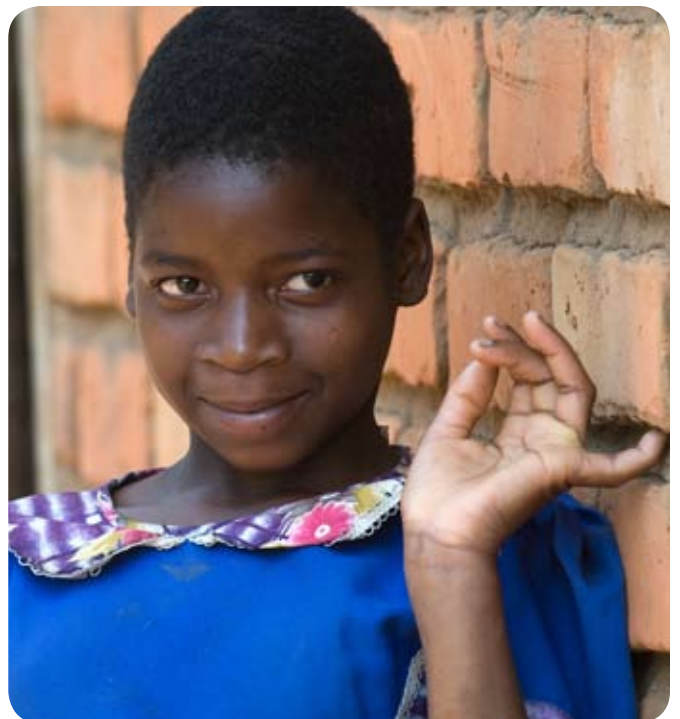


Orphans and Vulnerable Children Wellbeing Tool



User's Guide
April 2009

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Since 1943, Catholic Relief Services (CRS) has been privileged to serve the poor and disadvantaged overseas. Without regard to race, creed or nationality, CRS provides emergency relief in the wake of natural and man-made disasters. Through development projects in fields such as education, peace and justice, agriculture, microfinance, health, HIV and AIDS, CRS works to uphold human dignity and promote better standards of living. CRS also works throughout the United States to expand the knowledge and action of Catholics and others interested in issues of international peace and justice. Our programs and resources respond to the U.S. Bishops' call to live in solidarity—as one human family—across borders, over oceans, and through differences in language, culture and economic condition.

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<<http://crsproramquality.org/hiv-and-aids>>.

Use

Researchers and program staff in other organizations who wish to use the OWT in their work should contact Shannon Senefeld, ssenefel@crs.org, or pqpublications@crs.org. CRS welcomes such collaboration, and permission can normally be speedily granted in exchange for access and use rights to any data collected using the OWT.

Translations

The OWT has been translated into some local languages as well as the *lingua franca* of Africa and Latin America (French, Spanish, Portuguese); to obtain a translated version, e-mail Shannon Senefeld (ssenefel@crs.org) or visit <<http://crsproramquality.org/hiv-and-aids>>. Researchers using the OWT may by mutual agreement translate it into other languages, provided they furnish a copy of the translation to CRS to make available on our website; inquiries to Shannon Senefeld, ssenefel@crs.org, or pqpublications@crs.org.

TABLE OF CONTENTS

List of Acronyms	6
About the Authors.....	7
Acknowledgements	8
Executive Summary	9
Background	10
OWT Key Domains.....	11
Why the OWT was developed.....	12
Guiding Principles of the OWT.....	13
Who should use the OWT?	15
How to use the OWT information.....	16
Methodology.....	17
How to Use the OWT.....	19
<i>Informed Consent</i>	19
<i>Translation</i>	19
<i>Administration</i>	19
<i>Scoring</i>	20
OWT Strengths and Limitations.....	21
Next Steps.....	23
Conclusions.....	24
Annexes.....	25
Annex 1: OVC Wellbeing Tool	26
Annex 2: Field Scoring Sheet.....	28
Annex 3: Country Specific Methodology.....	30
<i>Haiti</i>	30
<i>Kenya</i>	30
<i>Rwanda</i>	30
<i>Tanzania</i>	31
<i>Zambia</i>	32
Annex 4: Scoring Syntax	33
Annex 5: Resources Consulted	34

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CARO	Central Africa Regional Office
CRS	Catholic Relief Services
CSI	Child Status Index
ERT	Emergency Response Team
HIV	Human Immunodeficiency Virus
HQ	Headquarters
LACRO	Latin America and the Caribbean Regional Office
M&E	Monitoring and Evaluation
OVC	Orphans and Vulnerable Children
OWT	OVC Wellbeing Tool
PEPFAR	President's Emergency Plan for AIDS Relief
SARO	Southern Africa Regional Office
SEAPRO	Southeast Asia and Pacific Regional Office
SD	Standard Deviation

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EXECUTIVE SUMMARY

A goal of orphan and vulnerable children (OVC) programs is to improve wellbeing. Yet, measuring wellbeing has proven to be an elusive concept for many engaged in OVC programming. Catholic Relief Services (CRS) has placed an agency priority on OVC programming and aimed to find a way to measure the wellbeing of OVC in a holistic manner. Using a scientific process, CRS developed an OVC Wellbeing Tool (OWT) for use as a self-report measure for OVC aged 13-18.

