PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

XXIII PAN AMERICAN SANITARY CONFERENCE

XLII REGIONAL COMMITTEE MEETING

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CSP23/12 (Eng.)
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ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

In view of the fact that HIV infection and AIDS are placing an increasing burden on social and health services in the Member Countries, and given the changing situation in the epidemiology of AIDS and HIV infection in the Region, as well as the current status of national and regional activities for AIDS prevention and control in the Region of the Americas, the Secretariat presented to the Executive Committee, at its 105th Meeting, an analysis of activities undertaken by the Regional AIDS Program in support of efforts at the national level.

In the discussion that followed presentation of the Secretariat's report (Document CE105/7 and ADD. I), some aspects were pointed out that were not sufficiently explicit in the document, in particular those relating to: education and the efficient utilization of communications media; technological development and quality control of serologic diagnosis; medical care; active participation of PAHO in the mobilization and management of resources for national programs; and integration of the Regional AIDS Program with national programs at the regional, inter-country, and intra- and intersectoral levels and with other related programs. Attention was called to the need to establish more specific targets for AIDS prevention and control in the Region of the Americas. The session concluded with a request that the document be revised to give it greater clarity in terms of the points raised by the participants in the Meeting and, above all, to spell out more precisely the targets for AIDS prevention in the Region of the Americas.

The changes suggested by the Executive Committee have been introduced in the revised document (Annex). In particular, the targets for the AIDS Program in the Region of the Americas have been made more specific. Changes have also been made in reference to resource mobilization and management for the execution of national plans, to various aspects of education and research, and to integrated care of the infected patient.

It is requested that the XXIII Pan American Sanitary Conference review this document, analyze the status of the AIDS epidemic in the Americas, and decide on the targets for 1990-1991. Finally, the Conference is asked to consider the resolution recommended by the Executive Committee, as follows:

THE 105th MEETING OF THE EXECUTIVE COMMITTEE,

Having reviewed the report on acquired immunodeficiency syndrome (AIDS) in the Americas (Document CE105/7 and ADD. I),

RESOLVES:

To recommend to the XXIII Pan American Sanitary Conference the adoption of a resolution along the following lines:

THE XXIII PAN AMERICAN SANITARY CONFERENCE,

Having reviewed the report on acquired immunodeficiency syndrome (AIDS) in the Americas (Document CSP23/12);

Noting the changing situation of the epidemiology of AIDS and HIV infection in the Region and the status of national and regional AIDS prevention efforts in the Region;

Considering the important health, social, and economic consequences of the AIDS pandemic and its long-term repercussions on health programs and social services in the Americas; and

Cognizant of the financial and technical needs to ensure long-term, sustained efforts in the prevention of the sexual, blood-borne, and perinatal transmission of the human immunodeficiency virus (HIV) in the socioeconomic context of each individual Member Government,

RESOLVES:

1. To endorse the targets for the AIDS program in the Americas, as presented in Document CSP23/12.

2. To urge Member Governments to identify and mobilize adequate internal and external resources to ensure a continued and efficient multisectoral, governmental and nongovernmental participation in AIDS prevention and control at the national level.

3. To request the Director of the PASB, in coordination with GPA/WHO, to strengthen the regional managerial and resource mobilization capacities in support of national AIDS prevention programs.

Annex

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

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ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

1. INTRODUCTION

The AIDS epidemic continues to spread throughout the world. As of 29 July 1990 a cumulative total of 266,098 cases of AIDS were reported officially from 156 countries to the World Health Organization's Global Program on AIDS (GPA). GPA now estimates the actual cumulative number of AIDS cases to date to be more than 600,000, or more than twice the number of officially reported cases.

Transmission of the human immunodeficiency virus (HIV) continues throughout the world, and WHO estimates that over 5 million people are currently infected with the virus.

2. EPIDEMIOLOGY OF AIDS IN THE AMERICAS

All 46 countries and territories in the Americas have now reported cases of AIDS or persons infected with the human immunideficiency virus. As of 29 July 1990, a total of 165,934 cases of AIDS have been reported to the Pan American Health Organization since the beginning of surveillance in 1983. North America reported the largest number of cases, i.e., 140,289. Most of these cases occurred in the United States of America. Mexico has reported 4,416 cases, while the Latin Caribbean (Cuba, Haiti and the Dominican Republic) has reported a total of 3,781. The countries of the Central American Isthmus have reported 1,417 cases, and the English-speaking Caribbean countries have reported 2,153 cases. Brazil has reported 11,080 cases, while the Andean Area and the Southern Cone have reported 1,824 and 974 cases, respectively. As before, five countries, the United States of America, Brazil, Canada, Haiti and Mexico, continue to contribute over 95% of all the cases in the Region. Table 1 shows the AIDS cases by year for all Member Countries.

It is important to remember that geographic distribution of AIDS cases is not homogenous and that some of the smaller territories and islands in the Caribbean have an inordinate number of cases in proportion to their populations. The same is true in the larger countries where most of the cases are still concentrated in urban areas, or in some but not all states and provinces. On the other hand, the rate of increase in cases has been quite similar in North America, Latin America and the Caribbean, and the only difference has been the time of the initial recognition and notification of cases.

2.1 Transmission of the Human Immunodeficiency Virus (HIV)

In the Americas, as everywhere in the world, there are only three ways in which the HIV is being transmitted: 1) through sexual contact between two men, or between a man and a woman; 2) parenterally, through blood, blood products, organ transplants, contaminated syringes, needles, and other instruments; and 3) perinatally, from an infected mother to her child.

