**IRISH AID PROGRAM FUNDING**

**Community Caring for Children Project (CCCP)**

**Siraro Child & Family Development Association**

**ETHIOPIA**

**PROGRAM DESIGN**

**2012 - 2015**

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# List of Acronyms

**AIDS** Acquired Immune Deficiency Syndrome

**AO**Area Office

**AOPB**Annual Operation Plan& Budget

**ASP**Area Strategic Plan

**CBMS**Community Based Monitoring System

**CBO**Community Based Organization

**CCCP**Community Caring for Children Project

**CSA**Central Statistical Authority

**CSO**Charitable Society Organization

**CSP**Country Strategic Plan

**CT**Coverage Table

**DEV**Deprived Excluded Vulnerable

**DHS**Demographic Health Survey

**DIP**Detail Implementation Plan

**ECCD**Early Childhood Care & Development

**ECCE** Early Childhood Care & Education

**FGM**Female Genital Mutilation

**FIT**Financial Indicator Tool

**GBV** Gender Based Violence

**GPI**Gender Parity Index

**HIV**Human Immunodeficiency Virus

**IAPF**Irish Aid Program Funding

**ITN**Insecticide treated Net

**KM**Knowledge Management

**LP**Local Partner

**LQAS**Lot Quality Assurance Sampling

**M&E**Monitoring & Evaluation

**MDG**Millennium Development Goal

**MOH**Ministry of Health

**MSC**Most Significant Change

**NGO** Non-Governmental Organization

**NO**National Office

**PLWHA**People Leaving With HIV/AIDS

**RBM**Result Based Management

**SCFDA**Siraro Child & Family Association

**SNNPR**Southern Nation Nationalities People Region

**TOT**Training of Trainer

**UNDP**United Nation Population Division

**UPE**Universal Primary Education

**VSL**Voluntary Saving & Loan

**Project Summary**:

**Project Title:** Community Caring for Children Project (CCCP)

**Goal and project objectives:**

**Goal:**By the end of 2015, the program will have contributed to ALL children 0-5 years old in the programme area are protected and supported to have equal opportunities to realise their rights and develop to their full potential.

**Outcomes & Objectives:** It has **three outcomes** and **seven objectives** as summarised below.

1. Improved quality of ECCD services in the target areas
2. To improve parenting knowledge & practice of caregivers of 0-5 years
3. To improve school readiness of 3-5 centre based children
4. To increase target household income to support ECCD interventions
5. Strengthened community structures for child care, protection and case management
6. To improve the capacities of identified community structures to care & protect children
7. To develop/strengthen referral networks of child care and protection service providers, (including health, education, legal & protection)
8. Improved culture of learning & knowledge management on ECCD approaches & practices
9. To develop & implement knowledge mgt strategy that facilitates frequent reflection & programme improvement
10. To improve intra & cross country learning & KM for better ECD & Child Protection services

**Core program area**: Core Program 1: Early Childhood Care Development (ECCD)

**Location of project**: Siraro District, West Arsi Zone: Ropi Sinta, Ropi town, Damine leman, Boye awarkasa, and Alemtena Sirbo kebeles.[[1]](#footnote-2)

**Target groups:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Female** | **Male** | **Total** |
| **Direct beneficiaries:** |  |  |  |
| * **Children under five** | **2,855** | **2,531** | **5,386** |
| * **Women (15-49)** | **14,360** | - | 14,360 |
| **Indirect beneficiaries** |  |  |  |
| * **Adult males** | - | **14,040** | 14,040 |
| **Total** |  |  | **33,786** |

**Project start and end date:** February 1, 2012 to December 31, 2015

**Local implementing partner**: Siraro Child and Family Development Association

**Donor:**  IRISH AID through ChildFund Ireland

**Total budget by year and source of funding**:

1. **Budget for the project life**

|  |  |  |  |
| --- | --- | --- | --- |
| Budget year | IRISH AID/  ChildFund Ireland  (in Euro) | ChildFund Eth.iopia/Siraro CFDA  (in Euro) | Total  (in Euro) |
| 2012 | 150,000.00 | 50,000.00 | 200,000.00 |

Direct Program cost**144,616.30 Euro** =>**3,398,482.94 Birr (72%)**

Administration cost **55,383.70 Euro** =>**1,301,517.06 Birr (28%)**

**Contact person and address:** Charles Danzoll, National Director  
ChildFund Ethiopia  
 Bole Sub-City, House No.2310, P.O. Box 5545  
 Email: [cdanzoll@ethiopia.childfund.org](mailto:cdanzoll@ethiopia.childfund.org)

1. **Background**

Siraro is located in West Arsi Zone in Oromia National Regional State, approximately 325km away from the capital city of Ethiopia, Addis Ababa. Siraro Child and Family Development Association (SCFDA) is a child focused Community Based Organization (CBO) established by community members of five kebeles in the district namely; Ropi sinta, Ropi town, Damine leman, Boye awarkasa, and Alemtena Sirbo. It is registered as an Ethiopian Resident Charities with the Ministry of Justice and has been operational in the said kebeles with its head quarter located in Ropi Town.

SCFDA has been actively engaged in the management of different child and family development program activities through its catchment and executive committee members since ChildFund Ethiopia began operating in the area in 2005. Beneficiaries in the district have been actively participating in identifying the problems that affect their children and families and designing and managing projects aimed at ensuring the wellbeing of the disadvantaged children and their families. The establishment of the associations is thus emanated from the long term objective of bringing visible and sustained changes in the lives of disadvantaged children and youths through enhanced ownership and role of the community - parents, youth and children – and other stakeholders in all the processes.

Various humanitarian problems such as Water borne diseases and other frequent child illnesses, prevalence of child mal-nutrition and poor nutritional practices, prevalence of different Harmful Traditional Practices, low level of mothers and child immunization services, poor pre-school preparation of infants and young children and high dropout and absenteeism and limited capacity of the government structure to alleviate the human tribulations are among the top rating problems in Siraro Woreda.

Although reasonable efforts have been exerted to mitigate the prevalence of multifaceted problem of early childhood in the Woreda, the enormity of the problem required more organized and structured effort than ever before. Consequently, Siraro Child and Family Development Association in partnership with ChildFund Ethiopia and ChildFund Ireland have initiated this proposal, with determined effort, for the mitigation of ubiquitous problem of the community in the target area.

1. **Project rational and Justification**

**Ethiopia** has a total population of 82.8m, 46% of whom are between 0-14years, and 20% aged from 15-24 years. The majority of the population (83%) live in rural areas (United Nations Population Division (UNPD), 2009). Siraro Woreda is located 325km from Addis Ababa in West Arsi Zone of Oromia Regional State covering an area of 599.35 km² with a total population of 159,212, the majority of whom depend on subsistence agriculture. Life expectancy at birth for women and men is 60 years and 57 years respectively.

Children constitute the largest proportion of the Ethiopian population (46%), yet children’s access to resources and opportunities for education, health, adequate nutrition, recreation, etc. are very limited; a considerable part of the child population is exposed to different forms of exploitation and abuse, hindering the full realisation of their potential. Data from the 2005 Ethiopian Demographic Health Survey (DHS) shows that one in every thirteen Ethiopian children dies before reaching the age of one, while one in eight dies before the age of 5. Fifty per cent of infant deaths in the country occur during the first month of life. Over 90% of under-five mortality is caused by pneumonia (28%), neonatal complications (25%), malaria (20%), diarrhoea and measles (20%). More than half of these deaths have underlining malnutrition (Ethiopia Millennium Development Goal (MDG) Report, 2010).

Although the immunisation coverage *(% of children aged 12-23 months fully immunised with standard vaccines)* is 75% at national level, 51% of children aged 5 and below are reported to having stunted growth (DHS, 2009). Immunisation in Siraro is only 10.3%. Siraro also faces various harmful traditional practices such as female genital mutilation (FGM), polygamy, early marriage and wife inheritance which negatively affect the wellbeing of girl children. Other environmental factors affecting child health in Ethiopia include a limited availability of improved sanitation facilities at 12%, and improved water source to which only 38% of the households have access,(World Bank 2008).

Over the past ten years in Ethiopia, maternal mortality per 100,000 live births has decreased from 750 to 600 in 2010 with a goal of 300 by 2015. Since maternal mortality is closely correlated with access to and quality of health facilities and services, challenges still remain to be addressed. Although investment over the past five years has been promising with primary health service coverage reaching 89% in 2008/09, some maternal health indicators are still low. Only 12% of pregnant women receive prenatal and antenatal care and the ITN coverage is 53% (households with treated mosquito nets); 33% of mothers with children 0-5 have treated mosquito nets (DHS, 2009). This is even lower in Siraro where coverage of delivery assisted by skilled personnel is merely 1.1%; antenatal care coverage is 5.3% and contraceptive prevalence is only 22.1%.Efforts have been made by the Ministry of Health (MoH) which has trained and deployed 34,000 health extension workers throughout the country as part of their policy to increase the reach of essential preventative health services.

