Monitoring Outcomes of PEPFAR Orphans and Vulnerable Children Programs in Mozambique

2017 Baseline Evaluation of Project Força à Comunidade e às Crianças

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PEPFAR

MEASURE Evaluation

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Cover photo: Prince Mulondo Yosia, World Education, Inc./Bantwana

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TABLES

ABBREVIATIONS

CI	confidence interval
DHS	Demographic and Health Survey
ESI	essential survey indicators
Project FCC	Project Força à Comunidade e às Crianças
IR	intermediate result
LL	lower limit
MER	monitoring, evaluation, and reporting
MUAC	mid-upper arm circumference
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
UL	upper limit
UNICEF	United Nations Children's Fund
WEI/B	World Education, Inc./Bantwana

EXECUTIVE SUMMARY

Evaluation Purpose

In 2014, the United States President's Emergency Plan for AIDS Relief (PEPFAR) introduced a set of outcome indicators for programs serving orphans and vulnerable children (OVC)—referred to as monitoring, evaluation, and reporting (MER) essential survey indicators—with the requirement that these indicators be collected every two years by a research organization not providing services to OVC households. These outcome indicators reflect internationally accepted developmental milestones and collectively measure holistic well-being of children over time. A standard survey method and tools have been developed to collect these data in countries where PEPFAR is supporting OVC programs. The purpose of this study is to collect the MER essential survey indicators at two points in time (2017 and 2019) from active beneficiaries of Project Força à Comunidade e às Crianças (Project FCC).

Project Background

Project FCC, implemented by World Education Inc./Bantwana (WEI/B), is a five-year (2015–2020) PEPFAR-funded initiative aimed at improving and expanding evidence-based models of integrated support for OVC and their households across Gaza, Manica, Sofala, Zambezia provinces in Mozambique. In collaboration with the Government of Mozambique, ChildFund International, EcoVentures International, the Regional Psychosocial Support Initiative, and a range of local implementing partners, the project will utilize schools and communities to reach more than 72,000 vulnerable children and adolescents with integrated services, with the goal of reducing the socioeconomic impact of HIV/AIDS on OVC and their caregivers.

Evaluation Design

MEASURE Evaluation—funded by the United States Agency for International Development and PEPFAR—conducted a survey of 680 households using cluster random sampling from among active beneficiaries of Project FCC enrolled before June 30, 2017 (Year 1 of the project). The MEASURE Evaluation survey team interviewed caregivers of OVC about services received and the well-being of the children in their households using a brief, standard questionnaire developed by MEASURE Evaluation for global application.

Findings

The survey team completed 658 interviews with caregivers about 500 children ages 0–4 and 1,849 children ages 5–17. The survey response rate was 97 percent. Summary findings are presented in the table below.

Summary of PEPFAR MER OVC essential survey indicator results

Ref. no.	Indicator	n =	N =	%	95% confidence interval	
					LL	UL
Health						
CW.4	Percent of children too sick to participate in daily activities	543	2,349	21.2	20.5	21.8
NC.1	Percent of children whose primary caregiver knows the child's HIV status	786	2,349	33.9	33.2	34.7
Nutrition						
CW.1	Percent of children <5 years of age who are undernourished	13	457	2,6	2,0	3,2
Early childhood development						
CW.13	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	445	457	95.6	94.8	96.3
Legal rights						
CW.9	Percent of children who have a birth certificate	1,009	2,349	42.6	41.8	43.4
Education						
CW.11	Percent of children (ages 5–17 years) regularly attending school	1,164	1,849	63.8	63.0	64,7
CW.12	Percent of children who progressed in school during the last year	1,054	1,369	74.8	74.0	75.8
Attitudes about child punishment						
CW.14	Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school	128	658	20.8	19.6	22.0
Household economic well-being and resilience						
HW.2	Percent of households able to access money to pay for unexpected household expenses	249	467	49.5	47.8	51.3

Note: n=numerator; N=denominator

These findings illuminate beneficiary population needs and program gaps and should be interpreted as a baseline situation analysis. The results from this first round of data collection also will serve as a reference for tracking changes over time in the next round of data collection, planned for 2019.

INTRODUCTION

Evaluation Purpose and Questions

Globally, PEPFAR has invested considerable resources in OVC programs but has not studied either systematically or on a large scale the effect of its programs on the well-being of beneficiary OVC and households (Sherr & Zoll, 2011). To fill this gap, in 2014, PEPFAR introduced a new global reporting requirement for monitoring the outcomes of its OVC programs, referred to as the MER OVC essential survey indicator(s) (ESI). The objective is to measure and track child and household well-being using nine indicators and standard method across projects and countries. The nine indicators, selected by global PEPFAR OVC program and strategic information leaders, reflect internationally accepted developmental milestones and the ways OVC programs gain from and contribute to broader HIV and child protection responses (MEASURE Evaluation, 2014). PEPFAR requires that OVC MER indicators be collected at two points, two years apart, to track progress over time. Therefore, indicators that could reasonably be expected to change over a two-year period were a priority. The indicators were designed to supplement routine PEPFAR monitoring (which primarily tracks project inputs and outputs) and project evaluations. The nine indicators, including why they were selected, are presented in Table 1.

Table 1. PEPFAR MER essential survey indicators for OVC programs

No.	Indicator	Rationale for inclusion
NC.1	Percent of children whose primary caregiver knows the child's HIV status	If a child's HIV status is unknown to her/his caregiver, the child will not have access to life-saving care, treatment, and support interventions.
CW.1	Percent of children <5 years of age who are undernourished *For this indicator, the interviewer will obtain measurement of mid-upper arm circumference (MUAC) for children ages 6–59 months. It is the only indicator whose measurement requires direct interaction with a child.*	Nutrition is a critical factor in reducing infant mortality and builds a strong foundation for a child's health, growth, and development.
CW.4	Percent of children too sick to participate in daily activities	PEPFAR OVC programs support critical linkages to health services and treatment, aiming to reduce the number of sick children and improve functional well-being.
CW.9	Percent of children who have a birth certificate	Ensuring children access to basic legal rights, such as birth certificates, enables them to access other essential services and opportunities, including health, education, legal services, and legal employment when they grow older.
CW.11	Percent of children regularly attending school	Despite being important in themselves, efforts to keep children in school have positive impacts on HIV prevention.
CW.12	Percent of children who progressed in school during the last year	Studies in many countries have linked higher education levels with increased AIDS awareness and knowledge, higher rates of contraceptive use, and greater communication regarding HIV prevention among partners.
CW.13	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	Early childhood cognitive, social, and physical stimulation is essential for promotion of long-term learning, growth, and health.
CW.14	Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school	Reducing harsh physical discipline, violence, and abuse against children is a PEPFAR priority. Perceptions of physical discipline have been linked to actual use of physical discipline against children.
HW.2	Percent of households able to access money to pay for unexpected household expenses	The key goal of household economic strengthening programs is to improve a household's resiliency to economic shocks, such as unexpected household expenses. Child well-being is assumed to be affected by the household's resiliency to economic shocks.

Source: MEASURE Evaluation, 2014

The overall objective of the study is to assess the well-being of those children—and their households—who are active beneficiaries of Project FCC. This survey is being conducted to fulfill PEPFAR global reporting requirements that aim to measure and track the progress of PEPFAR-supported OVC

programs. The primary research question is *What is the well-being of Project FCC beneficiaries, as measured by the PEPFAR MER essential survey indicators?*

This report describes the methods used to conduct the Project FCC MER OVC ESI survey and presents results for the ESI in accordance with MER guidance. This information is intended to help Project FCC better understand the strengths and weaknesses of its beneficiary population at this time. It also is intended to support the project, the PEPFAR OVC team, and other program decision makers and stakeholders, including those from the Government of Mozambique, to take evidence-informed actions to improve OVC program strategy, resource allocation, and implementation, to improve the well-being of the children and households they serve. In addition, findings presented in this report will contribute to a global PEPFAR-wide evidence base on the effectiveness of PEPFAR OVC programming. As this round is the first data collection for the ESI, the report also serves as a reference for the second round of data collection, allowing tracking of the indicators over time.

Background

Project Context

On the 2017 End of Childhood Index published by Save the Children, Mozambique ranked 160 (out of 172 countries), driven by an extremely high under-5 mortality rate (78.5 per 1,000 live births) and high malnutrition (Save the Children, 2017). Of children under age five, 43 percent are chronically malnourished (DHS, 2011), and 64 percent are anemic (IMASIDA, 2015). Three-quarters of primary school-age children attend school, but only one-quarter attend secondary school (IMASIDA, 2015). Even though 80 percent of children have had their births registered, only 38 percent have an actual certificate at hand (IMASIDA, 2015). (The high levels of birth registration reflect the requirement of a birth certificate for school exams, starting in Grade 2.) Young girls face additional risks related to early marriage and childbearing—46 percent of girls under 18 years have a living child or are pregnant (IMASIDA, 2015), which contributes to a birth rate of 143 births per 1,000 women ages 15–19 (World Bank, 2014).

