STANDARD SECTOR INDICATOR CODE: HE-165	**1 Care Service - Food and/or other Nutritional Support:** Number of eligible individuals who received food and/or other nutrition services.	

HEALTH SECTOR	**Sector Schematic Alignment**
	• **Project Area:** HIV Mitigation
	  • **Project Activity Area/Training Package:** HIV Prevention
	  • **Project Activity Area/Training Package:** Community Care of OVC
	  • **Project Activity Area/Training Package:** HIV Care, Support, and Treatment	

Type: Output	**Unit of Measure**: Eligible individuals	**Disaggregation:** **Sex:** Male, Female **Age:** 0-4, 5-9, 10-14, 15-17, 18-24, 25-49, 50+

To be counted for this indicator the following criteria must be met:

- The individual must have received at least one (1) nutritional support service (see definitions below).
- The services must have been provided by the PCV or their partners in an individual or small group setting.
- Research shows ideal group size is less than 25 individuals, although in some instances group size can be significantly larger.
- Receipt of service must be documented by the Volunteer or their partner

Definitions:

Food and/or other nutrition services included under this indicator refer to:

I. **Nutrition services:** nutritional assessment and counseling services including anthropometric, clinical, dietary, food security, and WASH (water/hygiene/sanitation) assessment to support care and treatment of PLHIV and their families, as well as OVCs. Nutrition counseling should be offered to maintain or improve nutritional status, prevent and manage food- and water-borne illnesses, manage dietary complications related to HIV infection and ART, and promote safe infant and young child feeding practices and linked to community nutrition surveillance and home-based care support. Home and community gardens can also be used to improve nutritional status.

II. **Equipment** – procurement of adult and pediatric weighing scales, stadiometers, MUAC tapes, and other equipment required to conduct effective nutrition assessment.

III. **Food services may include the provision:**

- Micronutrient supplementation including vitamin A, zinc and multi-micronutrients for OVCs, and where individual dietary assessment determines a likelihood of inadequate intake to meet vitamin and mineral requirements of PLHIV within NACS programs;
- Competitive procurement of specialized foods including processed foods from local, regional or international companies that meet internationally recognized standards for safety and quality:
- Therapeutic and supplementary feeding support for undernourished PLHIV and OVC –support for nutrition rehabilitation of severely and mild-to-moderately malnourished PLHIV and OVC. Eligibility criteria and protocols for therapeutic and supplementary feeding should be based on WHO and national guidelines, as well as OGAC/PEPFAR policy guidance. Therapeutic and supplementary feeding through Food by Prescription (FBP) is a critical component of HIV care and support and is most effectively utilized when provision is based on established eligibility criteria. Specialized food products, including therapeutic foods, e.g. Plumpy'Nut or other ready-to-use therapeutic foods (RUTFs), and supplementary foods, e.g. corn-soy blend or other fortified blended flours (FBFs), are prescribed for a limited duration on the basis of clear anthropometric entry and exit eligibility criteria or nutrition vulnerability. RUTF and FBF are typically provided monthly, as a take-home ration for the individual patients, not to be shared within the household

- Supplemental, complementary and replacement feeding of specialized foods for nutritionally vulnerable women in PMTCT programs to improve birth outcomes and to support lactation, as well as complementary feeding (with breastfeeding beyond 6 mo of age) and replacement feeding (post-weaning) support. Infant formula may be provided on an emergency basis for individual infants where breastfeeding is not an option (e.g. maternal death or incapacitation).

Recommended prioritization of feeding support within and across sites based on relative vulnerability:

- Complementary/replacement food for *all* HIV-exposed infants from 6 months up to 2 years of age, irrespective of anthropometric status;
- Supplementary food to women in PMTCT program who are underweight or fail to gain adequate weight in pregnancy or underweight during lactation;
- Therapeutic/supplementary food to OVC with evidence of growth faltering (wt/ht <-2 z-score); and
- Therapeutic/supplementary food to adult HIV/AIDS patients w/ BMI <18.5;
- *Provision of HAART, cotrimoxazole and treatment for opportunistic infections and comorbidities per clinical guidelines.* The benefits of improved food and nutrient intake can be greatly muted by uncontrolled health conditions that compromise appetite, absorption, metabolism and nutrient losses. A majority of clinically malnourished PLHIV (BMI <18.5) who initiate HAART will gain weight, even without feeding support.

