

Using statistics to guide response to the HIV epidemic

High Impact Medicine

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May 2023

Outline

1. Precision public health for HIV
2. Estimating risk group proportions
3. Some broader thoughts on careers

1. Precision public health for HIV

What is precision public health

- In medicine, we want to deliver the right intervention, at the right time
- Precision medicine seeks to do that at the individual-level
- Precision public health seeks to do it at the population-level

*Recognizing that “**one size does not fit all**”, the Strategy prioritizes tailoring of differentiated service packages and service delivery approaches to the **unique needs of people, communities and locations**, using granular data to focus programmes most effectively.*

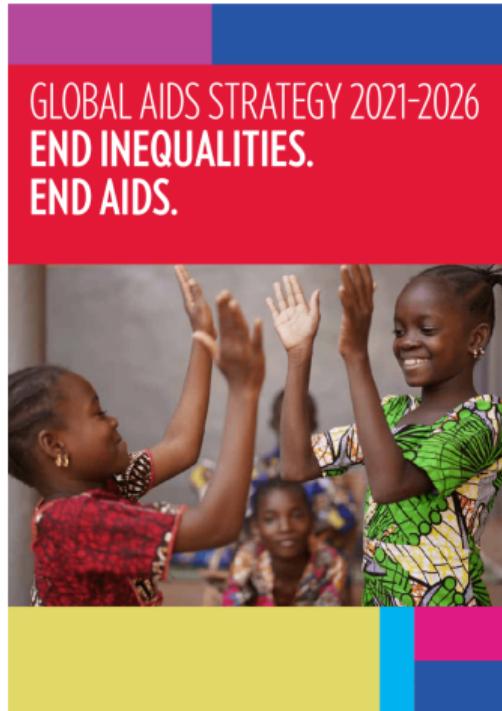


Figure 1: A key feature of the HIV response, both historically and into the future.

How can statistics help?

- Granular estimates of relevant quantities are required
- Disaggregation by geography, sex, age, and behaviour
 - HIV prevalence: proportion of people who are infected
 - HIV incidence: rate of new infections
 - Antiretroviral therapy (ART) coverage: proportion of people living with HIV who take ART