Mozambique faces a mounting crisis of children orphaned by AIDS. The country has approximately 2 million OVC, 800,000 of whom have been orphaned owing to AIDS (Brown & Winberg, 2013). The most recent demographic and health survey (DHS) data show that 11 percent of children have lost one or both parents (IMASIDA, 2015).

Young people are also at high risk of acquiring HIV. The national prevalence is 13.2 percent, up from 11.5 percent in 2009 (IMASIDA, 2015). Mozambican youth ages 12–19 account for 6.8 percent of the overall cases of HIV (INSIDA, 2009), with girls disproportionately at risk compared to boys.

The National Strategic Plan Against HIV/AIDS (PEN IV, 2016–2020), the Five-Year Plan (*Plano Quinquenal* 2015–2019), the National Early Childhood Development Strategy (DICIPE 2012–2021), and the National Action Plan for Children II (PNAC 2013–2019) provide guidance on strengthening social services for continued improvements in family welfare.

The Government of Mozambique also is implementing its second National Strategy for Basic Social Security (ENSSB 2015–2019), which aims to improve targeting and provide new types of support, such as social grants. Resources to support vulnerable families include the Ministry of Gender, Children and Social Action's National Institute of Social Action social grants and consumption support; Ministry of Education funds for school fee exemption and provision of school materials; Ministry of Health facility- and community-based free health services (including expansion into adolescent-friendly services); and Ministry of Agriculture extension support.

Project Description

Project FCC, implemented by WEI/B, is a five-year (2015–2020) PEPFAR-funded initiative aimed at improving and expanding evidence-based models of integrated support for OVC and their households across Manica (Manica, Chimoio, Gondola), Sofala (Beira, Dondo, Nhamatunda), Zambezia (Quelimane, Nicuadala, Namacurra), and Gaza (Xai Xai City, Xai Xai District, Chokwe) provinces. In collaboration with the Government of Mozambique, ChildFund International, EcoVentures International, the Regional Psychosocial Support Initiative, and a range of local implementing partners, the project is using schools and communities to reach more than 72,000 vulnerable children and adolescents with integrated services to help them thrive and grow into productive and healthy adults.

The goal of the project is to reduce the socioeconomic impact of HIV/AIDS on OVC and their caregivers by enhancing the capacity of families and communities to support, protect, and care for them. To this end, WEI/B is working to achieve five intermediate results (IRs). IR1 focuses on strengthening the capacity of community- and district-level structures to deliver and coordinate OVC services. IR2 leverages schools as safety nets to reach large numbers of OVC with a comprehensive range of services and ultimately increase access to education and improve educational outcomes. IR3, IR4, and IR5 focus on delivering specific health, nutrition, psychosocial support, and economic strengthening interventions through a range of models that build on strengthened communities and schools.

Conceptual Framework of Change

The PEPFAR MER OVC ESI are intended to measure change over time.[1] Table 2 describes the pathways of change for each indicator through Project FCC interventions. At end line, MEASURE Evaluation will test the robustness of this framework through a process evaluation.

[1] Please see note in study limitations section on the challenges of attributing changes in indicators over time, to the project.

Table 2. Framework mapping Project FCC services to the PEPFAR MER OVC essential survey indicators

No.	Indicator	Hypothesized causal pathways of change
NC.1	Percent of children whose primary caregiver knows the child's HIV status	Project FCC will supervise local implementing partners in supporting school health managers to provide for the healthcare needs of OVC, including HIV testing; the importance of knowing children's status will be a focus of the caregiver support groups. Project FCC also will build the capacity of local implementing partners to increase demand for HIV/AIDS adherence support groups, through which efforts will be made to enhance HIV-positive caregivers' awareness of the importance of having children tested.
CW.1	Percent of children <5 years of age who are undernourished	Project FCC is implementing parenting support groups and village savings and loan groups. These interventions are expected to reduce child malnutrition by building awareness of the signs of malnutrition and addressing issues of food security (through economic empowerment). Further, Project FCC is supporting school health and nutrition assessments. Although children under age five do not attend school, school-age children with abnormalities will be followed up at home; during these home visits, any other malnourished children in the home will be referred/supported.
CW.4	Percent of children too sick to participate in daily activities	Project FCC is not implementing interventions explicitly focused on addressing this indicator. Any changes in this indicator over time need to be grounded in a causal pathway.
CW.9	Percent of children who have a birth certificate	Through local implementing partners, Project FCC will establish and implement child rights activities in schools. These activities are expected to encourage birth registration.
CW.11	Percent of children regularly attending school	Project FCC is providing educational subsidies to children, which are expected to directly improve school attendance and progression. Project FCC is also implementing village savings and loan groups, which are expected to improve access to money to pay for school-related expenses and, in turn, attendance and progression. Third, caregiver support groups and other parenting interventions will build awareness of the importance of schooling.
CW.12	Percent of children who progressed in school during the last year	
CW.13	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	Project FCC is implementing parenting support groups, which will include guidance on early childhood stimulation.
CW.14	Percentage of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school	Project FCC is implementing parenting support groups, which will include awareness raising on nonviolent methods for disciplining children.
HW.2	Percent of households able to access money to pay for unexpected household expenses	Project FCC is implementing village savings and loan groups to improve households' access to money.

METHODS

MEASURE Evaluation surveyed a cross-sectional sample of active beneficiary households of Project FCC by using two-stage cluster sampling.

Participants

The survey team conducted interviews with the primary caregivers of the children residing in the selected households. Female and male caregivers of all ages were eligible for the survey. We asked caregivers questions about themselves, the household, and the children under their care. All children ages 0–17 years (at their last birthday) who regularly slept in the household were considered eligible for the survey, even if they were not present during the day of the survey;[2] this included both children actively registered as beneficiaries of Project FCC and those who were not.

Sample Size and Sampling

To detect an increase of 15 percent between baseline and end line using a cluster design, the survey team calculated a sample size of 680 households (alpha = 0.05, two-sided, power = 0.80, design effect = 2; assumed that only 60 percent of households would have a child ages 0–4; and assumed 20 percent nonresponse). To reach 680 households, we adapted a 34-cluster-by-20-household design.

The sampling frame included all "active" beneficiary households of Project FCC in Manica, Sofala and Zambezia provinces,[3] meaning households that had received project services or had been newly registered to receive them in the three months before the survey. The survey team selected primary sampling units (neighborhoods or "bairros") based on probability proportional to size sampling, drawn from information found in the Project FCC beneficiary registers as of June 30, 2017. We worked with the Project FCC data management team to correct missing information and data inconsistencies in the listing before selecting the primary sampling units. The initial beneficiary roster provided by Project FCC included 13,348 households located within 161 barrios across nine districts. In the beneficiary roster used to select the primary sampling units, we included only bairros with 20 or more households to ensure enough households for the next stage of sampling in the bairros. As a result, our final sampling frame included 12,986 households across 93 bairros, which was about 97.3 percent of the initial sampling frame. At the first stage of sampling, we selected 33 clusters (we selected one cluster twice).

The team decided to select the secondary sampling units from the updated lists of beneficiaries rather than using the project registries, which can be out of date. To obtain the new lists in these 33 clusters, data collectors interviewed all current caseworkers to get accurate information on all active beneficiary households. They also consulted project records. We did not include children registered to receive services at school. We listed 1,832 beneficiary households across the 33 clusters. From these lists, we randomly selected 20 households per cluster (40 households in the one cluster selected twice during the first sampling step), using a systematic random sampling.

[2] Interviewers did not include children who were present on the day of the survey but were not regular household members (i.e., those who did not routinely sleep in the household).

[3] Beneficiaries in Gaza province were excluded, because at the time of sampling, Project FCC work in this province was focused specifically on adolescents and not on OVC more broadly.

Data Collection

The survey team conducted interviews with caregivers using a standard questionnaire previously developed by MEASURE Evaluation for the PEPFAR OVC Technical Working Group specifically for collecting data for the MER OVC ESI. The survey tool included questions about the caregiver and children ages 0–17 in the household (directed at the caregiver). We made only minor modifications to the standard questionnaire to adapt it to the Mozambique context. The English version of the questionnaire is given in Appendix 1.

The team conducted data collection between July 29 and August 17, 2017; the team comprised a trained field manager, two field supervisors, and 10 field interviewers. The team worked with Project FCC local implementing partners to locate the selected households, using information from the household listing—e.g., village, names of the case managers assigned by the local partner to support the household, the caregiver's name, and telephone number (if available). In all instances, the case managers accompanied the data collection team to the household and facilitated introductions. The case managers then left the household before the interview started.

