪ [etc.]
  o Annex V: Statement of Differences (if applicable)
  o Annex VI: Disclosure of Any Conflicts of Interest
  o Annex VII: Summary information about evaluation team members, including qualifications, experience, and role on the team.

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

The Evaluation Report should exclude any potentially procurement-sensitive information. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XIX. USAID CONTACTS

<table>
<thead>
<tr>
<th>Name:</th>
<th>Primary Contact</th>
<th>Alternate Contact</th>
<th>Alternate Contact</th>
<th>Alternate Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Molisa Manyando</td>
<td>Abeje Zegeye</td>
<td>Daniel Lee</td>
<td>Johanna Mufeti</td>
</tr>
<tr>
<td>Program Management Specialist</td>
<td>HIV/AIDS Team Lead</td>
<td>Strategic Information Team Lead</td>
<td>Data Analyst</td>
<td></td>
</tr>
</tbody>
</table>
XX. OTHER REFERENCE MATERIALS
Documents and materials needed and/or useful for consultant assignment, that are not listed above

XXI. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (To be completed after Assignment Implementation by GH Pro)
## Annex II. Dreams Layering for Namibia

<table>
<thead>
<tr>
<th>10-14</th>
<th>15-19</th>
<th>20-24</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Interventions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In-school HIV/GBV prevention education</td>
<td>• In-school or community HIV/GBV prevention education</td>
<td>• Screened and linked to HTS as needed</td>
</tr>
<tr>
<td>• Risk assessment for HIV and referral for those in need of HTS</td>
<td>• Screened and linked to HTS as needed</td>
<td>• SRH screening and referrals with method provision as appropriate</td>
</tr>
<tr>
<td>• SRH risk assessment and referrals as appropriate</td>
<td>• SRH screening and referrals with method provision as appropriate</td>
<td>• GBV screening and referrals with appropriate intervention</td>
</tr>
<tr>
<td>• GBV screening and referrals with appropriate intervention</td>
<td>• GBV screening and referrals with appropriate intervention</td>
<td>• Social asset building</td>
</tr>
<tr>
<td>• Social asset building</td>
<td>• Social asset building</td>
<td>• Condom provision</td>
</tr>
<tr>
<td><strong>Secondary Interventions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Post-violence care</td>
<td>• PrEP as appropriate</td>
<td>• PrEP as appropriate</td>
</tr>
<tr>
<td>• In-school HIV/GBV prevention education</td>
<td>• Post-violence care</td>
<td>• Post-violence care</td>
</tr>
<tr>
<td>• Parenting program</td>
<td>• In-school or community HIV/GBV prevention education</td>
<td>• Socio-economic strengthening</td>
</tr>
<tr>
<td>• Economic strengthening for families</td>
<td>• Parenting program</td>
<td>• Education support – bridge to tertiary or employment</td>
</tr>
<tr>
<td>• Education support</td>
<td>• Economic strengthening for families</td>
<td></td>
</tr>
<tr>
<td>• GBV prevention for the girl</td>
<td>• Economic strengthening for the AGYW</td>
<td></td>
</tr>
<tr>
<td>• Condom provision</td>
<td>• Education support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• GBV prevention for the girl</td>
<td></td>
</tr>
<tr>
<td><strong>Contextual</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community mobilization &amp; norms change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Referrals (HTC, VMMC, ART) for male sex partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• GBV Post Violence: training and dissemination of clinical guideline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Condom promotion campaign/demand creation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ANNEX III. HUMAN RESOURCES STAFFING

As at September 30, 2019

<table>
<thead>
<tr>
<th>Job Category</th>
<th># of Position</th>
<th>DOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country Director</td>
<td>1</td>
<td>Aug-18</td>
</tr>
<tr>
<td>Dep. Chief of party</td>
<td>1</td>
<td>Jun-18</td>
</tr>
<tr>
<td>Sr. OVC Advisor</td>
<td>1</td>
<td>Jun-18</td>
</tr>
<tr>
<td>Cavity Dev. Manager</td>
<td>1</td>
<td>Jul-18</td>
</tr>
<tr>
<td>Driver</td>
<td>2</td>
<td>Sep-19</td>
</tr>
<tr>
<td>Reg. Comm. Serv. Manager</td>
<td>2</td>
<td>Sep-19</td>
</tr>
<tr>
<td>FAO</td>
<td>1</td>
<td>Oct-18</td>
</tr>
<tr>
<td>Database Mng Officer</td>
<td>4</td>
<td>Nov-19</td>
</tr>
<tr>
<td>Health Informatic Advisor</td>
<td>1</td>
<td>Oct-18</td>
</tr>
<tr>
<td>Finance Clerk</td>
<td>2</td>
<td>Nov-19</td>
</tr>
<tr>
<td>Cleaner</td>
<td>3</td>
<td>Jan-19</td>
</tr>
<tr>
<td>Child Protection Officer</td>
<td>5</td>
<td>Jan-19</td>
</tr>
<tr>
<td>District Team Leader</td>
<td>3</td>
<td>Feb-19</td>
</tr>
<tr>
<td>Family Matter Facilitator</td>
<td>16</td>
<td>Feb-19</td>
</tr>
<tr>
<td>Data Entry Clerk</td>
<td>5</td>
<td>Jun-19</td>
</tr>
<tr>
<td>Temp. R/Nurse</td>
<td>10</td>
<td>Jun-19</td>
</tr>
<tr>
<td>R/Nurse</td>
<td>3</td>
<td>Jun-19</td>
</tr>
<tr>
<td>Sr. Gender Officer</td>
<td>1</td>
<td>Jul-19</td>
</tr>
<tr>
<td>Temp Data Entry clerk</td>
<td>3</td>
<td>Jul-19</td>
</tr>
<tr>
<td>Social worker</td>
<td>1</td>
<td>Sep-19</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>2</td>
<td>Aug-19</td>
</tr>
<tr>
<td>CCW</td>
<td>47</td>
<td>Nov-19</td>
</tr>
<tr>
<td>CCW</td>
<td>43</td>
<td>Feb-19</td>
</tr>
<tr>
<td>CCW</td>
<td>41</td>
<td>Jun-19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>199</strong></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX IV. PEPFAR INDICATORS REPORTED ON BY DREAMS NAMIBIA

PP_PREV: Number of AGYW reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake

AGYW_PREV: Percentage of adolescent girls and young women (AGYW) that completed the DREAMS primary package of evidence-based services/interventions

