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Acronyms

ARI	Acute Respiratory Infection
AIMES:	Annual Impact Monitoring & Evaluation System (Program)
CCF	Christian Children's Fund
DHS	Demographic and Health Surveys
ECD	Early Childhood Development
FIT:	Finance Impact Tool
H/A	Height for Age
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
NCHS	National Center for Health Statistics
M&E	Monitoring & Evaluation
NO	National Office
NGO	Non Government Organization
ORS	Oral Re-hydration Solutions
ORT	Oral Re-hydration Treatment
PMT	Project Management Tool
SPA	Service Provision Assessments
SITE:	Standard Indicator Tool for Evaluation
SSIMS:	Sponsor Services Indicator & Measurement System (SR)
SA	Supervision Area
TT2	Tetanus Toxoid (TT)
TUFF:	Tool Used For Focus
U5MR	Under-5 Mortality Rate
UN	United Nations
UNDP	United Nations Development Program
W/A	Weight for Age
W/H	Weight for Height
WHO	World Health Organization

Annual Impact, Monitoring & Evaluation System

1. Introduction:

AIMES is a system of measuring program impact and is designed to show if the interventions are making a positive and measurable difference in the lives of children and communities served by CCF projects. All interventions must result in 'improving' children's well-being and better quality of life in the community. AIMES helps CCF projects do this by closely monitoring the impact with the use of several carefully selected indicators:

All interventions must strive to promote three top IMPACT INDICATORS:

- To reduce the incidence of **deaths of children** under-five years old.
- To reduce the prevalence of **malnutrition among children** under five years of age.
- To reduce the prevalence of **illiteracy** among population over 15 year of age.

The PROCESS /PROJECT INIDATORS measure increasing number of:

See Section 14 For TEMPLATES on approaches and interventions.

- Live Births that are TT2 protected (mothers immunized with TT2 vaccine during pregnancies).
- 1-2 year olds who are fully immunized.
- Under-5 year old malnourished children becoming normal.
- Families who know how to home-manage cases of diarrhea with Oral Re-hydration Solutions.
- Families who are competent at early detection/treatment of Acute Respiratory Infection (ARI) and referral of cases.
- Families who have access to safe water in adequate quantity.
- Families who have access to and practice sanitary disposal of excreta.
- Children 0 to 5 who have access to quality early childhood care and development programs (includes preschool).
- Children 5+ to 15 who attend schools and receive quality education.
- Persons 15+ to 20 attaining a level of learning and skill development.

The first three are "Impact Indicators" (sometimes referred to as Goals or Targets) and the next ten are Process or Program Indicators. Timely, consistent and effective interventions lead to desired changes in the process indicators, which in turn improve impact indicators. AIMES is an evolving system and more indicators can be added, especially for "Project Specific" Indicators.

The correlation between **"Health Knowledge" and "Health Practice"** has drawn much attention in CCF Projects. To address this important issue, a set of indicators have been developed in the next section (*Page 9)*.

What is 'AIMES'?

There are 4 components or tools that constitute the system:

- **FAMILY CARDS: The 'Family Card' is the most basic tool in the system. It contains all information in respect of the family and for each member of the family. Family Cards are used firstly to create baseline data for the community and then to update the information periodically.**
- **SERVICE ROSTERS: They contain lists of target groups and are used for regular follow up of the progress individual member of the family is making towards the set targets.**
- **VITAL EVENTS REPORTING: All vital events like pregnancy, birth, death, and migration in and out are tracked and reported as they occur and entered into registers maintained by CCF project/center office. Accurate information on these events is very useful for organizing services and for compiling data.**
- **STANDARD IMPACT TOOL FOR EVALUATION OR SITE: This provides a tabulation of data in order to create a community snapshot of where it stands. Can be prepared periodically as needed. Covers all indicators.**

☞ What are the prerequisites for implementing AIMES?

Evolved in response to the need for measuring the impact of CCF programs and interventions on the lives of children and communities they cover, the system presupposes and reinforces the following:

1 That the programs are community based and the family is a unit of intervention.

2 That CCF programs funded by sponsorship and/or other support must cover all or large majority of families in a given community for AIMES to be implemented purposefully.

3 That the critical needs of women in child-bearing age, mothers, other caregivers and children in 0 to 5 years age group must receive due attention and support in view of the fact that AIMES focuses on measuring program impact on this age group. *The rationale: early childhood care builds the foundation for life.*

Early Childhood Care Builds the Foundation for Life!

4 That even in a sponsorship supported CCF program, efforts must focus on promoting and eventually ensuring access to quality ECD programs & quality education *for all children in a given community and not just enrolled ones.*

5 That networking with the Government and other agencies, local/community health facilities and schools is increasingly critical for ensuring the kind of effective and timely interventions necessary for creating desired impact on the target population.

6 That large initiatives are needed for improving access to clean and adequate quantity of water, safe sanitation and enhanced family income to create favorable environments for children's healthy growth and development being measured by AIMES. *This calls for mobilization of additional resources.*

☞ How are Home visits organized?

For AIMES, the key driving force is ***Home Visiting.*** It is like an engine that drives the entire system. In order that each and every family covered by CCF program is visited regularly at the interval of not less than a month, it becomes absolutely necessary to use the services of *community volunteers*. Select those with adequate level of literacy and impart them necessary training. In order to be effective, each volunteer may be assigned not more than 20 families. Each volunteer will then be responsible for all activities including completion and regular updates of family cards, maintenance of service rosters, and vital events reporting for a set of 20 families only. *They will work under the supervision of a qualified and skilled project staff.* While there can be several clusters of families assigned to different volunteers, the information and data they gather will be compiled to *prepare one SITE for the given community that the project serves. (Refer to section on Home Visitation for more information).*

The key driving force is Home Visiting!

☞ How does this system work?

Accounting for each family and keeping close contact with all of them through regular home visiting are basic for the system to work. This is critical for the process of AIMES. Local community members (Parents and Community Volunteers) are trained to become home visitors and they make regular rounds throughout the community, visiting families house to house. They act as important link between the project and the families bringing in information and data from the families and carrying useful information and messages to families. They provide on the spot training and health education to the caregivers and motivation and moral support to **the families.**

DID YOU KNOW THAT:

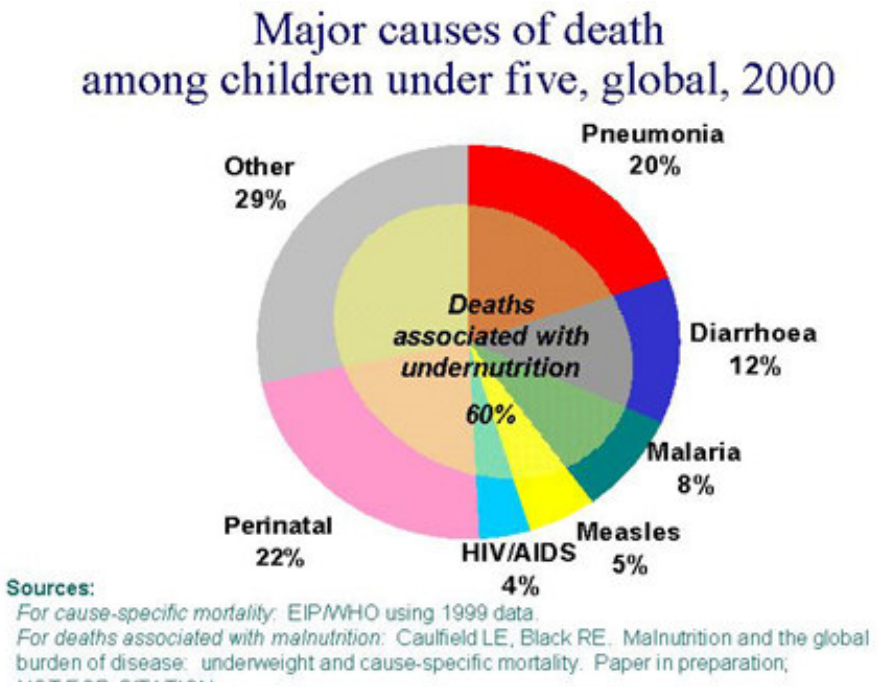
- 2 million children under five die annually from pneumonia in developing countries
- Another 2.2 million children under five die each year due to diarrheal disease
- Diarrheal disease and acute respiratory infections in children under five, 5 million neonates still die annually due to infection
- A total of 9.2 million children lives lost from preventable and treatable diseases

Communities need to be strengthened and families, caregivers and CCF home visitors supported to provide the necessary care to improve child survival, growth and development. CCF strongly indorses and recommends that families should:

12 Key Family Practices:

1. Breastfeed infants exclusively for at least six months. (mothers found to be HIV positive require counselling about possible alternatives to breastfeeding).
2. Starting at about 6 months of age, feed children freshly prepared energy and nutrient rich complementary foods, while continuing to breastfeed up to 2 years.
3. Ensure that children receive adequate amounts of micronutrients (vitamin A and iron in particular), either in their diet or through supplementation.
4. Dispose of faeces, including children's faeces, safely; and wash hands after defecation, before preparing meals, and before feeding children.
5. Take children as scheduled to complete a full course of immunizations (BCG, DPT, OPV, and measles) before their first birthday.
6. Protect children in malaria-endemic areas, by ensuring that they sleep under insecticide-treated bed-nets.
7. Promote mental and social development by responding to a child's needs for care, and through talking, playing, and providing a stimulating environment.
8. Continue to feed and offer more fluids, including breast-milk, to children when they are sick.
9. Give sick children appropriate home treatment for infections.
10. Recognise when sick children need treatment outside the home and seek care from appropriate providers.
11. Follow the health worker's advice about treatment, follow-up & referral.
12. Ensure that every pregnant woman has adequate antenatal care. This includes having at least four antenatal visits with an appropriate health care provider, and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period.

Source: Child and Adolescent Health and Development, WHO



2. Component One: Family Cards

The 'Family Card' is the most basic tool in the AIMES' toolbox. In order that every family covered under the program is accounted for, one card should be used for each **Family or a household.** The Family Card must have the following information:

Sample Family Card (See Appendix: 9)

Project Name:		Project No.		Date of Baseline Survey:	
Family Address:		Family No.		Follow-up (Dates):	

CCF Project Heading Information

Project Name	Name of the affiliated project or the center run by CCF
Project Number	For Sponsorship Projects only. Leave blank if not applicable
Date of Survey	Date the initial survey was conducted.
Family Address	Location or street address.
Family Number	In sponsorship project, child's case number. For others, if assigned
Follow-up Dates	Use every follow up visit to update the card and enter the date.

Individual Family Data Collected for the Family Card

#	Name	Relation to HH	Sex M/F	DOB D/M/Y	Date Immuniza-tion Completed	Educational Status	Literate over 15	Occupa-tion	Nutritional Status	Remarks

Enter relevant information against each member of the household:

Name	Names of individual family members
Relation to HH	See Code Reference on the next page.
Sex M/F	Sex: M for male, F for female
DOB: D/M/Y	The Date of Birth (DOB) is very important for targeting different age groups for tracking progress and addressing their different needs, like under-5, 5+ to 15 and 15+ to 20.

#	Name	Relation to HH	Sex M/F	DOB D/M/Y	Date Immuniza-tion Completed	Educational Status	Literate over 15	Occupa-tion	Nutritional Status	Remarks

Date Immuniza-tions Complete	In an on-going program, the home visitor will follow up: (1) Newly born children for immunizations to be completed as per the schedule (see appendix 4). (2) Pregnant women for two doses of tetanus toxoid vaccine to be given at the interval of one month after pregnancy. Mention the date of completion for both on the family card. For determining the percentage of children immunized, review the status of 1 to 2 year old infants ONLY[1]. If over-age, mark with an "x" or special code to show that the child falls outside of the target group. If the child is between 1 and 2 but not yet fully immunized, leave it blank and count the child as not immunized.
Educational Status	Date and type by code (see below Codes). Since this changes over time, the date must be recorded. 1. For 0 to 3 years old, determine if the child and caregivers have access to home based ECD program and enter the relevant code. 2. For 3+ to 5 year olds, determine if children have access to center based ECD or preschool program and enter the relevant code. 3. For 5+ to 20 year olds, enter relevant codes form primary schooling to university education and/or skill development training. 4. If not participating in any education program, leave blank.
Date literate	This date is once in a lifetime accomplishment, to be determined in respect of each and every member of the family (covered in the program), for persons of all ages above 15 years. If illiterate, leave blank.
Occupation	Date and type by code (see below codes)
Remarks/ Com-ments	This provides space for explaining vital events or making other similar notations. For example, during the time of the survey if a mother is pregnant, this information could be marked in these columns against her name for tracking vital information.
Enrolled Chil-dren	In case of sponsorship projects, circle the serial number of those children on the card who are enrolled for sponsorship.

Code Referencing within the Family Card

#	Name	Relation to HH	Sex M/F	DOB D/M/Y	Date Immuniza-tion Completed				Educational Status				Literate over 15	Occu-pation	Nutritional Status				Remarks
					D	C	D	C	I	(	I	(			I	(	I	C	

Codes	Relation	Education	Occupation
A	Self	Home Based ECD	Farmer
B	Spouse	Center Based ECD (Preschool)	Housewife
C	Child	Primary Formal	Laborer
D	Sister/Brother	Primary Non-Formal	Temporary
E	Parents	Secondary Formal	Service
F	Uncle/Aunt	Secondary Non-Formal	Tailor
G	Step/Sibling	University	Construction
H	Cousin	Vocational/Skill Development	Caterer
I	Others	Others	Others

D = Date, **C**= Code

[1] *The primary doses against six vaccine preventable diseases should be over within the first year. Therefore, the information collected here pertains to children who have completed the primary doses during their first year.*

FAMILY LEVEL DATA: This refers to the status of the family with regard to the following targets:

1 **Access to clean and adequate quantity of water:** CCF National Office adopts the definition acceptable in the country for 'access' in terms of distance and time, for quality of cleanliness and for adequacy of quantity available per person.

2 **Access to *sanitary* disposal of excreta:** Definition must include acceptable type of disposal considered sanitary.

3 **Knowledge about managing diarrhea using ORT:** This will include clear understanding on the part of the parents and caregivers about the following:

- The child should continue to receive normal feeding and water to drink
- The caregivers must obtain and prepare ORS and administer it continuously
- The caregivers must know when and where to refer the case for specialized medical assistance

4 **Competence of detecting and managing ARI:** This includes:

- Parents and caregivers' ability to recognize the symptoms of ARI such as fast breathing, sunken chest etc.
- Their ability to provide necessary home care including continued food and water intake.
- Their ability to refer the case to the nearest health facility without loss of time.

5 **Adequate Income:** Does this family have a sustained source of 'adequate' income? Expected response to this question is in 'yes' or 'no' using the definition of 'adequate income' relevant to the *poverty line* accepted in the country or as determined by the National Office. The "Millennium Goals" consider any income less than 1 $ per day as extreme form of poverty. *(See appendix: 1)*

6 **Adequate Housing:** National Offices to decide on the expected standard of housing.

7 **Access to Quality ECD programs:** In this family, do children 0 to 5, their mothers and other caregivers have access to services and programs for early childhood care and development? From birth to 3 years or so, children and caregivers will benefit most by home based programs. For children 3+ to the time they enter primary school, center ECD or preschool programs are recommended. *(See Section 12: Guidelines for ECD programs for more information)*

Motivation & moral support to the families!

8 **Access to Quality Education:** In this family, do children 5+ to 15 years of age have access to quality education facility? The definition of "quality" ECD and Education programs will be country specific and will be evolved by National Offices.

☞ *Health Knowledge Versus Health Practice*

Much discussion has taken place regarding CCF monitoring the impact of "Health Knowledge" as it translates to "Health Practice". When home visitation occurs, community volunteers record family knowledge in the family card that is reflected in ongoing and annual SITE/AIMES tabulation. However, the actual "Family Health Practice" as it pertains to Project monitoring tends to be a bit more subjective and can "fall through the cracks". The following matrix offer Projects various critical indicators that they can incorporate in their Family Card for the purpose of assessing **Family Health Knowledge against Health Practice:**

	Indicators	
Intervention	**Practice**	**Knowledge**
Nutrition	1. % children (0-23 mos.) who are </= 2SD below the median weight/age of reference population 2. % of children (0-23 mos.) who have a growth monitoring card	
Immunization	1. % of mothers who receive at least 2 (TT2) car confirmed before birth of youngest child less than 24 months of age 2. % children (0-23 mos.) who are fully immunized before 1st b-day	
Diarrhea	1. % of children (0-23 mos.) with diarrhea in last two weeks	1. % of mothers (0-59 mos.) who can correctly describe how to prepare ORS 2. % of mothers (0-59 mos.) who clearly cite at least 2 danger signs of diarrhea
ARI	1. % of children (0-23 mos) who have had continuous intake of fluids and cont. feeding in the last month.	1. % of mothers (0-59 mos.) who know at least 2danger signs of childhood illness that indicate the need for treatment.
Malaria	1. % children (0-23 mos.) who slept under insecticide treated net the previous night 2. % children (0-23 mos.) with a febrile episode during the last 2 weeks treated with effective malaria drug after fever began 3. % of mothers who took anti-malarials to prevent malaria during pregnancy	
Water/ sanitation	1. % household with drinking water source or covered well 2. % of households with access to a sanitary facility 3. % of households who discard excreta in a sanitary manner	1. % of mothers who can cite at least 3 hygiene practices

(Sample)

Key Monitoring Issue: [*CLEAN WATER]

GOAL:	**Access to clean and adequate water supply.**
Samples of Indicator's:	**1. Distance to nearest water point reduced.**
	2. User to water points ratio reduced.
	3. Percentage of newly constructed water and sanitation facilities, which are adequately maintained and utilized by the beneficiaries at equitable cost.
Samples of Additional "Project Specific" Indicator's:	**1. Back-up source(s) to water are established to be used during droughts.**
	2. The use of water in connection to daily heath and sanitation practices.
	3. Enough water to irrigate crops year round.
	4. Alternative water sources, i.e. solar pumps, rain catchments tanks, filtration, etc.

(The above is an example/sample (only) of priority setting for the water sector. Please click-on the format button { ¶ } to see hidden text explanations)

3. Component Two: Service Rosters

The Rosters contain complete lists of target groups to be tracked for data. These are the working guides for community workers to focus on specific age categories. Rosters are also used as service and programming tools to determine what group needs what services and if there is any progress over time. Rosters will have multi-year use. One Roster can be used for at least three years. It is recommended that the following rosters are maintained using the suggested format:

- Family Roster (list of the heads of households)
- ECD Roster (list of under-five children)
- Education Roster (list of children 5+ to 15 years old)
- Better Life Options Roster (list of youth-boys/girls 15+ to 20 yrs old)

☞ When are rosters prepared?

After the family cards are completed, the rosters are made, using the data from the cards. Separate lists of all the heads of household (families) and all the above listed age groups are drawn using birth month and year cut-off to determine which roster the name goes on. For example, all children born from July 1, 2002 back through June 30, 1997 will be included on the under-5's roster.

During the course of the year, if new families are enrolled, Family Cards are prepared for them and then the members are listed into various Rosters.

☞ How are Rosters used and updated?

Through regular home visiting, whereby a community worker using the roster as her guide, collects data and provides health education in the home, family by family. Continuous system of updating since the data changes. Indicators change such as immunization status, education enrollment, etc. Through home visiting the rosters can be updated or by using existing service statistics available (i.e. school records, health center data). The home visitor may have a home visit diary for the number of families he/she is responsible for visiting.

☞ How to update Rosters?

- Divide the number of families up to specific community workers. This is extremely important. Responsibility must be clearly delegated so that each family is assigned a particular visitor and each visitor knows whom they must visit.
- Provide practical roster books to be carried during home visits. They may have the family based roster or home visit diary if that is convenient.
- Monthly Home Visits are strongly recommended to motivate, educate and update.

☞ Who updates the Rosters?

Each community worker holds the roster for her area. If a worker is assigned to a particular set of families, it becomes clear whom she is responsible for. The roster serves as her service map. Local community

members are best since they are familiar with their own community and closer to the people. The data is also their own as well.

☞ Where are the Rosters kept?

The Rosters should be kept as close to the families as possible. There can be 2 sets, 1 set at the project level and the other set with respective family visitors, for the areas or families they are responsible for visiting.

☞ How are the Rosters Used?

- To track progress being made on different indicators by families and other groups of targeted population.
- To pass on messages pertaining to health, education & other developmental aspects of immediate concern to different target groups & families.
- To provide feedback to project manager & concerned staff on significant changes on different indicators as they relate to family & other target groups.

FAMILY ROSTER

1. List names of heads of the households
2. Identify each with House number
3. Provide against each enough space for recording the status of the family on six indicators described under "Family level data" with dates. For instance, date primary health care knowledge attained.

ECD ROSTER UNDER 5 YEARS OLD

List names of children below five years of age.
Identify each child by House No. to which he/she belongs.
Date of Birth (DOB) in case of each child *not just age, which changes.*
*(*Sex (male or female)
Provide space against each for the following information/data:

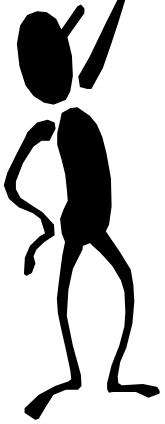
1. If the child and mother or caregiver has access to basic health care facilities including immunization.
2. If the mother/caregiver possesses "growth monitoring chart" for the child. Mark dates both attend growth-monitoring sessions.
3. Monitor child's nutrition status marking "normal" or degree 1st, 2nd, 3rd malnutrition by month/year.
4. Dates primary doses of immunization given (children 0-1)
5. Date child fully immunized (1-2 year olds)
6. If the mother/caregiver receives training and information on early childhood care and development from project or other source.
7. If children (3 yrs & above) participate in preschool or Center based ECD program.
8. Monitor each episode of disease/ illness the child suffers, In case of diarrhea & ARI, highlight if home managed, and mark the kind of medical attention the family could access.

EDUCATIONAL ROSTER 5 to 15 YEARS OLD

1. List all children in the age group 5-15 years.
2. Identify each with House #
3. Date of Birth.
4. Date admitted to Primary School.
5. Monitor progress being made, difficulties encountered, support received in the child's educational pursuit.
6. Enter the grade the child progresses into at the end of each academic year.
7. Enter the level of literacy accomplished for children who complete 15 years of age.
8. For children who drop out or not admitted to school, work with parents and schoolteachers for planning as needed. Record the outcome of your effort.

BETTER LIFE OPTIONS ROSTER 15 – 20 Years Old

1. List all individuals in this age group.
2. Identify each by House number
3. Date of Birth
4. For those who continue schooling, monitor progress and record grades.
5. For those entering college/university, mention streams of higher education
6. For those opting for skill development, mention for which vocation.
7. Options other than those mentioned above.
8. Those opting for none, current status, future plan.
9. For those completing 20 years of age, level of higher learning accomplished.



4. Component Three: Vital Events Reporting

Information about vital events such as ***pregnancy, birth, death*** *and* ***migration*** *(in and out)* are considered very critical for the kind of intervention necessary in impacting the indicators comprising AIMES. Therefore, as soon as AIMES is introduced in a project community and the initial survey is completed using the family cards, the system of reporting vital events should be in place and functioning. This is one of the responsibilities the community worker/volunteer will shoulder for a number of families he/she is assigned to. Projects may like to print reporting forms for each vital event to ensure uniformity and completeness of information.

