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ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

Of the more than 700,000 cases of AIDS reported to date by the Member States to the World Health Organization, more than 50% correspond to the Region of the Americas. In addition, it is estimated that there may be about 2.5 million HIV-infected persons in the Region: 1 million in North America and 1.5 million in Latin America and the Caribbean.

Given the magnitude and importance of the epidemic, it has become not only a health problem, but also one that affects all national sectors, including the education, economic, political, social, and legal spheres, and even national security. The sum of the impact of AIDS in each of these areas is likely to engender great instability and have serious repercussions on the development of the countries. The Regional Program on AIDS/STDs of PAHO/WHO has therefore promoted and supported the formulation of national plans designed not only to spur action in the health sector but also to prevent or mitigate the social, economic, and political consequences of AIDS through intersectoral articulation of efforts and resources. The World Health Assembly, in its Resolution WHA46.37, adopted in May 1993, requested the Director General to study the feasibility of establishing a joint and cosponsored United Nations program on AIDS and HIV. That resolution is aimed at optimizing coordination between the various agencies of the United Nations system, so that each, in its respective area of expertise, can help to prevent and reduce the impact of the epidemic.

Within the framework of the global strategy on AIDS and with the direction provided by the goals and priorities of the Regional Program on AIDS of PAHO, proposals for collaboration between the countries of the Region were presented during the Conference of Ministers of Health of the Ibero-American countries, held last May. These proposals underscored the need to mobilize all sectors of society.

During the 111th Meeting of the Executive Committee of PAHO in June there was considerable discussion in regard to the aforementioned resolution and recommendations, as well as the status of the epidemic, its impact in a variety of areas, and strategies for preventing it and dealing with its consequences. The report of Regional Program on AIDS/STDs on the AIDS situation was discussed by the Committee, which recommended that information be added and that some sections of Document CE111/9, including the corresponding annexes, be updated. (The revised text is included as an annex to the present document.)

In light of the foregoing, the Directing Council is asked to review the available updated information on the status of the epidemic of AIDS/HIV/STDs in the Americas, as well as the achievements of the technical cooperation provided by the PAHO/WHO Regional Program on AIDS/STDs. In addition, the Council is asked to make recommendations for future action, within the context of the global strategy on AIDS and the recommendations emanating from the conferences of Ministers of Health and Heads of State and Government, held in May and July 1993, respectively. Finally, Resolution V adopted by the Executive Committee at its 111th Meeting is submitted for consideration by the Directing Council.

RESOLUTION V

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

THE 111th MEETING OF THE EXECUTIVE COMMITTEE,

Having reviewed Document CE111/9 and ADD. I on acquired immunodeficiency syndrome (AIDS) in the Americas; and

Taking note of Resolution WHA46.37 and the conclusions and recommendations emanating from the Meeting of Ministers of Health of the Ibero-American Countries,

RESOLVES:

To request the Directing Council to adopt a resolution along the following lines:

THE XXXVII MEETING OF THE DIRECTING COUNCIL,

Having seen Document CD37/10 on acquired immunodeficiency syndrome in the Americas, and taking into account the recommendations of the Meeting of Ministers of Health of the Ibero-American Countries, as well as Resolution WHA46.37 of the World Health Assembly;

Aware of the growing threat posed by the AIDS epidemic, infection with human immunodeficiency virus (HIV), and the increase in sexually-transmitted diseases (STDs) for health and the social and economic development of the Member States; and

Taking note of the imperative need to mobilize all sectors of society in the campaign against HIV/AIDS/STDs, as well as the need to achieve the best possible coordination of preventive actions at the regional and country level,

RESOLVES:

1. To call on the Member Governments:

   a) To intensify national efforts to prevent HIV/AIDS/STDs and diminish the social and economic consequences thereof through the unification and coordination of all actions being carried out for this purpose at the country level;

   b) To promote the establishment of a national program for preventing and combating AIDS, which will bring together resources from the various sectors of society under the leadership of the ministry of health, in coordination with the government agencies and nongovernmental organizations involved in the effort to combat HIV/AIDS/STDs;

   c) To draw upon the expertise of all relevant UN system and Inter-American system organizations in establishing a well-conducted intersectoral program to combat HIV/AIDS/STDs at the country level.

2. To support fully Resolution WHA46.37, adopted in May 1993, in which the Director-General of WHO is requested to study, in close consultation with all organizations and bodies concerned, the feasibility and practicability of establishing a joint and co-sponsored United Nations program on HIV/AIDS.

3. To recognize PAHO's scientific and technical leadership in the health field in the Region of the Americas.

4. To request the Director to:

   a) Assist Member Governments in their efforts to establish strong intersectoral coordinating mechanisms on HIV/AIDS/STDs at the country level;

b) Request the Director to take the necessary steps to improve coordination to promote, bring together, and articulate the actions of the various agencies of the United Nations and the Inter-American systems in the Region of the Americas.

(Adopted at the sixth plenary session, 30 June 1993)

Annex

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

CONTENTS

1. Introduction

Since 1983, when a system for epidemiological surveillance of AIDS was established in the Region of the Americas, the progressive increase in the number of cases of this illness detected has been apparent. As 10 June 1993, 45 countries and territories of the Americas had reported a total of 371,086 cases of AIDS. This figure is not an exact indicator of the situation, partly because of problems with diagnosis, underreporting, and delayed reporting to pertinent authorities. Probably the real cumulative total of AIDS cases for the last twelve years is two to five times higher than the figure indicated. In addition, through various analytical methods, estimates of the extent of HIV infection in the Region have been prepared. It is estimated that there may be between 2 and 2.5 million persons who are carriers of the human immunodeficiency virus (HIV) but have not yet exhibited symptoms of AIDS. Three-fifths of this number (about one and a half million people) are in Latin America and the Caribbean, where, in addition, there are indications that the infection is continuing to spread rapidly among the population.

Considering that AIDS is the late stage of HIV infection, and that infected persons will develop AIDS within an average period of ten years, a significant increase in the number of AIDS cases is expected in the coming years, particularly in Latin America and the Caribbean. This increase will represent an additional burden on social and health services, which at present are already facing serious problems in trying to respond to both routine as well as emergency demands. The burden that the epidemic imposes on individuals, as well as on families, communities, and the social structure in general, is associated with the following facts:

- Once AIDS is diagnosed in infected persons, they and those close to them will face the difficulties associated with an incurable disease that will shortly result in death.

- Treatment of AIDS complications is expensive and relapses are frequent.

- The most seriously affected segment of the population is young adults who are in the most productive stage of their lives. Most of them are responsible for the support and care of their families. When a person with AIDS dies, their family is left unprotected.

- HIV infection has a synergistic effect with other infections, such as tuberculosis or other sexually transmitted diseases.

- The economic burden and work overload that AIDS imposes on the health sector will cause it to experience even more difficulties in trying to respond effectively and in a timely manner to the needs of the community.

The threat to health and development posed by the AIDS epidemic needs to be halted with foresight and effective actions.

2. Situation Analysis, Socioeconomic Impact, and Projections of AIDS and HIV Infection in the Americas

Having an operational definition of AIDS makes it easier to characterize the situation and trends of the epidemic and to predict its impact. Such an operational definition also makes it possible to develop interventions that are appropriate to the realities of both the target groups and the economic and sociopolitical context of the countries in the Region. Acquired immunodeficiency syndrome is a permanent and irreversible change in health status, the cause of which is associated with certain habits, practices, and lifestyles. AIDS tends to affect those persons who for reasons that are individual (such as misinformation, deep-seated habits, denial, rationalization) or social (beliefs, myths, stereotyped sexual roles, community values, lack of effective programs and interventions) persist in behaviors whose consequences include the risk of contact with bodily fluids that are potentially contaminated with HIV, such as semen, vaginal secretions, and blood. Because of this, there are three basic mechanisms of HIV transmission: 1) sexual relations (heterosexual or homosexual); 2) transfusion of contaminated blood (iatrogenic or through the use of unsterilized needles and syringes); and 3) transmission from an infected mother to her child (perinatal).

Epidemiological analysis demonstrates that the principal risk factor identified in the vast majority of AIDS cases (a cumulative world total of 718,894 cases reported to WHO as of 30 June 1993) has been unprotected sexual relations (homosexual and heterosexual).

The initial emergence of the epidemic among certain sectors of the population--for example, homosexual communities in industrialized countries--triggered an intensive mobilization effort to alert members of those communities to the risks inherent in certain behaviors and to produce more or less lasting changes in those behaviors. It could be speculated that perhaps because of the initial labelling of the epidemic as a homosexual problem, many heterosexual individuals who did not recognize themselves as members of the groups initially affected felt safe and thus persisted in their high-risk behavior. In addition, it is highly probable that the increased number of cases among women has been due to the fact that either they did not know that their partners had been involved in high-risk behavior or that, even if they were aware of this, culturally-bound sexual roles prevented them from taking protective measures. A study in Costa Rica indicates that most of the women with AIDS were infected by their partners, who without their knowledge were involved in high-risk behavior.

Studies show that the male:female ratio in some subregions (countries of Central America and the Caribbean) is approaching 1:1. Although in other subregions of the western hemisphere this ratio is still high (12:1 in the Andean Area, for example), the observed trend is toward a decline in that figure due to increased cases among women. The increasing prevalence among women of childbearing age indicates that there will be a corresponding increase in the transmission of HIV to the fetus or newborn, a fact already confirmed by the increased number of cases among children under 2 years of age in some countries. It is estimated that between 300,000 and 500,000 women are HIV carriers in the Western Hemisphere. Of this total, 150,000 live in Latin America and the Caribbean.

Other factors associated with a risk of HIV infection are the lack of services and of appropriate medical guidance and treatment for ulcerative genital lesions, such as herpes and soft chancre. Although complete data is not available for the entire Region, there is evidence of an important increase in the rates of syphilis and gonorrhea, particularly among the young, sexually active population (25 years of age and under).

At the same time, despite the fact that HIV is transmitted primarily through sexual relations, there is evidence of the growing importance of intravenous drug use as a high-risk behavior for transmission of the virus, at least in some countries. Thus, in some communities studied in Argentina, Brazil, and Uruguay, more than 50% of intravenous drug users may be infected with HIV. In the Southern Cone, intravenous drug use has been identified in approximately 25% of the reported cases, which places this behavior in second place as a risk factor, after sexual relations.

An epidemic that is associated with behaviors that have been clearly identified and described could be halted through interventions that are successful in affecting those high-risk behaviors and practices. However, the initiatives undertaken thus far do not seem to have had the desired impact; they have not produced the changes necessary to decrease high-risk behavior. This seems to be due, fundamentally, to the health sector's limitations when it comes to developing educational interventions. For example, there is the confusion between education and the transmission of factual information; the belief that communication is simply a matter of creating eye-catching materials; and the idea that people become ill because "they do not want to learn what they are taught." It seems that the educational interventions that were developed using a prescriptive, vertical, and doctrinal approach have not had the desired impact. Moreover, there is no objective means of verifying the impact of most of those interventions because no plans were set up to evaluate them. For all the reasons indicated, and since AIDS prevention through effective changes of behavior is a priority that must be met through concerted efforts, it is indispensable to treat educational interventions with the same serious and dynamic approach as purely medical interventions. The greatest challenge to be faced is that of trying to alter profoundly rooted behaviors and to reaffirm, as societies, the value of acceptance of healthy human sexuality.

It is much easier to eliminate the mechanism of HIV transmission through blood and blood products than to do away with those associated with individual and social behaviors and practices. To eliminate HIV transmission during blood transfusions is a goal that can be achieved in the short term through determination, initiative, and effort.

Finally, transmission from infected mothers to their children is closely related to heterosexual transmission and to drugs in the community, and to the ever-increasing number of women of childbearing age who are infected with HIV.

At the same time, the dynamics and true dimensions of the HIV/AIDS epidemic in the Region cannot be understood if the critical interaction between HIV and tuberculosis is not considered. These two illnesses have a synergistic relationship so that their effects are combined and strengthened at the individual and community levels. Problems with tuberculosis in individuals and communities, and with the complications and management of tuberculosis during the course of HIV infection, are some of the difficulties faced by countries where there is a high prevalence of tuberculosis. The interactions between HIV and *Mycobacterium tuberculosis* may include:

- Higher risk of developing tuberculosis in HIV-infected individuals.

- Increased severity of clinical tuberculosis and impaired response to treatment in HIV-infected individuals.

- More severe clinical picture of tuberculosis in HIV-infected individuals.

- Appearance of resistance to drugs utilized in multidrug therapy for tuberculosis in HIV-infected persons and AIDS patients.

- Reduced safety and effectiveness of BCG vaccine.

- Adverse impact of tuberculosis on the natural history of HIV/AIDS infection.

AIDS and, in general, HIV infection, primarily affect the adult population of the countries in the Region. This can cause serious damage to the economic and labor market dynamics in those countries where the epidemic has the strongest impact. An economic indicator such as years of economically active life, which ranges between 35 and 45 years and is based on the assumption that people begin their productive activity at age 15, can be drastically reduced as a consequence of the epidemic.

If we take a concrete example such as Brazil, we can better illustrate the impact of the epidemic on the economy of a country. Brazil is a country in which the epidemic is still in its initial stages. If the size of the economically active Brazilian population (between the ages of 15 and 60) is about 76 million and the average annual product per

capita is around US$5,920, and if the HIV/AIDS epidemic is assumed to affect 0.6% of the population, then there would be a loss of production amounting to $2,700 million once the disease had manifested itself in all the individuals infected with human immunodeficiency virus. If the expense of managing the complications associated with the disease is factored in as well, then the cost of the epidemic in a country can be extremely high. Clearly the amount that would need to be spent to prevent new infections through educational interventions and strategies for promotion and distribution of condoms would be several hundred times less than the amount needed to cover the losses caused by the disease. In other words, investment in prevention is cost-effective and this investment needs to be made now.

3. Programs for the Prevention and Control of AIDS in the Americas and Intersectoral, Interagency, and Interprogram Collaboration

When the seriousness of the rapid spread of the AIDS epidemic became apparent in the mid-1980s, emergency activities were initiated to control it. In 1987, the 40th World Health Assembly explicitly recommended that every country in the world develop a national program for the prevention and control of AIDS. In this context, PAHO provided its technical cooperation to the Member Countries so that they could develop their emergency strategies as well as short-term plans for AIDS control. The financial support from the funds mobilized by the Global Program on AIDS (GPA) permitted effective implementation of the activities envisaged in these strategies and plans. As it became clear that the problem would persist for a long time, the coordination of prevention and control activities over a longer period became a priority. Practically all the countries in the Region of the Americas received some form of financing for their AIDS prevention and control activities, within the framework of a short-term plan.

The programming cycle that followed consisted of detailed development of national activities within a three- to five-year planning framework. Multidisciplinary teams of experts, with continuous assistance from PAHO staff members and with the financial support of the Global Program on AIDS (GPA) and agencies of bilateral and multilateral cooperation, helped all the Member Countries to prepare, implement, and evaluate medium-term plans (MTPs) for the prevention and control of AIDS.

The medium-term plans were centered basically on initiatives and actions in the health sector. The implementation of MTPs helped, among other things, to bring about a notable improvement in systems for quality control of blood and blood products, to make various population sectors aware of the seriousness of the problem, and to develop a managerial structure that laid the groundwork for increased intersectoral integration for the prevention and control of AIDS. However, the experiences on the national level and worldwide have shown that the responses required to deal with the AIDS epidemic transcend the domain of the health sector.

The impetus and experience gained during the implementation of the medium-term plans set the stage for the initiation of a new planning stage, which would seek not only to involve various programs, sectors, and social strata, but also to coordinate their initiatives and efforts for effective prevention and control of AIDS and of its psychological, economic, and social consequences. In this next planning stage, the countries are also developing plans for periods of from three to five years. These are, accordingly, medium-term plans and it will be necessary to distinguish them from the plans in the previous cycle by calling them "second-generation" medium-term plans (MTPs II). The distinctive characteristics of these second-generation plans are as follows:

- They are supported by basic information (epidemiological, anthropological, socioeconomic, etc.) that is much more accurate than that used in any earlier programming.

- The planning does not rely on speculation but rather on the experience gained and the lessons learned, which ensures that the activities programmed will have a stronger impact.

- In their design, execution, and evaluation, they involve various sectors, programs, and professionals from a variety of related areas and disciplines.

This approach will help guarantee both effective implementation of the planned activities as well as comprehensive, collective care for the affected individuals, as called for in item 8 of the Declaration of the World Summit of Ministers of Health, held in London in January 1988.

With the technical and administrative assistance of PAHO, the countries of Central America and the Caribbean, Panama, and the Dominican Republic have completed their preparation of second-generation medium-term plans. PAHO will actively support, in the immediate future, the process of mobilization of funds for the execution of these plans. During 1993, the countries of the Andean Area, Uruguay, Paraguay, and Chile will be devoting efforts to the preparation of their MTPs II. Brazil is in the process of consolidating a large-scale national plan with the participation of the World Bank, UNDP, PAHO, WHO, and nongovernmental organizations. In the case of Argentina, PAHO will continue to provide the support needed to develop a national plan to respond to the needs and realities of the country.

From the point of view of managerial and administrative strengthening, PAHO's Regional Program on AIDS has developed an instrument to facilitate monitoring of the activities and work of the national plans. This instrument makes it possible for the national teams to carry out continuous monitoring of their progress, contributions, and reprogramming needs. Under the name "Control and Monitoring System (CMS)," this

instrument has been made available to the Member Countries and most of them have adopted it, pointing out that it has been very useful in helping them to oversee the management of the national programs. This system also provides a means through which the Regional Program on AIDS can report to the donors with regard to the utilization and impact of their contributions.

The active collaboration of PAHO with the territories of the United Kingdom in the Americas, Aruba, and the Netherlands Antilles, as well as the exchange of information with the French Overseas Departments in the Americas have helped to establish a basis for comprehensive participation by the western hemisphere in the global AIDS strategy.

In 1992 various activities that were aimed at achieving closer collaboration between the Regional Program on AIDS and the Global Program at WHO Headquarters were carried out. Among these, the joint missions that the Geneva and Washington teams carried out to select sites for research on vaccines are noteworthy. Brazil was identified as a country that has the appropriate conditions to serve as a collaborator in the western hemisphere in the process of development of HIV vaccines.

In addition, the Director of the Global Program on AIDS and the Regional Coordinator visited three countries of the Region (Brazil, Honduras, and Panama) for the purpose of negotiating the highest level of intersectoral and interinstitutional support for the AIDS programs in those countries. The Deputy Director of GPA and the Regional Coordinator traveled to Cuba to discuss GPA support for the national program and specific activities with the authorities in that country as well.

The exchange of opinions and experiences by the technical teams from PAHO and WHO Headquarters has not only served to give more importance to the activities of technical cooperation in the Region of the Americas, but has also allowed the lessons learned in the Member Countries of PAHO to be used to support preventive activities in other regions of the world.

