# Child, Caregiver & Household Well-being Survey Tools for Orphans & Vulnerable Children Programs

MEASURE Evaluation
MANUAL

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## Manual




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## PREFACE: TOOLS IN A TOOL BOX

To achieve impact and ensure standards, OVC programs collect diverse information. OVC programs require information to identify children and households needing assistance (targeting), to prioritize and attend to the needs of a particular child (case management), to ensure programs are being implemented as planned and on schedule (monitoring), and to plan program activities and evaluate their impact on improving children's well-being. These activities require different pieces of information, collected in different ways and by different people. Information collected for one purpose is often inapplicable for another purpose.

*Common definitions of terms used in this document include:*

- *Targeting* is usually carried out by community groups. Their task is to determine which households and children are most vulnerable, that is, most in need of assistance.
- *Case management* is usually conducted by a home visitor, who may be a community worker or a trained professional. His/her task is to work with the households and children previously selected by the community as most vulnerable, to determine which services are needed most.
- *Program monitoring* is carried out at all levels of a program, and is generally focused on program outputs.
- *Program evaluation* usually involves a household survey in OVC programs, and people who are unknown to the household collect data.

Information should be collected from tools that are fit-for purpose. There is no single data collection tool that can meet all OVC program targeting, case management and M&E requirements. This set of survey tools responds to distinct information needs related to program planning and evaluation, and fills a tools gap. These tools do not replace those needed for targeting individuals, case management and program monitoring.

# 1 PURPOSE

U.S. Government and other investment in programs to improve the well-being of orphans and vulnerable children (OVC) and their households have been substantial, and yet the impact of this investment is uncertain (Sherr and Zoll, 2011) and there are still questions regarding "what works" in improving OVC well-being (PEPFAR, 2012). One of the challenges to understanding impact is the lack of standardized measures and measurement tools for child and household well-being that are tailored to the OVC population.

To address this, in early 2012 MEASURE Evaluation released core indicators of child and caregiver/household well-being (MEASURE Evaluation, 2012). Using these core indicators as a starting point, MEASURE Evaluation has developed quantitative *child outcomes* and caregiver/*household outcomes* measurement tools for global application. The **purpose** of these data collection tools is:

- To enable and standardize the production of population-level child and caregiver well-being data *beyond* what is available from routine surveys,
- To produce actionable data to inform programs and enable mid-course corrections,
- To enable comparative assessments of child and caregiver well-being and household economic status across a diverse set of interventions and geographical regions

### USAID Evaluation Policy (2011) & the U.S. Government Action Plan on Children in Adversity (2012)

In large part, these tools have been developed to support USAID Missions and USAID-funded programs in fulfilling the aims presented in the USAID Evaluation Policy. Tools are a data collection solution for evaluators, ensuring standardized measurement across countries and programs. Measures are aligned to the U.S. Government Action Plan on Children in Adversity.

**Why a special OVC well-being questionnaire and survey**?

Several surveys already collect internationally comparable data on children, most notably the Demographic and Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS). Why should OVC programs invest in their own data collection?

There are two basic reasons why OVC programs may want to conduct their own child and caregiver well-being surveys:

1. The DHS and MICS employ nationally representative samples. Indicators may be derived at lower administrative levels (typically province-/state-level, urban/rural), but seldom at the level at which programs are conducted. Moreover, these surveys interview all households, and not specifically program households (beneficiaries). This makes it exceedingly difficult to discern the OVC program's contribution to the larger picture.
2. The DHS and MICS include some, but not all of the OVC core indicators. Given the size and complexity of these surveys, it is difficult to add more than a few items to the national questionnaire.

Table 1 outlines outcome measures included that MEASURE Evaluation survey tools compared to those in the DHS and MICS tools.

**Table 1. Routine Survey Indicators Versus MEASURE Evaluation Well-being Survey Indicators**

| Target group | DHS[1] and/or MICS | Additional indicators in the MEASURE Evaluation well-being survey |
|---|---|---|
| Household and caregiver | • Household size and composition<br>• Work<br>• Shelter<br>• Household wealth (assets)<br>• Gender attitudes including attitudes toward gender-based violence<br>• HIV testing experience<br>• HIV/AIDS knowledge and attitudes | • Changes in household composition<br>• Basic shelter (additional)<br>• Access to money<br>• Household expenditures on food, education, healthcare, shelter<br>• Health & health seeking behavior<br>• Caregiver felt support<br>• Parental self-efficacy<br>• Household food security<br>• Attitudes to condom education for youth<br>• Perceptions of child discipline and violence |
| All children <18 | • Orphanhood and living arrangements<br>• Relationship to head of household<br>• Birth certificate | • Identity of principal caregiver<br>• Disability<br>• Basic shelter<br>• Food intake (ages 2+)<br>• General health<br>• HIV testing experience<br>• Participation in OVC services |
| Children <5 | • Vaccinations<br>• Fever, diarrhea<br>• Nutritional status (height/weight)<br>• Early childhood education & stimulation<br>• Neglect<br>• Child slept under a mosquito net | • Nutritional status (MUAC) |
| Children 5-17 | • School attendance<br>• Child labor (5-14 years) | • Nutritional status (height, weight, MUAC)<br>• Basic social support<br>• Psychosocial indicators<br>• Chores & work (additional)<br>• Progression in school over time<br>• School drop outs |
| Children 13-17 | • Perceptions and experience of child discipline and violence (13-14 years)<br>• HIV/AIDS knowledge, attitudes (15-17 years)<br>• Sexual behavior (15-17 years)<br>• Alcohol consumption (15-17 years) | • Perceptions and experience of child discipline and violence (15-17 years)<br>• Child development knowledge<br>• HIV knowledge (13-14 years)<br>• Sexual behavior (13-14 years)<br>• Alcohol consumption (13-14 years) |

[1] Over time, the DHS has added questions, such as birth certificates, to the basic questionnaire. The items in Table 1 are found in the most recent DHS questionnaire but may be lacking from earlier surveys. Countries may add their own items of specific programmatic interest. All model questionnaires can be found on the DHS Web site: http://www.measuredhs.com/What-We-Do/Survey-Types/DHS-Questionnaires.cfm and country-specific questionnaires are included in the final reports.

# 2 DESCRIPTON AND AUDIENCE

These data collection tools are questionnaires for use in a household[2] survey of children ages 0-17 years and their adult caregivers. The questionnaires are designed to measure changes in child, caregiver and household well-being that can reasonably be attributed to program interventions. Tools are accompanied by:

- a tools manual (this document);
- a template survey protocol;
- a template analysis plan; and
- a training manual.

**What types of information do these tools yield?**

There is overwhelming consensus that OVC funds should be used to improve the *well-being* of HIV-affected children, households and communities. Well-being is challenging to define, but agreed-upon facets or components include good physical and mental health, education, and nutrition, among others. It is these components that formed the building blocks of these tools. Details of the structure and content of the tools follow.

**Who are these tools for?**

These tools may be useful to you if are seeking to answer one of these five questions:

1. Is my program having, or did my program have an impact on the children and households it reached?
2. What are the characteristics of children and their caregivers in my country, state/province or district/area, in terms of education, health, protection, and psychosocial status?
3. Where do the children most in need of program support live?
4. Approximately how many children need services or support?
5. What are the needs of my program's registered beneficiaries, in terms of education, health, protection, and psychosocial support?[3]

Table 2 outlines the information needs for which this set of tools may be useful.

[2] Although tools and accompanying guidance assume a household-survey approach, it may be possible to use tools in a school, healthcare, formal care, or other setting as long as guardians are present to provide consent for the children ages 10-17 under their care to participate, and respond to questions otherwise.

[3] This is different from: What are the needs of *each* of my program-registered beneficiaries? If this is your question, these tools are still valid; however, it is unlikely that such a census could be programmatically justified for cost and ethical reasons.

**Table 2. When This Is the Right Set of Tools**

| What you need to know | Why you need to know it | When information should be collected | Who should be surveyed[4] | Type of study | Suggested design |
|---|---|---|---|---|---|
| 1. Whether program or intervention[5] is having, or had an impact on the children and households it reached | To determine if changes are needed to program strategy to achieve maximum impact | Beginning, (middle), and end of a program | Program beneficiaries (and a comparison group) | Impact evaluation | RCT or quasi-experimental study with / without comparison group |
| 2. Characteristics of children and their caregivers in a country, state/province or district/area, in terms of education, health, protection, and social support<br>3. Where the children most in need of program support live<br>4. Number of children and households in need of services or support | • For needs-based resource allocation at policy or program level<br>• To advocate for more resources<br>• Last DHS or similar survey was many years earlier | Anytime | General population | Situation Analysis (with size estimation) | Cross-sectional study of general population (similar to DHS) |
| 5. The needs of *a sample of* program-registered beneficiaries, in terms of education, health, protection, and social support | For program planning | Beginning of a program[6] | Program beneficiaries | Baseline assessment | Cross-sectional study of beneficiaries |

[4] In most cases the household survey will be conducted among a statistical sample of either the general population or program beneficiaries.

[5] This set of tools gives priority to verifiable indicators that are directly actionable by typical PEPFAR-funded OVC programs. If the purpose of using these tools is to evaluate a specific intervention, investigators will need to adapt the tools to ensure that outcome measures are adequately addressed by survey questions.

[6] If repeated, data would represent the baseline evaluation. Data does not need to be collected at the beginning of a program (see Case Study 3 below), but data collected early in the project is most useful for program planning.

**When these tools cannot help**

This is not the right set of tools for you if you do not have any of the information needs outlined in Table 2. Specifically, this is not the right set of tools for you if you want to know:

- Which children in selected communities to target with program support
- How a particular child or household receiving services is faring
- Which households, children or caregivers are worst off
- What services to provide or refer for in reference to a particular child or household
- How many children and households are receiving program support, and the types of support received
- Whether program staff are carrying out their job responsibilities
- Whether program interventions are being implemented as planned

# 3 GUIDING PRINCIPLES

**The well-being questionnaires are designed to measure program outcomes**, that is, changes in child, caregiver and household well-being that can reasonably be attributed to program interventions. Indicators have been selected that are *amenable to change* from diverse, but typical OVC program interventions, and which are relevant across a wide range of program settings. Some of the outcome indicators may take a long time to manifest and may rely on referrals to other high-impact child survival, education, protection, and economic strengthening programs. In addition to program outcome indicators, the questions include a limited number of indicators that programs may not be able to change, such as household composition and age, but which may enhance or inhibit program success.

**Program outcome data should be collected by trained data collectors** who are external to service delivery. These tools are not intended to be implemented by service providers.

The collection of program outcome data by data collectors external to service delivery requires a **documented protocol**, outlining a technically robust, peer-reviewed study. An experienced and qualified team should develop the protocol and involve a statistician.

The protocol, including data collection tools, must undergo **ethical review in the country of research** and approvals must be received before the survey begins.

Once ethical approval is received, **tools should be pilot-tested** in the program setting; it may be necessary to revise the wording of some of the questions to ensure that the respondents understand what is being asked. Please see Appendix 4 for guidelines for local adaptation and translation into other languages.

# 4 STRUCTURE AND CONTENT

This manual relates to three survey tools, one for caregivers, which addresses the household and the caregiver, one for children ages 0-9 years (which is applied to the caregiver), and one for children ages 10-17 years (which is applied directly to children with their informed assent and parental consent).

Tools contain two types of questions: core questions, which are highly recommended, and optional questions or modules, which may be added depending on the objectives of the survey. For instance, education and food security are core modules. Examples of optional modules are household economic security or food consumption diversity. An overview of the questionnaires is presented in Tables 3, 4 and 5. The tools are outlined in full in Appendices 1, 2 and 3.

