A PRACTICAL HANDBOOK ON

FAMILY DEVELOPMENT PROGRAMS

ACTIVITIES, METHODS & TOOLS

ENFANTS DEVELOPPEMENT

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FOREWORD

Enfants&Développement has been developing family development projects in its four countries of intervention for more than 10 years. Since then, we have been explaining this methodology and its results in numerous proposals and reports and yet, when partners come to the field and meet social workers and followed-up families, everything makes sense.

As easy as it is to present the construction of a school, it is equally difficult to present the personal development of a very poor women and its family through a psychosocial approach. This manual will give you keys to implement family development projects, but as children and their families are E&D's priority, I prefer let Pot San speaking to introduce it. She is Cambodian 43 years old widow with 3 children and 2 grandchildren, and has been followed up by a social worker of our Family development project during 7 months.

«When we first arrived in Phnom Penh in 1992, we slept and stayed in the street or in the market. I sold my house in my hometown to buy this house built with substitute materials. My husband has been ill during a long time and we spent a lot of money to treat him. In 2011, my husband died, and same year, my 23 years old son. I worked very hard to look after my three children - I washed neighbors' clothes, I was waiter for a restaurant… I could earn 80 USD per month, but my children dropped out from school to work too. My daughter got married at 17 and has now two babies, but her husband is drug addicted and violent. When I met a field worker of SKO (E&D's local partner), I could explain my difficulties and problems. My daughter just left home and I was in charge of my two grandchildren. She listened to me very carefully, and helped me to find solutions. She came very regularly to my home during 7 months. She gave me counseling and information. It was good to have somebody giving interest to me! She was always saying that with her short support, I could solve my problems by myself. And I did! Now, thanks to a loan, I have my own business, I sell fish. I know how to manage my budget better and it helps me to provide food to my family every days. I know where I can have free milk for the baby and a place to treat my grand children illnesses with no cost. I even attended some activities with my grandchildren, and I discovered how I can be closer to them, I love my relationships with them! I thank SKO very much for their support!»

And to conclude, I will use the words of Ms P., a Vietnamese woman followed up under FDP, who said that "Family development helps families to be steady on their own feet.

Véronique Jenn-Treyer


Enfants
Développement

INTRODUCTION

From 2010 to 2014, Enfants&Développement (E&D) has implemented the multi-country project "Capacity building of Non-State-Actors involved in poverty alleviation and Social Work in poor urban communities of the capital cities of Burkina Faso, Cambodia and Nepal" (supported by the European Union). In the framework of this project, E&D has been working with 4 local NGOs, namely: Enfants du Sahel-Burkina Faso (**ES-BF**) and Action, Gouvernance, Integration, Renforcement (**AGIR**) in Burkina Faso; Samatapheap Khnom Organization (**SKO**) in Cambodia and Voice of Children (**VOC**) in Nepal. These organizations have been provided with technical support for the implementation of the Family Development (FD) approach in their respective countries.

Throughout the project, the Family Development methodology and practice have evolved to adapt to the different contexts of intervention. If Family Development Programs (FDP) have been implemented in Cambodia since 2004 and in Nepal since 2007, in Burkina Faso the implementation of a family development program only started in 2010.

Through annual dissemination workshops and quarterly coordination meetings, the methodology and tools have been disseminated locally to non-state actors and local authorities. Internationally, two (2) capitalization seminars have been organized in 2011 in Phnom Penh and in 2013 in Ouagadougou and allowed the 3 main partners of the different project's countries as well as other local and international partners to share about the family development methodology and tools. In 2012, a website (**http://www.enfantsetdeveloppement.org/outils-et-methodes**) has been created to post on line all documents related to E&D's social projects.

This handbook is published at the end of the multi-country project and aims at:

- Sharing with development practitioners (in the north and in the south) about the activities implemented, the methods and tools used in Family Development Programs;
- Promoting a culture of exchange and experience sharing among social work practitioners;
- Documenting the family development method and tools as implemented by E&D and its partners.

This publication is the result of the capitalization and documentation work done throughout the multi-country project by E&D's program managers, E&D's local partner organizations in Burkina Faso, in Cambodia, in Nepal and in Vietnam.
This manual also built on the technical resources and documents disseminated by Inter Aide through its website Pratiques (**http://www.interaide.org/pratiques/**). The bibliographic sources and references are listed at the end of this manual.

A HISTORY OF FAMILY DEVELOPMENT PROGRAMS

crédit : Ingrid Chiron

A HISTORY OF FAMILY DEVELOPMENT PROGRAMS

Family development at Enfants&Développement

I. THE EARLY DAYS OF FAMILY DEVELOPMENT / INTER AIDE[1]

The Family Development (FD) method was created by Inter Aide and implemented for the first time in the 1980s in Brazil, in both urban and rural areas. It was then duplicated in India, Madagascar and in the Philippines but exclusively in urban areas.

The Family Development method has therefore evolved to adapt to these different contexts and to the needs of the most vulnerable. Some general principles (non-dole out policy, individual vs. community development approach) and methodological aspects (selection of families, number of families per social worker, duration of the follow up, ...) have however remained.

It is in India that the so called "Family Development approach" was really formalized. In the beginning, family development activities were integrated to health and education programs (TB, leprosy, support to the Balwadi[2], support for primary education, vocational training). The FD method was then adopted by other associations having micro finance programs. In India, the FD method was progressively transferred to Inter Aide partners in Mumbai in the early 1990s and in Pune from 2000. From 2004, early childhood development activities have been developed to complement FD programs. In Madagascar, FD programs started in 1994 together with an education program that supported early childhood education centers. Since 1999, social counseling sessions, mother and child healthcare and protection sessions have been implemented while early childhood development sessions started from 2001.

In 2002, a FD program was created in collaboration with a micro-finance program, aiming at offering simultaneously these 2 complementary services to disadvantaged families. Two different teams run these programs. In 2008, a unique program combining family development and micro-finance was launched by an association. This type of integrated program was also implemented in Ethiopia between 2001 and 2007.

Social programs started in the Philippines in Manila in 1986 and in Cebu in 1997. In Manila, Family Development programs were run along preschool activities (LINGaP[3]) and early childhood activities (EnFaNCE[4] Manila). In Cebu, FD programs were implemented with Bidlisiw and SACMi[5] , and Early Childhood development activities were started at the same time. Then the FD method was disseminated to other interested organizations through the creation of STePS[6]. In 2008, the Piso Pisong Ipon program was launched in Manila to promote both micro saving and training on family budget designed for disadvantaged families. This experimental action was then duplicated in Cebu.

II FAMILY DEVELOPMENT AT ENFANTS&DÉVELOPPEMENT

II.1 A brief history

Founded in 1984 to help children victims of war and genocide in Cambodia, Enfants&Développement first implemented projects in this country. Projects were thereafter implemented in several countries in the region: in Laos and the Philippines from 1987, in Vietnam from 1991, in Nepal in 2001 and from 2004 in Burkina Faso.

E&D first conducted health and education projects. The first social project of E&D was implemented in the Philippines. Launched in 1990, this project aimed at supporting and reintegrating street children of Manila.

A similar project was later implemented in Nepal (2001) in partnership with the NGO Voice of Children (VOC) for the protection and the family and social reintegration of the street children of Kathmandu.

[1] French NGO specialized in the implementation of development projects www.interaide.org
[2] Balwadi: Nursery schools
[3] LINGaP Foundation: Linkuran sa Ikauunlad Na Ganap ng Pamilya
[4] EnFaNCE Foundation: Encourage Families in Need and Care for Education
[5] SACMi: Share a Child Movement
[6] STEPs: Suporta Technika para sa Pag-umad sa Pamilia Inc. (previously the Cebu branch of EnFaNCE created in 2003)

A HISTORY OF FAMILY DEVELOPMENT

In 2004, E&D launched a Family Development project in Cambodia, on the model of projects developed by Inter Aide. The following years, Family Development projects have been implemented in all E&D's countries of intervention: in 2007 in Nepal, and in 2010 in Vietnam and Burkina Faso. A multi-country project [7] is currently being implemented (2010-2014) in Nepal, Cambodia and Burkina Faso. It allows "south to south" experience sharing among the partners of the 3 countries involved and local and international partners (including Inter Aide).

II. 2 The contexts of intervention

The implementation of Family Development projects in 4 distinct geopolitical areas allows to underline the specificities of each context of intervention and highlighted some evolutions:

- Family development programs introduce an individual and family approach of social work that aims at targeting the most vulnerable who often are excluded from community development programs or community based support systems. Inspired by social work as it was practiced in France, the family development approach is somehow new in Asian countries where most of the social interventions are designed based on the Anglo-Saxon approach of "community development". The implementation of family development programs in Asia and in Africa highlighted differences in the way target beneficiaries comprehended the program activities. In particular, while the opening of social centers in the areas of intervention was met with immediate enthusiasm by the population of Ouagadougou, it took more time and efforts in Cambodia and Nepal where the population did not immediately understand the purpose and interest of these centers.

- Until the early 2000s, family development programs were mainly implemented in areas with high poverty rates and high density of population: slums in India and in the Philippines, relocation areas in the suburb of Phnom Penh, informal settlements in Ouagadougou. Slums being usually clearly delimited, poor families can easily be identified through door-to-door visits (main identification method used under FD programs) as they are often unable to go and ask for social support by themselves. However, in the last few years, slums have progressively been disappearing (destroyed by governments, relocation plans, ...), and poor families are thus scattered all over the cities. Poverty being less concentrated, poor people are also less and less visible and thus become more difficult to reach. Even if the door-to-door method of identification remains the most efficient, it now takes a lot more time. The FD method must thus adapt to this changes and find appropriate means to identify poor families in need of social support (e.g. referrals from neighbors and local services, community mechanisms, increased social center's visibility).

[7] Project supported by the European Union and co-funded by the AFD (Agence Française de Développement) and private Foundations

A HISTORY OF FAMILY DEVELOPMENT

II.3 Family Development in Cambodia

HISTORY OF SOCIAL PROJECTS IN CAMBODIA

In Cambodia, in the 1980s and 1990s, E&D mainly implemented health projects, bringing its technical expertise in various topics (nutrition, pediatric issues, health professional training, maternity wards...) and in early childhood education (teachers training, learning material development, creation of experimental schools...). E&D then opted for a community based approach, implementing development programs including health (mother and child health, basic health care, community health care, health education), education (community preschool, literacy classes, tutoring for elementary pupils facing learning difficulties...), economic development (vocational training, access to micro-credit and income generating activities...), child protection and access to water. These integrated development programs were the first E&D's social programs in Cambodia. The main objective of these projects was the improvement of the living conditions of children and their families, and they were essentially implemented in rural areas (mainly in Kampong Speu and Takeo districts).

From 2004 to 2008, a project of "Community and socio-economic development of disadvantaged families relocated in peri-urban areas of Phnom Penh"[8] was launched. This project was implemented in partnership with 2 local organizations: Krousar Yoeung and Sovann Phoum in areas where hundreds of squatter families had been relocated by the government but where very few services and employment opportunities were existing.
The project thus focused on 4 sectors of intervention:

- Early Childhood: creation of preschool centers and training of stakeholders.
- Family Development: home visits and social centers
- Health care / preventive Health care
- Vocational training and access to employment

It is in the framework of this project that E&D implemented for the first time the family development methodology as developed by Inter Aide. In the preparation phase, E&D visited EnFaNCE Foundation[9] in Manila and Cebu in the Philippines and Inter Aide conducted a workshop in Cambodia to introduce the FD methodology.
In 2007, at the end of this project, the local NGO Samatapheap Khnom Organization (SKO) was created and took over the family development project of E&D in urban areas.
From 2006 to 2011, the FD methodology was also implemented in rural areas in the integrated project "Empowerment of vulnerable families in rural areas". Thanks to this project, the psycho social dimension of FD could considerably be reinforced (psychosocial support was provided during home visit and group discussion for women). Indeed, in rural areas, referral systems are difficult to implement as households are isolated from one another and basic services are scarce. It was thus necessary to create internal supporting systems.

[8] Project supported by the European Union
[9] Local organization supported by Inter Aide

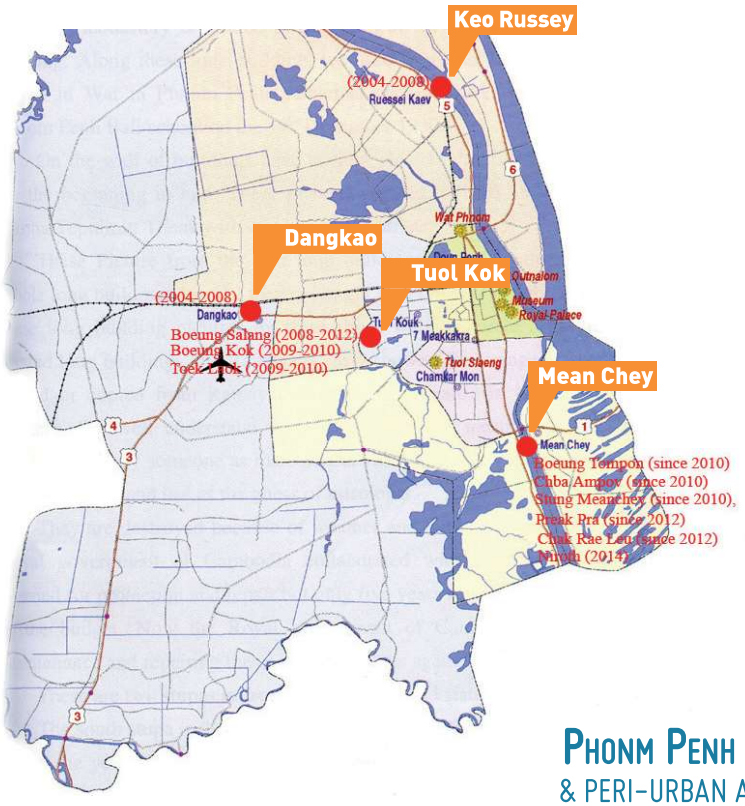
A HISTORY OF FAMILY DEVELOPMENT

AREAS OF INTERVENTION IN CAMBODIA

The first Family Development program was launched in the peri-urban areas of Phnom Penh (2004-2008) in the districts of Dangkao and Keo Russey, city of Phnom Penh.
The FD program in rural areas was implemented in the Kong Pisey district in Kampong Speu province (2006-2011).
Since 2009, family development programs have been implemented in Phnom Penh in the Districts of Mean Chey and Tuol Kok.

Tuol Kouk District		
Boeung Salang	2008-2012	Slum
Boeung Kok	2009-2010	Slum
Toek Laok	2009-2010	Slum
Mean Chey District		
Boeung Tompon	since 2010	Low rent
Chba Ampov	since 2010	Low rent
Stung Mean Chey	since 2012	Slum
Preak Pra	since 2012	Semi-rural
Chak Ang Rae Leu	since 2012	Semi-rural
Niroth	since 2014	Squat

Between 2010 and 2013, 2358 families were followed up under the Family Development Program.



PHONM PENH CITY
& PERI-URBAN AREAS

A HISTORY OF FAMILY DEVELOPMENT

SOME SPECIFICITIES OF THE FAMILY DEVELOPMENT PROJECTS IN CAMBODIA

FAMILY BUDGET

From 2009, more emphasize has been put on the relation between the economic and the psychosocial situation of vulnerable families when addressing their problems and needs. A "family budget management" tool has been created to help families to manage their family budget.

ART THERAPY

Experimented in 2013 in the area of Boeung Tompon, this new activity targeted children from vulnerable families and suffering from disruptive behavior disorders. This activity allowed these children to express their feelings and emotions through artistic creation (dancing, drawing, singing, Muppets workshops, etc...). But unfortunately this pilot project, involving 30 children, could not go on in 2014 because not enough participants had attended.

« TIME FOR ME »

Implemented from 2007, this activity targets SKO social workers, in order to help them keep the right professional distance when facing human problems in their work. Social workers gather on a quarterly basis to talk about their problems, emotions –at work and in their private life. This sharing sessions allows them to feel more comfortable in their work and to deal with families in a professional and serene way.

PARENTS–CHILD ACTIVITIES

Since 2011, SKO organizes Parent-Child workshops that aim at improving the relationship between parents/care-takers and their children and improving the knowledge of the parents regarding topics related to children development: nutrition, stages of children development, breast feeding, domestic environment, parenthood. Other topics can be discussed according to what parents feel they need to talk about. In 2013, 653 parents/care-takers and 2 128 children (among whom 938 aged from 0 to 3 years) participated.

PARTNERSHIP WITH UNIVERSITIES

E&D contributed to the elaboration of the first Cambodian curriculum in social work. Since 2010, SKO has established a partnership with the Royal University of Phnom Penh (RUPP), offering training and internship opportunities to students. The former director of SKO is currently teaching in this University. Since 2010, 24 students in social work have undertaken their internship in SKO.

A HISTORY OF FAMILY DEVELOPMENT

II. 4 Family Development in Nepal

HISTORY OF SOCIAL PROJECTS IN NEPAL

Since 2010 E&D has been supporting Voice of Children, a Nepalese association, whose actions in Kathmandu aim at protecting, supporting and reintegrating street children. The actions supported included: Prevention of and fight against child sexual abuse, street work, drop-in center, preparation center, family reintegration and social and professional reintegration.

In 2007, to meet the needs of the poorest families living in the urban area of the Kathmandu Valley, VOC and E&D decided to launch a FD social program in some neighborhoods of Kathmandu. With this program, VOC has developed a preventive action – to prevent children from going into the street – that complemented its other street children programs. The FD approach and methods built the capacity of VOC's social workers when working with families for children reintegration. Common trainings and tools could be developed that helped in the analysis of family's situations.

AREAS OF INTERVENTION IN NEPAL

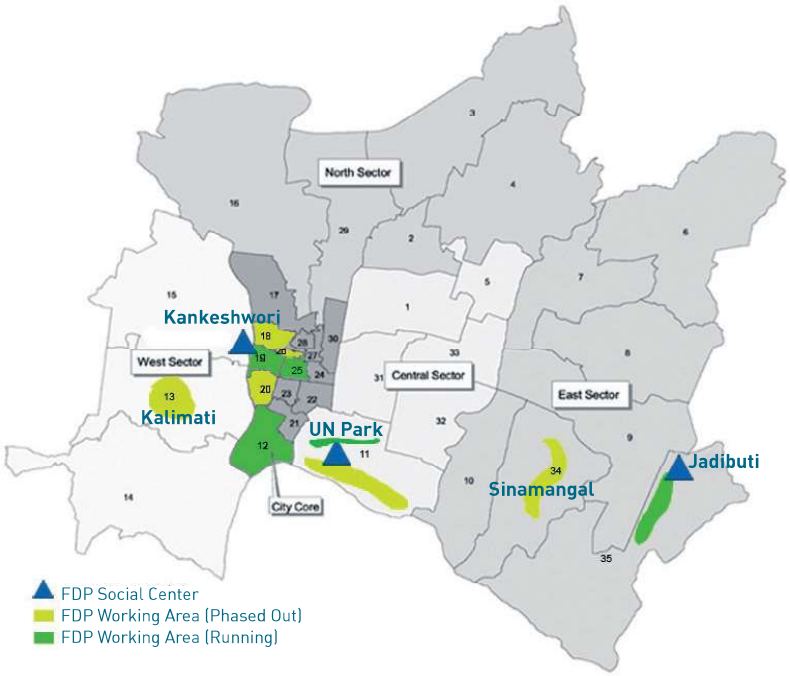
The team soon came across a major difficulty: vulnerable families are scattered all over the city and frequently move from one place to another. In Kathmandu, poor families generally live in precarious rooms, that they sublet and which are spread all over the city. They are often isolated and discriminated against because of their rural background ("migrants") and because of caste &/or ethnic issues. Families feel therefore obliged to change home frequently, thus making it difficult for social workers to identify and follow them.

→ From 2010 to 2013, 1215 families were followed up under the FD program.

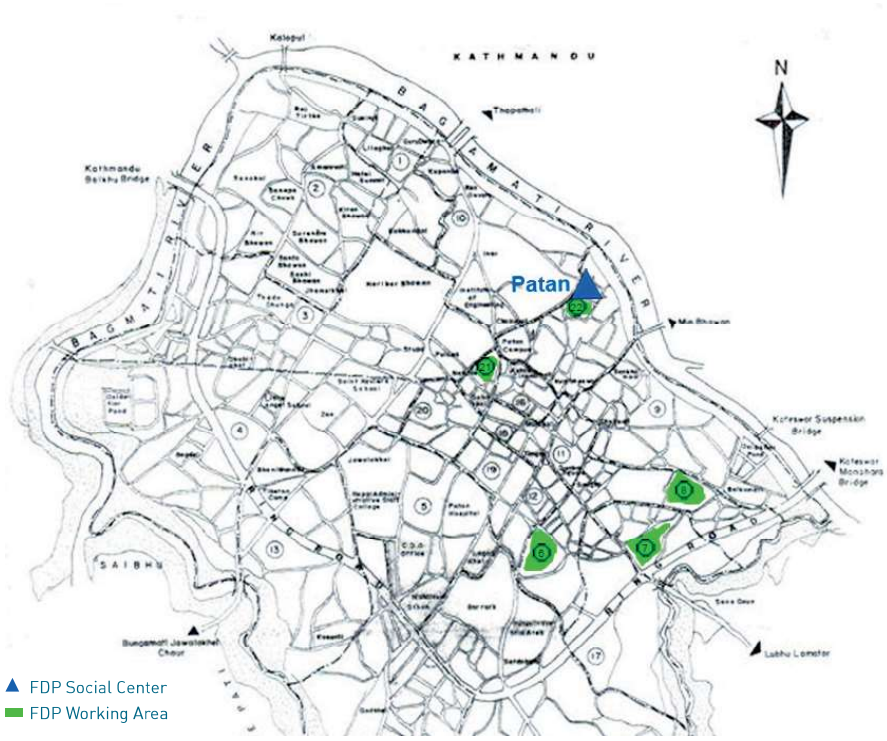
Since 2007, the FD program has been implemented in 6 areas:

Kalimati	2007-2010	Areas where poor families are living in low-rented rooms, precarious and not visible
Sinamangal	2007-2012	Slum area along the river
Kankeshwori	Since 2008	Areas where poor families are living in low-rented rooms, precarious and not visible
UN Park	Since 2009	Slum area (illegal squat) along the river
Jadibuti	Since 2011	Areas where poor families are living in low-rented rooms, precarious and not visible
Patan	Since 2013	Areas where poor families are living in low-rented rooms, precarious and not visible

A HISTORY OF FAMILY DEVELOPMENT



KATHMANDU METROPOLITAN CITY



LALITPUR SUB METROPOLITAN CITY (PATAN)

A HISTORY OF FAMILY DEVELOPMENT

SOME SPECIFICITIES OF THE FAMILY DEVELOPMENT PROJECTS IN NEPAL

TRAINING OF THE TEAMS

Social work trainings in Nepal remain very theoretical and few social work trainees actually end up working in the field. The title of "social worker" is not yet officially recognized in Nepal and most of the NGO workers can call themselves "social workers". In this context, social workers recruited under the FD program have received intensive training (FD methodology, social work, etc) and in particular during the first 3 years of project implementation.

crédit : Ingrid Chiron

BUILDING A NETWORK OF PARTNERS

With the multi-country project, efforts have been put on the building and strengthening of the network of service providers. The existing services have been systematically identified, met and evaluated. An evaluation tool has been developed to improve the referral mechanisms and to encourage service providers to improve their services. Since 2010, the referral system is more organized than before (coordination meetings, partnership agreements, dissemination workshops, evaluation of services and referrals). Nevertheless, difficulties remain as feedback mechanisms are still difficult to implement.

