Child, Caregiver, & Household Well-Being Survey Tools

For Orphans and Vulnerable Children Programs: Manual

September 2019

Child, Caregiver & Household Well-Being Survey Tools for Orphans and Vulnerable Children Programs: Manual

Jenifer Chapman, PhD, MEASURE Evaluation, Palladium
Karen Foreit, PhD, MEASURE Evaluation, Palladium
Mari Hickmann, MA, MEASURE Evaluation, Palladium
Lisa Parker, PhD, MEASURE Evaluation, Palladium
Lisa Marie Albert, MPH, MEASURE Evaluation, Palladium

May 2013, revised January 2015 and September 2019

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350
measure@unc.edu
www.measureevaluation.org

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government.
MS-13-62 rev

ISBN: 978-1-64232-162-3

ACKNOWLEDGMENTS

The authors thank the United States Agency for International Development (USAID) and the United States President's Emergency Plan for AIDS Relief (PEPFAR) for their support of this work.

The development of the survey tools was highly participatory. They represent current best practices in the measurement of the well-being of orphans and vulnerable children (OVC) and their caregivers in the context of PEPFAR-funded OVC programs.

The process of tool development was shepherded by Dr. Janet Shriberg and Gretchen Bachman at USAID, with important input from Stephen Volle and the wider PEPFAR Orphans and Vulnerable Children Technical Working Group, especially Dr. Beverly Nyberg at the Peace Corps and Dr. Nicole Benham at the Office of the Global AIDS Coordinator. We thank Dr. Krista Stewart and Kristen Wares for their guidance as the Agreement Officer Representatives of the USAID- and PEPFAR-funded MEASURE Evaluation project.

The contributions of implementing partners, researchers, government staff, and other stakeholders, too numerous to list, cannot be overstated. This was truly a community effort and we are grateful to our colleagues for their generosity in devoting time, resources, and experience.

We thank the knowledge management team at MEASURE Evaluation, University of North Carolina at Chapel Hill, for editorial, design, and production services.

Suggested citation

Chapman, J., Foreit, K., Hickmann, M., Parker, L., & Albert, L. M. (2013; rev. 2013 and 2019). Child, Caregiver, and Household Well-Being Survey Tools for Orphans and Vulnerable Children Programs: Manual (3rd ed.). Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina.

CONTENTS

Tables 7

Abbreviations 8

Introduction 9

  Synergies with International Child Surveys (DHS, MICS, & VACS) 9

Structure and Content 12

Study Design 15

  Defining Participants 18

  Sampling Strategy and Sample Size 18

  Recruitment and Consent 19

  Adapting and Translating the Tools 19

Data Collection and Security 20

Obtaining Ethical and Other Approvals 21

Child Protection 22

Data Analysis and Use 23

Conclusion 25

References 26

Bibliography 27

Appendix A. Implementation Checklist 31

TABLES

Table 1. Indicator overlap between MEASURE Evaluation's OVC well-being questionnaires and international child surveys 10

Table 2. Caregiver household questionnaire 12

Table 3. Child questionnaire ages 0–9 years (administered to adult caregiver) 13

Table 4. Child questionnaire ages 10–17 years 14

Table 5. Possible implementation approaches for using the OVC well-being questionnaires 17

ABBREVIATIONS

DHS	Demographic and Health Survey
IRB	institutional review board
MICS	Multiple Indicator Cluster Survey
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
RCT	randomized controlled trial
USAID	United States Agency for International Development
VACS	Violence Against Children Survey

INTRODUCTION

Investments by the United States Government and other donors in programs to improve the well-being of orphans and vulnerable children (OVC) and their households have been substantial, and yet the impact of these investments is uncertain (Sherr & Zoll, 2011). 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; however, the components that have been agreed on include good physical and mental health, education, and nutrition, among others. It is these elements that formed the building blocks of the survey tools in this manual.

Questions remain about what interventions are most effective in improving OVC well-being (United States President's Emergency Plan for AIDS Relief [PEPFAR], 2012). One challenge to knowing the impact of OVC programs 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 challenge, MEASURE Evaluation—funded by the United States Agency for International Development and PEPFAR—developed three quantitative questionnaires for use in a household survey of children ages 0–17 years and of their adult caregivers. The purpose of these questionnaires is:

- To enable and standardize the production of child and caregiver well-being data beyond what are available from routine surveys.
- To produce actionable data to inform project interventions and facilitate course corrections.
- To enable comparative assessments of child and caregiver well-being and household economic status across projects and geographic regions.

The questionnaires can be implemented using the following approaches: (1) a situation analysis of the general population; (2) a needs assessment for program beneficiaries; or (3) an assessment of outcomes for the beneficiary population. Therefore, the audience for this manual includes research teams intending to implement the aforementioned types of studies of OVC beneficiary populations. The evaluation indicators included are based on the core indicators of child, caregiver, and household well-being in which change over time can reasonably be attributed to project interventions and are directly actionable by typical PEPFAR-funded OVC programs (MEASURE Evaluation, 2012).