**Table 3. Caregiver Questionnaire**

| Sections | Core questions | Optional modules |
|---|---|---|
| **Section 1: Household schedule** | • Household schedule<br>• Changes in household composition | |
| **Section 2:** Background information on Caregiver and Household | • Demographic information<br>• Work<br>• Access to money<br>• Shelter | • Household Economic Status<br>• Progress out of Poverty Index (country specific)[7] or similar |
| **Section 3:** Household Food Security | • Household food security | • Household Food Diversity |
| **Section 4:** Caregiver Well-being | • General health<br>• Social support<br>• Parental self-efficacy | • Gender roles and decision-making power<br>• Perceptions and experience of child discipline, including violent discipline |
| **Section 5:** HIV/AIDS Testing, Knowledge, Attitudes | • Basic HIV/AIDS knowledge<br>• HIV testing experience | • HIV/AIDS attitudes |
| **Section 6:** Access to HIV Prevention, Care & Support | • Household access to services | |

[7] Investigators looking to assess the poverty status of survey respondents, and particularly the change in poverty status over time, may wish to consider adding the relevant Progress out of Poverty Index questions (there are always 10) in the country of study. Importantly, PPI questions are a scale, and must be added as an entirety, and analyzed as a scale. More information is available from: www.progressoutofpoverty.org.

**Table 4. Child Questionnaire Ages 0-9 years (Applied to Adult Caregiver)**

| Sections | Core questions | Optional modules |
|---|---|---|
| **Section 1:** Child Health and Protection | • Demographic information<br>• Birth certificate<br>• General health<br>• Vaccinations, experience of fever/diarrhea<br>• Slept under mosquito net<br>• HIV testing experience<br>• Experience of neglect | • Fever (extended)<br>• Diarrhea (extended) |
| **Section 2:** Child Education and Work | • School attendance, progression<br>• Early childhood stimulation<br>• Work for wages | |
| **Section 3:** Food Consumption | • Food security | • Dietary diversity |
| **Section 4:** Access to HIV Prevention, Care & Support | • Child access to services | |
| **Section 5:** Anthropometric Measures (of Children) | • Weight<br>• Height<br>• Mid-upper arm circumference | |

**Table 5. Child Questionnaire (Ages 10-17)**

| Sections | Core questions | Optional modules |
|---|---|---|
| **Section 1:** Background Information on Child | • Demographic information<br>• Identity of caregiver | |
| **Section 2:** Diary | • Daily log | |
| **Section 3:** Education | • School attendance, progression | |
| **Section 4:** Chores & Work | • Chores<br>• Work | |
| **Section 5:** Food & Alcohol Consumption | • Food consumption<br>• Alcohol consumption | • Dietary diversity |
| **Section 6:** Health, Support & Protection | • Birth certificate<br>• General health<br>• Social support | • Perceptions and experience of violence |
| **Section 7:** HIV Testing, Knowledge, and Attitudes | • HIV/AIDS knowledge<br>• HIV testing experience | • Child development knowledge<br>• HIV/AIDS attitudes and beliefs |
| **Section 8:** Sexual Experience | • Sexual behavior (ages 13-17) | • Sexual behavior (ages 13-17) |
| **Section 9:** Access to HIV Prevention, Care & Support | • Child access to services | |
| **Section 10:** Anthropometric Measures: Weight and Height | • Weight<br>• Height<br>• Mid-upper arm circumference | |

# 5 IMPLEMENTING THE TOOL

**Designing a study to meet objectives**

A number of factors will influence your survey design choice, including whether you are seeking information for policy and advocacy, program planning, or an impact evaluation. *In most cases*:

- If you want to ***evaluate a program*** you will need at least two surveys conducted at ***two points in time***. Ideally, the first (baseline) is conducted as early in the program cycle as possible. Baseline measures can be taken of programs that are already underway, but they might not capture changes (positive or negative) that have occurred from the start of the intervention up to that point. Consequently, comparisons with future surveys may underestimate or overestimate changes over time.

- If you want to attribute observed changes to the program, you should consider a ***comparison group***. There are times when this might not be programmatically necessary or feasible. Changes in program beneficiary well-being can be measured without a comparison group. This does not impair the validity of the measurement, but attributing the change to the program requires ancillary data to rule out other influences. The strongest case for attributing positive change to program interventions requires a comparison group that did not receive program services or the intervention, and baseline and follow-up measurements of both the program and comparison group. This requires selecting the comparison group at baseline. The cost of a comparison group needs to be justified in light of the added value of the information it will generate.

- If you want to conduct a ***situation analysis*** of the general population or a baseline assessment of program beneficiaries, a cross-sectional design is appropriate.

**Defining participants**

The questionnaires in this manual are intended to be administered to children's caregivers and children ages 10-17. In some cases, both the head of household and caregiver, if different, can be interviewed.

If you are conducting a situation analysis, participants will be from the general population. If you are conducting a baseline survey of beneficiaries for program planning and/or evaluation, participants will include program beneficiaries (intervention group) and comparable households who do not receive the intervention or access the program under study (comparison or control group).

You will also need to decide whether to interview every child in the household or only a single (index) child. This will depend on the objectives of the survey. For statistical precision, you will need a certain number of households in each community (cluster). Collecting data from all children in the household increases the total number of interviews, which may increase costs. It also increases the complexity of the analysis; investigators will need to control for clustering of indicators at household level. However, if you are interested in differences between boys and girls, children of different ages, or biological and non-biological children or other intra-household issues, then you may want to interview every child in the household. If you choose to interview an index child, or two index children (one aged 0-9 years, one aged 10-17 years) you will need to choose a sampling method at household level to determine which child to

interview. Random sampling methods include, choosing the child alphabetically (does not work in all contexts) or applying a Kish Grid (Kish, 1949). A specialist in survey sampling design can help you make the best decision for your situation. If sampling, during the interview, this should be done after the implementation of the household survey, which is part of the caregiver questionnaire.

**Determining a sampling strategy and calculating sample size**

Although a census survey is theoretically possible, generally, investigators sample from their population of interest for budget and time reasons, and because, statistically, a census will tell us little more than a well-structured sample. The sampling strategy is linked to survey objectives, or for an evaluation, how the program or intervention is being implemented, and how people access the intervention or program (and the extent to which you can control uptake). A first step is determining the unit of the sample: households, children, or adults/caregivers.

Sampling may be multi-step, in that investigators may select or randomly sample provinces or states within the country of study, and then within those sampled provinces select wards or lower geographic units or even schools, formal care institutions or health care facilities, ultimately leading to the sampling of households or people. Some sampling strategies require considerable information about the target population; a lack of available information may preclude certain sampling strategies. Costs also influence sampling; often investigators limit the number of geographic units to reduce transport costs during data collection.

The sample size needed depends on the frequency at which you expect to find the outcomes of interest in your population. If you are implementing these survey tools as part of an evaluation with data collection at two points in time, the sample size will also depend on the extent of change expected in key outcome measures between the data collection points (i.e., baseline and endline). A statistician can advise on sample size.

**Outlining procedures for recruitment and consent**

Again, the method of identifying households or individuals to be sampled depends on survey objectives, and whether you are sampling members of the general population or program/intervention beneficiaries. If the latter, often, data collectors are supported by local service providers to identify households. Investigators need to discuss and document call-back procedures if adults or children are not available for interview at the time of visit.

Regardless, once data collectors identify the adult caregiver in the household (or other setting), they should explain the purpose and nature of the survey, its expected risks and benefits, and request household participation. All potential respondents should be made aware that their participation is voluntary and does not affect their eligibility to receive services. (Anyone who provides services to the household should not be present when data collectors seek informed consent/assent. This is because the presence of service providers may influence household members to participate in the survey.)

Household members should be given the opportunity to ask questions. When there are no more questions and data collectors feel strongly that the adult caregiver understands what is being requested of him/her and the children, the data collection team should seek informed consent from the adult using consent

forms approved by a research ethics committee or institutional review board (see "Obtaining ethical and other approvals" below). Adults must provide consent for themselves and children younger than 10 under their care. Participating children ages 10 and above must also provide their assent to participate. Investigators must decide whether consent should be written or verbal.

**Adapting and translating tools**

Investigators should adapt the tools, choosing optional modules to fit their survey objectives and tweaking question language to align with local discourse and enhance clarity. Recall periods should not be changed.

In many cases, tools will need to be translated. During translation, it is important to agree to a variation that maintains the core meaning of the question, and not translate verbatim.

Survey tools – all translated survey questions and response categories – must be pilot tested and further refined to ensure that they produce valid data in the country and context of study. During adaptation and translation, the goal is always to maintain the integrity of the indicator. Further guidance for adapting and translating the tools is provided in Appendix 5.

**Outlining procedures for data collection and management**

Investigators need to discuss and document how, when, and where data will be collected, who will collect information (and who may be present during data collection), and how data will be captured, stored, moved, and protected.

Responses to some survey questions (e.g., food security, income) are subject to seasonal fluctuations. For this reason, it is important to consider the best time in the year to conduct the survey. If the survey tools are being implemented as part of an evaluation with data collection at two points in time, it is imperative that data collection occurs at the same time in each survey year.

Survey tools should be implemented by trained data collectors who have passed child protection screening. A data collector training manual accompanies tools. Adults should be interviewed out of earshot of other adults or children over age 5. Children should be interviewed out of earshot but within plain sight of an adult caregiver or guardian not connected to the survey.

Currently, a mobile phone application for these survey tools does not exist. Data should be captured on paper copies of the tools. Investigators must consider how completed questionnaires will be transferred securely to the point of data entry and by whom, how, and when hard copies of questionnaires will be destroyed, and how electronic data will be protected.

All information gained from interviews must be kept confidential. Members of the data collection team should sign a document to ensure that privacy of participants is maintained.

**Obtaining ethical and other approvals**

These tools must not be implemented without written ethics approval from a formal committee. Investigators must seek and obtain written ethical approval from a research ethics committee or

institutional review board (IRB) in the country of study prior to collecting any information (including piloting). Generally, IRBs require submission of a protocol, data collection tools, and consent/assent forms for approval. Many IRBs also have an application form.

In addition to research ethics approval, many countries require written approval from the relevant line Ministry prior to data collection.

**Child protection**

Investigators should discuss and document a set of child protection procedures specific to the survey. This should include, at least, screening of data collectors and training of data collectors in child protection (see Training Manual), field work monitoring, and a child protection response system. If a data collector learns of a current abusive situation or if there is evidence that the child is in any serious danger (emergency), then the data collector must report the matter to an appropriate source. The child should be made aware of this exception to maintaining confidentiality during the assent process.

## IMPLEMENTATION CHECKLIST

| ☑ | **Task** |
|---|---|
| ☐ | Research protocol that details study objectives, sampling and sample size, procedures for recruitment and data collection, and data management, has been developed and peer-reviewed by an expert team (including a statistician) |
| ☐ | Participant inclusion and exclusion criteria are documented. Comparison group is well-defined, if applicable |
| ☐ | Statistician, with other experts, has calculated the sample size. Sampling method is well-defined. |
| ☐ | Procedures for recruitment are well-defined, are ethically and culturally appropriate, allow parental informed consent and child assent, and do not perversely incentivize participation |
| ☐ | Informed consent (adult) and assent (child) forms have been developed and consenting process is well-defined |
| ☐ | Logistics and data management plans are well-documented |
| ☐ | Tools have been adapted, if necessary, and translated/back-translated, if necessary |
| ☐ | Protocol, tools and consent/assent forms have been reviewed by an official research ethics committee in country of study and written approval has been obtained |
| ☐ | Research approval from relevant government ministries has been obtained, if necessary |
| ☐ | Experienced, educated data collectors have been recruited, have signed confidentiality agreements, and have undergone data collection training, which included modules on ethics and child protection |

## Examples from the field

The OVC program evaluation tools are being applied in a number of settings, for different purposes. Examples of tool applications for (intervention) impact evaluation and baseline assessment are outlined. The corresponding information needs presented in Table 2 above, are listed with the Case Studies.

### Case Study 1: Impact evaluation of an economic strengthening intervention in Zambia

*Information Need 1: Whether program or intervention is having, or had an impact on the children and households it reached*

**Study aim:** To assess the impact of savings and internal lending communities (SILC), a community savings group model, on participants, households, and children over time.

**Methods:** This is a longitudinal, quasi-experimental study with intervention and comparison groups. Participants and households in both groups will take part in an annual interviewer-administered survey for three study years. Data collection will occur at the same time each year to reduce seasonal confounding.

