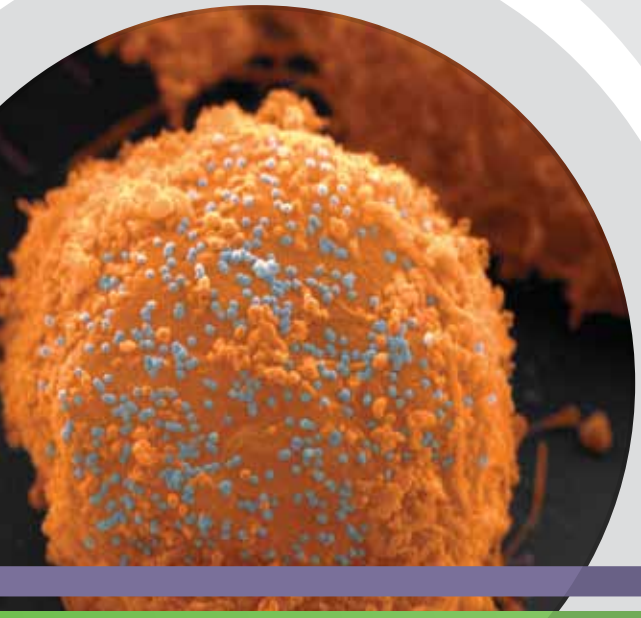

MISSION REPORT

Country mission Romania: HIV, sexually transmitted infections, and hepatitis B and C

11–13 May 2011

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Contents

Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARV	Antiretroviral
ATLL	Adult T-cell leukemia/lyphoma
CDC	Centers for Disease Control and Prevention
CCM	Country Coordinating Mechanism
DIHF	District Health Insurance Funds
DPHA	District Public Health Authorities
DPHD	District Public Health Departments
ECDC	European Centre for Disease Prevention and Control
ELISA	Enzyme-linked immunosorbent assay
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HAM/TSP	HTLV-1-associated myelopathy/tropical spastic paraparesis
HBV	Hepatits B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HTLV	Human T-lymphotropic virus
IDU	Injecting drug user
IUMSP	Institut Universitaire de Médecine Sociale et Préventive
MSM	Men who have sex with men
NAAT	Nucleic acid amplification testing
NCCDSC	National Centre for Communicable Disease Surveillance and Control
NGO	Non-Governmental Organisation
NIPH	National Institute for Public Health
PCR	Polymarese Chain Reaction
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
RAA	Romanian Angel Appeal
RPR	Rapid plasma reagin
STI	Sexually transmitted infection
TB	Tuberculosis
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary counselling and testing

Executive summary

Objectives of the country visit

Following a request by the Romanian government, ECDC conducted a second follow-up country visit to Romania covering HIV, sexually transmitted infections (STIs) and hepatitis B and C between the 11th and 13th May 2011. This followed an earlier visit in 2007. The aim of the second country visit was to gain an update of progress since the previous visit and to address specific issues more recently identified by the Romanian authorities.

The objectives of the mission were:

- discuss the developments in HIV and STI prevention and control that have been made since the last visit in 2007;
- address the current situation with respect to hepatitis B and C in Romania and discuss possible steps for the future;
- discuss the first results of pre-testing of the self-assessment tool within the ECDC behavioural surveillance project as well as future steps.

The visit comprised of meetings with officials at the Ministry of Health, National Institute for Public Health (NIPH), National Institute for Infectious Diseases 'Prof. Matei Bals', National Institute for Research-Development for Microbiology and Immunology 'I. Cantacuzino', Central Reference Laboratory for Transfusion Transmitted Infections, National Institute of Blood Transfusion and representatives of various Romanian non-governmental organisations (NGOs) (Appendix 2).

Epidemiology of HIV, sexually transmitted infections and hepatitis B and C

Since the start of the century, there have been steady declines in the number of new cases of HIV, STIs (gonorrhoea and syphilis) and of acute hepatitis B in Romania, although no trends in acute hepatitis C were reported. Nonetheless, Romania has the highest rate of reported syphilis in the European Union and a very high prevalence of both hepatitis B and C. The large majority of HIV diagnoses are reported to have acquired their infection through heterosexual contact. The number acquiring it through homosexual contact or injecting drug use remains low[1]. The ratio of male to female cases of syphilis was very much lower compared to gonorrhoea (0.96 versus 7.5). There are a number of possible explanations for this including health service use (e.g. antenatal screening for syphilis, unreported homosexual contact) or differential diagnostics (e.g. less likelihood of symptoms in females, the use of less sensitive diagnostic techniques).

National co-ordination

Romania has an established and comprehensive healthcare system, which is overseen by the Ministry of Health. Healthcare in Romania is largely publically financed, the administration of which is increasingly decentralised. HIV services are primarily funded by the National Programme for Communicable Diseases.

A cross-ministerial national public health strategy for HIV and AIDS was first launched in 1999. Key responsibilities are currently overseen by the Country Coordinating Mechanism (CCM). A new national strategy on HIV/AIDS to cover the period 20112015 is under discussion and pending approval.

Prevention, treatment and care

HIV and AIDS treatment and care are delivered through a network of county hospitals, nine regional centres and the National Institute for Infectious Diseases 'Prof. Matei Bals'. At the end of 2010, 7 276 individuals were receiving antiretroviral therapy (compared to 7 244 in 2009 and 7 434 in 2008). However, budgets for the purchase of antiretroviral drugs for the treatment of HIV have been decentralised in recent years resulting in recorded treatment interruptions.

The diagnosis, treatment and management of STIs are based on a ministerial order and free of charge for insured and uninsured individuals. The diagnosis and treatment of STIs are delivered through a variety of health care providers, but most commonly gynaecologists, dermato-venereologists and general practitioners.

[1] Subsequent to the country visit HIV case reports among IDU increased in Romania during 2011 (http://ecdc.europa.eu/en/publications/Publications/120112_TER_Joint-EMCDDA-and-ECDC-rapid-risk-assessment-HIV-IDU.pdf)

The control of hepatitis B is affected through an infant vaccination programme that has been in place since 1995. Older age groups have also been targeted by national vaccination programmes including all nine year old children (1999-2004) and all younger adults. To date, approximately 17 000 individuals have been treated for hepatitis C infection in a programme part-funded by pharmaceutical companies.

Surveillance, monitoring and evaluation

The Romanian National Institute for Public Health is responsible for the surveillance of STIs, hepatitis B and hepatitis C through the National Centre for Communicable Disease Surveillance and Control (NCCDSC). Notification of new diagnoses is required within five working days to the four regional centres, and subsequently to the NCCSDC. The surveillance of HIV is maintained through the National Institute for Infectious Diseases 'Prof. Matei Bals'. An extensive data collection system has been established, monitoring patients in care for HIV and collecting a wide range of biomedical and clinical data.

Testing and diagnosis

There exists a network of 18 voluntary counselling and testing centres organised by Romanian Angel Appeal. Although successful, a number of problems were identified in this network including the recent closure of four centres. HIV testing services are included at national level in the antenatal health services package and an estimated 50% of pregnant women are tested for HIV.

The diagnosis of STIs is assured by an extensive laboratory network and the national reference centre for STIs at the Cantacuzino Institute. In a recent survey conducted by NCCSDC in 2008, 947 laboratories reported performing syphilis diagnoses, 403 gonorrhoea and 186 laboratories chlamydia. Only five laboratories reported using polymarese chain reaction (PCR) to diagnose chlamydia, the remaining 181 laboratories used various enzyme-linked immunosorbent assay (ELISA) techniques

Behavioural surveillance

A meeting was held with Romanian representatives working in different areas of behavioural surveillance. Currently there is no formal behavioural surveillance system in place. However, many surveys have been carried out including bio-behavioural surveys, all of them with international funding. The continuation of behavioural surveillance projects is uncertain due to this funding ending in the next year.

A review of the self-assessment tool was undertaken before and during the country visit. The self-assessment tool was regarded as useful by the Romanian participants but they requested further improvements to the guidance on how to start the process and further refine the tool. Furthermore, there was a need to establish and maintain an inventory of behavioural surveillance projects in Romania.

Conclusions and recommendations

The main recommendations following the visit are:

- **Continued support of the HIV programme:** Many examples of best practice are to be found in this programme, especially the close link between treatment and other additional support services. Non-governmental organisations are highly involved in prevention services, but the vast majority are funded from international sources. However, severe concerns were expressed of recent increases in the number of injecting drug users (IDUs) being diagnosed with HIV and whether this presaged an outbreak. A similar risk was identified among men who have sex with men (MSM) given the high prevalence rates observed in recent surveys.
  Recommendation: ECDC could support HIV prevention services in Romania by highlighting urgent needs and exploring the possibility for bridge funding to maintain the level of services until public funding becomes available in the coming years. The exact nature of support needs to be further elaborated between ECDC and Romanian authorities.
- **Strengthening of the sexually transmitted infections programme:** There is an urgent need to strengthen the STI control programme, which will require strong leadership and political commitment. In particular, the limited capability of both public health and private laboratories to diagnose STIs, the current procurement scheme to outsource STI laboratory services, and the use of currently available technologies need to be addressed. Reporting of cases is currently a complex process involving many parties and consideration should be given to simplifying this in order to make it more effective.
  Recommendation: If requested by the Romanian authorities, ECDC could support any possible external review and evaluation of the performance and division of work of STI laboratory networks, including the national and regional reference laboratories and the regional and national reporting of new STI cases.

