WORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SAN

GLOBAL PROGRAMME ON AIDS

The Current Global Situation of the HIV/AIDS Pandemic

3 July 1995

As of 30 June 1995, 1 169 811 cumulative AIDS cases in adults and children have been reported to the World Health Organization Global Programme on AIDS since the onset of the pandemic. This represents a 19% increase from the 985 119 cases reported in the 1 July 1994 Report.

The accompanying tables provide, by country and WHO Region, the number of reported AIDS cases to date, by year of diagnosis.

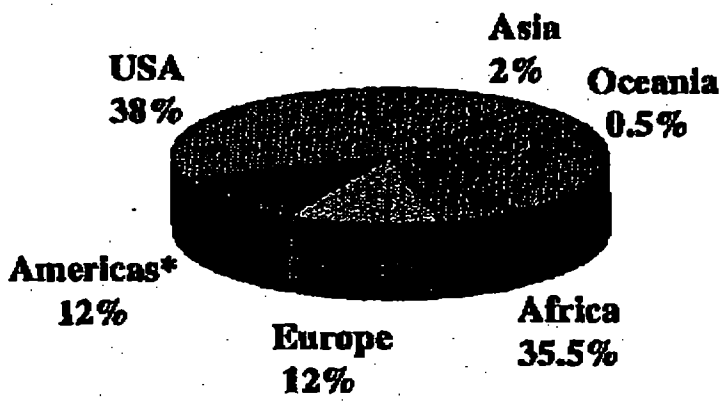
Figure 1 presents the global distribution of reported and estimated AIDS cases as of mid 1995. Allowing for under-diagnosis, incomplete reporting and reporting delay, and based on the available data on HIV infections around the world, it is estimated that over 4.5 million AIDS cases in adults and children have occurred worldwide since the pandemic began.

As of mid 1995, it is estimated that around 18.5 million adults, and more than 1.5 million children, have been infected with HIV since the beginning of the pandemic (late 1970s to early 1980s). Figure 2 presents the estimated regional distribution of total HIV infections in adults to date. The continued increase in HIV infections, particularly in southern and central Africa and South Asia, will accentuate the disproportionate impact of HIV/AIDS on the developing world.

Figure 3 shows the estimated regional distribution of HIV-infected adults (including AIDS cases) alive as of mid 1995.

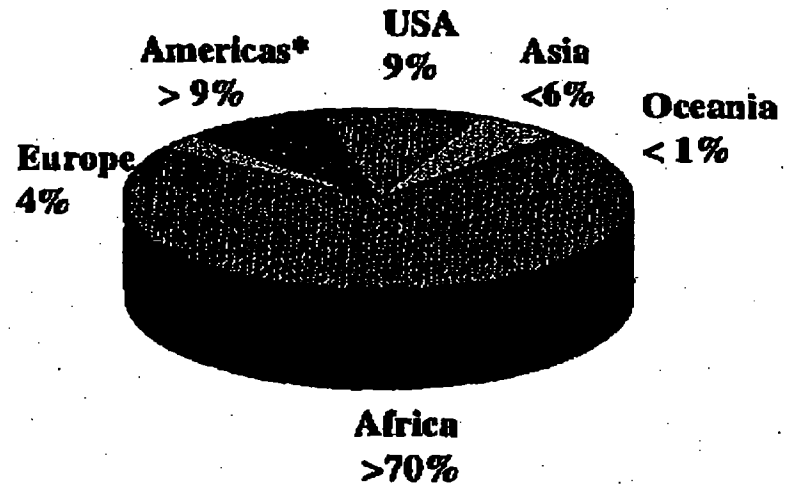
Figure 1
Total number of AIDS cases in adults and children from late 1970s/early 1980s until mid-1995

Reported: 1 169 811



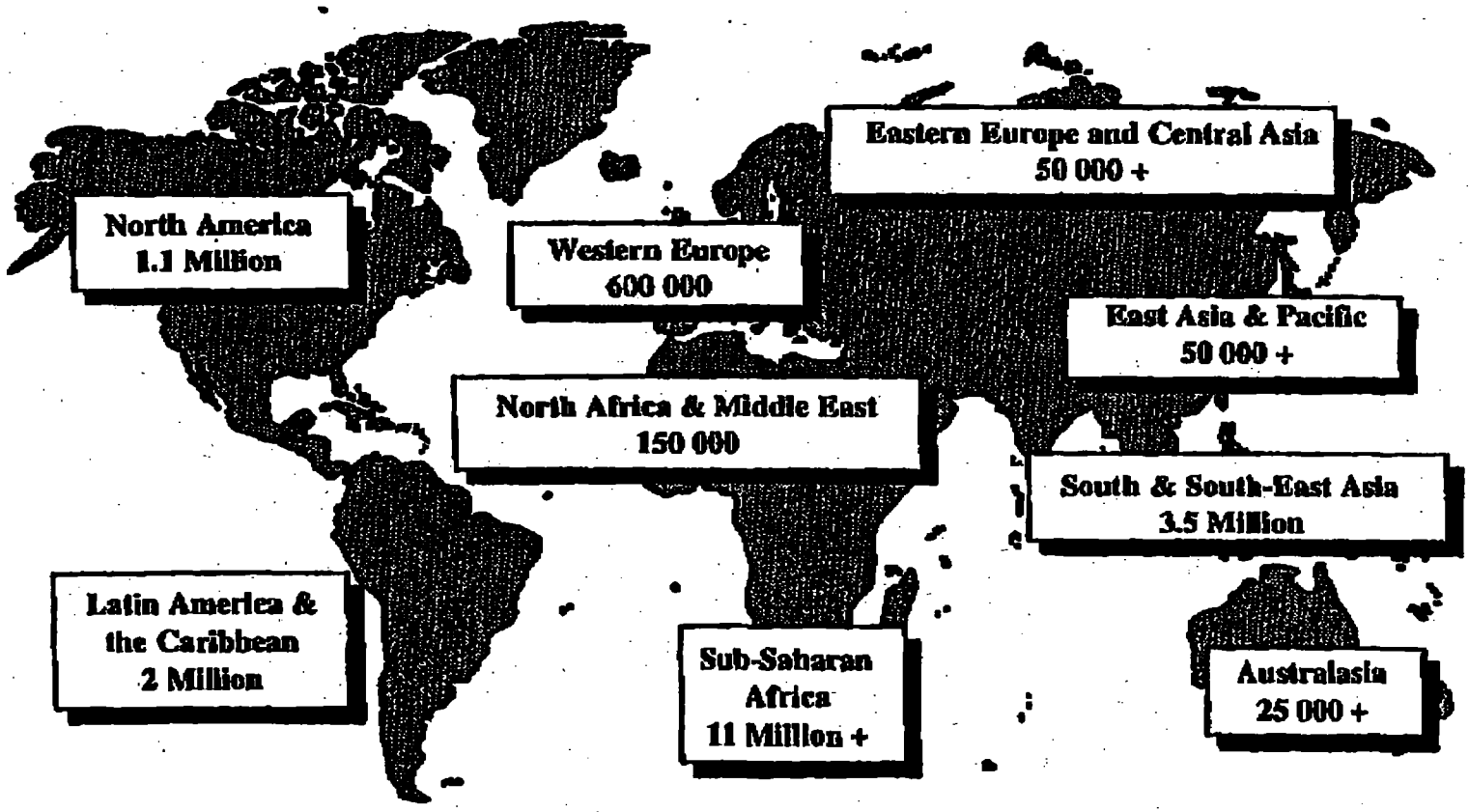
*Excluding USA

Estimated: 4 500 000 +



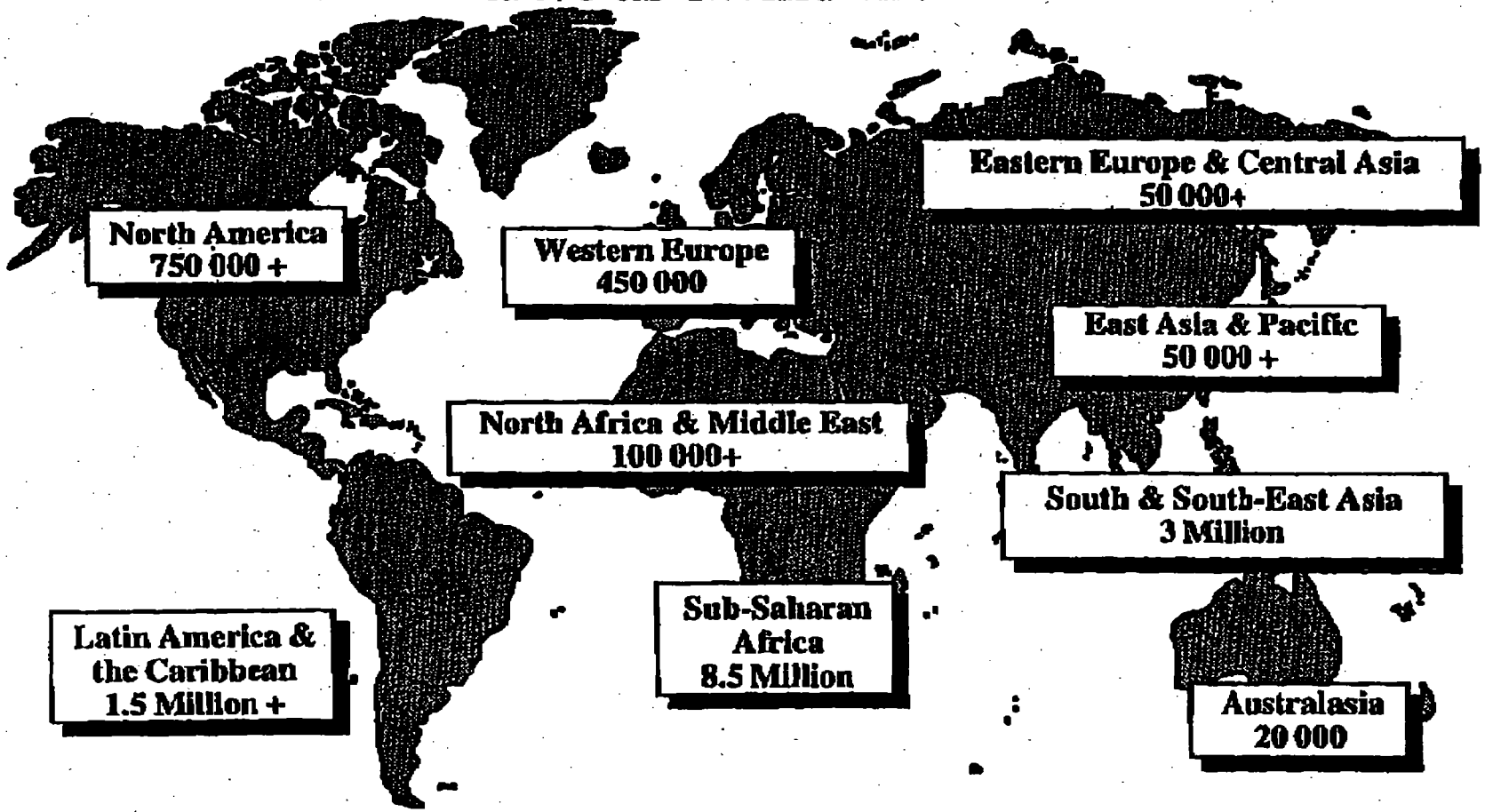
WHO Global Programme on AIDS

Figure 2
Estimated distribution of total adult HIV infections from late 1970s/early 1980s until mid-1995



Global Total: 18.5 million

Figure 3
Estimated distribution of HIV-infected adults alive as of mid-1995



Global total: 4-5 Million

Regional Office for Africa (AFRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1979-92	1993	Rate	1994	Rate	1995	Total	Last Report	Comments
Algeria	98	48	0.1	78	0.1	0	217	31/12/94	
Angola	588	135	1.2	157	1.4	35	885	31/03/95	
Benin	485	277	5.3	114	2.1	0	858	14/12/94	
Burkina Faso	2888	638	8.5	0	0.0	0	3722	31/12/93	
Botswana	1078	870	61.0	888	85.8	194	2110	05/08/95	
Burundi	6763	117	2.0	144	2.4	0	7024	31/12/94	
Cameroon	21187	1781	14.4	1417	11.3	8	6378	31/12/94	
Central African Rep.	3730	0	0.0	0	0.0	0	3730	30/11/93	
Cape Verde	85	17	4.1	10	2.3	0	82	31/12/94	
Chad	587	1018	18.5	1288	20.2	582	3467	31/05/95	
Congo	5287	1206	58.7	1300	58.4	0	7773	22/04/95	
Comoros	3	0	0.0	2	0.3	0	5	31/03/94	
Equatorial Guinea	18	24	5.1	18	3.3	15	74	07/08/95	
Eritrea	388	300	***.*	825	***.*	245	1538	31/05/95	
Ethiopia	4884	5124	10.1	5558	10.7	2478	18042	12/05/95	
Gabon	393	128	8.8	204	15.3	156	881	29/05/95	
Gambia	238	38	4.1	53	5.5	13	340	31/03/95	
Ghana	10305	2371	14.4	2330	13.7	0	15008	31/12/94	
Guinea-Bissau	288	188	16.8	254	23.5	0	707	31/12/94	
Guinea	677	328	4.4	843	7.1	0	1848	04/01/95	
Cote d'Ivoire	14855	4015	28.3	8588	44.8	0	25238	31/05/95	
Kenya	37928	11588	40.7	7347	24.6	837	58673	25/04/95	
Lesotho	162	287	15.4	38	1.8	0	515	31/12/94	
Liberia	28	153	5.8	0	0.0	0	181	31/03/94	
Madagascar	5	8	0.0	7	0.1	0	18	31/03/95	
Mali	1313	872	8.6	809	8.8	0	2994	10/01/95	
Malawi	28858	4816	58.8	4732	48.2	1078	37873	05/08/95	
Mauritius	15	3	0.3	8	0.8	0	27	31/12/94	
Mauritania	40	10	0.5	9	0.4	0	59	30/09/94	
Mozambique	992	184	1.8	634	3.1	455	1815	31/03/95	
Namibia	3522	1479	71.8	0	0.0	0	5101	31/12/93	
Nigeria	705	288	0.2	898	0.6	0	1891	31/05/95	
Niger	809	453	6.8	429	5.3	0	1891	07/03/95	
Reunion	85	0	0.0	0	0.0	0	85	20/03/92	
Rwanda	8488	1220	15.2	0	0.0	0	18708	30/06/93	
Senegal	848	348	4.4	188	1.2	0	1287	22/11/94	
Seychelles	0	1	1.5	5	7.8	0	8	12/09/94	
Sierra Leone	88	23	0.5	22	0.5	22	155	31/05/95	
South Africa	1891	1587	4.2	381	1.0	0	3849	27/07/94	
Sao Tome & Principe	11	2	1.8	0	0.0	0	13	25/02/94	
Swaziland	258	183	18.5	0	0.0	0	419	15/02/94	
United Rep. Tanzania	42422	3327	10.8	318	0.7	0	46888	30/06/94	Provisional distribution of cases by year
Togo	2142	1339	35.1	1284	32.8	353	5109	05/08/95	
Uganda	38552	2841	12.8	4927	23.2	0	45120	31/12/94	
Zaire	22158	586	1.5	3384	8.3	0	28131	09/07/94	Provisional distribution of cases by year
Zambia	7124	22810	238.3	0	0.0	0	29734	20/10/93	Provisional distribution of cases by year
Zimbabwe	18731	8174	86.0	10647	85.7	0	38552	31/12/94	
Total for the Region	270857	81738		58929		8283	415585		

***.* in the rate column indicates no population data available

Rate = per 100,000 population

Regional Office for the Americas (AMRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1979-82	1983	Rate	1984	Rate	1985	Total	Last Report	Comments
Antigua Barbuda	27	7	8.5	8	7.3	0	40	31/12/94	
Anguilla	5	0	0.0	0	0.0	0	5	31/03/85	
Argentina	2877	1358	4.1	1620	5.4	132	6187	31/03/95	
Bahamas	1092	287	121.2	322	131.4	0	1711	31/12/94	
Barbados	330	88	32.9	118	44.1	0	537	31/12/94	
Bermuda	208	15	28.2	44	77.2	0	287	31/12/94	
Belize	68	24	13.8	8	4.5	0	100	30/06/94	
Bolivia	63	20	0.3	14	0.2	0	97	31/12/94	
Brazil	42158	12491	7.8	7855	4.7	0	62314	25/02/95	Provisional distribution of cases by year
Canada	8668	1417	5.2	1633	5.8	73	11782	31/03/95	
Cayman Islands	15	0	0.0	3	17.6	0	18	31/12/94	
Chile	742	178	1.3	88	0.7	0	1016	30/06/94	
Colombia	3709	725	2.2	1143	3.3	0	5577	28/02/95	
Costa Rica	481	124	3.4	148	4.5	27	780	31/03/95	
Cuba	178	89	0.8	87	0.8	19	384	31/03/95	
Dominica	12	14	18.1	5	6.7	0	31	30/06/94	
Dominican Republic	2051	311	4.1	227	2.8	0	2589	31/12/94	
Ecuador	286	85	0.7	117	1.0	24	491	31/03/95	
El Salvador	429	176	3.1	387	6.7	104	1096	31/03/95	
French Guiana	342	17	10.3	0	0.0	0	359	31/03/93	
Grenada	35	21	20.2	7	6.7	0	63	31/12/94	
Guadeloupe	353	17	4.9	0	0.0	0	370	31/03/93	
Guatemala	388	118	1.2	110	1.1	0	594	31/12/94	
Guyana	280	107	9.8	105	9.5	0	602	31/12/94	
Haiti	4987	0	0.0	0	0.0	0	4987	31/12/92	
Honduras	2482	885	17.2	785	13.8	71	4223	31/03/95	
Jamaica	433	237	9.0	359	13.5	0	1029	31/12/94	
Martinique	240	28	7.5	0	0.0	0	268	30/09/93	
Mexico	12292	5095	5.4	4048	4.2	618	22053	31/03/95	
Montserrat	6	1	10.0	0	0.0	0	7	31/03/95	
Netherlands Antilles	117	48	28.2	2	1.1	0	168	30/09/94	Includes 11 cases reported in Aruba
Nicaragua	47	17	0.4	37	0.8	0	101	31/12/94	
Panama	478	179	7.0	175	6.7	31	864	31/03/95	
Paraguay	41	38	0.8	13	0.3	0	84	31/12/94	
Peru	858	240	1.0	77	0.3	8	1178	31/12/94	
Saint Lucia	41	12	8.4	13	9.1	3	69	31/03/95	
Saint Vincent	48	8	7.1	8	7.1	4	68	31/03/95	
Saint Kitts & Nevis	27	3	8.6	6	10.8	1	46	31/03/93	
Suriname	134	35	8.3	20	4.7	0	189	31/12/94	
Turks and Caicos Is.	25	14	140.0	0	0.0	0	39	30/09/93	
Trinidad & Tobago	1230	249	18.1	269	19.7	0	1742	31/12/94	
Uruguay	335	103	3.2	118	3.7	30	587	31/03/95	
USA	329205	71273	28.0	41110	16.0	0	441528	31/12/94	Includes 13,980 cases in Puerto Rico
Venezuela	3148	798	3.6	483	2.2	46	4475	31/03/95	
British Virgin Is.	5	2	20.0	1	10.0	0	8	31/03/95	
Total for the Region	420894	98958		80991		1186	686128		

Rate = per 100,000 population

Regional Office for Eastern Mediterranean (EMRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1979-92	1993	Rate	1994	Rate	1995	Total	Last Report	Comments
Afghanistan	0	0	0.0	0	0.0	0	0	15/02/92	
Bahrain	11	4	0.7	5	0.9	0	20	15/04/95	
Cyprus	24	6	0.8	11	1.5	0	41	28/04/95	Consolidated report
Djibouti	308	144	32.4	186	42.7	69	712	30/05/95	
Egypt	82	28	0.1	22	0.0	0	113	23/01/95	
Iran (Islamic Rep.)	68	32	0.1	19	0.0	3	114	07/08/95	
Iraq	13	11	0.1	12	0.1	2	38	11/04/95	
Jordan	24	7	0.1	7	0.1	0	38	07/02/95	
Kuwait	8	2	0.1	5	0.2	0	15	22/01/95	
Lebanon	37	32	1.0	14	0.4	0	83	10/04/95	
Libyan Arab J.	10	2	0.0	3	0.1	0	15	10/04/95	
Morocco	126	44	0.2	77	0.3	18	265	03/05/95	
Oman	30	4	0.2	14	0.8	3	51	07/05/95	
Pakistan	25	12	0.0	8	0.0	0	45	09/01/95	
Qatar	89	10	2.5	12	3.8	0	112	22/03/95	
Saudi Arabia	66	12	0.1	30	0.2	8	108	30/05/95	
Somalia	13	0	0.0	0	0.0	0	13	01/01/91	
Sudan	592	181	0.7	201	0.7	45	1129	31/01/95	
Syrian Arab Republic	23	3	0.0	4	0.0	0	30	31/05/95	
Tunisia	150	36	0.4	43	0.5	0	229	24/02/95	
United Arab Emirates	8	0	0.0	0	0.0	0	8	12/02/93	
Yemen	4	4	0.0	3	0.0	2	13	23/04/95	
Total for the Region	1752	585		684		140	3171		

Above statistics do not include 6 cases reported for UNRWA

Rate = per 100,000 population

Regional Office for Europe (EURO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1979-82	1983	Rate	1984	Rate	1985	Total	Last Report	Comments
Albania	0	0	0.0	0	0.0	0	0	31/03/95	
Armenia	2	0	0.0	0	0.0	0	2	30/04/93	
Austria	841	215	2.8	147	2.0	30	1333	31/03/95	
Azerbaijan	0	0	0.0	1	0.0	0	1	31/03/95	
Belgium	1380	244	2.4	219	2.2	29	1872	31/03/95	
Belarus	8	2	0.0	2	0.0	0	12	31/03/95	
Bulgaria	18	6	0.1	10	0.1	0	34	31/03/95	
Croatia	50	18	0.2	17	0.4	8	85	31/03/95	
Czech Republic	52	15	0.2	12	0.1	4	83	31/03/95	
Denmark	1158	238	4.7	225	4.4	40	1662	31/03/95	
Germany	9737	1675	2.8	1305	2.2	95	12809	31/03/95	
Estonia	2	1	0.1	1	0.1	0	4	31/03/95	
Finland	123	25	0.5	46	0.9	5	199	31/03/95	
France	25181	5235	9.2	4887	8.5	470	35773	31/03/95	
Georgia	2	0	0.0	0	0.0	0	2	30/04/93	
Greece	732	171	1.7	121	1.2	21	1045	31/03/95	
Hungary	115	33	0.3	23	0.2	9	180	31/03/95	
Iceland	25	9	3.3	3	1.1	0	35	31/03/95	
Ireland	344	88	1.7	50	1.3	3	483	31/03/95	
Israel	240	48	1.0	23	0.5	4	316	31/03/95	
Italy	17259	4695	8.2	5114	8.9	843	27911	31/03/95	
Kazakhstan	0	2	0.0	3	0.0	0	5	31/03/95	
Kyrgyzstan	0	0	0.0	0	0.0	0	0	30/04/93	
Lithuania	4	1	0.0	0	0.0	0	5	31/03/95	
Luxembourg	57	20	5.4	13	3.5	5	95	31/03/95	
Latvia	4	3	0.1	2	0.1	0	9	31/03/95	
Malta	25	3	0.8	5	1.4	0	34	31/03/95	
Republic of Moldova	4	0	0.0	0	0.0	0	4	31/03/95	
Monaco	23	7	25.9	3	11.1	2	35	31/03/95	
Netherlands	2583	455	3.1	408	2.7	44	3488	31/03/95	
Norway	305	83	1.5	70	1.6	9	467	31/03/95	
Poland	134	88	0.2	80	0.2	9	289	31/03/95	
Portugal	1437	472	4.8	452	4.4	45	2413	31/03/95	
Romania	2303	421	1.8	395	1.7	0	3119	31/03/95	
Russian Federation	129	12	0.0	25	0.0	7	173	31/03/95	
San Marino	1	0	0.0	0	0.0	0	1	31/03/95	
Spain	19931	4971	12.5	5878	14.2	843	31221	31/03/95	
Slovak Republic	6	1	0.0	3	0.1	2	12	31/03/95	
Slovenia	24	7	0.4	6	0.3	3	40	31/03/95	
Sweden	805	178	2.1	167	2.0	22	1170	31/03/95	
Switzerland	3449	668	9.5	428	6.5	32	4685	31/03/95	
Tajikistan	0	0	0.0	0	0.0	0	0	31/03/95	
Turkmenistan	1	0	0.0	0	0.0	0	1	30/04/93	
Turkey	97	31	0.1	32	0.1	4	164	31/03/95	
Ukraine	12	10	0.0	10	0.0	4	36	31/03/95	
UK	7587	1575	2.8	1288	2.4	145	10593	31/03/95	
Uzbekistan	1	1	0.0	0	0.0	0	2	31/03/95	
Yugoslavia*	280	88	0.9	80	0.3	28	448	31/03/95	
Total for the Region	86357	21811		21438		2384	141750		

* Refers to states/areas of the former Socialist Federal Republic of Yugoslavia not otherwise listed separately

Rate = per 100,000 population

Regional Office for South-East Asia (SEARO)*

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1979-92	1993	Rate	1994	Rate	1995	Total	Last Report	Comments
Bangladesh	1	0	0.0	0	0.0	0	1	17/04/95	
Bhutan	0	0	0.0	0	0.0	0	0	17/04/95	
India	242	252	0.0	381	0.0	151	1038	17/04/95	
Indonesia	34	17	0.0	9	0.0	7	67	17/04/95	
Dem.P.Rep. of Korea	0	0	0.0	0	0.0	0	0	17/04/95	
Maldives	0	0	0.0	1	0.5	1	2	17/04/95	
Myanmar	47	142	0.3	186	0.5	99	476	17/04/95	
Nepal	12	12	0.1	8	0.0	3	35	17/04/95	
Sri Lanka	20	13	0.1	8	0.0	8	47	17/04/95	
Thailand	2141	5312	10.8	10309	17.5	339	18095	30/04/95	
Total for the Region	2497	5748		10916		597	20758		