**Tool adaptation:** Data are being collected from children and primary caregivers, but also from heads of household and SILC participants (when not the same person). Similar tools will be applied across primary caregivers, heads of household, and SILC participants. Added modules to the adult questionnaires about adults include: household economic status, gender roles and decisionmaking, general self-efficacy, caregiver support (extended), and self-esteem and outlook. Added modules to the adult questionnaire about children <10 years include: fever (extended, <5 years only), diarrhea (extended, <5 years only), psychosocial well-being (5+ years), and food consumption (2+ years). An added module to the child questionnaire (ages 10-17) is psychosocial well-being. Other modules added for this study include social capital (all adults), illness and health seeking behavior (all adults), financial self-efficacy (SILC members), and group participation (SILC members). Section 8, sexual experience, was not included.

**Data analysis & use:** Data will be analyzed to determine the impact of participation in this household economic strengthening intervention to child, caregiver and household well-being. Data will be used in policy and programming decisions around interventions to improve child well-being.

### Case Study 2: Baseline assessment for an OVC Care and Support program in Nigeria

*Information Need 5: The needs of a sample of program-registered beneficiaries, in terms of education, health, protection, and psychosocial support*

**Study aim:** To determine the baseline characteristics, strengths, and needs of vulnerable children, caregivers and households selected to receive services as well as those in a comparison group, with respect to health and nutrition, education, social and legal protection, psychosocial status, and economic status.

**Methods:** This is a longitudinal, quasi-experimental study with intervention and comparison groups. Participants and households in both groups will take part in an interviewer-administered survey. The study will apply a multi-stage cluster sampling approach whereby a sample of program households in select wards will be compared with households in nearby wards where the program has not been established.

**Tool adaptation:** Data are being collected from children and primary caregivers. Added modules to the caregiver questionnaire about adults include: household economic status, financial self-efficacy, gender roles and decision-making, general self-efficacy, social capital, caregiver support (extended), illness and health, HIV/AIDS knowledge and attitudes, food diversity, and outlook. Added modules to the adult questionnaire about children <10 years include: fever (extended, <5 years only), diarrhea (extended, <5 years only), psychosocial well-being (5+ years), and food consumption (2+ years). Added modules to the child questionnaire (ages 10-17) include psychosocial well-being, hope, HIV knowledge and attitudes, and sexual behavior (ages 12-17).

**Data analysis & use:** Baseline data will be used to shape the Nigerian program, allowing more efficient use of resources, and ultimately leading to enhanced program impact. Data will also be used as an advocacy tool, supporting policy and programming decisions around interventions to improve child well-being at state and national level in Nigeria. Over the long-term, data will be analyzed alongside endline information to determine the impact of participation in this OVC program on child, caregiver and household well-being.

# 6 DATA USE

Depending on the scope of the survey, type of sample, and the sample size, policymakers and program staff may use data for strategic planning and resource allocation decisions, for program planning/design and program management, and to advocate for resources.

If you have drawn a *representative sample of program beneficiaries* (or households scheduled to receive services), data will represent your target populations' needs. These data should be used immediately for program planning or design, or mid-course corrections, and should influence how program resources are allocated. For instance, if high food insecurity is found, then the program may want to make provision of (or referral for) food and nutritional support a key intervention, *even* if this was not originally planned.

If you have drawn a *representative sample of program beneficiaries at the end of a program and have similar data from an earlier point in the program*, the difference in data values across indicators represents the change in well-being across your population over time, if the datasets were collected at the same time of the year (e.g., pre-harvest).[8] The extent to which any change in well-being (whether it is positive or negative) can be attributed to a particular intervention or program depends on a number of factors, for instance: whether there are other programs operating in the area and what they do, new policies that may influence outcomes, drought, conflict, etc. Our ability to attribute changes in well-being to program impact improves if investigators gathered information from a comparison group, at the same two points in time. If investigators conclude that an intervention or program has led to a change in well-being, this information should be used to influence future programming and policy.

If you have drawn a *representative sample of the general population*, data will indicate the characteristics of children and their caregivers in the survey area, where the children most in need of services or support live, and the number of children and households that need services or support. Data should be used for needs-based resource allocation in the survey area. If a national or state/provincial survey, data should be used to support national or state/provincial policy, respectively. The level at which the data can be used (country, state/province, local government area or district) will depend on how the sample was designed.

Regardless of the purpose of the survey, it is important to analyze survey data alongside other available data, such as DHS or MICS data. This is called "data triangulation." If you have drawn a representative general population sample at a national or state/provincial level and maintained high data quality, DHS indicators included in the survey tool should align between your data and DHS data (depending on the year of the last DHS). If they do not, it is important to consider why. If you have drawn a sample of program beneficiaries, DHS indicators, including in the survey tools, will give you an indication of how much better or worse off your beneficiary population is compared to the general population. In OVC programs, we would expect beneficiaries to be worse off than the general population on key indicators. If your beneficiaries are better off than the general population, it might be appropriate to rethink your target population.

[8] This is because core and optional questions are subject to seasonal bias, meaning that responses to questions are likely to change throughout the year particularly within farming households.

# 7 SUMMARY

There is no single data collection tool that can meet all OVC program targeting, case management, and M&E requirements. This set of survey tools responds to distinct information needs related to program planning and evaluation, and, in the context of OVC programming, aims to standardize measures and processes for assessing child, caregiver, and household well-being at the population level.

Tools are appropriate for investigators, program staff, or policymakers wanting to answer one of the following questions:

1. Is my program having, or did my program have an impact on the children and households it reached?
2. What are the characteristics of children and their caregivers in my country, state/province, or district/area, in terms of education, health, protection, and psychosocial status?
3. Where do the children most in need of program support live?
4. Approximately how many children are in need of services or support?
5. What are the needs of my program's registered beneficiaries, in terms of education, health, protection, and psychosocial support?[9]

Tools should be implemented as part of a wider survey protocol, by trained data collectors, and with research ethics approval.

[9] This is different from: What are the needs of *each* of my program-registered beneficiaries? If this is your question, these tools are still valid; however, it is unlikely that such a census could be programmatically justified for cost and ethical reasons.

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# APPENDIX 1: CAREGIVER SURVEY TOOL IN-DEPTH

Information about each section with enumerator instruction is provided here. Questions with an asterisk (*) indicate core indicators. Questions that originate from the Demographic and Health Survey (DHS) or the Multi-Indicator Cluster Survey (MICS) are noted.

**SECTION 1: HOUSEHOLD SCHEDULE**

This section poses questions about household size and composition. This is important because household composition changes the demands on a household and on a caregiver, providing context for why well-being may improve or decline among children and caregivers. The household schedule questions all come from the Demographic and Health Survey, though we have simplified the schedule considerably for ease of administration. There are 14 questions total in this section, though the household schedule questions must be posed for each member of the household. This section may be tricky to administer especially among larger households. Practice is important.

| | |
|---|---|
| **101** | **Names of household members and people who stayed last night** (DHS) |
| | List the names of all household members in capital letters, starting with the head of household. Include the caregiver (respondent) in this list. Probe for "anyone else", including people who may have stayed in the household last night, but who do not normally stay in this household. Make sure to spell names as accurately as possible, and print clearly. After listing names, ask age-appropriate questions 102-110 for each household member. Complete 102-110 for each household member before proceeding to the next household member. There are 14 spaces for names. If there are more than 14 household members, use back of page to add more. |
| **102** | **Relationship of named individual to head of household** (DHS) |
| | Using the codes 01-11 provided, record the response. If the caregiver does not know the relationship of the person to the head of household, record 88 for "don't know". |
| **103** | **Sex of named individual** (DHS) |
| | Record response. |
| **104** | **Is named individual a usual household member** (DHS) |
| | Record response. |
| **105** | **Did named individual stay last night** (DHS) |
| | Record response. |
| **106** | **Age of named individual** (DHS) |
| | Record age in years. If individual is less than 1 year old, record age as "0". |
| **107** | **Relationship of named individual to caregiver – respondent** (DHS) |

| | |
|---|---|
| | For all listed individuals aged 0-17, pose this question. Using codes 01-06 provided, record response. If response is "parent", probe for biological/non-biological and record appropriately. |
| **108*** | **Usual caregiver of named individual** (DHS) |
| | For all listed individuals aged 0-17, pose this question. If response is "I do" (respondent normally cares for named individual), circle "1". If another household member usually cares for the named individual, record the line letter of that individual and circle "2" for "other". If the named individual usually takes care of him or herself (no adult caregiver), record "00" and circle "2" for "other". |
| **109*** | **Biological mother alive** (DHS) |
| | If the biological mother of the named individual is the respondent (as reported in question 107, code=01) or the usual caregiver named in question 108, SKIP this question. Otherwise, pose this question for all named individual aged 0-17. Record response. |
| **110*** | **Biological father alive** (DHS) |
| | If the biological father of the named individual is the respondent (as reported in question 107, code=02) or the usual caregiver named in question 108, SKIP this question. Otherwise, pose this question for all named individual aged 0-17. Record response. |
| **111** | **Death of household members in last 12 months** |
| | Record response. If "no", SKIP to question 113. |
| **112** | **Number of household members who passed in last 12 months, by age group** |
| | Pose question, reading each age group one at a time. Record response for each age group. The total number should equal all household members who passed away in the last 12 months. |
| **113** | **New household members in last 12 months** |
| | Record response. If "no", SKIP to question 201. |
| **114** | **Number of household members new in last 12 months, by age group** |
| | Pose question, reading each age group one at a time. Record response for each age group. The total number should equal all household members who are new to the household in the last 12 months. New babies and children and adults who have moved into (or back into) the household should be included. |

**SECTION 2: BACKGROUND INFORMATION ON HOUSEHOLD AND CAREGIVER**

This section elicits basic demographic information on the caregiver and the economic status of the household. As poverty is the biggest driver of child well-being, understanding the basic economic status of the household is important. This section has 20 questions, 10 of which align to core indicators, and two optional modules.

| | |
|---|---|
| **201** | **Sex of caregiver-respondent** |
| | Record response. |
| **202** | **Month & year born** (DHS) |
| | If the respondent/caregiver knows his/her date of birth, write it in the appropriate boxes for MONTH and YEAR. You will need to convert the month into numbers. For this, January is '01', February is '02', March is '03', and so on. If he/she does not know her month of birth, leave blank. And ask for the year of her birth. If he/she knows the year, write it in the boxes for YEAR. |
| **203** | **Age at last birthday** (DHS) |
| | If the respondent/caregiver knows his/her age, write it in the space provided. If the respondent/caregiver does not know his/her age, calculate age from question 104. Confirm the response with that provided in the household schedule. Address any discrepancies. |
| **204** | **Ever attended school** (DHS) |
| | Record response. If "no", SKIP to question 206. |
| **205a** | **Level of school attended** (DHS) |
| | Record highest level of school attended: primary, secondary or higher. |
| **205b** | **Highest grade/form/year completed** (DHS) |
| | Adapt question to country of study by choosing grade, form or year.<br>Record highest grade/form/year completed *at the level recorded in 205(a)*. If less than one year completed, circle "00". |
| **206** | **Literacy** (DHS) |
| | Pose phrase: "Now I would like you to read this sentence to me." Show card to respondent. If respondent cannot read the whole sentence, ask: "Can you read part of the sentence?" Record as appropriate. If you do not have a card with the appropriate language for the respondent, record 4 and specify the language that the respondent speaks so that a card can be produced at the next survey round. If the respondent is blind or visually impaired, record 5.<br>Any simple, short, culturally-appropriate sentence may be used. Make sure cards with sentences are printed before the field work begins and that field workers have these as part of their survey package. |
| **207** | **Marital status** (DHS) |
| | Record response. If "other", record 66 and specify. |
| **208** | **Work in last 3 months** (DHS) |

