Monitoring Outcomes of PEPFAR Orphans and Vulnerable Children Programs in Haiti

Zanmi Lasante/Partners in Health 2018 Survey Findings

September 2018

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation

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Cover: Children at a Partners In Health facility in Lascahobas, Haiti. Photo: Direct Relief, Flickr Creative Commons

CONTENTS

FIGURES

TABLES

ABBREVIATIONS

ART	antiretroviral therapy
BEST	Bien Et ak Santé Timoun
ESI	essential survey indicator
EMMUS	Enquête Mortalité, Morbidité et Utilisation des Services
GBV	gender-based violence
GEM	Gender Equitable Men Scale
IBESR	Institut du Bien-Être Social et de la Recherche
IHE	Institut Haïtien de l'Enfance
MENFP	Ministère de l'Éducation Nationale et de la Formation Professionnelle
MER	monitoring, evaluation, and reporting
MSPP	Ministère de la Santé Publique et de la Population (Ministry of Public Health and Population)
MUAC	mid-upper arm circumference
ONPES	Observatoire National de la Pauvreté et de l'Exclusion Sociale
PEPFAR	United States President's Emergency Plan for AIDS Relief
PIH	Partners in Health
PMTCT	prevention of mother-to-child transmission of HIV
PNLS	Programme National de Lutte contre les IST/VIH/Sida (National AIDS Control Program)
SEFIS	Société d'Etudes et de Formation en Information Stratégique
SD	standard deviation
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The AIDS epidemic in Haiti has left many children in the country vulnerable to HIV, often without parents to care for them. Recognizing the enormous need for programs and services for orphans and vulnerable children (OVC), the United States President's Emergency Plan for AIDS Relief (PEPFAR) has partnered with the government of Haiti to strengthen services for OVC and their households. Since 2010, PEPFAR OVC support has included services such as HIV testing and linkages to care and treatment, potable water, immunizations, access to healthcare and psychosocial support, provision of school fees and supplies, dietary assessment and nutritional support, HIV prevention and life skills programs, and assistance with income generating activities for foster families and caregivers.

To better understand the effects of its programs on the well-being of OVC, PEPFAR launched a global reporting requirement in 2014 to monitor the outcomes of selected projects in Haiti and other countries where it provides support for OVC. The requirement involves the collection of data for nine outcome indicators, referred to as the PEPFAR monitoring, evaluation, and reporting (MER) OVC essential survey indicators (ESIs). In 2016, the United States Agency for International Development (USAID)/Haiti requested assistance from the USAID- and PEPFAR-funded MEASURE Evaluation project to conduct surveys to collect the required data for two of its ongoing OVC programs: the Zanmi Lasante/Partners in Health (PIH) project, funded through the United States Centers for Disease Control and Prevention, and the USAID Bien Et ak Sante Timoun (BEST) project. This report presents the findings from the survey that MEASURE Evaluation with its local research partner, Société d'Etudes et de Formation en Information Stratégique (SEFIS), conducted for the PIH project in 2018. Survey results for the BEST project are reported separately.

Using a single-stage cluster design, the MEASURE Evaluation survey team selected a sample of 480 beneficiary households and conducted survey interviews with 413 caregivers about themselves, their households, and the 1,197 children under age 18 who were under their care. The survey tools and methods followed guidance previously developed by MEASURE Evaluation for PEPFAR for collection of the OVC essential survey indicators (ESIs). The survey collected data for the nine ESIs and six supplemental indicators of interest to the PEPFAR Haiti OVC team and PIH project managers.

Results for the OVC ESIs, presented below, provided a snapshot of the well-being of children and households served by the PIH project in 2018. The findings showed a high prevalence of children, particularly young children, who were ill, most commonly with fever, flu, and cough; low prevalence of birth certificates; high rates of school enrollment but rather low rates of regular school attendance (including preschool); widespread acceptance of harsh physical punishment of children; and limited household economic resilience. Caregivers reported knowledge of the HIV status of two-thirds of the children under their care. Among the children whose caregivers reported knowing their status, 6.5 percent were reported to be living with HIV. Among those living with HIV, nearly all were reported to be receiving ART and to have taken ARV drugs within the past day. Few young children were found to be acutely undernourished; activities that promote early childhood development were reported to be commonly practiced. Additional indicators captured in the survey showed the limited ability of households to cover expected household expenses and lack of support for gender-equitable norms among caregivers.

Based on these findings, recommendations for strengthening programs for orphans and vulnerable children in Haiti include: raise caregivers' awareness about childhood illness, prevention, and services, and provide support to help keep children healthy; continue efforts to assess children's HIV risk and ensure those at risk get tested for HIV; continue to support access to ART and adherence; address HIV stigma and discrimination; increase enrollment of young children in preschool; help children obtain birth certificates; address barriers to

school attendance; change caregiver norms regarding acceptance of harsh physical punishment of children and gender inequalities; and intensify efforts to build the economic resilience of OVC households.

Summary of PEPFAR MER OVC essential survey indicator results for the PIH project, Haiti

Reference name	Indicator	*n*	*N*	%	95% Confidence interval	
					LL	UL
Health						
OVC_SICK	Percentage of children (aged 0–17 years) too sick to participate in daily activities	274	1190	**23.0**	18.6	28.2
OVC_HIVST	Percentage of children (aged 0–17 years) whose primary caregiver knows the child's HIV status	805	1195	**67.4**	55.8	77.1
Nutrition						
OVC_NUT	Percentage of children (aged 6–59 months) who are undernourished	2	112	**1.8**	0.4	8.1
Early childhood development						
OVC_STIM	Percentage of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	165	188	**87.8**	78.1	93.5
Legal rights						
OVC_BCERT	Percentage of children (aged 0–17 years) who have a birth certificate [among caregivers interviewed at the household]	424	842	**50.4**	43.1	57.6
Education						
OVC_SCHATT	Percentage of children (aged 5–17 years) regularly attending school	581	1001	**58.0**	48.4	67.1
OVC_PRGS	Percentage of children (aged 5–17 years) who progressed in school during the last year	755	860	**87.8**	84.8	90.3
Attitudes about child punishment						
OVC_CP	Percentage of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or at school	204	411	**49.6**	43.7	55.6
Household economic well-being and resilience						
OVC_MONEY	Percentage of households able to access money to pay for unexpected household expenses	71	258	**27.5**	19.7	37.0

LL, lower limit; UL, upper limit

BACKGROUND

Orphans and Vulnerable Children in Haiti

Haiti is home to more people living with HIV than any other country in the Caribbean region (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2017b). Among the estimated 150,000 Haitian adults and children living with HIV, 7,600 are younger than 15 years of age (UNAIDS, 2017a). Much progress continues to be made in delivering life-saving antiretroviral treatment (ART) to adults and children. In 2016, 56 percent of adults and 49 percent of children ages 0–14 years living with HIV were receiving ART (UNAIDS, 2017b). However, despite these significant gains in the fight against HIV/AIDS, the many Haitian children infected and affected by HIV/AIDS face many challenges.

Haiti's Ministry of Public Health and Population has recognized the need to act to improve the health and well-being of OVC. The national 10-year health plan, *Plan Directeur de Santé 2012-2022,* defines comprehensive support to OVC and their families as a key strategy to improve the state of children's health in Haiti (Ministère de la Santé Publique et de la Population [MSPP], 2013). Additionally, Haiti's national HIV/AIDS strategy aims to reduce the proportion of HIV-positive infants born to mothers living with HIV to less than two percent by 2018, and promotes psychosocial care and priority integration of people living with HIV/AIDS and affected families living with difficult challenges in social and public assistance programs supported by the Haitian government and its national and international partners (Programme National de Lutte contre les IST/VIH/Sida [PNLS], 2016).

As a key international partner, PEPFAR has supported the Haitian government in its fight against HIV/AIDS since 2004. PEPFAR remains the largest contributor to OVC activities in Haiti, working closely with PNLS and Institut du Bien-Être Social et de la Recherche (IBESR), the government entity responsible for OVC under the Ministry of Social Affairs. Since 2010, PEPFAR OVC support has included services such as HIV testing, linkages to HIV care and treatment, potable water, immunizations, access to healthcare and psychosocial support, provision of school fees and supplies, dietary assessments and nutritional support, HIV prevention and life skills programs, and assistance with income generating activities for foster families and care givers (PEPFAR, May 2017).

OVC Outcomes Monitoring

Globally, PEPFAR has invested considerable resources in OVC programs, but has not undertaken a systematic or large-scale study of the well-being of beneficiary OVC and their households (Sherr & Zoll, 2011). To fill this gap, in 2014 PEPFAR introduced a new global reporting requirement for monitoring the outcomes of its OVC programs, named the monitoring, evaluation, and reporting (MER) OVC essential survey indicators (ESIs). The ESIs are intended to measure and track child and household well-being using standard indicators and methods across projects and countries. They reflect internationally accepted developmental milestones and ways that OVC programs gain from and contribute to broader HIV and child protection responses (MEASURE Evaluation, 2014). They were designed to supplement routine PEPFAR monitoring (which primarily tracks project inputs and outputs) and project evaluations. To date, the MER OVC ESIs have been collected in more than 15 countries.

In 2017, the PEPFAR Haiti OVC team requested the assistance of the USAID-funded project, MEASURE Evaluation, to collect data for the MER OVC ESI for two of its OVC projects:

1. "Reinforcing HIV Clinical Services within a Network of Public Health Institutions in the Central Plateau and the Lower Artibonite of Haiti under the President's Emergency Plan for AIDS Relief (PEPFAR)" implemented by PIH and funded through the CDC

2. BEST project, implemented by the Caris Foundation and funded through USAID

MEASURE Evaluation, in partnership with its subcontractor SEFIS, conducted two household surveys, one for each project, to collect data for the OVC ESI. The methods used for both surveys was similar and followed established guidance (MEASURE Evaluation, 2014). This report presents the MER OVC ESI survey that MEASURE Evaluation conducted for the PIH project. The survey for the BEST project is presented in a separate report, available here: https://www.measureevaluation.org/resources/publications/tr-18-287.

Intended Use of This Report

This report describes the methods used to conduct the MER OVC ESI survey and presents results for the ESIs in accordance with MER guidance. A brief discussion of the findings is also provided. This information is intended to help PIH project managers better understand the current well-being of its beneficiaries. In addition, the information will help support the project, the PEPFAR Haiti OVC team, and other program decision makers and stakeholders, including those from the government of Haiti, to take evidence-informed actions for improving OVC program strategy, resource allocation, and implementation, with the ultimate goal of improving the well-being of the children and households they serve. Findings presented in this report also contribute to a global PEPFAR-wide evidence base on the effectiveness of PEPFAR OVC programming.

