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Another step forward in using surveillance for prevention

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Two decades ago in the USA, partner services programmes and HIV surveillance programmes frequently had very little cooperation, with guidance typically more focused on limiting sharing of surveillance data with prevention programmes (eg, partner services) than encouraging it.¹ Stigma and discrimination experienced by people with HIV, especially those who were members of socially marginalised populations, fuelled reluctance to share surveillance data that identified infected people.²

The emergence of antiretroviral therapy (ART), however, changed HIV partner services. The availability of therapy offered the opportunity for public health investigators to not only notify people exposed to HIV and offer testing, but to connect partners infected with HIV with care. In the USA, public health recommendations reflected a change in emphasis towards use of surveillance data to improve programme services and in getting people exposed to HIV notified, evaluated, and linked to care or prevention as needed.^{3,4} In *The Lancet HIV*, Chi-Chi N Udeagu and colleagues⁵ demonstrate the use of HIV partner services in New York City to not only bring newly diagnosed partners to care, but to assess those previously diagnosed and ensure they are either in care and virally suppressed or are relinked to ART services. In doing so, the programme provides a health service to notified people not in care or adequately treated (the individual benefit) and a public health benefit in that returning individuals to care reduces the number of persons in a given population who could plausibly transmit infection.

Udeagu and colleagues show the expanding vision of partner services, including the use of surveillance data to inform partner notification activities and the expansion of partner notification services in 2014 to include people with previous diagnoses of HIV (the need for enabling legislation is worth noting). This expansion is not trivial: previously diagnosed partners were shown to outnumber new diagnoses by around a factor of five in these data, and even the subset not in care (never or not currently) outnumbered new diagnoses. Moreover, among the much larger group in care, fewer than half were virally suppressed. Reaching previously diagnosed people and reconnecting them with care therefore has great potential in contributing to viral suppression at the population level and for reducing overall transmission rates. The authors note that the likelihood of not being virally suppressed, even while in care, increased with the amount of time since diagnosis, further justifying emphasis on interviewing and evaluating people previously diagnosed with HIV.

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What Udeagu and colleagues describe is also a deepening of integration between surveillance operations and programme services with the common purpose of improved population health irrespective of location or timing of HIV diagnosis. Other instances in which information sharing can assist prevention include monitoring sexually transmitted disease (STD) diagnoses as predictors for HIV seroconversion,^{6,7} a task that would have been much harder in the era when STD and HIV programmes were often organisationally distinct. Additional possibilities for bolstering integration for population health include ascertainment of social services needs and linkage to those services. Greater recognition of the effects of social determinants of health supports more routine surveillance of social determinants and ascertainment of social services among people vulnerable to HIV. US STD and HIV programmes appear increasingly attuned to these needs, and international examples abound. Integrated prevention and care packages for maternal and child health are one example.⁸

Udeagu and colleagues note age and race were associated with reduced odds of being virally suppressed even if in care and with increased odds of being newly diagnosed. Such disparities are longstanding in the US HIV epidemic (and in STD rates).⁹ Broad integration of surveillance and programme functions, such as that described by Udeagu and colleagues, offer opportunity to mitigate disparities by enabling rendering of services to those who would otherwise be missed or underserved by health-care systems. Certainly, policies involving sharing surveillance data, especially data including personally identifying information, must be managed with care and with an eye to protecting the individuals concerned. That noted, these data highlight that strengthening surveillance data sharing across programme services supporting the HIV care continuum strengthens the entire continuum.

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