Uganda Vulnerability Index Assessment Results

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Abbreviations and Acronyms

CDC	Centers for Disease Control and Prevention
CSI	Child Status Index
CDO	Community Development Officer
CPA	Core Program Areas
DCDO	District Community Development Officer
FGD	Focus Group Discussion
HQ	Headquarters
IPs	Implementing Partners
MGLSD	Ministry of Gender, Labour, and Social Development
MRC	Medical Research Corps
M&E	Monitoring and Evaluation
NAT	Needs Assessment Tool
OVC	Orphans and Vulnerable Children
PAT	Poverty Assessment Tool
PEPFAR	President's Emergency Plan for AIDS Relief
PIN	Production for Improved Nutrition
PLHIV	People Living with HIV/AIDS
SCORE	Sustainable COmprehensive REsponses
TASO	The AIDS Support Organization
TSO	Technical Services Officers
TWG	Technical Working Group
VHT	Village Health Teams
VAT	Vulnerability Assessment Tool
VI	Vulnerability Index
USAID	United States Agency for International Development
USG	United States Government

Executive Summary

Background

In 2011-2012, Uganda's Ministry of Gender, Labour, and Social Development approved use of the Vulnerability Index (VI), a tool to identify vulnerable households and the extent of their vulnerability. Five U.S government-funded implementing partners started using the VI in 2012-2013. USAID/Uganda asked MEASURE Evaluation to conduct an assessment of the VI tool's usefulness, feasibility, and data quality. The following questions guided the assessment:

1. How feasible is it for volunteers to administer the VI? What are the benefits and challenges of the VI application?
2. Who analyzes the data and how well prepared are they to provide information for decision making?
3. How well does the VI assess household vulnerability?
4. What is the quality of the data generated from the VI?

Methods

We used a mixed methods descriptive cross-sectional study that included primary and secondary data collection. We conducted in-depth interviews and focus group discussions with program and M&E staff, as well as government and community workers at purposively selected program sites of the five implementing partners using the VI and three sites where the VI was not used. Secondary data analysis involved reviewing up to 50 randomly selected VI forms per implementing partner for completeness and accuracy in scoring, as well as for how children were distributed among the three vulnerability categories defined by the VI tool (critically, moderately, and slightly vulnerable).

Findings

We collected information from 62 individuals and reviewed a total of 248 VI records. Four of the five programs use the VI for targeting households for enrollment. In four of five sites, the VI is administered by staff, counselors, or community resource persons who conduct household visits; in another it is administered by local government staff. Most respondents indicated it is feasible to administer the VI, though some government staff noted challenges given workload and resources.

Overall, participants find the VI to present a comprehensive, standardized approach for assessing and categorizing household and individual child vulnerability. Some of the challenges related to VI administration include the length of time to administer the tool, resources required, and the inability of the tool to track households over time. At the time data were collected, there was an absence of standardized training manuals and data collection and scoring guidelines.

Data collection participants perceive that the VI score does not always reflect the actual vulnerability of a child/household. Analysis of VI records reveal that three of the five sites had no critically vulnerable children identified, and the other two sites identified 2 percent and 14 percent as critically vulnerable.

Furthermore, children that were rated as "slightly vulnerable" in the VI, which reflects a relatively good score, were found to be in more precarious situations than this score would suggest: 70 percent were in a household with an economic adverse event in the last year, 45 percent had someone go a whole day without food, 20 percent had a caregiver/head of household with severe disability, nearly 30 percent with a caregiver emotionally troubled most of the time, and over 50 percent using a form of harsh discipline in the household.

Challenges related to VI data quality include inaccuracy in scoring composite questions (questions that involve ticking several boxes and then assigning a score based on the number of ticks) as well as summing the total scores. In addition, participants indicated that responses and accompanying scores of select VI questions may not reflect the indicator, particularly for urban areas. It was also noted that the tool's ability to capture "critically vulnerable" children may be limited due to the fact that there are a different number of questions per core program area (CPA), inadvertently weighting the findings.

Conclusions

While the VI provides a comprehensive, standardized tool for OVC programs, findings reveal that the tool may not identify the most critically vulnerable children. While one possible remedy would be to adjust the criteria used to capture children who fall in the "critically vulnerable," category, secondary data analysis illustrates that the tool design (e.g., number of questions per CPA, scoring rubric) should be reviewed more broadly.

Recommendations

In light of the findings, we recommend the following:

- Re-examine the VI tool. Given the concerns related to validity, it is worth re-visiting the tool to address the following issues:
    - The consultant who initially developed the tool had identified a reduced list of indicators that may be more likely to predict vulnerability. It may be worth re-visiting these indicators to identify the most important and those most predictive of vulnerability.
    - The scale used to rank vulnerability: Some of the individual items in the instrument have different ways to score responses, which may result in unintentional weighting of some of the questions.
    - Identify what impact "not applicable" or skipped responses may have on the overall vulnerability score. Identify questions that may not be applicable for some respondents and provide guidance on the scoring in those cases.
- Clarify purpose of tool. For each situation where the tool is used, determine its best/most appropriate use, whether used for targeting for enrollment, needs assessment, monitoring, or graduation. These uses should then be described in subsequent guidance documents.

- Develop guidance materials to accompany the tool. These could include, for example, training materials and guidance on data collection, scoring, use of information for selection, and assessing needs (based on purposes determined above).
- Exercise caution in basing program enrollment solely off total scores, particularly if programs are not covering all CPA areas.

Introduction

Like many African countries, Uganda has a high HIV prevalence rate of 7.3% for men and women aged 15-49.[1] HIV prevalence is higher among women than men: 8.3 per cent in comparison to 6.1 per cent. It is higher among women in urban areas (10.7%) than in rural areas (7.7%), but the same, 6.1 per cent, for men in urban and rural areas.[1] Recent estimates also indicate twenty percent of children (< 18 yrs.) are not living with a biological parent and at least 2.3 million children (12.7 % of children under the age of 18) have lost at least one or both parents.[2] In addition, 33% percent of households have an orphan or foster child living in the household.[1]

The United States Government (USG) supports several different implementing partners to carry out work related to HIV/AIDS care and support. A key component of these projects is to identify the vulnerability of the households they serve, particularly for households of people living with HIV/AIDS (PHLIV) and orphans and vulnerable children (OVC). The Vulnerability Index (VI) was a tool developed in 2011 by the Uganda Ministry of Gender, Labour and Social Development (MGLSD) with support from the United States Government's (USG) President's Emergency Plan for AIDS Relief (PEPFAR) Orphans and Vulnerable Children (OVC) Technical Working Group (TWG) in Uganda. The report titled "Developing the National OVC Vulnerability Index for Uganda[3]" describes the development, pilot testing, and validation of the VI tool.

According to guidelines released by the Ministry of Gender, Labour and Social Development (MGLSD) in 2013, the primary goal of the VI was to have a standardized, objective, context-specific, sensitive, and easy to use tool which can be used to define and capture vulnerability. It is highlighted as a tool developed to: a) identify and assess OVC household needs; b) target households; and c) monitor and evaluate – leading to graduation of program clients.[4]

The National Strategic Programme Plan of Interventions for Orphans and Other Vulnerable Children 2011/12—2015/16 underlines that OVC programs should focus on providing services to the critically and moderately vulnerable given limited resources. Table 1 defines the types of children who would fall into the critically and moderately vulnerable categories according to the National Strategic Programme Plan.

Table 1: Types of Children Falling into Critically or Moderately Vulnerable Categories

Critically Vulnerable	Moderately Vulnerable
• Orphans whose rights are not fulfilled • Children infected and/or affected by HIV/AIDS • Children with disabilities • Street children/abandoned children and/or	• Children out of school • Child mothers • Children in poverty stricken (impoverished) households

[1] Uganda Ministry of Health, ICF International. *UGANDA AIDS INDICATOR SURVEY 2011*.Calverton Maryland, USA, 2012.
[2] Uganda Bureau of Statistics (2010). Uganda National Households Survey 2009/2010: Socio-Economic Module (Abridged Report), Kampala, Uganda.
[3] Twesigye, G., Mukasa, A., Tuyiragize, R., Bankusha, C. *Developing The National OVC Vulnerability Index for Uganda.* 2012.
[4] MGLSD (2013). Guidelines For Operationalising The Three Factor Criteria For Ovc Identification, Vulnerability Index (Vi) Tool And Child Status Index (Csi) Tool (Nov 2013). Kampala: Ministry of Gender, Labour and Social Development

Critically Vulnerable	Moderately Vulnerable
neglected children • Children in contact with the law • Children in child headed households • Children in worst forms of child labour (commercial sex exploitation, illicit activities, paid domestic work, work that interferes with school attendance) • Children in armed conflict (captives or child soldiers, internally displaced, ex combatants) • Children experiencing various forms of abuse and violence (survivors of sexual violence, children in abusive homes or institutions)	• Children living with the elderly, and/or parents/guardians with severe disabilities • Children in hard to reach areas (fishing communities, mountainous areas, nomadic communities)

Since its development, the VI has been implemented in a subset of districts where select United States Agency for International Development/Uganda (USAID/Uganda), Centers for Disease Control and Prevention Uganda (CDC/Uganda) and Walter Reed programs operate.

While the VI has been taken up by various USG funded implementing partners, the usefulness, feasibility, and quality of data generated from use of the tool has not yet been assessed. USAID/Uganda has requested that MEASURE Evaluation conduct an assessment to determine the Vulnerability Index's value as a tool used to identify household vulnerability and to provide information to guide future use of the tool.

The following questions guided the assessment:

1. How feasible is it for volunteers to administer the VI? Identify benefits and challenges of the VI application.
2. Who analyzes the data and how well prepared are they to provide information for decision making?
3. How well does the vulnerability index (VI) assess household vulnerability?
4. What is the quality of the data generated from the VI?

The Tool

The VI (Appendix A) is divided into two sections – the first section covers indicators related to household vulnerability; whereby the second section covers questions related to the Core Program Areas (CPAs) for each child in the household. There is a total of 15 questions in the household section and 14 in the child section. Each question is given a score from 0 to 4 (with some questions including a scale and some including options of just "1" or "4" for example). A score for each CPA is summed and then again summed for the household section and each individual child. For each child, a grand total score is calculated based on the household score + the individual child score. Vulnerability levels are then assigned based on the grand total score as indicated in Table 2.

Table 2: Scoring Rubric for Vulnerability Index

LEVEL OF VULNERABILITY	GRAND TOTAL SCORE
Critically Vulnerable	**90 – 116 points**
Moderately Vulnerable	**50 – 89 points**
Slightly Vulnerable	**Less than 50 points**

Methods

Design

We used a descriptive cross-sectional study that including qualitative data collection and record review at multiple project levels. The protocol was submitted and approved by the Health Media Lab in Washington DC and the Uganda National Council of Science and Technology. Further, the protocol was reviewed by CDC Uganda.

Selection Process

All USG funded (USAID, CDC, Walter Reed) projects/IPs that implemented the VI in at least one location were included. USAID currently funds six[5]programs in Uganda that provide support and assistance to vulnerable children and their households. Of those six, two (i.e. Production for Improved Nutrition (PIN) and The AIDS Support Organization - TASO), have begun to use the VI. In addition, the CDC currently funds nine[6] projects that provide support and assistance to vulnerable children and households. Of those, two (i.e. Medical Research Council (MRC) and Baylor-CDC) have used the VI. Also, Walter Reed funds another project that uses the tool. This assessment focused on all five of these USG funded projects using the VI.

Each of the implementing partners implements the VI in a different number of districts across three main regional clusters: Eastern, Central, and Western. For each IP, one district was selected based on willingness of staff and district officials to participate in the assessment and availability of staff. Where there were multiple sub-counties or locations, we purposively selected a sub-county based on travel feasibility and availability of staff.

Comparison Sites

Three of the implementing partners (IPs) were administering the VI among all of their site locations (RECO INDUSTRIES, MRC, Baylor-Uganda). For the other two IPs (Baylor-Uganda and TASO), we selected comparison locations to understand how OVC are selected for program inclusion in those locations. We

[5] SCORE, IRCU/MRC, Reco/PIN project, SUNRISE, RHU, TASO

[6] This list compiled from an internal USG Uganda spreadsheet: Baylor SNAPS-WEST; Baylor E-W Nile; IDI-KCC; Kalangala DHO/HCT & CARE; MILDMAY; MUFM/MJAP; REACH OUT MBUYA PARISH, HIV/AIDS INITIATIVE (ROM); Uganda Episcopal Conference; MRC. MEASURE Evaluation is working to verify with CDC.

also collected data from another IP, Sustainable COmprehensive REsponses (SCORE), that is not using the VI. Table 3 presents the projects and sites selected for data collection.

