



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

Walter Reed Program/Henry Jackson  
Foundation Medical Research International  
2016 Survey Findings

January 2018



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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 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. 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 U.S. Department of Defense project led by Walter Reed Program/Henry M. Jackson Foundation Medical Research International (WRP/HJFMRI); the U.S. Centers for Disease Control and Prevention project, Timiza 90; and the USAID project, APHIAplus Western Kenya. 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 the WRP/HJFMRI project. Survey results for the other two PEPFAR projects are reported separately.

At the time of the survey, the WRP/HJFMRI project was providing OVC services to about 9,000 households in Bomet, Kericho, and Narok counties. Using a two-stage, cluster randomized design, the MEASURE Evaluation survey team selected a sample of 477 beneficiary households and conducted survey interviews with 353 caregivers about themselves, their households, and 1,136 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 ESI and two supplemental indicators, presented below, provided a snapshot of the well-being of children and households served by the WRP/HJFMRI project in late 2016 and fulfilled PEPFAR reporting requirements. Although the survey was not designed to assess the effectiveness of the WRP/HJFMRI 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 among those under age five; 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; 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). Also, awareness among caregivers of children's HIV status was quite high, and nearly all children reported to be living with HIV were reported to be taking antiretroviral (ARV) drugs. 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 the WRP/HJFMRI OVC project

Reference Name	Indicator	n	N	%	95% Confidence Interval	
					LL	UL
<b>Health</b>						
OVC_SICK	Percent of children (aged 0–17 years) too sick to participate in daily activities	213	1,136	<b>18.8</b>	15.8	22.2
OVC_HIVST	Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status	755	1,136	<b>66.5</b>	60.6	71.9
OVC_KE1	Percent of children (aged 0–17 years) living with HIV who are taking antiretroviral (ARV) drugs	33	38	<b>86.8</b>	8.1	95.3
<b>Nutrition</b>						
OVC_NUT	Percent of children (aged 6–59 months) who are undernourished	2	129	<b>1.6</b>	0.4	6.0
<b>Early childhood development</b>						
OVC_STIM	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	152	171	<b>88.9</b>	82.8	93.0
<b>Legal rights</b>						
OVC_BCERT	Percent of children (aged 0–17 years) who have a birth certificate	210	1,136	<b>18.5</b>	14.5	23.3
<b>Education</b>						
OVC_SCHATT	Percent of children (aged 5–17 years) regularly attending school	709	965	<b>73.5</b>	69.3	77.3
OVC_PRGS	Percent of children (aged 5–17 years) who progressed in school during the last year*	768	906	<b>84.8</b>	81.7	87.4
<b>Attitudes about child punishment</b>						
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	248	353	<b>70.3</b>	66.0	74.2
<b>Household economic well-being and resilience</b>						
OVC_KE2	Percent of households able to access money to pay for expected household expenses	91	353	<b>25.8</b>	19.3	32.3
OVC_MONEY	Percent of households able to access money to pay for unexpected household expenses	30	223	<b>13.4</b>	8.6	20.5



# 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 [NASCOPI], 2014). In 2015, 660,000 children under age 18 were orphaned because of a parent dying from 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 United States Department of Defense HIV and AIDS project, implemented by the WRP/HJFMRI
- The United States Centers for Disease Control and Prevention project Timiza 90 (formerly Pamoja Project), implemented by Elizabeth Glaser Pediatric AIDS Foundation
- The USAID project APHIAplus Western Kenya, implemented by PATH

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 survey. 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 survey. 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 WRP/HJFMRI project. The other two surveys are presented separately.

## **Intended Use of This Report**

This report describes the methods used to conduct the WRP/HJFMRI project 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 WRP/HJFMRI project better understand the well-being of its beneficiaries 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 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: WRP/HJFMRI OVC Program

The survey team conducted interviews with WRP/HJFMRI project managers and managers of two of its four 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. The WRP/HJFMRI OVC program is part of a larger PEPFAR project led by WRP/HJFMRI and funded through the U.S. Department of Defense. The OVC program began in 2004. It works now in three counties: Bomet, Kericho, and Narok in the Rift Valley region. Adult HIV prevalence is 2.5 percent in Bomet, 3.5 percent in Kericho, and 3.1 percent in Narok. Prevalence in all three counties is lower than the national average of 5.9 percent (NASCO, 2016).

OVC interventions are delivered through the four local faith-based and nongovernmental partners. All local partners provide the same package of OVC services and assess beneficiary needs using the same methodology and criteria. Community health volunteers play a lead role in assessing household needs twice annually and delivering services through quarterly visits, or more frequently if needed. Services are tailored to the needs of the individual child and household.

