

<p>STANDARD SECTOR INDICATOR CODE: HE-142-PEPFAR PEPFAR CODE: #P8.3.D</p>	<p>Key Populations (CSW, IDU, MSM, etc.) Reached with HIV Interventions: Number of key populations reached with individual and/or small group level HIV 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: HIV Prevention 	
<p>Type: Output</p>	<p>Unit of Measure: Key Populations</p>	<p>Disaggregation:</p> <p>Sex: Female Age: 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years Key Population: Commercial sex workers/sex workers, injecting drug users, men who have sex with men, other at-risk populations</p>

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

- The individuals must be a commercial sex workers, injection drug users, men who have sex with men or other vulnerable population (informal sex workers, mobile population, military, incarcerated or non-injecting drug users)
- The individuals must have been reached with one of the following services
 - Community-based peer outreach
 - Voluntary testing and counseling (If providing these services, also use indicator #P11.1.D)
 - Behavior change programs including targeted condom distribution for those who practice high-risk sexual behavior
 - Diagnosis and treatment of STIs (If providing these services, also use indicator #C2.1.D)
 - Referrals to a range of substance abuse and treatment services
 - Linkages through referral networks with other health services
 - Programs to prevent alcohol/drug- related sexual risk-taking behaviors and HIV transmission
 - Vocational skills training or other income-generation activities
 - Drop-in centers for creation of “safe space”
- Services must have been provided by the PCV or their partner in an individual or small group setting comprised of no more than 25 people
- Provision of services must be documented

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), and transgender individuals (TG).

Other Vulnerable Populations:

Please note: there may be other populations that have increased vulnerability to HIV due to a combination of behavioral, social, or environmental factors. Groups that should be counted in the category of Other Vulnerable Populations include:

- Military and other uniformed services
- Incarcerated persons

- o Mobile populations (e.g. migrant workers, truck drivers)
- o Clients of sex workers
- o Non-injecting drug users

Core Package of Services for Key Populations (formerly Most-at-risk Populations): Based on the epidemiologic profile for each country the aim of the country team should be to scale-up a combination of targeted interventions adapted for different sub-groups especially vulnerable to HIV.

These interventions could include but are not limited to:

- Community-based peer outreach
- Voluntary testing and counseling (If providing these services, also use indicator #P11.1.D)
- Behavior change programs including targeted condom distribution for those who practice high-risk sexual behavior
- Diagnosis and treatment of STIs (If providing these services, also use indicator #C2.1.D)
- Referrals to a range of substance abuse and treatment services
- Linkages through referral networks with other health services
- Programs to prevent alcohol/drug-related sexual risk-taking behaviors and HIV transmission
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Service models (e.g. VCT) developed for a general population may need to be adapted to reach, engage and meet the needs of key populations. The country team is encouraged to incorporate tailored or innovative approaches that are likely to increase access and remove barriers to services for these populations. Use of qualitative methods to guide these adaptations has proven to be an effective strategy.

The network model encourages and supports linkages to care and treatment as well. Keeping linkages in mind as care and treatment programs are planned will help achieve the overall PEPFAR goals and assist MARP populations.

Commercial Sex Workers (CSW): Effective CSW prevention programming should:

- Ensure participation of target group in the development, implementation and monitoring of prevention programs
- Promote consistent and proper use of condoms to achieve >90% use with both clients and regular non-paying partners/boyfriends/husbands
- Ensure consistent availability of quality male and female condoms and lubricant
- Ensure availability of comprehensive health care services with special emphasis to quality VCT, STI and FP services and provision of or linkages to HIV treatment and care services (If actually providing these services, also use indicators #P11.1.D and #C2.1.D)
- Integrate violence reduction (both social and structural) in prostitution settings
- Link with relevant social welfare services for the target group and their families
- Provide vocational training (If vocational training is HIV/health related, then also use indicator #H2.3.D)

Men Who Have Sex With Men (MSM): Effective MSM prevention programming should:

- Ensure participation of MSM in the development, implementation and monitoring of prevention programs
- Promote consistent and proper use of condoms to achieve >90% use with both regular and non-regular partners
- Ensure consistent availability of quality male condoms and lubricant
- Ensure availability of comprehensive health care services with special emphasis to quality VCT and STI services and provision of or linkages to HIV treatment and care services. (If actually providing these services, also use indicators #P11.1.D and #C2.1.D)

Injection Drug Users: Generally speaking, PEPFAR promotes three approaches to HIV prevention for injecting drug users:

1. Tailoring HIV prevention programs to injecting drug users: these programs should rely on tools, guidelines and evidence-based interventions designed to reduce risk of HIV transmission. A comprehensive program should include, information and education, community based outreach, risk reduction counseling, targeted condom distribution

activities and substance abuse treatment, and to address HIV prevention and risk reduction. These services should be provided in multiple venues to reach this hard to reach population and engage them in activities to enable them to eliminate/reduce risks for acquiring and or transmitting HIV

2. Offering HIV-infected drug users a comprehensive program to reduce their risk of transmission: a comprehensive multi-component HIV/AIDS treatment program for injecting drug users should promote recovery through confidential HIV counseling and testing, ART, palliative care, STI and tuberculosis treatment, substance abuse treatment (including medication assisted therapies) and transitional services between treatment facilities and the community.

3. Supporting substance abuse programs as an HIV prevention measure: these programs may include behavioral models or medication-assisted treatment (e.g. using methadone or buprenorphine), or a combination of the two, and should also include case management and counseling services. Medication assisted treatment programs have been demonstrated to be an effective HIV prevention strategy. Medication assisted therapy program should be an access point for IDUs and the program should refer and link to ARV treatment programs, PMTCT for female IDUs and a range of other prevention services. (If actually providing opioid substitution therapy, also use indicator #P4.1.D)

See Indicator #P8.1.D for definitions of additional terms required to define this indicator:

Comprehensive Prevention Programs

Intended Target Population

Small group level interventions (GLI)

Evidence-based interventions

Number reached

Minimum Standards Required

Intended number of sessions

Catchment area: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. MARP/key population estimates for subdistricts/districts/regions can be used if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.

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 to the appropriate populations is an important component of combination 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 target population with HIV prevention programming. Headquarter staff can use this information to plan and make decisions on how well a certain target population is being reached with individual and/or small group level interventions. If a small percentage of the intended target population 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 target population 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 (for Peace Corps staff use):** Volunteers should use data collection tools to measure progress against project indicators. For this Standard Sector Indicator, a tracking sheet that collects the names and sex of participants who were trained in working with and addressing the HIV prevention needs of key populations will capture the needed data. However, a data collection tool to measure this indicator could be based on [one of the](#) following methods—program records, survey, and observation—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 [this link](#) on 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 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 working with or addressing the HIV prevention needs of key populations, 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 at least one (1) hour of 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