A HISTORY OF FAMILY DEVELOPMENT

ACTIVITIES FOR THE CHILDREN

Started in 2012, these activities are organized in the social centers: remedial classes, recreational activities, parent-child activities, and awareness sessions. They have made social centers more appealing to families.

THE FAMILY DEVELOPMENT APPROACH IN THE FAMILY REINTEGRATION OF STREET CHILDREN

Following up families before and after the reintegration of a child having lived on the streets is crucial for a successful reintegration. The Family Development project's implementation has enabled the development of skills for all social workers of the partner organization VOC. Although the child remains the focus of the action, the family development approach offers a holistic approach which takes into consideration the family's situation and issues.

crédit : Ingrid Chiron

SYNERGIES WITH THE VOCATIONAL TRAINING PROGRAM

In 2010, the families followed up under the Family Development Program have started to benefit from the socio-economic insertion program of VOC. Youths and women now have access to vocational training and benefit from a personalized follow up to prepare their access to employment.

A HISTORY OF FAMILY DEVELOPMENT

II. 5 Family Development in Burkina Faso

HISTORY OF SOCIAL PROJECTS IN BURKINA FASO

Enfants&Développement has been in Burkina Faso since 2004 and started with the implementation of a project on the Global Development of children in the rural area of Barsalogho. In 2008, a first prospective missions was organized to evaluate the needs, the relevance and the feasibility of implementing social actions in urban and suburban zones.
The Family Development program has been implemented in 2010 in the informal settlements of Ouagadougou in partnership with the local NGO ES-BF (created in 2007 by former members of E&D). In 2013, the partnership with ES-BF ended and the family development program was transferred to AGIR, which is retaining the same team of social workers.

AREAS OF INTERVENTION IN BURKINA FASO

The program is implemented in the informal settlements of three districts in the north and east of the city of Ouagadougou: Bogodogo, Sig-Noghin, and Nongr-Maasom.

District	Area	No. of Inhabitants
Sig-Noghin	Nonguin	20,000
Nongr-Maasom	Nioko 2	12,000
Bogodogo	Tabtenga	10,000

→ Between 2010 and 2013, 761 families were followed up under the Family Development Program.

More than a third of the population of Ouagadougou lives in informal settlements or spontaneous living areas.
The informal settlements are characterized by:

- precarious and cramped housing
- a high density of population
- impractical paths and a virtually non-existent sanitation network
- difficulties in accessing water, no electricity
- a lack of educational and sanitary infrastructures, among others
- location far from the economic center and difficulties in accessing employment (many woman are sand harvesters)

A HISTORY OF FAMILY DEVELOPMENT

OUAGADOUGOU CITY
AREAS OF INTERVENTIONS

A HISTORY OF FAMILY DEVELOPMENT

SOME SPECIFICITIES OF THE FAMILY DEVELOPMENT PROJECT IN BURKINA FASO

SOCIAL CENTERS

Social centers have been met with great success by the population of the areas of intervention. As a result other partner organizations have taken this opportunity to organize activities in the social center for the benefit of the local population. E.g. gynecological consultations and awareness sessions on reproductive health are organized.

BASELINE SURVEY

E&D concluded a partnership with the Ouagadougou Population Observatory (OPO), part of the ISSP (Higher Institute for the Population Sciences[9]), to implement a baseline survey and impact study for the program in two areas of intervention (baseline conducted in 2012 and endline conducted in 2014). In addition, this partnership allowed to obtain statistics on the population living in these districts and to identify vulnerable families for the program.

At the end of 2010, a baseline survey was also conducted in 500 homes in the Bogodogo area.

TOOLS CREATION AND STAFF TRAINING

The process of building tools with the FD team from the start has facilitated their appropriation. The program's first year was largely dedicated to staff training.



Health training by the association VERSO
Tools: "Pedagogical trunks"
Method: "Observe, Manipulate, Understand and take Action"

II. 6 Family Development in Vietnam

HISTORY OF THE SOCIAL PROJETCS IN VIETNAM

E&D has been present in Vietnam since 1993 and has implemented several programs in the field of health (preventive and curative health in schools, creation of « baby kangaroos » units for premature babies, training for parents and health workers in nutrition, in primary, maternal and infant health, and in sexual and reproductive health), sanitation (construction of wells and latrines, creation of management committees), education (primary and preschool, training of teachers and village educators, construction, rehabilitation and equipment of schools, establishment of a network of informal kindergartens, establishment of the "friends of the children" approach aiming at creating an environment adapted to children's needs). Between 1995 and 2000, a street children project in the city of Nha Trang (Khanh Hoa province) has also been set up and included a family reinsertion program.

[9] Institut Supérieur des Sciences de la Population

A HISTORY OF FAMILY DEVELOPMENT

Between 2005 and 2009, E&D has led several missions aiming at evaluating the needs and at measuring the relevance and feasibility of a FD program in Ho-Chi-Minh-City (HCMC). These missions have been supported by Mrs Nguyen Thi Oanh, a specialist in community development and social work having worked to bring professional social work back in Vietnam after over 20 years without any training in this field (1975-1989). In 2009, two workshops to raise awareness on FD were organized by E&D in two universities with departments in social work : the Ho Chi Minh City Open University (HCMCOU) and the University of Labor and Social Affairs 2 (ULSA2) to implement the method and start creating partnerships.

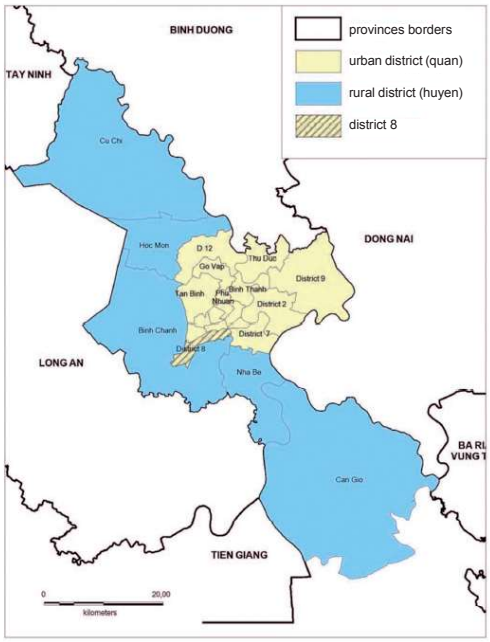
HCMC family development program has officially started in November 2010 (opening of the office, recruitment of the team and training of local actors). The field activities were launched in District 8 in August 2011 (home visits, opening of a social guidance center, identification of basic services and creation of a network).

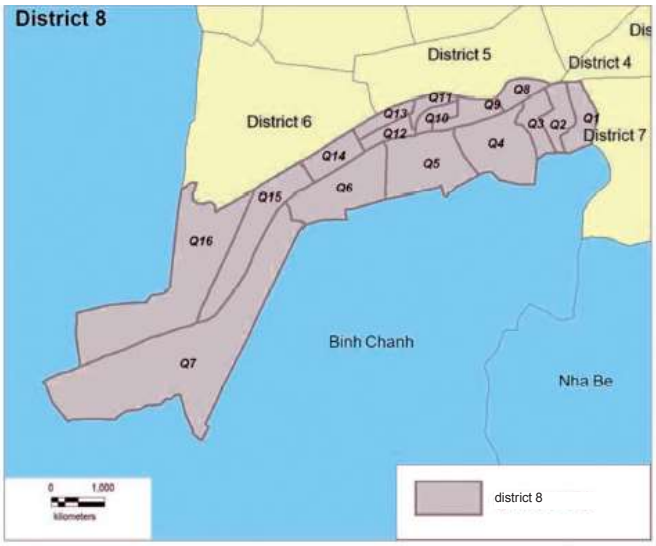
The political context in Vietnam gives this FD program a particular touch: obligation to obtain authorizations to intervene in the city and district, work in close collaboration with the local authorities in the neighborhoods and sub-neighborhoods, constant surveillance and obligation to provide quarterly activity reports and weekly action plans for the home visits.

AREAS OF INTERVENTION IN VIETNAM

The family development program is implemented in the district 8 in Ho-Chi-Minh-City. At the beginning of the project, the targeting of the areas of intervention has been decided in collaboration with the local authorities of the District 8 (at the level of the People Committee of the District). 4 areas of intervention have then been chosen according to criteria of vulnerability and geographical proximity between the zones (1 social guidance center for 2 areas). These areas of intervention have been chosen given the variety of profiles of the families in a situation of vulnerability living there. The main difficulties met by these families being : a low level of instruction, little professional skills, precarious jobs and little access to the national and/or local social policies. These vulnerabilities were aggravated in the following situations: large families, single-parent families, families affected by issues of physical, mental or psychological health, and immigrant families.

→ Between November 2010 and April 2014, 768 families were followed up under the FD program.





VIETNAM
DISTRICTS OF INTERVENTIONS

A HISTORY OF FAMILY DEVELOPMENT

SOME SPECIFICITIES OF THE FAMILY DEVELOPMENT PROGRAM IN VIETNAM

IMPOSED COLLABORATION WITH THE LOCAL AUTHORITIES

Close collaboration with the people's committees in the areas of intervention for the identification and follow-up of the vulnerable families. A work of explanation of the method and activities implemented is therefore essential at the beginning and during the project to «help understand » and « reassure ».

DEVELOPMENT OF A VOCATIONAL TRAINING AND ECONOMIC DEVELOPMENT PROGRAM

Since 2013, a new Vocational Training and Economic development activity has been implemented and has given the project a rather economic aspect. A particular focus has been set on issues of vocational training and professional insertion. Many unskilled youths and young adults have been supported and the network of training centers and partner companies has been developed. In April 2014, the network of partners included 102 local, national or international structures intervening in the fields of vocational training and employment.

In May 2014, a project called « Project 360° » has been launched. Within this project, to face varied and complementary needs in terms of family support, vocational training and access to employment, E&D has decided to offer the most destitute families a set of solutions covering and coordinating their overall social, educational and economic needs : family development, vocational training and economic insertion. This innovative approach must give more efficiency and a stronger impact to each actions: the family development is efficient if concrete solutions of good quality are offered to the families, notably in terms of economic and professional insertion ; the vocational trainings proposed to youths in difficult situations are even more effective that social issues which could interfere with their trainings are known and dealt with at the same time. Furthermore, the adults in the families who wish to do so could benefit from an extra reinforcement of their management capacities if they are entrepreneurs, or from a support in the creation of an Income Generating Activity. They will be given priority for the access to these trainings which will also be proposed to other informal business managers.



Vocational training in technics of maintenance

DEVELOPMENT OF A HEALTH AND NUTRITION PROGRAM

Since September 2012, monthly health check up sessions have been organized in Hoai Thanh's social centre. They mostly concern children aged 0 to 5 suffering from malnutrition.
In addition, awareness sessions are organized for parents on nutrition and baby and child development.

A HISTORY OF FAMILY DEVELOPMENT

II.7 Activities implemented within the multi-country project

TWO INTERNATIONAL CAPITALIZATION SEMINARS ON FAMILY DEVELOPMENT HAVE BEEN ORGANIZED

The first one took place in November 2011 in Phnom Penh and gathered representatives from ES-BF, VOC and SKO (main partners of the multi-country project), representatives from local and international partner organizations (Inter Aide, Entrepreneurs du Monde from France, EnFaNCE Foundation from the Philippines, Eria Asie-Tana from India, Friends International and Mit Samlanh from Cambodia) as well as the partners of the FD program in Vietnam (University of Labor & Social Affairs - Campus II - ULSA2, HCMC Open University – HCMCOU and the People's committee of District 8).

Seminar in Ouagadougou 2013

The second seminar took place in November 2013 in Ouagadougou and gathered representatives from AGIR, VOC and SKO as well as representatives from partner organizations intervening in the region and in particular from Madagascar.

CREATION OF A WEBSITE DEDICATED TO TOOLS' SHARING

In 2012, a website was created to encourage the different teams to share methods and support tools (http://www.enfantsetdeveloppement.org/outils-et-methodes).

CAPITALIZATION

Finally, the multi-country project has encouraged the sharing of experiences and resources between the different contexts of intervention. The result of this work is the object of this capitalization document.

WHAT IS A FAMILY DEVELOPMENT PROGRAM?

WHAT IS A FAMILY DEVELOPMENT PROGRAM ?

A DESCRIPTION OF FAMILY DEVELOPMENT PROGRAMS (FDP)

OBJECTIVES OF FAMILY DEVELOPMENT PROGRAMS

GENERAL OBJECTIVES:

To contribute to poverty alleviation by improving the autonomy and building the capacities of vulnerable families.

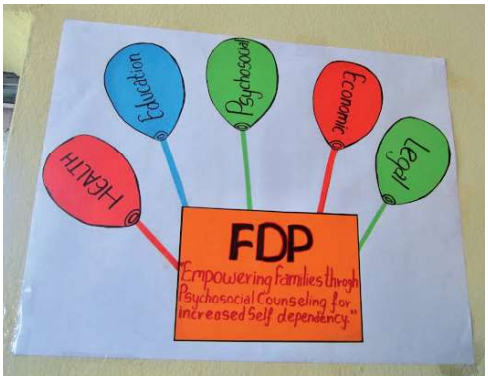
SPECIFIC OBJECTIVES:

- To sustainably bridge the gap between vulnerable families and public or private organizations delivering services in health, education, economic development, administrative matters, etc.
- To improve the capacity of the poorest and most vulnerable families to address their specific problems and needs, to improve their living conditions and thus to provide a protective environment to their children.
- To improve the living conditions of autonomy, the skills and the problems solving skills of vulnerable families

SCOPE OF WORK

Family Development Programs generally intervene on problems or objectives related to:

- **HEALTH** (immunization, prenatal check up, post natal check up, family planning, basic health, prevention of TB, STD and other diseases, awareness on hygiene, ...)
- **EDUCATION** (preschool, primary school, prevention of drop out, literacy, ...)
- **ECONOMY** (access to employment, vocational training, savings, family budget...)
- **ADMINISTRATION / ACCESS TO CITIZENSHIP** (to obtain administrative documents: ID cards, birth certificate, ...)
- **FAMILY WELFARE / PSYCHOSOCIAL** (problems of alcoholism, violence, abuse, communication within the family, with neighbors, disabilities, etc)



WHAT IS A FAMILY DEVELOPMENT PROGRAM ?

EXPECTED RESULTS

- Families have improved their self-confidence, awareness, knowledge and have developed appropriate problems solving skills
- Families are able to identify their needs and to use the available services in order to respond to these needs
- Parents are able to meet their children's developmental needs in appropriate ways; children are given opportunities to fully develop their potentials
- The results of the family follow up are sustainable, i.e. families are able to maintain the results obtained during the follow up and continue to progress.
- Families have improved their situation and their living conditions.

TARGET GROUP

Vulnerable families are facing social difficulties (poor sanitation, unemployment, out of school, etc) and psychosocial problems (neglect, abuse, violence...). Despite the existence of public services (schools, health centers) and local associations implementing social programs, very vulnerable families are excluded from the development path and are generally not benefiting from community development programs. It is these vulnerable families whom FD programs target. The added value of such program being to reach, through home visits, the families that are excluded from existing programs.

SOCIAL INTERVENTION

The effectiveness of the family development approach relies on the availability of public and private services to whom families can be referred (schools, health centers, etc) and that must be accessible financially and geographically to the poorest.

The social intervention proposed to families under a family development program can be divided into 2 sets of activities:

A. **Home based interventions (regular home visits)**
B. **Community based interventions (activities organized in the social centers or in the areas of intervention)**

The family development concept is a development approach and it therefore follows a strict no dole-out policy.

LIMITS OF FDP

In some cases, the family development program may not be able to respond to the needs of the families identified. In particular when:

- The families have severe addictions (drug and alcohol addictions)
- The head of the family has severe psychological or psychiatric problems
- The family members are involved in crime or serious delinquent acts
- The family is living in the street or does not have stable housing: they may need another kind of support (emergency shelter, etc)

These families can be referred to specialized organizations that have the means and expertise to provide appropriate support.

WHAT IS A FAMILY DEVELOPMENT PROGRAM ?

Ingredients to make a "good" family development program:

- a spoon full of home visits
- a spoon full of community based interventions
- to be mixed with network building and referrals mechanisms
- to add a professional team of social workers (trained and supervised)
- to stir fry clear process for team work and case management
- to prepare tools for monitoring and evaluating the activities and results

AREAS OF INTERVENTION

AREAS OF INTERVENTION

What are the characteristics of selected areas of intervention in Cambodia, Nepal, Burkina Faso and Vietnam?
How to identify areas of intervention? What methodologies and tools are used?

I. SELECTED AREAS IN CAMBODIA, NEPAL, BURKINA FASO AND VIETNAM

BURKINA FASO – OUAGADOUGOU

Informal settlements (« zones non-loties ») / located on the outskirt of Ouagadougou

- Poor housing conditions (confined and precarious)
- High density of population
- Lack of basic services (schools, health centers,...)
- Difficult road access
- No water waste management
- Difficult access to water and electricity
- Distance from economic centres and difficult access to employment

AREAS OF INTERVENTION

NEPAL – KATHMANDU

Squat on the river side (UN Park)

- Illegal settlement threaten of eviction
- Prone-to-flood area
- Poor housing conditions
- No water, no electricity

Slum on the river side (Sinamangal)

- Prone-to-flood area
- Poor housing conditions
- High density of population
- Lack of basic services
- No water / no electricity

Low rent (Kankeswhori)

crédit : Ingrid Chiron

- Rent of small room for one family
- Poor housing conditions (precarious, confined, lack of ventilation, ...)
- Difficult access to water and sanitation
- Scattered in the whole city

AREAS OF INTERVENTION

CAMBODIA

Peri-urban area / Districts of Dangkao & Keo Russey

- Relocation area in the outskirt of Phnom Penh
- Lack of basic services
- Distance from economic centres and difficult access to employment
- Poor housing conditions

Slums / District of Toul Kouk and District of Mean Chey, areas of Stung Mean Chey

- Squatting on public land (for Toul Kouk, the slum is built along the railway)
- Make-shift housing
- Small houses (approx 1.5 square meters).
- Garbage dump for Phnom Penh trash
- Lack of sanitation facilities
- Poor hygiene

AREAS OF INTERVENTION

Semi-rural area / District of Mean Chey: areas of Preak Prah & Chak Ang Rae Leu

- Owner of their own house with 4 to 5 families living in each house
- Far from services

Low rent areas / District of Mean Chey, areas of Boeung Tompon & Chba Ampov

- Poor housing conditions (precarious, confined, lack of ventilation, ...)
- Difficult access to water and sanitation

Squatters / District of Mean Chey: area of Niroth

- Squat on Pagoda owned Land (no rent)
- Far from services

AREAS OF INTERVENTION

VIETNAM – HO CHI MINH CITY

Semi-rural / Ho Chi Minh (District 8)

- Large proportion of migrant population living in low-rent housing zones
- High population and maze of alleys and narrow streets (Hem)
- Area crossed by a network of canals resulting in difficult travel conditions

COMMON CHARACTERISTICS OF THE SELECTED AREAS

Urban setting: most of the FD programs have been implemented in urban settings so as to facilitate the referral mechanisms with service providers. FD programs implemented in rural or peri-urban setting (relocation areas) faced difficulties in improving the access of vulnerable families to basic services.

High density of population: Most of the areas selected show a high density of population and in particular of vulnerable people. We observe however some changes in the urban settings: while poverty was mainly concentrated in slums and squat areas, more and more it is now diluted in the city. Poor and vulnerable people are less visible. Living in low rented rooms (1 room rented to one family) they are less visible from the outside.

Difficult living conditions: Confined rooms, common toilets and difficult access to water, insanitary environment, lack of welfare services, education, vocational training, etc. at a close distance; poor neighbors and environment, victim of general discrimination and prejudice from the remaining city population.

II. HOW TO SELECT AN AREA OF INTERVENTION ?

STEP 1 – Data collection

Depending on the contexts, some data and information may be collected among local authorities and /or local organizations in order to help in the identification process.

STEP 2 – Area visits - Observation

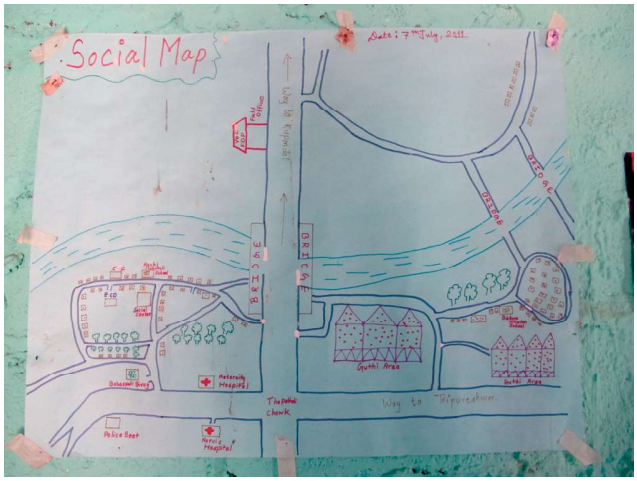
Based on available data and information, several areas are visited. First visits are made to have a global view of the poverty situation and to compare the areas. They mainly include observation of the living conditions and informal discussions with dwellers and local organizations.

→ Area visit report: Filled up by the social workers who visited the area to record their observations and /or informal discussions they led with inhabitants. It allows to have a first idea of the area situation and its organization. A report is updated every semester during all the area follow-up period and may orient the strategy of intervention in the area.

STEP 3 – Area visits – Area profiling

After pre-selection of a few areas, further area visits are conducted in order to make a more precise area profile. At this stage, focus group discussions with the inhabitants are organized in order to identify main problems / needs in the area (as per the 5 domains of FD intervention: Health, education, psychosocial, economic, legal).

