

<p>STANDARD SECTOR INDICATOR CODE: HE-140-PEPFAR</p> <p>PEPFAR CODE: P8.1.D</p>	<p>Individual or Small Group, Excluding PLHIV, Reached with an HIV Prevention Intervention: Number of general population (NOT including MARPs/Key populations and PLHIV) reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required.</p>	
<p>HEALTH SECTOR</p>	<p>Sector Schematic Alignment</p> <ul style="list-style-type: none"> • Project Area: HIV Mitigation <ul style="list-style-type: none"> • Project Activity Area/Training Package: Behavioral Prevention Support 	
<p>Type: Output</p>	<p>Unit of Measure: General Population</p>	<p>Disaggregation</p> <p>Sex: Male, Female</p> <p>Age: 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years</p>

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

- The individuals must have attended training on the HIV Prevention interventions that had clearly defined goals and objectives **and**
 - Was based on sound, evidence-based behavioral and social science theory
 - Was focused on reducing specific risk behaviors
 - Had activities that addressed the targeted risk behaviors
 - Employed instructionally sound teaching methods
 - Provided opportunities to practice relevant risk reduction skills
- 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.
- Provide opportunities to practice relevant risk reduction skills.
- Attendance in the session/s must be documented by the Volunteer or their partner.

Definitions:

Key Populations – (formerly most-at-risk populations/MARPs) are defined as populations at increased vulnerability to HIV due to behavioral, social, or environmental factors and include: sex workers/commercial sex workers (SW/CSW), injecting drug users (IDU), men who have sex with men (MSM).

HIV prevention intervention: HIV prevention interventions can include programs, services, and messages which encourage consistent use of condoms, uptake of male circumcision services, getting tested for HIV, reduction of behaviors that place a person at higher risk for contracting HIV, eliminating or reducing risky sexual or drug taking behaviors, and open communication about sexuality.

Abstinence and/or being faithful: AB interventions can be measure by this indicator and include programs, services, and messages which encourage sexual abstinence, delay of sexual debut and secondary abstinence, mutual fidelity, mutual knowledge of HIV status, and social and gender norms which promote mutual respect and open communication about sexuality. AB interventions can also include programs, services, and messages which discourage multiple and/or concurrent partnerships, cross-generational and transactional sex, sexual violence, stigma, and other harmful gender norms and practices. AB interventions targeting youth should support skills based sexuality and AIDS education as well as involve parents and guardians to improve communication with children and parenting skills.

Individual-level interventions (ILI): Interventions that are provided to one individual at a time (e.g., individual counseling. The intervention assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Counseling associated with testing and counseling should not be counted here.

Small group level interventions (GLI): Trainings must have been provided in a small group setting. Research shows that ideal group size is 25 individuals or less, although in some instances group size can be significantly larger. Trainings should assist clients in making plans for behavior change and appraisals of their own behavior. Small group can include a family or couple.

Evidence-based interventions: Interventions based on the country's epidemic, the drivers of that epidemic, and the most current understanding of behavioral and/or social science. Evidence-based HIV behavioral interventions have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy (e.g. elimination of reduction of risky sexual or drug taking behaviors). These interventions are considered to be scientifically sound, provide sufficient evidence of efficacy in other contexts and/or target populations, and address HIV prevention needs of the communities by targeting the specific target population.

Minimum Standards Required: In the absence of evidence-based interventions, other interventions that could be considered for implementation are those that meet the minimum standards required. These interventions are based on sound behavioral science theory and do have some empirical evidence in the form of being based on formative assessment results. They can also be based on past successful programs. All programs should use process monitoring data to continually gauge the appropriateness of the intervention and plan to collect outcome monitoring data to determine effectiveness.

Intended number of sessions: The number of sessions defined in the program description and as prescribed in the intervention. One component linked to the effectiveness of curriculum-based programs is completing the intended number of sessions of that curriculum. If fewer sessions are conducted, then that program is not following one of the criteria for effective curriculum-based sessions. Activity narratives or partner plans should define the number of sessions that are planned and how many (percent of) sessions that must be attended/completed by an individual in order to "count". This may be done activity by activity with oversight from PEPFAR in-country team or the in-country team may wish to set a standard for all partners working in the area of prevention.

Comprehensive Prevention Programs: Implementing a comprehensive prevention program at the country level involves multiple components such as setting epidemiologically sound priorities, developing a strategic prevention portfolio, employing effective program models, supporting a coordinated and sustainable national response, establishing quality assurance/monitoring/evaluation mechanisms, and expanding and strengthening PEPFAR prevention staff.

Comprehensive prevention programs include: interventions at multiple levels (e.g. mass media, community-based, workplace, small group, and individual) as well as providing a range of messages that are appropriate for the country's epidemic and the specific target group. Prevention programs should appropriately link to services such as male circumcision and counseling and testing, address stigma and discrimination, and increase awareness of social norms that affect behaviors. Effective ABC messages are also a goal.

ABC paradigm: The ABC paradigm includes abstinence, delay of sexual debut, mutual faithfulness, partner reduction, and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV. The most appropriate mix of programs and messages will depend on the country's epidemic, what populations are being focused on, the circumstances they face, and behaviors within those populations that are targeted for change. Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required.

Rationale: Individual and small-group level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviors. Delivering these interventions with fidelity (including intended number of sessions) to the appropriate populations is an important component of comprehensive HIV prevention strategies.

It is important to know how many people complete an intervention in order to monitor how well programs are reaching the intended audience with HIV prevention programming.

This information can be used to plan and make decisions on how well a certain audience is being reached with individual and/or small group level interventions. If a small percentage of the intended audience is being reached with either one intervention, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended audience is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.

Measurement Notes:

1. **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 following data should be developed:
 - 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. Names of organizations/partners collaborated with in implementing the intervention
 - f. Beneficiaries – *see disaggregation*
 - 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 HIV Prevention, 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 HIV prevention skill to be counted for this indicator is that an individual or group must attend training on HIV Prevention skills. This could include: behavioral approaches such as risk behaviors and risk reduction, biomedical approaches (condom use, adherence to treatment, VMMC), or structural approaches (availability of prevention services and social norms).

- 6. Reporting:** In the case of output indicators, Volunteers only have one box to fill in on their VRF: “total # (number).”
- 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 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years and the total number of female individuals by 0-9 years, 10-14 years, 15-17 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: HIV Prevention Interventions