Table 3: Data Collection Sites by VI Use.

VI Use	Non VI Use
Baylor-Uganda Kasese/Kisinga	Baylor Kasese/Kilembe
MRC - Kampala	Not applicable*
RECO Kibaale	Not applicable*
TASO Tororo	TASO Masaka
Walter Reed – Kayunga	Not applicable*
Not applicable	SCORE

*There were no comparison sites as the locations.

Data Collection

Data collection involved primary and secondary data collection. All instruments and consent forms are included in Appendix B. The Uganda National Council for Science and Technology and the Health Media Lab Institutional Review Board in Washington, DC both reviewed and approved the study protocol and consent process. In addition, the United States Center for Disease Control and Prevention in Uganda also approved this study. Written informed consent for all instruments, which describes the rights and risks of those participating in the study was obtained by all study participants.

Primary data collection

Data collection activities included in-depth interviews and focus group discussions as follows:

1) **In-depth interviews with district officers and technical service officers involved in decision making based on VI scores or other vulnerability assessment results** – interviews focused on the process of VI scoring and use of scores to identify vulnerable households; and usefulness of the tool for identifying vulnerable households.
2) **In-depth interviews with selected sub-grantee program staff and monitoring and evaluation (M&E) officers**– interviews focused on the process of VI administration including planning, training, and implementation; usefulness of the tool for identifying vulnerable households; perceptions of data quality; and data management and analysis.
3) **Focus group discussions (FGD) with community workers who have used the VI.** All individuals involved in administering the VI were invited to participate in a focus group discussion of between seven to ten individuals (e.g., counselors, Village Health Team (VHT) members, local government staff). Questions focused on the feasibility of the VI given other duties; the usefulness of the tool for identifying vulnerable households; preparedness to administer and use information generated from the tool; and benefits/challenges of using the VI.

Secondary data collection

Secondary data collection involved a review of a sample of VI forms. Depending on where VI paper forms were stored, we reviewed up to 50 randomly selected VI forms per implementing partner (Up to 250 in total). After selecting the forms, we transcribed scores for the household section questions from

the forms and entered them into an Excel database. We then selected a random index child per household and transcribed those scores. We reviewed the records for completeness and accuracy in scoring, as well as the extent to which individual child and household scores were summed correctly. We also observed where VI forms were stored or entered.

Data collection was conducted by two Ugandan based consultants from November to December 2013. All interviews were recorded and transcribed verbatim in English.

Data Analysis

Primary Data

After data collection was complete, the team divided the transcripts and read through to identify preliminary themes and sub-themes. The team met to discuss the themes and came to agreement on thematic definitions and coding scheme for qualitative data analysis. One team member described the process of VI administration at each site based on transcripts and another coded transcripts using the agreed upon coding frame. The coding was done using QSR, Nvivo version 8.0. Matrices of themes by program and respondent type (e.g., government, person administering the VI, program staff) were developed to assist in identifying patterns of responses.

Document Review

We conducted several different types of analyses in Microsoft Excel. These tabulations were conducted for each site and for all sites combined.

a) We conducted frequency tabulations to present the percentages of individual and household core program area scores that were scored correctly.
b) We conducted frequency tabulations for composite questions HH CPA6 Question 6 and individual child (IC) CPA2 Q2 and CPA6 Q14.
c) Also, based on the HH and IC total scores, we determined the percentage of grand total scores that were scored correctly.

In addition, we calculated the proportion of children who were slightly, moderately, and critically vulnerable based on transcribed data, as well as from re-calculated data (according to a formula created in Excel). For files that were incomplete, we indicated them as missing.

For the sub-set of slightly vulnerable children based on the transcribed scores, we conducted a frequency distribution of select indicators indicative of vulnerable situations. The same was done for the sub-set of moderately vulnerable children. Before conducting frequency tabulation, we coded variables so that each one had only two values – “Yes” and “No.” Table 4 present the codes assigned for the “Yes” value for each indicator:

Table 4: Re-coding for Select Indicators

Indicator number	Codes for "Yes"
HH CPA1:#4	4
HH CPA2:#6	"4" or "1"
HH CPA3:#8	4
HH CPA5:#13	4
HH CPA6:#15	"4" or "1"
IC CPA2:#1	"4" or "3"
IC CPA2:#2	"4" or "2"
IC CPA3:#4	4
IC CPA4:#6	"4" or "2"
IC CPA5:#8	4
IC CPA5:#9	4
IC CPA6:#14	"4" or "2"

Finally, we created categorical values ("none", "one", "two to three", "four to six" and "more than six") to determine the range of such indicators for slightly and moderately households. We then calculated the proportion of these groups for slightly and moderately vulnerable children.

Limitations

While the study team aimed to use a standardized approach to assessing the VI, they had to modify some of the methods based on how the project was using the VI. For example, one site was using a different version of VI from the other sites. In some sites, village health teams administered the VI; whereas in others program staff or counselors administered the tool. This assessment did not assess which children were enrolled into the program.

Findings

Respondents

In total, we collected information from 62 participants (Table 5). Thirty-one interviews were conducted, seven of which were with program technical representatives, seven M&E representatives, four technical services officers (TSOs), and 15 local government informants such as district and community development officers and probation officers. In addition, 32 individuals participated in eight FGDs – the size of FGDs varied considerably depending on who administered the VI.

Table 5: Response Rates for VI Data Collection

Method	Participant	Number
In-depth interviews	Program lead	7
	M&E lead	7
	TSO	4
	LG informants	15
FGD	Those administering tools	8 groups; 32 individuals
Record review	VI paper forms	50 per site, total of 248

Process of VI Administration

At each site we clarified the purposes of administering the VI. Four of the five VI sites used the VI tool to target households for enrollment/assess needs (TASO, MRC, RECO Industries, Baylor-Uganda). At Walter Reed, where they had already selected households for enrollment, they used the VI to assess vulnerability levels of current households. At their next enrollment, they plan to use the VI for selecting households for program enrollment. A large part of the VI administration for Baylor- Uganda is to build capacity and support the local government on the VI process which is included as one of their Performance Management Plan indicators.

At the time when data were collected, the VI had been administered at all project locations for RECO Industries PIN project and MRC; the other projects were in varying phases of VI administration. None of the project sites had yet to repeat the VI and were unsure whether and how frequently to repeat its use.

All of the sites except for MRC were using the same VI form that is included in the National M&E plan. MRC uses a revised version of the pilot VI tool. MRC added two questions to collect information on how much was earned per week in the household, and whether the child is currently enrolled in school (ages 6 – 17). They eliminated the following questions: main source of water; existence of caregiver or head of HH with a disability; food diversity for child; and two questions related to psychosocial/care (# sets of clothes, whether or not child is sad/withdrawn). MRC also uses a different scale (lowering the cut off points) to determine vulnerability level.

- Critical = 70-100
- Moderate = 50 – 69
- Slightly = less than 50

Table 6 illustrates the overall VI process in each of the sites. The entry point for determining whether or not to administer the VI differs for each site depending on program activities/targets. At Sites 1 and 2 the VI tool was administered to specific households identified based on lists of registered vulnerable households - compiled during the OVC mapping exercise under the SUNRISE Project. For Sites 3, 4 and 5, lists of households were generated from client lists, which included either commercial sex workers or HIV positive clients. At Site 5, other referrals could be made to participate in the program by clinic staff.

Who administers the VI varies by project site. Only one program was using volunteers (mainly VHTs) to administer the VI. Other programs use counseling staff (n=2), or Local Government (LG) staff (primarily community development officers (CDOs) and health assistants) (n=1) to administer the VI. One program initially hired experienced research assistants to administer the VI. However for subsequent assessments, it relied on its field staff (community mobilisers) to administer the VI. In all sites, those who administer the VI are also responsible for scoring it – with differing processes in place for ensuring data quality.

The VI is scored as it is administered with a subsequent selection process that works differently for each of the sites. At Site 3, selection of beneficiary households is done by a designated selection committee, while at Site 2 - it is done by local government staff involved in administering the VI with input from program staff and key community leaders. At Site 5, completed VI forms are sent to the institution's data processing and statistics unit at headquarters (HQ) in Entebbe for entry into a pre-designed database. The data processing and statistics unit generates list of households, according to level of vulnerability, and forwards the list of households back to the field office. The OVC program staff at field office use the generated lists to enroll households. At Site 1, OVC program staff (i.e. the OVC and gender specialist + M&E officer) sit together to review scores, along with additional information about a child/household and then select participants. Finally, at Site 4 since participants have already been selected, VI scores are used to determine the level of vulnerability of clients.

Table 6: VI Administration Process by Site

Site	Entry Point	VI administration
Site 1	List from OVC mapping	Village Health Teams/community resource personnel
Site 2	List from OVC mapping	Local government staff
Site 3	HIV+ client	Counselors/social support officer
Site 4	HIV+ child	Project community nurse and counselors
Site 5	Clinic clients	Project field officers

At four of five sites, only children who are critically or moderately vulnerable are selected for program enrollment. In case of a vulnerable child in a less vulnerable household, most OVC programs enroll the households for support or refer the household to other organizations for services they are not in position to provide. This assessment did not cross check which children were enrolled.

How feasible is it for volunteers to administer the VI?

As indicated, community volunteers are not the only ones administering the VI. Regardless of who administered the tool, respondents indicated that the people who had administered the VI were the right ones to do it since they know the households and are likely to have good rapport with caregivers and get accurate, unbiased responses. In one location where research assistants were used at the first administration, and field officers at the second administration, a participant had this to say:

> *My only concern relates to data collected in the first assessment, when we used research assistants. I am more comfortable with the results of the second round--because the VI was administered by our field mobilization team. Given the sensitivity of our target group—the FSWs, our mobilisers are likely to have elicited more accurate information. Our mobilisers know these women very well [are familiar with them]. So the women [FSWs] could not lie to them, and were free to open up to them than to some strangers.*

For the OVC program where VHTs administer the VI, one participant had this to say regarding the benefits of using someone who knows the population to administer the VI [project staff],

> *They will tell you how they are facing a lot of challenges but these people work with them and they know these households though they would put in this issue of I know that one etc but if you train them well and explain why we need to have quality data, I think they are very good people because they go and ask about something and these people know that this person knows something so they wouldn't lie a lot than someone coming from other districts.*

However, some also discussed how having VHTs administer the VI could present challenges. The challenges related to using VHTs mainly involved low literacy levels of some VHTs, and VHTs having multiple commitments (i.e. work with many partners etc.)

> *…Like I said the level of education of the CRPs [Community Resource Persons], you need an intensive training that can take like a week emphasizing why the smallest information of the form is needed and to also go through the pre- test with them and with a lot of support then there I know I will be confident that I will get good data because these people know their people and if this is so then they would get the right information.*
>
> *These people the VHTs help different NGOs so as they pass on information for another organization, they administer a tool the time is limited so you can't say they have all the time to do your project work.*
>
> *If you have time limits, they are not the best people unless when you are going to have them commit and pay them for working the whole day.*

With regard to the locations where the CDOs are involved in administering the VI, some challenges were described given the multiple roles/responsibilities of the CDO and their ability to conduct a VI at each household:

They are not appropriate, the CDO is very busy and I do not think the local government staff (that is, the CDOs and probation officers) are best placed to do this job because they do not have time. Secondly they do not know the households so how can they administer the VI… There should be a lower level of personnel [to administer the VI] may be people who do this at parish level because if a sub-county has 6000 household when will these people get time to assess the 6000 households long side their routine work.

At most of the sites (e.g. TASO, MURWP), those who administer felt that they had sufficient time to do it- describing it as "part of their role/job description" and/or the process "is incorporated into the organization work plan". As such it was not a burden to administer the VI. For government staff however, they indicated it takes a lot of time to administer and is challenging to fit into their schedules. On average, participants indicated it takes about 40 minutes to complete the VI.

What are the benefits and challenges of the VI?

VI Benefits

Respondents indicated several benefits of the VI including the tool's comprehensiveness, that it offers a standardized approach, points to specific action, categorizes vulnerability, and due to the pre-selection criteria, can save time.

Many interviewed noted that the tool is comprehensive, indicating that it assesses the household as well as each child in the household as noted by one project leader,

The kind of questions asked in the VI can enable programs to assess the vulnerability of households and the children in that given household.

Additionally, respondents noted that it covers all of the core program areas (CPAs) as described by one of the counselors who administers the VI.