* Mongolia is a member of the WHO Western Pacific Region as of 1.7.95

Rate = per 100,000 population

Regional Office for Western Pacific (WPRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1979-82	1983	Rate	1994	Rate	1995	Total	Last Report	Comments
American Samoa	0	0	0.0	0	0.0	0	0	30/03/95	
Australia	4186	782	4.5	787	4.5	0	5737	31/12/94	
Palau	0	1	10.0	0	0.0	0	1	31/03/95	
Brunei Darussalam	2	1	0.4	0	0.0	0	3	31/05/94	
Cambodia	0	0	0.0	9	0.1	4	13	30/04/95	
China	15	22	0.0	28	0.0	0	85	31/12/94	
Cook Islands	0	0	0.0	0	0.0	0	0	31/12/84	
Fiji	4	1	0.1	2	0.3	0	7	20/03/95	
French Polynesia	33	9	4.8	3	1.6	0	45	31/12/94	
Guam	14	6	4.0	11	8.8	0	30	31/12/94	
Hong Kong	73	19	0.3	38	0.6	12	142	31/03/95	
Japan	538	147	0.1	204	0.2	35	924	04/04/95	
Kiribati	0	0	0.0	0	0.0	0	0	12/04/95	
Republic of Korea	10	8	0.0	11	0.0	5	32	31/05/95	
Lao People's Dem Rep	2	4	0.1	4	0.1	0	10	30/03/95	
Malaysia	89	40	0.2	72	0.4	19	200	31/01/95	
Macao	4	2	0.4	2	0.4	0	8	31/12/84	
F. States Micronesia	2	0	0.0	0	0.0	0	2	15/04/95	
Mariana Islands	4	0	0.0	2	22.0	0	6	12/04/95	
Mongolia *	0	0	0.0	0	0.0	0	0	17/04/95	
Rep.Marshall Island	2	0	0.0	0	0.0	0	2	12/04/95	
New Caledonia	28	8	3.8	7	4.5	2	43	08/08/95	
New Zealand	380	52	1.5	41	1.2	0	473	31/12/94	
Niue	0	0	0.0	0	0.0	0	0	26/04/95	
Nauru	0	0	0.0	0	0.0	0	0	24/03/95	
Philippines	99	32	0.0	58	0.1	11	188	27/02/95	
Papua New Guinea	67	8	0.2	16	0.4	0	91	31/12/94	
Singapore	53	22	0.8	48	1.7	0	123	31/12/84	
Samoa	1	0	0.0	0	0.0	0	1	08/05/95	
Solomon Islands	0	0	0.0	0	0.0	0	0	26/04/95	
Tokelau	0	0	0.0	0	0.0	0	0	19/05/95	
Tonga	3	1	1.0	1	1.0	0	5	02/11/84	
Tuvalu	0	0	0.0	0	0.0	0	0	31/12/94	
Vanuatu	0	0	0.0	0	0.0	0	0	10/04/95	
Viet Nam	0	110	0.2	118	0.2	0	228	03/04/95	Provisional distribution of cases by year
Wallis and Futuna Is	0	0	0.0	1	12.5	0	1	15/03/95	
Total for the Region	5589	1271		1492		88	8390		

* Mongolia is a member of the WHO Western Pacific Region as of 1.7.95

The above statistics do not include 48 cases in the Province of Taiwan

Rate = per 100,000 population

AIDS C reported to WHO by Contis t/year
Based on Reports Received through 30 June 1 95

NEW CASES							CUMULATIVE CASES					
Year	Africa	America	Asia	Europe	Oceania	TOTALS	Africa	America	Asia	Europe	Oceania	TOTALS
1979	0	2	0	0	0	2	0	2	0	0	0	2
1980	0	185	1	17	0	203	0	187	1	17	0	205
1981	0	322	1	20	0	343	0	509	2	37	0	548
1982	2	1158	1	69	91	1320	2	1665	3	117	91	1878
1983	17	3352	6	295	6	3678	19	5017	11	412	97	5556
1984	207	8880	6	870	78	7541	226	11697	18	982	175	13097
1985	518	12882	27	1475	142	14544	744	24379	46	2457	315	27641
1986	4108	21222	85	2418	288	28200	4852	45701	131	4873	604	56141
1987	13401	34552	150	9608	419	58040	18253	80263	281	14381	1023	114181
1988	24805	45880	174	10774	580	82023	42858	126143	456	25155	1583	196204
1989	37841	49380	288	14307	872	102678	80799	176603	744	39462	2272	298780
1990	49307	69882	482	17251	756	137674	130100	246385	1225	56713	3030	436454
1991	77012	77841	833	18824	666	175176	207112	323026	2059	75537	3698	611630
1992	84899	97999	2052	20477	810	186206	272011	420894	4111	96014	4708	797838
1993	82182	96956	7378	21528	885	208909	354193	517952	11487	117542	5571	1006745
1994	63471	60981	11718	21377	871	162428	417664	578943	23205	138918	6442	1165173
1995	6387	1186	707	2356	2	10638	418051	580129	23912	141275	6444	1169811
TOTALS	418051	580129	23912	141275	6444	1169811	418051	580129	23912	141275	6444	1169811

Reporting Countries by continent

	One or more cases	No of cases
AFRICA	54	418051
AMERICAS	45	580129
ASIA	42	23912
EUROPE	37	141275
OCEANIA	14	6444
TOTAL	192	1169811

Reporting countries by WHO Region

	One or more cases	No of cases
AFRICA	47	415588
AMERICAS	45	580129
EASTERN MEDITERRANEAN	21	3171
EUROPE	45	141768
SOUTH-EAST ASIA	8	20758
WESTERN PACIFIC	28	8390
TOTAL	192	1169811

WORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SAN

GLOBAL PROGRAMME ON AIDS

The Current Global Situation of the HIV/AIDS Pandemic

3 July 1995

As of 30 June 1995, 1 169 811 cumulative AIDS cases in adults and children have been reported to the World Health Organization Global Programme on AIDS since the onset of the pandemic. This represents a 19% increase from the 985 119 cases reported in the 1 July 1994 Report.

The accompanying tables provide, by country and WHO Region, the number of reported AIDS cases to date, by year of diagnosis.

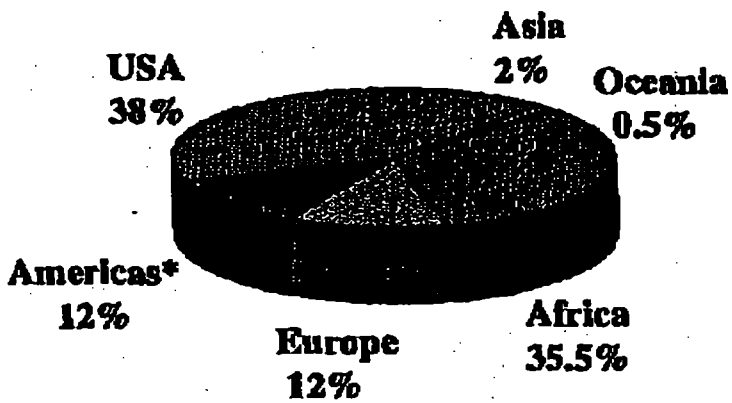
Figure 1 presents the global distribution of reported and estimated AIDS cases as of mid 1995. Allowing for under-diagnosis, incomplete reporting and reporting delay, and based on the available data on HIV infections around the world, it is estimated that over 4.5 million AIDS cases in adults and children have occurred worldwide since the pandemic began.

As of mid 1995, it is estimated that around 18.5 million adults, and more than 1.5 million children, have been infected with HIV since the beginning of the pandemic (late 1970s to early 1980s). Figure 2 presents the estimated regional distribution of total HIV infections in adults to date. The continued increase in HIV infections, particularly in southern and central Africa and South Asia, will accentuate the disproportionate impact of HIV/AIDS on the developing world.

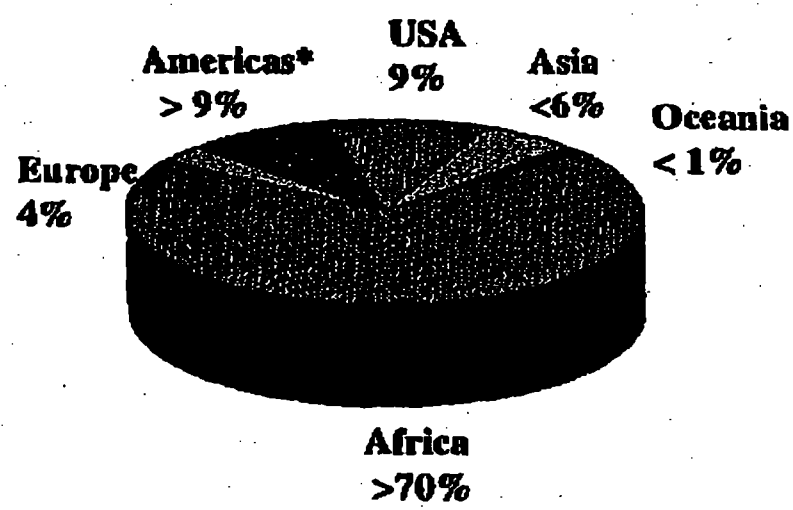
Figure 3 shows the estimated regional distribution of HIV-infected adults (including AIDS cases) alive as of mid 1995.

Figure 1
Total number of AIDS cases in adults and children from late 1970s/early 1980s until mid-1995

Reported: 1 169 811



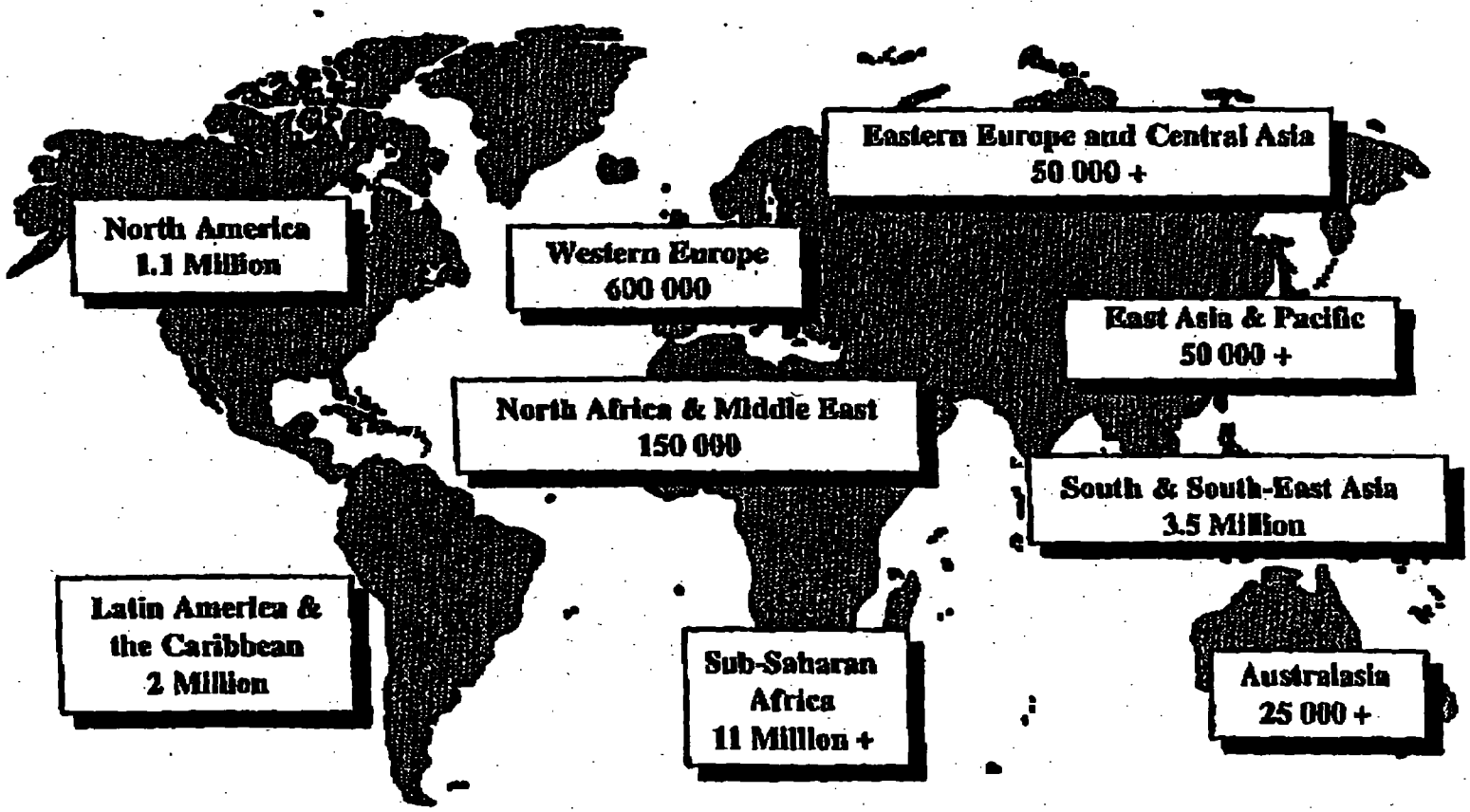
Estimated: 4 500 000 +



*Excluding USA

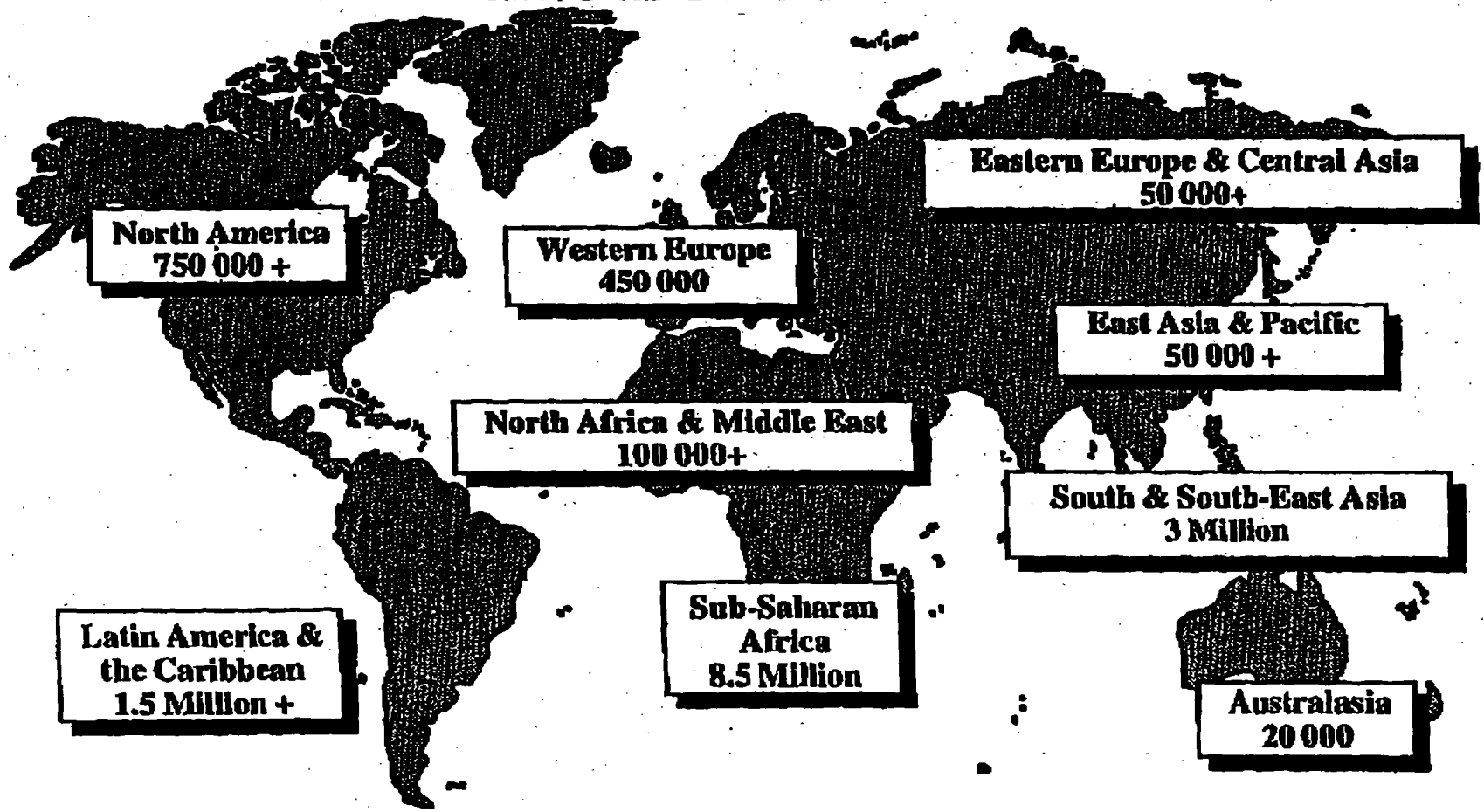
WHO Global Programme on AIDS

Figure 2
Estimated distribution of total adult HIV infections from late 1970s/early 1980s until mid-1995



Global Total: 18.5 million

Figure 3
Estimated distribution of HIV-infected adults alive as of mid-1995



Global total: 4-5 Million

Regional Office for Africa (AFRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1978-92	1993	Rate	1994	Rate	1995	Total	Last Report	Comments
Algeria	95	48	0.1	78	0.1	0	217	31/12/94	
Angola	588	135	1.2	157	1.4	35	885	31/03/95	
Benin	465	277	5.3	114	2.1	2	858	14/12/94	
Burkina Faso	2888	636	8.5	0	0.0	0	3722	31/12/93	
Botswana	1978	870	51.0	888	85.8	184	3110	05/08/95	
Burundi	8763	117	2.0	144	2.4	0	7924	31/12/94	
Cameroon	2187	1781	14.4	1417	11.3	0	6375	31/12/94	
Central African Rep.	3730	0	0.0	0	0.0	0	3730	30/11/93	
Cape Verde	85	17	4.1	10	2.3	0	82	31/12/94	
Chad	687	1010	18.5	1288	20.2	882	3467	31/08/95	
Congo	5287	1206	55.7	1300	58.4	0	7773	22/04/95	
Comoros	3	0	0.0	2	0.3	0	5	31/08/94	
Equatorial Guinea	18	24	5.1	16	3.3	15	74	07/08/95	
Eritrea	388	300	---.*	825	---.*	345	1539	31/05/95	
Ethiopia	4884	5124	10.1	5658	10.7	2478	18542	12/05/95	
Gabon	393	125	9.9	204	15.3	158	881	29/05/95	
Gambia	238	38	4.1	53	5.5	10	340	31/03/95	
Ghana	10305	2371	14.4	2330	13.7	0	15008	31/12/94	
Guinea-Bissau	288	188	15.6	254	23.5	5	707	31/12/94	
Guinea	677	328	4.4	843	7.1	0	1848	04/01/95	
Cote d'Ivoire	14855	4016	28.3	8528	44.8	0	25236	31/05/95	
Kenya	37028	11588	40.7	7347	24.8	837	58873	25/04/95	
Lesotho	182	287	15.4	35	1.8	0	515	31/12/94	
Liberia	28	163	5.8	0	0.0	0	191	31/03/94	
Madagascar	5	6	0.0	7	0.1	0	18	31/03/95	
Mali	1213	872	8.6	808	8.8	0	2584	10/01/95	
Malawi	28888	4818	52.8	4732	49.2	1078	37873	05/08/95	
Mauritius	15	3	0.3	8	0.8	0	27	31/12/94	
Mauritania	40	18	0.8	8	0.4	0	68	30/09/94	
Mozambique	883	184	1.8	634	3.1	455	1815	31/05/95	
Namibia	3822	1478	71.8	8	0.0	0	5101	31/12/93	
Nigeria	705	288	0.2	830	0.6	0	1991	31/05/95	
Niger	809	462	5.8	429	5.3	0	1991	07/03/95	
Reunion	85	0	0.0	0	0.0	0	85	28/02/92	
Rwanda	8488	1220	15.2	0	0.0	0	18708	30/06/93	
Senegal	848	848	4.4	188	1.2	0	1287	22/11/94	
Seychelles	8	1	1.5	5	7.8	0	8	12/08/94	
Sierra Leone	88	28	0.5	22	0.5	22	158	31/05/95	
South Africa	1881	1867	4.2	381	1.0	0	3849	27/07/94	
Sao Tome & Principe	11	2	1.8	0	0.0	0	13	28/02/94	
Swaziland	250	183	18.5	0	0.0	0	415	15/02/94	
United Rep. Tanzania	42422	3327	10.8	816	0.7	0	46888	30/08/94	Provisional distribution of cases by
Togo	2142	1338	36.1	1284	32.8	253	5109	05/08/95	
Uganda	38558	2841	12.9	4827	23.2	0	48120	31/12/94	
Zaire	22158	586	1.5	3384	8.3	0	28131	08/07/94	Provisional distribution of cases by year
Zambia	7124	22810	238.3	0	0.0	0	29734	20/10/93	Provisional distribution of cases by
Zimbabwe	18731	8174	88.0	10647	15.7	0	38552	31/12/94	
Total for the Region	270887	81738		58923		6283	415585		

*** in the rate column indicates no population data available

Rate = per 100,000 population

Regional Office for the Americas (AMRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1979-92	1993	Rate	1994	Rate	1995	Total	Last Report	Comments
Antigua Barbuda	27	7	8.5	6	7.3	0	40	31/12/94	
Anguilla	5	0	0.0	0	0.0	0	5	31/03/95	
Argentina	2977	1158	4.1	1620	5.4	132	5187	31/03/95	
Bahamas	1052	287	121.2	332	131.4	0	1711	31/12/94	
Barbados	350	68	32.8	119	44.1	0	537	31/12/94	
Bermuda	208	15	28.3	44	77.2	0	267	31/12/94	
Belize	68	24	13.6	8	4.5	0	100	30/06/94	
Bolivia	63	20	0.3	14	0.2	0	97	31/12/94	
Brazil	42158	12401	7.8	7855	4.7	0	62214	25/02/95	Provisional distribution of cases by year
Canada	8068	1417	5.2	1659	5.8	73	11182	31/03/95	
Cayman Islands	15	0	0.0	3	17.6	0	18	31/12/94	
Chile	742	178	1.3	98	0.7	0	1018	30/09/94	
Colombia	3709	725	2.2	1143	3.3	0	5577	28/02/95	
Costa Rica	481	124	3.6	148	4.6	22	780	31/03/95	
Cuba	178	88	0.8	87	0.8	10	364	31/03/95	
Dominica	12	14	19.1	5	6.7	0	31	30/06/94	
Dominican Republic	2051	311	4.1	227	2.9	0	2589	31/12/94	
Ecuador	285	85	0.7	117	1.0	24	491	31/03/95	
El Salvador	429	176	3.1	387	6.7	104	1096	31/03/95	
French Guiana	342	17	19.3	0	0.0	0	359	31/03/93	
Grenada	35	21	20.2	7	6.7	0	63	31/12/94	
Guadeloupe	353	17	4.8	0	0.0	0	370	31/03/93	
Guatemala	538	118	1.2	118	1.1	0	894	31/12/94	
Guyana	390	107	9.8	105	9.5	0	602	31/12/94	
Haiti	4987	0	0.0	0	0.0	0	4987	31/12/92	
Honduras	2482	885	17.2	785	13.5	71	4223	31/03/95	
Jamaica	453	257	9.0	359	13.5	0	1029	31/12/94	
Martinique	240	25	7.5	0	0.0	0	265	30/09/93	
Mexico	12282	9095	5.4	4048	4.2	618	22955	31/03/95	
Montserrat	6	1	10.0	0	0.0	0	7	31/03/95	
Netherlands Antilles	117	49	28.2	2	1.1	0	168	00/00/94	Includes 11 cases reported in Aruba
Nicaragua	47	17	0.4	37	0.8	0	101	31/12/94	
Panama	478	179	7.0	175	6.7	31	864	31/03/95	
Paraguay	41	39	0.8	13	0.3	0	84	31/12/94	
Peru	858	240	1.0	77	0.3	0	1178	31/12/94	
Saint Lucia	41	12	8.4	13	9.1	3	69	31/03/95	
Saint Vincent	48	8	7.1	8	7.1	4	68	31/03/95	
Saint Kitts & Nevis	27	3	6.6	5	10.8	1	46	31/03/95	
Suriname	134	35	8.3	20	4.7	0	189	31/12/94	
Turks and Caicos Is.	25	14	140.0	0	0.0	0	39	00/00/93	
Trinidad & Tobago	1290	242	18.1	209	15.7	0	1742	31/12/94	
Uruguay	355	103	3.2	119	3.7	30	587	31/03/95	
USA	329205	71873	28.0	41110	16.0	0	441528	31/12/94	Includes 13,980 cases in Puerto Rico
Venezuela	3148	798	3.6	483	2.2	48	4475	31/03/95	
British Virgin Is.	5	2	20.0	1	10.0	0	8	31/03/95	
Total for the Region	422994	98858		80997		1186	605128		

Rate = per 100,000 population

Regional Office for Eastern Mediterranean (EMRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1978-92	1993	Rate	1994	Rate	1995	Total	Last Report	Comments
Afghanistan	0	0	0.0	0	0.0	0	0	15/02/92	
Bahrain	11	4	0.7	5	0.9	0	20	15/04/95	
Cyprus	24	8	0.8	11	1.5	0	41	28/04/95	Consolidated report
Djibouti	308	144	32.4	186	41.7	63	712	30/05/95	
Egypt	82	28	0.1	22	0.0	0	113	23/01/95	
Iran (Islamic Rep.)	68	32	0.1	10	0.0	3	114	07/08/95	
Iraq	13	11	0.1	12	0.1	2	38	11/04/95	
Jordan	24	7	0.1	7	0.1	0	38	07/02/95	
Kuwait	8	2	0.1	5	0.2	0	15	22/01/95	
Lebanon	37	32	1.0	14	0.4	0	83	18/04/95	
Libyan Arab J.	10	2	0.0	3	0.1	0	15	10/04/95	
Morocco	126	44	0.2	77	0.3	18	265	03/05/95	
Oman	30	4	0.2	14	0.8	3	51	07/05/95	
Pakistan	26	12	0.0	8	0.0	0	46	08/01/95	
Qatar	99	10	2.5	12	2.8	0	112	22/03/95	
Saudi Arabia	88	12	0.1	36	0.2	8	108	30/05/95	
Somalia	13	0	0.0	0	0.0	0	13	01/01/91	
Sudan	892	191	0.7	201	0.7	45	1129	01/01/95	
Syrian Arab Republic	23	3	0.0	4	0.0	0	30	31/05/95	
Tunisia	150	38	0.4	43	0.5	8	239	24/02/95	
United Arab Emirates	4	0	0.0	0	0.0	0	4	12/02/93	
Yemen	4	4	0.0	3	0.0	2	13	23/04/95	
Total for the Region	1752	885		884		148	3171		