Fast-Track Targets

by 2020

90-90-90

Treatment

500 000

New infections among adults

ZERO

Discrimination

by 2030

95-95-95

Treatment

200 000

New infections among adults

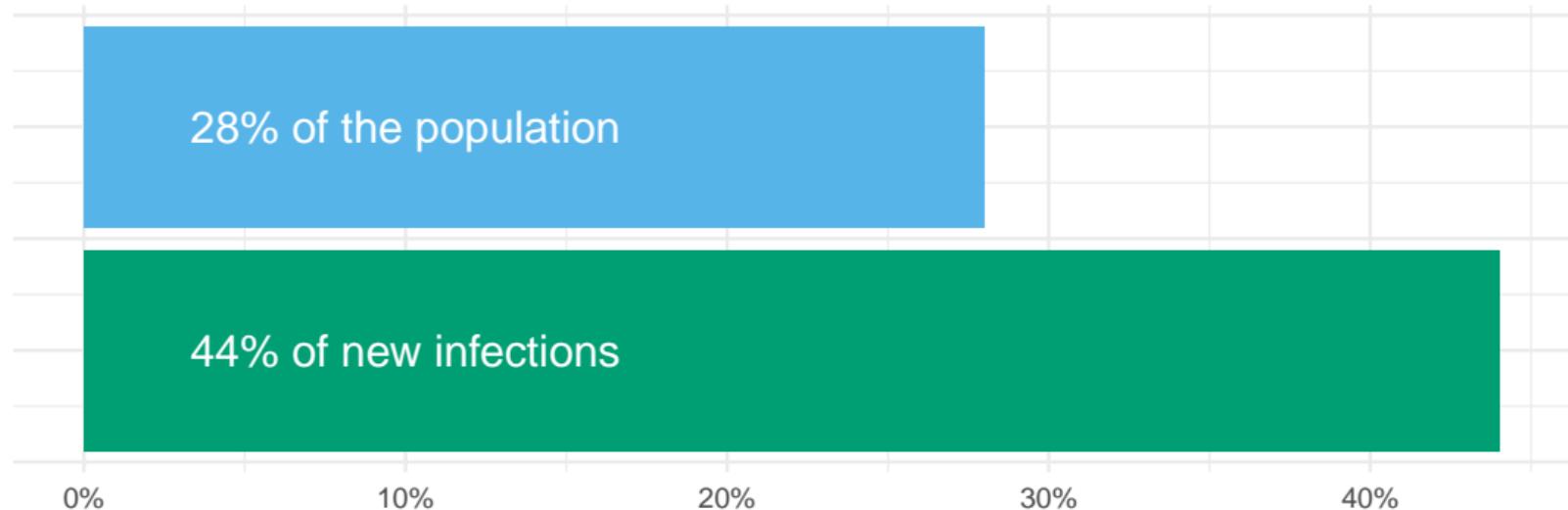
ZERO

Discrimination

Figure 2: Example population health goals.

2. Estimating risk group proportions

Adolescent girls and young women (AGYW) 15–29 are



(Across 13 AGYW priority countries in sub-Saharan Africa)

Why?

1. Younger age at first sex
2. Age patterns of sexual mixing
3. Structural vulnerabilities and power imbalances
4. Increased susceptibility to HIV infection



UN SECRETARY-GENERAL'S REPORT ON HIV

RECOMMENDATION 5:

Put gender equality and the human rights of women and girls in all their diversity at the forefront of efforts to mitigate the risk and impact of HIV.

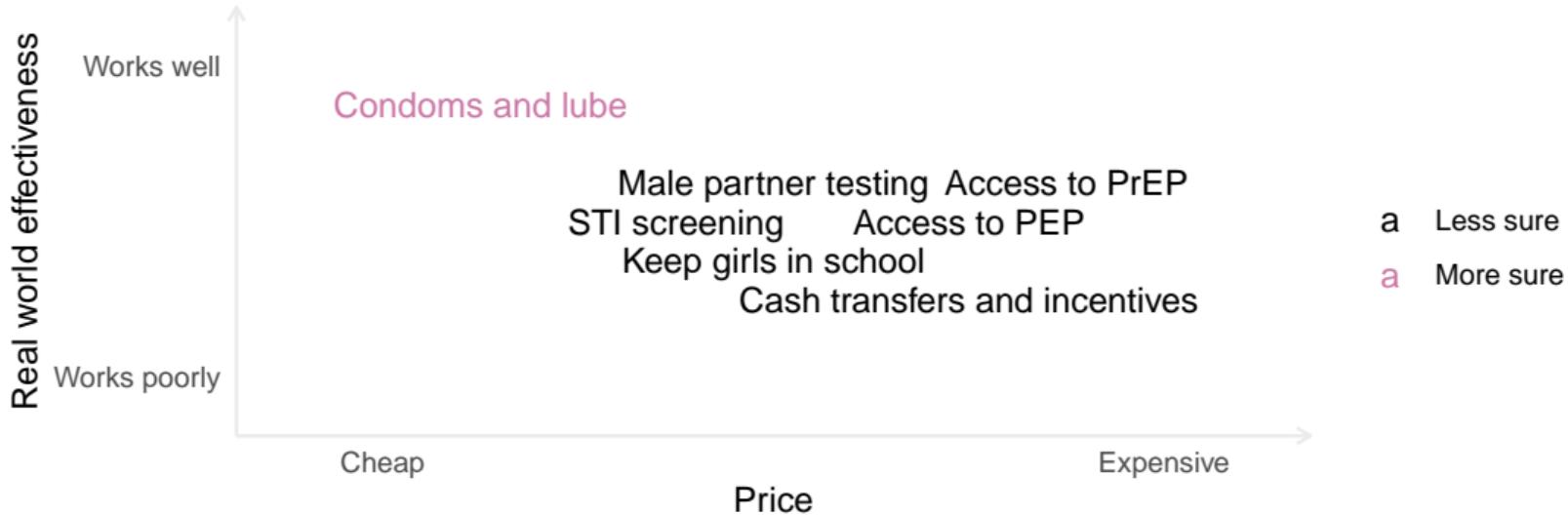


High-Level Meeting on AIDS
END INEQUALITIES. END AIDS.



