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1. INTRODUCTION

1.1. Sociodemographic Data

The first AIDS case in Romania was recorded in 1985. Since 1987, cases have been reported to county PHIs who make epidemiological inquiries aimed at finding contacts and keeping track of HIV-infected persons. As per this reporting procedure, 13 AIDS cases among adults were recorded with the Ministry of Health (MOH) and World Health Organization (WHO) through the beginning of 1990. HIV infection cases among children have been tracked since 1989, with the first data made public in 1990.

Until 1990 there was no PHS system for tracking HIV/AIDS infection in the real meaning of the definition. Only one hospital in Bucharest was empowered to give a diagnosis, and MOH legislation stipulated that cases identified there be reported. In March 1990, a PHS system for HIV/AIDS was set up. This system was developed in collaboration with WHO and the Centers for Disease Control.

The Emergency Short-term Action Plan for HIV/AIDS infection, which was drafted upon the Health Minister's request by the Preventive Medicine Directorate and WHO/GPA, stated that knowing the extent of HIV infection in the country was its first objective. Other objectives were added later and included the following:

- monitoring morbidity, mortality, and evolution tendencies for HIV/AIDS infection;
- providing guidance for public health actions, prevention purposes, and to end some modes of transmission;
- planning health services for the HIV-infected persons; and
- developing a special budget, which was done for the first time in 1995.

The PHS system for HIV/AIDS infection developed in parallel with increased possibilities of clinical confirmation at country and national reference laboratories. Epidemiologists had the fundamental role of introducing and making the PHS system operational by training clinicians to appropriately define cases; prepare questionnaires; collect, process, and analyze data; and report to the Preventive Medicine Directorate in the MOH. A computerized data management system was developed by WHO and CDC for tracking AIDS cases. Initially, the system was available only at the MOH, but in time, spread to several counties. In 1992, the same algorithm was put into practice for HIV infection.

1.1.1. Case Definitions

A group of WHO, CDC, and Romanian experts drew up a case definition that reflected (as close to the truth as possible) the distribution of AIDS in Romania. In choosing a definition, the real possibilities of laboratory diagnosis, extension of diagnosis responsibilities from one hospital to several hospitals throughout the country, and training health workers were considered. All were under heavy financial constraints. It should be stressed that, at the beginning of 1990, only three laboratories in Bucharest practiced routine serologic HIV testing, because the necessary kits were not provided.

The AIDS case definition the group decided upon is an adaptation of the clinical definition from Bangui, which was drawn up in 1985. Unlike the Bangui definition, this one includes laboratory confirmation of HIV infection. The AIDS case definition was developed for PHS system requirements, not for clinical care management.

Since 1992, the HIV case definition considers HIV infection present if two tests of different principles were positive. The latest figures published by the Romanian MOH show that, by 31 December 1997, 5,147 AIDS cases and 3,552 HIV cases had been registered.

1.2 Current Status of AIDS in Romania

1.2.1. Annex 1, AIDS Cases

Annex 2, Causes of Infection for Adults (AIDS file; MOH data at 31 Dec 1997)

Annex 3, Causes of Infection for Children (AIDS file; MOH data at 31 Dec 1997)

Annex 4, HIV Positive Evolution in Romania (MOH data at 31 Dec 1997)

In Romania, 4594 pediatric AIDS cases were recorded by December 31, 1997, representing 89.3% of the total number of cases in the country. The share records a very slow downtrend compared to previous years, as the “tanker” of pediatric nosocomial cases goes out and the epidemic among the adult population is revealed. Furthermore, the national trend indicates the possibility of leveling in two to three years. Retrospective case-control studies carried out in 1990 (institutionalized children) and 1992 (family children, national) brought arguments that, no matter what their origin, pediatric AIDS cases are exposed to the risk of infection by parents, correlated to hospitalization, associations being statistically significant.

Apart from the epidemic dimension of pediatric AIDS cases, 94% of HIV infection transmissions in Romania can be ascribed to factors other than mother-child transmission. Differences are high for mother-child and nosocomial transmission and categories with indication of infection origin among children. Transfusion might be allotted an exaggerated share of cases in Romania, given low HIV seroprevalence among the donor population between 1990-1996. The share of cases with unknown transmission is high in Romania, related to the high number of abandoned children and untested mothers. In most cases, information regarding a mother’s serologic status comes after her child has been diagnosed with HIV, which entails discussions related to considering mother-child transmission correlated with the age at diagnosis and presence of exposures by hospitalization and injection treatment. For children born before 1990, the estimated risk of contracting HIV infection following injectable treatments is 10 times higher than for a child born after 1989, with a probability of 95%.

Low death cases (37.6%) lend support to accounts of clinicians declaring HIV cases as AIDS cases in order to gain access to prophylactic treatment with anti-retrovirals and to social material support for families.

1.2.2. Pediatric HIV Epidemics Mask the Epidemic Among Adults

In Romania there were 553 AIDS cases (10.7% from the total number of our cases) by December 31, 1997. In a dynamic view, 82 AIDS cases were known among adults in 1991 (6.5% from a total of 1,282) and were distributed in 21 counties. However, in 1997, they were distributed in 36 counties.

Two urban agglomerations, Bucharest and Constanta, show an evolution of epidemic type, visible here through the iceberg top, which is AIDS. The two urban agglomerations suggest that the entry point for HIV infection was probably the end of the 1970s. No epidemiological surveys have been published on the geographical distribution of HIV1 subtypes or the spread of HIV among adult sub-populations in Romania. The slow, steady, and relatively diffuse spreading of HIV infection among adults in the rest of the country might suggest a pattern of heterosexual transmission. Related to this, agglomeration along highways could show up in the near future. Based on the model of infection in the Ukraine, big cities can quickly become centers for HIV infection among drug addicts.

Case-control studies of 1990 and 1992 (among children) showed that the epidemic evolution among adults and children, was not practically related. HIV infection among adults determined only introducing HIV infection in children population (vertically and horizontally by transfusions), while diffusion among these occurred horizontally nosocomial, for at least 41.4% of cases.

