Notes from the periphery: When policy drives data
(and how to keep data in the driver's seat)

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Notes from the periphery: Lessons for immunization from fertility decline and HIV prevention

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Lessons for immunization from research on fertility decline and links to policy

Lesson 1: Population-level behavior change is possible, but non-linear and dependent on a process of social interaction

- **European Fertility Project 1978 (Coale and Watkins 1978)**
  - Once fertility transition begins, it is irreversible
  - No threshold of economic development found
  - Patterns of spread follow innovation – diffusion pattern
    - Strong language contours
  - Occurred despite lack of modern fertility control methods and strenuous opposition of all key social institutions (church and state)

- **Policy consequences:** "Development is the best contraceptive" argument weakened

Lesson 2: Science may require course correction

- **1988 National Academy of Sciences report: Population growth and Economic Development: Policy questions**
  - Method: systematic comparison of population growth rates and GDP growth rates
  - No consistent relationship found
  - Pop growth no longer seen as causal for development
  - Policy consequences: Economic justification for family planning weakened
- **1992 Cairo Declaration on Population and Development**
  - Shift emphasis from 'population control' to women's rights, health and self-determination
  - Policy consequences: Sustained support for FP, but not reflected in MDGs / SDGs

Implications for Immunization from family planning research and policies

- Behavioral adaptations to new threats or opportunities requires time and a process of social interaction to 'domesticate' the problem and its solution (Cleland and Watkins 2006)
- Local ownership of the agenda is a necessary requirement of sustainable demand
- Political will and sufficient funding can accelerate the process
- Providers important, but voices of friends, neighbors and relatives ultimately the most powerful

