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COMMUNICATION FROM THE COMMISSION

on the fight against AIDS

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I. INTRODUCTION

Detected for the first time in June 1981 in Los Angeles, United States, acquired immunodeficiency syndrome (AIDS) is a contagious virus disease which leads to morbidity and high mortality. Its exponential propagation speed is giving great cause for concern, since the number of recorded cases in the European Community is doubling approximately every nine months. From 232 in October 1983, the number of cases of AIDS identified in the twelve Community Member States reached 3 354 in October 1986. On the basis of these recent trends, and in the absence of an appropriate vaccine, one hundred thousand Europeans could thus have AIDS by 1990. Moreover, it has also been estimated that for every declared case of AIDS there are between 50 and 100 asymptomatic carriers of the virus (see Annex "Basic facts"). Faced with such a threat, much work has been undertaken at national and international level to contain and eradicate this epidemic.

Early in 1983 a team at the Institut Pasteur in Paris succeeded in isolating the human retrovirus causing AIDS, and this discovery was confirmed a year later in the United States. The virus is now known as HIV (human immunodeficiency virus). In the summer of 1983, serological tests that could detect the presence of this retrovirus were developed and were put on the market in 1985, thus opening up new prospects for the screening of the disease. Despite these remarkable advances, established AIDS researchers expect that it will take at least five years to develop an effective vaccine. Fortunately, however, thanks to rapid progress in epidemiological research, the transmission mechanisms of the retrovirus are now known, essentially operating through sexual activity and the blood. Appropriate preventive measures have now been devised and all the European Community Member States are implementing them in one form or another: compulsory screening of all blood donors; information and health education campaign of the high-risk categories (homosexuals, prostitutes, intravenous drug users), certain target populations, such as young people of school age, or the population as a whole (see Annex "Basic facts").

At European level, the European Community[1] [2] [3] concerned itself very early on with the fight against AIDS, by carefully avoiding any duplication of the work of the World Health Organization (WHO) and the Council of Europe. More recently, at its meeting in London on 5 and 6 December 1986, the European Council asked the Commission to organize an exchange of information at Community level on the spread of AIDS, its prevention and treatment, to examine what cooperation measures Member States might take in future, and to study the other possibilities of cooperation on research. That is the purpose of this communication.

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1 Resolution of the European Parliament on AIDS: OJ C 46, 20.2.1984; OJ C 88, 14.4.1986; proposal for a resolution, 19.1.1987.

2 Communication from the Commission of the European Communities COM(84)502 final on cooperation at Community level on health-related problems and COM(86) 549 final on a fourth research and development coordination programme on medical and health research.

3 Resolution of the representatives of the governments of the Member States, meeting within the Council, on AIDS, OJ C 184, 23.7.1986.

II. AREAS OF COMMUNITY ACTION

The Commission of the European Communities is convinced that Community action, reinforcing the effectiveness of action taken at national level, is possible and necessary in the following areas:

(a) exchanges of experience, notably in the field of information and health education;

(b) joint examination of the possible relevance of certain measures relating, in one way or another, to migration policy, freedom of movement of persons, freedom of establishment and equal access to employment;

(c) research on epidemiology, viro-immunology and treatment of the disease, in Europe and developing countries;

(d) international cooperation in the fight against AIDS.

II.1 Exchange of experience on AIDS prevention, notably in the field of public information and health education

Given that no effective treatment or vaccine is expected in the near future, the only real way of halting the spread of the AIDS virus at the moment is to properly inform and educate the public. However, Member States' initiatives in this area have so far varied widely, often without a systematic assessment of the results obtained (see Annex on "Basic facts").

The setting up, at Community level, of a flexible coordination, assessment and information dissemination system concerning national practices on public information and health education is therefore essential. It would enable each Member State to draw on the experience of its neighbours, while avoiding unnecessary and costly duplication. The Commission proposes to set up such an observation unit at European level which could also help to adapt and disseminate the initiatives that prove to be the most fruitful.

At the same time, comparative studies on the other aspects of national prevention policies will have to be undertaken and the results disseminated.