| | |
|---|---|
| | Record response. If “no”, SKIP to 211. |
| **209** | **Frequency of work** (DHS) |
| | Record response. |
| **210** | **Type of payment for work** (DHS) |
| | If payment is reported, clarify if “cash and kind” or only cash, only kind. Record response. |
| **211*** | **Food related expenses** |
| | Pose question and record response. If no, skip to 214. |
| **212*** | **Able to pay for food related expenses** |
| | Pose question and record response. If no, skip to 214. |
| **213*** | **Method of payment at last foodstuffs purchase** |
| | Pose question. Do not read response categories. If necessary, prompt using suggested words. Record one primary response only. If “sold other asset”, circle 6 and specify other asset sold. If “other”, circle 66 and specify. |
| **214*** | **School related expenses** |
| | Pose question and record response. If no, skip to 217. |
| **215*** | **Able to pay for school related expenses** |
| | Pose question and record response. If no, skip to 217. |
| **216*** | **Method of payment for last school expenses** |
| | Pose question. Do not read response categories. If necessary, prompt using suggested words. Record one primary responses only. If “sold other asset”, circle 6 and specify other asset sold. If “other”, circle 66 and specify. |
| **217*** | **Unexpected household related expenses** |
| | Pose question and record response. If no, skip to 220. |
| **218*** | **Able to pay for unexpected household expenses** |
| | Pose question and record response. If no, skip to 220. |
| **219*** | **Method of payment for last unexpected household expense** |
| | Pose question. Do not read response categories. Record one primary response only. If “sold other asset”, circle 6 and specify other asset sold. If “other”, circle 66 and specify. |
| **220*** | **Shelter** |
| | Do not ask, observe only. Record response. |

| | | |
|---|---|---|
| **Optional Module 1** | **Household assets and expenditure** | |
| | If your program is specifically seeking to help households smooth their basic consumption (expenditure), and build their resiliency to economic shocks, though a household economic strengthening intervention, you may wish to include this module. Questions focus on basic household assets (DHS asset schedule) and expenditures in key areas. | |
| | **1.1** | **Main material of floor** |
| | Pose question and record response. | |
| | **1.2** | **Main material of roof** |
| | Pose question and record response. | |
| | **1.3** | **Main material of exterior walls** |
| | Pose question and record response. | |
| | **1.4** | **Sense of financial security** |
| | Pose question and record response. | |
| | **1.5** | **Asset schedule** |
| | Ask respondent whether they own each of items A through T and record response. | |
| | **1.6** | **Transport assets** |
| | Ask respondent whether they own each of items A through F and record response. | |
| | **1.7** | **Animal assets** |
| | Ask respondent how many of each type of animal, A through J, they own and record response. If none, write 00. If they do not know how many they own, write 98. | |
| | **1.8** | **Agricultural land ownership** |
| | Pose question and record response. If no, skip to 1.10. | |
| | **1.9** | **Acres of agricultural land owned** |
| | Pose question and record response. Circle whether the recorded amount is in acres or hectares. | |
| | **1.10** | **Expenditure on food last month** |
| | Pose question and record response. If respondent is unsure, ask them to estimate. You may need to help them recall an event that occurred one month ago to enable them to place the time frame. If zero, record 0. The tools should be updated prior to use with the appropriate currency. | |
| | **1.11** | **Comparison of food expenditure over time** |

| | | |
|---|---|---|
| | Pose question and record response. If less, skip to 1.13. If the same, skip to 1.14. | |
| | **1.12** | **Reason for spending more** |
| | Pose question and record one primary response. All skip to 1.14. | |
| | **1.13** | **Reason for spending less** |
| | Pose question and record one primary response. | |
| | **1.14** | **Expenditure on health care in last month** |
| | Pose question and record response. If respondent is unsure, ask them to estimate. You may need to help them recall an event that occurred one month ago to enable them to place the time frame. If zero, record 0. The tools should be updated prior to use with the appropriate currency. | |
| | **1.15** | **Comparison of health care expenditure over time** |
| | Pose question and record response. If less, skip to 1.17. If the same, skip to 1.18. | |
| | **1.16** | **Reason for spending more** |
| | Pose question and record one primary response. All skip to 1.18. | |
| | **1.17** | **Reason for spending less** |
| | Pose question and record one primary response. | |
| | **1.18** | **Expenditure on education in last 12 months** |
| | Pose question and record response. If respondent is unsure, ask them to estimate. You may need to help them recall an event that occurred 12 months ago to enable them to place the time frame. If zero, record 0. The tools should be updated prior to use with the appropriate currency. | |
| | **1.19** | **Comparison of education over time** |
| | Pose question and record response. If less, skip to 1.21. If the same, skip to 1.22. | |
| | **1.20** | **Reason for spending more** |
| | Pose question and record one primary response. All skip to 1.22. | |
| | **1.21** | **Reason for spending less** |
| | Pose question and record one primary response. | |
| | **1.22** | **Expenditure on shelter in last 12 months** |
| | Pose question and record response. If respondent is unsure, ask them to estimate. You may need to help them recall an event that occurred 12 months ago to enable them to place the time frame. If zero, record 0. The tools should be updated prior to use with the appropriate currency. | |

| | | |
|---|---|---|
| | **1.23** | **Comparison of shelter over time** |
| | Pose question and record response. If less, skip to 1.25. If the same, skip to 201. | |
| | **1.24** | **Reason for spending more** |
| | Pose question and record one primary response. All skip to 201. | |
| | **1.25** | **Reason for spending less** |
| | Pose question and record one primary response. | |
| **Optional Module 2** | **Progress out of Poverty Index (PPI) or similar measure of household poverty status** | |
| | If your program is specifically seeking to improve the economic status of households, you may wish to include the relevant Progress out of Poverty Index (PPI) for your country, or another similar index. The PPI is an index of 10 questions, all of which must be asked and analyzed together. The PPI will help you track whether your household is economically better off at endline, compared to baseline. It will also help you analyze the factors associated with household wealth, and changes in household wealth. More information about the PPI can be found here: www.progressoutofpoverty.org. | |
| **SECTION 3: FOOD CONSUMPTION**<br>This section poses questions about recent food and alcohol consumption. Questions on food consumption are from the USAID-funded FANTA Project's Household Hunger Scale. There are 6 questions in this section, one of which aligns to the core indicators. | | |
| **Optional Module 3** | **Dietary diversity** | |
| | If your program is specifically seeking to improve dietary diversity of household members, including adults, then you may wish to include this module developed by the USAID-funded FANTA Project, in your survey. This module contains only one question. | |
| | **1.1** | **Types of foods eaten yesterday** |
| | Read list of foods A through L, one at a time, and record response: yes/no. | |
| **301*** | **Ever no food to eat in last 4 weeks** | |
| | We are interested in whether there was ever no food to eat in the household due to a lack of resources to buy food. Record response. If "no", SKIP to 303. | |
| **302** | **Frequency of ever no food to eat in last 4 weeks** | |
| | If caregiver responded yes to 301, pose question. Responses require recoding to: rarely; sometimes; or often. | |
| **303** | **Slept hungry in last 4 weeks** | |
| | We are interested if anyone in the household, including the respondent, went to sleep hungry at any point in the last four weeks because of a lack of food in the household / a lack | |

| | |
|---|---|
| | of resources to buy food. Record response. If “no”, SKIP to 305. |
| **304** | **Frequency of slept hungry in last 4 weeks** |
| | If caregiver responded yes to 303, pose question. Responses require recoding to: rarely; sometimes; or often. |
| **305** | **Went whole day and night without food in last 4 weeks** |
| | We are interested if anyone in the household, including the respondent, went a whole day and night without eating because of a lack of food in the household / a lack of resources to buy food. Record response. If “no”, SKIP to 401. |
| **306** | **Frequency of going whole day and night without food in last 4 weeks** |
| | If caregiver responded yes to 305, pose question. Responses require recoding to: rarely; sometimes; or often. |

**SECTION 4: CAREGIVER WELLBEING**

This section poses questions about caregiver health, social support and parental self-efficacy.

Although these questionnaires may be used for all purposes outlined in Table 2, the impetus to their development was program evaluation (and not intervention evaluation). In developing these program evaluation survey tools, we have prioritized questions that are clear, verifiable, programmatically relevant, and actionable *at the population level* in the context of PEPFAR-funded OVC programs. Questions on psychosocial well-being have been the most challenging to build consensus around. Most of the scales that exist are lengthy and specific questions on their own, mean very little. Also, often nuances between questions are lost in translation, especially in local dialects. Furthermore, population-level information on, for instance, depression, self-esteem, general self-efficacy, is difficult to action in the context of current PEPFAR-funded OVC programs, and programs themselves are so complex, usually involving a number of different interventions, that it is not possible to tease out the effect of any one intervention. For these reasons, at this time we recommend limiting questions on psychosocial wellbeing to four questions on social support, which come from the Rand Corporation Medical Outcomes Study. The exception to this would be if your study is evaluating a specific intervention designed to improve psychosocial well-being, rather than a program (group of interventions). If this is the case, we strongly recommend consultation with a specialist in psychometrics during the survey adaptation process.

This section has seven questions, four of which are aligned to core indicators, and two optional modules.

| | |
|---|---|
| **401*** | **Too sick to participate in daily activities** |
| | Record response. Daily activities may include preparing meals, working, playing with children, etc. |
| **402** | **Frequency of too sick to participate in daily activities** |
| | Read out response categories and record response. |
| **403*** | **Someone to turn to for suggestions about how to deal with a personal problem** |

| | | |
|---|---|---|
| | This question aims to assess the respondent's/caregiver's emotional support. Record response. | |
| **404*** | **Someone to help with daily chores if you were sick** | |
| | This question aims to assess the respondent's/caregiver's physical support. Record response. | |
| **405*** | **Someone to show you love and affection** | |
| | This question aims to assess a respondent's/caregiver's affectionate support. Record response. | |
| **406*** | **Someone to do something enjoyable with** | |
| | This question aims to assess a respondent's/caregiver's social support. Record response. | |
| **407** | **Parental self-efficacy** | |
| | This question aims to assess the caregiver's parental (or caregiving) self-efficacy. Read out response options one by one and record response. | |
| **408** | **Attitudes toward violent discipline in the home** | |
| | Record response. | |
| **409** | **Attitudes toward violent discipline at school** | |
| | Record response. | |
| **Optional Module 4** | **Perceptions and Experience of Child Discipline** | |
| | This question set elicits information on respondents'/caregivers' attitudes toward and experience of child discipline, including violence, linked to the US Government Action Plan on Children in Adversity. This is a highly sensitive question set and should only be administered (1) if the program/intervention under study employs specific interventions to address violence, and (2) if the study has specific protocols in place that address referral and enumerator training. Investigators must directly refer all respondents reporting harsh discipline to a local provider for parenting support to ensure child protection. It is important for investigators to know that inclusion of this module may delay timely ethics approval. This optional module, with guidance, is forthcoming. | |
| **Optional Module 5** | **Gender roles, decision making power and attitudes toward intimate partner violence** | |
| | If your program is specifically seeking to empower women to make decisions in the household, or to improve gender equity at household level, or address attitudes toward intimate partner violence, you may wish to include this optional module. All questions are from the DHS. There are 10 questions. | |
| | **5.1** | **Filter – partnership** |

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| | Record response. If no, skip to 5.9. | |
| | **5.2** | **Filter – sex of respondent** |
| | Record response. If male" skip to 5.8. | |
| | **5.3** | **Decisions about how money earned by woman will be used** (DHS) |
| | Pose question to female respondents only. Record response. If the respondent does not earn any money, record 4. If "other", record 66 and specify who. | |
| | **5.4** | **Decisions about women's healthcare** (DHS) |
| | Pose question to female respondents only. Record response. If "other", record 66 and specify who. | |
| | **5.5** | **Decisions about major household purchases** (DHS) |
| | Pose question to female respondents only. Record response. If "other", record 66 and specify who. | |
| | **5.6** | **Decisions about purchases for daily household needs** (DHS) |
| | Pose question to female respondents only. Record response. If "other", record 66 and specify who. | |
| | **5.7** | **Decisions about visits to women's family** (DHS) |
| | Pose question to female respondents only. Record response. If the respondent does not earn any money, record 4. If "other", record 66 and specify who. | |
| | **5.8** | **Decisions about how money earned by man will be used** (DHS) |
| | Pose question to male respondents only. Record response. If "other", record 66 and specify who. | |
| | **5.9** | **Attitudes about decision-making authority** (DHS) |
| | Pose questions to males and females. Pose questions A to E one by one. Record response. | |
| | **5.10** | **Attitudes about intimate partner violence** (DHS) |
| | Pose questions to males and females. Pose questions A to E one by one. Record response. | |
| **SECTION 5: HIV/AIDS KNOWLEDGE & ATTITUDES**<br>A clear objective of many OVC programs is to improve HIV/AIDS knowledge and attitudes among older children and caregivers. This section has 11 questions and one optional module. | | |
| **501** | **Ever heard of HIV/AIDS** (DHS) | |
| | Record response. If "no", SKIP to 601. | |
| **502** | **HIV prevention: Being faithful** (DHS) | |

