Monitoring Outcomes of a PEPFAR Orphans and Vulnerable Children Program in Lesotho

ASSIST Project 2017 Survey Findings

September 2018

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MEASURE Evaluation

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ABBREVIATIONS

ART	antiretroviral therapy
ARV	antiretroviral
ASSIST	Applying Science to Strengthen and Improve Systems
CI	confidence interval
ESI	Essential Survey Indicators
LMOH	Lesotho Ministry of Health
MER	monitoring, evaluation, and reporting
MUAC	mid-upper arm circumference
ODK	Open Data Kit
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The HIV epidemic in Lesotho has left one-third of the children in the country vulnerable to the virus, often without parents to care for them. Recognizing the enormous need for programs and services for orphans and vulnerable children (OVC), the United States President's Emergency Plan for AIDS Relief (PEPFAR) has partnered with the Government of Lesotho to strengthen services for OVC and their households. PEPFAR support has focused on delivery of a comprehensive set of core interventions that include healthcare and referrals for nutrition; linkages to HIV testing, care, and treatment, including integration of adherence to antiretroviral therapy (ART) in routine household monitoring; promotion of positive parenting; economic strengthening activities for households, such as group savings and loans, cash transfers, and food subsidies; and educational support for children.

Recognizing the need to better understand the effects of its programs on the well-being of OVC, PEPFAR launched a global reporting requirement in 2014 to monitor the outcomes of selected projects in Lesotho and the other countries where it provides support for OVC. The requirement involves the collection of data for nine outcome indicators, referred to as the PEPFAR monitoring, evaluation, and reporting (MER) OVC Essential Survey Indicators (ESIs). In 2016, the United States Agency for International Development (USAID)/Lesotho requested assistance from the USAID- and PEPFAR-funded MEASURE Evaluation project to conduct a survey that would collect the required data for the Applying Science to Strengthen and Improve Systems (ASSIST) Project, its largest OVC project, implemented by University Research Co. LLC in partnership with six local implementing partners. This report presents findings from the survey that MEASURE Evaluation, along with its local research partner, Nonyana Hoohlo and Associates, conducted for the ASSIST Project in September 2017.

Using a two-stage cluster randomized design, the MEASURE Evaluation survey team selected a sample of 480 beneficiary households and conducted survey interviews with 437 caregivers about themselves, their households, and 1,157 children under age 18 under their care. The survey tools and methodology followed guidance previously developed for PEPFAR by MEASURE Evaluation for collection of the OVC ESIs. The survey collected data for the nine ESIs and two supplemental indicators of interest to the PEPFAR/Lesotho OVC team and ASSIST Project managers.

Results for these indicators, presented below, provided a snapshot of the well-being of children and households served by the ASSIST Project in 2017. Although the survey was not designed to assess the effectiveness of the ASSIST Project OVC program, it was useful in pointing out potential needs and program gaps. They included a rather high prevalence of children who were ill, particularly young children; substantial awareness among caregivers of children's HIV status and access to antiretroviral (ARV) drugs among children living with HIV; low presence of birth certificates; low rates of regular school attendance, especially among secondary school students; widespread acceptance of harsh physical punishment toward children; and limited household economic resilience. Caregivers reported knowledge of the HIV status of more than three-quarters of the children under their care. Among the children whose caregivers reported knowing their status, 4.0 percent were reported to be living with HIV. Among those living with HIV, about three-quarters were reported to be receiving ART. Dimensions of well-being that appeared not to be of concern were nutrition and early childhood development (measured in terms of adult engagement in stimulating activities with young children).

Based on these findings, recommendations for strengthening programs for orphans and vulnerable children in Lesotho include to: examine the causes of childhood illness and possible interventions to address them; raise caregivers' awareness about childhood illness, prevention, and services, and provide support to help keep children healthy; continue efforts to assess children's HIV risk and ensure those at risk get tested for HIV; continue to support access to ART and adherence; explore options for increasing enrollment of young children in preschool; help children obtain birth certificates; address barriers to school attendance; accelerate project efforts to change caregiver norms regarding acceptance of harsh physical punishment toward children; and intensify efforts to build the economic resilience of OVC households.

Summary of PEPFAR MER OVC Essential Survey Indicator results for the ASSIST Project

Indicator		Unweighted			Weighted		
		n	*N*	%	%	95% Confidence interval (CI)	
						LL	UL
Health							
OVC_SICK	Percent of children too sick to participate in daily activities	304	1,148	26.5	**27.1**	22.7	32.0
OVC_HIVST	Percent of children whose primary caregiver knows the child's HIV status	946	1,157	81.8	**83.1**	79.8	86.0
OVC_LS1	Percent of children living with HIV who are taking antiretroviral (ARV) drugs	27	37	73.0	**77.3**	58.7	89.1
Nutrition							
OVC_NUT	Percent of children (aged 6–59 months) who are undernourished	4	170	2.4	**1.9**	0.4	8.5
Early childhood development							
OVC_STIM	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	21	236	89.4	**87.3**	77.3	93.3
Legal rights							
OVC_BCERT	Percent of children who have a birth certificate	281	1,157	24.3	**24.2**	20.3	28.6
Education							
OVC_SCHATT	Percent of children (aged 5–17 years) regularly attending school	600	921	65.1	**65.0**	60.4	69.3
OVC_PRGS	Percent of children who progressed in school during the last year	626	761	82.3	**81.9**	79.2	84.3
Attitudes about child punishment							
OVC_CP	Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school	309	436	70.9	**71.3**	65.5	76.5
Household economic well-being and resilience							
OVC_LS2	Percent of households able to access money to pay for expected household expenses	260	437	59.5	**59.8**	53.6	65.8
OVC_MONEY	Percent of households able to access money to pay for unexpected household expenses	67	170	39.4	**38.1**	31.1	45.6

INTRODUCTION

Situation of Orphans and Vulnerable Children in Lesotho

Lesotho has the second highest HIV prevalence rate in the world, with about a quarter of adults ages 15–49 living with HIV. Women bear a disproportionate burden of the epidemic, with a prevalence of 29.7 percent compared to 19.1 percent among men (Lesotho Ministry of Health [LMOH], 2017). The epidemic has taken a terrible toll on the country, including its children. In 2014, 74,000 children (ages zero to 18 years) were estimated to have lost one or both parents because of HIV/AIDS. Although this number has declined in recent years (i.e., down from 78,000 in 2012), it represents about one-third of the children in the country (LMOH, 2015). The magnitude of the orphan challenge in Lesotho has caused many of the traditional systems of care and support for orphaned children to disintegrate. In many families, the "middle generation" has succumbed to the HIV epidemic, with children left in the care of grandparents or on their own in child-headed households (LMOH, 2015). These children often have an unmet need for basic goods and services. Many of them live in substandard conditions, living in unhygienic houses, with poor nutrition and little or no provision of school materials (Tanga, 2013). Their long-term psychological health, resilience, self-worth, and self-esteem are in jeopardy (Ntaote, 2012). Being raised without the protection or guidance of their parents, they are often the victims of social ills, including poverty, disease, and abandonment, often suffering psychosocial trauma (Goldberg & Short, 2012). Lesotho's National Strategic Plan for HIV and AIDS (2011/2012–2017/2018) indicates that vulnerable children in the country are more at risk of early sexual debut and sexual abuse. They also experience more stigma and discrimination, and are more likely (especially girls) to take on the roles of caregiver and household head, compromising their access to education and healthcare (Government of Lesotho [GOL], 2015).

Prevention of mother-to-child transmission services have significantly reduced the number of children born with HIV, from 4,400 new child infections in 2009 to 1,300 in 2015 (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2016). Progress has also been made in decreasing the number of deaths among HIV-positive children under age five from 860 in 2004 to 260 in 2014 (LMOH, 2015). Yet, HIV prevalence among children in Lesotho remains among the highest in the world, at 2.1 percent among 0- to 14-year-olds (2.6% among girls and 1.5% among boys) (LMOH, 2017). ART coverage among HIV-infected children in Lesotho, at 56 percent in 2015, has improved but remains low (UNAIDS, 2016).

Orphans and vulnerable children need care and protection that the traditional extended family system in Lesotho typically is unprepared to offer because of social and economic strains on households in the country and the magnitude of the problem. A 2011 Lesotho situational analysis redefined a vulnerable child as "a child whose rights to survival, development, protection and participation are not met because of certain conditions or circumstances" (GOL, 2015). The study found serious shortcomings in the ability of government and nongovernmental partners to intervene quickly enough to avoid significant harm to the most vulnerable children. It showed that the determinants of children's vulnerability stemmed from larger social and economic challenges affecting households, particularly the inability of many of the adult members of these households to find reliable sources of livelihood. It also noted how the burden of HIV/AIDS had contributed to the erosion of community and household coping mechanisms that had previously protected and nurtured vulnerable children (Department of Social Welfare, Ministry of Health and Social Welfare, 2011).

To respond to these challenges and alleviate the impact of negative socioenvironmental conditions on children, the Government of Lesotho works with multi-sectoral partners to expand programs and services

for OVC (LMOH, 2015). In 2011, the country's parliament approved and enacted the Children's Protection and Welfare Act. Its provisions signaled a fundamental change in the focus and intensity of Lesotho's efforts to support and protect its children by fully domesticating the provisions of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. At the end of 2010, the parliament approved and enacted the Education Act, which sets out the legal framework for free and compulsory primary education for all school-age children. Another government undertaking was the development and roll out of the Lesotho Child Grants Programme, which provides financial support to households caring for OVC. Also, with assistance from donors and partners, the Government of Lesotho is improving its capacity to identify children in distress; reach them with supportive interventions to protect their well-being; and remove them from situations and environments where they are in danger of sexual or physical abuse, exploitation, and neglect. Similarly, more child-friendly, appropriate, and effective programs for assisting children in situations of conflict with laws or customs are being implemented (LMOH, 2015). However, coverage of these efforts is inadequate, leaving many OVC in Lesotho without safe and immediate access to essential child protection systems because of the ever-expanding number of children and adolescents who find themselves in situations of extreme vulnerability (LMOH, 2015).

