

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC**



REPORT

**WORKSHOP ON HIV, AIDS AND STI
IN THE WESTERN PACIFIC REGION**

Manila, Philippines
21 – 25 June 1999

Manila, Philippines
July 1999

CONTENTS

	<u>Page</u>
1. INTRODUCTION	1
1.1 Objectives	1
1.2 Participants and resource persons	2
1.3 Organization of the workshop.....	2
2. PROCEEDINGS	2
2.1 Summary of day 1: HIV/AIDS surveillance - latest development	2
2.2 Summary of day 2: Behavioural surveillance.....	3
2.3 Summary of day 3: STI surveillance and gonococcal antimicrobial surveillance...4	
2.4 Summary of day 4: Disseminating and using data from surveillance programmes.5	
2.5 Summary of day 5: HIV, AIDS and STI surveillance indicators and targets	6
3. CONCLUSIONS.....	7
 <u>ANNEXES:</u>	
ANNEX 1 - TIMETABLE	11
ANNEX 2 - LIST OF PARTICIPANTS	13
ANNEX 3 - STI SURVEILLANCE PRODUCTS	20
ANNEX 4 - PROPOSED INDICATORS AND TARGETS	21
ANNEX 5 - WORKSHOP EVALUATION	23

1. INTRODUCTION

The second Regional workshop on HIV, AIDS and STI surveillance was organized by WHO in the Western Pacific Region. Since the previous meeting in 1997, a number of Member States had improved their HIV, AIDS and STI surveillance methodology essentially through:

- reviewing HIV/AIDS surveillance strategies and procedures;
- integrating behavioural surveillance into existing HIV and AIDS epidemiological surveillance activities;
- improving STI surveillance;
- expanding the Gonococcal Antibiotic Susceptibility Programme network

In addition, since 1997, WHO had:

- provided increased resources for surveillance in the Region;
- facilitated the development of a regional network of experts, including the GASP network, and a network of consultants;
- drafted guidelines for STI surveillance and use of new technologies, including the use of saliva testing for HIV, and new methods of STI diagnosis;
- provided technical and financial support for the implementation of surveillance programmes and country level; and
- strengthened data collection, analysis and dissemination through publications, establishment of a internet site and meetings.

1.1 Objectives

The general objective of the workshop was to strengthen HIV, AIDS and STI surveillance in the Western Pacific Region.

At the end of the workshop, participants would have:

- (1) identified strengths and weaknesses of existing surveillance systems;
- (2) finalized operational guidelines for HIV, AIDS and STI surveillance in the Region;
- (3) defined regional standards, indicators and targets HIV, AIDS and STI surveillance;
- (4) reviewed methodologies and instruments for the flow and use of epidemiological data at national and regional level; and

(5) finalized a report on the status and trends of HIV, AIDS and STI.

The detailed programme of the workshop is attached as Annex 1.

1.2. Participants and resource persons

There were twenty-two participants from 14 countries in the Western Pacific Region, who are epidemiologists in charge of STI, HIV and AIDS surveillance at national level in their respective countries.

The secretariat from the Western Pacific Regional Office provided technical and operational support for the workshop. The list of participants, consultants, temporary advisers and secretariat is attached as Annex 2.

1.3 Organization of the workshop

The workshop was held at the Western Pacific Region Office, Manila, the Philippines, from 21 June to 25 June 1999. Methods used in the workshop were: short presentations; small group work; and plenary discussions, to encourage active involvement by the participants. A chairperson was selected each day to coordinate activities during the session. Participants were asked to fill the expectation form at the beginning and the evaluation form at the end of the workshop.

On behalf of Dr S. Omi, Regional Director, Dr R. Nesbit, Director, Programme Management, opened and closed the workshop. He highlighted major progress in improving surveillance systems made by countries and WHO in the last few years. He also emphasized the usefulness of accurate epidemiological data on HIV, AIDS and STIs. He urged participants to be realistic in their goal setting, so that efforts and resources for intervention designs would be used most efficiently. On behalf of WHO/WPRO, he made a commitment to support surveillance activities.

