executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

101st Meeting
Washington, D.C.
June-July 1988

Provisional Agenda Item 4.1

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29 April 1988
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ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

The epidemic of acquired immune deficiency syndrome (AIDS) has spread throughout the Americas and continues to grow. As of 31 March 1988, of the 85,273 cases reported to the World Health Organization by 137 countries, 73.3% have occurred in the Region of the Americas. With the exception of Montserrat and the British Virgin Islands, evidence of spread of AIDS virus has been found in all the countries and territories of the Americas. As the epidemic continues to grow, its impact will grow.

In 1987 and 1988 the World Health Organization identified two phases for the development of national AIDS prevention and control programs. The first phase involves the preparation of short-term programs (STP), lasting 6-12 months, and in some cases medium-term programs (MTP), lasting 3-5 years. All plans are compatible with WHO's "Global Guidelines, Objectives and Strategies for AIDS Prevention and Control."

WHO non-regular funds have been used in the short run to provide immediate support for all countries who have initiated AIDS plans. In 1987 a total of US$2.09 million of direct financial support was provided. An additional $323,000 was granted for the Caribbean region. In 1988, a total of $1.09 million has been granted, with an additional $155,000 for the Caribbean Epidemiology Center in support of the subregional program in the Caribbean.

The Executive Committee is asked to review the current situation in the Americas, to review PAHO's approach to AIDS prevention and control in the Americas within the context of WHO's global efforts, and to endorse PAHO's targets for AIDS prevention and control in the Region.

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ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

1. INTRODUCTION

The epidemic of acquired immune deficiency syndrome (AIDS) has spread throughout the Americas and continues to grow. As of 31 March 1988, of the 85,273 cases reported to the World Health Organization by 137 countries, 73.3% have occurred in the Region of the Americas. With the exception of Montserrat and the British Virgin Islands, evidence of spread of AIDS virus has been found in all the countries and territories of the Americas. As the epidemic continues to grow, its impact will grow.

2. EPIDEMIOLOGY OF AIDS

2.1 Regional Surveillance

The Pan American Health Organization initiated Regionwide AIDS surveillance in 1983. Only officially reported cases of AIDS have been tabulated. Surveillance of human immune deficiency virus (HIV) infection has not been carried out in a systematic fashion as yet. As in all other Regions of the world, the number of AIDS cases grossly underestimates the magnitude of the problem. PAHO estimates that between 2.0 and 2.5 million persons are infected in this Region. Approximately 500,000 to 750,000 are located in Latin America and the Caribbean.

The Andean group of countries has reported a total of 419 cases as of 18 April 1988. The Southern Cone countries have reached a total of 229, while Brazil has reported a total of 2,766 cases. The Central American countries and Panama have reported a total of 217 cases while Mexico has reached 1,233. The Latin Caribbean countries, which include Cuba, Dominican Republic and Haiti, have reported a total of 1,645 cases. The non-Latin Caribbean countries have reported a total of 812 cases. North America reported a total of 62,264 cases, with the great majority coming from the United States of America. Thus, since the initiation of surveillance in 1983, a total of 68,585 cases and 37,144 deaths has been reported. The overall case fatality rate is 54%.

Table 1 compares data from 1986 and 1987 and reveals the percentage increase in the number of reported cases. Although reported cases from North America increased by 13%, several other subregions reported dramatic increases, e.g., 207% in the Southern Cone countries, 139% in the Latin Caribbean, and 118% in the Central American Isthmus.

Today the world has tracked this epidemic by monitoring the total number of accumulated cases since 1981 when the epidemic began. The total number of cases by country is not particularly useful for making comparisons between countries because of differences in the size of their population. A better method of comparison is the ratio of reported cases

