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**AN ASSESSMENT OF THE HIV/AIDS/STD
SITUATION IN ROMANIA**

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Confidentiality of Data

A number of individuals mentioned in this report kindly provided unpublished data to the assessment team to help in our understanding of the HIV/STD situation in Romania. Data in this report should be considered confidential, and were provided only for the purpose of this assessment. These data should not be reproduced, presented or published in any other context outside this assessment report.

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Acronyms

ARAS	Romanian Association Against AIDS
AIDS	Acquired Immunodeficiency Syndrome
CSWs	Commercial sex workers
ENAAADS	European Non-Aggregate Data Set
ELISA	Enzyme-linked immunosorbent assay
HIV	Human Immunodeficiency Virus
IDU	Injection Drug User
IE&C	Information, Education and Communication
NGO	Non-governmental Organization
PSI	Population Services International
STD	Sexually Transmitted Disease
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UNDP	United Nations Development Programme
UNFPA	United Nation's Population Fund
WHO	World Health Organization

Executive Summary

The major focus of this consultation was to evaluate the current HIV situation in Romania, assess current prevention activities for HIV and other STDs, and make recommendations concerning future areas of USAID involvement. During this evaluation, four consultants conducted interviews in Bucharest and (for one day) in the port city of Constanta on the Black Sea. Documents supplied by USAID or collected during the visit to Romania were also reviewed.

The HIV epidemic in Romania is characterized by a complex and changing situation. A major wave of HIV infection occurred in Romanian children in the late 1980's, due to repeated injections and blood transfusions (typically in the amount of 50-100 ml). Although we cannot rule out the possibility that some nosocomial transmission is still occurring, such transmission seems largely to have ended, reflecting screening of the blood supply and government interventions promoting infection control. However, largely as a consequence of this major wave of HIV infection, new cases of AIDS are continuing to develop in Romanian children. As of September 30, 1997, a total of 4,376 cases of pediatric AIDS have been reported in Romania.

At the same time, some HIV infection is occurring in adults, although levels, trends and risk factors have not been well defined. A total of 529 cases of AIDS in Romanian adolescents and adults have been reported as of September 30, 1997, with a male:female ratio of 1:1. New HIV infections representing vertical transmission are occurring in children, and can be expected to increase as the number of HIV-infected women also grows. There are anecdotal reports of HIV infection in a number of adult groups, including sailors (especially those traveling to foreign countries), female commercial sex workers, STD patients and prisoners. These reports are consistent with HIV infection through unprotected sexual intercourse. Increases in unprotected sexual contact are also supported by rising rates of syphilis. The number of reported syphilis cases rose from < 2,000 cases in 1986 to 7,277 cases in 1996.

Adolescents and young adults represent one group which may engage in unsafe sexual intercourse increasing the risk of HIV and other STDs. Of 2,025 cases of syphilis during 1996 among women in urban areas, 22% were age 15-19 and 48% age 20-29 years. In a 1996 reproductive health survey of young people aged

15-24 years, women who reported that their first sexual intercourse was premarital were asked about their contraceptive use at the time of this first intercourse; only 13% reported condom use. When men who reported that their first sexual intercourse was premarital were asked the same question, only 16% reported condom use.

Prevention efforts for HIV and other STDs in Romania face a number of important obstacles. The present surveillance system for HIV in Romania is not adequate to evaluate past, current or future trends. The Romanian government has neither articulated nor implemented a systematic, comprehensive national strategy for HIV prevention. Government efforts which have been articulated focus primarily on testing issues (such as screening the blood supply), or on medical issues. Present government efforts and the current climate do not target specific groups at increased risk for HIV infection. Options for voluntary, anonymous HIV testing (in which names are not recorded) are very limited and not easily accessible. Although condoms are available, they are not commonly used. There is no comprehensive, systematic inclusion of AIDS education in the school health curriculum. STD management and treatment appears variable, with use of different treatment strategies in different settings. Suboptimal, prolonged or incorrect treatments may be used in some settings, including use of drugs to which a patient's infection is resistant.

Most nongovernmental organizations are focusing on the important issue of care and support of those children who are already HIV-infected. However, there are a few NGOs that are making major contributions to HIV prevention in Romania. Most notable is the Romanian Association Against AIDS (ARAS). However, despite their important role, NGOs typically work with no financial backing, leadership or support from the government.

The most important overall priority for new USAID action should be to support expanded efforts in Romania for primary prevention of new HIV infections in adolescents and adults, particularly those persons who are infected through unsafe sexual contacts. The team developed five specific recommendations for USAID involvement. In all of these recommendations, it is essential that there be a full partnership between outside consultants and Romanians. With the assistance of the local USAID Mission, key individuals in Romania should be included in both the planning and implementation phases. Although all recommendations are important, we felt that #1 and #2 are the most critical. These recommendations are:

1. USAID should provide support to the Romanian Association Against AIDS (ARAS) and other NGOs for their HIV and STD prevention activities.

2. USAID should support a technical assessment team to Romania to conduct a systematic review of the HIV/AIDS surveillance system.
3. USAID should support expanded efforts in Romania to reduce high-risk, unsafe sexual behaviors in youth.
4. USAID should explore opportunities to expand condom marketing programs into a national AIDS awareness campaign.
5. USAID should fund a team to systematically evaluate current strategies and policies for STD management and treatment in Romania. This team should also make recommendations concerning ways to better integrate HIV and STD prevention and control.

Sexual transmission (particularly heterosexual transmission) of HIV may represent the next major wave of the AIDS epidemic in Romania, and there is considerable potential for such an epidemic to occur. By the time cases of AIDS appear, large numbers of individuals may already have acquired HIV. The objective is therefore to prevent the spread of the epidemic before it gets out of control.

I. Methodology and Scope of Work

A team of three consultants (Alan Lifson, Team Leader; Françoise Hamers; and Elizabeth Preble) and one member of USAID/Washington (John Novak) visited Romania between November 15 and November 22, 1997. Specific issues included in the scope of work included defining the current epidemiology of HIV/AIDS and other STDs; reviewing diagnostic and treatment procedures of HIV/AIDS and STDs; evaluating HIV/AIDS prevention/intervention systems, resources and strategies (including prevention barriers); identifying HIV/AIDS country strategies; evaluating condom availability and promotion; and describing other donor and organizational inputs into the HIV/STD situation.

Given the short time available in Romania, the team decided (based on briefings and consultation with USAID officials) to focus on assessing the current status of the HIV epidemic, characterizing current prevention efforts (particularly for preventing new HIV infections in children and adults), and making recommendations concerning areas for future USAID support.

Because the team had only five days to conduct their evaluation, the team at times divided up into groups in order to have conversations with a greater number of individuals (see Annex A for a list of individuals interviewed). Meetings were primarily held in Bucharest, although the team also traveled for one day to the port city of Constanta on the Black Sea. This city was selected because of the high prevalence of HIV infection. Documents made available to the team or collected as part of this assessment were also reviewed (see Annex B).

Based on this evaluation, specific conclusions concerning the current HIV/AIDS/STD situation and prevention strategies in Romania were made. This

report also contains specific recommendations for future USAID involvement to help control this serious situation.

II. Epidemiology of HIV/AIDS in Romania

A. NUMBER OF REPORTED CASES OF AIDS AND HIV INFECTIONS

1. Description of AIDS Surveillance System

The AIDS case surveillance system has been operating since 1990. Reporting of AIDS cases is mandatory by law. The completeness of reporting was estimated by the national HIV/AIDS coordinator to be between 90 and 95%, although this estimate was not based on a formal study. The case definition used in Romania is a modified Bangui definition, using the Bangui clinical criteria and an HIV positive test (ELISA plus Western blot).

Several potential biases and problems with the reporting of AIDS cases were mentioned. First, in Romania, persons with an AIDS diagnosis are classified as having a "first degree disability" which entitles them to government financial assistance. As a consequence, HIV infections without AIDS may be reported as AIDS in order to allow HIV-infected persons to receive financial assistance. Second, a pediatrician mentioned that babies born to HIV-infected mothers may be reported as cases of AIDS or HIV infections (because they test HIV positive due to the passive transfer of maternal antibodies) without the HIV infection being confirmed. Finally, increased diagnosis of AIDS may result in an apparent increase in the numbers of AIDS cases. For example, it was reported that in 1996 a new hospital for children opened, followed by an increase in the number of diagnosed pediatric AIDS cases. All these factors may contribute to observed variability in temporal trends for AIDS incidence.

The information collected on the AIDS reporting form includes: first two letters of name and surname; district of residence; sex; date of birth; vital status; date of death; place of living; and risk factors. Risk factors for children (0-12 years of age) include: having an HIV positive mother; a history of multiple hospitalizations; treatment with injections; transfusion of blood or plasma; and hemophilia or other coagulation disorder. The risk assessment for adults includes questions about sex with men; sex with women; injecting drug use; transfusion of blood or plasma; hemophilia or other coagulation disorder; multiple past hospitalizations; treatment with injections; and multiple sexual partners. Clinical information is collected about presence of major and minor signs, as well as specific AIDS indicative disease (such as Kaposi's sarcoma) as the initial diagnosis. Information is also requested about the HIV test, including results of ELISA and Western blot testing.