2. PROCEEDINGS

2.1 Summary of day 1: HIV/AIDS surveillance - latest development

Outline of points covered:

- Dr Lazzari, UNAIDS/Geneva, presented an overview of the second generation HIV/AIDS surveillance, HIV/AIDS reporting and HIV surveillance.
- Experience in HIV/AIDS reporting in Malaysia and HIV sentinel surveillance in Viet Nam were shared with participants.
- Participants worked in three small groups, discussing key issues of HIV/AIDS reporting and HIV surveillance:
 - + How to improve detection and HIV/AIDS reporting
 - + Ethical and confidentiality issues

- + Integration in communicable disease surveillance system
- + Advantage and disadvantages of different sentinel groups in WPR countries
- + How to reach a sufficient sample size
- + Measuring HIV prevalence in Asian populations

Major outcomes or conclusions:

- Cautious interpretation should be made of HIV/AIDS reported data because of underreporting and under diagnosis.
- Although HIV and AIDS case reporting has many limitations, it should be continued because:
 - it is a good instrument for advocacy;
 - it can provide an early warning on emerging epidemics;
 - it is a useful instrument for monitoring trends and drawing estimates and projections; and
 - it provides an idea of the burden of AIDS on the health care system.
- Consideration should be given to developing cross sectional surveys of AIDS in selected hospitals to monitor the trends of bed occupancy related to AIDS.
- WHO should provide guidelines to assign mode of transmission to AIDS case reports.
- There is no need to develop a specific "Asia" AIDS definition
- Other data sources (e.g. blood screening data, one-off studies) should be used to calibrate prevalence estimates.
- HIV case reports are mainly useful in the early stage of an epidemic or in low-level epidemics.
- Clearly defined national protocols for HIV testing and surveillance should be developed, taking into account ethical issues. Linked HIV testing requires informed consent and appropriate follow-up of HIV-positive cases.
- Particular attention should be paid to ensuring the continuous monitoring of trends of HIV prevalence in selected populations.
- Integration of HIV/AIDS reporting into existing communicable disease reporting systems is recommended to make use of available facility and human resources and therefore reduce cost.

2.2 Summary of day 2: Behavioural surveillance

Outline of points covered:

- Mr Steve Mills and Dr Tobi Saidel, Family Health International, presented key issues on behavioural surveillance: conceptual overview of behavioural surveillance, methodological lessons learned, continuing challenges, sample groups, indicators and other variables, sampling techniques, validity, and common misperceptions of behavioural surveillance system (BSS). During the plenary session, participants discussed methodological issues, and special challenges: (difficult to reach sample groups: MSM, IDU; cross border sites; linking HIV and behavioural surveillance; implementation: private or public?).
- The Philippines and Cambodia presented their experiences in behavioural surveillance.

Major outcomes or conclusions:

- Behavioural surveillance studies (BSS) provide key information for planning and decision-making. However, BSS should be carefully used to evaluate specific prevention programmes
- BSS may be particularly relevant in the low-level and concentrated epidemic in the Asia-Pacific region
- BSS is not simple to implement and requires close attention to design, sampling, implementation issues, population needs, and effective dissemination.
- Validity of BSS is difficult to assess directly, and careful attention should be given to quality control (development and testing of questionnaires, selecting and training interviewers and triangulating with other biological and behavioural data sources). Good collaboration between social and biomedical researchers should be ensured.
- General population surveys might be considered every 4-5 years, regardless of the stage of epidemic.
- Other sources of information can complement BSS: e.g. geographic mapping of sex worker activity; or behavioural studies undertaken for other reasons

2.3 Summary of day 3: STI surveillance and gonococcal antimicrobial surveillance

Outline of points covered:

- Dr John Kaldor, Deputy Director and Professor of Epidemiology, gave a short presentations about key issues of STI surveillance: objectives of STI surveillance, methodology, strengths and weaknesses, feasibility, barriers and challenges of different methods used for STI surveillance (passive case reporting, monitoring routine practices at STI and non-STI clinics, laboratory based-surveillance, prevalence assessment and monitoring). He took several examples from countries in the region like Australia, Cambodia, the Philippines and Viet Nam, as basis for discussion.
- Dr J. Tapsall, GASP Coordinator, presented key issues of the Western Pacific Region Gonococcal Antimicrobial Surveillance Programme (GASP): Objectives and performance of gonococcal susceptibility surveillance; networks, principles, and methods for gonococcal susceptibility; past and present GASP data, improving GASP (participation, samples tested , access to isolates, infrastructure, logistics, and analysis of data)
- A country presentation about network experience recent expansion of GASP in China was illustrated for further discussion.

Major outcomes or conclusions:

- STI surveillance is very difficult. No one system can supply all answers. (Annex 3).

- The system supplying most outcomes – the special survey option – is expensive. It requires sophisticated laboratory support services which may not be available, and needs to be repeated at longer intervals e.g. 3-5 years.
- Reporting criteria should be matched to diagnostic criteria, e.g. syndromic diagnosis and syndromic reporting (although different systems may co-exist, e.g. etiological diagnosis).
- Simple options for surveillance can be used to supply quality information at little expense.
- A matrix of choosing toolkits for STI surveillance products was provided as a guide for STI programme managers to choose appropriate methods to meet certain objectives of the STI surveillance programme (Annex 3).
- GASP is well established in WPRO. It is an essential component of STI surveillance. Most countries are participating although the level of coverage varies and sustainability problems are encountered.
- It is sometimes difficult to reach a sufficient number of samples and there is a need to better define minimum sample sizes.
- Frequency of GASP sampling should be minimally annual and where possible, programmes should collect additional information on the isolates.
- Unavailability and high cost of STI drugs are common problems in many countries of the Region. Also, misuse and excessive use of antibiotics is contributing to the emergence of resistance.