TABLE 1

AIDS SURVEILLANCE IN THE AMERICAS
CUMULATIVE NUMBER OF CASES AND DEATHS
As of 29 July, 1990

SUBREGION Country	Cases through 1986	Cases year 1987	Cases year 1988	Cases year 1989	Cases year 1990	Cum. total cases	Total deaths	Date of last report
REGIONAL TOTAL	44952	32341	39386	41171	8121	165934	96072	—
LATIN AMERICA a)	3687	4478	6586	7722	1050	23492	9243	—
ANDEAN AREA	229	323	465	727	110	1824	884	—
Bolivia	3	2	3	3	0	11	7	30 Jun 89
Colombia	84	119	105	335	0	643	333	31 Dec 89
Ecuador	15	19	25	15	7	79	56	31 Mar 90
Peru	37	60	68	117	70	324	122	31 Mar 90
Venezuela	90	123	264	257	33	767	366	31 Mar 90
SOUTHERN CONE	100	128	259	353	134	974	391	—
Argentina	69	72	174	251	85	651	242	30 Jun 90
Chile	22	41	55	60	0	178	71	31 Dec 89
Paraguay	1	6	2	4	3	16	13	31 Mar 90
Uruguay	8	9	28	38	46	129	65	30 Jun 90
BRAZIL	1568	2077	3314	3706	415	11080	5555	31 Mar 90
CENTRAL AMERICAN ISTHMUS	87	155	309	538	329	1417	629	—
Belize	1	6	4	0	0	11	8	31 Sep 88
Costa Rica	20	23	52	56	18	169	96	31 Mar 90
El Salvador	7	16	48	94	27	192	38	31 Mar 90
Guatemala	18	16	13	18	27	92	56	30 Jun 90
Honduras	15	66	130	301	231	743	306	30 Jun 90
Nicaragua	1	0	2	2	3	7	4	30 Jun 90
Panama	25	28	60	67	23	203	121	30 Jun 90
MEXICO	793	997	1192	1434	0	4416	1270	31 Dec 89
LATIN CARIBBEAN b)	910	798	1047	964	62	3781	514	—
Cuba	0	27	24	12	0	63	29	31 Mar 90
Dominican Republic	115	294	292	499	62	1262	188	31 Mar 90
Haiti	795	477	731	453	0	2456	297	31 Dec 89
CARIBBEAN	462	387	525	716	69	2153	1261	—
Anguilla	0	0	3	1	1	5	1	30 Jun 90
Antigua	2	1	0	0	0	3	3	31 Mar 89
Bahamas	86	90	93	168	0	437	229	31 Dec 89
Barbados	32	24	15	40	16	127	97	30 Jun 90
Cayman Islands	2	1	1	1	0	5	5	31 Dec 89
Dominica	0	6	1	3	0	10	10	31 Dec 89
French Guiana	78	25	34	54	0	191	118	31 Dec 89
Grenada	3	5	3	5	1	17	15	31 Mar 90
Guadeloupe	47	41	47	47	0	182	85	31 Dec 89
Guyana	0	10	34	40	12	96	43	31 Mar 90
Jamaica	11	33	30	66	10	150	80	31 Mar 90
Martinique	25	21	25	44	10	125	65	31 Mar 90
Montserrat	0	0	0	1	0	1	0	30 Jun 89
Netherlands Antilles	0	23	16	2	0	41	16	30 Jun 89
Saint Lucia	3	7	2	4	0	16	10	31 Mar 89
St. Christopher–Nevis	1	0	17	0	0	18	9	31 Dec 89
St. Vincent and the Grenadines	3	5	8	6	0	22	12	31 Dec 88
Suriname	4	5	4	35	19	67	52	30 Jun 89
Trinidad and Tobago	155	86	158	164	0	557	376	31 Dec 89
Turks and Caicos Islands	3	4	1	0	0	8	4	31 Dec 88
Virgin Islands (UK)	0	0	1	0	0	1	0	31 Mar 90
Virgin Islands (US)	7	0	32	35	0	74	31	31 Mar 90
NORTH AMERICA	40803	27476	32275	32733	7002	140289	85568	--
Bermuda	51	21	28	35	0	135	102	31 Dec 89
Canada	1151	833	919	919	128	3950	2321	30 Jun 90
United States of America b)	39329	26313	30514	28007	821	124984	83145	30 Jun 90

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

b) Puerto Rico included in USA.

Initially, AIDS cases in Latin America and the Caribbean were reported among male homosexuals and bisexuals with a history of travel outside Latin America and the Caribbean. With increasing frequency, this pattern is shifting toward heterosexual transmission, and there are now two distinct patterns of sexual transmission in the Americas.

Figure 1 clearly contrasts the two patterns found in the Region. Pattern 1 is found in countries where the disease is transmitted by homosexual/bisexual men, as shown in four representative countries: the United States of America, Canada, Chile, and Bolivia. Pattern 2 is characterized by heterosexual transmission, as found in the Dominican Republic, Trinidad and Tobago, Honduras, and Bahamas. Over time, more and more countries will move from pattern 1 to pattern 2. A direct consequence of this movement toward heterosexual transmission will be an increase in the perinatal transmission of AIDS to children and further spread of the epidemic in the heterosexual community.

