

Claims and realities in HIV programme evaluation



Condom demonstration by youth group at Soweto Youth Centre, South Africa
Photo: UNAIDS/Pirozzi

The example of loveLife in South Africa

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HIV/AIDS interventions face particular challenges in meeting funding goals on the one hand, and proving impacts on the other. In some instances this may result in approaches where evaluation methods and findings are insufficiently critical. One such example can be found in the research approaches and claims made by the loveLife programme in South Africa.

Launched in 1999, loveLife had ambitious goals as an HIV prevention programme targeting South Africa's youth – one being to “reduce the incidence of HIV among 15 to 20-year olds by 50 percent over the next three to five years.” This goal was framed alongside a model of large-scale and multi-faceted national intervention that would tap into youth aspirations through an intervention of unprecedented scale, with an annual budget requirement of around R200 million (\$31 million).

Investment in this programme was led by loveLife's founding funders, the US-based Henry J. Kaiser Family Foundation, which drew on endorsements from politicians, business and media elites in South Africa, and numerous individuals and organizations globally, to acquire additional funding support. The goals of the programme were framed against an evaluation plan that included regular monitoring and regular reporting of findings.

The challenge for the loveLife programme was two-fold. The first was to demonstrate rapid results and impacts, and the second, to demonstrate that loveLife was the single causal factor that brought about such changes. Apart from the national antenatal

prevalence surveys, no baseline data was available against which the claim to ‘incidence’ reduction was to be measured. Instead, evaluation during the first three years was conducted through monitoring of programme activities, small-scale qualitative research and ‘national’ surveys.

Claims to impact

In the early phases, findings were used to suggest generalizable national impacts even though sample sizes were small. For example, based on a number of small scale studies, a 2001 summary of evaluation findings stated: “In just under 12 months loveLife has succeeded in creating national recognition among close to 60% of the

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population” and that “loveLife has had a remarkably balanced impact across age groups and regions.”¹ Sample sizes for the studies from which these conclusions were drawn were small (1000 in one and 141 in another) and sampling methodologies were not presented in detail.

Claims to early impact were soon reinforced by a follow-up study reported in 2002 of youth aged 12-17 – loveLife's primary target group – which suggested that loveLife had an impressive ability to socially engineer youth response to HIV prevention. Findings included:

- Of all young South Africans, 62% know about loveLife.
- Of those who know about loveLife, 76% say loveLife has made them more aware of the risks of unprotected sex; 65% say loveLife caused them to delay or abstain from sex.
- Among sexually experienced youth who know about loveLife, 78% say loveLife has caused them to use a condom; 69% have reduced their number of sexual partners; 63% say they are more assertive in insisting on condom use.²

Whilst experienced researchers and evaluators would immediately note the problems

and limitations of using leading questions to derive such findings, the results were directed towards wider audiences beyond the research community. The study report itself carried these findings on the cover, and findings were also repeated under the headline ‘HIV prevention that works’ in



various versions of the organization's promotional brochure. Findings were also widely promoted in the media, in a number of reports related to HIV/AIDS and on

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various websites. In 2004, the results were also integrated into the cover design of loveLife's promotional brochure.

HIV prevalence rates

Such claims about making significant impacts did not correlate with HIV prevalence rates amongst youth as reflected in ante-natal studies, where numbers were not declining (let alone being reduced by half). In 2000, the level for pregnant females under 20 was 16.1%. With minor fluctuations it was, once more, 16.1% in 2004. National population-based surveys have also shown high rates of prevalence amongst youth – one in twenty 15-19 year-olds were found to be HIV positive in 2003 in a survey conducted by the Reproductive Health Research Unit (RHRU) – a loveLife partner organization.³

The lack of progress in relation to HIV prevention has been subtly moderated in loveLife promotional material over time. In 2002 the organization's brochure framed the goal as "to cut the infection rate amongst young South Africans by 50 percent," without reference to the initial three to five year timeframe, and in 2003 the goal was restated as "to substantially reduce the

infection rate" without reference to the goal of 50 percent HIV reduction. The programme's timeframe for impacting on HIV has also been shifted. In mid-2005 loveLife's website stated the programme was "now in its fifth year... in the middle of what was originally designed

as a 10 year campaign." Claims to impact have continued to be made, including, for example, most recently, that loveLife has a 'protective effect' for HIV prevention – a claim that is insufficiently substantiated.

Implications

HIV prevention is a complex process and it is impossible to absolutely measure the impacts of specific HIV prevention interventions. This poses problems for programme evaluation. Programme funders and implementers are often closely involved in the design of monitoring and evaluation systems, and findings that suggest impacts are useful to securing ongoing funding. It therefore requires considerable discipline and critical capacity to ensure that findings are not skewed to support these long-term goals.

Research findings, particularly quantitative findings, are often accepted at face value, and when repeated in the media, in brochures, reports and websites, they have the capacity to appear rigorously grounded and 'true.' When they are presented in ways that circumvent peer review and commentary by other researchers in the field, they are able to avoid or limit critique. Additionally, when findings are promoted internationally, they are well beyond the critical voice of local researchers and others who may be aware of the programme's limitations.

In the initial phases of the loveLife programme, claims to high levels of impact helped to foster buy-in amongst political, media and corporate elites in South Africa – many of whom are represented on the programme's local advisory board. Internationally, the programme has been presented as an effective model for HIV

prevention, and the research claims above have been widely repeated in conferences and reports. The claims also formed part of the programme's proposal to the Global Fund for HIV/AIDS, TB and Malaria – eliciting an initial commitment of \$12 million, and with a further \$56 million currently under review.

The research claims outlined here, along with many others made by loveLife, have made it difficult to understand what the programme's actual impacts might be. An approach based on critical evaluation would have value in that it would provide the capacity to adjust the intervention design as one proceeds – no model is perfect from the start. Claims that the model is working however, prevent any modification of design, and, in the case of loveLife, little has changed in the basic approach of the programme. In the short-term, claims about impact help to secure funding, and positive evaluation findings are no doubt pleasing to donors who make financial commitments. In the long-term however, this may breed cynicism of HIV prevention programmes as a whole. Ultimately, it's bad practice. ■

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