

Understanding the Research to Policy Process in Zambia:

The case of Cotrimoxazole Preventative Therapy

Results for Dissemination - Comments Welcome

Background

Cotrimoxazole prophylaxis for the prevention of HIV-related infection in adults and children has been recommended by the WHO and UNAIDS since 2000. WHO, UNAIDS and UNICEF produced a statement on its paediatric use in 2004 and in 2006 the WHO provided detailed guidelines on the use of Cotrimoxazole preventative therapy (CPT) for adults and children.

In Zambia, a complex process was involved behind the eventual provision of CPT, the study of which can provide insights into the important aspects of policy change. Providing CPT first appeared as a Zambian policy goal in 2006 but it was only in 2007 that a detailed 'policy' was published by the government. This timing was surprising as one of the most important clinical trials on CPT (the 'CHAP' trial) was conducted in Lusaka several years earlier (between 2001- 2003). Although the results of the study were widely disseminated, both changes in practice on the ground, and development of an official government 'policy', appeared to require more than simply study

findings. While the National AIDS Council technical working group on treatment and care accepted the use of CPT in principal after the publication of the CHAP study (2004), this did not appear to influence practice widely, and an official policy was not developed until 2007, in part because it was seen as an issue requiring higher level policy change at first. Investigation of this case illustrates the importance of understanding key issues such as the difference between guidelines, practice, and 'official' policy, as well as the factors which facilitate official policy change.

The study

This study, conducted by members of the Evidence for Action research consortium on HIV treatment and care, aimed to understand the process by which policy change happens in Zambia, in order to learn how to best facilitate the uptake of research evidence into policy. It used CPT as a case study. Methods included document review and interviews with key informants involved in the policy process. The fieldwork was conducted and completed in 2008.

There are plans for the Evidence for Action programme partners to continue with additional research focussing more specifically on the implementation of the policy, and provision of CPT on the ground – but this briefing reports on the completion of this initial piece of work.

Results

The multiple 'faces' of policy

The term 'policy' can have multiple meanings. For some, it is simply the field of activities of a government agency. For others, it can mean a much more specific official document that has been approved at the highest level. In most countries there will be a range of social and health services provided, only some of which have explicit national policy dictates behind them. There may also be many aspects of care which are left open to clinical judgement, or for which less official 'guidelines' will suffice. Whether or not a specific treatment, or specific aspect of care, is written into the highest level of policy may depend on a range of factors, including if there is a perceived need to do so. So, for example, while

very few countries would have official policies on the provision of analgesics to help with headaches, many will have official policies on Tuberculosis treatment. The case of CPT illustrates these nuances in a treatment for HIV infected individuals which originally was not written into any official policy in Zambia, but which changed over time. The reasons for both of these are explored here.

Analysis of the process of policy uptake shows that three key factors were critical in influencing changes in both policy and practice CPT. These were:

- The nature of the evidence, and how it was conceptualised;
- The role of key networks and individuals to facilitate policy change;
- The importance of changes in the policy context which provide both barriers and windows of opportunity.

Evidence and perception of the problem

According to interviews, the initial 2000 UNAIDS/WHO policy recommendations were seen sceptically by Zambian clinicians. This was because it was based on research undertaken in areas with low in vitro resistance to Cotrimoxazole (while in Zambia the in vitro resistance to CPT was high). As such, both practice and policy did not change dramatically in this time, as there was a need for more local verification. The CHAP study appeared to provide

this. While it was a study of treatment for children, it showed that Cotrimoxazole was effective in an area of high in vitro resistance – a finding critically important to the debate on CPT for adult care.

Following the dissemination and publication of the results of the CHAP study, the benefits of using CPT were widely accepted. This is where the first complexity of the policy process became apparent. Senior medics and researchers appear to have perceived the results to be an issue of clinical practice rather than government policy. For much health care, a national policy may not be needed to guide practice when there is flexibility or initiative on the part of front-line providers. Unfortunately, much HIV treatment in Zambia at this point was being provided by clinical officers rather than physicians. These staff had less discretion and choice over clinical practice, particularly for complex issues such as management of individuals infected with HIV. Without a government policy directive, it was not easy for it to be taken up in practice. As such, an official policy change appeared necessary.

Networks and individuals

In the field of policy analysis, key individuals who take up an issue and press for policy change are termed 'policy champions'. These individuals may not necessarily be the highest level officials or even the most well known, but they are the ones who provide voice to a particular issue, lobbying for or insisting on its inclusion in new

policy. According to interview statements, at first, no such champion appeared to emerge from the group of senior clinicians and medical researchers involved in the CHAP study, apparently due to the conceptualisation of CPT as an issue of clinical practice. This left a situation where practice was not changing in response to the evidence (as clinical officers did not alter practice as easily as physicians), but CPT was not being taken up in higher level policy arenas. Our study found, however, that by 2006, this situation changed. Multiple interviewees mentioned a key individual who came from outside who took up the issue more actively. It appears that the issue of CPT was finally taken up by a policy champion who had been involved in the creation of CPT policy in other countries, and who recognised the need to put CPT back onto the NAC/government policy agenda. This individual was also interviewed, and apparently he insisted that CPT be discussed and utilised in Zambia. As in most countries, Zambia has groups of actors who can often influence health policies at a national level. It is important for someone in these groups to press for an issue to be taken up in order to achieve official policy change.