Sex ratio (men/women) is a little higher than one in Romania, specifically, 1.02:1, which is characteristic of countries where heterosexual transmission is prevalent. After years of stability, heterosexual transmission had a share higher than 80 in 1996. The importance of this share is correlated with the presence of several HIV1 subtypes (A and C, E). The share of cases with unknown transmission remains high overall and can hide cases among the male population practicing homosexual/bisexual relations and not declaring it, as well as nosocomial cases which have not been declared till now, which is common where the number of nosocomial transmitted cases among children is very high.

1.3. Current Status of STDs in Romania

Over the last 10 years there has been a dramatic increase in the number of reported cases of syphilis in Romania. Although less than 2000 cases were reported in 1986; 5000 were recorded in 1990, and 7277 in 1996.

1.3.1 Annex 5, Syphilis Cases (MOH data at 31 December 1996)

It is of note that approx. 73% of all syphilis cases in women are among those aged 15 – 29. Sixty-one percent of men with syphilis are also in this age range. For the entire country, 2459 (34%) cases occurred in rural areas, while 4818 (66%) were recorded in urban areas. Of 2025 cases of syphilis among women in urban areas, 22% were among those aged 15 – 19 and 48 % were among those aged 20 – 29 years. Of 2793 cases of syphilis among men in urban areas, 10 % were among those aged 15 – 19, while 50 % were among those aged 20 – 29 years. These data are consistent with reports of unprotected sexual activity among adolescents and young adults.

The number of reported cases of gonorrhea is very similar to that of syphilis and decreased over the period 1990 – 1996 from 33.5 per 100.000 inhabitants to 17.8. In 1997 3219 cases were reported—2463 among males and 756 among females respectively. This decline strongly suggests that underreporting is greater for gonorrhea than for syphilis. Patients with gonorrhea are more likely to seek care through private practitioners who do not report cases through the surveillance system. As for other STDs, mycosis and trichomoniasis are more likely to be detected in women treated in gynecology cabinets; therefore, reports show a larger number of women than men. Hepatitis B and C are not reported inside the system of STD surveillance and are treated like infectious diseases.

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. Even if the test for syphilis is mandatory for obtaining a marriage license and driver's license, applying for a job, and admission to military service, for pregnant women and other groups, the reporting system is weak and the monitoring and surveillance system does not function properly. These diagnosis and reporting issues also reflect larger issues that may result in inappropriate or incomplete diagnosis of different STDs, such as chlamydia.

2. NATIONAL AND INTERNATIONAL RESPONSE

2.1. National STD Program

The national STD program is one of the programs financed by the state budget outside the Health Insurance System. The program is focussed on the following areas:

- developing accessible testing and treatment facilities
- carrying out epidemiologic surveys on the population at risk
- planning and implementing prevention measures, including IEC activities; and
- training the medical staff.

2.2. National AIDS Program

The government currently does not have an active comprehensive program of AIDS prevention. To date, most efforts have focused on treatment for PLWA, ensuring the safety of the blood supply, and preventing HIV transmission through unsterile needles and injections. The health system in Romania is undergoing a major reform process. Since January 1998, the Health Insurance Law has been enforced and the emphasis has shifted to primary care. Nevertheless, for major health issues like TB, HIV/AIDS, and other STDs National Programs were established and budgeted central level under the authority of the MOH. Out of a proposed budget of 250 billion lei, the AIDS program received just 28 billion (3.2 mil US\$) this year. The program focuses on following areas:

- medical care, including anti-retroviral treatment and treatment for opportunistic infections for PLWA;
- securing the blood supply and medical interventions;
- strengthening monitoring and surveillance systems;
- conducting epidemiologic surveys of at-risk groups;
- issuing IEC materials for prevention; and
- training medical staff

The experts consider the program to be severely under-funded and there are doubts that the money will be sufficient even for treatment.

There are no other AIDS programs in other ministries, despite the fact that some ministries have parallel medical networks. The Ministry of Labor and Social Protection is ensuring social support for the PLWA and for the families that have children with AIDS through the regular program for handicapped people. In addition, there is no Multisectoral AIDS Commission in place. Although a Multisectoral AIDS Commission was in place from 1994 – 1996 under the authority of MOH, it was not reactivated after the changes made in the 1996 elections. The only officially established body is the National AIDS Commission from the MOH, a consultative body for the MOH program.

In 1997, a group initiative formed by government officials, NGOs, and UN agencies proposed the establishing a National AIDS Commission under the authority of the Prime Minister. Although the response was positive, political instability during the last part of 1997 and the beginning of 1998 delayed the process. In the meantime, the UN Theme Group on HIV/AIDS took the initiative to facilitate the work of an informal AIDS commission, which was called the Analysis and Evaluation Commission (AEC). In the absence of the National AIDS Commission, AEC

represented the interests of the involved partners and included representatives from ministries, NGOs, and international organizations.

2.2.1 Annex 6, Members Analysis and Evaluation Committee

Guiding principles of AEC

- Plays a consultative role
- Decisions are made by consensus
- Each member represents its sector
- Flexible, broad framework
- Work in respect to human rights and not discriminatory to vulnerable groups and people living with AIDS

AEC Mission

- Gather all the available data concerning the determinants of the epidemic in Romania.
- Evaluate the need for new data and call working groups to provide these data.
- Gather all the available information concerning the national response and evaluate programs and actions in the field.
- Produce a report concerning the situation and national response in Romania and make recommendations for the formulation of the strategic plan.

AEC Meetings

- AEC will meet twice a month.

