



Monitoring Outcomes of PEPFAR Orphans and Vulnerable Children Programs in Kenya:

APHIAplus Western Kenya 2016
Survey Findings

January 2018



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January 2018

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. TR-17-221

ISBN 978-1-9433-6486-2



ACKNOWLEDGMENTS

We thank the United States President's Emergency Plan for AIDS Relief (PEPFAR) for its support of this research and publication.

We wish to thank Lize Ojowi, Jeniffer Wasianga, and Rose Kerubo of the United States Agency for International Development (USAID)/Kenya East Africa, Wilkister Ombima of the United States Centers for Disease Control and Prevention in Kenya, and Sarah Goretty of the United States Department of Defense in Kenya for their guidance on this activity and review of the report. We also thank Christine Fu and Gretchen Bachman of USAID Washington and the orphans and vulnerable children team, led by Lisa Parker, of the USAID- and PEPFAR-funded MEASURE Evaluation project for their technical input and reviews.

We are grateful to colleagues at the African Population and Health Research Center for their support during implementation of the study, especially Clement Oduor, Marylene Wamukoya, Joseph Ouma, Daniel Maina, Stella Chege, and the field team who collected the data. We thank Lillian Mageto, of MEASURE Evaluation, for her outstanding support in Kenya throughout the project; the APHIAplus Western Kenya team and their local partners for their collaboration; and the women and men who participated in the survey for their time and the valuable information they provided.

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

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ABBREVIATIONS

APHIAplus	APHIAplus Western Kenya
APHRC	African Population and Health Research Center
ART	antiretroviral therapy
ARV	antiretroviral
ESI	essential survey indicators
KDHS	Kenya Demographic and Health Survey
KNBS	Kenya National Bureau of Statistics
MER	monitoring, evaluation, and reporting
MUAC	mid-upper arm circumference
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WRP/HJFMRI	Walter Reed Program/Henry M. Jackson Foundation Medical Research International

EXECUTIVE SUMMARY

The AIDS epidemic in Kenya has left hundreds of thousands of children vulnerable to HIV and many 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 Kenya since 2003 to strengthen services for OVC and those who care for them. PEPFAR support has focused on delivery of a comprehensive set of core interventions that include healthcare and referrals for nutrition; linkages to HIV testing, care, and treatment, including integration of adherence to antiretroviral therapy (ART) in routine household monitoring; promotion of positive parenting; provision of psychosocial support to affected households; economic strengthening activities for households, such as group savings and loans, cash transfers, and food subsidies; and educational support for children.

Recognizing the need 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 Kenya and the 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 PEPFAR Kenya OVC team requested assistance from the United States Agency for International Development (USAID)- and PEPFAR-funded MEASURE Evaluation project to conduct surveys to collect the required data for three of its ongoing OVC projects located in western Kenya: the USAID project, APHIAplus Western Kenya (APHIAplus); the United States Centers for Disease Control and Prevention project, Timiza 90; and the United States Department of Defense project, led by the Walter Reed Program/Henry M. Jackson Foundation Medical Research International (WRP/HJFMRI). This report presents the findings from the survey that MEASURE Evaluation and its local research partner, African Population and Health Research Center (APHRC), conducted November to December 2016 for APHIAplus. Survey results for the other two PEPFAR projects are reported separately.

At the time of the survey, APHIAplus, led by PATH and implemented through a consortium that included 76 local partners, was providing OVC services to over 100,000 households throughout Bungoma, Busia, Homa Bay, Kakamega, Kisii, Kisumu, Migori, Nyamira, Siaya, and Vihiga counties. Using a two-stage, cluster randomized design, the MEASURE Evaluation survey team selected a sample of 480 beneficiary households and conducted survey interviews with 426 caregivers about themselves, their households, and 1,458 children under age 18 who were under their care. The survey tools and methodology used followed guidance previously developed by MEASURE Evaluation for PEPFAR for collection of the OVC ESIs.

Results for the nine ESIs and two supplemental indicators, presented below, provided a snapshot of the well-being of children and households served by APHIAplus in late 2016 and fulfilled PEPFAR reporting requirements. Although the survey was not designed to assess the effectiveness of the APHIAplus OVC program, it was useful in pointing out potential needs and program gaps. These included a rather high prevalence of children who were ill, particularly young children; substantial, but not yet universal awareness among caregivers of children's HIV status and access to antiretroviral (ARV) drugs among children living with HIV; low occurrence of birth registration; high rates of school enrollment and progression but rather significant rates of absenteeism; widespread acceptance of harsh physical punishment toward children, especially among female caregivers; and very limited household economic

resources. Dimensions of well-being that appeared not to be of concern were nutrition and early childhood development (measured in terms of adult engagement in stimulating activities with young children). Further analysis of the results is recommended to explore factors that could inform future programming. The results from this first round of data collection will also serve as a reference for tracking changes over time, with the next round of data collection planned for 2018.

Summary of PEPFAR MER OVC essential survey indicator results for APHIAplus

Reference Name	Indicator	n	N	%	95% Confidence Interval	
					LL	UL
Health						
OVC_SICK	Percent of children (aged 0–17 years) too sick to participate in daily activities	451	1,438	31.4	28.4	34.5
OVC_HIVST	Percent of children (aged 0–17 years) whose primary caregiver knows the child’s HIV status	1,064	1,438	74.0	68.3	79.0
OVC_KE1	Percent of children (aged 0–17 years) living with HIV who are taking antiretroviral (ARV) drugs	49	56	87.5	73.8	94.6
Nutrition						
OVC_NUT	Percent of children (aged 6–59 months) who are undernourished	4	159	2.5	0.8	7.8
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	167	177	94.4	89.5	97.0
Legal rights						
OVC_BCERT	Percent of children (aged 0–17 years) who have a birth certificate	521	1,438	36.2	31.3	41.5
Education						
OVC_SCHATT	Percent of children (aged 5–17 years) regularly attending school	891	1,261	70.7	67.3	73.8
OVC_PRGS	Percent of children (aged 5–17 years) who progressed in school during the last year*	1,082	1,208	89.6	87.9	91.1
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	308	426	72.3	67.6	76.9
Household economic well-being and resilience						
OVC_MONEY	Percent of households able to access money to pay for unexpected household expenses	90	232	38.8	29.7	48.8
OVC_KE2	Percent of households able to access money to pay for expected household expenses	157	425	36.9	31.8	42.4

BACKGROUND

Situation of Orphans and Vulnerable Children in Kenya

In Kenya, approximately 2.6 million children have lost one or both of their parents (Lee, et al., 2014). They represent nearly 15 percent of all Kenyan children under 18 years of age (National AIDS and STI Control Programme, 2014). In 2015, 660,000 children under age 18 were orphaned because of a parent dying from AIDS (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2015). Additionally, 190,000 children ages zero to 14 in Kenya were living with HIV (UNAIDS, 2013). Thus, the HIV epidemic has placed an undue burden on the country's youngest residents, leaving orphans to be raised without the protection or guidance of their parents. These children are often the victims of social ills, including poverty, disease, abandonment, natural disasters, trafficking, early work, forced conscription into conflict, and harmful traditional practices such as female genital mutilation. They also suffer psychosocial trauma because of their conditions. Some of these children are hosted by charitable children's institutions or are living on the streets in major urban areas, while others are taken in by members of the family or community. When fostered, they may face heightened vulnerabilities due to additional pressure on emotional, financial, and material resources in their new households. Many of them become vulnerable long before their parents die. Often, girls are "forced" to take care of their ailing parents and siblings, sometimes taking on income-generating activities that endanger their lives (UNAIDS, 2014).

Orphans and vulnerable children need care and protection that the traditional extended family system typically is unprepared to offer due to social and economic strains on households in the country. Also, as in many developing countries, Kenyan systems and services that provide care and protection for OVC are weak and, in many cases, inadequate for providing even basic services. Support and programs for OVC, therefore, are needed to improve the well-being of OVC through increased access to essential services, including social and economic support of affected families and households. The Government of Kenya has acknowledged the need to respond to the needs of the OVC population and is working to strengthen social protection programs. The Kenya AIDS Strategic Framework (2014/2015-2018/2019) promotes the protection of OVC and encourages closing "the gap of the unmet need for support services for [OVC] to ensure the protection, care, and support of at least 2.6 million children" (National AIDS Control Council [NACC], 2014).

