

*executive committee of  
the directing council*



**PAN AMERICAN  
HEALTH  
ORGANIZATION**

*working party of  
the regional committee*

**WORLD  
HEALTH  
ORGANIZATION**



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**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)  
IN THE AMERICAS**

As of 10 March 1994 a total of 445,295 cases of AIDS had been reported in the Region of the Americas; however, it is estimated that the number of cases may be twice those reported (close to 800,000). In addition, estimates of the extent of HIV infection in the Region indicate that there may be between 2.5 and 3 million asymptomatic persons carrying the human immunodeficiency virus. The expected increase in AIDS cases resulting from current HIV infections will place an enormous burden on social and health services throughout the Region. Moreover, changes in the epidemic in recent years have resulted in an increase in the number of cases of AIDS and HIV infections among women and children.

To assist countries of the Region in their fight against HIV transmission and AIDS, the PAHO's Regional AIDS and Sexually Transmitted Diseases (STD) Program has continued to collaborate in the strengthening of national AIDS programs. Furthermore, because the success of country AIDS prevention programs will depend on the establishment of a national capability to develop, implement, and evaluate a specific mix of technically sound and culturally appropriate interventions, technical cooperation will be focused on these areas. Emphasis will be placed on interprogrammatic, interagency and intersectoral involvement and collaboration, under the technical leadership of the ministries of health.

AIDS is a global concern and its prevention and control requires interagency cooperation at the global, regional, and national levels. To achieve interagency cooperation, the Ninety-third Session of the WHO Executive Board recommended the development and eventual establishment of a joint and cosponsored United Nations program on HIV/AIDS. The program is to be administered by WHO. Because of the implications of the UN program for PAHO's technical cooperation on AIDS prevention in the Region, the Subcommittee on Planning and Programming addressed the issue at its 21st Meeting in December 1993. Also, PAHO's Secretariat prepared a proposal to improve interagency coordination in the Region (Annexes II-A and II-B). The Executive Committee is asked to consider the proposal, and to endorse it, if acceptable.

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## **1. Introduction**

In a relatively short period of time, the human immunodeficiency virus (HIV) has spread throughout the entire world. The World Health Organization (WHO) estimates that more than 2.8 million AIDS cases have already occurred worldwide, and that close to 15 million men, women, and children have been infected by HIV throughout the various regions of the world.

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 has been apparent. As of 10 March 1994, 45 countries and territories of the Americas had reported a total of 445,295 cases of AIDS. This figure is not an exact measure of the situation, partly because of problems with diagnosis, underreporting, and delayed reporting of cases. Actually, a total of around 800,000 cumulative cases of AIDS are projected for the Region by 1995. In addition, estimates of the extent of HIV infection in the Region indicate that there may be between 2.5 and 3 million persons carrying the human immunodeficiency virus who do not yet exhibit symptoms of AIDS.

Considering that AIDS is the late stage of HIV infection and that infected persons will develop AIDS within an average period of 10 years, a significant increase in the number of AIDS cases is expected in the coming years, particularly in Latin America and the Caribbean, and among specific population groups in North America. 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 regular and emergency demands.

## **2. Situation Analysis**

As of March 1994, a total of over 400,000 cases of AIDS had been reported to the Organization through the AIDS Regional Surveillance System (Annex I). Eighty per cent of these cases were reported in the United States of America, Canada, and the United Kingdom territory of Bermuda, and 20% in Latin American and Caribbean countries. In Latin America and the Caribbean, underreporting of AIDS cases has been estimated to range between 20% and 80%, leading to the projection of 800,000 AIDS cases for 1995 in the Region.

The most significant change in the epidemic in recent years has been that more and more countries are seeing a shift from a disease that was predominantly transmitted among homosexual and bisexual males to heterosexual transmission, with the consequent rise in the number of AIDS cases and HIV infections among women and children.

The most recent available data indicate that the male-to-female ratios of AIDS cases have gradually decreased in many countries, reflecting the aforementioned shift in transmission patterns (Annex I, Table 4). In the Caribbean and the Central American Isthmus, where heterosexual transmission was apparent from the beginning of the epidemic, these ratios are around 2:1 and 3:1 respectively. In the rest of the Region where male:female ratios used to be over 10:1 and even over 20:1, these have now fallen to around 5:1, i.e., Argentina, 3.9:1; Brazil, 4.5:1; Mexico, 5.6:1. This shift can be attributed at least partially to heterosexual transmission between bisexual males and their female sexual partners and between male injecting drug users and their female partners. In fact, although HIV is predominantly transmitted through sexual relations, seroprevalence data point to the increasing importance of injecting drug use as a route of transmission in some countries. In Argentina, Brazil and Uruguay, for example, over 50% of injecting drug users may be infected in some communities. In addition, transmission by blood has not yet been eliminated in the Region, and a few countries report that blood screening has not reached satisfactory levels.

As has been well established by now, the number of AIDS cases in a population represents only the tip of the iceberg of the epidemic. The Regional AIDS Program has estimated that by 1993, a total of between 1.5 and 2.0 million persons may have been infected with HIV in Latin America and the Caribbean. In addition, at least 1 million infections have been estimated in North America, bringing the total of HIV infections in the Region to around 3 million. These numbers must be taken into account when assessing the impact of this epidemic on health services and on the overall economic and social structure of a community or a country.

The increasing incidence of active and transmissible tuberculosis among HIV infected persons adds to the worrisome situation posed by the AIDS/HIV epidemic: in many countries, tuberculosis is the most common opportunistic infection in AIDS cases, affecting up to 25 % of the individuals who are immuno-compromised by HIV.

The situation of AIDS and HIV infection in the Americas is, undoubtedly, serious and likely to worsen. As more and more people become infected and develop symptoms of the disease, health and social services will be increasingly overburdened in most, if not all, countries of the Region.

### **3. Scientific Advances and Effective Approaches and Interventions for AIDS/HIV/STD Prevention and Care**

#### **3.1 *Advances in Prevention***

The three basic mechanisms of HIV transmission are: (1) through sexual relations (heterosexual or homosexual); (2) through contaminated blood (iatrogenic or

through the use of unsterilized needles and syringes); and (3) from an infected mother to her child (perinatal).

To prevent the sexual transmission of HIV and other STD agents, several interventions are available, all of which have varying degrees of effectiveness:

### 3.1.1 *Promotion of Specific Safer Sexual Practices*

Preventive measures promoted as safer sexual practices (such as adoption of non-penetrative sex), although theoretically sound, have been difficult to implement due to practical obstacles to altering deeply rooted sexual behaviors and values. Campaigns that promote sexual abstinence and/or mutually exclusive relationships through prescriptive, vertical and doctrinal approaches have not proven to be as effective as expected. However, promotion of safer sexual practices should not be abandoned just because they are difficult to achieve. Appropriate approaches--mainly person-to-person interventions--need to be developed to help targeted populations understand and determine whether such practices are meaningful and rewarding to them. There is evidence that safer sexual practices are easily adopted by motivated individuals, and motivation may be triggered and maintained through outreach programs.

### 3.1.2 *Consistent and Correct Use of Condoms*

All available research indicates that the correct use of condoms is highly effective in preventing sexual transmission of HIV infection. The overall effectiveness of condoms in preventing sexual transmission of HIV has been estimated at around 80%; obviously, consistent and correct use of condoms increases their effectiveness.<sup>1</sup> Furthermore, use of condoms also reduces the risk of gonorrhea, herpes simplex virus infection, genital ulcers, and pelvic inflammatory disease which aside from being health problems *per se*, also increase the risk of HIV transmission.<sup>2</sup> Up to now, there are no definitive data on the effectiveness of the female condom, nor evidence that the use of spermicides increases the protection against HIV infection provided by condom use alone.

Unfortunately, the demonstrated effectiveness of condom use in the prevention of sexual transmission of HIV infection has not been used advantageously for public health

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<sup>1</sup>Rietmeijer, C.A.M. and Judson, F.N. Condoms as physical and chemical barriers against human immunodeficiency virus. *Journal of the American Medical Association*. March 1988; 259 (12):1851-1853.

<sup>2</sup>Rosenberg, M.J., Hill, H.A., and Friel, P.A. Spermicides and condoms for the prevention of HIV and other sexually transmitted diseases. Presented at Strategies for Virucide Research Meeting, World Health Organization, 28 March 1990.

purposes. Most initiatives undertaken so far to promote the consistent and correct use of condoms have utilized only timid promotional activities and an irregular distribution of supplies. Furthermore, these initiatives are mostly aimed at small and limited population groups. The underlying limitation seems to be, fundamentally, a timidity grounded on fears about disturbing sexual mores and beliefs, as well as on the lack of well established logistics to ensure availability of good quality condoms. As a consequence, the promotion of condoms as an intervention to halt sexual transmission of HIV has had a limited impact, if any at all. It is essential to realize that any further delay in the implementation of strong and aggressive interventions to ensure correct and widespread use of condoms will contribute further to the AIDS epidemic.

### 3.1.3 *Education for Sexual and Reproductive Health*

Sex education for young persons is a preventive measure more effective than previously thought. A review of the studies on the effects of sex education in school settings shows that it does not lead to earlier or increased sexual activity among young people nor does it elicit curiosity for sexual experimentation.<sup>3</sup> On the contrary, these studies show that sex education leads to a delay in onset of sexual activity among those who are as yet not sexually active. Furthermore, the same review shows that sex education leads to a decrease in overall sexual activity and to an increase in the adoption of safer practices by sexually active youth. Moreover, these studies also show that access to counselling and contraceptive services did not encourage earlier or increased sexual activity. Thus, sexually active youth should have easy access to such services and sex education must be available for everyone, whether sexually active or not. It is important to realize, nevertheless, that sex education, to be effective, must not be limited to the mere transmission of facts and information on sexuality and reproduction (i.e., anatomy and physiology) but must be geared to the adoption of healthy behaviors that prevent HIV/STD. In addition, sex education must provide the motivation to act and skills to translate knowledge into practice. Among the latter skills that have proven relevant to HIV/STD preventive behaviors are: integration of sexuality into an acceptable self-image; high self-esteem; autonomous decision-making skills; assertiveness to resist pressure to use drugs or to have sex; negotiation skills to ensure protected sex; and practical skills for effective condom use.

Therefore, implementing sexual and reproductive health curricula in schools will help to diminish the unwanted consequences of sexual experimentation, and avoid early pregnancies and STDs, including HIV.

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<sup>3</sup> Ford, N. *et al.* Review of literature on the health and behavioral outcomes of population and family planning education programmes in school settings in developing countries. The Institute of Population Studies, University of Exeter, October 1992. Review commissioned by the World Health Organization, Global Programme on AIDS.

#### 3.1.4 *Reduction of the Incidence of Curable STDs*

Lack of services and appropriate medical guidance and treatment for genital lesions caused by curable STDs are other factors associated with the risk of HIV infection. Although reliable data are not available, there is evidence of increases in incidence rates of syphilis and gonorrhea, particularly among the young, sexually active population (25 years and under).

STD programs have not been adequately developed to respond to the rapid increase in disease incidence; therefore, specific actions are required to strengthen STD programs and to foster their close collaboration with HIV/AIDS programs when integration into a single program does not exist.

It is also necessary to promote effective case management, including the need to promote the availability of appropriate drugs for the management of STDs. In this regard, PAHO is promoting a simplified algorithm based on the proper management of STD syndromes, i.e., urethral discharge, vaginal discharge, and genital ulcer, to train health personnel, and improve the management of STDs in the Region.

#### 3.1.5 *Prevention of Blood-borne Transmission of HIV*

Compared to sexual transmission of HIV, blood-borne transmission is easier to prevent through aggressive initiatives carried out by the health sector. Rational use of safe blood and blood products and observance of universal precautions during invasive medical procedures are goals that once achieved, will undoubtedly have additional favorable outcomes, such as effective prevention of other blood-borne infections (e.g., hepatitis, Chagas' disease, syphilis) as well as reduction in the number of unnecessary transfusions and, therefore, a concomitant reduction in the cost of care.

Interventions and activities to limit blood-borne spread of HIV include: recruiting voluntary, non-remunerated regular blood donors to ensure a safe blood supply; providing donors with pre-test counselling and referrals for continued counselling as required; screening donated blood for HIV prior to transfusion; training the staff of blood transfusion services in correct procedures, including techniques for rendering blood products safe for use; and educating the prescribers of blood and blood products in order to reduce unnecessary transfusions.

#### 3.1.6 *Needle Exchange/Bleach Provision*

Injecting drug use is a significant risk factor for HIV transmission in some countries in the Region, and there is some evidence that it might become a serious problem in others. In developing countries where aggressive needle exchange and bleach

provision programs for disinfection of needles and syringes have been implemented, HIV transmission among injecting drug users has decreased up to 50 %. Unfortunately, such programs are difficult to implement due to ethical and legal constraints. To tackle this problem effectively, three specific initiatives need to be carried out, namely: (1) the review of legal instruments to ensure the implementation of these effective preventive measures; (2) support to initiatives undertaken by NGOs and self-support groups; and (3) development and evaluation of intervention strategies among injecting drug users.

### 3.1.7 *Vaccine Development*

More than a dozen HIV candidate vaccines are being studied, which include both preventive and therapeutic products. Some of these candidate vaccines have already been shown to be safe and capable of producing immune responses, and some of them will go on to be studied for their effectiveness in both industrialized and developing countries in the near future.

Multiple trials in different populations and geographical areas may be required to answer questions related to vaccine efficacy against different HIV strains and routes of transmission. With the support of WHO, national plans for HIV/AIDS vaccine development and evaluation are being prepared in Brazil, Rwanda, Thailand, and Uganda, to facilitate the collaborative participation of the international scientific community in the conduct of HIV vaccine trials.

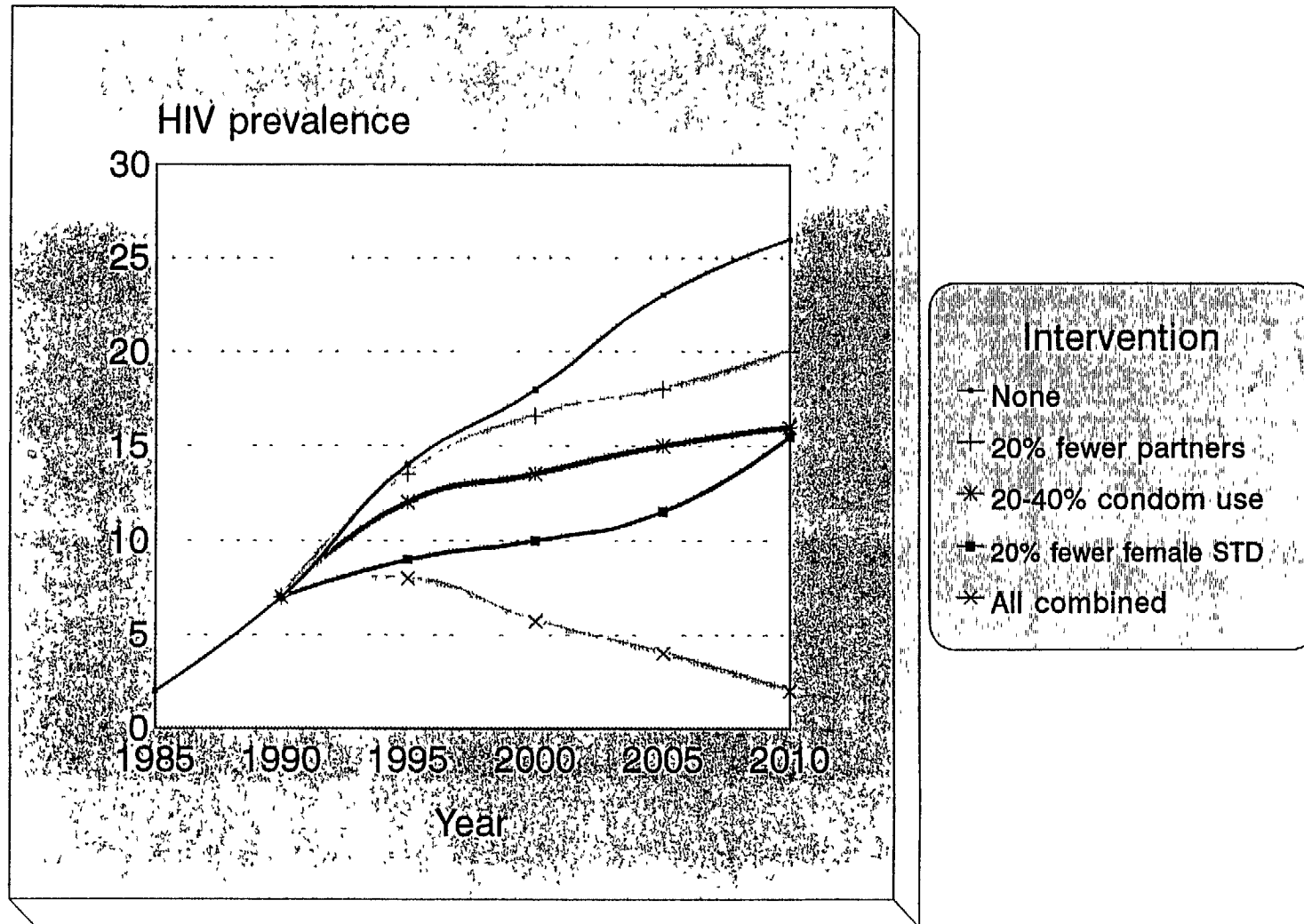
The first vaccines may not be sufficiently effective and will have to be further improved to offer broad protection against geographically divergent HIV strains in different populations. Developing such a vaccine could take about 5-10 years, and a minimum of 10 years may pass before a preventive vaccine may be fully evaluated and available.

### 3.1.8 *Combination of Interventions*

Given the limitations of any single measure mentioned above, the most effective prevention program involves a combination of several strategies. Recent data show that an effective blend of AIDS prevention measures, adapted to local needs and constraints, should include condom promotion and distribution; treatment of curable STDs; broad AIDS education programs in schools and through the media; person-to-person promotion of safer sex practices, including condom promotion to prostitutes and their clients; provision of a safe blood supply; and needle exchange programs for injecting drug users in countries where there is a problem, such as Brazil and the Southern Cone countries. Figure 1 illustrates the kind of combined effect three of these measures could have.



**FIGURE 1. EFFECT ON HIV PREVALENCE OF SEVERAL INTERVENTION STRATEGIES**  
MODELING SIMULATION



modeling with iwgaIDS

Without comprehensive implementation of such measures now, more than 2 million additional adults will have become infected in Latin America and the Caribbean before the year 2000.

### 3.2 *Advances in Care*

Once a diagnosis of AIDS is made, survival often will not exceed two to three years. Opportunistic infections or neoplasms significantly hasten the disease process and are the cause of most deaths, hospitalizations, and disabling episodes. The length of time that an HIV patient survives depends on many factors, among which the most important are the presence of specific complications and the availability of and access to care for these complications. The timely provision of care for treatment-responsive complications such as *Pneumocystis carinii* pneumonia (PCP), cryptococcosis, toxoplasmosis and tuberculosis (TB) are essential for the appropriate care of HIV patients. Despite the availability of treatments for opportunistic infections, the adequate prophylaxis schemes for the prevention of opportunistic infection are desperately needed. While a variety of clinical trials are either planned or currently in progress, an effective prophylaxis regimen has been documented only for one opportunistic infection, namely, *Pneumocystis carinii* pneumonia.

Current drugs that work against HIV are nucleoside analogs, e.g., zidovudine (AZT), which provide only temporary benefit at an extremely high cost. A recent report of the Concorde study carried out in Great Britain and France<sup>4</sup> indicated that there may be no benefit in starting AZT early rather than late in HIV infection, although the drug is beneficial in improving the quality of life and survival of persons with AIDS. These results have led to a reassessment of when to begin antiretroviral therapy. More recent findings indicate that AZT reduces the rate of maternal transmission of HIV from approximately 30% to below 10%. However, these findings are only preliminary and cannot yet be translated into public health practice.

## 4. **Progress and Obstacles in the Implementation of AIDS/STD Programs in the Americas**

To assist countries of the Region in their fight against HIV transmission and AIDS, the Regional AIDS/STD Program has continued to collaborate in the strengthening of National AIDS Programs. During 1992, second cycle medium-term plans (MTP-II) were prepared for six countries in the Central American Isthmus. Similarly, in 1993, MTPs were completed in four South American countries. By 1994, all countries will have completed this activity. In addition, during 1993 and early 1994, program reviews

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<sup>4</sup>Aboulker, J.P., Swart, A.M. Preliminary analysis of the Concorde trial. Concorde Coordinating Committee (letter). *Lancet*. 3 April 1993; 341(8849): 889-90.

were conducted in 10 countries and 4 United Kingdom dependent territories in the Caribbean.