II.2 Policy on migration, freedom of movement, freedom of establishment, equal access to employment and AIDS prevention

In view of the scale of the AIDS epidemic, a number of serious questions, challenging the full exercise of certain fundamental rights of the citizens of the European Community, are inevitably being asked. Basically, these national measures range from compulsory or voluntary notification of AIDS cases to

systematic screening, in certain circumstances or in respect of certain categories at risk, involving special screening measures for people entering certain Member States after long stays in non-Community countries. Finally, it would seem that there are plans in certain Member States for specific measures of a financial or contractual nature.

These highly complex and delicate questions cannot however be avoided. There should clearly be a joint examination of the necessary answers, so as to prevent contradictory national practices developing, and contribute, where appropriate and in good time, any measures which might prove necessary at Community level. In this spirit, the Commission suggests that these various topics should be discussed in detail with the Member States' representatives responsible for AIDS prevention.

II.3 European research and the fight against AIDS

II.3.1 In September 1983, following the Resolution of the European Parliament, the Commission called together a working party on AIDS composed of national coordinators, selected experts and representatives of the WHO. The aim was to assess the scale of the problem and the state of the art. As a result of the working party's work, the Commission prepared a proposal for emergency action accompanied by a request for specific resources. The Scientific and Technical Research Committee (CREST), consulted on this proposal, considered that the specific resources requested by the Commission did not need to be allocated to significant Community research. Therefore, in 1984 and 1985, the Commission had to restrict itself to monitoring developments and advances in knowledge. It held four workshops to this end. The workshop on immunology (Copenhagen) proposed a coordinated investigation into HIV-induced immuno-pathology, immunogenetics, vaccine development, etc. The workshop on virology (Paris) proposed action in the fields of standardization of detection methods, isolation methods and animal models. The epidemiology workshop (Bilthoven) proposed coordination and integration of surveillance studies. The workshop on clinical research (Brussels) proposed studies of the clinical presentation, evaluation of treatments and coordination of clinical trials.

II.3.2 These activities continued in 1986 and for 1987-89 the Commission has prepared a proposal for a Council Regulation relating to a research and development coordination programme in the field of medical and health research.[4] This programme identifies AIDS as a target area and contains the following projects:

- disease control and prevention
  * prospective epidemiological surveillance studies,
  * comparison of macro modelling for public health research.

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4 COM(86) 549 final/2.

- viro-immunological research
  * serological testing (antibodies and antigens),
  * quantification of HIV infection,
  * pathogenesis and experimental therapies in animal studies and in vitro,
  * promotion of vaccine development and antiviral protection,
  * AIDS virus-host interaction: immunocompetence, immunopathology and immunogenetics.

- clinical research
  * therapeutic surveys and clinical trials of opportunistic infections and tumours,
  * development of multicentre clinical trials on AIDS.

The budget requirement for this programme is set at 5.45 million ECU.

II.3.3 It should also be noted that, as part of the first programme of research and development in the field of science and technology for development, and in particular in the sub-programme on medicine, health and nutrition in tropical areas (1983-86), the European Community has already taken a preliminary initiative for the epidemiological study of AIDS in Africa, the scale of the disease and the ways in which it spreads.

In this context, five teams from the Member States joined forces with their African counterparts to undertake research in Cameroon, the Congo, Ethiopia, Gabon, Kenya, the Central African Republic, Rwanda, Somalia and Zaire.

In its proposal for a second research and development programme in the field of science and technology for development (1987-90), which has just been laid before the Council,[5] the Commission recommends not only stepping up existing epidemiology research but also extending it to the virological, immunological and clinical aspects of the disease.

II.3.4 Through these various activities, the Research Workers' Europe cannot fail to make a valuable contribution, at low cost, to combatting AIDS in Europe.

II.4 <u>International cooperation and the fight against AIDS</u>

II.4.1 Other industrialized countries are also seriously concerned by the AIDS epidemic, particularly the United States which at the start of 1987 had already recorded 30 000 cases of AIDS and expects to have 300 000 cases by 1991. International cooperation has now been established with the United States, Sweden, Switzerland and Canada, the WHO in respect of medical and health research, and the countries signatory to the Lomé Convention under the research programme on science and technology for development.

II.4.2 In several parts of the developing world, with which the European Community has a special relationship, the spread of the HIV virus has become a serious public health problem. Moreover, in the absence of appropriate prevention measures, there are real and serious risks of AIDS spreading into hitherto healthy areas.