Ethiopia is progressing in attaining Universal Primary Education (UPE), as per MDG2. There is a significant increase in primary school enrolment from 87% in 2004/05 to 93% in 2009/10 for grades 1-4. However, despite encouraging progress in education coverage, the general literacy rate remains very low, standing at 36% in 2009/10. In Siraro district, the proportion of 12-16 year old boys and girls who have completed primary basic education is low in almost all Kebeles (4.4%). High school dropout and absenteeism is evident, for example 47.4% of children are reported to have dropped out of school and 45.3% of them have been absent from school for more than 15 days in the past six months. Different factors contribute to such high dropout and absenteeism, particularly the current drought.

Although Ethiopia has developed a National Policy Framework for Early Childhood Care and Education (ECCE), 2010, given that more than 50 per cent of the population in Ethiopia is estimated to live in poverty, it is difficult for households and communities to provide children with adequate nutrition and care. This fact underscores the importance of providing ECCD services to assist them in doing so. However, ECCD in Ethiopia seems not to have received the necessary attention, and its linkages with overall human resources development efforts have not been well established (World Bank, February 2000). These efforts include the 1994 Education and Training Policy, which emphasizes the need to enhance young children’s physical and mental development through early education, and the National Health Policy, which emphasizes the importance of improving nutrition for preschool children and supporting other programs that enhance the health of mothers and young children. There is also a Social Security Development Policy that declares the need to expand health, education, and social services targeted to preschool-age children and other programs designed to support families in child management and care.

This has left ECCD programs majorly under the NGOs and traditional providers (church, public, Koranic sites). The three principal NGOs offering ECCD in Ethiopia are Save the Children and ChildFund which support ECCD programs in different parts of the country.

According to ChildFund’s Siraro Area Strategic Plan (ASP) 2010, about 6.3% of children between 36-59 months attend some form of early childhood education program (child care centres, nurseries, pre-school and kindergarten programs). The culture/practice of in-house support of children in their pre-school learning is low with only 10% of parents engaged in activities that promote pre-school learning. As a result there is a considerably low ECCD attendance and low birth registration where only 6.3% of children aged 0-23 months and 2.1% of those aged 24-59 months were reported to have been registered.

The HIV and AIDS epidemic is heterogeneous with significant regional variations. At national level the epidemic has been stable with HIV prevalence in 2010 estimated at 2.4% or about 1.1 million people living with HIV[[2]](#footnote-3); incidence of tuberculosis is 359 per 100,000 people and tuberculosis case detection rate (all forms) is 50%.

Therefore, Siraro Child and Family development Association will intervene to challenge these through improving the quality of ECCD service and strengthened community structures for child care, protection and case management and realise the right and full potential development of under 5 years children in the target area.

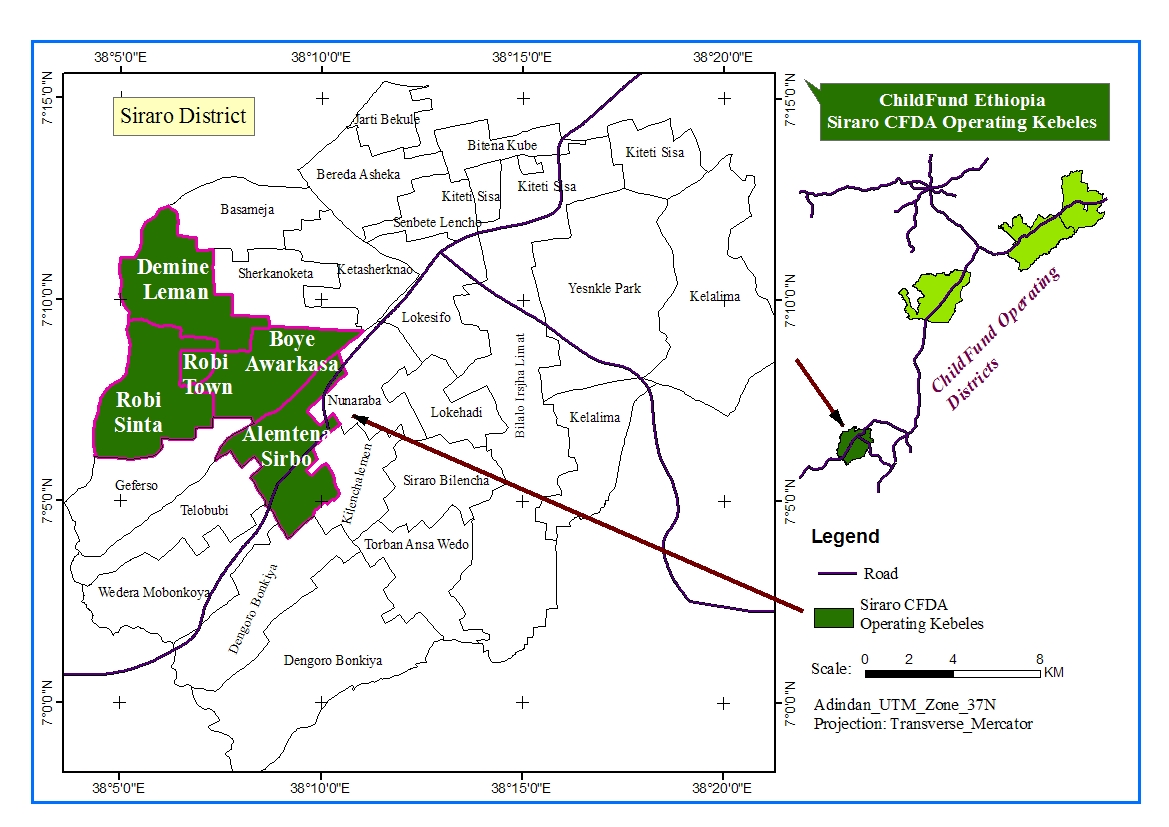
1. **Location and Target Population**

The program will be implemented in one district with direct target population being children below 5 in both home and centre based environment. In Ethiopia, the program district will be Siraro covering 5 Kebeles with direct beneficiaries of 5,386 children under five.The general profile of the district Siraro is summarized as follows.

Siraro Woreda is located in west Arsi zone with in Oromia National regional state. Ropi town where the head office of the Association is located at 325 kilometer from Addis Ababa and 68K km from the Zonal town –Shashmane to south direction. It is found in the Great Rift Valley system having a total area of 599.35 km². Geographically, the woreda is sharing borders with SNNPR-Halaba woreda in the north, Shala woreda in the east and in south and west Borcha and Fango woredas of SNNPR respectively.

Administratively Siraro Woreda is divided into 30 kebeles[[3]](#footnote-4), (28 rural and 2 towns) having a total land area of 63710 hectares. The Altitude of the Woreda ranges from 1500- 2300 meters above sea level having the land feature of plain (68% ), and mountainous and hilly(32%).

**Map of the program Area-Siraro District, the shaded green areas are the targeted five kebeles.**

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**Fig.1 Map of the program area (source: adopted from 2005 CSA population census map)**

According to the 2007 Statistical Abstract of Central statistical Authority (CSA), the total population of Siraro district is about 145, 404 of while 71, 554 males and 73, 850 females.

The district is also estimated to have population density of 265.6 people per Sq. km. Out of this total population of the woreda, the program area covers nearly 20%-.i.e. 32,651 people.

**Population profile of kebeles covered under the program area is illustrated in the following table**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Country | Ethiopia | | | | Remarks |
| Program Area/District | Siraro | | | |
|  | Life Stages (Age in years) | Male | Female | Total |  |
| Total Population in Programme Area | 0 – 5 | 1,700 | 1,700 | 3,400 |  |
| 6 – 14 | 3,290 | 3,290 | 6,580 |
| 15 – 24 | 900 | 900 | 1,800 |
| 24 and above | 11,050 | 11,050 | 22,100 |
|  |  |  |  |  |  |
| Impact population | 0 - 5 | 2,855 | 2,531 | 5,386 |  |
| Target population/ beneficiaries |  |  |  |  |  |
| 6 – 14 | 10 | 8 | 18 |  |
| 15-24 | 23 | 19 | 42 |
| 24 and above | 1200 | 1500 | 2700 | ECD Management Committee members, VSL groups, Care givers, ECD facilitators, Woreda advisory board, Selection committee at kebele level |
|  |  |  |  |  |  |
| **Target Groups** |  |  |  |  |  |
| Child & Youth Forum | 6 – 14 | 10 | 8 | 18 |  |
| 15-24 | 23 | 19 | 42 |  |
| District advisory board | 24 and above | 3 | 4 | 7 |  |
| Health Extension workers | 0 | 10 | 10 |  |
| 10 Schools | 60 | 32 | 92 |  |
| IGA group-Youth | 6 | 4 | 10 |  |
| SACA | 6 | 100 | 106 |  |
| 2 Health Centers | 20 | 11 | 31 |  |

1. **The Program Objectives and Primary Components**

From the above analysis in the country, children and women’s poverty and poor health are related to a wide range of factors inherent in vulnerability, exclusion and deprivation. Health and education services and protection mechanisms for vulnerable children and women are weak, leaving them at great risk of diseases, abuse, neglect and exploitation. Food insecurity and poor nutrition are closely linked to poverty and marginalisation, with direct and damaging effects on children’s growth and women’s well-being. The most common causes of child diseases are given as malaria, diarrhoea, HIV&AIDS, with malaria and malnutrition being the main causes of child mortality. Malnutrition is related to inadequate food with various diseases derived from shortage of food, inadequate maternal and child care practices, particularly deficient breastfeeding, and shortage of drinking water, poor sanitation and healthcare.