METHODS

Survey Context: Partners in Health's OVC Program

Since 2004, PIH has been providing support for OVC, delivering its OVC program through its larger PEPFAR-funded HIV/AIDS project. The project's objectives are to provide:

1. High-quality HIV testing and counseling services and prevention of mother-to-child transmission (PMTCT) of HIV services
2. High-quality pediatric and adult HIV care and treatment services
3. Tuberculosis prevention, diagnosis, and treatment services

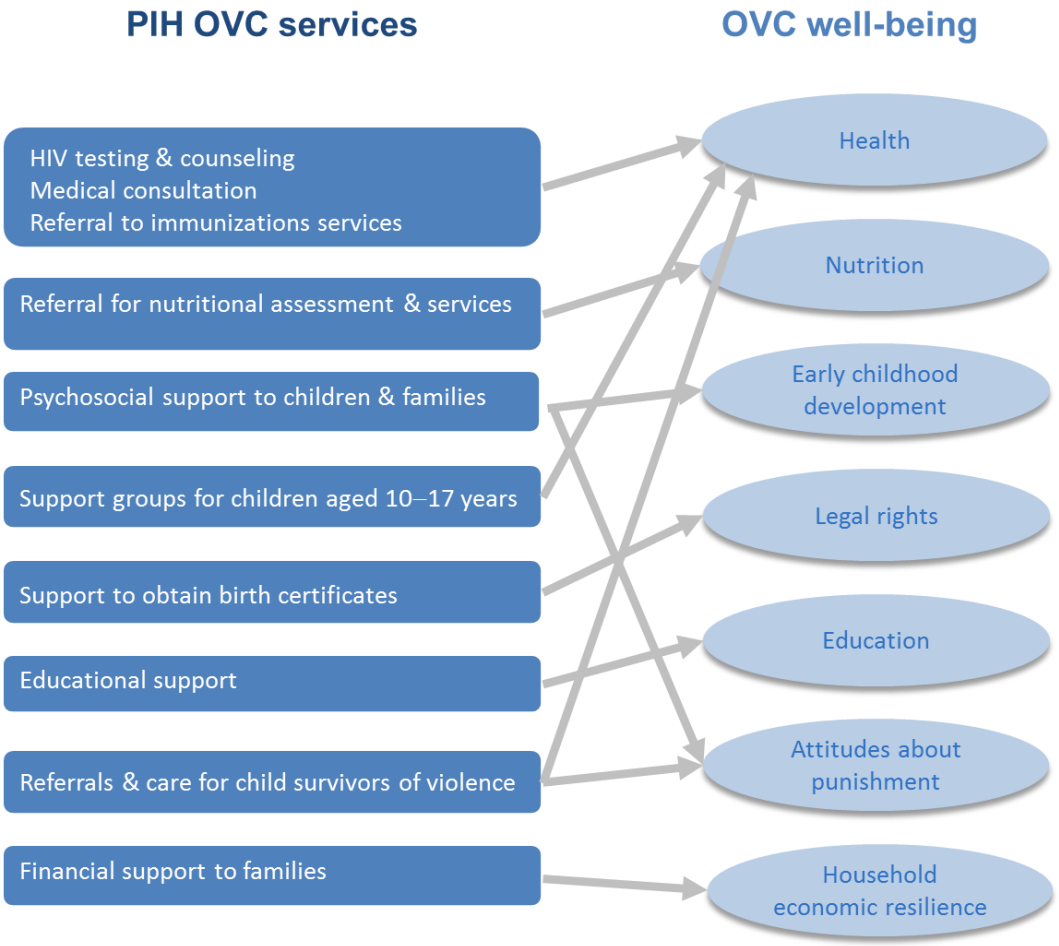
Partners in Health registers OVC beneficiaries through the public health facilities it supports with HIV/AIDS programs and services. PIH supports 11 health facilities (seven hospitals and four health centers) located in the Central Plateau and the lower Artibonite Department of Haiti. Children who test positive for HIV at the health facility and children who have (or had) at least one parent who tested positive for HIV at the health facility are referred by a healthcare provider to a social worker, who then conducts a psychosocial evaluation of the child and makes a home visit to the child's household. During this visit, the presence of children in the household is verified, information is gathered on the children, and a care plan is developed for the children and their parents or caregivers. All households where a home visit is made are considered registered in the OVC program. Partners in Health reports 9,377 children were actively enrolled in the OVC program as of January 2018. Orphan and vulnerable children services provided at the facility and through home visits include the following:

- Testing for HIV and counseling
- Medical consultation for HIV-positive children
- Psychosocial assessment of the child, and psychosocial support for children and their families
- Development of a care plan for children and parents
- Support to families to obtain children's birth certificates
- Referral of children less than age five years for nutritional assessment and nutritional services, as needed
- Referral of children less than age one year to immunization services
- Educational support for children, including payment of school fees and follow-up in schools
- Support group for children ages 10–17 years that includes psychosocial support, sex education, risk reduction education, and provision of condoms
- Financial support to families, according to need as assessment by a social worker
- Referrals and facilitation of care for child survivors of sexual and physical violence
- Placement of children in foster homes, in concert with IBESR

Conceptual Framework

The PEPFAR MER OVC ESIs measure seven dimensions of OVC and caregiver (or household) well-being. Figure 1 shows how the PIH OVC program maps to these dimensions. Many of the services also contribute indirectly to the various dimensions of well-being, which themselves are interrelated. For example, child support groups may also contribute to education outcomes, while financial support to families may also contribute to child health, nutrition, and education outcomes, in addition to its primary contribution to household economic resilience.

Figure 1. Conceptual framework mapping PIH's OVC services to well-being dimensions of MER OVC ESI



Survey Indicators and Questionnaire

The survey interview collected data for the nine OVC MER ESIs. The PEPFAR Haiti OVC team also wanted to collect supplemental data to elaborate on the ESIs or inform their interpretation. Six supplemental indicators were added to the survey, for a total of 15 indicators. These indicators, their associated PEPFAR MER reference names, and the rationale for their inclusion in the survey are presented in Table 1. They are categorized according to the dimensions of OVC well-being they represent.

Table 1. PEPFAR OVC MER essential survey indicators and Haiti supplemental indicators

Indicator name	Indicator	Rationale for inclusion
Health		
OVC_SICK	Percent of children (aged 0–17 years) too sick to participate in daily activities	PEPFAR OVC programs support critical linkages to health services and treatment, aiming to reduce the number of sick children and improve functional well-being.
OVC_HT1*	Types of sickness among children too sick to participate in daily activities in the past two weeks	Knowing the reason for child illness will help OVC programs better understand beneficiary needs and target services.
OVC_HT2*	Percentage of children too sick to participate in daily activities in the past two weeks who went to a health facility for that sickness	This indicator measures the extent to which project beneficiaries are accessing services from a health facility. The use of health services for many illnesses is essential for the health and well-being of the child.
OVC_HIVST	Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status	If a child's HIV status is unknown to her or his caregiver, the child will not have access to life-saving care, treatment, and support interventions.
OVC_HT3*	Percentage of children living with HIV who are taking antiretroviral (ARV) drugs	This indicator provides a measure of the well-being of children living with HIV. Promotion of HIV testing and linking children living with HIV to treatment services is a current PEPFAR programming priority.
OVC_HT4*	Percentage of children accessing antiretroviral treatment who took their drugs within the last day	This indicator provides a measure of adherence to ARV drugs. Drug adherence is critical in order to maintain viral suppression and to promote the health of the child.
Nutrition		
OVC_NUT	Percent of children (aged 6–59 months) who are undernourished *For this indicator, the interviewer obtained MUAC measurement for children ages 6–59 months. It is the only indicator whose measurement required direct interaction with a child.*	Nutrition is a critical factor in reducing infant mortality and builds a strong foundation for a child's health, growth, and development.
Legal rights and social protection		
OVC_BCERT	Percent of children (aged 0–17 years) who have a birth certificate	Ensuring children's access to basic legal rights, such as birth certificates, enables them to access other essential services and opportunities, including health, education, legal services, and legal employment, when they grow older.

Indicator name	Indicator	Rationale for inclusion
Education		
OVC_SCHATT	Percent of children (aged 5–17 years) regularly attending school	In addition to being important in its own right, children's attendance at school has positive impacts on HIV prevention.
OVC_PRGS	Percent of children (aged 5–17 years) who progressed in school during the last year	Studies in many countries have linked higher education levels with increased AIDS awareness and knowledge, higher rates of contraceptive use, and greater communication regarding HIV prevention among partners.
Early childhood development		
OVC_STIM	Percent of children < 5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	Early childhood cognitive, social, and physical stimulation is essential for promotion of long-term learning, growth, and health.
Attitudes about child punishment		
OVC_CP	Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school	Reducing harsh physical discipline, violence, and abuse against children is a PEPFAR priority. Perceptions of physical discipline have been linked to actual use of physical discipline against children.
Household economic well-being and resilience		
OVC_HT5*	Percentage of households able to access money to pay for expected household expenses	This indicator is routinely collected by the implementing partners that provide OVC services. Collecting data for this indicator through the OVC MER survey allowed for data triangulation and validation, and provided another measure of household economic well-being.
OVC_MONEY	Percent of households able to access money to pay for unexpected household expenses	The key goal of household economic strengthening programs is to improve household's resiliency to economic shocks, such as unexpected household expenses. Child well-being is assumed to be affected by the household's resiliency to economic shocks.
Gender norms		
OVC_HT6*	Gender Equitable Men (GEM) Scale: violence and daily chores domains (for caregivers)	This indicator provides a measure of attitudes toward gender equitable norms, which have been found to be associated with household decision-making, violence, and risk behaviors, and may be helpful to program managers in the design of care plans for OVC households. The GEM Scale has been validated in a number of countries among both women and men (Pulerwitz and Barker, 2008).

*Supplemental indicator for the Haiti PIH survey

The PEPFAR MER OVC ESI were vetted and selected in 2014 by global PEPFAR OVC program and strategic information technical leaders. They applied a number of criteria in their selection, including relevancy among the various countries where PEPFAR provides OVC program support and representation of factors amenable to change over a two-year period. All selection criteria and the indicator reference sheets that define the ESIs can be found in the MEASURE Evaluation guidance developed for the surveys (MEASURE Evaluation, 2014).

Data collectors conducted interviews with caregivers using a standard questionnaire previously developed by MEASURE Evaluation for the PEPFAR OVC Technical Working Group specifically for the purpose of collecting data for the MER OVC ESIs. The survey questionnaire included three components: (1) caregiver, (2) child ages 0–4 years, and (3) child ages 5–17 years. Data collectors administered the caregiver component in all sample households and, depending on the number and ages of the children in the household, one or both of the child components to the caregiver. The survey team administered child components for each child in the household under the care of the caregiver. The team made only minor modifications to the standard questionnaire to adapt it to the Haitian context. Specifically, questions were added to measure the six supplemental indicators, and questions regarding receipt of OVC program services were tailored to the PIH OVC program. Additionally, the questionnaire was translated into Creole. Minor changes were made to the translations following pilot testing to enhance clarity of the translations. The English version of the questionnaire is provided in the Appendix.

Ethics Review and Compliance for the Surveys

All study activities adhered strictly to U.S. and international research ethics guidelines, including 45CFR46 and the Council for International Organizations of Medical Sciences International Ethical Guidelines for Health-related Research Involving Humans. The team sought institutional review board (IRB) review of the study protocol and received approval on February 7, 2018 from the Comité National de Bioéthique in Haiti and Health Media Lab IRB in the United States.

Survey Design

The survey team used a single-stage cluster design for the survey. The sampling frame comprised all households enrolled and active in the OVC program as of January 2018. The list—provided by the project—included 2,467 households served by the 11 health facilities. The survey team worked with the PIH OVC program manager to correct missing information and data inconsistencies prior to selection of the sample. A sample size of 480 households was chosen to achieve an approximate 6.5 percent margin of error for caregiver indicator estimates and 4.5 percent for child indicator estimates. Clusters were defined by health facilities, and households were randomly selected within clusters proportionate to the cluster size (i.e., the number of enrolled households at the facility). The number of households selected per cluster ranged from 15 to 80.

The study team randomly selected the sample of 480 households prior to field data collection, using a random number generator in SPSS version 25 (IBM, 2017). However, at the time of field data collection some of the selected households could not be confirmed by PIH staff at the facilities as active program participants. In these instances, the study team randomly selected additional households to meet the targeted number of households for that cluster.