Transmission through blood continues to be a major problem in the Americas. Many countries do not have an HIV-free blood supply because the basic infrastructure for transfusion services does not permit screening 100% of transfused blood. HIV antibody prevalence among blood donors is highly variable, as shown in Table 2.

The contribution of contaminated needles and syringes to the transmission of the AIDS virus among drug abusers and through inappropriately sterilized medical equipment appears to be less important for most countries in the Region. However, HIV transmission among IV drug users is increasing rapidly in several cities of North and South America and in some smaller territories in the Caribbean.

Table 3 summarizes the prevalence of HIV infection in different population groups according to their risk behavior. Studies on homosexual men have disclosed HIV prevalence ranging from 9.4 to 20.3%. As it can be seen from this table, IV drug use is a phenomenon that has not been sufficiently studied. However, there are indications leading to the assumption that in some areas it is a determining factor in the high prevalence of infection.

At the world level, it is estimated that five million people are already infected with HIV. Based on current knowledge of the natural history of HIV infection, international experts have predicted that even if we could stop HIV transmission now, we could still expect five to six million cases of AIDS worldwide by the year 2000. If HIV transmission is not greatly reduced or stopped, the number of infected individuals may exceed 16 million by the same year. Medical care costs and social services required by the increasing numbers of AIDS patients and HIV-infected individuals will undoubtedly pose a major challenge to achieving the goals of "Health for All by the Year 2000" in many countries of the Region and the world.

FIGURE 1

AIDS SURVEILLANCE IN THE AMERICAS
Bisexual/Homosexual vs Heterosexual Transmission 1987 - 1988

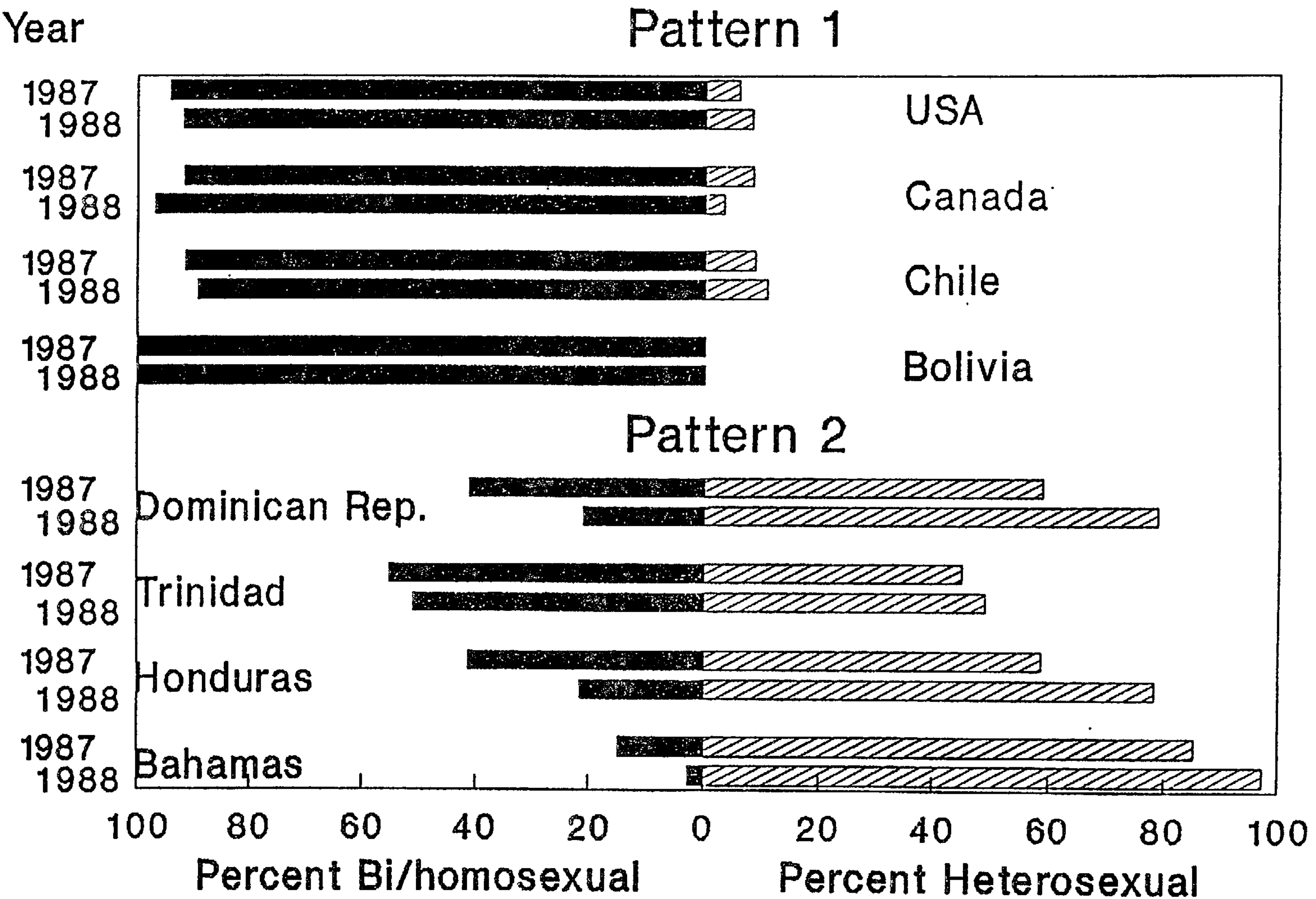


TABLE 2

HIV PREVALENCE IN BLOOD DONORS

SELECTED LATIN AMERICAN CITIES

City, Date	Sample Size	Prevalence rate %
Panama City, 1986 PANAMA	7720	0.2
7 Cities, 1987 COLOMBIA	38077	0.1
Buenos Aires,1987 ARGENTINA	9810	0.1
Mexico City, 1986-87	319153	0.7
Puebla, 1985-86 MEXICO	1362	0.7
Rio de Janiero,1985-7	21679	0.2
Sao Paulo,1985-86 BRAZIL	22245	0.2