The AEC agreed to the following working plan for the strategic planning process:

2.2.2. Annex 2, Workplan for the Strategic Planning Process in Romania

National NGOs

-
- Romanian Association Against AIDS: prevention for risk groups, IEC, hotline, summer campaigns, social services
 - SECS: education for family planning (FP), services for FP
 - Youth for Youth: education for access to FP services, prevention of STDs, campaigns
 - Adolescent: education for reproductive health, FP education
 - Marie Stops Foundation: education for FP and reproductive health, FP services
 - Others

International NGOs

-
- Holt International: HIV+ abandoned children integration in family and society
 - Save the Children Romania: social assistance for abandoned HIV+ children
 - Romanian Children's Appeal: runs 4 clinics for HIV/AIDS outpatient care, 2200 beneficiaries, \$82,000/year and supports the Romanian Forum for Children and Families Affected by HIV/AIDS, \$60,000/year
 - Health Aid U.K: humanitarian aid for abandoned positive children
 - Nightingales Children Project: building medical and education facilities for positive children
 - World Vision
 - Medicine du Monde, Equilibre: L'observatoire Européen de l'enfance, SERA, providing testing kits and drugs
 - Population Service International: project on social marketing of condoms

- Foundation for Open Society: primary care project 1997 – 2000, \$10 mil., training for medical staff (including HIV/AIDS curricula), TB prevention program

Bilateral Donors

- The Netherlands: supporting Romania Social Marketing Project for condoms, for the sexual and reproductive health of youth
- USAID: had a Family Planning program 1992 – 1997 and launched a new program for child welfare and reproductive health, \$7 mil.
- Canadian International Agency for International Development: grant of 1 mil Canadian dollars for UNICEF's "Romanian adolescent health HIV/AIDS project" that has the following major components: support to HIV/AIDS strategic planning, support establishment of a national monitoring and surveillance system, IEC for behavior change

UNAIDS Cosponsors and Other UN Agencies

UNDP	Activities: UNDP is leading the UN Theme Group on HIV/AIDS and provides accommodations and facilities to CPA. HIV/AIDS and STD information is also included in two major projects: "Poverty Ellevation" and "Strengthening the Romanian Capacity on Gender Issues."
UNICEF	Activities include care and social support for children living with AIDS, training for medical staff, HIV/AIDS IEC, school based programs, youth support service, and support for NGOs.
UNESCO	European Center for Higher Education has not implemented any projects, but will start this year with nationally executed projects.
UNFPA	Activities: Two major projects in 1997: "Reproductive Health and Sexuality Education for Adolescents" were implemented by the NGO Youth to Youth, and funding was also provided for "Support to the Romanian National Family Planning Program", as well as for other outreach activities developed together with NGOs, contractor for WB condom purchasing program.
WHO	Activities include development of national health policy, prevention of communicable diseases (including AIDS), protection of women and children, and health care delivery reform.
World Bank	Activities: Provided a \$150 mil. loan for health service rehabilitation, from which \$21.5 mil. was given for HIV/AIDS (WB data), small NGO support program.

3. DATA COLLECTION AND ANALYSIS

3.1. Annex 3, Table 1. Information sources for HIV/AIDS infection, Romania, 1998

Hospitals are the main data source for case information. If the clinical and serological diagnoses are confirmed, the clinician attending the case should fill in the declaration questionnaire.

Questionnaires can be monitored in the hospital only if a hospital epidemiologist or purposely-appointed person deals with them, otherwise they are collected at the statistics department. Extremely few hospitals now have a computerized data management system.

Each hospital has questionnaires and legislation covering the duties incumbent on them.

In common practice, some aspects bearing upon the filling in and reporting procedures have been ascertained.

From this point of view, hospitals can be classified:

- Reference hospitals, where HIV-infected patients are constantly taken care of and where questionnaires are constantly filled-in (infectious disease hospitals). The share of cases reported by such hospitals, for Bucharest, exceeds 85%. These hospitals also offer care for many cases from the country, especially from adjacent counties.
- Hospitals attending HIV-infected patients, which were selected by patients or because they render medical services for specific fields. The pediatric hospitals are by far more concerned with filling-in and reporting the questionnaires than the adult hospitals. This category also includes the phtisiology or STD hospitals whose common practice is to transfer these cases to infectious disease hospitals. Filling-in accuracy requires relatively frequent interventions with a view to validating.
- Hospitals which may casually care for such patients and which do not fill-in the questionnaires on the grounds that they transfer the case to infectious diseases hospitals, or that they learn the serologic result very late and do not enter the result in the questionnaire, even though they mention the diagnosis. This category still includes maternity wards, where HIV-infected patients can no longer be considered rare cases.

HIV testing laboratories report monthly the number of tests/positive tests. Laboratory confirmation criteria are not clearly defined. This aggregate data source has been used in 36 countries in Europe.

This type of data would be more useful for epidemiologists if they made available information on population age and group.

In NCFA's opinion, laboratories should make available case information instead of aggregate information.

Anonymous free testing is used in 37 European countries. There is one single center in Romania (Bucharest) functioning by cooperation between PHI (capacity) and ARAS (counseling).

HIV infection trend can be monitored, especially with some population groups, *by uncorrelated anonymous testing* (sentry), with advantages related to costs as well as ethic and legal aspects. Since the method is used at very large periods of time (year), sudden changes in the trend may not be noticed (for instance, the population of I.V. drug addicts).

By protocol authorizing a national monitoring information center for HIV infection, the problem of correlating information from **other networks** can be solved.

3.2. Data Processing

Questionnaires can be managed by computer, through Epi-Info software package. Data are entered in a guided manner. At the end of each term, after successive entering, data are checked again to find out any logical inconsistencies, and are further submitted to routine analysis programs.

The quarterly data processing may take in all, for Bucharest, up to one week, depending on the number of questionnaires, as well as on the existence of inconsistencies. Entering the data as they come in and solving inconsistencies at the end of the term increase the time allocated, and that is why an alternative would be to have this stage by the end of the term.

Data are processed at the national level by processing the questionnaires received from PHI, which becomes less involved, and has consequences for the analysis stage.

The national and county codes are little used, although they would be useful to prevent double records. This could be made possible especially with HIV database, which is built on the principle of anonymity.

3.3. Data Analysis and Interpretation

Data analysis is done quarterly, at national and county level. Since 1990, the same methodology has been maintained, thus being possible to compare evolution tendencies at different moments, in different places and among different groups of persons.

The main characteristics on which the analysis is founded are time, space, and person. Their interaction can also provide useful information.

Apart from this unique methodology, by using the Epi-Info package, exploratory analysis can be performed, taking into account the fact that data are not always clear enough.

3.4. Data Dissemination

At the national level, data are reported quarterly to the WHO European Center in Paris, which, after one term, makes available to whom it may concern a report and a European database.

Feedback to the county level was operational practically between 1990-1992. In those years, the authorized Directorate in the MOH prepared and edited newsletters, also comprising information on HIV/AIDS infection.

Since 1994, national data have been more accessible through the WHO European Center or media, as MOH feedback to counties was not operational. National database, confidentiality measures assured, is not available to the public. Lack of feedback can be detrimental to the image of the PHS and leaves place for pseudoscientific speculations from inside the medical system or from the outside (public or media).