Figure 3: Convergence of marginal utility with equity and human rights.

Insufficient resources to provide all interventions to everyone



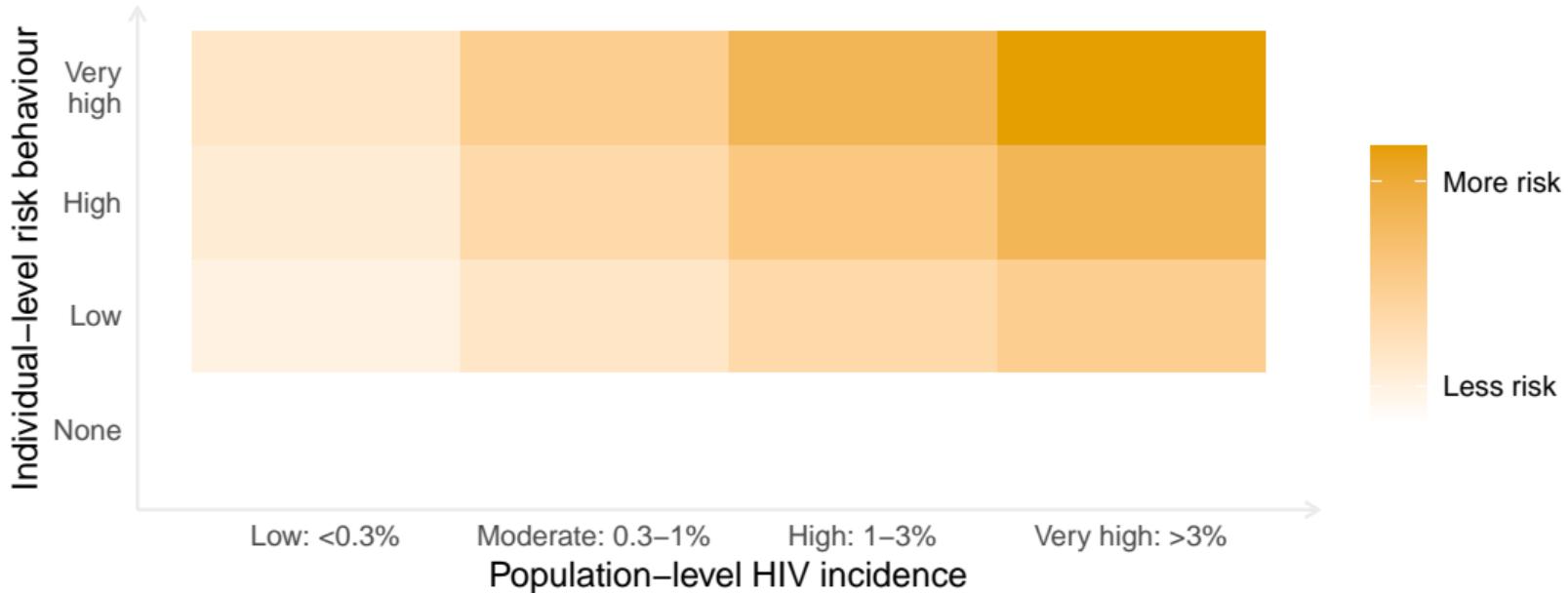
Positions on plot depend on setting and should not be interpreted too precisely.
Some interventions do not only have the effect of reducing HIV incidence.

How to prioritise interventions?

