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| **STANDARD SECTOR INDICATOR CODE:** HE-171<br>**PEPFAR CODE**: NA | **Educated on Best Practices in Care and Treatment:** Number of PLHIV/caregivers educated on best practices in care and treatment | |
| **HEALTH SECTOR** | **Sector Schematic Alignment**<br>• **Project Area:** HIV Mitigation<br>• **Project Activity Area/Training Package:** HIV Care, Support, and Treatment | |
| **Type:** Output | **Unit of Measure**: PLHIV, Caregivers | **Disaggregation:**<br>**Sex:** Male, Female<br>**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:**

- Must have participated in at least 1 hour of training on the best practices in 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.

**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, including taking 95% of prescribed pills.

**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 with a 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

For additional best-practices to promote treatment adherence, consult the Care, Support & treatment Training Package.

**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. Please check PCLive for data collection tools. 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.

   You may also develop your own data collection tool, particularly for one-on-one, on-the-job training, and other forms of trainings. A data collection tool to measure this indicator could be based on the following standards:
   - Provide basic information on the trainee(s), including name, sex, age, HIV status, type of health care profession. (Note: If the use of names is restricted due to confidentiality concerns, ensure a proper coding system to effectively track individuals across the relevant services).
   - Title of the training and a brief description of the objectives or content.
   - Date(s) of training.
   - Where appropriate, pre-and post-test scores.
   - Any other information relevant for VRT reporting requirements.

   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. Also, share the tool with OGHH.

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 holds a training event (or series of events) on best practices in care and treatment, 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 VRT.

5. **Definition of change**: Outputs do not measure any changes. However, if desired, a minimum expectation can be set for meeting the output, which can be particularly useful in the area of training. For instance, a Peace Corps project may decide that for any training participant to be counted as having been sufficiently trained in a certain area, he/she needs to attend at least "X% of the training" or "X number of days of the training." If a specific requirement is not set forth here in the indicator data sheet, it is up to project staff to determine what minimum criteria they want to set (if at all).

6. **Reporting**: In the case of output indicators, Volunteers only have one box to fill in on their VRT: "total # (number)."

7. **Reporting on Disaggregated Data in the VRT:** This indicator is disaggregated by "Sex" and "Age". When reporting in the VRT, a Volunteer should disaggregate the total number of individuals by these specifications.

**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