

**PROTOCOL FOR A NATIONAL CENSUS AND
SURVEY ON CHILDREN IN RESIDENTIAL CARE**

January 2022

This provisional draft has not been fully edited or fact-checked

PROVISIONAL DRAFT

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UNICEF Data and Analytics Section
Division of Data, Analytics, Planning and Monitoring
3 United Nations Plaza, New York, NY 10017, USA
Email: data@unicef.org

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SECTION 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

This protocol for data collection on children living in residential care facilities (RCFs) aims to provide governments with clear guidance on recommended actions and steps for undertaking a census to map and enumerate such facilities and the children living in them.

A child's care status impacts his or her health, developmental outcomes and overall well-being, both during childhood and later in life. There is wide recognition, and a growing body of evidence, of the adverse impacts of institutionalization. Children outside of family settings are more likely than their peers to experience abuse, neglect, exploitation, lack of stimulation, poor nutrition and toxic stress.¹ The lifelong physical and psychological harm that institutionalization or lack of quality family-based care can cause is well-documented, with numerous studies revealing that children who remain in institutions after the age of 6 months often face severe developmental impairments.² This has led many countries to undertake efforts to reduce the number of children living in institutional care. Whenever possible, they are seeking to prevent institutionalization in the first place or to reunite children with their families – in line with their obligations under the United Nations Convention on the Rights of the Child (CRC) and the UN Guidelines for the Alternative Care of Children. The Guidelines, welcomed by the UN General Assembly in 2009, encourage efforts to maintain children with their families, where possible. When this is not in the child's best interests, the State is responsible for protecting the rights of the child and ensuring appropriate alternative care: kinship care, foster care, other forms of family-based or family-like care, residential care or supervised independent living arrangements. Recourse to alternative care should only be made when necessary, and in forms that promote the child's well-being. The aim is to find a stable and safe long-term response, including, where possible, reuniting the child with his/her family.

Accurate and reliable figures on the number of children living in institutions are essential for countries to meet these objectives. In fact, the 2019 United Nations General Assembly Resolution on the Rights of the Child urged States to improve data collection and information management and reporting systems related to children without parental care in order to close existing data gaps and develop global and national baselines.³ Since children in residential care are not covered by household surveys, the availability and reliability of existing figures are, to a large extent, a reflection of how well an information management system (if there is one) is functioning to capture and record information on these children. This information can then be used to develop or strengthen national monitoring systems, improve service provision to children and families, implement childcare system reforms that promote family strengthening and reunification, and to fulfil countries' obligations under the CRC. In addition, the availability of accurate figures and disaggregated data on children living in institutions can directly inform government policy and practice in support of deinstitutionalization by providing clear information on the characteristics of children placed in these types of formal alternative care settings. These data can then be used to assess gaps in information and service provision or to identify appropriate interventions for children vulnerable to family separation in order to reduce inappropriate placement of children in alternative care, especially institutional care. Having more accurate data will also allow for stakeholders to observe trends and changes over time, thus enabling a process of thoughtful reflection on the impact of their work and areas for improvement.

Many countries still lack accurate statistics on the number (and characteristics) of children living in institutions, despite their importance and countries' own obligations to their children. Official records in many countries capture only a small fraction of the actual number of children in residential care, and children living in privately owned or unregistered centres are often not counted. In some countries, due to budget incentives and definitional issues, the number of children in residential care may be overestimated in official statistics. Additionally, administrators may intentionally inflate reported numbers of children living in facilities or even recruit children in order to receive funding or other incentives.⁴ Moreover, children living in institutional settings are frequently missing from official statistics since reporting for many indicators, particularly those that comprise global monitoring frameworks such as the Sustainable Development Goals (SDGs), rely heavily on data collected through household surveys. This hinders efforts to include the most vulnerable in SDG monitoring and to ensure that no one is left behind.

Therefore, it is urgent that countries invest in efforts to produce useful, accurate and comprehensive listings of all existing residential care facilities. It is also important that they undertake, at regular intervals, thorough counts of the number of children living in these facilities in order to strengthen official records. In addition, periodic data collection on the well-being of children in residential care is needed to improve service delivery. Building on such efforts, countries should undertake comprehensive quality assessments of all residential care facilities as well as initiate and maintain individual case management records for each child living in such facilities. All of this will serve to assist countries in fulfilling their obligations under the CRC and their own national laws, in many cases. This information will also provide a concrete source of administrative data on these children for improved and targeted service delivery and policy and programme reform or development. Overall, it will strengthen a government's capacity to respond effectively to the specific needs of each child living in residential care.

1.2 Data needs

To implement this protocol, countries should begin by considering their national and international obligations and consequent data needs related to alternative care. These considerations will inform decisions about which type of data collection is needed.

A wide range of data is needed to fully understand a country's alternative care system and the situation of children living in alternative care. If countries are to work towards reducing the number of children who are inappropriately in alternative care, they must first work to understand the magnitude and distribution of children in alternative care, including foster care, those who have been adopted and those who are in residential care, as well as the system through which a child enters alternative care. Other data needs include data on the patterns and drivers of placement into alternative care, the quality of care provided in alternative care and the gatekeeping mechanisms in policy and in practice.

The specific data needs for residential care include knowing: 1) how many residential care facilities (both registered and unregistered) operate within a country and where they are located, 2) the precise number and basic characteristics, including age and sex, of children living in residential care, 3) the quality of care provided in residential care facilities, and 4) the characteristics, and well-being, of children living in residential care in order to provide them with individual case management.

These data needs are complementary and sequential, since it would not be possible to provide case management to children who are not individually known to the regional or national government, and the different data needs add complexity in terms of steps and partnerships.

Table 1 outlines these data needs and corresponding considerations in terms of process and partnerships.

Table 1. Data needs

Data need	Recommended implementing agency	Process
1 Number and location of RCFs	<ul style="list-style-type: none"> – National statistical office <p>Supported by a technical working group that includes the ministry with a mandate on alternative care</p>	<ul style="list-style-type: none"> – National database mapping and listing of residential care facilities – Link to census activities
2 Number and basic information on child residents	<ul style="list-style-type: none"> – National statistical office <p>Supported by a technical working group that includes the ministry with a mandate on alternative care</p>	<ul style="list-style-type: none"> – Concurrent with or following the mapping and listing of RCFs – Database of children living in RCFs – Link to census activities
3 Quality of care provided in RCFs	<ul style="list-style-type: none"> – Ministry with a mandate on alternative care 	<ul style="list-style-type: none"> – Following the collection of basic characteristics of children living in RCFs – Quality assessment of RCFs
4 Individual case management	<ul style="list-style-type: none"> – Ministry with a mandate on alternative care 	<ul style="list-style-type: none"> – Continuation of prior database to allow for responsive actions on individual cases – Includes referral pathway for reunification, foster care and special services

The protocol presented on the following pages provides technical guidance on the recommended steps for planning and implementing two phases of data collection. The two-step process is designed to address the first two data needs outlined above while also providing an estimation of the well-being of children living in residential care. For more guidance on how to assess current country context and data needs, see section 2.1.1.

1.3 Definitions of alternative care

The UN Guidelines for the Alternative Care of Children state that, in cases where the prevention of family separation is no longer possible, children may be placed in alternative care. However, this

should happen only when necessary and when the placement is appropriate to children's individual needs. Alternative care may be provided informally, defined in the Guidelines as, "any private arrangement provided in a family environment, whereby the child is looked after on an ongoing or indefinite basis by relatives or friends or by others in their individual capacity, at the initiative of the child, his/her parents or other person with this arrangement having been ordered by an administrative or judicial authority or duly accredited body."⁵ Alternative care may also be provided formally, defined in the Guidelines as, "care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment including in private facilities, whether or not as a result of administrative or judicial measures."⁶

A distinction is often made between public and private formal care, where public refers to services provided for, or arranged by, the State, and private to those organized by non-State actors such as non-governmental organizations (NGOs), faith-based organizations and other private agencies.⁷ Similarly, there is a distinction between family care and care provided outside of family-based settings. Family care usually refers to kinship care, where the child is placed with the extended family or close friends of the family known to the child either formally under the mandate of an authority, or informally, or to foster care, where the child is placed by a competent authority with a family other than the child's own that has been approved for providing care.⁸

Two of the main types of care settings that are not family-based are residential care and supervised independent living arrangements, where the latter includes living arrangements that may include the provision of accommodation and access to support workers.⁹ Residential care is defined in the UN Guidelines as "care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short- and long-term residential care facilities, including group homes."¹⁰ This definition includes a wide range of care settings, from small group homes to large residential facilities, such as orphanages or institutions, and typically refers to settings with either volunteer or paid personnel who normally do not reside in the facility or institution.^{11,12} More generally, children outside of family care may refer to street-associated or homeless children, those who are separated or unaccompanied, trafficked children, child-headed households, as well as children living in residential care or in independent living arrangements.¹³

Conceptual definitions, such as those in the Guidelines, aim to describe what is meant by particular terms or concepts related to a topic and serve to outline a range of ideas or notions that are directly related to a particular topic but tend to be abstract and vague. The Guidelines' definition of residential care, for example, is useful in outlining the boundaries of what can be considered residential care, but leaves many concepts open to interpretation, such as what constitutes a 'group setting'. Operational definitions, on the other hand, are clear, concise and detailed definitions of the way in which a particular concept or topic is to be measured. These types of definitions clarify the scope of what is being measured or captured within data collection efforts and are essential to ensure that everyone has a common understanding of exactly what is being measured and that data are collected in the same way. Operational definitions seek to remove ambiguity to ensure data are collected on the issue in a way that is both unbiased and standardized. Section 3.1 includes a more detailed discussion on operational definitions.

1.4 Research methodologies for collecting data on children living in residential care

Children living in residential care facilities are broadly considered to be living outside of family care. For this reason, their magnitude and distribution require the implementation of methods designed to capture populations that are bypassed by traditional household surveys. The methods outlined here have been applied in the research of populations of children living outside of family care and have informed the development of this protocol and the methodology for listing and counting children living in residential care.

Desk review

The desk review is a critical part of the data collection process for exercises that seek to list and count residential care facilities and child residents. The desk review involves compiling existing secondary data on known facilities. Possible secondary sources of relevant data may be existing government listings of such facilities, existing government records of children living in residential care, census data on 'group quarters', data collected by major private groups supporting residential care such as religious organizations, key informant interviews, or results of previous studies that sought to enumerate children outside of family care in a country or regionally.

Participatory research

Participatory research methods have been used in qualitative research on populations of children living outside of family care. Participatory research refers to a range of qualitative data collection methods in which respondents are engaged as partners in the research inquiry process. It relies on the equalizing of the researcher/respondent power dynamic and encourages respondents to articulate their views and express their knowledge at all stages of the research process. Different methods of participatory research are designed for purposes that can range from gaining a deeper understanding of a specific issue, evaluating programmes, or identifying factors that contribute to social problems in order to focus and organize to initiate change.¹⁴ An example of this is a 2007 study on the quality of care in childcare institutions in Indonesia that included child-led research in six childcare institutions in two provinces.¹⁵ In this study, 60 child researchers between the ages of 11 and 18 living in institutions participated in two, one-week workshops during which they discussed their experiences in institutions, schools and communities in Indonesia. They also conducted interviews with their peers, teachers, facility staff and management, and religious leaders.

Face-to face interviewing

Face-to-face interviewing is a widely used mode of data collection in surveys on populations of children living in residential care facilities. In face-to-face interviewing, the interviewer typically visits the respondent at the residential care facility and administers the questionnaire in person, either using paper forms or a personal electronic device such as a mobile phone or tablet.

Face-to-face interviewing has been used to administer questionnaires that collect information on basic characteristics of facilities as well as those of children. Surveys implemented by interviewers enable the interviewer to keep respondents focused on completing the entire survey and also to probe for more details or more information, if necessary. Interviewers are also available to introduce the survey, explain its purposes and aide in explaining the terms of consent. In addition, the physical

presence of the interviewer can create a rapport that may be helpful in situations where respondents are uneasy about granting access to the facility.

A possible drawback is that face-to-face interviewing requires a pool of well-trained interviewers, which signifies high training and personnel costs. Also, the quality of the data collected is dependent on the skills of interviewers; variations in these skills could introduce bias in the way they ask questions, record responses, or follow procedures. These potential limitations could be mitigated through rigorous training and ongoing quality-control measures.

Direct observation

Direct observation is an approach to data collection that has been used in studies that have assessed the overall quality of childcare in residential care facilities.^{16,17} It is a mode of data collection for qualitative research and generally involves a trained researcher visiting a site to record observations of interactions, schedules and activities occurring in a defined area.

Direct observation enables researchers to capture the nonverbal expression of feelings, observe how participants communicate with and relate to one another, and record how much time participants spend on activities. This method provides opportunities for researchers to view or participate in unscheduled and informal events that may otherwise be difficult to access. The quality of the data collected from observation is heavily reliant on the training of the researcher and his or her ability to remain neutral during observation interactions.

Because the quality of the direct observation data is dependent upon the skills of the researcher, training targeted on observation methods is necessary. This training can help minimize the potential biases of the recorded observations. The success of the data collection is also dependent on building rapport with the participants prior to the observation. This rapport is essential to minimizing the risk of reactivity, or people behaving differently when they are aware of being observed; it also facilitates access to participants in more intimate settings.¹⁸

Head counts

Conducting a physical head count of children present in residential care facilities is one method of enumeration. This method requires that researchers visit residential facilities during a time of day when the greatest number of child residents are likely to be present, such as mealtimes or immediately prior to bedtime. To avoid double counting children who may move between residential facilities, researchers visit all facilities within a geographic area on the same day or night, or over a short span of nights when same-day visits are not feasible. These visits generally occur on a mid-week night during the school term to maximize the likelihood that most of the children living in the facility will be present. During the visit, the researchers physically count and tally all child residents and, when possible, also record the child's age and sex.^{19,20}

Record review

The review of existing administrative and/or case records can be informative for research on residential care facilities and their residents. This requires a systematic review of registration and attendance records within a facility to determine the reported number, age and sex of children who

live in the facility as well as reasons for their placement, and also to determine key characteristics of the facility, such as government registration status.

The review of attendance records is useful for research that specifies sleeping habits in the inclusion criteria for what is considered a child resident. For example, some studies require that a child has slept in the facility a certain number of nights in the week of data collection for inclusion.

In-depth interviewing

In-depth interviewing has been used in research on children who live and/or work on the street. It refers to a qualitative research method during which a small number of respondents are interviewed using open-ended questions and probes.²¹ These interviews are usually conducted after a researcher or team of researchers has built a rapport with respondents and may last several hours, usually over several days. In-depth interviews are useful for providing context to survey or questionnaire data, as well as for capturing attitudes and beliefs surrounding behaviours, issues or existing programmes.²² While in-depth interviewing can be an effective method for capturing detailed information that may otherwise be difficult to collect, it can also be time-consuming, is vulnerable to interviewer bias and yields results that are not generalizable.

Focus group discussions

Focus group discussions have been used in qualitative and mixed methods research on children who live and/or work on the street. Focus groups are organized discussions with a moderator and a small group of 6-12 participants. A facilitator, either a local hire or external researcher, moderates the discussion in the local language and the discussions are later translated, if necessary. Focus groups are useful for collecting qualitative information and are designed to stimulate active participation and dialogue among participants. They are usually organized by a series of questions and probes that are designed to facilitate discussions on participant views on a given topic.²³ A limitation of focus group data is that they are often not generalizable, and their success relies heavily on the skill of the facilitator to moderate and guide discussions.

Censuses

Some countries that undertake a national census at regular intervals have methods for reaching populations living outside of households (see Box 1). These methods include service-based enumerations where census enumerators visit locations known to be frequented by populations of people without housing, such as soup kitchens, homeless shelters, mobile food vans and outdoor living locations known to the community. Group-quarter enumerations reach populations living in group housing, including nursing facilities, residential treatment facilities, and university housing halls and hospitals, among others. Often these methods of enumerating populations living outside of households are not designed to focus on child populations. However, they may pick them up as part of the data collection, especially if children are living in mixed-population facilities with adults, such as health or correctional facilities.^{24,25,26}

Box 1. United States Census methods for counting children and young people living in facilities

The United States Census Bureau collects information on residential facilities and children living in residential placement through the Juvenile Residential Facility Census (JRFC) and the Census of Juveniles in Residential Placement (CJRP). While these are intended to capture information on children living in various forms of correctional facilities, the methods employed are useful to inform the collection of data on children living outside of family care and in institutions.

The JRFC collects basic information on facility characteristics, including size, structure, security arrangements, type of facility and ownership. The JRFC also collects additional information on the health and education services available to youth in the facilities and includes questions about other residential services provided by the facility, including independent living, foster care, or other alternative care arrangements.

The CJRP provides the United States Government with a detailed individual record on each juvenile held in over 3,100 state, county, municipal and privately run residential facilities that house juveniles, including their sex, race, admission date, and offence and adjudication status.

For both censuses, the inclusion criteria for facilities are that the facility be in operation on the census reference date, that it is public or private operation, and that it is intended for juvenile offenders. For the CJRP, the inclusion criteria for individual-level data are that the person is under the age of 21, is assigned a bed in the facility at the end of the date on the census reference date, is charged with an offence or court-adjudicated for an offence, and is in residential placement because of the offence.

The JRFC is administered every other year in even-numbered years, and the census reference date is the last Wednesday in October. The CJRP is administered every other year in odd-numbered years and the census reference date is the last Wednesday in October. Representatives of the surveyed juvenile residential facility are notified of the census by mail and may complete the questionnaires by mail, fax or through web-based reporting applications.

Sources: United States Census Bureau, 'Census of Juveniles in Residential Placement (CJRP)', undated, <<https://www.census.gov/econ/overview/go3100.html>>; United States Census Bureau, 'Juvenile Residential Facility Census', undated, <<https://www.census.gov/econ/overview/go3200.html>>; National Juvenile Corrections Data, 'Resource Guide', 2021, <<https://www.icpsr.umich.edu/icpsrweb/content/NACJD/guides/ncjd.html>>.

1.5 Modes of data collection

Paper-and-pencil questionnaires

When paper questionnaires are used to collect data, interviewers read questions from a printed questionnaire and fill in answers based on participant responses. A traditional mode of data collection, paper questionnaires can be developed and printed quickly during the research design phase. After data collection has taken place, data entry personnel are needed to clean and input the data into a computer database. The use of paper questionnaires also may require the inclusion of a field editor responsible for ongoing data quality assurance of the paper questionnaire data. Paper questionnaires are generally a cost-effective mode of data collection but may add substantial time to fieldwork and data analysis.

Computer-assisted personal interviewing

Computer-assisted personal interviewing (CAPI) is a modern mode of data collection where the interviewer reads and records responses to questionnaires that are loaded onto a smartphone,

tablet or laptop computer. A number of existing software packages can be used for data entry, editing and tabulation when employing CAPI methods: One of the most commonly used for large-scale data collection efforts such as censuses and household surveys is the Census and Survey Processing System (CSPPro).²⁷ CSPPro is a free software package used by hundreds of organizations. It is designed to be user-friendly, yet able to handle complex applications. CAPI requires the development of data entry applications within the chosen software package as well as the purchase of all electronic equipment necessary for data collection. CAPI eliminates the need for data entry personnel since data are immediately digitized during the interview process and data quality assurance processes can be programmed and conducted on an automated and ongoing basis by the research team. Ideally, the CAPI application should be developed for use on tablets/laptops/smartphones in order to streamline data collection and skip patterns and minimize the occurrence of missing data. A standard CSPPro application has been developed and is available for countries to adapt and use when implementing this protocol.