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[5] COM(86) 550 final/2.

II.4.3 In view of the scale and complexity of the problem, and in addition to the action already begun and proposed under the Community research programme on science and technology for development, the Commission is prepared to cooperate with the developing countries to combat AIDS and in this spirit will propose to the ACP countries, under the Lomé Convention, an intervention programme to combat AIDS.

The prime objective of such a programme, which will first have to be approved by the countries signatory to the Lomé Convention, will be to support governments who ask for help in stepping up primary prevention of AIDS by implementing public health campaigns, and by setting up public information and health education campaigns.

II.4.4 In this way, the European Community will make a valuable contribution to international efforts to combat AIDS, closely coordinated with the work of the Member States and the WHO, while giving specific Community aid to the countries signatory to the Lomé Convention.

III. CONCLUSIONS

The Community action envisaged in this communication takes account of the concerns of Parliament and the London European Council.

As regards international cooperation, the Council and the European Parliament are asked to take note of the actions already undertaken or planned by the Commission.

In the field of AIDS research, the Council is asked to adopt as soon as possible the proposals that have been laid before it relating to the fourth research programme on medicine and health (1987-1989) and a second research programme in the field of science and technology for development (1987-90).

Finally, the Council and Parliament are asked to take note of the Community action described above in the field of AIDS prevention (II.1 and II.2) to be taken by the Commission, and to take account of it when adopting the 1988 budget.

1. Background

Annex : Basic Data on AIDS

1.1 The acquired immune deficiency syndrome (AIDS) is a contagious viral disease. It was first recognised in the USA in 1981 and since that time its incidence has risen rapidly in the USA, Europe and Africa resulting in considerable morbidity and mortality.

1.2 AIDS is caused by a RETROVIRUS, described previously in the scientific literature as LAV or HTLV-III and now designated HIV. The virus is readily inactivated by heat and different antiseptic agents (ether, ethanol etc), but it is relatively resistant to UV and ionizing radiation. It is worthwhile mentioning that some ingredients of spermicides inactivate HIV.

1.3 The HIV virus is in fact not very contagious and seems to be less communicable than hepatitis B. Transmission of the virus is easier when the virus is intracellular and therefore transmission is good by means of blood and spermatozoa. Epidemiological data indicate that the HIV infection in humans occurs through one or more of four routes :

1) sexual contact ;
2) intravenous drug administration with contaminated needles ;
3) transfusion of blood or blood products ;
4) passage of the virus from infected mothers to their newborns ;

1.4 There is no evidence of HIV transmission by casual social contact, sneezing, coughing or the sharing of cutlery etc.

1.5 In the light of these facts the following principal risk groups can be identified (in chronological order) :

1) homosexual males with more than one partner ;
2) intravenous drug users ;
3) haemophiliacs receiving transfusions of blood clotting factors (before the introduction of blood and donor screening and inactivation procedures on blood products)
4) sexual partners of all the above groups ;
5) infants born to infected mothers ;
6) prostitutes ;
7) heterosexuals with more than one partner.

1.6 Although it has been shown that the virus can be transmitted by accidental needle-stick injury, the occupational risk for health care workers, caring for AIDS patients or handling specimens from them, is extremely low. The precautions necessary when treating AIDS patients are basically the same as those for hepatitis B treatment.

1.7 We do not yet know enough about the natural history of HIV infection. American experience, however, has shown that the incubation period could be 3 to 10 years and that the proportion of asymptomatic carriers in whom AIDS could develop could be 25-50 %.

1.8 The case fatality rate of AIDS is very high. Over 50 % of AIDS patients die within a year after diagnosis and another 30 % within the following 2 or 3 years.

1.9 Tests for antibodies against HIV are now widely available. Demonstration of antibodies gives strong support to the diagnose of AIDS when clinical symptoms are present or to the infectious state of the tested person when symptoms are absent.

1.10 The Treatment of AIDS is directed into three fields : specific antiviral action, treatment of the immuno-deficiency and treatment of the opportunistic diseases. In the first two fields many substances have been tried but none have proved effective. Some progress has been made to combat the opportunistic diseases, but the results are poor so that it can be said that the disease cannot currently be treated with any chance of success at this time.