To me the tool is quite comprehensive. It looks at all the core programme areas in the NSPPI-2 [National Strategic Programme Plan of Interventions for OVC]. It looks at the different aspects of the household: sanitation, education, child protection and legal rights and so on. That is why I say it is a good tool. It is comprehensive tool, because it covers everything.

Participants also noted that it provides a standardized approach for assessing a household and child's vulnerability and having such a standardized approach can help reduce bias in selection for program enrollment. A district probation officer described this in the following way,

It [the VI] even protects you from somebody thinking you have just decided to favor some people. It provides an objective way to assess and identify the most vulnerable. Because, at the end of the day, it [VI] brings out clearly [the basis] why you are selecting one child and not the other…how you arrived at that decision.

Such a standardized approach also helps enable programs to compare vulnerability across program sites as indicated by an M&E officer,

> *Using the VI also gives a standard approach to assessing vulnerability so we can compare findings across different settings.*

The VI is perceived by some as a useful way to determine what action to take for a specific child or household based on overall vulnerability or scores in specific core program areas. A project officer and government official described their perceptions,

> *The categorization is also another good thing we are able to identify the critically vulnerable who need immediate attention and what services they urgently need.*

> *The strength, of the VI is that it was actually giving us the level of vulnerability of the household. We could know that this household is critically vulnerable, or slightly vulnerable. It was giving us the right picture of the household.*

With respect to how the VI helps determine how to help an individual child in a core program area, a program officer described this in more detail,

> *It is a useful tool. It has some relevant questions, which can inform us about what the needs of children are. And I think I mentioned this. It also gives us an idea of what kind of support or interventions are need for vulnerable households/children, across different domain- for example, what the child right protection needs are? Are they eating well? Are they going to school?*

Several aspects of the tool are seen to save time overall – for example, a counselor explained how the pre-selection criteria saves time and helps avoid bias,

> *I like the pre-selection criteria questions on the first page. They help in the pre-selection of households where the VI tool will be administered. They are about four. If you have not selected any yes, then you know the household is not eligible. It means you have to move to another household. For me this makes my life [work] very easy and it avoids bias.*

VI Challenges

In this section, we present some of challenges described regarding VI administration. Challenges with respect to data quality will be reported in another section of the report.

Few challenges with actual administration of the tool were raised though the primary challenge presented related to the length of the tool. The length of time to administer the tool is particularly an issue when administered to many children. A government official who administers the VI, as well as an information management officer described such challenges,

> *It takes a lot of time. Looking at all these pages…they are six… someone might start thinking: how will I manage to complete all this and yet I have other things to do somewhere else.*

> *The routine users complain and say that it is quite long therefore you take long to interview one respondent because it has many sections and if someone has seven children you have to get information for all the seven children.*

A few participants also described how the VI can be resource intensive and may prohibit administering the VI information for all households. A local government respondent noted,

> *The time in terms of length, its long therefore administering it even to one household it takes hours then secondly the cost involved if you are to do every parish for example if you are to do 50 households in a parish that would be an enormous amount of money the cost involved in terms of money is enormous so and for us as local government unless we get support we don't have local resource to carry out such a survey.*

Another challenge mentioned was that the tool did not capture information on the caregiver and/or household location (e.g. sub-county, village etc) which presents challenges for aligning information with the local government service register at sub county level, and makes it hard to know which community has more vulnerable households for effective programming. A government participant also explained this scenario,

> *Yes, on the side of filling the VI tool as I had said earlier on, the tool did not cater for the care giver. So it was more challenging to see how can put in the name of the care giver, the age because the age was already in the service register, because we had to write the age of the care taker, yet the VI booklet did not provide for that. So you could first scratch your head, think about what you are going to do. So that is somehow challenging.*

Another participant also explained:

> *Then this tool does not capture information on the location of the household. Capturing this information, for example the village, parish, or sub-county, where a household is located is important for programming purpose. For example, it can help with identification of which are areas are more vulnerable.*

A staff member further described how insufficient household detail could prevent being able to repeat the VI at the same household at a later date,

> *We had data cleaning back and forth asking different CRPs about that specific household because I remember the tool didn't have a care giver so we were wondering how we would connect this household to this particular kid and in our communities' people refer to the name of the household by the name of the care giver so we thought having a care giver on the form was very important and also attach the kid to the care giver in case we wanted to know and follow up.*

Lastly, a few participants mentioned that their program may not address all of the core program areas even though they are assessing against all of those,

> *We have to choose a CPA or at least 3 areas we want to support. And we can't support anything else. So even if this VI tool gives us a variety of areas where we can support the children, we can't promise to support them in everything.*

Who analyzes the data and how well prepared are they to provide information for decision making?

Table 7 summarizes the data management process as it relates to the VI. This information helps illustrate how the VI scoring is done and how the decision making process works using the VI scores. At all sites, the individuals who administer the VI are also responsible for scoring the VI. When they complete the VI administration, the forms are completed and reviewed by designated individuals or teams, typically a staff member or in the case of government the CDO.

Two of the project sites use a database to assist analysis of the VI scores and subsequent determination for selection. At another site data are entered at a second location where a statistician is located and a list of selected households based on their analyses is sent back to project staff. At another site, project staff reviews scores, along with other information, to determine which households are selected for enrollment. Two sites use the paper forms to assist with the selection process; whereby, scores are reviewed and then a determination is made for enrollment. At another site, the households had already been selected prior to VI administration and scores are reviewed by project staff to determine levels of vulnerability of existing clients.

Table 7: Data Management Process

	VI Scoring	Review of files for accuracy, completion	Database	Selection Process
Site 1	Person who administers	Field officers and Kampala staff	Yes	OVC staff based on scores and other supporting information
Site 2	Person who administers	CDO	No	Selection Committee (LG officials)
Site 3	Same	Social Support Officer	No	Selection Committee
Site 4	Same	Community nurse, OVC coordinator	No	Not applicable
Site 5	Same	Project coordinator	Yes	Lists generated by data processing and statistics unit

We also asked respondents about training and training materials/guidance available. The training varied by each of the project sites with two receiving formal training from the Ministry of Gender, Labour and Social Development. One of those sites was a pilot site for the VI. At the other site that had training, the training did not cascade down to all of those involved in the data collection,

> *There is a challenge with VHT, because sometimes, we go with them, and yet some were trained and are not conversant with the tool that compromises the quality of the data. So these people need training. There is also another challenge; the district recruited the sub county community workers and assistant community workers and they are not trained. You may find that in sub county x, they posted there a CDO who is not conversant with this information. So lack of training is a challenge and it is compromising the quality of the data.*

The three other sites had someone (e.g., a staff member) who had been exposed through their involvement with its development and then oriented their staff or volunteers to the tool. One of those sites had a more structured training approach (i.e., 2 days) where they pre-tested materials in the field.

Overall, none of the sites described formal training manuals or data collection/scoring manuals/guidelines available. Regardless, most of the respondents who administer the VI felt confident or comfortable in administering the VI, either because they were trained on how to use the VI, and/or

received supportive supervision during the process of administering the VI. However, one person described they were confident in administering the tool, but had challenges with some of the questions,

> *Confident, because we had training for it and we went through everything. We were fully confident by what we were doing maybe the challenge was on the content some of the questions were not reflecting the exact picture.*

Another participant described what happens in the field and how support could be needed,

> *These people do not have quick reference documents and you know you can get stuck with something whilst in the field so that is another problem.*

How well does the vulnerability index (VI) assess household vulnerability?

Many respondents expressed concerns during interviews and FGDs that the tool may not be picking up the most vulnerable and that during the process administering the tool, they perceived that specific children should have been more vulnerable than the score received. Examples were given where there were child headed households, widows, families with several members HIV+, and others that did not put the child in a critically vulnerable category. There were numerous examples of this and here are just a few quotes to illustrate the point:

> *But the tool does not reflect the vulnerability of some households. For example, we have widow-headed household. The widow is looking after 12 children, and two of those are HIV positive. The widow is also HIV positive. But when we administered the VI, the scores indicated that the children are moderately vulnerable.*

> *The grand weakness is when you come to grand total score (which combines the household score and the individual child score). I have administered to VI to child headed families…but children in these [households] did not score 90+; which is the threshold for a child to be considered critically vulnerable.*

> *So with this VI book [booklet with the VI forms], we were not able to capture all households that were critically vulnerable. Some questions do not adequately assess specific core program areas. .. you could find a household that is not vulnerable, but the household might have a child who is HIV positive or a child who is disabled in such a case the child has to be enrolled on the program because they are vulnerable and they need care.*

> *This is a mother who has a child of 1 year of course the marks are not there for a child who is one year old so by the time you total up the marks of the child, you find that the marks are actually very low so you find that the mother is going to be thrown out to be less vulnerable. That is what the tool indicates.*

As mentioned in the methods section, we reviewed a random selection of VI forms from each site. For each of those forms we randomly selected one index child and transcribed the scores, as well as the level of vulnerability based on the total score. Table 8 illustrates the proportion of the index child selected at each site that was rated as slightly, moderately, and critically vulnerable. In three sites, no children were critically vulnerable – one of those sites had already selected its program enrollees before the VI administration and thus deemed vulnerable enough for program inclusion. In the other two sites, 2% and 14% of all children were critically vulnerable. Interestingly, at Site 1, 95% and at Site 4, 68% of children were slightly vulnerable.

Table 8: Proportion of Children Scored as Slightly, Moderately, or Critically Vulnerable.

	Slightly	Moderately	Critically
Site 1 (n=40)*	95%	5%	0%
Site 2 (n=50)	44%	56%	0%
Site 3 (n=50)	2%	96%	2%
Site 4 (n=50)	68%	32%	0%
Site 5 (n=48)	19%	67%	14%

*For 10 forms, the total vulnerability score could not be calculated because of missing values

For the total number of slightly and moderately vulnerable households (n=104 and 126 respectively), we identified select household indicators that were thought to present a critical scenario. These indicators included:

- Whether there was an adverse event that led to an economic loss in the last year;
- If over the past month, anyone in the household had gone without food for a whole day because there wasn't enough;
- Has a household head or caregiver with any form of disability that's severe enough to affect their daily activities
- In the last year has a caregiver felt so troubled that they needed to consult help; and
- In the past 12 months, has any adult used a form of discipline (punched, withheld meal, abusive language)

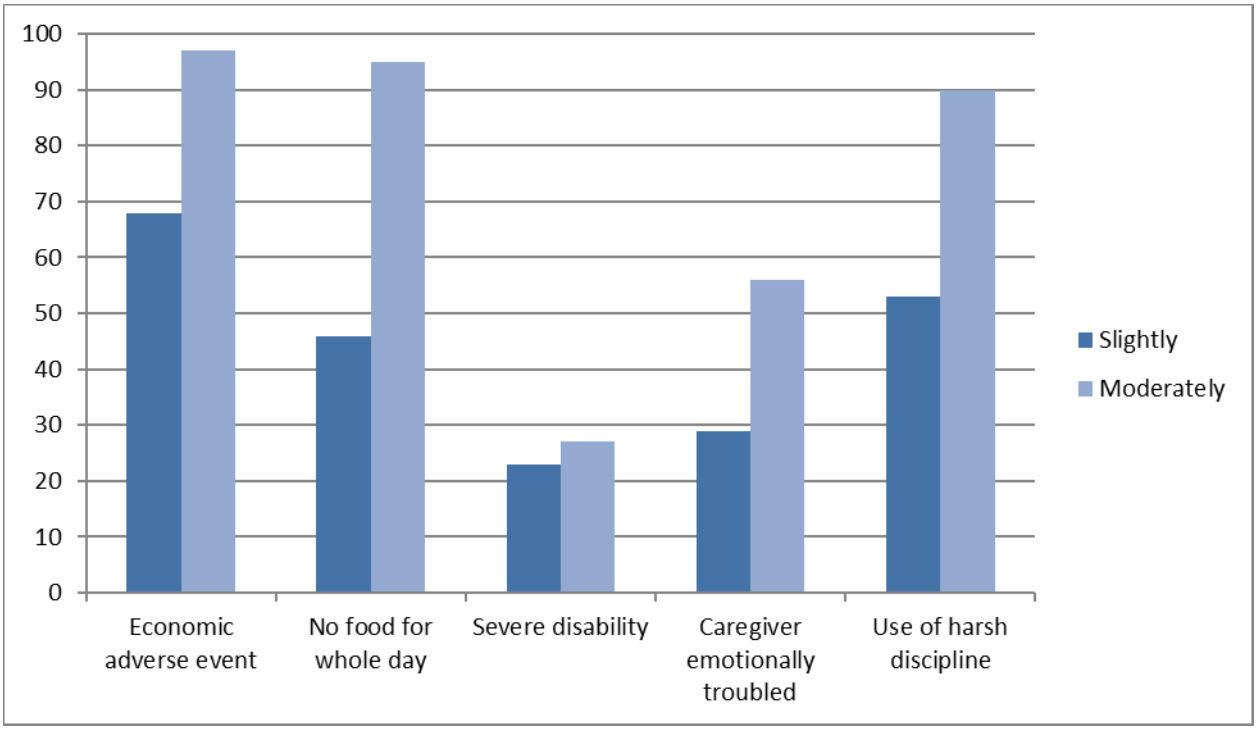
Figure 1 presents the percentage of slightly and moderately vulnerable households with these household indicators[7]. Of all slightly vulnerable children, 70% were in a household with an economic adverse event, 45% had someone go a whole day without food, over 20% had a caregiver/head of

[7] Note, for "severe disability", this does not include MRC as their instrument does not ask this question.

household with severe disability, nearly 30% with a caregiver emotionally troubled most of the time, and over 50% using a form of harsh discipline in the household.