For many years, PEPFAR has partnered with the Government of Lesotho to strengthen services for OVC; it currently focuses its support in five districts hit hardest by the AIDS epidemic: Maseru, Leribe, Berea, Mafeteng, and Mohale's Hoek. In 2016, PEPFAR pledged support to nearly 90,000 out of the estimated 164,000 OVC living in these five districts. In line with PEPFAR legislative guidance, PEPFAR/Lesotho is supporting OVC services and interventions to mitigate the impact of AIDS by building resilience among children and families in addition to preventing and treating child and adolescent HIV infection. Core activities include the following: identification and registration of vulnerable children; ensuring effective integration with existing or planned child-focused community and home-based activities, such as HIV treatment and child survival; facilitating referral to care and services, such as HIV testing and counseling, prevention of mother-to-child transmission, and pediatric care and treatment; establishing linkages and referral systems between community- and clinic-based programs; providing parenting and family support interventions; strengthening community caregiver support; creating and enhancing access and linkages to government-supported cash grant programs; mobilizing child protection committees; strengthening data and information flow among community councils, district governments, and national headquarters; and improving monitoring and evaluation for interventions (U.S. Department of State, 2016).

OVC Outcome Monitoring

Globally, PEPFAR has invested considerable resources in OVC programs but has not undertaken a systematic or large-scale study of the well-being of beneficiary OVC and their households (Sherr & Zoll, 2011). To fill this gap, in 2014 PEPFAR introduced a new global reporting requirement for monitoring the outcomes of its OVC programs, referred to as the MER OVC ESIs. They are intended to measure and track child and household well-being using standard indicators and methodology across projects and countries for seven dimensions of well-being: health, nutrition, early childhood development, legal rights, education, attitudes about child punishment, and household economic resilience. The ESIs reflect internationally accepted developmental milestones and ways that OVC programs gain from and contribute to the broader HIV and child protection response (MEASURE Evaluation, 2014).

PEPFAR/Lesotho requested the assistance of MEASURE Evaluation, a USAID project, to conduct a study to collect the OVC MER ESIs. The survey was the first of its kind conducted in Lesotho.

Intended Use of This Report

This report describes the methods used to conduct the ASSIST Project MER OVC ESI survey and presents results for the ESIs in accordance with MER guidance. It also provides a brief discussion of the findings. This information is intended to help project managers better understand the current well-being of their beneficiaries and support the PEPFAR OVC teams in Lesotho and at headquarters, and other program decision makers and stakeholders, including those from the Government of Lesotho, to take evidence-informed actions that will improve OVC program strategy, resource allocation, and implementation, with the ultimate goal of improving the well-being of the children and households they serve. Findings presented in this report will also contribute to a global PEPFAR-wide evidence base on the well-being of beneficiaries of PEPFAR OVC programming.

METHODS

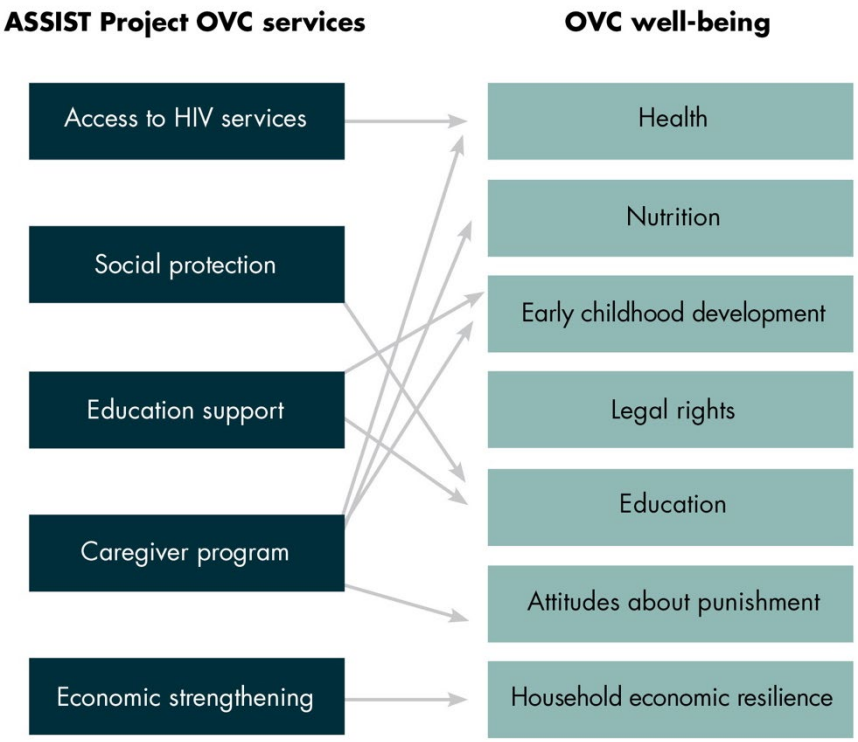
Survey Context: The ASSIST Project

The PEPFAR Lesotho OVC team selected its largest OVC project, the USAID ASSIST Project, as the focus of this study. The ASSIST Project was implemented by URC in partnership with six local implementing partners: the Lesotho Network of AIDS Service Organizations, Centre for Impacting Lives, Lesotho Inter-Religious AIDS Consortium, Society for Women and AIDS in Africa Lesotho, Sentebale, and Phelisanang Bophelong. The project, which began in 2015, was targeted to provide services to 44,000 OVC in the five PEPFAR priority districts. Households and children under age 18 were assessed in 2016 to determine project eligibility and needs; registration of beneficiaries was completed in December 2016. The project then began delivering selective, tailored packages of services to households and children, including access to HIV services, education support, social protection, parenting/caregiver programs, and household economic strengthening. In September 2017, just after data collection for the MER ESI survey was completed, the ASSIST Project ended and a new project led by Catholic Relief Services assumed service delivery for the beneficiaries in these five districts.

Conceptual Framework

The PEPFAR MER OVC ESIs measure seven dimensions of OVC and caregiver (or household) well-being. Figure 1 shows how the ASSIST Project services map to these dimensions. Many of the services contribute indirectly to the various dimensions of well-being, which themselves are interrelated. For example, economic strengthening activities are hypothesized to contribute to child health, nutrition, and educational enrollment and performance, in addition to their primary contribution to household economic resilience.

Figure 1. Conceptual framework mapping ASSIST Project services to OVC well-being



Survey Indicators and Questionnaire

The survey interview focused on collecting data for the nine OVC MER ESIs and two supplemental indicators of interest to the ASSIST Project and PEPFAR/Lesotho program managers. These indicators, their associated PEPFAR MER reference names, and the rationale for their inclusion in the survey are presented in Table 1. They are categorized according to the dimensions of OVC well-being they represent.

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

Indicator name	Indicator	Rationale for inclusion
Health		
OVC_SICK	Percent of children (aged 0–17 years) too sick to participate in daily activities	PEPFAR OVC programs support critical linkages to health services and treatment, aiming to reduce the number of sick children and improve functional well-being.
OVC_HIVST	Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status	If a child's HIV status is unknown to her or his caregiver, the child will not have access to lifesaving care, treatment, and support interventions.
OVC_LS1	Percent of children (aged 0–17 years) living with HIV who are taking ARV drugs	This supplemental indicator provides a measure of the well-being of children living with HIV. Promotion of HIV testing and linking children living with HIV to treatment services is a current PEPFAR programming priority.
Nutrition		
OVC_NUT	Percent of children (aged 6–59 months) who are undernourished *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.
Early childhood development		
OVC_STIM	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	Early childhood cognitive, social, and physical stimulation is essential for promotion of long-term learning, growth, and health.
Legal rights		
OVC_BCERT	Percent of children (aged 0–17 years) who have a birth certificate	Ensuring children access to basic legal rights, such as birth certificates, enables them to access other essential services and opportunities, including health, education, legal services, and legal employment when they grow older.
Education		
OVC_SCHATT	Percent of children (aged 5–17 years) regularly attending school	In addition to being important in its own right, children's attendance at school has positive impacts on HIV prevention.
OVC_PRGS	Percent of children (aged 5–17 years) who progressed in school during the last year*	Studies in many countries have linked higher education levels with increased AIDS awareness and knowledge, higher rates of contraceptive

Indicator name	Indicator	Rationale for inclusion
		use, and greater communication regarding HIV prevention among partners.
Attitudes about child punishment		
OVC_CP	Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or at school	Reducing harsh physical discipline, violence, and abuse against children is a PEPFAR priority. Perceptions of physical discipline have been linked to actual use of physical discipline against children.
Household economic well-being and resilience		
OVC_LS2	Percent of households able to access money to pay for expected household expenses	This supplemental indicator is routinely collected by the implementing partners that provide OVC services. Collecting data for this indicator through the MER ESI survey will allow for data triangulation/validation and provide another measure of household economic well-being.
OVC_MONEY	Percent of households able to access money to pay for unexpected household expenses	The key goal of household economic strengthening programs is to improve household's resiliency to economic shocks, such as unexpected household expenses. Child well-being is assumed to be affected by the household's resiliency to economic shocks.

Global PEPFAR OVC program and strategic information technical leaders vetted and selected the PEPFAR MER OVC ESIs in 2014. They applied a number of criteria in their selection, including relevancy among the various countries where PEPFAR provides OVC program support and representation of factors amenable to change over a two-year period. All selection criteria and the indicator reference sheets that define the indicators can be found in the MEASURE Evaluation guidance developed for the surveys (MEASURE Evaluation, 2014).

