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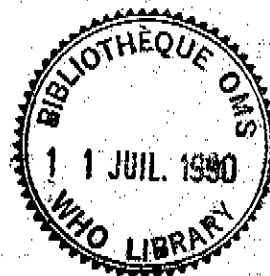


REGIONAL PROGRAMME ON AIDS

EUROPEAN NATIONAL AIDS PROGRAMME SUPPORT INITIATIVE FOR SELECTED LOW PREVALENCE COUNTRIES

Report on a WHO meeting

Copenhagen
27 February - 1 March 1990



1990

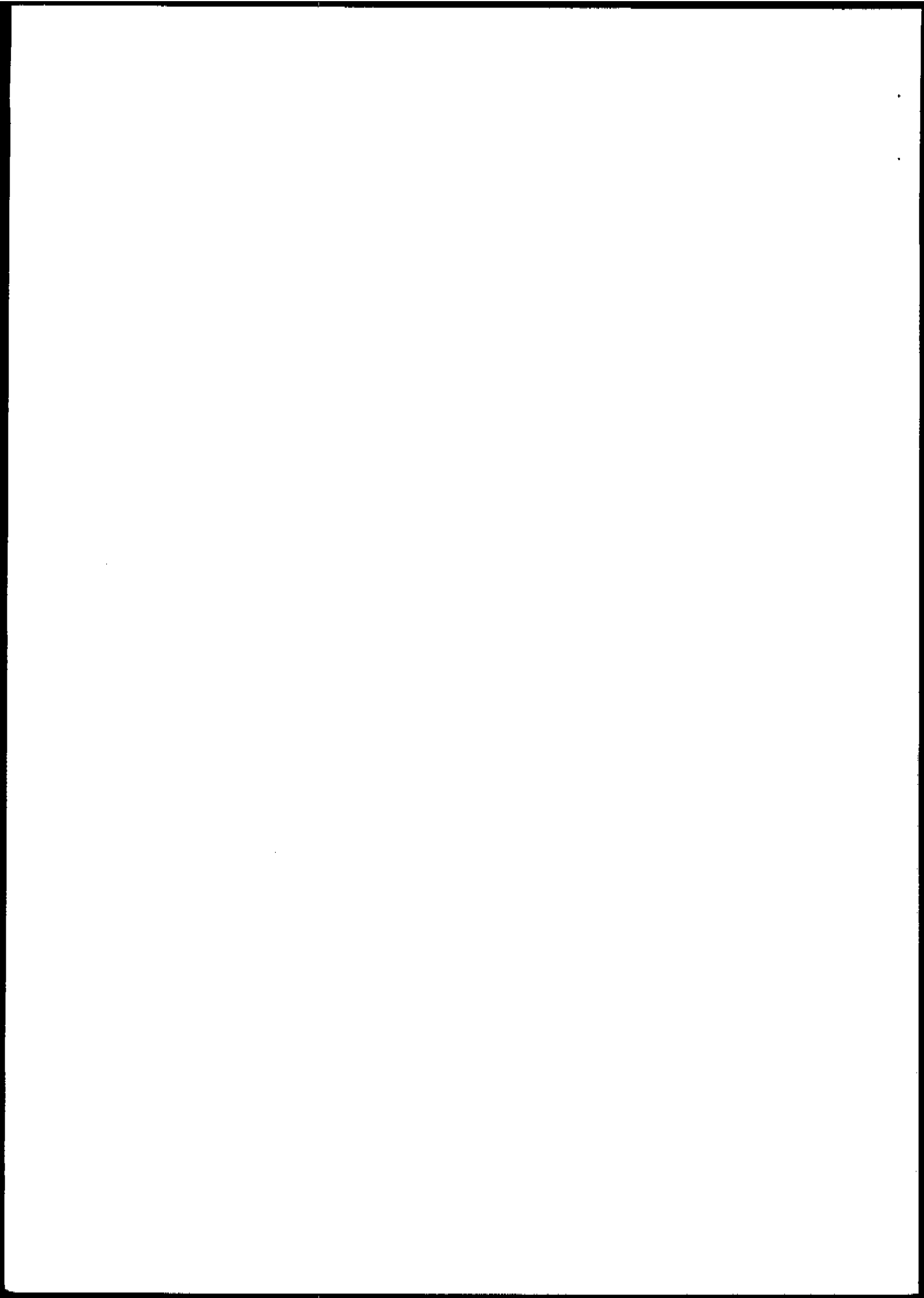
EUR/HFA target 4

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1. Introduction

The first meeting on AIDS prevention and control strategies in low HIV-endemic countries took place in Balatonszemes, Hungary, 30 October - 2 November 1989. This meeting was attended by representatives of 11 Member States (mostly from the eastern part of Europe) and appropriate recommendations to limit the spread of HIV infection were made. Now when the borders between eastern and western European countries have become more open, the problem of spread of HIV infection might become far more serious and special attention should be paid to this threat. Furthermore, a new alarming situation arose: in Romania due to the administration of contaminated blood not screened for HIV and the use of unsterilized medical equipment more than 500 children became infected, 135 of them already developed AIDS and 127 died. After the ELISTA outbreak (USSR) this is the second country in the European Region where an outbreak of HIV infection occurred in childrens' hospitals.

Taking into account the changed situation, a special meeting on European AIDS National Programme Support Initiative for Selected Low Prevalence Countries was held, in Copenhagen, from 27 February to 1 March 1990. Representatives of eight contiguous European countries: Bulgaria, Czechoslovakia, the German Democratic Republic, Hungary, Poland, Romania, USSR and Yugoslavia; observers from the Council of Europe, the World Bank; temporary advisers and WHO staff from the global and regional programmes on AIDS attended the meeting. The list of participants is attached as Annex 3.

