

The Child Status Index Usage Assessment

Prepared by:

Molly Cannon
Elizabeth Snyder



MEASURE Evaluation is funded by the U.S. Agency for International Development (USAID) under Cooperative Agreement GHA-A-00-08-00003-00 and is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with Futures Group, ICF International, John Snow, Inc., Management Sciences for Health and Tulane University.

Contents

Acknowledgements	4
Executive Summary	5
Background	5
Methods	5
Findings	5
Conclusion	6
Recommendations	6
Background	9
Methods	11
Process	11
Study Design	11
Data Collection	11
Data Analysis	12
Limitations	12
Findings	13
Respondents	13
Motivation to Use the CSI	13
Government-Led Initiatives	14
Program Use of the CSI	14
Linkages and Referrals	16
Administration of the CSI	17
Data Management of the CSI	18
Data Analysis	19
Training	19
Adaptations	21
Implementation of the CSI	22
Advantages of the CSI	24
Suggestions for Improvement	25
Discussion	27
Conclusion and Recommendations	29
References	31
Appendix: Interview Questions	33

Acknowledgements

The authors wish to acknowledge and express sincere gratitude for the contributions of several individuals in the design and conceptualization of this assessment.

- ❑ The Child Status Index (CSI) authors — Karen O'Donnell, with the Departments of Pediatrics and Psychiatry and Behavior Science at Duke University Medical Center and Center for Child and Family Health; Florence Nyangara, formerly with MEASURE Evaluation and now with ICF International; and Beverly Nyberg, formerly with the Office of the Global AIDS Coordinator (OGAC) and currently with the United States Peace Corps — who provided important insights into the history of the CSI and helped to define the purpose of the assessment.
- ❑ Jenifer Chapman, Scott Moreland, Karen Foreit, and Heidi Reynolds of MEASURE Evaluation for technical guidance and input.
- ❑ Janet Shriberg and Gretchen Bachman with the Office of HIV/AIDS, U.S. Agency for International Development (USAID) and U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Orphans and Vulnerable Children Technical Working Group, who provided considerable technical guidance on the assessment protocol and interpretation of assessment findings.
- ❑ MEASURE Evaluation and Futures Group field staff members Leontine Gnassou (Côte d'Ivoire), Senait Tibebe (Ethiopia), Candy Basomingera (Rwanda), Shannon Salentine (Kenya), and Yinka Falola-Anoemuah (Nigeria), who provided initial contact with individuals and organizations using the CSI during the recruitment process.
- ❑ Candy Basomingera translated the interview guide into French, conducted all French interviews, and oversaw the transcription of those interviews. MEASURE Evaluation staff at the University of North Carolina at Chapel Hill and Nora Weiss with Futures Group provided assistance with editing, formatting, layout, and design.
- ❑ Special thanks to all of the individuals who participated in interviews.

The CSI is a MEASURE Evaluation tool authored by Karen O'Donnell, Florence Nyangara, Robert Murphy, and Beverly Nyberg with funding from PEPFAR.

Executive Summary

Background

Prior to 2008, programs for children who are orphaned and made vulnerable by HIV/AIDS assessed their interventions primarily by tallying the numbers of children served, as well as services provided to those children/households through the programs. At that time, there was an absence of monitoring and evaluation (M&E) tools to guide such programs in determining the needs of children, monitoring children's well-being, and assessing how programs were making a difference in the lives of the children they served.

To assist these programs in collecting and using information about the well-being of vulnerable children, the Child Status Index (CSI) was created in 2008.¹⁻³ The CSI was designed to meet demand for a tool that could be implemented by low-literate (typically volunteer) community caregivers to periodically capture children's status across the six domains of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) programs for children who are orphaned and made vulnerable by HIV/AIDS: food and nutrition; shelter and care; child protection; health; psychosocial; and education and skills training.

There were hopes that the CSI, with some adaptation, might meet a broad range of information needs from local to the national levels. Consequently, the CSI has been implemented as a tool for different purposes, from case management to program evaluation. In response to this, MEASURE Evaluation and the U.S. Agency for International Development (USAID) determined a need to systematically assess how programs are implementing the CSI and using its information. In addition, we wanted to understand program needs for additional tools to meet care, support, and M&E demands.

Methods

MEASURE Evaluation conducted a qualitative study involving in-depth telephone interviews with program technical leads among large programs implementing the CSI. During interviews, participants were asked about materials created to complement the CSI, such as presentations, manuals, training materials, new or additional tools linked to child well-being measurement, and other language translations of the CSI. The study team collected these materials and analyzed them for common adaptations and training themes. Content analysis was applied to interview data using a coding scheme developed by the authors, and as well as newly identified themes using QSR, Nvivo version 8.0.

Findings

A total of 25 organizations in 13 countries took part in the in-depth interviews, most of which were conducted by telephone. The majority of interviews were conducted with technical leads of large programs for children who are orphaned and made vulnerable by HIV/AIDS; four interviews were conducted with smaller case management or social work programs. Twenty-one interviews were conducted with organizations in sub-Saharan Africa and four with those in the Latin America/Caribbean and Asia regions.

Most respondents indicated that their program uses the CSI in multiple ways to suit a variety of information needs. The most common uses of the CSI were to conduct needs assessments, monitor the status of individual children, and as a decision support tool for individual children. Several programs also reported using the CSI for outcome evaluation, program evaluation, and performance monitoring.

Overall, the CSI has been translated into at

least 15 different languages. Most interviewees described making minor changes to the CSI, such as changing pictures or scales. However, several organizations made more significant changes, such as removing/modifying entire domains. In two instances, the CSI had been changed extensively and renamed.

Most organizations conduct step-down or cascade training for the CSI, though a few organizations reported conducting ad hoc or informal training. The amount of training time devoted to the CSI ranged from 45 minutes to three-and-a-half days. Several concerns were raised regarding the cascade training approach, in that the quality of training declines as the training steps down each level.

The greatest challenge described by interviewees was that the CSI scores are based on perceptions of the CSI users and caregivers, which led to concern that inter-rater reliability may be low. The achievement of inter-rater reliability requires the CSI users to be sufficiently trained and supported in the field to manage their caseload and assess the needs of children in their care using the CSI.

Despite challenges raised with implementation of the CSI, all interviewees reported that the CSI is useful. Respondents reported that the CSI is comprehensive, allows for monitoring the well-being of children, aids in program planning, uses a numeric scoring system, and provides a framework for service delivery of programs for children who are orphaned and made vulnerable by HIV/AIDS. Further, four countries have included the CSI as a national tool and two countries are linking the CSI to their service delivery standards and quality improvement guidelines.

Conclusions

This study confirms that there is wide variability in how programs are using the CSI and a lack of clear guidance on the purpose of the CSI, who should use it, when and how often it should be implemented, and how information generated from the assessments should be used. It is evident that while the CSI is a useful tool, it is unable

to meet all M&E needs and should be used in conjunction with other tools and information available. Programs for children who are orphaned and made vulnerable by HIV/AIDS need to define information needs and align M&E tools to meet those needs.

While improved inter-rater reliability can be achieved through strengthened training, the CSI was designed to support an assessment of children's strengths and needs relative to their local environment. Therefore, it is possible that a child may score differently depending on his or her community of residence. Certainly, comparison across countries of scores among individual children is not possible. This assessment confirmed that some programs are aggregating the CSI data to the national level. This may not be appropriate given that ratings are relative to the local context.

Recommendations

In light of findings, the following recommendations are provided to help MEASURE Evaluation meet the M&E needs of programs for children who are orphaned and made vulnerable by HIV/AIDS:

- ❑ Clarification should be provided on the more challenging aspects of the CSI implementation, including appropriate uses of the CSI, referral protocols, and data management and analysis.
- ❑ A training manual for the CSI should be made available to better address training needs.
- ❑ Existing documents (manual, field guide, and a "made easy" booklet) for the CSI should be revised to reflect new guidance. The manual should, to the extent possible, provide further explanation on how to provide ratings of 1, 2, 3, and 4.
- ❑ Pictorials should be adapted for the Latin America/Caribbean and Asia regions. Additionally, thought should be given to adapting

the tool more comprehensively for these regions as the issues, norms, and guidance are different.

