

Decision Making Among Community-Based Volunteers Working in Vulnerable Children Programs

CHILD STATUS INDEX USAGE ASSESSMENT PHASE 2

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Executive Summary

Background

In 2009, MEASURE Evaluation published the Child Status Index (CSI), a tool designed to be implemented periodically by low-literate community caregivers to capture children's status across the six domains of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) programming for children who are orphaned and made vulnerable by HIV/AIDS. Based on anecdotal reports of widespread use, MEASURE Evaluation conducted a CSI usage assessment in 2011-2012 to understand how large programs were using CSI to meet a range of information needs. Findings from that study, along with other studies previously conducted regarding CSI, have been useful, but did not get the perspective of community-based caregivers. This study was designed to complement the first study and others by collecting data from caregivers who work directly with vulnerable children to explore how care decisions are made by community-based volunteers, and the utility of CSI at the community level as a job aid.

Methods

MEASURE Evaluation conducted a qualitative study among large U.S. government-funded programs where community-based volunteers work with orphans and vulnerable children (OVC). The study involved data collection with CSI users, non-users, and community committee representatives and sampled from several different levels to identify countries, programs, and sub-grantees for selection, and key informants to participate in focus group discussions and interviews.

Findings

Seventy nine caregivers participated in 12 focus groups in urban and rural settings in Côte d'Ivoire, Kenya, Malawi, and Zambia. In addition, nine representatives from community-based committees were interviewed. Male and female caregivers participated in focus groups, and on average were more mature than expected in terms of age, experience, and education.

Volunteers play a central role in the case management of children. They describe liaising and networking with many community-based entities and work closely with other volunteers. In several of the communities, volunteers have started income generation activities either among volunteer groups or family groups and discuss how these activities generate money to be given

or loaned. While volunteers often work closely together and form networks, there are opportunities for sharing information to improve coordination of resource allocation, monitoring children's well-being, and ensuring adequate coverage of services for children and families.

Volunteers use CSI as a tool for assessing individual children's well-being and make decisions about how to respond based on CSI scores. This was especially evident in cases where a child scores a "1", or a low score, which triggers an automatic response. Despite this, volunteers did not describe clear guidelines for how to respond to different scores across the varying domains. Volunteers who do not use CSI also describe assessing needs and trying to address them through direct care of referrals, but they do not articulate having a trigger for a response in the same way volunteers using CSI do.

The majority of focus group participants indicated that they like using the CSI and find it useful for assessing the comprehensive needs of children. What could be improved, however, is supporting CSI documentation, particularly around the nutrition domain. Volunteers' confidence was high, both in making decisions for children and in using the CSI – in both cases they attribute it to the training they received in general and on using CSI. While they have confidence, participants also acknowledged challenges when they are unable to provide referrals or resources to meet needs. In particular, volunteers talked about challenges in meeting needs related to food security, shelter, and school fees and talked about challenges with referral follow-through.

Many examples of child protection issues, including physical and sexual abuse, neglect, and exploitation, came up during focus groups in three of the four countries. In many instances when probed, volunteers described dealing with these problems directly with families and trying to change attitudes around abuse. It was unclear, however, how well established protocols are for dealing with such child protection issues.

Conclusions

Volunteers, regardless of CSI use, describe an assessment and prioritization process for addressing needs, but volunteers using CSI articulated how CSI scores triggered responses and helped prioritize needs for a specific child and/or across groups of children. Those using the CSI find the tool useful for assessing comprehensive needs of children and a platform for monitoring children's status over time. Most volunteers like the CSI tool the way it is, but recommend having supportive documentation for clarifying CSI scores (particularly nutrition) and indicating how to respond to scores.

This study demonstrates that volunteers act autonomously to provide basic health education, services, and referrals, but rely heavily on other volunteers and, in some cases, programs to make decisions on more challenging cases. Informal and formal networks among volunteers provide additional resources for training and mentoring on service delivery, as well as on use of the CSI. Further, volunteers serve a central role in coordinating service delivery and resources with many community-based groups, such as village administration, police, schools, churches, hospitals and clinics, victim support units, and others. Despite these strong linkages, volunteers are often faced with challenges with referral networks and meeting needs of children and families they serve. There are opportunities to strengthen referral networks and information sharing among community groups and volunteers.

Recommendations

In light of the findings, the study team provides the following recommendations:

- Changes made to the CSI tool and accompanying materials should be considered relative to the potential additional work required (e.g., training, new forms) for programs and volunteers.
- Provide further guidance and explanation on how to score the domains, particularly nutrition. This may be addressed by programs during training, when they work with training participants on how to score the different domains.
- Ensure volunteers have a way to keep CSI information for individual children so they have a record for the child (e.g., copy of the CSI form, notebook) and a sustained information system from which to provide care and support to a vulnerable child. Ensure steps are taken to maintain child confidentiality when volunteers have such notebooks or forms.
- Work with programs locally to develop supportive documentation that guides volunteers on responses to certain scores, especially low scores (1 or 2). This is particularly important for severe health issues like malnutrition and child protection issues.
- Work with programs to promote linkages between volunteers and existing community based structures — coordinating care and support and information sharing to ensure needs are met in a timely fashion.
- Given the importance of informal and formal networking among volunteers, encourage support networks among volunteers on how to score and make decisions about taking action for children.

- Encourage programs to discuss with volunteers how to address situations when referrals/resources are not available in certain domain areas — and how to respond/explain to families when programs/volunteers are not able to meet needs.
- Projects should consider coordinating with community leadership (chiefs etc.) to explain and highlight the volunteer role within the community in order to reduce stigma and discrimination faced by volunteers.

I. Background

To assist programs in collecting information about the well-being of children who are orphaned and made vulnerable by HIV/AIDS, the Office of the Global AIDS Coordinator (OGAC) and the U.S. Agency for International Development (USAID)/Office of HIV/AIDS (OHA) commissioned MEASURE Evaluation to develop a tool that would collect such information. In conjunction with the Center for Child and Family Health and the Health Inequities Program at Duke University, MEASURE Evaluation published the *Child Status Index: A Tool for Assessing the Well-Being of Orphans and Vulnerable Children* in 2008.¹ The Child Status Index (CSI) was designed to meet demand for a tool that could be implemented by low-literate (typically volunteer) community caregivers to periodically capture children’s status across the six domains of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) programming for children who are orphaned and made vulnerable by HIV/AIDS: food and nutrition; shelter and care; protection; health; psychosocial; and education and skills training. The tool was designed to be child-centered, simple to use, reliable, broadly applicable, and scalable.

Since the launch of the manual, field guide, and a “made easy” pamphlet version of CSI, 4,156 copies have been downloaded from the MEASURE Evaluation Web site and 1,507 printed copies have been distributed.² In addition, an online community of practice, Child Status Network (CSNet), was formed in May 2009 as a way for participants from the CSI Regional Conference held in Kigali, Rwanda to share best practices about CSI. Given widespread usage of the CSI as indicated by CSNet membership, MEASURE Evaluation and USAID determined that there was a need to assess systematically how programs implement and use CSI and to understand program field needs for additional tools to meet care, support, and monitoring and evaluation (M&E) demands. To complement other studies related to the CSI,³ in 2012 MEASURE Evaluation conducted a qualitative study, a CSI usage assessment, to assess how programs were implementing the CSI and using CSI data to understand gaps in the availability of

¹ O’Donnell K, Nyangara F, Murphy R, Nyberg B. *Child Status Index. A Tool for Assessing the Well-Being of Orphans and Vulnerable Children—MANUAL* [MS-08-31a]. Chapel Hill, NC: MEASURE Evaluation; 2009. Available at: <http://www.cpc.unc.edu/measure/publications/ms-08-31a>. (Discussion of validation testing found on pages 47-49.)

² Both download and printed copy totals are from publication dates to December 31, 2012.

³ Sabin L, Tsoka M, Brooks M, Miller C. Measuring vulnerability among orphans and vulnerable children in rural Malawi: validation study of the Child Status Index tool. *J Acquir Immune Defic Syndr*. 2011;58(1):e1-10; Foreit K, Chapman J, O’Donnell K, Cannon M, Moreland S. Child Status Index validation study by Sabin et al. misses the mark. *J Acquir Immune Defic Syndr*. 60(2):e67-e69.

tools to meet care, support, and M&E demands.⁴ Findings indicated that many programs working with vulnerable children are using the CSI as a job aid/decision-support tool, with use leading to direct service provision or referrals for services. The study findings represented the opinions of program directors and M&E officers of large vulnerable children programs, but did not include the perspectives of community-based volunteers who are charged with assessing vulnerable children's needs, linking those children and families to services, and monitoring the children's status.

As a result, in this study MEASURE Evaluation sought to explore how care decisions are made by community-based volunteers/social workers, and the utility of the CSI at the community level as a job aid. This information will assist MEASURE Evaluation in improving M&E guidance for programs working with vulnerable children and help us to understand more about the community care givers providing these services to vulnerable children.

The four main study questions are the following:

- 1) How do community-level volunteers/workers make care decisions? What is the difference in how decisions are made between CSI users and non-users?
- 2) Among community-level volunteers/workers who report implementing the CSI, to what extent do they believe that the CSI process/data supports improved decision making?
- 3) Among communities where community-level volunteers/workers are working, to what extent are care decisions made independently by volunteers/workers versus in care teams (e.g., community groups, teams of volunteers/workers)?
- 4) Among community-level volunteers/workers who report implementing the CSI, to what extent have they been trained to use the CSI? Are there differences in the decision-making process based on characteristics of volunteers/workers?

