

Using data for program planning,
resource allocation and policy:
Opportunities for collaboration,
technical assistance and capacity
building

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Components of 3rd Generation HIV Surveillance

Societal conditions Home Risk behavior STIs HIV infection Acute, incident ART initiation Prevalent OIs, AIDS Orphans Death Societal impact

Population based surveys with HIV testing and risk behavior: DHS+, AIS

Population based surveys with risk behavior: DHS, MICS

BSS in MARPs, STIs Integrated Bio-Behavioral Surveys MSM, IDU, FSW IBBS other

PLACE, RAP, RARE, qualitative research

Molecular Epi

STI clinic sentinel surveillance, other facility-based

Antenatal clinic sentinel surveillance

Acute and incident infection (BED) KP surveys, STI clinics

KP size estimation

Incidence surveillance (BED) in ANC and DHS+

Case reporting: HIV, AIDS, OIs, STD, case registries HIV/AIDS/related conditions

Enhance care and treatment surveillance, ART use, drug resistance, morbidity, mortality

Greater use of existing data, research, M&E, program, data synthesis, dissemination

That doesn't even include routine program data!

Drowning in data & information!



- Just too much of it
- Information goes up and never comes down
- Due to competing priorities basic reporting is often the only analysis performed.
- Data from different sources is often never seen side-by-side

Tracking trends, burdens, determinants and response in the HIV epidemic requires...

- HIV prevalence
- HIV incidence
- Population sizes
- Epidemic response data
- Stratified by sub-populations, geographies, behaviors, interventions

Existing data sources are often not fully exploited.

- Data collection and basic reporting fill up a lot of time.
- Novel methods require resources to implement.
- Disconnect between those asking key questions and those that can answer them.

Existing data sources are not always complete or reliable.

- HIV cases in the registry underestimate the total number as only diagnosed infections are reported.
- HIV prevalence is not a reliable measure of the direction of the epidemic due to ART.
- National level surveys that get at population sizes of MSM or PWID, for example are not specific enough for local planning.

Overarching methodologies

- Further analyses
- Synthesis
- Triangulation

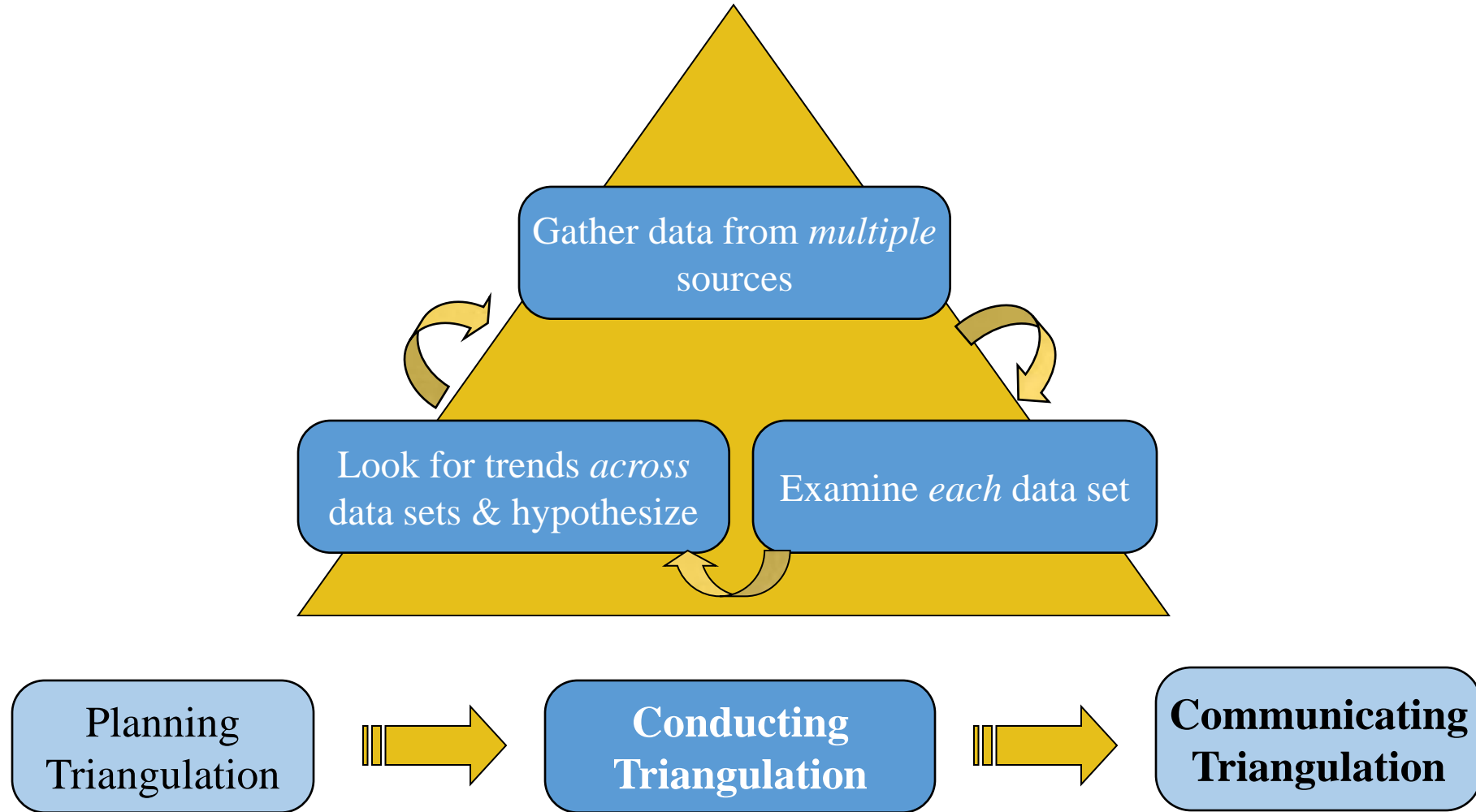
Further analyses

- In short, using to its fullest the data that have already been collected.
- Novel approaches to: incidence estimation, population size estimation
- Correlations to demographics, behaviors, geography to fine tune focus and content of interventions.

Synthesis

- Triangulation “lite”
- Very focused on a specific question
- Very focused data mining
- Quick turnaround
- Less stakeholder process

Triangulation Process



Triangulation Process: 12 steps

Which part of the process?	What steps are involved?
Planning for Triangulation	<ul style="list-style-type: none">• Identify key questions• Ensure question is answerable/ actionable
	<ul style="list-style-type: none">• Identify sources & gather data• Refine research question
Conducting Triangulation	<ul style="list-style-type: none">• Gather data• Make observations• Note trend & hypothesize
	<ul style="list-style-type: none">• Check hypotheses• <i>IF NECESSARY</i> Identify & gather add'l data• Draw conclusions
Communicating Triangulation	<ul style="list-style-type: none">• Hypotheses, limitations & recommendations• Outline next steps

Process includes government, community, academic stakeholders at every step.

Examples of questions

- How many persons are at risk / in need of services?
- Is the type and level of intervention in a given place and population adequate?
- In what sub-populations and / or geographies is HIV incidence highest?
- How many undiagnosed infections are there?
- What are the trends in HIV risk related behaviors such as multiple partners, condomless sex, needle sharing, substance use by key populations, sub-population and geography?
- How many diagnosed infections are not on ART?