AIDS program management has been strengthened through meetings with national AIDS program managers and program management courses which were introduced in the Region in early 1994, with additional management training planned for 1994-1995.

A successful meeting of Latin American ministers of health took place in Brazil in 1993, followed by the second Ibero-American Summit of Heads of State and Government. At the summit a resolution on AIDS was discussed and approved by leaders of the Region which gave the basis for strengthening and expanding AIDS and STD prevention activities.

With only one exception, all of the 25 regional targets set for the 1992-1993 biennium were totally or almost totally achieved. Worthy of note are the execution of at least 85 % of all planned activities by national AIDS programs in all but five countries; over 80 % achievement of the blood safety target; and participation of NGOs in the execution of at least 15 % of activities at the national level.

Despite these achievements, several constraints and barriers to program implementation remain. At the country level there is still a lack of political commitment reflected in the low or absent priority assigned to STD and AIDS prevention, and weak managerial and administrative structures. Other obstacles include the sometimes adversarial positions of NGOs and government agencies, and the increasing competition between programs, agencies, and sectors for ever-shrinking resources devoted to AIDS prevention and control.

#### **5. A Proposal for Coordinated Cost-Effective and Sustainable Programs for AIDS/STD Prevention in the Americas**

The recognition that the AIDS and HIV epidemic is a long-term health problem with serious and potentially devastating social, economic, and political consequences at the community, country, regional, and global levels has resulted in a genuine interest and increased, albeit still cautious, involvement of the various sectors of society in many countries of the world. Thirteen years ago the first alert was given internationally by the medical and public health community of the United States of America, and seven years ago the World Health Organization initiated an unprecedented global effort to lead the international fight against AIDS. However, resources devoted to AIDS prevention and control (approximately US\$120 million annually) still represent only 5 % to 10 % of the amount needed to mount an effective response to curb this worldwide epidemic. Even these limited resources are often underutilized or used to support politically correct rather than programmatically and scientifically effective interventions. Table 1, adapted from

**TABLE 1**  
**RELATIVE USE OF RESOURCES BY STRATEGY**

STRATEGY	STATUS OF THE EPIDEMIC			
	Incipient epidemic	Rising epidemic	Established epidemic	Generalized epidemic
MONITORING OF EPIDEMIC THROUGH SENTINEL SURVEILLANCE	++++	++	+	+
INTERVENTIONS IN HIGH RISK GROUPS	+++	++++	++++	++++
EDUCATION OF ADOLESCENTS	+++	++++	++++	++++
INTERVENTIONS IN GENERAL POPULATION *	-/+	+	+++	++++
"SAFE" BLOOD **	+++	++++	++++	++++
VOLUNTARY TESTING AND COUNSELLING	-	+	++++	++++
CARE OF AIDS PATIENTS	-	+	++	+++

\* INTERVENTIONS (MARKETING OF CONDOMS, PEER EDUCATION AND COMMUNICATION, STD CONTROL, ETC.)

\*\* SAFE BLOOD (EDUCATION, SELF-EXCLUSION, SCREENING)

a background document prepared for the World Development Report 1993 of The World Bank, shows the relative effectiveness of the various interventions in relation to the stage of the epidemic in a given country. As an example, during the early stages of the epidemic, small core populations composed of individuals with high risk behaviors, (e.g., unprotected sex with multiple partners or exposure to contaminated needles, syringes, or infected blood), should be targeted, educated, and protected to prevent further spread of HIV within these core groups and to the general population. Commercial sex workers, their clients, and their regular partners as well as intravenous drug users and their spouses and children are examples of individuals belonging or related to these high-risk core groups.

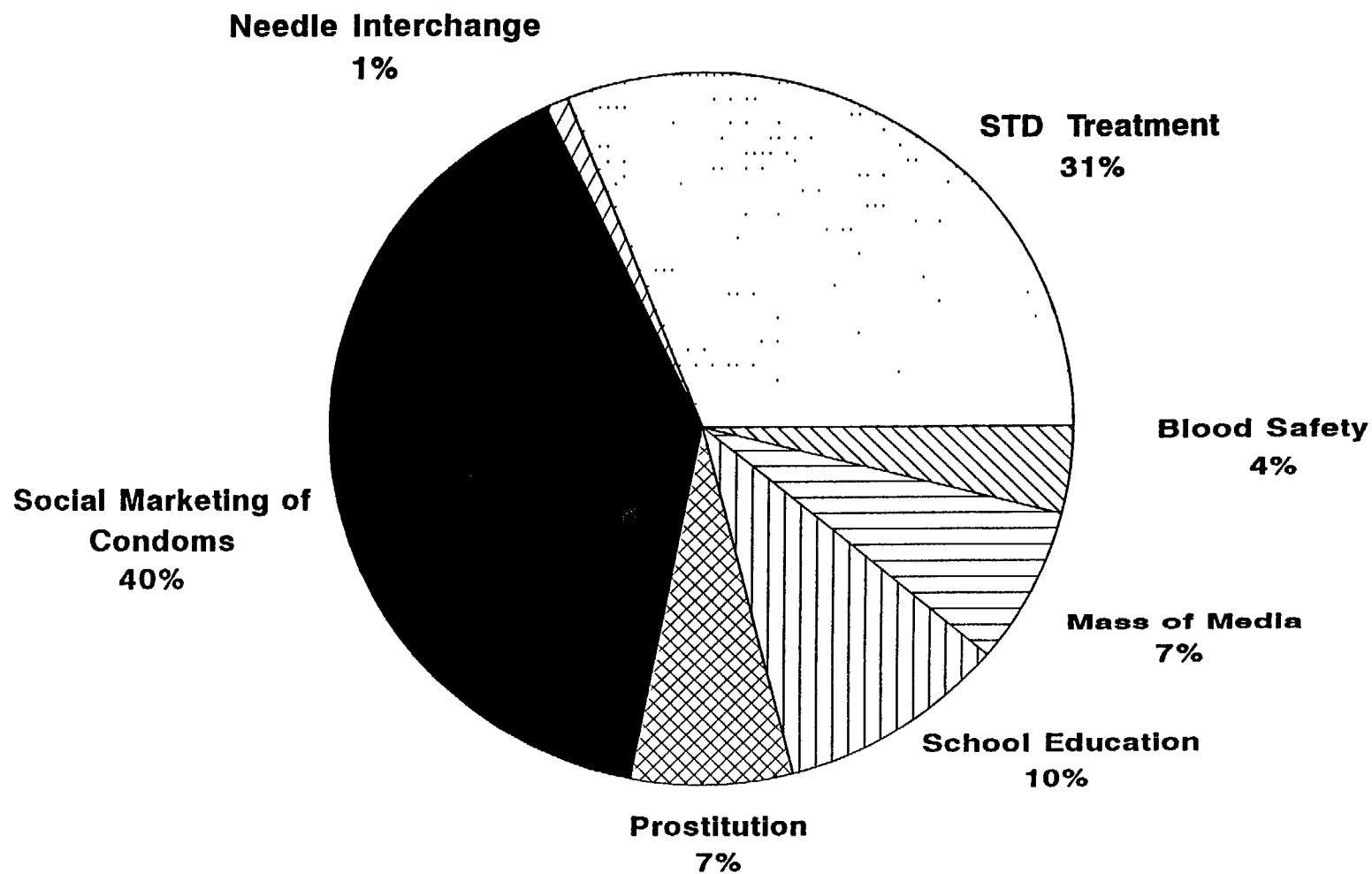
Logically, the interventions and educational messages directed to these individuals with frequent or continuous high risk behaviors will not be identical to those directed to the general population. Similarly, the scope, intensity, and contents of mass media campaigns and educational interventions will differ according to the stage of the epidemic and the need to be more explicit or more specific in delivering the most appropriate messages to the target populations. In other words, it is not only the right mix of interventions that is important but also the timing and intensity of such interventions in reaching the populations at risk at the most appropriate time. On the other hand, investments in AIDS programs should conform to the cost-effectiveness and feasibility of interventions. Section 3 of this document has addressed the state of the art regarding interventions that work in reducing the sexual, blood-borne, and perinatal transmission of HIV, as well as advances in the provision of care to HIV infected persons and AIDS patients. Clearly, despite the strong pressure to provide medical and social services to all HIV-infected individuals, national AIDS programs will need to concentrate efforts and devote a higher proportion of resources to the prevention of HIV transmission, especially among the youth.

Figure 2 shows the proportion of resources that could be devoted to the various interventions in order to have a comprehensive and technically sound program at the country level. The success of country AIDS prevention programs will depend on the establishment of a national capacity to develop, implement, and evaluate a specific mix of technically and culturally appropriate interventions. Evidently, the technical leadership for this national effort must rest within the ministries of health, but interprogrammatic, interagency, and intersectoral involvement and collaboration will be indispensable for the long-range success and sustainability of a truly national AIDS program. The NAP should be supported with national resources and must develop the capacity to:

- promote and coordinate effectively all external cooperation, which is complementary to the national effort;

**FIGURE 2. RELATIVE CONTRIBUTION OF VARIOUS STRATEGIES  
ON TOTAL COST ON HIV/STD PREVENTION.**

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- incorporate HIV/AIDS/STD related activities in the national health services system at the local level;
- utilize efficiently available resources and mobilize additional resources, both nationally and internationally.

Since AIDS is a global concern, interagency cooperation (multilateral and bilateral) is indispensable at the global, regional, and country levels to ensure effectiveness in the mobilization of resources and for efficient and effective promotion and execution of a worldwide program.

At its Ninety-third Session in January 1994, the Executive Board of the World Health Organization, taking into account Resolution WHA46.37, adopted by the Forty-sixth World Health Assembly in May 1993, recommended the development and eventual establishment of a joint and cosponsored United Nations program on HIV/AIDS, to be administered by WHO. The Executive Board also requested the Director-General to report on this resolution to the World Health Assembly in May 1994. Because of the implications of this UN program on the delivery of PAHO's technical cooperation for AIDS prevention in the Region of the Americas, the Subcommittee on Planning and Programming of the Executive Committee of PAHO addressed this issue at its 21st Meeting in December 1993. As a follow-up, the PAHO Secretariat has prepared a proposal to improve interagency coordination in the Region of the Americas (Annex II-A and B) which the Executive Committee is asked to consider and endorse, if acceptable.

Finally, a series of challenges must be faced at the country, global, and regional levels in order to halt the transmission of HIV and reduce the social and economic consequences of the HIV/AIDS epidemic.

*At the country level*, the challenge is for the national AIDS programs to adapt activities and interventions to the epidemiological situation and its continuing changes, and to seek opportunities to obtain resources and collaboration within and outside the health sector, as well as the necessary political and financial support for the long-term sustainability of the program.

*At the global level*, the greatest challenge is to recover WHO's credibility as an agency which is efficient and capable of maintaining its technical leadership in this area, while coordinating its actions with those of other agencies.

*At the regional level*, PAHO must face the following challenges: (1) adapting its technical cooperation to the epidemiological situation and the developmental stage of the national programs, with major emphasis on preventive activities; (2) supporting the national and international levels to obtain additional resources, especially in the areas of

medical care and social services for the ill and infected; (3) improving administrative efficiency and better coordinating the provision of interagency and interprogrammatic technical cooperation; and (4) supporting NAPs in the imminent and necessary process of intra- and intersectoral decentralization and integration within the next three years.

## Annexes



**ANNEX I**

**AIDS SURVEILLANCE IN THE AMERICAS**

**QUARTERLY REPORT  
10 March 1994**

CE113/16 (Eng.)  
ANNEX I

# **AIDS SURVEILLANCE IN THE AMERICAS**

## **QUARTERLY REPORT**

**10 March 1994**

### **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 March 1994**

### **Cumulative number of cases reported**

**worldwide: 860,945**

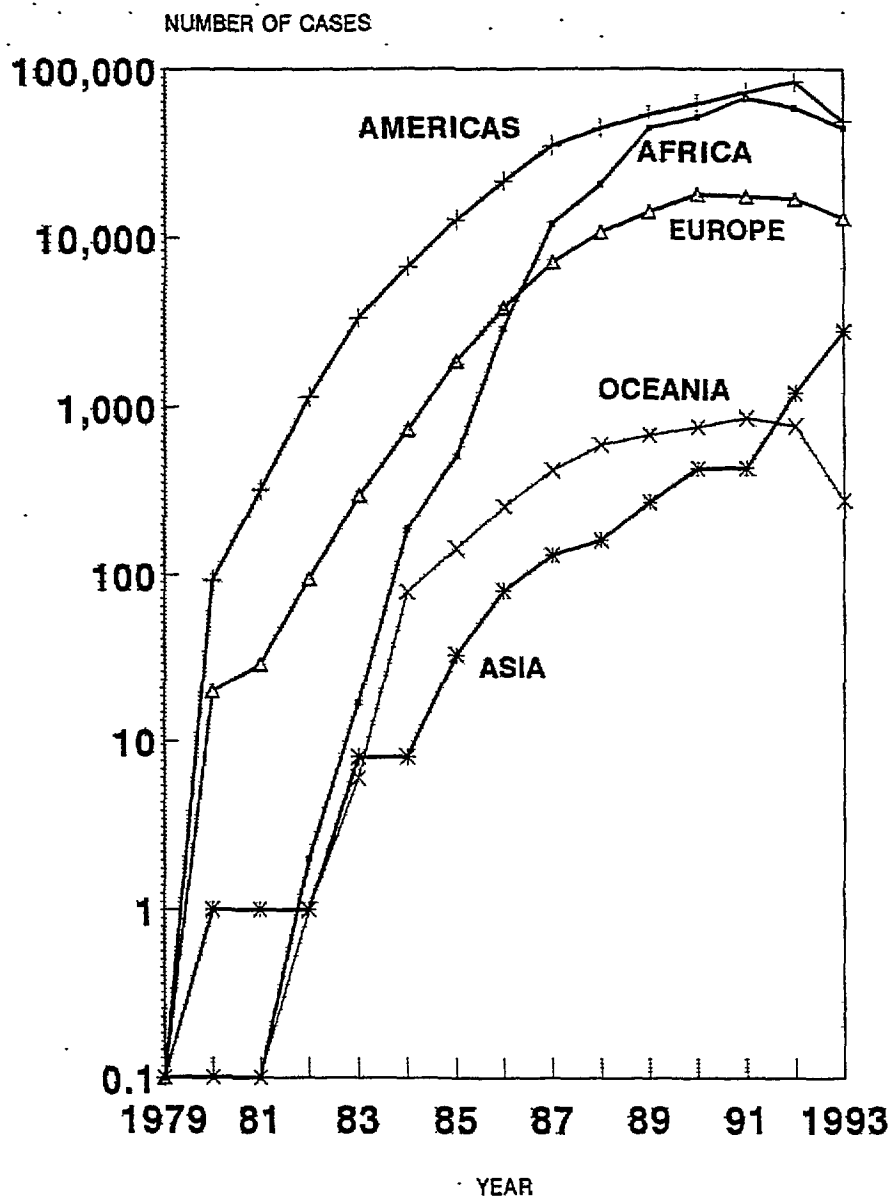
### **Cumulative number of cases reported**

**in the Americas: 445,295**

### **Cumulative number of deaths reported**

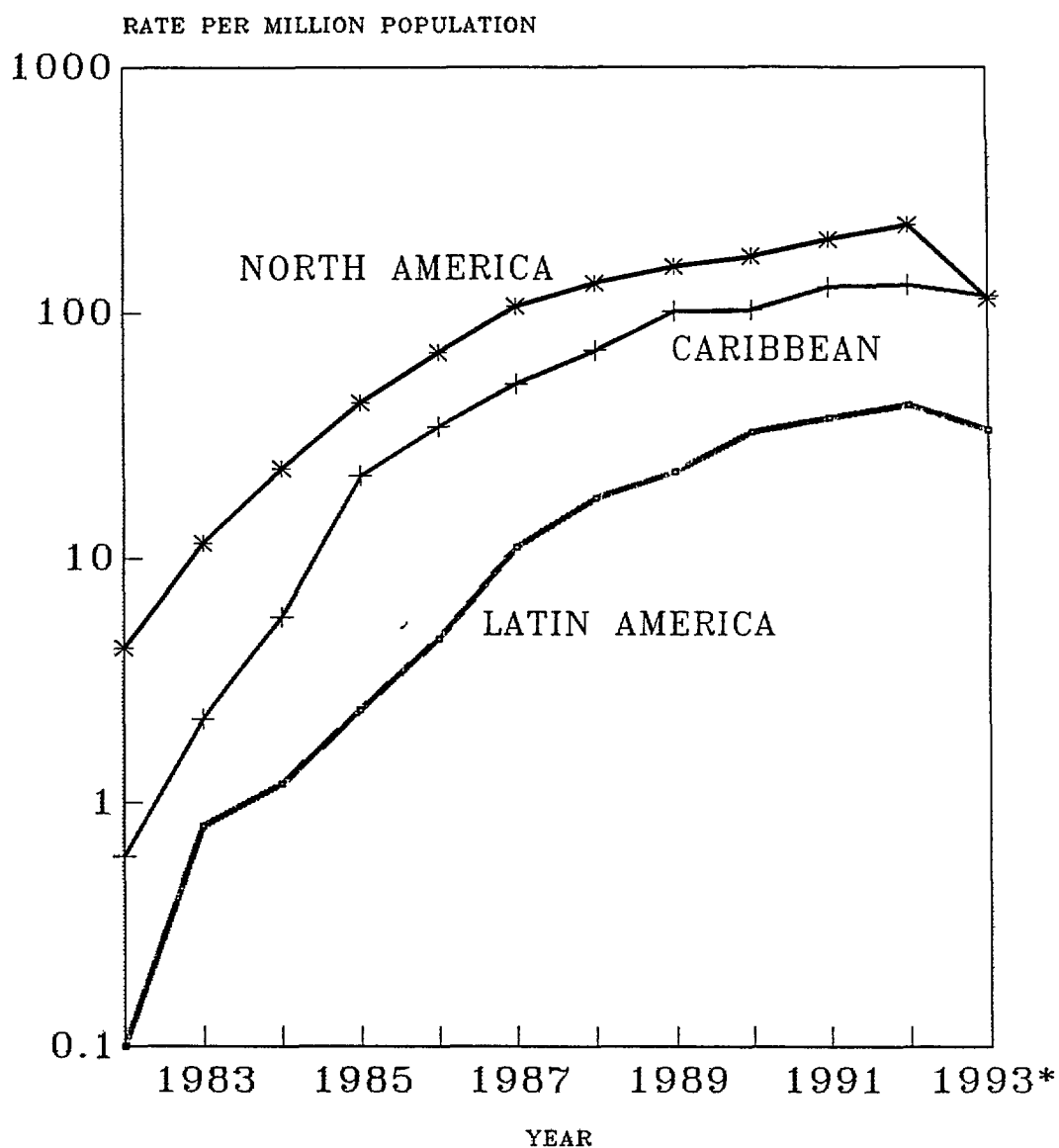
**in the Americas: 250,959**

FIG. 1. ANNUAL INCIDENCE OF AIDS CASES,  
BY REGION OF THE WHO, BY YEAR, 1979-93.\*



\* 1993 data incomplete due to delayed reporting.