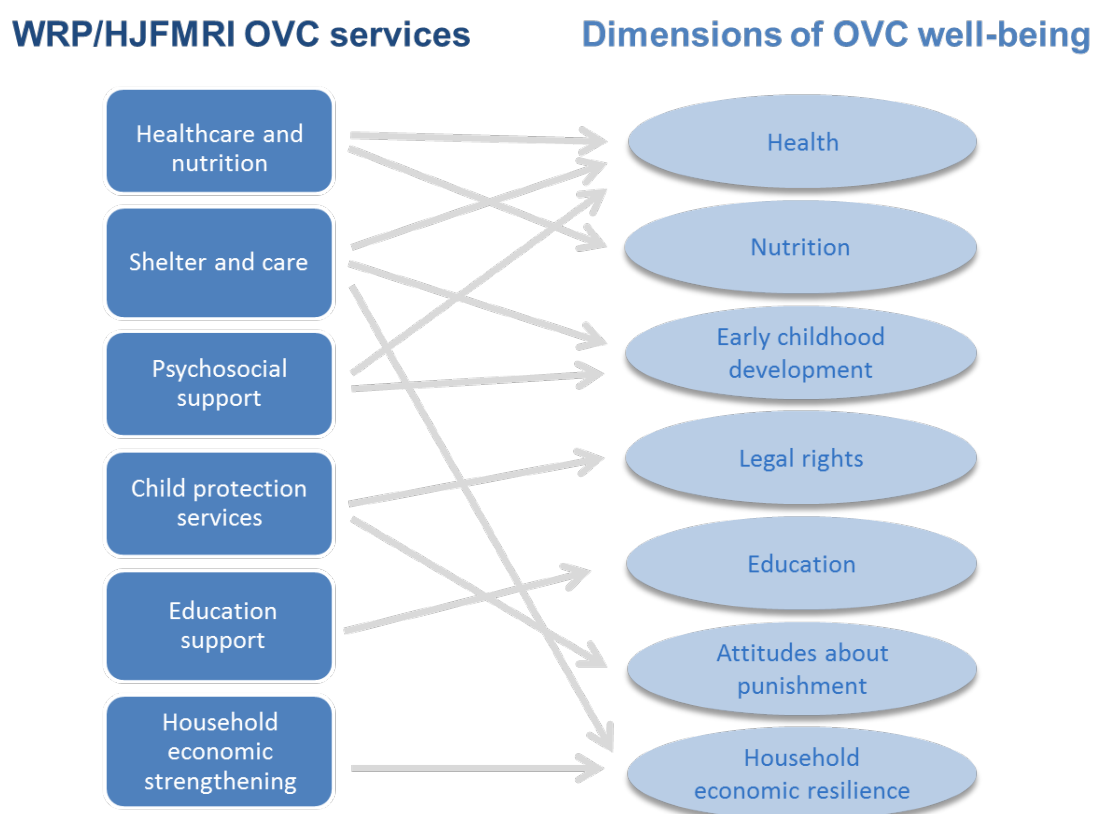
The WRP/HJFMRI OVC program includes six intervention components. They are:

1. **Healthcare and nutrition.** Three of the four local partners are linked directly to affiliated health facilities, and one partner links OVC beneficiaries through referrals to the district hospital and other nearby PEPFAR-supported health facilities. Support includes HIV testing (for children and caregivers), facilitating access of children to HIV care and treatment, and treatment (or financial assistance for treatment) for minor child ailments. With regard to nutrition, based on assessed needs, partners may provide food or provide food supplements/medications.
2. **Shelter and care** with a focus on the well-being of the OVC. Services and products include house rebuilding (to local standards); housing renovation (e.g., roofing, walls, etc.); bedding (e.g., procurement of mattresses and blankets); clothing; and soap and personal care items.
3. **Psychosocial support.** A range of services are provided, including counseling related to HIV testing services, parental support, and children's forums. Local partners conduct home visits, explore the household problems, and provide individual and group counseling for both children and caregivers. The *Families Matter!* program curriculum is used to educate parents and caregivers on positive parenting and effective parent-child communication about sexuality and sexual risk reduction, including risk for child sexual abuse and gender-based violence.
4. **Child protection services.** WRP/HJFMRI facilitates birth registration with the Department of Civil and Vital Statistics for children to obtain birth certificates, and it provides support for living parents to obtain wills and for families to obtain death certificates. Local partners also network with government child protection services and train children on caregiver abuse and negligence.
5. **Educational support.** Based on assessed need, local partners provide payment of school fees (primary, secondary, and vocational training), support for uniforms (shoes and clothing), sanitary pads for girls, and scholastic materials (e.g., writing materials and pens). Local partners monitor school attendance and performance and offer career counseling and guidance sessions. They also work with school management committees on issues such as punishment and accountability.
6. **Household economic strengthening.** Interventions currently focus on training or linkages to training programs for caregivers (e.g., in agriculture, business skills, etc.) and linkages/referrals to financial programs and services.

## Conceptual Framework

The PEPFAR MER OVC ESIs measure seven dimensions of OVC and caregiver (or household) well-being. Figure 1 shows how the WRP/HJFMRI OVC program maps directly to these dimensions. Many of the services also 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 impacts most of these dimensions of OVC well-being.

Figure 1. Conceptual framework mapping WRP/HJFMRI services 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 WRP/HJFMRI 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
<b>Health</b>		
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 life-saving 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.
<b>Nutrition</b>		
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>
<b>Early childhood development</b>		
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.
<b>Legal rights</b>		
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
<b>Education</b>		
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.
<b>Attitudes about child punishment</b>		
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.
<b>Household economic well-being and resilience</b>		
OVC_KE2	Percent of households able to access money to pay for expected 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 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.

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 ESI surveys. 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 WRP/HJFMRI 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 WRP/HJFMRI MER ESI survey. The sampling frame comprised the listing of all households served by the WRP/HJFMRI OVC project in Bomet, Kericho, and Narok counties as of October 2016. The listing, which was provided by the project, included 8,952 households located within 53 administrative wards. The survey team worked with the WRP/HJFMRI data management team to correct missing information and data inconsistencies in the listing prior to selection of the sample.

At the first sampling stage, 40 clusters, defined by ward, were 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 all but one of the selected clusters, where only nine registered households resided and all were selected. This yielded a total sample size of 477 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 WRP/HJFMRI 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 18, 2016. The team worked with WRP/HJFMRI 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 years 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 in 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 on a daily basis. 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). Ninety-five percent confidence intervals (CI) were calculated, taking into account the cluster sample design. Chi-square tests were used to test differences between sub-groups. For 2x2 tables, p-values from Fisher's Exact Test (2-sided) were used.

