

<p><b>STANDARD SECTOR INDICATOR CODE:</b> HE-140-PEPFAR</p> <p><b>PEPFAR CODE:</b> PP_PREV</p>	<p><b>Gen Population/Youth HIV Prevention Intervention:</b> Number of each <u>priority population</u> who completed a standardized HIV prevention intervention during the reporting period.</p>	
<p><b>HEALTH SECTOR</b></p>	<p><b>Sector Schematic Alignment</b></p> <ul style="list-style-type: none"> <li>• <b>Project Area:</b> HIV Mitigation             <ul style="list-style-type: none"> <li>• <b>Project Activity Area/Training Package:</b> Behavioral Prevention Support</li> </ul> </li> </ul>	
<p><b>Type:</b> Output</p>	<p><b>Unit of Measure:</b> Number of Individuals of Priority Population</p>	<p><b>Disaggregation</b></p> <p><b>Sex:</b> Male, Female</p> <p><b>Age:</b> 0-9 years, 10-14 years, 15-19 years, 20-24 years, 25-49 years, 50+ years</p>

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

Every intervention for adult populations must include all of these components:

1. Targeted risk assessment and provision of risk reduction information, education and/or counseling to correctly identify HIV prevention methods, reject misconceptions about HIV transmission, and accurately gauge and personalize risk for HIV infection.
2. Condom promotion, condom skills training – including negotiation skills – and facilitated access to condoms whether through direct provision, linkages to social marketing outlets or other means (or referrals for condom promotion, provision and related skill development).
3. Informational sessions on HIV testing and counseling with active referrals to or provision of HTC services.
4. Demand creation to increase awareness, uptake and acceptability of relevant clinical services such as voluntary medical male circumcision (VMMC), prevention of mother-to-child transmission (PMTCT), HIV care and treatment, TB testing and treatment and reproductive health.
5. Activities which: promote gender equitable principles; address harmful norms related to sex and gender; and seek to reduce stigma and discrimination associated with HIV; and prevent gender-based violence.

Every intervention for youth populations must include all of these components:

1. Targeted risk assessment and provision of risk reduction information, education and/or counseling to correctly identify HIV prevention methods, reject misconceptions about HIV transmission and increase perception of risk for HIV infection.
2. Curriculum-based, age-appropriate, HIV prevention skills and sexuality education to prevent HIV acquisition and encourage safer sex strategies for sexually active youth.
3. Informational sessions on HIV testing and counseling with active referrals to or provision of youth-friendly HTC services.
4. Community programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.
5. Demand creation to increase awareness, uptake and acceptability of youth-friendly clinical services such as voluntary medical male circumcision (VMMC), HIV care and treatment, and TB testing and treatment.
6. Condom promotion, condom skills training – including negotiation skills – and facilitated access to condoms whether through direct provision, linkages to social marketing outlets or other means (or referrals for condom promotion, provision and related skill development) for sexually active youth.

7. Activities which: promote gender equitable principles; address harmful norms related to sex and gender; and seek to reduce stigma and discrimination associated with HIV and to prevent gender-based violence.

To be reported in this indicator, the participant must have completed at least the minimum number of sessions for completion of the prevention intervention.

**Note:** PEPFAR may fund prevention programs that do not provide or refer for condom promotion and provision. These programs may **not** be counted under this indicator.

**Definitions:**

**Priority populations:** PEPFAR-funded programs will identify priority populations for HIV prevention in their COPs and will report on these populations within this indicator. Please note that priority populations will include "Other Vulnerable Populations." Groups that might be counted in the category of Other Vulnerable Populations include the following and should always be selected on the basis of available epidemiological data:"

- Clients of sex workers
- Military and other uniformed services
- Incarcerated persons
- Mobile populations (e.g., migrant workers, truck drivers)
- Non-injecting drug users

Delivery of prevention packages for all priority populations will be tracked with this indicator, with the exception of packages for key populations as defined by UNAIDS and WHO: sex workers, men who have sex with men/transgender, and people who inject drugs. These key populations should be reported through the indicator "KP\_PREV".

**Standardized HIV Prevention Intervention:** an activity or set of activities designed for a specific priority population to reduce HIV transmission that is implemented the same way each time. These interventions adhere to written protocols, include goals and activities tailored to the priority population, typically comprise multiple encounters with the same individuals or small groups, and have a system for tracking and reporting the completion of every element of the intervention.

**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.

**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.

**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. Denominator:** Posts need to calculate the number of individuals in each priority population at the sub-national level. The process and data source should be standardized by the inter-agency PEPFAR team. Post can decide to share this number with PCVs or have staff enter it while reviewing VRFs.
- 2. Reporting:** PCVs should report each priority population separately even if they participated in the same intervention. PCVs should also report if the intervention was school or community based and if it met the minimum required components. **Posts should determine source of data and who should enter the *estimated size of the priority population in the catchment area.***
- 3. 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 has been developed and can be adapted by Post:
  - 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' age, gender, and type of priority population
- 4. 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).

5. **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.
6. **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.
7. **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).
8. **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 0-9 years, 10-14 years, 15-19 years, 20-24 years, 25-49 years, and 50+ years and the total number of female individuals by 0-9 years, 10-14 years, 15-19 years, 20-24 years, 25-49 years, and 50+ years. Volunteers should report each priority population separately.

**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