1.11 A vaccine is not yet within sight. Many difficulties are foreseen and most authors expect that a generally available effective vaccine will not be issued within the next five or ten years.

2. The AIDS epidemic

2.1 Since the beginning of the AIDS epidemic in 1981, the prevalence has increased exponentially with a doubling time of 6 to 12 months. In the Member States of the European Community 3154 cases have been reported up to 30 September 1986. Statistical modelling permits a prediction that the cumulative total number of cases diagnosed in the European Community could reach at least 100 000 cases by 1990. It also estimated that for every person with AIDS there are between 50 and 100 asymptomatic carriers. The following table gives the data for the Member States of the European Communities.

Total Number of reported AIDS cases for the EC countries*

	Oct. 83	Oct. 84	Oct. 85	Oct. 86
B	38	65	118	180
DK	13	31	57	107
D	42	110	295	675
E	6	18	63	201
F	94	221	466	1 050
GR	-	2	10	25
IRL	-	-	-	12
I	3	10	92	367
L	-	-	3	5
NL	12	26	83	180
P	-	-	-	40
UK	24	88	225	512
EC	232	571	1 412	3 354
CH	17	33	77	170
S	4	12	36	76
Total	253	616	1 525	3 600

These data indicate that on average 35 cases of AIDS are reported each week in the European Community.

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* Source : WHO Collaborating Center on AIDS

2.2 Some further information can be given on the basis of the reported cases :

- 90 % of the cases are male ;
- the age distribution can be summarised as following :

  . +/- 25 % between 20 and 29 years ;
  . +/- 35 % " 30 and 39 years ;
  . +/- 20 % " 40 and 49 years ;
  . 1 % under 1 year.

- the risk groups :

  . 74 % are homosexual or bisexual men ;
  . 13 % are heterosexual drug users by injection ;
  . 3 % are homosexual drug users by injection ;
  . 6 % have received transfusions of blood and blood-components ;
  . 5 % have no identifiable risk factor.

- concerning the children :

  . 66 % have a mother with AIDS or on risk for AIDS ;
  . 33 % have received blood transfusion or blood components.

2.3 As regards certain Member States :

- the figure for Belgium (18,2/million) does not reflect the true rate of infection as 50 % of the cases are non-resident Africans.

- the risk-group of male homosexuals represents only 30 % in Belgium, Spain and Italy (EC mean : 70 %)

- the risk group of heterosexual drug users by injection represents 50 % in Spain and 60 % in Italy (EC mean : 13 %)

2.4 The US has almost 30 000 cases of AIDS and a rate of 110 cases/million inhabitants. In parts of Africa, particularly the countries of Central Africa, AIDS has taken on epidemic proportions ; the HIV virus has appeared in East Africa more recently but is spreading rapidly. The infection seems to be more widespread in the urban areas and the 25-40 age group. It is transmitted mainly amoung heterosexuals but the lack of proper health services reduces protection against transmission through the blood which is therefore much more common in these countries.

3. National public policy and AIDS control measures

3.1 It is obvious that the increasing incidence of a disease with a high fatality rate and the absence of an effective vaccine or treatment poses major problems for public health authorities. Cost per patient with AIDS in the different Member States is estimated at between 75.000 to 150.000 ECU per patient.

3.2 The classic public health approach for infectious disease cannot be applied to AIDS because :

- the virus is no longer confined to any geographic area or population ;
- the incubation period is unknown so that prevention of transmission during this period is impossible ;
- isolation of infected individuals from society is unnecessarily restrictive of liberty.

3.3 The first legal measure issued in all Member States was the screening of blood or blood products to protect against transmission by these products.

Other measures or actions concerning compulsory reporting, compulsory screening, sexual behaviour, AIDS and drug use, and information of general public and risk groups have been initiated in some Member States.

3.4 Reporting is compulsory in some Member States and voluntary in others. It may be anonymous, personal or coded.

3.5 Compulsory screening measures have been proposed for different groups such as the principal risk groups, foreign students, people entering the country, health care workers, prisoners or even the whole population. A general agreement exists that in all these cases compulsory screening should be rejected on the basis of effectiveness, logistical problems, costs and consideration of civil liberties. In some Member States a voluntary, free and anonymous screening service is also available in conjunction with medical surveillance.

