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THE DAC NETWORK ON DEVELOPMENT EVALUATION

Evaluation Insights

Preventing HIV

Lessons from evaluations

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Spending on the international response to HIV rose dramatically from $300 million in 1996 to more than $15 billion in 2009 (Kaiser Family Foundation, 2010). But, in its 2011 World AIDS Day report, the Joint United Nations Programme on HIV/AIDS (UNAIDS) raised concerns that the current economic crisis and dwindling international resources had reduced financing available for the AIDS response. UNAIDS argued that it was of critical importance to ensure resources are invested wisely to maximise return and achieve value for money. To do this, evidence is needed regarding effective and efficient ways to spend funds available to HIV responses. Evaluations are potentially a valuable source of such evidence.

In 2008, however, a synthesis study, commissioned by the Ministry of Foreign Affairs of Denmark, concluded that the international community lacked knowledge about how to spend the considerable funds raised, particularly in relation to HIV prevention, because there had been a failure to collect and analyse this knowledge and to make it available to others. In 2009, its second five-year evaluation recommended that UNAIDS should convene a working group to develop a coherent joint global evaluation plan structured around the priority areas of the epidemic. As a first step, the UK's Department for International Development (DFID) and UNAIDS conducted a stock take of who was doing what in terms of HIV evaluation internationally. Results of this stock take were presented to a meeting of the UNAIDS Monitoring and Evaluation Reference Group (MERG) in February 2011. That stock take exercise did not, however, involve identification of evaluation reports or review of their findings. In 2011, DFID commissioned a study to synthesise evidence from completed HIV/AIDS evaluations. The aim of this study was to build on the earlier stocktaking exercise conducted by DFID and UNAIDS in order to provide a synthesis of current knowledge on HIV prevention.

Photo 1. Children holding an HIV banner at the 20th World AIDS Day event in Fitche, Ethiopia. (2008)

This edition of Insights seeks to present the findings and conclusions from the DFID synthesis study of relevance to HIV prevention. This study identified a total of 61 evaluation reports focused on a range of different prevention topics.

Note: Full details on all studies mentioned here are provided in the References section.

HIV EVALUATIONS AND THEIR THEMATIC FOCUS

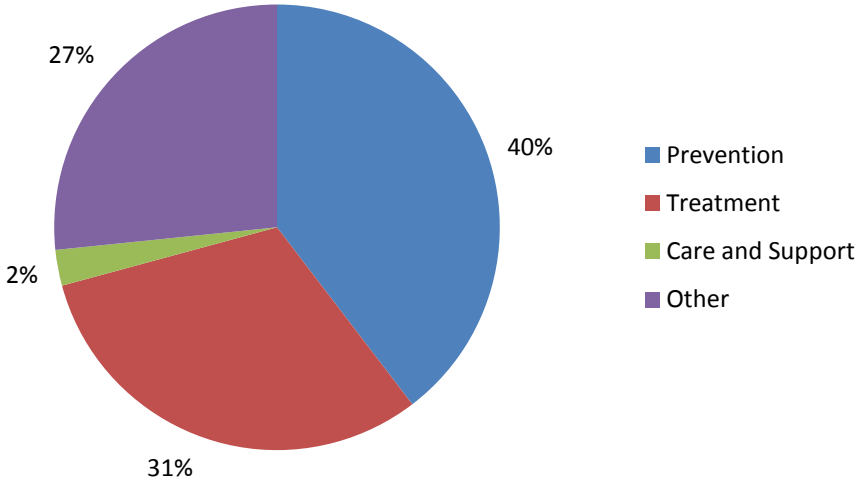
In the stocktaking exercise, 548 evaluation studies were self-reported by 16 international agencies, including eight bilateral donors, seven multilateral organisations and the Gates Foundation. Evaluation studies were defined as the rigorous, scientifically-based collection of information about programme/intervention activities, characteristics and outcomes that determine the merit or worth of the programme/intervention. Evaluation studies were considered to include:

1. Operational research, which is defined as the systematic and objective assessment of the availability, accessibility, quality, and/or sustainability of services designed to improve service delivery.
2. Evaluation studies using secondary data analysis such as a meta-evaluation or a meta-analysis. Studies of this type included evidenced opinion pieces, a small number of meeting reports, literature reviews and systematic reviews.

Reported studies that were not considered to meet these criteria were excluded. Common reasons for exclusion included studies which were considered situation analyses or unevidenced opinion pieces. Most of the reported studies were published in the period 2007 to 2011. Full details of method and details of all references are available in the report of the study (DFID, 2012).