- The most proximal drivers of transmission are

$$\mathbb{P}(\text{transmission}) \propto \text{sexual partnerships} \times \mathbb{P}(\text{each partner can transmit})$$

Important we consider **both** population setting and individual behaviour



Individual-level behavioural risk

Level	Behavioural risk group	Risk ratio
None	Not sexually active	0
Low	One cohabiting partner	1
High	Multiple or non-regular partner(s)	1.72
Very High	Female sex workers	13

What have we done

- Goal: enable **prioritisation** of HIV programming for AGYW
- Audience: programme managers, service providers and policy makers
- Plan: estimate district-age-behavioural risk group proportions, HIV prevalences and HIV incidences across 13 high priority countries in sub-Saharan Africa
- Method: a Bayesian spatio-temporal model of survey data

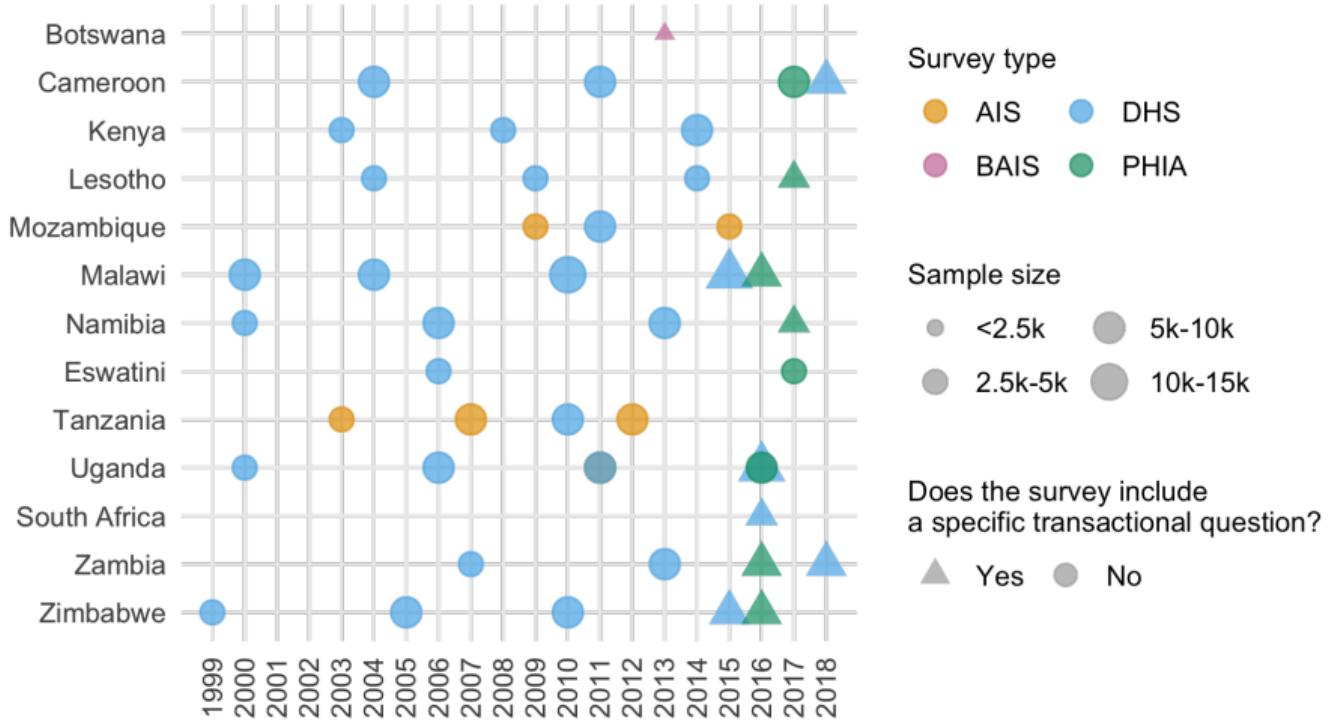


Figure 4: A total of 46 surveys: importance of good data processing code!

Geography



Graph

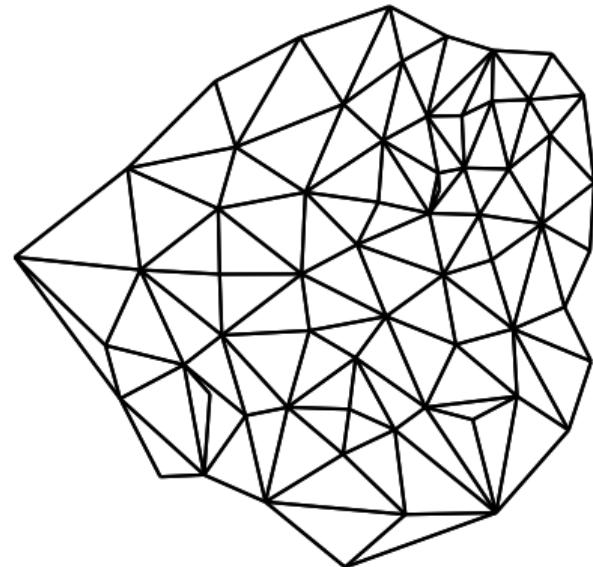


Figure 5: Example of model structure: we assume that neighbouring districts are similar.