This manual presents an overview of the three OVC well-being questionnaires: (1) a caregiver household questionnaire; (2) a questionnaire for children ages 0–9 years (which is administered to the caregiver); and (3) a questionnaire for children ages 10–17 years (which is administered directly to children with their informed assent and parental consent). The tools can be found at https://www.measureevaluation.org/our-work/ovc/ovc-program-evaluation-tool-kit.In addition, this manual gives focus on the structure and the indicator content of the questionnaires, while pointing out synergistic overlaps with validated nationally representative surveys. It also covers considerations for study design; ethics; child protection; sampling; recruitment; and data collection, analysis, and use.

Synergies with International Child Surveys (DHS, MICS, & VACS)

Many countries collect outcome indicators through the Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and Violence Against Children Survey (VACS). Most of these studies are conducted every five years and measure population-based estimates of outcomes that provide important data on long-term shifts. However, these surveys do not provide data on the complex needs of OVC program beneficiaries, multisectoral outcomes along the path to intended HIV outcomes, or data on the direct impact that investments are having on the lives and well-being of children and caregivers. Moreover, population-based surveys are expensive and the results are typically released many months—often years—after the data are collected, making it difficult for projects to use the findings for timely improvements.

We have supplemented the OVC core indicators recommended by MEASURE Evaluation with questions from validated surveys, such as the DHS, MICS, and VACS. Using indicators that are common across validated surveys allows for comparisons between those indicators in the general population with the study population in your study design. The OVC well-being questionnaires contain two types of questions: (1) core questions, which are highly recommended; and (2) optional questions organized in modules, which may be added, depending on the objectives of your survey.

The OVC well-being questionnaires developed by MEASURE Evaluation serve a purpose for which the standardized nationally representative surveys cannot fulfill, such as measuring the direct impact of OVC programs on beneficiaries.

DHS, MICS, and VACS indicators can be measured at lower administrative levels (typically province/state-level, urban/rural), but seldom at the level at which programs are conducted. Moreover, these surveys interview a sample of all households, not specifically OVC program beneficiary households. Therefore, using results from nationally representative surveys, it is usually impossible to discern an OVC program's contribution to child- and household-level outcomes of their own beneficiaries. In addition, DHS and MICS are usually implemented every five years and not all countries implement such standardized questionnaires.

Table 1 presents the outcome measures that are in the OVC well-being questionnaires, including those that overlap with the DHS, MICS, and VACS survey indicators.

Table 1. Indicator overlap between MEASURE Evaluation's OVC well-being questionnaires and international child surveys

Target group	Overlap with DHS, MICS, and/or VACS[1]	Additional indicators in the MEASURE Evaluation well-being survey
Household and caregiver	• Household size and composition • Education • Work • Shelter • Gender attitudes, including attitudes toward gender-based violence	• Relationship of primary caregiver to children in his/her care • Access to money • Household expenditures on education, medical costs, and unexpected expenses • Sources of money • Perceived financial security

---

[1] The items in this column are found in the most recent DHS, MICS, or VACS questionnaires at the time of publication but may be lacking from earlier surveys. All standard DHS questionnaires can be found at http://www.measuredhs.com/What-We-Do/Survey-Types/DHS-Questionnaires.cfm and country-specific questionnaires are included in the final reports.

Target group	Overlap with DHS, MICS, and/or VACS[1]	Additional indicators in the MEASURE Evaluation well-being survey
	• HIV testing experience • HIV/AIDS knowledge and attitudes	• Health and health-seeking behavior • Caregiver felt support • Parental self-efficacy • Household food security • Dietary diversity • Perceptions of child discipline • HIV treatment and disclosure • Participation in savings groups and OVC services
All children <18	• Orphanhood and living arrangements • Relationship to head of household • Birth certificate	• Disability • Basic shelter • Dietary diversity (ages 2+) • General health • HIV testing experience • HIV disclosure • HIV test results • Participation in OVC services
Children <5	• Vaccinations • Fever, diarrhea • Early childhood education and stimulation • Neglect • Child slept under a mosquito net	• Nutritional status (middle-upper arm circumference [MUAC])
Children 5–17	• School attendance • Child labor (ages 5–17) • HIV/AIDS knowledge, attitudes (ages 10–17) • Sexual behavior (ages 10–17) • Alcohol consumption (ages 10–17) • Drug use (ages 10–17) • Violence experienced (emotional, physical, sexual) (ages 10–17)	• Basic social support • Spending of money • School progression over time • School dropouts • Child development education (ages 10–17) •

Standard MICS questionnaires can be found at http://mics.unicef.org/tools. Standard VACS questionnaires can be found at https://www.togetherforgirls.org/violence-children-surveys.