- **Strengthening of the programmes for hepatitis B and C:** There is a high burden of disease with high prevalence rates and high related morbidity and mortality. The new plan for hepatitis surveillance seems to be very effective and is in line with the proposal for the new ECDC enhanced surveillance for hepatitis B virus/hepatitis C virus (HBV/HCV). The current framework for prevention and control is based on universal vaccination of newborns; however, screening pregnant women would increase the effectiveness of any hepatitis control plan.
  Recommendation: ECDC is preparing a cost-effectiveness tool to assess which national strategies would be the most effective in the prevention and treatment of hepatitis, and Romania could be a pilot country in this project. The European framework for hepatitis prevention and control that may be developed by ECDC should be deployed to support the establishment of a Romanian strategy in this area.
- **Establish and strengthen antenatal screening programmes:** Antenatal screening programmes are currently in place for HIV (50% screening coverage) and syphilis (33% screening coverage), but not for hepatitis B. The antenatal care (ANC) programme needs to be reinforced to provide a comprehensive programme for all relevant issues.
  Recommendation: ECDC could support the development of a comprehensive ANC programme for the screening of infectious diseases by facilitating the availability of tools to promote screening in pregnant women. It could also provide access to the evidence for cost-effectiveness of screening pregnant women for HIV, syphilis and hepatitis, and contributing with technical expertise to prepare a study protocol for possible (regional) pilot projects which could be submitted for international funding.
- **Human T-lymphotropic virus 1 (HTLV1):** There is preliminary evidence from blood donor screening of an endemic status of HTLV-I transmission in Romania, which may be maintained by sexual transmission and/or mother-to-child transmission by breastfeeding.
  Recommendation: ECDC will monitor the issue as well as provide scientific support for any further investigations.
- **Behavioural surveillance:** The self-assessment tool within the ECDC behavioural surveillance project was tested in Romania and was considered very useful. Currently, in Romania, all behavioural surveys are funded externally and this financial support will end in the next year.
  Recommendation: ECDC and Romanian organisations to work together to find the best approaches for the continuation of behavioural surveillance.

1 Objectives of the country visit

1.1 Background

In 2007, ECDC undertook a first HIV and STI country visit to Romania following a request from the Ministry of Health. The objective of that visit was to review, together with country experts, the status of HIV and STI surveillance, prevention and control in order to:

- identify priority areas where ECDC, within its mandate can provide support.
- direct ECDC activities and propose actions for improvement.
- enhance the knowledge of ECDC's HIV/STI team on the HIV/STI situation in the country.
- identify good practice in HIV/STI prevention and control.
- share country experiences.

The visit resulted in an agreed recommended action list for improvement and further support from ECDC. A detailed report of the 2007 country visit was produced by ECDC and the country representative. The report highlighted examples of good practice including integrated care for young people living with HIV/AIDS, the establishment of a network of voluntary counselling and testing (VCT) centres in 18 counties, and a programme of peer education for prison inmates.

The key recommendations from the report addressed ways of strengthening the public health component of the control and surveillance of HIV/AIDS and STIs. These recommendations included:

- increase the uptake in HIV testing through the established VCT centres;
- assess the prevalence and risk behaviours in hard-to-reach populations;
- improve STI services and surveillance;
- improve HIV surveillance and harmonise with other surveillance systems;
- integrate antenatal care, prevention of mother-to-child transmission (pMTCT) and prevention of congenital syphilis;
- Promote and strengthen health education;
- Roll out a national program for prevention of STI and HIV in prisons.

In 2010, discussions on a possible follow-up visit were initiated between ECDC and Romanian officials. The purpose of the follow-up visit was to review developments since 2007 and to concentrate on specific issues identified by and agreed upon between Romania and ECDC.

The discussions resulted in an official invitation for ECDC to visit Romania from the 11th–13th May 2011.

1.2 Scope and purpose

The follow-up ECDC country HIV and STI country visit to Romania had the following objectives:

- discuss the developments in HIV and STI prevention and control that have been made since the last visit in 2007;
- address the current situation with respect to hepatitis B and C in Romania and discuss possible steps for the future;
- discuss the first results of pre-testing of the self-assessment tool within the ECDC behavioural surveillance project as well as future steps.

In each of the disease-specific areas (i.e. HIV, AIDS, STIs, hepatitis B and C) the discussion focused on aspects related to prevention, surveillance (epidemiology and microbiology), treatment and care.

These discussions described the current situation, highlighted unmet needs and sought possible alternative approaches for the future, including areas of technical assistance and support from ECDC to the relevant institutions and organisations in Romania.

The agreed deliverable of the ECDC country visit is this report, which describes the visit and its main findings and provides recommendations.

1.3 Team

The joint ECDC Romanian country visit team consisted of:

1. ECDC, Disease Specific Programme for STIs, HIV and hepatitis B and C

- Dr. Marita van de Laar, Head of Programme on HIV, STI and hepatitis (team leader);

- Dr. Mika Salminen, Senior Expert HIV and hepatitis B and C;
- Dr. Irina Dinca, Senior Expert Communicable Diseases.

2. ECDC contracted consultants

- Ms Michelle Cole, ECDC consultant, STI microbiology (Euro-GASP);
- Dr. Francoise Dubois, ECDC consultant, Behavioural Surveillance project;
- Dr. Jean-Pierre Gervasoni, ECDC consultant, Behavioural Surveillance project;
- Dr. Anthony Nardone, ECDC consultant, country visits HIV and STI (rapporteur).

3. Romania

Ministry of Health

- Dr. Amalia Canton, Deputy Director Public Health and Control, Public health Department, ECDC AF alternate member;
- Dr. Laurentiu Zolotuscă, Counsellor;
- Dr. Iuliu Todea, Counsellor.

National Institute for Infectious Diseases 'Prof. Matei Balş'

- Prof. Dr. Alexandru Rafila, ECDC management board member

1.4 Organisation

The country visit was conducted in Bucharest over three days (11th–13th May 2011) and consisted of meetings with a range of institutions and organisations. In addition to the ECDC country visit team, a representative from the Euro-GASP[2] project to discuss Romanian participation in the project, and the project team of behavioural specialists from the University of Lausanne were present to review behavioural surveillance in Romania and thus fulfil the third objective of the visit (pre-testing of the self-assessment tool within the ECDC behavioural surveillance project).

In addition to representatives from the Ministry of Health, meetings included representatives from the National Institute for Public Health (NIPH), National Institute for Infectious Diseases 'Prof. Matei Bals', National Institute for Research-Development for Microbiology and Immunology 'I. Cantacuzino', Central Reference Laboratory for Transfusion Transmitted Infections, National Institute of Blood Transfusion and representatives of various Romanian non-governmental organisations (Appendix2). The detailed programme of the three day visit is in Appendix1.

The visit commenced with a meeting at NIPH, where the programme, scope and objectives of the visit were presented. At the end of the visit, a feedback session was held at the Ministry of Health at which the main findings were presented by the ECDC team leader to Ministry and NIPH representatives. The ECDC team is grateful for the time that was generously offered to the team by the many professionals met during the country visit.

Outputs from the visit consist of summaries of findings from the presentations and discussions held during the visit, site visit experiences and background documents collected through research prior to the visit.

[2] http://www.ecdc.europa.eu/en/activities/diseaseprogrammes/hash/Pages/index.aspx

2. Overview of HIV, sexually transmitted infections, and hepatitis B and C epidemiology in Romania

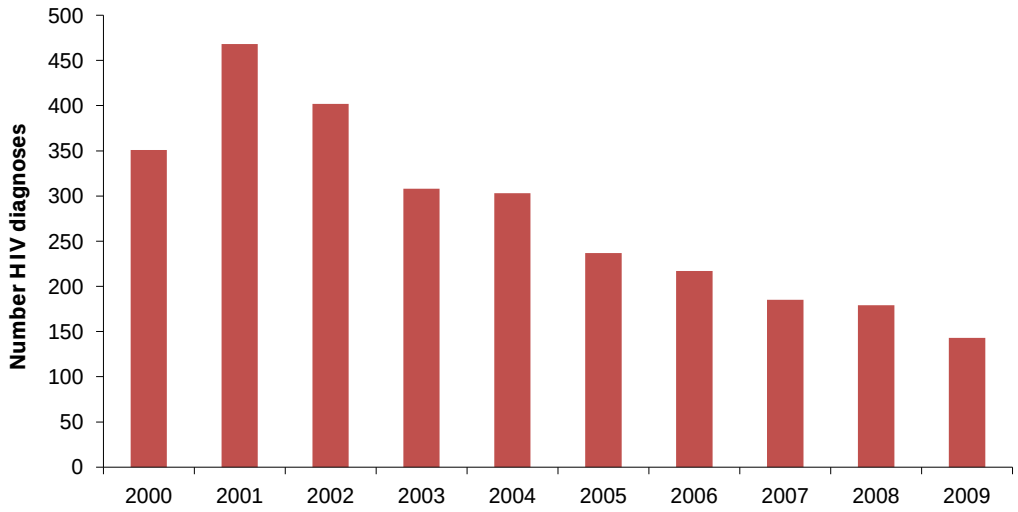
2.1 HIV and AIDS

By 2009, there had been 4 574 diagnoses of HIV infection reported in Romania in total. The annual number of new diagnoses peaked in 2001 at 468 cases and has declined gradually thereafter, falling to 143 new diagnoses in 2009. The annual decline in new diagnoses occurred despite a sustained rise in numbers of HIV tests carried out between 2004 (220 734) and 2009 (284 053).