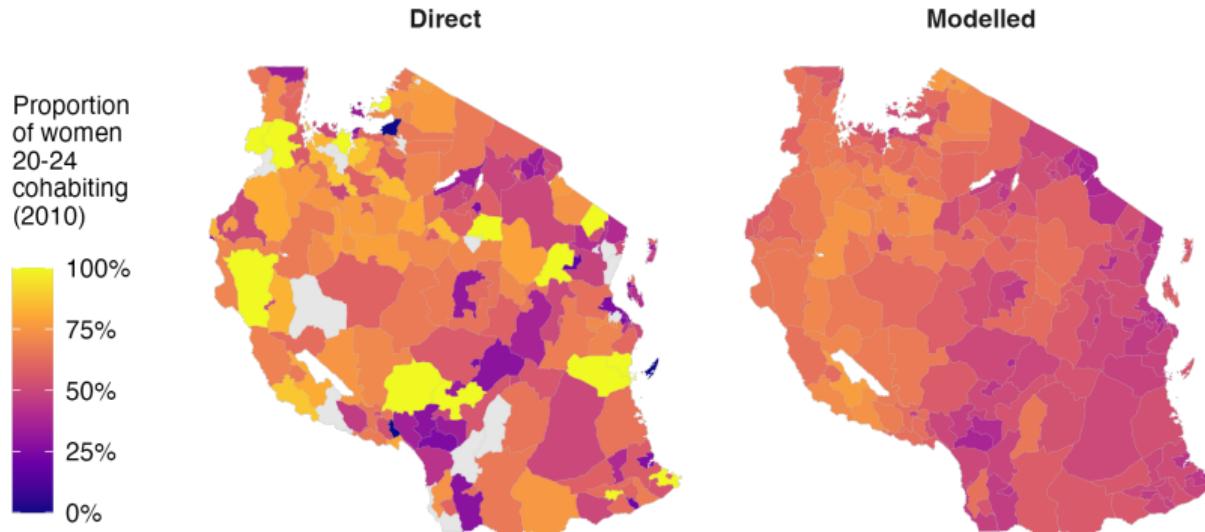


Figure 6: Direct survey estimates are too noisy to work with due to low sample sizes, but our modelled estimates don't have the same issue.

