


Child Status Index

A Tool for Assessing the Well-Being of Orphans
and Vulnerable Children — **MANUAL**



SUPPORT
ORPHANS AND VULNERABLE
CHILDREN

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Karen O'Donnell, Ph.D

Child Psychologist and Associate Professor

Departments of Pediatrics and Psychiatry and Behavioral Science
Duke University Medical Center and Center for Child and Family Health

Senior Research Fellow

Health Inequities Program, International Sector
Duke University Global Health Institute

Florence Nyangara, Ph.D

Senior Research and Evaluation Specialist

M&E Advisor for PEPFAR/OVC Programs
MEASURE Evaluation Project
Futures Group International

Robert Murphy, Ph.D

Senior Research Fellow

Health Inequities Program, International Sector
Duke University Global Health Institute

Beverly Nyberg, Ed.D

Senior Technical Advisor for Orphaned and Vulnerable Children

Office of the United States Global AIDS Coordinator, Department of State

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Abbreviations and Acronyms

ACE	Action in the Community Environment
AFR/SD	Bureau for Africa Office of Sustainable Development
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-Based Organization
CHW	Community Health Workers
CSI	Child Status Index
DCOF	Displaced Children and Orphans Fund
EGAT	Bureau for Economic Growth, Agriculture and Trade
FBO	Faith-based Organization
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
NGO	Nongovernmental Organization
OHA	Office of HIV/AIDS
OGAC	Office of Global AIDS Coordinator
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
POFO	Positive Outcomes for Orphans Research Program
UNAIDS	United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government

Executive Summary

A Tool to Improve Service Delivery for Children Who Have Been Orphaned or Made Vulnerable by HIV/AIDS

The President's Emergency Plan for AIDS Relief (PEPFAR) through the Office of the Global AIDS Coordinator (OGAC) and USAID Office of HIV/AIDS (OHA) requested a tool to assess vulnerabilities, needs, and outcomes of orphaned and other children made vulnerable by HIV/AIDS. This tool would initially be used for monitoring the well-being of children as part of global initiatives supported by PEPFAR. In the past, programs for orphans and vulnerable children (OVC) were generally evaluated by reporting the numbers of children and the services they received. In order to provide the appropriate care, service providers need to know more. They need to be able to systematically assess the needs of children and their households and to evaluate whether their efforts are making a difference. However, there were limited measures of well-being specific to children affected by HIV/AIDS to support such assessment.

The Child Status Index (CSI) was developed to fill this gap. The CSI provides a framework for identifying a child's needs, creating goal-directed service plans, and assessing outcomes with intervention.

Developed through a Community Participatory Process

The CSI was developed through a community participatory process with potential users, including PEPFAR/OVC program implementing partners and community workers and caregivers in Kenya and Tanzania. The domains and factors selected for the Child Status Index—as well as the cultural and linguistic relevance of the ratings on each factor—were derived from a series of informal discussions with community workers, guardians and other service providers in these countries. Each step in developing the index was reviewed by U.S. and international experts.

A Targeted and Child-Centered Assessment Strategy

The result is a child-centered assessment strategy that addresses the areas of a child's life endorsed by guardians, children and other experts as most indicative of the child's relative well-being or vulnerability. The 12 factors of the Child Status Index were chosen because they can be measured on an inferential scale and could potentially be changed by program interventions. The factors also enable a community worker to identify an urgent or emergency need for the child or family.

Field-Tested for Inter-Rater Reliability and Construct Validity

The CSI was successfully field tested for inter-rater reliability and construct validity in Kenya and Tanzania. It has been in trial use in other countries, including Ethiopia, Rwanda, India, and Cambodia—with ongoing feedback from field workers about the applicability of the factors and ratings to their context. The CSI is being adapted and translated for use in different geographical, linguistic and cultural contexts. This manual includes guidelines for making local adaptations.

The complete Child Status Index toolkit includes the CSI tools (rating form and report form), this manual, a Field User's Guide, a CSI Made Easy booklet, and the Pictorial CSI.

Chapter 1. Introduction to the Child Status Index

Scenario – Why is This Tool Important?

A tool for assessing the well-being of orphans and vulnerable children.

The Challenge

The HIV/AIDS pandemic brought a dramatic increase in the number of orphans and vulnerable children (OVC) due to parental illness and death (Children on the Brink, 2004). In sub-Saharan Africa, the area most affected by the disease, there were 12.3 million orphans due to HIV/AIDS in 2003. This number is expected to rise to 15.7 million by 2010 (UNAIDS, 2006). In Swaziland, for example, nearly one-third of all children are orphaned or considered vulnerable because of HIV/AIDS (Swaziland's emergency response council report, November, 2007).

Millions more children in HIV-affected communities are vulnerable because their parents are ill or live in poor communities and households that have absorbed orphans, or they are stigmatized by having HIV/AIDS in their family (Andrews, Skinner, & Zuma, 2006).

These orphans and other vulnerable children face serious problems that affect their growth and development, including the lack of or limited access to health, food, education, love and affection, and safety. These children can also face rejection, discrimination, fear, and loneliness, all of which challenge their outlook and hope for becoming happy and productive members of adult society.

Definition of Orphans and Vulnerable Children

(PEPFAR OVC Programming Guidance, 2006, p. 2)

A child, 0-17 years old, who is either orphaned or made more vulnerable because of HIV/AIDS

Orphan: A child who has lost one or both parents to HIV/AIDS.

Vulnerable: A child more vulnerable because of any or all of the following factors that result from HIV/AIDS:

- Is HIV-positive
- Lives without adequate adult support, such as in a household with chronically ill parents
- Lives in a household that has experienced a recent death from chronic illness
- Lives in a household headed by a grandparent and/or a household headed by a child
- Lives outside of family care, for example, in residential care or on the streets
- Is marginalized, stigmatized, or discriminated against

The Response

In response to this crisis, efforts to care for and support orphaned and vulnerable children became a priority among local and international communities, seen in the increased attention and funding for OVC services in highly affected countries.

The United States government and other donor organizations are working with local communities, grassroots organizations, non-governmental organizations (NGOs), faith based organizations (FBOs), community based organizations (CBOs), and governments of countries with a high prevalence of HIV/AIDS to implement programs of care and support for these children, to reduce the risks they face, to improve their health and well-being, and to give children a reason to hope for a good future.

How well are these programs achieving these aims? What program modifications would yield even better results? What new services are needed? It can be hard to answer these questions, because programs tend to be multi-dimensional in their approach and a child's well-being is the result of many inter-related factors. Programs have traditionally been monitored using summary-level information (e.g., how many children received assistance) or discrete indicators (e.g., a change in school attendance)—neither of which accurately captures the whole of a child's life.

The Importance of Monitoring and Evaluation

Organizations that develop programs for OVC need a relevant and systematic way to assess the impact of their programs on children at the individual level.

In general, several methods can be used to demonstrate program results, including:

- Output or process indicators to demonstrate program achievements (such as how many children have been reached by the program);
- Outcome indicators to show that program interventions made a difference in a child's life (such as improved school attendance);
- Accounting reports to demonstrate effective use of resources (program costs per outcome); and
- Information regarding most effective practices as a basis for improving programs in the future.

Regardless of the array of methods used to measure program progress and participant outcomes, the central goal of evaluating service programs is to show whether and how they benefit those they serve, both directly and indirectly. The holistic, easy-to-use CSI is a step toward systematically monitoring how these programs make a difference in children's lives and improving field-level practices and services.

Description – What Does This Tool Do?

Provides meaningful data about improving the status of orphaned and vulnerable children and to determine the effectiveness of programs.

The CSI provides an easy-to-use tool to assess the current needs of a child, monitor improvements in specific dimensions of child well-being, and identify areas of concern that can served by program interventions. The index gathers information in the following areas:

1. *Food/nutrition:* Does the child have sufficient and nutritious food at all times to grow well and to have an active and healthy life?
2. *Shelter and care:* Does the child have shelter that is adequate, dry and safe? Is there at least one adult who provides consistent love and support?
3. *Protection:* Is the child safe from abuse, neglect or exploitation? Is there adequate legal protection for the child?
4. *Health care:* Is the child healthy? Does he/she have access to preventive and treatment health services?
5. *Psychosocial:* Is the child happy and does he/she have hope for a good life? Does the child enjoy good relationships with other children and adults?
6. *Education:* Is the child performing well at home, school, job training or work and developing age appropriate knowledge and skills? Is the child receiving the education or training he/she needs to develop knowledge and skills?

Data gathered by the Child Status Index can be used in several ways, including:

- Help field staff/caregivers monitor problems and benefits in their efforts in serving children.
- Help identify the specific needs of a child and his/her household and to translate these needs into intervention strategies.
- Help decision-makers plan, implement, and modify child services based on aggregate information about child well-being over time.
- Support advocacy for resources and improvements in service quality.
- Raise awareness among frontline staff (such as community health workers and caregivers) about the multiple dimensions of child well-being to help them understand and address these areas routinely in their work.
- Compare performances within and across programs, countries, and cultures.

This simple, low-cost tool will help stakeholders to monitor systematically and continuously the changes occurring in a child's life in order to promote shared learning, support outcome reporting, inform program decisions, and improve the quality of services to children.

Initially, the tool has been applied to PEPFAR-funded programs that support children affected by HIV/AIDS; but it is applicable to many other organizations that provide programs for disadvantaged or at-risk children. In many arenas, the CSI has potential for building broad consensus on the best ways to serve children.

Audience – Who Would Use this Tool?

The tool is used by those developing and implementing services at different levels.

The CSI was designed primarily for use by community workers and other field personnel working directly with children and their families, but it can also be useful to guide program decisions as well as community and national policies.

Using the Child Status Index to assess an individual child

This type of user...	Would use the CSI to...
Leaders of local program management committees	Replace or supplement hand-written notes to record systematically a child's progress over time.
Local organizations	Identify the needs of a child, household, or community and use the information to develop appropriate interventions.
Leaders of guardian committees (caregiver groups)	Document for themselves the changes in and needs of children under their care and for whom they advocate.
Service providers for NGOs (e.g., food-delivery volunteers)	Track well-being of children in households they visit, especially related to food security and school attendance.
Caregivers/guardians	Share child well-being information with others to advocate for specific needs and track children's progress under their care.

Using the CSI to assess a program

This type of user...	Would use the CSI to...
Program monitoring and evaluation (M&E) staff	Systematically track outcomes of children receiving support from their organizations to improve programs.
Community health workers	Identify community needs and better understand the factors that are agreed upon as good child outcomes.
Other service providers (e.g., donors, community organizations, other partners)	Validate the effects of their program activities, align their activities with changing needs, and lobby effectively for additional resources.

The CSI can also be adapted for research, evaluation, and other population-based surveys.

Timing – When Would the CSI Be Used?

How often the CSI is used depends on how the information will be used, the capacity of the organization or community conducting the assessment, and what other M&E procedures are being used. For example, the CSI can be used to:

- Assess needs at the start of an OVC initiative to select children for programs and/or to design individual care plans for them.
- Compare baseline and end-of-project data for an OVC program.
- Regularly and periodically monitor the needs, services provided, and progress of child well-being, such as every six, 12, or 24 months.
- Collect periodic (e.g., annual or biannual) data for program evaluation research in order to assess the collective needs and well-being of children in a community, region or country.

Chapter 2. Domains and Factors of the Child Status Index

The six broad domains of the CSI parallel the domains on PEPFAR/OVC guidelines: Food and Nutrition; Shelter and Care; Protection; Health; Psychosocial; and Education and Skills Training. For each domain, there are two factors that:

- Have been identified and endorsed as areas of concern;
- Affect the status of that particular domain;
- Can potentially be changed by providing services; and
- Identify urgent situations for the child or household.

For each factor, this manual presents the child-centered goal for that factor, a definition of the factor and why it is important, and examples for observations to be made and questions a field worker could ask to assess the factor.

PEPFAR OVC Service Domain	Child Status Index factor
1 – Food and Nutrition	1A. Food Security 1B. Nutrition & Growth
2 – Shelter and Care	2A. Shelter 2B. Care
3 – Protection	3A. Abuse and Exploitation 3B. Legal Protection
4 – Health	4A. Wellness 4B. Health Care Services
5 – Psychosocial	5A. Emotional Health 5B. Social Behavior
6 – Education and Skills Training	6A. Performance 6B. School and Work

Each of the 12 factors is rated on four levels of well-being. The higher the score, the better the well-being of the child.

- | | |
|---------------------|--|
| 4 = Good | The child's status or situation is good; there are no concerns and no apparent risk for this factor. |
| 3 = Fair | The child's status or situation is generally acceptable, but there are some concerns on the part of the caregiver or field worker. |
| 2 = Bad | There is concern that the child's status or situation on this factor is not good. Additional resources or services are needed. |
| 1 = Very bad | The child is at serious risk on this factor. Urgent attention to the child or the situation may be needed. |

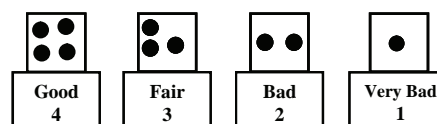
Domain 1 — Food and Nutrition

Does the child have sufficient and nutritious food at all times to grow well and to have an active and healthy life?

