STANDARD SECTOR INDICATOR CODE: AG-053	**Nutrition Education – Types of Malnutrition:** Number of caretakers, out of the total number the Volunteer/partner worked with, who named one or more types of malnutrition. (AG-053)	
AGRICULTURE SECTOR	**Sector Schematic Alignment** • **Project Area:** Resilience & Stability • **Project Activity Area/Training Package:** Nutrition for Healthy Families	
Type: Outcome	**Unit of Measure**: Caretakers	**Disaggregation:** **Sex**: Male, Female

Definitions:

Knowledge of the ***types of malnutrition*** is captured in this indicator. To determine capacity of caretakers to satisfactorily name at least one type of malnutrition, the following list of types of malnutrition can be considered:

- **Acute malnutrition**—measured by weight-for-height and caused by present or recent illness or food consumption shortfall. Presence of any bilateral swelling (observable swelling in BOTH feet/ankles/legs) is indicative of acute malnutrition
    - *Wasting* - A nutritional state typified by weight loss and/or nutritional edema, measured as a weight-for-height less than -2 standard deviations from the median of a reference population. Alternatively, a measure of Mid Upper Arm Circumference (MUAC) can be used when screening for wasting. The physical condition of ***acute malnutrition***, this manifestation of undernourishment is driven primarily by insufficient caloric intake, as well severe deficits of protein, often in combination with recurrent disease.
    - *Kwashiorkor* - Condition typified by abnormal metabolic processes brought on by nutritional deprivation, resulting in nutritional (or bilateral) edema (swelling). Children with kwashiorkor are often apathetic, frequently having little or no appetite, and many present with concurrent infections.
    - *Marasmus* - Condition typified by severe wasting and emaciation. Marasmic sufferers have little to no subcutaneous fat remaining, experience significant muscular atrophy, and children with marasmus may appear to have an “old man’s” face. Additionally, a “baggy pants” appearance is notable in the pelvic and buttocks area due to the loss of fat and muscle tissue resulting in loose skin.
- **Chronic malnutrition**—measured by height for age and caused by prolonged deficits in nutrition. Often caloric intake is adequate, but a lack of dietary diversity and nutrient dense foods can put the body at greater risk of micronutrient deficiencies.
    - *Stunting* - A nutritional state of sub-optimal linear growth and development measured by a height-for-age less than -2 standard deviations from the median of a reference population. Termed ***chronic malnutrition***, this manifestation of undernourishment results from sub-optimal quality and diversity of diet and/or repeated or chronic illness that negatively affects the absorption of nutrients.
    - *Underweight* - A nutritional state of ***either chronic or acute malnutrition*** that results in a weight-for-age less than -2 standard deviations from the median of a reference population. Millennium Development Goals are measured against underweight and underweight is tracked most frequently on World Health Organization (WHO) growth cards.
- **Micronutrient deficiencies**—can co-exist with other forms of malnutrition. Often called ‘hidden hunger’ since

most frequently deficiencies are sub-clinical only manifesting in obvious symptoms in advanced stages.

- **Overnutrition—**occurs with excess calories consumed relative to requirements. Factors that drive obesity include high intake of energy dense/nutrient poor processed foods, inactivity, and general overeating. Overnutrition carries risk of chronic diseases such as diabetes, cancer, hypertension and others.
    - Overweight – refers to a body mass index of 25 to 29.9
    - Obesity – refers to a body mass index of 30 and greater

Body Mass Index (BMI) – a measure calculated using the height and weight of a person and used as a proxy for body fatness. The formula is as follows:

For kg: weight (kg)/height(m)^2

For lbs: weight(lbs)/[height(in)^2 X 703]

An online calculator can be used to determine BMI in adults.

Caretaker —any individual for whom some responsibility of providing care for children applies. This also includes Caregivers

Partner/s— refers to the local counterpart who is co-facilitating malnutrition type numbering activities with the Volunteer

Rationale:
Though the pathways for *undernutrition* are many, increased awareness and education for caretakers is seen as a mechanism through which to effect positive change. Demonstration, on the part of the caretaker, of specific knowledge regarding child malnutrition types is seen as a first step in the process of behavior change aimed at improving nutritional status.

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—survey, observation, or interview—though there may be other data collection methods that are appropriate as well. For more information on the suggested methods, please see **Appendix I in the MRE Toolkit.** Also be sure to check the intranet page as sample tools are regularly uploaded for post use. 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 "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 a caretaker or group of caretakers. 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 indicator (i.e. determine whether or not a caretaker in question has named one or more types of malnutrition before working with the Volunteer) early in their work focused on nutrition education and understanding the type of malnutrition. 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 "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 caretakers 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 caretakers 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 caretakers 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 caretaker(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 caretaker 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 caretaker (or group of caretakers) for the following valid reasons:
   a. Volunteers may want to measure whether or not any additional caretakers 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);
   b. 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;
   c. 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 caretakers achieving the outcome in their next VRF.

5. **Definition of Change**: The minimum change to report against this indicator is a caretaker named one or more types of malnutrition as compared to what was measured initially at baseline. In the case of this indicator, if the caretaker the Volunteer/partner works with already has knowledge about and can name acute and chronic

malnutrition 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 caretaker obtains knowledge and can name overnutrition as a type of malnutrition, that would count because the Volunteer's work influenced the caretaker obtaining knowledge about overnutrition.

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 caretakers who named one or more types of malnutrition , 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 caretakers who participated in the activities designed to meet this indicator.

7. **Reporting on Disaggregated Data in the VRF:** This indicator is disaggregated by "Sex". When reporting in the VRF, a Volunteer should disaggregate the caretakers who achieved the outcome based on male and female.

Data Quality Assessments (DQA): DQAs 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: AG. CHILDHOOD HEALTH/NUTRITION TRAINING (INDIIVDUALS)