January 2010

School Health and Nutrition Manual:

A Guide for program planning and implementation in Bangladesh

School-based Health Services

Health Education

Water and Sanitation

Community Support

Save the Children®
USA

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Introduction

The purpose of this manual is to guide Save the Children School Health and Nutrition program staff, old and new staff alike, and implementing partners in Bangladesh on how to implement the SHN activities, setting out some basic programming standards. This manual is a reference point and should be followed and used by all relevant program staff and agreed partners, starting from program design and planning to implementation, monitoring and reporting of SHN programs in primary and pre-schools, and in the community.

Save the Children USA, Bangladesh Country Office manages different programs in the field of health, education, food & nutrition, food security, adolescent development and HIV/AIDS, covering all six divisions of Bangladesh. The SHN program targets primary school and pre-school aged children. The main aim of SHN is to improve children's health and nutrition status so as to improve their educational performance and remove all health related factors that prevent children from learning and performing well at school.

The manual is divided into 6 chapters. Chapter 1 gives an overview of Save the Children (mission, guiding principles, priority results and strategies), including Save the Children's work in Bangladesh. Chapter 2 introduces SHN (rationale and guiding framework) and describes the SHN need and Save the Children's SHN programs in Bangladesh; Chapter 3 provides guidance on designing an SHN program using the SHN Results Framework and the agency approved program cycle as a basis; Chapter 4 describes how the program planning process at every level (school/community, district, national and Save the Children); Chapter 5 describes each intervention by Intermediate result and how it is implemented; Chapter 6 lays out the requirements for monitoring, supervision and reporting.

The primary users of this manual will be staff working for Save the Children, particularly SHN Program staff and implementing partners. It is an organizational reference document and can be used at any time by staff for reference purposes. This manual should be used in program implementation by field staff and management and for supervision and monitoring by the supervisor. It can also be used in program planning and design by Save the Children or by its partners.

Schoolboys

Preface

Save the Children's SHN program in Bangladesh has grown significantly over the past few years, thanks to generous funding from GlaxoSmithKline, Dubai Cares, and Save the Children's own private funds. As the government of Bangladesh moves forward with the national SHN strategy, SHN is likely to grow further and be taken up by more partners on the ground. SHN is one of four core programs supported with Save the Children's sponsorship fund, alongside ECD, BE and AD working together to improve the lives of children and their communities. These programs are developed inline with international frameworks and evidence and adapted to the local context. Save the Children's goal is to create a model program in country which can be replicated and scaled up by partners. SHN addresses the key health and nutrition problems that prevent children from attending and learning to their full potential. Since SHN is relatively new in Bangladesh and few partners are implementing a comprehensive SHN program, there is very little capacity in the field to implement SHN.

This operation manual is designed to establish the base references from which Save the Children SHN programs should be managed and operated. The procedures found herein establish the responsibilities of Save the Children staff and partners. This manual should also help program managers and supervisors to act with a greater degree of certainty in terms of design, planning, implementation, monitoring and the supervision of the decisions and actions generated throughout the program. The manual helps establish responsibility for specific duties and lays down procedures for the performance of those duties.

This manual should be a reference point for all Save the Children program staff, and should be followed and used by all program staff and partners. It is important that all program staff familiarize themselves with the contents of the manual and all procedures contained within. Compliance with the stated procedures is expected from all SHN personnel responsible for implementing SHN programs in the field.

We hope that this manual will facilitate the work on behalf of children that drives us as individuals and as an organization. Many thanks to all of the program staff of Save the Children for their commitment to making a difference in the lives of children in need.

Kelland Stevenson
Country Director

Useful Acronyms

AUEO	Assistant Upazilla Education Officer
AD	Adolescent Development
AP	Annual Plan
BdCO	Bangladesh Country Office
BCP	Behavior Centered Programming
BE	Basic Education
BRAC	Bangladesh Rural Advancement Committee
CASP	Common Approach to Sponsorship-funded Programming
CBIRD	Community-Based Integrated Rural Development
CO	Country Office(s)
CS	Civil Surgeon
DCD	Deputy Country Director
DGHS	Directorate General of Health Services
DGPE	Directorate General of Primary Education
DIP	Detailed Implementation Plan
DM&E	Design, Monitoring & Evaluation
DPE	Directorate of Primary Education
DPEO	District Primary Education Officer
DPHE	Department of Public Health Engineering
ECD	Early Childhood Development
EFA	Education For All
EPI	Expanded Program on Immunization
FAK	First Aid Kit
FPO	Family Planning Officer
FRESH	Focusing Resources on Effective School Health
FW	Field Worker
GOB	Government of Bangladesh
GPS	Government Primary School
INGO	International Non-Governmental Organization
IR	Intermediate Results
MDG	Millennium Development Goals
M & E	Monitoring and Evaluation
MOH	Ministry of Health
MOH&FW	Ministry of Health & Family Welfare
MOLGRD	Ministry of Local Government Rural Development
MOPME	Ministry of Primary and Mass Education
NCTB	National Curriculum & Test Book Board
NDD	National Deworming Day
NFPE	Non Formal Primary Education
NGO	Non-Governmental Organization
NID	National Immunization day
NTB	National Textbook Board
ORS	Oral Rehydration Salts
PHASE	Personal Hygiene and Sanitation Education
PIT	Process Indicator Tool
PR	Priority Result
PRSP	Poverty Reduction Strategic Process
PTA	Parent Teacher Association
RF	Results Framework
RIPT	Result Indicator Planning Tool
RSH	Reproductive Sexual Health
SB	Student Brigade(s)
SCA	Save the Children Australia
SCSD	Save the Children Sweden-Denmark
SCUK	Save the Children United Kingdom
SC/US	Save the Children USA
SHN	School Health and Nutrition
SIP	Summary Implementation Plan
SLIP	School Level Improvement Plan
SMC	School Management Committee
SO	Strategic Objective
UEO	Upazilla Education Officer
UH	Upazilla Health
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UP	Union Parishad
WATSAN	Water and Sanitation
WFP	World Food Program
WHO	World Health Organization
WWO	Westport Washington Office

Acknowledgements

This manual is the first one produced by a Save the Children Country Office, which provides guidance on all elements of SHN programming. This manual was produced with funding from GlaxoSmithKline and is based on experience implementing the GlaxoSmithKline and Save the Children funded PHASE (Personal Hygiene And Sanitation Education) and SHN program in Bangladesh.

It has been a long journey to develop this comprehensive document and to follow the series of steps required in the process of manual development. We would like to thank A. B. M. Moazzem Hossain, Kurratool Ayen Shuja, Md. Hasanuzzaman, Md. Shahad Uddin Thakur, Choyan Kumar Talukder, Syed Nashidul Hoque, Mohd. Monjurul Islam, Md. Habib Mahmood, Akter Hossain, Dr. Ataur Rahman and Dr. Ikhtiar Uddin Khandaker for their hard work and valuable contributions in the design and development of this document.

We are very grateful to Margarita Clark and Natalie Roschnik for their comments on drafts of this manual and for their support to make it user friendly.

We would also like to thank Mohammad Aslam for editing and for comments on drafts to make it more perfect and contextual.

We would like to thank Erica Khetran, Carmel Crawford and Helen Waller for editing and designing the manual.

Finally, we would like to thank Kelland Stevenson for approving this document for publication.

Chapter 1
Save the Children

Chapter 1 presents the guiding principles of Save the Children's work, it's vision, mission, and the four priority results and strategies to achieve its intended impact. It also provides a short background on Save the Children's work in Bangladesh.

Save the Children fights for children's rights. It delivers immediate and lasting improvements to children's lives worldwide. Save the Children works for:

- A world which respects and values each child
- A world which listens to children and learns
- A world where all children have hope and opportunity

Working together, Save the Children represents the world's largest independent global organization for children with programs in over 120 countries. Save the Children was founded on 19 May 1919 by Eglantyne Jebb, the woman behind the Charter on Children's Rights, which formed the basis of the Convention on the Rights of the Child[1].

Save the Children's Mission:

To create lasting positive change in the lives of children in need.

Operational definitions of Save the Children's principles:

Save the Children has established a set of Program Principles to reinforce and guide its programs. These principles represent the underlying foundation of all of Save the Children's programming.

Child-Centeredness
Children are central to Save the Children's mission. Programs in economic opportunities, education, health, and humanitarian response address the rights of girls and boys as well as their physical, intellectual, social, and emotional needs.

Gender Equity
Save the Children programs support a woman focus as a matter of equity and principle to ensure maximum benefits to girls and boys. In recognition of women's multiple roles and contributions to their families and communities, Save the Children programs promote increased equality, initiative, and leadership of women and men resulting in sustainable development.

Empowerment
Programs are designed to increase the capacity of disadvantaged groups to make choices, and take actions on their own behalf with self-confidence from a position of economic, political, and social strength. Participation and empowerment are linked and mutually reinforcing.

Sustainability
Programs seek to make lasting, positive change in institutions, behaviors, or policies that affect human wellbeing. This is accomplished by enabling individuals, communities, and institutions to adopt new behaviors and systems that promote change and endure beyond Save the Children's involvement. Save the Children recognizes, promotes, and supports sustainability at four levels within its programs: institutional, financial, behavioral, and policy.

[1] The first legally binding international instrument to incorporate the full range of human rights: civil, cultural, economic, political and social. Adopted by the United Nations General Assembly on 20 November 1989; after ratification it came into force 2 September 1990.

Scaling-Up

Save the Children seeks to expand programs that have far-reaching and measurable impact on the lives of children. Key strategies include expanded geographic coverage, pursuit of partnerships to increase the extent of program impact, focused support of policy and legislative activities that benefit children, and development of new models of collaboration, new technologies, and new fundraising relationships that can achieve impact on a greater scale than was previously considered possible.

Measurable Impact

Save the Children seeks to demonstrate positive impact on women and children through clear objectives and systematic collection of information about activities and program outcomes. This is done to improve program effectiveness and to articulate what Save the Children programs have accomplished.

Four Priority Results and four strategies

Save the Children's intended impact is that children are safe, educated and healthy, and better able to attain their rights. To achieve this intended impact, Save the Children is pursuing four priority results (figure 1) with four key strategies (figure 2):

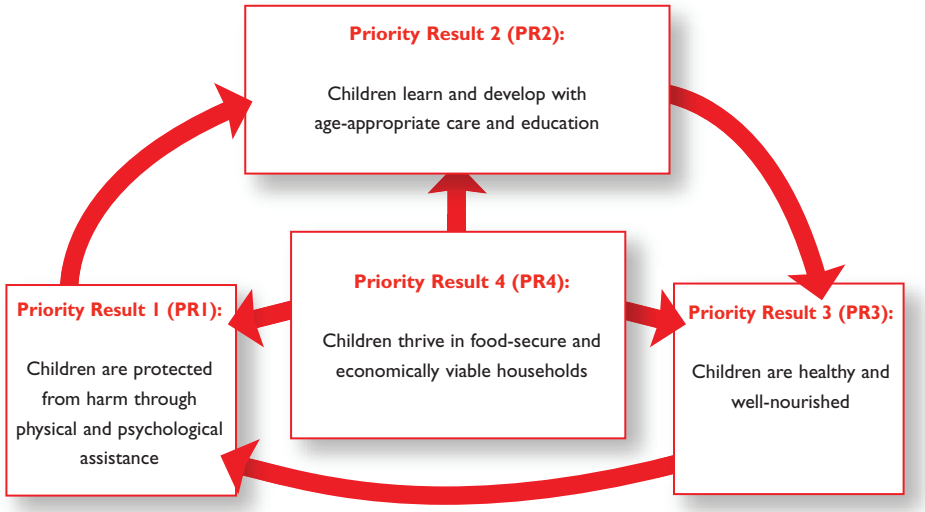


Figure 1 : Save the Children's Priority Results.

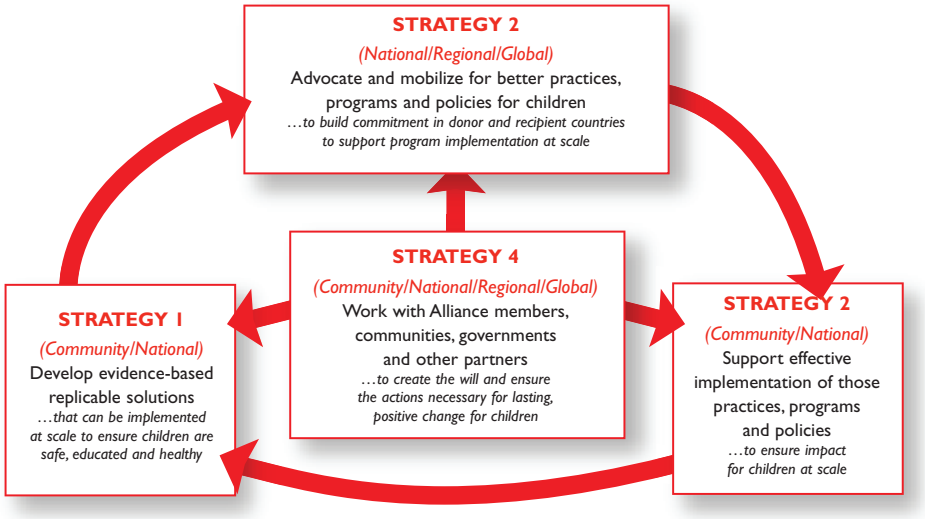


Figure 2 : Save the Children's Strategies

SHN contributes primarily to PR2 because it's main goal is to improve children's ability to learn and develop. Since school age children are less likely to die from the health problems they encounter, the main argument for improving their health is an educational one, which is why SHN is in PR2. However SHN also contributes to PR3 by improving pre school and primary school children's health and indirectly by influencing the health of their family and their community today and as they become adults and parents in the future.

Save the Children in Bangladesh

Save the Children currently includes 29 members, which are gradually coming together as one agency, with a common vision and strategy. In Bangladesh, there are currently four Save the Children members, including, USA, UK, Australia and Sweden, these will eventually be unified into one single Save the Children. This manual was developed by Save the Children USA in Bangladesh.

In Bangladesh, Save the Children promotes the realization of the UN Convention on the Rights of the Child through direct implementation, support to partner organizations, networking and advocacy.

The main thematic areas are:

- Health and Nutrition
- Education
- Non-discrimination
- Poverty alleviation and children's work
- Violence, juvenile justice, sexual abuse and trafficking
- Children's rights, citizenship, and participation
- Poverty Reduction Strategy Process (PRSP) and children

The US branch of Save the Children came to Bangladesh in a relief role immediately after the cyclone of 1970. Its rehabilitation program began in 1972 when Save the Children worked closely with the Co-ordination Division of the Prime Minister's Secretariat. Save the Children then worked under the Ministry of Local Government and Co-operatives. Since 1973-75 its Community-Based Integrated Rural Development (CBIRD) Program has been consistent with the Bangladesh Government's Rural Development strategy as articulated in its development plans.

Save the Children's programs seek to complement the government's plan, filling those gaps that arise in essential programs due to resource constraints. Since May 1990 Save the Children has been working under the NGO Affairs Bureau of the Government of Bangladesh.

The Program components are:

- Health, Population and Nutrition
- Education
- Emergencies and Humanitarian Response
- Food Security

Save the Children Guiding Values	Save the Children Program Principles
Accountability Commitment Excellence Innovation Teamwork	Child-centeredness Gender Equity Empowerment Measurable Impact Scaling-Up Sustainability

The Common Approach for Sponsorship-funded Programming (CASP)

A large part of Save the Children USA's private funding comes from child sponsorship. Sponsorship is a fund raising mechanism where by individual donors (called sponsors) are linked to individual or representative children in Bangladesh. It provides regular funding to support Save the Children's programs. Sponsorship is important to Save the Children because it is a steady, reliable source of funding, which allows for long-term programming and innovation. Specifically, it allows Save the Children to:

- **Promote evidence-based, replicable solutions, which can be taken to greater scale.**
- **Develop, pilot, and document innovative solutions towards the advancement of children's education, health and wellbeing.**
- **Continuously improve program quality based on local evidence and experience.**
- **Build community and partner capacity to sustain programs.**
- **Leverage other sources of funding so that we may reach even more children.**

CASP is the framework that defines the program focus for Sponsorship-funded programming. CASP is designed to ensure that Sponsorship achieves its goal of implementing higher quality field programs by concentrating resources on children 3-18 years, building on Save the Children's better practices, and supporting a results-oriented and information-based learning process.

CASP focuses on five core program areas: Early Childhood Development (ECD); Basic Education (BE); School Health and Nutrition (SHN); Adolescent Development (AD); and HIV/AIDS. These core programs are defined in documents called Core Program Modules, which can be found on savenet.

Save the Children Country Offices (COs) that receive funding from sponsorship must spend 75% of their sponsorship funds in one or more of sponsorship's four Core Program Areas. The goal of CASP is for Country Offices to successfully design, implement, monitor, and evaluate programs.

The CASP approach to the program cycle emphasizes not only a standard process for design, monitoring and evaluation, but also a process of continuous improvement. All programs should follow the CASP Program Cycle, and should collect information about program implementation that is used to modify and improve future program operations. For more information, read the CASP Design, Monitoring and Evaluation (DM&E) Module, which is available on savenet.

Save the Children's Vision:

Save the Children, by mobilizing citizens throughout the world, envisions a world in which every child is ensured the right to survival, protection, development, and participation as set forth in the UN Convention on the Rights of the Child.

Chapter 2
School Health and Nutrition

Chapter 2 gives an overview of SHN internationally and within Save the Children. It describes the rationale for implementing SHN, the internationally agreed framework for SHN, Save the Children's SHN Programs worldwide, the SHN need in Bangladesh and the history of SHN Programming by Save the Children in Bangladesh.

Rationale

Estimates suggest that between 25 and 35 percent of school age children in the world are infected with one or more parasitic worms, between 48 and 56 percent are stunted, 53 percent suffer from iron deficiency anemia, 5 percent remain affected by iodine deficiency and 7 per cent by vitamin A deficiency. In many cases, children don't know they have a health problem, and their under-nutrition, fatigue and inability to concentrate is considered normal. But these mild chronic infections may have a substantial effect on their school attendance and their ability to learn. Children who lack certain nutrients in their diet, particularly iron and iodine or who suffer from protein-energy malnutrition, hunger, or parasitic infections, are more likely to be absent from school than healthy children or to have a diminished capacity for learning. Unhealthy or malnourished children are also more likely to repeat grades and drop out of school.