At the county level a horizontal informational feedback is created, from PHI to the Health Directorate, from which the information, theoretically, should reach basic units. Information is formal and complex analyses are required only in crisis situations (mostly caused by the media).

Direct feedback between PHI and basic units depends to a large extent on the degree of understanding the role of dissemination by the epidemiologist - “the man at the crossroads” - and on the degree of involvement of those in the basic units, which do not identify in PHI a constant partner for dialogue.

3.5. Discussions

On the whole and at first sight the PHS did not go through modifications between 1990-1997. This is an advantage, as comparisons can be made without great errors related to changing case definition or operating conditions. Initial efforts, originating at national level, allowed for gradual understanding of the PHS role, especially by epidemiologists. Due to lack of further efforts and formal character of PHS activities, it was possible to reintroduce the old practices based on the key word “reporting.” Reporting is nothing but an element in the PHS and cannot substitute monitoring, as it still happens. Lack of feedback had an important share in resetting this situation.

Table 2. Informational transfer by the PHS system—flowchart

Stage	Level	Accomplishment	Observations
Source	Primary Hospital, etc.	Yes Yes	Diagnosis Questionnaire
↓			
Collection Validation Processing Analysis	County PHI	Yes Yes ? ?	
Feed-back		Yes	Upward - Yes Horizontal - Yes Downward - ?
↓ ↓ ↓			
Collection Validation Processing Analysis	National MOH	Yes Yes Yes Yes	
Feed-back		Yes	Upward - Yes Horizontal - ? Downward - ?

The priorities of the PHS, as seen in 1990, did not represent, surely, priorities for 1998. Deficiencies in system operation can be seen by flowchart analysis synthesizing the informational transfer, depending on stage, level, and achievements (Table 2).

Primary level, source, is vital, because here originate information which constitute the reason for existence of a PHS system. Information originates as the diagnosis is made, this activity being developed by sources (hospitals) by their own functions, surely related to the degree of endowment with equipment and diagnosis kits.

The next step, questionnaires' filling-in, remains unfulfilled, both from the point of view of not reported cases (subreporting), influencing the covering rate of the PHS system, as well as from the point of view of questionnaires' filling-in rate, an indirect indicator of acceptance. Filling-in rate is not related to correctness of data provided, to which contribute several factors: endowment for diagnosis, doctors' training, acceptance, motivation, etc.

Units' and doctors' agreement is not asked, being imposed. Recording the agreement could represent a guarantee for correctness and completeness of data.

The present case definition is viewed only from the inside of the PHS system, because at the primary level the diagnosis and questionnaires' filling-in is made on criteria belonging to case CDC definitions, which is also true for reference hospitals in Bucharest, as well as for some from other counties (Constanta, Mures, Dolj, etc).

Thus, the case definition should be reviewed in order to eliminate difficulties encountered by clinicians about their role within the PHS system. Reviewing can only be done by a careful assessment of the necessary resources for all sources, not only for a few specialized centers. By reviewing, only the European definition or the CDC definition can be taken into account (more precisely by using the CD4 counting), both very complex as compared to the simplicity of the present one. Once accepted, reviewing also imposes modification of questionnaires and therefore, of the structure of AIDS and HIV databases. Reviewing can only be done by maintaining the existing information (one should not start from scratch).

Questionnaires on HIV/AIDS infection should be standard, thus eliminating the possibility of using "adapted" forms and increasing the degree of importance destined to their filling-in.

The county level is involved in collection and validation. Local data processing is necessary for analyses and local specific interventions. Shifting stress on processing from national to county level could determine the county level to attach the necessary significance and could decrease the present workload at the national level only for validating data received from counties and avoiding double recording. Surely, this stage has certainly a different share in the counties, depending on case prevalence, but it would be unrealistic to wait for computerized management of data from counties with 1-2 cases. Stimulation can appear by extension to other databases of local interest.

Data processing at the national level is often a source of inaccuracies generated by: lack of knowledge of cases at county level, misallocation of cases (depending on the county where the hospital which diagnosed is located and not on domicile county of the patient), difficulty (including costs) of data validation. Anecdotally, on March 31, 1997, Bucharest was validating by processing 550 cases, and the national statistics developed by MOH, without validation, stated 557 cases. The explanation originated in the very high number of cases in the counties, diagnosed and reported in Bucharest, county allocation at the national level being for the source and not patients' domicile. This kind of inadvertence can affect the image of the PHS.

The role of analyses at county level is not defined exactly, although programs and report forms which can be used both by the national and county level were set up. The uneven application does not allow for the possibility of comparisons between counties at given moments.

If until 1992 the role of feedback was understood as necessary, in upward, horizontal or downward sense, understanding the PHS system philosophy being proven (information was obtained for developing actions, by knowledge from the ones concerned), the situation worsened afterwards.

The national level must assure data confidentiality with a view to protecting infected persons and not to limiting the access inclusively for NCFA.

This aspect generated multiple reactions, national and international, questioning the statistical data regarding HIV/AIDS infection in Romania. An example can be quoted from a report of a UNAIDS team of May 1996: "... there was controversy and to some extent uncertainty about the epidemiological situation in the country. Several agency representatives expressed... that there was a certain degree of underreporting. There also was controversy concerning the relative importance of nosocomial versus sexual transmission in Romania."

Lack of feedback can lead to functioning of the PHS system under the sign of formalism and obligation with primary consequences on data quality and secondary on the quality of prevention actions.

Feedback to the non-governmental sector is still regarded from a reticent perspective, while gaining its contribution would be crucial to solve some interventions, especially local.

Resources and costs necessary for PHS system functioning should be the focus of a careful concern if the need for accurate interventions is identified, even in the framework of a limited budget granted by MOH for an AIDS program. This budget should allocate a compulsory fund for PHS system functioning.

Disfunctionalities evaluative approach, within the team, by participating epidemiological and public health experts, represents the solution to avoid a modern contemporary PHS system making history.

