MANUAL – SECOND EDITION - 2013

Child Status Index

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A tool for monitoring the well-being of children orphaned or otherwise made vulnerable as a result of HIV/AIDS

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About this Document

Welcome to the second edition of the Child Status Index Manual

The *Child Status Index* (CSI) provides a framework for identifying the needs of children and households, creating individualized goal-directed service plans for use in monitoring the well-being of children, and program-level monitoring and planning. As of 2013, the CSI has been used in 16 countries in sub-Saharan Africa, Asia, and Latin America. It has been translated for use in a variety of geographical, linguistic, and cultural contexts. MEASURE Evaluation has conducted two studies of CSI use to understand how the tool is implemented and its utility as a job aid for decision making. These studies have provided useful information that has helped enhance the tool's implementation processes, support materials, and its effectiveness.

While the CSI remains essentially the same, this second edition provides further guidance in key areas, such as training, best practices for using the CSI, and developing plans to respond when CSI scores indicate a need for a child. Insights gleaned from CSI users in the field – both at the program level and care worker level – are reflected in this second edition. The six broad domains of the CSI continue to parallel the domains on the 2006 PEPFAR/OVC guidelines: Food and Nutrition, Shelter and Care, Protection, Health, Psychosocial, and Education and Skills Training. The President's Emergency Plan for AIDS Relief (PEPFAR) updated the OVC guidelines in July 2012. The *Guidance for Orphans and Vulnerable Children Programming* document can be found at http://www.pepfar.gov/documents/organization/195702.pdf.

In this second edition of the *Child Status Index Manual*, you will find:

- A description of the purpose and functions of the *Child Status Index*
- The guiding principles for developing the *Child Status Index*
- Detailed descriptions of domains and factors the tool measures
- Step-by-step instructions for using the *Child Status Index*
- Guidelines for adapting the tool to different cultural settings
- Recommendations for using information generated from the CSI at the child, household, community, and program levels
- Guidelines for training care workers to use the *Child Status Index*

The *Child Status Index* tool kit includes:

- This *Child Status Index Manual (Second edition)*
- The *Child Status Index* and the *CSI Record Form*
- A pictorial version of the *Child Status Index* for low-literacy users
- A quick-reference *CSI Made Easy Guide* for field users of the tool
- The *CSI Training Manual*

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Abbreviations and Acronyms

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

Care worker: A person responsible for assessing children with the *Child Status Index* – often informally called a community worker, community volunteer or field worker.

Executive Summary

A tool to improve service delivery for children who have been orphaned or made vulnerable by HIV/AIDS

Purpose of the *Child Status Index*

The President's Emergency Plan for AIDS Relief (PEPFAR) – through the Office of the Global AIDS Coordinator (OGAC) and USAID Office of HIV/AIDS (OHA) – requested a tool to assess the vulnerabilities and needs of children who have been orphaned or made vulnerable by HIV/AIDS. This tool is used for monitoring the well-being of children, case management, and program planning as part of global initiatives supported by PEPFAR.

To provide appropriate care, service providers need to be able to assess systematically the needs of children and their households – to assess the individual child's status – to guide decision-making about services for children and their households. Before the *Child Status Index* (CSI) was developed, (See Appendix A for the tool) there were limited measures of well-being specific to children affected by HIV/AIDS to support such assessment. While the tool assesses child well-being, the strategies for addressing these needs are most often focused on strengthening the household.

The *Child Status Index* (CSI) was developed to fill this gap. The CSI (Appendix A of this document) provides a framework for identifying the needs of children and households, creating outcome-directed service plans, and for program-level monitoring and planning.

As of 2013, the CSI has been used in 16 countries in sub-Saharan Africa, Asia, and Latin America. It has been translated for use in different geographical, linguistic, and cultural contexts. MEASURE Evaluation has conducted two studies of CSI use to improve and enhance the tool's implementation processes, support materials, and its effectiveness in the field.

Developed Through a Community Participatory Process

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

A Targeted and Child-Centered Assessment Strategy

The resulting tool, the *Child Status Index* (CSI), is a child-centered assessment strategy that addresses the areas of a child's life endorsed by guardians, children, and other experts as most indicative of the child's relative well-being and vulnerability. The 12 factors of the *Child Status Index* were chosen because they can be measured on an inferential scale and could potentially be changed by program interventions directed at the child or, most often, at the family/household. Unlike many assessments, the CSI yields information that is child- and household-specific and can be used to develop tailored intervention plans for individual children and families. The factors also enable a care worker to identify an urgent or emergency need for the child or family.

Field-Tested for Inter-rater Reliability and Construct Validity

The CSI was successfully field tested in Kenya and Tanzania for inter-rater reliability and construct validity. In Malawi, the CSI has been compared to a child self-report using the Orphan Well-Being Tool (OWT), and the results indicated high consistency between the CSI ratings and the child self reports on the OWT (Senenfeld *et al.*, 2011).[i] Another study conducted in Malawi showed that using items derived from internationally standardized, population-based survey tools did not compare favorably with some of the CSI factors (Sabin *et al*., 2011;[ii] Foreit *et al*.,[iii] 2012; Sabin *et al*., 2012).[iv] This study demonstrated yet again the importance of a community-led approach to produce community-founded tools such as the CSI aimed at assessing the specific needs of target families and children and monitoring their well-being as opposed to using pre-determined measures.

MANUAL

Child Status Index

A tool for assessing the well-being of children orphaned or made vulnerable by HIV/AIDS

Chapter 1. Introduction to the Child Status Index

Scenario—Why Is This Tool Important?

The Challenge

The HIV/AIDS pandemic brought a dramatic increase in the number of children orphaned or otherwise made vulnerable by the disease (Children on the Brink, 2004).[v] An estimated 16.6 million children have had at least one parent die from HIV/AIDS, and 90 percent of these children live in sub-Saharan Africa, the area most affected by the disease (UNAIDS Report on the Global Epidemic 2010).[vi] Despite progress in global identification and treatment in HIV/AIDS in adults, the numbers of children affected by the disease is still increasing.

Millions more children in HIV-affected communities are vulnerable because their parents are too ill to provide needed care, or they live in poor communities and households that have absorbed orphans, or they are stigmatized by having HIV/ AIDS in their family (Andrews *et al.*, 2006).[vii]

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

The Response

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

The United States government and other donor organizations are working with local communities, grassroots organizations, non-governmental organizations (NGOs), faith based organizations (FBOs), community based organizations (CBOs), and governments of countries with a high prevalence of HIV/AIDS to implement programs of care and support for these children, to reduce the risks they face, to improve their health and well-being, and to give children a reason to hope for a good future. During the past decade, more than $2 billion dollars of PEPFAR support has targeted global efforts for orphans and children vulnerable because of HIV/AIDS.

The Intended Beneficiaries of these Programs

According to the July 2012 PEPFAR document, *Guidance for Orphans and Vulnerable Children Programming*, and as set forth in the Hyde-Lantos Act of 2008, the intended beneficiaries of PEPFAR programs include children who have lost a parent to HIV/AIDS, are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects.

The Hyde-Lantos Act further states that PEPFAR strategies should be guided by an analysis of (1) factors that contribute to children's vulnerability to HIV/AIDS and (2) vulnerabilities caused by the impact of HIV/AIDS on children and their families.

The legislation also stipulates the need, in areas of higher HIV/AIDS prevalence, to promote a community-based approach, maximizing community input into determining which children participate.

The Importance of Monitoring and Evaluation

Given the importance of support for these most vulnerable children, programs have needed tools for monitoring and evaluating their efforts, in particular for documenting and tracking the well-being of individual children and their families. In many cases, M&E tools have been limited to counting activities and numbers of children served instead of assessing child well-being and individual and community needs – and mapping services and programming accordingly.

Programs have traditionally been monitored using summary-level information (e.g., how many children received assistance) or discrete indicators (e.g., a change in school attendance) – neither of which accurately captures the whole of an individual child's life.

The CSI Within the Information Needs Framework

Programs for orphans and vulnerable children gather information on several levels – individual child, household, program, population – to meet the information needs of a diverse group of stakeholders. Key information needs may include:

- **Targeting** – Identifying vulnerable children and households requiring assistance in a target locality
- **Case Management** – Planning resource provision that addresses the individualized needs of vulnerable children and their households
- **Monitoring** – Documenting the extent to which the program is being implemented as planned, on schedule, and to quality standards
- **Evaluation** – Documenting if and to what extent program components have had an impact on children and households
- **Program planning** – Determining important characteristics and needs of children and families who have been registered by a local program

The CSI was first envisioned as a tool to serve multiple information needs. In the first five years since it was introduced, the CSI was implemented in more than 16 low- and middle-income countries, translated into multiple languages, and became the focus of several studies (Cannon & Snyder, 2012;[viii] Cannon & Snyder, 2013).[ix] We now have a better understanding of how the CSI best fits into the M&E framework.

The CSI is not recommended for use in targeting.

The process of targeting involves identifying the most vulnerable children and households that would benefit most from program assistance. The CSI is of limited support in targeting because:

- Programs may find it more feasible to have general criteria for inclusion in a program rather than undertaking a needs assessment for each child.
- The level of engagement required by the CSI may lead to expectations of action or service enrollment that may not be forthcoming for all children included in the selection process.
- It is not appropriate to make targeting decisions using aggregate scores across CSI factors, as these factors are not intended to be analyzed that way.
- Evidence from community volunteers/caregivers indicates that it is difficult to get completely accurate CSI scores the first time the CSI is used.

A primary use of the CSI is case management.

The CSI may be most useful as a case management tool for serving highly vulnerable children and families. The CSI provides a consistent and individualized method for assessing a child's status and well-being to guide decision making about services for the child and household. Furthermore, with repeated administration, the tool enables volunteers and programs to follow up on the status of children and ensure services are being effectively delivered to the child and household. The CSI factors are child-centered, but often the best strategy for addressing areas of a child's need may be by supporting the family.

The CSI can be used for monitoring.

Similar to its value for case management, the CSI, as a component of the M&E framework, can offer important information for program monitoring. The CSI *Child Status Record* sheet provides simple monitoring information about the kinds of services provided and changes in child and household needs over time.

The CSI is not recommended for evaluation purposes.

Since the CSI requires users to identify children's needs and status relative to their local community, it cannot be used as an indicator or comparator for national or multi-country standards. Broad evaluation of the impact of a regional or national program on child well-being usually requires several considerations and multiple approaches.

For broader evaluation purposes, USAID and MEASURE Evaluation are developing a standard program evaluation tool for programs that work with vulnerable children. This tool will include a sample protocol and accompanying household and child instruments for use. This *OVC Program Evaluation Tool Kit* is available on the MEASURE Evaluation website: http://www.cpc.unc.edu/measure/our-work/ovc/ovc-program-evaluation-tool-kit

The CSI is appropriate for program planning.

Programs may make use of local CSI data for program planning by aggregating CSI ratings on individual factors in their local service provision area. This information may help a program decide that one or two factors represent the overall greatest needs in its catchment area. For example, knowing that many children are able to go to primary school but few have access to health care will inform an organization about where to focus funds and support.

The holistic, easy-to-use CSI is a step toward systematically monitoring how programs determine child and household needs and how they plan difference in children's lives and improve field-level practices and services.

Description—What Does This Tool Do?

The CSI provides meaningful data about improving the status of orphans and others made vulnerable by HIV/AIDS, their caregivers, and households through individualized child assessment, service planning, and program provision.

Assessment of Child Needs and Well-being

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

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

The CSI as a High-Inference Tool

The *Child Status Index* was developed as a *high inference* tool (McKenzie, 1994),[x] meaning it requires an observer to make inferences or conclusions based on direct observations and interviews with guardians, children, and community members – and rate each factor on a four-point scale.

This approach collects meaningful information about a child and household in a community context. This type of assessment is frequently used in studies of school environments and teacher effectiveness (Chavez, 1984),[xi] and in anthropological information gathering (White, 1990).[xii]

Many of the CSI interview questions and observations address concepts, such as happiness and performance, that require combining sources of information and making judgments based on the information. The design of the CSI facilitates community workers making inferences from multiples sources of information in a reliable and valid manner.

Benefits of the CSI in Broader Context

More broadly, using the CSI within the context of a program has added benefits. In many arenas, the CSI has introduced a method for building broad consensus on the best ways to serve children through these additional functions:

- CSI use **serves a rapport-building function** in that it supports care workers in asking introductory and open-ended questions of a caregiver and child. The process involves direct engagement of household members in understanding and communicating their needs, making the care workers welcome in the household. The approach offers the care worker a consistent way of thinking about a child in factors that facilitate careful consideration of the child's individual needs and decisions about services.

- The CSI **orients care workers to the holistic needs of vulnerable children**, helping those who provide resources and services in limited domains (e.g., psychosocial support) recognize needs in other previously unaddressed areas that contribute to the child's overall well-being.

  Repeat observations allow care workers to consider the multiple influences on observed changes (e.g., benefits of service, change in family income, natural disaster). The assessment may also encourage referrals to other agencies and community-based organizations, where necessary, to address needs outside the range of services in one organization, thereby providing a system of care for the child.