School health and nutrition programs aim to prevent and treat the causes of ill health that affect children's ability to learn, while creating a safe and supportive school environment that promotes healthy behaviors. Simple interventions such as regular deworming and micronutrient supplementation can prevent children from becoming anemic and can have a substantial effect on their school performance. Hand washing with soap is among the most effective and inexpensive ways to prevent diarrheal diseases and pneumonia, which together are responsible for the deaths of more than 3.5 million children under 5 years. Promoting healthy behaviors through school, such as hand washing with soap, is a very effective way of improving the health of the entire community today and in the future, as these children become parents themselves.

Improving the health and nutrition of children also has an impact on children's education and community development more generally. Healthy and well-nourished children stay in school longer than malnourished children; they learn more and become healthier and more productive adults. Keeping girls enrolled in school can delay the age at which they first get pregnant, and such girls tend to have fewer babies than girls who drop out of school, with babies who are heavier and healthier. These outcomes are difficult to measure, as they show effects from one generation to the next, but they are no less important.

FRESH framework: A Global framework for SHN

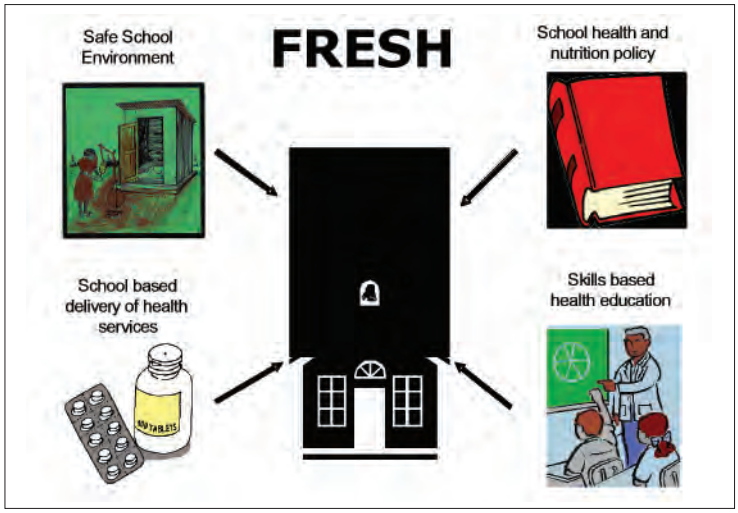


Figure 3 : The FRESH Framework

At the Dakar World Education Forum in 2000, international organizations (WHO, UNICEF, UNESCO and the World Bank) agreed that SHN was essential to reaching Education For All Goals and a framework was developed outlining the key elements of SHN Programming – the FRESH (Focusing Resources on Effective School Health) Framework is a common approach to SHN programming (Figure 3). It forms a starting point for program design and establishes the basis for country programming.

The four components of the FRESH Framework are:

- School based delivery of health and nutrition services
- A safe school environment
- Skills based health education
- School health and nutrition policies

SHN is highly cost-effective because: a) it uses generalized approaches such as mass deworming or micronutrient supplementation rather than selective treatment based on a diagnosis, and b) it uses the existing health and education systems. Because there are generally more schools than health centers, school-based health interventions reach more homes and more children, including non-school going children and their families.

Save the Children's SHN programs

In 2008, Save the Children's SHN programs reached around 1.4 million school-age children in over 3,400 schools in 19 countries across Africa, Asia, the Middle East, Latin America, and the Caribbean. Internationally, Save the Children is one of the leading Non-Governmental Organizations (NGOs) in SHN and, in many countries, the only international NGO implementing a comprehensive SHN program. Save the Children is recognized for its innovative approaches to reaching school-age children in poor communities providing treatments for common illnesses such as malaria and intestinal parasites. Save the Children works at various levels to address the health and nutrition problems of school-age children. At the community level, Save the Children mobilizes and supports community and parent partnerships with schools for the delivery of school-based health and nutrition services and the promotion of healthy behaviors.

Using the successful model of delivering SHN through community and formal schools, Save the Children has increased its impact through advocacy, government partnership, and the establishment of national SHN policies and programs.

The SHN situation in Bangladesh

In Bangladesh, both malnutrition and micronutrient deficiencies remain significant problems that limit children's potential to succeed in school. Among school-aged children, 32% are stunted[2], 70% are underweight[3], 13% are wasted[4] , 55% are anemic[7] and 34% have iodine deficiency[6]. But among the adolescent population, 98% of girls are anemic and 94% of boys are anemic[7]. Although rates vary across the country by region and by age, wasting, stunting, anemia, and vitamin A and iodine deficiencies are all significant, current public health problems in Bangladesh. As an example, a survey conducted by Save the Children in Meherpur district found that more than 75% of primary school children are anemic and 20% of children reported diarrhea in last two weeks[8]. Worm infections are also widespread, with over 50% of children infected in northern Bangladesh, and up to 97% infected in some districts.

Water and sanitation facilities are present in many schools. However, nearly a quarter of the water points are contaminated with arsenic. If consumed daily over many years, arsenic can cause cancer. Latrines are common in schools, but are often poorly maintained and are not always segregated by sex all child-friendly. This may discourage children and girls particularly from using them. Hand washing facilities are not common in schools, and soap is rarely available.

Save the Children began implementing elements of SHN within its education program in Nasirnagar, Brahmanbaria district, in 2002. In 2004, the program was strengthened to address all four recommended elements of SHN and covering six of Nasirnagar's 13 unions. In 2006, a new partnership with Glaxo SmithKline's PHASE (Personal Hygiene and Sanitation Education) program allowed Save the Children to strengthen the health education element of the program and scale it up to all 13 Unions of Nasirnagar. In 2008, the Brahmanbaria District Education Office requested Save the Children's support to introduce

[2] *Asiruddine, et al. 1998, Nutritional Status of Children in the BRACs Urban Primary Schools.*
[3] *Khurshid Talukder et al. 2002, Relationship between School Achievement and Nutritional Status of School Children in 20 Primary Schools in Rural Bangladesh.*
[4] *Save the Children USA 2004, Baseline survey report, SHN Program, February-March 2004.*
[5] *Save the Children USA 2004, Baseline survey report, SHN Program, February-March 2004.*
[6] *UNICEF 2001. www.unicef.org/Bnagladesh/child_ and _maternal_nutrition.pdf*
[7] *Shahabuddin AKM et al. 2000 Adolescent nutrition in a rural community in Bangladesh – 2000;67(2) 93-98*
[8] *Meherpur baseline report, Save the Children, 2008*

PHASE materials into the remaining 950 schools in the district, an effort which is entirely managed by the Ministry of Education. In 2008, Save the Children phased it's programming out of Nasirnagar to Meherpur district where a comprehensive SHN program, modelled after the program in Nasirnagar is now being implemented and will soon be covering the entire district. SHN has also been expanded to the non formal education sector with funding from Dubai Cares in the Northwest and Southwest regions of Bangladesh.

Save the Children is one of the few agencies in Bangladesh implementing a comprehensive SHN program and as a result is a key player in helping move the national SHN strategy in Bangladesh forward. In 2007, Save the Children was commissioned by the World Bank to conduct a national SHN Situation analysis which was then used as a basis to develop a national SHN strategy.

Rice field

Chapter 3
Program design

Chapter 3 summarizes Save the Children's SHN Results Framework which is the basis for SHN program design, and lists the key SHN interventions which contribute to each SHN result. It also describes Save the Children's recommended program cycle and each step within it.

SHN Results Framework

Save the Children's SHN Results Framework (RF) is a diagram (Figure 4) that shows how the program will produce positive change for children. It is in line with the international FRESH framework, but was adapted to the agency's generic results framework, which focuses on access (availability of services), quality, knowledge and attitudes and support and policy. There are four major levels in the results framework, from top to bottom:

1) The Goal, or "big picture" positive change sought.
2) **Strategic Objective (SO):** the measurable behavior change needed to reach the goal.
3) **Intermediate Result (IR):** the measurable, lower-level results that must be achieved in order to reach the SO. Each IR may be supported by several strategies, or kinds of activities. Achieving all of these lower-level results will ensure the achievement of the related SO and contribute towards the achievement of the Goal.
4) **Indicators:** Indicators are yardsticks for measuring progress towards the IR and the SO.A full list of Save the Children's recommended SHN indicators is provided in annex 1.

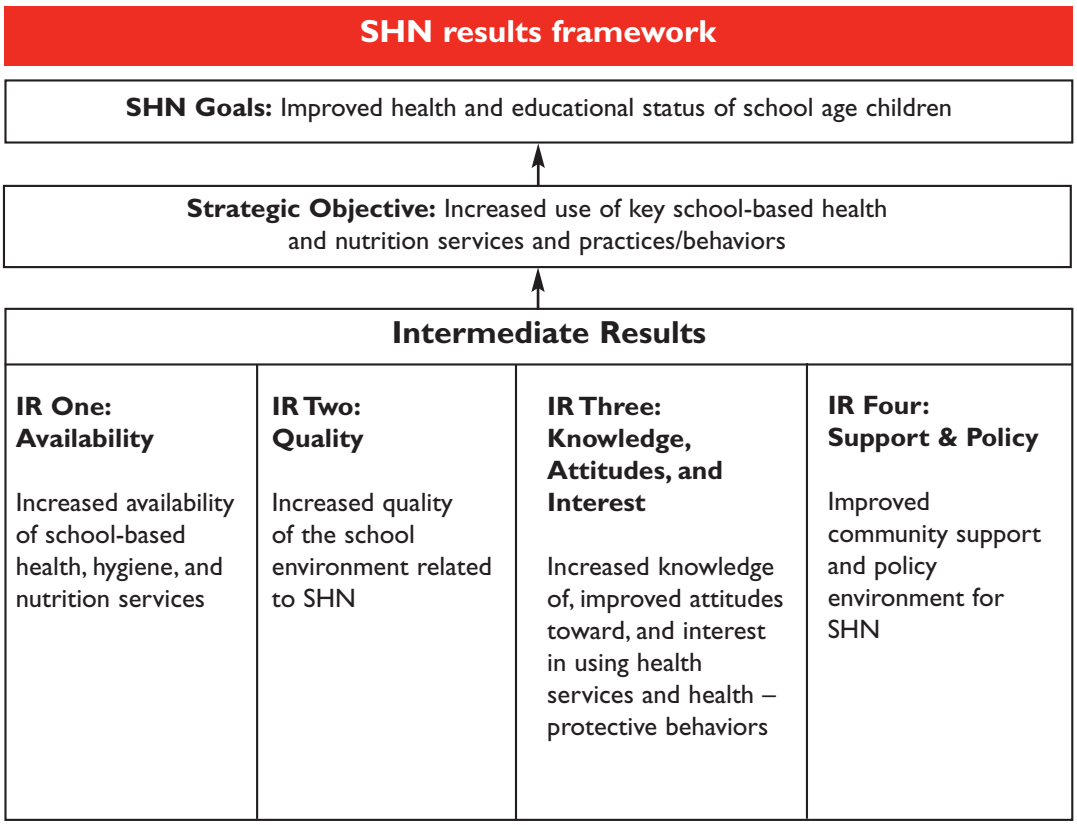


Figure 4 : Save the Children's SHN framework

IR One: Availability

The first intermediate result addresses problems of the availability of school-based health, hygiene, and nutrition services.

Strategies and activities for IR1 include:

- Iron, Vitamin A, or multi-vitamin supplementation
- Routine mass treatment of intestinal parasites
- Treatment of common health problems, e.g. eye infections, head aches and wounds
- Screening and treatment of vision or hearing impairments
- Psychosocial counseling for children

IR Two: Quality

The second intermediate result addresses the quality of the school environment, with a particular focus on access to water and sanitation facilities.

Strategies and activities for IR2 include:

- Provision of hand washing facilities and adequate latrines (including latrines for girls)
- Provision of potable water in schools
- Development of a system for maintaining SHN facilities, e.g. school hygiene committees

IR Three: Knowledge, Attitudes, and Interest

The third intermediate result addresses problems of child knowledge of, attitude towards, and interest in health services and health-protective behavior. Strategies to address this IR consist of behavior-centered health and nutrition education and communications.

Strategies for IR3 include:

- Skills-based health education to enable children to stay healthy and avoid risky behaviors
- Teacher training on skills-based health and nutrition education
- Training of health workers and community participants on the different elements of SHN services

IR Four: Community Support & Policy

The fourth intermediate result addresses problems of support systems and policy.

Strategies for IR4 include:

- Educating caregivers and parents on improving children's health and nutrition
- Training the SMCs to support and maintain SHN activities and a safe school environment
- Establishing security and safety in and around schools and establishing school health related policies with the community
- Working with key stakeholders from the community up to the national level to ensure effective program implementation, increase sustainability and create an environment favorable to meeting the health and nutrition needs of school-age children
- Advocacy to scale-up to national-level SHN programming

Save the Children's Bangladesh Country Office created a broader conceptual framework and results framework for all sponsorship funded programs, such as ECD, BE, SHN and ARSH, to show how together they respond to the needs identified in Save the Children's current impact area (Meherpur district). It was developed to encourage integration between the core programs and is summarized in Annex 2 and 3.

CASP Program Cycle

The implementation of the core sponsorship funded programs, including SHN, must follow Save the Children's recommended program cycle (Figure 3), which promotes a continuous improvement approach to programming. This approach emphasizes the program planning, monitoring and evaluation of activities using a standard process, and collecting program information in such a way that it can be used to modify and improve future program implementation. Guidance on each step of the program cycle is provided in the CASP DM&E Module[9].

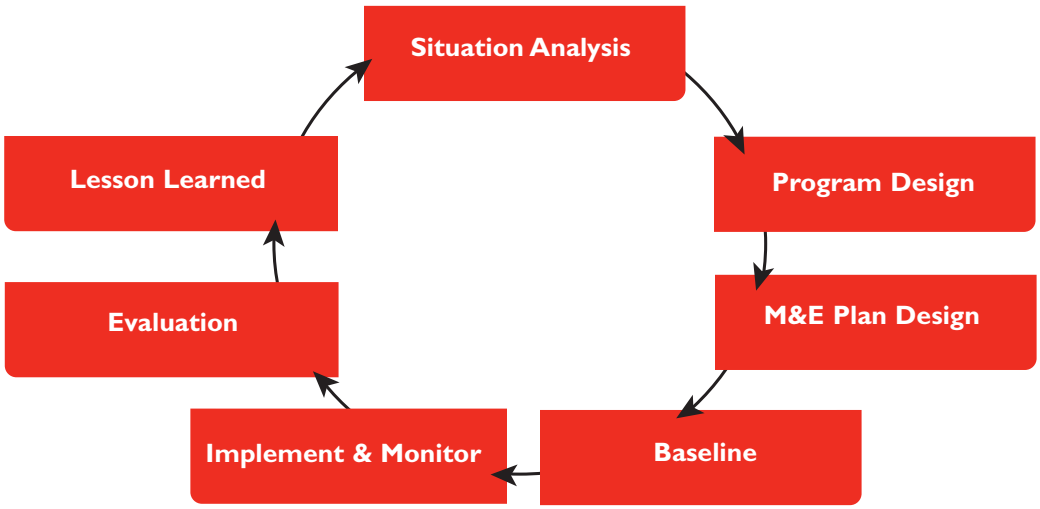


Figure 5 : CASP Program Cycle

Step 1: Situational Analysis

This step begins the program cycle by gathering information, needs, resources, conditions, and barriers to health and education in the impact area. These should be analyzed and the findings written up in a brief Situational Analysis Report.

Steps 2-5: Program Design

The CASP Core Program Modules and the findings from the Situational Analyses are the foundation for designing a quality program that is tailored to the needs of each impact area and takes into account established good practices from Save the Children's work around the world. The Target Population Tool. This process is essential for planning program implementation and for understanding the amount of resources required to reach program results. Next, the designer should select program strategies from the Key Strategies Matrix found in each Core Program Area Module. Then prepare a summary of the specific details of program design and implementation for inclusion in the Summary Implementation Plan (SIP). The SIP reports to WWO the key strategies and activities to be used to achieve the desired program results. It is updated and submitted to headquarters on an annual basis. Once the design for each of the core program areas is complete, it is necessary to write a Program Description to summarize why, what, who, how, and when the Sponsorship-funded program services will be implemented.

[9] Save the Children (2007), CASP Design, Monitoring & Evaluation Module

Steps 6-7: M&E Plan Design

Baseline values, or first-time values, for the selected results indicators should be collected after the situational analysis and program design and prior to program implementation, using appropriate data collection methods. For SHN this means conducting a survey in a sample of communities. The SHN baseline should be linked to the baseline of other core programs, they usually include an assessment of children's status, there and community KAP and the school environment may include service delivery use and quality assessments, surveys, or other methods designed for the specific program. All baseline findings should be documented in a short CASP Baseline Report, and recorded in the first column of the Results and Process Indicator Report (RPIR).

Steps 9-10: Implementation & Monitoring

Once implementation begins, results and process indicators should be regularly collected and reviewed. This data should then be used to periodically review and assess the effectiveness of the program implementation and design, and to examine how well Core Programs are progressing towards reaching desired results. Results Review should be done every six months, to examine current values and trends in both process and results indicators, identify key findings, and make relevant program decisions. The Results and Process Indicator Report (RPIR) should be used to report indicator data on an annual basis to WWO. The RPIR contains the baseline values and all annual values to date for results indicators, and compares process indicator values to the targets set at the beginning of the year. An accompanying RPIR Progress Narrative should explain the conditions and circumstances around program implementation progress: the "story behind the numbers." SHN indicators are also collected through the GOI.

Step 11: Evaluation

Evaluation helps to identify whether change has occurred in program sites over the course of implementation, and to assess the degree to which these changes resulted from Save the Children's programming. The DM&E module gives a brief overview of some approaches to evaluation design.

Step 12: Lessons Learned

During the process of review of the indicators, important lessons about the most effective strategies should be extracted. The process of identifying, documenting, and sharing the lessons learned should help all Save the Children staff to further improve the effectiveness of programs.

Focus Group discussion with women to discuss lessons learned in Nasirnagar.