PAHO continues to carry out efforts to promote active participation by community groups and nongovernmental organizations (NGOs) in the development and execution of activities under the national programs for the prevention and control of AIDS. These have included specific activities for technical assistance (including in the area of management) to community groups and NGOs in Central America, the Andean Area, the Southern Cone, and the United States; a meeting in Uruguay with NGOs from Southern Cone countries; and the careful and objective consideration of requests for financial support that have been submitted to WHO under the Small Grants Program (Partnership Program).

With the support of WHO Headquarters, an inventory was made of research and research resources on AIDS and HIV that identified more than 600 scientific studies and projects in Latin America and the Caribbean. Once the inventory was published, it was distributed to research and educational groups, centers, and institutions in the Region. In this way an effort is being made to disseminate scientific information and to promote the exchange of knowledge and the transfer of appropriate technology among the countries.

In addition, with the support of the Sociedad Española Interdisciplinaria de SIDA (Spanish Interdisciplinary AIDS Society), it has been possible to distribute the monthly publication that the Society puts out, which contains continuously updated articles and essays of very high quality, to nearly 200 researchers and academic institutions in Latin America.

In the area of research, there has been continued collaboration with the National Institute of Allergy and Infectious Diseases (NIAID) of the National Institutes of Health (NIH) in the United States, and this has translated into: a) direct technical collaboration with researchers in the countries of Latin America and the Caribbean; b) mobilization of resources from NIH; and c) dissemination of scientific findings. The projects carried out within the framework of PAHO/NIAID collaboration include a study in Jamaica on the incidence of HIV seropositivity among individuals using the services of an STD clinic in Kingston; the continuation of a study on heterosexual transmission of HIV in Brazil; and a comparative study of tuberculosis incidence among seropositive and seronegative individuals in Mexico.

Research activities related to women have been centralized at WHO Headquarters in Geneva. However, the Regional Program plans to convene a working group of professional women and men to prepare specific recommendations on the implementation of interventions linked to research among groups of women whose characteristics will need to be specified.

The recognition that the AIDS/HIV epidemic is a problem whose dynamics and dimensions will cause it to spread over time has reinforced the idea that AIDS prevention and control activities need to be made into permanent programs that are integrated into the existing health and development structures. In addition, these programs should be able to operate continuously, so that they can be part of the ongoing effort to safeguard public health and contribute to development in the Region.

Among the efforts aimed at ensuring broad, integrated, and continuous programming, the following examples should be cited: the initiative to involve nongovernmental organizations and community groups in the national programs for the prevention and control of AIDS; the execution of interinstitutional and interprogram activities by the Regional Program on AIDS of PAHO; and the introduction of

multidisciplinary teams, who in turn will receive interprogram orientation and information that will enable them to provide technical and managerial collaboration in the formulation and execution of national AIDS programs.

During 1992, PAHO, with the collaboration of the WHO Global Program on AIDS (GPA), mobilized US$11 million from various donors for activities in 40 countries of the Region and at the Regional level. Although there was a reduction of 23% with respect to the funds mobilized in 1991, the fact that the national programs are well established and have a greater capacity to carry out activities fostered a firmer commitment on the part of the countries of the Region, which in turn was translated into a greater allocation of national resources to this priority area. The recommendation that had been made in the past to increase national contributions for the programming of activities has become a reality, and most of the resources allocated for AIDS control activities are now of national origin. However, a balance must be achieved between the need for AIDS control activities and the need to prevent or provide care for other diseases and health conditions. Consequently, it is indispensable to ensure international cooperation, for which purpose it is necessary for the countries to strengthen their capacity to monitor the management of program activities (both from the technical and financial points of view) and to periodically and systematically document their achievements, progress, and difficulties. PAHO will continue to support this effort at strengthening and will provide the necessary assistance to mobilize resources from agencies and donor organizations.

Five years after the World Summit of Ministers of Health, several of the issues discussed there and considered to be fundamental for the implementation of a global strategy to combat AIDS continue to constitute challenges which must be faced with renewed vigor. These challenges include: persuading the general public to adopt behaviors that lower the risk of infection; securing a commitment from the communications media to fulfill their social mission to report objectively; and developing educational programs and carefully and rigorously evaluating them and assessing their impact in order to replicate or restructure them.

Other pressing challenges are: developing interventions aimed at reducing the transmission of HIV among intravenous drug users; developing interventions to increase the use of condoms; reducing the incidence of other sexually transmitted diseases; eliminating HIV transmission through blood and blood products; securing the active participation of NGOs in national program activities; and overcoming sectoral barriers to the effective control and prevention of AIDS/HIV.

4. Present and Future Priorities for the Prevention of AIDS in the Americas

The Regional Program on AIDS of PAHO is fully staffed in so far as its technical team is concerned, both at Headquarters and in the field. The formation of this team,

in addition to enabling a clear definition of the functions and responsibilities of each of its members, has facilitated the management of technical cooperation activities, so that work can be carried out in a coordinated manner in order to fulfill program goals, lines of action, and expected outcomes. Under this modality of strategic planning, more than 90% of the activities included in the annual plan of the Regional Program on AIDS were in fact carried out on schedule, in addition to those that were carried out in response to needs that arose and were addressed as soon as was feasible.

Although it is true that at the national and Regional level the system for the preparation of progress reports has not been entirely perfected, with the development and implementation of computerized means for monitoring the activities of the national programs (Control and Monitoring System), it will be possible to improve the production of such reports. In addition, three meetings were held with managers and administrators of programs (one in the Caribbean on implementation, one in Central America on preparation of reports, and a third in South America on planning and development of programs), which helped to improve coordination and technical cooperation between PAHO personnel (at Headquarters and in the countries) and their counterparts in the national programs for the prevention and control of AIDS in all the countries of the Region.

Considerable progress has also been made on the regional system for epidemiological surveillance of AIDS. As a result of the two subregional workshops on surveillance carried out in 1991, in 1992 seven countries initiated specific activities to improve surveillance of HIV infection at the national level. It is expected that by the end of 1993 all countries with more than one million inhabitants will have a similar system in place, which will make it possible to monitor the status of the epidemic, assess trends in various population groups, apply preventive measures where more are needed, and change the attitudes of those who are unwilling to recognize the magnitude of the problem of HIV/AIDS.

PAHO and the Member Countries have committed themselves to implementing the global strategy for the prevention and control of AIDS/HIV in the Americas. The main objectives of this strategy are: (a) to prevent infection with HIV, (b) to reduce the personal and social impact of HIV infection, and (c) to mobilize and unify national and international efforts against AIDS.

In order to achieve these objectives it is necessary to establish certain priorities at the various levels: priorities of the Global Program on AIDS (GPA) and priorities of the Member Countries.

The priorities of the GPA are the following:

- To strengthen national AIDS programs with respect to the formulation of plans and the coordination of AIDS prevention through behavior modification--including the use of condoms--and the care of persons with HIV/AIDS.

- To formulate plans for dealing with the social and economic consequences of AIDS that threaten families, communities, and the economic stability of many developing nations.

The goals common to all the Member Countries are:

- To formulate and implement medium-term plans (strategic national plans).
- To strengthen managerial capacity.
- To involve nongovernmental organizations and the private sector.
- To establish the surveillance systems necessary for planning.
- To develop educational activities and interventions aimed at bringing about behavioral change that are adapted to the national (local) situation.
- To develop activities geared specifically toward reducing the sexual transmission of HIV to women.
- To promote effective practices for reducing the sexual transmission of HIV and STDs among groups at risk (by promoting the use of condoms and other barrier methods).
- To transmit explicit and culturally appropriate messages to combat conformism and denial.
- To develop feasible strategies for the care of AIDS patients.
- To achieve adequate capacity to care for the most common opportunistic infections, particularly tuberculosis.
- To ensure an HIV-free supply of blood and blood products.
- To establish a technical-scientific information network.

In addition, given that the prevention of AIDS is a program priority for PAHO, the Organization has set as the general objective for the Regional Program to both decrease the transmission of HIV and other agents of STDs and to reduce the social and economic impact of these diseases.

The specific objectives of the Program are: (a) to strengthen the national capacity of all the Member Countries to respond in an adequate, effective, efficient, and long-term manner to the challenge of preventing and controlling AIDS, HIV infection, and STDs in the Region of the Americas; and (b) to lead and to promote interagency, intersectoral, and interprogram cooperation for the prevention of AIDS and STDs at the national, subregional, and regional levels.

The Program's lines of action are:

- Support for the development of national capacity.
- Coordination of international and interagency initiatives.
- Establishment and maintenance of intersectoral participation.
- Mobilization of resources.
- Interprogram articulation.
- Support for the identification of risk groups.
- Promotion and support for interventions at the local health system (SILOS) level.
- Strengthening of technology transfer, research, and the dissemination of scientific information.
- Support for procurement of supplies, such as condoms and laboratory reagents.
- Promotion of the exchange of information, experience, and knowledge in the Region of the Americas.

5. Program Approaches and Proposed Policies in the Context of the Conference of Ministers of Health of the Ibero-American Countries, and the III Ibero-American Summit of Heads of State and Government

AIDS is not only a health problem, but also a social, economic, and political problem with long-term repercussions for communities and whole countries. At the country level, the fight against AIDS and the reduction of its consequences in society will require a concerted and sustained effort involving, among others, the Ministries of Health, Education, Labor, Justice, Finance, and Planning, as well as social security institutions, the mass media, the private sector, nongovernmental organizations,

professional associations, universities, religious organizations, and other community groups.

To achieve this, it is necessary to secure the political support of the highest governmental levels, the technical leadership of social services and health sectors, financial contributions and other resources from the various national and international agencies, and, in particular, the unconditional commitment of local health systems and local communities to the prevention of AIDS.

The AIDS epidemic, in addition to the suffering it inflicts on the peoples of the Region, has enormous costs--both direct and indirect. The extent to which these costs can be reduced is directly proportional to the capacity of the national AIDS programs to implement preventive actions and to rationalize curative interventions. At present there is a great disparity at the international level with respect to per capita investment and expenditure for preventive activities, to wit: North America, $2.70; Europe, $1.18; sub-Saharan Africa, $0.07; and Latin America, $0.03.

The time has come to strengthen the recognition that the HIV/AIDS epidemic, in addition to being a health problem, has serious social, economic, educational, legal, and political repercussions. The sum of these repercussions can generate instability and have serious consequences for the development process in the countries. It is for this reason that at the Conference of Ministers of Health of the Ibero-American Countries, in May 1993, proposals were presented for collaboration among the countries in accordance with the following objectives and strategies, with a view to establishing a common Plan of Action:

- To reduce the socioeconomic impact of the epidemic.

- To reduce the transmission of HIV from intravenous drug use, which is a significant problem in a growing number of countries in the Region.

- To ensure collective and individual rights.

- To avoid the effects of the epidemic on migratory movements, both national and international.

- To develop human resources in all the areas related to the prevention of AIDS.

- To transfer and use appropriate technology for the prevention and control of STDs and HIV.

In the areas of human resources development and use of appropriate technology, it is recommended that the following activities be considered:

- Curriculum reforms.
- Training and consolidation of multidisciplinary resources.
- Programs of continuing education with systems of long-distance education.
- Use of simple laboratory technologies.
- Evaluation of algorithms for the clinical management of STDs.
- Evaluation and adaptation of alternative care models.
- Improvement of diagnostic capabilities.

In the areas of protection of human rights and migratory movements, the following activities are proposed:

- The preparation of legal instruments to prevent discrimination.
- The drafting and implementation of agreements that eliminate all requirements for serological tests for any type of visa.
- The development of quantitative and qualitative research to track migratory movements and design programs for prevention of HIV infection.
- Sharing of information, education, and communication (IEC).

In the area of reducing transmission of HIV from intravenous drug use, the following are proposed:

- Joint research to identify the epidemiological, anthropological, behavioral, and socioeconomic profile of intravenous drug users.
- Training of community agents in this area.
- Development of pilot projects to test various intervention strategies.

Finally, in order to reduce the socioeconomic impact of the epidemic, three activities are proposed:

- The definition of national priority areas for the mobilization and allocation of financial resources.

- The preparation and execution of projects to assess the economic and social impact of preventive strategies.

- The development of appropriate methodologies to obtain information on the direct and indirect costs of HIV infection and AIDS and to systematically analyze this information.

The Member Governments are urged to give priority to investment in AIDS prevention, control, treatment, and research in the countries of the Region. This is desirable not only for public health reasons and out of respect for human dignity and rights, but as a contribution to national growth and development. In order to provide a solid technical and administrative basis for this investment, it will be necessary to make sizable investments in information systems and socioeconomic studies related to the AIDS/HIV epidemic so as to guide political decision-making at the highest levels of government in the Member Countries.

An additional recommendation was made by the Conference of Ministers of Health of the Ibero-American Countries to develop a large-scale project in the Region to eliminate congential syphilis by the year 2000 through preventive actions, the provision of services, and community participation.

The decisions and recommendations of the Conference of Ministers of Health of the Ibero-American Countries were presented for the consideration of the III Ibero-American Summit of Heads of State and Government, which took place in July 1993.

The document containing these decisions and recommendations requested the Heads of State to lend their support in order to implement a broad-based strategy for the prevention and control of AIDS, including the topics presented in the same document. Increased resources were also requested for implementing the strategy, in addition to legal and administrative support in order to carry out the activities envisioned in the strategy as expeditiously and efficiently as possible.

Appendix

APPENDIX

AIDS SURVEILLANCE IN THE AMERICAS

QUARTERLY REPORT

10 June 1993

REGIONAL PROGRAM ON AIDS/STD

Division of Communicable Disease Prevention and Control

Pan American Health Organization/
World Health Organization
525 Twenty Third St. N.W.
Washington D.C. 20037.

AIDS SURVEILLANCE IN THE AMERICAS
Summary

Data as received by 10 June 1993

Cumulative number of cases reported worldwide:	669,592

Cumulative number of cases reported in the Americas:	371,086

Cumulative number of deaths reported in the Americas:	217,276

FIG. 1. ANNUAL INCIDENCE OF AIDS CASES, BY REGION OF THE WHO, BY YEAR, 1979–92.

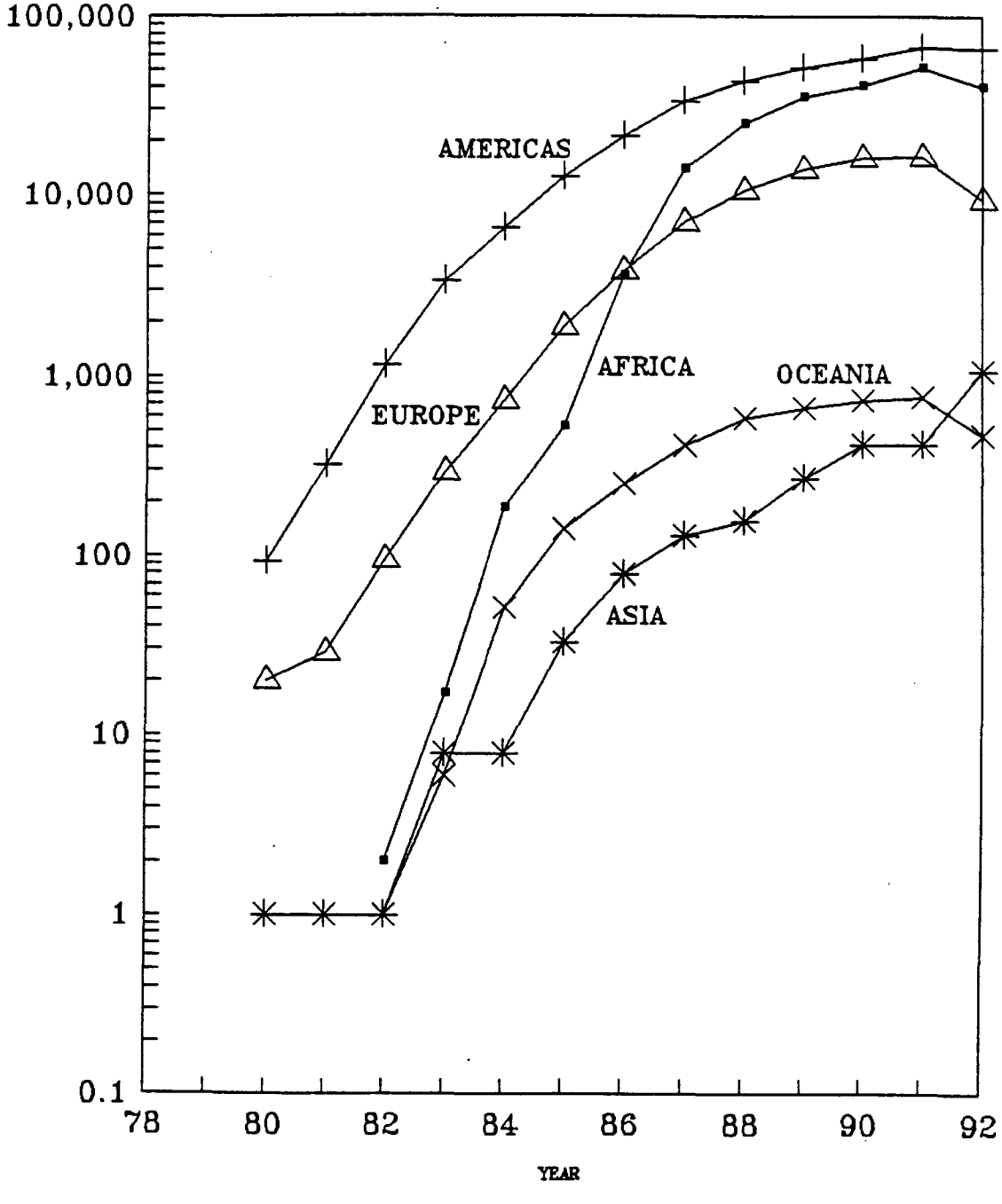


Fig.2. ANNUAL INCIDENCE RATES OF AIDS IN THE AMERICAS, (PER MILLION), THREE MAJOR SUBREGIONS, 1982–1992.