STRUCTURE AND CONTENT

The OVC well-being questionnaires developed by MEASURE Evaluation contain two types of questions: (1) core questions, which are highly recommended; and (2) optional questions, which are organized in modules and can be added to a survey, depending on its objectives. Examples of the optional modules are dietary diversity, and decision making and gender roles. An overview of the core and optional modules for each questionnaire is presented in Tables 2, 3, and 4.

Table 2. Caregiver household questionnaire

Sections	Core questions	Optional modules
Section 1: Household schedule	• List of children • Relationship to the child/children in the household • Status of the child's/children's biological parents	
Section 2: Background information on the caregiver and the household	• Demographic information • Work • Sources of money • Household expenditures on education, medical costs, and unexpected expenses • Shelter • Perceived financial security	• Household economic status (using the Household Economic Vulnerability Tool Indicator Guide) • Poverty Probability Index (country specific)
Section 3: Household food security	• Household food security	• Household dietary diversity
Section 4: Caregiver well-being	• General health • Social support • Parental self-efficacy	• Decision making and gender roles
Section 5: HIV/AIDS knowledge, testing, attitudes, and behavior	• Basic HIV/AIDS knowledge • HIV testing experience • HIV test results	• Attitudes about HIV/AIDS • HIV treatment and disclosure
Section 6: Program services received	• Household access to OVC program services	• Participation in savings groups

Table 3. Child questionnaire ages 0–9 years (administered to adult caregiver)

Sections	Core questions	Optional modules
Section 1: Child health and protection	• Demographic information • Birth certificate • General health • Experience of fever/diarrhea • Slept under a mosquito net • HIV testing experience • HIV test results • Experience of neglect	• Immunizations
Section 2: Child education	• School attendance, progression • Early childhood stimulation	
Section 3: Work and chores	• Chores • Work for wages • Child labor/unsafe work environment • Use of wages	
Section 4: Food consumption	• Food security	• Dietary diversity
Section 5: Program services received	• OVC program services received	
Section 6: Anthropometric measures (of children)	• MUAC	

Table 4. Child questionnaire ages 10–17 years

Sections	Core questions	Optional modules
Section 1: Well-being and protection	• Demographic information • Birth certificate • General health	
Section 2: Education	• School attendance, progression	
Section 3: Chores and work	• Chores • Work for wages • Child labor/unsafe work environment • Use of wages	
Section 4: Food and alcohol consumption	• Food consumption • Alcohol consumption • Drug use	• Dietary diversity
Section 5: Social support	• Social support • Child development knowledge	
Section 6: HIV/AIDS testing, knowledge, and attitudes	• HIV/AIDS knowledge • HIV testing experience • Sexual behavior and contraception	• HIV treatment and disclosure
Section 7: Violence	• Violence against caregiver witnessed • Violence experienced (emotional, physical, sexual) • Medical treatment sought	
Section 8: Program services received	• Child access to OVC program services	

STUDY DESIGN

Depending on the research question that needs to be answered, the OVC well-being questionnaires can be used in various types of study designs and settings. Although these questionnaires were designed with a household survey approach in mind, the tools can be used in a school, healthcare, formal care, or other setting if guardians are present to provide consent for children ages 10–17 under their care to participate and respond to the questions.

Several factors will influence your survey design choice, including whether you are seeking information for policy and advocacy, program planning, or to better understand outcomes resulting from program participation. Table 5 provides some research questions that these tools can help address, and the types of study designs, settings, and timing to use for implementation. A general implementation checklist is given in Appendix A.

If you want to conduct a ***situation analysis*** of the general population or a ***needs assessment*** of program beneficiaries, a cross-sectional study design is appropriate. To follow trends in the population, the same assessment can be implemented every three to five years.

If you want to do an ***impact or outcome evaluation*** of a program, you need to administer the questionnaires in a randomized controlled trial (RCT) or a quasi-experimental study design. The questionnaires should be implemented at two points in time (e.g., baseline and end line), during the same time of year, at least two years apart, or at least allowing for an appropriate amount of time in which the project can be expected to impact change on an outcome. Ideally, the baseline survey should be conducted as early in the program cycle as possible. Baseline measures taken of programs that are already underway may not capture changes (positive or negative) in outcomes that have occurred from the start of the intervention up to that point in time. Consequently, comparisons with future surveys may underestimate or overestimate changes in outcomes over time. In determining the exact timing, investigators should balance two needs.

1. A sufficient number of beneficiaries should be enrolled before conducting the survey so that the data are as representative of program beneficiaries as possible.
2. Ideally, beneficiaries will not have received services for more than six months before the first round of data collection so that the first round is a true baseline.

The strongest case for attributing positive change in outcomes to program interventions requires a RCT using a control group that has not received program services or interventions. In this case, sampling of the program and control groups should happen simultaneously and should be methodologically equivalent. Moreover, administration of the questionnaires should follow the same methodology in both groups at all study timepoints. The cost of a control group needs to be justified, considering the added value of the information it will generate. Another possibility is to do a quasi-experimental design using a comparison group, which is as similar as possible to the intervention group, but not using random assignment.

