NEWSLETTER
TRAINING IN SECOND GENERATION HIV SURVEILLANCE
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Starting the Training in 2nd Generation Surveillance of HIV/AIDS for the Countries of Central and Eastern Europe and Central Asia

In September 2003, the Andrija Stampar School of Public Health in Zagreb, Croatia started to carry out the WHO and GTZ funded project on Training in Second Generation HIV/AIDS Surveillance. The goal of the project is to support countries of Central and Eastern Europe (CEE) and Newly Independent States (NIS) in the optimal access to and use of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other large resources through supporting the development of local technical capacity in launching large-scale and urgent responses to HIV/AIDS.

This project occurs within the framework of the WHO Project Capability Strengthening for Improved Utilisation of Financial Resources to Fight HIV/AIDS which aims to develop a number of existing regional institutions and networks. It is funded through a grant of the "Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)", Germany.

The goal of the training course is to to improve the surveillance of HIV and STI (sexually transmitted infections) in the countries of Central and Eastern Europe and the Newly Independent States.

In the late 1990s a framework termed "second generation HIV surveillance" was developed by WHO and UNAIDS with the aim to tailor surveillance systems to the needs of the specific epidemic states. AIDS case reporting, HIV case reporting, sero-surveillance and behavioural surveillance together with the STI surveillance are indispensable for monitoring epidemic trends and evaluating the effects of prevention measures[1]. The surveillance of HIV requires the collection of demographic and behavioural data because of the unique link between HIV epidemiology and behaviours. Purpose of surveillance is to promote the most effective use of health resources and to gather information in such a way that it is directly applicable to prevention programmes.

The training in Second Generation HIV/AIDS Surveillance at the Andrija Stampar School will be provided through the following modules from May 2004:

- Introduction to 2nd generation HIV/AIDS surveillance
- Biological/serosurveillance
- Behavioural surveillance
- Surveillance of sexually transmitted infections
- Surveillance in hard to reach populations

Training courses will be provided in both Russian and English language for:

- AIDS programme managers
- Government officials responsible for planning and implementation of HIV prevention policies and services
- Other key stakeholders from NGOs, academic institutions and educational organisations
- Private sector
- Religious and faith groups with responsibility for planning and implementation of HIV prevention and treatment policies and services

By UNAIDS and WHO classification, the countries of CEE and NIS have been characterised by a low-level or concentrated epidemic. In the low-level epidemic stage (HIV prevalence has not consistently exceeded five per cent in any defined sub-population), where HIV infection is largerly confined to groups with high-risk behaviours (sex workers, drug injectors, men having sex with men), surveillance systems should focus largely on behavioural data and STs data collection, as markers of risk. In concentrated epidemics where HIV is over five percent in any sub-population at higher risk of infection but remains below one percent in pregnant women in the general population, surveillance systems should monitor infection in those groups and pay particular attention to behavioural links between members of those groups and the general population[2].

Surveillance systems should be able to provide data for the purposes of advocacy and resource mobilisation, planning of prevention programmes and their monitoring and evaluation. Better understanding of the conditions and high-risk behaviours for potential wider heterosexual spread of HIV in this region would enable predictions of the future course of the epidemic and planning of prevention services. The greatest challenge for surveillance in low-level and concentrated epidemics is gaining access to the high-risk communities in order to track both behaviour and infection.

Principles of 2nd generation surveillance:

- Be appropriate to the epidemic state
- Be dynamic, changing with the epidemic
- Use resources where they will generate most useful information
- Compare biological and behavioural data for maximum explanatory power
- Integrate information from other sources
- Use data produced to increase and improve the national response

The course will:

- Describe the theory and practice of public health surveillance for HIV/AIDS and STIs and principles and practice of behavioural surveillance in general and in hard to reach populations (sex workers, injecting drug users, men who have sex with men)
- Provide an overview of data collection, analysis, interpretation and reporting
- Enable better understanding of practice of surveillance by building

SURVEILLANCE OF HIV/AIDS AND STIS IN EUROPE

The European Centre for the Epidemiological Monitoring of HIV/AIDS (EuroHIV), which is the UNAIDS/WHO Collaborating Centre on HIV/AIDS, collects and reports on the HIV/AIDS data for 52 countries of the WHO European Region according to the three geographical areas: the West, the Centre and the East[3].

