STANDARD SECTOR INDICATOR CODE: HE-116	**Able to Identify Symptoms Indicative of the Need to Seek Care for Pneumonia:** Number of individuals able to identify at least 2 symptoms indicative of the need to seek immediate care for pneumonia.

HEALTH SECTOR	**Sector Schematic Alignment**
	
	 • **Project Area:** Maternal, Neonatal and Child Health
	  • **Project Activity Area/Training Package:** Infant and Young Child Health
	
	 • **Project Area:** HIV Mitigation
	  • **Project Activity Area/Training Package:** Community Care of OVC

Type: Short-term Outcome	**Unit of Measure:** Individuals	**Disaggregation:** **Sex:** Male, Female **Age:** 0-9 years, 10-17 years, 18-24 years, 25+

To be counted for this indicator the following criteria must be met:

- The individual must have attended training on prevention of common childhood illnesses, to include the identification, management and prevention of pneumonia
- The training must have been provided by the PCV or their partner in an individual or small group setting. Research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger. PC/Post staff determines what comprises a small group.
- Attendance at educational session/s must be documented by the Volunteer or their partner
- Based on results of a pre and post test, the individual must be able to identify at least 2 symptoms indicative of the need to seek immediate care for pneumonia with an appropriate health provider

Definitions:
Presumed pneumonia is defined as a mothers/caretakers perception of a child who has a cough, is breathing faster than usual with short quick breaths or is having difficulty breathing, excluding children that had only a blocked nose.

The WHO Integrated Management of Childhood Illness (IMCI) guidelines for diagnosis of pneumonia are below:
- Children aged 2 months to 5 years exhibit a cough and fast or difficult breathing. Thresholds for fast breathing depend on the child's age. If the child is 2 months to 12 months old, 50 breaths or more per minute is considered fast. If the child is 12 months to 5 years old, 40 breaths or more per minute is considered fast
- Severe pneumonia is diagnosed if the child exhibits lower chest wall indrawing (when the child's chest moves in or retracts during inhalation) or stridor (a harsh noise made during inhalation).
- Infants under two months with signs of pneumonia/sepsis (symptoms lethargy, feeding poorly, grunting, fever) are at risk of suffering severe illness and death more quickly than older children, and should be immediately referred to a hospital or clinic for treatment

Signs and symptoms indicative of the need to seek immediate care for pneumonia:
- **Cough AND fast breathing**
- **Cough and difficulty breathing** (excluding children that had only a blocked nose)
- **Lower chest wall indrawing**

Appropriate health provider the definition of "appropriate" care provider varies between countries but is anyone trained

to spot the symptoms of ARI and provide antibiotics as treatment.

Treatment should consist of antibiotics. Local remedies should not count as treatment.

If the Volunteer is working with OVCs or caregivers this indicator can be counted under "one care service."
Orphans and Vulnerable Children: are defined as children affected by AIDS, often referred to as orphans and vulnerable children (OVC), are children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects.

Rationale: It is estimated that more than 150 million episodes of pneumonia occur every year among children under five in developing countries, accounting for more than 95 per cent of all new cases worldwide. Between 11 million and 20 million children with pneumonia will require hospitalization and more than 2 million will die from the disease. Prompt treatment of pneumonia with a full course of appropriate antibiotics is lifesaving. Caregivers need to seek appropriate medical care immediately for children with signs of pneumonia and yet, according to WHO only 1 in every 5 caregivers knows pneumonia's danger signs. Educating caregivers on early care seeking for pneumonia needs to be a top priority.

Measurement Notes:

1. **Sample Tools and/or Possible Methods (for Peace Corps staff use):** Volunteers should use data collection tools to measure progress against project indicators. A data collection tool to measure this indicator could be based on one of the following methods—pre/post-test—though there may be other data collection methods that are appropriate. Please check PCLive for data collection tools. Once a tool has been developed, post staff should have a few Volunteers and their partners pilot it, and then distribute and train Volunteers on its use.

2. **General Data Collection for Volunteer Activities:** All Volunteer activities should be conducted with the intention of achieving outcomes – knowledge change (short-term), skills demonstration (intermediate-term), and behavioral changes (intermediate to long term) as defined by the progression of indicators within the objectives of a project framework. The progression of measurement for all Volunteer activities should begin with baseline data being conducted prior to the implementation of an activity (or set of activities), followed by documenting any outputs of the activities and then later at the appropriate time, measurements of specific outcomes (see the bullet on "frequency of measurement").