A cumulative total of 11 456 AIDS cases were reported in Romania by 2009. In 2009, 114 individuals were diagnosed with AIDS in Romania which represents a steady decline since the peak of cases reported in 2000 (599). No data was presented for AIDS-related deaths.

In Romania, the HIV epidemic came to the fore in the early 1990s when a large number of HIV infections were detected among young children and newborns between approximately 1987 and 1991. In recent years, most new HIV diagnoses are reported to have acquired their infection through heterosexual contact (65% in 2009). The proportion of infections acquired through reported homosexual contact or injecting drug use remains low as do the number through mother-to-child transmission. The numbers of male and female HIV diagnoses are approximately equal (48% male in 2009). The large majority of HIV cases were diagnosed at younger ages, reflecting the early nature of the epidemic. However, in more recent years, age groups of those diagnosed are older.

Figure 1. Newly diagnosed HIV reported in Romania, 2000–2009

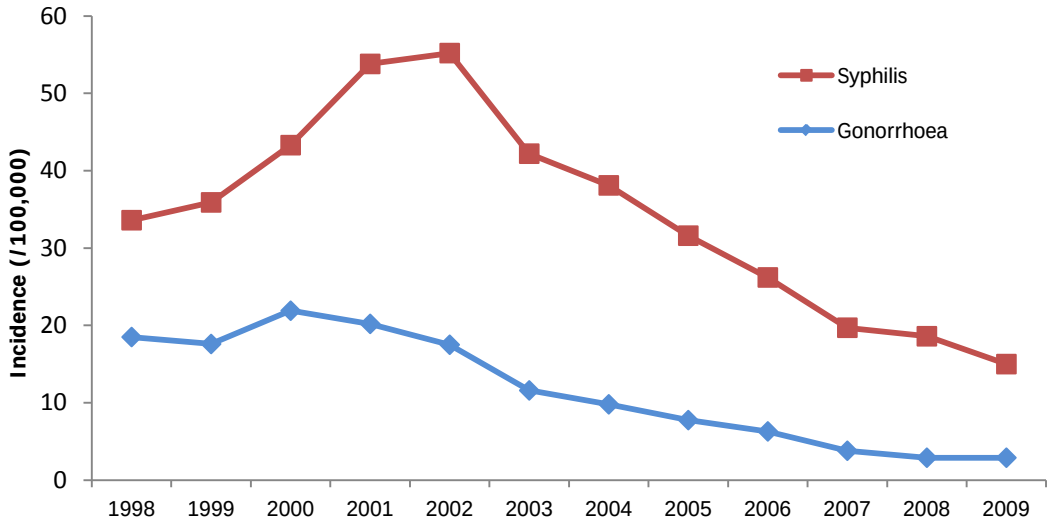


Source: National Institute of Infectious Diseases ”Prof Dr Matei Bals”

2.2 Sexually transmitted infections

The rates of diagnosis of syphilis and gonorrhoea in Romania have been in decline (Figure 2). In the 11 years between 1999 and 2009, rates fell from 34.5 to 15.0/100 000 for syphilis, still the highest in Europe, and from 18.5 to 2.9/100 000 for gonorrhoea. The relative decline in notification for both STIs represent among the largest decreases reported in Europe during the last ten years.

Figure 2. Rates of diagnosis of syphilis and gonorrhoea in Romania, 2001–2009



Source: National Centre Communicable Disease Surveillance and Control

The reported epidemiology in 2009 of gonorrhoea and syphilis, however, contrast widely:

- **Gonorrhoea:** the rate of reports per 100 000 population was 2.9 (616 cases), among the lowest in Europe. However, the ratios of males to females was 7.5 (543 males and 73 females), the third highest ratio in Europe. Of the 615 gonorrhoea cases with reported sexual orientation, only one was reported to be in the MSM category.
- **Syphilis:** the rate of reports per 100 000 population was 18.6 (3 229 cases), the highest report rate in Europe. However, the ratios of males to females was 0.96 (1 576 males and 1 650 females), the third lowest ratio in Europe. Of the 3 229 syphilis cases whose sexual orientation was reported, only five were reported to be MSM.

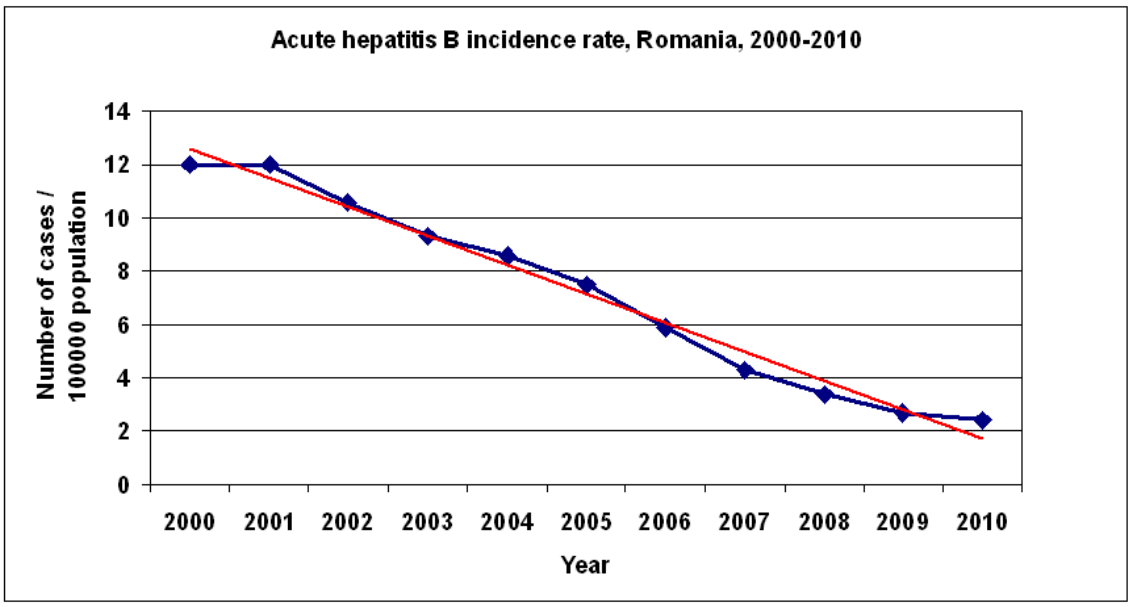
Chlamydia remains very poorly diagnosed (by Immunoglobulin M (IgM) serology testing rather than by nucleic acid amplification testing (NAAT) and reported in Romania. In 2009, 91 cases of chlamydia were reported through the national surveillance system.

2.3 Hepatitis B and C

Romania has been long-recognised has having one of the highest burdens of hepatitis B and C in Europe [1]. The reported incidence of acute hepatitis B has declined from 12 per 100 000 population in 2000 to 2.4 per 100 000 in 2010. In 2010, the majority (59%) of cases were male and the incidence was higher in urban (2.6/100 000) than in rural populations (2.0/100 000).

Although all age groups up to the age of 24 have been targeted by national vaccination campaigns, the highest age-specific incidence of reported acute hepatitis B in 2010 peaked among those aged 20–24 year olds (5.4/100 000). It is also high among 15–19 year olds (2.5/100 000). The reported incidence in infants and children aged less than four years of age was 1.0/100 000, ages which would have been targeted by universal infant vaccination.

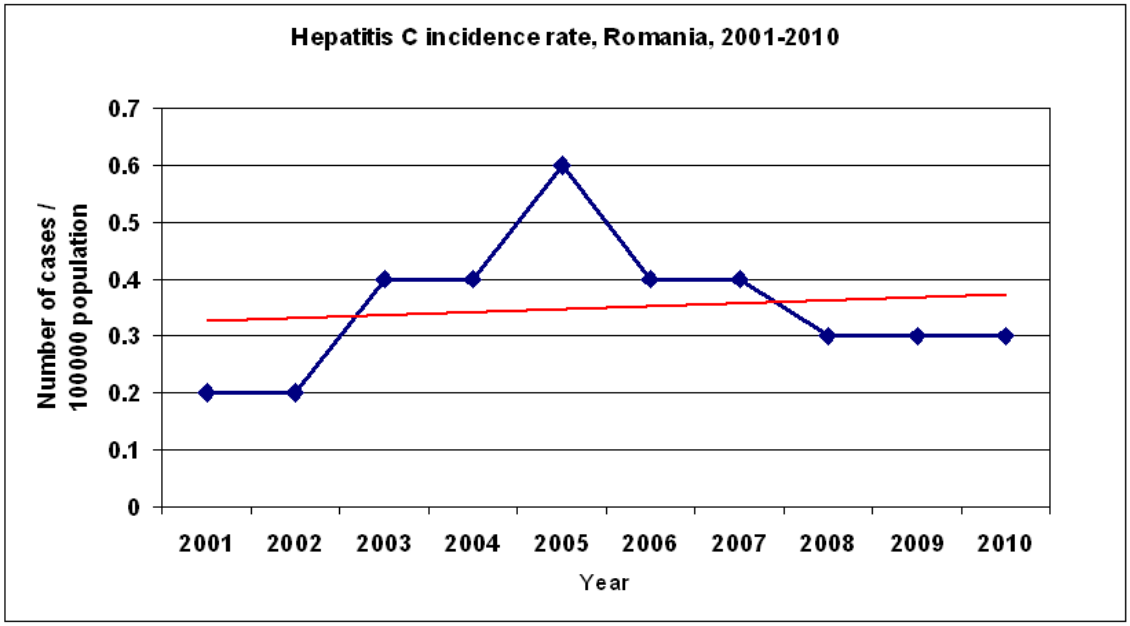
Figure 3. Rates of diagnosis of acute hepatitis B in Romania, 2000–2010