- ❑ An M&E tool kit should be created to highlight how the CSI complements other M&E tools used by programs that serve children who are orphaned and made vulnerable by HIV/AIDS. Such programs would be guided to consider their M&E needs and select from available M&E tools to meet those needs.
- ❑ The U.S. government Orphans and Vulnerable Children Technical Working Group and MEASURE Evaluation should develop a communications strategy that reaches all agencies currently using the CSI and those who may use the CSI in the future.
- ❑ In addition to expanding the scope of Child Status Net, additional opportunities and support for those using the CSI should be considered.

Background

Programs for children who are orphaned and made vulnerable by HIV/AIDS collect information at individual child, household, program, or population levels to meet the information needs of a diverse group of stakeholders, from social welfare workers and home visitors to program staff and national policymakers. Prior to 2008, programs primarily assessed their interventions by tallying the numbers of children served and services provided to those children/households by the program. During that time, there was an absence of monitoring and evaluation tools (M&E) available to guide such programs in determining the needs of children, monitoring the children's well-being, and understanding whether or not these programs made a difference in the lives of the children they served.

To assist programs in collecting information about the well-being of children who are orphaned and made vulnerable by HIV/AIDS, the Office of the Global AIDS Coordinator (OGAC) and the U.S. Agency for International Development (USAID) /Office of HIV/AIDS (OHA) commissioned MEASURE Evaluation to develop a tool that would collect such information. In conjunction with the Center for Child and Family Health and the Health Inequities Program at Duke University, MEASURE Evaluation published the *Child Status Index: A Tool for Assessing the Well-Being of Orphans and Vulnerable Children* in 2008. The Child Status Index (CSI) was designed to meet demand for a tool that could be implemented by low-literate (typically volunteer) community caregivers to periodically capture children's status across the six domains of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) programming for children who are orphaned and made vulnerable by HIV/AIDS: food and nutrition; shelter and care; protection; health; psychosocial; and education and skills training. The tool was designed to be child-centered, simple to use,

reliable, broadly applicable, and scalable.¹

The CSI authors used a community participatory process to create the CSI, and the tool was field tested for construct validity and inter-rater reliability. Once the tool was complete, a manual,¹ field guide,² and booklet³ for the CSI were published and posted to the MEASURE Evaluation Web site. Organizations quickly began using the tool and adapting it for their purposes. Although there was no formal rollout or launch of the tool, a regional conference was held in Kigali, Rwanda in 2009 to provide training. Participants felt that they would benefit from an online community of practice, so Child Status Net (CSNet) was launched as the primary vehicle for sharing knowledge and experiences regarding the CSI. In addition, a training-of-trainers session was held in Mombasa, Kenya in the summer of 2010. Otherwise, training for the CSI was conducted informally, without the involvement of MEASURE Evaluation.

Since the CSI was created at the request of OGAC and OHA, it was initially used for monitoring projects funded by PEPFAR for orphans and other children made vulnerable by HIV/AIDS. Following the availability of the CSI, MEASURE Evaluation had evidence suggesting that the CSI was becoming increasingly popular and was being used worldwide by a variety of programs that serve such children (PEPFAR and non-PEPFAR). Since the launch of these publications for the CSI, 2,715 copies have been downloaded from the MEASURE Evaluation Web site and 1,750 printed copies have been distributed. CSNet membership indicated that the CSI was being used in approximately 16 countries, including 13 sub-Saharan nations. Two recent studies related to the CSI also point to its widespread use.⁴⁻⁵

While usage of the CSI was increasing, anecdotal evidence suggested that the CSI was being used in

different ways and that information generated from the CSI was being used at child and programmatic levels. A University of North Carolina study⁴ had a low response rate (21%) and a Boston University study⁵ collected information from users of the CSI in different countries, but through the use of an on-line questionnaire that yielded limited information. Given the widespread usage and anecdotal evidence, MEASURE Evaluation and USAID determined that there was a need to systematically assess how programs implement and use the CSI and to understand program field needs for additional tools to meet care, support, and M&E demands.

Methods

Process

To prepare for the assessment, seven key informant interviews were conducted with representatives from MEASURE Evaluation and Duke University, including the original authors of the CSI tool; and from USAID OHA, and OGAC. An initial assessment protocol was drafted with input from the Orphans and Vulnerable Children (OVC) Technical Working Group (TWG) comprised of OHA and OGAC membership. In April 2011, a meeting was held in Washington, DC to review the purpose of the study with the TWG and discuss key concerns and areas of interest for the study. Following that meeting, the key study questions were agreed upon:

- ❑ For what purposes are programs using the CSI?
- ❑ What are the advantages and limitations of the CSI?
- ❑ What are the unmet M&E needs of programs?

Study Design

To ensure maximum spread across geographic regions/countries using the CSI, the study design included in-depth interviews with representatives from large programs serving children who are orphaned and made vulnerable by HIV/AIDS in each of the 16 countries where use of the CSI was known. To identify the programs to be included, a snowball sampling approach was used at two levels.

First, the study team identified key contacts through colleagues at MEASURE Evaluation, OVC focal persons at USAID, and/or CSNet members in countries where use of the CSI was known and e-mailed them requesting the names and contact information for key programs in the country. MEASURE Evaluation selected up to four programs per country to target for in-depth interviews. E-mail invitations requesting a telephone interview with the technical lead for

children who are orphaned and made vulnerable by HIV/AIDS were sent to each program's contact, who was either the chief-of-party, program technical lead for such children, or the M&E officer. The study team followed up between one and five times, depending on the program and the response.

Second, each interviewee was asked for a list of other programs using the CSI that should participate in the assessment. The interviewer obtained contact information and followed up as needed, depending on the total number of programs already interviewed in a country. MEASURE Evaluation reached out to 16 key contacts. Seven were MEASURE Evaluation staff, five were CSNet members, and there was one contact each from USAID Washington, Futures Group, United Nations Children's Fund (UNICEF), and FHI 360. All five of the CSNet contacts were eligible to participate, and interviews were conducted with four of them. From the initial key contacts, we reached out to an additional 28 interviewees, of which 20 participated. The remaining eight contacts did not respond to requests for an interview. In addition, one interviewee who was not a key contact provided us with an additional contact who was interviewed, for a total of 25 interviews.

Data Collection

A semi-structured interview guide was created for the assessment (see appendix). The guide was divided into four sections: programs for children who are orphaned and made vulnerable by HIV/AIDS, use of the CSI, training involving the CSI, and reporting and information use of the CSI. The guide was pilot tested in two countries using cognitive interviewing techniques and then translated into French by a native French speaker from the MEASURE Evaluation staff.

The interview guide was submitted to the Futures Group's Internal Research Review Committee for review. The assessment process, including the

interview guide, was determined to be exempt from institutional review board (IRB) review.

The interview guide, including a statement obtaining informed consent, was provided to all interview participants via e-mail prior to the interview. Verbal consent was obtained at the start of the interview, both for the use of information gathered in the study and for permission to record the interview. A participant could consent to participate in the interview without consenting to be recorded.

Twenty-two interviews were conducted between May and June of 2011. Interviews lasted from 60 to 80 minutes. In addition, two interviewees requested to fill out the interview guide and return the answers via e-mail as a result of time constraints and scheduling conflicts.

Interviews were conducted primarily by two MEASURE Evaluation staff members located in Chapel Hill, NC. Interviews were conducted over the phone or via Skype and were recorded. During each interview, the interviewer took detailed notes. Three interviews with users of the CSI in francophone countries were conducted by the MEASURE Evaluation staff member who had translated the interview guide into French. These telephone interviews took place from Kigali, Rwanda. Interviews conducted in French were translated and transcribed by an independent firm in Rwanda. Interviews recorded in English were transcribed by an independent firm in North Carolina, when possible. Due to telephone reception issues, not all recordings were clear enough to be transcribed, in which case the detailed interviewer notes were used for data analysis.

During interviews, participants were asked about materials created by their organization in relation to the CSI. These materials include presentations, manuals, training materials, new or additional tools, and translations of the CSI. After the interviews were completed, staff e-mailed and requested copies of relevant materials from the interviewees. The materials were compiled and analyzed for

common adaptations and training themes.

Data Analysis

After data collection was complete, staff selected five interview transcripts and both interviewers read through each to identify preliminary themes and sub-themes from the interviews. The two came to agreement on the themes to be explored in data analysis. The primary interviewer conducted content analysis using the agreed upon coding scheme and newly identified themes using QSR, Nvivo version 8.0. The identified themes were aggregated by program variables (i.e., size and type of program) and type of user of the CSI (i.e., person administering the CSI to children). After themes were identified, staff created tables and matrices of cross-cutting themes including important quotes from interviewees. In addition, all manuals, adaptations, training materials, and related materials for the CSI were collected and catalogued. Staff analyzed all materials to discern themes, which were used to supplement and verify interview data.