If a RCT or a quasi-experimental design is not feasible or if it is not programmatically necessary, changes in program beneficiary well-being can still be measured. However, attributing any changes in outcomes to the program will require ancillary data to rule out other influences or spillover effects. If the purpose of using these tools is to evaluate a specific intervention, investigators are encouraged to adapt the tools, if necessary, to ensure that the survey questions adequately address outcome measures for the intervention being assessed.

Table 5. Possible implementation approaches for using the OVC well-being questionnaires

Research Question	Justification	Timing	Target Respondents[1]	Study Type	Study Design
What are the characteristics of children and their caregivers, in terms of education, health, protection, and social support?	For effective resource allocation at the policy or program level	Anytime, every 3–5 years	General population	Situation analysis (with size estimation)	Cross-sectional
In what geographic area(s) do the children most in need of support live?	To advocate for more resources				
How many estimated children and households need services or support?	Last DHS or similar survey was conducted many years earlier				
What are the needs of beneficiaries, in terms of education, health, protection, and social support?	For program planning	Beginning of a program[3]	Beneficiaries	Needs assessment	Cross-sectional
Is the intervention[2] having, or has it had, an impact on the children and households it reached?	To determine whether changes are needed in program strategy to achieve maximum impact	Beginning, (middle), and end of a program, after change is expected (1–2 years)	Program beneficiaries (and a comparison group)	Impact or outcome evaluation	RCT or quasi-experimental study, with or without a comparison group

---

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

[2] If the purpose of using these questionnaires is to evaluate a specific intervention, investigators will need to adapt the tools to ensure that outcome measures are adequately addressed by the survey questions.

[3] If repeated, the data will represent the baseline assessment. Data collected early in project implementation are most useful for program planning.

Defining Participants

Selection criteria for participation may differ, depending on the information needs of your program. In the case of a situation analysis, participants will be from households sampled from the general population. For a needs assessment, impact evaluation, or outcome evaluation, participants will be sampled from beneficiary households, where at least one household member is a program beneficiary.

In any of the study designs, participants should include the following:

- The primary caregiver, the person mainly responsible for the emotional and physical care of the child and is seen to play a long-term ongoing role in their lives
- All adolescents ages 10–17 under the care of the primary caregiver, who live in the same household (or slept in the household on the night before the interview)
- All children ages 6 months to–4 years who are under the care of the primary caregiver also participate in the study during the measurement of their MUAC, with consent from the primary caregiver

Sampling Strategy and Sample Size

A statistician should be consulted to determine the appropriate sampling approach based on the study design. Although a census survey is theoretically possible, investigators generally sample from their population of interest for budget and time reasons, and because a census will statistically tell us little more than a well-structured sample. The sampling strategy is linked to the study design and the survey objectives. The first step is to determine the unit of the sample: households, children, or adults/caregivers. Some sampling strategies require considerable information about the target population; therefore, a lack of available information may preclude certain sampling strategies. Costs also influence the study design and, therefore, sampling. Investigators often limit the number of geographic units to reduce transport costs during data collection. Investigators should agree on the most appropriate indicator on which to power the study. This decision is guided by 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 subpopulations, such as between males and females, or urban and rural residents, the sample size needs to be increased. An example of a sample size calculation can be found in the *Monitoring, Evaluating, and Reporting PEPFAR's Essential Survey Indicators for Orphans and Vulnerable Children Programs: Research Protocol Template* (MEASURE Evaluation, 2018) located at https://www.measureevaluation.org/resources/files/ms-18-128.pdf.

If you are doing a **situation analysis** or **needs assessment** at one point in time, then your sample size depends on the precision you would like your estimates to have. The study sample size will therefore be guided by the primary outcome of interest. We strongly recommend against powering a study based on indicators that are not expected to change during the evaluation period or that cannot be changed by the program intervention. If you are implementing these survey tools as part of an evaluation involving data collection at two points in time, the sample size will also hinge on the extent of change expected in key outcome measures between the data collection points (i.e., baseline and end line). In this case, an estimated proportion of refusals, loss to follow up, and attrition should be considered in advance such that they inform the baseline sample size.

Recruitment and Consent

As stated above, the method of identifying households or individuals to be sampled depends on the study objectives and whether you are sampling members of the general population or program/intervention beneficiaries. If the latter, data collectors are often supported by local service providers to identify the households.

Investigators need to discuss and document call-back procedures if adults or children are not available for interview at the time of the visit.

Regardless, once the data collectors identify the adult caregiver in the household (or another 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 the data collectors seek informed consent/assent 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 the 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 (IRB). (See the section on "Obtaining Ethical and Other Approvals" below.) Adults should provide consent for themselves and for children younger than age 18 under their care. Participating children ages 10 and above should also provide their assent to participate.

Investigators should decide whether consent will be written or verbal.