As compiled by U.S.Census Bureau 1989

TABLE 3

SEROPREVALENCE BY RISK GROUP SUBREGIONS

Subregion	Homo-Bisexual	I.V. Drug User
Andean	20.3% (n=128)	N.A
Brazil	12.3% (n=283)	48.9% (n=366)
Central America	9.4% (n=668)	N.A
Mexico	21.1% (n=3370)	N.A.
Latin Caribbean	15.1% (n=233)	N.A.
Southern Cone	11.7 (n=556)	35.6% (n=1302)

1989 U.S. Census Bureau (Pooled averages)

2.2 Recent Advances in AIDS Research and AIDS Prevention

During the last year, the advances in scientific knowledge related to AIDS and HIV infection have not been as dramatic as in previous years. However, a steady progress has been achieved in several areas. These include the diagnosis and management of HIV-infected individuals with utilization of more sophisticated laboratory tests such as IgA detection in perinatal AIDS, the polymerase chain reaction (PCR) and the wide use of prognostic indicators such as the CD4 count; the development of an HIV staging system; implementation of clinical trials of established and promising drugs (AZT, ddC, ddI, interferon) at earlier stages of the infection and in pediatric age groups; better understanding of gene regulation of HIV; interaction of HIV infection and other infectious agents; initial evaluation of additional candidate vaccines and immunomodulators, and others. However, a cure for AIDS and the primary prevention of HIV infection through vaccination remain elusive.

On the other hand, research on and evaluation of educational interventions have begun to show that behavioral changes are possible and perhaps sustainable in some specific population groups. Finally, epidemiological biomedical, clinical, behavioral and economic research are increasingly being conducted in developing countries to answer questions relevant to AIDS prevention in those particular settings.

3. DEVELOPMENT OF PROGRAMMING TO COMBAT AIDS IN THE AMERICAS

Programming to combat AIDS in the Americas began in 1986 with the initiation of emergency activities for AIDS control. This phase included emergency funding from the Global Program on AIDS to country efforts. PAHO-assisted Member Countries in developing both their emergency strategies and short-term programs for AIDS control with a one-year term of financing and activities. By mid-1988, all countries had received some funds for AIDS control and the last of the short-term plans was approved and funded in 1989. As the long-term nature of the problem became clear, medium-term coordinated control efforts replaced short-term efforts as a priority. The medium-term plan process to detail national activities over a three-year planning frame allows countries to plan more effective interventions and also brings donors other than GPA into the financing of AIDS efforts. Such plans have been elaborated by 35 Member Countries.

The appreciation of the long-term nature of the AIDS epidemic reinforced not only the appreciation of the need for medium-term planning efforts but also the appreciation that AIDS control efforts need to become a permanent, integrated and sustainable program within the ongoing efforts to insure the public health in the Region. Early national AIDS control programs, in view of the urgency with which they were conceived

and implemented, tended to have a vertical approach. GPA and GPA/Americas have undertaken concrete action to assist national programs in broadening the programming approach to include links with other programs such as MCH and family planning programs, STD and tuberculosis control activities, and adult health programs. Such links serve to assure permanence and integration of AIDS programming.

The initiative to involve NGOs in national AIDS programs, the institution of interagency and interprogrammatic activities by GPA/Americas, the introduction of multidisciplinary teams and the interprogrammatic briefing and orientation of such teams to provide technical collaboration in national AIDS program formulation and execution, all represent examples of efforts to insure broad programming in the effort against AIDS at both the regional and national level.

There has been an increasing emphasis on the national contribution to AIDS programming. It is clear that the fight against AIDS requires strong national commitment and the dedication of national resources to this priority area. At the same time, there must be a balance between the imperatives of AIDS control and the ongoing need for health care and disease prevention for other conditions and problems. It is clear that the majority of resources dedicated to AIDS control are national resources. It is is estimated that the financial contribution of GPA to national programs is approximately 20% of moneys spent on such programs from national and international sources.

4. GLOBAL PROGRAM ON AIDS IN THE AMERICAS

PAHO continues to execute the Global Program on AIDS in the Americas. Since 1987, PAHO has been promoting the establishment of national AIDS prevention and control programs in all the major territories and countries in the Region of the Americas in accordance with WHO/GPA guidelines. In the process, more than $15 million from GPA sources has been applied in direct support of national programs and more than $5 million, for regional activities. During this time, the regional effort has moved from emergency and short-term support to longer-term objectives for the next three to five years, specifically the development of medium-term national plans and the consolidation of the Regional capacity to provide leadership and technical collaboration to Member Countries.