Limitations

While the study team took care to ensure high quality telephone calls and recording, there were challenges. As mentioned earlier, some interviews could not be transcribed due to poor connections. In order to alleviate any data gaps resulting from missing transcripts, interviewers took excellent notes to refer to when transcripts were unavailable or unclear. Although the transcriber could not make out all of the interviews, the interviewers were able to use the recordings to resolve any confusion in their notes. In addition, interviewees were e-mailed for clarification in cases where the notes and the recordings were unclear.

The study, by design, only spoke to a couple of high-level program staff in each country. For the most part, the interviews only captured the perception of the CSI use in the field. We have no data from those community-level workers who actually administer the CSI.

Findings

Respondents

A total of 28 people in 25 organizations were interviewed, representing 13 countries and one regional-level technical supervisor (table 1). The majority of interviews were conducted in sub-Saharan Africa (n=21), but interviews with organizations were also conducted in Cambodia (n=2), India (n=1), and Honduras (n=1). While the CSI is being used in Lesotho and South Africa, the study team was not able to schedule an interview with any organizations in those countries. Interviews with 21 organizations were conducted by telephone or Skype, two in person, and two were self-administered and submitted via

Table 1. Number of Organizations Where Interviews Were Conducted, by Country

Country or Region	Number of Organizations
Cambodia	2
Cote D'Ivoire	1
Ethiopia	2
Honduras	1
India	1
Kenya	2
Malawi	2
Nigeria	4
Rwanda	3
Tanzania	3
Uganda	1
Zambia	1
Zimbabwe	1
Regional (Africa)	1
Total	25*

* A total of 28 people from the 25 organizations were interviewed. In India, four people from two projects within the same organization were interviewed.

e-mail at the request of the interviewees. Three of the interviews were curtailed due to time constraints or connection challenges.

While the initial focus was on “large umbrella” programs for children who are orphaned and made vulnerable by HIV/AIDS, through snowball sampling a mix of program types were included in interviews. Twenty of the organizations were large programs such as Save the Children, FHI 360, Pact, Pathfinder, and Catholic Relief Services (CRS). These organizations typically were awarded large grants to serve such children and oversaw sub-grantees responsible for program implementation. Four of the organizations were smaller case management or social work programs that had a specific focus area, such as working with street children or drug users and their children. At these smaller organizations, those administering the CSI were typically paid case workers or social workers. A representative from a research organization was interviewed, as well as a ministry-level government agency. While most of the organizations interviewed use the CSI to serve individual children, three of them use the CSI to serve all children within a family, using a more “vulnerable family” approach.

Of the 28 interviewees, most held positions from three main categories, although there were exceptions. Positions included managers and technical staff of programs for children who are orphaned and made vulnerable by HIV/AIDS (n=15), other technical staff (n=6), M&E staff (n=4), a researcher (n=1), an executive director (n=1), and one respondent who did not answer this question.

Motivation to Use the CSI

Interviewees were asked to describe how they first learned of the CSI and how they came to use it in their organization. Responses included

hearing about the CSI from USAID (n=8), their own nongovernmental organization (NGO) (n=6), a government department or agency (n=5), other NGOs or organizations (n=2), MEASURE Evaluation (n=2), UNICEF (n=2), the CSI authors (n=2), the U.S. Centers for Disease Control and Prevention (n=1), and a colleague (n=1). One interviewee described how her organization learned about the CSI:

It was related to another initiative from USAID — the Quality Assurance and Improvement Initiative ... they were looking at quality assurance and felt the CSI tool would be useful. It was recommended by MEASURE Evaluation and the USAID mission in Ethiopia.

In another example, an interviewee explains how her organization learned about it from their headquarters staff:

The tool was introduced by an OVC specialist working at the headquarters level who had experience using it in Africa and strongly recommended we use it to “assess the overall status of the child”.

Government-Led Initiatives

Respondents from six countries described the involvement that various government agencies have had in the countrywide usage of the CSI. In Nigeria, Rwanda, and Côte d’Ivoire, the governments led the process of adapting the CSI for nationwide use. In Nigeria and Rwanda, the CSI has been adopted as a national tool and in Côte d’Ivoire and Tanzania (as part of the Most Vulnerable Child Guidelines), the CSI is highly recommended as a national tool. In Ethiopia, the CSI is associated with the Standardized Service Delivery guidelines; and in Kenya, the government is rolling out Quality Improvement Guidelines tied to programming and the core areas of the CSI. One interviewee described the process of such government coordination:

It’s first a consensus that we wanted to have at the national level. That consensus, of course, brought together the government, financial partners, technical partners, i.e., the big NGOS ... and field partners including social service centers and local NGOs at the community level. So, it’s through different meetings that we weighed each and every tool, we assess the tools with their individual purpose and benefits, and we adopted them. ... It’s rather a national consensus and it is not imposed in any way; but of course, there is a high recommendation of their use.

In another country, the government has also trained district-level staff to assist NGOs and other implementing partners in monitoring children who are orphaned and made vulnerable by HIV/AIDS and results of the CSI. A government official said all stakeholders involved were using the CSI:

That’s why we have planned a training session for partners, with centers for children with disabilities ... with orphanages, where we call upon some training on CSI so that they can use it easily ... and implementation is at the district level ... that’s why we trained district officers on CSI so that they can understand the CSI tool and that they can help partners’ staff ... our partners at the district level with coordination but also to advise them and assist in monitoring the use of the CSI tool.

Program Use of the CSI

Interviewees were asked to describe purposes for which they use the CSI — for example, as a tool to assess needs, monitor children’s status, provide case management, or evaluate program activities. Respondents indicated they use the CSI in more than one way, depending on their programmatic needs and on requirements of their organizations. Most of the respondents interviewed (n=16) described using the CSI to conduct needs assessments, either for individual children or at a programmatic level, to monitor the status of individual children, and to

make decisions about services provided to children.

Needs Assessment — For organizations that use the CSI to assess needs, interviewees described being able to identify domains or sub-domains in which children needed assistance, or which areas should be targeted to address programming gaps. One interviewee described how the organization used the CSI to assess needs:

We used it to make a decision about the program needs at the beginning, to know what were the needs so we could implement and develop actually new components to the program to support children of drug users. So, that was the main objective of the CSI tool at the beginning.

Another interviewee shared how the CSI was used for a needs assessment:

After carrying out the CSI, we noticed that for most of the children, the challenge is education. Now, out of 100 children, if the challenge is education with 80% or 90%, then you know that that community has a challenge for education.

Monitoring Status of Children — Organizations also described using the CSI to help monitor the status of individual children, particularly after services are provided. As one interviewee described it:

When we take a child back to a family, there's obviously the placement visit and then we provide a series of follow-up visits; so we're using it at the placement and then at the follow-up to assess the family situation. So, I think I can talk about it in terms of monitoring a lot.

Another interviewee explained how the organization uses the CSI for child monitoring:

It helps in assessing the child's status at the time when he gets in contact with an organization through volunteers; and then, the progress made within the time of intervention.

Individual Child Care — Another way that interviewees describe using the CSI is to make decisions about providing services for children:

It can assess decisions about placing the child, but then also about what follow-up support they need and, in some cases, whether a child actually needs to be removed from that family if the placement isn't going very well.

Decisions about what services to provide to children are often made either through referrals or through targeted case management (n=5). Use of referrals will be described in more detail later in this report, as this is a common approach programs use to provide services across the six domains and 12 sub-domains. Another way that programs make decisions about service provision is through case management, and this is primarily done by the organizations that employ social workers or case managers. One interviewee from a case management organization described how the CSI data are used to inform a family plan:

Well then, the information gathered in forms is used to help with putting together the family plan. So the case manager then meets with the social worker. After the social worker has done their diagnostic piece they come up with what areas of priority should be addressed and then they put the plan together. They present the plan to the family including the information from the tool and then the plan is implemented based on that. Then the file goes into each family's chart.