See Table 2 for a comparison of these two methods of data collection when using face-to-face interviewing.

Table 2. Comparison of computer-assisted and paper-and-pencil methods used during face-to-face interviewing

Item	Computer-assisted methods	Use of paper and pencil
Questionnaire design	<ul style="list-style-type: none"> - Allows for more complex questionnaire design - Automatic skip pattern programming is incorporated into the questionnaire design - Reduces data inconsistencies 	<ul style="list-style-type: none"> - Can be easier and quicker to develop questionnaires - The questionnaire must be simple enough for the interviewer to easily navigate through the filters and skips patterns
Cost	<ul style="list-style-type: none"> - More costly to develop due to software design and computer programming expertise - High costs related to hardware (if purchase is required) 	<ul style="list-style-type: none"> - Can be developed at low cost - High costs in relation to printing questionnaires and data entry
Training	<ul style="list-style-type: none"> - Reduces interviewer training on skip pattern sequencing and field validation - Interviewers who are not used to using tablet technology may require additional time to become familiar with using the devices 	<ul style="list-style-type: none"> - Training may be longer and require additional practice time if questionnaires contain complex or numerous skip patterns, which can be difficult for interviewers to grasp
Data collection	<ul style="list-style-type: none"> - Electronic devices are easy to carry between interview locations - Potential impact on disclosure in geographic areas with limited exposure to technology - Potential challenges in recharging computer devices in areas with little or no electricity 	<ul style="list-style-type: none"> - Can be difficult to carry sufficient questionnaires between locations
Data entry	<ul style="list-style-type: none"> - Data are immediately digitized when entered into the chosen technology during data collection, thus eliminating the need for data entry and data entry errors 	<ul style="list-style-type: none"> - Data must be entered by hand, either in the field (if laptops or other necessary technology is provided) or once data collection is completed

		- Increased risk of data entry errors
Data transportation and storage	<ul style="list-style-type: none"> - Transmission of data from the field is swift and secure - Data are typically transferred to a central data centre via USB and a local WiFi connection - Data can be easily stored on a server or local hard drive - Precautions must be taken to ensure that data are securely transferred – that is, through encryption – and stored 	<ul style="list-style-type: none"> - More difficult to transport questionnaires to the field and store them until needed - Completed questionnaires must be securely transported from the field to the central data centre - A suitable space is required to securely store completed paper questionnaires - Data must be securely stored once entered electronically
Quality control	<ul style="list-style-type: none"> - Consistency checks can be built into programming - Real-time validation checks of data are possible - Helps to eliminate routing errors - Data can be available instantly to aid in the identification of problems 	<ul style="list-style-type: none"> - Random spot checks of completed questionnaires can be undertaken during implementation of the survey to verify the quality of data gathered - During data entry, two quality control measures are possible: 1) one person enters the data and a second person randomly checks the quality of data entered, or 2) double data entry is used whereby operators enter the information twice and compare the entries to ensure they match
Time to data	<ul style="list-style-type: none"> - Data are available as soon as interview teams upload data to the server. This may be only a few days into fieldwork 	<ul style="list-style-type: none"> - Data are only available once the data entry operators have entered and cleaned the data. This is typically weeks or months after the end of data collection

Source: Adapted from United Nations Children’s Fund, ‘Draft Guidelines for the Production of Data on Violence against Children’, UNICEF, New York, 2018 (unpublished).

1.6 Ethical principles

Confidentiality, privacy, informed consent and minimizing risks to participants and protecting them from harm must be carefully negotiated during the planning and implementation of research activities. The three basic ethical principles that guide research involving human participants – respect, beneficence or ‘do no harm’, and justice – are considered universal principles that should guide the thinking and behaviour of all individuals involved in the planning, design, implementation and dissemination of human-centred research and data collection. Respect refers to two ethical beliefs: first, that all individuals have the right to be treated as autonomous and given the opportunity to make their own decisions; and second, that individuals with diminished capacity are entitled to special protection when participating in research. ‘Do no harm’ refers to the obligations of researchers to maximize potential benefits and minimize the potential for harm to research participants. Justice refers to the principle that requires that the risks and benefits of research are fairly distributed among all participants.²⁸ These principles are meant to preserve the dignity of participants as well as minimize their risks and maximize any benefits to participating in the research.

1.7 Considerations for conducting data collection with children

Conducting data collection on children living in residential care requires the direct and indirect participation of this population of children, who often contend with additional vulnerabilities due to lack of guardianship, poverty, stigma and other factors.²⁹ An ethical approach to data collection involving children requires the recognition of and reflection on the multiple contexts that shape children's lives and experiences. These contexts include the wider cultural, social, political and economic forces and also the multiple relationships that are formed around the research, including those of the researchers, participants and institutions.³⁰ The responsibility to respect the dignity of children involved lies with all who participate in undertaking, commissioning, funding and reviewing data. Moreover, all aspects should adhere to the standards set forth in the Convention on the Rights of the Child.

1.8 Compensation

It is generally good practice to reimburse those involved in data collection for any minor expenses, such as travel and lunch, incurred as a result of participation, and this practice is generally accepted as ethically acceptable. The provision of compensation, however, including incentives and gifts, can be ethically problematic and requires careful consideration. Compensation can distort choices regarding participation as well as the content of participant responses, and this is particularly true for children or young people who may try to provide an anticipated desired or preferred response.³¹ Alternatively, the offer of compensation may help to motivate potential respondents to participate and make them feel valued for their time and effort. The determination on compensation should be made in consultation with local counterparts, community leaders and experts, and the participants should be informed of any reimbursement or compensation during the informed consent process.³²

1.9 Addressing conflicts of interest

All data collection staff should demonstrate honesty, integrity and impartiality in their conduct with all stakeholders. Conflicts of interest should be disclosed at the outset to determine whether it is appropriate for an individual to proceed with his or her involvement.³³

Due to the often-difficult circumstances and situations that may be observed in facilities during data collection, interviewers or other members of the fieldwork team may feel compelled to offer assistance or to return to the facility to bring gifts or donations. While this is likely to come with the best intentions, any gifts or donations received by members of the fieldwork teams could be misconstrued by the facility as a reward for participation in the data collection process or could create unrealistic expectations for more resources. It is crucial that fieldwork teams are properly trained and made aware in advance that such behaviour is deemed inappropriate.

1.10 Mandatory reporting

Some countries have laws and regulations that require certain professionals, including teachers, social workers or health workers, to disclose suspected or known cases of child abuse or neglect to relevant authorities. These requirements vary widely across, and sometimes even within, countries and, depending on the context, may apply to all forms of child abuse or only certain types. Mandatory reporting requirements have wide implications when conducting data collection on the well-being of children. The confidentiality of respondents cannot be guaranteed in settings with

activated regulations on mandatory reporting, and this is likely to affect the findings since respondents may not wish to participate without such a guarantee.

In some countries, researchers or those involved in data collection may be exempt from mandatory reporting laws. If this is not the case, then there are ways to minimize the impact of mandatory reporting on data collection activities. They include using self-administered interviewing methods, which usually allow for respondents to respond anonymously, or to recruit interviewers from professions that are not mandated to report cases of child abuse or neglect. Whatever the solution, the decision on how to proceed should be based on the best interests of the child and after consulting the relevant mandatory reporting laws and legislation in the country pertaining both to child protection as well as those governing statistical activities.

1.11 Previous data collection and research on children in residential care facilities

Many countries facilitate the collection of administrative data, which may include data on children in a variety of alternative care settings. A review of data availability on children in residential care found that data are available from some 140 countries covering over 80 per cent of the global population of children.³⁴ Despite this, many countries still lack a functional system for producing accurate figures on the number of children in residential care, and existing data are often of uneven quality due to poor administrative record-keeping, inconsistent implementation of data quality assurance processes, and a lack of resources or investment in collecting reliable data. Evidence suggests that data on children in residential care are further limited by national measurement efforts that may not include information on residential care facilities that are not registered with government bodies. This means that official records may only capture a small fraction of the actual number of children living in residential care, and that children living in privately owned centres are often not counted.³⁵ An important conclusion of the review was that it is critical for governments to keep more accurate and comprehensive listings of all existing residential care facilities and to undertake regular and thorough counts of children living in these facilities in order to strengthen official records.

A number of research studies and guideline papers have been commissioned by governments and by international NGOs on mapping and enumerating children living outside of households, including those in various forms of alternative care. These exercises have been largely dependent on country contexts and specific data needs. In general, they have been undertaken by governments with the purpose of providing baseline data on the number of children currently living in residential care, creating national or regional listings of residential care institutions, recording the locations of residential care facilities using GPS (global positioning systems), and assessing residential care institutions' adherence to national guidelines on alternative care. These data have been used across contexts to advocate for additional data collection exercises and policy reform, monitor trends over time, understand the reasons for placement into residential care and, in at least one case, to inform planning of a population census.

Data collection and research efforts on children in residential care facilities have been implemented across the Americas and the Caribbean, Eastern and Southern Africa, East Asia and the Pacific, and Central and Eastern Europe. In preparing the protocol outlined in this report, 25 such mapping and enumeration exercises were reviewed and analysed on the basis of purpose and intended uses of

the data, data collection and sampling methods, operational definitions and inclusion criteria, and partnership development and stakeholder engagement. The methodological rigour and documentation of the reviewed exercises vary greatly, and it is likely that examples of good practices have been missed due to lack of reporting and dissemination. This review was also limited in terms of language, since reports, methods and guidelines available in English were included.

While systems development varies by region and context, each of these has seen efforts in alternative care system strengthening through such mapping and enumeration exercises. The previous efforts demonstrate the flexibility and breadth of potential purposes and uses of this research. In Cambodia, three distinct exercises undertaken by two different government ministries exemplify the range of purposes and uses of mapping and enumeration studies on residential care. These studies used differing methodologies to first provide an estimation of the magnitude of children living in residential care, then to conduct a full mapping and enumeration of facilities and children in pilot districts only, and then to conduct a complete mapping and enumeration exercise that was implemented as a stage of planning the national census. Similarly, in Uganda, at least three national and regional mapping efforts have been implemented by government and international NGOs to build baseline data and begin a system of monitoring quality of care. Mapping activities have also been implemented in Haiti, where researchers sought to estimate the number of children moving into residential care due to Hurricane Matthew in 2016.

For a full listing of previous mapping and enumeration exercises reviewed as background to inform the development of this protocol, [see Annex A](#).

1.12 Purpose and objectives

The protocol outlined in this report – and related tools – is the first-ever comprehensive package developed to collect data on children living in residential care settings. The protocol outlines the recommended steps for gathering data and is accompanied by 12 data collection tools and a comprehensive implementation package covering every aspect of the process – from design to dissemination of the findings. The utilization of a standard approach allows for data that are broadly comparable across locations and over time and generates findings that will contribute to raising awareness on the adverse impact of institutionalization both globally and nationally. The protocol can be replicated and adapted to a variety of country contexts.

Drawing on knowledge from previous research efforts to understand the magnitude and distribution of populations of children living in residential care institutions, this protocol is designed to outline the recommended steps for undertaking the following data collection activities:

1. Conduct a census and mapping of all residential care facilities in a country (both registered and unregistered)
2. Conduct a thorough enumeration of child populations living in residential care facilities
3. Conduct a survey of well-being on a representative sample of children living in such facilities.

These objectives are achieved through two phases of data collection: Phase One aims to collect data on the number, location and basic characteristics of all residential care facilities in a country as well as the number and basic characteristics of all children living in these institutions. Phase two is a

follow-up survey on a representative sample of children living in residential care facilities to collect data on selected measures of well-being.

The data generated through this exercise is intended to produce official statistics on the number and location of all residential care facilities in a country as well as the number and basic characteristics of children living in institutions. Therefore, it has been designed and is primarily intended for use in countries where information management systems for monitoring children living in residential care are either nonexistent or incomplete/insufficient.

Ideally, the data generated through this exercise can feed into the development of a national registry or database of residential care facilities and the children living in them. The database can then be used to inform and shape national discussions and processes facilitating care reform as well as efforts to strengthen or develop routine systems for administrative record-keeping. This effort to strengthen the systematic collection of administrative data may be used as a basis to support future initiatives aimed at fulfilling other data needs. Countries should aim to build on the census and enumeration in order to undertake, at regular intervals, assessments and inspections of residential care facilities measured against their own national standards. Additionally, building or strengthening an individual case management system for this population is another critical follow-up step. Both of these activities are essential but require a different set of considerations, actors, tools and methodologies. They should be carried out through separate and dedicated exercises that would ideally be the responsibility of the government body/ministry that has the lead mandate on alternative care and regulatory authority in the country.

As a broader objective, the results of this exercise can also generate data and evidence that feed into a country's implementation and review, using the Tracking Progress Initiative tool (see Box 2).

Box 2. The Tracking Progress Initiative

The Tracking Progress Initiative is an interactive diagnostic and learning tool designed to help governments, children's service providers and other national and international actors determine the extent to which a state or region has effectively implemented the Guidelines for the Alternative Care of Children and identify priorities for policy change and action. The online toolkit outlines the process for using the tool, from team-building to analysing and comparing the data collected. Through this online tool, users can enter, review and analyse data on the care of children in their country and generate reports on that data. The data collection tool is comprised of six surveys that are grounded in the principle that alternative care is appropriate and genuinely needed by the individual child.

For more information on the Tracking Progress Initiative or to view the toolkit, visit: trackingprogressinitiative.org.

The approach outlined in this protocol has been developed through a technical process that involved a review of previously used methods and tools as well as consultation with key technical experts. Additionally, the protocol has undergone testing and validation in a few countries, and the results helped further refine and improve the methodology and tools.³⁶

A thorough desk review was conducted of previous data collection exercises on children outside of family care, mappings of residential care institutions and existing national census exercises that include residential facilities. A reference group was convened to provide ongoing technical support and inputs and recommendations on both the standard protocol and accompanying tools and questionnaires. This group, comprised of over 20 technical experts from the United States Agency for International Development (USAID), Better Care Network, Hope and Homes for Children, Washington University, UNICEF headquarters in New York and UNICEF regional and country offices, was consulted through webinars designed to solicit feedback and gather inputs for selected sections of the protocol and data collection tools.

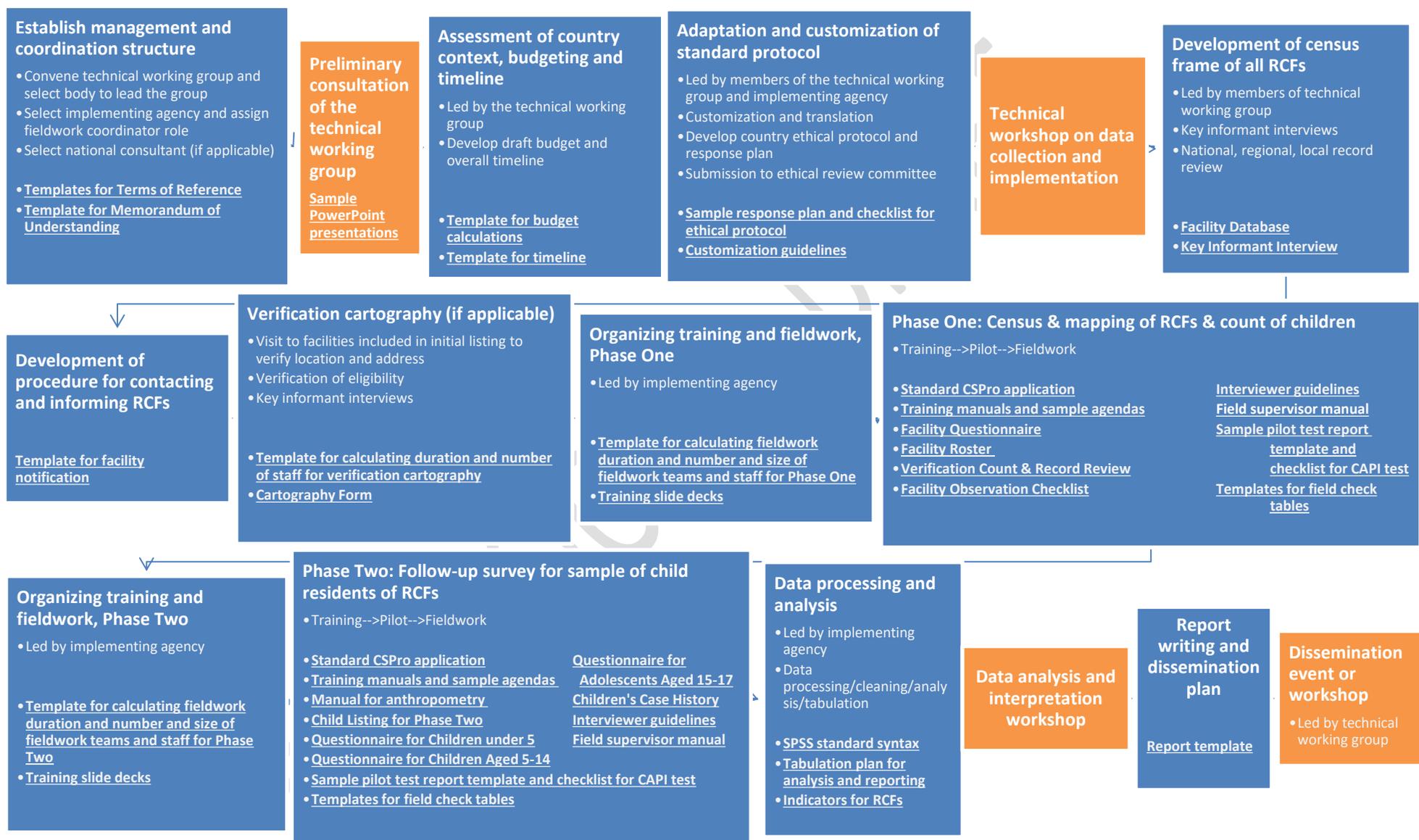
Figure 1 is a visual overview of the main phases and steps included in this protocol, along with a list of the relevant tools and questionnaires associated with each stage.

The remaining sections of the protocol are structured as follows:

- ❑ Section 2, on the preparatory phase, provides guidance on how to assess the situation of country data availability and data needs, how to establish a management and coordination structure, and includes an overview of budget and timeline considerations.
- ❑ Section 3, on the design phase, presents operational definitions and inclusion criteria, provides guidance on adaptation of the standard protocol and tools, and outlines the basic steps for recruiting a field team, developing an initial listing of residential care facilities, conducting a verification cartography, and designing a customized ethical referral protocol, risk management strategies, and informed consent and confidentiality procedures.
- ❑ Section 4, on the implementation phase, offers guidance on organizing fieldwork, training the field team, and outlines procedures for the two phases of data collection. This section also includes guidance on data management and backup and addresses topics of quality control.
- ❑ Section 5, on the analysis and dissemination phase, covers plans for data processing and analysis, drafting a report of the findings, and introduces suggestions for dissemination channels.

Figure 1. Overview of steps for data collection on children in residential care facilities

PROVISIONAL DRAFT



SECTION 2: PREPARATORY PHASE

The preparatory phase is intended to identify relevant national frameworks or legislation, guide partnership development and budget considerations, and provide an overview of an action plan and timeline.

2.1. Assessing country context

Undertaking a review of the national alternative care system is crucial to understanding the potential uses of the data and results of the census and enumeration exercise. The success of the implementation and analysis will largely depend upon first gaining a thorough understanding of the specific systems activated in the country. It is through understanding where and in what capacity the formal care system of a country exists that one will be able to implement the methodology to collect data on the situation of children in residential care facilities.

