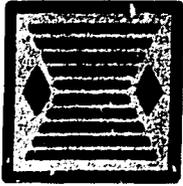


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# LATIN AMERICA AND CARIBBEAN HEALTH AND NUTRITION SUSTAINABILITY:

Technical Support for Policy,  
Financing and Management

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**MEXICO AIDS ASSESSMENT**

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## EXECUTIVE SUMMARY

The first case of Acquired Immune Deficiency Syndrome (AIDS) in Mexico was reported in 1983. In just ten years, the number of reported cases has grown rapidly. More than 13,250 AIDS cases have been officially reported; some estimates are as high as 20,000. Estimates of the number of people infected with HIV, the virus which causes AIDS, range between 200,000 and 650,000.

As in other countries, groups most at risk in Mexico include gay and bisexual men and their female sex partners, commercial sex workers (female and male) and their clients, and intravenous drug users. Migrant workers who travel to and from the U.S. and their communities are also at special risk, as their sexual practices are not well studied and could include high risk behaviors. The porousness of the U.S./Mexico border also means that AIDS prevention in either country can be both strengthened or undermined by the other: both the U.S. and Mexico have much to gain from preventing the further spread of AIDS.

A major risk factor for the continued spread of HIV in Mexico is the current complete lack of clinics dedicated to the treatment and prevention of other sexually transmitted diseases. The commercial sex worker population reports a high incidence of other sexually transmitted diseases, and though difficult to estimate STD prevalence in the general population, it is generally assumed to be significant.

A.I.D. has been active in the fight against AIDS in Mexico since 1987, often working directly with CONASIDA, the National Committee for the Prevention of AIDS. A.I.D.'s provision of condoms to CONASIDA has been an important component of AIDS prevention, as condoms are not manufactured locally. A.I.D.'s support of NGOs in various communities in Mexico has helped send AIDS prevention messages to a wide audience. A discontinuation of A.I.D.'s support of these and other activities would mean a serious setback in AIDS prevention in Mexico.

On the basis of the field work and desk review conducted over the course of this assessment, the team recommends that A.I.D.:

- o Maintain current level of funding for AIDS prevention activities for FY 1993.
- o Increase level of funding for FY 1994 and FY 1995.
- o Maintain supplies of donated condoms through FY 1994.
- o Provide start-up funding and technical assistance for condom social marketing program.
- o Reallocate a portion of A.I.D.'s family planning budget to AIDS prevention activities.

- o Support STD treatment and prevention.
- o Support NGOs active in the defense of human rights of people with AIDS.
- o Support NGOs involved in low-income communities.
- o Support behavioral research on the sexual practices of migrant workers.
- o Support the development of educational materials for CONASIDA.

## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention (A.I.D. centrally-funded contract with Family Health International and others, 1992-1997)
AIDSCOM	AIDS Communication (A.I.D. centrally-funded contract with the Academy for Educational Development and others 1987-1992)
AIDSTECH	AIDS Technical Assistance (A.I.D. centrally-funded contract with Family Health International and others 1987-1992)
CONASIDA	Consejo Nacional para la Prevención del SIDA (Mexican National AIDS Control Program)
CONAPO	National Population Council
COESIDA	Comites Estatales para la Prevención y Control de SIDA (State-level AIDS Control Programs)
CRISSOL	Colectivo Sol program funded by WHO
CSW	Commercial Sex Worker
FSW	Female Sex Worker
FEMAP	Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario (NGO)
GIS-SIDA	Grupo de Intervención Social en SIDA y Defensa de Derechos Humanos (Human Rights NGO)
GPA	WHO Global Program on AIDS
HIV	Human Immunodeficiency Virus
ICASO	International Council of AIDS Service Organizations (Secretariat: Colectivo Sol)
IMIFAP	Mexican Institute for Research into the Family and Population (NGO)
IMSS	Instituto Mexicano de Seguro Social (Government Social Security)
INDRE	Instituto Nacional de Diagnóstico y Referencia Epidemiológicos (Research arm of the Ministry of Health)
KAP	Knowledge, Attitudes and Practices Research Study
MCSC	Mexicanos Contra el SIDA (NGO Confederation)
MSM	Men who have Sex with Men
MEXFAM	Mexican Federation of Private Family Planning Associations (NGO in family planning)
MTP	WHO Medium Term Plan
MUSA	Mujeres Unidas Contra el SIDA (NGO working with prostitutes)
NGO	Non-Governmental Organization
OAR	Office of the A.I.D. Representative
OPS	Organización Panamericana de Salud: Regional Office Western Hemisphere for WHO
PAHO	Pan American Health Organization (OPS in Spanish)
PROFAM	Profamilia (family planning NGO)
PWA	Person with AIDS
SIDA	Síndrome de Inmunodeficiencia Adquirida (AIDS in Spanish)
STD	Sexually Transmitted Disease
VIH	Virus de Inmunodeficiencia Humana (HIV in Spanish)
WDR	World Development Report
WHO	World Health Organization