## **Responses Rates**

The field team completed interviews at 353 of the 477 households in the sample, giving an overall household response rate of 74.0 percent. Of the 124 households where interviews were not completed, 29 resulted from inaccuracies in the household listing, 42 had permanently moved out of the survey area, 41 were due to temporary or longer-term unavailability of the caregiver, and the remaining 12 were refusals. This information and additional details are presented in Table 2.



**Table 2. Household response rates in WRP/HJFMRI survey**

Category	Number
1. Households served by the WRP/HJFMRI OVC program (based on the project listing)	1,617
2. Households in the survey sample (selected for interview from the project listing)	477
3. Sample households (or caregivers) unknown to the local implementing partner, assigned community home visitor, or local guide <sup>†</sup>	29
<b>Percentage of sample households not matching the project listing</b>	<b>6.1% (29/477)</b>
4. Sample households that had permanently moved out of the survey area	42 <sup>††</sup>
5. Caregivers in sample households reported to be temporarily away from the household for extended period	13
6. Caregivers residing at sample household but could not be located for interview after three attempts	28
7. Caregivers who refused an interview	12 <sup>†††</sup>
8. Total number of sample households where an interview was not conducted (household nonresponse)	<b>124</b>
<b>Survey household response rate</b>	<b>74.0% (353/477)</b>

<sup>†</sup> 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.

<sup>††</sup> This includes three households reported to have relocated more than two years ago.

<sup>†††</sup> Nine of 12 caregivers indicated that they would not participate because they feared stigmatization as a result of participating. Community home visitors indicated that this was because these individuals are living with HIV. Eight of these nine caregivers resided in the same cluster/ward.

Interviews conducted at the 353 households resulted in the completion of the three questionnaire components as follows: 426 caregivers, 177 children ages zero to four years, and 1,261 children ages five to 17 years. Additional information on the caregiver and child 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 WRP/HJFMRI 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**

<b>Sample Information</b>	<b>Number</b>
Number of “caregiver” components completed	353
Number of “child ages 0–4 years” components completed	171
Number of “child ages 5–17 years” components completed	965
Total number of child components completed	1,136
Number of eligible children in the household (listed by the caregiver)	1,210
<b>Percentage of child components completed among eligible children in the household<sup>†</sup></b>	<b>93.9%</b> <b>(1,136/1,210)</b>
Average number of completed child components per household	3.2
Percentage of children listed by caregivers who were registered with the project	66.3% (802/1,210)

<sup>†</sup>During first several 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 353 successfully interviewed caregivers were female (81.3%) and about half were between the ages of 31 and 50. The youngest caregiver was age 18 and the oldest, age 84. The age distributions among female and male caregivers were similar. Among all caregivers, 81.0 percent reported ever attending school. While female caregivers were somewhat less likely to have attended school compared to male caregivers, the difference was not statistically significant (79.4% vs. 87.9%, respectively,  $p=0.077$ ). More than three-quarters of those who attended school (80.8%) reported that primary school was the highest level they attended. A higher percentage of male compared to female caregivers had attended secondary school or higher (38.0% vs. 14.5%, respectively,  $p<0.001$ ). 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	0	0.0	0	0.0	0	0.0	-		
18–30	55	19.2	7	10.6	62	17.6	88.7		
31–50	148	51.6	41	62.1	189	53.5	78.3		
51+	84	29.3	18	27.3	102	28.9	82.4		
<b>All ages</b>	<b>287</b>	<b>100.0</b>	<b>66</b>	<b>100.0</b>	<b>353</b>	<b>100.0</b>	<b>81.3</b>		
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	228	287	79.4	58	66	87.9	286	353	81.0
Highest level attended is primary	195	228	85.5	36	58	62.1	231	286	80.8
Highest level attended is secondary or higher <sup>†</sup>	33	228	14.5***	22	58	38.0	55	286	19.2

<sup>†</sup> Four female and three male caregivers reported attending college.

\*\*\* Difference between females and males is statistically significant at  $p<0.001$ .

### Children

Table 5 presents the distribution of children represented in the survey by sex and age. About the same numbers of female and male children were represented (571 girls and 565 boys, or 50.3% girls). The age distributions were similar for both sexes. Children ages 10–14 years made up 34.9 percent of all children sampled. The smallest age group was zero to four years, representing 15.8 percent of girls and 14.3 percent of boys. There were very few infants under the age of one year (10 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	90	15.8	81	14.3	171	15.1	52.6
0-5 months	5	0.9	3	0.5	8	0.7	62.5
6-11 months	5	0.9	6	1.1	11	1.0	45.4
12-23 months	13	2.3	14	2.5	27	2.4	48.1
2-4 years	67	11.7	58	10.3	125	11.0	53.6
5-9	160	28.0	152	26.9	312	27.5	51.3
10-14	202	35.4	195	34.5	397	34.9	50.9
15-17	119	20.8	137	24.2	256	22.5	46.5
<b>All ages</b>	<b>571</b>	<b>100.0</b>	<b>565</b>	<b>100.0</b>	<b>1,136</b>	<b>100.0</b>	<b>50.3</b>

### OVC Services Received

Caregivers were asked if they had personally ever participated in program activities or received services from the WRP/HJFMRI 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 6. Only 66.9 percent of all caregivers reported ever participating in or receiving services and only about one-third (34.8%) reported participation or services in the past 6 months. Female compared to male caregivers were more likely to report ever participating in or receiving services (69.3% vs. 56.1%, respectively,  $p=0.043$ ). Female caregivers were also somewhat more likely than male caregivers to report recent participation or services, but the difference was not statistically significant (36.9% vs. 25.8%,  $p=0.114$ ). On average, those caregivers who reported ever receiving services reported that they started receiving services 33.1 months ago, with a range of one month to 120 months. The observed difference between female and male caregivers was not statistically significant ( $p=0.218$ ).

