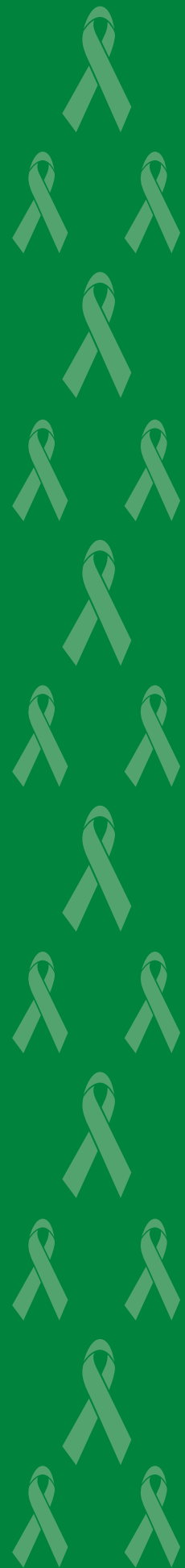


# GUIDE TO MONITORING AND EVALUATION OF THE NATIONAL RESPONSE FOR CHILDREN ORPHANED AND MADE VULNERABLE BY HIV/AIDS



Joint United Nations Programme on HIV/AIDS  
**UNAIDS**  
UNHCR • UNICEF • WFP • UNDP • UNFPA  
UNODC • ILO • UNESCO • WHO • WORLD BANK





# **GUIDE TO MONITORING AND EVALUATION OF THE NATIONAL RESPONSE FOR CHILDREN ORPHANED AND MADE VULNERABLE BY HIV/AIDS**

Monitoring and evaluation in relation to the response for orphaned and vulnerable children is a relatively new area. A number of indicators included in this guide are still being refined and further tested. For updates on these indicators or for examples of tools to collect these indicators please go to the following website:

[http://www.unaids.org/en/in+focus/monitoringevaluation/m\\_e+library.asp](http://www.unaids.org/en/in+focus/monitoringevaluation/m_e+library.asp)

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## ACRONYMS

<b>ARI</b>	acute respiratory infection
<b>CRIS</b>	Country Response Information System
<b>DHS</b>	Demographic and Health Surveys
<b>HIV/AIDS</b>	human immunodeficiency virus/acquired immune deficiency syndrome
<b>LSMS</b>	Living Standards Measurement Study
<b>M&amp;E</b>	monitoring and evaluation
<b>MDG</b>	Millennium Development Goal
<b>MICS</b>	Multiple Indicator Cluster Surveys
<b>NAC</b>	national AIDS council
<b>NCHS</b>	National Center of Health Statistics (U.S.)
<b>NGO</b>	non-governmental organization
<b>OVC</b>	children orphaned and made vulnerable by HIV/AIDS (see box 3.1)
<b>PSU</b>	primary sampling unit
<b>STI</b>	sexually transmitted infections
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNGASS/AIDS</b>	United Nations General Assembly Special Session on HIV/AIDS
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

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## CHAPTER 1 – BACKGROUND AND INTRODUCTION

### Background

The AIDS epidemic continues to result in increasing numbers of children being orphaned and made vulnerable by HIV/AIDS. One of the major challenges facing governments, international organizations and non-governmental organizations (NGOs) in their response is the lack of data on the quality and effectiveness of their interventions.

In June 2001, the United Nations General Assembly convened a Special Session on HIV/AIDS. At the close of this Special Session, 189 UN Member States signed a Declaration of Commitment<sup>1</sup> towards achieving a set of goals and targets in order to intensify international action to fight the epidemic and mobilize the necessary resources. The declaration reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal (MDG) of halting and beginning to reverse the HIV/AIDS epidemic by 2015. Special attention is paid to children orphaned and made vulnerable by HIV/AIDS, and a set of specific goals was formalized. These goals – establishing the importance of developing national strategies, ensuring non-discrimination, mobilizing resources and building international cooperation (see box 1.1) – were reiterated in May 2002 at the United Nations General Assembly Special Session on Children in its outcome document, ‘A World Fit for Children’.<sup>2</sup>

#### **Box 1.1.** International promises made to children orphaned and made vulnerable by HIV/AIDS:

By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family, and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support; ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphaned and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of destigmatization of children orphaned and made vulnerable by HIV/AIDS;

Urge the international community, particularly donor countries’ civil society as well as the private sector to complement effectively national programmes to support programmes for children orphaned and made vulnerable by HIV/AIDS in affected regions, in countries at high risk, and to direct special assistance to sub-Saharan Africa.

Source: Declaration of Commitment on HIV/AIDS: United Nations General Assembly Special Session on HIV/AIDS 2001. Page 29.

Since then, a strategic framework for the protection, care and support of orphans and children made vulnerable by HIV/AIDS has been developed to target action areas and provide operational guidance to governments and other key stakeholders as they work to achieve the goals. The five key strategies in this framework for accelerating the response to the crisis were endorsed in November 2001 by the Committee of Cosponsoring Organizations of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and reiterated during the global partnership meeting on orphaned and vulnerable children in October 2003. These strategies involve:

<sup>1</sup> United Nations. Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS. New York, 25–27 June 2001.

<sup>2</sup> United Nations. A World Fit for Children. United Nations General Assembly Special Session on Children. New York, 8–10 May 2002.

- (1) Strengthening the capacity of families to protect and care for orphans and other children made vulnerable by HIV/AIDS
- (2) Mobilizing and strengthening community-based responses
- (3) Ensuring access to essential services for orphaned and vulnerable children
- (4) Ensuring that governments protect the most vulnerable children
- (5) Raising awareness to create a supportive environment for children affected by HIV/AIDS.

In 2002, under the direction of the UNAIDS secretariat in collaboration with UNAIDS Cosponsors and other partners, a series of core indicators to measure progress in implementing the Declaration of Commitment were agreed on.<sup>3</sup> A subset of these indicators will be used to monitor progress in achieving the MDGs. One of the core indicators is related specifically to orphans (orphan school attendance ratio, see core indicator 6).

This indicator reports progress at global level, but is insufficient to guide national governments and the organizations and agencies involved in the response to the needs of orphans. To assess if national strategies are effective in improving the welfare of orphans, governments must continuously assess the capacities of families and communities to take care of orphans and children made vulnerable by HIV/AIDS. In addition, assessment of policies and strategies must demonstrate *provision of psychosocial support, access to shelter, good nutrition, and health and social services to orphans on an equal basis with other children*. Furthermore, the protection of orphans *from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance* should also be monitored.

### **Introduction**

This document provides guidance to governments, international organizations and NGOs in the monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS. It includes methods and tools for measurement at the national level. The indicators in this guide supplement the UN General Assembly Special Session on HIV/AIDS (UNGASS/AIDS) and MDG 'orphan school attendance' indicator with a set of recommended standardized core indicators that each country could monitor to assess the effectiveness of its national response and thereby inform programming.

While monitoring should be an integrated activity conducted from the global to the local level, this guide does not cover the much more detailed monitoring and evaluation needs of individual projects for children orphaned and made vulnerable by HIV/AIDS.<sup>4</sup> Some of the indicators may remain relevant at the level of monitoring and evaluating a specific intervention by one community-based organization, but they will certainly not cover the full range of project monitoring and evaluation needs. Also, at project/community level the indicators will probably need to be adjusted to the situation of the beneficiaries and the response for specific communities for which an intervention is programmed. Neither does this manual attempt to cover in detail the more general aspects of monitoring and evaluation.

This guide has been developed under the direction of the UNAIDS Monitoring and Evaluation Reference Group. It complements other indicator guidelines on monitoring and evaluation related to HIV/AIDS (HIV prevention among young people, prevention of infections among infants and young children, care and support for people living with HIV/AIDS, etc.) coordinated by the MERG.

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<sup>3</sup> United Nations General Assembly Special Session on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators. UNAIDS/02.51E (English original, August 2002). ISBN 92-9173-238-9.

<sup>4</sup> Guidelines for monitoring and evaluation at the programme/project level are being developed by Family Health International. Check [www.fhi.org](http://www.fhi.org) for details.

The indicators recommended in the guide are based on a special technical consultation meeting on development of indicators that was hosted by UNAIDS, UNICEF and the Government of Botswana in Gaborone, from 2–4 April 2003.<sup>5</sup> They were field tested in Kingston (Jamaica) and Blantyre (Malawi) in 2004 (see Methodological Report, forthcoming). Despite the field-testing, the indicators are still being refined. Updates on data-collection instruments and suggestions for adjustments to the indicators can be found at the UNAIDS website ([www.UNAIDS.org](http://www.UNAIDS.org)).

### **How the guide is organized**

The guide is divided into two main parts and annexes. The first part discusses issues related to the general monitoring and evaluation of orphans and other children made vulnerable by HIV/AIDS (chapter 2). The second part provides specific guidance in the use of the recommended indicators (chapter 3). The annexes contain a sampling methodology that can be used to incorporate children living outside of family care who are normally not captured in household surveys. The annexes also contain recommended instruments for measuring the indicators.

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<sup>5</sup> Report on the Technical Consultation on Indicators Development for Children Orphaned and Made Vulnerable by HIV/AIDS; UNAIDS/UNICEF, Gaborone, Botswana, April 2–4, 2003

## CHAPTER 2 – MONITORING AND EVALUATION

### **Importance of monitoring and evaluation**

Monitoring and evaluation of the national response for orphans and children made vulnerable by HIV/AIDS should have a triple benefit as a management tool for planning and implementing a response, as an accountability tool for performance monitoring, and as an advocacy tool.

Tracking the progress and effectiveness of efforts to support orphans and other children made vulnerable by HIV/AIDS should provide an evaluation of what is working and what is not. It should help in planning better programmes and using resources more efficiently in the future. It should help raise awareness of the gravity of the situation among those who could do more to change things for the better, both nationally and internationally. It should help convince those who are putting time, energy and money into supporting orphans and other children made vulnerable by HIV/AIDS that their efforts are worthwhile and should be continued.

### *Different functions of monitoring and evaluation*

While ‘monitoring’ and ‘evaluation’ are often used interchangeably, their functions are quite different.

**Monitoring** is the routine process of tracking inputs and outputs. It can provide information on whether an intervention is on track or on budget, whether it is reaching the desired number of households with orphans and children made vulnerable by HIV/AIDS, or registering the targeted number of children at birth.

To reduce the impact of HIV/AIDS, these outputs must then produce changes in children’s lives, for example, by increasing the number of orphans attending school or by reducing the levels of food insecurity among vulnerable households. Measuring changes in these outputs and their effect on the well-being of orphans and other children made vulnerable by HIV/AIDS is more akin to assessing the impact of programmes. Such measurements try to ascertain whether the outputs have produced the desired results – that is, *evaluate* their effectiveness.

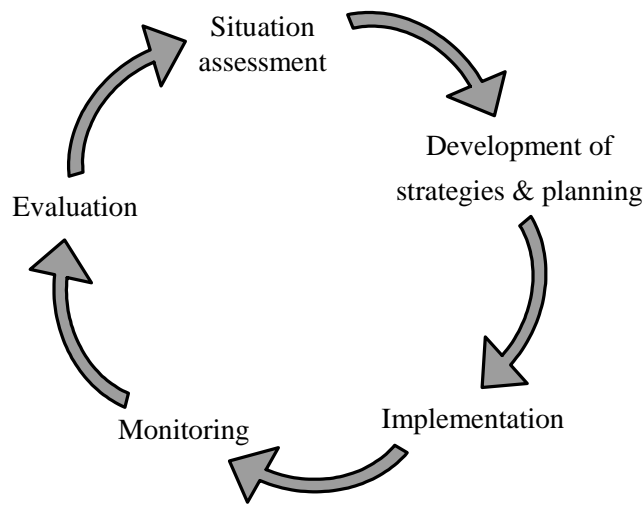
In general, findings of routine monitoring should be fed directly back into ongoing programmes to correct for weaknesses and improve performance. Evaluation results can be used to inform future programme design, prompting a decision to replicate an effective intervention in other areas or to discontinue an intervention because it is expensive and not making any difference.

### **Monitoring and evaluation as part of the overall national response for children orphaned and made vulnerable by HIV/AIDS**

*Monitoring* and *evaluation* should not be seen as isolated exercises. They are integrated components of the national response for children orphaned and made vulnerable by HIV/AIDS that also includes: *situation analysis*, *strategic planning*, and *implementation*. The ‘programme cycle’ (figure 2.1) shows how monitoring and evaluation feed back into planning and setting strategies as part of a continuous process. At its simplest, it represents a mechanism to ensure that stakeholders involved in a national response for orphaned and vulnerable children:

- Think about what they are trying to achieve
- Develop the most effective strategies and plans to achieve their goals
- Ensure that they monitor their effectiveness
- Take action to address any problems or changes that arise in the process and adjust the original strategy if necessary.

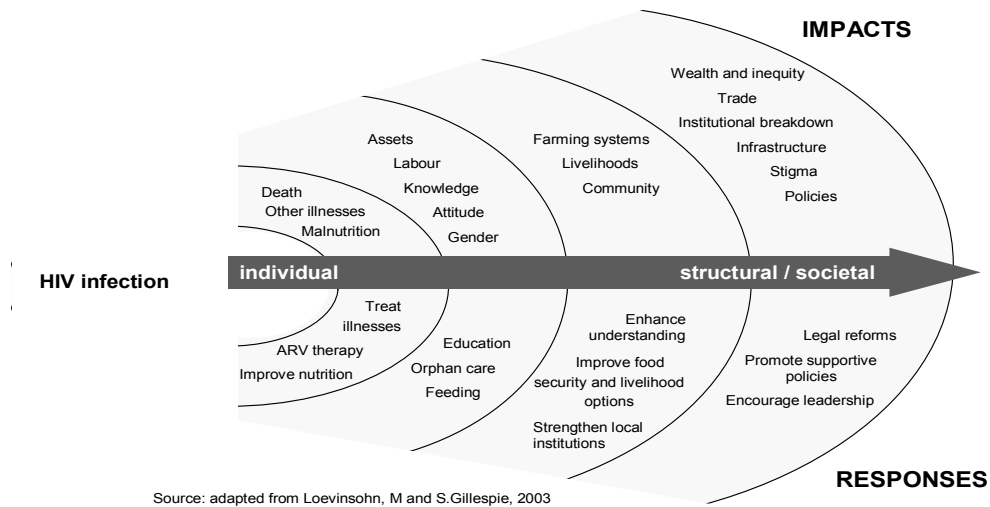
**Figure 2.1. Programme Cycle**



*National situation analysis*

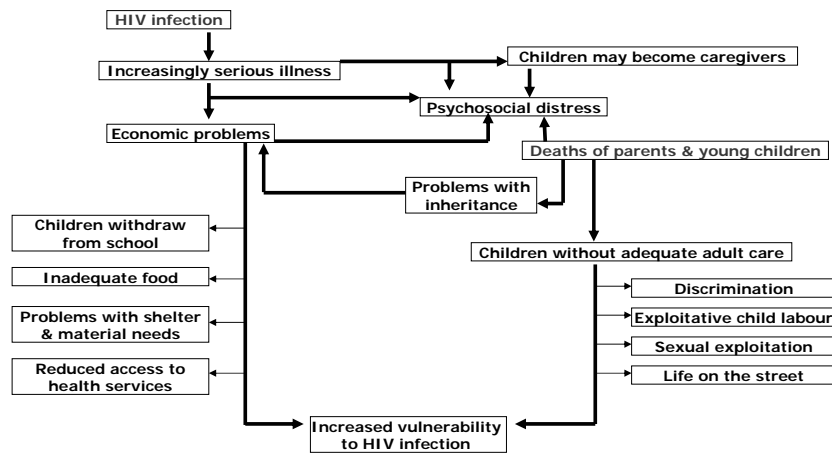
The situation analysis should form the basis of a comprehensive national response and a ‘baseline study’ against which efforts to change the situations of children affected by HIV/AIDS may later be measured. A national situation analysis on the impacts of HIV/AIDS on children should involve gathering information about the epidemic, its consequences, household and community coping responses, and relevant policies and programmes. The purpose is to identify the needs, interests, priorities and resources of the stakeholders at all levels from central government to the final beneficiaries, and to assess the possibilities for improving the situation. Figure 2.2 presents major impacts of HIV/AIDS at individual, household, community and society levels and responses to them identified during national situation analyses of HIV/AIDS. These effects are not one-time events, but rather continuing processes that are sometimes hidden, slow-moving and destructive.

**Figure 2.2. Continuum of impact and response to HIV/AIDS**



These impacts are manifested in different ways among children<sup>6</sup>. Common problems found during situation assessments among children and families affected by HIV/AIDS have been described elsewhere<sup>7</sup> and are presented in figure 2.3.<sup>8</sup>

**Figure 2.3 Problems among children and families affected by HIV/AIDS**



<sup>6</sup> Adapted from Loevinsohn, M and S. Gillespie. 'HIV/AIDS, food security, and rural livelihoods: understanding and responding.' Food Consumption and Nutrition Division Discussion Paper No. 157. International Food Policy Research Institute. Washington, D.C., September 2003.

<sup>7</sup> For detailed guidelines on situation analysis of orphaned and vulnerable children see: A framework and resource guide: Conducting a situation analysis specific to orphaned and vulnerable children affected by HIV/AIDS. Prepared by the PHNI Project, Draft II Submitted on September 26, 2003.

<sup>8</sup> Foster G. and J. Williamson, 'A Review of Current Literature of the Impact of HIV/AIDS on Children in sub-Saharan Africa'. AIDS 2000, vol. 14 (suppl. 3), pp. 275–284.

The impact of HIV/AIDS on children when their parents become ill and die is complex. Children are affected by HIV/AIDS long before they are orphaned. When a parent develops HIV-related symptoms, children take on the role of caregivers. The care of sick parents, death, costs of funerals and loss of inheritance may result in economic problems and psychosocial distress. Economic problems could increase the likelihood of not being able to meet basic needs, including food, shelter, health services and education, which again produces additional psychosocial distress. The economic and psychosocial problems and possibly the absence of adequate adult care may also lead to increased risk of discrimination and exploitation. These factors might result in an increased risk of affected children becoming infected with HIV. Strategies for coping used by extended families also have negative impacts on children in households indirectly affected by HIV/AIDS, thus enlarging the overall impact and number of children affected. For example, children may find their quality of life compromised if a mother spends time providing home care for an HIV/AIDS-affected relative or because of transfers of money to a sick relative's household. Children may see their standard of living deteriorate when cousins come to live with them following the death of an aunt or uncle.

#### *National strategies for children affected by HIV/AIDS*

Most countries with generalized epidemics have conducted some kind of situation analysis of children affected by HIV/AIDS. But the majority do not yet have national policies and strategies in place to build and strengthen government, family and community capacities to provide a supportive environment for orphans and other children made vulnerable by HIV/AIDS.<sup>9</sup>

Several countries with a national policy concerning orphaned and vulnerable children in place have incorporated the internationally developed framework for interventions, which includes the five strategies defined in chapter 1.

The development of a national framework for the monitoring and evaluation of programming in this area should be based on a national situation analysis and a consequent strategy that every country will need to prepare, as agreed in the Declaration of Commitment. It is not possible to monitor or evaluate progress identified in the strategies unless the goals of the overall national response are clear. An important step in developing an M&E plan, therefore, is to have a clear understanding of the interventions. An M&E system should be designed with the national goals in mind. Ideally, the national plan should include quantifiable goals, although in practice this does not often happen.

Most countries with a generalized epidemic organize an annual national consultation on children affected by HIV/AIDS. Such meetings bring a broad range of stakeholders together and provide important opportunities for the dissemination of information and for the strengthening of partnerships necessary in a solid M&E system.

Every second year, regional consultations are organized to review countries' progress in meeting the commitments made at UNGASS/AIDS regarding children orphaned and made vulnerable by HIV/AIDS. During previous regional consultations,<sup>10</sup> very few countries were able to report on any progress since no comprehensive M&E plan was in place. These guidelines therefore serve as a tool for reporting on progress in the implementation of a national strategy during future consultations.

#### **Coordination of monitoring and evaluation of the national response**

UNAIDS stresses three principles for a coordinated national AIDS response, including one action framework, one national AIDS coordinating body and one country-level M&E system. The responsibility for the national coordination of monitoring and evaluation of HIV/AIDS programmes generally rests with national AIDS councils (NACs). Any M&E system focused on orphaned and

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<sup>9</sup> Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS. Progress Report on the Response to the HIV/AIDS Epidemic, 2003. UNAIDS/03.37E.