Lessons for immunization from HIV in Uganda and Ethiopia

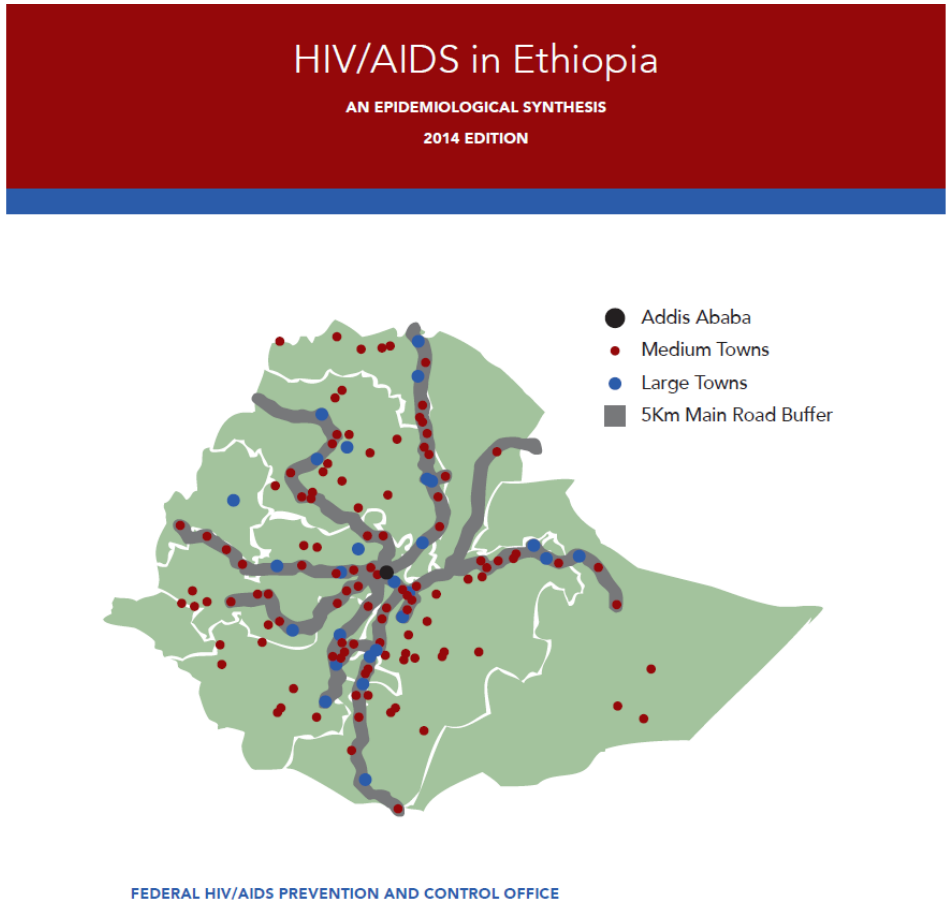
