

WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION  
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ORGANISATION MONDIALE DE LA SANTÉ  
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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ  
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

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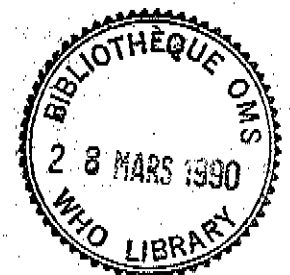
REGIONAL PROGRAMME ON AIDS

AIDS PREVENTION AND CONTROL STRATEGIES  
IN LOW HIV ENDEMIC COUNTRIES

Report on a WHO Subregional Meeting

Balatonszemes

30 October - 2 November 1989



1990

EUR/HFA target 4

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## TARGET 4

### Reducing disease and disability

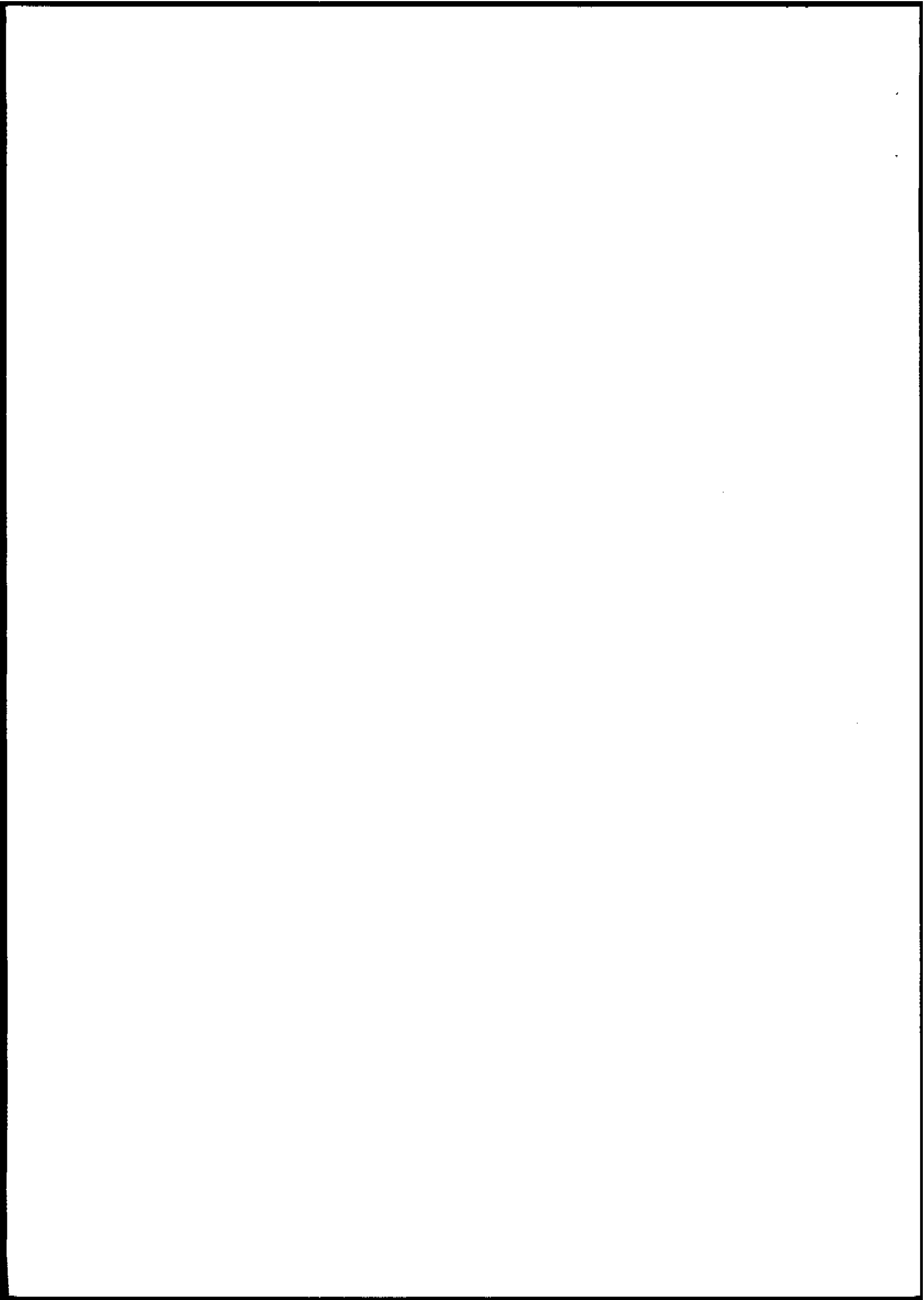
By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.