A total of 154 evaluation reports were reviewed. Of these, almost half (40%) related to prevention with just under one third (31%) related to treatment. Relatively few (2%) related to care and support while just over a quarter (27%) related to other areas (see Figure 1). The different types of topics classified to these thematic areas are summarised in Box 1.

Figure 1: Thematic focus of identified evaluation reports



HIV PREVENTION: LEARNING FROM PREVIOUS EVALUATION SYNTHESES

The 2008 DANIDA synthesis study referred to earlier focused on HIV-related prevention evaluations supported by donors and concluded that:

- Almost all were based on a combination of desk reviews of the available documentation, case studies/field visits and interviews with key stakeholders
- They did not establish the baseline prior to intervention
- They usually did not collect primary data
- They usually did not include a control group to assess programme effects
- There were very few examples of peer-reviewed papers/processes. Where these were available, they largely focused on small scale projects and did not provide sufficient guide for scaling up efforts

- They usually failed to distinguish between whether programme failure resulted from faulty programme design or poor programme implementation
- They usually relied extensively and excessively on use of case stories
- They rarely, if ever, had any focus on cost, cost effectiveness and sustainability
- They rarely, if ever, attempted to link programme outputs to outcomes and impact
- They tended to focus on very broad national indicators rather than more specific programme indicators

However, the DANIDA study considered that there was sufficient evidence available to draw the following conclusions for a range of common HIV prevention interventions:

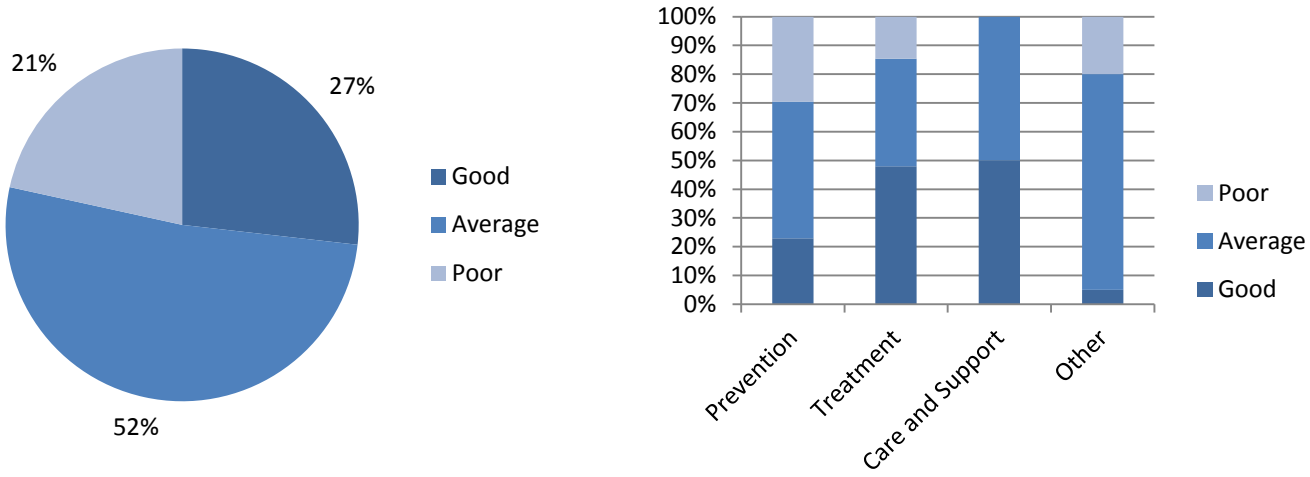
- Although information campaigns increase knowledge, there was limited evidence on outcomes or impact
- Similarly school-based prevention programmes may improve knowledge but show less changes in attitudes and behaviour
- There was no solid evidence base relating to programmes for out-of-school youth
- Data from condom marketing programmes was largely limited to the numbers of condoms distributed
- Data from studies of treating STIs was conflicting
- Data relating to voluntary counselling and testing was mixed but VCT appears to contribute to reducing risky sexual behaviour among recipients
- Randomised controlled trials of male circumcision showed a reduction in HIV incidence in both Rakai and Kisumu
- The administration of a short course of antiretroviral drugs is effective in reducing HIV transmission from mother to child

PREVENTION EVALUATIONS WERE OF LOWER QUALITY THAN TREATMENT EVALUATIONS

Many of the issues raised in the DANIDA synthesis study relate to the relatively poor quality of HIV prevention evaluations prior to 2008. This study confirms similar findings for the period to 2007 to 2011, although the number of evaluation reports reviewed was much higher than for the DANIDA study.