Table 1

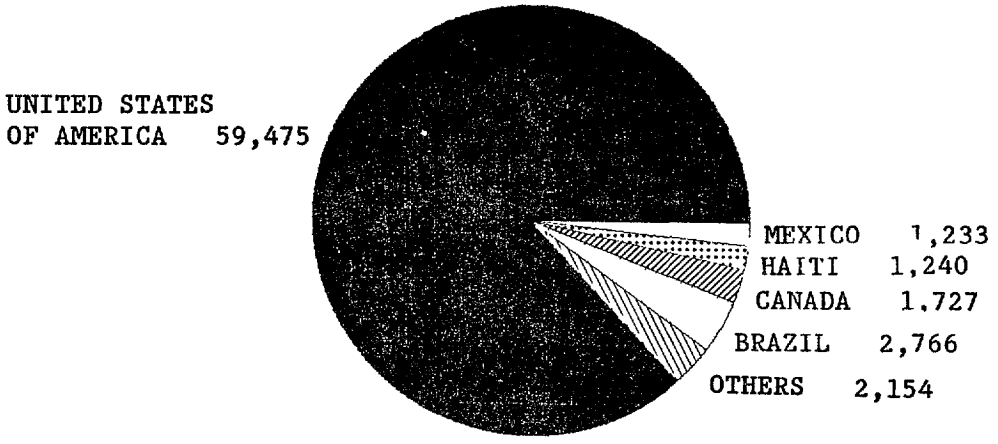
AIDS IN THE AMERICAS
Reported Cases in 1986 and 1987 with Per Cent Increase

	1986	1987	Per cent Increase
TOTAL	17,923	20,994	17
LATIN AMERICA	1,812	2,673	48
Andean Area	110	233	112
Southern Cone	42	129	207
Brazil	867	1,068	23
Central American Isthmus	62	135	118
Mexico	423	373*	(-)*
Latin Caribbean	308	735	139
CARIBBEAN	252	379	50
NORTH AMERICA	15,859	17 942	13

* 1987 data not complete

Figure 1 reveals that five countries--the United States of America, Brazil, Canada, Haiti and Mexico--have contributed approximately 97% of all the cases in the Region.

AIDS IN THE AMERICAS
Number of Reported Cases by Country
Notified by 18 April 1988



for a given calendar year to the median population estimates for the same year. PAHO data reveal that the Caribbean subregion with 52.6 cases per million population is second only to the North America subregion with 66.6 AIDS cases per million. These averages obscure significant differences between the countries, which range from 4.6 to 370.0 AIDS cases per million population.

2.2 Sexual Transmission

Initially, AIDS cases in Latin America were reported among male homosexuals and bisexuals with a history of travel outside Latin America and the Caribbean. The first cases, many of which had already been diagnosed in Europe and North America, were found in Mexico, Colombia, Argentina, Brazil, and other Latin American countries from 1982 to 1985. This pattern of predominant male sexual transmission continues in North America and most countries in the southern part of South America (Chile, Argentina, Uruguay and Paraguay), as well as the Andean countries (Venezuela, Colombia, Ecuador, Peru and Bolivia).

An important feature in some countries in Latin America is the proportion of bisexual males, who account for 15 to 25% of all AIDS cases. Many of them are married or have stable female partners. Furthermore, seroprevalence studies to detect the presence of HIV antibodies in some groups of homosexual and bisexual men, most of them volunteers, have disclosed various rates of infection, e.g. 8.3% in the Dominican Republic in 1986, 20% in Costa Rica in 1985 to 1986, 37.5% in Brazil in 1987, and 30.9% in Mexico in 1987. Although these rates contrast with the very high rates (above 70%) of HIV infection among some homosexual groups in some areas of the United States of America, the data may indicate only a delayed introduction and dissemination of HIV infection among homosexual men in Latin American and Caribbean countries. Thus, HIV prevalence rates among homosexual/bisexual men in some prospective studies have gone from below 5% to the present rates of 10 to 20% in studies conducted in countries such as Argentina and Uruguay.

The proportion of cases in which heterosexual transmission of HIV is implicated is still below 10% of all cases in most countries in Latin America. However, in the Caribbean and parts of Central America, significant numbers of AIDS cases and HIV infections in women are being detected. As an example, during 1987, 24 cases of AIDS were diagnosed in Jamaica, of which ten occurred in women. Prevalence of HIV infection in sexually transmitted disease (STD) clinic patients has not been systematically evaluated outside of the United States of America and Canada. Studies in female prostitutes have shown HIV infection rates ranging from 0 in some studies in Mexico and Argentina, to a high of 49% in one limited study of prostitutes in Haiti.