To address these issues requires comprehensive interventions. The Irish Aid Program Funding has carefully selected Early Childhood Care and Development (ECCD). The ECCD refers to the physical, cognitive, linguistic, and socio-emotional development of a child from the prenatal stage up to age eight. This development happens in a variety of settings (homes, schools, health facilities, community-based centres); and involves a wide range of activities from child care to nutrition to parent education[[4]](#footnote-5). The IAPF borrows from this definition and recognises distinct sub-stages of ECCD, each of which presents particular needs:

**Did you know………?**

* 85%of the human brain develops by age 5. It is more difficult to improve cognitive development later.
* 50% of a child’s cognitive capacity is influenced by his/her environment
* 77million children across Africa don’t reach their full potential due to poverty and poor health, nutrition and care.

Africa Human Development, FAQs, early Childhood, *The World bank, July 20120*.

* Pregnancy and pre-natal: prenatal care, attended births, registration, postnatal care
* 0 to 3: parent education, early stimulation and nutrition interventions, home-based care,
* 3 to 6: parent education, preschool services,
* 6 to 8: transition to formal education, improved early primary school

The IAPF also recognizes that children who come from the most vulnerable and disadvantaged backgrounds need good-quality services and care the most, including children with special needs. These early years of life are a window of opportunity to lay a strong foundation for a child’s life. Proper health, nutrition, and early stimulation play a critical role for brain development and child well-being. Poor children under 5 lag behind their more advantaged peers in physical, language, cognitive, and socio-emotional development. Without access to quality ECCD, poor children often fall behind their more advantaged peers before they even begin school. As they get older, the gaps widen: they are likely to perform poorly in school, earn less as adults, and engage in risky social behaviours. With this in mind, IAPF will define/adopt tested, appropriate and non- discriminatory criteria in enrolling families and children into the ECCD program.

Some of the most important research findings on early childhood care and development

* Early childhood development and care in the early years can do much to prevent malnutrition and increase children’s chances of survival.
* Intervention during the early years can assist in the healthy development of children cognitively, socially, emotionally and physically.
* Participation in preschool programs promotes cognitive development in the short term and prepares children to succeed in school.
* Early childhood programs can reduce educational inequalities
* Early interventions can raise the status of mothers in the home and community.
* Early Interventions reduce gender inequalities.
* Early interventions generate economic returns and reduce social costs by reducing grade retention, special education placement, juvenile delinquency, and substance abuse.
* Environments, which encourage children’s development, will support them physically, emotionally, socially and intellectually.

Thus, the ultimate concern of any ECCD program should be the wellbeing and holistic development of the child, and regardless of the institutional setting, the program should embody developmentally appropriate practices which attend to health, nutrition, security/protection and learning. Of essence, is that ECCD must capture the three integral concepts of early childhood care, development, and education.

Although MDG reports in the three countries have shown that education indicators are towards attaining UPE (MDG2) and that there is a significant increase in primary school enrolments and increased Gender Parity Index (GPI) for secondary schools, ECCDhas not been given due attention, leading to poor home-to-school transitions for young children. Secondly, despite the fact that theEthiopian governments has formulated ECCD policies and/or guidelines, the early years of child development receive least investment from governments. ECCD is mostly being offered by non-governmental organisations (NGOs), communities, private operators and some public institutions with a very limited coverage. The culture of in-house support of children in their pre-school learning is low and the number of adults engaged in activities that promote pre-school learning is minimal.

The description of components of ECCD and its benefits combined with analysis of ECCD challenges in all the country in the previous section, provide the basis of defining IAPF 2012-2015 interventions which aim at addressing needs of children: combining health, nutrition, education/learning, psychosocial stimulation and child protection, to have a more positive impact on children’s development. This program specifically limits itself to three areas; child care and nutrition, protection and learning – focusing both home-based and centre based interventions. This will help focus on immediate improvements in areas such as cognitive ability, school readiness (e.g., curriculum, class size, quality, etc.). The impacts are therefore expected to be realised in three areas: cognitive abilities, school achievements, and social-emotional adjustment.

The conceptualisation and implementation of the program follows the elements of ChildFund International’s strategy of building civil society and protective environments for children as a core driver for sustainable, responsive and legitimate child development and protection programs. This recognises further that if properly supported by programs, caregivers and communities (families) have the skills to provide safe spaces for children’s healthy development, safe and quality learning opportunities. This is the resilience part in communities and that these children are contributing to their own protection, and to the protection of their siblings and neighbours.

This ChildFund philosophy is reflected in the IAPF goal of *contributing to a sustainable community based childhood care, development andprotection system that helps to realise the rights of vulnerable children*. It is also based on the Irish Aid Program Approach that emphasises clear organisational policy, results framework, partnership and institutional capacity development. The central players in the program will be the child, parents and community with the premise that child care, education and protection services are critical to children’s development and that mother’s education is strongly correlated with child mortality.

Included in this approach is the advocacy at both district and national level and networking with other NGOs and actors on early childhood development to maximise the program impact. The advocacy will target to increase the awareness at four levels: family, community, district and national on the benefits of ECCD aiming to influence these layers for increased participation and resource allocation to ECCD.

* 1. **Program Goal:**By the end of 2015, the program will have contributed to ALL children 0-5 years old in the programme area are protected and supported to have equal opportunities to realise their rights and develop to their full potential.

ECCD Indicator Categories:

1. Coverage, access, use
   1. Gross Enrolment: Gross enrolment in early childhood programmes, expressed as a percentage of the relevant agegroup in a given year
   2. Parental Education: The number of young children whose parents participate in ECCD educationprogrammes, expressed as a percentage of the relevant population group.
2. Program quality
   1. Number of children per teacher/caregiver (child/teacher ratio)
   2. Physical environment (amount of space available per child, safety precautions taken, the presence of functional and clean sanitary facilities, availability of potablewater, etc.)
3. Political will, policy and financing
   1. Policy. Presence of a national ECCD policy and/or plan
   2. Budget allocation. The percentage of the educational budget allocated, to or spent on, ECCD programmes
4. Costs and expenditures
   1. Costs (or average expenditure) by government per child on ECCD
   2. Costs (or average expenditure) by government per child on ECCD programmes as a percentage of GrossNational Product per inhabitant
   3. Average expenditure per child by family on ECCD for children under six as a percentage of minimum salary (or offamily income)
5. Status of or effects on children and parents (outcomes and impact)
   1. Child development
   2. School readiness
   3. Nutritional status
   4. Health status
   5. Parental knowledge and expectations

*Source: The Consultative Group on Early Childhood Care and Development, WB*

The program has three outcomes,and these outcomes will be achieved through the objectives under each outcome.

* **Outcome 1:**Improved Quality of ECD services in the target areas
* **Outcome 2:** Strengthened community structures for child care, protection and case management
* **Outcome 3:** Improved culture of learning and knowledge management on ECD approaches and

practices

1. **Improved Quality of ECD services in the target areas**

This outcome has three objectives:

**1**: To improve parenting knowledge and practice of caregivers of 0-5 years (home-based)

**2**: To improve school readiness of 3-5 center based children

**3**: To increase target household income to support ECD interventions

The home-based care will target parenting education and support, early child stimulation, child immunization and nutrition interventions. The home-based activities will target parent/child interaction, training of parents/caregivers on parenting and child health, volunteers and professional staff on child protection[[5]](#footnote-6), gender and gender based violence (GBV). Specific activities will include:

* 1. A mother-training intervention to support women in their parenting roles, instructing them in child development and healthy family relationships, and train them on health education, optimal breast feeding, feeding of sick children , how to help their children learn including making of educational toys for their children, child growth and development, empowerment (learning to see themselves as role models), how to teach their children and what social services were available to them in the community
  2. Stimulate household awareness and ownership in the request for and provision of critical services for children including health care.
  3. Promote kitchen gardening and village savings and loans (VSL) for mothers/caregivers and people living with HIV and AIDS (PLWHAs) so as to enable them to support their children’s ECD expenses as well as support the center.
  4. Support quarterly routine child immunization programs of health centers through logistic support (fuel for motorcycle, kerosene for refrigerator and stationeries
  5. Organizeawareness raising workshop on the advantage of immunization of children.
  6. The intervention will include both alternating weekly group discussions and home visits. This is expected to increase parents’ engagement in ECCD activities.