By the end of 2002, there were 484.910 people living with HIV/AIDS in Europe, out of that 165.454 in West, 19.272 in Centre and 300.184 in East. By 2002 data, the reported number of HIV incident cases increased since 1999 by 62% in West, 10.4% in Centre and 137% in East. In several countries in Western Europe (Denmark, France, United Kigdom), it is estimated that about two thirds of the HIV infected population has been diagnosed. The proportion of diagnosed in countries of central and eastern Europe is estimated to be lower. Very few countries in central and eastern Europe have data on HIV prevalence in high-risk groups (IDUs, sex workers, men who have sex with men). For the most of CEE and NIS targeted surveillance systems for HIV that would also include monitoring of STIs and monitoring of behaviours have not been undertaken[4].

HIV/AIDS and sexually transmitted infections (STI) pose a significant threat to the health of eastern Europeans. In Centre, injecting drug use was the most common risk factor for HIV in men (89.3% of diagnosed men were IDUs). In women, heterosexual transmission was the most widespread way of HIV transmission. In even 34.8% of males and 44.3% of females infected by HIV the transmission category in CEE countries was unknown. The countries of central and eastern Europe have been characterised by a low-level epidemic, though some countries experienced a rapid increase of HIV cases. Such was the case in Estonia where in 1999 the number of recorded cases of HIV was 12, whereas in 2002 it increased to as high as 890. In Latvia, there was the increase from 242 cases in 1999 to 542 cases in 2002. In East, 61% of male and 44% of female HIV cases in 2002 were among IDUs. Similarly as in CEE, data on transmission route often has quite high proportion of missing values (in 31.8% of males and 35.4% of females the transmission category was left as unknown)[5]. To control HIV epidemic, target groups for HIV/STI sentinel surveillance and behavioural surveillance should include high-risk groups (IDUs, sex workers, prisoners, men who have sex with men) and bridging populations (clients of sex workers, sex partners of IDUs) and pregnant women in urban areas.

The epidemiological surveillance system for HIV/AIDS and STIs and behavioural surveys should be used as critical tools for generating public awareness and public health action against HIV and sexually transmitted infections. By quantifying risk behaviours and multiple modes of exposure they provide an evidence-based approach to primary and secondary HIV and STI prevention programmes.

The HIV epidemic in the countries of central and eastern Europe and central Asia is currently the fastest growing HIV epidemic in the world. It is happening in the context of the rapid social change and economic hardship, widespread drug injecting, increased sexual risk behaviour, poor access to information and to preventative services, and lack of knowledge and skills on protection. Ongoing high vulnerability to HIV points out the need to set up surveillance systems that enable the first step in ensuring evidence-based and targeted interventions.

In spite of significant threat of HIV/AIDS, this region has many strengths and commitments to successfully fight it. High-quality training that will provide both theoretical and practical advise to those involved in monitoring the epidemic is therefore of paramount importance.

Recommendations for HIV surveillance in a low-level epidemic

- Cross-sectional surveys of behaviour in sub-populations with risk behaviour
- Surveillance of STIs
- HIV surveillance in sub-populations at risk
- HIV and AIDS case reporting
- Tracking of HIV in donated blood

Recommendations for HIV surveillance in a concentrated epidemic

- HIV and behavioural surveillance in sub-populations with risk behaviour
- HIV and behavioural surveillance in bridging groups
- Cross-sectional surveys of behaviour in the general population
- HIV sentinel surveillance in the gereral population, urban areas

Preventability of the HIV epidemic and scaling up of the resources to fight it, urge the need for the high-quality surveillance which should provide relevant, accurate, and timely data to enable development of prevention initiatives.

