1.0. INTRODUCTION:

WHO AFRO established the AFRO Technical Network on HIV/AIDS and STI Surveillance in 1998. The terms of reference of the Network are:

- To assist in providing technical support aimed at strengthening HIV/AIDS and STI surveillance in the WHO African Region;
- To serve as a panel providing feedback on the HIV/AIDS and STI epidemiological situation in the Region to WHO/AFRO

Meetings of the Network, organized in Accra in June 1998 and in Cotonou in September 1999, facilitated the development of a strategic plan for strengthening HIV/AIDS and STI surveillance in the Region, policy guidelines for HIV surveillance, and draft training modules for HIV/AIDS and STI surveillance. Members of the Network have been mobilized to provide technical support in HIV/AIDS and STI surveillance to 17 countries in the Region.

The third meeting of the Network was held in Pretoria, South Africa, from 22 - 26 October 2001. The general objective of the meeting was to contribute to the strengthening of HIV/AIDS and STI surveillance in the WHO African Region. The specific objectives were:

- To make recommendations on selected issues in implementing second generation HIV surveillance
- To make recommendations on improved approaches for AIDS case reporting, including using the Internet
- To make recommendations for strengthening the work of the Network

The meeting was attended by members of the Network, and staff members of WHO/AFRO, WHO/Headquarters, the Centers for Disease Control and Prevention, and Family Health International (see Annex 1 for the list of participants). The method of work included group work, and plenary presentations and discussions (see Annex 2 for the programme of the meeting).

Dr. Wellie Shasha, WHO Liaison Officer in South Africa, opened the meeting on behalf of the Regional Director.
2.0. PROCEEDINGS:

2.1 Lessons learnt and challenges in implementing HIV/AIDS and STI surveillance Systems in the African region

The above presentation was made by Dr. Emil Asamoah-Odei, Medical Officer responsible for HIV/AIDS/STI surveillance in the WHO Regional Office for Africa.

He indicated that some of key lessons and challenges include the following:

- Vertical AIDS case reporting is not sustainable and hence countries face the challenge of using the IDS approach while supplementing this with AIDS case reporting from sentinel sites. However attempts need to be made to reach rural and young populations
- HIV sentinel surveillance using ante-natal attendees remains the backbone of HIV surveillance systems
- While HIV sentinel surveillance is less expensive to conduct than general population surveys, the latter are still occasionally required.
- Laboratory quality assurance systems for HIV need to be strengthened to enhance the accuracy of HIV sentinel survey results
- Involvement of all key stakeholders in the planning and conduct of HIV sentinel surveillance enhances the credibility and acceptance of the results
- Over-dependence on donor support does not enhance sustainability; it is necessary for governments to demonstrate their political commitment through increased allocation of human and financial resources
- Syndromic STI case reporting is the most feasible STI surveillance system in the region. This should be integrated into IDS while sentinel sites are set up to collect additional and higher quality data.
- While behavioural sentinel surveillance is currently the best option to monitor trends in sexual behaviour, standard indicators and simpler methodologies and tools are required for resource poor countries

The main issues that came up in the ensuing discussions were:

- the need to assess the extent to which new interventions like voluntary counseling and testing and the prevention of mother-to-child transmission of HIV were affecting the pattern of health facility utilization, and ultimately the trends of HIV prevalence in those facilities.
- The need to increase in-country capacity for making HIV estimates and projections
2.2 Ethical issues related to using the unlinked anonymous method in HIV sentinel surveillance

The above presentation was made by Dr. Nicolas Meda of WHO/AFRO. He indicated that the main concerns revolved around the need to obtain informed consent and the fact that where unlinked testing was done, the situation presented a missed opportunity for providing services to infected people. This was against the alternative scenario where obtaining informed consent could result in substantial selection and participation bias that would affect the goals of the surveillance system. He also noted that some testing schemes such as mandatory testing without consent were clearly unethical. The merits and demerits of data arising from unlinked anonymous testing and voluntary counseling and testing were extensively discussed during the group work and the following observations made:

- Ethical questions could be raised with unlinked anonymous testing (UAT) and indeed some donors were unwilling to fund studies that use UAT. It was however felt that the goal of surveillance using UAT was to measure with sufficient accuracy, HIV prevalence and monitor trends, to provide a basis for advocacy, resource allocation and targeting interventions, and not for identifying infected individuals. The attack on surveillance was therefore misdirected; the actual ethical problem was lack of services. Efforts should be made to provide the required resources in a rational manner.