Child Status Index Factor 1A: Food Security



Goal: Child has sufficient food to eat at all times of the year.



Food security is defined as the ability of the household or institution to get enough food for the child to eat at all times whenever hungry. This food should be obtained through socially acceptable ways, without resorting to emergency food supplies, scavenging, begging, stealing, or other coping strategies.

Why This Factor is Important

According to existing research on children affected by HIV/AIDS, food security and nutrition is an area of significant vulnerability. Increased risk for poor health and malnutrition among orphans is stressed. At the same time, there are conflicting data about the relationship between orphan status *per se* and malnutrition when they occur in resource-poor countries where poverty and adversity are widespread and not exclusive to orphan status (Sarker, Neckermann, & Muller, 2005).

In the case of the loss of a head of household through illness or death, child vulnerability to hunger and malnutrition is known to increase. Crop production is reduced by as much as 50 percent when the head-of-household dies (Birdthistle, 2004.)

Makame and colleagues reported that orphans talk about lacking food at home, being hungry at school and going to bed hungry (Makame, Ani, & Grantham-McGregor, 2002). In Zimbabwe, almost 25 percent of older orphans interviewed for one study reported that they did not have enough food to eat several times a week or more (Gilborn, Nyonyintono, Kabumbuli, & Jagwe-Wadda, 2001).

Poorly fed children suffer in a number of areas. Food security interacts with other domains and factors that both contribute to and are the consequences of poor nutrition. Severe malnutrition (marasmus, kwashiorkor, and marasmic kwashiorkor) has been found to be associated with HIV in the family (parents or children) and with weaning practices, parent death from any cause, male gender and higher birth order (study in rural South Africa; Saloojee et al., 2007.)

Protective factors for severe malnutrition were diverse food intake and receipt of a state child support grant. Poor nutrition affects other aspects of child well-being. Hungry children may steal food and be labeled as delinquent (e.g., Foster, Makufa, Drew, Mashumba, & Kambeu, 1997).

Food supplementation is one of the core services frequently provided by local services, but food supplements can be inconsistent and vulnerable to changes in funding. In addition, food security is vulnerable to seasons for crops, particularly corn/maize.

Gathering Information to Rate This Factor

To rate a child on food security, the community worker/rater can ask both the child and the guardian about their food supply, how they get food, what the child ate during the past week, and whether the child ever complains of going to bed hungry.

The rater also might observe the granary (where harvested foods from the farm, such as maize, are stored). If the granary is empty, the field worker can begin a conversation about the year's harvest and whether the crop is sufficient to sustain the family all year.

Depending on time of day, the field worker observes the cooking area and cooking pots for signs of food preparation. For example, if it is the lunch hour and children have come home from work or school, the field worker can see whether food is prepared or being prepared. If the pots look empty or forgotten, it may be a sign that lack of food is a problem. The family may be skipping meals as a coping strategy.

When food seems available in the household, the field worker inquires about whether food availability is seasonal and what the meals include. For example, does a typical meal consist of maize with greens, or does it have any sources of protein, such as meat, beans or eggs?

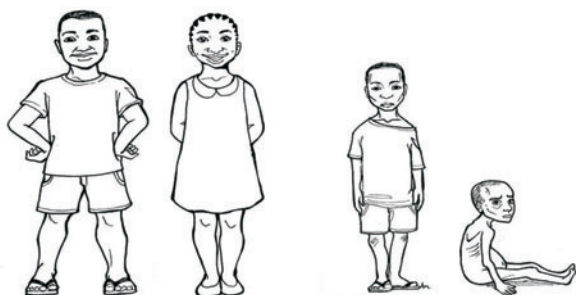
Sample Questions

- What does the family/child eat?
- How does this household/institution get the food?
- Tell me about times when there is no food.
- Does this child complain of hunger?

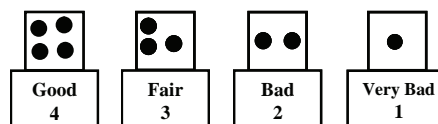
Observations

When possible, observe food storage facilities such as the granary, observe the cooking area and cooking pots for signs of any recent food preparation activities and observe the types of foods available (e.g., kitchen, garden, fruit trees, banana plantation, livestock).

Child Status Index Factor 1B: Nutrition and Growth



Goal: Child is growing well compared to others of his/her age in the community.



Why This Factor is Important

Growth is an important marker of child well-being. Improving the nutritional status of infants and children is associated with improved mental and motor development as well as growth (Walker et al., 2007; Pollitt et al., 1993).

The relationship between growth and development is particularly true during infancy and early childhood and it has been shown to be true with general food supplementation as well as programs focused on specific supplements, particularly, protein, iron, and iodine (Walker et al., 2007; O'Donnell et al., 2002). In general, preschool or other stimulation programs plus food supplementation seem to have the best outcomes, especially on cognitive development (e.g., Engel et al., 2007). These studies affirm the interdependence of multiple factors on the CSI.

However, child growth has been slow to emerge as a priority outcome area, perhaps because there is such widespread food insecurity in resource-poor areas. It has also been difficult to monitor, because community workers would have a hard time carrying around heavy scales and local workers often do not readily make meaning of the resulting statistics.

Nutrition is particularly relevant if services from an OVC provider include food supplements or if collecting data about the need for school-based nutritional programs is an important goal for the program.

Gathering Information to Rate This Factor

In many evaluation efforts, the nutritional status of the child refers to classifications from direct anthropometric measures (e.g., weight-for-age; height-for-age) compared to reference populations. These measures are expressed in terms of the number of standard deviation (SD) units from the median of the NCHS/WHO international reference population (2007).

However, for the CSI, growth is intentionally assessed in a subjective way. The community worker observes the child and/or discusses with the guardian or parent how the child's growth (weight and height relative to age) is seen by the guardian compared to children of the same age and gender group in the local community.

The rating should include the field worker's concerns from observing the child for signs of malnutrition, stunting and wasting. Compared to statistical measures, this inferential assessment may have more immediate meaning to the field worker, guardian, or program.

Sample Questions

- How is the child growing?
- Does he/she seem to be growing like other children that age?
- Are you worried about this child's growth? Weight? Height?

Observations

Observe the child's growth as apparent by his/her weight and height, relative to others his or her age in the community. If possible observe the child's energy level if playing or working.

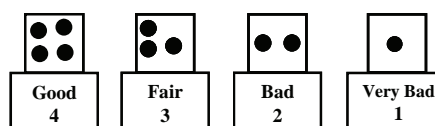
Domain 2 — Shelter and Care

Does the child have shelter that is adequate, dry, and safe? Is there at least one adult who provides consistent love and support?

Child Status Index Factor 2A: Shelter



Goal: Child has a stable shelter that is adequate, dry, and safe.



“Shelter” describes the physical place or structure of the home or institution where the child lives and the extent to which the structure provides security, comfort and protection from weather. Stability is defined in terms of the past six months.

Why This Factor is Important

Adequate housing is associated with a child's social, emotional, physical, and overall well-being and development (Horizons, 2003). Many vulnerable children, especially orphans, face unique obstacles in this regard. They tend to live in poorer households and in less adequate main dwellings (Nyamukapa, Foster, & Gregson, 2003). These studies use employment and income of head-of-household as proxy indicators of poor living conditions or household adversity. Inadequate housing is especially the case for paternal orphans (Case, Paxson, & Ableidinger, 2004).

Other investigators found that orphans describe themselves as less content with their living conditions than non-orphans in the same community (Atwine, Cantor-Graae, & Bajunirwe, 2005). In two cities in Zimbabwe, half of the children living on the street without any consistent shelter were identified as orphans, more than twice the proportion of orphans in the general population. A majority of these street children were double orphans (56 percent; Mawoneke, Sexton, & Moyo, 2001).

Orphaned children living with family or community members often receive less adequate care than others in the households. These children sometimes sleep in a different and less adequate place than other children in the household or do not have mattresses or mosquito nets when other members of the household do. These examples may reflect stigma or discriminatory views related to HIV/AIDS and should be documented under the factors for child protection.

Gathering Information to Rate This Factor

The field worker observes where and how the child lives and (when there are concerns) asks the child how he/she lives and where he or she sleeps. The field worker may observe aspects of how the child lives that also influence the understanding of the child's experience in other factors, such as whether he/she is being stigmatized or receiving poor care.

The rating of adequacy of shelter includes two concepts:

- The adequacy of the shelter itself for all household or institutional members; and
- The adequacy and stability of the living arrangement specifically for the child being assessed.

In some cases, orphaned children may not have a permanent home; they might be staying in different households at different times. Sometimes a child does not have a place (room, bed or space) to sleep within the household or institution and goes elsewhere for the night.

The field worker observes the type and condition of the house or other shelter and whether that shelter is adequate to protect from the weather. The rating for stability and adequacy of shelter for an individual child indicates the relative needs for community or outside resources for the child to have a safe and comfortable place to live.

Sample Questions

- Where does the child live?
- Where does he/she sleep?
- Is this house or institution adequate or in need of repairs? What kind of repairs?

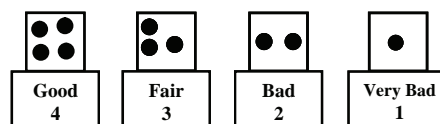
Observations

Observe the type and condition of the dwelling. Is the way the child lives similar to others in the household? Ask the child to show you where he/she sleeps.

Child Status Index Factor 2B: Care



Goal: Child has at least one adult (age 18 or over) who provides consistent care, attention, and support.



The child's care is seen as good when there is an adult (parent or guardian) who provides the child with a stable, nurturing, and emotionally secure environment. The relationship between the child and the caregiver should provide physical and psychological security for the child. This factor captures how committed the caregiver is to the child and to his/her relationship with the child.

Why This Factor is Important

It is widely acknowledged that a most important aspect of childhood is the physical safety and psychological security provided by the adult or adults who are involved in the child's life.

Recent statistics show that the HIV/AIDS epidemic in already impoverished communities has lead to increased infections and deaths of adults of reproductive age. As a result, grandparents, siblings, and other relatives who are already overwhelmed and exhausted have stepped in to raise children affected by the disease. Some children in these situations are well loved; others are without the loving care they need to thrive.

The provision of loving care may be as important as food security—and perhaps even more important (e.g., Bowlby, 1980, 1982; Suomi, Collins, Harlow, & Ruppenthal, 1976). In studies in Western countries, the lack of loving care is associated with negative child outcomes, including learning problems, mood disorders (such as depression), and behavior disorders (such as delinquency). Children become especially vulnerable when their mothers and/or fathers die or are so sick they cannot provide consistent care.

This factor has not received adequate attention in studies of children who have been orphaned in high-prevalence HIV/AIDS areas. Nonetheless, there is little doubt that the presence or absence of consistent loving care is a critical element in the health and well-being of these children.

Gathering Information to Rate This Factor

The worker explores the role of the adult(s) in the child's life, whether there is a primary care provider for the child, how the adult parent or guardian sees the child, the extent to which the adult knows the child and empathizes with the child, and the manner in which the child relates to the parent(s)/guardian(s).

Rating this factor requires that the field worker observe as well as ask about the relationship. The field worker might ask the child, "Who takes care of you?" or, "Who loves you?"

The field worker can ask about the guardian's availability. The adult's presence may be limited by illness or extensive work hours; and as a result, a caregiver may know little about what is going on in the child's life.

Note that the child may receive loving care from someone who for some reason is not able to commit to long-term care for the child. This would be the case for a very ill parent or guardian or when the child is receiving temporary care from a family member or neighbor. Another aspect of care is the frequency with which the child's primary caregiver has changed.

Sample Questions

- Who is the most important adult in this child's life?
- Who takes care of this child?
- How long has he/she been the most important adult in the child's life?
- Does this person plan to care for the child as long as needed?
- When something exciting or fun happens, who does the child tell?
- Who does the child go to when hungry?
- Who does he/she go to if sad?—or talk to about worries?
- Who does he/she go to if they are hurt?

Observations

When possible, observe caregiver interactions. Does the adult seem to know the child well? Does this adult or someone else feel responsible for this child? Is this child on his/her own, without adult care?

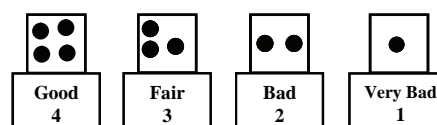
Domain 3 — Child Protection

Is the child safe from abuse, neglect or exploitation? Is there adequate legal protection for the child?

Child Status Index Factor 3A: Abuse and Exploitation



Goal: Child is safe from any abuse, neglect, or exploitation.



Maltreatment is defined as a child's exposure to any of the different types of abuse and exploitation including: physical, emotional or sexual abuse, neglect, stigma, discrimination or exploitation.