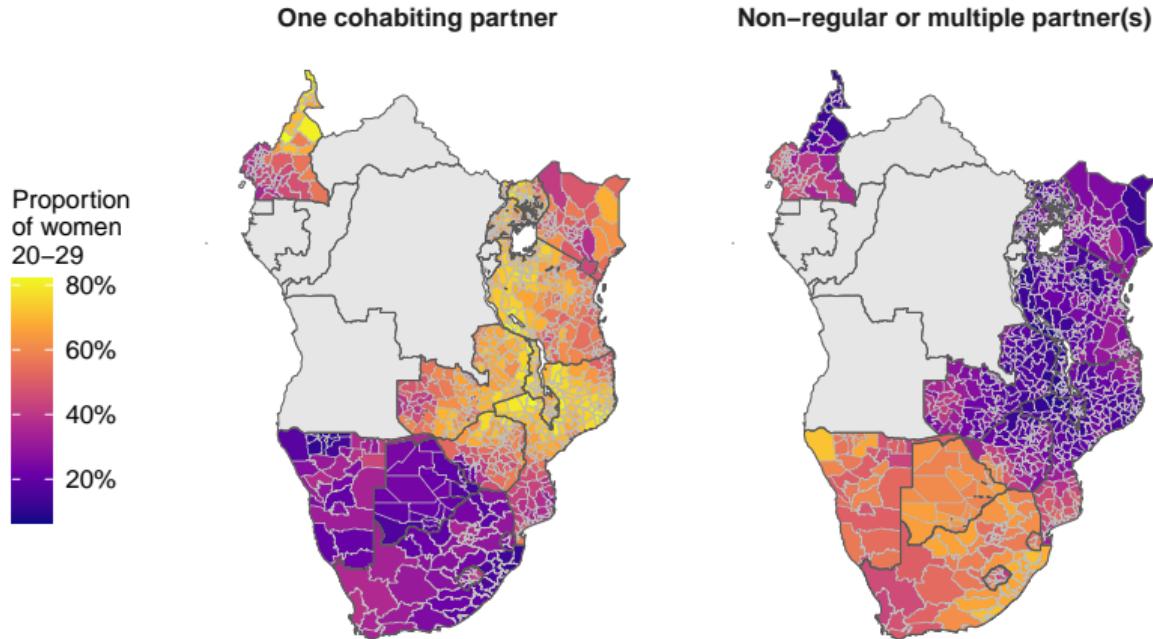


Figure 7: We found a prominent geographic discontinuity between eastern and southern Africa in risk group membership for women 20-29.

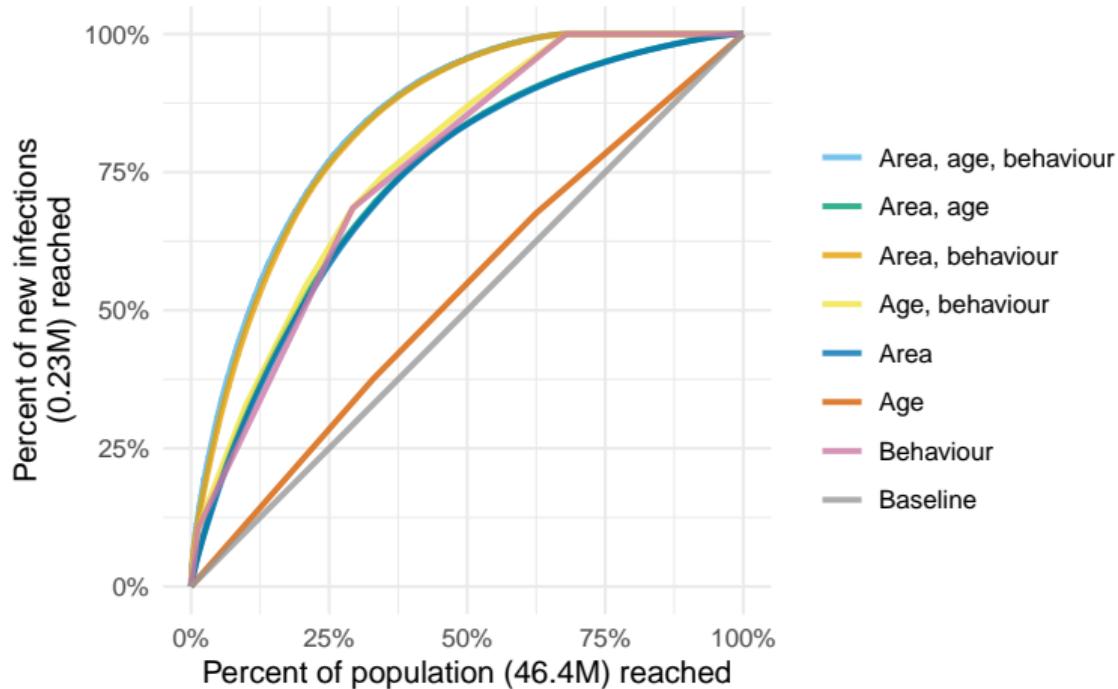
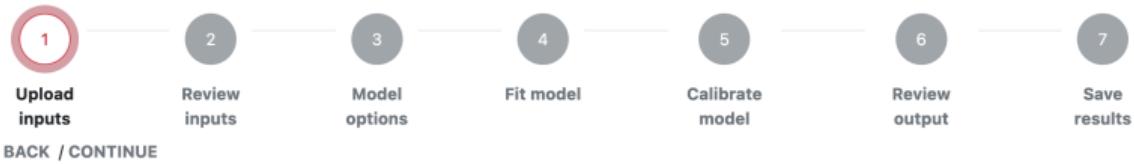


Figure 8: Supposing you prioritised those in the highest incidence strata, what percent of new infections could you find per percent of the population reached?

