Summary of 3rd Global Consultation Meeting on HIV Surveillance
Held in Bangkok, Thailand 11 to 14 May 2015

Background

In May 11-14, 2015 UNAIDS and WHO organized the 3rd Global Consultation on HIV surveillance, where close to 200 people from 60 different countries attended the consultation. The consultation have specific goal and objectives:

**Goal:** WHO, UNAIDS, GFATM and other stakeholders in the global HIV response have laid out ambitious goals to end the AIDS epidemic as a public health threat, to achieve 90, 90, 90 in the health sector cascade and to achieve HIV epidemic control. Accountability for these goals will require a strong and simplified surveillance agenda to generate and use routine, robust and relevant data. The goal of this Consultation is to map out a consolidated global agenda for collecting high quality, relevant HIV surveillance data to prove and improve global and national responses to the HIV epidemic.

Objectives:

1. **Surveillance needs and innovations** - Discuss and identify the surveillance data needed to monitor achievement of the long term goals (e.g., 90/90/90; AIDS-free generation, consolidated Strategic Information indicators, mortality reduction, incidence reduction, stigma and discrimination reduction) based on country priorities. This includes, most critically, measuring the health services cascade and uptake of prevention services.

2. **Priority gaps to generate and use quality data** - To identify priority gaps in current surveillance systems that affect the ability of national programs to achieve HIV epidemic control and discuss methodologies, investments and strategies to improve surveillance systems.

3. **Consolidate a surveillance agenda for the next 5 years** - To develop a consolidated global surveillance agenda to guide global and national programs as they implement sustainable surveillance systems to measure progress towards long term HIV control goals.

There were XX technical sessions around different topics. Each session had similar structure. The sessions started with strategic, state-of-the-art presentations to introduce the session topics, outline challenges, and map out future directions or needs. This was followed by 2-3 technical presentations that showcase innovative examples or (methodological) improvements in the area. The underlying questions considered were: 1) can this approach provide data to inform the health sector cascade?; 2) can this approach provide data to inform impact indicators, specifically incidence or mortality? And 3) should this approach form part of a prioritised surveillance agenda, and can it be country-owned, financially supported in the next decade?
At the end of the consultation there was an agreement in developing a global surveillance agenda for UNAIDS and WHO that is presented below:

**Global Surveillance Agenda, 2015-2020**

The country and global partners have come together to shape and support the global surveillance agenda for the next 5 years. We see surveillance data as:

- **A key component of ending AIDS** is better quality, local, granular and disaggregated data to design and support a sustainable response
- Supporting the **health services cascade** requires a cascade of linked data
- **Surveillance data is an intervention** in itself allowing programs and communities to better respond to the epidemic with services
- **Surveillance requires systematic investments** of at least 5-10% of program funds so that overall funds are focused on the epidemic and that impact can be assessed
- Increased support for **routine, integrated, district health data** which is integrated with health information systems including STIs and hepatitis, and relevant to real time health decisions

We have developed a focused surveillance agenda for the next five years which sets five priorities to provide:

1. **HIV prevalence (and incidence) data** which is granular and disaggregated to local level, by age, sex and populations
2. **Key population data**: which inform program and national estimates, includes stigma, behaviours and links to services
3. **HIV Case reporting and facility data**: which monitors coverage and linkages from prevention to treatment and to other health areas
4. **Measurement and review of mortality and incidence**, including modeling and estimation approaches, and program impact reviews
5. **Analysis capacity** to use multiple large data sets from various sources, including data from surveys, facilities and communities, and from new media, for advocacy, programme improvement and estimating impact.

These priorities were reviewed based on the evidence of surveillance methods and country implementation, in a joint partner and country meeting in Bangkok in May 2015,

This resulted in the following surveillance plan for the next 5 years. The plan distinguishes approaches in implementation, those ready for global guidance (led by WHO and UNAIDS), and those which will be a focus of method development before guidance is proposed.
<table>
<thead>
<tr>
<th>Area</th>
<th>Implementation</th>
<th>WHO/UNAIDS (or other) Guidance</th>
<th>Method development</th>
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<tbody>
<tr>
<td>Incidence assay algorithm (RITA)</td>
<td>Yes – HH survey</td>
<td>- June meeting on RITAs for surveys and resulting guidance</td>
<td>Consultation with partners and experts CEPHIA/FIND (validation, MDRI, FRR, estimation formula)</td>
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<td></td>
<td></td>
<td>- Application of RITAs on HIV case reporting</td>
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| Mortality                                | Yes for CRVS Clinic and ART cohorts DSS sites     | - Guidance on sentinel or routine data on HIV related mortality (in and outside facilities) | Collaboration with: *IeDEA regional mortality on ART, corrected for mortality among people lost to follow up  
*Mortality in undiagnosed and in unlinked  
*Routine facility based and overall mortality by age and sex, to assess AIDS related mortality  
Country case studies |
| Household survey                         | Yes                                                | - Guidance under development that will be completed for July 2015  
- dissemination of guidance                                                            | CDC, ICAP, DHS  
Interpolation and GIS approaches                                                      |
| Key population: Surveys                  | Yes                                                | - Bio-behavioural surveys being developed (BSS) Guidelines (end 2015)  
- Strategic Framework for use of data on key populations, program to national levels | Measurement of stigma  
Nationally representative estimates of awareness and coverage (from surveys + programmes)  
Reporting including trends over time and sampling frames (include in blue book)  
Integration of hepatitis and STI                                                      |
| Key population: size estimation          |                                                    | - Guidance re size estimate algorithm, national vs local, quantify bias, and related to purpose | Methods for internet-linked KPs and non place based methods                         |
| HIV Case surveillance                    | *Yes  
*Pilots or extended pilots in generalised epidemics CASCADE workshops | - Guidance on patient and case reporting: systems, linkages, electronic, capacity, including resistance, toxicity, key pops  
- Unique Identifiers, EMR, HMIS integrated into case reporting guidance and links to testing, hepatitis and STIs | Incidence estimation:  
*Ref Group on E, M, P  
*ECDC  
Systems and methods to estimate % diagnosed from case diagnoses  
Links to key population and outreach                                                   |
| PMTCT data for prevalence surveillance.  | Shift from ANC UA sentinel to PMTCT                | - Use of PMTCT data for surveillance that is being developed and completed in 2015  
- Dissemination of guidance and lessons learned from countries                           | Adapt EPP-Spectrum  
Lessons learned from use in countries                                                  |