## BACKGROUND

In March 1993, OAR/Mexico requested that LAC HNS contract a team of consultants to conduct "an objective assessment of ongoing AIDS prevention activities in Mexico to date" to be used as input in the formulation of the OAR/Mexico FY94 Action Plan. The objectives of the assessment were as follows:

- o to identify the current status of the HIV/AIDS epidemic and prevention activities in Mexico;
- o to examine options for A.I.D. in the face of potentially reduced budget levels; and
- o to recommend priorities among those options.

The assessment is intended to serve as an examination of various scenarios that offers recommendations on the best course of action. It is based on limited field access and desk review of existing documents. The team visited sites in Mexico City and Ciudad Juarez, and conducted numerous interviews with A.I.D. and Mexican government officials, NGO representatives, private individuals, male and female prostitutes and representatives from gay men's organizations. A contact list is included in Appendix 3. This report contains information gathered during those interviews. The team's Scope of Work is attached as Appendix 4.

The team consisted of: Ms. Nancy A. Sweeney (Project Coordinator, OAR/Mexico), Dr. Paul Raza (Public Health Specialist), Dr. Gerardo de Cosio (Epidemiologist), and Ms. Sys Trier Morch, (Communications and Marketing Specialist). Their cv's are attached as Appendix 5. Mary Guinn Delaney (LAC HNS Health Financing and Management Analyst) reviewed and edited the team's final report in Washington, and incorporated additional commentary from other LAC HNS staff, LAC/DR/HPN, and OAR/Mexico.

The first case of Acquired Immune Deficiency Syndrome (AIDS) in Mexico was reported in 1983. In just ten years, the number of reported cases has grown to more than 13,250. Some estimate that there are actually more than 20,000 AIDS cases, and more than 500,000 carriers of HIV, the virus that causes AIDS. Both public and private organizations acknowledge that the current level of resources now available in Mexico is inadequate to combat the epidemic.

CONASIDA, the Mexican National AIDS Control Program, was established in 1986. It is the government body established to evaluate the situation in Mexico with regard to HIV infection and to establish norms for diagnosis, treatment, prevention and control. Since 1987, A.I.D. has been actively involved in the fight against AIDS in Mexico, often working directly with CONASIDA. PAHO is the other major donor, and its funds are channeled through CONASIDA, rather than awarded directly to any specific project or group. As a strong tradition of fundraising and corporate response does not exist in Mexico, many NGOs are currently dependent on A.I.D. funding to support their efforts in AIDS prevention.

Condom promotion for AIDS prevention has been an important component of AIDS awareness activities carried out in Mexico to date, including those sponsored by A.I.D. However, A.I.D. has announced a complete phase out of A.I.D. - donated condoms to Mexico by 1994. Since WHO and other international donors have not announced plans to increase their funding support for condoms, and none are manufactured locally, the supply of affordable and accessible condoms to Mexico will be seriously jeopardized.

## **I. Mexico: Health and Population Overview**

### **A. General Health Conditions in Mexico**

Mexico has a population of 86.2 million inhabitants, almost forty per cent of which is under 15 years of age. The population is growing at an annual rate of 2% (1992 World Development Report). An estimated 58% of the population is concentrated in eight of the 32 states (the Federal District, Mexico, Puebla, Guanajuato, Veracruz, Nuevo Leon, Michoacan and Oaxaca). CONAPO, Mexico's National Population Council, projects that by the year 2000 more than three quarters of the Mexican population will be living in urban, semiurban areas and/or inner cities and slums. More than 35% of the total population of Mexico is clustered in five major metropolitan cities (Mexico, D.F., Monterrey, Guanajuato, Puebla and Juarez). These cities and states present the highest AIDS prevalence rates in Mexico.

Currently, Mexico presents an epidemiological transition profile that is called "prolonged and polarized." It is termed "prolonged" because infectious diseases continue to be counted among the ten leading causes of death. These include infectious diseases (especially intestinal), pneumonia and AIDS. In the 25-34 age group, AIDS has become the fourth leading cause of death. The infectious diseases are more common in rural and semiurban areas because of their association with poverty and malnutrition. The other side of this profile shows the urban population dying more often of causes associated with higher-income groups: chronic illnesses such as heart disease, cancer, hypertension, diabetes and injuries (intentional and unintentional).

In 1990, the infant mortality rate was thirty-nine deaths per thousand live births (WDR 1992). However, studies conducted by CONAPO suggest that deaths are underreported by as much as thirty per cent, particularly in rural areas.