All the evaluation reports reviewed were classified as good, average or poor based on an assessment of the description of method. Overall, more than half (52%) of all documents were rated average quality, more than a quarter (27%) were rated good and slightly less than a quarter (22%) were rated poor (see Figure 2). However, less than a quarter (23%) of prevention-related evaluation reports were considered good compared to almost half (48%) of treatment-related reports (see Figure 2).

Figure 2: Perceived quality of reviewed documents overall and by thematic area



Box 1: Topics classified to each thematic area

Where possible, the categorisations used by agencies were retained. For this reason, HIV testing and counselling was classified as prevention, programmes focused on antiretroviral therapy (ART) adherence were classified as treatment and services for orphans and vulnerable children were classified as 'other'. In general, the following approach was adopted:

Prevention included papers on HIV testing and counselling; HIV disclosure; services for particular populations including men who have sex with men, sex workers, migrants/mobile populations, people who inject drugs/injecting drug users; pre-exposure prophylaxis; male circumcision; effect of alcohol on behaviour and HIV transmission; prevention of mother to child transmission; cash transfers; schools programmes; and condoms.

Treatment included various aspects of ART delivery including different models of delivery, cost and cost effectiveness. Other topics covered included adherence monitoring and support; prevention and treatment of malaria among people living with HIV; laboratory monitoring of people living with HIV; effect of funding crisis on HIV services[1]; task shifting; treatment and management of opportunistic infections including tuberculosis and cryptococcus; and resistance to antiretroviral medicines.

Care and support was used not only for services described explicitly as care and support but also included papers focused on services specifically for people living with HIV.

'Other' included evaluations of national HIV responses; evaluations of other broad programmes; evaluations of the roles of NGOs and communities; and all programmes focused on providing services for orphans and vulnerable children. 'Other' also covered some papers[1] which covered more than one of the thematic areas highlighted in this synthesis – prevention, treatment and care and support.

One possible reason for this was that prevention-related reports were less frequently published in peer–reviewed journals than those focused on treatment. The proportion of prevention-related reports published in peer-reviewed journals was 11% whereas for treatment-related evaluation reports the percentage was 79%. Almost half (46%) of the reports published in peer-reviewed journals were rated good, as compared to only one sixth (17%) of those in the grey literature.

However, one drawback of publishing reports in peer-reviewed journals is that they rarely include recommendations as specified in the OECD DAC principles for the evaluation of development assistance (OECD DAC, 1991). Indeed, although almost two thirds (63%) of evaluation reports in the grey literature contained recommendations, this was only the case for 15% of reports published in peer-reviewed journals.

ALTHOUGH CONDOM PROGRAMMES RESULT IN INCREASED REPORTED USE, EVALUATIONS ARE OFTEN NOT ROBUST

Evaluations of "100% condom programmes" in both Thailand and Indonesia concluded that the programmes were effective. For example, in Thailand, the evaluation claimed directly that the programme resulted in high rates of condom use in commercial sex and in reduced incidence of STIs. However, there are significant issues with these claims. First, both studies lacked a rigorous counterfactual, that is, a clear measure of what would have happened in the absence of the intervention, for example, as might be provided by having control or comparison groups which did not benefit from the intervention. As a result, it is not possible to state that an observed change occurred because of the intervention. Second, the assumption is made that certain observed changes, e.g. increasing condom use or reduced STI incidence will lead to reduced HIV incidence. This means that these measures are being used as 'proxies' of HIV incidence. This is however based on assumption and no evidence is provided that this is the case.

These issues of weak/missing counterfactuals and use of flawed proxy indicators for HIV incidence have undermined the evidence from many HIV prevention-related evaluations. For this reason, they are highlighted here. Rigorous evaluations of the effectiveness of HIV prevention interventions require a robust counterfactual and biological measures of HIV incidence as indicators of impact.

EVIDENCE FOR THE EFFECTIVENESS OF BEHAVIOUR CHANGE PROGRAMMES WAS NOT IDENTIFIED

Disappointingly, no direct evaluation evidence was identified related to behaviour change programmes and this remains a significant gap in the HIV knowledge base. A document was reviewed which consists of a report from the Global HIV Prevention Working Group in 2008 focused on (re)considerations of behaviour change and HIV prevention for the 21st century. Essentially, this is an evidenced opinion piece produced by an expert group. One important strength of the paper is in advocating for a range of evaluative methods to answer questions related to HIV prevention that cannot be answered solely through experimental methods. One example the paper provides of such questions relates to trying to understand the key success factors in countries which are recognised as having been successful in their HIV prevention efforts, e.g. Australia, Senegal and Uganda.