2.3 Transmission Associated with Blood and Blood Products

In some countries, between 5 and 10% of all cases of AIDS are presumed to be secondary to blood transfusions, notably in Costa Rica, Mexico, Brazil and Jamaica. HIV antibody prevalence among blood donors

is highly variable, ranging from 0.00% among 4,000 donors in Argentina and 0.1% in more than 1,400 blood samples in Barbados to a high of 1.5% in the Dominican Republic and 7.3% among some paid blood donors in high risk areas of Mexico City. The contribution of contaminated needles and syringes to the transmission of the AIDS virus among IV drug abusers appears to be less significant in Latin America than in the United States of America. Less than 1% of AIDS cases are believed to be associated with IV drug abuse in Latin America, as opposed to 17% in the United States of America.

2.4 Transmission in Children

The cases associated with perinatal transmission in Latin America and the Caribbean are still few. For example, less than one fifth of cases in infants and children have been associated with perinatal transmission in Brazil. In Mexico, 16% of cases occur in infants of infected mothers. However, limited studies in Haiti have found prevalences of HIV infection of 3 to 8% in pregnant women. The majority of cases in children have thus far been associated with transfusion of blood and blood products and, in rare cases, with sexual abuse and child prostitution. In contrast, more than 75% of pediatric cases in the United States of America can be traced to a parent with HIV infection or engaged in one of the high risk behaviors, principally IV drug abuse.

3. AIDS PREVENTION AND CONTROL

3.1 National Program Development

The World Health Organization has identified two phases for the development of national AIDS prevention and control programs. The first phase involves the preparation of short-term programs (STP) lasting 6-12 months. The second phase involves the development of medium-term programs (MTP) lasting 3-5 years. In 1987 and 1988, PAHO moved as quickly as possible to collaborate with countries to establish at least an STP and in some cases an MTP for AIDS prevention and control. These programs have been variable in their quality and in the period of time covered. Some STPs range from 6-18 months, while some MTPs range from 18-36 months. However, all plans are compatible with WHO's "Global Guidelines, Objectives and Strategies for AIDS Prevention and Control."

WHO non-regular funds have been used in the short run to provide immediate support for all countries who have developed either STPs or MTPs. The immediate support has been designed to permit the implementation of those activities called for in the STP or MTP during the first six months of these programs. Thus, in 1987, Argentina, Brazil, Chile, Dominican Republic, Ecuador, Haiti and Mexico received a total of US$2.09 million of direct financial support for the initial phases of their STP or MTP. An additional $323,000 was granted for the initiation of AIDS prevention and control activities in the Caribbean through the Caribbean Epidemiology Center (CAREC) and the subregional program for AIDS prevention and control.

In 1988, nine countries and two territories (Bahamas, Barbados, Belize, Grenada, Jamaica, Cayman Islands, Dominica, Trinidad and Tobago, Turks and Caicos, El Salvador and Uruguay) have already received a total of US$1.09 million in support of their short-term efforts. An additional $155,000 grant was provided to CAREC in support of the subregional program in the Caribbean.

Plans have been received from Costa Rica, Colombia, Suriname and Panama and are in various stages of review by PAHO and WHO. Plans are in preparation in Guyana, Paraguay and Guatemala and are expected to be received by June 1988. Consultation teams will collaborate with national authorities to develop plans in Bolivia, Peru, Venezuela, Nicaragua and Honduras. PAHO expects that all countries and territories in the Western Hemisphere will have either an STP or MTP in operation by the end of 1990.