Adapting and Translating the Tools

The set of questions has been carefully designed and chosen. We therefore recommend minimizing changes. The questions are expansive but are not exhaustive; investigators may wish to add new questions to meet their information needs. If this is the case, we strongly recommend limiting the number of additional questions. Investigators need to remember that increasing the number of questions may reduce overall data quality.

Investigators should adapt the question language and response categories to align with local discourse and to enhance clarity. All data collection tools, including the quantitative questionnaires, should be pilot-tested in the program setting. Following the pilot test, revision to the wording of some of the questions may be needed to ensure that respondents understand what is being asked and that the questions produce valid data in the country and context of study. During adaptation and translation, the goal is always to maintain the integrity of the indicators. Recall periods should not be changed.

In many cases, the questionnaires will need to be translated. During translation, it is important to agree on language that maintains the core meaning of the question, rather than translating verbatim.

DATA COLLECTION AND SECURITY

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

The collection of program outcome data by enumerators external to service delivery requires a documented protocol that describes a technically robust analysis plan. An experienced and qualified team should develop the protocol and a statistician should be involved in the preparation of the protocol.

Investigators need to discuss and document how, when, and where data will be collected; who will collect the information (and who can be present during data collection); and how the data will be captured, stored, moved, and protected. All information gained from the interviews should be kept confidential. Members of the field team should sign a document to ensure that the privacy of participants is maintained.

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 of year to conduct the survey. If the survey tools are being implemented as part of an evaluation involving data collection at two points in time, it is imperative that data collection occurs at the same time in each survey year.

The questionnaires should be administered by trained data collectors who have passed child protection screening. A data collector training accompanies the tools and is located at https://www.measureevaluation.org/our-work/ovc/training-for-pepfar-ovc-survey-data-collectors . Adults should be interviewed out of earshot of other adults or children over age five. Children should be interviewed out of earshot but within plain sight of an adult caregiver or guardian.

If you are conducting the survey using paper-based questionnaires, you should consider how the completed questionnaires will be transferred securely to the point of data entry; by whom, how, and when hard copies of the questionnaires will be destroyed; and how electronic data will be protected.

If the survey is being conducted using electronic data collection, the entire questionnaire should be entered in an electronic database and checked for accuracy and consistency using an appropriate program, such as Epi Info,[2] Census and Survey Processing System (better known as CSPro),[3] or Microsoft Excel. It is extremely important that geographic information, sex, and age-group information be retained in the computer records. Data dictionaries, variable and value labels, and metadata should also be created.

Data handling techniques should be considered and adapted for the implementation of your study, as needed. The *Monitoring, Evaluating, and Reporting PEPFAR's Essential Survey Indicators for Orphans and Vulnerable Children Programs: Research Protocol Template* (MEASURE Evaluation, 2018) located at https://www.measureevaluation.org/resources/files/ms-18-128.pdf provides a sample list of tablet and data security measures to consider.

---

[2] United States Centers for Disease Control and Prevention (CDC). (n.d.). Epi Info. Atlanta, GA, USA: CDC. Retrieved from https://www.cdc.gov/epiinfo/index.html.

[3] United States Census Bureau. (2019). Census and Survey Processing System (CSPro). Washington, DC, USA: United States Census Bureau. Retrieved from https://www.census.gov/data/software/cspro.html,

OBTAINING ETHICAL AND OTHER APPROVALS

The questionnaires should not be implemented without written ethics approval from a formal committee. Investigators should seek and obtain written ethical approval from a research ethics committee or IRB in the study country before collecting any information (including piloting the questionnaires). IRBs generally require submission of a protocol, the data collection tools, and the 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 government line ministry before data collection begins.

CHILD PROTECTION

Investigators should document a set of child protection procedures specific to the study in the study protocol. The assent process with children should clearly communicate that an exception to maintaining confidentiality during the interview will occur if the field team member learns about an abusive situation or that the child is in danger.

Applicants for the field team should be screened to ensure that they do not have any past criminal violations, including child abuse. Study and field team members should also be trained in child protection.

Because of the sensitive nature of the questions in the survey, some respondents may recall negative experiences, which could cause a strong emotional response. Respondents may also be currently experiencing violence and may request immediate assistance with their situation. The study team should therefore develop a child protection response procedure that enables the enumerators to respond to the needs of the respondent by linking him or her to support if a recent or current abusive situation is discovered or if a child is in any danger (emergency). This procedure should have a list of services, for example, free programs, services, and amenities currently offered in the area, and including but not limited to services for victims of violence. Legal and cultural context should be considered.

DATA ANALYSIS AND USE

The approach to data analysis will depend on the study design; it is therefore recommended that a sampling statistician be consulted to provide guidance on sampling and the corresponding analysis methods. If a self-weighted sampling method was not followed, sampling weights should be calculated and applied to the data before descriptive analysis and statistical testing are performed. Data imputations can be performed for nonresponse to items, as needed.