Data collectors conducted interviews with caregivers using a standard questionnaire previously developed by MEASURE Evaluation for the PEPFAR OVC Technical Working Group specifically to collect data for the MER OVC ESIs. The survey questionnaire included three components: (1) caregiver, (2) child ages 0–4 years, and (3) child ages 5–17 years. Data collectors administered the caregiver component in all selected households and, depending on the number and ages of the children in the household, administered one or both of the child components to the caregiver. The survey team administered the child components for each child in the household under the care of the caregiver. The team made only minor modifications to the standard questionnaire to adapt it to the Lesotho context. Specifically, the team added questions to measure the two supplemental indicators and inserted the names of the local OVC project partners into questions that referenced the ASSIST Project. Additionally, the questionnaire was translated into Sesotho. Minor changes were made to the translations following pilot testing to enhance their clarity. The English version of the questionnaire is provided in the Appendix.

Ethics Compliance

All study activities adhered strictly to U.S. and international research ethics guidelines, including 45CFR46 and those of the Council for International Organizations of Medical Sciences. In accordance with Government of Lesotho requirements, the Principal Secretary of the Ministry of Social Development in Lesotho reviewed and approved the study protocol, survey questionnaire, and procedures. Institutional

review board (IRB) review of the study protocol was sought and approval was received from the Health Media Lab IRB in the United States.

Study Design and Sampling Strategy

The survey team employed a two-stage, 40x12 design for the survey. The sampling frame comprised all households currently registered by the ASSIST Project as of July 2017. The list, provided by the project, included 13,259 households located within 47 community councils. The survey team worked with the ASSIST Project data management team to correct missing information and data inconsistencies in the list before selecting the sample.

At the first sampling stage, the survey team randomly selected 40 clusters, defined by community council, from among the community councils served by the project proportionate to the number of households in each council. At the second stage, it randomly selected 12 households from within each of the 40 selected clusters. This selection yielded a total sample size of 480 households. Household selection was done in the field at the time of data collection, using updated listings of registered beneficiaries obtained directly from staff of the local implementing partner. The team conducted second stage selection in this manner because a trace and verify exercise on the ASSIST Project listing carried out by the study team following first stage cluster selection showed discrepancies between the listings maintained by the ASSIST Project team and the local partners.

Data collectors conducted survey 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. The data collectors asked caregivers questions about themselves, the household, and the children under their care. All children ages 0 through 17 (at their last birthday) who slept within the household on the night before the interview were considered eligible for the survey, including both children actively registered as beneficiaries of the ASSIST Project and those who were not. However, the data collectors recorded registration status for each child.

Field Data Collection

Ten trained fieldworkers conducted the field work: two teams of three interviewers and a team leader each, one community liaison officer, and one field survey manager. They conducted the fieldwork September 4 and September 29, 2017. The teams worked with local implementing partner managers, social workers, case workers, and community leaders to locate the selected households using information from the beneficiary listings and maps of the communities, as available. The teams made a minimum of three attempts to conduct interviews with caregivers who were temporarily absent from their home at the time of the data collector visit.

Once the data collector identified the caregiver in the household, the collector explained the purpose and nature of the survey and its expected risks and benefits. The caregiver was made aware that her or his participation was voluntary and would not affect eligibility to receive or continue services. The data collectors also gave caregivers the opportunity to ask questions. If they agreed to participate, they signed an informed consent form before the interview began.

Data collectors administered questionnaires programmed by Open Data Kit (ODK) using password protected Android tablets to facilitate and automate response recording for sampling, interviews, and measurements. Using ODK, the questionnaires were programmed into the tablets to allow data collectors

to progress through the survey questions and input prompts. The tablets were also programmed to incorporate skip patterns, internal logic, and range and consistency checks in real time.

Although no child was interviewed directly, the survey did include mid-upper arm circumference (MUAC) measurements of children ages 6–59 months. All data collectors were trained to measure the circumference of a child's left upper arm, measured at the midpoint between the tip of the shoulder and the tip of the elbow. They used a special tape, called a MUAC tape. When the left arm was bent, they used a string to find the midpoint of the arm between the shoulder and the tip of the elbow, and measured the arm in this bent position. They then measured the MUAC while the arm was hanging down the side of the body and relaxed, and directly recorded the measurements (in millimeters) into the tablets.

The teams implemented quality assurance through a continuous process of data quality control. On a daily basis, once team leaders had performed all data quality checks and corrected recording errors (as appropriate), approved the data, and backed up the data onto memory cards, the data were uploaded via Internet connection to the secure online ODK server at the study team's headquarters in Maseru. The data manager in Maseru checked the data for completeness and quality in real time as they were received from the field.

Data Analysis

The ESIs were derived as specified in the MEASURE Evaluation guidance document "Collecting PEPFAR essential survey indicators: A supplement to the OVC survey tools" (MEASURE Evaluation, 2014). Data analysis was performed using IBM SPSS version 25. The data were weighted to (1) account for the discrepancies found between ASSIST Project household counts used for cluster selection and the local implementing partner household counts obtained at the time of fieldwork, and (2) for household nonresponse. Calculations of confidence intervals (CIs) (95%) for the weighted estimates accounted for the cluster sample design. Differences between subgroups were tested using an adjusted F statistic—a variant of the second-order Rao-Scott adjusted chi-square statistic. Statistical significance was based on the adjusted F (likelihood ratio) and its degrees of freedom (IBM, n.d.). Differences significant at the $p<0.05$ level were considered statistically significant.

RESULTS

Survey Response Rate

The field team completed interviews at 437 of the 480 selected households in the sample, giving an overall household response rate of 91.0 percent. Details about the response rate and reasons for nonresponse are presented in Table 2.

Table 2. Household response rates in ASSIST Project survey

Category	Number
1. Households served by the ASSIST Project OVC program based on the ASSIST Project listing	13,259
2. Households in the 40 clusters (community councils) selected for the sample (from the ASSIST Project listing)	10,694
3. Households in the 40 clusters (community councils) selected for the sample (from local implementing partner caseworker log books)	9,997
Difference in number of households in the project listing and caseworker log books	**-697**
4. Households selected for the sample	480
5. Households mistakenly not surveyed	12
6. Households where caregiver and beneficiaries had relocated and the new location was unknown or outside of the service area	9
7. Households with no children under age 18 under the care of the registered caregiver (children had recently turned 18)	4
8. Households where caregiver resided at the household but could not be located for interview after three attempts	18
9. Households for which an interview was completed	437
Survey household response rate	**437/480 (91.0%)**

As shown in Table 3, interviews with the 437 caregivers resulted in 437 completed caregiver questionnaires, as well as information collected on 236 children ages 0–4 years and 921 children ages 5–17 years.

Table 3. Questionnaire components completed and other sample information

Sample information	
Number of "caregiver" components completed	437
Number of eligible children in the household (listed by the caregivers)	1,157
Number of "child ages 0–4 years" components completed	236
Number of "child ages 5–17 years" components completed	921
Total number of child components completed	1,157
Percentage of child components completed among eligible children in the household	**100% (1,157/1,157)**

Background Characteristics of the Respondents

Caregivers

The majority of the 437 successfully interviewed caregivers were female (369 of 437, or 84.4%); more than half of caregivers were older than 50 years of age (59.3%). The average age was 50.9 years; the youngest

caregiver was 18 and the oldest 98. Female caregivers were somewhat older than male caregivers, but the difference was not statistically significant. The complete sex and age breakdown is presented in Table 4.

Table 2. Characteristics of caregivers in the survey—age distribution

Age (years)	Female caregivers			Male caregivers			Both sexes		
	Unweighted		Weighted	Unweighted		Weighted	Unweighted		Weighted
	n	%	%	*n*	%	%	*n*	%	%
<18	0	0.0	**0.0**	0	0.0	**0.0**	0	0.0	**0.0**
18–30	48	13.0	**10.6**	16	23.5	**28.9**	64	14.6	**13.6**
31–50	122	33.1	**28.7**	21	30.9	**18.7**	143	32.7	**27.1**
51+	199	53.9	**60.6**	31	45.6	**52.3**	230	52.6	**59.3**
All ages	**369**	**100.0**	**100.0**	**68**	**100.0**	**100.0**	**437**	**100.0**	**100.0**
Weighted	**Mean**	**S.E.**	**Range**	**Mean**	**S.E.**	**Range**	**Mean**	**S.E.**	**Range**
Age	51.5	0.19	18–93	47.5	3.12	18–98	50.9	1.06	18–98

As shown in Table 5, the majority of caregivers were either currently married or living with a partner (41.9%), or widowed and not living with a partner (40.4%). Female compared to male caregivers were more likely to be widowed (43.6% and 21.8%, respectively), whereas male caregivers were more likely than female caregivers to be currently married or living with a partner (56.5% and 39.3%, respectively; p=0.004).

Table 3. Characteristics of caregivers in the survey—marital status

Marital status	Female caregivers			Male caregivers			Both sexes		
	Unweighted		Weighted	Unweighted		Weighted	Unweighted		Weighted
	n	%	%	*n*	%	%	*n*	%	%
Never married, not living with a partner	50	13.6	**13.1**	13	19.4	**20.7**	63	14.5	**14.3**
Currently married or living with a partner	141	38.3	**39.3**	39	58.2	**56.5**	180	51.4	**41.9**
Divorced or separated, not living with a partner	13	3.5	**3.9**	1	1.5	**1.0**	14	3.2	**3.5**
Widowed, not living with a partner	164	44.6	**43.6**	14	20.9	**21.8**	178	40.9	**40.4**
All marital status	**368**	**100.0**	**100.0**	**67**	**100.0**	**100.0**	**435**	**100.0**	**100.0**

As shown in Table 6, the majority of caregivers (63.2%) had attended school at the primary level. About one-quarter (28.5%) had attended secondary level or higher. However, a higher percentage of male compared to female caregivers had never attended school (26.7% and 5.2%, respectively; p=0.001).