☞ Getting to know vital events:

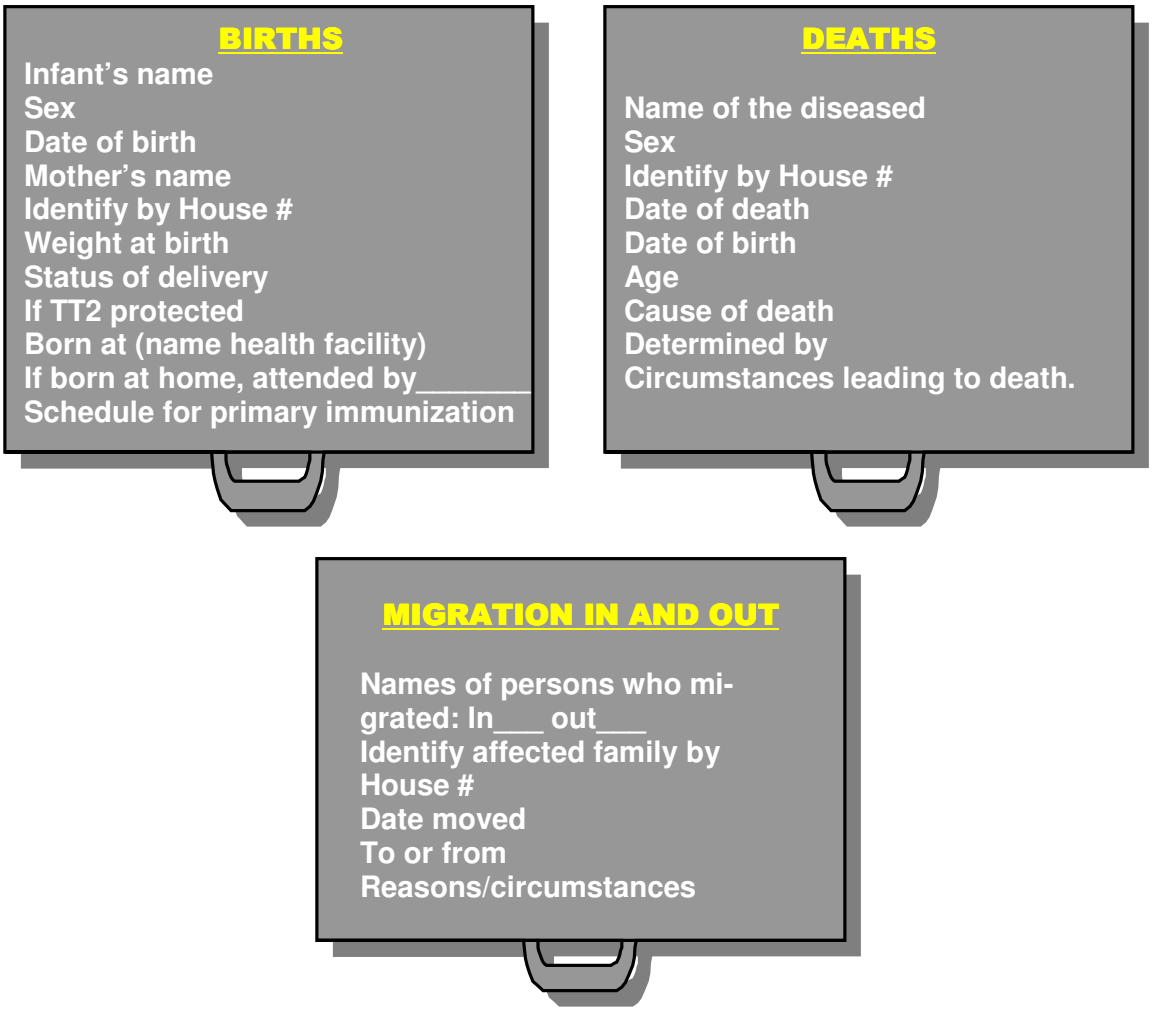
The community volunteer makes monthly home visits updating family cards and service rosters. These vital events are then easily noticed and/or reported by family members. Also, the community volunteer invariably lives in the same community where the CCF targeted families are located. She/he may hear about an event like birth or death in a family and make a special visit to welcome the newly born child or to express condolence and sympathy for the loss of a dear one. These occasions can be used for collecting details about the vital event.

☞ What information is required?

Detailed below is information that a home visitor or a community volunteer should report to the project supervisor for each vital event occurring in a community.

PREGNANCY

Date of reporting:
Name of the pregnant woman:
Identify by House #
Expected date of delivery:
TT vaccine (date given):
If already TT protected, date booster given:
Prenatal care and delivery plan
_____ Nearest Hospital/Nursing Home
_____ Project Health clinic
_____ Any other (specify)
_____ If none, whether skilled Birth Attendant is available
Suggested Risk Codes (finalized by project health staff): Age:
Height:
Weight:
Nutrition status:
Any previous complications:
If obstetric care needed:



The Project Supervisor maintains ***Vital Events Registers*** by entering each event reported by the community volunteer/home visitor in relevant register:

- **Pregnancy/Birth Register** Keep pregnancies in the same register as the births to follow the pregnancy outcomes. It should be the same continuous row across the book. The left side of the open book is for pregnancies and the right side is for pregnancy outcomes.
- **Death Register**: A complete list of all deaths in the community as reported.
- **Migrations Register**: separate sections for In and Out.

5. Component Four: SITE

SITE stands for ***Standardized Impact Tool for Evaluation.*** Data collected and maintained using the Family Cards, Rosters and Vital Events reports *(see Appendix 9)* are compiled *using excel software (See Appendix 8)* to create a *snapshot* of the community showing the status of children and family on all indicators included in AIMES.

☞When is a SITE prepared?

Projects can prepare SITE at any point of time by using past one year's data. The one-year period enables Projects to calculate rates and percentages by which the impacts on different indicators are measured.

For the purpose of self-monitoring, a project may decide to prepare SITE at any interval found necessary.

For the purpose of international monitoring, all National Offices must get their projects prepare SITEs *annually covering the period of one full calendar year.* ***This requires all CCF projects to treat December 31 as the cut-off date for the compilation of AIMES data.*** Each National Office in turn aggregates all project SITEs to compile a National Office SITE, analyze data in the light of country situation and send a detailed report to Richmond office so as to reach by February 28 every year.

This process itself is good enough for the National Offices to monitor their projects. However if necessary, they can obtain more than one SITE during the year and establish periodicity accordingly.

☞How are data compiled?

Once the system is in place and data are collected and updated regularly using the family card, rosters and vital events reports, compilation is very easy. It is done manually by tabulating all data and transferring on the SITE format. Community volunteers and project staff involved in the process of data collection and those supervising the process will participate in the tabulation and compilation. If the National Office develops AIMES software and projects have access to computers, data compilation with Excel Software (See Appendix8) becomes easier and faster.

SITE allows the project to know at any point of time the impact of its program

☞How is the project SITE used?

AIMES is primarily a system for project's use. The AIMES SITE allows the project to monitor coverage, quality and effectiveness of it's programs and to know at any point of time the impact of its program and services on children and the community – positive impact as well as shortcomings or *red flags.* It can, therefore, be used effectively to work with parents and caregivers in promoting desirable childcare practices and with community as a whole for promoting and planning larger interventions to create broader impact.

Project staff and the community analyze and identify the factors responsible for red-flags (examples: malnutrition, high incidence of death, low school participation etc.) and plan programmatic as well as management responses.

☞ What does SITE contain?

Usual title and Period covered (a calendar year, e.g. 2002)

- Project name and number (for project SITE)
- National Office name and number (for National Office SITE)

1 **Demographics:** Use different rosters and double check with family cards to provide the following statistics. Give break up of population below in male, female and total.

a. Number of children under 5 years of age.
b. Number of children 5+ to 15 years old.
c. Total child population (total of A and B).
d. Number of youth 15+ to 20 years old.
e. Number of adults 20 years and above.
f. Total adult population (total of D and E).
g. Total Population (total of C and F)
h. Total number of families.
i. Total number of infants 1+ to 2 years old.
j. Total number of live births during the year. (Use Pregnancy/Birth Register)

2 **Deaths:** Use Death Register to count all deaths in the following age groups:

Infants (0 to 1 year)
Children 1+ to 5 years
Children 5+ to 15 years
Adults (15+)
Total

Divide the number of deaths in each group by *causes*. Consult Death Register and family cards and double check with close family members of the deceased and establish the cause of each death as far as possible and specify.

SITE format provides a list of causes (death codes) ascribed to commonly or more frequently occurring deaths. However, *there are large numbers of deaths due to causes other than those listed on the SITE. When this is the case, please attach a sheet giving distribution of deaths by causes other than those listed.*

Data compiled creates a snap-shot of the community!

Calculate ***Infant Mortality Rate (IMR)*** by using the following formula:

$$\frac{\text{Number of deaths of infants (0 - 1 year) X 1000}}{\text{Number of live births}}$$

The rate shows the number of infants (newly born to one year olds) dying against one thousand live births during one year. *It is not a percentage.* Stillbirths are not

included in the denominator (live Births) neither are they counted as infant deaths.

For calculating ***Under-5 Mortality Rate (U5MR):*** Take the totals of deaths in age group (a) 0 to 1 and (b) 1+ to 5. The sum total gives total number of deaths of children 0 to 5 years old. Use the following formula to calculate U5MR:

$$\frac{\text{Number of deaths of children 0-5 years X 1000}}{\text{Number of live births}}$$

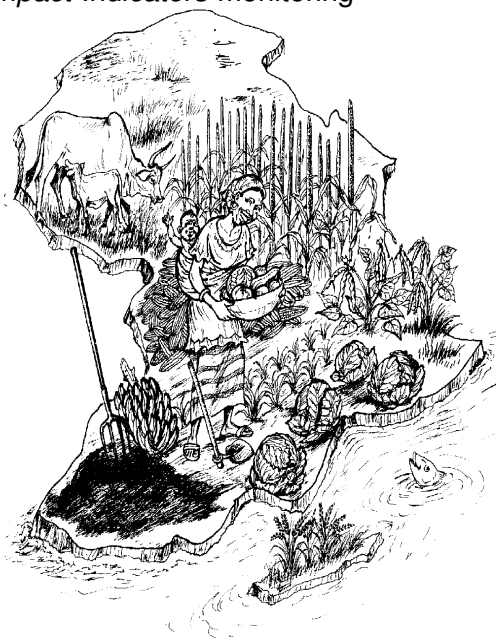
The Under-5 Mortality Rate thus arrived represents number of children in the age group 0 to 5 dying during one year against every one thousand live births. *This is not a percentage.*

3 **Immunization:** The SITE requires the *number and percentage* of children fully immunized and the *number and percentage* of live births protected by TT2 during the year for which the SITE is prepared.

Children: Count the total number of children immunized fully with all antigens in the age group between 1 to 2 years. All children should be completely immunized by their first birthday so this provides a window up until children's 2nd birthday and allows counting of children immunized fully by their first birthday during the year. The under-5 roster contains this information. Crosscheck with updated family cards. Count percentage of 1 to 2 years olds fully immunized.

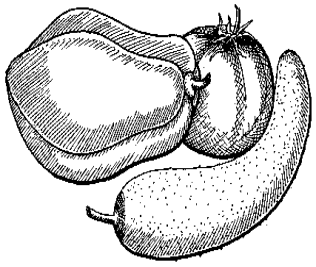
TT2 protected Live Births: Use Pregnancy/Birth Register, check each birth and verify if the mother in each case received two doses of *Tetanus Toxoid vaccine* during her pregnancy. Count the percentage of live births TT2 protected.

4 **Nutritional Status:** This is one of the three *Impact Indicators* monitoring of which presupposes the following process:



- Growth monitoring is done as prescribed for each and every child – newly born to five years of age – within the community of enrolled families covered by the CCF project.
- Growth charts are maintained for each child in the under-5 age group.
- Caregivers of children in this age group have access to training and guidance on appropriate feeding and other child care practices.
- Children found to be malnourished receive supplementary diet and health check up as needed.

Count the number of under-five children, as of the cut-off date, and determine what category they are nutritionally. Every under-five child will fall into one of the four nutritional categories:



- **Normal,**
- **Malnourished with: First Degree (Mild),**
- **Malnourished with Second Degree (Moderate), or**
- **Malnourished with Third Degree (Severe).**

The total must equal the total number of under-5 children in the given community. The total percentage must add up to 100%.

☞ **Monitoring the progress back to "normal"**

This is to measure the effectiveness of nutrition program. Count those children with different degree of malnutrition as they *graduate out of 3rd degree to 2nd, 2nd to 1st and 1st to normal.* Progress is measured through improved nutritional status. Every child must be counted and monitored. ECD or under-5 roster, Growth Charts and the family cards will provide this information. Project may like to maintain a list of malnourished children in different groups or cohorts of children suffering from 1st, 2nd, and 3rd degree malnutrition to monitor their status and progress effectively.

Mild or 1st degree malnutrition is potentially as dangerous as moderate or severe and hence must be addressed with same priority as 2nd and 3rd degree malnutrition. *(Refer to #4 & Section 11 on Nutrition/Growth Monitoring for more details).*

5 **Family Status on Critical Indicators:** This is as given under Family Level Data Using the given criteria; count total number of families for each of the first six indicators on which family level data are sought:

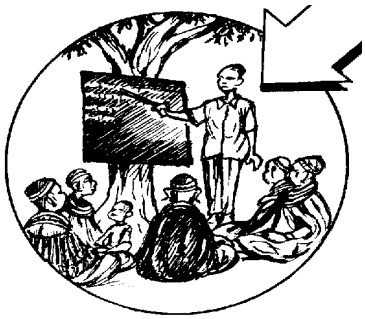
The "Family Roster" must contain this information on cross-check with the updated "Family Card".

- Number of families having access to clean and adequate quantity of water as per the definition accepted by the NO.
- Number of families having access to sanitary disposal of excreta as per the criteria accepted by the National Office.
- Numbers of families in which parents and caregivers know how to home manage diarrhea-using ORT. (3 Messages)
- Number of families in which parents and caregivers has the ability to detect and manage a case of ARI. (3 Messages)
- Number of families with adequate housing as per the standard determined by the National Office (NO).
- Number of families with adequate income level determined by the NO.

6 **Families with Children's access to quality ECD and Education:** As described under the Family Level Data, the National Offices will define the expected "quality" of ECD and Education programs. The home visitor must use that definition to determine if children in the family have access to ECD and Education programs of that quality standard. SITE requires the number and percentage of families.

7 **Adult Literacy:** Count the number of persons above 15 years of age (by gender) who are literate. The Better Life Options roster will give the number of 15+ to 20 persons. Count the number of 20+ persons from the

family cards. The total of both will give the total adult population. SITE requires the following:



- Number and percentage of *Literate Male* population
- Number and percentage of *Literate Female* population
- Total number and percentage of *Literate Adult* population
- (This information is to be compiled annually as on the cut-off date)

8 **Access to ECD Support:** Early childhood care and development support programs can be *home based* as well as *center based.* Children 0 to 5 are most of the time under the care of their mothers or other family members. Therefore, these programs should appropriately focus on care-givers. ECD support for children under three years of age can best be provided by home based approach. Children three years and older will be ready for center based activities. However, it will not be realistic to divide them into two age groups, firstly because their needs are not exclusive and secondly, age for admission to preschool or nursery defer from country to country. The following method is suggested:

- Using ECD or Under-5 Roster, reviews all children 0 to 5.
- Count those children participating in a center based ECD activity known by 'preschool' or any other name. Show this number under *center based ECD.*
- Among the remaining kids, count those who (along with their caregivers) receive early childhood care and development support at home. Show this number under *home based ECD.*
- Count the rest who receive no benefit of either home based or center based ECD support. Show them under *none.*
- Classify all three categories into male and female.

9 **Children's Participation in Schools:** Refer to Education or 5+ to 15 Rosters and count children *enrolled in and attending* formal schools or non-formal education centers. Those not enrolled or not attending any education program are counted as 'none'. The total must equal to all children in this age group.

10 **Higher Education/Skill Development:** Refer to Better Life Options (15+ to 20) Roster and classify all young persons according to their current pursuits. It is likely that most of them may be continuing they're schooling at the higher secondary or university levels. Some may be doing vocational training or skill development courses. Classify them accordingly and show none for those who are not pursuing any option.

11 **Level of Learning Achieved:** Using Better Life Option (15+ to 20) Roster, count all girls and boys completing 20 years of age during the calendar year (or the year preceding the cut-off date) and compile data on their scholastic and skill related achievements. SITE requires the number and percent of youth completing (a) High School Graduation, (b) College Graduation (c) Skill training degree or diploma.

6. Guidelines to Baseline Surveys

The baseline survey will show the status of the family on the above-mentioned indicators at the start of the initial survey (when a new project is being launched and in case of existing projects, when AIMES is being introduced). In the subsequent years, family level information is collected once a year to determine if there is any change in the status.

Family Level Data	Year 1	Year 2	Year 3	Year 4	Year 5
Access to Water					
Access to Safe Sanitation					
ORT Knowledge					
ARI Knowledge					
Adequate Income/Livelihood					
Adequate Housing					
Access to Early Child Dev.					
Access to Quality Education					
*Health Knowledge and Health Practice *(*see Page 9)*					

All indicators listed above will be responded to by the home visitor in 'yes' or 'no' using the standards and definitions provided by the National Office and very carefully reviewing the family on each indicator.

Compilation of these responses at the project level will give negative and positive status of all families on each indicator. Similarly, the National Office will get an overall picture about the communities covered by CCF in the country as a whole. This will help both Projects and the National Office to prioritize the indicators on which consistent efforts are to be made to improve the status of the family.

What are Baseline surveys?

The term "baseline surveys"/[2] refers to two types of surveys that are ideally conducted early in CCF the planning process:

- A census of all affected persons and assets, and
- A survey of the socio-economic conditions of the affected persons.

Baselines surveys are essential since:

- They form the basis for identifying the various types of project impacts.
- They are a vital guide to designing effective CCF programs and projects.
- They constitute a baseline against which the indicators, i.e. health, water, education, incomes and standards of living, etc., of AIMES after which the project can be measured.
- They form the basis of all CCF project planning.

The entitlement policies, costs and budgets, institutional arrangements for implementation, etc. can only be worked out once the baseline surveys are completed.

[2] A valuable resource for this section was obtained from the LQAS Manual for baseline surveys and regular monitoring (Trainers Guide & Participant's Manual): J. Valadez, W. Weiss, C. Leburg, R. Davis. Dec. 2001. NGO Networks for Health.

Baseline surveys can be useful in gathering general information that can be applied, for example, in developing a countrywide AIMES strategy or designing targeted programs or projects.

Baseline/Follow-up Surveys are:

Individual CCF Project surveys are designed to cover a limited number of indicators for specific projects. In general, they are more limited in content than the interim surveys and are less standardized. They are useful in measuring problems and impacts restricted to a particular region of a country that may not be a problem in other regions. An example may be a cholera outbreak.

Demographic and Health Surveys (DHS) are

Nationally representative household surveys with large sample sizes of between 5,000 and 30,000 households, typically. DHS surveys provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition.

The core questionnaire for DHS emphasizes basic indicators and flexibility. It allows for the addition of special modules so that questionnaires can be tailored to meet host-country and CCF data needs. The standard DHS survey consists of a household questionnaire and a women's questionnaire. A nationally representative sample of women ages 15-49 are interviewed.

Examples of Household Questionnaires might contain information on the following topics:

- **Household listing:** For every usual member of the household and visitor, information is collected about age, sex, relationship to the head of the household, education, and parental survivorship and residence.
- **Household characteristics:** Questions ask about the source of drinking water, toilet facilities, cooking fuel, and assets of the household. There are additional questions about the use of bednets in the household.
- **Nutritional status and anemia:** The height and weight of women age 15-49 and young children are measured to assess nutritional status. For the same individuals, the level of hemoglobin in the blood is measured to assess the level of anemia.

Examples of Core Indicators might contain information on the following topics:

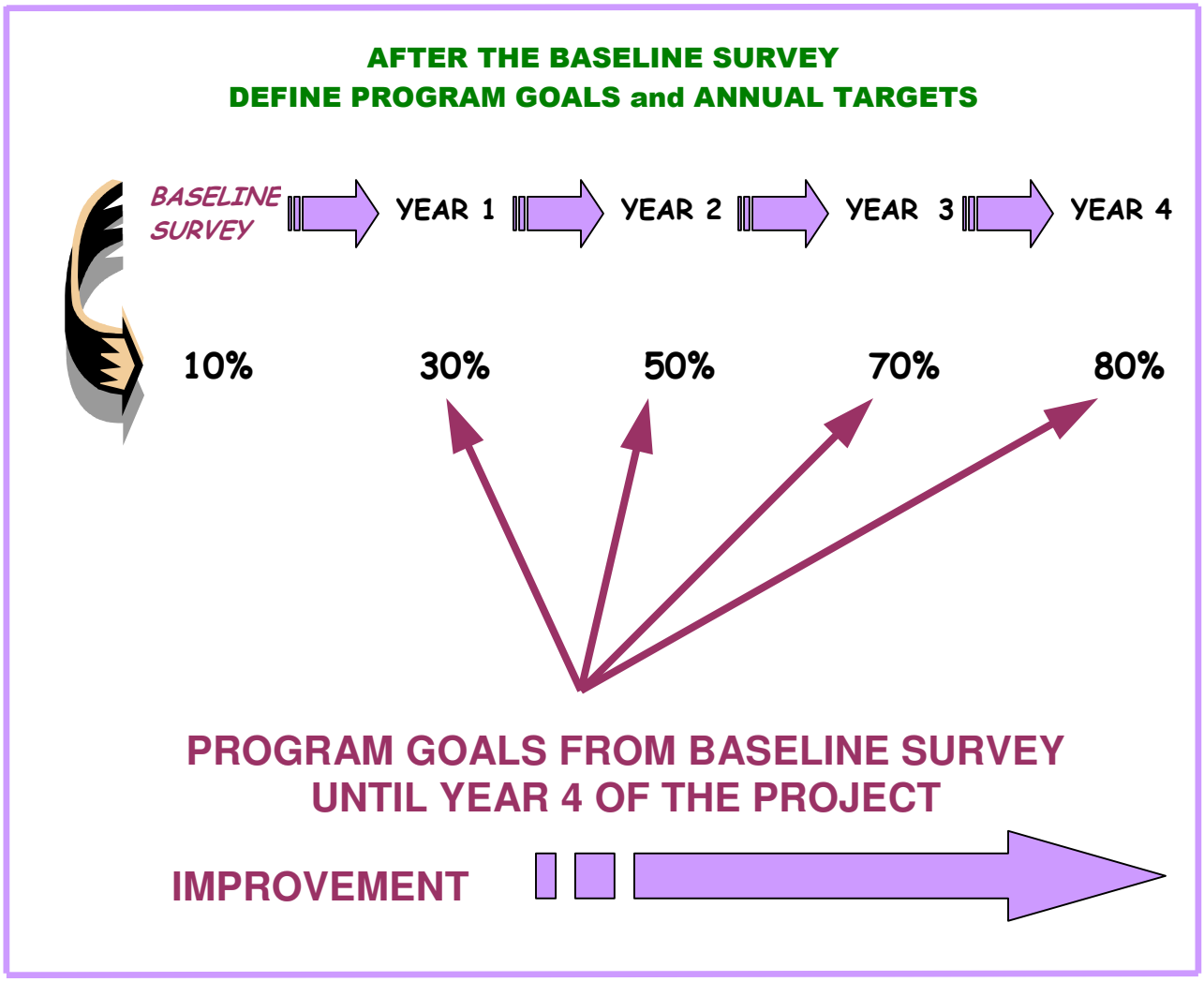
- **Background characteristics:** Questions on age, marital status, education, employment, and place of residence provide information on characteristics likely to influence demographic and health behavior.
- **Under five years old infant mortality:** Questions on the causes of deaths and were the causes of death preventable?
- **Malnutrition among children under five years old:** Questions on the causes of malnutrition, monitoring of growth and weights, breastfeeding, iron, iodine, vitamin A, protein, etc.

