STANDARD SECTOR INDICATOR CODE: HE-142-PEPFAR **PEPFAR CODE**: KP_PREV	**Key Populations HIV Prevention Intervention:** Number of key populations reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required.	
HEALTH SECTOR	**Sector Schematic Alignment** • **Project Area:** HIV Mitigation • **Project Activity Area/Training Package:** HIV Prevention	
Type: Output	**Unit of Measure**: Number of Individuals of Key Populations	**Disaggregation:** **Sex:** Male, Female **Age:** 0-9 years, 10-14 years, 15-19 years, 20-24 years, 25-49 years, 50+ years **Key Population:** Female sex workers, PWID, MSM or transgender, MSM or transgender who are sex workers

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

- The participants in the prevention intervention must be: female sex workers, PWID, MSM or transgender, MSM or transgender who are sex workers
- This indicator only counts those interventions at the individual and/or small group level. Individual and small group level interventions are components of a comprehensive program but are not by themselves defined as a comprehensive program. Partners do not have to implement the full array of services recommended in the comprehensive prevention programs (please see tables below) to utilize this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities that they work in.
- The prevention intervention must be evidence-based and/or meet the minimum standards required.
- 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
- Participation 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: female sex workers, people who inject drugs (PWID), men who have sex with men (MSM), and transgender individuals (TG).

Comprehensive Prevention Programs <u>should</u> include the following:

MSM/Transgender	Female Sex Workers	People Who Inject Drugs
Outreach/Empowerment	Outreach/Empowerment	Outreach/Empowerment
Targeted IEC	Targeted IEC	Targeted IEC
Provide or refer to VCT	Provide or refer to VCT	Provide or refer to VCT
Condoms/lubricant	Condoms/lubricant	Condoms/lubricant
Refer to STI Screening, prevention,	Refer to STI Screening, prevention,	Refer to STI Screening, prevention,

and treatment	and treatment	and treatment
Link or refer to ART	Link or refer to ART	Link or refer to ART
Prevention and refer to diagnosis, treatment of TB	Prevention and refer to diagnosis, treatment of TB	Prevention and refer to diagnosis, treatment of TB
Refer to screening and vaccination for viral hepatitis	Refer to screening and vaccination for viral hepatitis	Refer to screening and vaccination for viral hepatitis
	Refer to Reproductive Health (Family Planning, PMTCT)	Refer to Reproductive Health (Family Planning, PMTCT)
		Refer to medication-assisted therapy (MAT)
		Refer to needle syringe program (NSP)

Note: If mobilization for HIV Testing and Counseling was provided as part of the comprehensive prevention package, then the number of individuals mobilized should also be counted under the HE-148-PEPFAR indicator.

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. **Denominator:** Posts need to calculate the number of individuals in each key population at the sub-national level. The process and data source should be standardized by the inter-agency PEPFAR team. Key population estimates for sub-districts/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. Post can decide to share this number with PCVs or have staff enter it while reviewing VRFs.

2. **Key Populations Reached:** PCVs should report which target populations (female sex workers, PWID, MSM or transgender, MSM or transgender who are sex workers) were reached. They should report multiple target populations in the same intervention as separate activities.

3. **Note of deduplication:** The numerator can be generated by counting the number of deduplicated individuals from an activity defined target population who are reached with and complete a prevention intervention

designed for the intended key population. For example, it means that when a unique individual receives condoms and lubricant at more than one occasion during the reporting period, the person is counted once for being reached for this indicator.

4. **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.

5. **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).

6. **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.

7. **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.

8. **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).

9. **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, 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, 50+ 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