2.4 Summary of day 4: Disseminating and using data from surveillance programmes

Outline of points covered:

- Dr James Chin, Family Health International, presented the Global HIV epidemiology, and patterns of prevalence, heterosexual transmission of HIV, limitations and factors influencing HIV estimates and projections.
- Country experience in using data for estimation and projection in Australia and Viet Nam were presented.
- Experience from Japan about HIV, AIDS, STI and behavioural surveys were presented.
- Dr Tim Brown, East-West Centre for Population and Health Studies, Hawaii, presented the key issues on how to communicate results for advocacy and for planning interventions.
- All participants shared their experience in disseminating HIV and STI data.
- Dr Pומרol, WHO Regional Adviser on Sexually Transmitted Infections and AIDS, presented the draft report on the Regional HIV, AIDS and STI situation.

Major outcomes or conclusions:

- The HIV epidemic is composed of many epidemics, at different stages in different countries, and among sub-populations within countries.
- National or sub-population estimates of HIV prevalence are subject to inaccuracy, but are in demand by political leaders, media and the public, and are frequently used for planning and for advocacy.
- If estimates or projections result from a stable and transparent methodology, this inspires confidence in the system. An overestimation of the magnitude of the epidemic in any country or population group may be more difficult to correct than an underestimation. These problems are more acute in countries with a low prevalence of HIV.
- There is a need to adjust methodologies for making estimates and projections to each situation. Guidelines for the process of estimation and projection, especially in low prevalence countries, including in Asia, should be developed .
- There is a need for studies to evaluate the usefulness and representation of antenatal HIV prevalence as a surrogate for HIV prevalence levels in the 15-49 year old male and female population in Asian Pacific countries for concentrated and generalized HIV epidemics. For generalized HIV epidemics, studies to evaluate potential HIV prevalence differentials in urban and rural populations in Asian Pacific countries are needed.
- Dissemination and use of data justifies its collection. Data may be disseminated for advocacy, for targeting prevention efforts, for designing programmes, and to encourage behaviour change
- Regional epidemiology report will be finalized after revision of country-specific reports.

2.5 Summary of day 5: HIV, AIDS and STI surveillance indicators and targets for the Western Pacific Region

Outline of points covered:

- Dr Tim Brown presented the introduction to indicators: objectives, and criteria for good indicators.
- Participants discussed in 4 small groups to select and develop indicators and targets for surveillance in the Region: HIV/AIDS, STI, behaviour surveillance and data dissemination
- Agreement was made on four sets of indicators for use in the Region (see Annex 4).

Major Outcome:

The workshop identified a limited list of national and regional indicators, to be used monitoring STI, HIV and AIDS programmes. (see Annex 4)

3. CONCLUSIONS

There is a need to define national protocols for STI, HIV and AIDS surveillance, which should follow the standards of ethical practice. All linked HIV testing must be preceded by counselling and informed consent, and needs to include appropriate follow-up care.

3.1 HIV and AIDS surveillance

- (1) Need for a flexible approach: A flexible surveillance approach is necessary to meet the needs of countries in different stages of the epidemic, and with different levels of resources for surveillance.
- (2) Value and limitations in HIV and AIDS case reporting: HIV and AIDS case reporting continues to be useful in:
 - providing information for advocacy;
 - serving as an “early warning” on emerging epidemic;
 - contributing information for monitoring trends and developing estimates and projections; and
 - providing information on the impact of AIDS on the health care system.

It is suggested that HIV and AIDS case reporting continue, and that this be used as part of surveillance information. However, there are a number of limitations in this information, especially regarding under-reporting and under-diagnosis of cases. Therefore, this information should be used cautiously and countries should try to estimate the level of underreporting.

- (3) Concentrate HIV surveillance on higher-risk groups in low prevalence countries: While HIV prevalence remains low (e.g., below 5%) in higher risk groups, it is very likely that HIV prevalence among lower-risk populations will be very low . Such higher risk groups usually include sex workers, IDU, men who have sex with men, STI patients, and groups likely to be clients of sex workers (e.g., frequent travellers, the military or police).

To make the best use of resources, sentinel surveillance in low-level epidemics should concentrate on population sub-groups at higher risk of HIV infection. Regular monitoring of lower risk groups (such as women attending ante-natal care) is only recommended once HIV prevalence in higher risk groups becomes 2%-3% or higher, and there is likely to be larger spread of the epidemic to lower risk groups.