II. Methods

Study Design

MEASURE Evaluation conducted a qualitative study among large U.S. government-funded programs where community-based volunteers work with orphans and vulnerable children (OVC). The study involved data collection with CSI users, non-users, and community committee

⁴ Cannon M, Snyder E. *The Child Status Index Usage Assessment*. Chapel Hill, NC: MEASURE Evaluation; 2012. Available at: <http://www.cpc.unc.edu/measure/publications/SR-12-68>.

representatives and sampled from several different levels to identify countries, programs, and sub-grantees for selection, and met with key informants who participated in focus group discussions and interviews.

Step 1: Country Selection — CSI use has been documented in 16 countries worldwide,⁵ two in Latin America/Caribbean (Honduras and Haiti), two in Asia (Cambodia and India), and 12 in sub-Saharan Africa (Côte d’Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe). The country-based sampling frame included 13 of the 16 countries where CSI use has been documented. Three of the four countries in Latin America/Caribbean and Asia regions were excluded for the following reasons: in Honduras, only one relatively small organization is using CSI, using more of a case management approach; in Haiti, CSI training had only recently been conducted and thus the organization had limited exposure to CSI; and in Cambodia, there were only two known organizations using CSI — one was a research organization and the other was a small NGO that did not meet the study criteria.

The remaining countries were reviewed with the OVC Technical Working Group and five countries were selected based on geographic location and countries where the study team had contacts that could assist with program and consultant identification. Countries selected for inclusion were: Côte d’Ivoire, Kenya, Malawi, Zambia, and Lesotho. After recruitment procedures were followed (see step 2), Lesotho did not meet the criteria for CSI use and was dropped from the study.

Step 2: Program Selection — MEASURE Evaluation or the USAID OVC Technical Working Group sent an e-mail to lead contacts (USAID focal persons, MEASURE Evaluation staff, Futures Group staff, or other contacts) in each of the five countries to request their assistance by identifying two programs working with vulnerable children in their country to participate — one that uses the CSI and one that does not use the CSI. Selection criteria for programs included organizations that were funded by the U.S. government, willing to identify sub-grantees for participation, and willing to work with sub-grantees on selecting community-based volunteers/workers for interviews/focus groups as needed. For the organizations using CSI that were being considered, an organization had to have at least one year of experience using the CSI. Efforts were made to recruit new programs into this phase of study, rather than contacting only programs included in the first phase of study.

⁵ Cannon M, Snyder E. *The Child Status Index Usage Assessment*. Chapel Hill, NC: MEASURE Evaluation; 2012. Available at: <http://www.cpc.unc.edu/measure/publications/SR-12-68>.

The study team also requested that the lead contacts assist the team in recruiting qualitative data specialists to conduct and record interviews, note takers, transcribers, and translators. The study team collected curriculum vitae (CVs) from qualitative candidates and requested other information to ensure technical capability and cost competitiveness. A final selection was made and consultancy agreements were issued to all consultants.

Step 3: Program Sub-grantee Selection — Once the organizations were identified, the study team either worked directly with the program staff or, in some cases, with the consultant to select sub-grantees to participate in the study. For each organization using CSI, two sub-grantees were selected, while one sub-grantee was selected for each non-CSI user organization. The sub-grantees had to be willing to participate in the study, help coordinate logistics with the consultant, and facilitate selection of focus group and interview participants. Efforts were also made to obtain geographic variation (urban versus rural).

Step 4: Key Informant Selection — Consultants worked with sub-grantees to identify community volunteers to participate in the study. Between five and eight volunteers from each sub-grantee participated in a focus group lasting approximately 90 minutes. Where applicable, program staff also worked with the sub-grantee on identifying the primary community-based group involved in making decisions about vulnerable children (e.g., school group, village development committee, social welfare committee) and identified the chair of that committee to participate in an interview lasting approximately 30 minutes. All interviews and focus group discussions were recorded.

Data Collection

Data collection involved focus group discussions (FGD) with community-based volunteers and in-depth interviews with the chair of the community-based group in each study community. All data were collected by the qualitative data consultant and notes were taken by consultant note-takers. The data collection instruments were submitted to the Futures Group's Internal Research Ethics Review Committee for review, and determined to be exempt from requirements for research involving human subjects and therefore exempt from submission to an institutional review board (IRB).

There were two FGD guides, one specific to CSI users and one for non-users. Each asked questions about the types of decisions made regarding vulnerable children under their care, how individual follow ups on decisions were made, and for CSI users the FGD guide asked additional questions about how the individual uses the CSI. FGD participants were also asked several questions using an individual data collection sheet in order to gather descriptive information. The

in-depth interview asked questions specific to how decisions about care for vulnerable children are made in the community, how the committees work with community-based volunteers on issues related to vulnerable children, and types of information needs they have related to these children. All instruments, including an informed consent form, can be found in the appendices of this report.

Data collection instruments were translated into local languages as needed, either by translators or by the data collection consultants themselves. In Côte d'Ivoire, instruments were translated into French; in Kenya, Swahili; in Malawi, Chichewa; and in Zambia, Bemba, and Nyanja. Instruments were then piloted in the field and adjustments to the instruments were made as needed.

During data collection, qualitative data consultants and note-takers read the informed consent to all participants and obtained verbal consent of each participant, using the participant's initials to verify consent was obtained. In cases where volunteers could initial the form themselves, they signed the consent form. No one refused consent for participation or recording of the focus groups or interviews.

All recordings of interviews were transcribed and translated into English in-country, and supplemented by note-takers' notes.

Training

The US-based study team conducted an on-line training via webinar on May 30, 2012 for data collection consultants to review the study protocol and interview guides. Follow-up assistance was also provided to consultants via e-mail, telephone, or Skype.

Data Analysis

After data collection was complete, the authors reviewed a sample of transcripts and read through them to identify preliminary themes and sub-themes from the interviews. The two came to agreement on the themes to be explored in data analysis. The primary analyst conducted thematic analysis using the agreed upon coding scheme and newly identified themes using QSR, Nvivo version 8.0. The identified themes were aggregated by program type (i.e., CSI use and non-use) and type of participant (i.e., committee chair or volunteer). After themes were identified, tables and matrices were created for content analysis of cross-cutting themes including quotes from study participants.

III. Limitations

While the study team took care to ensure high quality data collection, there were challenges. Data collection consultants had a difficult time finding appropriate community committees for inclusion in the study. In some cases, the interviews were conducted with the volunteer team leader; in other instances, no interview was conducted; and yet in other cases, church-based committees or village leaders were interviewed. This variation means the study team was limited in what can be concluded overall about such committees. There were also some challenges in identifying organizations to participate in the study, particularly in Kenya. In one case, volunteers from an organization where CSI was not used had already been exposed to CSI.

IV. Findings

Programs and Respondents

The study reached 12 sub-grantee community-based organizations in total. Five of the organizations had programs whose primary target was vulnerable children. One of those five was a school-based program. Six of the organizations were combined home-based care and vulnerable children programs where volunteers work with both populations. One program dealt exclusively with children living with HIV/AIDS. Table 1 illustrates the type of organization included by country. The programs in Zambia were all church-based programs. Seven of the organizations were located in urban settings and five in rural settings.

Table 1. Type of Program and Location, by Country

Country	Type of Program (Rural, Urban)
Côte d'Ivoire	Three organizations working with vulnerable children (all urban)
Kenya	Two organizations working with vulnerable children (one urban, one rural) One school-based organization
Malawi	Three combined vulnerable children/home-based care programs (all rural)
Zambia	Three combined vulnerable children/home-based care programs (two urban, one rural)

A total of 79 community-based volunteers participated in the focus groups with 51 of the participants coming from organizations that use the CSI (65%) and the remaining 28 coming from organizations where the CSI is not used (35%). Table 2 presents the demographics of the two participant groups.

Table 2. Participant Demographics by CSI User and Nonuser

	CSI User N=51	CSI Nonuser N=28
Average age in years (range)	37.5 (19 to 72)	38.7 (22 to 60)
Gender (percent of total)	Male=17 (33%) Female=34 (67%)	Male=9 (33%) Female=18 (67%)
Education*	1 = 6 (12%) 2 =12 (24%) 3 =19 (38%) 4 =13 (26%)	1 = 0 (0%) 2 = 8 (29%) 3 = 13 (46%) 4 = 7 (25%)
Years as volunteer (range)	4.6 (0.2 to 13)	5.1 (0.5 to 15)
Median caseload (range)	Children: 25 (6 to 273) Households: 12 (4 to 576)	Children: 14 (2 to 205) Households: 5 (1 to 60)
Receives payment [†]	Stipend = 14/49 (29%) Travel = 2/47 (4%) Other = 2/46 (4%)	Stipend = 8/28 (29%) Travel = 0/28 (0) Other = 0/28 (0)
Average number of CSI training sessions [‡]	1.6 (0 to 5)	NA
Average # of CSI training days [‡] (range)	2.5 (0 to 5)	NA

Notes:

* Education scale: 1 = less than primary completed
2=primary completed
3=some secondary
4=secondary completed or higher

Only 50 of the 51 CSI users responded to this question.