- **Breastfeeding and nutrition:** Questions cover feeding practices, the length of breastfeeding, and children's consumption of liquids and solid food.
- **Antenatal, delivery, and postpartum care:** The questionnaire collects information on antenatal and postpartum care, place of delivery, who attended the delivery, birth weight, and the nature of complications during pregnancy for recent births.
- **Immunization rate among infants (up to 2 years):** Questions on TT rate for pregnant women, are immunization services available, quality of services, motivation of parents to bring children in for immunization, educational programs available to the community on immunization.
- **Children/family health knowledge:** Questions examine knowledge of immunization coverage, vitamin A supplementation, treatment of diarrhea, fever, chronic respiratory infections in young children and treatment of childhood diseases.
- **Access to safe water:** Questions on quantity/quality and distance to water sources.
- **Families practicing good sanitation:** Questions on adequacy of sanitation facilities, methods of disposes of excreta, knowledge of personal sanitation (boiling water, washing hands before/after cooking, eating, using toilet facilities).
- **Percent of children (0-5 years and 5-15 years) enrolled in educational activities:** Questions on pre-school and public schools (available), accessibility to the community, how well are they utilized, motivational factors for parents to keep children in school, what are the gender differences, repletion and drop-out rates.
- **Literacy rate among children over 15 years by gender:** Questions on opportunities for literacy training, motivational factors, government and other programs available to the community.

Service Provision Assessments (SPA) Surveys conducted in health facilities and communities to obtain information about the health and family planning services available in a region. The objective of the SPA is to provide information about the characteristics of health services including their quality, infrastructure, utilization, and availability. The SPA can be national or individual Project oriented and can be implemented as a stand-alone assessment of services or can be linked to household survey information to identify relationships between health surveys and health-care outcomes and behavior. SPAs can be used to compare services of various providers such as between public and private, non-governmental organization (NGO) facilities and community health workers, and to track service improvements over time.

Additional Surveys: Other surveys are required to coordinate with other population-based surveys during the course of the AIMES program. Such surveys may be designed to obtain specialized information from a population subgroup such as young adults or children. Since children are the targets of CCF programs, a special survey of this group is required. CCF National Programs may also identify needs for special surveys on specific topics, e.g., expenditures on health care,

women's empowerment, and education. There may also be scope in some countries for an "add-on" survey, in which a limited number of questions are added to an existing survey.



Baseline Survey Report Format

CONTENT	MAX. PAGES
Summary	One
Program Overview (locations, objectives, main activities, beneficiaries, etc.)	One
Purpose of the Baseline Survey and Methodology	One
Main Findings: Priorities by Supervision Area(s) and for the Program as a Whole	Five
Action Plans and Goals/Coverage Targets for Key Indicators	Two
Conclusions and Recommendations	Two
Appendix (Summary Tabulation Tables/Graphs)	One

How to Identify Priority Supervision Areas Using The Summary Tables During Monitoring

Supervision Areas (SA)		Priority Status
Below the Coverage Target	Below Average	Highest
Below the Coverage Target	Not Below Average	Second Highest
Not Below the Coverage Target	Below Average	Second Highest
Not Below the Coverage Target	Not Below Average	Not a Priority

MAIN FINDINGS:

PRIORITIES: Specify the program priorities by the indicator, by supervision area and by type of respondent, i.e. men, women, and/or mothers with children of different age groups.

FOR EXAMPLE: The percent of women who know the danger signs during pregnancy (that indicate the need to seek care) is below average only in Supervision Areas 3 and 5. We need to focus on Areas 3 and 5 in our efforts to improve this indicator.

Among the infant and child feeding indicators, the percent of mothers who continue to breastfeed up to and beyond 12 months of age appears to be the biggest problem (across all Supervision areas, only 20% of mothers of children aged 12-15 months were breastfeeding at the time of the Survey). This practice will receive special attention in the project's nutrition intervention.

ACTION GOALS/COVERAGE TARGETS FOR KEY INDICATORS:

FOR EACH PRIORITY: List the main activities that CCF will implement (in a given project) to reduce the identified problem.

FOR EXAMPLE: A priority activity could be to identify terms, perceived causes, preferred treatments and preferred providers for the danger signs during pregnancy that women in the community/project recognize. Then we can build upon the local understanding of pregnancy danger signs to develop appropriate strategies for improving recognition & care seeking further.

REPORT key indicators, coverage targets & goals for future planning.

Results of Baseline Survey, Coverage Targets and End of Project Goals

Key Indicators	Baseline Survey Average Cost	Projected Coverage Target Yr 1	Projected Coverage Target Yr 2	Projected Coverage Target Yr 3	End of Project Goal Year 4

Example of M&E Baseline Survey Results with Regard to one Target and their Indicators

TARGET	Key Indicators	Baseline Survey	M&E Date_	Goal for Planning
Reduce the Incidence of Deaths in Children less than 5 years old.	The percent of live births TT2 protected (mothers immunized with TT2 vaccine during their pregnancies)	25%	38%	80%
	1-2 year olds who are fully immunized	35%	55%	90%
	The percent of women who know the danger signs during pregnancy (that indicate the need to seek care)	45%	70%	95%
	Among the infant and child feeding indicators, the percent of mothers who continue to breastfeed up to and beyond 12 months of age	10%	35%	70%
	The percent of women's knowledge of AIDS and other sexually transmitted infections, and high-risk sexual behavior.	30%	65%	85%
	The percent of women receiving antenatal and postpartum care	20%	36%	65%

7. Data Collection, Validation and Tabulation

To be completed in collaboration with H. Kellam & Dola Mohapatra

8. Data Analysis and Responses

Reporting: The Staff at CCF Richmond are interested in collecting all project SITEs for AIMES at one point in time for comparisons between National Officies (NO) and to see progress over time within each NO. Therefore, in February of each year, a SITE for the period of the previous full calendar year (January through December) is to be submitted as the annual evaluation.

Comparing: Data standing on its own will have very little meaning unless it is compared to some standard. A number on a wall stating how many children were immunized does not mean a thing unless we are able to put it in a context.

There are several comparisons to make: COMPARE TO:

- **Yourself:** look at previous data in your project: what was it last month? Last year? Is there improvement? What is the trend?
- **Other CCF projects:** neighboring projects in the region: how are other projects doing?
- **Other surrounding areas without CCF support:** case-control study using data from contiguous areas around project.
- **To local data and national data:** where does it stand in relation to the government data?
- **To other NGOs:** where do we stand in regard to the CCF universe?

Red Flagging: The purpose of collecting the data is to point to areas of weakness in order to be able to focus efforts to address real needs. Red flags are raised when the data on the SITE points to problems. For instance, if the immunization rate seems unusually low compared to the surrounding areas data, then it raises a red flag. The response to the red flags is what is of utmost importance. In this case, a project may conduct focus group discussions among mothers, have a meeting with the Expanded Program for Immunization team from the health center, conduct a campaign to encourage immunizations or provide necessary equipment which was a missing link in service provision.

The red flag raised will determine the focus of your efforts

If the death data shows a large number of dengue fever deaths, then the project will have to address the major killer and shift efforts to prevent death. There are preventive measures to take which must be introduced immediately such as the distribution of a larvacide, the covering of potable water and sanitary clean up of an area. The red flag raised will determine the focus of your efforts……

What is Monitoring & Evaluation

A monitoring and evaluation system (M&E) consists of a set of systematic activities to monitor and evaluate project implementation and impact.

Monitoring is the provision of information and feedback to project management on whether the project uses the resources as agreed upon (inputs); and whether it is progressing as expected (outputs). Monitoring is a continuous process throughout the project aimed at improving implementation.

Evaluation aims to determine whether the project is achieving the intended results, and to measure the impact of the project. Evaluations are done during implementation (e.g. mid- project cycle to evaluate overall project achievements; or to study a specific aspect of the project), at the end of the project, and ideally, a few years after project completion to measure the long-term effects.

The M&E system allows the project management team to make appropriate, informed decisions in order to decide whether project design, approach, implementation and/or activities should be adjusted to better achieve the objectives. In other words, a well-designed M&E system answers the questions:

Are we doing the things right? = **monitoring**
Are we doing / have we done the right things? = **evaluation**

To be completed in collaboration with H. Kellam & Dola Mohapatra

9. Home Visitation: Role of Project Staff and Community Volunteers

AIMES is run through a system of home visiting which is at the center of AIMES. If home visits are not conducted, the system will break down. There are 14 "P's" that describe the characteristics of home visiting.

1 **Pro-active: c**ommunity out-reach, going to the people rather than waiting for them to come to you.

2 **Person-specific**: one-on-one personal contact helps to tailor health education to the individual and family levels.

3 **Preventive** aimed at preventing illnesses rather than waiting until it's too late.

4 **Protective**: adopting protective health behaviors rather than services only.

5 **Promotion**: based on promoting healthy behaviors.

6 **Project-specific**: beyond the core indicators projects select indicators appropriate to their community and choose health messages specific to the context of the project too.

1 **Prospective**: data is collected at the present and into the future. It is not a retrospective data system I in which past data is collected.

8 **Progressive**: data is compared to previous data points to observe trends. It works in a step-by-step progression to study trends.

9 **Public**: all the data is public domain and is to be fed back to the community. It is community-wide data regarding Public Health and Education. It is to be shared.

10 **Positive reinforcing**: through encouragement a visitor can strengthen and sustain a desired behavior by rewarding it which occurs during a home visit.

11 **Performance-based**: a home visitor is responsible for a set number of families. Supervisors can monitor the success of a home visitor by looking at the data of individual workers.

12 **Process-oriented**: it is a process rather than a service or product which is provided.

13 **Primary**: it is based on the provision of Primary Health Care and Primary Education.

14 **Prioritization**: a system of prioritizing top needs and focusing on a few interventions leads to doing a few interventions well rather than many not so well.

GIVE and TAKE

During a home visit, the home visitor gives and takes from a big basket. Basically, the basket contains all the training goodies, which are provided to the family. The basket also contains record books, which are filled in during a visit by information that the family provides.

A Home Visitor ***GIVES:***

- **Health Education and Training:** Home visitors train families in protective behaviors through personalizing the messages at the home level. Health and education messages are tailored to fit the family situation. Actual demonstration of new behaviors is practiced on the spot (ORT mixing, cooking nutritious meals, etc.).
- **Motivation:** Home visitors motivate family members to attend services. They activate participation in community activities and encourage volunteers to help support projects. Simply providing health messages is not enough.
- **Moral Support:** Providing continual reinforcement of a new behavior is needed to sustain the behavior.
- **Behavioral change** takes place over time, through repetition and reinforcement. In order to adopt a new behavior, people must be motivated to drop an old behavior. Clear demonstration of a new behavior's benefits will help bring adoption of the new practice.
- **Treats:** Sometimes home visitors will distribute tangibles, which help to promote the new behaviors. ORT packets, malaria prophylactics, Road to Health cards, school registration forms, flyers for events, brochures with preventive messages, etc. These are optional incentives and given according to need.

People also need to feel encouraged to change

People also need to feel encouraged to change and change does not occur instantly. It takes a period of experimentation. Even though a family does not succeed at first, they should not be reprimanded or denigrated. Home visitors provide attention, care, understanding and respect. Every one needs love from thy neighbors.

A Home Visitor ***TAKES:***

Service statistics: A home visitor will update her rosters with home level records such as immunization dates and weights from the Road to Health cards held by the family, or new school enrollments.
Vital events: All new pregnancies, births, deaths, migrations will be captured.
Family-Home environment: Becoming aware of housing situation and family dynamic through direct observation and active listening to a family points to particular needs. "A picture is worth a thousand words" and there is nothing that can substitute for a home visit in this regard.

Why visit so often? Home visits must occur at least quarterly (every three months) in order to effectively fuel the preventive, protective behavioral change approach. Ideally, monthly visits are recommended, but given the practicality of this is some settings, three months suffices. Within three months many changes could occur. A child may have three consecutive months of no weigh gain. This would signal an action to quickly assist the family to combat a nutritional problem. A woman may become pregnant and will need to seek prenatal care especially during the first trimester. If this is not known, the woman will already be a third of the way through her pregnancy. If a child is born, she will need to be immunized for at least five antigens within the first three months of life: BCG, DPT and Polio. So there are many immediate issues, which need to be addressed by a family. The child's name is Today!

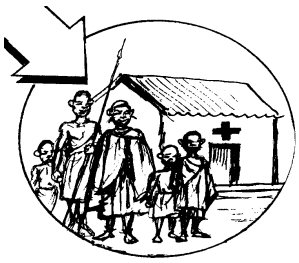
A True Story?

A Home visitor was responsible for all families listed in her roster. One day she decided to bring all the family cards with her on her rounds to verify the family information. She did a "roll call" in each household, updating the information to crosscheck the vital events reporting. In one house, which she hadn't visited in 6 months, she asked about each of the children. The family said that everyone was doing well and that all the children were at school. Just as the visitor was about to leave, she heard a cry from the back. She asked who it was. It was their 6-year-old daughter who was hid underneath the bed. When the visitor asked to see her she was shocked to see the malnourished condition of the girl. She weighed 5 kilos at 6 years old. Since she was over-five, she was not on the roster for weighing. She had fallen through the cracks.

The girl could not possibly have attended school since she was unable to sit up on her own. She needed immediate attention. The parents were embarrassed of her condition and were feeling helpless. The child was brought to the hospital for an IV and naso-gastric feeding. This illustrates how a complete family enrollment checks on each member of the family. It also shows the importance of visiting regularly since conditions can change rapidly. It also shows how everyone counts in the system.

10. Caregivers: Role and Responsibilities

Both prevention and care are important at all times, but the balance between them shifts over time for primary caregivers, from when children are born to the age 19, when they move into adulthood.



Prevention and Care for Illness: For infants up to one year old, care for illnesses are both very important, and both focus primarily on the mother and other caregivers. In addition to healthy prenatal and delivery practices, prevention for these very young children includes important issues about breast-feeding and the appropriate introduction of complementary foods, hygiene practices, and caring behaviors that contribute to the healthy development of the young child. Care for illnesses in infants and neonates is also very important, as young children can die very quickly if an illness is not recognized. Sick young infants must be taken immediately to a trained provider who can give appropriate care.

Most deaths among children are due to diseases that can be prevented, but that can also be treated very easily at home or in health facilities.

- For some of the most deadly childhood diseases, such as measles, vaccines are available andtimely completion of immunization will protect a child from death.
- Diarrhoea can be prevented by good hygiene and sanitary practices. When a child with diarrhoea becomes dehydrated, rapid and appropriate treatment is necessary both at home and in the health facility.
- Malaria can be prevented by the use of protective nets treated with insecticide that prevent mosquitos from biting a child. Once the child has been bitten and has malaria, rapid and appropriate care is essential.
- Much less is known about how to prevent respiratory illnesses in children. One contributing factor is indoor air pollution, but the only intervention available now is to teach families how to build and use better stoves. Once children have a serious respiratory illness, they need appropriate care by a trained health provider.
- Malnutrition is also a major contributor to childhood deaths. Mothers and other caretakers need to know how to feed their child correctly to prevent nutritional problems. If a child becomes malnourished appropriate health care from a trained provider is essential.

For this age group, then, both prevention and the appropriate care of illness are essential.

As a child moves through the school-age years of five to nine, and on into **adolescence**, prevention takes on greater and greater importance. The major

health burdens in the adolescent years are related to sexual and reproductive health, substance use, mental health including suicide, and accidents and injuries. There are relatively few deaths due to other illnesses and disease, and most of these deaths are caused by malaria or tuberculosis.

12 Key Family Practices in Caregiving:

Communities need to be strengthened and families supported to provide the necessary care to improve child survival, growth and development. The evidence suggests that families should:

1. Breastfeed infants exclusively for at least six months. (mothers found to be HIV positive require counselling about possible alternatives to breastfeeding).
2. Starting at about 6 months of age, feed children freshly prepared energy and nutrient rich complementary foods, while continuing to breastfeed up to two years or longer.
3. Ensure that children receive adequate amounts of micronutrients (vitamin A and iron in particular), either in their diet or through supplementation.
4. Dispose of faeces, including children's faeces, safely; and wash hands after defecation, before preparing meals, and before feeding children.
5. Take children as scheduled to complete a full course of immunizations (BCG, DPT, OPV, and measles) before their first birthday.
6. Protect children in malaria-endemic areas, by ensuring that they sleep under insecticide-treated bed-nets.
7. Promote mental and social development by responding to a child's needs for care, and through talking, playing, and providing a stimulating environment.
8. Continue to feed and offer more fluids, including breast-milk, to children when they are sick.
9. Give sick children appropriate home treatment for infections.
10. Recognise when sick children need treatment outside the home and seek care from appropriate providers.
11. Follow the health worker's advice about treatment, follow-up and referral.
12. Ensure that every pregnant woman has adequate antenatal care. This includes having at least 4 antenatal visits with an appropriate health care provider, and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family & community in seeking care at the time of delivery and during the postpartum and lactation period.

To provide this care, families need knowledge, skills, motivation and support. They need to know what to do in specific circumstances and as the child grows and develops. They need skills to provide appropriate care and to solve problems. They need to be motivated to try and to sustain new practices. They need social and material support from the community. And finally, families need support from the health system, in the form of accessible clinics and responsive services, and health workers able to give effective advice, drugs and more complex treatments when necessary.

Source: *Child and Adolescent Health and Development, WHO, http://www.who.int/child-adolescent-health/prev.htm*

Caregivers and Child Nutrition:/ [3] The concept that care—the time and attention paid to children—affects their health and nutrition is not new in the nutrition field. But care practices vary widely among different cultures in developing countries, making it difficult to measure the relationship between care, food availability, and nutritional status.

A child's behavior is found to be a key element in the quality of care received. For example, a passive child will elicit less response from the caregiver than a demanding one. Caregivers may expend less effort to feed a child who refuses food or is difficult to feed. A positive relationship between caregiver and child leads to increased intake of food by the child.

In examining the resources that caregivers draw on to meet the physical, mental, and social needs of the growing child, one can consider six factors:

1. Education, knowledge, and beliefs. The paper finds that better-educated caregivers are more likely to take advantage of, say, available community health programs and to seek help if a child is ill.
2. Physical health and nutritional status. If a caregiver is undernourished or ill, he or she is likely to spend less time on child care.
3. Mental health and level of stress and self-confidence. Although depression and stress have been linked to poor caregiving in developed countries, measures need to be developed that are tailored to developing countries.
4. Autonomy and control of resources. When women control household resources, they tend to allocate a larger share to children.
5. Workload and availability of time. Whether a mother's working outside the home is good or bad for young children may depend on the quality of replacement caregivers and the amount of income earned.
6. Family and community social support. With the increased entry of women into the labor force, the major form of social support needed is provision of competent alternative caregivers. Institutional child care is rarely available in developing countries, and child care comes at a high social cost if older girls are kept out of school to care for young children.

Feeding practices that can affect nutrition include adapting the foods offered to a child's abilities (offering finger food, for example) and responding to a child's cues (perhaps offering more food or a different food).

Psychosocial care—the provision of affection and attention to the child— includes physical, visual, and verbal interactions between caregiver and child. Practices depend on cultural norms.

[3] Care and Nutrition: Concepts and Measurement, a new IFPRI occasional paper by Patrice L. Engle, Purnima Menon, and Lawrence Haddad. Volume 19, Number 2, June 1997

11. Guidelines on Nutrition & Growth Monitoring

Nutrition Indicators can reinforce project monitoring and evaluation systems by establishing benchmarks that can be used to estimate project impact during mid-term reviews and completion evaluations. These indicators also enable CCF's contribution to reaching global targets for children well being and elimination of hunger to be demonstrated more easily.

The main objectives of a Growth Monitoring Program are:

- In the child, to prevent death, illness or malnutrition; and refer him or her for medical care, medical specialist assessment or professional social support follow-up.
- In the mother, to improve nutritional knowledge, to increase knowledge and interest about the child's health, and reassure her satisfaction with project services.
- In the program, to help the health worker assess the health status of the individual child in order to decide on appropriate action, and to interest the family in the health of the child.
- To remind health workers about different aspects of child care which should be reviewed

AIMES states that every project should assess the nutritional status of individual children less than five years old at least each quarter (monthly to children less than one year old, each two month to children 1 – 2 years old) using the indicator Weight for Age, through a Growth Monitoring Program, using the WHO/NCHS growth chart. *(See Appendix 2)*

CCF also recommends assessing:

- **Chronic malnutrition (also called "stunting")** using the indicators Height for Age, at the beginning of every project and during the strategic planning (each three years) because provides a vision of the overall well-being of a community. High levels of chronic malnutrition reflect deprivation over a period of months or years. Children who are chronically malnourished may suffer irreversible disability in mental and physical development, causing poor performance in school and reduced physical productivity for the rest of their lives.
- **Acute malnutrition (or "wasting")** using the indicator Weight for Height, in cases of temporary shocks or emergencies, such as famine or episodes of illness, and in cases of moderate and severe malnourished children, to monitor their evolution and evaluate recovery.

Nutrition assessment as part of AIMES follows these standards:

- Use of the WHO Growth Chart for individual child nutrition evaluation;
- For project-based assessment use cut-off-based prevalence. Z-score cut-off point of <-2 SD is classify low weight-for-age, low height-for-age and low weight-for-height as moderate under nutrition, and <-3 SD is defined as severe under nutrition. The cut-off point of >+2 SD classifies high weight-for-height as overweight in children.
- Use of appropriate equipment and standard measurement techniques.