Outcome Evaluation — Eleven of those interviewed described using the CSI to conduct outcome evaluation, with an additional three organizations planning to use it for outcome evaluation. In this regard, one interviewee described what the interviewee's organization would like to be able to do with the CSI:

One of the things we really want to be able to say is, "This is the impact we've had on children's lives, when they've gone home. Can we say this is the improvement we've seen

either in the different domain areas or overall from each?” We want to be able to make statements about improving the children’s well-being.

Another interviewee described a similar need for outcome evaluation data:

We would like to have a baseline to sort of say this was the situation before we started, what are some of the things that we didn’t take into account, what can we take into account going forward and then at the end of it all because we’re running the CSI every year, then at Year 5 we can say this is how we started, this is what emerged, this is what didn’t work, and this is where we are at. I think for us that’s what’s really important.

Program Evaluation — Interviewees also described using the CSI for program evaluation purposes to determine if their programs are on track with regard to meeting the needs of children and for making programmatic decisions (n=7). An interviewee described how his or her organization analyzes the CSI data to make such program decisions:

An electronic database has been developed by us to generate information on each OVC in a local government area/district. The program is able, at a click, to view the proportion of OVC enrolled with very bad, bad, and fair scores and plan areas of resource needs. A large proportion with high good scores in one particular domain means it is not necessary to put resources in that area.

Performance Monitoring — Two organizations described how they use the CSI for performance monitoring to determine if they are doing well or if sub-grantees that are providing services to vulnerable children are doing an adequate job of providing care. One interviewee explained how he reviews the CSI data by sub-grantee over a given time period to look for changes in scores across domains. If one sub-grantee’s scores have worsened, he indicated this provides information

on how the sub-grantee may not be performing adequately.

One organization is using the CSI to conduct research. In this case, the CSI is one of many instruments used to evaluate an intervention among children who are orphaned and made vulnerable by HIV/AIDS. Two other organizations using the CSI are applying research methods to the use of the CSI through sampling. In one of those cases, Lot Quality Assurance Sampling (LQAS) is used to identify a sample of vulnerable children for whom the CSI will be administered.

Linkages and Referrals

Programs for children who are orphaned and made vulnerable by HIV/AIDS provide different types and levels of service to children depending on program targets, goals, and objectives. Nevertheless, programs typically administer the full CSI to children covering all domains and sub-domains. Respondents described giving referrals for many of the domains and sub-domains, though the most frequent external referrals were for legal, health, and shelter-related services. Nearly all respondents indicated that their organizations refer for services, either internally or externally. For example, some of the organizations may have smaller units that can provide services directly to a child, or to a caregiver or family; and in other cases, organizations may need to refer people to another agency for services. One interviewee described how this process works for the interviewee’s program:

If it’s a nutritional problem ... we’ve got food baskets and vitamins ... that would be an internal reference to our nutrition program. If it’s a legal issue, like for example kids are not being treated properly by their families, there’s abuse and that’s usually in combination with a social worker, they would make a reference to the family court system.

Formal and informal referral protocols were described by interviewees. Formal referral protocols involve those where there is written guidance

for providing referrals, a form for documenting referrals, and steps for conducting follow-up on referrals. Informal referral protocols are those where written documentation is not available, though a process for the referrals was described by the interviewee. We attempted to substantiate the existence of referral protocols but were unable to do so, even after repeated emails. Just three interviewees provided protocol documentation upon request. In addition, interviewees from 10 organizations responded to our request by indicating that, although their organizations make referrals, the organizations do not have a written referral protocol. The remaining organizations did not respond. Three e-mails were sent as part of the follow-up process for referral protocols. Despite not being able to substantiate referral protocols, we are presenting some examples of how representatives described the referral process. One organization's representative described how the CSI prompts them to make a referral:

If a child scores a 1, a bad situation triggers referral and follow-up. Each partner has a protocol with a reference sheet they create, listing referral places in their district/area.

The interviewee at that same organization spoke about using mobile technology to follow up on referrals, saying that the program,

keeps track of the active follow-up list and triggers the case worker to select if the case is closed or if there is a need for further follow-up. The extent of follow-up depends on the severity of the case.

Some program representatives (n=5) described how they use existing community-based committees that review the CSI findings and make decisions about service delivery. One described it this way:

During monitoring visits, when a child is identified by either a volunteer or a field officer with a need, they look for alternative ways of getting support, either through the [community-based] committees, through the caregiver, through the volunteer, or through

the local organization — if all of the above is not possible, then a referral is made and a child is referred to a service provider who is able to support that need.

Some interviewees discussed the importance of fostering relationships with other service providers in the catchment area, to ensure adequate availability of services in all referral areas. One interviewee described her organization's work in this area and how information generated from the CSI could inform the referral system:

We've been experimenting with how to build relationships locally to connect the families that we're working with into a bigger system ... and I think CSI is going to be part of the decision-making procedure for how we do that; I think it's going to give us that information about the kids in families which we previously haven't had.

Administration of the CSI

The majority of respondents indicated that their organizations (n=19) use some type of volunteers to administer the CSI. Interviewees used the following terms to describe the volunteers: community-based volunteers, community health workers, family care volunteers, parish action volunteers, and teachers. In some cases, these volunteers are offered a stipend for their work. A few of the organizations (n=6) use paid staff such as health educators, research staff, social workers, or case managers to administer the CSI.

Interviewees were asked to describe how the CSI information is collected in the field. In most cases, those administering the CSI complete the form in the field just after they visit a home rather than during the visit itself, to ensure that children and caregivers feel more comfortable.

When asked how frequently the CSI is administered, most respondents indicated every six months, and they typically referred to the CSI manual recommending this frequency. The frequency of administration of the CSI varies

depending on whether or not a visit is being combined with another programmatic need, the needs of an individual child, and logistical considerations of the program. Respondents indicated that the CSI is one of many tools used in their programs; for example, other often-cited tools used included identification forms, registration forms, home visit forms, activity summaries, and service tracking tools. It appears that some programs have exclusive administration visits for the CSI, whereas others tie the CSI more directly to the needs of an individual child, as indicated by this interviewee:

We can't say it happens every six months, because it entirely depends on the child and the family, so for some children — some children, they may not get any follow-up support if we place them and we're confident in the family and there isn't really any support they need from [our organization], then they may never see [our staff] again. But for those kids that perhaps are going back into families that are struggling a lot, then they may see us a few weeks later and then a few months later, and that may continue for a couple of years. For other children somewhere in the middle, they may only see us once or twice after the placement, so it's quite random.

A couple of interviewees discussed how challenging it is for large programs to implement the CSI every six months due to logistical reasons as well as the reality of how much improvement a child can actually make during such a brief period.

Data Management of the CSI

Interviewees were asked to describe how the CSI information is processed once it has been collected at the child or household level. Nearly all respondents reported that those administering the CSI complete a form about the CSI on paper and then typically submit the form to a higher level (e.g., community committee, district, or program) for data processing. In fact, 17 organizations have created databases for the CSI

data. Three interviewees specifically mentioned data quality processes in place after the CSI information has been gathered. One said, "It [the CSI form] is cross-checked and handed over to the M&E officer of the organization." Another said, "When it [the CSI form] is submitted to a line manager for supervision, they want to check how well is the tool filled in."

When prompted, interviewees acknowledged that completing a paper version of the CSI form and passing it on for data processing presents challenges for maintaining a copy of the CSI findings in the field with the volunteer who collected the information. Nine of the respondents described various ways they have attempted to keep copies of the CSI form with the CSI administrator, such as photocopying when possible or keeping two sets of the CSI forms. Respondents also described a time lag from when paper forms are submitted for data processing to when they are returned to volunteers.

The smaller case management organizations do not describe this same type of process as they often meet to discuss cases among their own staff. One interviewee described in detail how they process information involving the CSI:

Our social workers have their own diagnostic tool that they use and then the case managers use the CSI tool and then together they put the information together to come up with the family plan. So basically there's just two main diagnostic tools and then when they're providing services then we have tools or ways of documenting the interventions that each case manager or social worker are providing for our families and the social workers mainly focus on the scaled services, maybe more the legal services or the services that require a little bit more counseling or training and then the case managers intervene more in the area of family education and training and support and addressing psychosocial issues; maybe discipline with the kids, proper disciplining versus some of the disciplining tools that the families are currently using, making sure the

kids are in school. The case managers would be visiting the schools. So the main two tools that we use are the CSI and the social workers' diagnostic tool.

