

<p>STANDARD SECTOR INDICATOR CODE: HE-182</p>	<p>Addressing Stigma related to HIV - Number of the general population with accepting attitudes toward people living with HIV</p>	
<p>HEALTH SECTOR</p>	<p>Sector Schematic Alignment</p> <ul style="list-style-type: none"> • Project Area: HIV Mitigation <ul style="list-style-type: none"> • Project Activity Area/Training Package: HIV Prevention 	
<p>Type: Short-term Outcome</p>	<p>Unit of Measure: General Population</p>	<p>Disaggregation:</p> <p>Sex: Male, Female Age: 0-9 years, 10-14 years, 15-17 years, 18-24 years, and 25+ years.</p>

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

- The individuals must have received at least 1 hour of training or provision of services that had clearly defined goals and objectives **and**
 - Was based on sound behavioral and social science theory
 - Was focused on reducing specific stigma behaviors
 - Had activities that addressed the targeted stigma reducing behaviors
 - Employed instructionally sound teaching methods
 - Provided opportunities to practice relevant stigma reduction concepts
- The training or services must have been provided by the PCV or their partners in an individual or small group setting comprised of no more than 25 people
- Provide opportunities to practice relevant stigma reduction skills
- Attendance in the session/s must be documented by the Volunteer or their partner

Definitions:

HIV-Related Stigma- This refers to unfavorable attitudes, beliefs, and policies directed toward people living with HIV and their family members, close associates and communities.

HIV awareness programs- These are programs designed to increase accepting attitudes toward people living with HIV or those perceived to be living with HIV.

Rationale: This indicator measures accepting attitudes toward people living with HIV among women and men aged 15-49. HIV-related stigma can reduce the effectiveness of programs and services designed for those living with HIV and those who are affected by the disease. For example, studies have shown that some families with orphans have chosen not to receive relief services in order to avoid the stigma attached to these benefits. Other studies found that some families cut themselves off from social support networks long before an AIDS death occurs in the family in order to avoid HIV-related stigma.

This indicator provides a measure of the effectiveness of HIV awareness programs and can highlight whether more needs to be done to counter HIV-related stigma.

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. 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. Volunteers should collect baseline information early in their work with the general populations, and may use their judgment to determine timing because the information will be more accurate if the Volunteer has built some trust with the general population 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:** This indicator measures the percentage of the population with accepting attitudes toward people living with HIV, and it provides a measure of HIV-related stigma. It is not, however, a perfect measure of HIV-related stigma. While a low value for the indicator suggests high level of HIV-related stigma, a high value for the indicator could be interpreted in several ways: that there are low levels of HIV-related stigma, or that people know they should not discriminate and therefore report accepting attitudes. High scores may also reflect the respondent's limited personal experience with HIV.

Another limitation of this indicator is that there is frequently not a direct relationship between attitudes and behavior. What people actually do in the face of HIV may well differ from what they say they would do. Some studies have found, for example, that people expressing very negative attitudes toward those living with HIV actually provide supportive care for an HIV-infected relative in their own home. On the other hand, some people who deny having negative attitudes towards people with HIV may actively discriminate against them in specific settings, such as in the provision of health care.

The numerator is calculated by first asking survey respondents if they have ever heard of HIV. If they answer yes, then they are asked a series of questions about people with HIV, including:

- If a member of your family became sick with the HIV virus, would you be willing to care for him or her in your household?
- If you knew that a shopkeeper or food seller had the HIV virus, would you buy fresh vegetables from him/her?;
- If a female teacher has the HIV virus but is not sick, should she be allowed to continue teaching in school?; and
- If a member of your family became infected with the HIV virus, would you want it to remain a secret?

Only respondents who report an accepting or supportive attitude on all four of these questions is counted in the numerator. An accepting attitude for the respective questions is considered to be (1) yes; (2) yes; (3) yes; and (4) no.

The denominator consists of all respondents in the survey who have heard of HIV.

6. **General Reporting in the VRF:** This indicator is intended to capture changes in behavior regarding accepting attitudes toward people living with HIV (PLHIV). The “number achieved” (or numerator) is all women and men who report an accepting attitude on all four of these questions. The “total number” (or denominator) that Volunteers will report all women and men aged 15-25+ surveyed who have heard of HIV.
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: HIV Prevention