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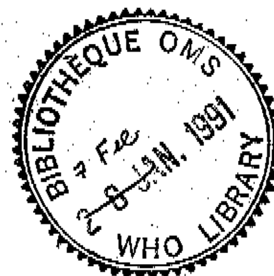
WHO

REGIONAL OFFICE FOR EUROPE

GLOBAL PROGRAMME ON AIDS

AIDS PREVENTION PROGRAMMING IN COUNTRIES WITH LIMITED RESOURCES



SCHERFIGSVEJ 8
DK-2100 COPENHAGEN Ø
DENMARK

TEL.: (45) 31 29 01 11
TELEFAX: (45) 31 18 11 20
TELEX: 15348

1990

EUR/HFA TARGET 4

This document presents the findings, conclusions and recommendations of the Workshop on AIDS Prevention Programming in Countries with Limited Resources held in Jerusalem from 26 to 28 March 1990. It was organized jointly by the Regional Office for Europe and the USSR to promote work aimed at achieving the following target in the health for all strategy.[a]

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%.

Index terms

HIV INFECTIONS - prevent/control
ACQUIRED IMMUNODEFICIENCY CONTROL - prevent/control
BULGARIA
CZECHOSLOVAKIA
GREECE
HUNGARY
ISRAEL
MALTA
POLAND
PORTUGAL
ROMANIA
TURKEY
YUGOSLAVIA

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[a] *Targets for health for all.* Copenhagen, WHO Regional Office Europe, 1985 (European Health for All Series No. 1).

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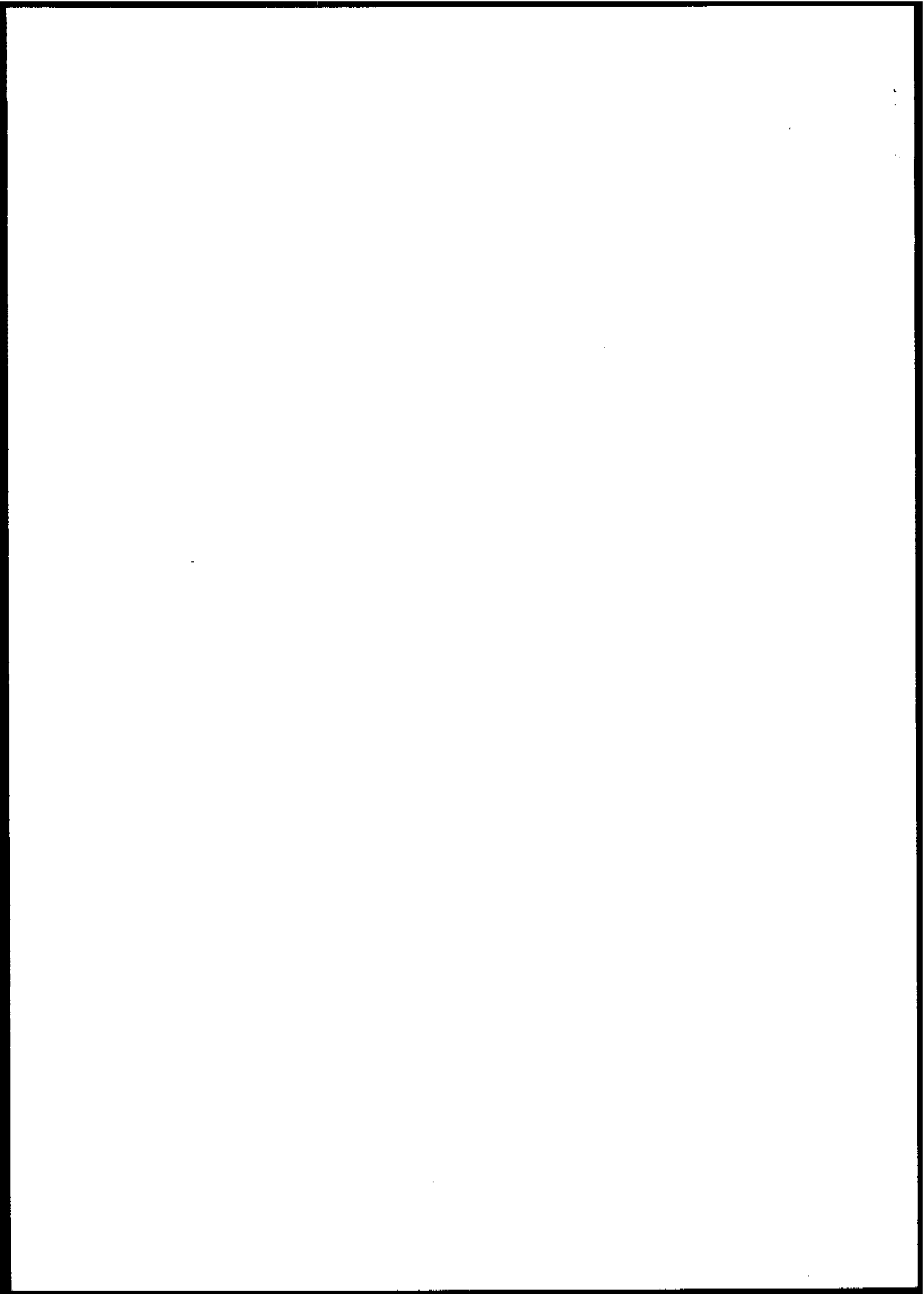