Fig.2. ANNUAL INCIDENCE RATES OF AIDS IN THE AMERICAS,  
(PER MILLION), THREE MAJOR SUBREGIONS,  
1982-1993.\*



\* 1993 data incomplete due to delayed reporting

TABLE 1. NUMBER OF REPORTED CASES OF AIDS BY YEAR, AND CUMULATIVE CASES AND DEATHS, BY COUNTRY AND SUBREGION  
As of 10 March, 1994

SUBREGION	Number of Cases							Cumulative total (a)	Total deaths	Date of last report
	Through 1987	1988	1989	1990	1991	1992	1993			
<b>REGIONAL TOTAL</b>	<b>80,160</b>	<b>43,835</b>	<b>52,943</b>	<b>61,901</b>	<b>72,855</b>	<b>84,496</b>	<b>48,700</b>	<b>445,295</b>	<b>250,959</b>	
<b>LATIN AMERICA b)</b>	<b>7,839</b>	<b>7,372</b>	<b>9,892</b>	<b>14,344</b>	<b>16,773</b>	<b>19,413</b>	<b>15,305</b>	<b>81,144</b>	<b>36,501</b>	
<b>ANDEAN AREA</b>	<b>787</b>	<b>779</b>	<b>1,028</b>	<b>1,562</b>	<b>1,718</b>	<b>1,923</b>	<b>1,185</b>	<b>8,960</b>	<b>4,485</b>	
Bolivia	6	10	2	9	17	8	6	60	45	31/Mar/93
Colombia	368	338	453	771	857	921	519	4,227	1,963	31/Dec/93
Ecuador	36	32	27	44	55	66	49	309	213	30/Sep/93
Peru	65	69	120	186	159	246	214	1,039	369	31/Dec/93
Venezuela	292	330	424	572	630	682	395	3,325	1,895	31/Dec/93
<b>SOUTHERN CONE</b>	<b>246</b>	<b>267</b>	<b>353</b>	<b>604</b>	<b>757</b>	<b>1,024</b>	<b>509</b>	<b>4,098</b>	<b>1,727</b>	
Argentina	145	169	228	388	478	739	285	2,767	971	30/Jun/93
Chile	77	66	84	128	183	178	112	831	489	31/Dec/93
Paraguay	7	4	3	12	10	17	9	62	40	30/Sep/93
Uruguay	17	28	38	76	86	90	103	438	227	31/Dec/93
<b>BRAZIL</b>	<b>4,099</b>	<b>3,959</b>	<b>5,273</b>	<b>7,168</b>	<b>9,396</b>	<b>10,854</b>	<b>7,417 *</b>	<b>48,166</b>	<b>19,252</b>	<b>29/Jun/94</b>
<b>CENTRAL AMERICAN ISTHMUS</b>	<b>284</b>	<b>362</b>	<b>495</b>	<b>920</b>	<b>926</b>	<b>1,198</b>	<b>953</b>	<b>5,142</b>	<b>1,808</b>	
Belize	7	4	0	19	11	12	29	82	46	31/Dec/93
Costa Rica	46	52	57	86	91	125	109	566	352	31/Dec/93
El Salvador	23	34	72	54	132	114	85	514	128	30/Jun/93
Guatemala	31	18	31	92	96	94	97	459	171	30/Nov/93
Honduras	120	189	256	596	497	733	474	2,865	723	30/Jun/93
Nicaragua	0	2	2	7	13	6	17	51	36	30/Sep/93
Panama	57	63	77	66	86	114	142	605	352	31/Dec/93
<b>MEXICO</b>	<b>805</b>	<b>905</b>	<b>1,607</b>	<b>2,588</b>	<b>3,167</b>	<b>3,220</b>	<b>5,095</b>	<b>17,367</b>	<b>8,413</b>	<b>31/Dec/93</b>
<b>LATIN CARIBBEAN c)</b>	<b>1,638</b>	<b>1,100</b>	<b>938</b>	<b>1,502</b>	<b>809</b>	<b>1,194</b>	<b>208</b>	<b>7,391</b>	<b>816</b>	
Cuba	16	14	14	29	37	68	67	245	148	31/Dec/93
Dominican Republic	351	355	473	257	280	320	139	2,179	371	30/Sep/93
Haiti	1,271	731	451	1,216	492	806	..	4,967	297	31/Dec/92
<b>CARIBBEAN c)</b>	<b>912</b>	<b>505</b>	<b>738</b>	<b>757</b>	<b>902</b>	<b>931</b>	<b>650</b>	<b>5,596</b>	<b>3,719</b>	
Anguilla	0	1	2	1	1	0	0	5	3	30/Sep/93
Antigua	5	0	0	3	6	13	7	34	5	31/Dec/93
Bahamas	178	92	170	168	230	254	237	1,329	677	30/Sep/93
Barbados	56	15	40	61	80	78	88	418	323	31/Dec/93
Cayman Islands	3	1	1	2	4	4	0	15	12	31/Dec/93
Dominica	5	2	3	2	0	0	14	26	11	31/Dec/93
French Guiana	103	34	54	41	..	..	..	232	144	30/Sep/90
Grenada	6	3	8	5	7	4	21	56	39	31/Dec/93
Guadeloupe	82	48	55	53	67	48	0	353	216	31/Mar/93
Guyana	81	36	53	59	46	67	17	359	353	31/Mar/93
Jamaica	43	30	86	62	133	99	143	576	381	30/Sep/93
Martinique	47	30	47	44	30	42	26	266	184	30/Sep/93
Montserrat	0	0	1	0	0	0	1	2	0	31/Dec/93
Netherlands Antilles	18	13	16	30	23	10	47	157	79	30/Jun/93
Saint Kitts and Nevis	10	9	5	8	1	4	3	40	26	31/Dec/93
Saint Lucia	10	5	8	4	6	8	12	53	48	31/Dec/93
St. Vincent and the Grenadines	7	6	6	4	14	7	10	56	41	31/Dec/93
Suriname	15	13	29	33	16	28	35	169	150	31/Dec/93
Trinidad and Tobago	236	158	187	174	235	260	174	1,404	998	30/Sep/93
Turks and Caicos Islands	5	6	7	1	2	4	14	39	30	30/Sep/93
Virgin Islands (UK)	0	1	0	2	1	1	1	6	1	30/Sep/93
<b>NORTH AMERICA</b>	<b>71,409</b>	<b>65,958</b>	<b>42,513</b>	<b>48,800</b>	<b>55,180</b>	<b>64,151</b>	<b>32,545</b>	<b>348,556</b>	<b>210,739</b>	
Bermuda	72	28	35	33	23	17	15	223	162	30/Jun/93
Canada	2,126	1,073	1,263	1,276	1,296	1,330	719	9,083	6,187	31/Dec/93
United States of America c)	69,211	34,857	41,215	45,491	53,861	62,804	31,811	339,250	204,390	30/Sep/93

\* Includes cases diagnosed in January 1994  
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,  
1988-1993

SUBREGION Country	RATE PER MILLION					
	1988	1989	1990	1991	1992	1993*
<b>LATIN AMERICA a)</b>	17.6	22.6	32.8	37.6	42.7	33.6
<b>ANDEAN AREA</b>	8.9	11.4	17.0	18.2	20.1	12.0
Bolivia	1.4	0.3	1.2	2.3	1.0	1.0
Colombia	11.1	14.5	24.2	25.5	26.9	14.9
Ecuador	3.1	2.6	4.1	5.1	5.9	4.3
Peru	3.2	5.5	7.4	7.2	11.0	9.3
Venezuela	17.6	22.0	29.0	31.1	33.7	18.6
<b>SOUTHERN CONE</b>	5.2	6.8	11.4	14.1	18.8	9.2
Argentina	5.4	7.1	12.0	14.6	22.3	8.5
Chile	5.2	6.5	9.7	13.7	13.1	8.1
Paraguay	1.0	0.7	2.8	2.3	3.8	1.9
Uruguay	9.1	12.2	24.3	27.5	28.8	32.7
<b>BRAZIL</b>	27.4	35.8	47.7	61.3	69.5	46.6
<b>CENTRAL AMERICAN ISTHMUS</b>	13.2	17.5	31.6	31.0	39.0	30.2
Belize	23.0	0	104.4	60.4	64.5	155.9
Costa Rica	18.1	19.4	28.5	29.5	39.5	33.7
El Salvador	6.8	14.0	10.3	24.6	20.7	15.0
Guatemala	2.1	3.5	10.0	10.1	9.6	9.7
Honduras	39.1	51.4	116.0	93.8	134.2	84.2
Nicaragua	0.6	0.5	1.8	3.3	1.5	4.0
Panama	27.1	32.5	27.3	34.9	45.3	55.4
<b>MEXICO</b>	10.7	18.5	29.2	35.0	34.9	54.1
<b>LATIN CARIBBEAN b)</b>	47.2	39.7	62.6	32.8	47.6	11.1
Cuba	1.4	1.4	2.8	3.5	6.3	6.1
Dominican Republic	51.7	67.4	35.8	38.2	42.8	18.2
Haiti	116.7	70.7	186.9	74.0	118.8	
<b>CARIBBEAN a)</b>	70.6	101.7	102.9	128.1	130.6	118.1
Anguilla	142.2	284.5	142.9	142.9	0	0
Antigua	0	0	34.9	69.8	168.8	90.9
Bahamas	363.6	661.5	646.2	884.6	969.5	904.6
Barbados	58.4	154.6	233.7	313.7	304.7	342.4
Cayman Islands	47.5	47.6	95.2	190.5	148.1	0
Dominica	25.3	37.5	24.7	0	0	168.7
French Guiana	386.3	600.7	445.7			
Grenada	30.0	79.2	48.5	68.0	42.4	222.8
Guadeloupe	142.0	162.2	155.4	194.2	138.3	0
Guyana	35.8	51.8	56.7	57.5	83.2	21.0
Jamaica	12.3	26.6	24.6	53.5	39.4	56.2
Martinique	90.9	142.2	133.0	87.5	121.7	74.9
Montserrat	0	76.7	0	0	0	76.9
Netherlands Antilles	69.1	83.7	155.4	119.2	51.8	243.5
Saint Kitts and Nevis	187.5	103.1	160.0	20.0	90.1	67.6
Saint Lucia	37.6	59.3	29.4	44.1	50.7	76.0
St. Vincent and the Grenadines	74.1	55.0	36.0	126.1	58.4	83.5
Suriname	33.2	72.9	81.9	37.3	64.1	78.7
Trinidad and Tobago	127.1	132.2	135.6	180.6	197.1	130.0
Turks and Caicos Islands	750.9	876.1	111.1	222.2	400.0	1400.0
Virgin Islands (UK)	76.7	0	153.4	76.7	76.9	76.9
<b>NORTH AMERICA</b>	132.2	154.9	169.7	199.1	229.2	115.4
Bermuda	490.8	601.4	569.0	396.6	293.1	258.6
Canada	41.1	48.0	48.1	48.5	49.4	26.5
United States of America b)	141.8	166.1	182.5	215.2	248.3	124.9

\* Data incomplete due to delayed reporting

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

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

TABLE 3. ANNUAL INCIDENCE RATES OF AIDS (PER MILLION POPULATION), BY SEX, BY COUNTRY AND BY YEAR, 1988-1993

SUBREGION	RATE PER MILLION POPULATION											
	MALE RATES						FEMALE RATES					
	1988	1989	1990	1991	1992	1993*	1988	1989	1990	1991	1992	1993*
COUNTRY												
LATIN AMERICA a)	29.3	37.8	53.8	61.5	66.6	52.8	5.4	6.7	10.9	12.1	15.2	11.9
ANDEAN AREA	15.2	19.4	29.3	27.1	23.2	13.2	1.1	1.8	2.4	2.0	2.3	1.5
Bolivia	2.9	0	1.9	4.3	1.8	1.8	0	0.6	0	0	1.0	0.2
Colombia	17.7	23.5	40.8	30.9	23.7	21.1	1.6	2.3	3.2	1.8	1.7	1.9
Ecuador	6.0	4.5	7.0	9.0	10.7	7.3	0.2	0.6	1.1	1.1	1.1	1.2
Peru	5.8	9.9	13.6	13.6	19.8	16.3	0.7	0.8	1.2	0.8	2.0	2.3
Venezuela	31.0	38.5	50.5	53.6	40.3	4.5	1.9	3.0	4.2	4.8	4.6	0.8
SOUTHERN CONE	9.7	12.4	20.8	26.1	30.8	13.2	0.7	1.1	2.1	2.2	6.5	2.9
Argentina	10.4	12.9	21.6	26.8	35.7	13.6	0.4	1.2	2.4	2.5	8.9	3.5
Chile	9.2	12.2	19.1	26.2	22.3	11.0	1.2	0.8	0.9	1.5	2.3	1.0
Paraguay	2.0	1.4	4.6	4.5	7.0	1.7	0	0	0.9	0	0.4	0.9
Uruguay	15.8	22.3	42.9	50.8	51.1	35.8	2.6	2.5	6.3	5.6	7.5	7.4
BRAZIL	48.1	63.1	83.6	103.5	113.9	74.2	6.9	8.6	11.8	19.3	25.3	19.1
CENTRAL AMERICAN ISTHMUS	17.5	21.7	40.6	45.3	57.5	43.7	6.2	8.1	17.0	15.2	18.4	15.2
Belize	23.0						11.5					
Costa Rica	33.2	32.3	45.2	51.9	68.2	49.0	2.8	4.8	5.4	2.6	5.1	1.9
El Salvador				36.8	31.1	24.9				12.4	7.8	5.6
Guatemala	3.6	5.8	16.6	16.5	18.7	25.1	0.5	1.4	3.3	3.6	2.5	6.0
Honduras	50.4	66.4	148.1	129.8	185.8	105.7	27.8	36.2	83.3	57.1	81.6	62.4
Nicaragua	1.1	1.1	3.1	4.5	2.4	6.1	0	0	0.5	0.5	0	0.9
Panama	43.9	55.4	45.5	52.6	74.3	79.1	9.7	8.6	8.4	16.5	14.6	11.1
MEXICO	18.4	31.4	49.1	59.3	59.3	92.4	2.9	5.7	9.4	10.8	10.5	16.0
LATIN CARIBBEAN b)	63.8	49.1	66.7	36.1	55.2	11.7	31.1	29.0	55.4	28.3	35.0	4.8
Cuba	3.9	0.2	0.8	4.3	5.9	7.5	0.8	0.2	0	1.3	2.4	2.8
Dominican Republic	72.3	87.5	46.9	49.2	55.3	17.6	29.9	45.9	21.3	24.7	19.1	7.7
Haiti	154.4	87.1	197.6	73.6	135.4		80.0	55.4	176.6	74.5	102.8	
CARIBBEAN a)	96.1	135.7	124.6	163.1	170.0	222.2	42.0	63.8	60.7	80.4	80.6	96.7
Anguilla	0		0	0	0	0	281.7		284.1	281.7	0	0
Antigua	0	0			264.2	158.5	0	0			76.6	25.5
Bahamas	432.0	732.9	794.5	1147.4	1222.7	1106.6	296.8	591.9	501.5	642.4	723.0	707.9
Barbados	73.9	244.5	409.6	520.3	471.5	487.8	44.4	73.5	73.2	105.3	150.4	223.9
Cayman Islands	0	96.2	192.3	155.6	150.2	0	93.9	0	0	151.6	146.2	0
Dominica	49.9	49.3	48.7				0	25.4	0			
French Guiana	545.0	735.0					204.6	466.7				
Grenada	20.2	100.3	78.7	62.4	20.7	351.9	39.5	0	19.2	87.4	0	65.3
Guadeloupe	217.6	253.1	222.9	285.7	200.0	1508.8	69.5	75.1	91.4	107.3	78.7	530.7
Guyana	55.5	70.2	65.2	78.3	103.0	22.4	16.0	33.3	48.2	37.1	64.0	19.5
Jamaica	18.2	38.2	32.6	59.1	52.8	72.6	6.5	15.2	16.6	48.0	25.3	39.9
Martinique	137.2	230.1	191.4	120.5	95.8	202.4	47.2	82.4	82.9	33.9	50.6	39.1
Montserrat	0		0	0	0	0	0		0	0	0	177.6
Netherlands Antilles	10.9						20.8					
Saint Kitts and Nevis	381.0	126.6	248.1	46.8	140.4	46.8	0	80.6	77.5	0	43.4	86.8
Saint Lucia	46.6	107.4	30.4	66.6	52.3	78.4	29.2	14.3	28.4	12.5	49.1	73.7
St. Vincent and the Grenadines	57.2	37.7	55.6	122.2	103.3	120.5	72.0	89.3	17.5	98.4	16.2	48.6
Suriname	46.5	106.9	120.0	56.3	87.6	113.1	20.1	39.7	44.3	18.5	40.9	44.6
Trinidad and Tobago	182.3	193.7	180.1	248.8	280.5	204.5	72.2	71.1	91.5	113.1	114.6	56.5
Turks and Caicos Islands	1012.7	1519.0	0	404.9	809.7	1417.0	495.0	247.5	219.5	0	0	1378.0
Virgin Islands (UK)		0	144.0	155.0	155.0	0		0	14.2	0	151.7	0
NORTH AMERICA	223.9	242.7	291.9	299.9	305.1	50.6	25.8	28.6	37.7	43.1	47.0	3.9
Bermuda	850.2	975.6	489.5	664.3	419.6	419.6	138.8	237.3	238.1	136.1	170.1	102.0
Canada	78.7	91.4	93.1	92.2	93.6	49.8	4.2	5.3	4.0	5.6	6.0	3.6
United States of America b)	239.4	258.9	313.4	322.3	327.9		28.1	31.0	41.2	47.1	51.3	

\* Data incomplete due to delayed reporting

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, 1988-1993

SUBREGION	MALE:FEMALE RATIO					
	1988	1989	1990	1991	1992	1993
<b>LATIN AMERICA a)</b>	<b>5.4</b>	<b>5.6</b>	<b>4.9</b>	<b>5.1</b>	<b>4.4</b>	<b>4.4</b>
<b>ANDEAN AREA</b>	13.4	11.1	12.3	13.6	10.2	8.7
Bolivia	N/A	0	N/A	N/A	1.8	7.0
Colombia	11.3	10.2	13.0	16.6	13.4	11.1
Ecuador	31.0	8.0	6.3	8.2	10.0	6.0
Peru	8.9	12.1	11.8	16.7	10.2	7.2
Venezuela	16.3	12.9	12.3	11.4	9.0	6.0
<b>SOUTHERN CONE</b>	13.1	11.0	9.6	11.6	4.7	4.4
Argentina	23.1	10.3	8.9	10.6	3.9	3.8
Chile	7.3	15.6	20.7	17.3	9.4	10.7
Paraguay	N/A	N/A	5.0	N/A	16.0	2.0
Uruguay	6.0	8.5	6.6	8.6	6.5	4.6
<b>BRAZIL</b>	6.9	7.3	7.1	5.3	4.5	3.9
<b>CENTRAL AMERICAN ISTHMUS</b>	2.8	2.7	2.4	3.0	3.2	2.9
Belize	2.0	..	..	..	..	..
Costa Rica	12.0	6.9	8.6	20.3	13.6	26.7
El Salvador	..	..	..	2.9	3.8	4.3
Guatemala	8.0	4.3	5.1	4.6	6.8	4.2
Honduras	1.8	1.8	1.8	2.3	2.3	1.7
Nicaragua	N/A	N/A	6.0	9.0	N/A	6.5
Panama	4.7	6.7	5.6	3.3	5.3	7.4
<b>MEXICO</b>	6.4	5.6	5.2	5.5	5.6	5.8
<b>LATIN CARIBBEAN b)</b>	2.1	1.7	1.2	1.3	1.6	2.5
Cuba	5.0	1.0	N/A	3.3	2.5	2.7
Dominican Republic	2.5	1.9	2.3	2.1	3.0	2.3
Haiti	1.9	1.5	1.1	1.0	1.3	..
<b>CARIBBEAN a)</b>	<b>2.2</b>	<b>2.1</b>	<b>2.0</b>	<b>2.0</b>	<b>2.1</b>	<b>2.3</b>
Anguilla	0	..	0	0	N/A	N/A
Antigua	N/A	N/A	..	..	3.3	6.0
Bahamas	1.4	1.2	1.5	1.7	1.6	1.5
Barbados	1.5	3.0	5.1	4.6	2.9	2.0
Cayman Islands	0	N/A	N/A	1.0	1.0	N/A
Dominica	N/A	2.0	N/A	..	..	..
French Guiana	2.7	1.6	..	..	..	..
Grenada	0.5	N/A	4.0	0.8	N/A	5.7
Guadeloupe	3.0	3.2	2.3	2.5	2.4	2.7
Guyana	3.5	2.1	1.4	2.1	1.6	1.1
Jamaica	2.8	2.5	2.0	1.2	2.1	1.8
Martinique	2.8	2.6	2.2	3.3	1.8	4.9
Montserrat	N/A	..	N/A	N/A	N/A	0
Netherlands Antilles	0.5	..	..	..	..	..
Saint Kitts and Nevis	N/A	1.5	3.0	N/A	3.0	0.5
Saint Lucia	1.5	7.0	1.0	5.0	1.0	1.0
Saint Vincent and the Grenadines	0.8	0.4	3.0	1.2	6.0	2.3
Suriname	2.3	2.6	2.7	3.0	2.1	2.5
Trinidad and Tobago	2.5	2.7	1.9	2.2	2.4	3.6
Turks and Caicos Islands	2.0	6.0	0	N/A	N/A	1.0
Virgin Islands (UK)	..	N/A	1.0	N/A	1.0	N/A
<b>NORTH AMERICA</b>	<b>8.2</b>	<b>8.1</b>	<b>7.4</b>	<b>6.6</b>	<b>6.2</b>	<b>12.8</b>
Bermuda	6.0	4.0	2.0	4.8	2.4	4.0
Canada	18.5	16.8	22.6	16.3	15.4	13.4
United States of America b)	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.

