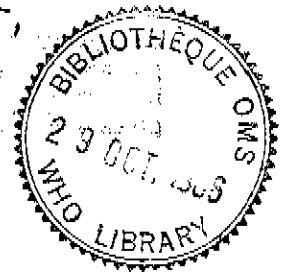


AIDS in Europa



Berichte der Länder von der WHO-Tagung in Graz
vom 7.-9. April 1986

Introduction

The meeting on AIDS in Europe (on AIDS-Containment) was convened by the WHO Regional Office for Europe in collaboration with the Institute of Social Medicine at the University of Graz, and with the financial support of the Austrian Ministry of Health. It was held at Graz from April 7th to 9th 1986, and attended by 49 participants from 24 member states, 11 temporary advisers, 8 WHO HQ and Regional Office staff members, and additionally by 11 observers among them also from Japan and Commission of the European Communities.

The meeting was opened by Dr. E. Leparski, Director, Disease Prevention and Control, on behalf of the Regional Director of the WHO Regional Office for Europe, and Dr. G. Liebeswar for the Austrian Minister of Health.

Professor B. Velimirovic, Director of the Institute of Social Medicine in Graz, was elected chairman, and Dr. L. Aires from the National Institute of Health in Lisbon as vice-chairman. Dr. R.G. Covell acted as rapporteur, and Dr. B. Bytchenko was the secretary of the meeting.

The purpose of the meeting was the rectification of data on AIDS as a newly recognized and

spreading epidemics with unusually high case fatality rates and the means and measures which may and should be used by National Public Health Services for the effective containment of the disease under the present circumstances. It was directly related to EURO and WHO Programme on AIDS containment and in fact will clarify EURO strategy and approaches to effective measures of control.

As until now there is no effective means for prevention and therapy of AIDS patients, the efforts of the public health authorities should be concentrated on the rational and effective systems of epidemiological and serological surveillance, on health education, health legislation, health information and the strengthening of quality control of blood, blood products and other biologicals.

The meeting also had the specific aim to review the social, ethical and legal aspects of AIDS in Europe. Through public health measures, participants shared their experiences on national AIDS programme surveillance and approaches to containment of the disease. The meeting drew conclusions on the EURO AIDS programme and on the national programmes on AIDS containment (see AIFO, copy 9, 1986).

Albania

There were two delegates from Albania, but they asked for dispensation from presenting a report.

Belgium

Prof. Dr. J. Desmyter, Department of Virology and Epidemiology,
Katholieke Universiteit Leuven, Rega Instituut, Leuven

1. An AIDS Commission, attached to the Health Council of the Ministry of Health, is operative since 1983, with several expansions since that time. Until now, its major recommendations have been implemented.

2. Its original attribution has been the registry of AIDS cases, CDC definition. We still advise

against compulsory *notification* through the channel which is official for other notifiable infectious diseases, because this system 1. has led to notorious underreporting: the doctors don't trust that the local 'Inspectors of Hygiene' (administration officials) will be sensitive, reasonable and confidential in the way they handle the cases; 2.

the system does not incite to give the name of the patients to the AIDS Commission, which makes it impossible to check the truth of the cases, and gives yield to duplicate notifications, since patients frequently wander from one hospital to the other.

Instead, we approach about 150 hospital departments where an AIDS diagnosis is most likely to be made, and where all AIDS patients are thought to converge eventually. If there is any doubt from the reporting form, the reporting doctor is contacted by telephone for additional data. Following the decision by the AIDS Commission that this is a true and new case, the data are entered in the computer at the Health Ministry, except for the names of the patient and the doctor which remain under custody of 4 physicians of the AIDS Commission.

A comparison with regular reporting to the Inspectors of Hygiene has shown that direct reporting to the Commission does not miss cases, and that the number of true cases reported to the Commission is 10 times higher than those reported to Hygiene.

Since there is no legal way to make notification to the Commission compulsory, the Commission is against compulsory notification to Hygiene, because of certain non-compliance, and a decrease in the efficiency of reporting.

The Commission follows the prescriptions of the WHO Center in Paris in its 3-monthly reports.

3. Early in 1983, two hospitals in Brussels and one in Antwerp have simultaneously identified AIDS cases in *Central Africans*, residing in or coming to Belgium for treatment of an illness which was then unidentified in Africa. This has resulted in several reports, and to identification of the problem in Africa. The African cases seen in Belgium easily fit in the CDC definition, and any differences with US or other European cases are minor and probably due to different ecologies of the opportunistic infections. Belgian institutions are now heavily involved in AIDS studies in Zaire, Rwanda and Kenya. The number of AIDS patients coming from Central Africa to Belgium for treatment has decreased.

Retrospectively, the first African patient with seropositive stored serum has been treated in Belgium in 1976.

4. Belgium has had, per capita, the *highest number of AIDS diagnoses* in Europe (as reported to and verified by the AIDS Commission); see the enclosed status for 31.12.85. However, it is the only country with a majority of diagnoses in non-residents (74 % in persons who have been in Belgium for less than 5 years). Only 17 % are in residents who are Belgian nationals. If only the latter would be counted, Belgium would be a country with less AIDS cases per capita than any of its neighbours, and there is no indication that the reporting of AIDS cases in Belgium is lower than in neighbour countries; the opposite may be true. In fact, the first Belgian with AIDS was

diagnosed only after the African cases had come to attention.

Interestingly, drug users with CDC definition AIDS are almost absent.

No AIDS cases have been ascribed to blood transfusion or blood products administered in Belgium, but some may be in the making (donors found to be true seropositives after testing was introduced, had given previously their blood to recipients who have seroconverted).

Interestingly, autochthonous Belgians with AIDS split up in two categories: homosexuals, and those with non-homosexual contacts with Africans in Belgium or Africa.

5. *Blood banks.* In part of the blood banks since 1982, and universal since 1983, AIDS risk groups have been requested not to give blood, without any requirement or even possibility to identify them as homosexuals etc. On recommendation of the AIDS Commission, screening of each blood donation for anti-LAV/HTLV-III has been made compulsory and is fully operative since August 1, 1985.

The number of haemophiliacs with the confirmed antibody has been estimated at less than 2 %, and all recipients of Factor VIII are now being screened before they get a heated, Belgian product. The reason for this exceptionally low rate is self-sufficiency with locally made cryoprecipitate; very few patients have received American concentrates.

6. The AIDS Commission has agreed so far with all commercial screening assays for use in the blood banks. By law, when a positive assay is repeatable with the same reagents, the unheated serum must be submitted to the AIDS Commission, which divides aliquots of the sera among its 6 AIDS reference centers. Many assays are made in duplicate among several centers, and the centers meet in the Commission to compare results and decide on true positives. In those donors whose blood has been first examined since 1.8.85, about 5 in 100,000 were true positives. So far, all *confirmed positives* have been positive by immunofluorescence, Western blot, the Wellcome competitive ELISA, and the Abbott p24/p41 assay. Immunofluorescence has given false positives in a few instances (subjective reading; distinguishing between true and false fluorescence); Western blot is creating problems with faint reactions or reactions restricted to 1 or 2 bands; and there is not enough experience with the 2 other assays for judgment.

The predictive value (rate of true positives to all positives) has been about 1 of 40 in this population, certainly justifying continuation of the confirmatory procedure.

7. *Clinical laboratories* have started serological screening as soon as the assays became commercial in April 1985, and their number is being amplified in 1986. The AIDS Commission also recommends confirmation of positives by the AIDS reference centers. This is expected to become the nucleus of a registry of seropositives

WHO-Länderberichte

at the AIDS Commission, with strict safeguards on confidentiality, as has been achieved for AIDS cases. Screening by clinical laboratories is reimbursed by Social Security. Probably because of availability of this facility, there is no evidence for a significant attempt by risk groups to have themselves screened as blood donors.

8. The AIDS Commission has consistently taken the stand that testing of risk groups should be favoured (including Africans), and that, after due confirmation, *any true positive result must be communicated* with due precautions to the person, since this is a key element in prevention of spread. No resistance to this policy has been encountered so far.

9. Promiscuous *homosexuals* are mostly concentrated in Brussels and Antwerp, and are perhaps less in number than in other countries. Testing and information are mainly handled by the AIDS reference centers. Denominators are difficult to establish, but present rates of seropositivity seem to be between 5 and 25 %, depending on the group tested. Homosexuals are, in general, responding well to information - or is it to the AIDS scare generated by the media? Indications are that the risk within this group is being substantially reduced.

10. In contrast, *parenteral drug users* are difficult to approach and to reason. Indications are that the virus has affected them at a later date than homosexuals, but that the spread has been more fulminant. In certain groups, 50 % are now seropositive. A comprehensive view is difficult.

11. At this time, we have little or no evidence for infection in *prostitutes* who do not belong to another risk group (drug users, Africans, homosexuality in males).

12. *Prisons*, in spite of information, are a continuous source of unrest and at times turmoil, both in prisoners and in their guards. In general, prisoners with full-blown AIDS (no cases so far) or with severe ARC will be released, since it is estimated that adequate care is not possible within the prison system. Serological testing is on a voluntary basis, and the Order of Physicians has advised against compulsory testing of anyone. It has also advised against separate units for seropositives, which would hardly be feasible. When a positive is found, he gets a separate cell - which is the rule for all Belgian prisoners although, because lack of space, about 50 % of Belgian prisoners now share cells. Seropositives are virtually limited to drug users.

S.I.D.A. EN BELGIQUE RAPPORT CUMULATIF DE LA SITUATION AU 31 DECEMBRE 1985

SITUATION GENERALE

Le nombre de cas signalés depuis l'apparition du S.I.D.A. en Belgique s'élève à 139 au 31/12/1985. La Belgique est ainsi le pays d'Europe ayant le plus grand nombre de cas par million d'habitants. Cette situation est toutefois biaisée par le grand nombre de cas étrangers, non résidents, originaires pour la plupart du continent africain, dont la présence en Belgique est récente et motivée pour la majorité par la prise en charge thérapeutique. Pour évaluer la prévalence réelle du S.I.D.A. en Belgique, il est donc plus logique de faire la distinction entre les personnes ayant été exposées au risque de contracter la maladie en Belgique et celles n'ayant pu l'être, soit entre:

1. Les RESIDENTS: Belges et étrangers installés en Belgique depuis au moins 5 ans.
2. Les NON RESIDENTS: Etrangers en Belgique depuis moins de 5 ans et Belges installés à l'étranger.

Sur cette base, le nombre de cas au 31/12/1985 s'élève à:

- 34 cas résidents dont 23 de nationalité belge.
- 105 cas non résidents, dont 10 de nationalité belge.

Le taux de cas par million d'habitants parmi les résidents place la Belgique dans une situation comparable à celle de la R.F.A., la Norvège, l'Autriche.

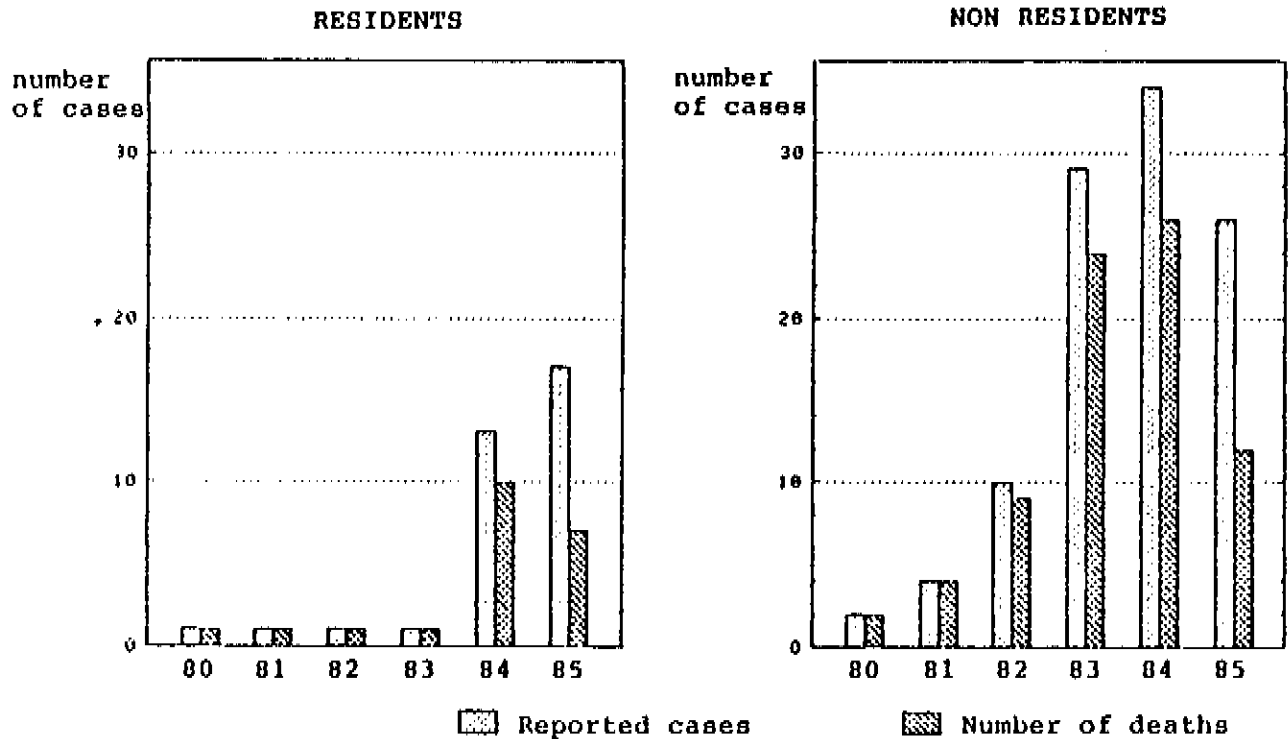
Le nombre de cas diagnostiqués en 1985 est comparable à celui de 1984 et on n'assiste donc pas encore à une augmentation exponentielle comme dans certains autres pays. Toutefois, le nombre de cas parmi les résidents est en 1985 légèrement supérieur à celui de 1984. En 1985, 39,5% des cas sont des résidents, en 1984, ils n'étaient que 27,5%.

Table 1: Nationality of AIDS patients according to residents or not (situation up to 31/12/1985).

| RESIDENTS | | NON-RESIDENTS | |
|-------------|----|---------------|----|
| Nationality | n | Nationality | n |
| Belgian | 23 | Belgian | 10 |
| French | 2 | Greek | 2 |
| Dutch | 1 | French | 2 |
| Italian | 1 | Portugese | 1 |
| | | British | 1 |
| Zairese | 4 | Zairese | 77 |
| Rwandese | 1 | Rwandese | 4 |
| Maroccan | 1 | Burundese | 4 |
| Senegalese | 1 | Tchadian | 1 |
| | | Malian | 1 |
| | | Kenyan | 1 |
| | | Haitian | 1 |

Figure 1: Yearly number of reported cases and number of deaths (situation up to 31/12/1985)

Ratio $\frac{\text{Non residents}}{\text{Residents}}$: 1983 : 29,0
 1984 : 2,6
 1985 : 1,5



Most frequent opportunistic infections:

Residents: Pn. carinii : 17
 Cerebr. toxopl. : 10
 Non-Residents: Mucocut. herpes : 34
 Pn. carinii : 30
 Cryptococose : 15

Table 2: Distribution by age, group, and sex (situation up to 31/12/1985).

| AGE GROUP | RESIDENTS | | | NON-RESIDENTS | | |
|---------------|-----------|----|-------|---------------|----|-------|
| | M | F | Total | M | F | Total |
| 0-11 months | 0 | 0 | 0 | 4 | 2 | 6 |
| 1- 4 years | 0 | 0 | 0 | 0 | 0 | 0 |
| 5-19 years | 0 | 0 | 0 | 0 | 1 | 1 |
| 20-29 years | 7 | 3 | 10 | 4 | 15 | 19 |
| 30-39 years | 9 | 4 | 13 | 29 | 10 | 39 |
| 40-49 years | 2 | 1 | 3 | 24 | 3 | 27 |
| 50-59 years | 4 | 1 | 5 | 10 | 0 | 10 |
| over 60 years | 2 | 1 | 3 | 3 | 0 | 3 |
| Total | 24 | 10 | 34 | 74 | 31 | 105 |