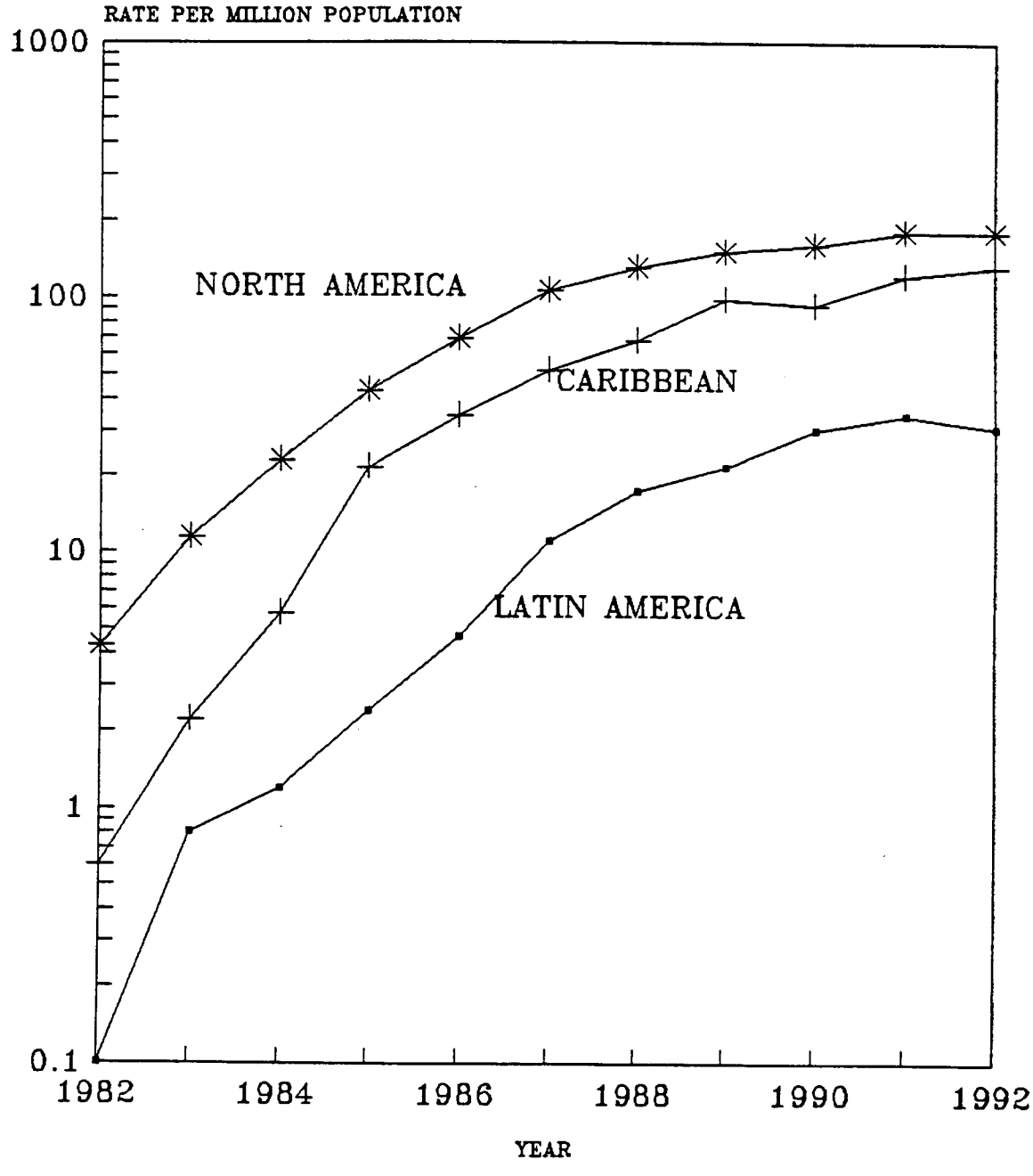


TABLE 1. NUMBER OF REPORTED CASES OF AIDS BY YEAR, AND CUMULATIVE CASES AND DEATHS, BY COUNTRY AND SUBREGION.

As of 10 June, 1993

SUBREGION Country	Number of Cases Through 1987	1988	1989	1990	1991	1992	1993	Cumulative total(a)	Total deaths	Date of last report
REGIONAL TOTAL	79,523	43,206	51,321	58,056	66,336	65,494	6,709	371,086	217,276	
LATIN AMERICA b)	7,850	7,294	9,357	13,165	15,332	14,029	1,633	69,089	29,206	
ANDEAN AREA	623	734	940	1,468	1,536	900	25	6,226	3,134	
Bolivia	6	10	2	9	17	8	8	60	45	31/Mar/93
Colombia	247	319	410	765	782	434	...	2,957	1,483	30/Sep/92
Ecuador	35	29	22	42	51	57	17	253	161	31/Mar/93
Peru	62	65	118	141	155	73	...	614	216	31/Mar/92
Venezuela	273	311	388	511	531	328	...	2,342	1,229	31/Dec/92
SOUTHERN CONE	246	268	352	606	758	875	149	3,594	1,489	
Argentina	145	169	228	388	478	605	103	2,456	915	31/Mar/93
Chile	77	67	83	130	184	162	20	723	352	31/Mar/93
Paraguay	7	4	3	12	10	18	2	56	38	31/Mar/93
Uruguay	17	28	38	76	86	90	24	359	184	31/Mar/93
BRAZIL	4,017	3,868	5,094	6,884	8,746	7,640	232	36,481	15,619	13/Apr/93
CENTRAL AMERICAN ISTHMUS	280	359	491	907	911	1,151	260	4,436	1,559	
Belize	7	4	0	19	11	12	...	53	46	30/Sep/92
Costa Rica	43	52	57	86	91	117	24	470	285	31/Mar/93
El Salvador	23	34	72	54	132	114	41	470	120	31/Mar/93
Guatemala	31	18	32	92	96	94	25	434	148	31/Mar/93
Honduras	119	189	251	585	495	709	142	2,510	657	31/Mar/93
Nicaragua	0	2	2	7	13	6	6	39	30	31/Mar/93
Panama	57	60	77	64	73	99	22	460	273	31/Mar/93
MEXICO	1,049	964	1,499	2,395	3,166	3,219	967	13,259	6,789	31/Mar/93
LATIN CARIBBEAN c)	1,635	1,101	981	905	215	244	...	5,093	616	
Cuba	16	14	15	28	38	57	...	168	94	31/Dec/92
Dominican Republic	347	356	513	247	177	187	...	1,839	225	31/Dec/92
Haiti	1,272	731	453	630	...	...	...	3,086	297	31/Dec/90
CARIBBEAN c)	836	493	725	701	872	951	102	4,692	2,869	
Anguilla	0	1	2	1	1	0	0	5	3	31/Mar/93
Antigua	3	0	0	3	...	...	...	6	5	31/Dec/90
Bahamas	176	93	168	162	235	259	68	1,161	700	31/Mar/93
Barbados	56	15	40	61	80	78	20	350	271	31/Mar/93
Cayman Islands	3	1	1	2	4	4	...	15	11	31/Dec/92
Dominica	5	2	3	2	...	...	...	12	11	30/Jun/90
French Guiana	103	34	54	41	...	...	...	232	144	30/Sep/90
Grenada	8	3	8	5	7	4	...	35	25	31/Dec/92
Guadeloupe	88	47	47	...	...	...	...	182	85	31/Dec/89
Guyana	10	34	40	61	85	160	...	390	102	31/Dec/92
Jamaica	43	30	66	62	133	99	...	433	299	31/Dec/92
Martinique	48	30	51	45	28	25	10	237	164	31/Mar/93
Montserrat	0	0	1	0	0	0	0	1	0	31/Mar/93
Netherlands Antilles	18	13	16	30	23	10	...	110	55	30/Jun/92
Saint Kitts and Nevis	10	9	5	8	1	4	1	38	24	31/Mar/93
Saint Lucia	8	2	8	3	7	9	...	49	25	31/Dec/92
Saint Vincent and the Grenadines	7	8	6	4	14	7	3	49	34	31/Mar/93
Suriname	9	4	35	35	16	29	...	128	100	31/Dec/92
Trinidad and Tobago	236	160	167	173	235	257	...	1,228	787	31/Dec/92
Turks and Caicos Islands	5	6	7	1	2	4	...	25	23	31/Dec/92
Virgin Islands (UK)	0	1	0	2	1	2	0	6	1	31/Mar/93
NORTH AMERICA	70,837	35,419	41,239	44,190	50,132	50,514	4,974	297,305	185,201	
Bermuda	72	28	35	33	23	17	7	215	156	31/Mar/93
Canada	2,116	1,068	1,238	1,199	1,184	931	34	7,770	5,128	29/Apr/93
United States of America c)	68,649	34,323	39,966	42,958	48,925	49,566	4,933	289,320	179,917	31/Mar/93

a) May include cases for year of diagnosis unknown.
b) French Guiana, Guyana, and Suriname are included in the Caribbean.
c) Puerto Rico and the U.S. Virgin Islands are included in the United States of America.

TABLE 2. ANNUAL INCIDENCE RATES OF AIDS (PER MILLION POPULATION), BY COUNTRY AND BY YEAR, 1988–1992.

SUBREGION	RATE PER MILLION				
Country	1988	1989	1990	1991	1992
LATIN AMERICA a)	17.4	21.9	30.1	34.4	30.8
ANDEAN AREA	8.4	10.5	16.0	16.3	9.3
Bolivia	1.4	0.3	1.2	2.3	1.0
Colombia	10.4	13.1	24.0	23.3	12.7
Ecuador	2.8	2.1	3.9	4.7	5.1
Peru	3.1	5.4	6.3	7.0	3.3
Venezuela	16.6	20.2	25.9	26.3	15.8
SOUTHERN CONE	5.2	6.7	11.5	14.1	16.1
Argentina	5.4	7.1	12.0	14.6	18.3
Chile	5.3	6.4	9.9	13.7	11.9
Paraguay	1.0	0.7	2.8	2.3	4.0
Uruguay	9.1	12.2	24.3	27.5	28.8
BRAZIL	26.8	34.6	45.8	57.0	48.9
CENTRAL AMERICAN ISTHMUS	13.0	17.4	31.2	30.5	37.5
Belize	23.0	0	104.4	60.4	64.5
Costa Rica	18.1	19.4	28.5	29.5	37.0
El Salvador	6.8	14.0	10.3	24.6	20.7
Guatemala	2.1	3.6	10.0	10.1	9.6
Honduras	39.1	50.4	113.9	93.4	129.8
Nicaragua	0.6	0.5	1.8	3.3	1.5
Panama	25.8	32.5	26.5	29.0	39.4
MEXICO	11.4	17.3	27.0	35.0	34.9
LATIN CARIBBEAN b)	47.3	41.5	37.7	8.7	9.7
Cuba	1.4	1.5	2.7	3.5	5.3
Dominican Republic	51.8	73.1	34.4	24.2	25.0
Haiti	116.7	71.0	96.8	...	...
CARIBBEAN a)	67.9	98.4	93.0	121.2	131.7
Anguilla	142.2	284.5	142.9	142.9	0
Antigua	0	0	34.9	...	...
Bahamas	367.5	653.7	623.1	903.8	988.5
Barbados	58.4	154.6	233.7	313.7	304.7
Cayman Islands	47.5	47.6	95.2	190.5	148.1
Dominica	25.3	37.5	24.7	...	...
French Guiana	386.3	600.7	445.7	...	...
Grenada	30.0	79.2	48.5	68.0	42.4
Guadeloupe	139.0	138.6	...	...	...
Guyana	33.8	39.1	58.6	106.3	198.8
Jamaica	12.3	26.6	24.6	53.5	39.4
Martinique	90.9	154.3	136.0	81.6	72.5
Montserrat	0	76.7	0	0	0
Netherlands Antilles	69.1	83.7	155.4	119.2	51.3
Saint Kitts and Nevis	187.5	103.1	160.0	20.0	90.1
Saint Lucia	15.0	59.3	22.1	51.5	57.0
Saint Vincent and the Grenadines	74.1	55.0	36.0	126.1	58.4
Suriname	10.2	87.9	86.8	37.3	66.4
Trinidad and Tobago	128.7	132.2	134.8	180.6	194.8
Turks and Caicos Islands	750.9	876.1	111.1	222.2	400.0
Virgin Islands (UK)	76.7	0	25.8	12.9	153.8
NORTH AMERICA	130.3	150.2	160.2	180.9	180.5
Bermuda	490.8	601.4	569.0	396.6	293.1
Canada	40.9	47.1	45.2	44.3	34.5
United States of America b)	139.7	161.1	172.4	195.4	196.0

a) French Guiana, Guyana, and Suriname included in the Caribbean.

b) Puerto Rico and the U.S.Virgin Islands included in the United States of America.

TABLE 3. ANNUAL INCIDENCE RATES OF AIDS (PER MILLION POPULATION), BY SEX, BY COUNTRY AND BY YEAR, 1987–1992.

SUBREGION	RATE PER MILLION POPULATION											
	MALE RATES						FEMALE RATES					
Country	1987	1988	1989	1990	1991	1992	1987	1988	1989	1990	1991	1992
LATIN AMERICA a)	19.0	28.9	37.3	49.0	56.4	49.4	2.7	5.4	6.7	8.9	10.1	10.3
ANDEAN AREA	8.6	14.5	18.5	26.2	23.3	14.6	0.4	1.1	1.7	3.0	1.7	1.2
Bolivia	0.9	2.9	0	1.9	4.3	1.8	0	0	0.6	0	0	1.0
Colombia	11.8	17.7	23.5	40.8	30.9	23.7	0.5	1.6	2.3	3.2	1.8	1.7
Ecuador	4.0	5.5	3.8	7.0	8.1	9.1	0.4	0.2	0.4	0.7	1.3	1.1
Peru	2.9	5.5	9.7	8.1	13.1	6.0	0.2	0.6	0.8	4.5	0.9	0.4
Venezuela	14.8	28.4	34.8	42.3	37.1	16.6	0.7	2.0	2.9	3.5	3.4	1.3
SOUTHERN CONE	5.1	9.7	12.1	20.7	25.8	23.4	0	0.7	1.2	2.1	2.2	5.1
Argentina	4.6	10.4	12.9	21.6	26.8	29.3	0	0.4	1.2	2.4	2.5	7.2
Chile	6.9	9.2	11.4	18.4	24.7	11.8	0.2	1.2	1.1	0.7	1.3	1.3
Paraguay	2.6	2.0	1.4	4.6	4.5	7.4	0	0	0	0.9	0	0.4
Uruguay	6.0	15.8	21.6	42.9	50.8	36.0	0	2.6	2.5	6.3	5.6	6.2
BRAZIL	29.8	47.0	61.1	80.6	96.5	80.4	3.1	6.7	8.1	11.1	17.8	17.5
CENTRAL AMERICAN ISTHMUS	10.0	17.2	20.6	37.7	40.1	50.6	3.1	6.2	7.6	16.3	13.6	16.9
Belize	23.5	23.0	...	11.0	...	...	11.8	11.5	...	...	...	...
Costa Rica	16.3	33.2	33.0	40.7	50.6	54.4	0	2.8	2.7	4.7	2.6	5.1
El Salvador	...	...	...	...	36.8	31.1	...	...	...	...	12.4	7.8
Guatemala	3.3	3.6	3.1	13.3	16.1	14.2	0.5	0.5	0.7	3.1	3.6	2.3
Honduras	28.5	50.4	64.8	140.4	107.7	180.0	15.4	27.8	35.8	80.5	48.4	78.7
Nicaragua	0	1.1	1.1	3.1	4.5	2.4	0	0	0	0.5	0.5	0
Panama	25.0	41.4	55.4	44.7	40.7	29.7	1.8	9.7	8.6	7.6	15.7	4.0
MEXICO	17.1	19.0	33.3	41.0	59.3	59.3	1.8	3.3	6.1	8.0	10.8	10.6
LATIN CARIBBEAN b)	39.2	64.2	51.0	44.3	10.4	8.8	18.3	30.6	30.0	27.6	5.0	2.9
Cuba	4.1	3.9	0.2	0.8	4.3	5.9	1.2	0.8	0.2	0	1.3	2.4
Dominican Republic	44.7	73.8	94.0	44.2	28.5	20.8	23.7	28.1	49.3	21.3	15.3	6.3
Haiti	92.7	154.4	87.1	116.2	...	...	39.8	80.0	55.4	76.7	...	...
CARIBBEAN	75.1	94.9	128.5	107.7	157.2	177.9	29.0	38.4	59.9	47.3	79.0	82.3
Anguilla	0	0	...	0	0	0	0	281.7	0	284.1	281.7	0
Antigua	24.6	0	0	...	...	...	0	0	0	...	...	...
Bahamas	430.0	448.0	701.3	747.8	1155.3	1292.4	294.2	289.0	607.2	501.5	673.0	692.9
Barbados	173.3	73.9	244.5	409.6	520.3	471.5	22.3	44.4	73.5	73.2	105.3	150.4
Cayman Islands	96.2	0	96.2	96.2	...	75.1	0	93.9	0	0	...	73.1
Dominica	101.3	49.9	49.3	48.7	...	...	26.0	0	25.4	0	...	...
French Guiana	395.2	545.0	735.0	...	...	...	186.0	204.6	466.7	...	...	...
Grenada	62.0	20.2	100.3	78.7	62.4	20.7	20.2	39.5	0	19.2	87.4	0
Guadeloupe	187.9	217.6	210.9	...	...	...	58.1	63.7	69.3	...	...	...
Guyana	28.2	61.4	42.9	86.3	149.0	268.8	0	10.0	9.8	30.9	64.4	130.5
Jamaica	15.9	18.2	38.2	32.6	59.1	52.8	10.7	6.5	15.2	16.6	48.0	25.3
Martinique	100.1	137.2	230.1	191.4	120.5	95.8	41.5	47.2	82.4	82.9	33.9	50.6
Montserrat	0	0	...	0	0	0	0	0	...	0	0	0
Netherlands Antilles	110.2	10.9	...	...	...	...	21.0	20.8	...	...	...	...
Saint Kitts and Nevis	85.0	381.0	126.6	248.1	46.8	140.4	81.5	0	80.6	77.5	0	43.4
Saint Lucia	47.3	15.5	107.4	15.2	66.6	65.4	14.8	14.6	14.3	28.4	25.0	49.1
Saint Vincent and the Grenadines	77.6	57.2	37.7	55.6	122.2	103.3	18.4	72.0	89.3	17.5	98.4	16.2
Suriname	15.8	20.7	137.5	125.0	56.3	82.9	10.2	0	39.7	49.3	18.5	50.0
Trinidad and Tobago	103.3	187.1	193.7	144.0	248.8	277.4	26.1	70.6	71.1	54.3	113.1	113.1
Turks and Caicos Islands	253.2	1012.7	1519.0	0	404.9	809.7	247.5	495.0	247.5	219.5	0	0
Virgin Islands (UK)	0	...	0	144.0	155.0	155.0	0	...	0	14.2	0	151.7
NORTH AMERICA	149.9	223.9	242.5	291.3	299.1	302.4	13.3	25.8	28.6	37.7	43.1	46.8
Bermuda	638.3	850.2	975.6	489.5	664.3	419.6	104.2	138.8	237.3	238.1	136.1	170.1
Canada	65.7	78.4	89.5	87.1	84.1	66.1	4.1	4.1	5.3	4.1	5.3	3.7
United States of America b)	158.9	239.4	258.9	313.4	322.3	327.9	14.3	28.1	31.0	41.2	47.1	51.3

a) French Guiana, Guyana, and Suriname are included in the Caribbean.
b) Puerto Rico and the United States Virgin Islands are included in the United States of America.

TABLE 4. MALE:FEMALE RATIO OF REPORTED AIDS CASES, BY COUNTRY AND BY YEAR, 1987–1992.