Source: National Centre Communicable Disease Surveillance and Control

In contrast, the reported incidence of acute hepatitis C is very much lower (0.3/100 000 in 2010) and there is no discernible trend in the reported incidence, varying between 0.2/1000, in 2000 and 0.6/100 000 in 2005. In 2010, there were 72 reported cases of acute hepatitis C, with a majority being reported among females (61% females). However, the incidence of HCV is underreported due to its asymptomatic nature. Research studies have estimated the prevalence of hepatitis C in Romania to be between 3.2% [2] and 4.5% [3]. If these estimates of HCV prevalence are applied to the Romanian population, then over 1 million individuals are infected with hepatitis C in Romania. However, within certain populations the prevalence of hepatitis C is very much higher. For example, a recent survey among injecting drug users reported the prevalence of hepatitis C to be in excess of 80%.

Figure 4. Rates of diagnosis of hepatitis C in Romania, 2001–2010



Source: National Centre Communicable Disease Surveillance and Control

3. National coordination

3.1 Health service organisation

In Romania, the total health expenditure was 4.7% of GDP in 2008, of which government expenditure represented 81% of this total.

The Romanian healthcare system has been changed from an integrated model, in which healthcare providers were directly employed by the Ministry of Health, to a contract model in which healthcare providers in the curative health system are independent and are contracted by health insurance funds. The decentralisation strategy of the health system began with the primary care sector in 1999, and culminated in April 2011 with the transfer of the majority of hospitals (471 of 501) to local authority control.

Healthcare is free for those registered and the system works on the reimbursements of costs by the National Health Insurance Fund. The health sector is funded in two distinct ways:

- state budget for the national health programs coordinated by the Ministry of Health (prevention programs and health promotion);
- National Health Insurance Fund: money is disbursed to healthcare providers (primary care, hospital care, specialist ambulatory care, dental care, pharmacy and others). The payment is based on the national framework contract for medical assistance (approved by governmental decision) which assesses payment to healthcare providers by an individual contract with district health insurance funds (DHIFs).

The main components of the healthcare system are the Ministry of Health, health care providers, 42 District (county) Public Health Authorities (DPHA), the National Insurance House, 42 DHIFs, and the National Institute for Public Health (NIPH).

The public health system in Romania is described under various government legislations and orders. Within the Department of Health, the Public Health Department coordinates strategy and policy for the four major national programmes: immunisation; communicable diseases (HIV/AIDS, TB, STI); monitoring environmental risk factors; and evaluation of health status and health promotion.

The NIPH was established in 2009 and consists of three national centres (communicable diseases surveillance and control; monitoring the risks in the community; evaluation and promotion of the health status) along with six regional centres of which four have a responsibility for communicable disease control. These centres interact with the 42 District Public Health Authorities (DPHA).

3.2 Communicable disease surveillance

The surveillance of communicable disease was established by governmental order and further governmental orders defined the information flow and the obligation of all healthcare providers to report listed communicable diseases through the National Electronic Register for Communicable Diseases (see Appendix 3). Cases reported by healthcare providers are reported to the DPHA and onto four Regional Centres for Public Health and then to the National Centre for Communicable Disease Surveillance and Control (NCCDSC). The NCCSDC works in close collaboration with the National Reference Laboratory based at the Cantacuzino Institute.

Nonetheless, the surveillance of HIV/AIDS and tuberculosis are based on reporting systems that run in parallel to those for communicable diseases (see Appendix 3):

- HIV and AIDS surveillance: hospitals and infectious disease units report cases to nine regional centres and then to the National Institute for Infectious Diseases ‘Prof. Matei Bals’.
- Tuberculosis: cases diagnosed by TB medical units and primary care services are reported to the district TB medical unit and then onto the National Institute Pneumology ‘Marius Nasta’

Sexually transmitted infections and hepatitis are reported through the communicable disease surveillance system requiring notification by healthcare providers to the NCCSDC through local and regional public health departments. For each group of infections:

- Sexually transmitted infections that are listed as notifiable include gonorrhoea, syphilis, Chlamydia, genital herpes and Lymphogranuloma venereum.
- Hepatitis: currently acute viral hepatitis (A, B, C and other types) are notifiable through the communicable disease surveillance system. However, to better understand the epidemiology of hepatitis B and C, a new methodology for the surveillance is now being established to monitor chronic viral hepatitis B and C, perinatal hepatitis B and the monthly collation of prevalence data from the testing of first time blood donors.

3.3 National HIV and AIDS strategy

The first national strategy on HIV/AIDS in Romania was implemented in 1999, even though HIV/AIDS was recognised as a major public health problem in the early 1990s. In 2002 the national multi-sectoral commission for the surveillance, prevention and control of HIV/AIDS was established involving ministries, NGOs, civil society, and the private sector. This commission produced the national strategy on HIV and AIDS 2004–2007.

The National HIV/AIDS Commission was reorganised in 2007 under the Ministry of Health. Most of the key responsibilities of the Commission were transferred during the period under review to the Country Coordinating Mechanism (CCM), an entity with the role of overseeing the implementation of the HIV/AIDS services granted by GFATM as well as prerequisite of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) funding for Romania. The CCM is not a legally organised entity, but is structured and presided over by the representative of the Ministry of Health and co-chaired by UNOPA, the representative of the large Network of People Living with HIV. It includes all governmental authorities, civil society, academia and international agencies.

A new national strategy on HIV/AIDS to cover the period 2011–2015 has been adopted and the main aims of the new strategy are to:

- keep HIV incidence below 1% in general the population,
- ensure universal access to prevention, treatment and care for HIV positive people and all vulnerable populations,
- develop and maintain an efficient surveillance system.

The strategy addressed the needs of vulnerable groups (young people, IDUs, female sex workers, MSM, inmates, children living on the street/in institutions, pregnant women, PLWHA). There is neither an action plan nor a budget attached to the strategy.

4. Prevention, treatment and care

4.1 HIV and AIDS

HIV care is organised through the 42 county infectious disease hospitals (under the auspices of the Ministry of Public Health), nine regional centres and the National Infectious Diseases Institute 'Matei Bals' in Bucharest. The county infectious disease hospitals offer day care services which patients are required to attend regularly (monthly is routine) to obtain their medication, for medical checks and for psychological and social support. The regular day care visits aim to keep the patients within the system and to facilitate and improve the adherence for treatment in the adolescents. Mobile units provide the same kind of service, as well as offering HIV testing, for remote areas and hard-to-reach populations.

At the end of 2010, 7 276 individuals were receiving antiretroviral therapy (compared to 7 244 in 2009 and 7 434 in 2008). Access to HIV/AIDS medication is free and provided through the national program funds established in 2001 for HIV and AIDS. The increasing numbers of PLHIV receiving antiretroviral (ARV) treatment required extensive budget allocation (37.263.289 euro in2008 and 39.334.177 euro in 2009). In 2009, 650 patients on ARV did not continue with ARV for a variety of reasons (492 in 2009).

Reports of treatment interruptions due to failure in the supply of ARV have been reported, which has been attributed to the decentralisation of ARV procurement in 2008 as well as limited local management capacity and resources. These reports appear to have continued with at least 10 of 42 counties in Romania experiencing one or more interruptions of treatment at the start of 2011.

HIV testing services are included at a national level in the antenatal health services package (free of charge, recommended by general practitioners). A reported total of 111 037 pregnant women were tested for HIV in 2010, of whom 117 (0.1%) were reported as positive. This represents approximately 50% coverage of the estimated 220 000 live births recorded annually, a coverage that has been increasing steadily in recent years.

There was a network of 18 centres organised by Romanian Angel Appeal (RAA) foundation in the framework of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). GFATM projects funded in round II were included in the District Public Health Authorities structures at the end of 2006. At the end of 2009, monitoring and evaluation activities pointed out a number of problems, including: the closure of four centres (two in the country and two in Bucharest); registered delays in procurement of ELISA testing kits; a decrease in outreach activities for VCT and PMTCT in the counties; and a registered loss of trained staff (counsellor and nurses).

4.2 Sexually transmitted infections

The diagnosis, treatment and management of sexually transmitted infections are mostly delivered through gynaecologists, dermato-venereologists and family doctors (general practitioners). The diagnosis, treatment and management of STIs (gonorrhoea, syphilis and chlamydia) is free of charge for both insured and uninsured individuals as well as their partners.