Chapter 4
Program Planning

Chapter 4 describes how the program is planned at every level: school and community level, district/Upazilla and Union level, national level and within Save the Children. Program planning tools are also provided and explained.

Program planning is a process by which activities are set, responsibilities are distributed by time and by resources and accomplishment is assessed through ongoing monitoring of the plan. Save the Children's role is to build community, school and partner capacity to plan effectively by involving different stakeholders in the planning process and supporting the process by facilitating or participating in the different planning meetings. Effective planning at every level helps maximize the use of limited resources, transfer program ownership and responsibility to stakeholders and avoid duplication of efforts by the program.

Community Mobilization

Community mobilization is a capacity building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health, education and other needs. In general, community mobilization involves:

- Developing an ongoing dialogue between community members regarding health and education issues.
- Creating or strengthening community organizations aimed at improving their health and education.
- Assisting in creating an environment in which individuals can empower themselves to address their own and their community's needs.
- Promoting community member's participation in ways that recognize diversity and equity, particularly of those who are most affected by the health issue.
- Working in partnership with community members in all phases of a project to create locally appropriate responses to the health and education needs.
- Identifying and supporting the creative potential of communities to develop a variety of strategies and approaches to improve children's health and education.
- Assisting in linking communities with external resources (such as organizations, funding or technical assistance) to aid them in their efforts.

It is vital to commit enough time to work with communities, or with a partner who works with them, to accomplish the above. At every step of programming (planning, program design, monitoring and evaluation), community mobilization principles must be followed. These are described in more detail in *How to Mobilize Communities for Health and Social Change*, by the Health Communication Partnership (2003).

Community and School Level Planning

The first step in program planning is to invite the community and school to an orientation on Save the Children, its mission and values, and what it does or does not do. This should be followed by a discussion on how the community and Save the Children can work together and an agreement on some basic principals of working in partnership. Only once the orientation has taken place and a sense of mutual trust and understanding has been built can school level planning begin.

School Level Annual Plan

The annual action plan is a school level activity plan prepared jointly by the teachers, the SMC and PTA to cover one year's activities. The purpose of the plan is to reach a common set of objectives for the school to achieve during the year, plan activities to achieve these goals, monitor the activities throughout the year and at the end of the year, discuss what was and was not achieved, why and possible solutions. Developing and using the plan promotes community involvement and ownership of the program, builds community capacity to plan and monitor community and school development and encourages the use of local resources and long term sustainability

Standard Procedures

- A Save the Children staff member should always be present when developing the first plan to facilitate the process, since this may be the first time the community develops a plan. The role of Save the Children is as a facilitator and, when needed, technical advisor to the community. The plan must be developed and owned by the community.
- Every school should have one action plan for each calendar year, from January to December.
- Once the Action Plan has been developed at the school level, it should be approved by the Upazilla Education Office and displayed in the office room.
- Every month, the plan should be reviewed and discussed by the SMC in the SMC monthly meeting.
- Development of the Action Plan should be completed by February each year and all planned activities should be accomplished by December of that year.
- AUEO, UEO and the SHN team should follow up on the implementation of the planned activities during the school visit using the school visit checklist, which can be found in Annex 12.
- The Annual Plan should support the School Level Improvement Plan (SLIP), which is developed by a committee based on school need.

Upazilla[10] and Union[11] level planning

All Save the Children programs are planned with and supporting of government initiatives, either directly or indirectly, to reach specific targets. Within the government structure, there are offices at district, Upazilla or union levels, which are responsible for implementing or with the authority to be informed of the activities conducted by any other organization. All relevant departments at these different levels are duly required to be consulted or updated before program implementation begins. All organizations are required to report or notify the relevant government department about their school or community activities. Joint planning for Save the Children programs and participation in review meetings is vitally important to ensure the maximum support from government. There are additionally some ad-hoc meetings, such as meetings with the Deputy Commissioner, the Union, Parishad[12] and municipalities, held at different levels to plan for various National and International Days.

Standard Procedures

- Planning meetings should be held at the beginning of every type of program activity and whenever there is a need.
- Planning meetings typically held at district level are listed in table 1 and table 2 by type of facilitation or participation.
- Meetings can be joined if the timing and participation is similar.

[10] Districts are units of Divisions and provide decision-making and administrative support to Sub-districts
[11] Sub-districts, or Upazilla (also Upazilla) are units of districts, which give administrative direction to Unions
[12] Unions are the lowest administrative units in Bangladesh and are responsible for administering a number of villages

Table 1: Planning meetings facilitated or organized by Save the Children SHN staff

SL	Name of Activity	Frequency of meeting	level of meeting	Period	Participation	Content
1	SHN Yearly Program Planning and Review Meeting	1/year	District, Upazilla and Municipality	By January	CS, DPEO, Exen (DPHE), UH&FPO, UEO, AUEO & Mayor of Municipality	- Share previous year's performance - Review DIP and collect feed back
		5/year	Union level		Union Parishad, SMC Chairman, Community Elders	
2	School-wide Annual Action Plan Development and SLIP Meeting	1/year	District, Upazilla	By January	DPEO, UEO & AUEO	- Develop action plan - Follow-up /Supervision of activities - Reporting
3	Vitamin "A" Supplementation	4/year	District, Upazilla and Municipality	May & November	CS, DPEO, UH&FPO, UEO, AUEO & Mayor of Municipality	- Plan Vitamin "A" distribution - Orient partners - Plan awareness activities - Follow-up /Supervision - Reporting
4	Iron Supplementation	2/year	District, Upazilla and Municipality	March	CS, DPEO, UH&FPO, UEO, AUEO & Mayor of Municipality	- Plan Tablet distribution - Orientation - Awareness activities - Follow-up /Supervision - Reporting
5	Vision screening and treatment	3/year	District, Upazilla and Municipality	April - May	CS, DPEO, UH&FPO, UEO, AUEO & Mayor of Municipality	- MOU with partner -Teacher orientation - Vision screening schedule - Union-wise eye campaign schedule - Treatment - Follow-up / Supervision
6	First aid management	2/year	District, Upazilla and Municipality	June	CS, DPEO, UH&FPO, UEO, AUEO & Mayor of Municipality	- Head Teacher orientation - School-wide teachers and SMC schedule - Refill - Follow-up / Supervision
7	Safe water and Latrine	As needed	District, Upazilla and Municipality	March - June	DPEO, DPHE UEO & AUEO	- School selection for repair and construction /installation - Technical support - Follow-up / Supervision
8	Waste management	2/year	District, Upazilla and Municipality	April & July	DPHE UEO & AUEO	- School selection for construction waste corner - Follow-up / Supervision
9	Cluster-wide Teachers Training on HE	2/year	District, Upazilla and Municipality	June	DPHE UEO & AUEO	- Cluster-wide teachers training schedule - Follow-up / Supervision
10	Annual Sports	2/year	District, Upazilla and Municipality	January	DPHE UEO & AUEO	- Implementation process - School-wide schedule - Follow-up / Supervision
11	School-wide Mothers Gathering Plan	2/year	District, Upazilla and Municipality	June	DPHE UEO & AUEO	- Implementation process - School-wide schedule - Follow-up / Supervision
12	Support for Community Water and Sanitation Provision	6/year	District, Upazilla and Municipality	June – October	DPHE and Union Parishad	- Area selection for latrine construction - Technical support - Follow-up / Supervision
13	SMC Conference	2/year	District, Upazilla and Municipality	August	DPEO, UEO & AUEO	- Implementation process - School-wide schedule - Follow-up / Supervision
14	Staff SHN Planning Meeting	12/year	IAO	Jun – Dec	Staff of SHN Program	- Monthly activity plan - Implementation and reporting

Table 2 Planning meeting attended by Save the Children SHN staff

SL	Name of Activity	Frequency of meeting	level of meeting	Period	Participation	Content
1	Deworming	4 /year	District, Upazilla and Municipality	May & November	CS, DPEO, UH&FPO, UEO, AUEO & Mayor of Municipality	- Tablet distribution - Orientation - Awareness activities - Follow-up /Supervision - Reporting

National Level Planning

Ministry of Health (DGHS) Planning

Save the Children's SHN Program Manager is a member of the National Technical Committee for the planning and implementation of the National Deworming Day with the leadership of the Directorate General of Health Services and the Ministry of Health & Family Welfare. Other INGOs, such as WFP, BRAC, UNICEF and others also attend in order to discuss issues and divide responsibilities prior to National Deworming Day according to the following agenda:

1. Advocacy Meetings at different levels;
2. Media Coverage, print and electronic;
3. Social Mobilization prior to the day itself;
4. Tablet Procurement and Distribution;
5. Orientation for teachers and volunteers.

The Save the Children SHN team contributes technical input as well as some contributions on advocacy, social mobilization, teacher orientation and tablet distribution. A member of the SHN team attends meetings as and when needed.

Ministry of Education (DGPE)

Save the Children USA is also working with the Ministry of Primary and Mass Education, UNICEF, WFP and others to plan and design an SHN package to be gradually scaled up nationwide. These meetings take place once per quarter and as and when needed. The Ministry of Education (DGPE) planning is taking the lead role, UNICEF is providing technical and financial assistance and Save the Children and others are providing technical assistance for the development of the package and scale-up.

All National Level Planning will be needs based and in coordination and collaboration with the government and development partners.

Save the Children Planning

Every year, every country office needs to submit their Country Annual Plan (CAP), which is then reviewed by regional and WWO (Westport and Washington Office) staff in various departments.

In Bangladesh, Country Annual Plans are developed after forming a Priority Result (PR) group. Save the Children has four driving PRs: PR 1 Children are Protected; PR2 Children Learn and Develop; PR3 Children are Healthy and Well-Nourished and PR4 Children Thrive in Food-Secure and Economically Viable Households (see page 8). Of the four PR areas, SHN and Education come under PR2. As with other PR areas, there is one focal person leading the area group and one common format covering all the programs that come under each PR area.

Detail Implementation Plan (DIP)

DIP is a detailed Save the Children implementation plan for a program, which is target-oriented, responsibility-specific and time-bound. It helps program managers and field staff to implement the program as planned and keep the program on track. An example of a DIP can be found in Annex 5.

Program Managers at Country Office level are responsible for program design, annual planning, monitoring of field implementation, national networking and budgets. Program Officer/Program Office at Impact Area Office level are responsible for the implementation of plans, networking with local government and reporting. Field Officers at Impact Area Office level are responsible for field level implementation concerning quality and planning and networking with lower level stakeholders.

Standard Procedures

- The DIP is an annual plan prepared by the Save the Children program team following a recommended process, outline and framework.
- It should be developed in September/October for the following year, January to December.
- It is a tracking tool to monitor progress in implementing planned activities on a monthly or quarterly basis.
- The DIP should list all major activities, supporting sub-activities, planned targets, resources required, persons responsible for carrying out each activity, timeline, partners involved, level of community contribution, estimated budgets and process indicators.
- The DIP may be reviewed and revised after six months of implementation as needed following the same process and outline.

Women's health education session

DIP Definitions

Major activities: Defined by the program, based on findings from the situation analysis, baseline survey, previous program experience and the process of program design. Example: weekly iron supplementation may be selected as an intervention to address the problem of anemia found during the baseline survey.

Sub-activities: Supporting activities required to carry out the major activity. Example: teacher orientation, meetings with government and SMC, arrangement referrals, and support treatments are the sub-activities for vision screening

Targets: These quantify the activities to be achieved in terms of the number of meetings, trainings, or orientations; the number of schools with access to safe water; the number of teachers, students, SMCs and PTAs trained. Example: two meetings are held with the government, 500 teachers are trained on vision screening.

Person Responsible: The staff member who has to ensure that the activity is carried out and the target achieved. The choice of the person responsible will depend on their job description and objectives. Example: Program Managers are responsible for conducting round table meetings at national level; Program Officers are responsible for conducting training of teachers; Field Officers are responsible for distributing iron tablets to schools.

Time Lines: These define when an activity has to be done. These are set according to the holiday calendar, school working days, seasonal factors and workload. Examples: Deworming will be held in May and November; iron supplementation will be started immediately after deworming.

Partners: Non-Save the Children staff, such as community members, Education Office staff or partner NGOs, who directly or indirectly support the activity. Example: Union Parishad will be treated as a partner to support activities to be implemented by providing logistics and a fund for schools.

Budget: The amount of funding allocated to a particular activity. It is based on previous expenditure for that activity and current activity need.

Community contributions: Actions taken by the community on a voluntary basis to support program implementation. Community involvement and contributions are essential for ensuring community ownership of the program and long-term program sustainability. Example: SMCs replenish first aid supplies and soap for toilets; communities give gifts for Annual Sports.

Process indicators: Measures used to assess progress in achieving the planned activities. They indicate whether a target has been reached and whether it was reached within the set timeline. Example: the number of meetings held compared to the number given in the plan; the number of tablets distributed to a given number of children. (Annex 5)

DIP Preparation workshop.

Summary Implementation Plan (SIP)/Process Indicator Tool (PIT)

The Summary Implementation Plan (SIP) (Annex 6) is a tool developed for sponsorship funded programs to plan program strategies and activities that will help achieve each of the identified intermediate results in the RF. SIP is a summary form of all activities outlined in the detailed implementation plan (DIP). The SIP will assist programs in summarizing and reporting CASP program implementation progress for core programs on an annual basis to WWO. A SIP will be completed annually for each core sponsorship-funded program area that COs plan to implement. Strategies should be selected from the *Key Strategies Matrix* in the core program modules, and supporting activities should be identified. Both strategies and activities will help to achieve each of the intermediate results in the Results Framework.

SIP Definitions

Key Strategies: Key strategies are set to achieve the IR and should address the issues identified in the situational analysis summary tool, building strength in the impact area and addressing any barriers to achieving results. Prior to selecting a strategy, target population and resource availability must be reviewed and considered.

Activities: Identify the most important activities that will be undertaken to carry out the strategies identified from the key strategies matrix. Activities should be specific enough so that team members know the 'what, when, where, who and how' of each activity.

Time Frame: This indicates when the identified activities will be implemented. Note that activities may occur throughout the entire year (school visits), once a year (annual vision screening), twice a year (vitamin A supplementation), or once a quarter (teacher training, mother's gathering).

Funding: This indicates how much money is needed to execute specific activities and where the money will come from, whether sponsorship or grants. There is a provision for "N/A" if no money is needed for a specific activity.

Standard Procedures

- The SHN Program Manager is responsible for preparing the SIP with support from all field staff.
- All major planned activities for that year are listed for each IR and program strategy. The time of each activity, by quarter, and funding needed is also noted. The SIP is linked to the Process Indicator Tool (PIT), another sponsorship program tool that lists the process indicators, and the number planned for each activity by IR and strategy (Annex 6).
- At the end of each fiscal year, the Program Manager should prepare an annual report on the basis of the SIP and PIT developed at the start of the year.
- The SIP cannot be prepared without completing a detailed DIP beforehand.

Female teachers training on Menstrual hygiene

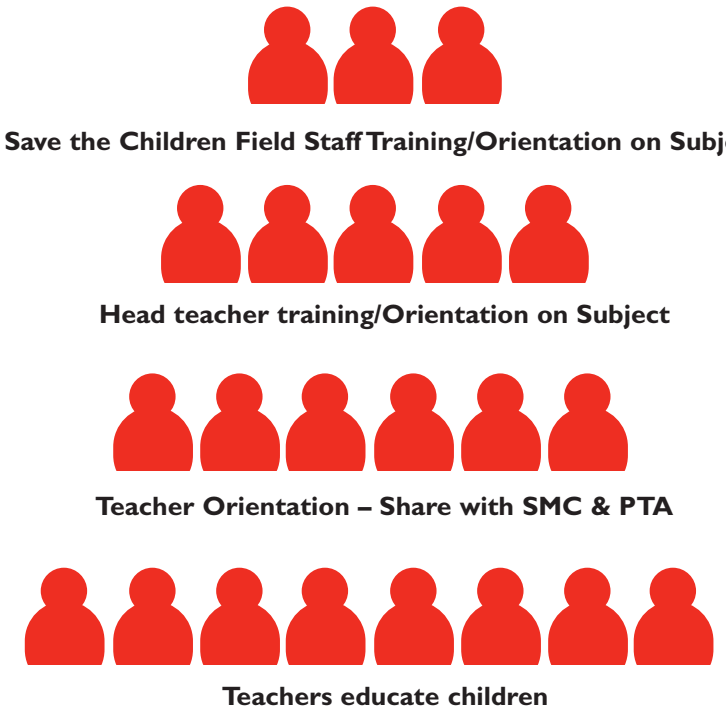
Chapter 5
Program Implementation

Chapter 5 describes each SHN intervention and how it should be implemented. The SHN interventions are organized by Intermediate Results (IRs) which are aligned with the four FRESH elements (school based health services, health education water and sanitation and community support).

Training and capacity building

Most of the interventions described below are delivered using the same training system, which is summarized in the training tree below. It indicates how information is shared at all levels and who is responsible for each level of training and orientation. A list of materials used for each intervention (training manual, health education materials and monitoring and supervision forms) is provided in annex 8.

figure 6 : Training tree



School-Based Health Services

School based health and nutrition services are simple and easy to administer by the teachers. The typical and most cost effective services include mass deworming and micronutrient supplementation (vitamin A and iron) to treat intestinal worm infections and improve children's health and nutritional status. It is very inexpensive and has an immediate impact on children's health and nutritional status and consequently their ability to concentrate and learn in school. Annual deworming, vitamin A and iron supplementation costs approximately Taka 30 per child per year.

Deworming

More than 150 million school-age children worldwide are severely affected by intestinal worms. In Bangladesh, worm infections are widespread, especially in rural areas due to poor personal hygiene and unsanitary environmental conditions. Intestinal worms are parasitic organisms, which reside in the human intestine, and affect the absorption of nutrients needed for growing, learning and staying healthy. There are several types of worms, for example roundworm, hookworm, threadworm and tapeworm, but roundworms and hookworms are the most prevalent among school-aged children in Bangladesh[13].

13 SC Baseline Nasirnagar. 2004

Deworming kills the worms and if done regularly prevents children from building heavy worm loads, which have more severe consequences on their health and education. Deworming is a safe, easy and cheap intervention: the most commonly used drug, Albendazole, is bio-chemically proved to be a safe, single administration drug in chewable form, costing less than 0.02 US$ per child per year.