  In general, the CSI can raise awareness among frontline staff (such as community health workers and caregivers) about the multiple dimensions of child well-being, to help them understand and address these areas routinely in their work. The CSI process also motivates the care worker and organization to develop services and intervene in the identified area of individual child and household need.

- The CSI **promotes an individualized approach for programs** working with vulnerable children. As a result, the services and resources provided are more likely to address the specific needs of one or more children living in a household instead of providing all program recipients with the same services. The approach lends itself to identifying an appropriate course of action or intervention for a child and household – an individualized care plan based on information about child well-being over time.

- The CSI **helps programs focus on** whether an individual child or children in a community are achieving **desired outcomes** (e.g., child is attending and succeeding in school) rather than only monitoring inputs (e.g., provision of educational supplies). In addition to improving program planning, this information can support advocacy for resources and improvements in service quality.

  CSI scores that increase or decrease call for further assessment of the influences that led to change, such as program quality, changes in the child or family situation, and/or change in the child's living environment. With this information, decision makers can plan, implement and modify child services based on information about child well-being over time.

- CSI assessments provide a tool to **help trained care workers/caregivers identify urgent situations**. For example, a score of "1" in any factor requires immediate attention. As is true for any intervention context, if an urgent situation is identified, it cannot ethically be ignored by the organization gathering the data.

  Examples of urgent circumstances include when a child is very sick and not receiving medical care, abused or neglected by a caregiver, exploited in a variety of ways (child labor), excluded from school, or when a child is in danger of serious harm to him/herself or others.

  Note that the CSI is only one source of information and should be used in conjunction with other information to determine the appropriate urgent response. The needed response is determined by local guidelines for responding to urgent cases, to be appropriate for the local standard of care. Such guidelines should be included in the training of CSI users, so that each user knows how to respond when confronted with an urgent situation.

Audience – Who Would Use This Tool?

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

The CSI was designed primarily for use by care workers and other field personnel working directly with children and their families, but it can also be useful to guide program decisions as well as community policies. Table 1 shows examples of how the CSI could be used by different user groups.

Table 1. How Different Stakeholders Would Use the CSI

This type of user…	Could use the CSI to…
Care workers	Identify individual needs of vulnerable children and households. Replace or supplement hand-written notes to record systematically such information. Assist with making care decisions for individual children and households.
Leaders of local committees working to address children's needs	Provide consistent information on the needs of vulnerable children and households in their community and assist with decision making.
Monitoring and evaluation (M&E) staff	Systematically track changes on individual CSI factors (improvements and losses) for children receiving support from their organizations within the local context.
Local organizations	Identify the needs for a child, household, or community and use the information to develop appropriate program priorities.
Leaders of guardian committees (caregiver groups)	Document for themselves the needs of children in their care and for whom they advocate.
Caregivers/guardians	Share child well-being information with others to advocate for specific needs and understand children's needs and progress under their care.
Other service providers (e.g., donors, community organizations, other partners)	Align their activities with changing needs, and lobby effectively for additional resources.

Timing – When Is the CSI Used?

When the CSI is used is determined by service programs and community advocates – and depends on how the information will be used, the capacity of the organization or community conducting the assessment, resources, and the timeframe in which a child may be expected to experience change among factors.

There is no strict rule regarding how often the CSI should be applied. The frequency of use should be programmatically useful. For example, the CSI can be used at the following times:

- If the CSI is being used at the start of a program, it can identify areas of need most in common for a community of children.
- If the CSI is being used as a case management tool, then quarterly to semi-annual application may be appropriate.
- If the CSI is being used to assess a child's progress over time on specific factors, then every six, 12 or even 24 months may be sufficient.

In all cases, factors rated as "urgent" should have close follow-up and not be postponed until the next scheduled visit.

Chapter 2. Domains and Factors of the *Child Status Index*

Attributes of child well-being measured by the tool

The six broad domains of the CSI parallel the domains on the 2006 PEPFAR/OVC guidelines: Food and Nutrition, Shelter and Care, Protection, Health, Psychosocial, and Education and Skills Training. For each domain, there are two factors that:

- Are identified and endorsed as areas of concern,
- Affect the status of the domain,
- Can potentially be changed by providing services and resources, and
- Identify urgent situations for the child or household.

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

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

Each of the 12 factors is rated on four levels of well-being. Higher scores indicate better child and household status in that area. In assigning a rating for a factor, the care worker should use information from multiple respondents and observations during the home visit. Further clarity about scoring can be found in the Training section of this manual.

Each of the 12 factors is rated on a numerical scale from 1-4.

4 = Good The child's status or situation is good; there are no concerns and no apparent risk for the child in this factor.

3 = Fair The child's status or situation is generally acceptable, but there are some concerns on the part of the caregiver or care worker. Additional resources might be helpful, if available.

2 = Bad There is concern that the child's status or situation on this factor is observably not good. Additional resources or services are needed.

1 = Very bad The child is at serious risk on this factor. Urgent attention to the child or the situation may be needed.

2.1 Domain 1—Food and Nutrition

Does the child have adequate and secure sources of food at all times of the year?

Child Status Index Factor 1A: Food Security

Goal

The child has sufficient and nutritious food at all times of the year to grow well and to have an active and healthy life.

Definition

The ability of the household or institution to obtain and provide enough food for the child. This food should be obtained through socially acceptable ways, without resorting to emergency food supplies, scavenging, begging, stealing, or other coping strategies.

Why This Factor is Important

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

In the case of the loss of a head of household through illness or death, child vulnerability to hunger and malnutrition is known to increase. Crop production is reduced by as much as 50 percent when the head-of-household dies (Birdthistle, 2004).[xiv] When families take in additional children when other members are sick or die, the same supply of food may need to be spread across a larger number of people. In some instances, hunger increases for all family members.

Makame and colleagues reported that orphans talk about lacking food at home, being hungry at school, and going to bed hungry (Makame *et al.*, 2002).[xv] In Zimbabwe, almost 25 percent of older orphans interviewed for one study reported that they did not have enough food to eat several times a week or more (Gilborn *et al.*, 2001).[xvi]

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

Poor nutrition affects multiple aspects of child well-being. Protective factors that mitigate the damaging effects of severe malnutrition include diverse food intake and receipt of a government-funded child support grant. Conversely, hungry children may steal food and be labeled as delinquent (e.g., Foster *et al.*, 1997),[xviii] resort to substance abuse to alleviate hunger, or engage in sex work to gain funds for food.

Food supplementation is one of the core services frequently provided by local services, but food supplements can be inconsistent and vulnerable to changes in funding. In addition, food security fluctuates according to crop seasons, particularly corn/maize in harvest season versus "hungry" seasons, and is affected by environmental conditions, such as drought or flood.

Gathering Information to Rate This Factor

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

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

Sample questions

- What does the family/child eat?
- How does this household/institution get the food?
- Tell me about times when there is no food.
- Does this child complain of hunger?
- How can you tell this child is hungry?
- (Ask child) What did you have to eat yesterday?

Observations

The rater also might observe the granary (where harvested foods from the farm, such as maize, are stored). If the granary is empty, the care worker can begin a conversation about the year's harvest and whether the crop is sufficient to sustain the family all year. One may also observe the types of foods available (e.g., kitchen, garden, fruit trees, banana plantation, livestock).

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

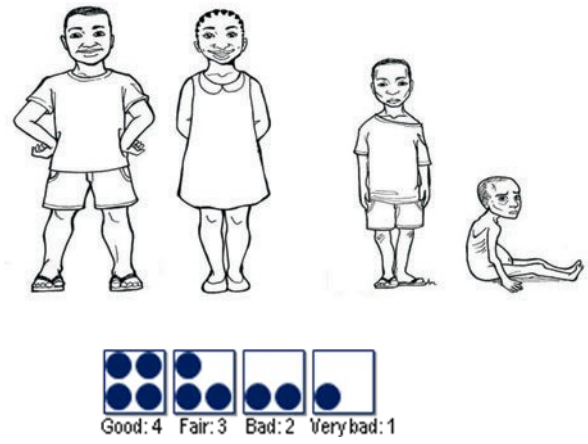
Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

Child Status Index Factor 1B: Nutrition and Growth

Goal

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



Why This Factor Is Important

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

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

However, child growth has been slow to emerge as a priority outcome area, perhaps because there is such widespread food insecurity in resource-poor areas. It has also been difficult to monitor, because care workers find it difficult to carry equipment, such as heavy scales. Local workers often do not readily make meaning of the resulting anthromorphic measurements, such as weight for age or weight for height relative to other children in the local area.

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

Gathering information to rate this factor

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

However, for the CSI, growth is intentionally assessed from observations and from the care workers' comparisons with other local children the same age. The care worker observes the child and/or discusses with the guardian or parent how the child's growth (weight and height relative to age) compares to children of the same age and gender group in the most local area.

A care worker may receive conflicting information – for example, the guardian is not concerned about the child's height or weight, but the care worker's observation indicate the child is undernourished relative to other children in this area. In this case, care workers have to rely on their best judgment; and if they think the child is in need, rate accordingly.

Compared to statistical measures, this inferential assessment may have more immediate meaning to the care worker, guardian, or program. When direct measures are available, the observational rating can add to other information about the child's nutritional status.

Sample Questions

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

Observations

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

> It is critical that people using the *Child Status Index* be trained to respond according to local guidelines for responding to suspected cases of extreme malnourishment. It is imperative that the person administering the CSI is aware of the local standards for care in these circumstances.

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

2.2 Domain 2—Shelter and Care

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

Child Status Index Factor 2A: Shelter

Goal

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

Definition

Shelter describes the physical place or structure of the home or institution where the child lives and the extent to which the structure provides security, comfort and protection from weather.

Stability is defined in terms of living in the same place for at least the past six months.

Why This Factor is Important

Adequate housing is associated with a child's social, emotional, physical, and overall well-being and development (Horizons, 2003).[xx] Many vulnerable children, especially orphans, face unique obstacles in this regard. They tend to live in poorer households and in less adequate main dwellings (Nyamukapa *et al.*, 2003).[xxi]

Studies about vulnerable child housing often use employment and the income of head-of-household as proxy indicators of poor living conditions or household adversity. Inadequate housing has been found to be especially the case for paternal orphans (Case *et al.*, 2004),[xxii] and this may or may not be related to inadequate legal protection from land grabbing.

Other investigators found that orphans describe themselves as less content with their living conditions than non-orphans in the same community (Atwine *et al.*, 2005).[xxiii] In two cities in Zimbabwe, half of the children living on the street without any consistent shelter were identified as orphans, more than twice the proportion of orphans in the general population. A majority of these street children (56 percent) were double orphans (Mawoneke *et al.*, 2001).[xxiv]

Orphaned children living with family or community members often receive less adequate care than others in the households. These children sometimes sleep in a different and less adequate place than other children in the household or do not have mattresses or mosquito nets when other members of the household do. These examples may reflect stigma or discriminatory views related to HIV/AIDS and should also be documented under Factors 3A and 3B that cover child protection.

Gathering Information to Rate This Factor

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

The rating of adequacy of shelter includes two concepts:

- Adequacy of the shelter itself for all household or institutional members; and
- Adequacy and stability of the living arrangement specifically for the vulnerable child.

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

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

Sample Questions

- Where does the child live?
- Where does he/she sleep?
- Is this house or institution adequate or in need of repairs? What kind of repairs?
- Has the child had to move frequently?
- (Ask child) Where do you sleep?

Observations

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

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

Child Status Index Factor 2B: Care

Goal

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

Definition

The child's care is seen as good when there is an identified adult (parent or guardian) who provides the child with a stable, nurturing, and emotionally secure environment.

The relationship between the child and the caregiver should provide physical and psychological security for the child. This factor captures how committed the caregiver is to the child and to his/her involvement with the child.

Why This Factor is Important

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

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

The provision of loving care may be as important as food security – and perhaps even more important (e.g., Bowlby, 1980;[xxv] Bowlby, 1982;[xxvi] Suomi *et al.*, 1976).[xxvii] In studies in Western countries, the lack of loving care is associated with negative child outcomes, including learning problems, mood disorders (such as depression), and behavior disorders (such as disobedience and delinquency). Children become especially vulnerable when their mothers and/or fathers or other guardians die or are so sick they cannot provide consistent care.

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

Gathering Information to Rate This Factor

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

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

The care worker can ask about the guardian’s availability. The adult’s presence may be limited by illness or extensive work hours – and as a result, a caregiver may know little about what is going on in the child’s life. Conversely, there may be an adult caregiver living in an adjacent dwelling who actually does provide consistent care for the child. It is important to ask who is responsible for the child as well as to whom does the child go when hurt, sad, or sick.

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

Sample Questions

- Who is the most important adult in this child’s life?
- Who takes care of this child?
- How long has he/she been the most important adult in the child’s life?
- Does this person plan to care for the child as long as needed?
- When something exciting or fun happens, whom does the child tell?
- Who does the child go to when hungry?
- Who does he/she go to if sad?—or talk to about worries?
- Who does he/she go to if hurt?
- What does the adult do for the child if he/she is sick or hurt?
- (Ask child) Who takes care of you?
- (Ask child) Who loves you?

Observations

When possible, observe the adult caregiver’s interactions with the child. Does the adult seem to know the child well? Does the adult speak of the child in positive ways? Does this adult or someone else feel responsible for this child? Does the child seem to feel happy and safe around the caregiver? Is this child on his/her own, without adult care?