Dr J.E. Asvall, Regional Director, opened the meeting and outlined the scope and purpose.

The objectives of the meeting were:

- * to discuss the assistance required in these Member States,
- * to formulate a plan of action following an in-depth consideration of the following for each country represented:
 1. review of the HIV/AIDS epidemiology;
 2. action to prevent sexual transmission;
 3. prevention of transmission through blood;
 4. prevention of perinatal transmission;
 5. prevention of transmission through the use of medical equipment;
 6. availability and effectiveness of counselling services;
 7. organization of health promotion activities;
 8. identification of areas in which WHO's help would be most valuable.

In a global overview, Dr Tarantola analyzed the current stage and trends of HIV/AIDS epidemiology, the new knowledge gained to better understand the disease and identified possible weaknesses in national AIDS prevention programmes.

Dr George submitted an overview on the epidemiological situation in the European Region with special regard to Eastern European countries, intercountry activities and National Programme Support planned for 1990 and thereafter. The overview was supplemented by Dr Gromyko's analysis of nosocomial HIV outbreaks which have occurred in Romania and the USSR, and Dr Branckaert's report on the role of health promotion in the framework of the European AIDS prevention programme. The following training courses and workshops of special interest to Eastern Europe organized by the Regional Office were announced:

March 1990: Training Workshop on AIDS/HIV Counselling, Balatonöszöd, Hungary.

March 1990: AIDS Prevention and Control in Countries with Limited Resources, Jerusalem, Israel.

April 1990: Education, Public Information and Health Promotion. Dresden, DDR.

May 1990: Expert Workshop and Peer Counselling for AIDS Education for Young People. Warsaw, Poland.

June 1990: Teachers' Symposium on AIDS Education in Schools. Southampton, United Kingdom.

November 1990: International Training Course on Clinical Management on AIDS and HIV Infection for Senior Medical Officers.

Detailed country reports referring to the eight key points identified in the scope and purpose followed. Tables summarizing epidemiological surveillance are presented in Annex 1.

Eight working groups (participants are listed in Annex 2), discussed:

1. Formulation of a national plan, monitoring and evaluation.
2. Information, education and communication/media.
3. Intravenous drug users.
4. Homosexuality.

5. Blood transfusion.
6. Prostitution and control of sexually transmitted diseases.
7. Nosocomial transmission.
8. Counselling and care.

Based on discussions in the working groups, participants agreed on the following summary statement and action plan.

2. Summary statement and subregional action plan

2.1 National planning and policy development

2.1.1 National AIDS committees

All represented countries have a national AIDS committees (NAC). It was recognized that the problem of preventing and controlling AIDS is not simply a medical one and that committees and programmes require broad representation and linkages. Examples of important other sectors to be included on NACs are, for instance, ministries of education, justice, finance, foreign affairs; representatives of the media, organizations and institutions involved in health education; Non-governmental Organizations (NGOs) and national AIDS service organizations (ASOs). In addition, other interested groups which can make a contribution should be welcomed, at least in advisory or ad hoc capacities

In this subregion NGOs and ASOs are recent developments. However, given their positive role in other regions, the promotion and facilitation of work with these groups is thought to be especially important for effectively working with all groups and sectors that require information and services.

The exact role of NACs, primarily advisory versus primarily managerial, depends on the needs and existing structures within individual countries and, therefore, may vary and change over time.

2.1.2 Programme development

The participants agreed that programme development would be facilitated through a series of activities in cooperation with WHO. Building on the existing national programmes, the start of this initiative is a country visit by a WHO team. However, prior to the arrival of the WHO team, Member States should prepare a situation analysis and needs assessment so that the visit can be as efficient and effective as possible. Following the visit by WHO staff and discussion on the country assessment, a short-term programme can be developed to meet immediate needs. This series of activities is the first step of developing a medium-term plan for the next three to five years. One result of these first country visits will be an assessment of the overall needs as part of a comprehensive plan for the region.

Countries are encouraged to perform comprehensive situation assessments that better define the magnitude of their risk populations, their distribution, and some qualitative aspects of their risk behaviours and characteristics. For example, estimates could be made as to the number of injecting drug-users, their geographic distribution, habits and the best ways to access them so as to provide needed service and information. Similar types of assessments may also include those for homosexual men and prostitutes which will be useful for estimating, for instance, condom requirements or educational material needs. These assessments can be initiated immediately followed by specific technical assistance from WHO as required.

2.2 Recommendations by strategy area

2.2.1 Information, education and communication/media

Although AIDS related information appears to be adequate and abundant in quantitative terms, it lacks in terms of quality or target orientation. Not surprisingly, the problem of information in relation to AIDS is quite different from one country to another. This applies to the need for education/information, as well as to the identification of risk and/or target groups. According to places and situations, it can be due to cultural or social determinants.

Furthermore, social rejection of people with AIDS or of people infected with HIV appears to be a major problem. And it was agreed that this could probably be alleviated only through general information and/or education of the public at large, notwithstanding specific actions to be taken towards risk behaviour groups.

Given the above, a consensus was reached as to the following.