Following traning courses will be provided as of May 2004 in Croatia, in collaboration with the WHO Regional Office for Europe, WHO Headquarters and the Hamburg University of Applied Sciences:

1. ***Introduction to 2nd generation HIV/AIDS surveillance***
2. ***Biological/serosurveillance***
3. ***Behavioural surveillance***
4. ***STI surveillance***
5. ***Surveillance of hard to reach populations***

Each module will last one week, and will comprise of lectures and case-study examples.

1 Second generation surveillance for HIV/AIDS: the next decade. UNAIDS/WHO. Geneva. 1999.
2 Second generation Surveillance for HIV: The Next Decade. WHO & UNAIDS. Geneva. 2000.
3 West includes: EU countries - Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom and others: Andorra, Iceland, Israel, Malta, Monaco, Norway, San Marino, Switzerland Centre includes: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, Macedonia, Poland, Romania, Slovakia, Slovenia, Turkey, Serbia and Montenegro East includes: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazahstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan
4 Kelly JA, Amirkhanian YU. The newest epidemic: a review of HIV/AIDS in Central and Eastern Europe. In J of STD & AIDS 2003; 14: 361-71.
5 HIV/AIDS Surveillance in Europe. End-year report 2002. European Centre for the Epidemiological Monitoring of AIDS. UNAIDS/WHO Collaborating Centre on AIDS. No. 68. 2003.

**The information on the project and the courses can be found on the web pages www.snz.hr.
For other information, please contact us on the following address:**

**Training in HIV Surveillance
School of Public Health "Andrija Stampar"
Rockefellerova 4
10 000 Zagreb, Croatia**

**Tel: + 385 1 290 25 75, Fax: + 385 1 290 37 52
E-mail: training@snz.hr**

We look forward to working with you!

By Professor Stjepan Orešković, PhD

Behavioural surveillance

In low level and concentrated HIV epidemics, surveillance systems for HIV should rely greatly on behavioural data, yet many behavioural aspects of the HIV epidemic remain incompletely documented and poorly understood.

Behavioural surveillance for HIV includes cross-sectional surveys in the general population and surveys in specific sub-populations that are at more risk for HIV.
General population-based surveys should yield standardised data that are comparable over time and geographic areas. General population-based surveys of sexual behaviour, known as KAPB studies of knowledge, attitudes, behaviours and practices, have been undertaken in a large number of countries since the late 1980s. They enable assessment of levels of risk behaviours and links between the population with low and higher risk behaviour. They also enable evaluation of prevention campaigns[1] and can be useful for advocacy, further programme development and as a source of explanation for changes in trends of HIV infection in the general population.[2]
Sub-population based behavioural surveys are carried out in populations that are at higher risk of HIV like injecting drug users, men who have sex with men and sex workers. Such surveys can also include questions about the links with people outside the populations in question.

Constructing a reliable sampling frame in these populations can be very challenging and can require mapping of sites. As there is considerable potential for bias due to problems of sampling, sources of bias should be presented along with the survey results. Bias can be minimalised by ensuring fully informed consent and absolute confidentiality and by using self-administered anonymous questionnaires that yield less reporting bias than face-to-face interviews. By behavioural surveys we can identify sub-populations at risk and set up serosurveillance systems where they can yield maximum information about the epidemic. The main objective of the recommended behavioural surveillance systems is to use a consistent sampling strategy in multiple rounds of data collection to track trends in key indicators over time.[3] Developing any system of behavioural data collection should begin with a careful preliminary assessment of the behavioural situation. The assessment will have several components: a review of existing behavioural studies and data sources in the country, a rapid assessment of risk behaviours, mapping of where the risk is and who is at risk, and formative qualitative research to identify opportunities, barriers and appropriate approaches to promoting behaviour change.[4]
Biological and behavioural data within the second generation surveillance system for HIV should be used to validate one another.[5]

Behavioural surveillance programmes have been implemented e.g., in the USA, UK, Switzerland and Australia and in some of these countries indicators that include sexual, protective and health seeking behaviour for HIV and STIs have been developed.[6]

Behavioural indicators:

- Sex with a nonregular partner in last 12 months
- Condom use at last sex with a nonregular partner
- Youth: age at first sex
- Drug injectors: reported sharing of unclean injecting equipment
- Sex workers: reported number of clients in the last week

Although HIV epidemics are influenced mainly by behaviour, national prevention programmes are often designed with limited understanding of determinants of high risk behaviour in various populations vulnerable to HIV.