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| | If respondent/caregiver has heard of HIV/AIDS, pose question. Record response. | |
| **503** | **HIV prevention: Using condoms** (DHS) | |
| | If respondent/caregiver has heard of HIV/AIDS, pose question. Record response. | |
| **504** | **Can healthy-looking person have HIV** (DHS) | |
| | If respondent/caregiver has heard of HIV/AIDS, pose question. Record response. | |
| **505** | **HIV myths: transmission from mosquito bites** (DHS) | |
| | If respondent/caregiver has heard of HIV/AIDS, pose question. Record response. | |
| **506** | **HIV myths: transmission from sharing food** (DHS) | |
| | If respondent/caregiver has heard of HIV/AIDS, pose question. Record response. | |
| **507** | **Knowledge of mother-to-child transmission** | |
| | If respondent/caregiver has heard of HIV/AIDS, pose questions A, B and C one at a time. Record responses. | |
| **508** | **Ever tested for HIV** (DHS) | |
| | If respondent/caregiver has heard of HIV/AIDS, pose question sensitively. Record response. If respondent/caregiver chooses not to respond, leave response field blank. Do not press respondent/caregiver to respond if he or she seems uncomfortable. If respondent/caregiver responds “no” or “don’t know”, SKIP to 510. | |
| **509** | **Received results of HIV test** (DHS) | |
| | If respondent/caregiver reports a previous HIV test, pose question sensitively. Record response. If respondent/caregiver chooses not to respond, leave response field blank. Do not press respondent/caregiver to respond if he or she seems uncomfortable. | |
| **510** | **Place for HIV testing** (DHS) | |
| | If respondent/caregiver has heard of HIV/AIDS, pose question. Record response. | |
| **511** | **Attitudes toward teaching children about condom use** (DHS) | |
| | Record response. | |
| **Optional Module 6** | **HIV/AIDS Attitudes** | |
| | Investigators studying HIV/AIDS attitudes, or who are planning a program that will seek to change HIV/AIDS attitudes, may wish to add this four-question section. | |
| | **6.1** | **Buying vegetables from HIV positive shopkeeper** (DHS) |
| | Record response. | |
| | **6.2** | **Keeping HIV positive status of family member a secret** |

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| | Record response. | |
| | **6.3** | **Caring for HIV positive family member** |
| | Record response. | |
| | **6.4** | **Female teacher with HIV continuing teaching** |
| | Record response. | |
| **SECTION 6: ACCESS TO HIV PREVENTION, CARE & SUPPORT**<br>We are interested in the types of services that the household has received or accessed to enable comparisons between wellbeing measures and services received. | | |
| **601** | **Services received in last 6 months by caregiver or other household member** | |
| | This question should be adapted to fit the program being evaluated. Illustrative service areas are given.<br>Read out services from list individually (i.e., A to O) and ask the caregiver if the caregiver or anyone else in the household has received this service in the last 6 months. If yes, confirm that they received the service in the last 6 months. Record final responses. | |

# APPENDIX 2: CHILD SURVEY TOOL AGES 0-9 YEARS IN-DEPTH

Information about each section with enumerator instruction is provided here. Questions with an asterisk (*) indicate core indicators. Questions that originate from the Demographic and Health Survey (DHS) or the Multi-Indicator Cluster Survey (MICS) are noted.

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| **SECTION 1: BACKGROUND INFORMATION**<br>This section elicits background demographic information of the child. Some of this information may be transcribed from the caregiver's questionnaire. There are 30 questions in this section, 19 of which align to the core indicators. There are an additional three optional modules. | |
| **101** | **Child's name** |
| | Record child's name. |
| **102** | **Child's line letter** |
| | Transcribe child's line letter from household schedule in the caregiver's questionnaire. |
| **103*** | **Child's sex** |
| | Record child's sex. |
| **104*** | **Month & year born** |
| | If the respondent knows his/her date of birth, write it in the appropriate boxes for MONTH and YEAR. You will need to convert the month into numbers. For this, January is '01', February is '02', March is '03', and so on. If she does not know her month of birth, leave blank. And ask for the year of her birth. If she knows the year, write it in the boxes for YEAR. |
| **105*** | **Age at last birthday** |
| | If the child knows his/her age, write it in the space provided. If the child does not know his/her age, calculate age from question 104. Confirm the response with the caregiver's response in the household schedule.<br>If child does not know the year of his/her birth, transcribe the age as documented by the caregiver. |
| **106** | **Perceived health** |
| | Read out response categories. Record response given. |
| **107*** | **Too sick to participate in daily activities** |
| | Record response. Daily activities may include school, chores, eating with the family, playing with friends and siblings, etc. |
| **108** | **Disability** |
| | Record response. |

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| **109** | **Type of disability** |
| | Record response. |
| **110*** | **Birth certificate** |
| | Record response. If “no” or “don’t know”, SKIP to 603. |
| **111*** | **Birth certificate seen** |
| | Record response. |
| **112** | **Age filter** |
| | The next several questions are only appropriate for children aged 5 years and below. Record age and follow skip pattern. |
| **113*** | **Vaccination card** |
| | Pose question. If “yes”, ask to see card. If “no” or “don’t know”, SKIP to question 113. |
| **114*** | **Documented vaccination record** |
| | Check name on card to make sure card relates to child in question. Document the vaccinations recorded on the card. Only include documented vaccinations here. |
| **115*** | **BCG** (DHS) |
| | Record response. |
| **116*** | **Polio** (DHS) |
| | Record response. If “no” or “don’t know”, SKIP to question 121. |
| **117*** | **OPV-0** (DHS) |
| | Record response. |
| **118*** | **OPV-1** (DHS) |
| | Record response. |
| **119*** | **OPV-2** (DHS) |
| | Record response. |
| **120*** | **OPV-3** (DHS) |
| | Record response. |
| **121*** | **DPT** (DHS) |
| | Record response. If “no” or “don’t know”, SKIP to question 123. |
| **122*** | **Number of times received DPT** (DHS) |
| | Record response. |

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| **123*** | **Measles** (DHS) | |
| | Record response. | |
| **124*** | **Diarrhea in last two weeks** (DHS) | |
| | Record response. If caregiver has trouble recalling, help them to think of an event that occurred about two weeks ago to enable better recall. | |
| **Optional Module 1** | **Diarrhea (extended)** | |
| | If your program is specifically seeking to address health-seeking behavior for diarrhea, home management of diarrhea, or access to healthcare for children under 5 years, you may wish to include this three question section. | |
| | **1.1** | **Treatment sought** (DHS) |
| | Record response. If "no", SKIP to 1.3. | |
| | **1.2** | **From where treatment sought** (DHS) |
| | Record response. If necessary, recode into response categories given. | |
| | **1.3** | **Fluids taken** (DHS) |
| | Read out questions A to C one at a time and record the response (yes/no) for each. | |
| **125*** | **Fever in last two weeks** (DHS) | |
| | Record response. If caregiver has trouble recalling, help them to think of an event that occurred about two weeks ago to enable better recall. | |
| **Optional Module 2** | **Fever (extended)** | |
| | If your program is specifically seeking to address health-seeking behavior for febrile illnesses or access to healthcare among children under 5 years, you may wish to include this 4-question section. | |
| | **2.1** | **Treatment sought** (DHS) |
| | Record response. If "no", SKIP to 2.3. | |
| | **2.2** | **From where treatment sought** (DHS) |
| | Record response. If necessary, recode into response categories given. | |
| | **2.3** | **Drugs taken** (DHS) |
| | Record response. If "no", SKIP to 126. | |
| **126** | **Number of days left alone for more than one hour** (MICS4) | |
| | The response should indicate the number of *days* in the last week (7 days) that the child was left alone for more than one hour. The range of possible responses is 0 to 7. | |

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| **127** | **Number of days left in care of other young child** (MICS4) |
| | The response should indicate the number of *days* in the last week (7 days) that the child was left in the care of a child aged 10 or under. The range of possible responses is 0 to 7. |
| **128** | **Slept under mosquito net** |
| | Record response. |
| **129** | **Ever tested for HIV** (DHS) |
| | Pose question sensitively. Record response. If caregiver chooses not to respond, leave response field blank. Do not press caregiver for response if he or she seems uncomfortable. If caregiver responds "no" or "don't know", SKIP to 201. |
| **130** | **Received results of HIV test** (DHS) |
| | If caregiver reports that child has had a previous HIV test, pose question sensitively. Record response. If caregiver chooses not to respond, leave response field blank. Do not press caregiver to respond if he or she seems uncomfortable. |
| **Optional Module 3** | **Health of children living with HIV/AIDS** |
| | This question set is specifically for children living with HIV/AIDS, eliciting information on pediatric patient health and treatment. You may wish to include this optional module if your program or intervention employs specific activities to improve patient health. This optional module is forthcoming. |
| **SECTION 2: EDUCATION**<br>We are interested in knowing whether children are attending school and progressing in school. There are 14 questions in this section, of which five align to the core indicators, and an age filter. | |
| **201** | **Age filter** |
| | This section poses questions to children aged 5 years and more, and children aged 3-4 years. Record age and follow skip patters as appropriate. |
| **202*** | **School enrolment** |
| | Pose question and record response. If no, skip to 206. |
| **203*** | **Missed school days** |
| | If child is enrolled in school, record whether child missed any school days in last school week. If the timing of the survey corresponds to school holidays, prompt child to recall last school week. If "no" skip to 205. |
| **204** | **Reasons for missed school days** |
| | If child missed school days during last school week, record reasons. |
| **205*** | **Current grade** |

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| | Record grade (or equivalent) in which child is currently enrolled. All skip to 208. |
| **206** | **Reason child is not attending school** |
| | Pose question and record one primary response. |
| **207** | **Ever school attendance** |
| | If child is not attending school, pose question. The term "school" means formal schooling, which includes primary, secondary, and post-secondary school and any other intermediate levels of schooling in the formal school system. It includes mechanical or vocational training beyond the primary-school level, such as long-term courses in mechanics or secretarial work. However, this definition of school does not include Bible school or Koranic school or short courses like typing or sewing. Record response. If no, skip to 211. |
| **208*** | **Enrolled last year** |
| | Pose question and record response. If no, skip to 210. |
| **209*** | **Grade last year** |
| | Record grade (or equivalent) in which child was enrolled last year. Our interest is whether the child progressed from one grade to the next in the last year. All skip to 211. |
| **210** | **Highest grade completed** |
| | If the child is not attending school, record the highest grade (or equivalent) completed. |
| **211** | **Worked in last 6 months for money or kind** |
| | Record response. If "no", SKIP to 301. |
| **212** | **Type of work performed** |
| | Record all responses mentioned. If "other", please specify. If necessary, probe with response categories. All should SKIP to 301. |
| **213** | **Attendance in an early childhood development program** |
| | This question is for children ages 3-4. Record response. If "yes", SKIP to 301. |
| **214** | **Early childhood stimulation** |
| | This question is only for children ages 3-4 who do not attend an early childhood development program.<br>Read question options A to F one at a time and record response. |
| **SECTION 3: FOOD CONSUMPTION**<br>This section poses questions about recent food consumption. Questions on food consumption are from the USAID-funded FANTA Project's Household Hunger Scale. There are eight questions in this section, and an age filter. One question aligns to the core indicators. | |