<sup>10</sup> West and Central Africa Regional Workshop on Orphans and other Vulnerable Children, Yamoussoukro, Cote d'Ivoire, 7–12 April 2002; 2002 Eastern and Southern Africa Regional Workshop on Children Affected by AIDS, Windhoek, Namibia, 25–29 November 2002.

vulnerable children should work very closely with the NAC. Where the NAC is the coordinating body for monitoring the situation of orphaned and vulnerable children, it is recommended that the council works closely with a technical working group of designated M&E focal points of key stakeholders, especially since certain aspects of monitoring and evaluation of interventions to benefit orphaned and vulnerable children extend beyond HIV/AIDS.

The importance of a strong entity that coordinates monitoring and evaluation of programming for children affected by HIV/AIDS cannot be reiterated sufficiently as there are so many different stakeholders involved in a comprehensive response, including the ministries of social welfare, education, health, agriculture and justice; faith-based organizations; community-based organizations; and international organizations. This coordinating role should be with the government agency that carries most responsibility for the national response for children orphaned and made vulnerable by HIV/AIDS.

Good coordination should result in wide acknowledgement, ownership and the accessibility of information collected to all interested partners. Coordination does not necessarily mean implementing the different activities that result in an effective M&E system. Some aspects are best delegated to technical expertise, others to policy makers, and yet others to communication expertise. It is the role of the coordinating entity to make sure the parts of the system reinforce each other efficiently.

#### **Box 2.1. – Country Response Information System**

Responding to the needs at the national and global levels for improved information and analysis, UNAIDS has established a Country Response Information System (CRIS) to support national AIDS responses. CRIS provides an important tool that could facilitate greater information exchange throughout the national response children affected by HIV/AIDS.

CRIS provides a tool for improved monitoring and evaluation, and offers an opportunity to consolidate a common understanding of the challenges posed by the HIV/AIDS epidemic, to stimulate better data gathering and analysis by countries for decision-making, and to generate greater synergy with regard to reporting requirements.

It is anticipated that CRIS will serve as a common platform at the country level for data storage (particularly M&E-related data collection) and thus reduce demands on countries to meet local and international M&E requirements.

It uses technology to link information sources and existing database systems, as well as to support improved collection and storage of documents and publications. The components of CRIS include: (1) an indicator database; (2) a project/resource-tracking database; (3) a research inventory database; and (4) the capacity to store additional important information.

The data collected and stored in the system:

- Allows the NAC to demonstrate the value of its respective responses to national and international audiences;
- Provides key components of the national response with the appropriate recognition of their results;
- Allows for the sharing of lessons learned and good practices within responses and between national responses; and
- Supports resource mobilization efforts.



Where CRIS is established, it offers a databank of information that is very relevant for monitoring the response to children made vulnerable by HIV/AIDS because it ties any programme for such children to ongoing efforts on HIV/AIDS in general. By linking to this system, stakeholders can gain insights on responses from the experiences of others and from parallel developments in other areas that are monitoring the same indicators.

More information is available at: [www.unaids.org](http://www.unaids.org) or by contacting [cris@unaids.org](mailto:cris@unaids.org).

### **Components of a national M&E system**

In general, the national M&E system itself should provide an overview of the methods and sources for data collection, processing, analysis, management and dissemination for efficient use of the data collected. It should also reflect a strategic combination of research, surveillance and monitoring the use of resources and programme activities. There are several texts that describe setting up and maintaining M&E systems, this aspect will therefore not be covered in detail in this guide.<sup>11</sup>

Key aspects of any M&E system that require special attention include ownership and capacity, adequate resources, quality of data collection, analysis and use, attribution, and collaboration.

#### *Ownership and capacity*

Ownership of the monitoring process must be assumed by the mandated government agency. For this, existing national capacity must be strengthened to guarantee uniform, good-quality data within a sustainable framework (for example, sound training in monitoring and evaluation of programmes to benefit orphaned and vulnerable children and wider HIV/AIDS issues for institutions such as the Bureau of Statistics is usually the best way to ensure this sustainability because such institutions already have survey experience).

#### *Adequate financial resources*

In many countries, additional financial resources will be needed to strengthen a management information system that covers orphaned and vulnerable children and coordinates stakeholders. The budgetary allocation could be set at a fixed proportion of the total budget for orphaned and vulnerable children, depending on the size of the total programme. A commonly cited amount is 10 per cent of the total budget.

#### *Data collection, analysis and use*

Data must be reliable and of good quality in order to be useful. It is essential to invest time and effort throughout the data collection, processing and analysis stages to ensure data quality. The M&E system must be limited to collecting only information that is critical for response. Information should be obtained in a systematic way following certain principles regarding monitoring and evaluation, such as a logical approach, sound measurement to support decision-making and justification for action taken. Therefore, to the extent possible, data needs should be incorporated within existing data-collection mechanisms that are internationally recognized, such the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and Living Standards Measurement Study (LSMS) for cost-effectiveness. As far as possible, data should be widely available and disseminated for further use among all stakeholders in as transparent a manner as possible.

#### *Attribution*

Governments, implementing agencies and donors are increasingly concerned with linking specific interventions with results of HIV/AIDS programmes, including those for the improved welfare of orphans. For example, a country may want to demonstrate that improved inheritance laws, correctly

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<sup>11</sup> For example, 'Monitoring and Evaluation Operations Manual: National AIDS Councils.' UNAIDS/World Bank. UNAIDS/02.47E, August 2002.

implemented, will lead to a reduction in property dispossession, which in turn will lead to smaller numbers of children living outside of family care. But other aspects, such as access to education for orphans, psychosocial support, and support for families and communities, which may also influence the number of children living outside of family care, may be difficult to predict. It cannot be assumed that these factors would have the same influence in different settings, as outcomes are embedded in specific and local contexts, each with their own social and cultural values.

### *Collaboration*

To be successful, a system needs to involve all stakeholders in the development of a sound knowledge base of the situation of children orphaned and made vulnerable by HIV/AIDS. While it is necessary for the national government to own the process, it requires the active and willing collaboration of key partners to adequately collect, or provide, and help analyse information.

### **Specific challenges to the monitoring and evaluation of the national response**

Monitoring and evaluation of a national response in this area has particular challenges that must be recognized at the outset. These relate to the lack of experience with data collection on orphaned and vulnerable children, operationalization of measurable indicators, representative sampling of orphans, and adoption of a standardized, measurable definition of children orphaned and made vulnerable by HIV/AIDS.

First, there is little experience with monitoring and evaluation of national efforts to respond to the needs and rights of orphans and other children made vulnerable by HIV/AIDS. Much of the focus in relation to HIV/AIDS and children has been on the prevention side of the pandemic: ‘HIV prevention among young people’ and ‘prevention of mother-to-child transmission’. In the case of orphans, the emphasis has been mainly on estimating the size of the target population. It is only recently that the impact of HIV/AIDS on lives of children, families and communities and the effectiveness of the national response have started to be systematically included in national monitoring and evaluation efforts. Though household surveys such as DHS and MICS have collected data on orphans in the past decade, very little work has been done in analysing this information. Better use of existing data and improvement in data collection and management will be necessary to monitor the national response.

Second, certain components of the national response are difficult to operationalize into measurable indicators for methodological reasons. Since the prevalence of orphans is higher among older children, existing indicators related to younger children will generally not have large enough sample sizes for meaningful subpopulation comparison. For older orphans, no measurable and meaningful indicators exist. For example, it is desirable to know if orphans have access to health services – for example, treatment of acute respiratory infections (ARI), malaria, use of oral rehydration salts, immunization – on an equal basis with other children. These indicators are only measured for children under five. The small sample size of orphans in this age group in national household surveys does not allow meaningful comparison to other children. The status of access to health care for older children has not been routinely established. Further work needs to be undertaken on establishing appropriate indicators for measuring access to health care by orphaned and vulnerable children.

Third, gathering data from children can be difficult, especially if the data are sensitive. Some of the indicators in this guide require sensitive data (on sexual behaviour or psychological health, for example). Ethical issues should be considered before surveys are conducted to ensure that the safety and rights of the child are protected. Guidelines on gathering information from children and adolescents have been developed by the US Agency for International Development (USAID) and the Population Council’s Horizons project.

Fourth, most national-level monitoring and evaluation of HIV/AIDS programmes is done through household surveys. This is a useful and valid methodology to assess the scope of certain problems at population level. This single methodology, however, does not capture an important group of orphans and other children made vulnerable by HIV/AIDS, which probably needs special attention, i.e., children living outside of family care (children living on the streets and in institutions). In most

countries, the number of this population in relation to the number of orphaned and vulnerable children in households will be negligible. Most national-level indicators on orphaned and vulnerable children will be measurable through household surveys. But if a country can accurately estimate that more than 5 per cent of the population aged 0–17 lives outside of households, a combination of methodologies might be required to monitor the well-being of children orphaned and made vulnerable by HIV/AIDS. A proposed methodology to include the out-of-household group is provided in annex I.

Finally, the understanding of orphans and children made vulnerable by HIV/AIDS often varies from one cultural and socio-economic context to another and therefore tends to differ between countries and sometimes even between programmes within countries. It is therefore impossible to have one *standardized measurable definition* that meets all needs. It is important to make a clear distinction between any definition developed for monitoring and the criteria used for targeting purposes by programmes or community efforts. Those concerned with orphaned and vulnerable children need to recognize this distinction and establish a ‘firewall’ between a very specific definition established for monitoring and a definition or criterion used to determine who can benefit from a particular intervention. Problems with stigma, as well as resentment and conflicts within households and communities, occur when very specific definitions established for quantitative purposes are used for programme targeting or eligibility criteria in policy and programme implementation. The quantitative process must have clear boundaries and allow for absolute distinctions. In contrast, developing and implementing programmes and services must take into account local variations in the factors that cause or constitute vulnerability. For programming and service delivery, no one specific definition will suffice for every context.

While defining ‘orphan’ for national study purposes is fairly easy, establishing a measurable definition of ‘vulnerable’ is a bigger challenge. It is recommended that the concept of ‘vulnerability’ be captured with a minimum number of variables to strictly specify the population measured and ensure replicability.

The focus of this guide is to measure the well-being of children affected by HIV/AIDS. It is not feasible to know the HIV status of the adults or children in most circumstances, and so proxy measures are used to estimate children who are affected by high adult mortality and morbidity. The definition below thus identifies children who have had a parent or an adult household member die or become chronically ill. In a setting with high HIV prevalence, this definition is likely to be a fairly reliable proxy for children affected by HIV/AIDS.

Following field tests in Jamaica and Malawi, a review of recent quantitative studies that included different concepts of vulnerability and a series of consultations on the findings, the UNAIDS Monitoring and Evaluation Reference Group recommends the following definition of orphans and other children made vulnerable by HIV/AIDS:

*An orphan is a child below the age of 18 who has lost one or both parents.*

*A child made vulnerable by HIV/AIDS is below the age of 18 and:*

- i) has lost one or both parents, or*
- ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child), or*
- iii) lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before he/she died, or*
- iv) lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or*
- v) lives outside of family care (i.e. lives in an institution or on the streets).<sup>12</sup>*

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<sup>12</sup> For household surveys it is recommended to include only categories: i, ii, iii and iv.

Countries can add or exclude categories based on their country context. It is, however, recommended to use the above definition where possible in order to monitor changes over time and compare and learn from different countries.

### **National-level indicators for monitoring response**

This guide provides a set of indicators and methods for measuring those indicators to be used at the national level. The indicators are intended to measure a broad range of issues regarding orphans and other children made vulnerable by HIV/AIDS and the country's response. The selected indicators should provide a way to track changes over time. As the indicators have to cover a broad range of topics and because substantial resources can go into collecting indicators at the national level, the number of indicators in any particular area must remain limited. In the Declaration of Commitment, 37 specific commitments are made in relation to orphans and other children made vulnerable by HIV/AIDS (see annex II). Clearly, not all these commitments can be individually monitored.

#### *Framework for indicator selection (input, output, outcome, impact)*

The selection of a set of core indicators for the monitoring and evaluation of a national programme is essential. The most commonly used framework for the selection of indicators is the input-output-outcome-impact framework described in figure 2.4. The indicators can measure what goes into a programme (money, number of textbooks, meals, training, etc. – these are known as the input indicators). And what comes out of it (orphans supported with school fees, trained counsellors, seed money for income-generating activities, memory books, etc. – these are known as output indicators). These indicators should be measured at all levels – project, district programme, provincial and national.

At the national level, various indicators are needed to track changes in the outcome of different programmes. Programme outcomes and impacts are the set of intermediate and longer-term results expected to occur at the population level due to programme activities and the generation of programme outputs. Outcomes are often best measured through population-based data.<sup>13</sup>

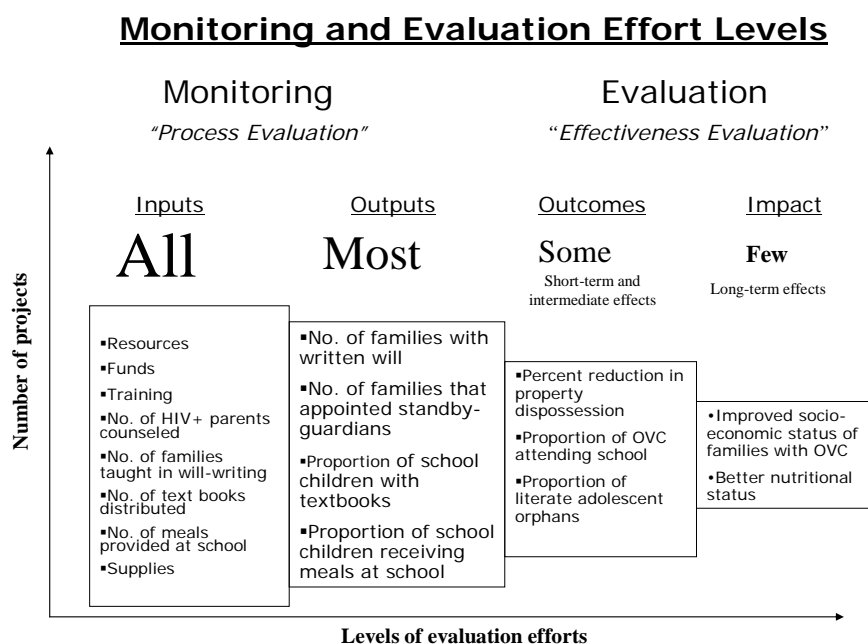
Evaluation of the national response to children affected by HIV/AIDS relies on sound monitoring of programme context, input, output, outcome and impact. The analysis and interpretation of trends in monitoring indicators at different levels form the basis for evaluation of the national programme. Taken together, monitoring indicators track the success of the national response as a whole. They give programme managers and decision makers an idea of whether the sum total of all efforts intended to benefit children orphaned and made vulnerable by HIV/AIDS in a district, region or country are making any difference in terms of slowing the epidemic spread of HIV and reducing its impact on individuals and families.

The following section discusses selected key issues related to the selection of indicators at different levels of the framework for monitoring and evaluation (see also figure 2.4 for an example).

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<sup>13</sup> Population-based data refer to information obtained from a probability sample of the target population. The data are generally collected from surveys, such as the DHS, MICS, LSMS, etc.

**Figure 2.4 – Framework for monitoring and evaluation of programmes that support orphaned and vulnerable children**



Source: adapted from Lamptey and Gayle (eds), "HIV/AIDS Prevention and Care in Resource-Constrained Settings", FHI, 2003

The choice of input and output indicators clearly depends on what programmes aim to do. For example, succession planning – preparing families before a parent’s death – is increasingly becoming a key programme objective, so monitoring at the *input* level includes indicators such as ‘number of HIV+ parents counselled’ or ‘number of families taught will-writing’. The number of families that ‘have a written will’ or ‘appointed a standby guardian’ are examples of *output* indicators. An important *outcome* of succession planning programmes should be a reduction in ‘the percentage of widows dispossessed of property’. The long-term *impact* of these interventions should be improved socio-economic circumstances and a better future for children affected by HIV/AIDS.

Similarly, programmes that aim to deliver such essential services as basic education should be monitored using indicators at different levels. Examples of input indicators that are used to monitor programmes that aim to ensure access to schooling for children affected by HIV/AIDS are measures of services made available, such as the number of textbooks distributed or the number of meals provided at schools in a district. Indicators at the output level would include the number of children with textbooks or the number of children that received a meal during the last school day. The outcome of such programmes should result in an increase in ‘school attendance’ among children affected by HIV/AIDS. The long-term impact should be reflected in an increase in literacy among adolescents orphaned or made vulnerable by HIV/AIDS.

Success of care and support programmes depends on the context in which they operate. The social, cultural and economic contexts in which children live and programmes operate are therefore important factors that need to be assessed when evaluating a national response. Indicators of the political, legal and attitudinal contexts in which a programme operates have been developed in recent years. The most commonly used is the AIDS Programme Effort Index (this guide recommends the Policy and Planning Effort Index as core indicator 8). Accepting attitudes towards those living with HIV-positive people is an important indicator in assessing the level of stigma and discrimination towards those who are infected and affected by HIV/AIDS.

### *Standardized comparable indicators*

Having information available that is reliable and consistent within and between countries is essential for planning and monitoring policies and programmes, national and global advocacy, making decisions about the support that should be provided to families and communities, and providing focus for the different sectors and actors involved. The use of standard quantitative indicators allows comparison of the overall implementation and effectiveness of the national response in different countries. Countries will be able to learn from one another, and it will be a useful approach to validate and document best practices in response strategies. Therefore, where they fit the needs of a country, national AIDS councils and other stakeholders are encouraged to use the indicators defined here to ensure standardization of information over time and across countries.

The indicators are not designed to explain why a situation has changed or has failed to change – they are designed simply to measure the change. It is therefore important to support and implement (smaller-scale) qualitative studies<sup>14</sup> and routinely perform a national situation analysis that can answer the ‘why’ question and contribute to decisions about ‘how.’ These are essential to link M&E systems and policy formulation (see the ‘programme cycle’, figure 2.1).

#### **Box 2.2. Characteristics of indicators<sup>15</sup>**

Ideally, indicators should be:

**Valid** – they should actually measure what they are supposed to measure;

**Reliable** i.e., *verifiable* or *objective* – conclusions based on them should be the same if measured by different people at different times and in different circumstances;

**Relevant** – they should be relevant to the objectives of the programme;

**Sensitive** – they should be sensitive to changes in the situation being observed;

**Specific** – they should be based on available data;

**Cost-effective** – the results should be worth the time and money it costs to apply them;

**Timely** – it should be possible to collect the data reasonably quickly.

### **Information on living arrangements and childcare**

While these guidelines recommend 10 core indicators to monitor the national response, it is useful to collect additional information on certain care practices for orphans and other children made vulnerable by HIV/AIDS. This information is typically collected as part of a situation analysis, but it should be regularly monitored in countries with high HIV levels. In these conditions, the persons responsible for orphans are likely to change over time as caregivers become infected and/or affected by HIV/AIDS.

At a minimum, it is recommended to additionally monitor:

- *Relationship of orphan to head of household* (surviving parent, grandparent, uncle, aunt, sibling, etc.)
- *Average age of caregiver*

<sup>14</sup> Key informant interviews, focus group discussions, participant observation, etc.

<sup>15</sup> Source: ‘Monitoring and evaluation: Guiding principles. For the Design and Use in Rural Development Projects and Programmes in Developing Countries’. United Nations ACC Task Force on Rural Development. Panel on Monitoring and Evaluation, International Fund for Agricultural Development, Italy, 1985.

- *Dependency ratio in households* (sum of children under 18 and persons 60 years or older divided by the number aged 18–59 years)<sup>16</sup>
- *Percentage of households with children that include one or more orphans.*

Also, where possible, the following data should be collected and considered in the situation analysis:

- *Relationship of orphan to the adult who has primary responsibility for the child* (surviving parent, grandparent, uncle, aunt, sibling, etc.)
- *Role of (surviving) parents in caring for children:*
  - % of non-orphans not living with any biological parent (fostered children)
  - % of single orphans not living with surviving parent
  - % of non-orphans residing with father
  - % of maternal orphans residing with father
  - % of non-orphans residing with mother
  - % of paternal orphans residing with mother
- *Effective dependency ratio* (dependency ratio adjusted to include chronically ill adults in the dependent category)
- *Average household size* (average number of people living in household with children)
- *Average number of orphans per household* (average number of orphans among households that include orphans).