Since its inception in 2003, PEPFAR has partnered with the Government of Kenya to strengthen services for OVC. PEPFAR support has focused on delivery of a comprehensive set of core interventions that include referrals for nutrition; integration of ART adherence in routine household monitoring; promotion of positive parenting; provision of psychosocial support to affected households; economic strengthening activities for households, such as group savings and loans, cash transfers, and food subsidies; and educational support for children. Linking HIV-infected children and adolescents to HIV care and treatment services is a current priority (U.S. Department of State, 2015).

OVC Outcomes Monitoring

Globally, PEPFAR has invested considerable resources in OVC programs but has not studied systematically or on a large scale the effect of its programs on the well-being of beneficiary OVC and 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, referred to as the MER OVC ESIs. The ESIs are intended to measure and track child and household well-being using standardized indicators and methodology 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.

In 2016, the PEPFAR Kenya OVC team selected three of its projects in western Kenya as the focus of ESI data collection:

- The USAID project APHIAplus, implemented by PATH
- The United States Centers for Disease Control and Prevention project Timiza 90 (formerly Pamoja Project), implemented by Elizabeth Glaser Pediatric AIDS Foundation (EGPAF Kenya)
- The United States Department of Defense HIV and AIDS project, implemented by the WRP/HJFMRI

Selection criteria included diversification of U.S. agency support, project funding levels, geographic burden of HIV, and planned continued support to the beneficiary populations served by these projects for at least another two years. The three projects deliver a similar comprehensive package of OVC services based on assessed needs of beneficiaries. Although there is some overlap in the counties served by the projects, all beneficiaries receive services from just one of the projects.

The PEPFAR Kenya OVC team requested the assistance of the USAID project, MEASURE Evaluation, to collect data for the MER ESI. In late 2016, MEASURE Evaluation, in partnership with its subcontractor, APHRC, conducted three household surveys, one for each project, to collect the first round of data for the OVC ESI. The methodology used for all three surveys was similar and followed established guidance (MEASURE Evaluation, 2014). This report presents the MER OVC ESI survey that MEASURE Evaluation conducted for the APHIAplus project. The other two surveys are presented under separate cover.

Intended Use of This Report

This report describes the methods used to conduct the APHIAplus 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 the APHIAplus project better understand the well-being of its beneficiaries at this point in time and to support the project, the PEPFAR OVC team, and other program decision makers and stakeholders, including those from the Government of Kenya, to take evidence-informed actions to improve 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 will also contribute to a global PEPFAR-wide evidence base on the effectiveness of PEPFAR OVC programming. As this is the first round of data collection for the ESI, the report also serves as a reference for future rounds of data collection that will allow tracking of the indicators over time.

METHODS

Survey Context: APHIAplus OVC Program

During the start-up phase of the survey project, the survey team conducted interviews with APHIAplus project managers and managers of several of its local partner organizations to gather information about the project history and operations in order to adapt the survey tools, as necessary, and to help contextualize the survey results. APHIAplus was a large, five-year, USAID project that began in 2011 and followed on a previous five-year project, resuming support for beneficiaries of the previous project and continuing to enroll new participants from 2011 onward. The project period was extended until the OVC program component ended in June 2017, at which time current beneficiaries were transferred to a new project led by Catholic Relief Services. The project delivered an array of programs and services, including HIV care and treatment; water and sanitation; malaria; family planning and reproductive health; maternal, neonatal and child health; and human resources for health. Its OVC interventions were integrated into this broader program platform. In the first six months of FY 2016, APHIAplus reported that it had provided OVC programs and services to 192,162 individual OVC beneficiaries. These interventions were delivered through 76 local nongovernmental, community-based, and faith-based partners, each of whom served from 1,000 to 4,800 OVC beneficiaries. All local partners provided the same package of OVC services and assessed beneficiary needs using the same methodology and criteria. Community home visitors played a lead role in assessing household needs through monthly visits and an annual household vulnerability assessment. They were also the primary service providers to registered OVC and their households. Each community home visitor was to have a maximum of 50 OVC whom they visited or monitored on a monthly basis or more.

The APHIAplus OVC program included six intervention components. They were:

1. **Healthcare and nutrition**, with a focus on child's health status, HIV status of child and caregiver, immunization of children under age five, growth monitoring, and deworming. Community home visitors help link sick children to health facilities to access care. APHIAplus directly supports some of these facilities and is networked with others. The project offers community sessions on how to feed children. And for the severely malnourished, it provides therapeutic food to children and adults and refers them to health facilities.
2. **Shelter and care**, with a focus on the well-being of the OVC. Services include housing renovation (e.g., roofing, walls, etc.); bedding (e.g., procurement of mattresses and blankets); and clothing (e.g., children who lack clothes are linked with providers of home clothes).
3. **Psychosocial support**. A range of services are provided, starting with counseling related to HIV testing services, parental support, children's forums, and kids' clubs. Children, especially adolescents, are often linked to peer educators. The project arranges for professional counseling, as needed, to supplement lay counseling. Career mentoring is also provided.
4. **Child protection services**. APHIAplus facilitates birth registration with the Department of Civil and Vital Statistics for children to obtain birth certificates and pays fees, as needed. The project also trains child protection champions in the community to report on abuse, and it works closely with the Department of Child Services to establish and strengthen child protection structures. Foster parenting services are provided for children who are abused in their homes.
5. **Education support**. OVC households submit requests for payment of children's school fees. Review committees established by local partner organizations evaluate the requests based on established criteria and make recommendations for support, which may include direct payment to the school or links to and coordination with other sources of support, e.g., Ministry of Education

bursaries. Community home visitors follow up on children’s school attendance. Additionally, APHIAplus provides school uniforms, scholastic materials, and sanitary pads for girls.

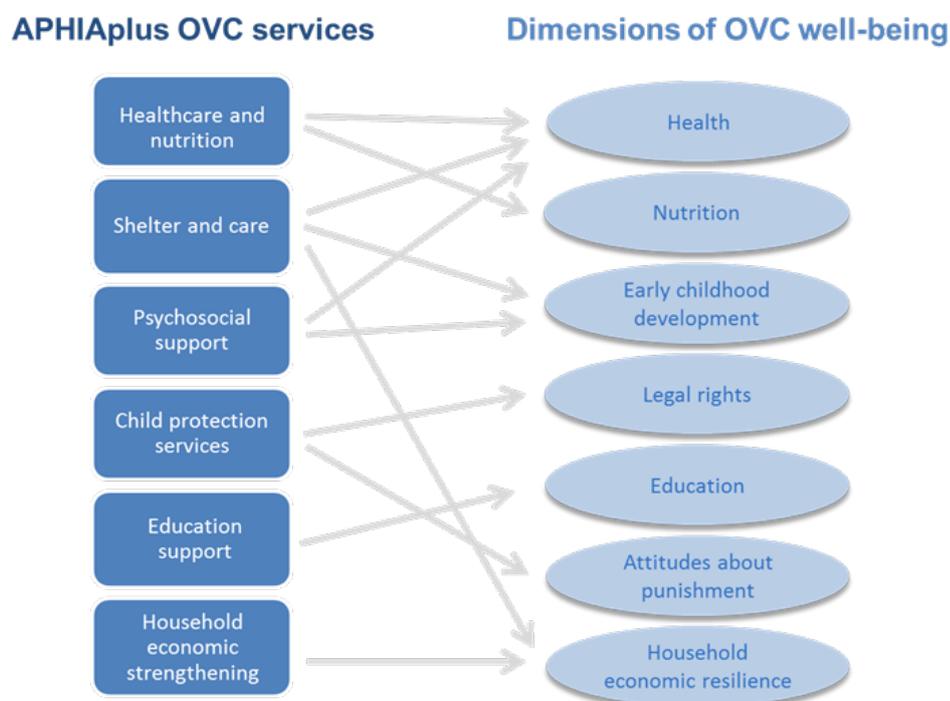
6. **Household economic strengthening.** Various types of support are provided, including provision of inputs to household, e.g., goats, chickens, etc., for income generation; capacity building to promote savings practices to diversify household income; support for savings groups; and links to vocational training, especially for older OVC to help them get jobs quickly and sustain themselves and their families.

Emphasis of interventions has continued to shift toward supporting children and caregivers to know their HIV status, linkages to health services for those testing positive, as well household economic strengthening. Households “graduate” out of the program based largely on economic capacity. In the first nine months of 2016, approximately 1,000 households with 4,814 children had graduated from APHIAplus support.

Conceptual Framework

The PEPFAR MER OVC ESIs measure seven dimensions of OVC and caregiver (or household) well-being. Figure 1 shows how the APHIAplus OVC program maps directly to these dimensions. Many of the services indirectly contribute to the various dimensions of well-being, which themselves are interrelated. For example, household economic strengthening activities are hypothesized to also contribute to child health, nutrition, and educational enrollment and performance. Similarly, psychosocial support contributes to better psychological well-being, which in turn potentially enhances the benefits of other services and indirectly affects most of these dimensions of OVC well-being.

