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| <p>STANDARD SECTOR INDICATOR CODE: HE-159-PEPFAR PEPFAR CODE: P1.2.N</p> | <p>Adhered to ARV Medications During Pregnancy: Number of HIV+ pregnant women reporting that they adhered to antiretroviral regimen during their pregnancy as a result of working with the Volunteer.</p> | |
| <p>HEALTH SECTOR</p> | <p>Sector Schematic Alignment</p> <ul style="list-style-type: none"> • Project Area: HIV Mitigation • Project Activity Area/Training Package: HIV Prevention | |
| <p>Type: Intermediate-term Outcome</p> | <p>Unit of Measure: HIV+ Pregnant Women</p> | <p>Disaggregation:</p> <p>Sex: Females Only Age: 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 individual must be an HIV+ women,
- The individual must have regularly participated in a group for pregnant women or a care and support group where the Volunteer or their partners encouraged and promoted adherence to antiretroviral medication,
- The individual must report that they took their ARVs as prescribed during pregnancy and labor,
- The Volunteer or their partner should ask to review documentation of monthly/weekly receipt of antiretroviral medications.

Definitions:

Medication Adherence is defined the ability to start, manage, and maintain a given medication regimen at the times, frequencies, and under specified conditions as prescribed by a health care provider.

Treatment adherence: refers to the ability of the patient to develop and follow a plan of behavioral and attitudinal change that ultimately serves to empower him/her to improve health and self-manage a given illness.

Promote: to help or contribute to bring about ARV adherence.

The WHO 2010 guidance on prevention of mother-to-child transmission of HIV refers to two key approaches:

- Lifelong antiretroviral therapy (three-drug regimen) for HIV infected women in need of treatment for their own health (with severe or advanced clinical disease (stage 3 or 4), or a CD4 cell count at or below 350 cells/mm3). This regime is also safe and effective in reducing mother to child transmission of HIV.
- Short-term antiretroviral prophylaxis (twice daily AZT) to prevent MTCT during pregnancy, delivery and breastfeeding for HIV infected women with CD4 cells counts above 350 cells/mm3.

Both regimes should be started at 14 weeks of pregnancy or as soon as possible thereafter.

Rationale: Establishing and maintaining excellent adherence to antiretroviral medication is necessary for viral suppression and the prevention of viral resistance. Suboptimal adherence is strongly associated with treatment failure including increased viral resistance, limited future treatment options, increased risk of HIV transmission to others, and increased mortality. After CD4 counts, adherence to antiretroviral medication has been called the next best predictor of progression to AIDS and death. Improving adherence to antiretroviral medication can reduce the risk of disease symptoms, progression of functional impairments, medical complications, co-morbidities, and health care utilization. Acceptable standards for adherence when treating HIV, is 95 percent or higher. Despite its importance, adherence rates may be only 50 to 70 percent or less in patients with HIV. The risk of mother- to- child-

transmission can be significantly reduced with the use of antiretrovirals for the mother. The Volunteer can play an important role in encouraging pregnant HIV+ women to access ARV services and adhere to their treatment regime.

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. 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:** Activity-level baseline data should be collected by Volunteers/partners before or at the start of their activities with an individual or group of individuals. It provides a basis for planning and/or assessing subsequent progress or impact with these same people. Volunteers should take a baseline measurement regarding the outcome(s) defined in this data sheet. Volunteers should collect baseline information early in their work with HIV+ mothers, and may use their judgment to determine timing because the information will be more accurate if the Volunteer has built some trust with HIV+ women first. The information for the baseline measurement will be the same or very similar to the information that will be collected in the follow-on measurement (see the bullet on “frequency of measurement”) after the Volunteer has conducted his/her activities and it is usually collected using the same data collection tool to allow for easy management of the data over time.

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:** For reporting accurately on this outcome indicator, Volunteers must take a minimum of two measurements with members of the target population reached with their activities. After taking the baseline measurement (described above), Volunteers should take at least one follow-on measurement with the same individual(s), typically 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. Please note that successful documentation of a behavior change or new practice may not be immediately apparent following the completion of activities and may need to be planned for at a later time.

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 a 'YES' response to question of whether or not HIV+ mothers have adopted one or more behavior(s) to reduce the risk of mother to child transmission of HIV during pregnancy and breastfeeding. This will need to be noted on the data collection tool to indicate accordance with the criteria.
- 6. General Reporting in the VRF:** The numerator or "number achieved" column in the VRF is where Volunteers will report the number of HIV+ pregnant women reporting that they adhered to antiretroviral regimen during their pregnancy as a result of working with the Volunteer. The denominator, or "total number" column in the VRF is where the Volunteer will report all HIV+ pregnant women who were in the group.
- 7. Reporting on Disaggregated Data in the VRF:** This indicator is disaggregated by "Age" and "Sex". 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: Reduced Maternal and Infant Morbidity and Mortality