Data Analysis

Interviewees described taking child-level findings from the CSI and analyzing the information at the individual child, community, and program levels. At the individual child level, interviewees indicated they compare domain and sub-domain specific scores at Time 1 and Time 2 to determine if a child has made any improvement on those domains and sub-domains during the intervening time. For example, a program may see that a child had a score of 1 for food security and a score of 2 for nutrition and growth at Time 1; and then at Time 2, a score of 3 for food security and a score of 4 for nutrition and growth. The program staff may then interpret that analysis to mean that the child's situation has improved in the areas of food and nutrition.

Another way interviewees described analyzing information from the CSI at the individual child level is to aggregate the scores across all domains for a child to produce a total score. The program staff may then interpret that total score to reflect the situation of a child. As one interviewee explained:

If looking at the CSI ... the high[est score] is 48 adding all the figures, then the low is 0. Now, we have, let's say, adding across all a score of 35 to 48. That's rather good because the higher the score, the better the child.

Once they have scores at the individual level, a program may then make decisions about providing services to children. The interviewee above described how his organization does this by saying, "A child who scores from 35 to 48 could be in need, but not urgent like the one who scored from 0 to 17."

These scores are also often aggregated at the community level to look for differences in scores

among communities and even across countries for programs that expand across geographic areas.

Training

Training Approaches — Interviewees described various training approaches for the CSI. Most organizations conducted a step-down or cascade training (n=18), five organizations self-trained or implemented informal training, four organizations included training for the CSI as one part of an overall training involving children who are orphaned and made vulnerable by HIV/AIDS, and two organizations mentioned their use of mentoring to strengthen their training approach. Regarding cascade trainings, one interviewee explained, "I did a centralized training for groups and government personnel who now step it down to other groups in their community."

In a few cases, several people from an organization were trained, either at a training-of-trainers session (TOT) or by another organization. For example, three master trainers from one organization were trained by Save the Children. Those master trainers went on to train 400 volunteer teachers and 25 program officers. In another program, six master trainers were trained by USAID before the master trainers began training others. In addition to these formal cascade training approaches, some organizations found mentoring support from other organizations already using the CSI. One interviewee described her visits to other organizations using the CSI:

I visited two organizations who were using it and that is informing how we're using the CSI as well. So, I guess that it was incredibly useful. It's not an official training, I suppose, but I visited ChildFund in Kenya and they've used it on a very, very large scale and that was really interesting to see how they were using their data from a monitoring — I did it from a monitoring perspective — how they were using large quantities of CSI data to develop their programs. And then I visited an organization that is smaller than ours and

how they were doing it. That was a really useful learning experience to see practically how other people are doing it and what they were — the challenges that they had faced and how they were kind of changing things and moving forward with it.

Of those who self-trained, one respondent explained:

I read through the training packet and I've looked at the documentation that's been published about when it's been presented to different organizations and stuff and so that's kind of how I got trained. So some of what our lack of [knowing how to use the tool] could be related to maybe not knowing the essence of it.

An interviewee from a smaller organization explained her informal training process and how it fit their use of the tool:

Well the first time, I think they got some explanation about the tool and how to use it. But it was not that much ... we had a lot of missing values, really a lot ... and the second time [after we adapted it] we went through it again with them, but this time, deeper ... we didn't want to use it as a questionnaire, so don't ask any direct question on each domain, but more establish a conversation with the caregiver and the child.

Another interviewee using an informal training process discussed how they conducted training:

We just did a training, actually, when I was in [country] last week showing them the CSI ... we spent the morning looking at how we measure our outputs and how we define all that. But then we spent the whole afternoon looking at the CSI tool. ... We have done internal, informal trainings ourselves based on the resources that we've got and the experience that the [person who attended the TOT] had during that training ... it has been quite informal, more kind of discussing how

they would do it, looking at the manual that they've got, and rather than it being an actual kind of workshop setting.

After the interviews, the interviewers requested supporting documentation to verify the information received about the training approaches. Of the 16 organizations that conducted formal training, sample agendas were received from seven. Time dedicated to the CSI in the various agendas ranged from 45 minutes to three-and-a-half days. Four of the trainings were dedicated to the CSI, while the other three included the CSI in a larger workshop on M&E of vulnerable children or even HIV. Five organizations included a practice exercise in the field, although time for fieldwork and debriefing ranged from two hours to a day and a half. One organization that did not conduct field visits did have a two hour and 45 minute case study/role play session. In four of the agendas, there was no session on data analysis, although one agenda had a session on how to use data from the CSI for program quality improvement. Of the three that did include data analysis, the sessions ranged from 45 minutes to one-and-a-half hours.

Training Challenges — Although most organizations conducted step-down training, several concerns were raised about the adequacy of this method, including reduced quality of training as delivery steps down to lower levels, and inadequate funding and time for training beyond the initial TOT. One interviewee said:

Well, it's inevitable, just inevitable. You train people who aren't trainers. The TOT person is supposed to be a good trainer because that's that person's job. But the next level aren't trainers. And they get about half of what you teach them and then they teach them and it's about half. So if this is not crystal clear self-explanatory, it's fraught from the beginning. But that's true of everything that we do. I mean you really, in so much of what we train, you really need to hope to get a few core principles across, and a few extra things, but

not all the details. And again if you're going to be training people who don't use written material as reinforcement, who don't think abstractly as you would in a workshop setting, who learn by doing, who learn in different ways, the cascade approach is very difficult.

Not everything is stressed as it should be. This is at step down. At TOT, things are addressed more comprehensively.

One interviewee noted that one of the challenges regarding cascade training approaches is the availability of funding to continue on with training after the TOT:

At the community level, volunteers are not trained well enough ... if we want CSI to be used countrywide, it requires more efforts ... it requires more follow-up ... it required more trainings ... we had trained TOTs, but those TOTs have no budget to train officers.

Other challenges to training for the CSI were raised by participants, including the concern that training sessions do not provide adequate time and that refresher trainings are not held, or not held often enough. Interviewees explained why more training is needed. One said:

For the overall tools including CSI, we take three days for definitions and some details so that it can work ... but the training as such is not enough to fully understand the application of these different tools.

Another said:

Training with CSI shouldn't be one-time training — it should be flexible based on the input of the volunteers — if they identify issues around child abuse for example. Identify additional training needs for families or service providers.

Adaptations

Interviewees were asked to describe any changes they made to the CSI and why those changes were made. Many of the interviewees indicated

that their organizations made minor changes to the CSI, such as changing pictures or scales (n=7), removing pictures (n=2), simplifying the language to make the CSI easier for administrators of the CSI to understand (n=4), and adding sections to capture comments or observations of those administering the CSI (n=4). In addition, the CSI has been translated into at least 15 different languages (Amharic, Chichewa, French, Hausa, Hindi, Igbo, Khmer, Kinyarwanda, Pidgin English, Spanish, Swahili, Telegu, Yoruba, and local languages in Uganda and Zambia).

One interviewee said that the dot symbols were challenging for users to interpret. Further, they noted that in that country, a 1 is a good mark and 4 a poor mark, so users of the CSI were confused as this represented the opposite of the CSI scoring. As a result, the organization decided to replace the numbers with smiley faces.

Five organizations created materials to accompany the CSI as a way to help those administering the CSI to understand how to complete forms. The materials created included a users' guide, a field guide for community-based volunteers, a scoring form, a questionnaire to be used when assessing each of the CSI domains and sub-domains, and a summary document that highlights key points for administrators of the CSI to remember.

In some cases, adaptations of the CSI were more robust where elements of the CSI were incorporated into existing or new tools. For example, one country used the CSI domains to begin work on developing a national tool for identifying children who are orphaned and made vulnerable by HIV/AIDS, while another incorporated elements of the CSI into a family needs assessment. A third organization used elements of the CSI in a baseline survey for the high-risk population group it serves; and one organization created an entirely new tool based on the CSI that includes 25 discrete indicators to track over time. In this case, most questions have pictures, and most questions fall under four domains (social welfare, livelihood, health, or education).

Several organizations added questions or biometric markers to gather more concrete information along with the inferential data. For example, one organization replaced nutrition and growth with the mid-upper arm circumference test. As previously mentioned, another organization created questionnaires to accompany the CSI domains. Finally, a few organizations added, removed, or modified entire domains. Several organizations added economic strengthening measures to their tool; one combined emotional well-being and social behavior, and one simplified abuse and exploitation. When asked about removing a domain, a respondent replied, “We have removed the ‘protection’ domain, because the law of the land does not permit us to work in this area.”