→ Area visit reports
→ Area profiling
→ Area mapping (including mapping of services available)



Size of the areas

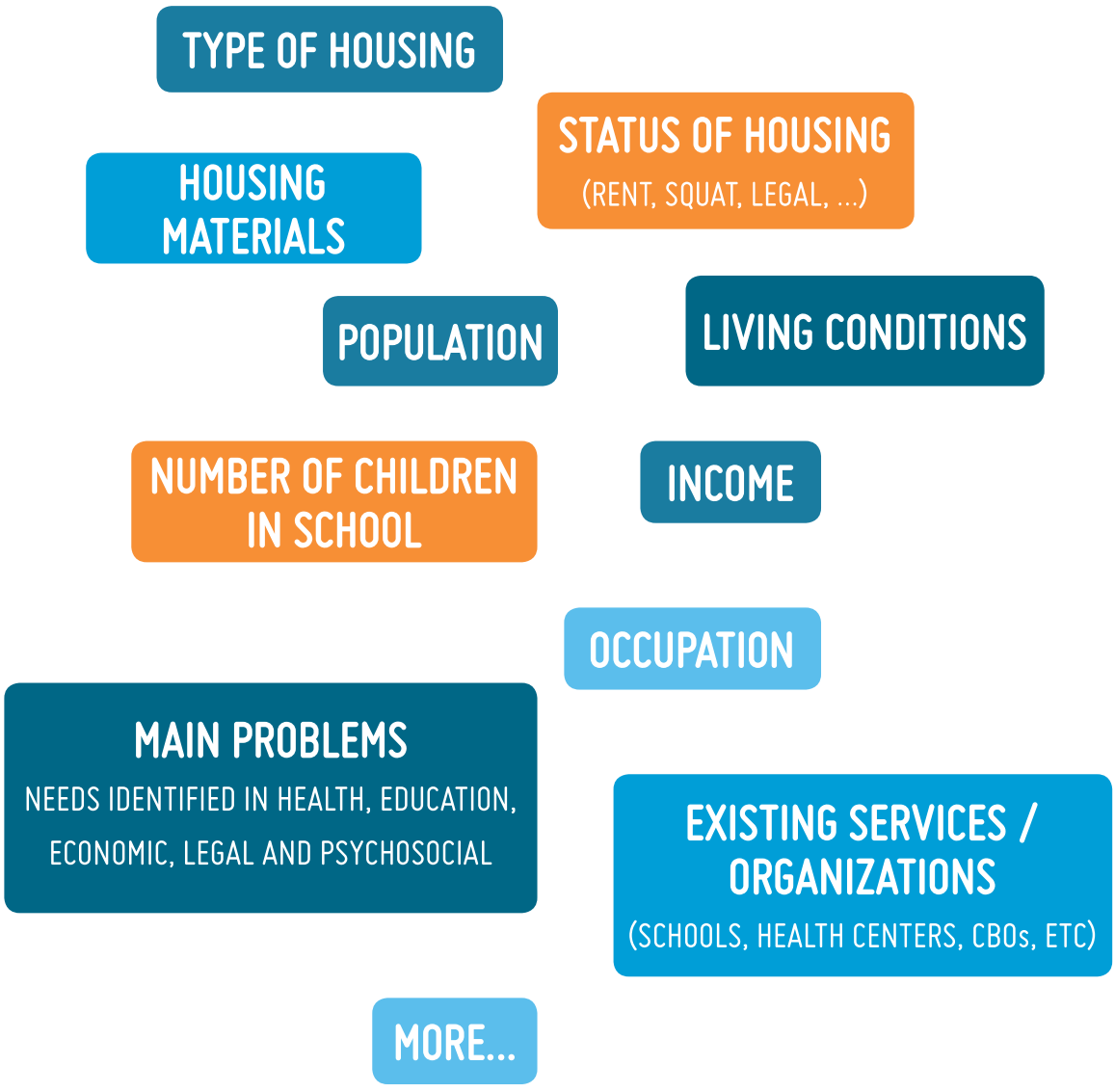
It is recommended to target relatively small areas in order to allow the team to cover the target families' needs in a limited time (3/4 years).

STEP 4 – Orientation meeting

It is recommended to organize an orientation meeting in the areas selected before starting the implementation of the activities. To be invited: inhabitants, community leaders, Community Based Organizations, Local Authorities, etc. Objective of the meeting: presentation of the implementing NGO and presentation of the activities / programs.

AREAS OF INTERVENTION

WHAT INFORMATION TO COLLECT ?



SOCIAL INTERVENTION

HOME-BASED INTERVENTION

I. IDENTIFICATION AND SELECTION OF FAMILIES

How to identify families in need of social support?

I.1 Target groups

DESCRIPTION OF THE FAMILIES TARGETED BY THE FAMILY DEVELOPMENT PROGRAM



crédit : Caroline Peyronel

Family development programs target vulnerable families excluded from programs implemented at community level. Isolated and lacking of self-confidence, they are not integrated in the community. A tailored family-centered approach allows to reach these families and to establish a trustful relationship between the social workers and the families. Through home-based intervention, the Family Development program targets particularly vulnerable families with heavy social and/or psychosocial difficulties that prevent them from taking appropriate decisions to improve their situation. These families need support to clearly identify their needs and find solutions to improve their living conditions. A home-based follow-up in a limited period of time is suitable for these families. This support enables them to increase their resilience and autonomy: they gradually become able to go by themselves and to find their way to the right existing services.

We can identify two categories of target beneficiaries:

1) Families with heavy social/psychosocial difficulties that hinder their capacity to improve their overall situation, and who need support in order to clearly identify their needs and to take action to improve the quality of their lives. The family members often are unable to ask for help in an appropriate way, their capacity to analyse their own situation, to use their potential as well as their self-confidence is affected, and a home based intervention with an intensive one-to-one approach appears necessary.

2) Families who mostly need information and training and who show capacity to take action on their own so as to improve their situation once properly informed. Most of the time these families do not need home visits as they are able to go to Social Counseling Centers to ask for help. A home-based follow up is not recommended as family development aims at developing the autonomy of the families. The efficiency of the program would also be affected if social workers were to include these families in their home-visits.

crédit : Caroline Peyronel

Children activities in the social center - Nepal

I.2 Process / Methodology proposed

DESCRIPTION OF THE METHODS USED FOR FAMILIES SELECTION

IDENTIFICATION

- → **House-to-House** visits
- → **Social centers** activities (counseling sessions, collective activities, children activities)
- → Referrals from **partner organizations**
- → Referrals from families / **neighbors**

↓

SELECTION

- → Selection meetings
- → Family Survey

IDENTIFICATION THROUGH SOCIAL CENTER ACTIVITIES

- Individual counseling
- Group activities
- Children activities

Some family members may come to the social center directly while their family has not been identified through house-to-house visits (absent during the time of the visit, just arrived in the area, house not yet visited by the social workers, ...).

During an individual counseling session or during group activities the person may ask for support or express serious difficulties that will persuade the social worker to propose a house-to-house visit and a social support (in the social center or at home depending on the family's situation and capacity).

Children activities

In programs where children activities are organized in the social center (Nepal, Cambodia), the children activities facilitators can refer children when they identify that they are at risk. The house-to-house visit is then organized by the social worker and the facilitator.

IDENTIFICATION THROUGH REFERRALS FROM PARTNER ORGANIZATIONS

Partner organizations (social services, NGOs, schools, community based organizations, community leaders, ...) may refer a family in need of social support and will be informed of the decision to select or not to select the family referred after the house-to-house visit. A member of the referring organization may participate to the house-to-house visits.

→ Confidentiality must be respected while family cases are discussed among partner organizations.

IDENTIFICATION THROUGH REFERRALS FROM NEIGHBORS

Followed up families can introduce other families who are facing difficulties.

To build on local resources for identifying families in need

In Burkina Faso, a partnership has been signed with the Observatory of the Population of Ouagadougou (OPO) for the identification of vulnerable families in the areas of intervention. The OPO is conducting research and survey in these areas and is collecting data on the socio-economic status of the families.

HOUSE-TO-HOUSE VISITS

When	• Starting in a new area • Number of on-going families per social worker is below the expected result • Referrals of partner organization / neighbors • First contact during social center activities
Who	Tandem of social workers: one in-charge of conducting the discussion and the other one in charge of observing the reactions and the environment (housing conditions, family members, body language, ...)
How	• Area mapping • Introduction of the social workers and the program • Informal discussion about the family situation (short assessment of the needs and interest) – No notes taken during the visit • Information about the social center (activities, place, opening time, ...)
Duration	Maximum 20 minutes
Tools	Area mapping House-to-house visit record book Family Survey (in Burkina Faso only)

crédit : Ingrid Chiron

SELECTION MEETINGS

Organized shortly after the house-to-house visits and involving the two social workers who participated in the visits and another one if possible. Debriefing about the visit and recording of the information collected so as to decide whether the family will be integrated in the family development program and how.

Area Committees

In Burkina, area committees are organized once a week to decide of the integration of families in the program, of the phasing out of the families or to discuss difficult cases.
If the family is selected, phase 1 of the follow up will start that is a phase of relationship building.

I.3 Selection criteria

Different criteria have been used in family development programs overtime. The criteria were often responding to specific needs or problems identified among the target population or were in line with the implementing organization's priorities (e.g. education, malnutrition, etc). The approach thus implemented tended to focus on the resolution of the problems identified.

Nowadays, family development programs tend to adopt a holistic approach that emphasizes not only the problems to be addressed in the 5 domains of Family Development (health, education, economic, administration/ legal, and psychosocial / family welfare) but also and most importantly the autonomy, the self-confidence and the capacity of the families to address the problems identified.

Examples of selection criteria used by Family Development Programs:

Cambodia	Nepal	Burkina	Vietnam
• Vulnerability • Family with minimum 3 members • At least one problem is identified	• Families having at least one problem (in health, education, legal, economic, psychosocial)	• Level of poverty • Social and psychosocial problems • Lack of autonomy (no initiative taken)	• Level of poverty • Lack of capacity in problem solving • Vulnerability • Psychosocial problems
• Families willing / agreeing to participate in the program			

FOCUS

→ The term "family" in the family development approach

In Cambodia, the program mainly targets families composed of minimum 3 members. It is not the case in other countries where the target group include single parents or couples without children.

→ Participation of the family in the program

The success of the approach relies on the willingness of the family members to participate in the program. It means that:

- they understand the approach (non-dole out and empowering)
- they accept to be present and available for home-visits on a regular basis and for at least 6 months
- they are willing to improve/change their situation

→ Level of poverty / Economic poverty

It is a determining factor but it is not sufficient to decide whether a family needs a home-based follow up or not. For example, a family who is very poor but has an income regular enough to meet its basic needs, whose children have identity papers, are adequately vaccinated, whose school-age children go to school, who knows how to use existing services in the neighborhood, who has friends, and good relationships with neighbors and the local community, etc. will not be selected for home visits because this family shows a good level of autonomy and problem-solving skills and, therefore, does not need follow-up. Families of this kind will, however, be invited to attend the social center and to participate in group activities implemented by the FD program (group discussions, awareness sessions, etc.).

→ Social and/or psychosocial problems & vulnerability

Poverty is not only an economic problem. It is multifactorial and extreme poverty always include a psychosocial dimension that comes to reinforce the vulnerability of poor families.

All families, regardless of religion or socio-economic class - poor or rich - may have social problems (unemployment, diseases, etc.) and psychosocial problems (violence, neglect, maltreatment, abuse, addiction, etc.). In a FD project, all families can come to receive information, referrals, individual counseling and support. Families having social and/or psychosocial problems will be selected for a home-based follow up if they are not able to use the existing services and in the first place if they are not coming to the social center.

The psychosocial dimension contributes to the vulnerability of poor families. Taking into account the psychosocial vulnerabilities of the families does not extend the follow up period but instead reduces it. Indeed, psychosocial vulnerabilities are often the core of a family's difficulties. The ability to quickly identify the root of family difficulties makes the follow-up more effective.

→ Poor autonomy and low capacity to take action

Vulnerable families may not be able to use available services because they may be frightened, shy, lack of self-confidence, have previous experience of being refused, lack of information about available services, think that it is too expensive or costly (while services are free or subsidized). A vulnerable family who is not able to use available services, including services available in the social centers will be selected for home-based follow up.

I.4 Tools

HOUSE-TO-HOUSE VISITS RECORD BOOK

Date of House-to-House	Social Worker	Name Family	Address	Problems identified	Decision (selected / not selected)

FAMILY SURVEY

Family surveys forms have been developed in Cambodia, Burkina Faso and Nepal. However, the objectives of the tool vary from one country to another.

Family surveys commonly aim at gathering information about the socio-economic situation of the families who are selected for family follow up (home visits). Information about their health and education status, economic and psychosocial situation, and legal or administrative aspects are thus collected.

	Burkina Faso	Cambodia	Nepal
Objective	To assess the families' situation To inform the decision to integrate the family in the program	To collect baseline information on the families followed up	To draw the socio-economic profile of the families followed up under the family development program
Process	Filled up during house-to-house visit and phase 1 of the follow up (i.e. relationship building period)	Filled up once a family is selected during phase 1 of the follow up (i.e. relationship building)	Filled up for a sample of families. Evaluation conducted once in 2014 and to be conducted once every 3 years.
Tools	Survey form Access database	Survey form Access database	Survey form Access database

Family survey

How was the family met?
The family contacted us ❑
Social center ❑ Referral ❑
Other ❑ To precise :
_____

Survey n°: _____ **Date:** _____

FD n°: _____ **Date:** _____

Social workers: _____

Surname & name of the family head: _____

Surname & name of 1st spouse: _____

Surname & name of 2nd spouse: _____

Area _____ **OPO code:** _

	Name and surname + N°	N°1 (Family Head)	N°2	N°3	N°4	N°5	N°6
A – GENERAL INFORMATION	A.1 - Gender	1 = M 2 = F ☐	☐	☐	☐	☐	☐
	A.2 – Religion *(for all the members)*	1 = Muslim 2 = Catholic 3 = Protestant 4 = Animist 5 = Other (to precise)…… 6= does not know ☐	☐	☐	☐	☐	☐
	A.3 – Relationship with the family head (FH)	1= Family Head (FH) ☐ 2= Spouse 3= Child of FH 4= Step child of FH 5= Grandchild of FH 6= Other ***(give the relation of the n°)*** ……	☐	☐	☐	☐	☐
	A.4 – Birthday/Age						

B- ADMINISTRATION	B.1 – Birth certificate	0 = never 01 = lost ☐ 02 = damaged/ to be modified 1 = yes valid	☐	☐	☐	☐	☐
	B.2 – ID *(if the child is under 15 years-old, put 2 = not applicable)*	0 = never 01 = yes expired 02 = damaged/to be modified ☐ 03 = lost 1= Yes valid 2 = NA	☐	☐	☐	☐	☐
	B.3 – Marital status *(only current status)* *(multiple answers are possible)* 1 = yes 2 = no	A Single B Live in partner C Married traditional D Religious marriage E Civil marriage F Divorced G Separated H Widow/widower	A B C D E F G H	A B C D E F G H	A B C D E F G H	A B C D E F G H	A B C D E F G H
	B.4 – Wedding certificate	0 = lost 01 = damaged ☐ 1 = valid 2 = NA	☐	☐	☐	☐	☐
	B.5 – Family record book	0 = no ☐ 1 = yes 2 = NA	☐	☐	☐	☐	☐

		N°1	N°2	N°3	N°4	N°5	N°6
	Age/Gender						
B- ADMINISTRATION	B.6 – Financial support provided by one of the parents in case of divorce or separation ?	0 = no 1 = yes 2= not applicable ☐	☐	☐	☐	☐	☐
	B.7 – Poverty card	0 = no 1 = yes 2 = NA ☐	☐	☐	☐	☐	☐
	B.8 – Disability card	0 = no 1 = yes 2 = NA ☐	☐	☐	☐	☐	☐
	B.9 – Other (to precise)						
C- EDUCATION	C.1 – Preschool (3 to 6 years-old)	0 = No Why ? ☐ …… 1 = yes	☐	☐	☐	☐	☐
	C.2 – Parents' interest for preschool	0= interested/to be informed 1 = not interested ☐ 2 = NA	☐	☐	☐	☐	☐
	C.3 – Schooling (6 to 14 years-old)	0 = never ☐ *Why?* …….. 01 = left school *When and why?* …… …… 02= in school but doubling *Level?* …….. 1 = in school Level? ……	☐ …… …… …… …… ……	☐ …… …… …… …… ……	☐ …… …… …… …… ……	☐ …… …… …… …… ……	☐ …… …… …… …… ……
	C.4 – Level of education of adults (above 15 years-old) G = graduated NG = not graduated	0= has never been in school 1= has been or is in school ⇨ *highest level reached + degree* …… 2= Professional training ☐ *(G/NG……)*	☐	☐	☐	☐	☐
	C.5 – Illiterate interested by alpha	0 = yes 1 = no 2 = NA ☐	☐	☐	☐	☐	☐
	C.6 – Interested by professional training (above 15 years-old)	0 =yes 1 = no 2 = NA ☐	☐	☐	☐	☐	☐
D - HEALTH	D.1- Pregnancy	0 = yes 1 = no 2 = NA ☐	☐	☐	☐	☐	☐
	D.2 – Prenatal check up? *(only pregnant women)*	0 = no 1 = yes 2 = not applicable ☐	☐	☐	☐	☐	☐
	D.3 – Attended delivery by trained professionals *(all children)*	0 = no 1 = yes 2 = not applicable ☐	☐	☐	☐	☐	☐
	D.4 – Excision	0= yes 1 = no 2 = not applicable ☐	☐	☐	☐	☐	☐

		N°1	N°2	N°3	N°4	N°5	N°6
	Age/Gender						
D - HEALTH	D.5 – Baby's medical consultation (0 to 2 years old)	0 = no 1 = yes 2 = not applicable ☐	☐	☐	☐	☐	☐
	D.6 – Exclusive breast feeding (0 à 6 mois)	0 = no 1 = yes 2 = not applicable ☐	☐	☐	☐	☐	☐
	D.7 - Vaccines (0 to 12 mois)	0 = none 01 = partially 1 = completed 2 = not applicable ☐	☐	☐	☐	☐	☐
	D.8 - Malnutrition (0 to 5 years-old)	0 = yes 1 = no 2 = not applicable ☐	☐	☐	☐	☐	☐
	D.9 – Family planning method used? (women between 15 to 49 years-old) 0 = no 1 = yes 2 = not applicable	A Pill ☐ B Injection ☐ C Norplan ☐ D IUD ☐ E Condom ☐ F Other (to precise) ☐ ……	A ☐ B ☐ C ☐ D ☐ E ☐ F ☐	A ☐ B ☐ C ☐ D ☐ E ☐ F ☐	A ☐ B ☐ C ☐ D ☐ E ☐ F ☐	A ☐ B ☐ C ☐ D ☐ E ☐ F ☐	A ☐ B ☐ C ☐ D ☐ E ☐ F ☐
	D.10 – If the woman does not use any contraceptive method, what is the reason?	0 = the husband does not want any 01 = health problem 02 = does not know any method 1 = wants to have other children 2 = no partners 3 = other (to precise) …… ☐	☐	☐	☐	☐	☐
	D.11 – Children between 12 and 19 years old knows about SR	0 = no 1 = yes ☐	☐	☐	☐	☐	☐
	D.12 – Handicap (H)	0 = yes 1 = no ☐ If yes, what disability is it ? ……	☐	☐	☐	☐	☐
	D.13 – Suitable support of the H	0 = no 1 = yes ☐ If yes, by which kind of organization ? ……	☐	☐	☐	☐	☐
	D14- Chronic untreated disease	0 = yes 1 = no ☐ If yes, which one ? ……	☐	☐	☐	☐	☐
	D.15 – Untreated disease	0 = yes 1 = no ☐ If yes, which one ? ……	☐	☐	☐	☐	☐
	D.16 - Tuberculosis	0 = suspected ☐ 01 = proved but untreated or badly treated 02 = proved and well treated 1 = no tuberculosis	☐	☐	☐	☐	☐
	D.17 – AIDS	0 = suspected ☐ 01 = proved but untreated 02 = proved but badly treated or bad hygiene 03 = proved and treated 1 = no AIDS	☐	☐	☐	☐	☐

		N°1	N°2	N°3	N°4	N°5	N°6
	Age/Gender						
D - HEALTH	D.18 – Therapeutic behavior for children under 5 years-old: *What do you generally do when your child <5 is sick?* 0 = yes 1 = no To order priorities (a, b, c…)	A Nothing until complications	A	A	A	A	A
		B Self-medication: medicines bought in the street	B	B	B	B	B
		C Self-medication: medicines bought in pharmacy	C	C	C	C	C
		D Sanitary training (public/private/ nurse)	D	D	D	D	D
		E Visit to the tradi-practitioner/ traditional medicines	E	E	E	E	E
		F Religious visit	F	F	F	F	F
	D.19 – Use of mosquito net for children under 5 years-old	0 = no 1 = yes ☐	☐	☐	☐	☐	☐
	D.20 – Hygiene 0 = yes 1 = no	A Physical carelessness	A	A	A	A	A
		B Slovenly clothing	B	B	B	B	B
		C Carelessness inside the house	C	C	C	C	C
		D Carelessness outside the house	D	D	D	D	D
		E Food carelessness	E	E	E	E	E
		F Elimination of used water	F	F	F	F	F
		G Elimination of garbage	G	G	G	G	G
	D.21 – Member of a healthcare insurance?	0 = no 1 = yes, where ? ☐	☐	☐	☐	☐	☐
	D.22 – Interested by information about healthcare insurance?	0 = no 1 = yes ☐	☐	☐	☐	☐	☐
E - PSYCHO	E.1 – Psychosocial support for people having AIDS	0 = no 1 = yes ☐ If yes by which organization? ……	☐	☐	☐	☐	☐
	E.2 – AIDS patient being excluded	0 = yes 1 = no ☐	☐	☐	☐	☐	☐
	E.3 – Couple relationship	0 = physical, moral, economic or sexual violence From whom to who? …….. 01 = unstable relationship/ frequent arguments 02 = lack of communication 03 = intrusion of a third person 1 = harmonious 2 = not applicable ☐	☐	☐	☐	☐	☐

		N°1	N°2	N°3	N°4	N°5	N°6
	Age/Gender						
E - PSYCHOSOCIAL	E.4 – Children/parents relationship	0 = violence 01 = abuse 02 = carelessness 03 = lack of support for learning and training 04 = lack of verbal relationship 05 = lack of stimulation for the young child 1 = harmonious relationship					
	E.5 – Relationship with neighbors	0 = isolated/rejected 01 = little integrated/frequent arguments/rare relationships 1 = good relationships/ Participation to the social events in the neighborhood 2 = known as a leader in the neighborhood					
	E.6 - Addiction	0 = alcohol 01 = drugs 02 = gambling 03 = tobacco 1 = no addiction					
	E.7 – Initiatives/life projects	0 = no project, even on a short term 1 = projects on a short term, which one? …… 2 = active family					
	E.8 – Autonomy	0 = lack of self-confidence/ depreciation 01 = low autonomy 1 = good autonomy 2 = active family					
	E.9 – Project of a forced or early marriage	0 = yes 1 = no					
	E.10 – Prostitution, rape, incest	0 = yes 1 = no					
	E.11 - Jail for a family member	0 = yes 1 = no					
	E.12 – Other (to precise)						
F – ECONOMY	F.1 – Occupation						
	F.2 – Expertise/ Foreign languages						
	F.3 - Situation of employment	0 = unstable 1= stable 2 = not applicable					
	F.4 – Searching for (another) job	0 = yes, in which sector ? …… 1 = no					

		N°1	N°2	N°3	N°4	N°5	N°6
	Age/Gender						
F – ECONOMY	F.5 – Owner of production good	0 = no 2 = not applicabl 1 = yes *What is it ?* ……..……... *Amount :* …….……..	☐	☐	☐	☐	☐	☐
	F.6 – Profitability of the activity	0 = not profitable 1 = profitable 2 = not applicable	☐	☐	☐	☐	☐	☐
	F.7 – Ongoing loan (more than *18 years)* From who ? 1 = no 2 = yes	A Usurer ☐ B Family/friends ☐ C Association/group ☐ D IMF / bank ☐ E Other ☐ *If C or D,where : ……..* *On what purpose ?* ……... *Total loan : ……* *Payment : ……..*	A ☐ B ☐ C ☐ D ☐ E ☐	A ☐ B ☐ C ☐ D ☐ E ☐	A ☐ B ☐ C ☐ D ☐ E ☐	A ☐ B ☐ C ☐ D ☐ E ☐	A ☐ B ☐ C ☐ D ☐ E ☐
	F.8 – Difficulties to repay the loan	0 = yes 1= no 2 = not applicable	☐	☐	☐	☐	☐	☐
	F.9 – Interest for a loan	0 = yes For what purpose? …… ……. 1= no 2 = not applicable	☐	☐	☐	☐	☐	☐
	F.10 – Savings 0 = no 1 = yes	A Bank / IMF / which one ? …… ☐ B Tontine ☐ C At home ☐ D Other (to precise) …… ☐ If yes, savings/time unit: ……	A ☐ B ☐ C ☐ D ☐	A ☐ B ☐ C ☐ D ☐	A ☐ B ☐ C ☐ D ☐	A ☐ B ☐ C ☐ D ☐	A ☐ B ☐ C ☐ D ☐
	F.11 – Interested by savings	0 = yes 1 = no 2 = not applicable	☐	☐	☐	☐	☐	☐
	F.12- Chronic debt	0= yes 1 = no 2 = not applicable	☐	☐	☐	☐	☐	☐
	F.13 – Unpaid rent	0= yes 1= no 2 = not applicable	☐	☐	☐	☐	☐	☐

F.14 – Family budget	Expenses		
	Per day	Per week	Per month
Food/kitchen energy			
Housing			
Soap			
Lighting			
Water			
Health			
Travels			
Clothing			
Equipment			
School/professional training/support class			
Spare-time activities			
Social events			
TOTAL			

Person N°	Income		
	Per day	Per week	Per month
TOTAL (income/month)			
TOTAL (available income)			

E.15 - Housing 0 = Mud and thatch house / damaged roof 1 = Mud and thatch house / well maintained 2 = Mud and thatch with roughcast (cement …) 3 = Concrete house		**E.16 - Openings** 0 = in straw and rice bags 1 = in wood 2 = metal		**E.17- Nber of rooms** 0 = 1 room 1 = 2 rooms 2 = more than 2 rooms		**E.18 - Fences** 0 = No fence 1 = Damaged 2 = Good state	
E.19 - Ownership 0 = Renting 01 = Owner without ownership title 1 =Owner with ownership title		**E.20 - Sanitation** 0 = No toilets 1 = Common toilets 2 = Individual toilets		**E.21 – Water** 0 = Well 1 = borehole or public pump 2 = tap / running water		**E.22 - Light** 0 = candle 1 = petrol, flashlight 2 = group / battery 3 = electricity	
E.23 - Transport 0 = none 1 = at least one bicycle 2 = at least one motorbike 3 =+ 2 motorbikes or 1 car		**E.24 - Furniture** 0 = mat, mattress 1 = chair, bench, stool, table 2 = sofa, bed, armchair 3 = cupboard / wardrobe		**E.25 – Other equipment** 0 = none 1 = radio, mobile 2 = TV, fridge, gas…			

Conclusion

Global objectives	Formulated by		Decision of the area committee	Comments
	The family	The social worker		
			☐ Family to be followed-up ☐ Family to be referred	

II. FAMILY FOLLOW UP

II.1 Objectives

GENERAL OBJECTIVE:

To empower the most deprived families to solve problems on their own in order to progress toward increased autonomy, self-confidence and sustainable social inclusion.

