

<p>STANDARD SECTOR INDICATOR CODE: HE-174 PEPFAR CODE: NA</p>	<p>Adopted One or More Behaviors to Support Care and Treatment: Number of PLHIV/caregivers adopting at least one new evidence-based behavior to increase treatment adherence and quality of care.</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: Intermediate-term Outcome</p>	<p>Unit of Measure: PLHIV, Caregivers</p>	<p>Disaggregation:</p> <p>Sex: Male, Female 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:

- The individual must have regularly participated in a care and treatment activity organized or facilitated by a PCV or their partner for at least 6 months.
- The activity or training must have been organized/provided by the PCV or their partner in an individual or small group setting. If training is provided, research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger. .
- The individual must have consistently practiced or taken part in at least one of the evidence-based practices listed below for a period of six months.
- The individual must have taken ARVs consistently for at least 6 months.

Definitions:

Adopting a new behavior is defined as consistently practicing a new behavior/practice for a period of not less than 30 consecutive days

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 the following activities organized by a Peace Corps Volunteer:

- Regularly attending a treatment adherence support group,
- 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 an attendance register, tracking sheet, or any other tracking tool that collects the following information:
 - a. Name of the individual. If the use of names is restricted due to confidentiality concerns, ensure a proper coding system to effectively track individuals across the relevant services.
 - b. Sex.
 - c. Age.
 - d. HIV status.
 - e. Type of service provided.
 - f. Attendance.
 - g. ARV adherence.

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.

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. For example, prior to admitting an individual to a support group, Volunteers should collect baseline information using a self-reported questionnaire or any other tool on the individual’s ART adherence record over the previous six months. The questionnaire (or any other tool) used for the baseline measurement will be the same or very similar to the tool used to collect the follow-on information after the Volunteer has conducted his/her activities (such as the support group meetings in this example). The use of the same data collection tool allows for easy management of the data and assessment of change 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 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 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 adopted at least one new evidence-based behavior to increase treatment adherence and quality of care as compared to what was measured initially at baseline. In the case of this indicator, if the person the Volunteer/partner works with is already attending all the required care and support services as well as adhering to ART at a level of 100%, 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, the individual decided to start participating in care & support services and increases adherence to ART from 75% prior to starting to 80% after three months of participation in the program, 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 have adopted at least one new evidence-based behavior to increase treatment adherence and quality of care. The “total number” (or denominator) that Volunteers will

report on for this indicator in their VRTs is the total number of individuals who have ever participated in the activities designed to meet this indicator.

- 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: PLHIV Served