Save the Children's role in Deworming

- Coordinate with district and Upazilla health offices to orient primary school teachers
- Mobilize parents and community to ensure children's attendance/participation in the national events on deworming (NID & Vitamin A week for 2-5 years, NDD for 6-12 years)
- Involve and use local media (newspaper, mosque, miking, leaflets) to inform communities prior to national days
- Participate with government health staff and teachers to ensure maximum tablet distribution and documentation

Standard Procedures

- School age children (in- and out-of-school children) should be dewormed by the teachers at school once or twice per year depending on the prevalence of worms.
- The number of deworming tablets required for each school is estimated from school enrollment figures[14] and the estimated number of 6-12 year old out-of-school children.
- The Upazilla Health and Family Planning Office and Municipality provide deworming tablets as part of the National Deworming Day campaign.
- Primary school Head Teachers should be oriented on deworming in their monthly meetings at Upazilla level. Head Teachers in schools should orient other teachers and SMCs on deworming. A deworming manual should be provided for every school to guide the teachers organizing the deworming. (see SHN user guide in annex 9).
- Save the Children assists the government by coordinating teacher orientation in order to ensure maximum participation from teachers and to mobilize the community and parents to maximize school attendance on National Deworming Day.

Child receiving deworming tablet

- Health Assistants supply the tablets to teachers who provide 1 tablet each to all children twice per year.
- Teachers provide health education on worms and deworming before giving the tablet to children so that children understand what worms do to their body, how they affect their life, such as their schoolwork, growth and health, and how to avoid getting worms in the future. Teachers explain what the drug is for and what the possible side effects might be.
- Teachers and Health Assistants shall keep records on deworming tablet distribution on forms supplied by the governmentand on the SHN Register (see annex 10).
- SMC's and student brigades should participate in the deworming in schools.

[14]Government Primary School, Register Non-Government Primary School, Community Primary School, Madrasa, Mission school, BRAC NFP School

- Parents and the community should be informed prior to National Immunization Day, National De-worming Day and vitamin "A" week using banners, miking, news paper advertisements and leaflet distribution.
- 2-5 year old children who do not attend schools should all be dewormed during National Immunization Day and Vitamin A Week (June and December), at the Health Center and EPI Outreach Center by the Health Assistant and a volunteer.

Use of Anthelmintic tablets: Albendazole

Indication:

In Bangladesh, there are many different deworming drugs available on the market including Albendazole, Mebendazole, Livamizole and Pyrental Pamoate. But in Save the Children's SHN program, Albendazole is used because of its low cost single dosage (only 1 tablet per child is needed). Albendazole enters the stomach and intestine slowly, but has a fast chemical reaction process.

Mechanism:

Albendazole blocks the worm's glucose absorption process and the worm dies of starvation. Albendazole is very effective on most worms, including round worm, tape worm, and hook worm – the most common worms in Bangladesh. At the same time, Albendazole is also effective at killing threadworms.

Dose:

400 mg of Albendazole tablet

Administration:

Each child should be given one tablet (400mg chewable tablet of Albendazole). Primary school aged children (6-12 years) will take one deworming tablet twice a year (May & November) on National Deworming Day. Children from ages 2-5 will also take one tablet twice a year, one on National Immunization Day and another during Vitamin A Week, but these are provided by the health system staff. Although other family members can also take deworming tablets at least twice a year, they are not provided for under these programs.

Teachers perform an essential role in the administration of the drug: before administering the tablets, teachers remind children, using participative methods as much as possible, about worms, their negative impact on their health and ability to learn and that the tablets kill the worms and prevent them from reproducing in their bodies. The teachers also inform the children about any possible side effects (which are rare) and how they should tell the teacher if they feel sick the day the drug is given.

Steps to administer tablet:

Step 1: Wash hands with soap

Step 2: Advise children to sit on their seats

Step 3: Start giving tablets from one corner of first row, one tablet per child

Step 4: Ask children to chew after giving the tablet

Step 5: Complete row by row to finish one class, and do the same in the next class, until the whole school is covered

Step 6: Fill in the SHN register (Annex 10) to record the tablets given to each child

Side-effect:

Albendazole has no known serious side effects, because Albendazole is easy to digest. However, in rare cases it can cause diarrhea, nausea, and temporary abdominal pains or even vomiting. Providing an oral saline solution is enough to solve the problems.

Caution:

Albendazole is not advised for pregnant women or children under two years of age. Albendazole should not be used in cases of jaundice or high fever. Those who are sensitive to Albendazole should not be given them. The teacher should check before administering the drug whether children have any history of the above conditions. No child should ever be forced to take the tablet. Explain to the child why the tablet is important and gently convince the child to take the tablet.

Iron Supplementation

Iron is a micronutrient essential for the human body and especially for child development and pregnant mothers. Iron deficiency anemia is the most common nutritional deficiency in the world, and school-age children are among the most severely affected. In Meherpur, the 2008 survey found that 70 percent of school children were anemic[15]. Anemia and other diseases are a consequence of iron deficiency. Iron deficiency anemia causes fatigue, low productivity, and a general sense of feeling unwell. School-aged children with iron deficiency anemia are more likely to have poor physical and cognitive development and poor academic performance. Iron is found in food: those foods that have the highest and most absorbable iron content are red meat and liver. Iron can also be found in green leafy vegetables, banana, beans, papaya, lentils, wheat, and molasses. School children need plenty of iron to grow up into strong healthy adults and to be able to learn and perform well at school. However, it is often hard to get enough iron in food if the diet is not varied. Iron is also produced artificially in the form of tablets or iron supplements. Iron supplements prevent children from becoming anemic, they increase the body's immunity and enhance cognitive development, and school performance. Since iron cannot be stored in large quantities in the body, like vitamin A, iron needs to be consumed regularly and thus iron supplementation must also be given regularly.

Standard Procedures

- Iron tablet requirements for schools, Government Primary School, Register Non Government Primary School, Community Primary School, Madrasa, Mission school, BRAC NFP School and Pre- School, are to be determined based on enrolled children in school for a given year.
- SHN programs shall provide iron tablets to schools based on their requirements according to enrolment.
- Primary school Head Teachers should be oriented on Iron supplementation in their monthly meetings at Upazilla level. Head Teachers should orient SMCs and other teachers on Iron supplementation (Annex 9).
- Teachers should provide health education information on iron and its use before giving supplementation to children.
- Teachers shall provide 2 iron tablets per week per child for 16 consecutive weeks in a year.
- Teachers shall keep records on Iron supplementation in the Iron Register Book.
- Student brigades should be involved in the Iron supplementation programs in schools.

[15]Save the Children (2009). Shishuder Jonno, Baseline Survey Report

Use of the Iron Tablets

Dose:

Ferrous Fumerate 200mg + Folic Acid 0.20 mg.

Administration:

The iron tablet at the given dose should be swallowed with water. Primary school children (6-12 years) should take two tablets on two separate days each week for 16 consecutive weeks. This schedule should be followed once per year. If other family members wish to take iron tablets they should be advised to consult a doctor. Pre-school children (4-5 years) should also take iron tablets following the same schedule. If young children experience difficulties in swallowing the tablet, the tablet may be divided into two halves and each half swallowed with water. If a child is completely unable to take the tablet, that child must be dropped from the Iron supplementation program.

Side-effects:

Iron tablets may sometimes cause nausea, abdominal discomfort, constipation, diarrhea, or black-colored stools, none of which pose any danger. However, if any of these problems become more and frequent, then a child should stop taking the Iron tablets for 2/3 days and then re-start.

Caution:

Excess doses of iron may cause harm for children. Children should be warned to avoid taking additional iron that is not recommended by the program or not on the advice of a doctor.

Vitamin A Supplementation

Vitamin A deficiency is the leading cause of preventable pediatric blindness in developing countries. The provision of adequate amounts of Vitamin A reduces child mortality related to Vitamin A deficiency and reduces susceptibility to diarrhea. Although school-aged children are not as likely as younger children to die of Vitamin A deficiency, around 85 million school-aged children are Vitamin A deficient, about 7 percent of the school-age population. A child with vitamin A deficiency is more likely to become ill and will be less able to fight disease. In the long term, chronic Vitamin A deficiency can cause blindness. Deficiency of Vitamin A is due to a shortage of Vitamin A in the diet. Vitamin A increases the body's immunity and prevents diseases. Foods containing Vitamin A include green leafy vegetables, yellow fruits, small fish, tomatoes, bananas, carrots, milk, butter, egg, and liver. As with iron, meat products have the highest amounts of Vitamin A. Night blindness, Bitot's spot, corneal ulcer followed by blindness, roughness of skin, and an interruption of physical growth are the consequences of Vitamin A deficiency in the body. Vitamin A supplementation helps to prevent night blindness and increase body immunity among school children.

Save the Children's role during Vitamin A and Iron Supplementation

Child receiving Vitamin A tablet

- Coordinate with district and Upazilla health offices to orient volunteers
- Mobilize parents and community to ensure children attendance/participation on the national events for vitamin A (NID & Vitamin A week for 1-5 years)
- Involve and use local media (newspaper, mosque miking, leaflets) to inform community prior to national days
- Participate with government health staff and pre-school teachers to ensure maximum capsule distribution and documentation

Standard Procedures

Primary School Children (6-12 years)

- Vitamin A capsule requirements for schools, Government Primary School, Register Non Government Primary School, Community Primary School, Madrasa, Mission school, BRAC NFP School and Pre- School, shall be determined according to the number of enrolled children in a school for a given year.
- Save the Children shall provide Vitamin A capsules to schools based on their requirements according to enrolment.
- Primary school Head Teachers should be oriented on Vitamin A in their monthly meetings at Upazilla level. Head Teachers at schools should orient SMCs and other teachers on Vitamin A supplementation. (see annex 9).
- Teachers shall provide 1 capsule (200,000 i.u) twice a year, 6 months apart, for each child.
- Teachers shall provide health education information on Vitamin A before giving the Vitamin A capsule to children at school.
- Teachers shall keep records on Vitamin A capsule distribution on the supplied form. (see annex 10).
- Student brigades should be involved in Vitamin A distribution in schools.

Pre-School Children (1-5 years)

- Pre-school children (1-5 years) should be given Vitamin A on National Immunization Day (NID) and as part of Vitamin A Week (June and December) at Health Centers and EPI Outreach Centers by the Health Assistant and volunteers.
- The Upazilla Health and Family Planning Offices and Municipalities shall provide Vitamin A capsules for 1-5 year-old children during NID and the Vitamin A Week campaign.
- Health Assistants and volunteers should be oriented on Vitamin A in their monthly meetings at Upazilla level.
- Health Assistants and volunteers shall provide 1 capsule (200,000 i.u.) twice a year, 6 months apart, for each child.
- Health Assistant will keep records on Vitamin A capsule distribution on government prescribed form.
- Pre-school Teachers shall mobilize parents to ensure that all children receive Vitamin A from EPI Outreach Centers or Health Centers on NID and Vitamin A Week.
- Parents and the community will be informed prior to NID and Vitamin A campaign through banner displays, miking, newspaper advertisements and leaflet distribution.

Use of Vitamin A capsules

Dose:

One Vitamin A capsule, 200,000 i.u. twice per year, 6 months apart.

Administration:

Swallow one Vitamin A capsule, 200,000 i.u. Primary school children shall take one capsule twice per year. Children 1-5 years old shall take one capsule twice a year, one on National Immunization Day and the other during the Vitamin A campaign. Other family members should only take Vitamin A capsules on the advice of a doctor.

Side-effect:

Vitamin A has no known side effects. Children easily digest the capsules.

Caution:

Excess doses of Vitamin A may cause harm for children. Excess Vitamin A is stored in the body and may become toxic thus it is essential that no more than one capsule should be administered to each child on each occasion. In the first trimester of pregnancy, **Vitamin A can harm the baby. If there is a risk that teenage girls are pregnant the Vitamin A capsule should not be given.**

Vision Screening

Vision: Any object will look the same from certain distances and the correct way to differentiate the blank spaces between two items is called vision.

Normal vision for a normal person: A healthy person with normal vision should be able to see letters above the 6th row of the large-version Vision Chart (Annex 11) and differentiate the blank spaces from a distance of 6 meters or 20 feet. Thus, an indication of 6/6 indicates that a child has normal vision.

Vision Screening: Vision problems significantly affect a child's ability to participate and learn at school since 75 to 90 percent of classroom learning occurs using visual systems. Information regarding the prevalence of vision problems in Bangladesh is unavailable, partly because many children with vision problems are not coming to school. Vision screening is the process whereby all children in a school have their eyes checked by a trained teacher to identify visual and other eye problems which may be preventing children from seeing the blackboard and following classes. Poor eyesight and other eye problems, such as eye infections or Vitamin A deficiency, can in the long run cause eye damage or blindness. When a problem is diagnosed, it can be treated or a solution found.

Standard Procedures

- Vision Screening should take place once a year, to be conducted by schoolteachers.
- All schoolteachers, both at primary and pre-school levels, should receive training using the vision chart and the visual acuity testing curriculum as part of the vision screening process in schools.
- Teachers should develop school-wide vision screening plans.
- Prior to vision screening sessions, teachers should inform children about the purpose of vision screening, how it will be conducted, what problems may be identified and what will happen if a problem is found.
- Teachers should record all children identified as having vision problems using the prescribed form.
- It is the responsibility of teachers to ensure that all children identified as having vision problems are rechecked by an eye specialist at selected sites.
- All identified children along with their parents, shall receive support to solve the problem identified. Save the Children USA, in coordination with a partner organization, shall provide the funding or a percentage of the funding needed to cover the cost of the necessary medical expertise, eyeglasses or treatment.
- SMCs should take an active role in supporting teachers and parents to ensure compliance with the treatment or management program prescribed for the child at school.

Vision screening by teacher

Standard steps to test vision for children

Child should sit 6 meters or 20 feet away from an Original Vision Chart (large size) or 3 meters or 10 feet for a half-sized Original Vision Chart (small size). (Annex 11)

1. For children who are not yet able to read the alphabet, the E-chart should be used for vision testing.
2. The child should sit up straight and not lean forwards or backwards.
3. It is essential that there is adequate light to view the vision chart.
4. The Vision chart should be placed so that the 4th line of the chart is at the child's eye level.
5. Each eye should be tested separately. When testing one eye, the other eye should be covered with a hand or a piece of card. The child should be told not to try to look through the hand or card with the covered eye and that only the eye that is uncovered should be able to see.
6. A child who cannot read lines 6-18 should be referred to an eye specialist.
7. Maintaining a fixed distance and a notation of what line a child can read from D-60 will indicate the childs vision level.
8. If a child can read up to D-6, then his vision is considered normal.

If the child is unable to read row D-6, the teacher should a) note that the child's vision is not normal; b) refer the child to a specialist; c) ensure the child is moved to the front of the class.

First Aid Management

Many health problems that children encounter at school, such as minor injuries, headaches or diarrhea, can be treated at school with the First Aid Kit (FAK). The purpose of the FAK is to provide immediate treatment to children at school to avoid them having to walk long distances to a health center and missing school, or be left untreated. It is also a way to identify more serious health problems which should be referred to a health professional, and which otherwise may be ignored until the point where they become more serious.

Standard Procedures

- One First Aid Kit should be given to each school, one kit, depends on the number of schools. The content of each kit depends on the number of children enrolled in each of the schools: Government primary school, Registered primary school, community school and Madrasa.
- A one-day First Aid Management Training should be organized for Primary School Head Teachers at Upazilla level, organized by the Upazilla Health and Family Planning Officer. The respective Head Teacher at school shall train all other schoolteachers.
- The trained Head Teacher should inform and orient SMC's on First Aid and the use of the FAKs.
- Teachers shall provide First Aid services to students as necessary as per the Teacher's Training Manual.
- Teachers should inform students about First Aid services in the classroom.
- Teachers shall keep records of all First Aid services given to children by using the First Aid Register.
- SMCs shall refill First Aid Kit supplies as and when necessary.
- SMCs and AUEOs should be responsible for following up the activities and the First Aid Register.
- FAKs should be stored in a cool and dry place.

First Aid Kit with materials and medicine

Medicines for each First Aid Kit

a. 100 x Tab. Paracetamol
b. 100 x Tab. Antihistamine (Histacin)
c. 4 x 60g Tube Antiseptic ointment (Savlon)
d. 2 x 112ml Bottle Dettol/Savlon
e. 1 x Bottle Iodine Tincture
f. 20 x ORS (SMC)

Equipment for each First Aid Kit

a. 10 x 4" rolls Gauze Bandage
b. 4 x 100g Sterile Cotton
c. 100 x Neo-step Bandaid
d. 1 x Plain 6" scissors
e. 1 x Plain 5" Tweezers
f. 5 x rolls Zinc Oxide Plaster with plastic cover
g. 4 x rolls ½ "Micropore
h. 1 x Clinical Thermometer
i. 1 x Tourniquet Rubber Tube
j. 5 x Nail Cutter, 3 x small, 2 x large

FAK training for teachers

Health Education

Classroom Session

Health Education is the process of sharing health-specific content in such a way as to increase knowledge, attitudes, and practices and thereby change individual behavior. Classroom-based health education sessions are designed to incorporate health information and messages for children by subject and in a way that forms part of their existing grade-specific curricula. They help school children to learn more about personal hygiene, safe water and sanitation, food and nutrition and first aid treatment. Health education sessions should help children to change their behavior regarding personal hygiene and food habits and also in protecting themselves from water-borne diseases and worm infestations. See Annexe 8 for full list of materials used.

Standard Procedures

- Health education sessions should be a part of class routines for all classes once per week.
- Teachers shall conduct health education sessions for every class as per the schedule adopted.
- Textbooks with health education content (NTB) and accompanying teacher's training manual[16] shall be used as teaching aids for these sessions. PHASE (Personal Hygiene and Sanitation Education) materials and any other health and nutrition materials, endorsed by the Government may be used as supplementary materials for these sessions.
- Program staff, with government support, shall train teachers prior to them conducting health education sessions.
- Female teachers should be trained on menstrual management before teaching sessions with girl students in grades 4 and 5.
- Teachers shall conduct at least two health education sessions on menstrual management per year for female students in grades 4 and 5.