The CRS Orphans and Vulnerable Children (OVC) Wellbeing Tool was developed over a two-year time period from 2006 to 2008. Piloted through a larger evaluation of existing OVC programs funded by the President's Emergency Plan for AIDS Relief (PEPFAR), the OWT was originally administered in Haiti, Kenya, Rwanda, Tanzania, and Zambia.

Based on the data collected within this pilot, advanced statistical analyses, along with feedback from the pilot countries further served to refine the OWT. Presently, the tool is 36 questions long and takes approximately 20 minutes to administer. Scoring can be done immediately or via a computer program. Results are used to monitor OVC programs over time.

The OWT was developed to serve as a fast, easy method of securing data about the overall wellbeing of children in OVC programs. By collecting this self-report data over time, CRS anticipates being able to see patterns within its OVC programs that will allow for real-time assessment and response to current issues within the program.

The OWT has now been used in Ethiopia, Haiti, India, Kenya, Malawi, Rwanda, Tanzania, Vietnam, and Zambia. Translations from all of these countries will be accessible for download from the OWT website as they become available:
www.crs.org/publications/ovc-wellbeing-tool.

BACKGROUND

In November 2006, CRS' regional and headquarters HIV technical advisors gathered for their HIV Global Technical Team meeting. Orphans and Vulnerable Children (OVC) programming was identified as a top global priority for technical work in 2007. Among the myriad tasks for this program area, it was decided that a data collection tool was needed to measure a child's wellbeing. Due to the varying needs by age group, it was clear that multiple tools would be needed. The technical advisors opted to begin with a tool aimed at the 13 to 18 year old age group as so many of CRS' existing programs are working with adolescents.

A common goal of humanitarian organizations that, like Catholic Relief Services, serve children worldwide is to improve their overall quality of life. But individual "quality of life" is dependent on a number of variables (physical and psychological needs) and can change based on an individual's perception of his or her situation. Therefore, the concept of quality of life or wellness of an individual can be difficult to define. This has led many programs supporting children to focus on measuring the quantity and quality of services rendered. While such data is necessary for routine program monitoring, it is not necessarily sufficient for understanding the wellbeing of the children being served. Areas that tend to be less service-focused have a significant role in the wellbeing of the child. These areas of focus pursue goals such as acceptance of vulnerable children within their community, including support from the faith community, integration and success at school and general care and protection of vulnerable children. The perceived wellbeing of a child, from the child's vantage point, can serve as a powerful outcome indicator for OVC programs.

The objective in developing this new tool was to create an instrument that could be used internationally across CRS OVC programs and which was valid, reliable and practical to administer. This tool was designed to capture the holistic "wellbeing" of a child. The technical advisors responsible for its development brainstormed on the key domains fundamental to a child's overall wellbeing. These domains were subsequently verified through a process of review and comparison against other tools and definitions of wellbeing available in published literature.

The OWT is based on the premise that wellbeing is ultimately determined by ten key domains listed below. High self-reported scores throughout the domains indicate a high level of wellbeing. In addition to the overall wellbeing score, which is generated from summing the individual domains, domains can be scored separately so that wellbeing can be tracked within specific domains.

OWT KEY DOMAINS:

1. Food and Nutrition: This domain is designed to measure the child's status related to food security and nutrition, including the availability of nutritious food for the child, the child's belief that he or she has enough food to eat, and—as a very concrete metric of nutrition—whether the child goes to bed hungry at night.
2. Shelter: This domain focuses on physical shelter and the infrastructure of the child's immediate environment.
3. Protection: This domain focuses on whether children are treated differently or similarly to other children in their communities, schools, and households.
4. Family: This domain measures whether the child feels supported by his/her family.
5. Health: This domain examines whether the child believes he or she is healthy and doing as well as other children of the same age.
6. Spirituality: This domain examines whether the child draws support from his/her spirituality and faith community.¹
7. Mental Health: This domain examines the child's mental health, looking at concepts such as emotional support from others and self-reported happiness.
8. Education: This domain explores school-related stigma, access to educational materials, and satisfaction with school.
9. Economic Opportunities: This domain explores the economic situation of the household in which the child lives and the child's contribution to the household.
10. Community Cohesion: This domain explores community cohesion by asking the child about how welcome he or she feels in the community and the availability of support for his or her family.

CRS currently implements a six-country OVC program funded by the President's Emergency Plan for AIDS Relief (PEPFAR). At the time this tool was developed, the program was operational in five countries and a larger evaluation of it was planned. The PEPFAR OVC evaluation served as a platform for piloting a new OVC Wellbeing Tool (OWT) in Haiti, Kenya, Rwanda, Tanzania and Zambia.

¹ Note that for the purposes of this tool, the children were asked explicitly about their relationship to God. Programs reaching other audiences have changed this to be locally appropriate.

WHY THE OWT WAS DEVELOPED

The goal of the OWT is to improve both the quality and responsiveness of OVC programs by identifying and responding to unmet needs and evolving circumstances which impact vulnerable children's lives. The OWT was developed to serve as a fast, easy, and practical method of securing quality data about the overall wellbeing of children in OVC programs. By collecting this self-report data over time, programs are able to see patterns within OVC programs that allows for real-time assessment of any changes that need to occur within the program. The OWT was not designed to provide in-depth information about individual children in the program. Instead the tool should be used as a rapid assessment tool to determine if additional intervention is needed at the program level.

Therefore the development of the tool is seen as an important component of monitoring, evaluating and ultimately improving services to orphans and vulnerable children. The goal of the OWT therefore is to improve both the quality and responsiveness of OVC programs by identifying and responding to unmet needs and evolving circumstances in vulnerable children's lives which impact on their wellbeing.