PrEP_NEW: Number of individuals who have been newly enrolled on antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period

GEN_GBV: Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package

OVC_SERV: Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV

OVC_HIVSTAT: The proportion of OVC with known HIV status

---

42 This indicator is reported on by the USG team rather than implementing partners. IPs collect the data and USG uses the layering data and service completion for its reporting.
ANNEX V. BIBLIOGRAPHY OF DOCUMENTS REVIEWED

5. A Focused Response to Children and Adolescents in an Evolving Pandemic; Ambassador Deborah L. Birx, M.D. U.S. Global AIDS Coordinator & U.S. Special Representative for Global Health Diplomacy May 29, 2019

6. Activity Monitoring, Evaluation and Learning Plan (AMELP), JUNE, 2018 – SEPTEMBER, 2023; DREAMS/Twagamenwa USAID/Namibia; Rosalia Indongo (Country Director Project HOPE Namibia)

7. Clinical Handbook on the Health Care of Survivors Subjected to Intimate Partner Violence and/or Sexual Violence, Namibia; REPUBLIC OF NAMIBIA Ministry of Health and Social services; World Health Organization; Department of Reproductive Health and Research World Health Organization

8. Database Briefer


10. DREAMS Core Package of Interventions Summary

11. DREAMS Efficiency Questions, 2018.02.01

12. DREAMS LAYERING FOR NAMIBIA; Layering Table – November 30, 2018

13. DREAMS Namibia Factsheet

14. DREAMS Namibia Factsheet (second)

15. DREAMS STTT – Completion and Saturation, 2019.01.07

16. DREAMS TWAGAMENWA; Year-I Implementation Work Plan June 04, 2018 to September 30, 2019 Revised version; Rosalia Indongo Country Director Project HOPE Namibia

17. DREAMS_Datim_DataTables_SARP.2019


20. Guidance for Completing the Data Entry Tracker sheet; DREAMS; March 2019

21. GUIDANCE FOR ORPHANS AND VULNERABLE CHILDREN PROGRAMMING; The U.S. President's Emergency Plan for AIDS Relief; July 2012

22. HIV COMBINATION PREVENTION GUIDELINE; NAMIBIA 2018; Republic of Namibia Ministry of Health and Social Services;

23. Implementing Mechanism Quarterly Report; DREAMS / Twagamenwa implemented by Project HOPE Namibia, AID 72067318CA00002, Reporting Period: Q1; FY19

24. Implementing Mechanism Quarterly Report; DREAMS / Twagamenwa implemented by Project HOPE Namibia, AID 72067318CA00002, Reporting Period: Q3; FY19
25. Implementing Mechanism Quarterly Report; DREAMS implemented by Project HOPE Namibia, AID 72067318CA00002; Reporting Period: Q2; FY19
26. Implementing Mechanism Quarterly Report; DREAMS/ Twagamenwa implemented by Project HOPE Namibia, AID 72067318CA00002, Reporting Period: Q4; 2018
27. Improving GEND GBV Data Quality to Enhance PEPFAR Program Performance, MEASURE Evaluation, September 2019
28. Layering in DREAMS; DREAMS Layering Guidance (version 2.0) September 26, 2018
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## ANNEX VI. LIST OF PERSONS INTERVIEWED

<table>
<thead>
<tr>
<th>Name</th>
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<td>Daniel Lee</td>
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<td>Johanna Mufeti</td>
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<td>Dee Dee Yates</td>
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<td>Julius Natangwe Nghifikwa</td>
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</tr>
<tr>
<td>Helvic Mpango</td>
<td>ESO</td>
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<tr>
<td>Prima Sepiso</td>
<td>CCW</td>
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<td>PHN</td>
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<tr>
<td>Precious Sililo</td>
<td>CCW</td>
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<tr>
<td>Naluca Musweu</td>
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<tr>
<td>Jacqueline Mukupi</td>
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<tr>
<td>Jacqueline Muhinda</td>
<td>Data Clerk</td>
<td>Female</td>
<td>PHN</td>
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<tr>
<td>Mwangala Mutau</td>
<td>OVC Caretaker Facilitators</td>
<td>Female</td>
<td>PHN</td>
<td>Katima Mulilo district, Zambezi region</td>
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<tr>
<td>Hilary Muyunda</td>
<td>OVC Caretaker Facilitators</td>
<td>Female</td>
<td>PHN</td>
<td>Katima Mulilo district, Zambezi region</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Gender</td>
<td>Organization</td>
<td>Location (Town/Facility/District/ Region)</td>
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<tr>
<td>Mercedes Liswaniso</td>
<td>OVC Caretaker Facilitators</td>
<td>Female</td>
<td>PHN</td>
<td>Katima Mulilo district, Zambezi region</td>
</tr>
<tr>
<td>Adolfine April</td>
<td>District Team Lead: Khomas</td>
<td>Female</td>
<td>PHN</td>
<td>Windhoek district, Khomas region</td>
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<tr>
<td>Martha Shimuleni</td>
<td>Regional CPO</td>
<td>Female</td>
<td>PHN</td>
<td>Windhoek district, Khomas region</td>
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<tr>
<td>David Nanub</td>
<td>ESO</td>
<td>Male</td>
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<tr>
<td>Dorian Angula</td>
<td>DMO</td>
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<tr>
<td>Pendukeni Shindombo</td>
<td>CCW</td>
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<tr>
<td>Veronica Mwatukange</td>
<td>CCW</td>
<td>Female</td>
<td>PHN</td>
<td>Windhoek district, Khomas region</td>
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**External Stakeholders**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Gender</th>
<th>Organization</th>
<th>Location (Town/Facility/District/ Region)</th>
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<tbody>
<tr>
<td>Ellen Lachlan</td>
<td>DREAMS Project Director</td>
<td>Female</td>
<td>ITECH</td>
<td>Windhoek, Khomas region</td>
</tr>
<tr>
<td>Serley Khaxas</td>
<td>Director/ Founder</td>
<td>Female</td>
<td>LIDAR Community Foundation</td>
<td>Windhoek, Khomas region</td>
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<tr>
<td>Romanzo Steenkamp</td>
<td>Programs Manager</td>
<td>Male</td>
<td>LIDAR Community Foundation</td>
<td>Windhoek, Khomas region</td>
</tr>
<tr>
<td>Taimi Amaambo</td>
<td>Country Director</td>
<td>Female</td>
<td>Society for Health</td>
<td>Khomas, Windhoek</td>
</tr>
<tr>
<td>Linda Baumann</td>
<td>Director</td>
<td>Female</td>
<td>Namibian Diverse Women’s Association</td>
<td>Khomas, Windhoek</td>
</tr>
<tr>
<td>Justina Amupolo</td>
<td>Director</td>
<td>Female</td>
<td>Namibian Diverse Women’s Association</td>
<td>Khomas, Windhoek</td>
</tr>
<tr>
<td>Teddy Kandjou</td>
<td>N/A</td>
<td>Transgender man</td>
<td>Wings to Transcend</td>
<td>Khomas, Windhoek</td>
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<tr>
<td>Mama Afrika (Nikodemus Aoxamub)</td>
<td>Director</td>
<td>Transgender woman</td>
<td>Rights not Rescue Trust</td>
<td>Khomas, Windhoek</td>
</tr>
<tr>
<td>Daniel Trum</td>
<td>Chairperson</td>
<td>Male</td>
<td>National Federation of People with Disabilities in Namibia</td>
<td>Windhoek, Khomas region</td>
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**Focus Group Discussions**