[16]Teacher's training manual produced by Save the Children USA

- Female teachers at each school shall also orient mothers of all girls in grades 4 and 5 on menstrual management and on how to support their girls during menstruation.
- Head Teachers of each school shall ensure regular health education sessions by the use of a tracking chart.
- Teachers should conduct health education sessions before activities such as deworming, Vitamin A capsule supplementation, Iron supplementation, Vision screening, Global Hand Washing Day, Sanitation Month and Cleaning Week Campaigns.

Peer Session (Student Brigades)

Student Brigades (SB) are structured groups of students from grades 4 and 5 in each primary school. The primary responsibilities of the SBs are to demonstrate healthy practices among themselves and to support the creation of a healthy environment at school and in classrooms. This peer approach is designed so that students share and learn from each other. This process also influences community members to take part in different kinds of hygiene education activity and helps to raise community awareness by creating a bridging relationship between schools and the community. It also helps to develop leadership skills in students.

Standard Procedures

- Students from Grades 4 and 5 are required to join a SB.
- Each group shall be made up of 7-8 members, both boys and girls, from the same school, during one school year.
- Groups should be created on the basis of neighborhood or residential area.
- Each SB shall have a group captain or leader.
- A nominated teacher shall train each group captain or leader about their roles and responsibilities.
- SBs will be introduced to their communities and overseen by a nominated teacher and an SMC member.
- Every SB shall have a name and shall be known by that name.
- The number of SB groups in a school shall depend upon the number of students in 4th and 5th grades of that school.
- An annual action plan for SBs shall be developed during February-March of every year.
- Each group shall perform their activities according to the SB routine and work plan.

Roles and responsibilities of SBs

In school	In community
• Clean the schoolyard and surrounding fields, latrines, water tank, tube well platform, class room and take part in gardening • Actively participate in the Cleaning Week Campaign • Assist class teacher during deworming, iron supplementation, Vitamin A supplementation and annual vision screening program • Assist class teacher during weekly health education sessions • Ensure availability of safe water in the class regularly • Ensure water and soap for washing hands is available in latrine • Conduct class room health education sessions with guidance from teachers • Assist class teacher during implementation of other health interventions at school • Seek support from teachers to promote a healthy environment at school.	• Conduct community Water Sanitation Survey (once per year) • Conduct community awareness activities through Cleaning Week Campaign. • Share health education messages learned at school with family • Seek support from their parents to keep a healthy environment at home.

Cleaning Week Campaign

- Cleaning Week Campaign will take place at school and in households in October every year in association with the National Sanitation Month and Global Hand Washing Day.
- Student Brigades will be involved in cleanliness activities during the campaign led by their schoolteachers and SMC members.
- SMCs will discuss and decide Cleaning Week Campaign dates and the required implementation steps in monthly SMC meetings as a separate agenda item.
- Teachers shall provide orientation to SBs regarding content and roles and responsibilities.
- SBs will ensure cleanliness at school and in the household.
- SMCs and teachers shall provide materials for the Cleaning Week Campaign according to needs.
- SBs should participate in the Cleaning Week Campaign and receive guidance and support from SMC members and teachers according to the agreed schedule.

Key Health Messages

- Cover all cooked food before consuming
- Low cost and locally available food can provide a balanced diet

Examples of Issues addressed in Courtyard Sessions

Courtyard Session (Community)

Children receive information and health education from schools by participating in class room-based health education sessions, and through peer education in the Student Brigades. Their school-based learning should be supported and promoted at household level since they spend most of their time at home. By sharing their health information with their parents they help to create a supportive environment in which to practice what they have learned at school. Courtyard sessions provide the platform to bring parents in to contribute to the learning of their children.

Courtyard sessions consist of a group of parents gathered together in a specified location, spending time sharing issues related to personal hygiene, water and sanitation and food and nutrition at household level. This is a community forum where parents meet each other, discuss their issues and try to find ways to solve those issues among themselves. Save the Children and partners supports and mobilizes this group gathering as a linked activity to create and facilitate children's health and hygiene practices at home. Courtyard sessions help to improve water and sanitation status at community level, create an enabling environment to practice personal hygiene at family level and improve awareness of low cost nutritious food for the whole family. The following four topics should be discussed in the courtyard meeting:

- Use of safe water for drinking and household use
- Use of hygienic latrine for defecation and excreta disposal
- Maintenance of personal hygiene in daily life, such as hand washing and wearing sandals
- Use of low cost nutritious foods

Standard Procedures

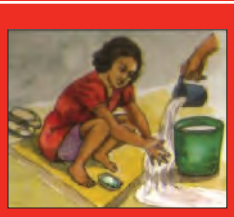
- Select location for courtyard meeting within program area.
- Select 20 participants for each courtyard session group, one participant from each family (At least 75% parents must have school going children between 4-12 years.)
- 2 sessions per staff member per month shall be held: a total of 16 sessions per staff member per year during eight months of the year, covering four topics in rotation.
- Each session shall last for 1½ hours and shall cover one topic.
- Sessions shall be conducted using the courtyard session module[17].
- Peers shall follow up session outcomes.

Demonstration Session (Community)

Demonstration is the process used to make health education sessions effective. It is designed to demonstrate correct health and hygiene practices and to make families understand its importance and the scope of its use in the family. Iodine testing in salt, ORS preparation and hand washing are the three areas demonstrated at family level. This helps to create awareness and to show the correct practice. The following three topics are those that are demonstrated in the sessions:

- Correct hand washing practice using soap (see below: Key Health Messages)
- Iodine testing in salt to confirm daily use
- Correct ORS preparation when needed

Key Health Messages



- Wash both hands with soap before touching any food with hands

- Wash both hands with soap after using toilet and cleaning children's bottom

Standard Procedures

- Teenage volunteers should be selected from 10 villages, two per union.
- Save the Children should train the selected volunteers through a demonstration session[18].
- Demonstration sessions should be conducted at home with the site selected prior to the session.
- Each volunteer should train 10 households in a day by conducting two separate sessions. A minimum of 5 families should participate in each session.
- All three issues, Iodine, ORS and hand washing, should be discussed and demonstrated in every session given by the volunteer.
- Each session should last 1½ hours (1 hour for session and half an hour for preparation).
- Volunteers, who work for 2 months per year, should conduct 2 sessions (total around 3 hours) in a day.
- Every household shall receive one visit card or household card, signed by the volunteer after the demonstration session.
- Save the Children program staff will monitor the volunteer's activity during routine visits.

[17] Courtyard session module – what is it? Where is it found? [18] Demonstration training module

Water and Sanitation

Safe Water

Water is life. It is needed for every stage and every level of daily life. Without water it is not possible to survive. Safe water is needed for life, but unsafe water is risky for health and even causes death. **Safe water** is water which does not contain pathogens or germs harmful to the human body and which does not contain above the recommended dose of arsenic, iron, metal or chemical elements. Arsenic free tube-well water, boiled water and rainwater are examples of sources of safe water. Safe water is needed for children in school and in the home. The purpose of having safe water is for drinking and for domestic use. Access to water and sanitation in primary schools throughout the country is the primary responsibility of the Government. Where the Government is not yet able to ensure such access, Save the Children supports the program and fills gaps in provision. Annex 12 details the procedure for testing arsenic levels in water. Although Save the Children does undertake some arsenic testing on behalf of the Government, all staff involved in this program should undertake appropriate training before beginning arsenic testing procedures.

Standard Procedures

- Every school should have safe, arsenic-free water in school. Every child should have access to safe water even in class with a jug, glasses and water provided.
- Every water source at school shall be tested for arsenic at least once per year.
- The mouth of every tube well shall be marked in green or in red based on the arsenic level in the water.
- There are seven indicators used for labeling arsenic ppb. The indicators are as follows: 0, 10, 25, 50, 100, 250 and 500ml. Tube wells shall be marked in green where the arsenic level is between 0 and 50, which indicates that the level is tolerable and the water safe to drink. Tube wells marked in red indicate that the arsenic levels are between 100 and 500 and thus the water is dangerous to drink.
- Replacement or installation of the ring or tube well by SMC, DPHE and/or Save the Children to ensure access to safe and arsenic-free water to children in school. DPHE will provide the technical assistance necessary for installing ring or tube wells.
- Shallow tube ring or tube wells should be installed at least 10 meters (33ft) away from the safety tank of sanitary latrines.
- SMCs and teachers shall do follow-up and minor maintenances for ring or tube wells. SMCs and teachers shall assure the classroom provision of drinking water. The SB in each school shall fill the classroom water daily.
- DPHE and/or the Save the Children shall undertake major repairs and maintenance with contributions from SMCs.
- Health education sessions by teachers in each class should raise school children's awareness of arsenic hazards and the sources of safe water.
- The community will be educated and encouraged to use safe and arsenic-free water at household level.

Sanitation

Water and sanitation related diseases remain one of the most significant child health problems worldwide. Bangladesh faces many challenges related to water, sanitation and hygiene because it is densely populated and prone to flooding. Frequent and recurring natural disasters trigger outbreaks of waterborne diseases and destroy existing sanitation facilities, thus compounding any existing health issues. In 2003, a nationwide baseline survey conducted by the government indicated that 67 percent of households lacked a sanitary latrine (a latrine with a water seal). In 2008, the Meherpur baseline survey conducted by Save the Children showed that 64 percent of schools do not have a sanitary latrine. Additionally, the school survey revealed that only 39 percent of schools have separate latrines for males and females.

A **sanitary latrine** is a latrine where the human excrement is contained in a closed space in such a way that insects, animal, birds, water or the open air cannot come into contact with the excrement by any means. Germs and bad smells cannot spread through the excrement and contaminate the environment. The sanitary latrine helps to keep the environment safe. It is well known that adequate sanitation is the basis for a sustainable solution to the threat of water-related diseases. A high incidence of intestinal diseases associated with the lack of safe drinking water and with inappropriate means of excreta disposal is typical, especially among school children in Bangladesh.

The provision of safe drinking water and basic sanitation, coupled with adequate personal hygiene behavior, can prevent viral diseases, such as hepatitis A and cholera, bacterial diseases, such as diarrheal diseases and typhoid, and worm infestations, such as roundworm, whipworm, hookworm, schistosomiasis and other flukes. Save the Children promotes child-friendly and gender balanced latrines in schools.

Standard Procedures

- Every school should have child-friendly sanitary latrines.
- Every school should have at least one separate latrine for boys and for girls.
- Every school should have at least one urinal for boys.
- Repair, maintenance or construction of sanitary latrines shall be done by SMCs, DPHE and/or Save the Children.
- DPHE shall provide necessary technical assistance for the construction or repair of child-friendly sanitary latrines.
- SMCs, together with SBs and teachers shall be responsible for the continuing functional maintenance of the latrines.
- Communities should be encouraged to use sanitary latrines in their own homes.
- There should be co-ordination between the Union Parishad and NGOs for the construction of low cost, ecologically viable sanitary latrines for the community.
- Teachers shall provide health education sessions to school children and encourage the children to use sanitary latrines while in school.
- Boys should clean the boy's latrines and girls should clean the girl's latrines.
- No latrines should be locked at any time during school hours.

Reasons for child-friendly latrines

In 2004, formative research conducted by Save the Children in Nasirnagar revealed that even those students who have access to functioning sanitary latrines at home or in school do not always use them. This is due to the type of latrine and social norms that do not require young children or boys to use latrines. Younger children in Grades 1 to 3 said that they fear latrines, as they are dark inside, dirty or have a hole that is too big. Some shared experiences of being locked inside a latrine in the past. Many students asked for smaller latrines with enough light inside and a handle to hold while defecating. Boys also said that they copy their fathers and other adult males in the family, who often defecate in open fields or bushes. For example, one boy in Grade 2 said: "As a boy, it is easier for me to go out with my father for defecation. As I stay out a lot throughout the day, I do not mind finding a hidden place to defecate. No one can see me in the bushes."

Criteria of child-friendly latrines

- Adequate number of latrines and urinals (1 per 75 children)
- Enough light and air inside the latrine
- Running water or adequate water access to the latrine
- Hand-washing facilities in the latrine (water, soap)
- Proper waste water drainage
- Proper placement of foot-rest
- Provision of hand rest
- Easy approach road
- Separate latrines for girls and boys
- Door easily locked and unlocked from the inside

Hand Washing

Hands are the main source of transmission of diseases. Proper hand washing practice with soap is one of the most effective and cheapest ways to prevent diarrheal diseases. In addition, hand washing with soap can limit the transmission of the kind of respiratory diseases that kill children. Proper hand washing can eliminate 44% of diarrheal diseases. Hand washing with soap is also a formidable weapon to combat a host of others illnesses, such as helminthiasis (worm), eye infections (trachoma), and skin infections (impetigo). Hand washing with soap is a life-saving intervention within the technological and financial reach of all communities. The critical times for hand washing with soap are after using the toilet or cleaning a child's bottom and before handling food. Access to soap and water and the education and encouragement to use them are the key ways to prevent many diseases.

Standard Procedures

- Every school should have hand-washing facilities (drum water or running water with soap) in or nearby latrines.
- Every separate latrine for boys and girls should have separate hand washing facilities.
- Hand washing facilities include, at a minimum, the provision of water with a water container and soap.
- SMCs take responsibility for the repair and maintenance of the hand washing facilities.
- SBs take responsibility for the daily maintenance and cleanliness of all latrines.
- SMCs with the support of teachers shall ensure:
    - Soap is available at all times in all latrines
    - Water is available at all times in all latrines
    - Children use soap and water at all critical times.

Global hand washing day

Hand Washing Technique

Begin by wetting the hands with water. Scrub all surfaces of the hands with soap, including the palms, the back, between the fingers and particularly under the finger nails, and continue for at least 20 seconds. Rinse well with running water and dry either on a clean cloth or by waving in the air. To understand 20 seconds, read the line "Happy Birthday to you" twice.

Five Facts about Hand Washing

1. Washing hands with water alone is not enough to ensure that hands are germ-free.
2. Hand washing with soap can prevent diseases that kill millions of children every year.
3. Hands must be washed with soap after using the toilet or cleaning a child and before handling food.
4. Hand washing with soap is the single most cost-effective health intervention.
5. Social mobilization for hand washing is more effective than the later treatment of diseases.

Community Support

Mothers Gatherings

Mothers Gatherings are one of the most effective ways to communicate school issues with parents. It is called Mothers Gathering since it is primarily mothers who participate in the event, although both parents are equally encouraged to participate. In this forum teachers take the opportunity to share different issues with parents, such as children's academic performance, health education and services provided from school, and personal hygiene and nutrition issues for which children need their parents support to practice at home. In the meeting, mothers are requested to send their child to school regularly and to be part of school improvement plan.

Mothers gathering to share SHN activities

Standard Procedures

- Every school shall organize Mothers Gatherings three times per year as per annual action plan.
- SMCs will fix the dates and discuss all preparations in their monthly meeting prior to the event. The SMC, jointly with teachers, shall select the topics and fix the schedule.
- Teachers should invite parents to participate one week prior to the meeting.
- The SMC, PTA, SB and teachers shall confirm parent's participation in the meeting.
- Each session of Mothers Gathering will last at least 2 hours.
- The Assistant Upazilla Education Officer and/or Save the Children shall provide management support and make the necessary arrangements for the event.

Annual Sports

Annual Sports is an annual event to nurture children's extra-curricula interests and to support schools to create grounds for physical exercise. Co-curricular activity aims to:

- Ensure the physical and mental fitness of the student
- Increase the attendance rate for a certain period
- Establish the school as a joyful place
- Bridge the gap between school and the community

Annual Sports

Standard Procedures

- An Annual Sports planning meeting should be held in the SMC January meeting with the participation of an SB representative.
- Each school shall organize Annual Sports once per year by January/February.
- SMCs shall take the lead role in organizing the sports.
- All school students shall have an equal chance to participate in the events.
- SMCs shall mobilize community resources to contribute to Annual Sports.
- SMCs will provide the necessary sports materials (prizes, playing materials, decorations and so on) by raising support from the community and other sources.
- Student groups shall be formed based on grade and height:
    - For outdoor games groups will be formed according to height;
    - For academic performance related events groups will be formed according to grade/class.
- Age appropriate sports events shall be selected.
- Annual Sports shall be organized by following guidelines provided.
- SBs will act as volunteers during Annual Sports.

Chapter 6
Monitoring, Supervision and reporting

Chapter 6 lays out requirements for monitoring, supervision and reporting of progress. It explains the difference between results and progress indicators and lists the recommended indicators by Intermediate Result (IR). It also describes the purpose of regular school visits and checklist as a supervisory and monitoring tool.

School Visits

The school visits are a monitoring process to follow up the annual schedule of activities planned for a year for schools. They form part of Save the Children SHN field staff's regular activities. They enable a comparison to be made between the plan itself and the actual implementation and can identify gaps in implementation. See Annex 13 for the School Visit Checklist.

Standard Procedures

- Every school shall be visited every month or alternate months using a checklist.
- Checklist findings may be shared with SMCs and teachers and even with parents and the Upazilla Education Office as necessary.
- School visit findings shall form the basis of follow-up action where necessary.
- When program staff visit any school, s/he should remain for at least 1 hour in the school and should sign in the appropriate file (kept in each school) with the date of the visit.
- At least five home visits for each school visit for those students who were absent for three consecutive days. Findings shall be shared with teachers.
- Visits should be performed during school hours.
- In addition to using the school visit checklist, the annual action plan shall be reviewed against progress.
- School visits may happen prior to any special events.
- All field staff should participate in at least two SMC meetings per month.
- Student brigade activity should be followed up during school visits.
- Staff will prepare monthly activity reports based on school visit findings and other plans.

Results Indicators

Results Indicators measure and document change in the intermediate results, strategic objective and goal. They measure use of key services and behaviors, and how we are doing in terms of improving the access to, quality of, demand and community/ policy support for SHN in the schools, communities and amongst children. Table 3 below lists the indicators which are used to measure progress towards achieving the SHN goal, SO and IRs, and the method by which these indicators are collected. These indicators are collected either through a survey (at baseline, mid term and end line) in a sample of schools or annually from all schools through school level activity reports, which are collected and summarised into overall program indicators.

Table 3: Results Indicators.