Background

At an early stage in the AIDS epidemic it was recognized that the epidemiological picture varied within the European Region, specifically in regard to the rate of HIV infection, prevalence of AIDS, mode of transmission and associated risk behaviour and at-risk groups. Two distinct trends were identified and classified as pattern I and pattern III (Annex 1). At the same time it was recognized that countries experiencing pattern III epidemiology could eventually assume pattern I characteristics and the consequent social, political and economic impacts involved.

In response to this possibility and to an identifiable increase in HIV seroprevalence and AIDS prevalence, the WHO Regional Programme on AIDS (RPA) began in 1989 a series of activities aimed at the situation in pattern III countries. An international Meeting on AIDS Prevention and Control Strategies in Low-endemic Countries was organized in Balatonszemes, Hungary, from 30 October to 2 November 1989, followed by a Meeting on European National Programme Support for Selected Low Prevalence Countries in Copenhagen from 27 February to 1 March 1990 (attended by representatives from Bulgaria, Czechoslovakia, the German Democratic Republic, Hungary, Poland, Romania, USSR and Yugoslavia). These two meetings, especially the latter, provided a solid basis for defining future needs.

The problem of limited resources and consequent inability to meet the costs of prevention and control of AIDS was common to all countries. However, the potential for economic disruption was far greater in parts of eastern, central and southern Europe, exacerbated by the recent political and social changes that have occurred in countries such as Bulgaria, Czechoslovakia, Hungary, Poland and Romania. A subregional workshop was therefore convened in Jerusalem from 26 to 28 March 1990 on AIDS Prevention and Control in Countries with Limited Resources, attended by 21 representatives, principally national AIDS coordinators and senior programme managers, from Bulgaria, Czechoslovakia, Greece, Hungary, Israel, Malta, Poland, Portugal, Romania, Turkey and Yugoslavia. WHO staff and temporary advisers provided expertise in epidemiology, health education and promotion, social policy, communications and the media and evaluative methods.

Scope and purpose

The aim was to set priorities in HIV/AIDS prevention and control strategies, so as to maximize the effectiveness and efficiency of Member States' national AIDS prevention and control programmes. Participating countries' existing programmes were reviewed in the light of the benefits of setting priorities, considerations of cost impact and evaluation. Contributions by voluntary organizations and the media and the better use of funds were also discussed. Representatives considered:

- the most recent available data on HIV/AIDS in Europe;

- information on the number of known AIDS cases and HIV seroprevalence in their countries;

- current prevention programmes, the setting of priorities and available budgets in their countries;

- issues involved in setting priorities and the cost-benefits and improved targeting of resources;

- the role of voluntary organizations in preventive programmes, in particular AIDS service organizations (ASOs) and nongovernmental organizations (NGOs);
- the role of the media in preventive programmes;
- fund-raising activities;
- evaluative techniques and performance indicators for use by national AIDS programmes;
- the incorporation of the discussions topics into national AIDS programmes.

The following recommendations were made:

- ways in which to sustain public interest in HIV/AIDS prevention programmes;
- feasible health promotion and education initiatives;
- possible evaluation strategies; and
- follow-up action which may need to be taken by WHO.