Guidelines for the diagnosis, treatment and management of STIs are based on a ministerial order a review of which is planned in the near future. The diagnosis of STIs is assured by both public and private laboratories. A reference centre for syphilis serology is based at the Cantacuzino Institute. Following the 2007 ECDC country visit, the NCCDSC conducted a survey in 2008 to assess the capacity of laboratories to diagnose STIs and reported that:

- Syphilis: 947 laboratories reported performing syphilis diagnoses, nearly two-thirds were private (62%) and the majority (620) were using rapid plasma reagin (RPR)
- Gonorrhoea: 403 laboratories reported performing gonorrhoea diagnoses, nearly two-thirds were private (62%) and the majority (366) reported using gram staining. Over a quarter (111) reported using culture and conducting diffusimetric susceptibility tests. Interestingly, this capacity of diagnosis and susceptibility testing is not offered by the national laboratory at the Cantacuzino Institute, which managed to collect 17 cultures during 2010 for transfer to the European Microbiology STI Surveillance Project.
- Chlamydia: 186 laboratories reported performing chlamydia diagnoses, of which 82% were in the private sector. Seven counties in Romania have no laboratory capacity to diagnose Chlamydia. Only a minority of laboratories (five) are using tests other than ELISA for the diagnosis of chlamydia.

There are no national guidelines describing a systematic approach to partner notification (although some STI guidelines refer to the need for partner notification to be done). Partner notification is legally compulsory for healthcare providers diagnosing HIV, syphilis, gonorrhoea and chlamydia. Partner notification for patients diagnosed with gonorrhoea and syphilis is performed by the dermatovenereology or gynaecology clinic where partner notification occurs through patient or provider referral.

4.3 Hepatitis B and C

Since the early 1990s, the prevention of hepatitis B has rested on a number of public health interventions. The first of these public health interventions was the introduction of single-use syringes for vaccination programmes and in all healthcare settings in Romania. Furthermore, in 1992, all blood donations were screened for hepatitis B surface antigen and anti-hepatitis B core antibodies using ELISA tests.

These interventions were followed in 1995 by the introduction of vaccination of all newborns against hepatitis B as part of the National Vaccination Programme with a schedule administered at zero, two and six months. The reported coverage of hepatitis B vaccination of infants is high (>95%) and has been at this level since the late 1990's. Routine vaccination has also been introduced for older age groups: for nine year olds between 1999 and 2004; and for 18–21 year olds since 2004. There is currently no screening of hepatitis B surface antigen.

Treatment of chronic hepatitis B and of chronic hepatitis C is available in the form of interferon and of antiretrovirals. To date just over 17 000 patients with hepatitis B or C have been treated in a programme that is part-funded by pharmaceutical companies. Currently, for patients of chronic hepatitis C, approximately 50% of cases end in virological failure, due in part to the very high levels of individuals infected with hepatitis C genotype I.

5. Role of non-governmental organisations

A meeting was held between the ECDC team (including externals consultants) and members from a range of different non-governmental agencies. Representatives from the Romanian Ministry of Health and the National Institute of Public Health were also present.

A range of organisations presented their work in different populations affected by the HIV/AIDS epidemic. Activities and services available for the vulnerable populations include:

- Men who have sex with men (MSM): community based behaviour change programmes (i.e. popular opinion leaders); internet interventions; anti-stigma campaigns; and support for MSM living with HIV;
- Injecting drug users (IDU): needle and syringe exchange programmes for IDUs are provided exclusively by civil society organisations in outreach and drop-in centers. Programme monitoring data indicates that in 2010 more than 16 000 IDUs had used needle and syringe exchange programmes and more than 3.3 million syringes were distributed.
- Female commercial sex workers nearly all HIV prevention activities for female commercial sex workers are provided by civil societies. Programme data from 11 areas reported nearly 6,000 contacts with this group with nearly 2 million condoms and almost 300 000 syringes distributed.
- People living with HIV and especially young people; services offered include psychosocial counselling and support, peer support, social and professional integration as well as information giving and positive prevention.
- The 'Education for Life' programme is an optional programme available to young people in schools and provides information and education activities.
- Other activities reported by organisations included those that targeted other vulnerable populations such as Roma, prisoners and young people as well as educational activities for professional target groups (e.g. teaching and medical professions);

Nearly all organisations were heavily reliant for their HIV prevention activities on funding from international donors, of which one of the largest is the Global Fund. All represented organisations expressed varying degrees of concern as how to continue HIV prevention activities after the ending of funding by these international organisations. The uncertainty of funding for HIV prevention services was cited as a major difficulty and this was exacerbated by the decentralisation of governmental funding for many aspects of HIV prevention and treatment. This was reflected by reports of on-going interruptions in treatment supply (ranging from short to long-term interruptions of up to six weeks), and of closure of four VCT centres in Romania, (of which two were in Bucharest).

Many organisations reported high levels of social stigma, most especially against the gay community and people living with HIV/AIDS. A number of organisation presented behavioural monitoring and evaluation data which are essential for the development of the programme's own activities and contribute to the national surveillance of HIV by the provision of behavioural information.

6. Behavioural surveillance

A meeting was held between the ECDC consultants working on the behavioural surveillance project and the following individuals from the Romanian team: Dr Viorica Gheorghui (STI contact point, NIPH); Dr Claudia Dima (Health Promotion, NIPH); Dr Mioara Predescu, (Academy of HIV/AIDS); Dr Laurentiu Zolotusca (counsellor, Ministry of Health); and Ms Fidelie Kalambayi (monitoring and evaluation, Romanian Angel Appeal)

6.1 Background

Currently there is no formal behavioural surveillance system in place. However, many surveys have been carried out including bio-behavioural surveys with international funding (GFATM, United Nations Office on Drugs and Crime, United Nations Development Programme, Centers for Disease Control and Prevention, etc.) over the last 15 years. The informal monitoring and evaluation group (mainly composed of representatives of NGO's) as well as the CCM that were set-up during the GFATM funding period, have a high level of expertise and knowledge about existing data and the use of it to develop programmes and monitor them. There have been reflections about future behavioural surveillance in the context of the new national AIDS strategy 2011–2015 that is being approved.

When UN agencies left Romania it led to a drop in funds and resources which was not replaced by European institutions. On the other hand the continued presence of UNODC and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) focal points in Romania is an important resource for some studies, especially on drug users.

6.2 Assessment of self-assessment tool

The self-assessment group has not followed all the steps proposed in the self-assessment tool. In particular the inventory of surveys and other data collection for behavioural surveillance has not been completed fully. The group has started to reflect on and fill in the excel template. During the meeting the main behavioural studies were listed.

General comments on the self-assessment tool stated that it was regarded as a useful tool, however there is a need to develop guidelines on how to use it.

The excel tool was considered especially relevant as a tool designed to follow the progress of the development of a behavioural surveillance system and not for benchmarking purposes. There is a need to clarify that the criteria used in the excel tool are self-defined (e.g. adequacy, frequency of data collection, etc.) by the country. A number of specific comments regarding the excel self-assessment tool were made:

- the column with comments should be used to explain the reason for the value of the score;
- the migrants/ethnic minority section should also include the Roma population for Romania;
- it is necessary to add a new section on sustainability that will provide a summary diagram by population.

6.3 Propositions for behavioural surveillance

The discussions raised a number of propositions and recommendations, both specific to the ECDC behavioural surveillance project, and more general:

- The Health Promotion Department of the NIPH could collect and compile the information on behavioural studies. This could be done by the NIPH organising quarterly meetings with the main actors (NGO's, etc.) to update the information on behavioural surveys.
- Two groups could be included for future work: representatives from the former Country Coordinating Mechanism (CCM) who are still in place, and representatives from the monitoring and evaluation group (informal) who are under the umbrella of the National Institute for Infectious Diseases 'Prof. Matei Bals'. They have already exchanged information on studies conducted, and provided data for the national plan on HIV/AIDS 2011–2015 and on a regular basis for the United Nations General Assembly Special Session report.
- Representatives from the association of Roma organisations could be invited into the self-assessment group, as they have already conducted studies in the Roma population.
- The Institut Universitaire Médecine Sociale et Préventive (IUMSP) could develop a one page document on how to inform experts on why it is important to join the self-assessment group. This document could then be translated and sent to the experts. The second proposition is that IUMSP develop a list of type of experts that could be invited to participate in the self-assessment group.
- The self-assessment group will convene a new meeting to conduct the inventory of surveys and send information to the members of the group before the meeting.

- There is a need to assure funding to maintain behavioural surveillance activities. A number of options could be explored including seeking money through structural funds for NGO's as well as requesting information from counterparts in Bulgaria and Estonia on how they were able to support and develop their surveillance systems after the withdrawal of international funding.