Photo 2. Local NGO staff teaching sex workers about the risk of HIV/AIDS. Cambodia. (World Bank/Goto, 2002)

MALE CIRCUMCISION IS A COST EFFECTIVE METHOD OF PREVENTION IN HIGH PREVALENCE SETTINGS

In 2008, a round table meeting on male circumcision was convened by the Forum for Collaborative HIV Research, the Gates Foundation, WHO and UNAIDS to review current research, gaps in knowledge and recommendations for additional research. It concluded that:

- Male circumcision is cost-effective in high prevalence settings and may be cost-saving
- Male circumcision shows a positive indirect impact on women at the population level due to the lowered prevalence of male HIV infection, if at least 5% of the male population is circumcised
- Behavioural risk compensation among circumcised men does not outweigh the benefits of male circumcision at the population level

Early post-operative resumption of sexual activity has a small effect at the population level, though the effect on the individual level may increase the risk of HIV acquisition or transmission and does delay wound healing. The report of the round table meeting also summarised results of individual studies (see Box 2).

Box 2: Evidence on male circumcision from individual studies (2008)

The Universities of Nairobi, Illinois, and Manitoba (UNIM) trial was continuing. Approximately 1,700 young men were still enrolled in the post-trial cohort, and they were being tested for HIV and STIs every 6 months. The study also included a behavioural questionnaire and the young men were expected to receive counselling. Preliminary results from the 42-month follow-up showed a protective effect of male circumcision that increased over time.

In South Africa, the Orange Farm phase 4 study, started in 2007 looked at implementation strategies. The goal was to offer free and safe male circumcision to 40,000 men over two years. Results from the baseline analysis of the study were published in 2008. They showed, for example, that more than two thirds (67.5%) of uncircumcised men intended to be circumcised in the future.

The Rakai site in Uganda encompassed four research areas: epidemiological, clinical, operational and basic science. As of 2008, Rakai had 3 years of follow up data available. Those preliminary results indicated a reduced acquisition of HSV-2 among circumcised men. The results also confirmed the increasing efficacy of male circumcision over time. The incidence of HIV infection per 100 patient-years among circumcised men was 1.2 between months 0-6 post-circumcision; 0.4 between months 6-12; 0.3 between months 12-24 and 0.0 between months 24-36 post circumcision. The incidence of HIV infection per 100 patient-years among uncircumcised men in the control group ranged between 1.2 and 1.8 during the same time periods. Adverse events and time required for surgery decreased as the number of surgeries increased. Adverse events were higher among those who initiated sex before healing was certified. Male circumcision provided benefits to women including significant reductions in genital ulcer disease, trichomonas, bacterial vaginosis and severe bacterial vaginosis.

PROVIDING CASH TRANSFERS TO YOUNG WOMEN CAN CONTRIBUTE TO REDUCING HIV TRANSMISSION

Data from Malawi in 2011 showed that, eighteen months after the cash transfer programme began, the HIV prevalence among programme beneficiaries was 60% lower than among the control group. Similar effects were seen in HSV-2 (herpes simplex virus) prevalence. However, the follow-up period was relatively short and some reviewers have questioned whether the improvement will be sustained over time. Some reviewers have also questioned elements of the methodology including the decision not to measure HIV prevalence among control and intervention groups at the start of the programme. This, they argue, means that the difference in prevalence between control and intervention groups could be because of some difference between the groups other than whether they received cash transfers or not.

There was no significant difference in HIV or HSV-2 prevalence between those offered conditional or unconditional payments. However, conditional cash transfers were more effective than unconditional cash transfers in increasing school enrolment rates, in improving regular school attendance and in increasing English reading comprehension. However, unconditional cash transfers were more effective than conditional cash transfers in reducing teenage pregnancy and teenage marriage rates. Some reviewers have questioned though whether the study had sufficient statistical power to distinguish between the value of different types of cash transfer.