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HIV SEROPOSITIVITY - prevent/control  
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CZECHOSLOVAKIA  
GERMANY, DEMOCRATIC REPUBLIC OF  
HUNGARY  
ISRAEL  
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## 1. Introduction

The Subregional Meeting on AIDS Prevention and Control Strategies in Low HIV Endemic Countries was held at Balatonszemes, Hungary, from 30 October to 2 November 1989. The meeting was attended by 26 representatives from 11 Member States, by World Health Organization (WHO) staff from the Global Programme on AIDS (GPA), the Regional Programme on AIDS (RPA/EURO), temporary advisers from four Member States, and four observers from Hungary.

## 2. Scope and purpose

To strengthen AIDS/HIV surveillance, prevention and control activities in Pattern III (low prevalence) countries. In these countries the experience gained in countries with a high prevalence of AIDS cases and HIV infection - Pattern I and II countries - is directly applicable in the majority of cases, but in certain matters different approaches may be needed. Participants were therefore expected to review existing national programmes and analyse the surveillance, prevention and control methods used in order to define possible specific measures that will keep the prevalence at a low level for as long as possible.

The objectives of the meeting were:

- to undertake a critical review of the present situation with regard to AIDS and HIV infection in low prevalence countries in Europe;
- to identify target groups characteristic of low HIV endemic areas;
- to find better ways of contacting the hard-to-reach using:
  - (a) epidemiological and laboratory methods
  - (b) education and public information
  - (c) counselling;
- to discuss ways of ensuring confidentiality in the provision of counselling services;
- to make appropriate recommendations to limit the spread of HIV infection in low prevalence countries.

Ms Zsuzsanna Jakab, Head of Department of International Relations in the Ministry of Social Affairs and Health of the Hungarian Republic, in welcoming participants stated that it was her Government's wish to work closely with the World Health Organization in an effort to control the spread of the Human Immunodeficiency Virus (HIV). The importance of the subregional meeting in developing a strategy for low endemic countries in Europe to achieve this objective was recognized.

Dr A.M. George welcomed delegates on behalf of Dr Jo Asvall, Regional Director of the WHO Regional Office for Europe, and thanked the Government of Hungary for agreeing to host this meeting and for providing such excellent facilities. Dr George emphasized the need for an agreed policy to contain the spread of HIV in Pattern III European Member States, reminding delegates that their situation was not an occasion for complacency. It was well known that if HIV is introduced into a Pattern III country and the conditions are right

for its spread, then it will do so with deadly rapidity. He emphasized that staff of both the Global and the Regional Programmes on AIDS were available to assist Member States.

The meeting should result in firm recommendations for National AIDS Programmes in Pattern III countries in the European Region to prevent and control the further spread of HIV.

Professor S. Dittmann was elected chairman, Dr Adam Vass vice-chairman and Dr Bulent Coskun rapporteur.

### 3. Global epidemiology

In a global overview participants were reminded that by 10 October 1989, 182 463 cases of AIDS had been notified to WHO, 25 589 of which were in the European Region. While the completeness of notification varied around the world, in Europe the system was considered to be working well. Of the European cases there were 325 from the low prevalence countries (1.27% of the total) and this percentage fell to 0.42% if Israel, Finland and Yugoslavia were excluded.