Depending on the scope of the survey, type of sample, and the sample size, policymakers and program staff can use the 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 the general population**, such as in a situation analysis, the data will indicate the characteristics of children and their caregivers in the survey area; where children most in need of services or support live; and an estimate of the number of children and households that need services or support. The data can be used for needs-based resource allocation in the survey area or for informing the design of programs or interventions. If a national or state/provincial survey has been conducted, the data can 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.

If you have drawn a **representative sample of program beneficiaries** (or households scheduled to receive services), such as in a needs assessment, the data will represent the needs of your target population. These data can be used immediately for program planning or design, or for course corrections, and can potentially influence how program resources are allocated. For example, if high food insecurity is found, then the program may want to implement a new intervention for the provision of food and nutritional support, even if this intervention was not originally planned.

If you have drawn a **representative sample of program beneficiaries** at the end of a program (e.g., end line) and have similar data from an earlier point in the program (e.g., baseline), such as in an impact or outcome evaluation, the differences in the data values across the indicators between these two timepoints represent the average changes across your population over time. It is strongly recommended that the data are collected at the same time of year (e.g., pre-harvest) because responses could be subject to seasonal bias, meaning that responses to questions are likely to change throughout the year, especially among farming households. Many years may be required to see a change in several of the indicators measured using these survey tools.

The extent to which any change in well-being (whether positive or negative) can be attributed to a particular intervention or program depends on several factors, for example: whether there are other programs operating in the area and what they do; the existence of new policies that may influence outcomes; drought; conflict, etc. The ability to attribute changes in well-being to program impact improves if investigators gather information from a comparison group and 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.

Regardless of the purpose of the survey, it is important to analyze the survey data alongside other available data, such as DHS, MICS, or VACS data. This is called "data triangulation." If you have drawn a representative general population sample at a national or state/provincial level and you have maintained high data quality, the DHS, MICS, or VACS indicators included in the questionnaires should align between your data and those reported in the most recent DHS, MICS, or VACS reports (depending on the year of the report). If they do not align, it is important to consider why. If you have drawn a sample of program beneficiaries, you can compare the results of the standardized DHS, MICS, or VACS indicators with those published on the general population to give an indication of how much better or worse off your beneficiary population is compared with the general population.

Published research findings on OVC programs and interventions are lacking in many countries, even if studies have been performed. We therefore encourage publication of your study findings, whether in report form or in academic peer-reviewed journals.

CONCLUSION

This manual presents an overview of the OVC well-being questionnaires, which MEASURE Evaluation prepared to provide standard measures and measurement tools for child and household well-being, tailored to the OVC population. Focus is given on the structure and the indicator content, while pointing out synergistic overlaps with validated nationally representative surveys. Various study types that can be implemented using these questionnaires are discussed, including situation analysis, needs assessments, and impact and outcomes evaluations. We hope that these questionnaires are effective in contributing to the understanding of how PEPFAR programs are improving OVC well-being. Please send any questions related to the OVC well-being questionnaires to measure@measureevaluation.org.

REFERENCES

MEASURE Evaluation. (2018). *Monitoring, evaluating, and reporting PEPFAR's essential survey indicators for orphans and vulnerable children programs: Research protocol template*. Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.measureevaluation.org/resources/publications/ms-18-130.

MEASURE Evaluation. (2012). *Core indicators for OVC program evaluation.* Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.measureevaluation.org/our-work/ovc/core-indicators-for-ovc-program-evaluation-draft.

Sherr, L., & Zoll, M. (2011, May). PEPFAR OVC evaluation: How good at doing good? Retrieved from http://ghpro.dexisonline.com/resource/pepfar-ovc-evaluation-how-good-doing-good.

United States President's Emergency Plan for AIDS Relief (PEPFAR). (2012). *Guidance for orphans and vulnerable children programming.* Washington, DC, USA: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/195702.pdf.

BIBLIOGRAPHY

The following bibliography highlights resources that were used to determine which indicators to measure in the Child, Caregiver, and Household Well-Being survey tools.

Measuring Child Well-Being

Barnes, H., Cluver, L., & Wright, G. (2007). *Findings from the Indicators of Poverty and Social Exclusion Project: Children, Key Report 5*. Pretoria, South Africa: Department of Social Development.

Ben-Arieh, A. (2007). The child indicators movement: Past, present, and future. *Child Indicators Research, (1)*1, 3–16. Retrieved from https://www.researchgate.net/publication/225586087_The_Child_Indicators_Movement_Past_Present_and_Future

Carboni, I., & Morrow, N. (2011). Finding the right balance between standardisation and flexibility: A compendium of indicators for measuring child well-being. *Child Indicators Research, 4*(4), 597–618. Retrieved from https://link.springer.com/article/10.1007%2Fs12187-011-9109-3.