Measurements are only as useful as they are accurate

CCF seek for accuracy (closeness to "truth") and precision (reproducibility of two or more independent measurements) when obtaining measurements and plotting growth charts. Measurements are only as useful as they are accurate. Accurate measurements recorded and plotted correctly are an essential first step in a child's nutrition assessment, therefore recommended that growth monitoring program should be base on well trained and supervised local workers, using well shaped equipment: hanging scales, Length Measuring Board (for children less than two years) and height scale for children more than two years old. Classification for assessing severity of malnutrition by prevalence ranges among children less than 5 years of age in communities are base on the following chart:

Indicator	Severity of malnutrition by prevalence ranges (%)			
	Low	Medium	High	Very high
Stunting	<20	20-29	30-39	40
Underweight	<10	10-19	20-29	30
Wasting	< 5	5-9	10-14	15

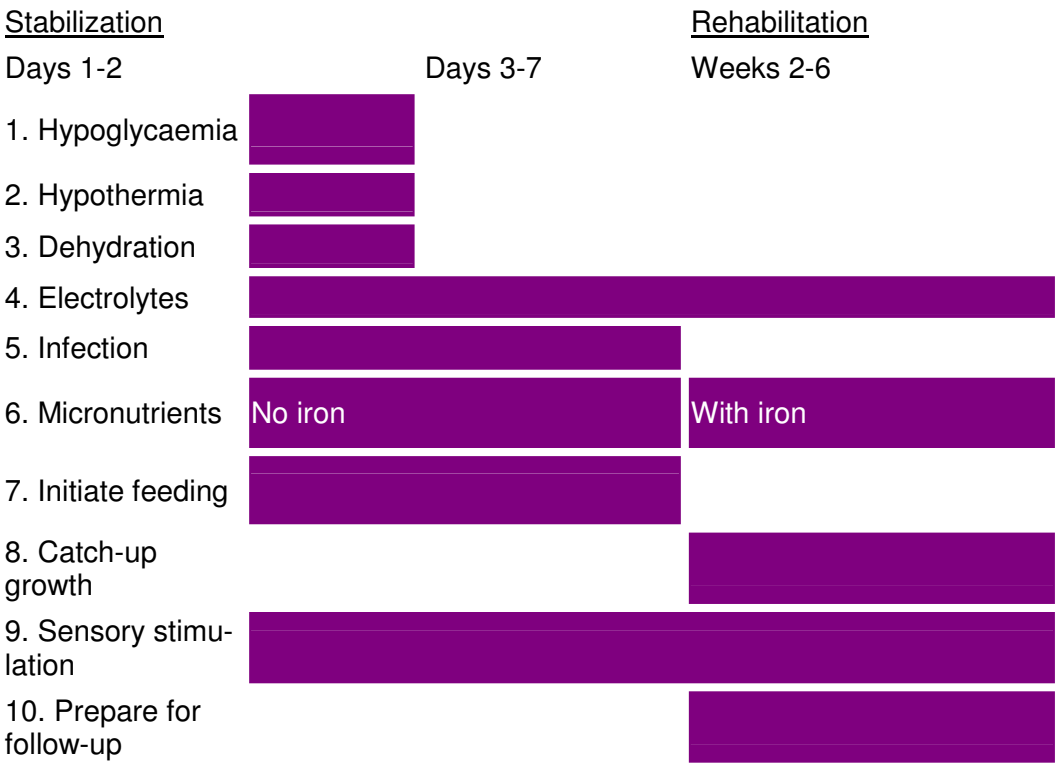
☞ *Malnutrition*

Malnutrition is frequently part of a vicious cycle that includes poverty and disease. These three factors are interlinked in such a way that each contributes to the presence and permanence of the others. Socioeconomic and political changes that improve health and nutrition can break the cycle; as can specific nutrition and health interventions. CCF seeks to contribute to the transformation of this cycle of poverty, malnutrition and disease into a virtuous one of wealth, growth and health.

GROWTH MONITORING CHECKLIST:

1. Is regular growth monitoring being conducted? Yes or No
2. How regular is it? Bi-weekly, Monthly, quarterly _____
3. Does each child have a 'Road to Health' Card? Yes or No?
4. Are the weights accurate? Scale calibrated? Yeas or No?
5. Is adequate follow-up being conducted? Yes or No?
6. Is there gender bias? Yeas or No?

Time frame for the management of the child with severe malnutrition



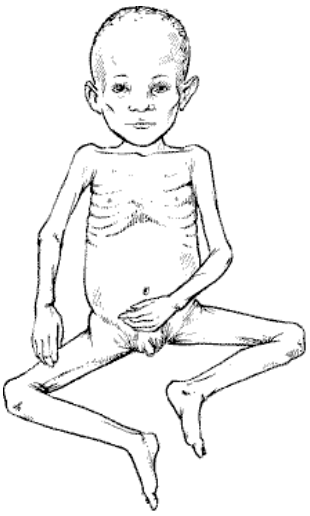
Malnutrition usually refers to a number of diseases

Malnutrition usually refers to a number of diseases, each with a specific cause related to one or more nutrients, for example protein, iodine, vitamin A or iron. In the present context malnutrition is synonymous with protein-energy malnutrition, which signifies an imbalance between the supply of protein and energy and the body's demand for them to ensure optimal growth and function. This imbalance includes both inadequate and excessive energy intake; the former leading to malnutrition in the form of wasting, stunting and underweight, and the latter resulting in overweight and obesity.

Malnutrition in children is the consequence of a range of factors that are often related to poor food quality, insufficient food intake, and severe and repeated infectious diseases, or frequently some combinations of the three. These conditions, in turn, are closely linked to the overall standard of living and whether a population can meet its basic needs, such as access to food, housing and health care. Growth assessment thus not only serves as a means for evaluating the health and nutritional status of children but also provides an indirect measurement of the quality of life of an entire population.

☞ **Severe Malnutrition:**

Severe malnutrition is defined in these guidelines as the presence of oedema of both feet, or severe wasting (<70% weight-for-height or <-3SD), or clinical signs of severe malnutrition. No distinction has been made between the clinical conditions of kwashiorkor, marasmus, and marasmic kwashiorkor because the approach to their treatment is similar.



Child with marasmus.

Children with severe malnutrition are at risk of several life-threatening problems like hypoglycaemia, hypothermia, serious infection, and severe electrolyte disturbances. Because of this vulnerability, they need careful assessment, special treatment and management, with regular feeding and monitoring. Their treatment in hospital should be well organized and given by specially trained staff. As recovery may take several weeks, their discharge from hospital should be carefully planned in order to provide outpatient care to complete their re-habilitation and to prevent relapse.

☞ **Physical Growth**

Physical growth refers to the change in body size during an interval of time. It depends basically on the amount of calories and proteins available from food ingested; that is why Physical Growth is one of the best indicators of nutritional status during infancy and childhood.

For this reason, most standardized indicators of malnutrition in children are based on Anthropometric measurements of the body at different levels of age and nutrition, and assess them in relation to appropriate reference data, to see if growth has been adequate. These are call “Anthropometric Indices” and are useful in identifying individuals whose nutritional deficiencies or excesses are reflected in growth.

☞ **Growth Indicators**

In children the three most commonly used anthropometrics indices to assess their growth status are weight-for-height, height-for-age and weight-for-age. These anthropometrics indices can be interpreted as follows:

Weight-for- Height (W/H): A low W/H is call wasting. Wasting or thinness indicates in most cases a recent and severe process of weight loss, which is often associated with acute starvation and/or severe disease. However, wasting may also be the result of a chronic unfavorable condition. Provided there is no severe food shortage, the prevalence of wasting is usually below 5%, even in poor countries. The Indian subcontinent, where higher prevalence’s are found, is an important exception. A prevalence exceeding 5% is alarming given a parallel increase in mortality that soon becomes apparent. On the severity index, prevalence’s between 10-14% are regarded as serious, and above or equal 15% as critical. Typically, the prevalence of low weight-for-height shows a peak in the second year of life. Lack of evidence of wasting in a population does not imply the absence of current nutritional problems: stunting and other deficits may be present.

Height-for-Age (H/A): A low height for Age is called stunting. Stunted growth reflects a process of failure to reach linear growth potential as a result of sub optimal health and/or nutritional conditions. On a population basis, high levels of stunting are associated with poor socioeconomic conditions and increased risk of frequent and early exposure to adverse conditions such as illness and/or inappropriate feeding practices. Similarly, a decrease in the national stunting rate is usually indicative of improvements in overall socioeconomic conditions of a country. The worldwide variation of the prevalence of low height-for-age is considerable, ranging from 5% to 65% among the less developed countries. In many such settings, prevalence starts to rise at the age of about three months; the process of stunting slows down at around three years of age, after which mean heights run parallel to the reference. Therefore, the age of the child modifies the interpretation of the findings: for children in the age group below 2-3 years, low height-for-age probably reflects a continuing process of "failing to grow" or "stunting"; for older children, it reflects a state of "having failed to grow" or "being stunted". It is important to distinguish between the two related terms, length and stature: length refers to the measurement in recumbent position, the recommended way to measure children below 2 years of age or less than 85 cm tall; whereas stature refers to standing height measurement. For simplification, the term height is used all throughout the database to cover both measurements.

Weight-for-Age (W/A): Weight-for-age reflects body mass relative to chronological age. It is influenced by both the height of the child (height-for-age) and his or her weight (weight-for-height), and its composite nature makes interpretation complex. For example, weight-for-age fails to distinguish between short children of adequate body weight and tall, thin children. However, in the absence of significant wasting in a community, similar information is provided by weight-for-age and height-for-age, in that both reflect the long-term health and nutritional experience of the individual or population. Short-term change, especially reduction in weight-for-age, reveals change in weight-for-height. In general terms, the worldwide variation of low weight-for-age and its age

Base on level of training needed from field workers, objectivity and reliability of the measurements, time required to take measurements, instruments, tools, financial resources and other logistic needed, and related cultural factors, CCF uses the indicators Weight for Age in a regular basis and the other two in specific conditions:

Looking at the current weight of a child in isolation is not very useful. Most methods of nutritional status assessment, including the ones that uses weight-for-age, use a chart on which a child's weight is plotted at intervals, ideally monthly, from birth to five years of age. It is the direction of the growth curve on the chart that is crucial, and a child whose growth curve shows a leveling off or flattening needs help. A falling weight curve is a more urgent sign for investigation and help.

☞ What is Growth Monitoring?

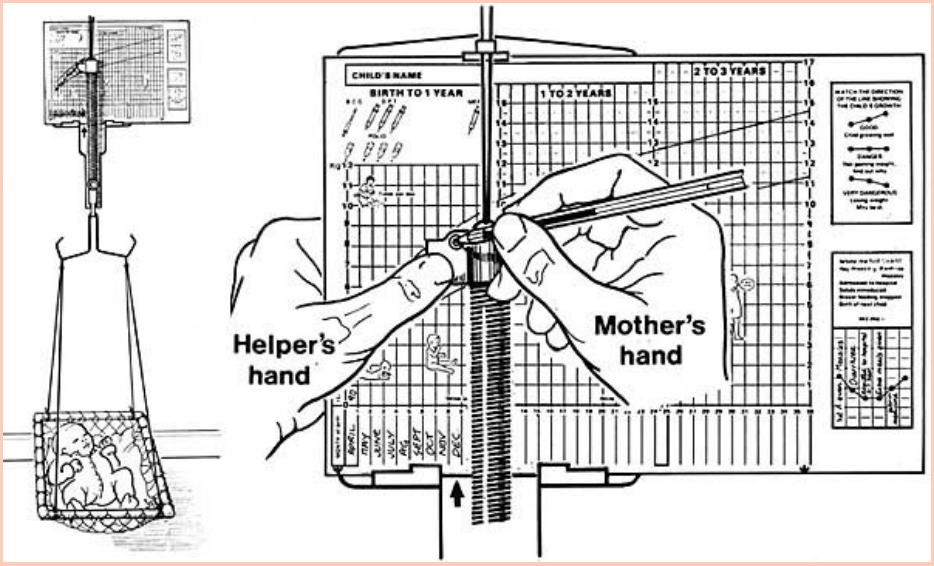
Growth monitoring is a routine measurements and regular recording of a child's weight, to detect abnormal growth, coupled with some specified remedial actions when this is detected. Although the causes of growth faltering and the responses to it may be region specific, the process is the same.

Growth monitoring is widely accepted and strongly supported by health professionals, and is a standard component of community health services throughout the world. For a relatively small expenditure per child, growth monitoring can greatly strengthen preventive health programs.

Growth is the best general index of the health of an individual child

Growth is the best general index of the health of an individual child, and regular measurements of growth permit the early detection of malnutrition, frequently associated with diarrhea, and other illnesses, when remedial action is relatively easy. Although acute signs of malnutrition are easily noted by health workers, it is often too late, and more expensive, to help the severely malnourished child.

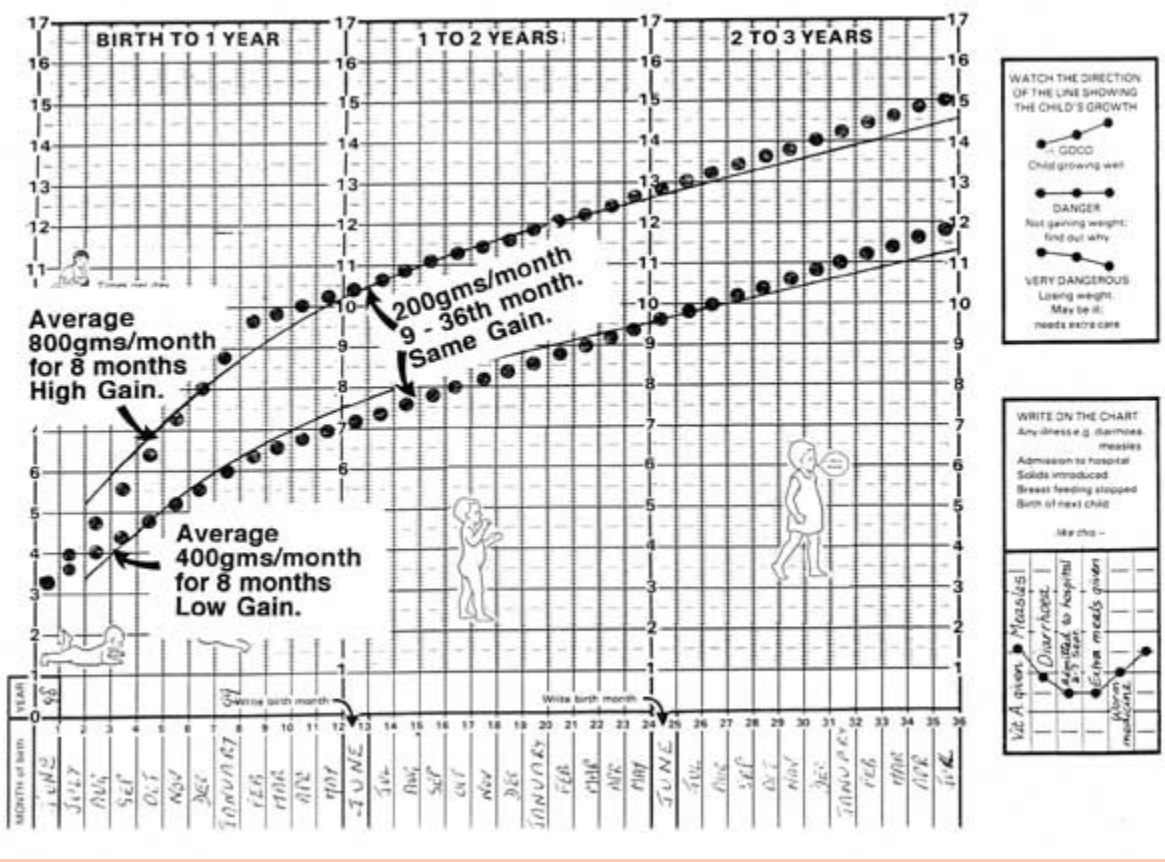
The direct recording scale



Royal Society of Tropical Medicine and Hygiene/ M. Meegan, D. Morley and R. Brown

CCF Growth Monitor Program is base in the index Weight for Age. To obtain weight-for-age, the weight of the child is compared with that of a healthy normal child of the same age from a reference population, using the following WHO growth-monitoring Chart.

Sample growth chart for two children



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☞ *Procedures & Interpretations*

Each time a child is weight, a point is drawn in the intersection between the weight obtained and the age of the child at the moment. Then, a line is drawn between all the points that form the growth curve of the child.

This curve is compared with the reference pattern. In analyzing the growth curve of an individual child, it is more important to see if this is parallel the reference pattern, which only sees the position. Example, a small child could be below the third percentile, but if his growth pattern has the same direction that the references pattern, there is not reason for concern. He is a small but a healthy child.

Advantages of weight-for-age as a monitor of growth*:*

- It is considered to be a useful indicator for growth monitoring in general terms.
- It is sensitive to small changes in the child's nutritional status, as reflected by weight and is a good indicator for detecting growth faltering.
- The only tools needed are weighing scales and charts - usually easy to carry and relatively cheap.
- Weighing is a fairly easy and quick task for inexperienced health workers although it does require a health worker to be numerate.

Disadvantages:

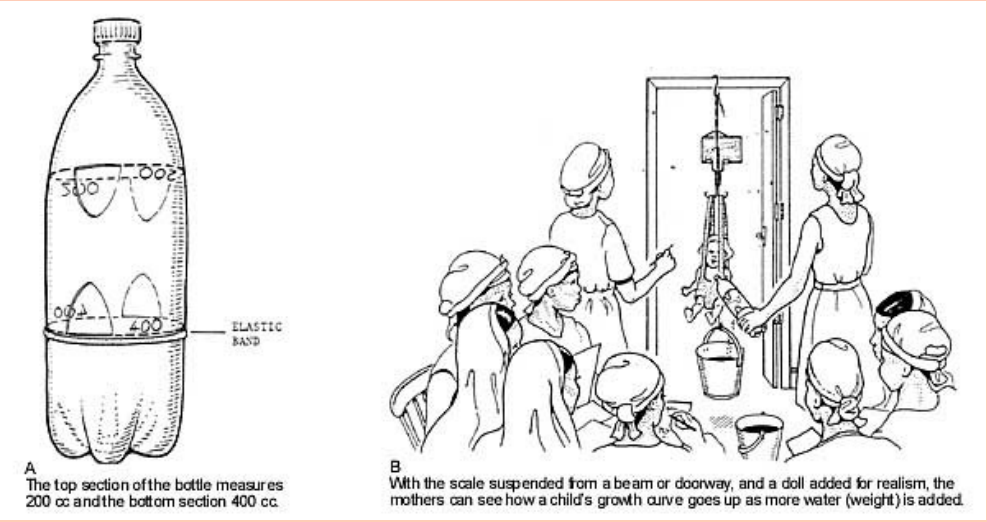
- Weighing should be done regularly and this is not always possible.
- It is necessary to know a child's age to the nearest month and this information is not always available. (It is harder to estimate accurately the unknown ages of children over two years old than those aged 0-2 years.)
- Mothers may object to their children being weighed by being suspended from hanging scales, in some cultures, and many children feel frightened and insecure.
- Malnourished children - aged over one year - who have edema may not be classed as malnourished when in fact they are.

Weighing scales criteria \[4]:

- The accuracy of the scale to nearest 250 gms (preferably the nearest 100 gms or quarter of a pound, especially for young children).
- A total weight capacity of at least 25 kg, or 50 lbs., for programs weighing children under six (although the majority of critical weightings will be in children under 15 kg).
- Ease of reading numbers, with no confusion between kg and pound gradients if they are both on the same scale. A direct transfer to growth charts and interpretation of the results should be possible without mathematical calculations.
- Does not lift the baby too high off the ground/floor.
- An adjusting mechanism which allows the scale to be tarred (this means to adjust the needle to zero. If the needle rests on one side or other of zero the reading will be inaccurate. When something like a basket to hold the child is hung on the scale this weight needs to be subtracted before the child is weighed. If the scale can be tarred it is not necessary to subtract from the indicated weight).
- The reading point of the scale should be at eye level so that it can be read more accurately.

[4] CCF RECOMMENDS *Spring hanging scales.* These scales are light to transport, durable, fairly accurate and easy to use. In some places, for example, it may be better to use a net, hammock, box or basket, rather than suspend the child in weighing pants. *CF DO NOT RECOMMENDS Bathroom-type scales*. Although these are widely used, they are not accurate, and become unreliable but they are portable and cheap.

Demonstrating how the growth chart works



A
The top section of the bottle measures 200 cc and the bottom section 400 cc.

B
With the scale suspended from a beam or doorway, and a doll added for realism, the mothers can see how a child's growth curve goes up as more water (weight) is added.

Royal Society of Medicine / Sohal, Wilkinson and Morley

☞ Estimating the Child's Age

Where a child's age is unknown the table shows some methods that may be useful in estimating the child's approximate age. A local events calendar, which includes harvest time, religious festivals, or natural disasters, is most valuable. Also useful, is comparing the child with other children in the village whose ages are known.

The child is like this:	He is this old:
No teeth, can't sit alone	0-5 months
Has 1-6 teeth, can sit alone, can't walk alone	6-11 months
Has 6-18 teeth, can walk, knows a few words	12-23 months
Has 18-20 teeth, walks well, starting to talk well	24-35 months
Walks and runs well, talks well, has not yet lost first baby teeth	36-59 months
Be careful: You should never look at the size of a child when you are guessing his age. If the child is malnourished, his small size will make you think he is younger than he really is.	

CCF uses as a basis for comparison across countries the National Center for Health Statistics (NCHS) growth reference, the so-called NCHS/WHO international reference population, which can be seen in Appendix: 2). The World Health Organization adopted the reference curves of the NCHS for international use in the late 1970s based on the then growing evidence that the growth patterns of well-fed, healthy preschool children from diverse ethnic backgrounds are very similar. Differences of genetic origin are evident for some comparisons; however, these variations are relatively minor compared with the large worldwide variation in growth related to health and nutrition.

12. Guidelines for Early Childhood Development Programs

Early childhood is the most rapid period of development in a human life. Although individual children develop at their own pace, all children progress through an identifiable sequence of physical, cognitive, and emotional growth and change. The Early Child Development (ECD) approach is based on the proven fact that young children respond best when caregivers use specific techniques designed to encourage and stimulate progress to the next level of development.

The specific enabling conditions for ECD are:

- *Community and family demand and resources: the cornerstones for ECD*
- *ECD skills at the CCF Project and national levels*
- *Availability and interest of local ECD workers*
- *Community capacity for participation (management, financial and other)*
- *Capacity of local institutions*
- *Public awareness and demand for supportive policy*
- *External and supra-national resources (for training, research, advocacy)*
- *Policy movers' support*
- *Mass media resources.*

☞ Why invest in Early Childhood Development?

The reasons for investing in ECD projects are numerous and interrelated. A child's ability to think, form relationships, and live up to his or her full potential is directly related to the synergistic effect of good health, good nutrition, and appropriate stimulation and interaction with others. A large body of research has proven the importance of early brain development and the need for good health and nutrition.

These inputs lay the foundation for healthy cognitive and emotional development, which translate into tangible economic returns. ECD project research has proven that children who participate in well-conceived ECD programs tend to be more successful in later school, are more competent socially and emotionally, and show higher verbal and intellectual development during early childhood than children who are not enrolled in high quality programs. Ensuring healthy child development, therefore, is an investment in a country's future workforce and capacity to thrive economically and as a society.

ECD encourages greater social equity

The benefits of ECD thereby encourage greater social equity, increase the efficacy of other investments, and address the needs of mothers while helping their children. Integrated programs for young children can modify the effects of socio-economic and gender-related inequities, some of the most entrenched causes of

poverty. Studies from diverse cultures show that girls enrolled in early childhood programs are better prepared for school and frequently stay in school longer. Early childhood interventions also free older sisters from the task of tending pre-schoolers, so that they can return to school.