GUIDING PRINCIPLES OF THE OWT

The OWT was developed specifically to be useful to the programmatic teams working directly with OVC. Its development was guided by the desire to create a reliable and valid measure that would improve the scientific base of OVC programs. Ideally, the tool would be used to monitor a program over time to enable program managers to make corrections in course and respond to the emerging needs of the beneficiaries. With this goal in mind, the OWT was created with several guiding principles:

- 1. Capture wellbeing from the child's perspective:** While it is standard practice for programs to collect data and reports from caregivers, teachers, and other adults interacting with OVC, at the time the OWT was developed the authors were unable to find any cross-culturally adapted and easy-to-use quantitative tools available that assessed a child's wellbeing from his or her perspective. To address this gap, an effort was made to design a tool that would be suitable for capturing wellbeing from the child's perspective. There was also a need for a tool that would move program monitoring beyond commonly collected output indicators, such as the number of children provided with a service, to a higher measure of outcome, such as quality of life or wellbeing.
- 2. A valid and reliable measure of wellbeing:** Since wellbeing is a vaguely defined construct, and factors which affect wellbeing are many and complex, the tool needed to be scientifically grounded and based on current best practices in OVC programs. The correlation with a previously validated tool was seen as essential to strengthen the validity and usefulness of the tool.
- 3. Age-appropriate:** The developers of the tool realized that although it would be ideal to have a self-reported measure for all age groups, it is necessary to develop different tools for different age groups due to their different developmental levels. As the majority of existing research focuses on adolescent self-reports, the developers opted to first focus on developing a tool for OVC aged 13-18. This tool should not be used for children outside this age range.²
- 4. Applicable to multiple settings:** While the team recognized the usefulness of a tool developed from an ethnographic methodology, ultimately the developers opted for a tool that could be applied in many settings and cultures. As such, the OWT was developed to be appropriate for multiple contexts, which allows for the same tool to be used, and for results to be compared, across various countries. In some cases, the tool may be strengthened by adapting it to the local culture. Such adaptation is encouraged as long as it follows a scientific process and is validated accordingly. Please note, however, that such adaptation will not necessarily allow the results to be compared to those derived from countries that used the standardized OWT.

² Please note that the authors are planning to develop a similar tool for younger age groups.

5. **Ease of use:** The team desired a tool that was straightforward and easy to administer. In addition, it was necessary to create a tool that could be administered quickly to the children in their natural environments.

6. **Repeated measure:** As this tool will be used with children over time to monitor trends, it was necessary to design a tool that could be easily repeated. Ease of use allows for repeated measures, which strengthens a program's ability to accurately track children's wellbeing and monitor and evaluate its effectiveness over time.

WHO SHOULD USE THE OWT?

The OWT should be used by OVC program staff s for the purpose of assessing patterns of overall wellbeing among project beneficiaries. It should also be used to identify areas needing additional assessment and intervention. The data generated by the OWT is intended to provide programmers with a snapshot glimpse of the wellbeing of the children in the program and is most useful when repeat measures are done.

However, while the primary purpose of the tool is to generate program outcome data, there is a need to ensure that this information is fed back into the communities where the programs are implemented. If the wellbeing scores of the children in a certain community begin to drop, the community should be informed of any issues that the children have identified and jointly develop a response plan.

While the primary purpose of the tool is to generate program outcome data for managers, communities who are directly caring for children, and children themselves, can also use the OWT. Again, these users of the OWT should ensure that results of the OWT are fed back into the wider community where the program is implemented. This will allow the community to develop an informed response to meet the needs of the children in their care.

HOW TO USE THE OWT INFORMATION

The information gathered from the administration of the OWT should be used to monitor OVC programs. The frequency of this monitoring will depend on individual programs; however more frequent monitoring is preferred, so that the data can be used in a real time response. As discussed earlier, the OWT should primarily be used at an aggregate level to identify patterns of OVC wellbeing within projects. Weaker domains should be explored to determine if these domains are temporarily hampered by external factors, such as seasonal food insecurity and whether the project needs to incorporate changes into the project design to address these specific issues. A secondary application is to use the data to respond directly to a specific child's need based on their OWT score. While the OWT is not intended to be an in-depth assessment tool at the individual level, several field personnel have found that rapid scoring of the results can highlight the need for follow-up and more in-depth assessment with children who report significant problems.

The OWT is not intended to be an in-depth individual assessment tool, and readers are encouraged to seek out appropriate assessment tools such as psychological assessment tools which have been validated for the local context. Instead, this is a rapid assessment that may indicate that there needs to be additional in-depth assessment in those domains where the scores are low. This tool should be used by OVC programmers to look at patterns of overall wellbeing among project beneficiaries and to identify areas needing additional assessment and intervention.

METHODOLOGY

Domains of wellbeing were identified after a thorough review of the literature. Those domains that had been identified in resource-poor environments as key domains in child wellbeing were included as domains in the OVC Wellbeing Tool.

Once the domains were identified, a literature review was conducted to determine what domains had been shown to contribute to child wellbeing across cultures.³ A total of ten domains were identified: nutrition/food security, shelter/environment, protection, family, health, spirituality, mental health, education, economics, and community cohesion.

Following domain identification, self-reported statements were generated for each domain using a free listing methodology as well as adaption from other validated tools. For example, for the food and nutrition domain, one statement was “I have enough food to eat.” More than 100 statements were generated for the different domains; many were taken or adapted from other validated tools.