Every quarter data are sent by each district to the national level, where they are entered into a computerized database. According to a recent survey (September 1997) conducted by the European Centre for the Epidemiological Monitoring of AIDS, cases are reported using a unique identifying code constructed using the district of report, first two letters of name and surname, date of birth, and year of report. There is no built-in procedure to identify double reporting. Death is reported passively by the treating physician in the AIDS surveillance system. Every quarter, line-listed computerized data are sent to the European Centre for inclusion in the European Non Aggregate Data Set. Quarterly reports from the European Centre concerning European AIDS data also contain country-specific information. According to the European Centre survey, a national quarterly report including data on AIDS, HIV testing, HIV prevalence, and mortality, prepared by the Ministry of Health is distributed to non-governmental organizations (NGOs) and hygiene and public health institutes. However, NGO and other public health professionals we met during our mission stressed that AIDS/HIV data were not sufficiently disseminated by the Ministry of Health.

There are plans to modify the AIDS case reporting system, including adopting the European AIDS case definition and using a new HIV/AIDS case report form. Discussion is also underway to include information on CD4 count and treatment in the AIDS surveillance data.

2. Reported Cases of AIDS

The following tables and figures show the cumulative number of AIDS cases in Romania which were reported through September 30, 1997. Tables 1 and 2 report cases for children and adults by transmission group and (for adults) by sex.

Table 1: Cumulative AIDS cases reported through September 30, 1997 in Romania, for children

Transmission Group	N	(%)
Hemophiliac	27	0.6%
Transfusion recipient	875	20.0%
Perinatal infection	244	5.6%
Nosocomial	1923	44.0%
<u>Undetermined</u>	<u>1307</u>	<u>29.9%</u>
TOTAL	4376	100.0%

Table 2: Cumulative AIDS cases reported through September 30, 1997 in Romania, for adults, by gender

Gender	Transmission Group	N	(%)
Males	Homosexual bisexual	25	9.4%
	Injection drug user	0	0.0%
	Hemophiliac	3	1.1%
	Transfusion recipient	6	6.0%
	Heterosexual contact	47	55.5%
	<u>Other/undetermined</u>	<u>74</u>	<u>27.9%</u>
	TOTAL (for males)	265	100.0%
Females	Injection drug user	1	0.4%
	Hemophiliac	0	0.0%
	Transfusion recipient	22	8.3%
	Heterosexual contact	147	55.7%
	<u>Other/undetermined</u>	<u>94</u>	<u>35.6%</u>
	TOTAL (for females)	264	100.0%

Table 3 indicates the number of pediatric AIDS cases reported by transmission group and year of birth through September 30, 1997.

Table 3: Pediatric AIDS cases reported through September 1997 in Romania, by transmission group and year of birth

Transmission Group	Year of Birth											
	<1987	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Hemophiliac	2	0	9	9	4	2	1	0	0	0	0	0
Transfusion recipient	9	43	254	421	133	7	5	0	2	1	0	0
Perinatal infection	4	8	40	89	52	15	9	6	7	9	2	3
Nosocomial	37	70	419	850	420	96	22	5	3	1	0	0
Undetermined	24	48	253	580	318	53	16	8	5	1	1	0
Total	76	169	975	1949	927	173	53	19	17	12	3	3
% of Total	1.7	3.9	22.3	44.5	21.2	4.0	1.2	0.4	0.4	0.3	0.1	0.1

Figures 1 and 2 graphically represent pediatric and adult/adolescent cases of AIDS reported through September 1997 and adjusted for reporting delays (adjustments by European Centre), by transmission group and year of diagnosis.

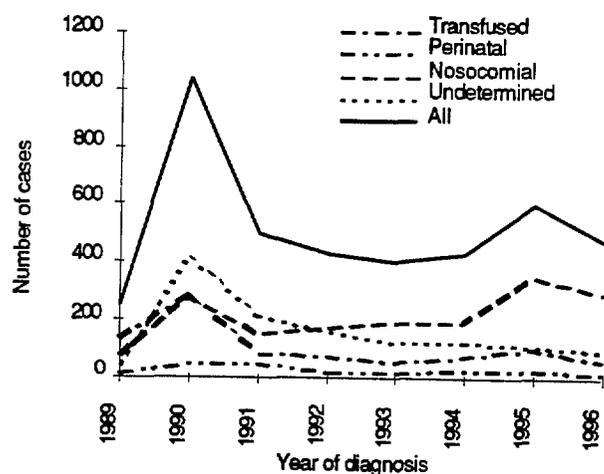


Figure 1: Pediatric AIDS cases by transmission group and year of diagnosis, reported through 30 September 1997, adjusted for reporting delays

II. EPIDEMIOLOGY OF HIV/AIDS IN ROMANIA

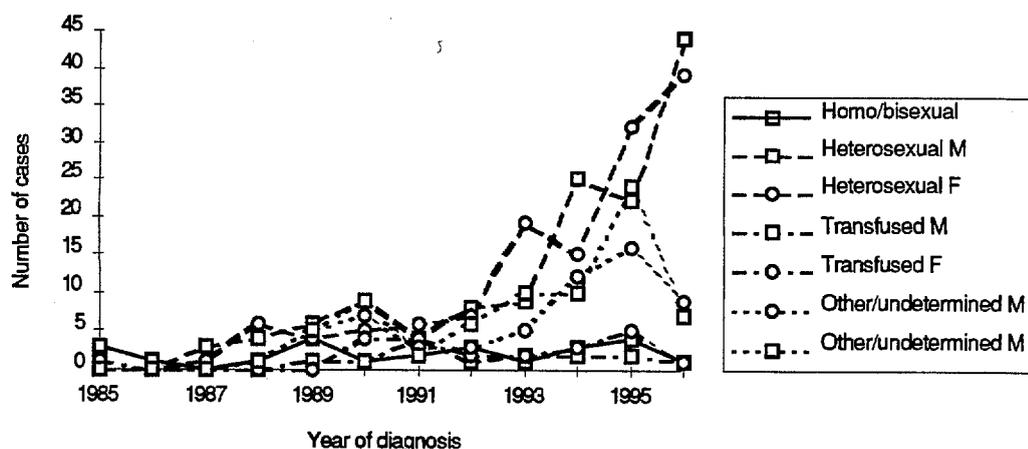


Figure 2: Adults/adolescent AIDS cases by sex, transmission group (main groups), year of diagnosis, reported through 30 September 1997, adjusted for reporting delays

Pediatric cases account for 89% (4376/4905) of all cases reported in Romania. Most of these cases were infected through transfusion of untested blood and reuse of improperly sterilized injection equipment. For a large proportion of cases (30%), the transmission mode could not be determined. The vast majority (88%) of infected children were born during the 1988-1990 period. A relatively high number of AIDS cases have been attributed to perinatal transmission (244 compared with 556 in France and 578 in Italy, two countries with a population nearly 3 times that of Romania and with very large and mature epidemics). However, because the prevalence among women, which according to available data is believed to be relatively low, and because most AIDS cases reported as perinatal infections occurred in children born during the same period (1988-1990) as the other pediatric cases, it seems that a certain degree of misclassification of pediatric AIDS cases does occur.

Among adult/adolescent AIDS cases, a relatively high proportion (56%) have been attributed to heterosexual transmission, with a similar number of cases among men and women. Also, for a large proportion (32%) of cases, the mode of transmission could not be determined. Because the number of male and female cases is similar, which is unusual in the European context, particularly, in the initial stage of an epidemic where the majority of heterosexually-infected persons are men, and because there is a large proportion of cases with no identified risk, it appears that for adults as for children, some problems occur in the ascertainment of transmission mode.

In summary, although the largest number of AIDS cases in Romania are in children, the number of adult/adolescent cases is also increasing. Among adults with AIDS, the major risk factor for both men and women is either heterosexual contact or "other/undetermined". This latter category may include persons infected due to unrecognized heterosexual transmission.

3. Description of HIV Surveillance System

Information about HIV infection in Romania comes from a variety of sources. Blood donations have been systematically tested for HIV since October 1990. It is recommended that all persons with TB be tested for HIV. STD patients are also systematically tested for HIV. A European Centre survey indicated that a total of 58 laboratories do confirmatory HIV tests in Romania and that data on HIV tests are systematically reported to the Ministry of Health. There is a policy to notify partners of HIV-infected persons, if partners are named. As discussed below, the availability of voluntary and anonymous HIV testing is very limited in Romania.

There is an HIV surveillance system based on HIV case reporting which was established in 1992. Diagnosed HIV infections are reported anonymously. Reporting is mandatory, and is done by both clinicians and laboratories. The case definition of HIV infection used for surveillance purposes is: a positive ELISA and a positive western blot and a clinical diagnosis. The information recorded on the HIV case report form is similar to that for AIDS cases. Additional questions on the form include marital status, clinical setting where the patient was evaluated (such as STD or TB clinics), number and country of origin of sex partners, and changes in sexual behaviour. There are separate forms for children and adults.

Every quarter, data are sent by each district to the national level, where they are entered onto a computerized database. According to the European Centre survey, HIV cases are reported using a code based upon district of report, date of birth, date of HIV positive test, and year of report. Concerns were expressed to members of the team about the quality of the HIV reporting system, including problems in identifying multiple reports; this problem is due at least in part to the lack of unique identifiers. There is no built-in procedure to identify double reporting. It was reported that the AIDS and HIV reporting systems can be linked, although from the description of the two systems (including the absence of an identifier for reported cases of HIV infection), this seems questionable.

