
GLOBAL
PROGRAMME
ON **AIDS**



REPORT ON THE INFORMAL INTERREGIONAL
CONSULTATION ON DEVELOPING AN
EPIDEMIOLOGICALLY BASED STRATEGY
FOR CONTROL OF AIDS/HIV IN ASIA

NEW DELHI, INDIA
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I. INTRODUCTION

The purpose of the Consultation was to apply the global strategy for the prevention and control of AIDS to the epidemiological and sociocultural situation(s) of Asian/Pacific countries in a manner consistent with the World Health Assembly Resolutions¹. The Consultation focused on the development of epidemiological surveillance prevention and control approaches for areas with presently low HIV/AIDS prevalence (HIV/AIDS epidemiologic pattern III).

The WHO Regional Director for South-East Asia, opening the proceedings, stated that HIV infection was an increasingly acute problem and stressed the need for countries to develop their own strategies within the Global AIDS Strategy.

The Director of the Global Programme on AIDS (GPA), then read the message sent by the Director-General of the World Health Organization (WHO). While Asia and Oceania account for only one per cent of AIDS cases at present reported to WHO, the number of AIDS cases and the incidence of HIV infection have increased. The approach required in areas where AIDS is so far rare may need to differ from that in countries where AIDS is already common. The challenge to the meeting was to provide more detailed guidance for the development of AIDS prevention and control activities in Asia and Oceania.

The global epidemiology of AIDS was reviewed by the Chief of the Surveillance Forecasting and Impact Assessment Unit of GPA. AIDS is a pandemic whose existence has been characterized by denial and underestimation, but is now understood as an unprecedented threat to global health.

The 250 000 AIDS cases which were estimated to have occurred as of June 1988 represent the tip of the iceberg of HIV infection, currently estimated to be 5 to 10 million people. At 1 June 1988, 136 countries had reported 96 433 cases of AIDS to WHO:

<u>Continent</u>	<u>Number of cases</u>
Africa	11 530
Americas	71 343
Asia	254
Europe	12 414
Oceania	<u>892</u>
Total	96 433

Worldwide, three epidemiological patterns of AIDS can be identified. In Pattern I, most cases occur among homosexual and bisexual men and intravenous (IV) drug users. In Pattern II, heterosexual cases predominate and perinatal transmission is common. In Pattern III areas, HIV was probably introduced only in recent years and AIDS cases are still rare. There is no evidence to suggest that genetic factors have an influence on the risk of infection with HIV, nor on the likelihood of an HIV-infected person developing AIDS.

¹Resolution WHA40.26: Global Strategy for the prevention and control of AIDS. Resolution WHA41.24 AIDS: Avoidance of discrimination in relation to HIV-infected people and people with AIDS.

Exposure to HIV through blood transfusion entails a very high rate of transmission (over 90%). Perinatal exposure appears to have a transmission rate of approximately 25-50 per cent. The risk of transmission from a single act of heterosexual intercourse varies from 1 in 100 to 1 in 1000 and is probably influenced by cofactors. Exposure to infection through IV drug use has a low rate of transmission for a single exposure but the cumulative risk is high due to repeated exposures. The risk of transmission to health care workers through a needlestick injury is about 0.5%, which is much lower than for hepatitis B (estimated at 20-25%).

The Director, GPA, summarized the global strategy for prevention and control of AIDS. The Global AIDS Strategy developed by WHO has received the support of every nation of the world. It has been unanimously approved and adopted as the foundation for global action by the World Health Assembly (Geneva, May 1987), the Economic and Social Council of the United Nations (Geneva, July 1987), the United Nations General Assembly (New York, October 1987) and the World Summit of Ministers of Health on Programmes for AIDS Prevention (London, January 1988).

The Global AIDS Strategy has three objectives:

- (a) to prevent HIV infection;
- (b) to reduce the personal and social impact of HIV infection;
- (c) to unify national and international efforts against AIDS.

Important concepts in the implementation of the Global AIDS Strategy include:

- (a) public health and human rights must be protected;
- (b) discrimination against infected persons must be prevented;
- (c) education and information play the most important role in preventing disease transmission;
- (d) the fight against AIDS has to be integrated within the national development plan for health;
- (e) the fight against AIDS requires a sustained commitment;
- (f) all countries need to have a comprehensive national AIDS programme designed in conformity with the Global AIDS Strategy;

The value of a good information and education programme was emphasized. This has to be reinforced by health and social services and a supportive social environment.