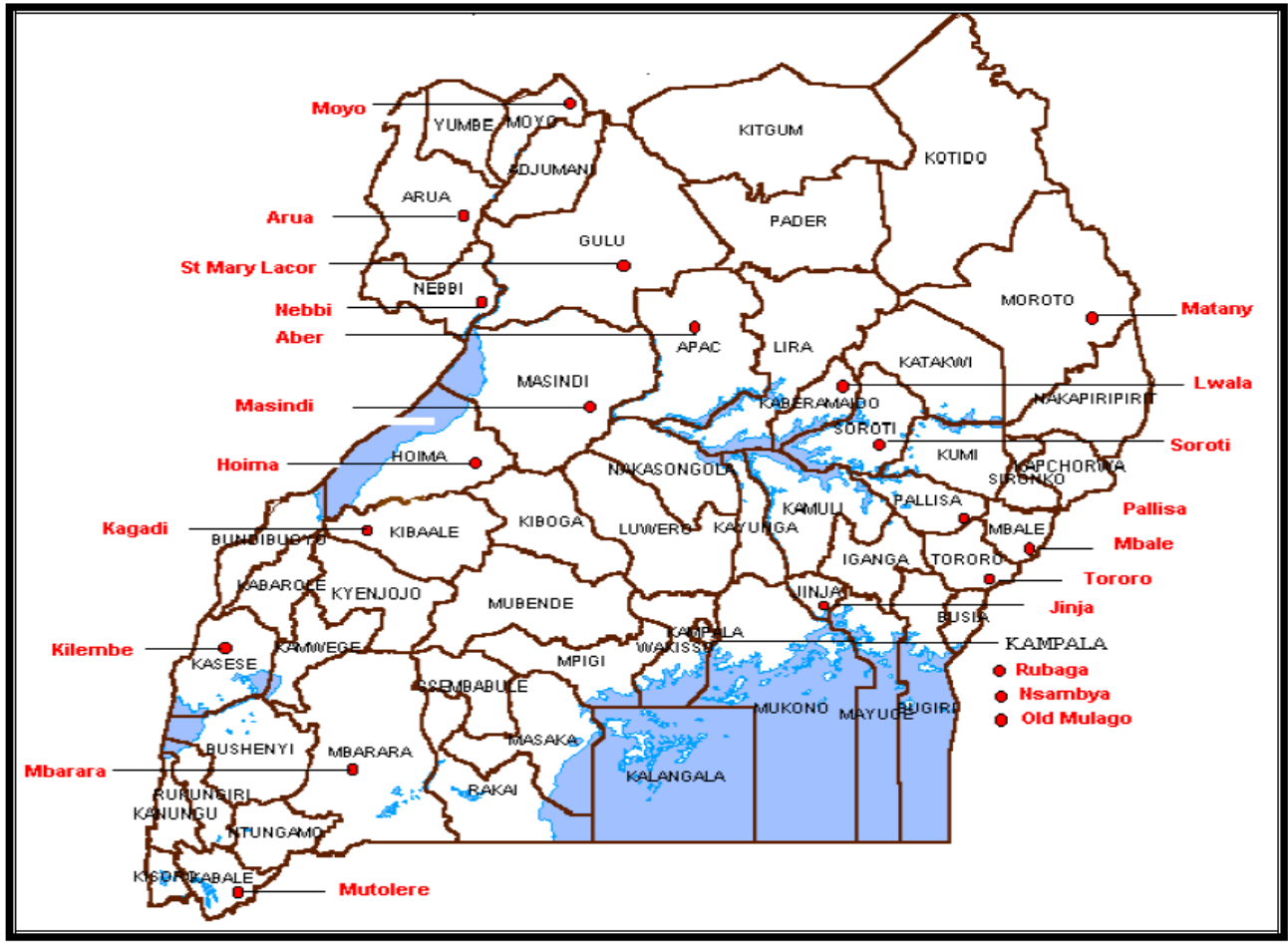
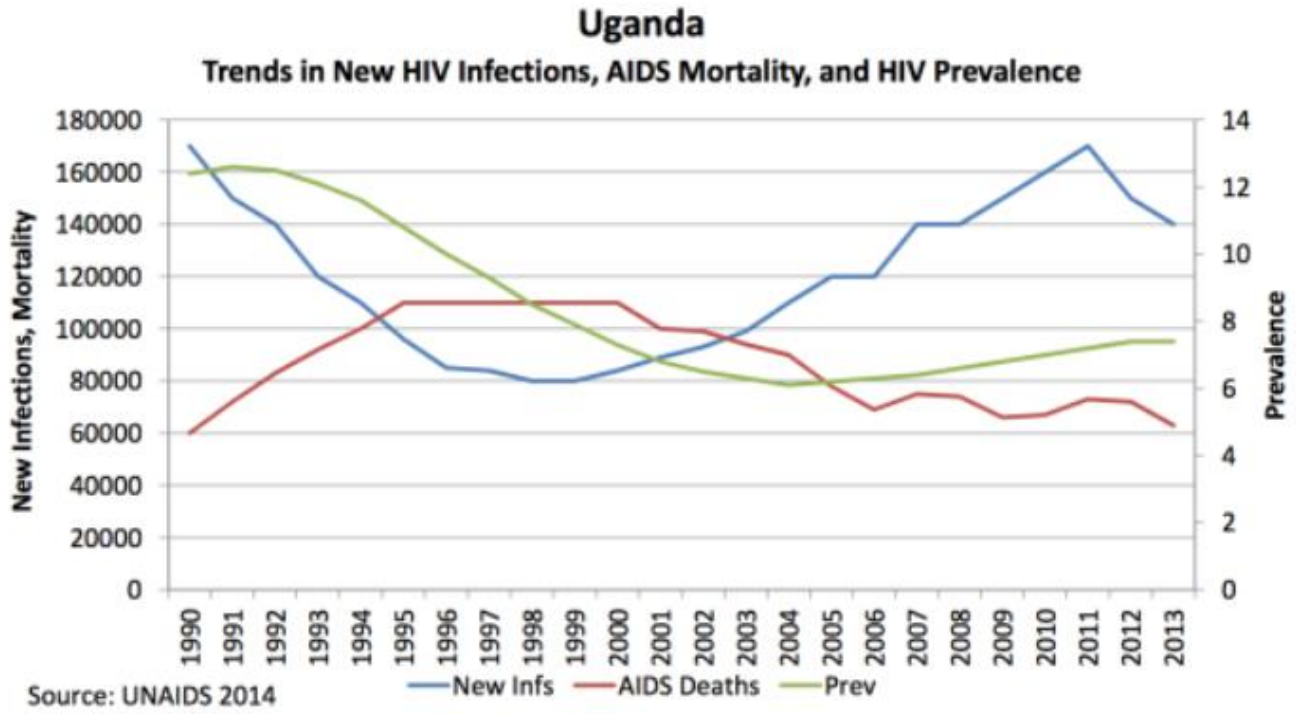