THERE ARE MANY WAYS OF INCREASING UPTAKE OF HIV TESTING: SOME METHODS WORK BETTER THAN OTHERS FOR PARTICULAR GROUPS AND IN PARTICULAR SETTINGS

There are many ways of increasing uptake of HIV testing. Evidence from Senegal showed that traditional methods of social mobilisation were more effective among men and peer mentoring methods were more effective among women. A systematic review of data related to HIV testing concluded that uptake of HIV testing can be increased by:

- Offering HIV testing routinely in health settings
- Mass media campaigns
- Training health care providers
- Replacing written informed consent with verbal consent
- Replacing pre-test counselling with brief pre-test information
- Replacing post-test counselling with brief post-test information for those who are HIV negative
- Greater use of rapid, point-of-care tests

A systematic review, published in 2012 in the Lancet, compared rapid, point-of-care HIV testing with oral specimens with whole blood specimens. The review found that although the positive predictive value of the two methods was similar in high prevalence settings, it was slightly lower for methods using oral specimens in low prevalence settings.

A Population Council study in Kenya demonstrated that it is feasible and acceptable to health care workers to self-test for HIV. However, the study had significant limitations. It did not demonstrate that self-testing increased the number of health workers having HIV tests. It did not show that self-testing was more effective or more cost-effective than other forms of HIV testing. It did not present any evidence that self testing for HIV increased the number of HIV diagnoses or contributed to earlier HIV diagnosis.

A systematic review of HIV disclosure in diverse settings concluded that structural changes, including making more services available, could facilitate HIV disclosure as much as individual approaches and counselling.

Photo 3. Child being tested for HIV/AIDS at Chernigov child rehabilitation center, Ukraine (World Bank/Yuri Mechitov)

TREATMENT CAN CONTRIBUTE TO PREVENTION INCLUDING USING ANTIRETROVIRAL DRUGS FOR PRE-EXPOSURE PROPHYLAXIS (PREP)

A randomised controlled trial in Kenya and Uganda concluded, in 2011, that pre-exposure prophylaxis among sero-discordant couples was effective in preventing HIV transmission. In this trial, the HIV uninfected partners in sero-discordant couples were randomly assigned to one of three study groups. One of the groups received tenofovir only, one group received a combination of tenofovir and emtricitabine and the final group received a placebo. As of May 2011, a total of 78 HIV infections had occurred – 18 among those on tenofovir, 13 among those on tenofovir and emtricitabine and 47 among those receiving a placebo. Those receiving tenofovir had an average of 62% fewer HIV infections and those who received tenofovir and emtricitabine had an average of 73% fewer HIV infections than those who received placebo. The differences between the use of tenofovir alone or in combination with emtricitabine were not statistically significant. Research into the most effective form of PrEP continues. The authors concluded that pre-exposure prophylaxis (PrEP) is an important strategy to prevent HIV infection. Studies are now underway as to how PrEP can be provided at scale outside of trial settings.

ANTIRETROVIRAL MEDICINES ARE EFFECTIVE AT PREVENTING HIV TRANSMISSION FROM MOTHER TO CHILD

There is a substantial body of evidence related to the effectiveness of programmes to prevent mother to child transmission of HIV. In 2010, an expert panel reported on preventing mother to child transmission to the US Congress and Global AIDS Coordinator. This recommended four 'prongs' to services to prevent mother to child transmission of HIV:

- Prevention of HIV among women of childbearing age
- Prevention of unintended pregnancies among women living with HIV
- Prevention of transmission of HIV from mothers living with HIV to their infants
- Treatment, care and support for mothers living with HIV, their children and families

The panel recommended addressing the third and fourth prongs through a PMTCT cascade consisting of:

- Antenatal care attendance
- HIV counselling and testing with same day return of results to the woman
- Determination of eligibility for HIV treatment through CD4 count assessment (or less optimally, through clinical staging) with rapid return of results to the woman and her provider
- Provision of antiretroviral therapy for women who require therapy for their own health and antiretroviral prophylaxis to prevent mother-to-child transmission to women who do not yet require therapy
- Adherence to HIV treatment or prophylactic regimens as medically appropriate
- Safe labour and delivery services
- Timely provision of HIV prophylactic regimens and cotrimoxazole for the infant
- Safe feeding practices for the infant (see findings below)
- Early follow-up HIV testing for the infant with rapid initiation of antiretroviral treatment for those who are infected, and testing to determine final HIV status in breastfed infants
- Ongoing, clinical, psychological and social care, support and monitoring for the mother, infant and family