Table 4. Characteristics of caregivers in the survey—education

Highest level attended	Female caregivers				Male caregivers				Both sexes			
	Unweighted			Weighted	Unweighted			Weighted	Unweighted			Weighted
	n	*N*	%	%	*n*	*N*	%	%	*n*	*N*	%	%
Did not attend school	17	369	4.6	**5.2**	16	68	23.5	**26.7**	33	437	75.5	**8.4**
Primary	246	369	66.7	**65.4**	36	68	52.9	**50.6**	282	437	64.5	**63.2**
Secondary or higher†	106	369	28.7	**29.5**	16	68	23.5	**22.7**	122	437	27.9	**28.5**
All levels	**369**	**369**	**100.0**	**100.0**	**68**	**68**	**100.0**	**100.0**	**437**	**437**	**100.0**	**100.0**

About half of the caregivers interviewed (48.8%) lived in urban areas. A somewhat higher percentage of male caregivers lived in rural areas compared to female caregivers, but the difference was not statistically significant. (See Table 7.)

Table 5. Characteristics of caregivers in the survey: residence

Household location	Female caregivers			Male caregivers			Both sexes		
	Unweighted		Weighted	Unweighted		Weighted	Unweighted		Weighted
	n	%	%	*n*	%	%	*n*	%	%
Urban	205	55.6	**50.0**	32	47.1	**42.3**	237	54.2	**48.8**
Rural	164	44.4	**50.0**	36	52.9	**57.7**	200	45.8	**51.2**
Both locations	**369**	**100.0**	**100.0**	**68**	**100.0**	**100.0**	**437**	**100.0**	**100.0**

Children

Table 8 shows the distribution of children represented in the survey by sex and age. A slightly higher number of male children were represented (603 boys and 554 girls), but the age distributions were similar for both sexes. The mean age was 9.6 years.

Table 6. Characteristics of children in the survey—age

Age (years)	Female			Male			Both sexes		
	Unweighted		Weighted	Unweighted		Weighted	Unweighted		Weighted
	n	%	%	*n*	%	%	*n*	%	%
0–4	107	19.3	**19.3**	129	21.4	**21.8**	236	20.4	**20.6**
0–11 mos	7	1.3	**1.2**	15	2.5	**2.3**	22	1.9	**1.7**
12–23 mos	21	3.8	**4.3**	20	3.3	**3.3**	41	3.5	**3.8**
24–59 mos	79	14.2	**13.8**	94	15.6	**16.2**	173	15.0	**15.1**
5–9	143	25.8	**25.7**	169	28.0	**27.4**	312	27.0	**27.4**
10–14	183	33.0	**32.7**	185	30.7	**31.0**	368	31.8	**31.0**
15–17	121	21.8	**22.3**	120	19.9	**21.0**	241	20.8	**21.0**
All ages	**554**	**100.0**	**100.0**	**603**	**100.0**	**100.0**	**1,157**	**100.0**	**100.0**
Weighted	**Mean**	**SE**	**Range**	**Mean**	**SE**	**Range**	**Mean**	**SE**	**Range**
Age	9.8	0.27	0–17	9.4	0.19	0–17	9.6	0.15	0–17

OVC Services Received

Caregivers were asked if they had personally ever participated in program activities or received services from the ASSIST Project. Additionally, they were asked if they had participated in or received these services within the six months preceding the survey. Results are provided in Table 9. Although all households were registered with the project, only 71.3 percent reported ever participating in or receiving services; 58.4 percent reported participation or services in the past six months. Female compared to male caregivers were somewhat more likely to report participation or services, but the differences were not statistically significant. On average, those caregivers who reported ever receiving services indicated that they started receiving services 9.2 months ago, with a range of 0 months to 6 years. The differences between female and male caregivers were not statistically significant.

Table 7. Caregivers' reports of their participation in or receipt of services from the ASSIST Project

ASSIST Project participation	Both sexes					
	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
Ever participated in activities or received services	315	437	72.1	**71.3**	64.9	77.0
Received services within the past six months	191	315	60.6	**58.4**	49.9	66.4

ASSIST Project participation	Female caregivers						Male caregivers					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
Ever participated in activities or received services	269	369	72.9	**72.1**	65.5	77.8	46	68	67.6	**67.2**	53.2	78.6
Received services within the past six months	164	269	61.0	**59.2**	50.8	67.1	27	46	58.7	**53.3**	32.6	73.0

Caregivers who reported receiving any ASSIST Project service were asked about the types of services they received in the past six months. Linkage to HIV services was the most commonly reported service, by 64.6 percent of caregivers, followed by parenting or caregiver services (43.8%), household economic strengthening (43.7%), and social protection services (40.1%). Only 17.4 percent of caregivers reported receiving education support for the children in their care. Differences between female and male caregivers were small and not statistically significant. (See Table 10.)

Table 8. Caregivers' reports of types of services received through the ASSIST Project (among those who reported ever having received a service)

Type of services received from the ASSIST Project	Both sexes					
	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
Linkage to HIV services	203	315	64.4	**64.6**	56.8	71.7
Parenting/caregiver services	139	315	44.1	**43.8**	34.7	53.3
Household economic strengthening	135	315	42.9	**43.7**	35.3	52.6
Social protection services	124	315	39.4	**40.1**	32.9	47.8
Education support for children	55	315	17.5	**17.4**	13.6	22.0

Type of services received from the ASSIST Project	Female caregivers						Male caregivers					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
Linkage to HIV services	178	269	66.2	**66.6**	57.5	74.5	25	46	54.3	**52.8**	38.6	66.5
Parenting/caregiver services	120	269	44.6	**45.1**	35.5	55.1	19	46	41.3	**35.5**	20.7	53.8
Household economic strengthening	117	269	43.5	**45.1**	36.6	53.9	18	46	39.1	**35.5**	19.7	55.2
Social protection services	107	269	39.8	**41.0**	32.7	49.8	17	46	37.0	**34.7**	24.0	47.1
Education support for children	48	269	17.8	**18.3**	13.9	23.7	7	46	15.2	**12.0**	5.2	25.3

Caregivers were also asked about support services that their households were receiving from the Government of Lesotho at the time of the survey. Results are shown in Table 11. About 12.3 percent reported receiving services through the Child Grant Program, 16.2 percent reported receiving public assistance, and 6.1 percent reported receiving OVC bursaries for secondary school. Differences between female and male caregiver households were small and not statistically significant.

Table 9. Caregivers' reports of their current receipt of services from the Government of Lesotho

Type of Government of Lesotho assistance	Both sexes					
	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
Child Grant Program	59	437	13.5	**12.3**	8.5	17.3
Public assistance	76	437	17.4	**16.2**	11.9	21.8
OVC bursary for secondary school	29	437	6.6	**6.1**	3.8	9.7

Type of Government of Lesotho assistance	Female caregivers						Male caregivers					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
Child Grant Program	50	369	13.6	**12.3**	8.7	17.3	9	68	13.2	**11.7**	5.0	25.0
Public assistance	66	369	17.9	**17.0**	12.2	23.1	10	68	14.7	**12.0**	6.2	21.7
OVC bursary for secondary school	22	369	6.0	**5.8**	3.2	10.1	7	68	10.3	**8.0**	2.8	20.5

PEPFAR MER OVC Essential Survey Indicators

Results for the survey indictors were disaggregated by sex and age, following PEPFAR MER requirements. For each indicator, a table is provided with the unweighted numerator (n), unweighted denominator (N), unweighted percentage, weighted percentage, and weighted CIs (95%) (lower limits [LLs] and upper limits [ULs]). Weighted estimates are used to describe the findings and test for age and sex differences. Indicator results are presented according to the dimension of OVC well-being they reflect (as outlined in Table 1).

Health

OVC_SICK: Percent of children (aged 0–17) too sick to participate in daily activities

Primary caregivers were asked if the children under their care had been too sick to participate in daily activities at any time within the two weeks before the survey. Results are presented in Table 12. Caregivers reported that about one-quarter (27.1%) of children were too sick to participate in daily activities. Children under age five were more likely to be reported sick (39.8%) than children in the older age groups (p=0.001). Differences among the age groups were somewhat more pronounced for female compared to male children. A slightly higher percentage of male compared to female children were reported sick, but the difference was not statistically significant.

Table 10. Children too sick to participate in daily activities

OVC_SICK	Both sexes					
Child's age (years)	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
0–4	87	236	36.9	**39.8**	31.2	49.1
5–9	83	312	26.6	**26.1**	20.0	33.2
10–14	79	368	21.5	**21.2**	16.2	27.1
15–17	55	241	22.8	**24.8**	19.2	31.3
All ages	**304**	**1,157**	**26.3**	**27.1**	**22.7**	**32.0**

Child's age (years)	Females						Males					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
0–4	42	107	39.3	**42.8**	30.2	56.4	45	129	34.9	**37.4**	29.1	46.6
5–9	32	143	22.4	**22.0**	14.9	31.1	51	169	30.2	**29.3**	21.3	39.0
10–14	37	183	20.2	**20.3**	13.9	28.8	42	185	22.7	**22.0**	15.9	29.7
15–17	22	121	18.2	**19.2**	13.0	27.4	33	120	27.5	**30.3**	22.4	39.6
All ages	**133**	**554**	**24.0**	**24.8**	**20.0**	**30.4**	**171**	**603**	**28.4**	**29.1**	**23.8**	**35.1**

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

Caregivers reported that they knew the HIV status of most of the children in their care in the household (83.1%). Caregivers were somewhat more likely to know the HIV status of female compared to male children, but the difference was not statistically significant. Caregivers were most likely to know the HIV status of children ages 5–9 (89.8%) compared to the other age groups (p= 0.002). This age difference was observed for both female and male children. (See Table 13.)