Changing contexts

However, in addition to having a key individual or group in place, the national context must also be conducive to policy change for it to occur. A number of changes in the national HIV/AIDS policy context, for instance, may have led to delays in the process by which CPT made its way into policy. Initially, for example, the National AIDS Council technical working group members raised concerns with a weak national health systems context. There was fear of a lack of resources to purchase Cotrimoxazole and a poor institutional framework for it to be scaled-up nationally. Effectively, there were larger problems at hand in the local context which made the decision about CPT use more difficult.

In addition, when the results of the CHAP trial were released, senior politicians (including the President) had turned their focus to securing publicly funded ARV therapy. This was in line with international movements for scale up of ARVs which appears to have eclipsed the results of the CPT trial results. So while there were pieces of evidence to support CPT, policy agendas are often set as much by public mood and popular ideas. At that point in time, the big idea in HIV treatment was ARVs, not drugs for opportunistic infections. As such, other issues such as CPT were sidelined from the policy change agenda.

However, context shifts can also provide opportunity to push through changes, particularly if key

individuals or groups are able to recognise windows of opportunity to do so. With ART scale up, significant amounts of international funding for HIV services became available to Zambia for the establishment of ART/HIV clinics. As such, the necessary institutional structure was created for provision of CPT, removing the concern about adequate systems in place. And finally, in 2007 another opportunity arose as the ART regimen for Zambia was changed by the Treatment and Care Thematic Group, requiring the publication of a new official ART policy document. The CPT supporters used this as a window to insist that CPT guidelines be included as well.

Discussion

Strategies to facilitate evidence uptake in Zambia

Perception of the problem

New treatments must be framed as policy changes, and not just changes in clinical practice. Changes in clinical practice may be taken up by physicians (particularly those in large hospitals), but in Zambia, a large amount of treatment is provided by clinical officers who follow dictates from the MoH much more rigidly. To change practice of these crucial health staff, a memo is needed from the Permanent Secretary, which necessitates a policy shift (see process above).

Networks and individuals

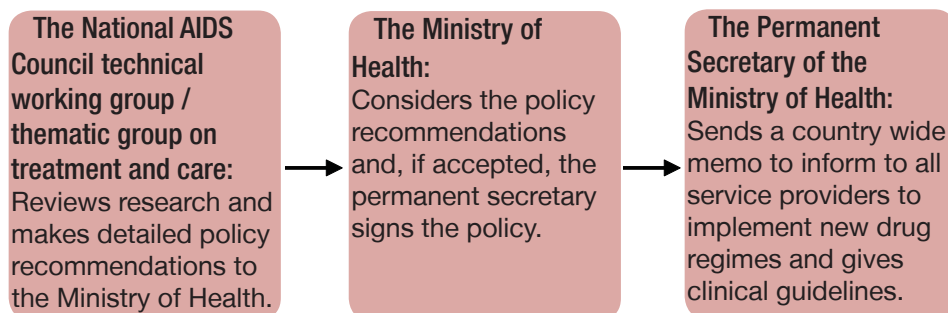
A policy champion, linked to the correct policy influencing networks, is often needed to put a new treatment on to the policy agenda. The case of CPT saw the research-to-policy process stall when no such champion existed. This resulted in CPT framed solely as an issue of clinical practice. Change materialised only after a champion arose who was involved in research on cotrimoxazole, implementation of HIV services, and who was linked to policy influencing groups.

Changing contexts

Often contexts cannot be controlled for, but they can be observed to identify when barriers might arise (as with the initial concern with systems in place), or when windows of opportunity arise to pursue policy change (such as when other changes are occurring). National and international attention to other issues (e.g. scaling up antiretroviral treatment) can push other, less politically visible, research findings off the agenda. It is therefore important to recognise how research results will be considered vis-a-vis other competing interests. However, the changes in policy that come with new priority issues can also provide opportunity to include new strategies in any ongoing policy changes. In Zambia, a process to develop new ART policy was used to finally include CPT in national policy. This required, however, a champion to recognise these opportunities and link to the appropriate policy process bodies.

Summary

CPT practice required a change in policy which appeared to follow a path such as the one below. This may be similar in other cases of changes to clinical practice for complex issues:



As such, it is important to recognise the strategic issues and challenges that influence progress at each step. For HIV treatment and care policy, the crucial elements include:

1. Framing the change as a policy shift, not clinical practice;
2. Ensuring a champion is able to promote uptake in the relevant policy process;
3. Looking for opportunities where policy change is going forward on larger issues, to integrate uptake of new evidence-based practices.

Credits

This work was conducted by members of the Evidence for Action research consortium on HIV treatment and care systems. Field work was conducted by Eleanor Hutchinson, London School of Hygiene and Tropical Medicine. Please send comments or suggestions to: Justin Parkhurst, London School of Hygiene and Tropical Medicine.

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on HIV treatment and care systems

About Evidence for Action

Evidence for Action is an international research consortium with partners in India, Malawi, Uganda, UK and Zambia, examining issues surrounding HIV treatment and care systems.

The research is organised in four key themes:

1. What “package” of HIV treatment and care services should be provided in different settings?
2. What delivery systems should be used in different contexts?
3. How best should HIV treatment and care be integrated into existing health and social systems?
4. How can new knowledge related to the first three questions be rapidly translated into improved policy and programming?

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