The field interviewers sought informed consent from the caregiver. They asked the adult caregivers (i.e., those age 18 and above) to consent to their own participation and that of children in the household ages 6–59 months (for the MUAC assessment). For minor caregivers (i.e., under age 18), the interviewers sought informed consent from the minor's guardian and assent from the minor caregiver, emphasizing that participation was voluntary. The team documented both consent and assent to participate in written form.

The field interviewers captured responses electronically on password-protected Android tablets that had been preprogrammed with the survey questionnaire via Kobo Toolbox. The electronic data capture tool mirrored the paper questionnaire and presented one question per screen. The tool included instructions to guide interviewers and facilitate interview flow. It had built-in skip logic; error messages and caution notices were triggered when interviewers entered faulty data to alert them to correct problems. The team interviewed caregivers in a private location out of earshot of others, including children and other family members. The interviewers obtained MUAC measurements on children ages 6–59 months in the presence of the caregiver and made a minimum of three attempts to conduct interviews with caregivers who were temporarily absent from the household at the time of their visit.

The field team met after each day's work to review their experiences and plan for the following day. Field supervisors reviewed all captured data daily; once approved, they transmitted the data using a mobile Internet connection to the cloud-based server. During data transmission, the supervisors cleared survey data from the tablets, meaning that, in most cases, the data were not stored on the tablets for more than a few hours. The survey team's data manager analyst ran daily checks based on a predesigned data cleaning script in Stata 14 that included checks for structure, uniqueness, and external consistency of key identifiers; completeness of data; acceptable data; and unexpected data. The analyst then generated an inconsistency report from the database and shared it with the field team daily. The field team then took immediate action/correction (e.g., reinterview, revisit to households for confirmation, etc.) to ensure they had collected high-quality data.

Data Processing and Analysis

The team carried out data cleaning, consistency, and missing analyses to ensure reasonable standards of data quality. For data cleaning, the team analysed frequency distributions of variables to assess the problems of outliers and values out of the expected range. Because of the data cleaning that took place in

real time as the data were being collected, minimal edits were required. Once it had conducted these checks, the team saved a clean version of the data for the analyses. We observed no missing cases in either the Caregiver or Child files, except for the MUAC field, in which there were 10 missing cases because the child was absent from the household when the fieldwork for the survey took place. The analytical files included data dictionaries with variable labels, value labels, and other standard specifications.

The team performed data analysis using in SPSS 23. We derived the indicators as specified in the MEASURE Evaluation guidance document "Collecting PEPFAR Essential Survey Indicators: A Supplement to the OVC Survey Tools" (MEASURE Evaluation, 2014). We calculated indicator estimates and confidence intervals (95%) for the indicator estimates incorporating the sample design. We used chi-square tests and a T-test to test differences between subgroups. For 2x2 tables, we used p-values from Fisher's Exact Test (2-sided).

Although we designed our sampling approach to be self-weighting by using probability proportional to size sampling to select clusters and then randomly selecting a fixed number of households in each cluster, we had to apply survey weights in the analysis. This procedure was necessary because of the differences in the number of households in selected clusters that we expected based on the project registries and the household listings conducted during data collection. In calculating the final sampling weights, we considered weights for both probability of selection and probability for nonresponse.

Ethics Review and Compliance for the Surveys

The survey team sought institutional review board (IRB) review of the study protocol for the survey and received reviews from the Comitê Nacional de Bioética para a Sáude in Mozambique and Health Media Lab institutional review board in the United States. All study activities adhered strictly to U.S. and international research ethics guidelines, including 45CFR46 and CIOMS.

FINDINGS

Responses Rates

The survey response rate was 97 percent. The survey team completed 658 interviews with caregivers regarding 500 children ages 0–4 and 1,849 children ages 5–17. This information and additional details are presented in Tables 3 and 4.

Table 3. Household response rates

Category	Number
1. Households served by Project FCC (based on the project listing)	1,832
2. Households in the survey sample (selected for interview from the project listing)	680
3. Sample households (or caregivers) unknown to the local implementing partner, assigned caseworker, or local guide	0
4. Sample households found to have duplicate IDs in the project listing	1
Percentage of sample households not matching the project listing	**0.1%**
5. Sample households that had permanently moved out of the survey area	9
6. Caregivers in sample households reported to be temporarily away from the household for extended period	0
7. Caregivers who resided in sample household but could not be located for interview after three attempts	12
8. Caregivers who refused an interview	1
9. Sample households with no resident children under age 18	0
10. Total number of sample households where no interview was conducted (household nonresponse)	22
Survey household response rate	**96.8% (658/680)**

Table 4. Questionnaire components completed and other sample information

Sample information	Number
Number of "caregiver" components completed	658
Number of "child ages 0–4" components completed	500
Number of "child ages 5–17" components completed	1,849
Total number of child components completed	2,349
Number of eligible children in the household (listed by the caregiver)	2,352
Percentage of child components completed among eligible children in the household*	**99.8%**
Average number of completed child components per household	3.6
Percentage of children listed by caregivers who were registered with the project	97.8%

Background Characteristics of the Respondents

Caregivers

The majority (85.0%) of caregiver respondents were female. The mean age was 41 years, with no differences between males and females (40.7 years old for females and 41.2 years old for males; $p = 0.46$). The youngest caregiver was 17 years old and the eldest was 99. Half of all interviewees (52.7%) were ages 31–50. Nearly 3.4 percent were 70 years and older. Although the average age did not differ between males and females, the difference in the age group distribution between males and females was significant ($p < 0.001$); see Table 5.

Table 5. Characteristics of caregivers in the survey

Age (years)	Female caregivers		Male caregivers		Both sexes		Percentage of caregivers who are female
	n	%	n	%	n	%	
< 18	1	0.1	0	0	1	0.1	100.0
18–30	161	24.9	31	28.6	192	25.5	83.0
31–50	288	54.7	37	41.5	325	52.7	88.3
51+	105	20.3	35	29.9	140	21.7	79.4
All ages	**555**	**100.0**	**103**	**100.0**	**658**	**100**	**85.0**

Children

The distribution of children who took part of the survey is presented in Table 6. Exactly 50 percent of children surveyed were female, as expected in a random sample. The age distributions were similar for both sexes. Children ages 10–14 made up 33.7 percent of all children sampled. The smallest age group was 0–4 years, representing 22.4 percent of girls and 18.3 percent of boys. Infants under age one included 36 girls and 35 boys.

Table 6. Characteristics of children in the survey

Child's age (years)	Female		Male		Both sexes		Percentage of children who are female
	n	%	n	%	n	%	
0–4 *years*	258	22.4	242	18.3	500	20.4	55.5
0–5 months	24	2.2	19	1.1	43	1.6	67.4
6–11 months	12	1.3	16	1.1	28	1.2	56.4
12–23 months	37	3.8	58	4.1	95	3.9	48.3
2–4 years	185	15.1	149	12.1	334	13.6	56.1
5–9 *years*	348	29.5	377	33.8	725	31.6	47.0
10–14 *years*	405	34.3	388	33.1	793	33.7	51.3
15–17 *years*	157	13.8	174	14.8	331	14.3	48.6
All ages	1,168	100.0	1,181	100.0	2,349	100.0	50.4

OVC Services Received

The interviewers asked caregivers if they had ever received services from the Project FCC local implementing partner in their community. Interviewers also asked if they had received these services within the six months before the survey. The results are presented in Table 7.

Table 7. Caregivers' reports of participation in Project FCC

	Female caregivers			Male caregivers			Both sexes		
	n	N	%	n	N	%	n	N	%
Ever received services	544	555	96.5	103	103	100	647	658	97.0
Received services within the past six months	268	555	57.4	58	103	68.3	326	658	59.1

Note: n=numerator; N=denominator

Almost all caregivers (97.0%) reported that their household had previously received Project FCC services; nearly 60 percent (59.1%) reported having received services in the past six months. Females were less likely to report receiving services in the past six months (57.4% vs. 68.3%, respectively; $p < 0.001$).

The interviewers asked caregivers when they first started receiving services from Project FCC. Data are presented in Table 8. Analyses exclude caregivers who replied that they started receiving services before the beginning of the project.

Table 8. Caregivers' reports of when the household first started receiving Project FCC services

	Female caregivers			Male caregivers			Both sexes		
	n	Mean (S.D.)	Range	n	Mean (S.D.)	Range	n	Mean (S.D.)	Range
Number of months ago household started receiving services or participating in activities	493	4,8 (2,5)	Less 1 month -13	98	4.4 (2.8)	Less 1 month -12	591	4.7 (2.6)	Less 1 month -13

Note: n=numerator; N=denominator

On average, caregivers reported that they started receiving services 4.7 months before the survey.

The interviewers asked caregivers who reported participating in or receiving services in the past six months about each of the six types of services provided by Project FCC. The results are shown in Table 9.