<table>
<thead>
<tr>
<th>Type of Group</th>
<th>Location</th>
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<tr>
<td>Group discussion with District DREAMS team</td>
<td>Several in following districts:</td>
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<tr>
<td></td>
<td>Windhoek</td>
</tr>
<tr>
<td></td>
<td>Tsumeb</td>
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<td></td>
<td>Omuthiya</td>
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<td></td>
<td>Onandjokwe</td>
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<tr>
<td>Type of Group</td>
<td>Location</td>
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<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Informal conversations with OOS AGYW participating in VSL (Queen Girls)</td>
<td>Females Tsumeb District, Oshikoto Region</td>
</tr>
<tr>
<td>Group discussion with nurses</td>
<td>Female (2 Nurses) Omuntele clinic, Tsumeb District, Oshikoto Region</td>
</tr>
<tr>
<td>Group discussion with AGYW 18+</td>
<td>Females 4 AGYW Omuntele clinic, Tsumeb District, Oshikoto Region</td>
</tr>
<tr>
<td>Group discussion with caregivers</td>
<td>Mixed, 24 Caregivers Gosen combined school, Tsumeb District, Oshikoto Region</td>
</tr>
<tr>
<td>Group discussion with coach, CCWs, STEM tutors, STEM teachers, Principal and</td>
<td>Mixed, 9 people Iipundi secondary school, Omuthiya district, Oshikoto</td>
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<tr>
<td>Life Skills Teachers</td>
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<tr>
<td>Informal conversations with FMP members</td>
<td>Female and One Male Omuthiya district, Oshikoto region Oshikoto region</td>
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<tr>
<td>Informal conversations with OOS AGYW participating in VSL</td>
<td>Female Tsumeb district, Oshikoto region</td>
</tr>
<tr>
<td>Group discussion with caregivers</td>
<td>Mixed, 17 caregivers and 3 facilitators Onakathila combined school, Omuthiya district, Oshikoto region</td>
</tr>
<tr>
<td>Group discussion with caregivers</td>
<td>Mixed, 19 caregivers and 3 facilitators Joseph Simaneka secondary school, Omuthiya district, Oshikoto region</td>
</tr>
<tr>
<td>Interview and discussion with coach, CCWs, STEM tutors, STEM teachers, Principal and Life Skills Teacher</td>
<td>Mixed, 12 people Omukwiwu Gwemanya secondary school, Ondangwa district, Oshikoto region</td>
</tr>
<tr>
<td>Group interview with male champions</td>
<td>3 male champions and Regional Prevention Gender Advisor Oniipa, Ondangwa district, Oshikoto region</td>
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<tr>
<td>Group discussion with participant from male champion session</td>
<td>25 males Oniipa, Ondangwa district, Oshikoto region</td>
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<tr>
<td>Discussion with Principal, STEM Tutors, STEM Teachers, Life skills and other</td>
<td>Mixed Several at the following schools:</td>
</tr>
<tr>
<td>subject teachers</td>
<td>Several at the following schools: Opawa Secondary School, Tsumeb district, Oshikoto region</td>
</tr>
<tr>
<td></td>
<td>Gosen combined school, Tsumeb District, Oshikoto Region</td>
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<td></td>
<td>Iipundi secondary school, Omuthiya district, Oshikoto region</td>
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<td></td>
<td>Onakathila combined school, Omuthiya district, Oshikoto region</td>
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<tr>
<td></td>
<td>Joseph Simaneka secondary school, Omuthiya district, Oshikoto region</td>
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<tr>
<td></td>
<td>Omukwiwu Gwemanya secondary school, Ondangwa district, Oshikoto region</td>
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<tr>
<td>Group discussion and data reviews with M&amp;E teams</td>
<td>Mixed Several in following districts: Windhoek</td>
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## Observations

<table>
<thead>
<tr>
<th>Type of Group</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Queen girls out of school safe space activity</strong> (MFMC and VSL)</td>
<td>Project HOPE Tsumeb office, Tsumeb district, Oshikoto region</td>
</tr>
<tr>
<td><strong>Observe in school safe space activity for AGYW 10 – 14 and interact with AGYW</strong></td>
<td>Tsintsabis primary school, Tsumeb district, Oshikoto region</td>
</tr>
<tr>
<td><strong>Shining stars out of school safe space activity</strong> (Aflayout and VSL)</td>
<td>Youth centre, Omuthiya district, Oshikoto region</td>
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<tr>
<td><strong>Observe in school safe space activity for AGYW 10 – 12 and interact with AGYW</strong></td>
<td>Omuntele primary school, Omuthiya district, Oshikoto region</td>
</tr>
<tr>
<td><strong>Observe FMP session and group interview caregivers</strong></td>
<td>Gosen combined school, Omuthiya district, Oshikoto region</td>
</tr>
<tr>
<td><strong>Observe VSL session</strong></td>
<td>Onakathila combined school, Omuthiya district, Oshikoto region</td>
</tr>
<tr>
<td><strong>Observe FMP session and interview caregivers</strong></td>
<td>Joseph Simaneka secondary school, Omuthiya district, Oshikoto region</td>
</tr>
<tr>
<td><strong>Observe in school safe space activity for AGYW 15 – 19 and interact with AGYW</strong></td>
<td>Omukwiyu Gwemanya secondary school, Ondangwa district, Oshikoto region</td>
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<tr>
<td><strong>Male engagement activity and clinical services</strong></td>
<td>Oniipa constituency office, Ondangwa district, Oshikoto region</td>
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<tr>
<td><strong>Observe VSL group</strong></td>
<td>Kaenda Clinic, Katima Mulilo rural Zambezi region</td>
</tr>
<tr>
<td>Type of Group</td>
<td>Location</td>
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<tr>
<td>WASH activity</td>
<td>Choto clinic, Katima Mulilo district, Zambezi region</td>
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<tr>
<td>Care Group Facilitator session</td>
<td>Otjomuise Orange Babies, Windhoek, Khomas region</td>
</tr>
<tr>
<td>Observe VSL group</td>
<td>Trust Investment - Havana Community, Windhoek, Khomas region</td>
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ANNEX VII. DATA COLLECTION INSTRUMENTS