The behavioural surveillance module aims to describe the contribution that monitoring behaviours can make to understand the determinants of HIV epidemics and their changes over time, as well as the planning and implementation of HIV prevention programmes.

The module will include a theoretical part and practical exercises which will address the following issues:

- What is Behavioural Surveillance (BS) and why are behavioural data needed?
- BS as component of 2nd generation HIV surveillance
- Uses and advantages of BS
- Overview of BS in Europe
- Steps of setting up a BS System
- Choosing population groups
- Choosing respondent groups by state of the epidemic
- Defining potential respondents: eligibility criteria
- Sampling approaches
- Importance of sampling
- Sampling plan
- Probability and non-probability sampling methods
- Multi-stage cluster sampling
- Sample size requirements and parameters for calculations
- Weighting in multi-stage sampling
- Weighting the data
- Potential bias from not weighting
- Calculating standard errors
- Adapting and using questionnaires
- Time frames of key behaviours
- Informed consent
- Assuring quality control
- Analysis and interpretation of results
- Recommended methods of statistical analysis
- Bivariate analysis
- Stratified analysis
- Multivariate analysis
- Analysis of trends in behaviours over time
- Sources of bias
- Use of BS for estimation and modelling
- Use and dissemination of BS information to improve HIV prevention efforts
- Packaging the data for different users
- A strategy for presenting data
- Data presentation for clarity and impact
- Indicators

1 Dubois-Arber F, Jeanin A, Spencer B. Lond term evaluation of a national AIDS prevention strategy: the case of Switzerland. AIDS 1999; 13: 2571-82
2 Rugg DL, Heitgerd JL, Cotton DA et al. CDC HIV prevention indicators: monitoring and evaluating HIV prevention in the USA. AIDS 2000; 14: 2003-13
3 http://www.fhi.org/en/HIVAIDS/FactSheets/behavdatacol.htm
4 Family Health International. Behavioral Surveillance Surveys: guidelines for repeated behavioral surveys in populations at risk of HIV. Arlington, VA: FHI, 2000.
5 UNAIDS|WHO Working Group on Global HIV|AIDS and STI Surveillance. 1999. Guidelines for second generation HIV surveillance. World Health Organization and the Joint United Nations Progamme on HIV|AIDS. 2000
6 McGarrigle CA, Fenton KA, Gill ON, Hughes G, Morgan D, Evans B. Behavioural surveillance: the value of national coordination. Sex Transm Infect 2002; 78: 398-405

By Professor Dražen Lalić, PhD

Surveillance in hard-to-reach populations

The rapid spread of HIV/AIDS in central and eastern Europe and in the central Asian countries in recent years has been particularly worrying in some vulnerable, socially marginalized groups. Members of these groups have a specific lifestyle and are engaged in high-risk behaviours. Many of these people are often involved in criminal activities and often experience problems with the police and the judiciary. They are exposed to social condemnation and because of that they often do not identify with such groups. Because of these and other reasons it is often hard for researchers, health professionals and social workers to reach people who are involved in high-risk behaviours and who belong (according to their lifestyle) to such groups.

Because of threat of HIV/AIDS and other health and social problems, it is of utmost importance to reach injection drug users (IDUs) - a subpopulation which has been in the last 13 years the most vulnerable to HIV/AIDS. Since 1990 the number of newly registered cases of AIDS in that subpopulation has become bigger than a number of cases in the subpopulation of male homosexuals.[1] In many countries of east and central Europe and central Asia, IDU is a major group affected by HIV. Moreover, growing dynamics of transmission of HIV from IDUs to their sexual partners and other people who have sexual contacts with them (namely, many IDUs are sex workers) in that countries is extremely important.