4. Reported Cases of HIV Infection

The table below provides information of the number of diagnosed cases of HIV infection by year of report and age group.

Table 4: Number of diagnosed HIV infections in Romania among adult/adolescents and children, by year

Year of report	Adults/adolescents	Children
1992	21	183
1993	71	492
1994	91	630
1995	145	709
1996	143	536

Although very useful, the HIV case reporting system cannot measure prevalence or incidence, and is dependent on HIV testing practice. However, these data do provide useful information on diagnosed HIV infections, including some that may have been acquired recently. Additional information on HIV testing is presented in Section V.B., (pg. 26).

5. HIV Prevalence Data

In 1990, a survey was conducted among apparently healthy children, aged 6 to 59 months, from a representative sample of about 500 families; a prevalence of 0.56% was found. Another 1990 survey among 9,777 children living in institutions indicated that 765 (7.8%) were HIV-infected.

The few prevalence data that are (or may be) available in Romania are mainly obtained from systematic HIV testing of specific populations including STD patients, IDUs in treatment and blood donations. HIV seropositivity among patients with STDs were provided for Romania (Table 5) by the national HIV/AIDS coordinator and for the city of Bucharest (Table 6) by the chief of the STD laboratory (provided as confidential data, not to be disseminated). Prevalences have been and are still very low (<1%) although there is a increasing trend since 1995. However, there appears to be some discrepancies in the data; for example, the number of HIV-positive persons found in the city of Bucharest alone is higher than the number of HIV-positive persons for the entire country. Data for STD patients are shown below; data for 1996 may be incomplete.

Table 5: HIV positivity among STD patients in Romania, 1991-1996

Year	Number tested	Number positive (%)
1991	4106	8 (0.19%)
1992	3779	6 (0.16%)
1993	4741	6 (0.13%)
1994	3116	4 (0.13%)
1995	3725	23 (0.62%)
1996	3849	19 (0.49%)

Table 6: HIV positivity among STD patients in the city of Bucharest, 1991-1996

Year	Number tested	Number positive (%)	
1989	4062	12 (0.30%)	
1990	2885	15 (0.52%)	
1991	4106	8 (0.19%)	
1992	3779	7 (0.19%)	
1993	4741	8 (0.17%)	
1994	3116	5 (0.16%)	
1995	3725	26 (0.70%)	
1996	4020	19 (0.47%)	
1997*	3869	20 (0.52%)	*through November 15

Among several thousand prisoners tested in 1993 for an HIV prevalence survey, only 2 or 3 were HIV positive. Among the 170 known IDUs in treatment in Romania, only 1 was found to be HIV infected at the time of our visit in November 1997. Although TB patients are routinely tested for HIV, no prevalence data were provided for this population by the national HIV/AIDS coordinator. Little information is available concerning HIV seropositivity among persons seeking anonymous testing, because testing options are limited. Among the very few (39 persons) tested in the only free and anonymous testing center of Bucharest, only one was found to be HIV positive. In 1996, excluding blood donations, 3,515 HIV tests were performed, of which 310 (0.8%) were found to be positive. According to the European Center for Epidemiologic Monitoring of AIDS, the prevalence of HIV among blood donors is generally higher than in the rest of Europe (5 per 100,000 donations in 1996) with large fluctuations in prevalence rates (such as 35 per 100,000 donations in 1995).

In summary, although the largest number of cases of reported HIV infection in Romania are in children, the number of adult/adolescent cases is also increasing. Although the numbers are not internally consistent, increases in

HIV seroprevalence among STD patients raise concerns that sexually active persons are increasingly becoming infected with HIV.

B. EPIDEMIOLOGY OF HIV IN DIFFERENT RISK GROUPS

1. Children

Romania has one of the highest rates of pediatric AIDS in the world. As of September 30, 1997, 4,376 cases of AIDS were reported in children under the age of 10, with over 1,500 deaths. HIV infection in Romanian children has complex social, political and economic routes. Until its fall in 1989, the Ceausescu regime's pronatal policies were opposed to family planning, including abortions. For a complex variety of reasons, including parents who could not afford to care for their children, many children were placed in state-run institutions. At least two practices contributed to the spread of HIV infection in these children. The first was transfusion of HIV-infected blood. In the late 1980's, many children in institutions were transfused with 50-100 ml of blood to treat malnutrition. The pressure to transfuse children was particularly great for those children under the age of one; members of the team were told that in some cases, physicians' pay would be cut if the number of deaths in children under one was high. The second practice contributing to the spread of HIV was frequent injections with reused and unsterile needles and syringes. Prior to 1989, there was a severe shortage of needles and syringes, as well as equipment necessary for proper sterilization. The team was told that injections were a common method of giving treatment to children (including those in hospitals), in part exacerbated by a severe shortage of oral medications.

New cases of HIV infection and AIDS in children who were infected by these two means in the late 1980's are still being identified. Although large-scale screening of children in institutions during the early 1990's identified many HIV-infected children, new HIV infections are still being identified. Many of these HIV-infected children are those who lived with their families, and therefore were not tested as early as children living in institutions.

One of the areas in Romania worst affected by HIV infection was Constanta. In this city alone, 1,500 pediatric AIDS cases have been identified since 1989. Of these, 500 have died, 300 have been abandoned and remain in institutions, and 700 are treated in "day clinics". Rates in Constanta may be especially high possibly because blood donors there included many HIV-infected sailors (who became infected abroad) and commercial sex workers (who may have become

infected through sexual contact with clients from other countries). The team was told that in some cases, prostitutes or prisoners in Constanta were punished by being forced to donate blood, even further exacerbating the problem of an infected blood supply.

Whatever the source of HIV infection, many of these children have been abandoned by their families, and currently reside in institutional care with multiple social as well as medical problems. The large cohort of HIV-infected children aged 8-12 poses considerable challenges. Many international donors (including USAID) have assisted AIDS-affected Romanian children by supporting the institutions which house them.

There is general agreement that nosocomial and transfusion-related pediatric HIV transmission has largely ended, due to aggressive efforts by health authorities to end unsafe practices in health care settings. Dr. Rodica Matusa of Constanta estimated that of the approximately 10 new cases of pediatric HIV/AIDS she sees per month, 30% are due to vertical transmission, and the remainder are children infected before 1990. New cases of HIV infection in children, through vertical transmission from HIV-infected women, are still occurring. Contributing factors include lack of HIV screening for pregnant women, and unavailability of zidovudine therapy for those pregnant woman found to be infected.

2. Commercial Sex Workers

Although the team found no studies on HIV rates among commercial sex workers, considerable anecdotal evidence indicates that female sex workers are becoming infected with HIV, especially in the port city of Constanta. For example, those operating an HIV testing program in Constanta reported that some of their HIV positive clients were female prostitutes. Several persons interviewed by the team reported that Romanian prostitutes go to other countries such as Turkey, Greece, Cyprus, Italy and Germany for customers. Prostitutes from other countries, such as Ukraine, Moldova and Bulgaria, may also come to Romania to practice their trade. The team was also told that some Romanian prostitutes preferred foreign customers.

A second worrisome trend the team heard about was international pedophilia. Mariana Neacsu of the Romanian Child Protection Department told the team that many people come to Romania for child prostitution (both male and female), and that a number of foreign pedophiles were well known to the police. The team was also told that Romanian children as young as 10-12 may engage in prostitution, in

some cases in other countries. Many of those children who engage in prostitution are street children. However, because other persons interviewed by the team felt that these reports were exaggerated, the true extent of this problem is unknown.

Although there is no doubt that both adults and children who engage in prostitution are at risk for HIV infection, there are no good data to help estimate the true magnitude of this problem. Such data are urgently needed.

3. Sexually Active Men

Although the team found no current studies on HIV prevalence among sexually active men, considerable anecdotal evidence indicates that these men are becoming infected with HIV, especially in the port city of Constanta. The team was told that those at greatest risk included male sailors and truck drivers. There were anecdotal reports about sailors engaging in male-male sexual contact, but the extent of this practice could not be determined. According to Dr. Popovici of the Bucharest Health Department's Department of Epidemiology, another at-risk population is construction workers who previously worked in Africa.

Although there is no doubt that some sailors and other sexually active men described above have become infected with HIV, the team found that much of the current information about this group was anecdotal and speculative. Behavior and seroprevalence data about these groups are needed.

4. Injection Drug Users

Drug use is generally believed to be a new phenomenon and still relatively uncommon in Romania, and the police could not provide an estimate of the actual number of drug users. The most commonly-used drug is believed to be marijuana (which is smoked). There appears to be very little injecting at this time. The first and so far only reported case of HIV infection in a person known to be an IDU was reported in late 1997. Among hard drugs, both heroin and Fortal (pentazocine), an opiate, were reported by the police (Unit of Toxic Substances) to be the most frequently-used substances. The first cases of heroin use were by smoking, but injecting is increasing. Other drugs used include benzodiazepines and barbiturates, which are often taken in combination with alcohol.

According to Dr. Popovici, although the number of IDUs is currently small, there has been an increase in drug users in Romania. Many of those starting to inject drugs are young, with heroin being the major drug used. The team was told that

drugs can be found in universities, discotheques, and other places where young people congregate. It was also reported that a number of drug users are from the gypsy population, suggesting that there may be special needs in working with this group.