**Table 6a. Caregivers' reports of 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	199	287	69.3*	37	66	56.1	236	353	66.9
Received services within the past six months	106	287	36.9	17	66	25.8	123	353	34.8
	<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	192	34.0 (25.29)	1-120	37	28.5 (22.61)	3-108	229	33.1 (24.91)	1-120

\*Difference between females and males is statistically significant,  $p=0.043$ .

Caregivers were asked a similar set of questions for each of the children under their care. These results are provided in Table 6b. Among children ages zero to four years, 10.5 percent were reported to have ever received services, and 5.8 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, 48.2 percent ever and 29.0 percent in the past six months. Differences among female and male children were small and not statistically significant. On average, caregivers reported that children ages zero to four years who had

ever received services started receiving services 16.8 months ago (standard deviation=11.23). The time period ranged from five to 36 months. Among the older children, the time period ranged from one month to 120 months with an average of 24.7 months (standard deviation=22.71).

**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	7	90	7.8	11	81	13.6	18	171	10.5
Received services within the past six months	4	90	4.4	6	81	7.4	10	171	5.8
	<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	7	10.7 (6.55)	5-24	11	20.6 (12.11)	5-36	18	16.8 (11.23)	5-36
	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	237	481	49.3	228	484	47.1	465	965	48.2
Received services within the past six months	123	481	25.6	109	484	22.5	232	965	24.0
	<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	237	25.0 (21.96)	1-120	228	24.4 (23.50)	1-120	465	24.7 (22.71)	1-120

Caregivers who reported participating in or receiving services in the past 6 months were asked about each of the six types of services provided by the WRP/HJFMRI project. Caregiver reports of the types of services they had received in the past six months are shown in Table 7. Psychosocial counseling, healthcare and nutrition, and education support were the most commonly reported services (reported by 25% to 30% of caregivers). Few (about 10% or less) reported receiving shelter and care, household economic strengthening, or child protection services from WRP/HJFMRI local partners.

**Table 8. Caregivers' reports of types of services received through the WRP/HJFMRI project in the past six months**

Type of Services Offered by the WRP/HJFMRI Project (N=353)	Number of Caregivers Who Reported Receiving This Service in the Past Six Months	% of Caregivers
Healthcare and nutrition	96	27.2
Shelter and care	40	11.3
Psychosocial counseling	106	30.0
Child protection services	25	7.1
Education support	89	25.2
Household economic strengthening	35	9.9

### 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 that 18.8 percent of children were too sick to participate in daily activities. Children under age five were somewhat more likely to have been reported sick compared to the other age groups, but the differences were not statistically significant ( $p=0.255$ ). Similarly, no differences between female and male children were found (17.9% vs. 19.6%, respectively,  $p=0.442$ ).

**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	41	171	24.0	17.8	31.4					
5–9	52	312	16.7	12.6	21.8					
10–14	74	397	18.6	15.1	22.9					
15–17	46	256	18.0	13.5	23.5					
<b>All ages</b>	<b>213</b>	<b>1,136</b>	<b>18.8</b>	<b>15.8</b>	<b>22.2</b>					
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	24	90	26.7	17.3	38.8	17	81	21.0	14.1	30.1
5–9	27	160	16.9	11.0	25.1	25	152	16.4	11.9	22.4
10–14	30	202	14.9	10.8	20.1	44	195	22.6	17.8	28.1
15–17	21	119	17.6	10.1	29.0	25	137	18.2	12.3	26.2
<b>All ages</b>	<b>102</b>	<b>571</b>	<b>17.9</b>	<b>13.7</b>	<b>22.9</b>	<b>111</b>	<b>565</b>	<b>19.6</b>	<b>16.7</b>	<b>22.9</b>

*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 most (66.5%) children under their care in their households. No differences were seen in knowledge of HIV status between girls and boys (66.9% vs. 66.0%, respectively,  $p=0.760$ ) and among the age groups ( $p=0.126$ ). 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	107	171	62.6	52.9	71.3
5–9	212	312	67.9	58.9	75.8
10–14	272	397	68.5	60.8	75.3
15–17	164	256	64.1	56.9	70.6
<b>All ages</b>	<b>755</b>	<b>1,136</b>	<b>66.5</b>	<b>60.6</b>	<b>71.9</b>

Child's Age (Years)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
0–4	54	90	60.0	46.1	72.4	53	81	65.4	54.4	75.1
5–9	105	160	65.6	57.7	72.8	107	152	70.4	56.6	81.2
10–14	145	202	71.8	62.2	79.8	127	195	65.1	56.6	72.8
15–17	78	119	65.5	57.0	73.2	86	137	62.8	56.6	72.8
<b>All ages</b>	<b>382</b>	<b>571</b>	<b>66.9</b>	<b>60.8</b>	<b>72.5</b>	<b>373</b>	<b>565</b>	<b>66.0</b>	<b>59.1</b>	<b>72.3</b>