Hard to reach populations are, first of all, IDUs, sex workers and men who have sex with other men. During the last ten years in some countries of central and eastern Europe and central Asia the number of IDUs, sex workers and male homosexuals who are infected by HIV virus and who have AIDS has risen. In some regions and towns the rise has been dramatic. For example, in the Russian Federation 90% of 1 million people infected with HIV in 2003 were IDUs.[2] In some cities, HIV prevalence among registered sex workers is high - in Yerevan, Armenia in 1999 it was 7.5%.[3] In drug-injecting sex workers in Kaliningrad, the Russian Federation HIV prevalence was in 1997 found to be as high as 65%.

In central and eastern Europe and Central Asia HIV/AIDS epidemics have characteristics of low-level and concentrated epidemics. The surveillance activities for HIV/AIDS should in these circumstances monitor infection and behaviours in high-risk groups, paying particular attention to links between members of these groups and "bridging populations" (sexual partners, clients of sexual workers and others) which link the core groups with the general population. Particular attention, especially in the low-level epidemics should be paid to searching for changes in behaviours that may lead to the increase of infection.

Surveillance in hard to reach populations, as a crucial part of the second generation surveillance for HIV, responds to the diversity of HIV epidemics, trying to explain changes over time by providing information about subpopulations at the highest risk. Surveillance for HIV/AIDS also considers differences between various countries, regions and towns according to the state of the epidemic: where the epidemic is concentrated in population with high-risk behaviours, the surveillance system should provide evidence-base for designing focused interventions, prevention programmes and health policies on HIV/AIDS.

Second generation surveillance systems make better understanding of the nature and dynamics of HIV/AIDS epidemic. Surveillance in hard-to-reach populations combines different methods: biological (sero-serosurveillance) and behavioural (repeated surveys in defined high-risk populations) and other sources of information (case surveillance, death registration).

Data from HIV/AIDS surveillance in hard-to-reach populations can be used to monitor trends in epidemic over time as well as to provide information necessary for development of primary and secondary prevention programmes and public policy related to HIV/AIDS.

The training module on the surveillance of HIV/AIDS in hard-to-reach populations will include theoretical part and practical exercises. Practical exercises will be in the form of case studies and examples, which will be drawn from experiences of different countries, regions and towns. Such will be, for example, the case study of Split, Croatia, as a town in which in 1996 the first needle-exchange programme in this part of Europe was established, along with the out-reach programmes for IDUs and sex workers by the non-government organisations and the municipality.

Training workshop on methods for HIV/AIDS estimates and projections for CEE and NIS Countries held in Šibenik, Croatia in July 2003.

Training module will address the following issues:

- Principles and structure of the surveillance for HIV/AIDS in hard to reach populations
- Study designs to assess HIV prevalence among hard to reach populations
- Sentinel HIV case reporting from IDUs and sex workers
- Data collection methods for HIV surveillance in hard to reach populations
- Case-studies and examples of the needle exchange and other forms of harm-reduction and out-reach programmes for IDUs and sex workers
- Analysis, interpretation and the use of data