Finally, the Director GPA described the role of WHO in providing guidelines, and technical and financial support.

Dr G.K. Viswakarma (India) was elected Chairman for the first part of the Consultation, and Dr T. Thirumorthy (Singapore) for the second part. Dr G.N. Jayakuru (Sri Lanka) was elected Rapporteur.

II. EXECUTIVE SUMMARY

The epidemiological situation in Pattern III countries provides an opportunity to prevent AIDS from becoming a serious public health problem of the magnitude already seen in Pattern I and II areas of the world. The Consultation considered how to design an epidemiologically based approach to HIV prevention in Pattern III countries, in complete harmony with the objectives, principles and activities of the Global AIDS Strategy.

Two strategies were recommended and discussed in detail. These strategies are:

- (1) Epidemiological surveillance; and
- (2) Identification and management of HIV-infected persons.

Both strategies should be considered as they can be carried out in a complementary manner.

A. Epidemiological surveillance for HIV infection is vital to guide public health efforts. The optimal methodology is to:

1. develop a country-specific description of behaviours, settings and groups with documented evidence, or presumed likelihood, of past, present or future exposure to HIV;
2. develop an assessment/monitoring approach which will provide the best quality epidemiological information. Operational and practical aspects of identifying and reaching such individuals or groups at risk must be considered. Surveys should be based on anonymous screening or testing (either voluntary anonymous or unlinked) to avoid strong selection bias. [Guidelines for HIV serosurveillance are being completed by WHO/GPA to meet this need.];
3. implement several such surveys;
4. analyze the data, taking steps to avoid stigmatization of particular groups in the presentation of the data.

B. Identification and management of HIV-infected persons is an approach which can help prevent further HIV infection by providing infected persons with counselling, medical and social support. This activity may make a useful contribution to national HIV prevention efforts. In such programmes, special attention must be given to pre- and post-test counselling, informed consent, and assurance of confidentiality, for if the programme leads to discrimination and stigmatization, or programmes are otherwise ill-conceived or poorly implemented, the negative effects may substantially outweigh the positive benefits for public health. It must be emphasized that if confidentiality is not respected, or if discrimination or stigmatization occurs against HIV-infected persons, public health will be substantially damaged in two ways. Firstly, others in the same setting (e.g., others attending sexually transmitted disease (STD) clinics or treatment centres for IV drugusers) will react by avoiding such clinics or centres or refusing to be tested. Secondly, people with the same risk behaviour will tend to avoid contact with health services out of fear of being tested. Regular contact with health and social services is essential to support the behaviour change needed for prevention. Thus, if discrimination occurs, it will have a strongly negative impact on the current and future potential to prevent HIV transmission in the community.

The optimal methodology for identification and management of HIV-infected persons is to:

1. develop a country-specific description of behaviours, settings and groups (see above);
2. determine the settings, sites and manner in which people at increased risk of HIV exposure may be approached for participation. As HIV-infected people must be individually identifiable in order for counselling and health and social support services to be provided, and since the cooperation of the infected person will be critical to the success of this approach, HIV testing must be voluntary and based on informed consent, including an assurance of confidential pre- and post-test counselling. Before starting an activity designed to identify HIV-infected persons, careful consideration must be given to all aspects, including the details of how an infected person will be counselled and supported;
3. HIV-infected persons must receive careful and sensitive counselling. If further HIV transmission is to be prevented, health and social services must be designed to strengthen and support their capacity to adopt sustained behaviour change. Confidentiality must be strictly maintained, discrimination must be strictly avoided, the infected person must be treated with dignity, and their rights must be protected. Referral of sex partner(s) must also be considered.²

C. Research Issues The ability to implement epidemiological surveillance as well as prevention strategies based on identification and management of HIV-infected persons may benefit from operational research in several areas, including:

1. improved knowledge of the dynamics of prostitution (the degree to which it is regulated or recognized, duration of prostitution, specific sexual practices) as well as information on the incentives required to influence prostitutes regarding "safer" sexual practices or changing occupation.
2. further knowledge of the effectiveness of different counselling approaches to help ensure long-term support and behaviour change;
3. patterns of IV drug user distribution and behaviour;
4. patterns of homosexual, bisexual and heterosexual behaviour;
5. health services research.