- (4) Studies of rural vs. urban HIV prevalence: in generalized epidemics, there is a need to undertake studies of the difference between urban and rural HIV prevalence, as part of HIV surveillance activities
- (5) Studies of antenatal HIV prevalence: there is a need to undertake studies to evaluate the usefulness and representation of antenatal HIV prevalence as a surrogate for HIV prevalence levels in the 15-49 adult population for generalized HIV epidemics.

- (6) Studies of the hospital-based occupancy of HIV-related diseases: in generalized epidemics, there is a need to undertake cross-sectional surveys of hospital patients to identify trends in the burden of HIV-related diseases on hospital services
- (7) Monitoring of HIV prevalence among tuberculosis patients: It can be useful to monitor HIV prevalence among tuberculosis patients for a range of purposes, including early detection and monitoring of advanced disease patterns
- (8) Making use of data collected for other purposes than surveillance: National surveillance systems need to consider making use of information available from other sources, such as regular HIV screening programmes among blood donors, military recruits and migrant workers, taking into account the limitations of these data.
- (9) Need to have continuity in sentinel groups: When sentinel surveillance groups are changed (e.g., increasing the proportion of younger age groups), there is a need to ensure the comparability of new data with previous work, to enable trends to be identified and monitored.

3.2 Behavioural surveillance:

- (1) Importance of behavioural surveillance: Behavioural surveillance is important in:
 - identifying behavioural practices that put people at high risk of becoming infected with HIV and STI;
 - monitoring changes in behaviour over time; and in
 - providing key information for planning and evaluating intervention programmes.

Behavioural surveillance should be an integral component of the national surveillance programme on HIV/AIDS and STI.

- (2) Focus of behavioural surveillance depends on severity of HIV epidemic: Behavioural surveillance may focus on different groups at different stages of HIV epidemics. These groups include higher-risk groups (“core groups”), medium-risk groups (“bridge groups”), and lower-risk groups (others; the general population aged 15-49 years).

Specifically:

- (a). In low-prevalence epidemics, the focus may be on (a) higher risk groups to monitor the epidemic, and (b) lower risk groups to establish the level of risk behaviour in the general adult population.
- (b) In epidemics concentrated among higher-risk groups, the focus may be on all three groups (higher-, medium- and lower-risk). This is in order to monitor: the possible spread of the epidemic (a) out of the higher-risk groups to the medium-risk groups, and (b) onward to the lower-risk group. Behavioural studies of the general youth population may be especially important in identifying what proportion are in the medium- and lower-risk groups, and therefore identifying the potential spread of the epidemic.

(c) In generalized epidemics, the focus is on higher- and medium-risk groups, which continue to drive the epidemic. However, it can also be useful to expand surveillance to the groups of general adult population in order to monitor behaviour change and guide interventions.

3.3 STI surveillance

Very few countries have already succeeded in establishing high quality, sustainable systems for STI surveillance due to many difficulties: underutilization of STI services, and a lack of laboratories, trained personnel and financial resources. These barriers and challenges should be considered when planning and evaluating surveillance activities. A range of methods can be used for STI surveillance. All these methods have their limitations and vary in terms of their cost, feasibility and ability to produce useful outputs in support of STI programmes.

- (1) Limitations of passive STI case reporting: passive case reporting is the most widely used method of STI surveillance. However, it can only provide limited information to support programmes due to underreporting.
- (2) Data from STI clinical services: the regular collection and analysis of data from STI clinical services can provide important information on disease prevalence and patterns. This information can be of considerable use in intervention planning.
- (3) Special STI surveys: special STI surveys, such as prevalence surveys, provide key information for STI programmes. However, as these surveys need considerable resources, they can only be undertaken every few years.
- (4) Monitoring antibiotic susceptibility and needed laboratory support: surveillance of *Neisseria gonorrhoea* for antibiotic susceptibility is an integral component of STI surveillance. It is essential that STI programmes maintain the laboratory resources needed for this work. There is a need to provide technical support on key issues, including sample size and access to isolates particularly as new technologies are introduced.

3.4 Use and diffusion of data

Many of the countries of the region disseminate their surveillance findings through:

- dissemination meetings
- newsletters and annual reports
- press releases and briefings for the mass media
- feedback to NGOs working with higher risk populations
- reports to provincial and community level personnel involved in HIV activities
- reports to national policymakers and Ministry officials

Careful attention needs to be given to dissemination of findings through the mass media to ensure the information is reported accurately. Maintaining close contact with journalists both on and off the record, and releasing data on a regular cycle, can improve the quality of mass media coverage, as can highlighting particular findings or issues of interest to the media and the public.