7. Blood transfusion services and HTLV

7.1 Blood transfusion services

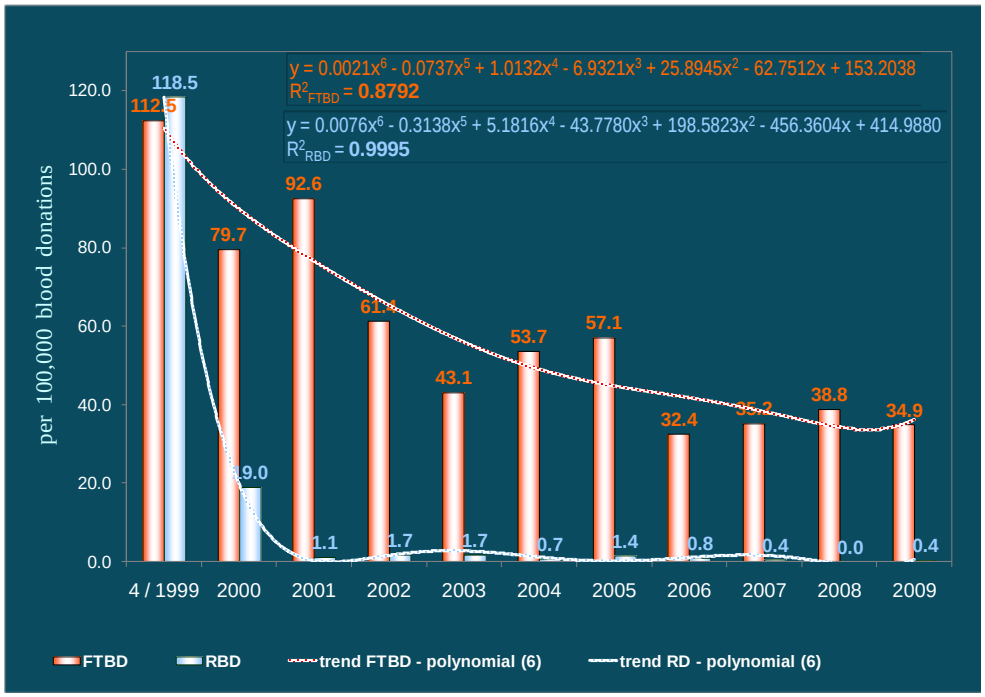
The Central Reference Laboratory for Transfusion Transmitted Services in Bucharest at the National Institute of Blood Transfusion was visited for a meeting with its head, Dr. Mihai Pecec and Dr. Oana Ciocan (from the 'Coltsea' Clinic of Haematology).

The meeting was arranged to discuss Human T-lymphotropic virus Type I (HTLV-1) prevalence in Romania. Some studies have suggested that prevalence may me significantly higher than in other EU member states.

7.2 HTLV epidemiology

Dr. Pecec presented data on the prevalence of confirmed HTLV-1 antibodies in blood donors in Romania. Dr. Ciocan presented information on the prevalence of adult T-cell leukemia/lymphoma (ATLL) in Romania.

Figure 5. Prevalence of confirmed HTLV-1 cases among blood donors in Romania

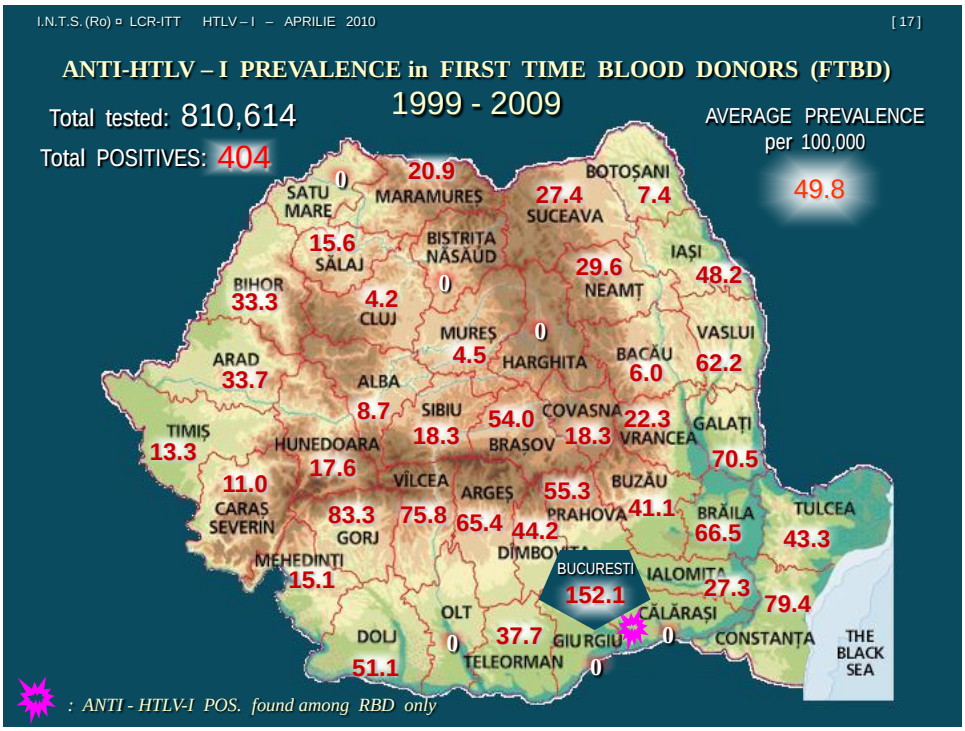


Source: Dr. Mihai Pecec FTBD: First time blood donors, RBD: repeat blood donors

In Romania, since 2000, screening of donated blood for HIV, HBV, HCV and HTLV-1/2 infection has been performed on all donations. Prevalence of HTLV-1 is clearly higher among first-time blood donors in Romania compared to other EU countries where data is available from. No cases of HTLV-2 have been recognised.

Among repeat donors however, incidence is low, suggesting that control measures of testing for HTLV-1 are effective in reducing the risk of blood-borne transmission.

Figure 6. Regional cumulative prevalence of HTLV-1 among FTBD



Source: Dr. Mihai Pecec

In a regional presentation of the geographic prevalence of HTLV-1 cases among fist-time blood donors, it is evident that cases can be found across the country, but the highest rates are seen in Bucharest. The figure is slightly misleading as it shows cumulative prevalence over a ten-year period, but cases have continued to be detected at a fairly constant rate in recent years.

In discussions with meeting participants, it was also shown that ATLL cases occur in the country, although not at a particularly high rate (23 cases positive for HTLV-1 in Bucharest from 2000–2009). However, case detection and correct classification is challenging and the natural lifetime incidence among carriers low. One single HAM/TSP has been described in Romania during the same time period.

Disaggregation according to age or gender was not available for the cases. Approximately 25–30 % of donors are first-time donors and significant proportions also come from socioeconomically disadvantaged population groups. HTLV-1 infected cases are generally not co-infected with HIV.

7.3 Implications of HTLV-1 among blood donors

The occurrence of HTLV-1 among first-time blood donors in most regions of the country with a comparatively high rate in Romania suggest that there may be a low level of endemic occurrence of this chronic infection in the general population, or some subset of it.

HTLV-infection in Europe is generally very rare, and associated with specific risk factors or population groups (injecting drug use, origin or history of origin from endemic areas or subpopulations outside the European region).

The lack of co-infection with HIV suggests that the establishment of the HTLV prevalence is not linked to the large cohort of children (most of whom are now adults or adolescents) iatrogenically infected in Romania in the 1980s and 1990s.

In European settings, equipment sharing in relation to injection drug use has been the major factor of risk leading to HTLV transmission, but this has exclusively been transmission of HTLV-2. No reported outbreaks of HTLV-1 due to injecting drug use equipment sharing have been described in the European setting. Also, IDU-associated outbreaks are usually relatively localised and lead to very high levels of prevalence within short time periods. This is inconsistent with the pattern seen among first-time blood donors in Romania.

HTLV-1 can be transmitted sexually, and by fresh blood/tissue products containing live cells as well as through mother-to-child transmission. In the latter case, transmission is linked to breastfeeding and the mechanism depends on cell-mediated transmission. In-utero transmission has not been described. Mother-to-child transmission of HTLV-1 has been extensively studied in Japan where prevalence in some regions of the country was shown to

be the highest in the world. This mode of transmission, however, can be efficiently prevented if breastfeeding time is limited. There is evidence that maternal antibodies may prevent transmission up to six months of age, and terminating breastfeeding at an earlier stage has been used as an intervention.

The data available from blood donors in Romania does not, however, allow for the identification of the main risk factors or transmission modes causing the endemicity. Possibilities include iatrogenic or nosocomial transmission either in the past or currently, mother-to-child transmission, sexual transmission or equipment sharing among injection drug users.

As blood donors are a non-random sample of the population they do not reflect the true population prevalence and incidence. A sufficiently powered prevalence study linked to a risk-factor survey will be necessary to conduct to reveal the true population prevalence and risk factors for HTLV-1 transmission. Such a study would potentially allow for the development of an intervention strategy which could stop further transmission. This has been successfully achieved in Japan for prevention of mother-to-child transmission.

The HTLV-1 endemicity may not be restricted to Romania only. As few countries in the region systematically screen blood donations for HTLV-1, further studies in neighbouring countries would be needed.

8. Health promotion and education

8.1 Organisation

The National Centre for Evaluation and Promotion of Health Status is affiliated to the NIPH and is responsible for the coordination and governance of the Health Promotion Network (HPN). The network is organised through the four Regional Centres for Public Health and the 42 District Public Health Directorates, and is responsible for the:

- technical coordination and methodological development, implementation, monitoring and evaluation of the annual subprogram for promotion of healthy lifestyle determined by the Ministry of Health.
- Development of the concepts for health promotion national campaigns.
- Identifying priorities for health promotion for specific populations
- Participating in research and studies for health evaluation and promotion.

The national centre coordinates the development of materials for World AIDS Day, provides advice for the development of district programmes and campaigns, and has participated in a number of research studies. The District Public Health Directorates are responsible for the local implementation of national campaigns as well as developing local programmes and partnerships. Thus, DPHDs have undertaken campaigns for HIV/STI prevention (including for World AIDS Day), provided school-based sex education, and training for local healthcare and educations providers.