### **Additional background characteristics**

Where possible the indicators and information on care practices will need to be analysed and presented by a number of background characteristics.

Background characteristics that are important to disaggregate include:

- *gender of child* (male or female)
- *urban and rural areas*
- *type of orphan* (maternal orphan, paternal orphan, double orphan)
- *vulnerable status* (vulnerable versus orphan)
- *age group* (0–4, 5–9, 10–14, 15–17)
- *length of orphanhood* (number of years orphaned)
- *mobility* (number of years lived in current residence)

Analyses of the pilot surveys of these indicators showed that children who were categorized as vulnerable had much worse outcomes than children who were orphaned. This is probably because children who are orphaned could have lost their parent many years prior to the survey, while children who are vulnerable, by definition, were made vulnerable in the past year. Disaggregating the data by vulnerable status will provide useful information for directing a national response for children affected by HIV/AIDS.

In addition, it would be useful to present the information on care practices by different categories. For example, the ‘dependency ratio’ will need to be presented separately (disaggregated) by *gender of the*

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<sup>16</sup> The recommended age groups used for the dependency ratio might be different in some countries.

*head of household* children live in (male-headed household/female-headed household). Thus, data should ideally (if sample size allows) be presented for:

- Dependency ratio for all households with children
- Dependency ratio for households with children who are not taking care of orphans
- Dependency ratio for households with orphans
- Dependency ratio for *households with orphans headed by a man*
- Dependency ratio for *households with orphans headed by a woman*.

### The importance of age structure in the analysis of data on orphans

As children get older they are more likely to be orphaned because the risk of a parent dying increases over time. Because of this correlation between age and orphan status, variables that are also correlated with age will have skewed results. For example, if we look at school attendance for children aged 7–14 we might find that orphans are more likely to be in school. This could be because orphans are on average older than non-orphans, and older children are more likely to be in school. If we compare non-orphans to orphans of similar ages, we might find that the orphans are actually worse off. This is a common problem demographers encounter when comparing populations with different age structures. A detailed example is provided in box 2.3.

#### Box 2.3: Adjusting for orphan age structure

It is recommended that the indicators in this guide be calculated using the age groups as recommended for each indicator. If the results seem contradictory or if a country needs wider (larger) age groups, it is recommended that analysis be conducted while controlling for the age structure.

For example, if we make up some data comparing school attendance for orphans and non-orphans, we find the following results:

<i>Age</i>	<i>Number of non-orphans</i>	<i>Number in school</i>	<i>Proportion in school</i>	<i>Number of orphans</i>	<i>Number in school</i>	<i>Proportion in school</i>
7	170	120	0.71	50	25	0.50
8	150	115	0.77	80	42	0.53
9	140	110	0.79	90	65	0.72
10	130	105	0.81	100	76	0.76
11	130	105	0.81	100	77	0.77
12	120	100	0.83	150	125	0.83
13	90	75	0.83	210	186	0.89
14	70	60	0.86	220	194	0.88
<b>7–14</b>	<b>1,000</b>	<b>790</b>	<i>Avg.</i> 0.80	<b>1,000</b>	<b>790</b>	<i>Avg.</i> 0.73

If we do a straight comparison of the proportion in school based on the number in school, we find that the two groups are the same (79 per cent versus 79 per cent). However, if we do a comparison of the proportions going to school by single-year age we see that for children ages 7, 8, 9, 10 and 11 the proportions are lower for orphans. If we average the single year age proportions (using equal weight for each age) we find that the non-orphans are better off (80 per cent versus 73 per cent).

Thus, to control for age structure simply calculate a proportion for each single-year age group (or for two-year age groups if the sample size gets too small) and then report the average proportion over all the age groups.



## Tools to measure indicators

This guide is accompanied by a number of data-collection instruments that can be found at [www.childinfo.org](http://www.childinfo.org). These instruments are based on existing tools where possible.

### *National representative sample of children*

As explained earlier in this chapter, reliable estimates and characteristics in the case of children orphaned and made vulnerable by HIV/AIDS will depend on the ability to capture a representative sample of this group among all children. Estimates of orphan prevalence could be *understated* through a household survey alone and orphan characteristics would be *biased* to the degree that those living in households are fundamentally different from those in institutions or on the streets, if the out-of-household population is sufficiently large. Pilot surveys based in Kingston (Jamaica) and Blantyre (Malawi) found that less than 1 per cent of the population under the age of 18 was outside of households. The population outside of households would need to be at least more than 5 per cent to have any significant effect on national-level indicators.

If the population outside of households is larger than 5 per cent, a survey intended to study the total population of orphaned and vulnerable children would have to sample from (1) all children in households, (2) all children residing in institutions and other group quarters and (3) all children sleeping on the streets. The survey process would have to cover each of these three populations in order to achieve unbiased distribution and characteristics of children orphaned and made vulnerable by HIV/AIDS. See annex I for more details.

**Table 2.1: Tools for monitoring orphaned and vulnerable children**  
(Examples available at [www.childinfo.org](http://www.childinfo.org))

Tool	Description
<b>Questionnaires</b>	
Household	Questionnaire administered to household heads
Individuals 15–49	Questionnaire administered to women and men 15–49
Individuals 12–14	Questionnaire administered to children aged 12–14

## CHAPTER 3 – INDICATORS

One of the principal aims of this guide is to emphasize the importance of choosing standard indicators and measuring them repeatedly over time. Steps were taken to ensure that the indicators recommended in these guidelines are the most useful and provide information that is most relevant to programme assessments and planning needs. Programme managers from different countries, M&E specialists and researchers in special areas participated in a consultative process to identify priority areas for monitoring and indicators, and to review tools for data collection.

During this process, a set of indicators was identified for the national level measurement of the global goals for children orphaned and made vulnerable from HIV/AIDS.<sup>17,18</sup> Working from the UNGASS/AIDS Declaration of Commitment, the experts distilled 37 key activities for improving the welfare of orphaned and vulnerable children (see annex II) into 10 key domains that need to be addressed and monitored at the national level. The domains are: (1) *policies and strategies*, (2) *resources and resource mobilization*, (3) *family capacity*, (4) *community capacity*, (5) *food security and nutrition*, (6) *health*, (7) *education*, (8) *protection*, (9) *psychosocial support* and (10) *institutional care/shelter*.

As outlined in table 3.1, the domains reflect the target action areas of the strategic framework as discussed in chapters 1 and 2. For each of these 10 domains indicators were identified and prioritized. For each indicator the strengths and weaknesses were reviewed. As a guiding principle, the indicators were selected on their existence, wide acceptance and use internationally. Many can be derived from existing questions in established data-collection tools (i.e., DHS or MICS).

Several of the domains are new and have never been monitored at the national level on a wide scale. For example, birth registration is an existing indicator, and the indicators for education and malnutrition are adapted from standard indicators and measurement tools, but most of the indicators for psychosocial support, protection, and family and community capacity are based on indicators previously used only at the subnational level.

This chapter is organized according to the five major elements of the strategic framework discussed in chapter 1. Each strategy is discussed briefly, touching on what it aims to provide and/or achieve in a given area. Key questions are identified to focus on what can or should be monitored. This discussion is followed by a review of measurement challenges in the area and the proposed indicators.

Each indicator is described in the context of the strategic framework and related programme goals. The data requirements are summarized, and reference is made to data-collection tools. Some of the indicators are useful for more than one strategic area, but to avoid duplication, they have been presented only once in the framework.

Two levels of indicators are provided: core and additional. Ten core indicators are recommended to be measured, with results to be shared by all countries. When necessary, countries should add or delete indicators to make certain the data collected are linked to improving the national response. Therefore, along with the 10 core indicators, seven additional indicators are presented that countries could consider to supplement the core set.

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<sup>17</sup> Report on the 'Technical Consultation on Indicators Development for Children Orphaned and Made Vulnerable by HIV/AIDS'; UNAIDS/UNICEF, Gaborone, Botswana, April 2–4, 2003. Report available at: <http://www.childinfo.org>

<sup>18</sup> Consultation on Measuring Vulnerability in the Light of the HIV/AIDS Pandemic'. United Nations Regional Inter-Agency Coordination and Support Office (RIACSO). Johannesburg, South Africa, 9–11 September 2003. Volume I: Consultation Proceedings. Report available at: [http://www.sahims.net/Events/riacso\\_consultation\\_vulnerability](http://www.sahims.net/Events/riacso_consultation_vulnerability)

As described in chapter 2, the proposed indicators are listed along with proposed tools for measuring the indicator. If a population-based survey is called for and the proportion of institutionalized children and children living on the streets is over approximately 5 per cent, a comprehensive survey including these two categories should be conducted. If a household survey is called for, then only children in household settings are required for calculation of the indicator.

**Box 3.1: A note on terminology**

To make this chapter easier to read, the acronym OVC has sometimes been substituted for the words ‘children orphaned and made vulnerable by HIV/AIDS.’ OVC comes from the term ‘orphaned and vulnerable children,’ which does not accurately describe the children who are the focus of this guide. For the purpose of brevity, however, this acronym will be used for describing the indicators and in the annexes. As mentioned in chapter 1, this guide is intended to capture information on children affected by HIV/AIDS; children who are orphaned and vulnerable are a proxy group used to monitor the well-being of children affected by HIV/AIDS.

**Table 3.1: Indicators by strategic approach, age of target group, key thematic domains and measurement tool**

Strategic approach	Age	Key domains	Measurement tool
<b>Strengthening the capacity of families to protect and care for children</b>			
<i>Core indicators</i>			
1: Basic material needs	5–17	Family capacity	Population-based survey
2: Malnutrition/underweight prevalence	0–4	Food security and nutrition	Population-based survey
3: Sex before age 15	15–17	Health	Population-based survey
<i>Additional indicators</i>			
A1: Food security	NA	Food security and nutrition	Household survey
A2: Psychological health	12–17	Psychosocial	Population-based survey
A3: Connection with an adult caregiver	12–17	Psychosocial	Population-based survey
A4: Succession planning	NA	Protection	Household survey
<b>Mobilizing and strengthening community-based responses</b>			
<i>Core indicators</i>			
4: Children outside of family care	0–17	Institutional care and shelter	Street children survey and institution survey
5: External support for orphaned and vulnerable children	0–17	Community capacity	Household survey
<i>Additional indicator</i>			
A5: Orphans living with siblings	0–17	Community and family capacity	Population-based survey
<b>Ensuring access to essential services</b>			
<i>Core indicators</i>			
6: Orphan school attendance ratio	10–14	Education	Population-based survey
7: Birth registration	0–4	Protection	Population-based survey
<b>Ensuring that governments protect the most vulnerable children</b>			
<i>Core indicator</i>			
8: Orphaned and Vulnerable Children Policy and Planning Effort Index	NA	Policies/strategies, resources and resource mobilization	Key informant interviews
<i>Additional indicator</i>			
A6: Property dispossession	15–49	Protection	Household survey
<b>Raising awareness to create a supportive environment</b>			
<i>Core indicators</i>			
9: Percentage of children who are orphans	0–17	Policies/strategies	Population-based survey
10: Percentage of children who are vulnerable	0–17	Policies/strategies	Population-based survey
<i>Additional indicator</i>			
A7: Stigma and discrimination	15–49	Protection	Population-based survey

## **Strengthening the capacity of families to protect and care for children**

When a household begins to feel the effects of HIV/AIDS, family relationships are the first and most immediate source of support. Mothers and fathers who lose their spouse to AIDS are burdened with increased economic and childcare responsibilities and, in some cases, may also be ill themselves. The vast majority of orphaned and vulnerable children are living with surviving parents or their extended family. Even the majority of children living or working on the streets live with or maintain ties with their families. Given this reality, the core of a strategy to respond to orphaned and vulnerable children must be to strengthen the capacity of families to care for and protect their children.

Families are the best hope for the care of vulnerable children, but they require support from outside sources for both immediate and longer-term survival needs. Families need a combination of economic, material and psychosocial support, as well as measures to help those living with HIV/AIDS to live longer, better and in greater dignity. Areas of interventions that are vital to the coping capacity of families include: (i) improvement of household economic capacity, (ii) provision of psychosocial support to affected children and their caregivers, (iii) strengthening and supporting childcare capacities, (iv) support of succession planning, (v) prolonging the lives of parents and (vi) strengthening young people's life skills. A partnership of governmental and community agencies, including faith-based organizations, will be needed to provide this support.

### *Key questions*

- Are families able to provide orphaned and vulnerable children with basic needs?
- Do orphaned and vulnerable children have a trusted caring adult as a stabilizing influence in their lives?
- Do orphaned and vulnerable children grow up in an environment that fosters a healthy approach to life and a capacity to cope in adversity?
- Do families make arrangements for orphaned and vulnerable children in the event of the premature death of caregivers?
- Are parents and caregivers able to access HIV counselling, testing and appropriate drugs if required?

### *Measurement issues*

Children's well-being and healthy development depend on the interplay of related factors, including physical, emotional, cognitive, material, social and spiritual factors. In order to reach their full potential, children require basic provisions for survival (adequate food, shelter, clothing), as well as nurturing and guidance from caring adults in a predictable and stable way. These components will need to be measured separately.

Basic health and education needs are discussed in the section on 'Ensuring access to essential services'. Basic material needs are covered in core indicator 1. The material needs, however, might differ per region or country and sometimes even within countries.

Perhaps the most complicated issue in measuring the well-being of orphans and other children made vulnerable by HIV/AIDS is psychosocial support and well-being. Monitoring psychosocial support programmes is difficult because the range of programmes that are termed 'psychosocial' have wide variations in approach and quality, and their actual reach is difficult to assess.

One way of assessing the psychosocial health of children and adolescents on a broad scale is by looking at the number of children living on the streets or institutions (see core indicator 4). The percentages of children living on the street or heading their own households are indicators of lost connections to adults who would otherwise be supervising and providing for these children. It is most useful to consider change in trends over time for these indicators. These children are in particular danger of developing psychosocial problems, and if rates are high, programmes need to target these

at-risk groups to ensure coverage. The history of institutionalization of children has shown that children raised in institutions often do not receive the same individual attention, stimulation and guidance as those raised in family or foster-care settings. As a result they risk being divorced from their cultural and social spheres, and show attachment disorders later in life, as well as difficulty in forming appropriate relationships.

Although standardized surveys exist to assess the psychological status of children and adolescents, most of these surveys are only applied in a limited number of countries. They are also limited in international application by cross-cultural variances in emotional distress symptoms and language, and sociocultural expectations for proper behaviour and emotional expression. Although the recommended indicator on psychosocial well-being in this guide is intended to be useful across cultures, pre-testing and validation are essential to ensure that the items are locally appropriate.

Another intermediate marker of psychosocial well-being for children and adolescents is the feeling of connection to an adult caregiver. This was found to work cross-culturally and is tentatively included in this guide although more work is needed to better define the indicator (additional indicator A3).

## CORE INDICATOR 1: BASIC MATERIAL NEEDS

<b>Definition</b>	Ratio of orphaned and vulnerable children (OVC) versus non-OVC who have three minimum basic material needs for personal care.
<b>Purpose</b>	To assess the capacity of families to provide basic material needs for children under their care.
<b>Priority</b>	Core.
<b>Numerator</b>	<p><b>(1) Proportion (%) of OVC who have three minimum basic material needs for personal care.</b></p> <p>Numerator 1: Number of OVC aged 5–17 surveyed with a minimum set of three basic personal material needs.</p> <p>Denominator 1: Number of OVC aged 5–17 surveyed.</p>
<b>Denominator</b>	<p><b>(2) Proportion (%) of non-OVC who have three minimum basic material needs for personal care.</b></p> <p>Numerator 2: Number of non-OVC aged 5–17 surveyed with a minimum set of three basic personal material needs.</p> <p>Denominator 2: Number of non-OVC aged 5–17 surveyed.</p>
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	<p>This indicator assesses the capacity of families to provide children with minimum basic material needs. The suggested items for measurement are availability of a blanket, shoes and two sets of clothes. These three items should be modified at country level if other basic needs are considered more important (sleeping mat, sheets, school books, soap, etc.). Food, education and medical care<sup>19</sup> are also considered essential survival needs; however, they are covered by other indicators in this manual and are therefore excluded from this indicator.</p> <p>The indicator estimates whether the overall levels of basic personal needs for children are being met. Furthermore, when calculated as a ratio of OVC to non-OVC, it assesses progress in preventing relative disadvantages for orphaned and vulnerable children.</p>
<b>How to measure it</b>	<p>Ratio of OVC to non-OVC who have their basic material needs met: The ratio of (1) proportion (%) of OVC who have three minimum basic material needs to (2) proportion (%) of non-OVC who have three minimum basic material needs.</p> <p>In a household survey, questions on the availability of each item should be asked for each child in the household. Items selected for inclusion should be the same for all children 5–17 years old.</p>
<b>Strengths and limitations</b>	<p>In some countries the chosen items will not be appropriate, so the indicator will not always be comparable between countries. Basic needs might also vary by regions within countries (i.e., variations in climate), so adjustments should be made as necessary.</p> <p>These questions could potentially raise respondents' expectations that free handouts might be provided to households who do not have these goods. This can be avoided if interviewers carefully explain the purpose and goals of the survey to respondents before the start of the interview.</p>

<sup>19</sup> Currently there is no indicator included on access to health care due to measurement issues (see section 2.5).

***Analysis and interpretation***

Strengthening the capacity of families to protect orphans and children made vulnerable by HIV/AIDS is the first line of support for impact mitigation. A comparison of OVC versus non-OVC who have the basic material needs will show the capacity of families to compensate for the extra burden of orphans in a household. If the ratio is less than one, this might indicate that the social welfare systems are failing to supply the external support to families to provide for orphaned children. This indicator should be analysed in conjunction with other basic social support services such as education (school attendance).

As children get older they are more likely to be orphaned because the risk of a parent dying increases over time. If there is also a correlation between basic material needs and age (i.e., older children are more likely to have shoes), there will be 'confounding' between orphan status and basic material needs. For calculating ratios between OVC and non-OVC, one should ideally adjust for the different age structure between the two groups (an example is provided in chapter 2.9).



## CORE INDICATOR 2: MALNUTRITION/UNDERWEIGHT PREVALENCE

<b>Definition</b>	Ratio of the proportion of OVC compared to non-OVC who are malnourished (underweight).
<b>Purpose</b>	To assess progress in preventing relative disparity in malnutrition among orphaned and vulnerable children versus other children.
<b>Priority</b>	Core
<b>Numerator</b>	<p><b>(1) Malnutrition rate among OVC (%)</b></p> <p>Numerator 1: Number of OVC aged 0–4 years who are malnourished (below -2 standard deviations from the median weight-for-age of WHO/NCHS reference population).</p> <p>Denominator 1: Number of OVC aged 0–4 years.</p>
<b>Denominator</b>	<p><b>(2) Malnutrition rate among non-OVC (%)</b></p> <p>Numerator 2: Number of non-OVC aged 0–4 years who are malnourished (below -2 standard deviations from the median weight-for-age of WHO/NCHS reference population).</p> <p>Denominator 2: Number of non-OVC aged 0–4 years.</p>
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	This indicator measures the level of malnutrition (underweight) among orphaned and vulnerable children versus other children. Weight-for-age reflects a combination of acute and chronic malnutrition for the child.
<b>How to measure it</b>	<p>Orphan malnutrition ratio: The ratio of (1) OVC' malnutrition rate to (2) non-OVC' malnutrition rate.</p> <p>For reliable assessment of the nutritional status of children, a representative sample of the population of children should be used rather than the children seen at health facilities. Large household survey programmes such as DHS and MICS collect anthropometric data from children.</p> <p>Well-nourished young children of all populations follow very similar growth patterns. Thus the World Health Organization (WHO) recommends that the nutritional status of children sampled in surveys be compared with an international reference population defined by the U.S. National Center of Health Statistics (NCHS). The nutritional status of a child is thus expressed as the standard deviation units (z-scores) from the median for the reference population. Those children found to be more than 2 standard deviations below the median for the reference population are considered to be underweight.</p> <p>Typically, household surveys have only measured malnutrition for children below the age of 5; however, because most orphans are older, the sample size of orphans in this age range are often too small to compare with non-orphans. In the pilot surveys in Jamaica and Malawi, weight and age data were collected and analysed for children up to and including age 8 to avoid this limitation. (Children older than 8 were excluded because once they reach pre-adolescence their growth is erratic and because internationally agreed-upon cut-offs for boys over 10 and girls over 8 are not available.) The pilot surveys showed, however, that as children get older, the variations in underweight are small, and thus comparing children ages 5–8 is not useful.</p>
<b>Strengths and limitations</b>	<p>This indicator does not cover the majority of orphans who are older than age 5. Malnutrition rates have been reliably used globally; they will be useful to maintain for assessing malnutrition status among pre-school orphaned and vulnerable children living in households, and orphaned and vulnerable children living in institutional care arrangements.</p> <p>The data on underweight reflect a child's overall growth progression during his/her lifetime. The status of orphaned or vulnerable might be a recent change and might not yet have affected the child's nutrition status. Analysis of this indicator should consider the timing of these events.</p>

***Analysis and interpretation***

National levels of child malnutrition are not expected to change markedly, except in situations of drought, famine or war. The situation of orphaned and vulnerable children may change more rapidly, however. The opportunity should be taken whenever there are national (or geographically representative) nutrition surveys to assess orphans and other children made vulnerable by HIV/AIDS.