Above statistics do not include 5 cases reported for UNRWA

Rate = per 100,000 population

Regional Office for Europe (EURO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1979-82	1983	Rate	1984	Rate	1985	Total	Last Report	Comments
Albania	0	0	0.0	0	0.0	0	0	31/03/95	
Armenia	2	0	0.0	0	0.0	0	2	30/04/93	
Austria	841	215	2.8	147	2.0	30	1233	31/03/95	
Azerbaijan	0	0	0.0	1	0.0	0	1	31/03/95	
Belgium	1380	244	2.4	219	2.2	29	1872	31/03/95	
Belarus	8	2	0.0	2	0.0	0	12	31/03/95	
Bulgaria	18	6	0.1	10	0.1	0	34	31/03/95	
Croatia	50	10	0.2	17	0.4	8	85	31/03/95	
Czech Republic	62	15	0.2	12	0.1	4	93	31/03/95	
Denmark	1158	238	4.7	225	4.4	40	1662	31/03/95	
Germany	9737	1878	2.8	1306	2.2	96	12809	31/03/95	
Estonia	2	1	0.1	1	0.1	0	4	31/03/95	
Finland	123	25	0.5	46	0.9	5	199	31/03/95	
France	25181	5238	9.2	4887	8.5	478	35773	31/03/95	
Georgia	2	0	0.0	0	0.0	0	2	30/04/93	
Greece	732	171	1.7	121	1.2	21	1045	31/03/95	
Hungary	115	33	0.3	23	0.2	9	180	31/03/95	
Iceland	15	9	2.3	3	1.1	0	25	31/03/95	
Ireland	344	65	1.7	50	1.3	3	463	31/03/95	
Israel	240	48	1.0	23	0.5	4	316	31/03/95	
Italy	17259	4535	8.2	5114	8.9	843	27811	31/03/95	
Kazakhstan	0	2	0.0	3	0.0	0	5	21/01/95	
Kyrgyzstan	0	0	0.0	0	0.0	0	0	30/04/93	
Lithuania	4	1	0.0	0	0.0	0	6	31/03/95	
Luxembourg	57	20	5.4	13	3.5	5	95	31/03/95	
Latvia	4	3	0.1	2	0.1	0	9	31/03/95	
Malta	25	3	0.8	5	1.4	0	34	31/03/95	
Republic of Moldova	4	0	0.0	0	0.0	0	4	31/03/95	
Monaco	23	7	25.9	3	11.1	2	35	31/03/95	
Netherlands	2583	455	3.1	408	2.7	44	3488	31/03/95	
Norway	308	83	1.8	70	1.6	8	447	31/03/95	
Poland	134	88	0.2	80	0.2	9	289	31/03/95	
Portugal	1437	472	4.8	459	4.4	45	2413	31/03/95	
Romania	2303	491	1.8	335	1.7	8	3119	31/03/95	
Russian Federation	128	12	0.0	25	0.0	7	173	31/03/95	
San Marino	1	0	0.0	0	0.0	0	1	31/03/95	
Spain	19931	4971	12.5	5878	14.2	843	31221	31/03/95	
Slovak Republic	6	1	0.0	3	0.1	2	12	31/03/95	
Slovenia	24	7	0.4	9	0.5	3	40	31/03/95	
Sweden	805	178	2.1	187	2.0	22	1170	31/03/95	
Switzerland	3449	668	9.5	428	6.5	32	4665	31/03/95	
Tajikistan	0	0	0.0	0	0.0	0	0	31/03/95	
Turkmenistan	1	0	0.0	0	0.0	0	1	30/04/93	
Turkey	97	31	0.1	32	0.1	4	164	31/03/95	
Ukraine	12	10	0.0	10	0.0	4	36	31/03/95	
UK	7587	1575	2.8	1288	2.4	145	10883	31/03/95	
Uzbekistan	1	1	0.0	0	0.0	0	2	31/03/95	
Yugoslavia*	280	88	0.9	80	0.8	28	448	31/03/95	
Total for the Region	86357	21811		21438		2384	141750		

* Refers to states/areas of the former Socialist Federal Republic of Yugoslavia not otherwise listed separately

Rate = per 100,000 population

Regional Office for South-East Asia (SEARO)*

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1978-92	1993 Data		1994	Rate	1995	Total	Last Report	Comments
Bangladesh	1	0	0.0	0	0.0	0	1	17/04/95	
Bhutan	0	0	0.0	0	0.0	0	0	17/04/95	
India	542	252	0.0	221	0.0	151	1038	17/04/95	
Indonesia	34	17	0.0	9	0.0	7	67	17/04/95	
Dem.P.Rep. of Korea	0	0	0.0	0	0.0	0	0	17/04/95	
Maldives	0	0	0.0	1	0.5	1	2	17/04/95	
Myanmar	47	142	0.3	188	0.5	99	476	17/04/95	
Nepal	12	12	0.1	5	0.0	3	35	17/04/95	
Sri Lanka	20	13	0.1	8	0.0	6	47	17/04/95	
Thailand	2141	5312	10.8	10303	17.5	338	18095	30/04/95	
Total for the Region	2497	6748		10916		587	20758		

* Mongolia is a member of the WHO Western Pacific Region as of 1.7.95

Rate = per 100,000 population

Regional Office for Western Pacific (WPRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995

Country	1978-82	1983	Rate	1994	Rate	1995	Total	Last Report	Comments
American Samoa	0	0	0.0	0	0.0	0	0	30/03/95	
Australia	4188	782	4.5	787	4.5	0	5737	31/12/94	
Palau	0	1	10.0	0	0.0	0	1	31/03/95	
Brunei Darussalam	2	1	0.4	0	0.0	0	2	31/05/94	
Cambodia	0	0	0.0	9	0.1	4	13	30/04/95	
China	15	23	0.0	28	0.0	0	66	31/12/94	
Cook Islands	0	0	0.0	0	0.0	0	0	31/12/94	
Fiji	4	1	0.1	2	0.3	0	7	20/03/95	
French Polynesia	32	9	4.8	3	1.8	0	46	31/12/94	
Guam	14	5	4.0	11	8.9	0	30	31/12/94	
Hong Kong	73	19	0.3	38	0.6	12	142	31/03/95	
Japan	338	147	0.1	204	0.2	35	824	04/04/95	
Kiribati	0	0	0.0	0	0.0	0	0	12/04/95	
Republic of Korea	10	8	0.0	11	0.0	5	32	31/05/95	
Lao People's Dem Rep	2	4	0.1	4	0.1	0	10	30/03/95	
Malaysia	69	40	0.2	72	0.4	19	200	31/01/95	
Macao	4	2	0.4	2	0.4	0	8	31/12/94	
F. States Micronesia	2	0	0.0	0	0.0	0	2	15/04/95	
Mariana Islands	4	0	0.0	2	20.0	0	6	12/04/95	
Mongolia *	0	0	0.0	0	0.0	0	0	17/04/95	
Rep.Marshall Island	2	0	0.0	0	0.0	0	2	12/04/95	
New Caledonia	26	8	3.8	7	4.6	2	43	08/08/95	
New Zealand	380	52	1.5	41	1.2	0	473	31/12/94	
Niue	0	0	0.0	0	0.0	0	0	28/04/95	
Nauru	0	0	0.0	0	0.0	0	0	24/03/95	
Philippines	99	32	0.0	58	0.1	11	198	27/02/95	
Papua New Guinea	87	5	0.2	16	0.4	0	91	31/12/94	
Singapore	53	22	0.8	48	1.7	0	123	31/12/94	
Samoa	1	0	0.0	0	0.0	0	1	08/05/95	
Solomon Islands	0	0	0.0	0	0.0	0	0	26/04/95	
Tokelau	0	0	0.0	0	0.0	0	0	19/05/95	
Tonga	3	1	1.0	1	1.0	0	5	02/11/94	
Tuvalu	0	0	0.0	0	0.0	0	0	31/12/94	
Vanuatu	0	0	0.0	0	0.0	0	0	10/04/95	
Viet Nam	0	110	0.2	118	0.2	0	228	03/04/95	Provisional distribution of cases by year
Wallis and Futuna Is	0	0	0.0	1	12.5	0	1	15/03/95	
Total for the Region	5589	1271		1482		88	8390		

* Mongolia is a member of the WHO Western Pacific Region as of 1.7.95

The above statistics do not include 46 cases in the Province of Taiwan

Rate = per 100,000 population

AIDS Cases reported to by Contin t/year
Based on Reports Received through 30 , 1995

NEW CASES							CUMULATIVE CASES					
Year	Africa	America	Asia	Europe	Oceania	TOTALS	Africa	America	Asia	Europe	Oceania	TOTALS
1978	0	2	0	0	0	2	0	2	0	0	0	2
1980	0	185	1	17	0	203	0	187	1	17	0	205
1981	0	322	1	20	0	343	0	509	2	37	0	548
1982	2	1158	1	68	91	1320	2	1665	3	117	91	1878
1983	17	3352	8	285	8	3678	19	5017	11	412	97	5556
1984	207	6830	8	570	78	7341	228	11867	19	982	175	13897
1985	516	12892	27	1475	142	14944	744	24879	48	2457	315	27841
1986	4108	21222	85	2418	288	28200	4852	46701	131	4873	584	56141
1987	13481	34582	160	9608	419	58040	18263	80283	291	14351	1003	114181
1988	24805	45880	174	10774	580	82023	43858	126143	465	25155	1583	196204
1989	37041	41380	288	14307	879	102578	80799	175603	744	39462	2272	298780
1990	49201	39882	482	17251	758	127674	130100	246385	1225	56713	3030	426454
1991	77012	77841	833	18824	866	175176	207112	323028	2059	75537	3896	611630
1992	84899	97998	2052	20477	810	186236	292011	420994	4111	96014	4706	797836
1993	82182	96958	7378	21528	885	209909	354193	517952	11487	117542	5571	1006745
1994	57471	80981	11718	21377	871	182428	411664	598943	23205	138919	6442	1189173
1995	6387	1185	707	2358	2	10638	418051	600128	23912	141276	6444	1189811
TOTALS	418051	600128	23912	141276	6444	1189811	418051	600128	23912	141276	6444	1189811

Reporting Countries by continent

	One or more cases	No of cases
AFRICA	54	418051
AMERICAS	45	600128
ASIA	42	23912
EUROPE	37	141276
OCEANIA	14	6444
TOTAL	192	1189811

Reporting countries by WHO Region

	One or more cases	No of cases
AFRICA	47	415588
AMERICAS	45	600129
EASTERN MEDITERRANEAN	21	3171
EUROPE	45	141768
SOUTH-EAST ASIA	6	20758
WESTERN PACIFIC	28	8397
TOTAL	192	1189811

CITY OF BALTIMORE

KURT L. SCHMOKE, Mayor

HEALTH DEPARTMENT

PETER BEILENSON, M.D., M.P.H., Commissioner
303 East Fayette Street
Baltimore, Maryland 21202

FAX TRANSMITTAL COVER SHEET
Division of Preventive Medicine and Epidemiology

Date: Sept 12, 1996 Time: 4:15 PM

Number of sheets (including this one): 9

To: LATOMA ROMAX FAX: 202-632-1096
WHITE HOUSE AIDS POLICY OFFICE
WASHINGTON, DC

Fr: TOM MCARDELL / MARY. J.
Tel: 410-396-8078 FAX: 410-837-0559

Comments:

Baltimore City Health Department
AIDS Statistical Summary

Cumulative AIDS Cases Among Baltimore City Residents

Includes persons diagnosed while in the custody of the Baltimore City Detention Center and 115 inmates of the Division of Corrections. There can be a substantial delay from date of diagnosis of AIDS to receipt of a case report at the Health Department. All figures are provisional and are subject to change.

August 31, 1996

1. Disease Category

Disease Category	Adult/Adolescent * Cases (%)	Adult/Adolescent * Deaths (%)	Pediatric * Cases (%)	Pediatric * Deaths (%)	Total Cases (%)	Total Deaths (%)
PCP	2423 (33)	1931 (80)	50 (33)	37 (74)	2473 (33)	1968 (80)
Other Disease w/o PCP	2481 (34)	1696 (68)	102 (67)	33 (32)	2583 (34)	1729 (67)
KS Alone	68 (1)	56 (82)	0 (0)	0 (.)	68 (1)	56 (82)
No Diseases Listed	2409 (33)	751 (31)	0 (0)	0 (.)	2409 (32)	751 (31)
Total	7381 (100)	4434 (60)	152 (100)	70 (46)	7533 (100)	4504 (60)

2. Age *

Age *	Cases (%)
Under 5	137 (2)
5-12	15 (0)
13-19	28 (0)
20-29	1133 (15)
30-39	3535 (47)
40-49	1998 (27)
Over 49	687 (9)
Unknown	0 (0)
Total	7533 (100)

3. Race/Ethnicity

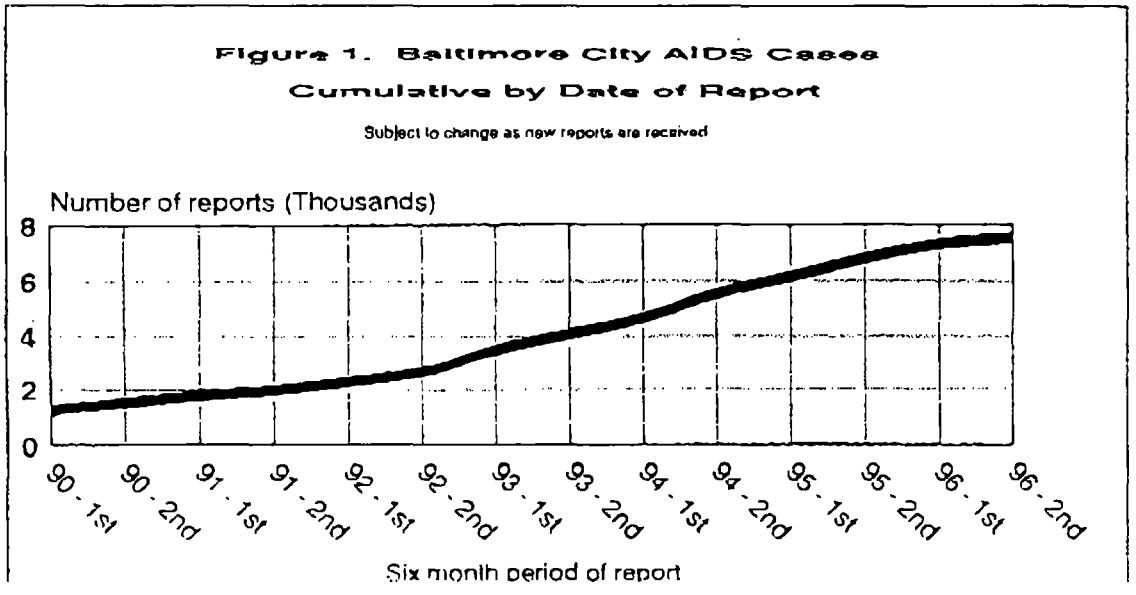
Race/Ethnicity	Adult/Adolescent * Cases (%)	Pediatric * Cases (%)	Total Cases (%)
White, Not Hispanic	1016 (14)	4 (3)	1020 (14)
Black, Not Hispanic	6296 (85)	147 (97)	6443 (86)
Hispanic	50 (1)	0 (0)	50 (1)
Asian/Pacific Is.	9 (0)	0 (0)	9 (0)
Am. Indian/Alaska Native	10 (0)	1 (1)	11 (0)
Unknown	0 (0)	0 (0)	0 (0)
Total	7381 (100)	152 (100)	7533 (100)

4. Exposure Category

Exposure Category	Adult/Adolescent Transmission Modes** Males (%)	Females (%)	Total (%)
Men who have sex with men	1914 (34)	0 (0)	1914 (26)
Injecting drug use	2806 (50)	1217 (69)	4023 (55)
Men who have sex with men and inject drugs	371 (7)	0 (0)	371 (5)
Hemophilia/coagulation disorder	8 (0)	0 (0)	8 (0)
Heterosexual contact	304 (5)	449 (25)	753 (10)
Receipt of blood, components, or tissue	37 (1)	27 (2)	64 (1)
Risk not reported/Other	171 (3)	75 (4)	246 (3)
Total	5611 (100)	1768 (100)	7379 (100)

	Pediatric Transmission Modes Males (%)	Females (%)	Total (%)
Hemophilia/coagulation disorder	1 (1)	0 (0)	1 (1)
Mother with/at risk for HIV infection	83 (98)	68 (99)	151 (98)
Receipt of blood, components, or tissue	1 (1)	1 (1)	2 (1)
Risk not reported/Other	0 (0)	0 (0)	0 (0)
Total	85 (100)	69 (100)	154 (100)

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).
**2 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children. They are counted as adults/adolescent cases in tables 1, 2, and 3; and as pediatric cases in table 4.



Baltimore City Health Department
AIDS Statistical Summary

Table 6. Race and Sex and Mode of Transmission by Date of Initial Diagnosis

August 31, 1996

Race/Sex	Mode of Transmission	Dx prior Sept 89*	9/89-8/90	9/90-8/91	9/91-8/92	9/92-8/93	9/93-8/94	9/94-8/95	9/95-8/96	TOTAL
Black/M	M-S-M	297	122	116	148	190	159	108	69	1,209
	IDU	270	186	244	398	482	482	379	223	2,664
	M-S-M/IDU	69	28	25	35	66	39	36	19	317
	Hemophiliac	1	2		2					5
	Hetero	17	7	11	34	49	72	50	40	280
	Transf/Trpl	4	5	4	6	2	1	5	1	28
	Unknown	7	4	10	14	16	17	37	33	138
	Hemophiliac									
	Vertical									
	Transf/Trpl									
Black/F	IDU	107	86	122	157	205	220	166	80	1,143
	Hetero	39	27	41	43	71	103	52	40	416
	Transf/Trpl	4		6	4	2	1	3	2	22
	Unknown	1	3	8	6	3	8	26	18	73
	Vertical									
White/M	M-S-M	224	65	78	67	86	80	47	26	673
	IDU	14	9	10	13	19	16	25	16	122
	M-S-M/IDU	10	6	5	9	7	7	3	3	50
	Hemophiliac		1		1					2
	Hetero	3	1		4	6	1	3	3	21
	Transf/Trpl	6			1	2				9
	Unknown	4	2	2	5	2	4	12	1	32
	Vertical									
White/F	IDU	3	4	3	12	17	13	12	6	70
	Hetero	1	3	7	6	3	4	3	2	29
	Transf/Trpl	1	1	1	1		1			5
	Unknown	1							1	2
	Transf/Trpl									
	Vertical									
Hisp/M	M-S-M	8	5	2	5	1	1	3	1	26
	IDU	1	2	1	5	2	1	1	1	14
	M-S-M/IDU	2								2
	Hetero					1		1		2
	Unknown								1	1
Hisp/F	IDU			1	1		1			3
	Hetero					1		1		2
Other	All Ages/Modes	1	1	1	3	4	6	3	1	20
TOTAL		1,138	582	716	1,007	1,256	1,255	987	592	7,533

CLEAR Age ≥ 13 years SHADED Age < 13 years

*Includes 45 cases with date of diagnosis unknown

Baltimore City Health Department
AIDS Statistical Summary

August 31, 1996

Table 5. AIDS Cases, case fatality rates and deaths by half year and age group.

Half-Year of Diagnosis	Number of Cases	Number of Deaths	Case-Fatality Rate
Before 1983	4	4	100%
1983 Jan -June	12	12	100%
July-Dec	3	3	100%
1984 Jan -June	13	13	100%
July-Dec	18	17	94%
1985 Jan -June	30	27	90%
July-Dec	40	38	95%
1986 Jan -June	56	51	91%
July-Dec	73	67	92%
1987 Jan -June	102	94	92%
July-Dec	106	98	92%
1988 Jan -June	154	134	87%
July-Dec	199	176	88%
1989 Jan -June	213	188	88%
July-Dec	238	206	87%
1990 Jan -June	317	259	82%
July-Dec	315	261	83%
1991 Jan -June	374	307	82%
July-Dec	429	334	78%
1992 Jan -June	552	402	73%
July-Dec	555	375	68%
1993 Jan -June	676	383	57%
July-Dec	623	312	50%
1994 Jan -June	648	284	44%
July-Dec	516	195	38%
1995 Jan -June	535	132	25%
July-Dec	381	93	24%
1996 Jan -June	330	38	12%
July-Sep 5	21	1	5%
Totals	7533	4504	60%

Baltimore City Health Department
Division of Preventive Medicine and Epidemiology
AIDS Program
February, 1995

IN BALTIMORE CITY IT IS ESTIMATED THAT:

- 14,800 residents of Baltimore are believed living with HIV infection:
  - 8,800 males and 6,000 females
  - 2,360 of these are living with AIDS
- 2,900 residents of Baltimore have died with AIDS since the epidemic began
- Women continue to grow in numbers, accounting for 23% of cumulative AIDS cases, 28% of living AIDS cases, and 40% of estimated persons living with HIV infection
- The largest growing groups among AIDS cases continue to be those that are Injection Drug Users (IDU's)
  - IDU is a factor for 63% of black male age > 12 years AIDS cases
    - Studies indicate that 20% of black male IDU's are HIV+
  - IDU is a possible factor in up to as much as 95% of black female age > 12 years AIDS cases
    - Studies indicate that 22% of black female IDU's are HIV+
- The trend for new AIDS cases continues upward, unchanged, except for cases among hemophiliacs and recipients of transfusions or transplants
- The Baltimore MSA has the 7th highest number of pediatric (age < 13 years) AIDS cases in the U.S.
  - Over 90% of pediatric HIV infections are related in some way to IDU
- Baltimore AIDS cases are concentrated mainly in nine ZIP codes, with Baltimore City representing more than 50% , and the Baltimore MSA nearly 65% of Maryland's total cumulative AIDS cases.
  - Given historical trends, it is believed that by the end of 1995 nearly 6% of the black male population and nearly 4% of the black female population of the City will have been infected with HIV since the epidemic began
  - In some neighborhoods HIV infection is likely present in greater than 10% of the population
- HIV/AIDS continues to drive death rates upward overall and has been the leading of cause of death among 25-44 year olds since 1989

HIV Disease Reporting Requirements in the City of Baltimore

- For each diagnosis made in the City of Baltimore regardless of place of residence -

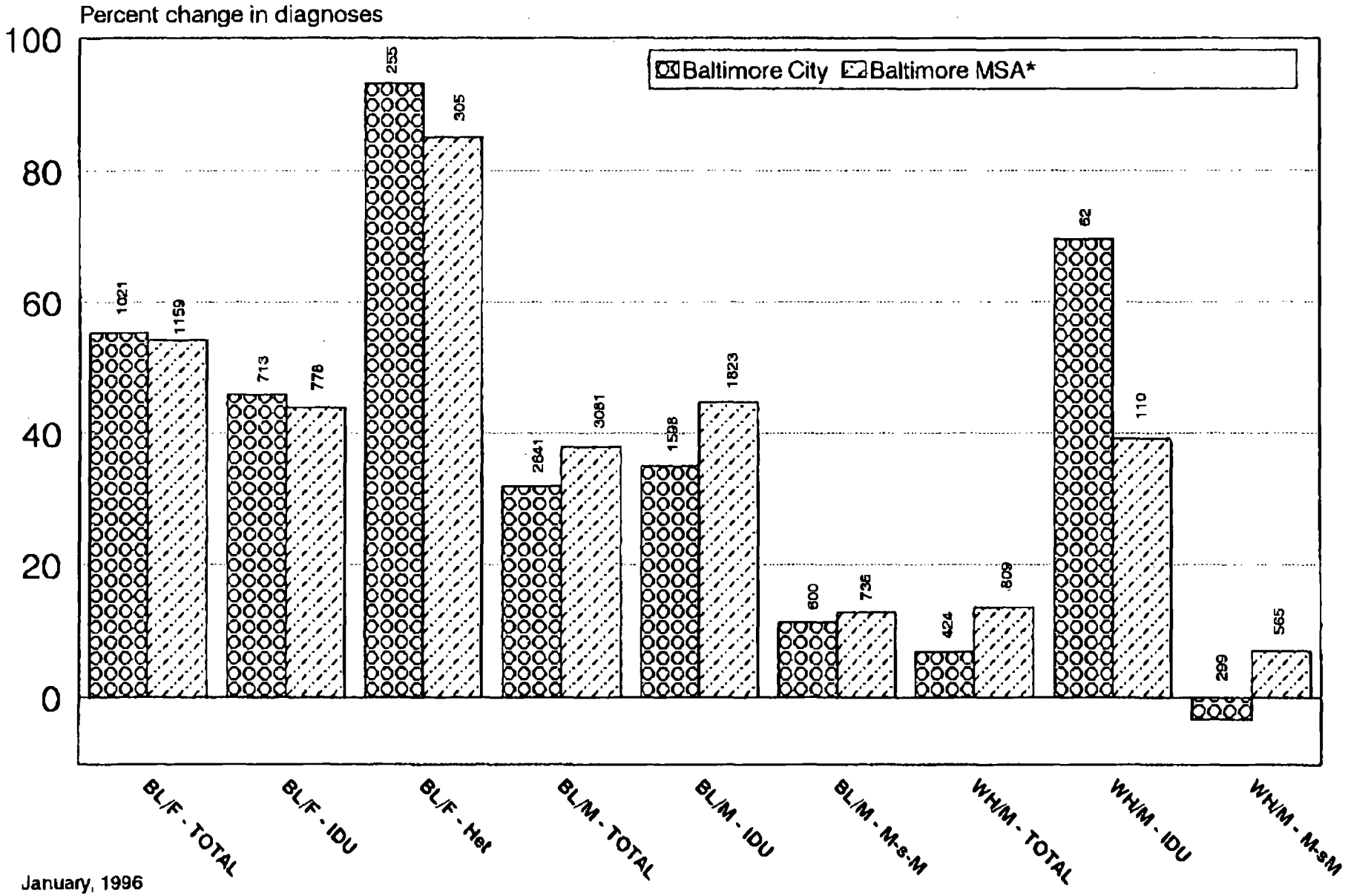
Report required from / HIV disease stage	Municipal Code of the City of Baltimore		Statutes of the State of Maryland[1]	
	Health Care Provider	Laboratory Director	Health Care Provider[2]	Laboratory Director
HIV infection			UNIQUE IDENTIFIER Health - General §18 -201	UNIQUE IDENTIFIER Health - General §18 -205
HIV + Symptomatic conditions[3]			NAME Health - General §18 -201	
CD4 ≤ 200/μL for patients age ≥ 13 years[4]	NAME Article 11 - Health §11-187		NAME Health - General §18 -201	UNIQUE IDENTIFIER Health - General §18 -201
AIDS clinical conditions[5]	NAME Article 11 - Health §11-187	NAME Article 11 - Health §11-187	NAME Health - General §18 -201	Note (6)

Note (1): To the local health officer for the county (city) where patient care is provided.
Note (2): Or administrative head of an institution reporting to the health officer for the county (city) where the institution is located with regard to a person "on the premises," (MD Health - General §18 -201).
Note (3): Specified in COMAR 10.06.01.02.12 (a) and (b).
Note (4): Specified as AIDS in MMWR 1993 v.41, no. RR-17
Note (5): Known also as opportunistic infections (OI's) and specified in MMWR 1993 v.41, no. RR-17 for patients age ≥ 13 years, and in MMWR 1987 v.36, (suppl) for patients age ≤ 12 years.
Note (6): Among the clinical conditions (OI's) [26 for patients age ≥ 13, 24 for patients age ≤ 12 years] which define AIDS, Cryptosporidiosis, Meningitis (viral, bacterial, parasitic, and fungal) Mycobacteriosis, M. tuberculosis., Salmonellosis, and Septicemia in newborns (COMAR 10.06.01.03) are each reportable for their own pathology and not as necessarily indicative of HIV disease. M. tb. is cross-reported to both TB Control and AIDS Surveillance at both local and state health departments.