Interviewees at a couple of organizations discussed how more work was still needed on the psychosocial domain, described by one interviewee this way:

I think they don’t understand — the staff didn’t understand it [psychosocial domain] very well and they don’t know how to talk about this subject with the parents and it’s quite a sensitive subject anyway ... so that’s a domain that still needs some adaptation.

Implementation of the CSI

Interviewees described several challenges to implementation of the CSI, including the fact that scores from the CSI are based on the perceptions of users and caregivers who serve vulnerable children (n=17), the CSI requires a lot of time to administer (n=8), the symbols are not always culturally relevant (n=3), the tool is technically challenging for volunteers (n=3), the CSI does not take into account the family context (n=2), and the CSI may not be a sustainable tool (n=2).

The greatest challenge described by interviewees was the fact that findings from the CSI are based on perceptions of those administering the CSI, as well as on the perceptions of children, family, and other individuals who answer questions related to the CSI. Some interviewees indicated that

this may result in the same child getting different scores depending on the person administering the CSI. Some of the interviewees noted that this situation causes them to be concerned about data quality and uncertain about how best to analyze information generated from the CSI:

The fact that CSI is so subjective makes it difficult for both people who are administering the questionnaire and program managers. Because of that, in some cases the reliability of the results places some reservations in all involved.

Unfortunately, we still have I think some difficulty with actual validity of the tool and so that has created some difficulty for us to actually take our CSI results and actually use that to solicit other funding or justify changes in funding or justify not having changes in funding and so it’s really not at a stage yet where we’ve been able to use it in that way [beyond individual child level] but that was certainly our intention.

Some interviewees noted that differences in scoring may be due to the fact that the CSI does not define a 1, 2, 3, or 4 for each sub-domain. As explained by one interviewee:

CSI does not have a standard. For example, in growth and nutrition — CSI does not say what should be a number 1, 2, or 3. It’s based on perception or understanding of each interviewer and each person may have a different standard, so it’s difficult for us to give the same score.

Differences in scoring may also occur due to cultural variations such as how caregivers self-report information from the CSI and how administrators of the CSI might interpret a 1, 2, 3, and 4 differently. One interviewee indicated that caregivers may respond differently depending on cultural norms. For example, in East Africa, one respondent said:

I think we have to understand ... here [East Africa] family caregivers, parents always try to

make their situation out to be as terrible as it possibly can be because they think, that way, they're going to get more support.

On the contrary, an interviewee in South America said that caregivers there are more likely to present their situation as better than it actually is:

Here in this culture you really don't want to put yourself in a bad light so you're going to say what you think the person wants to hear.

Interviewees from different regions of the world (South America, Africa, and Asia) also noted that a 1 in South America may mean something very different from a 1 in Africa, and that such variations may also exist at the national and sub-national levels.

Administrators of the CSI may also score the CSI differently because of the potential for a conflict of interest. For example, in some cases the same volunteer scores the child and provides services to the child. If a child then consistently scores low on subsequent assessments, that may reflect poorly on the person administering the CSI — with some believing that the CSI administrator/volunteer may not be doing a good job of providing or referring for services. One interviewee described how this occurred in his country:

At the beginning, they were afraid of giving a bad score ... they were like scoring themselves rather than the child or the family. You would feel like the score is somehow theirs.

A few interviewees noted challenges with scoring some of the CSI domains such as psychosocial, protection, and education, indicating that these are challenging at times to measure and that administrators of the CSI rate those domains differently. One interviewee explained a situation where two raters came up with very different scores for the same child:

... a child who has good shelter and a child who doesn't have good shelter and one picture showed a boy who was smartly dressed and was right in the middle of a very green field

and he was healthy and all was well but in the background were beautiful, healthy cattle and when we asked the person what do you have in mind ... the response was a one ... because this child is a 12-year-old who is not in school.

Another factor influencing variation in ratings is the turnover of administrators of the CSI. If there is variability in scoring and the administrator changes, then scores may fluctuate:

The CSI as a tool is subjective and depends on who is conducting the assessment. If a vulnerable child is enrolled by a volunteer and followed up six months later by another person, the results may not be reliable.

Also, a couple of interviewees noted that if the first administration of the CSI is the first opportunity to meet the family and child, the first set of scores may not be accurate, since caregivers and children need to build trust with the CSI administrator in order to provide accurate information.

Finally, a couple of interviewees mentioned that the number of children who are orphaned and made vulnerable by HIV/AIDS is so high in some programs that it is very challenging to maintain a standardized approach to the CSI scoring:

When you're managing a thousand community health workers, each one of them, as I told you, will understand something in their own very different way. How do we put that together? How do we ensure that everyone is on the same page? I think that's the inadequacy I see just because of the numbers.

Eight interviewees also indicated that the amount of time it takes to implement the CSI is challenging for their programs and for the volunteers. One interviewee explained her concern about the CSI adding work for the volunteer:

That's a big complaint. Volunteers didn't choose to be volunteers to do paperwork and it's a lot of paperwork ... it's quite daunting.

On a related note, some respondents (n=3) also indicated that the CSI is too complicated for

volunteers, despite it being specifically designed for low literacy field workers.

Interviewees outside of sub-Saharan Africa noted that the pictures used in the CSI are not culturally relevant or realistic for their settings and suggested that adaptations be made to reflect other cultures. Finally, a couple of respondents mentioned that the CSI does not take into account the family situation (n=2). One said:

CSI as a tool isn't able to identify needs of other family members and doesn't have room to allow a volunteer and members of the family to share responsibilities by developing a care plan of supporting children and caregivers.

Advantages of the CSI

All interviewees indicated they liked the CSI or their adapted version, and that it was useful, despite the limitations of the tool. Some interviewees described their overarching praise of the CSI, including these comments:

It is a fantastic tool for management, monitoring, and case management — it is extremely helpful.

I think it's an awesome tool and I think it covers all of the spheres that it should cover.

When asked in what ways the CSI has been helpful to their programs, interviewees cited that the CSI is comprehensive (n=8), allows for monitoring the well-being of children (n=8), aids in program planning (n=7), is quantitative in nature (n=6), and provides a framework for services to children who are orphaned and made vulnerable by HIV/AIDS (n=4). Regarding the comprehensive nature of the tool, interviewees said it collects information about all aspects of the child and not just one specific area. One interviewee said this allows them to “understand the complexity of children's needs” overall, including the issue of care for children who are orphaned and made vulnerable by HIV/AIDS. Another interviewee explained, “It's good at checking the whole parameter of a child's well-being. It doesn't deal

with one aspect and leave the others.”

Interviewees also noted the importance of the CSI in helping them to plan their programs by identifying areas for intervention. According to one person interviewed:

On areas where we are making no progress, what strategies can we adopt so that we can make better progress ... so, it helps us also in strategizing for a better support to our children, to our families.

Another person interviewed in Nigeria, where the Orphan Vulnerability Index⁶ (OVI) is used to identify such vulnerable children, expressed the view that OVI is insufficient to help with program planning, unlike the CSI:

The problem with the vulnerability index [OVI] is that it doesn't tell you exactly which domain the child needs help. In what areas should we concentrate on ... OVI gives you a score you can add up, but it wasn't answering the question, ‘so what?’.

Several of those interviewed discussed how the quantitative nature of the tool helped their programs set priorities, make comparisons across domains, and compare individual children over time. One interviewee indicated how the CSI has helped prioritize individual cases:

To get a numerical value of how vulnerable is the child because initially we had so many referrals and we weren't able to get to them all at the same time and so we really had to kind of figure out how to determine who was a biggest priority without really knowing a lot about them.

Another interviewee explained how the CSI has been able to help them quantify improvements of children over time:

The CSI advanced our knowledge and understanding of child-centered social service delivery and what it meant to focus from the child's point of view on improvement over time and being able to quantify that in some

way. It's use of a Likert type scale was brilliant ... that was the greatest advancement and the breakdown according to the six areas.

A few of the individuals discussed how the CSI has provided a framework for services among orphaned children made vulnerable by HIV/AIDS, and is influencing how they actually think about their programs for such children. This helpful aspect of the CSI was expressed in the following three comments from different individuals:

Previously, there wasn't the same structure and the same discipline to make them think and consider each of those areas, and they may just have judged the situation a bit more on what was obvious and what was there. So, it makes them think through and check that they've considered all those different elements.