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| **301** | **Age filter** | |
| | This set of questions is appropriate for children aged 2 years and over. Record whether child is 2 years or over, or less than two years. If less than two years, SKIP to question 401. | |
| **Optional Module 3** | **Dietary diversity** | |
| | If your program is specifically seeking to improve dietary diversity of children, then you may wish to include this module developed by the USAID-funded FANTA Project, in your survey. This module contains only one question. | |
| | **1.1** | **Types of foods eaten yesterday** |
| | Read list of foods A through L, one at a time, and record response: yes/no. | |
| **302** | **Smaller meals in last 4 weeks** | |
| | We are interested specifically in smaller meals that resulted from a lack of food/food insecurity (versus personal preferences, cultural reasons, etc.). Record response. If “no”, SKIP to 304. | |
| **303** | **Frequency of smaller meals in last 4 weeks** | |
| | If child responded yes to 302, pose question. Responses require recoding to: rarely; sometimes; or often. | |
| **304** | **Skipped meals in last 4 weeks** | |
| | We are interested specifically in skipped meals that resulted from a lack of food/food insecurity (versus personal preferences, cultural reasons, etc.). Record response. If “no”, SKIP to 306. | |
| **305** | **Frequency of skipped meals in last 4 weeks** | |
| | If child responded yes to 304, pose question. Responses require recoding to: rarely; sometimes; or often. | |
| **306** | **Slept hungry in last 4 weeks** | |
| | We are interested specifically in eating patterns resulting from a lack of food/food insecurity (versus personal preferences, cultural reasons, etc.). Record response. If “no”, SKIP to 308. | |
| **307** | **Frequency of slept hungry in last 4 weeks** | |
| | If child responded yes to 306, pose question. Responses require recoding to: rarely; sometimes; or often. | |
| **308*** | **Went whole day and night without eating in last 4 weeks** | |
| | We are interested specifically in eating patterns resulting from a lack of food/food insecurity (versus personal preferences, cultural reasons, etc.). Record response. If “no”, SKIP to 401. | |
| **309** | **Frequency of going whole day and night without eating in last 4 weeks** | |

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| | If child responded yes to 308 pose question. Responses require recoding to: rarely; sometimes; or often. |
| **SECTION 4: ACCESS TO HIV PREVENTION, CARE & SUPPORT**<br>We are interested in the types of services that the child has received or accessed to enable comparisons between wellbeing measures and services received. If a strong project monitoring system exists, investigators may want to triangulate/validate responses to question 401 with project monitoring data. | |
| **401** | **Services received in last 6 months** |
| | This question should be adapted to fit the program being evaluated. Illustrative service areas are given.<br>Read out services from list individually (i.e., A to F) and ask the caregiver if the child has received this service in the last 6 months. If yes, confirm that they received the service in the last 6 months. Record final responses. |
| **SECTION 5: WEIGHT, HEIGHT & MUAC**<br>A key outcome of OVC programs is to improve the health of children, and anthropometric measures are a strong measure of child health. Traditionally, measurements are taken for children under 5 years, but there is growing consensus that these measures are helpful for children of all ages, especially children living with HIV or other illnesses. We recommend completing measurements for all children. This is a core indicator. | |
| **501*** | **Weight, Height & Mid-Upper Arm Circumference** |
| | a) Weight: Ensure that the scale you use is placed on a hard surface (concrete or tile preferred) before you seek to weigh the child. Note that the type of ground on which the scale is placed will greatly affect your measurement. Do not place the scale on dirt/mud, grass, or another soft surface. Record weight. (If scale denotes pounds (lbs) and not kilograms: specify. Do not convert.)<br>b) Height: Ask child to take off shoes and stand against a flat surface (wall, side of building). Using a stiff measuring tape, measure the child's height without shoes. Record height in centimeters. (If measuring tape denotes inches and not centimeters: specify. Do not convert.)<br>c) Mid-upper arm circumference: Wrap MUAC tape around child's upper arm and record measurement in centimeters. Record measurement up to two decimal points. |

# APPENDIX 3: CHILD SURVEY TOOL AGES 10-17 YEARS IN-DEPTH

Information about each section with enumerator instruction is provided here. Questions with an asterisk (*) indicate core indicators. Questions that originate from the Demographic and Health Survey (DHS) or the Multi-Indicator Cluster Survey (MICS) are noted.

| | |
|---|---|
| **SECTION 1: BACKGROUND INFORMATION**<br>This section elicits background demographic information of the child. Some of this information may be transcribed from the caregiver's questionnaire. There are six questions in this section, three of which align to the core indicators. | |
| **101** | **Child's name** |
| | Record child's name. |
| **102** | **Child's line letter** |
| | Transcribe child's line letter from household schedule in the caregiver's questionnaire. |
| **103*** | **Child's sex** |
| | Record child's sex. |
| **104*** | **Month & year born** |
| | If the respondent knows his/her date of birth, write it in the appropriate boxes for MONTH and YEAR. You will need to convert the month into numbers. For this, January is '01', February is '02', March is '03', and so on. If she does not know her month of birth, leave blank. And ask for the year of her birth. If she knows the year, write it in the boxes for YEAR. |
| **105*** | **Age at last birthday** |
| | If the child knows his/her age, write it in the space provided. If the child does not know his/her age, calculate age from question 104. Confirm the response with the caregiver's response in the household schedule.<br>If child does not know the year of his/her birth, transcribe the age as documented by the caregiver. |
| **106** | **Caregiver** |
| | We are interested here in primary caregivers, as opposed to all the people who may have a role in the child's care, such as babysitters. Record one primary response. Probe if necessary. |
| **SECTION 2: DIARY**<br>Here we are interested in building rapport with the child, and understanding what they do during an average day. The diary asks children to refer to their day yesterday. If yesterday was not a school day (e.g. weekend or holiday), ask child to refer to last school day/weekday. There are six questions in this section. | |

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| **201** | **When child got up** |
| | Record if the child rose before or after sunrise. |
| **202** | **Pre-sunrise activity** |
| | There are a number of activities listed in the diary log, as well as space to enter other activities. Put a tick or an X in the boxes that correspond to the activities listed by the child, in the column for question 202. Add any activities not listed in the diary log under "other" and tick or X the corresponding box. Probe for any other activities before moving on. |
| **203** | **Morning activity** |
| | Put a tick or an X in the boxes that correspond to the activities listed by the child, in the column for question 203. Add any activities not listed in the diary log under "other" and tick or X the corresponding box. Probe for any other activities before moving on. |
| **204** | **Noon-time activity** |
| | Put a tick or an X in the boxes that correspond to the activities listed by the child, in the column for question 204. Add any activities not listed in the diary log under "other" and tick or X the corresponding box. Probe for any other activities before moving on. |
| **205** | **Afternoon activity** |
| | Put a tick or an X in the boxes that correspond to the activities listed by the child, in the column for question 205. Add any activities not listed in the diary log under "other" and tick or X the corresponding box. Probe for any other activities before moving on. |
| **206** | **Evening activity** |
| | Put a tick or an X in the boxes that correspond to the activities listed by the child, in the column for question 206. Add any activities not listed in the diary log under "other" and tick or X the corresponding box. Probe for any other activities before moving on. |
| **SECTION 2: EDUCATION**<br>We are interested in knowing whether children are attending school and progressing in school. There are 9 questions in this section, of which five align to the core indicators. | |
| **301*** | **School enrollment** |
| | Pose question and record response. Confirm response with diary and correct if necessary. If no, skip to 306. |
| **302*** | **Missed school days** |
| | If child is enrolled in school, record whether child missed any school days in last school week. If the timing of the survey corresponds to school holidays, prompt child to recall last school week. If "no" skip to 304. |
| **303** | **Reasons for missed school days** |

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|---|---|
| | If child missed school days during last school week, record one primary response. |
| **304*** | **Current grade** |
| | Record grade (or equivalent) in which child is currently enrolled. All skip to 307. |
| **305** | **Reason child is not attending school** |
| | Pose question and record one primary response. |
| **306** | **Ever school attendance** |
| | If child is not attending school, pose question. The term "school" means formal schooling, which includes primary, secondary, and post-secondary school and any other intermediate levels of schooling in the formal school system. It includes mechanical or vocational training beyond the primary-school level, such as long-term courses in mechanics or secretarial work. However, this definition of school does not include Bible school or Koranic school or short courses like typing or sewing. Record response. If no, skip to 401. |
| **307*** | **Enrolled last year** |
| | Pose question and record response. If no, skip to 309. |
| **308*** | **Grade last year** |
| | Record grade (or equivalent) in which child was enrolled last year. Our interest is whether the child progressed from one grade to the next in the last year. All skip to 401. |
| **309** | **Highest grade completed** |
| | If the child is not attending school, record the highest grade (or equivalent) completed. |
| **SECTION 4: CHORES & WORK**<br>In this section we are interested in whether the child is performing any household chores or work. For all children, performing some household chores, as long as these do not interfere with school, is appropriate. For older children, working may also be appropriate. Here we are trying to understand whether the child is undertaking both appropriate and inappropriate levels of household chores and work. There are 12 questions in this section. | |
| **401** | **Diary mention of chores** |
| | Check diary to see if chores were mentioned. Record yes/no. If yes, SKIP to 403. |
| **402** | **Sometimes household chores** |
| | If chores not mentioned in diary, pose question. Record response. If "yes", correct diary. If "no", SKIP to 405. |
| **403** | **Types of household chores** |
| | Record types of chores cited. Probe for other chores and circle all mentioned. If a chore not |

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| | listed in response categories is cited, record it as “other” and specify the nature of the chore. |
| **404** | **Time spent doing household chores** |
| | Record the amount of time spent each day doing household chores. Responses need to be recoded as: less than 1 hour; 1-2 hours; 3-4 hours; more than 4 hours; and it depends. |
| **405** | **Diary mention of work** |
| | Check diary to see if other work was mentioned. Record yes/no. If yes, SKIP to 407. |
| **406** | **Sometimes other work** |
| | If work not mentioned in diary, post question. Record response. If “yes”, correct diary. If “no”, SKIP to 411. |
| **407** | **Types of other work** |
| | Record types of work cited. Probe for other work and circle all mentioned. If work not listed in response categories is cited, record it as “other” and specify the nature of the work. |
| **408** | **Frequency of other work** |
| | Record frequency of work. Responses need to be recoded as: every day/most days; several times a week; once a week; and once in a while. |
| **409** | **Time spent doing other work** |
| | Record the amount of time spent each day doing work. Responses need to be recoded as: less than 1 hour; 1-2 hours; 3-4 hours; more than 4 hours; and it depends. |
| **410** | **Receipt of money for other work** |
| | Record response. |
| **411** | **Other ways to get money** |
| | All respondents should be asked this question as the response provides a reliability check of responses. If the respondent notes that they do work of any kind to get money, but have previously indicated that they do not work, return to question 406 and ask again. If respondent has reported work, record as appropriate and move forward. If respondent has not reported work, and does not indicate any way to get money, record as appropriate and move forward. |
| **412** | **Use of money received** |
| | Record as appropriate. Probe for multiple responses. Record all mentioned. |
| **SECTION 5: FOOD & ALCOHOL CONSUMPTION**<br>This section poses questions about recent food and alcohol consumption. Questions on food consumption are from the USAID-funded FANTA Project’s Household Hunger Scale. There are 11 questions in this section, one of which aligns to the core indicators. | |