Child abuse and/or maltreatment could include:

- Lack of proper care
- Being provided less food than others in the household
- Young children being put to work
- Children being forced into inappropriate work
- Being physically beaten by household members
- Being beaten by others and not protected by adults in the household
- Being sexually abused

The definitions of child abuse may vary according to culture. For this reason, raters should first understand what constitutes “child abuse” or “maltreatment” within the local and cultural context, especially with regard to physical discipline and what manner of children working is seen as unacceptable child labor.

Why This Factor is Important

Maltreatment of orphaned children is commonplace in high-prevalence HIV/AIDS areas. Preliminary analysis from a community study based in Tanzania revealed that about 76 percent of orphaned children reported being hit, kicked or beaten at home (Whetten et al., 2008, personal communication).

Without the safety provided by a loving and committed caregiver, girls in particular are vulnerable to exploitation, such as coercive and commercial sex and unwanted and early marriage and pregnancy (Gilborn, 2002); “under age girls are married to get the bride price” (interview with community member in Foster et al., 1997, p. 3.).

Community members interviewed by the Foster group (Foster, Shakespeare, Chinemana, Jackson, Gregson, & Marange, 1995) also reported on the ways people take advantage of orphaned children as laborers.

Despite these reports about the high incidence of child abuse and exploitation, there are few published studies and almost no program models for intervening with child maltreatment in this population of very vulnerable children.

Gathering Information to Rate This Factor

Child maltreatment can be a difficult and sensitive area for a community-based worker to assess, for two reasons:

- **Ambiguity of the definition.** Although there is universal agreement about child sexual abuse, there can be local and cultural differences in defining “abuse” or “neglect.” What level of physical discipline is acceptable and what is abuse? What level of work is seen as a child’s normal contribution to the household and what is unacceptable child labor?
- **The need for multiple visits.** Abuse or neglect may not be evident in a single visit. A more accurate assessment may come with time and familiarity with the household or institution, plus the opportunity to hear about possible maltreatment from neighbors and others in the community.

This factor is included in the CSI because:

- Abuse and maltreatment of orphaned and vulnerable children is high.
- Local agencies need support in being aware of risks for these children.
- The evidence supports development of effective intervention strategies.

Some guardians and parents may suspect that their child is being maltreated, and they have not addressed the issue directly because of fear or some other perceived barrier. There are also times that the primary caregiver is maltreating the child, and this becomes a difficult topic for the field worker. The field worker observes for possible indications of maltreatment: child has unexplained burns, bites, bruises, broken bones, scars, or black eyes, or shrinks at the approach of the caregiver.

When the adult describes a child in such terms as “devil,” “prostitute,” and “stupid,” or in some other very negative ways, possible maltreatment should be explored further. The field worker can ask whether anyone in the child’s world is concerned about sexual abuse or other exploitation. The interview observes whether the child seems to feel safe with the guardian or does the child seem afraid?

Neglected children may steal food or clothes or appear dirtier than other children in the family. Other forms of maltreatment include indications of overworking in the farm or fetching water using big containers that are not age-appropriate. A child may live with a grandmother who sends him/her to the market to sell produce on a school day; the grandmother might not tell the field worker this, but finding out about the child’s school attendance may suggest a problem to the field worker.

Field workers are encouraged to establish their own ways of exploring for possible child maltreatment. Community-based teams can share their methods with one another for rating this important but difficult domain.

Because of the complexity of establishing or verifying exploitation, this domain should reflect the field worker’s level of concern about exploitation. The field worker is not expected to establish the veracity of actual exploitation, but rather rate his/her judgment or inference.

Sample Questions

- Do you have any worries about this child's safety?
- Does anyone hurt this child?
- Do you think the child feels safe and secure?
- How does this child help in the household?
- Does the child work for anyone outside the household?
- Does anyone else who knows the child think he/she is being hurt by someone else? Or sexually abused?

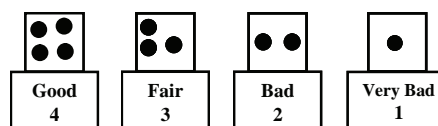
Observations

When possible, observe the child and the situation. Does the child have scars or other signs of physical abuse? Is anyone in the child's world concerned about sexual abuse or other exploitation? Does the child seem to feel safe with the guardian? Does he/she seem to be afraid?

Child Status Index Factor 3B: Legal Protection



Goal: Child has access to legal protection services as needed.



Legal protection is defined as having adequate legislative and judicial protection from harm related to identity, inheritance, or other threat of this sort. Legal protection can include birth registration or certificate, documents showing child is protected from land grabbing, support for inheritance rights, or protection from community-determined circumstances that are known to cause child vulnerability.

Why This Factor is Important

Many children affected by HIV/AIDS lack parental protection and are vulnerable to losing their inheritance, being exploited sexually, and subjected to other forms of abuse. Program, national, and international stakeholders consistently identify legal protection as an important outcome area for children.

However, community workers often don't know about child rights, feel helpless to call upon the legal system for child protection, and even fear addressing this issue. With this factor on the CSI, community workers can document the need for legal support for individual children and to provide evidence of the need at a community level.

In many places, birth registration represents the starting point for the recognition and protection of every child's fundamental right to support from the state or community. It refers to the permanent and official recording of a child's existence by some administrative levels of the state, which is normally coordinated by a particular branch of the government.

Legal protection with birth registration varies by culture. In many areas, birth registration provides the legal eligibility for government social services and other protections. In other areas, children can be denied (or provided) protection or services regardless of their birth registration. The CSI user will rate the child's vulnerability in this area according to local practice and application of a child's need for legal protection.

Gathering Information to Rate This Factor

The field worker can inquire about the child's legal needs in a number of ways, including asking about whether the child has a birth certificate or if the birth was legally registered (depending on local custom in this regard).

Some guardians may not know the answer to this question. Some will know if the child has any other necessary documents that protect them from being exploited or losing any inheritance. The field worker will discover whether the child has access to government supported services; and if not, why not. The lack of access to services may indicate the lack of legal status.

In many cases, the important information about the child's legal status is whether there is an adult who represents the child legally and promotes needed legal protections. This may become apparent to the field worker in a number of ways. When a child or guardian reports that upon the parent's death, the child lost access to previous housing and property, the lack of legal protection is obvious.

In the case of children whose biological parents have died, the field worker may ask about whether the child's inheritance of land or property was challenged or intact. In instances of concern about child maltreatment, the field worker will explore the sources of legal protection that may or may not be available to the child. It is important to know whether the caregiver can legally make decisions for the child and thereby provide legal protection.

Sample Questions

- Does this child have birth registration or certificate? Does the family have a will?
- Has he/she been refused any services because of legal status?
- Do you know of any legal problems for this child, such as land grabbing?
- Does this child have an adult who stands up for the child legally?
- Who has the legal responsibility for taking care of this child?
- Does the adult who cares for the child have legal authority to act for the child's best interests?

Observations

When possible, observe or ask about the child's fear of losing his/her family properties. Does the caregiver or volunteer have any concerns or hesitations when asked about the child's legal protection services?

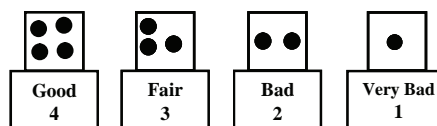
Domain 4 — Health

Is the child healthy, does he/she have access to preventive and treatment health services?

Child Status Index Factor 4A: Wellness



Goal: Child is physically healthy.



Wellness is defined as good overall physical condition and freedom from illness at any given time.

Why This Factor is Important

Mortality and morbidity are closely related to poorer nutrition, malnutrition, and an increased prevalence of stunting and wasting among orphans (Lindblade, Odhiambo, Rosen, & DeCock, 2003; Mishra, Arnold, Otieno, Cross, & Hong, 2005), although there are studies and locations in which the association does not hold up (e.g. Lindblade et al., 2003).

It is likely that mortality and morbidity among orphans is more complex than poverty-related food insecurity, again emphasizing interactions among CSI factors. A child whose parents are ill or have died may not have access to health care or adequate home care when needed. Mortality risks for children whose mothers had died were as high in the year preceding the mother's death as the first year after the mother's death (Ng'weshemi, Urassa, Isingo, Mwaluko, Ngalula, & Boerma, Marston, & Zaba, 2003).

It is widely acknowledged that one reason for poor health among OVCs is that they themselves have HIV/AIDS and that mother-to-child transmission is a part of the reason for the correlation between the death of a parent and the death of a child. In addition, multiple studies provide evidence for higher morbidity among orphans, including those not HIV-infected, compared to non-orphans in the same community (Bledsoe, Ewbank, & Isiugo-Abanihe, 1988; Oni, 1995), as well as higher mortality (Forsyth, Damour, Nagler, & Adnopo, 1996).

When children are ill, their ability to participate actively in age-appropriate activities is affected. Their well-being in a number of areas, including social relationships and school performance, is impaired.

Gathering Information to Rate This Factor

Wellness is rated from discussions with guardians and other caregivers about the child's illness over the past month and how often the child has been too ill to go to school or to perform work at home.

Due to the potential for discrimination, the field worker should never ask directly about the child's HIV status, although a caregiver may volunteer the information.

Often the guardian provides information about the nature of the child's illnesses: diarrhea diseases, malaria, and other diseases such as tuberculosis. Asking about the child's health also gives the community worker the opportunity to rate the child's access and use of health care services (see Factor 4B).

The field worker can observe the child's physical state, if the child is present at the home visit or interview—and evaluate whether this child looks healthy and not acutely ill. Information about health is also gathered when queries about school attendance, activity level or performance are made. A good conversation about health may begin by asking the caregiver if he/she worries about the child being sick or “falls ill too much.”

Sample Questions

- Tell me about this child's health.
- Tell me about the last sickness (or sicknesses) the child had.
- Does he/she get malaria often?
- Does he/she miss school or work because of illness?

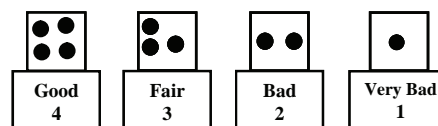
Observations

When possible, observe the child. Does this child look well? How often is he/she ill? Does the caregiver or others worry about him/her being sick? Does the child look energetic?

Child Status Index Factor 4B: Health Care Services



Goal: Child can access health care services, including medical treatment when ill and preventive care.



Adequate health care is defined as a child's access to basic health care services that are age-appropriate, including immunizations (for children under five), bed nets, health education (e.g., HIV prevention for youth), and other preventive measures—and appropriate medical care when sick.

Why This Factor is Important

There is evidence that children of parents with HIV/AIDS and children who have been orphaned by HIV/AIDS are less likely to access and use available medical care for prevention and treatment of illnesses, including but not limited to drug therapy for pediatric HIV/AIDS (e.g., Mishra, Arnold, Otieno, Cross, & Hong, 2005).

The reasons for less adequate health care for orphans and other vulnerable children are likely multiple and complex. For example, during CSI field testing, a mother described that, since the death of the children's father, there is no one to leave her other children with when she walks some distance to take a sick child to the health center. This observation is consistent with one study in the Democratic Republic of the Congo demonstrating that children whose mothers have died had a higher rate of missing scheduled clinic visits than children whose parents were alive (with or without parent HIV/AIDS) (Kamenga et al., 1990).

The higher overall morbidity found among orphaned children (Bledsoe et al., 1988) is also consistent with poor access to medical care. Children in Kenya who were ill with diarrhea were less likely to receive medical care for their illness when their parents were HIV-positive. The Brouwer group (Brouwer, Lok, Woffers, & Sebagalls, 2000) studied families in Uganda and concluded that parents with HIV disease are overwhelmed by despair, denial, and the anticipation of loss. These parents also indicated that they did not visit medical centers because they did not have the money to do so.

Access to medical care is one dimension of child well-being that is frequently addressed by local service agencies. If supported, this factor can greatly promote the child's well-being.

Gathering Information to Rate This Factor

Queries about access to health care can follow naturally from the information about the child's general health during the initial greetings when the field worker asks "How are the children doing?" In addition, the community worker asks the guardian about preventive care, such as immunizations for children under five years, as well as use of treatment for any child when ill.

If the child has been sick or was sick recently, the rater should explore if the child had access to a health professional or to needed medication and treatment. For purposes of service planning, the field worker may want to inquire about barriers to service availability, to determine if services were genuinely absent or were inaccessible for some reason, such as distance to a health provider or lack of funds for petrol to get to the health provider.

The field worker will occasionally talk with a guardian who does not know whether the child under five years has had immunizations. A child that young is unlikely to be able to report on preventive care received. The field worker can ask whether there are plans for health care/education for this child who has recently come into care. The field worker can also use information about the child's access to medical services when ill as an index for this factor.

Sample Questions

- What happens when this child falls ill?
- Does he/she see a nurse, doctor or any health professional?
- How does the child get to a doctor or a nurse when he/she needs one?
- When he/she needs medicine, how do you get it?
- Tell me about health services the child needs or needed but did not receive.
- Are the things that make it hard to get what the child needs to be healthy?
- Has the child had vaccinations to prevent illness?
- (For adolescents) Has anyone talked to the child about risks for HIV/AIDS and how to protect against these risks?