## **B. Border Areas: Issues in Health**

In 1991 the federal governments of Mexico and the United States awarded a grant to the El Paso Field Office of the Pan American Health Organization to conduct Project CONSENSO with the goal of identifying binational health priorities for the U.S.-Mexico border. The project's methodology was based on the establishment of health priorities through a consensus-building process, which included a series of questionnaires, four regional conferences and one borderwide conference. Health professionals, educators, housing experts, politicians and other persons interested in border issues were invited to participate. The survey ranked the most important issues facing the border areas in order of perceived importance; those listed included primary health care, substance abuse and AIDS. The U.S./Mexico border priorities established in accordance with the conferences were (in alphabetical order): environmental health, health promotion and disease prevention, maternal and child health, occupational health, primary health care, and substance abuse. Although AIDS was not considered a borderwide priority, three out of four regions (San Diego, California and Tijuana, Baja California; Nogales, Arizona and Nogales, Sonora; and El Paso, Texas and Juarez, Chihuahua) in which the conference was divided during CONSENSO considered AIDS a high binational priority. The fourth region (Lower Rio Grande Valley) was most concerned about health issues related to pesticides.

## **II. AIDS in Mexico: An Overview**

### **A. Epidemiology of AIDS cases in Mexico**

From 1983 until February of this year, 13,259 cumulative cases were officially reported. In global terms, Mexico ranks eleventh in number of AIDS cases. In the Americas it is third, after the United States and Brazil. Twelve percent of AIDS cases are found in border areas.

The geographical distribution of AIDS cases across Mexico is varied. For example, it is believed that growth of new AIDS cases in Mexico City has stabilized, while certain states, including several along the U.S./Mexico border are experiencing rapid growth in new cases. Historically, the growth of the AIDS epidemic in Mexico has been characterized by three relatively distinct periods. From 1983 to 1986, the number of new AIDS cases reported each year was low (245 cumulative cases). The number of cases exploded from 1987 to 1990, with 5662 cumulative cases. Since 1991, Mexican officials estimate that growth in new cases has stabilized: 6993 cases have been reported for that period. (Carlos del Río, Situación del SIDA en México. SIDA y Sociedad. 1992).

Several factors account for the considerable variation in the epidemic's geographic profile. The more prevalent modes of transmission of the HIV virus also vary among regions. While intravenous drug use does not account for a high percentage of reported cases at the national

level, in various border cities it is much more prevalent.

**Table 2: Cumulative AIDS prevalence rates (per million inhabitants), 1993.**<sup>1</sup>

State	# of cases per million inhabitants
Mexico City	416
Chiapas	24
Jalisco	236
Morelia	230
Baja California	186
Yucatan	168
Nayarit	143
City	
Guadalajara (Jalisco)	548
Morelia (Michoacan)	227
Cuidad Juarez (Chihuahua)	175

#### **B. Beyond the numbers: the problem of under-reporting**

INDRE officials estimate that for each AIDS case reported in Mexico, there are between ten to thirty HIV-infected persons.<sup>2</sup> Using this estimate, Mexico could have between 200,000 and 600,000 HIV-infected people. Under-reporting of AIDS cases is said to be as high as 65%, signifying that instead of the 13,259 cases reported up to February 1993, there could be over

<sup>1</sup> Morelia and Yucatan are popular tourist destinations. Baja California borders the U.S. Sources: Data on states are from CONASIDA's monthly bulletin on STD's (March 1993). The figure Guadalajara, Morelia and Ciudad Juarez are from INDRE (February 1993).

<sup>2</sup> Mohar, Carlos et al., "Model for the AIDS Epidemic in Mexico: Short-Term Projections." *Journal of Acquired Immune Deficiency Syndrome*. Volume 5, Number 3. 1992.

20,000 cases of AIDS. Nongovernmental organizations have also estimated numbers of AIDS cases at a level higher than government figures: GIS-SIDA, a group dedicated to defending the human rights of people with AIDS, reported 26,115 cases (*El Nacional*, Sociedad y SIDA supplement). INDRE also estimates HIV seroprevalence in the National Blood Bank System. In 1992, 0.08% of all blood tested for HIV infection was found to be infected with HIV. Extrapolating from this data, there would be approximately 650,000 HIV-positive people in Mexico.

### **C. Distribution of HIV/AIDS cases by reported modes of transmission**

In Mexico, HIV is spread through several modes of transmission. In order of importance, they are sexual contact, transfusions of contaminated blood and perinatal. Except for the border areas, intravenous drug use is currently a relatively unimportant transmission method within Mexico.