Of all moderately vulnerable children, 95% were in a household with an economic adverse event and had someone go a whole day without food, nearly 30% had a caregiver/head of household with severe disability, about 55% had a caregiver emotionally troubled most of the time and 90% were using a form of harsh discipline in the household.

Figure 1: Percentage of Slightly and Moderately Vulnerable HHs with Severe HH Indicators



For the total number of slightly and moderately vulnerable households (n=104 and 126 respectively), we identified select individual child indicators that were thought to present a critical scenario. These indicators included:

- The number of meals the child had in the last 24 hours (“none” or “one meal”);
- Food diversity;
- The child has been very sick for at least three months during the past 12 months;
- School attendance (not in school, misses three times a week or twice a week);
- How often the child feels sad, worried, withdrawn or hopeless (“often”);
- Has child witnessed abuse (“most of the time” – 4); and
- Has the child experienced any form of abuse in the last 30 days

Figure 2 presents the percentage of slightly and moderately vulnerable households with these indicators[8]. Of all slightly vulnerable children, approximately 20% had eaten either not at all or only one meal in the last 24 hours, about 60% were eating a very limited diet, about 30% were sick for a three month period in the last 12 months, nearly 40% miss school at least twice a week or are not in school, 20% feel depressed often, about 5% witnessed abuse, and over 50% experienced some sort of violence.

Of all moderately vulnerable children, approximately 40% had eaten either not at all or only one meal in the last 24 hours, about 90% were eating a very limited diet, about 70% were sick for a three month period in the last 12 months, nearly 90% miss school at least twice a week or are not in school, 40% feel depressed often, about 35% witnessed abuse, and 80% experienced some sort of violence

Figure 2: Percentage of Slightly and Moderately Vulnerable HHs with Severe HH Indicators

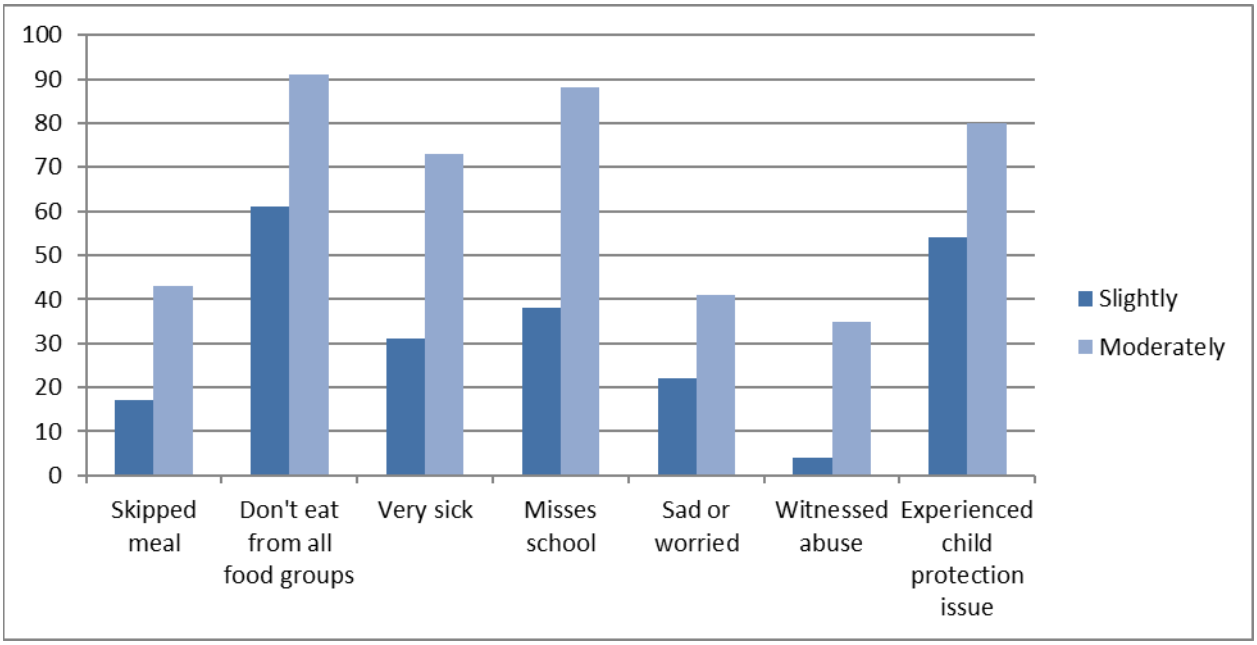
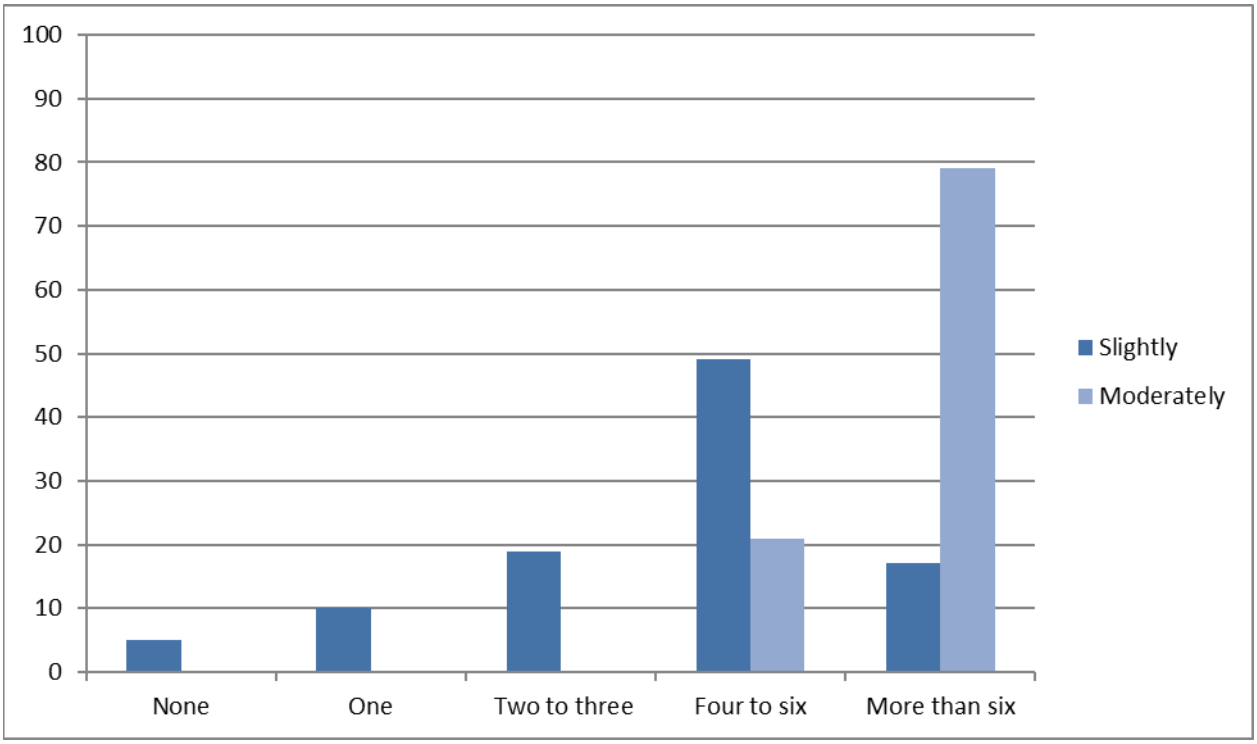


Figure 3 presents the percentage of slightly and moderately vulnerable households with the range of household and individual child indicators. Approximately 5% of slightly vulnerable households had none of the indicators presented, 10% had one of the indicators, about 20% had 2 or 3 of the indicators, about 50% had 4 or 6 indicators, and about 18% had more than six indicators.

Among children classified as moderately vulnerable, 79% of children (N=99), had more than six severe indicators.

[8] Note: for food diversity and sad or worried, this does not include MRC as their instrument does not ask this question.

Figure 3: Percentage of Slightly and Moderately Vulnerable HHs with Severe HH Indicators



What is the quality of the data generated from the VI?

Data quality includes five main elements: validity, reliability, timeliness, precision, and integrity. Respondents noted several issues that relate to data quality – in particularly the validity and reliability aspects.

The psychometric aspects of validity were presented in the previous section regarding how well the VI assesses vulnerability. There were some additional sub-themes related to validity that respondents discussed – particularly with the tool's ability to measure what it is intended to measure either for overall vulnerability or for individual indicators.

While not raised at all sites, it was noted that the VI is in English and has not be translated into local languages and thus affect data quality (both validity and reliability). While many of the individuals who currently administer the tool speak English, the beneficiary households often may not. Since the VI involves interviewing both caregivers and children, this then means that the person administering the VI would need to translate or interpret the VI while administering the tool. One participant described how this could be a challenge,

> *I will give an example of this region we have the Banyoro we have the Batoro we have the Bakonjos we have the Kakwas. Some of these at the households they don't speak English. Now if am not speaking if am not a born of that place and I can't speak Lukonjo I can't speak Runyoro I*

can't speak Rutoro it becomes a challenge . so the people who are administer this tool must be well conversant with the tool and the local language to help the community really see what and understand it that it is a tool to do this and let's see what it will lead to it will lead to referral it will lead to leakage it will lead to this.

It was also noted that each CPA area under the household and individual child sections have a different number of questions and thus potentially giving more weight to some of the CPA areas then others. For example in the household section, there are four questions under CPA1 (Economic Strengthening); two questions under CPA2 (Food Security and Nutrition), six questions under CPA3 (Health, Water, Sanitation, and Shelter), one question under CPA5 (Psychosocial Support and Basic Care), and two questions under CPA6 (Child Protection and Legal Support). Since the total vulnerability score is based on the overall sum, questions related to health, water, sanitation, and shelter would contribute more points to the overall score than Psychosocial which has just one question.

Another sub-theme relating to validity involves the extent to which question responses reflect the indicator, particularly in the household vulnerability section. The examples given were that the main income earner and main source of household income responses and corresponding scores may not present an accurate reflection of vulnerability. For example, a father may be the main household income earner but make very little and would receive a low score of "0". Respondents also noted they were not sure how to score a commercial sex worker. Another question that was identified as potentially not reflecting the actual vulnerability was whether or not the household has access to land. Participants indicated that access to land does not mean you can farm the land. Another example was given related to scoring of the household structure,

There is also this question the main type of dwelling. You find that most of our women are sleeping under mud but with iron sheets but here this tool is categorizing that woman as staying in a semi-permanent structure but when you go down there you would see that this woman is really vulnerable by the nature of the house she is staying in. When it comes to scoring this woman will score 1 yet from your own observation, you will give this woman 4.

Respondents indicated a few other challenges that could lead to data quality issues. For example, some of the questions may not be applicable to younger children (e.g., education, ever into marriage, sexually active, drunk alcohol) but the scoring rubric does not change so the total score would be much lower for a young child even if he/she were in a critical situation. A participant explained the scenario as follows,

Another thing still on scores for example, for a mother who is vulnerable on her section the scores might come up when they are high. This is a mother who has a child of 1 year of course the marks are not there for a child who is one year old so by the time you total up the marks of the child, you find that the marks are actually very low so you find that the mother is going to be thrown out to be less vulnerable. That is what the tool indicates.