SUBREGION	MALE:FEMALE RATIO					
Country	1987	1988	1989	1990	1991	1992
LATIN AMERICA a)	6.9	5.4	5.6	5.5	5.6	4.8
ANDEAN AREA	20.4	12.7	10.8	8.8	13.4	12.1
Bolivia	N/A	N/A	0	N/A	N/A	1.8
Colombia	22.3	11.3	10.2	13.0	16.6	13.4
Ecuador	10.0	28.0	10.0	9.5	6.3	8.5
Peru	15.0	9.8	11.9	1.8	14.5	13.6
Venezuela	22.8	14.2	12.1	12.4	11.1	13.3
SOUTHERN CONE	129.0	13.1	10.1	9.7	11.6	4.5
Argentina	N/A	23.1	10.3	8.9	10.6	4.0
Chile	43.0	7.3	10.4	24.0	18.1	8.8
Paraguay	N/A	N/A	N/A	5.0	N/A	17.0
Uruguay	N/A	6.0	8.3	6.6	8.6	5.5
BRAZIL	9.7	7.0	7.5	7.2	5.4	4.6
CENTRAL AMERICAN ISTHMUS	3.3	2.8	2.8	2.3	3.0	3.0
Belize	2.0	2.0	...	N/A	...	...
Costa Rica	N/A	12.0	12.3	8.9	19.8	10.9
El Salvador	...	...	...	...	2.9	3.8
Guatemala	7.0	8.0	4.7	4.4	4.5	6.4
Honduras	1.9	1.8	1.8	1.8	2.3	2.3
Nicaragua	N/A	N/A	N/A	6.0	9.0	N/A
Panama	14.5	4.5	6.7	6.1	2.7	7.6
MEXICO	9.5	5.8	5.4	5.1	5.5	5.6
LATIN CARIBBEAN b)	2.2	2.1	1.7	1.6	2.1	3.1
Cuba	3.5	5.0	1.0	N/A	3.3	2.5
Dominican Republic	1.9	2.7	1.9	2.1	1.9	3.4
Haiti	2.3	1.9	1.5	1.5	...	...
CARIBBEAN	2.5	2.4	2.1	2.2	1.9	2.1
Anguilla	N/A	0	...	0	0	N/A
Antigua	N/A	N/A	N/A	...	...	...
Bahamas	1.4	1.5	1.1	1.5	1.7	1.8
Barbados	7.0	1.5	3.0	5.1	4.6	2.9
Cayman Islands	N/A	0	N/A	N/A	...	1.0
Dominica	4.0	N/A	2.0	N/A	...	...
French Guiana	2.1	2.7	1.6	...	...	...
Grenada	3.0	0.5	N/A	4.0	0.8	N/A
Guadeloupe	3.1	3.3	2.9	...	...	...
Guyana	N/A	6.2	4.4	2.8	2.3	2.0
Jamaica	1.5	2.8	2.5	2.0	1.2	2.1
Martinique	2.3	2.8	2.6	2.2	3.3	1.8
Montserrat	N/A	N/A	...	N/A	N/A	N/A
Netherlands Antilles	5.0	0.5	...	...	...	...
Saint Kitts and Nevis	1.0	N/A	1.5	3.0	N/A	3.0
Saint Lucia	3.0	1.0	7.0	0.5	2.5	1.3
Saint Vincent and the Grenadines	4.0	0.8	0.4	3.0	1.2	6.0
Suriname	1.5	N/A	3.4	2.5	3.0	1.6
Trinidad and Tobago	3.9	2.6	2.7	2.6	2.2	2.4
Turks and Caicos Islands	1.0	2.0	6.0	0	N/A	N/A
Virgin Islands (UK)	N/A	...	N/A	1.0	N/A	1.0
NORTH AMERICA	10.7	8.2	8.1	7.4	6.6	6.2
Bermuda	6.0	6.0	4.0	2.0	4.8	2.4
Canada	15.6	18.8	16.4	20.8	15.7	17.6
United States of America b)	10.6	8.1	7.9	7.2	6.5	6.1

NOTE: N/A = Not applicable. No female cases reported for the period.
"..." = Data not available by sex.

a) French Guiana, Guyana and Suriname are included in the Caribbean.

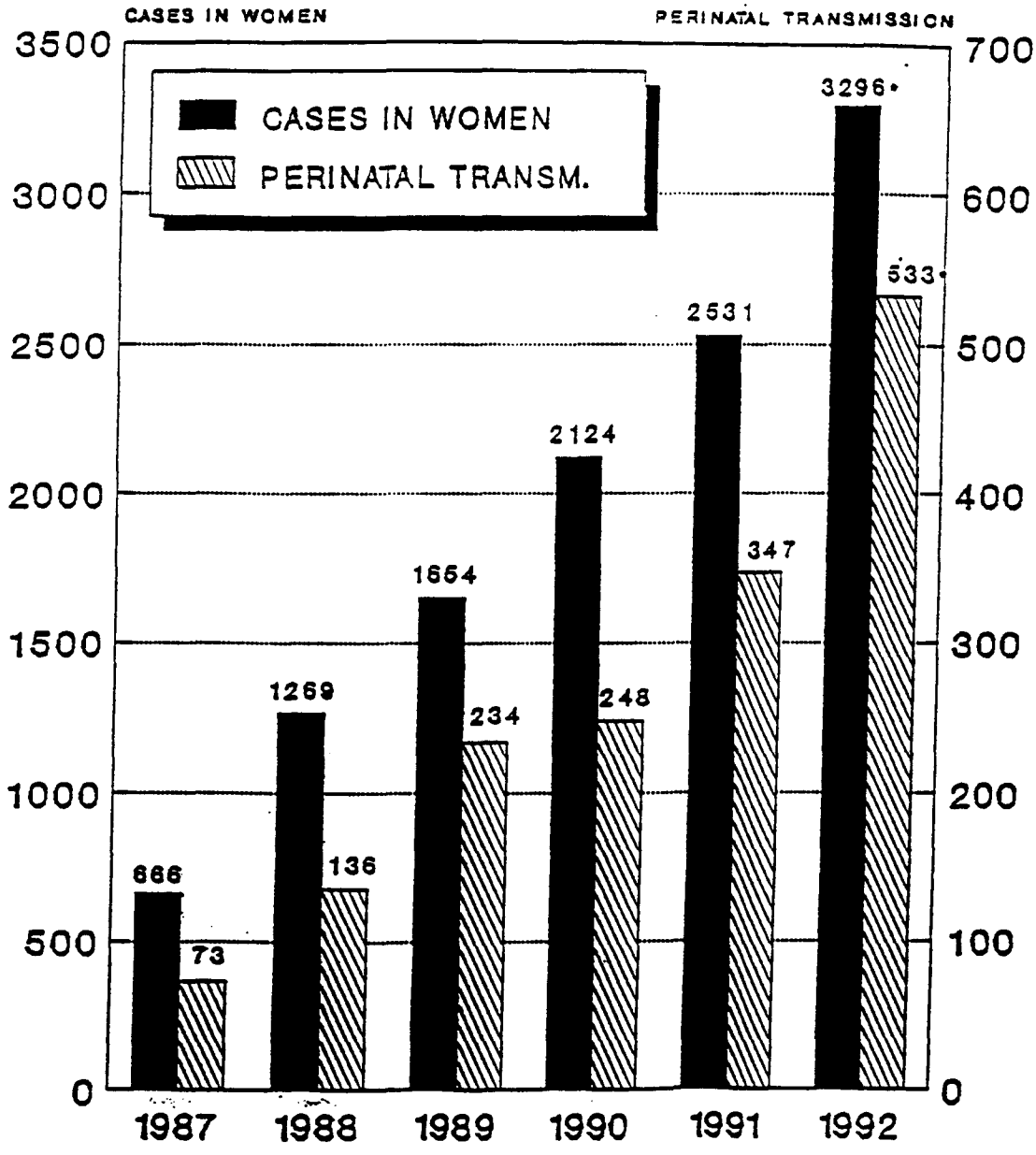
b) Puerto Rico and the United States Virgin Islands are included in the United States of America.

TABLE 5. TOTAL CASES, PEDIATRIC CASES, PERCENT OF PEDIATRIC CASES FROM TOTAL; PERINATAL CASES, AND PERCENT OF PERINATAL CASES FROM PEDIATRIC, BY SUBREGION AND COUNTRY(a), THROUGH JUNE 1993.

Country	TOTAL CASES	PEDIATRIC CASES	PERCENT PEDIATRIC	PERINATAL CASES	PERCENT PERINATAL
ANDEAN AREA					
Bolivia	60	1	1.7	1	100.0
Colombia	2,957	63	2.1	52	82.5
Ecuador	253	4	1.6	3	75.0
Peru	614	10	1.6	1	10.0
Venezuela	2,342	38	1.6	18	47.4
SOUTHERN CONE					
Argentina	2,456	70	2.9	51	72.9
Chile	723	14	1.9	10	71.4
Uruguay	359	9	2.5	9	100.0
BRAZIL	36,481	1,265	3.5	728	57.5
CENTRAL AMERICAN ISTHMUS					
Costa Rica	470	12	2.6	5	41.7
El Salvador	470	8	1.7	5	62.5
Guatemala	434	5	1.2	1	0
Honduras	2,510	91	3.6	78	85.7
Panama	460	8	1.7	6	75.0
MEXICO	13,259	397	3.0	180	45.3
LATIN CARIBBEAN					
Cuba	168	1	0.6	1	100.0
Dominican Republic	1,839	42	2.3	24	70.0
Haiti	3,086	82	2.7	16	19.5
CARIBBEAN					
Bahamas	1,161	93	8.0	91	97.8
Barbados	350	16	4.6	15	93.8
Dominica	12	1	8.3	1	100.0
French Guiana	232	17	7.3	16	94.1
Grenada	35	2	5.7	2	100.0
Guadeloupe	182	13	7.1	12	92.3
Guyana	390	9	2.3	9	100.0
Jamaica	433	44	10.2	41	93.2
Martinique	237	12	5.1	10	83.3
Netherlands Antilles	110	1	0.9	1	100.0
Saint Kitts and Nevis	38	1	2.6	1	100.0
Saint Lucia	49	3	6.1	3	100.0
Saint Vincent and the Grenadines	49	1	2.0	1	100.0
Suriname	128	3	2.3	2	66.7
Trinidad and Tobago	1,228	89	7.2	83	93.3
Virgin Islands(UK)	6	1	16.7	1	100.0
NORTH AMERICA					
Canada	7,770	79	1.0	60	75.9
U.S.A.	289,320	4,480	1.5	3,665	81.8

(a) Does not include countries which have not reported AIDS cases in children.

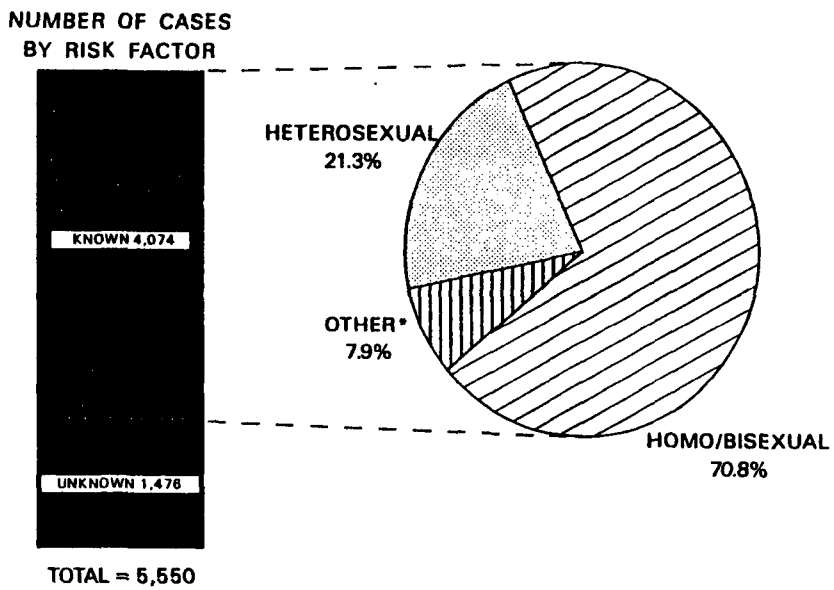
Fig. 3. NUMBER OF REPORTED CASES IN WOMEN, Y CASOS DE TRANSMISION PERINATAL, LATIN AMERICA AND THE CARIBBEAN, 1987-92.



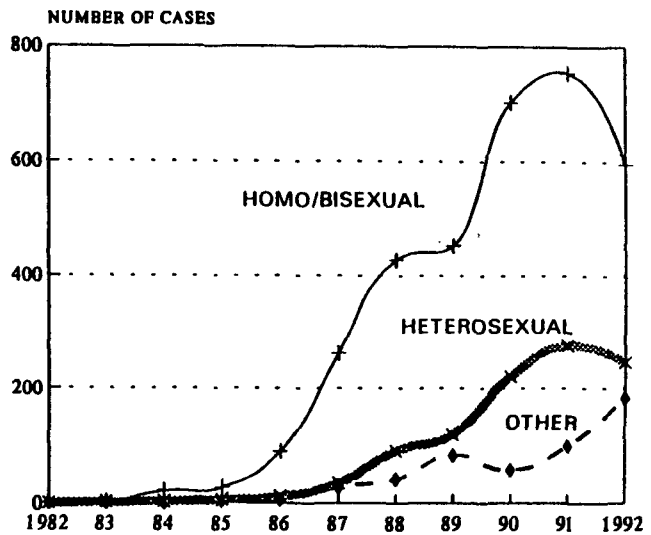
* 1992 data adjusted with the delayed reporting index.

e:\hq\jun93\femestim

FIG.4a. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1992, ANDEAN AREA.



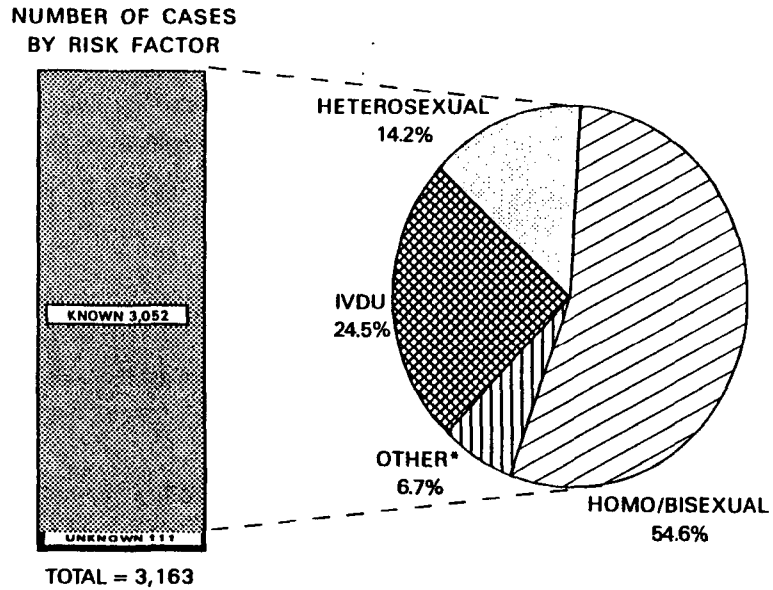
PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.



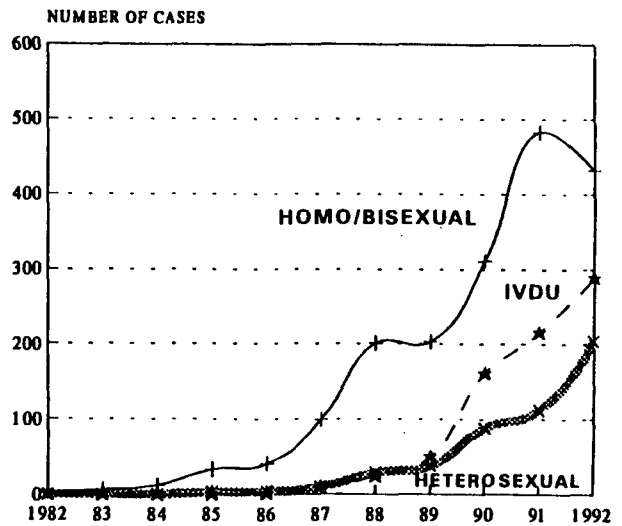
ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1992.**

* INCLUDES 2.8% BLOOD, 0.8% IVDU, 1.8% PERINATAL AND 2.4% OF OTHER KNOWN RISK FACTORS.
** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

FIG. 4b. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1992, SOUTHERN CONE.



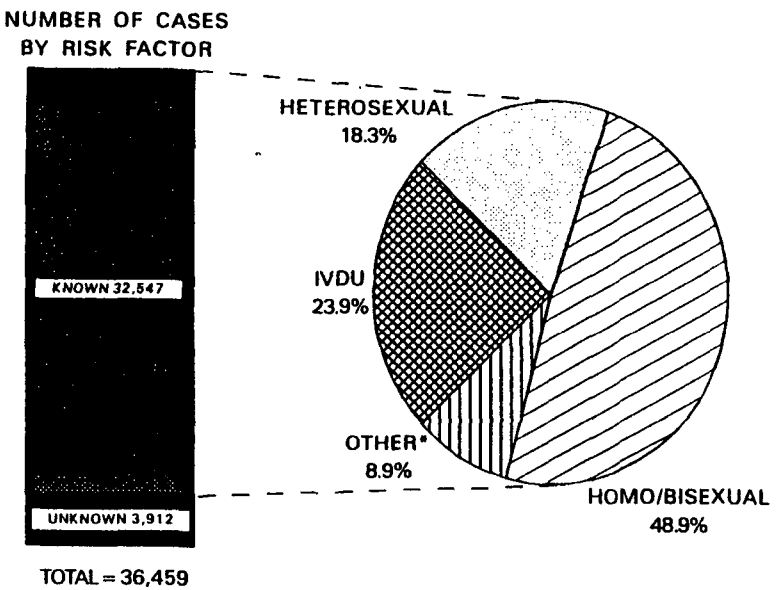
PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.



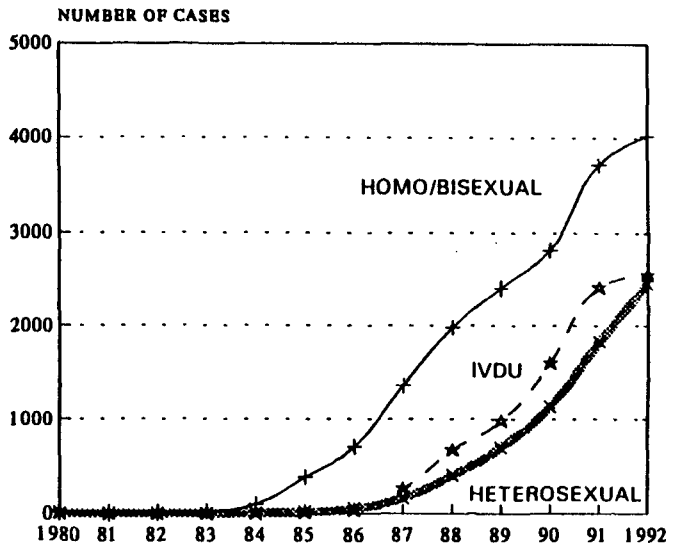
ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1992.**

* INCLUDES 4% BLOOD, 2.3% PERINATAL AND 0.4% OF OTHER KNOWN RISK FACTORS.
** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

FIG. 4c. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1980-1992, BRAZIL.