Observations

When possible, observe the child's immunization card, availability of bed net and basic hygiene. Given what you observe, how likely is the child to receive the health care services needed?

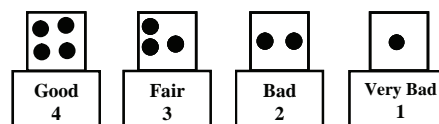
Domain 5 — Psychosocial

Is the child happy and does he/she have hope for a good life? Does the child enjoy good relationships with other children and adults?

Child Status Index Factor 5A: Emotional Health



Goal: Child is happy and content with a generally positive mood and hopeful outlook.



Why This Factor is Important

Children affected by HIV/AIDS are vulnerable to emotional health difficulties that influence their feelings and how they behave. A child with psychosocial distress may show internalized symptoms such as depression, poor self-esteem, anxiety, and frank suicidal thoughts. The grief and loss that children experience related to HIV/AIDS can be acute or chronic and will likely affect multiple aspects of their lives.

As a result, guardians describe orphaned children that worry about many things, are fearful of new things or situations, want to be alone, have no hope for a good future and appear unhappy, tearful, inactive, and distressed.

Children who are orphans are more likely to be depressed (Birdthistle, 2004; Makame et al., 2002; Forsyth et al., 1996) and to feel sad, helpless, angry, and depressed (Sengendo & Nambi, 1997). In Uganda, orphaned children were more likely to wish they were dead than non-orphans (12.2 percent versus 2.7 percent); and they indicated that they thought their life would be bad (32.5 percent versus 5.5 percent of non-orphans; Antwine et al., 2005).

In an ongoing longitudinal study of children orphaned by HIV/AIDS in five countries, a preliminary analysis of a cohort in Tanzania showed that a high rate of child trauma was reported by both guardians and children themselves (32 percent and 54 percent, respectively). They reported five or more traumatic events, such as being beaten or having a family member die. There was a high prevalence of trauma-related symptoms in these children, further demonstrating the urgent need to address grief, depression, and trauma in HIV/AIDS affected children (Whetten et al., 2008, personal communication).

The psychosocial needs of orphans in resource-poor countries have been emphasized by a number of recent publications (e.g., *Where the Heart Is*, Richter, Foster, & Sherr, 2006). Many service organizations attempt to address psychosocial needs by counseling, support groups, and social activities. To date, there are few published or otherwise reported psychosocial interventions developed for local application and studied for efficacy.

One study of a 16-week model of group interpersonal psychotherapy in Uganda showed improved scores on a culturally developed measure for depression in adolescents (Bass et al., 2006; Bolton et al., 2004).

This work is important from several perspectives, including the successful adaptation of a treatment model developed and used previously in resource-rich countries, the training of local providers to deliver the treatment in a culturally appropriate and successful way, and the development of a culturally derived tool for measuring depression.

Support for children and families in other domains can help the child's psychological adjustment. During the field work in developing the CSI, one guardian indicated that her niece was depressed and inactive when her mother died and she came to live with the aunt's family. However, when a community worker arrived with school uniforms, indicating to her that her life would continue as before in some ways, there was significant brightening of the child's affect and improved adjustment overall.

Identifying cases and causes of psychosocial distress can lead to effective interventions.

Gathering Information to Rate This Factor

During field testing of the CSI, the child's emotional well-being emerged as an area that parents and guardians are willing to talk about, especially when they are frustrated about not understanding what is going on with the child or what to do to help a child who is sad, inactive, and/or grieving.

The field worker can ask open-ended questions about the child's happiness and hope for the future, using the local language for concepts such as depression or grief. If a caregiver is not intimately involved with the child (see Factor 2B), the field worker must depend on personal observations of the child's emotional state or what the child says about his or her life. It may be informative to talk to teachers or other service providers about the child's emotional well-being.

Sample Questions

Ask the caregiver or other involved adult:

- Is this child happy or sad most of the time?
- How can you tell if he/she is happy or unhappy?
- What makes the child sad or worried?
- Do you worry about this child's sadness or grief?
- Have you ever thought the child did not want to live anymore?
- Do you worry he/she might hurt himself/herself?
- Does he/she talk about the parent(s) who died? (If applicable.)
- How is this child doing living here? (When applicable.)

Or, ask the child:

- Tell me about your goals in life.
- Do you think you will have a good life?

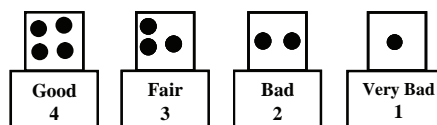
Observations

When possible, observe the child's demeanor. Is the child withdrawn, does he/she look fearful, sad or teary? Observe the child's emotional state or what the child says about his or her life. Does the caregiver seem concerned or seem to not know how the child is doing in terms of social and emotional well-being? (This can relate to Factor 2B, Care.) Does the child seem to have energy? Is the child involved in activities? (This can relate to Factor 5B, Social Behavior.)

Child Status Index Factor 5B: Social Behavior



Goal: Child is cooperative and enjoys participating in activities with adults and other children.



Why This Factor is Important

Playing well with other children and participating with adults and children in fun activities can indicate psychological adjustment that will extend to becoming a “good” adolescent and adult and this is a construct used frequently by guardians. It is also likely that this child imagines a good future that may include education, marriage, and being a good parent.

Interviews by the CSI team indicated that guardians worry that the orphaned child in their care will be a “bad” child, be disobedient and engage in antisocial activities, such as early sexual activity, drug use, and other high-risk behavior. Guardians generally describe externalized behaviors, such as fighting and bullying, for those children who act out their grief and loss.

Studies of the psychological well-being of children who have been orphaned in high-prevalence HIV/AIDS countries have generally found more internalizing symptoms, such as depression and worry, than externalizing behaviors, such as fighting and bullying.

Despite the lack of empirical evidence of behavioral acting-out for this group of children, social adjustment has been added to the CSI factors as an important indicator of adjustment for guardians, by their report, and an area to which interventions (e.g., COPE groups) can be effective.

The rating of this factor on the CSI addresses not only behaviors such as obedience/disobedience but also the child having good social relationships with other children and with adults. Orphaned children studied in South Africa were more likely to view themselves as not having a good friend (Cluver & Gardner, 2006).

Gathering Information to Rate This Factor

From a parent or guardian's point of view, an important aspect of the child is whether he/she is "good," often related to relationships with adults (obedience or disobedience) and children (getting along with others or fighting with others), as well as how they participate in family and community life.

A field worker may ask the parent or guardian to describe the child in general, asking them to do so in any way they like. At this point, behavior problems that suggest that the child is "bad" will often be introduced.

Sample Questions

- How would you describe the child's behavior towards others?
- What is his/her behavior toward adults? Obedient?
- Does this child need to be punished often?
- Does the child play with other children or have close friends?
- If so, does he/she enjoy playing/being with other children?
- Does he/she fight with other children?
- What do you do if he/she is unruly?
- Do you worry the child will get in trouble at school?
- What do you worry about for this child in the future?

Observations

When possible, observe the child's social behavior with other children and adults. What does his/her attitude seem to be toward the guardian or other children? Is the child involved in any activities with others? How does he/she interact with them and with you?

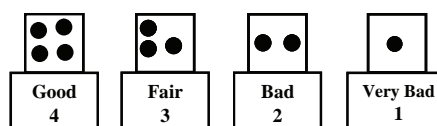
Domain 6 — Education and Skills Training

Is the child performing well at home, school, job training or work and developing age appropriate knowledge and skills? Is the child receiving the education or training he/she needs to develop that knowledge and those skills?

Child Status Index Factor 6A: Performance



Goal: Child is progressing well in acquiring knowledge and life skills at home, school, job training, or an age-appropriate productive activity.



The definition of “performance” is not limited to learning in school, but also addresses the child’s performance in any age-appropriate tasks, including daily activities in family life, household chores and (age-appropriate) work in the family’s income bearing activities, such as gardening and care of animals. This factor also reflects the extent to which a young infant or preschooler is progressing well in reaching developmental milestones in motor development, language, and play, according to expectations of the parent or caregiver.

Why This Factor is Important

It is well documented that orphaned children in low-resource countries with a high prevalence of HIV/AIDS are more vulnerable for developmental and learning problems, whether their performance is observed in the school or in activities at home.

Children whose parents have died were found, for example, to have a more difficult time concentrating on tasks than non-orphans (Cluver and Gardner, 2006). Developmental problems have been observed in children whose parents were HIV infected even before parental death. Developmental delays are associated also with related factors, such as malnutrition and less care from parent(s) and/or guardians (Foster, 2006). In addition, orphaned children need money for school fees and materials; the decreased resources associated with parent illness and loss can result in not being able to go to school and, if they do go to school, in difficulty learning (Foster, 2002).

One study in Kenya, Tanzania and Zimbabwe showed that orphans were less likely than non-orphans to be performing at the expected grade level, even when they were in school (Bicego, Rutstein, & Johnson, 2003). The findings from this study indicate that, from ages six to 14, children with both parents dead performed less well than those with one parent dead, who performed less well than children with both parents alive.

Gathering Information to Rate This Factor

Field workers ask questions about the child's performance relevant to the child's age and developmental expectations. This factor, reflecting development and learning, is often discussed with other topics. It is something that guardians discuss with little questioning needed.

Sample Questions

- Is this child developing as you would expect (younger child)?
- Is this child learning new things, as you would expect of others his/her age (younger child)?
- Do you have any worries about the child's performance or learning?
- Is the child quick to understand and learn?
- Is the young person doing well with work?
- Do teachers report that the child is doing well in school?
- Does he/she do a good job with chores at home, such as work in the garden?
- Tell me about something the child does very well.
- Is the child advancing to the next grade as expected?
- Have you worried that this child does not learn as well as other children?
- Do you think this child is very quick to learn, even a better learner than others?

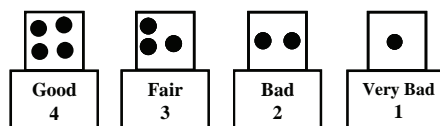
Observations

If the child is an adolescent, ask the child about skills training and learning skills that are useful to him/her. If in school, observe the response if asked about class performance ranking. If the child is five years old or younger, observe the child's developmental progress and compare it to what you expect for children that age (i.e., talking, walking).

Child Status Index Factor 6B: Education and Work



Goal: Child is enrolled and attends school or skills training or is engaged in age-appropriate play, learning activity, or job.



Why This Factor is Important

In preparation to be a productive member of the community, the child should be enrolled in, attend, and participate in school, a training program, or a learning mentorship. Infants and toddlers should receive developmental stimulation through play and social interactions with household members. In the case of an older, out-of-school child, this domain assesses whether the youth works regularly at an age-appropriate, income-generating job/task, such as maintaining a garden.

Gathering Information to Rate This Factor

The field worker can ask the guardian or the child about school enrollment and attendance, including how school fees are paid and how or if school uniforms are purchased. For infants or preschoolers, the field worker should ask whether the child is receiving stimulation by way of playing and interacting with household members. In the case of an older, out-of-school child, the field worker can ask if the youth has an income-generating job/task where he/she works regularly (may include maintaining a garden).

For children who are enrolled in school or have regular work, ask about attendance. For children who are not engaged in any age-appropriate activities (school or learning activities) as expected, the field worker should explore the barriers. Information here may also provide answers about other factors. For example, a child might not be at school because there was no adult to guide them or because he/she was hungry.

Sample Questions

- Is the child in (or has he/she completed) primary school?
- Where does he/she go to school?
- Tell me about the child's school or training.
- Who pays school fees and buys uniforms and school materials?
- (If enrolled) does this child attend school regularly?
- How often must the child stay out of school to help out at home?
- How often must the child miss school for any other reason?
- Does he/she go to work regularly?
- Ask the child about his or her play, school, or skills-training activities.

Observations

If possible, observe the child's school uniform or supplies and their usage. For infants or preschooler observe if he/she is involved in any play or learning activity with any family member(s).

Chapter 3. Administering and Scoring the Child Status Index

The CSI is primarily used as a tool to assess and monitor children who are receiving services from external sources, such as communities, neighbors, churches, NGOs, faith-based organizations (FBOs), and other organizations and/or with children who are being recruited into such programs. From an ethical perspective, frequent progress monitoring of children who are not receiving or not expected to receive any support or services from an organization in any way could create false hope and disappointment.

How Long Will This Take?

The total time required to collect the data and rate the child should be about 20 to 30 minutes, based on field-testing in East Africa. However, once a guardian starts talking, it can be difficult to keep the interview short.

Extended conversations can help you get to know the child and family even better and, consequently, to provide better services for them. Nonetheless, for purposes of efficiency and consistency from one interview to another, try to keep the CSI discussion to 30 minutes or less.

The following steps provide a guide for using the CSI.

Step 1. Prepare for the Child Assessment Visit Using the CSI

1.1 Learn about the Child Status Index and CSI Record Sheet

Be sure you understand the goal and content of each domain by memory, so you are prepared to ask the right questions and elicit the information necessary to rate the child on the CSI Record Sheet. If you don't have to refer to a written script, the visit can be more informal and agreeable to the child and caregiver. It is very helpful to conduct several practice interviews and scoring, whether in a workshop or in self-training.