KII Tool A. INTERVIEW AND FOCUS GROUP DISCUSSION TOOLS – USG

[Consent questions not asked for these interviews as these stakeholders comprise the Interagency team managing DREAMS in Namibia and these were contextual interviews.]

Questions for USAID DREAMS/AOR management

1. How was the DREAMS Namibia consortium formed? NAPPA was originally a sub partner; why did this change? Who is providing the services they were intended to provide?

2. Have there been any start up challenges or delays outside the control of Project Hope Namibia? E.g., related to partnership agreements, baseline assessment, funding issues

3. To what extent does DREAMS Namibia build on OVC work already being implemented by PHN as opposed to being a package of services designed specifically for AGYW? (Was it an efficient way to build on existing OVC program support?)

4. How was the baseline assessment data used to shape the project?

5. In your estimation, what percentage of overall services are directed to OVC and what percentage to AGYW their sexual partners and families? What is the funding breakout? Do you see this as an optimal spread of services based on the baseline assessment and country need?

6. Is the original reach of the AMELP being realized? If not, where are the shortcomings and why are they happening?

7. In your view, does the current layered package of services adequately (or optimally) meet the needs of intended beneficiaries? If not, what is missing?

8. What is the rationale for the realignment of the DREAMS portfolio to USAID management? Given that some DREAMS services are health facility-based (and may fall under the care and treatment portfolio), what are the implications for coordination between CDC funded partners and USAID funded partners providing DREAMS related services?

9. Is there value in aiming for a shared database across all DREAMS partners, regardless of USG funding source? How easy or difficult would this be to put into effect?

Questions for CDC DREAMS focal person

1. What DREAMS related services are currently being funded by CDC Namibia?

2. Who are the key implementing partners? (Is ITECH the only funded partner providing DREAMS related services?)

3. Have any formal agreements been made between CDC funded and USAID funded DREAMS implementing partners?
4. How are collaborations established, and how are cross referrals and linkages made? How well are these systems working? Where are the challenges, if any?

5. How are beneficiaries being counted when cross referrals are made? Are service units distinct so that there is no risk of duplication in counting?

6. In your view, does the current layered package of services adequately (or optimally) meet the needs of intended beneficiaries? If not, what is missing?

7. What is the rationale for the realignment of the DREAMS portfolio to USAID management? Given that some DREAMS services are health facility-based (and may fall under the care and treatment portfolio), what are the implications for coordination between CDC funded partners and USAID funded partners providing DREAMS related services?

Questions For USG PEPFAR DREAMS coordinator

1. Please describe your role with the USAID funded DREAMS Namibia project as well as with CDC DREAMS activities.

2. We understand that ITECH has been implementing DREAMS services about a year longer than PHN; are any lessons learned from ITECH’s longer experience being shared with PHN? Is there a formal information sharing mechanism in place?

3. In your estimation, what percentage of overall PEPFAR funded DREAMS services are directed to OVC and what percentage to AGYW their sexual partners and families? What is the funding breakout? Do you see this as an optimal spread of services based on baseline assessments and documented country need?

4. In your view, how well does the current layered package of services meet the needs of intended beneficiaries? How might it be improved?

5. What are the rationale and vision for the realignment of the DREAMS portfolio to USAID management in Namibia? Given that some DREAMS services are health facility-based (and may fall under the care and treatment portfolio), what are the implications for coordination between CDC funded partners and USAID funded partners providing DREAMS related services?

6. How is DREAMS as implemented by PHN different from the way it was / is implemented by ITECH? Can you describe any differences from ITECH’s implementation approach that could / should be adopted by PHN?

7. Do you see value in establishing a DREAMS Advisory Group? If so, who would its members usefully include?

8. Is there anything else you would like the evaluation team to know?

Thank you for your time and contributions.
KII Tool B. DREAMS Namibia: GRN Ministries (national, regional)

Date: ___________ Location: ____________________________

Interviewer/s:

Respondent/s: (Name, Title, Gender):

My/our name is ______. Thank you for making time to talk with me/us today.

I am (we are) a team member for an external assessment of the USAID funded DREAMS project, as implemented by Project Hope Namibia and partners. The assessment is intended to assess the effectiveness of the project’s start up and identify areas that need to be modified to increase the project’s success in Khomas, Oshikoto and Zambezi regions over the remaining life of the project.

As part of the assessment, the team is talking with many groups of stakeholders and participants. You have been identified as a key person/s to inform the assessment. All information you choose to share is confidential; your names will not be directly linked to any comments you make. You are free to choose not to answer any particular question and to stop your participation at any time. However, we feel that your perspective is valuable.

The interview will last about one hour. Do I/we have your consent to begin?

The first questions relate to GRN awareness of the DREAMS Namibia project and how it relates to Ministry functions (EQ1).

1. Please describe your Ministry’s programs and services for AGYW.

2. In your view, what is the purpose of the DREAMS Namibia project as implemented by Project Hope Namibia?

   Probe: CDC DREAMS implementation through ITECH.

3. What DREAMS activities relate directly to your Ministry?

4. Do you have any direct involvement with DREAMS Namibia? If so, please describe.

5. For how long have you been involved with DREAMS in Namibia? (Did you play any role in its planning and design, in the baseline assessment, in the project rollout, etc.)

6. Does your Ministry have any MOU or agreement with Project Hope Namibia for DREAMS activities? If so, for what purpose? eg, for work at HF level? for referrals to GRN services?