The centre-based component of ECCD willtarget children’s cognitive development, parents’ participation in ECCD centre development and improving teachers’ skill to deliver ECCD services. Activities will include:

1. Construction of8 and refurbishment of 2 ECD centres in selected critical sites in the five kebeles that will include creating conducive learning environment: class sizes, playground, security, water and sanitation, etc.
2. Establishing a foundational ECCD teachers training based on experiential learning approach and in native languages. Teacher training is expected to improve the quality of teachers support to children’s learning as well as the quality of teacher interactions with the children. A clear relationship with primary schools will be established to facilitate transition. There will be exchange and interaction with district education administration for continuous mentorship and coaching.
3. Visual and user-friendly materials development to guide practice. There will be structured daily routine with emphasis on learning through play; greetings, literacy circle, creative corners, outdoor play, math circle, closing/review
4. Establishing and training ECCD Management committees attached to each ECCD centre established.
5. Home visits as an important element of the program, with monthly visits during which the classroom lessons will be reinforced and individual support provided at identified household levels.

The ECCD interventions will be designed to provide a complete range of services such as stimulation, play, growth monitoring and immunisation. For mothers, the centres will provide an opportunity to learn parenting skills and how to grow, preserve and prepare nutritious meals from locally available foods. Quality and equitable community led home and centre based early childhood approach has the ability to adjust services based upon family needs, cultures, and perspectives that allow them to keep families participating for longer periods of time. Parents of children in the ECCD are expected to take active roles in their children’s learning, including talking to the teachers, showing an interest in their children’s progress, engaging actively with the school management committees, raising issues that concern them, and calling for accountability from teachers and school committees.

Including parents’ participation in ECCD improves the parenting skills and their participation influences child outcomes. Among the outcomes on children performance of the parent-focused intervention are higher vocabulary scores, greater school attainment (length of time in school), higher grades, better attitudes toward school, and better family and social adjustment. The effect on mothers includes enjoying higher intra-family status, greater decision-making, more role sharing, and communication with their husbands. Parents provide more educationally stimulating environments, increasing their communication skills, and are emotionally supportive of their children, exhibiting a wider range of discipline strategies, and provide more support for language and learning. Additionally, parents are better advocates for their children when they enter primary schools.

1. **Strengthened community structures for child care, protection and case management**

The second outcome has the following two objectives:

1: To improve the capacities of identified community structures to care and protect children

2: To develop/strengthen referral networks of child care and protection service providers (health, HIV, education, legal and protection)

This program intends to go beyond simple partnership with local organisations to strengthening their capacities, creating knowledge and sharing experiences. Through this approach the program aims to strengthen the capacity of front-line service providers to carry out local advocacy for children and best respond to local needs over the long-term. While the landscape of local institutions across the targeted districts contain diverse capacities, overall stronger networking, learning and knowledge management capacity are crucial to a sustainable and evidence based program.

Engaging civil society and CBOs will aim at increase access and quality of community led home and centre based early childhood care and development services. In the country, major civil society players in ECCD are Save the Children, The program will engage with them to leverage resources for ECCD development as well as influence government on policies that support ECCD.The strategies to achieve this objective are:

1. Identifying and strengthening existing community and local institutions to protect and care for children.
2. Establishing and strengthening coordination of care systems across community stakeholders working to improve well-being of vulnerable children e.g. community groups, family clans, local government, community led committees, faith based institutions
3. Establishing networks of NGO/CBO working on ECCD for sharing lessons and resources for strengthening sustainable approaches to child protection projects.
4. Carrying out specific and targeted operations research to address any emerging issue in the program aiming to improve program results.
5. Support the District advisory Committee on ECD to conduct mapping, gap analysis, and training of ECD service providers and structures.
6. Promoting ECCD advocacy at community, district and national level to raise awareness and inclusion of ECCD at various policy levels.
7. Work with civil society and CBOs to obtain sustainable funding to expand cost-effective and well-targeted ECCD programs, especially for children who are most disadvantaged.
8. Facilitate birth registration of all unregistered children in the program area and mobilise caregivers and community members on the benefits of birth registration and support Health Institutions with Birth Certification Cards.

The second component will target to promote ECCD advocacy at national and district level to influence governments on ECCD policies and/or plans and referral and linkages with health centers. Activities in this component will include:

1. Organize communication campaigns, dialogue sessions and Produce billboards, posters, caps and t-shirts on key child development and care and celebration of key international/national events. And Influence and support the district to include ECCD in their education sector plans.
2. Influencing budget allocation and expenditures to ECCD programs.
3. Sensitise governments, especially at district level the need to establish a preschool class in each primary school in the covered kebeles.
4. Foster dialogue, consensus building, and capacity development related to ECCD programming.
5. Strengthen the referral networks to manage referrals by supporting health facilities through provision of medical and non-medical equipment/kits and essential drugs.
6. Develop the referral network and raise awareness of the functional network to the communities and service users through media.
7. **Improved culture of learning and knowledge management on ECD approaches and practices**

The third outcome has the following two objectives:

1. To develop and implement knowledge management strategy that facilitates frequent reflection and programme improvement.
2. To improve intra and cross country learning and KM for better ECD and child protection services.

These objectives intend to bring intra and cross country together the three Irish Aid Program Funding countries in Africa to share lessons, experiences and knowledge gained in the course of implementation. This will improve national and regional learning, information sharing and documentation. Strategies to foster this objective include:

Learning Indicators to be considered:

* Individuals feel that their ideas and suggestions are valued
* Mistakes and failures are considered important by everyone for learning and not shameful
* All the key groups involved in project implementation communicate openly and regularly
* Project implementers, including primary stakeholders, regularly and informally discuss project progress, relationships and how to improve actions
* Managers listen carefully to others and consciously seek solutions together
* During regular meetings and reviews, time is set aside for discussing mistakes and learning lessons
* The question, "Why is this happening?" appears often in discussions

1. Generating knowledge of cost-effective ECCD programs by carrying out the program baseline surveys, mid-term evaluation and final evaluation/impact evaluations and disseminating lessons learned to policymakers, practitioners, and development partners.
2. Adaptation of a Learning and Knowledge Management Framework to the Irish Aid program context, developing learning objectives and monitoring tools.
3. Organising regional reflection, learning and sharing events, including implementation support visits, special studies, operational research and one rotational learning workshop per country.
4. The expected outcome of this objective will be utilisation of vibrant community led systems for planning, monitoring, evaluation, accountability, learning and knowledge management on child development issues.Outputs will include systems for documentation, best practices and sharing of information; local learning networks addressing child rights, GBV, HIV prevention, gender and effective M&E system.
5. Organising technical support amongst implementing partners and countries, including placement for temporary duties.
6. Producing and disseminating evidence based lessons and promising practices.
7. Introducing monitoring and learning system that supports regional learning.

Outputs will include learning and knowledge management tools, technical support visits and reports, and learning events.

Learning in this program has been defined in two perspectives: with its own objective to ensure continuous and deliberate learning; and learning inbuilt into objective one to ensure learning happens through reflections, inquiry and analysis to understand and improve implementation, including how, when, and why elements of the program have to change/improve. This means the learning will be both incremental, in order to focus on refinements of the proposed the ECCD strategies, and transformative, so as to focus on creating strategy because target groups and other stakeholders understand the program or its work in new and changing environment.

Effective reflection and sharing will be key in the program. Periodical reviews, implementation support visits, meetings, on-line sharing are spaces factored in the project to improve learning through dialogue and enquiry. These events will not simply happen; they will be planned and executed to ensure they support and facilitate honest reflection and sharing. For reflections to lead to learning, lessons (and evidence) will be consciously identified, generalised and used to improve future action.

A systematic learning agenda in this program has three elements: (i) learning from experience of Block Grant and drawing practical conclusions and lessons; (ii) learning during implementation focusing on monitoring and continuously reviewing the program’s objectives, as well as capacities to deliver results; and (iii) learning after at completion involving a process for overall reflection, following up and future reapplication of lessons.

To support the learning, M&E proposed in this program goes beyond information generating to contribute to knowledge creation and the making of meaning, contributing to the creation of knowledge, approaches and methods. This means, through findings and reflections, M&E will push for improved strategies.

1. **Crosscutting Issues**

Throughout the interventions discussed above, HIV&AIDS, gender, governance and environmental issues have been integrated. These have been discussed and integrated further in the design.

* 1. **Gender Integration**

ChildFund Ireland aims to integrate gender perspectives into all its programs. This is reflected in various ways and includes selection of program beneficiaries – a balance in most cases but targeting women and girls in some, and men and boys in others. Equal representation and participation of males and females is promoted on child and youth committees, partner organisation governance bodies, etc. to encourage equality in decision making processes and equal access to resources. This further implies gender disaggregation in indicators. ChildFund Uganda has recently adopted a Gender Analysis Tool in order to understand the gender dynamics in the supported communities and how they affect programming. Proposed projects will be subjected to the tools to identify gender needs and interests, gender biases, access to resources and opportunities. This information will then be used to improve the program. While the tool is not yet in use in Ethiopia, it will be used for activities supported in this program.