Table 11. Children whose primary caregiver knows the child's HIV status

OVC_HIVST	Both sexes					
Child's age (years)	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
0–4	183	236	77.5	**79.7**	73.4	84.8
5–9	274	312	87.8	**89.8**	85.6	92.9
10–14	299	368	81.3	**82.6**	77.1	87.0
15–17	190	241	78.8	**78.3**	71.9	83.6
All ages	**946**	**1157**	**81.8**	**83.1**	**79.8**	**86.0**

Child's age (years)	Females						Males					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
0–4	83	107	77.6	**79.6**	69.5	87.1	100	129	77.5	**79.7**	72.0	85.7
5–9	128	143	89.5	**91.4**	86.1	94.7	146	169	86.4	**88.6**	82.9	92.6
10–14	155	183	84.7	**85.6**	77.6	91.1	144	185	77.8	**79.7**	71.9	85.8
15–17	96	121	79.3	**77.6**	67.1	85.5	94	120	78.3	**79.1**	70.4	85.7
All ages	**462**	**554**	**83.4**	**84.1**	**79.1**	**88.1**	**484**	**603**	**80.3**	**82.1**	**78.0**	**85.6**

Among the children whose caregiver reported knowing their HIV status, 4.0 percent were reported by the caregiver to be living with HIV. Although there were no differences between female and male children, the youngest children (0–4 years) were less likely to be reported living with HIV compared to the older age groups; the difference approached statistical significance (p=0.073). (See Table 14.)

Table 12. Children living with HIV (among children whose caregiver knows their HIV status)

Sex of child	Both sexes					
	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
Females	17	462	3.7	**3.8**	2.2	6.4
Males	20	484	4.3	**4.1**	2.8	6.6
Both sexes	**37**	**946**	**3.9**	**4.0**	**2.8**	**5.6**
Child's age (years)						
0–4	1	183	0.5	**0.4**	0.0	2.9
5–9	13	274	4.7	**4.3**	1.9	9.5
10–14	16	299	5.3	**5.5**	3.3	8.9
15–17	7	190	3.7	**4.6**	1.9	10.5

OVC_LS1: Percent of children living with HIV who are taking ARV drugs

As Table 15 shows, caregivers reported about three-quarters of children living with HIV (77.3%) were taking ARV drugs. The difference between female and male children was not statistically significant. Children ages 5–9 were less likely than the other age groups to be on ART. The differences among the age groups approached statistical significance (p=0.057).

Table 13. Children living with HIV who are taking ARV drugs

OVC_LS1	Both sexes					
Child's sex	Unweighted			Weighted		
	n	*N*	*%*	*%*	95% CI	
					LL	UL
Female	13	17	76.5	**81.4**	56.8	93.5
Male	14	20	70.0	**73.8**	47.1	89.9
Both sexes	**27**	**37**	**73.0**	**77.3**	**58.7**	**89.1**
Child's age (years)						
0–4	1	1	100.0	**100.0**	100.0	100.0
5–9	7	13	53.8	**54.7**	34.2	73.7
10–14	13	16	81.3	**87.1**	66.9	95.8
15–17	6	7	85.7	**89.0**	44.3	98.8

Nutrition

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

In accordance with PEPFAR MER OVC ESI guidance, a child was considered acutely undernourished if her or his MUAC measurement fell below 125 mm. Among the 170 children under the age of five years for whom a MUAC measurement was taken, only 4 children (1.9%) were undernourished. This information and the sex and age breakdown of undernourished children are given in Table 16.

Table 14. Children ages 6–59 months who are undernourished

OVC_NUT	Both sexes					
Child's age (months)	Unweighted			Weighted		
	n	*N*	*%*	*%*	95% CI	
					LL	UL
6–11	1	16	6.3	**6.4**	0.9	33.9
12–59	3	154	1.9	**1.5**	0.2	10.5
6–59	**4**	**170**	**2.4**	**1.9**	**0.4**	**8.5**

Child's age (months)	Females						Males					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	*%*	*%*	95% CI		*n*	*N*	*%*	*%*	95% CI	
					LL	UL					LL	UL
6–11	0	4	0.0	**0.0**	--	--	1	12	8.3	**8.7**	1.3	41.0
12–59	1	67	1.5	**1.2**	0.1	8.9	2	86	2.3	**1.7**	0.2	11.5
6–59	**1**	**71**	**1.4**	**1.1**	**0.1**	**8.4**	**3**	**98**	**3.1**	**2.5**	**0.6**	**9.8**

Early Childhood Development

OVC_STIM: Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age

Caregivers were asked whether the children under age 5 in their care had engaged in stimulating activities in the three days preceding the interview with the caregiver or another household member over 15 years of age. Stimulating activities that were queried included reading books; looking at the pictures in books; telling stories; singing songs or lullabies; playing with the child; or naming, counting, or drawing things. The most frequently reported activities were engaging in play (81.6%) and singing (74.1%). Most children (87.3%) were reported to have engaged in one or more stimulating activity in the previous three days. Differences between female and male children were not statistically significant. (See Table 17.)

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

OVC_STIM	Both sexes					
Activity	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
Read or looked at picture books	74	236	31.4	**30.5**	23.5	38.5
Told stories	102	236	43.2	**43.8**	35.7	52.2
Sang songs or lullabies	175	236	74.2	**74.1**	66.1	80.7
Engaged in play	195	236	82.6	**81.6**	72.3	88.2
Named, counted, or drew things	91	236	38.6	**37.5**	30.8	44.7
One or more of these activities	**211**	**236**	**89.4**	**87.3**	**77.3**	**93.3**

Activity	Females						Males					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
Read or looked at picture books	38	107	35.5	**32.7**	23.2	43.6	36	129	27.9	**28.8**	20.2	39.3
Told stories	44	107	41.1	**41.7**	33.9	50.1	58	129	45.0	**45.4**	34.3	56.9
Sang songs or lullabies	79	107	73.8	**71.4**	58.3	81.7	96	129	74.4	**76.2**	67.3	83.2
Engaged in play	88	107	82.2	**79.1**	63.2	89.2	107	129	82.9	**83.6**	75.1	89.5
Named, counted, or drew things	40	107	37.4	**35.0**	25.7	45.5	51	129	39.5	**39.5**	30.2	49.5
One or more of these activities	**94**	**107**	**87.9**	**83.6**	**65.7**	**93.1**	**117**	**129**	**90.7**	**90.2**	**83.5**	**94.4**

Percentage of children (ages 2–5 years) enrolled in and regularly attended pre-primary school

The lowest level of formal education in Lesotho comprises three years of integrated early childhood care and development (Lesotho Ministry of Education and Training, 2006). Although indicators on pre-primary school are not part of the OVC ESIs, the ASSIST Project survey collected information on enrollment and

attendance in pre-primary school among children ages 2–5 years as an additional measure of early childhood development. Results are given in Table 18. Caregivers reported that one-third (33.9%) of children between the ages of two and five years were enrolled in school. Fewer (19.7%) were reported to not have missed any school in the past school week. Enrollment among girls and boys was similar, but girls were somewhat less likely than boys to have regularly attended (13.5% and 23.8%, respectively; p=0.116).

Table 16. Children ages 2–5 years who were enrolled in and regularly attended pre-primary school

Pre-primary school: children ages 2–5 years	Both sexes					
	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
Enrolled	76	228	33.3	**33.9**	28.2	40.2
Regularly attended	43	227	18.9	**19.7**	14.6	26.0

Pre-primary school: children ages 2–5 years	Females						Males					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
Enrolled	35	105	**33.3**	**33.5**	24.5	43.8	41	123	33.3	**34.3**	27.2	42.3
Regularly attended	14	104	**13.5**	**14.4**	8.3	24.0	29	123	23.6	**23.8**	16.6	32.9

Legal Rights

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

Caregivers were asked if the children under their care had birth certificates; if they reported that a child had a birth certificate, they were asked to show the certificate to the interviewers. Although caregivers reported that 39.1 percent of children had birth certificates, only 24.3 percent had a birth certificate seen by an interviewer. Table 19 presents the breakdown of children whose birth certificate was seen (PEPFAR OVC_BCERT definition), by children's sex and age. No sex differences were observed (24.6% among girls and 23.9% among boys). However, the likelihood of having a birth certificate increased with age (p<0.001). The most common reasons caregivers gave for not being able to show a birth certificate were "can't locate it just now" (51.2%) and "someone else keeps it" (47.6%).

Table 17. Children who have a birth certificate

OVC_BCERT	Both sexes					
Child's age (years)	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
0–4	44	236	**18.6**	17.8	13.1	23.6
5–9	70	312	**22.4**	21.7	17.1	27.2
10–14	82	368	**22.3**	22.1	17.2	28.0
15–17	85	241	**35.3**	36.9	29.5	44.9
All ages	**281**	**1,157**	**24.3**	**24.2**	**20.3**	**28.6**

Child's age (years)	Females						Males					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
0–4	22	85	**20.6**	17.7	10.3	28.5	22	129	**17.1**	17.8	11.0	27.6
5–9	40	143	**28.0**	26.1	19.0	34.7	30	169	**17.8**	18.3	13.3	24.5
10–14	37	183	**20.2**	20.2	13.8	28.7	45	185	**24.3**	24.0	18.3	30.8
15–17	41	121	**33.9**	35.4	25.2	47.2	44	120	**36.7**	38.4	29.6	48.1
All ages	**140**	**554**	**25.3**	**24.6**	**19.3**	**30.8**	**141**	**603**	**23.4**	**23.9**	**19.6**	**28.7**

Education

OVC_SCHATT: Percent of children (ages 5–17) regularly attending school

Caregivers reported that most children ages 5 through 17 under their care were enrolled in school (88.0%). However, as shown in Table 20, only about two-thirds (65.0%) of children were reported to be attending school regularly (i.e., enrolled in school and did not miss any days in the school week before the interview). Regular attendance among girls (64.2%) and boys (65.7%) was similar. However, attendance varied by age group, with 10- to 14-year-olds showing the highest attendance ($p<0.001$). In Lesotho, children typically begin primary education at age 6 and secondary education at age 14. Defining school level by these age groups, regular attendance in secondary school was significantly lower than primary school attendance (55.1% and 71.7%, respectively; $p=0.001$). This difference was seen for both girls and boys.

