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JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

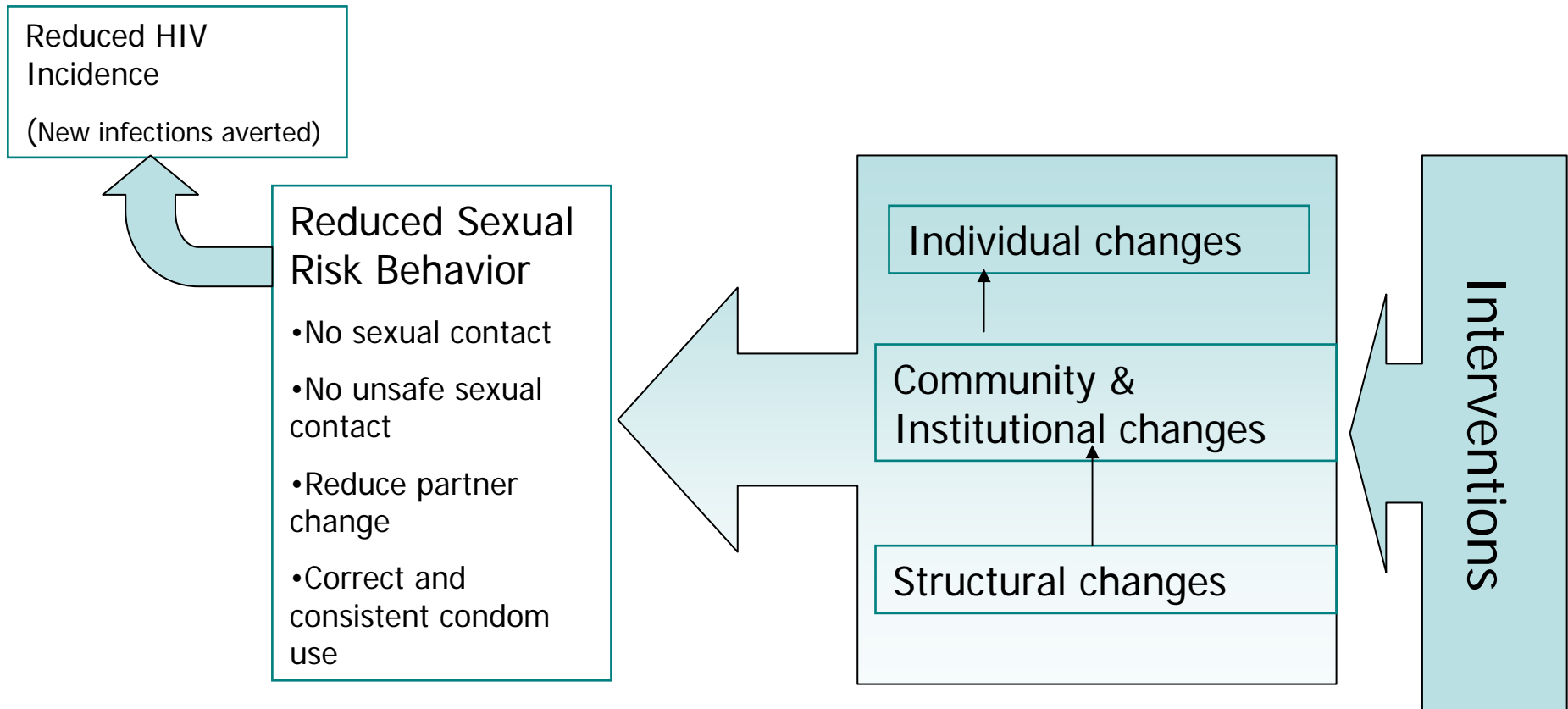
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How do we measure success? (Beyond counting condoms)

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What is “success” in behavior change to prevent sexual transmission of HIV?



UNAIDS policy paper (2005) outlined the actions to achieve the behavior outcomes

- To OPERATIONALIZE, LEARN and COMPARE, the language of behaviour change *interventions* has to be
 - *more specific*
 - *more scientific*
 - Especially about community and structural interventions

Science is “the accumulation of reliable, public knowledge”

More specific....

To describe, monitor and compare behavior change interventions, each design, and each report should define 4 dimensions:

•The inputs

- What exactly is done, by whom, with what intensity, and to what quality standards? i.e., the methodology

•The objectives

- What specific result, chain of results, is sought?

•The audience

- Who is it for? Who is the intended, and actual audience?

•The setting

- Where is it carried out?

For Example:

Inputs:

•Employer provided, peer education using 12 weekly contacts by employee volunteers, Stepping Stones curriculum, and monthly QA through mystery clients.

•**Objectives:** comprehensive knowledge of HIV and STI prevention, and increased perceived value of gender equity and interest in non-violent conflict resolution 6 months after program:
: reduced frequency of domestic violence 1 year after program.

•**The audience:** adult women and men employed in and living for over 1 year on the estate of a commercial farm.

•**The setting:** for men – the football pitch on the estate; for women: the waiting room outside the health clinic.

More scientific...