III. AN EPIDEMIOLOGICALLY BASED APPROACH TO HIV PREVENTION

This Consultation concluded that an epidemiologically based approach to HIV prevention in Pattern III countries can be designed in complete harmony with the objectives, principles and activities of the Global AIDS Strategy. Following a review of the general approach to be utilized in Pattern III areas, two strategies were identified as key elements of national AIDS programmes: epidemiological surveillance; and the identification and management of HIV-infected persons.

²Consensus Statement from Consultation on Partner Notification for Preventing HIV Transmission (WHO/GPA/INF/89.3).

A. General approaches in Pattern III areas

Certain general principles of AIDS prevention and control apply throughout the world. When applying the Global AIDS Strategy to a particular national AIDS programme, the following issues should be considered:

1. The approaches applied to the prevention and control of AIDS should reflect the social, cultural and epidemiological pattern in each country.
2. The prevention of sexual transmission through intensive education and communication emphasizes the importance of maintaining or adopting "safer" sexual practices and promoting the use of condoms. Voluntary testing should be encouraged for those who consider themselves at risk of having been exposed to HIV.
3. The prevention of HIV transmission through blood and blood products requires consideration of a donor deferral strategy, in which persons at increased risk of HIV infection agree not to donate blood as well as systematic HIV screening either alone or in combination with other laboratory tests such as those for Hepatitis B virus. The application of good sterilization practices for medical equipment must also be promoted.
4. The prevention of mother-to-infant transmission is based on preventing HIV infection of women of child-bearing age, promoting contraception for HIV-infected women, and advising pregnant HIV-infected women on risks to mother and child, taking the social and cultural context into account.
5. In the community, information and education programmes are essential to increase knowledge and understanding about HIV/AIDS, to reduce fear, and to help prevent discrimination and stigmatization. For the HIV-infected person, medical, psychological and social support will help reduce the impact of HIV infection and help maintain his or her integration in the community.
6. Intensive surveillance is of paramount importance in Pattern III countries as strategic decisions may depend upon changing patterns or trends of HIV infection.

B. Specific approaches applied in pattern III areas: epidemiological surveillance and identification and management of HIV-infected persons

At present, in marked contrast to Pattern I and II areas, where millions have already been infected with HIV, the number of HIV-infected people in Pattern III areas is relatively low. Surveillance for HIV infection is of paramount importance and the identification of the relatively small number of HIV-infected persons can focus education and partner notification efforts, which may contribute more to an overall reduction in the spread of HIV in Pattern III areas compared to Pattern I and II areas.

1. Epidemiological surveillance

(a) Purpose: to establish whether HIV infection has been introduced into the country or community, and to establish the extent and trend of HIV infection as reflected by the prevalence of serological markers of HIV infection in various sub-populations considered to be at greater risk of exposure to HIV.

(b) Methods: universal testing of the entire country or community is logistically impossible and would divert limited disease prevention and control resources away from effective and important programme activities. However, a series or group of surveys may

be used to obtain a composite national picture for surveillance purposes. However, even in identified high risk groups, it is not possible to identify or reach all persons. Taking the example of persons with STD, a survey limited to STD clinic attendees would miss the large number of STD patients who seek treatment with private practitioners, self-medicate, or go to traditional healers.

(i) General issues regarding surveillance: To organize an epidemiological surveillance system, certain issues need to be addressed, including:

- the rationale of the proposed programme;
- the population to be screened;
- the test method(s) to be used;
- where the laboratory testing is to be done;
- the intended use of data obtained from testing;
- legal and ethical considerations;

For a complete list of issues to be considered in the context of screening, please refer to the Report of Meeting on Criteria for HIV Screening Programmes (WHO/SPA/GLO/87.2).

(ii) Definition of groups to be screened:

(a) Description In each country or community, risk activities and groups at increased risk of past, current or future exposure to HIV should be described. The list may include prostitutes (male and female), STD patients, seamen, air-crew, IV drug-users, homosexual and bisexual men, heterosexual men and women with many sexual partners, street children, prisoners, persons with haemophilia, people in tourist and entertainment industries and military returning from overseas. The relative importance of the groups mentioned and other groups not mentioned will vary for countries within the Pattern III area.