Sex ratio (M/F): Residents : 2,4
 Non-Residents : 2,4
 Belgian Residents : 3,6

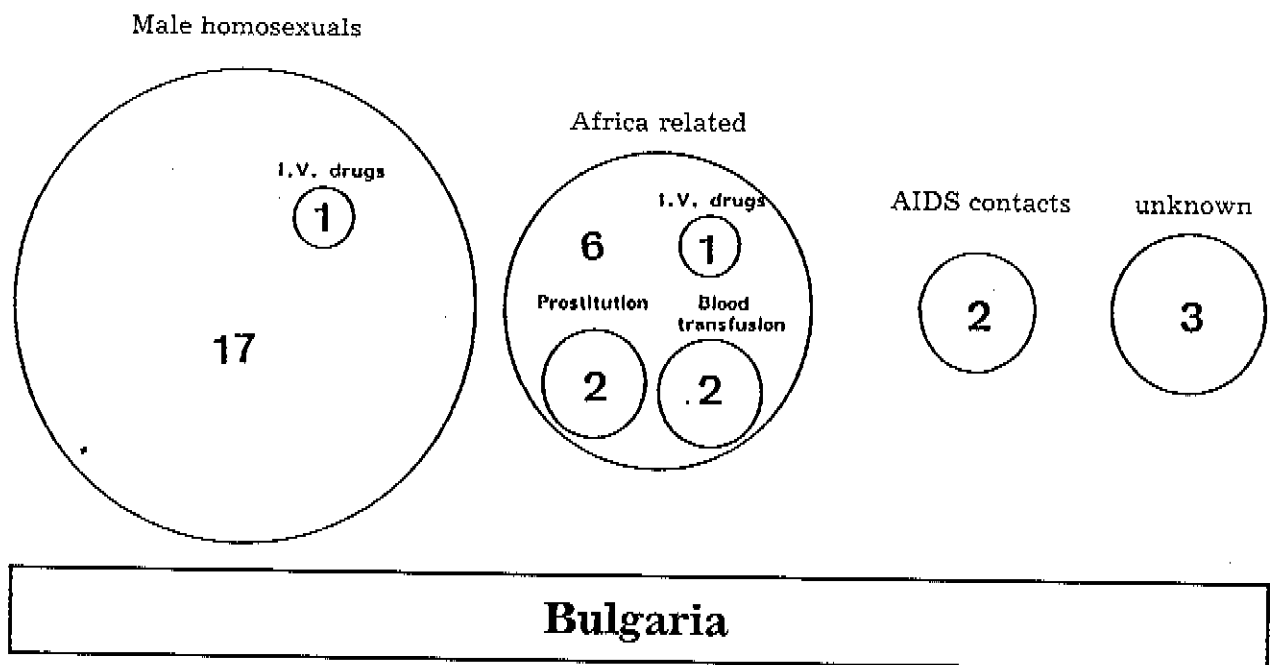
Table 3: Distribution of cases by disease category and number of deaths (situation up to 31/12/1985).

| DISEASE CATEGORY | RESIDENTS | | NON-RESIDENTS | |
|--------------------------|-----------|--------|---------------|--------|
| | CASES | DEATHS | CASES | DEATHS |
| Kaposi sarcoma | 2 | 0 | 7 | 1 |
| Opportunistic infect | 27 | 18 | 82 | 62 |
| Kaposi sarc. + opp. inf. | 5 | 3 | 14 | 12 |
| Others: | | | | |
| Fatal pneumopathy | 0 | 0 | 1 | 1 |
| Giardiasis | 0 | 0 | 1 | 1 |
| Total | 34 | 21 | 105 | 77 |

Les 2 principaux groupes à risques sont représentés par:

- les homosexuels masculins: 53% des cas
 - les personnes ayant des relations étroites avec le continent africain (voyages, résidence, partenaire . . .): 32% des cas
- Chez 9% des cas aucun facteur de risque n'a pu être mis en évidence (2 hommes, 1 femme)

Figure 2: Repartition of cases by risk factors (situation up to 31/12/1985) RESIDENTS ONLY



Bulgaria

Dr. P. Georgiev, Ministry of Public Health, Sofia

The careful epidemiological analysis of morbidity for the last few years have shown that no AIDS cases were registered in our country up to now. The serological tests carried out in risk groups have shown negative results at this stage of investigation. Laboratory control is in keeping with the development and constant increase in the supply of reagents for diagnostic tests.

In 1985, after analysing the situation all over the world, as well as in Europe, a national programme on surveillance on AIDS was made on basis of WHO prognosis and recommendations. The programme involves the following:

- A collaborating group of specialists to the Medical Academy and the Ministry of Health was organized. The tasks of this group are to study, apply and coordinate all necessary complex measures.
- A virology laboratory concerning AIDS is under organization at present. This laboratory will deal with introduction and carrying out of AIDS diagnostics, will survey risk groups of the population and will organize the production of kits for serological diagnostics and for

a complete control of blood and blood products. The laboratory will be as a national reference center for confirmation.

- A laboratory for clinical immunology has already been founded. This laboratory will carry out, when necessary, all tests for the control of ratio of T-helper to T-suppressor lymphocytes as well as skin multitest for demonstration of a reduced T-cell immune response.
- At the same time the qualification of specialists responsible for the clinical, ethiological and immunological diagnosis is constantly promoted. Measures were taken in education of health care workers concerning prophylaxis and precaution measures in clinical laboratories hematological, hemodialysis and pathological departments, surgeries, intensive care units, stomatological and ophthalmological consulting rooms, acupuncture and cosmetics centers, etc.
- Concrete measures for health information activities are carried out among the population at present.

Czechoslovakia

Dr. I. Masár, Chief, Department of Epidemiology, Ministry of Health of the Slovak Socialist Republic, Bratislava and Dr. G. Walter, Chief, Department of Epidemiology, Czech Socialist Republic, Ministry of Health of the CSR, Prague

The problems of AIDS were first discussed in Czechoslovakia during 1983 when the first suspected case was reported. A man from Kongo

died and the retrospective analysis of clinical symptoms revealed the similarity with AIDS cases. There were no laboratory tests done, nor

relevant epidemiological information obtained. The second suspected case died in March 1984 after having symptoms (Kaposi sarcoma, opportunistic infections) from late 1982. The patient was a bisexual but no relevant epidemiological data were obtained. Specific tests for antibodies were not performed. These 2 cases are considered as suspected and were not included in the official statistics.

The first confirmed AIDS case in Czechoslovakia developed symptoms in summer 1984 and died in March 1985 in Bratislava (Kaposi sarcoma, opportunistic infections - pneumocystis carinii). He was 36, bisexual and with a high probability got the infection in Paris during two study trips of several months duration. The case was positive in repeated Elisa tests and confirmed.

In January 1986 two more cases were reported in Prague - a 21 years old homosexual, often travelling abroad and his 35 years old homosexual partner. In both cases repeated opportunistic infections were observed, they are positive in ELISA test and WB confirmed.

By the end of February 1986 appx. 2000 serum samples from various risk groups were examined for HTLV-III antibodies by ELISA test. Two positive cases in ELISA test were confirmed in WB and at present they are without any symptoms.

The following measures were undertaken by both national ministries of healths:

1. In January 1984 an instruction was published in order to standardize measures in case a suspected case of AIDS is reported. The instruction was at that time based on the actual knowledge and included only the nonspecific immunological tests. Since then the instruction was complemented by specific laboratory tests. It contains:

- the background information for all health workers including clinical definition, epidemiology and laboratory tests,
- reporting of AIDS,
- information about the possibilities for laboratory testing in reference laboratories, hospitalization of suspected cases and of

epidemiological investigation of such cases,
- principles of safety for health workers at risk.

2. Information of health workers through articles in medical journals.
3. In both national republics reference laboratories for AIDS were established with the following tasks:
 - to standardize and to introduce routine laboratory tests for detection of HTLV-III antibodies,
 - to confirm positive ELISA tests from field laboratories,
 - to compare and to evaluate various commercially available tests for AIDS diagnostic,
 - to investigate serologically and virologically all suspected cases of AIDS or ARC, to conduct epidemiological studies,
 - to collect and analyse all relevant information on AIDS for both Ministries of Health,
 - to maintain HTLV-III viruses, antisera and selective tissue cultures,
 - to organize training courses for the newly established field laboratories (the workers of the reference laboratories were trained abroad).
4. In both republics special expert groups for AIDS were established. They include all the relevant specialists and their task is to prepare recommendations for the Ministries of Health.
5. A pilot study has been initiated in order to define the various risk groups especially from the point of view of the proportion of seropositives. Besides the risk groups, blood donors and samples from general population are going to be examined.
6. Health education of general public was started, using TV, radio, newspapers and various journals. The health education of special groups working or travelling abroad is emphasized.
7. Special precautions were made in order to assure the safety of blood products (imported and produced locally). The members of AIDS risk groups are excluded from donating blood and screening of all blood donors is envisaged for 1985.

Denmark

Dr. M. von Magnus, Head Division for Communicable Diseases, National Board of Health, Copenhagen

The first case of AIDS in Denmark was reported in 1981. AIDS was made compulsory notifiable in 1983. Denmark uses the same criteria as WHO and CDC, Atlanta. Infection with LAV/HTLV is not compulsory notifiable in Denmark due to confidentiality related problems. As per 1 March 1986 there have been 78 cases of AIDS in Denmark. Until 1983: 7 cases. In 1983: 12 cases. In 1984: 18 cases. In 1985: 36 cases. In 1986 5 cases as

per 1st March. Out of the 78 AIDS-patients 76 were men and 2 women. Out of the 76 men 71 were homosexual/bisexual. 2 patients were haemophiliacs, 3 patients were associated with heterosexual contacts. Concerning the women, one was associated with a blood transfusion and the other with contact with a bisexual man. 50 of the 78 AIDS patients have died. Geographically close to 90% of the cases appear in the Greater

Copenhagen area, and homosexual/bisexual men form the major risk group together with intravenous drug abusers. Sero-surveys have shown that approx. 20% of the homosexuals in Copenhagen are infected. Smaller Sero-surveys (approx. 200 persons) indicate that 15-20% of intravenous drug abusers in Copenhagen are infected. Smaller sero-surveys in other parts of the country have not shown infection in the drug abuse population. 320 haemophiliacs in Denmark, well over 30% of them are estimated to be infected by LAV/HTLV-III. Well over 2000 persons have been found LAV/HTLV-III-positive, and it is estimated that between 5-10000 persons are infected with LAV/HTLV-III.

Activities and Control Measures in Denmark up to 1986:

In 1983 an advisory committee was set up under the National Board of Health to assist the health authorities. In 1983 the National Board of Health issued guidelines on AIDS to all physicians in the country. At the same time information was distributed to blood donors requesting risk groups (homosexual and bisexual men, drug abusers, persons with contacts in Africa, haemophiliacs and the sexpartners of these groups) to refrain from donating blood. The population at large has received information material distributed to every house-hold in the country. Leaflets have been made for risk groups (homosexual/bisexual men, intravenous drug abusers). A cooperation has been established with the homosexuals' organisation and the haemophiliacs' organisation with good results. In 1985 the National Board of Health revised the guidelines on AIDS. The importance of advising on infection risks and prevention is strongly underlined, and the physicians are directed to inform persons belonging to the risk groups of the risks. Guidelines for prisons and police have been issued. Pamphlets have been issued for drug abusers recommending that drug abusers use clean needles and syringes. In Denmark everybody can buy syringes and needles at the pharmacies without medical prescription. The National Board of Health is, for the time being, engaged in working out guidelines on psycho-social support to AIDS patients and LAV/HTLV-III positive persons for the purpose of advising local authorities. To a smaller extent hot-lines have been established partly by the homosexuals' organisation, partly by the individual county. Testing of blood donors was initiated in the

autumn of 1985, and was made obligatory as per 1st January 1986. During the first 2 months of 1986 5 positive donors were found, equalling 1 per 15000 donors. As per 1st October 1986 all factor substances for treatment of haemophiliacs have to be heated. It is not allowed to use sperma or organs for transplantation purposes from persons who have not been tested for LAV/HTLV-III.

Legislation.

The question of transferring AIDS to the legislation on epidemics/veneral diseases has been discussed in Denmark. However, it was decided not to do so because of the lack of treatment possibilities.

Treatment and Care of AIDS Patients.

Four departments for infectious diseases at University Hospitals have been appointed to take care of the AIDS patients. All persons found LAV/HTLV-II antibody positive are recommended to be referred to these departments for the purpose of further examinations, counselling and treatment. It is stressed that the necessary psycho-social support and advice on safe sex is given.

Strategy concerning Prevention of AIDS.

The starting point for the present strategy has been to stop the spread of infection by information, education and advice to the risk groups and to the population at large. It is necessary to intensify these efforts in order to prevent spreading of the infection and a more comprehensive strategy is being elaborated.

The main element will be intensified epidemiological surveillance of the spreading of infection by the establishment of cohorts among the risk groups. It is considered to initiate sociological examinations concerning the life-style and sex habits among the risk groups with the aim of encouraging the use of safe sex. Improvement of information and educational activities by hot lines. Establishing further education and training of medical persons, social workers, school teachers etc. must take place in order to improve information and education in the local communities. The efforts towards drug abusers must be intensified partly by way of information but also by a change in the efforts of treatment which should be made more attractive to the drug abusers. It is considered to make use of proper information campaigns by professional advertising companies in order to influence the risk groups to use safe sex. Information material must be produced such as pamphlets and video films for schools, youth institutions etc.

Finland

M.L. Kantanen, M.Sc., National Public Health Institute, Helsinki

Antibody testing against HTLV-III was done in 9 laboratories during 1985. ELISA test is used for

screening and Western-Blot as a confirmatory test. By the end of year 1985 altogether 59087

serum samples had been tested. Of these 64 were positive (confirmed): 59 males and 5 females.

34 patients were clinically symptomatic:

10 had AIDS (5 dead)

7 had ARC

17 had LAS

Age distribution of these patients is as follows:

| | AIDS | ARC | LAS |
|-------------|------|-----|-----|
| 15-19 years | | | 1 |
| 20-29 years | 1 | 3 | 4 |
| 30-39 years | 7 | 3 | 8 |
| 40-49 years | 1 | 1 | 3 |
| 50-59 years | | | 1 |
| unknown | 1 | | |

During January 1986 additional 29682 tests were done. Of these 8 were found positive, and 1 AIDS, 1 ARC and 4 LAS cases were reported to medical authorities.

Official numbers of February are not yet available but according to direct information from the laboratories, the total number of antibody positives in the beginning of March is 76. These belong to different risk groups (unofficial numbers):

60 homosexual men

8 heterosexual persons

1 intravenous drug user (f)

2 hemophiliacs

2 transfusion recipients

3 information lacking

68 are Finns, 8 foreigners.

Screening of blood donors was started in the beginning of September 1985. During the period 2.9.1985-4.3.1986 altogether 96665 blood units had been screened. Of these 3 were confirmed positive which means about 1 positive/30000 samples. Screening of blood donors was mainly performed by the ELISA test of Organon.

Simultaneously with the start of blood donor screening, antibody testing was made available to anyone without charge. This is based on the Public Health system: blood samples are taken at local Public Health centers or at SDT policlinics and sent to Public Health Institute in Helsinki for testing. Through this channel 2184 blood samples had been tested from September 1985 till March 1986, and 6 were found positive. It is of interest that these samples are derived from females as often as from males (1088/1096), but all females have been negative so far.

Epidemic Situation of HTLV-III Virus in Finland

The first AIDS case in Finland was diagnosed in June 1983. Since that new cases of clinical HTLV-III infections have been found. Situation at the moment is shown in fig. 1. One of the AIDS patients (the latest one) is a woman, who was infected by a bisexual American man. The other 10 AIDS patients are men. 8 of them are homosexuals, the 2 others are heterosexuals, who got their infections from African women. 3 AIDS patients

had Kaposi's sarcoma. Of the 6 dead persons 4 had signs of cerebral infection. The frequency of the antibody positive cases is shown in fig. 2. Altogether some 10000 diagnostic tests have been performed in Finland, which means a frequency 1:122. Figure 3 shows how different risk groups are represented among the positive cases as far as this is known. Age distribution is as follows: figure 4. It can be seen that the younger age groups are strongly represented.

Most positive cases come from southern Finland, especially Helsinki Area. Antibody determinations are performed at the moment by 10 different laboratories in the 3 biggest cities in Finland. Figure 5 shows the main types of laboratories and how they get their samples. The channel from Health Centers to Public Health Institute in Helsinki is intended to serve people, who may in this way have their antibody status determined without charge. Test result is given to the person by the general physician in the health center. In case of positive result, the patient is advised to a specialist in internal medicine, usually to a central hospital. Reporting to National Board of Health is done anonymously so, that only age and sex are given from the antibody positives. Clinically diagnosed AIDS cases are, however, reported by their whole name and identity code.

Screening of blood donors

Screening of blood donors was started in September 1985, and since 1st January 1986 all blood units in the country are tested. This is done centrally in the Finnish Red Cross Blood Service in Helsinki. By the end of March 1986 altogether 120000 blood units have been tested. Among them 3 HTLV-III positives have been found, which means a frequency of 1:40000. 2 people are known to be infected by transfused blood. As to hemophiliacs, only 2 of them are infected, which is explained by the fact, that only domestic coagulation factor concentrates are used in Finland. In Finland AIDS does not belong under the Law on Venereal diseases. Contact tracing is left to the patient, who is only advised to search and inform the contact persons.

On the whole, HTLV-III antibody testing in Finland is completely voluntary.

HTLV-III positive cases in Finland as of march 1986

| | |
|----|---------------|
| 11 | AIDS (6 DEAD) |
| 9 | ARC |
| 27 | LAS |
| 10 | PLN |
| 19 | SYMPTOMLESS |
| 9 | UNKNOWN |
| 85 | |

Number of positives/diagnostic tests

82/10000 = 1:122

WHO-Länderberichte

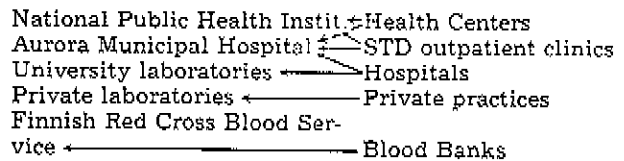
HTLV-III positives by risk group

- 67 Homosexuals
- 8 Heterosexuals (5m, 3f)
- 2 Hemophiliacs
- 2 Blood transfusion cases
- 1 i.v. drug abuser
- 5 unknown

Age distribution of HTLV-III positive cases

| Age | Number |
|-------|--------|
| 16-25 | 17 |
| 26-35 | 34 |
| 36-45 | 26 |
| 46-55 | 6 |
| 56-65 | 2 |

Laboratories performing HTLV-III antibody determinations and the main flow of blood samples to them.