Recognizing that Member Countries and territories in the Caribbean have unique characteristics which require specialized approaches, PAHO, with the support of CAREC and WHO, organized a unique approach for AIDS prevention and control. In November 1987, a Caribbean-wide workshop was held, and all but one of CAREC's member governments* attended to discuss and organize the preparation of STPs and MTPs under the umbrella of a coordinated subregional approach. During that meeting, potential donor agencies were invited to review the plan of action for the subregional effort. Nine governments developed STPs, which have been forwarded and reviewed in Geneva. A program of action has been developed in collaboration with WHO's Global Program on AIDS and CAREC to develop MTPs for the entire subregion into one consolidated subregional approach in time for a donors meeting in October-November 1988 to secure full financing for the period covered by these plans.

In some countries that developed STPs early in 1987, informal evaluations have revealed some problems. Even though initial funding has been provided in record time by WHO through PAHO, there have been delays in fully utilizing the available funds in some countries. In some cases the delay represents the lack of political commitment and in other cases it represents a certain amount of inertia and lack of installed capacity to deal with the problem. For example, many countries are faced with making an initial laboratory investment, including training of personnel and purchasing of supplies, which has a significant lead time. Nevertheless, most countries are working to overcome these problems.

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* Member governments of the PAHO-administered Caribbean Epidemiology Center include: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, and the United Kingdom. It also includes the Governments of such United Kingdom territories in the Americas as Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Montserrat, and Turks and Caicos Islands.

3.2 Regional Support for National Programs

The Regional Offices of WHO are fully participating components of the Global Program on AIDS. The Pan American Health Organization, WHO Regional Office for the Americas, executes the regional program on AIDS in the Americas. Overall, the PAHO/WHO program mobilized a total of US$5.1 million in 1987 from WHO non-regular funding sources for AIDS prevention and control activities in this Region. In countries where there has already been epidemiological and political recognition of the HIV problem, the PAHO Regional Program on AIDS provides technical assistance and financial support for the formulation and execution of national programs. This work will be strengthened and broadened to assist other Member Countries already engaged in confronting the AIDS HIV epidemic.

A wide variety of regional activities has been carried out in support of the development of national STPs and MTPs for the prevention of AIDS. PAHO has provided technical consultation and evaluation to Member Countries through teams of consultants and PAHO/WHO staff to collaborate in the development and refinement of STPs and MTPs. Four international workshops have been held since early 1987 to disseminate AIDS laboratory technology to Member Countries.

Major efforts have been made to distribute AIDS educational information to the countries. With support by WHO, two AIDS information/education exchange centers have been developed, one at CAREC and the other in Mexico. A total of US$267,000 has been made available for this purpose. The purpose of the centers is to collect, evaluate and disseminate AIDS information and education materials from as many countries as possible to assist other Member Countries in formulating their own AIDS educational efforts.

PAHO is very active in promoting AIDS education throughout the Region. PAHO organized the First Pan American Teleconference on AIDS in September 1987 in Quito, Ecuador. This teleconference was broadcast to over 650 sites in most countries and territories in the Western Hemisphere. For the first time in the history of PAHO and WHO, approximately 45,000 health workers participated in a PAHO/WHO technical scientific meeting. PAHO is currently organizing the Second Pan American AIDS Teleconference, which will take place in Sao Paulo, Brazil, 6-8 September 1988.

PAHO has disseminated technical information on AIDS and has participated in numerous national and international congresses, meetings and workshops. It has forwarded documents, policies and statements developed through global consensus by WHO. It has published "Guidelines for AIDS Prevention and Control," which has been reviewed, updated and distributed to all the countries.

PAHO has also established contact with private voluntary organizations, nongovernmental organizations and international agencies in the

United States of America, Canada and elsewhere to coordinate both technical and financial collaboration with national AIDS prevention and control programs.

4. PAHO/WHO GLOBAL PROGRAM ON AIDS IN THE AMERICAS

4.1 Objectives and Strategies

The objectives and strategies of the regional approach to AIDS are conceptually identical to WHO's global objectives and strategies and were discussed during the XXXII Meeting of the Directing Council.

Highest priority is being placed on direct technical collaboration with Member Countries in support of the development, execution and financing of national AIDS prevention and control programs. Second priority will be the dissemination of technical information on the epidemiological, biological, clinical, laboratory and educational/behavioral aspects of AIDS and HIV infection. These efforts will be complemented by regional support for research and training. PAHO will monitor the AIDS situation through Regional surveillance and provide regional leadership for the coordination of Hemisphere-wide efforts to stop the spread of AIDS.