(b) Access to groups The operational difficulties in gaining access to the defined groups would have to be considered before embarking on a surveillance programme. Several factors, including legal, cultural, religious, social and medical, would influence accessibility. For example, it would be difficult to gain access to prostitutes in a country where prostitution is illegal or not regulated.

(iii) Monitoring and assessment:

(a) Unlinked anonymous screening The optimal surveillance methodology is unlinked anonymous screening which involves the use of blood obtained for other purposes but tested for HIV serological markers after personal identity information has been removed. Thus, epidemiological data is collected but patient identification is eliminated. This reduces participation bias and ensures confidentiality. The use of unlinked anonymous screening provides an alternative to the need to obtain informed consent. The dilemma of whether to, and how to, inform infected persons is avoided by this method, which should be accompanied by education and an offer of voluntary individual testing for those who wish to learn the results of their test.

(b) Voluntary testing: In situations where unlinked anonymous screening is not possible, voluntary testing should be used, which may be anonymous (name of person tested not known) or confidential (safeguards to avoid unauthorised disclosure of personal identifiers or test results). These approaches are

logistically more demanding and introduce a bias by including only those who volunteered to participate in the programme rather than the whole defined group. For example, an unlinked anonymous testing of newborns could include all births in a given area if blood were already obtained for another purpose (i.e., metabolic screening). However, a voluntary testing programme will only include those newborns whose parents volunteer participation. Mandatory testing or screening for HIV has only a very limited role in programmes for AIDS prevention.

(iv) Information received from epidemiological surveillance The information received will document the prevalence of HIV infection in the tested population, which in turn will be an indicator of epidemiological status, trends and possible impact of interventions.

(v) Activities: Epidemiologically based intervention includes:

- continued surveillance of defined groups to study disease trends or detect introduction of infection;
- health education and counselling focused on the defined group;
- embarking on further studies for case detection;
- use of surveillance data for health planning and for education of national authorities and the general public;
- use of surveillance data to evaluate programme effectiveness.

2. Identification and management of HIV-infected people

(a) Purpose: HIV-infected people may be unaware of their infection and may unknowingly infect others.

(b) Methods:

(i) General issues The relative contribution of this activity to national HIV prevention efforts may be important where the number of HIV-infected people is small. However, if such efforts are discriminatory, stigmatizing, or otherwise ill-conceived or poorly implemented, the negative effects may substantially outweigh the positive benefits for public health. Therefore, special attention must be given to pre- and post-test counselling, informed consent, and assurance of confidentiality. It must be clearly understood that if confidentiality is not respected, or if discrimination occurs against an HIV-infected person, public health will be undermined in two ways: others in the same setting (e.g., IV drug use treatment centre, STD clinic) will then refuse to be tested, and people with the same risk behaviour will avoid contact with health services out of fear of being tested. Regular contact with health and social services is essential to support behaviour change needed for prevention. If discrimination or stigmatization occur, the potential to prevent HIV transmission will be reduced.

(ii) Describing groups of people for inclusion in a survey A description of behaviours, settings and groups with a documented or presumed increased risk of HIV infection should be prepared. This might include people with STD, IV drug users, people having received a blood transfusion while abroad or with imported blood, persons with haemophilia, and female or male prostitutes. In each instance, the practical aspects involved in reaching these people must be considered (e.g., of IV drug users, only those seeking treatment might be accessible; STD cases, only those attending STD clinics).

- (iii) Assessment/monitoring strategy As this relies upon identifying infected persons and requires the cooperation of the infected individual, testing must only be performed with informed consent, including pre- and post-test counselling.

(c) Action/intervention Persons tested and found seronegative should be informed and if their risk of exposure to HIV is continuing (e.g., female prostitutes, IV drug users) they should be counselled and supported in adopting risk-reducing behaviour. Some people (e.g., recipients of imported blood prior to 1986 in Pattern III countries, and persons with haemophilia) may not need further counselling if they are seronegative as the specific risk of HIV exposure is not ongoing.

People found to be seropositive must receive careful and confidential counselling and support from health and social services. Special attention should be given to identifying resources available to help seropositive persons (medical follow-up, special allowances or access to social services). Careful and sensitive discussions should determine what interventions may help prevent further HIV transmission. If feasible, sexual partner referral should be made.