August 22, 1996
HIV/AIDS Surveillance
AIDS Program
Baltimore City Health Department

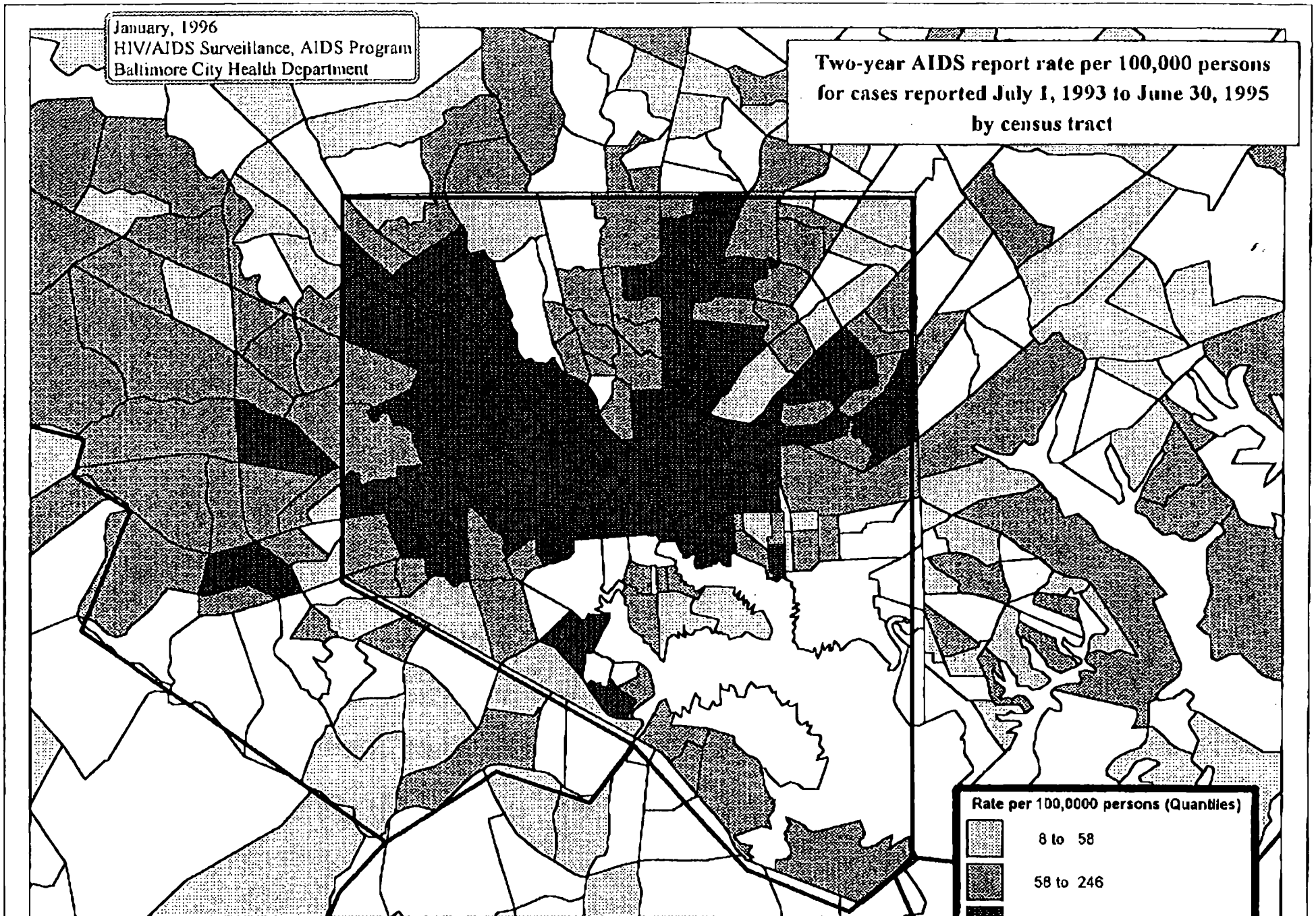
Baltimore's changing AIDS epidemic

Percent change in adult/adolescent (age > 12) AIDS case diagnoses between the periods Dec,90 to Nov,92 and Dec,92 to Nov,94 by race, gender, and risk behavior, and showing total diagnoses during the four-year period.



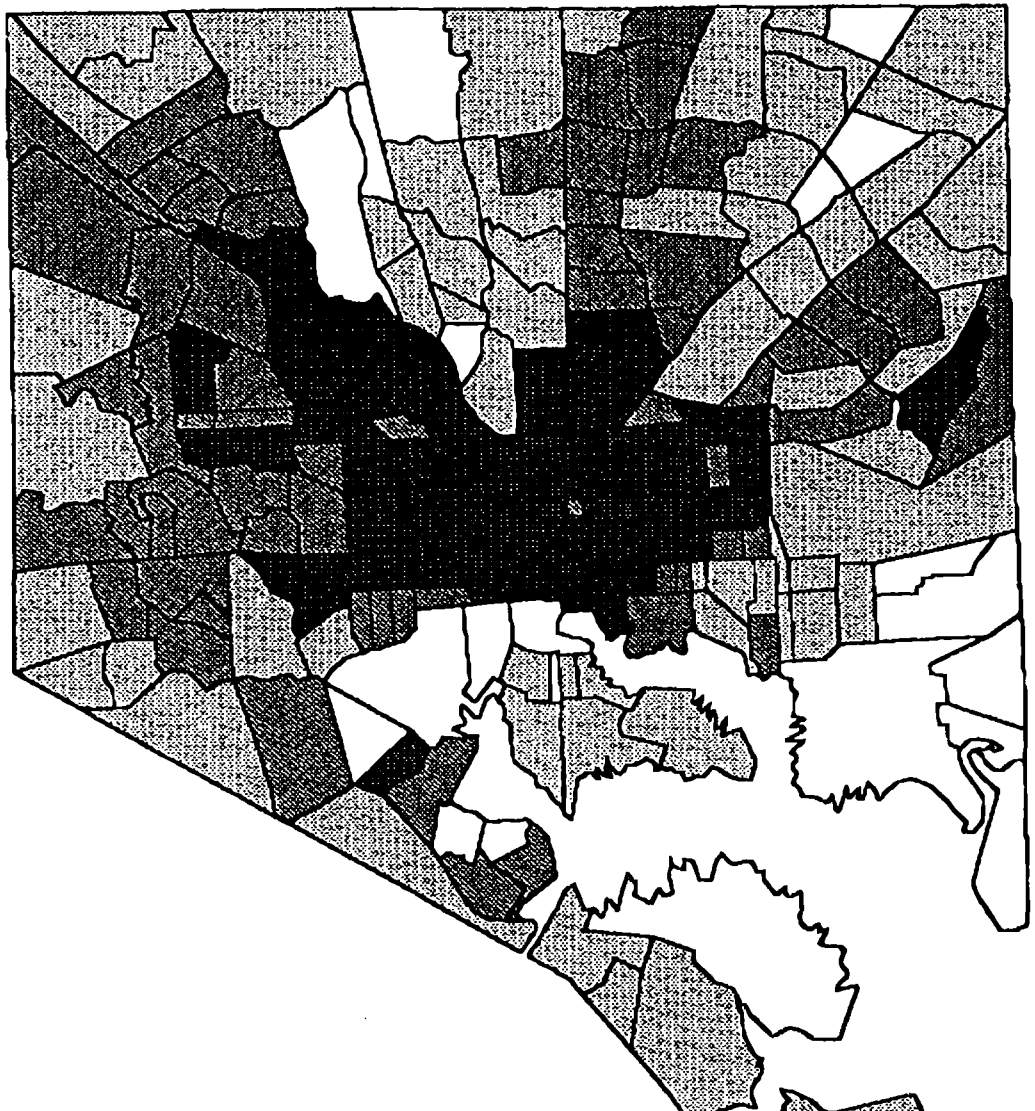
January, 1996
AIDS Program
Baltimore City Health Department

*Baltimore MSA includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's Counties


January, 1996
HIV/AIDS Surveillance, AIDS Program
Baltimore City Health Department
Two-year AIDS report rate per 100,000 persons for cases reported July 1, 1993 to June 30, 1995 by census tract
Rate per 100,0000 persons (Quantiles)
8 to 58
58 to 246
246 to 2965
Data for 90% of AIDS case reports. Data is provisional, subject to continuous updating, and not adjusted. Information deemed accurate at time of production. All rights reserved, use or reproduction prohibited without prior written permission.

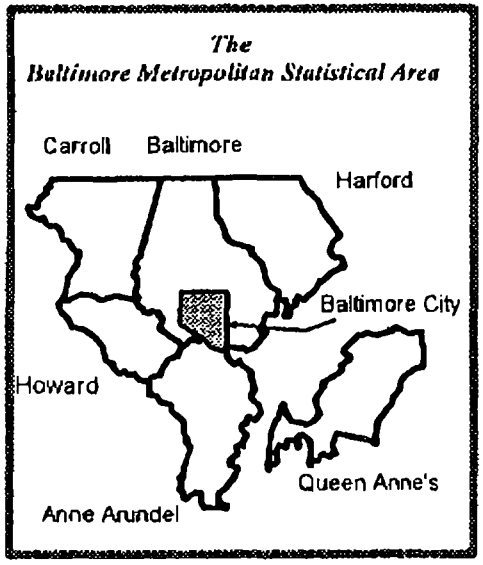
Two-year adult/adolescent AIDS case report incidence rate per 100,000 adult/adolescent residents of Baltimore City for AIDS cases reported July 1, 1993 to June 30, 1995 by latest known residence census tract

February, 1996
HIV/AIDS Surveillance, AIDS Program
Baltimore City Health Department



Rate per 100,000 (Quantiles)
- 27 to 228
- 229 to 627
- 628 to 2965
- None reported

The Baltimore Metropolitan Statistical Area



Miles
0 1 2

CDC HIV/AIDS PREVENTION

CENTERS FOR DISEASE CONTROL AND PREVENTION

Facts about

HIV/AIDS Surveillance

Background

Purpose: The Centers for Disease Control and Prevention (CDC) publishes a semiannual *HIV/AIDS Surveillance Report (HASR)*. This report provides descriptive statistics on HIV and AIDS for persons who report data, persons who use surveillance data to target or prioritize services for HIV prevention and patient care, and others who need the latest available data on cases of AIDS and HIV.

Reported AIDS cases: Reported AIDS cases represent the scope and magnitude of the epidemic and are useful for characterizing the demographic, geographic, and risk/exposure distribution. Numbers and characteristics of reported cases are useful for planning and allocating resources for prevention and care. Delays in reporting vary among different demographic, geographic, and exposure groups.

Diagnosed AIDS cases: Cases must be presented by date of diagnosis when presenting trends in AIDS incidence. More recent time periods will show an artificially low number of cases due to lag time for reporting after the AIDS diagnosis is made. Therefore, the *HASR* includes data which has been adjusted for lags in reporting.

Death reporting: Reporting of deaths among persons with AIDS is estimated to be more than 90% complete, with approximately 80% of deaths reported within 1 year.

HIV/AIDS

Cumulative data: Through June 30, 1996, a cumulative total of **548,102** persons with AIDS had been reported to CDC.

The 548,102 *cumulative reported AIDS cases* included:

- **540,806** adolescents and adults
  - **462,152** men
  - **78,654** women
- **7,296** children less than 13 years of age

A total of **343,000** of the 548,102 persons reported with AIDS have *died.*

Exposure groups: Among men and women who have been reported with AIDS, three HIV exposure groups continue to account for nearly all cases of AIDS:

- men who have sex with men - 51%
- injecting drug use - 25%
- heterosexual contact (primarily through sexual contact with injecting drug users) - 8%

Pediatric cases: Nearly all **(90%)** of the pediatric AIDS cases reported result from perinatal transmission.

HIV cases: Over **80,000** persons have been reported with HIV (not AIDS) in the 28 states that report cases of HIV infection.

HIV prevalence estimates: The Public Health Service has estimated that in 1992 between 650,000-950,000 persons were infected with HIV.

Trends

Trends from estimated AIDS opportunistic infections (OIs): In 1993, the CDC AIDS surveillance case definition was expanded to include persons with severe immunosuppression. Because most HIV-infected persons become severely immunosuppressed before the onset of AIDS OIs, researchers developed a method to examine trends over time. The term "estimated AIDS OIs" characterizes the expected dates for development of OIs in persons reported with AIDS. Recent trends of estimated OIs show an overall slowing in the growth of the AIDS epidemic. The following trends are observed:

- slight increases in the number of estimated OIs
- increases among women
- leveling among men who have sex with men
- leveling in the West but continued increases in other geographic areas
- leveling among whites but continued increases among blacks and Hispanics
- declines among children less than 13 years of age

Declines in certain groups likely reflect successful prevention interventions. These trends are expected to continue in the near future. However, these overall trends at the national level may possibly mask the diverse sub-epidemics in local areas.

Source: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report,* 1996;8(no.1):[inclusive page numbers].

Single copies of the *HIV/AIDS Surveillance Report* are available free from the CDC National AIDS Clearinghouse. Internet users may view an electronic copy of the *Report* by visiting CDC's home page (http://www.cdc.gov) and selecting the topic "Publications & Products."

For more information:

CDC National AIDS Hotline:	***1-800-342-AIDS (2437)***
Spanish:	***1-800-344-SIDA (7432)***
Deaf:	***1-800-243-7889***

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003

CDC AIDS SURVEILLANCE DATA AS OF DECEMBER 31, 1995

AIDS CASES FROM BALTIMORE

CUMULATIVE TOTAL

Cumulative

"B" PATIENT RACE/ETHNICITY

RACE	Frequency	Percent	Cumulative Frequency	Cumulative Percent
(1)White	1793	20.8	1793	20.8
(2)Black	6712	77.9	8505	98.7
(3)Hispanic	92	1.1	8597	99.7
(4)Asian	10	0.1	8607	99.8
(5)Indian	10	0.1	8617	100.0
(9)Unknown	4	0.0	8621	100.0

Total

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CDC AIDS S ILLANCE DATA AS OF 31, 1

AIDS CASES FROM BALTIMORE

REPORTED TO CDC IN 1995 (1/1/95-12/31/95)

"B" PATIENT RACE/ETHNICITY

RACE	Frequency	Percent	Cumulative Frequency	Cumulative Percent
(1)White	253	14.8	253	14.8
(2)Black	1446	84.3	1699	99.1
(3)Hispanic	11	0.6	1710	99.7
(4)Asian	2	0.1	1712	99.8
(5)Indian	2	0.1	1714	99.9
(9)Unknown	1	0.1	1715	100.0

14.8

Total 1715

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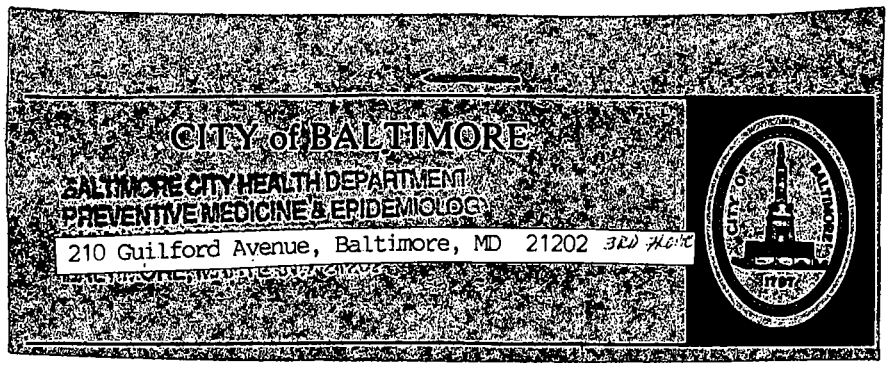
1 of 2


CITY of BALTIMORE
BALTIMORE CITY HEALTH DEPARTMENT
PREVENTIVE MEDICINE & EPIDEMIOLOGY
210 Guilford Avenue, Baltimore, MD 21202 3RD FLOOR

Baltimore City Health Department
AIDS Statistical Summary

Cumulative AIDS Cases Among Baltimore City Residents

Includes persons diagnosed while in the custody of the Baltimore City Detention Center and 115 inmates of the Division of Corrections. There can be a substantial delay from date of diagnosis of AIDS to receipt of a case report at the Health Department. All figures are provisional and are subject to change.

August 31, 1996

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Other Disease w/o PCP	2481 (34)	1696 (68)	102 (67)	33 (32)	2583 (34)	1729 (67)
KS Alone	68 (1)	56 (82)	0 (0)	0 (.)	68 (1)	56 (82)
No Diseases Listed	2409 (33)	751 (31)	0 (0)	0 (.)	2409 (32)	751 (31)
Total	7381 (100)	4434 (60)	152 (100)	70 (46)	7533 (100)	4504 (60)

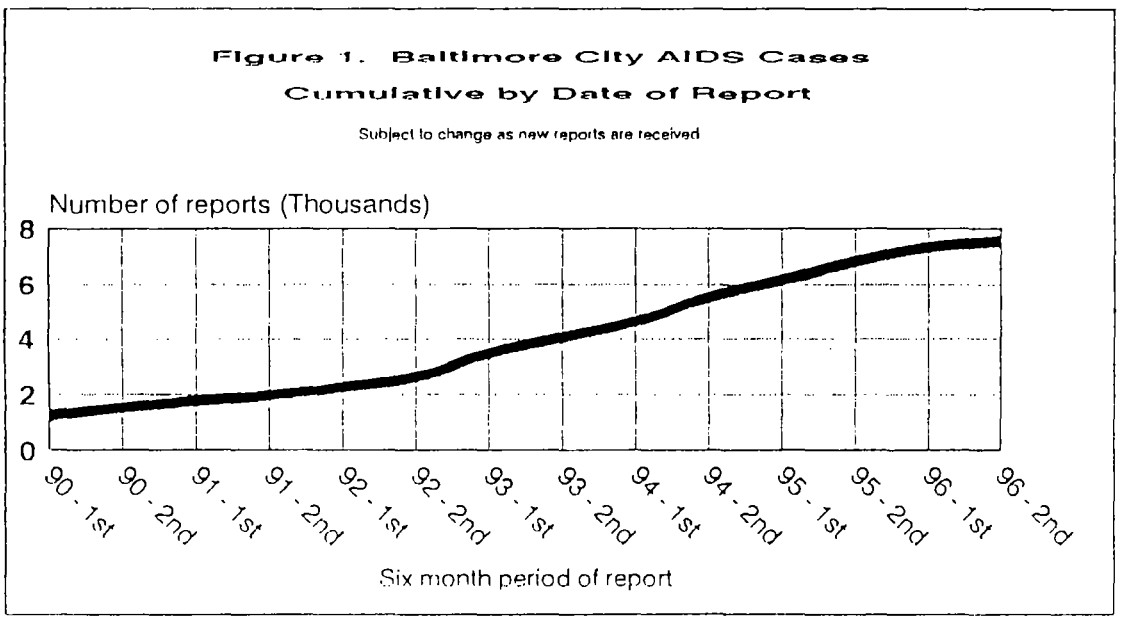
2. Age *	Cases (%)
Under 5	137 (2)
5-12	15 (0)
13-19	28 (0)
20-29	1133 (15)
30-39	3535 (47)
40-49	1998 (27)
Over 49	687 (9)
Unknown	0 (0)
Total	7533 (100)

3. Race/Ethnicity	Adult/Adolescent * Cases (%)	Pediatric * Cases (%)	Total Cases (%)
White, Not Hispanic	1016 (14)	4 (3)	1020 (14)
Black, Not Hispanic	6296 (85)	147 (97)	6443 (86)
Hispanic	50 (1)	0 (0)	50 (1)
Asian/Pacific Is.	9 (0)	0 (0)	9 (0)
Am. Indian/Alaska Native	10 (0)	1 (1)	11 (0)
Unknown	0 (0)	0 (0)	0 (0)
Total	7381 (100)	152 (100)	7533 (100)

4. Exposure Category	Adult/Adolescent Transmission Modes** Males (%)	Females (%)	Total (%)
Men who have sex with men	1914 (34)	0 (0)	1914 (26)
Injecting drug use	2806 (50)	1217 (69)	4023 (55)
Men who have sex with men and inject drugs	371 (7)	0 (0)	371 (5)
Hemophilia/coagulation disorder	8 (0)	0 (0)	8 (0)
Heterosexual contact	304 (5)	449 (25)	753 (10)
Receipt of blood, components, or tissue	37 (1)	27 (2)	64 (1)
Risk not reported/Other	171 (3)	75 (4)	246 (3)
Total	5611 (100)	1768 (100)	7379 (100)

	Pediatric Transmission Modes Males (%)	Females (%)	Total (%)
Hemophilia/coagulation disorder	1 (1)	0 (0)	1 (1)
Mother with/at risk for HIV infection	83 (98)	68 (99)	151 (98)
Receipt of blood, components, or tissue	1 (1)	1 (1)	2 (1)
Risk not reported/Other	0 (0)	0 (0)	0 (0)
Total	85 (100)	69 (100)	154 (100)

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).
**2 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children. They are counted as adults/adolescent cases in tables 1, 2, and 3;and as pediatric cases in table 4.



Baltimore City Health Department

AIDS Statistical Summary

Table 6. Race and Sex and Mode of Transmission by Date of Initial Diagnosis

August 31, 1996

Race/Sex	Mode of Transmission	Dx prior Sept 89*	9/89-8/90	9/90-8/91	9/91-8/92	9/92-8/93	9/93-8/94	9/94-8/95	9/95-8/96	TOTAL
Black/M	M-S-M	297	122	116	148	190	159	108	69	1,209
	IDU	270	186	244	398	482	482	379	223	2,664
	M-S-M/IDU	69	28	25	35	66	39	36	19	317
	Hemophiliac	1	2		2					5
	Hetero	17	7	11	34	49	72	50	40	280
	Transf/Trpl	4	5	4	6	2	1	5	1	28
	Unknown	7	4	10	14	16	17	37	33	138
	Hemophiliac						1			1
	Vertical	24	9	7	14	10	7	7	3	81
	Transf/Trpl	1								1
Black/F	IDU	107	86	122	157	205	220	166	80	1,143
	Hetero	39	27	41	43	71	103	52	40	416
	Transf/Trpl	4		6	4	2	1	3	2	22
	Unknown	1	3	8	6	3	8	26	18	73
	Vertical	15	3	11	12	9	10	3	2	65
White/M	M-S-M	224	65	78	67	86	80	47	26	673
	IDU	14	9	10	13	19	16	25	16	122
	M-S-M/IDU	10	6	5	9	7	7	3	3	50
	Hemophiliac		1		1					2
	Hetero	3	1		4	6	1	3	3	21
	Transf/Trpl	6			1	2				9
	Unknown	4	2	2	5	2	4	12	1	32
	Vertical	1								1
White/F	IDU	3	4	3	12	17	13	12	6	70
	Hetero	1	3	7	6	3	4	3	2	29
	Transf/Trpl	1	1	1	1		1			5
	Unknown	1							1	2
	Transf/trpl				1					1
	Vertical	2						1		3
Hisp/M	M-S-M	8	5	2	5	1	1	3	1	26
	IDU	1	2	1	5	2	1	1	1	14
	M-S-M/IDU	2								2
	Hetero					1		1		2
	Unknown								1	1
Hisp/F	IDU			1	1		1			3
	Hetero					1		1		2
Other	All Ages/Modes	1	1	1	3	4	6	3	1	20
TOTAL		1,138	582	716	1,007	1,256	1,255	987	592	7,533

CLEAR Age ≥ 13 years SHADED Age < 13 years

*includes 45 cases with date of diagnosis unknown

Baltimore City Health Department
AIDS Statistical Summary

August 31, 1996

Table 5. AIDS Cases, case fatality rates and deaths by half year and age group.