Related to this, some participants expressed concern about the scoring rubric and that for some of the individual questions, the response is a "yes" or "no" with a score of 0 or 4; whereas for other questions, the responses have more variation with a 0, 1, 2, 3, or 4. One respondent gave an example of how

he/she thought the scoring might not be appropriate,

> *If you look at education a child who is not enrolled in school or dropped out of school scores the same as a child misses school 3 or more times per week. Is that logical?*

With regard to the form itself, several respondents noted there is no room on the form to cater for households with more than six children.

Finally, there was some indication that there were issues with scoring related to the three composite questions that involve checking a few boxes and then based on those checks, assigning a score (i.e., CPA615 in household section; CPA2Q2 and CPA6Q14 in the child section). As one participant noted,

> *The scoring is also a big challenge, people do not know what to do [with] those questions which involved giving a score when a given number of items is selected…[they are] very tricky and they can mess up the whole thing.*

To determine the extent to which this was a problem, we calculated the proportion of overall responses that were scored correctly for each of those composite questions (Figure 4). At Site 1, the scoring on these items was overall fairly good. This was a site where they had indicated the need for extensive data cleaning after the VI was administered. At Site 2, just 40% of these questions were scored correctly. Site 3, the score for CPA6Q15 (use of any type of harsh punishment) was less than 20% and Site 4, CPA2Q2 (food diversity), less than 40% were scored correctly. Site 5 was excluded as a different instrument was used that did not have these same questions across the CPA6 and CPA2.

Figure 4: Proportion of Composite Questions Scored Correctly.

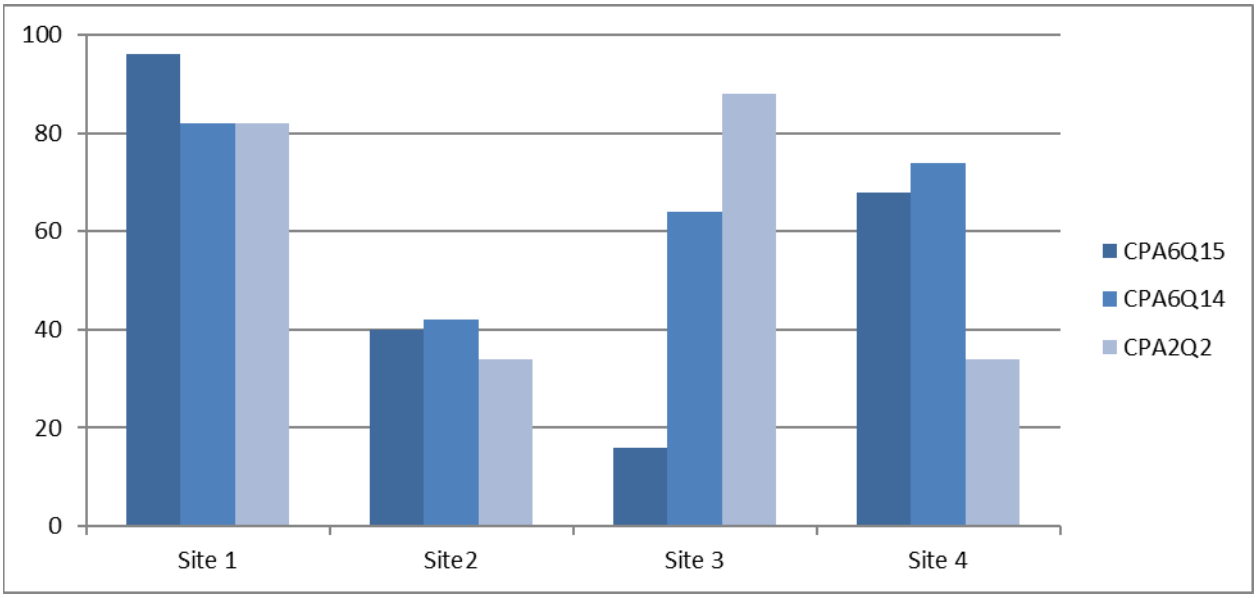


Figure 5 depicts the percent of household and individual child score totals that were correct based on the study teams' re-calculation of individual scores. The percent of correct scores ranged from about 50% to 85%.

Figure 5: Proportion of Household and Individual Child Totals Scored Correctly by Site

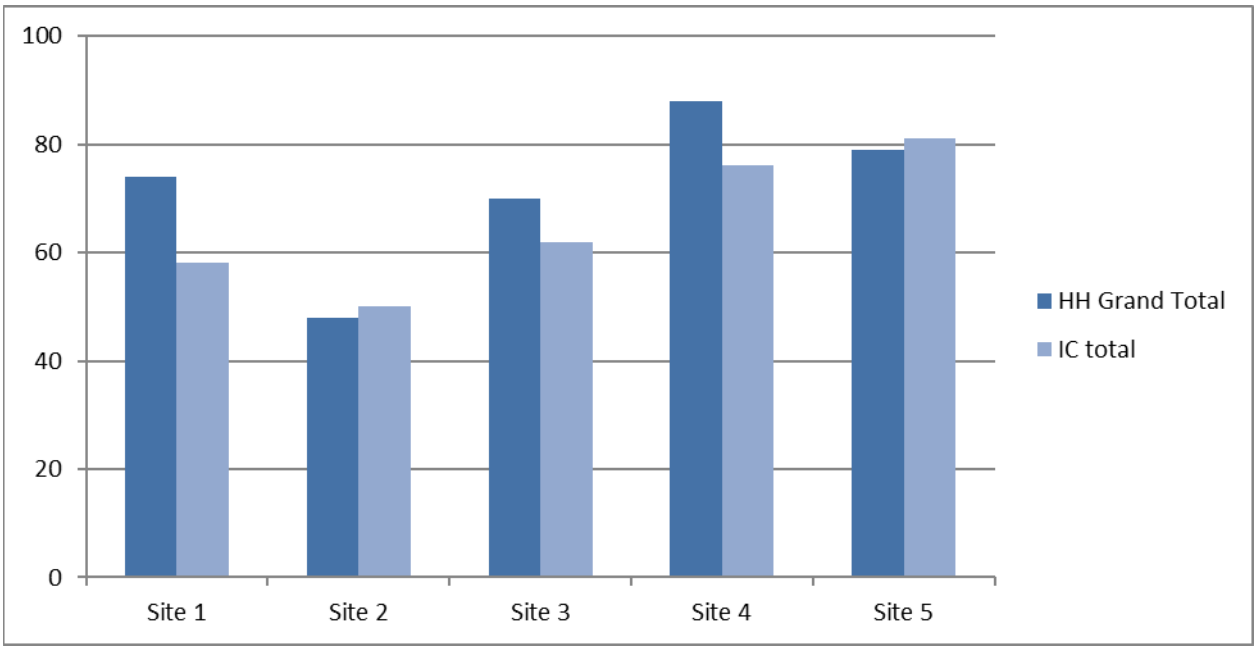


Table 9 presents the difference in transcribed vs. re-calculated scores. In general, as scores were re-calculated, scores lowered and level of vulnerability shifted from critically to moderately and from moderately to slightly vulnerable.

Table 9: Proportion of Slightly, Moderately, and Critically Vulnerable Children for Transcribed and Re-Calculated Scores by Site.

	Slightly		Moderately		Critically	
	T	R	T	R	T	R
Site 1	95%	100%	5%	0%	0%	0%
Site 2	44%	47%	56%	53%	0%	0%
Site 3	2%	18%	96%	82%	2%	0%
Site 4	68%	66%	32%	34%	0%	0%
Site 5	19%	22%	67%	65%	14%	13%

* T represents transcribed, R represents re-calculated scores.

Validity – given the qualitative findings and the analysis based on the VI record review, there is concern that the VI is not able to detect critically vulnerable households. Some respondents noted some caregivers and children may not give correct or accurate responses (e.g., questions related to sexual

experience, and child protection) or change their response if they think they will get support (though that would indicate you would have more in the critically vulnerable category which was not the case).

> *Children and caregivers do not usually tell the truth. When you ask about child abuse… the child cannot accept that she/he was punished. They tend to deny.*

> *… there is a concern that some people do not give honest responses, especially when it comes to child protection questions. Imagine asking a parent of a 12 year old, if their child has experienced any form of child abuse in the last thirty days. What do you expect the parent to say? The parent will not tell you the truth. Then there are questions on food: how many times have you missed food? They might think you are bringing them food and might not give you an honest answer.*

Regarding reliability of data, the VI has yet to be re-administered to the same set of households, so we were unable to fully assess reliability. Given the concern previously mentioned that fields such as the caregiver name or household ID/location are not included, it could be challenging to find the same household and conduct a repeat VI assessment. Also, as noted in the earlier section on preparedness of individuals to use and score the VI, there is an absence of training manuals and guidelines in place.

With respect to timeliness of data, the VI is not currently used for routine reporting and not administered within a set timeframe (e.g., had to be completed by the end of a quarter). As such, we were not able to assess timeliness in the conventional sense (i.e., were data submitted or entered on a specific date). However we assessed the extent to which the VI scores/analysis were available for decision making in a timely way. In all cases, the data were available to inform decisions with regard to selection of participants and that the data used were the most recently reported. The amount of time it took to have the scores available for decision making varied depending on the selection process. Three sites indicated that the selection process took a long time from when the household visits were conducted and in those cases, the ones who scored the VI were not directly involved in selecting households.

We were unable to assess precision of data given there were no anticipated changes for the overall vulnerability scores or select indicators within the VI (i.e., decrease those in the critically vulnerable category by x%) and we did not measure this instrument's ability to detect vulnerability over other tools/instruments.

Finally, regarding the integrity of data, the process of data management and storage differs at each location. Where there are databases and project staff directly involved, checks are in place and there is independence between data collection and management. In most instances, the files were stored in a locked office and not accessible for changes. Overall, guidelines for selection of households are not in place so there is a chance that committees or staff could still make decisions to include a child regardless of scores. Given how few children have fallen into the critically vulnerable category, this type of decision making is already happening.

What tools or processes are non-VI sites using? How do those processes differ from the VI?

Those interviewed from the comparison sites indicated other vulnerability tools used besides the VI such as the Child Status Index (CSI), Poverty Assessment Tool (PAT), Census Data Form, Vulnerability Assessment Tool (VAT), and Needs Assessment Tool (NAT). The CSI[9] is a government tool, accompanied by training materials and guidance documents. It is widely used by government staff and is seen as a useful tool because it covers most of the CPAs and is a short and easy to use tool. In fact, one TSO described his/her opinion on the creation of new tools,

> *We have the CSI and it is not very different from the VI, a lot has been invested into developing guidelines and manuals for users alongside training for users. So one wonders why we have to reinvent wheels when a lot has already been invested.*

The PAT is another tool used and captures information to identify vulnerability. According to one informant the PAT helps identify the following indicators of vulnerability,

> *If the household is child headed, cannot produce enough food, living in temporary house, there is no income earner, and children of school-age do not go to school.*

A member of the selection committee where the PAT is used indicated that they make decisions for program enrollment based on the number of children in a household, income level, and the extent to which the household is receiving other external support. One interviewee noted that the PAT does not allow for assessing needs in all the core program areas, but after selection they identify needs through baseline surveys and regular counselor visits.

In another comparison site, the VAT was used. The VAT is similar to the VI in that it is organized by objective areas reflective of CPAs but it does not cover all CPAs. It uses a scoring rubric that places households into slightly, moderately, or vulnerable categories and is administered to one index child per household. While the overall score determines level of vulnerability and program enrollment, if a household scores high in one objective area and less in another, those households can still receive support for interventions in that objective area.

In the location visited, the VAT was administered to households already identified as vulnerable through the community mapping exercise. A representative described the process for how the VAT is administered from the mapping list and provides perspective on how the VAT helped to identify additional households not already on the list,

> *So when this project started, we went to the district and talked to district community development officers (DCDO). He gave us the list of registered vulnerable households in the sub-*

[9] O'Donnell K, Nyangara F, Murphy R, Nyberg B. *Child Status Index Manual. A Tool for Monitoring theWell-being of Children Orphaned or Otherwise Made Vulnerable as a Result of HIV/AIDS*. Chapel Hill, NC: MEASURE Evaluation, 2008.

counties where we wanted to implement our program. We however [thought] the list of district vulnerable households was not exhaustive. It did not provide a complete list of all vulnerable households in the project areas. We discussed with the DCDO ways we could identify and enroll more vulnerable households into our program. We were given a go ahead to include more vulnerable households into our OVC program…so we went ahead and administered the VAT to assess the vulnerability of those households identified through the district register and the ones identified by us with support from the CDOs. ..when we administered the VAT, we found out that some of the households that had been included in the district vulnerable household register were not actually vulnerable. Yes some vulnerable households were excluded. So our assessment was more objective.