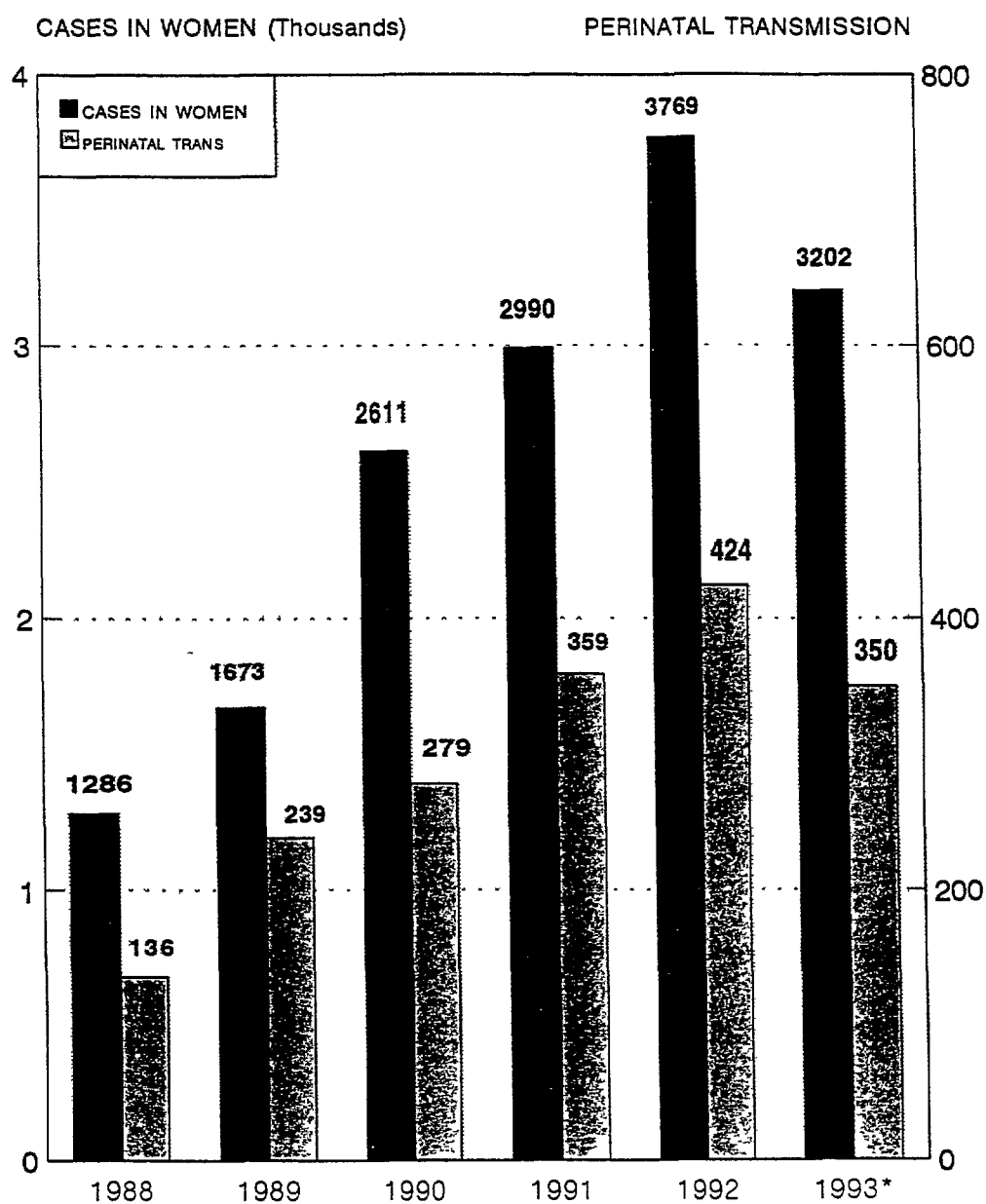
**TABLE 5. TOTAL CASES, PEDIATRIC CASES, PERCENT OF PEDIATRIC CASES FROM TOTAL; PERINATAL CASES, AND PERCENT OF PERINATAL CASES FROM PEDIATRIC, BY SUBREGION AND COUNTRY(a), THROUGH MARCH 1994.**

Country	TOTAL CASES	PEDIATRIC CASES	PERCENT PEDIATRIC	PERINATAL CASES	PERCENT PERINATAL
<b>ANDEAN AREA</b>					
Bolivia	60	1	1.7	1	100.0
Colombia	4,227	69	1.6	55	79.7
Ecuador	309	4	1.3	3	75.0
Peru	1,039	22	2.1	11	50.0
Venezuela	3,325	53	1.6	24	45.3
<b>SOUTHERN CONE</b>					
Argentina	2,767	77	2.8	56	72.7
Chile	831	16	1.9	13	81.3
Uruguay	438	16	3.7	14	87.5
<b>BRAZIL</b>	<b>48,166</b>	<b>1,494</b>	<b>3.1</b>	<b>927</b>	<b>62.0</b>
<b>CENTRAL AMERICAN ISTHMUS</b>					
Costa Rica	566	18	3.2	8	44.4
El Salvador	514	8	1.6	5	62.5
Guatemala	459	13	2.8	4	30.8
Honduras	2,865	119	4.2	107	89.9
Panama	605	20	3.3	16	80.0
<b>MEXICO</b>	<b>17,387</b>	<b>524</b>	<b>3.0</b>	<b>245</b>	<b>46.8</b>
<b>LATIN CARIBBEAN</b>					
Cuba	245	1	0.4	1	100.0
Dominican Republic	2,179	49	2.2	26	53.1
Haiti	4,967	213	4.3	16*	7.5
<b>CARIBBEAN</b>					
Antigua	34	6	17.6	6	100.0
Bahamas	1,329	129	9.7	129	100.0
Barbados	418	19	4.5	18	94.7
Dominica	26	1	3.8	1	100.0
French Guiana	232	17	7.3	16	94.1
Grenada	56	2	3.6	2	100.0
Guadeloupe	353	16	4.5	14	87.5
Guyana	359	44	12.3	40	90.9
Jamaica	576	51	8.9	43	84.3
Martinique	266	12	4.5	10	83.3
Netherlands Antilles	157	1	0.6	1	100.0
Saint Kitts and Nevis	40	1	2.5	1	100.0
Saint Lucia	53	4	7.5	4	100.0
Saint Vincent and the Grenadines	56	1	1.8	1	100.0
Suriname	169	4	2.4	4	100.0
Trinidad and Tobago	1,404	109	7.8	105	96.3
Virgin Islands (UK)	6	1	16.7	1	100.0
<b>NORTH AMERICA</b>					
Canada	9,083	93	1.0	71	76.3
United States of America	339,250	4,906	1.4	4,328	88.2

\* Number of perinatal cases dated as of 31/12/90

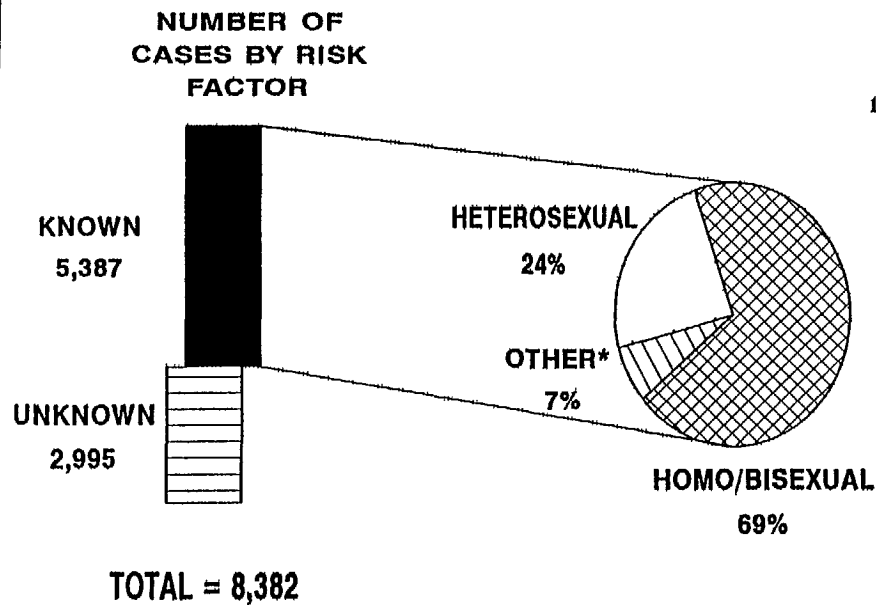
(a) Does not include countries which have not reported AIDS cases in children

**Fig.3. NUMBER OF REPORTED AIDS CASES IN WOMEN,  
AND CASES OF PERINATAL TRANSMISSION,  
LATIN AMERICA AND THE CARIBBEAN 1988-1993.\***

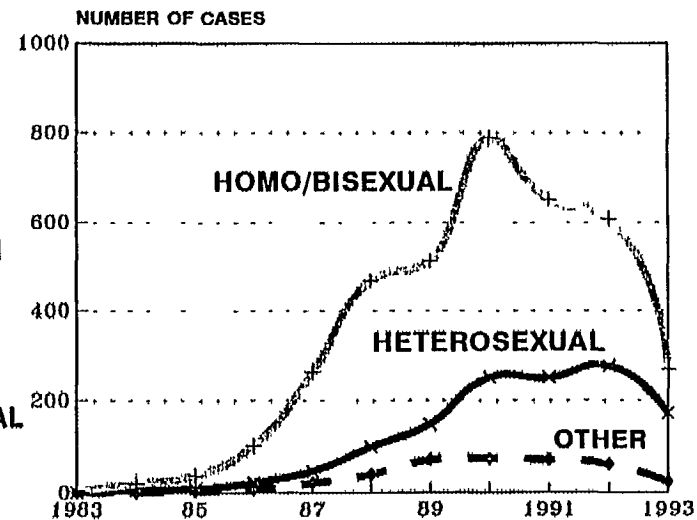


\* 1993 DATA INCOMPLETE DUE TO DELAYED REPORTING.

**FIG. 4a. PERCENT DISTRIBUTION OF AIDS CASES BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994 AND ANNUAL INCIDENCE OF AIDS CASES, 1983-1993, ANDEAN AREA.**



**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994.**

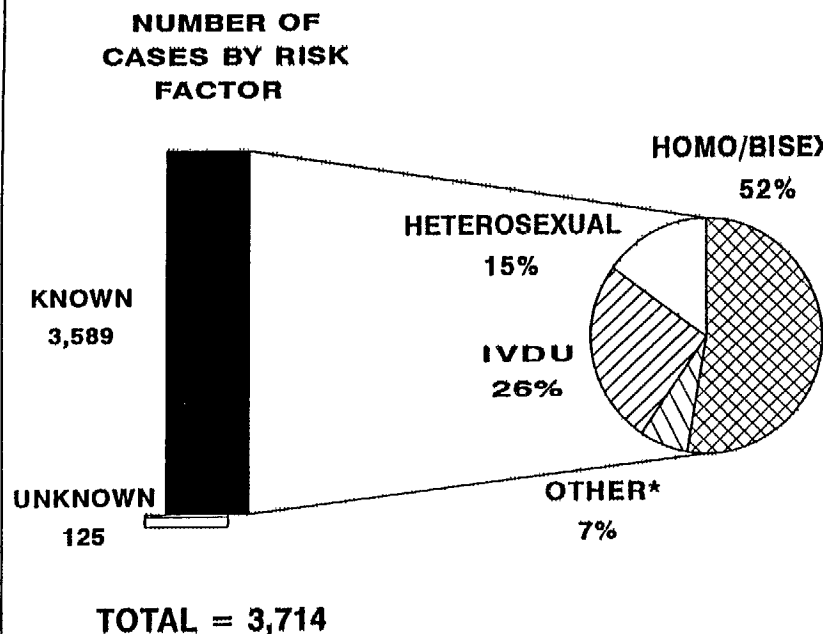


**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1983-1993.\*\***

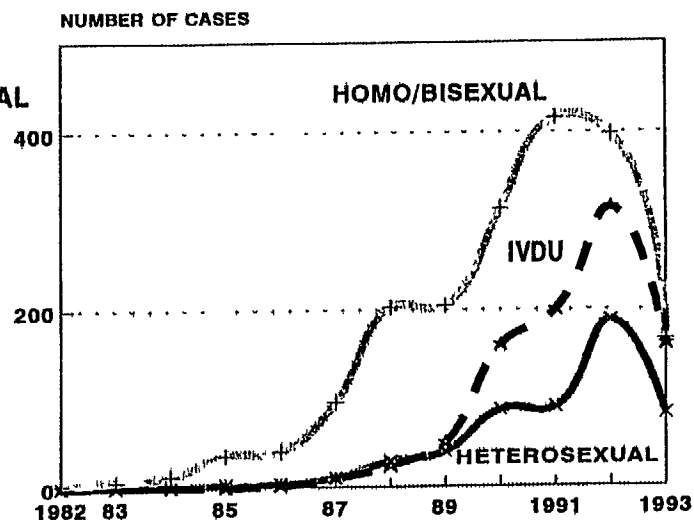
\* INCLUDES 3.1% BLOOD, <1% IVDU, 1.75% PERINATAL, AND 1.27% OF OTHER KNOWN RISK FACTORS.

\*\* 1993 DATA INCOMPLETE DUE TO DELAYED REPORTING.

**FIG. 4b. PERCENT DISTRIBUTION OF AIDS CASES BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994 AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1993, SOUTHERN CONE.**



**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994.**

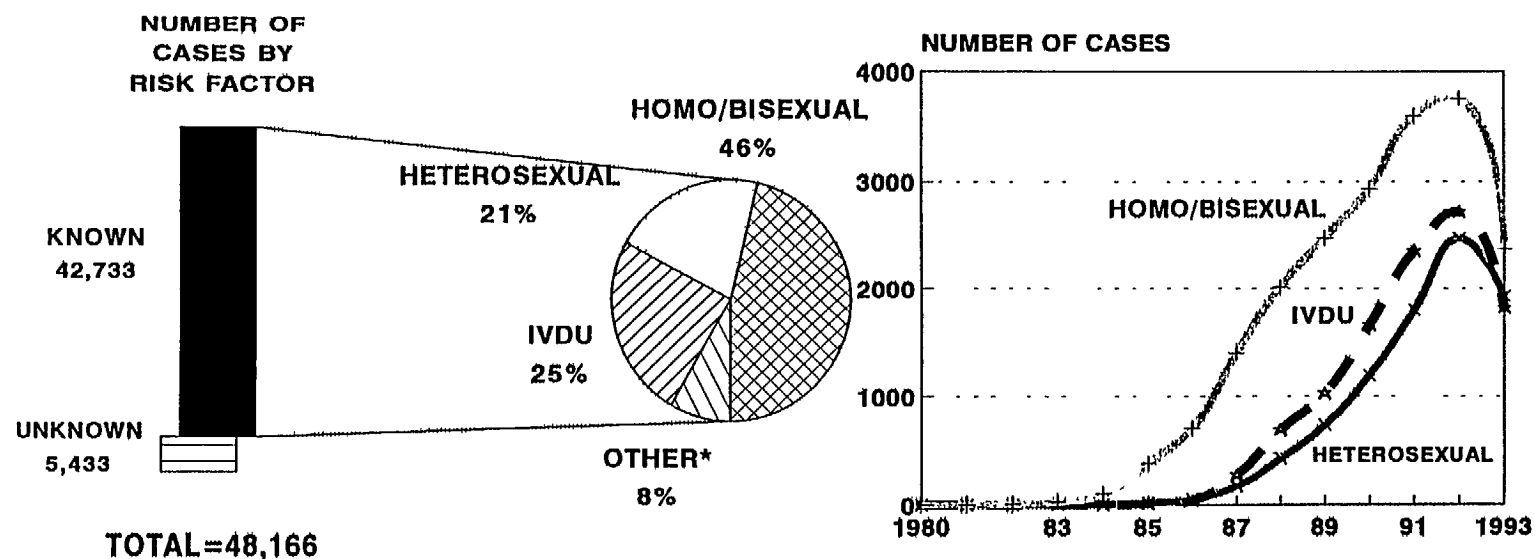


**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1993.\*\***

\* INCLUDES 3.6% BLOOD, 2.4% PERINATAL AND 1% OF OTHER KNOWN RISK FACTORS.

\*\* 1993 DATA INCOMPLETE DUE TO DELAYED REPORTING.

**FIG. 4c. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994 AND ANNUAL INCIDENCE OF AIDS CASES, 1980-1993, BRAZIL.**



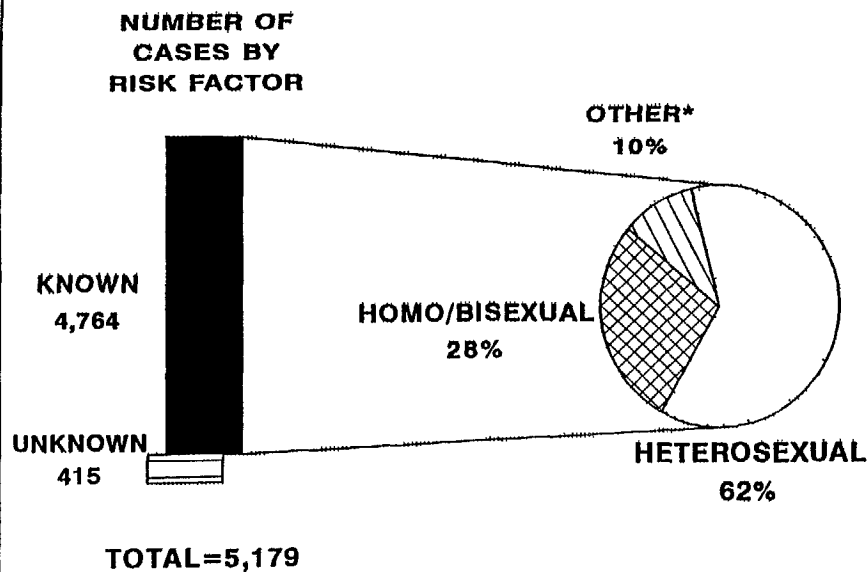
PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994.

ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1980-1993.\*\*

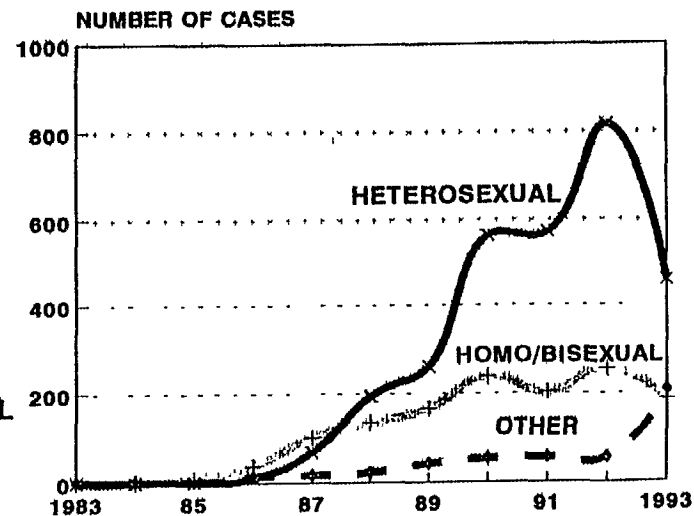
\* INCLUDES 6% BLOOD AND 2% PERINATAL OF OTHER KNOWN RISK FACTORS.

\*\* 1993 DATA INCOMPLETE DUE TO DELAYED REPORTING.