4.1 Objectives

The first priority of the AIDS Program is to improve the quality and intensity of technical collaboration with the countries to strengthen existing national programs. The program's main objectives are:

a) To prevent blood, sexual, and perinatal transmission of HIV;

b) To reduce the morbidity and mortality associated with HIV infection;

c) To diminish the impact of HIV infection on individuals, groups, and societies.

The second major regional priority is to consolidate the management of the program, mobilizing human and financial resources and providing leadership and coordination for AIDS prevention in the Americas.

4.2 Strategies

Highest priority has been placed on direct technical collaboration with Member Countries in support of the development, execution, financing and evaluation of their national AIDS prevention and control programs. PAHO has mobilized resources and has provided technical cooperation to the countries in all aspects of the national AIDS programs. Broadly, these activities have included support to national AIDS commissions; development of national managerial and administrative capacity; improvement of surveillance; enhancement of laboratory capability; and strengthening of national and international efforts to prevent sexual, blood-borne, and perinatal transmission of HIV through educational and other public health approaches.

Another strategy has been the dissemination of technical information on the epidemiological, biological, clinical, laboratory, and educational/behavioral aspects of AIDS and HIV infection.

4.3 Activities

Virtually 100% of the activities of the GPA/Americas program planned for 1989 were completed. The level of execution of the 1989 budget was 85%.

Due to the nature of the AIDS epidemic and its perception in the countries, a large number of non-programmed activities were implemented in response to country requests for specific technical assistance. In addition, there were unanticipated demands to have regional representation at global meetings on AIDS prevention and control.

4.4 Organization

The GPA/Americas program is a component of the Health Situation and Trend Assessment Program (HST) under the area of Health Services Infrastructure (HSI) of the Pan American Sanitary Bureau, the Secretariat of PAHO.

Program direction and coordination of activities is the responsibility of the Senior Regional Advisor (SRA) on AIDS/STD, under the overall coordination of the Program Coordinator (HST). The SRA office is

also responsible for special initiatives (e.g. laboratory strengthening; global blood safety initiative, teleconferences, etc.) and for coordination of PAHO's interprogrammatic group on AIDS and the interagency group for AIDS prevention in the Americas.

The main areas of activities of the AIDS program are carried out by three units: National Program Support (NPS), Health Promotion (HPR), and Research (RES). The AIDS program organizational chart is attached (Figure 2). During the last year PAHO initiated a change in program direction, from an emergency mode towards a more consolidated approach to planning and implementation of activities. In addition to the Washington staff, there are four intercountry advisors to provide technical cooperation to the Caribbean countries (stationed at CAREC), Central America and Panama (stationed in Costa Rica), the Andean countries (stationed in Ecuador), and Brazil and the Southern Cone (stationed in Brazil), as well as a country advisor in Haiti. In other words, there is a total permanent staff of 11 professionals, of whom six are in the Washington offices and five are assigned to countries in the Region. Two permanent posts are in the process of being filled.

5. ACHIEVEMENTS OF PAHO TECHNICAL COOPERATION WITH THE MEMBER COUNTRIES

The Region's emergency and short-term programs began to take shape in 1987. PAHO provided timely technical and financial assistance for development of the activities envisaged in these programs. Since 1988, medium-term (three- to five-year) plans have been developed as part of national AIDS prevention and control programs for the following subregions: the English-speaking Caribbean, the Latin Caribbean, Mexico and Central America. Plans have also been developed for Brazil and the countries of the Andean subregion. Plans for the Southern Cone countries are nearing completion.