The VAT is repeated on an annual basis but is used in conjunction with other tools such as the Needs Assessment Tool (NAT) to monitor progress of selected households over time. People administering the VAT have been trained and there is a VAT guide that accompanies the tool as well as a process for checking data quality[10]. According to one person interviewed,

We have not had many problems with the accuracy of the scores or completeness of the VAT

The main challenge identified regarding VAT administration was similar to one of the VI challenges – difficulty in obtaining accurate household responses about income earned and child protection issues.

In all three sites, the extent to which individuals were aware of the VI varied – with some participating in the tool development to others such as CDOs never hearing of the tool.

Discussion

Globally, governments and programs are working to develop OVC M&E tools that can be used for multiple purposes. In Uganda, under the leadership of the Ministry of Gender, Labour, and Social Development, the VI represents such a tool that aims to be used to target children/households for intervention, monitor status over time, and be used to graduate children from a program. The VI was developed with multiple stakeholders and findings suggest that the tool fills a gap in terms of providing a comprehensive, standardized assessment tool.

Overall, IPs are using the tool to target households for enrollment, but it remains unclear how they will use the tool moving forward (i.e., for re-assessment of similar households). The lack of consensus on future use of the tool may be due to the fact that the tool was recently rolled out and is not used by all partners in country. It is important to note that the way the tool is currently structured (it does not provide a space to track caregiver or household identification) may present challenges for re-administering the tool to the same households. The design of the form should ideally be able to serve the intended purpose of the tool.

[10] We did not verify the quality of the VAT or its training/resource materials.

Findings revealed that each IP was training, scoring, administering, and selecting children/households in slightly different ways. This may be in part due to the differing nature of each of the projects and where the entry point for VI administration occurs. However, the variation may also be due to the absence of standardized training manuals, and guidelines for using and scoring the tool, as well as selecting households for enrolment.

Perhaps one of the most important findings was that so few children fell into the "critically vulnerable" category and that the individuals administering the VI perceived the VI score did not reflect the actual vulnerability of a child/household – this is despite the fact that some participants think caregivers may give false information to make their situation seem worse and then be enrolled in services. While some may suggest that lowering the score required for critically vulnerable may address this issue, analysis from the document review shows it may involve more than just adjusting the scoring. For example, a child who was "slightly vulnerable" might not have not eaten for a whole day, missed school or not been in school, been very sick in the last three months, have a caregiver disabled and depressed, and may also be depressed him/herself.

As mentioned by one participant, the tool's ability to capture critically vulnerable may be limited due to the fact that there are a different number of questions per CPA area, inadvertently weighting the findings. For example, under the household section there are 5 different CPA areas asked about – each CPA area has a different number of questions and thus different number of total possible points. Table 10 illustrates the total number of possible points for the household level – with the maximum or highest risk score being a 4. The VI sums scores across all CPA areas and based on pre-determined cut off scores, determines whether there is a critically or moderately vulnerable child. This means that CPA5 [psychosocial] is worth 6% of the household vulnerability score (4/60), compared to CPA1 [economic strengthening] which is 27% of the total (16/60). Thus, more emphasis in the overall score is on CPA1 than CPA5 and someone who could be very critical in CPA5 may not get listed as critically or moderately vulnerable.

Table 10: Total Possible Points for CPA Areas, Household and Individual Child (IC).

CPA Area *scores between 0 to 4*	Total Possible Points for HH	Total Possible Points for IC
CPA1 – Economic Strengthening	16	n/a
CPA2 – Food Security	8	8
CPA3 – Health	24	12
CPA4 – Education	n/a	4
CPA5 – Psychosocial	4	12
CPA6 – Child Protection	8	12
Total Possible Points	60	48

The issues with scoring may also result from the scoring process. For example, some questions may not be applicable to child under 2 and thus result in many 0s. Since the VI is summed, such 0s would result in a lower score. The same issue could happen if a question was skipped for any reason.

The VI assess across all of the six CPA areas, though not all programs may address the six CPA areas. If enrolment is based on the total VI score, the reason for vulnerability may not be something that the program can change. For example, if the scores for a household/child related to health were low, but there were no program activities to address health, it is unclear how the program would help a child in that situation.

While some participants talked about the value of the CSI, it should be noted that the CSI is not recommended for use as tool to identify children/households for program enrolment given it is a high inference tool based on local norms and it takes one or two times of using it for care workers to obtain reliable scores (citation….). Further, it is not recommended to aggregate scores across CSI factors for a given child, as a child could be faring well in most CPAs and have a high overall score, yet have an extremely low score in another CPA and be left out of enrolment or graduated prematurely based on the overall CSI score.

Though we only had a limited number of comparison examples, it is important to acknowledge the other tools used to assess vulnerability. The SCORE program has also recently conducted a comparison of 500 index children using the VI, VAT, and CSI to understand the differences in how each instrument scores those children (citations). The report from that assessment also points to what the starting point might be for these and future versions of these tools – for example, is it best to start with the household lists

from community mapping, replace community mapping, or as others have pointed out use the three factor criteria first[11].

Recommendations

In light of the findings, we recommend the following:

- Re-examine the VI tool. Given the concerns related to validity, it is worth re-visiting the tool to address the following issues:
    - The consultant who initially developed the tool had identified a reduced list of indicators that may be more likely to predict vulnerability. It may be worth re-visiting these indicators to identify the most important and those most predictive of vulnerability.
    - The scale used to rank vulnerability: Some of the individual items in the instrument have different ways to score responses, which may result in unintentional weighting of some of the questions.
    - Identify what impact "not applicable" or skipped responses may have on the overall vulnerability score. Identify questions that may not be applicable for some respondents and provide guidance on the scoring in those cases.
- Clarify purpose of tool. For each situation where the tool is used, determine its best/most appropriate use, whether used for targeting for enrollment, needs assessment, monitoring, or graduation. These uses should then be described in subsequent guidance documents.
- Develop guidance materials to accompany the tool. These could include, for example, training materials and guidance on data collection, scoring, use of information for selection, and assessing needs (based on purposes determined above).
- Exercise caution in basing program enrollment solely off total scores, particularly if programs are not covering all CPA areas.

[11] Republic of Uganda. Ministry of Gender, Labour, and Social Development. Guidelines for Operationalising the Three Factor Criteria for OVC Identification, Vulnerability Index (VI) Tool, and Child Status Index (CSI) Tool. November 2013.

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Appendix A – Vulnerability Index Tool

Uganda OVC Vulnerability Index Tool

The Uganda OVC Vulnerability Index (VI) is intended for the selection of vulnerable households into OVC programs. The tool helps to determine a household's level of vulnerability (slight, moderate, and critical) based on individual and household level questions you will ask across all core program areas.

PRE-SELECTION CRITERIA

INSTRUCTIONS: Please use the following indicators to pre-select households where the VI tool will be administered. Pre-selection of vulnerable households requires the participation of community members and community workers. This ensures that the selection process is conducted in an efficient and transparent manner if critically and moderately vulnerable are to be identified**.**

HOUSEHOLD HEALTH STATUS			
		Yes	No
1.	Does the household have ANY adult member who has been very sick for at least three months during the past 12 months? *(By very sick, I mean that the household head or any adult member was too sick to work or do normal activities around the house for at least three of the past 12 months)*		
2.	Does the household have ANY severely disabled person? *(Applies to both children and adult household members)*		
CHILD EDUCATION STATUS			
		Yes	No
3.	Does the household have children not currently enrolled in school? (*Children between the ages of 6-17*)		
HOUSEHOLD ORPHANHOOD STATUS			
		Yes	No
4.	Does the household have or care for any orphans?		

DECISION: If you selected **"Yes"** for **at least ONE** of the pre-selection criteria questions above, please proceed to administer the remainder of the tool at this household.

HOUSEHOLD INFORMATION

INSTRUCTIONS: Please administer this section to heads of households, spouses, or to OVC in case of child-headed households. Ask each question and circle the appropriate response option. After circling the response, please write in the corresponding score to in the far right-hand column (labeled "SCORE").

At the end of each CPA, please add up the scores for all questions and write them down under the "CPA TOTAL" row. Finally, add up all CPA scores, and enter them under "HOUSEHOLD TOTAL SCORE".

CPA 1: ECONOMIC STRENGTHENING										
										SCORE
1.	Who is the MAIN household income earner?									
Option	Children (6 – 17 years)		Grand or Elderly Parents		Relatives		Mother		Father	
Score	4		3		2		1		0	
2.	What is the MAIN SOURCE of household income? (emphasis is main source only)									
Option	None	Remittances	Casual Labourer	Informal Employment	Peasantry/hiring out labour on other farms / gardens	Petty Business	Formal Business	Commercial Farming	Formal Employment / Wage	
Score	4	3	2	2	2	1	0	0	0	
3.	Does this household have access to land?									
Option	Does not own, not able to access land		Does not own, but able to access land		Owns but not able to access land		Owns and able to access land			
Score	4		2		1		0			
4.	In the last 12 months (MENTION THE MONTH), did the household experience any adverse event that led to an economic loss? (e.g. job loss, death in household, migration, loss of property, etc.)									
Option	Yes				No					
Score	4				0					
								CPA 1 TOTAL →		
CPA 2: FOOD SECURITY AND NUTRITION										
										SCORE
5.	Over the past month (MENTION THE MONTH), what has been the MAIN source of food consumed by your household?									
Option	Donated		Given in return for work		Bought from the market		Home grown			
Score	4		2		1		0			
6.	Over the past month, did anyone in the household ever go without food for a whole day because there wasn't enough?									
Option	Yes, more than 5 times a month		Yes, 1 – 4 times a month		Never					
Score	4		1		0					
								CPA 2 TOTAL →		
CPA 3: HEALTH, WATER, SANITATION AND SHELTER										
										SCORE
7.	What is the distance (in Km) to the health care facility your household often uses?									
Option	More than 5 Km or miles		2 – 5 km or 1 – 2 miles		Less than 2 km or 1 mile					
Score	4		1		0					

				SCORE
8.	Does the household head or caregiver have any form of disability that's severe enough to affect their daily activities? (e.g., physical, speech, visual, hearing, or mental handicap?)			
Option	Yes		No	
Score	4		0	
9.	What is the main source of water for members of your household?			
Option	River, Stream, Lake, Pond, Unprotected well / spring	Public taps, Bore hole, Rainwater, Protected spring/well, Gravity flow scheme	Private Connection	
Score	4	1	0	
10.	How long does it take to collect water for domestic use from the main source? (Time in minutes) Consider time TO & FROM the source of water, INCLUDING waiting time.			
Option	More than 30 minutes	16 – 30 minutes	15 minutes or less	
Score	4	1	0	
11.	What is the MAIN type of dwelling?			
Option	Temporary (mud, grass and wattle)	Semi-permanent (mud, iron sheet)	Permanent (Sand brick cement)	
Score	4	1	0	
12.	What is the type of a latrine/toilet facility used by members of your household?			
Option	Bush	Pit Latrine / Public toilet	Functional flush toilet, VIP	
Score	4	1	0	
			CPA 3 TOTAL →	
CPA 5: PSYCHOSOCIAL SUPPORT AND BASIC CARE				
				SCORE
13.	In the last year, how often have you felt so troubled that you felt you needed to consult a spiritual, faith or traditional healer, counselor or health worker?			
Option	Most of the time	Sometimes	Never	
Score	4	1	0	
			CPA 5 TOTAL →	
CPA 6: CHILD PROTECTION AND LEGAL SUPPORT				
				SCORE
14.	What would you do if any of your children experienced or became a victim of any form of child abuse or violence?			
Option	Nothing	Talk to neighbour / family only	Report to LC/Police/Probation, CDO, Human rights office	
Score	4	1	0	
15.	In the past 12 months (STATE MONTH), have you or another adult in the household used the following method of discipline with any child in your household? (Please select all the methods that apply)	☐ Punched, kicked or hit a child ☐ Withheld a meal to punish a child ☐ Using abusive words/language towards the child		
Option	If TWO or MORE of the methods are checked	If at least ONE of the methods is checked	If NONE of the methods are checked	
Score	4	1	0	
			CPA 6 TOTAL →	
			HOUSEHOLD TOTAL SCORE (ALL CPAs) →	

INDIVIDUAL INFORMATION

INSTRUCTIONS: Please administer this section to each child in the household. In particular, please interview the caregiver if the child is 12 years of age or below. Children who are 13 years and above should answer for themselves. Ask each question and write in the corresponding score for each child under his/her respective column (labeled "SCORES").