A report was subsequently issued with recommendations for action by Member States and the WHO Global Programme on AIDS.

Epidemiology of AIDS: global and European situations

In less than 10 years AIDS has progressed from the first case described to a pandemic. Of the five continents, only Asia has reported relatively few cases, although the mushrooming rate of HIV seroprevalence for intravenous drug users (IVDU) in Thailand indicates that the potential for the rapid spread of HIV infection leaves no room for complacency. The situation is even more alarming in Africa, as a result of the apparently gross undernotification of the continuing spread of AIDS due to non-diagnosis, late and non-notification. Australia and New Zealand appear to have the greatest problems in Oceania following pattern I epidemiology.

The rate of HIV infection and diagnosed AIDS cases in Europe continues to increase and can be expected to rise still further, especially in pattern III countries following the political and social changes sweeping across central and eastern Europe. A crude indicator of the risk showed that the cumulative number of AIDS cases in these areas was increasing at a rate parallel to that of western Europe in the early stages of the epidemic (Annex 2).

A new and disturbing trend is emerging in South America and Caribbean countries. Previously defined as pattern I, they are now showing features of mixed patterns I and II. At the end of the 1980s approximately 5-6 million people had been infected with HIV, and Delphi projections indicate that 14 million will have been infected by the end of the 1990s. One third of these infections could possibly be prevented by good preventive programmes.

Country presentations

All Member States have established national AIDS prevention and control programmes with fixed objectives and priorities, although there are some differences in priority areas for action.

Central and eastern European countries were particularly concerned about the possible increase in transmission as a result of the new mobility of the population and the expected influx of tourists.

Restraints of confidentiality in Israel and Malta make estimates of the prevalence of seropositivity unreliable, as it is suspected that some individuals may take more than one test while others with self-perceived high risk behaviour may shun testing or be tested abroad.

Poland revealed a rapid spread of HIV among its IVDU risk group: it is estimated that 521 or 67.5% of the 772 seropositive Poles now belong to this group. Investigations have shown that these IVDUs abuse a homemade version of opiate, and the crude equipment they use ensures multiple use of needles.

In Romania, 772 paediatric cases have so far been found to be infected with HIV, 317 of them diagnosed as suffering from AIDS. The main source of transmission appears to be contaminated blood products and the repeated use of unsterile medical equipment. The top priorities for action in Romania are expansion of the surveillance system and testing of all blood donations for HIV antibodies and HBsAG.

The resources available for national AIDS programmes were also discussed. Most Member States have separate budgets for their AIDS programmes, but in some the programme is integrated into the general health budget. A contentious issue was that in some countries the screening of blood donations for HIV antibodies was included in the AIDS budget and consumed as much as 90% of available resources.

Maximizing the effectiveness of national AIDS programmes

Below is a summary of the discussions of the fundamental requirements for maximizing the effectiveness of countries' national AIDS programmes in a climate of scarce resources.

Primary, secondary and tertiary prevention

When the cause and mode of transmission of a fatal disease is known, prevention becomes the best strategy for stopping its transmission.

The major effort should be directed towards primary prevention, which means stopping HIV infection of populations at risk. Secondary prevention is the early detection of people infected with HIV with the aim of reducing and delaying damage by the virus. Tertiary prevention is the care and treatment of HIV/AIDS patients and psychological support to help them cope with the stigma of the infection.

Secondary and tertiary activities relating to care and other necessary services for people living with HIV/AIDS should be part of national health care budgets, not national AIDS budgets.

Counselling

Pre- and post-test counselling is an essential and cost-effective component of secondary and tertiary prevention. Counselling is a mutual decision-making process based on two-way communication, and involves a continuing relationship geared to helping with the problems of the infected person.

HIV/AIDS counselling is extremely sensitive and requires special skills for which specialized training is needed. Medical doctors may not necessarily be the best people to provide counselling: various disciplines and lay people should be considered as potential counsellors. The necessary skills include listening to the individual, noting what is not said, providing information, assessing the psychological effect of this information on the patient, and helping and encouraging the patient to make informed decisions concerning his or her behaviour and how to cope with stress situations like extreme anger, hysteria or depression.

Counsellors must also be able to mobilize social support and the family. This is not necessarily the biological family and could involve, for example, a homosexual couple.