SPECIFIC OBJECTIVES:

STRENGTH-BASED APPROACH

- To create a trustful relationship between the social worker and the family members, thus enabling an effective social follow up
- To improve the capacity of the family members to identify, prioritize and address their needs and problems (problem-solving skills)
- To encourage the families to come to the social centers and to access available services
- To "bridge the gap" between very vulnerable families and existing public and private organizations delivering services related to administrative and social issues, economic issues, health, education, access to employment, etc.
- To provide psychosocial support

EXPECTED OUTPUTS:

- Families have improved their self-confidence, awareness, knowledge and have developed appropriate problems solving skills
- Families are able to identify their needs and to use the available services in order to respond to these needs

II.2 Method of intervention

"Home visits" are the core activities of the family development approach and is a part of the family follow up process together with the social center's activities.

It is a home-based intervention tailored to the specific needs/problems and strengths/resources of each family. Home visits (HV) are considered as an effective strategy to deliver services to families who are socially excluded and/or isolated and who face psychosocial problems as well as problems of access to health, education, economic and legal services. A home-based follow-up provides the social worker with a unique opportunity to meet the family in their own environment and to better understand their strengths and needs.

"Use the family strengths as the most effective means to create positive change"

"Challenging and respectful practice that require from social workers to discover the meaning people have of their own lives and situations and to discover the solutions they have for themselves".

Advantages of home visits:

- To reach the most deprived and isolated families
- To create an enabling environment for individualized follow up (The families feel more comfortable in their own environment)
- The social worker can see and better understand the family environment

II.3 Process

- In the target areas, the social workers identify the most vulnerable families and propose an appointment. During the follow up, the social worker will work with the families to identify needs, prioritize problems, listen, refer to existing services, measure progresses and results.
- Each family is visited once a week (minimum twice a month) but the frequency of visits may vary depending on the family's situation and the types of objectives or needs identified.
- The follow up is generally limited to 6 months so as to avoid dependency. However the duration of the follow up can be shortened if the family's situation quickly improve and when the family becomes autonomous. On the contrary, the follow up may be continued after 6 months depending on the complexity of the family situation and the perspectives of evolution.
- A social worker can have around 20 on-going families (maximum 30) for regular home-visits and should be able to visit 5 families per day on average.

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RELATIONSHIP BUILDING

OBJECTIVES

- To build a friendly but professional relationship with the family members to better understand the root causes of the difficulties they are facing
- To observe, understand and assess the family's situation, attitude, motivation and readiness
- To define more clearly the objectives on which the follow up will focus (problems/needs analysis)

METHOD PROPOSED

→ Duration / Frequency

- This first phase usually last maximum 2 months with weekly visits.
- Weekly home-visits but priority families (i.e. families with a lot of problems or heavy problems) may be visited daily.
- 30-45 minute / visit

→ Process

- Introduce purposes and content of the visit
- Inform about the project and process in detail (i.e regular Home visit, frequency, duration, referrals, etc.) and the roles of the social worker in charge of the follow up.
- Get preliminary information about the family, especially focus on:
    - Origin and culture, composition, history, sources of income, strengths and weaknesses, etc.
    - Level of awareness, especially on health, education and budgeting.
    - The family relationships (internally and with neighbors & community).
- Draw the genogram together with the family.
- Make subsequent visit schedule.

→ At the end of this phase, the following should be validated:

- A friendly but professional relationship has been established between the social worker and the family.
- The family trusts the social worker and understands the purpose of the visits and the program.
- The family feels comfortable during the visits and is willing to share their problems.
- The social worker understands the family situation, and has gathered enough information to be able to analyze it.

TOOLS USED

Genogram
ABC form (part A)
Family survey
Family file

COMMENTS

During this phase, the social worker will validate the selection of the family in FD program.
Some families may be able to solve all their problems during this step. In this case, the family can be phased out at the end of step 1 as there is no need to continue the follow up.
The social worker can ask the family to assess their own situation, their knowledge of resources and their autonomy.
In Vietnam, the selection meeting takes place at the end of the relationship building period (after 4-5 home-visits)
In Burkina Faso, the duration of the relationship building period is not counted in the total duration of the follow up.

REGULAR HOME VISITS / SOCIAL CONTRACT

OBJECTIVES

- To guide the family to build an understanding of its own situation, to set objectives and make plans
- To improve self-confidence, self-reliance of the family when identifying and approaching available resources and to solve the family problems
- To encourage the family's motivation in improving their situation as well as achieving their objectives
- To support the family in facing difficulties while working with them

METHOD PROPOSED

→ Duration / Frequency

- Establish the most convenient schedule for the family
- The frequency of the visits and their duration depend on precise criteria including the living conditions of the family, the number and level of problems and the opinion of the social worker with regard to the family's motivation to change

→ Social worker skills

- Understanding and analysis of the family's situation
- The social worker provides relevant and accurate information, referral, encouragement and counseling
- Suggest options, give the choice (establish an adult to adult relationship)
- Assist (if necessary) the family in using local available resources.

→ Process

Together with the family, make an action plan with the following contents:

- Clarify roles and responsibilities of the parties (family, social worker, service providers, local authorities and agencies, etc.).
- How long does the family need to be followed up.
- What frequency of visits is needed (once a week or more).
- Which objectives can be set with the family.
- Assess resources
- Analysis of needs, strengths, weaknesses, opportunities, threats (SWOT), etc.

→ Recommendations

- Problems are considered one by one depending on the family's priority
- Together with the family, deal first with easy but urgent issues, and then go into more difficult problems as the confidence increases.
- Prioritize objectives before each home visit and tackle only a limited number of problems per visit (ideally no more than 2).
- Give "tasks" to the family to fulfill before the next visit.

TOOLS USED

Dynamic family contract
Family file
Family budget management

COMMENTS

The dynamic family contract may not always be a written document. But it is important as it specifies what the family can do within a 6 months period to improve the family situation and formalizes expectations, defines concrete and realistic results to be achieved.

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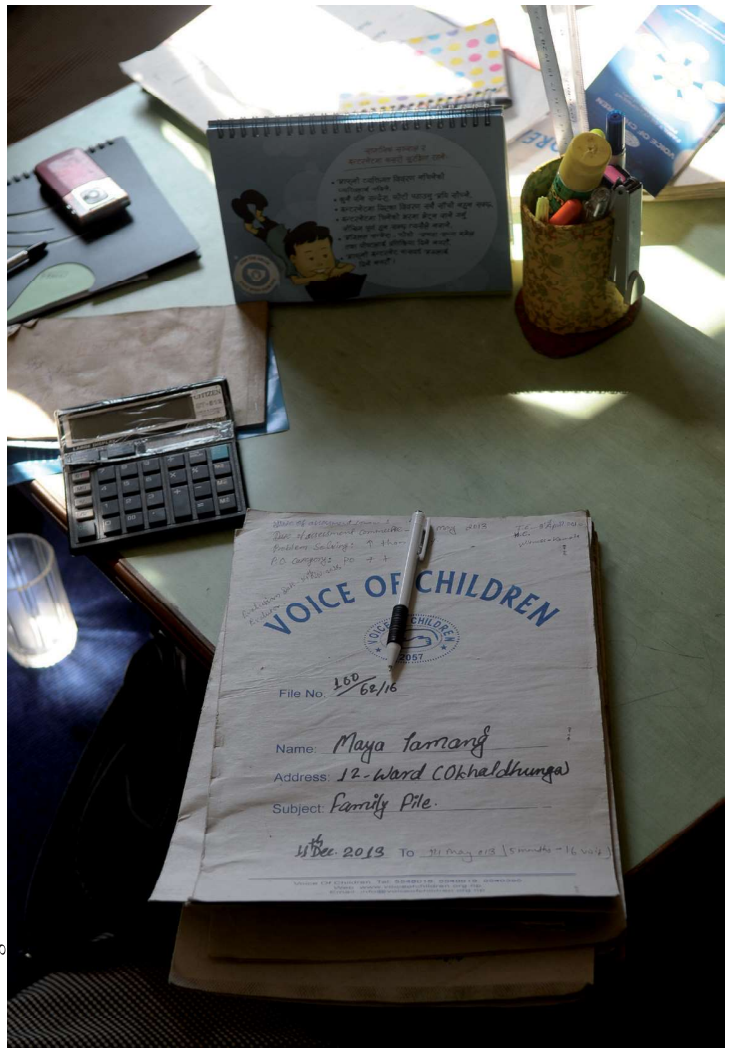
II.4 Some of the tools used by the social workers

FAMILY FILE

Family files are updated after each home visit or meeting with family members. They are generally composed of:

- Family profile (composition of the family, background/history, family tree)
- Objectives or problems identification form (record of the problems identified, by whom they have been identified – the family or the social worker, date of identification and resolution, the actions undertaken to solve the problems and the results of the intervention)
- Follow up forms (synthetic record of the points discussed during home visits or social center counseling sessions, plan of action for next visits)
- Referral forms (record of the services where the family members have been referred, date and result of referrals)
- Family survey forms (socio-economic information about the family)
- Family evaluation tool (ABC form)



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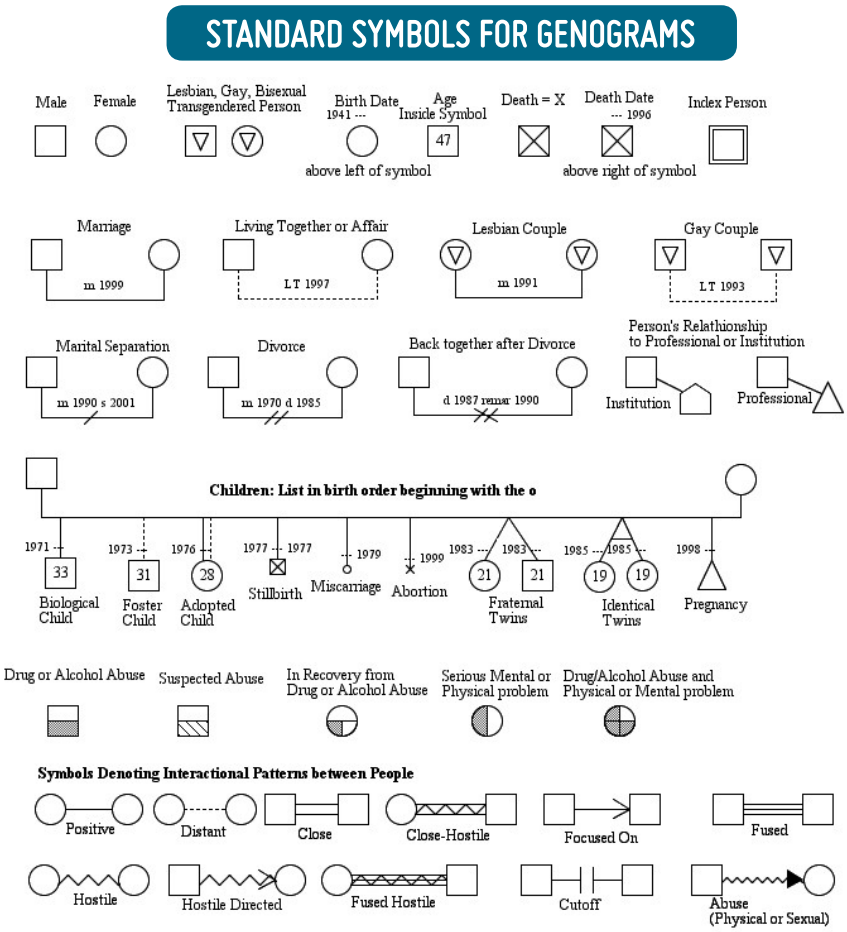
GENOGRAM / FAMILY TREE



→ What?

A genogram is a graphic representation of a family tree that displays information on the family members and their relationship.

→ What for?

To understand and analyze family emotional and social relationships. It can be used to identify repetitive patterns of behavior, significant events and personalities, roles of the individuals in the family system (decision-making process for example), power hierarchies (domination, flexibility, changes / resistance to change), crisis, etc...

→ Who?

The genogram is a tool that can be used either by the social worker alone or by the social worker and the family.
When it is used by the social worker alone, the genogram is a tool to organize the mass of information gathered during family visits. It can be used during briefing and cases studies to clearly present the family members and their relationships.
The objective remains: to understand and analyze the family situations and relationships.
It is an interesting tool to be used with the family members: it helps the families to clarify their own history, relationships, etc.

→ When?

A genogram can be done early in the relationship building process or it can be done later during the follow up. If it is a good tool to facilitate relationship building between the social worker and the family members, family members may not be ready to share all information with the social worker in the beginning of the follow up. The right time to do a genogram thus depends on the confidence established with the family and the time available as it can take time.

→ How?

- When collecting information in order to build the genogram, it is important to be attentive to the reaction of the family members to the questions you ask. Pay attention not only to the content (information collected) but also to the process itself (reactions, emotions, etc). Only the reactions and emotions of the family members will help you to understand and analyze.
- Important to simplify the genogram, only keep the information that are significant for the clarification of the family's situation.
- Write the date at which the genogram has been drawn.
- Write the names of those who participated in the drawing (the social worker, the father, the mother, etc)
- Drawing a genogram can also be presented to the family as a playful activity.

In family follow up we are not only interested in the content of the stories but also in the emotions that are expressed.

A family can be seen as an emotional unit or a system of interconnected and interdependent individuals. These individuals cannot be understood in isolation from one another but rather as part of their family. (Family System Theory)

Thus, the activity of making a genogram helps to understand and analyze the family unit. Understanding and analyzing the family unit are the first steps in social work.

COMMUNITY-BASED INTERVENTIONS

I. COUNSELING SESSIONS

I.1 Description

A counseling session is an individual and confidential discussion between a social worker and an individual.

Counseling sessions are generally organized in the social centers located at the heart of the areas of intervention. Social centers are open to all the inhabitants of the area regardless of their social and economic status.

I.2 Objectives

- To offer a conducive and confidential space to individuals in need of listening, support, and information.
- To provide listening, support and information to individuals facing difficulties in their personal lives.
- To promote an active participation of the inhabitants towards their own development, for the whole community's upliftment.

I.3 Target groups

FDP FAMILIES

Families benefiting from home-based follow up are invited to the social center to attend to collective activities or to meet the social worker during an individual counseling session.

In Nepal, some women chose to come to the social center to discuss about family violence rather than talking to the social worker during the home visits. In the social center, they can talk more freely about intimate problems without the fear of being heard by other relatives and neighbors.

Coming to the social center to ask for support or information is a sign of empowerment. It is to be encouraged. One way to encourage it is to provide referrals from the social centers rather than the home.

PHASE OUT FAMILIES

Even when the families are phased out they should be encouraged to continue visiting the Social Center whenever they have questions and/or new difficulties.

COMMUNITY FAMILIES

Social centers are open to all community members. All inhabitants can be received by social workers for individual counseling. In some instances, vulnerable families in need of a deeper social support are identified during counseling sessions. The family follow up can take place in the social center through regular counseling sessions or in the home of the family.

I.4 Implementation

VISIBILITY

- Provide written schedule of the social centers and counseling sessions to community members (FDP families, phase out families, community leaders...)
- Provide relevant information (schedules, presentation cards, etc) to community based organizations, local service providers, etc
- A schedule of the counseling sessions should be posted outside the Social Center

It is recommended to have regular opening time within the week.

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PROCESS

Inquire about the purpose of the visit & provide information on the social center and the counseling sessions.

Why did the person come? Did s/he come to inquire about the services provided in the social center? Did s/he come to inquire about other services in the area? Is s/he looking for specific information? Does s/he look for attention and support? Is s/he coming for a referral? Etc

Discussion to help the person identifying and prioritizing the problems / difficulties.

Listening & understanding

Discussion on the possible solutions

Information, orientation, decision-making understanding

Conclusion / End of session

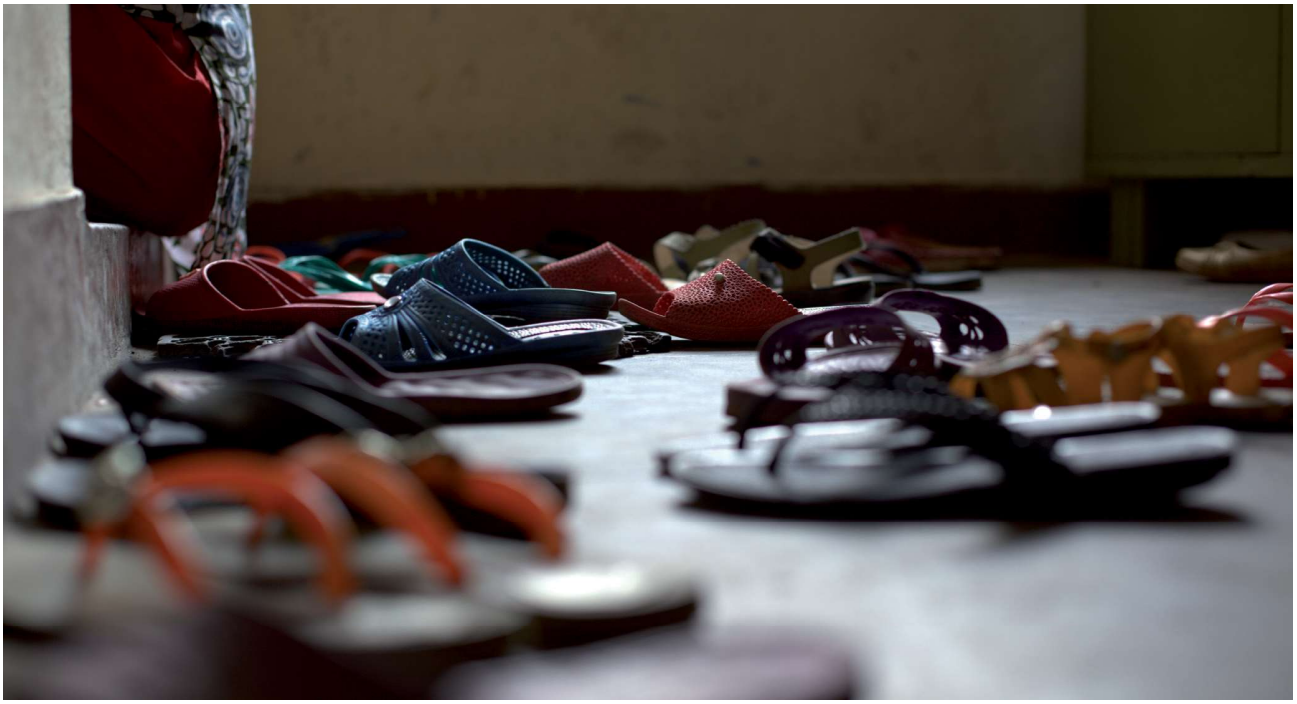
What's next? Next meeting? Home visit?

II. COLLECTIVE ACTIVITIES

As part of the social intervention, collective activities are organized in the social centers and at community level in the areas of intervention. Different types of activities have been developed and experienced in E&D's countries of intervention: awareness sessions, group discussions, mass orientations, etc.

The methodologies used for each type of activity and the names given to the activities described in this section may vary from one country to another. What is important to point out is that these activities can be categorized according to their principal goal being either mainly "educative / informative" or emphasizing more the "sharing and support" aspects.

To be noted that the concept of group discussion is understood in different ways depending on the countries of intervention. In Burkina Faso, the "group discussions" are "awareness sessions" and have an educative purpose. In Nepal, "group discussions" can be awareness sessions (with an educative goal) and in some cases can be compared to "support groups" that foster the sharing of experiences among participants. "Support groups" made to develop support mechanisms among participants, are more difficult to implement because they require professional skills and specific trainings. However, group discussions are offering sharing opportunities where support mechanisms can emerge with the support of experienced social workers.