At the end of each CPA, please add up the scores for all questions and write them down under the "CPA TOTAL" row for **each** child. Finally, add up all CPA scores, and enter them under "INDIVIDUAL TOTAL SCORE" for **each** child.

					SCORES					
					Child 1	Child 2	Child 3	Child 4	Child 5	Child 6
Child's Name										
Child's Identification Number										
Child's age (in years)										
CPA 2: FOOD SECURITY AND NUTRITION										
1.	How many meals (including breakfast) has (Name) had in the past 24 hours? (SKIP if child is breast feeding)									
Option	None	One meal	Two meals	Three meals or more						
Score	4	3	1	0						
2.	What does the child usually eat? Write down "Yes" or "No" for each type of food consumed by the child. Instructions: • Applicable to children of all age brackets (Breast feeding children take all the food values) • "Usually" means at least 3 times a week • Ask the parent/guardian and then a child where applicable (13 -17 yr.) to double check									
	a. Energy foods: (potatoes, banana, oils, posho, millet, rice, maize, bread, cassava)									
	Yes		No							
	b. *Body building foods*: (beans, meat, soya, peas, milk, eggs, chicken, fish)									
	Yes		No							
	c. *Protective and regulative foods*: (tomatoes, oranges, pawpaw, mangoes, pineapple)									
	Yes		No							
Option	ALL of the options are selected as "No"		One or Two of the options are selected as "No"	All options are selected as "Yes"						
Score	4		2	0						
				CPA 2 TOTAL →						
CPA 3: HEALTH, WATER, SANITATION AND SHELTER										
3.	Last night, did (Name) sleep under an Insecticide Treated mosquito Net (ITN)?									
Option	Yes		No							
Score	0		4							
4.	Has (Name) been very sick for at least three months during the past 12 months? (By very sick, I mean that (Name)was too sick to go to school, play or do normal activities around the house for at least three of the past 12 months)									

Option	Yes	No								
Score	4	0								
			SCORES							
			Child 1	Child 2	Child 3	Child 4	Child 5	Child 6		
5.	Has (Name) received the required immunization at his/her age? (Applicable to 0-5 yrs ONLY and ask for the immunization card/book)									
Option	Yes	No								
Score	0	4								
		CPA 3 TOTAL →								
CPA 4: EDUCATION										
6.	If the child is enrolled, what is his/her school attendance status? (Children aged 6;Days can be non-consecutive within the week)									
Option	Misses school 3 or more times per week or NOT in enrolled in school	Misses school twice per week	Attends school regularly (attends 4 or more days per week)							
Score	4	2	0							
		CPA 4 TOTAL →								
CPA 5: PSYCHOSOCIAL SUPPORT AND BASIC CARE										
7.	How many set (s) of clothing does (NAME) own? (Exclude school uniform)									
Option	Owns at least two sets	Owns one set of clothes	Owns no piece of cloth OR child is walking naked OR has tattered clothing							
Score	0	1	4							
8.	How often does (Name) feel sad, worried, withdrawn, or hopeless?									
Option	Often	Sometimes	Never							
Score	4	1	0							
9.	Over the past 3 months (STATE MONTH), how often have you seen someone in the your household being kicked, beaten, slapped, hit with a fist, threatened with a stick, had something thrown at, or being shouted at? (13-17 years)									
Option	Most of the time	Sometimes	Never							
Score	4	1	0							
		CPA 5 TOTAL →								
CPA 6: CHILD PROTECTION AND LEGAL SUPPORT										
10.	Does (Name) have a birth registration certificate?									
Option	Yes	No								
Score	0	4								
11.	Has (Name) ever been into marriage? (10-17)									
Option	Yes	No								
Score	4	0								
12.	Has (Name) been sexually active in past 12 months (STATE MONTH)? (10-17)									
Option	Yes	No								

Score	4	0						

						SCORES					
						Child 1	Child 2	Child 3	Child 4	Child 5	Child 6
13.	In the past 3 months, how often has (NAME) drunk alcohol? (age 5-17)										
Option	Everyday	Minimum of once a week	Less than once a week	On special occasions	Never						
Score	4	3	2	1	0						
14.	Has (Name) experienced any form of the following child abuses in the last 30 days? Please CHECK ALL that apply to the child. Probe or observe for any types or signs of abuse.										
	a) Denial of socialization with other children				a						
	b) Denial of legal rights/access to justice				b						
	c) Stigma & discrimination due to illness or disability				c						
	d) Physical violence/abuse inflicting pain or injuries *bruises, scratches, wounds*				d						
	e) Emotional abuse (e.g. shouting at the child, public humiliation)				e						
	f) Sexual abuse (*forced sex, raped, defiled..)*				f						
	g) Denial of food				g						
Option	If THREE or MORE behaviours are selected		If ONE or TWO of the behaviours are selected		If NONE of the behaviours is selected						
Score	4		2		0						
	CPA 6 TOTAL →										
	INDIVIDUAL TOTAL SCORE →										
	GRAND TOTAL SCORE (HOUSEHOLD + INDIVIDUAL SCORE) → (USE THIS SCORE TO DETERMINE LEVEL OF VULNERABILITY)										

DETERMINE THE VULNERABILITY LEVEL

INSTRUCTIONS: After totaling all the scores under "GRAND TOTAL", look at the table below and determine **WHERE** that child's GRAND TOTAL score falls in the score range below.

LEVEL OF VULNERABILITY	GRAND TOTAL SCORE
Critically Vulnerable	**90 – 116 points**
Moderately Vulnerable	**50 – 89 points**
Slightly Vulnerable	**Less than 50 points**

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6
WRITE DOWN EACH CHILD'S VULNERABILITY LEVEL →						

Write the level of vulnerability for each child below.

Appendix B – Data Collection and Consent Forms

Data and Document Review Consent

Good morning / afternoon, my name is [insert your name here], and I represent the USAID funded project, MEASURE Evaluation. Our project has been asked by USAID/Uganda to gather information on the Vulnerability Index (VI), the national tool developed by the Ministry of Gender, Labour, and Social Development, designed to determine levels of household and children vulnerability to determine who receives services. . This assessment focuses on use of the VI by United States Government funded programs who have administered the VI. We aim to assess user experiences with the VI, its ability to identify the most critically vulnerable, and the quality of information generated from the VI. The findings of this study will help inform future VI use and how best to further support orphans and other vulnerable children and related programs. If you have any concerns or further questions about this study, please contact Winfred Badanga at the National AIDS Review Committee of the Uganda National Council for Science and Technology using either winnfry@gmail.com or +25 641 4234567.

For today's meeting I will be reviewing randomly selected VI forms to:

- review scores for selected indicators
- look for completeness and accuracy in scoring
- determine whether the form was complete,
- determine whether skip patterns were followed, and
- determine whether or not the individual child and household scores were summed properly

This process may take several hours depending on the number of records selected and the availability of the forms. We will not record the names of any individual children or households, will not photocopy any of the forms, or remove any of the forms from the premises. We will review the forms in a location you select (e.g., a conference or meeting room) and you are welcome to have a staff member present to ensure the safety and confidentiality of your files.

We will use our own forms to capture the information we need from the selected VI forms. If you do not wish for this review to occur, you may stop the review at any time.

This assessment is being done to benefit the Ministry, donors, and implementing partners with new knowledge about the VI and to help benefit society. Therefore, I would like to clarify that your organization's involvement is completely voluntary; meaning you or your organization will not receive any direct benefit (material or monetary) for your participation in the study.

Do you have any questions about the record review that will occur today?

Signature:

I confirm that I have read the above information and agree to have the VI forms reviewed at this location. If you do not agree, you do not need to sign.

_____ _____

(Name) (Date)

Consent Forms (each consent form was slightly edited to reflect the individual interviewed)

Good morning / afternoon, my name is [insert your name here], and I represent the USAID funded project, MEASURE Evaluation. Our project has been asked to gather information on the Vulnerability Index (VI) as a tool used to identify vulnerable households enrolled in US government funded programs like xxx (TASO, RECO INDUSTRIES). In addition, the study aims to document user experiences with the VI and information generated from the VI. The findings of this study will help inform future VI use and how best to further support orphans and other vulnerable children and related programs. If you have any concerns or further questions about this study, please contact the Executive Secretary at the Uganda National Council for Science and Technology re: protocol ss3287 using +25 641 4234567.

In this interview I will ask you about:

1. How you use and implement the Vulnerability Index in your organization
2. The benefits/challenges of using the VI
3. Use of VI results
4. Training and preparation on VI administration and use of findings
5. Perceptions of data quality generated from the VI

This interview will take approximately one (1) hour. Please feel free to stop the interview at any time. All information provided by you is confidential. Your name will not be mentioned in any presentation or report. Feel free not to answer any question if you feel uncomfortable and if you prefer, you can choose not to answer any of the questions.

Studies are done to benefit society with new knowledge. Therefore, I would like to clarify that your participation in this interview is completely voluntary, meaning you will not receive any direct benefit (material or monetary) for your participation in the study.

I thank you in advance for your willingness to give honest and open answers to questions that I will ask you.

Recording

Additionally I would like to have your permission to record our conversation today, so that later I can remember all the information you will provide. The recording is heard only by the person transcribing the interview. The recordings will be destroyed after the transcription is complete.

Do you have any questions?

Signature:

I confirm that I have read the above information and agree to participate in this interview. If you do not agree, you do not need to sign.

_____ _____

(Initials) (Date)

Questions for TSO

1.1. What is your title? Can you please describe your role as it relates to working with programs supporting vulnerable children and households?

1.2. What are the various ways that OVC projects and others determine which households to support? [Please describe any tools, community input, or other means by which you identify which households you support] What are your experiences with these different ways? What works well/doesn't work well? Why?

1.3. Please describe your experience with the Vulnerability Index [When did you first hear about it? What do you know about it? What is your involvement – do you help administer or score it, provide assistance to the IP or DCDO?]

1.4. Please describe how you were informed of the VI [How was it disseminated in your region?]. Who told you about it? Describe how you were prepared for this role - to use the VI and to train others to use the VI? What was involved (e.g., training, supervision, etc.)

1.5. For what purposes is the VI used in this region? *Ask first open-ended and see where the response falls in the categories below). If not clear, then follow-up specifically by asking if they use it the ways described below.*

   a. to identify vulnerable households [targeting]

   b. to validate OVC lists generated from the community

   c. to identify levels of vulnerability [assessment]

   d. to monitor household vulnerability

   e. Other – please describe

1.6. Please tell me about the process of administering the VI by [specific IP] in this region. What is your involvement? [Visit households? Review scores? Determine which children are enrolled?] What happens when there is a critically or moderately vulnerable child in a less vulnerable household? What about a disabled or HIV+ child with an overall low VI score?

1.7. How useful is the VI in identifying the most vulnerable households? In identifying household needs? In monitoring households vulnerability over time?

1.8. Before the VI, how did your region assess household vulnerability?

1.9. Now that you have the information from the VI, would you say the VI is more helpful, about the same, or less helpful in identifying vulnerable households?

1.10. In what ways has the VI been helpful to your region? [Prompt – what is it good at doing?]

1.11. Please describe any challenges related to using the VI. What, in your opinion, is the VI not good at doing?

1.12. In your opinion, are there any negative effects of using the VI as a tool? Please describe.

1.13. In some areas of the region, VI is used, in others it is not. Can you please tell me the difference between the VI and other approaches or tools for identifying levels of household vulnerability? Do you have a preference of one or another? If so, which one and why? Please talk about the strengths and challenges of other vulnerability tools used in the region.

Questions for DCDO/Probation officer

1.1. What is your title? Can you please describe your role as it relates to working with programs supporting vulnerable children and households? [prompt: relationship to IP using the VI in this district]

1.2. What are the various ways that OVC projects and others in the district determine which households to support? [Please describe any tools, community input, or other means by which they identify which households to support. *If not covered in first answer, prompt:* please describe how (IP in this district) identifies which households to support.] What are your experiences with these different ways? What works well/doesn't work well? Why?

1.3. Once households are identified as vulnerable, what are the various ways that programs/service providers decide which services each household will receive? [Please describe any tools, community input, or other means by which you identify vulnerable households' needs]. How do these approaches work?

1.4. How do various programs/projects decide when a family is ready to graduate from receiving support? What are some of the tools/guidelines, etc. that you know of that help make this type of decision?

1.5. Please describe your experience with the Vulnerability Index [When did you first hear about it? What do you know about it? What is your involvement – do you help administer or score it, provide assistance to the IP/CBO or CDO?]