† Number of the 51 CSI users who responded on questions involving payment categories were 49 for stipend, 47 for travel, and 46 for other.

‡ Only 50 of the 51 CSI users responded to the question involving number of CSI training sessions, and only 49 responded to the question about number of days of CSI training.

NA = not applicable.

The age range and gender of participants was very similar between both groups, with the average age being 37.5 years for volunteers using the CSI compared to 38.7 years of age for volunteers not using the CSI. For gender, in both groups females comprised 67% of the participants and

males 33%. CSI nonusers reported higher educational attainment with 71% reporting some secondary education or higher, compared to 64% of those using the CSI. Both groups had similar volunteer experience (4.6 years among CSU users and 5.1 years among nonusers), and receipt of any kind of payment (29% of both groups received a stipend). The median child caseload was higher for CSI users (25) than for CSI non-users (14), and the range of caseloads was extreme. The higher caseloads came from social workers and teachers. In Côte d'Ivoire, volunteer caseloads were higher than in other countries. The average number of trainings attended was 1.6 per volunteer and on average the last CSI training attended was 2.5 days.

In addition to the focus groups, nine committee interviews were conducted, three each in Côte d'Ivoire, Malawi, and Zambia, and one in Kenya. Data collectors tried to interview representatives of established committees for vulnerable children, but there were no established government structures at the community level. We collected information from four faith-based groups, two youth committees, three committees formed by volunteers working with vulnerable children, and one government official (a child protection officer).

Volunteer Roles and Motivation

Volunteers describe several roles regarding their work with children and families. They see it as their role to look after the children; encourage guardians to treat the children well and ensure children's needs are met; mobilize care and support through referrals, income generation activities, and other means; and provide guidance to children.

Volunteers described many reasons for serving as a volunteer including their love for children and desire to protect them and help their future (n=10), faith (n=7), previous life experiences (n=6), exposure to additional knowledge (n=4), and commitment to their community/village (n=2). Nearly all of the focus groups had discussions around how much they love children and have a desire to protect them and help them realize their potential. One volunteer described what motivates her to serve as a volunteer:

We want to see those children progress and lead good lives. Sometimes a child may tell you something that is very touching ... that when you reach home it still rings in your head and you feel you need to go back there and find out how they are doing, if there is progress or not. Those OVCs and street kids have relatives but they don't care of them. I feel such a child should lead a life that I would like my own child to lead. Some of those on the street have uncles and aunties but because of the ill treatment they get from them is they run to the street; it hurts me to see that, and I don't wish any more children to live like that. So that is what has kept me going in doing this kind of work.

For those who discussed how faith drives them to do this work, they indicated it was their calling and that it was part of their faith to help those in need: “It is not easy to do this kind of work,” said one volunteer. “It is a calling from God and compassion. If it is not your calling, then you can’t manage.”

Many volunteers were able to empathize with children because they have their own children and could not imagine having them in such a vulnerable situation. They were also able to empathize because of their own previous experiences, either as orphans themselves or caring for family members who were orphaned.

I was orphaned at 13 years of age and, because of what I went through, I saw the need of helping OVCs ... it is a rough life.

For me, I was raised up by an uncle from the time I was three years old without knowing who my parents were, and I went through hell ... so that is why I am encouraged to do this kind of work, because I have slept without food before ... I know what it feels like. I have spent nights outside before, therefore I have experience and make reflections that these children are feeling exactly as I used to when I was going through what they are.

With regard to enhancing their knowledge, volunteers discussed how the training they attend brings them knowledge they can use in their lives, as evidenced by one participant:

We are well trained and we get good information as well. All this allows us to get something we can use in our daily lives. Therefore, it provides you self-confidence, it permits you to rely on yourself first. Then you are sure of what you say to people.

In a few of the focus groups, participants talked about how they were selected by the village authorities to serve as volunteers. In these cases, the volunteers described how it was their duty to the village to serve in this role of working with vulnerable children. “Since the village elected you on trust,” said one volunteer, “you need to fulfill the responsibility.”

Need Identification

Volunteers in all focus groups discussed how they assess the needs of the child by collecting information through home visits that include talking to guardians and children, as well as making observations in the household. Programs that involve school-based activities also may review school records to follow up on children. Participants in eight of the 12 focus groups reported using the CSI to collect information about the children they served. Volunteers in Kenya described how the CSI has helped identify needs among the children they serve:

There is another thing that helps, the CSI forms; because when we started using them, it really helped us because we came to notice that we could be giving a child a service that

they did not need, but with the CSI you know exactly what the child needs specifically; and you know we work with seven domains so we are able to identify where the child has a need, like if it is education or health or nutrition or shelter or psychosocial, and you get for each specific child because every child has different needs.

That is why we prefer the CSI, because it helps us identify exactly where the problem of the child is such that we do not offer education while the child is in need of nutrition.

In many cases, volunteers use other tools as well to collect information such as visitation books (n=4, primarily in Zambia) and identification sheets (n=3, Côte D'Ivoire). In one focus group in Côte D'Ivoire, a participant described how they used both the identification sheet and the CSI to complement each other for information gathering:

To get an idea about ... the needs of children, first there is the identification sheet at the preliminary contact with the child. With this form, we can identify some of his needs. Now during the home visits or the assessment with CSI, there are other needs that we successfully identify. Then according to all the identified needs, we provide the suitable support to the child.

In one of the focus groups where CSI is not used, volunteers mentioned the need for a tool that could help them better identify critical situations:

We do need another tool because the identification sheet is not always helpful. It does not take all the needs of the child into account

We need a document that attests the extreme vulnerability, the need to step in urgently. Thus, in case of extreme vulnerability, we don't need to meet before deciding. We need a document that shows that we should act urgently to what we saw or heard.

Decision Making

Confidence — Once volunteers have identified needs of the clients they serve, they often have to make decisions about what to do next, either to help the child directly, refer for services, or help identify resources to address the child or household need.

In most of the focus groups (n=9), volunteers indicated they were confident when making decisions about care or services for children, mostly because of the training they have received related to working with vulnerable children. One volunteer expressed it this way:

The knowledge we get from the training is what we use in our work, such that we don't face any problems in carrying it out.

In three focus groups, volunteers described that their confidence in decision making depended on what the issue was and the extent to which they have control over helping the child. They said it

was particularly difficult when a volunteer is unable to garner the resources necessary to help a child, as evidenced by this comment from a volunteer, “We are not confident because we are not addressing the OVC’s needs. We need resources.” Another said:

We sit and discuss, but some of those are not fulfilled because the funds we have are not enough to cater for the OVC we have and their needs. You find that of the 700 OVC we have, only 400 or 300 are catered for. They all have different problems so for us to solve all problems, it is a problem.

Decision Making Process — In all focus groups, volunteers indicated they can’t make decisions about all types of issues on their own, and in many situations they may require help from others. Table 3 depicts the scenarios where volunteers act independently to meet needs of the children they serve. As the table indicates, much of these autonomous actions involve such preventive measures as health and nutrition education; provision of basic health services and counseling; and garnering resources and support for shelter, food, and school fees.

When cases are more complicated or involve a situation the volunteer is unsure about, he or she may discuss the case with another volunteer, or a group of volunteers, to decide how to proceed. In other examples (Malawi, Zambia), coordinated volunteer groups are formed and meetings are held in which volunteers come together to discuss cases. One volunteer discussed the informal networking that occurs among volunteers:

Well, when we visit a household and find that a child there is facing many problems, before you write anything you call your colleagues and tell them about the problems you have found at that household. You ask them to suggest what ought to be done for that household. So you agree that, for example, the child should go to school or that the child has such and such problems. So we help each other.

Volunteers from other organizations described the formal gathering of volunteers:

After observing a child in the home, we meet as a group and discuss our findings; everyone puts in their thought basing on what was observed, then we make a decision on that child.

We make use of it in such a way that when we identify the children, we check their condition then classify them according to the needs of the CSI and then make a decision as a committee on how to help them.

In more serious cases, volunteers may need to report the situation to their organization and let them decide what to do like in the case of malnourishment. In one organization that had a more hierarchal approach, volunteers submit forms to a supervisor who then decides how to proceed with the situation.

Table 3. Autonomous Actions Taken by Volunteers.

Domain	Action Taken by Individual Volunteer
Health	<ul style="list-style-type: none"> • providing health education • providing basic medications (e.g., paracetamol) • negotiating financial support to pay for hospital or other health related fees • taking sick children to hospitals or clinics • follow up with children who are taking ARVs • referring for health services
Education	<ul style="list-style-type: none"> • following up to see how children are doing in school • providing or gaining support for material supplies and school fees • encouraging children and families about children going to school or receiving skills training • sensitizing teachers to the needs of these children trying to reduce stigma
Psychosocial	<ul style="list-style-type: none"> • counseling children about their situations • focusing on giving children hope and encouragement • providing opportunities to engage in sports and other community based activities • referring for enhanced counseling
Shelter	<ul style="list-style-type: none"> • helping to build houses • helping repair roofs and improve living conditions where children live
Nutrition	<ul style="list-style-type: none"> • providing basic nutrition education at the household level • offering direct food support (e.g., uni-mix) or have a nutritionist – two programs • referring malnutrition cases to the hospital/clinic • referring food insecurity cases to either the village chief, NGO, or another program that supports food distribution
Protection	<ul style="list-style-type: none"> • sensitizing and educating families • referring for assistance, support • reporting to authorities

In a couple of the focus groups, volunteers discussed how they try to work with the family first to address problems that the vulnerable child faces. One volunteer commented:

When a problem arises, we first resort to the family. We try to see in the family, if there are no resources to assist the OVC. If we explore all these ways and the situation does not improve, then we go beyond that family. We try to find a solution at the community level. When all these steps fail, we return to the NGO that entrusts the case to the social center.