Figure 1. Conceptual framework mapping APHIAplus service to OVC well-being



Survey Indicators and Questionnaire

The survey interview focused on collecting data for the nine PEPFAR OVC MER ESIs and two supplemental indicators of interest to APHIAplus and PEPFAR Kenya program managers. These indicators, their associated PEPFAR MER reference names (OVC_KE1 and OVC_KE2 represent the two supplemental indicators), and the rationale for their inclusion in the survey are presented in Table 1. They are categorized according to the dimension of OVC well-being they represent.

Table 1. PEPFAR MER OVC essential survey indicators and two supplemental indicators (from MEASURE Evaluation, 2014)

Reference 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_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/his caregiver, the child will not have access to lifesaving care, treatment, and support interventions.
OVC_KE1	Percent of children (aged 0–17 years) living with HIV who are taking ARV drugs	This <u>supplemental indicator</u> 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.
Nutrition		
OVC_NUT	Percent of children (aged 6–59 months) who are undernourished	Nutrition is a critical factor in reducing infant mortality and builds a strong foundation for a child's health, growth, and development. <i>For this indicator, the interviewer will obtain measurement of mid-upper arm circumference (MUAC) for children ages 6–59 months. It is the only indicator whose measurement requires direct interaction with a child.</i>
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.
Legal rights		
OVC_BCERT	Percent of children (aged 0–17 years) who have a birth certificate	Ensuring children 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.

Reference Name	Indicator	Rationale for Inclusion
Education		
OVC_SCHATT	Percent of children (aged 5–17 years) regularly attending school	Despite being important in its own right, efforts to keep children in school have 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.
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	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_KE2	Percent of households able to access money to pay for household expenses	This <u>supplemental indicator</u> is routinely collected by the implementing partners that provide OVC services. Collecting data for this indicator through the MER ESI survey will allow for data triangulation/validation and provide another measure of household economic well-being.
OVC_MONEY	Percent of households able to access money to pay for 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.

The nine PEPFAR MER OVC ESIs were vetted and selected in 2014 by the 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 indicators can be found in the MEASURE Evaluation guidance developed for the surveys (MEASURE Evaluation, 2014).

Interviews were conducted with caregivers using a standardized questionnaire previously developed by MEASURE Evaluation for the PEPFAR OVC Technical Working Group specifically for the purpose of collecting data for the MER OVC Essential Survey Indicators. The survey questionnaire included three components: (1) caregiver, (2) child ages zero to four years, and (3) child ages five to 17 years. The survey team made only minor modifications to the standardized questionnaire to adapt it to the Kenya context. Specifically, questions were added to measure the two supplemental indicators, and the names of the local OVC project partners were inserted into questions that referenced the APHIAplus project. Additionally, the questionnaire was translated into Kiswahili, Luhya, and Luo, the primary languages spoken among the project beneficiaries. 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 Appendix 1.

Ethics Review and Compliance for the Surveys

Institutional review board (IRB) review of the study protocol for the three surveys was sought and approval was received from the Amref Ethics and Scientific Review Committee in Kenya and Health Media Lab IRB in the U.S. Administrative clearance was provided by the Kenya National Commission for Science, Technology and Innovation. All study activities adhered strictly to U.S. and international research ethics guidelines, including 45CFR46 and CIOMS.

Survey Design

The survey team employed a two-stage, 40x12 design for the APHIAplus MER ESI survey. The sampling frame comprised the list of all households served by the APHIAplus OVC project as of October 2016. The list, which was provided by the project, included 110,202 households located within 218 administrative wards. The survey team worked with the APHIAplus data management team to correct missing information and data inconsistencies in the list prior to selection of the sample.

At the first sampling stage, 40 clusters, defined by ward, were randomly selected from among the wards served by the project proportionate to the number of households in each ward. At the second stage, 12 households were randomly selected from within each of the 40 selected clusters. This yielded a total sample size of 480 households.

Survey interviews were conducted with the primary caregivers of the children residing 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 to 17 (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 APHIAplus OVC program and those who were not. However, registration status was recorded for each child.

Field Data Collection

Survey data collection was conducted by a trained team comprising a field coordinator, two field supervisors, and 10 field interviewers between November 28 and December 17, 2016. The team worked with APHIAplus local implementing partners to locate the selected households using information from the household listing, e.g., village, name of the community home visitor assigned by the local partner to support the household, the caregiver's name, and telephone contacts. In most instances, the community home visitor or other members of the local implementing partner organization accompanied the data collection team to the household and facilitated introductions. This person then left the interview venue prior to the start of the interview.

Field interviewers sought informed consent from the caregiver. Adult caregivers (i.e., those age 18 and above) were asked to consent to their own participation and to the participation of children in the household ages six to 59 months (for the MUAC assessment). For caregivers who were minors (i.e., under age 18), informed consent was sought from the minor's guardian, and assent was sought from the minor caregiver, emphasizing that her/his participation was voluntary. Consent and assent to participate were documented in written form.

Field interviewers captured responses electronically on password-protected Android tablets that had been preprogrammed with the survey questionnaire using SurveyCTO. The electronic data capture tool

mirrored the paper questionnaire and presented one question per screen. Instructions were included in the tool to guide interviewers and facilitate interview flow. Skip logic was built in and error messages and caution notices were triggered when faulty data were entered to alert interviewers to correct problems. Caregivers were interviewed in a private location out of earshot of others including children and other family members. MUAC measurements on children ages six to 59 months were obtained within the presence of the caregiver. A minimum of three attempts were made to conduct interviews with caregivers who were temporarily absent from the household at the time of the field interviewer visit.

The field team met after each day's work to review experiences of the day and plan for the following day. Field supervisors reviewed all captured data daily, and once approved, they transmitted the data using a mobile Internet connection to the database server located at the APHRC office in Nairobi. The survey team's data analyst at APHRC ran daily checks based on a predesigned data cleaning script in Stata 14 that included checks for structure, uniqueness, and external consistency of key identifiers; completeness of data; acceptable data; and unexpected data. An inconsistency report from the database was then generated and shared with the field team daily. Immediate action/correction (e.g., re-interview, revisit to households for confirmation, etc.) was then taken by the field teams to ensure that high-quality data were collected.

Additional Data Processing and Data Analysis

Once data collection was completed, additional checks were run on the full data file. Minimal edits were required as a result of the data cleaning that took place in real-time as the data were being collected. Once all these checks were performed, a clean version of the data was saved for the analysis. The analytical files included data dictionaries with variable labels, value labels, and other standard specifications. Detailed metadata reports were also generated using Nesstar software. Missing data were minimal; thus, data imputation was not performed.

Data analysis was performed using Stata 14 and verified in SPSS. The essential survey indicators were derived as specified in the MEASURE Evaluation guidance document "Collecting PEPFAR essential survey indicators: A supplement to the OVC survey tools" (MEASURE Evaluation, 2014). Confidence intervals (95%) for the indicator estimates were calculated, incorporating the sample design. Chi-square tests were used to test differences between subgroups. For 2x2 tables, p-values from Fisher's Exact Test (2-sided) were used.

Responses Rates

The field team completed interviews at 426 of the 480 households in the sample giving an overall household response rate of 88.8 percent. Of the 54 households where interviews were not completed, 23 resulted from inaccuracies in the household listing and the remaining 31 were due primarily to temporary or longer-term unavailability of the caregiver or households that could not be located. This information and additional details are presented in Table 2.

Table 2. Household response rates in APHIAplus survey

Category	Number
1. Households served by the APHIAplus OVC program (based on the project listing)	110,202
2. Households in the survey sample (selected for interview from the project listing)	480
3. Sample households (or caregivers) unknown to the local implementing partner, assigned community home visitor, or local guide*	21
4. Sample households found to have with duplicate IDs in the project listing	2
Percentage of sample households not matching the project listing	4.8% (23/480)
5. Sample households that had permanently moved out of the survey area	12
6. Caregivers in sample households reported to be temporarily away from the household for extended period	4
7. Caregivers residing at sample household but could not be located for interview after three attempts	14
8. Caregivers who refused an interview	0
9. Sample households with no resident children under age 18	1
10. Total number of sample households where an interview was not conducted (household nonresponse)	54
Survey household response rate	88.8% (426/480)

*In the event that the caregiver present was not the person named in the project listing of registered households, the "new" caregiver was interviewed, and the local implementing partner was notified of the change.