- “Scientific” means
 - Objective
 - Empirical
 - Systematic (whether qualitative or quantitative)
 - Reliable
 - Specific enough about the methodology that it can be replicated and achieve same results
 - Comparable across settings and replications
 - Cultural equivalency
 - Comparable inputs (methodology), objectives, audience, and setting

Science is “the accumulation of reliable, public knowledge”

Lesson Learned:

Indicators drive programming!

- Two decades of progress in monitoring and reporting
 - For accountability
 - For program improvement
- Availability of standardized indicators, agreed by national AIDS programs, donors, and technical support providers is a success story in public health, and a key element of the Three Ones

The consensus M&E framework provides the outlines a sequence that is expected to result from an effect cascade (causal chain):

- Inputs (services, information provided)
- Outputs (people served)
- Outcomes - individual/short time frame (attitudes or knowledge changed, some behaviors changed)
- Outcomes - population/longer time frame (rates of STIs reduced, sexual risk behavior changed)
- Impact – population level (new HIV cases reduced....)

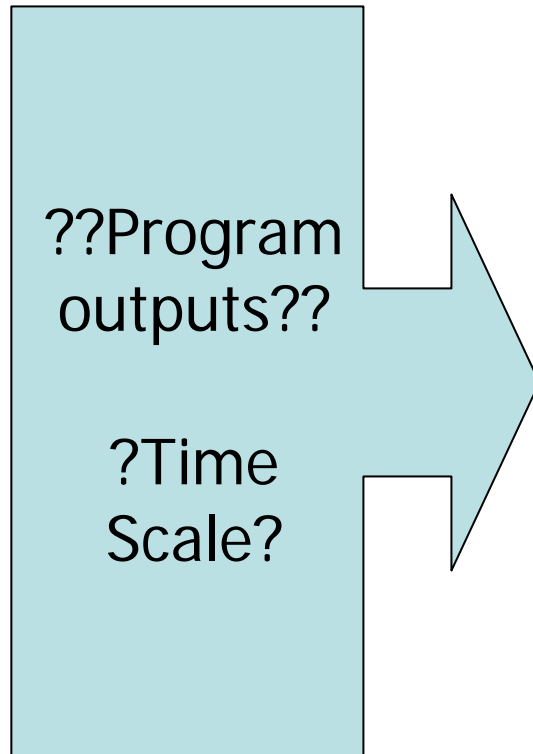
Framework for behavior change interventions is not complete

- UNGASS Indicators for HIV treatment, and care and support, require tracking and reporting of scale-up *processes*, for example
 - Numbers of people on ART Program level, **output**
Time scale: **annual**
 - Number of households receiving assistance (Program level, **output**)
Time scale: **annual**



Reduced morbidity and mortality (outcome, and impact)

UNGASS indicators for behavior change?

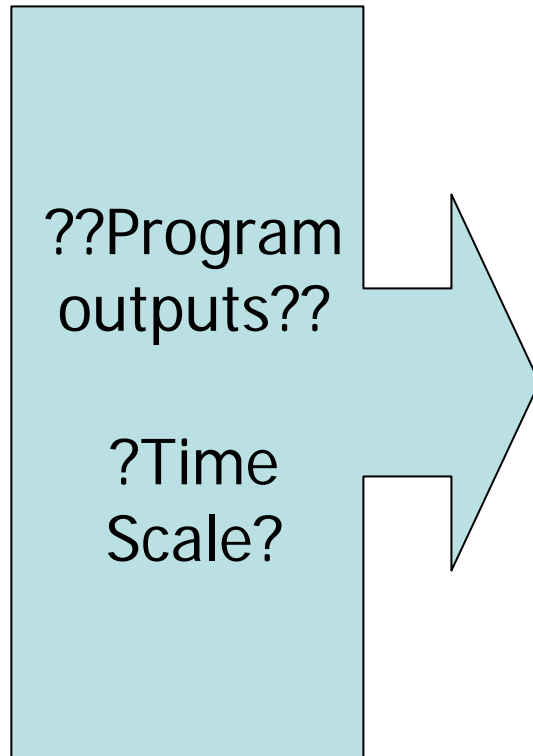


Generalised epidemics

1. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. **(Target: 90% by 2005; 95% by 2010)**
(Outcome)
2. Percentage of young women and men who have had sex before the age of (Outcome)
3. Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months (Outcome)
4. Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner (Outcome)

UNGASS indicators for behavior change

(continued)



Concentrated /Low level epidemics

1. Percentage of (most-at-risk population(s)) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Outcome)
2. Percentage of female and male sex workers reporting the use of a condom with their most recent client (Outcome)
3. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (Outcome)
4. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid using non-sterile injecting equipment and use condoms, in the last month (for countries where injecting drug use is an established mode of HIV transmission) (Outcome)

Conclusion:

- If we are going to make maximum impact with this meeting, on launching/promoting new approaches to achieve reduction in sexual risk behavior, we need to offer:
 - Concrete, measurable definitions of success, at the input, output and outcome levels
 - Recommended indicators (how to define and measure results) at the process and outcome levels

This is especially true for community and structural interventions!

Why so little on this in the international HIV and public health literature?

- Urgency and mobilized constituencies for health services/treatment
- Challenge of cultural variation in psychosocial variables
- Limited foundation, and limited people with training in behavioral sciences in and from developing countries
(people who can conduct rigorous research and define comparable study designs and indicators on social and behavioral issues)