2.1.1. Situation analysis and data needs

Undertaking a review of relevant national frameworks, legislation, policies and action plans on alternative care, residential care and facility standards is a good first step in understanding the potential uses of the results of the data collection efforts outlined in this protocol (see Box 3). Investigating what national policies exist around alternative care can help determine the political will surrounding the issue that will guide decisions about what kind of data collection to carry out in this exercise. Having a full understanding of the contextually specific pathways and systems of residential care will also help shape the overall intended use of the data generated from this exercise.

A thorough understanding of international standards laid out in the UN Guidelines for the Alternative Care of Children is also necessary. In the event that relevant national documents do not comply or align with these, then it is recommended that the Guidelines be used as the international reference document.

A step crucial in analysing the situation of alternative care systems in a country is understanding if the bodies of power with legal authority over alternative care are centralized or decentralized. Learning who has the national or regional mandate for monitoring children in alternative care will lead to identifying the main government, NGO, local and regional actors involved in the provision and monitoring of alternative care functions and how they interact with one another. Key considerations also include the system or systems through which a child enters formal care and if these differ between forms of alternative care. Additional considerations include the system for registering residential care

institutions at the national and regional levels and national or regional guidelines on regulating and/or monitoring residential care institutions. The Tracking Progress Initiative online toolkit includes an Overview Survey comprised of questions assessing the availability of alternative care

Box 3. Types of documents to review when assessing the national situation of alternative care

- National frameworks
- National legislation
- National action plans
- Policies/guidelines/documents on regulating/monitoring residential care facilities
- National or regional task forces on issues of alternative care
- National and regional registration bodies for residential care facilities.

services and programmes as well as legislation and national policies on alternative care. This may be a useful resource for countries to utilize as part of this initial stocktaking phase. Situations involving conflicts or natural disasters require special measures, as described in Box 4.

Box 4. Additional considerations for active- or post-emergency settings

This standard protocol has been developed for use in 'stable' development contexts, even where parts or regions of a country may reflect emergency or post-emergency situations. Further revision and adaptation of this protocol would be required for application in active/post-emergency/conflict settings.

Settings experiencing natural disaster or conflict-related emergencies often see increases in the number of unaccompanied and separated children. These children face higher levels of food insecurity and violence, are more likely to be exploited for labour and sex and have an increased risk of recruitment and abduction by armed groups.¹ Evidence indicates that the number of residential care institutions is increasing, particularly in countries affected by conflict, displacement and poverty.²

A key consideration for implementing such an exercise in emergency or conflict settings is deciphering who has the mandate for overseeing and registering institutions established in response to emergency-related separation. It may be necessary to explore additional methods of data collection to capture newly established care institutions, or to adapt the tools provided in this protocol to include additional questions tailored to these new facilities. Emergencies may exacerbate existing constraints of resources and time during data collection, and increased population mobility can complicate the task of finding and counting children in residential care. Emergencies also may intensify existing barriers to accessing the institutions. Moreover, restrictions in allowable travel time may make accessing children for follow-up interviews or mealtime counts difficult or impossible.³ Additional safeguards for information and ethical considerations are necessary when collecting data about children in emergencies.⁴

Sources:

¹ Rubenstein, Beth L., et al., 'Community-based Surveillance to Monitor Trends in Unaccompanied and Separated Children in Eastern DRC', *Child Abuse & Neglect*, vol. 50, December 2015, pp. 76-84.

² Williamson, John and Aaron Greenberg, 'Families, Not Orphanages', Better Care Network (BCN) Working Paper, BCN, September 2015.

³ Rubenstein, Beth L., et al., 'Measuring Movement into Residential Care Institutions in Haiti after Hurricane Matthew: A pilot study', *PLOS ONE*, vol. 13, no. 4, 2018.

⁴ Adapted from United Nations Children's Fund, 'Draft Guidelines for the Production of Data on Violence against Children', UNICEF, New York, 2018 (unpublished).

2.2. Establishing a management and coordination structure

The success of the mapping and enumeration exercise is dependent on the collective effort and motivation of many national and local child protection actors, including government. Government leadership is fundamental to successful efforts to enumerate children living in residential care. Government commitment and ownership are necessary at all levels of engagement since political support is essential to gain permission to access facilities. Political support is also needed to secure endorsement for the resulting data/statistics to ensure effective use of the findings. Ideally, these will be used to improve and enhance systems that monitor and protect children in residential care facilities.

The following recommendations are intended to ensure that the protocol is adapted and implemented in ways that produce data and results that are accurate and endorsed by the appropriate government bodies.

2.2.1. Technical working group

A multisectoral in-country technical working group should be established at the outset. The group will guide and support adaptation of the standard study protocol to ensure reliable and contextually appropriate data collection and utilization of the findings. It will also be responsible for: defining the purposes for which the data will be used, establishing partnerships, generating political support for the exercise, ensuring the proper adaptation of the standard study protocol and appropriate customization of the tools, identifying potential key informants, creating a custom ethical referral protocol, securing necessary permissions for data collection, providing technical and strategic inputs during implementation as needed, supporting dissemination of the findings and guiding the programmatic and policy responses to the findings.

2.2.1.1. Membership

A suitable leading government agency, such as a ministry or mechanism, should be identified to oversee and chair the technical working group. Ideally, this will be the government agency or ministry that has the lead mandate on alternative care and regulatory authority in the country. If this option is not feasible, then an appropriate lead could also be a national body, institution or mechanism that has been involved in the implementation of previous national exercises or has led previous efforts to enumerate children in residential care. It is important, however, that that body has the necessary political influence and ability to serve as a convening party to organize and coordinate stakeholders. This body will also be responsible for providing substantial input into the development of a customized ethical referral protocol that outlines planned actions to undertake in situations or cases observed or reported during fieldwork that require an immediate response. This body will also be responsible for endorsing and leading the release and dissemination of the results and engaging stakeholders and partners in incorporating recommendations into actions going forward.

The rationale for having the ministry (or ministries) with regulatory authority as the leading government agency and chair of the working group is that it has a legal obligation and mandate to oversee and regulate residential care within a country. In addition to providing technical input, this ministry will play a key role in notifying facilities and supporting data collection teams to gain access. Additionally, it is crucial that the ministry be involved from the outset and endorse the results, given that it will be accountable to take action and (ideally) use the resulting data to build a routine administrative system for record-keeping and, eventually, case management.

The rest of the working group should be composed of a wide range of relevant stakeholders, including those with technical expertise as well as those who may have institutional influence. They may include representatives from other relevant government agencies/ministries, government task forces or working groups with child protection or alternative care directives, NGOs working in child protection, relevant civil society organizations and academic institutions with expertise in data collection and use relevant to alternative care. The national implementing agency (see section 2.2.2) will also be a key member of the group. Engaging senior-level representatives from ministries, international and national NGOs and community organizations may help increase the reach and quality of the data collection and results.

2.2.1.2. Terms of Reference

A Terms of Reference (TOR) for the technical working group should be drafted by the leading government body to formally establish the structure and composition of the group. The TOR is an important step in establishing the management structure of the exercise since it provides a clear overview of roles and responsibilities and activities throughout the stages of planning and implementation. The TOR should clearly identify the objectives and major tasks of the group overall and delineate the roles and responsibilities of individual members. The TOR should also specify how frequently the group should meet and the administrative supports provided to the group. It may also outline group deliverables and a timeline of activities. Refer to [Annex B](#) for a sample template for the technical working group's Terms of Reference.

2.2.1.3. Frequency of meetings

The leading government body and members of the technical working group will need to determine how often the group will meet to complete the tasks and fill the responsibilities outlined in the TOR. The frequency of meetings should be guided by the planning and implementation timeline and also allow for the time required by members to progress on their individual responsibilities. Regular meetings may help to facilitate broad ownership of the findings and may be more frequent during the peak of the planning and adaptation stages.

2.2.1.4. Additional considerations

The leading government agency and members of the technical working group should identify focal persons to assist the group with administrative functions, such as organizing and scheduling meetings, preparing agendas, sending out invitations, photocopying and printing materials, preparing and circulating meeting reports, and keeping records of the group's documentation. In some contexts where members of the working group are unable to provide the human resources to fulfil the necessary administrative functions, a national facilitator/consultant may need to be hired to support the process and ensure timely implementation. In this case, the members of the working group should draft the TOR for the consultant. Refer to [Annex B](#) for a sample template for Terms of Reference for a facilitator/consultant to support the work of the technical working group.

In some contexts, an international organization or NGO with proven capacity in providing technical support to large data collection activities such as national household surveys may be called upon to support the leading government body in oversight and coordination of the exercise. That same body could also provide technical support and assistance with quality assurance and for analysis and interpretation of findings. However, it is vitally important that the technical working group, and its government members in particular, maintain control and ownership of the data produced as well as the data collection process, analysis and use. Support from an international organization or NGO may be necessary, but its role should clearly be for support rather than leadership.

Depending on the situation in the country, it may or may not be necessary to establish a Memorandum of Understanding (MOU) between the technical working group and the national implementing agency. If an MOU is required, refer to [Annex C](#) for a sample template.

2.2.2. National implementing agency

A national implementing agency/partner is needed to support the technical aspects of project implementation. It is important that the partner be objective and have extensive technical knowledge for conducting rigorous, large-scale data collection exercises such as a census or household survey. For these reasons, it is strongly recommended that the national implementing partner be the national statistics office, whenever feasible. An advantage of having this office lead implementation is the possibility of creating sustainability for inclusion of this type of population in future census rounds. If it is not feasible for the national statistical office to act as the direct implementing agency, then another government agency or academic/research institution with demonstrated ability in successfully conducting rigorous, large-scale data collection exercises could be considered for this role. In such instances, the national statistical office should be invited as a member of the technical working group, as a minimum, in order to review the methods used and endorse the findings as official statistics for the country (even if data are only being collected at the subnational level).

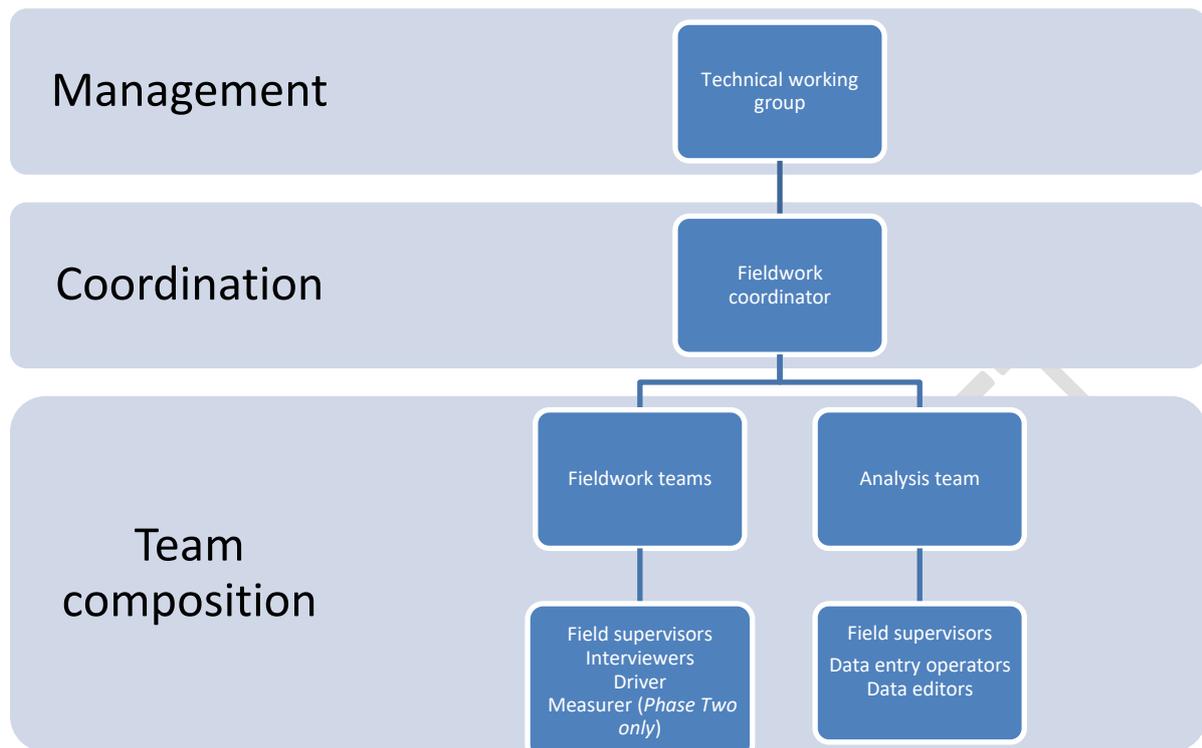
Within the chosen implementing agency, a fieldwork coordinator should be assigned. Ideally, this person is a full-time staff member of the implementing agency and is responsible for overseeing and managing the overall field implementation, including scheduling fieldwork in accordance with the timeline established in collaboration with the technical working group. The coordinator will direct field teams to specific geographic locations, review ongoing reports of data collection and quality assurance procedures, and support the logistics of data collection. The coordinator should have demonstrated experience in large-scale data collection efforts and strong technical knowledge of field practices and implementation methods. If the implementing agency does not have available full-time staff with the capacity to fulfil this role, a consultant with strong technical skills in survey implementation and fieldwork organization could be recruited.

2.2.2.1. Roles and responsibilities

The implementing agency will be responsible for supporting the work of the technical working group through both the preparatory and implementation phases. Activities include creating the sampling plan, recruiting and training enumerators, conducting pilot testing as well as actual field data collection and supervision, data entry and processing, and leading the data analysis. It is recommended that the implementing agency be a member of the working group and provide regular reports to the group on progress of the different activities throughout the implementation phase, as well as to any relevant government task forces and partners for additional inputs when needed. The implementing agency will also participate in adapting the study protocol, interview guides, and training materials, as necessary, and undertake the translation and back-translation of relevant materials.

Figure 2 provides a visual representation of the management and coordination structure described above.

Figure 2. Management and coordination structure for protocol implementation



2.3. Preliminary consultation of the technical working group

Once the management and coordination structure has been formally established, and members of the technical working group as well as the national implementing agency have been identified, a preliminary consultation should be organized with the following objectives:

- Discuss and reflect on the data needs and political/logistical context of the country, including the longer-term vision for how the results can feed into (or form the basis for establishing) a national system for monitoring residential care facilities and case management for children living in residential care
- Review and become familiar with the standard protocol and tools for both phases of data collection
- Discuss and agree on necessary adaptations and customizations of the standard protocol definitions and inclusion criteria
- Discuss, review and agree on the content of the standard tools for Phase One
- Discuss, review and agree on the content of the standard tools for Phase Two
- Discuss and agree on roles and responsibilities and timeline for developing an ethical protocol and submission to an institutional review board
- Discuss and plan for key informant interviews

- ❑ Discuss and agree on a feasible timeline for data collection.

It is recommended that the consultation be scheduled over two days as a minimum and should include participation from members of the technical working group (particularly management and decision makers from the lead agency and the implementing body). [Annex D](#) contains sample PowerPoint slides that can be adapted and used for the preliminary working group consultation.

2.4. Budget

Developing a detailed budget is an essential step in planning for the implementation of this protocol. The careful planning and monitoring of the budget will improve the organization of the exercise and the quality of the data and inform sampling strategies for the follow-up survey. Large-scale data collection exercises such as this are expensive to conduct, especially in countries where they are being implemented for the first time and at national scale. Budgets will differ among regions and countries of implementation, depending on the associated costs and local conditions. Reviewing budgets from similar efforts can be helpful and informative.

Major costs associated with both phases of data collection include those related to design and preparation, data processing and analysis, reporting and dissemination of results, and technical support costs at all stages of the process. If it is decided that respondents will be compensated in the form of gifts or snacks, these should be factored into the budget as their own line item. Even with careful planning, revisions will likely be necessary, and unforeseen and emergency costs should also be included in the budget.

Another significant factor affecting the cost of this exercise is the chosen mode of data collection. The data for this exercise may be collected through in-person interviewing using paper questionnaires or personal electronic devices such as smartphones, tablets or laptop computers; each choice has its own procedural and cost implications. Costs associated with paper questionnaires include printing costs, which tend to be high, as well as staffing costs for field editors and data entry personnel. More information on the recommended mode of data collection for implementing this protocol can be found in section 3.3.

It is also important to clarify the required software needs early in the budgeting process. For instance, CAPI methods of data collection require a data entry platform that can be programmed into an existing software application such as CSPro. This requires a period during which a computer programmer is needed to adapt the existing standard CSPro application; it may also have high equipment costs in situations where large quantities of devices need to be purchased. For more about data entry programming and applications, see section 5. Other software needs pertaining to the development of a case management platform or establishment of a registry or database for regular updating are beyond the scope of this exercise but would need to be separately considered at a later stage as a follow-up to this exercise.

Table 3 outlines general budget items for consideration, organized by phase of activities. It is not intended as an exhaustive list since each setting will be different. A more detailed template for budget calculations is included in [Annex E](#).

Table 3. Budget items for consideration

PERSONNEL	
Fieldwork coordinator	Administrative assistant
CAPI software programmer	Data analysts
Research assistants	Translation services
Driver(s)	
CARTOGRAPHY	
Enumerators	Supervisors
Drivers	
PHASE ONE ACTIVITIES	
Training staff	Training assistants
Field supervisors	Field interviewers
Field team drivers	
PHASE TWO ACTIVITIES	
Training staff	Training assistants
Anthropometry trainers	Field interviewers
Field supervisors	Field anthropometry measurers
Field team drivers	Anthropometry equipment
DATA PROCESSING AND ANALYSIS	
Data entry (<i>not applicable if CAPI is being used</i>)	Data processing
Data analysis	
REPORTING AND DISSEMINATION	
Reporting the findings	Launch event
Dissemination of results	
ADDITIONAL NON-SALARY COSTS	
Food	Accommodations
Equipment repairs	Office or meeting space
Postage	Fuel

Field communication costs	Vehicle maintenance
Printing, copying	Bag, hats, t-shirts, stationery for field teams
Venue hires	Training materials
EQUIPMENT COSTS	
Computers	Tablets/smartphones
Car chargers	Anthropometry boards
Scales	First aid kits
Information technology resources	

The expansive nature of Phase One objectives – to undertake a complete census by visiting all residential care facilities and counting all children living in them – requires a prolonged period of fieldwork during which personnel, training and logistical costs are high. Budget constraints should be carefully considered since these could impact the sampling strategy for Phase Two of data collection for the follow-up survey.

2.5. Timeline

The technical working group should create a detailed list of activities to be completed in each phase of the exercise. Responsibility for these tasks can be assigned to various members of the group, and this assignment should take into consideration their existing workload and commitments outside of the working group. Creating a timeline is a useful exercise to help maintain control and manage expectations over the entire life of the project. Activities in the timeline are likely to occur simultaneously, and it is important that each component is allotted sufficient time to be completed. The academic calendar should be considered when planning the timeline to ensure that children are present at residential care facilities and available to be counted. For example, children who normally live at a residential care facility during the school year may be difficult to locate if they travel during school breaks or holidays. Alternatively, older adolescents residing in facilities could be absent for periods of time to attend secondary school or vocational training.

For a template of timeline activities to assist in planning, see [Annex F](#).

SECTION 3: DESIGN PHASE

3.1. Operational definitions and inclusion criteria

When doing research and collecting data, it is important to operationalize conceptual definitions to clarify exactly what types of facilities will be included in the census. There are several key considerations for deciding what kind of facilities will qualify as providing residential care within any particular setting. The definition of a residential care facility used in the UN Guidelines on the Alternative Care of Children is very inclusive, meaning that a wide range of facilities may qualify. In some cases, facilities that provide education or health-care services, including boarding schools or religious homes, mental health facilities or those that provide care exclusively to children with disabilities, may also qualify as residential care facilities.