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE TRHOUGH JUNE 1993.

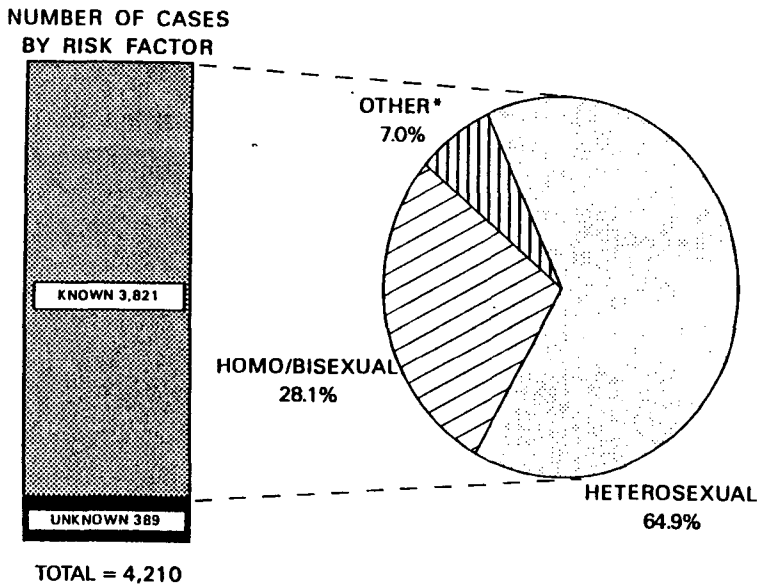


ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1980-1992.**

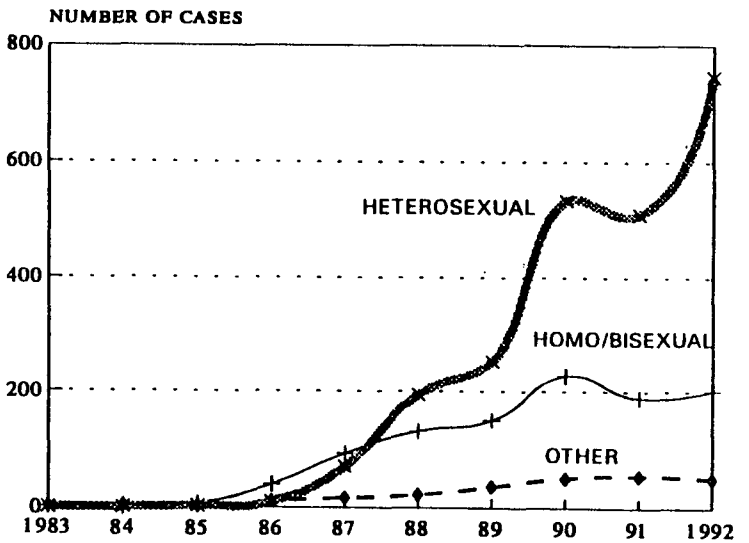
* INCLUDES 6.7% BLOOD, 2.2% PERINATAL AND 0.006% OF OTHER KNOWN RISK FACTORS.

** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

FIG. 4d. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1983-1992, CENTRAL AMERICAN ISTHMUS.



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.

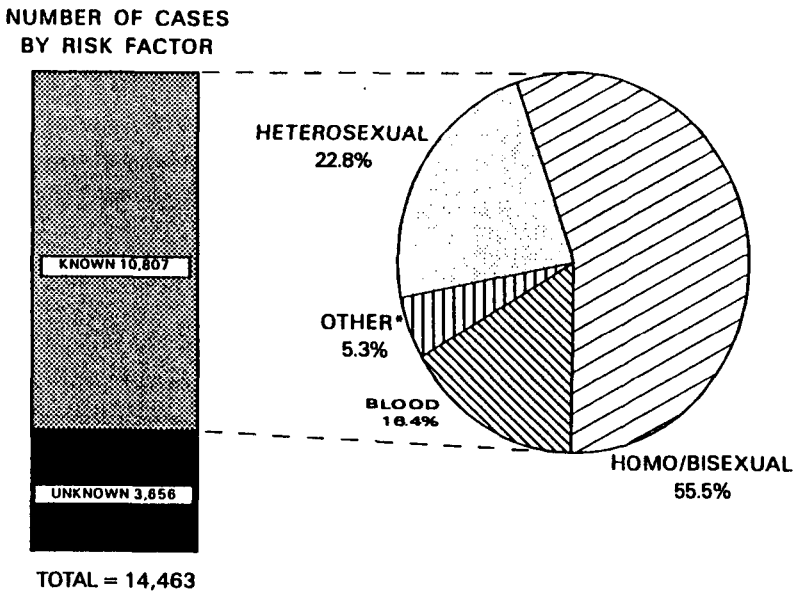


ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1983-1992.**

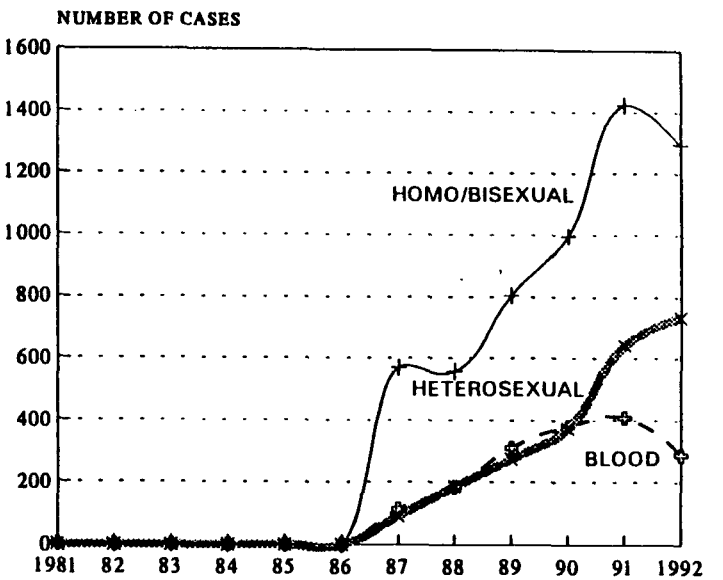
* INCLUDES 2.9% BLOOD, 1.2% IVDU, 2.5% PERINATAL AND 0.4% OF OTHER KNOWN RISK FACTORS.

** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

FIG. 4e. PERCENT DISTRIBUTION OF AIDS CASES BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1981-1992, MEXICO.



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.

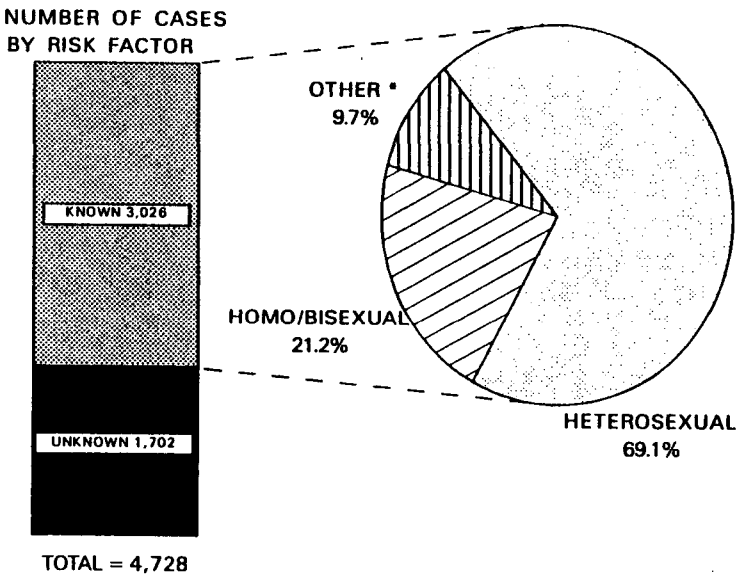


ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1981-1992.**

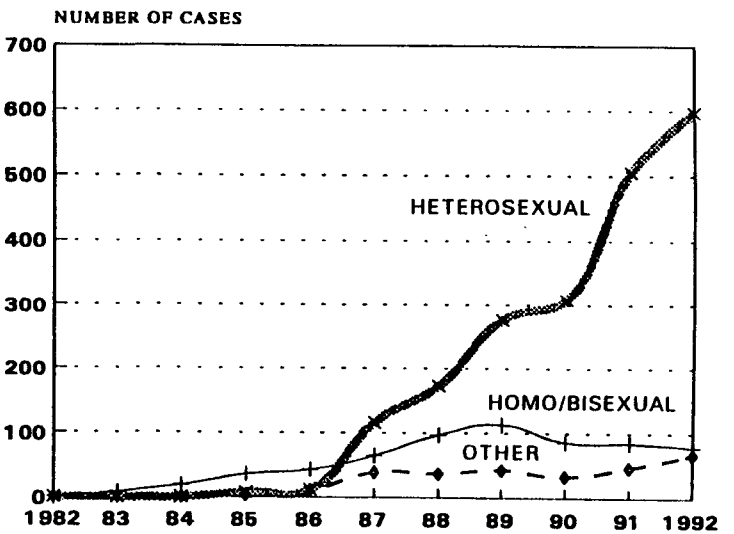
* INCLUDES 0.8% IVDU, 1.7% PERINATAL AND 2.8% OF OTHER KNOWN RISK FACTORS.

** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX. .

FIG. 4f. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1992, CARIBBEAN.



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.



ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1992.**

* INCLUDES 0.6% BLOOD, 0.2% IVDU, 8.5% PERINATAL AND 0.4% OF OTHER KNOWN RISK FACTORS.

** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

directing council | *regional committee*

PAN AMERICAN HEALTH ORGANIZATION | WORLD HEALTH ORGANIZATION

XXXVII Meeting | XLV Meeting

Washington, D.C.
September-October 1993

Provisional Agenda Item 5.2

CD37/10, ADD. I (Eng.)
20 August 1993
ORIGINAL: SPANISH

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

RECOMMENDATIONS ON AIDS EMANATING FROM THE III IBERO-AMERICAN SUMMIT OF HEADS OF STATE AND GOVERNMENT (SALVADOR, BAHIA, BRAZIL, 15-16 JULY 1993)

The topic "Health and Development: AIDS—A Social and Economic Issue" was addressed at this important meeting as a part of the discussions on cooperation between the countries of the area and specifically under the agenda item "Education, Culture, Health, Science, and Technology as Tools for Development; Joint Solutions and Intersectoral Issues," the outcome of which was the following text:

> At the Conference of Ministers of Health of the Ibero-American Countries, held in Brasília from 24 to 27 May 1993, it was recognized that it is urgent to draft and apply an overall policy in the Ibero-American area for the control of acquired immunodeficiency syndrome. We, the Heads of State and Government, hereby approve and endorse the conclusions and recommendations of that Conference. .. [Appendix]... We wish to emphasize, in particular, the importance of devoting greater financial and human resources to the fight against HIV/AIDS, as well as of promoting the transfer of technology and the dissemination of scientific and technical information. We support the proposal to maintain or implement programs for the prevention and control of HIV/AIDS, as well as corresponding initiatives to review, update, and enact laws and regulations for the adequate implementation of measures for the prevention of HIV/AIDS, within the framework of respect for human rights and the protection of public health.

From the point of view of PAHO and its Member States, the foregoing declaration emphasizes the importance that the Heads of State and Government have accorded to this pressing public health problem, and it implicitly endorses the approach

and the overall policies that have been followed by the Global Program on AIDS, PAHO, and the Member States in the fight against AIDS, based on the strategies of preventing HIV transmission, reducing its social and economic impact, and coordinating national and international efforts within the framework of respect for human rights and the protection of public health.

For the implementation of overall policies for the control of acquired immunodeficiency syndrome in the Ibero-American area, it becomes necessary to come to agreement, at both the regional level and the level of each of the countries, regarding the task and the efforts to be undertaken by the various sectors, institutions, and agencies that are already collaborating or that should be involved in the fight against AIDS. It is especially important to identify and mobilize resources, including those of the private sector, and to allocate resources to activities for the prevention and control of HIV and AIDS within the budgets of national governments. The secretariat will be responsible for following up this declaration, which has already been widely disseminated, by providing support in the form of knowledge and action to the various entities and groups involved in the fight against AIDS in the Ibero-American countries.

Annex

CONFERENCE OF MINISTERS OF HEALTH OF THE IBERO-AMERICAN COUNTRIES "HEALTH AND DEVELOPMENT: AIDS—A SOCIAL AND ECONOMIC ISSUE"

Brasília. 24-27 May 1993

CONCLUSIONS AND RECOMMENDATIONS

INITIAL CONSIDERATIONS

The Conference of Ministers of Health of the Ibero-American Countries, held in Brasília from 24 to 27 May 1993, approved the following conclusions:

Meeting pursuant to a recommendation of the II Ibero-American Summit of Heads of State and of Government, held in Madrid on 23-27 July 1992, which recognized the urgent need to develop and apply a comprehensive policy in the Ibero-American area for the control of acquired immunodeficiency syndrome;

Concerned about the rapid spread of the HIV/AIDS epidemic, which is threatening to reduce the life expectancy of millions of men, women, and children; undermine the achievements of recent decades in the area of health and social welfare; and impede the progress and socioeconomic development of the Ibero-American countries;

Aware of the need to devote increased national resources, promote intersectoral and international cooperation, and coordinate the actions of prevention, medical care, social service, and legal protection at the national level and between countries;

Recognizing that the marginalization, stigmatization, and discrimination of affected persons not only constitutes a violation of human rights but also hinders efforts to prevent and control the epidemic;

Firmly decided that the commitments undertaken at this conference shall result in concrete actions and effective measures for dealing with the challenges that this epidemic poses for the health and development of our peoples,

We hereby agree to promote and execute the following recommendations:

1. SOCIOECONOMIC IMPACT

In order to determine the socioeconomic impact of the epidemic and to guarantee that resources are duly utilized in accordance with technical directives and administrative regulations, it is necessary to develop socioeconomic information systems on HIV/AIDS prevention and control. We recommend the following:

1.1 Define national priority areas for the mobilization and allocation of financial resources, taking into account the realities and health policies of the country as well as of the status of the epidemic at the local, regional, and world level.

1.2 Draft protocols for systematically studying the direct and indirect costs of the epidemic.

1.3 Develop and/or adapt methodologies for evaluating the economic and social effects of strategies for the prevention of AIDS.

2. HUMAN DISPLACEMENT

We consider that AIDS has had an especially serious impact on migratory movements, and that, accordingly, effective agreements need to be drafted to prevent discriminatory restrictions on international transit.

We recommend the following:

2.1 Eliminate all requirements for serological testing to detect HIV infection for any type of visa (for workers, temporary residents, transients, tourists, students).

2.2 Carry out research on patterns of population displacement, epidemiological studies of behavior, and social investigations to establish patterns of HIV/AIDS/STD transmission; identify mechanisms for enlisting community support and dealing with the social impact in communities that are experiencing intense displacement as well as in border areas.

2.3 Establish bilateral and/or multilateral agreements between countries of the Ibero-American region that will guarantee medical care for persons from other countries of the region bearing in mind each country's laws and capacity to provide assistance.

2.4 Develop and carry out campaigns to provide information and education and develop public awareness on the prevention of HIV infection and other STD for travelers, tourists, transients, immigrants, and target populations.

3. HUMAN RIGHTS

We believe that the promotion of respect for human rights is an essential public health strategy. We recommend the following:

3.1 Study existing legal arrangments in each country with a view to identifying or developing the necessary legal instruments for the implementation of national programs on AIDS prevention and control that are consonant with national health and development policies and respect for human rights.

3.2 Recommend to international agencies that they continue to take a stand against any form of discrimination based on the fact that an individual is infected.

3.3 Ensure that ethical and legal issues, including an assessment of the status of human rights and a description of any difficulties identified, as well as options for dealing with them, are on the agenda of all national and international meetings on HIV/AIDS in the Ibero-American region.

4. USE OF DRUGS AND HIV/AIDS

We are concerned about the increasing role of intravenous drug use in the spread of the AIDS epidemic in the Ibero-American region, as well as the effect of existing policies and legislation regarding the use of drugs, which have limited the implementation of effective measures to prevent and control HIV/AIDS among drug users and their sexual partners.

We recommend the following:

4.1 Review existing policies and legislation regarding the use of drugs with a view to ensuring and facilitating the implementation of actions for the prevention and control of HIV/AIDS among drug users and their sexual partners based on knowledge about the subject and on national and international experience in this area.

4.2 Identify the epidemiological, anthropological/behavioral, and sociodemographic profile of drug users, especially users of intravenous drugs, through studies and research that will provide bases for the development of specific prevention strategies.

4.3 Establish reference centers specialized in providing care for drug users, especially users of intravenous drugs, and promote the exchange of experiences and information both within and outside the Ibero-American region.

4.4 Support the initiatives and activities of NGOs and self-support groups that work in this area, within the framework of the policy and strategies for the prevention and control of HIV/AIDS.

4.5 Develop experimental intervention models (replacement of syringes, distribution of sodium hypochlorite, education) for the prevention of infection among drug users at preselected sites (for example, reference centers), which will permit the comparison of results.

5. HUMAN RESOURCE DEVELOPMENT

The AIDS epidemic bears out the imperative need to strengthen the development of human resources and health teams that were inadequately prepared for the epidemic so that they can deal with the new and pressing health problem that it represents.

We recommend the following:

5.1 Promote reforms in the schools for the health professions with a view to changing their current individualized curative approach and gearing them up to meet the need for multidisciplinary teams for the comprehensive care of HIV/AIDS.

5.2 Develop systems and mechanisms for carrying out distance education and updating the knowledge of all members of the health team on the subject of HIV/AIDS.

5.3 Promote the exchange of up-to-date information, experiences, and human resources between countries through bilateral and multilateral agreements and other mechanisms such as periodical publications.

5.4 Stem the drain of qualified human resources to other areas and outside the region by guaranteeing salaries and working conditions that will

enable people to devote themselves to the program, providing necessary support for professional updating, and making a commitment to keep the program teams in place when there are political or administrative changes.

6. TRANSFER AND UTILIZATION OF TECHNOLOGIES

We recognize that current technologies for the prevention and control of HIV/AIDS are not the most appropriate, given the realities in most of the countries of the Ibero-American region.

We recommend the following:

6.1 Develop and implement "social marketing" projects (including the promotion and distribution of condoms) that will focus on health as a social benefit and a value.

6.2 Systematically disseminate health promotion and prevention messages on HIV/AIDS/STD in the mass media (radio, television, press, etc.) within the region.