9. Conclusions and recommendations

The conclusions and recommendations of the ECDC team following the visit are:

Continued support of the HIV programme: The HIV programme has been addressed by national strategies and ministerial orders and within it are many examples of best practice, which have also been highlighted in the previous ECDC country visit report of Romania in 2007.

- Since 2007, the successes achieved in the prevention field have been maintained. There is active involvement of NGOs in prevention work and a national network of prevention services has been established.
- The discontinuation of international funding for preventive programmes poses an acute risk for a potential epidemic in IDUs.
- There is a potential for interruption to the supply of ARV drugs and subsequent intermittent treatment due to the decentralisation of procurement budgets and subsequent lack of training at the local level.
- The VCT network has decreased recently (due to reduction of external funds) and there is a definite need for intense harm reduction services in IDU (but also in MSM) to prevent an outbreak in these populations.
- The clinical services are well designed and implemented. Treatment services are linked to an extended day care programme which provides further psycho-social services to PLWHA.
- A recent and sudden increase of HIV diagnoses among IDUs was reported by the national centre as a cause for concern of a possible HIV outbreak among IDUs
- NGOs are highly involved in prevention services – the vast majority of them being funded from international sources (Global Fund and European Economic Area grants mainly); some of them have been successful in raising additional international funding, e.g. EU structural funds. It is only the Ministry of Social Affairs that currently has a legal mechanism to fund NGOs.

Recommendation: ECDC could support HIV prevention services in Romania by highlighting urgent needs and exploring the possibility for bridge funding to maintain the level of services until public funding becomes available in the coming years. The situation regarding the increase in HIV diagnoses among IDUs needs to be closely monitored, so appropriate interventions for the control of any possible outbreak, (e.g. intensification of harm reductions services, increased outreach and HIV testing activities, appropriate health education) can be quickly implemented. A variety of possible international funding bodies could be explored.

Strengthening the sexually transmitted infections programme: There is an urgent need to strengthen the STI programme. Strong leadership and political commitment are needed in order to address these issues. The management of the STI programme appears weak and a comprehensive approach to the management of the programme could be achieved if a coordinating body were to be nominated.

- Sexually transmitted infections diagnostic services and treatment are free of charge and available to all patients (even the uninsured).
- Private laboratories that have a contractual agreement with health insurance houses for the performance of STI diagnostic tests (receive funds for the tests performed), do not report data to the national surveillance programmes. This results not only in a diminishing capability of public health laboratories but also reduces the quality of surveillance data and outputs. The capability of laboratories to diagnose STIs needs to be improved as many do not offer diagnostics (for instance for diagnosis of *Chlamydia trachomatis*) that meet current international standards. Contractual agreements between laboratories and health insurance houses could be reviewed to improve service quality and surveillance data reporting.

Recommendation: If requested by the Romanian authorities, ECDC should support any possible external review and evaluation of the performance and division of work of laboratory networks, including the national and regional reference laboratories. In order to harmonise the reporting of data from Romania with ECDC/The European Surveillance System (TESSy) requests, the ministerial order 1070/2004 should be reviewed.

Strengthening the programmes for hepatitis B and C: Strong leadership and political commitment will be required to address the issues of these programmes.

- For hepatitis it was acknowledged that there is a high burden of disease with high prevalence rates and high related morbidity and mortality. However, an estimated 10% of HCV patients are currently enrolled in a treatment programme.
- There are plans in place for a new surveillance method for hepatitis and these could be streamlined with ECDC work on the implementation of hepatitis surveillance in 2011 and 2012.

Recommendation: ECDC is preparing a cost-effectiveness tool to assess which national strategies would be the most effective. Romania is interested to be a pilot country in this project. The European framework for hepatitis prevention and control that may be developed by ECDC should be deployed to support the establishment of a Romanian strategy in this area.

Establish and strengthen antenatal screening programmes: Antenatal screening programmes are currently in place for HIV and syphilis, but not for hepatitis B.

- For HIV the percentage of pregnant women screened is estimated to be 50% and has increased over time. For syphilis the coverage is estimated to be 35% and appears to have remained unchanged in recent years.
- As screening pregnant women is a very cost-effective primary prevention method, the antenatal care programme needs to be reinforced to provide a comprehensive screening programme for all relevant infectious diseases. The wider implementation of such a programme could be supported by the establishment of pilots to determine the effectiveness of different screening strategies (e.g. 'opt-out versus opt-in testing).
- At present there is no screening for hepatitis B in pregnant women because of the universal vaccination programme. However, it was strongly recommended to include hepatitis in any pilot to promote a comprehensive ANC programme screening for infectious diseases.

Recommendation: ECDC could support the development of a comprehensive ANC programme for screening of infectious diseases by: facilitating the availability of tools to promote screening in pregnant women; providing access to the evidence for cost-effectiveness of screening pregnant women for HIV, syphilis and hepatitis; and contributing with technical expertise to prepare a study protocol for possible (regional) pilot projects (which could be submitted for international funding).

HTLV1: There is preliminary evidence from blood donor screening of an endemic status of HTLV-I transmission in Romania, which may be maintained by sexual transmission and/or mother-to-child transmission by breastfeeding. ECDC will monitor the issue, but a population representative sero-epidemiological study to map the magnitude of the prevalence and local risk factors/determinants for infection would be needed. ECDC could advise on this and support protocol development.

Behavioural surveillance: The self-assessment tool within the ECDC behavioural surveillance project was tested in Romania. While the self-assessment tool overall was considered very useful, some details were proposed to be amended (e.g. selection of participants, improved explanation of behavioural surveillance). Currently, in Romania, all behavioural surveys are funded externally and this financial support will end in the next year. Therefore, unless efforts are made to find alternative sources of funding and the development of an efficient approach for behavioural surveillance, the future of this activity is jeopardised. Romania is interested in working with ECDC on finding best approaches so that behavioural surveillance continues and adds value to the national surveillance system.

Health promotion: Health promotion and health education are seen as important for preventing the transmission of diseases and teenage pregnancies. ECDC could contribute to the on-going development of health promotion campaigns and activities by the provision of appropriate and relevant communication toolkits.

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Appendix 1. Programme of the country visit

Wednesday 11th May – Day 1

8.30-9:30: **ECDC country visit team meeting (Hotel Residence)**

10:30: **Introduction to country visit (Institute of Public Health):** Dr. A. Canton, Dr. L. Zolotusca, Dr. I. Todea, Dr. A. Pistol, Dr. V. Gheorghiu, Dr. C. Dima, Dr. O. Nicolae, Dr. M. Mărdărescu, Dr. M. Predescu, Silvia Assandi (NGO representative)

10.45: **ECDC team: background and terms of reference**

11.00: **Presentations by the Romanian team**

- Organisation of health care and public health in Romania
- National policies regarding HIV, STI and hepatitis B and C
- Update of HIV epidemiology
- Update of STI epidemiology
- Update of hepatitis B and C epidemiology
- Non Governmental Organisations (NGOs)

13:00: **Break for lunch**

14:00: **HIV prevention, treatment and care, NGOs and Behavioural Surveillance (Matei Bals Institute):** Prof. Dr. A. Streinu Cercel, Dr. S. Petrea, Dr. M. Mărdărescu, Dr. D. Pitigoi, Dr. M. Predescu, Dr. A. Canton, Dr. L. Zolotuscă, Dr. I. Todea, Dr. V. Gheorghiu, Dr. C. Dima, NGO representatives - Romanian Angel Appeal, ARAS, UNOPA, Romanian Harm Reduction Network (RHRN), CPSS, SECS, Tineri pentru Tineri.

- Extending of HIV testing programmes in general medical services (e.g.antenatal, primary care etc)
- HIV testing programmes for populations at risk
- Provision of treatment, care and social support

15.30: **Break**

16.00: **Meeting with NGOs**

- Activities with at risk groups and marginalised communities
- Support for activities by governmental institutions

18:00: **Closure**

19:00: **Dinner**

Thursday 12th May – Day 2

9:30-12:30: **TEAM I - Microbiology of STI and hepatitis (Cantacuzino Institute):** Dr. G. Ionescu, Dr. D. Ionescu, Dr. M. Balteanau, Dr. I. Todea, Dr. Jidovu, Prof I. Codita

9.30: **STI microbiology and diagnostic practices**

- Diagnostic practices in laboratories for common STIs
- Reference laboratory capacity
- Monitoring of anti-microbial resistance in gonococci

10.30: **Break**

11.00: **Hepatitis B and C microbiology and diagnostic practices**

- Diagnostic practices in laboratories across the country
- Reference laboratory capacity

12.30: **Break**

14:00-17:30: **TEAM I - Public health response (National Institute of Public Health):** Dr. A. Pistol, Dr. V. Gheorghiu, Dr. C. Dima, Dr. I. Todea, Prof. V. Benea,

14.00: **STI prevention and control programmes with representation from:**

- Focus on Chlamydia, Gonorrhoea and Syphilis
- Medical and non-medical service capacity for testing and treatment –reporting at local and national level
- Surveillance of STI
- Screening and testing programmes
- Partner notification and treatment
- Health education (for general and at-risk populations)

16.00: **Hepatitis prevention and control programmes with representation from:**

- Screening and testing programmes, partner notification and treatment
- Medical services capacity for hepatitis B and C
- Reporting and Surveillance of hepatitis B and C
- Health education (for general and at-risk populations)

17.30: **Closure**

9:30-17:30: **TEAM II - Self-assessment behavioural surveillance (Institute of Public Health):** Dr. V. Gheorghiu, Dr. C. Dima, Dr. M. Predescu, Dr. A. Pistol, Dr. L. Zolotusca, representative Romanian Angeal Appeal Discussion to discuss process and results of the self-assessment exercise.