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| **Optional Module 1** | **Dietary diversity** | |
| | If your program is specifically seeking to improve dietary diversity of children, then you may wish to include this module developed by the USAID-funded FANTA Project, in your survey. This module contains only one question. | |
| | **1.1** | **Types of foods eaten yesterday** |
| | Read list of foods A through L, one at a time, and record response: yes/no. | |
| **501** | **Smaller meals in last 4 weeks** | |
| | We are interested specifically in smaller meals that resulted from a lack of food/food insecurity (versus personal preferences, cultural reasons, etc.). Record response. If “no”, SKIP to 503. | |
| **502** | **Frequency of smaller meals in last 4 weeks** | |
| | If child responded yes to 501, pose question. Responses require recoding to: rarely; sometimes; or often. | |
| **503** | **Skipped meals in last 4 weeks** | |
| | We are interested specifically in skipped meals that resulted from a lack of food/food insecurity (versus personal preferences, cultural reasons, etc.). Record response. If “no”, SKIP to 505. | |
| **504** | **Frequency of skipped meals in last 4 weeks** | |
| | If child responded yes to 503, pose question. Responses require recoding to: rarely; sometimes; or often. | |
| **505** | **Slept hungry in last 4 weeks** | |
| | We are interested specifically in eating patterns resulting from a lack of food/food insecurity (versus personal preferences, cultural reasons, etc.). Record response. If “no”, SKIP to 507. | |
| **506** | **Frequency of slept hungry in last 4 weeks** | |
| | If child responded yes to 506, pose question. Responses require recoding to: rarely; sometimes; or often. | |
| **507*** | **Went whole day and night without eating in last 4 weeks** | |
| | We are interested specifically in eating patterns resulting from a lack of food/food insecurity (versus personal preferences, cultural reasons, etc.). Record response. If “no”, SKIP to 509. | |
| **508** | **Frequency of going whole day and night without eating in last 4 weeks** | |
| | If child responded yes to 507, pose question. Responses require recoding to: rarely; sometimes; or often. | |
| **509** | **Ever alcohol consumption** | |

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| | Record response. If “no”, SKIP to 601. |
| **510** | **Last alcohol consumption** |
| | If respondent reports pervious alcohol consumption, pose question. Responses need to be recoded as: yesterday/a few days ago; about a week ago; or more than a week ago. |
| **511** | **Frequency of alcohol consumption** |
| | If respondent reports pervious alcohol consumption, pose question. Responses need to be recoded as: only once in a while; or at least once a week. |

**SECTION 6: HEALTH SUPPORT & PROTECTION**

This section poses questions about children’s health, social support and protection.

Although these questionnaires may be used for all purposes outlined in Table 2, the impetus to their development was program evaluation (and not intervention evaluation). In developing these program evaluation survey tools, we have prioritized questions that are clear, verifiable, programmatically relevant, and actionable *at the population level* in the context of PEPFAR-funded OVC programs. Questions on psychosocial well-being have been the most challenging to build consensus around. Most of the scales that exist are lengthy and specific questions on their own, mean very little. Also, often nuances between questions are lost in translation, especially in local dialects. Furthermore, population-level information on, for instance, depression, self-esteem, general self-efficacy, is difficult to action in the context of current PEPFAR-funded OVC programs, and programs themselves are so complex, usually involving a number of different interventions, that it is not possible to tease out the effect of any one intervention. For these reasons, at this time we recommend limiting questions on psychosocial wellbeing to four questions on social support, which come from the Rand Corporation Medical Outcomes Study. The exception to this would be if your study is evaluating a specific intervention designed to improve psychosocial well-being, rather than a program (group of interventions). If this is the case, we strongly recommend consultation with a specialist in psychometrics during the survey adaptation process.

This section has nine questions, seven of which are aligned to core indicators, and three optional modules.

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| **601*** | **Birth certificate** |
| | Record response. If “no” or “don’t know”, SKIP to 603. |
| **602*** | **Birth certificate seen** |
| | Record response. |
| **603*** | **Too sick to participate in daily activities** |
| | Record response. Daily activities may include school, chores, eating with the family, playing with friends and siblings, etc. |

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| **604** | **Disability** |
| | Record response. If no, skip to 606. |
| **605** | **Type of disability** |
| | Record response. |
| **606*** | **Someone to turn to for suggestions about how to deal with a personal problem** |
| | This question aims to assess a child's emotional support. Record response. |
| **607*** | **Someone to help with daily chores if you were sick** |
| | This question aims to assess a child's physical support. Record response. |
| **608*** | **Someone to show you love and affection** |
| | This question aims to assess a child's affectionate support. Record response. |
| **609*** | **Someone to do something enjoyable with** |
| | This question aims to assess a child's social support. Record response. |
| **Optional Module 2** | **Perceptions and Experience of Violence** |
| | This question set elicits information on children's attitudes toward violence, and experience of violence discipline and gender-based violence, linked to the US Government Action Plan on Children in Adversity. This is a highly sensitive question set and should only be administered (1) if the program/intervention under study employs specific interventions to address violence, and (2) if the study has specific protocols in place that address referral and enumerator training. Investigators must directly refer all children who respond to this question set to a local provider for support and protection. If a child reports violence, particularly current or recent violence, enumerators must follow study procedures to report this violence and ensure the child is protected. It is important for investigators to know that inclusion of this module may delay timely ethics approval. This optional module, with guidance, is forthcoming. |
| **SECTION 7: HIV/AIDS KNOWLEDGE, ATTITUDES & SEXUAL BEHAVIOR**<br>A clear objective of many OVC programs is to improve HIV/AIDS knowledge, attitudes and behavior among older children and caregivers. The age groups targeted with HIV/AIDS messaging will differ from context to context. In many countries, this section will be appropriate for children aged 13-17 only. This section has 10 questions and three optional modules. | |
| **Optional Module 3** | **Child Development Knowledge** |
| | If your program is specifically looking to improve communication between parents and children, and teachers or other formal community caregivers and children, sexual development and HIV/AIDS, you may wish to include this section. Questions come from UNESCO. There are six questions in this section. |

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| | **3.1** | **Taught about how children grow and develop** |
| | Record response. If necessary, prompt with suggested words/phrases. If “no”, SKIP to 5.3. | |
| | **3.2** | **Who taught you about how children grow?** |
| | Do not read responses. After child responds, ask “anyone else?” Enumerator may have to recode response given by child to: teacher, family/household member or other. Circle all responses given. Specify “other”. | |
| | **3.3** | **Taught about sex / sexual behavior** |
| | Record response. If “no”, SKIP to 5.5. | |
| | **3.4** | **Who taught you about sex or sexual behavior?** |
| | Do not read responses. After child responds, ask “anyone else?” Enumerator may have to recode response given by child to: teacher, family/household member or other. Circle all responses given. Specify “other”. | |
| | **3.5** | **Taught about HIV/AIDS** |
| | Question 701 should be posed before this question. If child has heard of HIV/AIDS, pose question. Record response. If no”, SKIP to 702. | |
| | **3.6** | **Who taught you about HIV/AIDS?** |
| | Do not read responses. After child responds, ask “anywone else?” Enumerator may have to recode response given by child to: teacher, family/household member or other. Circle all responses given. Specify “other”. | |
| **701** | **Ever heard of HIV/AIDS** (DHS) | |
| | Record response. If “no”, SKIP to 801. | |
| **702** | **HIV prevention: Being faithful** (DHS) | |
| | If child has heard of HIV/AIDS, pose question. Record response. | |
| **703** | **HIV prevention: Using condoms** (DHS) | |
| | If child has heard of HIV/AIDS, pose question. Record response. | |
| **704** | **Can healthy-looking person have HIV** (DHS) | |
| | If child has heard of HIV/AIDS, pose question. Record response. | |
| **705** | **HIV myths: transmission from mosquito bites** (DHS) | |
| | If child has heard of HIV/AIDS, pose question. Record response. | |
| **706** | **HIV myths: transmission from sharing food** (DHS) | |
| | If child has heard of HIV/AIDS, pose question. Record response. | |

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| **707** | **Knowledge of mother-to-child transmission** | |
| | If child has heard of HIV/AIDS, pose questions A, B and C one at a time. Record responses. | |
| **Optional Module 4** | **HIV/AIDS Attitudes and Beliefs** | |
| | Investigators studying HIV/AIDS attitudes and beliefs, or who are planning a program that will seek to change HIV/AIDS attitudes and beliefs, may wish to add this four-question section. | |
| | **4.1** | **Attitudes: teachers with HIV** (DHS) |
| | Record response. | |
| | **4.2** | **Attitudes: Pupils with HIV** |
| | Record response. | |
| | **4.3** | **Beliefs: Treatment of pupils with HIV by other pupils** |
| | Record response. | |
| | **4.4** | **Beliefs: Treatment of pupils with HIV by teachers** |
| | Record response. | |
| **708** | **Ever tested for HIV** (DHS) | |
| | If child has heard of HIV/AIDS, pose question sensitively. Record response. If child chooses not to respond, leave response field blank. Do not press child to respond if he or she seems uncomfortable. If child responds “no” or “don’t know”, SKIP to 801. | |
| **709** | **Received results of HIV test** (DHS) | |
| | If child reports a previous HIV test, pose question sensitively. Record response. If child chooses not to respond, leave response field blank. Do not press child to respond if he or she seems uncomfortable. | |
| **710** | **Place for HIV testing** (DHS) | |
| | If child has heard of HIV/AIDS, pose question. Record response. | |
| **Optional Module 5** | **Sexual Behavior** | |
| | This section is for 13-17 year olds only. Investigators studying changes in sexual behavior arising from program interventions, or who are planning a program seeking to reduce sexual risk behavior among adolescents, may wish to include this five-question section. Questions must be posed sensitively, and children must be told at the start of this section that they do not have to answer any of these questions if they choose. | |
| | **5.1** | **Ever sexual intercourse** |
| | Pose question. If child is unclear what is meant by “sexual intercourse”, prompt with | |

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| | definition given. Record response. If “no”, SKIP to question 801. | |
| | **5.2** | **Age of sexual debut** |
| | Pose question. If child cannot recall their age at first sex, help them to estimate. For example, you might ask: Do you recall what grade you were in at school? Some children report ages of sexual debut far below the age of consent in the country. Respond sensitively; do not remark about young age of sexual debut. Record response in years. | |
| | **5.3** | **Sex in past one year** |
| | Record response. If “no”, SKIP to question 801. | |
| | **5.4** | **Number of different sex partners in past one year** |
| | Record response. If necessary, help child estimate number of different partners by going through first names. We are interested here in different partners, and not the number of times intercourse occurred. | |
| | **5.5** | **Condom use at last sex** |
| | Record response. If child does not know what a condom is, record “no”. | |
| **SECTION 8: ACCESS TO HIV PREVENTION, CARE & SUPPORT**<br>We are interested in the types of services that the child has received or accessed to enable comparisons between wellbeing measures and services received. If a strong project monitoring system exists, investigators may want to triangulate/validate responses to question 801 with project monitoring data. | | |
| **801** | **Services received in last 6 months** | |
| | This question should be adapted to fit the program being evaluated. Illustrative service areas are given.<br>Read out services from list individually (i.e., A to H) and ask the child whether they have received this service in the last 6 months. If yes, confirm that they received the service in the last 6 months. Confirm responses with the caregiver if in doubt. Record final responses. Some service question should only be posed to older children. | |
| **SECTION 9: WEIGHT, HEIGHT & MUAC**<br>A key outcome of OVC programs is to improve the health of children, and anthropometric measures are a strong measure of child health. Traditionally, measurements are taken for children under 5 years, but there is growing consensus that these measures are helpful for children of all ages, especially children living with HIV or other illnesses. We recommend completing measurements for all children. This is a core indicator. | | |
| **901*** | **Weight, Height & Mid-Upper Arm Circumference** | |
| | d) Weight: Ensure that the scale you use is placed on a hard surface (concrete or tile preferred) before you seek to weigh the child. Note that the type of ground on which the scale is placed will greatly affect your measurement. Do not place the scale on | |

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| | dirt/mud, grass, or another soft surface. Record weight. (If scale denotes pounds (lbs) and not kilograms: specify. Do not convert.)<br>e) Height: Ask child to take off shoes and stand against a flat surface (wall, side of building). Using a stiff measuring tape, measure the child's height without shoes. Record height in centimeters. (If measuring tape denotes inches and not centimeters: specify. Do not convert.)<br>f) Mid-upper arm circumference: Wrap MUAC tape around child's upper arm and record measurement in centimeters. Record measurement up to two decimal points. |

# APPENDIX 4: SURVEY TOOL DEVELOPMENT AND REFINEMENT

Survey tools were developed in a two-phase process. The objective of Phase I was to build consensus on minimum set of evaluation questions for OVC program evaluations. The objective of Phase II was to develop child and caregiver / household well-being survey tools for OVC programs, using the minimum set of evaluation questions agreed in Phase I as a starting point.