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

2.3 Domain 3—Child Protection

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

Child Status Index Factor 3A: Abuse and Exploitation

Goal

The child is safe from any abuse, neglect, or exploitation.

Definition

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

Child abuse and/or maltreatment could include:

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

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

Why This Factor is Important

Maltreatment of orphaned as well as other children is commonplace in high-prevalence HIV/AIDS areas. A total of 14,239 mothers in six nations (including Brazil, Chile, Egypt, India, Philippines, and the United States) were interviewed over a five-year period about their child discipline practices. Across income categories, 55 percent of mothers acknowledge using physical discipline, including "spanking." More extreme forms of punishment ranged from 55 percent to 89 percent for moderate physical punishment and 1 to 39 percent for harsh discipline with behavior consistent with physical maltreatment (Runyan *et al*., 2010).[xxviii] Research indicates that orphaned children may be even more vulnerable to maltreatment. Findings from a community study based sample in five resource-poor counties revealed that about 76 percent of orphaned children reported being hit, kicked, or beaten at home (Whetten *et al*., 2011).[xxix]

Without the safety provided by a loving and committed caregiver, girls in particular are vulnerable to exploitation, such as coercive and commercial sex and unwanted and early marriage and pregnancy (Gilborn, 2002)[xxx] – "underage girls are married to get the bride price" (interview with community member in Foster *et al*., 1997, p. 3)[xxxi] – or taken advantage of as laborers (Foster *et al.*, 1995).[xxxii]

Despite these reports about the high incidence of child abuse and exploitation, there are few published studies and almost no program models for intervening with child maltreatment in this population of very vulnerable children. Too often, neighbors and friends, as well as care workers, do not know what to do if they observe or suspect that a child is being abused or exploited. For example, in one community the care worker may report a sexual assault case to the police first; whereas in another, it may be first reported to the hospital. It is imperative that the person administering the CSI is aware of the local guidelines.

Gathering Information to Rate This Factor

Child maltreatment can be a difficult and sensitive area for a care worker to assess, for three reasons:

- **Ambiguity of the definition.** Although there is universal legal agreement about child sexual abuse, there can be local and cultural differences in defining "physical abuse" or "neglect." What level of physical discipline is acceptable and what is abuse? What level of work is seen as a child's normal contribution to the household, and what is unacceptable child labor? Again, the care worker must respond according to legal and local guidelines.
- **Need for multiple visits.** Abuse or neglect may not be evident in a single visit. A more accurate assessment may come with time and familiarity with the household or institution plus the opportunity to hear about possible maltreatment from neighbors and others in the community.
- **Disbelief.** It is not uncommon for adults not to believe that a child is being maltreated. These attitudes may arise from a number of sources: rejecting the occurrence of the abuse to avoid feelings of guilt or distress; believing that maltreatment is so out of the ordinary that its occurrence is not possible; blaming the child for supposedly eliciting the abuse; and the inability to confront this type of painful experience due to one's own history of abuse and trauma.

Despite the difficulties in assessment, this factor is included in the CSI because:

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

Some guardians and parents may suspect that their child is being maltreated, and they have not addressed the issue directly because of fear or some other perceived barrier. There are also times that the primary caregiver is maltreating the child, and this becomes a difficult topic for the care worker.

When the adult describes a child in such terms as "devil," "prostitute," "stupid," or in some other very negative way, possible maltreatment should be explored further. The care worker can ask whether anyone in the child's world is concerned about sexual abuse or other exploitation. The interviewer observes whether the child seems to feel safe or afraid with the guardian.

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

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

Sample Questions

- Do you have any worries about this child's safety?
- Has the child been hurt and, if so, how?
- Do you think the child feels safe and secure?
- Does this child help out in the household? In what ways does the child help out?
- Does the child work for anyone outside the household? In what ways does the child work?
- Does anyone else who knows the child worry that he/she is being hurt by someone else? Or sexually abused?
- Do you or anyone else worry that the child may be sexually abused, raped, or touched by adults or older children?

Observations

When possible, observe the child and the situation. Does the child have scars or other signs of physical abuse, such as unexplained burns, bites, bruises, broken bones, or black eyes? Is anyone in the child's world concerned about sexual abuse or other exploitation? Does the child seem to feel safe with the guardian? Does he/she seem to be afraid? If there is concern about maltreatment by the primary caregiver, speak with neighbors or other relatives, if possible, without making the child more vulnerable to punishment.

This domain should reflect the field worker's level of concern about exploitation. The worker is not expected to establish the veracity of actual exploitation, but rather rate his/her judgment or concern and determine further action with his/her work team.

> It is critical that people using the *Child Status Index* be trained to respond according to legal guidelines and local standards of care for reporting and/or intervening in cases of suspected or confirmed child maltreatment.

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

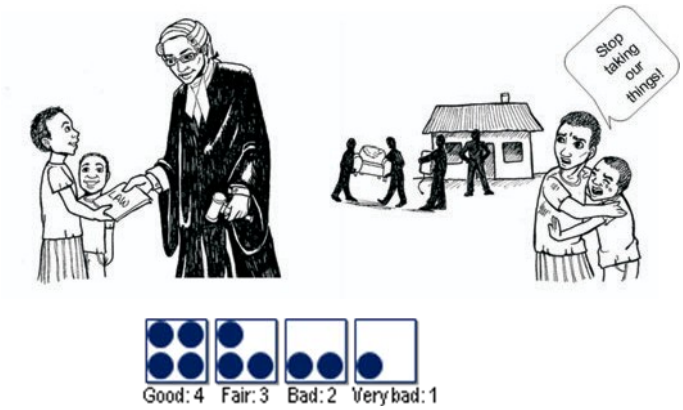
Child Status Index Factor 3B: Legal Protection

Goal

The child has access to legal protection services as needed.

Definition

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



Why This Factor is Important

Many children affected by HIV/AIDS lack parental protection and are vulnerable to losing their inheritance, being exploited sexually, and subjected to other forms of abuse (see Factor 3A). Program, national, and international stakeholders consistently identify legal protection as an important outcome area for children.

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

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

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

Gathering Information to Rate This Factor

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

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

In many cases, the important information about the child's legal status is whether there is an adult who represents the child legally and promotes needed legal protections. This may become apparent to the care worker in a number of ways.

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

Sample Questions

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

Observations

When possible, observe or ask about the child's fear of losing his/her family properties. Does the caregiver or volunteer have any concerns or hesitations when asked about the child's legal protection services? Is it apparent that the child has been sent off of family property because of a parent's death?

Is the child legally registered or does he/she have a birth certificate? Does the child need legal registration in order to receive services in the country or community? Different countries and areas vary by whether the child needs to be legally registered in order to receive services. The care worker needs to identify what the child(ren) need in order to become eligible for services and resources.

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

2.4 Domain 4—Health

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

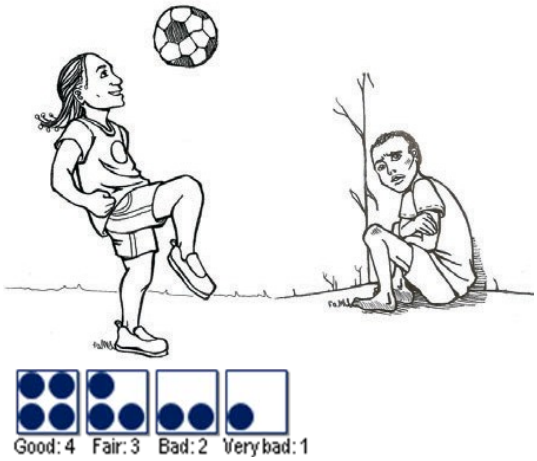
Child Status Index Factor 4A: Wellness

Goal

The child is physically healthy.

Definition

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



Why This Factor is Important

Child mortality and morbidity are closely related to poorer nutrition, malnutrition, and an increased prevalence of stunting and wasting among orphans (Lindblade *et al.*, 2003);[xxxiii] (Mishra *et al.*, 2005),[xxxiv] although there are studies and locations in which the association does not hold up (e.g. Lindblade et al., 2003).

It is likely that mortality and morbidity among orphans is more complex than poverty-related food insecurity, again emphasizing interactions among CSI factors. A child whose parents are ill or have died may not have access to health care or adequate home care when needed. When children are ill, their ability to participate actively in age-appropriate activities is affected. Their well-being in a number of areas, including social relationships and school performance, is impaired. It is important to note that mortality risks for children whose mothers had died were as high in the year preceding the mother's death as the first year after the mother's death (Ng'weshemi *et al.*, 2003).[xxxv]

It is widely acknowledged that one reason for poor health among children in this situation is that they themselves have HIV/ AIDS and that mother-to-child transmission is a part of the reason for the association between the death of a parent and the death of a child. In addition, multiple studies provide evidence for higher morbidity among orphans, including those not HIV-infected, compared to non-orphans in the same community (Bledsoe, Ewbank, & Isiugo-Abanihe, 1988);[xxxvi] (Oni, 1995),[xxxvii] as well as higher mortality (Forsyth *et al.*, 1996).[xxxviii]

Gathering Information to Rate This Factor

Wellness is rated from discussions with guardians and other caregivers about the child's illness over the past month and how often (during the past month, for example) the child has been too ill to go to school or to perform work at home. The child can be asked similar questions.

Often the guardian provides information about the nature of the child's illnesses: diarrhea diseases, malaria, and other diseases such as tuberculosis. Asking about the child's health also gives the care worker the opportunity to rate the child's access to and use of health care services (see Factor 4B). Due to the potential for discrimination, the care worker should never ask directly about the child's HIV status, although a caregiver may volunteer the information.

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

Sample Questions

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

Observations

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

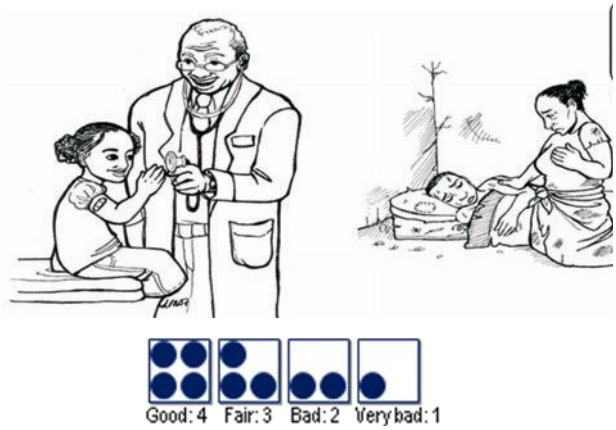
Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

Child Status Index Factor 4B: Health Care Services

Goal

The child can access health care services, including preventive care and medical treatment when ill.



Definition

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

Why This Factor is Important

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

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

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

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

Gathering Information to Rate This Factor

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

If the child has been sick or was sick recently, the rater should explore whether the child had access to a health professional and to needed medication and treatment. For purposes of service planning, the care worker may want to inquire about barriers to service availability, to determine if services were genuinely absent or were inaccessible for some other reason, such as distance to a health provider or lack of funds for petrol to get to the health provider. Some areas provide health cards on which clinic visits are recorded. If the caregiver(s) are open about HIV/AIDS in the family, it can be appropriate to ask about high risk child testing and to educate about the advantages of early diagnosis for children to have a long and quality life.

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

Sample Questions

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

Observations

When possible, observe the child's immunization card or health card, availability of medicated bed nets, and basic hygiene. Given what you observe, how likely is the child to receive the health care services needed? Does the caregiver or others worry about him/her being sick?

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

2.5 Domain 5—Psychosocial Well-Being

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

Child Status Index Factor 5A: Emotional Health

Goal/Definition

The child is happy and content with a generally positive mood and hopeful outlook.

Why This Factor is Important

Children affected by HIV/AIDS are vulnerable to emotional health difficulties that influence their feelings and how they behave. A child with psychosocial distress may show internalized symptoms such as depression, poor self-esteem, anxiety, and frank suicidal thoughts.

The grief and loss that children experience related to HIV/AIDS can be acute or chronic and will affect multiple aspects of their lives.

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

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

In an ongoing longitudinal study of children orphaned by HIV/AIDS in five countries, findings showed that a high rate of child trauma was reported by both guardians and children themselves (32 and 54 percent, respectively). They reported five or more potentially traumatic events, such as being beaten or having a family member die. There was a high prevalence of trauma-related symptoms in these children, further demonstrating the urgent need to address grief, depression, and trauma in HIV/AIDS affected children (Whetten *et al.*, 2009).[xlv]

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

One study of a 16-week model of group interpersonal psychotherapy in Uganda showed improved scores on a culturally developed measure for depression in adolescents (Bass *et al.*, 2006;[xlvi] Bolton *et al.*, 2004).[xlvii] Trauma-focused groups for orphans with unresolved grief have been shown effective when implemented in the Kilimanjaro region of Tanzania (O'Donnell *et al.*, 2011).[xlviii] There are, however, few evidence-based Western models tested for feasibility, applicability, and effectiveness in low- and middle-income countries and with vulnerable children.

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

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

Gathering Information to Rate This Factor

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

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

Sample Questions

In the psychosocial area, it is very important to explore the local language or idioms for describing emotional well-being, sadness, grief, and so forth. Often, English words do not translate directly, and time must be taken to ask the questions in the best manner specific to the language and culture.