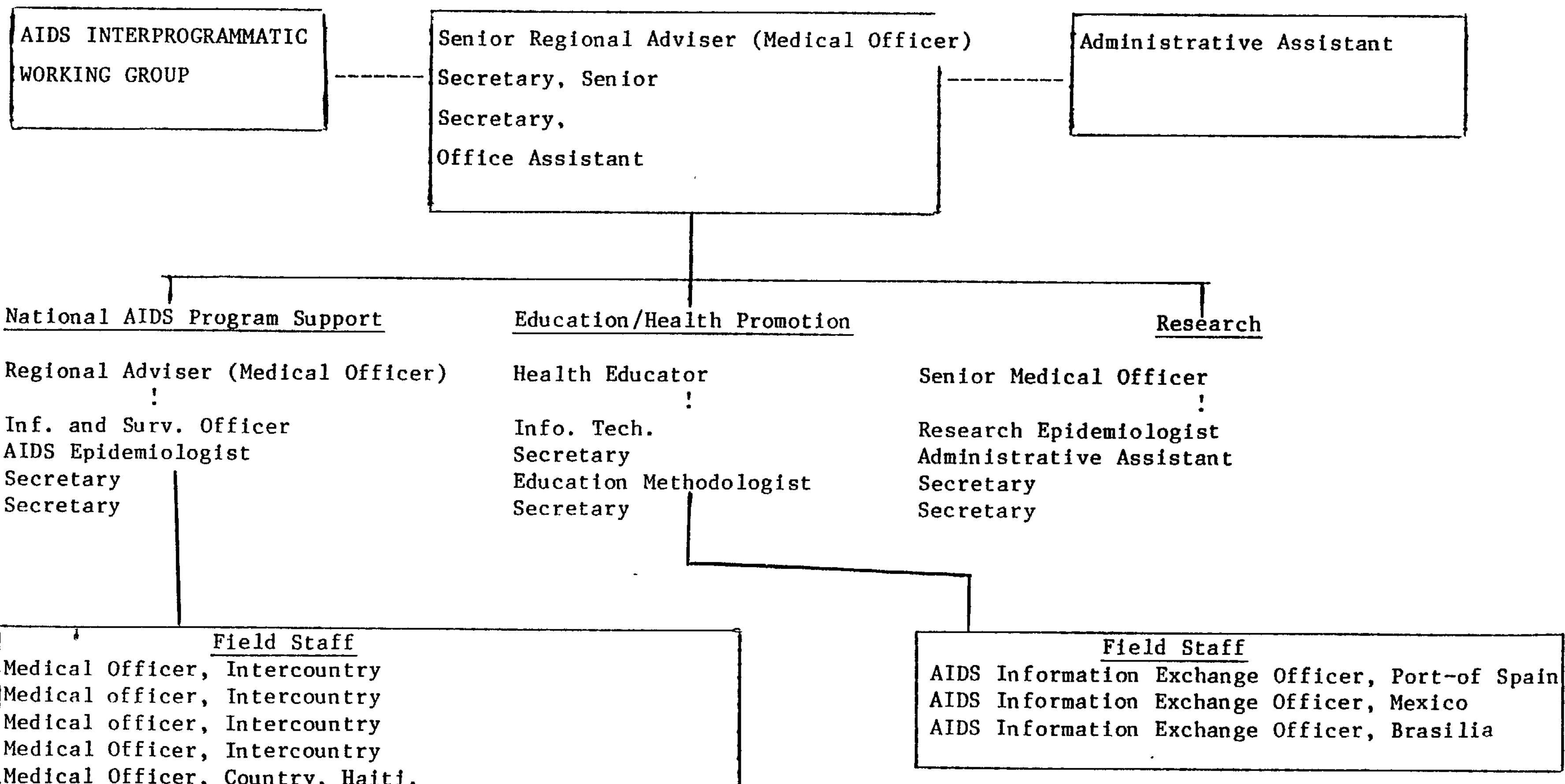
In connection with the development of these plans, PAHO has mobilized human resources for the delivery of technical assistance to the Member Countries in the areas of management and finances, epidemiology, health education and promotion, and laboratories. In 1989, 78 consultant/months were devoted to collaboration in the development of the medium-term programs. More than 85% of the consultants were from within the Region, not including the United States of America, which reflects the extent to which technical collaboration among developing countries has been promoted.

The consultants who visited the countries to evaluate national programs and collaborate in the development of strategies for bridging the transition between the short- and long-term approaches also worked actively with the national teams on strategies for the financing of these programs.

FIGURE 2

PROPOSED ORGANIZATIONAL CHART

HST/AIDS PROGRAM PERSONNEL



Currently, review and reprogramming activities are being carried out with the Caribbean countries and territories, which are now entering the second year of activities under their medium-term plans. A review and monitoring meeting held in Jamaica last year included 20 Member Countries and territories and produced a concrete plan for carrying out these activities in a timely way.

In general, the plans associated with the national programs continue to reflect the four key strategies for the prevention and control of AIDS, namely: prevention of sexual transmission of HIV, prevention of transmission through blood or blood products, prevention of perinatal transmission, and reduction of the impact of the AIDS epidemic on individuals and groups in society. The expertise on the consultant teams, consisting of an epidemiologist, a health education specialist, a laboratory expert, and an administrator, has helped to strengthen the capability to put these strategies into practice.

The Regional Program collaborated significantly in efforts to attain targets such as those of the Caribbean programs, which to date have managed to screen between 90 and 95% of the blood received for transfusions. In Central America, Costa Rica has succeeded in screening all blood received for transfusion, and the rest of the subregion has screened 80%.

Epidemiological surveillance activities at the regional level have improved, thanks to a review and major reprogramming undertaken at the end of 1989 and the beginning of 1990. In 1990 the Regional Program produced an epidemiological surveillance report for 1989, including data on numbers of AIDS cases and seroprevalence, as a supplement to the quarterly report which is delivered to the Member Countries.

The Program disseminates technical and scientific information to national AIDS prevention and control programs. Some special initiatives include the establishment of three Information/Education Communication Centers in Mexico and Brazil and at PAHO's Caribbean Epidemiology Center (CAREC) to collect, evaluate, and disseminate AIDS information and education materials from as many countries as possible to other Member Countries to assist them in formulating their national education efforts. Scientific information is distributed to the national programs utilizing compact disk technology. The compact disk contains the entire bibliography on AIDS from the US National Library of Medicine plus the full text of articles selected from major worldwide journals. PAHO will continue to utilize innovative technology to promote AIDS education through the broadcast of the Third Pan American Teleconference on AIDS in the near future. This Teleconference is expected to reach over 50,000 health care workers throughout the Americas.

The Regional Program has organized numerous workshops as a contribution to activities for the formation and technical training of in-service professionals and staff in the national programs, mainly in

the areas of health promotion, psychological guidance, epidemiological surveillance, and research techniques and methods, with the participation of personnel from all the countries of the Region.

As a part of the research activities and a special contract with the U.S. National Institutes of Health (National Institute of Allergy and Infectious Diseases), PAHO has established research programs on AIDS in several countries. Much of the research has been oriented toward obtaining information that will make it possible to understand how HIV is being spread in the Latin America and Caribbean countries. The objectives of the research already done or currently under way include the following: to determine seroprevalence in different population groups, to define the extent and consequences of perinatal infection and heterosexual transmission, and to identify chemoprophylactic treatments that are effective in preventing the opportunistic infections associated with AIDS. One of the studies in these areas has been completed, three of them are currently under way, and seven are undergoing scientific evaluation. PAHO is now seeking to extend its research activities beyond the biomedical sphere to include projects on behavioral research.