Survey interviews were conducted with the primary caregivers of the children who resided in the selected households. Female and male caregivers of all ages were eligible for the survey. The caregivers were asked questions about themselves, the household, and the children under their care. All children ages zero through 17 years (at their last birthday) who slept within the household on the night before the interview were

considered eligible for the survey. This included children who were actively registered as beneficiaries of the PIH OVC program and those who were not.

Field Data Collection

Two teams carried out survey data collection, each of which comprised a team lead and four data collectors (two pairs). All team members were experienced in household survey data collection and had completed a six-day training course led by the study team before deployment. Data collectors conducted the caregiver interviews with Samsung Android tablets preprogrammed with the questionnaires using Kobo Collect (Harvard Humanitarian Initiative, n.d.). As part of their training, the data collection teams conducted an external pilot test of the entire data collection process by using the tablets among a small group of project beneficiaries not selected into the survey sample.

The teams conducted field data collection between March 7 and April 4, 2018. They informed health facilities in advance of the scheduled data collection period. At the start of that period, the survey field manager or team lead met with key personnel at the health facility to present the survey objectives and methods, review and finalize the list of sampled households, and map the household locations. For some program beneficiaries, PIH delivers services only at the health facility; they do not visit the households because of concerns of stigmatization. For such households that were selected into the sample, the team lead worked with program staff to schedule interviews at the facility or a nearby, convenient location, such as a school or church. For interviews conducted at the household, a field agent from the health facility escorted the data collectors there, introduced them to the caregiver, and then left.

Upon meeting the caregiver, the data collector administered the informed consent process, conveying the study purpose, emphasizing the voluntary nature of her/his participation, and explaining potential risks and benefits. Caregivers were provided with the opportunity to ask questions. If the caregiver verbally consented, written consent was obtained. In the event that the caregiver was a minor (i.e., under the age of 18 years), the data collector first sought consent from the minor's guardian or parent to interview the minor and then sought the minor's assent for the interview.

After obtaining consent, the data collector began the interview using the "caregiver" component. Following completion of that component, the caregiver was asked to list the names and ages of all eligible children under age 18 in the household; the data collector then administered the relevant child components of the questionnaire to the caregiver, completing one component per eligible child.

The data collectors reviewed the questionnaire before leaving the interview location to ensure all questions were asked and answers were appropriately recorded. Team leads reviewed the completed questionnaires daily and checked for remaining errors, such as incorrectly filled out forms, missing data, and inconsistencies. On a daily basis, the survey field manager monitored data collection reports, data collectors transmitted verified data to the Kobo Collect server, and the software developer retrieved the data and ran additional data checks. The field team was contacted when questions with the data arose or clarification was needed, and actions were taken to address identified problems.

Data Analysis

Following data collection, additional validity and consistency checks were run on the full data file and data cleaning was performed. Master files were created in MS Excel; analysis files were created in SPSS with variable labels, value labels, and other metadata. Data analysis was performed using SPSS 25 (IBM, 2017). The ESIs were derived according to PEPFAR specifications (MEASURE Evaluation, 2014). Confidence intervals (CIs, 95%) for the indicator estimates were calculated incorporating the cluster sample design. Differences between

subgroups were tested using an adjusted F statistic: a variant of the second-order Rao-Scott adjusted chi-square statistic. Statistical significance was based on the adjusted F (likelihood ratio) and its degrees of freedom (IBM, n.d.). Differences significant at the $p<0.05$ level were considered statistically significant.

RESULTS

Response Rates

Among the 480 households in the original sample selected from the PIH master list, 116 (24.2%) were replaced because of eligibility misclassification as reported by PIH program staff at the health facilities. As noted above, these households were replaced through random selection of additional households to yield a sample of 480 households regarded as eligible by the facility program staff. The field team completed 413 caregiver interviews from the sample of 480 households, for a household response rate of 86.0 percent. The response rate and reasons for nonresponse among the 67 households for which interviews were not completed are provided in Table 2.

Table 2. Household response rates

Category	Number
1. Households served by the PIH OVC program based on the project beneficiary listing	3,389
2. Households sampled from the project listing	480
3. Sampled households classified by program staff at the facilities as ineligible: no children under age 18 years in the household, lost to follow-up (i.e., transferred to another facility, caregiver/child recently deceased, and whereabouts of children in the household unknown), or beneficiary households had duplicate IDs*	116
Households in the original sample that were replaced	116/480 **(24.2%)**
4. Households where an interview was attempted	480
5. Sample households where an interview was not conducted (household nonresponse) by reason	67
• Household had moved out of the area	24
• Household location unknown to program staff/could not locate	16
• Caregiver refused an interview	10
• Caregiver away from home during data collection period	8
• Unable to meet with caregiver after three attempts	7
• Ineligible, caregiver reportedly not responsible for any child ages 0–17 years	2
• Unable to complete interview	1
6. Households where an interview was successfully completed	413
Survey household response rate	413/480 **(86.0%)**

*These households were replaced by additional randomly selected households from within each cluster until the target sample size for the cluster was achieved.

Table 3 displays the numbers of interviews conducted at the 413 households. All child components were completed among eligible children in the households (N=1,197).

Table 3. Questionnaire components completed

Sample information	Number
Caregiver components completed	413
Eligible children in the completed households (listed by the caregivers)	1,197
Children ages 0–4 years components completed	188
Children ages 5–17 years components completed	1,009
Total child components completed	1,197

Background Characteristics of the Respondents

Caregivers

Of the 413 successfully interviewed caregivers, 317 (76.8%) were females. More than two-thirds of female and male caregivers were between the ages 31 and 50 years, with a mean age of 42.9 years and standard deviation (SD) of 13.94. The youngest caregiver was age 15 and the oldest age 79. Male caregivers were older than female caregivers (mean ages of 45.3 and 42.2 years, respectively). The difference between females and males among the age groups was statistically significant (p=0.026). Over one-third (37.1%) of the caregivers reported they have never attended school. Primary school was the highest level attended by roughly half of both female and male caregivers (48.1% and 58.3%, respectively). Male caregivers reported higher school attendance than female caregivers and at higher levels (p=0.036). The largest gap between female and male caregivers was among those who had never attended school (40.2% among females and 27.1% among males). Details of these caregiver characteristics are given in Table 4.

Table 4. Characteristics of caregivers in the survey

Age (years)	Female caregivers*		Male caregivers*		All caregivers	
	N	%	*N*	%	*N*	%
<18	1	0.3	0	0.0	1	0.2
18–30	39	12.3	2	2.1	41	9.9
31–50	219	69.1	69	71.9	288	69.7
51+	58	18.3	25	26.0	83	20.1
All ages	**317**	**100.0**	**96**	**100.0**	**413**	**100.0**
Education						
Never attended school	127	40.2	26	27.1	153	37.1
Highest level attended is primary	152	48.1	56	58.3	208	50.5
Highest level attended is secondary or higher	37	11.7	14	14.6	51	12.4
All education levels	**316**	**100.0**	**96**	**100.0**	**412**	**100.0**

*The difference between females and males among the age groups is statistically significant at p=0.026.
The difference between females and males among the education levels is statistically significant at p=0.036.

Caregiver Households

Less than one-third (31.7%) of the households were located in an urban area. A higher percentage of female compared to male caregivers owned the house or dwelling in which they live (56.8% and 41.7%, respectively). Most households (75.1%) had improved sources of drinking water and a little more than one-third (36.1%) had improved toilet, electricity (34.1%), and a cement floor (44.3%). Few of the houses or dwellings had a concrete roof. Although a higher percentage of female caregiver compared to male caregiver households had these amenities, the differences were not statistically significant. See Table 5.

Table 5. Characteristics of the surveyed households

Household characteristics	Female caregivers (N=317)		Male caregivers (N=96)		All caregivers (N=413)	
	n	%	*n*	%	*n*	%
Urban residence	101	31.9	30	31.3	131	31.7
House/dwelling is owned by the caregiver	180	56.8	56	41.7	236	57.1
Household has improved source of drinking water	242	76.3	68	70.8	310	75.1
Household has improved toilet	116	36.6	33	34.4	149	36.1
Household has electricity	110	34.7	31	32.3	141	34.1
Household has cement floor	147	46.4	36	37.5	183	44.3
Household has concrete roof	22	6.9	7	7.3	29	7.0

Children

A total of 1,197 children ages 0–17 years were listed among the 413 households where the field team conducted interviews, giving an average of 2.9 children per household/caregiver. Among the children, about 50 percent were female (Table 6). Age distributions were similar for both sexes. The 10- to 14-year-old age group had the most children, followed by the 5- to 9-year-old age group.

Table 6. Characteristics of children in the survey

Child's age	Female		Male		All children	
	n	%	*n*	%	*n*	%
0–4 years	101	17.0	87	14.4	188	15.7
0–5 months	*9*	*8.9*	*7*	*8.0*	*16*	*8.5*
6–11 months	*6*	*5.9*	*11*	*12.6*	*17*	*9.0*
12–23 months	*16*	*15.8*	*14*	*16.1*	*30*	*16.0*
24–59 months	*70*	*57.8*	*55*	*63.2*	*125*	*66.5*
5–9 years	171	28.8	181	30.0	352	29.4
10–14 years	218	36.7	221	36.7	439	36.7
15–17 years	104	17.5	114	18.9	218	18.2
All ages	**594**	**100.0**	**603**	**100.0**	**1197**	**100.0**

OVC Services Received

Among the sampled household beneficiaries of the project, nearly all caregivers reported that they were enrolled in PIH OVC program and had received services from the program within the past six months (Table 7a). Over 50 percent of caregivers reported that both they and the children of the household had received services, while nearly one-quarter reported receiving only caregiver services and a much smaller proportion reported receiving only children services. Male caregivers were somewhat more likely to report receiving caregiver services, but the differences between female and male caregiver reports were not statistically significant.

Table 7a. Caregivers' reports of household enrollment and recent receipt of services

Services reported	Female caregivers			Male caregivers			All caregivers		
	n	*N*	%	*n*	*N*	%	*n*	*N*	%
HH enrolled in PIH OVC Program	297	317	93.7	94	96	97.9	391	413	94.7
HH received services within the past six months	270	297	90.9	91	94	96.8	361	391	92.3
- Caregiver only	62	297	20.9	24	94	25.5	86	391	22.0
- Children only	44	297	14.8	11	94	11.7	55	391	14.1
- Caregiver and children	164	297	55.2	56	94	59.6	220	391	56.3
HH did not receive services in past six months	25	297	8.4	3	94	3.2	28	391	7.2

Caregivers were also asked how long household members had been enrolled in the PIH OVC program (Table 7b). On average, caregivers who knew when the household had been enrolled reported enrollment of more than six years, with average total enrollment time of 77 months. Although female caregivers reported shorter enrollment times than male caregivers, the difference was not statistically significant.

Table 7b. Caregivers' reported enrollment time in the PIH OVC program

Caregivers	Time since program enrollment, months				
	n	Mean	Median	SD	*Range*
Female caregivers	219	75.6	75.0	32.85	4–240
Male caregivers	79	81.0	84.0	43.56	4–312
All caregivers	298	77.0	82.0	66.93	4–312

Caregivers who reported receiving recent service were asked about the types of services they had received (see Table 7c). The three most commonly reported services were psychosocial support/counseling (83.1%), payment of school fees (66.8%), and household economic strengthening (63.2%). Services least likely to be reported were assistance with sexual violence, referral to family planning services, and obtaining a child's birth certificate. Few differences between female and male caregivers were reported, with the exception of male caregivers being more likely to report receipt of household economic strengthening support (78.0% and 57.0%, respectively, p=0.038) and female caregivers being more likely to report receipt of condoms (36.7% and 14.3%, p<0.001) and referrals to child protection services (22.2% and 4.4%, respectively, p=0.004).