Heroin is not produced in Romania but there is legal production of morphine and use of poppy-derived drugs. Heroin is imported from Turkey, Southeast Asia, Afghanistan, Pakistan, Iran and Iraq. Drugs are coming through Romania by at least three routes, often on their way to other areas such as Western Europe. The team was told that drugs are currently entering Romania from the Black Sea, by road from Asia, and by road from Russia or Kazakstan.

Drug trafficking is illegal but the use of drugs is legal. Syringes and needles can be bought in pharmacies without prescription. Injection equipment is often shared, but unlike in surrounding countries such as Poland and Ukraine, drugs are not shared from a large container. This is essentially because the mode of preparation is different; opiates are not consumed in the form of kompot, a preparation of poppy straw, as they are in Poland and Ukraine.

There is one 30-bed drug treatment hospital for detoxification, which opened in 1996 in Bucharest. A total of 100 drug addicts were admitted in 1996 and 400 in 1997. About two-thirds of them inject drugs. The first (and so far only) detected case of HIV-infection among IDUs was diagnosed in 1997. Although the opinion was that HIV in Romanian injection drug users is not currently a major problem, this situation could change rapidly. Behavior and seroprevalence data about injection drug users are urgently needed.

5. Youth

Several lines of evidence indicate that youth are engaging in unsafe sexual behavior that increased the risk of HIV and other STDs. Nine percent of all syphilis cases in Romanian males and 23% of all syphilis cases in Romanian females are in youth aged 15-19. Some of the most important data about this group comes from a reproductive health survey of young people (aged 15-24 years) which was conducted in 1996 with principal support from USAID. Overall, 25% of females and 66% of males reported premarital intercourse. Among nonmarried women who were sexually active, 41% reported that their first intercourse was at an age less than 18 years. Among all males who were sexually active, 73% reported their age at first intercourse as less than 18 years. When women who reported that their first sexual intercourse was premarital were asked about their contraceptive use at the time of this first intercourse, only 39%

reported using any method, with 21% reporting withdrawal and only 13% reporting condom use. When men who reported that their first sexual intercourse was premarital were asked about their contraceptive use at the time of this first intercourse, only 35% reported any method, with 15% reporting withdrawal and only 16% reporting condom use. When asked about contraceptive use at the most recent intercourse, of those adults who were not married or in consensual unions, only 22% of women and 37% of men reported using condoms.

Although this kind of detail related to drug use is not available, as noted above, it was the impression of several individuals the team spoke with that drug use among young people is increasing. Additional information is necessary to better define patterns of high-risk drug use and sexual behaviors in youth.

6. Nosocomial Transmission and Blood Transfusion

Nosocomial infection represented a major factor leading to thousands of HIV infections in institutionalized children in the late 1980's. It was the impression of many persons the team spoke with that such transmission has largely been halted. The policy of "microtransfusions" has been stopped. The Ministry of Health, according to one UNICEF report, received huge quantities of disposable needles and syringes, and has decided to adopt the use of disposable syringes throughout the country for all injections (Battersby and Ion-Nedelcu). The team was told that syringes and needles are widely available, even in rural areas. However, questions were raised by some individuals as to whether all health care personnel were adequately trained in proper infection control procedures. In summary, although we cannot rule out the possibility that some nosocomial transmission is still occurring (especially by staff who may not be adequately trained), the team did not find evidence that this route of transmission is accounting for large numbers of new HIV infections.

It is also not known whether HIV nosocomial transmission to adults occurs during medical procedures such as abortion. There are no such cases reported, although it is theoretically possible. Discussions with the Chairman of the National AIDS Committee indicated that abortion is a preferred option for HIV-infected pregnant women. Despite efforts to decrease Romanian women's reliance on abortion, many women still resort to abortion. Team members heard anecdotal reports that abortion mills which operate with unsterile equipment exist outside the formal health system. The price of abortions performed in Government centers has recently been raised to 60,000 lei (approx. USD 7.50). Although this represents an attempt to encourage women to adopt modern family planning methods, this new fee may drive women to less expensive, and less safe, alternative abortion

services. If increasing numbers of HIV-infected women select this option, the opportunities for nosocomial HIV transmission in such settings may be increased.

Blood is currently being screened in Romania for HIV, and compulsory testing is required for all blood donors. Dr. Petrea told members of the team that blood is also being screened for syphilis, hepatitis B and hepatitis C; screening for these other agents would even further reduce the risk of receiving HIV-infected blood. Of over 373,000 units of blood tested in 1996, 18 were HIV positive, according to data supplied to the European Center for Epidemiologic Monitoring of AIDS. This resulted in a rate of 4.8 HIV-positive units/100,000 units screened.

In summary, there are several HIV epidemics in Romania. Many children were infected through injections and receipt of contaminated blood during the 1980's, and a number of these children are still continuing to be diagnosed with AIDS and/or HIV infection. In addition, new HIV infections may also be occurring in sexually active adults, including men who have travelled to other countries and female commercial sex workers. As the number of HIV-infected women increases, more vertical transmission can also be expected. The extent of this more recent wave of HIV infection is unknown.

III. Epidemiology of Syphilis

Over the last 10 years, there has been a dramatic increase in the number of reported cases of syphilis in Romania. From less than 2,000 reported cases in 1986, the number rose to approximately 5,000 cases in 1990, approximately 6,000 cases in 1992, and 7,277 cases in 1996.

Data on numbers of syphilis cases can also help to provide a picture of the occurrence of unsafe sexual activity. Dr. Gradina Vasile of the Department of Dermato-Venereology kindly provided the following confidential data concerning the number of syphilis cases which occurred in Romania in 1996. Table 7 reports number of cases by age group and sex.

Table 7: Total Number of Reported Syphilis Cases in Romania in 1996, by Age Group and Sex

Age Group	Male	Female	Total
<1 year	30	33	63
1-9 years	9	5	14
10-14 years	10	29	39
15-19 years	379	735	1114
20-29 years	2165	1539	3704
30-39 years	766	418	1184
40-49 years	507	276	783
50-59 years	180	66	246
60-69 years	78	23	101
> 70 years	23	6	29
Total	4147	3130	7277

It is of note that approximately 73% of all syphilis cases in women are in those age 15-29; 61% of men with syphilis are also in this age range. For the entire country, 2,459 (34%) cases were in rural areas and 4,818 (66%) in urban areas. Of 2,025 cases of syphilis among women in urban areas, 22% were age 15-19 and 48% age 20-29 years. Of 2,793 cases of syphilis among men in urban areas, 10% were age 15-19 and 50% age 20-29 years. These data are therefore consistent with reports of unprotected sexual activity among adolescents and young adults.

The number of reported gonorrhoea is very similar to that of syphilis and has been decreasing, which strongly suggests that the amount of underreporting is greater for gonorrhoea than for syphilis. It was said that patients with gonorrhoea (or symptoms suggestive of gonorrhoea) are more likely to seek care through private practitioners who do not report cases through the surveillance system.

IV. Program Partners

A. GOVERNMENT RESPONSE

Dr. Geza Molnar, Secretary of State for the Ministry of Health, discussed several of the priority areas for HIV/AIDS control. With respect to the large number of children who were already HIV-infected, important issues include medical care and social integration of these children with their families, if possible. Although the media attention which focused on these infected children had benefits in leading to outside assistance, Dr. Molnar was concerned that by focusing only on those children who were already infected, attention would not be paid to heterosexual transmission which would become an increasing reality. He indicated the need for a national plan for control of HIV/AIDS, which the government hopes to have for 1998.

Members of the team met with Dr. Adrian Streinu Cerel, Chairman of the National AIDS Commission in the Ministry of Health, who kindly provided a draft copy of the National AIDS Program proposal to the team. The National AIDS Committee was formed in June 1997, and includes primarily physicians. This Committee reports to the Ministry of Health. The government currently does not have an active comprehensive program of AIDS prevention, and most efforts have focused on protecting the blood supply and preventing HIV transmission through unsterile needles and injections. The National AIDS Program proposal focuses on five major areas:

1. **HIV/AIDS diagnosis.** This includes developing uniform case definitions for children and adults, ensuring the accessibility of HIV/AIDS infection diagnosis, and developing standard criteria for HIV testing (including Western

blot confirmation). Those who are found to be HIV infected will be guided to regional HIV/AIDS centers, where evaluation (including stage of infection) will be determined.

2. **Diagnosis of associated infections**, including tuberculosis and STDs.
3. **Antiretroviral treatment**. The intention is to use three drugs (including a protease inhibitor) for all HIV-infected persons.
4. **Treatment of HIV-associated diseases**. Specific guidelines for treatment of these diseases will be in accordance with recommendations from special committees of the National AIDS Committee.
5. **Treatment monitoring**, including monitoring of antiretroviral treatment.

There is also interest in prospective studies to monitor HIV infection and AIDS.

The draft proposal notes that prevention programs are included in the activities of a variety of agencies including different departments in the Ministry of Health (Direction for Health Promotion, General Direction for Preventive Medicine, Direction for Maternal Child Health Care), other national ministries (Ministry of Education, Ministry of Interior, Ministry of National Defense, Ministry of Justice, Ministry for Youth and Sports), local municipal health departments and NGOs. The draft proposal notes that interdepartmental cooperation is important.