Table 9. Caregivers' reports of the types of services received through Project FCC in the past six months

Type of services offered by Project FCC	Number of caregivers who reported receiving this service in the past six months (N = 658)	% of caregivers
Home visits	318	55.7
Parenting group	21	3.2
Savings and loan groups	37	8.5
Scholarships/bursaries	45	6.4
Health services referral	65	9.9
Youth group	7	0.9
Others	24	4.1

Home visits were most commonly reported (55.7%), followed by referrals to health services (9.9%).

The interviewers asked caregivers the same set of questions for each child under their care. These results are presented in Table 10.

Table 10. Caregivers' reports of their children's project participation in Project FCC

	Female children ages 0–4			Male children ages 0–4			All children ages 0–4		
	n	N	%	n	N	%	n	N	%
Ever participated in activities or received services	252	258	96.3	236	242	95.2	488	500	95.8
Received services within the past six months	117	258	53.3	115	242	53.2	232	500	53.3
	Female children ages 5–17			**Male children ages 5–17**			**All children ages 5–17**		
	n	N	%	n	N	%	n	N	%
Ever participated in activities or received services	894	910	96.9	915	939	96.4	1,809	1,849	96.6
Received services within the past six months	451	910	59.6	438	939	55.9	889	1,849	57.7

Note: n=numerator; N=denominator

Among children ages 0–4, 95.8 percent were reported to ever have received services, and 53.3 percent were reported to have received services in the past six months. A similar percentage was reported for the 5–17 age group (96.6% had ever received services and 57.7% had received services in the past six months).

PEPFAR MER OVC Essential Survey Indicators

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

Health

CW.4: Percent of Children Too Sick to Participate in Daily Activities

The interviewers asked primary caregivers if the children under their care had been too sick to participate in daily activities at any time within two weeks before the survey. Results are presented in Table 11.

Table 11. Percent of children too sick to participate in daily activities

Child's age (years)	Both sexes				
	n	N	%	95% CI	
				LL	UL
0–4	150	500	27.6	26.0	29.1
5–9	160	725	21.9	20.8	23.1
10–14	159	793	16.8	15.8	17.8
15–17	74	331	20.6	18.9	22.3
All ages	543	2,349	21.2	20.5	21.8

Child's age (years)	Female children					Male children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
0–4	79	258	26.6	24.5	28.7	71	242	28.8	26.4	31.1
5–9	80	348	21.7	20.0	23.4	80	377	22.1	20.5	23.7
10–14	98	405	18.4	16.9	19.9	61	388	15.1	13.7	16.5
15–17	37	157	20.3	17.8	22.7	37	174	21.0	18.6	23.4
All ages	294	1,168	21.5	20.6	22.4	249	1,181	20.8	19.9	21.7

Note: n=numerator; N=denominator

Caregivers reported that 21.2 percent of children were too sick to participate in daily activities. We did not observe statistically significant differences between girls and boys; however, we did detect statistically significant differences by age group. Caregivers were more likely to report that children ages 0–4 years were too sick to participate in daily activities, compared to other groups ($p < 0.001$).

NC.1: Percent of children whose primary caregiver knows the child's HIV status

Data in Table 12 display caregivers' knowledge of the HIV status of children under their care.

Table 12. Percent of children whose primary caregiver knows the child's HIV status

Child's age (years)	Both sexes									
	n	N	%	95% CI						
				LL	UL					
0–4	206	500	39.9	38.2	41.6					
5–9	224	725	33.3	31.9	34.6					
10–14	241	793	30.4	29.2	31.7					
15–17	115	331	35.1	33.1	37.2					
All ages	786	2,349	33.9	33.2	34.7					
Child's age (years)	**Female children**					**Male children**				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
0–4	103	258	40.9	38.6	43.2	103	242	38.7	36.1	41.3
5–9	106	348	30.4	28.5	32.3	118	377	35.8	33.9	37.6
10–14	106	405	27.3	25.6	29.0	135	388	33.7	31.8	35.6
15–17	55	157	34.9	32.0	37.8	60	174	35.4	32.6	38.2
All ages	370	1,168	32.3	31.3	33.4	416	1,181	35.6	34.5	36.6

Note: n=numerator; N=denominator

Primary caregivers reported one-third (33.9%) of children as "HIV status known." Caregivers were slightly more likely to report knowing boys' HIV status than girls' (35.6% vs. 32.3%, respectively; $p < 0.001$). There were also differences by age groups; caregivers were more likely to report knowing the status of children ages 0–4 years than other age groups ($p < 0.001$).

Nutrition

CW.1: Percent of Children Who Are Undernourished

In accordance with PEPFAR MER OVC ESI guidance, a child was considered undernourished if her/his MUAC measurement fell below 125 mm. Data are presented in Table 13.

Table 13. Percent of children ages 6–59 months who are undernourished.

Child's age (in months)	Both sexes									
	n	N	%	95% CI						
				LL	UL					
6–11	3	28	8.4	4.9	12.9					
12–59	10	429	2.2	1.7	2.8					
6–59	13	457	2.6	2.0	3.2					
Child's age (in months)	**Female children**					**Male children**				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
6–11	2	12	7.7	3.7	14.1	1	16	9.3	4.1	16.6
12–59	6	222	2.5	1.8	3.4	4	207	1.8	1.2	2.7
6–59	8	234	2.8	2.1	3.8	5	223	2.2	1.5	3.2

Note: n=numerator; N=denominator

A small percentage of children ages 6–59 months (2.6%) were observed to be undernourished. Low numbers invalidate subgroup analyses.

Early Childhood Development

CW.13: Percent of Children <5 Years of Age Who Recently Engaged in Stimulating Activities with any Household Member over 15 Years

The interviewers asked caregivers whether the children under age five in their care had engaged in stimulating activities in the past three days with the caregiver or another household member over 15 years of age. Stimulating activities included reading books; looking at the pictures in the books; telling stories; singing songs or lullabies; playing with the child; or naming, counting, or drawing things. Data are presented in Table 14.

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

Activity	Both sexes				
	n	N	%	95% CI	
				LL	UL
Read or looked at picture books	53	457	12.5	11.3	13.7
Told stories	164	457	39.2	37.4	41.0
Sang songs or lullabies	355	457	79.1	77.6	80.6
Engaged in play	439	457	93.2	92.3	94.1
Named, counted, or drew things	162	457	37.9	36.1	39.6
One or more of these activities	445	457	95.6	94.8	96.3

Activity	Female children					Male children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
Read or looked at picture books	29	234	12.8	11.1	14.5	24	223	12.1	10.3	13.9
Told stories	81	234	38.1	35.7	40.6	83	223	40.5	37.8	43.2
Sang songs or lullabies	173	234	76.6	74.5	78.7	182	223	82.1	80.0	84.2
Engaged in play	226	234	94.4	93.3	95.5	213	223	91.8	90.3	93.3
Named, counted, or drew things	82	234	36.9	34.5	39.3	80	223	39.0	36.3	41.6
One or more of these activities	227	234	94.8	93.7	95.9	218	223	96.5	95.6	97.5

Note: n=numerator; N=denominator

Caregivers reported that nearly all children under age five in their care (95.6%) had engaged in at least one type of stimulating activity with an adult within the past three days. The most frequently reported activities were singing and playing—79.1 percent and 93.2 percent, respectively. Significant differences between girls and boys were found for some of the activities. For instance, caregivers were more likely to report singing songs for boys than girls (76.6% for girls and 82.1% for boys; $p < 0.001$.)

Percent of Children Ages 2–5 Years Enrolled in and Attending Preprimary School

In Mozambique, early childhood education or preprimary school begins as early as age two, and children typically begin primary education at age six. Although indicators on preprimary school are not part of the OVC ESI, this survey posed a question to caregivers of children ages 2–5, asking whether they were enrolled in preschool. Results are given in Table 15.

Table 15. Percent of children ages 2–5 years who were enrolled in and regularly attended preschool

Among children ages 2–5 years	Both sexes									
	n	N	%	95% CI						
				LL	UL					
Enrolled	24	468	6.0	5.0	7					
Regularly attended	19	468	5.1	4.2	6					
Among children ages 2–5 years	**Female children**					**Male children**				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
Enrolled	16	248	8.1	6.6	9.7	8	220	3.7	2.6	4.8
Regularly attended	14	248	7.3	5.9	8.8	5	220	2.6	1.7	3.5

Note: n=numerator; N=denominator

Caregivers reported that only 6 percent of children ages 2–5 were enrolled in preschool; about 5.1 percent of children regularly attended preschool (i.e., did not miss any school days in the week preceding the survey).

Legal Rights

CW.9: Percent of Children Who Have a Birth Certificate

The interviewers asked caregivers if the children under their care had a document showing that their birth had been registered; if they responded positively, they were asked to show the document to the interviewer. See data in Table 16.