1. **Intervention Logic in the Proposed Program of Work**

ChildFund’s vision is a global community free from poverty, where children are protected and have the opportunity to reach their full potential. ChildFund’s focus is child-centred development programs that are undertaken in partnership with local communities. ChildFund’s distinctive approach leverages our deep understanding of children’s experiences of and vulnerability, exclusion and deprivation. ChildFund places children’s experience of vulnerability, exclusion and deprivationat the centre of our policy and practice. We align what we learn from children with best practices to inform and deliver programs that ensure children not only survive, but thrive and bring positive change to their families and communities. This influences our Strategy, i.e. ChildFund exists to (1) help vulnerable, excluded and deprived children have the capacity to improve their lives and the opportunity to become young adults, parents and leaders who bring lasting and positive change in their communities, and (2) to promote societies whose individuals and institutions participate in valuing, protecting, and advancing the worth and rights of children. This is summarised in this figure, with children being central to our work.

That children can make a critical contribution to bringing about sustainable change in their lives and the lives of their communities is a fundamental belief underlying our work. We also recognise that for children to develop and become leaders they must be enabled by a broad and diverse range of actors at many levels of society. Further, the organisation has defined three results that drive towards achieving that intent and illustrate our understanding and belief of what needs to be in place to enable children to bring about lasting and positive change in their communities; i.e.

1. Healthy and secure infants, educated and confident children, and skilled and involved youth
2. Families and local organisations networked in their communities promote the development and protection of children
3. A broad constituency of supporters dedicated to the wellbeing and rights of children

Our engagement with families and communities is aimed at positive outcomes for children, rather than more general community outcomes. We recognise that children are impacted by policies and practices at national and global levels. These must be fostered and shaped through collective action. ChildFund places emphasis on the changes we make in the lives of children and the outcomes for children across the life stages. This is known as the Life Cycle Approach. Each outcome has a set of key interventions as summarised in the table below.

|  |  |
| --- | --- |
| **Core Program Area** | **Key Interventions** |
| Healthy and Secure Infants | Integrated Community Management of Childhood Illness and Nutrition |
| Safe Motherhood and Neonatal health |
| Early Childhood Care, Development and Protection |
| Educated and Confident Children | Promotion of Child-Friendly Schools |
| Participatory School Governance |
| Alternative Basic Education |
| Skilled and Involved Youth | Livelihood Education and Preparation |
| Reproductive Health Services and Education |
| Youth Leadership and Social Engagement |

The core program area picked up by this IAPF proposal is “Healthy and Secure Infants”; the design focuses on one key intervention: Early Childhood Care, Development and Protection. The figure below which is expanded in Annex 1 into a logic model explains our pathway of change for this program.

***If*** we increase access and quality of community led home and centre based early childhood care and development services,

***If***communities demonstrate increased understanding and application of key early childhood care and development services,

***If***there is vibrant community led systems for planning, monitoring, evidence based impact and accountability, cross learning and knowledge management,

***Impact Goal***

***Then*** we will have sustainable community based protection system that helps to realise the rights of vulnerable children

**+**

**=**

1. **Program Management and Capacity Building**
   1. **Strength of the organisation:**

ChildFund has been operating in Ethiopia since 1973. Currently it supports over 1,032,190community members in this country in various child-focused programs, in partnership with other like-minded civil society organisations and government departments. Today almost 40 thousand children are directly engaged in sponsorship funded holistic community based programs at national level and 2500 children are directly in Siraro child and family development.

ChildFund has invested heavily in strengthening the capacities of the community organisations it works with. There is a consensual understanding of the role of the organisation and its potential as an agent of change within civil society, both directly as an organisation dedicated to the well-being and protection of children and indirectly through the partner community based organisations. The projects in each country will be implemented under the established community structures, the ChildFund affiliated CSOs.

* 1. **Management Structure for the Program:** The national office Program Director will provide overall oversight to the program. Six qualified staff will be hired: a project coordinator with strong program background and experience and three technical officers with skills and experience in ECCD, VSL and M&E respectively, and two support staff, one finance officer and a driver. The project coordinator will be stationed in the national office and report to the ECCD officer at National office. The remaining four officers and a driver will be recruited by the local partner and stationed at field and the samereport to the association manger. All recruited staffs will have 100% of their time in the program. There are 5 ECD promoters and 5 community volunteers will be also recruited so as to facilitate the program at the community level.
  2. **Partnership Strengthening:** ChildFund’s key strength lies in mobilising communities and empowering them to play an active role in their own development efforts through community-based interventions, capacity building and ensuring sustainable practices in the community. In this program, ChildFund will promote the involvement of men, children and women in the design and implementation of ECCD. It will identify local organisations and government departments having an interest in ECCD and develop meaningful partnerships that mobilise more resources and support the implementation of the program.
  3. **Sustainability and Exit Strategy:** ChildFund works in partnerships with local communities, an engagement which is organised as a series of three or four community-driven planning cycles, with each cycle being around three years in length. A clear sense of the finite nature of this partnership is established at the beginning while the commitment is sufficiently long to increase community capacity to develop and sustain long term change. This planning process which enhances sustainability is the heart of this program which is designed to be implemented with the ChildFund affiliate framework.

Sustainable programs achieve enduring results which build local capacity and promote responsible management of resource use so future generations will be able to survive and grow. Sustainable development encompasses social, economic, legal, political and environmental issues. Sustainability and local capacity are fundamentally linked. The program will build on capacity building efforts made over the last four years to manage resources in an environmentally sustainable way.

ChildFund gives priority to working with and through established local and national institutions and groups, encouraging and supporting their creation where they do not already exist. ChildFund’s strength is empowering communities to play an active role in their own development efforts, ensuring sustainable practices in the community. As outlined above this program will go beyond simple partnership and will work to strengthen community child care systems, local institutions, and the capacity of front-line service providers to respond to needs of children over the long-term. While the local institutions across the targeted districts have varied capacities, stronger networking, learning and knowledge management capacity are crucial to a sustainable program, and as such is a strong focus of this program.

1. **Results-Based Management Systems**

A results based approach ensures that performance measurement is brought together with the strategic planning and budgeting processes of an organization to support the alignment between its overall goals and the delivery of policies and programs to recipients and stakeholders. A results based management framework is “a management strategy focusing on performance and achievement of outputs, outcomes, and impacts – the results chain which is the centre of RBM and it provides a structured logic model that lays out the sequence and steps necessary to achieve stated objectives - beginning with inputs, which support activities to generate outputs, outcomes and impacts[[6]](#footnote-7).” This simply means program design, annual planning and M&E are linked processes.

The results-based management system proposed in this section will take this approach, providing a framework on how M&E, based on this design will be set up during start-up, implemented during program implementation, and reviewed during program reviews. Effective planning, monitoring and evaluation systems are therefore required in the Program:

1. To assist the country and area program staff and implementing partners in effectively executing the program, track performance, note challenges and make appropriate changes
2. To demonstrate the contribution of the program to ChildFund development outcome indicators defined for healthy and secure infants and young children
3. To learn, share experiences and use the program information for improved program management and be accountable to program beneficiaries, donors and partners.

In keeping with the above objectives, the systems proposed in this section provide a broad outline to support principles, identification of information needs and indicators, methodologies, institutional arrangements and human capabilities that will be put in place and strengthened to support M&E. It clearly identifies four major components, i.e. planning, monitoring, evaluation, reflection and learning, all linked to the program elements described in the entire design document.

* 1. **Planning Subsystem:** The system proposes three levels of planning that will support M&E: (1) Detailed Implementation Plan, (2) M&E Plan, and (3) Annual Operational Plan and Budget (AOPB), all based on the objectives described in Program Summary. The DIP and M&E Plan will cover the four-year program period and will be reviewed annually through annual planning and budgeting.
  2. **Start-up Workshop**: The initial DIP and Detailed M&E Plan will be developed during program start-up, and discussed in a Start-up Workshop which will be held in each country targeting implementing staff and partners to create a thorough understanding of the program and develop the first AOPB with an annual monitoring plan.
  3. **Annual Planning:** Annual planning provides an opportunity to reflect on the program design, and implementation experience to make appropriate adjustments. This process will be crucial in this program. It will include annual review/reflection and development of an AOPB for the next year. The annual reviews and stakeholder analyses will focus on implementation achievements and challenges, analysis of stakeholders in supporting the program, financial expenditures, and the extent to which implementation is responding to program objectives. An Annual Review report and the AOPB documents will be the products of this process.
  4. **M&E Plan:** To make M&E operational for this program, an M&E Plan will be developed to provide the following information:
* Information needs and indicators (including operation definitions and information usage)
* Baseline information requirements, status and responsibilities
* Data-gathering methods, tools, frequency, data quality control methods and responsibilities
* Analysis, reporting, feedback and change processes and responsibilities
* Learning, knowledge creation and sharing

Performance Indicators and Information Needs: results framework outlining the program goal, objectives and results for each objective. This results framework sets the foundation of defining further country level performance indicators, with specific outputs and activities selected to ensure that they lead to intended objectives.