1.6. Please describe how you were informed of the VI [How was it disseminated in your region? Who told you about it and how did you obtain a copy? Describe how you were prepared – either by government, or others – to use the VI and to train others to use the VI? What was involved (e.g., training, supervision, etc.)]

1.7. For what purposes is the VI used in this district? [*Ask first open-ended and see where the response falls in the categories below). If not clear, then follow-up specifically by asking if they use it the ways described below.*]

   f. to identify vulnerable households

   g. to validate OVC lists generated from the community

   h. to identify levels of vulnerability

   i. to monitor household vulnerability over time

   j. Other – please describe

1.8. Please tell me about the process of administering the VI by [specific IP] in this district. What is your involvement? [Visit households? Review scores? Determine which children are enrolled?] What happens when there is a critically or moderately vulnerable child in a less vulnerable household? What about a disabled or HIV+ child with an overall low VI score?

1.9. How useful is the VI in identifying the most vulnerable households? In identifying household needs? In monitoring households vulnerability over time?

1.10. What information do you receive from the VI? Probe: individual household scores, subset scores, aggregated community scores? Do you keep the forms or does the project? Please explain.

1.11. How do you/your office use information reported from the VI? [probe: decision making, allocating resources, selecting households to serve, prioritizing interventions?]

1.12. Before the VI, how did your district assess household vulnerability?

1.13. Now that you have the information from the VI, would you say the VI is more helpful, about the same, or less helpful in identifying vulnerable households?

1.14. In what ways has the VI been helpful to your district? [Prompt – what is it good at doing? Strengths?]

1.15. Please describe any challenges in using the VI. [What, in your opinion, is the VI not good at doing? Weaknesses?]

1.16. In your opinion, are there any negative effects of using the VI as a tool? Please describe.

1.14. In some sub-counties in the district, VI is used, in others it is not. Can you please tell me the difference between the VI and other approaches or tools for identifying levels of household vulnerability? Do you have a preference of one or another? If so, which one and why? Please talk about the strengths and challenges of other vulnerability tools used in the district.

Questions for OVC Technical Lead/Program Officer

1.1. What is your job title and role within the project?

1.2. Please describe the aim of your project. What are the primary interventions provided by the project? [Probe: what is the main target group that you serve – households, individual children, people living with HIV/AIDS]

1.3. Approximately how many households does your project serve in this district/sub-county? Of these, with what % has the VI been used?

1.4. How does the organization determine which households to support? Who is involved in that process? [Community process? Involvement?]

1.5. Please explain how your organization uses the VI? What does it help you to do? [*Ask first open-ended and see where the response falls in the categories below). If not clear, then follow-up specifically by asking if they use it the ways described below.*]

a. to identify vulnerable households

b. to validate OVC lists generated from the community

c. to identify levels of vulnerability

d. to monitor household vulnerability over time

e. Other – please describe

1.6. How does your organization decide which services each household will receive? [Please describe any tools, community input, or other means by which you identify vulnerable households' needs].

1.7. In your opinion, how does the process you use to identify households work? Would you say it works very well, ok, or not well?

1.8. How does your organization determine when a family is ready to graduate from the program? What tools/guidelines, etc. are used to help make this decision?

1.9. Please describe the process you follow in using the VI [When did your project first use the tool? Plans for follow-up? Or Future?]

1.10. How satisfied were you with the data quality from the VI implementation? [accuracy, timeliness, completeness?]

1.11. Please tell me about who was involved in the following:

- Administering the VI [project level, community level, from government?]
- Reviewing the scores
- Selecting children/households for enrollment

1.12. Would you say that the VI identifies the most vulnerable households? Why? Why not? What happens when there is a critically / slightly vulnerable child in a less vulnerable household? What about a disabled or HIV+ child with an overall low VI score?

1.13. How do you/your office use information generated from the VI? [probe: decision making, allocating resources, selecting households to serve, prioritizing interventions?]

1.14. What happens with the household scores? Who uses the scores and in what ways? [Do you look at subscores?]

1.15. What other types of information do you need to make decisions? How are you obtaining that information? What information do you need from the VI (or any vulnerability assessment) to determine program enrollment and which services are needed to meet program objectives?

1.16. Before the VI, how did your program assess child/household vulnerability?

1.17. Now that you have the information from the VI, would you say the VI is more helpful, about the same, or less helpful in assessing child and household vulnerability?

1.18. In what ways has the VI been helpful to your program? [Prompt – what is it good at doing? Strengths?]

1.19. Please describe any challenges in using the VI. [What, in your opinion, is the VI not good at doing? Weaknesses?]

1.20. In your opinion, are there any negative effects of using the VI as a tool? Please describe.

Questions for M&E Officer

Program Information

1.1. What is your job title and role within the project?

1.2. Approximately how many households does your project serve in this district? Of these, with what percent has the VI been used? What percent of households in this location [district, clinic, sub-county] where the VI was administered, were enrolled in the program?

VI Administration

1.3. Please describe how the VI was administered. [Did you create a protocol? Obtain IRB review? Did you use the VI with every household in the community? With all of the households you serve?]

1.4. What was involved at this level [district, clinic, sub-county] to administer the VI assessment?

- How many trainers?
- How many days?
- How many volunteers/staff were used to collect information?
- How many days did it take them to collect the information?
- Who collected all of the forms? And entered the data? How many days did it take?

VI Training and Supervision

1.5. Please describe how those who administered the VI (volunteers/data collectors) were prepared to administer it. Was there training? If so, were all individuals administering the VI trained? If not all, why haven't they been trained? [overall training process]

1.6. Please describe the VI training approach your program uses [training methods].

1.7. Do you provide supervision or guidance to those who administer the VI on how to complete the forms? If so, please describe this process.

1.8. Please describe any VI supporting materials that you created (e.g., data collection protocols available and accessible; training materials; guidance on scoring)? [be sure to collect]

VI Scoring

1.9. Tell me what happens after administering the VI forms. Who is responsible for scoring the forms? What is the process for the scoring?

1.10. Once VI scores have been tallied, how are the scores used? Do those that administer the VI do anything with the scores? How are the scores used at the program level? Who facilitates use of scores?

1.11. What happens if a household is not vulnerable, but one or two children within the household are vulnerable? What do you do with that information? Would the child still receive services?

Data Quality

1.12. In general, how satisfied are you with how well the VI forms are completed? Would you say, very satisfied, somewhat satisfied, or not at all satisfied. Please explain your response.

1.13. Please describe any data quality checks conducted during data collection/entry of the VI.

Data Management and Analysis

1.14. What do you do with the paper forms when you receive them? Describe the step-by-step process for this. [Do you enter them into a database, summarize them into Word or PowerPoint]. Do you keep the forms at the office? And/or send them to a central location/HQ office? Is information entered electronically?

1.15. What do you do with the completed forms [do you store them, make copies and return to those who administered]? Who has access to the paper based and/or electronic files? How is security maintained on these files? How do you ensure confidentiality of the files?

1.16. How do you report information? [In a narrative format already summarized or raw data with tables, electronic database, other? How do you submit such reports [probe: by email, CD, flash drive, FTP or upload to website]. Do you collect the names of households or other identifying information in the database?

1.17. Please explain how VI findings are analyzed at your office? What types of analyses, if any, do you conduct? Whose job is it to do this?

Reporting

1.18. Do you report the summarized information back to those who administer the VI? If so, how does this occur? If data are not analyzed at this level, do you receive feedback from the national or regional level Project? If so, how often and what format do you receive it?

Other

1.19. Please describe whether or not you think those who administer the VI are the most appropriate individuals to do so. What are some of the challenges they encountered in administered the VI? What are some of the things that are working well?

1.20. In your opinion, do those who administer the VI have sufficient time to do so given their other duties? Please explain your response.

1.21. Before the VI, how did your program assess child/household vulnerability?

1.22. Now that you have the information from the VI, would you say the VI is more helpful, about the same, or less helpful in identifying vulnerable children/households?

1.23. In what ways has the VI been helpful to your program? Prompt – what is it good at doing? [strengths]

1.24. Please describe any challenges to using VI. What, in your opinion, is the VI not good at doing? [weaknesses]

1.25. In your opinion, are there any negative effects of using the VI as a tool? Please describe.

Document Collection – please be sure to collect the following documents:

- VI protocol
- VI guidelines
- VI decision support tool
- VI scoring/analysis guide
- VI training materials (agenda, slides)

Consent Form and FGD Questions for FGD

Part 1: Consent

Hello, my name is [insert your name] and I am working with MEASURE Evaluation on a study which aims provide information about the Vulnerability Index (VI) as a tool used to identify vulnerable households enrolled in US government funded programs like xxx (TASO, RECO INDUSTRIES). In addition, the study aims to document user experiences with the VI and information generated from the VI. The findings of this study will help inform future VI use and how best to further support orphans and other vulnerable children and related programs. If you have any concerns or further questions about this study, please contact the Executive Secretary at the Uganda National Council for Science and Technology re: protocol ss3287 using +25 641 4234567.

In this discussion, I will ask questions about:

1. How you use the Vulnerability Index in your work
2. What are some of the benefits/challenges of using the VI?
3. How do you use the VI results?
4. How well prepared you are to use the VI

This discussion will take about 2 hours. Your participation in this focus group is completely voluntary, and you will not be paid for your time. You may decline to answer any question that you are not comfortable with. Nevertheless, if you choose to respond, open and sincere responses to the questions will be very much appreciated. If you wish, you may stop participating in this focus group at any point.

Everything you say will not be shared outside of this room by the study team. Anything we report about our work will not link back to you. Your responses will help us understand ways to improve how OVC programs collect information for decision making. Do you have any questions at this time? If you have any questions after our discussion, please do not hesitate to contact the individual listed above. Do I have your permission to continue?

Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. You probably prefer that your comments not be repeated to people outside of this group. Please treat others in the group as you want to be treated by not telling anyone about what you hear in this discussion today.

Recording

Additionally we would like to have your permission to record our conversation today, so that later we can recall all the information you will provide. The recording is heard only by the person doing the interview transcript, and the recording will be destroyed after the transcript is complete.
Do you have any questions?

Individual initials of each of the participants of the focus group discussion:

_____ _____

(initials) (date)

Part 2: Questions

Date of FGD:	Start Time:	End Time:
FGD Moderator: **FGD Note taker:**		
Program: **District:** **Sub-county:** **Village:**		
Total Number of Participants: ____ **Ask – how many participants have used the VI? ____ [confirm all have used the VI, if not, politely indicate that FGD participants should have used the VI]**		

Household Identification

1.1 All of you here have a role in supporting vulnerable households. We'd like to hear more from you about what your work involves. Please explain your role in working with these households.

1.2 What does the term vulnerable household mean to you? What about the term vulnerable child?

Administering the VI

1.3 Now I am interested in learning more about the use of the Vulnerability Index tool. Can you tell us more about what you do when you arrive at a household to administer the VI? [How long did you spend filling out the VI? To whom did you ask questions? Did you fill in the VI while with the family or later? How many households did you visit in one day?]

1.4 Describe how confident/comfortable you feel administering the VI. Please explain why. Please describe what would help you feel more confident using the VI. [Probe why: ease of form? Training? Show form. Do not point out any specific questions, but make sure they identify anything confusing or challenging.]

1.5 Explain how you were prepared to use this tool. [training? Supervision?]

1.6 Please describe the strengths and / or weaknesses of the VI. [What do you like about this tool? What do you dislike about this tool?]

1.7 Tell us about the scoring process for the VI. [Who is involved in the scoring process? How are those administering supported (if involved)? How is the quality of the forms ensured? Forms after completion?]

1.8 What do you do with the scored VI forms when you are finished with them? [do you keep the forms, submit them to a supervisor?]

1.9 Are there households you think are vulnerable that are not picked up using the VI assessment? Can you give specific examples?

1.10 What happens if a household is not vulnerable, but one or two children within the household are vulnerable? What do you do with that information? Would the child still receive services? [Probe about children with disabilities, orphaned, HIV+, or subject to abuse]

1.11 How do you, in your role as you described it, use the information from the VI?

Feasibility

1.12 How does administering the VI fit into your schedule? Do you have sufficient time to perform all of your other responsibilities? Please explain.

1.13 What kind of technical support would help you in your work with vulnerable households and children? [To identify vulnerable children/households? To provide services to vulnerable children/households? Let them respond first, but if no responses ask about: supervision, training, materials, information]

Thanks very much. That completes the focus group questions. Is there anything else you'd like to add that we haven't already discussed?