Including early childhood interventions in larger programs can enhance the programs' efficacy. Early childhood interventions in health and nutrition programs increase children's chances of survival. Interventions in education programs prepare children for school, improving their performance and reducing the need for repetition. With ever more mothers working and more households headed by women, safe child care has become a necessity. Providing safe child care allows women the chance to continue their education and learn new skills, ***thereby addressing the intersecting needs of women and children.***

☞ ***Development Stages of ECD***

Every child is a unique person with an individual temperament, learning style, family background, and pattern and timing of growth. There are, however, universal, predictable sequences of growth and change that occur during the first nine years of life. As children develop, they need different types of stimulation and interaction to exercise their evolving skills and to develop new ones. At every age, meeting basic health and nutritional needs are essential. **The following outlines the various stages of Early Childhood Development:**

Birth to 3 months	
What they do:	At this age, children begin to smile, track people and objects with eyes, prefer faces and bright colors, reach, discover hands and feet, lift head and turn toward sound, and cry, but are often soothed when held.
What they need:	Protection from physical danger, adequate nutrition, adequate health care, (immunization, oral rehydration therapy, hygiene), motor and sensory stimulation, appropriate language stimulation, responsive, sensitive parenting

4 to 6 months	
What they do:	At this age, children smile often, prefer parents and older siblings, repeat actions with interesting results, listen intently, respond when spoken to, laugh, gurgle, imitate sounds, explore hands and feet, put objects in mouth, sit when propped, roll over, scoot, bounce, grasp objects without using thumb
What they need:	Protection from physical danger, adequate nutrition, adequate health care, (immunization, oral rehydration therapy, hygiene), motor and sensory stimulation, appropriate language stimulation, responsive, sensitive parenting.

7 to 12 months.	
What they do:	At this age, children remember simple events, identify themselves, body parts, familiar voices, understand own name, other common words, say first meaningful words, explore, bang, shake objects, find hidden objects, put objects in containers, sit alone, creep, pull themselves up to stand, walk, may seem shy or upset with strangers.
What they need:	Protection from physical danger, adequate nutrition, adequate health care, (immunization, oral rehydration therapy, hygiene), motor and sensory stimulation, appropriate language stimulation, responsive, sensitive parenting.

1 to 2 years	
What they do:	At this age, children imitate adult actions, speak and understand words and ideas, enjoy stories and experimenting with objects, walk steadily, climb stairs, run, assert independence, but prefer familiar people, recognize ownership of objects, develop friendships, solve problems, show pride in accomplishments, like to help with tasks, begin pretend play.
What they need:	In addition to needs from previous years, children at this age require support in the following: acquiring motor, language, and thinking skills, developing independence, learning self-control, opportunities for play and exploration, play with other children. Health care must also include deworming..

2 to 3 ½ years	
What they do:	At this age, children enjoy learning new skills, learn language rapidly, are always on the go, gain control of hands and fingers, are easily frustrated, act more independent, but still dependent, act out familiar scenes.
What they need:	In addition to needs from previous years, children at this age require opportunities to do the following: make choices, engage in dramatic play, read increasingly complex books, sing favorite songs, work simple puzzles

3 1/2 to 5 years	
What they do:	At this age, children have a longer attention span, act silly & boisterous, may use shocking language, talk a lot, ask many questions, want real adult things, keep art projects, test physical skills and courage with caution, reveal feeling in dramatic play, like to play with friends, do not like to lose, share and take turns sometimes.
What they need:	In addition to needs from previous years, children at this age require opportunities to do the following: develop fine motor skills, continue expanding language skills by talking, reading, and singing, learn cooperation by helping and sharing, experiment with pre-writing and pre-reading skills.

5 to 8 years	
What they do:	At this age, children grow curious about people and how the world works, show an increasing interest in numbers, letters, reading and writing, become more and more interested in final products, gain more confidence in physical skills, use words to express feeling and to cope, like grown-up activities, become more outgoing, play cooperatively.
What they need:	At this age, children grow curious about people and how the world works, show an increasing interest in numbers, letters, reading and writing, become more and more interested in final products, gain more confidence in physical skills, use words to express feeling and to cope, like grown-up activities, become more outgoing, play cooperatively.

BENEFITS & COST

A vast body of research has demonstrated that ECD programs benefit children, families, and communities. The reduced dropout and repetition rates, improved school achievements, greater adult productivity, and higher levels of social and emotional functioning encouraged by ECD programs make them a highly cost-effective means of strengthening society as a whole by ensuring that its individual members live up to their full potentials.

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Evaluations of ECD programs operating in developing countries show considerable positive outcomes for participating children. Several **longitudinal studies** demonstrate the substantial long-term impact. The following benefits have been firmly linked to integrated interventions in early childhood:

1. Improved Nutrition and Health……

By providing psychosocial stimulation, ECD programs can enhance the efficacy of health care and nutrition initiatives. They can also help ensure that children receive health care. Children participating in the Colombia Community Child Care and Nutrition Project, for instance, are required to complete their immunizations within six months of entering the program. Programs can also monitor growth and provide food supplements and micronutrients, as in India's Integrated Child Development Services program, and can help with such existing public health efforts as mass immunizations. Other programs specifically aim at changing parent behavior by educating parents about the health and nutrition needs of their children.

2. Improved Cognitive Development and School achievement

Children who participated in early child interventions under Jamaica's first Home Visiting Program, Colombia's Cali project, Peru's Programa No Formal de Educacion Inicial (Pronoei), and the Turkey Early Enrichment Project scored higher, on average, on intellectual aptitude tests than did non-participants. Early education activities aren't the only thing that improve cognitive development; better health and nutrition can have a similar impact too. For instance a longitudinal analysis of child nutrition in the Philippines shows how better nourished children perform significantly better in school (Glewwe, Jcaoby and King, 2001)

3. High School Enrollment

The Colombia Promesa program cited significantly higher enrollment rates (in later schooling) among program children than among non-participants.

4. Less Repetition

Children who participated in an early childhood program repeated fewer grades and made better progress through school than did non-participants in similar circumstances. Children in the Colombia Promesa study, in the Alagoas and Fortaleza study in Northeast Brazil, and in the Argentina study all had, on average, lower rates of repetition.

5. Fewer Dropouts

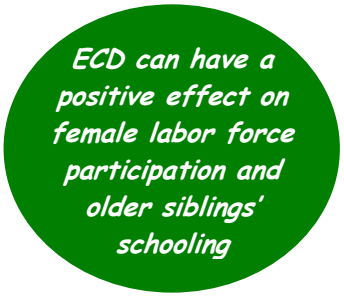
Dropout rates were lower for program children in three of four studies. In India's Dalmau program -- the only study in which attendance was measured -- later school attendance was 16 percent higher for children ages six to eight. In Colombia's Promesa project, third-grade enrollment rates rose by 100 percent, reflecting lower dropout and repetition rates. Moreover, 60 percent of program children reached the fourth grade, compared with only 30 percent of children in the comparison group.

6. Help for the Disadvantaged & Reduced Social Inequality

There is mounting evidence that interventions in early childhood particularly benefit the poor and disadvantaged. In India's Haryana project, for instance, dropout rates did not chance significantly for children from the higher caste but fell a dramatic 46 percent for the lower caste and an astonishing 80 percent for the middle caste (Chaturvedi et al 1987). A study conducted in Jamaica gives unequivocal proof that nutritional supplementation for undernourished children -- who are most likely to come from disadvantaged families --improves mental development (Grantham-McGregor et al 1991). Programs in India and Guatemala resulted in a significant decline in the enrollment age for another traditionally disadvantaged group - girls (Myers 1995).

Moreover, affordable early child care programs can have a positive effect on *female labor force participation and older siblings' schooling*. A recent study on the effects of child care costs on households' behavior in Kenya shows how women's labor force participation and older children's schooling are effected by the costs

of ECD programs. For households with children aged three to seven, the authors model household demand for mothers' participation in paid work, the participation in paid work of other household members, household demand for schooling, and household demand for child care. They find that: A) A high cost for child care discourages households from using formal child care facilities and has a negative effect on mothers' participation in market work. B) The cost of child care and the level of mothers' wages affect older children's school enrollment, but these factors affect boys' and girls' schooling differently. An increase in mothers' wages increases boys' enrollment but depresses girls' enrollment. C) Higher child care costs have no significant effect on boys' schooling but significantly decrease the number of girls in school (Lokshin, Glinskaya & Garcia 2000).



Young, Mary. 1996, **Early Child Development: Investing in the Future**, Washington, DC: The World Bank; Young, Mary (ed.). 1997. "Early Child Development: Investing in Our Children's Future". Amsterdam: Elsevier Science B.V.

Areas for action in order to accelerate investment in ECD:

1. Increase data available for planning and evaluating ECD. Focus especially upon impact and cost effectiveness, and the long-term benefits of ECD.
2. Increase access to ECD services particularly for children (and mothers) most in need.
3. Raise public awareness about the value of ECD and forge partnerships for action among communities, private and public sector organizations. National governments may not be direct providers of ECD, but many would do well to consider establishing a policy framework to give formal recognition to and bolster action at local level.
4. Pursue more coherent national frameworks for planning and implementing ECD. Work for better coordination and mutual support among policy, programs and research.

13. Guidelines on Education and Better Life Options

Patterns of educational attainment vary greatly across countries, and across population groups within countries. For some, basic education is practically universal whereas for others attainment is dismal. Education is a powerful instrument for reducing poverty and inequality, improving health and social well-being, and laying the basis for sustained economic growth. It is essential for building democratic societies and dynamic, globally competitive economies.

Reading, Writing, and retention: To reach the goal, schools must first enroll all school age children and then keep them in school for the full course of the primary stage. In many places schools fail to do both. As a result, there can be large gaps between reported enrollment, attendance, and completion rates. Disparities arise for many reasons. Children may start school late or they may repeat grades, putting them off track. Frequently children drop out of school, because of their own or a family member's illness or because their families need their labor. If they return, they reenroll in the same grade the following year. But many never finish

Attempts at policy level to make **schools and schooling** more effective can be either *statutory* or *non-statutory.*

statutory:

- channelling resources into schools lacking basic necessities, from sound and safe buildings and sanitation to textbooks and ICT facilities
- restructuring the curriculum and making specified content compulsory
- etablishing quality assurance systems: frequent independent inspections
- instituting regular standardised assessments of all pupils in core subjects
- recording and reporting the results of these assessments at school level, with the purpose of monitoring progress and identifying under-performance
- setting standards or targets for pupil achievement
- either using interventions – such as appointing replacement principals – to turn round, or else eventually closing, schools which fail to meet those standards or targets
- making schools more accountable to the local community by, for example, specifying parent and community representation on school governing boards
- linking school funding to performance

non-statutory:

- promoting the notion of schools' responsibility for helping each child to reach her/his potential
- instituting specific centrally-funded programs for which schools can bid

- promoting a culture of self-evaluation and review, using information ranging from 'benchmarking' data to pupils' experiences
- encouraging 'evidence-based' education and the use of research to support practice
- encouraging schools to involve both pupils and parents more actively in the life of the school
- promoting private sector involvement in aspects of schooling such as curriculum design/delivery through, e.g., education-business partnerships

In order to address these needs, *Effective Schooling* aims to:

- Generate greater consensus among agencies and client governments about how to develop and promote more effective schooling; Initiate and support *critical discussion* on school effectiveness issues for education.
- Enhance the ability of educational staff and development agencies to support changes (at both school and system levels) which will promote school improvement.

The factors which were seen as characterizing the different environment in rural developing countries include: dispersed populations, displaced populations (following conflict), situations of on-going conflict, nomadic populations, limited basic infrastructure, endemic malnutrition among children, the HIV/AIDS epidemic, and high levels of child labor in agriculture. The consequences of these factors for student learning are that:

- ***Schooling is an interrupted process:*** The demand for labor from school age children, their poor health, the difficulties associated with getting to school and the limited benefits accrued from being at school all conspire to reduce demand for, and increase the obstacles to schooling. The result is that children often attend school irregularly.
- ***The conditions of schooling and the nature of students' lives in rural areas act to reduce students' readiness to learn*:** Long journeys on foot to school, students' poor nutrition, poor or non-existent sanitation at schools, uncomfortable and even harmful conditions within classrooms all act to reduce students' capacity to learn.
- ***Teaching is often of poor quality and is poorly supported:*** Isolated conditions in rural areas fail to attract high quality teachers. This situation is made worse by the fact that poor infrastructure obstructs support from advisory agencies. Not only are teachers served less well by support services, they often have fewer text and other teaching resources.
- ***Formal schooling often fails to connect with the needs of rural communities:*** The curriculum often has little relevance to rural life, community involvement is mixed, and low levels of literacy in the community and traditional attitudes and practices provide little support for the learning students' receive in school. Furthermore, formal schooling is sometimes at odds with prevailing religious or cultural practices.

- ***Rural education is often not an immediate priority for governments*:** Owing to the remote nature of rural schools, governments give less weight to issues of low quality education in rural areas than to similar issues in urban schools.

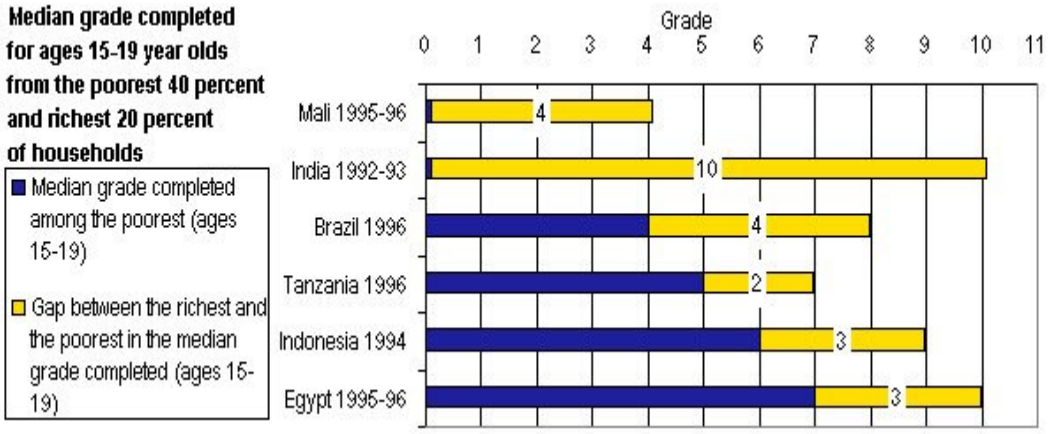
Assumptions about what make a good school underpin all efforts for school improvement. In order to explore these assumptions about, participants in the working group were asked to give their perceptions about the pertinent features of good schooling in rural Africa from the perspectives of three categories of stake holders: communities, teachers and district education officers.

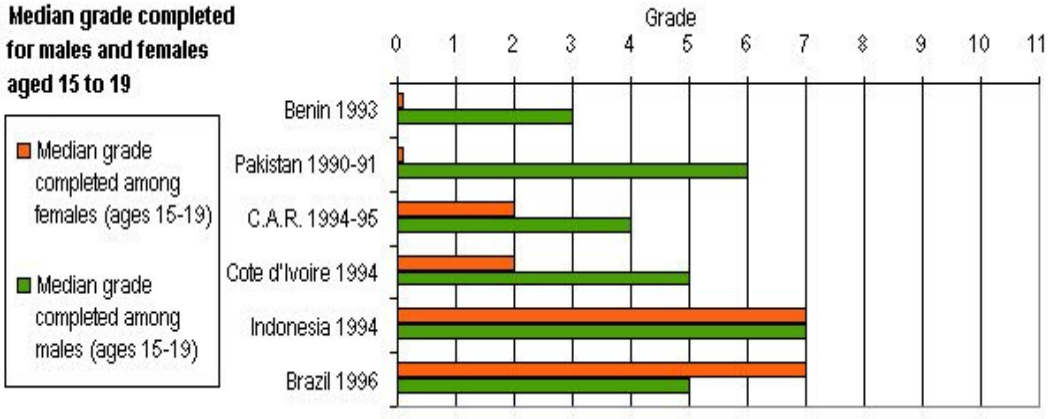
From the *community perspective,* access for all and safety (within and en route to school) both feature as pre-requisites for good schooling. Features of good schooling include qualified (local) teachers and a school environment which supports learning. Evidence of this should be found in good exam grades, which in turn provide access to the next level of education. While these features accord with standard conceptions of a quality formal education, close relations between the school and the community were also felt to be important features of a good schooling. Such relations should be reflected in a curriculum which connects the home with school knowledge, and which is sensitive to local religious and cultural beliefs. The administration should also be accountable to the community. Ideally, the school should be seen as a resource for the community to draw upon. However, with this, as with all other aspects of good schooling, it was noted that communities are not homogenous and that drawing general conclusions about community perceptions needs to be undertaken with care.

From the *teachers' perspective* a successful school is one which is strong on exam performance: a view shared by the community. However, teachers' immediate priorities are usually closely related to the demands made of them, and the rewards they receive. Top of the list is pay, especially in countries where pay is often received late or is insufficient to meet basic needs. From the teachers' perspective a good school is one where the prescribed curriculum is realistic; where classes are of a reasonable size (with well behaved, regularly attending and motivated students); and where they receive support for their work (in the form of teaching materials and advice).Working relationships within schools also have an immediate impact on their working lives. Strong collegiality, impartiality and the absence of corruption from school management all add to teachers' sense of what makes a good school. Recognition of achievement, coupled with opportunities to progress professionally and progress within the system is also key.

From an *administrative or inspectorate perspective*, once again good grades are a signal of successful schools. In addition other important indicators may include strong working relationships, extra-curricula activities and school's involvement in the community. Other indicators would include good attendance of pupils, an orderly and well-managed school environment and a safe environment which meets national standards.

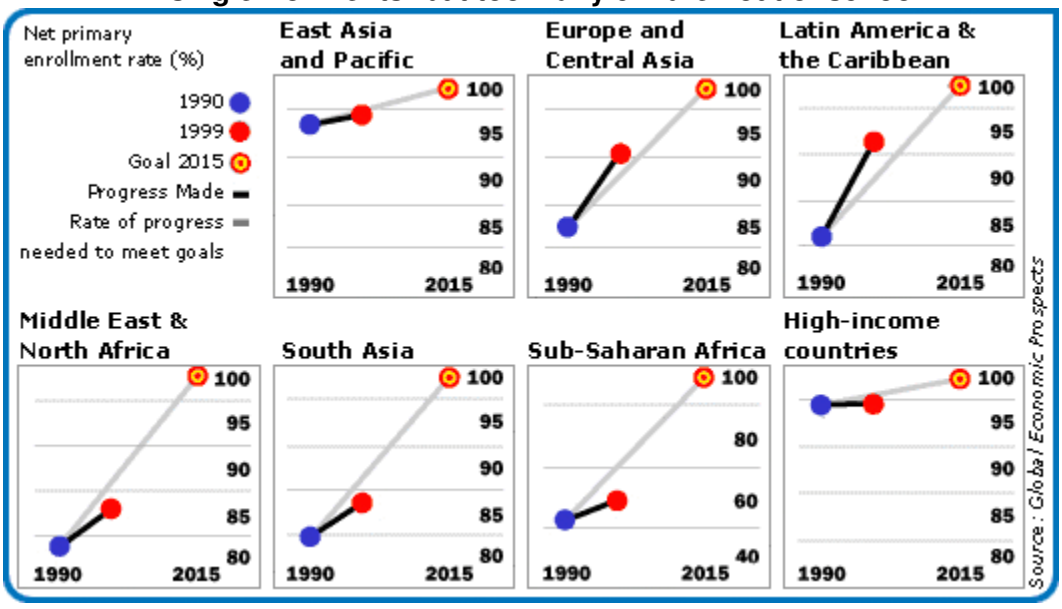
The exercise demonstrated several key issues. Firstly, that while high performance in examinations might be considered to be an important indicator of effectiveness by many stakeholders, different groups give different weight to particular aspects of schooling. The second related issue is that initiatives aimed at improving schooling need to take into account the views and aspirations of these different groups and to recognize the demands of different contexts and cultures. In order for this to happen, education planners and providers need to ensure that communities are consulted and involved in local schooling.





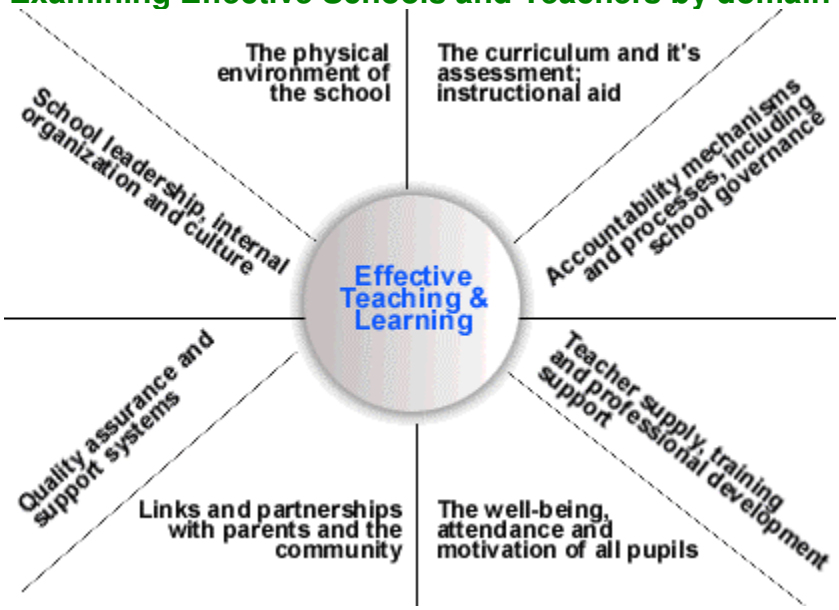
Under the United Nations Millennium Development Goals (MDGs), Ta**rget 3** Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Rising enrollments- but too many children out of school



Primary school enrollment rates are high and still rising in East Asia. Most other regions could reach full enrollment by 2015 if current trends persist. Some will be aided by a demographic shift, which will see relatively fewer school-age children and a larger working-age population in the next 15 years. But in Africa almost 80 million new places will have to be created to accommodate all children

Examining Effective Schools and Teachers by domain



14. AIMES Well-Being Template: Program Indicators, Approaches & Intervention

The Templates are tools to help projects respond to their red flags. The Templates begin with a top section that lines-out the Project Goals and Indicators. Generally, the Goal and 1st Indicator are universal and determined at headquarters and National Offices. The remaining are meant to be determined in a participatory manner at the "Project Specific" level. These can change over time to meet the specific needs of Projects and Communities. The 2nd section are the "Well-Being Templates". They are program options that represent some of CCF's best thinking on how a red flag might be addressed. They are meant to be guides for projects -- not to be used as a 'cookie cutter' where a single solution is assumed to fit every red flag that a project encounters. To the extent that these options help a project think about what the underlying causes of a red flag might be and what to do about them, then the Templates are serving their purpose. As a project builds up its own experience, it will want to refine its templates. Similarly, if a project has developed a template for a red flag, it might want to share it with other projects - which might encounter similar red flags.

These Templates are meant to be flexible and updated/refined based upon to project's changing needs and circumstances. No one Project would have exactly the same impact indicators or approaches and interventions. The following Templates are meant to be examples for projects. It is recommended that the Projects maintain their Templates in a separate document that can be changed to fit their needs. Further attachments and supporting information can also be included along with the Templates in a manner that suits the Projects monitoring needs.

Templates can be used in two basic ways:

First, when analyzing red flags, a Template can serve as a brainstorming tool for figuring out what the underlying causes of the red flag are and what different interventions might be to address the red flag. For example, if malnutrition is a red flag, the Nutrition Template offers some suggestions for further understanding what the causes of malnutrition might be. One suggestion is to look at a few families that have healthy children and compare them to families in which there are multiple cases of malnutrition. What are some of the differences between these families, and what might be learned that would help shape an intervention? Also included in the Nutrition Template are alternative interventions like providing nutrition education, encouraging exclusive breastfeeding for the first 4-6 months of infancy, and encouraging pregnant women to access prenatal care. To the extent that the Templates spur projects on to explore alternative "roads" to good nutrition, then the Templates are a useful tool.