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	Awareness sessions	Group discussions	Mass orientation
General objective	• To increase the knowledge and raise the awareness of community members on specific topics • To create a synergy among participants and hence among the inhabitants of the area. • To encourage support system among the inhabitants of the area		
Specific objectives	• Evaluate the level of awareness & knowledge among participants on a specific theme • Provide concrete information in order to encourage participants to adopt adapted behaviors when faced with these situations	• To encourage sharing and mutual listening among participants • To develop solidarity among participants • To reduce the psychosocial isolation of the participants • To allow each one to become an actor of change	• Raise the awareness of a large group of people in a given area on a specific topic • Encourage people to ask for more information on the topic presented or on other questions in the social centers open in the area.
Preparation	• Each theme is chosen carefully by the social worker • Activities are to be adapted to the level and capacities of the participants (e.g. if most participants are illiterate do not use written visual aids but rather images and audio) • Target groups should be systematically informed about the schedule and topics of activities • Attendance sheet should be prepared prior to each collective activity, clearly stating name, age, gender, type of follow up (family followed up, phased out or families from the community), participating for the first time or more frequently, address, etc.		

II.1 Awareness sessions

Awareness sessions are a more formal gathering of several community members to share experiences and knowledge on specific topics. It can be facilitated by the social workers or an external speaker with specific expertise. The topics covered are also related to the 5 domains of intervention: health, education, economic, legal and psychosocial (e.g. tuberculosis, malnutrition, process to obtain birth certificate, family budget, etc.). These sessions are educative and informative.

OBJECTIVES

- To evaluate the level of awareness and knowledge of the participants on a specific theme
- To provide concrete information in order to encourage participants to adopt appropriate behaviors when faced with these situations (correct misconceptions)

TARGET GROUPS

All inhabitants are targeted through these activities.
It can be interesting to mix families from different socio-economic backgrounds for sharing of experiences. Depending on the topic, it is also possible to target specific groups of people to raise their awareness. For example, if it is about raising the awareness of the families on schooling just before the beginning of the year, the activity will target families where children are not going to school.

PROCESS

Basic rules	**Proximity:** awareness sessions are to be organized in the heart of the areas to ensure the participation of vulnerable families. **No improvisation:** each topic must be carefully prepared in advance. Facilitation cards or curriculum must be written and visual aids prepared or available (posters...) **Choice of the topics adapted to the needs of the population:** topics can be proposed by the community leaders, chosen by the participants themselves, or by the facilitators according to problems often met in the area (e.g.: high level of tuberculosis in the area, new school year approaching, ...). **Facilitation by 2 persons** **Lively and interactive facilitations:** if possible with visual aids, manipulation of objects, diverse facilitation techniques. Avoid preaching or lecturing. **Make debates possible:** start from the knowledge of the participants/ check first what they know about the topic ... **Validate the understanding by the participants:** use fun and participative techniques. **Non-judgmental / respect of everyone's words**
Venue	In the heart of the areas to ensure the access of all In the social centers or any other places that provide adequate conditions for discussion and debate Outside but in a quiet environment in order to be able to hear each other, to listen and to manage the number of participants.
Duration / Frequency	35 minutes to 2 hours maximum. Factors to be considered when preparing the activity: availability of the participants and concentration capacity. After 2 hours, concentration and effectiveness tend to fade. Depending on the contexts of intervention, awareness sessions are organized 3 times a month (in NP), twice a month (in VN), and once every two months (in BF)
Facilitation	Awareness sessions are facilitated by social workers – always two working in tandem: one facilitates the discussion and the other takes notes, observes the participants, and manages visual aids. In some cases, an external facilitator can be invited. In this last case, the facilitation will be carefully prepared with the social workers because they know the target groups. Facilitation must encourage debate and interaction, promoting discussion with participants through question raising and reflective thinking. Limit preaching or lecturing and closed questions that inhibit discussion. Participants are encouraged to give feedbacks/comments on the awareness sessions in order to evaluate efficiency as well as to improve quality of services.
Number of participants	Depending on the contexts, between 20 and 25 participants in VN, maximum 15 participants in Nepal, 20 to 50 participants in Burkina Faso. In Nepal, as much as possible awareness sessions are organized with the same group of participants.

MONITORING TOOLS

The facilitators monitor the activity by recording the following information:

- Date
- Topic
- Number of participants (discriminated by gender)
- Number of persons coming from families followed up under FDP
- Number of new persons (those who never participated to an awareness session before)
- Feedbacks / comments and evaluation from the participants
- Minutes

II.2 Group discussion

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DESCRIPTION

Group discussions are an informal gathering of several community members (10-12 maximum) to share experiences and knowledge on specific topics defined by the participants themselves or the social workers according to problems identified. It is generally facilitated by one or two social worker(s) and can cover various topics related to health, family relationship, child development, education, legal documents, etc. This activity is non-educative.

SOCIAL INTERVENTION

Community-based interventions

It is interesting to tackle sensitive topics during group discussions such as alcoholism, marital violence, etc. but require professional facilitators. By tackling these topics in a group, participants realize they are not the only ones to suffer from this situation and are able to support each other.

OBJECTIVES

- To encourage sharing and mutual listening among participants:
  This activity creates the conditions for the participants to speak freely without fear of judgment. It encourages sharing and open expression of feelings including suffering and deep emotions related to the topic discussed.
- To develop solidarity among the participants, to mobilize necessary resources to face the difficulties and to create support mechanisms among the participants.
- To reduce the psychosocial isolation of the participants
- To allow each one to become actor of change

TARGET GROUPS

Participants are generally identified and invited by the social workers. Most often, they are followed up at home. Group discussions are complementary to home visits. It is an interesting activity to work on topics that are complex and heavy such as marital violence, addictions, etc.

The facilitators can identify the families having the same kind of problems and invite them to the group discussions. The topics can then be suggested by the participants themselves.

Participants are carefully selected on the basis of their willingness to share a specific difficulty and a common predicament.

PROCESS

Basic rules	Facilitation non directive and respecting the participants by a person trained (helping relationship and group dynamic) and supervised Speaking rules : discretion, confidentiality, freedom to remain silent, respect of everyone's own rhythm, non-judgment, non-violence, freedom to speak for everyone In a cycle of group discussions on a given topic, some informative sessions can be necessary (e.g. knowledge about the law on legal protection in case of marital violence). It is important to distinguish clearly the group discussions from these informative sessions. It is necessary to prepare all the group discussions in advance.
Venue	In the heart of the areas to ensure the access of all In the social centers or any other closed places that provide adequate conditions for discussion (confidentiality)
Duration / Frequency	To be defined with the participants (from 45 minutes to 2 hours maximum) Between twice a month and once a month.

Facilitation	Group discussions are facilitated by social workers – always two working in tandem. It is important that the same facilitators carry on the group discussions with the same groups to enable trust and measure the evolution of the participants and group. For the informative part, it is possible to have an external facilitator. In this last case, the facilitation will be carefully prepared with the social workers because they know the target groups. The role of the facilitator is to help the participants structure the discussion, to summarize ideas, etc. Participants are encouraged to give feedbacks/comments on the group discussions in order to evaluate efficiency as well as to improve quality of services.
Number of participants	Between 8 and 12 participants in order to allow everybody to speak, participate and get to know each other. Trust and support will be enhanced if a same group of participants is gathered regularly.

MONITORING TOOLS

The facilitators are monitoring the activity by recording the following information :

- Date
- Topic
- Number of participants (discriminated by gender)
- Number of persons coming from families followed up under FDP
- Number of new persons (those who never participated to a group discussion before)
- Feedbacks / comments and evaluation from the participants
- Minutes

II.3 Thematic mass orientation

Mainly organized in Burkina Faso, these activities are organized in the heart of the areas of intervention. Various themes can be suggested depending on the families' requests, community leaders' propositions, or needs identified by the social workers: administrative documents, savings, schooling, tuberculosis, family planning, etc. These activities can gather an important number of people and are a mean to mobilize the inhabitants toward the social centers.

OBJECTIVES

- Raise the awareness of a large group of people in a given area or community and on a specific topic (schooling, birth certificate, ...)
- Encourage people to ask for more information on the topic presented or on other questions in the social centers open in the area

TARGET GROUPS

All the inhabitants of an area / community.

PROCESS

Basic rules	• Prior to implementing the activity, always contact the local authorities or the community/area leaders who can support in the organization and facilitation of the activity. • Chose a date and time that is convenient for most of the inhabitants (e.g. week-ends) and when it is not too hot under the sun! • Mobilize 3 to 4 facilitators to take turn during the facilitation, to distribute documents if necessary, to manage the crowd... • Prepare clear, accurate, short messages. If needed, prepare visual aids. Theatre and puppet show can also be relevant. • Think of megaphone or any material useful for a crowd to hear
Venue	• Outside • Chose a space big enough to accommodate a large number of people • Have a space from which the facilitator will be seen by all. Maybe this space will need to be bounded (with a rope, a banner, a stage, ...)
Duration / Frequency	• 1 to 2 hours maximum • Depends on the problems identified in the areas (e.g. 6 per year maximum in Burkina Faso)
Facilitation	• Social workers • Experts in facilitation and in particular theatre groups, dancers, puppet theatre, etc. that can help mobilizing big groups of people • Other partners (associations, NGOs, public institutions, ...) specialist on the topic presented
Number of participants	Not limited in number as it is organized in an open space

MONITORING TOOLS

The facilitators are monitoring the activity by recording the following information:

- Topic presented
- Area where the activity is implemented
- Approximate number of participants

NETWORK OF SERVICE PROVIDERS & REFERRALS

INTRODUCTION

In a family development program, networking is one of the core activity to be undertaken by the social workers and the network officer.

One of the objective of a Family Development Program is to bridge the gap between vulnerable families and existing basic services. Building a strong network of service providers to respond to the needs of vulnerable populations is contributing to a more equitable access to basic services.

Networking should thus allow social workers to have a comprehensive knowledge of the services available in the areas of intervention and more generally in the whole city so as to be able to orient the families to the right services according to their needs.

Under FD programs, "service providers" can be public or private (NGOs, private clinics, etc) and include:

- Education: schools, vocational training centers, literacy classes, etc
- Health: health centers, hospitals, etc
- Administration: local authorities (delivering legal documents such as ID, birth certificate, etc)
- Economy: MFI, savings, etc
- Psychosocial: Psychologists, shelters, etc.

OBJECTIVES OF A NETWORK OF SERVICE PROVIDERS

- To improve the access of vulnerable families to existing service providers so as to meet their basic needs;
- To improve the autonomy of the families through a better knowledge of their environment and their rights;
- To empower families and strengthen their capacities to identify and access existing basic services;
- To contribute to improving the quality of services through adequate feedback among the network of service providers;
- To prompt service providers to develop more open-minded attitudes towards underprivileged and/or vulnerable persons;
- To improve the perception families have of the services (e.g. public services are often considered as corrupted, inefficient, unfriendly)

I. BUILDING THE NETWORK

I.1 Mapping of service providers

A mapping of service providers is systematically conducted in the areas of intervention while main service providers are also identified in the city where the program is implemented (e.g. for main hospitals). A resource map is drawn and can be posted in the social centers.

All service providers are met and practical information about the services they deliver is collected and documented. A booklet of service providers can be published and distributed to families and partners (it is done in Nepal since 2013). Information about the service providers shall be regularly updated and in some countries database have been specifically developed to record information about the network of service providers.

I.2 Coordination with service providers

During the process of identification and selection of existing services, the social workers introduce and explain the family development methodology implemented. Collaborations can then be established at local level between the existing services and the family development program. Whenever possible, partnership agreement are signed in order to facilitate the referrals and to improve the access of vulnerable families to those services.
Coordination meetings have been implemented in most of the countries of intervention. Organized in each area of intervention (on a quarterly basis in Nepal), the objectives of these meetings are to improve the knowledge of all stakeholders about the existing services, to improve the knowledge and understanding of the needs of the vulnerable population and the main issues encountered in the areas of intervention, and to strengthen the referral mechanisms between the services. Thematic coordination meetings area also organized to share about common issues faced by vulnerable populations across areas and in order to advocate for them at government level (e.g. birth certificate, access to education).

Local coordination meeting in Nepal

I.3 Assessment of service providers

More recently (from 2011), the importance of developing tools to assess the service providers has emerged so as to ensure equitable access to quality services. Criteria for assessment generally include:

- The quality of the services provided
- The reception (behavior of staff toward vulnerable families)
- The location (easy-to-access, proximity, visibility)
- The cost of service (including whether the service is available free of charge or with discounts upon referrals)

In Nepal, the assessment is based on feedbacks provided by the social worker (reflecting the feedbacks of family members referred), the network officer and representatives of the service providers.

FEEDBACK MECHANISMS

The readiness of the service providers to give and receive feedbacks can also be assessed. However feedback mechanisms have proved to be difficult to implement in many contexts due to high turnover in the partner organizations or lack of will and time to implement those feedbacks.

I.4 Tools

NETWORKING REPORT

Example of a networking report from Nepal

Networking Report

Date of contact: ___/____/_____ **Name of staff:** _____

ORGANIZATION PROFILE

Name: ..... **Type of organization:**

Address: ..... ☐ Clubs/CBO

Website:..... ☐ NGO ☐ INGO

Email: ..... ☐ Private ☐ Public

Phone: .....

Is this organization and its services relevant for FDP families: ☐ YES ☐ NO

Head of organization - Name: _____ **Position:** _____

Contact persons

Name	Position / Designation	Phone	Email

Main sector of activity

☐ Health ☐ Education ☐ Access to employment

☐ Psycho-social / Family Welfare ☐ Legal issues / Admin Other

Provides training: ☐ Yes ☐ No

Topics of training: _____

_____

_____

For whom :

☐ For staff/social workers ☐ For families

General description of the organization (establishment date, etc.):

Area coverage:

Description of the services provided or problems concerned:

Services provided	Contact Person	Opening hours	Cheap / discount / free	Comments

Other comments / outputs of contact:

Organization interested by FDP: ☐ Yes ☐ No

PARTNER INFORMATION CARD

Contains information about the different service providers met during network building. They provide a format for collecting useful information about the services.

Example of information cards from Burkina Faso

http://www.enfantsetdeveloppement.org/_new_bdd/IMG/pdf/Partners_information_card_ENG-2.pdf

ASSESSMENT TOOLS

Example of assessment tools from Nepal

Questionnaire for the social workers			
1.1 How many referrals were done to this service provider this semester?			
☐ 1 to 3	☐ between 3 and 5	☐ more than 6	
1.2 How many persons actually went to this service provider this semester?			
☐ All	☐ 1 to 3	☐ between 3 and 5	☐ more than 6
The area in charge gives the real number and the network in charge converts it in %:			
1.3 Percentage of families referred who have gone to the service			%
1.4 How many persons received a consultation?			
☐ All	☐ 1 to 3	☐ between 3 and 5	☐ more than 6
The area in charge gives the real number and the network in charge converts it in %:			
1.5 Percentage of families referred having received the service			%
1.6 Reasons for not receiving the service?			
☐ Date not appropriate	☐ Waiting time	☐ Service not adapted to the needs / problems of the family	☐ Other:
1.7 Waiting time			
☐ No need to wait	☐ one hour	☐ two hours	☐ more than two hours
1.8 Feedback from the families referred			
1.8.1 Did they easily find the service provider (accessibility of the place/location)?			
☐ easily	☐ not easily	☐ not found	
1.8.2 Was s/he properly taken care of?			
☐ yes	☐ no	☐ don't know	
1.8.3 Was s/he given clear information, explanation?			
☐ yes (well)	☐ yes a little	☐ not at all	
1.8.5 How much did s/he pay for the service? (precise the service)			
The network in charge answers this question: 1.8.6 Did he/she pay the expected fees, more or less?			
☐ Yes/ equal	☐ No	☐ less	☐ more

Questionnaire for the network in charge					
2.1 What is the level of accessibility of the service provider (in the area)?					
☐ Easy to find (signs, board…)			☐ Difficult to find		
☐ Easy to access (on foot, by tempo)			☐ Difficult to access (on foot, by tempo)		
2.2 What is the level of availability of the service provider?					
☐ 24/24	☐ 6/24	☐ sometimes only			
☐ Opening times are clearly posted		☐ Opening times are not posted and not clearly understood			
2.3 Are information about the costs of services clearly explained and transparent?					
☐ Fees are posted / transparency	☐ Fees are partially posted	☐ Fees are not posted			
(Below question for organizations providing shelter) 2.4 What is the level of hygiene of the service provider?					
☐ clean	☐ depends on the departments	☐ dirty			
2.5 Is drinking water available?					
☐ Available for all clients	☐ Available for some clients only	☐ Not available			
2.6 Are latrines accessible for the clients?					
Number of latrines		Number of clients		Ratio (latrine per client)	

Questionnaire for the service providers		
3.1 What do you do to improve the accessibility of your organization to the poorest families?		
Answer:		
☐ Good initiatives taken (according to the network in charge)	☐ Has tried to improve the accessibility	☐ Didn't do anything
3.2 Have you already provided a service to a client referred by VOC?		
☐ yes	☐ no	
3.3 Do you know the referral document from VOC?		
☐ yes	☐ no	
3.4 How many clients per day?		
3.5 How many staff?		
3.6 What is the ratio (staff per patient?) *(filled by the network in charge)*		
3.7 Do you apply discount to poor people?		
☐ yes	☐ No	

II. REFERRALS

II.1 Process

A referral is when the social worker orients a client to one of the available services after having assessed the need/problem to be addressed and provided comprehensive and accurate information about the service (incl. process, cost, location). The social worker will assist the client to access the service and in some cases may accompany him/her to the service.

Referrals can be made formally (i.e. with a referral slip to be given to the service provider) or informally when no specific agreement has been settled with the service provider. Nevertheless, all referrals shall be recorded and monitored so as to assess whether the persons referred actually received the service they were looking for.

Example of assessment criteria for referrals

Result of referrals	Description
1. Successful	• The client has access to and is provided with services as expected • The client continues to get the services from the service provider (for example: treatment of tuberculosis or antenatal examination)
2. Successful but not sustainable	• The client has access to and is provided with services once, but does not continue to access the services (for example: tuberculosis treatment, school drop-out).
1. Failed	• Client does not make contact with the service provider. • The service is not provided.

The role of the social worker and the network officer will be to encourage the families to use the right services by providing accurate information on the existing services and making referrals. They are also responsible for collecting feedbacks from the family members on the service provided. A follow up with the service providers is necessary in case of problem (service not provided, unfriendly behavior, etc) so as to improve the service delivery for the target population.

II.2 Tools

REFERRAL FORM / SLIP

Example of a referral form from Nepal

Referral Form
Referral date : .....
Referred by : ..... Referred to : .....
Name of the person referred : ..... Age : ..... Sex : ..... Address : .....
Problem identified : .... Recommendation : ....

TEAM WORK & CASE MANAGEMENT

This chapter proposes a description of the types of meetings and exercises that can be used in case management. During the follow up, social workers can use different tools to help them with the family cases. The tools proposed are helping them to deal with difficult cases, to share their difficulties but also their successes with other team members and eventually to keep other team members informed about the on-going cases.

Team work is taking place during: team meeting, briefing and debriefing (before/after home visits), case conferences, assessment committees and triangular exercises.

I. THE IMPORTANCE OF TEAM WORK

In their daily work, social workers are facing difficult family situations, they often conduct home visit alone and it is thus crucial to organize regular schedules for team work. **Team work** will help social workers to keep the **professional distance** needed with the families they are following, it provides them with **support for case management**, and is part of a continuous **training** scheme.

Different opportunities for team work can be created at program levels:

- Monthly team meeting to allow the team to discuss about specific situations encountered in their area of intervention or about more general issues concerning the program.
- Monthly sharing meetings for social workers only (without managers) to share about training, experiences, work, feelings, ...
- Weekly area committees / area team meetings for family selection, phasing out, case study, and/or case management
- Briefing / debriefing with another social worker

II. BRIEFING AND DEBRIEFING

Short discussion before and after a home visit between the social worker in-charge of the follow up and another social worker who knows the family (the other social worker may or may not have participated to the home visit). Briefing and debriefing help the social worker to structure his/her understanding of the case, to prepare the home visit, to analyze the family situation, to reflect on the follow up, to highlight difficulties, to plan the next visit, etc. It is an important tool for the training of new social workers.

III. CASE STUDY / CASE CONFERENCE

Meeting during which complex cases are presented to other team members (including if needed a psychologist, the team leader and/or the program coordinator). Generally, cases are presented during case conference when the social worker in charge encounters difficulties in a case management that could not be resolved in triangular exercise.

IV. ASSESSMENT COMMITTEE / PHASE OUT COMMITTEE

Phase out committees or assessment committees are organized after assessment visits. The objective of the assessment committee is to decide on the phase out of the family and to assess the changes in the family's situation.

V. TRIANGULAR EXERCISE

If the social worker is confronted to a difficult case which makes her/him feel confused, useless or powerless, s/he is encouraged to share her/his difficulties with her/his colleagues in order to broaden the reflection, to find alternative ways of working and to unblock the situation. The triangular exercise is designed for three persons: usually, the social worker in charge of the case, the observer and a mediator. This exercise helps the social worker to develop a synthetic mind, to distinguish what is important and what is not, to formulate hypothesis, to pay attention to the non-verbal information that are given during home visits.

ROLE OF THE MEDIATOR:

- To make sure the social worker and the observer keep their own roles during the home visit
- To make sure that the discussion takes place in a kindly manner and that neither the social worker nor the observer are judgmental
- To make sure that the presentation of the case is clear and understood by everyone
- To encourage the debate and the sharing of ideas
- To encourage equal participation
- To control the timing

PROCESS:

A first triangular exercise can be organized at the end of the relationship building period (usually within the first 2 months of the follow up) to help the staff to understand and analyze the situation, to find the rooting problems and to formulate some propositions and feedbacks to be made to the families.
Other triangular exercises can be organized whenever the social worker needs it or whenever the team leader or area-in-charge feels that it is needed: i.e. as soon as the social worker feels confused, lost in the follow up, or not confident, when the client is repeating the same information over and over again, if nothing is changing, etc.
A triangular exercise can also be organized to prepare the phasing out.
The program can also decide to organize systematic triangular exercises every 3 months for each family.

Steps	Description	Duration
Briefing	The social worker presents the family's situation to the mediator and the observer. The presentation includes: • The date of the first visit • The family profile • The problems/needs identified by the family and/or the social worker • The objectives already achieved • The difficulties encountered during the follow-up • The next objectives	30 min. maximum
Home visit	The social worker conducts the home visit together with the observer. The family accepts the presence of the observer.	20-45 min.
Debriefing	Back to office, the social worker describes the home visit and the observer adds her/his observations. The observer's comments must be helpful and kind but never criticizing or judging. The social worker, the observer and the mediator discuss about the home visit, make hypothesis and propose a plan of action.	30 min. maximum
Conclusion	At the end of the debriefing, an agreement is reached on the actions to be undertaken with the family. A case summary is written after the exercise and included in the family file.	

VI. A FORMAT FOR CASE STUDIES

Example of a case study format used during phase-out committee

Case studies can be written by the social workers at different times during and after the follow up. It is a tool to help social workers to organize, summarize and analyze family cases.