Counselling has to overcome resistance to behavioural changes, assist people in recognizing the need for change, encourage them to effect these changes, and invite individuals, their families, communities and societies to take advantage of the support groups at their disposal and thus help them to maintain their desired behaviour patterns.

Information, communication and the mass media

Mass media information and education campaigns have a limited use in primary prevention as they only tend to put AIDS on the social agenda. They cannot be expected to change behaviour. Once individuals become aware of AIDS in this manner, they pass through interest, evaluation, trial and adoption or rejection phases. Mass media campaigns are expensive, particularly when they involve packages prepared by professional agencies, and their use must be carefully weighed against alternative strategies.

Communicating with journalists as equal partners and encouraging their cooperation can overcome these costs to some extent, but the media should in any case be used sparingly, as it may be counter-productive to overexpose the general public to AIDS information. Timing in this situation is important.

An alternative approach is to target groups, seeking out key people already in touch with members of these groups and encouraging their involvement in preventive work. A highly cost-effective communication infrastructure can be set up in this way. The long drawn out process of changing attitudes and behaviour towards sexuality and drugs among large groups of the population involves the need for long-term planning; a low-cost communication infrastructure can be a cost-effective avenue to this end.

Futures workshops[a], originally developed by Mr Robert Jungk, provide one method for establishing this infrastructure. These informal groups help their members to decide the important issues for themselves, but they require the training of facilitators to organize the workshops and a planned long-term follow-up programme to achieve the desired results.

Targeting resources

The targeting of resources in health promotion involves activities focused on specific risk behaviour rather than mass programmes. The latter are useful for showing activity but can be a waste of valuable resources.

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[a]WHO Workshop on Social and Cultural Problems in AIDS Prevention through Health Education and Health Promotion, Stockholm, 2-4 October 1989.

Such targeting necessitates the identification of risk behaviour or at-risk groups and the application of the following checklist before resources are allocated:

- What information needs to be given?
- Who needs to receive it?
- Who is best qualified to give it?
- When should it be given?
- Where should it be given?
- How should it be given?

Prevention strategies must be well thought out and carefully planned. Flexibility is important in involving the appropriate organizations and people to implement activities designed to meet the objectives, as these might include religious or voluntary organizations such as gay self-help groups.

AIDS education in schools

AIDS education for youth and in schools must use existing infrastructures. AIDS is a medically defined condition, whose only solution at present is educational. It is logical therefore to use the valuable resource available in teachers who have invested in and are committed to education. Health promotion in schools has already worked in education about tobacco and other lifestyles.

A new concept is the health promoting school, where what children learn in the classroom, in the school community and in their local environment and homes is coordinated at the school to best promote the health of both pupils and teachers.

The teacher is obviously crucial. It is therefore important that an appropriate training manual should be produced which incorporates the idea of a continuity spiral, whereby an issue is visited repeatedly throughout the child's school career to ensure that it is absorbed.

Monitoring and evaluation

Monitoring and evaluation are important in maximizing the efficiency and effectiveness of AIDS prevention and control programmes. The three basic components of policy and programme evaluation include formative, process and outcome evaluation.

Formative evaluation is a question of "What works better?", attempting on a small scale to identify and resolve systematically issues of intervention and evaluation before a programme is widely implemented. For example, prior to the implementation of a full-scale media campaign, individuals can be randomly assigned to view different preliminary presentations (whatever the media form), and the self-reported knowledge, attitudes and behavioural intentions can be compared for different versions. Even on a small scale, formative evaluation requires financial resources and trained staff.

Process evaluation attempts to answer the question "What services are actually delivered?". Fewer additional resources are normally required and the costs are small relative to the cost of the programme. For example, recipients of HIV counselling can be evaluated through information gathered and reported (anonymously) about them.

However, while data on the number of individuals served or questions of accessibility can be obtained through process evaluation, information on whether there are the desired changes in outcome or outputs cannot. Since the effectiveness of programmes cannot be demonstrated, it is not a sufficient process to determine results.

Outcome evaluation assesses the effectiveness of an intervention to answer the question "Does the intervention or programme make a difference?" and, by association, "What works better?". Since the statistical considerations of randomization, bias, reliability and validity are important, outcome evaluations can be expensive and pose ethical problems. For example, the use of no-treatment control groups in HIV counselling is usually considered unethical, and surrogate measures to evaluate outcome therefore take on added importance.