**FIG. 4d. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994 AND ANNUAL INCIDENCE OF AIDS CASES, 1983-1993, CENTRAL AMERICAN ISTHMUS.**



**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994.**

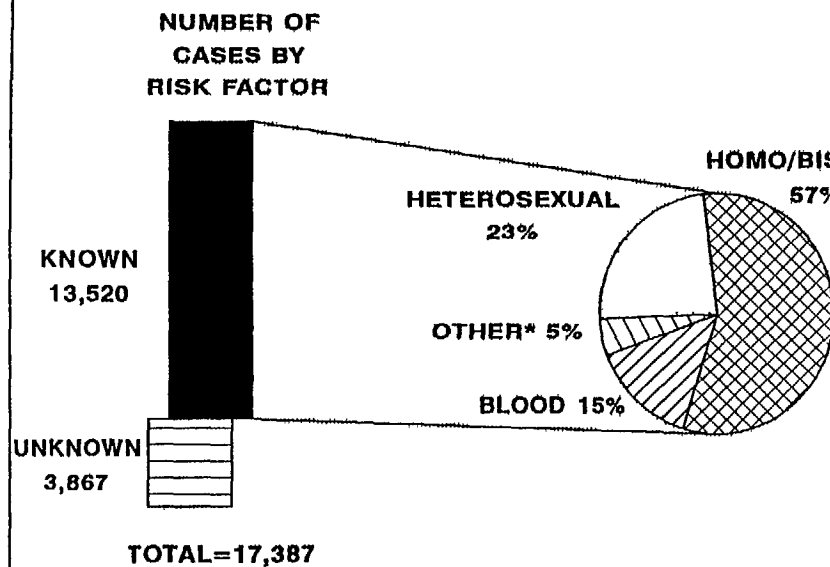


**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1983-1993.\*\***

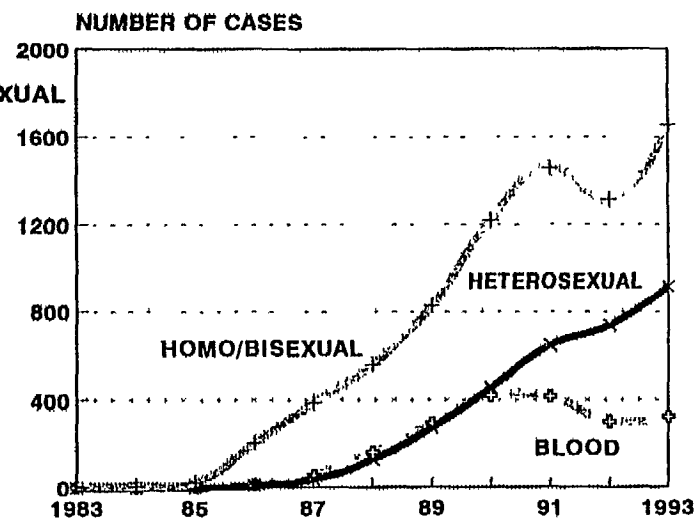
\* INCLUDES 2.6% BLOOD, 1% IVDU, 3% PERINATAL AND 3.4% OF OTHER KNOWN RISK FACTORS.

\*\* 1993 DATA INCOMPLETE DUE TO DELAYED REPORTING.

**FIG. 4e. PERCENT DISTRIBUTION OF AIDS CASES BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994 AND ANNUAL INCIDENCE OF AIDS CASES, 1983-1993, MEXICO.**



**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994.**



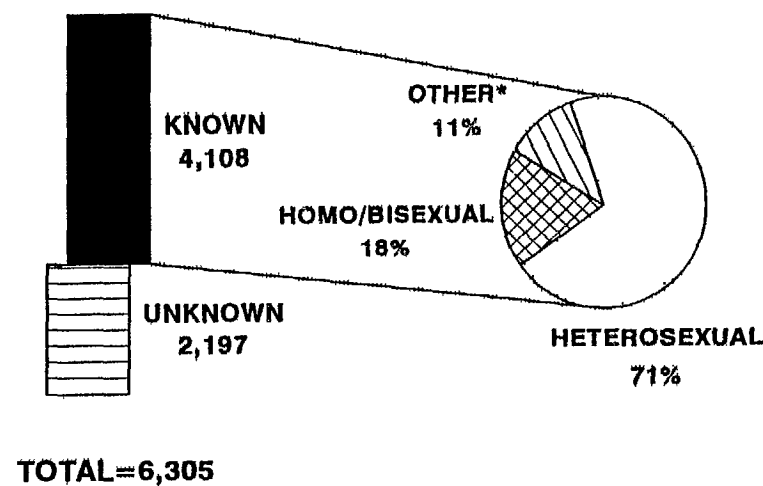
**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1983-1993.**

\* INCLUDES <1% IVDU, 1.8% PERINATAL AND 2.4% OF OTHER KNOWN RISK FACTORS.



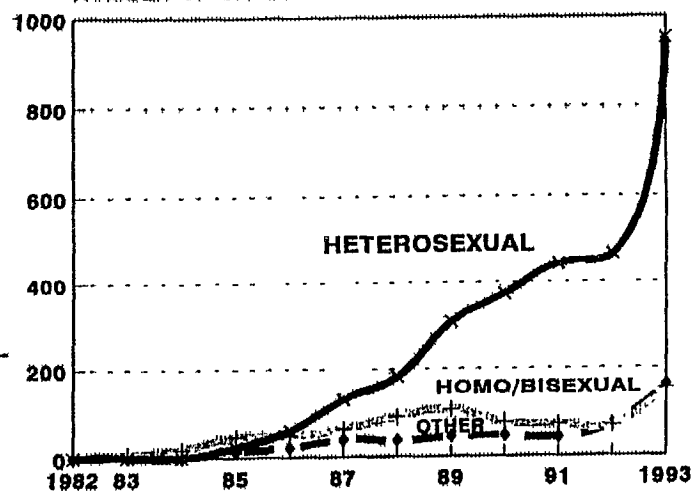
**FIG. 4f. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH MARCH 1994 AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1993, CARIBBEAN.**

NUMBER OF  
CASES BY  
RISK FACTOR



PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR,  
CUMULATIVE THROUGH MARCH 1994.

NUMBER OF CASES



ANNUAL INCIDENCE OF AIDS CASES, BY  
SELECTED RISK FACTORS, 1982-1993.\*\*

\* INCLUDES 1% BLOOD, 0.9% IVDU, 9% PERINATAL AND < 1% OF OTHER KNOWN RISK FACTORS.

\*\* 1993 DATA INCOMPLETE DUE TO DELAYED REPORTING.

**ANNEX II-A**

**ESTABLISHMENT OF A JOINT AND COSPONSORED  
UNITED NATIONS PROGRAM ON HIV/AIDS**

**A Proposal for the Region of the Americas  
from the Pan American Health Organization**

**ESTABLISHMENT OF A JOINT AND COSPONSORED  
UNITED NATIONS PROGRAM ON HIV/AIDS**

**A Proposal for the Region of the Americas  
from the Pan American Health Organization**

**1. Background**

The Pan American Health Organization grew out of the First General International Sanitary Convention of the American Republics, which was held in Washington, D.C., on 2-5 December 1902 and which formed the International Sanitary Bureau, with headquarters in Washington, D.C. In 1923, this entity became the Pan American Sanitary Bureau (PASB) and functioned as the secretariat for the Pan American Sanitary Organization (PASO) and effectively as the health bureau of the Organization of American States, out of whose building it operated for several decades. In 1949, PASO also became the Regional Office for the Americas, by formal agreement with the World Health Organization, while continuing its former status as the international health organization for the Americas. Also in 1949, PASO and the Organization of American States (OAS) signed an agreement establishing the former as a specialized inter-American organization, and in 1951, the Directing Council of PASO approved regular contributions by Member States. (PASO had until then depended on irregular voluntary contributions from its Member Governments.) In 1958, PASO was renamed the Pan American Health Organization (PAHO). (PASB remains the secretariat for PAHO.)

According to its Constitution, which is based on the Pan American Sanitary Code signed in 1924, "The fundamental purposes of the Pan American Health Organization...shall be to promote and coordinate efforts of the countries of the Western Hemisphere to combat disease, lengthen life, and promote the physical and mental health of the people." (Article 1)

According to Article 3 of the agreement between WHO and PAHO, "The Pan American Sanitary Conference may adopt and promote health and sanitary conventions and programmes in the Western Hemisphere, provided that such conventions and programmes are compatible with the policy and programmes of the World Health Organization and are separately financed."

PAHO receives approximately 50% of its total funding from extrabudgetary sources, that is donor countries, international development agencies, financial institutions, foundations and corporations. Of its regular budget, approximately 70% is provided by quota contributions from Member States in the Americas and 30% by WHO.

## **2. Basis for an HIV/AIDS Program in the Region**

AIDS is fundamentally a health problem with important implications for several other sectors. The response to the problem requires participation of other sectors, with intersectoral cooperation and coordination under the strong leadership of the health sector.

AIDS is a regional, as well as a global, concern. Cooperation of multilateral and bilateral agencies is essential to ensure effectiveness in the mobilization of resources and the development of efficient and effective programs.

Because of its constitutional mandate and agreements with the Organization of American States and the World Health Organization, PAHO must work with its Member States to assist them to formulate and execute effective programs to control and prevent HIV/AIDS. This will be done in collaboration and coordination with other agencies of the inter-American system, such as the Inter-American Development Bank (IDB), and should be done in cooperation with other international and bilateral agencies, particularly those of the UN system.

Success at the national level requires the development of national capacity to:

- incorporate HIV/AIDS programs into national health systems;
- assure the allocation of sufficient national resources and their efficient use;
- promote the involvement of other sectors, nongovernmental organizations and communities;
- mobilize additional resources from other sectors and the international community;
- foster coordination of national and international agencies under the leadership of the Ministry of Health.

## **3. Organization Implications**

At the *country level*, the following factors must be taken into consideration in planning a joint and cosponsored UN program:

- the capability of the Ministries of Health to play a leading role at the national level must be strengthened; a prime function of the Ministry of Health is to coordinate inputs into the health sector, with support from the PAHO/WHO Representative, and to do so it must take the lead responsibility for the national HIV/AIDS plan;

- national commissions will help to promote and coordinate efforts at the national level;
- there should be correspondence between global orientations and strategies and national programming, while taking account of local realities;
- a national plan which is comprehensive in nature should be the reference for cooperation among all agencies supporting HIV/AIDS prevention and control and should be the basis for mobilizing resources;

With the above factors in mind, external cooperation activities at the *country level* should include the following:

- a UN Committee on HIV/AIDS consisting of all agencies involved, chaired by the UN Resident Coordinator or his/her delegate and for which the PAHO/WHO Representative will act as secretary. Other multilateral and bilateral agencies which are involved in HIV/AIDS will be invited and encouraged to participate;
- each agency will deal with its specific area of expertise and responsibility within the agreed coordinated program of cooperation and in support of the national medium-term plan;
- the PAHO/WHO Representative will be specifically responsible for supporting the health sector and health activities, in particular through and with the Ministries of Health;
- external funding will be complementary to national resources and will be committed only on the basis of the national plan. Funding through UN agencies will be coordinated by the UN Committee.

At the *regional level* in the Americas, each cosponsor will organize its component of the joint and cosponsored program according to its own organization and practices but consistent with the decision of the Programme Coordinating Board at the global level. To assure that there is effective coordination and collaboration, while the constitutional mandates of PAHO are met, the following entities will be established in the Region of the Americas:

- a Regional Coordinating Commission (RCC) consisting of representatives of the cosponsoring agencies and principal multilateral and bilateral agencies providing resources for HIV/AIDS in the Region. Major nongovernmental organizations may be invited to participate as space permits. The RCC will be chaired by a representative selected from among the agencies of the United Nations and Inter-

American System, while the representative from PAHO will serve as secretary. The RCC shall define its terms of reference.

- an Interagency Secretariat will coordinate and support the regional and intercountry activities of the joint and cosponsored program and will support the work of the RCC. The Secretariat will be located in PAHO and will report to the Director of PAHO and through him to the Directing Council of PAHO (Regional Committee for the Americas), as well as to the Executive Director of the UN Programme and the Director General of WHO;
- PAHO as the Regional Office for the Americas will include HIV/AIDS in its regional budget proposals to help in the financing of the regional components critical to the joint and cosponsored program. PAHO will also ensure the complementarity of the HIV/AIDS program with other WHO-related programs at the regional and country levels;

Details of the functioning and staffing of the Regional Secretariat will be arranged by the Director of PAHO in consultation with the Executive Director of the UN Programme and the representatives of the other cosponsoring UN agencies.

**ANNEX II-B**

**JOINT AND COSPONSORED  
UNITED NATIONS PROGRAM ON HIV/AIDS**

**A Proposal for Coordination  
in the Region of the Americas**

**JOINT AND COSPONSORED  
UNITED NATIONS PROGRAM ON HIV/AIDS**

**A Proposal for Coordination  
in the Region of the Americas**

**1. Rationale**

Six agencies of the United Nations--WHO, UNDP, UNICEF, UNESCO, UNFPA, and the World Bank--will be initiating a joint and cosponsored program on HIV/AIDS intended to foster coordination of actions to support countries in their efforts to prevent transmission of HIV and reduce the impact of AIDS. WHO, UNICEF, UNESCO, and UNFPA have regional or subregional offices in the Americas which will be executing activities and projects falling within the technical competence of that agency. These projects will form part of an approved global plan to combat HIV/AIDS and may support single or multiple countries within the Region. However, global plans cannot achieve a level of detail and specificity desirable in a Region as diverse and complex as the Americas, nor will global approaches be able to take advantage of linguistic and cultural features that are common within the Region. Furthermore, most countries in the Americas have reached a level of structural and functional development that provides them with an effective operational capacity. In addition, some of these countries are forming common markets (e.g., NAFTA, MERCOSUR) which will stimulate integration in areas of health as well as economic issues. Because the regional/subregional offices of the UN agencies are familiar with national situations and geographically close to the countries they serve, they will play a vital role in the successful execution of the global plan and national and regional projects. They will also be able to offer advantages of scale in pursuing regional and subregional approaches to issues. Therefore, coordination of actions among all six agencies within the Region will be essential, if the purposes of the joint and cosponsored program are to be realized.

The Pan American Health Organization is a specialized agency of both the United Nations (through WHO) and of the Organization of American States (OAS). Both OAS and the Inter-American Development Bank (IDB), which is also a specialized agency of the Inter-American System, are assisting Member Governments to combat AIDS in the Region. As intergovernmental entities, they must participate along with UN agencies in coordination efforts.

Several bilateral and multilateral agencies and nongovernmental organizations are active in HIV/AIDS in the Americas. Among the former are the United States Agency for International Development (AID), the Canadian International Development Agency



(CIDA), and agencies of several European countries. The European Community has also supported programs in several countries of the Region. Among the major NGOs are the Red Cross, CARE, and Project HOPE. While the UN Program seeks to achieve coordination primarily among the intergovernmental agencies, it would be valuable and more effective to include major bilateral agencies and international NGOs in regional coordination efforts.

## **2. Regional Coordinating Commission**

A Regional Coordinating Commission (RCC) will be established to assure effective coordination and collaboration among UN and inter-American agencies, bilateral institutions and nongovernmental organizations working in the Region of the Americas. (It should be noted that this coordination mechanism has been modelled partially on that employed by the Expanded Program on Immunization in the Americas.)

- The RCC would consist of representatives from the six cosponsoring UN agencies and other UN agencies which chose to participate, the Organization of American States, and the Inter-American Development Bank. Major bilateral institutions and international NGOs active in the Region will be invited to participate.
- PAHO will serve as host and Secretariat to the RCC.
- At its first meeting, the RCC will discuss and define its terms of reference, based on a draft prepared by its Secretariat and distributed in advance. The RCC will elect its chairperson, who will be the representative of one of the UN or OAS agencies, and who will serve for a term of one year.
- The RCC will develop a multilateral agreement recognizing the need for coordination and collaboration among the participating agencies which will be signed by the executive heads of those agencies.
- The RCC will prepare and approve a regional plan for HIV/AIDS prevention and control, based on a draft to be produced by the Secretariat. The regional plan will be consistent with the global plan prepared and approved by the UN Program and will be reviewed and revised annually.
- During the first year, the RCC will meet every four months to keep agencies fully informed about activities in AIDS, to agree on specific plans, and to coordinate subregional and regional projects. The frequency of meetings after the first year may be modified according to the need for coordination.

- The RCC may appoint working committees consisting of technical advisors and staff of the participating agencies to deal with specific issues which will benefit from a regional or subregional approach. These committees will perform their work as specified by the RCC and will report to the RCC, as well as to the executive heads of the respective agencies.
- The RCC will report through its Secretariat and through its agency heads to the UN Program.
- The RCC may convene the international community for resource mobilization within the terms of the approved global plan.

### **3. Regional Secretariat**

The Regional Secretariat will be headquartered at PAHO and will consist of a small staff of professionals and support personnel needed to execute regional and subregional aspects of the UN Program, to support the RCC, and to develop and execute projects specific for the Region that are consistent with and complementary to the global plan.

- The Secretariat will be supported with financing from both the UN Program and PAHO.
- Other agencies of the UN and OAS will be invited to place staff with the Secretariat should they wish to do so. However, it is recognized that other agencies are more likely to locate staff in their own offices. The Secretariat and staff of other agencies working on HIV/AIDS projects will be required to maintain frequent contact in order to ensure adequate coordination.
- The Secretariat staff which is recruited by PAHO will be hired according to the rules of PAHO and WHO.
- The Secretariat will prepare an annual plan and budget, which will be presented for approval by the RCC and the UN Program.
- The Secretariat will present an annual report and evaluation to the RCC. It will also report to the RCC at each meeting on progress made and any difficulties in executing the regional plan.

*executive committee of  
the directing council*



**PAN AMERICAN  
HEALTH  
ORGANIZATION**

*working party of  
the regional committee*

**WORLD  
HEALTH  
ORGANIZATION**



113th Meeting  
Washington, D.C.  
27 June - 1 July 1994

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Provisional Agenda Item 4.8

CE113/16, ADD. I (Eng.)

21 June 1994

ORIGINAL: ENGLISH-SPANISH

**ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS**

The Director is pleased to present to the Executive Committee an updated report on the status of AIDS surveillance in the Americas as of 10 June 1994.