In order to promote international coordination, PAHO has organized quarterly meetings attended by well over 40 representatives from various international and national agencies and institutions. This has helped to coordinate support for PAHO's Member Countries for AIDS prevention and control.

Finally, through the strategy of resource mobilization, PAHO, with the collaboration of the GPA, has secured funding for the countries from WHO and other donors in the amount of $20 million since the beginning of the program. These funds have been distributed to 35 countries and PAHO's Caribbean Epidemiology Center (CAREC). During the period 1987-1990, 75% of these funds were distributed directly to the countries. The largest share went to the Caribbean countries (39%) while Brazil, the Central American Isthmus and the Latin Caribbean received 14, 11, and 11%, respectively. In 1989 alone, $5.4 million was secured for Regionwide AIDS prevention and control. Of the total amount, $4.5 million was channeled directly to the countries in support of their programs. The Caribbean areas received the largest amount (34%), followed by Central America (27%), and Brazil (19%).

During the second half of 1989 and the first half of 1990 resource mobilization meetings for the five central American Republics, Panama, and Mexico were held.

In the remainder of 1990 the medium-term plans for the five Andean countries, the Southern Cone countries, and Brazil will be finalized, and PAHO will continue to assist its Member Countries in seeking additional international support for their national AIDS prevention plans. A formal review of the progress of the Caribbean programs will be undertaken in

accordance with the recommendations of national AIDS program managers, meeting in Kingston, Jamaica, in March 1990. The strengthening of regional and national managerial capacity will remain as a top priority for PAHO's AIDS program.

6. TARGETS FOR 1990-1991

For the biennium 1990-1991, the following targets for AIDS prevention in the Americas are proposed:

a) By 1991, all countries and territories of the Region will have medium-term programs for AIDS prevention and control in written form, fully funded, and under way.

b) During the biennium, administrative and managerial capacity will be developed in all the national programs, with emphasis on middle-level management.

c) During the biennium, all national AIDS prevention and control programs will strive to develop explicit national policies aimed at achieving and supporting the coordination of these programs with other programs for woman, children, and the family, particularly maternal and child health, reproductive health, and family planning, as well as programs on the sexually transmitted diseases.

d) By the end of 1991, 100% of the blood and the blood products used in the public sector will have been screened for HIV in all the countries of the Region. In addition, all needed support will be being given to the private sector for the attainment of an equivalent target. Screening should be supplemented by educational efforts so that potentially infected donors will exclude themselves.

e) By the end of 1991, all countries will have established national reference laboratories and laboratory networks for detecting HIV infection and will have implemented quality control programs for HIV testing. In addition, the development and use of tests that are rapid, inexpensive, specific, and sensitive will be encouraged.

f) By the end of 1991, at least four subregional collaborating laboratories will have been developed for purposes of reference, training, and technology transfer in the diagnosis of HIV infection.

g) By 1991, all the countries will have enacted the necessary legal provisions to implement safety standards on blood used for transfusion, as well as to safeguard the identity of seropositive individuals and protect them against discrimination.

h) By 1992, all national programs will have developed capability in the serological surveillance of HIV infection, with a view to orienting and evaluating control programs.

i) By the end of 1991, PAHO will have developed guidelines and procedures for the optimum utilization of all communication and education media and material and human resources, including community health promoters and other members of the primary care team, with a view to making specific interventions in behavior aimed at effective and lasting changes in the younger sexually active population.

j) By 1991, there will be at least 15 research projects under way for the purpose of defining the extent and consequences of heterosexual and perinatal transmission of HIV and other retroviruses. Quantitative and qualitative research will also be being carried out on knowledge, attitudes, beliefs, and practices in at least 10 countries of the Region. Other operations research pertinent to the work of the national programs will be initiated, including aspects such as the cost-effectiveness of interventions and follow-up of contacts.

k) By 1991, PAHO will have developed guidelines and procedures for promoting, obtaining, maintaining, and distributing condoms and virucidal products.

l) By 1991, PAHO will have prepared guidelines and examples for use in schools in teaching preventive behavior and ways of locating appropriate health services, as well as the development of attitudes of solidarity and responsibility, with a view to reducing the spread of HIV and other sexually transmitted diseases.

m) During the biennium, PAHO will actively support the national programs' activities in health worker training, education, and social communication, with special emphasis on laboratory aspects, epidemiology, and health education and promotion.

n) By 1991, all national programs should have outlined a national plan for the care of infected patients. This plan should include such aspects as prophylaxis against associated infections, support for community participation in patient care, and psychological orientation for patients and their families.

PAHO has played, and will continue to play, an important role in the attainment of these targets, both by giving technical and scientific support and by coordinating technical cooperation among the countries. Also important is the role that PAHO plays and will continue to play in

the Member Countries' search for the additional international support needed in order to fully carry out their plans. However, attainment of the targets above will depend basically on efforts made by the national programs to mobilize and obtain the support of nongovernmental, governmental, and private organizations and interested groups for the activities envisaged in the countries' respective medium-term plans.