Support for Decision Making — Volunteers were asked to whom they would go if they have a question about their work with vulnerable children. In eight of the 12 focus groups, they indicated they would go to their supervisor for assistance; and in five of the focus groups, they talked about going to other caregivers for support.

When asked about to whom they would go if they had questions about how to use the CSI, they indicated they would either go to a supervisor, the trainer who conducted the CSI training, or other volunteers. One volunteer described going to another colleague with questions about a CSI related issue:

Most of the times when you encounter such a situation, you call your colleague to come and assist you so that you look at the situation together and make a unanimous decision.

Use of CSI in Decision Making — In eight of the 12 focus groups, volunteers talked about how, after the assessment process, they prioritize the needs of a child to determine where to start with assistance. This prioritization process occurs among both CSI and non-CSI using volunteers, and a volunteer described how to go about this:

There are households which face the problem of food shortages, although the family tries all it can to overcome this. There are also households where there are many problems: a dilapidated house, inadequate food, etc. We obviously will treat these two households differently.

Another volunteer said that a child scoring high on the CSI form, indicating the child was better off, “that one is good; you cannot compare with a child that scores one or two [a low score], so you first attend to scores one and two.”

Five of the nine groups of volunteers were able to discuss how they used the CSI to trigger a response for an urgent issue, or what to do when a child has a low score in a given domain. Volunteers talked about this in a more general sense rather than describing specific protocols for how to respond:

There isn't any particular arrangement, but the NGO told us to give advice and make references, when we face an alarming score. Then the NGO together with the quality improvement team find the appropriate solution. But we first make references.

If the child scores a one you must take action immediately; like in wellness, if they score poorly, then you have to investigate if the child is sick and maybe not getting treatment so you link them with medical services and you follow up until they move to score two; you must take action.

One of the NGOs not using the CSI had volunteers who were exposed to it and the volunteers discussed the value of using such a tool to provide documentation and reference points from which to make decisions. One volunteer commented:

The CSI allows us to clearly identify the needs of the child. With it, our partner is convinced because the references on it make it more reliable. In case we need a piece of information, there is no worry. Some information that was verbally said, are systematically written on it.

Use of CSI for Monitoring Child Well-Being — In six of the focus groups, volunteers discussed how they monitor the well-being of a child (five focus group discussions took place in organizations where the CSI is used, and one where CSI was not used). Where CSI is used, volunteers gave examples of how they follow up with a child to assess the child's scores compared to a first CSI assessment. A volunteer gave this example of how CSI helped monitor the status of a child:

At the beginning of the first quarter, we assessed a child. Initially, there were three needs: food, health, and education. We gave him support in education. We made a plea for him so that he can attend school without paying fees. This same child has received a support in food and nutrition. He now eats three times a day in addition to dietary advice that are given and applied. After six months, we assessed the child again. We found that the need for education no more existed since he regularly attends school and previously he had received a school kit. Then we no more bring him support, apart from assistance in terms of diet.

One aspect of monitoring the well-being of children involves volunteers having a reference point from which to monitor children between time periods. Volunteers were asked about how they maintain records or copies of data collection forms, regardless of the type of tool they used. Responses varied with some volunteers turning data collection forms in to the NGO and, in other cases, tearing pages out of their books to turn in to supervisors. While many volunteers indicated they did not keep copies of their forms, they also described using notebooks to take notes and record information about children. A volunteer from an organization that does not use notebooks indicated how helpful it would be to have one, given the delay in having forms returned:

That way [if we had notebooks], we could be able to follow the progress the children are making since the CSI form, once it goes to the office, takes a long time to come back. Having the records could improve the way we work.

A volunteer in an organization that does not use the CSI talked about how they need a tool to record information about a child's progress, so they can track over time how the child is doing and follow up on references:

Forms that could help us measure the progress the children we work with are making, from the time we begin our intervention up to a certain period of time. If we could keep one of the forms and send the other one to our referral partners, we could be able to follow how we are doing because we would have a reference point.

Volunteer Attitudes of the CSI

As mentioned previously, volunteers who use CSI report using it to assess child needs, trigger referrals and care-based decisions for children and families, and to monitor the status of children over time. The frequency with which CSI is used varies depending on the organization. For example, some use CSI during every home visit; others use CSI on a quarterly or bi-annual basis. Seven of the nine organizations using the CSI are using the data collection form, and a few were not aware that there was a simplified pictorial version of the manual, but indicated that such a version would indeed be helpful.

When asked about challenges using the CSI, there were not many consistent themes across CSI users. In three of the focus groups, volunteers mentioned that the form can be complicated for low-literacy volunteers; and that there are challenges when scoring nutrition because it is difficult to accurately measure this. One said:

It says here that a child's height is normal and the skin is good but the weight is less than when you look at [other children], score three; you find a child is growing well in health and height for this age but has abnormal skin, then for score 2; child looks too thin has lower weight, that one the child's weight is not good but does not fit in two and the height and skin is good but the weight is not good; so I wonder where to place such a child.

Most of the suggestions on the CSI came from volunteers in Côte D'Ivoire, with both groups indicating the form is not easy to fill out and that they face challenges obtaining some of the basic client data (e.g., date of birth). One of the organizations described several challenges, but also indicated that additional training would be helpful and that a "dictionary" that describes each of the ratings would be helpful.

In one organization that focuses on HIV/AIDS, volunteers indicated that it was difficult to score a child who is HIV-positive with the same tool used to score a healthy child; and for scoring children living in informal settlements as opposed to those living in normal households. Also, they said the tool is not suitable for children less than a year old, and that there is no psychosocial score for such young children.

Some volunteers indicated that when visiting households and asking questions about needs (n=4 focus groups), expectations are raised. If volunteers do not meet those needs, it can be challenging, they said. For example, in organizations where a service is not provided or a referral not available (e.g., shelter), volunteers indicated they do not want to ask about this during home visits. Most volunteers said they do not bring the CSI form into the household, but complete the form after the visit.

In Zambia, the project stopped providing school fees and this has presented a challenge to volunteers who are now trying to explain to families why they are no longer able to support the fees. A volunteer described the problem:

Educational support has now ended, they are complaining saying “you have neglected us, why have you stopped giving us educational support?” Most OVC that have not paid school fees or have balances have not gone back to school because they have not been allowed entry. They keep asking why we can’t help by speaking for them so that they can be somebody as well in society.

Overall, most volunteers like the CSI the way it is (the way the form is laid out, the scales, and other aspects of the form). In fact, one volunteer commented that it would create challenges if they made changes to the CSI form:

We are used to this one. Should you change the way it is, it would bring problems for us as we will have to learn how to use the new one first. With this one, whenever we go to a household, we look at the condition of the child and compare it with what we see on the pictures, and then we make a decision.

A volunteer for one organization mentioned how the government could be more involved in supporting documentation for decision-making:

For the ministry, they should have departments that deal with all these issues here [referring to the CSI form], such that when you have a problem you know where you get help of each problem.

Referrals and Mobilizing Resources

As previously mentioned, volunteers are able to provide some services by themselves, but they often need to collaborate with others (e.g., other volunteers, families, NGOs, village administrators) on meeting identified needs, either through income generation activities, direct service provision, or referrals. Volunteers in six communities discussed their role in trying to mobilize resources through income generation activities, either with volunteers themselves contributing or raising funds, or facilitating the formation of family groups that contribute or raise funds to be used or borrowed by families to pay school fees, health services, or meet other needs. A volunteer provided an example of how volunteers raise funds to address children's needs:

We make a lot of bricks which we sell at 5 KSH [Kenyan shillings] each and the money that we make we pay school fees for the children; or if they do not have clothes, we buy clothes for them; that is the most important role for us as service providers.

Volunteers' responses in terms of service provision and referrals were largely dependent on needs of the children, the programs children are affiliated with, and the networks available within the community (e.g., youth groups, church groups, government structure, other NGOs providing services). Table 4 presents a matrix depicting the entity where volunteers described referring for the different domains of health, education, psychosocial, shelter, nutrition, and protection. For health issues that are beyond the volunteers' capacity, such as in cases of malnutrition, HIV, or other illnesses, referrals for testing and treatment are made to hospitals or clinics nearby; as described by one volunteer, "in case of illness, references are made either to the health center or to hospital." Volunteers also describe how they advocate for patients and help find resources to pay for treatment if needed.

For education, volunteers work to gain resources for school fees, and the source for those fees varies from community to community. In some instances, it is the volunteers themselves who provide the fees (local churches, NGOs, community groups, or village administration). Regarding psychosocial concerns, when a child's situation is beyond what a volunteer can do to help, the volunteer may require assistance from others, such as from a church, village elder or, if available, a social worker from a project.

For shelter, the volunteer often has to refer back to the NGO for help or look for assistance from the village and/or family itself. When there is food insecurity, volunteers often refer these cases to either the village chief, NGO, or another program that supports food distribution.