7. Are you aware of the National AGYW Framework under development? To what extent do DREAMS Namibia’s interventions align with the Framework?
The next questions relate to strengths and challenges for DREAMS Namibia's implementation to date, and the quality of services for each age category of AGYW (EQ1 2)

1. What are key challenges for AGYW programming in Namibia?

2. How if at all is PHN DREAMS Namibia helping to address these challenges?

3. In your view, what are the PHN DREAMS Namibia project's strengths?

4. What in your view have been key successes for DREAMS Namibia to date?

   Probe:

   AGYW 10 to 14, 15 to 19, 20 to 24
   AGYW male sexual partners
   Families/caregivers

5. What do you see as key factors that may have influenced these successes?

The next questions relate to systems in place to identify and remedy challenges on program management and structure. (EQ3)

1. How has the AGYW Technical Working Group supported coordination between DREAMS Namibia and GRN and other partners, if at all?

2. How might the coordination be improved between DREAMS Namibia and other AGYW services and partners?

   Probe: Is there coordination and awareness between AGYW related GF/DREAMS Namibia/gov't AGYW programs/other NGOs? If yes, at what level does this coordination or information sharing occur?

3. Does your Ministry have any direct involvement with the DREAMS partners at regional or district level (eg, coordination, planning)? Please describe.

4. Is any DREAMS Namibia project data reported directly to your Ministry? If so, what data?

5. How is DREAMS Namibia data supporting your program planning, if at all?

Is there anything else you would like the assessment team to know about DREAMS NAMIBIA that we haven’t discussed?

Thank you for your time and contributions to the evaluation.
KII Tool C. DREAMS Namibia: Implementing Partner Managers & Technical Leads

Date: ____________ Location: _________________

Interviewer/s:

Respondent/s: (Name, Title, Gender):

My/our name is ______. Thank you for making time to talk with me/us today.

I am (we are) a team member for an external assessment of the USAID funded DREAMS project, as implemented by Project Hope Namibia and partners. The assessment is intended to assess the effectiveness of the project's start up and identify areas that need to be modified to increase the project's success in Khomas, Oshikoto and Zambezi regions over the remaining life of the project.

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The interview will last about one hour. Do I/we have your consent to begin?

REQUEST HARD COPY OR ELECTRONIC REPORTS FROM SUB PARTNERS

ASK IF THERE IS AN ORGANIGRAM FOR THEIR DREAMS STAFF

QUESTIONS THAT RELATE TO EQ 1: Implementation, efforts to mitigate barriers, factors that facilitated success.

1. Please describe your DREAMS Namibia program activities.

2. In your program, what types of AGYW are you reaching in terms of vulnerability? (snapshot of beneficiaries you are serving). What proportion of the most vulnerable are you currently reaching?

3. (those who meet three or more eligibility criteria, or if you are serving OVC, children leading households, OOS youth) – this question gets at whether the most vulnerable OVC/AGYW are being reached

   Probe: How is the DREAMS project using this data to prioritize the most vulnerable with the right package of interventions?

4. How were consortium partners and their roles defined?
5. Is there a project-wide organigram that shows what each partner implements and where? Or an organogram for your organization?

6. Do you feel that your participation in the DREAMS project is adequately resourced for your scope of activities? Do you feel that your organization is optimally utilized in your role in DREAMS?

7. Do you have a workplan from your subpartners that clearly outlines their roles, deliverables, timelines?

8. What has been the participation of partners and other stakeholders in planning the DREAMS package?

9. Please describe how the DREAMS core components were introduced through the start-up phase e.g. community mobilization/schools, rationale for the order in which services were introduced, etc.

10. Does the layered services table seem effective as it is designed? What seems to be working best among the services? What services are weaker or struggling? How would you make the package stronger if you were in charge of all the planning and resource allocation?

11. Is there any mechanism to track AGYW who enroll and disengage and/or “graduate”, and then re-engage / re-enroll?

12. How does the project link with government services outside DREAMS that also support OVC and AGYW?

13. Please describe any variations in implementation between regions. What region-specific challenges are there?

   Probe: AGYW screening and enrollment

14. Please tell us about your experiences with lost to follow up DREAMS beneficiaries to date. How are beneficiaries who move geographically from their enrolled location retained in DREAMS or referred to other AGYW services?

15. QUESTION FOR S4L and LL/CL: What are the differences in your DREAMS partnerships with PHN and ITECH? What is working best in each of the partnerships? What are the key challenges in each of the partnerships? Are there good practices in your partnership with ITECH that seem important to transfer to the PHN consortium?

16. Do you feel the current number of sites within each district are sufficient to meet saturation targets and the needs of enrollees? Please describe any plans to expand to additional sites/locations within the same district e.g. more schools, health facilities, safe spaces for OOS AGYW.

17. What are the primary factors that lead to the main causes of vulnerability (i.e. what are the leading causes of “off track” girls)?

   Probe: structural (e.g. poverty) or behavioral

18. What Economic Strengthening activities does your program implement? Who primarily receives them? Do you see opportunities for ES to extend beyond training and VSL?

   Probe: Is it poverty or is it behavioral?
19. What are the linkages opportunities to other AGYW services including other ES not yet realized within and outside of DREAMS?

QUESTIONS THAT RELATE TO EQ 2. Strengths and challenges to program inputs, implementation of interventions/activities and processes, and quality of outputs and outcomes for each age category?

1. What have been the project’s key successes to date in terms of what your organization is implementing and more broadly?

   Please specify for each key intervention and by target population/age group.

   AGYW – 3 age ranges
   Male sexual partners
   Families/caregivers

2. What do you see as key factors that influenced these successes?

3. What beneficiary feedback mechanisms are in place to help measure success and challenges? How is beneficiary feedback being captured and used?

4. What have been your organization’s key implementation challenges and how have you mitigated them?

   Probe for:
   Community mobilization receptivity
   Enrollment – by age group.
   Monitoring/reporting
   Retention
   Linkages or referrals: How are they occurring? How they be strengthened?
   Partner relationships
   Partner capacity
   Other

5. In your view, how well has the DREAMS Namibia project inspired trust in the communities where it operates?

6. What efforts have been made to include marginalized groups (e.g. w/disabilities, transgender young women, female sex workers, vulnerable children of female sex workers, those living in extreme poverty). What have been the challenges for their inclusion?

7. How do you define and measure quality of interventions and outcomes? How is quality showing up in quarterly reports, if at all?