Table 18. Children regularly attending school

OVC_SCHATT	Both sexes					
Child's age (years)	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
5–9	209	312	67.0	**67.4**	61.5	72.9
10–14	271	368	73.6	**73.3**	66.6	79.0
15–17	120	241	49.8	**49.5**	42.0	57.1
Ages 5–17	**600**	**921**	**65.1**	**65.0**	**60.4**	**69.3**
Age groups according to school levels						
6–13 (primary)	395	550	71.8	**71.7**	65.4	77.4
14–17 (secondary)	177	316	56.0	**55.1**	48.4	61.7

	Females						Males					
Child's age (years)	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		n	N	%	%	95% CI	
					LL	UL					LL	UL
5–9	92	143	64.3	**64.8**	55.9	72.7	117	169	69.2	**69.6**	62.5	75.8
10–14	134	183	73.2	**73.4**	63.8	81.3	137	185	74.1	**73.1**	63.8	80.7
15–17	60	121	49.6	**50.0**	40.9	59.1	60	120	50.0	**49.0**	38.3	59.8
Ages 5–17	**286**	**447**	**64.0**	**64.2**	**58.3**	**69.7**	**314**	**474**	**66.2**	**65.7**	**59.4**	**71.5**
Age groups according to school levels												
6–13 (primary)	191	266	71.8	**71.8**	62.9	79.3	204	284	71.8	**71.7**	64.0	78.3
14–17 (secondary)	87	155	56.1	**56.0**	48.4	63.2	90	161	55.9	**54.4**	44.7	63.7

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

Table 21 shows the percentage of children reported to have progressed in school during the past year (i.e., the percentage of children whose caregiver reported them to be in a higher grade level at the time of the survey compared to their grade in the previous school year). Overall, 81.9 percent of children ages 5 through 17 were reported to have progressed in school, with no statistically significant difference between girls and boys. School progression was highest among 10- to 14-year-olds relative to younger and older children (p=0.024). Looking at age groups defined according to school level shows higher grade progression for primary compared to secondary school (86.4% and 78.5%, respectively; p=0.009). Girls and boys showed similar progression within primary and secondary school.

Table 19. Children who progressed in school during the past year

OVC_PRGS	Both sexes					
Child's age (years)	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
5–9	186	236	78.8	**79.7**	73.7	84.5
10–14	308	354	87.0	**86.4**	81.6	90.1
15–17	132	171	77.2	**75.9**	69.7	81.2
Ages 5–17	**626**	**761**	**82.3**	**81.9**	**79.2**	**84.3**
Age groups according to school levels						
6–13 (primary)	428	496	86.3	**86.4**	83.4	89.0
14–17 (secondary)	192	241	79.7	**78.5**	72.7	83.4

Child's age (years)	Females						Males					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		*n*	*N*	%	%	95% CI	
					LL	UL					LL	UL
5–9	80	108	74.1	**73.4**	64.1	80.9	106	128	82.8	**84.8**	77.0	90.4
10–14	161	178	90.4	**89.7**	82.6	94.1	147	176	83.5	**82.9**	77.1	87.5
15–17	73	91	80.2	**77.3**	66.7	85.3	59	80	73.8	**74.2**	63.8	82.5
Ages 5–17	**314**	**377**	**83.3**	**81.9**	**77.5**	**85.7**	**312**	**384**	**81.3**	**81.8**	**77.0**	**85.8**
Age groups according to school levels												
6–13 (primary)	212	241	88.0	**87.4**	83.0	90.8	216	255	84.7	**85.5**	79.7	89.8
14–17 (secondary)	100	124	80.6	**78.3**	69.4	85.1	92	117	78.6	**78.7**	71.3	84.7

Attitudes toward Child Punishment

OVC_CP: Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or at school

Nearly three-quarters of caregivers (71.3%) agreed that hitting or beating a child was always or sometimes an appropriate means of discipline or control in the home or school. No overall difference was seen between female and male caregivers. Caregivers over age 50 were somewhat more likely to agree with harsh physical punishment than younger caregivers; differences among the age groups approached statistical significance (p=0.098). However, this age difference was seen only among female caregivers (78.4% among those age 51+ compared to 67.1% among 18- to 30-year-olds and 64.3% among 31- to 50-year-olds; p=0.046). The oldest group of male caregivers was somewhat less likely to condone harsh physical punishment compared to the younger groups, but the differences were not statistically significant. (See Table 22.)

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

OVC_CP	Both sexes					
Caregiver's age (years)	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
<18	0	0	--	--	--	--
18–30	44	64	68.8	**68.8**	59.2	77.0
31–50	94	162	66.2	**65.1**	56.0	73.1
51+	171	230	74.3	**75.8**	67.1	82.7
All ages	**309**	**436**	**70.9**	**71.3**	**65.5**	**76.5**

Caregiver's age (years)	Females						Males					
	Unweighted			Weighted			Unweighted			Weighted		
	n	*N*	%	%	95% CI		n	N	%	%	95% CI	
					LL	UL					LL	UL
<18	0	0	--				0	0	--			
18–30	33	48	68.8	**67.1**	53.8	78.1	11	16	68.8	**73.6**	45.6	90.3
31–50	80	121	66.1	**64.3**	54.0	73.4	14	21	66.7	**70.1**	48.6	85.3
51+	153	199	76.9	**78.4**	68.6	85.7	18	31	58.1	**57.7**	44.0	70.3
All ages	**266**	**368**	**72.3**	**72.3**	**65.6**	**78.2**	**43**	**68**	**63.2**	**71.3**	**65.5**	**76.5**

Household Economic Well-Being and Resilience

OVC_LS2: Percent of households able to access money to pay for expected household expenses

Caregivers were asked if their households were able to cover expected household expenses in the past 12 months. Results are provided in Table 23. Overall, 59.8 percent of caregivers reported being able to access money to pay for expected household expenses, with no difference between female and male caregivers.

Table 21. Households able to access money to pay for expected household expenses

OVC_LS2	Unweighted			Weighted		
Sex of caregiver	*n*	*N*	%	%	95% CI	
					LL	UL
Female caregivers	220	368	59.8	**60.4**	53.7	66.7
Male caregivers	40	68	58.8	**56.7**	43.6	69.0
Both sexes	**260**	**436**	**59.6**	**59.8**	**53.6**	**65.8**

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

About 38.5 percent of caregivers reported an unexpected household expense, such as a house repair or urgent medical treatment, in the year preceding the survey. Although female compared to male caregivers were somewhat more likely to report an unexpected expense, the difference was not statistically significant (39.6% and 32.1%; p=0.245). Among those who had experienced unexpected household expenses, 38.1 percent reported they were able to access money to pay for them. Male compared to female caregivers

were somewhat more likely to report the ability to cover such expenses, but the difference was not statistically significant (52.4% and 36.0%, respectively; p=0.165). (See Table 24.)

Table 22. Households able to access money to pay for unexpected household expenses

	Unweighted			Weighted		
	n	*N*	%	%	95% CI	
					LL	UL
Households that experienced an unexpected expense in past 12 months						
Female caregivers	146	368	39.7	**39.6**	35.6	43.8
Male caregivers	24	68	35.3	**32.1**	21.2	45.3
Both sexes	**170**	**436**	**39.0**	**38.5**	**34.4**	**42.7**
Households able to access money to pay for unexpected expenses (among those experiencing an unexpected expense)						
Female caregivers	54	146	37.0	**36.0**	28.2	44.7
Male caregivers	13	24	54.2	**52.4**	32.2	71.8
Both sexes	**67**	**170**	**39.4**	**38.1**	**31.1**	**45.6**

DISCUSSION

The nine PEPFAR MER OVC ESIs and the two supplemental indicators collected in the survey provided a snapshot of the well-being of children and households served by the ASSIST Project in September 2017. They fulfill PEPFAR reporting requirements and, although they do not necessarily reflect the effect of the program on these various dimensions of well-being, the findings are useful in pointing out potential needs and program gaps.

With regard to **children's health**, more than one-quarter of children were reported to be too ill to participate in daily activities at some point during the two weeks preceding the survey. Children under the age of five were less healthy than older children. Although there is no reference against which to compare these numbers to gauge the seriousness of the problem, the findings warrant closer examination of the causes of illness and possible interventions. Caregivers were aware of the HIV status of most (83.1%) children under their care. Even though this knowledge level is relatively high, it may highlight a potential gap in efforts to assess children for HIV risk and link those at risk to HIV testing services. Caregivers' reports of HIV prevalence of 4.0 percent among the children in their care is higher than the national estimate of 2.1 percent among 0- to 14-year-olds (LMOH, 2017), perhaps reflecting the heightened vulnerability of project beneficiaries. Three-quarters of children were reported to be taking ARV drugs, reflecting a fairly high level of access to treatment—a level also higher than the 57 percent reported nationally by UNICEF in 2016 (UNICEF, 2016). However, it also falls below the national target of 95 percent and points to a treatment gap, in that one-quarter of the children living with HIV were not yet receiving life-saving medication. This gap was most pronounced among 5- to 9-year-olds. The limitations of the data should be considered when interpreting these findings. First, the sample sizes are quite small and limit the precision of the estimates, as evidenced by the rather large CIs. Additionally, caregivers may have been reluctant to report that a child was HIV positive because of stigma or other factors, which could contribute to an underestimate of the prevalence. Also, it bears mentioning again that the child HIV status in the survey is the report of the caregiver, whose knowledge may not accurately reflect the child's actual HIV or treatment status, especially among older children who may know their status but not have disclosed it to the caregiver.