The requested budget for AIDS control activities is approximately USD 33.7 million. The largest requested amount (USD 20.9 million) is for HIV medications. Dr. Streinu-Cerel estimated that only 10-20% of HIV-infected adults and about one-third of children are currently receiving antiretroviral therapy. USD 0.9 million is requested for support personnel, the central laboratory, and a variety of clinical equipment including consumable material necessary for universal infection control precautions. Other requested amounts include approximately USD 488,000 for analysis kits (for HIV antibody, p24 antigen and CD4+ counts), and approximately USD 259,000 for computers and other information support.

USD 11.1 is requested for prevention activities. The primary goal of these activities is prevention of sexual transmission. Dr. Streinu-Cerel mentioned education and training activities that primarily involved school children and other youth. Teenagers were mentioned as an important target audience which needed to know how to reduce sexual risk (including information about condom use).

Funds are requested for development of print materials as well as use of the mass media.

With respect to other types of prevention activities, Dr. Streinu-Cerel spoke favorably of the previously strict drug policy, and advantages of drug testing for youth; however, it was not clear whether this was a specific component of the national plan. Although use of antiretroviral therapy to prevent vertical transmission is included in the draft national plan, Dr. Streinu-Cerel indicated his opinion that the preferred option for HIV-infected women was abortion.

B. NONGOVERNMENTAL ORGANIZATION (NGO) RESPONSE

The team met with representatives from several Romanian NGOs. The majority of NGOs (such as Holt International, World Vision, Romanian Angel Appeal, and Health Aid U.K.) focus on providing care and treatment for HIV-infected children and social support for their families. In terms of prevention, several types of activities were described. Several NGOs (Youth for Youth, SECS) work on educating youth in the use of "safer sex" practices in reproductive health. Youth for Youth projects include information, education and communication activities related to behavior change, as well as school-based programs. Another NGO named Provobis conducts educational efforts including posters and radio spots. Population Services International (PSI) works with social marketing of condoms for AIDS prevention. Goals include educating people (especially youth) about condoms (to create a demand) and providing quality condoms at an affordable price in outlets that are accessible.

By far and away, the NGO with the most comprehensive and widespread HIV/AIDS prevention program is ARAS (Romanian Association Against AIDS). ARAS has programs in areas throughout Romania (Bucharest, Constanta, Brasov, Platra Neamt, Iasi). ARAS programs and projects include the following:

1. Educational/informational activities for the general public, including an AIDS Hotline, informational campaigns, mass-media campaigns, poster contests and exhibitions. Target populations for activities have also included tourists, sailors, and commercial sex workers.
2. Activities focused on youth, including distribution of educational material, contests and public debates, training sessions for high school students, and training sessions for medical staff and other personnel who work with children (including orphanage staff, NGO employees and even journalists). Educational programs have also been held for high school parents and

teachers. In some areas, peer education activities are also being conducted with youth. These activities focus not only on education, but also attitudes and beliefs about HIV.

3. Social assistance programs for HIV-infected persons and their families, including education and advice for families of HIV-infected persons to prevent abandonment.
4. Support for a NAMES project, with displaying of the AIDS Quilt.

NGOs face a number of difficulties in trying to accomplish their missions. NGO representatives indicated that the government is not providing “leadership” in HIV/AIDS prevention nor actively supporting NGO efforts. Representatives expressed concerns that there was no national AIDS strategy, and that the actual government commitment to prevention was low. Representatives felt that most government officials did not fully recognize the value of NGOs or their contributions. There was also concern that HIV/AIDS trends in the population cannot be measured because of limited or absent sentinel surveillance data, and that data which were collected were not sufficiently analyzed and disseminated. Information which is collected often remains at the central level, without dissemination to the local level, general public, or at-risk groups in the population. Although the media does cover HIV issues, there was also concern that such coverage was limited and often sensationalistic.

C. OTHER DONOR INPUTS

1. United Nations Children's Fund (UNICEF):

UNICEF funds a variety of activities in Romania which impact on HIV/AIDS issues. Starting in 1997, this includes support for research on adolescent sexual behavior through Population Services International; an adolescent resource book; programs for HIV/AIDS awareness training; other information, education and communication activities for awareness raising and behavior change; a training workshop for persons working with adolescents; programs for teachers in high schools (with ARAS); and programs that provide care and counseling for HIV infected children. Approximately USD 760,000 is allocated, proposed or under consideration for these activities.

2. United Nations Development Program (UNDP):

UNDP has supported a variety of activities in Romania including those related to poverty alleviation, and support for women and gender equity. In 1997, support was also provided towards a UNAIDS officer, as well as to Population Services International for research related to adolescent sexual behavior. Approximately USD 16,000 is allocated for these latter two activities.

3. United Nation's Population Fund (UNFPA):

The United Nation's Population Fund supports a variety of activities related to reproductive health. These include support for training NGOs on reproductive health issues, as well as support for youth-related activities concerning family planning methods. Approximately one million dollars is allocated or proposed for these activities, with the largest share (approximately USD 703,000) going to the government for family planning methods. Many of these family planning efforts include AIDS prevention messages.

4. Joint United Nations Programme on HIV/AIDS (UNAIDS):

UNAIDS assistance includes training NGO or government officials in evaluation research, as well as providing local assistance in research and planning activities. A number of United Nations organizations help provide support for a UNAIDS officer. Approximately USD 142,000 has been allocated to these activities. UNAIDS also provides leadership in coordinating the AIDS-related activities of various UN agencies, and in fostering a governmental national plan.

5. World Health Organization (WHO):

In addition to its overall health mandate, WHO has specifically supported a workshop (for about USD 4,000) concerning safe blood supply.

6. World Bank:

The World Bank has provided a Health Service rehabilitation loan to Romania, and has also provided funds for capacity building.

In summary, government response has largely focused on clinical issues including HIV diagnosis and treatment of those who are already infected. Although prevention is mentioned as an important activity, most of the actual prevention activities that are conducted are done by NGOs. Most NGOs have focused on care and support of children who are already HIV-infected, although a few NGOs (including ARAS) have activities for prevention of new infections in adults and youth. UN agencies have a demonstrated interest in providing assistance, although funds are often limited or allocated only for certain types of activities (such as family planning or reproductive health).

V. HIV/AIDS Interventions by Sector

A. INFORMATION, EDUCATION AND COMMUNICATION (IE&C)

Although Romania has not yet launched a systematic AIDS prevention campaign, a number of effective efforts have been undertaken in different regions of the country, primarily through the NGO ARAS. The full scope of ARAS activities is described above. Three detailed examples of specific activities are indicated below:

1. Education programs for the prevention of HIV for high school students, parents and teachers: initial pilot projects were implemented at nine high schools in five cities from November 1995 to May 1996. Educational materials included brochures and videos. Discussions were also held with trained ARAS volunteers. The project was evaluated through questionnaires targeted towards students, parents and teachers.
2. AIDS Hotline: In 1996, the ARAS AIDS Hotline received 9,400 calls. The Hotline is run by three paid staff and thirty volunteers. The hotline is open seven days a week in Bucharest, Constanta and Iasi.
3. Summer campaign (1996): During July and August, 1996, a campaign took place involving 100 volunteers in multiple cities, including those at the seaside. In addition to the general public, activities were targeted towards young tourists, sailors, and commercial sex workers. Specific activities included discussion groups, contests on specific themes, distribution of educational materials, posters, and condom distribution. Mass media was

involved through radio broadcasts, television programs and newspaper articles. As part of this program, press kits were developed and distributed.

Through such activities, a number of school children have received school-based AIDS prevention education, although there has been no formal attempt to integrate this sector into school curricula. There appears to be no strong opposition to this education from either educators or parents, but materials need to be developed, and teachers trained. High quality print materials for AIDS prevention have been developed by ARAS (and other reproductive health NGOs), but a shortage of funds has prevented wider distribution of them. Peer education has been periodically used, although such activities, if supported, could be conducted on a much greater scale.

In general, the mass media in Romania has covered AIDS issues. However, it was the impression of some team members that this coverage (including television coverage) was often sensationalistic rather than educational in nature. Issues related to HIV-infected children appear to have been most intensively covered.

In summary, a range of information, education and communication activities (including activities directed towards youth in schools) have been conducted in Romania. These activities have been conducted primarily by ARAS.

B. TESTING AND COUNSELING

The team was told that all blood donations in Romania are tested for HIV. Blood is also screened for other infectious agents such as hepatitis B and syphilis which might also occur in those at risk for HIV. According to The European Centre for the Epidemiologic Monitoring of AIDS, during 1996, a total of 373,289 antibody tests were performed at blood banks in Romania, including 38,503 new donors and 318,012 repeat donors (HIV/AIDS Surveillance in Europe, Second Quarterly Report, 1997). The European Centre survey indicates that a total of 58 laboratories do confirmatory HIV tests in Romania and that data on HIV tests are systematically reported to the Ministry of Health.

Every judet in Romania has a center where HIV testing can be performed. According to Dr. Molnar, Secretary of State for the Ministry of Health, voluntary testing is recommended for a number of groups including commercial sex workers, injection drug users, and those who have been transfused many times. Testing is also systematically performed on patients in STD and tuberculosis clinics. In 1996, excluding blood donations, 36,515 HIV tests were performed, including 3,849 tests on STD patients.