The panel reviewed experience of implementing the previous WHO recommendations on infant feeding. These had recommended exclusive breastfeeding for all women unless formula feeding could be shown to be acceptable, feasible, affordable, sustainable and safe. These requirements were collectively known as the AFASS criteria. The panel concluded that these criteria had been difficult to implement and had been extremely confusing, largely because of complexities in applying these criteria to situations which varied widely in terms of individual women's circumstances and levels of knowledge of healthcare workers providing counselling and support. Given the results of trials which showed that antiretroviral drugs taken by the mother significantly decrease breast milk transmission, WHO now recommends that countries develop their own national plan for feeding guidance for all infants of HIV-positive women. Where this involves breastfeeding, this should be exclusive breastfeeding for 6 months followed by continued breastfeeding with appropriate complementary feeding through age 12 months accompanied by antiretroviral prophylaxis of the infant or mother to prevent breast milk HIV transmission. However, the shift away from individual client choice to national level plans for all HIV-infected women remains an area of controversy.

In 2010, a systematic review was conducted of HIV- free survival by feeding practice. This also looked for evidence of death from other causes, such as infectious diseases and malnutrition. Although the data available to answer these questions was considered of moderate to low quality, the review concluded that there was:

- Moderate quality evidence to support exclusive breastfeeding up to 6 months compared to replacement feeding or mixed feeding
- Low to very low grade evidence to support continued breastfeeding for 6 to 12 months and 12 to 24 months respectively
- Moderate quality evidence that abrupt cessation of breastfeeding or weaning had adverse health outcomes in terms of morbidity and mortality between 12 to 24 months of life

The review concluded that "the significance of these findings should be considered alongside the evidence on antiretroviral interventions to reduce postnatal transmission of HIV."

Photo 4. **A young mother breastfeeding her child in Lilongwe, Malawi. (2010)**

'HARM REDUCTION' PROGRAMMES ARE EFFECTIVE FOR PREVENTING HIV TRANSMISSION AMONG PEOPLE WHO INJECT DRUGS INCLUDING IN PRISON SETTINGS

There have been a number of systematic/literature reviews of the evidence of the effectiveness of HIV prevention programmes among people who inject drugs. A UK-based systematic review in 2008 concluded that the evidence was good that needle and syringe programmes reduced injecting risk behaviour among those who inject drugs. The review was less clear on the evidence for needle and syringe programmes reducing HIV incidence. Two reviews concluded that the evidence for this was 'good' while one concluded that the evidence was 'less than robust'. The review concluded that needle and syringe programmes were less effective in reducing hepatitis C transmission than in reducing HIV transmission. This was based on two reviews which concluded that the evidence that needle and syringe programmes reducing transmission of infection among injecting drug users was less for hepatitis C than for HIV.

However, a 2004 WHO literature review concluded that there was 'compelling' evidence that needle and syringe programmes reduce HIV infection 'substantially'. It also concluded that:

- There was no evidence of any major, unintended consequences
- Needle and syringe programmes were cost-effective
- Needle and syringe programmes had benefits in addition to HIV prevention including increasing recruitment to drug treatment programmes
- Bleach and other forms of disinfectant were not well-evidenced
- Pharmacies and vending machines increased the availability and probably the utilisation of sterile needles and syringes
- Injecting paraphernalia legislation was a barrier to effective HIV control
- Needles and syringe programmes were not sufficient alone to prevent HIV transmission among people who inject drugs

A 2010 literature review conducted for a US audience also concluded that the evidence was 'overwhelming' that needle and syringe programmes and medically-assisted treatment are both highly effective in preventing spread of HIV among injecting drug users.

In addition, a 2011 study in Vietnam showed a strong link between good programme coverage for injecting drugs users and stable or declining HIV prevalence among injecting drugs users. The modelling aspect of the study estimated that scaled up harm reduction programmes could reduce new HIV infections among injecting drug users by more than 50%.

In 2009, WHO compiled a series of comparative country case studies focused on assessing compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Vietnam. It found that these centres lacked effective drug treatment services. They also lacked HIV prevention or care services. It concluded that people who use drugs were at risk in these settings.

Finally, a number of individual project evaluations and a Canadian literature review included material related to harm reduction activities in prison/custodial settings. The literature review concludes that needle exchange programmes are an effective harm reduction measure and that experience shows that such programmes in prison:

- Do not endanger staff or prisoner safety, and in fact, make prisons safer places to live and work
- Do not increase drug consumption or injecting
- Reduce risk behaviour and disease, including HIV and HCV, transmission
- Have other positive outcomes for the health of prisoners
- Have been effective in a wide range of prisons
- Have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons.