Number of HTLV-III positives among blood units tested

$$3/120000 = 1/40000$$

German Democratic Republic

Prof. Dr. N. Sönnichsen, Dermatologische Klinik, Humboldt-Universität, Berlin

In the German Democratic Republic an interdisciplinary composed expert group for AIDS was established by the minister of Public Health in 1983. This group got the task to follow up the international situation and to prepare recommendations for suitable arrangements in our country. The decisive base of all the arrangements within the GDR represents the by the minister of Public Health edited directive for recognition, prevention, and surveillance of the Acquired Immunodeficiency Syndrome. This directive contains all the arrangements as announcement, information, diagnostic, medical care, questions of disinfection, and recommendations and directions of behaviour as well. The arrangements in the GDR can be outlined shortly in the following points:

1. By following up of the international literature, publications in medical journals of the GDR and special lectures, information and continued professional training was given for the medical staff. This instruction contains etiology, epidemiology, clinical symptoms, risk of transmission, information about the possibilities for laboratory testing, hospitalization of suspected cases and also principles of safety for health workers at risk. In the 2nd half of this year, on the base of the topical position of knowledge an obligatory training about AIDS will be carried out for all physicians and other medical workers. Parallel to the information of the medical staff the general public became informed by articles of weekly journals and popular-scientific journals. Above it our population was given the chance to inquire at numerous arrangements and to put questions. Furthermore, several papers of information became elaborated.

2. In all the districts of the GDR special consultation-centres became formed. These centres have the task to clarify diagnostically suspected cases, to look after carriers of antibodies as well as to advise the citizen and the medical staff. To the consultation-centres belong laboratories in which the LAV/HTLV-III-ELISA test is carried out. In case of a positive test result the immuno-blotting takes place as confirmation test in special central laboratories. For the work of the consultation-centres, general and obligatory directions of work are valid. The managers of the consultation-centres became separately improved.
3. Beside the consultation-centres of the districts, in Berlin central arrangements for medical attendance became prepared for adults and children, which take over the care of clinically manifest AIDS-cases.
4. All the central and districtal blood-donor centres of the GDR became in the meantime furnished with the technics for carrying out the HTLV-III-ELISA-Test. In this year, testing of each single blood-donor becomes introduced step by step in the GDR. The hitherto existing tests have yielded single positive results in the ELISA test, however, till now there have been found no confirmations in the immuno-blotting.

The epidemiologic situation in GDR is described shortly. Until now we have found no clinically cases of AIDS or ARC in the GDR. On the contrary a few carriers of antibodies became diagnosed. This is the question either of GDR-citizens from the risk-group of the homosexuals or of foreigners from endangered regions (Central Africa).

Greece

Prof. Dr. G. J. Papaevangelou, Athens School of Hygiene, Athens

1. Introduction

The evolution of the AIDS epidemic, initially in USA and later in Western Europe, clearly showed that the introduction and spread of the disease in Greece was imminent. Therefore it was decided to adopt preventive measures very early, even before the appearance of the first case in Greece. Thus a National Committee on AIDS was set up by the Ministry of Health, Welfare and Social Security in July 1983. Its mandate was: a) to advise the Ministry as to the current status of knowledge on AIDS and suggest measures for its combat; b) to organize a nation wide epidemiologic surveillance system; c) to organize diagnostic facilities and periodically review suspected cases; and d) to provide adequate information to hospitals and other health personnel and education to the public.

2. Notification and surveillance of AIDS cases

As a first measure, in July 1983, AIDS was declared a reportable infectious disease by ministerial order. For that reason a special epidemiological record for reporting suspected cases was established. Specific instructions for its completion were issued. Physicians taking care of patients suspected of AIDS should complete the record and send it directly to the Direction of Public Health of the Ministry of Health, Welfare and Social Security. Special care is taken to secure confidentiality. Reporting physicians are not obliged to declare the name, but only the initials, of the patients. The report includes all relevant epidemiological, clinical and laboratory data to allow diagnosis and define the specific characteristics of the patients. Every report is discussed during the regular meetings of the National Committee on AIDS. The case is considered as AIDS only when data are sufficient to comply with the CDC definition. Otherwise cases remain under surveillance until further data are available for a final decision. Only full-blown AIDS cases are reported to the WHO Center in Paris. Recently further steps have been taken in order to strengthen surveillance. Blood banks and microbiological laboratories screening for anti-LAV/HTLV-III should report any positive results regarding patients, hospitalized or otherwise suspected of having AIDS. They are also obliged to confirm positive results by Western Blot at the Reference Centers for AIDS. Reference Centers report confirmed results regularly to the Direction of Public Health of the Ministry of Health, Welfare and Social Security. This double check enables better detection and surveillance of the suspected cases. Thus under-reporting should be minimal restricted mainly to cases hospitalized

outside Greece following diagnosis by private practicing physicians. The first case was diagnosed in November 1983. Fourteen cases have been reported up to now. Their main characteristics are shown in table 1.

3. Hospitalization and treatment of patients

Patients may be hospitalized in any major general hospital in Greece. Any exceptional patient lacking social security is hospitalized free of charge in the Infectious Diseases Hospital of Athens or Thessaloniki. Each patient is hospitalized in a separate room with private toilet facilities. Specific recommendations for preventing transmission of infection with LAV/HTLV-III within the hospital and precautions for clinical and laboratory staffs have been issued. A special booklet has recently been published and distributed to almost all health personnel (enclosed). It provides general information on the etiology, epidemiology, diagnosis, clinical presentation and treatment of the disease as well as recommendations and special precautions for caring for patients and handling infectious materials. In parallel special courses in Public Health Control measures and laboratory training were organized at the Athens School of Hygiene. Up to now more than 100 physicians from all over Greece have followed these courses. The state of the art on AIDS has been discussed repeatedly in seminars and conferences, organized in every hospital in Greece. At the beginning serious reactions including reluctance to accept the hospitalization of patients were noted. Resistance soon subsided. Presently several fullblown and pre-AIDS cases are hospitalized in various hospitals of Athens. The establishment of one or two special units for experimental antiviral treatment in the framework of multicenter clinical trials is under consideration.

4. Prevention of spread among high risk groups

Special measures have been taken to approach high risk groups and disseminate relevant information. Cooperation has been established with the main organization of homosexuals in Greece. A booklet containing special information and recommendations for homosexuals has been prepared. It will be distributed through this organization as widely as possible. A special telephone hot line for counselling on AIDS has been established at the Athens Reference Center. Since August 1985 screening for antibodies is offered to high risk groups free of charge at the Athens Reference Center. Confidentiality is secured through special arrangements with the

Table 1. Characteristics of the 14 AIDS patients in Greece.

| Date diagnosis | Year | Origin | Sex | Age | Possible source of infection | Anti-LAV/HTLV-III | Clinical Symptoms | Outcome |
|----------------|------|---------|------|-----|------------------------------|-------------------|-------------------|---------|
| 1 November | 1983 | Zambia | male | 26 | Homosexual | + | O.I | death |
| 2 June | 84 | Greece | male | 36 | Bisexual | + | O.I | death |
| 3 June | 84 | USA | male | 31 | Bisexual | + | O.I | unknown |
| 4 April | 84 | Burundi | male | 33 | Heterosexual | + | S.K | death |
| 5 August | 84 | Greece | male | 35 | Homosexual | + | O.I | death |
| 6 January | 85 | Cyprus | male | 62 | Haemophiliac | + | O.I | death |
| 7 September | 84 | Greece | male | 60 | Bisexual | + | O.I | death |
| 8 April | 85 | Greece | male | 32 | Bisexual | + | O.I | death |
| 9 July | 85 | Greece | male | 35 | Homosexual | + | S.K | alive |
| 10 August | 85 | Greece | male | 49 | Heterosexual | + | O.I | death |
| 11 November | 85 | Greece | male | 35 | Bisexual | + | S.K | alive |
| 12 November | 85 | Greece | male | 35 | Homosexual | + | O.I | death |
| 13 November | 85 | Burundi | male | 55 | Heterosexual | + | O.I | death |
| 14 February | 86 | Greece | male | 37 | Homosexual | + | O.I | alive |

Homosexual Society. Information and advice is offered to those attending voluntarily. Special psychological and social support is offered according to the specific needs of each individual. Positive results are confirmed by Western Blot. C.M.I. studies are recommended to those found positive. These are offered free of charge in centers specially designated for this reason. Asymptomatic carriers as well as individuals with lymphadenopathy syndrome or pre-AIDS are asked to report any clinical symptom or sign. Immunological and other diagnostic examinations are repeated every six months. No special legislative measures against those found positive have been implemented. The Athens Reference Center is responsible for screening imprisoned members of high risk groups and particularly prisoners with histories of i.v. drug abuse. However, we have not succeeded in approaching unimprisoned i.v. drug addicts, unless they are hospitalized (mainly for viral hepatitis). Registered female prostitutes are under strict control in Greece, being obliged to report twice a week to special STD clinics. In 1984-85, LAV antibodies were detected in 12 out of 350 prostitutes tested. These women, none of whom showed any clinical symptoms or signs, were advised to quit prostitution. Since December 1985, all prostitutes have been screened for antibodies every three months and no further LAV infections have been detected to date. All prostitutes have received a booklet with relevant information. In particular, they have been advised to oblige clients to use condoms. Individuals from endemic areas (Central Africa and Caribbean Islands) are also screened at the Athens Reference Center. In contrast haemophiliacs and polytransfused children are screened at the relevant treatment centers. Prevalences of antibodies in these various high risk groups are shown in table 2.

5. Screening of blood donors

Blood transfusion services are organized under the auspices of the Ministry of Health Welfare and

Social Security. There are five regional blood transfusion centers. Blood banks also have been established in all main general hospitals of Greece. Blood is collected from voluntary non-remunerated blood donors after medical examination. The yearly needs exceed 400000 units, of which about 350000 units are collected in Greece, while 50000 units of red cell concentrates are imported from the Central Laboratory of Swiss Red Cross. All needs in plasma are covered by the National Blood Transfusion Service. However 80% of factor VIII and IX is imported from commercial sources (Hyland-Merieux-Immuno). Since August 1985 only heat-treated factors are imported. As early as 1983 special instructions for exclusion of donors suspected of belonging to high risk groups for AIDS were issued by the National Blood Transfusion Service. Screening of blood donors for antibodies against LAV/HTLV-III by ELISA has been imposed throughout the country since August 1985. For this reason the Athens Reference Center for AIDS at the Athens School of Hygiene organised special workshops for surveillance and laboratory diagnosis of LAV/HTLV-III infection. Positive results are confirmed by Western-Blot at the Reference Center. Specific guidelines have been issued. Those found positive by Western-Blot are informed confidentially. Free screening for

Table 2. Prevalence of antibodies to LAV/HTLV-III in various population groups.

| Population Group | Number Examined | Anti-LAV/HTLV-III Number | Positive Per cent (%) |
|------------------|-----------------|--------------------------|-----------------------|
| Blood donors | 93984 | 11 | 0.018 |
| Homosexuals | 243 | 26 | 10.7 |
| Drug addicts | 288 | 6 | 2.1 |
| Haemophiliacs | 200 | 90 | 45.0 |
| Polytransfused | 270 | 4 | 1.5 |
| Central Africa | 280 | 6 | 2.1 |
| Prostitutes | 350 | 12 | 3.4 |

antibodies is offered to their sexual contacts and C.M.I. studies are recommended to those found antibody positive. Data from 93984 blood donors show that 80 (0.85%) of them were found positive by ELISA but only 11 (0.18%) were confirmed by Western-Blot. All of them admitted homosexuality.

6. Information and education for the general public

Newspapers and popular journals have repeatedly published lengthy reports on AIDS. It is obvious that some of them stressed the most horrifying facts as well as gossip and saulty stories about AIDS. Several efforts have been made by the National Committee on AIDS to provide useful information on AIDS through the mass media. Special radio and T.V. programs have been presented and several public lectures have been

organized by scientific, cultural and various other social associations. A special booklet containing simplified general information for the public has been published (enclosed). It is distributed to every Greek family.

7. Research activities

Several epidemiological studies have already been completed in Greece. They refer to high risk groups and blood donors. Profiles of antibodies to the various antigenic determinants of the virus in relation to the natural history of infection are studied. The virus is cultivated at the Reference Center of the Athens School of Hygiene. Isolation of the virus from special patients is performed for research purposes only. Collaboration with the Viral Oncology Unit of the Institut Pasteur Paris as well as with other European research centers has been established.

Hungary

Dr. A. Vass, Chief, Department of Epidemiology, Ministry of Health, Budapest

In the following 10 minutes I would like to summarize epidemiological situation of LAV/HTLV-III infection in Hungary and measures taken by the Hungarian health authorities for containing this infection.

As it was reported to WHO collaborating Centre on AIDS, no disease meeting the CDC case definition was found in Hungary by 31st December, 1985. No such case was observed in our country until now, although AIDS and even suspected AIDS is an obligatory notifiable disease in Hungary from September, 1985, and a systematic education about AIDS has been performed since that time among doctors, nurses and other health care personnel. The most probable explanation for this situation is that LAV/HTLV-III infection is a recent disease in our country and not enough time necessary for the development of full-blown AIDS has been elapsed since its appearance. Anti-LAV/HTLV-III measurements performed in Hungary seem to support this assumption.

First investigation concerning AIDS was made already in an early phase of AIDS epidemic in Europe, between November, 1983 and June, 1984. In the framework of an international collaborative study supported partly by the NIH, a complex clinical and immunological study was made in 73 patients with haemophilia treated exclusively with locally produced cryoprecipitate, 40 homosexual men and 37 heterosexual controls. At the end of 1984, anti-LAV/HTLV-III antibodies were measured in the stored serum aliquots from the same subjects by indirect membrane immunofluorescence assay, ELISA and Western blot techniques. No specific anti-LAV/HTLV-III antibodies were detected in any of the serum samples tested. Later on, anti-LAV/HTLV-III

measurements were continued in a limited number of sera by the indirect immunofluorescence assay. First positive results were obtained in the summer of last year: anti-LAV/HTLV-III antibodies were found by a commercial ELISA test confirmed by indirect immunofluorescence assay in sera of 2 promiscuous homosexual men with sexual partners from West-Europe out of 20 tested. The first relatively large-scale study on the prevalence of the anti-LAV/HTLV-III positivity was made in November, 1985. 374 serum samples from homosexual men volunteered for this study, 1095 sera from patients with venereal diseases, serum samples from 491 patients with haemophilia A, B or von Willebrand disease, 150 patients with autoimmune disease as well as from 903 blood donors were tested by two commercial enzyme immunoassay kits, Organon and Wellcome. Each repeatedly positive serum was tested by indirect immunofluorescence assay as a confirmatory test. Definitely positive samples occurred exclusively in the high risk groups: in 18 samples (3.7 %) from haemophiliacs, in 21 sera (5.6 %) from male homosexuals and 1 sample from a homosexual venereal disease patient. The 22 positive samples were taken from 17 homosexual men.

Since December, 1985 efforts have been concentrated on the study of haemophiliacs. Altogether serum samples from 692 patients with haemophilia A, B and von Willebrand disease were tested for the presence of anti-LAV/HTLV-III antibodies by the Organon ELISA kits, positive results were controlled by the enzyme immunoassay kit of other firms (SORIN/Biomedica, Wellcome, Electronucleonics, Pasteur Diagnostics) and confirmed by the indirect immuno-

fluorescence assay. Confirmed positive results were obtained in 26 patients that is in 3,8 % of the patients tested, representing the vast majority of the haemophiliacs registered in Hungary. Next slides show the distribution of the anti-LAV/HTLV-III positive patients by sex, age and diagnosis. As can be seen, most positive patients were found among patients with haemophilia B, whereas only 3 patients with haemophilia A and 3 patients with von Willebrand disease became anti-LAV/HTLV-III positive. This finding is rather unusual: in USA and West-Europe a higher percentage of patients with haemophilia A than those with haemophilia B or von Willebrand disease has anti-LAV/HTLV-III antibodies. Similarly, the age distribution of the anti-HTLV-III positives was also found to be unusual: half of the patients were younger than 15 years. The next slide shows the incidence of anti-LAV/HTLV-III positivity in Hungarian haemophiliacs treated or not treated with imported factor concentrates. Positives were detected only in patients ever treated with imported concentrates: one-third on the patients known to be treated with one of these preparations became anti-LAV/HTLV-III positive. By contrast, no patient treated exclusively with Hungarian blood products had antibodies in their sera against LAV/HTLV-III. Unusual findings concerning the distribution of positivity according to diagnosis and age can be also explained by the treatment applied: due to a temporary shortage in locally produced prothrombin complex concentrate many patients with haemophilia B (mainly children) had to be treated with imported factor IX concentrates.

As for the progression of the disease in anti-LAV/HTLV-III positive persons found so far, all but 2 of the haemophiliacs are symptomfree, two patients have ARC. Out of the 18 anti-LAV/HTLV-III positive homosexual men 13 have LAS or ARC. Data obtained in the investigations performed so far demonstrate that Hungary still can be considered as a low-risk area for AIDS. In order to take advantage of this favorable epidemiological situation, Hungarian health authorities took the necessary steps for the containment of LAV/HTLV-III infections. As it was already mentioned, in September, 1985 AIDS was declared to be an obligatory notifiable disease by the Minister of Health. Minister also ordered that all patients with AIDS will be hospitalized in the central hospital for infectious diseases in Budapest and an obligatory care and epidemiological control was directed for each anti-LAV/HTLV-III patient. An educational campaign was started in September-October, 1985 for the Hungarian physicians. Information about AIDS was distributed orally and detailed recommendations including case definition, clinical symptoms, laboratory signs as well as measures to be taken in the case of suspected AIDS were published in the leading Hungarian medical journals.

