

<p>STANDARD SECTOR INDICATOR CODE: HE-170</p> <p>PEPFAR CODE: NA</p>	<p>Treatment and Adherence Support Groups Established: Number of adherence support groups established.</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 Care, Support, and Treatment 	
<p>Type: Output</p>	<p>Unit of Measure: Adherence Support Groups</p>	<p>Disaggregation:</p> <p>Sex: Male, Female</p> <p>Age: 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years</p>

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

- A Support Group must be established by the PCV in conjunction with his/her counterpart or partners.
- The group must have met at least once a week for no less than 6 months.
- The group must follow guiding principles and processes (*Check with the Care, Support & Treatment Specialist for a copy*) or any other evidence-based guidelines.
- There must be a process in place for local management and sustainability.

Definitions:

Support groups are a group of people with common experiences and concerns who provide psychosocial other support for one another. They usually have weekly or monthly group meetings. CDC reports that the majority of successful HIV Treatment Support Groups are led by the peers. Meeting discussions center on the identification of barriers to HIV treatment adherence, problem-solving strategies to overcome barriers, access to ARVs and other life issues that impact adherence, including HIV status disclosure, dating, substance use, and struggles with mental health issues.

Peer: is defined as the same age, sex, sexuality, background, social class, and/or subculture to a target group.

Examples of peer support groups that have been shown to increase adherence:

A study of 268 patients in **South Africa** found that support of a treatment buddy, community health workers or support group had better ART outcomes than those patients who did not. Treatment buddies reminded the patient to take ARV drugs and 75.9% of study participants reported that their treatment buddy helped their adherence. Community health workers provided emotional support and motivation for adherence. And 89.9% of support group members reported that the support group meetings helped them by sharing knowledge and experiences. Over 85% of patients rated treatment buddies, community health workers and HIV support groups as good or excellent. Of the 268 patients, 76.4% had CD4 counts over 200 after 24 months of ART. (Wouters et al., 2009b).

In **Vietnam**, people living with HIV served as peer assistants to help other people navigate the steps from HIV diagnosis to enrollment in HIV outpatient care clinics. National guidelines in 2010 have resulted in community teams trained to support adherence, resulting in a rate of retention of 90% in some districts. In one district, antiretroviral therapy retention improved from 66% to 85% between 2009 and 2010. (WHO et al., 2011b).

A study between 2008 and 2010 with 1,384 people living with HIV enrolled in 291 groups in **Mozambique** found that support groups led to increased adherence. ART distribution and monitored adherence was conducted by community groups in a model developed by Médecins Sans Frontières and provincial authorities. Patients who were stable on ART for six months were informed about the community ART group model and invited to form groups. Group members facilitated monthly ART distribution to other group members; provided adherence and social support; monitored

outcomes and ensured that each group member had a clinical consultation once every six months. Group members visited the health center on a rotational basis, so that each group member had contact with health services at least once every six months. Group members were followed for 12.9 months. Of the 1,301 patients still in community groups after 83 transferred, 97.5% remained in care, 2% died, and 0.2% were lost to follow up. In other health settings in this area, up to one in five patients are lost to follow up. To join a community support group, patients had to be clinically stable on ART for at least six months and have CD4 counts over 200. Counselors trained the newly formed groups on their roles and responsibilities. Group members could still visit the health center for any reason at any time. At the facility, the group representative discussed each group member with a counselor or clinician, covering issues of adherence, clinical status, etc. The group monitoring form was reviewed. Upon return to the community, the group representative distributed medications and returned patient appointment cards and if needed, requested a group member to go to the health facility for follow up. All members for different community groups were invited every six months for a group session held either in the community or the health facility to discuss when to go to the clinic for unplanned consultations, patient education on TB, etc. CD4 counts are taken. The majority of community group members were female (70%). Median gain in CD4 cell count since initiation was 478.5. Of the patients, 3.5% decided to transfer back to conventional care. (Decroo et al., 2011).

A qualitative study of women living with HIV in **Colombia** with six in-depth interviews and five focus groups with 47 women found that participation in support groups was associated with higher adherence. (Arrivillaga et al., 2011 Colombia).

Rationale: PLHIV form support groups to give and receive emotional, social and spiritual support, to develop and sustain positive strategies for living with HIV and to strengthen their knowledge. A support group is a place where PHIV can share experiences confidentially, gain self-confidence, make friends and develop a public voice to overcome barriers. Support groups reduce isolation and stigma related to HIV. With the help of a support group, PLHIV can overcome barriers, help to solve problems, and see that living with HIV is possible. Emotional support and reduction of stress can improve the physical as well as the emotional well-being of PLHIV

Measurement Notes:

1. **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 should be developed:
 - a. The name/title of the support group
 - b. Date started
 - c. Location where the support group meets: *community and premises*
 - d. Frequency of meetings
 - e. A brief description of the topics that meetings focus on
 - f. Number of facilitators and training provided
 - g. Names of organizations/partners collaborated with in implementing the intervention
 - h. Number of participants – *see disaggregation*
 - i. Source and amount of funding, if funds are used
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:** 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.
4. **Frequency of measurement:** An output indicator only needs to be measured once—in this case, every time the Volunteer establishes an adherence support group, he/she will want to keep track of the required information (reflected in the measurement notes) and report on it in the next VRF.
5. **Reporting:** In the case of output indicators, Volunteers fill the appropriate boxes in the VRF.
6. **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 *male and female*, in addition to the following age groups: 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: No Link