#### **1. Sexual Transmission**

The most frequent mode of transmission is through sexual contact. As of March 1993, sexual transmission accounted for 80.7% of all reported cases (INDRE). Homosexual and bisexual transmission accounted for at least 60% of these cases. (A.I.D. Report to Congress, 1992) During the last three years, transmission of the virus through heterosexual intercourse has increased rapidly in both sexes, particularly through male-to-female transmission. INDRE officials are confident that infection rates through homosexual and bisexual transmission are underreported, as these behaviors are not socially accepted. To obtain a more accurate profile of transmission modes, INDRE reviewed all cases since 1983 and took into account sex, age, marital status, occupation and place of reporting as the most important variables for determining the appropriate category for each case. Self-reported categories were adjusted accordingly, suggesting that heterosexual transmission is not as frequent as has been reported, and that homosexual transmission is likely to be higher. Table 3 indicates the results.

#### **2. Transmission of HIV through contaminated blood products**

While many thousands of individuals were infected by transfusions in the early years of the epidemic, making this category the second leading mode of transmission among current AIDS cases, in recent years the blood supply has become virtually as safe from HIV as the technological limitations permit. INDRE has estimated that since commercialization of blood was forbidden by the Federal Government, more than 1278 cases due to transfusion have been avoided. It is expected that very few new infections are being transmitted through transfusions. Therefore, in less than ten years, HIV-infection through blood transfusions will no longer be a significant cause of new infections.

**Table 3. Percentage of AIDS cases by self-reported transmission mode, adjusted and non-adjusted, Mexico, cumulative through 1992**

<b>CATEGORY</b>	<b>non adjusted</b>	<b>adjusted</b>
Homosexual	41.1	48.3
Bisexual	27.8	32.6
Heterosexual	20.0	8.0
Blood Transfusion Receptor	6.2	6.2
Paid Blood Donor	2.8	2.8
Hemophiliac	1.3	1.3
IVDU	0.8	0.8
<b>TOTAL</b>	<b>100.0</b>	<b>100.0</b>

Source: INDRE

### 3. Perinatal Transmission of HIV

Perinatal transmission accounts for approximately half of the 400 cases of HIV found in children under 15 in Mexico. Although information on this group is very difficult to obtain, it is reasonable to assume that the remainder has been infected through blood transfusions and sexual activity.

#### D. Regional Epidemiology of AIDS

The U.S./Mexico border stretches 2000 miles from East to West. It demarcates ten states: four on the U.S. side (California, Arizona, New Mexico and Texas), and six on the Mexican side (Baja California, Sonora, Chihuahua, Coahuila, Nuevo Leon and Tamaulipas). Although there are many definitions of the U.S./Mexico border, the El Paso, Texas Field Office of PAHO defines it as "all those U.S. counties (25) that touch the international line and share a common border with all those Mexican municipalities (32) that touch the international border." If this definition is accepted, the U.S. and Mexico border population is eleven million, with six million on the U.S. side, and five million on the Mexican side. The U.S. side of the border is characterized by cities with large Hispanic populations, ranging from 25% in San Diego, California to 95% in Hidalgo, Texas. Communities on both sides of the border share common health problems. There is a high level of interdependency on both sides of the border in terms of culture, trade and socio-economic development.

Among U.S. states, California and Texas rank second and fifth in number of AIDS cases. Within Mexico, the states of Baja California, Nuevo Leon and Coahuila are among the ten

leading states with AIDS cases. The border cities of Tijuana and Ciudad Juarez are among the ten leading metropolitan areas for AIDS incidence in Mexico. On the U.S. side, San Diego and El Paso (the twin cities of Tijuana and Juarez) present the highest incidence rates along the border. Most HIV infection in the U.S./Mexico border area is sexually transmitted, with homosexual intercourse the dominant mode of transmission. Transmission through intravenous drug use (IVDU) in this region is higher than in the rest of Mexico.

Most immigrants to the U.S. come from the states of Michoacan, Oaxaca, Chiapas and Puebla; many eventually return. Trends in migration, especially to the U.S., are particularly important in AIDS prevention in Mexico: a study conducted by Mario Bronfman et al. found that approximately 10% of all AIDS cases in Mexico are found among those migrants returning to their rural communities in Mexico. Another study in a small town in Michoacan state claimed that half of the migrant workers from the town who had travelled to the U.S. returned to Mexico infected with HIV. (*El Excelsior*, December 1992) The high mobility, low educational level, and illegal status of migrant workers in the U.S. make them the most difficult group to reach with prevention messages.