1.2 Gather Child and Family Background Information

It may be helpful to refer to other information and records about the child and family, such as on an intake form, if it is available, prior to the visit. Important information may include but is not limited to: previous CSI results (to note improvements or continued needs), the frequency of changes of primary caregivers, and/or whether the child has any disabilities or other special needs.

1.3 Prepare CSI Record Sheet

Background information is entered on the top of the CSI Record Sheet. It is helpful to complete as much of this information as possible before entering the home for the assessment visit.

Child's Name: _____	Age in Years: _____
Gender F/M: _____	Child ID: _____
Location: District _____	Ward/Division: _____
Village/Neighborhood: _____	
Caregiver's Name: _____	Relationship to Child: _____

Step 2. Conduct the Child Assessment Visit

The CSI is often part of a home visit conducted by community members and front-line program staff. The community worker has a brief and informal discussion (usually about 30 minutes) with the child, the child's caregiver, or other adults as needed to gather general information about the child. You may want to discuss the child's well-being with neighbors or teachers as well.

The goal is to acquire information that relates to the 12 structured CSI factors to be rated, but the visitor should conduct the interviews in a natural and spontaneous way.

2.1 Make Introductions and Get Consent to Conduct the Assessment

Many Child Status Index assessments are completed at home visits that start with friendly and spontaneous greetings as expected in each culture.

- **Introduce yourself** to the guardian, other adult or child. The discussion about the child should be informal. Allow the interviewee to respond spontaneously and show your interest in the child.
- **Remind the child or guardian about the program** that serves this child or other children in the community/country and the reason for asking about the child in this manner. You may explain that the reason for the visit is to know how the children are doing, especially this child, what has been happening in the child's life (good or bad) since the last visit, and whether there are any changes in the child's life. Explain that getting this information about the child is done so that they can all determine how to best respond to the needs of the child.
- **Get the informant's consent** to provide this information before proceeding with the discussion. Oral consent is sufficient when you are collecting data to evaluate services and not as part of a research project. If the CSI is used for research, follow the country's human subjects review board guidelines for getting informed consent.

2.2 Talk with the Parent, Caregiver, or Guardian

Engage the parent, guardian or other informant(s) in a brief, informal discussion that addresses the 12 factors of the CSI without the structure of a formal survey or questionnaire. The assessment will take about 20 to 30 minutes.

Start the conversation with general, open-ended questions about the child and his/her life, to encourage the person to talk. For example, you might begin by saying, "Let's talk about this child; how is he/she doing?" The respondent is then invited to talk about the child in whatever way preferred.

After this general discussion, follow up with further questions as needed to gather information on CSI factors not yet discussed or observed. In most cases, guardians spontaneously describe the child in terms that provide useful information for many of the CSI factors.

If the informant provides credible responses for all the domains and factors—consistent with your observations and impressions—you can then rate the child in each outcome area.

2.3 Talk with the Child or Other Informants

If you believe any responses are inaccurate or incomplete, gather more information from other informants, as possible. For example, you can talk with a teacher about the child's performance, attendance, and/or social behaviors; with neighbors about suspected abuse or neglect; or with the child about shelter and care issues. Specifically, when questioning the child:

- Get verbal consent from the caregiver to speak to the child and verbal assent from the child to talk with you.
- If the child is old enough (and the child and guardian are willing), interview the child independently, in private.
- Instead of direct questions, it can be more helpful to ask the child to show you around the living environment and to talk about his/her life in general.
- Do not ask children questions that might frighten them or put them in conflict with the caregiver.
- Be prepared to respond in an appropriate and supportive manner to children who become sad or cry when talking about a parent who is sick or has died.

Tips for the Assessment Visit

- Keep the interview and observations informal and friendly. Guardians and children are generally happy to talk about these aspects of the child's life.
- Show the caregiver why knowing "How the child is doing" is important for them and other children in the community.
- Earn trust by showing your sincere interest in the family and child.
- Use general, open-ended queries, such as, "How are the children?" Where possible, avoid questions that can be answered with "yes" or "no."
- Users are encouraged to develop their own style of gathering information about the child to rate the 12 factors.
- As the conversation appears to be ending, review the 12 factors. If information for any factor remains unclear, ask more specific questions.
- Rate each factor before leaving the home. It is so easy to forget.

2.4 Observe the Child and/or Informant and/or the Living Environment

In addition to the informal discussion, observe the child's physical and psychosocial environment. Your observations of body language, speech patterns, and eye contact can help verify information about the child, the informant, and the relationship between the child and others in the household. For example:

- Concerns about child abuse and maltreatment may arise from seeing bruises on a child's body or from other people in the community who express worry that the child is neglected or otherwise maltreated.
- You may observe a child whose eyes are downcast, speech is overly quiet, and emotional expression appears sad and tearful (suggesting grief and sadness)—and be concerned even though the guardian reports that the child seems "happy."
- You may observe that an otherwise physically sound dwelling lacks food, cooking utensils, or beddings for the child.

These types of observations will provide a clearer and more detailed picture of the child than would either discussion or observation alone. Do everything you can to verify information revealed in conversation without being overly intrusive. The respondent should not feel challenged or criticized but rather feel your support and interest.



When possible, observe the cooking area and cooking pots for signs of any recent food preparation activities.

Using the Child Status Index with Children in Group Homes or Institutions

For children living in a group home or institution, three items on the CSI can probably be scored similarly for all the children in the group setting: Food Security, Shelter, and Health Services. Be aware of possible individual treatment.

To score the remaining nine factors, however, you must hold separate discussions about each child. If the designated caregiver in a group home or institution does not know the individual child well, identify others who do. You may ask: “Which adult or older child spends the most time with this child?” Or: “Who does this child go to when he/she needs something?”

With permission from the administrator of the home or institution, this would be a good opportunity to discuss these factors directly with the child.

Step 3. Complete the Child Status Record Form

3.1 Complete Part I of the CSI Record Form: Rating on All CSI factors

Immediately after the informal discussion and observations—but ideally after walking away from the household—rate the child on all 12 factors of the CSI.

Make a concerted effort to assign a score for each factor, for every child. The CSI tool uses a four-point scale that ranges from good to very bad:

- 4 = Good; no concerns and no apparent risk.
- 3 = Fair; generally acceptable. Little concerns from caregiver/field worker.
- 2 = Bad; concern, additional services or resources are needed.
- 1 = Very bad; major concerns/problems, situation serious and may be urgent.

I. CSI SCORES:	Date:	Evaluator's Name or ID:
Domains	Scores (Circle One)	Action taken today:
1 – FOOD AND NUTRITION		
1A. Food Security	4 3 2 1	
1B. Nutrition and Growth	4 3 2 1	
2 – SHELTER AND CARE		
2A. Shelter	4 3 2 1	
2B. Care	4 3 2 1	
3 – PROTECTION		
3A. Abuse and Exploitation	4 3 2 1	
3B. Legal Protection	4 3 2 1	
4 – HEALTH		
4A. Wellness	4 3 2 1	
4B. Health Care Services	4 3 2 1	
5 – PSYCHOSOCIAL		
5A. Emotional Health	4 3 2 1	
5B. Social Behavior	4 3 2 1	
6 – EDUCATION AND SKILLS TRAINING		
6A. Performance	4 3 2 1	
6B. Education and Work	4 3 2 1	
Source(s) of information: (Circle all that apply.)	Child, Parent/Caregiver, Relative, Neighbor, Teacher, Family Friend, Community Worker, Other (Specify) : _____ _____	

Circle all sources of information about the child at the bottom of the rating form. Alternative CSI Record Forms that show two or three home visits allow you to rate sequential interviews to compare the child's status over time. (A sample form is included in the appendix to this manual.)

If you are rating multiple children in one household or institution, pause between children and (with the permission of the guardian), rate each child after the interview.

It is important to score the child promptly; it is easy to forget information after interviewing for another child, walking to another household, or engaging in any activity other than thinking about the target child.

3.2 Complete Part II of the CSI Record Form: Important Events

The CSI Record Form includes a section for describing any important events that have happened in the child's life since the last CSI rating (or during the past year for children who have not previously been rated).

II. IMPORTANT EVENTS: <i>(Check any events that have happened since the last CSI assessment or six months.)</i>	<input type="checkbox"/> Child left program <input type="checkbox"/> Child pregnant <input type="checkbox"/> Child died <input type="checkbox"/> Parent ill <input type="checkbox"/> Parent/guardian died (specify who) _____	<input type="checkbox"/> Family member died <input type="checkbox"/> Change in caregiver/adoption <input type="checkbox"/> Change in living location <input type="checkbox"/> Community trauma (violence, famine, flood, etc.) <input type="checkbox"/> Other (Specify) _____	Comment(s) if necessary:
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3.3 Complete Part III of the CSI Record Form: Types of Support/Services Provided

Another section on the CSI Record Form is used to record all services and resources being received by the child, household, or institution at the time of the assessment. This requires a direct interview with the primary adult in the child's life, usually a parent or guardian.

III. TYPES OF SUPPORT/SERVICES PROVIDED (at present):	What was provided?	Who provided services? (e.g., NGO, neighbor, teacher, church, or other)
A. Food and nutrition support (such as food rations, supplemental foods)		
B. Shelter and other material support (such as house repair, clothes, bedding)		
C. Care (caregiver received training or support, child placed with family)		
D. Protection from abuse (education on abuse provided to child or caregiver)		
E. Legal support (birth certificate, legal services, succession plans prepared)		
F. Health care services (such as vaccinations, medicine, ARV, fees waived, HIV/AIDS education)		
G. Psychosocial support (clubs, group support, individual counseling)		
H. Educational support (fees waived; provision of uniforms, school supplies, tutorials, other)		
I. Livelihood support (vocational training, microfinance opportunities for family, etc.)		
J. Other: _____		
Suggestions for other resources or services needed:		

Step 4. Plan Follow-Up and Referrals

When someone uses the CSI to assess the well-being of a child and/or household, they will often identify areas of need in a child's life. Whether the CSI is conducted for evaluation purposes or to plan for a child's individual services, it is important to respond to what is learned about the child's needs, particularly urgent ones. The response should be based on the level of need and the available resources. Preparation of home visitors in using the CSI should include identifying locally appropriate and available responses for each domain/factor at each level of need.

The home visitor can use the CSI rating system (4 = Good, 3 = Fair, 2 = Bad, 1 = Very bad) to determine the type of response needed for each level of need identified during the home visit. The following table can be used as a guide for approaches to follow up.

Rating	Guidelines for scoring	Guidelines for follow up
4	Good. There are no concerns and no apparent risks for this factor.	No follow-up needed. General knowledge about resources can be shared, if appropriate.
3	Fair. The situation is generally acceptable. There are some concerns in this area on the part of the caregiver or visitor. Things could be a bit better.	This is an area that the visitor will want to be aware of in future visits to make sure the situation has not gotten worse. This is not seen as an urgent matter, but if the community worker has information that might help the child or family, it should be provided to them.
2	Bad. The situation is a problem for the child or family.	When a factor is rated as “bad,” it is recommended that the worker consider what the child and family needs are and if there are available resources or services to help. The worker can make the referral directly or discuss with the agency or the village leader to get help for the family, if possible.
1	Very bad. The situation is very bad and may create an emergency for the child and/or family.	When the community worker using the CSI discovers an emergency for the family, the worker must respond accordingly. It is not ethical to do nothing, even if the CSI is used only for evaluation and not specifically for services planning. Home visitors should address the situation or refer the family/child to the appropriate resources. When there are bad circumstances and the worker does not know what the best response is, then the worker should make a plan with the agency director or village or community leader, as appropriate.

The step(s) taken should be documented on the CSI Record Sheet.

Chapter 4. Interpreting the Results

The CSI was developed primarily for use by field workers and program evaluators to:

- Assess individual child well-being.
- Monitor improvements or deterioration of the child's well-being in the CSI factors.
- Identify areas of need for the child, institution or household.
- Understand the child's status comprehensively in terms of support services received and those that are needed over a period of time in the child's life.

Evaluating an Individual Child Receiving Program Services

The CSI may be used initially to assess a child's well-being and needs across areas and to use that information to plan program interventions specific to his/her needs.

To use the CSI to confirm the benefits of services received from a program or combination of programs and resources, community workers should gather information periodically, such as every six months. Note which factors show stability, improvement or deterioration over time.

Service organizations may use either a computer program or paper versions of the CSI Record Form to make comparisons across time. These comparisons can be instructive about the child's benefits from the program, future programming for this child, or the child's needs from other programs in the area.

Consider scores in the total context. The CSI provides a well-rounded picture of the child's life as a whole, across multiple factors. A holistic perspective is essential for understanding the effect of services. For example, a child receiving psychosocial interventions might still show decline on Factor 5A, Emotional Health. When the field worker discovers that this child's parent died since the last assessment, it becomes clear that the lower score does not reflect a failure of psychosocial programming. Furthermore, this information points to additional needs the child may have.