Interviews conducted at the 426 households resulted in the completion of the three questionnaire components as follows: 426 caregivers, 177 children ages zero to four years, and 1,261 ages five to 17 years. Additional information on the caregiver and children samples is provided in Table 3. Of note, child components of the questionnaire were not completed for some of the children listed by the caregiver as residing in the household due to a protocol violation at the start of the survey. Specifically, initially caregivers were asked about only those children registered with the APHIAplus OVC program. This error was subsequently corrected and the caregiver was asked questions from the child components about all children residing in the household.

Table 3. Questionnaire components completed and other sample information

Sample information	Number
Number of "caregiver" components completed	426
Number of "child ages 0-4 years" components completed	177
Number of "child ages 5-17 years" components completed	1,261
Total number of child components completed	1,438
Number of eligible children in the household (listed by the caregiver)	1,631
Percentage of child components completed among eligible children in the household*	88.2% (1,438/1,631)
Average number of completed child components per household	3.4
Percentage of children listed by caregivers who were registered with the project	55.5% (909/1,631)

* During first three days of data collection, caregivers were interviewed only about children registered with the program due to a misunderstanding regarding the protocol. Thereafter, caregivers were interviewed about all eligible children under their care (those registered and those not registered). Questionnaires were completed for all registered children.

RESULTS

Background Characteristics of the Respondents

Caregivers

The majority of the 426 successfully interviewed caregivers were female (84.0%) and about half, female and male, were between the ages of 31 and 50. The youngest caregiver was age 17 and the oldest, age 94. Nearly 10 percent were age 70 and older. Male caregivers were older than female caregivers ($p=0.006$); over half (57.4%) of male caregivers were ages 51 and over. Nearly all caregivers under age 30 were female. Among all caregivers, 86.6 percent reported ever attending school. About three-quarters of those who attended school (77.5%) reported that primary school was the highest level they attended, while 20.0 percent reported secondary school was the highest level attended. School attendance was somewhat higher among male compared to female caregivers, but the differences were not statistically significant. Details of these caregiver characteristics are given in Table 4.

Table 4. Characteristics of caregivers in the survey

Age (Years)	Female Caregivers		Male Caregivers		Both Sexes		Percentage of Caregivers Who Are Female		
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%			
<18	1	0.3	0	0.0	1	0.2	100.0		
18–30	43	12.0	2	2.9	45	10.6	95.6		
31–50	183	51.1	27	39.7	210	49.3	87.1		
51+	131	36.6	39	57.4	170	39.9	77.1		
All ages	358	100.0	68	100.0	426	100.0	84.0		
Education	Female Caregivers			Male Caregivers			Both Sexes		
	<i>n</i>	<i>N</i>	%	<i>n</i>	<i>N</i>	%	<i>n</i>	<i>N</i>	%
Ever attended school	307	357	85.8	62	68	91.2	369	426	86.6
Highest level attended is primary	242	307	78.8	44	62	71.0	286	369	77.5
Highest level attended is secondary	58	307	18.9	16	62	25.8	74	369	20.0

Children

Table 5 presents the distribution of children represented in the survey by sex and age. A slightly higher number of female children were represented (740 girls and 698 boys), but the age distributions were similar for both sexes. Children ages ten to 14 years made up 40.3 percent of all children sampled. The smallest age group was zero to four years, representing 12.7 percent of girls and 11.9 percent of boys. There were very few infants under the age of one year (six girls and nine boys).

Table 5. Characteristics of children in the survey

Child's Age (Years)	Female		Male		Both Sexes		Percentage of Children Who Are Female
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	
0-4	94	12.7	83	11.9	177	12.3	53.1
0-5 months	3	0.4	4	0.6	7	0.5	42.9
6-11 months	3	0.4	5	0.7	8	0.6	37.5
12-23 months	22	3.0	11	1.6	33	2.3	66.7
2-4 years	66	8.9	63	9.0	129	9.0	51.2
5-9	195	26.4	173	24.8	368	25.6	53.0
10-14	298	40.3	281	40.3	579	40.3	51.5
15-17	153	20.7	161	23.1	314	21.8	48.7
All ages	740	100.0	698	100.0	1,438	100.0	53.1

OVC Services Received

Caregivers were asked if they had personally ever participated in program activities or received services from the APHIAplus local implementing partner in their community. Additionally, they were asked if they had participated in or received these services within the six months preceding the survey. The results are provided in Table 6a. Although all households were registered with the project, only 81.0 percent of caregivers reported ever participating in or receiving services and 65.5 percent reported participation or services in the past six months. Female compared to male caregivers were more likely to report participating in or receiving services; the difference between them, however, was statistically significant only for report of recent services (68.2% vs. 51.5%, respectively, $p=0.012$). On average, those caregivers who reported ever receiving services reported that they started receiving services 44.4 months ago, with a range of one month to 10 years. The observed difference between female and male caregivers was not statistically significant ($p=0.552$).

Table 6a. Caregivers' reports of their OVC project participation or receipt of OVC project services

	Female Caregivers			Male Caregivers			Both Sexes		
	<i>n</i>	<i>N</i>	%	<i>n</i>	<i>N</i>	%	<i>n</i>	<i>N</i>	%
Ever participated in activities or received services	295	358	82.4	50	68	73.5	345	426	81.0
Received services within the past six months	244	358	68.2*	35	68	51.5	279	426	65.5
	<i>n</i>	Mean (S.D.)	Range	<i>n</i>	Mean (S.D.)	Range	<i>n</i>	Mean (S.D.)	Range
Months ago started receiving services or participating in activities	282	44.4 (26.18)	1-120	49	46.8 (29.04)	3-120	336	44.7 (29.59)	1-120

*Difference between females and males is statistically significant based on Fisher's exact test, $p=0.012$.

Caregivers were asked a similar set of questions for each of the children under their care. These results are given in Table 6b. Among children ages zero to four years, 8.7 percent were reported to ever have received services, and 5.6 percent were reported to have received services in the past six months. A

higher percentage of older children, ages five to 17 years, were reported to have received services, 63.9 percent ever and 47.9 percent in the past six months. Differences among female and male children were small and not statistically significant. On average, caregivers reported that the 15 children ages zero to four years who had ever received services started receiving services 14.7 months ago (standard deviation=11.76). The period ranged from one to 36 months. Among the older children, the period ranged from less than one month to 120 months, with an average of 32.9 months (standard deviation=25.05). Observed differences between female and male children were not statistically significant.

Table 7b. Caregivers' reports of children's OVC project participation or receipt of OVC project services

	Female Children Ages 0–4 Years			Male Children Ages 0–4 Years			All Children Ages 0–4 Years		
	<i>n</i>	<i>N</i>	%	<i>n</i>	<i>N</i>	%	<i>n</i>	<i>N</i>	%
Ever participated in activities or received services	10	94	10.6	5	83	6.0	15	177	8.7
Received services within the past six months	6	94	6.4	4	83	4.8	10	177	5.6
	<i>n</i>	Mean (S.D.)	Range	<i>n</i>	Mean (S.D.)	Range	<i>n</i>	Mean (S.D.)	Range
Months ago started receiving services or participating in activities	10	15.5 (12.70)	1–36	5	13.0 (10.77)	2–31	15	14.7 (11.76)	1–36
	Female Children Ages 5–17 Years			Male Children Ages 5–17 Years			All Children Ages 5–17 Years		
	<i>n</i>	<i>N</i>	%	<i>n</i>	<i>N</i>	%	<i>n</i>	<i>N</i>	%
Ever participated in activities or received services	415	646	64.2	391	615	63.6	806	1,261	63.9
Received services within the past six months	328	646	50.8	276	615	44.9	604	1,261	47.9
	<i>n</i>	Mean (S.D.)	Range	<i>n</i>	Mean (S.D.)	Range	<i>n</i>	Mean (S.D.)	Range
Months ago started receiving services or participating in activities	414	31.7 (24.33)	< 1 month –120	391	34.1 (25.77)	1–120	805	32.9 (25.05)	< 1 month –120

Caregivers who reported participating in or receiving services in the past six months were asked about each of the six types of services provided by the APHIAplus project. Caregiver reports of the types of services they had received in the past six months are shown in Table 7. Education and psychosocial counseling were the most commonly reported services (reported by the majority of caregivers), while health or nutrition services were the least likely to be reported (by 20.4% of caregivers).