From the beginning of 1986 in approximately half a year a network of about 40 laboratories for anti-

LAV/HTLV-III measurements will be step-wise established in various health institutions. Virognostika kit of the firm Organon Teknika will be used in each lab, about 600000 serum samples will be tested in 1986. An obligatory screening will be performed in the following groups: first of all, each unit of donated blood will be screened for anti-LAV/HTLV-III antibodies. In addition, the following high risk groups will be screened: homosexuals as well as other patients with sexually transmitted disease and their sexual partners, intravenous drug abusers fortunately rare in Hungary, haemophiliacs and patients treated with imported coagulation factor concentrates in the last years, organ donors, sperm donors, sexual partners of the anti-LAV/HTLV-III positive persons and newborn from such mothers as well as men released from prisons. We hope that these measures will be successful and LAV/HTLV-III epidemics will be effectively contained in our country.

1. Comparative trial, November, 1985

| Group | Number of sera tested | Sera with anti-LAV/HTLV-III-antibody | |
|--------------------------------|-----------------------|--------------------------------------|------------|
| | | Number | % |
| Haemophiliacs | 491 | 18 | 3.7 |
| Homosexual men | 374 | 21 | 5.6 |
| Patients with venereal disease | 1095 | 1 | 0.1 |
| Patients with SLE | 111 | 0 | 0.0 |
| Patients with MCTD | 39 | 0 | 0.0 |
| Blood donors | 903 | 0 | 0.0 |
| Total | 3013 | 40 | 1.3 |

2. Incidence of anti-LAV/HTLV-III positivity among Hungarian haemophiliacs

| | |
|----------------------------------|-------|
| Number of patients tested | 692 |
| Anti-LAV/HTLV-III positive | 26 |
| Percentage of positivity | 3.8 % |

3. Diagnosis of anti-LAV/HTLV-III positive haemophiliacs

| Diagnosis | Male | Female | Total |
|----------------|-----------|----------|-----------|
| Haemophilia A | 3 | 0 | 3 |
| Haemophilia B | 20 | 0 | 20 |
| Von Willebrand | 1 | 2 | 3 |
| Total | 24 | 2 | 26 |

4. Age distribution of anti-LAV/HTLV-III positive haemophiliacs

| Age/ys/ | Von Will. | Haem A | Haem B | Total |
|---------|-----------|--------|--------|-------|
| 0-5 | 0 | 0 | 2 | 2 |
| 6-10 | 0 | 0 | 5 | 5 |
| 11-15 | 1 | 0 | 5 | 6 |
| 16-20 | 0 | 2 | 2 | 4 |
| 21-30 | 0 | 0 | 2 | 2 |
| 31-40 | 0 | 1 | 3 | 4 |
| 41-50 | 2 | 0 | 1 | 3 |
| | 3 | 3 | 20 | 26 |

5. Incidence of anti-LAV/HTLV-III positivity in haemophiliacs treated or not treated with imported factor concentrates

| Treatment | Anti-LAV/HTLV-III | | |
|---|-------------------|---------------|---------------|
| | Positive | Negative | Total |
| Treated with imported factor concentrates | 26 /33%/ | 52 /67%/ | 78 /100%/ |
| Treated exclusively with Hungarian Blood products | 0 /0%/ | 504 /100%/ | 504 /100%/ |
| No data | - | - | 110 |
| Total | - | - | 692 |

Iceland

Dr. H. Briem, Consultant in Infectious Diseases, City Hospital, Reykjavik

Introduction

In 1982 the Director General of Public Health established an expert advisory group on AIDS, consisting of specialists in infectious diseases, immunology, virology and hematology. The advisory group was further extended in 1985 to include a psychiatrist. In 1985 the two major hospitals in Reykjavik, the City Hospital and the National Hospital, established a collaboration group to assist the Director General of Public Health in the epidemiological surveillance of the spread of the LAV/HTLV-III infection in the country and to improve diagnostic facilities, patient care and treatment and furthermore to educate health care personnel and the general public on the AIDS epidemic.

Epidemiological surveillance

In 1984 the Director General of Public Health decided that AIDS should be a notifiable disease.

After the introduction of tests for antibodies to LAV/HTLV-III in 1985, seropositive cases are also notifiable in the country. The reporting of LAV/HTLV-III positive persons to the Director General of Public Health is semi-anonymous. Patients are reported by month and year of birth and by sex. In November 1985 the screening of blood donors was initiated and simultaneously an "AIDS hot line" was established for information and advice. Alternative testing sites were made available for individuals from risk groups. The gay community has encouraged its members to be tested for antibodies to LAV/HTLV-III.

Prevention, education

Since 1984 the Blood bank has asked blood donors who might belong to a risk group to refrain from donating blood. Early in 1985 the Director General of Public Health distributed a leaflet to the general public describing the AIDS epidemic,

Table 1. The prevalence of antibodies to LAV/HTLV-III in various risk groups in Iceland

| Risk group | Until Dec 12 1985 | | | Jan 1 - Mar 31 86 | | | Total | | |
|-----------------------|-------------------|-----|--------|-------------------|---|--------|-------|----|--------|
| | N* | P** | (%) | N | P | (%) | N | P | (%) |
| Homosexuals/bisexuals | 51 | 14 | (27.5) | 34 | 3 | (8.8) | 85 | 17 | (20.0) |
| i.v. drug abusers | 50 | 2 | (4.0) | 17 | 3 | (17.6) | 67 | 5 | (7.4) |
| Heterosexuals men | 72 | 1 | (1.4) | 19 | 0 | (0.0) | 91 | 1 | (1.1) |
| women | 43 | 0 | (0.0) | 17 | 0 | (0.0) | 60 | 0 | (0.0) |
| Haemophiliacs | 11 | 0 | (0.0) | 0 | 0 | (0.0) | 11 | 0 | (0.0) |
| Total | 227 | 17 | (7.5) | 87 | 6 | (6.9) | 314 | 23 | (7.3) |

* Number tested

** Anti-LAV/HTLV-III positives

Table 2. The distribution of LAV/HTLV-III positives by risk groups in Iceland

| Risk groups | N | (%) |
|-----------------------|----|--------|
| Homosexuals/bisexuals | 17 | (74.9) |
| I. v. drug abusers | 5 | (21.7) |
| Heterosexuals | 1 | (4.3) |
| Hemophiliacs | 0 | (0.0) |
| Total | 23 | (100) |

Table 3. Classification of LAV/HTLV-III infected patients according to symptoms and age group by the end of March 1986

| Age group | AIDS | ARC | LAS | Asymptomatic | Total |
|-----------|------|-----|-----|--------------|-------|
| 0-9 | | | | | |
| 10-19 | | | | | |
| 20-29 | | 1 | 5 | 9 | 15 |
| 30-39 | 1 | | 2 | 3 | 6 |
| 40-49 | 1 | | | 1 | 2 |
| 50-59 | | | | | |
| >60 | | | | | |
| Total | 2 | 1 | 7 | 13 | 23 |

its mode of spread and measures that individuals should take to lessen the risk of infection. Later the same year recommendations regarding laboratory precautions and patient care were made. A pamphlet including advice and recommendations for outpatients, their sexual contacts and families is in progress. Groups such as policemen, ambulance personnel, social workers etc. who may be involved with infected persons have been educated in lectures and meetings which will continue as necessary. In addition, numerous lectures have been conducted for other groups and the public at large.

Patient care and treatment

Patients with AIDS and AIDS related complex will be treated in the two major hospitals in

Reykjavik. Organisation for outpatient care and psycho-social support to infected individuals is in progress.

Legislation

In March 1986 the Icelandic Parliament adapted a law that defines LAV/HTLV-III infection as a sexually transmitted disease (STD). Therefore, HTLV-III infection is like other STD notifiable by law and patients will not be charged for any treatment or measures for care. The notifications will be semi-anonymous as previously described to maintain confidentiality.

The epidemiological situation in Iceland

As of March 31 1986 2 AIDS cases have been documented in Iceland. The first was diagnosed in November 1985, the second was diagnosed in February 1986. Both patients suffered from opportunistic infections. The first diagnosed patient is dead. Both were homosexuals. Hitherto 23 individuals have been found to be positive for antibodies to LAV/HTLV-III (ELISA [ORGANON] and Western blot confirmed). The prevalence by risk groups is given in Table 1. The distribution by risk groups is given in Table 2. The distribution of symptoms by age is given in Table 3. Only 1 woman is seropositive. She is an i. v. drug addict. By March 31 1986, 8261 blood donors have been tested and none has yet been found to be seropositive (Western blot confirmed). Presently, the number of AIDS cases per million population is 8.3 in Iceland.

Comments

The AIDS pandemic has obviously taken its toll in Iceland and become endemic there as well as in other countries. LAV/HTLV-III infection seems to be widely spread among risk groups, notably the homosexuals and intravenous (iv) drug abusers. However, the actual number of homosexuals and iv drug abusers in the country is unknown to us. Based on epidemiological data from various sources, we estimate that at least 100-200 individuals in Iceland may presently be infected with LAV/HTLV-III.

Israel

Dr. T. A. Swartz, Director, Department of Epidemiology, Ministry of Health, Jerusalem

Between March 1983, when the first case of AIDS was diagnosed in Israel, and up to February 1986, 22 cases have been reported to the Department of Epidemiology of the Ministry of Health, out of which 18 had been found out in Israel, while the remaining 4 had come to Israel after they had been diagnosed as suffering from AIDS in their countries of origin. Based on an incidence of 18 cases, the attack rate is 4.2 per 10⁵ population.

As shown in Table 1, a quite considerable proportion of Israeli patients (44.4 %) had been infected abroad.

As illustrated in Table 2, two thirds of all cases belonged to the age groups 30-39 and 40-49, followed by 22.2 % in the age group 15-19. All the patients but one were males.

The distribution of cases by risk group was rather different from the pattern normally described:

only 50 % were homosexuals, while an unusually high proportion of patients (33.3 %) was recorded among hemophilic patients.

Details on disease categories are included in Table 3: opportunistic infections were most frequently reported (72.2%), Kaposi sarcoma, either alone, or associated with opportunistic infections, contributed with 16.7% only, and the remaining 11.1 % of cases were associated with other malignancies. The severity of the condition was attested in the Israeli series also: the case fatality rate of the whole group was 55.6 %. Details on the percent of deaths in different disease categories as well as by period of diagnosis are presented in Tables 4 and 5.

Table 1. AIDS cases, by region of diagnosis and infection

| Year | Diagnosed in Israel | | |
|-------|---------------------|-----------------|------------------|
| | Infected in Israel | Infected Abroad | Diagnosed Abroad |
| 1980 | 1 | - | - |
| 1981 | - | - | - |
| 1982 | - | - | 1 |
| 1983 | 4 | 4 | - |
| 1984 | 1 | 1 | - |
| 1985 | 3 | 3 | 3 |
| 1986 | 1 | - | - |
| Total | 10 | 8 | 4 |

Table 2. AIDS cases, by age and risk group

| Age Group | Number | % | Risk Group | | | |
|-----------|--------|------|--------------|-----------------------|------------------|---------|
| | | | Homo-sexuals | Hemo-philiac Patients | Blood transfused | Unknown |
| 15-19 | 4 | 22.2 | - | 4 | - | - |
| 20-29 | 1 | 5.6 | 1 | - | - | - |
| 30-39 | 6* | 33.3 | 5** | - | 1 | - |
| 40-49 | 6 | 33.3 | 3 | 2 | - | 1 |
| 50-59 | 1 | 5.6 | - | - | 1 | - |
| Total No. | 18 | | 9 | 6 | 2 | 1 |
| % | | 100. | 50.0 | 33.3 | 11.1 | 5.6 |

* one - female

** one - drug addict

Table 3. AIDS cases, by disease category

| Disease Category | Number | Percent |
|--|--------|---------|
| Opportunistic Infection | 13 | 72.2 |
| - Pneumocystis carinii | 7 | 38.9 |
| - Other | 6 | 33.3 |
| Kaposi Sarcoma | 1 | 5.6 |
| Opportunistic Infection and Kaposi Sarcoma | 2 | 11.1 |
| Lymphoma | 2 | 11.1 |
| Total | 18 | 100. |

Table 4. AIDS deaths, by disease category

| Disease Category | Cases | Deaths | |
|--|-------|--------|-------------------|
| | | Number | Fatality Rate (%) |
| Opportunistic Infections | 13 | 8 | 61.5 |
| - Pneumocystis carinii | 7 | 5 | 71.4 |
| - Other | 6 | 3 | 50.0 |
| Kaposi Sarcoma | 1 | - | - |
| Opportunistic Infection and Kaposi Sarcoma | 2 | 2 | 100. |
| Lymphoma | 2 | - | - |
| Total | 18 | 10 | 55.6 |

Table 5. AIDS cases and deaths, by year of diagnosis

| Period | Cases | Deaths |
|----------------|-------|--------|
| Before 1981 | 1 | 1 |
| 1.1981-12.1981 | - | - |
| 1.1982-12.1982 | - | - |
| 1.1983-12.1983 | 8 | 8 |
| 1.1984-12.1984 | 2 | - |
| 1.1985-12.1985 | 6 | 1 |
| Since 1.1986 | 1 | - |
| Total | 18 | 10 |

Italy

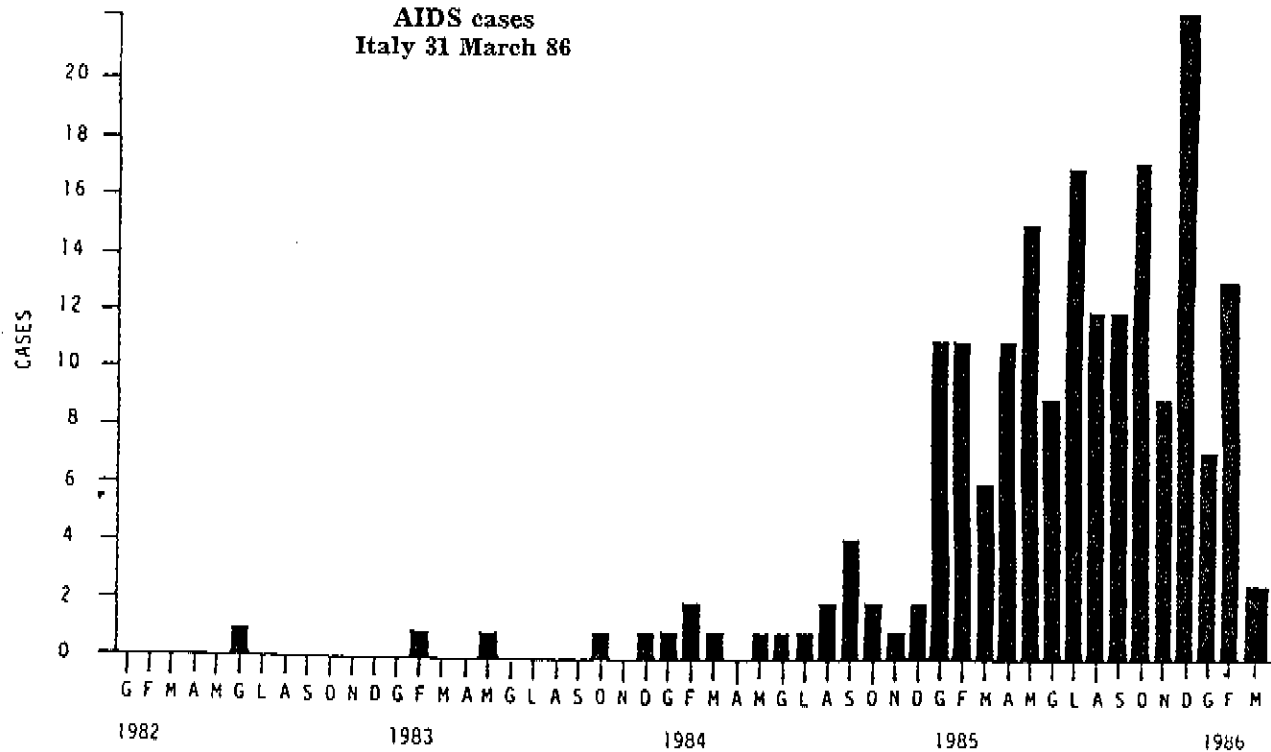
Dr. D. Donatella Ballada, Chief, Infections Diseases Department, Ministry of Health, Rome

The first AIDS case occurred in Italy in 1982 although it was reported only in 1983, when the national epidemiological surveillance system started; since then a progressively increasing

number of cases has been recorded: by the end of each year they were 5 - 1983, 23 - 1984 and 140 - 1985.