*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, 5.0 percent were reported by the caregiver to be living with HIV. Among those living with HIV, caregivers reported 86.8 percent were taking ARV drugs. Neither of the differences between female and male children were statistically significant (4.4% vs. 5.6%,  $p=.507$ ; 82.4% vs. 90.5%,  $p=0.999$ ). 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
<b>Children living with HIV (among children whose caregiver knows their HIV status)</b>					
Females	17	382	4.4	2.7	7.3
Males	21	373	5.6	3.4	9.3
<b>Both sexes</b>	<b>38</b>	<b>755</b>	<b>5.0</b>	<b>3.5</b>	<b>7.1</b>
<b>Children taking ARV drugs (among children reported by caregivers to be living with HIV)</b>					
<b>Females (all ages)</b>	<b>10</b>	<b>17</b>	<b>82.4</b>	<b>54.7</b>	<b>94.7</b>
0–4 years	0	1	0.0		
5–9 years	2	3	66.7		
10–14 years	8	9	88.9		
15–17 years	4	4	100.0		
<b>Males (all ages)</b>	<b>19</b>	<b>21</b>	<b>90.5</b>	<b>68.3</b>	<b>97.7</b>
0–4 years	1	1	100.0		
5–9 years	10	11	90.9		
10–14 years	7	8	87.5		
15–17 years	1	1	100.0		
<b>Both sexes</b>	<b>33</b>	<b>38</b>	<b>86.8</b>	<b>68.1</b>	<b>95.3</b>
0–4 years	1	2	50.0		
5–9 years	12	14	85.7		
10–14 years	15	17	88.2		
15–17 years	5	5	100.0		



## 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. Only two children in the sample ages six to 59 months were observed to be undernourished according to this classification (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	2	10	20.0	5.4	52.4
12–59	0	119	0.0	--	--
<b>6–59</b>	<b>2</b>	<b>129</b>	<b>1.6</b>	<b>0.4</b>	<b>6.0</b>

Child's Age (in Months)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
6–11	1	5	20.0	2.3	72.2	1	5	20.0	2.3	72.2
12–59	0	70	0.0	--	--	0	49	0.0	--	--
<b>6–59</b>	<b>1</b>	<b>75</b>	<b>1.3</b>	<b>0.2</b>	<b>10.1</b>	<b>1</b>	<b>54</b>	<b>1.9</b>	<b>0.3</b>	<b>12.3</b>

## 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 or 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. A higher percentage of girls compared to boys were reported to have named, counted, or drawn things (45.6% vs. 29.6%,  $p=0.041$ ); no other differences between girls and boys were found. Caregivers reported most children under age five (88.9%) had engaged in at least one of these types of stimulating activities with an adult within the past three days. Differences between girls and boys on this indicator were not statistically significant (93.3% for girls and 84.0% for boys;  $p=0.087$ ). 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	68	171	39.8	31.7	48.4					
Told stories	82	171	48.0	38.4	57.6					
Sang songs or lullabies	129	171	75.4	64.2	84.0					
Engaged in play	138	171	80.7	73.1	86.5					
Named, counted, or drew things	65	171	38.0	26.9	50.5					
<b>One or more of these activities</b>	<b>152</b>	<b>171</b>	<b>88.9</b>	<b>82.8</b>	<b>93.0</b>					
Activity	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
Read or looked at picture books	41	90	45.6	34.9	56.6	27	81	33.3	24.1	44.0
Told stories	46	90	51.1	40.6	61.6	36	81	44.4	32.3	57.2
Sang songs or lullabies	68	90	75.6	60.9	86.0	61	81	75.3	60.8	85.7
Engaged in play	73	90	81.1	69.3	89.1	65	81	80.2	67.9	88.6
Named, counted, or drew things	41	90	45.6	33.1	58.6	24	81	29.6	16.8	46.8
<b>One or more of these activities</b>	<b>84</b>	<b>90</b>	<b>93.3</b>	<b>85.6</b>	<b>97.1</b>	<b>68</b>	<b>81</b>	<b>84.0</b>	<b>74.4</b>	<b>90.4</b>

### 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 WRP/HJFMRI survey included children ages two to five in the survey questions regarding education. Results are provided in Table 13. Caregivers reported that about half (51.9%) of children ages two to five were enrolled in preschool, while a little more than one-third (37.7%) attended regularly (i.e., did not miss any school days in the week preceding the survey). No differences in enrollment were seen for girls compared to boys. Only about one-third (31.9%) of those who were enrolled in school in the previous year had progressed to the next level. The difference in progression between girls and boys was not statistically significant (28.6% for girls vs. 35.6% for boys,  $p=0.512$ ).

**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	95	183	51.9	43.3	60.5					
Regularly attended	69	183	37.7	29.7	46.5					
Progressed (among those ages 3–5)	30	94	31.9	22.2	43.5					
Among Children Ages 2–5 Years	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
Enrolled	50	93	53.8	41.6	65.5	45	90	50.0	42.2	57.8
Regularly attended	35	93	37.6	27.2	49.4	34	90	37.8	28.2	48.4
Progressed (among those ages 3–5)	14	49	28.6	18.2	41.9	16	45	35.6	21.1	53.2

## 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 32.4 percent of children had birth certificates, only 18.5 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 (18.8% among girls vs. 18.1% among boys,  $p=0.708$ ). However, 15- to 17-year-olds were more likely to have birth certificates than the younger age groups ( $p<0.001$ ).

