

# **Evaluating gay men's HIV prevention in the UK:**

## **The importance of focusing on programmes and on populations**

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## **Evaluation aims to explore:-**

- the impact of services on infections or on the factors that immediately determine this (eg. behaviour);
- how services works (eg. what needs they meet, what contextual factors affect whether they will work or not).

**Need outcomes for one and process for the other**

On their own both are inadequate.

## **Evaluation should focus on coherent programmes of HIV prevention rather than single interventions**

- Making It Count focuses on risk-reduction via a range of behaviours not just condom use;
- Therefore for measurable risk-reduction we probably require a range of synergistic interventions;
- Single interventions are unlikely to have measurable effects;
- Expecting them to have is hoping for health promotion on the cheap.

## **Look at effects on populations not merely individuals**

- Health promotion should address individuals AND social and political contexts within which they live (Ottawa Charter 1986);
- Importance of ‘herd effects’ (Richard Hayes 2002):
  - With infectious diseases those not directly receiving an intervention can still benefit;
  - Individual’s risk of infection affected by the form of the sexual network they are in, and the prevalence of STI cofactors within this network.

### **Two implications:**

- Outcomes should focus on social measures as well as individual measures - eg. homophobia, social exclusion;
- If using comparison or controlled trials, the unit should generally be the cluster not the individual

**Cluster should be real not artificial, ie. should be socially cohesive and reasonably discrete populations.**

**RCTs are ‘gold standard’ in principle but not generally applicable to UK gay men’s HIV prevention**

- not enough comparable clusters;
- division into intervention and controls is probably unrealistic, given national strategies.

## **Pragmatic alternatives to RCTs:**

### **(1) Programme outcome evaluation**

- Annual surveys of needs, behaviour and HIV incidence;
- Ideally would allow tracking of individuals in time using unique identifiers;
- Establish how programme seems to lead to changes
  - needs being or not being met;
  - behaviour changing;
  - incidence going up or down.
- Cannot guarantee that these changes reflect the programme rather than other factors.

## **(2) Intervention outcome evaluation**

- Where interventions very costly or considered potentially so important/intense;
- Designs used should be decided on a case-by-case basis: RCTs should neither be written off nor considered the automatic choice;
- Main outcome measures used should match the aims, but also scope for secondary outcomes.

### **(3) Process evaluation**

- Not enough attention has been paid to rigour of process evaluation
  - Few textbooks
  - Sometimes done sloppily
- Should focus on a few key questions
  - Is the intervention/programme acceptable to the community?
  - What needs is it attempting to meet and does it appear to be appropriate for this task?
  - Is it addressing groups particularly in need?
  - What contextual factors impede or promote the delivery and uptake of the intervention?
- Informs judgments about generalisability of interventions
- Two things need to be put in place:
  - Appropriate skills for evaluation
  - Ensuring all relevant questions are asked

## **More coherent programmes of evaluation**

- Prioritise topics: which programmes/ interventions are we most uncertain about; and which are thought to have greatest potential?;
- Ensure all relevant questions are asked;
- Diversity of stakeholders contribute to these decisions: researchers, commissioners, providers, affected communities;
- National programme of evaluation.