Table 16. Percent of children who have a birth certificate (seen by data collector)

Child's age (years)	Both sexes									
	n	N	%	95% CI						
				LL	UL					
0–4	146	500	31.8	30.1	33.4					
5–9	328	725	44.0	42.6	45.4					
10–14	389	793	47.6	46.3	49.0					
15–17	146	331	43.1	41.0	45.1					
All ages	1,009	2,349	42.6	41.8	43.4					
Child's age (years)	**Female children**					**Male children**				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
0–4	72	258	29.4	27.3	31.6	74	242	34.7	32.2	37.2
5–9	161	348	46.2	44.1	48.2	167	377	42.0	40.1	43.9
10–14	207	405	52.3	50.4	54.2	182	388	42.7	40.8	44.6
15–17	62	157	42.2	39.2	45.2	84	174	43.9	41.0	46.8
All ages	502	1,168	44.0	42.9	45.1	507	1,181	41.2	40.1	42.3

Note: n=numerator; N=denominator

Although caregivers reported that 74.3 percent of children had birth certificates, only 42.6 percent had birth certificates seen by the interviewer. Girls were more likely to have birth certificate than boys (44% of girls and 41.2% of boys; $p < 0.001$). Additionally, children ages 0–4 years were less likely to have birth certificates than those in other age groups ($p < 0.001$).

Education

Percent of Children Enrolled in School

Caregivers reported that 78.2 percent of children ages 5–17 under their care were enrolled in school, or approximately 83 percent of school-age children (ages 6–17). See Table 17.

Table 17. Percent of children enrolled in school

Child's age (years)	Both sexes					Male children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
5–9	502	725	67.3	65.9	68.6					
10–14	704	793	87.4	86.5	88.3					
15–17	261	331	80.6	78.9	82.2					
Ages 5–17	1,467	1,849	78.2	77.5	78.9					
Age groups according to school levels										
6–12 (Primary)	923	1,086	83.6	82.7	84.4					
13–17 (Secondary)	521	629	83.2	82.1	84.4					
Child's age (years)	**Female children**									
	n	N	%	95% CI						
				LL	UL					
5–9	249	348	67.3	65.4	69.2	253	377	67.2	65.4	69.0
10–14	356	405	89.6	88.4	90.7	348	388	85.2	83.8	86.6
15–17	121	157	81.1	78.7	83.4	140	174	80.1	77.7	82.4
Ages 5–17	726	910	79.6	78.6	80.6	741	939	76.9	75.8	77.9
Age groups according to school levels										
6–12 (Primary)	455	532	84.3	83.0	85.4	468	554	83.0	81.7	84.2
13–17 (Secondary)	256	315	84.9	83.3	86.4	265	314	81.6	79.9	83.3

Note: n=numerator; N=denominator

Reported school enrollment varied significantly by age group and sex. Children ages 10–14 years were more likely to be enrolled (87.4%), compared to other age groups ($p < 0.001$). Girls were more likely to be enrolled in school than boys (79.6% vs. 76.9%, respectively; $p < 0.01$). However, we found no difference in enrollment rates between primary school-age children (6–12 years) and secondary school-age children (13–17 years).

CW.11: Percent of Children Regularly Attending School

One of the MER ESI captures regular school attendance—that is, among children enrolled in school, what proportion did not miss any school days during the previous school week. In Mozambique, children typically begin primary education at age six and secondary education at age 13; data are presented using these age groups (6–12 years old for primary, 13–17 for secondary) as well as for the regular MER age groups. See Table 18.

Table 18. Percent of children regularly attending school

Child's age (years)	Both sexes					Female children					Male children				
	n	N	%	95% CI		n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL				LL	UL
5–9	403	725	54.7	53.3	56.1	198	348	54.2	52.2	56.3	205	377	55.2	53.2	57.1
10–14	561	793	72.3	71.1	73.5	282	405	76.4	74.7	78.0	279	388	68.0	66.2	69.8
15–17	200	331	63.9	61.9	65.9	96	157	68.7	65.9	71.5	104	174	59.3	56.5	62.2
Ages 5–17	1,164	1,849	63.8	63.0	64.7	576	910	66.6	65.4	67.8	588	939	61.1	59.9	62.3
Age groups according to school levels															
6–12 (Primary)	741	1,086	68.9	67.8	69.9	362	532	70.0	68.5	71.5	379	554	67.8	66.3	69.3
13–17 (Secondary)	405	629	66.8	65.3	68.2	201	315	71.7	69.7	73.7	204	314	61.9	59.8	64.0

Note: n=numerator; N=denominator

Among children enrolled in school, only 63.8 percent of those ages 5–17 were reported as attending school regularly—that is, the child was enrolled in school and did not miss any days in the school week before the interview. The pattern of distribution of attendance by age group and gender is like the one observed for the enrollment indicator. Attendance varied by age group, with attendance highest among children ages 10–14 years ($p < 0.001$); also, girls were more likely to attend school regularly than boys (66.6% female vs. 61.1%; $p < 0.001$). When applying standard school ages in Mozambique, we found that two-thirds of children were attending both primary and secondary school regularly (67.9% and 66.8%, respectively). Girls were more likely to be attending secondary school regularly than boys (71.7% vs. 61.9%).

CW.12: Percent of Children Who Progressed in School during the Last Year

Table 19 presents data on the percentage of children reported to have progressed in school during the last year—that is, the percentage of caregivers reporting that the child was in a higher grade at the time of the survey compared to the previous school year. The denominator (N) includes children enrolled in school during the previous school year.

Table 19. Percent of children who progressed in school during the past year

Child's age (years)	Both sexes				
	n	N	%	95% CI	
				LL	UL
5–9	278	366	74.6	72.8	76.3
10–14	584	725	78.0	76.8	79.2
15–17	192	278	67.3	65.2	69.4
Ages 5–17	1,054	1,369	74.8	74.0	75.8
Age groups according to school levels					
6–12 (Primary)	650	824	77.3	76.2	78.4
13–17 (Secondary)	404	544	71.1	69.6	72.6

Child's age (years)	Female children*					Male children				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
5–9	126	169	76.6	74.0	79.2	152	197	72.9	70.5	75.3
10–14	299	365	79.6	78.0	81.2	285	360	76.3	74.5	78.0
15–17	91	126	71.2	68.3	74.2	101	152	63.9	60.9	66.8
Ages 5–17	516	660	77.2	76.1	78.6	538	709	72.6	71.3	73.9
Age groups according to school levels										
6–12 (Primary)	311	394	79.0	77.4	80.5	339	430	75.8	74.2	77.4
13–17 (Secondary)	205	265	74.7	72.6	76.7	199	279	67.7	65.5	69.8

*Females were more likely to progress both in primary and secondary school ($p = 0.026$).
Note: n=numerator; N=denominator

Overall, 74.8 percent of children ages 5–17 were reported to have progressed in school, with differences detected between girls and boys (77.2% vs. 72.6%; $p < 0.001$). Differences also were detected by age group. Children ages 10–14 years were more likely to have progressed in school than other groups (78% of children ages 10–14 progressed in school, compared to only 67.3% of children ages 15–17 years; $p < 0.001$).

Attitudes about Child Punishment

CW.14 Percent of Caregivers Who Agree That Harsh Physical Punishment Is an Appropriate Means of Discipline or Control in the Home or School

The interviewers asked caregivers if they agreed that harsh physical punishment is an appropriate means of discipline or control in the home or school; see Table 20.

Table 20. Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school

Caregiver's age (years)	Both sexes				
	n	N	%	95% CI	
				LL	UL
< 18	0	1	0	0	0
18–30	37	192	20.2	17.8	22.5
31–50	73	325	24.0	22.3	25.8
51+	18	140	13.7	11.5	15.9
All ages	128	658	20.8	19.6	22.0

Caregiver's age (years) < 18	Female					Male				
	n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL
< 18	0	1	0	0	0	0	0	0	0	0
18–30	33	161	21.0	18.4	23.6	4	31	16.0	10.7	21.4
31–50	63	288	23.5	21.6	25.3	10	37	28.3	22.9	33.7
51+	13	105	14.4	11.9	17.0	5	35	10.8	6.4	15.2
All ages	109	555	21.0	19.7	22.3	19	103	19.6	16.5	22.6

Note: n=numerator; N=denominator

Approximately 21 percent (20.8%; see Table 20) of caregivers agreed that hitting or beating a child is an appropriate means of discipline or control in the home or school, with no differences between male and female caregivers (21.0% vs. 19.6%, respectively, $p = 0.43$). However, attitudes varied by caregivers' ages. Older caregivers (> 51+) were somewhat less likely to accept that harsh physical punishment is an appropriate means of discipline at home or school, compared to younger caregivers ($p < 0.001$). Caregivers ages 31–50 years were most likely to report agreement.