Table 8. Caregivers' reports of types of services received through the APHIAplus project in the past six months

Type of Services Offered by the APHIAplus Project (N=426)	Number of Caregivers Who Reported Receiving This Service in the Past Six Months	% of Caregivers
Healthcare and nutrition	87	20.4
Shelter and care	117	27.5
Psychosocial counselling	239	56.1
Child protection services	175	41.1
Education support	241	56.6
Household economic strengthening	117	27.5

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% confidence intervals (lower and upper limits) 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

Primary caregivers were asked if the children under their care had been too sick to participate in daily activities at any time within two weeks prior to the survey. Results are presented in Table 8. Caregivers reported about a third (31.4%) of children were too sick to participate in daily activities. No differences between girls and boys were observed. Caregiver reports of child sickness decreased with the age of the child ($p=0.003$).

Table 9. Percent of children too sick to participate in daily activities

Child's Age (Years)	Both Sexes									
	<i>n</i>	<i>N</i>	%	95% CI						
				LL	UL					
0–4	75	177	42.4**	35.2	49.9					
5–9	122	367	33.2	28.2	38.5					
10–14	168	577	29.1	24.7	33.7					
15–17	86	311	27.7	22.5	32.9					
All ages	451	1432	31.5	28.4	34.5					
Child's Age (Years)	Female Children					Male Children				
	<i>n</i>	<i>N</i>	%	95% CI		<i>n</i>	<i>N</i>	%	95% CI	
				LL	UL				LL	UL
0-4	41	94	43.6	33.6	54.2	34	83	41.0	31.9	50.7
5-9	60	195	30.8	24.1	38.3	62	172	36.0	29.1	43.2
10-14	85	297	28.6	23.5	34.2	83	280	29.6	23.5	36.4
15-17	46	150	30.7	22.8	38.5	40	161	24.8	18.1	33.1
All ages	232	736	31.5	27.5	35.5	219	696	31.5	27.4	35.6

**Difference among age groups was statistically significant, $p=0.003$.

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

Caregivers reported that they knew the HIV status of about three-quarters of the children under their care in their households (74.0%). Caregivers were somewhat less likely to know the HIV status of a boy child compared to a girl child, but the difference was not statistically significant (75.6% vs. 72.4%; $p=0.167$). Caregivers were least likely to know the status of children under age five compared to the other age groups, but the differences are not statistically significant. These results are given in Table 9.

Table 10. Percent of children whose primary caregiver knows the child's HIV status

Child's Age (Years)	Both Sexes				
	n	N	%	95% CI	
				LL	UL
0–4	121	177	68.4	58.8	76.6
5–9	286	368	77.7	70.9	83.3
10–14	431	579	74.4	68.4	79.7
15–17	226	314	72.0	64.7	78.2
All ages	1,064	1,438	74.0	68.3	79.0

Child's Age (Years)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
0-4	62	94	66.0	53.0	76.9	59	83	71.1	59.3	80.6
5-9	150	195	76.9	67.8	84.1	136	173	78.6	71.4	84.4
10-14	214	298	71.8	63.5	78.8	217	281	77.2	69.6	83.4
15-17	110	153	71.9	63.3	79.2	116	161	72.0	62.6	79.98
All ages	536	740	72.4	65.6	78.4	528	698	75.6	69.8	80.7

OVC_KE1: Percent of children (aged 0–17 years) living with HIV who are taking ARV drugs

Among those children for whom the caregiver reported knowing her/his status, 5.3 percent were reported by the caregiver to be living with HIV. Among those living with HIV, caregivers reported 87.5 percent were taking ARV drugs. Of note, all children under age 10 living with HIV were reported to be taking ARV drugs. No differences between female and male children were found. Table 10 summarizes these results.

Table 11. Percent of children living with HIV who are taking ARV drugs

Sex of Child	n	N	%	95% CI	
				LL	UL
Children living with HIV (among children whose caregiver knows their HIV status)					
Females	26	536	4.8	3.4	6.9
Males	30	528	5.7	3.6	9.0
Both sexes	56	1,064	5.3	3.7	7.4
Children taking ARV drugs (among children reported by caregivers to be living with HIV)					
Females (all ages)	23	26	88.5	67.2	96.6
0–4 years	3	3	100.0		
5–9 years	9	9	100.0		
10–14 years	8	10	80.0		
15–17 years	3	4	75.0		
Males (all ages)	26	30	86.7	62.5	96.2
0–4 years	1	1	100.0		
5–9 years	9	9	100.0		
10–14 years	14	16	87.5		
15–17 years	2	4	50.0		
Both sexes (all ages)	49	56	87.5	73.8	94.6
0–4 years	4	4	100.0		
5–9 years	18	18	100.0		
10–14 years	22	26	84.6		
15–17 years	5	8	62.5		

Nutrition

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

In accordance with PEPFAR MER OVC ESI guidance, a child was considered undernourished if her/his MUAC measurement fell below 125 mm. A small percentage of children ages six to 59 months (2.5%) were observed to be undernourished according to this classification. No age and sex differences were seen. Of note, the low percentages and small sample sizes did not allow for calculating margins of error for any of these estimates (see Table 11).

Table 12. Percent of children ages 6–59 months who are undernourished

Child's Age (in Months)	Both Sexes				
	n	N	%	95% CI	
				LL	UL
6–11	0	8	0.0	--	--
12–59	4	151	2.6	0.8	8.1
6–59	4	159	2.5	0.8	7.8

Child's Age (in Months)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
6–11	0	3	0.0	--	--	0	5	0.0	--	--
12–59	2	83	2.4	0.6	9.6	2	68	2.9	0.8	10.4
6–59	2	86	2.3	0.6	9.1	2	73	2.7	0.7	9.9

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

Caregivers were asked whether the children under age five in their care had engaged in stimulating activities in the past three days with the caregiver or another household member over 15 years of age. Stimulating activities that were queried included reading books, looking at the pictures in the books, telling stories, singing songs or lullabies, playing with the child, or naming, counting, or drawing things. The most frequently reported activities were singing and playing. Caregivers reported that nearly all children under age five (94.4%) had engaged in at least one type of stimulating activity with an adult within the past three days. No differences between girls and boys were found for any of the activities (for CW.13: 95.7% for girls and 92.8% for boys; $p=0.519$). See Table 12.

Table 13. Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age

Activity	Both Sexes				
	n	N	%	95% CI	
				LL	UL
Read or looked at picture books	67	177	37.9	32.0	44.1
Told stories	82	177	46.3	38.8	54.0
Sang songs or lullabies	149	177	84.2	76.8	89.5
Engaged in play	150	177	84.7	76.8	90.3
Named, counted or drew things	83	177	46.9	39.2	54.7
One or more of these activities	167	177	94.4	89.5	97.0

Activity	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
Read or looked at picture books	37	94	39.4	30.4	49.1	30	83	36.1	28.0	45.1
Told stories	44	94	46.8	36.5	57.4	38	83	45.8	34.3	57.7
Sang songs or lullabies	79	94	84.0	73.1	91.1	70	83	84.3	72.7	91.6
Engaged in play	79	94	84.0	72.8	91.2	71	83	85.5	75.3	92.0
Named, counted or drew things	48	94	51.1	40.1	62.0	35	83	42.2	33.4	51.4
One or more of these activities	90	94	95.7	89.2	98.4	77	83	92.8	84.6	96.8

Percent of children (aged 2–5 years) regularly attending school

In Kenya, early childhood education or pre-primary school begins as early as age two and children typically begin primary education at age six. Although indicators on pre-primary school are not part of the OVC ESI, the APHIAplus survey included children ages two to five years in the survey questions regarding education. Results are given in Table 13. Caregivers reported that a little over half (53.5%) of children ages two to five were enrolled in preschool, about one-third (33.5%) of children regularly attended preschool (i.e., did not miss any school days in the week preceding the survey), and about one-third of those who would have been in school in the previous year, i.e., those ages three to five, about one-third (34.0%) progressed to the next level from the previous year.

Table 14. Percent of children ages 2–5 years who were enrolled, regularly attended, and progressed in preschool

Among Children Ages 2–5 Years	Both Sexes									
	n	N	%	95% CI						
				LL	UL					
Enrolled	107	200	53.5	46.5	60.4					
Regularly attended	67	200	33.5	27.7	39.8					
Progressed (among those ages 3–5 years)	35	103	34.0	24.8	44.5					
Among Children Ages 2–5 Years	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
Enrolled	62	109	56.9	46.2	66.9	45	91	49.5	40.1	58.8
Regularly attended	38	109	34.9	26.4	44.4	29	91	31.9	22.5	42.9
Progressed (among those ages 3–5 years)	23	60	38.3	26.0	52.4	12	43	27.9	14.8	46.3

Legal Rights

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

Caregivers were asked if the children under their care had birth certificates, and if they reported that a child had a birth certificate, they were asked to show the certificate to the interviewer. While caregivers reported that 66.9 percent of children had birth certificates, only 36.2 percent of children had a birth certificate that was seen by an interviewer. Table 14 presents the breakdown of children for whom a birth certificate was seen (the PEPFAR CW.9 definition), by children's sex and age. No sex differences were observed (35.8% among girls vs. 36.7% among boys, $p=0.742$). However, the likelihood of having a birth certificate increased with age ($p<0.001$).