3.5 Estimation/projection

There is a need to develop guidelines and tools to encourage critical examination and use of existing data to: (a) prepare estimates/short term projections; and (b) to build consensus among the countries of the Region. Subsequently, there will be a need to build national capacity to do this work. Sizes of relevant populations must be analysed carefully in arriving at estimates consistent with the data.

One of the key factors in creating estimations that are accepted by the key stakeholders in a country is building confidence in the process. This can be accomplished by being transparent in the process so that people see the methodology, understand the assumptions that entered into the process, and can evaluate the outcome themselves.

Settling on a single working estimate through a consensus process allows attention to be focused on the real prevention and care needs in an epidemic, while minimizing counterproductive arguments over whether the number is higher or lower. Done properly, the process of preparing estimations and projections has the beneficial effects of forcing a close examination of the consistency and quality of existing epidemiological and behavioural data sources and identifying gaps in current knowledge to drive future data collection needs.

The process of estimation projection is most effective when it involves a mix of people with different skills (epidemiologists, social/behavioural scientists, and policymakers) from different levels (national and provincial) who understand the details of the local situation.

Timetable

**Workshop on HIV, AIDS and STI Surveillance in the Western Pacific Region
Manila, Philippines, 21-25 June 1999**

Agenda Item #1	Day and time schedule	Session description
1	<u>Monday, 21 June</u> 0800-0830	Registration
2	0830-0900 0930-1000	Opening ceremony (coffee break - 0900-0930) Objectives of the workshop
3	1000-1200	HIV and AIDS surveillance: latest development
	1200-1330	Lunch
	1330-16.00	HIV and AIDS surveillance (continue) (Coffee break - 1430-1445)
4	<u>Tuesday, 22 June</u> 0800-1000	Behavioural Surveillance (Coffee break - 1000-1030)
	1030-1200	Behavioural Surveillance (continue)
	1200-1330	Lunch
	1330-16.00	Behavioural Surveillance (continue) (Coffee break - 1430-1445)
5	<u>Wednesday, 23 June</u> 0800-1000	STI surveillance (Coffee break - 100-1030)
	1030-1200	STI surveillance (continue)
	1200-1330	Lunch
6	1330-1600	The WPRO Gonococcal Antimicrobial Surveillance (Coffee break - 1430-1445)

Annex 1

7	<u>Thursday, 24 June</u> 0800-1000 1000-1200	Disseminating and using data from surveillance system (Coffee break - 1000-1030) Disseminating and using data (continue)
	1200-1330	Lunch
8	1330-1430 1445-1600	Disseminating and using data (continue) (Coffee break - 1430-1445) Review of the draft regional HIV and AIDS and STI epidemiological report
9	<u>Friday, 25 June</u> 0800-1000 1030-1200	Regional STI, HIV and AIDS surveillance indicators and Targets (Coffee break - 1000-1030) Regional STI, HIV and AIDS surveillance -indicators (continue)
	1200-1330	Lunch
10 11 12	1350-1500 1430-1500 1500-1530	Conclusions Evaluation Closing ceremony

**LIST OF PARTICIPANTS, CONSULTANT
TEMPORARY ADVISERS, OBSERVERS AND SECRETARIAT**

1. LIST OF PARTICIPANTS

AUSTRALIA

Dr John Kaldor
Deputy Director and Professor of Epidemiology
National Centre in HIV Epidemiology and
Clinical Research
376 Victoria Street
Darlinghurst NSW 2010
Australia
Tel: +61 2 9332 4648
Fax: +6 12 9332 1837
Email: jkaldor@ncheer.unsw.edu.au

Dr Angela Merianos
Head of Surveillance
Centre for Disease Control
Northern Territory Health
P.O. Box 40596
Casuarina NT 0811
Tel: +61 8 8922 8265
Fax: +61 8 8922 8310
Email: angela.merianos@health.nt.gov.au

CAMBODIA

Dr Hong Rathmony
Deputy Chief
Communicable Diseases Control
and Prevention Bureau
#151-153 Kampuchea Krom Avenue
Phnom Penh
Tel: 023 725349

Dr Ly Penh Sun
Surveillance Officer
National Center for HIV/AIDs
Dermatology and STDs Control
170 Preah Sihanouk Blvd
Phnom Penh
Tel: 85523 722515

CHINA

Dr Chen Xiangsheng
Key person on National Surveillance
Systems of STD and Leprosy
National Center for STD and Leprosy Control
12 Jiangwangmiao Street
Nanjing 210042
Tel: 86 25 5421813
Fax: 86 25 5421323
Email: epicams@jlonline.com

Dr Qu Shuquan
Associate Professor
National Centre for AIDS Prevention and Control
27 Nanwei Road