Tables 21 and 22 present data separately for approval of physical punishment at home versus in school.

Table 21. Percent of caregivers who agree that physical punishment is an appropriate means of discipline or control in the home

Caregiver's age (years)	Both sexes					Female					Male				
	n	N	%	95% CI		n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL				LL	UL
< 18	0	1	0	-	-	0	1	0	-	-	0	0	0	-	-
18–30	13	192	10.3	8.6	12.2	10	161	9.6	7.8	11.6	3	31	13.7	9.5	19.4
31–50	39	325	11.2	10.0	12.6	33	288	11.9	10.5	13.4	6	37	6.2	3.8	9.6
51+	11	140	10.0	8.2	12.0	10	105	12.0	9.9	14.5	1	35	2.2	0.7	4.8
All ages	63	658	10.7	9.8	11.7	53	555	11.3	10.4	12.4	10	103	7.2	5.4	9.4

Note: n=numerator; N=denominator

Table 22. Percent of caregivers who agree that harsh punishment is an appropriate means of discipline or control in the school

Caregiver's age (years)	Both sexes					Female					Male				
	n	N	%	95% CI		n	N	%	95% CI		n	N	%	95% CI	
				LL	UL				LL	UL				LL	UL
< 18	0	1	0	-	-	0	1	0	-	-	0	0	0	-	-
18–30	30	192	17.3	15.2	19.6	27	161	17.9	15.5	20.5	3	31	14.5	10.0	20.0
31–50	62	325	20.6	19.0	22.3	53	288	19.8	18.1	21.6	9	37	26.7	21.6	32.1
51+	16	140	12.9	10.8	15.1	12	105	14.0	11.6	16.5	4	35	8.6	5.4	13.3
All ages	108	658	18.1	17.0	19.3	92	555	18.1	16.9	19.4	16	103	17.8	15.0	20.8

Note: n=numerator; N=denominator

When data are disaggregated, results show that caregivers were less likely to agree with physical punishment as an appropriate mean of discipline or control at home than in school (10.7% vs. 18.1%, respectively). Female caregivers were more likely to agree with physical punishment at home compared to male caregivers (11.3%, vs. 7.2 %, respectively; $p < 0.001$). There were no differences by sex for agreement with physical punishment at school.

HW.2 Percent of Households Able to Access Money to Pay for Unexpected Household Expenses

Interviewers asked caregivers if their household had an unexpected expense in the past 12 months. They then asked those who responded affirmatively if they were able to access money to pay for that expense. Results are presented in Table 23.

Table 23. Percent of households able to access money to pay for unexpected household expenses

	n	N	%	95% CI	
				LL	UL
Households that experienced an unexpected expense in past 12 months					
Female caregivers	395	555	67.1	65.6	68.6
Male caregivers	72	103	78.9	75.8	82.0
Both sexes	467	658	68.8	67.5	70.2
Households able to access money to pay for unexpected expenses (among those experiencing an unexpected expense)					
Female caregivers	202	395	46.2	44.2	48.1
Male caregivers	47	72	65.9	61.8	70.0
Both sexes	249	467	49.5	47.8	51.3

Note: n=numerator; N=denominator

Nearly 70 percent (68.8%) of caregivers reported having experienced an unexpected household expense, such as a house repair or urgent medical treatment, in the last 12 months. Among them, about half (49.5%) reported their households were able to pay for the unexpected household expenses. Male caregivers were more likely to report their household was able to pay for the unexpected expenses (65.9% vs. 46.2%, respectively; $p < 0.001$).

We also looked at these data by household location but found no differences. The proportion of households experiencing an unexpected expense in the last 12 months and able to access money to pay for it was the same among rural and urban households.

DISCUSSION

The nine PEPFAR MER OVC essential survey indicators collected in the survey provided a snapshot of the well-being of children and households served by Project FCC in mid-2017. This study fulfills PEPFAR reporting requirements. The findings illuminate beneficiary population needs and program gaps and should be interpreted as a baseline situation analysis. Readers are reminded that the project is just beginning implementation.

Regarding **children's health**, one in five children was reportedly too sick to participate in daily activities at some point during the two weeks before the survey. Caregivers were more likely to report recent illness among children under age five. The most recent DHS found that 5 percent of children under age five had symptoms of an acute respiratory infection, 29 percent had a fever, and 11 percent had diarrhea in the two weeks before the survey (IMASIDA, 2015)—data roughly in line with our findings. Although there is no reference against which to compare these numbers to gauge the seriousness of the problem for children ages 5–17, the finding warrants closer examination of the causes of illness and possible interventions. In this HIV-affected Project FCC beneficiary population, high rates of illness certainly may be related to AIDS, tuberculosis, and opportunistic infections. Malaria is also highly prevalent in Mozambique, affecting 40 percent of children under age five (IMASIDA, 2015).

Caregivers reported "**HIV status known**" for only one-third of children, clearly indicating an area for further intervention, especially linking HIV testing services and subsequent life-saving care and treatment. Caregivers were more likely to report knowing the status of children in the youngest age group (0–4 years) and boys (though only marginally so).

Nearly 3 percent of children ages 6–59 months were found to be **undernourished** based on MUAC measurements. The 2011 DHS found that 6 percent of children under five were wasted—2 percent severely so—in line with the estimates from this survey. Of note, MUAC measures *acute* undernutrition and is most commonly applied in famine contexts. Therefore, the low rate of undernutrition as measured by MUAC would be expected. That is not to say that *chronic* undernutrition is not a huge problem in Mozambique, or even within the Project FCC beneficiary population. The 2011 DHS reported that 43 percent of children under 5 are stunted.

The survey included two proxy indicators for **early childhood development**. The survey found widespread engagement of caregivers or other household members in stimulating activities with young children in the household. For nearly all (96%) of children, a household member over age 15 was reported to have read books to; told stories to; sung songs or lullabies to; engaged in play with; or engaged in naming, counting, or drawing things with them at some point during the three days preceding the survey. The most commonly reported activities were playing (93%) and singing songs (79%). Less commonly reported engagement included reading or looking at picture books (12.5%). The high degree of early childhood stimulation reported is reassuring, and the finding of low rates of book reading is unsurprising, given that the economic situation of most beneficiaries precludes the purchase of books and low caregiver literacy (per the 2011 DHS, only 40% of women and 68% of men are literate).

More work can be done to encourage storytelling, counting, and drawing between caregivers and children. For children ages two through five, the survey measured preschool participation and found that only 6 percent were enrolled, dropping to 5 percent if including only those who attend regularly. This finding is in line with other estimates—a 2011 World Bank study found that only 4 percent of children were enrolled in preschool, and these children were generally living in urban areas and affluent (Martinez, Naudau, & Pereira, 2012). Studies in Mozambique and elsewhere have demonstrated the role of

preschool in child development, including cognitive, fine motor, and socioemotional (though not language) development, which can affect school readiness and primary school enrollment (Martinez, et al., 2012). The long-term effects of a lack of early childhood stimulation certainly are well documented (e.g., Naudau et al., 2010). OVC projects are in a strong position to extend the reach of early childhood development interventions, so long as this remains a focus of programming.

Caregivers reported that 74 percent of children had **birth certificates**, although they showed a birth certificate to survey interviewers for only 43 percent of children. Girls and children ages 0–4 years were slightly more likely to have a birth certificate. These data are in line with the most recent DHS, which found that 38 percent of children had a birth certificate in hand, and 80 percent of children's births reportedly had been registered (IMASIDA, 2015). Because evidence of birth registration is required to enter school exams, beginning in Grade 2, Mozambique benefits from higher levels of birth registration (conversely, this requirement may affect school progression negatively). The government, together with the United Nations Children's Fund (UNICEF) and others, recently has made significant efforts to extend birth registration facilities. OVC projects can help with the last step—supporting registration of hard-to-reach children.

This study reported on three **education** indicators: enrollment, regular attendance, and progression. Even though reported enrollment rates were reasonably high (84% of primary school-age children and 83% of secondary school-age children—78% of children ages 5–17 years), only two-thirds of children were reported to be attending school regularly. Interestingly, at the secondary level, girls were more likely to be attending than boys (72% vs. 62%, respectively). Although the survey did not ask about reasons for missing school, considering the high rates of ill health reported, it is likely that sickness affects school attendance. Enrollment rates found in this study are slightly higher than those reported in the most recent DHS, possibly because Project FCC often identifies children in need of support through schools and education professionals. It might also mean that early Project FCC interventions around encouraging school enrollment are already showing results. It would certainly be helpful to triangulate findings to any routine project data on demographics and services received.