Figure 2.1 Map showing location of ANC sentinel surveillance sites in Uganda



Uganda HIV Epidemic Response



- Late 80s: Political leadership allows space for engagement and response
- ‘Zero Grazing’, Philly Lutaya (PLHIV), TASO (‘dying with dignity’)
- Uganda “this disease of ours” (vs. South Africa’s conspiracy theories)
- Initial declines prior to widespread promotion of condoms, testing
- Resurgent transmission after 2000. Why?

Lesson 3: Behavior change difficult to induce or replicate in the context of RCTs

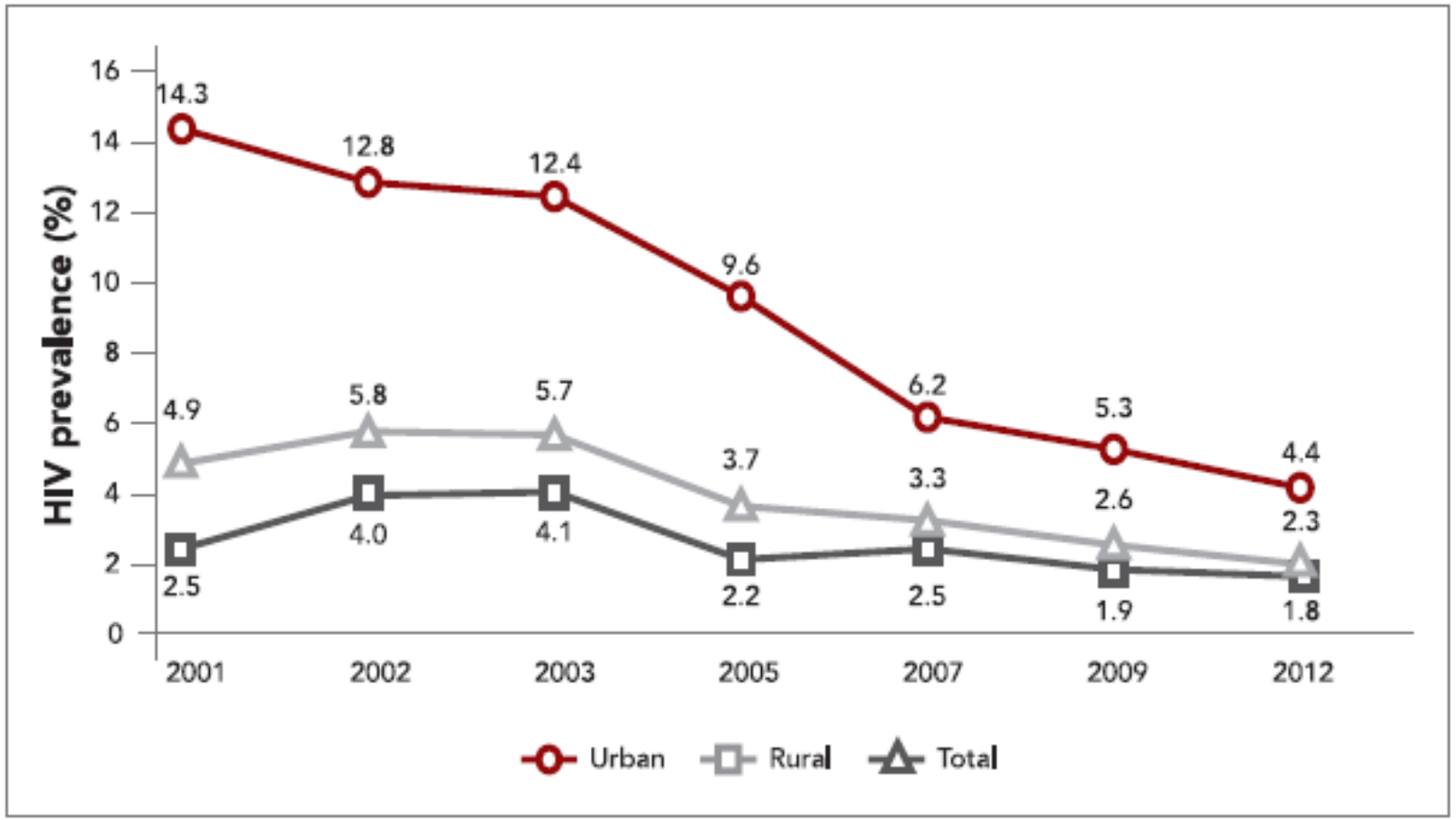
- Studies: 3 RCTs on syndromic treatment for STIs on HIV transmission
  - Mwanza Syndromic treatment intervention 1991-4
  - Rakai presumptive treatment intervention 1994-8
  - Medical Research Council mixed syndromic treatment- behavioral interventions 1994-2000
  - All had behavior change intervention arms showing no reduction in HIV incidence
- Studies: Mema kwa vijana (TZ adolescent HIV transmission study 1999 - 2002)
  - Strong effects on self-reported behavior, but none on STI or HIV transmission
  - Interventions missing older men who infect female study participants?