The second way Templates might be of use to a project is in their adaptation and use by project staff or volunteers who outreach to individual families and provide information to the family about roads to good health and

successful education. The information in each of the Templates might be conveyed in a series of messages that are communicated one-to-one or in small groups. For example, a Nutrition Template might be a tool that is used by a mother who has received some basic training on nutrition for the purposes of communicating this information to other mothers in her immediate neighborhood. The Template might be a sheet of paper that contains basic training information that can help a mother remember important information to be communicated to other mothers.

In summary, a Template has two potential uses. First, it is a tool to help a project respond to its red flags. Second, it is a tool to help an individual respond to red flags. In the following pages, Templates are presented for each of the AIMES indicators and there are no set number of indicators a project can have as long as they address a legitimate need or issue that is specific or relevant to the community and Project. For example, many Project will include "The Eradication of Malaria", while other Projects are not affected by Malaria.

Again, it should be stressed that these Templates should be considered as starting points and projects will want to build on them.

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More research and studies on the benefits and costs of early childhood interventions can be found in:

Early Childhood Interventions: Views from the Field: Report of a Workshop (2000) **Commission on Behavioral and Social Sciences and Education**

Early Head Start Research: Building their Futures: How Early Head Start Programs Are Enhancing the Lives of Infants and Toddlers in Low-Income Families. Summary Report, U.S. Dept. Health and Human Services (2001)

Early Head Start National Research and Evaluation Project: Further Studies Research on Early Childhood Education - School Improvement Research Series **(SIRS)** by Kathleen Cotton and Nancy Faires Conklin (1989)

The State of Early Childhood Intervention, Effectiveness, Myths and Realities, New Directions, by Reynolds, A. J., Mann, E., Miedel W., Smokowski, P. *Focus, University of Wisconsin-Madison: Institute for Research and Poverty*. Vol. 19, No. 1 Summer/Fall 1997.

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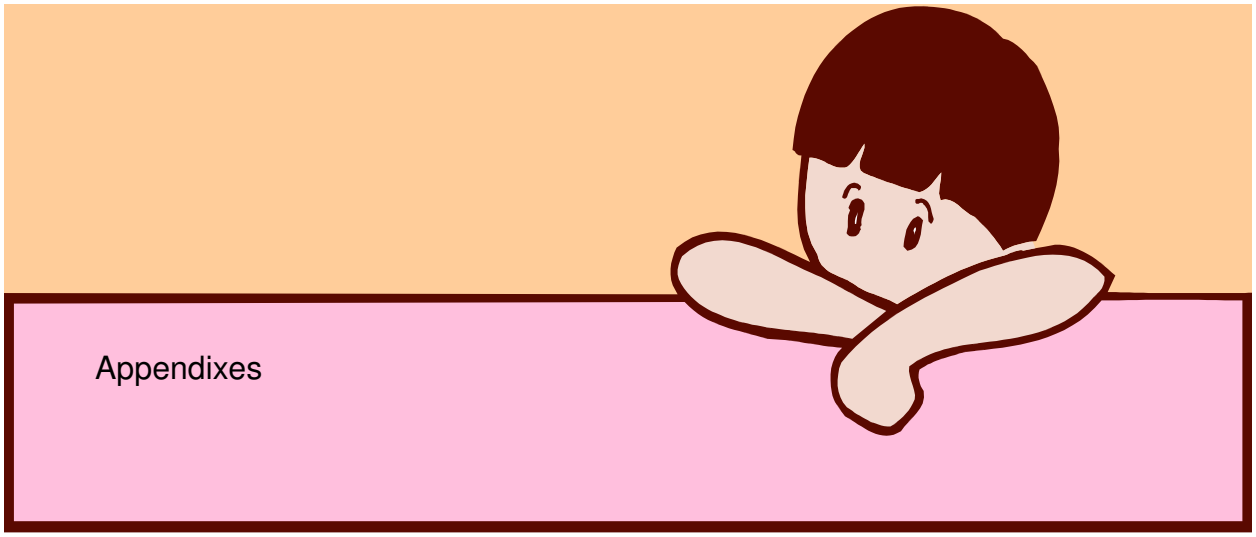

Appendixes

Appendix: 1

Millennium Development Goals (MDGs)		
Goals and Targets		**Indicators**
Goal 1: Eradicate extreme poverty and hunger		
Target 1:	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	Proportion of population below $1 per day Poverty gap ratio [incidence x depth of poverty] Share of poorest quintile in national consumption
Target 2:	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Prevalence of underweight children (under-five years of age) Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education		
Target 3:	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	Net enrolment ratio in primary education Proportion of pupils starting grade 1 who reach grade 5 Literacy rate of 15-24 year olds
Goal 3: Promote gender equality and empower women		
Target 4:	Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	Ratio of girls to boys in primary, secondary and tertiary education Ratio of literate females to males of 15-24 year olds Share of women in wage employment in the non-agricultural sector Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality		
Target 5:	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate Infant mortality rate Proportion of 1 year old children immunised against measles
Goal 5: Improve maternal health		
Target 6:	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	Maternal mortality ratio Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases		
Target 7:	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	HIV prevalence among 15-24 year old pregnant women Contraceptive prevalence rate Number of children orphaned by HIV/AIDS

Target 8:	Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases	Prevalence and death rates associated with malaria Proportion of population in malaria risk areas using effective malaria prevention and treatment measures Prevalence and death rates associated with tuberculosis Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)
Goal 7: Ensure environmental sustainability		
Target 9:	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	Proportion of land area covered by forest Land area protected to maintain biological diversity GDP per unit of energy use (as proxy for energy efficiency) Carbon dioxide emissions (per capita) [Plus two figures of global atmospheric pollution: ozone depletion and the accumulation of global warming gases]
Target 10:	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	Proportion of population with sustainable access to an improved water source
Target 11:	By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	Proportion of people with access to improved sanitation Proportion of people with access to secure tenure [Urban/rural disaggregation of several of the above indicators may be relevant for monitoring improvement in the lives of slum dwellers]

Goal 8: Develop a Global Partnership for Development*	
Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally **Target 13**: Address the Special Needs of the Least Developed Countries Includes: tariff and quota free access for LDC exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction **Target 14:** Address the Special Needs of landlocked countries and small island developing states (through Barbados Programme and 22nd General Assembly provisions) **Target 15:** Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	**Some of the indicators listed below will be monitored separately for the Least Developed Countries (LDCs), Africa, landlocked countries and small island developing states.** **Official Development Assistance** Net ODA as percentage of DAC donors' GNI [targets of 0.7% in total and 0.15% for LDCs] Proportion of ODA to basic social services (basic education, primary health care, nutrition, safe water and sanitation) Proportion of ODA that is untied Proportion of ODA for environment in small island developing states Proportion of ODA for transport sector in landlocked countries **Market Access** Proportion of exports (by value and excluding arms) admitted free of duties and quotas Average tariffs and quotas on agricultural products and textiles and clothing Domestic and export agricultural subsidies in OECD countries Proportion of ODA provided to help build trade capacity *Debt Sustainability* Proportion of official bilateral HIPC debt cancelled Debt service as a percentage of exports of goods and services Proportion of ODA provided as debt relief Number of countries reaching HIPC decision and completion points
Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	Unemployment rate of 15-24 year olds
Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	Telephone lines per 1000 people Personal computers per 1000 people **Other Indicators TBD**

** The selection of indicators for Goals 7 and 8 is subject to further refinement*

About the Goals

At the Millennium Summit in September 2000 the states of the United Nations reaffirmed their commitment to working toward a world in which sustaining development and eliminating poverty would have the highest priority. The Millennium Development Goals grew out of the agreements and resolutions of world conferences organized by the United Nations in the past decade. The goals have been commonly accepted as a framework for measuring development progress.

The goals focus the efforts of the world community on achieving significant, measurable improvements in people's lives. They establish yardsticks for measuring results, not just for develop-ing countries but for rich countries that help to fund development programs and for the multilateral institutions that help countries implement them. The first seven goals are mutually reinforcing and are directed at reducing poverty in all its forms. The last goal-global partnership for development-is about the means to achieve the first seven. Many of the poorest countries will need additional assistance and must look to the rich countries to provide it. Countries that are poor and heavily indebted will need further help in reducing their debt burdens. And all countries will benefit if trade barriers are lowered, allowing a freer exchange of goods and services.

For the poorest countries many of the goals seem far out of reach. Even in better-off countries there may be regions or groups that lag behind. So countries need to set their own goals and work to ensure that poor people are included in the benefits of development.

Appendix 2: WHO/NCHS normalized reference weight-for-length (49-84 cm) and weight- for-height (85-110 cm), by sex										
Boys' weight (kg)						Girls' weight (kg)				
-4SD	-3SD	-2SD	-1SD	Median	Length	Median	-1SD	-2SD	-3SD	-4SD
60%	70%	80%	90%		(cm)		90%	80%	70%	60%
1.8	2.1	2.5	2.8	3.1	49	3.3	2.9	2.6	2.2	1.8
1.8	2.2	2.5	2.9	3.3	50	3.4	3	2.6	2.3	1.9
1.8	2.2	2.6	3.1	3.5	51	3.5	3.1	2.7	2.3	1.9
1.9	2.3	2.8	3.2	3.7	52	3.7	3.3	2.8	2.4	2
1.9	2.4	2.9	3.4	3.9	53	3.9	3.4	3	2.5	2.1
2	2.6	3.1	3.6	4.1	54	4.1	3.6	3.1	2.7	2.2
2.2	2.7	3.3	3.8	4.3	55	4.3	3.8	3.3	2.8	2.3
2.3	2.9	3.5	4	4.6	56	4.5	4	3.5	3	2.4
2.5	3.1	3.7	4.3	4.8	57	4.8	4.2	3.7	3.1	2.6
2.7	3.3	3.9	4.5	5.1	58	5	4.4	3.9	3.3	2.7
2.9	3.5	4.1	4.8	5.4	59	5.3	4.7	4.1	3.5	2.9
3.1	3.7	4.4	5	5.7	60	5.5	4.9	4.3	3.7	3.1
3.3	4	4.6	5.3	5.9	61	5.8	5.2	4.6	3.9	3.3
3.5	4.2	4.9	5.6	6.2	62	6.1	5.4	4.8	4.1	3.5
3.8	4.5	5.2	5.8	6.5	63	6.4	5.7	5	4.4	3.7
4	4.7	5.4	6.1	6.8	64	6.7	6	5.3	4.6	3.9
4.3	5	5.7	6.4	7.1	65	7	6.3	5.5	4.8	4.1
4.5	5.3	6	6.7	7.4	66	7.3	6.5	5.8	5.1	4.3
4.8	5.5	6.2	7	7.7	67	7.5	6.8	6	5.3	4.5
5.1	5.8	6.5	7.3	8	68	7.8	7.1	6.3	5.5	4.8
5.3	6	6.8	7.5	8.3	69	8.1	7.3	6.5	5.8	5
5.5	6.3	7	7.8	8.5	70	8.4	7.6	6.8	6	5.2
5.8	6.5	7.3	8.1	8.8	71	8.6	7.8	7	6.2	5.4
6	6.8	7.5	8.3	9.1	72	8.9	8.1	7.2	6.4	5.6
6.2	7	7.8	8.6	9.3	73	9.1	8.3	7.5	6.6	5.8
6.4	7.2	8	8.8	9.6	74	9.4	8.5	7.7	6.8	6
6.6	7.4	8.2	9	9.8	75	9.6	8.7	7.9	7	6.2
6.8	7.6	8.4	9.2	10	76	9.8	8.9	8.1	7.2	6.4
7	7.8	8.6	9.4	10.3	77	10	9.1	8.3	7.4	6.6
7.1	8	8.8	9.7	10.5	78	10.2	9.3	8.5	7.6	6.7
7.3	8.2	9	9.9	10.7	79	10.4	9.5	8.7	7.8	6.9
7.5	8.3	9.2	10.1	10.9	80	10.6	9.7	8.8	8	7.1
7.6	8.5	9.4	10.2	11.1	81	10.8	9.9	9	8.1	7.2

7.8	8.7	9.6	10.4	11.3	82	11	10.1	9.2	8.3	7.4
7.9	8.8	9.7	10.6	11.5	83	11.2	10.3	9.4	8.5	7.6
8.1	9	9.9	10.8	11.7	84	11.4	10.5	9.6	8.7	7.7
7.8	8.9	9.9	11	12.1	85	11.8	10.8	9.7	8.6	7.6
7.9	9	10.1	11.2	12.3	86	12	11	9.9	8.8	7.7
8.1	9.2	10.3	11.5	12.6	87	12.3	11.2	10.1	9	7.9
8.3	9.4	10.5	11.7	12.8	88	12.5	11.4	10.3	9.2	8.1
8.4	9.6	10.7	11.9	13	89	12.7	11.6	10.5	9.3	8.2
8.6	9.8	10.9	12.1	13.3	90	12.9	11.8	10.7	9.5	8.4
8.8	9.9	11.1	12.3	13.5	91	13.2	12	10.8	9.7	8.5
8.9	10.1	11.3	12.5	13.7	92	13.4	12.2	11	9.9	8.7
9.1	10.3	11.5	12.8	14	93	13.6	12.4	11.2	10	8.8
9.2	10.5	11.7	13	14.2	94	13.9	12.6	11.4	10.2	9
9.4	10.7	11.9	13.2	14.5	95	14.1	12.9	11.6	10.4	9.1
9.6	10.9	12.1	13.4	14.7	96	14.3	13.1	11.8	10.6	9.3
9.7	11	12.4	13.7	15	97	14.6	13.3	12	10.7	9.5
9.9	11.2	12.6	13.9	15.2	98	14.9	13.5	12.2	10.9	9.6
10.1	11.4	12.8	14.1	15.5	99	15.1	13.8	12.4	11.1	9.8
10.3	11.6	13	14.4	15.7	100	15.4	14	12.7	11.3	9.9
10.4	11.8	13.2	14.6	16	101	15.6	14.3	12.9	11.5	10.1
10.6	12	13.4	14.9	16.3	102	15.9	14.5	13.1	11.7	10.3
10.8	12.2	13.7	15.1	16.6	103	16.2	14.7	13.3	11.9	10.5
11	12.4	13.9	15.4	16.9	104	16.5	15	13.5	12.1	10.6
11.2	12.7	14.2	15.6	17.1	105	16.7	15.3	13.8	12.3	10.8
11.4	12.9	14.4	15.9	17.4	106	17	15.5	14	12.5	11
11.6	13.1	14.7	16.2	17.7	107	17.3	15.8	14.3	12.7	11.2
11.8	13.4	14.9	16.5	18	108	17.6	16.1	14.5	13	11.4
12	13.6	15.2	16.8	18.3	109	17.9	16.4	14.8	13.2	11.6
12.2	13.8	15.4	17.1	18.7	110	18.2	16.6	15	13.4	11.9

Appendix 3: Example of a Monitoring Chart

Date:_____				**Hospital Record Number**_____
1. Child's name:				**Mothers name:**
Age:				Weight on Admission:
2. Diagnoses/Main Problems:				
1.				
2.				
3.				
4.				
3. Vital signs:	**DAY 1**	**DAY 2**	**DAY 3**	**DAY 4**
• Consciousness level (AVPU)				
• Temprature				
• Respitory rate				
• Pulse rate				
4. Fluid balance (record volumes and times)				
IV				
By nasogastric tube				
Oral				
Fluid output				
5. Treatments given (sign on chart when given)				
Name of treatment:	Dose:			
1.				
2.				
3.				
4.				
6. Feeding/nutrition				
Child breastfed				
Drink taken				
Food taken				
Feeding problems (give details)				
Weight				
7. Outcome (circle one of the following): Discharged well / Absconded / Transferred / Died				

24 Hour Food Intake Chart

Ward.....

Name.....

Hospital number.....

Age..... Weight..... Date of Admission.....

Date.....Feed.....feeds of.....ml each = ...ml per day						
Time	Type of feed	Volume offered (ml)	Volume left in cup (ml)	Amount taken (ml)	Vomit (estimate)	Watery diarrhoea (Yes/No)
Totals				sub-total		Total taken in 24 hrs

Daily Ward Feed Chart - example

Date 24/12/2000 **Ward** Johnson

	F - 75			**F - 100**		
Name	**Freq/day**	**Amount/ feed**	**Total**	**Freq/day**	**Amount/ feed**	**Total**
John Smith	6x	135	810			
Anne Jones	12x	40	480			
Jo Bloggs	8x	60	480			
Jim Brown				6x	150	900
Janet White	6x	100	600			
Paul Red	8x	35	280			
Billy Blue				6x	170	1020
Total amount needed		F-75 2650			F-100 1920	

Appendix 4: Feeding recommendations during sickness and health

				
Up to 4 months of age □ Breastfeed as often as the child wants, day and night, at least 8 times in 24 hours. □ Do not give other foods or fluids.	**4 months up to 6 months** □ Breastfeed as often as the child wants, day and night, at least 8 times in 24 hours. • Only if the child: • shows interest in semisolid foods, or • appears hungry after breastfeeding, or • is not gaining weight adequately, add complementary foods (listed under **6 months up to 12 months**). Give these foods 1 or 2 times per day after breastfeeding.	**6 months up to 12 months** □ Breastfeed as often as the child wants. □ Give adequate servings of: _____ _____ _____ _____ • 3 times per day if breastfed; • 5 times per day if not breastfed.	**12 months up to 2 years** □ Breastfeed as often as the child wants. □ Give adequate servings of: _____ _____ _____ _____ or family foods 5 times per day.	**2 years and older** □ Give family foods at 3 meals each day. Also, twice daily, give nutritious food between meals, such as: _____ _____ _____ _____
				

** A good daily diet should be adequate in quantity and include an energy-rich food (for example, thick cereal with added oil); meat, fish, eggs, or pulses; and fruits and vegetables.*

Appendix 5: Examples of local adaptations of feeding recommendations from Bolivia, Indonesia, Nepal, South Africa and Tanzania			
Country	**Age group: 6 months up to 12 months**	**12 months up to 2 years**	**2 years and older**
Bolivia	Cereal gruel, vegetable puree, minced meat or egg yolk, fruit. From 9 months: fish, whole egg	Family meals plus additional seasonal fruit, milk-based desserts (custard, milk rice), yoghurt, cheese, give milk twice a day	
Indonesia	Give adequate amounts of rice porridge with egg / chicken / fish / meat / tempe / tahu / carrot / spinach/ green beans / oil / coconut milk. Give also snacks 2 times a day between meals such as green beans, porridge, banana, biscuit, nagasari		Give adequate amounts of family foods in 3 meals each day consisting of rice, side dishes, vegetables and fruits. Also, twice daily, give nutritious foods between meals, such as green beans, porridge, banana, biscuit, nagasari etc
Nepal	Give adequate servings of (mashed) foods such as rice, lentils (dal), mashed bread (roti), biscuits, milk, yoghurt, seasonal fruits (such as banana, guava, mango etc), vegetables (such as potatoes, carrots, green leafy vegetables, beans etc), meat, fish and eggs		
South Africa	Porridge with added oil, peanut butter or ground peanuts, margarine and chicken, beans, full-cream milk, fruit and vegetables, mashed avocado or family food	Porridge with added oil, peanut butter or ground peanuts, margarine and chicken, beans, full-cream milk, fruit and vegetables, mashed avocado or banana, canned fish or family food	Bread and peanut butter, fresh fruit or full cream
Tanzania	Thick gruel, mixed food containing milk, mashed foods (rice, potato, ugali). Add beans, other legumes, meat, fish, or groundnuts. Add greens or fruit such as pawpaw, mango, banana, or avocado. Add spoonful of extra oil into food.		Give twice daily such as thick enriched uji, milk fruits or other nutritious snacks.

Appendix 6: Early Childhood Development in Sub-Saharan Africa: Policy and Programs

As Sub-Saharan Africa contends with persistent poverty, rapid population growth, and erosion of traditional family support structures, investment in early child development (ECD) is imperative. Investments must begin from birth and include health, nutrition, and attention to cognitive and social development to take children up to the transition into primary school. Broad-based investment in young children's survival and development should be a vital part of countries' systematic pursuit of social and economic development.

This study, *Review of Early Childhood Development Policy and Programs in Sub-Saharan Africa*, is the second in a series of three studies conducted under the World Bank's Africa Regional ECD Initiative. The first described the condition of young children in Africa and pointed to the benefits of ECD in increased efficiency of primary and secondary school investments, children's enhanced economic contribution to society, and the reduction of social inequity. The third study will synthesize lessons drawn from the preceding two studies and from case studies in Kenya, South Africa and Mauritius.

There are models of success: The findings of this *Review* are that weakened family and public social sector support for child development create a tremendous need for complementary and alternative forms of child care, *and* that there are models. The *Review* selects eleven case studies from across the Sub-Saharan region to illustrate a range of possibilities for an integrated response to the physical, socio-emotional, cognitive, economic and cultural dimensions of young children's development, so that impact is maximized through the interconnectedness of investments.

The policies and programs reviewed are shown in Table 1. Almost all of the programs have multiple objectives. The scope most often is determined by the extent to which existing delivery systems in education, health, grassroots organizations and others can be utilized innovatively and more effectively. The variation in program objectives translates into target populations that include not only children but also parents and others who figure in children's physical growth and socialization. In some cases the ECD action focuses directly on children; in others, on the household and community.

The case studies illustrate how these enabling conditions come into play to design and sustain ECD policies and programs for particular circumstances of regions, nations and communities. The findings are as follows.

1. ***Local culture offers options for implementing and extending ECD.*** The Angolan Mobile Trauma Team combines traditional culture and healing rites with recent scientific evidence on child development, trauma and healing. Professionals, paraprofessionals, parents and youth leaders are trained to interact with children in refugee camps, children's homes, schools and in street

children's programs. In Botswana, the Child-to-Child program for basic health education is adapted into a school readiness activity for primary school children to help prepare younger siblings for entry.

2. ***There needs to be a focal point for ECD:*** This may of course be home-based care as for Nigeria's Development Communication Project which uses national television to teach children (aged 3-6 years) and their caregivers active learning techniques. A mobile service brings the same instructional videos to local viewing centers. In Zimbabwe, the focal point is the Kushanda integrated community development project in commercial farming communities. The project began with skills training, material and financial inputs. It was supplemented with adult education, literacy and extension training for health, nutrition and ECD. In Ghana, Mali and Burkina Faso, maternal health and a child care curriculum were developed by women's joint liability credit associations. They were encouraged to analyze problems of child development and collectively produce a response.
3. ***Community participation is the bedrock of ECD and is necessary to attract human, financial and material resources at the local level.*** The Madrasa Preschool Programs in Kenya, Uganda and Zanzibar require community management and co-financing. Communities work with the Madrasa Resource Center to meet criteria to access endowments for continuous funding for the preschools. Local management committees appoint women from the community as ECD workers, who are trained by the Resource Center.
4. ***Grassroots organizations can make a significant impact on national development policy***. The National ECD Congress in South Africa emerged from extensive organizing and advocacy by community groups and local NGOs. It is a strong (voluntary) association, now a resource for implementing new government policy including a 'Reception Year' school readiness program. From the Kushanda project, a federation of preschool parents and teachers was created across the scattered communities. This now has national presence to advocate on behalf of more resources for ECD.
5. ***It is effective to combine nationwide activities and individual initiatives of smaller scope.*** This is evident in the Nigerian situation, described previously. Another example is Mauritius. The welfare of all children is addressed legally through the brief of the Ministry of Women's Rights, Child Development and Family Welfare. Complementing this are individual ECD programs in the private and public sectors.
6. ***Program quality and impact must be monitored more systematically to assess impact.*** Analysis of cost-effectiveness is hampered by extremely limited financial data. Assessments are however consistently positive across the cases reviewed in terms of children's social development (sharing of materials, independence, responsibility), school readiness and communication skills.
7. ***ECD is an institutional and social policy issue that cuts across health, education and other social sectors.*** ECD cuts across macro, meso and local levels of administration; government departments and non-government entities. Institutional arrangements and partnerships for ECD will be crafted according to the needs of the target population. The challenges are in going to scale and in sustaining initiatives.