Monitoring Tools: In relation to this program, three broad categories of monitoring will be needed: the extent to which the activities identified for the AOPB have been implemented. The details of the framework and monitoring tools for this will be derived from the AOPB itself. This is the AOPB-based monitoring tool. Secondly, monitoring and reporting will be required of key outputs as defined in the results framework and respective financial expenditures. The main monitoring tool proposed for this will be coverage tables (CTs) which have gained a deep understanding within ChildFund. The initial comprehensive CTs will be derived from the DIP and the program budget, immediately the designs are approved. The outputs in the CTs will be updated whenever results frameworks are updated, and reported quarterly.

Other tools will be developed to capture the quality and outcomes of milestones such as training sessions for staff, children, mothers, partners, ECCD centre staff, committees, etc, support visits to the field, good practice demonstrations, exchange visits, etc. In some cases, there will be development of ECCD centres for children to learn and play; including water and sanitation facilities, etc. Specific tools will be developed for monitoring any infrastructure development or rehabilitation (infrastructure development tools). Organised communities and systems are proposed in the design as mechanisms for protecting the child. Tools will be developed for community groups monitoring their activities around the wellbeing of the child. IAPF will strive to monitor its own performance and track changes in the community affiliate partner ability to deliver child protection and health promotion services. Tools will include pre- and post-training assessments (to measure skills, knowledge changes in trainees), trainees’ evaluations of Training of Trainers (TOT) sessions (to measure IAPF performance), accompaniment monitoring forms to record information on Affiliate partners’ application of skills and knowledge, and guides for capturing qualitative information on successes and failures in the field.

Quarterly Review and Reflection: The quarterly reviews and reflections have been inbuilt in the monitoring system to give an opportunity to implementing staff and communities to reflect on specific elements of the project at implementation level. They will be organised and coordinated by the Project Managers and can take any form ranging from a one day intensive meeting to an organised field visit to document case studies, Most Significant Change (MSC) stories, etc. The outcome of a quarterly review and reflection events will be a quarterly progress report.

Annual Review and Reflection: The annual review has been described under the planning sub-system as an element in the annual planning process. In this program, the annual review and reflection will be taken a step higher to focus on systematic performance review of implementation across and within the three countries. This will be organised and coordinated by ChildFund Africa Region and ChildFund Ireland. It will be rotational, one per country for four years. It will include technical program assessment, cross fertilisation, etc, and end up with annual workshop drawing participants from the three countries, ChildFund Africa and ChildFund Ireland.

* 1. **Evaluation Subsystem:** Evaluation systems are periodical and are aimed at checking whether the continuous activities/outputs are being transformed into long term benefits – the outcomes/impacts. The evaluation process begins with the selection of performance indicators (see results framework). The defined indicators will be included in the household survey whose objective is to evaluate the interventions supported by ChildFund and its partners. Data collected via these surveys will be used to set targets, identify priority issues and feed-back information into the planning of interventions at each stage.

Further, evaluations will analyse the effect of early childhood educational and development experiences on cognitive, social, communication, and problem solving competencies[[7]](#footnote-8) among children. These knowledge, skills, and dispositions are literacy, mathematics, problem solving, communication (receptive and expressive language), perseverance, social skills with peers and adults, self-management, curiosity, and motor skills.

* + 1. **Baseline Assessment**: IAPF baseline will be carried out in each area during the first six months of the program and will be both quantitative and qualitative. Baseline data and indicators will be disaggregated by gender. The quantitative household survey will adopt the LQAS methodology and will focus on ECCD indicators identified in the results framework. The qualitative assessment will focus on current child protection systems in communities and institutions with the aim of establishing the gaps for strengthening. With the help of a consultant who specialises in learning and capacity building, IAPF will gain a clear picture of the Affiliate partners’ and community systems starting capacities in a number of key areas and develop a plan to strengthen them for offering services to children.
    2. **Mid-term Evaluation:** The mid-term evaluation will be carried out at the end of second year and will take the form of intensive performance review, appraise performance and evaluate process. It will mainly be a qualitative process.
    3. **Final Evaluation:** A final evaluation will be carried out at the end of the program during the fourth year. It will adopt quantitative and qualitative approaches focusing on indicators and systems included in the baseline assessment to measure the households’ and communities’ capacities, skills and knowledge at the end-line.
  1. **Community Participation in M&E:** Communities and community-based organisations have long been monitoring and evaluating their work, developing their own procedures for recording and analysing information, and using that information for making decisions. Many of these local initiatives are carried out informally, and they provide rich potential for developing innovative approaches to monitor and evaluate change. Thus, the proposed results based M&E system will adapt community-led monitoring practices that are more participatory, to empower communities, and to promote ownership of the program and its M&E system.
  2. **Financial Monitoring:** Financial monitoring and reporting will follow ChildFund’s FIT (Financial Indictor Tool) and reporting system at field level. The project finance officer will compile and analyse monthly expenditures, discuss with program teams and forward to the Area Finance coordinator and again reviewed at the area office level and send to national office. Monthly and quarterly financial reports in the agreed format will be prepared by the NO and send the monthly report to the region only and the quarter report for submission to ChildFund Ireland with a copy to the Region. On quarterly basis, the Region will review and discuss financial expenditures alongside the narrative reports. Financial reports will be incorporated into the management accounts of ChildFund Ireland.
  3. Capacity Building:ChildFund Africa is engaged in improving program quality through systemic capacity building of NOs, area offices (AOs) and Partners structures, systems and roles in program design, monitoring and evaluation.This initiative has three objectives:

1. To enhance M&E quality through developing and rolling out design, monitoring and evaluation systems for NOs in the Region
2. To standardise and operationalise NOs M&E Plans as one of key ingredients within a design, monitoring and evaluation system
3. To increase staff M&E capacity by establishing and strengthening a cadre of Regional M&E champions
4. **Reporting:** A number of periodical reports are planned for this program: (1) monthly financial reports; (2) monthly progress reports; (3) quarterly progress reports (narrative, including analysis of M&E findings, and financial); (4) Annual reports - quarterly reports will be analysed by the the project coordinator to prepare an analytical annual progress report. (5) Project completion report. This will be a comprehensive analytical report giving an account of the project, narrative and financial. It will have critical appendices including but not limited to
5. Social analysis and action report
6. Gender analysis report
7. Publication of promising practices and lessons learnt

ChildFund has three levels of strategic planning: the Global Strategy, the Country Strategic Plan (CSP) and the Area Strategic Plan (ASP). The ASP or community plan is a three year program which is developed in a participatory manner involving local communities and government partners. Community-based partner organisations carry out area strategic planning with ChildFund staff. Children and youth are central in this planning process. The CSP guides NO’s programs and strategic decisions and define needed resources and growth strategy. It defines the priorities and objectives that NOs want to achieve over a five year period. NOs develop and align their strategies and plans in line with the Global Strategy. This allows for, consolidating, analysing and reporting progress against the core outcomes and the change ChildFund wishes to achieve as outlined in its Global Strategy.

# The IAPF has been designed within this strategic thinking. It contributes to the ASPs of the area which will allow measurement of commonly-agreed indicators within ChildFund Alliance to provide credible evidence of the contributions that ChildFund Alliance-supported programs are making to improve the wellbeing of vulnerable children and families in countries around the world.

1. **Ensuring Accountability to Program Beneficiaries**

Participation of beneficiaries in ChildFund programs is a cornerstone of its planning and implementation processes. The ChildFund ASP guide (2009) specifies five planning stages: Prepare and Commit, Conduct Community Reflections on Children’s Experiences of DEV, Synthesise Findings and Identify Program Responses, Validate Program Responses, and Plan Programs and Define Resources. In all these stages beneficiaries, especially children and youth are involved. Secondly, ChildFund monitoring systems includes a community component – Community Based Monitoring System (CBMS) in which beneficiaries are engaged in quarterly reviews and planning. Finally, annual reviews will provide another opportunity where ChildFund becomes accountable to beneficiaries.