Child Protection in Crisis (CPC). (2010). *Defining success: Developing locally meaningful indicators for child-centered psychological programming in Uganda*. New York, NY, USA.: CPC Network. Retrieved from www.cpcnetwork.org/wp-content/uploads/2014/04/Defining-Success.-Developing-Locally-Meaningful-Indicators-for-Child-centered-Psychosocial-Programming-in-Uganda.pdf.

Lippman, L. H., Moore, K. A., McIntosh H. (2011). Positive indicators of child well-being: A conceptual framework, measures, and methodological issues. *Applied Research in Quality of Life, 6*,425–449. Retrieved from https://www.scirp.org/(S(oyulxb452alnt1aej1nfow45))/reference/ReferencesPapers.aspx?ReferenceID=1567935.

Morrow, V., & Mayall, B. (2010). Measuring children's well-being: Some problems and possibilities. In Morgan, A., Ziglio, E., & Davies, M. (Eds.), *Health assets in a global context: Theory, methods, action* (pp. 145–169). New York, NY, USA: Springer. Retrieved from https://www.springer.com/gp/book/9781441959201.

Roelen K., & Gassmann, F. (2008) *Measuring child poverty and well-being: A literature review*. Maastricht, The Netherlands: Maastricht Graduate School of Governance, Maastricht University. Retrieved from https://core.ac.uk/download/pdf/12016453.pdf.

Snider, L. M. (2006, August 12). Psychosocial vulnerability and resilience measures for national-level monitoring of orphans and other vulnerable children: Recommendations for revision of the UNICEF psychological indicator. Retrieved from https://bettercarenetwork.org/sites/default/files/Psychosocial%20Vulnerability%20and%20Resilience%20Measures%20for%20NationalLevel%20Monitoring%20of%20Orphans%20and%20Other%20Vulnerable%20Children.pdf.

United Nations Children's Fund (UNICEF). (2005). *Guide to monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS*. New York, NY, USA: UNICEF. Retrieved from http://data.unaids.org/topics/m-e/ovc_me_guide_en.pdf.

United States Agency for International Development (USAID). (2011). *USAID evaluation policy*. Washington, DC, USA: USAID. Retrieved from https://www.usaid.gov/sites/default/files/documents/2151/USAIDEvaluationPolicy.pdf.

United States Government (USG). (2012). *United States government action plan on children in adversity*. Washington, DC, USA: USG. Retrieved from https://www.usaid.gov/sites/default/files/documents/1860/United%20States%20Action%20Plan%20on%20Children%20in%20Adversity.pdf.

World Vision International. (2013) *Compendium of indicators for measuring child well-being.* Monrovia, CA, USA: World Vision International. Retrieved from https://www.wvi.org/sites/default/files/Compendium_of_Indicators_for_Child_Well-being_0.pdf.

Scales

Berry, J. O., & Jones, W. H.. (1995). The parental stress scale: Initial psychometric evidence. *Journal of Social and Personal Relationships, 12*(3), 463–472. Retrieved from https://journals.sagepub.com/doi/abs/10.1177/0265407595123009#.

Canty-Mitchell, J., & Zimet, G. D. (2000). Psychometric properties of the multidimensional scale of perceived social support in urban adolescents. *American Journal of Community Psychology, 28*(3), 391–400. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/10945123.

Crandal, R. (1973). The measurement of self-esteem and related constructs. In Robinson, J.P. & Shaver, P.R. (Eds.), *Measures of social psychological attitudes. Revised edition* (pp. 80–82). Ann Arbor, MI, USA: Institute for Social Research, University of Michigan.

Deitchler, M., Ballard, T., Swindale, A., & Coates, J. (2010).*Validation of a measure of household hunger for cross-cultural use.* Washington, DC, USA: Food and Nutrition Technical Assistance II Project (FANTA-2), FHI 360. Retrieved from https://www.fantaproject.org/sites/default/files/resources/HHS_Validation_Report_May2010_0.pdf.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49,* 71–75. Retrieved from https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/SATISFACTION-SatisfactionWithLife.pdf.

Dowrick, C., Casey, P., Dalgard, O., Hosman, C., Lehtinen, V., Vázquez-Barquero, J. L., & Wilkinson, G. (1998). Outcomes of depression international network (ODIN). *The British Journal of Psychiatry, 172,* 359–363. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/9715340.

Lown, J. M. (2011). *Development and validation of a financial self-efficacy scale*. Westerville, OH, USA: Association for Financial Counseling and Planning Education. Retrieved from https://files.eric.ed.gov/fulltext/EJ952966.pdf.

Meltzer, H. (2003). Development of a common instrument for mental health. In Nosikov, A., & Gudex, C. (Eds.). *EUROHIS: Developing common instruments for health surveys.* Amsterdam, The Netherlands: IOS Press.

Pavrot, W. & Diener, E. (1993). Review of the satisfaction with life scale. *Psychological Assessment, 5*, 164–172. Retrieved from http://labs.psychology.illinois.edu/~ediener/Documents/Pavot-Diener_1993.pdf.