4.2 Targets for the Biennium 1988-1989

a) By mid-1988, all countries and territories of the Region will have medium-term programs (minimum three years) for AIDS prevention and control. These programs will be compatible with HFA/2000 and primary health care strategies and be fully integrated with national health systems.

b) By the end of 1988, all countries which received initial funding support from WHO's Global Program on AIDS (GPA) will be evaluated, and long-term financial needs and sources of funding will be identified. Periodic reevaluation of national programs will continue throughout this medium-term program.

c) By mid-1989, up to five subregional AIDS information/education exchange centers will be established.

d) By the end of 1989, AIDS research projects will be implemented in at least 12 countries.

e) By the end of 1989, a fully operational regional AIDS reference laboratory network will be established.

f) By the end of 1988, all blood and blood products utilized by the public sector in all countries in the Region will be screened for HIV. By the end of 1989, all blood and blood products utilized in all sectors in all countries in the Region will be screened for HIV.

4.3 Future Activities

Following discussions with GPA, PAHO is preparing a short-term Regional program for the remainder of 1988, to be followed by the preparation, review and approval of a three-year regional program in support of country efforts for the 1989-1991 period. PAHO estimates that the total requirement for both regional activities and full support of national activities will approximate US$35 to $40 million over the next three and a half years.

4.3.1 Technical Cooperation

PAHO will mobilize a staff of experts which will manage the program and provide direct technical cooperation to Member Countries in support of the planning, execution, evaluation, and financing of national AIDS prevention and control programs. The staff will be assisted by a cadre of specially trained short-term consultants which will be available to monitor and evaluate national and regional efforts to prevent AIDS.

4.3.2 Dissemination of Information

The regional program will develop activities in two general areas. Utilizing appropriate technology, including Compact Disks-Read Only Memory (CD-ROM), the program will provide the latest scientific literature to national programs, their staff and scientists to keep them up to date on the latest epidemiological, biological, clinical, laboratory and educational/behavioral aspects of AIDS and HIV infection. Periodic national and international meetings will be organized to share knowledge, such as meetings of national AIDS programs, maternal and child health programs, blood bank programs, etc. As appropriate, PAHO will sponsor Pan American AIDS teleconferences and inform professionals throughout the Region of relevant international meetings, scientific seminars and congresses.

A second area includes the establishment of five subregional AIDS education/information exchange centers strategically located throughout the Region. The first center has already been established at CAREC. The AIDS education effort must be innovative, and sharing of materials developed in a variety of settings by various countries will broaden perspectives and stimulate creativity in individual countries. As countries develop specific educational messages which are acceptable to their cultures and particular high risk population groups, a mechanism must be established to exchange these materials between countries. The program will utilize existing facilities in the countries to build a special capacity for the exchange of AIDS educational materials among the countries. The regional program will finance and provide technical support to these subregional centers.

4.3.3 Research

Through a research contract with the US National Institute on Allergy and Infectious Diseases (NIAID), PAHO will catalyze a tripartite relationship between NIAID, PAHO and national scientists to carry out

epidemiological research in four areas: several seroepidemiological studies in high, medium and low risk population groups; the natural history of the disease and its relationship to other endemic diseases; factors contributing to the heterosexual transmission of AIDS; and factors contributing to the perinatal transmission of AIDS. In the future, as more resources become available, this program will be broadened to include research in social and behavioral issues.

4.3.4 Training

Although PAHO has sponsored several international laboratory training courses, the regional program will focus future efforts in support of training done at the national level within the context of the country's AIDS prevention and control program. PAHO will provide appropriate short-term consultants, generic training materials, and occasional international courses as the need arises.

4.3.5 Regional Monitoring

PAHO will monitor the AIDS situation through regional surveillance and provide statistical and analytical support for the strengthening of national surveillance efforts, including standardization of case definition. PAHO is exploring coordination of an electronic AIDS information bulletin board and periodically will provide Member Countries with regional and subregional analyses of the AIDS situation. PAHO will also collaborate with Member Countries to evaluate national program progress on a periodic basis.