Five million people are estimated to be infected by HIV, half a million of them in Europe. They will proceed to clinical AIDS at the rate of 5% each year causing considerable problems for the health care systems in Member States.

Evidence was presented showing that in countries where mandatory testing had been introduced as a control measure it had failed. Examples were given from the United States, Australia and the Caribbean. There was a description of the technique used for forecasting the AIDS pandemic and of the problems associated with case reporting and serological testing.

Sentinel surveillance, using unlinked anonymous testing in parallel with a system for voluntary testing with pre- and post-test counselling was commended, together with information, education, counselling, partner notification and patient support, as preventive strategy.

### 4. Situation in the European Region

A detailed report on the situation in the European Region, and especially in the 11 Member States represented at the meeting, was presented by an epidemiologist from the WHO Collaborating Centre on AIDS in Paris. Reference was made to the different patterns within Europe: low prevalence in Eastern Europe; a belt of AIDS in intravenous drug users (IVDUs) extending from Spain, through the southern part of France into Italy and Yugoslavia; and finally the rest of the Region with the problem predominantly among male homosexuals and bisexuals. In the low prevalence Member States represented only Yugoslavia had a problem among IVDUs and the percentage of cases notified among male homosexuals/bisexuals ranged from 88% in Czechoslovakia to 17% in Turkey. Those who had relied upon imported blood products had a higher percentage of infected haemophiliacs. Only Israel and the USSR had reported a paediatric case with mother-to-child transmission. Several AIDS cases had been reported in population sub sets such as foreign students and nationals who had worked overseas.

All Member States represented routinely test blood donations and few cases of HIV seropositivity have been detected in this group. There have been very few cases of transfusion-associated AIDS cases.

Detailed presentations were given by a representative from each participating country listing the health promotion activities undertaken, the number of AIDS cases reported, the number of known HIV seropositives, the results of seroprevalence studies, and the number of HIV-2 seropositives detected. HIV-2 had been detected in Bulgaria, the German Democratic Republic, Hungary and the USSR.

Activities ranged from widespread testing of the general population without counselling, and with very few seropositive people detected, to a more selective process of targeted testing of people with risk behaviour and accompanied by counselling and support. The former procedure was questioned as being of doubtful value. The feeling was that resources being employed could be put to better use in educational programmes or by intermittent sentinel serosurveillance using bloods collected for another purpose, unlinking identifying data and then testing for HIV antibody. Such a system should be used in conjunction with a parallel system of voluntary testing with pre- and post-test counselling for those who wished to use such a service. These procedures would give a better cross-sectional view.

A questionnaire had been submitted in advance of the meeting and presentations were given summarising the data received.

## 5. "Hard-to-reach" groups

Temporary advisers gave presentations with particular reference to "hard-to-reach" population groups as follows:

- European practices for AIDS prevention in hard-to-reach groups;
- epidemiological and social approaches;
- counselling, partner notification and contact tracing;
- health education and information.

## 6. Working groups

Before dividing into three working groups a presentation was made on the prevention of HIV transmission in health care settings by staff from the Global Programme on AIDS.

### 6.1 Working Group A: National strategies for testing, screening, surveillance and legislation

This group discussed the definitions (Annex 1) used in the meeting which formed an essential background for their discussions.

After discussion of the public health use of mandatory testing of individuals it was acknowledged that this will not stop the spread of HIV infection. Some members of the working group expressed the view that by identifying infected international travellers or visitors and conducting partner notification the low prevalence countries might be able to slow the spread of the epidemic thus gaining time in which to educate and inform the public about HIV infection and its prevention. Should this be done then due regard should be given to World Health Assembly resolutions, recommendations of the WHO Global Programme on AIDS, the rights of the individual, and the avoidance of discrimination. New legislation should be a national decision using these guidelines.