RAND Corporation. *Medical Outcomes Study Social Support Survey.* Arlington, VA, USA: RAND Corporation. Retrieved from https://www.rand.org/health-care/surveys_tools/mos/social-support.html.

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ, USA: Princeton University Press. Retrieved from http://web.bvu.edu/faculty/goodfriend/documents/surveys/Self%20Esteem/Rosenberg1965.pdf.

Schwarzer, R., & Jerusalem, M. (1995). Generalized self-efficacy scale. In Weinman, J., Wright, S., & Johnston, M. *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 25–37). Windsor, UK: NFER-NELSON. Retrieved from www.contentedits.com/img.asp?id=13180.

Snyder, C. R., Hoza, B., Pelham, W. E., Rapoff, M., Ware, L., Danovsky, M., Highberger, L., Rubinstein, H., & Stahl, K. J. (1997). The development and validation of the children's hope scale. *Journal of Pediatric Psychology, 22*(3), 399–421. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/9212556.

Swindale, A., & Bilinsky, P. (2006) *Household dietary diversity score (HDDS) for measurement of household food access: Indicator guide – Version 2.* Washington, DC, USA: FHI 360/FANTA. Retrieved from https://www.fantaproject.org/sites/default/files/resources/HDDS_v2_Sep06_0.pdf.

United States Centers for Disease Control and Prevention (CDC). (2018). Health-related quality of life (HRQOL), CDC HRQOL–14 "Healthy Days Measure." Atlanta, GA, USA: CDC. Retrieved from http://www.cdc.gov/hrqol/hrqol14_measure.htm#3 .

Wylie, R. C. (1974*). The self-concept. Volume 1, A review of methodological considerations and measuring instruments Revised edition.* Lincoln, NE, USA: University of Nebraska Press.

World Health Organization (WHO). (2004). WHO Quality of Life-BREF (WHOQOL-BREF). Geneva, Switzerland: WHO. Retrieved from https://www.who.int/substance_abuse/research_tools/whoqolbref/en/.

Youthinmind. (2016, September). Strengths and difficulties questionnaires. Retrieved from http://www.sdqinfo.org/.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52*(1), 30–41. Retrieved from https://psycnet.apa.org/record/1988-18939-001.

Zimet, G. D., Powell, S. S., Farley, G. K., Werkman S., & Berkoff, K. A. (1990). Psychometric characteristics of the multidimensional scale of perceived social support. *Journal of Personality Assessment*, *55*(3–4), 610–17. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/2280326.

Ethics

FHI 360. (2011). Research ethics training curriculum, Second edition. Retrieved from http://www.fhi360.org/sites/all/libraries/webpages/fhi-retc2/index.html.

UNICEF. (2012). *Ethical principles, dilemmas and risks in collecting data on violence against children: A review of available literature.* New York, NY: UNICEF. Retrieved from https://data.unicef.org/wp-content/uploads/2015/12/EPDRCLitReview_193.pdf.

UNICEF Evaluation Office. (2002). Children participating in research, monitoring and evaluation (M&E) – Ethics and your responsibilities as a manager. Evaluation Technical Notes. Retrieved from http://www.unicef.org/evaluation/files/TechNote1_Ethics.pdf.

Study Design, Sampling, and Statistics

Kirkwood, B. R., & Sterne, J. A. C. (2003). *Essential medical statistics, Second edition.* Oxford, UK: Blackwell Science Ltd.

Education Centre, The Hillingdon Hospital. (2006). Sampling in research. Uxbridge, UK: The Hillingdon Hospital. Retrieved from http://www.thh.nhs.uk/documents/_Departments/Research/InfoSheets/16_sampling_research.pdf.

Knowledge 4 Health Project (K4Health. (2013). Demographic and Health Surveys toolkit. Baltimore, MD, USA: Johns Hopkins Center for Communication Programs. Retrieved from http://www.k4health.org/toolkits/dhs.

UNICEF. (n.d.) MICS6 tools. Retrieved from http://mics.unicef.org/tools.

APPENDIX A. IMPLEMENTATION CHECKLIST

	Task
☐	A research protocol that describes the 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. A control or comparison group is defined, if applicable.
☐	A statistician, with other experts, has calculated the sample size. The sampling method is defined.
☐	Procedures for the recruitment of survey participants are defined, are ethically and culturally appropriate, allow for parental informed consent and child assent, and do not incentivize participation.
☐	Informed consent (adult) and assent (child) forms have been developed and a consenting process is defined.
☐	Logistics and data management plans are documented.
☐	The tools have been adapted, if necessary, and translated/back-translated, if necessary.
☐	The protocol, tools, and consent/assent forms have been reviewed by an official research ethics committee in the study country 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 includes modules on ethics and child protection.

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, North Carolina 27516
Phone: +1-919-445-9350
measure@unc.edu
www.measureevaluation.org

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. MS-13-62 rev

ISBN: 978-1-64232-162-3