This list of statements was then shared with expert judges within CRS drawn from fields such as education, social protection, health, and food security. Nearly 40 different judges ranked the statements’ relevance as a proxy measure for wellbeing. Forty-eight statements, each answerable using a 3-point Likert scale, were kept based on $\geq 70\%$ agreement (S.D. ≤ 0.75) among judges.

Each statement is reported on by the child interviewed. The child is requested to state how often each statement applies to him/her using the 3-point Likert scale: none of the time, some of the time, or all of the time. While a 5-point Likert scale is preferable, field staff strongly felt the use of a 3-point scale was more practical. The tool was originally both sides of one piece of paper.

To validate the results of the OVC Wellbeing Tool (OWT), the tool was administered alongside another validated measure, the Children’s Hope Scale (Snyder et al., 1997), which allowed correlation of OWT results against a standardized, existing measure. The authors felt that the constructs of hope and wellbeing were strongly associated and thus justified this cross comparison. In addition, including the OWT as part of a larger survey administered within the multi-country CRS OVC PEPFAR evaluation allowed the developers of the tool to collect a larger data set from the targeted group of 13- to 18-year-old OVC against which the wellbeing data was further correlated. The tool was piloted in five countries under this evaluation: Haiti, Kenya, Rwanda, Tanzania and Zambia. While the same guidance was provided to each country program to pilot, slight variations in methodology were evident in each.⁴

³ See Annex 5 for a list of consulted resources.

⁴ Please see Annex 3 for a detailed description of each country program’s implementation methodology.

A total of 890 children aged 13–18 years participated in the pilot of the OVC Wellbeing Tool (OWT). Inter-item reliability analysis revealed a Cronbach's alpha of .85 for the overall tool. Inter-item reliability within domains ranged from 0.238 (Economic Security) to 0.7 (Family Support). To assess concurrent validity, the tool was also compared to the previously validated Children's Hope Scale (Snyder et al. 1997) showing strong correlation (Spearman's $\rho = 0.571$, $p < 0.01$). This significant association supported the authors' premise that the constructs of hope and wellbeing were related as well as showing a 3-point Likert scale could yield adequate results. The larger project evaluation through survey administration, collected objective data related to domains within the OWT; objective data supported the subjective, self-reported OWT responses, providing further evidence that the OWT was a valid measure of wellbeing.

However, many country programs expressed concern that, at 48 questions, the tool was too long to administer to large groups of children. In order to reduce the number of items in the tool, confirmatory factor analysis was conducted. Several questions in the domains with lower inter-time reliability were highlighted as not fitting within the specified domain. As a result, these questions were removed from the scale.

The factor analysis also revealed that the health domain as developed was not a valid domain and pointed to the multifaceted definition of "health." Simultaneously, the children who had participated in the pilot expressed their dissatisfaction with some of the questions in the health domain. As a result, the questions for the health domain were revised. The resulting tool consists of 36 statements. Statistical analysis demonstrates that the revised health domain is much more statistically sound and responds to the suggestions of both program evaluators and the children.

HOW TO USE THE OWT

The OWT is a relatively easy tool to use. Despite being a definite change from commonly used questionnaires, trained enumerators and children are able to quickly understand and complete the tool. However, there are several key components that the authors have stressed as imperative in using the tool which are described below.

INFORMED CONSENT

All children who complete the OWT should provide informed consent. The children should fully understand how the data will be used and that their answers linked to their names will not be shared publicly. Instead the data will be used to determine program needs and responses.

TRANSLATION

Starting with informed consent, everything associated with the OWT should be translated correctly into local dialect. To ensure that the translation is appropriate, back-translation by another independent translator should occur. Any discrepancies in translation should then be resolved.

Of special concern is that translation of some of the words in the OWT must be done from a figurative view rather than literally. Many languages do not have equivalent words to express some of the more abstract concepts in the OWT, including concepts such as feelings and self-worth. Therefore, it is essential that the translation be done by qualified personnel and that the back-translation is completed to ensure the integrity of the meaning of the OWT is maintained.

The time and energy required to ensure accurate translation should not be underestimated. Ensuring that the tool is translated well and that the essence of each question is preserved should be seen as a priority.

ADMINISTRATION

The OWT should be administered orally to children aged 13–18. The interviewer should follow the directions on the page verbatim, using the instructions printed on the sheet. At no time should the interviewer change words within the tool or expand on the concepts in the tool. If further explanation is needed, review of the translation process should be done to ensure the intended meaning of each question has been maintained.

Potentially, the OWT could be self-administered by the child. However, this method has not yet been researched to determine if it is effective. Due to high illiteracy rates and the numerous translations required, the tool was designed as an oral tool. If countries are committed to self-administration, literacy levels of the children should be closely assessed prior to administration. In this case, the box indicating self-administration should be checked on the form, and this should be entered into the database as a unique variable so that researchers are able to determine differences between oral and self-administered responses.

TIME REQUIRED

The tool is relatively short. Most children orally complete the tool within 20 minutes during the initial administration even when used by new enumerators. Time required varies from 15 to

25 minutes according to reports from the field. It is likely that the amount of time required to complete the tool will decrease upon re-administration, once the children and the enumerators become more familiar with the questions and answer options. This should be especially true when repeated measures are done and children become familiar with the tool. To date, no research has been conducted on the amount of time required for self administration.