I don't believe we would have made the progress we did in the [quality] standards if we didn't learn to think like the CSI made us think ... it fed the way we think about standards.

I don't know that we would have focused on the events that affect children and like past events how they could be affecting the current situation. I think the social workers are really good at that piece but I don't know necessarily that the case managers would have been able to look at those areas.

Suggestions for Improvement

In addition to describing helpful and challenging aspects of the CSI, interviewees were asked to provide any suggestions for improvement to the process involving the CSI, whether it be to the CSI itself, training, or guidance. Many of the suggestions reflect the challenges previously described by interviewees. Six interviewees suggested that MEASURE Evaluation provide guidance on how to analyze data from the CSI appropriately. As suggested by one interviewee:

Provide an analysis plan — how to deal with the data. ... We have received controversial

remarks from USAID about aggregating data, but we're doing the best we can. ... There needs to be consensus on how to do analysis.

As mentioned under challenges, some interviewees want to see the CSI expand beyond the individual child to capture more of what the program for children who are orphaned and made vulnerable by HIV/AIDS is doing at the family and community levels. For example, one interviewee said that "programs should have components that can focus not only at the child level, but at the district level, at the community level." The interviewee continued by saying:

If we work with the education office or department who reconsiders its curriculum and considers the OVC — that will directly benefit the OVC. ... So using a tool that focuses at the child level may not bring out what you are really doing in the program.

Four individuals suggested that additional guidance be provided on scoring to help improve scoring and increase inter-rater reliability. One of the individuals would like guidance to be clear as to what is a 1, 2, 3, or 4 so that any individual doing the scoring would rate these the same way.

Two individuals said there should be some consideration regarding how to sustain the use of the CSI in communities so that, when funding ends, scores from the CSI could remain within the community to help continue efforts to serve children beyond the life of the project. In one country, a ministry is trying to address this issue of sustainability:

There are cases where we worked with a partner NGO for two years, and when the NGO left, volunteers who were organized by that organization went scattered. ... That's why we are thinking of setting up a direct system at the grass-root level. ... We think of having community-based volunteers who will use CSI at the community level and who will be directly linked to the local government with support from partners.

One individual requested that the purpose of the CSI be clarified:

I think it would be very helpful if USAID were to be clear ... about the limitations of the CSI. I think a lot of people are still under the belief that our donor sees this as a central tool in our service delivery and in our evaluation.

Participants also discussed additional support they could use to help their programs better apply the CSI:

I think we need more training and we would love to get a chance for more of us to go to some external training and have a chance to interact with others.

Since we started, I don't know whether [the program] is on the right track or not. ... I think that we are on the right track, but is it what other stakeholders think? Is it working nationwide as well? How does it work in other countries? I would really request that there be another meeting.

Discussion

The assessment findings confirm anecdotal evidence that programs serving orphans made vulnerable by HIV/AIDS implement the CSI and use information generated from the CSI in various ways. The study illustrates that programs are eager to use the CSI and information generated through the tool to meet an array of programmatic and data needs, from needs assessment to outcome evaluation. The CSI was created mostly in a vacuum, when few other M&E tools existed for programs serving orphans made vulnerable by HIV/AIDS, and in the context of high demand for a tool to meet all information needs. Indeed, when the CSI was created, there were hopes that it might be applied to a range of purposes including program needs assessment, monitoring well-being of vulnerable children, supporting case management through referrals and linkages for services, evaluating programs (aggregating child-level information to the population-level), and even comparing child status across countries.

The purposes for which the CSI is used appear to vary among respondents depending on whether programs characterized the CSI primarily as an M&E tool or as case management tool. In many of the larger programs in which there are multiple sub-grantees, the focus of the CSI has often been on M&E, with an emphasis on data collection, management, and analysis. On the other hand, smaller organizations have used the CSI primarily as a tool to make care decisions involving orphans made vulnerable by HIV/AIDS. While there has been overlap in how the CSI is used between larger programs and smaller organizations, the primary purpose has generally delineated in this way.

The greatest challenge described by interviewees was that scores from the CSI are based on perceptions of users and caregivers serving vulnerable children, causing some to have concern that inter-rater reliability may be low. The achievement of inter-rater reliability requires

that users of the CSI are sufficiently trained and supported in the field to conduct the CSI. Respondents reported concerns about the quality of training involving the CSI in their organizations or programs due to inadequate time to conduct training, a lack of qualified trainers to lead TOTs, the ability to maintain quality of trainings as the trainings step down, and limited resources to conduct formal trainings and refresher trainings.

While improved inter-rater reliability can be achieved through improved training, it is important to remember that the CSI was designed to consider children's strengths and needs relative to their local environment. Therefore, it is not an expectation that findings from the CSI would yield similar results in different parts of a country, or across countries. This assessment confirmed that programs are aggregating data from the CSI at the national level when it may not be appropriate to do so, given that ratings are relative to local contexts.

Respondents also indicated that programs may not have sufficient support for use of the CSI in the field, particularly as it relates to data management and analysis. While a manual for the CSI exists, formal guidance has not been shared on how best to use data or how to manage and analyze data from the CSI.

While many of the programs indicated that the CSI is used to make care decisions for children either through referrals and linkages or through formal case management programs, few could provide formal referral protocols for orphans made vulnerable by HIV/AIDS and many indicated that written protocols do not exist. Further, interviewees discussed challenges with maintaining copies of the CSI record form with the administrator of the CSI in the field. Referral systems may indeed exist, but without written protocols in place, the extent to which

organizations are able to use the CSI effectively to make and follow-up on care decisions is unclear.

Despite some of the challenges related to implementation of the CSI, respondents described many ways the CSI has helped their programs. It is evident, however, that the CSI is unlikely to meet all of the M&E needs of programs serving orphans made vulnerable by HIV/AIDS and that additional tools may be needed.

Conclusion and Recommendations

This study confirms that there is wide variability in how programs for orphans made vulnerable by HIV/AIDS are using the CSI and a lack of clear guidance on the purpose of the CSI, who should use it, when and how often it should be implemented, and how information generated from the assessments should be used. It is evident that while the CSI is a useful tool, it is unable to meet all M&E needs and should be used in conjunction with other tools and information available. Programs serving orphans made vulnerable by HIV/AIDS need to define information needs and align M&E tools to meet those needs.

In light of the findings, we provide the following recommendations to help MEASURE Evaluation meet the M&E needs of the community serving orphans made vulnerable by HIV/AIDS:

- ❑ Clarification should be provided on the more challenging aspects of implementation of the CSI, including appropriate uses of the CSI, referral protocols, and data management and analysis.
- ❑ A training manual for the CSI should be made available to better address training needs.
- ❑ Existing documents (manual, field guide, and a “made easy” booklet) for the CSI should be revised to reflect new guidance. The manual should, to the extent possible, provide further explanation on how to provide ratings of 1, 2, 3, and 4.
- ❑ Pictorials should be adapted for the Latin America/Caribbean and Asia regions. Additionally, thought should be given to adapting the tool more comprehensively for these regions as the issues, norms, and guidance are different.
- ❑ A tool kit for M&E of programs serving orphans made vulnerable by HIV/AIDS should be created to highlight how the CSI complements other M&E tools for such programs. These programs would be guided to consider their M&E needs and select from available M&E tools to meet those needs.
- ❑ The OVC TWG and MEASURE Evaluation should develop a communications strategy that reaches all agencies currently using the CSI and those that may use the CSI in the future.
- ❑ In addition to expanding the scope of Child Status Net, additional opportunities and support for those using the CSI should be considered.