8. Is there a learning agenda and/or any implementation science research planned during DREAMS Namibia project? If so, what, by whom, when? How will findings be used?
9. How well do you think current training materials address the needs of AGYW and their caregivers? Do any training materials need adaptation? Why and how?

10. Is there an intention that they will be endorsed and/or used by government?

QUESTIONS THAT RELATE TO EQ 3: What systems are in place to identify and remedy challenges on program management and structure (i.e., planning, human resources, financial, operations, and communications)?

1. How do the consortium partners communicate?

2. If technical and operational challenges exist within any partner organization, how are they identified and how are they resolved?

3. Does PHN provide any technical support to help sub-partners resolve these challenges? If so, what kind of support?

4. How are actions to remedy operational and technical challenges communicated to USAID, if at all?

5. For sub-partners: Is PHN’s technical and operational support sufficient? Please explain.

6. How frequently do partners meet together to review data for program improvement? Is the S/APR for each enrollee layering status done collectively? Partners are to review each AGYW’s layering status at least semi-annually to determine if she has finished all primary and relevant secondary interventions, or if she is still in the process of finishing interventions. How is this being done?

QUESTIONS THAT RELATE TO EQ4. Capacity (i.e., planning, human resources, financial, operations, and communications) of PHN and sub partners to effectively implement the DREAMS program

1. How have you planned for sufficient human resources to achieve your targets and implement your interventions? Do you anticipate a need for additional HR? Please explain.

2. How will DREAMS Namibia determine additional current field staff (eg, nurses) needs as it absorbs additional beneficiaries? Is there any discussion underway for absorbing ITECH DREAMS staff resources? Is there a broader transition plan in place that you are aware of?

3. Are you aware of any operational or technical capacity gaps across the consortium that affect the implementation of the DREAMS services? Please explain. How might they be addressed?
   
   Probe: Safe spaces in communities e.g. for OOS youth.

4. How might any capacity challenges across partners best be addressed or resolved?
**M&E/Data questions**

1. How are you using mobile applications to facilitate M&E for data collection, site supervision, provision of TA from your HW to your field teams, reaching beneficiaries with messages etc.?

2. Please provide an overview of your data management systems, including SOPs, tools, DQA, data analysis and reporting.

3. How does your data feed into the PHN DREAMS MACHINE database?

4. Are you collecting any DREAMS related program data that isn’t part of mandatory reporting? (eg, data in addition to the PEPFAR indicators, qualitative data)? If so, how is it being used?

5. What input and/or output indicators are internally tracked as a form of early warning system to adapt as needed to ensure strong performance on your PEPFAR outcome indicators?

6. Have you encountered any challenges related to M&E for DREAMS? If so what and how addressed?

7. What are the plans for integrating your data into DHIS2? How do you report back to the different government ministries and stakeholders? How often?

8. Is there a plan in place to integrate ITECH beneficiaries into your services and report on them? Will you be tracking which of your beneficiaries were referred by ITECH?

9. How is performance data used to inform/shape program implementation from an adaptive learning approach? What is the feedback loop from M&E to program/technical staff/sub partners and to beneficiaries?

10. Does the M&E team do internal audits on what is reported into DATIM vs the field? How is variance tracked?

Is there anything else you would like the evaluation team to know that we haven’t discussed?

Thank you for your time and contributions to the evaluation.
KII Tool D. DREAMS Namibia Implementing Partner field staff (nurses, CCWs, CPOs, DMOs, Coaches, Mentors, Male Champions)

Interviewer/s:

Respondent/s: (Name, Title, Gender):

My/our name is ______. Thank you for making time to talk with me/us today.

I am (we are) a team member for an external assessment of the USAID funded DREAMS project, as implemented by Project Hope Namibia and partners. The assessment is intended to assess the effectiveness of the project’s start up and identify areas that need to be modified to increase the project’s success in Khomas, Oshikoto and Zambezi regions over the remaining life of the project.

As part of the assessment, the team is talking with many groups of stakeholders and participants. You have been identified as a key person/s to inform the assessment. All information you choose to share is confidential; your names will not be directly linked to any comments you make. You are free to choose not to answer any particular question and to stop your participation at any time. However, we feel that your perspective is valuable.

The interview will last about one hour. Do I/we have your consent to begin?

QUESTIONS THAT RELATE TO EQ 1: Implementation, efforts to mitigate barriers, factors that facilitated success.

1. What are your main responsibilities in your position with the DREAMS Namibia project? For how long have you been in this position?

2. How does your prior experience relate to this role?

3. What DREAMS services are offered in this location? by age group/target group?

4. How do you recruit and enroll beneficiaries?

5. What are the primary factors that lead to the main causes of vulnerability (ie what are the leading causes of “off track” girls)?
   
   *Probe: structural (e.g. poverty) or behavioral*

6. What have been key recruitment, enrollment and retention successes? Challenges?
   
   *Probe: More vulnerable AGYW and male sexual partners*

7. In your program, what types of AGYW are you reaching in terms of vulnerability? (snapshot of beneficiaries you are serving). What proportion of the most vulnerable are you currently reaching?
(those who meet three or more eligibility criteria, or if you are serving OVC, children leading households, OOS youth) – this question gets at whether the most vulnerable OVC/AGYW are being reached.

Probe: How is the DREAMS project using this data to prioritize the most vulnerable with the right package of interventions?

8. What confidentiality do you ensure to participants? How? At what stage?
9. What steps do you take to ensure safety and security of beneficiary data that is collected?
10. Who, if anyone, is being left out of DREAMS services and why?
11. In your view, how well do the DREAMS services you are providing meet the need of beneficiaries. How do you know?
12. Have additional needs or desired services been identified by participants that are not included in the package of DREAMS services? If so, what are they? How are these documented, if at all? Are there opportunities to share this with DREAMS management or others? Please describe.
13. How do you interact with other DREAMS Namibia Partners and stakeholders in this district [relationships/coordination/communication/data sharing]?
14. Please describe any linkages or referrals to other DREAMS or non-DREAMS services you provide. Please describe the referral process. How well is it working? Are there ways to improve or strengthen referrals?
15. For Zambezi and Khomas, how are you preparing to absorb ITECH beneficiaries into PHN DREAMS Namibia. Do you have any information about the likely number of beneficiaries to be absorbed by end of year? What planning is underway for this transition?
16. What data do you collect? To whom do you report this data and how often? [Ask to see data tools/records where relevant.]
17. Is there any mechanism to track AGYW who enroll and disengage and/or “graduate”, and then re-engage / re-enroll?