Case Study of Phase-Out family

Area Name:
Date:
SN:

1. General information:

First Visit:	Last Visit:	Duration:
Date of assessment committee:	Number of visits:	PO category:
Name of Witness:	A Score:	B Score:
Participation in	G.D: Yes☐ No☐	SC: Yes☐ No☐

Family profile:

Family Name	Relation	Age	Occupation	Income

2. History and Background of the family (including genogram):

3. Situation of the family before FDP support

Living conditions:

Resources and Strengths:

Root problem in the family:

Problems / needs identified:

4. Situation of the family after FDP intervention

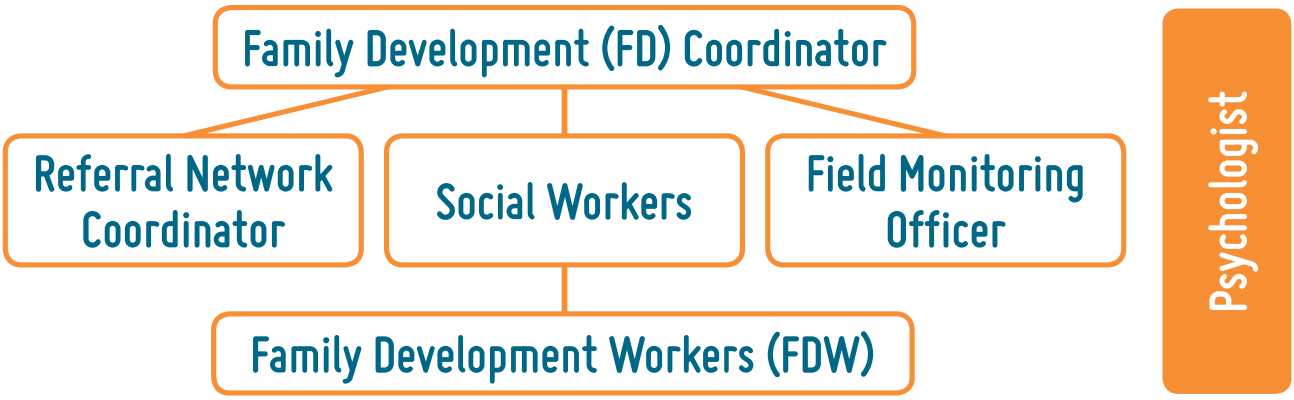
5. Conclusion

HUMAN RESSOURCES
FDP TEAM

crédit : Ingrid Chiron

HUMAN RESSOURCES FDP TEAM

I. COMPOSITION OF THE TEAM



II. ROLES & RESPONSIBILITIES OF TEAM MEMBERS

THE FD COORDINATOR

Supervises and provides technical support to the referral network coordinator, the field monitoring officer and the social workers through capacity building, case management (briefing/debriefing, case conference, assessment committees, etc).
The FD coordinator is responsible for the monitoring, evaluation and reporting of the activities and results.

THE REFERRAL NETWORK COORDINATOR

Also called Network In Charge (NIC), s/he works in close coordination with the Social Workers and the Field Monitoring Officer, and reports to the Family Development Coordinator.
The referral network coordinator is responsible for the identification of the existing services and coordinate with them for the effective referral of families. S/he assesses the quality of the services provided, capitalizes the information related to the network, sets up coordination mechanisms with service providers and monitors the referrals.

THE FIELD MONITORING OFFICER (FMO)

In coordination with the other team members, the FMO is in charge of developing monitoring tools, collecting and encoding data and information on the program activities and providing consolidated data for reports and analysis.

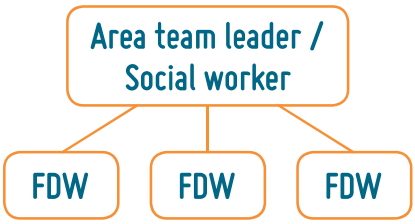
HUMAN RESSOURCES FDP TEAM

THE SOCIAL WORKERS

Social workers are directly working with the families and know well their areas of intervention (area profiling, data collection and analysis, ...). They conduct activities with the families at field level (house-to-house visits, home visits, counseling, and facilitation of collective activities in the centers), evaluate families' situations, coordinate with service providers at local level, refer family members to service providers. They are also in charge of managing the social centers.

SOCIAL WORKERS & FAMILY DEVELOPMENT WORKERS

Social workers always work in team. Team members are organized per area, usually around 1 social centre. For each area, one social worker (also called "area team leader", "area in charge" or "senior social worker") is in charge of managing the social centre and supervising a team of social workers also called "Family Development Workers (FDW)".
Teams shall remain relatively small so as to avoid too many meetings that would involve too many staff members. Area meetings with fewer staff are shorter and more easily done. This organization also implies that FDWs have more time to work with the families.



SPECIALIZATION OF THE SOCIAL WORKERS

Depending on the size of the teams and the types of activities implemented, it may be interesting for some social workers to be trained on specific topics in order to become "specialist" or referent social workers on some specific issues. Examples:

- In Nepal, some social workers are specialized in the implementation of activities for children
- In Cambodia, one social worker has received specific trainings on children development in order to develop all the activities related to children development (Parents-Child Activities). He's been acting as a referent staff for all FDP team members on issues related to children.
- Other topics on which FDP staff can be specialized: economic development, family budget, vocational training, etc

THE PSYCHOLOGIST

The role of the psychologist is to provide support to the team members on:

- Stress management and how to keep the right distance with the families' problems
- Case management and how to address some specific family problems during the follow up

Depending on the contexts of intervention, the size of the team, and the financial resources available, it may not always be possible to recruit a full time psychologist in the team. Different options may then be considered: part-time recruitment, technical support by a psychologist member of a partner organization (North or South), consultancies by an external psychologist, ...

« Time for me »

SELF CARE ACTIVITY FOR THE TEAM MEMBERS

Started in 2007 by / for SKO's social workers and family development workers in Cambodia.

OBJECTIVES

- To support the staff emotionally
- To encourage the staff to relief stress & practice insight reflection
- To support the group's cohesion & communication (team building)

METHOD

- Use of body movements, meditation, relaxation & arts
- Frequency : once a month
- Duration: ½ day or 1 day

LESSONS LEARNT

"I need to refresh my brain"

→ For the social workers to be able to express freely, it is best to have an external facilitator or at least someone who is not in their management line.
→ The managers are not participating to this activity.
→ Best to propose a time differentiated from the work and family's context.
→ This helps FDP's staff to analyze their clients cases.
→ Important to develop not only analyzing skills but also creative, empathetic skills as well as an attention on the body language
→ Individual follow-up shall also be proposed if needed. Some conflicts cannot be solved in/by a team.
→ Important to respect the confidentiality of the participants. Thus the reports to the line managers regarding the Time for me (TFM) cannot be too detailed and mention the participants' name.
→ However, the reports to managers may be useful when some information emerged in TFM and are interesting to improve/ question the team habits, organization.

HUMAN RESSOURCES FDP TEAM

III. RECRUITMENT

In their daily work, social workers are confronted with difficult and sometimes dramatic family situations, that may shake up their own values while making them more vulnerable to distress. It is thus important to be attentive to the following qualities and skills that a social worker shall have when recruited or shall acquire during initial trainings.

ATTITUDE:

- Listening and non-judgmental attitude: respect for the families' beliefs, wishes, opinions and decisions (even if the social worker does not agree)
- Confident in the families' capacity to improve their situation
- Non-directive support without giving lessons or solutions
- Confidentiality

MOTIVATION:

- Motivation to work with very deprived population and/or dysfunctional families (interest for social work and field work)
- Willingness to learn new skills and approaches (openness, learning attitude)

SKILLS:

- Interpersonal / communication skills for the families to feel comfortable to share
- Capacity to deal with stress and to keep a professional distance with the beneficiaries.
- Capacity to assess & summarize the families situation
- Capacity to work as a team

IV. NUMBER OF FAMILIES FOLLOWED UP PER STAFF

In most of the FD programs all staff are following families in order to keep contact with the field work.
However, depending on the roles and responsibilities of each staff, the number of families followed up may vary.

FDP coordinator	5 families
Referral network coordinator	5 families
Field Monitoring officer	5 families
Social worker / Area in charge	10-15 families
Social worker / Family Development Worker	25-30 families

V. STAFF APPRAISAL

Staff evaluations shall at least assess the following:

KNOWLEDGE:

- Technical knowledge about legal, health, education, psycho-social issues and economic development related issues
- Services and resources available (network)

SKILLS:

- Listening
- Counseling
- Networking
- Reporting
- Facilitation

ATTITUDE / BEHAVIOR:

- Relation to families (respect, confidentiality, non-judgmental)
- Reliability (attendance, punctuality, autonomy, take initiatives, responsible, committed, etc)
- Team player (relationship with other team members, team activities, etc)

MONITORING & EVALUATION

MONITORING & EVALUATION

It is important to be able to measure the results and impacts of a FD program for/on the families followed up. Different tools have been developed and are used in the programs of Cambodia, Burkina and Nepal. They all try to capture the changes that occurred in the lives of the families as assessed by the social workers and by the families themselves.

Part of the tools used aim at measuring objectively verifiable results (i.e. problem solving tool) while others aim at measuring more subjective results (for example: satisfaction of the families, feelings of well-being, self-confidence, and self-esteem).

This chapter aims at providing an overview of the tools used to assess the results and impacts of FDP in the 3 countries. It is also identifying some difficulties encountered in the evaluation process, opening the discussion for further improvements.

I. BASELINE SURVEY

Baseline surveys have not been conducted systematically in all areas before starting the implementation of the action. In Nepal for example, populations were reluctant to answer to surveys because too many times solicited by organizations without ever receiving any services in return. Also, as the FD methodology measures the progress for each family followed up, a large amount of data is collected during the implementation period that is considered as much more reliable than any baseline data gathered through general surveys.
However, in order to analyze the impact of FDP at the level of one area or to have a more scientific analysis of the results of FDP, some experiences have been led in Burkina Faso and Nepal where specific tools have been developed.

I.1 Two experiences of baseline survey in Burkina Faso

OCTOBER 2010: BASELINE SURVEY CONDUCTED IN THE AREA OF BOGODOGO BEFORE PROGRAM IMPLEMENTATION

Objective of the survey:

- To assess the level of poverty of the area
- To collect baseline data in order to evaluate the results and impact of the action after intervention

Sample:

Total number of families living in the area	53 000
Number of families in the area covered by FDP (10%)	5 300
Number of families targeted by FDP (20%)	1 060
Number of families interviewed	500

MONITORING & EVALUATION

Method:

- Time required: 1 month / 2 hours per interview.
- Human resources: 7 social workers (72 interviews per SW)

Indicators related to:

- Administration
- Education
- Economy
- Health
- Housing
- Access to water
- Body hygiene and sanitation
- Parents-Children relationships
- Relationship with the social environment
- New born care / breastfeeding / excision
- Mother-child relationship
- Contraception
- Couple relationships

Observations / Lessons learnt:

→ The development and implementation of the survey was quite heavy (in time and resources)

→ The survey questionnaire is collecting data on a wide range of indicators and is useful to obtain comprehensive information on an area when starting a FD Program

→ The survey allowed the team to identify a significant number of families for FDP

→ For program extension in a new area, a shorter survey questionnaire could be designed

→ For survey development, it is important to reflect first on the objective of the survey and to select the indicators accordingly. E.g. if the objective is to collect baseline data for future evaluation of the impact of FDP in a given area, it is necessary to select indicators on which FDP can have an impact and to design the survey accordingly.

MONITORING & EVALUATION

2012: BASELINE SURVEY CONDUCTED BY THE OBSERVATORY OF THE POPULATION OF OUAGADOUGOU

In Burkina Faso, E&D has been working with the Observatory of the Population of Ouagadougou (OPO) managed by the Institute of Population Sciences of the University of Ouagadougou (ISSP) for the development of a scheme for the evaluation of the results and impacts of the Family Development Program. The OPO is conducting research in 2 of the areas that were selected for FDP: Nioko II (district of Nongr-Maasom) and Nonghin (district of Sig-Noghin). Part of the evaluation scheme was therefore integrated to the on-going research.

The OPO and E&D have been identifying a list of indicators to be monitored in order to evaluate the impact of FDP. Questions relative to these indicators have been integrated in the surveys that have been conducted by the OPO in the 2 areas and in 1 area (Polesgo) where no Family Development activities are conducted. The encoding and analysis of the results have been done by the OPO.

19 indicators have been identified. Only indicators on which FDP can have a direct impact have been selected:

1) Contraceptive prevalence rate
2) Antenatal care coverage
3) Births attended by skilled health personnel
4) Immunization coverage for children under 1 year old
5) Participation to health trainings
6) Mosquito nets use
7) Early childhood care and education enrollment rate
8) Primary school enrollment rate
9) Primary school enrollment rate of girls
10) Ratio of adults having had a vocational training
11) Ratio of birth not registered
12) Ratio of persons above 15 years old who do not have an identity card
13) Ratio of persons in union without civil wedding
14) Ratio of persons having a savings account
15) Ratio of persons who had a loan
16) Ratio of persons member of savings and credit group
17) Ratio of adults who know a MFI
18) Attitude of adults toward disciplines for children
19) Attitude of adults toward domestic violence

I.2 Experience of a baseline survey in Nepal

2008 : BASELINE SURVEY CONDUCTED IN THE AREA OF KANKESHWOR

It was composed of an observation form and a survey questionnaire. The observation form presented below was completed during the home visit but without asking any questions. The survey questionnaire used during the baseline is not presented in this handbook but is similar to the questionnaire developed in 2013 (see page 92).

BASELINE SURVEY / OBSERVATION FORM

Date:	___/_____/____	**Serial number:**	.....
Interviewer:	.....	Ward number:	.....
Observer:	.....	Area:	.....
		Tole/Lane:	.....
Family selection:	☐ Family followed by FDP ☐ Families visited through H2H (not selected) ☐ PO family ☐ Other family		

HOUSING

1	Number of rooms:	☐ More than 1 separate bedroom ☐ 1 separate bedroom ☐ 1 big common room ☐ 1 small common room
2.	For Slum: Construction material	☐ Shanty ☐ Mud ☐ Brick / Cement
3	For low rent: Condition of the building	☐ New ☐ Old ☐ Dilapidated ☐ Renovated
4	Quality of shelter	☐ An adult can't stand up ☐ Floodable ☐ Dark and not ventilated ☐ Roof leaking / broken ☐ Good

5	Furniture in the house:	☐ Bed ☐ Sufficient bedding ☐ Table & chairs ☐ Shelves & cupboards ☐ Couch/arm chairs ☐ Gas stove ☐ Kerosene stove ☐ Wood stove ☐ Cooking material (pans, pressure cooker…) ☐ Water filter ☐ Electric kettle ☐ Fridge ☐ Radio/K7 device ☐ TV ☐ DVD player ☐ Carpet(s) ☐ Other: ……

HEALTH

UNDER 3 YEARS OLD CHILDREN NUTRITION

6	Are any of the children showing signs of malnutrition?	☐ Yes	☐ No
7	If yes, who:	……	
8	If no, was it possible to observe the children during the survey?	☐ Yes	☐ No

HYGIENE

9	Is the environment clean outside the house?	☐ Good	☐ Average	☐ Poor
10	Is the environment clean inside the house?	☐ Good	☐ Average	☐ Poor

MONITORING & EVALUATION

FAMILY SITUATION / AREA MAP
SOCIAL WORKER'S OBSERVATIONS

II. FAMILY SURVEY

Family surveys have been developed in Burkina Faso, Cambodia and Nepal. However, the objectives of these surveys vary from one country to another (see in Chapter: Home-based intervention)

	Burkina Faso	Cambodia	Nepal
Objective	To assess the families' situation To inform the decision to integrate the family in the program	To collect baseline information on the families followed up	To draw the socio-economic profile of the families followed up under the family development program
Process	Filled up during house-to-house visit and phase 1 of the follow up (i.e. relationship building period)	Filled up once a family is selected during phase 1 of the follow up (i.e. relationship building)	Filled up for a sample of families. Evaluation conducted once in 2014 and to be conducted once every 3 years.
Tools	Survey form Access database	Survey form Access database	Survey form Access database

2014 : FAMILY SURVEY CONDUCTED IN NEPAL

In Nepal, in 2013, a family survey was developed together with a database allowing the encoding and analysis of data. In the context of Nepal, the family survey aims at providing a clear and precise profile (picture and status) of the families followed up under the Family Development Program. This survey was also implemented by the Reintegration Program of Voice of Children.

TARGET

Respondents are the families selected by FDP through house-to-house visits and families of street children living in the preparation center. In 2014, 50 FDP families and 30 families of street children were selected.

PROCESS

Questionnaires are filled up by the social workers based on information already included in the family files or collected during home visits.
An access database has been created and allows the encoding and analysis of the data collected.

LESSONS LEARNT

- The process for collecting, analyzing data lasted 3 months and might be renewed every 3 years.
- Families are not requested to answer a questionnaire as answers are found in the family files.
- Family survey assess the socio-economic profile of the families followed up but do not evaluate changes in their situations.

FAMILY SURVEY - 2013
E&D and Voice of children

Serial number:

Project	☐ RP	☐ FDP

Interview date[1]	Interviewer

Living area:	☐ In urban area	☐ In rural area	
	☐ In Kathmandu Valley	☐ Out of Kathmandu Valley	
Religion :	Cast:	Number of family members in total[2]:	
Number living together :	Male : Female :	Children (under 16):	
Situation of family head	☐ single	Gender of family head	☐ Female
	☐ married		☐ Male
	☐ divorced	Migrant family ☐ Yes	☐ No
	☐ widower /widow	Reason of migration	
	☐ second marriage	☐ earning ☐ conflict	☐ inter cast[3]
	☐ polygamous	☐ education ☐ health care	☐ 2nd marriage
	☐ others	☐ no land ☐ other	

SECTION A: HEALTH

A.1. There is a pregnant woman in the household Yes ☐ No ☐

If yes in A.1.
A.2. Regular check-up is performed Yes ☐ No ☐

If no in A.2. Why
A.2.A. No access to health services center ☐
A.2.B. Family doesn't allow the check up ☐
A.2.C. Doesn't feel it's important ☐
A.2.D. Financial problem ☐
A.2.E. Only male doctor ☐
A.2.F. Other ☐

A.3. Place of delivery for the last pregnancy
A.3.A. Health facility ☐ A.3.B. At home ☐

If A.3.B. At home, whom?
A.4.A. TBA (traditional birth attendance) ☐
A.4.B. Sudeni (FCHV female community health volunteer) ☐
A.4.C. Relatives ☐
A.4.D. Alone ☐

[1] Date of 1st visit to the family
[2] Leaving or not in the same house
[3] If inter cast marriage not accepted by the families, in the village

A.5.A. Any problems during and/or after delivery Yes ☐ No ☐
If yes in A.5.A.,
A.5.B. No placenta delivery
A.5.C. PPH (post partum hemorrhage)
A.5.D. Convulsion
A.5.E. Other

If children aged of 5 or below 5 in the family
A.6. Consultation (including for immunization) with doctor for them Yes ☐ No ☐

If no in A.6. Why
A.6.A. No access to health service center ☐
A.6.B. Doesn't feel it's important ☐
A.6.C. Financial problem ☐
A.6.D. Other ☐

A.7. Children aged of 5 and below 5 are immunized Yes ☐ No ☐
If yes in A.7., please tick under the table[4]

Name of children	Age	BCG	DPT 1	DPT 2	DPT 3	Measles	Others	**Complete**	**Partial**

A.7.A. All the children are fully immunized[5] ☐ A.7.B. All are partially[6] ☐
A.7.C. Some fully and some partially ☐

If there are children aged of 5 or below 5 years old
In average, number of times that the children of 5 and below 5 years old have eaten (full meal):
A.8.A. 1 time ☐ A.8.B. 2 times ☐ A.8.C. 3 times ☐ A.8.D. 4 times ☐

What they ate yesterday
A.9.A. Djaulo ☐
A.9.B. Dhal bhat ☐
A.9.C. Dhal bhat tarkari ☐
A.9.D. Roti tarkari ☐
A.9.E. Lito ☐
A.9.F. Meat/eggs/fish ☐
A.9.G. Fruit ☐
A.9.H. Energy drinks ☐
A.9.I. Milk/yogurt ☐
A.9.J. Tea with biscuit ☐
A.9.K. Other ☐

If children aged of / up to 3 years
A.10. Breastfeeding Yes ☐ No ☐
A.11. Attendance weighing sessions (even during immunization session) Yes ☐ No ☐
If no why
A.11.A. No facility in Health clinic ☐ A.11.B. Clinic too far ☐ A.11.C. No time ☐
A.11.D. Doesn't know where to go ☐ A.11.E. Not interested ☐ A.11.F. Other ☐

[4] BCG within one month after birth date; DPT 1 at 45 days after birth date, DPT 2 at one month after DTP1, DTP 3 at one month after DTP2; Measles at 9 months
[5] According to the planning of vaccination (see footnote number 2)
[6] According to the planning of vaccination (see footnote number 2)

A.12. Use of family planning method Yes ☐ No ☐
If yes in A.12.
A.12.A Temporary method ☐ A.12.B. Permanent method ☐

If no in A.12.
A.13.A. Husband does not want ☐
A.13.B. No partner ☐
A.13.C. Health problem ☐
A.13.D. Doesn't know any method ☐
A.13.E. Wants to have children ☐
A.13.F. Family planning not available ☐
A.13.G. Menopause ☐
A.13.H. Others ☐

A.14. Have ever used a contraceptive method Yes ☐ No ☐

A.15. The 12-19 years old are aware about sexual reproductive health Yes ☐ No ☐
If yes, Very good knowledge ☐ Partial knowledge ☐
If yes, they get knowledge from
A.15.A. Parents ☐
A.15.B. School ☐
A.15.C. Friends ☐
A.15.D. Organization ☐
A.15.E. Other ☐

A.16. Handicap of any member family Yes ☐ No ☐
If yes, who
A.16.A. Father/mother ☐
A.16.B. Children ☐
A.16.C. Other adults of the family ☐

A.17. Health problems faced this last year

A.17.A. Diarrhea	☐	A.17.B. Common cold	☐	A.17.C. Pneumonia	☐
A.17.D. Typhoid	☐	A.17.D. Chicken pox	☐	A.17.E. Skin disease	☐
A.17.F. Asthma	☐	A.17.G. Jaundice	☐	A.17.H Other	☐

During the last five years:
A.18. Tuberculosis Yes ☐ No ☐
A.19. Sexual transmitted diseases[7] Yes ☐ No ☐

What is done when a family member is sick
A.20.A. Nothing until complications ☐
A.20.B. Self-medication: buy medicines in pharmacy ☐
A.20.C. Health Center ☐
A.20.D. Consultation of traditional healer / buy traditional medicines ☐
A.20.E. Religious consultations (prayers, etc.) ☐

Hygiene
A.21. Latrinesfacility Yes ☐ No ☐
If yes in A.21.
A.21.A. Use of the latrines Yes ☐ No ☐

A.22. where do you get drinking water from:
A.22.A. Tap at home ☐
A.22.B. Well at home ☐
A.22.C. Pump at home ☐
A.22.D. Public tap ☐

[7] Including Hepatitis B

A.22.E. River ☐
A.22.F. Purchase ☐

If the water is taken from an unprotected point, do the water is:
A.23.A. Boiled ☐
A.23.B. Purified with chlorine ☐
A.23.C. Solar water disinfection[8] ☐
A.23.D. Filtered ☐
A.23.E. Nothing ☐