Result	Indicator	Data collection Method
GOAL: Improved health and educational status of school and pre-school children	• % anemia amongst primary school children and pre school children in ECD Centers • Attendance rate of primary school and pre school children	• Baseline, mid-term and end line survey • Random spot checks to count number of children attending (By Education team)
SO: Improved use of key health, hygiene and nutrition services and practice	• % Decrease in anemia prevalence rate in primary school children and ECD	• School level activity records e.g. distribution records in SHN registers and school visits • KAP Survey at baseline, mid term and end-line
IR1: Increased access and availability of school health, hygiene and nutrition services	• % schools providing mass deworming, vitamin A and iron supplementation, vision screening and FAKs	• School level activity records and school visits
IR2: Improved quality of school environments with regard to health	• % Schools with access to safe water. proper sanitary latrines and hand-washing facilities	• School visits
IR3: Enhanced attitudes and interest among primary school-age children in using health services and adopting health-protective behaviors	• % School age children who know key health messages and have positive attitude towards practicing those messages • % schools with active student brigades	• KAP survey at baseline, mid term and end line
IR4: Improved community suppor and policy environment for SHN	• % of schools with SMCs trained in SHN • Change in policy environment related to SHN	• Training records and school visits • National level SHN policy updates

Progress Indicators

Process indicators are used to help a program manager track how a program is progressing; they track progress in the implementation of strategies and supporting activities. Progress indicators are collected regularly from training records, school level activity records and reports and school visits. Table 4 shows lists the main activities required to achieve the intended results and the progress indicators used to monitor the progress in implementing those activities.

Table 4: Progress indicators

IR 1: Increased access and availability of School Health, Hygiene and Nutrition Services and Practices

STRATEGIES: SCHOOL-BASED HEALTH SERVICES	
ACTIVITIES	**INDICATORS**
Deworming coordinated with government Iron and Vitamin A supplementation coordinated with GOB Annual vision screening and treatment (once a year) Health and nutrition support to ECD centers First Aid Kits at all schools in MP	• Number of schools participating in the deworming program • Number of students receiving deworming • Number of schools provided with iron and vitamin A capsules • Number of students receiving 32 Iron tablets & 2 Vitamin A capsules each • Number of schools conducting screening and providing treatment for vision problems • Number of preschools provided Health Nutrition and support • Number of schools which received and are maintaining FAK

IR 2: Improved quality of school environments with regard to health

STRATEGIES: IMPROVING WATER AND SANITATION SERVICES	
ACTIVITIES	**INDICATORS**
Safe and arsenic free water supply at school Sanitary latrines for boys and girls at school Hand washing facilities at school Waste management at school Menstrual management at school	• Number of schools with safe potable water • Number of schools with segregated latrines for boys and girls • Number of schools with hand washing facilities near latrines • Number of schools with waste management • Number of female teachers who received menstrual hygiene training and conduct session

IR 3: Enhanced attitudes and interest among primary school-age children in using health services and adopting health-protective behaviors

STRATEGIES: CAPACITY BUILDING OF TEACHERS, STUDENTS AND PARENTS ON HEALTH EDUCATION	
ACTIVITIES	**INDICATORS**
Nutrition and health education session taught at school and in community Teachers and parents capacity building (including provision of SHN education materials) Activation of Student brigade for BCC at school & community Mothers Gathering/ National Day Observation/ Annual Sports	• Number of schools that conduct weekly health education sessions • Number of courtyard health education sessions at community level • Number of teachers & parents trained • Number of student brigade groups activated • Number of students participating in student brigade SHN activities • Number of mothers Gatherings organized

IR 4: Improved community support and policy environment for SHN

STRATEGIES: COMMUNITY CAPACITY BUILDING	
ACTIVITIES	**INDICATORS**
• Training of SMCs in SHN	• Number of SMCs trained in SHN

Reporting Requirements

Reporting is the recognized process of sharing the progress of planned activities, timely accomplishments, challenges and gaps in programs to both external and internal audiences who are interested in the use and responsible for the further dissemination of the information and for planning. Various reports are prepared and targeted at different users with different timings. Timely reporting is an obligation for all programs: the table below sets out the required reporting requirements for the SHN program. All reports can be found in the M&E section of the Integrated Program document.

Name of report	Reporting period	Report		Responsible	Deadline	Remarks
		From	To			
Global Education Indicator (GEI)	One year	BdCO	Home Office	Program Manager	February-March	Integrated report for Education and SHN
Annual Report (Narrative)	One year	BdCO	Asia Area Office	DCD, Program Program Manager	October	Integrated report for all programs
Annual Status Report (ASR)	One year	BdCO	Sponsor	Sponsorship Chief Program Manager	September	Integrated with sponsorship operations
Self Assessment Report	One year	BdCO	Home Office	Sponsorship Chief Program Manager	April-May	Integrated with sponsorship operations
Quarterly Progress Report (Narrative)	One quarter	IAO	BdCO	DM-Implementation	First week of each quarter	By programs based on DIP
Monthly Expenditure Report	One month	IAO	BdCO	DM- Finance	25th of each month	All programs
	One month	BdCO-Finance	Program Manager	Finance team	First week of each month	By programs
Monthly activity report	One month	Staff	Supervisor	Individual staff	First week of each month	By positions

Annexes

Annex I

Table 1: Health and Nutrition Status Indicators

Result	Indicator Name	Definition		Means of Verification			Notes
		Description	Calculation	Source	Tool	Frequency	
Goal	**Prevalence of Anemia**	WHO defines anemia as follows: 5-11y: 115g hemoglobin/l 12-14y: 120 g hemoglobin/l Girls 15y+: 120 g hemoglobin/l Boys 15y+: 130 g hemoglobin/l (WHO, 2001) It is recommended to have a comparison group when evaluating SHN on anemia prevalence, because anemia prevalence tends to rise and fall seasonally, due to factors unrelated to Save the Children programming. A comparison group controls for these other factors and evaluates the impact of SHN only.	[Number of children who have anemia] x 100, divided by [Total number of children tested]	Survey. **Seek technical assistance.**	Hemoglobin Analysis using Blood Hemoglobin Photometer (Hemocue)	Baseline, (mid-term) and Endline	If possible, data should be collected at the same time of the year to minimize seasonal variation.
Goal	**Prevalence of intestinal parasites and/or urinary schistosomiasis**	Infection by intestinal parasitic worms (geohelminths) is widespread throughout the world and affects millions of people, especially children. Three of the most common kinds of worms that infect children are roundworm (Ascaris lumbricoides), whipworm (Trichuris trichiura) and hookworm (Ancylostoma duodenale and Necator americanus). There are two types of schistosomiasis, the urinary type, caused by Schistosoma haematobium and the intestinal type, caused by Schistosoma mansoni. Schistosomes are small parasitic worms (flukes) that live in blood vessels around the bladder (urinary type) or intestine (intestinal type).	[Number of children who have parasites*] x 100, divided by [Total number of children tested]	Survey. **Seek technical assistance.**	Stool examination and/or Urine Analysis	Baseline, (mid term) and Endline	*The specific types of parasites should be noted and the intensity of infection
Goal	**Prevalence of stunting (low height for age)**	Stunting (defined as less than two Height for Age Z-score (HAZ) from a reference population of the same age and sex – see EPINUT program for details) is a measure of chronic under nutrition. Although most stunting stems from early childhood under nutrition, anthropometric studies amongst school age children suggest that children become more stunted, throughout their school years. SHN interventions can prevent children from become more stunted and there is evidence that suggests that it can be reversed.	[Number of children with HAZ <-2] x 100, divided by [Total number of children tested]	Survey. **Seek technical assistance.**	Height measure (high quality that measures to the minimeter)	Baseline (mid term) and endline	
Goal	**Prevalence of health and nutrition problems** (according to context and program focus)	Other indicators of health and nutrition status may be collected, which may vary according to the context (types of problems present in particular area) and the program focus. For example, if promotion of iodized salt is an important element of the program, prevalence of goiter or urinary iodine may be collected. Guidelines on how to conduct health and nutrition surveys will be covered in a separate document.	[Number of children with health problem] x 100, divided by [Total number of children tested]	Survey. **Seek technical assistance.**	Will vary by health problem	Baseline (mid term) and endline	

Table 2: Outcome Indicators for SHN

Result	Indicator Name	Definition		Means of Verification			Notes
		Description	Calculation	Source	Tool	Frequency	
SO	**Percent of children dewormed or/and supplemented with micronutrients**	Efficacy of treatment increases when all children in the impact area regardless of their enrollment status are treated. For out-of-school children, the denominator should be all school-age children in the impact area. Intestinal parasites are treated with a single dose of either mebandazole or albendazole and schistosomiasis is treated with individualized dose of praziquantel. Vitamin-A and iron supplementation are often needed and in areas where iodized salt is unavailable supplementation of iodine is necessary.	[Number of children dewormed or supplemented with micronutrients] X 100, divided by [Total number of children enrolled in program schools]	Program records	SHN monitoring form	Annually	*Note the specific anti-parasitic medication or micronutrient used when reporting this result.
SO	**Percent of schoolchildren reporting a specific behavior or observed practicing a specific behavior**	The behaviors that are measured should be addressed in the interventions e.g. through the school health curriculum or other school-based health promotion activities	[Number of children reporting a specific behavior OR observed practicing a specific behavior] X 100, divided by [Total number of children surveyed or observed]	Survey	SHN KAP questionnaire and/or observation sheet*	Baseline and endline; use qualitative tools to check progressv	*All tools should be adapted to the local context and project needs and pre tested Cannot combine observation with reported behavior. Choose one. Observation is preferred but is more time intensive.
IR 1	**Percent of schools doing mass deworming and/or micronutrient supplementation**	Choose appropriate indicators to match project's interventions. Note the specific micronutrients or/and anti-parasitic available when reporting this result. If out-of-school children are targeted for the program service, the denominator should be all school-age children in the impact area or can be counted for progress indicator only.	[Number of schools doing mass deworming and/or micronutrient supplementation] X 100, divided by [Total number of schools within target area]	Program records	SHN monitoring form	Annually	
IR 1	**Percent of schools doing vision and hearing screening treatment and/or malaria treatment kits and/or psycho-social counseling and/or other SHN related services**	Choose appropriate indicator to match project's interventions and specify the intervention.	[Number of schools with providing vision and hearing screening or counseling or other SHN services] x 100, divided by [Total number of schools within target area]	Program records	SHN monitoring form	Annually	
IR 2	**Percent of schools with access to potable water**	Quality of school environment is improved with increased access to water in schools.	[Number of schools with access to potable water] x 100, divided by [Total number of schools within target area]	Program Records/School Enrollment	SHN monitoring form	Annually	
IR 2	**Percent of schools with functioning latrines* AND/OR with hand-washing facilities.**	Increasing the development of functioning latrines only is a key IR also. The presence of hand-washing facilities with soap near the latrines is ideal. Note the importance of soap when assessing hand-washing facilities.	[Number of schools with a functioning latrine with hand-washing facilities] x 100, divided by [Total number of schools within target area]	Program Records/School Enrollment	SHN monitoring form	Annually	* Specify what your FO considers "functioning" and use this to assess school latrines. Note these criteria when reporting your results

Table 2: Outcome Indicators for SHN (continued)

Result	Indicator Name	Definition		Means of Verification			Notes
		Description	Calculation	Source	Tool	Frequency	
IR3	**Percent of teachers trained to teach SHN curriculum using participatory methods (including Child to Child)**	Training may be conducted by SHN program directly or via partner organizations/government so the quality of training is key to the usefulness of this indicator. This is a progress indicator that will lead to results indicator but it is a key indicator that can be monitored annually.	Number of teachers trained x 100, divided by Total number of teachers in program schools	Program Records/School Enrollment	SHN monitoring form	Annually	
IR3	**Percent of children who know certain facts about health, hygiene, nutrition and/or HIV/AIDS prevention and have positive attitudes towards specific behaviors**	The knowledge and attitudes that are measured should be addressed directly in the interventions e.g. through the school health curriculum or other school based health promotion activities.	Number of children who know certain facts X 100, divided by the number of children interviewed	KAP survey	SHN KAP questionnaire*	Baseline and endline. Use qualitative tools to check progress. *All tools should be adapted to the local context and project needs and pre tested	
IR 4	**Percent of schools with functioning SHN Committees**	Identify the criteria you will use to determine whether or not a Committee is "functioning" (i.e. number of times it meets, degree of involvement, etc.) before conducting the assessment. Its links to school management committees should be part of the definition of "functioning". Note these criteria when reporting your results.	Number of schools in target area with functioning SHN Committees] x 100, divided by [Total number of schools in target area]	School Management Committee Records	SHN forms	Baseline & Annually	
IR 4	**Change in policy environment related to SHN**	Examples of these types of supportive policy initiatives include governmental task forces, regional/governmental initiatives, public-education campaigns, etc. For example, the establishment of food safety standards at schools.	During your situational analysis or baseline study, a 'baseline' should be established regarding the policy environment for SHN in the target area. Each year monitor the policy environment and record and changes that have taken place.	Information about resources may be found in government/ education departments, other NGO reports, local initiatives and/or universities	SHN forms	Baseline & Annually	

Annex 2

Save the Children Bangladesh Country Office Conceptual Framework

	Education	Health & nutrition	Adolescent development
CATEGORY	**Limited:** • Critical thinking skills • Productivity • Employment opportunities	**Increased:** • Risk of mortality and morbidity • Poor nutrition • Failure to reach full potential	**Increased:** • Detachment from community • Failure to follow through Vulnerability

Children who do not learn and develop to their full potential

CHILDREN	• No access to ECD • No early stimulation • Miss school	• High parasite load, anemia leads to sick and malnourished children • Short attention span, unable to concentrate • Water borne diseases	• Adolescents marry young, premature pregnancies, 3x higher risk of mortality in childbirth • Unaware of RSH, low education levels, little vocational training or employment opportunities • Low self esteem
FAMILY	• Do not prioritize schooling • Unaware of importance of stimulation • Cannot afford uniform, supplies	• Lack of resources or safety nets • Poor heath, nutrition practices • Lack of safe water and sanitation	• Burden to families • Risk to families • No value for adolescents
COMMUNITY	• No ECD or GPS • Poor quality of education • Inactive SMC	• Deficient WATSAN • Do not recognize connection between health and academic performance • No safety nets	• Acceptance of early marriage • Little or no value for young adults • No Youth Friendly Service

Cross cutting:
Not taking responsibility for changing situation for children and adolescents; not feeling empowered to make a difference.

Annex 3
Save the Children Bangladesh Country Office's Sponsorship Results Framework

Goal	Children Learn and Develop to their full Potential				
SO 1	Children learn and develop with age appropriate care and education	**SO 2**	Improved use of key health, hygiene and nutrition services and practices	**SO 3**	Adolescents contribute positively to well being and betterment of society
IR 1.1.1	Increased availability and access to quality ECD	**IR 2.1.1**	Increased access and availability of school health, hygiene and nutrition services and practices	**IR 3.1.1**	Increased availability and access to adolescent/ youth-friendly health services and opportunities
IR 1.1.2	Increased quality of ECD opportunities that protect & promote children's cognitive, social, emotional and physical development	**IR 2.1.2**	Improved quality of school environments with regard to health	**IR 3.1.2**	Improved quality of adolescent/ youth-friendly health services for adolescents
IR 1.1.3	Improved HH & community capacity to protect and increase children participation in quality ECD	**IR 2.1.3**	Enhanced attitudes and interest among primary school-age children in using health services and adopting health-protective behaviors	**IR 3.1.3**	Enhanced attitudes & interest among youth in using health services and adopting health protective behaviors
IR 1.2.1	Increased Availability and Access to quality basic education.			**IR 3.2.1**	Increased availability and access to education and livelihood opportunities for adolescents
IR 1.2.2	Increased Quality of basic education opportunities that protect & promote children's cognitive, social, emotional and physical development			**IR 3.2.2**	Improved quality of educational and livelihood opportunities for adolescents
IR 1.2.3	Improved household and community capacity to protect and increase children's participation in quality basic education			**IR 3.3.3**	Enhanced capabilities, skills and knowledge of adolescents
IR 4	Improved social and policy environment for children, adolescents and families.				

See Annex 1 for the series of standard indicators compiled by Save the Children USA relevant to the goals, objectives and intermediate results of its Bangladesh programs.