# **AIDS SURVEILLANCE IN THE AMERICAS**

## **Summary**

**Data as received by 10 June 1994**

**Cumulative number of cases reported**

**worldwide: 939,427**

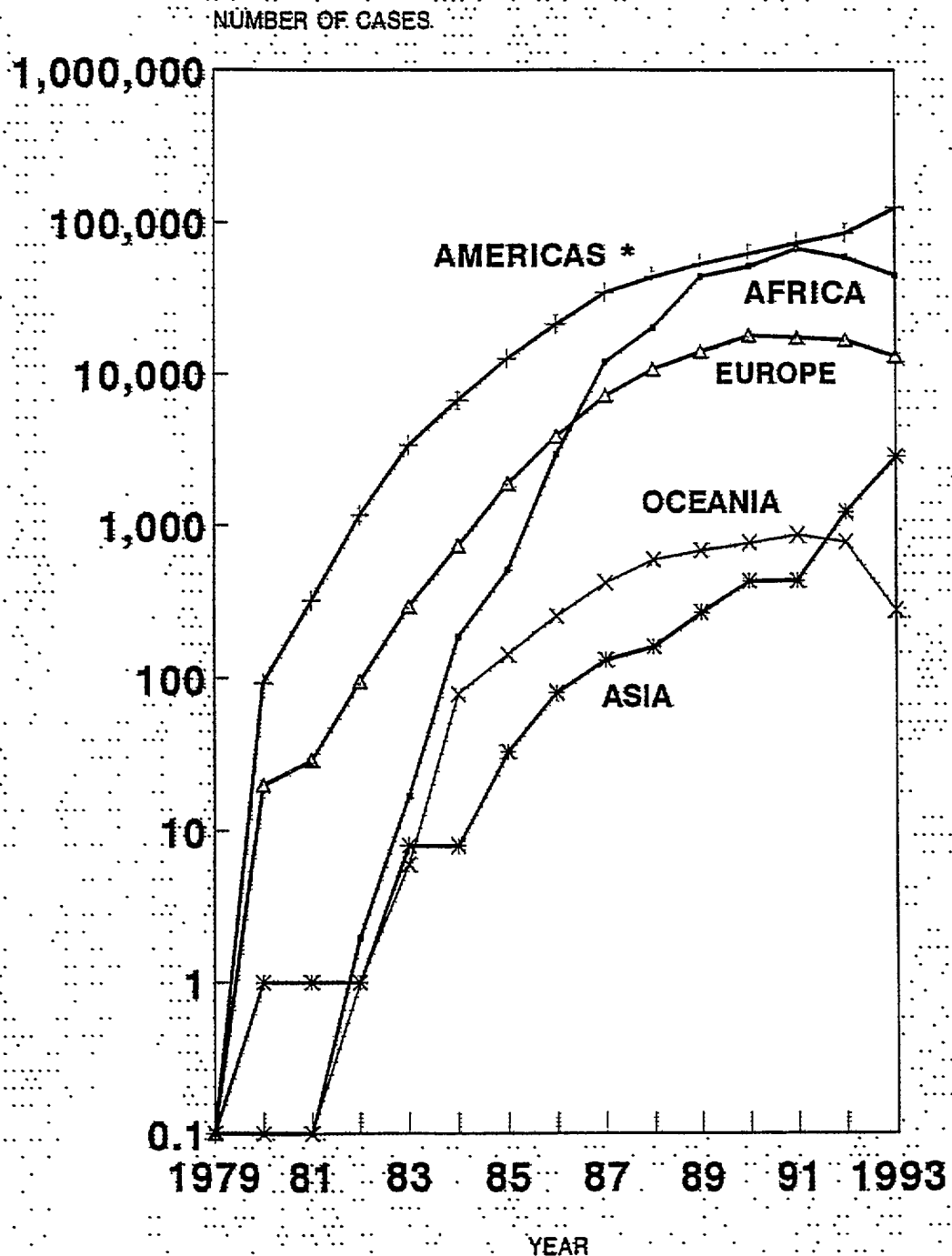
**Cumulative number of cases reported**

**in the Americas: 523,777**

**Cumulative number of deaths reported**

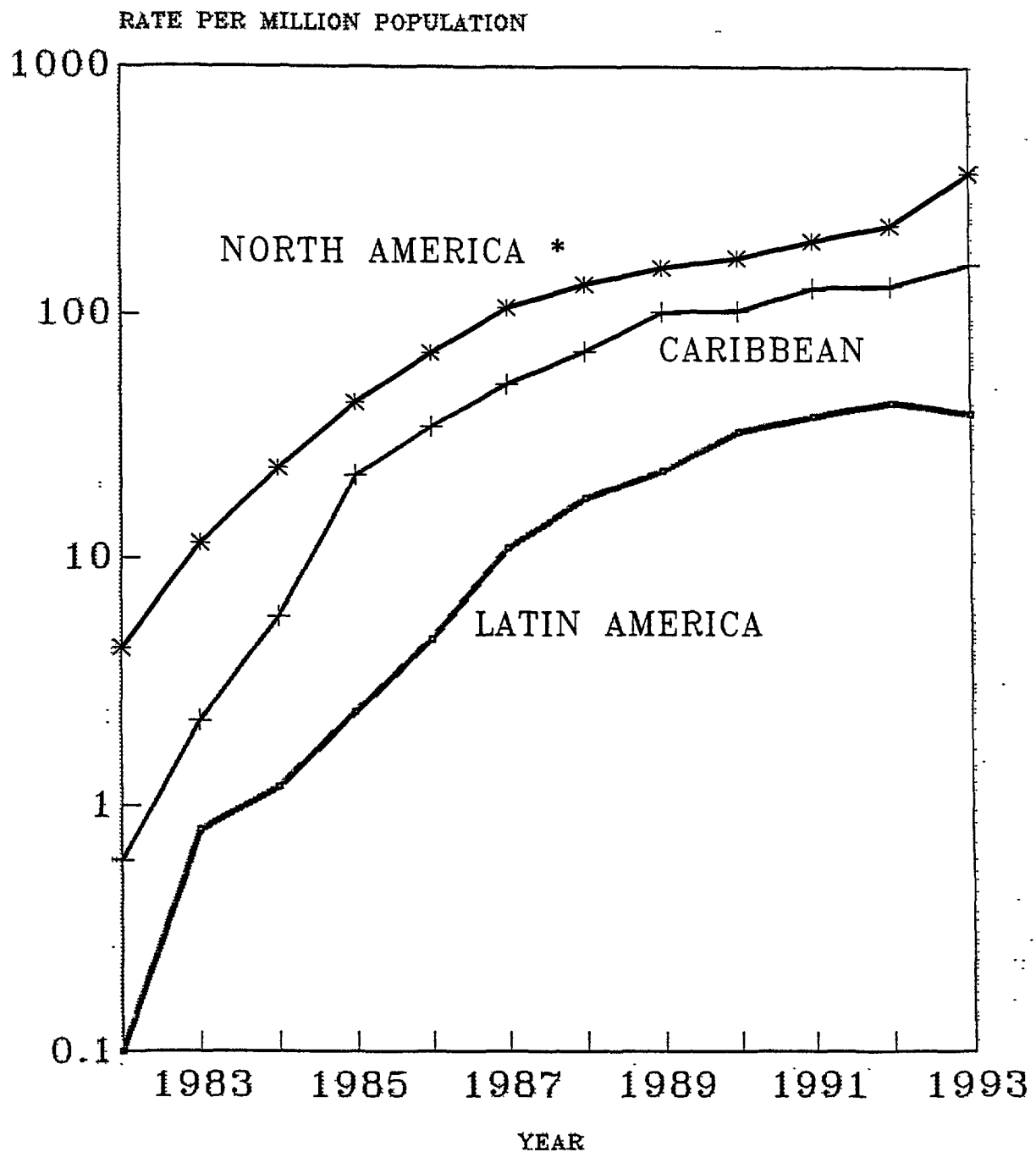
**in the Americas: 271,311**

FIG. 1. ANNUAL INCIDENCE OF AIDS CASES,  
BY REGION OF THE WHO, BY YEAR, 1979-93.



\* INCLUDES PROVISIONAL DATA FROM THE UNITED STATES OF AMERICA ON CASES CLASSIFIED ACCORDING TO THE AIDS CASE DEFINITION OF 1993.

Fig.2. ANNUAL INCIDENCE RATES OF AIDS IN THE AMERICAS,  
(PER MILLION), THREE MAJOR SUBREGIONS,  
1982-1993.



\* INCLUDES PROVISIONAL DATA FROM THE UNITED STATES OF AMERICA ON CASES CLASSIFIED ACCORDING  
TO THE AIDS CASE DEFINITION OF 1983.

TABLE 1. NUMBER OF REPORTED CASES OF AIDS BY YEAR, AND CUMULATIVE CASES AND DEATHS, BY COUNTRY AND SUBREGION.  
As of 10 June, 1994.

SUBREGION Country	Number of Cases							Cumulative total(a)	Total deaths	Date of last report
	Through 1988	1989	1990	1991	1992	1993	1994			
<b>REGIONAL TOTAL</b>	<b>124,065</b>	<b>53,040</b>	<b>62,002</b>	<b>73,147</b>	<b>84,918</b>	<b>124,589</b>	<b>1,757</b>	<b>523,777</b>	<b>271,311</b>	
<b>LATIN AMERICA b)</b>	<b>15,273</b>	<b>9,778</b>	<b>14,431</b>	<b>17,040</b>	<b>19,788</b>	<b>17,959</b>	<b>1,594</b>	<b>96,122</b>	<b>39,744</b>	
<b>ANDEAN AREA</b>	1,550	1,027	1,565	1,733	1,956	1,350	231	9,830	4,853	
Bolivia	16	2	9	17	18	20	5	87	65	31/Mar/94
Colombia	706	453	771	857	921	519	147	4,583	2,312	31/Mar/94
Ecuador	68	27	44	55	66	85	35	381	258	31/Mar/94
Peru	135	116	167	163	249	226	4	1,068	380	31/Mar/94
Venezuela	625	429	574	641	702	500	40	3,511	1,838	31/Mar/94
<b>SOUTHERN CONE</b>	549	406	667	939	1,199	1,338	180	5,281	2,048	
Argentina	352	281	457	665	914	1,093	142	3,904	1,268	31/Mar/94
Chile	143	84	128	183	178	112	.	831	489	31/Dec/93
Paraguay	9	3	6	5	17	30	7	77	48	23/May/94
Uruguay	45	38	76	86	90	103	31	469	243	31/Mar/94
<b>BRAZIL</b>	8,083	5,302	7,193	9,459	11,004	8,271 *	<---	49,312	19,513	26/Feb/94
<b>CENTRAL AMERICAN ISTHMUS</b>	646	492	915	933	1,210	1,564	183	5,981	2,037	
Belize	11	0	19	11	12	29	.	82	46	31/Dec/93
Costa Rica	98	57	86	91	125	109	21	587	362	31/Mar/94
El Salvador	57	72	54	132	114	177	24	830	144	31/Mar/94
Guatemala	49	31	92	96	94	118	19	499	188	31/Mar/94
Honduras	309	253	591	504	745	947	104	3,473	877	31/Mar/94
Nicaragua	2	2	7	13	6	17	3	66	48	31/Mar/94
Panama	120	77	66	86	114	167	12	644	372	31/Mar/94
<b>MEXICO</b>	1,710	1,607	2,588	3,167	3,220	5,095	966	18,353	10,366	31/Mar/94
<b>LATIN CARIBBEAN c)</b>	2,735	944	1,503	809	1,199	341	34	7,565	927	
Cuba	30	14	29	37	68	67	..	245	148	31/Dec/93
Dominican Republic	703	479	258	280	325	274	34	2,353	482	31/Mar/94
Haiti	2,002	451	1,216	492	806	..	..	4,967	297	31/Dec/92
<b>CARIBBEAN c)</b>	<b>1,416</b>	<b>741</b>	<b>760</b>	<b>904</b>	<b>929</b>	<b>1,153</b>	<b>111</b>	<b>6,014</b>	<b>4,000</b>	
Anguilla	1	2	1	1	0	0	.	5	3	30/Sep/93
Antigua	5	0	3	6	13	7	..	34	5	31/Dec/93
Bahamas	270	170	188	230	254	297	..	1,389	737	31/Dec/93
Barbados	71	40	61	80	78	88	..	418	323	31/Dec/93
Cayman Islands	4	1	2	4	4	0	0	15	13	31/Mar/94
Dominica	7	3	2	0	0	14	..	26	11	31/Dec/93
French Guiana	137	54	41	..	.	..	..	232	144	30/Sep/90
Grenada	11	8	5	7	4	21	2	58	41	31/Mar/94
Guadeloupe	130	55	53	67	48	0	.	353	216	31/Mar/93
Guyana	117	53	59	46	67	100	23	465	366	31/Mar/94
Jamaica	73	66	62	133	99	236	..	669	480	31/Dec/93
Martinique	77	47	44	30	42	26	.	266	184	30/Sep/93
Montserrat	0	3	1	2	0	1	0	7	0	31/Mar/94
Netherlands Antilles	31	16	30	23	10	47	..	157	79	30/Jun/93
Saint Kitts and Nevis	19	5	8	1	4	3	1	41	27	31/Mar/94
Saint Lucia	15	8	4	6	8	12	3	56	51	31/Mar/94
St Vincent and the Grenadines	14	7	6	14	5	8	2	56	51	31/Mar/94
Suriname	28	29	33	16	28	35	8	177	158	31/Mar/94
Trinidad and Tobago	394	167	174	235	260	243	72	1,545	1,100	31/Mar/94
Turks and Caicos Islands	11	7	1	2	4	14	..	39	30	30/Sep/93
Virgin Islands (UK)	1	0	2	1	1	1	0	6	1	31/Mar/94
<b>NORTH AMERICA</b>	<b>107,376</b>	<b>42,521</b>	<b>46,811</b>	<b>55,203</b>	<b>64,201</b>	<b>105,477</b>	<b>52</b>	<b>421,641</b>	<b>227,567</b>	
Bermuda	100	35	33	23	17	15	..	223	162	30/Jun/93
Canada	3,208	1,271	1,287	1,319	1,380	994	52	9,511	6,534	31/Mar/94
United States of America c)	104,068	41,215	45,491	53,861	62,804	104,468 d)	.	411,907	220,871 d)	31/Dec/93

\* Includes cases diagnosed in January and February of 1994

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

d) Provisional data (includes cases classified according to the AIDS case definition of 1993)

TABLE 2. ANNUAL INCIDENCE RATES OF AIDS (PER MILLION POPULATION), BY COUNTRY AND BY YEAR, 1988-1993,  
AS OF 10 JUNE 1994.

SUBREGION Country	RATE PER MILLION					
	1988	1989	1990	1991	1992	1993
<b>LATIN AMERICA a)</b>	<b>17.7</b>	<b>22.8</b>	<b>33.0</b>	<b>38.2</b>	<b>43.5</b>	<b>39.3</b>
<b>ANDEAN AREA</b>	<b>8.9</b>	<b>11.4</b>	<b>17.0</b>	<b>18.4</b>	<b>20.4</b>	<b>13.7</b>
Bolivia	1.4	0.3	1.2	2.3	2.3	2.5
Colombia	11.1	14.5	24.2	25.5	26.9	14.9
Ecuador	3.1	2.6	4.1	5.1	5.9	7.5
Peru	3.3	5.3	7.5	7.4	11.1	9.9
Venezuela	17.8	22.3	29.1	31.7	34.7	23.6
<b>SOUTHERN CONE</b>	<b>5.5</b>	<b>7.8</b>	<b>12.6</b>	<b>17.5</b>	<b>22.1</b>	<b>24.3</b>
Argentina	6.0	8.8	14.1	20.3	27.6	32.6
Chile	5.2	8.5	9.7	13.7	13.1	8.1
Paraguay	0.2	0.7	1.4	1.1	3.8	6.5
Uruguay	9.1	12.2	24.3	27.5	28.8	32.7
<b>BRAZIL</b>	<b>27.5</b>	<b>36.0</b>	<b>47.8</b>	<b>61.7</b>	<b>70.4</b>	<b>51.9 *</b>
<b>CENTRAL AMERICAN ISTHMUS</b>	<b>13.2</b>	<b>17.4</b>	<b>31.5</b>	<b>31.2</b>	<b>39.4</b>	<b>49.6</b>
Belize	23.0	0	104.4	60.4	64.5	155.9
Costa Rica	18.1	19.4	28.5	29.5	39.5	33.7
El Salvador	6.8	14.0	10.3	24.6	20.7	31.3
Guatemala	2.1	3.5	10.0	10.1	9.6	11.8
Honduras	39.3	50.8	115.0	95.1	136.4	168.3
Nicaragua	0.6	0.5	1.8	3.3	1.5	4.0
Panama	27.1	32.5	27.3	34.9	45.3	65.2
<b>MEXICO</b>	<b>10.7</b>	<b>18.5</b>	<b>29.2</b>	<b>35.0</b>	<b>34.9</b>	<b>54.1</b>
<b>LATIN CARIBBEAN b)</b>	<b>47.2</b>	<b>39.9</b>	<b>62.6</b>	<b>32.8</b>	<b>47.8</b>	<b>18.4</b>
Cuba	1.4	1.4	2.8	3.5	6.3	6.1
Dominican Republic	51.7	68.3	36.0	38.2	43.5	36.0
Haiti	116.7	70.7	186.9	74.0	118.8	.
<b>CARIBBEAN a)</b>	<b>70.5</b>	<b>102.2</b>	<b>103.3</b>	<b>128.4</b>	<b>130.4</b>	<b>160.2</b>
Anguilla	142.2	284.5	142.9	142.9	0	0
Antigua	0	0	34.9	69.8	168.8	90.9
Bahamas	363.6	661.5	646.2	884.6	969.5	1133.6
Barbados	58.4	154.6	233.7	313.7	304.7	342.4
Cayman Islands	47.5	47.6	95.2	190.5	148.1	0
Dominica	25.3	37.5	24.7	0	0	168.7
French Guiana	386.3	600.7	445.7			
Grenada	30.0	79.2	48.5	68.0	42.4	222.8
Guadeloupe	142.0	162.2	155.4	194.2	138.3	0
Guyana	35.8	51.8	58.7	57.5	83.2	123.3
Jamaica	12.3	26.6	24.6	53.5	39.4	92.7
Martinique	90.9	142.2	133.0	87.5	121.7	74.9
Montserrat	0	230.2	76.9	153.8	0	78.9
Netherlands Antilles	69.1	83.7	155.4	119.2	51.8	243.5
Saint Kitts and Nevis	187.5	103.1	160.0	20.0	90.1	67.6
Saint Lucia	37.6	59.3	29.4	44.1	50.7	76.0
St. Vincent and the Grenadines	64.8	64.2	54.1	126.1	41.7	66.8
Suriname	33.2	72.9	81.9	37.3	64.1	78.7
Trinidad and Tobago	127.1	132.2	135.6	180.6	197.1	181.6
Turks and Caicos Islands	750.9	876.1	111.1	222.2	400.0	1400.0
Virgin Islands (UK)	76.7	0	153.4	76.7	76.9	76.9
<b>NORTH AMERICA</b>	<b>132.3</b>	<b>154.9</b>	<b>169.7</b>	<b>199.2</b>	<b>229.4</b>	<b>374.1</b>
Bermuda	490.8	601.4	569.0	396.6	293.1	258.6
Canada	41.5	48.3	48.5	49.3	51.2	36.6
United States of America b)	141.8	166.1	182.5	215.2	248.3	410.1 c)

\* Includes cases diagnosed in January and February 1994

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

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

c) Provisional data (includes cases classified according to the AIDS case definition of 1993)



TABLE 3. ANNUAL INCIDENCE RATES OF AIDS (PER MILLION POPULATION), BY SEX, BY COUNTRY AND BY YEAR, 1988-1993.

SUBREGION	RATE PER MILLION POPULATION											
	MALE RATES						FEMALE RATES					
Country	1988	1989	1990	1991	1992	1993	1988	1989	1990	1991	1992	1993
<b>LATIN AMERICA a)</b>	<b>29.4</b>	<b>37.9</b>	<b>53.8</b>	<b>61.7</b>	<b>67.2</b>	<b>59.7</b>	<b>5.4</b>	<b>6.7</b>	<b>10.9</b>	<b>12.1</b>	<b>15.4</b>	<b>13.8</b>
<b>ANDEAN AREA</b>	15.2	19.4	29.3	27.1	23.2	13.8	1.1	1.8	2.4	2.0	2.3	1.7
Bolivia	2.9	0	1.9	4.3	1.8	1.8	0	0.6	0	0	1.0	0.2
Colombia	17.7	23.5	40.8	30.9	23.7	21.1	1.6	2.3	3.2	1.8	1.7	1.9
Ecuador	6.0	4.5	7.0	9.0	10.7	12.2	0.2	0.6	1.1	1.1	1.1	2.6
Peru	5.8	9.9	13.6	13.6	19.8	16.3	0.7	0.8	1.2	0.8	2.0	2.3
Venezuela	31.0	38.5	50.5	53.6	40.3	4.5	1.9	3.0	4.2	4.8	4.6	0.8
<b>SOUTHERN CONE</b>	9.6	12.4	20.5	26.0	30.8	32.9	0.7	1.1	2.1	2.2	6.5	8.2
Argentina	10.4	12.9	21.6	26.8	35.7	46.1	0.4	1.2	2.4	2.5	8.9	12.2
Chile	9.2	12.2	19.1	26.2	22.3	11.0	1.2	0.8	0.9	1.5	2.3	1.0
Paraguay		1.4		2.2	7.0	1.7		0		0	0.4	0.9
Uruguay	15.8	22.3	42.9	50.8	51.1	35.8	2.6	2.5	6.3	5.6	7.5	7.4
<b>BRAZIL</b>	48.2	63.5	83.9	104.2	115.5	82.9*	6.9	8.6	11.9	19.4	25.6	21.2*
<b>CENTRAL AMERICAN ISTHMUS</b>	17.5	21.7	40.6	45.3	57.5	61.6	6.2	8.1	17.0	15.2	18.4	22.0
Belize	23.0						11.5					
Costa Rica	33.2	32.3	45.2	51.9	68.2	49.0	2.8	4.8	5.4	2.6	5.1	1.9
El Salvador				36.8	31.1	56.0				12.4	7.8	13.5
Guatemala	3.6	5.8	16.6	16.5	16.7	28.8	0.5	1.4	3.3	3.6	2.5	6.4
Honduras	50.4	66.4	148.1	129.8	185.8	168.7	27.8	36.2	83.3	57.1	81.6	91.4
Nicaragua	1.1	1.1	3.1	4.5	2.4	6.1	0	0	0.5	0.5	0	0.9
Panama	43.9	55.4	45.5	52.6	74.3	79.1	9.7	8.6	8.4	16.5	14.6	11.1
<b>MEXICO</b>	18.4	31.4	49.1	59.3	59.3	92.4	2.9	5.7	9.4	10.8	10.5	16.0
<b>LATIN CARIBBEAN b)</b>	63.8	49.1	66.7	36.1	55.2	15.4	31.1	29.0	55.4	28.3	35.0	5.4
Cuba	3.9	0.2	0.8	4.3	5.9	7.5	0.8	0.2	0	1.3	2.4	2.8
Dominican Republic	72.3	87.5	46.9	49.2	55.3	26.6	29.9	45.9	21.3	24.7	19.1	9.3
Haiti	154.4	87.1	197.6	73.6	135.4		80.0	55.4	176.6	74.5	102.8	
<b>CARIBBEAN a)</b>	<b>96.1</b>	<b>135.7</b>	<b>124.9</b>	<b>163.4</b>	<b>169.5</b>	<b>281.6</b>	<b>42.0</b>	<b>63.8</b>	<b>61.0</b>	<b>80.4</b>	<b>80.6</b>	<b>122.8</b>
Anguilla	0		0	0	0	0	281.7		284.1	281.7	0	0
Antigua	0	0			264.2	158.5	0	0			76.6	25.5
Bahamas	432.0	732.9	794.5	1147.4	1222.7	1362.0	296.8	591.9	501.5	642.4	723.0	911.3
Barbados	73.9	244.5	409.6	520.3	471.5	487.8	44.4	73.5	73.2	105.3	150.4	223.9
Cayman Islands	0	96.2	192.3	155.6	150.2	0	93.9	0	0	151.6	148.2	0
Dominica	49.9	49.3	48.7				0	25.4	0			
French Guiana	545.0	735.0					204.6	466.7				
Grenada	20.2	100.3	78.7	62.4	20.7	351.9	39.5	0	19.2	87.4	0	65.3
Guadeloupe	217.6	253.1	222.9	285.7	200.0	1508.8	89.5	75.1	91.4	107.3	78.7	530.7
Guyana	55.5	70.2	65.2	78.3	103.0	184.1	16.0	33.3	48.2	37.1	64.0	78.0
Jamaica	18.2	38.2	32.6	59.1	52.8	123.1	6.5	15.2	16.6	48.0	25.3	62.6
Martinique	137.2	230.1	191.4	120.5	95.8	202.4	47.2	82.4	82.9	33.9	50.6	39.1
Montserrat	0				0	0	0				0	177.6
Netherlands Antilles	10.9						20.8					
Saint Kitts and Nevis	381.0	126.6	248.1	46.8	140.4	46.8	0	80.6	77.5	0	43.4	86.8
Saint Lucia	46.6	107.4	30.4	66.6	52.3	78.4	29.2	14.3	28.4	12.5	49.1	73.7
St. Vincent and the Grenadines	57.2	37.7	74.1	139.6	68.9	86.1	72.0	89.3	35.1	98.4	16.2	48.6
Suriname	46.5	106.9	120.0	56.3	87.6	113.1	20.1	39.7	44.3	18.5	40.9	44.6
Trinidad and Tobago	182.3	193.7	180.1	248.8	280.5	285.7	72.2	71.1	91.5	113.1	114.8	78.8
Turks and Caicos Islands	1012.7	1519.0	0	404.9	809.7	1417.0	495.0	247.5	219.5	0	0	1378.0
Virgin Islands (UK)		0	144.0	155.0	155.0	0		0	14.2	0	151.7	151.7
<b>NORTH AMERICA</b>	<b>223.9</b>	<b>242.8</b>	<b>292.0</b>	<b>300.1</b>	<b>305.4</b>	<b>70.1</b>	<b>25.9</b>	<b>28.6</b>	<b>37.7</b>	<b>43.1</b>	<b>47.0</b>	<b>4.7</b>
Bermuda	850.2	975.6	489.5	664.3	419.6	419.6	138.8	237.3	238.1	136.1	170.1	102.0
Canada	79.2	92.0	93.8	94.0	97.1	69.4	4.4	5.4	4.1	5.6	6.2	4.5
United States of America b)	239.4	258.9	313.4	322.3	327.9		28.1	31.0	41.2	47.1	51.3	