HIV PROGRAMMES TARGETED AT SEX WORKERS ARE EFFECTIVE IN PREVENTING HIV TRANSMISSION

A randomised control trial in Armenia in 2010 showed that a single, 2-hour, face-to-face session implemented by a trained health educator resulted in more consistent condom use with clients as reported by sex workers and more sex workers reporting applying condoms on clients. The main limitation of this study is that the measured end point was self-reported condom use and not a biological measure of HIV transmission. A modelling study, conducted in India and published in 2011, concluded that HIV prevention programmes among sex workers were a cost-effective strategy for India.

A WHO literature review, conducted in 2011, described three types of interventions among sex workers. These included interventions for preventing HIV acquisition among female sex workers; treatment, prevention and care for sex workers living with HIV and prevention of HIV among clients of sex workers. Interventions for preventing HIV acquisition among female sex workers were divided into three types:

- Reducing the demand for unprotected sex – evidence was presented from five studies that targeted HIV prevention programmes for sex workers and their clients result in increased condom use. In one of these studies, increased condom use was associated with reduced STI and HIV prevalence.

- Reducing HIV transmission by diagnosing and treating STIs – evidence was identified from three studies which reported reduced STI and HIV incidence among sex workers.

- Empowering sex workers through a range of methods including sex work networks and organisations; information, education and communication; voluntary HIV testing and counselling; increasing skills for condom negotiation and prevention of gender-based violence. Some studies showed evidence of such initiatives increasing knowledge or condom use. Studies of voluntary HIV testing and counselling among sex workers in the US and Kenya showed that sex workers who knew they were HIV positive curtailed their sex work activities, had less unprotected sex and reduced drug use (in the US) and reported fewer sexual partners and higher condom use (in Kenya). In one South African study, an intervention to enhance skills, increase self-efficacy and empower sex workers who used drugs resulted in a decrease in substance use and STI symptoms.

Photo 5. Programme to empower sex workers and reduce HIV transmission, Sonagachi, Kolkata, India. (2012)

LIMITED EVIDENCE WAS IDENTIFIED CONCERNING HIV PREVENTION PROGRAMMES AMONG MEN WHO HAVE SEX WITH MEN, MIGRANT POPULATIONS AND ETHNIC MINORITIES

There is relatively limited evidence about the effectiveness of HIV prevention programmes among men who have sex with men (MSM). A European systematic review in 2009 identified six relevant controlled studies in four countries. However, all were considered to have a high or unclear risk of bias, and only one used a biological measure of STI as an indicator of change. Although the review concluded that there was some evidence of a short term reduction in the proportion of men who have sex with men reporting unprotected sex, the main conclusion of the review was that "rigorous outcome evaluations of any form of behavioural HIV/STI intervention for MSM in Europe are few and far between. There is an overall deficit in outcome evaluations of interventions aimed at reducing HIV/STI risk behaviour among MSM in Europe."

Similarly, in 2010, the International HIV/AIDS Alliance in Ukraine produced a document which featured case studies from eight Eastern European countries. This concluded that "reviews and evaluations of MSM programs are uncommon. There is insufficient available data to come to conclusions regarding the quality of MSM prevention programs, although most key informants are of the view that there is room for significant improvement. There is no consensus at either the regional or national level as to what should constitute a comprehensive package of services for MSM, nor a clear definition of what those services actually are."

Evidence relating to the effectiveness of HIV prevention programmes among migrants and ethnic minorities is very limited. One systematic review in Europe identified more than 30 relevant studies but found that most of them were qualitative in nature. As a result, the review was largely descriptive with little or no empirical evidence.

DISCUSSION

Overall, the evaluation reports reviewed provide strong evidence for the effectiveness of a range of HIV prevention interventions. These include male circumcision; the provision of cash transfers to young women; pre-exposure prophylaxis with antiretroviral medicines for HIV uninfected partners in serodiscordant couples; prevention of mother to child transmission and targeted prevention programmes for people who inject drugs and sex workers. Nevertheless, there are outstanding questions in many of these areas which merit further enquiry, such as the optimal antiretroviral combination for pre-exposure prophylaxis.

Less evidence was identified in a number of other areas and these would benefit from further evaluations. These areas include behaviour change programmes; condom distribution programmes and targeted programmes for men who have sex with men, migrants and ethnic minorities. It is of concern that evidence is most limited in some areas where activities are longstanding and most funds have been spent, for example on behaviour change programmes in sub-Saharan Africa.