Regardless of the social status or risk behaviour group to which the seropositive person belongs, it is essential to maintain confidentiality. The infected person must be treated with dignity and respect. Discrimination against, or stigmatization of the infected person must be avoided if the success of the HIV/AIDS control programme is to be ensured.

3. Additional considerations for epidemiological surveillance and identification and management of HIV-infected persons:

(a) Sexual partner referral Partner referral may contribute to HIV prevention programmes.³ In the case of the sexual partner of a HIV-infected person this may be especially useful because infection is avoidable through "safer" sexual practices. A female sexual partner of an HIV-infected man should know her HIV antibody status when considering pregnancy. The method of informing the sexual partner is important; all infected persons should be counselled and supported so that they inform their sexual contacts (patient referral, index person referral). However, if the infected person is unwilling or unable to do so, this infected person may allow the physician to notify the sexual partner directly or through the public health agency. In either case, it is essential that the infected (index) person be informed that his or her sexual partner is being notified. Confidentiality of the information has to be safeguarded. The sexual partner should receive counselling and other services, including access to voluntary confidential HIV testing.

(b) Counselling, pre- and post-test Testing for HIV infection includes an obligation to provide pre- and post-test counselling, the only exception being anonymous unlinked surveys. In the case of voluntary testing, pre-test counselling may provide vital information on the implications of HIV test results to the person if he or she wishes to learn the result. The availability of competent and accessible counselling support is a prerequisite for the conduct of other seroepidemiological surveys and for the establishment of voluntary testing programmes.

(c) Persisting risk behaviour for HIV transmission among HIV-infected persons In some situations, the usual efforts to help infected persons adopt behaviour to limit or

³Consensus Statement from Consultation on Partner Notification for Preventing HIV Transmission (WHO/GPA/INF/89.3).

eliminate the risk of HIV transmission to others may not be successful. Resistance to following recommended guidelines may result from economic necessity (e.g., an infected prostitute having no alternative means of support) or from psychological factors (e.g., IV drug addiction). In such instances, it is essential to mobilize social resources to promote rehabilitation such as alternative job training for prostitutes, and drug treatment programmes for IV drug users. In-depth counselling and social support may also be required. In such situations, it is essential to prevent discrimination and stigmatization, for these will interfere with, and may actually undermine the effectiveness of public health strategies to prevent and control AIDS.

(d) Risk Factors for HIV transmission Research has shown that other STD, particularly those involving genital ulceration, may increase risks of HIV dissemination and/or acquisition.⁴ If other STD are risk factors for HIV transmission, additional efforts to control STD in Pattern III areas would be indicated.

4. Research issues Several research issues were raised during the Consultation:

(a) Prostitution Data are needed on the dynamics of prostitution (the extent to which it is regulated or recognized, duration, factors associated with entering prostitution, sexual practices) and on the incentives required to influence infected prostitutes in practising "safer" sex or leaving the trade.

(b) Counselling Counselling has been identified as an important strategy for prevention of HIV spread. There is a need to assess its effectiveness on:

(i) changing the sexual behaviour of infected persons to prevent HIV infection. It is essential to evaluate the effectiveness of counselling among different high risk groups and under different epidemiological situations;

(ii) the behaviour of sexual contacts of cases and of people caring for those who are HIV infected;

(iii) the ability of infected persons to make and sustain behavioural changes;

(iv) examining the personal and social reasons for persisting in high risk behaviour.

(c) Political issues Where political decisions may supercede public health views on epidemiological surveillance of HIV infection, it would be most useful to assess the negative impact of discriminatory or stigmatory actions on the future capacity to identify HIV-infected persons.

(d) IV drug use Although it is believed that IV drug use in most Pattern III countries is not very significant, it is important to investigate its extent and nature, particularly in relation to factors promoting HIV spread such as sharing syringes.

(e) Patterns of sexual behaviour HIV/AIDS prevention and control programmes require information on sexual practices of homosexual and bisexual men, and heterosexual men and women. Studies of sexual behaviour and its important determinants are essential for the design of prevention programmes.

⁴Consensus Statement from Consultation on STD as a Risk Factor for HIV Transmission (WHO/GPA/INF/89.1).

(f) Health services research Research will be required to assess the impact of AIDS programmes within health systems and to determine the optimal methods for integration of AIDS prevention and control activities within existing programmes.