Table 3 Prevalence of HIV infection among vulnerable populations or with risk behaviors

Population	Prevalence	Source	Observations
Homosexuals	?NA	None?	
Prostitutes: males/females	?	?	
Clients of prostitution	?	?	
Convicted persons	0.5%	MOJ	Uncorrelated anonymous study, 1993-1995
Street children	?	?	
Drug users	0	PHI Bucharest	Data on the persons addressing the center for disintoxication, 1996-1998
Teenagers 13-19 years	?	?	
Pregnant women	0.2% (6 counties from Moldavia), 1990	MOH	to be filled in
TB patients	0.6%, 1995	MOH	to be filled in
STDs patients	0.2-0.8%	DVC	to be filled in
Health-sanitary staff	?	MOH	
Sailors	?	MOT	
Long distance drivers	?	MOT	
Recruits	?	MoND	
Military staff returned from		MoND	

missions			
....			

The table, which is not exhaustive is informative, and is open to be further completed, for both populations at HIV infection risk, as well as for other data.

The table suggests in fact the absence of conclusive data regarding HIV infection trend among vulnerable populations / with infection risk due to behavior. Based on these data, it is extremely difficult to reach conclusions on the process of setting priorities related to uncorrelate anonymous (sentry) testing, epidemiological studies, or other epidemiological activities.

4. ASSESSMENT BY TOPIC

4.1. Sexual Behavior

4.1.1 First Intercourse

- 38% of women reported sexual intercourse before 18 years old and 11% before 16 years old
- from the women having sexual intercourse before 18 years 66% had low education level
- 36.1% of men reported sexual intercourse before 16 years old and 72.9% before 18 years old
- Less than half of 15 – 25 year old women and two-thirds of 15 – 24 year old men have ever had sexual intercourse (Young adult reproductive health survey – YARHS 1996)

4.1.2. Premarital Experience

- 25% of women reported premarital sexual experience
- 65.6 of men reported premarital sexual experience
- unlike women young men benefit from social sexual permissiveness and may tend to exaggerate their sexual experience
- there are no significant differences between rural and urban in terms of age of first intercourse, premarital sexual experience

4.1.3. Number of Partners

- in the last three months 88% women and 65% men have had only one sexual partner
- almost 93% of the young adults who were married or living with a partner reported to be monogamous
- 4% of women and 24% of males with sexual activity reported having more than one sexual partner in the last three months
- over the lifetime 87% of men and 19% of women reported having 2 or more sexual partners

4.1.4 Abortion

- 2.8 % women between 15 – 19 years reported having an abortion and 12.4% between 20 – 24 years old
- the rate of premarital pregnancies carried over is 9%
- from the total rate of abortion of women between 15 – 24 years old 96.2% are unwanted pregnancies

4.1.5. Condom Use

- in 1996, 34% of the young adults used a condom at the first sexual intercourse
- condom is the second most used contraceptive method among young adults
- 22% of the women at the first intercourse asked the partner to use a condom and 4% succeeded
- 22% of the women and 36.7% of the men used a condom at the last sexual intercourse
- 5.8% of the stable couples use condoms
- 51.5% of women and 61.2% of men from the group using contraceptive methods reported that they buy condoms from commercial sales
- 0.3% men and women reported receiving condoms from public medical sector
- 2.2% men and women reported receiving condoms from private medical sector
- a high quality condom, lubricated and with reservoir costs approx. 50 cents. The prices range between 10 and 50 cents for different types of condoms
- the condom sales in Romania in 1997 were 15 mil., 35% were Durex
- number of condom selling points in 1996 was:
 - 2,500 pharmacies, 90% in the urban area
 - undetermined number of other shops: supermarkets, cigarette stores, street market, etc.
 - private medical clinics of FP and gynecology
 - there are no female or anal condoms available on the market
 - there are no special lubricants available on the market
 - there is no current free condom distribution program

4.1.6. Condom Knowledge

- 59% of women 15 – 24 years old and 76% of men consider the condom as the best method for STD prevention
- 16% women and 12% men consider the condom as not effective for STD prevention
- 46% women and 60% men consider that condom reduces sexual pleasure
- 47% women and 35% men consider it embarrassing to buy a condom
- school education proved to increase with 16% the number of women and with 8% the number of men with knowledge about condom use

4.1.7. Condom Behavior

- 93% women have heard about condoms and 67.4% know how to use it
- 97% men have heard about condoms and 91.5% know how to use it
- 83.5% women and 90.5% men know where to buy condoms
- the most popular contraceptive method among men and women is the condom: 22% for women and 37% for men

4.2. Knowledge and Attitudes Concerning HIV/AIDS/STDs

- 96.7% women and 97.6% men have heard about AIDS
- 57% women and 62% men heard about HIV/AIDS from radio or television
- 17% women and 10% men learned about AIDS in school

- 4.2% women and 2.2% men learned about AIDS from medical staff
- first source of information about AIDS and STDs is for 27% of women and 50% of men a friend or a peer
- 96.7% women and 98.1% men knew that HIV can be transmitted by heterosexual relation
- 95% women and 97% men knew that HIV can be transmitted by unsterile medical operations
- 91.2% women and 95.1 men knew that HIV can be transmitted by transfusions
- 85.1 men knew that HIV can be transmitted by homosexual relations
- 58.5% women and 44.6% men consider themselves to be out of risk for HIV transmission
- 4.4% women and 10% men consider themselves at high risk for HIV transmission

4.3. STD Control Program

- there is one National Institute for STDs
- there are 41 clinics/hospitals (one in each county) that test, diagnose, treatment and in patient care for STDs. There are 3,818 beds in public hospitals allocated for STDs
- at each county level there is an epidemiologist that is in charge of STD surveillance and establish the local intervention programs. The local epidemiologist is in charge also with reporting the data to the central level
- testing for STDs are free of charge, confidential
- the epidemiologic survey is done with mandatory partner notification
- there is no clear testing protocol for STDs
- some of the STDs are reported based on clinical symptoms
- HIV testing is generally done among STD patients
- 0.5 – 0.6% HIV seroprevalence among STD patients
- *bugetul actual pt 98*