Only 2 percent of children ages 6 to 59 months were found to be undernourished based on MUAC measurements, suggesting that severe, acute **malnutrition** may not be a significant problem among ASSIST Project beneficiaries. This estimate is consistent with findings from the Lesotho Demographic and Health Survey (LDHS) 2014, which found that 3 percent of children under age five nationally were wasted (too thin for their height) and 2 percent were severely underweight (too thin for their age) (LMOH & ICF Macro, 2016).

The survey found widespread engagement of caregivers or other household members in stimulating activities with young children in the household. About 87.3 percent of children were reported to have been read to; told stories; sang songs or lullabies; engaged in play; or named, counted, or drew things at some point during the three days preceding the survey. The most commonly reported activities were playing (84.6%) and singing (74.1%). Less commonly reported engagement involved telling stories (43.8%), counting and drawing (37.5%), and reading books (30.5%) —activities more highly associated with **early childhood development**. For children ages two through five, the survey measured pre-primary school participation as an additional indicator of early childhood development and found that 22 percent were enrolled and less than 10 percent were regularly attending school. This enrollment rate is lower than the

33.1 percent national enrollment rate reported by the World Bank (World Bank, 2016), suggesting that child beneficiaries of the ASSIST Project may be disadvantaged in having access to pre-primary schooling.

Caregivers reported 39.1 percent of children under age 18 in their care had a **birth certificate** but could produce a birth certificate for only 24.2 percent of children. Caregivers were less likely to report a birth certificate for younger children (28.7% of children under age five) and showed one for only 18.6 percent of children in the youngest age group. This finding is consistent with the similarly low percentage (14.1%) of birth certificates among children below age five reported in the LDHS 2014 (LMOH & ICF Macro, 2016). About half of the caregivers who were unable to produce the child's birth certificate indicated that someone else kept it. Although there may be good reasons why a child's birth certificate is kept outside the household, not having ready access to it may present challenges for school registration and access to other services that require one. Options for making duplicate copies could be explored so the caregiver also has one in her or his possession.

Caregivers reported that 88.0 percent of children ages 5–17 were **enrolled in school**, a rate somewhat higher than the national net enrollment rates of about 80 percent for primary school and 38 percent for secondary school (World Bank, 2016). However, only about two-thirds (65.0%) of children were reported to be regularly attending school. Although the survey did not ask reasons for missing school, about one-quarter of children in this age group were reportedly too sick to participate in daily activities at some point in the two weeks preceding the survey. Poor health thus may have been a contributing factor to low school attendance. Findings from a study of secondary school attendance in Lesotho suggest that poverty, exacerbated by the AIDS epidemic, also keeps children, particularly older male children, away from school because they are called on to help support the family (Nyabanyaba, 2009). National statistics also point to a lower net secondary school enrollment among boys compared to girls (44.8% and 29.2%, respectively), (World Bank, 2016). Although findings from the OVC MER survey showed lower school attendance at the secondary compared to primary level (55.1% compared to 71.7%, respectively), no differences were found between girls' and boys' attendance at either level. School grade progression rates were found to be fairly high, at 86.4 percent for primary school and 78.5 percent for secondary school, again with no difference between girls and boys. These figures are consistent with the 87.5 percent progression rate from primary to secondary school reported nationally (World Bank, 2016).

The finding that nearly three-quarters (71.3%) of caregivers agreed that hitting or beating a child is an appropriate means of discipline aligns with other evidence that corporal punishment is commonly practiced in homes and schools in Lesotho (Weber, 2013; Global Initiative to End all Corporal Punishment of Children, 2018). Acceptance of violence against children may reflect cultural norms that also condone other forms of violence within the household. For example, although acceptance of physical violence perpetrated by a husband against his wife has declined in recent years, one-third of women and even more men still agree that a husband is justified in beating his wife (LMOH & ICF Macro, 2016). The MER OVC ESI survey found less acceptance of **harsh physical punishment** among younger compared to older women, suggesting that like spousal violence, acceptance of physical punishment toward children may also be declining, but this age trend was not observed among male caregivers.

More than half of the population of Lesotho lives below the national poverty line (GOL, 2015) so the finding that nearly 40 percent of caregivers reported their households were unable to cover expected household expenses is not surprising. Among the 38.5 percent of households that experienced a large, unexpected expense, only a little more than one-third (38.1%) were able to access money to pay for it,

reflecting low **economic resilience** among beneficiary households. Some 43.7 percent of caregivers reported that they had received household economic strengthening support from the ASSIST Project, likely also reflecting the large need for assistance.

Reports of low participation in or receipt of services from the ASSIST Project is of potential concern. Nearly one-third of caregivers (28.7%) reported they had never received support from the project; 41.6 percent indicated they had not received support in the past six months. Differences in reports of services between female and male caregivers were small, as were those among the age groups. Because OVC services are tailored to the priority needs of individual children and households, the variation found among the types of services received is not unexpected. Although the survey data suggest possible gaps in service delivery, they also may reflect shortcomings in the survey methodology. For example, caregivers may have misunderstood the interview questions about services. The recall of services received also may have been inaccurate. Further, there is a possibility that caregivers purposely underreported receipt of services in an attempt to be considered for more services or for other reasons. Finally, the low reports of program participation may also reflect the high mobility of the beneficiary population. For example, some caregivers listed in the project register were found to have been replaced by another caregiver; in such instances, the new caregivers were interviewed. It is possible that these "new" caregivers had not personally received services and were unaware of services provided to the household in the past.

Several additional limitations of the survey should be considered when interpreting the results, including the following: (1) As previously noted, data on children were reported by the caregiver, not the child, and thus may be subject to inaccuracies and bias regarding actual child well-being. (2) Tradeoffs were made regarding the size of the sample to contain survey costs, which limited the precision of indicator estimates and statistical power for comparisons among subgroups—for example, between female and male caregivers, given that few male caregivers were represented. (3) The association of the survey team with the local implementing partner during fieldwork (for the purpose of locating beneficiary households) may have influenced caregiver responses; however, without the partner's assistance, the field teams would not have been able to locate the households and as "outsiders" likely would have faced refusals for interviews. (4) The survey was designed for purposes of outcome monitoring only; the methodology does not allow for attribution of results to the ASSIST OVC project. Also, of note, the results cannot be generalized to populations outside of the project beneficiary population, given that the sample was selected from among project beneficiaries only.

In spite of these limitations, further analyses of the data are worth exploring. For example, although the survey asked about all children in the registered households, only 72.1 percent of these children as individuals were reported to have ever received services from the project. Comparisons between children who had received services and those who had not could be made to examine the effect of project exposure on outcomes. Effects on the various well-being indicators of covariates, such as caregiver's age, sex, and education level; number of children in the household; and receipt of government support could also be examined to potentially help target and tailor programming.

RECOMMENDATIONS

The MER OVC survey for the ASSIST Project provided valuable information on the current status of the well-being of project beneficiaries and highlighted several areas that merit further attention. Based on the survey findings, the following recommendations are offered to improve the well-being of orphans and vulnerable children in Lesotho:

- Examine the causes of childhood illnesses and possible interventions to address them, given the high prevalence of caregiver reports that children were too ill to participate in daily activities; sensitize caregivers about childhood illness, prevention, and services, and provide support to help keep children healthy
- Assess the HIV risk of children and ensure those at risk receive an HIV test; for those living with HIV, continue to strengthen linkages to HIV care and treatment and support ARV adherence.
- Explore options for increasing enrollment of young children in preschool to promote early childhood development
- Improve project assistance in registering births and help children obtain birth certificates, especially for those under age five
- Assess reasons why children enrolled in primary and secondary school are missing school, and address the barriers to their attendance, with emphasis on secondary school attendance
- Accelerate project efforts to change caregiver norms regarding acceptance of harsh physical punishment toward children
- Intensify efforts to build the economic resilience of OVC households

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

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APPENDIX. QUESTIONNAIRE

English version

MER Indicator Questionnaire: Cover Sheet

IDENTIFICATION DATA

001	QUESTIONNAIRE IDENTIFICATION NUMBER	
002	Local ASSIST Project OVC Service Delivery Partner	1= CIL 2=LENASO 3=SWAALES 4=PB 5=LIRAC 6=SENTEBALE
003	District	
004	Community Council	
005	VILLAGE/TOWN	
006	TYPE OF LOCATION *Circle*	Urban 1 Rural 2
007	HOUSEHOLD NUMBER (from sampling list)	**[__ __]**
008	Relationship to Household Head	

INTERVIEW LOG

	VISIT 1	VISIT 2	VISIT 3
DATE (day/month/year)			
009INTERVIEW STATUS			

Interview status codes:

1= Interview completed	5= Household moved out of the service delivery area more than 6 months ago, no follow up
2= Appointment made for later today	6= Caregiver refused to be interviewed
3=Appointment made for another day	7= Interview started, but not completed (note reason)
4= Household was unknown to CBO or local guides, no follow-up	8= Other (Specify)

010	INTERVIEWER	A) CODE	B) NAME
011	DATE INTERVIEW COMPLETED (day/month/year)		

COMMENTS

1. MER Indicator Questionnaire: Caregivers

First, I have a few questions about you and the children under your care.