Similarly, a child receiving food supplements and access to health care will not just be better fed (Factor 1A) and have better wellness (Factor 4A). This child may also grow better (Factor 1B), feel better or be happier (Factor 5A), and perform better at school or work (Factor 6A).

Scores may change as assessments get more accurate. Some factors will be rated more accurately when the community worker knows the family better. This is particularly true of Factor 3A, Abuse and Exploitation. A CSI rating might initially be "good" and then "bad" or "very bad" at a later review. That doesn't necessarily mean the situation has deteriorated, but rather that the field worker's knowledge has increased.

For these reasons, program providers should not look at the results of one or two factors in isolation, but rather consider the broader context—even if some factors seem not to be directly related to the services provided.

Furthermore, the holistic CSI approach raises awareness about the multiple dimensions of child development and well-being, which helps service providers and field workers better understand and routinely address these areas in their work with children. CSI information can help field staff/caregivers advocate for children and/or seek additional resources to help individual children, their households, and/or the community.

Evaluating and Improving Services at a Program Level

The CSI is designed to focus on an individual child, but the scores can also be aggregated to be used for program evaluation. An organization serving a number of children may evaluate the 12 factors across all children receiving services in order to assess the program benefits over time. If the program services are not achieving the desired results, potentially demonstrated by low aggregate CSI scores, the program should consider undertaking a quality improvement process. Such a process for OVC programs is described in the publication *Quality Programs for Orphans and Vulnerable Children: A Facilitator's Guide to Establishing Service Standards* (DiPrete Brown, 2008).

The information acquired through this tool can help decision-makers plan, implement and adjust child services based on aggregate information about children in the community or program. The information collected from the CSI across children can also be used to advocate for funding for additional and needed services in a program area.

Guidelines for using the CSI for this purpose are being developed.

Evaluating Outcomes at a Community or National Level

A community assessment before service delivery can help an organization define a program that addresses the documented needs of the children in their area. The aggregate CSI scores for all children in a community can provide a baseline for needed services and serve to inform the program design.

If used across multiple service providers in a community, the CSI can help the various providers collaborate and integrate services to their best advantage, rather than implementing fragmented or redundant services.

The CSI could provide the initial impetus for a community-level consortium of services. The information collected from this level can be used to inform local, district and national leadership for policy making and funding allocations. Aggregate CSI data used to inform government groups and officials can help identify components of care for national plans for orphaned and vulnerable children.

Guidelines for using the CSI for this purpose are being developed.



A focus group with caregivers to discuss child well-being in community, Moshi 2006.

Chapter 5. Translating and Adapting the Child Status Index

The CSI was designed to be broadly applicable for use with orphaned and vulnerable children, but national and local variations are to be expected. The tool can be adapted to different languages, cultures and program purposes, given the following considerations:

- The adaptations should preserve the central concepts, domains, and principles on which the CSI was developed.
- End users, such as home visitors and community workers, should be involved in the adaptation, so the language and concepts are grounded in their actual experience and there is ownership of the tool and process.
- Adaptations are offered for public sharing, so similar information can be shared and compared across countries and languages.

Translating the CSI into Other Languages

When the CSI is consistent with national, tribal, or local languages or dialects, users are more likely to value its use and feel a sense of ownership. Even when the field worker speaks English well, local translations can ensure consistency in interview approach and perceived meaning of domains and factors.

The tool currently is available in English, French, Kiswahili, Khmer, and Chichewa—with drafts being developed in other languages.

The process for translation involves four key steps:

1. The CSI and Record Forms are translated from the original English by person(s) fluent in English and the language to which the CSI will be translated. Translators should keep the essential and basic concepts of the CSI but need not attempt a word-for-word translation.
2. Another person or persons (independent of the first translator) translate this new-language edition back into English.
3. A CSI expert should review the back translation into English.
4. The parties reconcile any differences for the final translation, a process that sometimes requires several back-and-forth communications.

When this is done, the new translation will be made available to all users in that local language by the CSI Web site or by contact with the CSI developers. This process will ensure that all users are measuring the same constructs (domains and factors) with the same rating categories despite different languages.

Adapting the CSI for Local Needs

Local adaptations may involve more than translation to local language and meaning. An adaptation for a specific geographic area or service organization may include changing or adding factors, following these guidelines:

Preserve the six domains, because they were developed and field tested to provide a thorough overview of child well-being. Users may decide to add scales that are useful to their specific population or type of service (e.g., palliative care, adherence to drug therapy), but the existing CSI domains should remain.

Preserve the 12 factors, as much as possible. These dimensions of child development and well-being are universal and interdependent. For example, a program may argue that they are not supporting education, so Factor 6B should be deleted. However, the agency may find that supporting the child in other areas, such as Factor 4B, Health Care Services, improves school attendance. A program could miss an important benefit of their services if factors are deleted.

Follow the CSI model for new factors to be added. An organization may want to add a factor related to a specific service it provides, such as safe water or compliance with anti-retroviral drug therapy (not currently CSI factors). New factors can be added if they adhere to the CSI model for goals and ranking. If the adapted CSI will ever be used across programs, communities, and other geographic areas, number the added factor(s) as 13 and above, so the original 12 factors remain consistently numbered to aid in making comparisons across sites.

Use great caution when removing a CSI factor. Rarely, a CSI factor might be irrelevant to a program's services and desired outcomes. If so, remove the factor only with great caution, good reason, and after field-testing the factor. Preserve the original numbers of the remaining CSI factors to retain consistency.

Keep consistency for the basic scoring method. A common scoring system is important for comparing CSI scores across locations, assessing program performance, and improving service quality. The essential scores should be maintained as follows: 4 = no problems/at desired goal; 3 = fine; 2 = concerned; 1 = very bad/urgent need for action.

A local adaptation may require changing the meaning of a concept, such as "Child Legal Protection" or call for a rating scale other than "good," "fair," "bad" and "very bad." These adaptations should be done before translation and be consistent with the primary factors and their goals, to the extent possible.

Contributing the CSI to Public Domain

The goal for the CSI is that it be universally available and easy to access by all potential users. For that reason, a web site and software for public share are being developed. The web site will have all approved adaptations and translations free to download. Currently, available translations and adaptations are also available from MEASURE Evaluation (<http://www.cpc.unc.edu/measure/csi>).

Chapter 6. Training Field Workers to Use the Child Status Index

The CSI is a straightforward and inferential tool, so it can be used reliably with very little training. In fact, the tool can be used by people with limited literacy skills, which encourages wider participation in M&E.

The Pictorial CSI (Appendix D) can be used by those with very little literacy with the same results in assessing and monitoring child well-being.

Training needs are simple and should include: a review of the tool, how it is scored, and strategies for the interview and observation process.

Who Should Facilitate the Training?

OVC program staff members who understand the CSI factors and procedures and have used the CSI in the field can facilitate the training—or an external trainer can be engaged.

In either case, it is helpful if trainers are involved in or have a good understanding of M&E and how the CSI data may be used to plan services and assess change.

The facilitator should guide the users' discussion about the CSI components and how the tool can be used to gather information about children's well-being. In this manner, the facilitators serve a consultative role, by helping users to understand and apply the CSI to their own particular context without changing the fundamental domains and factors and their meanings.

The facilitator should be culturally sensitive and flexible and should encourage those being trained to participate openly and to ensure their understanding and ability to use the CSI in a consistent and useful manner.

Recommended Training Process

A recommended model for training involves:

- Brief introduction to the goals and value of the CSI;
- Discussion of each CSI domain and factor and how each is rated;
- Discussion of how to respond to each level of need identified (See Step 4);
- Practice in the field, comparing and discussing results;
- Follow-up meeting to discuss home visit and scoring issues.

The practice phase is a key element of the training. Field workers conduct interviews and ratings, then return to the facilitators to describe questions and problems they encountered in rating each domain, discuss how ratings were determined, and to get further clarification, if necessary.

It can be helpful to have two field workers make a joint home visit and score the CSI independently. By comparing any differences in the scoring the facilitator can see where there is difficulty and how to reach consensus about scoring.

To conduct this training, a facilitator will need:

- Paper and pencils;
- Adequate copies of the CSI and CSI Record Form;
- The *Child Status Index Field Users' Guide*, especially the sections describing the factors, sample questions, and suggested visit format;
- Listing or good knowledge of locally available resources and potential responses to identified needs.

The complete CSI packet includes:

- The Child Status Index Tool – the rating and record form;
- The Child Status Index Field Users' Guide;
- The Child Status Index Manual;
- The Child Status Index Pictorial version;
- The Child Status Index Made Easy booklet.

Who Should Participate in the Training?

Local community members and frontline program staff members are in an excellent position to monitor child well-being, because they live in the community, regularly visit households and institutions, and observe children in their community. These same people may also participate in planning and providing community services and hold leadership positions in the local community.

The CSI was created specifically for, and developed with, these frontline service providers as a practical means of assessing child well-being and as a basis for planning, monitoring, and providing services.

Other stakeholders and program administrators may also be trained in use of the CSI, so that they can help to use the information generated by the tool effectively to inform program and policy-level decision-making.

The Other Side of Training – Building Awareness and Consensus

The CSI has potential for building broad consensus within a community regarding the best ways to serve children in need. Users and facilitators should take advantage of ever-present opportunities to build awareness and extend the use of the tool.

Identify stakeholders involved in the care and support of orphaned and vulnerable children. On the local community level, this will include area leaders, caregivers, workers, and volunteers. On the program level, this may include project managers and others responsible for implementing certain types of services. On the national level, this may include ministry personnel responsible for the care of orphans and other vulnerable children and national directors of non-governmental agencies.

Use regular venues to discuss the purpose and value of the CSI. A facilitator who is familiar and knowledgeable about the CSI may interact with stakeholders during their usual committee meetings for discussing signs of child well-being, gathering and using information about child well-being and clarifying program goals and objectives for supporting orphans and other vulnerable children.

Develop a shared vision for taking advantage of the CSI. Facilitators can help stakeholders develop consensus on the purpose of the CSI in their context, why they need to collect and use this data and how often they will choose to collect the information, given the cost, their capacity, and time availability.

With awareness and regular use, the CSI can benefit stakeholders' ability to identify program needs and assess how well their programs are making a positive difference in children's lives.



Training of volunteers on the Child Status Index, Dodoma 2006.

Chapter 7. Development of the Child Status Index

In 2006, the Office of the Global AIDS Coordinator (OGAC) and the USAID/Office of HIV/AIDS (OHA) asked MEASURE Evaluation to develop a Child Status Index, working with the Center for Child & Family Health and the Health Inequities Program at Duke University. The team set out to develop a tool that would be:

- **Child-centered**, reflecting the many factors that describe a child's well-being and that feasibly could be altered through program interventions;
- **Simple to use** by community workers who do not have M&E knowledge;
- **Reliable**, yielding consistent results when information gathering was performed by several people;
- **Broadly applicable**, consisting of constructs that are relevant across diverse cultures and across all ages of childhood, yet adaptable as well; and
- **Scalable**, easily adapted to gathering information at the child, community, program and national levels.

The new tool would help service providers, program managers, community health workers, volunteers, and guardians/caregivers to regularly and systematically monitor the needs and outcomes of children under their care.

Guiding Principles for Developing the CSI

Collaborative Approach

Since the U.S. team included experienced demographers and child psychologists with experience working in HIV/AIDS issues, they could have developed a tool from their own experiences and perspectives. However, team members knew that collaborative development would yield an even stronger tool.

Therefore, the first guiding principle was to develop the tool through a community-based participatory process (e.g., Minkler, 2005)—an approach used to engage community members in addressing their own problems. The participatory approach arose in the 1970s in Africa and Latin American due to crises in governments, the increase in development efforts, and the wish of community members to participate in studies of their lives (Minkler & Wallerstein, 2003).

A collaborative approach produces a more effective assessment tool, for several reasons:

- Assessment is focused at the level of the individual child and based on perceptions of child well-being from local community members.
- In-country community workers are in the best position to understand and monitor child well-being on an ongoing basis. If they helped design the tool, they would be more likely to use it.
- Local representatives would have unique insights into the nuances of language; into specific ways of phrasing questions to produce the most accurate information.

Therefore, the CSI was developed by working with children, their guardians and others in the community, including grassroots organizations, volunteers, and community workers in areas of Kenya and Tanzania with a high prevalence of HIV/AIDS.

High-Inference Assessments

The second principle for developing the CSI was to maximize the direct observations and judgment of local service providers, making use of local experience and knowledge. Community health workers know the families and communities they serve and are familiar with locally acceptable norms and standards for child growth and development.

For example, objective data regarding child nutrition is often obtained using growth charts with which a health provider can provide a statistic for gauging child development, such as weight for age. However, valuable information about a child's nutrition can also be obtained through the subjective assessment of the service provider and the child's caregiver—their opinions about the extent to which the child appears to be growing like other children in a local community.

Depending on the intended use of the information, the most meaningful information may come from direct observations of caregivers, not from statistics. The CSI recognizes and capitalizes on this process, where a community worker observes and makes meaning from the observations. This motivates the worker and organization to intervene in the identified area of child and household need.