6.3 Identify opportunities and mechanisms for encouraging governments, private companies, and national and international press associations to donate time, space, etc., for messages on the prevention of HIV/AIDS.

6.4 Hold conferences via satellite on subjects of common interest directed toward specific audiences such as health professionals and other duly identified target groups.

6.5 Review and evaluate, through multicenter projects, national and international therapeutic schemes and recommendations for the management of STD.

6.6 Evaluate and implement studies and specific schemes for areas of high and low transmission of tuberculosis in the region, adjusting the latter to the status of the HIV/AIDS and tuberculosis epidemics in each country.

6.7 Carry out studies and evaluations of laboratory methods and strategies for controlling blood transfusions and tests for the clinical diagnosis of HIV/AIDS/STD.

6.8 Implement adequate assistance alternatives (for example, day hospitals, support houses, ambulatory services, household assistance).

6.9 Implement educational interventions in pharmacies, drugstores, or dispensaries directed toward users, employees, pharmacists, and workers in the pharmaceutical industry.

6.10 Implement education programs and campaigns in schools.

6.11 Develop educational programs based on a participatory approach and directed toward the general population, giving priority to groups that engage in risk-prone practices, depending on the resources available, within a multidisciplinary and intersectoral institutional framework.

6.12 Promote the identification and use of common indicators that make it possible to estimate the impact of HIV/AIDS prevention and control programs and to compare similar experiences.

6.13 Promote, with the cooperation of international agencies, the establishment of mechanisms for inventorying and facilitating the procurement or exchange of supplies among the Ibero-American countries (for example, condoms, reagents, drugs, equipment, etc.).

6.14 Create a group of representatives from the countries concerned to develop a proposal for implementing the foregoing recommendation, to be submitted for consideration at the IV Summit of Heads of State in 1994.

7. ADDITIONAL RECOMMENDATION

7.1 Develop a broad proposal in the region for the elimination of congenital syphilis by the year 2000, which would include actions in the areas of prevention, service delivery, and community participation.

We believe in a united effort to fight the AIDS epidemic, which will contribute to the social, economic, and political development of our countries. We reaffirm our commitment to democracy, to respect for human rights, and to the spirit of cooperation that must prevail in relations between our countries.

We call upon the Heads of State to:

1. Support the implementation of these recommendations through a multidisciplinary and intersectoral approach.

2. Commit increased financial and human resources to the fight against HIV/AIDS.

3. Support initiatives for the review, updating, and enactment of laws and regulations for the adequate and timely implementation of measures to prevent HIV/AIDS within the framework of respect for human rights and the protection of public health.

4. Promote the use and transfer of appropriate technology, as well as the dissemination of scientific and technical information, through the use of satellite telecommunication.

5. Maintain or enlist programs for the prevention and control of HIV/AIDS at a level within the ministerial structure that will permit the most expeditious and efficient execution of the actions envisaged in the national strategy against HIV/AIDS.

directing council

PAN AMERICAN HEALTH ORGANIZATION

XXXVII Meeting

regional committee

WORLD HEALTH ORGANIZATION

XLV Meeting

Washington, D.C.
September-October 1993

Provisional Agenda Item 5.2

CD37/10, ADD. II (Eng.)
10 September 1993
ORIGINAL: ENGLISH

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

The Director is pleased to present to the Directing Council a summary update of AIDS surveillance in the Americas as of 10 September 1993.

AIDS SURVEILLANCE IN THE AMERICAS
Summary

Data as received by 10 September 1993

Cumulative number of cases reported

worldwide: 751,267

Cumulative number of cases reported

in the Americas: 403,459

Cumulative number of deaths reported

in the Americas: 234,369

NOTE: Preliminary data. The countries are in the process of revising their information before the publication of the 1992 Annual Surveillance Report.

FIG. 1. ANNUAL INCIDENCE OF AIDS CASES, BY REGION OF THE WHO, BY YEAR, 1979–92.

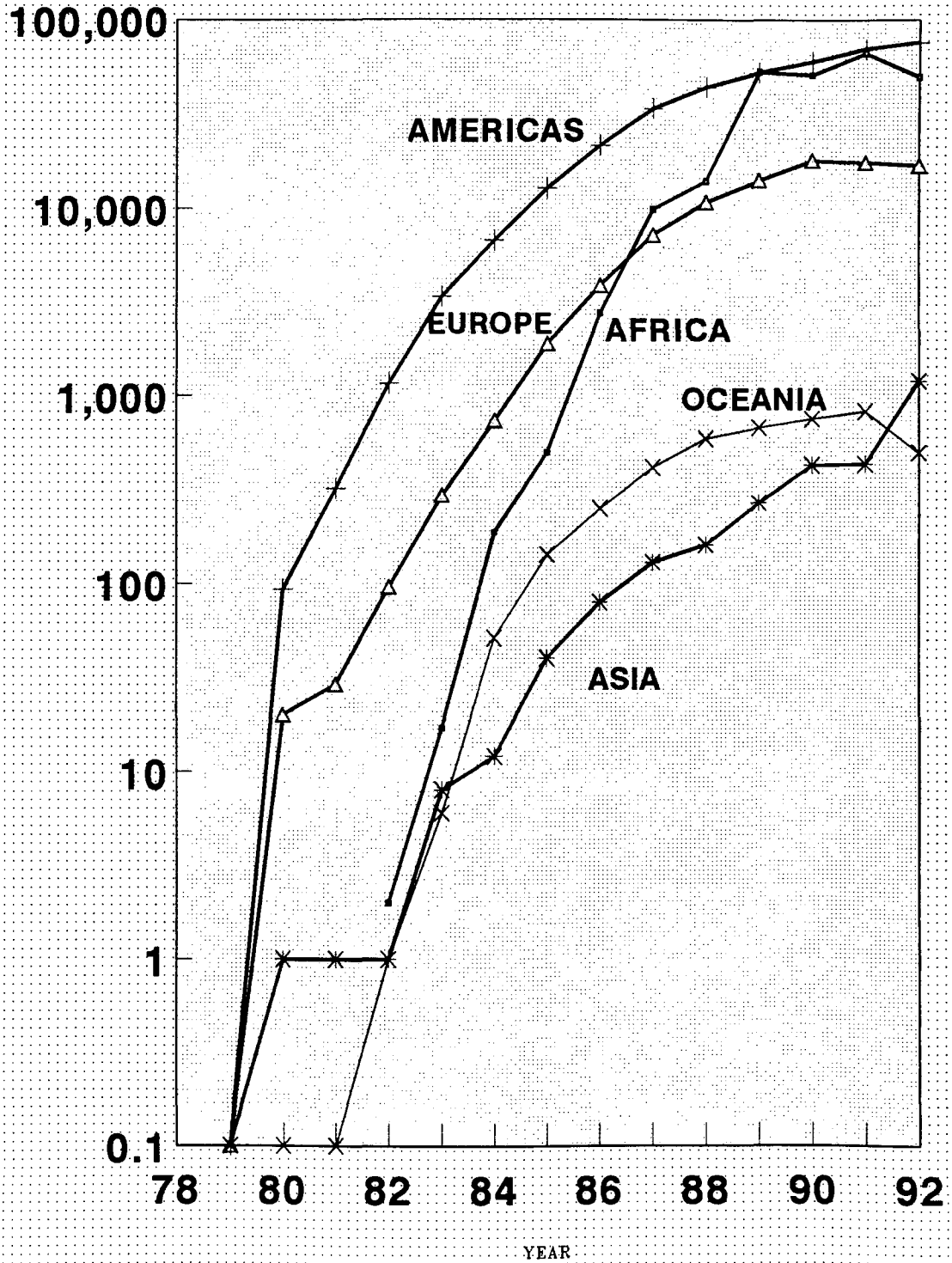


Fig.2. ANNUAL INCIDENCE RATES OF AIDS IN THE AMERICAS, (PER MILLION), THREE MAJOR SUBREGIONS, 1982–1992.

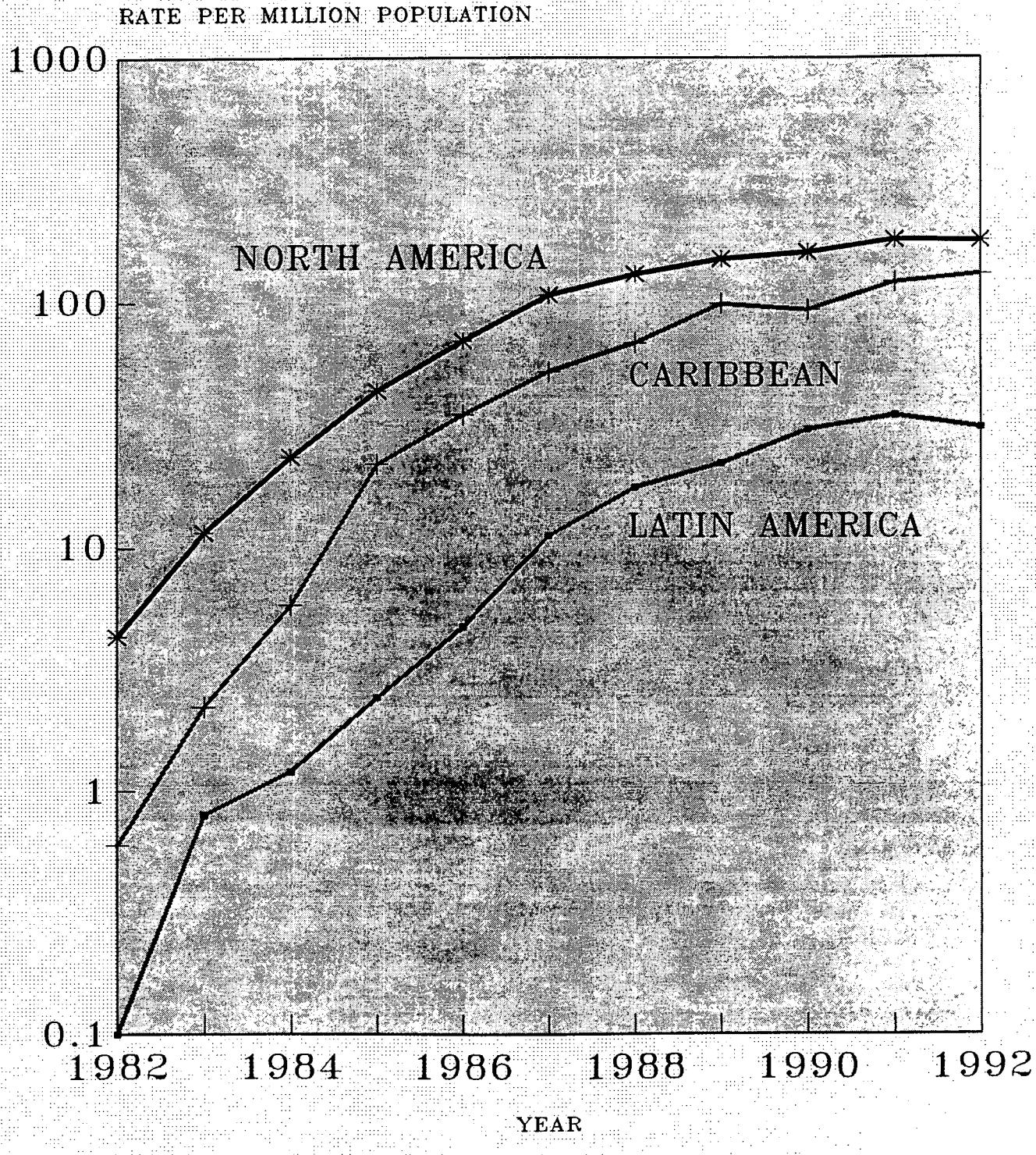


TABLE 1. NUMBER OF REPORTED CASES OF AIDS BY YEAR, AND CUMULATIVE CASES AND DEATHS, BY COUNTRY AND SUBREGION.

As of 10 September, 1993

SUBREGION / Country	Number of Cases: Through 1987	1988	1989	1990	1991	1992	1993	Cumulative total(a)	Total deaths	Date of last report
REGIONAL TOTAL	79,762	43,556	52,300	60,040	69,880	75,730	21,662	403,459	234,369	
LATIN AMERICA b)	7,636	7,256	9,478	13,449	15,680	15,963	4,753	74,579	31,261	
ANDEAN AREA	630	736	954	1,501	1,600	1,198	227	6,847	3,419	
Bolivia	6	10	2	9	17	8	8	60	45	31/Mar/93
Colombia	247	319	410	765	782	434	...	2,957	1,483	30/Sep/92
Ecuador	35	29	22	42	51	57	28	265	192	30/Jun/93
Peru	62	65	113	141	155	230	107	873	270	30/Jun/93
Venezuela	280	313	407	544	595	469	84	2,692	1,429	06/Sep/93
SOUTHERN CONE	247	267	352	606	757	878	214	3,661	1,588	
Argentina	145	169	228	388	478	605	103	2,456	915	31/Mar/93
Chile	78	66	83	130	183	166	51	757	437	30/Jun/93
Paraguay	7	4	3	12	10	17	6	59	39	30/Jun/93
Uruguay	17	28	38	76	86	90	54	389	197	30/Jun/93
BRAZIL	4,033	3,884	5,134	6,937	8,923	9,126	1,463	39,500	16,485	03/Jul/93
CENTRAL AMERICAN ISTHMUS	280	362	491	910	924	1,197	754	4,941	1,692	
Belize	7	4	0	19	11	12	...	53	46	30/Sep/92
Costa Rica	43	52	57	86	91	125	45	499	302	30/Jun/93
El Salvador	23	34	72	54	132	114	41	470	120	31/Mar/93
Guatemala	31	18	32	92	96	94	114	477	148	30/Jun/93
Honduras	119	189	251	586	495	733	474	2,867	723	30/Jun/93
Nicaragua	0	2	2	7	13	6	7	40	32	30/Jun/93
Panama	57	63	77	66	86	113	73	535	321	30/Jun/93
MEXICO	802	905	1,607	2,588	3,167	3,220	1,991	14,280	7,434	30/Jun/93
LATIN CARIBBEAN c)	1,644	1,102	940	907	309	344	104	5,350	643	
Cuba	16	14	14	29	37	62	32	204	117	30/Jun/93
Dominican Republic	356	357	473	248	272	282	72	2,060	229	30/Jun/93
Haiti	1,272	731	453	630	...	...	...	3,086	297	31/Dec/90
CARIBBEAN c)	836	493	725	701	872	951	453	5,043	3,211	
Anguilla	0	1	2	1	1	0	0	5	3	31/Mar/93
Antigua	3	0	0	3	...	...	...	6	5	31/Dec/90
Bahamas	176	93	168	162	235	259	137	1,230	751	30/Jun/93
Barbados	56	15	40	61	80	78	44	374	285	30/Jun/93
Cayman Islands	3	1	1	2	4	4	...	15	11	31/Dec/92
Dominica	5	2	3	2	...	...	...	12	11	30/Jun/90
French Guiana	103	34	54	41	...	...	...	232	144	30/Sep/90
Grenada	8	3	8	5	7	4	11	46	31	30/Jun/93
Guadeloupe	88	47	47	...	...	...	...	182	85	31/Dec/89
Guyana	10	34	40	61	85	160	...	390	102	31/Dec/92
Jamaica	43	30	66	62	133	99	104	537	359	30/Jun/93
Martinique	48	30	51	45	28	25	19	246	175	30/Jun/93
Montserrat	0	0	1	0	0	0	0	1	0	30/Jun/93
Netherlands Antilles	18	13	16	30	23	10	...	110	55	30/Jun/92
Saint Lucia	8	2	8	3	7	9	8	57	28	30/Jun/93
Saint Kitts and Nevis	10	9	5	8	1	4	1	38	24	30/Jun/93
St. Vincent and the Grenadines	7	8	6	4	14	7	7	53	36	30/Jun/93
Suriname	9	4	35	35	16	29	18	146	119	30/Jun/93
Trinidad and Tobago	236	160	167	173	235	257	104	1,332	963	30/Jun/93
Turks and Caicos Islands	5	6	7	1	2	4	...	25	23	31/Dec/92
Virgin Islands (UK)	0	1	0	2	1	2	0	6	1	30/Jun/93
NORTH AMERICA	71,290	35,807	42,097	45,690	53,328	58,816	16,456	323,837	199,897	
Bermuda	72	28	35	33	23	17	7	215	156	31/Mar/93
Canada	2,120	1,069	1,252	1,222	1,230	1,127	212	8,232	5,407	31/Jul/93
United States of America c)	69,098	34,710	40,810	44,635	52,075	57,672	16,237	315,390	194,334	30/Jun/93

a) May include cases for year of diagnosis unknown.
b) French Guiana, Guyana, and Suriname are included in the Caribbean.
c) Puerto Rico and the U.S. Virgin Islands are included in the United States of America.

TABLE 2. ANNUAL INCIDENCE RATES OF AIDS (PER MILLION POPULATION), BY COUNTRY AND BY YEAR, 1988–1992.

SUBREGION	RATE PER MILLION				
Country	1988	1989	1990	1991	1992
LATIN AMERICA a)	17.4	21.9	30.1	34.4	30.8
ANDEAN AREA	8.4	10.5	16.0	16.3	9.3
Bolivia	1.4	0.3	1.2	2.3	1.0
Colombia	10.4	13.1	24.0	23.3	12.7
Ecuador	2.8	2.1	3.9	4.7	5.1
Peru	3.1	5.4	6.3	7.0	3.3
Venezuela	16.6	20.2	25.9	26.3	15.8
SOUTHERN CONE	5.2	6.7	11.5	14.1	16.1
Argentina	5.4	7.1	12.0	14.6	18.3
Chile	5.3	6.4	9.9	13.7	11.9
Paraguay	1.0	0.7	2.8	2.3	4.0
Uruguay	9.1	12.2	24.3	27.5	28.8
BRAZIL	26.8	34.6	45.8	57.0	48.9
CENTRAL AMERICAN ISTHMUS	13.0	17.4	31.2	30.5	37.5
Belize	23.0	0	104.4	60.4	64.5
Costa Rica	18.1	19.4	28.5	29.5	37.0
El Salvador	6.8	14.0	10.3	24.6	20.7
Guatemala	2.1	3.6	10.0	10.1	9.6
Honduras	39.1	50.4	113.9	93.4	129.8
Nicaragua	0.6	0.5	1.8	3.3	1.5
Panama	25.8	32.5	26.5	29.6	39.4
MEXICO	11.4	17.3	27.0	35.0	34.9
LATIN CARIBBEAN b)	47.3	41.5	37.7	8.7	9.7
Cuba	1.4	1.5	2.7	3.5	5.3
Dominican Republic	51.8	73.1	34.4	24.2	25.0
Haiti	116.7	71.0	96.8	...	...
CARIBBEAN a)	67.9	98.4	93.0	121.2	131.7
Anguilla	142.2	284.5	142.9	142.9	0
Antigua	0	0	34.9	...	...
Bahamas	367.5	653.7	623.1	903.8	988.5
Barbados	58.4	154.6	233.7	313.7	304.7
Cayman Islands	47.5	47.6	95.2	190.5	148.1
Dominica	25.3	37.5	24.7	...	...
French Guiana	386.3	600.7	445.7	...	...
Grenada	30.0	79.2	48.5	68.0	42.4
Guadeloupe	139.0	138.6	...	...	...
Guyana	33.8	39.1	58.6	106.3	198.8
Jamaica	12.3	26.6	24.6	53.5	39.4
Martinique	90.9	154.3	136.0	81.6	72.5
Montserrat	0	76.7	0	0	0
Netherlands Antilles	69.1	83.7	155.4	119.2	51.3
Saint Kitts and Nevis	187.5	103.1	160.0	20.0	90.1
Saint Lucia	15.0	59.3	22.1	51.5	57.0
Saint Vincent and the Grenadines	74.1	55.0	36.0	126.1	58.4
Suriname	10.2	87.9	86.8	37.3	66.4
Trinidad and Tobago	128.7	132.2	134.8	180.6	194.8
Turks and Caicos Islands	750.9	876.1	111.1	222.2	400.0
Virgin Islands (UK)	76.7	0	25.8	12.9	153.8
NORTH AMERICA	130.3	150.2	160.2	180.9	180.5
Bermuda	490.8	601.4	569.0	396.6	293.1
Canada	40.9	47.1	45.2	44.3	34.5
United States of America b)	139.7	161.1	172.4	195.4	196.0

a) French Guiana, Guyana, and Suriname included in the Caribbean.

b) Puerto Rico and the U.S.Virgin Islands included in the United States of America.