1. The need of immediate action directed towards those responsible for education, clinical care and information, for instance, teachers, health professionals and media persons. There is a need for specific and intensive training. This education and background information would enhance and promote their awareness and/or their willingness to better meet their responsibilities. As a significant example, one can mention the fact that in one Member State, school teachers still consider that the sexual education programme should be dealt with by pupils as "homework".
2. The need to develop media and communication tools that respond adequately to the specific needs of target groups. This applies most acutely to youngsters and people with lower education who appear to be the least accessible to conventional written or audio-visual media, and for whom a special effort should be made. This might include comics and tailor-made video-clips to be broadcasted in discotheques.
3. The need to develop national policies with regard to clinical care, and to promote home care as opposed to hospital care for patients who are HIV infected. This, it was emphasized, can be achieved only with public support. In turn, requiring that social rejection is no longer a problem.

4. The importance of developing a better understanding between health professionals and the media. In this perspective, the media specializing in health information could be encouraged to promote contacts with the health profession.
5. Training is also important. Physicians and public health officers should be trained in communication, and journalists made more aware of health information. It is suggested to organize continuous education seminars to promote East/West exchanges and enable journalists to be trained in new media techniques concerning health.
6. Health professionals need more exposure and access to information and ongoing education. This could be achieved most easily by an increased circulation of Western European health publications.
7. In addition to initiating and improving programmes for specific groups as mentioned, attention should also be given to initiating programmes for schools, the workplace, and others.

2.2.2 Intravenous drug users

Drug abuse, including self-injecting drug use, will increase. Since the incubation is lengthy, active surveillance and sensitive mechanisms will be needed. Transmission occurs not only by needle sharing but also through sexual transmission. Therefore, attention must be given to both prevention and control programmes.

1. AIDS education and substance abuse education is an important strategy to prevent future problems and deserves detailed examination.
2. Where information, counselling and treatment services for drug abusers exist, they must be informed about AIDS prevention. If no services are available, they should be started.
3. There is a need for training in education, counselling and clinical medicine in the AIDS and drug field. This implies the need for local language versions of training materials, and for the availability of audiovisual material.
4. Experts in the drug field should be part of National Programme Support teams during country visits.
5. There is a need to have expert meetings where national experts from this region can discuss experiences and initiate joint programmes.

6. Projects in risk reduction, for example the availability of clean needles and/or bleach, must be considered important steps in reducing the spread of AIDS.
7. Health professionals should be informed, educated and trained in the management and care of drug users.
8. WHO guidelines were considered of great use and their translation into the regional languages was seen as extremely useful.
9. It was seen as important that countries with similar problems were given the opportunity to join efforts and collaborate in the preventive and curative aspects of substance abuse programmes.
10. Topics seen as requiring further attention are counselling, testing and antidiscrimination measures.

2.2.3 Homosexuality

Participants are aware of the magnitude of the risk of HIV transmission associated with homosexual and bisexual behaviour and its relationship to the AIDS epidemic. There was agreement that infection control amongst homosexual and bisexual men is possible and will be effective if they are well motivated and the programmes well organized.

The following recommendations were agreed upon.

1. Gay men should be encouraged to form groups and organizations so that they can be organized to play a preventive role in the HIV/AIDS epidemic. It was recognized that in Western countries they had already played a major role in preventing the further spread of infection.
2. Gay organizations should be supported and not discriminated against.
3. AIDS service organizations and non-governmental organizations working in the field of homosexuality should be encouraged.
4. Information is needed about men who have sex with other men so that effective targeted educational programmes can be provided.
5. More epidemiological data is required with regard to the influence of homosexual behaviour on HIV infection and its spread.
6. It was accepted that in some countries progress will necessarily be slow and will involve educating the general population.
7. Perhaps one way forward is to have a general educational programme promoting the concept of "safer sex" rather than one programme just aimed at homosexual/bisexual men.
8. In some areas homosexuality is still an illegal act. Colleagues working in the field of AIDS prevention are urged to adopt more liberal attitudes.

2.2.4 Sexually transmitted diseases

Participants recognized that one of the major routes of HIV transmission is sexual and that prevention of sexual transmission of HIV is a high priority. There was a consensus that control of sexually transmitted diseases was important because many sexually transmitted diseases have been implicated as risk factors which increase both heterosexual and homosexual transmission of HIV.

The status of STD control programmes varies considerably. Many countries have strong STD control programmes with well trained dermato-venereologists who are actively involved in or responsible for programmes. These include medical care, laboratory and public health services. Other countries have less developed STD services.

STD services identify individuals who persist in high risk sexual behaviour and therefore could be encouraged to increase health promotion for primary prevention of HIV in such individuals. Finally STD services are important for sentinel surveillance for HIV infection and for surveillance for STDs as an indicator for assessment of the effectiveness of AIDS prevention programmes. The following was recommended.

1. The global importance of STD, including complications particularly in women and new borns as well as the emergence of the HIV pandemic, determine the development and strengthening of STD control programmes in all countries and at all levels. There is a need to expand STD control programmes to include not only gonorrhoea and syphilis but also other STDs such as chlamydia which has been implicated as a potential risk factor for transmission of HIV.
2. Countries should consider how STD and AIDS control programmes can best be coordinated to address policy, programme and research issues in control of AIDS and other STDs. Countries should assess current STD services, identify the most urgent needs for programme enhancement for improved control of HIV infection, and include these services as a high priority in the AIDS control programmes. STD expertise should be included in teams involved in preparation of the medium-term plans.
3. As modes of transmission are similar, some of the primary prevention of either STD or sexual transmission of HIV will help to reduce transmission of the other. STD services should provide behavioural interventions including condom promotion to help reduce both STD and sexual transmission of HIV.
4. AIDS and STD control programmes should work with educators to develop and evaluate education for school children on STD and AIDS. Such education should be provided in the context of general health, sexual and ethics education.
5. Training and training materials concerning laboratory and clinical services for STD control are badly needed in many countries and should be provided and preferably translated into local languages.

