

<p>STANDARD SECTOR INDICATOR CODE: HE-167 PEPFAR CODE: NA</p>	<p>Improved Nutritional Status: Number of eligible individuals who improved their nutritional status as a result of receiving nutritional services.</p>	
<p>HEALTH SECTOR</p>	<p>Sector Schematic Alignment</p> <ul style="list-style-type: none"> • Project Area: HIV Mitigation • Project Activity Area/Training Package: HIV Care, Support, and Treatment 	
<p>Type: Intermediate-term Outcome</p>	<p>Unit of Measure: Eligible Individuals</p>	<p>Disaggregation:</p> <p>Sex: Male, Female Age: 0-4 years, 5-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years Pregnancy Status: Pregnant, Not Pregnant</p>

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

- Individual must be 6 months of age or older
- The individual must be living with HIV
- The individual must have received nutritional support services (see definitions below).
- The services must have been provided by the PCV or their partners
- Receipt of service must be documented by the Volunteer or their partner
- The individual must have been acutely malnourished (wasted) at prior assessment (see notes below for instructions on measurement and calculation)
 - 6-59 months: Mid Upper Arm Circumference (MUAC) less than 125mm¹
 - 5 yrs. to 18 yrs.: Body Mass Index (BMI)-for-Age Z-score ²of less than -2SD
 - Non-lactating, non-pregnant adults over 18 years: BMI-for-Age Z-score of less than -2SD
- Ideally, ongoing monitoring will show a stable recovery with normal nutrition status measurements at multiple intervals, but for this indicator, a single measure of “normal” after having been acutely malnourished is sufficient

¹ Most national policies use <115mm as a cut off for Severe Acute Malnutrition and <125mm for Moderate Acute Malnutrition. If national policies dictate another cut-off (for instance 110 mm and 120 respectively), then those can be used.

² BMI-for-Age requires a two-step process. The first step is to accurately weigh and measure which can then be used to calculate by hand or locate the BMI from a table. The second step requires using a BMI for Age table to locate the BMI and the client’s age in the table to determine the z-score/nutritional status.

Definitions:**Acute malnutrition (wasting):**

Age	Normal	Moderate Acute Malnutrition	Severe Acute Malnutrition
Children: 6-59 months	≥ 125mm	MUAC ≥ 115mm to < 125mm	MUAC < 115mm
Adolescents: 5 – 18 years	BMI-for-age by gender z-score ≥ -2SD	BMI-for-age by gender z-score ≥ -3SD < -2SD	BMI-for-age by gender z-score < -3SD
Adults: 18+ years	BMI-for-age z-score ≥ -2SD	BMI-for-age z-score ≥ -3SD < -2SD	BMI-for-age z-score < -3SD

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 months 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 the specific target population they are working with and report accordingly.

Caregiver: A parent, guardian, foster parent who has primary responsibility for the child in the home.

PLHIV: Persons living with HIV/AIDS.

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*

Rationale: PLHIV are particularly vulnerable to malnutrition due to a number of factors. As part of a treatment package, nutritional services are frequently extended to clients and the most relevant malnutrition issue in this population is acute malnutrition as appetites and caloric requirements are impacted during the progression of the disease. It should be noted that adults, adolescents and children who are acutely malnourished have an elevated risk of mortality. All cases of severe acute malnutrition (-2SD) should always be referred to the nearest clinic or hospital.

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 PLHIV, 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 members 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 an improvement of nutritional status from moderate or severe acute malnutrition to a normal status. The table above under definitions should inform the starting point from which change is to be measured, dependent upon age of the individual.

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 have improved their nutritional status, from moderate or severe acute malnutrition to normal, 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”, “Age” and “Pregnancy Status” for females. When reporting in the VRF, a Volunteer should disaggregate the individuals who achieved the outcome based on male and female, age bracket and pregnancy status.

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