TABLE 3. ANNUAL INCIDENCE RATES OF AIDS (PER MILLION POPULATION), BY SEX, BY COUNTRY AND BY YEAR, 1987–1992.

SUBREGION	RATE PER MILLION POPULATION											
	MALE RATES						FEMALE RATES					
Country	1987	1988	1989	1990	1991	1992	1987	1988	1989	1990	1991	1992
LATIN AMERICA a)	19.0	28.9	37.3	49.0	56.4	49.4	2.7	5.4	6.7	8.9	10.1	10.3
ANDEAN AREA	8.6	14.5	18.5	26.2	23.3	14.6	0.4	1.1	1.7	3.0	1.7	1.2
Bolivia	0.9	2.9	0	1.9	4.3	1.8	0	0	0.6	0	0	1.0
Colombia	11.8	17.7	23.5	40.8	30.9	23.7	0.5	1.6	2.3	3.2	1.8	1.7
Ecuador	4.0	5.5	3.8	7.0	8.1	9.1	0.4	0.2	0.4	0.7	1.3	1.1
Peru	2.9	5.5	9.7	8.1	13.1	6.0	0.2	0.6	0.8	4.5	0.9	0.4
Venezuela	14.8	28.4	34.8	42.3	37.1	16.6	0.7	2.0	2.9	3.5	3.4	1.3
SOUTHERN CONE	5.1	9.7	12.1	20.7	25.8	23.4	0	0.7	1.2	2.1	2.2	5.1
Argentina	4.6	10.4	12.9	21.6	26.8	29.3	0	0.4	1.2	2.4	2.5	7.2
Chile	6.9	9.2	11.4	18.4	24.7	11.8	0.2	1.2	1.1	0.7	1.3	1.3
Paraguay	2.6	2.0	1.4	4.6	4.5	7.4	0	0	0	0.9	0	0.4
Uruguay	6.0	15.8	21.6	42.9	50.8	36.0	0	2.6	2.5	6.3	5.6	6.2
BRAZIL	29.8	47.0	61.1	80.6	96.5	80.4	3.1	6.7	8.1	11.1	17.8	17.5
CENTRAL AMERICAN ISTHMUS	10.0	17.2	20.6	37.7	40.1	50.6	3.1	6.2	7.6	16.3	13.6	16.9
Belize	23.5	23.0	...	11.0	...	...	11.8	11.5	...	...	...	...
Costa Rica	16.3	33.2	33.0	40.7	50.6	54.4	0	2.8	2.7	4.7	2.6	5.1
El Salvador	...	...	...	...	36.8	31.1	...	...	...	...	12.4	7.8
Guatemala	3.3	3.6	3.1	13.3	16.1	14.2	0.5	0.5	0.7	3.1	3.6	2.3
Honduras	28.5	50.4	64.8	140.4	107.7	180.0	15.4	27.8	35.8	80.5	48.4	78.7
Nicaragua	0	1.1	1.1	3.1	4.5	2.4	0	0	0	0.5	0.5	0
Panama	25.0	41.4	55.4	44.7	40.7	29.7	1.8	9.7	8.6	7.6	15.7	4.0
MEXICO	17.1	19.0	33.3	41.0	59.3	59.3	1.8	3.3	6.1	8.0	10.8	10.6
LATIN CARIBBEAN b)	39.2	64.2	51.0	44.3	10.4	8.8	18.3	30.6	30.0	27.6	5.0	2.9
Cuba	4.1	3.9	0.2	0.8	4.3	5.9	1.2	0.8	0.2	0	1.3	2.4
Dominican Republic	44.7	73.8	94.0	44.2	28.5	20.8	23.7	28.1	49.3	21.3	15.3	6.3
Haiti	92.7	154.4	87.1	116.2	...	...	39.8	80.0	55.4	76.7	...	...
CARIBBEAN	75.1	94.9	128.5	107.7	157.2	177.9	29.0	38.4	59.9	47.3	79.0	82.3
Anguilla	0	0	...	0	0	0	0	281.7	0	284.1	281.7	0
Antigua	24.6	0	0	...	...	...	0	0	0	...	...	...
Bahamas	430.0	448.0	701.3	747.8	1155.3	1292.4	294.2	289.0	607.2	501.5	673.0	692.9
Barbados	173.3	73.9	244.5	409.6	520.3	471.5	22.3	44.4	73.5	73.2	105.3	150.4
Cayman Islands	96.2	0	96.2	96.2	...	75.1	0	93.9	0	0	...	73.1
Dominica	101.3	49.9	49.3	48.7	...	...	26.0	0	25.4	0	...	...
French Guiana	395.2	545.0	735.0	...	...	...	186.0	204.6	466.7	...	...	...
Grenada	62.0	20.2	100.3	78.7	62.4	20.7	20.2	39.5	0	19.2	87.4	0
Guadeloupe	187.9	217.6	210.9	...	...	...	58.1	63.7	69.3	...	...	...
Guyana	28.2	61.4	42.9	86.3	149.0	268.8	0	10.0	9.8	30.9	64.4	130.5
Jamaica	15.9	18.2	38.2	32.6	59.1	52.8	10.7	6.5	15.2	16.6	48.0	25.3
Martinique	100.1	137.2	230.1	191.4	120.5	95.8	41.5	47.2	82.4	82.9	33.9	50.6
Montserrat	0	0	...	0	0	0	0	0	...	0	0	0
Netherlands Antilles	110.2	10.9	...	...	...	...	21.0	20.8	...	...	...	...
Saint Kitts and Nevis	85.0	381.0	126.6	248.1	46.8	140.4	81.5	0	80.6	77.5	0	43.4
Saint Lucia	47.3	15.5	107.4	15.2	66.6	65.4	14.8	14.6	14.3	28.4	25.0	49.1
Saint Vincent and the Grenadines	77.6	57.2	37.7	55.6	122.2	103.3	18.4	72.0	89.3	17.5	98.4	16.2
Suriname	15.8	20.7	137.5	125.0	56.3	82.9	10.2	0	39.7	49.3	18.5	50.0
Trinidad and Tobago	103.3	187.1	193.7	144.0	248.8	277.4	26.1	70.6	71.1	54.3	113.1	113.1
Turks and Caicos Islands	253.2	1012.7	1519.0	0	404.9	809.7	247.5	495.0	247.5	219.5	0	0
Virgin Islands (UK)	0	...	0	144.0	155.0	155.0	0	...	0	14.2	0	151.7
NORTH AMERICA	149.9	223.9	242.5	291.3	299.1	302.4	13.3	25.8	28.6	37.7	43.1	46.8
Bermuda	638.3	850.2	975.6	489.5	664.3	419.6	104.2	138.8	237.3	238.1	136.1	170.1
Canada	65.7	78.4	89.5	87.1	84.1	66.1	4.1	4.1	5.3	4.1	5.3	3.7
United States of America b)	158.9	239.4	258.9	313.4	322.3	327.9	14.3	28.1	31.0	41.2	47.1	51.3

a) French Guiana, Guyana, and Suriname are included in the Caribbean.
b) Puerto Rico and the United States Virgin Islands are included in the United States of America.

TABLE 4. MALE:FEMALE RATIO OF REPORTED AIDS CASES, BY COUNTRY AND BY YEAR, 1987–1992.

SUBREGION	MALE:FEMALE RATIO					
Country	1987	1988	1989	1990	1991	1992
LATIN AMERICA a)	6.9	5.4	5.6	5.5	5.6	4.8
ANDEAN AREA	20.4	12.7	10.8	8.8	13.4	12.1
Bolivia	N/A	N/A	0	N/A	N/A	1.8
Colombia	22.3	11.3	10.2	13.0	16.6	13.4
Ecuador	10.0	28.0	10.0	9.5	6.3	8.5
Peru	15.0	9.8	11.9	1.8	14.5	13.6
Venezuela	22.8	14.2	12.1	12.4	11.1	13.3
SOUTHERN CONE	129.0	13.1	10.1	9.7	11.6	4.5
Argentina	N/A	23.1	10.3	8.9	10.6	4.0
Chile	43.0	7.3	10.4	24.0	18.1	8.8
Paraguay	N/A	N/A	N/A	5.0	N/A	17.0
Uruguay	N/A	6.0	8.3	6.6	8.6	5.5
BRAZIL	9.7	7.0	7.5	7.2	5.4	4.6
CENTRAL AMERICAN ISTHMUS	3.3	2.8	2.8	2.3	3.0	3.0
Belize	2.0	2.0	...	N/A	...	...
Costa Rica	N/A	12.0	12.3	8.9	19.8	10.9
El Salvador	...	...	...	...	2.9	3.8
Guatemala	7.0	8.0	4.7	4.4	4.5	6.4
Honduras	1.9	1.8	1.8	1.8	2.3	2.3
Nicaragua	N/A	N/A	N/A	6.0	9.0	N/A
Panama	14.5	4.5	6.7	6.1	2.7	7.6
MEXICO	9.5	5.8	5.4	5.1	5.5	5.6
LATIN CARIBBEAN b)	2.2	2.1	1.7	1.6	2.1	3.1
Cuba	3.5	5.0	1.0	N/A	3.3	2.5
Dominican Republic	1.9	2.7	1.9	2.1	1.9	3.4
Haiti	2.3	1.9	1.5	1.5	...	...
CARIBBEAN	2.5	2.4	2.1	2.2	1.9	2.1
Anguilla	N/A	0	...	0	0	N/A
Antigua	N/A	N/A	N/A	...	...	...
Bahamas	1.4	1.5	1.1	1.5	1.7	1.8
Barbados	7.0	1.5	3.0	5.1	4.6	2.9
Cayman Islands	N/A	0	N/A	N/A	...	1.0
Dominica	4.0	N/A	2.0	N/A	...	...
French Guiana	2.1	2.7	1.6	...	...	...
Grenada	3.0	0.5	N/A	4.0	0.8	N/A
Guadeloupe	3.1	3.3	2.9	...	...	...
Guyana	N/A	6.2	4.4	2.8	2.3	2.0
Jamaica	1.5	2.8	2.5	2.0	1.2	2.1
Martinique	2.3	2.8	2.6	2.2	3.3	1.8
Montserrat	N/A	N/A	...	N/A	N/A	N/A
Netherlands Antilles	5.0	0.5	...	...	...	...
Saint Kitts and Nevis	1.0	N/A	1.5	3.0	N/A	3.0
Saint Lucia	3.0	1.0	7.0	0.5	2.5	1.3
Saint Vincent and the Grenadines	4.0	0.8	0.4	3.0	1.2	6.0
Suriname	1.5	N/A	3.4	2.5	3.0	1.6
Trinidad and Tobago	3.9	2.6	2.7	2.6	2.2	2.4
Turks and Caicos Islands	1.0	2.0	6.0	0	N/A	N/A
Virgin Islands (UK)	N/A	...	N/A	1.0	N/A	1.0
NORTH AMERICA	10.7	8.2	8.1	7.4	6.6	6.2
Bermuda	6.0	6.0	4.0	2.0	4.8	2.4
Canada	15.6	18.8	16.4	20.8	15.7	17.6
United States of America b)	10.6	8.1	7.9	7.2	6.5	6.1

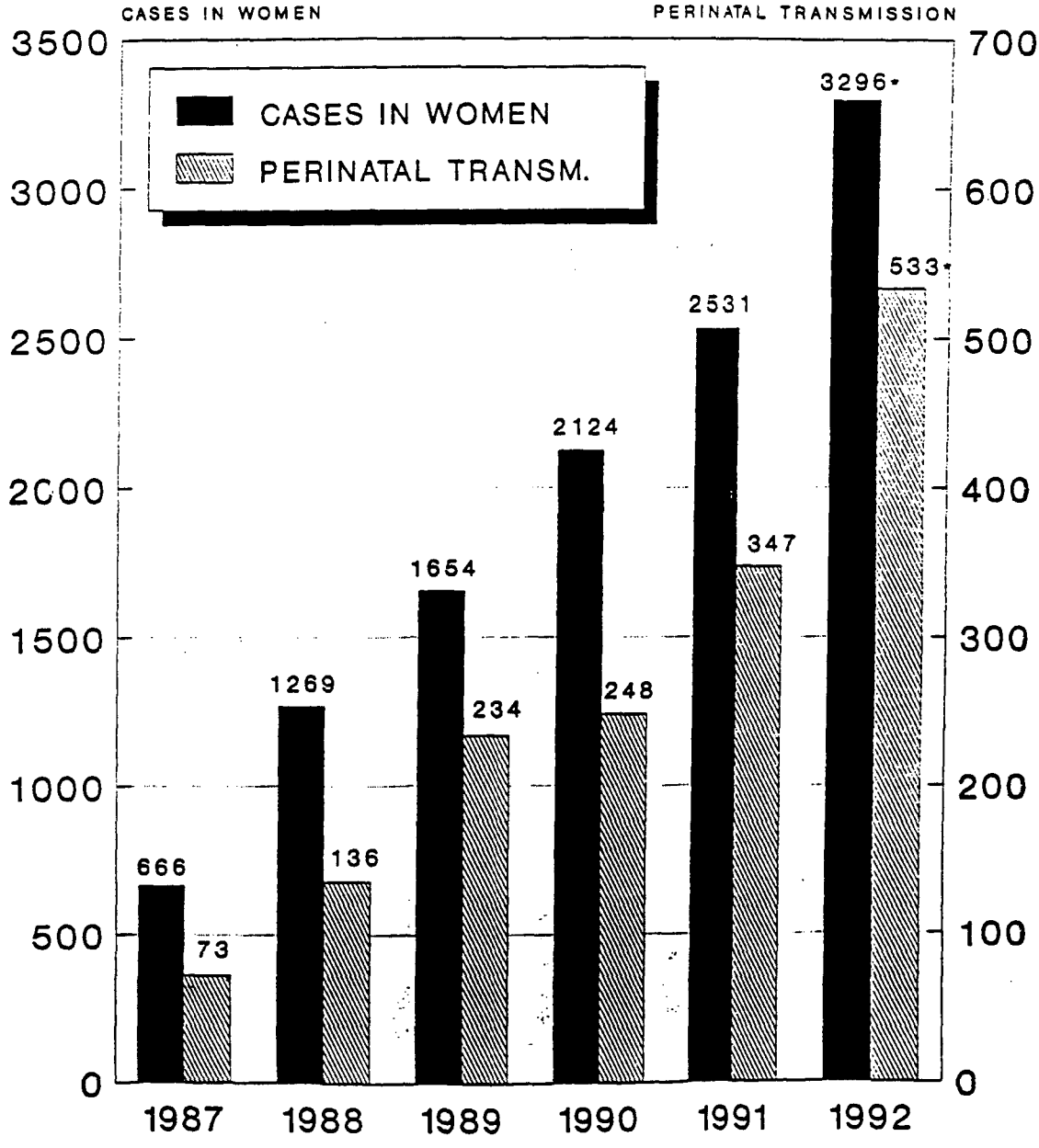
NOTE: N/A = Not applicable. No female cases reported for the period.
"..." = Data not available by sex.
a) French Guiana, Guyana and Suriname are included in the Caribbean.
b) Puerto Rico and the United States Virgin Islands are included in the United States of America.

TABLE 5. TOTAL CASES, PEDIATRIC CASES, PERCENT OF PEDIATRIC CASES FROM TOTAL; PERINATAL CASES, AND PERCENT OF PERINATAL CASES FROM PEDIATRIC, BY SUBREGION AND COUNTRY(a), THROUGH JUNE 1993.

Country	TOTAL CASES	PEDIATRIC CASES	PERCENT PEDIATRIC	PERINATAL CASES	PERCENT PERINATAL
ANDEAN AREA					
Bolivia	60	1	1.7	1	100.0
Colombia	2,957	63	2.1	52	82.5
Ecuador	253	4	1.6	3	75.0
Peru	614	10	1.6	1	10.0
Venezuela	2,342	38	1.6	18	47.4
SOUTHERN CONE					
Argentina	2,456	70	2.9	51	72.9
Chile	723	14	1.9	10	71.4
Uruguay	359	9	2.5	9	100.0
BRAZIL	36,481	1,265	3.5	728	57.5
CENTRAL AMERICAN ISTHMUS					
Costa Rica	470	12	2.6	5	41.7
El Salvador	470	8	1.7	5	62.5
Guatemala	434	5	1.2	1	0
Honduras	2,510	91	3.6	78	85.7
Panama	460	8	1.7	6	75.0
MEXICO	13,259	397	3.0	180	45.3
LATIN CARIBBEAN					
Cuba	168	1	0.6	1	100.0
Dominican Republic	1,839	42	2.3	24	70.0
Haiti	3,086	82	2.7	16	19.5
CARIBBEAN					
Bahamas	1,161	93	8.0	91	97.8
Barbados	350	16	4.6	15	93.8
Dominica	12	1	8.3	1	100.0
French Guiana	232	17	7.3	16	94.1
Grenada	35	2	5.7	2	100.0
Guadeloupe	182	13	7.1	12	92.3
Guyana	390	9	2.3	9	100.0
Jamaica	433	44	10.2	41	93.2
Martinique	237	12	5.1	10	83.3
Netherlands Antilles	110	1	0.9	1	100.0
Saint Kitts and Nevis	38	1	2.6	1	100.0
Saint Lucia	49	3	6.1	3	100.0
Saint Vincent and the Grenadines	49	1	2.0	1	100.0
Suriname	128	3	2.3	2	66.7
Trinidad and Tobago	1,228	89	7.2	83	93.3
Virgin Islands(UK)	6	1	16.7	1	100.0
NORTH AMERICA					
Canada	7,770	79	1.0	60	75.9
U.S.A.	289,320	4,480	1.5	3,665	81.8

(a) Does not include countries which have not reported AIDS cases in children.