Policy implications from Uganda

- **For global HIV programming**
  - PEPFAR III (2015 – 2019): Prioritization and pivot to Test and Treat
    - Must do / should do / nice to do / triage
    - Funding from ~$365m USD/yr in FY 2011 to $180m USD/yr in FY 2016
    - lowest tier 'transitioned to local ownership' = terminate funding
    - Exception: DREAMS interventions to protect adolescent girls
- **For Immunization programs**
  - RCTs pose methodological limitations for evaluating complex behavioral interventions
  - 'Plausibility designs' using mixed methods and quasi-experimental designs may be more appropriate (Laga 2012)
  - **What works, where, and for whom?**

Lessons from Ethiopia

Figure 3.1: Trends in HIV prevalence (%) among ANC mothers in all urban and rural sites reporting more than four ANC rounds, 2001 – 2012 (EHNRI & FMOH, 2013)



Lesson 4: Political will + good science can succeed where govt has the power to enforce

Uganda

- Strong research capacity
- Openness to outside collaboration
- Relatively independent press
- Open discussion of research results in public fora
- Govt not always responsive to research recommendations (e.g. MSM, male circumcision)
- Strong donor influence

Ethiopia

- Limited research capacity
- Less openness to donor influence
- Strong state control of information
- Govt strongly embraces research that support policy, resists or suppresses research which does not (e.g. MSM, slow ART expansion)
- Harnessing HIV to fund primary health care agenda (adjustment of 2005 EDHS HIV estimate)