Appropriate indicators for measuring the outcomes of interventions must be established through the identification of all interventions and desired outcomes and the establishment of targets which relate to the objectives and give a true measure of the indicators. To be valid, these indicators must be attributable to the intervention and capable of being reproduced at different times and by different people.

Targets can be used for either comparison or attainment. A comparative target can aim, for example, at increasing by 20% above the existing level the use of condoms in the sexually active population over the following twelve months. An attainment target would be to attempt to promote the regular use of condoms in 20% of the sexually active population. Baselines must be established for comparative targets.

Cost-benefit considerations

Cost-benefit analysis is a method of evaluating health and socioeconomic effects that are not necessarily common to different options, whereby all benefits and costs are reduced to monetary units and the conclusion is presented as a net benefit figure. It can be used to promote efficient strategies.

Relevant costs and benefits (impacts) are identified within a given geographical area together with associated individuals and social preferences. The benefits (according to preferences) are given a monetary value; this often involves the controversial question of the value of life. Value is arrived at through the costs of opportunities and willingness to pay, and is discounted for time and risk in the light of current values and expected monetary values (probability of occurrence). The choice of policy option is influenced by physical, budgetary and distributional constraints.

Cost-benefit analysis is useful even when values other than efficiency are relevant. If important factors cannot be given a monetary value, the identification and classification of impacts as costs or benefits can serve as a starting-point for a more appropriate multi-goal analysis.

The role of voluntary organizations

Aids service organizations (ASOs), nongovernmental organizations (NGOs) such as youth and women's organizations and trade unions, and other voluntary organizations should be provided for in AIDS prevention programmes and involved in the planning stages. They can all play important roles, and their

value has been demonstrated in particular by the ASOs (which are still dominated by the gay movement in Europe) with such innovative health promotion activities as the AIDS Hotline.

ASOs have a strong advocacy role plus identity and credibility in the eyes of the individuals and groups they serve. They have also been able to attract and use the potential of laymen on a large scale as voluntary staff - a resource which cannot be underestimated in the effort against AIDS. ASOs also carry out secondary and tertiary prevention by not neglecting the needs of people already infected or those with AIDS, their lovers, friends and families. Their personal experiences should be used as a powerful educational tool.

Approaches developed by ASOs, such as guidance on safer sex, have proved effective. Gay men are the only group which has so far successfully and dramatically adapted measures for risk reduction.

Testing and screening

Screening should be voluntary and confidential, since any attempt to introduce compulsory screening in low-incidence countries will induce people in risk groups to evade testing and thus miss this valuable opportunity for counselling. When screening has been compulsory it has produced a low yield and wasted valuable resources.

Although it is possible to introduce laws on questions such as the compulsory tracing of contacts and reporting of names, such measures are thought to be counter-productive as well as infringing individuals' human rights. Services will be used more and fear of stigmatization and social marginalization reduced if reporting is anonymous. The compulsory tracing of contacts implies a lack of cooperation from the patient regarding his or her contacts. Voluntary notification of partners, combined with the option for the individual to contact his or her own partners, will improve compliance and give better overall results.

The compulsory testing of groups such as sex workers is difficult to carry out because of problems with definition. Evidence of the spread of HIV from sex workers is scanty and produces little benefit. Better results can be expected from counselling sessions.

Public safety versus individual rights is a hoary argument that still rages in the debate about AIDS. In low prevalence areas the argument may tip more favourably towards the individual than in high prevalence areas.

Recommendations

1. National AIDS prevention programmes should be funded by governments.

2. Budgets for such programmes should be divided into four separate and independent sections, as follows:

- for ensuring the safety of blood;
- for HIV testing (antibody screening) of individuals at risk at voluntary walk-in clinics, and testing of target groups that is voluntary, anonymous and unlinked;

- for information and education campaigns, distributed as follows (subject to review by national AIDS committees):

  20% - public awareness campaign
  40% - targeted education (risk behaviour groups, schools, health officials, general public)
  40% - counselling;

- for evaluation.

3. Secondary and tertiary prevention costs must be explicitly incorporated into national health budgets for medical care.

4. The wider availability of condoms must be encouraged at a price acceptable to potential users.

5. Each country must develop an AIDS information system starting with epidemiological data and including behavioural, social and economic data as it becomes available.