4.3.6 Regional Coordination

The Regional Program on AIDS (RPA) will provide leadership for the coordination of the Hemisphere-wide effort to stop the spread of AIDS. The program has already established working relationships with USAID, UNICEF, World Bank, Inter-American Development Bank, International Planned Parenthood Federation, International Development Research Center, Canadian International Develpment Agency and other major international organizations in this Region to coordinate joint efforts for the prevention of AIDS. Through the development of an international AIDS commission, under PAHO leadership, the RPA will continue to share information with other international organizations participating in the AIDS prevention and control effort in this Hemisphere. This commission will serve as a mechanism for coordinating international efforts and preventing duplication.

Through the organization of a series of international meetings, the Regional program will coordinate interprogrammatic activities in support of AIDS prevention. The RPA will provide leadership for bringing together national maternal and child program coordinators, blood and blood-bank program directors, human resource development program directors, etc. for the exchange of information and coordination of efforts against AIDS.

5. SUMMARY

In this Region, the AIDS problem has been approached in a manner which will permit accomplishment of as much as possible as quickly as possible. Given the urgency of the AIDS pandemic, countries cannot follow traditional "business as usual" approaches. PAHO/WHO has made a commitment to its Member Countries in this Region and they in turn are committing themselves to confronting this unprecedented epidemic.

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CE101/17, ADD. I (Eng.)
17 June 1988
ORIGINAL: ENGLISH

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

The Director is pleased to present to the Executive Committee a summary update of AIDS surveillance in the Americas as of 17 June 1988.

AIDS SURVEILLANCE IN THE AMERICAS
CUMULATIVE NUMBER OF CASES AND DEATHS
17 June 1988

SUBREGION Countries and territories	CASES a)	DEATHS	First Report	Last Report
REGIONAL TOTAL	74,735	40,654		
LATIN AMERICA b)	7,083	2,557		
ANDEAN AREA	444	194		
Bolivia	6	3	31 Dec 85	31 Dec 87
Colombia	174	21	31 Dec 83	31 Dec 87
Ecuador	43	24	31 Dec 85	20 May 88
Peru	81	46	30 Jun 82	31 Mar 88
Venezuela	140	100	31 Dec 84	31 Dec 87
SOUTHERN CONE	268	149		
Argentina	163	95	31 Dec 83	31 Mar 88
Chile	77	33	31 Dec 84	20 May 88
Paraguay	8	8	31 Dec 86	31 Dec 87
Uruguay	20	13	31 Dec 83	31 Mar 88
BRAZIL	2,956	1,386	30 Jun 82	31 Mar 88
CENTRAL AMERICAN ISTHMUS	277	158		
Belize	7	5	31 Dec 86	31 Dec 87
Costa Rica	57	29	31 Dec 83	31 Mar 88
El Salvador	23	14	31 Dec 85	31 Dec 87
Guatemala	34	29	30 Sep 86	31 Dec 87
Honduras	109	54	30 Jun 85	31 Mar 88
Nicaragua	-	-	30 Sep 87	31 Mar 88
Panama	47	27	31 Dec 84	8 Apr 88
MEXICO	1,233	349	30 Jun 81	31 Mar 88
LATIN CARIBBEAN c)	1,905	321		
Cuba	27	7	31 Dec 87	31 Mar 88
Dominican Republic	504	54	30 Jun 83	31 Mar 88
Haiti	1,374	260	31 Dec 83	31 Mar 88
CARIBBEAN	905	553		
Anguilla	-	-	31 Mar 87	31 Mar 88
Antigua	3	3	31 Dec 85	31 Mar 88
Bahamas	188	95	31 Dec 85	31 Mar 88
Barbados	60	39	31 Dec 84	31 Mar 88
Cayman Islands	3	2	31 Dec 85	31 Mar 88
Dominica	6	6	31 Mar 87	31 Mar 88
French Guiana	113	78	31 Dec 82	31 Mar 88
Grenada	8	5	31 Dec 84	31 Dec 87
Guadeloupe	74	36	31 Dec 86	31 Dec 87
Guyana	16	8	30 Sep 86	31 Mar 88
Jamaica	56	40	30 Jun 86	31 Mar 88
Martinique	38	22	31 Dec 86	31 Dec 87
Montserrat	-	-	30 Jun 87	31 Dec 87
Netherlands Antilles	23	15	31 Mar 87	31 Dec 87
Saint Lucia	10	6	31 Dec 84	31 Dec 87
St. Christopher-Nevis	1	-	31 Dec 85	31 Dec 87
St. Vincent and the Grenadines	8	5	31 Dec 84	31 Dec 87
Suriname	9	7	30 Jun 84	31 Mar 88
Trinidad and Tobago	269	175	30 Jun 83	31 Mar 88
Turks and Caicos Islands	5	3	31 Dec 86	31 Dec 87
Virgin Islands (UK)	-	-	31 Mar 87	31 Dec 87
Virgin Islands (US)	15	8	31 Dec 86	31 Mar 88
NORTH AMERICA	66,747	37,544		
Bermuda	75	58	31 Dec 84	31 Mar 88
Canada	1,793	1,006	31 Dec 79	13 Jun 88
United States of America c)	64,879	36,480	31 Dec 80	17 Jun 88