This core indicator can be accompanied by two additional indicators: (a) stunting (height-for-age) and (2) wasting (height-for-weight). Stunting reflects long-term malnutrition, whereas wasting reflects more recent or acute malnutrition. The Body Mass Index (BMI) can also be considered for adolescents, related to standard BMI-for-age curves; this is recommended by the U.S. Centers for Disease Control and Prevention as the only valid measure for adolescents.<sup>20</sup>

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<sup>20</sup> For more details on BMI see: <http://www.cdc.gov/nchs/data/ad/ad314.pdf>  
<http://www.cdc.gov/nccdphp/dnpa/growthcharts/training/modules/module1/text/page5atext1.htm>

### CORE INDICATOR 3: SEX BEFORE AGE 15

<b>Definition</b>	Ratio of the proportion of OVC compared to non-OVC aged 15–17 who had sex before age 15.
<b>Purpose</b>	To assess progress in preventing early-age exposure to sexually transmitted infections/HIV/teenage pregnancies among orphans and other children made vulnerable by HIV/AIDS.
<b>Priority</b>	Core.
<b>Numerator</b>	<p><b>(1) Proportion (%) of OVC who had sex before age 15.</b></p> <p>Numerator 1: Number of OVC who report their age at first sex as under age 15.</p> <p>Denominator 1: Number of OVC aged 15–17.</p>
<b>Denominator</b>	<p><b>(2) Proportion (%) of non-OVC who had sex before age 15.</b></p> <p>Numerator 2: Number of non-OVC who report their age at first sex as under age 15.</p> <p>Denominator 2: Number of non-OVC aged 15–17.</p>
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	<p>One way young people can be protected from infection is by delaying sexual activity. There is evidence to suggest that a later age at first sex reduces susceptibility to infection per act of sex, at least for women. This indicator provides information on the prevalence of early sexual activity among orphaned and vulnerable children and other children aged 15–17. Adolescents form a high-risk group for HIV/AIDS because they are at a crucial stage of growth and might not be fully mature physically or emotionally. They may also be more likely to be bullied or exploited in sexual relationships. Teenage orphans and other vulnerable adolescents can be at especially high risk because of a lack of adult guidance to help them protect themselves.</p> <p>The ratio of early sex for OVC versus non-OVC will monitor whether the behaviour of OVC is different from that of non-OVC.</p>
<b>How to measure it</b>	<p>Ratio of OVC to non-OVC who had sex before age 15: The ratio of (1) proportion of OVC ages 15–17 who had sex before age 15 to (2) proportion of non-OVC ages 15–17 who had sex before age 15.</p> <p>This indicator is derived from responses to a question about the age of respondents when they first had penetrative sex. This indicator should be presented as separate percentages for boys and girls.</p>
<b>Strengths and limitations</b>	<p>First sex is a significant event for most people and can probably be remembered in this age group without too much difficulty. But young people may be unsure of their exact age or may give a different age: one that is more socially acceptable. There is evidence that young people do not always tell the truth about the age at which they first had sex, and there is also evidence that they may deny that they have ever had sex. Young people of both sexes may alter their responses as a result of their society's views on young people's sexuality.</p> <p>Analysis of the reporting of age at first sex has shown that the existence, extent and direction of the reporting or recall bias are not predictable. Furthermore, there is probably no difference in any potential bias between orphaned and vulnerable children and other children.</p>
<b>Analysis and interpretation</b>	<p>If sample sizes are sufficient, it might be useful to consider the standard UNGASS indicator on condom use at last high-risk sex by OVC status. This indicator assesses the proportion of sexually active young people who minimize their risk of HIV and other sexually transmitted infections through use of condoms. Condom use is one important component of HIV prevention. It is especially important for children who are having sex with non-regular partners; condom use provides an indication of life skills. Orphaned and vulnerable children may be at a disadvantage because they lack the opportunities for acquisition of life skills and may be more likely to be exposed to risky sexual encounters. For this reason it is important to compare the levels of protection between orphaned and vulnerable children and other children. For more details, see: <i>Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators</i>, UNAIDS, 2002.</p>

## ADDITIONAL INDICATOR A1: FOOD SECURITY

<b>Definition</b>	Ratio of food insecure households with OVC compared to households without OVC.
<b>Purpose</b>	To determine how widespread food insecurity is among the population and compare the food security status of households with OVC to the food security status of households without OVC.
<b>Priority</b>	Additional.
<b>Numerator</b>	<p><b>(1) Proportion (%) of households with OVC that are food insecure.</b></p> <p>Numerator 1: Number of sampled households with OVC that are food insecure.</p> <p>Denominator 1: Number of sampled households with OVC.</p>
<b>Denominator</b>	<p><b>(2) Proportion (%) of households with children that are not taking care of OVC.</b></p> <p>Numerator 2: Number of sampled households with children that are not taking care of OVC and are food insecure.</p> <p>Denominator 2: Number of sampled households with children that are not taking care of OVC.</p>
<b>Measurement tools</b>	Household surveys.
<b>What it measures</b>	This indicator measures the level of household food insecurity within the population, specifically those households with severe hunger. The ratio consists of households with orphaned and vulnerable children versus households that are not taking care of orphans or other vulnerable children but do contain children.
<b>How to measure it</b>	<p>OVC food insecurity ratio: Ratio of (1) proportion of households with OVC that are food insecure to (2) proportion of households without OVC, but with other children, that are food insecure.</p> <p>In a household survey the head of the household is asked a series of questions that characterize households having difficulty meeting their food needs. These questionnaires begin by assessing mild food insecurity and slowly progress through moderate to severe food insecurity. The questions and the determination of food security status generally follow this format:</p> <ul style="list-style-type: none"> <li>• <b>Food secure</b> <ul style="list-style-type: none"> <li>No worries about food security status</li> <li>Worries that food might run out</li> </ul> </li> <li>• <b>Food insecure</b> <ul style="list-style-type: none"> <li>Inability to diversify diet/reliance on low-cost food</li> <li>Adult cut size of serving or skipped meal</li> </ul> </li> <li>• <b>Food insecure with moderate hunger</b> <ul style="list-style-type: none"> <li>Adult cut size of serving or skipped meal repeatedly over the course of a year</li> <li>Adult lost weight</li> <li>Size of child's meal was cut</li> </ul> </li> <li>• <b>Food insecure with severe hunger</b> <ul style="list-style-type: none"> <li>Child forced to skip meal</li> <li>Adult and child forced to go entire days without eating</li> </ul> </li> </ul> <p>The progression follows a well-documented pattern. The inability to maintain diversity in diet is generally seen as the first sign of problems, followed by reduction in the size of meals, then skipping meals, and finally, going entire days without eating. This scale recognizes that adults are often forced to forgo food so that children can eat, therefore, it recognizes that when children begin to have a reduction in their meals or are forced to skip meals the problem has reached a new level of severity – sacrifices made by the adults are no longer sufficient to buffer the children from waning food stocks.</p>

	<p>If necessary, the questions that relate to less severe forms of food insecurity can be eliminated from the questionnaires to cut down on the number of questions. This is a decision that must be made by those implementing the survey.</p>
<p><b>Strengths and limitations</b></p>	<p>The indicator is at the household level, not the individual level as are most other indicators. Thus, it is not the food security status of the orphaned and vulnerable children that is measured but rather the food security status of the household as a whole. This enables a comparison to be made between households (OVC vs. non-OVC with children) but not between orphaned and vulnerable children and other children. The indicator is thus unable to take into account differences in food security status that might exist within the household unit itself.</p> <p>To address this problem, it would be necessary to ask these questions to the orphaned and vulnerable children themselves, but this is only possible when they are old enough to understand and answer the questions put to them. In so doing, it would limit comparisons with orphans in other age groups. There is also the possibility that the head of household could be asked a modified set of questions specifically about the orphan. It is not sure, however, that a head of household would admit to depriving the orphan of adequate amounts of food in order to ensure that the rest of the household did not suffer. Consequently, if there is not a way to measure food allocation patterns within the household, the only alternative is to compare the food security status of households with OVC to that of households without OVC. This comparison could be examined in relation to the nutrition (anthropometric) indicator (core indicator 2) of OVC and non-OVC to check for consistency.</p>
<p><b>Analysis and interpretation</b></p>	<p>Appropriate statistical methods are used to combine responses to the selected questions in order to create a scaled measure of household food security.<sup>21</sup> When reporting to the public or to policy makers, expert attention should be given to identifying thresholds to demarcate ranges of severity that are meaningful in the local context and to choosing language to name and describe the ranges so that prevalence statistics can be understood and correctly interpreted. As these measures become more reliable and accepted they are likely to be used increasingly for resource prioritization (targeting); thus serious consequences to human welfare could result if their meanings are not clearly understood.</p>

<sup>21</sup> The Kampala food security questionnaire, from which most of the recommended questions were taken, created a severity index that examined magnitude and duration of food security status. Specifics on this index and partial results from the study can be found in: Nord, Mark et al. 2002. 'Comparing Household Survey-Based Measures of Food Insecurity Across Countries: Case Studies in India, Uganda, and Bangladesh,' The Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy, Tufts University Food Policy and Applied Nutrition Program, Discussion Paper No. 7, June 14.

## ADDITIONAL INDICATOR A2: PSYCHOLOGICAL HEALTH

<b>Definition</b>	The ratio of OVC versus non-OVC aged 12–17 with an adequate score for psychological health.
<b>Purpose</b>	To assess the psychological health of orphans and other children made vulnerable by HIV/AIDS.
<b>Priority</b>	Additional.  NOTE: This indicator is still being developed. Please check the update of this guide on the UNAIDS website ( <a href="http://www.unaids.org">www.unaids.org</a> ) for future adjustments.
<b>Numerator</b>	<b>(1) Psychological health of orphaned and vulnerable children.</b>  Numerator 1: The number of OVC with an adequate score (at least 20 points out of maximum 32 points).  Denominator 1: All OVC interviewed.
<b>Denominator</b>	<b>(2) Psychological health of other children.</b>  Numerator 2: The number of non-OVC with an adequate score (at least 20 points out of maximum 32 points).  Denominator 2: All non-OVC interviewed.
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	<p>Children’s emotional, cognitive and social development is learned through interaction with their environment and the people (especially the caregivers) in their lives. Through appropriate care and stimulation, children learn: flexibility and adaptability in emotional response, appropriate social interactions, expectations for behaviour, mastery and capability, a stable and positive sense of self, and skills for daily living. Measuring the impact of psychosocial support arrangements can be accomplished through direct measures of emotional health and functioning. These measures also reflect children’s resilience and coping capacity. Psychosocial health and functioning of children and adolescents is reflected in a variety of well-being domains:</p> <ol style="list-style-type: none"> <li>1. Emotional (mood – including depression, grief, stress and worry; self-perception and self-esteem; cognitive aspects such as hopefulness and future orientation).</li> <li>2. Functioning (reflects the capacity of the child or adolescent appropriate to their developmental stage and age; for younger children, this can mean achievement of appropriate developmental milestones, for older children and adolescents, it can be reflected in school performance and the activities of daily living).</li> <li>3. Behaviour (internalizing and externalizing behaviours, including risk behaviours).</li> <li>4. Social connectedness and capacity.</li> </ol> <p>Good psychological health is evidenced by the concept of resilience, which is an overarching theme to the domains listed above. Individual resilience can be thought of as the development of emotional and practical intelligence, which includes:</p> <ol style="list-style-type: none"> <li>1. emotional strength</li> <li>2. social connectedness with peers and adults, including the ability to access necessary social support</li> <li>3. the ability to solve problems in ways that affect the child’s well-being, survival and meeting day-to-day needs.</li> </ol> <p>The environment around the child also fosters resilience through the availability of social supports (adults, positive peer groups, caregivers), and structural supports that offer care and protection (access to education, health services).</p>

	<p>The components of psychological health used in the survey are:</p> <p>(i) stress and worry, (ii) mood, (iii) future orientation, (iv) self-esteem/self-worth, (v) self-perception of physical health, (vi) functioning/capability, (vii) internalizing behaviour, (viii) externalizing behaviour, (ix) social connection and capacity.</p>				
<p><b>How to measure it</b></p>	<p>Orphan psychological health ratio: The ratio of (1) level of psychological health of orphaned and vulnerable children to (2) level of psychological health of other children.</p> <p>Adolescents will indicate their level of agreement to a series of statements related to different components of psychological health. The instructions ask the respondents to indicate how they have been feeling over the past two weeks. Questions are worded both positively and negatively, and the coding of response scales for analysis must be adjusted accordingly. Prior to administration of the survey, it is essential for assessors to ensure that the wording of questions is valid in the local language and sociocultural context. Many terms for emotional well-being and distress do not translate well between different languages and cultures, and so a validation procedure must be undertaken before the questionnaire is widely administered. Steps to validate the questions include:</p> <ol style="list-style-type: none"> <li>1. Translation into the local language, and separate back-translation.</li> <li>2. Focus groups with youths in the age range to ascertain local descriptors for emotional distress and well-being, and to review the survey for relevance to the local language and culture, relevance to adolescent concerns and priorities, and ease of use of the response scale.</li> <li>3. Focus groups with local service providers (psychologists, child-oriented care workers, parents and other caregivers) to ensure linguistic and cultural relevance.</li> </ol> <p>Adaptations to the survey to best fit the local language and culture may be necessary. As much as possible, however, the response scale and general domains of the questionnaire should remain intact to allow cross-country comparisons of results. Pictorial prompts of the response scale can also be used to ease use for adolescent respondents:</p> <table border="1" data-bbox="464 1043 1401 1133" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Strongly agree 1</td> <td style="text-align: center;">Agree 2</td> <td style="text-align: center;">Disagree 3</td> <td style="text-align: center;">Strongly disagree 4</td> </tr> </table> <p><i>Instructions to respondents.</i>  <i>The following is a list of questions about how you may have been feeling over the past two weeks. For each question, please answer by stating the number that most reflects how much you agree or disagree with the statement (show response scale):</i></p> <ol style="list-style-type: none"> <li>1. I feel stressed and worried (i)</li> <li>2. I enjoy doing things (ii)</li> <li>3. I feel like crying (ii)</li> <li>4. I can't shake off sad feelings (ii)</li> <li>5. I feel life isn't worth living anymore (iii)</li> <li>6. I have hope for my future (iii)</li> <li>7. I feel good about myself (iv)</li> <li>8. My health is good (v)</li> <li>9. I feel tired these days (v)</li> <li>10. I feel people dislike me (iv)</li> <li>11. I feel confident (iv)</li> <li>12. I feel able to solve problems in my life (vi)</li> <li>13. I am able to make decisions in my life (vi)</li> <li>14. I don't want to be around friends and family like usual (vii)</li> <li>15. I get into more trouble than usual (viii)</li> <li>16. I get so angry these days, I get into fights (viii)</li> <li>17. I get along well with other people (ix)</li> <li>18. I am able to make friends (ix)</li> </ol> <p>(The numbers in parentheses refer to the components of psychological health referred to above.)</p>	Strongly agree 1	Agree 2	Disagree 3	Strongly disagree 4
Strongly agree 1	Agree 2	Disagree 3	Strongly disagree 4		

<p><b><i>Strengths and limitations</i></b></p>	<p>Although intended to be useful across cultures, pre-testing and validation are essential to ensure that the items are cross-culturally appropriate. Expressions of emotional distress vary according to language, expectations for proper behaviour of children and adolescents, and social mores and gender.</p> <p>Many standardized surveys assess the psychological status of children and adolescents. However, they are limited in international application by cross-cultural variances in emotional distress symptoms and language, and sociocultural expectations for proper behaviour and emotional expression. In addition, depending on their age and developmental stage, children may express emotional distress through their behaviour or psychosomatic symptoms. Given the need for rapid, simple assessment tools, the survey questions developed for this indicator have focused on general concepts, in the hope of achieving greater cultural relevancy and ease of linguistic translation.</p>
<p><b><i>Analysis and interpretation</i></b></p>	<p>It is important to note that the indicator suggested above for psychological health is a general measure of emotional well-being. It cannot be used for clinical diagnosis of psychiatric conditions (i.e., major depression, anxiety disorders, post-traumatic stress disorder, psychosis).</p> <p>To assess the overall level of psychosocial problems, the data should also be presented for all children combined. In addition, research has shown that girls tend to respond with more internalizing symptoms, whereas boys tend to externalize. Indicators should be disaggregated by gender.</p> <p>If a tabulation of this indicator shows a correlation of psychological health with age, then further analysis of OVC status by psychological health should be done, controlling for age (see example in chapter 2.9).</p>



### ADDITIONAL INDICATOR A3: CONNECTION WITH AN ADULT CAREGIVER

<b>Definition</b>	Ratio of the proportion of OVC versus non-OVC aged 12–17 who have a positive connection with the adult they live with most of the time.
<b>Purpose</b>	To assess the extent to which adolescent OVC and non-OVC have a positive, emotional and stable connection with the adult they live with most of the time.
<b>Priority</b>	Additional.  NOTE: This indicator is still being developed. Please check the update of this guide on the UNAIDS website ( <a href="http://www.unaids.org">www.unaids.org</a> ) for future adjustments.
<b>Numerator</b>	<b>(1) Connection of OVC with adult caregiver.</b>  Numerator 1: The sum of the scores of all OVC interviewed.  Denominator 1: Number of OVC interviewed.
<b>Denominator</b>	<b>(2) Connection of non-OVC with adult caregiver.</b>  Numerator 2: The sum of the scores of all non-OVC interviewed.  Denominator 2: Number of non-OVC interviewed.
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	Adolescent (aged 12–17) perceptions of supportive behaviours that their primary caregiver enacts in the relationship with the adolescent, representing part of what the caregiver can do to foster a positive connection with the adolescent.  In order to reach their full potential, children require basic provisions for survival (adequate food, shelter and clothing), as well as nurturing and guidance from caring adults in a predictable and stable manner.  A positive, stable, emotional relationship has been shown to be one of the strongest protective factors for child and adolescent development. Children and adolescents conclude that the support they perceive from their caregivers indicates they are worthy and respectable individuals. This enhances their sense of self-worth, which, in turn, fosters self-respect and self-confidence. Further, it helps children and adolescents function successfully in society and establish positive relationships with peers and adults.