References

1. O'Donnell K, Nyangara F, Murphy R, Nyberg B. *Child Status Index: A Tool for Assessing the Well-Being of Orphans and Vulnerable Children — MANUAL*. [MS-08-31a]. Chapel Hill, NC: MEASURE Evaluation; 2009. Available at: http://www.cpc.unc.edu/measure/publications/ms-08-31a/at_download/document.
2. Nyangara F, O'Donnell K, Murphy R, Nyberg B. *Child Status Index A Tool for Assessing the Well-Being of Orphans and Vulnerable Children — FIELD USERS' GUIDE*. [MS-08-31b]. Chapel Hill, NC: MEASURE Evaluation; 2009. Available at: http://www.cpc.unc.edu/measure/publications/ms-08-31b/at_download/document.
3. Nyangara F, Nyberg B, Murphy R, O'Donnell K. *Child Status Index Made Easy*. [MS-08-31c]. Chapel Hill, NC: MEASURE Evaluation; 2008. Available at: http://www.cpc.unc.edu/measure/publications/ms-08-31c/at_download/document.
4. Cannon A, Noble C, Obure J, Devlin C. MEASURE Evaluation: Child Status Index. [Unpublished.]
5. Miller C, Sabin L, Brooks B, Tsoka M, Rybasack H. *Evaluation of the Child Status Index Tool: A Validation Study in Malawi*. Boston, MA and Zomba, Malawi: Center for Global Health and Development, Boston University School of Public Health and The Centre for Social Research, University of Malawi; 2010. Available at: <http://www.bu.edu/cghd/files/2011/10/CSI-Report-Final-December-20101.pdf>.
6. National Agency for the Control of AIDS (NACA) [Nigeria]. The orphans and vulnerable children (OVC) index. [Unpublished.] Abuja, Nigeria: NACA; nd. Available at http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=25&Itemid=268.

Appendix: Interview Questions

CSI Usage Study

The Key Informant Interview Guide for Program Management Unit (PMU) OVC Leads

Hello, my name is Molly Cannon/Elizabeth Snyder/Candy Basomingera and I work for MEASURE Evaluation. I am leading a study on usage of the Child Status Index (CSI) which aims to document how OVC programs are using the CSI and information generated from the CSI. The findings of this study will help inform future communication regarding CSI use and how best to further support OVC and OVC programs.

In this interview, I will ask questions about:

1. OVC Programs
2. CSI Use
3. CSI Training
4. CSI Reporting and Information Use

This discussion will take about one hour. Your participation in this interview is completely voluntary, and you will not be compensated for your time. You may refuse to answer any question that you are not comfortable with. Nevertheless, open and sincere responses to the questions will be very much appreciated. If you wish, you may stop this interview at any point. Your responses will remain confidential and no particular individual will be associated with an individual statement. All interview data will be de-identified prior to analysis and no reference will be made to your name if the report is published.

Do you have any questions at this time? If you have any questions after our discussion, please do not hesitate to contact me. Do I have your permission to continue?

To ensure we have correctly captured your responses, we would like to audiotape this session. The recording will have a unique anonymous identifier and will be kept on a password protected computer. Do I have your permission to audiotape this interview?

1. OVC Program Questions

- 1.1. What is your job title and role within the OVC program?
- 1.2. Please describe the goal and related objectives of your OVC program.
- 1.3. Please list the key sub-grantees or implementing partners of your OVC program (i.e., government, NGO's). How do you collaborate on providing services to OVC? How do you collaborate on sharing information regarding your programs?

1.4. Does your program provide OVC services in any of the following domains? If YES, what are the services being provided? [Food and Nutrition; Shelter and Care; Child Protection; Health; Psychosocial; Education and Skill Training]. Do you provide support to other programs or organizations for such services? Please describe.

1.5. What are all of the tools that an OVC caregiver is required to use (e.g., registration form, visitation form, CSI form)?

2. CSI Use

2.1 When did your program begin using the CSI?

2.2 Why did your program start using the CSI?

2.3 Has your program adapted the CSI in any way? Yes No

If yes, please indicate why you adapted it and at what point you adapted it? [get copy of adapted tool, including translation]

2.4 [If the CSI was adapted, ask:], Did you:

a) Add more domains/sub-domains?

Yes No (If yes, which ones did you add; why did you add them?)

b) Delete domains/sub-domains?

Yes No (If yes, which ones did you delete; why did you delete them?)

c) Change the pictures?

Yes No (If yes, which ones did you change; why did you change them?)

d) Add scales or quantitative questions?

Yes No (If yes, what types of questions did you add; why did you add them?)

e) Create accompanying documents? (which ones; why?)

Yes No (If yes, what types of documents did you create; why did you create them?)

f) Translate it?

Yes No (If yes, into which languages has it been translated?)

g) Make any other adaptations?

Yes No (If yes, please describe what other adaptations you made and why you made them)

2.5 Do you require sub-grantees/partners to use the CSI? Yes No

If yes, do all partners use the same version of the CSI? Please explain your response.

If no, why don't you require partners to use the CSI?

2.6 Approximately how many of your partners and sub-grantees are using the CSI? (collect list of names of organizations using the CSI).

Could you estimate how many different children have been assessed using the CSI in the last year through your program (overall including partners and subgrantees)?

2.7 For what purposes does your program use/apply the CSI? *Ask first open-ended and see where the response falls in the categories below). If not clear, then follow-up specifically by seeing if they use it the ways described below.*

- a. as a job aid to make decisions about the individual child or household service needs (intervention),
- b. to track individual child wellbeing over time (monitoring) – [Refer back to response from 1.4 and determine if they are tracking one of the domains, even though they do not provide the services directly],
- c. to aggregate information for program reporting (evaluation).
- d. Other – please describe

Is this (are these) purpose(s) consistent across all implementing partners? Please explain.

2.8 When a service provider identifies a child/beneficiary with a need that can be met through your program, what do they do? Can you please give an example? Is there formal program or local guidance on what to do if certain needs are identified? How are met needs documented?

2.9 When a service provider identifies a child/beneficiary with a need that cannot be met through your program, what do they do? Can you please give an example? Is there formal program or local guidance on what to do if certain needs are identified? Are unmet needs documented? Why?

2.10 At what stage of support (i.e., to a child) is the CSI generally administered? How did your program decide on administering the CSI at this stage?

2.11 How often is the CSI administered to a particular child? (does this happen at enrollment, every 6 months, at every visit?) Why is it administered in this way?

2.12 In what ways has the CSI been helpful to your program? Prompt – what is it good at doing?

2.13 Please describe any challenges to the CSI. What, in your opinion, is the CSI not good at doing?

2.14 How could the CSI be improved to better meet the programs' needs? How about to better meet the OVC' or their families' needs?

- 2.15 In your opinion, are there any negative effects of using the CSI as a tool? Please describe.

3. CSI Training

- 3.1 Who typically administers the CSI in your program? What are their job titles? Are these people paid or are they volunteers? Are they direct service providers to the children they administer the CSI to, or are they unlinked to the child?
- 3.2 Have all of the people who implement the CSI on behalf of your program been trained to use the CSI? Approximately how many of your staff and volunteers have been trained to implement the CSI (i.e. within the last year)? If not all, why haven't they been trained?
- 3.3 Please describe the CSI training approach your program uses. [*prompt - who conducted the training, was it a staged training, how long was the training, was the training evaluated, did the training include field practice – is that consistent at all levels?, have there been or are there plans for follow-up training*] (Ask for copies of both TOT and step down training agendas and materials.)
- 3.4 What is the primary focus of the training (e.g., identifying kids most in need, measuring the domains, or using it as a way to engage with families and provide services)?
- 3.5 Did your CSI training include a module on how to use CSI data? If so, describe what that module included.
- 3.6 Please describe the adequacy of the CSI training in your view? [*prompt: was it sufficient? If not adequate, what could be improved? If it went well, what in particular was helpful?*]

4. Data Reporting and Use

- 4.1 What does the person who implements the CSI do with the CSI form once they collect the information? (do they keep the paperwork themselves, hand it over to a program manager?)
- 4.2 Are partners and sub-grantees required to report data at the PMU level? Yes No
If yes, how does the data get reported? (through a database, paper forms, etc.)
If no, what do partners and sub grantees do with the data that has been collected?

4.3 Does your program use CSI information? [prompt: individual child level, household level, program level?] Please give examples of how the data are used. (get copies of any data use tools or decision support tools related to the CSI if these are discussed)

5. Final Questions

5.1 What other tools would be helpful for your OVC programs?

5.2 In what ways can the CSI, or another tool, incorporate family and child strengths as a way of providing care to OVC?

5.3 What are other big programs in your country using the CSI? Do you have a key technical contact you suggest I talk to?

Thanks very much. That completes the interview questions. Is there anything else you'd like to add that we haven't already discussed?

**MEASURE Evaluation
Carolina Population Center
University of North Carolina at Chapel Hill
206 W. Franklin Street
Chapel Hill, NC 27516 USA
919.966.7482 / measure@unc.edu
<http://www.cpc.unc.edu/measure>**