Four Phases of Child Status Index Development

Phase I: Exploratory

In phase one, the team conducted a review of relevant scientific literature, current practices and existing frameworks on child well-being measures, to identify the critical factors to be measured and monitored. The initial structure of the CSI was based on global OVC programming guidelines and frameworks, including the *USG/PEPFAR – OVC Programming Guidance* (2006) and *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World of HIV & AIDS* (UNAIDS, 2004). These guidelines are largely informed by prior research and the community experiences in developing programs for children affected by HIV/AIDS.

At the same time, the team initiated a participatory process in rural Bungoma, Kenya, and Moshi, Tanzania—using interviews with parents and guardians of OVC to determine which aspects of child development are seen as critical for a child who has lost one or more parents. These men and women generously provided a simple and consistent algorithm from which to work:

Every child should be:

(1) healthy, (2) happy, (3) safe, (4) learning, and (5) good

In addition, these caregivers demonstrated an ability to describe each of their children among these domains, using observations and judgments to infer their relative well-being. The results of these early interviews framed the basis of the CSI.

Phase II: Consultations with Communities and Experts

In the second phase, the team conducted multiple field consultations, using interviews and focus groups with community workers, village leaders, guardians, parents, and children in urban and rural areas of Kenya and Tanzania.

These local community members—including community workers, volunteers and guardians who live with, care for, and provide services to OVC—were seen as the ones to discuss how to assess a child’s development and needs.

Many of the domains and factors selected for the CSI involve constructs that were described through the lens of their cultural expectations, values, and norms. The field work in this phase, involving these local caregivers and providers, was essential for developing an evaluation tool that would be appropriate for and used by the target group.

Through this community-enhanced approach, the team selected six broad domains to be included in the CSI—aligned with core areas from the PEPFAR, 2006 – *Orphans and Other Vulnerable Children Programming Guidance* (www.pepfar.gov/pepfar/guidance/78161.htm):

- Food and Nutrition
- Shelter and Care
- Protection
- Health
- Psychosocial
- Education and Work

Within these broad domains, the team identified 12 factors that:

- Were child-centered, assessed at the level of the individual child;
- Could potentially be improved with intervention programs; and
- Provided information about urgent situations in a child’s life.

Each factor could be inferred, through informal discussions and observations in a home visit or interview, as “good,” “fair,” “bad,” or “very bad” in the life of a particular child.

The descriptive anchors for rating each factor were created through consultations with service providers in the field as well as technical experts for each domain (such as healthcare and education professionals, psychologists, and legal experts).

Community participants were especially helpful, because sometimes the meaning of a domain or factor was defined culturally. The tool needed to reflect local insights and cultural nuances. For example:

- In Kenya and Tanzania, it quickly became clear that the survey needed to better address the issue of grief—the depression and hopelessness that children felt after losing both parents to AIDS.
- Questions had to be carefully phrased to accurately capture the desired information. For instance, the quality of physical “shelter” might not reflect the child’s actual comfort and safety at home. After discussions in Tanzania, the tool instead gained the broader Swahili term “makazi,” meaning “way of living.”

The result of phase two was a working draft of the CSI.

Phase III: Translation and Field Testing

Refinements Based on Multiple Perspectives

In Kenya and Tanzania, experts from the community and U.S. agencies reviewed iterative drafts of the CSI, offering insights to further refine each factor. Potential users of the tool—including program staff, caregivers, and community workers—discussed every aspect of the tool in order to translate constructs and language and to build consensus among themselves on the operational definitions of the sub-domains.

Translation

The tool was translated into Kiswahili (first in Kenya by Kenyans, then in Tanzania by Tanzanians) and field-tested with community workers in Mombasa, Kenya, and Dodoma, Tanzania.

Testing for Inter-Rater Reliability

During this process, two raters visited a home and had informal discussions with household members. After the discussion, the two rated the child or children independently. Ratings from 118 households in both countries were tested for concordance. Scores were discussed in the group and different ratings understood and resolved. The procedures provided training as well as data on inter-rater reliability.

Testing the Constructs

A preliminary assessment of construct validity was conducted in Bungoma, Kenya, with 80 children and households that were also receiving extensive interviews using well-validated, standardized assessments in the context of a separate research study about orphans and their care (Positive Outcomes For Orphans [POFO]; Whetten, PI, NICHD funded research). Items from the research project were selected to compare with the high inference (subjective) ratings on the CSI to provide preliminary information about the validity of the CSI ratings.

The children and households in the POFO study were not necessarily receiving PEPFAR-funded OVC services. The CSI ratings were compared to items on the POFO interview that were seen as providing objective information about the CSI factor. For example, whether the child has a second set of clothing was compared to the CSI rating on Factor 2A, Shelter. Similarly, the guardian's report about whether the child has enough to eat was compared to Factor 1, Food Security. The CSI was generally supported by this preliminary validity study.

Phase IV: Publication and Dissemination

The fourth phase of CSI development involved creating this manual, a field users' guide, and a pictorial version of the tool. At the same time, team members:

- Trained field workers in the use of the tool;
- Assisted with translations into multiple languages;
- Consulted on adaptations of the tool for unique local circumstances; and
- Worked with various stakeholders in regional meetings and technical OVC forums to discuss policy questions, types of analysis, and how CSI information could be used in planning and developing OVC programs.

Early Positive Feedback

The first trial programs using this tool took place in Ethiopia, Rwanda, India, and Cambodia, where field workers provided additional feedback on the tool's applicability for their contexts.

Field testing affirmed that each factor provides an important and specific (albeit inter-related) view of the child's well-being and needs. Program-level collaborators indicated that the domains on the CSI caused them to consider a child and household more comprehensively and in areas not previously addressed. Community workers reported that using the CSI made a positive contribution to their practice. For example, workers who previously focused on nutritional and education support reported that they paid more attention now to the quality of parent-child relationships and the child's behavior adjustment.

Chapter 8. Validating the Scale

Testing for Inter-Rater Reliability

The domains and factors of the CSI were carefully selected and refined based on extensive research and field investigation. It was important to know if different raters, with their different perceptions, would provide consistent results that could be usefully compared or aggregated. Testing was needed to make sure the rating framework and scoring method were as objective as possible, so results would be credible across raters.

The precision of the CSI was tested in Mombasa, Kenya and Dodoma, Tanzania, with implementing partners (Pathfinder, CRS and AFRICARE) and community health workers. The research team:

- Gave community workers a brief introduction to the tool;
- Reviewed Child Status Index domains, factors, and rating scales;
- Gathered feedback about any needed language and cultural adaptations; and
- Described how to gather information through informal discussions.

Community workers then went in pairs into the field to interview families that had orphans and other vulnerable children in their care and who were receiving services from the agency. After the informal discussions or interviews, the community workers independently rated the same child on the 12 CSI factors. The pairs then returned to the program office or village center to discuss points of agreement and disagreement.

With their consent, the information was entered into an SPSS database to calculate inter-rater agreement. A total of 118 households were visited in both countries; and 118 children were scored on the CSI, each by two field workers.

The Kendall tau coefficient was used to measure the degree of correspondence between the two field workers' rankings for each domain for each child. For these analyses, tau-b is used, because the ranking by each field worker can take on four different values (4, 3, 2, or 1). If the two rankings agree perfectly, the Kendall tau value is 1.0; if the ratings disagree perfectly, the value is -1.0. Higher values indicate greater agreement between the two rankings. The p-values give the probability that the two rankings are consistent.

Results from tests of inter-rater agreement

Domain	Factor	Number of observations	Kendall tau-b value
FOOD AND NUTRITION	1A. Food security	118	0.7856****
	1B. Nutrition and Growth	Not assessed	
SHELTER AND CARE	2A. Shelter	118	0.7749****
	2B. Care	118	0.6256****
CHILD PROTECTION	3A. Abuse and Exploitation	107	0.7487****
	3B. Legal Protection	Not assessed	
HEALTH	4A. Wellness	115	0.7829****
	4B. Health Care Services	115	0.8243****
PSYCHOSOCIAL	5A. Emotional Health	115	0.7428****
	5B. Social Behavior	117	0.7282****
EDUCATION AND SKILLS TRAINING	6A. Performance	116	0.7552****
	6B. Education and Work	114	0.7582****

**** p < .0001

Even though overall agreement was high, the team determined that some factors, such as “Care” and “Abuse and Exploitation,” could benefit from better explanation and more suggestions about how to get the relevant information. For example, some field workers thought they needed to establish that abuse or exploitation took place, when in fact they only needed to rate their level of concern.

Future research with the CSI will use a more current version of the tool (August 2008) and examine inter-rater reliability when the two interviews are conducted separately.

Testing for Validity

Is the CSI a valid reflection of the domains and factors that influence child functioning, well-being, and needs? This question was tested in a preliminary manner by comparing CSI ratings to more objective data about each factor, when available.

For this purpose, the team collaborated with a study of children who have become orphans in Bungoma, Kenya. To date, 75 children have been evaluated with both the CSI and with the extensive interview protocol from the POFO study supported through the National Institute of Child Health and Development, U.S. (Whetten, et al.; unpublished results, 2008).

The POFO study includes measures of child growth and extensive interviews of child and guardian related to psychosocial functioning and symptoms. Data about shelter, education, care, and healthcare are collected using a household survey, which is an adaptation of the survey used by the World Bank for these purposes.

Owing to limited variance on either the CSI or the POFO Household Survey, validity coefficients could be calculated only for the following domains: food security, shelter, emotional well-being, and education. Restricted variance precluded calculation for this initial sample for the remaining factors. Scores for factors 1A and 1B (Food Security and Nutrition and Growth) were also compared to measures of weight for age and height for age. Results are presented in the table as a rank-order correlation coefficient, where a significant p-value indicates a relationship between variables.

Results of CSI accuracy tests (validity) for five domains

CSI domain	POFO item	Rank-order correlation
Food security	How often in the past month did the child go without getting enough to eat?	$Z = 4.37, p < 0.001$
Shelter	Does the child have more than one set of clothes?	$Z = 2.12, p < 0.05$
Wellness	Would you say that child’s health is very good (can do anything), good, fair, poor, or very poor (can’t do anything)?	$Z = 1.59, p > 0.10$
Emotional health	Child is unhappy, depressed, or tearful?	$Z = 2.20, p < 0.05$
Education and work	Is the child currently attending school?	$Z = 3.24, p < 0.001$

Further analysis of factors 1A and 1B (Food Security and Nutrition and Growth) using concurrent POFO data for weight and height demonstrates the relationship between the CSI ratings, determined by observation, judgment, and objective measures, which are often too cumbersome to obtain in the field.

For Food Security, the norms for age and gender for weight and height (WHO Growth Reference Data, 2007) were systematically associated with the CSI ratings (shown in the following tables in terms of standard deviations from the mean for age and gender; all $p < 0.05$ for group differences).

Similarly, the CSI ratings varied systematically for Nutrition and Growth according to the weight and height norms for age and gender ($p < 0.05$) with the exception of the mean standard deviations for height compared to height for age norms. The groups defined by CSI ratings were combined for these analyses when there was a very small number of children (e.g., $N = 5$ or 1) or no children in a group.

Weight and height for gender and age scores relative to CSI ratings

	N	Weight for age mean in SD	Weight for age median in SD
CSI rating for Food Security			
4 Good	56	-0.93	-0.30
3 Fair			
2 Bad	18	-1.64	-1.23
1 Very bad			
CSI rating for Nutrition and Growth			
4 Good	12	-0.92	-0.97
3 Fair	40	-0.98	-0.88
2 Bad	21	-1.11	-1.19
1 Very bad	0		

Height for gender and age scores relative to CSI ratings

	N	Height for age mean in SD	Height for age median in SD
CSI rating for Food Security			
4 Good	56	-0.87	-1.05
3 Fair			
2 Bad	18	-1.49	-1.26
1 Very bad			
CSI rating for Nutrition and Growth			
4 Good	12	-0.94	-1.02
3 Fair	40	-0.98	-1.10
2 Bad	21	-0.94	-1.40*
1 Very bad	0		

The preliminary results support the CSI ratings, relative to objective data about child growth. However, the sample was small ($N=73$) and the ratings were compared to a limited selection of data already being collected for another study. It will be important to continue to study the relationships among CSI ratings and other data on these domains and factors.

Chapter 9. Conclusion

Lessons Learned from Developing and Using the CSI

In the course of working with local community workers to develop the tool, the CSI team learned many important lessons about how this tool can benefit orphans and other children made vulnerable by HIV/AIDS in resource-poor areas.

Community participation produced a culturally appropriate tool that will actually be used. The development process gave potential users an opportunity to identify domains and factors, provide useful feedback, and make important corrections.

The ground-up approach to developing the CSI also improved communication, promoted buy-in, and ensured a local commitment to applying the tool appropriately. Fieldwork revealed that the CSI is well accepted by users.

The qualitative and inferential approach simplifies the process of gathering data and evaluating children, making the tool accessible and meaningful to many people. The simplicity of the framework makes it adaptable to various situations.