The Team was able to obtain reported case data for the El Paso/Ciudad Juarez area. As of July 1992, El Paso had 176 cases of AIDS, of whom 117 (66.4%) had died. Sixty-two percent of the cases occurred among Mexican Americans. Seventy-two percent of the Mexican American cases were reported to be homosexual or bisexual, and twelve percent of this latter group (or nine percent of the entire Mexican American group surveyed) were reported to be IV drug users. An additional 78 cases, of whom 57 (45%) had died, were reported as non-residents. In Ciudad Juarez, seventy-nine AIDS cases and 4450 HIV-positive individuals from Ciudad Juarez were reported. Of these 4,450 individuals, 3,450 (78%) were reported as homosexuals. This same source reports 5,300 heterosexual intravenous drug users who also were HIV-positive. (Compañeros Project) These infection rates imply a large reservoir of potential new infections.

The permeability of the border between El Paso and Ciudad Juarez is much higher than other border cities. This allows symptomatic HIV-positive individuals and AIDS patients to seek medical care on either side of the border. Someone with AIDS is more likely to seek better quality of care available on the US side which in most cases is provided at no cost. Cross-border differences in HIV prevalence rates may result from movement of people travelling both ways across the border, as most likely, there is not a major difference in prevalence rates between the two sides.

#### **E. Demographic and Economic Impact of the AIDS epidemic: Groups at risk**

The implications of AIDS in economic terms are potentially great. If present trends continue, AIDS will severely affect the Mexican population since most individuals are being infected during early adult life. Most are dying during the most economically and intellectually productive years of their lives. Nationally, AIDS is the sixth leading cause of death in the 25-44 age group. In Mexico City in the same age group, AIDS ranks in fourth place. It is expected to become the number one cause of death in this group before the turn of the century (INDRE).

## 1. Women

The AIDS epidemic represents an increasing threat to the health of women. The male-female AIDS case ratio in 1986 was 15:1. In 1990, it was 5:1, reflecting an increasing "heterosexualization" of the disease (CONASIDA Bulletin). Much of the shift in the ratio is due to the symptomatic progression from HIV infection to AIDS in these women. More than 60% of women with HIV/AIDS in Mexico were infected through blood transfusions; the remaining forty percent of infections are related to heterosexual transmission of the virus. As more women are infected, Mexico will experience more family problems, higher mortality in children due to infection, and the loss of mothers.

## 2. Commercial Sex Workers (Female and Male)

HIV seroprevalence among females is 0.2% in major metropolitan areas. (INDRE). In 1992, CONASIDA contacted 16,000 commercial sex workers and performed the ELISA test on blood samples from 3,084 of these women, forty-nine of whom (1.6%) tested positive for HIV. This low rate of infection may be partially due to awareness campaigns targeted specifically toward prostitutes, their clients and bar employees and owners.

While the prevalence of HIV infection is still relatively low in this population (0.7%), the presence of other sexually transmitted diseases among commercial sex workers. There is extensive evidence linking the presence of STDs and the increased risk of infection with HIV. A study conducted by INDRE surveyed 1066 prostitutes who were examined for STDs in five Mexican states (Hidalgo, Michoacan, Puebla, Morelos and Mexico City). Infection rates for certain STDs among this population are listed in the table below.

Table 3. Sexually Transmitted Diseases Among 1066 Female Sex Workers in Mexico.

Sexually Transmitted Disease	% testing positive
Syphilis	27.8
Gonorrhea	12.7
Chlamydia	14.4
Herpes	0.12
Hepatitis B	5.7

Source: INDRE.

With such high rates of STDs, the CSW population could be on the brink of a serious increase in HIV infection due to the high STD levels. CSW's are regularly screened for these diseases (some on a monthly basis), but they are not regularly tested for HIV.

Male prostitution in Mexico has not been well researched. Some estimates hold that approximately fifteen per cent of male prostitutes are already HIV positive. More research on this at-risk population is needed.

### **3. Sexually transmitted diseases in the general population**

The nature and extent of sexually-transmitted diseases (STDs) is not well known in Mexico as available information is generally very limited. The monthly data collection of data on syphilis and gonorrhea is neither accurate nor consistent. According to the Weekly Epidemiological Bulletin from the Ministry of Health in Mexico as December 31, 1992, there were a total of 14,113 cases of gonorrhea. The total cases of syphilis for the same period was 1,924. These numbers are lower than those reported for 1991 when totals were reported at 21,008 gonorrhea cases and 2,379 cases of syphilis.

One factor accounting for the difficulty in estimating the magnitude of the STD problem is the availability of over-the-counter antibiotics for self-treatment of STDs. In most drug stores, pharmacists recommend antibiotics based on previous treatment failures and/or a description of symptoms. The antibiotic(s) chosen may or may not be appropriate, the patient may or may not continue treatment for the appropriate length of time or at the right dosage. There is usually no follow-up to see if the infection has been eliminated. As in other countries, self-treatment often encourages the development of bacterial strains that become resistant to antibiotics. It can also create the false impression among patients that they are non-contagious, leading to further spread of the STD. Despite these negative elements, widespread self-treatment can be expected to help reduce the overall prevalence of STDs in the population.