According to guidelines from the Ministry of Health, if a patient is found to be HIV positive, health care personnel are obliged to communicate this information to the person themselves, or (if the HIV-infected person is a child) to a parent or guardian. When the person or parent is informed about the result, they must complete a questionnaire and be interviewed by a medico-sanitary official. During this interview, they will be informed about ways of transmission, preventive methods, and treatments for opportunistic infections. Romanian policy regarding reporting of HIV infection stresses the importance of respecting confidentiality, and indicates that all sanitary units are obliged to offer medical assistance to HIV-infected persons, no matter where they live.

Options for voluntary, anonymous testing appear quite limited. Members of the team visited an anonymous test site in Bucharest. The team was told that this was the only anonymous test center, and that not many people come to be tested. Since being opened in March 1997, only 39 people have requested anonymous testing. Publicity for this program was reportedly very limited. Another 139 people have requested confidential testing (giving their name), mainly because they need to show their test results for foreign travel, or for a job (such as construction abroad). This test center is located in Bucharest, and is only open from 8:00 A.M.-10:30 A.M. two days a week. During the pre-test counseling at this center, the client is asked why they want the test, and is given basic information about HIV. Information recorded on a standard form includes age, sex, city, and reason why they want the test; according to Dr. Luminata of the counseling and testing center, most people indicate they are curious. About half of those requesting anonymous testing and 20% of those requesting confidential testing are women. Testing is initially done with an ELISA; if results are positive, a second ELISA is performed, followed by a Western blot assay.

Other anonymous test sites were reportedly opened in 1991-1992, and were available seven hours per day. Dr. Popovici of the Bucharest Epidemiology Department told the team that between 1993 and 1995 there were a number of criticisms of anonymous testing programs, including concerns about accuracy of surveillance data from these sites due to double and triple reporting. According to Dr. Luminata, these sites were closed this year because they were not felt to be cost effective. The public health department also had a counseling department and hot line, but these were closed because there was little demand. It was noted that publicity for these programs was limited, such as through small posters in clinic settings.

ARAS has supported a counseling and testing program in Constanta, although funding has been an issue. This program is advertised by ARAS and on the Hotline. The center is open five days a week, on alternating mornings and

afternoons. From July to November, approximately 200 tests were performed, indicating that there is some interest in antibody testing if accessible, publicized and offered at convenient times.

In summary, HIV testing is available in Romania. Testing is systematically performed in certain settings (such as STD and TB patients), and recommended for a number of high-risk groups (such as CSWs and IDUs). Options for anonymous testing are quite limited, although experience from ARAS suggests that such testing would be requested if anonymity could be assured, and if testing were accessible, publicized and convenient.

C. CONDOM PROMOTION AND MARKETING

Conversations with government officials indicated that they were not opposed to condoms, and saw it as a part of the HIV/STD prevention strategy.

Approximately one year ago, Population Services International (PSI) established an office in Bucharest. PSI has received a two year, USD 1 million grant from the Dutch government to design and implement a national program to market an affordable condom, focusing on youth. According to the PSI representative, the present condom market offers a "high-end" Durex condom at USD 3 per package of 3, and several inexpensive, "low-end" products from Taiwan and South Korea which have poor reputations for quality and reliability. ARAS staff members in Constanta noted that condoms in that port city cost from USD 1 to USD 1.40 for a package of three.

PSI plans to offer a high-quality, affordable condom on a national scale, targeting youth and developing a national distribution system which will reach into the rural areas of Romania. They are presently conducting formative research to develop the brand name, package design and content for the national advertising campaign. The product launch is projected for mid-1998. PSI estimates that the Dutch grant will cover the product design costs and a "limited" launch of the product in the major urban areas, and are soliciting funds to expand their program. If the product launch were coordinated with a national AIDS awareness campaign, this could provide additional promotion for condoms as an available and affordable means to protect individuals from HIV infection. Conversations with a representative of one television station, PRO TV, indicated that the station would be willing to carry condom advertisements.

In summary, there are plans (primarily through PSI) for social marketing in Romania of affordable, high-quality condoms.

D. STD CASE MANAGEMENT

In Romania, persons with STDs are typically treated by dermatovenerologists although an increasing proportion of persons seek treatment through private clinics or carry out self-treatment. Treatment of STD in public clinics is free-of-charge. Partner notification is part of STD case management. Condoms are not provided in STD clinics.

The treatment regimen used for treating primary and secondary syphilis comprises two injections of benzyl penicillin for 2 days (in hospital), followed by two courses of 15 days each of daily injections of benzyl penicillin (1.2 million units). These two courses of injections are given 1 week apart, on an out-patient basis. The single dose treatment for primary and secondary syphilis recommended by both WHO and CDC is believed by at least some physicians in dermatovenerology clinics not to be effective.

STD management is based on extensive lab tests and does not use the syndromic approach. Laboratory tests (culture, direct microscopy) are done routinely for all patients. Treatment of gonorrhea is variable, and may depend on a variety of factors related to clinical presentation and laboratory results. Drugs used include penicillin, aminoglycosides, cephalosporins, and quinolones. Although penicillin resistance was reported to be around 90%, penicillin is still used in some settings. It was reported that patients with gonorrhea (or symptoms suggestive of gonorrhea) are more likely to seek care through private practitioners who do not report these cases to the surveillance system. There is therefore probably considerable underreporting of gonorrhea. Chlamydia is very likely underdiagnosed or unrecognized. In addition, chlamydia is often not routinely covered in treatment regimens (for example, for patients with urethritis).

In summary, there currently is considerable variation in STD diagnosis and treatment. Suboptimal, prolonged or incorrect treatments may be used in some settings, including use of drugs to which a patient's infection is resistant.

VI. Conclusions

1. The present surveillance system for HIV in Romania is not adequate to evaluate past, current, or future trends.

A number of concerns were noted relating to the current surveillance system in Romania. With respect to AIDS surveillance, issues included failure to use the European AIDS case definition and potential problems with risk assessment. For example, since the great majority of AIDS cases are in the “heterosexual contact” or “undetermined” category, the procedures for defining, classifying, and following up these cases should be reviewed. For example, team members heard anecdotal reports that some women who are HIV-infected through “unknown origin” had repeated hospitalizations; whether such hospitalizations were associated with invasive procedures that might represent an opportunity for nosocomial transmission could be further evaluated.

With respect to HIV surveillance, there did not appear to be a coherent strategy for monitoring HIV infection. Officials should consider strategies for sentinel surveillance, as discussed in the recommendations outlined below, in order to help monitor the emergence of HIV in different high-risk and target populations, and to evaluate the impact of different prevention and control efforts. Finally, surveillance data are of limited value unless they are analyzed and disseminated to those involved with HIV prevention and control, including NGOs and local government officials.

- 2. A major wave of HIV infection occurred in Romanian children in the late 1980's, due to repeated injections and blood transfusions (typically in the amount of 50-100 ml). Although we cannot rule out the possibility that some nosocomial transmission is still occurring, such transmission seems largely to have ended, reflecting screening of the blood supply and government interventions promoting infection control.**

In discussions with various Romanian officials, opinions were expressed that the issue of "microtransfusions" as a risk factor for infection may have been overemphasized, and that many of these infections were due to injections with unsterile needles. As a point of clarification, several individuals also mentioned that calling transfusions of 50-100 ml "microtransfusions" was not technically correct since this was an appropriate amount to transfuse a young infant. In response to the initial wave of infection in Romanian children, there was considerable public and media attention, which government and health officials seem to have responded to. It is also not known whether HIV nosocomial transmission to adults occurs during medical procedures such as abortion. There are no such cases reported, although it is theoretically possible.

- 3. Children are still continuing to develop AIDS from infections that were acquired in the 1980's through nosocomial transmission. New HIV infections representing vertical transmission are occurring in children, and can be expected to increase.**

Although some continued nosocomial transmission cannot be ruled out, vertical transmission will become an increasingly important issue as HIV moves into the adult population, and greater numbers of HIV-infected women emerge. As part of the HIV surveillance system, these trends will be important to monitor, including numbers of HIV-infected pregnant women, the age distribution of children with HIV/AIDS, and risk factors for newly diagnosed HIV-infected children.

- 4. Some HIV infection is occurring in adults, although levels, trends and risk factors have not been well defined.**

There are reports of HIV infection in a number of groups, including sailors (especially those traveling to foreign countries), female commercial sex workers, STD patients and prisoners. However, we do not have enough data to definitively conclude that there are major levels of infection in any of these groups. Injection drug use does not seem to be widespread or a major source of HIV transmission at this time. All of these trends require careful monitoring, since the HIV epidemic

in a country may rapidly and dramatically change and evolve. In addition, the possibility that there may be pockets of infection in certain high-risk groups (such as those along the port cities) cannot be excluded and deserves further evaluation.

- 5. Rates of syphilis are significantly increasing, consistent with increases in unprotected sexual contact. Although gonorrhea rates are reported to be decreasing, this very likely reflects considerable underreporting due to treatment outside public sector facilities in settings where reporting is not required.**

There are a number of difficulties with interpreting STD surveillance data, including limited information and a number of potential sources of reporting and diagnostic bias. These diagnosis and reporting issues also reflect larger issues that may result in inappropriate or incomplete diagnosis of different STDs, such as chlamydia. If individuals are treated in different settings for STDs, this also has significant consequences for STD treatment, as discussed below.