The operational definitions used in this protocol for residential care facilities and residents can be applied across contexts for the purpose of implementing this data collection exercise. The protocol is based on the following operational definitions that were drafted to align with definitions of residential care set forth in the UN Guidelines:

1. Residential care facility: a non-family-based group setting with paid or unpaid staff where some children live and receive care
2. Resident: someone who lives and receives care in a residential care facility.

These definitions are intentionally broad and are intended to help countries determine, at a very basic level, what to consider as a residential care facility and who should qualify as a resident. The purpose of establishing some predefined criteria is to ensure some level of comparability across countries while still allowing for. Therefore, this approach allows for a certain amount of country customization in deciding which types of facilities to ultimately consider and how residents are defined. For example, one country could decide to classify boarding schools as residential care facilities for the purposes of their census, while another could choose to exclude them. In this way, no decision is made *a priori* as to exactly which types of facilities should be included in the census. However, following the Guidelines, it is recommended that settings such as correctional or detention facilities not be classified as residential care facilities. This decision was made in light of the fact that children in these situations represent a distinct population that have been deprived of their liberty by a judicial or administrative authority as a result of having been accused of, charged with, arrested, or found guilty of having infringed the law.³⁷ The decision of whether to include facilities offering emergency or temporary housing should also be carefully considered in view of the country context, since, in some instances, children may end up staying in such places for extended periods of time. It is recommended that decisions regarding which facilities to include should be more inclusive (as opposed to more restrictive) in order to minimize the risk of missing out on some segments of the institutionalized population of children.

That said, the precise definition of a residential care facility, and the types of facilities included, will inevitably vary from country to country. However, the underlying principle of what it means to be a residential care facility (as operationally defined above) remains more or less the same. In other words, the census of facilities should capture all those places that are non-family-based group settings with at least some paid or unpaid staff and some children living and receiving care. The concept of 'living and receiving care' is left somewhat open to interpretation but is generally thought

to reflect situations where children are sleeping overnight and receiving some kind of care or service such as meals.

When it comes to determining whether individuals are considered residents of the facility, the general underlying principle should be to consider where the person (in this case, the child) usually lives/resides and receives care. The idea is to capture usual residents of the facility; in other words, the *de jure* population of children living in residential care facilities.

3.2. Adaptation of the standard protocol

The content of this protocol is intentionally generic in nature in order to allow for adaptation and use across a variety of country contexts. Therefore, an essential part of the design phase will be to take this standard protocol and use it as a basis for developing a country study protocol that includes necessary adaptation to the local context. The process of adapting this protocol should ideally be led by the technical working group that was established as part of the preparatory phase (see section 2.2.1), with involvement and input from all collaborating partners. This process can be lengthy, and sufficient time should be allocated in the timeline for this step of the design phase. While this protocol aims to be as comprehensive as possible, additional information or other elements may need to be detailed in the country study protocol, depending on local context.

3.2.1. Customization of questionnaires/tools

It is critical to customize the tools included in this standard protocol to make them appropriate to the local context where the data collection will be conducted. The process of customization will require the careful review of each of the tools in order to make changes to questions and answer choices that reflect cultural references and contextually relevant definitions. When beginning the process, it is important to keep in mind the specific data needs and available data on children living in residential care as well as the priorities of previous data collection efforts involving children in residential care facilities (where these exist). Adapting the tools in line with these considerations ensures that questions asked are both understandable and culturally appropriate. It is also critical that the tools be pilot tested before being finalized for data collection (see sections 4.2.3 and 4.3.4 for details on pilot testing). Pilot tests should take place after customization of the tools has been completed. Careful attention should be given during the pilot to any changes resulting from the customization process. Once adequately tested, revised and finalized, it is strongly recommended that no more changes be made to the tools, particularly in the event that CAPI is being applied as the mode of data collection. Making changes to the tools after teams have begun data collection risks degrading the quality and comparability of the data collected across facilities.

All adaptation should be done according to the standard principles and approaches included in this protocol to ensure the uniform application across all tools as well as to maintain the global comparability of the data being collected.

The standard data collection tools included in the protocol are:

Tools for fieldwork preparation

- Facility Database

- Key Informant Interview
- Cartography Form

Tools for Phase One

- Facility Questionnaire
- Facility Roster
- Verification Count and Record Review
- Facility Observation Checklist

Tools for Phase Two

- Child Listing for Phase Two
- Questionnaire for Children under 5
- Questionnaire for Children Aged 5-14
- Questionnaire for Adolescents Aged 15-17
- Questionnaire on Children's Case History

The standard tools will typically need to be adapted to reflect three types of potential changes:

1. Country-specific modifications to answer choices and, to a lesser extent, questions (that is, customization)
2. Deletions from the standard tools
3. Additions to the standard tools.

Annex G includes a detailed outline and description of the major changes and modifications to the standard tools that must be customized across all countries. These changes may include a context-specific recall period that helps respondents provide more focused responses and makes the resulting data analysis more meaningful. Similarly, for some questions, the response options will need to be examined to ensure that the available choices are applicable to the respondents and provide adequate coverage of common expected responses. In countries where previous exercises to collect data on children living in residential care facilities have been conducted, it may be useful to refer to existing tools or questionnaires to see how questions or response options were adapted to the country context. Alternatively, it may be appropriate to either delete or add questions or variables from the standard tools and questionnaires included in this protocol. Determining what to include and exclude is a delicate balancing act and should be undertaken with great care and consideration by the members of the technical working group.

In Phase One, countries should consider customizing the Facility Observation Checklist in particular to add components that are covered in existing national tools for inspecting or monitoring residential care facilities. In such cases, the results of the Facility Observation Checklist can then be compared against, and used as a means of verifying, national inspections/monitoring visits.

While it is necessary to adapt the tools provided to the specific setting of implementation, it is equally important to retain the integrity of the tools and the wording and ordering of the questions, whenever possible. To maintain the integrity of the tools, they should not be considered in isolation of one another, and all changes to variables and response options should be made uniformly across

all tools/questionnaires, when appropriate. If questions require rewording for translation purposes, the concept of the question must be retained (see section 3.2.2 for more on translation).

The content of the tools is not comprehensive and some important topics for assessing child well-being (such as exposure to violence and neglect) are not included due to lack of available standardized and validated measures. It may be tempting to add new modules or questions to collect data on other issues not covered in the tools. However, this should be done with great care and caution since there is no guarantee that the resulting data will be reliable or robust unless the new questions/modules have undergone a rigorous process of testing and validation.

3.2.2. Translation

Adapting this protocol will almost always include the translation of the data collection tools into one or more languages. This is often a difficult and time-consuming task and requires an expert translator who has familiarity with both data collection methods as well as with related alternative care terminology, when possible. Respondents should ideally have the opportunity to be interviewed in their primary language to maintain high data quality. In countries where there is language diversity across regions, tools should be translated into the local official languages.

Translators should have a thorough understanding of the intended meaning of each of the questions in the questionnaires before beginning the translation process. The aim is for the questionnaire to be conceptually equivalent across translations, ensuring that the concepts being measured are the same, even if different wording is being used. Once translated, the tools and questionnaires should be reviewed by a panel of members of the technical working group to identify inadequate translations or issues and suggest alternatives. Once there is a solid draft of the translated tools and questionnaires, these should be back-translated into English by an independent translator or someone who has no prior knowledge of the tools. Discrepancies between the translated and back-translated tools and questionnaires should be resolved by the panel to avoid, or at least minimize, field translation by interviewers.

Translations and their review need to be very carefully undertaken. The questionnaires have been designed to measure particular aspects of facilities and child well-being and changes to the content or meaning of the questions should be avoided as much as possible. The opportunity for field/spontaneous translation by interviewers should be minimized through exhaustive translation, since even small differences in interpretation of a question can significantly reduce the reliability and validity of the data. A detailed record of all translations, customizations and revisions of questions should be retained.

3.2.3. Developing an ethical protocol and response plan

It is necessary to develop a customized ethical protocol to outline planned actions that will be taken in situations observed or reported during fieldwork that require an immediate response. It is possible, for example, that during data collection fieldwork teams will encounter potential cases of abuse or neglect or may believe that children in the facilities are at imminent risk of harm. Additionally, since Phase Two involves direct interviews with adolescents between the ages of 15 and 17 years, it is critical to have a response plan in place to ensure that those expressing a desire for assistance can be confidentially provided with information and/or direct service referrals.

Since some of the questions included in the Questionnaire for Adolescents Aged 15-17 are personal and very sensitive in nature. For this reason, there is a short script at the end in which the interviewer is required to give the respondent a Service Information Card. The card includes the phone numbers of local services or organizations that can be contacted in case the respondent would like to speak with someone. These services will need to be identified in consultation with the technical working group and should ideally be free of charge and available/open 24 hours a day, 7 days a week (including holidays). Additionally, the script asks respondents if they would like to be linked directly to professional services (that is, have a direct referral to services). In the event that the respondent expresses a desire for this, the interviewer will record some details on the best and safest way and time to have professionals contact the respondent to follow up.

To guide the development of this ethical protocol, [Annex Q](#) provides some general considerations along with a recommended sample response plan. Annex Q also includes a list of some potential red-flag situations or conditions resulting from administration of the Facility Observation Checklist that would warrant immediate attention or action. The procedures for following up in such situations should be developed and customized at the country level.

3.2.4. Risk management³⁸

Thoughtful and careful budgeting and advance planning will help mitigate challenges to the implementation of this protocol. Even so, it is important to be as prepared as possible for issues that may arise during data collection.

Table 4 provides a list of potential risks to protocol implementation and suggested strategies to manage them. During the process of adapting the standard protocol, the table should be reviewed and revised – or customized as necessary – for the specific country context by inserting potential risks and strategies to mitigate these and by indicating who is responsible for following up on each item. The national implementing agency should develop this table in collaboration with the technical working group. The risk management strategy should be finalized and included as part of the ethical review process.

Table 4. Potential risks in implementing the protocol and possible risk-management strategies

Risk	Strategy for risk management	Responsibility
The presence of military or other authority figures are potentially affecting respondents' answers	Field supervisor negotiates the presence of the military escort and/or authority figures in such a way that will minimize any potential intimidation.	Field supervisor
Limited or no privacy (for example, supervisors or authority figures are in direct proximity to the interviewee)	Interviewers can ask to relocate to a more private space. In the case of administering the questionnaire for adolescents, privacy must be ensured. If this is not feasible, then the interview should be discontinued.	Interviewers Field supervisor
Data on respondents are shared (breach of confidentiality)	Field supervisor discusses individual cases with the interviewers. Retraining on confidentiality may be necessary.	Field supervisor

Hard copies of questionnaires are not stored in a secure location by field supervisor	Hard copies should be moved to secure location. All paper questionnaires are submitted to the field supervisor at the end of the day. Field supervisors submit hard copies to the national coordinator at a specified time. The national coordinator destroys paper questionnaires after the launch of results and final report.	Field supervisor National coordinator
Electronic devices, including those used for data collection, laptop computers, and hard drives are not stored in a secure location	Identified data are kept in a password-protected file. Data are de-identified when processed at the national level.	Field supervisor National data processing team
Interviewers know respondents	Field supervisor reassigns respondent to new interviewer.	Field supervisor
Communities or participants have complaints about the data collection	Concerns will, if possible, be addressed directly by interviewers and supervisors, then by the national coordinator.	Interviewers Field supervisor National coordinator
Denial of access to facility	Active participation and mobilization by ministries and relevant national stakeholders is a high priority and may help to mitigate potential access issues. The technical working group should consult with partners across various levels of government to facilitate access to facilities.	Field supervisor National coordinator Technical working group
Retaining interviewers between Phase One and Phase Two of data collection	Interviewers and field supervisors should be retained as much as possible across phases of pilot testing and main fieldwork. It is recommended that interviewers and field supervisors for Phase Two have prior experience working in Phase One implementation to reduce the need for retraining at Phase Two.	Field supervisor National coordinator National implementing body
Fieldwork teams are offered gifts (including food) by the facility	Field supervisors should politely decline and suggest that the offerings be saved instead for use/consumption by the children and staff.	Field supervisor
Members of the fieldwork team are asked (or feel inclined) to share personal contact details with facility staff or children.	Members of the fieldwork team should not give out their personal contact information to anyone involved in data collection (staff or children). It is advised to train members of the fieldwork team to instead offer the contact information of the national coordinator or appropriate organization within the technical working group should any participants wish to speak with someone further.	Field supervisor Interviewers

3.2.5. Approval by an ethical review committee

All research involving human subjects must receive approval by an independent ethical review committee prior to the start of data collection. This is to ensure that the research is well designed and that the risks to the participants are minimized across all stages of the research process. The country study protocol (adapted from the standard protocol presented in this manual) and the accompanying customized tools and training materials should be submitted to the relevant national ethical review committee. The national mechanisms governing the use of human research subjects varies across countries, ranging from a well-established national ethics committee to a university-based ethics review board. In countries where there is no national ethics committee/review board, this could be handled by an external or international ethical review committee (as was the case in the Kazakhstan testing). The specific criteria or documentation required by review committees should be understood prior to submission to ensure that adaptation of this standard study protocol complies with review board requirements. Once approved, the research should strictly adhere to the methods and procedures specified within the submitted country study protocol. Any modifications made after the approval has been given should be resubmitted in writing.

3.3 Determining the mode of data collection

The members of the technical working group and national implementing agency will need to choose between paper-and-pencil questionnaires or CAPI (computer-assisted personal interviewing) as the mode of data collection (see section 1.5 for an overview of the advantages and challenges of each). When making this determination, it is important to consider the available budget and timeline of each country context (see sections 2.3 and 2.4), but it is generally advised that CAPI is utilized whenever possible.

Electronic data collection is preferable because it streamlines many of the quality assurance processes, such as automatic skip pattern programming, and the immediate availability of data allows for ongoing quality and validation checks, including tabulations that can be produced quickly and easily. CAPI also reduces the chances that data entry errors will be introduced by eliminating the need for data entry personnel. While electronic data collection may be more efficient after data collection has begun, the necessary electronic equipment is costly since, in general, a national data collection exercise will require a large number of devices. Also, populations that are unfamiliar with personal electronic devices may require additional training time before they are comfortable using them. Countries choosing this method of data collection will need to build in additional time to adapt the existing CSPro data application into their timeline.

Paper questionnaires can be developed quickly and at a comparatively lower cost but require data entry and cleaning prior to analysis, which may be time consuming and costly and introduces opportunities for data entry error. Paper questionnaires may also be cumbersome and more difficult to keep track of, making their transport to and from the field more challenging. In addition, the use of paper questionnaires may also require the addition of a field editor to the field team. Moreover, the data are only available for analysis and automated quality checks once the data entry operators have entered and cleaned the data, which may be weeks or months after the completion of data collection.

More information on the budget and training implications of each mode of data collection may be found in the preparatory phase (section 2.3) and the implementation phase (sections 4.2 and 4.3).

3.4 Selection and recruitment of a field staff pool

The national implementing agency will need to recruit and select individuals to be invited to take part in training. The process of recruitment and selection will differ between countries depending on the existing capacity of the implementing agency. In some situations, the implementing agency may decide (or need) to recruit an entirely new set of staff for fieldwork. In others, they may be able to select from an existing pool of staff that have been involved in previous data collection efforts or from those who are currently on payroll.

In cases where recruitment needs to take place, individuals may be recruited through advertisements in newspapers or online. Other potential sources for identifying qualified candidates could include local research or academic institutions. Word of mouth can also be an effective way of finding candidates. However, this approach should be undertaken with some degree of caution since it may result in pressure to hire certain individuals who have personal contacts with those responsible for recruitment.

An objective set of requirements, based on those outlined in Box 5, should be developed and transparently applied. It is equally important that all applicants that meet the requirements are interviewed and tested as part of the selection process, and this requires advance planning. Simple testing can be applied (for example, if the candidate reads well, writes correct answers to simple questions, and can communicate in whatever languages are necessary). If CAPI is being used, there is a further need to at least check if candidates can operate simple functions in a tablet computer. Advanced computer literacy is not necessary, but a certain comfort with computers or smartphones is valuable.

Approximately 10 to 20 per cent more people than necessary for fieldwork should be selected for training alongside the main cohort of recruits and should meet the same characteristic and capability requirements.³⁹ This will ensure that there is a suitable and qualified reserve pool of field staff who are available to fill in for those who drop out, do not complete the training, or are dismissed during data collection.

Box 5. Recommended criteria for members of the field team

1. Recommended demographics
 - a. Teams should be comprised of both female and male team members
 - b. Interviewers and supervisors should not conduct interviews in areas where they know the community members since this may jeopardize the confidentiality of the respondents
2. Preferred skills
 - a. Fluency in local languages necessary for interviewing
 - b. University education for national coordinator and field supervisor positions
 - c. Previous research experience
 - d. Attitude
 - Friendly, eager to learn and hardworking
 - Responsive to feedback
 - Does not engage in aggressive or abusive behaviour
 - Respectful towards respondents and community members
 - Committed to following the study protocol
 - Physically fit (that is, the ability to walk long distances)
3. Highly recommended
 - a. Ability to read and write fluently in English and count accurately
 - b. Familiarity with smartphones.

Source: Adapted from United Nations Children’s Fund, ‘Draft Guidelines for the Production of Data on Violence against Children’, UNICEF, New York, 2018 (unpublished).

3.5 Technical workshop on implementation and data collection

Once some of the preliminary preparations have been completed (adaptation/customization, translation, ethical protocol and submission for ethical approval, identification of national coordinator, initial identification of potential members of fieldwork teams), a more technically focused workshop should be organized to discuss and plan for implementation. The key objectives of this workshop should be to:

- Finalize customization of Phase One questionnaires and tools
- Finalize customization of Phase Two questionnaires and tools
- Discuss strategies for mitigating potential access issues to facilities
- Discuss and plan for the verification cartography (if relevant)
- Discuss and plan for implementation of Phase One
- Discuss plans and timeline for developing a sampling plan for Phase Two.

It is recommended that the consultation be scheduled over three days as a minimum. It should include participation from: the fieldwork coordinator, field supervisors, sampling experts, data processing/information technology (IT) experts and other technical experts from the implementing agency, and technical experts from the technical working group lead (that is, the mandated authority), as relevant.

3.6 Developing the census frame of all residential care facilities

The national implementing agency, in consultation with the members of the technical working group, should compile an initial listing of known residential care facilities by reviewing existing records, available regional and/or national listings of facilities, and any previous data collection efforts to list or map facilities in the country. Any available lists of registered or unregistered facilities from local and national government should be consulted, but this information will need to be supplemented with key informant interviews to identify facilities that are unknown to government.

It is expected that the initial list will include a broad range of potential facilities, including, for example, orphanages/institutions, group homes, religious group quarters, boarding schools and other facilities where children may reside. It is important to include facilities that have children with disabilities if these conform with the chosen operational definition.

The information obtained by reviewing existing lists and records and conducting key informant interviews should be compiled into a master list of all known facilities that will comprise the census frame using the Facility Database. Once the master list has been compiled, separate lists of all facilities within a region/district/province should be created so that these can be provided to fieldwork teams in conducting the verification cartography.

The importance of ensuring that the listing of facilities is complete and accurate cannot be overstated since it will serve as both the frame for Phase One and used to draw the representative sample for Phase Two. Sufficient time should be dedicated to compiling and verifying the facility list.