- The goals of PMTCT and VCT services were primarily service provision and not surveillance. The data collected from these services is not good enough for epidemiological surveillance, but could be used for monitoring and evaluation of the programmes. VCT should be actively promoted as an intervention, not as a surveillance tool.

- UAT for surveillance could run parallel to VCT, as the two are not mutually exclusive. The data arising from the two sources should be closely monitored for any disparities. It would be premature to cease UAT in favour of VCT until such a time as the coverage of VCT programmes is almost universal and that there has been no significant disparity between the data from the two sources for at least 3 years.

- Sentinel surveillance using UAT method be maintained and even improved until there is adequate coverage of VCT services providing high quality data showing no disparity from the data currently provided by UAT. Until then, there is need to explain to policy makers and donors the roles of sentinel surveillance, and also advocate for efforts to provide services including VCT to be accessed by those who need them. Information to communities about the availability of services should be provided.
• In countries where UAT is considered unethical, it could still be done with informed consent. Efforts to ensure availability of services, where those wishing to know their status can be referred, should be stepped up.

2.3 Aggregation of data in HIV surveillance

The discussions on the above topic were introduced by Dr. Douglas Klucke of WHO Headquarters. He indicated that in general aggregation of results from different sites, or pooling of samples from different small volume sites should not be done unless justifiable conditions are met. He observed that aggregation was being done in different countries to different extents and for various reasons. There is the need to differentiate between aggregation of data and obtaining summary national/regional estimates which is a step wise process of standardization of rates using the median and weighted by different population categories including proportion of high risk groups. He stressed that current sentinel sites were designed to monitor trends and as such were not selected to be representative of their countries.

The following are the results of the group discussions:

• Aggregation could be done for the following reasons:
  o To obtain summary estimates for regional, provincial or national level for policy makers and for monitoring and evaluation of interventions.
  o To obtain adequate sample sizes to analyze subsets of data e.g. by age groups.
  o To obtain data to cover districts that are not included in the sentinel surveillance system and rural areas that may not readily raise the required sample sizes.
  o To decrease costs of surveillance

• Prevalence rates at national, regional or provincial level cannot be obtained accurately simply by aggregating data from sentinel sites since both site selection and sample selection within sites are not random. Moreover, there are usually different HIV epidemics at different stages in the same country and aggregation could lose sight of this scenario. If a summary measure is required, the most appropriate would be to use the median (and range of values, to adjust for outliers), and not the arithmetic mean.
• Circumstances in which aggregation could be done to obtain national or regional estimates include:
  
  o Where sites and samples selection followed statistically valid principles such as probability proportional to Size (PPS) as in South Africa and population sero-surveys.
  
  o Where sites were similar in characteristics and the site-specific rates were similar, however, the report should also state the site-specific rates.
  
  o When increasing sample sizes of specific groups by sex and age in each site is a better option.
  
• Within each site, if standard procedures have been used consistently over time, the results obtained from the same site over time can be regarded as coming from a probability sample and statistical methods can be used for analysis of trends and trend tests can be applied.
  
• Aggregating data in other circumstances was misleading and estimates were likely to be biased. There would also be loss of useful information in the process as true specific rates can be lost in the artificial construct. Equally, in analyzing trends, if trends in different strata such as urban and rural are in different directions, the aggregate might remain the same and give rise to misleading results.
  
• Aggregation is to be differentiated from making national or regional estimates which is a stepwise process in generalized epidemics involving:
  
  o Obtaining median prevalence for urban and outside sites separately,
  
  o Adjusting medians for representativeness of the sites for rural and urban areas.
  
  o Applying adjusted rates to female urban and outside urban populations
  
  o Using M/F ratio to determine number of men infected
  
  o Combining males and females to get the adult rate
  
• Extending the sampling period a little beyond the recommended 6-8 weeks is acceptable. Consideration for increasing the period of sample collection to 12 weeks could be made.
  
• Reducing sample sizes in areas with high prevalence while statistically valid, could hamper age stratification and run counter to the need to obtain adequate sample sizes in the 15-24 years age bracket.
There are data requirements at district level to enable districts come up with a rational basis for planning given the overall trend in health sector reforms, to give more autonomy and responsibilities to districts. In general, if data is required at district level, it should be collected. To facilitate the collection of this data, resources, including training and technical assistance to districts were necessary. It is not feasible to have a sentinel site in each district for the time being. Other data sources could be used such as behavioural data, service data from PMTCT and VCT, morbidity data on AIDS and STI.