a) Differences or changes in case-definition may lead to discrepancies with other published data.
b) French Guiana, Guyana, and Suriname included in Caribbean.
c) Puerto Rico included in USA.

AIDS SURVEILLANCE IN THE AMERICAS
Summary

As received by June 17, 1988

Cumulative number of cases reported
74,735

Cumulative number of deaths reported
40,654

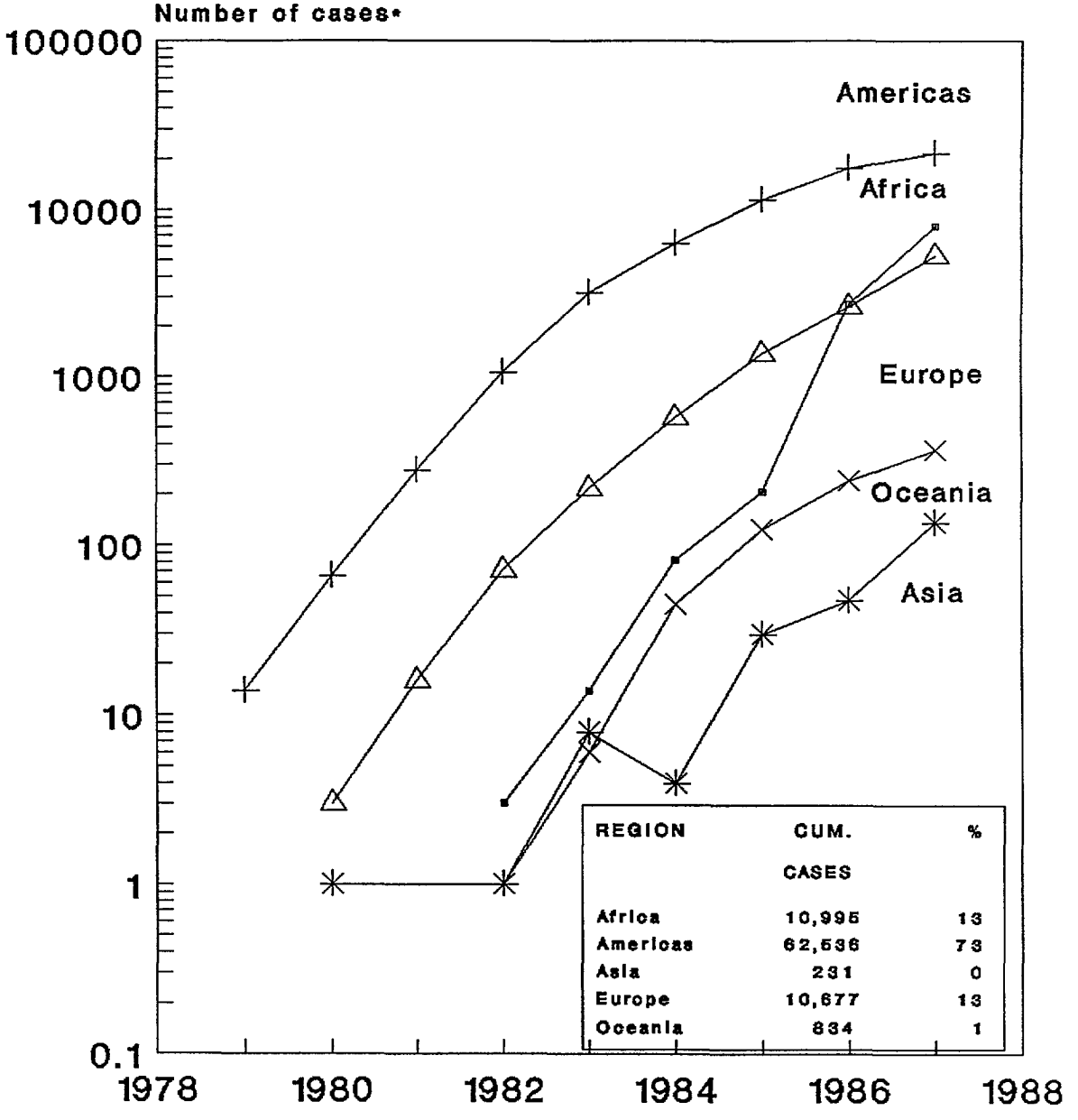
Number of countries reporting
for the first quarter 1988
29 out of 46