SCORING

The OWT is a relatively easy tool to score. Each of the ten domain responses are averaged according to the responses on the statements within that domain. Note that there are seven statements in the tool that need to be reverse coded for scoring before averaging the domain scores. Thus, each domain receives an average score within the range of 1 to 3.

The ten domain scores are then added together to create the total wellbeing score. The final score can thus range from a low of 10 to a high of 30. It is important to examine the overall OWT scores according to the local context. It is completely feasible that some settings will have an overall lower mean score on the OWT than others. This may be due to a number of different factors (e.g. recent natural disaster, larger number of double orphans, etc.). Thus, in order to fully examine whether the children in that area are improving or not, it is better to calculate the overall mean for that area and then compare the children to that mean. For example, if children in Village A had a mean OWT score of 24 with a standard deviation of 3, the program would want to look carefully at those children that fell more than one standard deviation from the calculated mean. This contextual examination of OWT scores provides the best systematic method of understanding what the data means from one setting to the next.

Despite possible contextual variations, it is possible to make some general statements regarding wellbeing overall and the OWT scores. Based on the pilot data from OVC in five countries, highly desirable scores are 25 or above. However, it is relatively rare to find baseline scores at this level. Instead, scores often center around 23, which are interpreted to mean that overall wellbeing is averaged at this level amongst such groups of vulnerable children, with room to improve wellbeing in certain domains. Based on research within the pilot, the authors recommend that special attention be paid to programs when the wellbeing average nears 22 or below, as this may signify deficits within certain domains. Scores below 15 require immediate action to determine if there was an error in response or if there is a problem affecting the children that needs to be addressed.

The tool was originally designed with the idea that the data would be taken back to a central location to be scored on a computer system. However, based on feedback from piloting, it was deemed necessary to develop a field scoring sheet that would enable rapid scoring in the field. This would allow staff to see instantly if there were changes in OVC wellbeing during the monitoring exercises and communicate this information to communities in real time. As such, the field programs created a scoring sheet that now has been used by monitoring staff in numerous countries (Annex 2).

While the field scoring sheet is a convenient tool for on-site monitoring and analysis of individual communities, in order to see overall patterns (which is the primary intended use of the OWT), within the OVC programs, it is still necessary to enter the data into a central database and to compare data over time and across fields. Syntax for scoring is attached in Annex 4.

OWT STRENGTHS AND LIMITATIONS

Like any tool, the OWT has strengths and limitations. These should be weighed carefully by any program before using the OWT to ensure that it is applicable and appropriate for the context in which it is being applied.

The greatest strength of the OWT is that it provides programmers with information from the children's perspective. OVC programs consistently report that they wish to involve the children in the programs and elicit their feedback, yet this is often an extremely difficult task to accomplish with limited monitoring budgets and staff time. The OWT is an easy-to-use, rapid tool that allows programs to elicit direct feedback from the children in the programs on how they view their wellbeing. It therefore is a tool which delivers on the goal of child participation and respects the right and need for children's voices to be heard.

Another strength of the OWT is that it covers multiple domains, providing information not just on a child's overall wellbeing, but also breaking that information into segments. In this way, OVC programs can analyze the data to determine which interventions require additional attention within the programs. For example, upon re-administration of the tool, one community may show marked decrease in the OWT education domain compared to an earlier measure. The OVC programmers can then go into the community to determine what is happening with the children's education and respond accordingly.

As mentioned earlier, accurate translation is at the center of how useful the OWT will be. If the initial time and effort is not invested in an accurate translation, the results will be invalid and meaningless. As such, the OWT does require an investment of time and effort on translation. As many of the concepts are abstract, there is a need to ensure that all questions are translated conceptually rather than literally. In the pilot, programs reported that the most effective means of translation was to sit and discuss what was meant with each statement in English and how that would translate into the local language. At times important debate occurred amongst local staff expert in the vernacular. This process was time intensive yet necessary to ensure that the essence of each statement was kept. Once a rough translation was accomplished, an additional back-translation was necessary to ensure that the concepts had been accurately captured. Field testing as an additional measure proved invaluable in many situations.

While there is significant time required before beginning to use the OWT (e.g., translations, training of enumerators, etc.), once this has been done, the OWT can be used rapidly and efficiently in the field. In addition, the OWT can and should be re-administered over time, so the initial time investment required is balanced by the long-term applicability of the OWT.

It is important to note that the OWT was designed as a tool that could have broad use across countries and regions. The OWT was not developed using an ethnographic approach. It is completely possible that communities in certain areas will have a different understanding

or definition of what constitutes “wellbeing” for the children in their contexts. As such, it is important to engage with communities to determine if the domains in this wellbeing tool are relevant to the culture before administering and subsequently running the risk of misinterpreting the data from their perspective. Yet, the authors believe that in general each domain represents an important universal component of healthy child development and wellbeing.

The OWT was developed to be administered orally to children aged 13-18. Much research has demonstrated that oral administration may exert some pressure on respondents to offer what they perceive as desirable responses. However, the developers of the OWT strongly believed that oral administration had to be offered since literacy rates varied so greatly from one child to the next. Additional research on self-administration is planned as the OWT is rolled out in more locations. The development of the tool triangulated the data provided by the OWT with data provided in focus groups and by caregivers, and no discrepant differences were found, suggesting that the children answered truthfully despite the oral administration. It should be noted that the questions were designed to be fairly innocuous so that children are not afraid to respond or do not feel embarrassed to offer their truthful responses.