Three-quarters of children ages 5–17 years enrolled in school during the survey year and the previous year reported progressing in school. Girls were more likely to progress compared to boys, both as primary students (79% vs.76%, respectively) and secondary students (75% vs. 68%, respectively). There is significant evidence relating to sexual relationships between female students and male teachers in secondary schools in Mozambique; professors coerce female students into having sex with the promise of good grades (ActionAid, 2013; UNICEF, 2014a). Though there is no evidence that these relationships actually lead to a student's progression in school in the absence of scholastic achievement, addressing coercive sex in schools between teachers and minors will be a critical component of promoting child rights in any program. It is important to note that data on progression are at best a proxy of actual scholastic achievement. The Mozambican education system requires students to pass exams at several points in their schooling, but several recent studies have documented falling pass rates at both the primary and secondary levels (Visser, 2013; Raupp, Newman, & Revés, 2013; Adelman, Shuh Moore, & Manji, 2011). Increasing preschool coverage might improve performance in later years and contribute to real progression, as would interventions to improve the quality of teaching.

As a proxy for **violence**, the survey asked caregivers whether they agreed that hitting or beating a child is an appropriate means of discipline in the home or school. Approximately one in five caregivers agreed that violence was acceptable in the home or school, with fewer agreeing that violence is acceptable in the home compared to school (11% vs. 18%, respectively). There are limited data on the prevalence of

violence against children (a violence against children survey, VACS, is planned) and caregivers' attitudes; however, violence against girls in school settings is widespread (ActionAid, 2013). Campaigns to sensitize both caregivers and teachers to the effects of violence (such as the one launched this year by World Vision in Mozambique), combined with a stronger reporting system (the government currently is making advances in this area) and the regular application of punitive measures for perpetrators, will help protect children. Changing cultural attitudes toward violence is always a long and complex process, however. This study found that female caregivers were somewhat more accepting of harsh physical punishment toward children than male caregivers, suggesting that norms about child punishment may also be linked to gender roles. This result is consistent with other studies, in which children report mothers to be among the most frequent perpetrators of physical violence (UNICEF, 2014b). We recommend continuing structural interventions to change norms around violence, particularly school-based violence and corporal punishment. The practice of corporal punishment creates a general environment for school-based violence, which can lead to poor educational outcomes (UNESCO, 2015).

To assess the **economic resilience of households**, interviewers asked caregivers whether their household had incurred an unexpected household expense during the last 12 months and, if so, whether they were able to access money to pay for that expense. Responses varied by caregiver sex. Two-thirds of female caregivers and 79 percent of male caregivers reported that their households incurred an unexpected expense. Of these, 46 percent of female caregivers and 66 percent of male caregivers reported being able to access money to pay for that expense. Indeed, more than half of Mozambique's population (56%) is living below the international poverty line (UNICEF, no date). This finding indicates a clear opportunity to link caregivers, especially female caregivers, to economic strengthening interventions, such as savings groups (only 8.5% of caregivers reported that someone in their household was part of a savings group) and social protection schemes, like the government cash transfer scheme.

Although nearly all caregivers (97%) reported participating in or receiving services from Project FCC local partners, only 59 percent reported receiving a service in the past six months. This finding is a cause for concern regarding service delivery coverage, given that OVC service delivery guidelines call for quarterly visits by community caseworkers. The most common service received in the last six months was a home visit. Very few caregivers reported receiving any other services in the past six months; however, this finding is not surprising because the project is relatively new and still enrolling beneficiaries. Although the survey data suggest possible gaps in service delivery, they also may reflect shortcomings in the survey method. For example, even though only 59 percent of caregivers reported receiving services in the last six months, the average length of time of enrollment was 4.7 months. It is possible that many households recently had been registered to receive services but had not yet actually received them, or caregivers may have misunderstood the interview questions about the services; for example, it may not have been clear that a set of meetings they attended in the community was a "parenting intervention." Furthermore, recall of services received may have been inaccurate, or caregivers might have under-reported their receipt purposely, in an attempt to gain consideration for more services.

There are several limitations to the methods—most significantly the following:

- The limited number of measures used in this study resulted in a limited assessment of well-being; also, most of them are subject to self-reporting bias.
- The information in the Project FCC database (from which we drew the primary sampling units) and that obtained from the household listing during data collection (from which we drew the secondary sampling units) did not match. This issue may be explained by three primary factors: (1) We did not list individual children registered to receive services at the school (part of Project

FCC's model) but rather *households* registered to receive services from the project (the database contained cases registered at the school and within households). (2) Inaccuracies existed in the database, which we cannot quantify. (3) It is possible that we missed some active beneficiary households in the selected clusters during listing. Using weights, we corrected for the selection of the primary sampling units during analysis, so to the extent that both Factors 1 and 2 are true, the results remain a robust analysis of the household beneficiary population. However, Factor 3 threatens the representativeness of the results. The process we used to list beneficiaries during field work was robust, so if active caseworkers forgot households they were serving, we could surmise they likely were not "active" beneficiary households (defined as having received services in the previous three months). However, we encountered high caseworker attrition; many households were between caseworkers. As we captured only those households that had an assigned caseworker at the time of survey, it is likely we missed some households that had been registered and may have received services in the previous three months from a caseworker who subsequently had left the project.

There are additional limitations to the methods related to assessing change over time; they will need to be considered for the "Time 2" survey, scheduled to be conducted in two years:

- The project strategy is to graduate beneficiaries after their case plans are complete and, over the life of the project, enroll new beneficiaries with needs. Thus, the sample drawn at Time 2 or end line will comprise different households than at Time 1 (baseline); this sample is likely to include beneficiaries new to the project who have multiple needs and fewer beneficiaries who have improved, as they will have graduated. Any changes detected over time will need to be interpreted carefully.[4]
- The geographic footprint of the project is shifting. At end line, stakeholders will need to determine whether to restrict the sample to the same geographic areas as the baseline survey, which would provide a better assessment of the results of the project, or widen the sample to include all active regions, resulting in a more generalizable assessment of the state of beneficiaries at one point (Time 2).
- The project strategy was not crafted around improving the nine indicators. We developed a framework of change for each indicator, as presented above in Table 2. These assumptions need to be tested through a process evaluation at end line to enable interpretation of the likely contribution of the project to any changes.

Despite these limitations, the Project FCC MER OVC ESI survey successfully produced data to meet PEPFAR OVC reporting requirements and provided valuable information on the status of well-being of project beneficiaries. The results from this first round of data collection also serve as a reference for tracking changes over time in the next round of data collection, planned for 2019.

[4] When this survey was completed, the PEPFAR MER ESI guidance was to conduct a cross-sectional survey of all project beneficiaries at Time 1 and Time 2. Soon after the survey was completed, the guidance changed to favor a panel design. This change in the guidance was precipitated by the change in the OVC programming model that calls for project beneficiaries to be graduated rapidly, if and when they meet graduation criteria. At Time 2, we recommend that USAID and partners consider the feasibility of a panel study (going back to the same households or at least the same clusters). We would also recommend a process evaluation of the project, including routine data analysis, to better understand progress in implementation and graduation rates in study areas.

RECOMMENDATIONS

The following are programmatic recommendations for the study:

- Link children and their caregivers with unknown HIV status to counseling and testing services, prioritizing children who are often unwell.
- Teach caregivers how to stimulate the young children under their care to prepare them for schooling; related to children's school preparation, teach caregivers about child development milestones.
- Support caregivers and communities in establishing community preschools and play groups.
- Engage with national birth registration efforts to support registration of those children hardest to reach, focusing on those near school age.
- Address coercive sex in schools between teachers and minors through engagement with national efforts and the leadership of local solutions.
- Launch campaigns to sensitize both caregivers and teachers to the effects of violence against children, using home visits and school events to promote positive messages around child protection.
- Link caregivers, especially female caregivers, to economic strengthening interventions, such as savings groups and social protection schemes, like the government cash transfer scheme.
- Triangulate findings with routine project and research data on demographics, well-being, and services received, and consider further research and analyses to answer such questions as the following:
    - How do various early childhood development interventions, including preschool, impact enrolment, and attendance in primary school (and later, in secondary school)?
    - What interventions are most likely to keep girls and boys in school?
    - What factors contribute to school progression, for both boys and girls?
    - How can the project best address scholastic achievement?
    - How does school-based violence affect educational indicators in this context?
    - How do HIV-positive children, and children living in HIV-affected households, fare compared to others on key measures of wellbeing? How can the project mitigate any excess vulnerability?
    - What is the relationship between regular school attendance and HIV incidence in adolescence?
    - What is the relationship between violence in the household and HIV—does violence predict HIV; does HIV predict violence?
    - To what extent do economic strengthening interventions reach HIV-positive households? Do HIV-positive households benefit from different types of household economic strengthening interventions?