6. Evaluation should not attempt to be all-encompassing. It should be linked to specific objectives relevant to each country to ensure the efficient use of resources.

7. Indicators readily available in each country should be monitored and, where possible, existing information systems used.

8. Evaluation strategies should be sufficiently flexible to adapt to changes in the AIDS pandemic.

9. National programme priorities should include:

- the establishment of universal blood and body fluid precautions in all medical care facilities;

- the screening of all donated blood, blood products, organs, tissues and other human products;

- basic continuing/periodic seroepidemiological surveillance;

- a baseline survey of specific risk practices in identified risk behaviour groups;

- the establishment of counselling, voluntary testing facilities and hotlines;

- the integration of AIDS information and education programmes into the general promotion of healthy lifestyles;

- the inclusion of specific AIDS information in the training of health professionals, and the development of continuing education programmes which ensure that skills basic to all professional practice are maintained;

- the intensification of the war against drugs;

- a clear allocation of responsibility for various activities among different ministries or agencies;

- a timetable of planned activities according to the urgency of the situation;

- cooperation and coordination between countries, and between ministries, agencies and NGOs within each country.

10. Media workshops should be held in each country with WHO participation.

11. WHO should designate an information resource centre for low incidence countries to facilitate the sharing of education and information materials. It should be linked to centres already established elsewhere.

12. Ways should be found to assist countries with limited resources to obtain up-to-date professional journals and information about HIV/AIDS research.

13. Professionals involved in the prevention of HIV transmission should meet periodically to share ideas in cooperation with WHO.

14. Peer group training methods in AIDS education for professionals and lay people should be tried.

15. Mutual respect, understanding and cooperation between journalists and the medical profession should be fostered so as to minimize the need to buy commercial time and space for delivering accurate information to the public.

16. Every country should introduce protocols to protect confidentiality and the means to ensure that they are observed.

17. All possible measures should be taken to encourage voluntary rather than mandatory testing.

18. Countries with a low incidence of HIV infection should consider using traditional STD contact tracing and partner notification techniques.

19. Countries should consider introducing legislation or regulations to protect the rights of people tested for HIV and those infected with it.