Ask the caregiver or other involved adult:

- How often is the child happy? How often is he/she sad?
- How can you tell if he/she is happy or unhappy?
- Does the child seem happy playing with other children?
- What makes the child sad or worried?
- Do you worry about this child's sadness or grief?
- Have you ever thought the child did not want to live anymore?
- Do you worry he/she might hurt himself/herself or want to die?
- Does he/she talk about the parent(s) who died?
- Do you worry about this child's sadness or grief?
- Does this child cry more than you would expect from most children?

Ask the child:

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

Observations

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

Rating this factor is made difficult because the child's emotional well-being is related to cultural expectations for children and to the language used to describe emotional difficulties. For example, in East Africa, the word for "inactive" (myonge / munyonge) is often used to describe a depressed child. All children are sometimes happy and sometimes angry or sad, so it is important to interview the caregiver and the child closely to explore the child's functioning and how it may or may not be related to the adults' expectations for recent loss. In other words, a child who is sometimes sad when thinking about the fairly recent death in the family may be rated "good" or "fair," since the grief is within reasonable expectations.

When a caregiver is worried and is not sure how to support a sad or depressed child, the rating is likely to be "bad" or "very bad," indicating that the child and household need help. It is helpful for care workers to discuss ratings on this factor with co-workers to develop consensus about child behavior and what is normal and what is more worrisome.

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

Child Status Index Factor 5B. Social Behavior

Goal/Definition

The child is cooperative and enjoys participating in activities with adults and other children.

Why This Factor Is Important

Playing well with other children and participating with adults and children in fun activities can indicate psychological adjustment that will extend to becoming a "good" adolescent and adult. "Obedient" and "good" are constructs used frequently by parents and caregivers when describing child behavior. It is also likely that this child imagines a good future that may include education, marriage, and being a good parent.

Interviews during CSI development indicated that guardians sometimes worry that the orphaned child in their care will be a "bad" child, be disobedient, and engage in antisocial activities, such as early sexual activity, drug use, and other high-risk behavior. Guardians generally describe externalized (problem) behaviors, such as fighting and bullying for those children who act out their grief and loss. Externalizing or problem behavior can include fighting, bullying, not following directions, not cooperating with adults, stealing, destroying things, not following rules, and/or arguing with adults. When caregivers become concerned about these behaviors, the care worker can also consider with the caregiver whether the child may be having difficulties with emotions (Factor 5A) or relationships.

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

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

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

Gathering Information to Rate This Factor

From a parent's or guardian's point of view, an important aspect of the child is whether he/she is "good," often related to relationships with adults (obedience or disobedience) and children (getting along with others or not fighting), as well as how they participate in family and community life.

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

Sample Questions

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

Observations

When possible, observe the child's social behavior with other children and adults. What does his/her attitude seem to be toward the guardian or other children? Is the child involved in any activities with others? How does he/she interact with them and with you? If there are behavior concerns, is it possible for you to also talk with the child and/or with a teacher? This may help you determine the severity of the problem and the need for help for the child and family.

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

2.6 Domain 6— Education and Skills Training

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

Child Status Index Factor 6A: Performance

Goal

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

Definition

The definition of "performance" is not limited to learning in school, but also addresses the child's performance in any age-appropriate tasks, including daily activities in family life, household chores, and (age-appropriate) work in the family's income bearing activities, such as gardening and care of animals.

This factor also reflects the extent to which a young infant or preschooler is progressing well in reaching developmental milestones in motor development, language, and play, according to expectations of the parent or caregiver. In other words, this factor describes the quality of the child's day-to-day activities in a way that is applicable to children of all ages, including infants and adolescents.

Why This Factor is Important

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

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

One study in Kenya, Tanzania and Zimbabwe showed that orphans were less likely than non-orphans to be performing at the expected grade level, even when they were in school (Bicego *et al.*, 2003).[lii] The findings from this study indicate that children with both parents who have died performed less well than those with one parent dead, who performed less well than those with both parents alive.

Gathering Information to Rate This Factor

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

Rating on this factor depends on the age of the child being discussed.

- An infant/toddler is evaluated according to observations and opinions about the child's development, such as whether motor milestones are on target; is the child making sounds or talking like others of the same age? Does the guardian believe the infant is developing like others his/her age?
- A school age child can be evaluated on performance in school and on household activities, asking the caregiver to comment on the child relative to other school age children.
- An adolescent or older child can be rated according to participation in school and/or income bearing activities. An older child will also perform in vocational training or other work preparation activities.

For children not old enough to go to school, rate questions about school attendance as "not applicable" rather than as a low numerical score, since this factor is not relevant.

Sample Questions

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

Observations

If the child is in school, observe the response if asked about class performance ranking. If the child is five years old or younger, observe the child's developmental progress and compare it to what you expect for children that age (i.e., talking, walking, playing with people and objects).

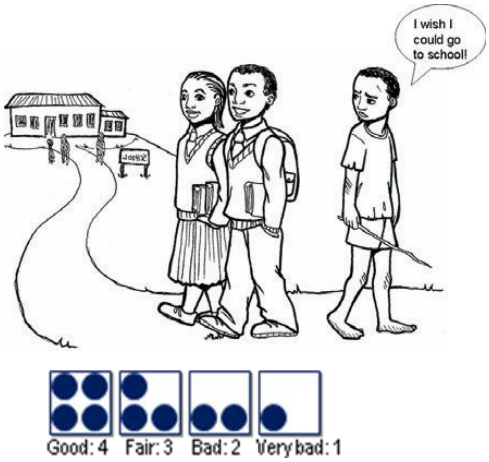
Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

Child Status Index Factor 6B: Education and Work

Goal/Definition

The child is enrolled and attends school or skills training or is engaged in age-appropriate play, learning activity, or job. Infants are developing according to parent/caregiver expectations.



Why This Factor is Important

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

Gathering Information to Rate This Factor

Gathering information on this factor depends on a child's age. Rating this factor for very young children is possibly more difficult, but the rating can be inferred from your observations and the parent/guardian's discussion about the child.

For infants or preschoolers, the care worker should ask whether the child is receiving stimulation by way of playing and interacting with household members. Is the baby isolated from others or close to his/her caregiver and others, learning about his/her world? Is the infant learning well at home or would he or she do better in a day care or preschool?

For school-aged children, the care worker can ask the guardian or the child about school enrollment and attendance, including how school fees are paid and how or if school uniforms are purchased. In the case of an older, out-of-school child, the care worker can ask if the youth has an income-generating job/task where he/she works regularly (may include maintaining a garden). If the youth is receiving job training, does he/she attend and do well?

This factor is designed so that care workers can explore whether the infant or youth has received or is receiving good early developmental intervention opportunities, participating in school, or learning job skills. For children who are enrolled in school or have regular work, ask about attendance. For children who are not engaged in any age-appropriate activities (school or learning activities) as expected, the care worker should explore the barriers. Information here may also provide answers about other factors. For example, a child might not be at school because there was no adult to guide that child, or because the child has no access to school fees or uniforms.

Sample Questions

For infants and preschool children:

- Does this infant have good opportunities to play and learn?
- Do people in the family play and talk with the baby?
- Is or should the child be in an early development center?

For school-age children and older:

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

Observations

If possible, observe the child's school uniform or supplies and their usage. For an infant or preschooler, observe whether he/she is involved in any play or learning activity with any family member(s). In some areas, an agency/organization may be involved with evaluating early childhood centers; this is important but not a part of rating this factor. The key here is whether the child is involved in age appropriate learning and working activities – whether the child is an infant or older youth.

Ratings

Based on information gathered from the interviews and observations, the care worker will assign a rating for this factor on a numerical scale from 1-4.

Chapter 3. Administering, Scoring, and Using CSI Assessments

A step-by-step process

The CSI is primarily used as a tool to assess, monitor, and make intervention decisions about individual children receiving services from external sources, such as communities, neighbors, churches, NGOs, community- and faith-based organizations (FBOs), and other organizations – and/or with children who are being recruited into such programs.

The assumption is that the CSI is used in combination with a program that provides some resources or services for vulnerable children and/or households. Not all programs provide services and resources in all 12 factors, yet it is important to assess children holistically across the 12 factors to document child needs and find resources/referrals/services if possible. The care worker may face challenges if resources are not readily available for identified areas of need. Care workers should be prepared to explain the purpose of the CSI and how the information may be used, even if services are not provided for all needs identified during the CSI process. This explanation prevents families from having unrealistic expectations.

How long will this take?

The total time required to collect information across all 12 factors and rate the child should be at least 30 minutes, based on field testing in East Africa. However, once a guardian starts talking and is engaged, it can be difficult to keep the information gathering short.

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

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

1.1 Learn about the *Child Status Index* and *CSI Record Form*.

Be sure you understand the goal and content of each factor and domain on the CSI by memory, so you are prepared to ask the right questions, make good observations, and elicit the information necessary to rate the child on the *CSI Record Form* (Appendix B). If you don't have to refer to a written script, the visit can be more informal and agreeable to the child and caregiver. It is very helpful to conduct several practice interviews and scoring. It has been helpful to some care workers to carry a small laminated version of the CSI to guide the assessment.

1.2 Gather child and family background information.

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

1.3 Prepare the *CSI Record Form*.

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

Child's Name _____ **Age in years** _____

Gender M/F ___ **Child Program ID** _____

Location: District _____ Ward/Division_____ Village/Neighborhood_____

Caregiver's Name _____ **Relationship to Child**_____

Step 2. Conduct the Assessment Visit

The CSI rating is often part of a home visit conducted by care workers and front-line program staff. The care worker has a brief and informal discussion (usually about 30 minutes) with the child, the child's caregiver, or other adults as needed to gather general information about the child. You may want to discuss the child's well-being with neighbors or teachers as well. The worker also observes the child's environment as well as the behavior of the child and caregivers toward each other, toward you and toward other adults and children.

The goal is to gather information from discussions and observations that relates to the 12 structured CSI factors, but the care worker should conduct the interviews in a natural and spontaneous way, so that observations about the child's life can be done in a friendly and supportive way.

Care workers conducting a home visit (Karen O'Donnell photo)

2.1 Make introductions and request consent to conduct the assessment.

CSI assessments are usually completed at home visits, and they begin with friendly and spontaneous greetings as expected in each culture.

- **Introduce yourself** to the guardian, other adult, or child. The discussion about the child should be informal. Allow the interviewee to respond spontaneously so that you show your interest in the child and others in the household.

- **Remind the child or guardian about the program** that serves this child or other children in the community/country and the reason for asking about the child in this manner. You may explain that the reason for the visit is to know how the children are doing, especially this child; what has been happening in the child's life (good or bad) since the last visit; and whether there are any big changes in the child's life. Explain that getting this information about the child is done so that you can together determine how to best respond to the needs of the child.
- **Get the informant's consent** (the person best able to represent your target child and to describe his/her well-being) to provide this information before proceeding with the discussion. Oral consent is sufficient when you are collecting data to evaluate services and not as part of a research project. For example, "I am here to ask about how [child's name] and your household are doing. I'd like to discuss several things with you and [child] today. If this isn't a good time or you don't want to participate, that's ok. Is it ok if I stay here today?]

2.2 Talk with the parent or child's primary caregiver.

Engage the parent, guardian, or other informant(s) in a brief, informal discussion that addresses the 12 factors of the CSI without the structure of a formal survey or questionnaire.

Start the conversation with general, open-ended questions about the child and his/her life, to encourage the person to talk. For example, you might begin by saying, "Let's talk about this child; how is he/she doing?" Open-ended questions allow caregivers to bring up topics that are of interest to them, and they serve as an indication of your interest and concern about what they think and feel. Often, the questions addressed by the CSI factors can be learned from just listening.

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

2.3 Talk with the child or other informants.

As indicated in Chapter 2, conducting informal discussions with guardians and children is an important part of administering the CSI. If you believe any responses from the guardian(s) are inaccurate or incomplete, gather more information from other informants, as possible. For example, you can talk with a teacher about the child's performance, attendance, and/or social behaviors; with neighbors you could talk about suspected abuse or neglect; or discuss with the child about shelter and care issues. Specifically, when questioning a child:

- Get verbal agreement from the caregiver and the child to speak with the child.
- If the child is old enough (and child and guardian are willing), interview the child in private so he/she can respond to you without worry about consequences from the parent or guardian.
- In addition to direct questions, it can be helpful to ask the child to show you around the living environment and to talk about his/her life in general.
- Do not ask children questions that might frighten them or put them in conflict with the parent or guardian.
- Be prepared to respond in an appropriate and supportive manner to children who become sad or cry when talking about a parent who is sick or has died. If the child is in danger or has severe health issues, be prepared to respond/report according to established local protocols for obtaining care. Practice with your team.

Care worker talking with child (Karen O'Donnell photo)

2.4 Observe the child and/or informant and/or the living environment.

As indicated in Chapter 2, conducting observations of the child's physical and psychosocial environment provides additional, important information when administering the CSI. Observations of body language, speech patterns, and eye contact can help verify information about the child, the informant, and the relationship between the child and others in the household. For example:

- Concerns about child abuse and maltreatment may arise from seeing bruises on a child's body or from other people in the community who express worry that the child is neglected or otherwise maltreated.
- You may observe a child whose eyes are downcast, speech is overly quiet, and emotional expression appears sad and tearful (suggesting grief and sadness). You may be concerned even though the guardian reports that the child seems "happy."
- Consider how the guardian responds to the child's behavior. Does he or she think the child is sad or that the child should be punished for being "bad?"