# Annex 1: Results Framework –Ethiopia

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Hierarchy** | | **Indicators** | **Means of verification** | **Baseline value (from secondary)** | **End-line value (estimated)** | **Specific strategy** | **Important outputs (1-3 most critical)** |
| Goal/ impact | ALL children 0-5 years old in the programme area are protected and supported to have equal opportunities to realise their rights and develop to their full potential | 0.1 % of children age appropriate to enter school who are entering primary education, disaggregated by gender & vulnerability | School enrolment data/District Education Bureau | 15% | 40% |  |  |
| 0.2 Prevalence of stunting (height for age) among children 0-24 months, disaggregated by gender [& vulnerability (need specific definition of vulnerability, e.g., children with disabilities, children born from disabled parents, HIV/AIDs affected & infected)] | -Health post/center  -Survey report | 60% | 45% |
| Outcome / outcome | 1. Improved quality of ECCD services in the target areas | 1.0.1 Average attendance levels at ECD centres among age-eligible pre-school children (e.g., 3-5 years old); disaggregated by gender | - ECD center attendance records of children and reports; | 44 | 100 per ECD center (51 girls and 49 boys); 1,000 in 10 ECD Centers (510 girls and 490 boys) | Home & Centre Based strategy, Behavioural Change & Communication, VSL methodology, advocacy, partnership; Infrastructure development |  |
| 1.0.2 % of one-year-old children in target households with complete immunization, disaggregated by gender & vulnerability | -Health posts/ center reports;  -Project records/reports | 60% | 85% (51% girls and 49% boys) |
| Objective / outcomes & outputs | 1.1. To improve parenting knowledge & practice of caregivers of 0-5 years | 1.1.1 % of targeted caregivers that demonstrate good child care knowledge, disaggregated by gender of caregiver | -M/E reports; end-line household survey reports; regular program performance reports | 15% | 50% | Training and awareness raising; Behavioral change: linking with available services; | 1950 parents and caregivers trained in good parenting and child care practices  1500 children supported to complete immunization through the outreaches  40 community Health extension workers, community promoters and volunteers (trained and facilitated to conduct Home based care |
| 1.1.2 Proportion of households that are using / practicing at least one of the ECD promoted household interventions (VSL, nutrition practices, case management, etc) | -Regular project reports;  -M/E reports;  -End line report;  Mid-term review | 5% | 40% | Create awareness about the existing interventions; provide training on and enhance participation of households in the selected interventions |  |
| 1.2. To improve school readiness of 3-5 centre based children | 1.2.1 % of children transitioning from ECCD centres to lower primary school every year, disaggregated by gender & vulnerability. | -ECD centers records and primary school enrollment records | 5% | 60% | Construction and furnishing of ECD centers, training care givers, community sensitization | 8 ECD centers constructed and equipped  20 ECD Facilitators trained in school readiness for transition  20 lower Primary teachers trained in continuous learning for transition |
| 1.2.2 Quality (appropriateness) of physical environment of ECD centre by standard quality criteria (space available per child, safety precautions taken, presence of functional & clean sanitary facilities, availability of potable water, playground etc.) | -M/E reports;  -Regular project reports  -ECD center reports/records  -Physical observation | NA | 40% | -construction of minimum standard of ECD center  -Provision ECD services package(furniture, water and play grounds) |
| 1.3. To increase target household income to support ECCD interventions | 1.3.1 % of ECD centre income/funding coming from community support | -Monthly ECD financial records;  -Projects reports | NA | 25% of ECD revenue generated from parents | Establishing VS and L group, provide skill training; community mobilization | 45 VSL groups established, trained (9 at each Kebeles) and linked to Available MFI  45 VSLA Groups Trained and supported to establish IGAs |
| 1.3.2 % of children 0-5 whose caregivers participate in ECCD education & then support programmes. | -Project reports;  -Community information | None | 50% | Organizing training |
| Outcome / outcome | 2. Strengthened community structures for child care, protection & case management | 2.0.1 Ratio of number of community structures that are able to plan, implement, & monitor child care & protection programmes to the number of 0-5 y/o children in the programme area | -Project report  -M&E report  -End line survey | NA | 1:50 | Partnership with formal & informal structures, Systemic Capacity building  Policy & advocacy strategy |  |
| 2.0.2 % of child protection cases, disaggregated by gender & vulnerability, reported & managed according to professional standards | -Project reports  -law enforcing bodies report | 15% | 40% (70% female and 30% male) |
| Objective / outcomes & outputs | 2.1. To improve the capacities of identified community structures to care & protect children | 2.1.1 # of ECD centres with functioning Community Management Committees (need operational definition of functioning, linked to minimum standards for quality practice) |  | 2 | 10 | Construction of ECD Centers and establishing of ECD community management committee | 10 ECD community management committees and one cluster technical working committee established and trained for child protection and care  800 children supported to acquire birth registration certificates |
| 2.1.2 % of identified community structures involved with / responsible for children, with clearly defined ECD advocacy agenda & actively engaging with local authorities | Quarterly and annual reports | NA | 20% | Training and strengthening community structures |
| 2.2. To develop/strengthen referral networks of child care & protection service providers, (including health, education, legal & protection | 2.2.1 Proportion of child care & protection service providers who can demonstrate use of early childhood national guidelines (policy and/or strategy) in their practices |  | NA | 50% | Awareness creation on policy guideline to actors | 8 ECD advocacy events held at national and district level to influence rolling out of ECD Frameworks and budgetary provisions  100 mothers and children referred for medical and legal support through the referral networks  20 Service providers trained on Gender sensitive Child care, HIV/AIDS |
| 2.2.2 Proportion of child care & protection service providers with functioning referral networks (health, HIV, education, legal, & protection) [will need operational definition] | Quarterly and annual reports | 3 | 6 | Awareness creation on policy guideline to actors |
| Outcome / outcome | 3. Improved culture of learning & knowledge management on ECCD approaches & practices | 3.0.1 ECCD systemic changes at programmatic level (as shown by documented changes in guidelines, approaches, tools & processes) | Quarterly and annual reports | NA | TBD | Knowledge management & learning strategy; Temporary Duty & Experiential Learning Opportunity approach; Annual reflections & publications |  |
| 3.0.2 % of local authorities or districts (lowest budgetary and service level of government) in the programme area that are using ECCD good practices & approachesfor educational planning. | Project M and E report, Government report | NA | 15% |
| Objective / outcomes & outputs | 3.1. To develop & implement knowledge management strategy that facilitates frequent reflection & programme improvement | 3.1.1 Stakeholders (including children) feel their ideas & suggestions on ECCD are valued. [mixed qualitative & quantitative data needed] | End survey report;  Quarterly and annual reports | 5% | 40% | Training and community conversation | 8 stakeholders reflections meetings held and guide lines Adapted for ECD, Child Protection and VSL  Lessons and promising practices documented and shared annually |
| 3.1.2 Quality of reflection events planned, conducted & knowledge products produced, shared applied in programme management. [Using standard criteria or perceptions?] | End survey | 5% | 30% | Organizing discussion and reflection events for stakeholders |
| 3.2. To improve intra & cross country learning & KM for better ECD & Child Protection services | 3.2.1 New& improved practices in ECCD applied at country/ community level following Experiential Learning Opportunity (ELO). | Quarterly and annual reports | TBD | 30% | Organizing country and local forums | Intra and cross country lessons and reflections (including stakeholders) included in the revised ECD and Child Protection guidelines (strategies, policies, protocols and approaches)  60 staff and local partners trained in ECD and cross cutting issues (Project management, monitoring evaluation gender programming, child protection)  Annual program quality assessments and reviews conducted to inform program learning |
| 3.2.2 Changes in the ECD/child-protection -related knowledge, competencies & practices stakeholders (including staff) as a result of programme-generated evidence & learning. | Survey results, Annual and quarterly reports | 5% | 45% | Through print and electronic media, organizing workshop and training |