Table 7c. Caregivers' reports of type of services received from PIH in the past six months

Services received by households in the past 6 months	Caregivers					
	Female (N=270)		Male (N=91)		Both sexes (N=361)	
	n	%	*n*	%	*N*	%
Psychosocial support/counseling	224	83.0	76	83.5	300	83.1
Payment of school fees	185	68.5	56	61.5	241	66.8
Household economic strengthening	154	57.0*	71	78.0*	225	63.2
Support for disclosing HIV Status	161	59.6	50	54.9	211	58.4
Referral to HIV testing and counseling	130	48.1	46	50.5	176	48.8
Referral for ART	124	45.9	33	36.3	157	43.5
Support for school supplies and materials	97	35.9	32	35.2	129	35.7
Provision of condoms	99	36.7***	13	14.3***	112	31.0
Referral to health services for a child	82	30.4	28	30.8	110	30.5
Water-treatment products	75	27.8	29	31.9	104	28.8
Referral of child for immunizations	58	21.5	20	22.0	78	21.6
Referral to child protection services	60	22.2**	4	4.4**	64	17.7
HIV prevention education	46	17.0	11	12.1	57	15.8
Referral to cervical cancer screening	39	14.4	14	15.4	53	14.7
De-worming medicines	38	14.1	14	15.4	52	14.4
Hygiene Kits	39	14.4	11	12.1	50	13.9
Support for housing or shelter	36	13.3	13	14.3	49	13.6
Referral to GBV services	29	10.7	17	18.7	46	12.7
Help to get child's birth certificate	27	10.0	12	13.2	39	10.8

Referral to family planning services	27	10.0	6	6.6	33	9.1
Help for addressing sexual violence	26	9.6	5	5.5	31	8.6

*, **, *** The difference between female and male caregivers is statistically significant at p=0.038, p=0.004, and p<0.001, respectively.

Caregivers were asked about participation in, or receipt of, services from the PIH project for each individual child under their care (Table 8). The majority (61.2%) of children were reported to have ever participated and received services and less than half (43.7%) were reported to have participated or received services within the past six months. Differences between female and male children were small. However, caregivers reported that older children were more likely to have ever participated or received services than younger children (64.3% and 44.6%, respectively, p=0.002) and to have received recent services (45.6% and 33.0%, respectively, p=0.015).

Table 8. Caregivers' reports of children's participation in or receipt of PIH services

Receipt of services	All female children			All male children			All children		
	n	*N*	%	*n*	*N*	%	*n*	*N*	%
Ever participated in activities or received services	360	589	61.1	365	596	61.2	725	1185	61.2
Received services within the past six months	263	589	44.7	254	595	42.7	517	1184	43.7
Receipt of services	**Female children ages 0–4 years**			**Male children ages 0–4 years**			**All children ages 0–4 years**		
	n	*N*	%	*n*	*N*	%	*n*	*N*	%
Ever participated in activities or received services	46	100	46.0	37	86	43.0	83	186	44.6**
Received services within the past six months	32	100	32.0	29	85	34.1	61	185	33.0*
Receipt of services	**Female children ages 5–17 years**			**Male children ages 5–17 years**			**All children ages 5–17 years**		
	n	*N*	%	*n*	*N*	%	*n*	*N*	%
Ever participated in activities or received services	314	489	64.2	328	510	64.3	642	999	64.3**
Received services within the past six months	231	489	47.2	225	510	44.1	456	999	45.6*

*, ** The difference between the two age groups is statistically significant at p=0.015 (for ever received services) and p=0.002 (for received services in the past six months.

PEPFAR MER OVC Essential Survey Indicators

Results for the survey indicators were disaggregated by sex and age following PEPFAR MER requirements. For each indicator, the numerator (*n*), denominator (*N*), indicator estimate (%), and 95 percent confidence intervals (lower and upper limits, LL/UL) are provided in table format. Findings are organized by the dimensions of OVC well-being that were measured.

Health

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

Caregivers reported that about one in four (23.0%) children were too sick to participate in daily activities at some point within the two weeks prior to the survey (Table 9). Reports of sickness among the youngest age group (42.2%) were about double that of any of the other age groups ($p<0.001$). No differences between female and male children were found.

Table 9. Children too sick to participate in daily activities

Child's age (years)	Female children					Male children					All children***				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
0–4	41	100	41.0	27.9	55.5	38	87	43.7	32.4	55.7	79	187	42.2	31.4	53.9
5–9	34	171	19.9	10.9	33.5	33	179	23.5	13.6	37.5	76	350	21.7	14.6	31.0
10–14	39	217	18.0	14.4	22.2	39	220	17.7	11.9	25.7	78	437	17.8	14.1	22.3
15–17	25	104	24.0	15.4	35.5	16	112	14.3	7.0	26.8	41	216	19.0	12.1	28.4
All ages	**139**	**592**	**23.5**	**17.7**	**30.5**	**135**	**598**	**22.6**	**17.6**	**28.5**	**274**	**1190**	**23.0**	**18.6**	**28.2**

*** The difference among age groups is statistically significant at p=0.001.

OVC_HT1: Types of sickness among children too sick to participate in daily activities in the past two weeks

Table 10a provides information on the types of sickness the children experienced as reported by the caregivers. Among those who were too sick to participate in daily activities in the past two weeks, fever (65.3%) and flu (56.2%) were the most commonly reported sicknesses, while malaria (2.6%) and injuries (7.7%) were the least likely to be reported. No statistically significant differences between female and male children were observed.

Table 10a. Types of sickness among children too sick to participate in daily activities in the past two weeks

Type of sickness	Female children					Male children					All children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
Fever	84	139	60.4	51.2	68.9	95	135	70.4	59.6	79.3	179	274	65.3	58.2	71.9
Diarrhea	21	139	15.1	8.9	24.4	24	135	17.8	11.1	27.3	45	274	16.4	10.6	24.6
Cough	58	139	41.7	36.4	47.2	57	135	42.2	28.4	57.3	115	274	42.0	33.9	50.5
Malaria	2	139	1.4	0.3	5.8	5	135	3.7	1.2	10.8	7	274	2.6	0.8	7.7
Flu	75	139	54.0	44.3	63.3	79	135	58.5	42.9	72.6	154	274	56.2	44.6	67.2
Injuries	9	139	6.5	2.6	15.2	12	135	8.9	5.0	15.2	21	274	7.7	5.5	10.6
Other	68	139	48.9	39.7	58.3	58	135	43.0	32.5	54.1	126	274	46.0	38.0	54.2

OVC_HT2: Percent of children too sick to participate in daily activities in the past two weeks who went to a health facility for that sickness

When caregivers were asked how they responded to the child's recent illness, they reported that about two-thirds (66.8%) were seen at a health facility (see Table 10b). Children ages 0–4 years were more likely to be seen at a health facility compared to older children (p=0.025). Male compared to female children were more likely to be seen at a health facility (p=0.050).

Table 10b. Sick children who went to a health facility

Child's age (years)	Female children					Male children					All children*				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
0–4	28	41	68.3	51.6	81.3	32	38	84.2	63.5	94.2	60	79	75.9	64.3	84.7
5–9	21	34	61.8	44.9	76.2	29	42	69.0	54.3	80.7	50	76	65.8	56.5	74.0
10–14	26	39	66.7	49.6	80.2	25	39	64.1	54.9	72.4	51	78	65.4	56.1	73.6
15–17	11	25	44.0	28.3	61.0	11	16	68.8	47.9	84.0	22	41	53.7	46.0	61.2
All ages	**86**	**139**	**61.9***	**53.9**	**69.3**	**97**	**135**	**71.9***	**64.9**	**77.9**	**183**	**274**	**66.8**	**61.4**	**71.7**

*The difference among age groups is statistically significant at p=0.025.

*The difference between female and male children is statistically significant at p=0.050.

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

Overall, caregivers knew the HIV status of about two-thirds of the children under their care in their households (Table 11). The difference in HIV status knowledge of girls and boys was small and not statistically significant. Caregivers were least likely to know the HIV status of children under the age of five years compared to the other age groups, but the differences were not statistically significant.

Table 11. Children whose primary caregiver knew their HIV status

Child's age (years)	Female children					Male children					All children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
0–4	57	101	56.4	41.3	70.5	53	87	60.9	42.8	76.5	110	188	58.5	43.4	72.2
5–9	119	171	69.6	54.4	81.5	113	180	62.8	48.6	75.1	232	351	66.1	52.3	77.6
10–14	165	217	76.0	66.8	83.4	150	221	67.9	56.5	77.4	315	438	71.9	62.6	79.7
15–17	64	104	61.5	42.5	77.6	84	114	73.7	58.1	54.9	148	218	67.9	51.4	80.9
All ages	**405**	**593**	**68.3**	**56.2**	**78.3**	**400**	**602**	**66.4**	**54.9**	**76.3**	**805**	**1195**	**67.4**	**55.8**	**77.1**

OVC_HT3: Percent of children (aged 0–17 years) living with HIV who are taking ARV drugs

Among children whose caregiver reported knowing her or his HIV status, 6.5 percent were reportedly living with HIV (Table 12a). Prevalence of HIV was highest among 10- to 14-year-olds. No difference in prevalence of HIV was observed between sexes.

Table 12a. Children living with HIV

Child's age (years)	Female children					Male children					All children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
0–4	2	51	3.5	0.3	29.8	2	53	3.8	1.0	12.8	4	110	3.6	1.0	12.7
5–9	6	106	5.0	2.3	10.5	7	113	6.2	2.2	16.3	13	232	5.6	3.3	9.4
10–14	15	136	9.1	4.2	18.6	14	150	9.3	6.0	14.2	29	315	9.2	6.1	13.8
15–17	3	81	4.7	1.2	16.5	3	84	3.6	1.2	9.8	6	148	4.1	2.1	7.6
All ages	**26**	**405**	**6.4**	**3.5**	**11.4**	**26**	**400**	**6.5**	**4.0**	**10.4**	**52**	**805**	**6.5**	**4.7**	**8.8**

Among children living with HIV, caregivers reported that nearly all (94.2%) were receiving ART (i.e., taking ARV drugs; Table 12b). Observed differences between female and male children and among age groups were not statistically significant.

Table 12b. Children living with HIV who are taking ARV drugs

Child's age (years)	Female children					Male children					All children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
0–4	2	2	100.0	100.0	100.0	1	2	50.0	3.5	96.5	3	4	75.0	14.0	98.2
5–9	5	6	83.3	24.7	98.7	7	7	100.0	100.0	100.0	12	13	92.3	49.0	99.3
10–14	15	15	100.0	100.0	100.0	13	14	92.9	59.7	99.1	28	29	96.6	72.8	99.7
15–17	3	3	100.0	100.0	100.0	3	3	100.0	100.0	100.0	6	6	100.0	100.0	100.0
All ages	**25**	**26**	**96.2**	**72.1**	**99.5**	**24**	**26**	**92.3**	**71.5**	**98.3**	**49**	**52**	**94.2**	**83.7**	**98.1**

OVC_HT4: Percent of children accessing antiretroviral treatment who took their drugs within the last day

High levels of ARV adherence were reported (see Table 12c). Only one child among those receiving treatment had not taken her ARV drugs within the past day.