Annex 4 Annual Work Plan 2008

Ujalpur Govt. Primary School Kutubpur Union, Sadar Upazila, Meherpur

No	Activities	Target	Implemented by	Time	Amout of Money	Source of Money	Follow up
1	Child Survey	From 4+ to 14+ years old children	Teacher, assistance with SMC	Jan-Feb08			Asst. Education Officer
2	Child admission and rally for campaign		Do	Do			
3	To identify handicapped children and ensure admission	All handicapped children	Do	Do			
4	Mothers gathering	3 times in a year				SMC, Teachers & Save the Children one time	
5	To make a map of Catchment area	01	Teachers	Jan-April 08			
6	Increase attendance of Students		Teacher, assistance with SMC	Round the year			
7	Completion of five years education for the students		Teacher, assistance with SMC	Round the year			
8	To make uniform and batch for the students		Teacher, assistance with Parents	Round the year			
9	Students reception (all students of Grade-1)		Teacher, assistance with Parents	Feb-Mar 08		SMC, Teachers & Save the Children	
10	Annual Sports	One time each year	Teacher, assistance with SMC				
11	Annual Picnic	One time each year	Teacher, assistance with SMC & PTA	Feb 08			
12	Maximum attendance, reward of talent student & mother	5 students & mother	SMC	After result of final exam		SMC, Teachers & Save the Children	
13	Home visit of SMC	12	SMC	Jan-Dec 08			
14	Evaluation test		Teachers	Every day			
15	Coaching for Grade-V students		Teachers				
16	To increase rate of success of scholarship exam		Teachers				
17	To build a Cub team and activate		Teachers	January			
18	To build a student brigade, training and to prepare workplan	Grade-IV & V students	Teacher, assistance with SMC	January		SMC, Teachers & Save the Children	
19	Health education in class and personal cleanliness activities	One time in a week	Class teacher	Jan-Dec 08		Arrange training for teacher by SC	
20	Cleanliness activities in the school and collect materials		Students, assistance with teacher	Jan-Dec 08		SMC, Teachers & Student brigade	
21	Set up tube well, latrine and repair	As per need	Teacher, assistance with SMC	Jan-Dec 08		SMC, Teachers & Student brigade	
22	Safe drinking water in the classroom	3 jag & 10 glass	Students, assistance with teacher	Jan-Dec 08		SMC, Teachers & Student brigade	
23	Distribute ring latrine among poor and meritorious students	10 sets	SMC assistance with teacher	Mar-April 08		Save the children	
24	Provide first aid kit box and refilling medicine	As per need	Students brigade, assistance with teacher	Jan-Dec 08		SMC, Teachers	
25	De-worming	6-12 yrs, two times	SMC, assistance with teacher	March & Aug		Save the children	
26	Vision screening and provide treatment	All Student	Students brigade, assistance with teacher	Mar-April 08		Save the children	
27	Vitamin A Capsule supplementation	All Student	Students brigade, assistance with teacher	Nov 07 & June 08			
28	Iron tablet supplementation	All Student	Students brigade, assistance with teacher	April-Aug 08			
29	SMC meeting	Once in a month	Teacher, assistance with SMC	Jan-Dec 08			
30	PTA meeting	3 times in a year	PTA assistance with teacher	Jan-Dec 08			
31	Tree plantation & gardening	One time in a year	Students brigade, assistance with teacher	May-June		SMC	
32	Day Observation		Teacher, assistance with SMC	Jan-Dec 08			

Signature: Head Teacher Signature: SMC Chairman Signature: Government Education Officer

Annex 5 Detail Implementation Plan (DIP)

IR 1: Increased access and availability of School Health, hygiene and Nutrition Services and practices

Major activities	Sub-activities	Target	Responsibility	Time Line (by week)																Sub-activities wise budget break up	Total cost
				Sep.				Oct.				Nov.				Dec.					
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
1.1. Deworming to all primary school children (2nd round)	1.1.1. Joint Planning meeting with the District & UZ health department official	1 Meeting	Choyan					√								■	■				–
	UZ education department official the District & UZ education department official	1 Meeting						√								■	■				–
	1.1.3. Upazila level school head Teachers orientation on de-worming activity & process for second round	113 head teachers				■		■	√							■	■			117 participants * 30TK.	3,500
	1.1.5. School wise Teacher & SMC Chairman orientation	113 School									✓■					■	■				–
	1.1.6. Awareness raising activities (Leaflet preparation and distribution, miking – mobile and mosque, banner display at school side and gathering place and add to local news paper)	1 time						■	■	■		√				■	■	■		17000 Leaflets*1.40/- .=23800TK; *12 Mobile Miking * 2days * 500/-=12000TK. 24 Banner* 300=7200TK. Ad to local Newspaper (2 days) 6500/-	49,500
	1.1.7. Ensure de-worming to all school children and record in the register	26781							■	■								■			–
1.2. Vitamin A supplementation to all school going children (2nd round)	1.2.2. Planning meeting with District & Upazilla education & health department officials	1 Meeting	Choyan		■	■		√								■	■			This activity is incorporated with National Deworming Day	–
	1.2.3. School wise Teacher & SMC Chairman orientation	113 School			■	■		■	√	√	√					■	■				–
	1.2.4. Planning meeting with the manager of BRAC Meherpur Sadar Upazila	4 managers			■	■		√								■	■				–
	1.2.6. Implement Vitamin-A Capsule Supplementation to primary school going children.	26781 students		■					■	■			✓■					■		document/ photocopy/ etc. – 500/-	500
1.3. Iron supplementation	1.3.7. Implementation of Iron supplementation (26781+1301=28082 Student)	28,082 student	Shuja	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	✓■	28082 student * 2 times in a week * 16 week	–
1.4. Annual vision screening to all school going children and necessary medical support	1.4.2. Meeting with District & Upazilla education & health department officials	1 Meeting	Monju				√		■	■											
	1.4.3. Planning meeting with the manager of BRAC	1 Meeting					✓■			■											
	an orientation on Vision Screening process (GPS, RNGPS, Community school, Madrasa – 113 RNGPS, Community school, Madrasa – 113 & Mission – 1 & BRAC-42, Pre-school 68, total – 224 schools)	224 School		✓■	✓■									■								

IR 1: Increased access and availability of School Health, hygiene and Nutrition Services and practices (continued)

Major activities	Sub-activities	Target	Responsibility	Time Line (by week)																Sub-activities wise budget break up	Total cost
				Sep.				Oct.				Nov.				Dec.					
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
1.4. Annual vision screening to all school going children and necessary medical support (continued)	1.4.6. Conduct Vision screening by the teachers and identify the cases with visual problem	224 School	Monju	✓	✓	■	■	✓	✓		■	■	■								–
	1.4.7. Share with Municipal & Union Parishad for vision camp organizing	6 Meetings							✓	■										Banner for camp	1.000
	1.4.8. Organize Municipal and Union wide eye camp for re-check	Need based								✓	✓									Doctors fee, accommodation & transportation charge etc.	50,000
	1.4.9. Arrange treatment for the identified children who have visual problem	Need based								✓	✓									Medicine, Spectacle & Operation charge etc.	200,000
	1.4.10. Ensure field visit by the health and education department manager/Supervisor for technical assistance of vision screening and treatment.	7 Person								✓	✓	■	■							Honorarium for technical expert and govt. officials	3,000
	1.4.11. Spectacle distribution among the vision problem studen	Need based		■									✓							Venue, snacks, decoration, honorarium, logistics (Banner)etc.	19,000
1.5. First Aid Kits management at schools	1.5.4. Organize school wise teachers training on first aid management	12 schools in Municipality of Meherpur Sadar	Nashid	■							✓	✓			■					Snacks & others: 80*30	2,400
	1.5.5. Regular follow-up & monitoring the use of the First Aid Kits & refilled by school teachers and SMC	101 School at 5 Union		✓	■	■	■	✓	✓	✓	✓	✓	✓	✓	■	✓	✓	■	■		
																				Program Running Cost	
																				Total budget of IR. 1	**328,900**

IR 2: Improved quality of school environments with regard to health

Major activities	Sub-activities	Target	Responsibility	Time Line (by week)																Sub-activities wise budget break up	Total cost
				Sep.				Oct.				Nov.				Dec.					
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
2.1. Repair & Maintenance of tube wells and latrine at schools	2.1.1 Repair and maintenance of disordered tube wells	10 tube wells	Hasan	■	■	■	✓■	✓■	✓■	■	■	■	■	■	■	■	■	■	■	Tube wells repairing Cost:	47,000
	2.1.2. Overhead water tank at Rudranagar school	1 overhead tank		■	■	■	✓■	✓■	✓■	■	■	■	■	■	■						126,000
	2.1.3. Water basin for hand washing at school	1 water basin		■	■	■	✓■	✓■	✓■	■	■	■	■	■	■						
	2.1.4. Water connection from overhead water tank to toilet and hand washing basin (with water pump)	2 spot water connection		■	■	■	✓■	✓■	✓■	■	■	■	■	■	■						
	2.1.5. Repairing and maintenance of Schools disordered latrine	11 latrines		■	■	■	✓■	✓■	✓■	■	■	■	■	■	■					Schools latrine repairing Cost:	180,00
2.2. Construction of latrine and urinal for boys & girls at school	2.2.1. Construction of safe latrines at school	12 school latrine	Monju				■	■	■	■	■	■	■	✓■	✓■	✓■	■	■		Latrines= 12 Schools ; 24 latrine	1,128,000
	2.2.2. Urinal for boys at school	113 schools					■	■	✓■	✓■	✓■	✓■	■	■	■	■	■	■			
	2.2.3. Ensure DPHE technical assistance for Construction of safe latrines at school.	12 Schools latrine					■	■	■	■	■	■	■	✓■	✓■	✓■	■	■		DPHE and Govt. technical assistance	12,000
2.3. Waste management at school	2.3.1. Discussion with Upazila education department	2 Meetings	Monju	✓■	✓■	■		■	■	■		■	■							At head teacher Monthly Meeting	–
	2.3.2. Discussion with SMC and teachers	Need based		✓■	✓■	■		■				■	■							Merged with School SMC meeting	–
	2.3.3. Construct School wise waste corner	113 schools		■	■	■	✓■	✓■	✓■	■	■	■	■	■	■					113 Schools 5000/-	565,000
	2.3.4. Construct basement for hand washing facility	70 schools		■	■	■	✓■	✓■	✓■	■	■	■	■	■	■					Basement=70 sch*300/-= 21,000; caring cost= 1500/- *5 unions= 7500/-	28,500
2.4. Menstrual management at school in collaboration with AD program	2.4.1. Meeting with District and Upazilla education official	1 Meeting	Ataur		■	■		✓■	■	■											–
	2.4.2. Prepare /adapt reading materials (folder) on menstrual management for grade 5 female student	1000 folder			■	■	✓■	■			■	■	■	■	■	■	■			20*1000	20,000
	2.4.3. Arrange all female teachers training on menstrual hygiene management by using ARSH materials	230 Female teachers (7 batches)			■		■	■			■	✓■	✓■	■	■	■	■			Food: 260*150/- = 39,000/-; Teachers transportation 230 person @ 200 = 46,000/- ; Resource person 2*7*700= 9,800/-; venue= 14,000/-; Logistic Cost (Bag, Banner): 85,200/- ; Printing, decoration, sound system =11,000/- others (note book, pen) = 1300;	206,300
2.5. Monitoring and Evaluation	2.5.1. DIP preparation workshop for FY201	10 Ppts	Ikhtiar	■	■	■						■	■		✓■						20,000
	2.5.2. Endline survey report (SHN-Nasirnagar) printing	500 copies	Ataur	■	■	■						■	■		■						150,000

IR 2: Improved quality of school environments with regard to health (continued)

Major activities	Sub-activities	Target	Responsibility	Time Line (by week)																Sub-activities wise budget break up	Total cost
				Sep.				Oct.				Nov.				Dec.					
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
2.5. Monitoring and Evaluation (continued)	2.5.3. KAP survey on health and nutrition	1 survey	Akter	■■	■■	✓■	✓■	✓■	✓■		■■	■■	■■		■■	■■	■■			Training materials (bag, pad, pen, clip board)= 14,500/-; Volunteer orientation (Food, venue)= 5,600/-; Data collection= 63,100/-; Data entry/coding= 11,400/-; others= 4,420/-)	100,000
	2.5.4. TOT on child protection for staff	9 staff		■■	■■	■■	■■	■■	■■		■■	■■	■■		■■	■■	■■				68,000
	2.5.5. Monthly staff meeting	12 Meetings	Monju	■■	■■	■■	✓■	■■	■■	■■	✓■	■■	■■	■■	✓■	■■	■■	✓■	■■	4 Meetings*1200/-	4,800
2.6. Partner Development and training	2.6.1. Select partners for new area		Ikhtiar	■■	✓■	■■	■■	■■	■■	■■	■■	■■	■■	■■	✓■	■■	■■	■■	✓■	Advert cost: 30,000/-	30,000
	2.6.2. Develop training plan to train partner staff for Mujbnagar	1 plan												■■	✓■			■■			89,950
	2.6.3. Provide TOT to partner staff for start-up of program in new area	10 staff												■■				✓■	■■		
	2.6.4. Planning meeting with UEO & HT by HT monthly meeting for health and hygiene assessment in primary schools at Mujibnagar	1 Meeting												■■			✓■	■■	■■		
	2.6.5. Health and hygiene assessment in primary schools in Mujibnagar	40 schools												■■	■■			✓■	■■	Volunteer orientation: Food 25*150/-=3750/- Pad & Pen 20* 65/-=1300/- Survey materials 2000/- Transport 500*10* 1 day= 5000 Vol. Honorium 1 day*20Vol.* = 4,000	16,050
	2.7.1. Translate operation guideline into Bangla	1 guideline	Ikhtiar				■■		■■	■■	■■									Resource cost for translation	150,000
	2.7.2. Printing of guidelines and other materials of SHN for distribution to staff and partner	100 copies					■■				■■	■■	■■	■■						Built in Printing cost of budget	
																				Program Running Cost	
																				Total budget of IR. 2	**3,859,200**

IR 3: Enhanced attitudes and interest among primary school-age children in using health services and adopting health-protective behaviors

Major activities	Sub-activities	Target	Responsibility	Time Line (by week)																Sub-activities wise budget break up	Total cost
				Sep.				Oct.				Nov.				Dec.					
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
3.1. Wall mural (message) on health hygiene at schools	3.1.1. Meeting with respective department for health message disseminations through wall writing	1mtg	Shahed	✓	■																–
	3.1.2. Sharing with selective school for health message disseminations through wall writing	60 schools		✓	■	■	■	■			■	■	■		■	■	■	■			–
	3.1.3. Health message disseminations through wall writing	60 schools		■	■	■	■	✓	✓	✓	✓	✓	✓		■	■	■	■		60 school* 3,000/-	180,000
3.2. Teachers and parents capacity building (including provision SHN education materials)	3.2.1. Sharing meeting with DPEO,UEO & AUEO to use of PHASE materials as supplementary materials by teachers	1mtg	Nashid	■		✓	■														–
	3.2.2 Orientation on use of PHASE materials for school teachers (merge with sub-cluster training)	113 school teachers		■	■	■	■	✓	✓	✓	✓	■	■		■	■	■	■		585*500 Bag for PHASE materials=292,500/-; Snacks 30*600=18,000	310,500
3.3. Health & Hygiene demonstration	3.3.1. Volunteer selection (2 Vol. Per village from 11 villages in 5 union for Community demonstration on correct health and hygiene practices at home	20 Vol.	Ikhtiar		✓	✓	■		■	■											–
	3.3.2. Develop Volunteer orientation package including hand washing, iodine, diarrhea, and arsenic	1 Package		✓	■	■	■	■	■	■											–
	3.3.3. Procurement and printing demonstration materials				■	✓	✓	■												20 Vol. field bag*350/-=7000/-; Reporting Format photocopy=2000/-; Register for family= 20* 80/-= 1600; Message card= 5100* 25= 127,500	138,100
	3.3.4. Volunteer training / orientation focusing hand washing, iodine, diarrhea and arsenic.	20 Vol.			■	■	■	✓	■	■										Orientation Cost: Food: 30 Ppts* 150/-*2 days=9000/- Vol. transportation: 20 Vol.* 100/-* 2 days= 4000/=; Session Cost: 20*1000/-*3 months = 60,000	13,000
	3.3.5. Demonstration and dissemination sessions by volunteers	5100 family						✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Session Cost: 20*1000/-* 3 months= 60,000	60,000
3.4. Hand Washing Day 2009	3.4.1. Advertisement to National dailies	2 newspapers	Nashid						✓		■	■	■	■	■	■	■	■		200,000	200,000
	3.4.2. Planning meeting with education and health department	2 Meetings			✓			✓			■	■	■	■	■	■	■	■			
	3.4.3. Sharing with head teachers monthly meeting	153 schools			✓						■	■	■	■	■	■	■	■			
	3.4.4. Organize and observe GHWD at District/ Upazila/ union and school level (MP-26836 & Moj-10000 Total 36836)	2 Papillas								✓	■	■	■	■	■	■	■	■		40,000 Soap (70gm)*10/-=400,000/-, 153 Banner*300/-= 45,900/-, 153 Rally, Local news ad= 4,000*2 days= 8,000/-	453,900

IR 3: Enhanced attitudes and interest among primary school-age children in using health services and adopting health-protective behaviors

Major activities	Sub-activities	Target	Responsibility	Time Line (by week)																Sub-activities wise budget break up	Total cost
				Sep.				Oct.				Nov.				Dec.					
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
3.5. NID and Vitamin A week campaign	3.5.1. Planning meeting with DPEO,UEO & AUEO	1Meeting	Shuja	■■	■■	■■	✓■				■■										–
	3.5.2. Meeting with teacher & SMC	113 School		■■	■■	■■	✓■	■■	■■	■■	■■	■■	■■	■■	■■	■■	■■	■■		Merged with school SMC meeting	–
	3.5.3. Participate with government to observe NID (miking, digital banner, leaflets, festoon etc.) to Vitamin A and deworming tablets to pre-school children	2 times		■■	■■	■■	■■		■■	■■								✓■		Miking= 2 days* 6*500/-=6,000; Banner= 46*300/-=14,000	20,000
																				Program Running Cost	
																				Total budget of IR. 3	**1,375,500**

IR 4: Improved social & policy environment for children & families

Major activities	Sub-activities	Target	Responsibility	Time Line (by week)																Sub-activities wise budget break up	Total cost
				Sep.				Oct.				Nov.				Dec.					
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
4.1. Support in water and sanitation at community	4.1.1. Discuss with Upazila/district DPHE and Union Parishad	6 Meetings	Shahed	✓■			■■	■■													–
	4.1.2. Identify 10 family on set criteria for construction ECO sanitary latrine at community.	10 families		✓■			■■	■■													–
	4.1.3. Provision of community eco sanitary latrine as demonstration.	10 latrines				✓■	✓■	✓■	✓■		■■	■■	■■	■■	■■	■■	■■			ECO sanitary latrine Cost 10*15,500/-	155,000
	4.1.4. Ensuring 100% sanitary latrine to 10 school area/ village by providing ring latrine (10 selected villages)	1600 sets									✓■	✓■	✓■	✓■	✓■					Ring latrine (5 ring & 1 slab) 1600*900/- Installation Cost (tk. 500) born by family	1,440,000
	4.1.5. Collect information from school going students family about water seal status	102 villages		■■	■■							✓■	✓■					■■			–
	4.1.6. Water seal to school going students family who have broken toilet without seal	3500 student family		■■	■■	■■	■■						✓■	✓■	✓■	✓■	✓■			Labor charge: @25/-*3500= 87,500/-; Drill machine 5*300/-= 1500/-; Screw .50/- *7200=3600/-	92,600
4.2. Safety on road crossing for School children	4.2.1. Meeting with respective department (Roads and high way)	1 Meeting	Monju	■■	✓■	■■															–
	4.2.2. Sharing with Upazila education department	1 Meeting		■■	✓■	■■															–
	4.2.3. Sharing with selective school	20 School		■■	■■	■■			✓■	✓■	✓■										–
	4.2.4 Road sign indicator preparation and installation	40 Sign Board			■■	■■						✓■	✓■	■■	■■	■■				40*2537/-= 101,500	101,500
	4.2.5. Aware school children about road sign by teacher	Road side School			■■	■■						✓■	✓■	■■	■■	■■					–