Table 4. Where Volunteers Go for Additional Support in Each Domain

	Health	Education	PSS*	Shelter	Nutrition	Protection
School		X				
Government		X				
Church		X	X			
NGO		X	X	X	X	X
Police						X
Hospital/clinic	X				X	X
Village				X	X	X
Elders			X			
Other programs	X				X	X

Note:

* PSS = psychosocial services

As volunteers discussed their work and how they try to meet the needs of children, volunteers in three of the four countries (Kenya, Malawi, and Zambia) gave examples of how they try to help children in the area of child protection, which involves physical abuse (n=8), sexual abuse (n=6), neglect (n=8), exploitation (n=5), and legal issues.

Physical Abuse — Volunteers mostly referred to physical abuse in a general sense, and not always providing specific examples as they did for other areas involving protection issues. Volunteers noted that a large part of their work in these cases involved talking to families and sensitizing them about the rights of children and not abusing vulnerable children in their care. Though in some cases — particularly more serious cases — volunteers discussed how they involved the village chief, another NGO, a hospital, community-based organization paralegal, a victim support unit, or a children’s officer to help address the issues. In one particularly severe case, a child officer in Kenya described how the problem was addressed through a coordinated effort:

The neighbors heard the child crying and they got to the house and rescued the child and went to report to the chief, who advised them to report to the police station then bring the child to the children’s officer. The child was here and he had been beaten; it was a pure assault case. When I saw the child, I wrote a case record and decided to take him to

hospital first and he was treated. From there was when we went to report the parents, because the father was not taking care of the child and the mother was accused of assault.

In particular, severe cases where a child may need to be removed from the home, volunteers and the child protection officer described challenges in finding a place where a child can live. The child officer described how, at times, an abused child will have to stay with a village chief (if the child is a boy) or with the volunteer or caseworker. The child officer in Kenya described how this situation presents a challenge:

There is nowhere we can refer because I tried a certain children's home and they told me that they only take kids at the beginning of the year. I tried at the beginning of the year but they told me it was a process to date I have not managed. I tried other organizations and I was told there are committees that need to sit and look into the cases of those children, and the kids are still in the same problem they were in; there is no place you can refer.

In Malawi, volunteers for a project that focuses on child protection talked extensively about their efforts to protect children. One head of a volunteer committee described how the situation had improved:

When it comes to child abuse, we first of all talk to the parents. For instance, we would tell them that what they are doing to the child is not right; you are abusing the child by doing such and such wrongs and this is in violation of the child's rights Most of them do understand and they change. We also repeat the advice when we visit the households to the parents when we go to visit the child if we see that the abuse is continuing. Of late, we have seen a reduction in such tendencies. Most people fear us; whenever they see us they are afraid to be seen to be abusing their children and the habit is dying out.

Sexual Abuse — Examples of sexual abuse, including cases of incest and rape, were given by volunteers. Volunteers described how they respond in such cases, and the response varies depending on the country and type of situation. In Kenya, for example, two program volunteers described a clear process for steps to take, including taking the child to a hospital, then reporting the situation to the police, and then reporting to the children's officer. Volunteers for another program in Kenya indicated that Medecins Sans Frontieres (MSF) has a hotline that they use to report such cases. In Zambia, the process is not as clear, as a volunteer explained:

In a case where an OVC has been raped, we rush them to the clinic or police. So I wouldn't come here but rush the OVC to the clinic, but sometimes when you go the clinic, you are asked why you have not gone to the police first.

In a few instances, volunteers described children being the victims of incest. The responses for how to handle these situations varied from engaging a social worker to talking to the family, as evidenced by these comments from two volunteers:

If it is rape, it is the parents that have the responsibility to go and report but at times it is us to report; if maybe the child was raped by a family member, you will get that the family wants to cover so the CHWs [community health workers] and the social worker will have to get in the case so that justice for the child is given.

There are mothers who offer their daughters to the daughters' fathers so that they can have sex with them. When we see such things, we visit the households and enlighten them on the rights of the child; for example, the right to stay in her parents' home, the right to education, and the freedom to do what she wants but under the guidance of the parents as well as us, the child caregivers.

One volunteer described how even some caregivers do not know rape is a problem and what they did to address this issue by saying “in my group, we called the children’s officer to talk to the caregivers about rape because most caregivers did not know that rape was an offence they used to negotiate.”

Neglect and Exploitation — Volunteers also gave examples of how children are neglected through unfair treatment compared to other children in the household (e.g., sleeping in worse conditions than the other children or not being able to go to school when other children did attend school) or not getting the treatment they need for HIV, tuberculosis, or other medical issues. With regard to unfair treatment, volunteers in these cases primarily talk to the families and encourage them to treat the child as their own. In cases of denying treatment to a child, volunteers may involve the village chief or report to the children’s officer, if there is one. A couple of volunteers also discussed how disabled children are neglected and even locked in homes as they do not know how to care for them. In one school based program, a resource center helps refer disabled children to appropriate places for assistance, as described this way:

There was one of our children who was disabled and was 12 years old and had never gotten health assistance; when we were told, we reported to the resource center officer who took one of the members and went there and the child was taken for therapy at the district hospital and is continuing with therapy.

Volunteers also gave examples of child exploitation either in the form of child labor or giving vulnerable children a disproportionate or excessive amount of work. In some cases, volunteers indicated that child labor, particularly in the teenage years, is seen as normal behavior and volunteers don’t consider it a problem. In more severe cases, volunteers may refer a case to paralegal services or a victim support unit, but mostly talk to families trying to help them understand the child’s rights.

Legal Issues — Volunteers described a few examples of how they help children in legal issues, like trying to obtain a birth certificate or assist in inheritance issues,

For protection, we make sure that the children have a birth certificate and we assist them to get them birth certificate or if the children are being denied their legal rights of inheritance we link them to people that can assist.

We help child-headed households with legal matters. Examples of cases of legal matters affecting OVC's: their relatives wanting to grab a house from OVC's after they have lost their parents. Sometimes it could be that the house was not bought when the parents were alive and so we help these children seek legal protection.

Referral Issues — Some organizations where focus groups took place had a social worker on staff where volunteers could refer more serious cases. But many of the organizations did not have this structure and provide referrals directly to community networks or other facilities. During focus groups (n=7) and some of the interviews, participants raised concerns about not being able to meet the needs of children, and how challenging it is when the referral system does not work well. As one volunteer said, “It demoralizes you when you reach a dead end.” Another described how even referring a case to authorities may not be effective:

We visit many households and meet issues some of which we cannot deal with. At the same time when we take those issues up to the responsible authorities, no solution is found.

And yet another volunteer described the challenge when referring a serious case by saying “we sometimes find children that are severely malnourished, but when we refer them to hospital they do not get any assistance as per our expectations.”

Community group representatives echoed the challenges raised by volunteers with regard to referrals, particularly follow through on referrals that are made. “We refer but certain things are left hanging...they just fail,” said one. An officer responsible for child protection also commented on the challenges of referrals, noting that the “referral system is very poor” and it is challenging to find places to link children with services.

Interaction with Community-Based Committees

As mentioned previously, data collectors experienced challenges finding community-based groups that work with vulnerable children. Despite this, data collectors interviewed other groups working in the community that address child issues as part of their mission. Those individuals involved government representatives, church-based groups, youth groups, and volunteer team leaders that were created by an NGO project.

Government — In Kenya, the Ministry of Gender and Children's Department have created district children's officers who respond on a case-by-case basis when reports of abuse or other child

concerns are brought to them. Volunteers in Kenya did talk about reporting to children's officers in serious cases. One volunteer commented:

Other links for services of rape — you first take the child to hospital, then you report to the police, then to the district children's office you report there, then they follow up all legal cases.

In the community where data were collected, the Location Area Advisory Council, comprised of faith-based organizations, businessmen, and two youth representatives, has a village level child officer volunteer. There used to be several such child officers at the village level, but now there is just one due to lack of payment. The children's officer does not have much interaction with the community-based volunteers and was not aware of the CSI tool, but volunteers did refer to the officer when talking about child protection issues.

Faith-Based Committees

In the faith-based committees (n=4), interviewees described their role in helping identify resources for vulnerable children through members of their congregations. They also described interacting with the programs and volunteers working with vulnerable children, mostly regarding services provided. When asked how their groups work with NGOs, an Imam reported meeting weekly with the program representative and described collaborating with them:

When there is a meeting and we are informed, we take part in it I met several of them [program representatives] and inform them about our goal, which is to help vulnerable children since they are much more informed than us. I am regularly in contact with the head of the NGO.... [The community volunteers] give us advice to provide support, then we give them advice so that they can provide spiritual support to the OVC.

The three Christian-based groups in Zambia have different approaches working with the volunteers, with one of the groups actually leading the selection of volunteers. In all cases, the churches help by providing material support to children or families in need. A committee member in another community where the CSI is not used described the relationship between their committee and volunteers on sharing of information during monthly meetings when volunteers provide reports and how resources are allocated based on these reports:

Caregivers go round talking to people and they hear these stories ... then they talk to the parents/guardians of the victim ... thereafter they also talk to the OVC, teach them on how to live with people and how to take care of themselves ... the care givers chat with the head man and so they ask, we hear there is such and such a case at such and such a village, what is going on ... then the headman tells ... and then we take it up from there.