Table 12c. Children living with HIV who took their ARV drugs within the past day

Child's age (years)	Female children					Male children					All children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
0–4	2	2	100.0	100.0	100.0	1	1	100.0	100.0	100.0	3	3	100.0	100.0	100.0
5–9	5	5	100.0	100.0	100.0	7	7	100.0	100.0	100.0	12	12	100.0	100.0	100.0
10–14	14	15	93.3	63.5	99.1	13	13	100.0	100.0	100.0	27	28	96.4	77.4	99.5
15–17	3	3	100.0	100.0	100.0	3	3	100.0	100.0	100.0	6	6	100.0	100.0	100.0
All ages	**24**	**25**	**93.3**	**72.1**	**99.6**	**24**	**24**	**100.0**	**100.0**	**100.0**	**48**	**49**	**98.0**	**85.0**	**99.8**

Nutrition

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

According to the MER OVC ESI guidance, a child is considered acutely undernourished if the measurement of her or his left mid-upper arm circumference is less than 12.5 cm. Among children ages 6–59 months for whom the measurement was taken, only two children (1.8%) met this criterion. Both were girls, ages 12–59 months. See Table 13.

Table 13. Children ages 6–59 months who are undernourished

Child's age	Female children					Male children					All children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
6–11 months	0	4	0.0	0.0	0.0	0	9	0.0	0.0	0.0	0	13	0.0	0.0	0.0
12–59 months	2	56	3.4	0.8	14.0	0	41	0	0.0	0.0	2	99	2.0	0.4	8.9
6–59 months	**2**	**60**	**3.2**	**0.7**	**13.6**	**0**	**50**	**0**	**0.0**	**0.0**	**2**	**112**	**1.8**	**0.4**	**8.1**

Early Childhood Development

OVC_STIM: Percent of children < 5 years of age who recently engaged in stimulating activities with any household member over 15 years of age

For children under five years of age, caregivers were asked if the child had engaged with the caregiver or anyone in the household ages 15 years or older in the past three days in the following activities: read or looked at a picture book; told stories; sang songs or lullabies; engaged in play; or named, counted, or drew things. As shown in Table 14, most children (87.8%) had engaged in at least one of these activities. Girls and boys were equally engaged (88.1% and 87.4%, respectively). The most frequently reported activities were playing (87.8%) and singing (65.4%). Just under half (43.6%) had been engaged in naming, counting or drawing. Less than one quarter of children had been engaged storytelling (24.3%) and in reading or looking at picture books (17.0%). Girls were more likely than boys to be engaged in storytelling (30.7% and 16.7%, respectively, p=0.026).

Table 14. Children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age

Activity	Female children					Male children					All children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
Read or looked at picture books	19	101	18.8	11.7	28.7	13	87	14.9	8.7	24.5	32	188	17.0	11.1	25.2
Told stories	31	101	30.7*	18.7	46.0	14	84	16.7*	11.3	16.8	45	185	24.3	16.8	33.9
Sang songs or lullabies	62	101	61.4	48.2	73.1	61	87	70.1	58.4	79.7	123	188	65.4	56.9	73.0
Engaged in play	89	101	88.1	74.1	95.1	76	87	87.4	76.6	93.6	165	188	87.8	78.1	93.5
Named, counted, or drew things	47	101	46.5	36.2	57.2	35	87	40.2	25.4	57.0	82	188	43.6	33.4	54.4
One or more of these activities	**89**	**101**	**88.1**	**74.1**	**95.1**	**76**	**87**	**87.4**	**76.6**	**93.6**	**165**	**188**	**87.8**	**78.1**	**93.5**

* The difference between female and male children is statistically significant at p=0.026.

Percent of children (aged 3–5 years) enrolled and regularly attending preschool

Caregivers reported that just over half (58.6%) of children ages three through five were enrolled in preschool and among them, nearly half (45.1%) regularly attended (i.e., did not miss any school days in the week preceding the survey). Girls were more likely to be enrolled than boys (66.7% and 48.7%, respectively, p=0.053), but among those enrolled, little difference was found in regular attendance (see Table 15).

Table 11. Children ages 3–5 years who were enrolled in and regularly attended preschool

Enrollment & attendance	Female children					Male children					All children ages 3–5 years				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
Enrolled	32	48	66.7	51.0	79.4	19	39	48.7	31.4	66.3	51	87	58.6	44.9	71.1
Regularly attended among those enrolled	14	32	43.8	17.4	74.2	9	19	47.4	19.9	76.5	23	51	45.1	20.9	71.8

Legal Rights

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

Caregivers reported that 89.2 percent of children under their care had birth certificates. These caregivers were subsequently asked to show the certificate to the interviewer. As presented in Table 16a, half of children had a birth certificate that was seen by the interviewers. Of note, caregivers who were interviewed in a location other than their households were excluded from the calculation of this indicator because they were not asked in advance to bring the birth certificate to the interview.

Table 16a. Children who had a birth certificate seen by the interviewer

Child's age (years)	Children of caregivers who were interviewed at their residence														
	Female children					Male children					All children***				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
0–4	23	74	31.1	22.1	41.8	10	54	18.5	11.2	29.0	33	128	25.8	18.7	34.5
5–9	58	115	50.4	33.8	67.0	72	129	55.8	38.5	71.8	130	244	53.3	37.6	68.3
10–14	82	153	53.6	45.8	61.2	86	157	54.8	43.0	66.0	168	310	54.2	46.1	62.1
15–17	45	77	58.4	43.0	72.4	48	83	57.8	49.8	65.5	93	160	58.1	50.3	65.6
All ages	**208**	**419**	**49.6**	**43.2**	**56.1**	**216**	**423**	**51.1**	**41.6**	**60.5**	**424**	**842**	**50.4**	**43.1**	**57.6**

**The difference among age groups is statistically significant at p=0.005.

Children ages 0–4 years were the least likely among the age groups to have a verified birth certificate (p=0.005). No difference between female and male children was observed. The most common reason given for not showing a birth certificate was that someone else kept it (see Table 16b).

Table 16b. Reasons no birth certificate was shown to interviewer

Reason given for not showing birth certificate	Children of caregivers who reported that the child had a birth certificate but did not show it to the interviewer	
	n	%
Caregiver prefers not to show it	10	2.8
Caregiver can't locate it	88	24.4
Someone else keeps it	262	72.8
All reasons	**360**	**100.0**

Education

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

Caregivers reported that almost all children ages five through 17 years under their care were enrolled in school (919 children, or 91.8%). However, as shown in Table 17, only slightly more than half (56.0%) of the children were reported to be regularly attending school (i.e., enrolled in school and did not miss any days in the school week before the interview). Regular attendance was highest among 10- to 14-year-olds (61.1%), but the difference among age groups was not statistically significant. Regular attendance among girls (60.4%) was slightly higher than among boys (55.8%), but the difference was not statistically significant. In Haiti, primary education begins at age six years and secondary education at age 14 years. Defining school levels by these age groups showed that regular attendance was significantly higher in primary compared to secondary school (62.4% and 53.4%, respectively, p=0.031). Observed differences between female and male children in primary and secondary school attendance were not statistically significant.

Table 12. Children regularly attending school

Child's age (years)	Female children					Male children					All school-age children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
5–9	107	170	62.9	50.3	74.1	95	179	53.1	43.4	62.6	202	349	57.9	48.5	66.8
10–14	143	217	65.9	57.7	73.2	124	220	56.4	46.8	65.5	276	437	61.1	53.4	68.3
15–17	46	103	44.7	24.9	66.3	66	112	58.9	45.4	71.2	112	215	52.1	35.1	68.6
Ages 5–17	**296**	**490**	**60.4**	**48.9**	**70.9**	**285**	**511**	**55.8**	**46.8**	**64.4**	**581**	**1001**	**58.0**	**48.4**	**67.1**
Age groups according to school levels															
6–13 (Primary)	206	313	65.8	56.9	73.8	187	317	59.0	51.4	66.2	393	630	62.4*	55.0	69.2
14–17 (Secondary)	78	151	51.7	35.0	68.0	88	160	55.0	43.8	65.7	166	311	53.4*	40.2	66.1

* The difference between primary and secondary school age groups is statistically significant at p=0.031.

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

Table 18 shows percentages of children by age group who progressed in school during the past year (i.e., the percentage of children whose caregiver reported them to be in a higher grade at the time of the survey compared to their grade in the previous school year). Overall, 87.8 percent of children ages five through 17 years progressed in school. A significantly higher percentage of girls compared to boys progressed in school (90.6% and 85.1%, respectively, p=0.023), but school progression was similar across all age groups.

Table 13. Children who progressed in school during the past year

Child's age (years)	Female children					Male children					All school-age children				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		n	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
5–9	129	144	89.6	83.4	93.6	117	138	84.8	77.8	89.9	246	282	87.2	82.7	90.7
10–14	183	200	91.5	86.8	94.7	173	200	86.5	81.0	90.6	356	400	89.0	84.5	92.3
15–17	72	80	90.0	81.2	94.9	81	98	82.7	73.9	88.9	153	178	86.0	78.3	91.2
Ages 5–17	**384**	**424**	**90.6***	**87.4**	**93.0**	**371**	**436**	**85.1***	**81.4**	**88.1**	**755**	**860**	**87.8**	**84.8**	**90.3**
Age groups according to school levels															
6–13 (Primary)	257	285	90.2	85.0	93.7	234	278	84.2	80.0	87.6	491	563	87.2	83.5	90.2
14–17 (Secondary)	110	121	90.9	81.1	95.9	121	140	86.4	72.9	93.8	231	261	88.5	82.4	92.7

* The difference between female and male children (ages 5-17) is statistically significant at p=0.023.

Attitudes about Child Punishment

OVC_CP: Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or at school

About half of caregivers (49.6%) agreed that hitting or beating a child was always or sometimes an appropriate means of discipline or control in the home or school (see Table 19). Although agreement with harsh physical punishment decreased with age of the caregiver, the differences among the age groups were not statistically significant. No overall difference was seen between female and male caregivers.

Table 14. Caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school

Caregiver's age (years)	Female caregivers					Male caregivers					All caregivers				
	n	*N*	%	95% CI		*n*	*N*	%	95% CI		*n*	*N*	%	95% CI	
				LL	UL				LL	UL				LL	UL
<18	0	1	0	-	-	0	0	-	-	-	0	1	0	-	-
18–30	23	39	59.0	39.5	76.0	1	2	50.0	3.5	96.5	24	41	58.5	38.1	76.4
31–50	114	218	52.3	43.1	61.4	36	69	52.2	37.0	66.9	150	287	52.3	43.8	60.6
51+	19	57	33.3	20.3	49.5	11	25	44.0	23.6	66.6	30	82	36.6	25.2	49.7
All ages	**156**	**315**	**49.5**	**42.2**	**56.9**	**48**	**96**	**50.0**	**39.7**	**60.3**	**204**	**411**	**49.6**	**43.7**	**55.6**

Household Economic Well-Being and Resilience

OVC_HT5: Percent of households able to access money to pay for expected household expenses

Few caregivers (16.9%) reported that their households were able to cover expected household expenses in the 12 months before the survey (Table 20). While male compared to female caregivers were more likely to report their households could cover expected expenses, the difference was not statistically significant (19.8% and 16.1%, respectively).

Table 20. Households able to access money to pay for expected household expenses

Sex of caregivers	Households				
	n	*N*	%	95% CI	
				LL	UL
Female	51	317	16.1	12.9	19.9
Male	19	96	19.8	15.4	25.0
All	**70**	**413**	**16.9**	**14.2**	**20.1**

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

Almost two-third of the caregivers (62.5%) reported they had experienced an unexpected household expense in the past 12 months (Table 21). Male compared to female caregivers were somewhat more likely to report an

unexpected expense (68.8% and 60.6%, respectively). Among those who experienced an unexpected expense, a little more than one-quarter (27.5%) of caregivers reported they had been able to access money to cover the expense. The difference in reports of female and male caregivers was not statistically significant.