To these figures, officially submitted to the WHO

**AIDS cases
Italy 31 March 86**



Collaborating Center in Paris, 33 further cases must be added since they occurred in 1985 and were reported later in 1986: 45 % of the reported cases occurred among i.v. drug abusers, slightly more than 35 % occurred in male homosexuals and 5 % in subjects with both these risk factors. Because of high incidence

among drug abusers, we registered also pediatric cases that account for a 6 % of the total and occurred only in children born from drug addict mothers; therefore young female drug abusers are suggested to avoid pregnancy. Six subjects

**Regional distribution of AIDS cases
Italy 31-03-86**



**AIDS in Italy: Cases by sex and risk group
31-03-86**

| | M | F | Total % |
|---------------------|------------|-----------|------------|
| homosexuals (os) | 70 | - | 70 (35.5) |
| drug addicts (da) | 70 | 19 | 89 (45) |
| os + da | 12 | - | 12 (6) |
| haemophiliacs | 3 | - | 3 (1.5) |
| transfusion rec. | 2 | 2 | 4 (2) |
| no risk factors | 5 | 2 | 7 (3.5) |
| children of addicts | 3 | 9 | 12 (6.1) |
| Total | 165 | 32 | 197 |

AIDS in Italy: by semester of notification 31-03-86

| Year | N. cases | N. deaths |
|-------------------|------------|-----------|
| 1982 Jan. - June | 1 | - |
| 1982 Jul. - Dec. | - | - |
| 1983 Jan. - June | 2 | 2 |
| 1983 Jul. - Dec. | 2 | 2 |
| 1984 Jan. - June | 6 | 2 |
| 1984 Jul. - Dec. | 12 | 11 |
| 1985 Jan. - June | 63 | 30 |
| 1985 Jul. - Dec. | 88 | 28 |
| 1986 Jan. - March | 23 | 10 |
| Total | 197 | 85 |

AIDS in Italy: Clinical pictures

| | N. Cases-Alive | N. Deaths |
|-------------------------------|----------------|-----------|
| Opportunistic infections (OI) | 94 | 77 |
| Kaposi Sarcoma (KS) | 10 | 4 |
| KS+OI | 8 | 4 |
| Total | 112 | 85 |

AIDS in Italy: Cases by sex and age group 31-03-86

| Years | M | F | Total |
|--------------|------------|-----------|------------|
| 0-1 | 1 | 8 | 9 |
| 1-4 | 1 | 2 | 3 |
| 5-9 | - | - | - |
| 10-14 | - | - | - |
| 15-19 | - | - | - |
| 20-29 | 79 | 20 | 99 |
| 30-39 | 40 | 2 | 42 |
| 40-49 | 24 | - | 24 |
| 50-59 | 13 | 3 | 16 |
| 60 + | 4 | - | 4 |
| Total | 162 | 35 | 197 |

showed no known risk factor involved, although an high heterosexual promiscuity can be hypothesized. Affected hemophiliacs were 2 and blood recipients were 4.

Since July 1985 testing every donated blood unit for anti-HTLV-III/LAV was recommended and the practice was brought into action throughout the national territory by the end of the same year; much earlier blood donors were asked to avoid donating blood and to contact doctors of transfusional services if they feel to be at risk. Seropositive subjects are informed when two positive ELISA tests have been confirmed also by a positive Western-blot examination. Similarly since July 1985 all coagulation factors VIII and IX used in Italy are heat treated.

Since november 1985 drug abusers attending Assistance Services (SAT) and/or therapeutic communities are serologically tested and similar testing and counselling is offered to their contacts. Anti-HTLV-III/LAV testing can by no means be used as a discriminant in order to give or refuse admission to a therapeutic community.

Homosexuals cooperate with health authorities (Ministry of Health and Istituto Superiore di Sanità) to acquire and to disseminate informations and to develop research programs which are in progress.

Luxembourg

Dr. P. Huberty Kran, Direction de la Santé Division de l'Inspection Sanitaire, Luxembourg

A small country . . . with a surface of 2586 square km. The distance from the extreme north to the extreme south is 82 km and from east to west barely 57 km. These facts show that it is easier for a small country to control the spread of infectious agents and of course to collect data.

Epidemiological situation.

1st April 1986: 3 cases of AIDS have been registered in Luxembourg. The first case was diagnosed in December 1984. 2 of 3 cases died, 2 belonged to the risk groups "homosexual men", one was a female case (the source of infection was unknown). The age of these 3 cases was between 26 and 36. We suggest that today there are about 30 antibody positive individuals in Luxembourg (that means tested and proved true positives by confirmative testing). A reported system of AIDS (giving sex, age, local residence and source of infection) has been instituted but there is no reported system for HTLV-III/LAV-antibody positive individuals. The Health Ministry is responsible for collecting all these data and reports to the WHO Collaborating Centres. A system of testing blood donors was instituted since 1st August 1985. About 17500 blood samples

have been tested and only one antibody positive donor has been found so far. It must be revealed that since 1984 blood donors had been asked not to give blood if they feel that they belong to one of a group at risk. As to the 12 haemophiliac patients who are living in Luxembourg actually and who receive heat-treated blood products imported mostly from the United States, three patients were found to be antibody positive. A self sufficient program has started since last year, so that in future (by the end of this year) no more blood products will be imported from abroad. Interpretation of results from testing homo- and bisexual men or drug abusers is very difficult. The reasons are sociological ones of incomplete data.

Strategy for prevention.

A) *Information:* In 1984 the Health Minister created on national level a committee for surveillance of AIDS. The mission of this committee consists in informing and counselling as well the general public as the groups at risk. One of the first charges of this committee was to give information by writing a document which was sent to all medical and health professionals. The general public was informed by a document that was also

written by this committee and that was presented to all Luxembourg media by the Health Minister himself. As to the different groups at risk, information is given in form of counselling them specially as to their particular lifestyle. But this can only be done with the help and the support of the organizations that represent those groups. So members of the committee for AIDS surveillance try to answer questions of drug-abusers or homosexual men as often as it is asked by them. This is done in a very informal way. Special information is offered to police and prison staff. In the next future the Health Ministry will publish a pamphlet in three languages (French, German and Portuguese) in order to inform the general public.

B) *Control programm*: Serological testing and

counselling are offered to high risk population. Donors of blood and other human material are tested before acceptance. The Health Ministry gives priority to participants in international meetings and workshops and also to health personnel to specialize in the different laboratory technics. A few health services are specialized to offer individual counselling to those people who have been found to be HTLV-III/LAV antibody positive. One hospital is prepared to receive and to treat cases of AIDS. Further it will be all done to promote qualification of specialists and to take all measures in education of health so that AIDS should not disseminate panic among the population but that all should be informed in a rational and responsible manner. This is the only way to help control the spread of AIDS.

Malta

Dr. A. Vassallo, Senior Medical Officer, Department of Health, Valletta

Background Information

The small size and population of Malta and ease of access facilitate central control for various health aspects and this applies to the AIDS problem. Other important considerations are the fact that Government is the main supplier of health care and this is provided free to all irrespective of means. Laboratory services for LAV/HTLV-III testing is only carried out at the main government hospital at two centres viz one at the Blood Transfusion Centre and the other at the Virology Department. Thus all cases with positive LAV/HTLV-III are automatically registered and brought to the attention of the health administration. Blood products are mainly imported and a significant element to the AIDS situation in Malta is that Factor VIII concentrate has been available free to all haemophiliacs in Malta since 1975. Tourism contributes significantly to the island's economy. Permissiveness has increased significantly over the last twenty years and drug abuse, though relatively not so extensive as in other countries, is becoming a serious problem. A small number of intravenous drug abusers are known to the health authorities and with the introduction in March 1986 of compulsory notification of drug addicts, the picture will be clearer in this respect.

Homosexuality is still to a certain extent a taboo but gays are coming more into the open. A bigger problem is the fact that these people are not organized and it is difficult to establish effective contact with the group.

Although generally notifiable under the statutory duties of doctors to report to the Health Authorities any matter affecting the public health, in order to avoid any misunderstanding, AIDS was on 1st March 1986 specifically listed

among the diseases to be notified to the Chief Medical Officer.

Present Situation

Today two cases of AIDS including one death have been reported in Malta. One of these cases was an imported case, a homosexual already diagnosed abroad where he had lived till his return to Malta in March 1986. He had extensive Kaposi Sarcoma and a number of opportunistic infections. The other case (fatal) was a haemophiliac who presented with neurological manifestations.

It is significant to point out that the overseas suppliers of factor VIII had way back in 1984 informed us of the development of AIDS in one of the donors of the batch supplied to us. This batch had already been supplied to the haemophiliacs and was immediately withdrawn.

Screening of risk groups

a) *Haemophiliacs*

Within the local situation the priority group for screening were recipients of Factor VIII. All (a total of 27) have been screened using the ELISA test. A high proportion were seropositive. Four of them have shown evidence of AIDS related complex.

The female contacts of this group were all negative.

b) *Drug Abusers*

As a result of compulsory notification of drug addicts which came into effect in March this year, screening for LAV/HTLV-III antibodies for cases with a history of intravenous drug abuse was recently started. To date there is no evidence of infection among this risk group except in one case who is also a haemophiliac.

c) Homosexuals/Bisexuals

For reasons already stated it is difficult to assess the size of the problem among this group. To date three cases of positive ELISA test are known among this group though none of them has developed AIDS or ARC.

Control Measures*a) Blood and Blood Products*

In mid September 1985 screening of blood donors for LAV/HTLV-III infection was started. All donated blood in Malta is presently being screened.

People in at risk groups are urged not to donate blood. All donors are informed that their blood is screened and examined for various diseases markers, including HTLV-III, Hepatitis B and Syphilitic infection. We do not give HTLV-III any preferential emphasis.

So far over 2000 blood donors have been screened and none were positive. All factor VIII purchased is now heat treated. Other measures in respect of blood products include: -

(i) substitution of all commercially purchased blood products with forms that have been sterilised by heat or chemical means.

(ii) where no sterilised product is available commercially, substitution with locally prepared product e.g. cryoprecipitate instead of fibrinogen.

(iii) extension of blood transfusion services to lessen dependence on imported products.

It is to be stated that laboratory facilities for AIDS testing are limited to ELISA testing for HTLV-III antibody. Both Abbott (US) and

Wellcome (UK) kits have been used. The Western Blot test is being introduced.

b) Other Measures

The most important measure which has been adapted in the fight against AIDS is the promotion of education and disseminating information about the infection. Information was widely disseminated to health workers, to the specific risk groups and to the community at large. Circulars were distributed to health workers and safety guidelines for health workers dealing with AIDS cases or with potentially infected material were widely distributed. The mass media were utilised for the community. Haemophiliacs and other seropositive cases are regularly screened clinically. Notified cases of AIDS and all seropositive cases are counselled as to prevention of risk to others. The situation is discussed with their families.

Education of the community at large which was also directed at risk groups has been carried out through discussions on television, radio and press. These also provided opportunity for the public to phone directly during such programmes. It is noted that there was particular interest from the risk groups. A break through in this field was recently achieved when two members of the gay groups participated in a television discussion on the AIDS problem.

A leaflet on AIDS directed at the general public and written in layman's language has been prepared, while stencilled information for seropositives and at risk groups is already available.

Netherlands

Dr. H. Bijkerk, Division of Infectious Diseases, Department of Health, Leidschendam, and Mr J. Moerkerk, Chairman, AIDS Coordination Team of the Netherlands, Health Education Centre, Amsterdam

Cases

The first case of AIDS in the Netherlands has been reported in April 1982. In 1982, 1983, 1984 and 1985, 3, 15, 29 and 51 patients respectively (total 98), were reported. There does not exist a compulsory notification for AIDS-cases. The medical profession is regularly informed about the AIDS-problem by brochures, Health Council's reports, articles in the Dutch Medical Journals etc. Regularly such publications contain a request to the doctors to report (suspected) AIDS-cases to the health authorities. At central level, at the division of infectious diseases of the State Supervision of Public Health, these data are collected and discussed quarterly by a small working-group of 4 experts. Cases are included in the statistics after being accepted as AIDS-cases by this working group. Most cases are male (96 %). The morbidity at the time of the introduction of a case is in-

cluded in the statistics. Opportunistic infection(s) (OI), Kaposi Sarcoma (KS), OI+KS or B-cell lymphoma were found in 69, 12, 15 and 3% respectively of the patients. Excluding two cases who are not traceable, 64 (67%) of all the patients died: of those diagnosed in 1982 up to and including the first half year in 1984 all died. Thirteen cases (13%) are foreigners, 12 of them have (had) their domicile in the Netherlands. The majority of the patients (58 = 59%) comes from Amsterdam. Homosexuals still constitute the greatest risk group (91%). Two patients are drug-addicts; one of them is also a homosexual. Four patients were infected by blood or bloodproducts; one of these is a girl of 2 years who received plasma during the neonatal period. One patient has most probably been infected by her husband who is a haemophilia A patient. The mode of infection in two male cases has not been revealed.

Approach of the AIDS-problem in the Netherlands

Almost from the time of the report of the first case in the Netherlands the main parties involved such as the Central Laboratory for Blood Transfusion, the Association for Haemophiliacs and the Association of Specialists in haemophilic treatment, the Dutch Association for Integration of Homosexuality, the Municipal Health Service of Amsterdam and the State Supervision of Public Health found each other to find ways to cope with the problem. Initially the attention focused on developing control activities to minimize the risk of transmitting the LAV/HTLV-III virus by blood and blood products. Brochures were published for potential blood donors, haemophiliacs and homosexuals. Reprints of this brochure and/or new brochures were necessary when new information came available (such as the serological tests on anti LAV/HTLV-III). It is felt that these measures contributed very much, and is still doing so, to rendering practically safe blood (-products) to those who need these products. The abovementioned groups were gradually joined by many other parties directly or indirectly involved in the AIDS-problem.

Together they form the so-called Broad Council on AIDS (BCA), consisting of about 35 persons as delegates from their respective organizations.

The council meets about twice a year. A so-called Coordination Team (CT) on AIDS meets about every one to two months. This team consists of about 10 persons from organizations very directly involved in the AIDS-problem such as medical institutions, governmental bodies and groups at risk. A coordinator on AIDS is thereby functioning as the pivot on which many issues on AIDS are turned. He, a physician, and his staff, try to coordinate all kind of activities in the field like setting up regional platforms on AIDS where regional groups such as delegates from municipal health organizations and dermatologists are trying to cope with the increasing specific problems on AIDS in the region. The coordinator also tries to be the focus for public relations (contacts with reporters etc.). Thereby he works in close collaboration with the public relation division of the Ministry of Welfare, Health and Cultural Affairs. The scientific projects, however, fall beyond the scope of the Coordination Team although the Coordination Team is regularly informed about the progress of these projects. Several members of the CT and the BCA are personally closely involved in scientific projects. The scientific coordinator is one of the directors of the National Institute of Public Health in Bilthoven. He tries to coordinate the various projects while he is also closely involved in scientific working groups such as the European Community Working Group AIDS. Finally the commission on AIDS of the Dutch Health Council, consisting of experts from a great variety of disciplines keeps a close watch on the scientific developments on AIDS as well as on the many other aspects such as psychosocial

questions, medical care in hospitals etc. So far two reports of this council have been published and are distributed on a great scale, particularly to the medical profession and others who are directly or indirectly involved in the AIDS-problem.

Prevention (policy, strategy and practice)

In the Netherlands AIDS prevention was primarily directed towards the main risk groups: men with homosexual contacts, i. v. drugusers and haemophiliacs. Combined with a campaign to request blood donors who consider themselves as belonging to a risk group to abstain from blood donation (a very successful campaign!) these activities started in the summer of 1983. Coordinated by the CT these activities continued and expanded since that time. Examples of such activities are:

- brochures, leaflets, posters, special broadcast programs and 2 videofilms for the different risk groups
- nationwide information meetings inside the gay-scene (bars, bathhouses etc.)
- the AIDS HOTLINE (information by telephone on weekdays)
- special pages in the gay-press
- a strongly organised contact with the media (papers, radio and TV)
- special activities for i. v. drugusers and prostitutes (e.g. the availability of clean needles).

The CT has chosen for a strategy primarily aimed at creating a reservoir of information for the people at risk; the motto of this continuing strategy is: "Frappez Toujours". We can reasonably assume that this strategy is successful; particularly in the group of men with homosexual contacts nearly everybody is familiar with the facts about AIDS. This creates possibilities for further action directed towards changing attitudes in sexual behaviour and drug use. Changing patterns in this respect are already observed all over the country. Practising anal intercourse between men is decreasing fast. The important decrease of syphilis and anal gonorrhoea in homosexual men (VD clinics of the Municipal Health Service Amsterdam) may very well be indicative of that changing behaviour. It is necessary that these developments continue. It is, however, imperative that those groups could be offered an acceptable alternative for their risky behaviour.

Simply fighting against undesired behaviour never has proven to be effective!

As "acceptable alternatives", the CT opted for three possibilities:

1. Actions directed towards *changing sexual behaviour* and changing behaviour of i. v. drugusers; campaigning for "safe sex" and "safe use" respectively (e.g. the introduction of a so-called gay-condom and the availability of clean needles for i. v. drugusers).
2. Actions trying to *change the lifestyle of a group*. On tries to do more than stated in ad 1,

by starting a process in which a subculture (like the gay-men), in discussing their (sexual) lifestyle, will be able to influence the whole group in such a way that realizing the dangers of present attitudes a change towards safer attitudes is necessary. The motto in this respect is *greater awareness*.

3. Actions trying to change the whole sub-culture (e.g. gay men or i.v. drugusers). Actually this implicates that rules and measures are used to try to stop the functioning of such a subculture.

We, the Netherlands have chosen for options 1 and 2 as the most acceptable actions directed against the spread and transmission of LAV/HTLV-III. Option 3 is considered as an ineffective and sometimes discriminative action that will not lead to the chosen objective. The information to the general public, focused on adequate information considered to be sufficient to ease the fear and uncertainty pertaining to the AIDS-problem, is a well organised media policy. Good relations with the publicity media are therefore necessary.

Norway

Dr. S. E. Ekeid, Special Medical Consultant for efforts against AIDS, Directorate of Health, Oslo

Epidemiological situation

As of 1st March 1986 20 cases of AIDS have been registered in Norway, 13 of whom have died. 18 patients have been categorized as belonging to be risk group "homosexual men". One was a haemophiliac and one an i.v. drug abuser. To date no female case has been reported.

A reporting system for HTLV-III/LAV antibody positive individuals has not been instituted yet. A system of semi-anonymous reporting will soon be brought into action, however, giving data on month and year of birth, sex, municipality of residence and risk group classification, but no name or day of birth in order to prevent disclosure by the medical officer of personal identification of the patient.