House building:
A.24.A. House in plastic, leaf, carton, damaged roof ☐
A.24.B. House in wooden, well maintained ☐
A.24.C. Mixed concrete / wood and brick / cement ☐
A.24.D. House in brick / cement ☐

A.25. Number of room 1 room ☐ 2 rooms ☐ More than 2 rooms ☐
A.26. The room/house is clean Yes ☐ No ☐
A.27. There is one window per room Yes ☐ No ☐
A.28. The room has good ventilation Yes ☐ No ☐
A.29. The garbage is well managed Yes ☐ No ☐

Section B: EDUCATION

B.1. Do the children (3 -6 years) go to pre-school? Yes ☐ No ☐
If no in B.1.
B .1.A. No pre-school ☐ B .1.B. Financial problem ☐ B .1.C. Not aware ☐

B.2. School age (6-14 years) children go to school Yes ☐ Not all ☐ No ☐
If not all in B2,
B.2.A Only the girls don't go ☐ B.2.B Both don't go ☐
If yes / not all, in B.2.
B.2 C. In governmental school ☐ B.2.D. In private school ☐ B.2.E. Both
If B.2.E.,
B.2.F. Only girls go to governmental school ☐ B.2.G. Both ☐

If yes / not all, in B.2.
B.3. Regular at school Yes ☐ No ☐

If no in B.2.why
B .4.A. Not access to school ☐ B .4.B. Financial problem ☐
B .4.C. Does not aware about education ☐ B .4.D. Taking caring to brother/ sister at home ☐
B .4.E. Health problem ☐ B .4.F. Others ☐

B.5. Receipt of any scholarship for the study of the children Yes ☐ No ☐
If yes, from who
B.5.A. From relatives ☐ B.5.B. From organization ☐ B.5.C. Other ☐

B.6. Relationship with schools where your children are reading:
From the last year, the parents discussed with teacher about their children[9] Yes ☐ No ☐

B.7. Level of education of parents
B.7.A. Father: Literate ☐ Illiterate ☐
If literate in B.7.A
B.7.B. Primary level ☐ B.7.C. Secondary ☐ B.7.D. Higher level ☐

[8] SODIS
[9] If it was a meeting for registration, it's No

B.7.E. Mother: Literate ☐ Illiterate ☐
If literate in B.7.E
B.7.F Primary level ☐ B.7.G. Secondary ☐ B.7.H. Higher level ☐

Section C. ECONOMY

C.1 Major income source
C.1.A. Employer ☐ C.1.B. Own business ☐
C.1.C. Daily wage ☐ C.1.D. Farming ☐ C.1.E. Others ☐

C.2. Occupation of the man (husband/father)
C.2.A. Employer ☐ C.2.B. Own business ☐ C.2.C. Daily wage ☐
C.2.D. Farmer ☐ C.2.E. Others ☐ C.2.F. No income ☐
C.2.G. Child care/house maker ☐

C.3. Occupation of the woman (wife/mother) (several options might be ticked)
C.3.A. Employer ☐ C.3.B. Own business ☐ C.3.C. Daily wage ☐
C.3.D. Farmer ☐ C.3.E. Others ☐ C.3.F. No income ☐
C.3.G. Child care/house maker ☐

C.4.A. The parents have any skills (without formal vocational training) Yes ☐ No ☐
C.4.B. If yes, the competences developed are used Yes ☐ No ☐

C.5. Participation of the parents in vocational training
C.5.A. Husband Yes ☐ No ☐
C.5.B. Wife Yes ☐ No ☐
If yes in C.5., the skills developed in training are used Yes ☐ No ☐

C.6. Total income and expenditure (Fill-up form below)

Person	Incomes
	Per month

Family budget in Month	Expenditure
	Per month
Daily Expenses (Food, Soap, Vegetable etc)	
Rent	
Electricity	
Water	
Health	
Transport	
Clothes	
Equipments	
School / vocational training fees	
Recreational (tobacco, games, video, cinema, etc)	
Social events (festivals, weddings, ceremony)	
Pay debt	
Instalment loan	
TOTAL expenses / month	

C.7. The family saves money last month Yes ☐ No ☐
Amount (last month):
If yes in C.7., percentage of the total income
C.7.A. Between 1 and 4% ☐ C.7.B. Between 5 and 8% ☐ C.7.C. Between 9 and 12 ☐
C.7.D. Between 13 and 20% ☐ C.7.E. More than 20% ☐

If no in C.7., why? C.8.A. Not enough income ☐ C.8.B. Not interested ☐

C.8. Family involves in saving and credit groups Yes ☐ No ☐
C.8.A. Family has received loan Yes ☐ No ☐
If yes, how the loan is used/has been used
C.9.A. Family's run costs ☐ C.9.B. Business ☐ C.9.C. Treatment ☐
C.9.D. Festival celebration ☐ C.9.E. Marriage ☐
C.9.F. New loan to pay previous loan ☐ C.9.G. Others ☐

C.10.A. The family is owner of the room/house where she is living Yes ☐ No ☐
C.10.B. The family is owner of one room/house but doesn't live in Yes ☐ No ☐
C.10.C. The family is owner of land Yes ☐ No ☐
C.10.D The family gets the documents acknowledging property/Lalpurja Yes ☐ No ☐

C.11. Electricity at home Yes ☐ No ☐

C.12. The family gets some assets in the house Yes ☐ No ☐
C.12.A. One gas Yes ☐ No ☐
C.12.B. One bed Yes ☐ No ☐
C.12.C. Mattress Yes ☐ No ☐
C.12.D. Armchair/shelves/cupboard Yes ☐ No ☐
C.12.E. Radio Yes ☐ No ☐
C.12.F. Mobile Yes ☐ No ☐
C.12.G. TV Yes ☐ No ☐

C.13. Transportation means Yes ☐ No ☐
If yes in C.13.
C.13.A. One bicycle
C.13.B. One motorbike
C.13.C. More

C.14. Material / animals as income source Yes ☐ No ☐
If yes in C.14.
C.14.A. Sewing machine ☐
C.14.B. Other industrial machine ☐
C.14.C. Cattle/poultry/goats ☐

Section D: RELATIONSHIP

D.1. Couple relationship[10]

D.1. A Good relationship ☐
D.1.A.1. Together decision making ☐
D.1.A.2. Problem sharing ☐
D.1.A.3. Respect to each other's views ☐
D.1.A.4. Supportive behavior (participation in house's activities) ☐

D.1.B. Bad relationship ☐
D.1.B.1. Not stable relationship / frequent argument ☐
D.1.B.2. No communication ☐
D.1.B.3. Intrusion of a third person in the couple relationship ☐
D.1.B.4. Domestic violence - Physical violence ☐
D.1.B.5. Domestic violence - Mental violence ☐
D.1.B.6. Domestic violence - Physical and mental violence ☐

D.2. Addiction to drugs
D.2.A. Husband Yes ☐ No ☐

[10] If the person interviewed is not single

D.2.B. Wife Yes ☐ No ☐
D.2.C. Children Yes ☐ No ☐

If yes in D.2. which drug
D.3.A. Tobacco
D.3.B. Alcohol
D.3.C. Soft drug[11] (except alcohol and tobacco)
D.3.D. Hard drug[12]
Addiction to the drug with consequence domestic violence Yes ☐ No ☐

D.4 Relationship between Parents and children

D.4.A	Good verbal relationship with	All	☐	Some	☐	No one	☐
D.4.B	Children receive support in learning	All	☐	Some	☐	No one	☐
D.4.C.	Children victims of physical violence	All	☐	Some	☐	No one	☐
D.4.D.	Children victims of mental violence	All	☐	Some	☐	No one	☐
D.4.E.	Children victims of physical and mental violence	All	☐	Some	☐	No one	☐
D.4.F.	Children victims of sexual abuse	All	☐	Some	☐	No one	☐
D.4.G.	Children victims of early marriage[13]	All	☐	Some	☐	No one	☐
	D.4.G.1. For girls	At 15 and below	☐	Above 15	☐		
	D.4.G.2. For boys	At 15 and below	☐	Above 15	☐		
D.4.H.	Children victims of labor child	All	☐	Some	☐	No one	☐
D.4.I.	Children victims of neglect	All	☐	Some	☐	No one	☐
	D.4.I.1. No care	All	☐	Some	☐	No one	☐
	D.4.I.2. No food	All	☐	Some	☐	No one	☐
	D.4.I.3. No love	All	☐	Some	☐	No one	☐
	D.4.I.4. No education	All	☐	Some	☐	No one	☐
	D.4.I.5. No health care	All	☐	Some	☐	No one	☐

If the woman works and the couple have children, who take care of the children
D.4.J.1.Grandparents ☐
D.4.J.2.Brother-sister ☐
D.4.J.3.neighbor ☐
D.4.J.4.Relatives ☐
D.4.J.5.Child care center (ECD) ☐
D.4.J.6.Other ☐
D.4.J.7.Nobody ☐

D.5. Relationship with extended family[14]

D.5.A.	Good relation	Yes	☐	No	☐
D.5.B.	Support (not financial)	Yes	☐	No	☐
D.5.C.	Financial support	Yes	☐	No	☐

D.6. Relationship with neighborhood

D.6.A.	Good relation /participate in social events in the area	Yes	☐	No	☐
D.6.B.	Sharing resources (e.g. water, land, equipments, etc)	Yes	☐	No	☐
D.6.C.	Financial support by each other if needs by any one	Yes	☐	No	☐

Section E: ADMINISTRATIVE/ LEGAL

E.1. Citizenship of family's members Yes all ☐ Some of the members ☐ No one ☐
If no, why

[11] Cannabis, hashish, marihuana, ecstasy
[12] Cocaine, crack, LSD, heroin
[13] We follow the law, the early marriage is a wedding before 18 for boys and before 20 for girls
[14] Not nuclear family

E.1.A. Legal problems ☐
- E.1.A.1. No parents ☐
- E.1.A.2. No knowledge of the permanent place ☐
- E.1.A.3. No knowledge of the process ☐
- E.1.A.4. No knowledge of the importance ☐
- E.1.A.5. Family refusal (inter cast context) ☐
- E.1.A.6. No witness (no supportive neighbor) ☐

E.1.B. Lack of time to go to birth place ☐ E.1.C. Financial problem ☐

E.2. Marriage registration Yes ☐ No ☐

If no in E.3.

E.2.A. Doesn't know the process ☐ E.2.B. Doesn't feel the importance ☐

E.2.C. No citizenship of parents ☐

E.3. Birth registration of children Yes ☐ No ☐

If no in E.2.

E.3 .A. Doesn't know the process ☐ E.3.B. Doesn't feel the importance ☐

E.3 .C. Far of his/her permanent place ☐ E.3.D. No citizenship/ marriage certificates of parents ☐

E.3.E. Children from other marriage ☐

III. AREA EXIT SURVEY

In areas where no baseline survey was conducted before implementing FDP activities, it is not possible to compare the overall situation of the families before and after FDP intervention. Nevertheless, it is necessary to be able to assess the results of FDP at the level of one area in order to draw lessons and improve action. This assessment can be done through the compilation and analysis of data collected throughout program implementation (family files, phase out assessment, etc) and in Nepal a simple evaluation scheme has also been developed to evaluate the action from the perspectives of the target population and of the partner organizations working with FDP in the area. It has been implemented in 2 areas: Kalimati and Sinamangal after phasing out from these areas.

III.1 Objectives of the area exit survey

GENERAL OBJECTIVE

- To evaluate the results/impacts of FDP at the level of one area.

SPECIFIC OBJECTIVES

- To assess the visibility of FDP in the area
- To assess the suitability and relevance of the actions
- To assess the capacity of FDP to address the needs of the target population

III.2 Scope of the evaluation

Scope of the evaluation for the target population (Families followed up under FDP, families participating to center-based activities; residents of the target area):

1. Knowledge of FDP by the target population
2. Participation of the target population to FDP activities
3. Satisfaction of the target population in relation to the FD program
4. Results or changes observed by the target population in the area and in their situation

Scope of the evaluation for the partner organizations:

1. Knowledge of FDP by the partner organizations
2. Participation of the partner organizations to the coordination activities initiated by FDP
3. Satisfaction of the partner organizations in relation to the FD program
4. Results and changes observed by the partner organizations in the area

AREA EXIT SURVEY
QUESTIONNAIRE TO SERVICE PROVIDERS

ABOUT THE INTERVIEW			
Date of the interview			
Name of the interviewer			
Status of the questionnaire *(to be filled in at the end of the interview)*	1 = complete	2 = not complete	
If not complete, why? *(to be filled in at the end of the interview)*	1 = person absent	2 = refusal	3 = other
Observations *(to be filled in at the end of the interview*			

ABOUT THE SERVICE PROVIDER	
ID Service provider (networking number)	

INTRODUCTION and AGREEMENT

Namaste! Thank you for accepting to discuss with me/us. We have been working in this neighborhood for some time and we are now planning to leave the area. Before leaving, we would like to know what other organizations and service providers know of our program, if they knew it, and what they thought about it. We are therefore conducting a short survey and we are proposing you to answer some questions.

All the information that you will disclose will remain confidential. You can speak freely. Your participation to this survey is voluntary.

If you have questions on this study, you can ask them to us or contact: VOC (5548018)

This survey will take approximately 20 minutes.

Do you agree to participate in this study?
1 = no
2 = yes ☐

IDENTIFICATION OF THE RESPONDENT		
Name of the organization / Service Provider		
QN1> Status of the organization / Service Provider	a. Public (LA)	b. Private (NSA)
QN2a> Domains of intervention	a. Health c. Admin e. Psycho	b. Education d. Eco f. Other (specify)
Name of the person interviewed		
QN2b> Did this SP work in the area for FDP support?	a. Yes b. No	
Did the person interviewed work with this SP for FDP support?		
Position of the person interviewed		

A - KNOWLEDGE		
QN3a> Have you ever heard about FDP / VOC working in the area?	a. Yes	b. No
QN3b> ***If no –thank the respondent: the survey is ending here!***		
If yes - How did you hear about FDP?	Contacted by VOC/FDP staff ☐ Client / Beneficiary ☐ Colleague ☐ Coordination meeting ☐ Other organization ☐ Other (specify):	
QN4> Do you remember when you heard about this program for the first time? a. 3 years ago b. 2 years ago c. Last year d. In the last 6 months		

QN5a> Do you know what VOC (FDP) was doing in the area?	a. Yes	b. No	c. DK
QN5b> If yes, to ask the respondent to tell what he/she knows about FDP (objectives, type of service provided, target population, …) and to assess the level of knowledge the respondent has and select the appropriate answer: **a.** Good knowledge about FDP (knows about VOC, knows about the coordination meetings, the home visits, the purpose of the home visits, knows about the social center activities, and the referrals) **b.** Knows only a few things about FDP (knows at least coordination meetings or referrals) **c.** Does not know about FDP (does not remember or is not able to explain)			

QN6> Do you know where the social center was located?	a. Yes	b. No
QN7> Do you know what was happening in the social center?	a. Yes	b. No

B – COORDINATION			
QN8a> Has your organization ever referred someone to FDP?	a. Yes	b. No	c.DK
QN8b> **If yes** – Do you know what happened after the referrals? a. Family came to FDP center b. Family didn't come to FDP c. Family followed up by FDP d. Family not followed up by FDP e. DK			
QN9> Do you know why these persons were referred to FDP?	a. The person had problems we could not address b. We didn't know how to help this person c. We thought this person needed some regular support (home visits and counseling) d. We thought the service proposed by FDP could be helpful (specify the service): e. Other: f. DK		
QN10a> Has your organization ever received someone referred by FDP?	a. Yes	b. No	c. DK
QN10b> **If yes** – Do you think the referral was appropriate?	a. Yes	b. No	c. DK
QN10c> **If No** – Explain why	a. The person was not properly informed about us b. Our criteria did not fit the person's demand c. The person did not have money to pay the service d. We don't accept referrals e. Other (specify):		
QN11a> Did you ☐ a. organize ☐ b. participate ☐ c. both to/in coordination meeting? QN11b> If yes, how many times did you participate on the total FDP duration in the area? ☐ a. once ☐ b. twice ☐ c. more than twice			
QN11c> **If No** – Why?	a. Not invited b. DK about coordination meetings c. Not interested	d. Don't understand the purpose e. No time f. No staff available for that	
	g. Other (specify):		

C – SATISFACTION			
QN 12> In general, were you satisfied by the coordination initiated by FDP/VOC with you? (Coordination work done through visits to the service provider) a. Very satisfied b. Satisfied c. Not satisfied d. DK			
QN 13> What was positive about this coordination?	a. to know about FDP/VOC actions b. to avoid duplication of action c. to better answer the needs of the people when referred by FDP		

	d. to be able to refer families/persons to FDP e. to be able to participate to coordination meetings and therefore to coordinate with other SP as well f. Other:
QN14> According to you, what needs to be improved?	a. VOC/FDP should have contacted us earlier b. VOC should organize regularly c. Presentation of VOC/FDP (not clearly understood) d. Other:
QN15> According to you, what needs to be improved?	a. the frequency of the coordination meetings b. the objectives of the coordination meetings could be clearer c. the activities of the coordination meetings could be more concrete d. the duration of the coordination meetings e the choice of the participants f. Other (specify):

Now, concerning the services proposed by FDP/VOC to the population in the area:
QN16a> Do you think they were answering the needs of the population here?

a. Yes, absolutely b. Yes, partly c. Not at all d. DK

QN16b> **If yes** – Explain what activities in particular and why?	a. Home visits	
	b. Social counseling sessions	
	c. Referrals	
	d. Group discussions	
	e. Other (specify):	
QN16c> **If no** – Explain what activities in particular and why?	a. Home visits	
	b. Social counseling sessions	
	c. Referrals	
	d. Group discussions	
	e. Other (specify):	
QN17> What recommendations would you make for further improvement of the program?		

D - RESULTS			
QN18a> Do you think that something has changed in this area thanks to FDP?	a. Yes	b. No	c. DK
QN18b> **If yes** – Prompt the respondent to explain what has changed. a. Health b. Education c. Family relationship d. Economical situation e. Legal situation			
QN19a> In the last 3 years, did you implement some actions to improve the access of poor people to your service?	a. Yes	b. No	c. DK
QN19b> **If yes** – What did you do?			
QN20> Do you feel that you better understand and address the needs of poor families now?	a. Yes	b. No	c. DK
QN21a> Do you think that FDP/VOC has helped you in any way to deliver or adjust your services to the poor?	a. Yes	b. No	c. DK

QN21b> **If yes** – How?	a. Referrals b. Coordination meetings c. Participation to trainings d. Feedbacks on the referrals	e. Better understanding of the needs of poor people f. Other (specify):

QN22a> Do you think that FDP/VOC should have provided you with any kind of additional support?	a. Yes	b. No	c. DK

QN22b> **If Yes** – What kind of additional support?	a. Training b. Feedback on referrals c. Referrals	d. Financial support e. Other:

More precisely, thanks to FDP activities with poor people and/or local service providers do you think that:			
QN23> More people in the area use or have access to your service?	a. Yes	b. No	c. DK
QN24> You know more about other organizations and service providers in the area?	a. Yes	b. No	c. DK
QN25> FDP has enabled more families of this area to be aware of your organization/service?	a. Yes	b. No	c. DK
QN26> FDP has enabled families to solve problems and improve their situation?	a. Yes	b. No	c. DK

Additional comments:

AREA EXIT SURVEY
QUESTIONNAIRE TO TARGET POPULATION

INTERVIEW NUMBER (filled up after interview in team): the three first letters of the area/two numbers for the year/number of the interview in three numbers
For example: SIN/12/004
Number:

ABOUT THE INTERVIEW			
Date of the interview			
Name of the interviewer			
Status of the questionnaire ***(to be filled in at the end of the interview)***	1 = complete	2 = not complete	
If not complete, why? ***(to be filled in at the end of the interview)***	1 = person absent	2 = refusal	3 = other
Observations ***(to be filled in at the end of the interview***			

ABOUT THE FAMILY			
Status of the family	FDP (supported through HV) ☐	Community (participants in social center activities, GD) ☐	Resident (live in the area but did not participate in FDP activities) ☐

Note:

- For FDP -> A;B;C;D;E;G;H
- For Community -> A;B;D;E;F;G;H
- For Resident -> A;G;H

INTRODUCTION AND AGREEMENT

Namaste! Thank you for accepting to discuss with me/us. We have been working in your neighborhood for some time and we are now planning to leave the area. Before leaving, we would like to know what the inhabitants think of our program, if they knew it, if they used it and whether they were satisfied by the services. We are therefore conducting a short survey and we are proposing you to answer some questions. Other members of your family can also participate and help you to answer the questions.

All the information that you will disclose will remain confidential. You can speak freely. Your participation to this survey is voluntary.

If you have questions on this study, you can ask them to us or contact: VOC (5548018).

This survey will take approximately 20 minutes.