In another example where the CSI is not used, the interviewee talked about how they work with volunteers on providing reports that go to the social welfare office and to the diocese, yet these reports primarily focus on the services delivered to a child and not on the status of individual children. The interviewee stated:

As regards the children's development, we couldn't say with emphasis that this is what we do. All we do is keep the reports on what we do to help the children. We do not have particular information about the progress of individual children and the number of children with whom we are working.

Another church committee member described the steps the committee took to ensure their church-based groups and mission of helping children would be maintained as an NGO came to support their activities:

The whole thing started as a church department supporting orphans and other underprivileged and we were getting funds from within the church. The program began expanding, [the NGO] came in and funding increased. So, initially the idea to allow outside people to come in and start helping people, we had to check that. We had to approve of [the NGO's] involvement because we didn't want a situation of exciting people by [the NGO] using the name of the church and then suddenly fall off.

Youth Groups

Representatives from both youth groups described having interaction with volunteers, noting that they collaborate on some educational activities related to HIV/AIDS; and one noting that they serve as an intermediary if there are issues between volunteers and children. When asked about how they keep track of information related to children, one representative expressed their desire to know more information:

That is the problem. This is why we want to be more involved since we are aware of the quality of their contribution to our children. When we pay a visit to the recipients, we are satisfied, but see no tracks.

A representative of the second group described good coordination, meeting quarterly with volunteers, and expressed how the volunteers inform them about issues the children are facing:

They [community caregivers, volunteers] provide us with information about the OVC. They inform us about their living conditions ... they provide information on the marginalization and the stigmatization.

Family Relationships — Volunteers in six of the focus groups described the work they do to maintain a positive relationship with the guardians and households as this positive relationship ensures that volunteers can visit the children and provide assistance when needed. Volunteers in

six of the focus groups specifically discussed how good their relationship is with the children they serve, indicating that the children know they can come to them if they have a problem or need help. Volunteers in nine focus groups also discussed the extent to which they are well reputed in the communities where they work, often with the families that are needy or have a child who has been orphaned. One volunteer said:

We are warmly welcomed in the homes where they have needy and orphaned children; we are allowed to do our work freely without getting any hindrances from the people in the households.

In four of the focus groups, volunteers talked about how some of the families rely on them to take care of the child and have expectations that the program will take care of their needs, as indicated by a volunteer in Zambia who said, “The problem with the guardian is they have surrendered everything to me ... they literally do not want to do anything about it.”

While volunteers are looked upon favorably among the clients in households they serve, volunteers in eight of the focus groups described that they are at times looked upon unfavorably, either by certain clients and households or within the community at large. The explanations for this varied. In two focus groups, volunteers described that some guardians are concerned the volunteers will report them for mistreating a child or for issues related to inheritance. In another focus group, volunteers talked about the stigma that OVC have in the community and how some households may not want a volunteer to visit the home, since that may indicate to neighbors that someone in the family is HIV-positive. This was particularly the case in the program that focuses on HIV/AIDS, as expressed by a volunteer:

You will get that there is a group of people that will seclude you because you are helping the HIV-positive people in the community or you find that those who are HIV-positive when they see you they avoid you because they think since you know their secret you might want to share with the whole community.

Another reason volunteers indicated they are at times looked upon unfavorably is because community members wonder or question why they choose to work for no pay. As one volunteer put it, “Most members do not talk good of us ... [they] mock us for being involved with charitable work, think it’s a waste of time, and do not appreciate services.”

V. Discussion

This is one of several studies conducted related to the CSI. A phase one study looked at program-level data use and M&E needs.⁶ The results of that study showed that the CSI was used by programs for a variety of information needs including assessing needs, providing case management,⁷ monitoring the well-being of children, and in some instances evaluating programs. Study findings led to a fact sheet that provides guidance on how the CSI fits into the overall M&E framework and best uses for the CSI.⁸ One of the most appropriate uses of CSI is as a case management tool for volunteers or other individuals working with vulnerable children. While the phase one study pointed to the tool being used for case management, it only assessed senior program managers and M&E officer perspectives and not the perspectives of community-based workers who provide care and support to vulnerable children in their communities.

This study confirms that volunteers are indeed using the CSI as a tool for assessing individual children's well-being across six domains and 12 sub-domains, and make decisions about how to respond based on those scores. Volunteers gave numerous examples of how they score children using CSI and how that prompts them to prioritize needs with a given child and across children in their care. This was especially evident in cases where a child scores a very low score that triggers an immediate response. While using the CSI for prioritization is useful, MEASURE Evaluation has not assessed whether the prioritization is appropriate or if the prioritization leads to better care decisions.

Volunteers did not describe clear guidelines for how to respond to different scores across the varying domains; and since all sub-domains are essentially equal weight, CSI does not provide guidance for this. Volunteers who do not use the CSI also describe assessing needs and trying to address them through direct care or referrals, but they do not articulate having a trigger for a response in the same way volunteers using the CSI do.

⁶ Cannon M, Snyder E. *The Child Status Index Usage Assessment*. Chapel Hill, NC: MEASURE Evaluation; 2012. Available at: <http://www.cpc.unc.edu/measure/publications/SR-12-68>.

⁷ Case management in this case refers more to care coordination rather than the explicit case management definition used by social workers. The *care coordinator* serves as a guide who is responsible for overseeing the community-level team process and takes the lead on cross-system/agency collaboration, pooled resources, collective mandates, family voice and choice, and consensus building.

⁸ MEASURE Evaluation. Clarification regarding usage of the Child Status Index (CSI) [fact sheet]. Chapel Hill, NC: MEASURE Evaluation; 2012.

The majority of focus group participants indicated that they like using the CSI and find it useful for assessing the comprehensive needs of children. Though volunteers were asked about any changes they would like made to the tool, most indicated that the tool was fine the way it is and several indicated they do not need new versions of the tool or additional data collection tools. For those not using the pictorial version, they believe the addition of pictures to the CSI would be helpful in their work.

What could be improved however is supporting CSI documentation, particularly around the nutrition domain, which mirrors findings from the phase 1 study. The first study also suggested that many programs collect CSI forms from volunteers and do not always return them to volunteers to close the feedback loop and to provide volunteers with a platform for monitoring children's well-being over time. Findings from this study confirm that most volunteers submit CSI forms, yet show that volunteers keep notebooks where they record information from the CSI assessments and other visits. We did not validate this by reviewing volunteer notebooks. It may be useful for program staff to ensure a feedback loop on CSI forms, and provide summary information or trends on the children in a given volunteers' caseload.

Volunteers clearly play a central role in the case management of children. They describe liaising and networking with many entities including co-volunteers, the programs with which they are affiliated, village administration, religious groups, schools and teachers, guardians, hospitals and clinics, and in child protection issues, with legal authorities or groups like children's officers, victim support units, police, and others. In several of the communities, volunteers have started income generation activities, either among volunteer groups or family groups; and they discussed how these activities generate money to be given or loaned for school fees or food security. While volunteers often work closely together and form networks, there are opportunities for collaborating with these and other existing community-based structures on sharing information that might be used for resource allocation, monitoring children's well-being, and ensuring adequate coverage for children and families.

Volunteer confidence was high, both in making decisions for children and in using the CSI — in both cases, they attribute this confidence to the training they received in general issues related to vulnerable children and on the CSI. While they have confidence, participants also acknowledged challenges when they are unable to provide referrals or resources to meet needs. They mostly feel confident when they know they can meet needs of children. Furthermore, some volunteers expressed challenges when they are assessing needs in areas where they are unable to provide a

referral or resource. In particular, volunteers talked about challenges in meeting needs related to food security, shelter, and school fees.

The demographics of volunteers in this study show that volunteers were on average older, have a long tenure as a volunteer, and have a higher education level than expected. We were not able to confirm that our sampling of volunteers within each of the 11 organizations was representative of all volunteers within each program, but from the organizations we heard back from they did indicate it was representative. This study examined the motivation to serve as a volunteer to understand whether volunteers were using this experience as a stepping stone for other positions or to enhance their career. Results indicate that volunteer motivation was primarily altruistic, based on a desire to care and protect children, and something they plan on continuing doing. The demographics and motivation was similar for CSI users and non-users.

While volunteers describe strong relationships with the children they serve and, in many cases, with the families, their relationship with the broader community is at times strained, either due to stigma or disrespect from community members who do not understand why volunteers work for no pay or may assume incorrectly that volunteers benefit financially from their work. However, volunteers describe persevering despite this because of their strong motivations toward working with children and the positive relationships they have with them.

Volunteers indicated the delicate balance in maintaining good relationships with families and guardians to ensure they can access children and provide support to them, while at the same time protecting children from some of the abuse committed by guardians. Volunteers often see it as their role to counsel guardians about how to care for vulnerable children and respect these children's rights. At times this balance is challenging when referral networks are not well established and volunteers are unable to meet needs.

Finally, many examples of child protection, including physical and sexual abuse, neglect, and exploitation came up during focus groups in three of the four countries. In many instances when probed, volunteers described dealing with these problems directly with families and trying to change attitudes around abuse. It was unclear, however, how well established protocols are for dealing with such child protection issues. While there were only two examples of cases of incest, volunteers described dealing primarily with family in these cases, rather than reporting to authorities.