Finally, the use of the tool may elicit both positive and negative feelings from children. They may feel they are being listened to and misinterpret that as offering an opportunity to share further thoughts, feelings, and experiences. While important, the administration of the tool cannot take the place of much needed psychosocial counseling and support. This distinction should be clear to both program managers and people administering the tool. Prior to administration of the tool, program staff should have a plan of referral for any children identified as needing further immediate assistance.

NEXT STEPS

Further use to assess test/retest reliability is encouraged. The original data collected for the validation of the OWT was one-time data. As such, additional research to determine test/retest reliability is currently underway in several countries. This will provide useful longitudinal information.

To improve understanding of higher level outcomes of OVC programs further use and evaluation of the tool is encouraged. While the OWT is designed as a simple monitoring tool, it is possible that its scores may be correlated to higher level outcomes of OVC programs. For example, OVC who score consistently high on the OWT may have better education outcomes than OVC who score consistently low. The predictive value of the OWT on other OVC program outcomes has not yet been established. Additional long-term research should be conducted to determine if the OWT is predictive of higher-level outcomes.

Research is currently underway in Malawi to determine how the OWT and the Child Status Index (CSI) correlate. Researchers from Duke University and CRS are administering both the OWT and the CSI, along with other validated tools (e.g., Strengths and Difficulties Questionnaire, the Children's Hope Scale) to children in the 13-18 year old age group. The research is focused on how the self-report data from the OVC using the OWT correlates with caregiver and volunteer reports using the CSI and other validated tools.

CONCLUSIONS

The OWT is a practical self-reported measure of child wellbeing. This new tool, pilot tested in five countries, shows evidence of acceptable reliability and validity. Advanced statistical analyses demonstrate that the domains within the OWT are valid, and that they correlate to larger reported data on the same domains. Additionally, the overall OWT score correlates significantly with scores on another validated measure (i.e., Children’s Hope Scale).

The OWT is an easy-to-use tool that is a rapid means of eliciting children’s feedback on their wellbeing. The tool is meant to be used as a program monitoring tool for OVC programs, so that project managers have access to real-time data from the OVC in the programs on what they believe of their own wellbeing.

On average, it is estimated that the OWT takes approximately 15–20 minutes per child to administer on the first administration. As such, it is a relatively rapid tool to use to gather a large amount of data on various domains within the children’s lives. However, it is imperative to state that there should be significant time invested before administration to ensure that the translations are done correctly and accurately.

Designed as a tool that could have broad use across regions, the OWT was not developed using an ethnographic approach. It is possible that communities in certain areas will have a different understanding or definition of what constitutes “wellbeing” for the children in their contexts. As such, it is important to engage with communities to determine if the domains in the wellbeing tool are relevant to the culture before administering and subsequently running the risk of misinterpreting the data.

The OWT has now been used in Ethiopia, Haiti, India, Kenya, Malawi, Rwanda, Tanzania, Vietnam, and Zambia. Translated versions in the languages of these countries will be made available for download from the OWT website: www.crs.org/publications/ovc-wellbeing-tool.

Other organizations are invited to use the OWT free of charge. However, the authors request appropriate citation. In addition, other organizations are requested to share their use of the OWT and experiences with the developers to further improve the OWT and OVC programming.

ANNEXES

OVC WELLBEING TOOL ANNEX 1

Name of OVC: _____

Identification Number: _____

Gender: Male _____ Female _____

Age: _____

Administration: Oral _____ Self-administered _____

Statement	None of the Time	Some of the Time	All of the Time
1. I eat at least two meals a day			
2. I have enough food to eat			
3. I go to bed hungry			
4. My teachers treat me like the other students			
5. I have the materials I need to do my class work			
6. I am not treated as well as the other students in my class			
7. I like school			
8. I have enough books and supplies for school			
9. I have a house where I can sleep at night			
10. I feel secure in my neighborhood			
11. I feel safe where I live			
12. My school attendance is affected by my need to work			
13. My family has enough money to buy the things we need			
14. One of the adults taking care of us (me) earns money working at a job			
15. I'm treated differently from the other children in my household			
16. I'm treated the same as other children in my school			
17. I'm treated differently from other children in my village, neighborhood, compound			
18. I do not get enough sleep and feel tired because of all the work I do before and after school			
19. I have people I can talk to when I have a problem			
20. I am able to do things as well as most other people			
21. I am as happy as other kids my age			
22. I feel I live in a safe place			
23. At home, I have someone to look after me if I get hurt or feel sad			
24. I have adults that I can trust			
25. I get the emotional help and support I need from my family			
26. I feel I am supported by my extended family			
27. I feel strong and healthy			

Statement	None of the Time	Some of the Time	All of the Time
28. I worry about my health			
29. My health is good.			
30. I am growing as well as other kids my age			
31. My belief in God gives me strength to face difficulties			
32. My belief in God gives me comfort and reassurance			
33. My faith community is important to me			
34. People in my community try to help me			
35. I feel welcome to take part in religious services			
36. My household receives <i>free</i> support to care for the children who live here			