Observations about the living space

You may observe that an otherwise physically sound dwelling lacks food, cooking utensils, or beddings for the child.

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

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

Cooking area inside home (Karen O'Donnell photo)

Using the CSI with Children in Group Homes or Institutions

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

To score the remaining nine factors, however, you must hold separate discussions about each child. If the designated guardian in a group home or institution does not know the individual child well, identify others who do.

You may ask: "Which adult or older child spends the most time with this child?" Or: "Who does this child go to when he/she needs something?" Also, as you consider the accuracy of the information, you might ask how often the person takes care of the child, how much time the adult spends with the child, and how many other adults care for the child.

With permission from the administrator or director of the home or institution, this would be a good opportunity to discuss these factors directly with the child if the child is old enough to participate in this type of conversation about his/her own well-being.

Tips for the Assessment Visit

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

Step 3. Complete the *CSI Record Form*

3.1 Complete Part I of the *CSI Record Form*: Rating on all CSI factors.

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

Make a concerted effort to assign a score for each factor and for every child, on the four-point CSI scale that ranges from good to very bad. Rate each factor relative to the average situation in your community or village. Use local standards as you know them to rate each factor as:

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

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

There may be times when it is not possible to score every factor. In this case, note "Not able to assess" next to that factor. This will probably not happen often. All of the factors are needed to understand a full picture of an individual child and his/her life.

If you are rating multiple children in one household or institution, pause between children (with the permission of the guardian), and rate each child after the interview so you do not forget his/her scores.

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

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

These important events may have an effect on the child's well-being that is outside of the resources you are providing or may indicate a need for the child at this time. For example, a child who has had another family member die between assessments may indicate more sadness or grief since the previous assessment and now need psychosocial resources that he or she did not previously need.

II. IMPORTANT EVENTS: *Check any events that have happened since the last CSI assessment or six months.*	___ Child left program ___ Child pregnant ___ Child died ___ Parent ill ___ Parent/guardian died (Specify who)	___ Family member died ___ Change in caregiver/adoption ___ Change in living location ___ Community trauma, such as violence, famine, or flood ___ Other (Specify) _____	**Comment(s)** *If necessary:*

3.3 Complete Part III of the *CSI Record Form*: Support/Services Provided.

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

Some organizations use a Service Form to document services received by child and household. In these cases it is not necessary to complete this section of the *CSI Record Form*. Whichever form is used, it is important to report the services provided, because that may indicate why a child is doing well in a certain factor. Therefore, it is important not to use higher CSI scores as a reason to discontinue those services when the higher score is due, at least in part, to these services.

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

Step 4. Interpret CSI Assessments

The holistic approach of the CSI raises awareness about the multiple dimensions of child development and well-being, which helps service providers and care workers better understand and routinely address these areas in their work with children. CSI information can help field staff/caregivers advocate for children and/or seek additional resources to help individual children, their households, and/or the community. Local service providers, volunteers, and community leaders are in the best position to help interpret, use, and communicate CSI child assessment results.

Consider that scores may change as assessments get more accurate. A study conducted in 2012 found that some care workers view the first set of CSI scores obtained for a child as less reliable than future sets (Cannon & Snyder, 2012). Initially, children and family members may be unrealistically positive out of concern for being judged negatively by the care worker. Others may be overly negative, exaggerating need in an effort to obtain higher levels of service. As care workers get to know a child and family better and spend more time in the household, they are more likely to score the child more accurately, especially as respondents develop more trust with the interviewer.

> "The CSI pushes everyone in the field to individualize their work with children and focus on outcomes and quality care," said Lucy Steinitz, Senior Technical Advisor with Pact in Ethiopia, in an interview for the *Child Status Index* Usage Assessment. A village care worker reported to Steinitz that the CSI has completely changed their approach: "Previously, we thought that all poor children had the same needs, but now we find that each one is different."

Consider scores in the context of related factors. Care workers and programs can use CSI results to understand child well-being for specific factors. Importantly, individual factors can also be assessed in relation to other factors. For example, a child receiving food supplements and access to health care will not just be better fed (Factor 1A) and have better wellness (Factor 4A). This child may also grow better (Factor 1B), feel better or be happier (Factor 5A), and perform better at school or work (Factor 6A).

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

Aggregating scores across factors is not recommended. The use of aggregated CSI scores across all factors as a global measure for ranking or rating program participants or programs is strongly discouraged. Aggregated scores across factors do not reflect the variation underlying those total scores, and very serious issues for a child may be underestimated.

For example, a child may be rated as "3" (good) in all 12 factors, equaling a total score of 36, which requires no immediate action. Another child may also have a total score of 36, but have a "1" (urgent) and "2" (bad) in two factors – requiring attention in these two areas – but scores of 3 and 4 in the other areas. Also, the CSI scale is not equal-interval but rather ordinal in nature, and distinctions among scores are lost when added together. Comparison of aggregate CSI scores across diverse settings is equally not valid, given that the reference for CSI ratings is local expectations and comparisons.

Ensure that raters are scoring consistently. For CSI ratings to be considered valid, care workers must rate CSI factors consistently. There must be a training and quality assurance plan that addresses inter-rater reliability. More information on this training is found in Chapter 5, "Training and Quality Assurance for the *Child Status Index*."

Use the CSI factors and ratings in concert with other indicators. The CSI was designed to assess and monitor multiple dimensions of child well-being, but it is a snapshot in time; and it is not an exhaustive measure of all outcome indicators of child well-being. In general, multiple measures using different approaches – such as child self-report, subjective questionnaires, and global demographic indicators – will provide a more complete view of child and family.

Step 5. Respond to the CSI Assessments

When someone uses the CSI to assess the well-being of a child and his/her household, they will likely identify areas of need. Whether the CSI is conducted to plan for an individual child's services, household services, or to track ongoing needs, it is very important to respond to what is learned about the child's needs, particularly urgent needs revealed in the assessment.

This may mean that a care worker provides direct support on site (such as psychosocial counseling or food support); a referral (such as to a health facility or social worker); or reaches out to other resources (such as CBOs, FBOs, churches, or village leaders) to meet needs such as school fees, shelter, emotional support.

5.1 Create a Care Plan

CSI assessment results help organizations and care workers understand the needs of a child and household, which leads to a plan for services. There are many models for creating an individualized care plan for children and families, and each organization will have its own approach. However, the CSI often identifies immediate and urgent needs that are not directly provided by the organization. In these cases, care workers need to know about other local services and resources.

One approach is to develop a local *standard of care* by systematically interviewing community members and local stakeholders about the resources – informal and formal – they use when urgent situations occur for them or their neighbors. A standard of care procedure is an ethnographic approach to identify community resources to which families with immediate problems can be directed. The aim is to have an array of resources that can be recommended. In a resource poor context, resources can be organizations or informal types of support.

Defining the standard of care strategy. Developing a local standard of care involves conducting interviews with community members, leaders and workers about services and support available in their town or village. The informal interview asks what action they would recommend when a person or family in their community or neighborhood has serious difficulties.

The interview uses minimalist, open ended questions aligned with the 12 CSI factors to encourage people to describe what naturally occurs in the community in response to different situations. "When you come across a person with these difficulties, what is your common response? What do you usually suggest to try to help them? We understand you may refer to others in the community or to informal supports." Note that interview subjects are not asked what they have done or would do but rather what resources would be available to them – from a street leader to a church or other organization or other formal or informal resources already in the community.

The goal is to query 15-20 respondents for each of the 12 CSI factors and to record the answers in the local language. When people say there are no resources, explain that we are just asking what naturally/usually occurs. Write down what they say, including responses such as "There are no supports" or "Talk with God."

Try not to offer your own suggestions; but, if necessary, you might ask whether they would refer to a wise person in the village, a good teacher, a health care clinic, community organization, or other familiar resources.

This process can include group interviews, if desired. These are not artificially created focus groups but rather naturally formed groups to which you might have access and that agree to contribute to the listing of resources and services.

Results from these informal interviews are then put into a table or list that is shared with all care workers so they are aware of the common local responses to urgent problems. These can result in referrals agency to agency or in recommendations to the guardian.

Example of stakeholder listing for Standard of Care

Ask community stakeholders or service providers (organizations, churches, leaders) to respond to the questions: • If someone in your community comes to you to ask you for help with these problems, what would you suggest? • What kind of support or services might be able to help with their needs?" • We are trying to find out what resources, services, and informal support services people might use when there are problems.	
Area of concern:	**Services, supports, organizations that might be recommended for someone who lives in this area**
The child or family member has urgent health problems that need treatment, and they have not received care. They have little or no money to get medical care. (CSI factor Health Care Services.)	

5.2 Determine if Action is Needed

The care worker can use the CSI rating system to determine the appropriate response for each level of need identified during the home visit. Once the care plan has been created, the following table can be used as a guide for approaches to follow-up. It is important to note that when there is a score reflecting a "very bad" situation, the community worker is obliged to respond by making referrals or recommendations to the family – and to document steps taken on the *CSI Record Form*.

At right: **Ambulance used to transport clients to a health facility**

(Karen O'Donnell photo)

Rating	What It Means	Guidelines for Follow-Up Action
4	**Good** The child's status or situation is good. There are no concerns and no apparent risk for the child in this factor.	No follow-up or care plan needed. General knowledge about resources can be shared, if appropriate.
3	**Fair** The child's status or situation is generally acceptable, but there are some concerns on the part of the caregiver or care worker. Additional resources might be helpful, if available.	This is an area that the visitor will want to be aware of in future visits to make sure the situation has not gotten worse. This is not seen as an urgent matter, but if the community worker has information that might help the child or family, it should be provided to them as a recommendation.
2	**Bad** There is concern that the child's status or situation on this factor is observably not good. Additional resources or services are needed.	The care worker should consider what the child and family needs are and if there are available resources or services to help. The care worker can directly make the referral or discuss with the agency or the village leader to get help for the family, if possible.
1	**Very bad** The child is at serious risk on this factor. Urgent attention to the child or the situation may be needed.	When a family emergency is discovered, the care worker must respond accordingly, either by services within their own agency or by referring the family/child to the appropriate resources based on local standards. When the care worker does not know the best response to a bad situation, he/she should make a plan with the agency director or village or community leader as appropriate.. It is not ethical to do nothing when there are urgent child/household needs.

5.3 Communicate and Archive the Findings

Provide feedback to care workers. When scores are reviewed or analyzed by others, such as supervisors or M&E staff, they should give the care workers feedback about how these scores will be used or what services were provided or actions taken.

Keep a copy of the *CSI Record Form*. Care workers administering the CSI should keep a copy of the *CSI Record Form* or the ratings for reference during the next home visit or to follow-up on child needs and resources provided. Too often, CSI forms are submitted to higher levels of the organization for reporting and are not readily available to care workers who need them for case management and child monitoring. To ensure care workers have a copy of the form, they may photocopy or hand-copy the form, with care for confidentiality.

Chapter 4. Translating and Adapting the *Child Status Index*

Modifying the tool for specific languages, cultural conditions, or research requirements

The CSI was designed to be broadly applicable for use with orphaned and vulnerable children, but national and local variations are to be expected. The inferential nature of the tool means that care workers will rate factors in a way that reflects their local norms – their local experience of children and households. So the tool can and should be adapted to different languages, cultures, and program purposes.

Translating the CSI Into Other Languages

The first step for a community using the CSI is translating the tool into the local language. A multi-stage process of translation and back-translation addresses nuances related the language, local idioms, and the meaning behind the factors. Translation is a lengthy but critical process to ensure that the factors have the same meaning as intended and are understood by local workers. The CSI translation model usually requires three or more rounds of translation and back-translation.

Step 1. Translate the English CSI edition into the local language.

Someone fluent in both English and the target language translates the CSI and *CSI Record Form* from the original English into the language in which it will be used. This is the first draft translation. Translators should keep the essential and basic concepts of the CSI but do not have to create a word-for-word translation. Step 1 can be done by individuals, but there are benefits to doing this with small groups, when possible.

Step 2. Back-translate the first translation into English.

One or more people who were not involved in the first draft translation translate this new-language edition back into English. This is a very important step to be done by an individual or group not very familiar with the original CSI in English.

Step 3. A CSI expert reviews the back translation into English.

After noting inconsistencies (and there will be many), the CSI expert and local translators should discuss local meaning and language issues that may not be served by direct translation. In this way, the translation can use local idioms with confidence. Often there is not a direct translation for concepts such as “anxiety,” so this collaboration with local language users is very important.

Step 4. Reconcile any differences to create a second draft translation into the local language.

Step 5. Back-translate the second translation draft into English.

A translator then reviews the revised English version of the CSI, and a local group reviews each section to correct language and meaning in the local language until the group agrees that the translation validly reflects the intent of the CSI as well as local usage for the concepts. If this translation is not satisfactory, repeat steps 4 and 5.

When the CSI is being adopted in a new geographic area – a new country or region – this translation process may occur as part of the CSI training. It adds at least two half-days to the training, but future users will then understand and own the tool in a better way.