2.2.5 Prostitution

The status of prostitutes varies considerably. In some areas prostitution is legal and extensive clinical services are provided; in others prostitution is illegal and prostitutes do not have reasonable access to STD services or other health services. The following recommendations were put forward.

1. It is essential to engage as rapidly and forcefully as possible in efforts that reduce HIV infection of prostitutes, clients of prostitutes and other partners of prostitutes. Interventions aimed at changing HIV-related risk taking practices associated with prostitution must be urgently promoted among all prostitutes and their clients. Such interventions should be designed in consultation with prostitutes and should be cost effective and not impeded by legal structures.
2. Governments should be encouraged to acknowledge the presence of prostitution in their countries and the urgency of developing sustainable interventions to decrease health risks to prostitutes and clients including the risk of HIV infection.
3. Voluntary based projects to provide literacy education and technical skills as well as job development and placement assistance to HIV-infected prostitutes should be encouraged in national AIDS prevention and control programmes. Similar projects should also be encouraged for non-infected prostitutes who want to leave the sex industry.

2.2.6 Foreign Nationals

A key area of national and international importance was identified as the testing of foreigners and returning nationals. There is some variability in the approach to this among countries represented but compulsory testing according to certain criteria is common. One approach is the testing of foreign students according to bilateral agreement with the originating country which requires a health certificate including the screening of students for other medical conditions. The rationale for this policy is to identify conditions which may impair the students' ability to complete the education and thereby negate the investment in training.

Aside from the issue of screening students for suitability for long-term training, the broader question of the effectiveness of screening other foreigners or returning nationals was thought to be an issue that governments should review. Indeed, it was noted that in some countries this policy has been discontinued. It was agreed that a review of these policies is a positive step and should consider the following points.

1. The special epidemiological situation of the country which is changing and may now be less dependent on this strategy.
2. The perceived effectiveness of such policies and practices.
3. The possible negative effects on health education programmes where the public may be led to believe that screening of foreigners controls the problem.

In all circumstances, it was agreed that any testing should be done with complete respect for the protection of human rights with safeguards for confidentiality with both pre- and post-test counselling.

2.2.7 Prevention of nosocomial infection

Nosocomial HIV infection, defined as infection occurring in a health care setting, is present in this region as in other regions. Two documented outbreaks, one in Romania and the other in the USSR, have clearly shown the devastating results.

The epidemiology of nosocomial HIV infection does not differ from other blood borne nosocomial infection, for example, Hepatitis B. The source is infected blood. Needles and syringes are not the only vehicle for nosocomial infection - surgical equipment, other skin piercing equipment or supplies are also important.

To prevent nosocomial HIV infection the following recommendations are put forward.

1. Countries should not assume that they are immune from the possibility of transmission of HIV through nosocomial infection.
2. Nosocomial transmission control should be a priority for prevention and control of AIDS programmes.
3. WHO guidelines and materials on sterilization and nursing management of AIDS patients should be adapted, translated or incorporated into existing guidelines at national level and used in training of health personnel.
4. Countries should review the efficacy and efficiency for both disposable needles and syringes used once and destroyed and non-disposable, sterilizable equipment that can also be used safely if properly sterilized always mindful of the best means of preventing nosocomial transmission.
5. Health staff must be encouraged to safely use the available equipment and be well supervised to assure universal sterilization procedures.
6. Fear of nosocomial spread should not result in discrimination against patients suspected of infection or proven HIV seropositive, as a means of preventing nosocomial transmission; persons with suspected or confirmed HIV infection must be appropriately treated and equipment used in treating them thoroughly sterilized.
7. Patients with AIDS or HIV infection can be treated in hospital along with non-HIV infected persons. If, however, there is bleeding, special precautions will need to be introduced to protect other patients and health care staff.

2.2.8 Prevention of HIV transmission by blood and blood products

Organization of blood transfusion services are similar within countries in the area. Specifically, these services are managed by the state and centrally organized with differences reflecting the individual character and legislation of each country.

Recent events in Romania have raised concern about the efficacy of some practices and raised questions on the safe use of plasma and other blood products. In this context, technical support from WHO was seen as a priority area.

The following recommendations were proposed.

1. Increased emphasis should be placed on recruiting blood donors from the general population and introducing urgent measures to facilitate self-exclusion of members of risk behaviour groups.
2. Individuals responsible for the administration of blood donation centres should be adequately trained in the elements of motivating the population to donate blood and in the proper handling of donors found to be HIV positive.
3. An intensive effort must be made to ensure that blood collection procedures and the manufacture of blood products conform to internationally accepted practices and standards.
4. Resources should be made available to allow safe preparation of the required quantities of blood components and existing policies for the availability and production of plasma products should be reviewed.
5. Resources must be made available for HIV screening of all blood donations. This includes resources for testing materials and technical training for their use.
6. Training for clinicians in the appropriate use of blood and blood products is a positive measure which would reduce the exposure of patients to the potential risks of transfusion related diseases.
7. National policies should be established to import and use only blood products that are manufactured to standards set by WHO.
8. A quick assessment of the blood transfusion questionnaire should highlight areas requiring urgent attention by Member States and support from WHO.