**Table 15. Percent of children who have a birth certificate**

Child's Age (Years)	Both Sexes				
	n	N	%	95% CI	
				LL	UL
0–4	17	171	9.9	5.4	17.6
5–9	36	312	11.5	7.2	18.0
10–14	74	397	18.6	13.9	24.6
15–17	83	256	32.4	26.0	39.6
<b>All ages</b>	<b>210</b>	<b>1,136</b>	<b>18.5***</b>	<b>14.5</b>	<b>23.3</b>

Child's Age (Years)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
0–4	10	90	11.1	5.3	21.7	7	81	8.6	4.1	17.5
5–9	18	160	11.3	6.3	19.3	18	152	11.8	6.0	22.0
10–14	36	202	17.8	12.8	24.2	38	195	19.5	13.4	27.4
15–17	44	119	37.0	27.0	48.3	39	137	28.5	20.5	38.1
<b>All ages</b>	<b>108</b>	<b>571</b>	<b>18.9</b>	<b>14.7</b>	<b>24.0</b>	<b>102</b>	<b>565</b>	<b>18.1</b>	<b>13.4</b>	<b>23.9</b>

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

## Education

### *OVC\_SCHATT: 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 (95.8% of girls and 93.8% of boys). However, only about three-quarters (73.5%) 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 (74.0% of girls vs. 72.9% of boys,  $p=0.716$ ). Attendance by age group differed somewhat with the highest attendance (77.3%) observed among 10- to 14-year-olds and the lowest (68.4%) among 15- to 17-year-olds ( $p=0.038$ ). 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. Attendance rates were slightly higher among primary compared to secondary school-aged children, but the difference was not statistically significant (74.6% vs. 71.7%, respectively,  $p=0.351$ ). No difference in attendance between female and male children was found at either level.

**Table 16. Percent of children regularly attending school**

Child's Age (Years)	Both Sexes									
	n	N	%	95% CI						
				LL	UL					
5–9	22 7	312	72.8*	64.9	79.4					
10–14	30 7	397	77.3	72.2	81.8					
15–17	17 5	256	68.4	62.5	73.7					
<b>Ages 5–17</b>	<b>70 9</b>	<b>965</b>	<b>73.5</b>	<b>69.3</b>	<b>77.3</b>					
<b>Age groups according to school levels</b>										
6–13 (Primary)	42 4	568	74.6	69.3	79.3					
14–17 (Secondary)	24 3	339	71.7	67.0	76.0					
Child's Age (Years)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
5–9	11 8	160	73.8	65.7	80.5	109	152	71.7	60.8	80.5
10–14	15 5	202	76.7	67.5	83.9	152	195	77.9	72.6	82.5
15–17	83	119	69.7	58.9	78.7	92	137	67.2	60.2	73.5
<b>Ages 5–17</b>	<b>35 6</b>	<b>481</b>	<b>74.0</b>	<b>68.1</b>	<b>79.2</b>	<b>353</b>	<b>484</b>	<b>72.9</b>	<b>68.3</b>	<b>77.1</b>
<b>Age groups according to school levels</b>										
6–13 (Primary)	21 9	293	74.7	68.0	80.5	205	275	74.5	68.7	79.6
14–17 (Secondary)	11 6	162	71.6	62.3	79.4	127	177	71.8	66.1	7.8

\*Difference among age groups is statistically significant,  $p=0.038$ .

*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 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, 84.8 percent of children ages five to 17 were reported to have progressed in school, with no difference observed between females and males (84.7% vs. 84.9%). Progression rates decreased by age ( $p=0.016$ ). Age differences were seen primarily among male children ( $p=0.004$ ); the differences in age groups among female children were not statistically significant ( $p=0.137$ ).

Looking at age groups defined according to school level showed higher rates of grade progression for primary compared to secondary school (88.2% vs. 79.4%, respectively,  $p<0.001$ ). These differences were seen for both female and male children, but the difference was statistically significant only among male children (89.8% vs. 78.8%,  $p=0.002$ ). 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	239	272	87.9	83.5	91.2					
10–14	334	388	86.1	82.2	89.2					
15–17	195	246	79.3	72.5	84.7					
<b>Ages 5–17</b>	<b>768</b>	<b>906</b>	<b>84.8*</b>	<b>81.7</b>	<b>87.4</b>					
<b>Age groups according to school levels</b>										
6–13 (Primary)	479	543	88.2	85.2	90.7					
14–17 (Secondary)	259	326	79.4** *	74.0	84.0					
Child's Age (Years)	Female Children					Male Children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
5–9	123	137	89.8	84.8	93.3	116	135	85.9	77.5	91.5
10–14	164	199	82.4	76.0	87.4	170	189	89.9	85.9	92.9
15–17	94	114	82.5	75.1	88.0	101	132	76.5	66.9	84.0
<b>Ages 5–17</b>	<b>381</b>	<b>450</b>	<b>84.7</b>	<b>80.5</b>	<b>88.1</b>	<b>387</b>	<b>456</b>	<b>84.9**</b>	<b>81.4</b>	<b>87.8</b>
<b>Age groups according to school levels</b>										
6–13 (Primary)	242	279	86.7	81.7	90.5	237	264	89.8	85.9	92.7
14–17 (Secondary)	125	156	80.1	72.8	85.9	134	170	78.8**	71.4	84.7

\* Difference among age groups was statistically significant ( $p<0.016$ ).

\*\*\* Difference between progression in primary and secondary school was statistically significant ( $p<0.001$ ).

\*\* Differences among age groups and school levels among male children were statistically significant ( $p=0.004$  and  $p=0.002$ , respectively).