Half-Year of Diagnosis	Number of Cases	Number of Deaths	Case-Fatality Rate
Before 1983	4	4	100%
1983 Jan - June	12	12	100%
July-Dec	3	3	100%
1984 Jan - June	13	13	100%
July-Dec	18	17	94%
1985 Jan - June	30	27	90%
July-Dec	40	38	95%
1986 Jan - June	56	51	91%
July-Dec	73	67	92%
1987 Jan - June	102	94	92%
July-Dec	106	98	92%
1988 Jan - June	154	134	87%
July-Dec	199	176	88%
1989 Jan - June	213	188	88%
July-Dec	238	206	87%
1990 Jan - June	317	259	82%
July-Dec	315	261	83%
1991 Jan - June	374	307	82%
July-Dec	429	334	78%
1992 Jan - June	552	402	73%
July-Dec	555	375	68%
1993 Jan - June	676	383	57%
July-Dec	623	312	50%
1994 Jan - June	648	284	44%
July-Dec	516	195	38%
1995 Jan - June	535	132	25%
July-Dec	381	93	24%
1996 Jan - June	330	38	12%
July-Sep 5	21	1	5%
Totals	7533	4504	60%

Baltimore City Health Department
Division of Preventive Medicine and Epidemiology
AIDS Program
February, 1995

IN BALTIMORE CITY IT IS ESTIMATED THAT:

- 14,800 residents of Baltimore are believed living with HIV infection:
  - 8,800 males and 6,000 females
  - 2,360 of these are living with AIDS
- 2,900 residents of Baltimore have died with AIDS since the epidemic began
- Women continue to grow in numbers, accounting for 23% of cumulative AIDS cases, 28% of living AIDS cases, and 40% of estimated persons living with HIV infection
- The largest growing groups among AIDS cases continue to be those that are Injection Drug Users (IDU's)
  - IDU is a factor for 63% of black male age > 12 years AIDS cases
    - Studies indicate that 20% of black male IDU's are HIV+
  - IDU is a possible factor in up to as much as 95% of black female age > 12 years AIDS cases
    - Studies indicate that 22% of black female IDU's are HIV+
- The trend for new AIDS cases continues upward, unchanged, except for cases among hemophiliacs and recipients of transfusions or transplants
- The Baltimore MSA has the 7th highest number of pediatric (age < 13 years) AIDS cases in the U.S.
  - Over 90% of pediatric HIV infections are related in some way to IDU
- Baltimore AIDS cases are concentrated mainly in nine ZIP codes, with Baltimore City representing more than 50% , and the Baltimore MSA nearly 65% of Maryland's total cumulative AIDS cases.
  - Given historical trends, it is believed that by the end of 1995 nearly 6% of the black male population and nearly 4% of the black female population of the City will have been infected with HIV since the epidemic began
  - In some neighborhoods HIV infection is likely present in greater than 10% of the population
- HIV/AIDS continues to drive death rates upward overall and has been the leading of cause of death among 25-44 year olds since 1989

HIV Disease Reporting Requirements in the City of Baltimore

- For each diagnosis made in the City of Baltimore regardless of place of residence -

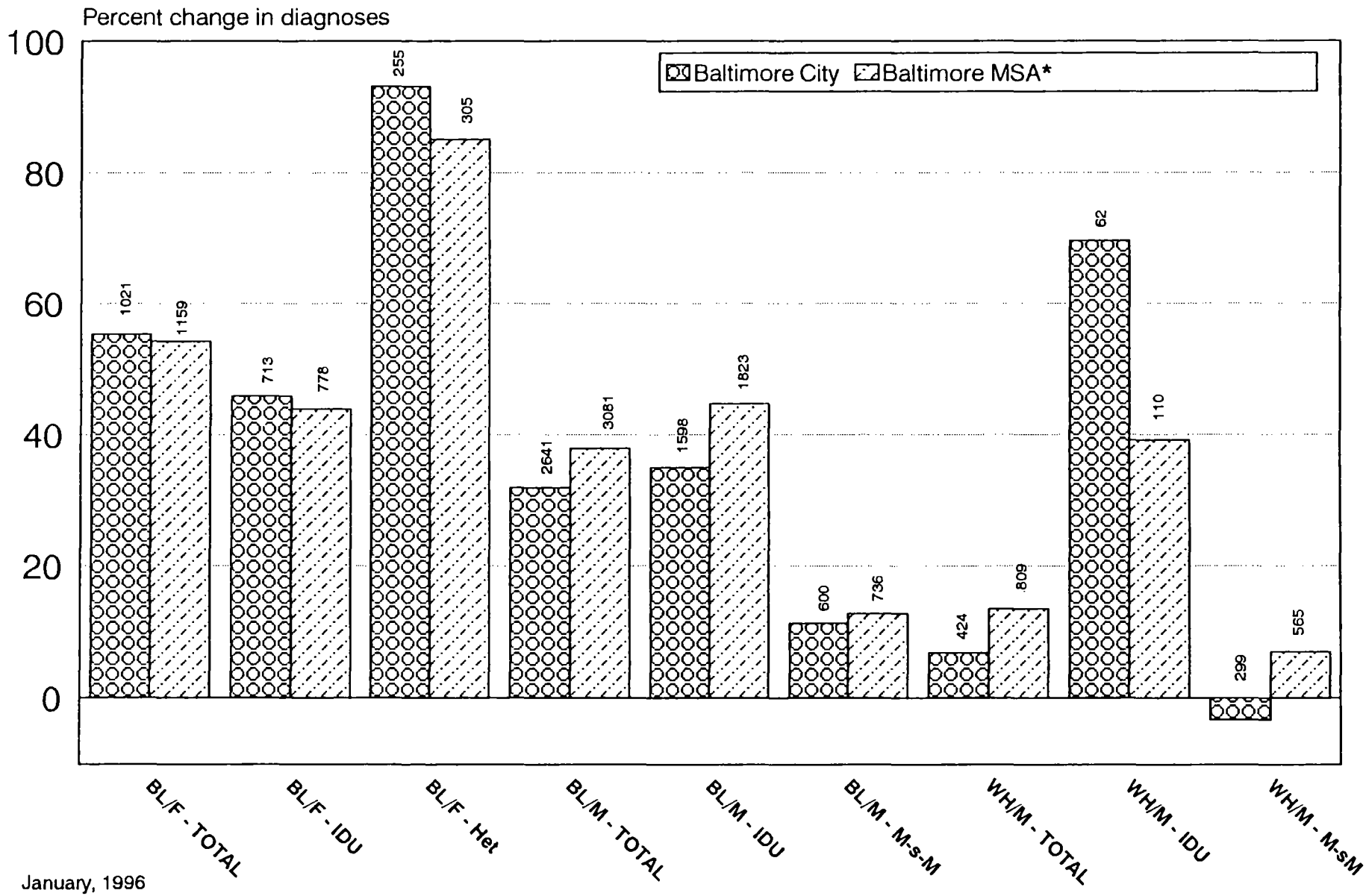
Report required from / HIV disease stage	Municipal Code of the City of Baltimore		Statutes of the State of Maryland[1]	
	Health Care Provider	Laboratory Director	Health Care Provider[2]	Laboratory Director
HIV infection			UNIQUE IDENTIFIER Health - General §18 -201	UNIQUE IDENTIFIER Health - General §18 -205
HIV + Symptomatic conditions[3]			NAME Health - General §18 -201	
CD4 ≤ 200/μL for patients age ≥ 13 years[4]	NAME Article 11 - Health §11-187		NAME Health - General §18 -201	UNIQUE IDENTIFIER Health - General §18 -201
AIDS clinical conditions[5]	NAME Article 11 - Health §11-187	NAME Article 11 - Health §11-187	NAME Health - General §18 -201	Note (6)

Note (1): To the local health officer for the county [city] where patient care is provided.
Note (2): Or administrative head of an institution reporting to the health officer for the county [city] where the institution is located with regard to a person "on the premises," (MD Health - General §18 -201).
Note (3): Specified in COMAR 10.06.01.02.12 (a) and (b).
Note (4): Specified as AIDS in MMWR 1993 v.41, no. RR-17
Note (5): Known also as opportunistic infections (OI's) and specified in MMWR 1993 v.41, no. RR-17 for patients age ≥ 13 years, and in MMWR 1987 v.36, (suppl) for patients age ≤ 12 years.
Note (6): Among the clinical conditions (OI's) [26 for patients age ≥ 13, 24 for patients age ≤ 12 years] which define AIDS, Cryptosporidiosis, Meningitis (viral, bacterial, parasitic, and fungal) Mycobacteriosis, M. tuberculosis., Salmonellosis, and Septicemia in newborns (COMAR 10.06.01.03) are each reportable for their own pathology and not as necessarily indicative of HIV disease. M. tb. is cross-reported to both TB Control and AIDS Surveillance at both local and state health departments.

August 22, 1996
HIV/AIDS Surveillance
AIDS Program
Baltimore City Health Department

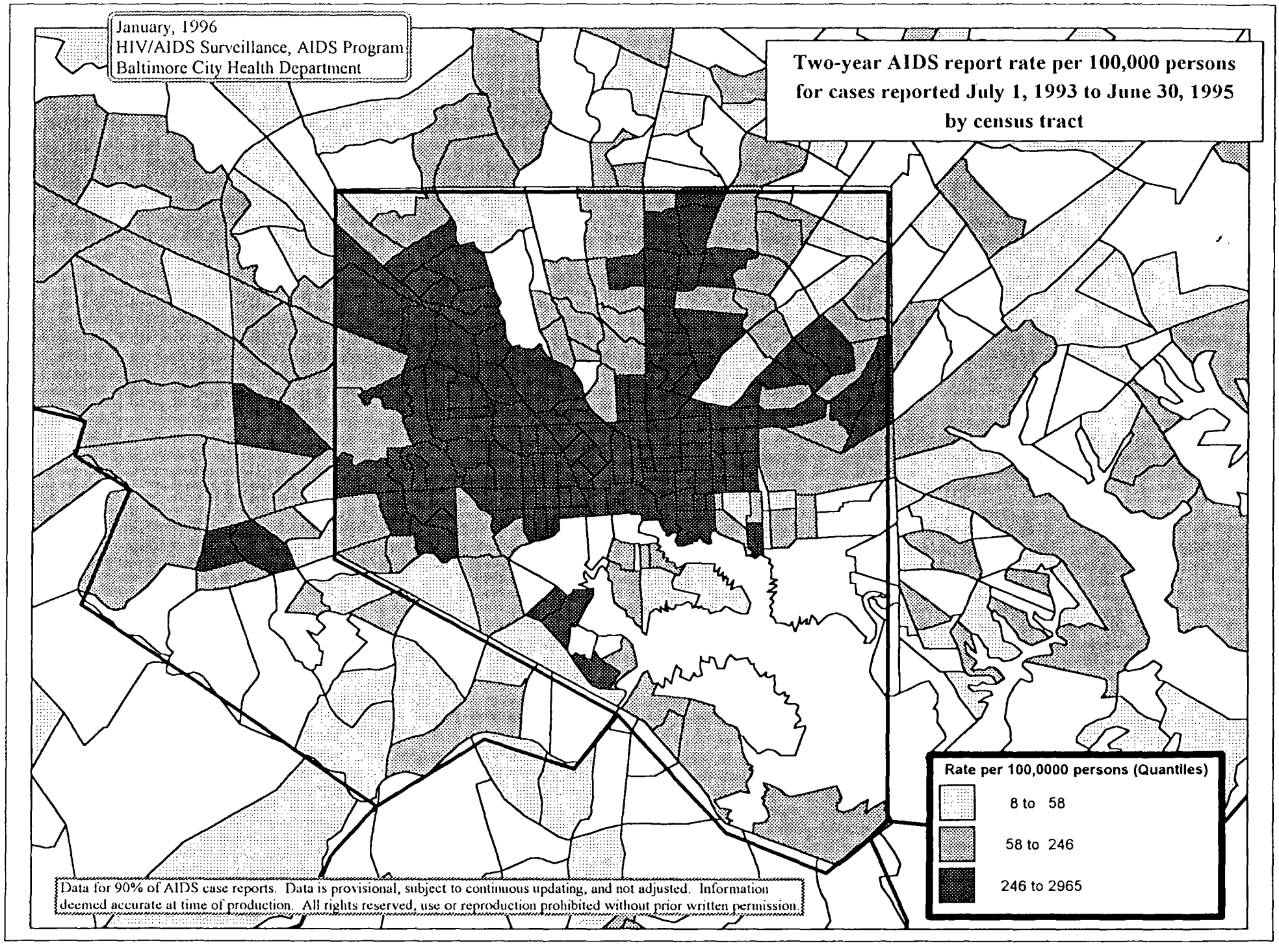
Baltimore's changing AIDS epidemic

Percent change in adult/adolescent (age > 12) AIDS case diagnoses between the periods Dec,90 to Nov,92 and Dec,92 to Nov,94 by race, gender, and risk behavior, and showing total diagnoses during the four-year period.



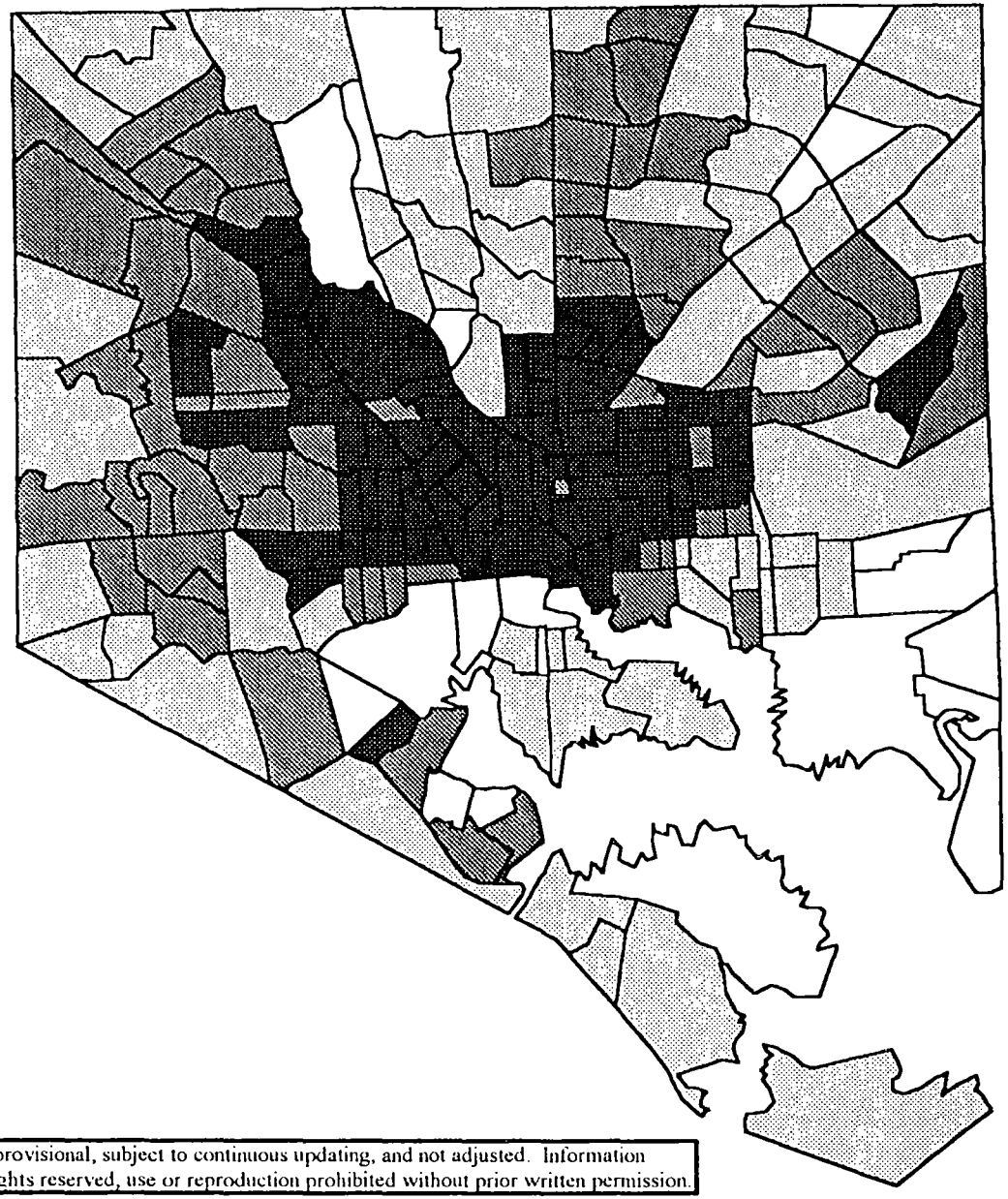
January, 1996
AIDS Program
Baltimore City Health Department

*Baltimore MSA includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's Counties


January, 1996
HIV/AIDS Surveillance, AIDS Program
Baltimore City Health Department
Two-year AIDS report rate per 100,000 persons for cases reported July 1, 1993 to June 30, 1995 by census tract
Rate per 100,0000 persons (Quantiles)
8 to 58
58 to 246
246 to 2965
Data for 90% of AIDS case reports. Data is provisional, subject to continuous updating, and not adjusted. Information deemed accurate at time of production. All rights reserved, use or reproduction prohibited without prior written permission.

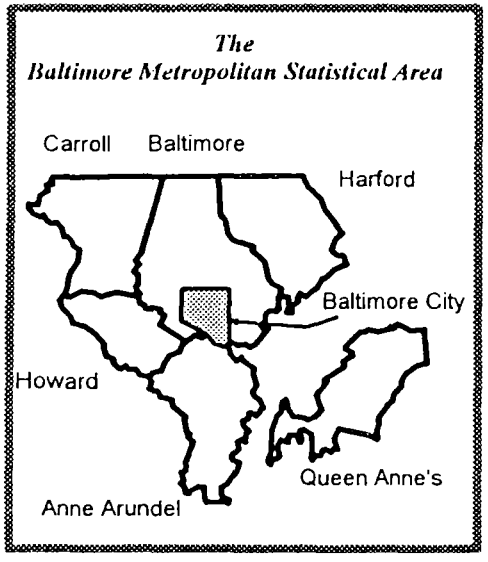
Two-year adult/adolescent AIDS case report incidence rate per 100,000 adult/adolescent residents of Baltimore City for AIDS cases reported July 1, 1993 to June 30, 1995 by latest known residence census tract

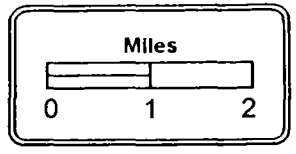
February, 1996
HIV/AIDS Surveillance, AIDS Program
Baltimore City Health Department



Rate per 100,000 (Quantiles)

- 27 to 228
- 229 to 627
- 628 to 2965
- None reported

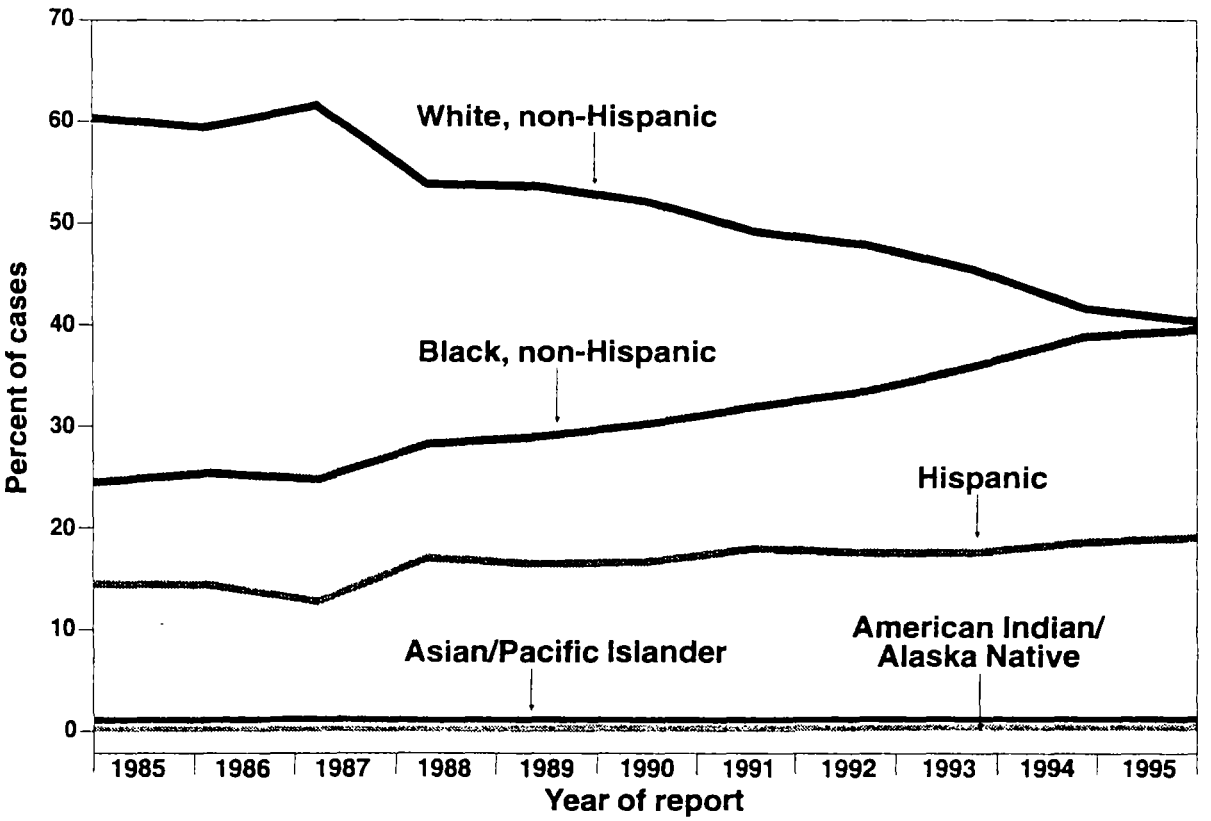




HIV/AIDS Surveillance Report

U.S. HIV and AIDS cases reported through December 1995 Year-end edition Vol. 7, No. 2

Percent of AIDS cases by race/ethnicity and year of report 1985-1995, United States



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for HIV, STD, and TB Prevention
Atlanta, Georgia 30333

Table 1. AIDS cases and annual rates per 100,000 population, by state, reported in 1994 and 1995;[1] and cumulative totals, by state and age group, through December 1995, United States

State of residence	1994		1995		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Alabama	582	13.8	642	15.1	3,611	52	3,663
Alaska	59	9.8	69	11.4	324	4	328
Arizona	610	15.0	678	16.1	4,436	19	4,455
Arkansas	285	11.6	277	11.2	1,863	27	1,890
California	12,132	38.6	11,134	35.2	88,447	486	88,933
Colorado	812	22.2	673	18.0	5,212	26	5,238
Connecticut	913	27.9	1,652	50.4	7,257	153	7,410
Delaware	269	38.0	316	44.1	1,484	12	1,496
District of Columbia	1,400	246.9	1,029	185.7	8,041	116	8,157
Florida	8,522	61.1	8,059	56.9	50,726	1,112	51,838
Georgia	2,266	32.1	2,291	31.8	14,393	156	14,549
Hawaii	216	18.3	259	21.8	1,784	13	1,797
Idaho	61	5.4	49	4.2	326	2	328
Illinois	3,062	26.0	2,220	18.8	16,221	190	16,411
Indiana	617	10.7	529	9.1	3,802	30	3,832
Iowa	130	4.6	116	4.1	867	8	875
Kansas	233	9.1	320	12.5	1,614	10	1,624
Kentucky	318	8.3	298	7.7	1,812	14	1,826
Louisiana	1,230	28.5	1,087	25.0	7,568	98	7,666
Maine	117	9.4	130	10.5	702	6	708
Maryland	2,686	53.7	2,575	51.1	12,826	240	13,066
Massachusetts	1,382	22.9	1,447	23.8	10,493	171	10,664
Michigan	1,021	10.8	1,201	12.6	7,345	81	7,426
Minnesota	419	9.2	369	8.0	2,690	19	2,709
Mississippi	429	16.1	442	16.4	2,377	37	2,414
Missouri	707	13.4	791	14.9	6,360	45	6,405
Montana	30	3.5	25	2.9	192	2	194
Nebraska	88	5.4	114	7.0	682	7	689
Nevada	384	26.3	493	32.2	2,627	21	2,648
New Hampshire	92	8.1	112	9.8	616	7	623
New Jersey	4,872	61.7	4,409	55.5	28,704	623	29,327
New Mexico	213	12.9	164	9.7	1,232	4	1,236
New York	14,729	81.1	12,399	68.4	92,972	1,779	94,751
North Carolina	1,188	16.8	1,000	13.9	6,329	91	6,420
North Dakota	21	3.3	5	0.8	65	–	65
Ohio	1,193	10.7	1,110	10.0	7,540	90	7,630
Oklahoma	268	8.2	295	9.0	2,442	17	2,459
Oregon	605	19.6	459	14.6	3,386	14	3,400
Pennsylvania	2,510	20.8	2,377	19.7	14,891	198	15,089
Rhode Island	275	27.7	223	22.5	1,411	14	1,425
South Carolina	1,151	31.6	976	26.6	5,337	63	5,400
South Dakota	20	2.8	19	2.6	101	4	105
Tennessee	751	14.5	897	17.1	4,670	42	4,712
Texas	5,847	31.8	4,477	23.9	34,830	284	35,114
Utah	153	8.0	164	8.4	1,169	20	1,189
Vermont	38	6.5	44	7.5	272	3	275
Virginia	1,155	17.6	1,610	24.3	7,782	134	7,916
Washington	929	17.4	892	16.4	6,783	24	6,807
West Virginia	92	5.0	127	6.9	617	8	625
Wisconsin	373	7.3	350	6.8	2,498	23	2,521
Wyoming	19	4.0	17	3.5	133	–	133
Subtotal	**77,474**	**29.8**	**71,411**	**27.2**	**489,862**	**6,599**	**496,461**
Guam	1	0.7	–	–	14	–	14
Pacific Islands, U.S.	–	–	–	–	2	–	2
Puerto Rico	2,283	62.5	2,594	70.3	15,978	335	16,313
Virgin Islands, U.S.	52	50.1	39	37.4	249	12	261
Total[2]	**79,897**	**30.2**	**74,180**	**27.8**	**506,538**	**6,948**	**513,486**

[1]See Technical Notes for a discussion of the impact of the 1993 AIDS surveillance case definition for adults and adolescents (implemented January 1, 1993) on the number of cases reported annually since 1993.
[2]Totals include 435 persons whose state of residence is unknown.