Annex 2

Beijing 100050
Tel: 86 10 63152571
Fax: 86 10 63165758
Email: QUS@public.bta.net.cn

HONG KONG/CHINA

Dr Samuel Tze-Kiu Yeung
Senior Medical Officer
Department of Health
21/F, Wu Chung House
213 Queen's Road East
Wanchai, Hong Kong
Tel: 852 29618909
Fax: 852 2836 0071
Email: stky@netvigator.com

JAPAN

Dr Kenichi Tsujii
Medical Officer
Infectious Disease Control Division
Ministry of Health and Welfare
Tokyo
Japan
Tel: 813 3595 2263
Fax: 813 35816251
Email: KT-PXL@mhw.go.jp

Dr Shinichi Tanihara
Lecturer
Department of Public Health
Jichi Medical School
3311-1 Yakushiji
Minamikawachi-machi, 329 0498
Japan
Tel: 81285 58 7338
Fax: 81285 44 7217
Email: taniyan@jichi.ac.jp

**LAO PEOPLE'S
DEMOCRATIC
REPUBLIC**

Dr Sithat Insisiengmay
Director
Centre for Laboratory and Epidemiology
Ministry of Health
KM3, Route Thadeua
Vientiane
Tel: 856 21312351
Fax: 856 21315347

MALAYSIA

Dr Ahamad b. Jusoh
Principal Assistant Director (AIDS/STD)
Division of Disease Control
Department of Public Health
Ministry of Health Malaysia
Kuala Lumpur
Tel: 03 2540088
Email: ahamad@dph.gov.my

Annex 2

Dr Jamilah bt. Hashim
Medical Officer of Health (STD/AIDS)
Sarawak Health Department
Jalan Tun Abang Haji Openg
93590 Kuching
Sarawak
Tel: 082 256 566
Fax: 082 424 959

MONGOLIA

Dr Budbazar Enkhtuya
Epidemiologist
Infectious Diseases Centre
Ministry of Health and Social Welfare
Ulaanbaatar
Tel: 976 1451798
Fax: 976 1320916 / 327872

NEW ZEALAND

Dr Nigel Dickson
Senior Research Fellow
AIDS Epidemiology Group
Department of Preventive and
Social Medicine
University of Otago Medical School
P.O. Box 913
Dunedin
Tel: 0064 3 479 7211
Fax: 0064 3 479 7298
Email: ndickson@gandalf.otago.ac.nz

PAPUA NEW GUINEA

Dr Tompkins William Tabua
Senior Medical Officer
STD/HIV AIDS Unit
National Department of Health
P.O. Box 807
Waigani, NCD
Tel: 675 3013734
Fax: 675 325 9424

Dr Ninkama Moiya
Senior Medical Adviser
National AIDS Council Secretariat
P.O. Box 1345
Boroko, NCD
Tel: 675 3013748 675 323 1619
Fax: 675 325 9424 675 3013604

PHILIPPINES

Dr Ma. Consorcia Lim-Quizon
Resident Advisor
National HIV/AIDS Sentinel
Surveillance System (NHSS)
Field Epidemiology Training Programme
Bldg. 9, San Lazaro Compound
Sta Cruz
Manila
Tel: 6 32 743 6076
Home Tel : 0452 985 0058
Email: hssfetp@portalinc.com

Annex 2

Dr Eumelia P. Salva
Medical Officer VII (Division Chief)
Communicable Disease Control Service
Department of Health
San Lazaro Compound Sta Cruz
Manila
Tel: 63 2 7116808
Fax: 63 2 7116804
Email: eps@doh.gov.ph

REPUBLIC OF KOREA

Dr Un-Yeong Go
Senior Researcher
Laboratory of Epidemiology
National Institute of Health
5 Nokbundong, Eunpyeongku
Seoul 122-701
Tel: (02) 380 1482
Email: yyyng@hitel.net

SINGAPORE

Dr Jeffery Lawrence Cutter
Deputy Director
Epidemiology and Disease Control Department
Ministry of Health
16 College Road
Singapore 169854
Tel: 65 325 9018
Fax: 65 325 9194
Email: jefferey_cutter@moh.gov

VIET NAM

Dr Dam Thi Hoa
Deputy Head of Consulting
National Institute of Dermatology and
Venereology
Bach Mai Hospital
Ha Noi
Tel: 84 4852 1179

Dr Duong Cong Thanh
Researcher
Sub-Committee of HIV/AIDS Surveillance
National Institute of Hygiene and Epidemiology
No. 1, Yersin Street
Ha Noi
Tel: 84 8 211501
Fax: 84 8 210853
Email: niheids@netnam.org.vn