IR 4: Improved social & policy environment for children & families

Major activities	Sub-activities	Target	Responsibility	Time Line (by week)																Sub-activities wise budget break up	Total cost
				Sep.				Oct.				Nov.				Dec.					
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
4.3. Networking, advocacy, policy influence	4.3.1.Round table meeting at district: Better health better education	1mtg	Habib						■	■	✓■			■		■	■				100,000
	4.3.2. Exposure visit to & from Govt counterpart and Program staffs	60 schools	Ataur						■	■	■			■		■	■				75,000
	4.3.3. Conduct National level round table conference to share experiences (Nasirnagar/ Meherpur)	1 conference	Ikhtiar											✓■							300,000
																				Program Running Cost	
																				Total budget of IR. 4	**2,264,100**
																				G. Total Taka	**7,827,700**
Total for all activities to be implemented by Save the Children USA/SHN program																				**US$**	**111,824**

Signature:

Program Manager- SHN

Signature:

Program Director

Annex 6
Summary Implementation Plan (SIP)

Country / Field Office: Bangladesh
Core Program Area: SHN
Total Sponsorship Funding: $293,839 Total Other Funding: $ 90,000

Interventions*	Associated Activities*	Time Frame (quarters)				Funding	
		Q1	Q2	Q3	Q4	Sponsorship	Other* Yes or No?
Intermediate Result (IR) #1: *Increased access and availability of School Health, Hygiene and Nutrition services and practices*							
Provision of health services	Deworming coordinated with government (twice a year) for both pre & primary school aged children		✓		✓	✓	**Yes** for multivitamin from Sight & Life
	Vitamin A capsule supplementation coordinated with government (twice a year)		✓		✓	✓	
	Iron supplementation (twice in a week for 16 weeks/year) for all school going children			✓		✓	
	Annual vision screening, referral and treatment (once a year)			✓		✓	
	First Aid Kits (FAK) box and services	✓	✓	✓	✓	✓	
	Multivitamin supplementation to 100 primary school children in Gangni as study	✓	✓	✓	✓		
Intermediate Result #2: *Improved quality of school environments with regard to health*							
Improving water and sanitation services	Construction & repairing of hygienic latrines for boys & girls at schools	✓	✓	✓	✓	✓	H20 for Life
	Rehabilitation of hand washing facilities at school	✓	✓			✓	
	Safe and arsenic free water supply at school (Ring/ Deep Tube Well) and class room (Jug, glass, water)	✓	✓	✓	✓	✓	
	Arsenic testing for drinking water in all schools		✓	✓		✓	
	Waste management at school for all classes	✓	✓	✓	✓	✓	
	Menstrual management at school for grade 5	✓	✓	✓	✓	✓	
Intermediate Result #3 *Enhanced attitudes and interest among primary school-age children in using health services and adopting health-protective behaviors*							
Capacity building of teachers, students and parents on health education	Class room based nutrition & health education session by teacher	✓	✓	✓	✓	✓	
	Training of teacher's and SMC / parent's on SHN (including provisioning SHN education materials)	✓	✓	✓	✓	✓	
	Orientation & activation of Student Brigade for BCC at school & community	✓	✓	✓	✓	✓	
	Parents awareness on health & hygiene issues through facilitating courtyard session and house hold demonstration	✓	✓	✓	✓	✓	
	Mothers gathering/ Global & National Day Observation/ Annual sports	✓	✓	✓	✓	✓	
Intermediate Result #4: *Improved social and policy environment for children, adolescents and families*							
Develop a advocacy strategy/plan to promote sponsorship (SHN) and BdCO advocacy priorities	Work with Government (DPE) and development partners (UNICEF, WFP) to develop SHN package and roll-out	✓	✓	✓	✓		
	Work with Government (DGHS) and development partners to organize and observe National Deworming Day	✓	✓	✓	✓		
Promote a adoption of positive practices and supportive social environment for SHN services and opportunities	Round table meeting/workshop/seminar at local and national level		✓		✓	✓	
	Experience sharing visit by government officials to gear up support to practice	✓	✓		✓	✓	

Annex 7
Process Indicators Tool (PIT)

Country / Field Office: Bangladesh
Core Program Area: SHN

PLEASE SEE NOTES ABOUT THIS TEMPLATE BELOW BEFORE COMPLETING

Interventions*	Associated Activities*	Process Indicators	# Planned	# Actual**	If the planned # was not reached, please explain why**
Intermediate Result #1:	*Increased access and availability of School Health, Hygiene and Nutrition services and practices*				
Provision of health service	Deworming coordinated with government (twice a year) for both pre & primary school aged children	# of children received deworming tablets at least twice in a year	38,000		
	Vitamin A capsule supplementation coordinated with government (twice a year)	# of children received vitamin A capsule at least twice in a year	36,000		
0	Iron supplementation (twice in a week for 16 weeks/year) for all school going children	# of children received at least 24 iron tablets in a year	36,000		
	Annual vision screening, referral and treatment (once a year)	# of children screened for vision once in year	36,000		
	Multivitamin supplementation to 100 primary school children in Gangni as study	# of schools provided multivitamin to children	100		
Intermediate Result #2:	*Improved quality of school environments with regard to health*				
Improving water and sanitation services	Construction & repairing of hygienic latrines for boys & girls at schools	# of schools constructed & repaired latrines for boys and girls	40		
	Rehabilitation of hand washing facilities at school	# of schools supported for hand washing facilities	40		
0	Safe and arsenic free water supply at school (Ring/Deep Tube Well) and class room (Jug, glass, water)	# of schools with access to safe drinking water	40		
	Arsenic testing for drinking water in all schools	# of schools tested its water sources for arsenic	153		
	Waste management at school for all classes	# of schools established waste management system in schools	153		
	Menstrual management at school for grade 5	# of schools received training for female teachers	153		
Capacity building of teachers, students and parents on health education	Class room based nutrition & health education session by teacher	# of schools conducted weekly health education sessions for all grade	153		
	Training of teacher's and SMC / parent's on SHN (including provisioning SHN education materials)	# of teachers trained on SHN	900		
0	Orientation & activation of Student Brigade for BCC at school & community	# of schools oriented and activated SB for hygiene promotion	153		
	Parents awareness on health & hygiene issues through facilitating courtyard session and house hold demonstration	# of courtyard session held at community	1,000		
	Mothers gathering/ Global & National Day Observation/ Annual sports	# of parents participated in the school events	14,500		
Develop a advocacy strategy/plan to promote sponsorship (SHN) and BdCO advocacy priorities	Work with Government (DPE) and development partners (UNICEF,WFP) to develop SHN package and roll-out	# of coordination meeting participated	4		
	Work with Government (DGHS) and development partners to organize and observe National Deworming Day	# of meeting attended	2		
Promote a adoption of positive practices and supportive social environment for SHN services and opportunities	Round table meeting/workshop/seminar at local and national level	# of round table meeting held at levels	2 (1 for district,1 for national)		
	Experience sharing visit by government officials to gear up support to practice	# of visits held with government officials	2		

Annex 8
SHN Program Materials

Name of intervention	Training Manual used	Health Education Materials used	Monitoring and Supervision forms
Deworming	• Teacher's training manual • Medicine user guideline	• Leaflet • Video on worm • PHASE materials (poster, puzzle, flipchart, flash card)	• School visit checklist • SHN register at school
Iron Supplementation	• Teacher's training manual • Medicine user guideline	• Leaflet • Health message card	• School visit checklist • SHN register at school
Vitamin A supplementation	• Teacher's training manual • Medicine user guideline	• Leaflet	• School visit checklist • SHN register at school
Vision screening	• Training Manual (developed by Addin)	• N/A	• School visit checklist • SHN register at school
First Aid Kit (FAK)	• Teacher's training manual	• Booklet for school	• School visit checklist • First Aid register
Health Education	• Teacher's training manual • Menstrual management training manual (Adapted from AD program) • Parenting manual (in process) • Operation manual (in process)	• Booklet for school	• School visit checklist • First Aid register

Annex 9
SHN Medicine User Guide

Anthelmintic- Albendazole

Indication:
In Bangladesh, usually Albendazole, Mebendazole, Livamizole and Pyrental Pamoate are used as anthelmentic drugs. But in the SHN program of Save the Children USA only Albendazole is used for anthelmintic purposes.
Though Albendazole gains entry slowly to the stomach and intestine, its chemical reaction process happens very quickly. The main chemical element albendazole sulfoxide is only suitable for anthelmintic action.

Mechanism:
Albendazole prevents the nutrient absorption of the worm by blocking the glucose absorption process: as a result the worm dies. Albendazole is very effective on most round worms, tapeworms and hookworms. At the same time Albendazole is also effective at killing thread worms.

Dose:
400 mg of Albendazole tablet

Administration:
Take one 400mg chewable tablet. Primary school aged children (6-12 years) will take one deworming tablet twice a year (May & November) on National Deworming Day. 2-5 year old children will also take deworming tablets twice a year, one on National Immunization Day and the other in Vitamin A Week. Other family members can take deworming tablets at least twice a year.

Side-effects:
Albendazole has no known serious side effects. Albendazole is easily digested. But short-term diarrhea, nausea or temporary abdominal pain may result. Moreover, vomiting may occur, but oral saline is sufficient to address the problem.

Caution:
Albendazole is not permitted for pregnant women or children below two years. Albendazole should not be used in cases of jaundice or high fever. Those who are sensitive to albendazole should not take them. It is important to check before administration whether children have taken deworming tablets within the previous 15 days. If so, they should not be given again.

Iron Tablets

Indication:
Iron is a micronutrient. It plays a very important role in both physical and brain development. Hemoglobin becomes deficient in the body due to a shortage of iron rich food. To prevent anemia, iron tablets works as a supplement to iron rich foods.

Dose:
Ferrous Fumerate 200mg + Folic Acid 0.20 mg

Administration:
Swallow one tablet of above-mentioned dose with water. Primary school aged children (6-12 years) should take one tablet once per week for consecutive 16 weeks. This schedule should be followed annually. If other family members wish to take iron tablets they should seek the advice of a doctor.

Side-effects:
Sometimes iron tablets may cause nausea, abdominal discomfort, constipation or diarrhea or black colored stool, which is not a danger. But if these problems persist, children should stop taking the tablet for 2/3 days and then re-start.

Caution:
Excess doses of iron may cause harm for children. Avoid taking iron that is not recommended by the program or on the advice of a doctor.

Vitamin A Capsules

Indication:
Vitamin A is one kind of micronutrient. It is essential to increase the body's immunity to disease. Vitamin A deficiency results from a shortage of Vitamin A rich food. Vitamin A capsules supplement Vitamin A rich foods to meet the body's requirement for protection against disease and to prevent night blindness and other diseases.

Dose:
1 Vitamin A capsule 200,000 i.u.

Administration:
Swallow one Vitamin A capsule 200,000 i.u. Primary school aged children (6-12 years) will take one capsule twice per year. Children 1-5 years old should take 1 Vitamin A capsule twice per year, one on National Immunization Day and the other during Vitamin A Week. Other family members can take Vitamin A capsules on the advice of a doctor.

Side-effect:
Vitamin A has no known side effects. The capsule are easily digested.

Caution:
Excess doses of Vitamin A may cause harm for children. Pregnant woman should avoid taking Vitamin A. Avoid taking any Vitamin A not recommended by the program or advised by a doctor.

Annex 10
SHN Register

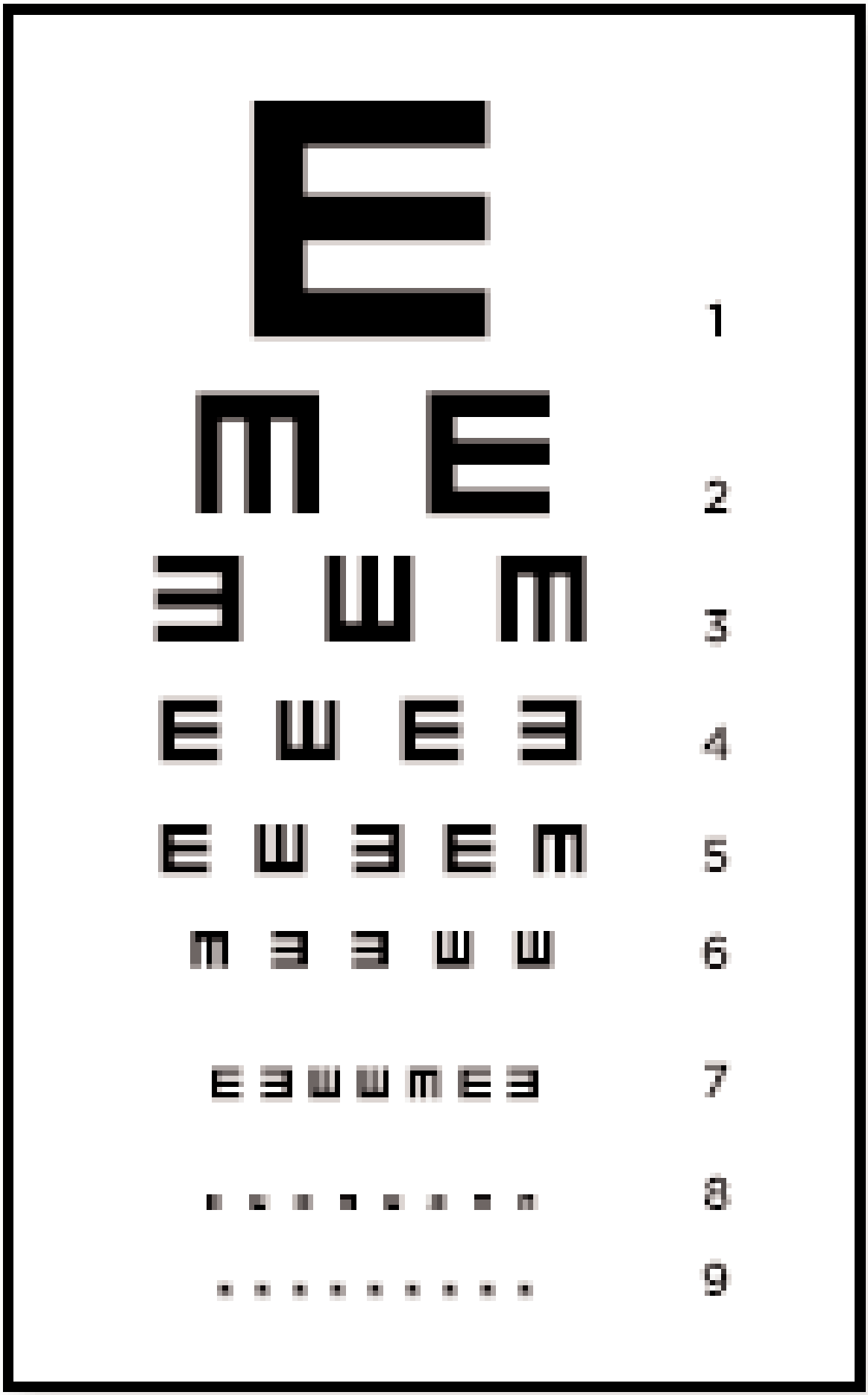
School Name **Year:**

Student name	Class/ Grade	Roll	Deworming tablet (Date)		Vitamin A (Date)		Iron tablet (Start & End date. In between √ mark)																Vision screening (date if yes)	
			1r	2r	1r	2r	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	3	16	Y	N

1r = 1st Round; 2r = 2nd Round

(Signature Teacher) (Signature SAG) (Signature PO)

Annex 11
Vision Chart



Annex 12
Steps to Test Arsenic in Water

Step: 1
Take water for testing from the tube well using the following method: take water according to the depth of the tube well and keep the water from the deepest level in a container. For example, if the tube well is 70 feet deep, then use the water extracted from the 70th time pressure. Water is to be discarded up to the 70th time pressure, then use water from the next pressure.

Step: 2
Water should be kept in a clean jar, up to the level of the arrow marked in the testing jar from the Arsenic Kit Box.

Step: 3
Pressing on the top of the extended parts of the mouth of the jar will open the upper part. Take one strip from the Arsenic Kit Box with a four cornered area pasted with paper and then place over the water and keep tight pressure on the upper parts.

Step: 4
Pour whole reagents from one packet in the water taking Reagent-1 from the Kit Box opening zip lock. Then pour whole reagents from Reagent-2 in the water as before. Lock the mouth of the jar. Keep the jar on a flat surface for 20 minutes. During that time shake the jar twice very lightly. Take care that no water touches the strip.

Step: 5
After 20 minutes, take the strip out of the jar and then wash out with the water kept in the other jar for testing, to ensure that the strip color is more permanent.

Step: 6
The strip should match one of the colors marked in the box according to the arsenic ppb (parts per billion). Whichever color in the Box the strip matches indicates the level of arsenic in the water.

Based on arsenic level, the water is classified and suitable or not for drinking:
There are seven indications marked for labeling arsenic ppb. Indications are: 0, 10, 25, 50, 100, 250 and 500. 0 to 50 indicates tolerable levels for drinking. A level of between 100 and 500 indicates that the water is dangerous to drink.

Caution:
Hydrogen and Arsine gases are produced during the testing of arsenic. Thus, arsenic testing should be done in only in an open, ventilated space and should be kept away from flammable items. Wash hands properly at all times.

Annex 13
School Visit Checklist

	Jan		Feb		March		April		May		June		July		August		Sep		Oct		Nov		Dec		Total		%	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the School Premises clean?																												
Is the Classroom clean?																												
Have the cleaning materials																												
Is the waste box in the classroom?																												
Number of students receive First Aid treatment	#		#		#		#		#		#		#		#		#		#		#		#		#		#	
	#		#		#		#		#		#		#		#		#		#		#		#		#		#	
Have the First Aid medicine and First Aid box																												
Have the First Aid medicine re-filling system at school																												
How many Health Education sessions held?	#		#		#		#		#		#		#		#		#		#		#		#		#		#	
	#		#		#		#		#		#		#		#		#		#		#		#		#		#	
Is the tube-well running?																												

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