Epidemiological data suggest that today there are some 2000 antibody positive individuals in Norway, i.e. a national prevalence of 0,05%. Of these some 200-250 have been tested and proved true positive by confirmative testing in reference laboratories.

The present rate of development seems to be a doubling by 8-9 months.

A system of testing all blood donors was instituted by the end of 1985. So far 70.-75.000 donors have been tested, revealing two confirmed antibody positive donors, i.e. 0,02%. It must be noted, however, that donors since 1983 have been asked to withdraw voluntarily from the blood donor pool if they feel that they belong to a population group at risk.

All Norwegian haemophilia-A patients have been tested and 21, i.e. 20%, were found to be antibody positive, half of which have been infected by imported and half by indigenous blood products.

Occasional screening of i.v. drug abusers seem to suggest that some 20% of this group are antibody positive. The tested individuals belong, however, to a highly selected group of i.v. drug abusers drawn from institutions and prisons. The selection makes it difficult to interpret the result in relation to the total population of i.v. drug abusers of 3-4.000 individuals in the country.

Testing of homo- and bisexual men have given a prevalence of 10% HTLV-III/LAV antibody positive individuals in the tested population. For demographic and sociological reasons interpretation of the result is very difficult. Norwegian organizations for homosexuals have so far by and large encouraged members of this risk group to present themselves for testing, providing a psycho-social counselling service has been made available for those who are found to be antibody positive.

Strategy for prevention

In July 1985 the Director General of Health published a Control Programme for AIDS which is in the process of implementation. The Control Program comprises an epidemiological surveillance system as mentioned above (nomenclative reporting of AIDS and summary/semi-anonymous reporting of HTLV-III/LAV-infections). High risk populations (homo/bisexual men, i.v. drug abusers, haemophiliacs and the sexual partners of these groups) are offered serological testing and counselling on an individual basis. Donors of organs, sperm, blood and other human material are tested before acceptance. The screening programme was deliberately delayed, until an offer of individual counselling of seropositive individuals could be assured, and was implemented in all geographical areas by New Year 1986. The Control Programme further outlines the targets and strategy for information and dissemination of knowledge. Target groups include the public at large, high risk populations and health personnel, as well as public employees (police, prison staff, social workers, etc.) who might fear that they are at risk. The programme further outlines the counselling necessary for those who are found to be antibody positive, their sexual contacts, families and personnel involved in their treatment. Information and counselling has been, and will be also in the future, developed and executed in close collaboration with voluntary organizations and interest groups of, or close to, the

WHO-Länderberichte

population at risk. The Control Programme stresses the need for all levels of health services to prepare for the expected further development. Care and services will have to be integrated organizationally into the ordinary network of services at primary, specialist and regional levels. The administrative authorities of the various levels of services have been advised to take this into consideration in their health and social service planning management and budgeting. At regional level the Regional Medical Officers have been asked to form resource groups for implementation of the various strategies necessary at county and municipal levels and to act as advisory bodies for county and municipal health authorities. The strategy of the Control Programme is continually under revision in the Directorate of Health, and an advisory group has been in existence since 1983 at national level to keep the situation under surveillance and offer such advice as is deemed necessary.

Strategy for care and treatment

All levels of the health services have been asked to be prepared to offer individual counselling to those who have been found to be HTLV-III/LAV antibody positive, and to be ready to refer (and have referred) individual patients for such counselling. Central county hospitals have been asked to be prepared to offer necessary diagnostic and psycho-social counselling services and amenities to patients referred by the primary care level for assessment or treatment for crisis reactions, LAS/ARC, etc.

Regional hospitals are prepared to receive and treat cases of AIDS. The two regional university hospitals in Oslo are being developed as "centres of excellence" for further dissemination of knowledge and training of personnel from the country's other three regional/university hospitals. Reference laboratories are in the process of expanding their abilities for serological and virological examinations.

Research and training

The National Research Council has resolved to give priority to research on epidemiological, basic and clinical research on HTLV-III/LAV, HTLV-III/LAV infections and AIDS.

Priority is given to international meeting, seminars and courses and for study tours to improve the level of knowledge at national level for key health personnel and representatives of collaborating voluntary organizations.

At regional level health personnel involved in care and treatment of AIDS patients and HTLV-III/LAV infections receive intensive training and counselling in all aspects of the disease and its implications.

At county and municipal level the health authorities have been asked to give priority to training health personnel in the problems connected with the problems of AIDS and HTLV-III/LAV infections. Regional Medical Officers and their AIDS resource groups are involved in this training.

Finances

In 1985 and 1986 a total of NOK 26 million have been earmarked by Parliament for efforts against AIDS. So far almost 90 % of this money - primarily intended for prevention purposes - have been used to develop and improve the infrastructure (laboratory competence and capacity, etc.). Further funds have been promised by the Minister of Social Affairs. It is expected that Parliament will be asked to provide some additional NOK 50 millions in the current budgetary year for prevention of AIDS. 60 % of the money planned being used to improve services for drug abusers in an effort to stem both drug abuse and prevent spread of HTLV-III/LAV in this risk group.

Poland

Prof. Dr. W. Magdzik, National Institute of Hygiene, Warsaw

No symptomatic case of AIDS fulfilling the CDC criteria has been diagnosed in Poland till March 1, 1986. Since June 1985 till March 1, 1986 a total of 8262 serum samples was serologically examined for the presence of antibodies to LAV/HTLV-III. The examination was performed with the use of immunoenzymatic tests of Abbott, Organon and Wellcome production. The samples repeatedly positive were additionally tested by the Western-Blot technique and only those found positive by the latter method were considered as truly positive. Western-Blot confirmed positive results

were obtained with serum samples from fourteen persons. These included four homosexuals out of 199 examined (2%), seven haemophiliacs out of 482 examined (1,5%), and two prostitutes out of 668 examined (0,3%). One of these prostitutes gave recently birth to a seropositive girl. The age of the homosexual men is between 29 and 32 years, that of haemophiliacs between 1 and 22 years, and the prostitutes are 19 and 29 years of age. Among them are 11 men and 3 women. All these persons are permanent inhabitants of a few large cities including Warsaw.

Except for one homosexual, all the seropositive persons are symptomless. In this one man histopathological examination of an enlarged lymph node revealed reactive follicular hyperplasia.

According to the epidemiological data, all the seropositive persons apparently represent first generation of infection with LAV/HTLV-III in Poland. All the homosexuals and prostitutes had occasional contacts with partners from Western

Europe or USA. The haemophiliacs have been treated with Factor VIII or IX imported from Austria or USA.

No seropositive persons were detected among 68 drug addicts, 280 multiply transfused patients, 19 convalescents after surgical operations performed in Holland and USA as well as among 6176 blood donors and among 372 hospitalized patients (mostly HBsAg positive) which could not be classified to any of the high risk groups.

Portugal

Prof. Dr. L. Ayres, Coordinator of the Working Group for the Surveillance of AIDS,
National Institute of Health, Lisbon

Table 1. AIDS-Distribution by date of diagnosis

| Year | Semester | | | cases | deaths |
|-------|----------|----|---|-------|--------|
| | 1. | 2. | ? | | |
| 1983 | - | - | 1 | 1 | 1 |
| 1984 | 1 | - | - | 1 | 1 |
| 1985 | 6 | 10 | 1 | 17 | 4 |
| Total | 7 | 10 | 2 | 19 | 6 |

Table 2. AIDS-Distribution by age group and sex

| Age group | M | F | ? | Total |
|-----------|----|---|---|-------|
| 0-11 mo. | | | | |
| 1-4 y. | | | | |
| 5-9 y. | | | | |
| 10-14 y. | 1 | - | - | 1 |
| 15-19 y. | - | - | - | - |
| 20-29 y. | 3 | - | - | 3 |
| 30-39 y. | 5 | - | - | 5 |
| 40-49 y. | 4 | - | - | 4 |
| 50-59 y. | 2 | - | - | 2 |
| ≥ 60 y. | 1 | - | - | 1 |
| Unknown | 2 | 1 | - | 3 |
| Total | 18 | 1 | - | 19 |

Table 3. AIDS-Distribution by category of disease (cases and deaths)

| Category of disease | cases | deaths |
|---------------------|-------------|--------|
| OI | 11 (57,8 %) | 2 |
| KS | 4 (21,1 %) | 1 |
| OI + KS | 4 (21,1 %) | 3 |
| Total | 19 | 6 |

OI - Opportunistic Infections
KS - Kaposi's Sarcoma

Table 4. AIDS-Distribution Pathology/Groups at risk

| Groups at risk | Pathology | | | Total |
|---|-----------|----|---------|-------|
| | OI | KS | OI + KS | |
| Homosexuals or Bisexuals | 8 | 3 | 3 | 14 |
| Drug-abusers | - | - | - | - |
| Haemophiliacs | 1 | - | - | 1 |
| Homo- or Bisexuals + Drug-abusers | - | - | - | - |
| Total | 9 | 3 | 3 | 15 |

3 male, heterosexual
1 woman

1. The epidemiological surveillance of AIDS began in June 1985. It is based on a voluntary notification of cases, under strict confidentiality, no names being reported. The notification form is being modified so as to include cases of PGL and ARC as well as LAV/HTLV-III antibody positive individuals.

2. As of 31st December 1985, 19 cases of AIDS have been registered in Portugal, 6 of whom died. Tables 1 to 4 show their distribution according to date of diagnosis, age group and sex, disease category and group at risk. Five more cases have been reported during the first trimester of 1986.

3. There are 12 cases reported in people from Guinea-Bissau which are followed in a Hospital in Lisbon; a new virus was identified in the Pasteur Institute, in Paris, from one of these patients (LAV 2).

4. Steps are being taken in order that all blood donors will be tested for LAV/HTLV-III antibodies by June 1986. Up to now about 23.000 donors have been tested revealing 2 confirmed antibody positive donors. The great majority of

blood donors are not paid with the exception of a very small number that deals with private clinics. Donors are requested to withdraw voluntarily from blood donation if they belong to a population at risk.

5. Serological studies are being carried out concerning haemophiliacs, homo- and bisexual men and drug abusers with variable results from study to study which are now under consideration. No cases of AIDS have been reported among drug abusers.

6. The strategy for prevention lies mostly in the

improvement of the *Surveillance System*, in studies of the *dynamics of the infection*, in the *information* of the public in general, high risk population and health personnel with special emphasis on general practitioners and the *control* of blood and blood products.

7. AIDS cases are treated in Central and District Hospitals with conditions for the treatment of communicable diseases.

Patients with PGL and ARC as well as positive carriers are followed preferentially by General Practitioners.

Scotland

Dr. R. G. Covell, Senior Medical Officer, Scottish Home and Health Department, Edinburgh

HTLV-III/LAV-infection in intravenous drug misusers in Scotland

Only seven cases of AIDS out of the total of 305 cases from the United Kingdom up to the end of March 1986 have been registered in Scotland and none of these have been intravenous drug misusers. However, as mentioned in Dr Galbraith's paper, an unusually high level of HTLV-III/LAV antibody positivity has been discovered in groups of intravenous drug misusers in the east of Scotland. In one study of 106 serum samples collected from drug addicts in Edinburgh who attended the outpatient department or were admitted to the wards of a large general hospital in 1985, 24 males and 16 females (38 %) were confirmed as positive for anti HTLV-III/LAV. In another study of a general practice population of 164 intravenous drug misusers, also in Edinburgh, 83 (51 %) of those tested were found to have antibodies to HTLV-III/LAV; indications were that this group first became infected in the autumn of 1983. In Dundee, of 120 needle sharing drug misusers 49 % were found to be HTLV-III/LAV antibody positive. In contrast, in Glasgow, only 70 km from Edinburgh where needle sharing among drug misusers appears to be equally common, of 606 sera taken from known drug misusers in Glasgow and the west of Scotland in 1985 only 27 (4.5 %) gave confirmed positive anti HTLV-III/LAV tests. Of those 27, 20 (74 %) had a home base in or had recently moved from Edinburgh, 3 were from Dundee, only 3 were based in the west of Scotland and one had returned to Scotland after living in France. In England and Wales the level of antibody positivity in intravenous drug misusers appears to be about 11 % from reports of testing at various centres.

Though transmission of the virus amongst intravenous drug misusers by the needle is undisputed, a great deal more needs to be discovered about the relative roles of differing populations, geographical areas, drug taking habits and

management styles in determining the differing prevalence of HTLV-III/LAV infection in groups of drug misusers in differing geographical areas. A committee chosen from those interested on the one hand in the control of infection and on the other in the control of drug misuse has been set up by the Chief Medical Officer in Scotland to consider and advise on these and other problems related to HTLV-III/LAV infection and drug misuse.

Open access HTLV-III/LAV testing and counselling clinic

In October 1985 this clinic was started in the Edinburgh Regional Infectious Diseases Unit (supported by Scottish Home and Health Department on an experimental basis) to provide open access HTLV-III/LAV antibody testing and counselling coincident with the beginning of testing of all blood donations by the Blood Transfusion Service. The clinic is supervised by a consultant in infectious diseases. It operates for a 4 hour session four times a week, each session is being staffed by a doctor and a nurse counsellor. The clinic has its own telephone with an answering machine which informs callers of clinic hours. Apart from self referrals, patients may be referred by social workers, drug self help groups and general practitioners. HTLV-III/LAV antibodies are detected by an ELISA and confirmed by a different ELISA system. Doubtful positives are confirmed by immunofluorescence and Western blotting.

Of the first 100 patients studied out of a total of 170 who attended the clinic up to the end of March 1986, 91 were self referred. Forty six were intravenous drug misusers and 30 (65 %) were positive for HTLV-III/LAV antibodies. Study of these patients confirms the previous work in Edinburgh which has reported HTLV-III/LAV antibody rates of between 38 % and 51 %. Those infected are characteristically in the younger age groups, have markers of current or past infection

with hepatitis B virus and are more likely to share needles/syringes frequently. Out of 16 Edinburgh based intravenous drug misusers who had shared needles in other cities 11 (69 %) were positive for HTLV-III/LAV antibody. This together with recent reports that the HTLV-III/LAV seropositivity rate is rising in England and Wales suggests that it will not be long before other cities begin to experience similar problems to Edinburgh.

HTLV-III/LAV testing in the Scottish Blood Transfusion Service

Since mid October 1985, all donations have been tested by a competitive ELISA (Wellcome diagnostics) for antibody to HTLV-III/LAV. Any donation found reactive or equivocal is considered non transfusable regardless of the result

of the repeat screening test. All samples which are repeatably ELISA positive are confirmed by Western blot in one or two reference laboratories. A further fresh sample from the donor must be demonstrated to be Western blot positive before the donor is informed of the result.

During the period October 1985 to February 1986, 12,700 donations have been tested with a total of eight confirmed positive tests giving prevalence of one in 15,300. However taking the three east coast centres, a total of 7 confirmed positives were found in 51,970 donations, giving a prevalence of one in 7,424.

It is likely that this high prevalence in the Scottish east coast donors reflects the problem of HTLV-III infection among IVD misusers since all the 7 east coast donors give a history of drug misuse.