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported in 1994 and 1995;[1] and cumulative totals, by area and age group, through December 1995, United States

Metropolitan area of residence	1994		1995		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Akron, Ohio	46	6.8	37	5.5	319	-	319
Albany-Schenectady, N.Y.	144	16.5	204	23.4	1,040	20	1,060
Albuquerque, N.Mex.	90	13.9	92	13.9	680	2	682
Allentown, Pa.	76	12.4	88	14.3	489	6	495
Ann Arbor, Mich.	24	4.7	54	10.3	272	5	277
Atlanta, Ga.	1,550	46.5	1,556	45.3	10,355	84	10,439
Austin, Tex.	456	47.2	323	32.3	2,635	17	2,652
Bakersfield, Calif.	104	17.0	126	20.4	615	3	618
Baltimore, Md.	1,868	76.0	1,715	69.4	8,448	173	8,621
Baton Rouge, La.	178	31.9	121	21.5	851	13	864
Bergen-Passaic, N.J.	638	49.0	559	42.7	3,767	64	3,831
Birmingham, Ala.	167	19.1	194	22.0	1,121	14	1,135
Boston, Mass.	1,179	20.6	1,266	21.9	9,337	149	9,486
Buffalo, N.Y.	100	8.4	84	7.1	877	10	887
Charleston, S.C.	165	32.0	146	28.8	981	10	991
Charlotte, N.C.	185	14.7	244	18.9	1,302	14	1,316
Chicago, Ill.	2,732	35.6	1,912	24.8	14,165	170	14,335
Cincinnati, Ohio	243	15.4	195	12.2	1,288	12	1,300
Cleveland, Ohio	306	13.8	429	19.3	2,203	32	2,235
Columbus, Ohio	277	19.5	192	13.4	1,607	10	1,617
Dallas, Tex.	1,359	46.8	1,289	43.6	8,691	34	8,725
Dayton, Ohio	88	9.2	48	5.0	646	8	654
Denver, Colo.	615	34.3	522	28.5	4,225	18	4,243
Detroit, Mich.	684	15.9	794	18.4	5,083	60	5,143
El Paso, Tex.	89	13.3	139	20.5	549	2	551
Fort Lauderdale, Fla.	1,443	104.2	1,271	90.0	8,019	182	8,201
Fort Worth, Tex.	544	37.1	213	14.3	2,171	22	2,193
Fresno, Calif.	106	12.7	144	17.1	792	8	800
Gary, Ind.	94	15.2	77	12.4	429	3	432
Grand Rapids, Mich.	83	8.4	98	9.8	527	3	530
Greensboro, N.C.	207	18.7	200	17.8	1,084	16	1,100
Greenville, S.C.	187	21.4	126	14.2	883	2	885
Harrisburg, Pa.	97	15.9	128	20.9	549	5	554
Hartford, Conn.	394	35.3	561	50.3	2,476	40	2,516
Honolulu, Hawaii	149	17.0	180	20.5	1,313	10	1,323
Houston, Tex.	1,889	51.7	1,158	31.2	12,459	114	12,573
Indianapolis, Ind.	308	21.1	232	15.7	1,852	11	1,863
Jacksonville, Fla.	268	27.7	454	46.4	2,901	62	2,963
Jersey City, N.J.	820	148.7	760	138.1	4,680	101	4,781
Kansas City, Mo.	300	18.2	359	21.6	2,918	12	2,930
Knoxville, Tenn.	112	17.8	69	10.8	434	5	439
Las Vegas, Nev.	326	30.2	385	33.8	2,060	20	2,080
Little Rock, Ark.	96	17.8	86	15.8	686	10	696
Los Angeles, Calif.	4,375	47.9	3,997	43.7	30,885	200	31,085
Louisville, Ky.	136	13.9	144	14.6	807	8	815
Memphis, Tenn.	273	25.9	323	30.2	1,671	14	1,685
Miami, Fla.	3,070	151.8	2,381	117.2	15,975	397	16,372
Middlesex, N.J.	409	38.2	350	32.4	2,247	61	2,308
Milwaukee, Wis.	209	14.4	195	13.4	1,350	14	1,364
Minneapolis-Saint Paul, Minn.	371	13.8	318	11.7	2,371	16	2,387
Mobile, Ala.	110	21.5	118	22.8	736	9	745
Monmouth-Ocean City, N.J.	346	33.4	340	32.4	2,028	50	2,078
Nashville, Tenn.	214	20.0	277	25.3	1,446	14	1,460
Nassau-Suffolk, N.Y.	565	21.3	585	22.0	4,439	76	4,515
New Haven, Conn.	448	27.6	948	58.3	4,199	106	4,305
New Orleans, La.	698	53.3	594	45.2	4,404	51	4,455
New York, N.Y.	12,958	151.1	10,496	122.5	79,984	1,620	81,604
Newark, N.J.	1,844	95.4	1,681	86.8	11,521	270	11,791
Norfolk, Va.	352	23.0	603	39.1	2,019	51	2,070
Oakland, Calif.	969	44.4	655	29.8	5,918	33	5,951

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported in 1994 and 1995;[1] and cumulative totals, by area and age group, through December 1995, United States (Continued)

Metropolitan area of residence	1994		1995		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Oklahoma City, Okla.	117	11.6	118	11.6	1,123	2	1,125
Omaha, Nebr.	53	8.0	78	11.6	480	2	482
Orange County, Calif.	505	19.9	570	22.2	4,063	25	4,088
Orlando, Fla.	576	42.2	709	51.0	3,636	62	3,698
Philadelphia, Pa.	1,923	38.9	1,810	36.6	11,489	163	11,652
Phoenix, Ariz.	431	17.4	504	19.7	3,205	11	3,216
Pittsburgh, Pa.	297	12.4	234	9.8	1,718	10	1,728
Portland, Oreg.	483	28.8	341	19.9	2,822	8	2,830
Providence, R.I.	259	28.4	206	22.7	1,320	13	1,333
Raleigh-Durham, N.C.	268	27.7	170	17.1	1,285	20	1,305
Richmond, Va.	223	24.3	287	30.9	1,584	19	1,603
Riverside-San Bernardino, Calif.	875	30.1	768	26.0	4,617	42	4,659
Rochester, N.Y.	216	19.8	297	27.3	1,304	8	1,312
Sacramento, Calif.	315	21.9	383	26.3	2,276	21	2,297
Saint Louis, Mo.	367	14.5	423	16.6	3,169	27	3,196
Salt Lake City, Utah	130	11.0	136	11.3	1,023	14	1,037
San Antonio, Tex.	543	37.9	419	28.7	2,644	23	2,667
San Diego, Calif.	963	36.6	1,068	40.4	7,299	45	7,344
San Francisco, Calif.	2,585	157.4	2,135	129.7	22,800	35	22,835
San Jose, Calif.	391	25.2	262	16.7	2,278	11	2,289
San Juan, P.R.	1,446	75.7	1,502	77.9	9,969	213	10,182
Sarasota, Fla.	193	37.3	155	29.5	938	19	957
Scranton, Pa.	37	5.8	47	7.4	284	3	287
Seattle, Wash.	601	27.6	645	29.4	4,942	14	4,956
Springfield, Mass.	222	37.3	186	31.4	1,037	21	1,058
Stockton, Calif.	114	22.0	74	14.1	508	12	520
Syracuse, N.Y.	91	12.1	106	14.1	732	7	739
Tacoma, Wash.	83	13.0	73	11.2	540	7	547
Tampa-Saint Petersburg, Fla.	751	34.8	709	32.5	5,474	74	5,548
Toledo, Ohio	59	9.6	37	6.0	373	8	381
Tucson, Ariz.	137	18.7	120	15.9	913	6	919
Tulsa, Okla.	78	10.5	91	12.2	744	6	750
Ventura, Calif.	66	9.4	70	9.9	532	2	534
Washington, D.C.	2,368	53.0	2,130	47.2	14,435	205	14,640
West Palm Beach, Fla.	708	74.2	810	83.3	4,566	159	4,725
Wichita, Kans.	68	13.4	99	19.5	454	2	456
Wilmington, Del.	226	41.8	265	48.5	1,167	9	1,176
Youngstown, Ohio	33	5.5	40	6.6	232	–	232
Metropolitan areas with 500,000 or more population:	**66,934**	**41.1**	**60,912**	**37.1**	**427,754**	**5,874**	**433,628**
Central counties	***65,695***	***44.1***	***59,552***	***39.7***	***420,032***	***5,766***	***425,798***
Outlying counties	***1,239***	***8.8***	***1,360***	***9.5***	***7,722***	***108***	***7,830***
Metropolitan areas with 50,000 to 500,000 population:	**7,816**	**16.3**	**8,045**	**16.6**	**49,440**	**662**	**50,102**
Central counties	***7,300***	***17.1***	***7,589***	***17.6***	***46,467***	***605***	***47,072***
Outlying counties	***516***	***9.8***	***456***	***8.6***	***2,973***	***57***	***3,030***
Non-metropolitan areas	**4,648**	**8.7**	**4,737**	**8.8**	**27,109**	**395**	**27,504**
Total[2]	**79,897**	**30.2**	**74,180**	**27.8**	**506,538**	**6,948**	**513,486**

[1]See Technical Notes for a discussion of the impact of the 1993 AIDS surveillance case definition for adults and adolescents (implemented January 1, 1993) on the number of cases reported annually since 1993.
[2]Totals include 2,252 persons whose area of residence is unknown.

Table 3. AIDS cases by age group, exposure category, and sex, reported in 1994 and 1995;[1] and cumulative totals, by age group and exposure category, through December 1995, United States

Adult/adolescent exposure category	Males				Females				Totals[2]				Cumulative total[3]	
	1994		1995		1994		1995		1994		1995			
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	35,524	(55)	30,671	(51)	–	–	–	–	35,524	(45)	30,671	(42)	259,672	(51)
Injecting drug use	16,044	(25)	14,057	(24)	5,923	(43)	5,204	(38)	21,967	(28)	19,261	(26)	128,696	(25)
Men who have sex with men and inject drugs	4,234	(7)	3,425	(6)	–	–	–	–	4,234	(5)	3,425	(5)	33,195	(7)
Hemophilia/coagulation disorder	483	(1)	423	(1)	25	(0)	22	(0)	508	(1)	445	(1)	4,107	(1)
Heterosexual contact:	3,009	(5)	2,840	(5)	5,575	(40)	5,253	(38)	8,585	(11)	8,093	(11)	40,038	(8)
Sex with injecting drug user	*963*		*928*		*2,118*		*1,921*		*3,081*		*2,849*		*18,710*	
Sex with bisexual male	*–*		*–*		*394*		*376*		*394*		*376*		*2,209*	
Sex with person with hemophilia	*2*		*12*		*56*		*50*		*58*		*62*		*330*	
Sex with transfusion recipient with HIV infection	*66*		*53*		*63*		*59*		*129*		*112*		*734*	
Sex with HIV-infected person, risk not specified	*1,978*		*1,847*		*2,944*		*2,847*		*4,923*		*4,694*		*18,055*	
Receipt of blood transfusion, blood components, or tissue[4]	405	(1)	366	(1)	329	(2)	298	(2)	734	(1)	664	(1)	7,433	(1)
Other/risk not reported or identified[5]	5,276	(8)	7,834	(13)	2,035	(15)	2,987	(22)	7,311	(9)	10,821	(15)	33,397	(7)
Adult/adolescent subtotal	64,975	(100)	59,616	(100)	13,887	(100)	13,764	(100)	78,863	(100)	73,380	(100)	506,538	(100)
Pediatric (<13 years old) exposure category														
Hemophilia/coagulation disorder	14	(3)	5	(1)	–	–	–	–	14	(1)	5	(1)	227	(3)
Mother with/at risk for HIV infection:[5]	463	(91)	345	(89)	494	(94)	385	(93)	957	(93)	730	(91)	6,256	(90)
Injecting drug use	*145*		*104*		*153*		*107*		*298*		*211*		*2,594*	
Sex with injecting drug user	*73*		*59*		*75*		*55*		*148*		*114*		*1,164*	
Sex with bisexual male	*10*		*6*		*9*		*4*		*19*		*10*		*128*	
Sex with person with hemophilia	*2*		*–*		*–*		*2*		*2*		*2*		*25*	
Sex with transfusion recipient with HIV infection	*3*		*–*		*2*		*2*		*5*		*2*		*26*	
Sex with HIV-infected person, risk not specified	*96*		*66*		*97*		*68*		*193*		*134*		*731*	
Receipt of blood transfusion, blood components, or tissue	*4*		*2*		*9*		*2*		*13*		*4*		*139*	
Has HIV infection, risk not specified	*130*		*108*		*149*		*145*		*279*		*253*		*1,449*	
Receipt of blood transfusion, blood components, or tissue[4]	23	(5)	17	(4)	17	(3)	9	(2)	40	(4)	26	(3)	366	(5)
Other/risk not reported or identified[5]	9	(2)	20	(5)	14	(3)	19	(5)	23	(2)	39	(5)	99	(1)
Pediatric subtotal	509	(100)	387	(100)	525	(100)	413	(100)	1,034	(100)	800	(100)	6,948	(100)
Total	**65,484**		**60,003**		**14,412**		**14,177**		**79,897**		**74,180**		**513,486**	

[1]See Technical Notes for a discussion of the impact of the 1993 AIDS surveillance case definition for adults and adolescents (implemented January 1, 1993) on the number of cases reported annually since 1993.
[2]Includes 1 person whose sex is unknown.
[3]Includes 9 persons known to be infected with human immunodeficiency virus type 2 (HIV-2). See *MMWR* 1995;44:603–06.
[4]Thirty-three adults/adolescents and 2 children developed AIDS after receiving blood screened negative for HIV antibody. Ten additional adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Three of the 10 received tissue, organs, or artificial insemination from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.
[5]See Table 16 and Figure 7 for a discussion of the "other" exposure category. "Other" also includes 29 persons who acquired HIV infection perinatally but were diagnosed with AIDS after age 13. These 29 persons are tabulated under the adult/adolescent, not pediatric, exposure category.

Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population, for cases reported in 1995, United States

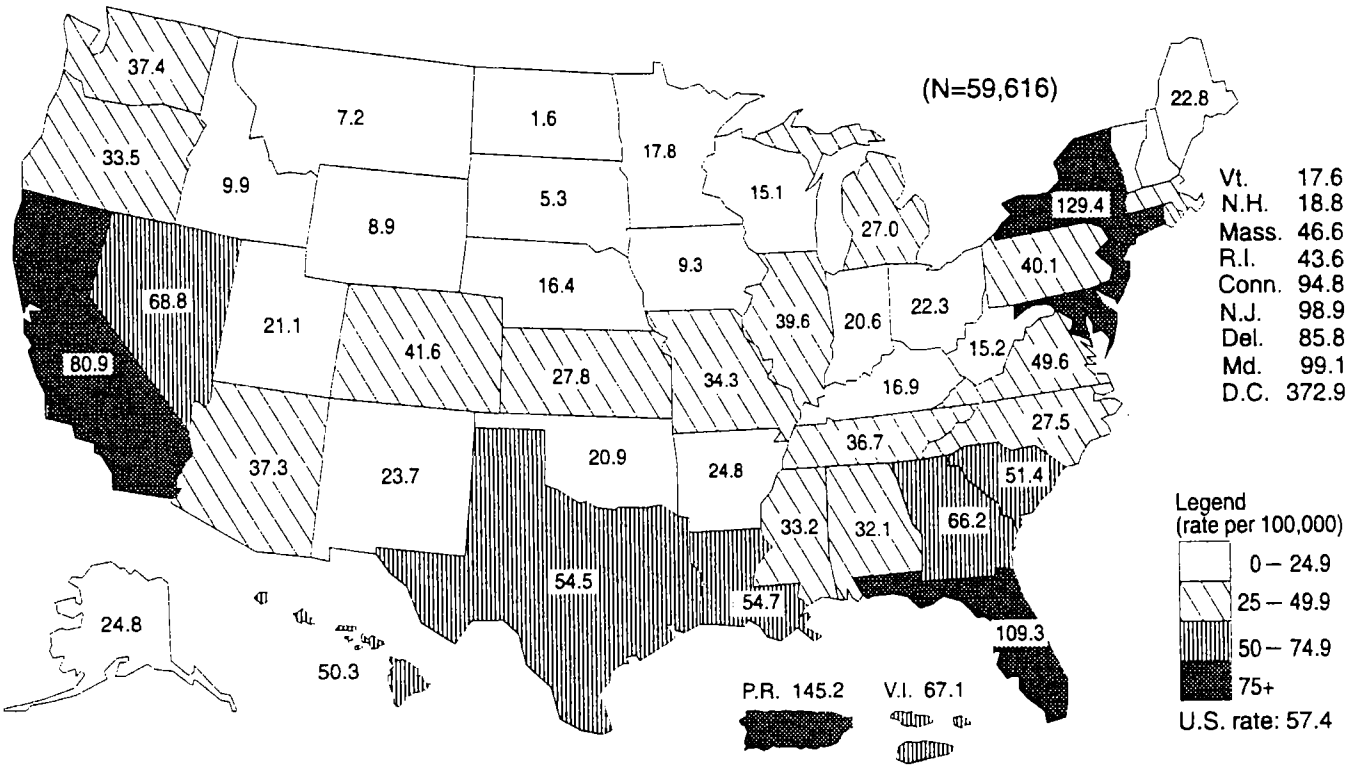


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported in 1995, United States

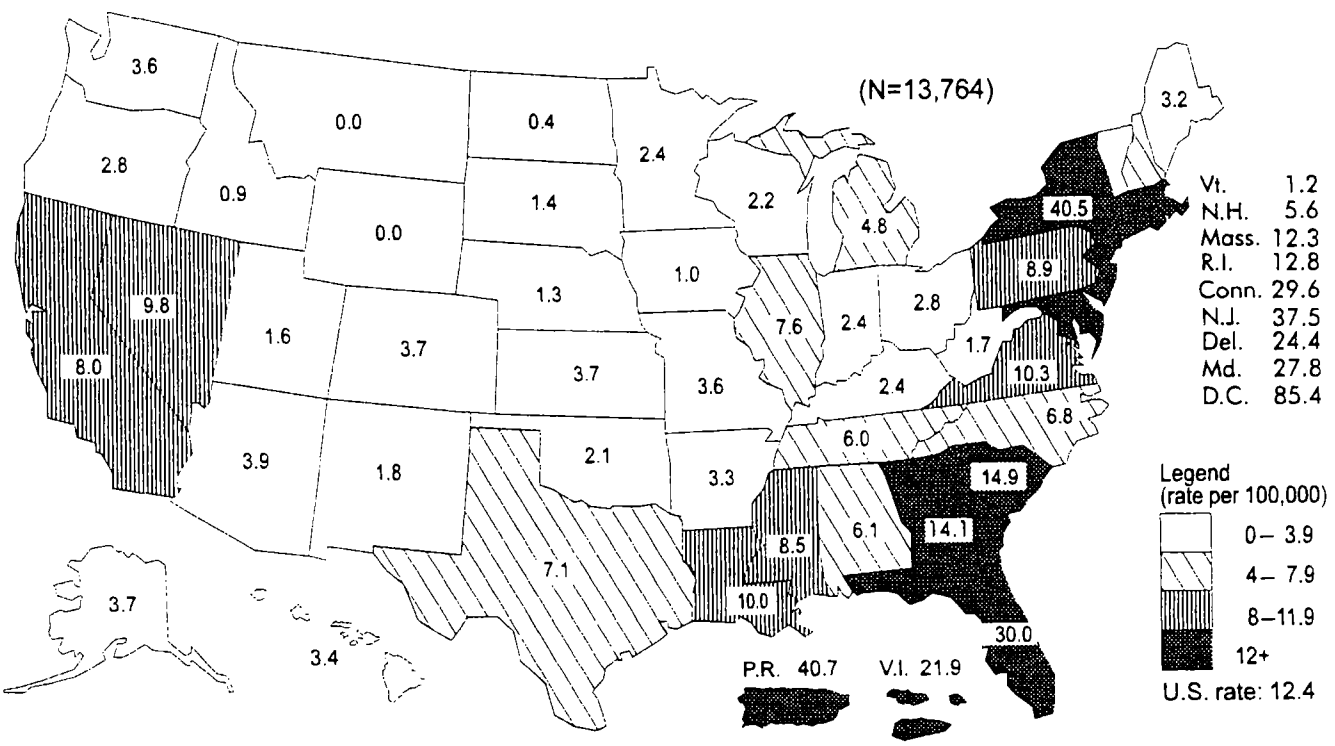


Figure 3. Male adult/adolescent AIDS cases reported in 1995, United States

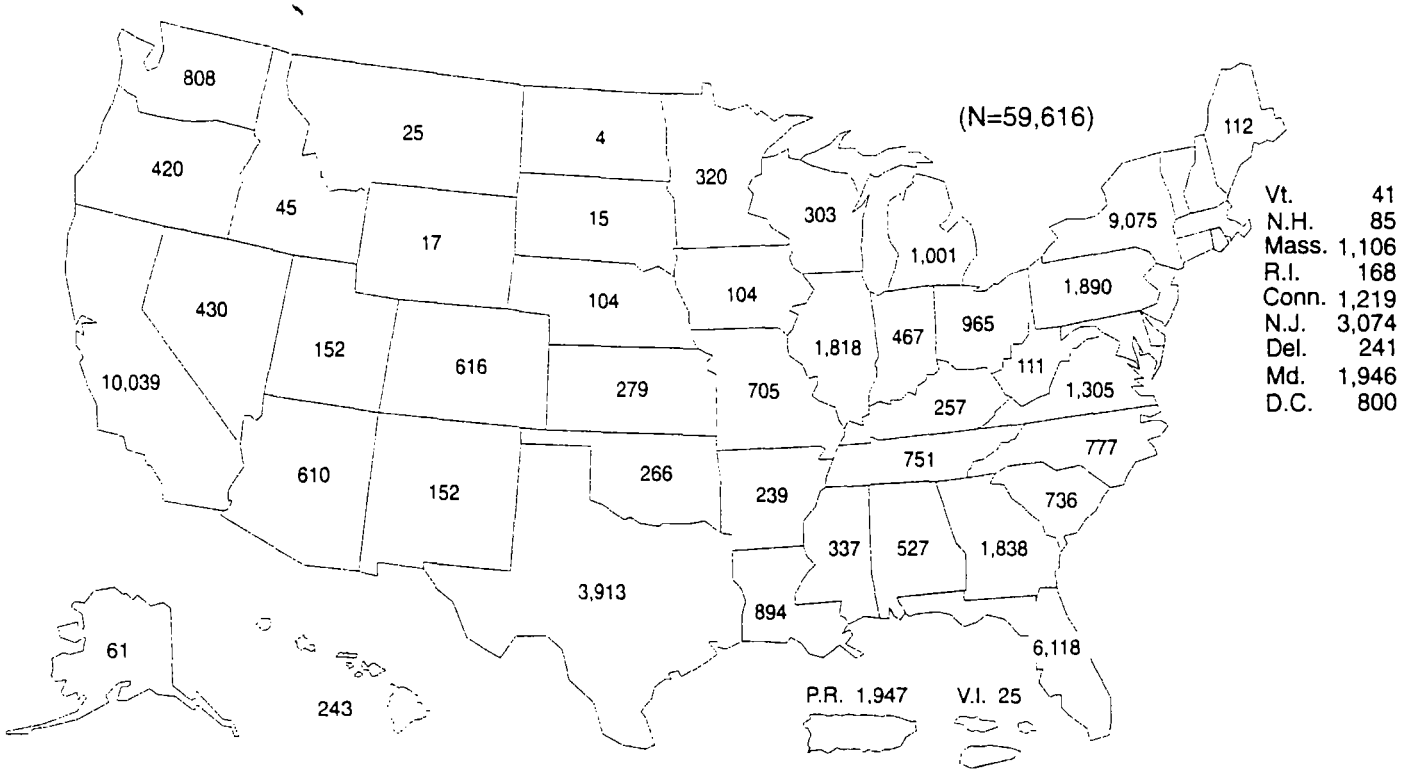
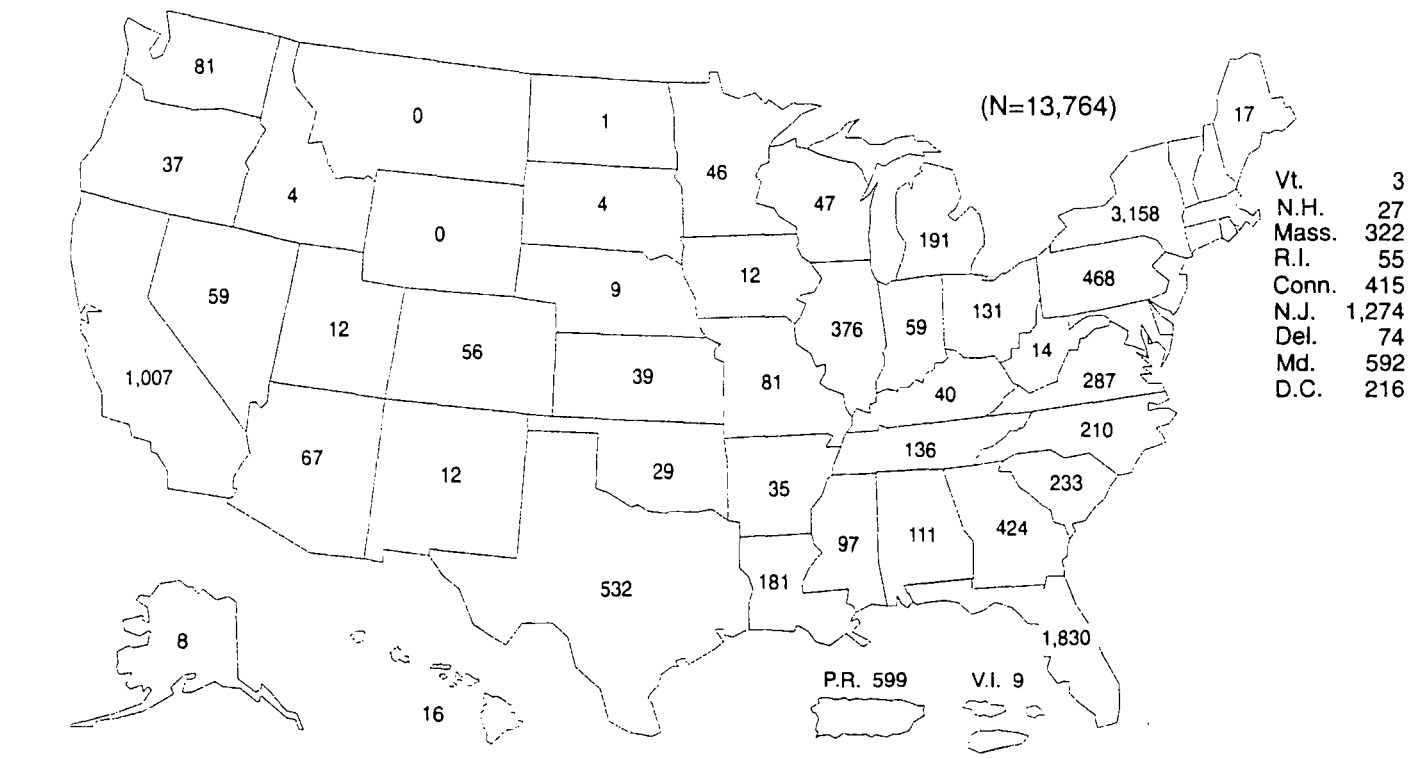


Figure 4. Female adult/adolescent AIDS cases reported in 1995, United States



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Facsimile

To: LaHoma
Office of Ms P. Fleming

Fax No: +1.202.632.1096

Pages: 14

Ref.:

From: Corinne Marclay

Office of Dr P. Piot

Date: 14 November 1996

Subject:

Dear LaHoma,

As per your request, please find attached a copy of the HIV/AIDS situation in mid 1996, global and regional highlights. As I said the latest figures will be issued for WAD at the end of the month. You can access our homepage at: http://www.unaids.org.

With regard to your request for Peter's speech, I'm afraid he gave it without anything in writing. So, I'm afraid I will not be able to give you a copy of that. Sorry about that.

With best regards,

Yours sincerely,

Corinne Marclay

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AIDS in the World II (AIW II)* and UNAIDS Estimates

Both the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the François-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health make estimates of the magnitude and trends of the global HIV/AIDS pandemic. Both sets of estimates are based on similar data and comparable methods. National estimates of HIV prevalence are based on HIV seroprevalence studies. If no relevant data are available a national estimate is made based on data from countries sharing similar epidemiological characteristics. These national prevalence estimates are then aggregated to produce regional estimates which are used to locate the current status of the epidemic along a theoretical epidemic curve.

AIW II and UNAIDS differ slightly on two assumptions:

1. While UNAIDS assumed a 10-year median progression from HIV to AIDS for all regions, AIW II used three different progression rates: a 7-year median progression for sub-Saharan Africa, a slightly longer one for developing countries outside of sub-Saharan Africa, and a 10-year median progression for developed countries.