Govt embrace of HIV testing agenda

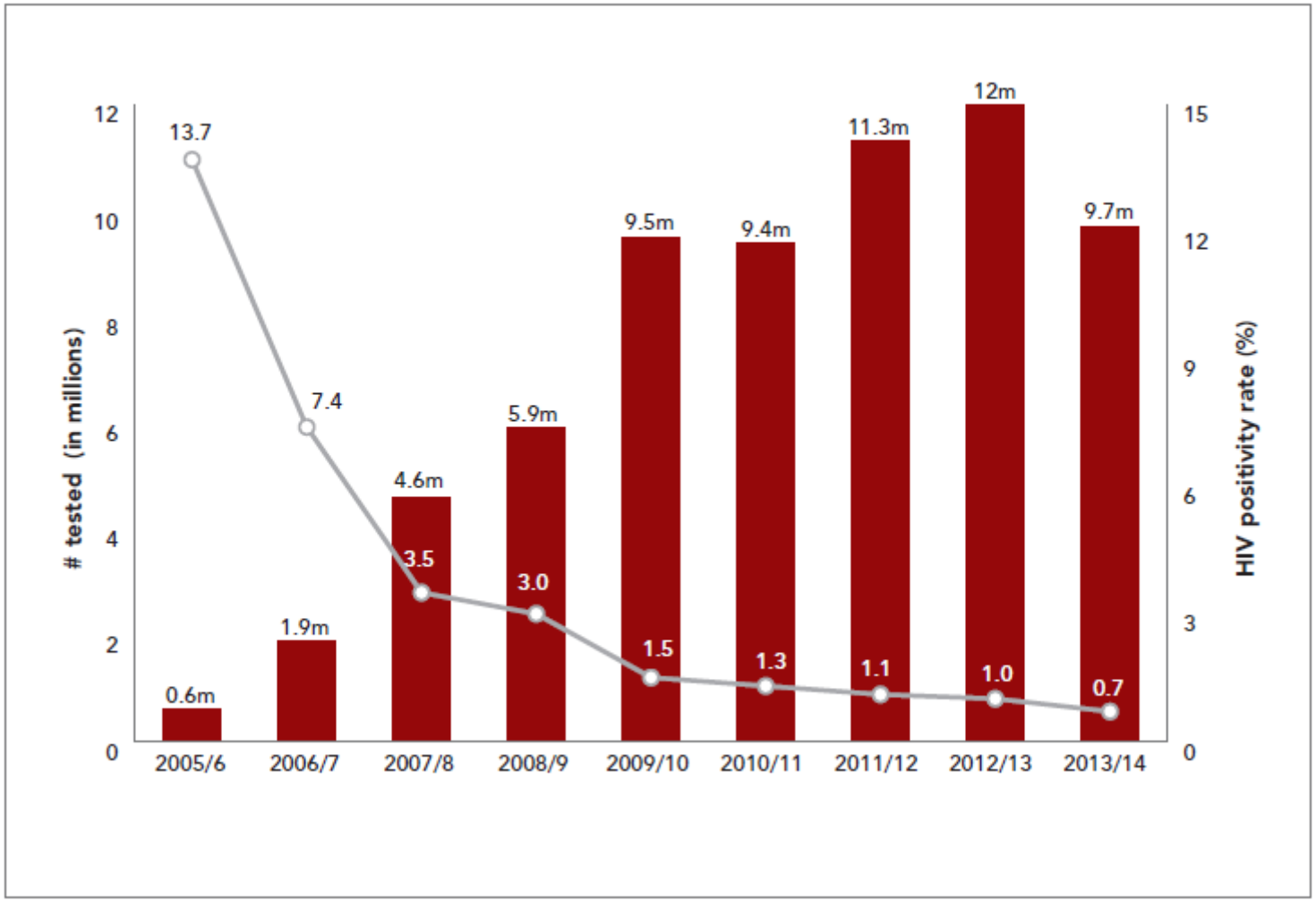
Testing strategies

- Millenium Development Campaign 2005-6
- **Opt-out (presumptive) testing at all outpatient facilities**

EDHS 2011, urban areas:

- 93% know where to test;
- 59% ever tested
- 34% tested last year
- 77% PLHIV ever tested

Figure 6.4: Number of People Tested for HIV (in millions) and HIV Positivity Rate in Ethiopia, 2005/06-2013/14 (FHAPCO, 2014)



Govt embrace of blood banks

CDC support for blood banks

- 2009: 16 new banks promised within one year
- Construction starts but stalls for years
- 2014: Analysis of EDHS shows no improvement in maternal mortality
- Risk of failing on MDG 5
- **2015: all but 1 blood bank completed within 6 months**

Under construction

Policy implications for immunization

- Opt-out immunization as a sustainable model for increasing uptake
  - DeCock 1998: pre-test HIV counselling was a barrier to knowing status
  - Option of withdrawal harnesses social pressure to conform
  - Significantly increased testing rates (e.g. >90% acceptance in clinics vs ~ 10% for optional VCT in rural field sites in Uganda)

- Align goals with pre-existing government priorities
  - MDGs / SDGs matter to Ethiopian govt!
  - Measles elimination vs Reach Every Child 90/80 as Next Big Thing?

Conclusions

- Engagement with key stakeholders
  - community
  - Government
  - Caregivers
- Time
- Listening
- Critical evaluation
- Repeat as needed