2. CONSULTANT

Dr Nguyen Tran Hien
Department of Epidemiology
Ha Noi Medical College
1 Ton That Tung Street
Khuong Thuong, Dong da
Ha Noi, Viet Nam
Tel: 84 4 852 4141
Fax: 844 852 3032
Email: vnholand@netnam.org.vn

3. TEMPORARY ADVISERS

Dr Tim Brown
The East-West Centre
Population & Health Studies
1601 East-West Road
Honolulu, Hawaii 96848
United States of America
Tel: 808 944 7476
Fax: 808 944 7490
Email: tim@wiliki.eng.hawaii.edu

Dr M. Kamakura
Department of Preventive
Medicine and Public Health and
Clinic for Infectious Diseases
School of Medicine
Keio University
Tokyo
Japan
Tel: 813 3358 1955
Fax: 813 3359 3686
Email: mkamakur@po.ijnet.or.jp

Dr John Tapsall
GASP Coordinator
Department of Microbiology
The Prince of Wales Hospital
Randwick, NSW 2031
Australia
Tel: 612 9382 9079
Fax: 612 9398 4275
Email: j.tapsall@unsw.edu.au

4. REPRESENTATIVES/OBSERVERS

**FAMILY HEALTH.
INTERNATIONAL**

Mr Steve Mills
Associate Director, Technical
FHI Asia Regional Office
Arwan Building, 8th Floor
1339 Pracharat 1 Road
Bangsue, Bangkok 10800
Tel: 662 587 4750
Fax: 662 587 4758
Email: smills@fhibkk.org

Dr Tobi Saidel
Senior Technical Officer
Evaluation, Surveillance and
Epidemiological Research
FHI Asia Regional Office
Arwan Building, 8th Floor
1339 Pracharat 1 Road
Bangsue, Bangkok 10800
Tel: 662 587 4750
Fax: 662 587 4758
Email: tsaidel@fhibkk.org

Annex 2

Dr James Chin
4578 Pine Valley Circle
Stockton, CA 95219
United States of America
Tel: 209 477 4714
Fax: 209 477 0684
Email: jchin@socrates.berkeley.edu

**JAPAN INTERNATIONAL
COOPERATION AGENCY**

Dr Gladys Mauricio
Dr Ma. Theresa Ang-Singh
Clinical Pathologist
SACCL
San Lazaro Hospital
Sta Cruz
Manila

UNAIDS/APICT

Dr Laurent Zessler
Country Programme Adviser
4th Floor, Room 405
44B Ly Thuong Kiet
Ha Noi
Tel: 844 934 3417
Fax: 844 934 3418
Email: zessler@netnam.org.vn

**UNITED STATES AGENCY FOR
INTERNATIONAL
DEVELOPMENT**

Dr Corazon Manaloto
Special Objective (AIDS)/Results
Package Team Leader
Office of Population, Health and Nutrition
US Agency for International Development
Ramon Magsaysay Center Building
1680 Roxas Boulevard
Manila
Tel: 632 522 4411
Fax: 632 5215241
Email: cmanaloto@usaid

5. SECRETARIAT

Dr Gilles Pומרol
Regional Adviser in
Sexually Transmitted Diseases and AIDS
WHO Regional Office for the Western Pacific
United Nations Avenue
Manila
Tel: 63 2 528 8001
Fax: 63 2 521 1036
Email: poumerolg@who.org.ph

Mrs Nancy Fee
Intercountry Programme Adviser
WHO Regional Office for the Western Pacific
United Nations Avenue
Manila
Tel: 63 2 528 8001
Fax: 63 2 521 1036
Email: feen@who.org.ph

Annex 2

Ms Sharifah Tahir
Technical Officer/Short-term Professional
WHO Regional Office for the Western Pacific
United Nations Avenue
Manila
Tel: 63 2 528 8001
Fax: 63 2 521 1036
Email: tahirs@who.org.ph

Dr Michael O'Leary
Medical Officer c/o WHO Representative Office
Suva
Fiji
Tel: 679 30 4600
Fax: 679 30 0462
Email: olearym@who.org.fj

Dr Stefano, Lazzari
Medical Officer/Epidemiologist HIV/AIDS
Communicable Diseases Surveillance and Response
World Health Organization
Geneva
Switzerland
Tel: 4122 79121 11
Fax: 4122 79107 46
Email: lazzaris@who.ch

Dr N. Walker
Epidemiologist/STP
UNAIDS
Geneva
Switzerland
Tel: 4122 7913666
Fax: 4122 7914187
Email: walkern@unaid.org

ANNEX 3

ST1 SURVEILLANCE PRODUCTS

SYSTEM	Important STIs and groups at risk	Clinic access	Gono Antimic. sensitivity	STI-related behaviour	STI prevalence and rate	Feasibility
Passive Case Reporting	+	++				High
Routine Reporting from STI sites	++	+		+	+	Medium
Routine Reporting from non STI sites					+	Medium
Laboratory-based Surveillance	+		++			Medium
Surveys of STI prevalence and Incidence	++	+	++	+	++	Low
Other Special Survey	+	++		+		Low