4.4. Proposal for Monitoring Additional Indicators

- number of medical and paramedical staff, level of training, involved in STD program breakdown on regions
- introducing and reporting all the STDs confirmed by lab analysis
- total number of tests run breakdown on different types of STDs and the total number of positive tests and the total number of positive tests
- evolution of the costs of the testing kits
- types of tests available in each region
- total number of testing facilities for STDs, private/state owned
- incidence in other health networks than MOH (ministry of defense, interior, justice, transport)
- number of patients having more than one intervention for an STD
- number of patients with several episodes of the same infection
- number of anonymous testing centers
- number of testing facilities that offers pre and post testing counseling
- incidence on associated STDs
- average cost of specific treatment for each STD
- average daily cost of in patient care
- salary and bonuses of the medical staff in comparison with medium national wage
- number of studies of STD incidence in risk groups
- number of nongovernmental programs for STD prevention (beneficiaries, funding etc)

4.5. Prevention Programs

4.5.1 Health Workers Training Program

- in Romania there is no medical specialization in AIDS
- the doctors that treat AIDS are specialized in infectious diseases and to work in AIDS they are self-trained or trained abroad
- the training of the nurses for HIV/AIDS has been done recently in the curricula of infectious disease
- theoretically all the medical staff was trained in universal precautions
- there is no evaluation of the level of training in AIDS of the medical staff and of the number of trained personnel for working with AIDS
- the curricula for training in universal precautions was developed by UNICEF and ARAS (NGO) and was integrated in the curricula of MOH
- most of the AIDS medical conferences and training sessions were organized by NGOs (professional or community based) and drug companies
- the hospitals in the regions with more cases become resource centers in terms of training and information for the other areas.

4.5.2. Blood Transfusion Protocols

- Blood safety is insured by the law issued in 1995 that rules the donation and utilization of the human blood and derivatives
- Blood transfusion centers in all the districts – 41, coordinated by the National Institute for Hematology; large hospitals have their own transfusion facilities. Also the health network of Ministry of Defense has its own transfusion network
- Donated blood is currently tested for HIV, hepatitis B and C, and for syphilis
- Blood donation is voluntary. The donors are paid or offered benefits. The entire system of collecting blood is non-profit
- Blood donation campaigns are conducted regularly by Red Cross and MOH
- in 1996 there were 143,973 liters of blood donated and 124,172 liters of blood and blood derivatives transfused
- 156,436 patients received blood and blood derivatives
- 70% of the blood comes from regular donors, 14% from irregular donors and 16% from donors at first donation
- number of donors in 1996 is estimated to be between 137,768 and 213,735
- the rate of regular donations in different from region to region
- the rate of donation at 1000 inhabitants dropped from 19 in 1995 to 17 in 1996
- the biggest number of donors was registered in 1993 when the allocation for the donation was substantially increased
- the HIV incidence in donated blood in 1996 was 0.0152%, most of the incidence coming from first time donors. The number of samples tested + in 1997 were 27, 2 of them were potentially infective donations.
- The share of hemophiliacs in Romania is at least 5 times lower as compared to the other three countries. The hemophiliacs/transfused share ratio is supraunitary in Spain and Italy, subunitary in France (0.4/1) and Romania (0.03/1). Differences between shares with hemophiliacs and discrepancy of the ratios against transfusions suggest the possibility of an allocation.
- Apparently, 1 out of 5 children in Romania were infected following transfusions with contaminated (not tested) blood. A simple explanation would be that all children received transfusions when this was not checked. Analysis of the ages at the diagnosis' date reveals that at least a third of children are born after introducing screening of donations (1990).

- The transfusion risk factor disappears for children born after 1989, which can be explained by introduction of blood screening, and also by a more judicious use of transfusions.
- counseling for blood recipients is not usually done

4.5.3. *Proposal for Monitoring and Reporting Additional Indicators*

- period and way of monitoring for a patient that received a potentially infectious donation
- number of donors rejected from donation because the initial investigation (anamnesis) shows major risks

4.6. HIV Testing Facilities *de pus la capitolul 3 data sources*

- from the total of 930 Hospitals and Polyclinics and 6058 Medical clinics health network just 100 have HIV testing facilities
- another 10 private clinics have testing facilities
- there are also approx. 500 private laboratories that have the capacity to perform HIV testing, but they do not have authorization for that
- several anonymous private testing facilities were established in Bucharest and other major urban areas. Latest reports show that they do not work

Table 3 Prevalence of HIV infection among vulnerable populations or with risk behaviors

Population	Prevalence	Source	Observations
Homosexuals	?	?	
Prostitutes: males/females	?	?	
Clients of prostitution	?	?	
Convicted persons	0.5%	MOJ	Uncorrelated anonymous study, 1993-1995
Street children	?	?	
Drug users	0	PHI Bucharest	Data on the persons addressing the center for disintoxication, 1996-1998
Teenagers 13-19 years	?	?	
Pregnant women	0.2% (6 counties from Moldavia), 1990	MOH	to be filled in
TB patients	0.6%, 1995	MOH	to be filled in
STDs patients	0.2-0.8%	DVC	to be filled in
Health-sanitary staff	?	MOH	
Sailors	?	mot	
Long distance drivers	?	mot	
Recruits	?	MoND	
Military staff returned from missions		MoND	
....			

- by law the testing is done confidentially
- the test is mandatory for TB patients

- the test is free of charge twice a year for: medical staff at risk, dialyzed patients, pregnant women, military recruits, STD patients and their contacts, prisoners, prostitutes, homosexuals. Because of the discrimination (cultural and legislative in the case of homosexuals) some of these groups do not use the testing services. Despite that just few tests are run for those groups because of shortage in testing kits.
- There are two major testing services inside the MOH: the network of blood donation centers and the network of Local Public Health Departments. Each of them reports directly to MOH. For each of them there is a reference laboratory for confirmation of the initial positive tests (the confirmation is done by other types of tests)
- The confirmation of the positive tests is done after 2 different ELISA at local level and one Western Blot done at reference laboratory.
- The legislation requires that the reporting of HIV positive tests to be done anonymous
- the pre- and post-test counseling is done just in a few facilities. The public health facilities do not have special personnel. In some facilities the doctors or NGOs provide the counseling.
- Also hospitals and clinics do not have social assistants
- The cost of usual testing in public health network is up to 10 US\$
- Types of HIV tests used:
 - ELISA different types used especially at the local level
 - Western Blot, used mainly by the reference laboratories
 - P24 protein determination used in few large urban university clinics
 - Viral load – just 2 facilities one in Constanta and the second to be installed this year in Bucharest (cost of one test approx. 100 US\$)