<p><b>How to measure it</b></p>	<p>Orphan connection ratio: The ratio of (1) the average level of connection for OVC to (2) the average level of connection for non-OVC.</p> <p>Adolescents are asked to identify the adult they spend the most time living with. Then they are asked to indicate how often the specific adult does the following things:</p> <table border="0"> <tr> <td>1. Supports and encourages me.</td> <td>10. Gives me advice and guidance.</td> </tr> <tr> <td>2. Gives me attention and listens to me.</td> <td>11. Provides for my necessities.</td> </tr> <tr> <td>3. Shows me affection.</td> <td>11. Gives me money.</td> </tr> <tr> <td>4. Praises me.</td> <td>12. Buys me things.</td> </tr> <tr> <td>5. Comforts me.</td> <td>13. Has open communication with me.</td> </tr> <tr> <td>6. Respects my sense of freedom.</td> <td>14. Spends time with me.</td> </tr> <tr> <td>7. Understands me.</td> <td>15. Supports me in my school work. (NA if not in school).</td> </tr> <tr> <td>8. Trusts me.</td> <td></td> </tr> </table> <p>Adolescents assign a score for each of these 15 questions, selecting from the following scoring options: 1 = not at all, 2 = hardly ever, 3 = sometimes, 4 = often, 5 = very often.</p>	1. Supports and encourages me.	10. Gives me advice and guidance.	2. Gives me attention and listens to me.	11. Provides for my necessities.	3. Shows me affection.	11. Gives me money.	4. Praises me.	12. Buys me things.	5. Comforts me.	13. Has open communication with me.	6. Respects my sense of freedom.	14. Spends time with me.	7. Understands me.	15. Supports me in my school work. (NA if not in school).	8. Trusts me.	
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7. Understands me.	15. Supports me in my school work. (NA if not in school).																
8. Trusts me.																	
<p><b>Strengths and limitations</b></p>	<p>This is a set of items compiled from a careful review of theory, empirical work and existing programming in many developed and developing countries. The list is a synthesis from many sources; thus, any one or two sources would not sufficiently cover the breadth. It represents, therefore, a comprehensive assessment of the supportive behaviours caregivers engage in that help create a positive connection with adolescents. It is limited, of course, to adolescent perceptions of the occurrence of these behaviours, which may or may not be consistent with how the caregiver would assess the same behaviours.</p> <p>Findings from samples of adolescents from Jamaica and Malawi indicate that the 15-item scale represents two relatively independent sub-dimensions: support from an adult and provision of resources from an adult. Further validations of the full 15-item scale will be conducted in early 2005 by WHO. Once analyses of those additional datasets are completed, a revision is likely to be made on the structure and item content for measuring connection to an adult. Until that is complete, it is recommended that all 15 items be used in further surveys. If it is not possible to include all 15 items, then it is recommended that 6 items be collected, and analysed separately, i.e., using separate scales for support and for provision of resources. The three items that measure 'support' are: comforts me, has open communication with me, and trusts me; and the three items that measure 'provision of resources' are: provides for my necessities, gives me money, and buys me things.</p>																
<p><b>Analysis and interpretation</b></p>	<p>A number of studies across the world have demonstrated that adolescents who perceive that their caregivers support them in the ways we are measuring in this study have statistically higher levels of well-being and lower levels of risk behaviours.</p> <p>This indicator should provide information as to whether orphaned or vulnerable adolescents, compared to other adolescents, report experiencing more or less connection with the adult they spend the most time living with.</p> <p>Similar indicators (with many of the same components) have been tested in different cultural settings and are found to be equally relevant in all of them. There is still a possibility, however, that one or two items will not be specific to a particular culture (e.g., if perhaps youth in one culture report substantially lower levels of a certain type of connection than in other cultures). In any such case, the item should be excluded from the analysis, and the overall score for connection will be calculated based on the relevant items.</p>																

## ADDITIONAL INDICATOR A4: SUCCESSION PLANNING

<b>Definition</b>	The percentage of mothers or primary caregivers who report having identified a standby guardian who will take care of the child in the event that she/he is not able to do so.
<b>Purpose</b>	To assess the extent to which parents and caregivers make succession plans for their dependent children.
<b>Priority</b>	Additional.
<b>Numerator</b>	Number of mothers or caregivers who have identified a standby guardian to take care of the dependent child.
<b>Denominator</b>	All mothers or caregivers who are responsible for children aged 0–17.
<b>Measurement tools</b>	Household surveys.
<b>What it measures</b>	<p>Succession planning is a promising approach for increasing the extent to which parents take action to ensure a better future for their children, particularly in terms of appointing guardians. In most countries, family laws stipulate a process to appoint a guardian. This 'legal guardian' may be an executor of a will, or a decision maker, and could, but not necessarily, be in a position to provide care in a family environment. This indicator seeks to identify a person who would provide direct care and support to a child.</p> <p>The identification of a caring guardian involves other processes that together comprise succession planning. For children made vulnerable by HIV/AIDS, this is particularly helpful, because it allows HIV-positive parents, while they are identifying guardians, to deal with disclosure of their status to their children, help prepare the children for the future, discuss family property with them, and seek the children's assistance during the time of parental illness.</p>
<b>How to measure it</b>	Each woman who reports being the mother or primary caregiver for a child will be asked if she has identified a person with whom the child could live if she was not able to care for the child. <sup>22</sup>
<b>Strengths and limitations</b>	<p>When parents appoint standby guardians, they will also most likely take action to disclose their status, protect their children's assets, help the children understand their past, and plan for their future. The indicator therefore points to a larger effort to plan succession with orphaned and other vulnerable children.</p> <p>The indicator cannot be used to approximate what actually happens after death of parents, whether the identified standby guardians actually take on the role, or how they take on the role. Furthermore, the indicator does not provide any information about the strength of the social safety net for AIDS-affected children or the capacities of standby guardians.</p>
<b>Analysis and interpretation</b>	<p>It would be useful to determine whether the parents had talked to the guardian of choice, and if this guardian lives in the same community. This would be helpful in assessing the proportions of children likely to be displaced from their communities.</p> <p>It would also be important to assess the gender of the appointed guardian. Often, women provide care and support to children, so if more males are named, then there could be a difficulty with interpreting this as the estimate of people who have planned on a guardian, since they would probably have been thinking more of an executor or financier than a caregiver.</p>

<sup>22</sup> This indicator is based on research work undertaken by Horizons in Uganda. For detailed information, please see: [https://www.popcouncil.org/horizons/ressum/orphans/orphanssum\\_findings.html](https://www.popcouncil.org/horizons/ressum/orphans/orphanssum_findings.html)

## **Mobilizing and strengthening community-based responses**

When families cannot adequately meet the basic needs of their children, the community provides the next level of a safety net. In practice, care for orphaned and vulnerable children comes from nuclear families with support from the extended family. With organized community assistance, extended families can keep relationships intact when the nuclear family structure is no longer able to bear the strain of increased numbers of dependent children. In extreme cases, communities will need to care for children with no family involvement to maintain social cohesion. The foundation of an effective response that matches the enormous scale and long-term nature of the impacts of HIV/AIDS on children is therefore to reinforce the capacity of communities to provide support, protection and care. To be successful, this approach requires that local leaders be engaged in responding to the needs of vulnerable community members. It is important to recognize that faith-based and non-governmental organizations, along with other community structures, have a key role to play in mobilizing and supporting community efforts. Other key areas of intervention in the community include: organizing and supporting activities that enable community members to talk more freely about HIV/AIDS; organizing cooperative support activities; and promoting and supporting community care for children without any family support.

### *Key questions*

- Are communities able to identify children needing care, and are they able to intervene?
- Are communities able to provide essential support to families with orphaned and vulnerable children?
- Are communities able to provide support to children without an extended family?
- Do communities receive support from government and non-governmental organizations to provide assistance to the most vulnerable families and children in their community?

### *Measurement issues*

Monitoring the capacity of communities to care for orphans and other children made vulnerable by HIV/AIDS is not easy. For example, assessing coverage by surveying non-governmental organizations, faith-based organizations and other community-based organizations to map their interventions has a risk of 'double counting'. The same families might be reached by different interventions and organizations, and a simple addition of all people reached by all organizations would overestimate the real number of orphans, vulnerable children and families reached.

Coverage measured through a household survey provides no indication of the quantity and quality of support provided. Some communities might be reached with a comprehensive package of food, support for school fees and psychosocial counselling, while other communities only received support in succession planning. In a household survey they will both be considered as having been reached. In order to monitor the quality of services, more in-depth studies should be undertaken. For example, the quality of counselling is not easy to measure through a population-based survey.

Children outside of family care are an indicator of communities' not being able to take care of their children. Monitoring trends on the numbers of children living on the streets and in institutions is a useful measure to assess community capacity to care for children. Special studies are required to estimate the number of children living outside of family care.

## CORE INDICATOR 4: CHILDREN OUTSIDE OF FAMILY CARE

<b>Definition</b>	The proportion of all children aged 0–17 living outside of family care.
<b>Purpose</b>	To obtain estimates of children living on the streets and in institutions.
<b>Priority</b>	Core.
<b>Numerator</b>	Number of children aged 0–17 living outside of family care.
<b>Denominator</b>	All children aged 0–17.
<b>Measurement tools</b>	Survey of children living on the streets, and survey of children living in institutions.
<b>What it measures</b>	This indicator assesses the number of children living outside of traditional households, including homeless children and children living in institutions. There is little information available on children living outside of households because national surveys such as DHS and MICS normally exclude structures that are not considered households.
<b>How to measure it</b>	<p>See annex I for a detailed description.</p> <p>Children living in institutions – A census of institutions that take care of children will need to be conducted. Once the institutions have been identified, all orphaned and vulnerable children living in them are enumerated. A sample of institutions could be used in countries where there are large numbers of children living in institutions. These should, however, be stratified by the type of institution (orphanage, home for the physically disabled, juvenile justice facility, etc.).</p> <p>Homeless children – The methodology for sampling and surveying homeless orphans is more complicated. The main issues are conducting interviews and locating homeless orphans. The method used to locate them involves developing a sampling frame. As children living on the streets are a mobile, ‘floating’ population group, they need to be sampled using the concept of time-location sites, a method of sampling mobile youth populations that minimizes bias and adheres to the tenets of probability sampling.</p> <p>On the grounds that children who sleep in households will be covered in a household survey, it is recommended that the sampling of street children<sup>23</sup> be confined to children who actually slept on the streets the night before the survey. By contacting government officials, NGOs, religious leaders and others who work with them and are knowledgeable about places where they sleep, a sampling frame can be developed. After the selection of time-location sites, the second stage of sampling consists of posting interviewers at the sites for the time interval designated and interviewing all the youth who are present or arrive at the sites during that period.</p> <p>The estimated number of children living on the streets and in institutions is divided by the estimated number of children aged 0–17 from census data to estimate the proportion of children living outside of family care.</p>
<b>Strengths and limitations</b>	<p>Children in formal care<sup>24</sup> in household settings (i.e. orphans placed in community homes with appointed guardians) are at risk of being counted as children in family care. In some places with high epidemic levels, this is becoming an increasingly common phenomenon, in particular, for children who have been orphaned by AIDS.</p> <p>To locate children living on the streets for surveys requires going to the sites where they congregate, visit frequently or sleep. In some instances this might be difficult because the sampling points might be insecure for interviewers.</p>

<sup>23</sup> Street children can be divided into two main groups that have important characteristics for sampling: ‘*Children on the streets*’ are children who spend their days on the streets, but normally go to their home at night to sleep. These children should typically be captured in a standard household survey. ‘*Children of the streets*’ do not have a home and sleep at night on the streets.

<sup>24</sup> Formal care: care of the child is assumed or designated by the State or an organization.

***Analysis and interpretation***

In a country where many orphans are placed in community homes (households) with appointed guardians, such living arrangements should be included in the count for children living outside of family care. It is important to include the time spent on the streets or in institutions, mobility, etc., among the background variables for children living in institutions or on the streets. These surveys should be done in close collaboration with programmes and seen as an opportunity to collect information for planning and programming purposes.

## CORE INDICATOR 5: EXTERNAL SUPPORT FOR ORPHANED AND VULNERABLE CHILDREN

<b>Definition</b>	The percentage of OVC whose households received free basic external support in caring for the child.
<b>Purpose</b>	To assess the support provided to households that are caring for OVC.
<b>Priority</b>	Core.
<b>Numerator</b>	<p>Number of OVC who live in households that received at least one of the following services for the child:</p> <ul style="list-style-type: none"> <li>• Medical support within the past 12 months</li> <li>• School-related assistance within the past 12 months</li> <li>• Emotional support within the past 3 months</li> <li>• Other social support, including material support, within the past 3 months.</li> </ul>
<b>Denominator</b>	Total number of OVC.
<b>Measurement tools</b>	Household surveys.
<b>What it measures</b>	This indicator measures support that is given free of charge to households with OVC. In practice, care for orphaned children comes from nuclear families surviving with assistance from extended families and from the community. The foundation of an effective response is to reinforce the capacity of families and communities to provide protection and care for vulnerable children. An increase could indicate that the national efforts to support OVC have reached families and communities.
<b>How to measure it</b>	<p>This indicator should only be monitored in settings with high HIV prevalence. As part of a household survey, household rosters can be used to identify all eligible orphaned and vulnerable children less than 18 years of age. A series of questions is asked for each orphan and vulnerable child about the types and frequency of support received, and the primary source of the help. Pilot surveys of this indicator showed that asking this question once for all OVC in the households resulted in an overestimation of the amount of support that was received. In addition, by asking the question for the household, gender and age differentials were not available.</p> <p>External support for OVC may fall into any of the following categories:</p> <ul style="list-style-type: none"> <li>▪ <i>Medical</i> (medical care, medical care supplies)</li> <li>▪ <i>Emotional/psychological</i> (counselling from a trained counselor, emotional or spiritual support or companionship)</li> <li>▪ <i>School fees/school-related assistance</i></li> <li>▪ <i>Other social support</i> including socio-economic (clothing, extra food, financial support, shelter) and instrumental (help with household work, training for caregiver, childcare, legal services).</li> </ul> <p>The instrument used in the household setting can also be used for monitoring programmes or in targeted populations with similar but adapted methods – for example, through special studies where households with orphaned and vulnerable children are sampled. Those findings should be interpreted with caution, however, as very often listings of households with orphaned and vulnerable children are derived from institutions that care for these households, and coverage will therefore overestimate the scope of the problem and the response efforts.</p>

<p><b>Strengths and limitations</b></p>	<p>This indicator does not measure the needs of the household or the OVC. Additional questions could be added to measure expressed needs of families caring for orphans. The indicator implicitly suggests that all households with orphaned and vulnerable children need external support: Some orphaned and vulnerable children are more in need of external support than others. Therefore it is important to disaggregate the information by other markers of vulnerability such as socio-economic status of the household, dependency ratio, head of the household, etc.</p>
<p><b>Analysis and interpretation</b></p>	<p>It should also be noted that duration of orphanhood plays a key role in determining the type of support that is needed. For example, an orphan whose parent(s) died 10 years ago will need different support from one whose parent(s) died within the past year. The child's age is also a factor (i.e., school assistance needs). The data should also be tabulated by orphans versus other vulnerable children.</p> <p>Many of the care and support interventions are directed to the household level, and the respondent might not know for which child the support was intended. Also, respondents may not wish to single out one child during a response. An alternative approach could be to ask this question at the household level. If this is done, the indicator should be the proportion of households with OVC that received external support, instead of the proportion of OVC whose households received external support.</p> <p>External support is defined as free help coming from a source <i>other than friends, family or neighbours</i> unless they are working for a community-based group or organization. In most settings, family, friends or neighbours provide support. Programme managers may consider disaggregating the support from within the community (i.e., family, friends and neighbours).</p> <p>This indicator is the same as indicator 10 described in <i>A Guide to Monitoring and Evaluating HIV/AIDS Care and Support</i> (UNAIDS, 2004).</p>



## ADDITIONAL INDICATOR A5: ORPHANS LIVING WITH SIBLINGS

<b>Definition</b>	The percentage of orphans who are not living in the same household with all their siblings under the age of 18.
<b>Purpose</b>	To assess the extent to which orphans are separated from their siblings.
<b>Priority</b>	Additional.
<b>Numerator</b>	Number of orphans who do not live in the same household as their biological siblings ages 0–17.
<b>Denominator</b>	Number of orphans who have siblings ages 0–17.
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	This indicator assesses family capacity and community capacity to keep orphan siblings together in one household. Generally, sibling connections and attachments are even closer than usual when there has been inadequate parental care and nurture. Helping siblings remain together on the death of their parent(s) is therefore another way of strengthening orphans' ability to cope. Many extended families disperse orphaned siblings among different households to share the cost of their care. Interventions that enable families to keep siblings together help these children recover from their loss, support one another and remain in their own community. Siblings who are living together in foster care tend to have fewer emotional and behavioural problems than those who are living separately.
<b>How to measure it</b>	In the household-listing module of a household survey, the head of the household is asked whether all biological siblings (under age 18) of each child lives in the household. The indicator is limited to biological brothers and sisters to ensure the indicator is collected consistently and to ensure the relatedness of the children.
<b>Strengths and limitations</b>	<p>Separation of siblings is often a result of life processes, and eventually happens to most children. It is therefore important to exclude these 'natural' separation events from the forced separation due to orphanhood during childhood. Siblings who are separated due to marriage or further schooling should therefore be excluded. By limiting the focus of the siblings to under age 18, most of the bias will be avoided.</p> <p>Economically, it might not be feasible to always keep siblings together. Communities should be sensitized, however, on the need for siblings to have opportunities to be together, particularly in the immediate years after the death of their parent(s). For that reason, siblings should, as far as possible, remain in the same community in the event that one family is not able to care for them all. It would therefore be useful to add a question on the frequency of visits between siblings.</p>
<b>Analysis and interpretation</b>	<p>For this analysis, an orphan is considered as separated if one or more of his/her siblings aged 0–17 years are living outside of the sampled household.</p> <p>Orphans with a larger number of siblings are more likely to be separated on the death of parents. Therefore, when possible, it is important to tabulate the results by overall number of siblings (1, 2–3, 4+ children).</p>

## Ensuring access to essential services

A critical component of the response is to increase access to essential services and to ensure access on an equal basis by orphaned and vulnerable children, compared to non-orphans. These essential services include education, birth registration, basic health and nutrition, access to water and sanitation, and ensuring placement services for children without family care. Governments play a critical role in providing services to all children and communities. At the local level, non-governmental organizations, faith-based organizations, other indigenous community groups and the private sector often play an equally important role in extending the reach of these services. As part of overall government service-provision plans, there is a need for increased resources and innovative services, such as combined mobile services to reach children where they live. To ensure greater impact and sustainability, interventions that build the capacity, quality, collaboration and reach of effective service-delivery programmes are warranted.

### *Key questions*

- Do orphaned and vulnerable children have access to basic services?
- Do they access these services on an equal basis with other children?
- Are the psychosocial support services developed for orphaned and vulnerable children reaching the children in need?
- Are all children being registered at birth?

### *Measurement issues*

Measuring the quality of services is an important component in evaluating the success of interventions that are aimed at increasing access. For example, there is a concern that policies to abolish school fees, which are particularly beneficial for orphaned and vulnerable children, are likely to result in increased demand for education and a deterioration in the quality of education. Quality is difficult to assess in a household survey, so it is recommended that quality issues be assessed at programme or subnational level.

Children's access to health services is normally measured through proxy-indicators such as immunization coverage (DTP3) or use of health services in case of acute respiratory infections (ARI) or malaria. As described in chapter 2, existing indicators related to younger orphans (aged 0–4) will generally not have large enough sample sizes for meaningful subpopulation comparison, and for older orphans no measurable and meaningful indicators exist. Further work will be needed to establish appropriate indicators for access to health care for orphaned and vulnerable children.

There are currently few indicators defined in the area of psychological and social support, partly because, until recently, programme activities in these areas tended to be weaker and less coordinated than in prevention.