In the public arena, very little is being done to combat STDs. Neither the private nor public sectors have made significant attempts to create public understanding of the co-factor relationship between STD infection and HIV spread among sex workers or the general population. In the early 1970s, the only major STD clinic in Mexico City (Clinica Benito Juarez) was closed for lack of funding. Unlike several other Latin American countries, Mexico has failed to implement modern programs for STD treatment and education. INDRE and CONASIDA officials discussed the Federal interagency plans that have been formulated and approved to address Mexico's serious STD problem. They are hoping to open six STD centers in Mexico City in 1993/1994 and five regional clinics in following years. At the time of the Team visit, the plans with programs to be implemented jointly by CONASIDA, INDRE, and three other agencies did not have funding.

In recent years, INDRE has begun to develop the laboratory capacity to function as an STD Reference Center. Small-scale STD prevalence studies have also been carried out, culminating in the development of treatment algorithms based on those of the CDC. Subject to availability of funding, CONASIDA/INDRE is planning the immediate development of training manuals for clinicians, laboratory workers and STD patients.

FEMAP, a family planning organization, is a major exception to the general inactivity in STD treatment and education. In Ciudad Juarez, FEMAP is using sex workers as peer educators to train female sex workers to identify STD symptoms themselves and their clients, and to seek early treatment for them. This program is being duplicated in Tijuana. MUSA, an NGO based in Mexico City, has also been working to persuade female and male sex workers of the necessity of examining their potential clients for symptoms. It is hoped that as access to quality STD services improves, Mexico can begin to alter the current situation, thus slowing the spread of HIV.

### III. The Burden of AIDS on the Health Care System

#### A. Expenditures on Health in Mexico

Data on health care expenditures in Mexico are very difficult to obtain. The World Bank estimates that in 1990, total health care expenditures in Mexico equalled 3.2% of GNP (US \$89 per capita per year, which is slightly below the average for Latin America), compared to 13.3% (US \$2896 per capita) in the USA (WDR 1993). The available data from the Ministry of Health of Mexico indicates that in 1988, the public institutions of the National Health System spent 7.7 billion pesos (US\$ 2.5 billion), or 1.9% of GNP (Mexican Academy of Medicine. Report on the Free Trade Agreement. 1993).

Table 4 illustrates the percentage distribution of the health expenditures by program in Mexico in 1985 and shows the heavy levels of expenditures on curative services.

Table 4. Percent public health expenditures, by use, Mexico, 1985.

Preventive Services	6.5
Curative Services	87.1
Health Education	1.2
Training	3.9
Research	1.3

Source: Report on the Free Trade Agreement (1993).

Although the public health expenditure budget grew at an annual rate of 3.5% (in current pesos) from 1983 to 1988, it was estimated that the Ministry of Health budget in 1987 was only 53.3% of the 1981 budget at 1980 prices. Partial economic recovery in 1990 helped the Ministry of Health to increase its budget to a level comparable to 86.1% of the 1981 budget. (Report on Free Trade) This trend in increased health expenditures is expected to continue as Mexico recovers from the economic crisis.

## B. AIDS Expenditures

Although the Ministry of Health policy gives high priority to AIDS prevention, this orientation is not reflected in its budget. As in other countries, the costs of treatment for AIDS patients monopolizes the available funds assigned to AIDS in general. The director of CONASIDA estimates that total public expenditures on AIDS prevention and treatment is approximately US \$40 million annually, and rising rapidly. Currently, Mexico's AIDS health care expenditures are about 1% of the federally-funded health budget. In 1992, the Federal Government assigned US\$ 3.0 million to the National Council for AIDS Prevention and Control (CONASIDA). Of the CONASIDA budget, US \$700,000 is spent in medications, US \$400,000 for advertisement, publications, comics and office space and the remaining US \$1,900,000 for salaries and administrative costs.

## C. The Response of the Public Health System

As in other countries, Mexican health-care institutions and personnel have adapted significantly to the rapid increase in AIDS cases. Confidentiality regarding patients HIV status has improved among health providers. Unjustified fear of casual transmission has almost been eliminated among the upper levels of health-care providers. Techniques for protection of personnel are followed reasonably well in the more sophisticated hospitals and clinics. Mexico has had only two known cases of possible patient-provider transmission and no known cases of provider-patient transmission.

Currently, 36.1% of all AIDS cases in Mexico have been reported by IMSS, 45.8% by the Ministry of Health and 18% by other public and private institutions (INDRE). It is expected that overall costs for treating AIDS will continue to rise both in absolute terms and as a proportion of the total health-care budget. Availability of new, costly drugs and technologies to fight AIDS will increase. A study by Dr. Roberto Tapia of CONASIDA and AIDSTECH estimated that in 1989, average total lifetime costs for treatment of a person with AIDS at approximately US \$3,300 per patient. Of total AIDS expenditures, 86% is represented by fixed, overhead costs. (AIDSTECH: *Analyzing the Direct Health Care Costs of AIDS*. 1992.)