2.4 Monitoring HIV prevalence in young persons

A presentation on the rationale, issues involved and sampling requirements for monitoring HIV prevalence in young persons was made by Dr. Endang Mamahit of WHO Headquarters. She reminded participants of the UNGASS resolution that “by 2005, HIV prevalence among young men and women age 15-24 years be reduced by 25% in the worst affected countries, and by 2010, be reduced by 25% globally. The onus was now on countries to set the baseline levels, and to come up with practical approaches for measuring the attainment of the UNGASS target. The following are the results of the group and plenary discussions on monitoring HIV prevalence in young persons:

- Obtaining ANC surveillance data is the most readily available and practical way to monitor HIV prevalence in young persons. Other alternatives are population-based surveys, military conscripts, university entrants, data from VCT and PMTCT programmes etc. Although population-based sero-surveys would provide the best epidemiological data, they are not routinely conducted and are expensive. The other sources of data had several shortcomings.

- ANC data however has biases in representativeness of the other non-pregnant young women, young men and the general population as a whole. Moreover, there are concerns regarding the coverage of antenatal clinics attendance, particularly in rural areas. In most cases, sample sizes in this age cohort are small leading to unstable estimates. The size of this age cohort is likely to shrink even further as age of sexual debut and first pregnancy increase. It is necessary to increase the sample size of women 15-24 years in ANC surveillance so as to obtain stable estimates to confidently detect changes in HIV prevalence.

- To obtain adequate sample size in this age group during surveillance, options suggested were: increasing the total ANC sample sizes until adequate numbers of young women were enrolled, collecting samples from all pregnant women until the regular sample size is achieved and then continue sampling only 15-24 year olds til adequate numbers are attained, or conducting separate sampling for ANC women aged 15-24. The consensus was that despite increased costs, the first option was most feasible, although the second was also possible. It is not necessary for this over sampling to be done in all sites.
• Adequate sample sizes are to be determined in each country taking into consideration the background HIV prevalence, the amount of change required to be detected as well as the precision and power with which this determination is to be done. For rural sites where adequate sample sizes may be difficult to achieve, aggregation of data from several sites with similar characteristics and HIV prevalence can be considered.

• Data shows that in general, ANC HIV prevalence among young women tend to over represent the population prevalence, while in older age groups, the converse happens. This overrepresentation among young age groups was even greater for men because women tend to be infected at younger age. There is the need to conduct population-based surveys to validate these observations.

• WHO should consider modeling to determine the level of reduction in incidence required to achieve a 25% reduction in prevalence among young people given the current level of HIV prevalence in most countries in the region.

2.5 Problems and approaches to AIDS case reporting

A presentation highlighting the potential uses of AIDS case data and the problems with AIDS case reporting was made by Dr. Stefano Lazzari of WHO Headquarters. This ranged from limited utility of standard case definitions to under recognition and under reporting of AIDS cases. A new approach to improving AIDS case reporting at country level based on the IDS strategy was discussed which includes an option for sentinel AIDS case reporting. In addition, the roles of HIV case reports and its limitations were outlined. Collection of additional data on the impact of AIDS such as morbidity and mortality data as well as monitoring coverage of patients under ARVs were also discussed. A proposed new approach for countries to report AIDS case to WHO on line via an interactive web interface was presented and explained to participants. This interactive web based application is a feasible way of overcoming reporting delays by countries to WHO. The system will be pre-tested and would be ready by the end of 2002.

The following are the results of the group discussions:

• In some countries different case definitions were being used concurrently, while countries are using different case definitions, which rendered inter country comparison complicated. In any case, the case definitions are very old, dating back to 1986-94. There is need for harmonization, or re statement or revision of the AIDS case definition. There is the need for WHO/AFRO to provide technical leadership as the problem of case definition was really a problem of the AFRO region.
Concern was raised that while AIDS case reports to WHO via a web enabled environment could improve reporting by countries to WHO, it is unlikely to improve case reporting within countries. In addition, operational issues such as access to inter-net and hardware would have to be addressed. It was suggested that WHO sorts out with national governments issues of official clearance before submission of reports online. Reporting of HIV and STI via this web-based facility should also be considered.