## 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 (70.3%) agreed that hitting or beating a child is always or sometimes an appropriate means of discipline or control in the home or school. Male caregivers were somewhat less accepting of harsh physical punishment compared to female caregivers, but the difference was not statistically significant (62.1% vs. 72.1%, respectively;  $p=0.135$ ). Acceptance of harsh physical punishment tended to decrease with age, but the differences were not statistically significant ( $p=0.562$ ).

**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	0	0	0.0	--	--
18-30	46	62	74.2	63.0	82.9
31-50	134	189	70.9	64.1	76.9
51+	68	102	66.7	58.3	74.1
<b>All ages</b>	<b>248</b>	<b>353</b>	<b>70.3</b>	<b>66.0</b>	<b>74.2</b>

Caregiver's Age (Years)	Female Caregivers					Male Caregivers				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
<18	0	0	0.0	--	--	0	0	0.0	--	--
18-30	41	55	74.5	61.5	84.3	5	7	71.4	28.5	94.0
31-50	108	148	73.0	64.5	80.0	26	41	63.4	50.9	74.4
51+	58	84	69.0	60.0	76.8	10	18	55.6	37.5	72.3
<b>All ages</b>	<b>207</b>	<b>287</b>	<b>72.1</b>	<b>67.6</b>	<b>76.3</b>	<b>41</b>	<b>66</b>	<b>62.1</b>	<b>52.0</b>	<b>71.3</b>

## 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 given in Table 18. Overall, one-quarter (25.8%) of all households reported that they were able to pay for expected expenses. Male compared to female caregivers were somewhat more likely to report ability to cover expected household expenses, but the difference was not statistically significant (33.3% vs. 24.0%, respectively,  $p=0.083$ ).

**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	69	287	24.0	18.1	31.2
Males	22	66	33.3	20.3	49.5
<b>Both sexes</b>	<b>91</b>	<b>353</b>	<b>25.8</b>	<b>19.5</b>	<b>33.2</b>

### *OVC\_MONEY: Percent of households able to access money to pay for unexpected household expenses*

More than half of caregivers (63.4%) reported that they had experienced an unexpected household expense such as a house repair or urgent medical treatment in the last 12 months. Male compared to female caregivers were somewhat more likely to report having experienced an unexpected expense, but the difference was not statistically significant (69.2% vs. 62.0%, respectively,  $p=0.319$ ). Among them, only 13.5 percent reported that their households were able to pay for the unexpected household expenses. The difference between male and female caregivers was not statistically significant ( $p=0.629$ ). 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	CL
<b>Households that experienced an unexpected response in past 12 months</b>					
Female caregivers	178	287	62.0	54.4	69.1
Male caregivers	45	65	69.2	52.9	80.3
<b>Both sexes</b>	<b>223</b>	<b>252</b>	<b>63.4</b>	<b>56.4</b>	<b>69.4</b>
<b>Households able to access money to pay for unexpected expenses (among those experiencing an unexpected expense)</b>					
Female caregivers	23	178	12.9	8.1	20.0
Male caregivers	7	45	15.6	6.2	34.1
<b>Both sexes</b>	<b>30</b>	<b>223</b>	<b>13.5</b>	<b>8.6</b>	<b>20.5</b>



## 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 the WRP/HJFMRI OVC program 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 one-fifth of children were reported to be too ill to participate in daily activities at some point during the two weeks prior to the survey. 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 HIV status of about two-thirds of the children under their care, suggesting a potential gap 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 5.0 percent of children were living with HIV and among them, most (86.8%) 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.

Very few (1.6%) children ages six to 59 months were found to be **undernourished** based on MUAC measurements. Although this finding suggests that severe, acute malnutrition may not be a problem among young WRP/HJFMRI OVC program beneficiaries, it should be cautiously interpreted, as the sample size for this age group was very small. Nonetheless, the finding is consistent with those from the Kenya Demographic and Health Survey (KDHS) 2014 that showed that Rift Valley region, portions of which are served by WRP/HJFMRI, had relatively low 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. Nearly 90 percent of children were reported to have been read books, told stories, sung 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 (51.9%) of children were enrolled in preschool, about one-third (37.7%) attended regularly, and about one-third (31.9%) of those who were enrolled 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 WRP/HJFMRI beneficiaries may be lower than children elsewhere in Kenya (World Bank, 2016). However, the World Bank also reports 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**, WRP/HJFMRI helps to register births and helps children obtain birth certificates. Caregivers reported that only about one-third (32.4%) of children had birth certificates, and a birth certificate was shown to survey interviewers for only 18.0 percent of children. While the actual estimate of existing birth certificates may lie somewhere between these two estimates, it is still low and suggests there is room for improvement, especially for young children (i.e., those under age 10) among whom only about 10 percent had verifiable birth certificates. These survey estimates are consistent, however, with other findings. For example, the KDHS 2014 reported that only 20.1 percent of children under age five in Rift Valley region had birth certificates, among the lowest in the country (KNBS and ICF Macro, 2015).

While reported **education** enrollment rates were very high (95.8% of girls and 93.8% of boys, ages five to 17), only about three-quarters (73.5%) 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. Regular attendance was highest among 10- to 14-year-olds (77.3%) and lowest among 15- to 17-year-olds (68.4%); this pattern was seen for both boys and girls. Among ages that correspond to school level, similar rates of regular attendance for primary and secondary school were observed, 74.6 percent vs. 71.7 percent, respectively. While the primary attendance rate is similar to the 85.0 percent primary net attendance ratio reported for Rift Valley region in the KDHS 2014, the secondary attendance rate is more than twice that found in the KDHS 2014 (i.e., 27.6% of 14- to 17-year-olds in Rift Valley region were reported to be attending secondary school) (KNBS and ICF Macro, 2015). 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. Progression rates among five-to 19-year-olds were high, i.e., 85 percent for both girls and boys. Grade progression among children of primary school age was higher than that among children of secondary school age, especially for boys.