FIELD SCORING SHEET ANNEX 2

	Scoring Template Statement	None	Some	All	Calculation	Domain SUM
FOOD AND NUTRITION	1. I eat at least two meals a day	1	2	3	Sum divide by 3	
	2. I have enough food to eat	1	2	3		
	3. I go to bed hungry	3	2	1		
EDUCATION	4. My teachers treat me like the other students	1	2	3	Sum divide by 5	
	5. I have the materials I need to do my class work	1	2	3		
	6. I am not treated as well as the other students in my class	3	2	1		
	7. I like school	1	2	3		
	8. I have enough books and supplies for school	1	2	3		
SHELTER	9. I have a house where I can sleep at night	1	2	3	Sum divide by 3	
	10. I feel secure in my neighborhood	1	2	3		
	11. I feel safe where I live	1	2	3		
ECONOMIC	12. My school attendance is affected by my need to work	3	2	1	Sum divide by 3	
	13. My family has enough money to buy the things we need	1	2	3		
	14. One of the adults taking care of us (me) earns money working at a job	1	2	3		
PROTECTION	15. I'm treated differently from the other children in my household	3	2	1	Sum divide by 4	
	16. I'm treated the same as other children in my school	1	2	3		
	17. I'm treated differently from other children in my village, neighborhood, compound	3	2	1		
	18. I do not get enough sleep and feel tired because of all the work I do before and after school	3	2	1		
MENTAL HEALTH	19. I have people I can talk to when I have a problem	1	2	3	Sum divide by 4	
	20. I am able to do things as well as most other people	1	2	3		
	21. I am as happy as other kids my age	1	2	3		
	22. I feel I live in a safe place	1	2	3		
FAMILY	23. At home, I have someone to look after me if I get hurt or feel sad	1	2	3	Sum divide by 4	
	24. I have adults that I can trust	1	2	3		
	25. I get the emotional help and support I need from my family	1	2	3		
	26. I feel I am supported by my extended family	1	2	3		

	Scoring Template Statement	None	Some	All	Calculation	Domain SUM
HEALTH	27. I feel strong and healthy	1	2	3	Sum divide by 4	
	28. I worry about my health	3	2	1		
	29. My health is good	1	2	3		
	30. I am growing as well as other kids my age	1	2	3		
SPIRITUALITY	31. My belief in God gives me strength to face difficulties	1	2	3	Sum divide by 3	
	32. My belief in God gives me comfort and reassurance	1	2	3		
	33. My faith community is important to me	1	2	3		
COMMUNITY	34. People in my community try to help me	1	2	3	Sum divide by 3	
	35. I feel welcome to take part in religious services	1	2	3		
	36. My household receives free support to care for the children who live here	1	2	3		
<p style="text-align: center;">Total Domain Sum _____ Divide by 10 _____</p>						SCORE:

HAITI

Haiti used the same sample to test the OVC Wellbeing Tool (OWT) as the larger OVC evaluation. A total of 219 OVC aged 13 to 17 were included in the sample. All OVC from the Haiti sample were in institutional settings.

The OWT was translated from English to Creole, back-translated and checked for accuracy by bilingual team members. The OWT was field tested as part of the overall field testing of tools for the OVC evaluation. No changes were made to the tool as a result of the field testing. A total of seven interviewers were used to administer the tool. The interviewers were trained over a three-day period, which included training on survey techniques and the administration of the evaluation tools, including the OVC Wellbeing Tool.

On average, the OWT took approximately 30 minutes to administer. There were no reported problems with the administration or comprehension of the tool.

KENYA

Kenya administered the OWT to 197 OVC in the 13–17 age group during the pilot. The OWT was administered to the participants in the OVC PEPFAR Evaluation a couple of weeks after they were given the evaluation questionnaire. A total of 225 OVC completed the evaluation questionnaire, but 28 of them could not be tracked at the time of the administration of the OWT.

In addition, CRS Kenya had received additional supplemental funding from the local USAID mission to support OVC. The questionnaire was administered to more than 1,700 OVC between the ages of 13 and 17 years enrolled during this program.

The OWT was translated from English to Swahili and Luo by CRS staff members. The OWT was then back translated into English by a group of project social workers. This led to many lively discussions on the exact meaning of words and phrases. The groups agreed on what the correct translations should be. All project social workers were trained in the administration of the tool during a one-day workshop. The OWT took about 20 minutes to administer. The OVC were enthusiastic and very open and stated that they were very pleased to be able to give their opinion on matters relating to them. There were no reported difficulties on the part of the OVC in understanding the questions on the OWT tool.

RWANDA

Rwanda was the first country to pilot the OWT, and the experience there inspired significant changes to the methodology. The tool used in Rwanda was a shorter version than used in subsequent country evaluations. In addition, the tool, while designed for OVC aged 13 to 18, was also administered to a small group of OVC aged 8 to 12 years in Rwanda. In general, the country evaluation found that the abstract ideas references in the OWT were too complex for OVC in the younger age group, and subsequent countries did not include

that group in the pilot of the OWT. (It should be noted that the tool was designed for the older age group, so the finding that it is not applicable to the younger age group is expected and reinforces standard research protocols that demand that appropriate tools be chosen for the targeted audiences.)

The OWT was not ready for piloting at the time the overall evaluation started, so the methodology for administration of the OWT was different from that used subsequently in other countries. Whereas other countries administered the OWT to all the OVC in the evaluation during individual data collection, in Rwanda, OVC participating in focus group discussions were invited to complete the OWT. A total of 234 OVC aged 13 to 17 completed the OWT, and a total of 119 OVC aged 7 to 12 completed the OWT.⁵

The OWT was administered in Kinyarwanda. The translation from English to Kinyarwanda was done by CRS staff and was cited as one of the main problems in the administration of the tool. The translation of some of the abstract ideas from the English version was reportedly not easily done. Experiences in Rwanda encouraged other country evaluations to pay special attention to ensuring that the text was translated and then back-translated to ensure that conceptual, abstract ideas were correctly captured.