Support for training, supervision and utilization of data should be provided. Analysis of the data and data utilization for projection of drug requirements, advocacy and planning at lower levels should be encouraged.

The move to integrate AIDS case reports into IDS offers an opportunity to improve completeness of reports at country level. Loss of some detail would be compensated by the anticipated completeness of reporting and synergy with other surveillance programmes. Detailed data could still be obtained from sentinel sites. Concerns remain about accuracy and completeness of AIDS case reports from IDS, case definitions to be used, and whether aggregate reports to be collected at national level would meet the requirements of reporting to WHO via the web based facility.

Selection of AIDS case sentinel sites could be guided by the following - sites already reporting well, sites already reporting on other conditions such as STIs, ANC HIV, sites with VCT services, sites for other IDS target conditions. This move to a more active form of AIDS case surveillance is likely to have a cost implication.

There is the need to monitor the impact of AIDS - AIDS mortality and morbidity, orphans, absence from work, etc. Owing to incompleteness of registration of vital events obtaining in most countries, no standard approach emerged. Ways suggested included community verbal autopsy studies, funeral census, monitoring coffin sales, etc.

Monitoring patients on ARV therapy should only be considered for monitoring of the programme and not as a surveillance tool for the time being.

WHO and governments should attempt to counter donor fatigue in funding AIDS case surveillance through advocacy, increased utilization of AIDS data and improved reporting, presentation and dissemination of the data.
2.6 Strengthening the work of the WHO/AFRO Network on HIV/AIDS and STI Surveillance

A presentation covering the historical background, terms of reference, composition, achievements and future challenges of the network was made by Dr. Nicolas Meda of WHO/AFRO. He emphasized that the major challenges facing the network include effective operationalization of second generation HIV surveillance and establishing and operating systems for monitoring and evaluating the health sector response to the HIV/AIDS epidemic. The following are the results of the group discussions on the network:

- The network has been very relevant since its establishment as a forum for technical discussions, and as a panel for providing advice and support to AFRO and countries in the region.

- The network should build on its achievements in the implementation of HIV/AIDS and STI surveillance, expand its activities, and ensure the involvement of other disciplines besides surveillance epidemiologists.

- The network should institute mechanisms for sharing information among members of the network and foster close working relationships with similar networks in the area of HIV prevention and control.

- The network should meet at least once every 2 years, but working committees on identified priority topics could meet more frequently. Considerations should also be made to monitoring the implementation of the recommendations of the network.

- There is need for WHO to formalize membership of the network. Selection of members should still be done by WHO/AFRO but consideration to inclusion of members from all the regional blocks of WHO should be examined.
3.0 CONCLUSIONS & RECOMMENDATIONS:

The meeting reached the following conclusions and recommendations:

Roles and ethics of the unlinked anonymous testing (UAT) and voluntary confidential testing (VCT) in HIV sentinel surveillance

1. HIV sentinel surveillance using pregnant women antenatal clinics continues to be the backbone of systems for monitoring trends in HIV prevalence in the Region. The continued use of unlinked anonymous testing (UAT) is justified because it:
   a. allows countries to measure the magnitude of the HIV epidemic problem and to monitor its trend over the years
   b. is simple, practical and relatively cheap with little disruption in ante-natal services, it requires no counselling and informed consent and ensures anonymity
   c. is feasible in resource-constrained settings
   d. minimises participation bias, and provides quality data for making estimates and for advocacy, and planning and targeting interventions.

2. Within the context of UAT in HIV sentinel surveillance, the major ethical issue seems to be the missed opportunities for counseling, identifying and managing HIV positive pregnant women, and for prevention of mother-to-child transmission. It is clear that this has resulted from the lack of HIV/AIDS prevention, treatment and support services and not due to intrinsic flaws in the surveillance approach.

3. While voluntary confidential testing (VCT) may respond to the ethical concerns raised with UAT, VCT cannot replace UAT for surveillance purposes because of the associated participation bias and the large human, financial, and logistic resources required. Indeed, while there must be linkages between surveillance and service provision for HIV/AIDS, the two have very different objectives. These objectives should be kept separate in order not to compromise the quality of both surveillance activities and service provision.

4. In situations where UAT is not acceptable for surveillance, UAT with informed consent (ICUAT) should be considered as an option. This approach does not compromise the principles of UAT and also responds to some of the ethical concerns raised by UAT. However in such situations it must be ensured that ANC attendees have adequate access to HIV/AIDS prevention and treatment services.