The finding that nearly three-quarters (70.3%) 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 a high prevalence of physical violence against women and men in Rift Valley region, although the regional prevalence was lower than in surrounding areas. (KNBS and ICF Macro, 2015). Although not statistically significant, the OVC ESI survey found that female caregivers were somewhat 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).

About one-quarter (25.8%) of caregivers reported that their households were able to cover expected household expenses in the past 12 months. The KDHS 2014 reported that 25.4 percent of households in Rift Valley region did not have sufficient food or money to buy food in the seven days preceding the survey, suggesting that the WRP/HJFMRI OVC program is serving the more economically vulnerable households in the geographic areas where it works. A fairly high percentage (63.4%) of caregivers

reported that they had experienced an unexpected household expense, such as a house repair or urgent medical treatment, in the last 12 months, and very few of them (13.5%) reported that their households were able to pay for unexpected household expenses, further reflecting low **household economic well-being and resilience**. It may be informative to triangulate the OVC survey findings with routine monitoring data on these indicators.

Surprisingly, only 66.9 percent of caregivers reported that they had ever participated in or received services from WRP/HJFMRI local partners, and only 34.8 percent reported that they had received a service in the past six months; this raises some concern regarding service delivery coverage, given that OVC service delivery guidelines call for quarterly visits by community health volunteers. Psychosocial counseling was the most commonly reported service (by 30.0% of caregivers), and child protection services were the least reported (by only 7% of caregivers). Since OVC services are tailored to the prioritized needs of individual children and households, however, the variation found among the types of services received was not unexpected. An overwhelming majority of caregivers were female (81.3%), and they were more likely to report having received services than male caregivers. 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, and examples of household economic strengthening activities were not provided). 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. 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) a high household survey nonresponse rate due primarily to inaccuracies or outdated information in the project registration list from which the sample was drawn may have resulted in bias in the estimates; (4) the association of the survey team with the local implementing partner during fieldwork (for the purpose of locating beneficiary households) may have influenced caregiver responses (and led to refusal to participate in the survey among a small number of caregivers); however, without assistance of the partner, field teams would not have been able to locate the households and likely, as “outsiders,” would have faced more refusals for interviews; and (5) the survey was designed for purposes of outcome monitoring only, and the methodology does not allow for attribution of results to the WRP/HJFMRI 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 66.3 percent 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 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 between those households where caregivers reported receiving services and those which did not to examine the effect of project exposure on outcomes.

## RECOMMENDATIONS

The WRP/HJFMRI MER OVC ESI survey provided valuable information on the current status of the well-being of WRP/HJFMRI 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 10
- Assess reasons why children enrolled in primary and secondary school are missing school and address the barriers to their attendance
- 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 in order 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	Urban                      1 <i>Circle</i> 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? <b>Do not leave blank. If unknown, ask respondent to estimate.</b>	[ ____ ] 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	<b>If No, DK, or No answer: 7</b>
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? <b>Read each type.</b>		
	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 Primary . . . . . 1 Secondary . . . . . 2 College . . . . . 3 University . . . . . 4 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? <b>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.</b>	[ ____ ] 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]:  <b>Read out (a) through (e) one at a time.</b>	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	<b>If No, DK, or No answer: 8</b>
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	

No.	Question	Coding Category	Skip
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? <b>Measure the child's mid-upper arm circumference using the MUAC tape and record measurement.</b>	[ ][ ] . [ ][ ] 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	
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

No.	Question	Coding Category	Skip
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?  <b>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.</b>	[ ] [ ] 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	<b>If No, DK, or No answer: 7</b>
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?	<p>[ ][ ]</p> <p>Record 88 for Don't know; 99 for No answer</p>	
7	Was [NAME] enrolled in school during the previous school year?	<p>Yes 1</p> <p>No 2</p> <p>Don't know 8</p> <p>No answer 9</p>	<b>If No, DK, or No answer: 9</b>
8	8.1 What education level did [NAME] attend during the previous school year?	<p>Pre-primary/nursery/ECD . . . 0</p> <p>Primary . . . . . 1</p> <p>Post-primary training . . . . . 2</p> <p>Secondary . . . . . 3</p> <p>Post-secondary training . . . . . 4</p> <p>College . . . . . 5</p> <p>Vocational training . . . . . 6</p> <p>University . . . . . 7</p> <p>Don't know . . . . . 8</p> <p>No answer . . . . . 9</p>	
	8.2 What school grade did [NAME] attend during the previous school year?	<p>[ ][ ]</p> <p>Record 88 for Don't know; 99 for No answer</p>	
9	At any point in the last 2 weeks, has [NAME] been too sick to participate in daily activities?	<p>Yes 1</p> <p>No 2</p> <p>Don't know 8</p> <p>No answer 9</p>	
10	Has [NAME] ever received services or participated in activities from [insert name of CBO]?	<p>Yes 1</p> <p>No 2</p> <p>Don't know 8</p> <p>No answer 9</p>	<b>If No, DK, or No answer: 13</b>
11	How many months ago did [NAME] start receiving services or participating in activities from [insert name of CBO]?	<p>[ ] months</p> <p>Record 88 for Don't know; 99 for No answer</p>	
12	Has [NAME] received services or participated in activities from [insert name of CBO] in the last 6 months?	<p>Yes 1</p> <p>No 2</p> <p>Don't know 8</p> <p>No answer 9</p>	

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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