During various interviews, the Team was informed that Burroughs Wellcome, the pharmaceutical company that produces AZT, sells approximately 4,000 person-years of AZT annually in Mexico. Consequently it is reasonable to assume that half of the reported individuals with AIDS in 1992/3 are receiving AZT. The public health care system throughout the country makes available the AZT when possible. Small quantities of AZT also enter the country through private sources, and a somewhat smaller quantity goes out from Mexico to other Latin American countries. There are no reliable data on the variety of doses and treatment schedules that are used in Mexico, or on the quantity of AZT used on asymptomatic HIV-positive individuals. The ratio of detected to undetected AIDS cases is improving with time, but there are no reliable estimates on the number of undetected cases, nor on the number of detected cases not registered nationally or locally. As the Team was unable to obtain cohort survival rates, AZT requirements per average AIDS patient were not calculable. Despite all these caveats, it can be

assumed that AZT requirements are at least twice and probably many times current consumption.

No analogous data was obtained for other currently available AIDS drugs such as DDI or DDC, or those commonly used to combat opportunistic infections such as Bactrim. Anecdotally, those interviewed thought that these drugs are less available than AZT, and when they are available, they come through private hands.

Though available data suggests that the rate of growth of the epidemic has slowed in recent years, the number of new cases will continue to be large for a number of years. Every year approximately five per cent of the population infected with HIV will develop AIDS. Thus, within ten years, about 50 per cent of the HIV-infected population in Mexico will become symptomatic.

#### **IV. AIDS Prevention in Mexico**

##### **A. Behavioral and Cultural Considerations**

Certain behavioral and cultural considerations are important to take into account when assessing the Mexican AIDS situation. While Church and state are officially separated, the Catholic Church plays an influential role on issues of sex, birth control, abortion and other social issues. Opus Deo, Provida and Legionnaires for Christ are three conservative groups which oppose the efforts of the government and the private sector to distribute condoms. Provida recently sued CONASIDA's coordinator for promoting condom use among sexually active high school students. These groups consistently interfere with attempts to disburse essential educational information on sensitive subjects as AIDS and STD prevention, family planning, and sexuality in general.

Cultural and social attitudes toward sex tend to encourage promiscuity among men and reinforce stereotypical distinctions between "good" women (the modest, faithful wife and patient, devoted mother), or "bad" women who demonstrate unworthy, undesirable behavior (with the prostitute as the most extreme example). As male homosexuality is not tolerated in the dominant culture, homosexual activities are kept secret. Many men who have sex with men are difficult to reach with AIDS prevention messages, as they often don't identify themselves as being gay and hence are not part of the target audience for many AIDS prevention messages.

These socio-cultural considerations are significant determinants of levels of condom use. The distributor of *Sico* condoms (a popular brand in Mexico) conducted several sets of focus group research among men and women from all socioeconomic classes aged 15 to 30. From these groups, it appears that only people from the middle and upper classes use condoms with any degree of regularity, with much less frequent use reported by the lower classes. They also learned that as young women become better educated and more professional, they start protecting themselves more, buying condoms more frequently as both a contraceptive alternative to long-term use of the birth control pill and as protection against STDs and HIV. Some of the women interviewed used their husbands' infidelities as a bargaining point to force the husbands to use

condoms with them, letting the husbands think their wives actually accepted their wandering behavior. Bisexuality did not surface in this set of focus groups.

The orientation of the Catholic Church, general attitudes toward promiscuity and homosexuality and lack of acceptance of condom use, especially among the lower socio-economic groups present cultural and social barriers to many of the preventive activities of AIDS programs.

## **B. Prevention Activities**

### **1. Public Sector**

Most expenditure on prevention in Mexico has come from the federal government, primarily CONASIDA, the Mexican National AIDS Control Program. State governments have done little, despite the creation of local AIDS-prevention offices called COESIDAs. The most serious problem in the implementation of a national prevention strategy seems to be the inability of CONASIDA to exert real influence over the various state governments and the thirty-one COESIDAs (State Committees for the Prevention and Control of AIDS) they have set up. Only five appear to be functioning at all (Guadalajara, Tampico, Tijuana, Tabasco and Chihuahua). The others appear to simply comply with the federal requirement to create a COESIDA by maintaining office space. It was reported to the Team that random telephone calls during business hours are rarely answered, even though all have published numbers. It was unclear to the Team what role AID could play to improve this situation. With time, CONASIDA should be able to spread its influence to the various states, particularly with its planned introduction of five regional STD clinics outside Mexico City. These clinics will be managed by CONASIDA INDRE; CONASIDA will provide counselors.