4.6.1. Proposal for Monitoring and Reporting Additional Indicators

- number of testing centers that have counseling
- the schedule of the testing and counseling centers
- number of medical staff that was trained for HIV counseling
- number of jobs of counseling nurse
- number of persons counseled pre testing and post testing

4.7. AIDS Care

- medical assistance is 80% ensured by the public health network both in term of resources and implementation
- the rest of 20% in terms of resources (drugs, equipment, counseling) and care is ensured by NGOs and private sector
- 90% of the social workers working in AIDS are provided by NGOs
- the 47 Infectious Disease Hospitals or Departments provide the AIDS medical care. There is at least one in each of the 41 counties.
- There are approx. 110 medical doctors who specialize in infectious diseases
- There are 6 day clinics in main urban areas for PLWA that provide services for approx. 73% of the PLWA. In addition there are 10 outpatient clinics
- The etiologic medical treatment is done in the infectious disease hospitals or departments.
- The treatment of the opportunistic infections is done by the specialized departments of infectious diseases, TB clinics
- The treatment for other maladies is done in the specialized departments in accordance with the nature of the malady (surgery, ophthalmology, obstetrics, dental care, etc.)
- The etiologic treatment for HIV infection is done with anti-retrovirals
- The anti-retrovirals available in Romania are: NNRTI, NRTI and PI.

- 80% of the patients in Romania receive treatment with ARVs
- from the total number of HIV/AIDS registered cases (reported to MOH) approx. 10% receive monotherapy (AZT), 50% receive double therapy (NRTI: AZT + 3TC/HIVID), 10% receive triple therapy (2NRTI + PI)
- the cost of the therapy: monotherapy approx. 2300 US\$/year, double therapy between 3500 and 6700 U\$, triple therapy approx. 10,000 US\$.
- Double therapy on the larger scale was introduced in the second half of 1997 and triple therapy at the beginning of 1998
- The budgetary execution for 1997 shows that approx. 1.7 mil US\$ were spend for ARV treatment
- The price of the drugs in Romania is the same as in the EU
- The ARVs are not available in pharmacies being exclusively distributed by the public health network.
- 80% of the PLWA receive treatment for prevention/treatment of the PC infection
- part of the etiologic treatment of the rest of opportunistic infections is done through the primary care network. Some of the drugs for treating opportunistic infections are not accessible: they are not registered in Romania (e.g. "Primatene") or cannot be covered by the budget because of the high cost (e.g. acyclovir injectable, the treatment for CMV)
- the treatment is done in most of the cases by clinical monitoring, mostly by monitoring CD4 (in the 6 day clinics)
- there are only two facilities for determining the viral load but they are not yet functioning
- The National AIDS Commission from MOH established the criteria for inclusion, exclusion, monitoring and interrupting treatment. These criteria are not universally applied in the country
- The treatment and care is developed based on protocols and evaluation forms: nutritional, TB, ARV, neurological. This is also not universally applied in the country.
- The system does not provide hospice home care.
- There are only 2 residential hospices for terminal children care with a capacity of max. 120 beds. The international NGOs established them.

4.8. Additional Indicators

1. Structure of the National AIDS Commission - NAC from MOH. NAC has a central committee and 41 districtual committees. Total number of persons involved is 400. One percent of them are experts in education, 1% experts in psychology, 2% policemen and the rest are medical doctors (epidemiologists, infectious disease specialists, pediatricians, nutritionists, obstatritians, health promotion experts, hematologists etc)
2. For the STD program in each district/county there is one epidemiologist in charge of monitoring, surveillance and reporting.
3. Annual resources for AIDS care 1997:
 - MOH approx. \$2 mil. for treatment, the costs of salaries, in patient treatment, care, are not estimated
 - Social assistance for PLWA not estimated (PLWA are covered by the handicapped law and the child protection law and are receiving different types of social support)
4. The estimated number of prevention programs:
 - 15 NGO IEC national programs (mostly targeting youth), data not available yet about number of beneficiaries
 - 100 NGO IEC local programs

- there are no special regular programs medical staff at risk
- there are no prevention programs for sex workers and clients, MSM, IDUs, prisoners, truck drivers, sailors, immigrants, pregnant women

Condom

Marketing social PSI

NR.

Val. Totala pt. Durex+ estimarea acoperirii pieteii 80%

PI2 PI3

PI1

6 HIV/AIDS/STD IMPACT DATA

OUTCOMES PI 8,9,10

ANNEXES

Annex 1 AIDS cases

YEAR 1997	DECEASED TO DATE (31.12.97)	LOST FROM RECORDS	LIVING WITH AIDS	TOTAL
Adults	176	21	356	553
Children	1727	61	2806	4594
Total	1903	82	3162	5147

Annex 2 Causes of infection for adults (AIDS file cumulated data at 31 Dec 1997, MOH)

Causes of infection	Male	Female	Total	%
Homosexual	28		28	5.1
Heterosexual	139	143	282	51
IDUs	1	1	2	0.4
Transfusions	15	27	42	7.6
Hemophilia	11	0	11	2.0
Other (unknown)	83	105	188	34
TOTAL	277	276	553	100.0

Annex 3 Causes of infection for children (AIDS file cumulated data at 31 Dec 1997, MOH)

Causes of infection	No	%
Vertical Transmission (mother infected through)		
- IDUs	0	0
- heterosexual	138	3
- other (unknown)	104	2.3
Total vertical	242	5.3
Hemophilia	28	0.6
Transfusions	884	19.2
Nosocomial	2119	46.1
Unknown	1321	28.8
Total	4594	100.0

Annex 4 HIV Positive evolution in Romania (MOH data at 31 Dec 1997)

YEAR	NR. OF ADULTS	NR. OF CHILDREN	TOTAL
1993	4	702	706
1995	268	1095	1363
1996	113	488	601
1997	184	698	882
TOTAL	569	2983	3552

Annex 5 Syphilis cases (MOH data at 31 December 1996)

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
39 – 39 years	766	418	1184
40 – 49 years	507	276	783
50 – 59 years	180	66	246
60 – 69 years	79	23	101
> 70 years	23	6	29
TOTAL	4147	3130	7277