It is recommended that nutrition assessment and counseling should be extended to all care and treatment sites as rapidly as possible, even where the procurement and distribution of food, i.e. Food by Prescription, is limited by inadequate funding and supply chain systems.

Volunteers working with specific target populations such as OVCs, PLHIV, or others affected by HIV should disaggregate the information by target population they are working with and report accordingly.

Orphans and Vulnerable Children: Children <18 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.

Caregiver of an OVC: A parent, guardian, foster parent (formal or informal) who has primary responsibility in the home for caring for a child affected by HIV/ AIDS.

PLHIV: Persons living with HIV/AIDS.

Rationale: Nutritional care plays a critical role in HIV treatment, care and support. Country programs and their partners are encouraged to integrate nutrition assessment and counseling and support into routine HIV services and strengthen the capacity of the government health care providers to implement nutrition care.

Measurement Notes:

1. **Sample Tools and/or Possible Methods: Sample Tools and/or Possible Methods:** Volunteers should use data collection tools to measure progress against project indicators. For this Standard Sector Indicator, a tracking sheet that collects the names, sex and age of participants who received food and/or other nutrition services. A tracking sheet may include:
    a. The name/title of the intervention/project
    b. The start and end date
    c. Location where the intervention is conducted
    d. A brief description of the activities of the intervention
    e. Beneficiaries - see disaggregation
    f. Names of organization/partners collaborated with in implementing the intervention
    g. Source and amount of funding, if funds are used

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:** Because this is an output indicator that does not measure any change, there is no need to take a baseline measurement before reporting the results of this indicator. However, Volunteers should take baseline measurements for any outcome indicators that are related to this output indicator. Refer to the project framework to review related outcome indicators.

4. **Frequency of measurement:** An output indicator only needs to be measured once—in this case, every time the Volunteer holds a training event (or series of events) on nutrition or provides someone with a he/she will want to keep track of the number of unique individuals who participated in the event(s) and report on it in the next VRF.

5. **Definition of change**: Outputs do not measure any changes. However, a minimum expectation for any nutrition service to be counted for this indicator is that an eligible individual must have received at least one (1) nutritional support service such as nutritional assessment and counseling services including anthropometric, clinical, dietary, food security, and WASH (water/hygiene/sanitation) assessment to support care and treatment of PLHIV and their families, as well as OVCs. Nutrition counseling should be offered to maintain or improve nutritional status, prevent and manage food- and water-borne illnesses, manage dietary complications related to HIV infection and ART, and promote safe infant and young child feeding practices and linked to community nutrition surveillance and home-based care support. Home and community gardens can also be used to improve nutritional status.

6. **Reporting**: In the case of output indicators, Volunteers only have one box to fill in on their VRF: "total # (number)." This indicator is intended to capture programs targeting caregiver of an OVC, PLHIV, or an OVC or any other eligible individual. The number can be generated by counting the number of caregivers of OVC, PLHIV or OVCs in attendance at a nutritional training or receiving a nutritional service.

7. **Reporting on Disaggregated Data in the VRT:** This indicator is disaggregated by Sex and Age. When reporting in the VRF, a Volunteer should disaggregate the total number of individuals by Sex and Age. When reporting in the VRF, a volunteer should disaggregate the total number of male individuals by 0-4 years, 5-9 years, 10-14 years, 15-17 years, 18-24 years, 25-49 years, 50+ years and the total number of female individuals by 0-4 years, 5-9 years, 10-14 years, 15-17 years, 18-24 years, 25-49 years, and 50+ 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