5. Using service provision data for surveillance purposes is not recommended for the Region. A recommendation for this switch can only be made when there is adequate coverage for HIV/AIDS prevention and treatment services and appropriate studies with results showing a good correlation between service provision data and surveillance data have been done. This will also imply having high quality data for monitoring these services.
Aggregation of Data in HIV Sentinel Surveillance

6. In principle, it is not appropriate to aggregate data from HIV sentinel sites since the sites are generally selected by non-probability sampling and the populations using these sites may have different social and demographic characteristics, thus hiding variability in HIV rates in certain sites and areas, and making interpretation of trends difficult. However, aggregation may sometimes be necessary in order to obtain provincial/regional and national estimates, to increase sample size or reduce sampling periods, and to analyze sub-sets of data. In such situations precautions to be taken include ensuring consistency in the sites selected for each round, including the range and median results to show variability, indicating the homogeneity or otherwise of the sample populations, weighting by population size, if necessary, and including the data by site in the report. Appropriate tools for data management need to be developed and countries should be supported to increase their capacity for management and utilization of HIV surveillance data at all levels. This should include capacity for producing national and sub-national HIV estimates.

Monitoring HIV Prevalence in Young Persons

7. The most feasible approach for monitoring trends in HIV prevalence in young persons is HIV sentinel surveillance in pregnant women attending ante-natal clinics. In this context the most appropriate option for over-sampling young pregnant women is increasing the total ANC sample size until a sufficient number of pregnant women aged 15 - 24 years has been obtained. This option is unlikely to be applicable in rural settings where population densities and the volume of ante-natal clinic attendance are low.

8. Extrapolating data form young pregnant women to young persons is currently problematic as scientific approaches are yet to be developed. Population-based surveys will have to be conducted to obtain a more accurate estimate of HIV prevalence in young persons of both sexes. The results form such surveys and from special studies could then be used to obtain empirical data on correlates and understand the relationship between young pregnant women attending ante-natal care and young persons in general. Where possible and acceptable population-based HIV prevalence studies could be integrated into on-going health surveys for other communicable diseases or Demographic and Health Surveys (DHS).

9. WHO, UNAIDS and other partners should continue to support the testing of new technologies and approaches that can facilitate the monitoring of HIV prevalence trends in young persons.
AIDS Case Reporting

10. AIDS case reporting continues to be useful for advocacy, planning of health services, allocation of resources and for epidemiologic purposes (information on socio-demographic characteristics, probable modes of transmission, etc). AIDS case reporting, including utilization of the data generated, should therefore be continued and strengthened in the Region. However case definitions for paediatric and adult AIDS cases are still problematic and countries will require clear technical guidance on these from WHO.

11. Several countries of the Region are implementing Integrated Disease Surveillance (IDS). Integrating AIDS case reporting into the universal communicable disease case reporting system is the way forward but there is the need to retain selected health facilities as sentinel sites for AIDS case reporting in order to collect more detailed information on AIDS cases and deaths (age, sex, mode of transmission, presenting symptoms, residence, risk behaviour groups, socio-economic status, cause of death, etc.)

12. At the present level of access to HIV testing in the Region and difficulties in including private testing, HIV case reporting for surveillance purposes is not recommended. However the number of positive HIV tests could be reported from laboratories and used to monitor access to HIV testing for preventive and/or palliative treatment (OI, ARV)

13. The Global Atlas System for remote data entry offers an opportunity to improve global AIDS case reporting. This would allow countries to enter and manage their own data in a standardized way, reduce paperwork, and reduce inconsistencies and reporting delays. This approach should however be piloted in selected countries and access to the Internet improved in countries before it is introduced on a wide scale.

14. Currently estimated from modeling of HIV prevalence, HIV/AIDS mortality figures have been challenged in several countries. There is therefore the need for direct measurement of mortality. Since viral registration is weak in most countries of the Region, alternative methods (AIDS sentinel sites, verbal autopsies, funeral census, etc.) should be explored.
Strengthening the Network

15. The AFRO Technical Network has been very relevant since its establishment and has been used as a forum for technical discussions, and as a panel of experts providing advice and support to AFRO and countries. The network should build on its achievements in the implementation of HIV/AIDS and STI surveillance, expand its activities, making sure other relevant disciplines are involved, improve sharing of information amongst network members, and foster close working relationships with similar networks in the area of HIV/AIDS prevention and control.