2.2.9 Counselling and care

It was recognized that counselling and comprehensive care services in relation to HIV must be an integral and essential component of AIDS prevention and control programmes. This is because HIV presents a series of problems which are unique. These include:

1. the infectious nature of the virus;
2. its modes of transmission;
3. the long incubation period; and
4. the variations in the progression of the disease.

It is essential that counselling and care are available as needed to those at risk of infection, those fearful of infection, those knowing they are infected, those with disease presentation, with illness; and finally at the terminal stage of AIDS. However, the priority areas for counselling should initially be concentrated on those with HIV infection, but who are asymptomatic, with the aim of slowing the spread of infection. Counselling for this group would assist them to change their behaviour to avoid further spread of the infection.

1. The immediate priority should be given to counselling of seropositive individuals identified in any testing programme. Appropriate pre- and post-test counselling should also be provided in conjunction with voluntary testing and counselling of high-risk seronegative individuals should be given high priority to promote risk reduction.
2. Constraints on counselling and care currently include lack of trained counsellors, reticence of health care providers to give care to persons with HIV infection because of a perceived stigma of AIDS, lack of participation of voluntary organizations in the effort, slow response of the social network to the changing psychosocial needs of risk behaviour groups, recognition by persons in need of counselling that existing services for counselling and care are unattractive and inaccessible, and fear of breach of confidentiality and of prejudicial repercussions.
3. Services for counselling and care should be integrated into and built upon existing related health care services.
4. A multidisciplinary and interdepartmental approach is needed for development and provision of counselling and care. There is a need initially to train and depend upon the existing health care providers for counselling and health promotion.
5. Therefore training workshops and materials to develop counselling skills are needed for persons providing health care to persons with HIV infection. In addition innovative training programmes should also provide counselling skills to individuals who have not necessarily been trained in the health care field particularly to young counsellors who may be peers or those in risk-behaviour groups.

6. In the area of medical care there is a need for:
 - more attractive and accessible services;
 - improvement of medical supplies including essential diagnostic tests, equipment and therapeutic agents;
 - education of health care staff that includes strategies for a multidisciplinary approach to the management of HIV infection; and
 - attention to the entire continuum of care including out-of-hospital care and home care, recognizing that a major constraint in developing home care is the overcrowded living conditions in many cities.

7. Regarding the reluctance of some health care providers to take care of patients with HIV infection there is a need for
 - education on the actual risks of the infection if exposed and on methods for reduction of risk of occupational exposure,
 - provision of needed supplies for risk reduction such as latex gloves, sterilization of equipment and disposal of supplies, and
 - inclusion of procedures for managing HIV exposed health care workers as a part of an occupational health care system for health care workers.

2.3 Monitoring and evaluation

Participants agreed that there is substantial benefit in monitoring prevention and control programmes. As a starting point, specific programme indicators should be included in initial prevention and control plans. Indicators would include process indicators whereby programme progress is monitored and outcome indicators which can evaluate the outcome of activities and assess their effectiveness and impact.

It is recognized that WHO is developing a list of indicators and methods which will be shared with Eastern European Member States. This will facilitate cross-national comparisons as well as providing important feedback to improve the programmes themselves.

3. Summary

Countries involved find themselves in a situation where the incidence of HIV infection is increasing and when they are not as well prepared as perhaps needed at a time when major political and social changes are occurring. There appears to be a large deficit in the amount of technical capabilities and material needs, and it is the nature of this action plan that the participants resolve to work together as a group of countries within a region, part of the international effort to share information and resources in mobilizing and improving efforts. It is recognized that the political and social changes present new opportunities for transmission as well as new opportunities for prevention.

3.1

COOPERATION WITH WHO

* Country visits

- Assistance in planning and development
- Assistance with programme review and evaluation
- Assistance with resource mobilization

* Exchange of scientific and operational information

- Materials and training in health education and techniques
- Special training for members of the popular media
- Focus on training of non-medical disciplines
- Specialized workshops for target groups of professionals

* Designation of Eastern European collaborating centres for the prevention and control of AIDS

- Epidemiology
- Intravenous drug users (IVDU)
- Information and education
- Evaluation

4. Closure of meeting

The summary report and final regional report in the form of an action plan were presented to the participants by the Rapporteur. With only minor changes, they were unanimously endorsed. The report and action plan was seen to accurately represent the past days discussion, describe the current status of national AIDS programming and the necessary future direction.

Dr Asvall closed the meeting and commended the participants for their willingness to discuss often sensitive issues feeling this to be a strong step forward. He noted the interest in monitoring and evaluation of national programmes described in the report and stated that while crucial to AIDS policy, this is also a fundamental objective of the regional HFA strategy.

The meeting was adjourned by the vice-chairman Professor Magdzik.

Annex 1

Table 1

Reported AIDS cases and deaths/
AIDS cases by transmission group
27 February 1990

<u>Cases by transmission group (excluding international visitors and travellers)</u>									
	Cases	Deaths	Homo-/ bisex.	IVDU	Hetero- sex.	Haemoph.	Transf.	Nosoc.	Unknown
BUL	7	3							
CZE	20 ¹	9	17	-	-	1	-	-	-
DDR	19 ²	9	14	-	-	2	-	-	1
HUN	32 ³	21	23	-	1	-	3	-	1
POL	32 ⁴	18	21	5	2	-	-	-	-
ROM	156	132	1	-	15	1	47	84	8
USSR	28	19							
YUG	109	63	28	40	12	20	2	-	7

¹including 2 foreigners
²including 2 foreigners
³including 3 foreigners
⁴only 28 cases distributed by transmission group
blank spaces indicate: data not presented

Data were presented by the participants of the meeting.