The cost-benefits of large-scale testing should be assessed and compared to those of selected sentinel surveillance with unlinked testing which has been shown to be effective in some low prevalence countries. Voluntary, confidential testing, with pre- and post-test counselling should be available to all persons requesting such tests.

There was complete agreement that all donors of organs or tissues to be used for medical purposes should be routinely tested.

## 6.2 Working Group B: Counselling, management of medical care and partner notification

AIDS poses questions which cannot be satisfactorily answered by medical responses alone. Comprehensive case management must include a counselling component.

The aim of counselling is to:

- ensure stable behavioural changes;
- improve lifestyles;
- provide assistance in coping with problems;

In addition:

- confidentiality between counsellor and clients should be ensured as otherwise the aims of counselling may not be reached;
- facilities and counsellors should be acceptable to clients;
- counsellors should be well trained, competent, with non-judgmental continuously supportive attitudes.

Effective policies and social support ensuring equality and equity in services for people at risk for or with HIV infection and disease should be available. Although counselling is mostly carried out in government institutions, by non-governmental organizations and self-help groups, e.g. gay mens' associations, it should be expanded to the hard-to-reach persons. It should also ensure individual needs.

Pre- and post-test counselling in connection with HIV antibody testing should be provided. Counselling is a personal matter, and the decisions to be tested for HIV antibody should be made voluntarily with full understanding of the possible consequences. It should include medical and psychosocial aspects.

(1) Partner notification

A partner is defined as an individual who has sexual intercourse or shares injecting equipment with an index person during the periods of infectiousness. Partner notification is a balanced integrated part of counselling and should be in harmony with the global AIDS strategy and national AIDS programme goals. The aims of partner notification are to prevent the transmission of HIV and reduce the personal and social impact of HIV infection.

The principles of partner notification are:

- non-compulsory; if compulsory infected persons may be driven underground.
- through counselling enabling the necessary behavioural changes and informing about the implications of exposure to infection;
- careful balance between individual rights and public health interests;
- complete confidentiality;
- full access to and availability of services for index persons and their partners whether willing or unwilling to participate in partner notification.

When index persons refuse to notify or permit notification of a partner known to the health worker, the health worker will be obliged to make a decision consistent with medical ethics and the relevant law.

When planning partner notification the following must be taken into account: local and national variable factors, for example financial and personal resources, facilities for diagnosis, relevant legislation and political realities.

(2) Medical care

Persons with HIV infection and AIDS can safely be cared for in general in-patient facilities. The following aspects were discussed in detail:

- Networks for out-patient care should be promoted taking into account the medical progress, especially the possibilities for prevention of opportunistic infections;
- health professionals must be properly trained in clinical, laboratory, psychosocial and public health aspects;
- governments, through bilateral agreements and WHO, should support exchange programmes for visits to pattern I countries;

- central in-patient facilities should play a leading role in the dissemination of information through seminars, workshops and continuing postgraduate education;
- national health authorities should ensure regular updating of developments in case management;
- prevention of HIV transmission in health care settings should be an integrated part of training programmes, and
  - establish a baseline defining the problem;
  - apply universal precautions in the treatment and care of all patients;
  - establish appropriate criteria for parenteral treatment and administration of injectables;
  - apply appropriate housekeeping routines and high level disinfection and sterilization practices.

### 6.3 Working Group C: Education and public information

Populations need and are entitled to information and education about HIV and AIDS in order to protect themselves. Groups with at-risk behaviour, who are intellectually or economically disadvantaged, need special attention. Comprehensive, integrated and long-term programmes to educate the general public and to reach specific groups are needed. Existing educational channels such as schools, universities and other institutions training and educating people should be used to reach whole populations.