Number of countries reporting 10 or more cases
for the first quarter 1988
13

Number of countries reporting zero cases
for the first quarter 1988
6

AIDS SURVEILLANCE WORLDWIDE

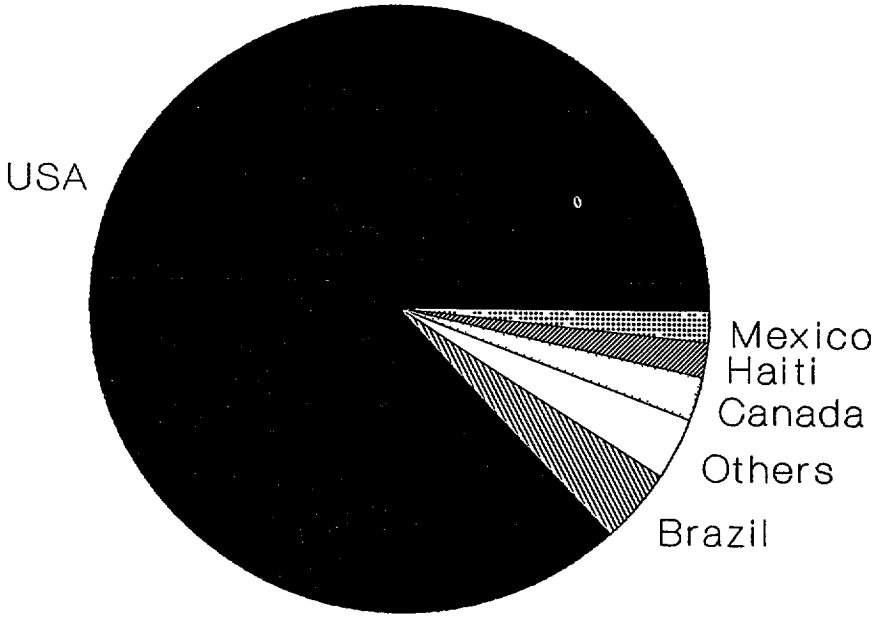
Cases reported by region
1979-1987



*1987 data are incomplete.

AIDS SURVEILLANCE IN THE AMERICAS

Cases reported by country
As received by June 17, 1988



COUNTRY	CUM. CASES	PERCENT
USA	64,879	87
Brazil	2,956	4
Canada	1,793	2
Haiti	1,374	2
Mexico	1,233	2
Others	2,500	3