Table 2

Reported HIV Infections (excluding AIDS)/
 HIV Infections by Transmission Group
 27 February 1990

HIV Infections by transmission group (excluding international visitors and travellers)							
HIV infections	Homosexual	IVDU	Heterosexual	Haemoph.	Transf.	Nosoc.	Unknown
	bisex.		sex.				
BUL	4	-	67	11	1	-	1
CZE	50	-	4	15	12	-	6
DDR	69	-	13	5	-	-	1
HUN	123	-	10	28	6	-	2
POL	75	521	94	16	7	-	59
ROM	496						
USSR	4295,6	2	102	-	-	-	17
YUG	1690	1200					

1 including 84 foreigners

2 including 53 foreigners

3 including 194 foreigners

4 including 33 foreigners

5 not including 503 foreigners

6 306 seropositives identified through epidemiological investigation. Transmission groups not presented

blank spaces indicate: data not presented

Data were presented by the participants of the meeting.

Table 3

AIDS and HIV infections in Romania
27 February 1990

	0 - < 13 years	>13 years	Total
AIDS	135 ¹	27	156
ARC	182 ²	23	205
HIV infections (other)	229 ³	60	289
Total	546 ⁴	104	650
Deaths	121	11	132

¹including 132 cases in children < 3 years

²including 180 cases in children < 3 years

³including 227 cases in children < 3 years

⁴including 539 cases in children < 3 years

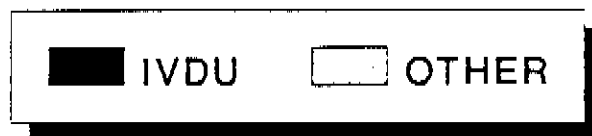
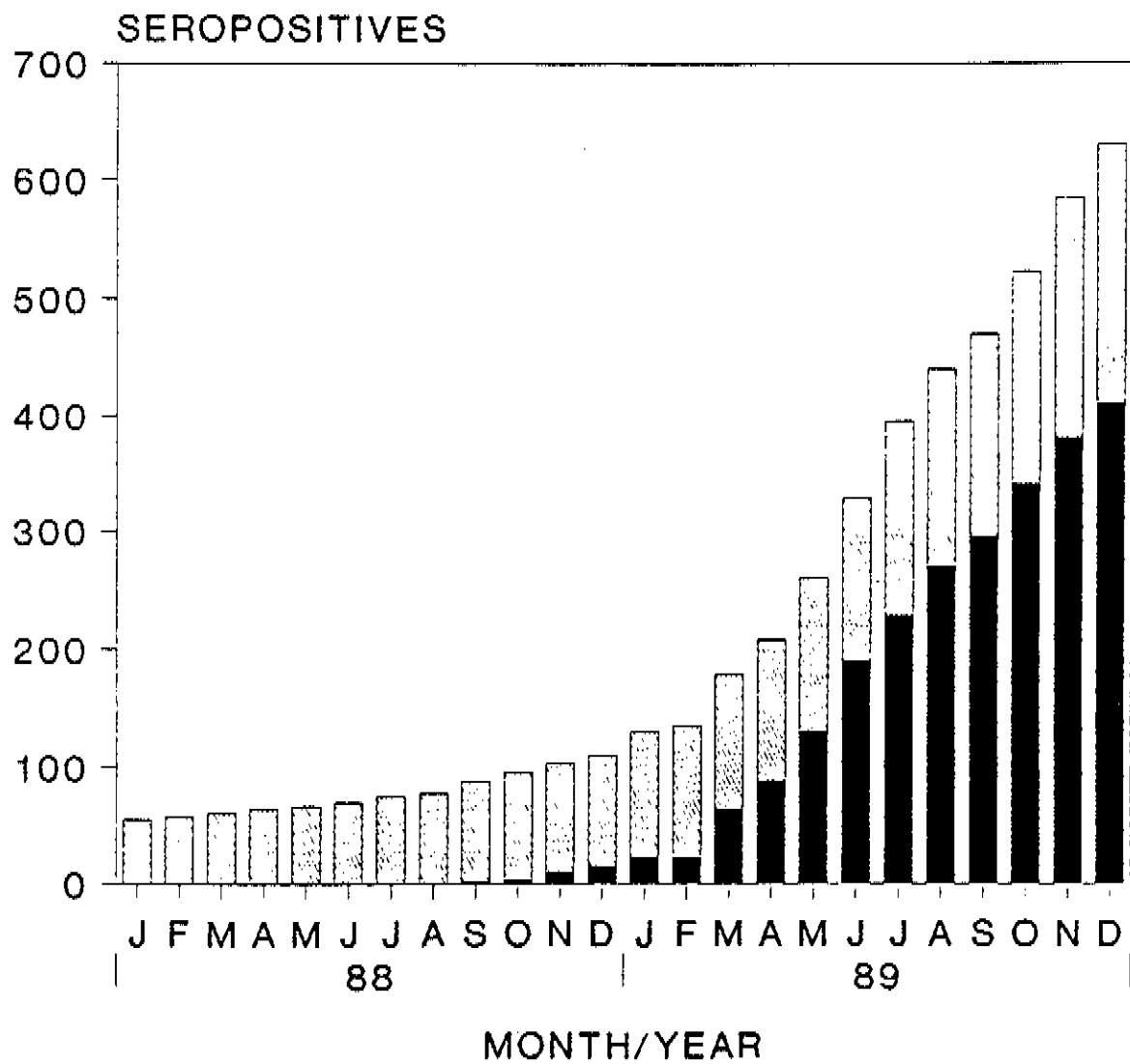
Data were presented by the participants of the meeting.