Adapting the CSI for Local Needs

A large part of adapting the CSI for local usage is done by the language translation process, but there are other ways to adapt the tool for specific geographic areas or service organizations, with the following considerations:

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

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

Programs will need to develop a strategy for care workers when resources are not available for a given Factor, because this situation can sometimes create tension between families and community workers. The care worker should alert the caregiver to this possibility, as well as develop a local standard of care for referrals and recommendations to other agencies and resources.

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

Use great caution when removing a CSI factor. Rarely, a CSI factor might not be relevant to a program's services and desired outcomes. If so, remove the factor only with great caution, good reasoning, and after field-testing the factor to make sure it is not relevant and cannot be scored with reliability in that area. Preserve the original numbers of the remaining CSI factors to retain consistency across sites.

Keep consistency for the basic scoring method. A common scoring system is important for comparing CSI scores across locations, assessing program performance, and improving service quality. The essential scores should be maintained as follows: 4 = Good; 3 = Fair; 2 = Bad; 1 = Very bad/urgent need for action.

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

Contributing to the CSI Public Domain

The goal for the CSI is that it be universally available and easy to access by all potential users, so CSI materials are available online. If you have revised or adapted the CSI, please let MEASURE Evaluation know, so your versions can be uploaded onto the MEASURE Evaluation website and made available to others who may have a need for the CSI in a given language.

To download current CSI publications:
http://www.cpc.unc.edu/measure/tools/child-health/child-status-index

Chapter 5. Training and Quality Assurance for the CSI

A brief guide for facilitators

Although the CSI is user-friendly and easy to learn – even by those with very little literacy – it does require *systematic training* and periodic *quality assurance* to ensure consistency in assessment practice from child to child and from one user to another. The primary goal of CSI training is to make sure care workers agree about the meaning of each factor, how it is rated, and how to respond to scores.

Because consistency across CSI workers is so important, this second edition of the *Child Status Index Manual* includes a proposed training model based on experience using the CSI in the field. This section presents recommendations for the training model, training content and quality assurance checks.

CSI training is detailed in the *CSI Training Manual*, available for download from the MEASURE Evaluation website at: http://www.cpc.unc.edu/measure/tools/child-health/child-status-index

5.1 The Learning and Mentoring Model for CSI Training

After five years of experience using the CSI around the world, it is clear that the best results are obtained when didactic training is augmented with practice, mentoring, and quality assurance activities. In a *Learning and Mentoring* model (Ebert *et al.*, 2008),[liii] local experts:

1. Learn how to use the CSI tool.
2. Practice using the tool under supervision.
3. Use the same training approach to train larger groups of new CSI users.

This model – cascading knowledge and mentoring from expert to trainer to trainee – has several benefits:

- Preserves best practices as the CSI reaches larger audiences
- Limits the need for external experts to conduct large-scale training sessions
- Promotes local ownership and expertise

An effective training program – not only for CSI but for other M&E assessment approaches as well – involves a flexible and iterative process with didactic sessions, interactive small groups, and collaborative learning activities, as follows:

Organize a CSI Leadership Team at the local, community, or countrywide level.

Convene in person or via distance technology a leadership group with the following representation:

- At least one external or internal CSI expert
- At least one individual with expertise in coaching organizations in M&E
- Persons with national or local leadership to develop and support the collaborative mission for CSI training, implementation, and ongoing quality assurance. This may involve representation from government ministries overseeing OVC programs.

This collaborative CSI Leadership Team will identify goals, plan training and action sessions, become users and trainers themselves, and support the training model in their regions.

Provide training for the CSI Leadership Team.

This process begins with learning sessions provided by an external (or internal, if available) expert for the Leadership Team members who, once trained, become the experts who will disseminate the training and implementation country-wide or agency-wide. This training schedule would follow one of two possible agendas. If translation and adaptation will be included, the training will follow a five-day minimum agenda. Training can be completed in three to four days if translation and adaptation have already been completed.

Have the CSI Leadership Team perform CSI assessments.

During the action period, the initial leadership team members conduct a designated number of CSI assessments – for example, 10 over a three-month period. During this time, the CSI leaders will confer with the internal or external CSI expert in weekly or biweekly calls to discuss any scoring issues, usage concerns, or care plan decisions. Through this mentoring, the CSI Leadership Team members become the experts to more widely disseminate the training.

The CSI Leadership Team trains users in community groups.

When translation and adaptation of the CSI have already been done, these community group learning sessions can be completed in three days. In addition to learning about the CSI tool, these community group members will be briefed on activities for the subsequent action period: how many children/households to visit, the type of data to gather, and how to establish quality and consistency. If literacy is an issue, the pictorial version of the CSI can be used (Appendix C).

Community group members participate in CSI field work.

The action period for community groups involves field work in each site, coupled with weekly and then biweekly telephone or Skype calls – or direct mentoring from one or more members of the original CSI Leadership Team.

Community group members conduct quality assurance checks.

Each group or organization is strongly encouraged to plan periodic quality assurance activities in which two users independently score the same child/household and compare/discuss the results. This peer-based validation should be done at once a quarter or, at minimum, twice yearly. CSI teams report this is a very useful process for joint learning and sharing of the assessment experience.

5.2 Key Training Content

CSI training includes didactic content, group discussion, and practice activities. If the CSI has not previously been used in this locality, several days of training might be added for adapting the tool for local use, including translation, back-translation, and other local adaptations.

This section provides a summary view of a syllabus for these three components of CSI training.

CSI Training – Didactic Content

Background and rationale for CSI development

- The need for individualized and child centered assessments by programs that serve orphans and children made vulnerable due to HIV/AIDS
- The community participatory process used for identifying major factors for individualized assessment

- The aims of the CSI approach: Child-centered, easy to learn and administer, participant-friendly, reliable among users, applicable to a range of ages and settings, reflecting local norms and expectations, and able to capture change over time as services are provided
- The six domains and 12 factors in the CSI, as well as why some factors were not chosen

The CSI method

- How the high-inference approach differs from objective, subjective, and projective assessments
- The use of multiple sources of information, including interviews and observations
- The method for informal and friendly encounters with children, caregivers, and others
- Emphasis on non-directive interviews, using open ended questions

How CSI factors are rated and the *CSI Record Form* is completed

- How to integrate observations and interviews to infer child well-being and needs
- How to develop local consensus in rating standards, and what constitutes acceptable variance, given that there is always variability when using judgment to infer a child's status
- How to complete the *CSI Record Form*

How the results of CSI assessments are used

- The power of data for understanding the needs of vulnerable children in a community, the status of individual children or households, planning services, and using the CSI over time for case management
- USAID guidelines for CSI usage as well as other assessment approaches that can complement the CSI assessment
- How to create a care plan to respond to needs identified in a CSI assessment, including what to do when a child's situation is urgent and available resources are insufficient

CSI Training – Practice and Mentoring Activities

Facilitate small group discussion of each domain and factor and what to look for when visiting a household.

Use role-playing to practice using the CSI. One person can be the interviewer, another the guardian/caregiver, and a third person comments on the process. Because this is done in the training session, participants can be open and forthcoming about challenges with discussion and rating.

Training participants practicing role play (Karen O'Donnell photo)

Practice using the CSI in the field. For the first field practice, training participants go in pairs to households that have already agreed to participate in the training. The families must understand that the team is practicing and that no real services or resources will be forthcoming. If funds are available, small incentives may be used, such as sugar or soda or colorful pens for the child. During this field practice:

- Two trainees practice the CSI in the household using interviews and observations, with one actively conducting the interview and the other listening and observing so he/she is also prepared to provide a rating.
- At the end of the visit, each trainee rates the child/household, without conferring with the other.
- Trainees return to the training center and discuss each factor, how the rating was reached, and what was learned. Differences in ratings should be emphasized and embraced, because the discussions around those differences help everyone better understand the meaning of the factors and ratings.
- Trainers calculate the percent agreement between the two persons on all factors.

Conduct a second field practice the next day. This is a very important opportunity for the trainees to apply what they learned from the day before. The same two-person team visits another volunteer household, using the same process as before. Upon returning to the training center, ratings are discussed, with emphasis on differences in ratings between the two persons. This validation process is worth the time for discussion, mentoring, and agreement among all workshop participants.

CSI Training – Quality Assurance Activities

Quality CSI information depends on knowing that those who use the CSI are rating children and households in a similar manner – that there is shared understanding about what a 1, 2, 3 or 4 means on a specific factor. In any M&E or intervention, individual drift from original training and quality of implementation is expected and common. The inconsistency that arises from frequent use over time can result in CSI ratings that differ by user rather than by actual child status.

Inter-rater reliability is not difficult to achieve, but it requires specific procedures at the program level. The two-person validation process that took place in the training should be repeated at regular intervals. Two CSI workers visit the home. One person takes the lead, and both rate the factors independently and then compare the results. This process should be done preferably at least every six months and at a minimum, annually.

Discussions about emerging differences in ratings are very helpful in resolving differences between raters and promoting consensus and reliability among all raters. Perfect agreement is not expected; a reasonable goal is around 80 percent. The important aspect of quality assurance activities is the discussion about factor and the meanings of each judgment and rating.

Adaptation, training, and consensus building with community care workers on the *Child Status Index*, Dodoma 2006 (Karen O'Donnell photo)

Conclusion

Lessons learned from developing and using the CSI

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

Community participation = Community endorsement and better communication
Community participation in the design of the CSI produced a culturally appropriate tool that is well accepted. The development process enabled potential users to help identify domains and factors, provide useful feedback, and make important corrections.

The ground-up approach to developing the CSI also improved communication, promoted buy-in, and ensured a local commitment to applying the tool appropriately. Studies of CSI usage conducted in 2012 and 2013 revealed that the CSI is well accepted by users – and has led to clarifications and enhancements to make the tool even more useful and adaptable (Cannon & Snyder, 2012, 2013).

Adaptable, inferential approach
The high-inference approach simplifies the process of gathering information and evaluating children, making the tool accessible and meaningful to many people. The simplicity of the framework makes it adaptable to various situations. In the first five years of use, the CSI has been translated into 16 languages and used around the world.

Holistic understanding at an individual level
End users have expressed appreciation for being able to assess a child as an individual, and say the time is worth it, because existing M&E approaches didn't enable such tailored response. In the words of a program representative interviewed for a CSI assessment study (Cannon & Snyder, 2012): [The CSI] is good at checking the whole parameter of a child's well-being. It doesn't deal with one aspect and leave the others."

Delivering child- and household-level insights
Although the CSI is child centered, the individualized assessment embraces factors in the household/family as well as the child, providing targets for organizational support.

This report from a program representative is typical: "We used it to make a decision about the program needs at the beginning, to know what were the needs, so we could implement and develop actually new components to the program to support children of drug users."

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

> "After carrying out the CSI, we noticed that for most of the children, the challenge is education. Now, out of 100 children, if the challenge is education with 80 or 90 percent, then you know that that community has a challenge for education."
>
> "We've been experimenting with how to build relationships locally to connect the families that we're working with into a bigger system … and I think CSI is going to be part of the decision-making procedure for how we do that; I think it's going to give us that information about the kids in families which we previously haven't had."

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

The CSI may be best used with the USAID Guidance about the CSI (http://www.cpc.unc.edu/measure/publications/fs-12-75) and, when feasible, in the context of other data, such as child self-report and international demographic data. The CSI has a specific role in child assessment when the focus is to identify areas of child and household need leading to additional resources and direct intervention.

MANUAL – SECOND EDITION

Child Status Index

A tool for monitoring the well-being of children orphaned or otherwise made vulnerable as a result of HIV/AIDS

Appendices

Appendix A. The *Child Status Index* (CSI)

Appendix B. The *CSI Record Form*

Appendix C: Pictorial Version of the *Child Status Index*

Appendix D: Development of the *Child Status Index*

Appendix A. The *Child Status Index* (CSI)

DOMAIN	*1 — FOOD AND NUTRITION*		*2 — SHELTER AND CARE*		*3 — PROTECTION*	
	1A. Food Security	**1B. Nutrition and Growth**	**2A. Shelter**	**2B. Care**	**3A. Abuse and Exploitation**	**3B. Legal Protection**
GOAL	*Child has sufficient food to eat at all times of the year.*	*Child is growing well compared to others of his/her age in the community.*	*Child has stable shelter that is adequate, dry, and safe.*	*Child has at least one adult (age 18 or over) who provides consistent care, attention, and support.*	*Child is safe from any abuse, neglect, or exploitation.*	*Child has access to legal protection services as needed.*
Good = 4	Child is well fed, eats regularly.	Child is well grown with good height, weight, and energy level for his/her age.	Child lives in a place that is adequate, dry, and safe.	Child has a primary adult caregiver who is involved in his/her life and who protects and nurtures him/her.	Child does not seem to be abused, neglected, do inappropriate work, or be exploited in other ways.	Child has access to legal protection as needed.
Fair = 3	Child has enough to eat some of the time, depending on season or food supply.	Child seems to be growing well but is less active compared to others of same age in community.	Child lives in a place that needs some repairs but is fairly adequate, dry, and safe.	Child has an adult who provides care but who is limited by illness, age, or seems indifferent to this child.	There is some suspicion that child may be neglected, over-worked, not treated well, or otherwise maltreated.	Child has no access to legal protection services, but no protection is needed at this time.
Bad = 2	Child frequently has less food to eat than needed, complains of hunger.	Child has lower weight, looks shorter and/or is less energetic compared to others of same age in community.	Child lives in a place that needs major repairs, is overcrowded, inadequate and/or does not protect him/her from weather.	Child has no consistent adult in his/her life that provides love, attention, and support.	Child is neglected, given inappropriate work for his or her age, or is clearly not treated well in household or institution.	Child has no access to any legal protection services and may be at risk of exploitation.
Very Bad = 1	Child rarely has food to eat and goes to bed hungry most nights.	Child has very low weight (wasted) or is too short (stunted) for his/her age (malnourished).	Child has no stable, adequate, or safe place to live.	Child is completely without the care of an adult and must fend for him or herself or lives in child-headed household.	Child is abused, sexually or physically, and/or is being subjected to child labor or otherwise exploited.	Child has no access to any legal protection services and is being legally exploited.