Table 5. Households able to access money to pay for unexpected household expenses

Sex of caregivers	Households that experienced an unexpected expense in past 12 months				
	n	*N*	%	95% CI	
				LL	UL
Females	192	317	60.6	53.3	67.4
Males	66	96	68.8	61.8	74.9
All	**258**	**413**	**62.5**	**55.8**	**68.7**
Sex of caregivers	**Households able to access money to pay for unexpected expenses (among those experiencing an unexpected expense)**				
Females	51	192	26.6	17.6	38.0
Males	20	66	30.3	23.3	38.3
All	**71**	**258**	**27.5**	**19.7**	**37.0**

Gender Norms

OVC_HT6: Gender Equitable Men's (GEM) scale: Violence and daily chores domains (for caregivers)

Two domains of the GEM Scale—"Violence" and "Daily Chores"—were included in the survey (Pulerwitz and Barker, 2008). Caregivers were read a series of statements and asked whether they agreed, partially agreed, or did not agree with the statement (scored 1, 2, and 3, respectively). The percentages of caregivers who agreed with each statement are given in Table 22a. There was greater agreement with the Daily Chores domain statements (which ranged from 70.1% to 94.2% agreement) compared to the Violence domain statements (which ranged from 7.6% to 30.1% agreement). Agreement among female and male caregivers differed on several of the statements in both domains.

Table 22a. Agreement with GEM Scale statements

GEM Scale Agreement with the following statements	Female caregivers		Male caregivers		All caregivers	
	n/N	%	n/N	%	n/N	%
Violence domain						
There are times when a woman deserves to be beaten.	27/313	8.6	4/96	4.2	31/409	7.6
A woman should tolerate violence to keep her family together.	66/315	21.0	15/95	15.8	81/410	19.8
It is alright for a man to beat his wife if she is unfaithful.	114/314	36.3***	9/95	9.5***	123/409	30.1
A man can hit his wife if she won't have sex with him.	54/314	17.2*	4/96	4.2*	58/410	14.1
If someone insults a man, he should defend his reputation with force if he has to.	90/314	28.7	32/95	33.7	122/409	29.8

GEM Scale Agreement with the following statements	Female caregivers		Male caregivers		All caregivers	
	n/N	%	n/N	%	n/N	%
A man using violence against his wife is a private matter that shouldn't be discussed outside the couple.	83/314	26.4	24/96	25.0	107/410	26.1
Daily chores domain						
Changing diapers, giving a bath, and feeding kids is the mother's/woman's responsibility.	298/316	94.3***	74/96	77.1***	372/412	90.3
A woman's role is taking care of her home and family.	302/317	95.3*	87/96	90.6*	389/413	94.2
The husband should decide to buy the major household items.	166/315	52.7	66/96	68.8	232/411	56.4
A man should have the final word about decisions in his home.	210/312	67.3*	76/96	79.2*	286/408	70.1
A woman should obey her husband in all things.	223/317	70.3	75/96	78.1	298/413	72.2

*, *** The differences between female and male caregivers in degrees of agreement were statistically significant at p<0.05 and p<0.001, respectively.

Scores for the statements were tallied to give each caregiver a total score for each domain. Higher scores represent more gender-equitable norms. Results are shown in Table 22b. The mean score for the Violence domain was 14.0 (out of a maximum possible score of 18) with a minimum score of 6 and a maximum score of 18. Male caregivers scored higher than female caregivers on this domain (mean=14.6 and 13.8, respectively, p=0.036). The mean score for the Daily Chores domain was 6.3 (out of a possible score of 13) with a minimum score of 5 and a maximum score of 13. No difference in scores between female and male caregivers was found for this domain.

Table 6b. GEM Scale: Violence and Daily Chores domains

Sex of caregiver	n	Mean	Median	SD	Range
Violence domain (score range 6–18)					
Female caregivers	307	13.8*	14.0	3.15	6–18
Male caregivers	93	14.6*	15.0	2.68	7–18
All caregivers	**400**	**14.0**	**14.0**	**3.06**	**6–18**
Daily Chores domain (score range 5–15)					
Female caregivers	311	6.3	6.0	1.39	5–12
Male caregivers	96	6.2	6.0	1.63	5–13
All caregivers	**407**	**6.30**	**6.0**	**1.45**	**5–13**

* The difference between female and male caregivers is statistically significant at p=0.036.

DISCUSSION

Orphan and vulnerable children programs deliver health and social services that are critical to child well-being and improved HIV prevention, care, and treatment outcomes, contributing directly to the accelerated PEPFAR 90-90-90 targets, and ultimately, epidemic control (USAID, 2017; PEPFAR, December 2017). The PIH project supports child-centered, family-focused, community-based, and government-backed OVC programming that targets the full range of OVC needs according to the age and developmental stage of the child. The PEPFAR MER OVC ESI survey conducted for the PIH OVC program provides data to help assess the well-being of children and households currently served by the project, measured in terms of internationally accepted developmental milestones. The results are useful in informing OVC policies and programs in Haiti and at PEPFAR headquarters.

The MER OVC survey targeted households actively enrolled in the PIH OVC program. Thus, it was somewhat unexpected to find that 5.3 percent of surveyed caregivers reported that they were not enrolled in the program, while 7.2 percent reported that they had not received services from PIH in the past six months, in spite of additional measures taken at the time of household sample selection to update the beneficiary listing. It is uncertain if these findings are true reflections of challenges in accessing PIH program services or if they reflect shortcomings of the survey methods. For example, caregivers may have misunderstood the interview questions about receipt of services or their recall of receipt of services may have been inaccurate. Further, it is possible that caregivers purposely underreported receipt of services in an attempt to be considered for more services. Finally, the low reports of certain services received by program participants may also reflect high mobility of the beneficiary population, as reported by PIH program managers and community agents.

The percentage of children too ill to participate in daily activities is a direct measure of **children's health** and well-being (MEASURE Evaluation, 2014) and reflects their ability to function in daily life. About one in four children were reported by caregivers to be too sick to participate in daily activities at some point within the two weeks before the survey. Children under five years of age were twice as likely as older children to be sick. Fever, cough, and flu were the most common types of illness reported. About two-thirds of children with recent illness were seen at a health facility. Children under five years of age were more likely to be seen at a health facility (75.9%) than older children. These estimates are higher than those reported in the recent Demographic and Health Survey (EMMUS VI), which found that advice or treatment was sought for 42.2 percent, 40.1 percent and 34 percent of Haitian children under age five years that had recent fever, respiratory infection, and diarrhea, respectively (Institut Haïtien de l'Enfance (IHE) [Haiti] and ICF, 2018). This may suggest that sick children served by the PIH project are more likely than other sick children in Haiti to be linked to health services. Reasons for the higher rates of health facility visits among male compared to female children are not obvious given that no differences were found between males and females with regard to prevalence of type of sickness, but could perhaps be explained by differences in severity of illness (which was not captured in the survey).

Caregivers reported awareness of HIV status for about two-thirds of the children under their care. Among the children for whom caregivers reported knowing their HIV status, 6.5 percent were reported to be living with HIV. Nearly all children living with HIV (94.2 %) were reported to be taking ARV drugs and almost all were reported to have taken their medication within the past day. The finding that the HIV status of one-third of the children was unknown to the caregivers may point to a potential gap in efforts to get children tested for HIV. However, it may also be the case that these children were assessed for HIV risk and an HIV test was not indicated. The survey did not ask about risk assessment. Other limitations of the data should also be kept in mind. For example, these indicators capture only caregivers' knowledge, which may or may not accurately reflect the child's knowledge (especially among older children), the child's HIV status, or treatment access. Additionally, given the extent of HIV stigma in Haiti, it is possible that caregivers were unwilling to

acknowledge awareness of a child's HIV status or disclose that status, thus potentially contributing to under-reporting on these indicators.

Proper nutrition in early life is crucial for child development and subsequent life outcomes (Naudeau, et al., 2011). Based on MUAC measurements, the survey showed that only 1.8 percent of children age six to 59 months were found to be **undernourished**, indicating that severe, acute malnutrition may not be a significant problem among PIH beneficiaries. This estimate is somewhat lower than the EMMUS-VI national estimate of 3.7 percent (1.5% for Artibonite and 4.3% for Centre departments), which measured acute malnutrition (moderate and severe) in terms of weight for height (IHE & ICF, 2018). Differences between the two surveys perhaps can be explained by the different measures used to assess malnutrition, or may reflect that PIH project beneficiaries are somewhat better off nutritionally than are children under the age of five in the population at large.

Early childhood development is essential to a full and productive life for a child and to the progress of a nation (UNICEF, n.d.). Stimulating activities enhance a young child's physical and mental development. The survey found high levels of caregiver or other household adult engagement in stimulating activities with children under age five years: 87.8 percent of children were reported to have been read to or looked at a picture book together; told stories; sang songs or lullabies; engaged in play; or named, counted, or drew things at some point during the three days preceding the survey. The most frequently reported activities were playing and singing. More stimulating activities of reading or looking at books were less commonly reported. Girls and boys were equally engaged by adults. These estimates are somewhat higher than those reported in the EMMUS-VI, which found that 63.3 percent of children age 36–59 months were engaged in four or more activities to promote learning and school readiness with an adult in the household in the three days preceding the survey (IHE & ICF, 2018). However, direct comparisons between OVC_STIM and the EMMUS-VI child engagement measure should be made with caution given the difference in their definitions.

Haiti's Ministry of Education and Vocational Training promotes early childhood education and defines two periods of education, provided both formally and informally: initial education, from 0 to 3 years of age, and pre-primary school education, from 4 to 6 years of age. The objective of this early education is to foster a child's overall development by bringing out her or his potential for lifelong learning (UNESCO International Bureau of Education , 2006). The survey measured pre-primary school participation as an additional indicator of **early childhood development** and found that 58.6 percent of children ages three through five were enrolled in preschool. EMMUS-VI reports a similar preschool enrollment rate of 62.7 percent. However, the MER OVC survey found higher enrollment rates among girls compared to boys (66.7% and 48.7%), while EMMUS-VI found no difference between sexes (IHE & ICF, 2018). Among enrolled pre-primary school students in the survey, only about half had regularly attended school (i.e., did not miss any school days in the week preceding the survey). The survey did not ascertain reasons for absenteeism, but the high rates of illness found among young children may offer a partial explanation.

According to Article 7 of the 1989 U.N. Convention on the Rights of the Child, "*A child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality, and as far as possible, the right to know and be cared for by his or her parent,*" (United Nations General Assembly, 1989). Haitian law (Chapter II of Law No. 3 of the Haitian Civil Code, Article 55) stipulates that births are to be registered in the month of the child's birth and birth certificates are to be issued (Gouvenement d'Haiti, 1864). PEPFAR has acknowledged the importance of birth certificates as essential for tracking vital health statistics and for facilitating access to services. Birth registration and certificates are also acknowledged as important tools in the prevention of child trafficking (UNICEF, 2013). Caregivers in the survey who were interviewed in their households reported that 89.2 percent of children under their care had birth certificates, but were able to show certificates for about half of the children. The youngest children were the least likely to have birth certificates (i.e., birth certificates were seen for only 25.8 percent of zero- to four-year-olds). The most common reason

cited for not showing a birth certificate was that someone else kept it. EMMUS-VI asked about birth certificates for children under the age of five years only and found slightly higher rates for this age group. In that survey, birth certificates were seen by the interviewer for 42.1 percent of children nationally, and for 30.4 and 32.2 percent for Artibonite and Central departments, respectively: the lowest rates in the country (IHE & ICF, 2018).