Table 15. Percent of children who have a birth certificate

Child's Age (Years)	Both Sexes				
	n	N	%	95% CI	
				LL	UL
0–4	22	177	12.4***	8.1	18.6
5–9	112	368	30.4	23.7	38.2
10–14	244	579	42.1	35.6	48.9
15–17	143	314	45.5	38.9	52.3
All ages	521	1,438	36.2	31.3	41.5

Child's Age (Years)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
0–4	12	94	12.8	8.0	19.8	10	83	12.0	5.2	25.4
5–9	57	195	29.2	20.7	39.6	55	173	31.8	24.0	40.8
10–14	125	298	41.9	34.1	50.3	119	281	42.3	35.9	49.0
15–17	71	153	46.4	36.5	56.6	72	161	44.7	37.1	52.6
All ages	265	740	35.8	29.6	42.6	256	698	36.7	31.8	41.8

***Difference among the age groups was statistically significant at $p<0.001$.

Education

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

Caregivers reported that most children ages five to 17 under their care were enrolled in school (96.9% of girls and 97.6% of boys). However, only about three quarters (70.7%) of children were reported to be attending school regularly, i.e., enrolled in school and did not miss any days in the school week prior to the interview. No difference in regular attendance between girls and boys was observed (71.7% of girls vs. 69.6% of boys, $p=0.351$). However, attendance varied by age group, with 10- to 14-year-olds showing the highest attendance ($p=0.002$). Regular attendance by sex and age group is presented in Table 15.

In Kenya, children typically begin primary education at age six and secondary education at age 14. Attendance by these age groupings is also given in Table 15. Nearly three-quarters of children were reported to be regularly attending both primary and secondary school (70.9% and 71.8%, respectively).

Table 16. Percent of children regularly attending school

Child's Age (Years)	Both Sexes									
	n	N	%	95% CI						
				LL	UL					
5–9	237	368	64.4**	59.4	69.1					
10–14	434	579	75.0	69.9	79.4					
15–17	220	314	70.1	65.0	74.6					
Ages 5–17	891	1,261	70.7	67.3	73.8					
Age groups according to school levels										
6–13 (Primary)	514	725	70.9	66.9	74.6					
14–17 (Secondary)	334	465	71.8	67.1	76.2					
Child's Age (Years)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
5-9	127	195	65.1	58.3	71.4	110	173	63.6	56.2	70.4
10-14	230	298	77.2	71.3	82.2	204	281	72.6	65.3	78.8
15-17	106	153	69.3	61.50	76.1	114	161	70.8	62.9	77.7
Ages 5-17	463	646	71.7	67.5	75.5	428	615	69.6	65.0	73.9
Age groups according to school levels										
6–13 (Primary)	277	376	73.7	68.5	78.3	237	349	67.9	61.1	74.0
14–17 (Secondary)	162	227	71.4	64.7	77.2	172	238	72.3	65.5	78.1

**Difference among the age groups was statistically significant at $p=0.002$.

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

Table 16 presents the percentage of children reported to have progressed in school during the last year, i.e., the percentage of children whom caregivers reported to be in a higher grade level at the time of the survey compared to the grade they were in the previous school year. Overall, 89.6 percent of children ages five to 17 were reported to have progressed in school, with no difference observed between females and males (89.2% vs. 89.9%; $p=0.52$). No differences in school progression were observed among the age groups five to nine, 10–14, and 15–17.

Looking at age groups defined according to school level shows slightly higher grade progression for primary compared to secondary school (91.3% vs. 87.7%, $p=0.051$). Most of this difference is seen among females (91.9% in primary vs. 85.7% in secondary, $p=0.026$). Differences between females and males within both primary and secondary school were not statistically significant.

Table 17. Percent of children who progressed in school during the past year

Child's Age (Years)	Both Sexes									
	n	N	%	95% CI						
				LL	UL					
5–9	294	327	89.9	86.3	92.6					
10–14	516	575	89.7	87.0	92.0					
15–17	272	306	88.9	84.9	91.9					
Ages 5–17	1,082	1,208	89.6	87.9	91.9					
Age groups according to school levels										
6–13 (Primary)	647	709	91.3	89.3	92.9					
14–17 (Secondary)	400	456	87.7	84.1	90.6					
Child's age (years)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
5–9	157	175	89.7	83.4	93.8	137	152	90.1	84.7	93.8
10–14	266	296	89.9	86.0	92.8	250	279	89.6	85.8	92.5
15–17	131	150	87.3	81.6	91.5	141	156	90.4	83.7	94.5
Ages 5–17	554	621	89.2	86.4	91.5	528	587	89.9	87.4	92.0
Age groups according to school levels										
6–13 (Primary)	340	370	91.9*	88.2	94.5	307	339	90.6	87.5	92.9
14–17 (Secondary)	191	223	85.7	80.2	89.8	209	233	89.7	84.6	93.3

*Difference between progression in primary and progression in secondary school was statistically significant among female children ($p=0.026$).

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

Nearly three-quarters of caregivers (72.5%) agreed that hitting or beating a child is always or sometimes an appropriate means of discipline or control in the home or school. As shown in Table 17, female caregivers were more likely than male caregivers to condone physical punishment (74.6% vs. 60.3%, respectively, $p=0.018$). Older caregivers were somewhat less accepting of harsh physical punishment compared to younger caregivers, but the differences were not statistically significant.

Table 18. Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school

Caregiver's Age (Years)	Both Sexes				
	n	N	%	95% CI	
				LL	UL
<18	1	1	100.0	--	--
18–30	35	44	79.5	64.4	89.3
31–50	154	210	73.3	66.7	79.1
51+	118	170	69.4	61.6	76.3
All ages	308	425	72.5	67.6	76.9

Caregiver's Age (Years)	Female Caregivers					Male Caregivers				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
<18	1	1	100.0	--	--	0	0	0.0	--	--
18–30	33	43	78.6	62.2	89.1	2	2	100.0	--	--
31–50	137	183	74.9	68.6	80.3	17	27	63.0	45.7	77.4
51+	96	131	73.3	64.8	80.4	22	39	56.4	42.3	69.6
All ages	267	357	74.6*	69.7	79.3	41	68	60.3	48.4	71.0

*Difference between female and male caregivers was statistically significant at $p=0.018$.

Household Economic Well-being and Resilience

OVC_KE2: Percent of households able to access money to pay for expected household expenses

Caregivers were asked if their households were able to cover expected household expenses in the past 12 months. Results are provided in Table 18. Overall, 36.9 percent of all households reported that they were able to pay for expected expenses with little difference between female and male caregivers (37.3% vs. 35.3%, respectively, $p=0.786$).

Table 19. Percent of households able to access money to pay for expected household expenses

Sex of the Caregiver	n	N	%	95% CI	
				LL	UL
Females	133	357	37.3	31.3	43.6
Males	24	68	35.3	27.4	44.1
Both sexes	157	425	36.9	31.8	42.4

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

About half of the caregivers (54.6%) reported that they had experienced an unexpected household expense such as a house repair or urgent medical treatment in the last 12 months. Among them, 38.8 percent reported that their households were able to pay for unexpected household expenses. While female caregivers were more likely to report ability to pay than males caregivers, the difference was not statistically significant (40.5% vs. 29.7%, respectively, $p=0.271$). These results are given in Table 19.

Table 20. Percent of households able to access money to pay for unexpected household expenses

Sex of the Caregiver	n	N	%	95% CI	
				LL	UL
Households that experienced an unexpected expense in past 12 months					
Female caregivers	195	357	54.6	46.7	62.0
Male caregivers	37	68	54.4	40.6	67.5
Both sexes	232	425	54.6	46.9	61.8
Households able to access money to pay for unexpected expenses (among those experiencing an unexpected expense)					
Female caregivers	79	195	40.5	30.8	51.0
Male caregivers	11	37	29.7	17.4	45.9
Both sexes	90	232	38.8	29.7	48.8

DISCUSSION

The nine PEPFAR MER OVC essential survey indicators and the two supplemental indicators collected in the survey provided a snapshot of the well-being of children and households served by APHIAplus in late 2016. They fulfill PEPFAR reporting requirements and although they do not necessarily reflect the effect of the program on these various dimensions of well-being, the findings are useful in pointing out potential needs and program gaps.