3.6 The assumption that the spread of the disease can be stopped, or at least slowed down by a change in sexual behaviour has led to a series of different measures, for example :

- safe sex campaigns amongst homosexual peer groups ;
- information campaigns on sexual transmission for seropositives and their relations ;
- information for female and male prostitutes ;
- information campaigns on heterosexual transmission for the general public ;
- promotion of the use and supply of condoms to the general public and some risk groups.

Because most of these actions were initiated only recently the evaluation of the effect of such actions is difficult. Preliminary results suggest that "safe sex campaigns" have a positive influence in the homosexual groups.

3.7 HIV transmission can be stopped partially in the risk group of intravenous drug users by acting upon the choice of drug and the sharing of needles and syringes. Measures have included, for example :

- information on transmission of AIDS amongst drug user groups by means of leaflets, media information, information in treatment centers ;
- promotion of the single use of needle and syringes ;
- substitution of drugs eg methadone;
- free supply of drugs to prostitutes.

In this sector too few evaluations have so far been made.

3.8 Information to the general public is the preferred method of counteracting the heterosexual transmission of HIV. Brochures of general information, leaflets, newspaper articles, TV campaigns, safe sex promotion, advertising of the use of condoms, information for school teachers, and AIDS information telephone lines are some of the actions that have been undertaken. One of the problems that has to be faced is that a large majority of the public is still convinced that only homosexual and drug users are at risk. Again evaluation of these actions has as yet not been undertaken.

3.9 Striking differences exists in the efforts undertaken in the field of information and health education by the Member States. Some consider AIDS as a high priority in the health field and allow large budgets. In other Member States actions are more discrete.

FINANCIAL STATEMENT

Concerning the only aspects of AIDS prevention

1. Budget headings

Article 647 "Action in the field of health" and item 6481 "studies in the field of health" for the only actions concerning the prevention of AIDS.

2. Legal basis

EEC Treaty

3. Proposal for classification under compulsory/non-compulsory expenditure

Non-compulsory

4. Description and justification of project

The Community actions in the field of AIDS prevention described in this Communication follow directly on the conclusions of the European Council of 5-6 December 1986 and the resolutions of the European Parliament of 20.1.1984 and 13.3.1986. The actions aim in a first phase, which is to last 2 years, essentially to organize and coordinate an exchange of information and experience in the Member States in connection with the prevention of AIDS.

To this end the following action is envisaged :

- setting up, on a Community level, of a flexible system of coordination and of distribution of national data on public health education and information ;

- promotion of a common approach to measures taken and planned by the Member States in connection with the prevention of AIDS ;

- keeping a watch on developments in methods and provisions in the Member States in connection with the prevention of AIDS ;

- drawing up of comparative studies in particular to assess AIDS prevention measures and the economic and socio-medical effects of the disease.

5. Type of expenditure and method of calculation

Method of calculation for the first year : 1988

Article 647 (- expenses for the organization of conferences and seminars, experts' and consultants' fees ;
- contribution to joint adaptation and dissemination of public health information and education) 750 000

Item 6481 (diagnostic studies and comparative assessment of national preventive measures) 250 000

Total ECUS: 1 000 000

The distribution of expenses will be identical for 1989

6. Financial implications for intervention appropriations

6.1. The initial phase of the work is expected to take two years. This period may be extended in due course after assessment.

The first year is to be devoted mainly to :

- the setting up of a system for the coordination and distribution of information on public health education and information ;
- the preparation of information material ;
- comparative assessment of AIDS prevention measures.

Annual appropriations determined on the basis of the budgetary procedure should not exceed the following amounts :

	Non-differentiated appropriations (Ecus)
1st year	1 000 000
2nd year	1 000 000
	2 000 000

These annual appropriations are covered by the 1987-1990 four-year budget forecasts.

6.2. Proportion financed from the Community budget :

100 %

7. Remarks :

Nil

8. Financial implications for staff and current administrative appropriations

Staff working exclusively on the project : 1 A and 1 C.

The staff will be found either by internal redeployment of staff or within the framework of the Rolling Plan/posts.