Education support through the payment of school fees was the second service that caregivers most commonly reported receiving from PIH (i.e., about two-thirds of caregivers indicated they had received this support in the past six months). While more than 90 percent of school-age children were reportedly enrolled in school, only about half were reported to be regularly attending school (i.e., enrolled in school and did not miss any days in the school week prior to the interview). Regular attendance (and also enrollment) among secondary school-age children (i.e., ages 14–17 years) was found to be lower than among primary school-age children (i.e., ages six–13 years), which is consistent with other national-level data that show a drop-off in school enrollment starting at age 15 years (World Bank & Observatoire National de la Pauvreté et de l'Exclusion Sociale (ONPES), 2014). The Ministry of Education and Vocational Training's current strategic plan recognizes that, in addition to poverty, there are many obstacles to school enrollment: "*The strong correlation of school enrollment with individual and household factors, particularly disability and living in a household not headed by one's parents, points to important barriers besides costs,"* (Ministère De L'Éducation Nationale Et de La Formation Professionnelle (MENFP), 2013). These same factors are likely to also affect school attendance.

High rates of **grade progression** were reported among both primary and secondary school-age children. They are consistent with estimates from other sources that about 10 percent of primary school children repeat grades (World Bank and ONPES, 2014; Education Policy and Data Center, 2009). However, as the World Bank notes, these progression rates tell only part of the education challenge. For example, when these progression rates are combined with a two to six percent dropout rate for each primary school grade and the fact that Haitian children begin primary school two years late (i.e., at an average age of about 7.8 years), projections show that only about 58 percent of children in first grade will arrive at sixth grade, and only 29 percent will reach the final year of upper secondary (World Bank and ONPES, 2014). In the OVC MER survey, students in the first year of primary school had a mean age 7.4 years, echoing the national figure. As the authors of the World Bank and ONPES report highlight, there is a need to identify and address the drivers behind late primary school starts, as well as grade repetition and dropout.

In the OVC MER survey, about half of the caregivers agreed that hitting or beating a child was always or sometimes an appropriate means of discipline or control in the home or school. This acceptance of **harsh physical punishment** against children is higher than findings from other recent data. For example, a UNICEF study found that 30 percent of adults think that corporal punishment is necessary to raise children (UNICEF, 2014) and the EMMUS-VI reported that 27 percent of parents or caregivers agreed that physical punishment is necessary to educate a child (IHE & ICF, 2018). These attitudes are also reflective of the high rates of physical violence experienced by children. For example, 85.1 percent of children ages one to 14 years reportedly experienced physical or psychological violence as a mean of discipline during the month preceding the EMMUS-VI survey and 14.2 percent were subjected to severe physical punishment (IHE & ICF, 2018). Almost two-thirds of both females and males who participated in the Haiti Violence Against Children Survey reported experience of physical violence before age 18 years by an adult household member or authority figure in the community (CDC, Interuniversity Institute for Research and Development, & Comité de Coordination, 2012). This generally accepted cultural practice has deep implications for children who are already vulnerable. The results of the OVC MER survey reiterate the need to intensify child violence prevention and response programs and policies to address abuse and violence against children.

Less than 20 percent of caregivers reported that their households were able to cover expected household expenses in the past 12 months, which confirms the **economic vulnerability** of the households served by the PIH OVC program. This finding is supported by EMMUS-V reports that 64 percent of Haitian households did

not have sufficient food, or money to buy food, and experienced a complete lack of food in the four weeks preceding the survey (Cayemittes, et al., 2012). It is also consistent with national estimates of an overall poverty headcount of 58.5 percent and an extreme poverty rate of 23.8 percent (World Bank & ONPES, 2014). Sixty-two percent of caregivers reported they had experienced an unexpected household expense such as a house repair or urgent medical treatment in the past 12 months, a somewhat lower prevalence than the nearly 75 percent of Haitian households impacted by at least one economically damaging shock in 2012 (World Bank & ONPES, 2014). Among the caregivers whose households had experienced an unexpected expense, less than 30 percent were able to access money to cover the expense, indicating low **household economic resilience** and the absence of adequate safety nets for OVC households.

Gender norms held by caregivers influence the ways in which they nurture and care for children. Two domains of the GEM scale, Violence and Daily Chores, were included as supplemental indicators in the survey to assess the extent to which caregivers supported gender equitable norms. Results showed greater agreement with inequitable Daily Chores domain statements (range: 56.4 % to 94.2%) compared to the inequitable Violence domain statements (range: 7.6% to 30.1%). While female and male caregivers scored similarly on the Daily Chores scale, male caregivers scored higher than female caregivers on the Violence scale. Similar male-female differences in GEM scale scores with men reporting more gender-equitable norms than women have been found in studies from other countries (Stephenson, et al., 2012; Kazaura, et al., 2015; Husey, et al., 2018). Female (36.3%) compared to male (9.5%) caregivers were more likely to agree that it is all right for a man to beat his wife if she is unfaithful. A similar difference between women and men was found in another recent survey in Haiti although agreement with the statement among both sexes was much higher (i.e., 71.4% of women and 28.6% of men agreed that it is acceptable for a man to hit his wife if she slept with another man) (Philippe, et al, 2017). Similarly, more female (17.2%) than male (4.2%) caregivers agreed that a man can hit his wife if she refuses to have sex with him, which is somewhat consistent with EMMUS-VI finding that 17 percent of women and 11 percent of men agreed with this statement (IHE & ICF, 2018).

RECOMMENDATIONS

The MER OVC survey for the PIH OVC program provided valuable information on the current status of the well-being of project beneficiaries and highlighted several areas that merit further attention. Based on the survey findings, the following recommendations are offered to improve the well-being of orphans and vulnerable children in Haiti:

- Raise caregivers' awareness about childhood illness, prevention, and services, and provide support to help keep children healthy, particularly young children. Continue to study the causes of illness and barriers to prevention and care to target interventions. A high percentage of children are receiving health facility care, so the types and quality of care they are receiving should also be examined.
- Assess the HIV risk of children and ensure those at risk receive an HIV test. For those living with HIV, continue to strengthen linkages to HIV care and treatment and support ARV adherence.
- Accelerate efforts to reduce HIV-related stigma and discrimination to promote HIV testing, access to care, and viral load suppression– as well to promote human rights and dignity.
- Increase enrollment of young children in preschool to promote early childhood development. Additionally, raise caregivers' awareness of the importance of engaging children in mentally stimulating activities and offer support to caregivers to increase their engagement in more stimulating activities, such as drawing, counting, story-telling, and reading and looking at picture books.
- Assist caregivers to register births and help children obtain birth certificates, especially for those under age five.
- Determine causes of school absenteeism and address barriers to attendance and retention. As noted earlier, identify and address the drivers behind late primary school starts and address factors that contribute to lower grade progression among primary school students. Address factors that may contribute to lower rates of grade progression among male compared with female students.
- Strengthen psychosocial support to households to include parenting programs that emphasize the dangers of harsh physical punishment and impart supportive parenting skills. Consider working with other primary adults in children's lives, such as healthcare providers and educators, to change norms and practices related to corporal punishment.
- Implement strategies to address harmful norms and practices surrounding intimate partner violence as they are also linked to attitudes and perpetration of violence against children and other factors that affect child well-being. Implement or strengthen programs, such as positive parenting to promote a shift in gender norms and to support an expanded role for men in the care of children and the household.
- Intensify economic strengthening interventions to build the economic resilience of OVC households. Evaluate the impact of current economic strengthening interventions and scale up evidence-based approaches.
- Further analyze the survey data to explore determinants of child and household well-being and associations among outcomes. Cross-validate and triangulate the survey findings with routine project monitoring data and other data sources to facilitate interpretation of data and inform future programming.

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APPENDIX

Haiti MER OVC ESI Survey Questionnaire

Cover Sheet

IDENTIFICATION DATA

001	Household IDENTIFICATION Key	
002	OVC Service Delivery Partner (IP)	BEST/Caris Foundation 1 Partners in Health 2
003	Hospital where household is registered	Name: Code: Department: Commune:
004	Location of interview	Caregiver residence 1 Hospital 2 School 3 Other 4 Specify: _____
005	Caregiver residence location	Department: Commune: Locality:
005a	Caregiver residence area	Urban 1 Rural 2
006	HOUSEHOLD ID from IP database	

INTERVIEW LOG

	Interview Attempt 1	Interview Attempt 2	Interview Attempt 3
DATE (day/month/year)			
INTERVIEWER COMMENTS			

Interview comment codes: 1–Interview completed; 2–Appointment made for later today; 3–Appointment made for another day; 4– Household was unknown to facility or local guides, no follow-up; 5– Household moved out of the service delivery area less than 6 months ago, no follow up; 6-Household moved out of the service delivery area more than 6 months ago, no follow up; 7- Caregiver refused to be interviewed; 8- Interview started, but not completed (note reason); 9- Other (specify)

009	INTERVIEWER	A) CODE	B) NAME
010	DATE INTERVIEW COMPLETED (day/month/year)		

COMMENTS:

1. MER Indicator Questionnaire: Caregivers

First, I have a few questions about you and the children under your care.

No.	Question	Coding Category	Skip
1	**Record caregiver sex.**	Female 1 Male 2	
2	How old were you at your last birthday? **Do not leave blank. If unknown, ask respondent to estimate.**	[_____] years	
3	For BEST: Have you or any child in the household you care for ever participated in a Mothers Club or Kids Club at the hospital? For PIH: Is your household enrolled in the PIH program that serves vulnerable children? For example, have you ever received a home visit from the social worker regarding care for you and the children you care for? Or have you been screened at the facility regarding services for you and the children you care for?	Yes, Mothers Club only 1 Yes, Kids Club only 2 Yes, both Mothers and Kids Clubs 3 No club participation 4 Don't know 8 No answer 9 Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 7**
4	For BEST: How many months or years ago did you or any child you care for start participating in a Mothers Club or Kids Club at the hospital? *If more than one participant, record time for the longest participating.* For PIH: How many months/years ago was your household first enrolled in the PIH program?	[_____] months Record 88 for Don't know; 99 for No answer	
5	Have you received any services for you and/or the child/children you care for in the past 6 months?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 7**

6	What types of services have you or other members of your household received from [BEST/PIH] in the past 6 months? **Read each item and check if caregiver says s/he has received the service. Ask if s/he received any other services from [BEST/PIH] and if so, write out responses (under Other) for those not on the list.**		
	6.1 Referral to health services for a child 6.2 Referral of child for immunizations 6.3 Referral to HIV testing and counseling 6.4 Support for disclosing HIV status	[__] [__] [__] [__]	
	6.5 Referral for ART 6.6 Psychosocial support/counseling 6.7 Payment of schools fees 6.8 Support for school supplies and materials 6.9 Help to get child's birth certificate 6.10 Water-treatment products 6.11 Hygiene kits 6.12 De-worming medicines 6.13 HIV prevention education 6.14 Help for addressing sexual or other forms of violence 6.15 Referral to GBV services 6.16 Household economic strengthening such as MUSO, savings groups, or kitchen gardens 6.17 Provision of condoms 6.18 Referral to family planning services 6.19 Referral to child protection services 6.20 Referral for cervical cancer screening 6.21 Support for housing or shelter 6.22 Other	[__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] Specify:_____	
7	Have you ever attended school?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 9**
8	What is the highest level of school you attended?	Kindergarten . . . . .0 Primary . . . . . .1 Secondary . . . . .2 University . . . . . .3 Don't know . . . . . 8 No answer 9	

9	Do you think that hitting or beating a child is an appropriate means of discipline or control in the home?	Always an appropriate means of discipline . . . . . 1 Sometimes an appropriate means of discipline. . . . . 2 Rarely an appropriate means of discipline . . . . . 3 Never an appropriate means of discipline . . . . . 4 Don't know . . . . . 8 No answer 9	
10	Do you think that hitting or beating a child is an appropriate means of discipline or control at school?	Always an appropriate means of discipline . . . . . 1 Sometimes an appropriate means of discipline. . . . . 2 Rarely an appropriate means of discipline . . . . . 3 Never an appropriate means of discipline . . . . . 4 Don't know . . . . . 8 No answer 9	