In countries with a large number of residential care facilities, or areas where there are many unregistered facilities, it might be necessary to consider some alternate strategies for creating the census frame. Also, there might be a desire to draw a sample of residential care facilities for Phase One as opposed to undertaking a full census. If there is an existing list/database of registered residential care facilities, the sampling procedures using stratified sampling with probability proportionate to size (PPS) selection is relatively straightforward and will result in the selection of a probability sample so standard weights can be calculated. In this case, it would be necessary to develop a separate frame to draw a sample of unregistered residential care facilities. Another possibility for the unregistered facilities would be to utilize an area frame, where enumeration areas or other primary sampling units (PSUs) are selected at the first stage and a listing is then conducted in the sampled PSUs to identify unregistered residential care facilities for the second sampling stage. This approach would also generate a probability sample (of unregistered residential care facilities) that would be independent of the registered facility frame, so it should be possible to calculate appropriate weights. However, such a listing is likely to be costly and time-consuming. Therefore, this approach would need to be carefully considered in light of the available budget and timeline.

Tool: Facility Database

3.6.1 Key informant interviews

Because it is possible that some facilities providing residential care services will remain unaccounted for in existing registries or databases, key informant interviews should also be conducted to inquire

about the names and locations of any facilities housing children under age 18 in an attempt to identify and capture any additional unrecorded or unregistered facilities. In order to do this, interviewers will show respondents a complete listing of all facilities included in the census frame and ask them whether they are aware of any other facilities where at least some children reside.

Key informants should have significant knowledge on the population of interest. Relevant national stakeholders, regionally based NGO staff, and public health, social services, faith-based organization and law enforcement officials should be considered for interviewing. It is recommended that at least some residential care facility directors or leadership be approached as key informants as well. A list of potential key informants should be generated by the technical working group as part of the planning and preparation phase.

Tool: Key Informant Interview

3.7 Contacting and informing facilities

It is expected that there will be some variation in terms of which bodies have regulatory authority over residential care facilities in any given country. In certain contexts, there may be more than one government ministry mandated to oversee and regulate residential care, or local authorities may have regulatory power over some facilities. Other potential regulatory authorities could include faith-based or religious organizations or NGOs. And some facilities may exist without any type of regulation or oversight.

Prior to undertaking the verification cartography or any of the data collection activities, the relevant regulatory body or bodies (ministries or other appropriate authorities) should send a notification (in writing) to all those facilities listed in the Facility Database (to the extent possible) over which they have authority and jurisdiction. If there are unregistered or unregulated facilities in the census frame and Facility Database, then the government ministry with the mandate for residential care in the country should send the advance notification letter. The purpose of the letter is to inform facilities of the general purpose and overall timeframe of the data collection exercise. It should not reveal too many details that could potentially bias the results in some way by giving facilities an opportunity to alter the conditions in the facility. See [Annex H](#) for a template for the facility notification letter. This template should be used to develop separate notification letters for Phase One and Phase Two.

It is important that facilities are informed in advance of the intended objectives of the data collection. They should also be reassured that this is not a formal inspection or assessment of the facility and that the results will not be linked in any way to determining the facility's registration or licensing status. This is particularly important in the case of unregistered or unlicensed facilities that might otherwise mistake the data collection as an attempt to inspect the facility with the objective of shutting it down.

Additionally, a critical lesson learned from the pilot testing of the protocol and tools was the need to give facilities some advance notice about the types of documents and materials needed for Phase One data collection, in particular the existing registry/record book as well as children's individual case files. Ensuring that facilities have at least been notified that these documents will need to be accessed in advance can greatly facilitate the data collection process.

It is expected that finding an entry point to some types of facilities and unregulated residential facilities may prove especially challenging. However, it is critical that these are included since, ideally, all centres should be registered with some type of regulatory body, preferably the ministry with this mandate. Therefore, this exercise can serve as a useful starting point for identifying and locating these kinds of facilities and form the basis for recommendations about registration and regulation of facilities in the country.

3.8 Verification cartography

The cartography exercise will take place after an initial listing of all residential care facilities in the country has been compiled as the census frame. Cartography teams will conduct a cartography of facilities to verify the physical location and/or address and GPS coordinates of each facility included in the census frame. They will also determine whether a facility meets the basic eligibility criteria for inclusion in the census (that is, at least some children are living in the facility).

As a general recommendation, cartography teams should be comprised of supervisors, interviewers, mappers (if needed, see below) and drivers. Depending on the geographic area to be covered, there should either be one supervisor per team (if large geographic areas are to be covered) or one supervisor to manage two teams (if smaller geographic areas are to be covered).

Local representatives of the relevant regulatory body should accompany cartography teams, if feasible, in order to facilitate contact and access to the facilities. These representatives may help ensure that cartography teams are not turned away. The government ministry with the mandate for residential care in the country could designate a local representative (if one does not already exist) to accompany cartography teams. This approach can serve to encourage the relevant ministry to assume a stronger role in overseeing and regulating all facilities, including those previously unknown or unregulated.

If physical (hard copy) maps are being used instead of GPS, it will be necessary to also train and hire both mappers and mapping editors/administrators to manage and compile maps received from the field.

The expected duration of the verification cartography depends on a number of factors: the number of facilities included in the census frame and their geographic distribution throughout the country, the anticipated number of facilities that each team can list in a day, and the total number of teams. Similarly, the required number of cartography staff depends on the number of facilities included in the census frame and their geographic distribution, the total number of teams, and the expected duration. Once the total number of cartography staff has been estimated, it is recommended to plan to train roughly 10 per cent more individuals than needed in case some need to be replaced. [Annex J](#) includes a template for calculating the duration and number of cartography staff required both for training and implementing the verification cartography.

Cartography teams should visit each facility included in the census frame to verify the location/address and record GPS coordinates, if possible, or physically mark the location of the facility on a map. Additionally, they should establish contact with the facility and identify who is considered to be the most knowledgeable person there (most likely the facility director or most senior staff member). It is necessary to allow sufficient time at the start of the visit for a brief

introduction/meeting with the facility director or other relevant staff to share some basic information about the overall project and remind him or her of the upcoming data collection, referencing the facility notification letter he or she should have received in advance.

Assuming that verbal consent from the facility director or other designate is obtained (as described in the Cartography Form), the team will also try to confirm if children are living in the facility in order to establish eligibility. The cartography will also serve as an opportunity to administer the Key Informant Interview to the most knowledgeable person in each facility as a way to identify any additional facilities that should be included in the census frame.

Before leaving, the team should notify the most knowledgeable person that a data collection team will return for further activities sometime soon. This can be a good opportunity to remind him or her of the general timeline for data collection in terms of when to anticipate a team to return and to request that the facility prepare the necessary documents (registry/record book and children's case files) in advance, if feasible (as mentioned in the closing script of the Cartography Form).

If the facility director or other knowledgeable person is not available at the time of the verification visit, the team should attempt to revisit the facility at least one additional time to administer the Cartography Form. If, after the second attempt, the most knowledgeable person is still unavailable, the team should verify the location/address and record GPS coordinates as a minimum and then leave a printout of some basic information about the exercise and a notification that the data collection team will return in the future to conduct follow-up data collection activities.

The need for a verification cartography, and the extent of this stage, is likely to vary by country. For instance, in countries where the locations of all residential care facilities in the census frame are well-known, up to date and accurately recorded, it may only be necessary to conduct the verification cartography on a selection of facilities (for example, those that are unregistered/unrecorded or previously unknown) as opposed to a full cartography of every facility in the census frame. Similarly, countries with relatively small census frames (that is, relatively few residential care facilities) or those being implemented at the subnational level (in only certain parts of the country, such as one region) could decide not to implement the cartography. All these considerations should be carefully weighed when deciding on whether to implement the cartography and should be balanced against the potential risk of spending unnecessary time during the main fieldwork to locate facilities that could have otherwise largely been avoided. Ultimately, these types of decisions will have to be made at country level by the technical working group, in consultation with the implementing agency.

For details on how to administer the Cartography Form, see [Annex Q](#). Interviewer guidelines.

Tool: Cartography Form

3.9 Designing informed consent procedures

Informed consent is an ongoing process between researchers and individuals who participate in research. It refers to the “process of fully informing... [participants] as to the purpose of the research and what their involvement will be, prior to their decision as to whether or not they participate in the research. Informed consent is an explicit agreement which requires participants to be informed

about and have an understanding of the research. It must be given voluntarily and be renegotiable...”⁴⁰

Informed consent procedures should be disclosed to each individual at the onset of their involvement in the research. The disclosure should include information on the purpose and content of the research, a description of procedures that researchers and participants are expected to follow, and the disclosure of any personal benefits or risks associated with participation.⁴¹ These disclosures are necessary for individuals to make an informed choice about whether or not to participate in the research process. However, even if consent is granted, it may be withdrawn at any time.

Participants always have the right to decide at any point that they no longer want to take part in the research, and in these cases, the interview should stop immediately. All discussions of consent should take place in a quiet and private setting and interviewers should be sensitive to verbal and nonverbal cues of discomfort.

Consent procedures for implementation of this protocol differ depending on who the respondent is. In the case of facility directors, informed written consent is obtained and recorded as part of administering the Facility Questionnaire. After interviewers read a script regarding consent and confidentiality, facility directors will be asked to provide their signature to confirm that they have agreed to be interviewed and for the facility to take part. If CAPI is being used, the respondent will sign directly on the tablet.

In the case of caregivers and social workers responding to questions about selected children in Phase Two, only verbal informed consent is obtained and recorded (unless the requirements in the country as part of the ethical review clearance differ).

Depending on the requirements in the country as part of the ethical review clearance, it may be necessary to obtain a signature when directly interviewing adolescents as part of Phase Two. This was the case in the field test in Ghana. The standard version of the Questionnaire for Adolescents Aged 15-17 assumes that verbal consent to participate is sufficient, but in the event that local ethical reviews require written consent, the introductory script on the Questionnaire for Adolescents Aged 15-17 would need to be customized to request the respondent’s signature (see [Annex G](#) for details).

3.9 Designing confidentiality and privacy procedures

Standard procedures that clearly describe how confidentiality will be maintained during and after the collection of data should be clarified during the design phase. These standard procedures should include measures for storing data and consent forms, how to handle breaches of confidentiality, and guidance on what to do if confidentiality cannot be maintained due to mandatory reporting laws. Each member of the data collection and research team should be trained on confidentiality processes to ensure participant privacy and maintain confidentiality of data. He or she should be explicitly instructed not to discuss individual participants outside of the research context. To ensure that research staff understand and agree to the privacy procedures decided upon during the design phase, each person involved in data collection should sign a confidentiality agreement outlining his or her responsibilities in maintaining the confidentiality of data and the anonymity of participants.

Annex I also includes a sample confidentiality agreement for those involved in data collection that can be adapted as needed.

The need to secure a physical location that is private and minimizes distractions in order to conduct interviews is key to the success of the data collection and to maintaining respondent confidentiality, particularly for Phase Two. This can be especially challenging within an institutional setting in which there are often many people, including other children and adults, within the same space. However, it is of utmost importance, especially when it comes to interviewing adolescents aged 15 to 17 years, that the field team take the necessary steps to find a private space to conduct the interview. If weather permits, this might mean finding a private space outside. It is equally important to maintain privacy throughout the interview. In the event that someone enters the space during the interview process, interviewers should be trained to pause the interview until privacy can be restored.

PROVISIONAL DRAFT

SECTION 4: IMPLEMENTATION PHASE

4.1 Organizing fieldwork⁴²

The census exercise involves a large number of interviews in residential care facilities and requires detailed planning on how operations for the two phases of data collection will be organized in the field. The following sections include general guidance and considerations for planning implementation of both Phase One and Phase Two data collection, while details regarding the estimation of fieldwork duration and teams are provided in sections 4.2 and 4.3.

4.1.1 Timing and length of fieldwork

National and seasonal calendars should be considered when planning fieldwork; data collection should not conflict with periods of time during which access to communities will be difficult. Rainy season, harvesting periods, national and religious holidays, elections and seasonal school closures may significantly affect the number of children present in a facility at the time of the visit. Fieldwork should begin as soon as possible after training has been held so that fieldwork teams collect data while the training topics are fresh in their minds.

The time between the two phases of data collection should be as short as possible in order to minimize the possibility of changes in the population of interest (that is, children living in residential care facilities) since the census frame of facilities and roster generated in Phase One will be used to draw the sample for Phase Two (see section 4.3.1). The use of CAPI can greatly reduce the time needed between the two phases of data collection.

This data collection differs from that of a typical household survey in which teams might reasonably visit multiple households in one day. In most cases, teams will visit only one facility per day (both in Phase One and Phase Two). Fieldwork staff should anticipate spending more or less the entire day, typically from 8:00 or 9:00 am to 5:00 or 6:00 pm, in one facility. Obviously, all members of the fieldwork teams will have to be prepared to end the day only after the assigned facility for that day has been completed or in the event that the supervisor has determined the need to return the following day to complete the data collection activities.

More specific guidance and details on the length of time required for fieldwork for each phase of data collection can be found in sections 4.2.1 (Phase One) and 4.3.2 (Phase Two).

4.1.2 Establishing fieldwork teams

A number of factors should be considered when making decisions about establishing a fieldwork team. The estimated number of residential care facilities and their geographic distribution, the anticipated difficulty of finding the facilities, and the expected duration and available resources for fieldwork are all factors in determining the total number of teams and number of team members needed for fieldwork. Therefore, the information provided in this section is best viewed as a recommended starting point, while recognizing that some aspects of building the fieldwork team will inevitably depend on local context.

Size and composition

A fieldwork coordinator at the national level is needed to oversee and manage the activities of all field teams deployed in the country during both phases of data collection.

Fieldwork teams for Phase One data collection:

Ideally, field teams should include a mixture of both males and females, both for safety purposes as well as cultural appropriateness. While the exact number and composition of the field teams will vary somewhat according to the local context (see above), it is recommended that they be comprised, at a minimum, of:

- a. Supervisor
- b. Interviewers
- c. Local representatives of the relevant regulatory body
- d. A driver.

Additionally, using fewer teams over a longer period of fieldwork is preferable to using a greater number of teams over a shorter period. The former is both more cost-effective, due to training and staff salary or per diem payments, but it also encourages higher data quality because interviewers are known to become more skilled as they gain experience and familiarity with the tools and questionnaires.

Exercises that use paper questionnaires may consider adding a field editor to each team that is responsible for ongoing quality assurance of the implementation of the questionnaires. This is also a task that could be handled by the supervisor.

Fieldwork teams for Phase Two data collection:

Phase Two of data collection and implementation of the follow-up survey will require a smaller number of field teams, but the composition will essentially be the same, with the inclusion of an additional team member dedicated to taking anthropometric measurements of children. It is recommended that field teams from Phase One data collection be retained if possible.

If CAPI is being used for data collection, then those responsible for developing the CAPI application/IT specialists should be on hand (to the extent possible) throughout fieldwork to respond to and address any issues or concerns raised by the fieldwork team.

Roles and qualifications

The fieldwork coordinator should operate at the national level and is ideally a full-time staff member of the implementing body. This person is responsible for overseeing, coordinating and managing overall field implementation, including scheduling fieldwork in accordance with the established timeline. The coordinator will direct field teams to specific geographic locations, review ongoing reports of data collection and quality assurance procedures, and provide support for the logistics of data collection. The coordinator should have demonstrated experience in large-scale data collection efforts and strong technical knowledge of field practices and implementation methods. If the implementing body does not have a full-time staff member available who has the capacity to fulfil

this role, a consultant with strong technical skills in survey implementation, data collection and fieldwork organization should be recruited.

Field supervisors are responsible for quality control of fieldwork activities as well as for ongoing reporting of field activities to the fieldwork coordinator. Additionally, field supervisors are responsible for ensuring that all procedures related to privacy and confidentiality are adhered to and that interviewers are following established protocols. Field supervisors should have knowledge of and experience with quality control processes in the field and a university education with training in research methods.

Interviewers are responsible for collecting the tools and administering questionnaires to respondents. Depending on the country, interviewers may need to know several languages and should, as a minimum, be fluent in the language/s that the tools have been translated into. All interviewers should be able to read, write and do basic arithmetic; prior experience administering questionnaires in large-scale data collection efforts is a helpful qualification. Professionalism and social aptitude are key characteristics to consider when recruiting for interviewer positions.

Local representatives of the relevant regulatory body will assist in making contact with and facilitating access to facilities. Their presence can also serve to strengthen their own capacity (and that of the regulatory body they represent) to play a stronger regulatory role. Their role in data collection, however, should be minimized since their presence should not be interpreted as an attempt to inspect or assess the facility in any way. Additionally, interviewers should conduct interviews with respondents in private, without the presence of local representatives, in order to maintain confidentiality and privacy.

Drivers are needed to transport field teams between facilities. They should have the necessary and legal licence(s) to drive in the country, be familiar with local roads and have a clean driving record as well as a background suitable for data collection on child protection issues.

The role of measurers in Phase Two of data collection is to take the measurement of heights and weights of all selected children as part of implementing the module for anthropometry included in the Questionnaire for Children under 5. Although the measurer will be the main team member responsible for anthropometric measurements, other fieldwork team members will also receive training on how to weigh and measure children in order to act as the measurer's assistant. Measurers must be able to see well (with glasses, if needed) since they will be reading out measurements that may be unclear in certain lighting.

If included as part of the field team, field editors are responsible for ensuring the quality of completed questionnaires. Field editors may supervise interviewers, especially during early stages of fieldwork when it is possible to eliminate error patterns before they become habitual. Field editors should be mature, responsible and detail oriented.

4.1.3 Transportation, food and accommodation

Field teams will need access to safe and reliable transportation. It is recommended that each field team include a driver with a safe and mechanically sound vehicle who is familiar with car mechanics. Interviewers may also need to walk to facilities that are not accessible by road. The field team will

need to consider the availability of food and accommodation in each of the areas. In some areas, accommodation and food items may be easily secured and available for purchase. However, the field teams may need to arrange to carry food provisions with them to remote areas or ask community leaders to find a place for them to stay, such as a community centre or religious facility, if no other rooms are available.

It is generally recommended that fieldwork teams leave the facility in order to secure any food or drinks during breaks, as opposed to accepting these from the facility, if offered (with the exception of drinking water). Given that most facilities will have set daily schedules and a standard routine, it may be most appropriate for teams to schedule daytime breaks for lunch, for instance, when the children are also being fed a meal. This can also serve to minimize disruptions to the children's daily routine and to limit any infringement on the established schedule and functioning of the facility.

4.1.4 Supplies, materials and equipment

Field teams need to travel with printed authorization letters, lists of facilities in their designated areas, consent forms for respondents, Service Information Cards (for Phase Two only), and printed paper questionnaires. If using CAPI, interviewers will also need to travel with the appropriate electronic equipment, including batteries and power cords, and will also need to have Internet access/WiFi in order to upload questionnaires while in the field. When using CAPI, the system should be set up to also work offline in case of Internet connectivity issues while in the field.

Other supplies may include t-shirts and identification cards, paper and pens for completing forms and notetaking, backpacks, first aid kits (including hand sanitizer) for storage in the vehicles and mobile phone credit.

A measuring board and electronic scale are needed for anthropometric measuring in Phase Two. It is recommended that each field team be given two measuring boards and two scales so that one can be used as a back-up, if needed. Therefore, the total number of measuring boards and scales needed will depend on the total number of field teams (see section 4.3).