AIDS messages need to be integrated into broader educational messages about healthy sexuality, drug use and healthy lifestyles and to use all avenues of communication, ranging from mass media campaigns to face-to-face communication. Special training should be organized for those involved in AIDS health promotion such as teachers, students training other students, youth workers, social workers and outreach workers. Since the press has an important role to play there is a special need for journalists to receive appropriate briefings. Because counselling is an integral part of a health promotion approach in AIDS prevention these activities must be planned and carried out in coordination with information, education and promotion programmes.

Since programmes to prevent injecting drug use can slow down the spread of HIV special initiatives are needed to strengthen such programmes.

The group expressed the hope that WHO would organize a workshop on the role of health promotion in AIDS prevention in low endemic countries to exchange experiences and plan future efforts.

## 7. Recommendations

The following recommendations emerged from the discussions in the three working groups:

1. Organs, tissues, blood and blood products should continue to be certified as HIV free.
2. Sentinel surveillance using unlinked anonymous testing should be established.
3. There should be a parallel system of voluntary testing with pre- and post-test counselling.
4. Counsellors should be well trained, be acceptable to their clients and conduct their work in complete confidence.
5. Non-governmental organizations and self-help groups should be encouraged to undertake counselling.
6. Partner notification should be voluntary and implemented by persuasion rather than by compulsion. In case of non-compliance the care provider will be required to make a decision consistent with medical ethics and the relevant laws.
7. The wishes of people infected with HIV should be taken into account when planning their care.
8. Health care professionals and others involved in care services should be adequately trained and regularly updated on aspects of HIV infection relevant to their work.
9. The whole population needs information and education about HIV infection and AIDS.
10. Special programmes are needed for groups with risk behaviour who are intellectually or economically disadvantaged.
11. Use should be made of existing educational institutions such as schools and universities and other institutions which train and educate people.
12. AIDS messages should be integrated into broader educational messages about healthy sexuality, drug use and healthy lifestyles, using all methods of communication.
13. Those involved in such programmes should receive adequate training.
14. The press has an important role in such education and should receive appropriate briefings.
15. Since programmes to prevent injecting drug use can slow down the spread of HIV, such programmes should be initiated or strengthened.
16. The Regional Programme on AIDS should organize a workshop on the role of health promotion in AIDS prevention in low prevalence countries so as to exchange experiences and plan future efforts.

Annex 1

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.

Source: Report on the informal interregional consultation on developing an epidemiologically based strategy for control of AIDS/HIV in Asia: report on a meeting, New Delhi, India, 6-8 June 1988. Global Programme on AIDS. World Health Organization, Geneva, 1989. WHO/GPA/SFI/89.1.

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.

## Definitions

1. **Public health surveillance** is the collection of information of sufficient accuracy and completeness regarding the distribution and spread of infection to be pertinent to the design, implementation, or monitoring of prevention and control programmes and activities.
2. **Unlinked anonymous screening** is the testing of specimens for markers of infection after elimination (unlinking) of all personal identifying information from each specimen.
3. **Bias:** Two forms of bias are pertinent to a discussion of unlinked anonymous screening for public health surveillance purposes; participation bias and selection bias. The occurrence of either type of bias leads to inaccuracies in the results relative to the true situation in the community.
  - **Selection bias** occurs when those persons selected to participate in a study differ in some important way from those not selected to participate.
  - **Participation bias** occurs when in a selected group, those persons who elect to participate in a study differ in some important way from those persons who elect not to participate in the same study.
4. **Mandatory testing** or screening occurs where testing is required of all individuals who voluntarily decide they wish to avail of a service or activity (such as attending a clinic). This is to be distinguished from compulsory testing, where both the testing and the service or activity are required (such as testing of new prison inmates).
5. **Voluntary testing** or screening occurs where participation in both the testing, and the service or activity, are up to the individual to decide.

Source: Unlinked anonymous screening for the public health surveillance of HIV infections: Proposed guidelines. Global Programme on AIDS. World Health Organization, Geneva, 1989. GPA/SFI/89.3.

Annex 2

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