## CORE INDICATOR 6: ORPHAN SCHOOL ATTENDANCE RATIO

<b>Definition</b>	The ratio of orphaned children compared to non-orphaned children aged 10–14 who are currently attending school.
<b>Purpose</b>	This indicator assesses progress in preventing relative disadvantage in school attendance among orphans versus non-orphans.
<b>Priority</b>	Core.
<b>Numerator</b>	<p><b>(1) Orphans' school attendance (%).</b></p> <p>Numerator 1: Number of children who have lost both parents and are attending school.</p> <p>Denominator 1: Number of children who have lost both parents.</p> <p>Alternatively, vulnerable children (children whose parents are chronically ill or whose households have experienced the death of an adult or whose households contain a chronically ill adult) can be included in the numerator of the ratio.</p>
<b>Denominator</b>	<p><b>(2) Non-orphans' school attendance (%).</b></p> <p>Numerator 2: Number of children, both of whose parents are still alive, who live with at least one parent and who are attending school.</p> <p>Denominator 2: Number of children whose parents are both still alive and who live with at least one parent.</p>
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	<p>One of the early effects of AIDS sickness and death is that children are taken out of school. This can happen for many reasons: inability to pay school fees, stigma, or the need to stay at home to care for sick parents or for younger siblings their mother is no longer able to look after. Education is vital for children's futures and is important for their psychosocial development. Schools can provide children with a safe, structured environment, the emotional support and supervision of adults, and the opportunity to learn how to interact with other children and develop social networks.</p> <p>Interventions to enhance enrolment and retention include reducing or eliminating school fees and hidden costs; improving the quality of schools; introducing life skills development into curricula; implementing school feeding programmes; and engaging schools as community resources for information, psychosocial support, day care, HIV prevention and other support functions. These interventions need to be measured at the programme level.</p>
<b>How to measure it</b>	<p>Orphan school attendance ratio is: The ratio of (1) orphans' school attendance to (2) non-orphans' school attendance.</p> <p>In a population-based survey respondents are asked whether they are currently attending school. The indicator is the ratio of the current school attendance rate of children aged 10–14 both of whose biological parents have died to the current school attendance rate of children aged 10–14 whose parents are both still alive and who currently live with at least one biological parent.</p> <p>Countries are also strongly encouraged to report the ratio of OVC attending school versus non-OVC attending school. In countries where the number of children who are orphans is relatively small (less than 5–8 per cent of the population under age 18) this indicator will overcome the problem of small numbers of double orphans.</p>
<b>Strengths and limitations</b>	<p>This Millennium Development Goal indicator is confined to children 10–14 years old because age at entry into school varies widely in many countries, so including younger age groups would lead to large variations not related to parental death. At the national level, an additional indicator using country-appropriate age ranges could supplement the indicator.</p> <p>Instead of comparing all orphans and non-orphans aged 10–14 as is done with other indicators, this indicator compares children with more specific characteristics. These special subgroups (double</p>

	<p>orphans and non-orphans living with at least one parent) are chosen to show the maximum disadvantage resulting from orphanhood.</p> <p>It should be noted that orphaned children are typically older than non-orphaned children because the parents of younger children are more likely to still be alive, and older children are more likely to have left school. Thus the value of this indicator will tend to be slightly less than one, even when orphans suffer no relative disadvantage.</p> <p>In countries where there are few double orphans, a standard household survey might not collect data from enough double orphans to calculate this indicator. In these cases countries should consider adding vulnerable children to the definition of orphans. The indicator should only be calculated if there are at least 50 children to estimate the proportion in school. In a survey of approximately 4,000 households, assuming 2 children per household, there will be more than 50 double orphans aged 10–14 <b>only</b> if the prevalence of double orphans is over 2 per cent. If the survey contained 6,000 households the prevalence of double orphans could be as low as 1.3 per cent to have an adequate sample. (The biannual publication <i>Children on the Brink</i> provides independent estimates of double orphans for many countries. Check the UNICEF or USAID websites for this publication.)</p>
<p><b><i>Analysis and interpretation</i></b></p>	<p>School attendance data should be calculated for single orphans by paternal or maternal orphaned and vulnerable children to identify potential disparities among these groups. If the number of children used to calculate the numerator of the ratio is less than 50, this indicator should not be presented.</p> <p>Another indicator that could be considered is the ratio of primary school completion for orphans versus non-orphans. The indicator is defined as the ratio of orphans aged 13–17 who have completed primary school compared to non-orphans of the same age who have completed primary school.</p>

## CORE INDICATOR 7: BIRTH REGISTRATION

<b>Definition</b>	Proportion of children aged 0–4 whose births are reported registered.
<b>Purpose</b>	To determine whether children in the country are being registered and kept under the supervision of the government. <sup>25</sup>
<b>Priority</b>	Core.
<b>Numerator</b>	Number of children aged 0–4 whose births are reported registered.
<b>Denominator</b>	Total number of children aged 0–4 surveyed.
<b>Measurement tools</b>	Household survey, survey of street children, survey of children in institutions.
<b>What it measures</b>	<p>This indicator assesses the extent of registration of children. Orphans without proof of birth lack the essential protection that stems from this legal form of identity. Proof of lineage is critical for orphans in order to inherit the property of deceased parents. In general, birth registration is the first step towards recognizing a child's inalienable rights as a human being. Without proof of birth, children are especially vulnerable to exploitation and abuse and as adults may be denied the rights of a citizen. In some countries, children without a birth certificate cannot receive vaccinations or enrol in school; as adults, they cannot get married, open a bank account, acquire a passport or vote.</p> <p>Birth registration is also critical to the functioning of every nation. Every government requires accurate data on births. Countries that have ratified the United Nations Convention on the Rights of the Child and other international human rights agreements are committed to registering children at birth. National birth registration systems provide vital data countries need for planning and policy development, for monitoring the situation of children and allocating resources.</p>
<b>How to measure it</b>	<p>This indicator is derived from responses by caretakers of children to a question about the registration status of the child. Ask the primary caregivers about birth registration documents and obtain physical evidence if the document exists.</p> <p>The age range could be extended to age 9 or higher depending on country needs and will provide immediate information for programmatic response. The data, however, should also be reported separately for the 0–4 age group in order to assess trends. Many countries have baseline data through DHS and MICS for this age group. The efforts to increase registration of children at birth will be better captured with the smaller age cohort.</p>
<b>Strengths and limitations</b>	If there is a legal obligation to register births, questions about registration may be perceived as threatening, and they must be administered with care. It is essential that respondents understand that the information they provide is confidential and that individual data will not be disclosed to government authorities. The knowledge about birth registration could be unreliable if the primary caretaker is not a parent, is an absentee parent or primary caregiver (especially in the case of migrant workers), or is someone who took over care of the child without access to all available official information on the child.
<b>Analysis and interpretation</b>	It is not necessary to disaggregate the information by orphan status, since birth registration is critical for all children. The registration of children usually should take place long before a child is likely to have been orphaned. Thus there is no need to compare the proportion registered by orphans versus non-orphans. Registration of orphans is probably higher in some settings because children are being registered in response to having become an orphan.

<sup>25</sup> The United Nations Statistical Division, UNICEF, the United Nations Population Fund, national governments and a range of civil society organizations have worked together to push for changes in laws, to build or improve civil registry systems and to strengthen public demand for birth registration. Many obstacles to universal birth registration have been addressed. Mobilization campaigns have strengthened public demand for birth registration and registration fees have been eliminated, registration procedures simplified and laws updated, such as ending the requirement that parents present their own identity papers.

	<p>Beside the overall percentage of children who are registered information should be provided on the proportion that actually possess such a certificate. Along with identifying the extent of the problem of non-registration, two questions are recommended to identify obstacles to registration and knowledge of the registration process among those caregivers whose children are not registered.</p>
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## Ensuring that governments protect the most vulnerable children

While the family has primary responsibility for the care and protection of children, national governments have the ultimate responsibility to protect children and ensure their well-being. Almost all countries have ratified the United Nations Convention on the Rights of the Child and by doing so have accepted this responsibility. In order to meet these obligations, countries must undertake and be supported in a broad range of multisectoral actions, including adopting national policies, strategies and action plans; and allocating and mobilizing increased resources for children. Most countries have several policy instruments and pieces of legislation that relate to the rights, protection, care and support of children. In many instances, existing laws have been or are being reviewed and revised to reflect current international standards and to address the challenges posed by HIV/AIDS. Most important, effective structures are needed to implement and enforce legislation.

No ministry has sole jurisdiction over the issues surrounding orphaned and vulnerable children. Governments must find ways to bring together the main stakeholders to respond in a coordinated and effective way to assure that resources reach communities and that these responses meet the many needs of orphaned and vulnerable children.

### *Key questions*

- Are policies in place to protect orphaned and vulnerable children?
- Do laws exist to protect widows, widowers, orphans and other children made vulnerable by HIV/AIDS?
- Are these laws enforced?
- Are adequate resources allocated and used?
- Are children only placed in institutional care when no better placement options are possible and only on an interim basis until family or community placement can be made?

### *Measurement issues*

It is difficult to identify objective indicators to measure policy changes or legal reforms. Most measures tend to include some subjectivity – which means they are of limited use for intercountry comparison but, much more important, can be difficult to interpret in measuring trends over time.

When enforcement of laws that protect women, orphaned and vulnerable children improves, this may result in an increase in the number of problems reported (property dispossession, child abuse, etc.). Caution is therefore needed when interpreting certain findings, such as those contingent on changes in policy or law; the greater number of cases might be a result of an increase in reporting by victims as they realize and take advantage of opportunities for action, rather than as a result of an increase of the problem. In general, it is recommended that both routine and survey data be used to assess the effect of the policy or law change on the problem being monitored.

An indicator that would monitor budget allocations for orphaned and vulnerable children would be useful to provide insight into the genuine interest and political commitment towards orphans. Recently tools<sup>26, 27</sup> have been developed to track funds for HIV/AIDS. However, for orphaned and vulnerable children, many different ministries are involved in a comprehensive national response (education, social welfare, health, agriculture, social works, etc.) that may also be supported by external resources. It is therefore quite difficult to track the inputs by the different stakeholders.

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<sup>26</sup> National HIV/AIDS Accounts. National estimation of financial flows and expenditures on HIV/AIDS. Technical handbook for estimating the national health accounts on HIV/AIDS. SIDLAC. 2001.

<sup>27</sup> Estimates of National Health Accounts (NHA) for 1997. Poullier, J.P. and P. Hernandez. GPE Discussion Paper Series: No. 27. EIP/GPE/FAR. World Health Organization.

UNICEF is currently working with partners to develop a guide for monitoring the well-being of children in formal care. This will include children in orphanages, juvenile justice centres, and other care settings. More information on this guide and indicators on formal care is available at the UNICEF website ([www.unicef.org](http://www.unicef.org)).



## CORE INDICATOR 8: OVC POLICY AND PLANNING EFFORT INDEX

<b>Definition</b>	National Policy and Planning Effort Index score for orphaned and vulnerable children.																		
<b>Purpose</b>	The purpose of the effort index is to measure the current response at the national level to the crisis facing orphaned and vulnerable children. It will identify specific strengths, weaknesses, and gaps in policy and planning efforts.																		
<b>Priority</b>	Core.																		
<b>Measurement tools</b>	<p>The OVC Policy and Planning Effort Index is a self-assessment by key stakeholders made by completing a country assessment questionnaire with 100 questions. The indicator is based on a score of 1–100, with 100 being the best score and 1 the lowest.</p> <p>The components covered in the tool are:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Component</th> <th style="text-align: left;">The questions related to this component explore:</th> </tr> </thead> <tbody> <tr> <td>1. National situation analysis</td> <td>whether the country has investigated the situation of orphans and other children made vulnerable by HIV/AIDS and, if so, the nature of that research.</td> </tr> <tr> <td>2. Consultative process</td> <td>the extent to which key stakeholders are involved in planning interventions for orphans and other children made vulnerable by HIV/AIDS.</td> </tr> <tr> <td>3. Coordinating mechanism</td> <td>whether action for orphans and other children made vulnerable by HIV/AIDS is being coordinated and the nature of that coordination</td> </tr> <tr> <td>4. National action plans</td> <td>whether the country has a national plan of action for orphans and other children made vulnerable by HIV/AIDS, and the nature of that plan</td> </tr> <tr> <td>5. Policy</td> <td>whether the country has a policy on orphans and other children made vulnerable by HIV/AIDS and the nature of that policy</td> </tr> <tr> <td>6. Legislative review</td> <td>whether the country has reviewed and updated the legal framework relating to orphans and other children made vulnerable by HIV/AIDS</td> </tr> <tr> <td>7. Monitoring and evaluation</td> <td>whether M&amp;E is being conducted nationally of the situation of orphans and other children made vulnerable by HIV/AIDS, and of programmes addressing their needs</td> </tr> <tr> <td>8. Resources</td> <td>the availability of resources to meet the needs of orphans and other children made vulnerable by HIV/AIDS</td> </tr> </tbody> </table>	Component	The questions related to this component explore:	1. National situation analysis	whether the country has investigated the situation of orphans and other children made vulnerable by HIV/AIDS and, if so, the nature of that research.	2. Consultative process	the extent to which key stakeholders are involved in planning interventions for orphans and other children made vulnerable by HIV/AIDS.	3. Coordinating mechanism	whether action for orphans and other children made vulnerable by HIV/AIDS is being coordinated and the nature of that coordination	4. National action plans	whether the country has a national plan of action for orphans and other children made vulnerable by HIV/AIDS, and the nature of that plan	5. Policy	whether the country has a policy on orphans and other children made vulnerable by HIV/AIDS and the nature of that policy	6. Legislative review	whether the country has reviewed and updated the legal framework relating to orphans and other children made vulnerable by HIV/AIDS	7. Monitoring and evaluation	whether M&E is being conducted nationally of the situation of orphans and other children made vulnerable by HIV/AIDS, and of programmes addressing their needs	8. Resources	the availability of resources to meet the needs of orphans and other children made vulnerable by HIV/AIDS
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<b>What it measures</b>	The index reflects the national OVC task force's opinion on how well the country is doing in eight areas of response to OVC. In other words, the index measures how the national OVC task force judges the national response when stakeholders are asked to rate the programme on a list of important items. The effort index is intended to measure policy and planning effort independent of programme outputs. For example, policy and planning efforts include items such as the degree of political support, whether laws have been reviewed, and the availability of resources, but do not include output measures such as the proportion of orphans attending school or showing evidence of malnutrition. The effort score can be used as a diagnostic tool to indicate the strength of various areas and to suggest corrective action. In this context, the term 'effort' encompasses not only the activities of the national government but also includes those of non-governmental organizations, multilateral and bilateral organizations and others. It assesses if appropriate policies and strategies are in place and can be used to monitor year-to-year changes.																		
<b>How to measure it</b>	Each component has a series of questions that follow the same format. First, an overarching question is asked about producing a national product (e.g., 'Has a body been formally established to coordinate national action for orphans and other children made vulnerable by HIV/AIDS?'). This question is answered either 'yes' or 'no.' The second section then asks detailed probe questions,																		

	<p>depending on the answer to the overarching question. These probe questions are also 'yes/no' questions and seek more detailed information (e.g., 'Is this body led by government?'). The number of probe questions varies by component. Finally, there is an overall more qualitative rating question, where respondents are asked at the end of each section to rank the quality of work done in that particular area of activity on a scale of 0 to 5. The tool is attached in annex III.</p> <p>The final score for each component is the average score of the 'yes/no' questions (which is the proportion of questions answered 'yes' of the maximum possible number of questions that could be answered with 'yes' in that section) and the qualitative rating score. The qualitative rating score for each component is the proportion of the maximum possible points (5).</p>
<p><b>Strengths and limitations</b></p>	<p>The OVC Policy and Planning Effort Index mainly builds on two tools recently developed in the area of HIV/AIDS. First, it is based on the experience of the AIDS Programme Effort Index (API) developed by UNAIDS, the United States Agency for International Development (USAID) and the Policy Project.<sup>28,29</sup> The API was developed to measure political commitment and programme effort in areas of HIV prevention and care. Furthermore, it expands on the National Composite Policy Index<sup>30</sup> recently implemented by UNAIDS to measure progress towards specific goals of the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). The tool and questions could be incorporated into the National Composite Policy Index.<sup>31</sup></p> <p>The major concern surrounding an effort index is its subjectivity and its reliability. The outcome depends entirely on the choice of informants, and informants will likely change from year to year. The indicator is simple to assess, however, and is designed to complement the existing National Composite Index.</p> <p>Its simple quantitative nature means that it does not give information on the effectiveness of national policies and strategies, only whether they exist or not.</p>
<p><b>Analysis and interpretation</b></p>	<p>An average score will not provide information on the areas from which the components are drawn. To understand more about the gaps in policies and strategies, the index should be broken down by its components and major issues should be reported on.</p> <p>The OVC Policy and Planning Effort Index scores are based on responses that are a mixture of fact and judgement. Most items are simple statements of fact. In theory, responses to these items should reflect the true situation in a country, and scores based on these items alone could be compared across countries. But some items that appear to be simple statements actually require some judgement. For example, the question 'Is the government actively soliciting funds for orphans and other children made vulnerable by HIV/AIDS from the international community?' requires a value judgement as to what is considered to be 'actively soliciting'.</p> <p>Other items, such as the final rating assessment for each component, are purely the judgements of the respondents. On the subjective items, respondents' expectations may play a role in their assessments. If respondents expect that in a certain area much will be done in the future, they may give a low score to a level of effort that might in fact deserve a higher score compared to an area where respondents do not expect that much will be done. The extent to which these expectations vary over time will affect the usefulness of the scores for trend analysis.</p>

<sup>28</sup> The Policy Project. 2000. HIV/AIDS Toolkit – Measuring political commitment. August 2000.

<sup>29</sup> USAID, UNAIDS, WHO and the Policy Project. 2003. The level of effort in the national response to HIV/AIDS: The AIDS Programme Effort Index (API) 2003 Round. December 2003.

<sup>30</sup> United Nations General Assembly Special Session on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators. UNAIDS/02.51E (English original, August 2002). ISBN 92-9173-238-9.

<sup>31</sup> United Nations General Assembly Special Session on HIV/AIDS – Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators. UNAIDS, 2002. 'National commitment and action indicators: number 2 – National Composite Policy Index (page 21)'.

## ADDITIONAL INDICATOR A6: PROPERTY DISPOSSESSION

<b>Definition</b>	The percentage of widows who have experienced property dispossession.
<b>Purpose</b>	To determine the prevalence of property dispossession among widows after their spouses have died.
<b>Priority</b>	Additional.
<b>Numerator</b>	Number of widows aged 15–49 who experienced property dispossession.
<b>Denominator</b>	Total number of women ever widowed, aged 15–49.
<b>Measurement tools</b>	Household surveys.
<b>What it measures</b>	Property dispossession could potentially make caregivers and their children especially vulnerable. In many countries, (non-written) customary law, (written) statutory law, common law and sometimes religious laws operate in parallel. As a result, widows and their children are often denied their inheritance. In many cases enforcement of inheritance laws are weak, and relatives take the children's inheritance even where the laws provide for property transfer to widows and children. It is important that succession plans (arrangements) made for children are legally binding. An increasing number of countries are establishing and harmonizing legislation to give women and dependent children inheritance rights when their husbands/fathers die.
<b>How to measure it</b>	In a household survey, women are asked whether they have ever lost a husband. If they have, they are asked if they had any property taken because of the death. Survey implementers should estimate the number of widows potentially included in a household survey before collecting this indicator. This can be done by looking at a previous census or nationally representative survey and multiplying the proportion of widows aged 15–49 by the expected number of women in the survey. If the number of projected widows is below 50, the indicator will not be stable enough to monitor over time.
<b>Strengths and limitations</b>	<p>While it is important to have a written will, enforcement of the law at the local level in light of traditional inheritance patterns carries equal weight. For this reason the indicator does not measure the number of wills but rather the level of property dispossession in society in order to assess if improved laws and the enforcement of laws have made any difference in the lives of vulnerable women and their dependent children.</p> <p>The indicator focuses on widows to simplify the possible complexities of this phenomenon. It therefore does not cover the entire problem. For example, double orphans who are living with other adults are excluded. The new caregiver might be the dispossessor, and the orphan is unable to report on this. At the programmatic level, the other groups (orphans, widowers and caregivers of orphans) should also be monitored.</p> <p>Before deciding to collect this indicator, survey implementers should estimate the approximate number of widows who will be covered in the survey. This can be done based on previous surveys that collect data on marital status. If the expected number of widows in the survey is under 50, this indicator will not provide reliable data.</p>
<b>Analysis and interpretation</b>	<p>Additional questions that inquire whether the deceased spouse made a will before dying and if the wife and/or children were named as beneficiaries in the will would provide useful information for programming.</p> <p>Ideally, it would also be useful to know what property was taken and who took it, but given the small number of widows likely to respond to this question it would not be possible to further disaggregate these data.</p>

## **Raising awareness to create a supportive environment**

From the beginning, the HIV/AIDS epidemic has been accompanied by fear, ignorance and denial, leading to silence and inaction on the part of governments and other stakeholders. Orphaned and vulnerable children are often victimized by stigma, discrimination and abuse against people with HIV/AIDS and their families. Stigma and discrimination engender rejection, hostility and isolation and can lead to human rights violations. Reducing stigma and discrimination will require increasing access to information, challenging myths and transforming the public perception of HIV/AIDS.