DOMAIN	*4 — HEALTH*		*5 — PSYCHOSOCIAL*		*6 — EDUCATION AND SKILLS TRAINING*	
	4A. Wellness	**4B. Health Care Services**	**5A. Emotional Health**	**5B. Social Behavior**	**6A. Performance**	**6B. Education and Work**
GOAL	*Child is physically healthy.*	*Child can access health care services, including medical treatment when ill and preventive care.*	*Child is happy and content with a generally positive mood and hopeful outlook.*	*Child is cooperative and enjoys participating in activities with adults and other children.*	*Child is progressing well in acquiring knowledge and life skills at home, school, job training, or an age-*	*Child is enrolled and attends school or skills training or is engaged in age-appropriate play, learning activity, or job.*
Good = 4	In past month, child has been healthy and active, with no fever, diarrhea, or other illnesses.	Child has received all or almost all necessary health care treatment and preventive services.	Child seems happy, hopeful, and content.	Child likes to play with peers and participates in group or family activities.	Child is learning well, developing life skills, and progressing as expected by caregivers, teachers, or other leaders.	Child is enrolled in and attending school/training regularly. Infants or preschoolers play with caregiver. Older child has appropriate job.
Fair = 3	In past month, child was ill and less active for a few days (1 to 3 days), but he/she participated in some activities.	Child received medical treatment when ill, but some health care services (e.g. immunizations) are not received.	Child is mostly happy but occasionally he/she is anxious, or withdrawn. Infant may be crying, irritable, or not sleeping well some of the time.	Child has minor problems getting along with others and argues or gets into fights sometimes.	Child is learning well and developing life skills moderately well, but caregivers, teachers, or other leaders have some concerns about progress.	Child enrolled in school/training but attends irregularly or shows up inconsistently for productive activity/job. Younger child played with sometimes but not daily.
Bad = 2	In past month, child was often (more than 3 days) too ill for school, work, or play.	Child only sometimes or inconsistently receives needed health care services (treatment or preventive).	Child is often withdrawn, irritable, anxious, unhappy, or sad. Infant may cry frequently or	Child is disobedient to adults and frequently does not interact well with peers, guardian, or others at home or school.	Child is learning and gaining skills poorly or is falling behind. Infant or preschool child is gaining skills more slowly than peers.	Child enrolled in school or has a job but he/she rarely attends. Infant or preschool child is rarely played with.
Very Bad = 1	In past month, child has been ill most of the time (chronically ill).	Child rarely or never receives the necessary health care services.	Child seems hopeless, sad, withdrawn, wishes could die, or wants to be left alone. Infant may refuse to eat, sleep poorly, or cry a lot.	Child has behavioral problems, including stealing, early sexual activity, and/or other risky or disruptive behavior.	Child has serious problems with learning and performing in life or developmental skills.	Child is not enrolled, not attending training, or not involved in age-appropriate productive activity or job. Infant or preschooler is not played with.

Public Domain: Developed by the support from the U.S. President's Emergency Fund for AIDS Relief through USAID to MEASURE Evaluation & Duke University.
O'Donnell K., Nyangara F., Murphy R., & Nyberg B., 2008

Appendix B. The *CSI Record Form*

Child's Name: _____ Age in years: _____ Gender: F/M _____ Child ID: _____

Location: District _____ Ward/Division: _____ Village/Neighborhood: _____

Caregiver's Name: _____ Relationship to Child: _____

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

II. IMPORTANT EVENTS: *(Check any events that have happened since the last CSI assessment if applicable.)*	___ Child left program ___ Child pregnant ___ Child died ___ Parent ill ___ Parent/guardian died (specify who) _____	___ Family member died ___ Change in caregiver/adoption ___ Change in living location ___ Community trauma (violence, famine, flood, etc.) __ Other (Specify) _____	**Comment(s)** *if necessary:*

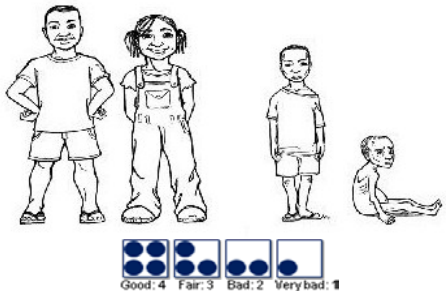
III. TYPES OF SUPPORT/SERVICES PROVIDED *(at present):*	**What was provided?**	**Who provided services?** (e.g., NGO, neighbor, teacher, church, or other)
A. Food and nutrition support (such as food rations, supplemental foods)		
B. Shelter and other material support (such as house repair, clothes, bedding)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

Appendix C. Pictorial Version of the *Child Status Index*

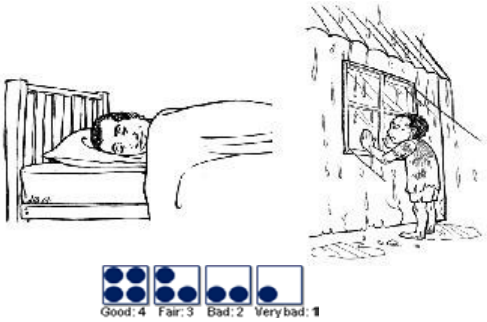
Illustrated by Loide Marwanga

Factor 1A. Food Security

Factor 1B. Nutrition & Growth



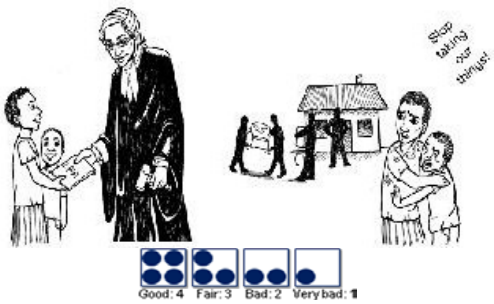
Factor 2A. Shelter



Factor 2B. Care

Factor 3A. Abuse and Exploitation

Factor 3B. Legal Protection



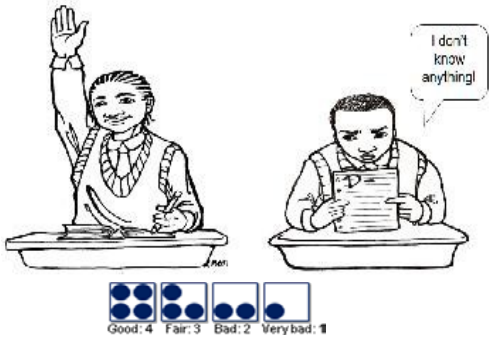
Factor 4A. Wellness

Factor 4B. Health Care Services

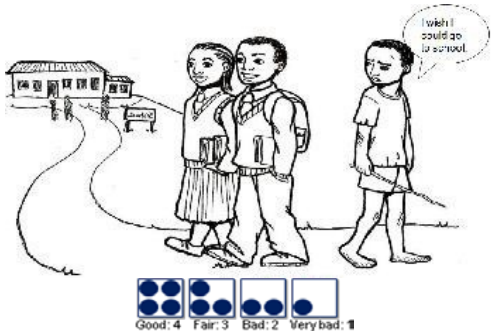
Factor 5A. Emotional Health

Factor 5B. Social Behavior

Factor 6A. Performance



Factor 6B. School and Work



Appendix D. Development of the *Child Status Index*

A systematic process, enhanced by community involvement and validated by field testing

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

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

The tool was designed to help service providers, program managers, care workers, volunteers, and guardians/caregivers to regularly and systematically monitor the needs of children to guide their care over time.

Collaborative Approach

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

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

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

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

Four Phases of *Child Status Index* Development

Phase 1. Exploratory

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

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

Every child should be:
(1) healthy, (2) happy, (3) safe, (4) learning, and (5) good.

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

Phase 2. Consultations with Communities and Experts

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

These local community members – including care workers, volunteers, and guardians who live with, care for, and provide services to affected children – were seen as the choice participants to discuss how to assess a child's status and needs.

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

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

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

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

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

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

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

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

- In Kenya and Tanzania, it quickly became clear that the survey needed to better address the issue of grief – the depression and hopelessness that children felt after losing one or both parents to HIV/AIDS.

- Questions had to be carefully phrased to accurately capture the desired information. For instance, the quality of physical "shelter" might not reflect the child's actual comfort and safety at home. After discussions in Tanzania, the tool instead gained the broader Swahili term "makazi," meaning "way of living."

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

A discussion group with caregivers to discuss factors for child well-being, Kilifi, Kenya, 2006 (Karen O'Donnell photo)

Phase 3. Translation and Field Testing

Refinements based on multiple perspectives

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

Translation

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

Testing for inter-rater reliability

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

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

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

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

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

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

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

Results from Tests of Inter-rater Agreement

Domain	Factor	Number of observations	Kendall tau-b value
Food and Nutrition	1A. Food Security	118	0.7856****
	1B. Nutrition and Growth	Not assessed during this field test	
Shelter and Care	2A. Shelter	118	0.7749****
	2B. Care	118	0.6256****
Child Protection	3A. Abuse and Exploitation	107	0.7487****
	3B. Legal Protection	Not assessed during this field test	
Health	4A. Wellness	115	0.7829****
	4B. Health Care Services	115	0.8243****
Psychosocial	5A. Emotional Health	115	0.7428****
	5B. Social Behavior	117	0.7282****
Education and Skills Training	6A. Performance	116	0.7552****
	6B. Education and Work	114	0.7582****

**** $p < .0001$

Testing the constructs

A preliminary assessment of construct validity – , the Positive Outcomes for Orphans (POFO) study – was conducted in Bungoma, Kenya, with 80 children and households that were also administered extensive interviews using a well-validated, standardized assessment in the context of a separate research study about orphans and their care (Whetten *et al.*, 2009). Items from the research project were selected to compare with the high inference ratings on the CSI to provide preliminary information about the validity of the CSI ratings.

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

The POFO study included measures of child growth and extensive interviews with children and guardians related to psychosocial functioning and symptoms. Data about shelter, education, care, and healthcare were collected using a household survey adapted from the World Bank's survey for these purposes.

Owing to limited variance on either the CSI or the POFO Household Survey, validity coefficients were calculated only for the following domains: Food Security, Shelter, Emotional Health, and Education and Work. Restricted variance precluded calculation for this initial sample for the remaining factors. Scores for Factors 1A and 1B (Food Security and Nutrition and Growth) were also compared to measures of weight for age and height for age. Results are presented in the table below as a rank-order correlation coefficient with which a significant p-value indicates a relationship between the measures of these variables.

Results of CSI Accuracy (Validity) Tests for Five Domains

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

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

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

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

Weight and Height for Gender and Age Scores Relative to CSI Ratings

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

Height for gender and age scores relative to CSI ratings

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

The preliminary results support the CSI ratings, relative to objective data about child growth. However, the sample was small (N=73) and the ratings were compared to a limited selection of data already being collected for another study. Further studies of CSI compared to other types of child and household data are also noted in this manual.

The conclusion of the CSI team is that with proper training and demonstrated inter-rater reliability, this tool gathers one very important aspect of the assessment of vulnerable children: their status inferred from a number of sources and rated relative to local norms and the experience of the care worker.

Phase 4. Publication and Dissemination

The fourth phase of CSI development involved creating V1 of this manual and a pictorial version of the tool. At the same time, team members:

- Trained care workers in the use of the tool
- Assisted with translations into multiple languages
- Consulted on adaptations of the tool for unique local language and circumstances
- Worked with various stakeholders in regional meetings and technical forums to discuss policy questions, types of analysis, and how CSI information could be used in planning and developing programs for children made vulnerable or orphaned by HIV/AIDS.

Early positive feedback

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

Field testing affirmed that each factor provides an important and specific (yet interrelated) view of the child's well-being and needs:

- *Program-level collaborators* indicated that the domains on the CSI caused them to consider a child and household more comprehensively and in areas not previously addressed.
- *Care workers* reported that using the CSI made a positive contribution to their practice. For example, workers who previously focused on nutritional and education support reported that they paid more attention now to the quality of parent-child relationships and the child's behavior adjustment.

Feedback from care workers has reinforced the importance of understanding the child as an individual, noting that although the CSI took more time and effort, the benefits of this more individualized approach are worth it.