The children ultimately benefit. Local workers indicated that the interview and rating process changed their practice and significantly increased their knowledge of the households that they were responsible for monitoring. Because the process emphasizes listening instead of asking direct questions, the interview process also improved relationships between care providers and service recipients.

Community workers using the CSI were motivated to do more for the children than they had done before, which suggests that its continued use will lead to improved quality of children's services.

The data collected through the CSI raises awareness among caregivers and community workers about the multiple dimensions of child well-being, including previously unaddressed areas. This heightened awareness supports them in understanding and addressing these areas routinely in their work and advocacy.

Child Status Index Toolkit

The complete CSI toolkit includes:

- The Child Status Index Tool – the rating and record form;
- The Child Status Index Field Users' Guide;
- The Child Status Index Manual;
- The Child Status Index Pictorial version;
- The Child Status Index Made Easy booklet.

Chapter 10. Tools

APPENDIX A — The Child Status Index

APPENDIX B — The Child Status Index Record Form

Child Status Record

Child's Name: _____ **Age in years:** _____ **Gender:** F/M ____ **Child ID:** _____
Location: District _____ Ward/Division: _____ Village/Neighborhood: _____
Caregiver's Name: _____ **Relationship to Child:** _____

I. CSI SCORES:		Date:	Evaluator's Name or ID:
Domains	Scores (Circle One)	Action taken today:	
1 — FOOD AND NUTRITION			
1A. Food Security	4 3 2 1		
1B. Nutrition and Growth	4 3 2 1		
2 — SHELTER AND CARE			
2A. Shelter	4 3 2 1		
2B. Care	4 3 2 1		
3 — CHILD PROTECTION			
3A. Abuse and Exploitation	4 3 2 1		
3B. Legal Protection	4 3 2 1		
4 — HEALTH			
4A. Wellness	4 3 2 1		
4B. Health Care Services	4 3 2 1		
5 — PSYCHOSOCIAL			
5A. Emotional Health	4 3 2 1		
5B. Social Behavior	4 3 2 1		
6 — EDUCATION AND SKILLS TRAINING			
6A. Performance	4 3 2 1		
6B. Education and Work	4 3 2 1		
Source(s) of information: <i>(Circle all that apply)</i>		Child, Parent/Caregiver, Relative, Neighbor, Teacher, Family Friend, Community Worker, Other (Specify) : _____	
II. IMPORTANT EVENTS:		Comment(s) if necessary:	
<i>(Check any events that have happened since the last CSI assessment if applicable.)</i> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Child left program <input type="checkbox"/> Child pregnant <input type="checkbox"/> Child died <input type="checkbox"/> Parent ill <input type="checkbox"/> Parent/guardian died (specify who) _____ </div> <div style="width: 45%;"> <input type="checkbox"/> Family member died <input type="checkbox"/> Change in caregiver/adoption <input type="checkbox"/> Change in living location <input type="checkbox"/> Community trauma (violence, famine, flood, etc.) <input type="checkbox"/> Other (Specify) _____ </div> </div>			
III. TYPES OF SUPPORT/SERVICES PROVIDED (at present):		What was provided?	
A. Food and nutrition support (such as food rations, supplemental foods)			
B. Shelter and other material support (such as house repair, clothes, bedding)			
C. Care (caregiver received training or support, child placed with family)			
D. Protection from abuse (education on abuse provided to child or caregiver)			
E. Legal support (birth certificate, legal services, succession plans prepared)			
F. Health care services (such as vaccinations, medicine, ARV, fees waived, HIV/AIDS education)			
G. Psychosocial support (clubs, group support, individual counseling)			
H. Educational support (fees waived, provision of uniforms, school supplies, tutorials, other)			
I. Livelihood support (vocational training, micro-finance opportunities for family, etc.)			
J. Other:			
Suggestions for other resources or services needed:			

APPENDIX C — Sample Interview Questions

General Discussion with the Parent, Guardian, or Other Informant

- How are you and your family?
- How are the children?
- Tell me more about this child (use the name of child receiving services).
- How is (tell me about) this child's life?
- What is it like to take care of this child?

If you are talking with the child:

- Tell me about your life.
- Tell me about your typical day.
- Tell me about your future goals and plans.

Food and Nutrition: Factors 1A-1B (Food Security, Nutrition and Growth)

- What does the family/child eat?
- How does the household/institution get the food?
- Tell me about times when there is no food.
- Does this child complain of hunger?
- How is the child growing?
- Does he/she seem to be growing like other children that age?
- Are you worried about this child's growth? Weight? Height?

Observations: Food preparations, food availability, food storage, and the child's growth relative to children of the same age in the community.

Shelter and Care: Factors 2A-2B (Shelter, Care)

- Where does the child live? Sleep?
- Is this house adequate or need repairs? What kind of repairs?

Observations: What is the type and condition of the dwelling? Is the way the child lives similar to others in the household? Ask the child to show you where he/she sleeps.

- Who is the most important adult in this child's life?
- Who takes care of this child?
- For how long has he/she been the most important adult to this child?
- Does this person plan to care for the child as long as needed?
- When something exciting or fun happens, who does the child tell?
- Who does the child go to when hungry?
- Who does he/she go to if sad? — or talk to about worries?
- Who does he/she go to if is hurt?

Observations: Does the adult seem to know the child well? Does this adult or someone else, feel responsible for this child? Is this child on his/her own, without adult care?

Protection: Factors 3A-3B (Abuse and Exploitation, Legal Protection)

- Do you have any worries about this child's safety?
- Does anyone hurt this child?
- Do you think the child feels safe and secure?
- How does this child help in the household?

- Does the child work for anyone outside the household?
- Does anyone else who knows the child think he/she is being hurt by someone else? Or sexually abused?
- Does this child have birth registration or certificate?
- Has he/she been refused any services because of legal status?
- Do you know of any legal problems for this child, such as land grabbing?
- Does this child have an adult who stands up for the child legally?
- Who has the legal responsibility for taking care of this child?
- Does the adult who cares for the child have legal authority to act for the child's best interests?

Observations: Does the child have scars or other signs of physical abuse? Is anyone in the child's world concerned about sexual abuse or other exploitation? Does the child seem to feel safe with the guardian? Does he/she seem to be afraid?

You may want to talk to the child and explore other issues related to legal protection, such as the distribution of land or other goods after parent death.

Health: Factors 4A-4B (Wellness, Health Care Services)

- Tell me about this child's health.
- Tell me about the last sickness (or sicknesses) the child had.
- Does he/she get malaria often?
- Does he/she miss school or work because of illness?
- What happens when this child falls ill?
- Does he/she see a nurse, doctor or any health professional?
- How does the child get to a doctor or a nurse when he/she needs one?
- When he/she needs medicine, how do you get it?
- Tell me about health services the child needs or needed but did not receive.
- Are there things that make it hard to get what the child needs to be healthy?
- Has the child had vaccinations to prevent illness?
- (For adolescents) Has anyone talked to the child about risks for HIV/AIDS and how to protect himself/herself?

Observations: Does this child look well? Has the child been ill on previous visits? Do the caregiver or others worry about him/her being sick? How likely is the child to receive needed health care services?

Psychosocial: Factor 5A (Emotional Health)

- Is this child happy or sad most of the time?
- How can you tell if he/she is happy or unhappy?
- What makes the child sad or worried?
- Do you worry about this child's sadness or grief?
- Have you ever thought the child did not want to live anymore?
- Do you worry he/she might hurt himself/herself?
- Does he/she talk about the parent(s) who died? (If applicable.)
- How is this child doing living here? (when applicable)

Or, ask the child:

- Tell me about your goals in life.
- Do you think you will have a good life?

Observations: What is the adult's attention to the child's emotional well-being? Does the caregiver seem concerned or appear to not know how the child is, emotionally? Does the child seem to have energy? Is the child involved in activities?

Psychosocial: Factor 5B (Social Behavior)

- How would you describe the child's behavior towards others?
- What is his/her behavior toward adults? Obedient?
- Does this child need to be punished often?
- Does the child play with other children or have close friends?
- If so, does he/she enjoy playing/being with other children?
- Does he/she fight with other children?
- What do you do if he/she is unruly?
- Do you worry the child will get in trouble at school?
- What do you worry about for this child in the future?

Observations: If the child is present, what does his/her attitude seem to be about the guardian or other children? How does he/she interact with you?

Education and Skills Training: Factor 6A (Performance)

- Is this baby developing as you would expect?
- Is this baby doing new things, as you would expect of others his/her age?
- Do you have any worries about the child's abilities or learning?
- Is the child quick to understand and learn?
- Is the young person doing well with work?
- Do teachers report that the child is doing well in school?
- Does he/she do a good job with chores at home, such as work in the garden?
- Tell me about something the child does very well.
- Is the child advancing to the next grade as expected?
- Have you worried that this child does not learn as well as other children?
- Do you think this child is very quick to learn, even a better learner than others?

Observations: If the child is very young (under five years of age), observe for yourself the developmental progress, as compared to what you expect for children that age. If the child is an adolescent, ask the child about skills training and learning skills that are useful to him/her.

Education and Skills Training: Factor 6B (Education and Work)

- Is the child in (or has he/she completed) primary school?
- Where does he/she go to school?
- Tell me about the child's school or training.
- Who pays school fees and buys uniforms and school materials?
- (If enrolled) does this child attend school regularly?
- How often must the child stay out of school to help out at home?
- How often must the child miss school for any other reason?
- Does he/she go to work regularly?
- Ask the child about his or her play, school or skills-training activities.

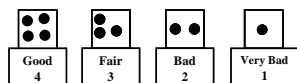
Observations: If possible, observe child's school uniform or supplies and their usage. For infants or preschoolers observe if he/she is involved in any play or learning activity with any family member(s).

APPENDIX D — Pictorial Version of the Child Status Index

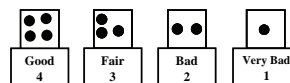
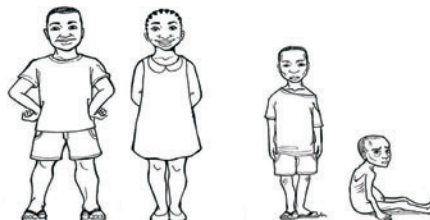
Illustrated by Loide Marwanga

Domain 1. Food and Nutrition

Factor 1A: Food Security

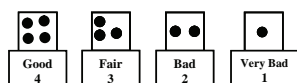


Factor 1B: Nutrition and Growth

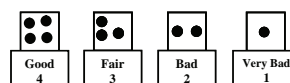


Domain 2. Shelter and Care

Factor 2A: Shelter

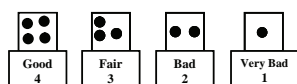


2B: Care

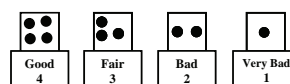
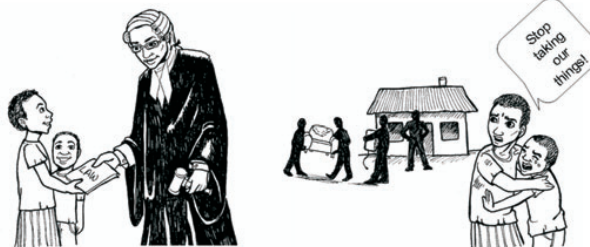


Domain 3. Protection

Factor 3A: Abuse and Exploitation

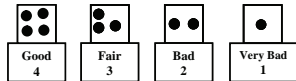


Factor 3B: Legal Protection

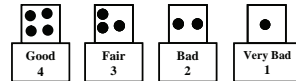


Domain 4. Health

Factor 4A: Wellness

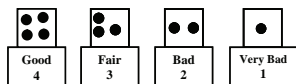


Factor 4B: Health Care Service

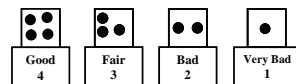


Domain 5. Psychosocial

Factor 5A: Emotional Health

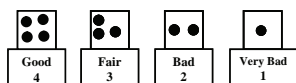
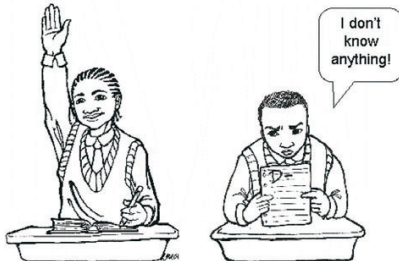


Factor 5B: Social Behavior

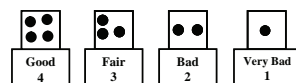
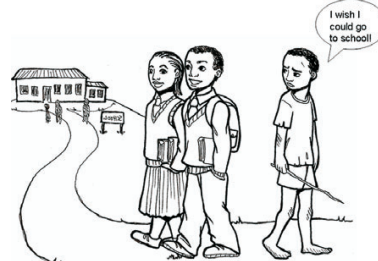


Domain 6. Education and Skills Training

Factor 6A: Performance



Factor 6B: Education and Work



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Carolina Population Center
The University of North Carolina at Chapel Hill
206 W. Franklin St., CB 8120
Chapel Hill, NC 27516 USA
www.cpc.unc.edu/measure

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