\* Includes cases diagnosed in February and January 1994

\* \* 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 4. MALE:FEMALE RATIO OF REPORTED AIDS CASES, BY COUNTRY AND BY YEAR, 1988-1993.

SUBREGION	MALE:FEMALE RATIO					
	1988	1989	1990	1991	1992	1993
<b>LATIN AMERICA a)</b>	<b>5.4</b>	<b>5.6</b>	<b>4.9</b>	<b>5.1</b>	<b>4.4</b>	<b>4.3</b>
<b>ANDEAN AREA</b>	13.4	11.1	12.3	13.6	10.2	8.2
Bolivia	N/A	0	N/A	N/A	1.8	7.0
Colombia	11.3	10.2	13.0	16.6	13.4	11.1
Ecuador	31.0	8.0	6.3	8.2	10.0	4.7
Peru	8.9	12.1	11.8	16.7	10.2	7.2
Venezuela	16.3	12.9	12.3	11.4	9.0	6.0
<b>SOUTHERN CONE</b>	12.8	11.0	9.7	11.5	4.7	3.9
Argentina	23.1	10.3	8.9	10.6	3.9	3.7
Chile	7.3	15.6	20.7	17.3	9.4	10.7
Paraguay	...	N/A	...	N/A	16.0	2.0
Uruguay	6.0	8.5	6.6	8.6	6.5	4.6
<b>BRAZIL</b>	7.0	7.3	7.0	5.3	4.5	3.9
<b>CENTRAL AMERICAN ISTHMUS</b>	2.8	2.7	2.4	3.0	3.2	2.8
Belize	2.0	..	...	..	...	...
Costa Rica	12.0	6.9	8.6	20.3	13.6	26.7
El Salvador	...	...	...	2.9	3.8	4.0
Guatemala	8.0	4.3	5.1	4.6	6.8	4.6
Honduras	1.8	1.8	1.8	2.3	2.3	1.9
Nicaragua	N/A	N/A	6.0	9.0	N/A	6.5
Panama	4.7	6.7	5.6	3.3	5.3	7.4
<b>MEXICO</b>	6.4	5.6	5.2	5.5	5.6	5.8
<b>LATIN CARIBBEAN b)</b>	2.1	1.7	1.2	1.3	1.6	2.9
Cuba	5.0	1.0	N/A	3.3	2.5	2.7
Dominican Republic	2.5	1.9	2.3	2.1	3.0	2.9
Haiti	1.9	1.5	1.1	1.0	1.3	...
<b>CARIBBEAN a)</b>	<b>2.2</b>	<b>2.1</b>	<b>2.0</b>	<b>2.0</b>	<b>2.1</b>	<b>2.2</b>
Anguilla	0	...	0	0	N/A	N/A
Antigua	N/A	N/A	...	...	3.3	6.0
Bahamas	1.4	1.2	1.5	1.7	1.6	1.5
Barbados	1.5	3.0	5.1	4.6	2.9	2.0
Cayman Islands	0	N/A	N/A	1.0	1.0	N/A
Dominica	N/A	2.0	N/A	...	...	...
French Guiana	2.7	1.6	...	...	...	...
Grenada	0.5	N/A	4.0	0.8	N/A	5.7
Guadeloupe	3.0	3.2	2.3	2.5	2.4	2.7
Guyana	3.5	2.1	1.4	2.1	1.6	2.3
Jamaica	2.8	2.5	2.0	1.2	2.1	2.0
Martinique	2.8	2.6	2.2	3.3	1.8	4.9
Montserrat	N/A	...	..	...	N/A	0
Netherlands Antilles	0.5	...	...	...	..	...
Saint Kitts and Nevis	N/A	1.5	3.0	N/A	3.0	0.5
Saint Lucia	1.5	7.0	1.0	5.0	1.0	1.0
Saint Vincent and the Grenadines	0.8	0.4	2.0	1.3	4.0	1.7
Suriname	2.3	2.6	2.7	3.0	2.1	2.5
Trinidad and Tobago	2.5	2.7	1.9	2.2	2.4	3.6
Turks and Caicos Islands	2.0	6.0	0	N/A	N/A	1.0
Virgin Islands (UK)	...	N/A	1.0	N/A	1.0	0
<b>NORTH AMERICA</b>	<b>8.2</b>	<b>8.1</b>	<b>7.4</b>	<b>6.6</b>	<b>6.2</b>	<b>14.5</b>
Bermuda	6.0	4.0	2.0	4.8	2.4	4.0
Canada	17.7	16.7	22.4	16.6	15.2	15.0
United States of America b)	8.1	7.9	7.2	6.5	6.1	...

\*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 1994.**

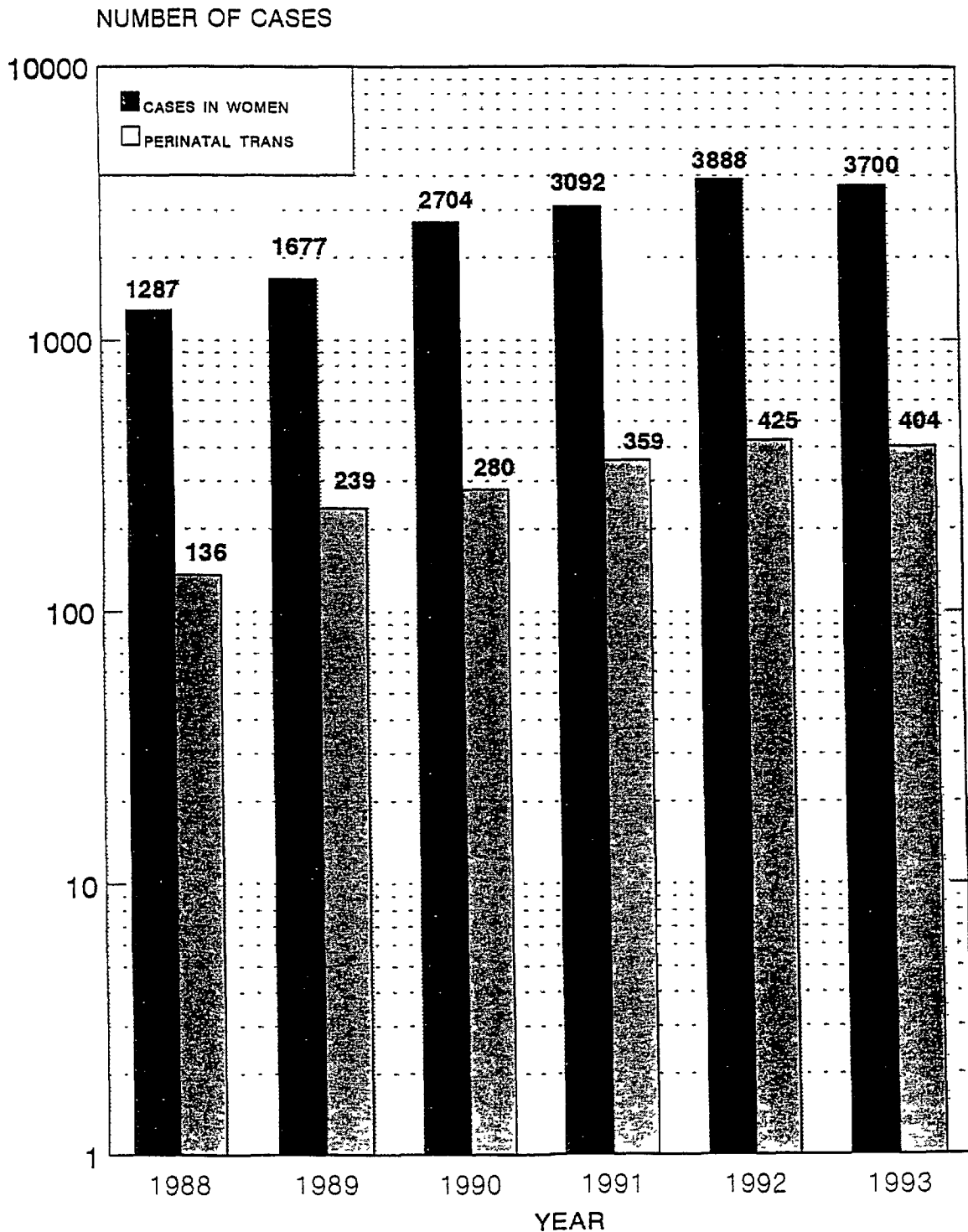
Country	TOTAL CASES	PEDIATRIC CASES	PERCENT PEDIATRIC	PERINATAL CASES	PERCENT PERINATAL
<b>ANDEAN AREA</b>					
Bolivia	87	1	1.1	1	100.0
Colombia	4,583	70	1.5	56	80.0
Ecuador	381	5	1.3	4	80.0
Peru	1,088	22	2.1	11	50.0
Venezuela	3,511	54	1.5	24	44.4
<b>SOUTHERN CONE</b>					
Argentina	3,904	135	3.5	111	82.2
Chile	831	16	1.9	13	81.3
Uruguay	469	21	4.5	18	85.7
<b>BRAZIL</b>	<b>49,312</b>	<b>1,513</b>	<b>3.1</b>	<b>944</b>	<b>62.4</b>
<b>CENTRAL AMERICAN ISTHMUS</b>					
Costa Rica	587	18	3.1	8	44.4
El Salvador	630	12	1.9	6	50.0
Guatemala	499	14	2.8	5	35.7
Honduras	3,473	136	3.9	124	91.2
Panama	644	20	3.1	16	80.0
<b>MEXICO</b>	<b>18,353</b>	<b>542</b>	<b>3.0</b>	<b>253</b>	<b>46.7</b>
<b>LATIN CARIBBEAN</b>					
Cuba	245	1	0.4	1	100.0
Dominican Republic	2,353	50	2.1	26	52.0
Haiti	4,967	213	4.3	16*	7.5
<b>CARIBBEAN</b>					
Antigua	34	6	17.6	6	100.0
Bahamas	1,389	131	9.4	131	100.0
Barbados	418	19	4.5	18	94.7
Dominica	26	1	3.8	1	100.0
French Guiana	232	17	7.3	16	94.1
Grenada	58	2	3.4	2	100.0
Guadeloupe	353	16	4.5	14	87.5
Guyana	465	44	9.5	40	90.9
Jamaica	669	60	9.0	43	71.7
Martinique	266	12	4.5	10	83.3
Netherlands Antilles	157	1	0.6	1	100.0
Saint Kitts and Nevis	41	1	2.4	1	100.0
Saint Lucia	56	4	7.1	4	100.0
Saint Vincent and the Grenadines	56	2	3.6	2	100.0
Suriname	177	4	2.3	4	100.0
Trinidad and Tobago	1,545	116	7.5	109	94.0
Virgin Islands (UK)	6	1	16.7	1	100.0
<b>NORTH AMERICA</b>					
Canada	9,511	96	1.0	73	76.0
United States of America b)	411,907	4,906	1.2	4,328	88.2

\* Number of perinatal cases dated as of 31/12/90

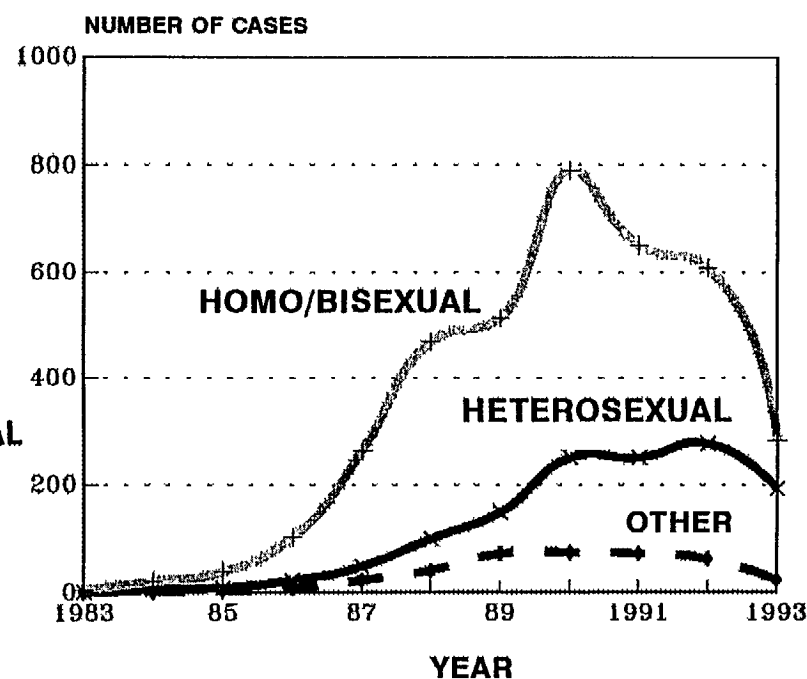
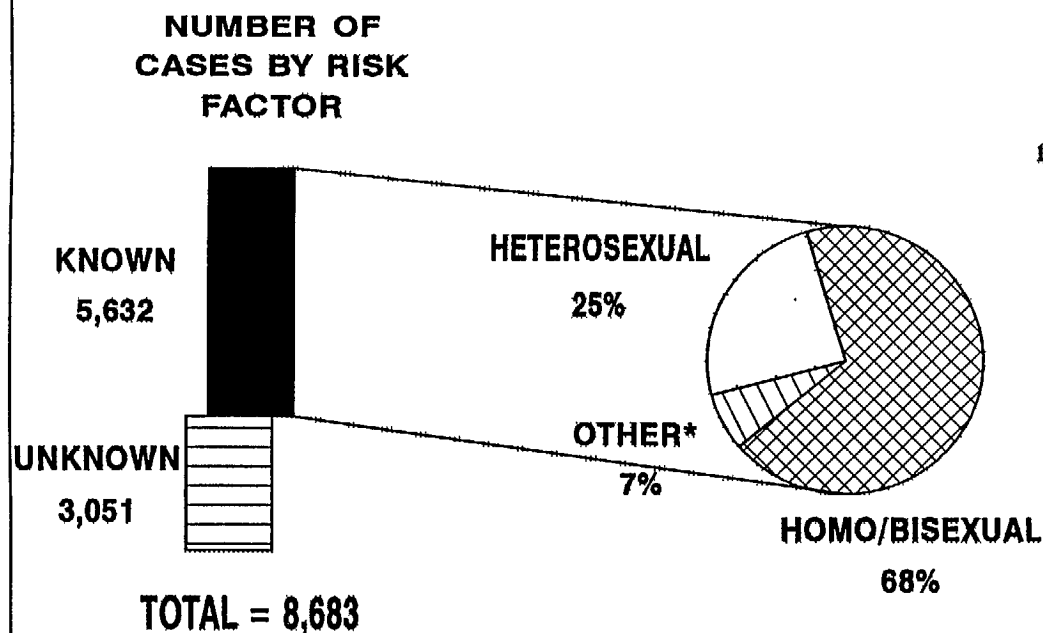
(a) Does not include countries which have not reported AIDS cases in children

b) Provisional data (includes cases classified according to the AIDS case definition of 1993)

**Fig.3. NUMBER OF REPORTED AIDS CASES IN WOMEN,  
AND CASES OF PERINATAL TRANSMISSION,  
LATIN AMERICA AND THE CARIBBEAN, 1988-1993.**



**FIG. 4a. PERCENT DISTRIBUTION OF AIDS CASES BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994, AND ANNUAL INCIDENCE OF AIDS CASES, 1983-1993, ANDEAN AREA.**

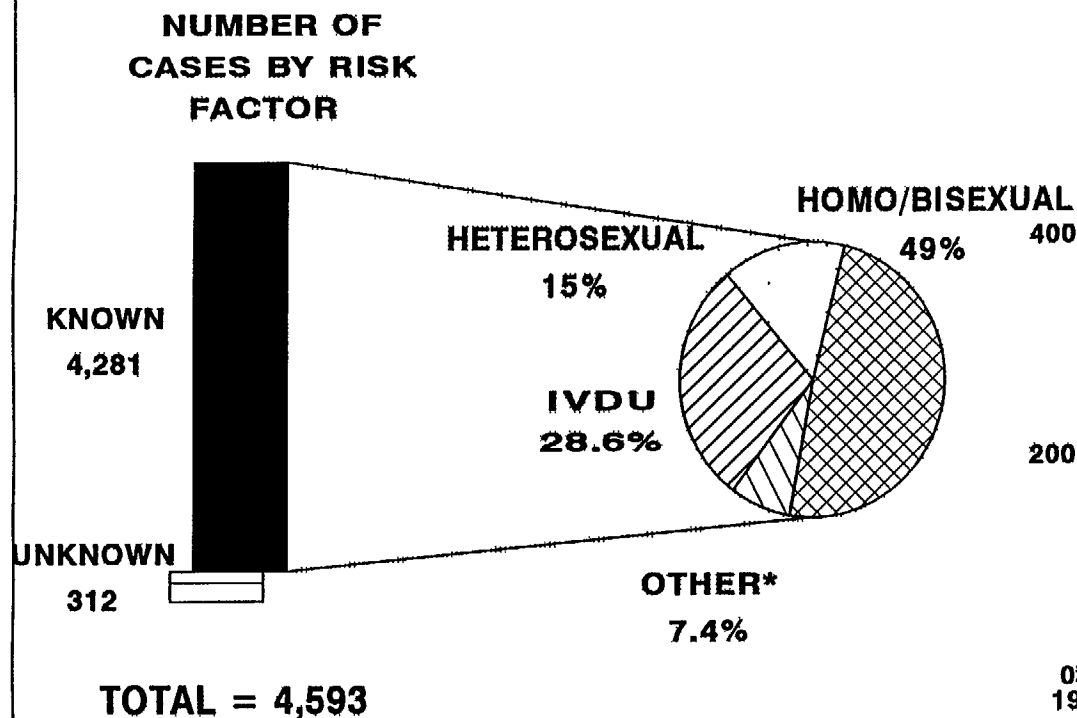


**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1983-1993.\*\***

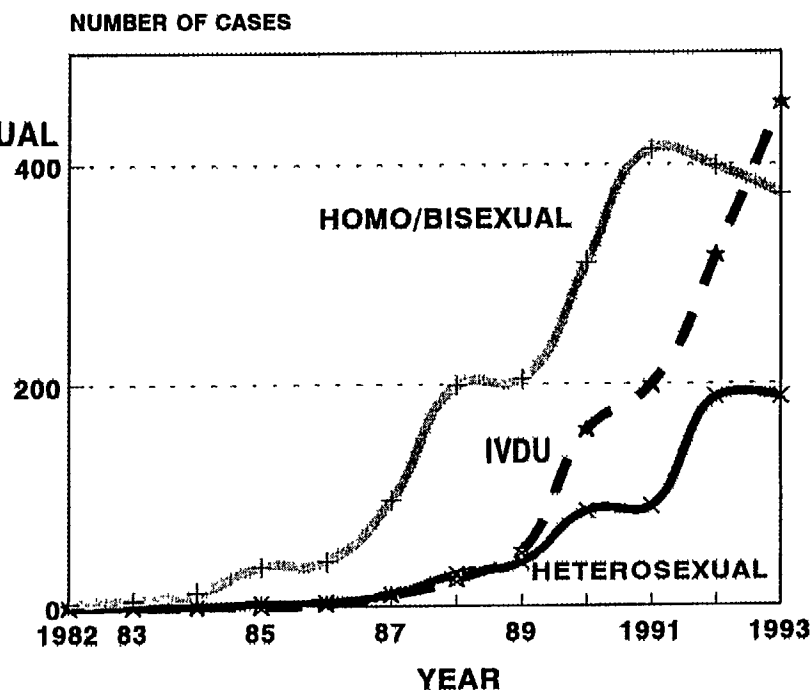
\* INCLUDES 2.9% BLOOD, <1% IVDU, 1.7% PERINATAL, AND 1.4% OF OTHER KNOWN RISK FACTORS.