CONCLUSION

MEASURE Evaluation's survey of 680 households of active beneficiaries of Project FCC involved interviews with caregivers of OVC about services received and the well-being of the children in their households using a brief, standard questionnaire developed by MEASURE Evaluation for global application. These findings show that the Project FCC MER OVC ESI survey successfully produced data to meet PEPFAR OVC reporting requirements and provided valuable information on the status of well-being of project beneficiaries. The report also illuminates beneficiary population needs and program gaps, and should be interpreted as a baseline situation analysis.

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APPENDIX 1. QUESTIONNAIRE

Capa

No.	Pergunta	Categoria de Codificação
001	DISTRITO	MANICA 1 CHIMOIO 2 GONDOLA 3 BEIRA 4 DONDO 5 NHAMATANDA 6 QUELIMANE 7 NICUADALA 8 NAMACURRA 9
002	POSTO ADMINISTRATIVO	
003	BAIRRO	
004	COORDENADAS GEOGRÁFICAS	LATITUDE LONGITUDE
005	LOCALIZAÇÃO	ZONA URBANA 1 ZONA PERI-URBANA 2 ZONA RURAL 3
006	NÚMERO DO AGREGADO FAMILIAR (da lista de amostragem)	
007	NOME DO ENTREVISTADOR	
008	DATA DA ENTREVISTA (dia/mês/ano)	
009	INÍCIO **Relógio de 24 horas**	__ __ : __ __

Questionário para as Cuidadores de Menores

Tenho algumas perguntas sobre si e sobre as crianças que estão sob os seus cuidados.

No.	Pergunta	Categoria de Codificação		Avançar
1a	**Registar o sexo do(a) cuidador(a).**	FEMININO MASCULINO	1 2	
1b	Qual é o seu nome?			
2	Quantos anos tem? ***Não deixar em branco. Se não souber, peça ao entrevistado para estimar.*** ***Peça algum documento ou alguma referência histórica que possa ter acontecido, como por exemplo, se nasceu antes ou depois da independência (1975)/antes ou depois da Guerra civil ter iniciado (1980-81)/antes ou depois do acordo de paz (1992), etc.***	[__ __] ANOS		
3	O seu agregado familiar teve despesas familiares <u>não programadas</u>, tais como reparação da casa ou tratamento médico urgente nos últimos 12 meses?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	**Caso 2, 88 ou 99 salte para pergunta 5**
4	A sua família foi capaz de pagar estas despesas?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	
5	Acha que bater numa criança é um meio apropriado de garantir disciplina ou controlo <u>em casa</u>?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	
6	Acha que bater numa criança é um meio apropriado de garantir disciplina ou controlo <u>na escola</u>?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	

No.	Pergunta	Categoria de Codificação				Avançar
7	Quando foi o mês e ano que se juntou ao Projecto FCC / Projecto da World Education - o tempo que a pessoa do projecto pediu e registou os seus dados, como por exemplo, os seus nomes e datas de nascimento?	MÊS ANO NÃO SEI SEM RESPOSTA	_____ _____ 88 99			
8	Que serviços ou tipos de apoio a sua família recebeu do Projecto FCC? Por favor, diga-me que serviços ou o apoio tem recebido por qualquer membro desta família. ***Aguarde que o respondente diga espontaneamente. Depois, experimente com categorias de resposta.*** ***Possíveis respostas múltiplas. Registe todas as respostas dadas.***		SIM	NÃO	NS/SR	
		VISITA DOMICILIÁRIA	1	2	99	
		GRUPO DE APOIO AOS PAIS/ CUIDADORES	1	2	99	
		GRUPOS DE POUPANÇA E CRÉDITO	1	2	99	
		BOLSAS DE ESTUDO/SUBSÍDIOS	1	2	99	
		REFERENCIA PARA SERVIÇIO DE SAUDE	1	2	99	
		GRUPO DE ADOLESCENTES E JOVENS	1	2	99	
		OUTROS (especifique): _____	1	2	99	
9	Quantas crianças de 0 a 17 anos de idade pelas quais você é responsável?	[__ __] CRIANÇAS				

Lista de crianças sob cuidados

	Nome
Começando pela criança mais velha, diga os nomes das crianças que você cuida ou pelas quais é responsável. Qual é o nome da sua criança mais velha? Qual é o nome do seu filho a seguir ao mais velho? ***Certifique-se de que o número total de crianças é o mesmo que o da resposta dada à pergunta 10.*** ***Entrevistador: Aplique o "questionário para crianças" a cada uma das crianças listadas.***	1.
	2.
	3.
	4.
	5.
	6.
	7.
	8.
	9.

Questionário para Crianças

Este questionário deve ser aplicado a todas as crianças sob cuidados. Comece com a criança mais velha e trabalhe através da lista. Comece um novo questionário para cada criança.

Tenho algumas perguntas sobre [inserir o nome da criança].

No.	Pergunta	Categoria de Codificação	Avançar
1	[NOME] é do sexo feminino ou masculino?	FEMININO 1 MASCULINO 2	
2a	[NOME] tem certidão de nascimento?	SIM 1 NÃO 2 NÃO SEI 88 SEM RESPOSTA 99	**Caso 2, 88 ou 99 salte para a pergunta 3b**
2b	Poderia, por favor, me mostrar a certidão de nascimento de [NOME]?	VISTO/CONFIRMADO 1 NÃO VISTO/ NÃO CONFIRMADO 2	**Caso 2, salte para a pergunta 3b**
3a	**Registe a data de nacimento da criança.**	[____ / ____ /__ __] DIA/MÊS/ANO	
3b	Quantos anos [NOME] tem? ***Não deixar em branco. Se não souber, peça ao cuidador de menores para estimar. Peça algum documento ou alguma referência histórica que possa ter acontecido, como por exemplo, se nasceu antes ou depois da independência (1975)/antes ou depois da Guerra civil ter terminado (1980-81)/antes ou depois do acordo de paz (1992), etc.*** ***Se menos de 1 ano, registre "0".*** ***A criança precisa nascer em 2000 ou antes para serem incluída. Se a criança Ç maior de 17 anos de idade (nasceu em 1999 ou antes), suspender a entrevista e passar para a criança seguinte, se existir, ou terminar o questionário.***	[__ __] ANOS	**Caso 1-17 anos, salte para a pergunta 4**
3c	Quantos meses tem?	0-5 MESES 1 6-11 MESES 2	

No.	Pergunta	Categoria de Codificação		Avançar
4	Nas últimas 2 semanas, [NOME] esteve muito doente que não conseguia participar nas actividades diárias?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	
5	Não quero saber os resultados, mas [NOME] alguma vez fez testagem para saber se ele / ela tem o vírus do SIDA?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	**Caso 2, 88 ou 99 salte para a pergunta 7**
6	Não quero saber os resultados, mas você sabe os resultados do teste do(a) [NOME]?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	
7	**FILTRO: Idade de criança**	0-4 ANOS 5-17 ANOS	1 2	**Caso 1 salte para a pergunta 14**
8	[NOME] está matriculado(a) numa escola neste momento?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	**Caso 2, 88 ou 99 salte para a pergunta 11**
9	Em que classe [NOME] está neste momento?	[__|__]		
10	Durante a última semana de aulas, [NOME] perdeu aulas por alguma razão?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	
11	[NOME] esteve matriculado no ano lectivo anterior?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	**Caso 2, 88, ou 99 salte para a pergunta 13**
12	Em que classe [NOME] estava no ano lectivo anterior?	[__|__]		
13	[NOME] recebeu apoio educacional do Projecto FCC / Projecto da World Education – bolsas ou material escolar?	SIM NÃO NÃO SEI SEM RESPOSTA	1 2 88 99	**Todas as respostas, salte para a pergunta 16**

No.	Pergunta	Categoria de Codificação					Avançar
			SIM	NÃO	NS	SR	
14	Nos últimos 3 dias, você ou qualquer membro do agregado familiar maior de 15 anos de idade envolveu-se em algumas das seguintes actividades com [NAME]: **Ler de a) até e), uma pergunta de cada vez.**	A. Leu alguns livros para [NOME] ou viu livros ilustrados com [NOME]?	1	2	88	99	
		B. Contou histórias para [NOME]?	1	2	88	99	
		C. Cantou músicas para [NOME] ou com [NOME] incluindo canções para adormecer?	1	2	88	99	
		D. Brincou com [NOME]?	1	2	88	99	
		E. Atribuiu nomes, contou ou desenhou coisas com [NOME]?	1	2	88	99	
15a	**FILTRO**	0-5 MESES 6-11 MESES 1-4 ANOS			1 2 3		**Caso 1: salte para a pergunta 16**
15b	Posso medir a circunferência do braço da sua criança? **Medir a circunferência do braço da criança usando a fita métrica apropriada e documentar as respectivas medidas.** **Se não for possível gravar MUAC, coloque como opção de resposta: 999.**	[__|__|__] mm					
16	**Conclusão** **Relógio de 24 horas**	__ __ : __ __					

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