1 Begovac J. Spread of HIV infection in the world. In: Begovac, Beus and al. HIV/AIDS Disease. Zagreb. 1996.

2 Burrows D, Holmes D, Schwalbe N. HIV/AIDS in the former Soviet Union. Aids Link #72. February/March 2002.

3 UNAIDS/WHO working Group on Global HIV/AIDS Surveillance.

By Ivana Božičević, MD, MSc

Surveillance of sexually transmitted infections

It has become increasingly appararent that sexually transmitted infections present a major public health problem and contribute substantially to the overall burden of disease in central and eastern European and central Asian countries. WHO estimated that there were 22 million new cases of curable STI among adults in 1999 in this region.
STI surveillance has an important role in the second generation HIV surveillance because trends in the STI incidence and prevalence serve as useful indicators of changes in sexual behaviour. The increase in the number of STI diagnoses over the past years and the emergence of several outbreaks in Europe have highlighted the need to develop more effective STI surveillance[1,2]. The heterogeneity of STI surveillance systems results in poor comparability of surveillance data and limits the ability to interpret Europe-wide trends. The importance for strengthened surveillance of sexually transmitted infections is recognised as they are featuring among 12 potential major European health protection emergencies that will be monitored by the European Union Public Health Centre for Communicable Diseases and Other Threats to Health which is planned to be established in the near future[3]. The EU Decision (EC 2119/98) also listed STIs as one of the disease groups for which an EU-wide STI surveillance network should be established.[4]

The dramatic rise in STIs, particularly syphilis has been recorded in eastern Europe and Newly Independent States though the reported data underestimate the true size of the epidemic. STIs are particularly present in the marginalised groups, such as sex workers, drug users, homosexual men, homeless and street children. Antibiotic resistance poses another serious problem in the region.[5] Young people have also become highly vulnerable to STIs in the wake of the rapid social change, economic hardship and increased insecurity. Widespread drug injecting, increased sexual risk behaviour, poor access to information and to preventative services, and lack of knowledge and skills to protect themselves from the infection significantly increased the overall risk of HIV and STI infections among youth in the region.

Surveillance of sexually transimitted infections provides a valuable source of information for shaping health policies on HIV/AIDS. Within the 2nd generation surveillance of HIV, surveillance of sexually transmitted infections acts as an early warning system of HIV transmission and, in mature epidemics, can be used as the evaluation tool for HIV prevention programmes. Main components of STI surveillance include STI case reporting, STI prevalence assessment and monitoring of anti-microbial resistance. The advantages of sentinel STI case reporting as compared to universal is that sentinel surveillance enables a more complex data collection from a fewer and highly motivated health care facilities. Surveillance of STIs usually relies on the data supplied from the various clinical settings where patients seek diagnoses and tretment, as well as laboratories. Clinical services for STIs are important point of contact with persons at high risk of both HIV and STIs, not only for diagnoses and treatment, but also for surveillance purposes.

STIs, both curable and uncurable, can facilitate the transmission of HIV which makes early diagnosis and effective treatment of sexually transmitted diseases an important strategy for the prevention of HIV transmission.[6] Research results from sub-Saharan Africa indicate that intercurrent STIs are particulary important as cofactors for HIV in epidemics where significant proportion of transmissions are occurring between core and bridging groups.[7]

Data from the STI surveillance system can be used to assess the burden of sexually transmitted disease, to monitor their trends over time and to provide information necessary for management of primary and secondary prevention programmes and advocacy and resource mobilisation. Many current surveillance systems of STIs do not provide necessary information on risk factors and have poor coverage. In eastern European countries in particular, sexual health services are often provided by private practicioners and reporting from such settings is often inadequately established.

The quality and completeness of data on STIs depend on the patterns of health seeking behaviour and characteristics of health services organisation such as quality of reporting and the intensity of case finding and diagnosis. The completeness of STI data are also affected by the natural course of the STIs, since a large number of them are asymptomatic. In countries of eastern Europe and Newly Independent States where injection drug users (IDUs) represent a major core group affected by HIV, sexual transmission also plays an important role in the dynamics of HIV infection among IDUs and their sexual partners which can have implications for the wider heterosexual transmission.[8]

Photo: Vjeran Hrpka

Training module on the surveillance of sexually transmitted infections that will be organised at the Andrija Stampar School at Public Health in collaboration with WHO will address the following issues through lectures, case studies and exercises:

- Principles and structure of the STI surveillance system and its contribution to the Second Generation HIV surveillance
- Appropriate study designs to assess STI prevalence in symptomatic and asymptomatic populations
- Laboratory requirements in the STI surveillance
- Universal STI case reporting
- Sentinel STI case reporting and selection of sentinel sites
- Monitoring antimicrobial resistance as a core component of the surveillance system
- Analysis, interpretation and the use of data
- Dissemination of data and reporting

1 Heyden JHA, Catchpole MA, Paget W J, Stroobant A. European Study Group. Trends in gonorrhoea in nine western European countries, 1991-6. Sex Transm Infect 2001; 76:110-6.