Faith-based organizations, civic associations and other non-governmental organizations can play an important role in raising awareness and promoting community responsibility to help those affected by HIV/AIDS. In many countries, religious networks are more extensive than those of government. Faith-based and other community groups also play a critical role in identifying the most vulnerable among those affected and help mobilize community responses to their needs. A good situation analysis, particularly one that has included broad participation among stakeholders, can provide much of the raw material needed for this kind of social mobilization.

### *Key questions*

- Are programmes to promote acceptance and support for the HIV-infected and -affected working?
- Are information systems adequate and effective in catalysing awareness?
- Are people infected and affected by HIV/AIDS accepted by their communities?
- How many children are orphaned or made vulnerable by HIV/AIDS?
- Are partners and partnerships at all levels (community, district, provincial and national) strong enough for an adequate national response?

### *Measurement issues*

Discrimination and stigma are among the most difficult aspects of the epidemic to quantify. It is perhaps for this reason that, while many prevention and care programmes have the reduction of stigma and the fostering of more supportive attitudes as a stated objective, virtually none has developed a reliable way of measuring this most intangible of phenomena. In the first place, no clear definitions exist of stigma or the qualities that characterize it, and if something cannot be clearly defined it cannot be accurately measured.

A powerful indicator to raise awareness to create a supportive environment is the (increasing) number of orphans, as well as the number of children made vulnerable by HIV/AIDS. If a significant number of children are living outside of households (more than 5 per cent of the population under age 18) a combined survey of households, institutions and children living on the streets should be used (see annex I) to estimate these numbers.

## CORE INDICATOR 9: PERCENTAGE OF CHILDREN WHO ARE ORPHANS

<b>Definition</b>	Percentage of children under 18 whose mother, father or both parents have died.
<b>Purpose</b>	To monitor the levels of orphanhood in a country.
<b>Priority</b>	Core.
<b>Numerator</b>	Number of children under 18 whose mother, father or both parents have died.
<b>Denominator</b>	All children under 18.
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	This indicator tracks levels of orphanhood in a country.
<b>How to measure it</b>	<p>In a household survey, respondents are asked the ages of all children in the household and whether the mothers and fathers of those children are alive. Those children who are currently under the age of 18 and whose mother or father or both are dead form the numerator for this indicator.</p> <p>If the number of children living outside of households is substantial (more than 5 per cent of children under age 18), two supplemental surveys should be considered to estimate the number of orphans living on the streets and living in institutions. (See annex I for detailed sampling guidelines.)</p>
<b>Strengths and limitations</b>	<p>Besides tracking trends and patterns, data on orphans can be a very powerful general indicator to create awareness of the scope of the problem and the impact of an AIDS epidemic on society.</p> <p>One limitation of this measure is that it is not able to distinguish AIDS-related orphanhood from orphanhood due to other causes. However, since young adult mortality was stable or falling in most countries for some years before the arrival of HIV, it is not unreasonable to assume that the bulk of any rise in orphanhood over baseline levels is attributable to HIV (if there is no other reason, such as armed conflict, for a high rate of young adult mortality).</p> <p>Orphans may be more mobile than other children. Those most in need of care may be in child-headed households, which do not always qualify for inclusion in a household survey. Households with AIDS-related deaths often completely disintegrate following the death of a household head, and children are sent to live with relatives in the same or another area. Using a household survey and asking about whether the parents are still alive will provide information about caring practices, and opportunities to alleviate the primary household disintegration problem.</p> <p>Definitions of orphanhood differ among countries. In some countries, the legal definition includes all children under 18 who have lost their mother. It is suggested that the standard definition given in this indicator be used to allow for comparison across populations. However, countries may also wish to compile an indicator based on their own national definition of orphanhood. The methodology for constructing the indicator remains unchanged.</p> <p>Parental survival status may be unknown if the child has been separated from the parent for a long time. As with all indicators, the proportion of respondents indicating 'don't know' should also be tabulated.</p>
<b>Analysis and interpretation</b>	<p>This indicator tracks levels of orphanhood in a country. In order to better monitor and target responses to orphans, the data should be disaggregated by gender and age. If the sample size allows, the four age groups 0–4, 5–9, 10–14 and 15–17 are recommended. It is also useful to break down the results into maternal, paternal and double orphanhood.</p> <p>To get a better idea of care practices, it is important to assess the relationship of the child with the head of the household and the primary caregiver, and to record the gender of the head of the household and the dependency ratio of households with orphans as compared with the dependency ratio of households with children but no orphans.</p>

## CORE INDICATOR 10: PERCENTAGE OF CHILDREN WHO ARE VULNERABLE

<b>Definition</b>	Percentage of children under 18 who are vulnerable according to the national definition.
<b>Purpose</b>	To monitor the proportion of children who are made vulnerable by HIV/AIDS.
<b>Priority</b>	Core.
<b>Numerator</b>	Number of children under 18 who are classified as vulnerable.
<b>Denominator</b>	All children under 18.
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	<p>This indicator tracks the proportion of children made vulnerable by HIV/AIDS who potentially have special needs. If measured consistently over time, this indicator is a proxy measure of the trends in number of children in need of services and support.</p> <p>The percentage of children who are vulnerable taken alone or in combination with the percentage of orphans can be a very powerful indicator to create awareness of the scope of the problem and the impact of an AIDS epidemic on society. Many orphans also have characteristics that would categorize them as vulnerable, so the two proportions cannot simply be summed.</p>
<b>How to measure it</b>	<p>The definition of vulnerable should be decided by the country. It can take on different forms, as described in chapter 2. <b>Please read chapter 2 before using this indicator.</b></p> <p>When developing the definition of vulnerable, it is essential to make sure the criteria are measurable. For example, living in a household with a chronically ill adult is measurable, while living in a household that is impoverished is much more difficult to measure. As with any new indicator, if new measures are being proposed they should be tested in a pilot survey before being implemented in a large-scale survey.</p> <p>If the number of children living outside of households is substantial (more than 5 per cent of children under 18) two supplemental surveys should be considered to estimate the number of vulnerable children living on the streets and living in institutions. (See annex I for detailed sampling guidelines.)</p>
<b>Strengths and limitations</b>	<p>The biggest limitation to this indicator is the difficulty in defining vulnerable. The concept of a <i>vulnerable child</i> is a social construct that varies from one culture and socio-economic context to another. In addition, the term takes on various definitions that can be at odds depending on whether the term was developed for the purpose of gathering and presenting quantitative data or for developing and implementing policies and programmes. It is important to make a clear distinction between definitions developed for these two purposes and to establish a 'firewall' between them.</p> <p>Problems occur in the field when definitions established for quantitative purposes are picked up and used for programme targeting or eligibility criteria in policy and programme implementation. The quantitative process must have clear boundaries and allow for absolute distinctions. In contrast, developing and implementing programmes and services must take into account local variations in the factors that cause or constitute vulnerability. For programming and service delivery, no single specific definition will suffice for every context. The concept of <i>vulnerability</i> is complex and may include children who are destitute from causes other than HIV/AIDS.</p> <p>Children living on the streets or in institutions should also be categorized as vulnerable. These children are not covered in household surveys. As described earlier, if this population is estimated to be more than 5 per cent of all the children, surveys should be conducted in these two settings in addition to household surveys to get a truly nationally representative sample.</p>
<b>Analysis and interpretation</b>	For this indicator to be valuable for programmers it will be important to disaggregate the data by the type of vulnerability. In addition, the data should be disaggregated by gender and age. If the sample size allows the four age groups 0–4, 5–9, 10–14 and 15–17 are recommended.

## ADDITIONAL INDICATOR A7: STIGMA AND DISCRIMINATION

<b>Definition</b>	Percentage of people expressing accepting attitudes towards people with HIV, of all people surveyed aged 15–49.
<b>Purpose</b>	To assess the level of stigma and discrimination in society towards people living with HIV/AIDS.
<b>Priority</b>	Additional.
<b>Numerator</b>	The number of respondents aged 15–49 expressing accepting attitudes towards people with HIV.
<b>Denominator</b>	All respondents aged 15–49 who have heard of AIDS.
<b>Measurement tools</b>	Population-based surveys.
<b>What it measures</b>	<p>Stigma and discrimination undermine support to orphans and other children made vulnerable by HIV/AIDS. Studies have shown that some orphan families have chosen not to receive relief services (food and clothing benefits) in order to avoid the stigma attached to such welfare benefits. Other studies found that some families cut themselves off from social support networks long before death occurs in order to avoid disclosure and stigma.</p> <p>This is an indicator based on answers to a series of hypothetical questions about men and women with HIV. It reflects what people are prepared to say they feel or would do when confronted with situations involving people living with HIV.</p>
<b>How to measure it</b>	<p>Respondents in a general population survey are asked a series of questions about people with HIV, as follows:</p> <ul style="list-style-type: none"> <li>▪ If a member of your family became ill with the AIDS virus, would you be willing to care for him or her in your household?</li> <li>▪ If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from them?</li> <li>▪ If a female teacher has the AIDS virus but is not ill, should she be allowed to continue teaching in school?</li> <li>▪ If a member of your family became infected with the AIDS virus, would you want it to remain a secret?</li> </ul> <p>Only a respondent who reports an accepting or supportive attitude on all four of these questions enters the numerator. The denominator is all people surveyed who have heard of AIDS.</p>
<b>Strengths and limitations</b>	<p>While some stigmatizing attitudes and discriminatory practices are all too obvious, others remain largely hidden. There is no clear relationship between attitudes and behaviour in this context. What people actually do in the face of something as frightening as AIDS may well differ from what they say they would do, and the dichotomy seems to run in different directions. Some studies have found, for example, that people expressing very negative attitudes to those infected with HIV actually provide supportive care for an HIV-infected relative in their own home. On the other hand, some people who deny any negative attitudes towards people with HIV may actively discriminate against them in specific settings, such as the provision of health care.</p>

**Analysis and interpretation**

Methodologically, this is a relatively easy way to construct an indicator of attitudes to people with HIV. A low score on the indicator is a fairly sound indication of high levels of stigma, and for that reason alone it is worth measuring. There are, however, difficulties in interpreting indicators based on hypothetical questions, and a high score on the indicator is harder to understand. It could mean there is little real stigma attached to HIV. Or it could mean that people know they should not discriminate, and therefore report accepting attitudes. This may not change their behaviour, which may continue to be discriminatory towards people with HIV. Changes in the indicator could therefore reflect a reduction in stigma or simply a growing awareness that one should not admit to prejudice. That in itself may, however, constitute the first step in programme success. High scores may also reflect the respondent's limited personal experience with anyone who is HIV-infected.

It is difficult to collect information about behaviour towards those with HIV. Partly because of stigma itself, the HIV status of people who are in fact infected is rarely openly acknowledged, even within their own families. So most questions that attempt to measure stigma focus on hypothetical situations, such as the willingness to care for a relative with AIDS, or beliefs about whether people with HIV should be permitted to continue working with others.

It is not clear to what extent hypothetical willingness to care for a family member who is ill is matched in practice, or, indeed, to what extent it is a useful indicator of social stigma. Other hypothetical questions such as a willingness to be tested for HIV have been shown to be very poor predictors of actual behaviour, possibly precisely because of the magnitude of social stigma. However, for want of anything more accurate, hypothetical questions about people's attitudes are likely to remain central to attempts to track changes in negative attitudes towards people with HIV.

Many recent DHS and MICS included only two or three of the recommended questions listed above. One has to be cautious, therefore, in comparing levels of discrimination over time using these surveys. The different components will need to be reported and compared separately.



## Annex I – Sampling guidelines: Estimating the size and characteristics of orphaned and vulnerable children

### Introduction – background, uses

As noted in chapter 2 of this guide, in most countries the number of children missed in household surveys will have no statistically significant effect on the estimates of characteristics of orphaned and vulnerable children<sup>32</sup> (as defined in this guide). However, if the proportion of children living outside of households is estimated to be roughly more than 5 per cent, then data from children living in households and living outside of households is required to assess the situation of orphaned and vulnerable children. These guidelines describe a methodology for sampling children in all settings.

This annex is a summary of a more extensive manual titled ‘Guidelines for sampling orphaned and vulnerable children’ (available at [www.childinfo.org](http://www.childinfo.org)). National estimates of the population of orphaned and vulnerable children in developing countries are imperfect, as there has not been a focused effort to develop specific guidelines on how to survey OVC – and, in particular, how to sample them to ensure complete coverage. The manual upon which this summary is based is intended to help correct the gap in methodological approaches for surveying/sampling OVC. It provides detailed and explicit guidelines on sampling approaches: (a) to estimate the size of the OVC population, or its prevalence and (b) to study the characteristics of OVC, particularly as a target population of special interest in the campaign against HIV/AIDS.

The manual is oriented towards national-level surveys and studies in developing countries, but the methods proposed are equally applicable in developed nations and for comparatively large geographic sub-areas such as big cities, regions or major provinces. Scientific probability sampling is assumed to be the standard in the proposed guidelines.

The manual emphasizes sampling methods for surveys intended to study the *entire population* of OVC, which may be considered as consisting of three subpopulations: (1) OVC in households, (2) OVC residing in institutions and other group quarters and (3) homeless OVC including street children. The presentation distinguishes between *linked* surveys, when all three components are conducted in tandem, and *stand-alone* surveys restricted to one of the components.

### Definitions of orphan, vulnerable child

The current, operational definitions of an orphan and a child made vulnerable by HIV/AIDS that are used in the guidelines are:

*An orphan is a child below the age of 18 who has lost one or both parents.  
A child made vulnerable by HIV/AIDS is below the age of 18 and:*

- (i) has lost one or both parents, or*
- (ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child), or*
- (iii) lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before he/she died, or*
- (iv) lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or*
- (v) lives outside of family care (i.e. lives in an institution or on the streets)*

The formal definitions of orphan and vulnerable children are important because they have implications for the overall survey purpose and data-collection strategy, including the sampling methodology. When the survey objective is to estimate prevalence (the size of the OVC population)

<sup>32</sup> See box 3.1 in the guide regarding the use of the term ‘orphaned and vulnerable children’ and the acronym ‘OVC’.

the entire age group under 18 is obviously targeted. On the other hand, a survey focused on HIV/AIDS may, in some country applications, be confined to 10- to 17-year-old children, especially when sexual issues are emphasized. The primary age group in another survey might be OVC under the age of 10 when health status and socio-economic impact of HIV/AIDS make up the key content of the questionnaire.

### **Survey coverage of the target population**

The target population – orphans or OVC – is found in a variety of residential settings. These include traditional households, communal group care quarters, orphanages and other institutions. In addition there are homeless youth living on the streets and elsewhere in non-fixed places of residence.

Estimates of prevalence would be *understated* through a household survey alone and characteristics would be *biased* to the degree that those living in households are fundamentally different from those in institutions or on the streets.

Consequently, a survey intended to study the total population of OVC must encompass those living outside of traditional households, including those who are homeless. Each of these three subpopulations must be *covered* by the survey process in order to achieve unbiased estimates of OVC numbers. The characteristics of OVC are only likely to be biased if a significant proportion (more than 5 per cent) of the children in the population are living outside of households.

### **Sample size**

The sample size is a key parameter of sample design for OVC, whether estimating the size (prevalence) of the population or its distribution and characteristics. The factors that affect sample size are many and include precision requirements, confidence level needed, magnitudes of the characteristics being estimated, and sample design effect. We look at sample size along two dimensions: sample size needed for prevalence estimation versus characteristics; and sample allocation among households, institutions and homeless. Chart 1 and tables 1 and 2 summarize various possibilities, the mathematical details of which are in the full manual.

Determination of sample size requirements for the household component of OVC coverage is an important initial consideration since a large majority of OVC are orphans who reside in households of surviving parents or other households. Table 1 below is based on the assumption that 95 per cent of OVC live within households. A more precise sample size can be calculated for any country that has more accurate data on the percentage of OVC in households.

Chart 1 illustrates how sample sizes vary according to (a) whether the survey objective is to estimate the prevalence of OVC or their characteristics and (b) whether a stand-alone survey is planned for one or more of the three components.

**Chart 1. Sampling coverage for various types of OVC surveys and recommended *minimum* sample sizes**

Target population	Type of estimate	Linked or stand-alone survey	Survey type(s)	Sample size <sup>33</sup>
All OVC 17 or younger	Prevalence (size of OVC population)	Linked	Household	1,225–2,500 households
			Group quarters	[Census]
			Homeless sites	1,000 homeless persons (to yield 100–150 OVC)
All OVC 17 or younger	Characteristics	Linked	Household	1,600–3,200 households (to yield 400 OVC)
			Group quarters	100 OVC
			Homeless sites	800 homeless persons (to yield 100 OVC)
OVC in households	Characteristics	Stand-alone	Household	1,600–3,200 households
OVC in group quarters, institutions	Characteristics	Stand-alone	Group quarters, institutions	400 OVC
Homeless OVC	Characteristics	Stand-alone	Homeless sites	Up to 4,000 homeless persons (to yield 400 OVC)

Table note: In the last two rows the figures of 400 institutional OVC and 400 homeless OVC apply only in countries where there are a large number of OVC in those living arrangements. When there are fewer than 400 in the population, all of them should be included in the sample, which was the situation in pilot studies conducted in Kingston (Jamaica) and Blantyre (Malawi) where there were fewer than 50 homeless OVC in each city. Note also that it may be necessary to screen as many as 4,000 homeless persons for age in order to identify 400 children.

Table 1 shows the number of households that must be surveyed to estimate, with moderate reliability, the number or proportion of OVC who reside in households. The smallest sample size needed is in the sub-Saharan African countries, where the average is about 1,225 households. In the average Latin American country and in China, which have proportionately much smaller OVC populations, about twice as many households are needed.

<sup>33</sup> The sample size is doubled when separate, equally reliable data are wanted for boys and girls, in which case each sex is regarded as a separate estimation domain.

**Table 1. The estimated percentage of the total population that is orphaned children living in households and the approximate sample size (number of households) necessary to measure OVC prevalence<sup>34</sup>**

Area (1)	Estimated percentage of the total population that is orphaned children living in households (2)	Sample size (households) (3)	Estimated number of OVC in sample (4)
Sub-Saharan Africa	4.37%	1,225	321
Asia, except China	3.65%	1,475	323
China	2.19%	2,500	328
Latin America, Caribbean	2.35%	2,325	328

The last column of the table is computed as (column 2)/100 x column 3 x 6.0, where 6.0 is the expected household size on average.

Table 2 shows the required number of households to be sampled to obtain various numbers of OVC under 18 years old, and this table applies when the objective is to study the characteristics of OVC.

**Table 2. Approximate number of households to sample in order to locate OVC aged 0–17 for detailed study of characteristics<sup>35</sup>**

Area	400 OVC	600 OVC	800 OVC	1,000 OVC
Sub-Saharan Africa	1,600	2,400	3,200	4,000
Asia, except China	1,925	2,900	3,850	4,800
China	3,200	4,800	6,400	8,000
Latin America, Caribbean	3,000	4,475	5,975	7,475

The figures are rounded to the nearest 25.

The figures in table 2, as in table 1, apply to the OVC population that would be expected to live in households. Note that the sample sizes shown would also be applicable in cases where the survey team was studying OVC in households as a stand-alone target population, that is, without intending to combine the results with other data from institutions or the homeless.

### Sample frame construction

For sample frame development, the locations where OVC can be found must be considered. We have identified those venues in the previous sections as traditional households, group living quarters (including institutions) and places where homeless children congregate or sleep.

A separate and independent sample frame is required for each of these three venues. The sample plan for an OVC survey intended to study *all* OVC would thus be based on a multi-frame design. In cases

<sup>34</sup> This is the estimate of the proportion of OVC in the population measured with precision of  $\pm 0.15$  of the estimate and at the 95 per cent level of confidence. See full manual for the calculation formula and assumptions made.

<sup>35</sup> For countries that might design an OVC survey confined to a different age group, the approximate number of households needed for OVC aged 0–9 or 10–17 are, respectively, 1.8 times and 2.25 times the numbers shown in table 2.

where a research effort is focused on only one of the component parts (for example, OVC living on the streets), a single-frame approach suffices.

The principal frame for sampling OVC residing in households is obviously a household frame. The features of household sampling frames are well known and well documented. Moreover, it is recommended that when household surveys are used for OVC measurement they be done through existing household surveys rather than an independent survey developed from scratch. Accordingly, the guidelines do not discuss household sample frame construction.