With regard to **children's health**, nearly a third of children were reported to be too ill to participate in daily activities at some point during the two weeks prior to the survey. Children under age five were less healthy than older children. While there is no reference against which to compare these numbers to gauge the seriousness of the problem, the finding warrants closer examination of the causes of illness and possible interventions. Caregivers reported awareness of the HIV status of about three-quarters of the children under their care. While this knowledge is relatively high (but, again, with no standard of reference), it indicates that a gap remains in efforts to get children tested for HIV and, subsequently, linked to life-saving care and treatment. Of note, a new PEPFAR routine monitoring indicator, HIV_STAT, which similarly measures caregiver awareness of a child's HIV status and will be reported by OVC implementing partners later this year, will provide an additional estimate of this indicator that can be triangulated with these survey results. Caregivers reported that 5.3 percent of children were living with HIV and among them 87.5 percent were taking ARV drugs. All children under age 10 were reported to be taking ARV drugs. The extent of caregivers' unwillingness to disclose a child's HIV status is unknown but may have contributed to under-reporting for this indicator. It is also important to keep in mind that these indicators capture only caregivers' knowledge of a child's HIV status and not whether the child has actually been tested for HIV and knows his/her status. For example, some children, especially older children, may have received an HIV test, know their status, and perhaps be on treatment without their caregivers' knowledge.

Only 2.5 percent of children ages six to 59 months were found to be **undernourished** based on MUAC measurements, suggesting that severe, acute malnutrition may not be a significant problem among APHIAplus beneficiaries. This estimate is consistent with findings from the Kenya Demographic and Health Survey (KDHS) 2014 that showed that Western and Nyanza regions, which are served by APHIAplus, have the lowest levels of wasting in the country (Kenya National Bureau of Statistics [KNBS] and ICF Macro, 2015).

The survey found widespread engagement of caregivers or other household members in stimulating activities with young children in the household. Some 94.4 percent of children were reported to have been read books to, 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 commonly reported activities were singing and playing. Less commonly reported engagement involved telling stories, counting and drawing, and reading books. Given the difference in prevalence among the types of activities, in future rounds of the MER OVC ESI surveys it may be worth also tracking the disaggregated activities in measuring **early childhood development**. For children ages two through five, the survey measured preschool participation as an additional indicator of early childhood development and found that about half (53.5%) were enrolled in preschool, about one-third (33.5%) regularly attended preschool, and about one-third (34.0%) of those who would have been in school in the previous year had progressed to the next level. The World Bank reports about 74 percent enrollment among children ages three to five in government preschools, suggesting that enrollment among APHIAplus beneficiaries may be lower than

among children elsewhere in Kenya (World Bank, 2016). However, the World Bank also reports the ineffectiveness of government preschools in preparing children for primary school. An evaluation is currently under way to assess the impact of low-cost, private preschools on cognitive and noncognitive skills, the results of which may be helpful to inform future OVC programming and measurement strategies for early childhood development.

As a component of its child protection services and in support of **child legal rights**, APHIAplus provides assistance to register births and help children obtain birth certificates. While caregivers reported that 66.9 percent of children had birth certificates, a birth certificate was shown to survey interviewers for only 36.2 percent of children. While the actual estimate of existing birth certificates may lie somewhere between these two estimates, it is still quite low and suggests that there is room for improvement, especially for young children (i.e., those under age five), among whom only 12.4 percent had verifiable birth certificates. These survey estimates are consistent, however, with other findings. For example, in the KDHS 2014, about 20 percent of children under age five in Western and Nyanza regions were reported to have birth certificates, among the lowest in the country (KNBS and ICF Macro, 2015).

Education support was the most frequently reported service received from APHIAplus by the caregivers (i.e., 56.6% of caregiver indicated they had received this support in the past six months), confirming program managers' mention its importance to their program during interviews with the study team. While reported enrollment rates were high (96.9% of girls and 97.6% of boys, ages five to 17), only about three-quarters (70.7%) of children were reported to be attending school regularly. Although reasons for missing school were not asked in the survey, there is some evidence from the child health indicator that school absence may be at least partially due to ill health. A grouping of ages that corresponds to school level showed similar rates of regular attendance for primary and secondary school, 70.9 percent and 71.8 percent, respectively. The KDHS reported higher primary net attendance ratios than those found in the OVC survey (i.e., 87.9% in Western and 84.5% in Nyanza regions). However, secondary school attendance in the OVC survey was found to be twice that of the regional net secondary attendance ratios reported in the KDHS 2014 (i.e., 26.1% and 37.5% of 14- to 17-year-olds in Western and Nyanza regions, respectively, were reported to be attending secondary school). Of note, however, the KDHS rates reflect attendance at any time during the year preceding the survey and, thus, are not entirely comparable to the OVC survey indicator. High rates of grade progression were reported at both primary and secondary school levels (91.3% and 87.7%, respectively). Among girls, the rate of progression in secondary school was lower than in primary school (91.9% vs. 85.7%, respectively); among boys this difference was not observed. This was the only gender difference found among the education indicators. Of note, because the survey collected information only about children who slept within the household on the night before the interview, the education indicator estimates do not include students who were away at boarding school at the time of the survey.

The finding that nearly three-quarters (72.5%) of caregivers agreed that hitting or beating a child is an appropriate means of discipline implies that more efforts should be directed to changing acceptance of **harsh physical punishment** against children. Acceptance of violence against children may reflect cultural norms that condone violence in general. The KDHS 2014 found that physical violence against women and men is most prevalent in Western and Nyanza regions compared to other parts of the country (KNBS and ICF Macro, 2015). The OVC ESI survey found that female caregivers were more accepting of harsh physical punishment toward children than male caregivers, suggesting that norms about child punishment may also be linked to gender norms. This result is consistent with other studies

that have found mothers to be among the most frequently reported perpetrators of physical violence, as reported by children (UNICEF, 2014).

Only 36.9 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 APHIAplus. Among the 54.6 percent of caregivers who reported they had experienced an unexpected household expense, such as a house repair or urgent medical treatment, in the last 12 months, only 38.8 percent reported that their households were able to pay for unexpected household expenses, reflecting low **household economic well-being and resilience**. These findings are supported by KDHS 2014 reports that 44.6 percent and 41.9 percent of households in Western and Nyanza regions, respectively, did not have sufficient food or money to buy food in the seven days preceding the survey. While it will be informative to triangulate the OVC survey findings with routine monitoring data on these indicators, the survey findings suggest that low rates of “graduation” of households from project services, which is based on household economic resilience, likely will continue in the absence of intensified efforts to strengthen household economic resources.

The low reports of participation in or receipt of services from APHIAplus local partners are of potential concern (e.g., 19.0% of caregivers reported they had never received services). Only 65.5 percent reported receiving any service in the past six months, although OVC service delivery guidelines call for monthly visits by community home visitors. An overwhelming majority of caregivers were female (84.0%), and they were more likely to report having received services than male caregivers. Since OVC services are tailored to the prioritized needs of individual children and households, the variation found among the types of services received is not unexpected. However, survey findings that healthcare and nutrition (received by only 20.4% of caregivers) and household economic strengthening services (reported by 27.5% of caregivers) were the least likely to be reported are incompatible with information communicated by program managers that linkages to HIV care and treatment and household economic strengthening currently are focus areas of the project. While the survey data suggest possible gaps in service delivery, they also may reflect shortcomings of the survey methodology. For example, caregivers may have misunderstood the interview questions about the services, since specific services were not described in detail (e.g., linkages to HIV services were not mentioned in the survey question on receipt of health-related services). Recall of services received also may have been inaccurate. Further, there is a possibility that caregivers purposely underreported receipt of services, in an attempt to be considered for more services. Finally, the low reports of program participation may also reflect high mobility of the beneficiary population, as reported by APHIAplus program managers and noted during the survey fieldwork. For example, some caregivers listed in the project register were found to have been replaced by another caregiver, and in these circumstances, the new caregivers were interviewed. It is possible that these “new” caregivers had not personally received services and were unaware of services provided to the household in the past. To address these challenges and improve measurement of program exposure, future survey rounds should consider alternative ways of asking about receipt of services and the addition of questions on how long the caregiver (and, perhaps, also the children) had been living in the household.