20. The responsibilities of people with HIV/AIDS towards society should be emphasized.

Annex 1

PATTERNS OF AIDS

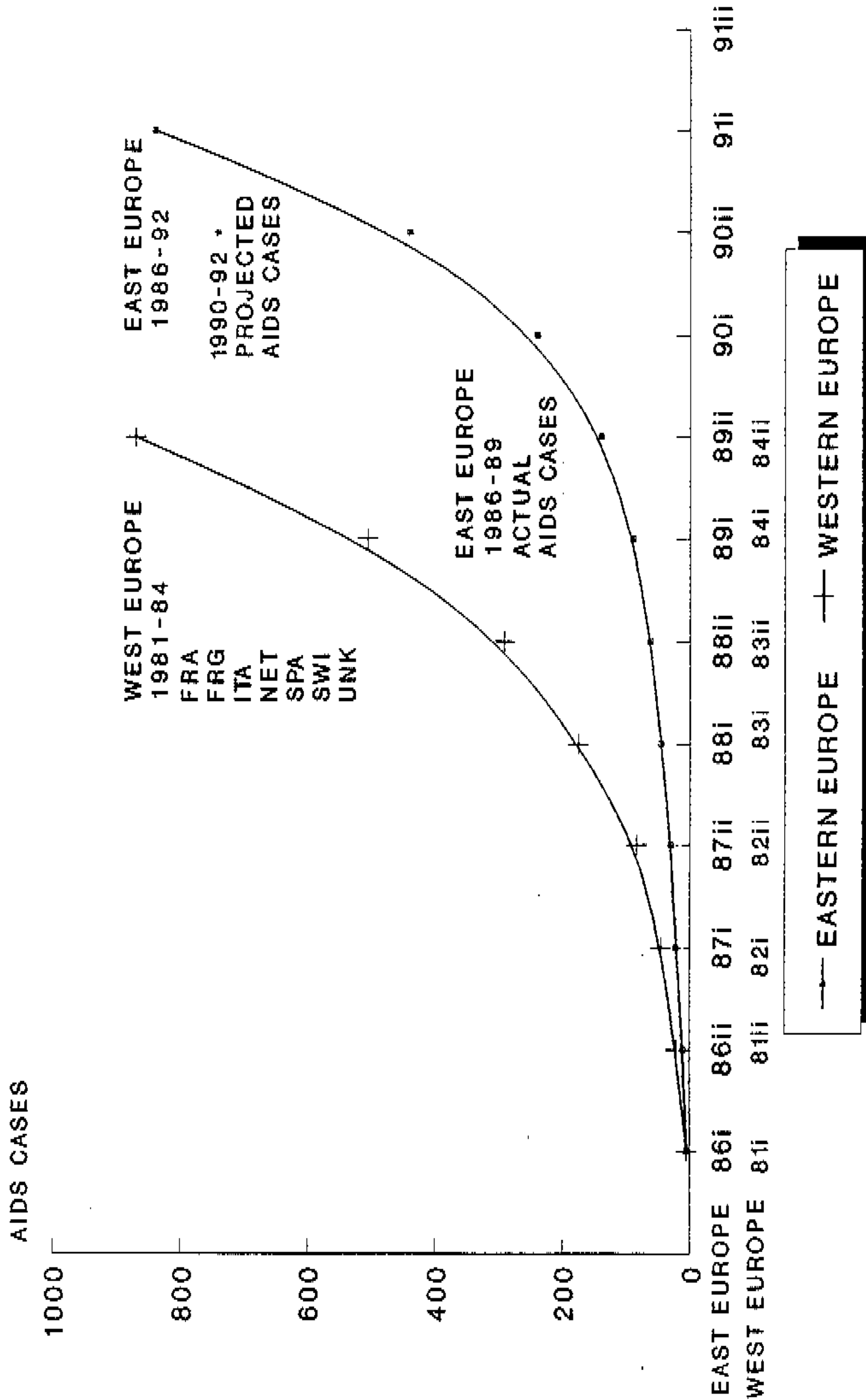
Three distinct patterns of AIDS have been recognized globally.

Pattern I countries are those where the extensive spread of HIV began in the late 1970s and early 1980s, including western Europe, north America, Australia, New Zealand and parts of latin America. Most cases have been among homo/bisexual males and urban intravenous drug users (IVDU). Heterosexual transmission accounts for only a small percentage of cases. The male/female sex ratio ranges from 10:1 to 15:1. The prevalence of HIV infection in the total population is much less than 1%, but in the risk behaviour groups it can range from 10% to 50%. Transmission due to blood and other blood and human products occurred early in the pandemic but has been more or less under control since 1985.

Pattern II occurs where the extensive spread of HIV since the late 1970s and early 1980s has been mostly among heterosexuals. This includes countries in central, eastern and southern Africa and areas of the Caribbean. The male/female ratio is approximately 1:1. Homosexual transmission accounts for a very small percentage of cases, but transmission due to blood and other blood and human products continues in many of these countries, and the use of unsterile needles and other skin piercing instruments poses a threat. Perinatal transmission is common. The prevalence of HIV in the adult population is often greater than 1%, with pockets of higher prevalence (up to 30%) found among urban young and middle-aged adults.

Pattern III countries are those where HIV was only introduced in the early to mid 1980s, including eastern Europe, the eastern Mediterranean, north Africa, Asia and most of the Pacific region. Homosexual, heterosexual and IVDU transmission has been documented, although overall only a few cases have occurred so far. The initial cases were generally among travellers to endemic areas. Infected blood products, usually imported, were responsible for many of the cases.

Annex 2



Annex 3

LIST OF PARTICIPANTS

BULGARIA

Dr Stanislava Popova
Chief, Epidemiological Department, Ministry of Public Health and Social Care, Sofia

Professor Svetoslav Todorov
Vice-President, Medical Academy, Ministry of Public Health and Social Care, Sofia

CZECHOSLOVAKIA

Dr Jaroslav Kriz
Chief Hygienist of the Czech and Slovak Federal Republic, Prague

Professor Jan Sejda
Chairman, Advisory Body for the Prevention of AIDS, Ministry of Health and Social Affairs, Prague (Vice-Chairman)

GREECE

Mr Themistoklis Sapounas
Director, Public Health Division, Ministry of Health, Welfare and Social Security, Athens