8. ***Adopt a long term perspective.*** Several of the programs began or are beginning from small pilot experiences. In Kenya, the national program emerged from over a decade of experimentation with community-based ECD. After twenty-five years, the program covers no more than a third of the relevant age cohorts across the country. Zimbabwe's Kushanda project was built upon nearly a decade of work in supporting commercial farm communities and resettlement communities. In Mauritius, the government-Export Zone partnership is a pilot private-public collaboration. The expectation is that this will catalyze investment for additional populations and industries to meet the child care needs of working parents.
9. ***Institutional capacity is key to sustainability.*** Measures in combination ¾ mobilizing parents' demand for services, collaboration of various parties in program delivery, external funding and training ¾ contribute to institutionalization of ECD services.
10. ***If ECD coverage is to be broadened and sustained, governments clearly need to be ore involved.*** To the extent that sustainability hinges on financing, the success with ECD to date mainly represents the financial and technical support of foundations, international and national NGOs, religious groups, bilateral and multilateral aid agencies. Government GDP specifically earmarked for ECD is nil for nineteen of twenty-five Sub-Saharan countries for which data exist.
11. ***Localizing ECD initiatives is critical to effectiveness.*** a. Program quality is enhanced by using community members as teachers and trainers, and building ECD curricula from local traditions and culture; b. The effectiveness of training will be increased by locating training close to the actual work sites and alternating training and practice.

These last two principles relating to local initiatives are so central that they figure in every case in the *Review*. Employing local people enhances connections and collaboration between the community and the ECD supporting agency. ECD workers' training in close proximity to the location of their work helps instill realistic expectations and boost trainees' confidence.

Directions and Challenges for the Future. *The* Review *signals areas for action in order to accelerate investment in ECD:*

- Increase data available for planning and evaluating ECD. Focus especially upon impact and cost effectiveness, and the long-term benefits of ECD.
- Increase access to ECD services particularly for children (and mothers) most in need.
- Raise public awareness about the value of ECD and forge partnerships for action among communities, private and public sector organizations. National governments may not be direct providers of ECD, but many would do well to consider establishing a policy framework to give formal recognition to and bolster action at local level.
- Pursue more coherent national frameworks for planning and implementing ECD. Work for better coordination and mutual support among policy, programs and research.

These various ECD programs have built on the strengths of African tradition and culture, and multi-sectoral policy frameworks which certain countries have constructed for the protection and development of young children. They illustrate choices for other countries to consider, to tailor to their respective institutional and socio-economic circumstances. Thus, ECD is not only imperative, it is also affordable and effective. However, a key message that emerges is the need to emphasize a long-term perspective.

1. Can I explain and discuss what is meant by "early childhood", "child care" and "child development"?
2. Can I explain the program implications of the definitions adopted?
3. Can I explain to a skeptical colleague why it is worthwhile to invest in ECD?
4. Do I know the basic approaches to ECD, and which interventions are complementary?
5. Can I make intelligent suggestions about programs and understand where projects or components fit into the larger health and education picture?
6. Have I obtained information about the status of children in the country: Survival, health and nutrition -- Cognitive, psycho-social and emotional child development -- Progress and performance in primary school
7. Have I obtained information about child-rearing practices in the country (see sample table **Child rearing practices matrix**)?
8. Have I obtained information about the economic, social, cultural, demographic and political context?
9. Have I identified projects in the country that should be coordinated with an ECD project or attached as a subproject?
10. Have I checked with other child and ECD organizations to find out what ECD activities they are supporting in the country and what people and organiza-

tions might be available there for consultancies? (See sample table Inventory of ECD projects matrix)

11. Does a national Plan of Action for Children exist? Have relevant social policy statements been identified?
12. Have relevant stakeholders been identified and consulted in order to locate levels of interest, different perceptions of problems, and possible conflicts? (See sample table **Stakeholder matrix**)
13. Has an institutional analysis been carried out? What resources are available or lacking?
14. Has a central problem been identified and agreed upon?
15. Has a project objective been formulated and agreed upon that is clearly stated and associated with indicators (of quantity, quality and time) that can be used to assess its attainment?
16. Have the project approach and the project outputs/activities been agreed upon that are clearly stated and associated with indicators (of quantity, quality and time) that can be used to assess attainment?

This matrix might be used to synthesize results of an initial inquiry with stakeholders:

Groups	Interest in ECD	Problems perceived	Potential conflicts	Projects underway
Beneficiaries: - Children - Families - Communities				
Government - Education - Health - Welfare - Planning - Finance - Others				
Independent organizations - NGOs - Religious organizations - Universities				
Private sector				
Unions				
Professionals				
Media				
Donors - UN - World Bank - Bilateral donors - Internationals NGOs				
Others				

Project Matrix: An Inventory of Existing Programs

One result of the initial consultation with potential stakeholders will be an inventory of existing projects and programs, including specific information about the programs. To inform subsequent conversations, this project matrix might be used.

Institution	Program/ project name	Start date	Goals/ objectives	Target population.	Size	Components	Ratio ECD worker/ participant	Cost per beneficiary	Source of funds	No. of participants	Link to other programs
1.	1.1 1.2 etc.										
2.	2.1 2.2 etc.										
Etc.											

Childrearing Beliefs/Practices (birthing practices, feeding, nurturing, etc.)
Who cares for the child? How is this changing?

Stages	Mother	Father	Other Family	Neighbors	Professional Caregivers	Nobody
0 - 1						
1 - 3						
3 - 5						

In some countries, this kind of information will be available, at least in part, from household surveys. In others, specific studies will be available that give an idea of who is responsible for care at different ages within particular social or cultural groupings.

How? What practices are followed? What changes in practices are occurring?

	Health	Nutrition	Intellectual Development	Socialization
Pre-natal				
Birth				
Post-natal				
Infant				
Toddler				
Preschooler				

For instance, under nutrition and in the post-natal and infant periods, it would be important to know to what extent children are breastfed and how that practice is changing. If a program will target the pre-school age, information about diets and feeding practices for children in that age should be sought. With respect to socialization, one would like to know to what extent parents show affect, and in what ways. And information about the extent of child abuse at the different stages of development should be sought.

Source: The Inter American Development Bank

Appendix 7 : Education: Priority Issues and Knowledge Gaps

Priority Issues	Knowledge Gaps
Teacher Performance/Development • Recruitment and deployment in rural working conditions (isolation, limited resources…), incentives for job satisfaction, improving the numbers of female teachers • Classroom teaching strategies for: large classes, multi-grade, varied abilities and learning styles, refugee camp classrooms, irregularly attending students (nomadic communities) • **Initial preparation and ongoing professional development: special preparation for rural teachers** • **Teacher manuals and use of materials**	• Information with a specific rural African context • Successful initial training programs for teachers going to rural postings • Teaching strategies for nomadic communities, large class sizes and refugee situations • The what and how of increasing the supply of female teachers in rural areas
Getting Accurate Information • Student performance data (systemic assessment and evaluation data) • Qualitative data on activities within classrooms/ schools (with a contextual analysis) • **Good quality information about innovative activities in schools and programs for support through the education system as a whole.**	• Information on different types of 'measuring' instruments and explanations of how to use both at classroom, school and system levels
Processes involved in School Improvement • Community action in school development • Methods for ensuring the participation of various stakeholders • The process of building political will • The process (and sequence) of building capacity throughout the system • The place of coaching/mentoring/support assistance in developing capacity to implement/design reforms	• **Information on HOW various innovations were developed at various levels of the education system and community, with key steps highlighted** • Well documented examples of community driven school improvement projects
Relevance of Learning and Schools • Expanding the concept of school to the broader learning environment • **Defining the goals for learning for children in rural communities** • **Meeting community expectations for value of learning** • **The link between the curriculum and employment.** • Balance between national curriculum guidelines/local needs/ responsive to student needs	• Practical information which goes beyond the philosophical debates concerning the nature of the curriculum and which documents the extent of the success of rural education programs
Effective Support from the Education System • Concrete measures to reduce dropout and repetition, especially for girls • The role of 'inspectors', how to engage them in being supportive to the teaching/learning process • How to strengthen headteacher skills and support • Creating flexible schedules and use of resources to respond to different rural community needs e.g. harvests • The form and content for basic instructional materials • Mainstreaming girls education issues • Which language of instruction?	• Case study information on the what and how of implementation, together with information about who and the impact in context.
Parent and Community Support • Ensuring that students come to school healthy and ready to learn • Importance of early childhood preparation as part of basic education • Helping communities meet the cost of schooling	• **Research guidelines available in these areas** • More case studies about what, how, who, impact etc. (particularly in varied rural learning contexts) would be helpful
Health Links • HIV/AIDS crisis and its impact on education (teacher shortages, children affected from as young as babies, link with women's reproductive health issues, curriculum…) • Need for greater links between health and education programs • Latrines and hygienic conditions at schools	• Need for information which focuses on rural communities to highlight possible actions • Lack of comprehensive knowledge of impact of 'HIV/AIDS on education' (need for case studies, clearinghouse of information, examination of what is being done by donors and governments)

Appendix: 8

STANDARD INDICATOR TOOL FOR EVALUATION (SITE)

PERIOD:	OFFICE/PROJECT:	NUMBER:

DEMOGRAPHICS	MALE	FEMALE	TOTAL
A Under 5			
B 5+ to 15			
C Total Child Population A + B			
D 15+ to 20			
E Over Twenty			
F Total Adult Population D + E			
G Total Population			
H Families			
I 1 to 2 Years Old			
J Live Births			

DEATHS	AGE GROUPS				
(CODES)	<1 Yr	1+ to 5 Yrs	5+ to 15 Yrs	=>15 Yrs	**TOTAL
A Accidents					
B HIV/AIDS					
C ARI					
D Cancer					
E Dengue Fever					
F Diarrhea					
G Diphtheria					
H Malaria					
I Maternal					
J Measles					
K Neo. Tetanus					
L Old Age					
M *Others					
N Pertussis					
O Tuberculosis					
P Unknown					
TOTAL					

* Please attach a sheet showing the distribution of deaths by causes other than those listed in the codes
** Total Deaths *all age groups*
TOTAL DEATHS 0 - 5 YRS:
INFANT MORTALITY RATE: *(of children under 1 yr / live births x 1,000)*
UNDER 5 MORTALITY RATE: *(of children under 5 yrs / live births x 1,000)*

IMMUNIZATION COVERAGE RATES		
1 to 2 year olds fully immunized:	Number Percent	Number Percent
Tt2 protected live births:		

NUTRITIONAL STATUS (under-fives)					
	Normal	1st Degree	2nd Degree	3rd Degree	TOTAL
Number					
Percent					
	Number Moved Up	Number In Original	Percent From Last Year		
2nd Group					
3rd Group					

STATUS OF FAMILIES ON:

	ORT	ARI	Safe Water	Sanitary Disposal	Adequate Income	Adequate Housing
Number						
Percent						

FAMILIES WITH CHILDREN'S ACCESS TO QUALITY ECD/EDUCATION

	Number	Percent
Access to Quality Early Childhood Devt Programs		
Access to Quality Education		

ADULT LITERACY*

	Number	Percent
Male		
Female		
TOTAL		

* For adult population aged 15 years and above, please see Demographics item F

CHILDREN'S PARTICIPATION IN EARLY CHILDHOOD EDUCATION

Age Group		Home-Based	Center-Based	None	Total
0 to 5 Years	Male Number				
	Male Percent				
	Female Number				
	Female Percent				
	Total Number				
	Total Percent				

CHILDREN'S PARTICIPATION IN SCHOOLS

Age Group		Formal	Non-Formal	None	Total
5+ to 15 Years	Male Number				
	Male Percent				
	Female Number				
	Female Percent				
	Total No.				

HIGHER EDUCATION/SKILL DEVELOPMENT

Age Group		High School	University	Skill Training	None	Total
15+ to 20 Yrs	Male No.					
	Male%					
	Female No.					
	Female%					
	Total No.					

20 YEAR OLDS' LEVEL OF LEARNING ACHIEVEMENTS*

Learning Level		Male	Female	Total
High School Graduates	Number			
	Percent			
College Graduates	Number			
	Percent			
Skill Training Degree/Diploma	Number			
	Percent			
None	Number			
	Percent			
Total	Number			
	Percent			

* Using the Better Life Options Roster, count all girls and boys completing 20 years of age during the year.

Appendix 9: CCF SAMPLE FAMILY CARD, LEVEL DATA & CODES

Project Name:		Project No.		Date of Baseline Survey:	
Family Address:		Family No.		Follow-up (Dates):	

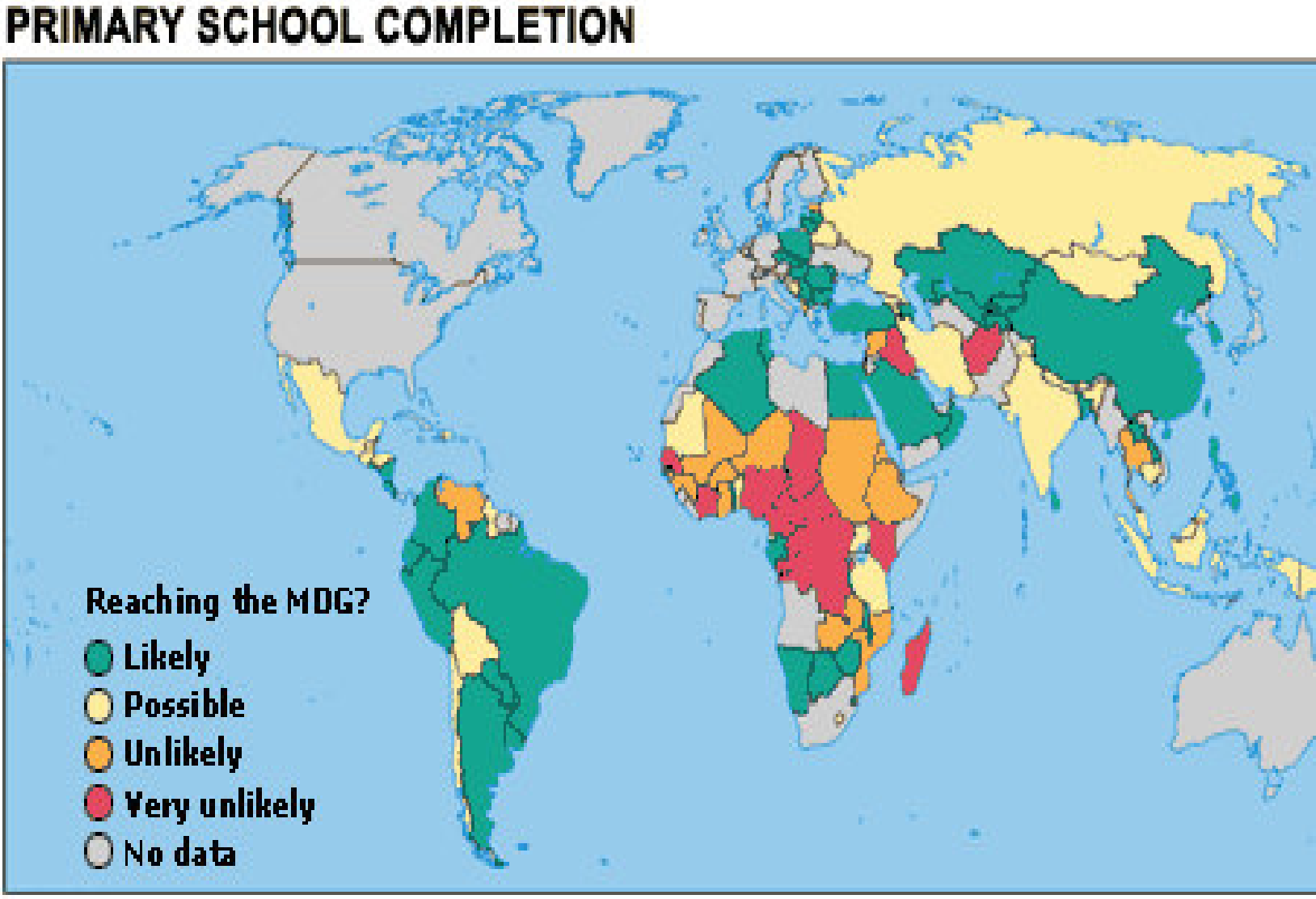
No.	Name	Relation to HH	Sex M/F	DOB D/M/Y	Date Immunization Completed		Educational Status				Literate over 15	Occupation				Nutritional Status				Remarks
					1-2 yrs	TT2	Date	Code	Date	Code		Date	Code	Date	Code	Date	Code	Date	Code	

Family Level Data	Year 1	Year 2	Year 3	Year 4	Year 5
Access to Water					
Access to Safe Sanitation					
ORT Knowledge					
ARI Knowledge					
Adequate Income/Livelihood					
Adequate Housing					
Access to Early Child Dev.					
Access to Quality Education					
*Health Knowledge/Practice					
**Other - Community Specific					

Codes	Relation	Education	Occupation
A	Self	Home Based ECD	Farmer
B	Spouse	Center Based ECD (Preschool)	Housewife
C	Child	Primary Formal	Laborer
D	Sister/Brother	Primary Non-Formal	Temporary
E	Parents	Secondary Formal	Service
F	Uncle/Aunt	Secondary Non-Formal	Tailor
G	Step/Sibling	University	Construction
H	Cousin	Vocational/Skill Development	Caterer
I	Others	Others	Others

*See page 8 and 71 on suggested indicators to qualify health knowledge and health practice.
** This issue/concern will be determined by each individual CCF Project at the Community level in a participatory manner, i.e. HIV/AIDS, Malaria, etc.

Appendix 10: World Map of Primary School Completion



IMPORTANT NOTE: This section is meant to be updated regularly by individual projects. ***(After updating – simply replace in a ringbinder or other adaptable binder)***
Goal and the 1st Indicator is set by CCF Richmond, the remaining indicators are determined by the national office and various Projects (Project specific). Approaches and Interventions are also to be tailored at the Project level. Keep in mind that this section offers EXAMPLES that can be built upon and altered to meet the specific needs of any given project.

GOAL	1 Reduce Mortality in Children under 5 years old
INDICATORS / OBJECTIVES	1. Increase the percent of live births TT2 protected (mothers immunized with TT2 vaccine during their pregnancies) 2. Increase the percent of 1-2 year olds who are fully immunized 3. Increase the percent of women who know the danger signs during pregnancy (that indicate the need to seek care)
PROJECT SPECIFIC INDICATORS	1. Among the infant and child feeding indicators, increase the percent of mothers who continue to breastfeed up to and beyond 12 months of age 2. Increase the percent of women's knowledge of AIDS and other sexually transmitted infections, and high-risk sexual behavior. 3. Increase the percent of women receiving antenatal and postpartum care

APPROACHES & INTERVENTIONS

1. *HOME VISITING*	***Conduct a home visit to every family with a child death in order to:*** 1. Console family and provide emotional support 2. Determine factors leading to death. Was it preventable and if so provide details, circumstances, etc 3. Provide methods/education to prevent death(s) of surviving siblings.
2. *COMMUNITY EDUCATION*	***Contact community leaders and organize meetings to:*** 1. Display death statistics in a community bulletin to raise awareness of the leading killers in the community 2. Hold/organize community meetings to discuss ways to prevent future deaths. 3. Train community health workers/volunteers in preventive health behaviors/practices. 4. Train community health workers/volunteers to train families to adopt preventive behaviors/practices. 
3. *PARTNERING*	***Contact all Health related persons/organization in the community in order to:*** 1. Partner with local health center medical staff to discuss ways to prevent deaths. 2. Partner with other local NGO's or organizations dealing with health related issues so as to collaborate/coordinate efforts to prevent deaths in children.
4. *COMMUNITY ACTION*	1. Make an effort to lower death rates in young children through a multi-pronged/ integrated approach to adopt preventive heath standards and behaviours. 2. Follow-up by organizing committees that monitor deaths and coordinate with heath practitioners, NGO's and others concerned with heath matters.
3. *CAREGIVERS ACTION*	The above approaches should facilitate, motivate and educate mothers and other caregivers in the most relevant methods to prevent (preventative) deaths of children under 5 years old. Caregivers should have ready access to all prevention techniques.
4. *OTHER ISSUES*	Describe any other relevant issues/concerns regarding heath in this project, i.e. remoteness to hospitals/emergency services, extreme poverty hampering preventive heath care, security issues, droughts or other conditions that affect agricultural production and in-turn nutrition, etc.
5. *PROJECT STATISTICS*	1. Population: Male/female (ages), Households 2. Health Providers: List all types of health facilities, organizations, etc. 3. Health Activities: Describe general health knowledge and practices in community *(Please refer to the completed SITE Chart, Family Level Cards, any previous baseline surveys completed in the Project/Community for additional brief statistics, etc.)*

GOAL 2	Access to Clean and Adequate Water supply
INDICATORS / OBJECTIVES	1. Distance/access to nearest water point reduced. 2. User to water points ratio reduced. 3. Increase the number of newly constructed water sources, which are adequately maintained and utilized by the beneficiaries at equitable cost.
PROJECT SPECIFIC INDICATORS	1. Back-up source(s) to water are established to be used during droughts. 2. The use of water in connection to daily heath and sanitation practices. 3. Enough water to irrigate gardens and crops. 4. Alternative water sources, i.e. solar pumps, rain catchments tanks, filtration, etc.

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Look at the situation of water access on a per family basis. 2. Teach family members on how to store water to assure that it is safe.
2. COMMUNITY EDUCATION	***Contact community leaders and organize meetings to:*** 1. Conduct a survey of all the water sources in the community. *(If this is a large project/community with many water sources, one should consider placing them on a map through Geographical Information System)* 2. Discuss in a participatory setting, various methods to assure equal distribution of water for everyone. 3. Train community members in water conservation practices and techniques. 4. Train community members on proper water storage. 
3. PARTNERING	***Contact all water related persons/organization in the community in order to:*** 1. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with water matters to install future facilities. 2. Leverage funds for the construction of new water sources. 3. Make internet inquires to tap possible resources.
4. COMMUNITY ACTION	1. Create a demand for safe water access. 2. Form a task group to install water sources. 3. Educate the community with regards to the relationships between water and sanitation practices. 4. Form task group to prepare project proposals for soliciting funds from in country donors other than CCF.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding water in this project/ community, i.e. remoteness/access to facilities (what is considered safe/access), droughts, contamination or other conditions that affect water sources, etc.

GOAL 3	Access to Safe Sanitation Facilities
INDICATORS / OBJECTIVES	1. Distance/access to nearest sanitation facilities reduced. 2. User to sanitation facilities ratio reduced. 3. Increase the number of families who practice sanitary disposal of excreta.
PROJECT SPECIFIC INDICATORS	1. Increase knowledge and practice of families who wash thoroughly before and after eating and using toilet facilities. 2. Increase knowledge and practice of families who prepare and store food in a sanitary fashion. 3. Increase the percentage of mothers who can cite at least 3 hygiene practices.

