STANDARD SECTOR INDICATOR CODE: HE-013	**Showed Improvement in Knowledge of Diseases Related to Tobacco Use:** Number of individuals who are able to identify 2 or more diseases linked to tobacco use.	
HEALTH SECTOR	**Sector Schematic Alignment** **Project Area:** Life Skills for Healthy Behaviors **Project Activity Area/Training Package:** NCD Mitigation and Nutrition	
Type: Short-term Outcome	**Unit of Measure**: Individuals	**Disaggregation:** **Sex:** Male, Female **Age:** 0-9 years, 10-17 years, 18-24 years, 25+ years

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

- The individual must have participated in training on non-communicable disease risk factors related to tobacco use and importance of tobacco cessation.
- 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 setting.
- Attendance at educational session/s must be documented by the Volunteer or their partner.
- The individual must correctly identify 2 or more diseases linked to tobacco use.

Definitions:

Diseases linked to tobacco: coronary heart diseases, stroke, and peripheral vascular disease, lung cancer and many other cancers (oral, larynx, esophageal, stomach, pancreas, colorectal ovarian, cervix) bronchitis, emphysema and COPD)

Smoking cessation: is defined as abstaining from cigarettes for 90 consecutive days or since the last reporting period.

Tobacco cessation: is defined as abstaining from all tobacco products (pipes, cigars, cigarettes, snuff, and chewing tobacco) for 90 consecutive days or since the last reporting period.

Rationale: According to the Centers for Disease Control and Prevention, tobacco use is one of the leading preventable causes of death. Worldwide, tobacco use causes more than 5 million deaths per year, and current trends show that tobacco use will cause more than 8 million deaths annually by 2030. Smoking causes cancer, heart disease, stroke, and lung diseases (including emphysema, bronchitis, and chronic airway obstruction). For every person who dies from a smoking-related disease, 20 more people suffer with at least one serious illness from smoking.

Cigarette smoke contains a deadly mix of more than 7,000 chemicals; hundreds are toxic and about 70 can cause cancer. Cigarette smoke can cause serious health problems, numerous diseases, and death. People who stop smoking greatly reduce their risk for disease and premature death. Although the health benefits are greater for people who stop at earlier ages, cessation is beneficial at all ages.

Smoking cessation is associated with the following health benefits:

- Smoking cessation lowers the risk for lung and other types of cancer.
- Smoking cessation reduces the risk for coronary heart disease, stroke, and peripheral vascular disease. Coronary heart disease risk is substantially reduced within 1 to 2 years of cessation.
- Smoking cessation reduces respiratory symptoms, such as coughing, wheezing, and shortness of breath. The rate of decline in lung function is slower among persons who quit smoking.
- Smoking cessation reduces the risk of developing chronic obstructive pulmonary disease (COPD), one of the leading causes of death in the United States.

- Smoking cessation by women during their reproductive years reduces the risk for infertility. Women who stop smoking during pregnancy also reduce their risk of having a low birth weight baby.

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. For this Standard Sector Indicator, Peace Corps post staff can access a sample tool on the intranet page through **this link** and adapt it at the post level for their Volunteers' 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 the bullet on "frequency of measurement").

3. **Activity-Level Baseline Data Collection:** This indicator builds off of indicator **HE-012: *Educated on NCD Risk Factors Related to Tobacco Use*** as it measures an increase in knowledge following training on non-communicable disease risk factors related to tobacco use. Therefore, baseline data collected in the form of a pre-test for HE-012 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 measurement (described above), Volunteers should take at least one follow-on measurement with the same individual(s), to assess whether their knowledge of diseases related to tobacco use has improved. 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 identify at least two diseases linked to tobacco use. In the case of this indicator, if the person the Volunteer/partner works with has already identified at least two diseases linked to tobacco use 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 improved their knowledge of diseases linked to tobacco use, then that would count because the Volunteer's work influenced the individual's knowledge.

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 correctly identified at least two diseases linked to tobacco use 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, and 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