Spain

Dr. O. Tello, Dirección General de Salud Pública, Ministerio de Sanidad y Consumo, Madrid; Dr. M. J. Medrano, Dirección General de Salud Pública, Ministerio de Sanidad y Consumo, Madrid; Dr. R. Arrieta, Asesor del Ministro para el Plan Nacional de Hemoterapia, Madrid

1. Epidemiological situation by 18th March 1986

As of 18th March 1986, 212 possible cases of AIDS have been reported to the General Direction of Public Health, 145 of them being registered as cases of AIDS according to the criteria of the CDC definition. 93 out of these 145 patients are known to have died, creating a mortality rate of 64 %

(table 1). The probability of survival by months after diagnosis is illustrated in figure n° 1. 131 of the cases are male and 14 female. 90 % and 10 % respectively. As it is shown in table 2, almost 50 % of the cases belong to the age group 20-39 years old. This age distribution correlates with that of risk groups (table 4). These male homosexual patients, drug addicts or both, account for almost 80 % of the reported cases. It

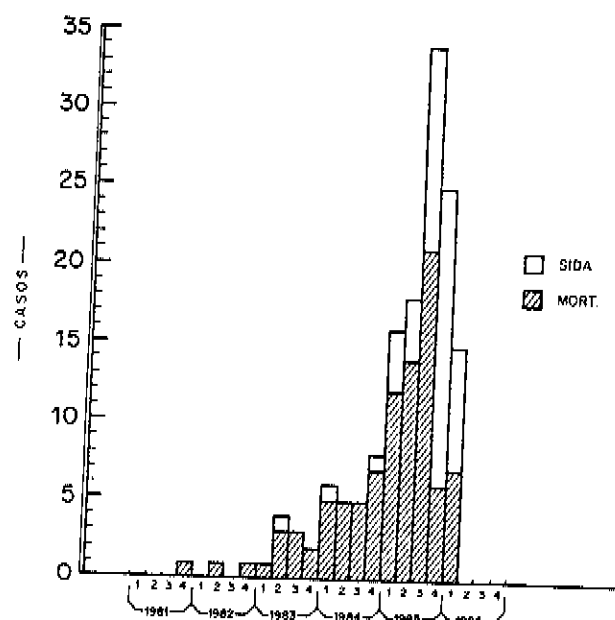
AIDS in Spain (Situation by 18th March 1986):

- N° of registered cases: 145
- Cumulated incidence rate: 3,68 (per million inhabitants)
- N° of known deaths: 93
- Case fatality ratio: 64 %
- Distribution by sex, male: 131 = 90 %, female: 14 = 10 %

AIDS in Spain (18th March 1986): distribution by age

| Age group | Cases | | Total | % |
|-----------|-------|--------|-------|-------|
| | Male | Female | | |
| 0-4 | 2 | 1 | 3 | 2,06 |
| 5-9 | 3 | | 3 | 2,06 |
| 10-14 | 3 | | 3 | 2,06 |
| 15-19 | 6 | 2 | 8 | 5,52 |
| 20-29 | 65 | 11 | 76 | 52,41 |
| 30-39 | 38 | | 38 | 26,21 |
| 40-49 | 9 | | 9 | 6,21 |
| 50-59 | 4 | | 4 | 2,76 |
| > 60 | 1 | | 1 | 0,7 |
| Total | 131 | 14 | 145 | 100 |

Distribucion de los casos de sida y mortalidad segun el trimestre de diagnostico. España a 18-marzo-1986



AIDS in females in Spain (18th March 1986):

| Risk group | Cases | Deaths | Age group | Cases | Deaths | Disease category | Cases | Deaths |
|------------------------------------|-------|--------|-----------|-------|--------|--------------------------|-------|--------|
| Drug addicts | 11 | 7 | 0-4 | 1 | 1 | K. sarcoma | 1 | - |
| Blood or blood products recipients | 1 | - | 5-9 | - | - | Other tumors | - | - |
| Parents with or at risk for AIDS | 1 | 1 | 10-14 | - | - | Opportunistic infections | 12 | 8 |
| Other/unknown | 1 | - | 15-19 | 2 | 1 | Ks + OI | 1 | - |
| | | | 20-29 | 11 | 6 | | | |
| | | | 30 | - | - | | | |

AIDS in Spain (18th March 1986): distribution by risk group and disease category

| Risk group | Disease category | | | | Cases | Deaths |
|---|------------------|---------|-----|--------------------|-------|--------|
| | KS | KS + OI | OI | Other tumors alone | | |
| 1. Male homosexuals or bisexuals | 10 | 9 | 11 | - | 30 | 19 |
| 2. I.V. drug addicts | 3 | 2 | 66 | 1 | 72 | 42 |
| 3. 1 + 2 associated | - | 2 | 6 | - | 8 | 5 |
| 4. Haemophiliacs | - | - | 25 | 2 | 27 | 22 |
| 5. Children of parents at risk for AIDS | - | - | 2 | - | 2 | 1 |
| 6. Transfusion recipients | - | - | 1 | - | 1 | 1 |
| 7. Other/unknown | - | - | 5 | - | 5 | 3 |
| Total | 13 | 13 | 116 | 3 | 145 | 93 |

AIDS in Spain (18th March 1986): distribution of cases by date of diagnosis (three-months periods)

| Year | Quarter-year of diagnosis | | | | Annual | Deaths |
|-------|---------------------------|-----|-----|-----|--------|--------|
| | 1st | 2nd | 3rd | 4th | | |
| 1981 | - | - | - | 1 | 1 | 1 |
| 1982 | - | 1 | - | 1 | 2 | 2 |
| 1983 | 1 | 4 | 3 | 2 | 10 | 9 |
| 1984 | 6 | 5 | 5 | 8 | 24 | 22 |
| 1985 | 16 | 18 | 34 | 25 | 93 | 52 |
| 1986 | 15 | | | | 15 | 7 |
| Total | | | | | 145 | 93 |

should be noted that more than a half of the total number of cases (55 %), and 61 % of the adult patients belong to the risk group of drug addicts. These data specially concern the Spanish health authorities because it means that special measures should be adopted to protect this group as well as to strengthen efforts to control drug addiction in our country. Groups other than homosexuals present opportunistic infections most frequently, while Kaposi's sarcoma is more frequent in male homosexuals or bisexuals. Table 5 shows the distribution of paediatric cases under 15 years old, by risk group. Data on the female cases are reflected in table 3. Most of the cases concentrate in the big cities, and all of them are of Spanish origin except for 1 from USA and 1 from the UK. The first AIDS case was diagnosed in 1981 and since then the number of cases has

enlarged exponentially as shown in the table. Figure 2 shows the epidemic curve of the AIDS epidemic in Spain. We have predicted the number of cases expected to occur in the next two years on the basis of a polynomial regression model, as illustrated in the table.

2. Approach of the AIDS epidemic in Spain

As a first measure it was established a surveillance system based on a special epidemiological record for reporting suspected cases. Notification of cases is voluntary, and a so-called National working group on AIDS, constituted by 12 experts, studies each report in their regular meetings. The case is considered as AIDS only when data completely fulfill the CDC definition. Only full-blown AIDS cases are included in

Table 1. HTLV-III/LAV antibody prevalence in cases with clinical symptoms

| Syndrome | N° tested | Positives | | Negatives | |
|---------------------------------------|-----------|-----------|-----|-----------|----|
| | | N° | % | N° | % |
| AIDS | 26 | 26 | 100 | 0 | 0 |
| ARC | 180 | 131 | 73 | 49 | 27 |
| Immunocompromised patients | 489 | 277 | 57 | 212 | 43 |
| Congenital or neonatal infections (1) | 49 | 27 | 55 | 22 | 45 |
| Hepatitis (2) | 16 | 2 | | 14 | |
| Pneumonia (2) | 3 | 1 | | 2 | |
| Encephalopathies | 4 | 0 | | 4 | |
| Total | 767 | 464 | | 303 | |

(1) Includes newborns from mothers who are drug addicts with or without symptoms.

(2) From persons belonging to risk groups without any other symptoms suggestive of AIDS.

Table 2. Prevalence of antibodies to HTLV-III/LAV samples from high risk groups without symptoms

| Group | N° tested | Positives | | Negatives | |
|-----------------------------|-----------|-----------|------|-----------|------|
| | | N° | % | N° | % |
| IV Drug addicts | 511 | 331 | 64.8 | 180 | 35.2 |
| Unselected male homosexuals | 198 | 33 | 16.7 | 165 | 83.3 |
| Haemophiliacs (1983) | 71 | 54 | 76.1 | 17 | 23.9 |
| Haemophiliacs (1985) | 307 | 209 | 67.6 | 98 | 31.7 |
| Prostitutes | 19 | 1 | 5.3 | 18 | 94.7 |
| STD (1) | 373 | 26 | 7.0 | 347 | 93 |
| Other (2) | 193 | 31 | 16.1 | 162 | 83.9 |
| Unknown | 58 | 24 | 41.4 | 34 | 58.9 |
| Total | 1732 | 709 | 40.9 | 1021 | 58.9 |

(1) Unselected patients from one STD clinic not suspected of AIDS.

(2) Sexual contacts with AIDS cases, ARC or seropositive individuals. Health care workers from an haemophilia clinic and others.

Table 3. Antibodies to HTLV-III/LAV positive sera received for confirmation. High risk groups and blood donors (1985)

| Group | Samples received | Confirmed as positives | | Results not yet available |
|-------|------------------|------------------------|------|---------------------------|
| | | N° | % | |
| DR | 902 | 832 | 92.3 | 1 |
| HO | 92 | 79 | 85.7 | - |
| HE | 170 | 152 | 89.4 | - |
| DSR | 120 | 116 | 97.5 | 1 |
| O | 160 | 92 | 57.5 | - |
| N.C. | 408 | 291 | 73.3 | 11 |
| DS | 186 | 33 | 17.7 | - |
| Total | 2038 | 1595 | 78.8 | 13 |

DR: (IV drug addicts).

HO: (male homo/bisexuals)

HE: (haemophiliacs)

DSR: (paid blood donors) this represented 1.4 % of all blood donations in Spain and has been completely forbidden since 1985.

O: (other groups)

N.C.: (unknown)

DS: (altruist blood donors)

*: % over total number of samples with final result.

Table 4. Antibodies to HTLV-III/LAV positive sera received for confirmation high risk groups and blood donors geographical distribution (1985)

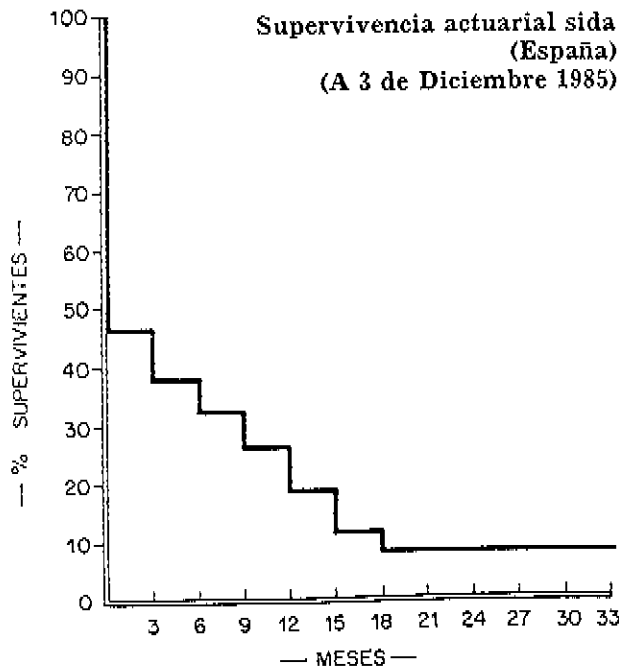
| Risk group | HO | | DR | | HE | | O | | DS | | DSR | | NC | |
|--------------------|-----------|-----------|------------|------------|------------|------------|------------|-----------|------------|-----------|------------|------------|------------|-----------------|
| | S | C | S | C | S | C | S | C | S | C | S | C | S | C |
| Andalucía | 0 | 0 | 21 | 21 | 7 | 7 | 1 | 0 | 9 | 0 | 1 | 1 | 31 | 24* |
| Aragón | 3 | 3 | 65 | 62 | 18 | 17 | 10 | 9 | 11 | 3 | 0 | 0 | 1 | 1 |
| Asturias | 3 | 2 | 65 | 53 | 17 | 17 | 12 | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Baleares | 1 | 1 | 17 | 14 | 28 | 21 | 6 | 4 | 4 | 3 | 0 | 0 | 19 | 19 |
| Canarias | 0 | 0 | 0 | 0 | 22 | 21 | 4 | 1 | 1 | 0 | 0 | 0 | 22 | 29 |
| Cantabria | 0 | 0 | 15 | 15 | 1 | 1 | 19 | 7 | 0 | 0 | 0 | 0 | 4 | 3 |
| Castilla-León | 0 | 0 | 6 | 6 | 4 | 4 | 6 | 0 | 9 | 0 | 0 | 0 | 1 | 0 |
| Castilla-la Mancha | 0 | 0 | 4 | 4 | 1 | 0 | 1 | 1 | 3 | 1 | 0 | 0 | 0 | 0 |
| Cataluña | 49 | 47 | 98 | 95** | 3 | 2 | 25 | 17 | 39 | 11 | 0 | 0 | 36 | 28 |
| M. Valenciana | 6 | 2 | 67 | 52 | 1 | 1 | 9 | 5 | 1 | 0 | 12 | 11 | 0 | 0 |
| Extremadura | 0 | 0 | 0 | 0 | 4 | 4 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Galicia | 0 | 0 | 5 | 5 | 2 | 2 | 3 | 1 | 10 | 1 | 0 | 0 | 18 | 8 |
| Madrid | 23 | 21 | 165 | 146 | 4 | 3 | 31 | 26 | 71 | 13 | 0 | 0 | 127 | 89 |
| Murcia | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 105 | 102*** | 0 | 0 |
| Navarra | 5 | 1 | 199 | 197 | 11 | 11 | 1 | 1 | 8 | 0 | 0 | 0 | 4 | 0 |
| Pais Vasco | 2 | 2 | 160 | 148 | 47 | 41 | 21 | 7 | 18 | 1 | 0 | 0 | 122 | 89**** |
| Rioja | 0 | 0 | 10 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 23 | 11 |
| Ceuta y Melilla | 0 | 0 | 5 | 4 | 0 | 0 | 10 | 8 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 92 | 79 | 902 | 832 | 170 | 152 | 160 | 92 | 186 | 33 | 120 | 116 | 408 | 291..... |

Total cases: S: 2038 C: 1595

S: number of sera sent // C: number of sera confirmed. HO: (male homo/bisexuals). DR: (IV drug addicts). HE: (haemophiliacs). O: (Other groups). DSR: (paid blood donors) this represented 1.4 % of all blood donations in Spain and has been completely forbidden since 1985. DS: (altruist blood donors). NC: (unknown). *: 3 results pending. **: 1 result pending. ***: 1 result pending. ****: 8 results pending. *****: 11 results pending.

the statistics and reported to the WHO Center in Paris. Local, Regional and National Health Authorities, the National working group on AIDS and the National Reference Laboratory of Majadahonda periodically publish recommendations for the prevention of AIDS as well as all the

available epidemiological information. When serological tests were available other specific measures were adopted, such as the blood donation screening for LAV/HTLV-III antibodies, in a large multicentric study carried out by our Laboratory of reference. Since 1985 it is compulsory for plasma industries to test every unit of plasma before its commercial setting. All blood products must be tested and labelled with a "HTLV-III negative" ticket. Factor VIII must be heat-treated. All blood donors are asked to exclude themselves from donation if they belong to a known group of risk. All these measures are aimed to control the AIDS transmission through blood and blood products. Other ways of transmission are prevented mostly through information and health education.



Pediatric cases of AIDS in Spain (< 15 years old) (18th March 1986)

| Risk group | Cases |
|-------------------------------------|----------|
| 1. Parents with or at risk for AIDS | 2 |
| 2. Haemophiliacs | 6 |
| 3. Transfusion recipients | 1 |
| 4. Other/unknown | - |
| Total | 9 |

Table 5. Prevalence of antibodies to HTLV-III/LAV in sera from altruist blood donors in Spain

| Region | N° of donations tested | N° positives in origin | N° confirmed | Seropositives per 1000 |
|-----------------|------------------------|------------------------|--------------|------------------------|
| Andalucía | 1842 | 6 | 0 | 0 |
| Aragón | 2330 | 8 | 3 | 1.28 |
| Baleares | 5039 | 5 | 3 | 0.58 |
| Canarias | 2328 | 2 | 0 | 0 |
| Castilla-León | 817 | 5 | 0 | 0 |
| Extremadura | 1969 | 1 | 0 | 0 |
| Galicia | 3109 | 9 | 1 | 0.32 |
| Madrid | 14306 | 85 | 13 | 0.90 |
| Navarra | 6153 | 8 | 0 | 0 |
| Pais Valenciano | 452 | 1 | 0 | 0 |
| Pais Vasco | 483 | 5 | 0 | 0 |
| Melilla | 96 | 1 | 0 | 0 |
| Total | 38924 | 136 | 21 | 0.53 |

Sweden

Prof. Dr. M. Böttiger, National Bacteriological Laboratory, Stockholm

The first cases of AIDS, ARC and LAS were observed in Sweden in 1982. Since March 1983 AIDS has been obligatory to report to the national epidemiologist. Until today, April 1986, 50 cases were reported. Forty-five of the cases concern homosexual men, the remaining five include 3 haemophiliacs, 1 man who lived in Africa and one man with no known riskfactor.

Statistical data are given in the attached tables. Testings for LAV/HTLV-III infection started in the summer of 1984 first by use of a "dot blot" method and later - when available - different commercial kits. Western blotting was used for confirmation. Reporting of antibody positive individuals together with epidemiological data was made obligatory in November 1984 when LAV/HTLV-III infection also was included among the venereal diseases regulated by law. Only part of the person's so-called person-number is reported to ensure confidentiality.

Reports are also sent directly from the laboratories giving both the total number of tests performed and the numbers of positive persons. In summary close to 40.000 tests from persons other than blood donors have been performed (as some persons have been tested several times especially from the high risk groups the figure does not give the number of persons tested). The figure of antibody positive persons reported is about 1000. Half of these persons were homo- or bisexual, about one third drug addicts and 100 infected by blood products. For 15 persons heterosexual contact in Sweden is given as route of infection.

Of the known LAV/HTLV-III antibody positive homosexual men thus 9 % were diagnosed as AIDS and up to half of them are estimated to have

some symptoms due to the infection. The last year about 10 cases of acute mononucleosis like LAV/HTLV-III infection were observed. Among the drug addicts none so far has developed AIDS but about 20 have some symptoms. Two out of 92 infected haemophiliacs have developed AIDS.

All blood donations are tested. From the first 260,000 units tested 6 positive persons were disclosed. 13 persons infected by blood transfusions have been discovered.

A number of preventive measures have been undertaken. It goes without saying that written information has been distributed to all categories of people involved in the AIDS problems and to the general public.

Among other measures than information and building up laboratory facilities the following can be mentioned:

Special clinics for homosexual men were set up in the major cities already in 1982.

Medical teachers from different specialities have given numerous lectures all over the country and also trained further teachers.

Support is provided to associations representing the interests of the groups at risk.

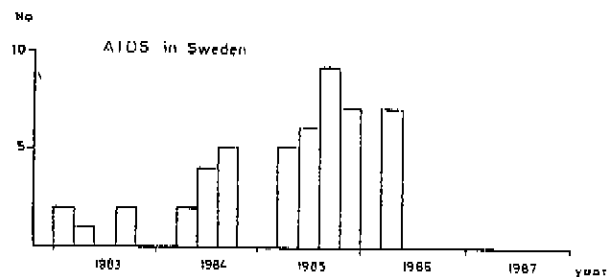
Psychosocial counselling to infected people and the "worried well" is given.