\*\* 1993 DATA INCOMPLETE DUE TO DELAYED REPORTING.

**FIG. 4b. PERCENT DISTRIBUTION OF AIDS CASES BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994, AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1993, SOUTHERN CONE.**



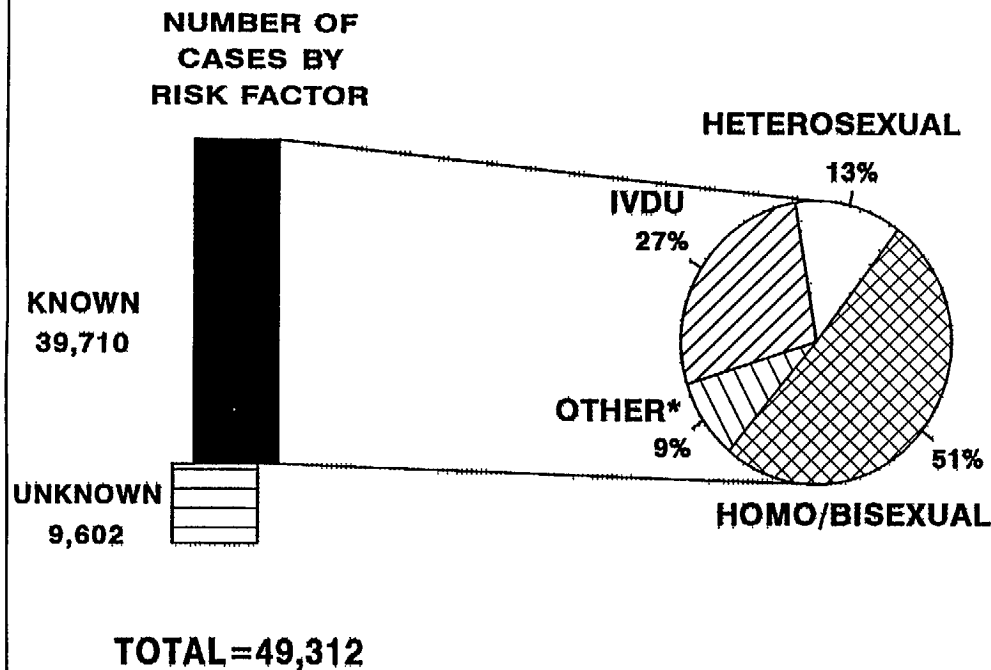
**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994.**



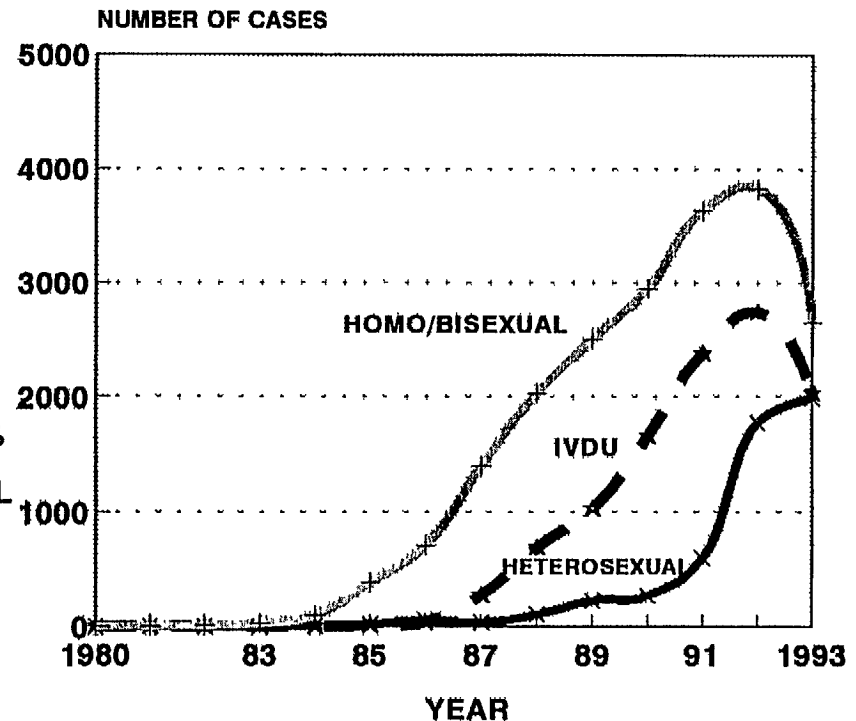
**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1993.**

\* INCLUDES 3.3% BLOOD, 3.3% PERINATAL AND .8% OF OTHER KNOWN RISK FACTORS.

**FIG. 4c. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994, AND ANNUAL INCIDENCE OF AIDS CASES, 1980-1993, BRAZIL.**



**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994.**

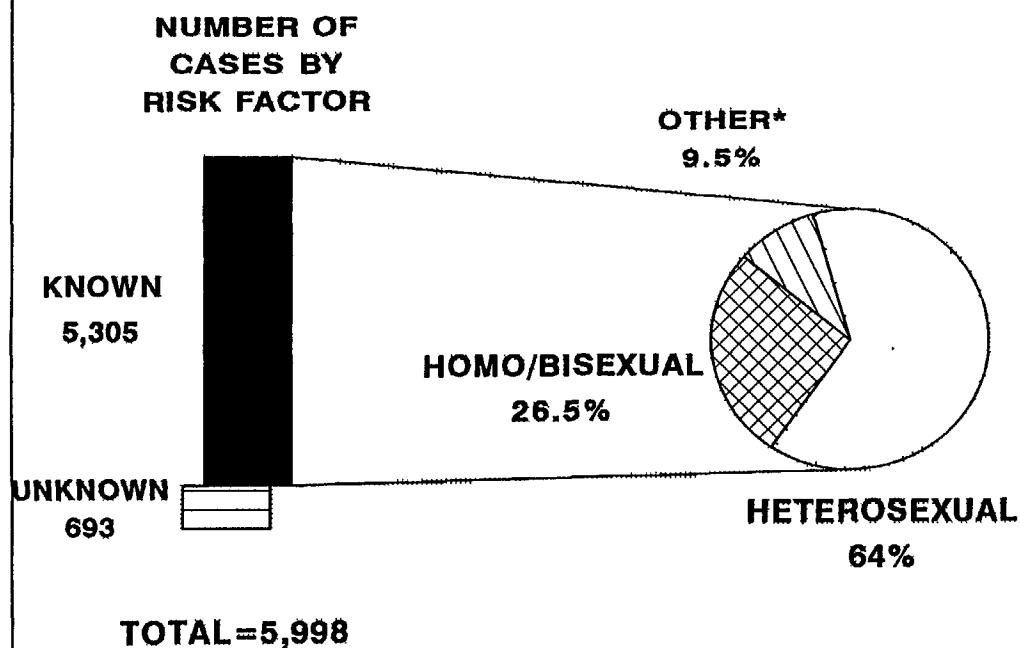


**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1980-1993.\*\***

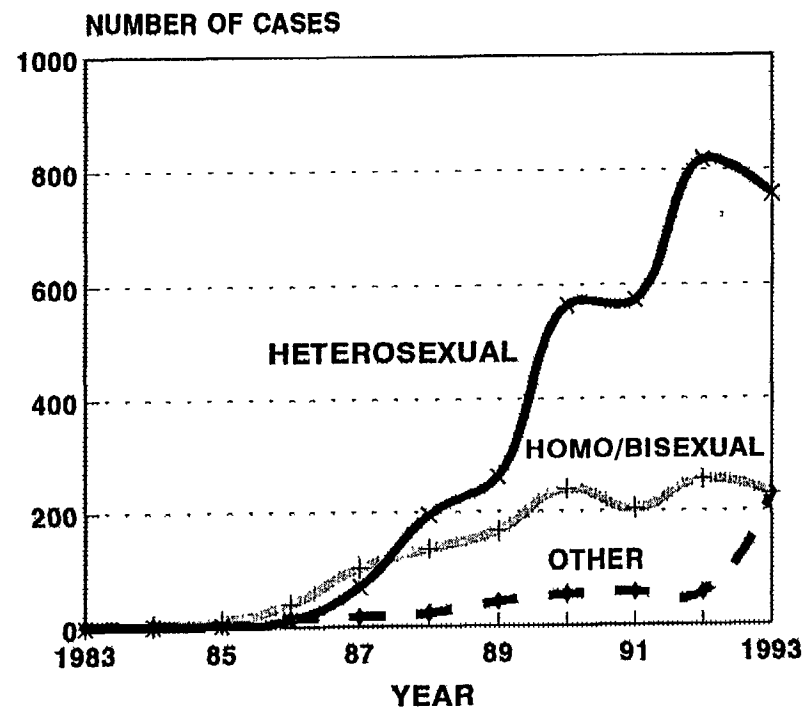
\* INCLUDES 6.6% BLOOD AND 2.3% PERINATAL AND <1% OF OTHER KNOWN RISK FACTORS.

\*\* 1993 DATA INCOMPLETE DUE TO DELAYED REPORTING.

**FIG. 4d. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994, AND ANNUAL INCIDENCE OF AIDS CASES, 1983-1993, CENTRAL AMERICAN ISTHMUS.**



**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994.**

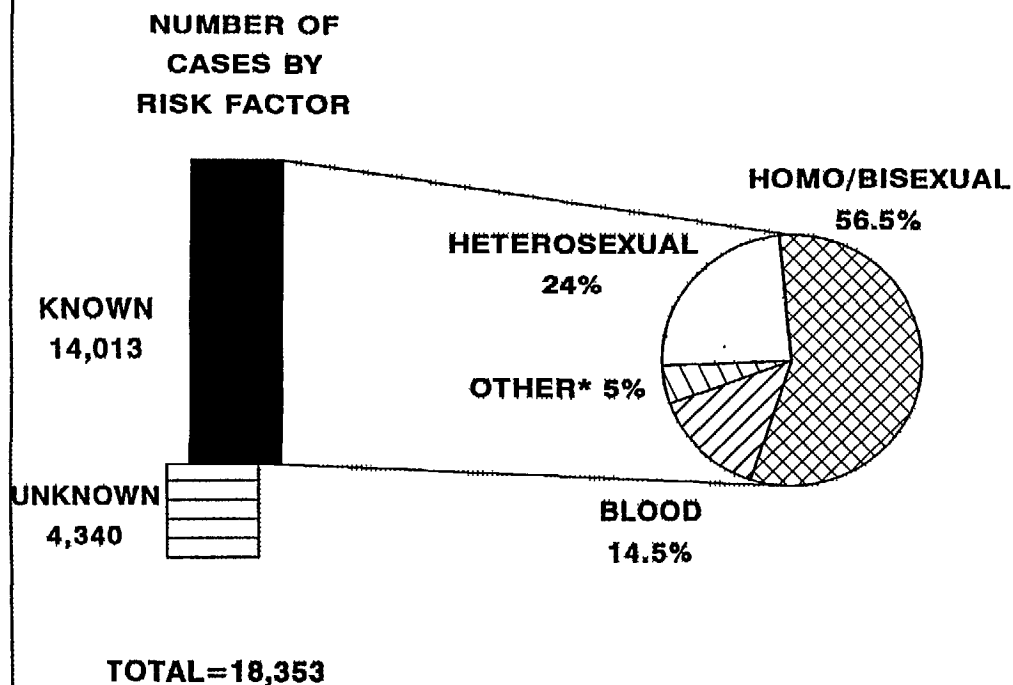


**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1983-1993.**

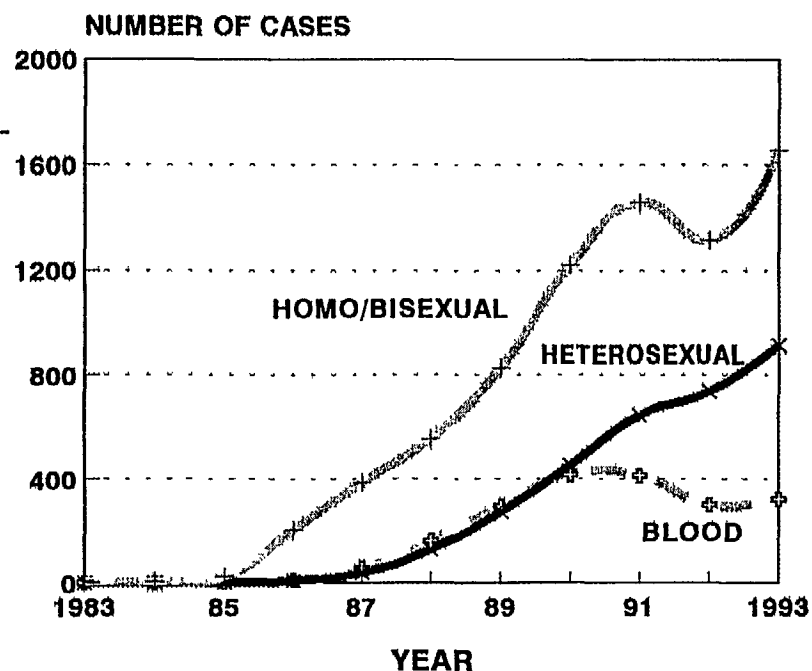
\* INCLUDES 2.5% BLOOD, 1% IVDU, 3% PERINATAL AND 3% OF OTHER KNOWN RISK FACTORS.



**FIG. 4e. PERCENT DISTRIBUTION OF AIDS CASES BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994, AND ANNUAL INCIDENCE OF AIDS CASES, 1983-1993, MEXICO.**



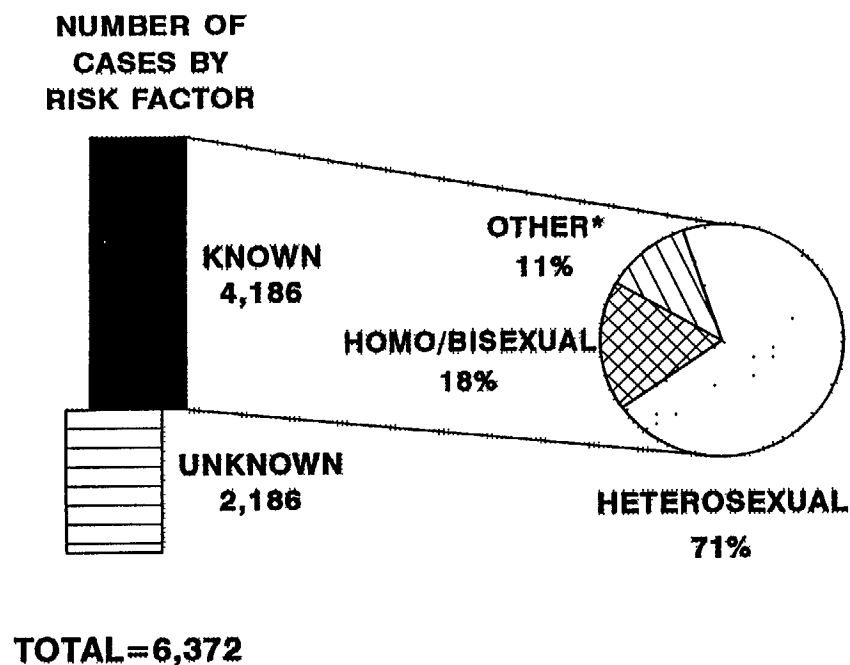
**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994.**



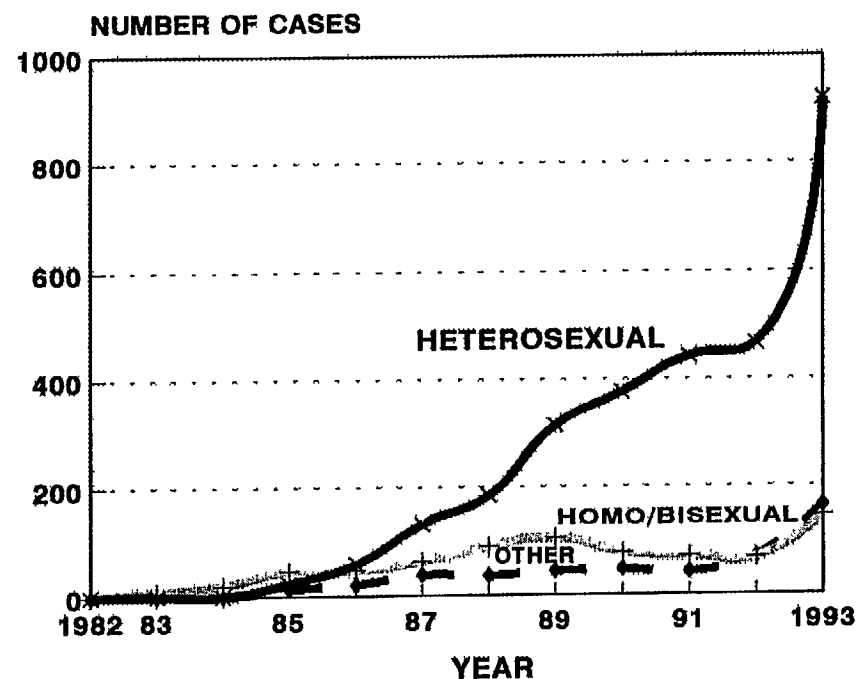
**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1983-1993.**

\* INCLUDES <1% IVDU, 2% PERINATAL AND 2.2% OF OTHER KNOWN RISK FACTORS.

**FIG. 4f. PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994, AND ANNUAL INCIDENCE OF AIDS CASES, 1982-1993, CARIBBEAN.**



**PERCENT DISTRIBUTION OF AIDS CASES, BY RISK FACTOR, CUMULATIVE THROUGH JUNE 1994.**



**ANNUAL INCIDENCE OF AIDS CASES, BY SELECTED RISK FACTORS, 1982-1993.**

\* INCLUDES <1% BLOOD, < 1% IVDU, 8% PERINATAL AND 1.5% OF OTHER KNOWN RISK FACTORS.