- 6. Many young people are practicing unprotected sexual intercourse.**

A number of lines of evidence support this conclusion. A high proportion of syphilis cases in both males and females are in those aged 15-29. Limited data from reproductive health surveys indicate that some adolescents and young adults are engaging in premarital sex, and that condom use is uncommon. Anecdotal evidence from some individuals interviewed by the team indicated that these trends may be increasing over time. Additional studies and behavioral data will help to better define these trends, and factors promoting an increase in unsafe activity.

- 7. The Romanian government has neither articulated nor implemented a systematic, comprehensive national strategy for HIV prevention.**

This represents a major conclusion from this assessment team. For example, there appears to be no major government support (including financial support) for public awareness or a national media campaign. Although some government officials indicated a major commitment to such a strategy, a comprehensive and detailed plan does not seem to have been articulated. The team felt that there was no systematic government support for legitimizing HIV/AIDS as an important public health issue. Government efforts which have been articulated focus primarily on testing issues (such as screening the blood supply), or on medical

issues. For example, the draft national AIDS protocol focuses largely on clinical issues, diagnosis of HIV infection and opportunistic infection, and treatment of AIDS and other HIV-related diseases. Certainly these are important needs and priorities. However, the most cost effective and rational way to deal with HIV infections is to prevent such infections from occurring in the first place.

8. Nongovernmental organizations make an important contribution to the care of HIV-infected children. NGOs, primarily ARAS, also provide important and needed resources for HIV prevention. However, NGOs typically work with no financial backing, leadership or support from the government.

In the meeting with NGOs, most organizations were in some way involved with care or provision of social support for HIV-infected children or their families. These are important and needed efforts. However, there are also critically important needs to prevent future HIV infections from occurring in adolescents and adults. Few NGOs appear to have major programmatic efforts in this area. ARAS (Romanian Association Against AIDS) is notable for having a large number of well thought out prevention efforts which target different at-risk populations (including youth), use a variety of interventions (including provision of educational materials, training of parents and teachers, and peer education), and have provided informational resources (such as the AIDS Hotline) accessible to the general public.

Although acknowledging the role of NGOs, the Romanian government and National AIDS Committee appears ambivalent about the role of NGOs in AIDS control efforts. There appears to be an expectation on the part of many officials that NGOs will receive funding from international or foreign donors. Some government officials also do not seem favorably inclined towards allowing representatives of NGOs to have a significant role in determining HIV policy. At the same time, the government has not assumed a major leadership role in helping to define what the priorities for NGO activity should be.

9. Options for anonymous HIV testing (voluntary testing in which names are not recorded) are very limited and not easily accessible.

Options for both anonymous testing (voluntary without recording names) and confidential testing (voluntary with recording of names maintained confidentially) both appear limited, but the availability of anonymous testing is particularly limited. The one site for anonymous testing which is currently available in

Bucharest is characterized by very limited hours and accessibility, and virtually no publicity. For a number of reasons, this does not seem to be a “user-friendly” or convenient site in terms of facilitating HIV testing. Because of concerns about confidentiality (whether real or perceived) some at-risk individuals may not seek HIV testing unless anonymity can be assured. This may be particularly true for youth, as well as members of potential high-risk groups (such as female sex workers, gay men or drug users) who have legitimate reasons to fear discrimination or stigmatization. The ARAS experience in Constanta strongly supports the idea that there is a demand for HIV testing if such testing can be offered in an accessible, convenient and nonthreatening context.

10. Present government efforts and the current climate do not target specific groups at increased risk for HIV infection.

A number of government and health officials stressed the importance of initiating educational and intervention efforts directed towards the general public. These are critically important. However, in a country in which the HIV epidemic may first emerge in certain high-risk populations, it is also important to have prevention efforts which specifically target and are relevant for these high-risk groups; these include commercial sex workers, sailors who travel to foreign countries, men who have sex with men (including those who may not be gay-identified), and injection drug users. Current laws and the general climate promote stigmatization of many of these groups, and may make it more difficult for current and future AIDS control efforts to have a positive impact.

11. Condoms are available, but not commonly used.

Reproductive health surveys support the idea that condoms are not commonly used as a strategy to prevent pregnancy or HIV/STDs. Reasons why condoms are not commonly used are diverse, and may include concerns about quality and cost, as well as a general lack of awareness. At the same time, there does not seem to be strong government or public opposition to the use of condoms. Several government officials mentioned use of condoms as an HIV prevention strategy, at least one television station was willing to carry condom advertisements, and efforts of NGOs to promote condom use have not met with public opposition.

12. There is no comprehensive, systematic inclusion of AIDS education in the school health curriculum.

ARAS has specifically conducted a number of school-based educational programs for students, parents and teachers. However, there is no national policy for HIV/AIDS education in the school health curriculum, and the government has not taken an active role in developing materials which could be used in such a curriculum. At the same time, there does not seem to be strong government or public opposition to such education, or to discussion of these issues by youth. Several government officials mentioned the need to educate youth about HIV and other STDs, and efforts of NGOs concerning school-based education have not met with public opposition.

13. STD management and treatment appears variable, with use of different treatment strategies in different settings.

Team members had a number of concerns relating to the current system in Romania for STD diagnosis and treatment. Many treatment strategies, such as those for syphilis, were not consistent with current scientific knowledge. Other treatment strategies, such as those for gonorrhoea, might be ineffective because of development of antibiotic resistance. Certain important STDs (such as chlamydia) were not routinely evaluated for, or covered in, treatment regimens. Individuals apparently go to STD clinics, private physicians, pharmacies or friends for STD treatment or advice, and may engage in self-medication without proper follow-up. In general, the entire STD treatment situation is characterized by lack of consistency or standardization. Consequences of this pattern include increased cost (for example, if patients receive prolonged and unnecessary treatment for syphilis), further promotion of antibiotic resistance (for example, if patients receive inappropriate or incomplete treatments), spread of STDs (because of incorrect diagnosis and treatment), and sequelae of chronic infection (which in women may include infertility, and increased risk of ectopic pregnancies, and other complications). Since STD infections also increase the risk of HIV infection, the two epidemics are strongly interrelated. Because of limitations in STD surveillance discussed above, the true magnitude of the STD problem may not be fully appreciated.

14. HIV is a growing health problem in Romanian women. AIDS prevention should be an integral part of women's reproductive health programs

HIV/AIDS prevention should form part of women's reproductive health programs in Romania for a number of reasons. STD rates in Romanian women are rising, the same high-risk sexual behavior which puts women at risk for STDs also puts them at risk for HIV, and STD infection increases women's vulnerability to HIV infection. As noted above, as heterosexual transmission of HIV increases, rates of vertical transmission will rise correspondingly. With an increase in the number of HIV-infected women, women's health providers will have to deal with a variety of issues including prenatal screening for HIV, demand for zidovudine for pregnant women, altered recommendations on breastfeeding, and special needs for contraception and abortion for infected women who wish to terminate or avoid pregnancy.

Despite efforts to decrease Romanian women's reliance on abortion, many women still resort to abortion, and HIV-infected women are no exception. Discussions with the Chairman of the National AIDS Committee indicated that abortion is a preferred option for HIV-infected pregnant women. As noted above, abortion mills which operate with unsterile equipment and which exist outside the formal health system have been anecdotally reported. Increasing fees may drive women to less expensive, and less safe, alternative abortion services, with greater opportunities for nosocomial HIV transmission. Providing HIV/AIDS education, access to voluntary and confidential testing, and referral for safe modern contraception could help reduce the reliance of HIV-infected women on abortion.

Reproductive health services provide ideal channels for reaching women with AIDS prevention and other needed information. These and other opportunities should be explored.

VII. Recommendations For USAID Support

The most important overall priority for new USAID action should be to support expanded efforts in Romania for primary prevention of new HIV infections in adults. A major focus of the HIV/AIDS response in Romania has been on medical and social support of children in institutions who were infected with HIV during the late 1980's. Certainly there should be continued attention to the needs of HIV-infected children, including provision of family and social support. As these children become older, the care needs for these children will also continue to evolve.

However, there also needs to be considerable attention to prevention of new HIV infections. Of particular concern is the prevention of new HIV infections in adolescents and adults, particularly those persons who are infected through unsafe sexual contacts. Sexual transmission (particularly heterosexual transmission) of HIV may represent the next major wave of the AIDS epidemic in Romania, and there is considerable potential for such an epidemic to occur. By the time cases of HIV disease appear, large numbers of individuals may already have acquired HIV. The objective is therefore to prevent the spread of the epidemic before it gets out of control.

In this section, the team has identified five prevention recommendations for USAID assistance to Romania. The team believes that all of these are important and would be of assistance to Romania. However, we have identified two (#1 and #2) that we feel are of particularly critical priority for immediate USAID action. In all of these activities, it is essential that there be a full partnership between outside consultants and Romanians. With the assistance of the local USAID Mission, key individuals in Romania should be included in both the planning and

implementation phases. Interventions implemented now can prevent many cases of HIV and other STDs in the near future.

1. USAID should provide support to the Romanian Association Against AIDS (ARAS) and other NGOs for their HIV and STD prevention activities.