Appendix E. Clarification Regarding Usage of the Child Status Index (CSI)

The following is also available as a four-page brochure at:
http://www.cpc.unc.edu/measure/publications/fs-12-75

The Child Status Index

The *Child Status Index1* (CSI)—an information collection tool—is widely used among programs for children who are orphaned or made vulnerable by HIV/AIDS. The last several years of CSI implementation have enabled MEASURE Evaluation and others to learn about how the CSI fits into the overall package of monitoring and evaluation (M&E) tools and when (and in which circumstances) the tool is best used. This document briefly describes the tool, its purposes, and the lessons learned about best usages.

Child Status Index Description

The CSI was developed during the early years of The U.S. President's Plan for AIDS Relief (PEPFAR) when few other M&E tools existed for programs working with vulnerable children. The CSI was designed as a simple, cost-effective, comprehensive tool to be used by low-literate (and often volunteer) community caregivers to capture a child's status and well-being across twelve factors. These factors fell under the six domains of PEPFAR vulnerable children programming at that time. The CSI is a *high-inference* tool that requires an observer to make inferences or "conclusions" regarding each factor based on observations from home visits and interviews with guardians, children, and community members and rate each factor on a four-point scale.[1] The factor ratings made on the CSI are based on local standards; in other words, each community group or program will determine what "1", "2", "3" or "4" is in their community. Importantly, while the ratings refer to child needs, they do not imply a specific intervention; for many factors, supporting the household may be the best strategy for addressing the varied needs of the child. CSI ratings provide a method for trained community workers (1) to assess critical areas of child well-being that may be susceptible to intervention and (2) to incorporate this knowledge into planning and service delivery.

The Child Status Index within the Vulnerable Children M&E Framework

Programs for orphans and vulnerable children gather information on several levels—individual child, household, program, population—in order to meet the information needs of a diverse group of stakeholders. Key information needs may include:

- identification of vulnerable children and households requiring assistance in a target locality (**targeting**);
- planning resource provision that addresses the individualized needs of vulnerable children and their households (**case management**);

[1] The current revised scale is 4 = good; 3 = fair; 2 = bad; 1 = very bad.

- documenting the extent to which the program is being implemented according to an established plan, schedule, and standard of quality (**monitoring**);
- documenting if and to what extent the program components have had an impact on children and households (**evaluation**); and
- determining important characteristics and needs of children and families who have been registered by a local program (**program planning**).

It was anticipated that the CSI, with some adaptation, might meet a broad range of information needs from the local to the national level. Five years after the CSI was introduced, it has (1) been implemented in over 16 low- and middle-income countries, (2) been translated into multiple languages, and (3) become the focus of several studies. The CSI has been implemented by a wide range of programs as a tool for different purposes, from case management to program evaluation. This has led to a better understanding of how the CSI fits into the M&E framework for programs working with vulnerable children and how the tool can provide improved guidance on CSI usage. The core functions of the CSI are listed below and are followed by a brief description of the M&E tasks and information needs for which the CSI is recommended.

Core Functions of the Child Status Index

1. CSI use serves as a **rapport-building function** in that it encourages volunteers and service providers to ask introductory, open-ended questions of a caregiver and child. The approach offers the home visitor a consistent way of thinking about a child which facilitates careful consideration of the child's individual needs as decisions are made about services.
2. The CSI orients volunteers and service providers to the **holistic needs of vulnerable children** by helping those who provide resources and services in limited domains (e.g., psychosocial support) recognize needs in other previously unaddressed areas that contribute to a child's overall well-being. Repeat observations allow volunteers and service providers to consider the multiple influences on observed changes (e.g., benefits of service, change in family income, natural disaster). The assessment may also encourage referrals to other agencies and community-based organizations (where necessary) to address needs outside the range of services in one organization, thereby providing a system of care.
3. The CSI promotes an **individualized approach** for programs working with vulnerable children. As a result, the services and resources provided are more likely to address the specific needs of one or more children living in a household instead of providing all program recipients with the same services. The approach lends itself to identifying an appropriate course of action or intervention for a child and household, i.e., an individualized care plan.
4. The CSI helps programs focus on whether an individual child or children in a community are achieving **desired outcomes** (e.g., child is attending and succeeding in school) rather than only monitoring inputs (e.g., provision of educational supplies). Importantly, observed increases or decreases in CSI scores requires the further assessment of the influences that led to change such as program quality, changes in the child or family situation, and/or change in the environment in which the child lives.

5. CSI assessments provide trained community volunteers or caregivers with a tool to help identify **urgent situations**—for example, a score of "1" in any factor requires immediate attention. As is true for any intervention context, if an urgent situation is identified, the situation cannot ethically be ignored by the organization gathering these data. Examples of urgent circumstances include when a child is very sick and not receiving medical care, is being abused or neglected by a caregiver, is being exploited in a variety of ways (child labor), is being excluded from school, or when a child is in danger of serious harm to him/herself or others. Of note, the CSI is only one source of information and should be used in conjunction with other information to determine the appropriate urgent response. The needed response is determined by local guidelines for responding to urgent cases, i.e., a local standard of care. Such guidelines should be included in the training of CSI users so that each user knows how to respond when confronted with an urgent situation.

Using the Child Status Index in Programs that Work with Vulnerable Children

Below are descriptions of the M&E framework components that the CSI supports and an explanation of uses for which the CSI is not appropriate. It is important to keep in mind that the M&E community is still learning about and studying the CSI and other tools in an M&E context. These statements concerning usage reflect current views and recommendations.

1. **Targeting (NOT RECOMMENDED FOR USE).** The process of targeting involves identifying the vulnerable children and households in a specific locality that would benefit most from program assistance. Because the tool is locally referenced (e.g., child well-being is compared to other children in their location), the CSI would only be used for targeting locally. However, the CSI is of limited support in targeting because (1) evidence from community volunteers or caregivers indicates that it is difficult to get accurate CSI scores the first time the CSI is used (see explanation below);3 (2) programs may find it easier to have general criteria for inclusion in a program rather than undertaking a needs assessment for each child; (3) the level of engagement required by the CSI may lead to expectations of action or service enrollment that may not be forthcoming; and (4) it is not appropriate to make targeting decisions using aggregate scores across CSI factors (see explanation below).[2]
2. **Case Management (PRIMARY USE).** In general, the CSI may be most useful as a case management tool for serving highly vulnerable children and families. The CSI provides a consistent and individualized method for assessing a child's status and well-being to guide decision making about services for the child and household. Furthermore, with repeated administration, the tool allows volunteers and programs to follow up on the status of children and ensure services are being effectively delivered to the child and household. The CSI factors are child-centered, but the best strategy for addressing areas of a child's need may be by supporting the family to support the children.

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[2] Cannon, M., & Snyder, E. (2012). *The Child Status Index Usage Assessment*. Chapel Hill, NC: MEASURE Evaluation. Available at: http://www.cpc.unc.edu/measure/publications/SR-12-68.

3. **Monitoring (APPROPRIATE USE).** Similar to its value for case management, the CSI—as a component of the M&E framework—can offer important information for program monitoring. The CSI "Child Status Record" sheet provides simple monitoring information regarding who is being served, the kinds of services provided, and individual contact history and change over time.
4. **Evaluation (NOT RECOMMENDED FOR USE).** Since the CSI requires users to identify children's needs and status *relative* to their local community, it cannot be used as an indicator or comparator for national or multi-country standards. Specifically, the CSI should not be used among a sample of children as an evaluation tool. Broad evaluation of the impact of a regional or national program on child well-being requires several considerations and, likely, multiple approaches. USAID/MEASURE Evaluation is currently developing a standard program evaluation tool for programs that work with vulnerable children that will include a sample protocol and accompanying household and child instruments for use. This tool kit will be available at the end of 2012.
5. **Program planning (APPROPRIATE USE).** Programs may make use of local CSI data for program planning by aggregating CSI ratings by individual factor in their local service provision area. This information may help a program decide that one or two factors represent the overall greatest needs in its catchment area. Knowing, for example, that many children are able to go to primary school, but few have access to health care will inform an organization about where to focus funds and support.

Other Considerations for Child Status Index Usage

- **Cautions about using aggregate scores across factors.** The use of aggregated CSI scores across all factors as a global measure for ranking or rating program participants or programs is strongly discouraged. Aggregated scores across factors do not reflect the variation underlying those total scores. For example, a child may be rated as "3" (good) in all 12 factors, equaling a total score of 36, which requires no immediate action. Another child may also have a total score of 36, but have a "1" (urgent) and "2" (bad) in two factors—requiring attention in these two areas—but 3's and 4's in the other areas. Also, the CSI scale is not equal-interval, but ordinal, and distinctions between scores are lost when aggregated together. Comparison of aggregate CSI scores across diverse settings is equally **not** valid given that the reference for CSI ratings is local norms.
- **Training and reliability**. Quality assurance in the use of the CSI depends on knowing that those who use the CSI are rating children and households in a similar manner—that there is shared understanding about what a "1", "2", "3" or "4" means on a specific factor. Inter-rater reliability is not difficult to achieve but requires specific procedures at the program level. First, when a CSI Training of Trainers (ToT) is offered, the program must ensure that participants have the support necessary to implement an adequate training to community volunteers or others administering the CSI. Conducting a ToT alone may not be sufficient for the new cadre of trainers to successfully implement training. Continued mentoring of lead trainers should be built into budgets and plans. Next, all subsequent trainings should ensure a training approach that combines instruction and discussion of the CSI and its purpose, domains, and factors, along with guided practice that involves dyadic independent ratings of the same child and family with subsequent comparison and expert consultation. Quality assurance may be achieved through periodic checks by having two volunteers visit the same household and rate the CSI independently for comparison and discussion. *Scores obtained from untrained staff or volunteers should **not** be accepted to guide any child or program*

decisions, since no consensus has been reached about the meaning of the ratings. USAID and MEASURE Evaluation are modifying the CSI Manual to include the guidance contained in this document. MEASURE Evaluation is also planning to finalize a CSI training to be available late 2012.

- **Frequency of CSI administration.** There is no rule regarding how often the CSI should be applied; the frequency of use should be programmatically relevant. If the CSI is being used as a case management tool, then quarterly to semi-annual application may be appropriate. If the CSI is being used to assess a child's progress over time on specific factors, then a semi-annual or annual application may be sufficient. In all cases, factors rated as "urgent" or "urgent" should have close follow-up and not be postponed until the next proscribed program follow-up assessment.
- **Retention of CSI scores by CSI users.** CSI scores should be retained by community volunteers or others using the CSI to enable individualized long-term care management and planning. When scores are reviewed or analyzed by others, for example supervisors or M&E staff, feedback should be provided to the volunteers for their use. Case workers should be trained to regularly review a child's CSI scores to better understand how a child's needs may be changing over time.
- **First Set of CSI Scores.** A study conducted in 2012 found that some community volunteers view the first set of CSI scores obtained for a child as less reliable than future sets, especially in specific factors such as Abuse and Exploitation (Factor 5a). Initially, children and family members may present in an unrealistically positive light out of concern for being judged negatively by the volunteer or service worker. Others may present in an overly negative light, exaggerating need in an effort to obtain higher levels of service. As CSI users and case workers get to know a child and family better and spend more time in the household, they are more likely to score the child more accurately, especially as respondents develop more trust with the interviewer. It is also important for the interviewer/volunteer to talk to multiple informants when possible and to use good observation skills to contribute to his/her high inference ratings. For example, the supply of grain stored in the household provides important information in addition to the caregiver's view of food security.
- **Multiple approaches.** CSI results provide a snapshot in time of the overall well-being of a child. Although the CSI was designed to assess and monitor multiple dimensions of child well-being, it is not an exhaustive measure of all outcome indicators of child well-being. In general, multiple measures using different approaches will provide a more complete view of child and family, (e.g., child self-report, subjective questionnaires, global demographic indicators) and local service providers, volunteers, and community leaders are in the best position to help interpret, use, and communicate CSI child assessment results.
- **Translation and adaptation of the CSI.** As described more fully in the CSI Manual, the CSI can be adapted for local usage. In particular, the meaning or anchors for ratings under each factor may be described differently by geographic and cultural location. There may be circumstances in which an additional factor may be useful; an example might be trauma symptoms in an area of recent disaster. There may be a geographical or cultural area in which one existing factor has no relevance or in which the differentiation of good to very bad is meaningless; for example, Legal Protection may not be validly rated if there is no legal protection for children and households there. MEASURE Evaluation recommends applying caution in reducing CSI factors to reflect only those areas in which a program provides direct services. To do so, the program may lose important information about where other critical services are needed for the target population.

About MEASURE Evaluation

MEASURE Evaluation strengthens the capacity of host-country programs to collect and use population and health data. We are a key component of the United States Agency for International Development (USAID) program, Monitoring and Evaluation to Assess and Use Results (MEASURE) framework, and promote a continuous cycle of data demand, collection, analysis and use to improve population health conditions.

MEASURE Evaluation fosters demand for effective program monitoring and evaluation. We seek to empower our partners as they improve family planning, maternal and child health and nutrition, and prevent HIV/AIDS, STDs and other infectious diseases worldwide.

The *Child Status Index* (CSI) tool was developed to help consultants and host country representatives apply best practices by ensuring that holistic data about child well-being is captured and made available to guide the best program decisions.

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