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Look at the situation of sanitation facilities access on a per family basis and provide solutions to become sanitary. 2. Assess methods that the family disposes of excreta. 3. Provide education on the reasons for sanitary disposal (prevention).
2. COMMUNITY EDUCATION	***Contact community leaders and organize meetings in order to:*** 1. Conduct a survey of all the sanitation facilities in the community. *(If this is a large project/community with many sanitation sources, one should consider placing them on a map through Geographical Information System)* 2. Discuss in a participatory setting, various methods to assure equal distribution of sanitation facilities for everyone. 3. Train community members in the different sanitary practices and techniques and the relationships between disease/infections and sanitation 4. Train community members on proper sanitary methods of disposal. 5. Form task group to prepare project proposals for soliciting funds from in country donors other than CCF. 
3. PARTNERING	***Contact all sanitation related persons/organization in the community to:*** 1. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with sanitation matters to install future facilities. 2. Leverage funds for the construction of new sanitation facilities. 3. Make internet inquires to tap possible resources.
4. COMMUNITY ACTION	1. Create a demand for safe water and sanitation facilities access. 2. Form a task group to build additional water and sanitation facilities. 3. Educate the community in the connection between sanitation practices and the prevention of diseases and infections, etc.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding sanitation in this project/ community, i.e. remoteness/access to facilities (what is considered safe/access).

GOAL	4 Eradicate Premature Death of Children by Diarrhea
INDICATORS / OBJECTIVES	1. Increase knowledge of families who home-manage cases of Diarrhea. 2. Increase the percent of mothers (0-59 mos.) who can correctly describe how to prepare ORS 3. Increase the percent of mothers (0-59 mos.) who clearly cite at least 2 danger signs of diarrhea
PROJECT SPECIFIC INDICATORS	1. Increase knowledge of families who understand the relationship of personal hygiene/safe water and disease/infection prevention, i.e. wash thoroughly before and after eating and using toilet facilities, prepare meals properly, etc.

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Teach families/caregivers how to prepare and administer Oral Dehydration Solutions (ORS) using utensils/ingredients at home and review this regularly. 2. Distribute packets (and/or sell) of OPS if packets are being used. 3. Review the messages and methods of mixing and using with each visit to assure knowledge is retained. 4. Provide education to families on how to detect early warning signs and refer.
2. COMMUNITY EDUCATION	***Contact community leaders & organize meetings to:*** 1. Demonstrate in a participatory setting, how to mix Oral Dehydration Solutions. 2. Hold well-baby contest and test caregivers knowledge on mixing Oral Dehydration Solutions 3. Post messages at the community building and distribute flyers to families on ORS. 4. Train community members in the different sanitary practices and techniques and the relationships between disease/infections and sanitation. 5. Train community members on safe water and on proper sanitary methods of disposal. 6. Form task group to prepare project proposals for soliciting funds from in country donors. 
3. PARTNERING	***Contact all health related persons/organization in the community in order to:*** 1. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with high-risk families and health matters. 2. Leverage funds for the construction of water & sanitation facilities. 3. Assure adequate supply of anti-bionics are always on supply in the community. 4. Form task group to prepare health related project proposals for soliciting funds from in country donors other than CCF.
4. COMMUNITY ACTION	1. Discuss ways of preventing Diarrhoea within the community: Clean-up days securing a safe water source, avoiding polluted waters, etc. 2. Create a demand for community health services to address health issues. 3. Form a working group that rotates to homes of high-risk children. 4. Educate the community in the connection between water and sanitation practices.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding Diarrhea prevention in children this project/ community.

GOAL	5 Eradicate Premature Death of Children by ARI
INDICATORS / OBJECTIVES	1. Increase the percent of families who know how to manage cases of ARI. 2. Increase the percent of mothers (0-59 mos.) who know at least 2 danger signs of childhood illness that indicate the need for treatment. 3. Increase the percent of families who take children to the clinic at the first signs of Acute Respiratory Infections (ARI).
PROJECT SPECIFIC INDICATORS	1. Increase the percent of Families who minimize environmental factors such as open cook fires in the home.. 2.

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Observe household environmental risk factors, i.e. poor ventilation , smoke stove in kitchen, smokers in the household, etc. 2. Provide education to families and caregivers on how they detect ARI and what to do if early symptoms arise.
2. COMMUNITY EDUCATION	***Contact community leaders & organize meetings to:*** 1. Hold well-baby contest and test caregivers knowledge on early danger signs of ARI 2. Post messages at the community building and distribute flyers to families on ARI practices. 3. Train community members in the different sanitary techniques and the relationships between disease/infections and sanitation. 4. Form task group to prepare project proposals for soliciting funds from in country donors. 
3. PARTNERING	***Contact all health related persons/organization in the community in order to:*** 1. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with high-risk families and health matters. 2. Assure adequate supply of anti-bionics is always on supply in the community. 3. Form task group to prepare health related project proposals for soliciting funds from in country donors other than CCF.
4. COMMUNITY ACTION	1. Discuss ways of preventing ARI 2. Create a demand for community health services to address health issues. 3. Form a working group that rotates to homes of high-risk children. 4. Educate the community in the connection between environmental dangers and ARI.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding ARI in this project/ community.

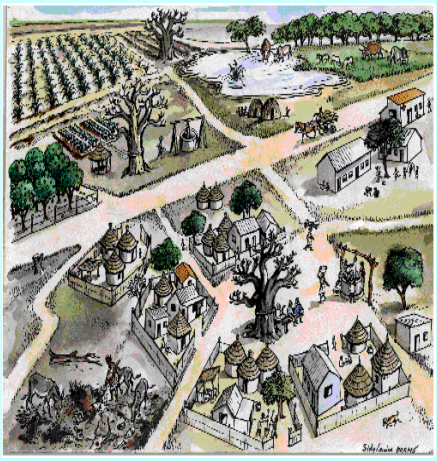
GOAL	6 Access to Adequate Income and Livelihood
INDICATORS / OBJECTIVES	1. Increase average household income. 2. Increase income opportunities of households. 3. Increase educational/vocational opportunities of members of households.
PROJECT SPECIFIC INDICATORS	1. Increase accessibility to markets 2. Maximize on the income making potentials of the community and their resources. 3. Provide low interest lending programs for small enterprise start-ups.

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Look at the situation of income on a per family basis and provide solutions to increase their overall intake. 2. Assess methods that the family subsidies their income. 3. Impress the relationship between education and income potentials.
2. COMMUNITY EDUCATION	***Contact community leaders and organize meetings in order to:*** 1. Conduct a survey of all the various income potentials of the community. 2. Investigate whether all resources of the community are being explored. 3. Discuss various methods to of emergency assistance to families in need. 4. Make clear the relationships between good education and income potentials. 5. Form task group to prepare project proposals for soliciting funds for low interest loans for small enterprise development from in-country donors. 
3. PARTNERING	***Contact all business related persons/organization in the community to:*** 1. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with small enterprise development. 2. Leverage funds for the construction of new/expanded market areas. 3. Make Internet inquires to tap possible resources.
4. COMMUNITY ACTION	1. Create a demand for continued education and vocational services. 2. Form a task group to stimulate economic potentials of the community. 3. Educate the community in the connection between continued schooling and income potentials.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding income potentials of households. What is considered an adequate income/livelihood level for the community?

GOAL	7 Access to Adequate Housing/Shelter
INDICATORS / OBJECTIVES	1. Increase the percent of families with safe housing conditions. 2. Decrease extreme crowded condition of families in a household (person to square footage ratio). 3. Maintain homes of families, i.e. roof leaks, fire hazards, etc.
PROJECT SPECIFIC INDICATORS	1. Increase the number of homes (when possible in areas such as urban) that have access to running water, toilet facilities and electric, etc. 2. Increase knowledge and practice of families who monitor safety conditions in their homes regarding dangerous conditions. 3. Implement fair housing programs for families who live in 'below standards' housing conditions.

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Look at the situation of sanitation in households on a per family basis and provide solutions to become more sanitary. 2. Assess general conditions of the homes for problems that might present safety hazards, i.e. sharp nails, rodent infestation, etc. 3. Provide education on the reasons for sanitary/safe conditions (prevention).
2. COMMUNITY EDUCATION	***Contact community leaders and organize meetings in order to:*** 1. Conduct a survey and rate the conditions of homes/shelter in the community. *(Record the housing condition survey on a map through Geographical Information System)* 2. Discuss in a participatory setting, various methods to assure equal housing facilities for everyone. 3. Train community members in the different maintenance practices and the relationships between poor housing and health and safety. 4. Train community members on regular maintenance of their homes. 5. Form task group to prepare project proposals for soliciting funds from donors. 
3. PARTNERING	***Contact all housing/shelter related persons/organization in the community to:*** 1. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with housing/shelter. 2. Leverage funds for the construction of new homes. 3. Make Internet inquires to tap possible resources.
4. COMMUNITY ACTION	1. Create a demand for safe and sanitary housing conditions. 2. Form a task group to build additional housing and to repair old ones. 3. Educate the community in safe houses and the prevention of fires, diseases caused by poor housing conditions, etc.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding housing/shelter in this project/ community (what is considered safe and adequate housing standards).

GOAL	8 Access to Early Childhood Development (ECD)
INDICATORS / OBJECTIVES	1. *Net Enrollment: Increase the ratio of CCF sponsored children under 5 years old attending pre-school or participating in formal or non-formal education programs. 2. Integrate Promotion: Increase the ratio of CCF sponsored children under 5 attending pre- school who get promoted to the next grade (on a yearly bases). 3. School Completion: Increase the ratio of CCF sponsored children who complete pre-school or an equitant non-formal program.
PROJECT SPECIFIC INDICATORS	1. Increase knowledge and practice of families who make a variety of educational and development activities available to pre-schoolers, especially at the child to child level. 2.

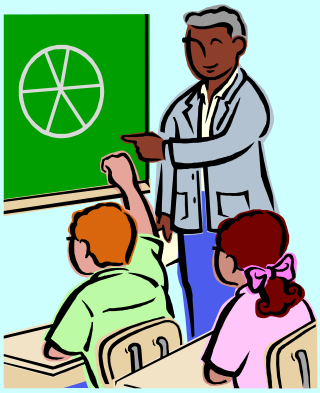
APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Look at the situation of ECD on a per family basis and provide training in the benefits of ECD stimulation. 2. Encourage caregivers to bring their children to group activities. 3. Train caregivers in appropriate play. 4. Encourage caregivers to interact fully and genuinely with their children.
2. COMMUNITY EDUCATION	***Contact community leaders and organize meetings in order to:*** 1. Conduct a survey of all the children that are not enrolled in early childhood development activities and find out the reasons why – offer solutions. 2. Find out what group of children enrolled in early education development activities are best and use them as roll models for others. 3. Look at the communities traditional means of early child development care and build upon them. 4. Look into developing family-based child-care among a group of families. 5. Train older siblings and others connected with the household in ECD methods in a child-to-child approach. 
3. PARTNERING	***Contact all education related persons/organization in the community to:*** 1. Partner with other organizations, NGO agencies and other donors dealing with early childhood development activities to collaborate efforts. 2. Work with the local women's groups to develop ECD groups. 3. Look at government programs for pre-schoolers and assure accessibility.
4. COMMUNITY ACTION	1. Form playgroups to bring children together for healthy play and stimulation. 2. Develop stimulating child-care alternatives for children in the form of playgroups, family childcare and group childcare.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding early childhood development in this project/ community.

* As apposed to Gross Enrollment (children counted who are either under or over normal school age group)

GOAL	9 Access to Quality Education
INDICATORS / OBJECTIVES	1. *Net Enrollment: Increase the percent ratio of CCF sponsored children and siblings of primary school age attending formal or non-formal programs leading to a degree or certification. 2. Integrate Promotion: Increase the percent ratio of CCF sponsored children and siblings attending primary school who get promoted to the next grade (on a yearly bases). 3. School Completion: Increase the percent ratio of CCF sponsored children and siblings who complete primary school or an equitant non-formal program.
PROJECT SPECIFIC INDICATORS	1. Literacy Rate: Increase the ratio of CCF sponsored children and siblings who can pass a CCF standard literacy test. 2.

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Encourage parents to enroll their children in school. 2. Provide motivation for parents to keep their children in school. 3. Assist parents to overcome barriers to education. 4. Prevent child labor through income generation for parents. 5. Provide income generating for families unable to afford school fees.
2. COMMUNITY RESEARCH and EDUCATION	***Contact community leaders and organize meetings in order to:*** 1. Conduct a survey of all schools and determine who is falling through the cracks. 2. Determine the gender differences. 3. Determine what are the repetition rates. 4. Determine what are the dropout rates. 5. Determine what the families with children in school are doing different than those not in school. 6. Educate parents as to the value of education. 7. Invite primary school teachers to community meetings. 8. Encourage Parent Teacher's associations to be active. 
3. PARTNERING	***Contact all education related persons/organization in the community to:*** 1. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with education. 2. Work with an NGO/Donor to address learning problems and set-up referral systems for them to tap appropriate attention are care. 3. Leverage funds for the construction of new or expanded education facilities.
4. COMMUNITY ACTION	1. Address the issue of primary school quality. 2. Offer incentives – nutritious snake foods. 3. Create a demand for adequate government schooling.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding education in this project/ community, i.e. remoteness/access to facilities (what is considered adequate).

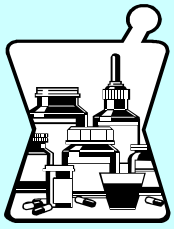
GOAL	10 Eradicate Malnutrition In Children
INDICATORS / OBJECTIVES	3. Increase the percent of children (0-23 mos.) who are </= 2SD below the median weight/age of reference population
PROJECT SPECIFIC INDICATORS	4. Increase the Percent of children (0-23 mos.) who have a growth monitoring card

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family of a malnourished child in order to:*** 1. Provide nutrition education and motivation to caregivers. 2. Explore income generation activities for the family. 3. Encourage exclusive breastfeeding for at least the first 6 months. 4. Encourage pregnant women to get prenatal care.
2. COMMUNITY EDUCATION and RESEARCH	***Contact community leaders and organize meetings:*** 1. Do a positive deviant study of a similar family to determine behavior that prevents malnutrition. 2. Conduct a community meeting to discuss malnutrition levels and solutions to address the problem. 3. Conduct a survey of locally available inexpensive foods in the market that are nutritious. 4. Conduct a survey of foods available in general. 5. Determine if there are micro-nutrition deficiencies, i.e. iron, iodine, vitamin A. 
1. PARTNERING	***Contact all health education related persons/organization in the community to:*** 1. Partner with the local health centers to refer malnourished children for examinations to determine if there are underlying illnesses. 2. Partner with a NGO to form a nutrition rehabilitation center. 3. Work with advertising groups to promote nutritious foods to counter ads for infant formula and bottle-feeding. 4. Weigh children at Early Child Development activities.
2. COMMUNITY ACTION	1. Institute monthly weighing sessions among all under 5's by locally trained mothers. (especially focus on under 3's) 2. Train community health workers and mothers in nutrition counselling/education. 3. Form women's savings groups to increase family income to buy food.
3. MOTHERS GROUPS	1. Invite all mothers with malnourished children to a daily cooking/feeding session. Teaching mothers how to prepare nutritious meals and learn to feed their child. 2. Create a 'stone soup' where mothers bring ingredients to a community pot. 3. Weigh 'at-risk' children weekly. 4. Deworm all 'at-risk' children regularly (quarterly) 5. Provide vitiam A to all children between 1-6 years old bia-annually. 6. Promote exclusive breastfeeding up to 6 months & promote child spacing. 7. Promote maternal nutrition through prenatal care. 8. Promote early childhood stimulation. 9. Encourage hygienic weaning practices, hand and food washing 10. Encourage nutritional curriculum to be included in primary schools.

GOAL	11 Immunization of all Children 0-5 Years Old
INDICATORS / OBJECTIVES	1. Increase the percent of live births TT2 protected (mothers immunized with TT2 vaccine during their pregnancies) 2. Increase the percent of 1-2 year olds who are fully immunized
PROJECT SPECIFIC INDICATORS	1. Increase the percent of mothers who receive at least 2 (TT2) car confirmed before birth of youngest child less than 24 months of age

APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 1. Motivate parents to bring their children for immunization during home visits. 2. Especially visit families of not immunized just before the event to invite them to the upcoming session.
2. COMMUNITY EDUCATION	***Contact community leaders and organize meetings in order to:*** 1. Conduct focus group discussions to determine why mother are not bringing their children in for immunization. 2. Display death statistics based upon non-immunized children in a community bulletin to raise awareness in the community. 
3. PARTNERING	***Contact all business related persons/organization in the community to:*** 1. Partner with the local government departments/officials, EPI Programs, NGO agencies, other donors and organizations dealing with immunization to provide services. 2. Partner with the local health center to determine effectiveness of immunizations by reviewing morbidity and the leading causes of illnesses..
4. COMMUNITY ACTION	1. Conduct campaigns to “jump start” motivation for immunization. 2. Conduct “well Baby” contests to create a healthy competition. 3. Emphasize immunization before the first birthday to mothers of newborns. 4. Use radio and other media to convey message of the importance of immunization. 5. Create a demand for immunization so the community itself is able to request government services where they are lacking. 6. Use AIMES, provide statistics to the government to aid them in meeting their targets.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding immunization in the country and communities.

GOAL	12 *Eradicate Death by HIV/AIDS
INDICATORS / OBJECTIVES	1. Increase the percent of women's knowledge of AIDS and other sexually transmitted diseases, and high-risk sexual behavior. 2. Increase the percent of men's knowledge of AIDS and other sexually transmitted diseases, and high-risk sexual behavior. 3. Increase the knowledge of practicing 'safe sex' methods. (Sustain, condoms).
PROJECT SPECIFIC INDICATORS	1. Begin introducing HIV/AIDS prevention programs that are directed towards youth. 2. Increase the accessibility to current drug treatments. 3. Increase the accessibility for those infected to special care programs that boost natural immune systems.

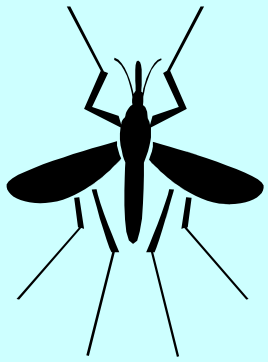
APPROACHES & INTERVENTIONS

1. HOME VISITING	***Conduct a home visit to every family in order to:*** 5. Look at the knowledge of HIV/AIDS prevention a per family basis and provide information where there are gaps or misperceptions of the virus. 6. Assess the knowledge of the family's methods for preventing the virus. 7. Impress the relationship between 'safe sex' and prevention. 8. Provide support to families who have the virus or have had members die.
2. COMMUNITY EDUCATION	***Contact community leaders and organize meetings in order to:*** 1. Conduct a survey of all the HIV/AIDS cases (deaths & currently infected, male/female and ages) in the community. 2. Produce educational materials to be distributed to the community on HIV/AIDS. 3. Discuss various methods to prevent the spread of the HIV/AIDS virus. 4. Make clear the relationships between safe sex and the prevention of the virus. 5. Form task group to prepare project proposals for soliciting funds for HIV/AIS prevention from in-country donors. 
3. PARTNERING	***Contact all health education related persons/organization in the community to:*** 5. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with HIV/AIDS education prevention. 6. Leverage funds for aggressive educational programs on prevention. 7. Make Internet inquires to tap possible resources.
4. COMMUNITY ACTION	4. Create a demand for education in the prevention of HIV/AIDS. 5. Form a task group to monitor education prevention activities. 6. Educate the community in the connection between 'safe sex' and the prevention of HIV/AIDS.
5. OTHER ISSUES	Describe any other relevant issues and concerns regarding HIV/AIDS prevention specific to the community's customs. What is considered 'safe sex' when it comes to HIV/AIDS and the community?

GOAL	13 *Eradicate Death by Malaria
INDICATORS / OBJECTIVES	1. Decrease 'ideal' conditions for mosquito breeding areas. 2. % children (0-23 mos.) with a febrile episode during the last 2 weeks treated with effective malaria drug after fever began 3. % children (0-23 mos.) who slept under insecticide treated net the previous night
PROJECT SPECIFIC INDICATORS	1. Increase the number of trained persons testing for malaria. 2. Provide 'Early Alert' programs during early breakouts in highly populated areas to prevent the rapid spread of Malaria. 3. Increase emergency treatment for severe cases of Malaria.

APPROACHES & INTERVENTIONS

6. HOME VISITING	***Conduct a home visit to every family in order to:*** 3. Look at the situation of malaria breeding areas on a per family basis and provide solutions to minimize breeding especially during rainy periods. 4. Assess methods that the family reacts to malaria symptoms. 5. Impress the relationship between early detection/treatment and saving lives.
7. COMMUNITY EDUCATION	***Contact community leaders and organize meetings in order to:*** 3. Conduct a survey of the cases of malaria and if there are any concentrations in cases. 4. Distribute educational materials to the community and keep alert postings current at the community building. 5. Discuss various methods to of emergency malaria treatment to families in need. 6. Make clear the relationships between early detection, treatment and saving lives. 7. Form task group to prepare project proposals for soliciting funds for malaria prevention campaigns from in-country donors.
8. PARTNERING	***Contact all business related persons/organization in the community to:*** 3. Partner with the local government departments/officials, NGO agencies, other donors and organizations dealing with malaria prevention. 4. Leverage funds for malaria prevent and detection. 5. Make Internet inquires to tap possible resources.
9. COMMUNITY ACTION	7. Create a demand for malaria prevention/treatment and education. 8. Form a task group to monitor malaria outbreaks and treatment programs. 9. Educate the community in the connection between early detection/ treatment and saving lives.
10. OTHER ISSUES	Describe any other relevant issues and concerns regarding malaria detection, treatment and prevention for the community?



* These Goals and Indicators are considered "OTHER" under the Family Level Data. In other words, these may only relate to areas, regions or certain countries whereby they are consider a particularly "high risk" problem. Other projects may identify their own Indicators.

The Relationship Between Knowledge and Practice Regarding Health Indicators

	Indicators	
Intervention	**Practice**	**Knowledge**
Nutrition	1. % children (0-23 mos.) who are </= 2SD below the median weight/age of reference population 2. % of children (0-23 mos.) who have a growth monitoring card	
Immunization	3. % of mothers who receive at least 2 (TT2) car confirmed before birth of youngest child less than 24 months of age 4. % children (0-23 mos.) who are fully immunized before 1st b-day	
Diarrhea	2. % of children (0-23 mos.) with diarrhea in last two weeks	3. % of mothers (0-59 mos.) who can correctly describe how to prepare ORS 4. % of mothers (0-59 mos.) who clearly cite at least 2 danger signs of diarrhea
ARI	2. % of children (0-23 mos) who have had continuous intake of fluids and cont. feeding in the last month.	2. % of mothers (0-59 mos.) who know at least 2danger signs of childhood illness that indicate the need for treatment.
Malaria	4. % children (0-23 mos.) who slept under insecticide treated net the previous night 5. % children (0-23 mos.) with a febrile episode during the last 2 weeks treated with effective malaria drug after fever began 6. % of mothers who took anti-malarials to prevent malaria during pregnancy	
Water/sanitation	2. % household with drinking water source or covered well 5. % of households with access to a sanitary facility 6. % of households who discard excreta in a sanitary manner	4. % of mothers who can cite at least 3 hygiene practices