ARAS in particular has taken a major leadership role in Romania in primary prevention, and has a number of innovative and wide-ranging programs. Their efforts deserve continued and strong support. USAID support can help ARAS and other regional NGOs to systematically provide more comprehensive and geographically widespread HIV prevention programs. The teams recommends that conversations be immediately held between USAID/Washington, USAID/Bucharest, and the ARAS office in Bucharest to identify current and future projects which require the greatest support. Such support could then be provided as soon as possible.

2. USAID should support a technical assessment team to Romania to conduct a systematic review of the HIV/AIDS surveillance system.

As discussed above, there are a number of concerns about the current HIV/AIDS surveillance system. In the absence of good surveillance data about this rapidly-evolving epidemic, it may be considerably more difficult to target and evaluate prevention and control efforts. A major goal of the technical review we are suggesting would be to design and implement a baseline survey or surveys to acquire needed and relevant seroprevalence and behavioral data. Potential study populations for these surveys could include pregnant women, STD patients, commercial sex workers and military recruits. Each of these populations could help provide an important perspective on the current status of the HIV epidemic in adults. Good baseline surveys would help define the present HIV infection levels in different groups, and provide data for projecting future HIV and AIDS trends in the population. In addition, the results of such surveys could be used to raise the awareness of government officials and policy makers about the importance of implementing appropriate HIV/AIDS prevention programs.

The proposed review of the surveillance system would also make recommendations for technical assistance needed to improve the surveillance capacity for HIV and other STDs. This technical assistance could be quickly implemented and would be relatively inexpensive for USAID. Consultants could provide help with data management, analysis, survey methodology and other epidemiologic issues. A final assessment would be to determine to what extent

surveillance data is being communicated to the local level, including those involved with HIV prevention efforts (including NGOs). This review would be conducted in collaboration with the Ministry of Health and others in the national government who have primary and direct responsibility for HIV/AIDS surveillance. Members of this assessment team would also communicate closely with officials in the National AIDS Commission in the Ministry of Health.

3. USAID should support expanded efforts in Romania to reduce high-risk, unsafe sexual behaviors in youth.

Romanian youth represent a population at increased risk for HIV and a variety of other STDs. Given low rates of condom usage, a heterosexual HIV epidemic fueled by STDs may particularly impact on adolescents and young adults. In addition to the direct morbidity and mortality which would result from such an epidemic, HIV infection and resulting HIV disease in large numbers of young adults would have serious social and economic consequences which could threaten all aspects of Romanian development.

Because high-risk sexual activity may start at an early age, intervention and education efforts should include programs directed towards school-aged children. Programs could be conducted within schools and other institutions frequented by youth, as well as in the community. A variety of interventions should be explored including (but not limited to) development of educational materials, peer education, videos and comic books, creative use of the mass media, condom promotion, and development of counseling programs.

The team specifically proposes that an evaluation team be sent to Romania to determine ways in which USAID can provide specific support to activities designed to reduce unsafe behaviors in youth. This team should include those with expertise in epidemiology, behavioral science, and adolescent health. Based on this evaluation, the team recommends that USAID implement a specific prevention program for youth, with the goals of promoting safe sexual activities.

4. USAID should explore opportunities to expand condom marketing programs into a national AIDS awareness campaign.

Population Services International (PSI) with support from the Dutch government, is presently planning to launch a socially marketed condom product in spring or summer of 1998. By coordinating this product launch with a national AIDS awareness campaign, AIDS awareness messages could promote the need for

condoms (including the PSI brand), and the PSI campaign would educate the public to sources of affordable condoms. NGOs could consider being affiliated with this campaign and selling the PSI brand. USAID could provide technical assistance to design such a national AIDS awareness campaign, and work to implement the campaign through organizations such as ARAS. This would allow USAID to provide leadership in an area of technical strength (use of mass media, behavior change and awareness raising).

The World Bank representative indicated that two million dollars remain from its first health sector loan to Romania, and would be interested in proposals on how to use these funds. USAID could seek funding from the World Bank, other donors and the government to provide assistance with such a campaign. USAID could provide leadership in helping to “leverage” other donor resources.

5. USAID should fund a team to systematically evaluate current strategies and policies for STD management and treatment in Romania. This team should also make recommendations concerning ways to better integrate HIV and STD prevention and control.

STDs are associated with considerable morbidity. Chronic or recurrent STDs which are improperly treated may lead to infertility, ectopic pregnancies, poor pregnancy outcomes, and other serious complications in women. Congenital syphilis may cause life-long sequelae. STDs may also facilitate HIV infection. The increased risk associated with ulcerative STDs such as syphilis and herpes is well recognized. Nonulcerative STDs such as gonorrhea and chlamydia may also facilitate HIV transmission.

In Romania, there is considerable variability in diagnosis and treatment of STDs. Some common STDs, such as gonorrhea and chlamydia, may be greatly underdiagnosed. Patients may go to a variety of sources for STD treatment. Treatment for a variety of STDs may be incorrect or suboptimal, even if dispensed by physicians, and treatment regimens may be used which foster propagation of resistant strains.

The review suggested above should be conducted in collaboration with the Ministry of Health and others in the national government who have primary and direct responsibility for STD management. One question for this team of consultants is whether Romania should promote use of the syndromic approach in STD treatment. The team may also choose to recommend a nation-wide survey evaluating current STD management practices. Based on the results of this consultation and any follow-up surveys which are conducted, USAID, in

coordination with health officials in Romania, should help to promote standard guidelines for STD diagnosis and treatment. In setting up this initial consultation as well as any follow-up measures, it may also be useful to coordinate activities with WHO. WHO has taken a major interest in STD management, and could provide considerable expertise and technical assistance in this area.

Annexes

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Annex A: Persons Interviewed

USAID

Elizabeth DuVerlie, Communications Advisor,
USAID, Romania

Peter Lapera, Mission Representative
USAID, Romania

Randal Thompson
USAID, Romania

Romanian Government

Daniela Bartos, Vice-President, Committee for Health and Family,
Chamber of Deputies, Romanian Parliament

Nicolae Beldescu, Epidemiology and Control of Communicable Diseases Unit
Institute of Public Health, Bucharest

Marian Dragan, Squad for Countering Organized Crime and Corruption
General Inspectorate of Police, Ministry of Interior

Tudor Manea, Chief of Precursors and Toxic Substances Unit,
Police General Inspectorate, Ministry of the Interior

Geza B. Molnar, State Secretary,
Ministry of Health

Mariana Neacsu, Government Expert
Department of Child Protection

Florin Popovici, Epidemiology Department,
Bucharest Sanitary Police

Valentina Simion, Vice-President,
National AIDS Committee, Ministry of Health

Adrian Streinu-Cercel, Chairman,
National AIDS Committee, Ministry of Health

United Nations/International Organizations

Richard Florescu, Project Officer,
World Bank

Eduard Petrescu, Country Programme Advisor,
United Nations Programme on HIV/AIDS (UNAIDS)

Tim Schaffter, Project Officer,
United Nations Children's Fund (UNICEF)

Kathy Shroff, Technical Advisor,
United Nation's Population Fund (UNFPA)

Other Physicians

Christian Bellu-Bengescu, Senior Psychiatrist, Chief of Drug Addiction
Department,
Clinic Psihiatrie-Toxicomanie, Bucharest

Dan Duiculescu, Infectious Diseases
"Dr. Victor Babes" Hospital, Bucharest

Diaconu C. Dumitru Justin, Director
Centrului Dermato-Venerian, Bucharest

Sechel Luminita,
HIV/AIDS Testing and Counselling Center, Bucharest

Rodica Matusa, AIDS Clinic,
Spitalul Municipal Constanta, Constanta

Mariana Mordorescu,
"Floarea Soarelui", N. Gh. Lupu Hospital, Bucharest

Comon Oona,
Centrului Dermato-Venerian, Bucharest

Sorin Petrea, Day Medical Center
"Floarea Soarelui", N. Gh. Lupu Hospital, Bucharest

Dr. Sorin Rugina, Director,
Clinical Constanta Hospital

Gradina Vasile,
Centrului Dermato-Venerian, Bucharest

Nongovernmental Organizations

Daniela Avram, Social Worker,
Health Aid Romania

Andrei Cristian , Project and Development Manager,
Romanian Angel Appeal, Romanian Forum HIV/AIDS Children and Families,

Becky Davis, Participant (Training for USAID)
World Learning

Maria Georgescu, Executive Director,
ARAS (Romanian Association Against AIDS)

Catalin Gheorghe, Information Officer,
World Learning

Roxana Girip, Director,
ARAS Constanta

Tania Goldner, Director,
Holt International -- Romania

Michael Holscher, Country Representative,
Population Services International, Romania

Mark Parkison,
World Learning

Laurentire Zolotusca, Technical Team Coordinator
World Vision

Other Organizations

Irina Reisler, Reporter,
PRO TV, Bucharest

The team also visited a children's institution entitled "Leaganul De Copii" in the town of Cernavoda, located in the judet of Constanta.

Annex B: Documents Reviewed

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- Explanation of Current Conditions on Romanian Institutionalized and Abandoned Children
- Humanitarian Assistance in Romania--Pediatric AIDS (October 2, 1995)
- Romania
- Romanian Children (May 13, 1993)
- Unmet Needs for HIV+/AIDS Children in Romania
- USAID's Health Programs in Romania (1994)

Whiting, Leila. Evaluation of the Social Work Component of the World Vision/ARAS, Community Outreach Team, April 1995.