2. UNAIDS assumes that the incidence of HIV in South and South-East Asia follows a linear curve while AIW II applies an exponential curve. As a result UNAIDS estimates 7,500 new adult infections a day during 1996 while AIW II estimates 11,500 new adult infections daily.

These two assumptions combine to produce more AIDS adult cases (an additional 2.8 million) and adult deaths associated with HIV/AIDS (3.2 million more) in the AIW II estimations despite the small difference (1.3 million) in the estimates of the number of adults living with HIV/AIDS.

Global estimates as of 1 July 1996	*AIDS in the World II*	*UNAIDS*
Cumulative adult HIV infections	30,000,000	25,500,000
Cumulative adult AIDS cases	8,900,000	6,090,000
Cumulative adult AIDS deaths	7,700,000	4,480,000
Adults living with HIV/AIDS	22,300,000	21,000,000

Acknowledgements

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International Program Center, U.S. Bureau of the Census; François-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health; WHO European Collaborating Centre for the Epidemiological Surveillance of AIDS; UN Population Division; DKT Viet Nam; AIDSCAP; and national AIDS programmes.

* *AIDS in the World II*, The Global AIDS Policy Coalition, J Mann & D Tarantola, ed., Oxford University Press, in press.

Global Estimates

By 30 June 1996, 1,393,649 cumulative cases of AIDS in adults and children had been officially reported by countries - an increase of approximately 19% over the 1,169,811 cases reported by 30 June 1995. However, taking into account under-recognition, under-reporting and reporting delays, it is estimated that more than 7.7 million AIDS cases have actually occurred since the start of the global HIV/AIDS epidemic* (Figure 1).

A more appropriate indication of the trends in the global epidemic is the number of new infections with the human immunodeficiency virus (HIV), which causes AIDS. According to UNAIDS estimates, over 3.1 million new HIV infections are expected to occur during 1996, or more than 8,500 a day - 7,500 adults and 1,000 children.

During 1995 HIV/AIDS-associated illnesses caused the death of 1.3 million people, including 300,000 children below the age of five.

Since the start of the global epidemic, around 28 million people have been infected with HIV (Figure 2) - 25.5 million adults and 2.4 million children.

Of these, an estimated 4.5 million adults and 1.3 million children have died.

Today, 21.8 million people are estimated to be living with HIV/AIDS (Figure 3). Of these, 21 million are adults and 830,000 are children.

Approximately 42% of the 21 million adults living with HIV/AIDS are women and the proportion is growing.

The majority of newly infected adults are between 15 and 24 years old.

Modes of Transmission

Worldwide, between 75 and 85 of every 100 HIV infections in adults have been transmitted through unprotected sexual intercourse.** Heterosexual (male-female) intercourse accounts for more than 70% of all adult HIV infections to date and homosexual (male-male) intercourse for a further 5-10%.

Transfusion of HIV-infected blood or blood products accounts for 3-5% of all adult HIV infections. In many parts of the world HIV transmission through the transfusion of infected blood has been reduced by the use of voluntary blood donors, the routine screening of donated blood for HIV, and through a more rational use of blood aimed at reducing the number of transfusions.

The sharing of HIV-infected injection equipment by drug users accounts for 5-10% of all adult HIV infections. This proportion is growing. In many areas of the world, injecting drug use is the dominant mode of transmission.

Mother-to-child (vertical) transmission accounts for more than 90% of all infections in infants and children. Around 25-35% of all infants born to HIV-infected women themselves become infected with HIV before or during birth, or through breast-feeding. Studies conducted in

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* Also known as the HIV/AIDS pandemic.

** Sexual intercourse without a condom.

industrialized countries have shown that the administration of antiretroviral drugs to HIV-infected pregnant women and their newborn babies decreases the risk of vertical transmission by two-thirds. However, these drugs are expensive and difficult to deliver, which puts them beyond the reach of most women living with HIV.

Studies to date, primarily from industrialized countries, indicate that about 60% of adults will progress to AIDS within 12-13 years of becoming infected with HIV. Few data are available beyond 12 years, but it is expected that the vast majority of HIV-infected persons will eventually develop AIDS. Although no long-term cohort studies have been completed, progression from initial HIV infection to the onset of AIDS might be more rapid in developing countries. A more rapid progression would result in a higher estimate of the number of AIDS cases.

Survival after the onset of AIDS has been increasing in industrialized countries from an average of less than 1 year to about 3 years at present. Survival time with AIDS in developing countries remains short and is estimated to be less than 1 year. Longer survival appears to be directly related to routine treatment with antiretroviral drugs, the use of drugs for opportunistic infections, and a better overall quality of health care.

The majority of AIDS cases occur before age 35, and over 90% of all AIDS deaths occur in people under the age of 50.

Children with HIV/AIDS

Basing its HIV/AIDS estimations and projections on assumptions very similar but not identical to those applied by UNAIDS and WHO, the François-Xavier Bagnoud Center for Health and Human Rights of the Harvard University School of Public Health estimates that by 1 July 1996, worldwide, about 3 million children had acquired HIV infection through mother-to-child transmission since the beginning of the global epidemic. Because of the rapid progression of paediatric HIV infection to the onset of AIDS and the short survival once paediatric AIDS has set in, most of these children have already died.

About one quarter of all AIDS-related deaths thus far have been in children who were infected vertically.

To date, over 85% of all children infected through mother-to-child transmission have been in sub-Saharan Africa. During 1995, approximately 500,000 children were born with HIV infection (about 1,400 per day); of these children, 67% were in sub-Saharan Africa, 30% in South-East Asia, 2% in Latin America, and 1% in the Caribbean.

As of July 1996, about 1 million children are living with HIV/AIDS, of whom 65% are in sub-Saharan Africa.

HIV incidence among children in sub-Saharan Africa, South-East Asia, and the Caribbean is higher than HIV incidence among adults in all other regions of the world.

HIV/AIDS prevalence among children is almost 35 times higher in the developing world than in the industrialized world.

The HIV/AIDS epidemic also affects children through the premature death of their parents. One in every three children orphaned by HIV/AIDS is younger than 5 years old. Since the beginning of the global epidemic, over 9 million children under the age of 15 have lost their mother to HIV/AIDS. Of these maternal orphans, 90% have been in sub-Saharan Africa.

Background information

The acquired immunodeficiency syndrome (AIDS) was first recognized in 1981 among homosexual men in the United States of America.

The human immunodeficiency virus (HIV) - the virus that causes AIDS - was identified in 1983.

Extensive spread of HIV appears to have begun in the late 1970s and early 1980s among men and women with multiple sexual partners in East and Central Africa and among homosexual and bisexual men in certain urban areas of the Americas, Australasia, and Western Europe. Today, the virus is being transmitted in all countries.

Two major types of HIV have been recognized, HIV-1 and HIV-2. HIV-1 is the dominant type worldwide. HIV-2 is found principally in West Africa but cases have been reported from East Africa, Europe, Asia and Latin America. There are at least 10 different genetic subtypes of HIV-1, but their biological and epidemiological significance is unclear at present.

Both HIV-1 and HIV-2 are transmitted in the same ways.

- The main route is through unprotected sexual intercourse between man and woman (heterosexual) or between men (homosexual). There are no documented cases of sexual transmission between women.

- HIV is also transmitted through blood, blood products, and donated organs or semen. Bloodborne transmission occurs primarily through the use of inadequately sterilized needles, syringes or other skin-piercing instruments, and the transfusion of infected blood.

- Finally, the virus may be transmitted from an infected mother to her fetus or infant during pregnancy or delivery, or when breast-feeding. This is known as mother-to-child, or vertical, transmission.

While the routes of transmission are the same, HIV-2 appears to be less easily transmitted than HIV-1 and the progression from HIV-2 infection to AIDS appears to be slower than in the case of HIV-1. AIDS seems clinically indistinguishable whether it results from HIV-1 or HIV-2.

AIDS is late-stage HIV infection characterized by a severely weakened immune system which can no longer ward off life-threatening opportunistic infections and cancers.

Regional Estimates

There are wide variations in HIV prevalence throughout the world (Figure 4). More than 90% of all adults with HIV infection or AIDS live in developing countries (Figure 5). Countries in sub-Saharan Africa and the Caribbean have the highest national rates of adult HIV prevalence.* At the end of 1994, adult prevalence ranged from approximately 1 per 100,000 (0.001%) in the Central Asian Republics and the Democratic People's Republic of Korea to more than 10% in five African countries (Botswana,18%; Zambia and Zimbabwe, 17%; Uganda, 15%; Malawi,13%). Part of this disparity can be attributed to the maturity of the epidemic in Africa and the more recent introduction of HIV into Central and East Asia.

Sub-Saharan Africa

Most of the epidemiological evidence indicates that the extensive spread of HIV in sub-Saharan Africa began in the mid to late 1970s.

Currently, an estimated 13.3 million adults are HIV-infected (over 5% of all people aged 15-49 in sub-Saharan Africa) . More than three-fifths of all adults living with HIV/AIDS worldwide are in this region.

Adult HIV prevalence rates in sub-Saharan Africa range from approximately 1 per 1000 (0.1%) in the Comoros to more than 18% in Botswana.

Women account for slightly more than half of all infected adults.

Demographic impact

The United Nations now incorporates the demographic impact of HIV/AIDS into its population estimates and forecasts. In 1995 the Population Division of the Department for Economic and Social Information and Policy Analysis of the United Nations Secretariat examined the demographic impact of HIV/AIDS in 15 sub-Saharan African countries with a 1994 HIV prevalence of more than 1% in the adult (age 15-49) population. Below that level of prevalence, the epidemic's impact on the national demographic picture is insignificant.

Population size: In 1995, because of HIV/AIDS, the combined population of all 15 countries will be 2 million smaller than expected (221.2 million people versus 223.4 million). In the year 2005 it will be 11.6 million smaller (291.8 million versus 303.4 million).

Number of deaths: In 1990-1995, HIV/AIDS accounted for 1.7 million of the total 15.8 million deaths in these 15 countries.

Life expectancy at birth: In 1990-1995, HIV/AIDS decreased life expectancy at birth in these 15 countries from 52.8 to 49.6 years. In 2000-2005 life expectancy without AIDS would have been 57.1 years. HIV/AIDS will reduce this by more than 7 years, to 49.6 years.

* Defined as the number of adults aged 15-49 years living with HIV/AIDS divided by the total number in that age group.

The majority of the world's children with HIV/AIDS live in sub-Saharan Africa.

In this region, the average age of infection and onset of AIDS is younger than the global average. Almost 90% of adult AIDS cases occur before the age of 40. Cases in women occur about 4 years earlier than in men, possibly reflecting infection at an earlier age.

Heterosexual transmission accounts for the majority of infections in the area, while transmission through blood transfusions accounts for up to 10% of infections.

South and South-East Asia

Despite the fact that the spread of HIV began in this area only in the mid 1980s, there are already more than 4.7 million adults living with HIV/AIDS, or 5 for every 1000 adults (0.5%). Because of the large populations of countries such as Ind a and Indonesia, this region accounts for more than a fifth of all global adult HIV infections.

Over 90% of the HIV-infected adults in South and South-East Asia live in India, Thailand, Myanmar and Cambodia.

With estimated adult infections exceeding 3 million, India is the country with the largest number of HIV-infected adults in the world, even though adult prevalence has not yet reached 1%.

Thailand has the highest prevalence, with slightly more than 2% of the adult population infected. Cambodia and Myanmar have adult prevalence rates approaching 2%.

Around a third of all infected adults are women.

The predominant route of transmission is heterosexual intercourse; second in importance is injecting drug use.

Latin America

Extensive HIV spread in this area most likely began in the late 1970s or early 1980s.

Overall adult prevalence is slightly more than 5 infections per 1,000 adults (0.5%). Almost 1.3 million adults live with HIV/AIDS in this area, or 6% of the global total.

National adult prevalence rates range from 6 per 1,000 (0.6%) in Bolivia to over 2% in Belize.

Brazil and Mexico together account for more than 7 out of 10 infections in Latin America.

Early in the epidemic, most HIV infections occurred among homosexual and bisexual men. Today there are increasing levels of transmission through heterosexual intercourse and the sharing of contaminated drug injection equipment.

In Latin America 18% of infections are in women; this proportion is rising as heterosexual transmission becomes more prominent.

Caribbean

Although the Caribbean with more than 250,000 HIV infections in adults accounts for only 1% of the current global total, the adult prevalence is second only to that of sub-Saharan Africa: out of every 1,000 adults, 14 are living with HIV/AIDS (1.4%).

Heterosexual transmission has predominated since the beginning of the epidemic in the late 1970s.

More than 40% of all HIV-infected adults in the Caribbean are women.

The most severely affected countries are Haiti, with an adult prevalence of 4%, and Barbados, with an adult prevalence approaching 4%.

Together Haiti and the Dominican Republic account for more than 85% of all Caribbean infections.

Cuba has the lowest prevalence rate in the region (2 infections for every 10,000 adults, or 0.02%).

Industrialized countries of North America, Western Europe and Australasia

More than 1.2 million adults in these countries are living with HIV/AIDS; they account for 6% of the global total. Adult HIV prevalence rates range from 12 HIV infections per 10,000 (0.12%) in Australasia, through 2 per 1,000 (0.2%) in Western Europe, to 5 per 1,000 (0.5%) in North America.

In the early 1980s homosexual intercourse dominated as the mode of transmission in these countries. Today, HIV infections acquired through the sharing of drug injection equipment and through heterosexual intercourse are playing an increasingly important role in the epidemic. In some countries, over 75% of AIDS cases are related to drug injecting or heterosexual contact with a drug injector.

North Africa and the Middle East

In North Africa and the Middle East there are an estimated 192,000 adults living with HIV/AIDS, giving a prevalence rate of 12 HIV infections per 10,000 adults (0.12%). While injecting drug use plays a role in some parts of the region, the dominant mode of transmission appears to be heterosexual intercourse.

Eastern Europe and Central Asia

This region, with an estimated 29,000 HIV-infected adults, has an overall adult prevalence of 15 per 100,000 (0.015%). However, there is evidence of rapid spread of HIV, particularly in Ukraine and Poland.

HIV outbreak in injecting drug users in Ukraine

Following several years of low but slowly rising levels of HIV infection, an outbreak has occurred among injecting drug users in Ukraine. In January 1995 1.4% of drug users were HIV positive. By August 1995 the prevalence had increased almost ten-fold, to 13%. It has now reached 55% in Nikolayev, with rates in four other cities ranging from 4.2% to 12.1%. Similar increases are expected in other Ukrainian cities, in other groups, and in neighbouring countries.

East Asia and the Pacific

Epidemiological evidence indicates that widespread transmission of HIV in East Asia and the Pacific began only recently. Partly for this reason, there are now fewer than 50,000 adults living with HIV/AIDS. Given the huge adult populations of this region, which includes China, the overall prevalence is less than 4 HIV infections per 100,000 adults (0.004%).

Encouraging Trends

Declining or stable HIV rates

In a number of industrialized countries, in parts of sub-Saharan Africa, and among some populations in Thailand, HIV prevalence appears to be decreasing or stabilizing. In the USA about 40,000 new infections now occur annually, down from 100,000 a few years ago. Among women attending selected antenatal clinics in Uganda and among Thai military recruits, HIV prevalence has dropped. New infections are also declining in Australia, New Zealand, and some northern European countries. There is growing evidence that behavioural changes such as increased condom use, reduction in the number of sex partners, and later initiation of sexual activity contribute to these hopeful trends.

HIV prevention through STD treatment

The risk of HIV transmission through sexual intercourse is significantly higher in the presence of other sexually transmitted diseases (STD) such as syphilis or gonorrhoea in one or both partners. It has now been confirmed that early detection and treatment of other STDs can reduce HIV transmission. In a recent study in Tanzania, 12 communities with AIDS prevention programmes were followed for two years. In six of them STD prevention and care were improved by establishing an STD reference clinic, ensuring regular supply of antibiotics, training peripheral health workers, and providing clients with health education about STDs. At the conclusion of the study, it was found that the six communities with improved STD control had 40% fewer new HIV infections than the other communities.

Condom use

In Viet Nam, condom distribution rose from 40 million in 1991 to 117 million in 1995. In 1995, 20 of the 117 million were distributed as a result of a dynamic HIV/STD condom social marketing campaign.

In Thailand, condom distribution rose steeply from 15 million in 1990 to 88 million in 1992, a six-fold increase over a period of three years.

In Ethiopia the number of condoms distributed rose markedly from 20,000 in 1987 to over 26 million in 1993.

In Africa as a whole, demand for condoms has risen greatly since 1988, when less than 1 million were sold; in 1994 110 million condoms were sold by one social marketing firm alone.

Concurrent with the rise in the number of condoms distributed worldwide, there has been an increase in reported condom use. For example, in Thailand between 1989 and 1994, condom use rose from 14% to over 90% of all commercial sex acts. In Ghana consistent condom use among sex workers rose from 6% to 71% in 6 months. In Switzerland, a survey of sexually active 17-20 year olds showed that the proportion always using condoms increased from 19% to 73% between 1987 and 1990.

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Joint United Nations Programme on HIV/AIDS

UNAIDS AND WHO

The HIV/AIDS situation in mid 1996
Global and regional highlights

Estimates as of 1 July 1996*

People living with HIV/AIDS	Adults	21 million
	male	12.2 million
	female	8.8 million
	Children	800,000
	Total	**21.8 million**
HIV/AIDS-associated deaths in 1995	Adults	1 million
	male	600,000
	female	400,000
	Children	300,000
	Total	**1.3 million**
Cumulative HIV infections	Adults	25.5 million
	male	14.9 million
	female	10.5 million
	Children	2.4 million
	Total	**27.9 million**
Cumulative AIDS cases	Adults	6.1 million
	male	3.5 million
	female	2.6 million
	Children	1.6 million
	Total	**7.7 million**
Cumulative HIV/AIDS deaths	Adults	4.5 million
	male	2.6 million
	female	1.9 million
	Children	1.3 million
	Total	**5.8 million**

* Because of rounding, figures may not tally.

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Figure 5.
Percentage of total number of adults living with HIV, by subcontinent, mid 1996
(Global total: 21.8 million)

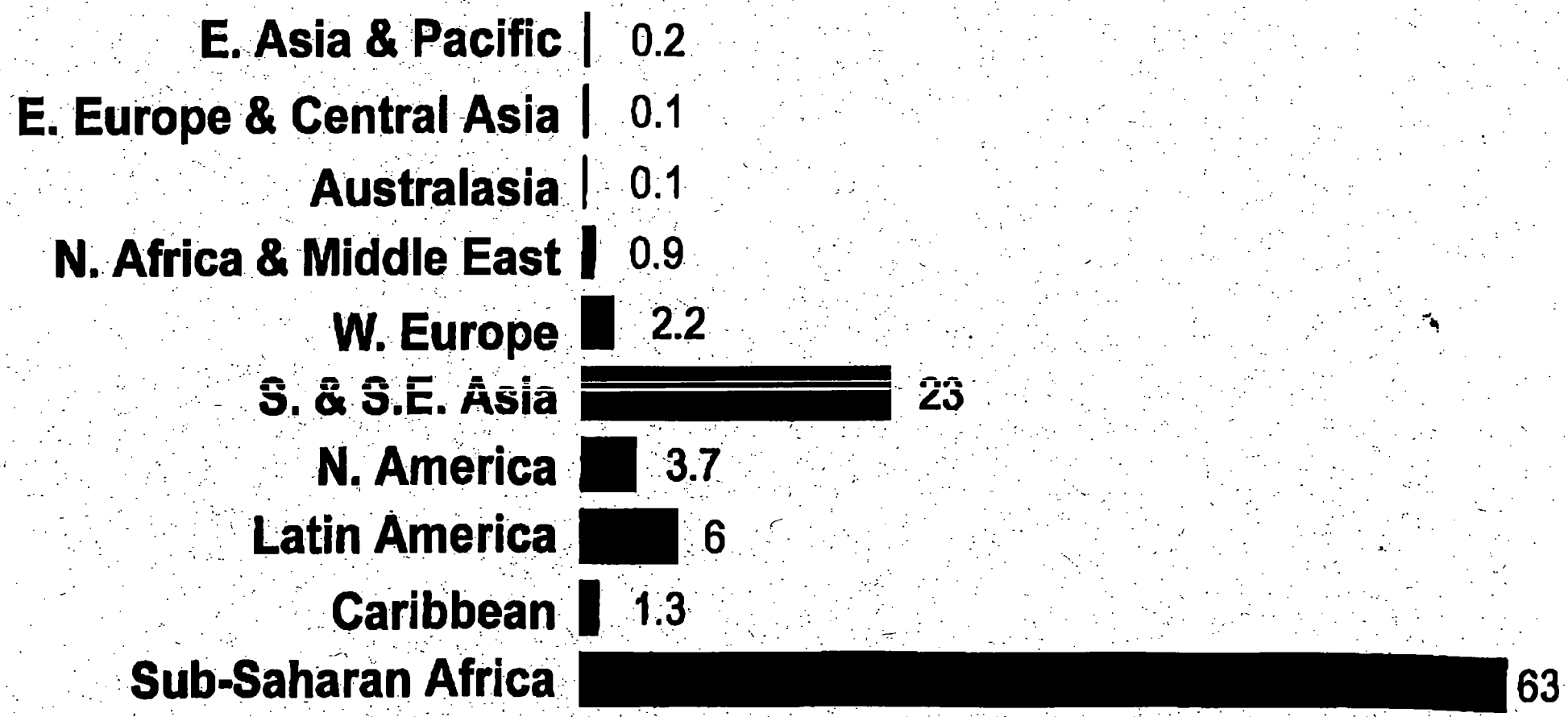


Figure 4.
Adult HIV prevalence rates (%) by subcontinent, mid 1996

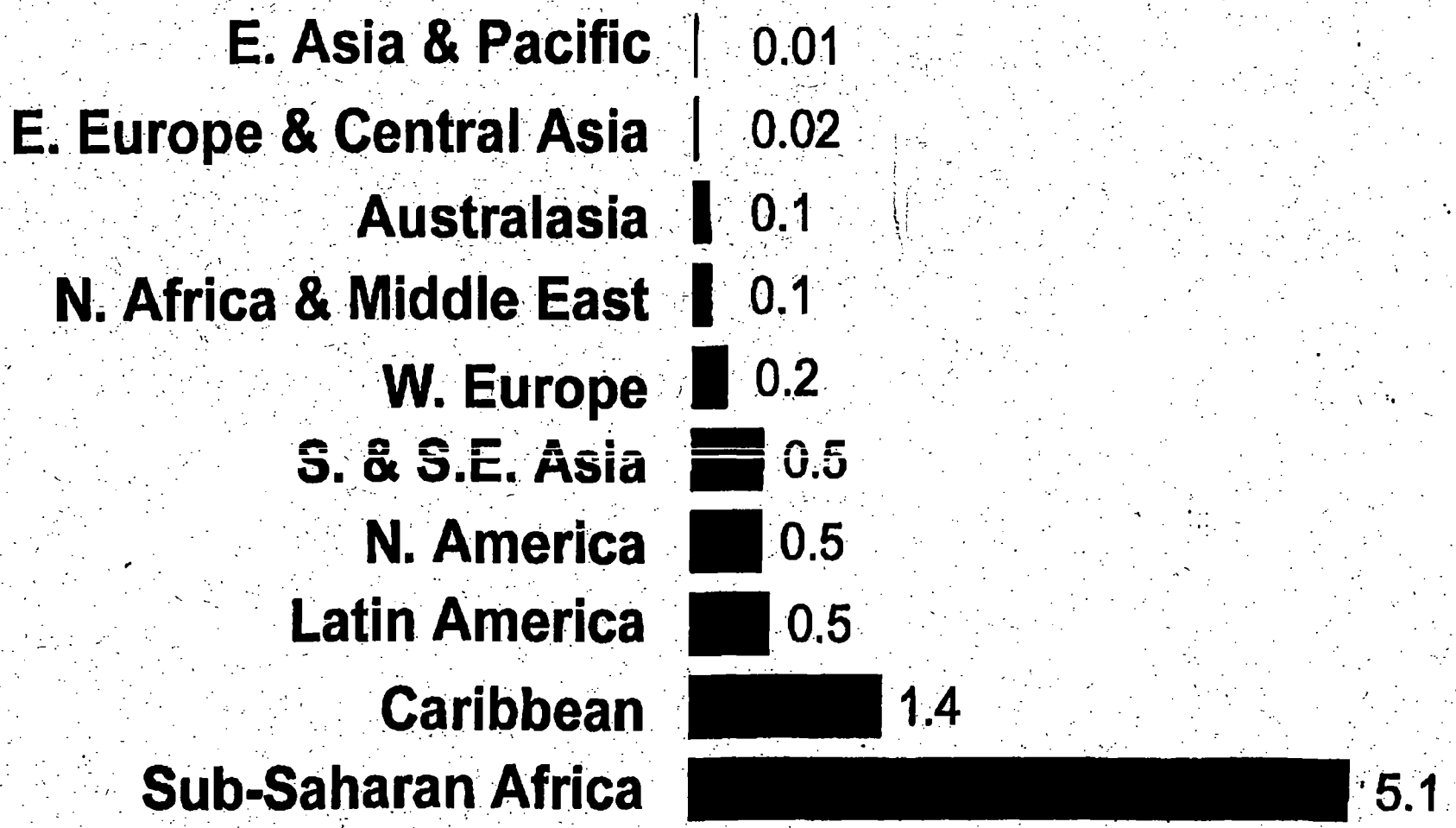
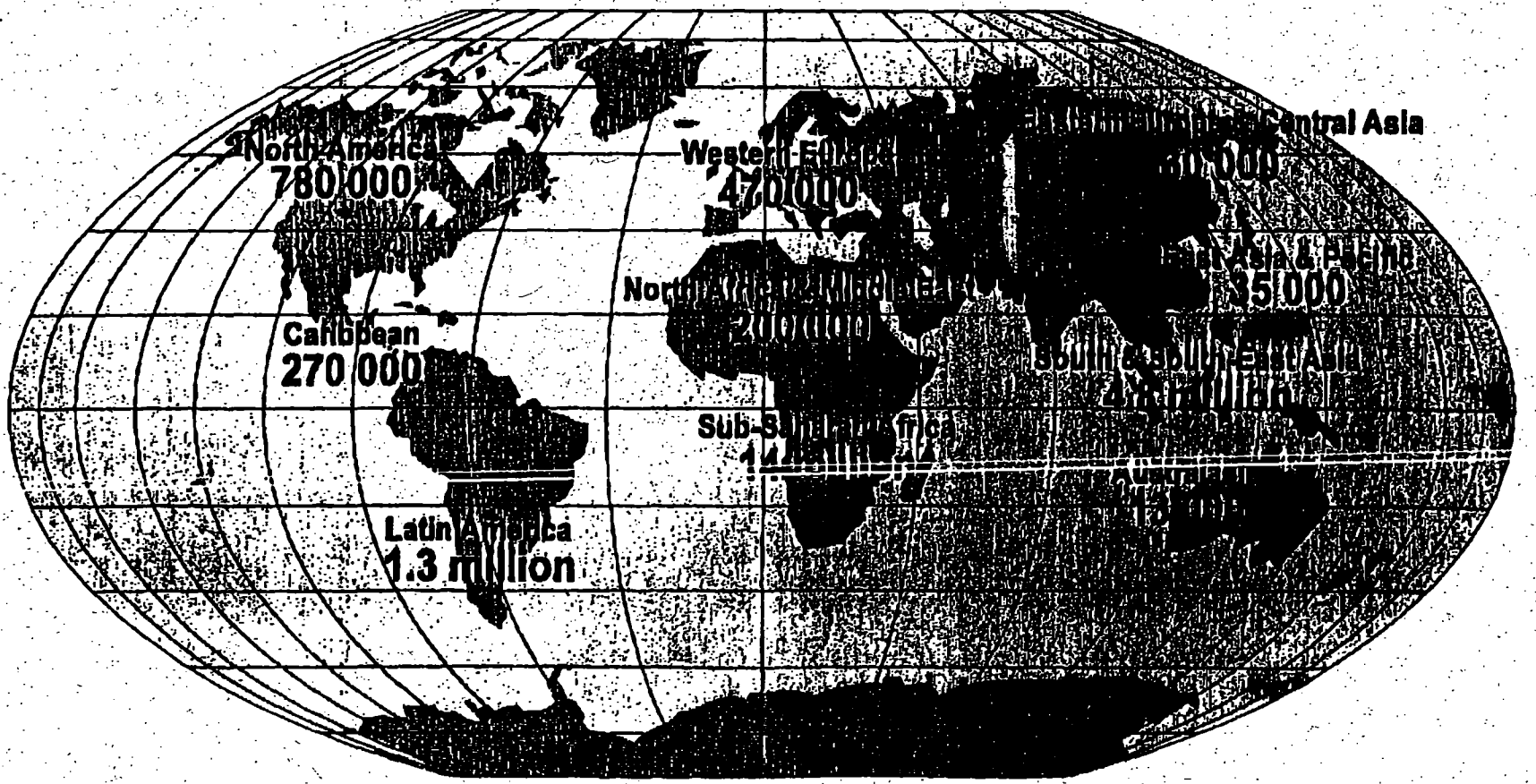