4.1.5 Communication

A clear and consistent communication plan is necessary for the successful implementation of field activities. A reliable system for communicating with the national fieldwork coordinator as well as between members of the field team should be in place prior to the start of data collection. Field teams should regularly report on progress and provide data to the fieldwork coordinator at pre-arranged intervals, and all problems should be communicated as they arise. Mobile phones and Internet connections through mobile phone data may be used as the primary method of communication; sufficient mobile phone credit should be factored into the budget for fieldwork.

4.1.6 Safety and well-being of fieldwork teams

All members of the fieldwork teams are responsible for ensuring that the data collection is ethical and minimizes harm to researchers and participants alike. It is important that members of the fieldwork teams are carefully selected, trained and provided with continuous support throughout the duration of the fieldwork to ensure their safety and well-being as well as that of respondents.

It is necessary to plan in advance for fieldwork teams to take sufficient breaks throughout the period of data collection, including by providing them with appropriate rest and downtime.

While interviewers involved in this project may be very experienced with conducting other types of surveys, such as those in households, for many it will be the first time they are involved in data collection within an institutional setting. The reality of children living in residential care and the conditions of some facilities can be quite disturbing. Many facilities operate without a licence, with little or no oversight, and may not comply with minimum national standards (when these exist). In some institutions, particular groups of children, such as those with disabilities or very young infants, may receive little attention or be kept in very poor conditions. Fieldwork teams need to be prepared to encounter such situations and to potentially hear stories that can be distressing or alarming. The interviewer guidelines (Annex O) and sample training slide decks include more details on how teams can prepare for this.

Because the fieldwork for this exercise can be especially difficult and intense for a number of reasons, it is absolutely critical that teams are offered opportunities for regular debriefing sessions during the period of field data collection. It is recommended that a period of time be set aside for the sharing of personal experiences in dealing with distressing or upsetting incidents encountered during fieldwork, while maintaining the confidentiality of respondents. Debriefings are helpful at all stages of data collection, during the initial phase to provide space for reflection, clarification and sharing of experiences, and in the final stages where interviewer fatigue and low morale may require an additional boost and encouragement from supervisors.⁴³ Additionally, a dedicated interviewer debriefing session or meeting at the completion of fieldwork is also recommended. This should include an opportunity for members of the fieldwork team to request referrals for additional support services or counselling, if needed.

4.1.7 Selecting members of the fieldwork teams

In most cases, selections are based on the practice of the implementing body; typically, such institutions have well-established procedures on this. However, the following is recommended generally:

- Supervisors: In most cases these are predetermined since they have experience from previous involvement in data collection efforts. However, it is advisable to remain flexible and not guarantee supervisor roles in advance, since some individuals may not perform up to the standard required. This is particularly relevant with regards to computer literacy and the ability to internalize the work processes of supervising a CAPI fieldwork team. Regardless of experience, it is recommended that all aspects of the supervisor role be covered in detail to refresh and ensure understanding of all responsibilities.
- Interviewers: It is strongly recommended that interviewers be selected as a result of their performance during training. Some interviewers need additional time to internalize material and work, so it is recommended to not release any candidates until the end of the full training. Keep in mind that the best interviewers might not necessarily be perfect at using the tablet as an interviewing tool. Similarly, the most computer-literate individuals might not end up being good interviewers.

- ❑ **Measurers:** There are two potential options for identifying measurers. Either trainees for the position of measurer are identified in advance (for example, from the staff of a nutritional surveillance survey) or they are selected from the overall group of trainees prior to the start of the dedicated training sessions for measurers. Either way, the best performing individuals should be selected as part of the dedicated anthropometric sessions.

Quizzes and observations in class and the field can form the basis for selection of members of the fieldwork teams. Once all tools/questionnaires have been covered, the trainees should be given a final quiz on content across the questionnaires.

4.2 Design and field procedures for Phase One census and enumeration

The fieldwork plan, training, pilot testing and procedures outlined for Phase One are intended to produce an accurate, complete and up-to-date listing of all existing residential care facilities and the actual number and basic characteristics of children living in these facilities.

4.2.1 Developing a fieldwork plan

A detailed fieldwork plan must be developed prior to the start of data collection and should include two main elements: 1) calculation of estimated length/duration of fieldwork, and 2) calculation of the required number of fieldwork teams and individual fieldwork staff.

Estimating fieldwork duration will need to account for the length of time each team will spend in an area, including rest and travel time, and the time needed to administer all the tools and questionnaires in each facility. Key factors that will affect anticipated fieldwork duration include the total number of facilities included in the census frame (finalized after the verification cartography if one was implemented), the expected number of facilities that can be visited by each fieldwork team in a day, the total number of fieldwork teams, and the number of interviewers per team.

The number of required fieldwork teams and individual staff depends on the total number of facilities included in the census frame, estimated duration of fieldwork, the expected number of facilities that can be visited by each fieldwork team in a day, and the number of interviewers per team. As example, Box 6 provides an overview of the Phase One fieldwork undertaken in Ghana.

Annex K includes a template for calculating fieldwork duration as well as the number of teams and individual staff needed for Phase One training and fieldwork.

Box 6. Overview of Phase One fieldwork in Ghana

The training and pilot for Phase One fieldwork in Ghana took place over a period of three days – from 28 through 30 October 2019. Training lasted two full days and included a review and training on questionnaire administration and fieldwork procedures. The training also involved a session on CAPI basics and troubleshooting and provided an opportunity to identify and resolve some issues with the application.

On 30 October, all members of the fieldwork teams (a total of 48 interviewers and supervisors) participated in a one-day pilot at a residential care facility close to the training venue. Participants were divided into four teams and each team practised administering all of the questionnaires on CAPI, with the exception of the verification count, which was completed by only one team to avoid burdening the facility staff and children.

Data collection for Phase One was conducted over a period of around two weeks from 6 to 19 November 2019.

4.2.2 Phase One training

4.2.2.1 Preparation, supplies and logistics

Prior to holding the training, the implementing agency should plan the training in detail, secure a training venue and organize or finalize procedures, data collection tools and materials needed for training activities. It is recommended that the venue be in a central location with adequate space and seating for all participants, as well as sufficient light and ventilation. A venue with on-site catering or place to serve food and snacks is also recommended. Trainers will need to supply all necessary electronic equipment for CAPI-administered data collection, poster board or projection equipment (where possible), along with up-to-date printed questionnaires and tools and other training materials, including field procedure flow charts, contact information for supervisors, notebooks, pens and mobile phone credit for participants, when necessary. Box 7 is a checklist to use when preparing training sessions.

Box 7. Training preparation checklist

- Final questionnaires (pre-tests, reviews and translations are completed)
- Final CAPI application
- Translated and adapted annex documents, including
 - Interviewer guidelines
 - Training manuals
- Translated and adapted field procedure documents, including
 - Service Information Cards (for Phase Two only)
- Fieldwork logistics
 - Payments
 - Plan for paying field team members
 - Accommodations
 - Transport
 - Insurance
- Training logistics
- Identified accessible field locations for practice
- Prepared equipment, visuals, tools for use in demonstrations during training and for practice
- Field equipment secured, including
 - Tablets and accessories (if using)
 - First aid kits, flashlights
 - Rain boots, umbrellas, bags, caps, t-shirts
- Agreed upon agenda and methodology – also for selection of field teams.

Adapted from United Nations Children’s Fund, ‘Main Fieldwork Training: Recommendations and template agenda’, MICS6 Tools, 20 September 2017, <mics.unicef.org/tools#survey-design>.

4.2.2.2 Content and length of Phase One training

It is recommended that training for interviewers and supervisors comprising the field teams for Phase One data collection cover the following topics over a period of about four working days.

- Background information on the purpose and objectives of the overall exercise, including a general overview of Phase Two activities. This will provide field teams with important context for implementation activities, with necessary knowledge to answer respondents’ questions about the survey and help to motivate them to participate in the survey process.
- A detailed review of the methodology and field procedures for Phase One and how to implement them in practice. This includes an understanding of operational definitions and inclusion criteria.
- General interviewing techniques, including building rapport with respondents, communicating clearly, asking questions in an objective manner without suggesting responses, and dealing with interruptions.
- Detailed review of ethical principles relating to conducting research that involves children, including the consent processes, and maintaining privacy and confidentiality.
- A detailed and participatory review of each Phase One questionnaire and tool so that the supervisors and interviewers understand the content and purpose of each question and the possible responses, as well as how to navigate through the questionnaires with the

appropriate use of filters, skip patterns and screening questions. The review should include role-playing and adequate time for practice; comprehension testing should be built into the training agenda.

- A detailed and participatory review of Phase One consent procedures.
- Technical training on quality assurance procedures and quality control of data – before, during and after data collection.
- Technical training for computer-assisted interviewing, if using CAPI as the mode of data collection. Through this training, interviewers should become confident in using electronic devices for collecting data and have a basic understanding of troubleshooting, backing up and sending data to supervisors. The training should also include sufficient time for the supervisors and interviewers to practise questionnaires on the tablets. CAPI programming staff should be on hand to assist with any troubleshooting or correction of errors.
- Dedicated supervisors' training.

For detailed guidance on training methodology and a suggested training agenda, see [Annex L](#). Training manuals and sample agenda.

Recommendations on length of training (for both phases) should be considered ideal. The time needed for training is likely to vary somewhat across countries and might need to be adapted due to a number of factors including budget, number of fieldwork teams and interviewers, number of institutions, sample size (for Phase Two), and qualifications/experience of the interviewers. A shorter training may be warranted, for example, if interviewers are very experienced in collecting data within the context of household surveys, particularly if they have been involved with implementing a Multiple Indicator Cluster Survey (MICS) given the large amount of overlap with the content of Phase Two questionnaires.

Depending on the fieldwork plans, it may be possible or even advisable to conduct Phase One and Phase Two trainings consecutively. Particularly in the case of CAPI administration, and given that the time between Phase One and Two could be quite short, it may be most efficient to train the fieldwork teams on both phases of data collection at once as opposed to planning separate dedicated training sessions.

4.2.3 Phase One pilot testing

The pilot will test the feasibility and appropriateness of the adaptation of the study protocol and field procedures as well as customization of the standard tools/questionnaires. The objective is to ensure that team roles, logistics and management will function smoothly when fieldwork commences. Pilot testing will help identify problems or issues in the adapted protocol and translated questionnaires and tools. For example, it will confirm whether questionnaires are understandable, if translated questions are clearly understood by respondents, and if they are measuring what they are intended to measure.

To conduct the pilot test, field teams will implement Phase One activities as specified in this protocol in a pre-identified area/location/administrative unit that is logistically convenient to the location of the training. It is not necessary to visit each and every facility within the pre-identified area or

location, but each fieldwork team should be given the opportunity to visit one facility as part of the pilot test. Depending on a number of factors, the pilot test could run one or two days.

In deciding how many (and which) facilities to include in the pilot, consideration should be given to budget, logistics (for example, the number of days allocated for the pilot) and the need to include residential care facilities with diverse characteristics (such as large versus small, government versus private institutions) in order to get an accurate picture of how fieldwork will function across different settings.

In addition to testing the tools and procedures for data collection, the pilot should also include a test of the CAPI application (where relevant) to check supervisor assignment of interviews in tablets, data transfer, and utilization of interviewer, supervisor and central office menus. In fact, it might be more economical and practical to conduct data collection for the pilot using paper and pencil and then develop/adapt the CAPI application afterwards, since the pilot is likely to result in changes that would need to then be reflected in the CAPI application.

Any observations obtained as part of implementing the pilot will need to be reviewed by the team to determine whether any adjustments are required to the tools, procedures, fieldwork manual (such as interviewer guidelines) or CAPI application prior to implementing the main fieldwork. This should include the evaluation of customized response options, where answers falling into the 'other (specify)' category of a multiple-choice question that constitute 5 per cent or more of all answers to that question should be considered for an additional separate answer category. The team will also need to check that skip patterns and numbering were preserved in cases where questions (or entire modules) have been added to or deleted from the questionnaires. The team will also need to assess the chosen mode of data collection, including the question format and length of the questionnaire, as well as data entry procedures and coding. Any decisions or adjustments made should be carefully noted and documented.

In this exercise, the pilot test will also serve as a first round of training for field staff who could become supervisors during the main fieldwork.

A sample pilot test report template and checklist for CAPI test can be found in [Annex M](#).

4.2.4 Phase One field procedures

4.2.4.1 Assigning fieldwork teams

Using the census frame of all facilities contained in the final Facility Database (which was previously compiled from government and regional lists and key informant interviews and subsequently verified), the national coordinator will assign the facilities to the fieldwork teams, according to geographic areas as defined by the relevant administrative unit in the country. These assignments will be communicated to fieldwork teams by supervisors. Supervisors are then responsible for assigning interviewer roles within their designated team(s).

See [Annex N](#) for a field supervisor manual.

4.2.4.2 Locating and visiting facilities

Fieldwork teams will visit the facility (or facilities) included in their list during the day. The procedure for establishing contact with the facility, introducing the fieldwork team and purpose of the visit, and identifying the most knowledgeable person is detailed in section 4.2.4.4. as well as in [Annex O](#). Interviewer guidelines.

As mentioned previously, in section 3.8, local representatives of the relevant regulatory body should accompany teams (if feasible and applicable in the local context) in order to facilitate contact with and access to facilities. This person should be designated to establish contact with the facility director or other most knowledgeable person and briefly introduce the fieldwork team and reiterate the purpose of the visit. However, this person should not administer the consent or any parts of the questionnaire or tools as this should be left to the interviewers.

If the facility director or other most knowledgeable person is not available at the time of the visit and no suitable alternate can be identified, then the team should attempt two more visits to the facility before moving on to the next facility on their list.

In the event that a facility cannot be located, is destroyed or is vacant/closed upon the fieldwork team's arrival, this should be recorded appropriately on the Facility Questionnaire (see [Annex O](#). Interviewer guidelines).

4.2.4.3 Obtaining informed consent

The interviewer will read the script in either RIP5A or RIP5B, which explains the rationale of the study and relevant details about the interview process, including personal risks or benefits associated with participation. It should be clearly stated that the respondent may refuse to participate in the interview without any penalty and may withdraw consent at any time. After reading the script, the interviewer will request the respondent's signature to indicate his/her agreement to be interviewed and for the facility to take part in the data collection.

If the intention of the data collection in Phase One is to use the information from the Facility Roster as a starting point for building a national registry/database of all children in residential care, then this needs to be disclosed to the person consenting to the facility's participation. In this case, it is recommended to include in the script in RIP5A and RIP5B a short sentence along these lines (see Annex G on customization guidelines for suggested text).

Conversations on consent should ideally take place in a private and quiet setting.

4.2.4.4 Administering the questionnaires/tools

Regarding the flow and order of questionnaires to administer during Phase One: it is recommended that teams within each facility split the tasks and be assigned to different tools/questionnaires to be completed simultaneously. For example, if there are two interviewers per team, supervisors should assign one interviewer to administer the Facility Questionnaire and collect the Facility Observation Checklist and the other interviewer to compile the Facility Roster and conduct the verification count. This way, the team is working simultaneously to complete the questionnaires/tools as opposed to collecting the information sequentially.

The Facility Roster needs to be completed before the verification count. After the verification count has been completed, there may be a need for the team to return to the Facility Roster and update it on the basis of information gathered during the verification count.

Facility Questionnaire

The Facility Questionnaire captures the basic characteristics of the facility. The preferred respondent is the person most knowledgeable about the facility's characteristics and operations, usually the facility director. If the facility does not have a formal director, the most senior staff member may be interviewed. Note that who is determined to be the most appropriate respondent might vary by facility and across country contexts.

In most countries implementing this protocol, fieldwork teams will be accompanied by a local representative; it is expected that this person will facilitate access and introduce the team to the facility director or other most knowledgeable person. If the fieldwork team is not accompanied by a local representative of the relevant government ministry/department, then it will be necessary for the teams to introduce themselves, explain the purpose of their visit and try to identify the most knowledgeable person.

Regardless of the approach, once this person has been identified, interviewers complete the respondent information panel and seek consent from the respondent to be interviewed. After establishing consent, the interviewer confirms that the facility meets the eligibility criteria (that is, that children are living in the facility). The interviewer also asks whether the facility has an existing registry, database or other type of record that includes the names of all persons who usually live in the facility (noting that these could either be in electronic or hard copy form) before proceeding with the rest of the questionnaire. If the most knowledgeable person says there are no children living in the facility, then the interview will end.

If the most knowledgeable person is not available at the time of the visit, the fieldwork team should attempt two more visits to the facility before recording in the Facility Questionnaire that no knowledgeable respondent was identified for the facility.

At the end of the Facility Questionnaire, there is a question about whether the respondent knows of any other facilities in the area where children live. The purpose of this question is to identify additional facilities that may exist but have not been captured in the census frame (Facility Database). If the respondent is aware of other facilities in the area, then the fieldwork team will need to establish whether these facilities are already included in the census frame or not. If they are not, then the fieldwork team should collect some basic information about the facility (or facilities) using the Other Facility Information Form included in the Facility Questionnaire. A separate form should be completed for each additional facility identified by the respondent. These newly identified facilities will need to be added to the fieldwork assignments, and teams will need to visit these facilities to conduct the data collection.

For detailed guidance on how to administer the Facility Questionnaire, see [Annex O](#). Interviewer guidelines.

Tool: Facility Questionnaire

Facility Roster

The Facility Roster is meant to contain a complete listing of all persons in the facility who are not staff or volunteers (including name, sex and age).

The instructions on how to complete the Facility Roster differ depending on whether or not the facility has existing records or a registry/database that can be consulted in order to transcribe information. To the extent possible, it is recommended that fieldwork teams request that the facility print or have any existing registry/roster with information about the residents ready in advance of their arrival to speed up the process of building the roster. The availability of such records is more likely in countries with established information management systems (as was the case in Kazakhstan, where the government has a web-based information management system for tracking children in institutions). Where these exist and can be made readily available, fieldwork teams can rely on these pre-existing records to generate and verify the Facility Roster.

Regardless of the approach, it is important to follow up with the director or other respondent to ensure that the information recorded in the Facility Roster is as complete and accurate as possible. The importance of ensuring the accuracy and completeness of the roster cannot be overstated, since it will form the basis of the verification count and be used for sampling in Phase Two (after appropriate updating, as needed, following the count).

For detailed guidance on how to administer the Facility Roster, see [Annex O](#). Interviewer guidelines.

Tool: Facility Roster

Facility Observation Checklist

The purpose of the Facility Observation Checklist is to capture basic information about the facility's infrastructure, the availability of basic amenities and any obvious signs of health or safety issues. It has been designed with the following objectives in mind:

- a. Gather additional details about the facility that cannot reliably be collected through the Facility Questionnaire
- b. Verify some of the information collected in the Facility Questionnaire
- c. Identify any discrepancies between observations recorded in the checklist and those outlined as part of standard operating procedures or inspection forms used in the country
- d. Identify red-flag situations or conditions that would warrant immediate action (as flagged in Annex Q).

The checklist is not intended to be exhaustive and should not be considered as a thorough inspection or assessment of the facility. If there are existing standard operating procedures or standard inspection forms used in the country for the purposes of monitoring residential care facilities, it is recommended that these be consulted in order to align the relevant components of the Facility Observation Checklist with the standards applied in the country (to the extent possible).

For detailed guidance on how to use the Facility Observation Checklist see [Annex O](#). Interviewer guidelines.

Tool: Facility Observation Checklist

4.2.4.5 Procedures for conducting the verification count and completing the record review

The procedures for conducting the verification count might differ somewhat by country. The purpose of the question at the end of the Facility Questionnaire is to have the respondent identify a time of day when most children are expected to be present at the facility, since this is when the count should be conducted. It may be the case that this is later in the same day of the initial visit, or it could be the next day. For example, if the respondent indicates that the greatest number of child residents are present at the facility at the end of the school day, then the interviewers should wait (or return) to the facility during that time (on the same day, whenever possible). Alternatively, if the respondent indicates that the greatest number of child residents are present at the facility during breakfast, then the interviewers should return to the facility during breakfast the next morning.