VI. Conclusion

This study reveals that volunteers working with vulnerable children make care-based decisions based on information collected primarily through household visits. Volunteers, regardless of CSI use, describe an assessment and prioritization process for addressing needs, but volunteers using CSI articulated how CSI scores triggered responses and helped prioritize needs for a specific child or across groups of children. Those using the CSI find the tool useful for assessing comprehensive needs of children and a platform for monitoring children's status over time. Most volunteers like the CSI tool the way it is, but recommend having supportive documentation for clarifying CSI scores (particularly nutrition) and indicating how to respond to scores.

This study demonstrates that volunteers act autonomously to provide basic health education, services, and referrals, but heavily rely on co-volunteers and in some cases programs to make decisions on more challenging cases. The informal and formal networks volunteers have among each other provide an additional resource for training and mentoring on service delivery, as well as on use of the CSI. Further, volunteers serve a central role in coordinating services delivery and resources with many community based groups such as village administration, police, schools, churches, hospitals and clinics, victim support units, and others. Despite these strong linkages, volunteers are often faced with challenges with referral networks and meeting the needs of the children and families they serve. There are opportunities to strengthen referral networks and information sharing among community groups and volunteers.

VII. Recommendations

In light of the findings, we provide the following recommendations:

1. Changes made to the CSI tool and accompanying materials should be considered relative to the potential additional work required (e.g., training, new forms) for programs and volunteers.
2. Provide further guidance and explanation on how to score the domains, particularly nutrition. This may be addressed by programs during training, when they work with training participants on how to score the different domains.
3. Ensure volunteers have a way to keep CSI information for individual children so they have a record for the child (e.g., copy of the CSI form, notebook) and a sustained information system from which to provide care and support to a vulnerable child. Ensure

steps are taken to ensure volunteers maintain child confidentiality when they have such notebooks or forms.

4. Work with programs locally to develop supportive documentation that guides volunteers on responses to certain scores, especially low scores (“1” or “2”). This is particularly important for severe health issues like malnutrition and child protection issues.
5. Work with programs to promote linkages between volunteers and existing community based structures — coordinating care and support and information sharing to ensure needs are met in a timely fashion.
6. Given the importance of informal and formal networking among volunteers, encourage support networks among volunteers on how to score and make decisions about taking action for children.
7. Encourage programs to discuss with volunteers how to address situations when referrals/resources are not available in certain domain areas — and how to respond/explain to families when programs/volunteers are not able to meet needs.
8. Projects should consider coordinating with community leadership (chiefs, etc.) to explain and highlight the volunteer role within the community in order to reduce stigma and discrimination faced by volunteers.

Appendix A. Caregiver Individual Data Form

Caregiver Individual Data Form

MEASURE Evaluation is conducting focus groups for a study which aims to understand how caregivers⁹ make decisions about care for orphans and other children made vulnerable by HIV/AIDS¹⁰ and the caregivers' needs for additional job aids and decision support tools. In addition the study aims to document user experiences with the Child Status Index (CSI) and information generated from the CSI, if applicable. The findings of this study will help inform future communication regarding CSI use and how best to further support orphans and other vulnerable children and related programs.

In this interview, I will ask questions about:

1. How care and support decisions are made in programs for orphans and other vulnerable children
2. CSI use
3. Data reporting and information use from the CSI and other tools

This discussion will take about 90 minutes. Your participation in this interview is completely voluntary, and you will not be compensated for your time. You may decline to answer any question that you are not comfortable with. Nevertheless, if you choose to respond, open and sincere responses to the questions will be very much appreciated. If you wish, you may stop participating in this focus group at any point.

Your responses will remain confidential and interviewees will not be associated with particular statements. All interview data will be de-identified prior to analysis and no reference will be made to your name or organization if the report is published.

⁹ Caregiver is defined as community volunteers or workers who provide services to children.

¹⁰ Many programs focus on orphans or other children made vulnerable by HIV/AIDS. However, some countries/programs may have a broader definition and provide services to orphans and other children made vulnerable by other means. For the purpose of this study we will use the definition that each country uses.

Do you have any questions at this time? If you have any questions after our discussion, please do not hesitate to contact the individuals listed below. Do I have your permission to continue? To ensure we have correctly captured your responses, we would like to audiotape this session. The recording will help us remember what was discussed during our focus group today and will not be used for any other purpose. Do I have your permission to audiotape this focus group?

Age: _____

Gender: _____

Education level:

- Less than primary complete
- Primary complete
- Some secondary
- Secondary complete or higher

Organization: _____

Role: _____

How long have you been working as a caregiver with this organization?

What is your current caseload? _____ Children _____ Households

Do you receive any form of payment? ___ Stipend ___ Travel reimbursement ___ Other (please specify): _____

Do you currently use the Child Status Index? Yes / No

What is the total number of trainings you have ever attended on the CSI:

For the last training you attended, what was the total number of days of the training?

For the last training, who conducted the training?

I have read (or been read) the consent form and:

_____ I understand my participation is voluntary. I would like to participate.

_____ I give my permission for this focus group to be recorded. I understand that my comments will be used in the study, but that I will not be identified.

_____ I understand that if I have questions about the study, I can contact the study coordinators at either mcannon@futuresgroup.com OR esnyder@futuresgroup.com or I can call [XX from my program](#)

Appendix B. Focus Group Guide for CSI Users

Focus Group Discussion Guide - CSI Users

Number of participants: _____

Name of the country: _____

Name of the community: _____

Is the community considered urban OR rural (circle one).

Name of the Organization: _____

Name of the focus group facilitator (full name): _____

Date of the focus group discussion: _____

Information to Share with Participants

Hello, my name is XXX and I am working with MEASURE Evaluation on a study which aims to understand how caregivers¹¹ like yourselves make decisions about care and support for orphans and other children made vulnerable by HIV/AIDS¹² that your program serves and your needs for additional job aids and decision support tools. In addition the study aims to document user experiences with the Child Status Index (CSI) and information generated from the CSI. The findings of this study will help inform future communication regarding CSI use and how best to further support orphans and other vulnerable children and related programs.

In this interview, I will ask questions about:

1. How care and support decisions are made in programs for orphans and other vulnerable children
2. CSI use

¹¹ Caregiver is defined as community volunteers or workers who provide services to children.

¹² Many programs focus on orphans or other children made vulnerable by HIV/AIDS. However, some countries/programs may have a broader definition and provide services to orphans and other children made vulnerable by other means. For the purpose of this study we will use the definition that each country uses.

3. Data reporting and information use from the CSI and other tools

This discussion will take about 90 minutes. Your participation in this focus group is completely voluntary, and you will not be compensated for your time. You may decline to answer any question that you are not comfortable with. Nevertheless, if you choose to respond, open and sincere responses to the questions will be very much appreciated. If you wish, you may stop participating in this focus group at any point.

Your responses will remain confidential and interviewees will not be associated with particular statements. All interview data will be de-identified prior to analysis and no reference will be made to your name or organization if the report is published.

Do you have any questions at this time? If you have any questions after our discussion, please do not hesitate to contact the individuals listed on the individual data sheet we shared at the beginning of the meeting. Do I have your permission to continue?

To ensure we have correctly captured your responses, we would like to audiotape this session. The recording will help us remember what was discussed during our focus group today and will not be used for any other purpose. Do I have your permission to audiotape this focus group?

Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. You probably prefer that your comments not be repeated to people outside of this group. Please treat others in the group as you want to be treated by not telling anyone about what you hear in this discussion today. Let's start by going around the circle and having each person introduce herself. (Members of the research team should also introduce themselves and describe each of their roles.)

NOTE TO FACILITATOR: Start audio recording as soon as introductions are complete to protect interviewee anonymity.

1. All of you here have a role in supporting orphans or other vulnerable children. We'd like to hear more from you about what your work involves. Please explain your role in working with these children. [What, if any, is your role in linking children with services? Explain any involvement you have in providing services to children. Please describe any interaction you have with the family.]

2. Tell us about what motivates you to do this work? [How does this role fit into your career path? How do your past personal experiences affect your desire to work with children? How is your status in the community affected by this role/job?]

3. How were you trained for this role? [Number of days of training? How long have they been working with these children? Years of experience?]

4. How do you gather information about the children's care and support needs? [What forms/job aides/forms do you use? How do you record the information (notebooks, memory or recorders, etc.)? Once you have the information, what do you do with it? e.g. Do you report it and if so, to whom? Do you keep a copy?]

5. How do you decide what care and support orphans and other vulnerable children need? [Do you make these decisions independently, with input from others in your organization or with community involvement? Do the different service areas (health, education, psychosocial, food/nutrition, shelter, or protection) affect how decisions are made? Does the level of risk to the child affect how decisions are made?]

6. How do you keep track of each child's needs or services? [Are you able to track their progress over time? What challenges do you have doing this? What works well?]