While the enumerators were trained in the administration of the OWT, there was confusion among the enumerators with regard to the function of the OWT, and many reportedly did not understand the tool themselves. This observation enabled subsequent countries to adjust their enumerator training to ensure that adequate time was devoted to training the enumerators on the administration of the tool after the trainers themselves had fully understood and grasped the tool. The Rwanda experience also influenced subsequent country programs to include the OWT as part of the pre-testing as a means of providing the enumerators with an opportunity to field test their own administration of the tool.

TANZANIA

As in the other pilot countries, Tanzania administered the OWT to the sampled orphans and vulnerable children at the end of a general program survey. The overall sample size envisioned for this evaluation was 150. Through a random sampling methodology 92 OVC aged 13 to 17 were selected from urban setting represented by PASADA, and 58 OVC of same age were selected from the rural Catholic diocese of Njombe. All of the surveyed children participated in the CRS program. Of the 150 children sampled for OWT interview, only 140 children were included in the data collection. During the process of the survey, eight children sampled for the survey exercise were not located in their rural households by the survey enumerators; while in the urban setting, the interviewers could not manage to locate two sample cases. At the time of data entry, only 133 of the interviewed 140 survey forms were correctly filled in and qualified for data entry.

Translation of the OWT was translated from English to Kiswahili by a national consultant in collaboration with the CRS country program team. The translated OWT was then shared with CRS Kenya–OVC program staff. The aim was to cross check the linguistics and

⁵The younger age group data was not included in the validation of the OWT or any of the statistical analyses.

compare standard Swahili translation between Kenya and Tanzania Swahili Speakers. This process resulted in a decision by CRSTanzania to further consult a Swahili expert for proof reading the translated OWT while comparing the translated Swahili questions with the original English questions in the OWT questionnaire. Finally the experts decided on the standard Swahili translation.

Training of survey interviewers and field supervisors on the administration of the OWT was conducted in both settings during a one-day workshop. On average each interviewer spent about 20 minutes administering the OWT. Overall comments on the tool from the surveyed children were that the tool is useful and user-friendly, and that for the first time the children were given the opportunity to express their concerns.

Important challenges observed were related to distance between the two surveyed areas and timing that seemed poorly chosen for rural participants. The survey was conducted in April, which is also a farming season. Some of the sampled OVC were missed because they had to engage in farming activities. Another challenge was related to general knowledge of the interviewers especially in rural areas, where majority of the interviewers had only primary school education level, which required additional training and explanation for them to fully understand the tool.

Since then, the OWT has been piloted in six sites and administered to an additional 1,382 OVC. CRSTanzania is effectively promoting the OWT in all the CRS sites where the OVC program is implemented and at National level, the OWT has been shared with the Quality Task Force Team Implementing Partners with the aim of learning and improving the quality of OVC programs in Tanzania.

ZAMBIA

Zambia used the same sample to test the OWT as the larger OVC evaluation. A total of 249 OVC aged 13 to 17 were included in the sample.

The OWT was translated from English to the local languages Lozi and Kaonde. The translation was conducted by professional translators and followed the methodology of translation and back-translation. The OWT was not field tested among OVC prior to administration, but the enumerators practiced administration amongst themselves prior to administration to OVC.

A total of seven enumerators were used to administer the tool. The enumerators were received training on survey techniques and the administration of the evaluation tools, including the OWT. There were no reported problems with the administration or comprehension of the tool in the original pilot. Subsequent administration with new children demonstrated difficulties with translation of certain questions and stressed the need for appropriate translation at all points.

On average, the OWT took approximately 10 minutes to administer.

SCORING SYNTAX ANNEX 4

NOTE: Be sure that the items for each of the variables listed in this SPSS syntax correspond with the numbered items for the domains and total scale for the OWT.

The variable “FN1” corresponds with the first question in the Food Security and Nutrition domain. “FN2” corresponds with the second question in this domain. “Ed1” corresponds with the first question in the Education domain and so on.

“FNA” is the variable for the average of the Food and Nutrition domain. “EDA” is the variable for the average of the Education domains and so on. “OWT” is the total average of the scores across the 10 domains.

Please ensure that you have reverse coded the scores on questions 3, 6, 12, 15, 17, 18, and 28 prior to running this calculation. E.g., recode the responses for these variables as 1=3, 2=2, and 3=1.

```
COMPUTE FNA = MEAN (FN1, FN2, FN3)
COMPUTE EDA= MEAN (Ed1, Ed2, Ed3, Ed4, Ed5)
COMPUTE SHA= MEAN (Sh1, Sh2, Sh3)
COMPUTE ECA= MEAN (Ec1, Ec2, Ec3)
COMPUTE PRA = MEAN (PR1, PR2, PR3, PR4)
COMPUTE MHA = MEAN (MH1, MH2, MH3, MH4)
COMPUTE FA= MEAN (F1, F2, F3, F4)
COMPUTE HA = MEAN (H1, H2, H3, H4)
COMPUTE SPA = MEAN (SP1, SP2, SP3)
COMPUTE CCA = MEAN (CC1, CC2, CC3)
COMPUTE OWT = FNA+EDA+SHA+ECA+PRA+MHA+FA+HA+SPA+CCA
```

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