Figure 3.
Estimated mid-1996 distribution of adults and children living with HIV/AIDS (global total: 21.8 million*)

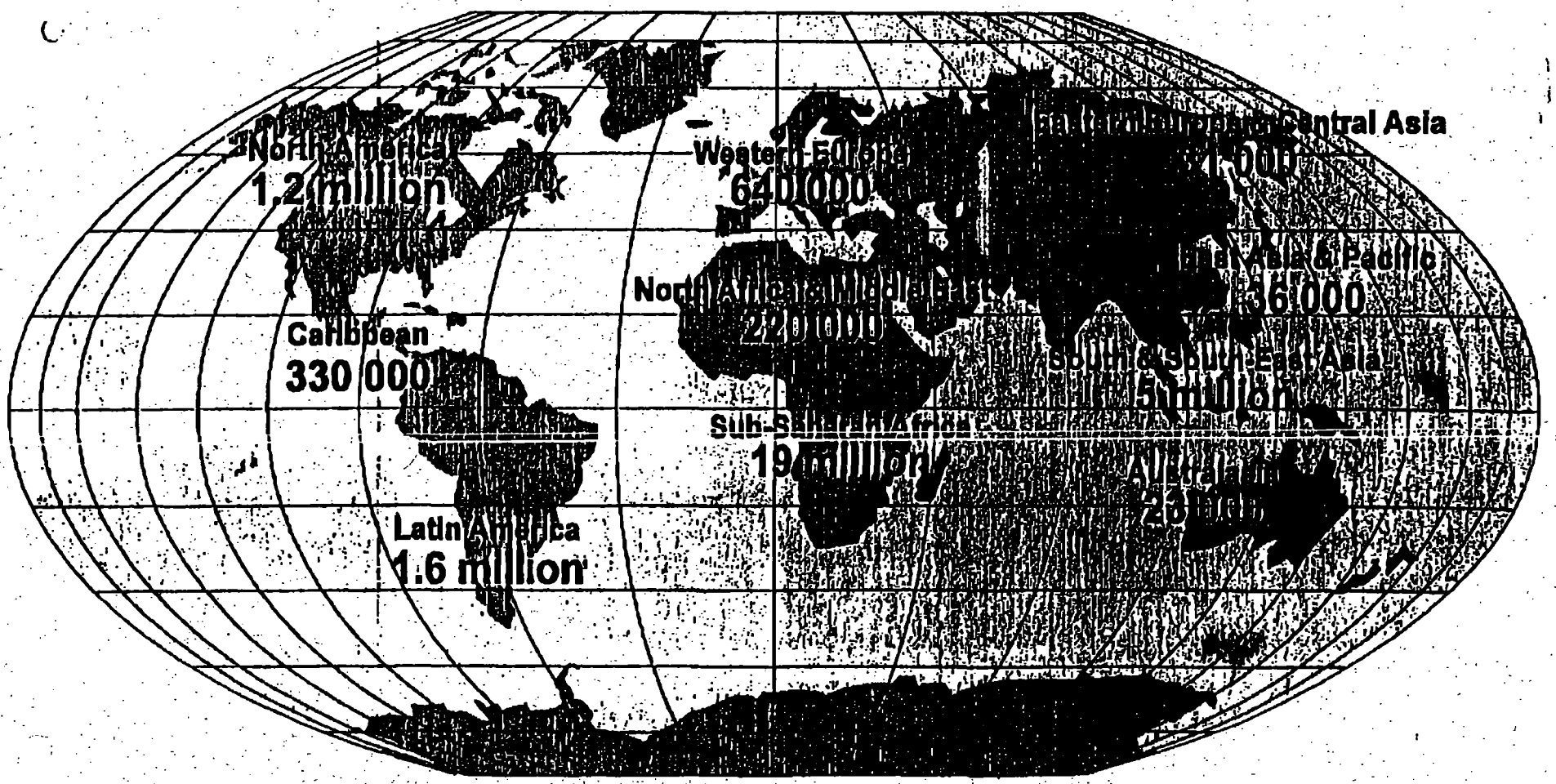


*Because of rounding, the figures may not tally.

UNAIDS - Joint United Nations Programme on HIV / AIDS

UNAIDS/COS/SG/96017-2bw 30 June 1996

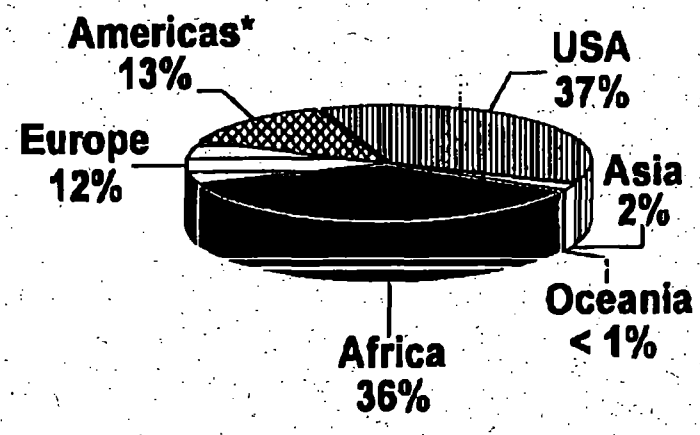
Figure 2.
Estimated distribution, as of mid 1996, of adults and children infected with HIV since the late 1970s (global total: 27.9 million*)



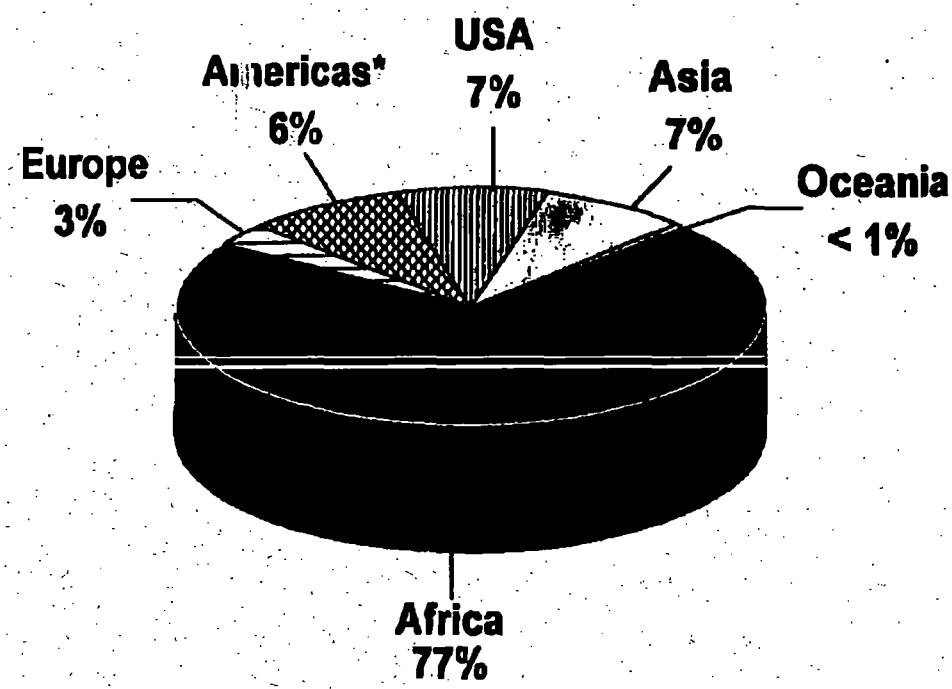
*Because of rounding, the figures may not tally.

Figure 1.
Reported and estimated AIDS cases in adults and children from late 1970s/early 1980s until mid 1996

Reported: 1 393 649**



Estimated: 7.7 million



* Excluding USA

** AIDS cases reported to WHO as of 30 June 1996

WHO's Global Programme on AIDS

WHO/UNDP Alliance to combat AIDS

I. Policy Framework

1 The prevention and control of AIDS requires urgent, worldwide action, first and foremost in the health sector. AIDS also has profound social and economic implications. Its control therefore requires political commitment at the highest level, and appropriate social and educational measures. In response, WHO has assumed its constitutional role of directing and coordinating the global fight against AIDS. Its Global Strategy for AIDS, approved by the 40th World Health Assembly, includes a wide range of research and development activities in diverse health and related socioeconomic and behavioural fields, as well as operational support to countries based on existing and emerging knowledge in these fields. This support aims at strengthening national capacities to set up and operate national AIDS plans, and focuses on ministries of health fulfilling their function of directing and coordinating authority on national health work with their related multisectoral health councils, in accordance with World Health Assembly Resolution WHA33.17.

2 Countries engaged in AIDS prevention and control have expressed concern about uncoordinated, ill-timed or inappropriate offers of external assistance to combat AIDS. Similarly, in order to ensure relevant, effective and efficient action, donor agencies have insisted on well coordinated activities in countries as a prerequisite for their support.

3 To ensure a well-coordinated, multisectoral approach in the global fight against AIDS, the United Nations General Assembly (UNGA) in Resolution A/42/8 confirmed WHO's directing and coordinating role. It also urged bilateral and multilateral agencies, including those of the UN system, as well as nongovernmental and voluntary organizations, to support national and international action against AIDS in conformity with WHO's Global Strategy. The UNGA further requested the Secretary-General of the United Nations, in close cooperation with the Director-General of WHO, to ensure a coordinated response by the UN system.

4 A key component of the reforms taking place in the UN system is coordinated, complementary and harmonious action by all its bodies. Within that system, UNDP plays the lead role, at the country level, regarding social and economic development. The UNDP Resident Representative in any country is, at the same time, the Resident Co-ordinator of the United Nations System's Operational Activities for Development. UNDP is therefore the natural body to ensure coordinated support by the UN system for socioeconomic matters in countries.

5 WHO, through its Global Programme on AIDS (GPA), and UNDP are therefore forging an alliance to control AIDS globally, combining the strengths of WHO as international leader in health policy as well as in scientific and technical matters relating to health, and of UNDP as leader in socioeconomic development and of the role of its Resident Representatives as Resident Co-ordinators of the United Nations System's Operational Activities for Development (UN Resident Co-ordinators).

6 This alliance will support countries in developing, implementing, monitoring and evaluating well coordinated, multisectoral national AIDS plans in line with the Global Strategy. It will also help countries to ensure coordinated support for such national plans by all external partners, including those of the UN system. In this way, all partners will find their rightful place, in their field of competence, in the fight against AIDS.

II. Managerial framework

A. Country-level collaboration

1. General considerations

a. UNDP will support GPA in its collaboration with all developing countries in formulating, coordinating, implementing, monitoring and evaluating national AIDS plans and mobilizing the required external resources.

b. UNDP will support GPA in its collaboration with the governments concerned to ensure that all external support is an integral part of their national AIDS plans and consistent with WHO's Global Strategy on AIDS. The development of such national AIDS plans will be a prerequisite for the provision of external support, except for limited, urgent assistance.

c. Therefore, GPA and UNDP, in consultation with the parties concerned, will jointly review and make recommendations to the governments concerned regarding offers of support originating from the UN system as well as from bilateral and other multilateral agencies, non-governmental organizations and voluntary bodies. In this context GPA will ensure that these offers are consistent both with governments' national AIDS plans and WHO's Global Strategy on AIDS; UNDP will seek to ensure that such offers are consistent with governments' overall development priorities, plans and resource allocation.

2. Specific roles and responsibilities

a. **Planning**: GPA has the sole responsibility for providing to the governments concerned the policy and technical inputs required for the development of their national AIDS plans. UNDP will provide support to governments and GPA through its experience and expertise in multi-sectoral approaches to socio-economic development.

Within the overall context of the planning process, UNDP will assist governments in ensuring full integration of the national AIDS plan into their overall national development policies and priorities, as well as into the consultation processes in use by UNDP and governments as appropriate.

Any required reprogramming of national AIDS plans will be carried out through a similar division of tasks between GPA and UNDP.

b. **Resource Mobilization**: Activities designed to support government efforts to raise external funds for their national AIDS plans will be undertaken by GPA with the support of UNDP. In this context, GPA will provide all technical and policy guidance needed by donors. GPA will also continue to fund, subject to the availability of voluntarily contributed global GPA funds, individual plans of countries when other support is insufficient or inequities exist. It will continue to request undesignated funding for this purpose, inter alia, from donors.

In order to bridge the time between pledges of external support being made and received for country-level activities, UNDP will provide a facility (by means of a reimbursable global IPF project) under which funds could be advanced on the basis of firm pledges having been made by donors to the WHO established trust fund sub-account for that country indicating the amounts and the dates when the funds would be remitted to WHO/GPA. Funds which are advanced by the UNDP will be reimbursed by WHO upon receipt of the pledged contribution and within six months of the date of the advance in each case.

c. **Financial Management**: WHO has established a trust fund to receive voluntary contributions made available by governments and other participating parties to combat AIDS. The use of such contributions will follow a programme and budget established by GPA and governed by the AIDS Management Committee in conformity with WHO policy. The budget will be revised in the light of contributions received and current requirements of GPA. The

global activities of the programme supported by such contributions will be implemented by GPA. Voluntary contributions received from donors for activities in specific countries will be placed in separate sub-accounts of the trust fund established in the name of the country for which they were deposited. The use of such contributions will be governed by national budget proposals created by governments with the assistance of GPA in consultation with UNDP and other relevant participating parties. The activities for any specific country will be implemented by the government, an agency, or any other organization, as determined between the government and GPA, in consultation with UNDP. Authority to incur obligations for local expenditures will be derived from a Plan of Operation or a project document approved by the government, GPA and UNDP. Authority to incur obligations for non-local expenditures will require a request co-signed by the government and GPA. All activities financed from the trust fund will be subject to the programme support costs provision presently established at 13% of actual disbursements. Interest accruing in the trust fund will be credited to the fund itself.

d. All participating parties, including those within the UN System, will be encouraged to make unrestricted contributions to the national AIDS plan through the sub-accounts of the trust fund established by WHO in the name of the country concerned. Where it may assist the efficient implementation of their national AIDS plan, governments receiving external support will also be encouraged to direct this support, particularly in the form of unrestricted contributions, to the appropriate sub-account of the trust fund. WHO will have responsibility for the accounting and reporting functions arising from the trust fund in accordance with WHO Financial Regulations and Financial Rules. Other contributions should be provided in a manner that supports the national AIDS programme, avoids creating parallel planning, implementing, monitoring or evaluating mechanisms, and is consistent with WHO's Global AIDS Strategy.

e. **Coordination**: The UN Resident Co-ordinator will exercise responsibility (UNGA resolution 42/8), in conformity with WHO's Global Strategy on AIDS and in full accordance with the national AIDS plan, to coordinate support originating from within the UN system. In this context GPA will provide technical and policy guidance to the UN Resident Co-ordinator.

f. **Role of WHO Representatives**: National AIDS Control Programmes must contribute to the rise of self-sustaining, socially and economically relevant, national health strategies and related programmes managed by the countries themselves, and lead to the mobilization and most rational use of national and external resources for health to that end. To be effective, these endeavours have to be consistent with the policies, strategies and related programmes that have been decided upon by WHO Member States. In supporting governments to attain this goal, WHO Representatives, in the country concerned, will make an important contribution to the control of AIDS as well as providing a direct link between this programme and the other WHO activities in the countries. A more detailed presentation of potential supportive actions by WHO Representatives is given in Annex 1.

3. Implementation

a. **General Considerations**: GPA will provide technical and policy leadership in support of the government's implementation of its national AIDS plan. UNDP will provide GPA and the government with in-country support (administrative, accounting, logistics, etc.) (see Annex 2). GPA will finance the cost of any additional local staff which the UNDP field office may require as a result of providing these support services. Such staff will be recruited by UNDP and integrated into the UNDP Resident Representative's office. With regard to any other additional services provided by UNDP field offices as described in Annex 2, to the extent that these may require identifiable increases in resources, UNDP will negotiate with WHO/GPA on a country-by-country basis the appropriate amount to be reimbursed to UNDP by GPA for this purpose (pursuant to UNDP Governing Council decision 80/33). Details of these arrangements will be incorporated in an exchange of letters between WHO/GPA and UNDP for each country concerned.

b. **Non-Local Purchases**: WHO/GPA will be responsible for the specification, international purchase and shipping of supplies and equipment. UNDP will be responsible for processes subsequent to the arrival of supplies and equipment in the country, (e.g. customs clearance, transportation, storage, distribution).

c. **Staff**: Professional international staff will be appointed by WHO/GPA. The senior GPA staff member will report to, and be supervised and directed by, GPA in Geneva. Any necessary locally recruited GS staff will be appointed and administered by UNDP in consultation with WHO/GPA.

d. **Monitoring**: Governments, GPA and UNDP will each have responsibility for monitoring their respective activities.

e. **Evaluation**: GPA will have primary responsibility for supporting the government in evaluating its national AIDS programme, under the framework developed by all relevant participating parties in conformity with WHO's Guiding Principles on Health Programme Evaluation. UNDP will participate in this process.

B. Regional collaboration

1. General considerations

Regional programmes will be based on the recognition of the prime responsibility of governments for the use of WHO resources in the countries in conformity with WHO policy. Consequently regional and intercountry activities provided by WHO Regional Offices directly or indirectly shall support health development action as decided upon by individual countries, provided that: (a) similar needs have been identified by a number of countries in the region following a rational process of programming or a common awareness of joint problems; (b) the activity will be useful for eventual application by countries; (c) the pursuit of the activity as a cooperative effort of a number of countries in the same region is likely to contribute significantly to attaining the programme objective; and (d) for reasons of economy the intercountry framework is useful for pooling selective national resources.

2. Specific Roles and Responsibilities

WHO's Regional Offices will be asked to prepare regional programmes annually, to be approved and funded by GPA, in conformity with the above criteria as integral parts of the Global Strategy on AIDS, which should include, inter alia, support for the:

a travel of regional or country-based WHO staff for GPA approved regional or intercountry activities;
b organization of intercountry workshops in collaboration with GPA;
c regional adaptation of health information/education materials, with GPA clearance; and
d appropriate and speedy training of staff in AIDS activities in conformity with the above criteria.

Support for these activities by the Regional Bureaux of UNDP will be provided only with the approval of, and through, GPA. These Regional Bureaux will also assist GPA to ensure that all external support for regional activities originating from the UN system is in conformity with WHO's Global Strategy on AIDS.

3. Implementation

a. To assist in the implementation of these activities and to reinforce the regional and national capacity to participate in and support the Global Strategy, the Global Programme on AIDS, in consultation with WHO's Regional Offices, will establish and finance posts for personnel in each Regional Office.

b. In fulfilment of WHA Resolution 40.26, Regional Offices will ensure that GPA is kept fully informed of all regional and intercountry activities undertaken by them and will explore innovative communication linkages for exchanges of information between key national programmes, Regional Offices and GPA.

C. Global collaboration

1. General considerations

To ensure a well-coordinated, multisectoral approach in the global fight against AIDS, UNGA confirmed WHO's directing and coordinating role and urged bilateral and multilateral agencies, including those of the UN system, as well as nongovernmental and voluntary organizations, to support national and international action against AIDS in conformity with WHO's Global Strategy. UNGA further requested the Secretary-General of the United Nations, in close cooperation with the Director-General of WHO, to ensure a coordinated response by the UN system.

2. Specific Roles and Responsibilities

The WHO/UNDP alliance will extend to the Headquarters of WHO/GPA and UNDP with their respective roles as described under the Policy Framework section of this document.

3. Implementation

In response to the United Nations General Assembly's request that the Secretary-General of the United Nations, in close cooperation with the Director-General of WHO, ensure a coordinated response by the UN system, the alliance welcomes the Secretary-General's appointment of the Under Secretary-General for International Economic and Social Affairs, in his personal capacity, as focal point at United Nations Headquarters for activities related to the prevention and control of AIDS. It further welcomes the Under Secretary-General's initiative in establishing, under his chairmanship, and in close cooperation with the Director General of WHO, a United Nations Steering Committee to coordinate United Nations activities in support of WHO's Global Strategy for the Prevention and Control of AIDS, to identify possible joint activities and to develop linkages between individual programmes in this field. For its part, WHO will establish an inter-agency advisory group, under its chairmanship, to facilitate the effective coordination of activities in the UN system in support of WHO's Global Strategy on AIDS. The decision of the UN Steering Committee to provide a coordinated input to the work of this group will significantly assist its endeavours.

III. Evolution of the Alliance

The struggle against AIDS is based on existing and emerging knowledge in diverse health and related socioeconomic and behavioural fields. It is against such a constantly changing background that this alliance is forged. Consequently, in its operational aspects there must exist some flexibility. WHO and UNDP acknowledge that these agreements should not be seen as static but that they can, with the agreement of both Organizations, evolve over time to meet changing circumstances.

ANNEX 1

The role of WHO Representatives

WHO Representatives will undertake to provide, in conjunction with GPA personnel and UNDP Resident Representatives, the following assistance:

- supporting governments to ensure that medium-term national AIDS plans are fully integrated with other elements of primary health care and consistent with long-term health policies and strategies;
- supporting governments to ensure that national AIDS plans meet the criteria for the implementation of programme activities as stated in WHO's Seventh General Programme of Work;
- strengthening governments' ability to manage national AIDS plans in conjunction with other country-wide health programmes;
- helping ensure that national AIDS plans and all other WHO supported health activities complement each other through joint government/WHO policy and programme reviews, which include the participation of GPA personnel and UNDP Resident Representatives;
- supporting the monitoring and evaluation of national AIDS programmes by strengthening governments' programme monitoring and evaluation capabilities as part of the managerial process for overall national health development; and
- facilitating contacts with ministries of health and other national health institutions.

WHO Representatives will keep their Regional Offices regularly informed of their AIDS related activities and the support provided to GPA personnel and UNDP Resident Representatives in this regard.

ANNEX 2

The role of UNDP

Arising from its position of leadership in socioeconomic development and of the role of its Resident Representatives as UN Resident Co-ordinators, UNDP will support WHO in its collaboration with countries in formulating, coordinating, implementing, monitoring and evaluating national AIDS plans and mobilizing the required external resources. Furthermore, it will support WHO in its collaboration with the governments concerned to ensure that all external support is an integral part of their national AIDS plans and consistent with WHO's Global Strategy on AIDS.

Working administrative arrangements related to the implementation of country activities

The UNDP Office will provide, to the extent necessary, the following logistic support to GPA and National AIDS Plans:

- equipped office space, e.g. with telephones, photocopiers, typewriters, etc.;
- General Service staff, e.g. secretaries, clerks, night-watchmen, store-keepers, drivers, etc.;
- services in support of "meetings" such as seminars, training courses, e.g. arranging premises, paying participants' stipends, acquittance rolls, provision of audio-visual apparatus, etc;
- services in support of within-country transportation and travel, e.g. provision of vehicles and trucks, internal airtickets, etc.;
- management of vehicles;
- reception and subsequent services in connection with imported supplies and equipment.

UNDP will also undertake to provide services excluded from normal Government obligations, such as:

- local purchase of non-technical equipment and supplies;
- personal services to international staff e.g. housing assistance, permits, visas, advice on schooling, etc;
- accounting of funds in local currency in support of any of the above, i.e. comparable to imprest account activity.

Working financial arrangements related to the implementation of country activities

1. Local expenditure will be effected by RR/UNDP offices or WHO offices as determined for each country, by agreement between WHO and UNDP. Such expenditures to be incurred by RR/UNDP will be authorized by WHO staff, who will at the same time provide the relevant allotment/sticker number or account to be charged.

2. For the handling of these payments made on behalf of WHO, UNDP would issue under the established procedure IOVs which should be addressed to WHO, Geneva and recorded in the existing UNDP/WHO operating fund. As required, taking into account the overall traffic of transactions under the operating fund, WHO may adjust its funding requirements from UNDP or, eventually, should AIDS activity payments made by UNDP be higher than WHO activities financed by UNDP, WHO would fund UNDP on the basis of two months' disbursements in advance.

3. As and when PL 480 funds are made available by USAID, such funds shall be deposited in the local currency bank account operated by the RR/UNDP. They shall be credited to the sub-account of the trust fund established by WHO for that country. WHO will authorize RR/UNDP to effect any required disbursements in local currency against PL 480 funds. Such disbursements shall be debited to WHO by IOV in accordance with paragraph 2 above.