STANDARD SECTOR INDICATOR CODE: HE-172 **PEPFAR CODE**: NA	**Able to Identify Two Practices to Support Care and Treatment including Adherence:** Number of PLHIV/caregivers able to identify at least two practices to support treatment and adherence.	
HEALTH SECTOR	**Sector Schematic Alignment** • **Project Area:** HIV Mitigation • **Project Activity Area/Training Package:** HIV Care, Support, and Treatment	
Type: Short-term Outcome	**Unit of Measure**: PLHIV, Caregivers	**Disaggregation:** **Sex:** Male, Female **Age:** 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+

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

- The individual must have participated in at least 1 hour of training on the best practices in positive living and treatment and adherence.
- 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.
- Attendance at educational session/s must be documented by the Volunteer or their partner.
- The individual must correctly identify at least two practices from the list below that have been shown to increase treatment adherence. For additional best-practices to promote treatment adherence, consult the Care, Support & treatment Training Package.

Definitions:

Medication adherence is defined as 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.

Evidence-based practices that have been shown to increase treatment adherence include:

- Regularly attending a treatment adherence support group coordinated by a Peace Corps Volunteer and counterpart
- Taking part in a peer support or buddy system to support treatment adherence
- Taking part in an incentive program like food supplementation with pick-up of ARVs
- Regularly attending scheduled health care provider appointments
- Taking part in a direct observation therapy (DOTS) program for medication adherence for at least 1 month
- Keeping a pill diary, pill count, pillbox system or taking part in a cell phone reminder system
- Trained as a lay counselor to address substance abuse or depression to support adherence
- Trained to provide peer support for adherence

PLHIV: Persons living with HIV

Rationale: 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. 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. Adherence involves more than taking ART as prescribed. It also includes retention in care and attending regular follow-up visits. Improving adherence to antiretroviral medication can reduce the risk of disease symptoms, progression of functional impairments, medical complications, co-morbidities, and health care utilization.

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 though there may be other data collection methods that are appropriate as well.

    a. A training pre & post-test survey: The survey should contain demographic information as required by the desegregations for this indicator as well as questions that test the individual's knowledge of the desired outcome or content to be addressed by the training. To capture knowledge gained from the session, the same test (survey) should be administered before and after the educational session.
    b. A sign-in sheet with post-test results: The sign-in sheet should contain demographic information as required by the desegregations for this indicator, with an additional column for test results. Although unable to determine knowledge gained, a test administered at the end of the training event through oral or written assessment will assess participants' grasp of the desired content.

    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.

    For this indicator, Volunteers should take a baseline measurement regarding the outcome(s) defined in this data sheet. Volunteers should collect baseline information by administering a pre-test (survey) just before an education session for PLHIV and caregivers on practices to support treatment and adherence. The information collected on the pre-test for the baseline measurement will be the same or very similar to the information on the post-test that will be collected in the follow-on measurement just after the education session.

    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 (pre-test described above), Volunteers should take at least one follow-on measurement (post-test) with the same individual(s), typically just 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 collected pre & post-test data, they should report on it in their next VRT.

   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 pre & post-test 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 VRT.

5. **Definition of Change:** The minimum change to report against this indicator is an individual created at least one new value-added product OR added value to at least one existing product or service as compared to what was measured initially at baseline. In the case of this indicator, if the person the Volunteer/partner works with has already created a value- added product by identifying *at least two practices to support treatment and adherence* before beginning to work with the Volunteer/partner (pre-test), 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 (post-test), the individual who was previously unable is now able to identify at least two practices to support treatment and adherence, that would count because the Volunteer's work influenced adding value to an existing product.

6. **General Reporting in the VRT**: The "number achieved" (or numerator) that Volunteers will report against for this indicator in their VRTs is the number of individuals who were previously unable (on pre-test) are now able to identify at least two practices to support treatment and adherence , after working with the Volunteer/partner (post-test). The "total number" (or denominator) that Volunteers will report on for this indicator in their VRTs is the total number of individuals who participated in the education session (who take the post-test).

7. **Reporting on Disaggregated Data in the VRT:** This indicator is disaggregated by "**Sex**" and "Age". See

disaggregation box above for specifics.
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