3. **Activity-Level Baseline Data Collection:** This indicator builds off of indicator **HE-114:** *Educated on Prevention of Childhood Illnesses*, as it measures an increase in knowledge following a learning event on childhood illnesses. Therefore, baseline data collected in the form of a pre-test for HE-114 would apply to this indicator as well.

   Because Volunteers are expected to implement relevant and focused activities that will promote specific changes within a target population (see the "unit of measure" above), taking a baseline measurement helps Volunteers to develop a more realistic snapshot of where individuals within the target population are in their process of change instead of assuming that they are starting at "0." It also sets up Volunteers to be able to see in concrete terms what influence their work is having on the individuals they work with during their service. Please note that data collection is a sensitive process and so Volunteers will not want to take a baseline measurement until they have been able to do some relationship and trust-building with the person/people the Volunteer is working with, and developed an understanding of cultural norms and gender dynamics.

4. **Frequency of Measurement:** After taking the baseline measurement (described above), Volunteers should take at least one follow-on measurement with the same individual(s), to assess whether they are able to correctly identify at least 2 symptoms indicative of the need to seek immediate care for pneumonia with an appropriate

health provider. This measurement is typically taken after completing one or more activities focused on achieving the outcome in this indicator and once they have determined that the timing is appropriate to expect that the outcome has been achieved. Once Volunteers have measured that at least one individual has achieved the indicator, they should report on it in their next VRF.

Volunteers may determine to take more than one baseline and one follow-on measurement with the same individual (or group of individuals) for the following valid reasons:

- Volunteers may want to measure whether or not any additional individuals initially reached with activities have now achieved the outcome in the indicator, particularly for any activities that are on-going in nature (no clear end date);
- Volunteers may want to enhance their own learning and the implementation of their activities by using the data collected as an effective monitoring tool and feedback mechanism for the need to improve or increase their activities;
- A Peace Corps project in a particular country may choose to increase the frequency of measurement of the indicator and Volunteers assigned to that project will be required to follow in-country guidance.

In all cases, any additional data collection above the minimum expectation should be based on the time, resources, accessibility to the target population, and the value to be gained versus the burden of collecting the data. Following any additional measurements taken, Volunteers should report on any new individuals achieving the outcome in their next VRF.

5. **Definition of Change:** The minimum change to report against this indicator is an individual was able to identify at least 2 symptoms indicative of the need to seek immediate care for pneumonia with an appropriate health provider, including:
   - Cough AND fast breathing
   - Cough and difficulty breathing (excluding children that had only a blocked nose)
   - Lower chest wall indrawing

In the case of this indicator, if the person the Volunteer/partner works with identified at least 2 symptoms indicative of the need to seek immediate care for pneumonia with an appropriate health provider during the pre-test, then the Volunteer would not be able to count him/her for this activity because the person already had this knowledge prior to working with the Volunteer. However, if as a result of working with the Volunteer/partner, the individual 's knowledge on the these symptoms increased, that would count because the Volunteer's work provided the individual with the training needed to be able to identify at least 2 symptoms indicative of the need to seek immediate care for pneumonia with an appropriate health provider.

6. **General Reporting in the VRF**: The "number achieved" (or numerator) that Volunteers will report against for this indicator in their VRFs is the number of individuals who, after working with the Volunteer/partner, identified at least 2 symptoms indicative of the need to seek immediate care for pneumonia with an appropriate health provider. The "total number" (or denominator) that Volunteers will report on for this indicator in their VRFs is the total number of individuals who participated in the activities designed to meet this indicator.

7. **Reporting on Disaggregated Data in the VRF:** This indicator is disaggregated by "Sex" and "Age". When reporting in the VRF, a Volunteer should disaggregate the total number of individuals by 1) male and female, and 2) 0-9 years, 10-17 years, 18-24 years, 25+ years.

Data Quality Assessments (DQA): DQA are needed for each indicator selected to align with the project objectives. DQAs review the validity, integrity, precision, reliability, and timeliness of each indicator. For more information, consult the Peace Corps MRE Toolkit.

Alignment with Summary Indicator: No link