There are several additional limitations of the survey that should be considered when interpreting the results. These include: (1) data on children were reported by the caregiver, not the child, and thus, may be subject to inaccuracies and bias with regard to actual child well-being; (2) tradeoffs were made with regard to the size of the sample in order to contain survey costs, which limited precision of indicator estimates and statistical power for comparisons among subgroups; (3) association of the survey team with the local implementing partner during fieldwork (for the purpose of locating beneficiary households) may have

influenced caregiver responses; however, without assistance of the partner, field teams would not have been able to locate the households and likely, as “outsiders,” would have faced refusals for interviews; and (4) the survey was designed for purposes of outcome monitoring only, and the methodology does not allow for attribution of results to the APHIAplus OVC project. Also, of note, the results cannot be generalized to populations outside of the project beneficiary population given that the sample was selected from among project beneficiaries only.

In spite of these limitations, further analyses of the data are worth exploring. For example, while the survey asked about all children in the registered households, only about half of these children as individuals were registered. Comparisons between registered and nonregistered children could be made to determine if registration is associated with the various measures of well-being. The effects of covariates such as caregiver’s age, sex, and education level, as well as the number of children in the household cared for by the caregiver, on the various well-being indicators could also be examined to potentially help target and tailor programming. Similarly, comparisons could be made among those households where caregivers reported receiving services and those which did not to examine the effect of project exposure on outcomes.

RECOMMENDATIONS

The APHIAplus MER OVC ESI survey provided valuable information on the current status of the well-being of APHIAplus project beneficiaries and highlighted several areas that merit further attention.

Specifically, program managers are advised to:

- Examine the causes of childhood illness and possible interventions to address them, given the high prevalence of caregiver reports that children were too ill to participate in daily activities
- Step up efforts to link children to HIV testing services and lifesaving HIV care and treatment
- Explore options for increasing enrollment of young children in cost-effective preschools to promote early childhood development
- Continue project assistance to register births and help children obtain birth certificates, especially for those under age five
- Assess reasons why children enrolled in primary and secondary school are missing school and address the barriers to their attendance; examine and address lower grade progression among girls in secondary school
- Accelerate project efforts to change caregiver norms regarding acceptance of harsh physical punishment towards children
- Intensify efforts to build economic resiliency of OVC households

Project managers are also encouraged to cross-validate and triangulate the survey findings with routine project monitoring data to facilitate interpretation of data from both sources and inform future programming. Given the unexpectedly low rates of caregiver reports of receipt of project services, accuracy of project beneficiary registers should be assessed and the registers should be routinely updated to reflect current program participation and service coverage. This includes reconciling beneficiary records maintained at project headquarters with those kept by local implementing partners and ensuring that beneficiary information at these levels reflects the beneficiary registers kept by frontline case workers and other OVC service providers. New ways of tracking registered children and their caregivers and service delivery should be explored among beneficiary groups known to be highly mobile in order to ensure that those eligible are getting the services they need and that project resources are directed as planned. Finally, changes in the OVC program introduced after this first ESI survey round should be thoroughly documented, to facilitate interpretation of any observed changes in the OVC ESI indicators in the next round of data collection planned for 2018.

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APPENDIX

Questionnaire

MER Indicator Questionnaire: Cover Sheet

IDENTIFICATION DATA

001	QUESTIONNAIRE IDENTIFICATION NUMBER	
002	OVC Service Delivery Partner	Timiza 90 APHIAplus Western Kenya WRP/HJFMRI
002	COUNTY	
003	Subcounty	
005	WARD	
006	VILLAGE/TOWN	
007	TYPE OF LOCATION <i>Circle</i>	Urban 1 Rural 2
008	HOUSEHOLD NUMBER (from sampling list)	[_ _]

INTERVIEW LOG

	VISIT 1	VISIT 2	VISIT 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–Refused to continue and no appointment made; 5–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	Have you personally <u>ever</u> received services or participated in activities from [insert name of OVC CBO]? By this, I mean have you ever been visited by a community worker, or have you ever participated in any activities organized by this organization such as a savings group or parenting program?	Yes 1 No 2 Don't know 8 No answer 9	If No, DK, or No answer: 7
4	How many months/years ago did you start receiving services or participating in activities from [insert name of CBO]?	[____] months [____] years Record 88 for Don't know; 99 for No answer	
5	Have you personally received services or participated in activities from [insert name of CBO] in the <u>last 6 months</u> ?	Yes 1 No 2 Don't know 8 No answer 9	
6	What types of services have you or other members of your household received from [organization] in the past 6 months? Read each type.		
	6.1 Health or nutrition	Yes 1 No 2 Don't know 8 No answer 9	
	6.2 Education	Yes 1 No 2 Don't know 8 No answer 9	
	6.3 Shelter	Yes 1 No 2 Don't know 8 No answer 9	

No.	Question	Coding Category	Skip
	6.4 Household economic strengthening	Yes 1 No 2 Don't know 8 No answer 9	
	6.5 Legal and social protection	Yes 1 No 2	
	6.6 Psychosocial counselling	Yes 1 No 2	
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?	Pre-primary/nursery/ECD . . .0 Primary1 Secondary2 College3 University4 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 <u>in the home</u> ?	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 <u>at school</u> ?	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	

No.	Question	Coding Category	Skip
11	Has your household been able to cover <u>expected</u> household expenses in the last 12 months?	Yes 1 No 2 Don't know 8 No answer 9	
12	Did your household incur any <u>unexpected</u> 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: 14
13	Was your household able to pay for these expenses?	Yes 1 No 2	
14	How many children ages 0–17 years are you responsible for?	[_____] children	

Starting with the oldest, please tell me the first names and ages of the children you care for or for whom you are responsible. **Make sure that the total number of children is the same as the response given to question 14 above.**

No.	First name	Age (years)	Questionnaire		Registered beneficiary of [organization's] OVC program
			0–4 years	5–17 years	Y/N
1	<i>Example. Samuel</i>	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	
3	3.1 Does [NAME] have a birth certificate?	Yes 1 No 2 Don't know 8 No answer 9	
	3.2 Could you please show me [NAME'S] birth certificate?	Seen/Confirmed 1 Not seen/Not confirmed 2	
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 (a) through (e) one at a time.	Yes No DK NR	
		(a) Read books to or looked a picture books with [NAME]?	1 2 8 9
		(b) Told stories to [NAME]?	1 2 8 9
		(c) Sang songs to [NAME] or with [NAME] including lullabies?	1 2 8 9
		(d) Played with [NAME]?	1 2 8 9
(e) Named, counted, or drew things with [NAME]?	1 2 8 9		
5	Is [NAME] currently enrolled in school (Early Child Development)?	Yes 1 No 2 Don't know 8 No answer 9	If No, DK, or No answer: 8

No.	Question	Coding Category	Skip
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 ECD grade (or year) is [NAME] in now?	[][] Record 88 for Don't know; 99 for No answer	
8	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: 10
9	What ECD grade (or 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	
11	May I measure your child's mid-upper arm circumference? 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	
12	Has [NAME] ever received services or participated in activities from [insert name of CBO]?	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 [insert name of CBO]?	[] months Record 88 for Don't know; 99 for No answer	
14	Has [NAME] received services or participated in activities from [insert name of CBO] in the last 6 months?	Yes 1 No 2 Don't know 8 No answer 9	

No.	Question	Coding Category	Skip
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, or 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, or No answer: end
18	Is [NAME] currently taking antiretroviral (ARV) drugs?	Yes 1 No 2 Don't know 8 No answer 9	

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

Age group	5–9 years	10–14 years	15–17 years
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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	
	3.2 Could you please show me [NAME’S] birth certificate?	Seen/Confirmed 1 Not seen/Not confirmed 2	
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?	Pre-primary/nursery/ECD . . . 0 Primary 1 Post-primary training 2 Secondary 3 Post-secondary training 4 College 5 Vocational training 6 University 7 Don’t know 8	

No.	Question	Coding Category	SKIP
	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?	Pre-primary/nursery/ECD . . . 0 Primary 1 Post-primary training 2 Secondary 3 Post-secondary training 4 College 5 Vocational training 6 University 7 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	
10	Has [NAME] ever received services or participated in activities from [insert name of CBO]?	Yes 1 No 2 Don't know 8 No answer 9	If No, DK, or No answer: 13
11	How many months ago did [NAME] start receiving services or participating in activities from [insert name of CBO]?	[] months Record 88 for Don't know; 99 for No answer	
12	Has [NAME] received services or participated in activities from [insert name of CBO] in the last 6 months?	Yes 1 No 2 Don't know 8 No answer 9	

No.	Question	Coding Category	SKIP
13	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
14	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
15	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
16	Is [NAME] currently taking antiretroviral (ARV) drugs?	Yes 1 No 2 Don't know 8 No answer 9	

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. TR-17-221

ISBN 978-1-9433-6486-2