Articulation of efforts at the intrasectoral and intersectoral level is also necessary in order to be able to deal with some of the problems that have recently emerged, such as the widespread use of drugs, especially injectable drugs, among young people.

It is strongly recommended that all national programs include among their activities the formulation of explicit policies aimed at striking a balance between individual human rights, on the one hand, and public health needs, on the other, in the prevention and control of AIDS. A contribution to this effort is the meeting that PAHO is organizing in 1990 on legal and ethical aspects of AIDS.

PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

XXIII PAN AMERICAN SANITARY CONFERENCE

XLII REGIONAL COMMITTEE MEETING

WASHINGTON, D.C.
SEPTEMBER 1990

Provisional Agenda Item 5.10

CSP23/12, ADD. I (Eng.)
12 September 1990
ORIGINAL: ENGLISH

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

The Director is pleased to present to the Conference an updated report on the status of AIDS surveillance in the Americas as of 12 September 1990.

AIDS SURVEILLANCE IN THE AMERICAS
CUMULATIVE NUMBER OF CASES AND DEATHS
As of 12 September, 1990

SUBREGION Country	Number of cases Through 1986	1987	1988	1989	1990	Cumulative Total (a)	Total deaths	Date of last report
REGIONAL TOTAL	45,095	32,526	40,033	42,353	13,894	173,933	101,602	
LATIN AMERICA (b)	3,647	4,513	6,801	7,480	1,321	23,794	9,955	
ANDEAN AREA	200	328	461	772	166	1,957	965	
Bolivia	3	2	3	3	...	11	7	30/Jun/90
Colombia	84	119	105	335	...	643	333	31/Dec/89
Ecuador	13	19	25	15	7	81	56	31/Mar/90
Peru	9	60	68	117	70	352	122	31/Mar/90
Venezuela	91	128	260	302	89	870	447	30/Jun/90
SOUTHERN CONE	100	128	259	353	138	978	391	
Argentina	69	72	174	251	85	651	242	30/Jun/90
Chile	22	41	55	60	...	178	71	31/Dec/89
Paraguay	1	6	2	4	3	16	13	31/Mar/90
Uruguay	8	9	28	38	50	133	65	31/Aug/90
BRAZIL	1,558	2,077	3,314	3,706	415	11,070	5,555	31/Mar/90
CENTRAL AMERICAN ISTHMUS	86	155	309	538	359	1,448	642	
Belize	1	6	4	...	...	11	8	30/Sep/88
Costa Rica	20	23	52	56	48	199	109	30/Jun/90
El Salvador	7	16	48	94	27	192	38	31/Mar/90
Guatemala	18	16	13	18	27	92	56	30/Jun/90
Honduras	15	66	130	301	231	743	306	30/Jun/90
Nicaragua	0	0	2	2	3	8	4	30/Jun/90
Panama	25	28	60	67	23	203	121	30/Jun/90
MEXICO	793	1,027	1,411	1,147	76	4,454	1,882	30/Jun/90
LATIN CARIBBEAN (c)	910	798	1,047	964	167	3,887	520	
Cuba	0	27	24	12	0	63	29	31/Mar/90
Dominican Republic	115	294	292	499	167	1,368	194	30/Jun/90
Haiti	795	477	731	453	...	2,456	297	31/Dec/89
CARIBBEAN	458	387	528	726	257	2,356	1,371	
Anguilla	0	0	1 *	2 *	1 *	4 *	1	30/Jun/90
Antigua	2	1	0	0	0	3	3	31/Mar/90
Bahamas	86	90	93	168	70	507	273	30/Jun/90
Barbados	32	24	15	40	16	127	97	30/Jun/90
Cayman Islands	2	1	1	1	...	5	5	31/Dec/89
Dominica	0	6	1	3	2	12	10	30/Jun/90
French Guiana	78	25	34	54	...	191	118	31/Dec/89
Grenada	3	5	3	5	1	17	15	31/Mar/90
Guadeloupe	47	41	47	47	...	182	85	31/Dec/89
Guyana	0	10	34	40	24	108	49	30/Jun/90
Jamaica	11	33	30	66	26	166	80	30/Jun/90
Martinique	25	22	28	50	10	135	78	30/Jun/90
Montserrat	0	0	0	1	0	1	0	30/Jun/89
Netherlands Antilles	0	23	16	2	...	41	16	30/Jun/89
Saint Lucia	3	7	2	4	...	16	10	31/Mar/89
St. Christopher–Nevis	1	0	17	0	...	18	9	31/Dec/88
St. Vincent and the Grenadines	3	5	8	6	...	22	12	31/Dec/89
Suriname	4	5	4	35	19	67	52	30/Jun/90
Trinidad and Tobago	151	85	160	167	85	648	423	30/Jun/90
Turks and Caicos Islands	3	4	1	...	...	8	4	31/Dec/88
Virgin Islands (UK)	0	0	1	0	0	1	0	31/Mar/90
Virgin Islands (US)	7	0	32	35	3	77	31	31/Aug/90
NORTH AMERICA	40,990	27,626	32,704	34,147	12,316	147,783	90,276	
Bermuda	51	21	28	35	12	147	114	30/Jun/90
Canada	1,236	865	961	1,026	339	4,427	2,518	31/Aug/90
United States of America (c)	39,703	26,740	31,715	33,086	11,965	143,209	87,644	31/Aug/90

* Provisional.

(a) May include cases for year of diagnosis unknown

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

(c) Puerto Rico included in USA.