No.	Question	Coding Category	Skip
1	**Record caregiver sex.**	Female 1 Male 2	
2	How old were you at your last birthday? **Do not leave blank. If unknown, ask respondent to estimate.**	[_____] years	
3	What is your current marital status?	Married 1 Living with a partner as if married 2 Never married 3 Divorced or separated, not living with a partner 4 Widowed, not living with a partner 5 Other (Specify) 6 No answer 9	
4	Do you or the children you care for in this household currently receive services or support from the Government of Lesotho through: • Child Grants Program (CGP)? • Public Assistance (PA)? • OVC bursary for secondary school?	Yes 1 No 2 Don't know 8 No answer 9	
5	Have you or the children you care for in this household ever received services or participated in activities from [insert name of ASSIST Project OVC CBO]? By this I mean, have you ever been visited by a community worker, or have you ever participated in any activities organized by this organization such as a savings group or parenting program?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 7**
6	How many months ago did you or the children you care for in this household start receiving services or participating in activities from [insert name of ASSIST Project CBO]?	[_____] months Record 88 for Don't know; 99 for No answer	
7	Have you or the children you care for in this household received services or participated in activities from [insert name of Assist Project CBO] in the last six months?	Yes 1 No 2 Don't know 8 No answer 9	

8	What types of services have you or other members of your household received from [ASSIST Project CBO] in the past 6 months? **Read each type**.		
	8.1 Education support (for the children in this HH) For example, were children linked to bursary programs, helped with tuition payment, helped with school supplies and materials? Did [CBO] provide community volunteers to help take care of sick parents/relatives so children could then go to school? Did children in the HH participate in homework clubs formed by [CBO]?	Yes 1 No 2 Don't know 8 No answer 9	
	8.2 Social protection services For example, did they help you or the children under your care get legal documents such as birth certificates, identity documents, or death certificates for deceased? Or to prepare/obtain a will?	Yes 1 No 2 Don't know 8 No answer 9	
	8.3 Parenting/caregiver program services For example, are you a member of a Caregiver Committee? Or did you receive training from [CBO] on issues such as gender-based violence and correct disciplining of children?	Yes 1 No 2 Don't know 8 No answer 9	
	8.4 Household economic strengthening services For example, has [CBO] helped you or others in your HH join a village bank? Did your HH receive food and nutritional support including through activities such as key-hole gardens?	Yes 1 No 2 Don't know 8 No answer 9	
	8.5 Support to access HIV services Did [CBO] refer you and/or other members of your HH to services for HIV & AIDS-related healthcare needs such as HIV testing, care & treatment, and adherence support?	Yes 1 No 2 Don't know 8 No answer 9	
9	Have you ever attended school?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 9**
10	What is the highest level of school you attended?	Pre-primary/nursery/ECD . . 0 Primary . . . . . 1 Secondary . . . . . .2 College . . . . . 3 University . . . . . 4 Don't know . . . . . 8 No answer 9	

11	Do you think that hitting or beating a child is an appropriate means of discipline or control <u>in the home</u>? *Interviewer: read the responses*	Always an appropriate means of discipline . . . . . 1 Sometimes an appropriate means of discipline. . . . 2 Rarely an appropriate means of discipline . . . . . 3 Never an appropriate means of discipline . . . . . 4 Don't know . . . . 8 No answer 9	
12	Do you think that hitting or beating a child is an appropriate means of discipline or control <u>at school</u>? *Interviewer: read the responses*	Always an appropriate means of discipline . . . . . 1 Sometimes an appropriate means of discipline. . . . . 2 Rarely an appropriate means of discipline . . . . . 3 Never an appropriate means of discipline . . . . . 4 Don't know . . . . 8 No answer 9	
13	Has your household been able to cover <u>expected</u> household expenses in the last 12 months?	Yes 1 No 2 Don't know . . . . 8 No answer 9	
14	Did your household incur any <u>unexpected</u> household expenses, such a as a house repair or urgent medical treatment, in the last 12 months?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 14**
15	Was your household able to pay for these expenses?	Yes 1 No 2	
16	How many children in this household aged 0-17 years are you responsible for?	[_____] children	

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

No.	First name	Age at last birth day (years)	Questionnaire		Registered beneficiary of *[insert name of CBO's OVC program]*
			0-4 yrs.	5-17 yrs.	Y/N
1	*Example.* Samuel	6	-	X	Y

2. MER Indicator Questionnaire: Child Aged 0-4 years

I have a few questions about [insert child's name]. **Check to make sure the sampled child is present. You will need to take this child's mid-upper arm circumference.**

No.	Question	Coding Category	Skip
1	Is [NAME] female or male?	Female 1 Male 2	
2	How old was [NAME] at her/his last birthday? **Do not leave blank. If unknown, ask caregiver to estimate. If the child is older than 4 at last birthday, use 5-17 years questionnaire. Proceed to next household/child on list.**	[_____] years	
3	3.1 Does [NAME] have a birth certificate?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 4**
	3.2 Could you please show me [NAME'S] birth certificate?	Seen/Confirmed 1 Not seen/Not confirmed 2	
	3.3 What is the reason you're unable to show it to me?	Can't locate it just now 1 Permanently missing/ destroyed 2 Someone else keeps it 3 Other reason (Specify) 8	

No.		Yes	No	DK	NR
4	In the past 3 days, did you or any household member over 15 years of age engage in any of the following activities with [NAME]: **Read out a through one at a time.**				
	a) Read books to or looked a picture books with [NAME]?	1	2	8	9
	b) Told stories to [NAME]?	1	2	8	9
	c) Sang songs to [NAME] or with [NAME] including lullabies?	1	2	8	9
	d) Played with [NAME]?	1	2	8	9
	e) Named, counted, or drew things with [NAME]?	1	2	8	9

5	Is [NAME] currently enrolled in school (Early Child Development)?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 8**

6	During the last school week, did [NAME] miss any school days for any reason?	Yes 1 No 2 Don't know 8 No answer 9	
7	What ECD grade (or year) is [NAME] in now?	[__|___] Record 88 for Don't know; 99 for No answer	
8	Was [NAME] enrolled in school during the previous school year?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 10**
9	What ECD grade (or year) was [NAME] in during the previous school year?	[__|___] Record 88 for Don't know; 99 for No answer	
10	In the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2 Don't know 8 No answer 9	
11	Has [NAME] ever received services or participated in activities from [insert name of ASSIST Project CBO]?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 15**
12	How many months ago did [NAME] start receiving services or participating in activities from [insert name of ASSIST Project CBO]?	[_____] months Record 88 for Don't know; 99 for No answer	
13	Has [NAME] received services or participated in activities from [insert name of ASSIST Project CBO] in the last six months?	Yes 1 No 2 Don't know 8 No answer 9	
14	Has [NAME] ever been tested to see if he/she has the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**

15	Do you know the results of [NAME's] test?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
16	Did [NAME] test positive for the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
17	Is [NAME] currently taking Antiretroviral (ARV) drugs?	Yes 1 No 2 Don't know 8 No answer 9	
18	May I measure your child's mid-upper arm circumference? **Measure the child's left mid-upper arm circumference using the MUAC tape and record measurement.**	[___|___] [___.|__] mm Record 888.8 if permission not given 999.9 if child not present	

3. MER Indicator Questionnaire: Child Aged 5-17 years

Age group	5-9 years	10-14 years	15-17 years

I have a few questions about [insert child's name].

No.	Question	Coding Category	SKIP
1	Is [NAME] female or male?	Female 1 Male 2	
2	How old was [NAME] at their last birthday? **Do not leave blank. If unknown, ask caregiver to estimate. If the child was less than 5 years old at last birthday, complete the 0-4 yr old form. If the child is 18 or older, stop the interview for this child.**	[__|___] years	
3	3.1 Does [NAME] have a birth certificate?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 4**
	3.2 Could you please show me [NAME'S] birth certificate?	Seen/Confirmed 1 Not seen/Not confirmed 2	
	3.3 What is the reason you're unable to show it to me?	Can't locate it just now 1 Permanently missing/destroyed 2 Someone else keeps it 3 Other reason (Specify) 8	
4	Is [NAME] currently enrolled in school?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 7**
5	During the last school week, did [NAME] miss any school days for any reason?	Yes 1 No 2 Don't know 8 No answer 9	

6	6.1 What education level is [NAME] currently attending?	Pre-primary/nursery/ECD . . 0 Primary . . . . . .1 Post-primary training. . . . . 2 Secondary . . . . . 3 Post-secondary training . . . 4 College . . . . . 5 Vocational training . . . . . 6 University . . . . . 7 Don't know . . . . . 8 No answer 9	
	6.2 What school grade is [NAME] currently attending?	[__|___] Record 88 for Don't know; 99 for No answer	
7	Was [NAME] enrolled in school during the previous school year?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 9**
8	8.1 What education level did [NAME] attend during the previous school year?	Pre-primary/nursery/ECD. . 0 Primary . . . . . 1 Post-primary training. . . . . 2 Secondary . . . . . 3 Post-secondary training. . . 4 College . . . . . 5 Vocational training . . . . . 6 University . . . . . 7 Don't know . . . . . 8 No answer 9	
	8.2 What school grade did [NAME] attend during the previous school year?	[__|___] Record 88 for Don't know; 99 for No answer	
9	At any point in the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2 Don't know 8 No answer 9	
10	Has [NAME] ever received services or participated in activities from [insert name of ASSIST Project CBO]?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 13**

11	How many months ago did [NAME] start receiving services or participating in activities from [insert name of ASSIST Project CBO]?	[_____] months Record 88 for Don't know; 99 for No answer	
12	Has [NAME] received services or participated in activities from [insert name of ASSIST Project CBO] in the last six months?	Yes 1 No 2 Don't know 8 No answer 9	
13	Has [NAME] ever been tested to see if he/she has the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
14	Do you know the results of [NAME's] test?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
15	Did [NAME] test positive for the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, No answer: end**
16	Is [NAME] currently taking Antiretroviral (ARV) drugs?	Yes 1 No 2 Don't know 8 No answer 9	

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