

<p>STANDARD SECTOR INDICATOR CODE: HE-021</p>	<p>Showed Increase in Knowledge of Alcohol Consumption and Blood Alcohol Levels: Number of individuals who are able to identify the number of drinks and blood alcohol level related to intoxication, coma, and death.</p>	
<p>HEALTH SECTOR</p>	<p>Sector Schematic Alignment</p> <ul style="list-style-type: none"> • Project Area: Life Skills for Healthy Behaviors • Project Activity Area/Training Package: Alcohol and Substance Use Prevention 	
<p>Type: Short-term Outcome</p>	<p>Unit of Measure: Individuals</p>	<p>Disaggregation:</p> <p>Sex: Male, Female Age: 0-9 years, 10-17 years, 18-24 years, 25+ years</p>

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

- The individual must have attended training the harmful effects of alcohol and drugs and the prevention of alcohol and drug abuse.
- 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 the number of drinks and corresponding blood alcohol levels related to intoxication, coma and to death

Definitions:

Blood alcohol level or blood alcohol concentration (BAC) is the amount of alcohol present in a fixed volume of blood of blood and measured by a percentage based on milligrams of alcohol per deciliter of blood. A BAC of .10 means that .1% of your bloodstream is composed of alcohol. BAC is used as a measure of the degree of intoxication in an individual. The BAC depends on body weight, the quantity and rate of alcohol ingestion, and the rates of alcohol absorption and metabolism. The following BAC levels are related to intoxication, coma and to death

- 0.08 - 0.10 definite impairment of muscle coordination and driving skills. This is the legal intoxication level in most states.
- 0.35-0.50 coma, unconsciousness.
- 0.45+ risk of death from respiratory arrest.

1 drink of alcohol: is defined as a ‘shot’ 1.5 fluid ounces (oz.)* of 80 proof liquor or 14.0 grams (0.6 ounces) of pure alcohol. Generally this amount of alcohol is found in:

- 12-ounces of beer.
- 8-ounces of malt liquor.
- 5-ounces of wine.
- 1.5-ounces or a “shot” of 80-proof distilled spirits or liquor (e.g., gin, rum, vodka, or whiskey).

*1.5 ounces is equal to approximately 45 ml.

Rationale: The harmful use of alcohol is a global problem which compromises both individual and social development. It results in 2.5 million deaths each year. Alcohol is the world’s third largest risk factor for premature mortality, disability and loss of health; it is the leading risk factor in the Western Pacific and the Americas and the second largest in Europe. Men consistently have higher rates of alcohol-related deaths and hospitalizations than women. Among drivers in fatal

motor-vehicle traffic crashes, men are almost twice as likely as women to have been intoxicated. Excessive alcohol consumption increases aggression and, as a result, can increase the risk of physically assaulting another person or of engaging in risky sexual activity including unprotected sex, sex with multiple partners, or sex with a partner at risk for sexually transmitted diseases. The harmful use of alcohol is associated with several infectious diseases like HIV/AIDS, tuberculosis and sexually transmitted infections (STIs). This is because alcohol consumption weakens the immune system and has a negative effect on patients' adherence to antiretroviral treatment.

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-020: *Educated on Harmful Effects of Alcohol and Other Substances***, or a training that contains similar content as it measures an increase in knowledge of alcohol consumption and blood alcohol levels. Therefore, baseline data collected in the form of a pre-test for HE-020 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 alcohol consumption and blood alcohol levels was 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 the number of drinks and blood alcohol level related to intoxication coma and death. In the case of this indicator, if the person the Volunteer/partner works with has already identified the number of drinks and blood alcohol level related to intoxication coma and death 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 the number of drinks and blood alcohol level related to intoxication coma and death, 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 are able to identify the number of drinks and blood alcohol level related to intoxication, coma, and death. 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