IV. RECOMMENDATIONS FOR NATIONAL AIDS PROGRAMMES IN PATTERN III AREAS

1. Maximum advantage should be taken of the opportunities to prevent HIV infection which are offered by the prevailing epidemiological situation in pattern III countries. The national approaches which are developed must be in conformity with the Global AIDS Strategy. In addition, they must be consistent with World Health Assembly Resolution on preventing discrimination against HIV-infected persons, persons with AIDS, and members of population groups.
2. The implementation of a national epidemiological surveillance system according to the guidelines in section III.B.1 (page 10) should be considered. This will also require assessment of laboratory capability and needs.
3. The implementation of a system to confidentially identify HIV-infected persons for the purpose of preventing HIV spread should be considered. Strict assurance of voluntary participation, informed consent, pre- and post-test counselling, confidentiality, support for behaviour change, and prevention of discrimination, as outlined in section III.B.2 should be made explicit in national strategies.
4. Education on the public health rationale for the epidemiological and HIV prevention methods selected should be provided for decision-makers and the public.
5. National, intercountry, regional, and global research needs to be developed, to increase the effectiveness of national strategies for HIV prevention and control within the Global AIDS Strategy.

DEFINITIONS

1. Patterns I, II and III: Epidemiological data available in 1988 permit description of three broad but distinct patterns of HIV/AIDS in the world. The basic modes of HIV transmission are the same worldwide: sexual intercourse, blood, and from infected mother to infant. In Pattern I areas, HIV principally involves homosexual men and IV drug users, although heterosexual transmission is also occurring. Pattern I areas include North America, Western Europe, Australia, New Zealand, and many urban areas of Latin America. In Pattern II areas, HIV principally involves heterosexual men and women, recipients of unscreened blood transfusions, persons exposed to needles or other skin-piercing instruments, and children born of infected mothers. Pattern II areas include Sub-saharan Africa and, increasingly, Latin America, especially the Caribbean. In Pattern III areas, HIV infection and AIDS are rare; early cases have generally been associated with persons from Pattern I or II areas and transmission has also been documented from imported blood products. HIV apparently entered Pattern III areas later than other areas, but there is increasing evidence of local HIV transmission. Pattern III areas include Eastern Europe, the Middle East, North Africa, and most countries in Asia and the Pacific.
2. HIV testing: A serological procedure for HIV infection markers (usually antibodies, but possibly also antigens) for an individual person, whether recommended by a health care provider or requested by the individual.
3. HIV screening: The systematic application of HIV testing to any or all of the entire population, selected target population, donors of blood and blood products and cells, tissues and organs.
4. Anonymous HIV testing: HIV testing performed on blood samples without personal identity information which would enable the laboratory or an official unit/agency to trace the results to the individual. There are two types of anonymous HIV testing; in the first, the individual decides to have the test anonymously (voluntary) and in the second, the test is made anonymous by those carrying it out (unlinked).
5. Voluntary anonymous testing: An HIV test requested by an individual can be made anonymous when the individual does not provide a name or other information which would reveal his or her identity. However, general demographic data such as age, race, sex, general area of residence (urban/rural), educational level, socioeconomic class, occupation, and HIV risk behaviours or factors can be collected. In some settings, the person to be tested is given a card with a number or other code; the same number is attached to the blood specimen. The person tested can then obtain the result by referring to or presenting the card. As only the person tested knows his or her number, other people cannot have access to the result.
6. Unlinked anonymous screening: When blood has been collected for a purpose other than HIV testing, it can be used for unlinked anonymous screening by removing personal identity information, including the name and address (but not demographic data). Each blood specimen is given a number and the same number replaces the personal identity information on the forms. Thus, the results cannot be linked with information which would identify a specific individual. It is important to note that in this system, people cannot know the result of their test; they may not even be aware that testing for HIV has been performed.