Do you agree to participate in this study?
1 = no
2 = yes ☐

IDENTIFICATION OF THE RESPONDENT		
QN1> Person interviewed	a. Father b. Mother c. Child	d. Both e. Other (specify):
Number of persons living in the house		
Since when are they living in the area	Date:	

<table>
<tr><th colspan="4">A - KNOWLEDGE</th></tr>
<tr><td colspan="2">QN2a> Have you ever heard about FDP / VOC working in the area?</td><td>a. Yes</td><td>b. No</td></tr>
<tr><td colspan="4">If no –thank the respondent: the survey is ending here!</td></tr>
<tr><td colspan="2" rowspan="2">QN2b> If yes - How did you hear about FDP?</td><td>a. H2H
b. Visit to social center
c. Friend</td><td>d. Family
e. Other organization</td></tr>
<tr><td colspan="2">f. Other (specify):</td></tr>
<tr><td colspan="2">QN3> Do you know what VOC (FDP) was doing in your area? (If respond say No jump to the No.5 question.)</td><td>a. Yes</td><td>b. No</td></tr>
<tr><td colspan="4">QN4> What do you know about VOC (FDP)?

a. Good knowledge about FDP (knows about VOC, knows about the home visits, the purpose of the home visits, knows about the social center activities, and the referrals)
b. Knows only a few things about FDP (knows at least one FDP activity)
c. Does not know about FDP (does not remember or is not able to explain)</td></tr>
<tr><td colspan="2">QN5> Do you know where the social center was located?</td><td>a. Yes</td><td>b. No</td></tr>
<tr><td colspan="2">QN5a> Do you know what was happening in the social center?</td><td>a. Yes</td><td>b. No</td></tr>
<tr><td colspan="4">QN5b> If yes, ask the respondent to explain and assess the level of knowledge

a. Good knowledge (knows about the group discussions, the social counseling sessions, the opening time (days and hours)
b. Knows only a few things (the location of the social center, some activities)
c. Does not know (does not remember or is not able to explain)</td></tr>
<tr><td colspan="2">QN6a> Have you ever talked about FDP to or with someone else (neighbors, friends, family, etc)?</td><td>a. Yes</td><td>b. No</td></tr>
<tr><td rowspan="2">QN6b> If yes, what did you talk about?</td><td>a. Home Visit
b. SW/FW
c. Social center
d. Group discussions</td><td colspan="2">e. Social counseling sessions
f. Referrals</td></tr>
<tr><td colspan="3">e. Other (specify):</td></tr>
<tr><td colspan="2">QN7> Have you ever advised someone to contact FDP?</td><td>a. Yes</td><td>b. No</td></tr>
</table>

<table>
<tr><th colspan="6">B - PARTICIPATION</th></tr>
<tr><td colspan="3">QN8a> Have you participated to FDP activities or benefited from any service of FDP?</td><td>a. Yes</td><td colspan="2">b. No</td></tr>
<tr><td rowspan="3">If No –
(Ask the 2 questions here and Go to Section H: Recommendations)</td><td colspan="2">QN8b> Would you rather have participated to any of the activities?</td><td>a. Yes</td><td>b. No</td><td>c. DK</td></tr>
<tr><td rowspan="2">QN8c> Why didn’t you participate?</td><td colspan="2">a. No need
c. Not interested</td><td colspan="2">b. No time</td></tr>
<tr><td colspan="3">d. Other (specify):</td></tr>
<tr><td colspan="6">QN8d> If Yes – What services did you receive from FDP / what activities did you participate to?</td></tr>
<tr><td colspan="3">a. Home visits
b. Group discussion
c. Individual counseling with a SW</td><td colspan="3">d. Referral
e. Information given by a SW</td></tr>
<tr><td colspan="6">f. Other (specify):</td></tr>
<tr><td colspan="6">If the respondents received HV but did not participate in centre-based activities (Counseling and GD):
Ask why they did not participate?</td></tr>
<tr><td colspan="2" rowspan="2">QN9> Why didn’t you come to social center for individual counseling?</td><td colspan="2">a. Didn’t know about it
b. Not interested
c. No time
d. No need</td><td colspan="2">e. Too far
f. Opening hours not convenient</td></tr>
<tr><td colspan="4">g. Other (specify):</td></tr>
<tr><td colspan="2" rowspan="2">QN10> Why didn’t you come to social center for GD?</td><td colspan="2">a. Didn’t know about it
b. Not interested in the topics
c. No time</td><td colspan="2">d. Schedule time not convenient
e. Too far</td></tr>
<tr><td colspan="4">f. Other (specify):</td></tr>
<tr><td colspan="6">If the respondents participated to centre-based activities (counseling and GD) but did not received HV →Ask why they didn’t receive HV?</td></tr>
<tr><td colspan="2">QN11> Why didn’t you receive HV?</td><td colspan="2">a. Didn’t know about it
b. It was not proposed to me and I didn’t ask
c. Not interested
d. No need
e. No time
f. Someone from my family didn’t want (specify who):</td><td colspan="2">g. Difficult to talk in front of my family
h. Fear of what my neighbors would say
i. All above
j. Other (specify):</td></tr>
</table>

C - SATISFACTION Home visits		
QN12> Did you like receiving the visits of the social worker in your home? a. Liked a lot b. Liked a bit c. Didn't like d. DK		
QN13> What did you like about the visits?	a. To be able to share my problems with the SW	c. To learn new things about: ☐ Maternal Health ☐ Child development ☐ Child Health ☐ Administrative matters ☐ Vocational training ☐ Other organizations / services ☐ Other:
	b. To find solutions to my problems	
	d. Other (specify):	
QN14> What did you dislike about the visits?	a. The relation with the SW b. The schedule c. The duration	d. Useless talk / loss of time e. Couldn't find solutions to my problems f. Obligation to commit to the visits (pressure)
	g. Other (specify):	

D - SATISFACTION Social counseling sessions		
QN15> Did you like going to the social center to meet a social worker? a. Liked a lot b. Liked a bit c. Didn't like d. DK		
QN16> What did you like about the social center?	a. Confidentiality (more comfortable to talk than at home)	b. Comfortable space
	c. Welcoming staff	d. Free access / open to all
	e. Got useful information	f. the SW were able to help me
	g. Other (specify):	
QN17> What did you dislike about the social center?	a. Opening hours not convenient	b. Opening hours not clear
	c. Staff not available / not welcoming	d. Didn't feel comfortable to talk
	e. Lack of confidentiality	f. No useful information provided
	g. Staff didn't understand my problem	h. Other (specify):

QN18> Today, (since the SC was closed), what do you do when you encounter a problem? a. Share with family b. Share with Friends c. visits to different organization d. Nothing
QN19> Which kind of problem? a. Personal problem not shared b. New information not received c. No referral

E - SATISFACTION Group Discussion		
QN20> Did you like the group discussions? a. Liked a lot b. Liked a bit c. Didn't like d. DK		
QN21> In which topics did you participate?	a. Ante Natal Care b. Bird Flu c. Blood Pressure d. Child Rights e. CSA f. DEPO g. Diabetes h. Education (importance of)	i. Family Planning j. Family Planning (permanent methods) k. Gender l. HIV/AIDS m. Jaundice n. SOLIS o. Uterus / Breast cancer p. Uterus prolapse

F - RESULTS for participants to FDP activities
QN22a> Do you think FDP has changed something in your life? a. Yes a lot b. Yes a little c. Not really d. Not at all e. DK
QN22b> **If yes** – Prompt the respondent to explain what has changed. a. Health b. Education c. Family relationship d. Economical situation e. Legal situation
More precisely, do you think that:
QN 23a> FDP has helped you to solve your problems? a. Yes a lot b. Yes a little d. Not really e Not at all f. DK
QN 23b> **If yes** – Ask the respondent to give concrete examples of the problems solved a. Health b. Education c. Family relationship d. Economical situation e. Legal situation
QN24> FDP has helped you to feel happier/better? a. Yes a lot b. Yes a little c. Not really d. Not at all e. DK
If yes/No – Ask the respondents to explain
QN25> FDP has helped you to know more about other services and organizations? a. Yes a lot b. Yes a little c. Not really d. Not at all e. DK

QN26a> Which kind of services and organizations? ☐ Health ☐ Education ☐ Family relationship ☐ Economy ☐ Legal and administration
QN26b> **If yes** – ask the respondents to give concrete examples of services and organizations they have known thanks to FDP a. Know more than 5 service providers b. between 3 and 5 c. Less than 3 d. Nil
QN27a> FDP has helped you to have new and better relationship with others? a. Yes a lot b. Yes a little c. Not really d. Not at all e. DK

QN27b> a. I made new friends b. I met new people c. I feel more self-confident to address people I don't know	d. I have better relationships with my neighbors e. I have better relationships with my family (at home) f. I have better relationships with my family (extended family / in laws)

QN28a> FDP has helped you to cope with your problems by yourself? a. Yes b. No c. DK

QN28b> If yes, a. I can now find solutions to my problems b. I feel confident enough to ask others for help	c. I now know where to go when I have a problem d. I feel confident to go to any SP/organization to ask for help
e. Other (specify):	

For respondents who participated to GD only QN29> How useful were the topics in your life? a. Very useful b. Quite useful c. Not useful d. DK
Prompt the respondent for concrete examples:

G – COMPARISON OF CHANGE
QN30> Did you find any difference in the area between FDP support time and after FDP support? ☐ a lot ☐ a bit ☐ not at all ☐ DK

H- RECOMMENDATIONS			
QN31a> Do you have any recommendations or remarks to make about the activities proposed by VOC/FDP?	a. Yes	b. No	c. DK
QN31b> About the staff			
About the home visits (frequency, schedule, etc)			
About the social center (schedule, activities, etc)			
Other (specify):			
Additional remarks			

Thank you for your participation!

IV. EVALUATION OF THE FAMILY FOLLOW UP

Evaluations are taking place at different times during the follow up. After 2 or 3 months of follow up to assess whether the follow up shall continue or the family referred to the social center, and at the end of the follow up period (generally 6 months) to assess whether the family shall be phased out or not. Depending on the contexts, these evaluations are validated through area committees, case conferences, assessment committees, or triangular exercises. In all cases, other team members are associated to the process. Frequent evaluations are important to validate the objectives of the follow up, the motivation of the family and to highlight the objectives already achieved. Case studies are usually written when an evaluation is conducted.

IV.1 Phase out

At the end of the follow up, each social worker must assess the progress made by the family during the follow up. An **assessment visit** is generally conducted prior to the assessment committee during which the case of the family is presented. It is conducted by the social worker in charge of the family follow up and an observer. During this visit, the social worker and the family discuss the objectives identified during the follow up and the extent to which they are achieved at the end of the follow up. All other changes in the family situation are assessed. During the **assessment committee**, the social workers decide whether to phase out the family and assess the changes in the family situation.

Most of the Family Development Programs have developed similar phase out categories that give a simple and immediate measure of the result of the follow up. It is a tool easily understood by the teams and by the donors. It can be summarized as follows:

(++) if the results of the follow up are very positive
(+) if the results of the follow up are positive
(=+) if the results of the follow up are not certain
(=) if the family doesn't seem to have progressed nor regressed during the follow up

The choice of the PO category is made on the basis of different elements: a measure of the problem resolution and a measure of less tangible concepts such as self-reliance, autonomy, self-confidence, self–esteem, etc. If the resolution of problems seems to be easily measurable in all countries, the measure of less tangible concepts proves to be more complex. It often reflects a subjective (but not necessarily wrong) assessment made by the social workers and the family. The tools developed were all an attempt to capture changes in the psychosocial situation of the families.

The decision is based on:

→ **Objective and quantitative information** comparing the number of objectives achieved (or problems solved) and the number of objectives (or problems) identified with the family during the follow up.
→ **Observations and intuitions** by the social workers of changes that may have occurred during the follow up but that are not easily quantifiable (e.g. self-confidence, autonomy, improvement of the family relationships)

Category of Phase Out (PO)	Description
PO ++	**Most of the problems have been solved and the family is self-reliant.** The objectives identified in the beginning of the follow up have been achieved and the progress are sustainable. Example: Parents are helping each other, share responsibilities and are able to make plans for the future. The family has been motivated during the follow up, has participated to collective activities and is integrated in the economic and social environment. They are able to access existing services and to take initiative in case of crisis or emergency.
PO +	**The family solved some of their problems and reached a certain level of autonomy** More than half of the objectives identified at the beginning of the follow up have been reached. The objectives not reached are not problems endangering the family or the children. Example: Parents gained in self-confidence. The family has irregular income but manages to cover basic needs. Parents are more autonomous and more attentive to their children. They participate to activities organized at community level. The family has access to existing services and is able to take initiatives. But the capacity of the family to face crisis and emergency remains uncertain.
PO +=	**1/ Some objectives are solved but the family's self-reliance is uncertain.** **2/ None of the objectives are achieved but the family may be self-reliant** The objectives identified in the beginning of the follow up have not been reached (or only few). The family is however aware that they could improve their situation and know that they can access the social center if needed.
PO =	**The family neither progressed nor regressed** The family has not been able to overcome their difficulties despite the follow up. They have not been able to use existing services. Progress are not visible or not significant.
Non analyzable cases	**Give Up (GU)** - Wrong selection or the family is not interested by the follow-up **Transfer Residence (TR)** - The family moved out of the area during the follow up and cannot be located

IV.2 Evaluation tools

PROBLEM RESOLUTION

It seems that there is a consensus about the monitoring of the problems resolution among the 4 countries of intervention. The number of problems identified is recorded per type of problem (health, education, economics, administrative, psychosocial) and the problems are then assessed as "totally solved", "partially solved" or "not solved".

This measure will provide a general picture of the problems the families are facing and therefore the sector in which a Family Development program is working. For the team, it is important to know what problems families have to be able to adjust and prepare their intervention through training and relevant networking.

Further, for advocacy purpose, it is interesting to know what type of problem is recurrent but with a low resolution rate (e.g. because of inefficient services). For donors, it is also interesting to be able to illustrate the work done with the families with a concrete representation of the problems faced by the families targeted by the project.

	Problems identified	%	Problems solved	%	Problems partially solved	%	Problems not solved	%
Health								
Education								
Economic								
Legal								
Psychosocial								
Total								

"ABC EVALUATION FORM", "FAMILY PICTURE", "VULNERABILITY ASSESSMENT TOOL" (See form page 120-121)

ABC forms have been designed and tested in all countries where FDP is implemented. Each tool is adapted to its own context. However despite multiple hours to design and test the tools, improvements remain possible and such tools shall thus be used with flexibility.

WHAT IS IT?

A form composed of open questions to be answered through discussions with family members and observations during home visits at different points in time.
Generally, the tool is composed of different items corresponding to 5 domains:

1. Economy
2. Health
3. Education
4. Administration
5. Psychosocial
6. Housing / Habitat (Optional. In Burkina Faso only)

WHAT FOR?

The objective of the tool is:

a) To measure the level of vulnerability of the family
b) To measure the progress made by the family during the follow up

This tool informs the decision regarding the phase out category (++, +, =+, =) and justifies it.

WHEN IS IT USED?

Evaluation forms have been developed in each country to measure the families' situations and the changes observed at regular intervals.

- → A the beginning of the follow up - during relationship building - in order to assess the initial situation of the family (A);
- → At the end of the follow up - during phase out – in order to assess the changes observed being positive or not (B);
- → 6 months after phase out in order to assess whether the changes observed at the time of phase out were sustainable or not (C).

In Burkina Faso, this tool is more largely used at each important evaluation:

- → In the beginning (T0)
- → After 3 months of follow up (T3)
- → After 6 months (T6)
- → Etc.

HOW IS IT USED?

In Burkina Faso, it is recommended to fill up the form during the area committee and shall be the result of a collective discussion. It is not the case in other countries where the form is usually filled up after debriefing with one other social worker ("observer").

In some countries, the result of the evaluation forms allow to classify the families in different categories and to assess whether the program is targeting the most vulnerable. The more points a family get, the better off they are and changes can be measured when a family is moving from one level to another.

Example of a leveling tool:

Level 0	Very difficult situation: the family is among the most vulnerable of the area
Level 1	Difficult situation: the family is very poor and has low income and few assets
Level 2	Acceptable situation: the family somehow is able to earn for the everyday life but hardly prepare or save for other needs. For example, the family could not save for health or other needs in the future.
Level 3	The living condition of the family seems better among the poor. They could save somehow for their future needs. But they may face some other difficulties such as conflict in the family. They may need short term support.

Throughout the multi-country project, the tool has evolved to integrate new ideas:

- → **Indicators of vulnerability** – Identification of the indicators / items on which the social follow up can have an impact and those on which we consider that the follow up will have less impact (e.g. a family with 11 children may be more vulnerable than a family with less children but the program does obviously not intend to reduce the number of children!). These items reinforce the vulnerability of the families and are therefore useful to measure the level of vulnerability of the family and to confirm that the program is targeting the poorest but they are not useful to compare the evaluation A with the evaluation B. They may even distort the results. For simplification, these items have been removed from the most recent versions of the forms.

Family NAME :		FAMILY PROGRESSION TOOL	Total A Score 54															
Staff NAME:			Total B Score 54															
			Total C score 54															
			3 points				2 points				1 points				0 point			
	Situation family	3 point	A	B	C	2 point	A	B	C	1 point	A	B	C	0 point	A	B	C	
ECONOMIC	Employment of 16-60 years old	100% of the family members aged 16-60 have job				50% of the family members aged 16-60 have job				Less than 50% of the family members aged 16-60 have job				None of the family members aged 16-60 have job				
	Per capita Income/month	Per capita income of the family is NRs. 4000 per month				Per capita income of the family is NRs. 3000 per month				Per capita income of the family is NRs. 2000 per month				Per capita income of the family is NRs. 1500 or less per month				
A B C	Budget management	Good planning, no debts or relevant debts with good management and repayment well planned				Planning, good management of the priorities but occasional debts for a relevant (or exceptional) event, reimburse but with difficulties				Difficulty in planning, difficulty to manage priorities, regular debts and difficulties to reimburse				No planning, regularly borrow money even for basic expenses, difficulty to manage priorities				
	Saving	Per capita income of the family is NRs. 4000 per month				Regular savings of small amount (informal group or at home)				Savings but for very small amounts and irregularly (at home or in informal groups)				Does not save and thinks it is useless				
	Equipment / Assets	Enough assets and equipments (furniture, TV, radio, cooking materials, mobile)				Basic assets and small furniture (mattress, chairs, stool, table, radio, mobile)				Minimum assets (cooking pot, mattress)				No basic assets				
HEALTH	Immunization	Immunization complete for all the children under 1 year old / no children under 1 year old				All the children under 1 year old have been immunized but immunization not complete				Some of the children under 1 year old have been immunized but immunization not complete				None of the children under 1 year old is immunized				
A B C	Health care	Is looking for adequate health care (specialist consultation) and prevention (adequate nutrition, environment clean, ANC/PNC)				Is looking for adequate health care but then does not complete the follow up / no preventive measure (e.g. PNC, ANC, nutrition, environment clean)				Is looking for inadequate health care and thus the disease is not treated well (auto medication, buy medications in the street, follow several types of treatment, does not finish the treatments) / No preventive actions				Health needs visible like ANC/PNC, chronic illness, disability, but not treated or neglected / no preventive actions (ANC/PNC, hygiene, nutrition)/Does not do anything until it becomes an emergency				
	Nutritional Status	All children are healthy / regular lunch and adequate food				Children unhealthy showing sign of under nutrition / parents have engaged an action and know the importance of regular lunch and balance diet				Under weight or malnutrition / parents are aware of the problem but did not engage any adequate action (irregular meals, non balanced diet)				Malnutrition / under nutrition / the mother is not worried/not aware of the problem and does not do anything about it.				
	Attitude towards Family Planning	FP users or No FP needs				With FP needs and both are interested				With FP needs but only one is interested				With FP needs but not interested and or have no knowledge.				
PSYCHOSOCIAL	Husband , Wife and in-laws Relationship	Supportive Family (income sharing and helping relationship), or no partner and no family-in-law				supportive family but having money issues / communication problem				Family conflict without physical violence but frequent arguments, no shared decision making				Family conflict with violence (both physical and psychological)				
A B C	Parent - child relationship	Care, good relation / communication, support for education				Child is taken care of but few communication and few support for education				Child left to himself. No support from the parents (e.g. child left without supervision all day)				Violence or serious neglect				
	Attitude for problem solving	Confident and assertive towards problem solving, seeks support and acts for the solution				is able to identify the problem and takes action with support				Identify the problem but no action even with support				Problems not identified				
	Support System	good relation with the extended family, friends, frequent relation with external services, good coping strategies,etc				Family intergrated (strong relationship with extended family and friends)				Isolated family (eg. Conflict with extended family, few friends)				Very Isolated family (no family, no friends)				

Date Evaluation (A): _____ Score:_____ Progression (difference B - A) = _____

Date Evaluation (B):_____ Score:_____ Date Evaluation (C):_____ Score:_____

EDUCATION			Preschool Education of children in age of going to preschool	All the children in preschool age are in preschool / no children in this age group				Some of the children in preschool age are going to preschool (but not all children)				None of the children in age of going to preschool is going but the parents are very interested				None of the children in preschool age is going to preschool and the parents are not interested or are against it					
A	B	C	Primary Education of children in age of going to primary school	primary school are enrolled in the grade corresponding to his/her age / no children in age of going to primary school				Some of the children in age of going to primary school are enrolled, and all are in the grade corresponding to his/her age				Some of the children in age of going to primary school are enrolled, but none is in the grade corresponding to his/her age				None of the children in age of going to primary school is enrolled and the parents think school is useless					
			Education of adolescents and young adults (12-25 years old)- or (12-18 years old	All the adolescents/young adults are in secondary class / no adolescents or young adults in the family				All the adolescents/young adults are following classes but some in vocational training (having failed in secondary school)				Some adolescents/young adults are following classes in secondary school or vocational training				None of the adolescents / young adults of the family is enrolled in secondary school or vocational training					
ADMIN/LEGAL			Citizenship and marriage certificate for the adults	All of the family members have citizenship and those married have marriage certificate				At least 50% of the family members have citizenship certificate but the marriage certificate is missing				Atleast one member has citizenship certificate but the marriage certificate is missing				No citizenship for any adult and no marriage certificate for the married ones					
A	B	C																				
			Birth Certificate	All the children have birth certificate				At least 50% of the children have birth certificate				At least one child has birth certificate				No birth certificate for any child					
			Total	**Total 3 point**				**Total 2 point**				**Total 1 point**				**Total 0 point**					
				Note:- Given Score ÷ Total Score × 100 % , Total % ÷ 10 Scale																		
	Vulnerability Tools		Size of Family	2 children are dependent				2 children with 2 member are dependent				4 children with 4 member are dependent				**More than 4 children and more than 4 member are dependent**					
			Health Condition	All the family members of the household are healthy (no handicap, no Diesese)				One Parents or adult has an addicational gambling, Alcohol, tabacco				one of the family member has handicap & cronic disease, one of the parents has an addication gambling, Alcohol				one Or Several family members suffer from chronic disease or disability and are not receving treatment					
			House Condition	Severals rooms secure, toilet & good manage of all the things				congested, house is ok use of common toilet				Living space is small congested, a small window house is made of mud, no toilet				Living space is small no vantelitation only one room house is made of plastic cartoon or wood the roof is damaged the ground is in trodden window and door are not secured					
			Level of education of Parents	One or two parents are illiterate or have not completed primary education				one parent are literate but not complete secondary education				one parent is literated				none of the Parents are literate					

→ **Points, levels, grades** – The computation system was too complex and comparison of the results between countries was impossible. The results of the ABC form was translated into a grade out of 10 in most of the countries and the leveling system is not used anymore.

→ **Assessment per domain** – Each domain can be given a result (/10) and it is possible to distinguish between the domains related to problems solving (health, education, administration, economy) and the domain related to the psychosocial situation of the family. By proposing 2 domains, we emphasize the importance of the psychosocial factors in problem resolution and it is a step further in the psychosocial evaluation of FDP.

EVALUATION 6 MONTHS AFTER PHASE OUT

An evaluation is generally conducted 6 months after phase out in order to assess whether the improvements of the family situation have been sustained after the phase out. A family that has improved its situation during the follow up period can feel lost once the follow up stops and the situation can worsen again. On the contrary, a family that didn't improve during the follow up period and was phased out (=) may have become more aware and may have made positive changes in their situation after the phase out.

The same tool is used at the beginning of the follow up, at the time of phase out, and 6 months after phase out ("ABC form").

TARGET FAMILIES

This evaluation can be conducted on all phase out families or on a sample of families only. As the objective is to measure the sustainability of the changes, a sample of families phased out positive only may be selected. Families who did not complete their follow up (Give Up) or who transferred residence during the follow up are not included in this evaluation. The evaluation of families who were phased out +/= or = could also be interesting as it could reveal positive changes that may occur once the family is phased out.

PROCESS

→ Home visit 6 months after phase out

→ Home visit conducted by two members of the FDP team

- the social worker who was in charge of the family. S/he is the one who conducts the evaluation visit by introducing the objectives of the visit. After asking to the family if she wants to participate in this evaluation, s/he leads informal discussion in order to identify the changes that occurred in the last six months
- the observer

→ Debriefing

→ Case study reflecting on the situation of the family at the time of phase out (6 months earlier), the major events during the last 6 months, a description of the situation at the time of evaluation and an analysis/ evaluation of the changes.

→ Completion of the "C" section of the ABC form

EXAMPLE ON HOW TO REPORT THE RESULT OF THE EVALUATION 6 MONTHS AFTER PHASE OUT.

	PO ++	%	PO +	%	PO +/-	%	PO =	%	Total	%
Number of families visited 6 months after PO										
Number of families whose situation has improved										
Number of families whose situation remained the same										
Number of families who have seen their situation deteriorating										

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