STANDARD SECTOR INDICATOR CODE: HE-097	**Ability to Identify Optimal Complementary Feeding Practices:** Number of individuals who are able to identify at least three optimal complementary feeding practices using locally available foods.	
HEALTH SECTOR	**Sector Schematic Alignment** • **Project Area:** Maternal, Neonatal, and Child Health • **Project Activity Area/Training Package:** Infant and Young Child Health	
Type: Short-term Outcome	**Unit of Measure:** Individuals	**Disaggregation:** **Sex:** Male, Female **Age:** 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years

To be counted for this indicator the following criteria must be met:
The individual must be able to describe three of the four optimal ***characteristics*** of complementary feeding practices as defined by WHO (see definitions below) **and** be able to identify at least 4 locally available foods that are nutritionally appropriate for complementary feeding.

Definitions:
Complementary feeding: the process of introducing foods (to complement breast milk) to an infant. Introduction of safe, appropriate complementary foods should take place at six months of age to supplement breastfeeding as the nutritional requirements of children at this age begin to exceed that which breast milk can supply. The complementary feeding period is from six months to two years of age; prior to six months breast milk provides all of the nutrients that an infant requires as well as delivering important growth factors and immunity characteristics.

Complementary foods: any food, whether manufactured or locally prepared, suitable as a complement to breast milk or to a breast milk substitute

Optimal complementary feeding practices: are defined by WHO as timely, adequate, safe and appropriate.

- **Timely** means that all infants require the introduction of complementary foods beginning at six months of age to supplement the nutrition they receive from breast milk. As the child ages, quantity of food given in addition to continued breastfeeding should increase (according to the age) and the frequency of meals should also increase with age.
- **Adequate** means "given in amounts, frequency, consistency and using a variety of foods to cover the nutritional needs of the growing child while maintaining breastfeeding." A child 6-8 months of age should receive both breast milk AND 3 or more feedings from 4 out of the 7 food groups each day.
- **Safe** means that the food is prepared safely (hands washed before preparing foods, foods are cooked or boiled), and in a way that minimizes the risk of contamination by harmful pathogens. Safe complementary feeding also includes use of clean and safe utensils as well as not using bottles or teats.
- **Appropriate** refers to the texture (first foods should be smooth pureed foods to mashed foods with soft lumps at 6-9 months and finger foods by 9-12 months) and style of feeding the child to make sure that it is age-appropriate and follows the principles of psycho-social care. Feeding should be done in an active feeding manner, with caregiver responding to cues of appetite and satiety. Consistency should neither be too watery (reduces nutritional density, filling small stomach with too much water), nor too thick (risk of choking and difficult to eat and digest).

Rationale: The time from birth to two years of age is crucial to ensure proper development and health for all children. Complementary feeding and proper complementary feeding for infants is an important component in the care of a young child to ensure proper health, promoting optimal linear growth and cognitive development.

Measurement Notes:

1. **Sample Tools and/or Possible Methods (for Peace Corps staff use):** Volunteers should use data collection tools to measure progress against project indicators. Please check PCLive for data collection tools. Once a tool has been developed, post staff should have a few Volunteers and their partners pilot it, and then distribute and train Volunteers on its use.

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

3. **Activity-Level Baseline Data Collection:** Activity-level baseline data should be collected by Volunteers/partners before or at the start of their activities with an individual or group of individuals. It provides a basis for planning and/or assessing subsequent progress or impact with these same people. Volunteers should take a baseline measurement regarding the outcome(s) defined in this data sheet. Volunteers should collect baseline information early in their work with mothers/caregivers and may use their judgment to determine timing because the information will be more accurate if the Volunteer has built some trust with the community first. The information for the baseline measurement will be the same or very similar to the information that will be collected in the follow-on measurement (see the bullet on "frequency of measurement") after the Volunteer has conducted his/her activities and it is usually collected using the same data collection tool to allow for easy management of the data over time.

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

4. **Frequency of Measurement:** For reporting accurately on this outcome indicator, Volunteers must take a minimum of two measurements with members of the target population reached with their activities. After taking the baseline measurement (described above), Volunteers should take at least one follow-on measurement with the same individual(s), typically after completing one or more activities focused on achieving the outcome in this indicator and once they have determined that the timing is appropriate to expect that the outcome has been achieved. Please note that successful documentation of a behavior change or new practice may not be immediately apparent following the completion of activities and may need to be planned for at a later time. Once Volunteers have measured that at least one individual has achieved the indicator, they should report on it

in their next VRF.

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

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

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

5. **Definition of Change:** The minimum change to report against this indicator is a mother or caregiver who is able to identify three of the four characteristics of optimal complementary feeding.

6. **General Reporting in the VRF**: The "number achieved" (or numerator) that Volunteers will report against for this indicator in their VRFs is the number of mothers/caregivers who are able to identify three of four characteristics related to optimal complementary feeding, after working with the Volunteer/partner. The "total number" (or denominator) that Volunteers will report on for this indicator in their VRFs is the total number of individuals who participated in the activities designed to meet this indicator.

7. **Reporting on Disaggregated Data in the VRF:** This indicator is disaggregated by age and sex. See disaggregation box above.

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

Alignment with Summary Indicator: No Link