Table 4

AIDS and other HIV infections
by transmission group and age
in Romania
27 February 1990

Children and adults > 13 years of age		
Haemophiliacs	10	9.6%
Homo-/bisexuals	5	4.8%
Heterosexuals	73	70.2%
Unknown	16	15.4%
Total	104	100.0%
Children < 13 years of age		
Mother-to-child	11	2.0%
Transfusion	189	34.6%
Nosocomial	342	62.6%
Unknown	4	0.8%
Total	546	100.0%

FIGURE
CUMULATIVE HIV SEROPOSITIVES
POLAND, JAN/88 TO DEC/89



SOURCE: MEMBER STATE

Table 5

Comparison of AIDS and HIV infections
in the Federal Republic of Germany and
the German Democratic Republic
31 January 1990

	<u>HIV-positive persons</u>			<u>AIDS</u>		
	Reported (cum.)	Estimated	Rate per million (estimated)	Reported (cum.)	Rate per million	Death
DDR	88 (nationals)	400	25	17	1.0	8
DEU		50.000 - 100.000	800 1.600	4.443	72.7	1.910

Data were presented by the participants of the meeting.

Table 6

Comparison of HIV prevalence data in
the Federal Republic of Germany
and the German Democratic Republic
31 December 1989

	IV-drug-abusers		Male homosexuals	
	Seroprevalence (according to investigations)	Estimated positive-rate of the total population	Seroprevalence (according to investigations)	Estimated positive-rate of the total population
DDR	-	-	1.75%	0.15%
DEU*	20%	11-38%	10-30%	7-11%

*Data were presented by the participants of the meeting.

Annex 2List of working groupsWorking Group 1: Formulation of a national plan, monitoring and evaluationMembers

Professor T. Tzonevski	BUL
Dr I. Masar	CZE
Professor S. Dittman	DDR
Ms K. Fedinecz	HUN
Dr B. Illes	HUN
Professor W. Magdzik	POL
Dr N. Beldescu	ROM
Dr A.J. Kondrusev	SSR
Dr V. Kosmac	YUG
Dr M. E-Ming Young	WB

Chairman: Professor S. Dittmann

Moderator: Dr G. Slutkin

Rapporteur: Mr S. Wayling

Working Group 2: Information, education and communication/mediaMembers

Dr S. Popova	BUL
Dr G. Walter	CZE
Dr G. Kulcsar	HUN
Professor R.J. Juszczky	POL
Dr M. Zamfirescu	ROM
Mr N.V. Gogol	SSR
Professor I. Vodopija	YUG
Mrs V. B. Massarelli	CE

Chairwoman: Dr S. Popova

Moderators: Dr D. Clarke
Dr P. Kliment

Rapporteur: Mr M. Gombeaud

Working Group 3: Intravenous drug users

Members

Professor R. Argirova	BUL
Dr V. Schwanzer	CZE
Dr A. Vass	HUN
Dr C. Sikorska-Godwod	POL
Professor F. Caruntu	ROM
Dr V.A. Polesskyi	SSR
Professor V. Suvakovic	YUG

Chairman: Dr C. Sikorska-Godwod

Moderators: Dr J. Branckaerts
Mr C. Goos

Rapporteur: Professor V. Suvakovic

Working Group 4: Homosexuality

Members

Professor J. Sejda	CZE
Dr W. Kiehl	DDR
Dr E. Czeizel	HUN
Dr Z. Dajek	POL
Dr A. Calomfirescu	ROM
Dr V.G. Fedenev	SSR

Chairman: Dr W. Kiehl

Moderators: Dr A.M. George
Mr T. Snee

Rapporteur: Dr Z. Dajek

Working Group 5: Prostitution/STD control

Members

Professor J. Sejda	CZE
Dr W. Kiehl	DDR
Dr E. Czeizel	HUN
Dr Z. Dajek	POL
Dr A. Calomfirescu	ROM
Dr V.G. Fedenev	SSR

Chairman: Dr Z. Dajek

Moderator: Dr K. Holmes

Rapporteur: Dr V.G. Fedenev

Working Group 6: Nosocomial transmissionMembers

Professor R. Argirova	BUL
Dr V. Schwanzer	CZE
Dr A. Vass	HUN
Dr C. Sikorska-Godwod	POL
Professor F. Caruntu	ROM
Dr V.A. Polesskyi	SSR
Professor V. Suvakovic	YUG

Chairman: Dr A. Vass

Moderators: Dr A. Gromyko
Dr D. Heymann

Rapporteur: Dr D. Heymann

Working Group 7: Blood transfusionMembers

Professor T. Tzonevski	BUL
Dr I. Masar	CZE
Professor S. Dittman	DDR
Ms K. Fedinecz	HUN
Dr B. Illes	HUN
Professor W. Magdzik	POL
Dr N. Beldescu	ROM
Dr A.J. Kondrusev	SSR
Dr V. Kosmac	YUG
Dr M. E-Ming Young	WB
Mrs V. B. Massarelli	CE

Chairman: Dr I. Masar

Moderators: Dr G. Gabra

Rapporteur: Ms K. Fedinecz

Working Group 8: Counselling and care

Members

Dr S. Popova	BUL
Dr G. Walter	CZE
Dr G. Kulcsar	HUN
Professor R.J. Juszczky	POL
Dr M. Zamfirescu	ROM
Mr N.V. Gogol	SSR
Professor I. Vodopija	YUG