**PROPOSED INDICATORS
FOR HIV, AIDS AND STI SURVEILLANCE - WPRO**

HIV and AIDS

- 1) Reported AIDS and HIV cases by age, sex and mode of transmission
- 2) Estimated annual AIDS cases (up to current year)
- 3) Projected annual AIDS cases (for the next five years)
- 4) Reported annual AIDS death at Country and Regional level
- 5) Proportion of patients with HIV related illnesses in hospitals
- 6) Estimated HIV prevalence in risk groups
- 7) Estimated HIV prevalence at Country and Regional level
- 8) Approved national protocol for HIV/AIDS surveillance
- 9) Yearly HIV sentinel surveillance

STI

- 10) Prevalence of the most common STI ethiological agents among sex workers
- 11) Prevalence of syphilis rate in primipare
- 12) Proportion of Gonoccal infections resistant to the most common antibiotics
- 13) Prevalence of the most common STI ethiological agents in pregnant women
- 14) Prevalence of the most common STI in group(s) representative of the general population (other than pregnant women)
- 15) Approved national protocol for STI surveillance
- 16) Yearly STI sentinel surveillance
- 17) Estimated STI incidence and/or prevalence
- 18) Estimated proportion of STD cases seeking care in the public sector and the private sector

Annex 4

Sexual behaviours

- 16) Proportion of female sex workers with consistent condom use with non regular sex partner
- 17) Proportion of men who have sex with men with consistent condom use with non regular sex partners
- 18) Proportion of injecting drug users sharing equipment
- 19) Proportion of Injecting drug users bleaching equipment
- 20) Median age at first sex among sexually active youths (15 -24)
- 21) Proportion of youth (15 - 24) with more than one sexual partner in the last 12 month
- 22) Proportion of youth (15 - 24) with consistent condom use with non regular sexual partner
- 23) Proportion of males (15-49) having sexual intercourse with CSW in the last 12 month
- 24) Proportion of males (15-49) consistently using condom with female sex workers
- 25) Approved national protocol for behavioral surveillance
- 26) Yearly behavioral surveillance

Use and diffusion of data

- 27) Standardized annual report on the epidemiological situation of STI, HIV and AIDS at National level
- 28) Bi annual report on the epidemiological situation of STI, HIV and AIDS at Regional level
- 29) Annual advocacy meeting conducted at National level with Policy Makers, Media and programme implementers
- 30) Bi-annual National Consensus meeting for the analysis of the ST, HIV and AIDS situation

ANNEX 5

WORKSHOP EVALUATION

1. General views: I personally found the workshop: (please tick boxes)

Stimulating	12	14	1	1	0	Boring
Useless	0	2	0	6	20	Useful
Relevant	16	8	2	0	2	Irrelevant
Plenty of discussion	7	11	8	2	0	Too little discussion
Rigid	0	2	9	9	8	Flexible
Well conducted	is.	9	3	1	0	Poorly conducted
Demanding	4	13	9	2	0	Undemanding
Patronizing	0	4	6	14	4	Challenging
Too spread out	1	0	19	6	2	Too condensed
Coherent	9	10	6	2	1	Fragmented
Focused on my needs	8	8	6	3	2	Focused on facilitator's opinion
Objectives achieved	14	10	4	0	0	Objectives not achieved
Little activity	1	1	10	7	9	Plenty of activity
Worth time, spent	20	7	1	0	0	Not worth time spent

Annex 5

2.1. The three most helpful things that I learned at the workshop:

- Second generation of HIV surveillance
- STI surveillance and GASP
- Estimation and projection
- Behavioural surveillance
- Surveillance system
- Surveillance Indicators
- HIVAIDS and STI situation in the WPR

2.2. What I liked best about the workshop:

- Comprehensiveness
- Good documentation
- Excellent group of experts/facilitators
- Opportunity to share and exchange experience
- Quality and practicality of the topics
- Informal networking
- New information
- Very good preparation and well organized

2.3. What I would have liked to have been different/recommendations for future workshops:

- Group work expected outputs need to be more clear
- Country presentation should be more well prepared
- Inform more in detail about schedule and back ground reading before the workshop
- Invite other Pacific and Asian countries like Thailand, India
- Do exercises about estimation and projection
- More time for group discussion
- It is better to focus on some selected topic given limited time
- More sharing and exchanging between countries

4. Any other comments on the workshop?

- Update information need to be circulated at frequent intervals
- Looking for further similar workshop
- Speaker talks more slowly
- Organize a trip to enjoy Manila.