HUNGARY

Dr Bela Illes
Deputy Minister for Social Affairs and Health, Ministry of Social Affairs and Health of the Hungarian Republic, Budapest

Dr Adam Vass
Head, Department of Hygiene and Epidemiology, Ministry of Social Affairs and Health of the Hungarian Republic, Budapest

ISRAEL

Dr Gedalia Paz
Coordinator, National AIDS Committee, Director of Laboratories, Ichilov Medical Center, Tel Aviv

Dr Paul Slater
Chief Epidemiologist, Ministry of Health, Jerusalem

MALTA

Dr Joseph Pace
Head, Department of Dermatology, Boffa Hospital, Floriana

Dr A.J. Amato-Gauci
Secretary, National Advisory Committee on AIDS, Department of Health, Valletta (Rapporteur)

POLAND

Professor Lech Zdunkiewicz
Head, Department of Hygiene Education, National Institute of Hygiene, Warsaw

Mr Jerzy Wysocki
Director, Department of Economics, Ministry of Health and Social Welfare, Warsaw

PORTUGAL

Mr Joao Santos Lucas
Escolla Nacional de Saude Publica, Lisbon

Ms Maria Luiza Sequeira
Departamento de Estudos e Planeamento da Saude, Lisbon

ROMANIA

Dr Roxana Apetrei
Secretary, AIDS Commission, Ministry of Health, Bucharest

Dr Constantin Ciufecu
Deputy Director, Cantacuzino Institute, Bucharest

TURKEY

Mr Mehmet Biliker
Deputy Director General of Primary Health Care in charge of AIDS programme, Sihhye, Ankara

Dr Nevzat Sahan
Director General of Primary Health Care, Sihhye, Ankara

YUGOSLAVIA

Dr Dunja Kosmac
Director, Institute of Public Health and Social Welfare, Ljubljana

Dr Katarina Bukumirovic
Coordinator, Department of Epidemiology, Institute of Public Health, Belgrade

OBSERVERS

Dr Vera Adler
Head, Public Health Services, Ministry of Health, Jerusalem, Israel

Dr Shula Bar Shani
Director, National Blood Bank, Tel Hashomer

Dr Don Berns
Director, Research Authority, Ministry of Health, Jerusalem, Israel

Ms Paula Edelstein
Deputy Director, Department of Health Education, Ministry of Health, Jerusalem, Israel

Ms Pnina Herzog
Director, Department of International Relations, Ministry of Health, Jerusalem, Israel

Dr Varda Soskolni
School of Public Health, Hadassah Hebrew University, Hadassah Ein Karen, Israel

Dr Ami Vansover
Director, Virology Laboratory, Ministry of Health, Tel Hashome, Israel

Dr Nurity Vardinon
Head, Immunology Laboratory, Ichilov Medical Center, Tel Aviv, Israel

TEMPORARY ADVISERS

Dr Don Clarke
65 Grange Road, Blunham, Bedfordshire MK443 NS, United Kingdom

Professor Zeev Handzel
Head, Clinical Immunology Unit, Kaplan Hospital, Rehovot, Israel

Dr Israel Katz
Director, Centre for Social Policy Studies, Jerusalem, Israel

Mr Owen Metcalfe
Health Promotion, Dublin, Ireland

Professor A. Morag
Chairman, Interministerial Committee on AIDS Information & Education, Head, Department of Clinical Virology, Hadassah Hebrew University Medical School, Jerusalem, Israel (Chairman)

Dr Amiram Oleinik
Director, Department of Health Education, Kupat Holim Head Office, Tel Aviv, Israel

Ms Viveca Urwitz
Landstinget Förebygger AIDS, Stockholm läns landsting, Stockholm, Sweden

Mr Trefor Williams
Director, Department of Education, Health Education Unit, University of Southampton, United Kingdom

Mr Dan Yakir
Staff Attorney, Tel Aviv Chapter, Israeli Association for Civil Rights, Tel Aviv, Israel

WHO REGIONAL OFFICE FOR EUROPE

Ms Phyllis Dahl
Secretary, Global Programme on AIDS

Dr A.M. George
Acting Coordinator, Global Programme on AIDS

Mr Henning Mikkelsen
Short-term Professional, Global Programme on AIDS

Mr Steven Wayling
Short-term Professional, Global Programme on AIDS (Co-rapporteur)