4.0 CLOSING:

The following were identified as the follow-up actions of the meeting:

- AFRO to distribute meeting report to network members
- AFRO to review with WHO Headquarters and UNAIDS the conclusions and recommendations of the meeting
- AFRO to work with WHO Headquarters and UNAIDS and come out with new recommendations, where necessary
- AFRO to review the recommendations for strengthening the work of the network, make recommendations to the Regional Director, and implement the decisions of the Regional Director.

The meeting was closed by Dr. Wellie Shasha, WHO Liaison Officer in South Africa, on behalf of the Regional Director.
Annex 1: PROGRAMME

DAY 1: 22 OCTOBER 2001

08.30 Registration

09.00 Opening Session

Introductory Remarks
Opening Address

EPS/AFRO
WLO/South Africa

09.30 Objectives of the Meeting

Programme of Work
Administrative Arrangements

Dr. E. Asamoah-Odei
( WHO/AFRO )

OBJECTIVE 1: TO MAKE RECOMMENDATIONS ON SELECTED ISSUES IN IMPLEMENTING SECOND GENERATION HIV SURVEILLANCE

10.00 Lessons Learnt and Challenges in Implementing HIV/AIDS Surveillance Systems in the Region

Dr. E. Asamoah-Odei
(WHO/AFRO)

10.20 Discussions

10.30 Tea/Coffee Break

11.00 Ethical Issues Related to Using the Unlinked Method in HIV Sentinel Surveillance

Dr. N. Meda
(WHO/AFRO)

11.30 Discussions

12.00 Introduction to Group Work 1: What are the Roles of the Unlinked Anonymous and Voluntary Confidential Methods in HIV Sentinel Surveillance?

12.15 Lunch Break

14.00 – 17.00 Group Work 1

DAY 2: 23 OCTOBER 2001

08.30 Presentation and Discussion of Group Work 1

09.30 Aggregation of Data from Different Sites in Sentinel Surveillance

Dr. D. Klaucke
( WHO/HQ )

10.00 Discussions

10.30 Tea/Coffee Break
11.00 Introduction to Group Work 2: Effects of Aggregation on the Results of HIV Sentinel Surveillance

11.15 Group Work 2

12.30 Lunch Break

14.00 Group Work 2 continues

15.30 Tea/Coffee Break

16.00 - 17.00 Presentation and Discussion of Group Work 2

DAY 3: 24 OCTOBER 2001

08.30 Monitoring HIV Prevalence in Young Persons Ms. E. Mamahit (WHO/HQ)

09.00 Discussions

09.30 Revised Recommendations on Sample Sizes Dr. D. Klaucke (WHO/HQ)

10.00 Discussions

10.30 Tea/Coffee Break

11.00 Introduction to Group Work 3: Approaches for Monitoring HIV Prevalence in Young Persons

11.15 Group Work 3

12.30 Lunch Break

14.00 Group Work 3 continues

15.30 Tea/Coffee Break

16.00 - 17.00 Presentation and Discussion of Group Work 3
DAY 4:  25 OCTOBER 2001

OBJECTIVE 2: TO MAKE RECOMMENDATIONS ON IMPROVED APPROACHES FOR AIDS CASE REPORTING, INCLUDING USING THE INTERNET

08.30 Problems and Approaches to AIDS Case Reporting Dr. S. Lazzari (WHO/HQ)
09.00 Discussions
09.30 Introduction to Group Work 4: Improving AIDS Case Reporting
09.45 Group Work 4
10.30 Tea/Coffee Break
11.00 Group Work 4 continues
12.30 Lunch Break
14.00 - 15.30 Presentation and Discussion of Group Work 4

DAY 5:  26 OCTOBER 2001

OBJECTIVE 4: TO MAKE RECOMMENDATIONS FOR STRENGTHENING THE WORK OF THE NETWORK

08.30 Update on the AFRO HIV Surveillance Network Dr. N. Meda (WHO/AFRO)
08.45 Discussions
09.00 Group Work 5: Strengthening the HIV Surveillance Network; Future Perspectives
10.30 Tea/Coffee Break
11.00 Presentation and Discussion of Group Work 5
12.00 Conclusions and Next Steps Dr. E. Asamoah-Odei (WHO/AFRO)
12.30 CLOSING WLO/South Africa
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