Where might this work go

- Extension to adults 15-49 and further countries
- Generation of estimates led by country teams as a part of a yearly process:
data ownership, data use, and data quality



Spectrum file (required)

Select new file

Browse

Area boundary file (required)

Select new file

Browse

Population (required)

Select new file

Browse

Household Survey (required)

Select new file

Browse

ART

Select new file

Browse

ANC Testing

Select new file

Browse

BACK / CONTINUE

Figure 9: Example of user interface for estimates generation.

3. Some broader thoughts on careers

- Upside: could influence health outcomes for many people
- Downside: part of a (more?) complex theory of change

$$\begin{aligned}\mathbb{P}(\text{impact}) = & \mathbb{P}(\text{relevant people interact with your work}) \\ & \times \mathbb{P}(\text{what you've done is useful}) \\ & \times \mathbb{P}(\text{message correctly conveyed}) \times \dots \\ & \times \mathbb{P}(\text{intervention technically works}) \\ & \times \mathbb{P}(\text{intervention correctly implemented}) \times \dots\end{aligned}$$

- How does this balance out?

About me

- Maths undergraduate → statistics masters → statistics (and machine learning, sort of) PhD
- Involved with Effective Altruism during my masters, and since then I've been interested in impactful applications of statistics

Applied methodology

- Being good (perhaps not great) at a useful enough collection of things
- Feeling like no one care about the application at methods conferences, and no one cares about the methods at application conferences

Team science

- A lot of disciplines required: Epidemiology, public health, health economics, behavioural science, implementation science, mathematics, statistics, computer science, software engineering
- Academia pushes against this by wanting every contribution to be marginally interesting in each field

CLEARER THINKING

with Spencer Greenberg

the podcast about ideas that matter

Episode 157: Science is learning from start-ups (with Adam Marblestone)

May 16, 2023

What are focused research organizations? Which kinds of research projects lend themselves to the FRO model? Researchers in academia frequently complain about the incentive structures around funding and publishing; so how do FROs change those dynamics? Why must FROs be time-limited, especially if they're successful? Who's in charge in an FRO? How does "field-building" help to improve science? What effects might large language models have on science?

Figure 10: Alternative structures for science.

Thanks for listening!

- More information on my website: athowes.github.io/about
- Feel free to get in contact if I can be useful: ath19@ic.ac.uk
- My PhD is supervised by Seth Flaxman and Jeff Eaton, and the risk group work is in collaboration with Imperial's HIV Inference Group, within the MRC Centre for Global Infectious Disease Analysis, and UNAIDS



MRC Centre for
Global Infectious
Disease Analysis

Imperial College
London



MACHINE LEARNING
& GLOBAL HEALTH NETWORK

Estimating risk group proportions: informal discussion

A summary, some potentially useful takeaways, and reflections on the paper
“Spatio-temporal estimates of HIV risk group proportions for adolescent girls
and young women across 13 priority countries in sub-Saharan Africa”

Figure 11: For more (informal!) take a look at the blog post on my website⁴

PLOS GLOBAL PUBLIC HEALTH

OPEN ACCESS  PEER-REVIEWED

RESEARCH ARTICLE

Spatio-temporal estimates of HIV risk group proportions for adolescent girls and young women across 13 priority countries in sub-Saharan Africa

Adam Howes , Kathryn A. Risher, Van Kinh Nguyen, Oliver Stevens, Katherine M. Jia, Timothy M. Wolock, Rachel T. Esra, Lycias Zembe, Ian Wanyeki, Mary Mahy, Clemens Benedikt, Seth R. Flaxman, Jeffrey W. Eaton

Published: April 19, 2023 • <https://doi.org/10.1371/journal.pgph.0001731>

Article	Authors	Metrics	Comments	Media Coverage	Peer Review
					

Figure 12: For more (formal!) take a look at the paper.