If evaluation studies are to be carried out of interventions in these areas, it is important that they are rigorous and of high quality. It is of particular importance that they should have a robust counterfactual and that, for HIV prevention studies, the measured end point should be a reliable biological indicator of HIV transmission. Where activities and approaches do not make the use of conventional, experimental and quasi-experimental approaches to impact evaluation possible, alternative designs and methods may be available (Stern et al., 2012). Report quality may be improved by publishing in peer-reviewed journals. However, if this is done, it may be necessary to also produce additional briefing papers which clearly articulate the practical recommendations coming from the work conducted in order to link the learning to improved policy and programme design.

Photo 6. Gloria Lobi who is HIV positive, in Khayelitsha township outside Cape Town, South Africa, where the Treatment Action Campaign is holding an AIDS awareness campaigning (World Bank / Trevor Samson, 2002)

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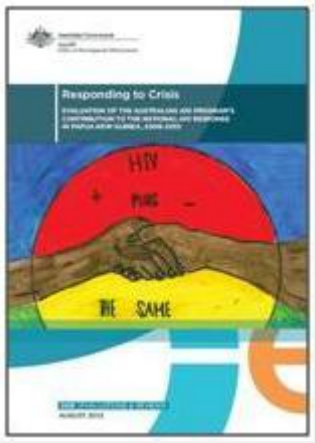
Evaluation Insights are informal working papers issued by the Network on Development Evaluation of the OECD Development Assistance Committee (DAC). These notes highlight emerging findings and policy messages from evaluations and share insights into the policy and practice of development evaluation. All notes are available at: http://oe.cd/evalinsights. This note presents learning on HIV prevention from a synthesis study conducted by the Department for International Development, United Kingdom, which reviewed learning from more than 150 reports of HIV-related evaluations. It was written by Roger Drew and peer reviewed by Amie Heap and Patrick Kaburi.

The macroeconomic impact of HIV/AIDS and HIV/AIDS interventions

July 2012

http://www.oecd.org/derec/publicationsdocuments/health/

A large number of cost-effectiveness assessments of HIV/AIDS interventions have been undertaken. A number of systematic reviews have demonstrated the diverse nature of these evaluation studies, different with respect to e.g. impact indicator, type of epidemic, type of intervention, etc. These assessments generally focus on evaluating either single or multiple interventions--the sheer number of different methodologies thus makes it difficult to summarize the results of cost-effectiveness assessments. While one methodology may be appropriate for capturing the financial impact of interventions for specific agents, it may not be appropriate for assessing the macroeconomic impact of overall intervention strategies in affected Sub-Saharan African countries.

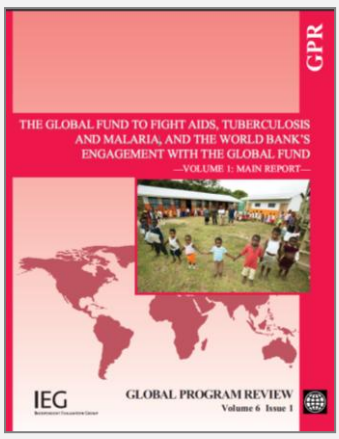


Responding to Crisis: Evaluation of Australia's contribution to the national HIV response in Papua New Guinea

August 2012

http://www.oecd.org/derec/publicationsdocuments/health/

AusAID responded to signs that the HIV epidemic in Papua New Guinea was becoming an emergency by establishing a dedicated HIV program. When it became clear that the public sector would struggle to implement key interventions, AusAID sought to achieve greater impact by shifting its efforts towards implementing organisations outside the public sphere with greater capacity and commitment. Overall the evaluation concurs with the consensus among stakeholders that much of the HIV policy, strategy and programming that exists in the country today would not be there without AusAID's support, and the response would be far less advanced.



The Global Fund to Fight Aids, Tuberculosis and Malaria, and the World Bank's Engagement with the Global Fund

February 2011

http://www.oecd.org/derec/worldbank/publicationsdocuments/health/

The principal purpose of this Global Program Review is to learn lessons from the experience of the Global Fund and its interaction with the Bank. The review found that collective donor efforts have contributed to increased availability and use of disease-control services, particularly for HIV/AIDS, and increased coverage of affected communities, which should ultimately reduce the disease burden. However, reliance on external funds and inadequate investments in long-term capacity raise concerns about the sustainability of recipient countries' disease-control programs.

More evaluations of HIV/AIDS and other health programmes are available at:
www.oecd.org/derec