**Phase I: Build consensus on a minimum set of outcome indicators for OVC programs**

Our approach was to identify and catalogue as many OVC indicators as possible, and then critically assess indicators against agreed inclusion criteria to achieve a minimum set.

We first carried out an extensive literature review, and reviewed international and national child well-being/OVC tools and indicators, OVC program evaluation tools, national OVC M&E plans, and indicators used in large surveys such as DHS, MICS, etc. The result was a catalogue of more than 600 child and household well-being indicators.

We then applied the eight criteria in Box 1 to each of these indicators and rejected those that did not fit. The result was a shorter list of measures/questions for discussion with an internal MEASURE Evaluation working group.

**Box 1: Eight Criteria**

1. Does the question/measure refer to impact/outcomes? (vs. inputs or outputs)
2. Do program interventions have the capacity to change result?
3. Is the question/measure relevant across a wide range of interventions (PEPFAR/OVC, system strengthening, protection, etc.)?
4. Does the question/measure contribute to a holistic vision of child well-being?
5. Can responses be verified (by documentation or another person or source)?
6. Is the question/measure easy to implement across different data collector skill levels?
7. Is the question/measure relevant across different regions / countries?
8. Is the question/measure relevant (or easily adapted) across age and sex?

The MEASURE Evaluation working group re-evaluated each measure/question against the criteria, discussing and documenting indicator limitations and data use/actionability. The result was a list of 14 draft measures/questions for external stakeholder review.

We then solicited review from 49 stakeholders and stakeholder groups including implementing partners, donors, national OVC teams, universities, projects, and task forces, and posted the indicators on ChildStatusNet and a notice on OVCSupport.net. The external working group focused on: (1) assessing the strengths and weaknesses of individual questions; (2) providing recommendations for improving questions/set of questions (including addressing gaps); and (3) assessing the usefulness of questions/information in evaluating and strengthening OVC programs. With these stakeholders, and the USG OVC Steering Committee, we finalized a core set of 12 child well-being indicators and three household well-being indicators.

**Phase II: Develop survey questionnaires based on core outcome indicators**

Using the core indicators as a starting point, and the DHS questionnaires as a reference for structure, we drafted the survey tools. Tools have undergone review by the USG OVC Steering Committee, other key U.S. Government staff, and have been shared with researchers and child well-being experts globally. Tool development is necessarily iterative. We revised these tools after piloting testing in Nigeria and Zambia, and as we learn more about the validity and reliability of measures, the tools and guidance will be updated accordingly.

# APPENDIX 5: ADAPTATION AND TRANSLATION GUIDELINES

**Adaptation**

**Adding questions**

Tools include core and optional modules, which may be added depending on the objectives of the survey. In considering optional modules, it is important to balance information needs with the risks to data quality of collecting more information than needed.

**Changing questions**

We recommend against changing questions in the *core modules*. A majority of these questions or scales have been gathered from validated tools. Specifically, questions that are common to the DHS should not be changed (as indicated in Appendix 1 and 2), and recall periods should not be changed.

We expect that some questions in the *optional modules* may require adaptation to the local context. Adaptation should be followed by rigorous pilot testing of the adapted tools. The aim of adaptation should be to retain the meaning, or conceptual validity, of the original question.

Questions that are part of scales (as indicated in Appendix 1 and 2) should be included as an entirety, and not broken up.

**Question order**

We recommend retaining the order of the questions and sections unless, upon pilot testing, it becomes clear that the question flow is sub-optimal. If investigators choose to change question order, skip patterns will also need to be revised. The order of questions that are part of scales (as indicated in Appendix 1 and 2) should be maintained.

**Translation**

The aim of translation is to develop versions of the tools that are conceptually comparable to the English version, taking into consideration cultural and linguistic norms in the area of study. Tools should not be translated word-for-word, but rather, the meaning of key concepts should be maintained. The gold standard approach to translation is forward translation from English into the study language by an expert translator and then back-translation into English (of the translated questionnaire) by a different expert translator. Variations between versions should be reviewed until an optimal translation is agreed by the study team. Translated versions of the tools should be pilot tested prior to use, to ensure both conceptual validity of measures and language, and appropriate flow. We recommend consulting the following guidance from the World Health Organization:
www.who.int/substance_abuse/research_tools/translation/en.

# APPENDIX 6: FREQUENTLY ASKED QUESTIONS

**What is the purpose of these tools?**

These well-being survey tools have been developed to:

- To enable the production of population-level child well-being data *beyond* what is available from routine surveys,
- To enable the production of population-level (aggregated) caregiver well-being data and household economic status data,
- To enable comparative estimates of child and caregiver well-being and household economic status across a diverse set of interventions and geographical regions

**Who are these tools for?**

Depending on the scope of the survey, type of sample, and the sample size, policymakers and program staff may use data for strategic planning and resource allocation decisions, for program planning/design and program management, and to advocate for resources. These tools may be useful to you if are seeking to answer one of these five questions:

1. Is my program having, or did my program have an impact on the children and households it reached?
2. What are the characteristics of children and their caregivers in my country, state/province or district/area, in terms of education, health, protection, and psychosocial status?
3. Where do the children most in need of program support live?
4. Approximately how many children need services or support?
5. What are the needs of my program's registered beneficiaries, in terms of education, health, protection, and psychosocial support?[10]

**How do other tools currently in use fit with these survey tools?**

To achieve impact and ensure standards, OVC programs collect diverse information. OVC programs require information to identify children and households needing assistance (targeting), to prioritize and attend to the needs of a particular child (case management), to ensure programs are being implemented as planned and on schedule (monitoring), and to plan program activities and evaluate their impact on improving children's well-being.

Information should be collected from tools that are fit-for purpose. There is no single data collection tool that can meet all OVC program targeting, case management and M&E requirements. This set of survey tools responds to distinct information needs related to program planning and evaluation, and fills a tools gap. These tools do not replace those needed for targeting individuals, case management and program monitoring.

[10] This is different from: What are the needs of *each* of my program-registered beneficiaries? If this is your question, these tools are still valid; however, it is unlikely that such a census could be programmatically justified for cost and ethical reasons.

**We already have DHS and MICS data. Why would we want to conduct another survey?**

There are two basic reasons why OVC programs may want to conduct their own child and caregiver well-being surveys:

1. The DHS and MICS employ nationally representative samples. Indicators may be derived at lower administrative levels (typically province-/state-level, urban/rural), but seldom at the level at which programs are conducted. Moreover, these surveys interview all households, and not specifically program households (beneficiaries). This makes it exceedingly difficult to discern the OVC program's contribution to the larger picture.
2. The DHS and MICS include some but not all of the OVC core indicators. The DHS does not include children aged 5 and over.

**Many of these questions are from DHS. Why?**

Wherever possible, we have included DHS questions, or questions from other validated surveys. DHS questions have been validated in countries with OVC programming, and may not require further validation or pre-testing. Also, common indicators allow for comparisons between the OVC household target population for these well-being survey tools and the general population (see below).

**How should DHS data be interpreted alongside data from these tools?**

How DHS data is interpreted against OVC well-being survey data depends on how the sampling was structured. If investigators sampled the general population, then data should match across common indicators. If investigators sampled specific households, such as OVC households or program beneficiary households, then data may or may not be different to DHS data. If the well-being survey tools are implemented among program beneficiaries or the program target population at baseline (i.e., prior to program implementation), then we would expect data to find a population worse off across common indicators, compared to the general population (if programs are targeting the most vulnerable).

**We use the Child Status Index (CSI) to evaluate our program. How does the CSI relate to this set of tools? Do we need to use these tools instead or can we still use the CSI?**

MEASURE Evaluation has recently released new guidance on appropriate CSI usage: http://www.cpc.unc.edu/measure/tools/publications/fs-12-75. The CSI is not recommended for use in program evaluation. Since the CSI requires users to identify children's needs and status *relative* to their local community, it cannot be used as an indicator or comparator for national or multi-country standards. If you wish to evaluate your OVC program, we highly recommend using these survey tools.

**Do organizations need to use every single question? Can they add some?**

Question sets have been carefully constructed and we recommend minimizing changes. However, tools contain two types of questions: core questions, which are highly recommended, and optional questions or modules, which may be added depending on the objectives of the survey. The questions provided are expansive but not exhaustive, and it is possible that investigators may wish to add new questions to meet their information needs. When this is the case, we strongly recommend limiting the number of additional

questions. Investigators need to remember that increasing the number of questions reduces data quality overall.

**How would sample size be calculated?**

Investigators would need to agree the most appropriate indicator on which to power the study. This will be related to both the objectives of the survey, and the current status of the population being surveyed. We suggest powering the study on a child-level outcome. If investigators want to assess differences in progress among sub-populations, such as between males and females, or urban and rural residents, the sample size needs to be increased.

For evaluations, we strongly recommend against powering a study based on indicators that are not expected to change over the evaluation period, or that are not changeable by program intervention. There are many other considerations in determining sample sizes, such as clustering effect, attrition over the evaluation period, non-response, etc. The sample size will need to be increased by an agreed upon factor to take into account these issues.

**How often would these tools be applied?**

It may require years to see a change in many of the indicators measured through these tools. If the tools are being implemented as part of a program evaluation, then a survey every 1-3 years is appropriate (depending on the intervention and when change is expected). If tools are being implemented as a part of a situation analysis of the general population, then a survey every 3-5 years is appropriate.

**How were questions on psychosocial well-being chosen?**

In developing these program evaluation survey tools, we have prioritized questions that are clear, verifiable, programmatically relevant, and actionable *at the population level* in the context of PEPFAR-funded OVC programs. Questions on psychosocial well-being have been the most challenging to build consensus around. Most of the existing measures of these concepts require lengthy question sets or scales; specific questions on their own, mean very little. Also, often nuances between questions are lost in translation, especially in local dialects. Furthermore, population level information on, for instance, depression, self-esteem, general self-efficacy, is difficult to action in the context of current PEPFAR-funded OVC programs, and programs themselves are so complex, usually involving a number of different interventions, that it is not possible to tease out the effect of any one intervention.

To determine the measurement focus of this survey tool kit, we mapped the components of psychosocial well-being that were broadly of interest to PEPFAR: social support; general self-efficacy; parental self-efficacy; financial self-efficacy; self-esteem; hope; functional aspects of well-being; and satisfaction with life. In discussion with the PEPFAR OVC technical working group and experts in the field, it was agreed that PEPFAR interventions were focused most heavily on improving social support, and that this should be the focus of measurement. We pilot tested The RAND Corp.'s Medical Outcomes Study social support scale, among other support questions, and recommend using four questions from that set – one for each of the areas of support; social, affectionate, emotional, and tangible.

As we know that tool users may be interested in adding measures for other components of psychosocial well-being, we did pilot a number of scales in both Zambia and Nigeria, and our lessons from pilot testing will be available on our website mid-2104 in a psychosocial wellbeing measurement supplement. If you do decide to add questions or scales measuring components of psychosocial well-being, we strongly recommend consultation with a specialist in psychometrics during the survey adaptation process.

**How were questions on child protection chosen?**

The tools currently include questions on birth certification, child labor and neglect. We are currently developing an optional module on violence, which will be accompanied with procedural guidance. This will be available on our Web site by mid-2014. Questions on violence were specifically left out of the full questionnaire as not all PEPFAR programs are targeting resources to violence mitigation and questions around violence require additional child protection and research ethics protocols. If abuse is identified or suspected at household level, data collectors must refer the respondent to appropriate services – which in some cases may be hard to identify. Furthermore, there is a lack of consensus on what information should be collection on violence at the population level. Although it is useful to have population-level information on violence for advocacy and program planning purposes, this information is more useful at an individual or case management level. The utility of the information generated must be balanced against any discomfort or risk faced by the respondent.

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