

<p>STANDARD SECTOR INDICATOR CODE: HE-117</p>	<p>Demonstrated How to Prepare Oral Rehydration Therapy/Solution: Number of individuals able to demonstrate how to prepare ORT/S.</p>	
<p>HEALTH SECTOR</p>	<p>Sector Schematic Alignment</p> <ul style="list-style-type: none"> • Project Area: Maternal, Neonatal and Child Health <ul style="list-style-type: none"> • Project Activity Area/Training Package: Infant and Young Child Health • Project Area: HIV Mitigation <ul style="list-style-type: none"> • Project Activity Area/Training Package: Community Care of OVC 	
<p>Type: Short-term Outcome</p>	<p>Unit of Measure: Individuals</p>	<p>Disaggregation: Sex: Male, Female Age: 0-9 years, 10-17 years, 18-24 years, 25+</p>
<p>To be counted for this indicator the following criteria must be met:</p> <ul style="list-style-type: none"> • The individual must have attended training on prevention of childhood illnesses, including the management and prevention of diarrhea. • The training must have been provided by the PCV or their partner in an individual or small group setting. Research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger. PC/Post staff determines what comprises a small group. • Attendance at educational session/s must be documented by the Volunteer or their partner • The individual must demonstrate how to prepare ORS according to one or more of the methods listed below. The demonstrations must be done under the supervision of the Volunteer or their partner in order to ensure that everything is done correctly. <p>Definitions:</p> <p>Oral rehydration therapy/solutions (ORT/S) are a combination of dry salts and sugars mixed with clean water. WHO and UNICEF recommend a single formulation that contains 75 mEq/l of sodium and 75 mmol/l of glucose, and has a total osmolality of 245 mOsm/l. In most countries, pre-packed packages of ORS can be found at health centers, pharmacies, markets and shops. Homemade ORS can also effective and can be made with locally available high-fiber vegetables such as rice, sweet potatoes, and bananas cooked with and clean water.</p> <p><i>***Country governments may recommend their own recipes for homemade ORS solutions. Posts should feel free to use those recipes instead, when applicable.</i></p> <p>How to prepare ORS</p> <p>I. Pre-packed formula called Oral Rehydration Salts (ORS) available in a sachet to make a liter of solution.</p> <ul style="list-style-type: none"> • Wash hands with soap and water before preparing the solution • Put 1 liter (5 cupfuls with each cup 200 ml) of clean water into a clean pot/container • Empty the contents of a packet into the water while stirring • Give the sick child frequent, small amounts of the solution until he/she is well hydrated. If child is experiencing vomiting, allow 15-20 minutes to pass before giving ORS. ORS should be given in small doses using a spoon, and 		

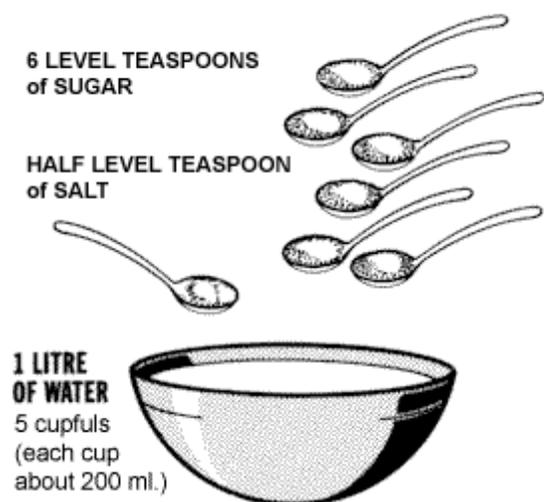
frequently. Taking large gulps of the liquid is discouraged, as it could lead to more vomiting.

II. Homemade Oral Rehydration Salts

- A very suitable and effective simple solution for rehydrating a child can be made by using salt, sugar and water. Molasses and other forms of raw sugar can be used instead of white sugar, and these contain more potassium than white sugar.
- Other solutions: Breast milk, gruels (diluted mixtures of cooked cereals and water), carrot soup, rice water - congee, fresh fruit juice, weak tea, green coconut water or water from the cleanest possible source brought to the boil and then cooled.

Preparing 1 (one) liter of homemade ORS

- Wash hands with soap and water before preparing the solution
- Put 1 liter (5 cupfuls with each cup 200 ml) of clean drinking or boiled water (that has cooled) in a clean container
- Add six (6) level teaspoons of sugar
- Add a half (1/2) level teaspoon of salt
- Stir the mixture until the salt and sugar dissolve.