7. Describe how confident you feel making decisions / recommendations about care for the children you work with? Please explain [What areas are challenging? Do you need a tool? How helpful was your training?]
8. What other information or materials would help you better provide / prioritize services for the vulnerable children you work with? [Additional data or information? Protocols or guidance? Different forms?]
9. If you use the Child Status Index, give us an example of how you use the CSI with vulnerable children? *Note: we do not need/want the names of specific children* [Tell us what you do when a child scores a “1”? Are there protocols from your organization? Does your response differ based on the service area (health, education, psychosocial, food/nutrition, shelter, or protection)?]
10. [If not already discussed] Describe how you use the information gained from using the CSI? [How is it used to make decisions about providing care/support? If it is not used, why? Explain how, if at all, the information is used to follow-up with specific children?]
11. Describe how confident/comfortable you feel using the CSI. [What areas are challenging? How helpful was your training? Do you receive support and supervision?]
12. When you have a question about how to do your job, who do you ask for help? [If you have a question about how to use the CSI tool who do you ask? If you have trouble scoring a child what do you do? If you are unsure how to provide support or care for a child, what do you do?]

Describe how the CSI could be made more useful to you? [How could it be more useful for decision making? Improvements to the layout, pictures, directions?]

Appendix C. Focus Group Guide for CSI Nonusers

Focus Group Discussion Guide – Non-Users

Number of participants: _____

Name of the country: _____

Name of the community: _____

Is the community considered urban OR rural (circle one).

Name of the Organization: _____

Name of the focus group facilitator (full name): _____

Date of the focus group discussion: _____

Information to Share with Participants

Hello, my name is XXX and I am working with MEASURE Evaluation on a study which aims to understand how caregivers¹³ like yourselves make decisions about care and support for orphans and other children made vulnerable by HIV/AIDS¹⁴ that your program serves and your needs for additional job aids and decision support tools. In addition the study aims to document user experiences with the Child Status Index (CSI)¹⁵ and information generated from the CSI, if applicable. The findings of this study will help inform future communication regarding CSI use and how best to further support orphans and other vulnerable children and related programs.

¹³ Caregiver is defined as community volunteers or workers who provide services to children.

¹⁴ Many programs focus on orphans or other children made vulnerable by HIV/AIDS. However, some countries/programs may have a broader definition and provide services to orphans and other children made vulnerable by other means. For the purpose of this study we will use the definition that each country uses.

¹⁵ O'Donnell K, Nyangara F, Murphy R, Nyberg B. Child Status Index. A Tool for Assessing the Well-Being of Orphans and Vulnerable Children—MANUAL. Chapel Hill, NC: MEASURE Evaluation; 2009. Child Status Index is a tool developed to “assess the current needs of a child, monitor improvements in specific dimensions of child well-being, and identify areas of concern that can be served by program intervention.”

In this interview, I will ask questions about:

1. Decision making in programs for orphans and other vulnerable children
2. CSI use
3. Data reporting and information use from the CSI and other tools

This discussion will take about 90 minutes. Your participation in this focus group is completely voluntary, and you will not be compensated for your time. You may decline to answer any question that you are not comfortable with. Nevertheless, if you choose to respond, open and sincere responses to the questions will be very much appreciated. If you wish, you may stop participating in this focus group at any point.

Your responses will remain confidential and interviewees will not be associated with particular statements. All interview data will be de-identified prior to analysis and no reference will be made to your name or organization if the report is published.

Do you have any questions at this time? If you have any questions after our discussion, please contact the individuals listed on the individual data sheet we shared at the beginning of the meeting. Do I have your permission to continue?

To ensure we have correctly captured your responses, we would like to audiotape this session. The recording will help us remember what was discussed during our focus group today and will not be used for any other purpose. Do I have your permission to audiotape this focus group?

Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. You probably prefer that your comments not be repeated to people outside of this group. Please treat others in the group as you want to be treated by not telling anyone about what you hear in this discussion today. Let's start by going around the circle and having each person introduce herself. (Members of the research team should also introduce themselves and describe each of their roles.)

NOTE TO FACILITATOR: Start audio recording as soon as introductions are complete to protect interviewee anonymity.

1. All of you here have a role in supporting orphans or other vulnerable children. We'd like to hear more from you about what your work involves. Please explain your role in working with these children. [What, if any, is your role in linking children with services? Explain any involvement you have in providing services to children. Please describe any interaction you have with the family.]
2. What motivates you to do this work? [How does this role fit into your career path? How do your past personal experiences affect your desire to work with children? How is your status in the community affected by this role/job?]
3. How were you trained for this role? [Number of days of training? How long have you been working with these children? Years of experience?]
4. How do you gather information about the children's care and support needs? [What forms/job aides/forms do you use? How do you record the information (notebooks, memory or recorders, etc.)?]
5. Once you have the information, what do you do with it? [Do you report it and if so, to whom? Do you keep a copy? Does it help you do your job? If so, how? If not, why not?]
6. How do you make decisions about what care and support orphans and other vulnerable children need? [Do you make these decisions independently, with input from others in your organization or with community involvement? Do the different service areas (health, education, psychosocial, food/nutrition, shelter, or protection) affect how decisions are made? Does the level of risk to the child affect how decisions are made?]

7. Describe how confident do you feel making decisions / recommendations about care for the children you work with? Please explain [What areas are challenging? Do you need a tool? How helpful was your training?
8. When you have a question about how to do your job, how do you get help? [If you have a question about how to use a tool who do you ask for help? If you are unsure how to provide support or care for a child, what do you do?]
9. How do you keep track of each child's needs or services? [Are you able to track their progress over time? What challenges do you have doing this? What works well?]
10. What other information or materials would help you better provide / prioritize services for the vulnerable children you work with? [Additional data or information? Protocols or guidance? Different forms?]
11. Have you ever heard of the Child Status Index? YES NO
Have you ever used the CSI? YES NO

Please tell us about any experience you have using the CSI. [How was it useful? How was it not useful? If the organization you worked for stopped using the CSI, why did they stop?]

Appendix D. Committee Chair Interview Guide

Committee Chair Interview Guide

Hello, my name is XXX and I am working with MEASURE Evaluation on a study which aims to understand how caregivers¹⁶ make decisions about care and support for orphans and other children made vulnerable by HIV/AIDS¹⁷ and the need for additional job aids and decision support tools. In addition the study aims to document user experiences with the Child Status Index (CSI)¹⁸ and information generated from the CSI, if applicable. The findings of this study will help inform future communication regarding CSI use and how best to further support orphans and other vulnerable children and related programs. The purpose of this interview is to learn about decision making for these children at the community level.

In this interview, I will ask questions about:

1. The role/function of your community committee
2. Decision making for orphans and other vulnerable children
3. CSI use
4. Data and information use from the CSI and other tools

This discussion will take about 30 minutes. Your participation in this interview is completely voluntary, and you will not be compensated for your time. You may refuse to answer any question that you are not comfortable with. Nevertheless, open and sincere responses to the questions will be very much appreciated. If you wish, you may stop this interview at any point.

¹⁶ Caregiver is defined as community volunteers or workers who provide services to children.

¹⁷ Many programs focus on orphans or other children made vulnerable by HIV/AIDS. However, some countries/programs may have a broader definition and provide services to orphans and other children made vulnerable by other means. For the purpose of this study we will use the definition that each country uses.

¹⁸ O'Donnell K, Nyangara F, Murphy R, Nyberg B. Child Status Index. A Tool for Assessing the Well-Being of Orphans and Vulnerable Children—MANUAL. Chapel Hill, NC: MEASURE Evaluation; 2009. Child Status Index is a tool developed to “assess the current needs of a child, monitor improvements in specific dimensions of child well-being, and identify areas of concern that can be served by program intervention.”

Your responses will remain confidential and no particular individual will be associated with an individual statement. All interview data will be de-identified prior to analysis and no reference will be made to your name if the report is published.

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

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

Name of the country: _____

Name of the community: _____

Is the community considered urban OR rural (circle one).

Name of the committee: _____

Purpose of the committee: _____

Name of the interviewer (full name): _____

Date of the interview: _____

I have read (or been read) the consent form and:

_____ I understand my participation is voluntary. I would like to participate.

_____ I give my permission for this interview to be recorded. I understand that my comments will be used in the study, but that I will not be identified.

_____ I understand that if I have questions about the study, I can contact the study coordinators at either mcannon@futuresgroup.com OR esnyder@futuresgroup.com

1. What is the role of your committee within the community for orphans and vulnerable children and related programs? [What is the purpose of the committee? What function(s) does it serve? Does it have authority to make decisions related to these children? Does it advise on decisions for the children?]
2. When was your committee established? Was it established by government mandate? How does this committee work together with the community? With local government? Local programs??
3. Who do the members of the committee represent? E.g. government, schools, NGOs? [Are members elected or appointed or volunteers?] What is your role in the committee?
4. How long have you been involved in the committee?
5. How does the community decide what support or services a child needs? [Give a recent individual child case example (no names) and a recent example of a decision at the community level.]
6. What is the relationship between your committee and the group of workers who provide support to vulnerable children? [Do you meet regularly? Do you coordinate? How do you engage with community caregivers to make decisions about the vulnerable children in the community? Do they share information with you? If so, what types of information?]
7. How does your community keep track of each child's needs / services? [Are you able to track their progress over time? What challenges do you have doing this? What works well?]
8. Have you ever heard of the Child Status Index? Tell me what you know about it. [Is it used in this community that you know of? Is it used to make decisions about care and support for children by your committee? How? Is it helpful? Are there limitations? What could be improved?]
9. What additional data/information does your committee need to help you make care and support decisions about the vulnerable children in your community?

10. Tell me about the referral process in your community. [For example, if a caregiver finds a child with a need that she cannot meet, where does she go to find support for the child? How does the process work?]