11	I'm now going to read some statements and I'd like you to tell me if you agree, partially agree, or do not agree.	**AGREE**	**PARTIALLY AGREE**	**DO NOT AGREE**	**No Answer**
	11.1 Changing diapers, giving a bath, and feeding kids is the mother's/woman's responsibility.	1	2	3	9
	11.2 A woman's role is taking care of her home and family.	1	2	3	9
	11.3 The husband should decide to buy the major household items.	1	2	3	9
	11.4 A man should have the final word about decisions in his home.	1	2	3	9
	11.5 A woman should obey her husband in all things.	1	2	3	9
12	*Continue reading statements…*	**AGREE**	**PARTIALLY AGREE**	**DO NOT AGREE**	**No Answer**
	12.1 There are times when a woman deserves to be beaten.	1	2	3	9
	12.2 A woman should tolerate violence to keep her family together.	1	2	3	9
	12.3 It is alright for a man to beat his wife if she is unfaithful.	1	2	3	9
	12.4 A man can hit his wife if she won't have sex with him.	1	2	3	9
	12.5 If someone insults a man, he should defend his reputation with force if he has to.	1	2	3	9
	12.6 A man using violence against his wife is a private matter that shouldn't be discussed outside the	1	2	3	9

	couple				
13	Do you own the house/dwelling where you live?	Yes 1 No 2 Don't know 8 No answer 9			
14	Does your household have any of the following? 14.1 Improved source of drinking water 14.2 Improved toilet facility 14.3 Electricity 14.4 House with cement floor 14.5 House with concrete roof	For each item: Yes 1 No 2 Don't know 8 No answer 9			
15	Has your household been able to cover expected household expenses in the last 12 months?	Yes 1 No 2 Don't know 8 No answer 9			
16	Did your household incur any unexpected household expenses, such as a house repair or urgent medical treatment, in the last 12 months?	Yes 1 No 2 Don't know 8 No answer 9			**If No, DK, or No answer: 18**
17	Was your household able to pay for these unexpected expenses?	Yes 1 No 2			
18	How many children ages 0–17 years in your household are you responsible for?	[_____] children			

Starting with the oldest, please tell me the first names and ages of the children under age 18 who you care for or for whom you are responsible in your household. **Make sure that the total number of children is the same as the response given to question 18 above.**

No.	First name	Age (years)	Questionnaire		For BEST only, Is child enrolled in a Kids Club?
			0–4 years	5–17 years	Y/N
1	*Example.* Samuel	6		X	Y

2. MER Indicator Questionnaire: Child Ages 0–4 years

I have a few questions about [insert child's name]. **Check to make sure that the sampled child is present. You will need to take this child's mid–upper arm circumference.**

No.	Question	Coding Category	Skip
1	Is [NAME] female or male?	Female 1 Male 2	
2	How old was [NAME] at her/his last birthday? **Do not leave blank. If unknown, ask caregiver to estimate. If the child is older than 4 at last birthday, use 5–17 years questionnaire. Proceed to next household/child on list.**	[_____] years Enter 0 if less than one year of age and then record age in months [_____] months	
3	3.1 Does [NAME] have a birth certificate?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 4**
	3.2 Could you please show me [NAME'S] birth certificate?	Seen/Confirmed 1 Not seen/Not confirmed 2	**If 1: Go to 4**
	3.3 Reason for not showing birth certificate	Prefers not to show it 1 Can't locate it 2 Someone else keeps it 3 Other 4 Specify: _____	

No.			Yes	No	DK	NR
4	In the past 3 days, did you or any household member over 15 years of age engage in any of the following activities with [NAME]: **Read out (1) through (5) one at a time.**	4.1 Read books to or looked a picture books with [NAME]?	1	2	8	9
		4.2 Told stories to [NAME]?	1	2	8	9
		4.3 Sang songs to [NAME] or with [NAME] including lullabies?	1	2	8	9
		4.4 Played with [NAME]?	1	2	8	9
		4.5 Named, counted, or drew things with [NAME]?	1	2	8	9

5	Is [NAME] currently enrolled in pre-school (Kindergarten)?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 8**
6	During the last school week, did [NAME] miss any school days for any reason?	Yes 1 No 2 Don't know 8 No answer 9	
7	What kindergarten year is [NAME] in now?	[__|__] Record 88 for Don't know; 99 for No answer	
8	Was [NAME] enrolled in pre-school (Kindergarten) during the previous school year?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 10**
9	What kindergarten year was [NAME] in during the previous school year?	[__|__] Record 88 for Don't know; 99 for No answer	
10	In the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 13**
11	What was the nature of the illness? **Read each item and enter caregiver response. Then ask if the child had any other illness, and if so, write out responses (under Other) for those not on the list.** 11.1 Fever 1=Yes 2=No 3=DK 11.2 Diarrhea 1=Yes 2=No 3=DK 11.3 Cough 1=Yes 2=No 3=DK 11.4 Malaria 1=Yes 2=No 3=DK 11.5 Flu 1=Yes 2=No 3=DK 11.6 Injuries 1=Yes 2=No 3=DK 11.7 Other 1=Yes 2=No 3=DK Specify: _____		

12	What did you do for this child's illness? **Read each item and enter caregiver response. Then ask the caregiver "What else did you do?" Write out responses (under Other) for those not on the list.** 12.1 Gave home remedy 1=Yes 2=No 3=DK 12.2 Took child to [BEST/PIH-supported] hospital 1=Yes 2=No 3=DK 12.3 Took child to other health facility 1=Yes 2=No 3=DK 12.4 Went to traditional healer 1=Yes 2=No 3=DK 12.5 Got medicine from street vendor 1=Yes 2=No 3=DK 12.6 Other 1=Yes 2=No 3=DK Specify:_____		
13	May I measure your child's mid–upper arm circumference? **For children 6- 59 months, measure the child's mid–upper arm circumference using the MUAC tape and record measurement.**	[__|__].[__|__] Cm Record 88.88 if permission not given 99.99 if child not present	
14	Has [NAME] ever received services or participated in activities from [BEST/PIH]? READ: For example, Referral to health services for the child, Referral of child for immunizations, Referral of child to HIV testing and counseling, Referral for ART, Psychosocial support/counseling, Payment of schools fees, Support for school supplies and materials, Help to get child's birth certificate, Water-treatment products, Hygiene kit, De-worming medicines, Referral to social protection services, Help for addressing sexual or other forms of violence, Referral to services for experience of violence, etc.	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 17**
15	How many months ago did [NAME] start receiving services or participating in activities from [BEST/PIH]?	[_____] months Record 88 for Don't know; 99 for No answer	
16	Has [NAME] received services or participated in activities from [BEST/PIH] in the last 6 months?	Yes 1 No 2 Don't know 8 No answer 9	

17	Has [NAME] ever been tested to see if he/she has the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
18	Do you know the results of [NAME's] test?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
19	Did [NAME] test positive for the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
20	Is [NAME] currently taking antiretroviral (ARV) drugs?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
21	When was the last time [NAME] took her/his ARV drugs?	Number of days ago: [__] 0=today 88= Don't know 99=No answer	

3. MER Indicator Questionnaire: Child Ages 5–17 years

Age group	5–9 years	10–14 years	15–17 years

I have a few questions about [insert child's name].

No.	Question	Coding Category	SKIP
1	Is [NAME] female or male?	Female 1 Male 2	
2	How old was [NAME] at their last birthday? **Do not leave blank. If unknown, ask caregiver to estimate. If the child was less than 5 years old at last birthday, complete the 0- to 4-year-old form. If the child is 18 or older, stop the interview for this child.**	[___|___] years	

3	3.1 Does [NAME] have a birth certificate?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 4**
	3.2 Could you please show me [NAME'S] birth certificate?	Seen/Confirmed 1 Not seen/Not confirmed 2	**If 1: Go to 4**
	3.3 Reason for not showing birth certificate	Prefers not to show it 1 Can't locate it 2 Someone else keeps it 3 Other 4 Specify: _____	
4	Is [NAME] currently enrolled in school?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 7**
5	During the last school week, did [NAME] miss any school days for any reason?	Yes 1 No 2 Don't know 8 No answer 9	
6	6.1 What education level is [NAME] currently attending?	Kindergarten (1-3) . . . . . 0 Primary (1-9). . . . . 1 Secondary (10-12) . . . . . 2 University (1-4). . . . . 3 Don't know . . . . . 8 No answer 9	
	6.2 What school grade is [NAME] currently attending?	[__|__] Record 88 for Don't know; 99 for No answer	
7	Was [NAME] enrolled in school during the previous school year?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 9**
8	8.1 What education level did [NAME] attend during the previous school year?	Kindergarten (1-3). . . . . 0 Primary (1-9). . . . . 1 Secondary (10-12). . . . . 2 University (1-4) . . . . . 3 Don't know . . . . . 8 No answer 9	

	8.2 What school grade did [NAME] attend during the previous school year?	[__|__] Record 88 for Don't know; 99 for No answer	
9	At any point in the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 12**
10	What was the nature of the illness? **Read each item and enter caregiver response. Then ask if the child had any other illness, and if so, write out responses (under Other) for those not on the list.** 10.1 Fever 1=Yes 2=No 3=DK 10.2 Diarrhea 1=Yes 2=No 3=DK 10.3 Cough 1=Yes 2=No 3=DK 10.4 Malaria 1=Yes 2=No 3=DK 10.5 Flu 1=Yes 2=No 3=DK 10.6 Injuries 1=Yes 2=No 3=DK 10.7 Other 1=Yes 2=No 3=DK Specify: _____		
11	What did you do for this child's illness? **Read each item and enter caregiver response. Then ask the caregiver "What else did you do?" Write out responses (under Other) for those not on the list.** 11.1 Gave home remedy 1=Yes 2=No 3=DK 11.2 Took child to [BEST/PIH-supported] hospital 1=Yes 2=No 3=DK 11.3 Took child to other health facility 1=Yes 2=No 3=DK 11.4 Went to traditional healer 1=Yes 2=No 3=DK 11.5 Got medicine from street vendor 1=Yes 2=No 3=DK 11.6 Other 1=Yes 2=No 3=DK Specify:_____		
12	Has [NAME] ever received services or participated in activities from [BEST/PIH]? READ: For example, Referral to health services for the child, Referral of child for immunizations, Referral of child to HIV testing and counseling, Referral for ART, Psychosocial support/counseling, Payment of schools fees, Support for school supplies and materials, Help to get child's birth certificate, Water-treatment products, Hygiene kit, De-worming medicines, HIV prevention education, Referral to social protection services, Help for addressing sexual or other forms of violence, Referral to services for experience of violence, etc.	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 15**

13	How many months ago did [NAME] start receiving services or participating in activities from [BEST/PIH]?	[_____] months Record 88 for Don't know; 99 for No answer	
14	Has [NAME] received services or participated in activities from [BEST/PIH] in the last 6 months?	Yes 1 No 2 Don't know 8 No answer 9	
15	Has [NAME] ever been tested to see if he/she has the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
16	Do you know the results of [NAME's] test?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, No answer: end**
17	Did [NAME] test positive for the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, No answer: end**
18	Is [NAME] currently taking antiretroviral (ARV) drugs?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, No answer: end**
19	When was the last time [NAME] took her/his ARV drugs?	Number of days ago: [__] 0=today 88= Don't know 99=No answer	

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