Annex 1

7. Counselling: This is a process of dialogue and mutual interaction aimed to discuss problems, facilitate understanding, and increase motivation. In counselling, the psychosocial needs of the individual are taken into account together with, and in the same way as, his or her medical, material and legal needs. Counselling is designed to provide support at times of crisis, to promote change when change is required, to propose realistic action in the context of different life situations, and to assist individuals in accepting information on health and well-being and adapting to its implications. Counselling can be a process of advice-giving or of education, or it can respond to individual psychosocial needs. In practice, these different forms of counselling often overlap.
8. Confidentiality: The protection of personal information from disclosure to unwarranted people. The decision regarding the balance between a need for others to know this information and the risks to the individual resulting from its unauthorized disclosure must be made extremely carefully. Persons learning confidential information must be made aware of their legal and ethical responsibilities to preserve its confidentiality.
9. Informed consent: The process of ensuring that prior to a test or procedure, the individual is sufficiently informed to understand the personal risks and benefits involved, in a setting and context in which choice is realistic and possible, and direct or indirect threat to comply is absent. The methods and details may vary, for example, written informed consent would not be appropriate for illiterate persons, but oral presentation would. Regardless of the details, the basic principles of informed consent must be respected. A failure to explain HIV testing properly could result in anger, misunderstanding, and confusion.
10. Global AIDS Strategy: The Global AIDS Strategy has been approved by all WHO Member States. Its objectives are:
 - to prevent HIV infection;
 - to reduce the personal and social impact of HIV infection; and
 - to unify national and international efforts against AIDS

The Global AIDS Strategy establishes basic principles for national and international AIDS prevention and control based on knowledge of HIV virology and epidemiology, and is derived from practical experience of programmes to control infectious diseases. It provides the necessary framework within which each country must develop its own detailed programme.
11. Target groups for HIV/AIDS surveillance: Population groups containing people who engage in risk behaviours, such as having multiple sexual partners or sharing unsterilized injection equipment, are epidemiologically important target groups for HIV/AIDS surveillance. It needs to be emphasized that being classified as belonging to a population group, such as homosexual men, does not by itself indicate any increased risk of HIV infection; it is the personal behaviour of having many sexual partners which increases risk of HIV infection.

ILLUSTRATION OF EPIDEMIOLOGICAL SURVEILLANCE AND
IDENTIFICATION AND MANAGEMENT OF HIV-INFECTED PEOPLE
IN A PATTERN III COUNTRY

This example illustrates the issues discussed in this report.

Target group: People with sexually transmitted diseases (STD)

1. Operational definition

Persons with symptomatic STD may present at public or private STD clinics, outpatient departments of general hospitals, private physicians' offices, pharmacists, STD laboratories or other diagnostic service sites, or traditional or folk healers.

2. Epidemiological surveillance

People with STD may be useful sentinel populations as the major route of HIV transmission is sexual. If unlinked anonymous screening is the surveillance method to be used, persons to be included must already have blood taken for other purposes. Therefore, only some of the sites given above will be suitable for collection of unlinked bloods.

If the voluntary anonymous testing approach is selected, the epidemiological surveillance will include a bias related to the client's decision on whether to participate, even though confidentiality is assured. Pre- and post-test counselling resources will also be required, along with a clear plan for management of people who, after being informed of a positive result, come forward for counselling and other services.

3. Identification of HIV-infected persons

The setting up of a programme to identify HIV-infected people requires careful selection of the site. To meet the conditions for informed consent, pre-test counselling must be organized. Steps must be taken to assure a non-coercive approach (i.e., persons refusing to be HIV-tested must not be penalized by being denied STD treatment). Details of how confidentiality of test results will be protected must be reviewed in advance, with explicit decisions made on who will have access to results, how the individual will be informed (this should be done in person), and on storage of the data.

However, the most vital aspect of such a programme is the management of the HIV-infected person. Services to be provided, approaches to counselling, sexual partner referral, and maintenance of confidentiality must be considered. If the HIV-infected person is discriminated against, or suffers personal harm or public embarrassment, the entire strategy of voluntary HIV testing at that site will be compromised or destroyed. For example, if the testing of people attending a public STD clinic is not performed correctly and/or HIV-infected persons are discriminated against, patients will either refuse to be tested for HIV or will avoid the clinic entirely. In both cases, the public health opportunity to prevent the spread of HIV will have been severely weakened.

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- Dr S. Pattanayak, Regional Office for South-East Asia, New Delhi
- Dr N.K. Shah, Director, Prevention and Control of Diseases, Regional Office for South-East Asia, New Delhi
- Dr D. Tarantola, Chief, National Programme Support Unit, Global Programme on AIDS, WHO Headquarters, Geneva
- Dr T. Umenai, Director, DPC, Regional Office for the Western Pacific, Manila
- Dr H. Wahdan, Director, DPC, Regional Office for the Eastern Mediterranean, Alexandria

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