Rice water ORS

Rice water works as well as salt and sugar solution for rehydration. Cook some rice in twice as much water as you would normally use. Add some salt to the water. (About $\frac{1}{2}$ teaspoon salt per liter of water or a big pinch in a glass of it). You can add a little sugar if you like. The child can eat the rice too.

Other home cereals

If you usually make porridge or gruel to eat or feed to young children, these can be watered-down for rehydration drink. Ground corn, daal, potato, or cassava will all help rehydrate someone (if they are well cooked and watered down to a thin liquid, and a little salt is added).

A thinned porridge like this does not replace food. If you thin down porridge for a rehydration drink, you can also

give regular, thick porridge to eat.

To recover from dehydration, give food as well as fluids.

For programs working with OVCs, PLWH, and children affected by AIDS this indicator should be disaggregated by the following target populations:

- **Orphans and Vulnerable Children:** Children affected by AIDS, often referred to as orphans and vulnerable children (OVC), are children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects. **H.R. 5501; Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008*
- **Caregiver:** A parent, guardian, foster parent who has primary responsibility for the child in the home.
- **PLWHA:** Persons living with HIV/AIDS

Rationale: In 2011, 1.6 million children died as a result of diarrheal disease and dehydration. ORT now helps save more than 1 million children's lives each year. The use of ORT to combat diarrheal disease is a cost-effective, WHO recommended intervention. It emphasizes giving a child plenty of fluids- prepackaged ORS and/or other appropriate household fluids--along with continued feeding during the illness and increased feeding for at least a week after an episode of diarrhea.

Measurement Notes:

1. **Sample Tools and/or Possible Methods (for Peace Corps staff use):** Volunteers should use data collection tools to measure progress against project indicators. A data collection tool to measure this indicator could be based on one of the following methods—checklist and observation—though there may be other data collection methods that are appropriate. Please check PCLive for data collection tools. Once a tool has been developed, post staff should have a few Volunteers and their partners pilot it, and then distribute and train Volunteers on its use.
2. **General Data Collection for Volunteer Activities:** All Volunteer activities should be conducted with the intention of achieving outcomes – knowledge change (short-term), skills demonstration (intermediate-term), and behavioral changes (intermediate to long term) as defined by the progression of indicators within the objectives of a project framework. The progression of measurement for all Volunteer activities should begin with baseline data being conducted prior to the implementation of an activity (or set of activities), followed by documenting any outputs of the activities and then later at the appropriate time, measurements of specific outcomes (see the bullet on “frequency of measurement”).
3. **Activity-Level Baseline Data Collection:** This indicator builds off of indicator **HE-114: *Educated on Prevention of Common Childhood Illnesses***, as it measures the skill and knowledge needed to correctly prepare ORS. Therefore, baseline data collected in the form of a pre-test for HE-114 would apply to this indicator as well.

Because Volunteers are expected to implement relevant and focused activities that will promote specific changes within a target population (see the “unit of measure” above), taking a baseline measurement helps Volunteers to develop a more realistic snapshot of where individuals within the target population are in their process of change instead of assuming that they are starting at “0.” It also sets up Volunteers to be able to see in concrete terms what influence their work is having on the individuals they work with during their service. Please note that data collection is a sensitive process and so Volunteers will not want to take a baseline measurement until they have

been able to do some relationship and trust-building with the person/people the Volunteer is working with, and developed an understanding of cultural norms and gender dynamics.

- 4. Frequency of Measurement:** After taking the baseline pre-test, Volunteers must take a minimum of one measurement with the same individuals to assess whether they have gained the skills needed to correctly prepare ORS. This measurement is typically taken after completing one or more activities focused on achieving the outcome in this indicator and once they have determined that the timing is appropriate to expect that the outcome has been achieved. 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 an individual was able to correctly prepare ORS. In the case of this indicator, if the person the Volunteer/partner works with already correctly prepared ORS before beginning to work with the Volunteer/partner, then the Volunteer would not be able to count him/her for this activity because the Volunteer's work did not actually lead to the desired change. However, if as a result of working with the Volunteer/partner, the individual was able to properly prepare ORS, that would count because the Volunteer's work provided the individual with the training needed to be able to learn this skill.
- 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 individuals who were able to demonstrate how to correctly prepare ORS, 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 "Sex" and "Age". When reporting in the VRF, a Volunteer should disaggregate the total number of individuals by 1) male and female, and 2) 0-9 years, 10-17 years, 18-24 years, 25+ years.

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