Toolkit module:
'HIV and viral hepatitis seroprevalence and behavioural studies in IDUs' – presentation of the draft

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Outline

Background:	• Module objectives
Module content	• Overview of sections
Harmonization of surveillance sero-behavioural surveys in Europe: can we arrive at common recomendations?	• (General practices) • Sampling frame • Sampling methods • Surveillance system?

Objectives of the module

- Provide overview of use of seroprevalence and behavioural studies as surveillance tool
  - Based on existing guidelines
  - Easy reference
  - Practical considerations and expert opinions
  - Update on new methodological developments (published literature)
- Highlight:
  - IDU/DU specific issues
  - European context
  - Use in surveillance
- Support harmonization of the DRID implementation in Europe

IDU/DU context

- Illegal nature
- Irregular lifestyles
- Informal congregation places
- Proven prevention methods of blood borne infections (BBI) and other health consequences

→ numerous services targeted at DU

EU context

- Level of stigma associated with DU and BBI probably lower in some countries
- Low threshold services rather accepted
- Coverage of services in some countries high

Use in surveillance

- Simplicity and cost-effectiveness
  (the system should be sustainable within public health structure)
- Picking up new trends (sensitivity)
- Reproducibility over time (reliability)
- Validity
  (representativeness of the sample and valid measurement)

Content of the module I

- „Technical" sections
  - Sampling techniques
  - Formative research
  - Laboratory methods (biological samples, available tests, principles of diagnosis)
  - Questionnaire development
  - Ethical requirements
  - Statistical analysis overview (focused on survey data)

Content of the module II

- „DRID harmonization" sections
  - Discuss (prefered) methods for DRID monitoring in Europe
    - Sampling frame
    - Sampling methods
    - Sero-behavioural studies as surveillance tool
  - Understanding sampling method choice recommendations
    - Trade-off: simplicity vs representativeness?
    - Surveillance as a system with various sources of data

DRID general practice

- Ever IDUs among recent PDU / recent IDUs (other possible e.g. PDUs)
- Preferably sero-beahvioural not only behavioural
- Preferably repeated cross-sectional rather than cohort, case-control, ecological etc
- Mainly HIV and viral hepatitis (HBV, HCV) though interest in other (HAV, TB, STIs, anthrax, other bacterial)

- (note parallel future module on routine diagnostic prevalence data)

Sampling frame

- Community
  - Resource intensive, safety issues, concerns re reproducibility
  - Access to population not reached by services
- Outpatients services
  - May miss important subgroups (ex. new IDU, stimulant injectors), may differ by service type
  - Logistically easier, potentially monitors the same population over time
- Closed settings
  - May be very selective, may differ by service type, bahaviours likely to change after admission
  - Easy to implement, easy collection of biological samples

Sampling at services

- Services attract different subpopulations
  - Type of service provided (specialized for drug users; general health; social etc.)
  - Ease of access (low-threshold, higher threshold)
- Inclusion of multiple settings (incl. LT services)
  - Analyze/ report them separately?
- Services to participate in following rounds of the study
- Current data come mainly from:
  - Drug treatment
  - Low-threshold
  - Prisons
  - Drop other settings from ST9?

Guideline	Survey type	Preferred sampling method	Alternative
(FHI, 2000)	Behavioural	TLS	Targeted, snow ball recruitment at sites
(UNAIDS/ WHO, 2011)	Sero-behavioural	RDS: community seeds	TLS: at street venues Convenience: treatment centres
(ECDC, 2010)	Behavioural: population reachable in known settings, not stigmatized	Service /venue based or on treatment entry	
	Behavioural: population not well known, not easy to reach, and/or stigmatized	RDS if networked population TLS if not networked population Community outreach if not networked and mapping difficult	
(CDC/GAP, UCSF, 2010)	Sero-behavioural: existing services, routinely collect blood	Service based sampling unlinked anonymous testing	
	Sero-behavioural: Limited services	TLS or targeted sampling if congregate in accessible locations RDS if no accessible congregation location or safety issues	

Surveillance system (for disucssion)

- Back-bone: Service based monitoring (e.g. annual)
  - few indicators
  - convenience sample of DU accessing services
  - Bio-behavioral or UAT+behavioral?

- Enhanced: Community bio-behavioural surveys (e.g. every 3 years)
  - existing premises and service staff
  - RDS/TLS or only RDS?

- Verification: surveillance methodology/system evaluation
  - TLS / RDS/ targeted sampling recruitment
  - Full formative research
  - Dedicated study team / dedicated study site

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- Which methods have been applied in surveillance and which hardly ever used in Europe? Why?
- Can we grade the methods used?
- What would be the process of selecting best methods?
- Is it possible to recommend one system for surveillance?