Annex 2 **M&E Plan**

| **Indicator** | **Definition of the indicator (short explanation of indicator)** | **Sources of information** | **Methods of data gathering** | **Who to collect, analyse data** | **Frequency of reporting (& to whom)** |
| --- | --- | --- | --- | --- | --- |
| **Programme Goal: ALL children 0-5 years old in the programme area are protected & supported to have equal opportunities to realise their rights & develop to their full potential** | | | | | |
| % of children age appropriate to enter school who are entering primary education, disaggregated by gender & vulnerability, and history of ECD participation/exposure | # of new entrants to primary grade one who have attended organized ECD programme to at least 3 months of the last school term, expressed as a percentage of total number of new entrants to primary grade one | * Programme targeted households * ECD centres and primary schools enrolment records | * Household (HH) baseline survey. * Evaluations * Review of schools enrolment. | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation |
| Prevalence of stunting (height for age) among children 0-24 months, disaggregated by gender &vulnerability | # of boys and girls 0-24 months who are below minus two standard deviations from median height for age of the reference population by the total number of boys and girls 0-24 months that were measured | * Health facility records * Households survey reports | * HH baseline survey. * Evaluations | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation |
| **Outcome 1: Improved quality of ECD services in the target areas** | | | | | |
| Average attendance levels at ECD centres among age-eligible pre-school children (e.g., 3-5 years old); disaggregated by gender.   1. *Net ECD enrolment ratio* 2. *Average attendance levels* | 1. the ratio of the number of children of official ECD age (3-5 y/o) who are enrolled in ECD centres to the total population of children of that age in the target programme areas  2. the ratio of total enrolled children in ECD centres that attend ECD programmes at least 3/5 days a week over the number of children enrolled in the same ECD centre, disaggregated by gender | * Programme targeted households * ECD centres enrolment and attendance records | * HH baseline survey. * Evaluations * Review of ECD enrolment and attendance records. | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation * Quarterly * Annual |
| % of one-year-old children in target households with complete immunization, disaggregated by gender and vulnerability | Basic complete child immunisation doses comprise BCG, Polio (0, 1, 2, 3), DPT (1, 2, 3), Measles and Vitamin A (Dose 1 & 3) | * Programme targeted households | * HH baseline survey. * Evaluations | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation |
| **Objective 1.1: To improve parenting/caregiver knowledge & practice of parents/caregivers of 0-5 years old children** | | | | | |
| % of targeted parents/caregivers that demonstrate good child care knowledge, disaggregated by gender | Effective parenting includes meeting the child’s basic physical needs, developing a secure and positive attachment between parent and child and developing a child’s social and cognitive skills. | * Programme targeted households | * HH baseline survey. * Evaluations | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation |
| Proportion of households that are using / practicing at least one of the ECD promoted household interventions | Interventions to be promoted by the programme include: nutrition practices, child illnesses/symptoms management, VSL, business planning | * Programme targeted households | * HH baseline survey. * Evaluations | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation * Quarterly/Annual |
| **Objective 1.2: To improve school readiness of 3-5 year old centre based children** | | | | | |
| % of children transitioning from ECD centres to lower primary school every year, disaggregated by gender vulnerability, and extent of ECD exposure | All children (100%) that have attended at least some ECD and attained age 6 or thereabout will transition from ECD centres to grade one. | * ECD centres and lower primary school records | * Baseline survey. * Evaluations * Annual reviews | * Programme teams (collect survey data), Consultant (analyse) * Programme teams | * Baseline * Midterm * End evaluation * Quarterly/Annual |
| Quality (appropriateness) of physical environment of ECD centre by standard quality criteria | Standard quality criteria include space available per child and learning materials, safety precautions taken, presence of functional & clean sanitary facilities, availability of potable water, playground and play materials etc. | * ECD compounds * ECD inspection reports by local authorities. | * Baseline survey. * Inspections using standard checklists | * Programme teams | * Baseline * Midterm * End evaluation * Quarterly/Annual |
| **Objective 1.3: To increase target household income to support ECD interventions** | | | | | |
| % of ECD center income/ funding coming from community support | Monetised communities contribution (monetary and in-kind) using a common system measured against the total ECD centre annual budgets. | * ECD centres budgets * CCCP annual reports | * Baseline survey. * Annual planning and reviews | * Programme teams | * Baseline * Midterm * End evaluation * Quarterly/Annual |
| % of children 0-5 whose parents/ caregivers participate in ECD education & then support programmes | CCCP will enrol parents/caregivers of all children 0-5 y/o in Family Education and Support education on child rearing, protection and development. | * Programme targeted households * ECD centres * CCCP quarterly reports | * Baseline survey. * Evaluations * Annual reviews | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation * Quarterly * Annual |
| **Outcome 2: Strengthened community structures for child care, protection & case management** | | | | | |
| Ratio of number of community structures that are able to plan, implement & monitor child care & protection programmes to the number of 0-5 y/o children in the programme area | CCCP will work through formal and informal child protection structures that will be trained on planning and implementing child protection programmes. They will be linked to formal structures. | * Community structure committees reports * CCCP quarterly reports | * HH baseline survey. * Evaluations * Annual reviews | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation * Quarterly * Annual |
| % of reported child protection cases, disaggregated by gender & vulnerability that are managed according to professional standards | This indicator will be linked to national documents for specific standards. This means a review of relevant documents from each of the three NOs. | * Identified formal & informal child protection structures * Households | * Baseline survey * Quarterly reviews | * Programme teams (collect) * Consultant (analyse) | * Baseline * Midterm * End evaluation * Quarterly * Annual |
| **Objective 2.1: To improve the capacities of identified community structures to care & protect children** | | | | | |
| % of ECD centres with functioning Centre Management Committees | A functioning Centre Management Committee will have a written constitution, regular meetings with agendas, minutes and actions. The constitution will include scope of work/terms of reference/role of the CMC (i.e., its function) | * ECD centre records * CCCP quarterly progress reports | * Baseline survey. * Evaluations * Quarterly reviews | * Programme teams | * Baseline/Midterm * End evaluation * Quarterly/Annual |
| % of identified community structures involved with /responsible for children, with clearly defined ECD advocacy agenda & actively engaging with local authorities | Community structures will engage local institutions (governments, NGOs, private sector, etc) to increase support for ECD programmes. | * formal & informal child protection structures * CCCP quarterly and annual reports | * Baseline survey * Document reviews | * Programme teams (collect) * Consultant (analyse) | * Baseline, Midterm * End evaluation * Quarterly, Annual |
| **Objective 2.2: To develop/strengthen referral networks of child care & protection service providers, (including health, education, legal & protection)** | | | | | |
| Proportion of child care & protection service providers who can demonstrate use of early childhood national guidelines (policy and/or strategy) in their practices | Local child care & protection service providers in this programme are district authorities from education, legal, health departments/sectors. The indicator establishes availability, knowledge of and utilization of early childhood national guidelines (policy and/or strategy) by these providers. | * Childcare & protection service providers records * CCCP quarterly and annual reports | * Baseline survey * Document reviews | * Programme teams (collect) * Consultant (analyse) | * Baseline, Midterm * End evaluation * Quarterly, Annual |
| Proportion of childcare & protection service providers with functioning referral networks (health, HIV, education, legal, & protection | Functioning referral network - members of the networks known to each other with their areas of child specialisation and mandate, have laid down referral protocols, have records of all community structures, have a clear communication procedure between formal and informal child protection structures. | * Childcare & protection service providers records * CCCP quarterly and annual reports | * Baseline survey * Document reviews | * Programme teams (collect) * Consultant (analyse) | * Baseline, Midterm * End evaluation * Quarterly, Annual |
| **Outcome 3. Improved culture of learning and knowledge management on ECD approaches and practices** | | | | | |
| ECD systemic changes at programmatic level (as shown by documented changes in guidelines, approaches, tools & processes). | Available ECD programming approaches within ChildFund and CCCP contribution to improving the ECD programming in ChildFund. | * ChildFund ECD guidelines * CCCP promising practices | * Document reviews | * Programme teams (collect & analyse) * Consultant (analyse) | * Baseline, Midterm * End evaluation |
| % of local authorities or districts (lowest budgetary &service level of government) in the programme area that are using ECD good practices & approaches for educational planning. | Influence of programme to local authorities planning and resource allocation to ECD. | * Local authorities plans and budgets * ECD centres plans and budgets * CCCP annual reports | * Document reviews | * Programme teams (collect & analyse) * Consultant (analyse) | * Baseline, Midterm * End evaluation |
| **Objective 3.1: To develop and implement knowledge management strategy that facilitates frequent reflection and programme improvement** | | | | | |
| Stakeholders (including children) feel their ideas & suggestions on ECD are valued. [mixed qualitative & quantitative data needed]. | Annual and reflections offer opportunities for reflections and planning. CCCP annual plans and reports will reflect stakeholders’ views. | * Reflection reports * Annual plans and budgets * CCCP quarterly and annual progress reports | * Reviews and reflections * Planning meetings | * Programme teams (collect & analyse) | * Quarterly and annual |
| Quality of reflection events planned, conducted & knowledge products produced, shared applied in programme management. [Using standard criteria orperceptions?] | Quarterly and annual reflections will be guided by reflection criteria to be developed as part of the Learning Strategy at the end of Year 12/early Year 13. | * Learning Strategy * Reflection reports. | Field & Exchange visits. | * Programme teams (collect & analyse) | * Quarterly and annual |
| **Objective 3.2. To improve intra and cross country learning and KM for better ECD and Child Protection services** | | | | | |
| New & improved practices in ECD applied at country/community level following Experiential Learning Opportunity (ELO). | Lessons learnt from ELO will be discussed during programme reviews and ECD promising practices documented and applied at country/community levels to improve ECD services provision. | Experiential Learning Opportunities and learning exchange visits reports | Programme support assignments and reviews | Programmes teams | Quarterly and annual |
| Proportion of stakeholders able to demonstrate solid knowledge and competence on basic ECD and child protection issues (disaggregated by staff, partners, other ECD/Child Protection providers in the community) | Identify CCCP stakeholders, have their initial knowledge and competence on ECD and child protection assessed and, using appropriate curriculum, facilitate their training. | * Targeted households * Targeted local authorities * ECD centres | * Reviews * Meetings * Observations | Programmes teams | * Baseline evaluation * Quarterly and annual * Mid and end evaluation |

1. Lowest level of government administrative structure. [↑](#footnote-ref-2)
2. The Ethiopian Aids Resource Centre, 2010 [↑](#footnote-ref-3)
3. Government lowest administrative unit [↑](#footnote-ref-4)
4. Africa Region Human Development, Marito Garcia (mgarcia1@worldbank.org) or Michelle Neuman (mneuman@worldbank.org) [↑](#footnote-ref-5)
5. The training will be based on a National Training Curriculum on Child Protection - Harmonization, Standardization and Institutionalization of Child Protection Training Materials in Uganda jointly produced by TPO Uganda, Ministry of Gender, Labour and Social Development, OAK Foundation and UNICEF [↑](#footnote-ref-6)
6. OECD-DCA, AFB/B.8/8, October 2009. [↑](#footnote-ref-7)
7. Competencies are defined as “…particular combinations of knowledge, skills, and dispositions – that seem to underpin successful learning, growth to adulthood, and adulthood itself” (Wylie & Thompson, 2003). [↑](#footnote-ref-8)