The purpose of the Verification Count tool is for interviewers to verify the names of all children living in the facility and to update the Facility Roster in the event that children not listed are found to be present during the count and are identified as usual residents of the facility. The record review summarizes key pieces of information from the verification count and includes instructions on how to update the Facility Roster.

The recommended approach is to conduct the verification count at a time when children are usually gathered together (during mealtime, for example). If there are any children who cannot walk or move (either because they are too young or are physically incapacitated), then the fieldwork team will need to physically go to the place where these children can be found for visual confirmation of their presence. One technique that was found useful in implementing the count during field testing in Ghana was to have children raise their hand when their name is called and then physically move to one side of the room. This can make the identification of any children not listed more efficient. Additionally, if children are attending school nearby or on the same property as the facility, it may be possible to count them during a break such as at lunchtime (so long as this does not create a disruption or interference). However, this should be discussed with the facility director or other relevant official. If children live in separate quarters/buildings grouped by age (and sex), it may be most practical for teams to move from room to room (or building to building) as opposed to requesting all children to gather in a common location (particularly if the facility is very large). Different approaches might be more practical or appropriate in different countries (or even across facilities within the same country). The approach to be followed for the verification count should be discussed, and agreed upon, with fieldwork teams during training.

It is anticipated that this activity may be sensitive in some contexts and in some facilities. It is possible that facility staff may view the verification count as an act of cross-checking due to a mistrust in the information given to the fieldwork teams. To mitigate this, interviewers will require extra sensitization, and training will focus on how to respond to facility staff in such situations. The purpose of the exercise is not to catch facilities doing something wrong, but to make sure that the data collected are as accurate and complete as possible. The physical count is one of the most important pieces of information and should not be skipped, unless there is a very good reason that it cannot be completed, and this should be at the discretion of the field supervisor. It is critical for both supervisors and the central office to put in place checks to verify that the teams are indeed completing the verification count.

For detailed guidance on how to use the Verification Count and Record Review tool, see [Annex O](#). Interviewer guidelines.

Tool: Verification Count and Record Review

4.2.4.6 Concluding the facility visit

Once fieldwork teams have finished administering all the tools and questionnaires for Phase One data collection, they should inform the facility director (or other most knowledgeable person who has acted as a respondent) that there will be a second phase of data collection. They should explain that selected facilities will be revisited, and additional information collected about a random sample of children. They should also say that, should their facility be selected, a data collection team will return within a few weeks. Further guidance on how to end the facility visit is included in [Annex O](#). Interviewer guidelines.

4.3 Design and field procedures for Phase Two: Follow-up Survey

The sampling plan, fieldwork plan, training, pilot testing and procedures outlined for Phase Two follow-up surveys are meant to produce data on selected indicators of well-being for children and adolescents living in residential care facilities. These surveys are administered to caregivers of a representative sample of children living in the facilities visited during Phase One as well as a representative sample of adolescents between the ages of 15 and 17.

4.3.1 Developing a sampling plan

It is recommended that the implementing body consult with a sampling statistician/expert (whether internal to the agency or external) to solicit assistance and technical input to clean the full census frame database, study the distribution of the frame, finalize the sample design (including stratification), and select the sample of facilities and children for Phase Two.

For Phase Two, it is recommended that a two-stage stratified sampling approach be implemented using the census frame generated in Phase One to create the sampling frame for Phase Two. [Annex R](#) provides more detailed guidance on sampling for Phase Two and includes a template that can be adapted and used for sample selection.

4.3.2 Developing a fieldwork plan

A detailed fieldwork plan must be developed prior to the start of data collection and include two main elements: 1) calculation of estimated length/duration of fieldwork, and 2) calculation of the required number of fieldwork teams and individual fieldwork staff.

Estimating fieldwork duration will need to account for the length of time each team will spend in each area, including rest and travel time and the time needed to administer all the questionnaires in each facility. Key factors that will affect anticipated fieldwork duration include the total number of facilities included in the sample frame, the expected number of facilities that can be visited by each

fieldwork team in a day, the total number of fieldwork teams, and the number of interviewers per team.

The number of required fieldwork teams and individual staff depends on the total number of facilities included in the sample frame, estimated duration of fieldwork, the expected number of facilities that can be visited by each fieldwork team in a day, and the number of interviewers per team.

For Phase Two, it is recommended that teams schedule facility visits at a time when most children are expected to be in school, since this will facilitate the process of interviewing caregivers and maximize time in the facility. All of the modules in the Questionnaire for Children under 5, with the exception of the module for anthropometry, and in the Questionnaire for Children Aged 5-14, with the exception of the foundational learning skills module, can be administered to the caregiver without the child being physically present. Similarly, the Questionnaire on Children's Case History can be administered to social workers without children's presence. Therefore, all of these questionnaires could be administered during the day while children are at school. The fieldwork team could then complete the remaining modules as well as the Questionnaire for Adolescents Aged 15-17 at the end of the school day, once children have returned to the facility.

As an example, Box 8 provides an overview of the Phase Two fieldwork undertaken in Ghana.

Annex S includes a template for calculating fieldwork duration as well as the number of teams and individual staff needed for Phase Two training and fieldwork.

Box 8. Overview of Phase Two fieldwork in Ghana

Following completion of Phase One fieldwork in Ghana, there was a period of around two and a half weeks allocated to drawing the sample for Phase Two, developing the CAPI application and conducting the training and pilot prior to the start of fieldwork.

The training and pilot for Phase Two took place over a period of five days – from 2 through 6 December 2019. Training lasted four full days and included a debriefing of Phase One and review and training on questionnaire administration and fieldwork procedures. As part of the training, all members of the fieldwork teams received basic instructions and training on administration of the module for anthropometry, since one interviewer per team was assigned to act as a measurer's assistant. The measurers (a total of 12 – one per fieldwork team) also received a parallel dedicated training for one afternoon with an expert trainer. The fourth day of training was dedicated entirely to a review and practice with the CAPI application for all members of the fieldwork teams, except measurers. Most interviewers and supervisors had been retained from Phase One and were therefore already familiar with CAPI and tablet basics. On the fourth day of training, measurers (pre-selected by the implementing agency) took part in a standardization exercise with children from the community. The objective of the exercise is to assess the performance of each measurer against him/herself, against the whole group, and against measurements performed by the expert trainer.

On the last day, 6 December, all members of the fieldwork teams (a total of 48 interviewers and supervisors) participated in a one-day pilot at two residential care facilities close to the training venue. At each facility, there were 12 interviewers, 6 supervisors and 6 measurers. Fieldwork teams practised administration of the questionnaires using CAPI and completing height and weight measurements for children under age 5.

4.3.3 Phase Two training

4.3.3.1 Preparation, supplies and logistics

For a detailed explanation of the preparation, supplies and logistics necessary for Phase Two training, see section 4.2.2.1. In addition to the items listed in Box 7, anthropometry equipment will also need to be secured.

Additionally, expert trainers in anthropometry should be invited to lead training sessions for the measurers and supervise the standardization and site practice for the module for anthropometry. It is imperative to invite experts since they will have the additional responsibility of selecting the measurers based on their performance during the training. Ideally, these are highly skilled trainers from a national nutrition programme that have experience in national nutrition surveys and who will also participate in field monitoring. Caution must be taken, however, to ensure that trainers do not implement alternative practices that do not adhere to these standard protocols. Ideally, one trainer per five measurers should be sought. This team of trainers must also be available for field practice and the pilot. Anthropometric training tools, including a measuring board and electronic scale, are also required for Phase Two training only.

As mentioned previously and depending on the fieldwork plans, it may be most efficient to conduct Phase One and Phase Two trainings consecutively, particularly in countries where the two phases of data collection will take place within a short period of time from one another.

4.3.3.2 Content and length of Phase Two training

It is recommended that training for interviewers and supervisors comprising the field teams for Phase Two data collection cover the topics below over a period of about nine working days. The schedule includes seven, 8-hour working days, each including a 1-hour lunch break and two health breaks; one off-day (Day 6), the timing of which can be revised or adjusted as appropriate and relevant in the country context; and one half-day session (Day 9). Parallel sessions for anthropometry training begin on Day 4 of the main training. In total, the training schedule for measurers is four days; this includes one full day of paired practice in a community setting and one full day for standardization.

It is recommended that interviewers and supervisors who participated in the earlier training and Phase One data collection be recruited to implement Phase Two activities, whenever possible. Phase Two training will cover the following:

- A review of the purpose and objectives of the exercise, as well as of Phase One activities previously implemented
- A review of general interviewing techniques and operational definitions and inclusion criteria
- A detailed review of Phase Two field procedures and techniques for replacement (if applicable)
- A detailed and participatory review of Phase Two questionnaires so that supervisors and interviewers understand the content and purpose of each question and possible responses, as well as how to navigate through the questionnaire with the appropriate use of filters, skip patterns and screening questions. The review should include role-playing and adequate time for practice; comprehension testing should be built into the training agenda.

- ❑ A detailed review of Phase Two consent procedures, including a participatory review of processes for obtaining children’s verbal consent (or written consent, if applicable in the country).
- ❑ A participatory review of the response plan and referral procedures.
- ❑ General anthropometric training for all fieldwork staff to learn procedures for height and weight measurement.
- ❑ Detailed technical anthropometric training for measurers and accompanying paired practice in a community setting, along with a standardization exercise.
- ❑ Technical training for computer-assisted interviewing, if using CAPI as the mode of data collection. Through this training, interviewers should become confident in using electronic devices for collecting data and have a basic understanding of troubleshooting, backing up and sending data to supervisors. The training should also include sufficient time for supervisors and interviewers to practise questionnaires on the tablets. Relevant CAPI programming staff should be on hand to assist with any troubleshooting or correction of errors.
- ❑ Dedicated supervisors’ training.

As was the case with Phase One, the length of training for Phase Two may need to be adapted in light of a number of factors (see section 4.2.2.2 for more details).

For detailed guidance on the training methodology and a suggested training agenda, see [Annex L](#). Training manuals and sample agenda.

4.3.4 Phase Two pilot testing

For general information on the intended purpose and uses of the pilot test and considerations for selecting the number and profile of pilot sites, see section 4.2.3, on Phase One pilot testing.

To conduct the pilot test for Phase Two, field procedures for Phase Two activities should be replicated as outlined in this protocol.

A pilot test report template and CAPI test checklist can be found in [Annex M](#).

4.3.5 Phase Two field procedures

4.3.5.1 Locating and revisiting facilities

The national coordinator will assign the sampled facilities to field teams according to geographic areas (as defined by the relevant administrative unit in the country), and these assignments will be communicated to fieldwork teams by supervisors. Fieldwork teams will then visit the facilities included in their list. If a local representative is accompanying fieldwork teams, then this person may take the initiative to introduce the team upon arriving at the facility and may briefly explain to the facility director or manager the general purpose of the visit. In the event that no local representative is accompanying the fieldwork team to the facility, then the supervisor should play this role, using the introductory script included as part of the Child Listing for Phase Two.

Generally speaking, the director or manager will have already been identified as part of Phase One data collection and his or her name should already be known and included as part of the field team’s

list of facilities. If that person is not available and no suitable alternate can be identified, then the team should attempt two more visits to the facility before moving on to the next facility on their list.

4.3.5.2 Identifying eligible respondents

The purpose of the Child Listing for Phase Two is to identify both the most knowledgeable person/caregiver and the social worker or assigned casework for each randomly selected child aged 0 to 17 years who will act as respondents to the questionnaires. In the case of adolescents aged 15 to 17, the most knowledgeable person will only act as respondent to some modules in the Questionnaire for Adolescents Aged 15-17 if the adolescent is found to be incapacitated and therefore cannot be directly interviewed.

The questionnaires for children under 5 and children aged 5 to 14 in Phase Two should be administered to the most knowledgeable person for each of the randomly selected children. This person will need to be an adult who is most knowledgeable about the child's daily habits and overall health and well-being. In the case of most facilities, multiple caregivers will tend to know about all children under their care, so there may be more than one suitable respondent. Depending on the number of interviews taking place, one option can be to split the interviews among the caregivers to minimize respondent fatigue. In the event that a single caregiver has to act as the respondent for more than five children, it is recommended to give him/her a break after completing a set of interviews in order to avoid respondent fatigue.

The eligible respondents for the Questionnaire for Adolescents Aged 15-17 are the randomly selected adolescents within this age range. In other words, adolescents will be responding to the questions themselves as opposed to having proxy respondents. The general recommendation is for interviewers to ask caregivers to introduce them to the selected adolescent and then, if appropriate, accompany the caregiver to the place where the adolescent can be found. One reason for doing this is to minimize the possibility of the caregiver or other facility staff influencing or advising the adolescent on how to respond during the interview.

Eligible respondents for the Questionnaire on Children's Case History are social workers/social welfare officers. These may be paid staff of the facility who are on-site or could be those at the local level who are employed by the relevant authority with the mandate for residential care in the country.

4.3.5.3 Obtaining informed consent

In the case of caregivers and social workers responding to questions about selected children in Phase Two, only verbal consent is obtained and recorded (unless the requirements in the country, as part of the ethical review clearance, differ).

The standard version of the Questionnaire for Adolescents Aged 15-17 assumes that verbal consent to participate is sufficient. But in the event that the local ethical review requires the respondent's signature, then the introductory script on the Questionnaire for Adolescents Aged 15-17 would need to be customized.

4.3.5.4 Administering the questionnaires/tools

For each selected child/adolescent, there are two questionnaires to be completed. In the case of children under 5 and those aged 5-14, caregivers will be interviewed using the relevant age questionnaire; social workers will also be interviewed using the Questionnaire on Children's Case History. For adolescents between the ages of 15 and 17 years, the adolescent him/herself will be directly interviewed (unless the adolescent is deemed to be incapacitated) and the adolescent's social worker will be interviewed using the Questionnaire on Children's Case History.

Child Listing for Phase Two

The purpose of the Child Listing for Phase Two is to identify the eligible respondents for each of the children/adolescents selected as part of the Phase Two sample. If CAPI is being used for data collection, then the names and relevant age group of all randomly selected children and adolescents in the facility should already be loaded into the child listing form. It is recommended that supervisors carry a hard copy list of the names of the randomly selected children for each of their assigned facilities as a reference and for verification purposes. If paper data collection is being conducted, then the fieldwork team will need to transcribe the names and relevant age group of all randomly selected children and adolescents into the Child Listing for Phase Two form from the assignments provided by the supervisor. Then, for each child and adolescent, the interviewer will need to ask the facility director or other designated respondent to provide the name of both the child's/adolescent's caregiver or person most knowledgeable about him/her as well as his/her social worker. If the child does not have a social worker or assigned caseworker, then the most knowledgeable person may need to act as respondent for the Questionnaire on Children's Case History.

For detailed guidance on how to administer the Child Listing for Phase Two, see [Annex O](#). Interviewer guidelines.

Tool: Child Listing for Phase Two

Questionnaire for Children under 5

The Questionnaire for Children under 5 collects information on some basic characteristics of the child and his or her background, as well as more detailed information on a range of topics, including early child development, child functioning, exposure to non-violent and violent disciplinary methods, treatment and care-seeking for illnesses during the first five years of life. The questionnaire also includes a module on anthropometry to collect height and weight information for each selected child.

The early childhood development and child functioning modules of the Questionnaire for Children under 5 are only administered to children between the ages of 2 and 4 years. Due to the transitional nature of the developmental process in young children, a developmental delay is not necessarily indicative of functional limitations; therefore attempts to assess difficulties in functioning may yield misleading results for children under the age of 2.⁴⁴ Additionally, domains of child functioning and early childhood development in the first few years of life are difficult to accurately measure through caregiver reporting methods, as has been established in research literature and also verified through attempts to test parental reporting methods.^{45,46} Assessment methods of child functioning based on parent or primary caregivers have been shown to not always represent the experience of the child accurately.⁴⁷ Due to the absence of well-validated and cross-culturally applicable measures that can

reliably assess delays in development or developmental difficulties through caregiver reporting in children under 2, these elements of child health and well-being are not captured in the Questionnaire for Children under 5.

For detailed guidance on how to administer the Questionnaire for Children under 5, see [Annex O](#). Interviewer guidelines.

For detailed guidance on implementing the anthropometry module in the Questionnaire for Children under 5, see [Annex P](#). Manual for anthropometry.

Tool: Questionnaire for Children under 5

Questionnaire for Children Aged 5-14

The Questionnaire for Children Aged 5-14 collects information on basic characteristics of the child and his or her background, as well as more detailed information on a range of topics, including child functioning, child work and activities, exposure to non-violent and violent disciplinary methods, and foundational learning skills. The foundational learning skills module is an assessment of basic reading and number skills administered by the interviewer to the selected child. Interviewers will need to use their judgement in cases where a child has a disability or impairment that might preclude him/her from being administered the foundational learning skills module.

For detailed guidance on how to administer the Questionnaire for Children Aged 5-14, see [Annex O](#). Interviewer guidelines.

Tool: Questionnaire for Children Aged 5-14

Questionnaire for Adolescents Aged 15-17

The Questionnaire for Adolescents Aged 15-17 collects information on basic characteristics of the adolescent and his or her background, as well as more detailed information on a range of topics, including adolescent functioning, adolescent work and activities, menstrual hygiene management, exposure to non-violent and violent disciplinary methods, violence and unintentional injuries, resilience and life satisfaction.

If the selected adolescent has a disability or impairment that precludes him or her from being interviewed directly, then the interviewer will record this on the questionnaire. The interviewer will instead administer the adolescent background, adolescent functioning, adolescent work and activities and adolescent discipline modules to a caregiver or most knowledgeable person.

It is absolutely essential that female respondents be interviewed by a female interviewer for administration of the Questionnaire for Adolescents Aged 15-17, due to the personal and sensitive nature of some of the content.

Many of the questions included in the violence and unintentional injuries module have been taken or adapted from the World Health Organization's Global School-based Student Health Surveys.⁴⁸ The measure used to assess resilience is the Child and Youth Resilience Measure (CYRM-R).⁴⁹

As part of the development and testing of the standard protocol and tools, modules on mental health (symptoms of anxiety and depression) and sexual violence were included in some countries. In both cases, the modules did not work well with this population and many of the questions were found to be especially sensitive.⁵⁰ In light of these observations, neither module has been included in the standard protocol and tools and cannot be recommended for use at this time. That said, if there is a particular interest in these issues, countries are encouraged to consult with UNICEF on suggested questions and protocols.

For detailed guidance on how to administer the Questionnaire for Adolescents Aged 15-17, see [Annex O. Interviewer guidelines](#).

Tool: Questionnaire for Adolescents Aged 15-17

Questionnaire on Children's Case History

The Questionnaire on Children's Case History collects information on basic characteristics of children's case history/background as well as case management. This includes information on when the child arrived at the facility, the primary reason for living in the facility, the living situation prior to arriving at the facility, parent survival status, contact with relatives, siblings also living in the facility, whether children were placed in the facility through the appropriate gatekeeping mechanism, whether they have an assigned a social worker/case worker and details on care plans where these exist.

For detailed guidance on how to administer the Questionnaire on Children's Case History, see [Annex O. Interviewer guidelines](#).

Tool: Questionnaire on Children's Case History

4.4 Management, storage and transportation of completed questionnaires/tools

Particular care should be taken to ensure the safe and secure storage of all information contained in the completed data collection tools and questionnaires. All raw and analysed data, questionnaires, and completed tools must be stored securely with the fieldwork team during data collection and with the national coordinator after data collection has concluded.