Friday 13th May – Day 3

9:00-10:30: **TEAM I - HTLV-I infection (National Institute of Blood Transfusion)** Dr. M. Pecec, Dr O. Ciocan, (Experts in Transfusion medicine and laboratory sciences)

9:00: **Discuss situation on HTLV-infection and HAM/TSP and ATLL:**

- Epidemiology
- Risk factors
- Vulnerable groups
- Prevention

TEAM II (Residence hotel)

9.00: **ECDC country visit team meeting to finalise debrief and extra time for pending issues**

12:00-13:00: **Debrief meeting (Ministry of Health):** Prof. A. Streinu-Cercel, Prof. G. Molnár, Dr. A. Pistol, Dr. A. Canton, Dr. M. Mărdărescu, Prof. Dr. A. Rafila, Dr. F. Popovici, Dr. I. Todea

12.00: **ECDC country visit team debrief with representation from:**

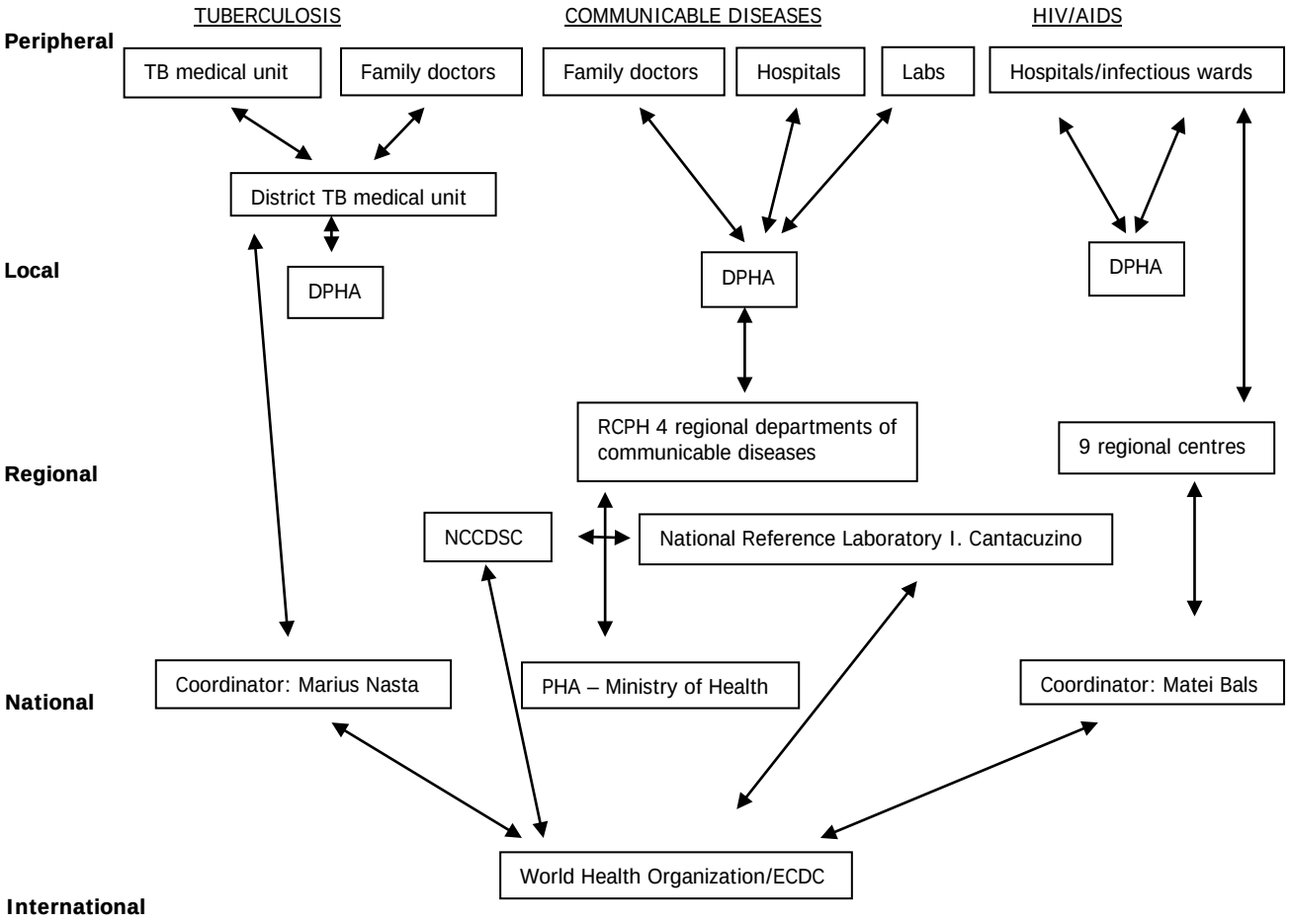
- Ministry of Health
- National Institute Public Health
- Matei Bals
- Other organisations

13.30: **Departure for the airport**

Appendix 2. List of participants

Institution	Participants
Romania, Ministry of Health	Dr. A. Canton, Deputy Director Public Health and Control, Public Health Department, ECDC AF alternate member
	Dr. L. Zolotusca, Counsellor
	Dr. I. Todea, Counsellor
National Institute for Public Health (NIPH)	Dr A. Pistol
	Dr. V. Gheorghiu
	Dr. C. Dima
	Dr O. Nicolae
National Institute for Infectious Diseases "Prof. Matei Bals"	Prof. Dr. A. Streinu Cercel
	Prof. Dr. A. Rafila, ECDC MB member
	Dr. M. Mărdărescu
National Institute for Research-Development for Microbiology and Immunology "I. Cantacuzino"	Dr. G. Ionescu
	Dr. D. Ionescu
	Dr. M. Balteanau
	Dr. Jidovu
	Prof. Dr. I. Codita
Central Reference Laboratory for Transfusion Transmitted Infections, National Institute of Blood Transfusion	Dr. M. Pecec
	Dr O. Ciocan
Dermato-venerology clinic "Prof. Dr. Scarlat Longhin" Bucharest	Professor V. Benea
Romanian non-governmental organisations (NGOs)	Dr. Silvia Asandi (Romanian Angel Appeal Foundation)
	Fidelie Kalambayi (Romanian Angel Appeal Foundation)
	Monica Dana (Romanian Association against AIDS)
	Tudor Kovacs (PSI Romania)
	Representatives of UNOPA, Romanian Harm Reduction Network (RHRN), CPSS, SECS, Tineri pentru Tineri
ECDC, Disease Specific Programme for STIs, HIV and hepatitis B & C	Dr. Marita van de Laar, head of programme on HIV, STI and hepatitis (team leader)
	Dr. Mika Salminen, Senior Expert, HIV and hepatitis B and C
	Dr. Irina Dinca, Senior Expert, Communicable Diseases
ECDC contracted consultants	Ms. Michelle Cole, ECDC consultant, STI microbiology (Euro-GASP)
	Dr. Francoise Dubois, ECDC consultant, Behavioural Surveillance project
	Dr. Jean-Pierre Gervasoni, ECDC consultant, Behavioural Surveillance project
	Dr. Anthony Nardone, ECDC consultant, country visits HIV and STI (rapporteur)

Appendix 3. Information flows for Romanian national surveillance



Appendix 4. Main behavioural studies

National samples

- World Health Organization health behaviour study among young (HBSC) every four years (11 to 15 years old)
- Centers for Disease Control and Prevention study at national level (age, time?)
- Centers for Disease Control and Preventionstudy of pregnant women in 1996 (n=5'000)
- National Reproductive Heatlh Survey started in 1999 (3 or 4 waves) the planned 2009 wave was not conducted (UNFPA)
- studies in prisons (national samples) (2007, 2009, 2010), 10% of funding from UNODC and 90% of funding from GFATM
- EMIS study on MSM (n=2'600 en 2010 compared to previous sample of only 300 participants).

Regional or local samples

- World vision tool in six counties on health, resilience, etc. (n=10'000) started in 2002 and currently entering the 3rd phase in using UNICEF indicators and also HIV/STI indicators
- Global Fund for AIDS, Tuberculosis and Malaria funds for many surveys (bio-behavioural studies among sex workers, IDU, MSM) done by NGO's mainly Romanian Angel Appeal who have now the expertise to conduct such complex studies
- United Nations Office on Drugs and Crime qualitative study on ethnobotanics (n=35)
- Evaluation of risk factors and behaviours related to HIV/AIDS in Iasi county 2009 in 5 schools (n=490, 1.42% of the total sample) among adolescents aged 15–19 years.
- Romanian Association for Health Promotion, TOTEM research among 15–24 years conducted in 2008 and 2010
- Bordernet study which started a bio-behavioural survey on STI and HIV in 2008 and is currently on-going.
- Health of Roma study