QUESTIONS THAT RELATE TO EQ 2. strengths and challenges to program inputs, implementation of interventions/activities and processes, and quality of outputs and outcomes for each age category?

1. What do you view as the project’s (district level) key strengths or successes to date? Please explain.
2. What have been the key challenges to date (in implementing the services you are responsible for)?

Probe:

Community receptivity

Enrollment - Please specify by intervention and age group.

Monitoring/reporting
Retention

Linkages or referrals

Partner relationships/coordination/communication/data sharing

Partner capacity

External collaborations

Other

3. What efforts have been made to address these challenges? How successful have they been?

4. What support do you need to successfully address documented challenges? What support do you receive to address these challenges? Timely?

5. Are there groups of eligible AGYW or male sexual partners being left out or reluctant to participate? If so, what measures are in place to include them?

6. What in your view needs to be modified or improved before the project expands to new districts? Are there important potential sub partners who haven’t yet been included in the DREAMS Namibia consortium?

   Are there potential collaborations or linkages with other PEPFAR funded partners or gov’t services not yet in place? What would be needed to establish these linkages?

QUESTIONS THAT RELATE TO EQ 3: What systems are in place to identify and remedy challenges on program management and structure (i.e., planning, human resources, financial, operations, and communications)?

1. How do the consortium partners communicate at district level? Eg, regular meetings? How often? Is this sufficient for sub partner needs to be communicated and responded to? Data sharing?

2. Partners are to review each AGYW’s layering status at least semi-annually to determine if she has finished all primary and relevant secondary interventions, or if she is still in the process of finishing interventions. How is this being done?

3. Do you participate in any district wide meetings or community meetings? Please describe.

4. Is there any involvement of community/traditional leaders in DREAMS activities? If so, please describe.

QUESTIONS THAT RELATE TO EQ4. capacity (i.e., planning, human resources, financial, operations, and communications) of PHN and sub partners to effectively implement the DREAMS program

1. What training or skills building have you received for your role in the DREAMS project? Was this sufficient? Are there additional skills you need to do your job well? If so, please explain.

2. Are the resources required for your tasks in place? Are there any gaps? Please describe. (e.g. training material, commodities, print materials, transportation, staff)
3. How are capacity gaps identified and communicated? How are these gaps addressed? Please provide an example.

4. Are identified capacity gaps affecting the implementation of the DREAMS services? Please explain.

   Probe for:
   
   Planning capacity
   Human resources capacity
   Financial management capacity
   Other administrative capacity
   Technical capacity
   Communications capacity
   Reputation

5. Readiness for transition?

6. Specific questions to male champions and their experiences in working with older men who may have relationships with AGYW, strategies to best reach them

Is there anything else you would like the evaluation team to know that we haven’t discussed?

Thank you for your time and contributions to the evaluation.
FGD Tool E. School and Community Level Supporters (Principals, teachers, community action teams, traditional leaders/influencers)

Interviewer/s:

Respondent/s: (Name, Title, Gender):

My/our name is ______. Thank you for making time to talk with me/us today.

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As part of the assessment, the team is talking with many groups of stakeholders and participants. You have been identified as key persons to inform the assessment. All information you choose to share is confidential; your names will not be directly linked to any comments you make. You are free to choose not to answer any particular question and to stop your participation at any time. However, we feel that your perspective is valuable.

The discussion will last about one hour. Do I/we have your consent to begin?

1. Please describe your role with the DREAMS Namibia project.
2. What do you see as the purpose of DREAMS Namibia?
3. How were you invited to be part of the DREAMS package of layered service?
4. How were you prepared for your role, if at all?
5. What benefit do you think the project offers AGYW? Why?
6. Is anyone being left out of the services you participate in? if so, who and how might they be included?
7. How could the DREAMS services you take part in be strengthened, if at all?
8. Is there anything you would like Project Hope Namibia, the main implementing partner, to know about what is taking place here at your site regarding DREAMS Namibia?
FGD Tool F. Beneficiaries

Interviewer/s:

Respondent/s: # males, # females, approximate age ranges

My/our name is ______. Thank you for making time to talk with me/us today.

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As part of the assessment, the team is talking with many groups of stakeholders and participants. You have been identified key persons to inform the assessment. All information you choose to share is confidential; your names will not be directly linked to any comments you make. You are free to choose not to answer any particular question and to stop your participation at any time. However, we feel that your perspective is valuable.

The discussion will last about one hour. Do I/we have your consent to begin?

For AGYW:

1. How did you hear about Safe Spaces?
2. How were you invited to participate?
3. What made you decide to take part?
4. Have you heard that Safe Spaces is something called DREAMS? What did you hear?
5. What difference has the Safe Space made in your life, if any?
   
   Listen to answers, then probe as needed for more knowledge, more confidence, decision to test for HIV, leadership skills, improved parenting/caregiving skills.

6. Is there anything that makes it hard for you to take part? Please describe.
   
   Listen, then probe for timing, distance, peer or family pressure not to participate, perceived stigma

7. What would make it easier for you to take part?
8. Do some people who have previously come drop out? If so, why do you think they drop out?

9. Are there ways it can be made better? How?

10. How comfortable do you feel here?

11. What other services do you participate in for your age group? Who if anyone from Safe Space encouraged you to go?
   
   Probe: mentoring, tutoring, parent support, etc.

12. Have you provided feedback on how useful these services are? To whom?

**Parents/Caregivers**

1. How did you hear about the Families Matter groups?

2. How were you invited to take part in them?

3. What made you decide to take part?

4. What difference does it make in your life, and family?

5. Listen to answers, then probe as needed for more knowledge, more confidence, decision to test for HIV, leadership skills, improved parenting/caregiving skills.

6. Are there any challenges that make it hard for you to take part? Please describe.

7. Listen, then probe for timing, distance, peer or family pressure not to participate, perceived stigma

8. What would make it easier for you to participate?

9. Do some people who have enrolled drop out? If so, why do you think they drop out?

10. How might the activities be more helpful to you?

**Male champions**

- Male Engagement groups?? Team needs to learn more.

**Community Leaders/Community Action Teams**

- How did you hear about DREAMS Namibia?
- What made you decide to support it?
- What difference has DREAMS made in your community? Who is benefiting?

Is there anything else you would like the evaluation team to know about DREAMS Namibia and how it can best support your lives?