While we discuss the sampling frame of institutions and other group living quarters, in general it is recommended that a census of such places be conducted for OVC prevalence estimation (in which case no sampling is involved). The requirements for compiling a list of non-household residential establishments for OVC are the same, however, irrespective of whether a census or a sample is undertaken.

Lists of institutions that are run by the government, religious or non-governmental organizations must be compiled. In order for the list to be acceptable as a frame it should be, as much as possible, complete, accurate and current. The contact persons for identifying institutions include both national and local officials at ministries of social welfare or human resources, religious leaders, NGOs that focus on youth and any organization that works on HIV/AIDS issues.

Information to be obtained from each residential establishment includes only its name, location and the number of resident OVC – the latter being its ‘measure of size.’ If the overall number of institutions is small enough that a census of OVC is to be conducted, the measure of size informs the survey team about the workload for interviewing in each institution. Second, when the number of institutions is so large that a sample of them must be selected, the measure of size is used to administer sample selection. Third, it is used to establish the sample probabilities and weights.

The principal challenge for sampling OVC who live on the streets is in locating them. Meeting that challenge is largely a matter of frame development. To locate OVC for survey-taking requires going to the sites where they congregate, visit frequently or sleep. It is recommended that these floating populations of youth be sampled using the concept of *time-location* sites, a method of covering mobile populations that is unbiased and adheres to the tenets of probability sampling. Each time-location site identified is defined as a separate primary sampling unit (PSU), all of which taken together then comprise the sample frame.

On the grounds that everyone sleeps somewhere, it is recommended that the sampling of street children be confined to places where youth are known to sleep – such as railway stations and other transportation terminals, under bridges, abandoned buildings, vacant lots, and any others that community leaders know about and can pinpoint.

Construction of the frame of PSUs, using the time-location definition, must begin with community experts and key informants who are knowledgeable about the behaviour of homeless or street youth. These experts are asked to identify all locations where the youth are known to sleep.

## **Sampling design and approaches**

### *Households*

For the household component the recommended methodology is use of a *double sample* approach, in which a large sample of households is used to conduct simple screening interviews to identify and locate households with OVC. For cost-effectiveness, the screening should be applied by appending the screening questions to another household survey that has a sufficiently large sample.

To estimate OVC prevalence it is a simple matter of tabulating the results from the screening interview. For OVC characteristics, however, a second-phase survey would be needed, in which a detailed questionnaire regarding OVC would be administered.

#### *Group quarters and institutions – prevalence*

As already mentioned, it may not be necessary to use sampling at all. In countries where few formal institutions exist for housing orphans or other vulnerable children, it is recommended to conduct a census of them.

To control costs, a sample of about 40–50 institutions would, however, be necessary when there are large numbers – say, 150 or more – of institutions and other residential facilities that house OVC. In this case, to estimate prevalence, a census of the children in the selected institutions would be conducted, that is, a simple count of the residents under 18 with collection of only minimal detailed data other than age. Note that for this reason there is only a single stage of sample selection – the institutions themselves.

Institutions would be selected systematically using size strata as well as geographic strata, by which the institutions are arranged in a geographic fashion by urban-rural and by province prior to sample selection, to ensure geographic spread of the sample.

#### *Group quarters and institutions – characteristics*

The sampling plans for estimating characteristics must consider two cases. One is the situation where the institutions in the universe are so few that all of them are included in the survey. A complete roster of the OVC from each institution must be compiled, from which the sample is selected systematically from the combined list of all OVC in those institutions.

The second case occurs when the sample of OVC is taken from a sample of institutions. Selection in this case would be based on a two-stage sample design. The first stage would be a sample of institutions selected systematically using probability proportionate to the size of the institution. A *fixed* number of OVC from each sample institution would then be selected to participate in the interview for the OVC survey.

#### *Homeless children – prevalence or characteristics*

A two-stage sampling plan is recommended for homeless children. The first stage is a selection of the time-location PSUs described above. The second stage consists of posting interviewers at the site for the time interval designated and interviewing all the youth who are present or arrive at the site during that period.

In constructing PSUs, each sleep location should be divided along the time dimension in 4- to 6-hour segments. In all PSUs a measure of size must be determined, that is, an approximate count of the number of homeless persons expected to be at a particular location during the time interval specified. PSUs would be stratified according to size categories based on the measures of size.

The size of PSUs and the number to select depend on the number of homeless youth expected, on average, to show up at a given site during the time interval. Two dimensions are considered: the number of homeless people at the PSU site; and the number of those who are OVC. Pilot studies in Blantyre and Kingston revealed that an overwhelming majority of the homeless at the sites identified were aged 18 or older. In that context, screening is necessary to eliminate homeless adults.

#### **Combining results for estimation**

Weighting will be required when the three components are combined in a linked survey for estimates of total OVC or their characteristics. This is because each component entails an independent sampling frame and design, and the probabilities of selection will necessarily differ among the three components. The weights are calculated separately (as described in the full manual) for each component and simply applied to the data files to produce the combined estimates.

**Documentation and evaluation**

The sampling technician should take steps to carefully document not only the sample plan for the OVC survey but also its implementation. Sample designs often require adaptation at some stage of the field work to reflect unforeseen situations that arise in the conduct of the survey.

To evaluate the results of the survey, sampling errors should be estimated. The sampling error, or *standard error*, is the measure that allows the confidence interval to be constructed around the estimate, so that users can evaluate how reliable the data are. Standard errors can be estimated from the survey data themselves, whenever the design adheres strictly to probability sampling methodology, by using variance-estimation software that is widely available.

## **Annex II – Declaration of Commitment: Monitoring and reporting country progress on orphaned and vulnerable children**

Within the UNGASS Declaration of Commitment, governments committed themselves to acting on the orphaned and vulnerable children goal (paragraph 65–67) by ensuring that national orphaned and vulnerable children policies and strategies were in place by the end of 2003; that they are under full implementation by 2005; and that country reports would be made annually to the UN Secretary-General to enable his report to the General Assembly on progress in the implementation of the Declaration of Commitment. Governments need to be supported to establish the capacities and procedures to prepare and disseminate these reports; governments and parliaments should be supported to discuss progress, needs and actions; and the media, civil society organizations, NGOs and development partners should be engaged to monitor progress and mobilize public attention to the situation and needs of orphaned and vulnerable children. In support of this, UNICEF and UNAIDS should provide guidance on a core format for monitoring and reporting on progress in implementing the national orphaned and vulnerable children response. Support should also be provided to regional (e.g. Southern African Development Community, Economic Community of West African States) and continental (Africa Union) institutions to prepare and disseminate progress reports.

*Report on the Africa Leadership Consultation: Urgent Action for Children on the Brink, Johannesburg, 9–10 September 2002*



## **Annex III – Questionnaire: Policy and Planning Effort Index for children orphaned and made vulnerable by HIV/AIDS**

### **Instructions:**

This questionnaire will be administered by a consultant in each country at a meeting of the OVC task force or similar group called by the national UNICEF representative. The consultant will guide the group through the following questions, seeking consensus among respondents as to the appropriate responses. The responses to most questions are either 'yes' or 'no.' Some questions are conditional, so answers are not required to all questions. To provide some idea of trends, each question should be answered for the present, and then as if it had been asked in mid-2001, at the time of the UN General Assembly Special Session on HIV/AIDS.

At the end of each section, respondents are asked to rank the quality of work done in that particular area of activity on a scale of 0–5. This ranking should also be given for the present and for 2001.

**1. NATIONAL SITUATION ANALYSIS**

2005	2001
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*This section explores whether your country has investigated the situation of orphans and other children made vulnerable by HIV/AIDS and, if so, the nature of that research.*

1. Has research been conducted into the situation of orphans in your country, which includes estimates of numbers and location, the reasons for their vulnerability and the challenges they face?

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***If the answer to question 1 is 'yes' please answer questions 2–8.***

2. Did this research also investigate the situation of children made vulnerable by HIV/AIDS (who may not be orphans)?

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3. Were the following stakeholders directly involved in conducting the research:

- Government?
- Children and young people?
- People living with HIV and AIDS?
- Community-based organizations?
- Traditional authorities?


4. Did this study produce an inventory of organizations involved with orphans and other children made vulnerable by HIV/AIDS?

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5. Did this study include a review of literature relating to orphans and other children made vulnerable by HIV/AIDS?

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6. Did this study produce specific recommendations for action?

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7. Are there specific plans to update this study within the next year?

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8. Has the study been made public?

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***If the answer to question 1 is 'no' please answer questions 9–14.***

9. Has the decision been made to conduct such a study?

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10. Have all necessary government approvals been obtained?

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11. Has a steering committee been established to supervise the study?

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12. Has agreement been reached on the structure and timing of the study?

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13. Has a report been drafted?

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14. Has the study been submitted to government?

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***Regardless of the answer to question 1, please respond to question 15.***

15. How would you rate the quality of the national situation assessment of orphans and other children made vulnerable by HIV/AIDS?

(0 = has not been done, 1 = very poor, 2 = inadequate, 3 = fair, 4 = useful, 5 = excellent)

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**2. CONSULTATIVE PROCESS**

<b>2005</b>	<b>2001</b>
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*This section explores the extent to which key stakeholders are involved in planning interventions for orphans and other children made vulnerable by HIV/AIDS.*

1. Have you held a national meeting of stakeholders to formally discuss the situation of orphans and other children made vulnerable by HIV/AIDS (e.g., a ‘national consultation’)?		
2. Were senior representatives from the following stakeholders directly involved in this meeting:		
• Government?		
• Children and young people?		
• People living with HIV and AIDS?		
• Community-based organizations?		
• Traditional authorities?		
3. Were the results of national research into the situation of orphans and other children made vulnerable by HIV/AIDS disseminated and discussed at this meeting?		
4. Were decisions taken that are considered binding on those who were represented (including government)?		
5. Was a structure created/mandated to carry the process forward?		
6. Was a report of the meeting made public?		
7. Is there a structure that meets regularly (even informally) with representatives from all the major stakeholders, to review activities relating to orphans and other children made vulnerable by HIV/AIDS?		
• If not, is there a multisectoral structure that meets regularly to consider children generally (rather than orphans and other children made vulnerable by HIV/AIDS)?		
8. Do government ministries involved with children meet regularly to review common goals, and to share ideas and concerns?		
9. How actively are stakeholders involved? (0 = no consultation, 1 = most do not attend, 2 = poor participation, 3 = fair participation, 4 = good participation, 5 = highly committed)		

**3. COORDINATING MECHANISM**

2005	2001
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*This section explores whether action for orphans and other children made vulnerable by HIV/AIDS is being coordinated and the nature of that coordination.*

1. Has a body been formally established to coordinate national action for orphans and other children made vulnerable by HIV/AIDS?

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***If the answer to question 1 is 'yes' please answer the questions 2–9.***

2. Is this body led by government?

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3. Does this body have representation from all relevant government ministries?

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4. Does this body have representation from major non-government stakeholders?

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5. Does this body have representation from donors or the international community?

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6. Is this a permanent body?

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7. Does this body have a constitution?

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8. Does this body have statutory authority?

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9. Has this body met (with a quorum) within the past three months?

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***Regardless of the answer to question 1, please answer question 10.***

10. How effective would you rate the coordination?  
(0 = no coordination, 1 = very poor, 2 = slight, 3 = fair, 4 = good, 5 = excellent)

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**4. NATIONAL ACTION PLANS**

2005	2001
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*This section explores whether your country has a national plan of action for orphans and other children made vulnerable by HIV/AIDS, and the nature of that plan.*

1. Do you have a national action plan specifically for orphans?		
<b><i>If the answer to question 1 is 'yes' please answer questions 2–13.</i></b>		
2. Does this plan also cover other children made vulnerable by HIV/AIDS (who may not be orphans)?		
3. Were the following stakeholders directly involved in developing the plan:		
• Government?		
• Children and young people?		
• People living with HIV and AIDS?		
• Community-based organizations?		
• Traditional authorities?		
4. Does the plan provide a strategy and timeline to reach all orphans and other children made vulnerable by HIV/AIDS?		
5. Does the plan include estimates of cost?		
6. Does the plan specify sources of funding and other resources?		
7. Does the plan prioritize services/interventions according to relative need/urgency?		
8. Does implementation of the plan require the involvement of young people?		
9. Does the plan specifically set out to achieve the goals to which your country committed itself at the UN General Assembly on HIV/AIDS in June 2001, in relation to orphaned and vulnerable children?		
10. Has this plan been adopted by government?		
11. Does this plan provide clear guidance to all ministries and departments which have a bearing on children?		
12. Does this plan provide clear guidance to non-government stakeholders?		
13. Has a multisectoral coordinating structure been set up/mandated to implement or monitor the implementation of the plan?		
<b><i>If the answer to question 1 is 'no' please answer questions 14–17.</i></b>		
14. Do you have a functioning national plan of action for children generally?		
15. Has a decision been made to create a national action plan specifically for orphans and other children made vulnerable by HIV/AIDS?		
16. Has a structure been created or mandated to develop this plan?		
17. Has a draft plan been completed?		
<b><i>Regardless of the answer to question 1, please answer question 18.</i></b>		
18. How would you rate your government's commitment to taking action for orphans and other children made vulnerable by HIV/AIDS? (1 = not committed, 2 = slight, 3 = fair, 4 = good, 5 = highly committed)		

**5. POLICY**

2005	2001
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*This section explores whether your country has a policy on orphans and other children made vulnerable by HIV/AIDS and the nature of that policy.*

1. Has your government adopted a policy specifically on orphans?

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***If the answer to question 1 is 'yes' please answer questions 2–12.***

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2. Does this policy include other children made vulnerable by HIV/AIDS (who may not be orphans)?

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3. Was this policy developed in consultation with all major stakeholders?

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4. Does this policy link to policies on HIV/AIDS?

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5. Does this policy include support for orphans and other children made vulnerable by HIV/AIDS who cannot afford school fees, uniforms, etc.?

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6. Does this policy provide for free medical care for orphans and other children made vulnerable by HIV/AIDS who cannot afford to pay?

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7. Does this policy provide nutritional support for orphans and other children made vulnerable by HIV/AIDS who need it?

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8. Does this policy provide for counselling and psychosocial support for orphans and other children made vulnerable by HIV/AIDS who need it?

--	--

9. Does this policy explicitly aim to fulfil your country's international obligations in relation to children (Convention on the Rights of the Child, UNGASS, etc.)?

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10. Has an inter-ministerial structure been set up to oversee implementation of the policy – or has this responsibility been located in a 'super-ministry' such as the office of the Vice President or President? (answer 'yes' if either is true)

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11. Has this policy been made public?

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12. Has a formal campaign been undertaken to disseminate the policy to all stakeholders, inside and outside government?

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***If the answer to question 1 is 'no' please answer questions 13–17.***

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13. Is it the view of government that the needs of orphans and other children made vulnerable by HIV/AIDS are adequately covered by existing policies?

--	--

14. Has government made a decision to establish a policy on orphans and other children made vulnerable by HIV/AIDS, by a certain date?

--	--

15. Has significant progress been made towards developing a policy on orphans and other children made vulnerable by HIV/AIDS?

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16. Does a draft policy exist?

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***Regardless of the answer to question 1, please answer question 17.***

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17. How effective is this policy in creating a supportive environment for effective programming?

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(0 = no policy, 1 = not effective, 2 = slight, 3 = fair, 4 = good, 5 = very effective)

## 6. LEGISLATIVE REVIEW

2005	2001
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*This section explores whether your country has reviewed and updated the legal framework relating to orphans and other children made vulnerable by HIV/AIDS.*

1. Has your country enacted laws specifically to protect orphans?

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***If the answer to question 1 is 'yes' please answer questions 1–6.***

1. Do these laws also protect children who are made vulnerable by HIV/AIDS (who may not be orphans)?

--	--

2. Have these laws been implemented?

--	--

3. Have mechanisms to enforce the laws been created?

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4. Does your country have the resources to fully enforce these laws?

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5. Do the laws explicitly protect orphans and other children made vulnerable by HIV/AIDS from:

- All forms of violence and abuse?
- All forms of exploitation?
- Loss of inheritance?
- Stigma and discrimination?

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6. Have existing laws been reviewed to assess what amendments are needed to adequately protect orphans and other children made vulnerable by HIV/AIDS?

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***If the answer to question 6 is 'yes' please answer questions 7 – 9.***

7. Have detailed amendments to existing laws been proposed?

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8. Have amended laws been approved by Parliament?

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9. Have amended laws been enacted by government?

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***If the answer to question 6 is 'no' please answer questions 10–11.***

10. Has a formal decision been made to identify and review existing laws?

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11. Has progress been made in reviewing the laws (e.g., approval of terms of reference)?

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***Regardless of the answers to the preceding questions, please answer question 12.***

12. How are orphans and other children made vulnerable by HIV/AIDS being protected by legislation?  
(0 = no legislation, 1 = not protected, 2 = poor, 3 = fair, 4 = good, 5 = fully protected)

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## 7. MONITORING AND EVALUATION

2005	2001
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*This section explores whether M&E is being conducted nationally of the situation of orphans and other children made vulnerable by HIV/AIDS, and of programmes addressing their needs.*

1. Do you have a nationally agreed-upon definition of orphans?		
2. Are data being collated nationally on the situation of orphans in your country?		
3. Have indicators for vulnerability been determined?		
4. Are data being collated nationally on the situation of children made vulnerable by HIV/AIDS (who may not be orphans)?		
5. Are government interventions for OVC being monitored and evaluated nationally?		
6. Are non-government interventions for OVC being monitored and evaluated nationally?		
7. Have the total number of OVC in your country been estimated?		
8. Do you have an estimate of the number of orphans and other children made vulnerable by HIV/AIDS being reached by existing interventions?		
9. Do you have a figure for the cost of interventions per child reached?		
<b><i>If national M&amp;E is being undertaken, please answer questions 10–17.</i></b>		
10. Were the indicators developed in consultation with:		
• Children and young people?		
• People living with HIV and AIDS?		
• Community-based organizations?		
• Traditional authorities?		
11. Do the data include children made vulnerable by HIV/AIDS (other than orphans)?		
12. Do the people who collect the data receive the results?		
13. Are the results made public?		
14. Are the results being used for policy development?		
14. Do you analyse qualitative data, in addition to quantitative?		
15. Do you collect data on the cost of orphans and other children made vulnerable by HIV/AIDS interventions?		
16. Is there a single organization mandated to conduct national M&E of orphans and other children made vulnerable by HIV/AIDS?		
17. Does your M&E include data relating to non-government programmes for orphans and other children made vulnerable by HIV/AIDS?		
<b><i>If national M&amp;E is not being undertaken, please answer question 18.</i></b>		
18. Has a formal decision been made to conduct national-level M&E of orphans and other children made vulnerable by HIV/AIDS?		
<b><i>Regardless of the answers to the preceding questions, please answer question 19.</i></b>		
19. Are M&E findings used in policy formulation and programme planning? (0 = no M&E, 1 = data not used, 2 = poorly used, 3 = fair use, 4 = good use, 5 = essential to planning)		



**8. RESOURCES**

2005	2001
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*This section explores the availability of resources to meet the needs of orphans and other children made vulnerable by HIV/AIDS.*

- |   |  |  |
|---|--|--|
| 1. Is government actively soliciting funds for orphans and other children made vulnerable by HIV/AIDS from the international community?   |  |  |
| 2. Does government provide funds to NGOs for programmes for orphans and other children made vulnerable by HIV/AIDS?   |  |  |
| 3. Does government support NGOs in their fund-raising efforts for orphans and other children made vulnerable by HIV/AIDS?   |  |  |
| 4. Is expenditure for orphans and other children made vulnerable by HIV/AIDS made in terms of a overall policy or plan?   |  |  |
| 5. How would you rate the adequacy of financial resources to combat HIV/AIDS?<br>(0 = no resources, 1 = very limited, 2 = modest, 3 = reasonable, 4 = good, 5 = adequate for all needs) |  |  |

Please provide copies of:

- National situation analysis (or comparable research)
- National action plans for orphans and/or children
- Government policies relating to orphans and other children made vulnerable by HIV/AIDS
- Any published data on orphans and other children made vulnerable by HIV/AIDS
- Any national-level evaluations of programmes for orphans and other children made vulnerable by HIV/AIDS.





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