STANDARD SECTOR INDICATOR CODE: HE-120	**Children Who Had a Cough and Fast or Difficult Breathing and Received Antibiotics by a Provider:** Number of children aged 0-59 months who had a cough and fast or difficult breathing since the last reporting period whose mothers report that their child received treatment by an appropriate health provider.	

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: Intermediate-term Outcome	**Unit of Measure:** Eligible Children	**Disaggregation:** **Sex:** Male, Female **Age:** 0-11 months, 1 -<5 years

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

- The child must be 0-59 months of age
- The child had a cough and fast or difficult breathing since the last reporting period
- The mother/caretaker of the child must have sought care and received antibiotics the last time the child had presumed pneumonia (cough and fast or difficult breathing)
- The mother/caretaker of the child 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

Definitions:

Acute Respiratory Infections (ARI) is defined by WHO as the proportion of children aged 0-59 months who had "presumed pneumonia (ARI)"in the last two weeks and were taken to an appropriate health provider.

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

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. In all cases, Volunteers should promote treatment guidelines outlined in their country's national policies. For example, in some countries, a more comprehensive approach is taken whereby the child is treated for both malaria and pneumonia at the same time.

Volunteers working with OVCs, should disaggregate the information by target population and report under one care service indicator:

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. Increasing the number of children who receive timely antibiotic treatment for ARI is a WHO recommended proven intervention to decrease childhood mortality due to ARI.

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—survey—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 Common Childhood Illnesses***, which measures the knowledge and attitudes of mothers/caregivers regarding identification, management and prevention of pneumonia. To measure the number of children aged 0-59 months who had a cough and fast or difficult breathing since the last reporting period whose mothers report that their child received treatment by an appropriate health provider, Volunteers should survey the mother/caregiver to take a baseline measurement regarding the outcome(s) defined in this data sheet. Volunteers should collect baseline information early in their work with community members, and may use their judgment to determine timing because the information will be more accurate if the Volunteer has built some trust with the individual first. The same tool used to collect baseline information will be used to take the follow-on measurement (see the bullet on "frequency of measurement"). The follow-on measurement should be taken after the Volunteer has conducted his/her activities (in this case, training on prevention of common childhood

illnesses, including pneumonia).

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 mothers/caregivers, to assess if the mother/caregiver sought care and received antibiotics the last time the child had presumed pneumonia (cough and fast or difficult breathing). 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. Please note that successful documentation of a behavior change or new practice may not be immediately apparent following the completion of activities and may need to be planned for at a later time. 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 a mother the Volunteer/partner worked with reporting that her child, 0-59 months, had a cough and fast or difficult breathing and received antibiotic treatment by an appropriate health provider. If the mother/caregiver the Volunteer/partner works with already sought the help of an appropriate health provider when their child was sick with pneumonia before beginning to work with the Volunteer/partner, then the Volunteer would not be able to count the child for this activity because the Volunteer's work did not actually lead to the desired change. However, if as a result of working with the Volunteer/partner, the mother/caregiver began seeking antibiotics for her sick child from an appropriate healthcare provider that would count because the Volunteer's work influenced the adoption of this practice.

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 children 0-59 months who had a cough and fast or difficult breathing since the last reporting period, received antibiotic treatment by an appropriate health provider, and whose caregiver/mother worked with the Volunteer/partner. The "total number" (or denominator) that Volunteers will report on for this indicator in their VRFs is the total number of children aged 0-59 months who had a cough and fast or difficult breathing since the last reporting period whose caregiver/mother participated in the activities designed to meet this indicator. If during the reporting period, no child of the caregiver/mother the Volunteer is working with presents with the signs and symptoms of pneumonia, the Volunteer should report a "0" in the VRF.

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 individuals who achieved the outcome based on 1) male and female and 2) 0-11 months and 1<5years.

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