ANNEX 1: The Members of Analysis and Evaluation Committee

- Health Promotion Department, Ministry of Health - 2 persons
- National AIDS Commission, Ministry of Health - 1 person
- Health Department, Ministry of Defense - 1 person
- Ministry of Education - 1 person
- INMRCP, Ministry of Labor and Social Protection - 1 person
- Health Department,, Ministry of Justice - 1 person
- Health Department,, Ministry of Interior- 1 person
- Programs Department, Ministry of Youth and Sports- 1 person
- Romanian Angel Appeal /Romanian Forum for Children and Family Affected by HIV/AIDS- 1 person
- Romanian Association Against AIDS - ARAS- 1 person
- UNICEF Health Officer- 1 person
- UNAIDS Romania Advisor- 1 person

Annex 2 WORK PLAN FOR THE STRATEGIC PLANNING PROCESS IN ROMANIA

NO	MONTH	ACTIVITY
1	February	<ul style="list-style-type: none"> - Establishing Multisectoral Situation Analysis & Response Analysis team – AEC - Establishing the meetings calendar of the AEC, objectives and competence (see annex 1 with the members and the defined role)
2	March	<ul style="list-style-type: none"> - Establishing the work plan of AEC, presenting sectoral situation and sectoral inventory of programs and activities related to HIV/AIDS - Identify gaps of information and establishing actions for collecting new information (see annex 2 concerning the proposed activities for covering information needs) - Establish the AEC secretariat at ARAS NGO (annex 2 bis) - Developing background paper on monitoring and surveillance
3	April	<ul style="list-style-type: none"> - Defining the TORs for Situation Analysis working group (see annex 3, 3bis) - Defining the TORs for Response Analysis working group (see annex 4, 4 bis) - Hiring consultants to work in the two working groups and starting SA and RA - Starting the Intravenous Drug Users Rapid Situation Assessment

4	May	<ul style="list-style-type: none"> - “Data needs for HIV/AIDS Strategic Planning” workshop (based on the background paper on monitoring and surveillance) - Review the work plan of the AEC and establish activity needs
5	June	<ul style="list-style-type: none"> - Presenting the first draft of Situation Analysis report - Circulating the SA report for comments - Integrating the conclusions of SA in the RA report and in the subsequent analyze
6	July	<ul style="list-style-type: none"> - Presenting the first draft of the RA report - Circulating the RA report for comments
7	September	Mid term workshop for: <ul style="list-style-type: none"> - SA and RA data validation - Conclusions of the RA based on the comparison with SA - recommendations and comments
8	October	<ul style="list-style-type: none"> - Final versions of SA and RA reports - Draft version of HIV/AIDS Strategic Plan (based on SA and RA recommendations and conclusions) - Circulating the reports and the draft of Strategic Plan
9	November/ December	<ul style="list-style-type: none"> - Strategic planning workshop - Producing the National AIDS Strategy

Annex 3 Table 1. Information sources for HIV/AIDS infection, Romania, 1998

Sources	Advantages	Disadvantages
Hospitals	<ul style="list-style-type: none"> – main source of information (> 80% from information extent) – the only source of case information collecting – collecting is continuous and uniform – case definition is used – brings information useful for epidemiology 	<ul style="list-style-type: none"> – obsolete case definition, different from the CDC or European one – many sources – two databases are generated, AIDS and HIV, uncorrelated – delays in filling-in – forced framing in AIDS – acceptability – not-reported cases – impose effort for validation – reporting is perceived as insignificant in clinical monitoring
HIV testing laboratories	<ul style="list-style-type: none"> – offer “quick dirty measure” – allow assessment of work load – allow quick cost estimation 	<ul style="list-style-type: none"> – data are aggregated – non-uniform in the “positive” definition – the real number of positives is not accurately reflected – correlation’s with age and transmission means are not included
Blood/blood products screening	<ul style="list-style-type: none"> – monitor a population apparently healthy 	<ul style="list-style-type: none"> – information validation is difficult – correlation’s with age, socio-economic status and transmission means are not included
Anonymous voluntary free testing	<ul style="list-style-type: none"> – offers information on the “invisible” population segment – can highlight recent infections 	<ul style="list-style-type: none"> – lack of political and decision support – does not answer the need for identification

Sources	Advantages	Disadvantages
	– useful in epidemiology, other sources missing	
PHS sentry type - anonymous uncorrelated testing	<ul style="list-style-type: none"> – is aimed at target populations – allows for trend monitoring – uses the anonymous uncorrelated method – is cheap – avoids ethic-legal implications 	<ul style="list-style-type: none"> – methodology is unknown – funds are not allocated – systematic selection errors can be introduced – contravenes to the need for identification – a trend modification can be left out, if the interval is too big
Special epidemiological studies	<ul style="list-style-type: none"> – useful in epidemiology to elucidate hypotheses – allow retro/prospective knowledge of what is happening in selected groups – allow analytical correlation's with factors/risk behaviors 	<ul style="list-style-type: none"> – need a sophisticated methodology – need trained staff – take time – are expensive – studies made until now are not known, an informational national center is missing
Other medical networks		
MoND	<ul style="list-style-type: none"> – could provide information from a network offering health services to about 20% from the country population – could provide information on vulnerable population (recruits) or population exposed to risk behaviors (foreign missions) 	<ul style="list-style-type: none"> – own system for information management – information is not integrated in the national HIV and AIDS data bases
MoIA	<ul style="list-style-type: none"> – could provide information on vulnerable population (arrested) or population exposed to risk behaviors (personnel) 	<ul style="list-style-type: none"> – own system for information management – information is not integrated in the national HIV and AIDS databases
MOJ	<ul style="list-style-type: none"> – uses MOH questionnaires – reports to MOH – introduced anonymous uncorrelated testing 	<ul style="list-style-type: none"> – lack of funds to support anonymous uncorrelated testing
MOT	<ul style="list-style-type: none"> – could provide information on populations exposed to risk behaviors (transporters) 	<ul style="list-style-type: none"> – own system for information management? – information is not integrated in the national HIV and AIDS databases
NGOs	<ul style="list-style-type: none"> – could provide information on vulnerable or “invisible” populations 	<ul style="list-style-type: none"> – use own management programs – databases are restricted to focus communities, with a social stress