Thank you for your time and contributions to the evaluation.
Key Information Interview Tool G. I-TECH Country Director

Date: ___________ Location:

Interviewer/s:

Respondent/s: (Name, Title, Gender)

My name is ______. Thank you for making time to talk with me today.

I am (we are) a team member for an evaluation of the Namibia DREAMS project. The evaluation is intended to assess the effectiveness of the project’s start up and identify areas that need to be modified to increase the project’s success in existing and potential new health districts over the remaining life of the project.

As part of the evaluation, the team is talking with many groups of stakeholders and participants. You have been identified as a key person/s to inform the evaluation. All information you choose to share is confidential; your names will not be directly linked to any comments you make. You are free to choose not to answer any particular question and to stop your participation at any time.

The interview will last about one hour. Do I have your consent to begin?

Questions for I-TECH Country Director

1. Please describe the I-TECH DREAMS model.
2. What components of your DREAMS model do you think were most successful?
3. What key lessons learned would you want PHN to be most aware of?
4. Where do you envisage challenges as ITECH’s DREAMS clients are turned over to PHN?
5. Do you have recommendations for the smoothest possible transition?
   a) eg. Data/recordkeeping
   b) Resources (HR, any other resources that will no longer be used by ITECH but might be useful to PHN?
6. Are there any key aspects of planning for transition that have not yet been addressed? Please explain.
Key Information Interview Tool H. External Stakeholders

Date: ___________ Location:

Interviewer/s:

Respondent/s: (Name, Title, Gender)

My name is ______. Thank you for making time to talk with me today.

I am (we are) a team member for an evaluation of the Namibia DREAMS project. The evaluation is intended to assess the effectiveness of the project’s start up and identify areas that need to be modified to increase the project’s success in existing and potential new health districts over the remaining life of the project.

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The interview will last about one hour. Do I have your consent to begin?

Questions for External Stakeholders

1. Please briefly your organization and any programs you have for adolescent girls and young women.
   a) Probe regions: Khomas, Zambezi, Oshikoto
   b) Probe services: adolescent friendly clinical services

2. What challenges do AGYW you serve face?

3. What gaps are not currently being addressed for AGYW?

4. What is needed to address these gaps?

5. Are there any successes or lessons learned you think DREAMS should be incorporating into their programming? If so, please describe.

6. Is there anything else you would like to share at this time?
ANNEX VIII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

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<tr>
<th>USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project</th>
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<tr>
<td>As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, &quot;sensitive but unclassified information,&quot; 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.</td>
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<td>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:</td>
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<td>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.</td>
</tr>
<tr>
<td>2. Before disclosing Sensitive Data, I must determine the recipient's &quot;need to know&quot; or &quot;need to access&quot; Sensitive Data for USAID purposes.</td>
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<td>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.</td>
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<td>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.</td>
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<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
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<td>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).</td>
</tr>
<tr>
<td>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</td>
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GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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.

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<td>Deborah McSmith</td>
<td>Consultant</td>
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GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT  
PROJECT

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### ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

**Darrin Adams**

Signature: ___________________________  
Date: July 5, 2019

| Darrin Adams  
Name: ___________________________  
Title: HIV advisor |

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GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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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.

Friedel L. Dausab 09/08/2019

Signature Date

Friedel Laurentius Dausab Consultant

Name Title
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date 15 June 2019

Name FREDDIE MYAMBA
Title MR
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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:
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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.

Officer's Signature Date

Sandra Ovoses Freelance Consultant
Name Title

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ANNEX IX. SUMMARY BIOS OF EVALUATION TEAM

Deborah A. McSmith, team leader, has garnered more than 30 years of experience in the global health arena. Her technical areas of expertise include maternal newborn and child health, adolescent health, sexual and reproductive health and rights, immunizations, infectious and vector-borne diseases, and child protection. Her HIV-related experience spans transfusion AIDS research; HIV/AIDS prevention, counseling, and testing; prevention of mother-to-child transmission and pediatric HIV; care and support for PLHIV and OVC; and advocacy including for older caregivers. She has served as both team leader and senior team member on USAID evaluations and assessments in Ethiopia, Malawi, Namibia, South Africa, Zambia, and Zimbabwe; led a global malaria case management review on behalf of the U.S. President’s Malaria Initiative and USAID; and led a national team to conduct a child protection gap analysis on behalf of USAID Moldova. She holds a master’s in public health from the University of California Berkeley.

Dee Adams, HIV-AGYW specialist, is a global HIV technical advisor with 15 years of experience across a variety of areas, including M&E, strategic planning and program design, program implementation, research and surveillance, and organizational and individual capacity development. She has conducted evaluations and assessments for USAID missions in 20 countries in South and Southeast Asia and sub-Saharan Africa. Adams has managed three “firsts” in surveillance and research in Southern Africa—Lesotho HIV research among men who have sex with men and women who have sex with women (United Nations Development Program), eSwatini HIV surveillance for key populations with the Ministry of Health, and South Africa research on PrEP and ART uptake among transgender women (Johns Hopkins and local partners). Adams has authored and co-authored 15 peer-reviewed journal articles and co-authored global guidance documents with WHO and other partners. She received her MS in Public Health from the Johns Hopkins Bloomberg School of Public Health.

Friedel Dausab, logistics coordinator-evaluation assistant, has more than 10 years’ experience working with marginalized communities, starting from the people living with HIV sector, LGBTIQ+ and diverse networks nationally, across Africa and internationally. These assignments were done with international and national NGOs, community-based organizations and as a consultant working with various stakeholders, including government line ministries. Her experience ranges from project management and research coordination to strategic planning and resource mobilization. She is particularly interested in strengthening community systems of data collection, integrity and use for better health outcomes for individual clients of services and for program service delivery areas. Dausab studied healthcare services management and attended a course on LGBT Health Research at the University of Pittsburgh School of Public Health.

Sandra Owoses, evaluation specialist, has a background in nursing and public health. She is a monitoring, evaluation and research specialist with more than 15 years’ experience in public health and development. She has specialized in providing strategic direction to public health and M&E of health development programs in Namibia. Owoses holds a master’s in public health and a diploma in nursing, and is currently in her final year toward a PhD in public health. As the evaluation specialist for this project, she participated in pre-data work; project planning and debriefing meetings with USAID and PHN; data collection in Khomas, Oshikoto, and Zambezi regions, including writing up fieldwork notes; and data synthesis and analysis.
For more information, please visit
http://ghpro.dexisonline.com/reports-publications