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3 Roles and functions of a European Union Public Health Centre for Communicable Diseases and Other Threats to Health. Eurosurveillance 2002; 7 (5): 78-84

4 Fenton K, Giesecke J, Hamers FF. Europe-wide surveillance for sexually transmitted infections: a timely and appropriate intervention. Eurosurveillance 2001; 6 (5): 69-70

5 Waugh MA. Task force for the urgent response to the epidemics of sexually transmitted disease in eastern Europe and central Asia. View from the WHO. Sex Transm Inf 1999; 75:72-3.

6 Sexually Transmitted Diseases. Policies and Principles for Prevention and Care. UNAIDS Best Practice Collection. 1997

7 Grosskurth H, Gray R, Hayes R, Mabey D, Wawer M. Control of sexually transmitted diseases for HIV-1 prevention: understanding the implications of the Mwanza and Rakai trials. The Lancet 2000; 355: 1981-7.

8 Lownedes CM, Renton A, Alary M, Rhodes T, Garnett G, Stimson G. Conditions for widespread heterosexual spread of HIV in the Russian Federation: implications for research, monitoring and prevention. In J Drug Pol 2003; 14: 46-62

By Bernard Kaić, MD, MSc

Biological / serosurveillance

Serosurveillance for HIV infection is being increasingly recognized as a tool for

1. **Assessment of the burden of HIV infection in the population;**
2. **Forecasting the burden of disease in the future;**
3. **Monitoring trends in HIV epidemiology, evolution of HIV infection in the population**
4. **Identifying groups at risk and target populations with the highest needs for intervention.**
5. **Evaluation of implemented public health measures aimed at prevention and control of HIV infection**

Most central and eastern European countries have a surveillance system in place for HIV infection and AIDS, based on data collected from HIV testing laboratories and treatment clinics. Such surveillance systems provide a good basis for monitoring the present burden of AIDS in the population. As the case reports are usually accompanied by information obtained through questionnaires, surveillance systems are capable of providing information about certain characteristics of people living with HIV/AIDS, according to the category of risk behaviour or the risk group.

Therefore, all countries are able to provide information on HIV/AIDS cases by risk group, which means they are able to answer how much a risk group contributes to the total number of reported cases.

However, in order to be able to target interventions to specific risk groups with the highest needs and in which the impact of intervention will be the highest, there is a need to know the prevalence of HIV infection in these groups, its trends and evolution, and to monitor them through time.

The surveillance systems that most central and eastern European (CEE) countries have set up, do not allow for calculations of prevalence or incidence. Only surveillance systems supplemented with well designed seroprevalence studies in the general population, as well as in risk groups, can provide reasonable assessment of HIV seroprevalence.

Combining seroprevalence studies with behavioural studies results provides a better understanding of risk behaviour in subpopulations and allows calculations of risk associated with a specific behaviour.
For low-level epidemic countries, as well as concentrated epidemic countries, it is essential to know seroprevalence trends in subpopulations at higher risk in order to find a link between risk behaviour specific to the subpopulation and the risk of HIV infection and to target prevention activities to subpopulations identified to be at the highest risk.

Seroprevalence studies in subpopulations at higher risk are difficult to carry out since every step of thestudy design is a specific problem to solve. The very first step, defining the study population, requires comprehensive understanding of the size and characteristics of subpopulations which are often very closed because they are subject to stigmatisation or because their lifestyle is illegal. It gets even more difficult when it comes to selecting a representative sample of such a subpopulation.