Chairman: Professor I. Vodopija

Moderators: Mr L. Curran
Ms L. Shore Paludan

Rapporteur: Professor R.J. Juszczky

Annex 3LIST OF PARTICIPANTS

BULGARIA

Professor Radka Argirova, Bulgarian Medical Central Laboratory on AIDS, Sofia

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

Professor Tentcho Tzonevski, Director, Department of Health Prophylactics, Ministry of Public Health and Social Care, Sofia

CZECHOSLOVAKIA

Dr I. Masar, Director of Public Health Services, Ministry of Health and Social Affairs of the Slovak Socialist Republic, Bratislava (Chairman)

Dr V. Schwanzer, Chief, Department of Virology, Institute of Preventive Medicine, Bratislava

Professor J. Sejda, Chief, Department of Epidemiology, Postgraduate Medical Institute, Prague

Dr G. Walter, Chief, Section for Epidemiology, Ministry of Health and Social Affairs, of the Czech Socialist Republic, Prague

GERMAN DEMOCRATIC REPUBLIC

Professor S. Dittmann, Director, Central Institute for Hygiene, Microbiology and Epidemiology, Berlin (Rapporteur)

Dr W. Kiehl, Central Institute for Hygiene, Microbiology and Epidemiology, Berlin

HUNGARY

Dr Endre Czeizel, Physician-in-Chief, National Institute of Hygiene, c/o Ministry of Social Affairs and Health of the Hungarian Republic, Budapest

Ms Katalin Vittay Fedinecz, Deputy Head, Division for International Relations, Ministry of Social Affairs and Health of the Hungarian Republic, Budapest

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

Dr Gyorgy Kulcsar, Deputy Head, Department of Preventive-Curative Care, 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

POLAND

Dr Z. Dajek, Intitute of Venereology, Medical Academy, Warsaw

Professor R.J. Juszczyk, Medical Academy, Poznan

Professor W. Magdzik, Director, National Institute of Hygiene, Warsaw

Dr Celina Sikorska-Godwod, Institute of Psyciatry and Neurology, Warsaw
(Vice chairwoman)

ROMANIA

Dr Nicolae Beldescu, Director, Preventive Medicine, Ministry of Health of
Romania, Bucharest

Dr Alexandru Calomfirescu, Head, EPI Laboratory, Institute of Hygiene and
Public Health, c/o Ministry of Health of Romania, Bucharest

Professor Florin Caruntu, Head, Clinic of Infectious Diseases "Colentina", c/o
Ministry of Health of Romania, Bucharest

Dr Mihai Zamfirescu, Senior Researcher, Cantacuzino Institute, c/o Ministry of
Health of Romania, Bucharest

UNION OF SOVIET SOCIALIST REPUBLICS

Dr V.G. Fedenev, Chief, External Relations Board, Ministry of Health of the
USSR, Moscow

Mr N.V. Gogol, Consultant, Department of Science of the Editorial Office of
the Newspaper "Pravda", Moscow

Dr A.J. Kondrusev, Deputy Minister of Health of the USSR, Ministry of Health
of the USSR, Moscow

Dr V.A. Polesskyi, Scientific Secretary, All-Union Research Centre of
Preventive Medicine, Moscow

YUGOSLAVIA

Dr V. Kosmac, Director, Institute of Public Health and Social Welfare,
University of Ljubljana, Ljubljana

Professor V. Suvakovic, Institute for Infective and Tropical Diseases, Belgrade

Professor I. Vodopija, Institute of Public Health, Zagreb

OBSERVERS

Mrs Vera Boltho Massarelli, Principal Administrative Officer, Health Division,
Council of Europe, Strasbourg, France

Dr Mary E-Ming Young, Technical Department of the EMENA Region, The World
Bank, Washington, USA

TEMPORARY ADVISERS

Mr Len Curran, H.M. Home Office, Prison Service Headquarters, London,
United Kingdom

Dr Gamel Gabra, Blood Programme Adviser, League of Red Cross and Red Crescent
Societies, Geneva, Switzerland

Mr Tom Snee, Department of Health, London, United Kingdom

WHO REGIONAL OFFICE FOR EUROPE

Dr J.E. Asvall, Regional Director

Dr J. Branckaerts, Acting Health Education Specialist, Regional Programme on
AIDS

Dr Don Clarke, Short-Term Professional, Regional Programme on AIDS

Mr C. Goos, Scientist, Abuse of Psychoactive Drugs

Ms June von Essen, Administrative Assistant, Regional Programme on AIDS

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

Mr M. Gombeaud, Acting Regional Officer, Communication and Promotion

Dr A. Gromyko, Medical Officer, Regional Programme on AIDS (Secretary)

Ms L. Shore Paludan, Short-Term Professional, Regional Programme on AIDS

Dr J. Rochon, Director, Programme Management

Ms Alice Schaumburg, Senior Secretary, Regional Programme on AIDS

Mr S. Wayling, Short-Term Professional, Regional Programme on AIDS
Co-rapporteur

WHO HEADQUARTERS

Dr D. Heymann, Chief, Epidemiological Support and Research Unit

Dr K. Holmes, Epidemiological Support and Research Unit

Dr P. Kliment, Short-Term Consultant, National Programme Support

Dr G. Slutkin, National Programme Support, Global Programme on AIDS

Dr D. Tarantola, Chief, National Programme Support, Global Programme on AIDS