LAV/HTLV-III antibody tests on blood donors

| Total no tested | Screen (%) pos | Western-Blot pos |
|-----------------|----------------|------------------|
| 259 499 | 653 (0.25 %) | 6 |

WHO-Länderberichte

A considerable improvement of the care of drug addicts beginning with case finding and ending with expanded care facilities has been initiated. Videofilms for hospitals and school children are available. Mass media are very active. In April 1986 the parliament agreed to contribute 200 million Sw crowns - that is 25 million dollars - to the fight against AIDS.



| AIDS cases (n = 50) (March 31st 1986) | Number Deaths | | |
|---|-----------------|----|----|
| Category | Stockholm area | 33 | 20 |
| Homo/bisex. 45 | Gothenburg area | 3 | 1 |
| Haemophiliac 3 | Malmö area | 11 | 6 |
| Heterosex. 2 | Other parts | 3 | 2 |
| | | 50 | 29 |

LAV/HTLV-III antibody positive persons reported from physicians up to March 31, 1986

| Category | ♂ | ♀ | Total |
|---|-----|-----|-------|
| HS/BS | 517 | - | 517 |
| I.v. drug ad. | 185 | 103 | 288 |
| Blood products (F VIII, IX, transf.) | 86 | 6 | 92 |
| Heterosex. contact | 6 | 9 | 15 |
| Foreigners | 10 | 8 | 18 |
| Not specified | | | 9 |
| | | | 939 |

Reports from laboratories of total number tested for HTLV-III antibodies

| Date | Accumulated number of tests | | |
|----------|-----------------------------|-------------------|-----------------|
| | HS/BS | i.v. drug-addicts | Other/no inform |
| Oct. 85 | 3.700 | 3.000 | 13.700 |
| Dec. 85 | 4.000 | 4.800 | 23.500 |
| Febr. 86 | 4.400 | 5.600 | 28.200 |

Reports of LAV/HTLV-III antibody positive tests from laboratories

| Date | Accumulated number of positive tests | | | |
|----------|--------------------------------------|-------------------|----------------|-----------------|
| | HS/BS | i.v. drug-addicts | Blood products | Other/no inform |
| Oct. 85 | 470 | 223 | 108 | 122 |
| Dec. 85 | 540 | 279 | 108 | 144 |
| Febr. 86 | 560 | 307 | 108 | 171 |

Total number positive tests 1.146

United Kingdom

Dr. N. S. Galbraith, Director, PHLS Communicable Disease Surveillance, Centre, London

Acquired immune deficiency syndrome (AIDS)

During 1985, 167 cases were reported to the Communicable Disease Surveillance Centre (CDSC), compared with 77 in 1984, 28 in 1983 and 3 in 1982; a total of 275 since surveillance began. Altogether, 140 deaths were reported, a case fatality ratio of 51 per cent, but calculated by date of first presentation to medical care the case fatality ratio was 77 per cent for cases presenting in 1983 or before and 38 per cent for cases presenting in 1984 and 1985. Most of the cases (79 per cent) were reported by physicians in clinics in the four Thames National Health Service regions in south-east England, a proportion which has not changed significantly since the beginning of the epidemic. Of the 275 cases reported up until the end of 1985, 265 were in males and 10 in females (table). Of the 265 males, 245 (93 per cent) were homosexual or

bisexual, 9 (3 per cent) were haemophiliacs, 4 (2 per cent) had had blood transfusions, one of them overseas, and 2 (1 per cent) were intravenous drug abusers although there were two others who were also homosexual. There were 5 male cases who denied any of these 'risk' factors, 3 were probably homosexuals or drug abusers, 1 had resided in Subsaharan Africa and 1 had had multiple female sexual partners. Of the 10 cases reported in females, 5 had resided in Africa, 1 was a sexual contact of an African and 1 had cared for an African patient at home, 2 others were heterosexual contacts of males in 'risk' groups and 1 was a recipient of a blood transfusion overseas.

HTLV-III/LAV-Infection

In the UK between July 1982 and May 1984 there was a five fold increase in the prevalence of HTLV-

III/LAV antibody amongst British homosexual men attending one London clinic at which sera were taken for syphilis serology, from 3.7 per cent to 21.0 per cent. Higher rates of 34 per cent and 35 per cent were obtained in other more recent studies in 1984 and 1985, although the samples examined may have included a higher proportion of homosexuals with clinical HTLV-III/LAV disease. Amongst homosexuals attending clinics outside London the prevalence of antibody was lower but more than doubled between 1984 and 1985, from 5 per cent to 11 per cent. Although a fall in acute gonorrhoea in homosexual men in one London clinic and a decline in national clinic returns of acute gonorrhoea in males aged 25 years and over suggests that homosexuals may be changing their behaviour and reducing their number of sexual partners, this does not yet appear to have influenced the rise in seroprevalence. A further rise in the number of reported cases of AIDS may, therefore, be expected in 1986 both in London and in the provinces. One statistical projection based on cases presenting up until the end of 1984 gave a national figure of 336 for 1986 but with wide 95 per cent confidence limits of 127 to 889. A rise in the prevalence of HTLV-III/LAV antibody was also observed in intravenous drug abusers from 1.5 per cent in 1983 and 1984 to 11 per cent in 1984 and 1985, but in one group of 164 intravenous drug abusers in Edinburgh, 51 per cent were seropositive by the end of 1985. Although only 4 cases of AIDS have so far been reported in intravenous drug abusers in the UK two of whom were homosexual, these data indicate that there is likely to be a substantial increase in the next few

Table. AIDS surveillance up to december 1985 patient characteristics

| Patient characteristic | Male | Female | Deaths |
|--------------------------------------|------------|-----------|------------|
| Homosexual/bisexual | 245 | - | 119 |
| Haemophilia | 9 | 0 | 8 |
| Recipient of blood | 4 | 1 | 4 |
| Intravenous drug abuser | 2 | 0 | 1 |
| Heterosexual contact | 0 | 2 | 1 |
| Visited USA/Caribbean, possibly risk | 3 | 0 | 1 |
| Associated with sub-saharan Africa: | | | |
| direct | 1 | 5 | 6 |
| indirect | 0 | 2 | 0 |
| Other | 1 | 0 | 0 |
| Total | 265 | 10 | 140 |

years, together with the appearance of cases in infants of infected drug-abusing mothers. Amongst haemophiliacs the seroprevalence of about 30 per cent has shown no recent increase, indicating that preventive measures have been effective in halting the spread of infection in this group. The prevalence of HTLV-III/LAV antibody in British blood donors was low, nil out of 1042 donors in 1984 and with the advent of universal donor screening in October 1985, further transfusion associated cases are very unlikely to occur. The results of donor screening in the last 3 months of 1985 indicate that there is minimal, if any spread of HTLV-III/LAV into the general population. Of 604,706 donors tested, 13 were seropositive and on detailed investigation 11 of them were found to be in high risk groups.

Yugoslavia

Dr. V. Burek, Medical School Clinics for Infectious Diseases, Zagreb

September, 1983: On the basis of data obtained mostly from WHO Weekly Epidemiological Record and CDC MMWR, the Federal Institute of Public Health issued an Information on AIDS for Health Personnel (containing incidence, epidemiology, clinical features, criteria for diagnosis, preventive measures, including recommendations for health staff dealing with AIDS patients and their biological material).

November, 1983: Following the Aarhus meeting on AIDS in Europe - Status quo 1983, the above mentioned Information was reviewed and innovated in conformity with the Recommendations adopted in Aarhus.

December, 1983: A National Committee for AIDS was established (consisting of virologists, immunologists, pathologists, skin specialists, epidemiologists and hematologists).

December, 1983: The first meeting of the National Committee for AIDS agreed to authorize, for the time being, only three university hospitals

(Belgrade, Zagreb and Ljubljana) for treatment of AIDS patients and suspected cases because of limited experience other similar institutions have in determining clinical and laboratory diagnoses.

July 1985: "Prevalence of anti-HTLV-III among high risk populations in Yugoslavia" Meeting organized by Academy of Croatian medical association, Zagreb.

July, 1985: The Federal Institute of Public Health was designated the Collaborating Centre for AIDS in Yugoslavia (contact person: Dr. S. Litvinjenko) and the Institute of Microbiology of the Medical School of Ljubljana was designated the AIDS Reference Laboratory (Chief: Prof. M. Likar).

July, 1985: The National Committee for AIDS developed and adopted a procedure for referral of suspected cases by GPs to one of the three university hospitals and for requirements to be fulfilled by the university hospitals in the final confirmation of the diagnosis. If clinical diagnosis was

supported by two positive ELISA tests, a blood sample of the patient has to be sent to the Reference Laboratory for the Western-Blot technique. If positive, the Collaborating Centre (FTPH) confirms the diagnosis on the basis of clinical and laboratory findings.

Since the end of 1984 (November), the testing of sera in donors blood and high risk persons has been initiated in various parts of the country (more than 40 towns). (See the results in the attached table).

September 1985: The national programme covering 5 % of general population and persons belonging to the groups providing testing of blood, relevant epidemiological investigations and measures was adopted in order to ensure a unique methodological approach and comparability of data obtained a group of specialists developed a working protocol comprising uniform questionnaires for every group at risk (forms attached).

September, 1985: The National Committee concluded that testing the blood of all blood donors is professionally justified and that there is an urgent need to establish facilities for this purpose in all blood banks. In the meantime, according to the National programme, 5 per cent of bottles collected annually will be tested (approx. 40,000). The blood banks are advised to inform donors through leaflets that persons belonging to some risk group should refrain from donation.

The Federal Institute of Public Health has prepared an Information for general population containing the essential data on the nature of the disease, the mode of transmission, risk groups, protective measures, etc. (attached).

The Federal regulation providing a compulsory notification of cases, deaths and carriers of antibodies, epidemiological investigation in the family and close surroundings is pending adoption.

The Information for Health Workers translated from WHO Chronicle, Vol. 39, No. 3, has been disseminated to all health services.

Since May, 1985, the Federal Institute of Public Health has established a collaborating on information exchange with the WHO Collaborating Centre on AIDS in Paris.

October, 1985: "AIDS - What is AIDS and How to Protect Yourself", a book by Dr. V. Šuvaković, member of the National Committee for AIDS, was published. It includes the information for general population on the disease prepared by the Federal Institute of Public Health.

April, 1986: The Serbian Medical Association organized a Symposium on epidemiological, clinical, and laboratory aspects of AIDS and preventive measures implementation, intended for physicians.

So far, three AIDS cases were registered in Yugoslavia:

| | 1985 | 1986 |
|-------------------|------|------|
| Homosexual | 1 | - |
| African - Namibia | 1 | |
| Haemophilic | - | 1 |

Form for Haemophiliacs

Date of Interview:
 Name and Family Name, Year of Birth, Sex:
 Occupation:
 Place of Birth:
 Place of Residence:
 Kind of Hemophilia (Degree of Manifestation):
 Medications Received:
 Preparation Origin:
 Date of the first Preparation Received:
 Total amount of Preparation Received:
 Blood Transfusion:
 Laboratory Findings:

If Seropositive
 Sexual Contacts:

Form for Homosexuals/Bisexuals

Date of Interview:
 Name and Family Name, Year of Birth, Sex:
 Occupation:
 Birth Place:
 Places of Residence in the past ten years:
 Nationality:
 Since when has Practiced Homosexual Relations:

Frequency of Homosexual Relations:
 Number of Partners (Monthly, Annually):
 Foreign countries Visited in the past ten years:
 Blood Transfusion:
 Belonging to other risk Groups:
 Laboratory Findings:

Form for i. v. Drug Addicts

Date of Interview:
 Name and Family Name, Year of Birth, Sex:
 Occupation:
 Place of Birth:
 Place of Residence:
 Nationality:
 Since when has been taking drugs:
 How often:
 Type of drug:
 Sharing of Syringes:
 Places Visited in the past ten years:
 Foreign countries Visited in the past ten years:
 Blood Transfusion:
 Belonging to other Risk Groups:
 Laboratory Findings:

If Seropositive
 Sexual Contacts:

Blood tested for LAV/HTLV-III antibodies in Yugoslavia by 31.3.1986

| Group | Tested | Positive | P.C. |
|---|---------|----------|------|
| Blood donors | 22,006 | - | - |
| Homo/bisexuals | 239 | 6 | 2,5 |
| IV drug users | 496 | 165 | 33 |
| Haemophiliacs | 253 | 32 | 12,6 |
| Patients on haemodialysis | 301 | 3 | 1 |
| Prisoners (drug users, vagabonds, etc.) | 200 | 11 | 5,5 |
| Patients with other STD | approx. | - | - |
| Students from African countries | 14 | - | - |
| Persons from various risk groups | 75 | - | - |
| Health workers | 45 | - | - |
| | 500 | - | 4,4 |
| Total | 24,219 | | |

USSR

Dr. Takir Bektimirov, Moscow, Institute of Virology, USSR, did not present a written paper. In his oral report Dr. Bektimirov indicated that there are no clinical cases as yet in the USSR but only 3 suspected positives. The examination of blood donors and risk groups has been initiated. He maintained that restrictive policy in respect of homosexuality is preventing the rapid spread of AIDS in the USSR.*

* At the International Conference on AIDS in Paris, 23.-25. June 1986, Prof. Victor Zdanov, virologist from Moscow, reported of 12 positives at his institution which is one of four hospitals where AIDS is taken care of in Moscow. Among 8 patients there are Africans and persons from other areas, about half of them are from the USSR. The first case was a 14 year old girl who received multiple transfusions at the age of 2. She has lymphadenopathy but no other symptoms. Zdanov concluded that the infection must have taken place in 1974. Among the patients two are in a critical state.

Japan

Dr. Y. Shiokawa, Chairman, AIDS Research and Investigation Committee, Ministry of Health and Welfare, Tokyo, Dr. F. Kumagai, Dr. S. Morio, Director, Deputy Director, Office of Infectious Diseases Control, Health Service Bureau, Ministry of Health and Welfare, Tokyo

In 1981, when the first case of AIDS was found in the USA, Japanese scientists and Government officials were prepared that Japan would be put under influence of AIDS problems in some days.

The Japanese Government has taken the following steps by today:

1. Establishment of an AIDS Research and Investigation Committee Supported by the Government

In June 1983, the Ministry of Health and Welfare formed "The AIDS Research Committee" headed by Dr. Takeshi Abe. The purpose of this committee was to investigate AIDS from various fields such

as internal medicine, virology, haematology and immunology.

In September 1984, "The AIDS Research and Investigation Committee" chaired by Dr. Yuichi Shiokawa, was organized in order to undertake diagnosis of AIDS patients and to formulate policy for preventive measures.

2. Establishment of AIDS Surveillance System for Early Detection and Prevention of Secondary Infection

Second step taken by the Ministry is the establishment of AIDS Surveillance System for early detection and prevention of secondary infection.

WHO-Länderberichte

In September 1984, the Director General, Health Service Bureau, Ministry of Health and Welfare, asked about 600 general hospitals with more than 300 beds to report AIDS cases to him through each Local Government Office. The Director General provided the hospitals with "The Guideline of Clinical and Immunological Diagnosis for AIDS" and "The Report Form" to support the above mentioned surveillance system. In July 1985, he also provided "The Precaution for AIDS Cases".

In addition to the surveillance system, the Ministry approved ELISA (Enzyme Linked Immuno Sorbent Assay) kit as pharmaceuticals, and added this kit to one of laboratory tests in national health insurance, so every medical facilities became to be able to test LAV/HTLV-III antibody. The Ministry made one national institute of health and 8 local governmental institutes of health be able to test the antibody by IFA (Immuno Fluorescence Assay) to confirm antibody positive cases by ELISA.

3. Prevalence of AIDS in Japan

On March 22, 1985, "The Research and Investigation Committee" reported the first Japanese case of AIDS, who was a male homosexual, an artist aged 36, living in the USA. He returned to Japan after 16 years' stay in foreign countries, and visited a hospital in Tokyo. As of the end of March, the committee has confirmed 14 cases of AIDS as meeting the criteria for case detection. Among those 14 patients, 7 are male homosexuals, and 7 are haemophiliacs. All patients were proved to be positive for serum LAV/HTLV-III antibody, and had a decreased OKT 4/OKT 8 ratio. As regards opportunistic infection, 7 had *Candida albicans* infections, and 4 had *Pneumocystis pneumonia*. 9 of 14 patients are known to have died.

Difference from AIDS patients with AIDS in the USA and Western Europe might be a high propor-

tion of cases with haemophilia, in particular haemophilia B (3 of 7 haemophiliacs), and with *Candida albicans* infections.

From retrospective diagnoses of 14 cases, the first case in Japan appeared in 1981. The onsets of AIDS had started as follows, two cases in 1982, four cases in 1983, two cases in 1984, five cases in 1985.

It was reported that 30 percents of patients with haemophilia and 5 percents of healthy homosexuals in Japan showed a positive antibody for LAV/HTLV-III. The number of patients with AIDS will continue to increase, as in other countries of the world.

4. Steps for Safe Blood

There are approximately 5000 haemophiliacs in Japan. The cause of AIDS infection among them was through the use of contaminated blood products from foreign countries. The steps taken by Government are as follows:

1. the heat treated Factor VIII products are available in and after September 1985.
2. the heat treated Factor IX products are available in and after December 1985.
3. the health check by questioner was made more strict in order to exclude members of high risk groups of AIDS from donating blood in and November 1985.
4. Donating blood in some large cities where there can be many high risk groups of AIDS was tested for LAV/HTLV-III antibody in and after February 1986.

5. Health Education

The Ministry asked every local governments to set counselling system to residents in July 1985. Today about 3/4 of local governments have set counselling system using health centers or medical facilities. The Ministry has supported publishers to publish books or booklets for residents.

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