Fig. 3. NUMBER OF REPORTED CASES IN WOMEN, AND CASES DUE TO PERINATAL TRANSMISSION, LATIN AMERICA AND THE CARIBBEAN,1987-92.



* 1992 data adjusted with the delayed reporting index.

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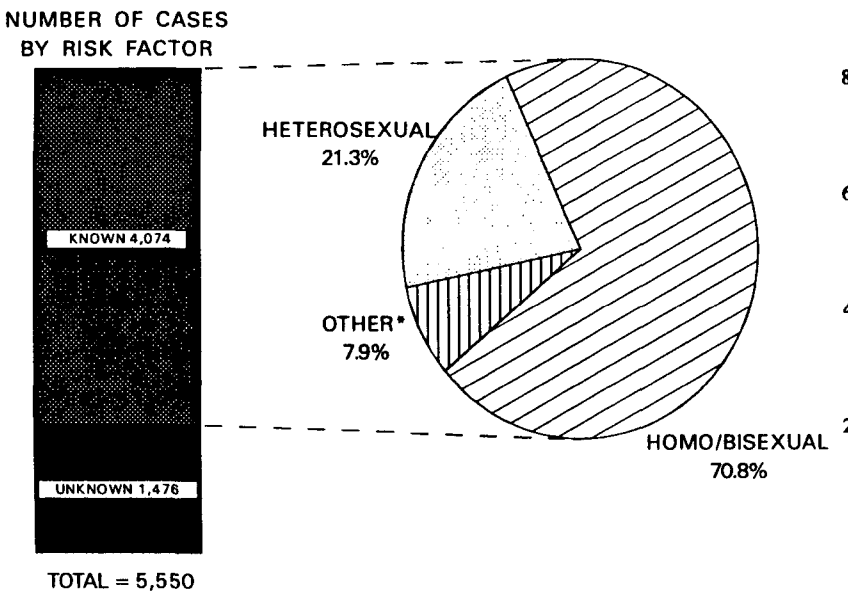
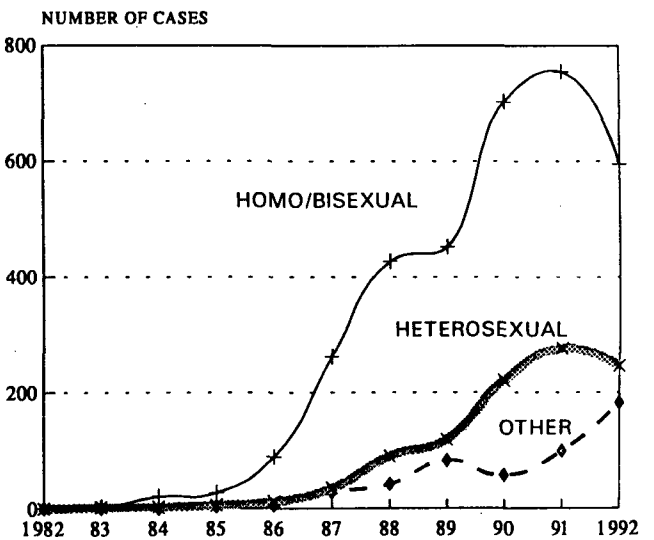
FIG.4a. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1992, ANDEAN AREA.



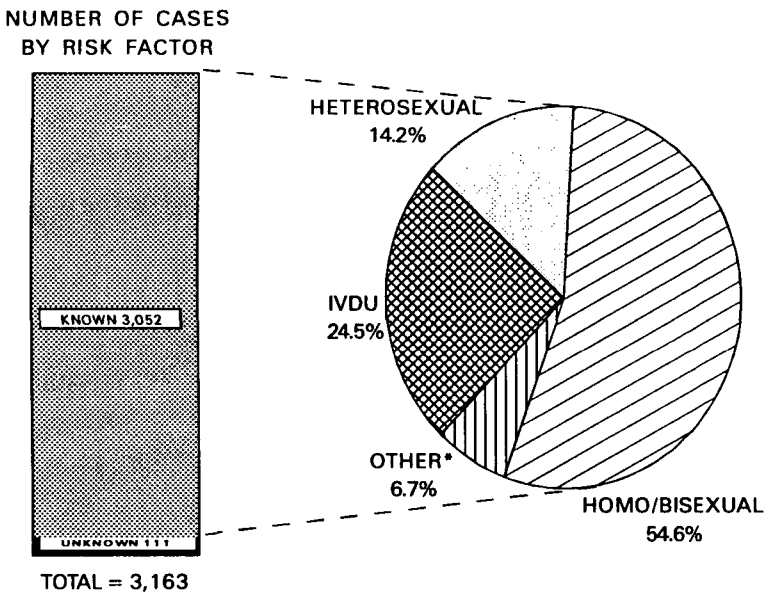
PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.



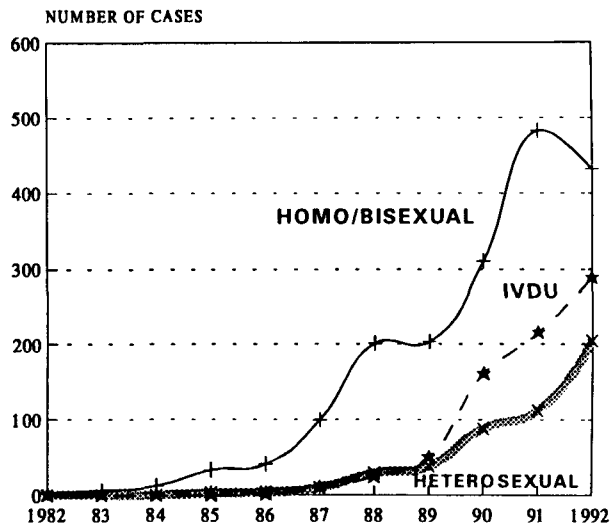
ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1992.**

* INCLUDES 2.8% BLOOD, 0.9% IVDU, 1.8% PERINATAL AND 2.4% OF OTHER KNOWN RISK FACTORS.
** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

FIG. 4b. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1992, SOUTHERN CONE.



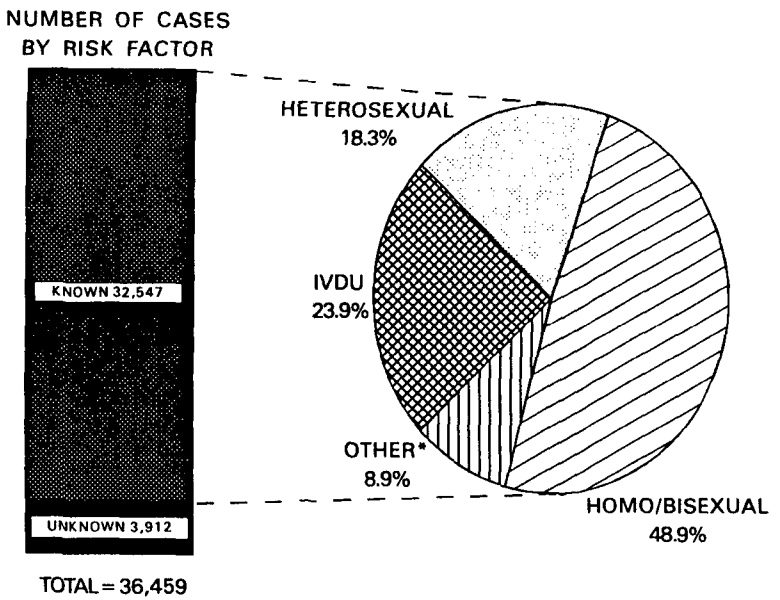
PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.



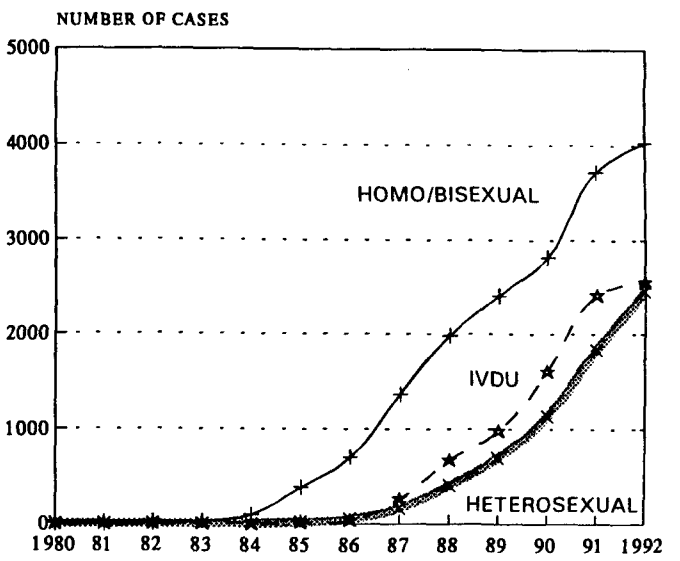
ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1992.**

* INCLUDES 4% BLOOD, 2.3% PERINATAL AND 0.4% OF OTHER KNOWN RISK FACTORS.
** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

FIG. 4c. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1980-1992, BRAZIL.



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE TRHOUGH JUNE 1993.

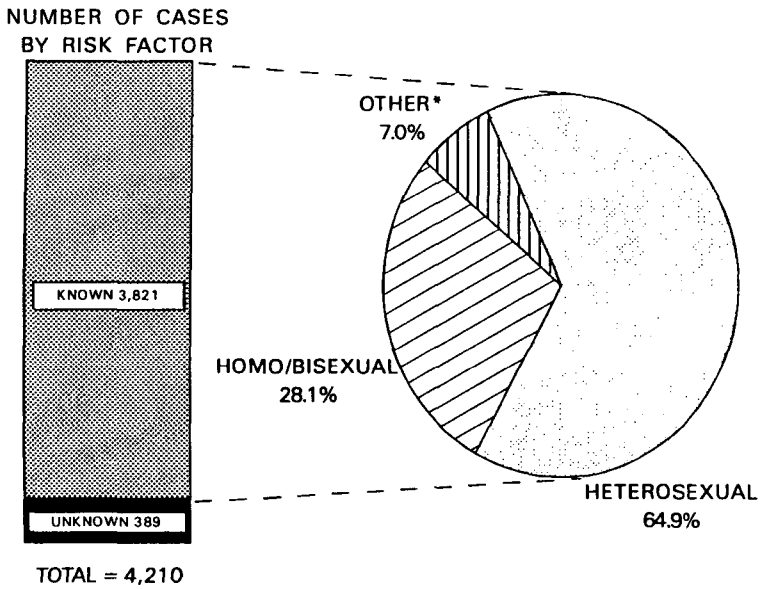


ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1980-1992.**

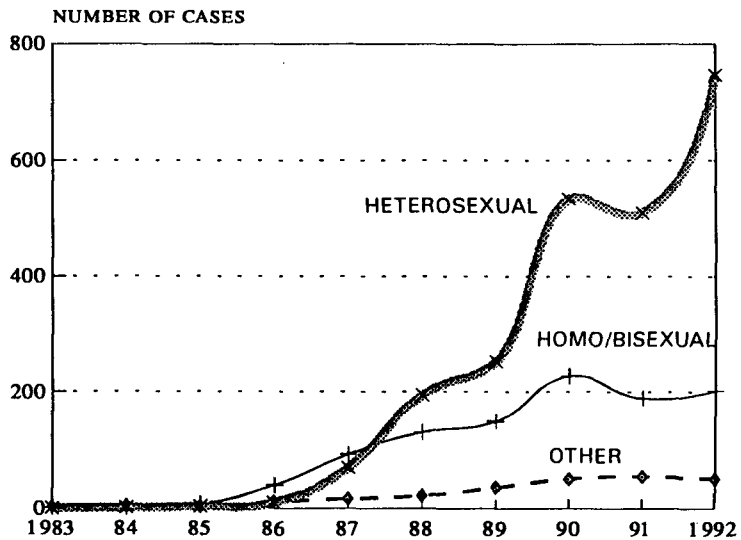
* INCLUDES 6.7% BLOOD, 2.2% PERINATAL AND 0.006% OF OTHER KNOWN RISK FACTORS.

** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

FIG. 4d. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1983-1992, CENTRAL AMERICAN ISTHMUS.



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.

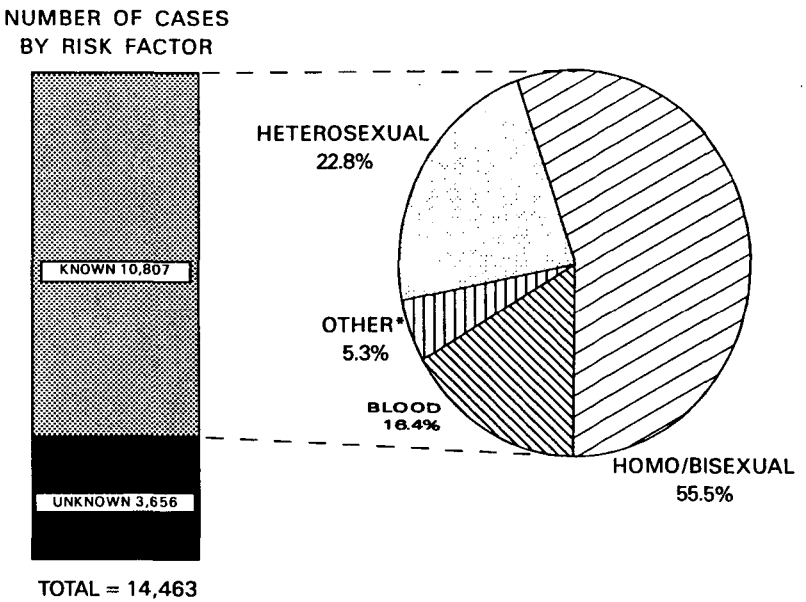


ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1983-1992.**

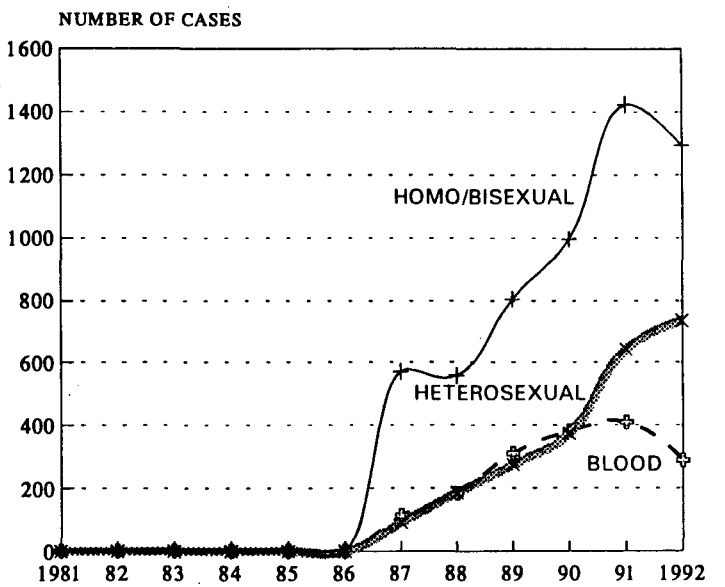
* INCLUDES 2.9% BLOOD, 1.2% IVDU, 2.5% PERINATAL AND 0.4% OF OTHER KNOWN RISK FACTORS.

** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.

FIG. 4e. PERCENT DISTRIBUTION OF AIDS CASES BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1981-1992, MEXICO.



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.

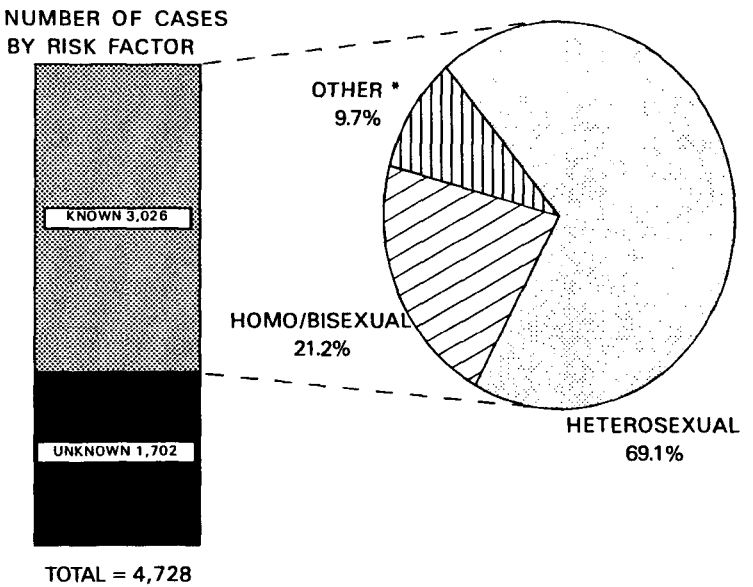


ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1981-1992.**

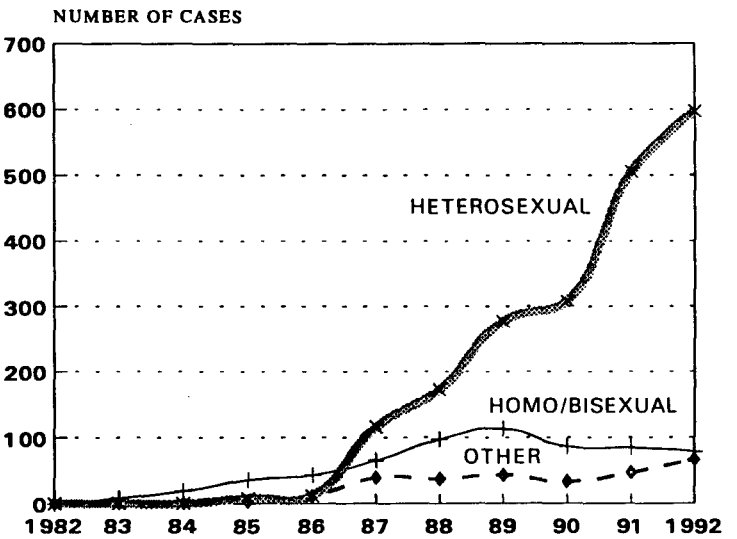
* INCLUDES 0.8% IVDU, 1.7% PERINATAL AND 2.8% OF OTHER KNOWN RISK FACTORS.

** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX. .

FIG. 4f. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993 AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1992, CARIBBEAN.



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1993.



ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1992.**

* INCLUDES 0.6% BLOOD, 0.2% IVDU, 8.5% PERINATAL AND 0.4% OF OTHER KNOWN RISK FACTORS.

** DATA FOR 1991 AND 1992 ADJUSTED WITH THE DELAYED REPORTING INDEX.