Paper questionnaires (if used), interviewer guidelines and other tools containing information that identifies facilities or respondents should be secured in locked cabinets during data collection and destroyed once data entry and checks have been completed. Electronic files containing data or information identifying facilities or respondents should be secured through password protection and through encryption when sending information over the Internet.

4.5 Data backup and transmission

For CAPI-implemented exercises, data will be entered by the interviewer at the time of the interview. At the end of each day, interviewers will submit their electronic devices to the field supervisor who will download the data onto a laptop and perform a backup of each interviewer's data using an encrypted USB flash drive. Once a supervisor has collected and backed up all the team's data, they should transmit the encrypted data electronically from the laptop to the central

office using a mobile Internet connection. Data should be backed up onto a hard drive at the national level and securely stored with national coordinators.

For paper questionnaires, the field editor will visually check the completeness of the questionnaires and accuracy of the responses. The field editor or supervisor will be responsible for storing the questionnaires during the period of data collection and transporting them to the national coordinator at the end of data collection. The national coordinator will then coordinate the data entry among data entry personnel (see section 5).

4.6 Quality control procedures

Quality control procedures are ongoing measures in place to ensure the quality and accuracy of the data being collected. All members of the data collection team are responsible for maintaining high data quality. Interviewers and measurers must follow the field and data collection procedures as specified during training. Environmental or behavioural anomalies during data collection, such as difficulty finding a private space or dealing with continuous interruption, or respondents who are particularly nervous or hostile, should be recorded by the interviewers and measurers at the end of administering the questionnaires or taking measurements (space for interviewer/measurer observations and notes are included at the end of each tool/questionnaire). These observations should be discussed at the end of each day with supervisors since they can provide context that may help to clarify inconsistencies in the data.

Field supervisors are responsible for monitoring interviewer progress and performance through careful record-keeping and the evaluation of completed interviews. Supervisors should collect information on the number of hours worked, the number of completed interviews and the refusal rate for each interviewer in their team. Ongoing monitoring of completed questionnaires/tools may also help the supervisor clarify un-codable responses or reasons for incomplete questionnaires. These checks help the supervisors (and interviewers) know if the field procedures are understood and if interviewers are following instructions and recording responses appropriately. It also provides an opportunity for early intervention and course correction while still in the field.

Supervisors should aim to conduct regular debriefings with interviewers during fieldwork, both as a means of maintaining an overview of their teams' progress as well as detecting and dealing with any problems, building rapport among team members, and providing an opportunity for learning and improvement. While most debriefings will take place as a group, individual debriefing sessions between interviewers and the supervisor may be appropriate (or necessary) if specific issues are identified and need to be addressed separately. Annex N (field supervisor manual) includes a checklist for fieldwork monitoring that supervisors should implement at regular intervals throughout the data collection.

The central office should also plan to undertake fieldwork monitoring visits. It is recommended that a minimum of 20 per cent of the total number of facilities should be monitored. The checklist included in Annex N can also be a useful tool for the central office when conducting fieldwork monitoring visits.

Data collected using CAPI can greatly enhance the efficiency and monitoring of data quality. Computer-assisted interviewing can help to standardize interviews, verify response consistency,

streamline filter and skip patterns and detect inadmissible responses. Additionally, CAPI can include a quality check in the automated recording of interview times. This helps supervisors and the central office to detect suspiciously short or long interview times, which may indicate a data quality issue.

It is recommended that, when using paper methods, supervisors use daily fieldwork control sheets as an additional tool for systematically monitoring interviewer performance.

After the completion of Phase One, the running of some simple frequencies is recommended to generate the total number of children captured by the Facility Roster compared to the number recorded in the verification count. Discrepancies between these two sets of numbers are to be expected, so if there is a perfect match, this can be an indication of a data quality issue such as teams not completing the verification count.

PROVISIONAL DRAFT

SECTION 5: DATA PROCESSING, ANALYSIS AND DISSEMINATION

5.1 Preparation and timeline

Prior to the start of fieldwork, teams should prepare materials and procedures for entering, checking, processing/editing and analysing data. Preparation will include acquiring computer equipment, organizing an office space, identifying and recruiting appropriate personnel, adapting and customizing standard data entry applications to be reflective of all changes introduced during adaptation and customization (see section 5.2 below), and setting up a system for managing the questionnaires (if in hard copy) and data files.

5.2 Data processing team composition and infrastructure

The data processing team may include up to three types of roles: a coordinator, field supervisor and data editors. If the survey method is paper-based, additional data entry operators will be needed to comprise a full data processing team.

The **field supervisors** check and organize the questionnaires as they arrive from the interviews. They should check that all of the questionnaires are completed, that coding is consistent and that the data pass basic quality checks. If there are missing or incomplete questionnaires, they should resolve this with the interviewers on an ongoing basis.

If using paper-based methods, **data entry operators** will enter the data into the chosen data entry program. Data entry operators should have prior experience with data entry and be familiar with the questionnaires. Operators should attend the interviewer training to familiarize themselves with the questionnaires. They will also need to attend an additional day of training to introduce them to the chosen data entry program and to review daily expectations and responsibilities.

The **data editors** follow up on and resolve complex inconsistencies discovered by the secondary editing program. They should have an in-depth understanding of the questionnaires and the goals of the data collection.

The **coordinator** will lead the data processing team and be responsible for adapting the statistical programs to suit their country's questionnaires and overseeing all processing tasks. The national coordinator should have experience managing data processing for national surveys, a thorough understanding of the questionnaires, and programming skills in the appropriate software packages. The coordinator should be identified early in the planning stages so that she or he they may be involved in the adaptation and customization and lead any revision, if necessary. She or he should also be consulted to ensure that the coding schemes are consistent and that all of the information necessary for identification is included. The data processing supervisor must also be able to assist in final revisions to the questionnaire based on experience gained while entering questionnaires from pilot tests.

In the event that a country does not feel it possesses adequate technical expertise and knowledge to conduct the data analysis themselves, it may be necessary to explore the possibility of soliciting and procuring outside technical assistance and support for data analysis. This external support may come from an academic or research institute or other national or international entity.

5.3 Data entry programming and applications

As mentioned previously, electronic modes of data collection require the use of a data entry platform and CAPI applications that can be programmed into an existing software package such as CPro. As part of the development of this protocol, a set of standard CAPI data entry applications has been developed for all data collection tools/questionnaires included in both Phase One and Phase Two. These will be made available to countries to adapt when implementing this protocol.

However, even though standard CAPI applications are readily available, countries will still need to undertake a careful process of customizing the applications to reflect any changes/additions/deletions introduced to the standard set of tools and questionnaires. This requires additional time and resources that should be factored into timeline and budget considerations.

The standard CPro application can be found in [Annex T](#).

5.4 Field checks and field check tables

It is recommended that the national coordinator and data processing team contribute to quality control through field checks and/or remote monitoring of data received from field teams. Field checks are done by directly monitoring interview and field activities and provide an opportunity for the national coordinator and field supervisor to jointly review the progress of interviewers and field teams as well as the quality of the data being collected. Remote quality control checks are useful for CAPI-implemented questionnaires in particular and are done by reviewing progress reports and field check tables generated by statistical software at regular, ongoing intervals. It is important to check data collected on a pre-identified set of core indicators and to summarize the total number of interviews and refusals disaggregated by interviewer, or to monitor how many referrals have been given during interviews.

Field check tables need to be produced at regular, timely intervals (once per week at a minimum) throughout the full duration of fieldwork for both phases. It is useful to monitor data quality so that issues can be identified and addressed while teams are still in the field. For each field check indicator, data should be produced both at the level of the team as well as at the level of individual interviewers. The advantage of having interviewer-level data on field check indicators is that these can be compared to the team average to determine if there are performance issues with certain individuals within a team and/or if there are issues with the team as a whole. Individual-level data is particularly important during Phase Two for field check indicators related to anthropometry in order to assess performance of measurers and address any issues.

During fieldwork for Phase One, it is recommended that the following minimum set of field check indicators be monitored:

- Facility response rate: Percentage distribution of facilities by result of facility interview, by fieldwork team
- Birth date reporting of children: Percentage distribution of children aged 0-17 years by completeness of date of birth/age reporting information, by fieldwork team
- Age displacement of children: Number of children aged 0-17 years listed in the Facility Roster by single year of age and age ratios 5/4 and 6/7, by fieldwork team

- Percentage of places for handwashing observed by the interviewer in all facilities, by fieldwork team.

During fieldwork for Phase Two, it is recommended that the following minimum set of field check indicators be monitored:

- Response rate for children under 5: Percentage distribution of eligible children under age 5 by result of individual interview with most knowledgeable person, by fieldwork team
- Response rate for children aged 5-14: Percentage distribution of eligible children aged 5-14 by result of individual interview with most knowledgeable person, by fieldwork team
- Response rate for children aged 7-14: Percentage distribution of selected children aged 7-14 by result of learning assessment, by fieldwork team
- Response rate for adolescents aged 15-17: Percentage distribution of eligible adolescents aged 15-17 by result of individual interview, by fieldwork team
- Birth date reporting of children: Percentage distribution of children aged 0-17 years by completeness of date of birth/age reporting information, by interviewer and fieldwork team
- Questionnaire for Children under 5, to be presented by interviewer/measurer and fieldwork team:
 - Percentage of children under 5 with: Diarrhoea in the last 2 weeks; a cough in the last 2 weeks; a fever in the last 2 weeks (care of illness module)
 - Percentage of children aged 1-4 years with all 'No' responses to child discipline questions (child discipline module)
 - Percentage distribution of children under 5 by result of height and weight measurements, and percentage of children measured who have out-of-range values or incomplete date of birth (anthropometry module)
 - Heaping in anthropometric measurements: Percentage of weight and height/length measurements by digits reported with 0 and 5 (anthropometry module)
 - Rounding of digits in anthropometric measurements
- Questionnaire for Children Aged 5-14, to be presented by interviewer and fieldwork team:
 - Percentage of children aged 5-14 years with all 'No' responses to child discipline questions (child discipline module)
- Questionnaire for Adolescents Aged 15-17, to be presented by interviewer and fieldwork team:
 - Percentage of adolescents aged 15-17 years with all 'No' responses to child discipline questions (adolescent discipline module)
 - Percentage of adolescents aged 15-17 years with all 'Yes' responses to resilience questions (resilience module)

Guidance on interpreting field check indicators is provided in Box 9. Templates for reporting tables on the above field check indicators can be found in [Annex U](#).

Box 9. Guidance on interpreting field check indicators

For Phase Two field check indicators, response rates for individual interviews should be examined to detect any issues. In general, response rates of at least 80 per cent should be targeted.

When it comes to examining the proportion of interviews with all 'No' responses to the child discipline modules, expected levels are normally below 10 per cent for household surveys. Given that the context for data collection differs in this case, it might be reasonable to see values higher than this since caregivers might be inclined to misreport the use of disciplinary practices (particularly violent ones) with children under age 15. In the case of adolescents aged 15-17, misreporting is less likely to be an issue since questions related to discipline are self-reported.

For the anthropometry-related field check indicators, height and weight values out of range should normally be 0 per cent, but levels below 5 per cent might be considered acceptable. Any values above 5 per cent should be examined carefully as this may indicate a need for additional training or coaching of individual measurers. For field check indicators on heaping in anthropometric measurements, patterns of rounding should be examined. Generally, this heaping tends to be more of an issue when it comes to height as opposed to weight measurement.

5.5 Data processing and editing⁵¹

During the primary data processing phase, data files are cleaned and checked for accuracy and consistency and backed up to a secure hard drive. This phase may also include checking the structure of data files and performing secondary editing on data files. After the data are cleaned and reformatted, as necessary, the goal is to produce data files that can then be used for analyses and production of standard tables by undertaking the following:

- Linking team data files into one master and merged data file
- Inputting missing information
- Exporting data to the analysis software
- Calculating sample weights
- Recoding variables to simplify analysis
- Archiving and distributing data files

5.6 Data analysis and indicators

There are a number of options when it comes to available software packages for countries to analyse their data. SPSS and STATA are two common commercial software packages used for data management, graphing and statistical analyses. Both are well-suited for producing descriptive statistics and multivariate analyses and are available for purchase online or through local software distributors. National statistics offices or other implementing bodies may have a preferred software for analysis and already have active licences.

Once the data have been prepared for analysis and the dataset has been exported to the analysis software program, statistical tables can be generated to summarize and present the results. When a significant amount of data has been collected, these types of tabulations help to simplify complex data and arrange them in a logical order in order to facilitate presentation, comparison and further computation.

As part of the development of this protocol, a tabulation plan has been created that outlines all the tables recommended for reporting on a set of core and expanded indicators, as outlined in section 5.6.1. The tabulation plan for analysis and reporting can be found in [Annex V](#). The standard syntax files (in SPSS) can be found in [Annex W](#).

5.6.1 Indicator set

The list of core indicators for reporting was developed in consultation with the reference group. It draws heavily from and builds upon the UNICEF and Better Care Network's Indicators for Children in Formal Care.⁵² The list of expanded indicators includes standard indicators for reporting on the MICS modules upon which the Questionnaire for Children under 5, Questionnaire for Children Aged 5-14 and Questionnaire for Adolescents Aged 15-17 are primarily based. These indicators are intended to report on information key to developing or feeding into existing information systems that monitor residential care facilities and the children who live in them. The core list provides a set of metrics most critical to understanding residential care at the facility and child level that are comparable across settings and time. The expanded list of indicators allows for reporting on a wider set of data collected through the facility and child questionnaires.

The purpose of outlining a recommended set of core indicators at the facility and child level was also to facilitate reporting in those countries that choose to only implement Phase One. All of the core indicators can be calculated on the basis of data collected in Phase One.

The complete list of both core and expanded indicators can be found in [Annex X](#).

5.7 Data analysis and interpretation workshop

Once the data processing, cleaning, analysis and tabulation have been completed, the technical working group should organize a workshop dedicated to reviewing the results of the data analyses. A key objective of this workshop is to discuss and agree upon the interpretation and presentation of results. It is recommended that the workshop be organized over three days as a minimum and include participation from the national coordinator, data processing/IT experts and other technical experts from the implementing body, along with key members of the technical working group, particularly those who are well placed to comment on the interpretation of the findings in light of the country context and who can provide feedback on policy and programmatic recommendations.

5.8 Report writing⁵³

A full report on the methods and results of the data collection should be developed. Presenting the findings in an organized and accessible manner is essential for ensuring that actions designed to prevent and respond to the institutionalization of children are most effective.

A written report should open with a foreword from the technical working group, followed by a list of definitions of, and acronyms and abbreviations for, technical language used throughout the report as well as an executive summary of the findings. The remainder of the report may include the following sections.

An **introduction and background** to introduce the research and objectives, describe the operational definitions of children and facilities, explain the country's data needs and previous research efforts on children in alternative care, and provide an overview of how the report is organized.

A section on **methodology** should describe the methods used to collect, process and analyse the data, as well as any limitations. Descriptions should be detailed enough to enable another researcher to replicate the study, compare its methods to a similar study and enable the reader to evaluate its rigour. This section should include a description of the study design, tools used, times and locations of data collection, sampling methods, sample size and ethical procedures. This may help readers evaluate the comparability of the data and methods.

A **results and discussion** section should summarize the findings of the data analysis, with any appropriate graphs, tables and figures. This section should interpret and describe the significance of the findings and should include a description and explanation, when possible, of any anomalies found in the data.

A **recommendations and conclusions** section may cover policy or other practical implications of the findings and discussion. Effort should be made to connect the findings to the national policy and research literature on children in alternative care and should explore the implications of the findings for care reform and systems strengthening in the country. This section should succinctly summarize the findings in an accessible manner and clearly link the findings to relevant policy or programme priorities. In this section, specific evidence-based recommendations directed at interventions and policy are preferred to general statements.

Appendices may be included in the report to provide, for example, additional data tables and questionnaires/tools.

Sufficient time should be allocated to this task and should account for time required for multiple rounds of review, feedback and revision.

See [Annex Y](#) for a report template.

5.9 Dissemination plan

Findings from the data collection should be shared widely among policymakers, researchers, service providers and community members and distributed to relevant agencies and institutions working with children in residential care. To ensure wide uptake of the findings and implications of the research, a dissemination plan should be developed by the team as part of the initial planning process.

It is recommended that the technical working group organize a national launch event or workshop to release the findings and present the main results to policymakers, civil society organizations, donors and other relevant national and regional actors. The findings should be endorsed by all members of the technical working group ahead of their release, if possible, to maximize the reach of the findings and uptake of the recommendations by diverse stakeholders. Launch events may also be organized at the regional level with the support of relevant regional entities and bodies, if useful.

It is also recommended that reports or other methods of reporting are made publicly available. If possible, reports should be available and downloadable online. This allows the methods and findings to be accessible to users nationally and internationally.

The technical working group, in consultation with the national implementing body, may also consider making the full datasets available to those who wish to use them for further analysis or comparison. In this case, extra caution should be taken in making sure all data are stripped of personal identifiers in order to guarantee the anonymity of the data and ensure the confidentiality of participating facilities and respondents.

5.9.1 Additional reporting methods

In addition to a full report, alternative methods may be considered for reporting the findings of the data collection on children in residential care. The different methods outlined below may support understanding of the findings to wider or different audiences and may be considered for effectively communicating study implications.

Fact sheets are one- or two-page documents highlighting key facts and findings, usually with data visualizations, in an easy to read and concise format. These are best suited for audiences who may appreciate a quick snapshot of the study and findings but are not interested in the background or methods. Fact sheets are also well suited for advocacy purposes and are often used by policymakers.

Presentations using slide decks are an effective way to present an overview of the most relevant information and findings to academics, policymakers and relevant stakeholders. In addition to the report, circulating and presenting PowerPoint and other presentations helps to share study findings and encourages engagement with relevant parties.

Press releases are typically one page and are meant to notify the public about research findings. These may notify news outlets of the release of the report or highlight specific findings.

Academic journal articles are useful methods for sharing the results of the research effort with a wider audience. Journal articles are typically short and may be designed to focus on methods, general findings or to highlight a particular finding of the research.

5.10 Publication strategy⁵⁴

When reporting the findings of the study on children in residential care, the objective is to clearly communicate the implications of what has been learned to stakeholders most active in work on alternative care. Language used should not be too technical, and statistical findings should include context and explanations of their relevance. Reports and other publications described above highlight the significance of the data collection and contribute to the greater body of research on children in alternative care. This is a crucial step in the research process and is critical for policy reform and improving the well-being of children.

Planning a publication strategy will begin with identifying a target audience and considering the different needs of each stakeholder. The content of communications may then be tailored to meet the expectations and needs of each. The table below outlines some potential audience groups and provides guidance on how to strategize communications.

Table 5. Possible target audiences and dissemination materials to meet their expectations

Audience	Expectation	Guidelines and methods
Polymakers	Key messages on residential care, case management and the well-being of children in residential care; summary of policy implications	Report Presentations Fact sheet
Practitioners	Statistics, key messages and practical suggestions for improving interventions or service delivery	Report Fact sheet
Donors	Overview of key findings, implications, recommended actions and next steps; challenges and financial expenditure	Report Presentations
Academics	Theoretical and methodological details, thorough discussion of results and implications	Report Academic journal
Public	Concise messages on advocacy; concrete stories relating findings to daily life	Fact sheets Press release
Media	Snapshots of findings and implications	Press release

PROVISIONAL DRAFT

ENDNOTES

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