For these reasons, it is of the utmost importance to cooperate with nongovernmental organisations which either represent the subpopulations of interest, or are involved in working with representatives of subpopulations (harm reduction services, education of subpopulations at risk, public campaigns aimed at educating the population and destigmatisation, promoting alternative lifestyles, increasing the availability of health care, etc.).

Most governmental institutions in central and eastern European countries have very limited or no experience in reaching hard-to-reach subpopulations (module V "Surveillance in hard to reach populations") and in working in close cooperation with NGOs, therefore, methodological and laboratory issues of surveillance covered by this module must be supplemented with guidelines for approaching hard to reach populations (module V).

GlaxoSmithKline's international programme of HIV education

Positive Action

Positive Action is GlaxoSmithKline's international programme of HIV education, care and community support. Through the programme, GSK works in partnership with individuals, community groups, healthcare providers, governments, international agencies and others, in order to pursue the common goals of more effective HIV prevention, education, enhanced care and support for people living with, or affected by HIV/AIDS. Since its inception in 1992, Positive Action has supported and implemented a wide variety of projects at both a national and international level, throughout the world.

Positive Action is focused on a number of major areas of activity, each addressing a specific area of identified need. The aim is to bring together people living with and affected by HIV, healthcare professionals, industry, government and the voluntary sector in order to develop innovative and effective programmes, share best practice and generate future strategies.

HIV Community Support

One response of people living with, or affected by HIV/AIDS has been to form a rich diversity of self-help organisations. These community-based groups provide a wide range of information, counseling care and other support services, and form the backbone of the fight against HIV in many countries.
Positive Action is actively working in partnership with HIV communities around the world to build on this foundation by providing support for partner organisations to conduct prevention and education campaigns, fundraising and awareness-raising programmes, outreach schemes for marginalised communities and counseling services.
Support is also provided for initiatives that share information among community groups, at both a national and international level - for example, through skills-building workshops. These projects help to share examples of best practice and ensure that communities can build on the success of others' innovative ideas.
Positive Action is also working in partnership with community-based organisations on activities designed to promote a wider understanding of HIV/AIDS-related issues among those not directly affected, in order to combat stigma and prejudice. Through such advocacy programmes Positive Action aims to empower vulnerable groups of HIV-positive individuals to demand the same standard of care as others.

Countries which have benefited from Positive Action partnership initiatives include:

Australia, Austria, Bangladesh, Belgium, Botswana, Brazil, Burkina-Faso, Cambodia, Cameroon, Canada, China, Cote d'Ivoire, Cuba, Ecuador, Ethiopia, France, Germany, Greece, Honduras, Hong Kong, India, Indonesia, Italy, Kenya, Malaysia, Mexico, Morocco, Netherlands, Nigeria, Peru, Philippines, Poland, Portugal, Romania, Russia, Senegal, South Africa, Spain, Sri Lanka, Switzerland, Taiwan, Tanzania, Thailand, Togo, Trinidad, Uganda, United Kingdom, USA, Zambia.

Preventing HIV epidemics and scaling up resources for interventions, need high-quality surveillance systems which can provide relevant, accurate, and timely data.

The following traning courses will be provided as of Spring 2004 at the School of Public Health "Andrija Stampar" in Zagreb/Croatia, in collaboration with the WHO Regional Office for Europe:

1 **Introduction to 2nd generation HIV/AIDS surveillance**

2 **Biological/serosurveillance**

3 **Behavioural surveillance**

4 **STI surveillance**

5 **Surveillance of hard to reach populations**

Each module will last one week, and will comprise lectures, exercises and case-study examples from the region.

Information on the project and courses

can be found on the web site **www.snz.hr**

For other information, please contact us at the following address:

Training in HIV Surveillance

School of Public Health "Andrija Stampar"

Rockefellerova 4, 10 000 Zagreb, Croatia

Tel: + 385 1 290 25 75

Fax: + 385 1 290 37 52

E-mail: training@snz.hr

We look forward to working with you!

WHO
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BACKUP Initiative
Building Alliances – Creating Knowledge – Updating Partners in the fight against HIV/AIDS, TB and Malaria

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