This year CONASIDA will provide a toll-free number in five metropolitan areas, enabling Mexicans outside of Mexico City to access the Information Hotline (currently a toll call from areas outside Mexico City). In Mexico City, this hotline fields fifty to one hundred calls a day. Another aspect of this program will encourage university students to provide their obligatory national service upon graduation by working in the COESIDAs.

### **2. The NGO Community**

A large number of private sector initiatives are aimed at AIDS prevention or the provision of psychological and social support for HIV-positive individuals, AIDS patients and their families. Most of these NGOs are based in Mexico City, but increasingly, groups are forming in other areas of Mexico. Appendix 1 includes a list of the main NGOs and a brief description of their activities. Currently CONASIDA provides US \$40,000 in annual funding to various NGOs. Many NGO documents mention assistance from CONASIDA and INDRE, or from individuals who work for these agencies. CONASIDA is also expecting that the NGO confederation, Mexicanos Contra SIDA, will provide training and organizational support to its member NGOs throughout Mexico.

Many private groups have taken on roles that prove difficult for the public sector to handle. Although CONASIDA has many prevention activities geared to marginal groups (homosexual and bisexual men, female and male sex workers, prisoners), and INDRE carries out epidemiological and ethnographic research among these groups, NGOs provide major interventions. Several are listed below. There does not appear to be significant duplication between public and private sector prevention activities with individuals practicing high-risk behaviors. It could be argued, however, that the small-scale research efforts and educational materials production of many of the NGOs are not coordinated well with those of CONASIDA or INDRE.

To avoid being embroiled in controversial human rights issues, CONASIDA refers individual human rights problems to GIS-SIDA, a Mexico City NGO. With limited resources, this organization has had singular success in addressing human rights violations in the public sector (hospitalization and pension rights within IMSS), the quasi-public sector (employee's rights at PEMEX, the national petroleum company) and private universities. Many of the public officials with whom the Team met seem to accept the important role this group plays. The widespread support for this group's activities has led to Team to recommend that A.I.D. support GIS-SIDA to help it to maintain and expand its role as advocate for the human rights of the HIV-infected population, as well as to organize and train similar groups in other parts of Mexico.

Another NGO, Colectivo Sol has taken on the major information clearinghouse role for Mexico. Among its many activities, staff members translate articles and documents from English into Spanish and distribute them widely throughout the Spanish-speaking world. It also provides the same service to parts of the French-speaking Americas. Colectivo Sol has begun the development of a series of Fotonovelas (comic-book format) that will aim AIDS prevention messages at a semi-literate gay audience. With the necessary outside support, they should be able to recoup a small percentage of the costs of production through sales of these comic books.

### **3. Private Sector Efforts: Trends in Condom Availability**

While there is standards testing, the condom industry is not regulated by legislation, and condom sales are not measured in Mexico. It is therefore very difficult to collect accurate information on the size, scope, and trends of the condom market. The information in this section summarizes comments from the executive director of CONASIDA, the managing director of the importer and distributor of Sico (a German company which sells the most popular condom in the private sector), and from an unscientific random selection of pharmacists and taxi drivers. Also included are comments on the social acceptance of condoms from officials, researchers, doctors, prostitutes, and health workers interviewed during the Team's visit.

Condoms became an over-the-counter product in 1991, primarily to protect merchants from being fined for selling condoms, which has led to the rapid spread of the availability of condoms in recent years. Today, 95% of condoms are sold in pharmacies, with the remaining 5% sold in supermarkets. The industry goal is to increase the supermarket share to 15% in order to access the proportionally greater traffic in supermarkets. This traffic generates a much higher

sales volume than the smaller, more specialized pharmacies. It was not possible to learn what percent of all pharmacies and supermarkets currently carry condoms. Vending machines in general are a very recent phenomenon in Mexico. Machines for condom distribution have only just been introduced in bars, clubs, gas and train stations, and vandalism is a problem. Sico is currently seeking a source of pilfer-proof vending machines. The company is interested in placing them throughout Mexico while other distribution channels are being developed, despite the high distribution and maintenance costs.

All condoms sold in Mexico are imported. Officially, imported condoms are required to meet international testing standards. The government claims that the National Consumers' Institute is doing a good job of testing and controlling the quality of imports. Both the private sector and pharmacists disagree, saying the government quality controls are very lax. Most condoms come from the U.S.A. (Ansell's *Sultans*, *Profam*, *Flash*, and *Evitex*; Carter-Wallace's *Trojans*, *Sheik*, and *Ramses*), Germany (*Sico*), Malaysia, Korea (*Dung Kook*). Several other poor-quality brands are also smuggled in from the U.S.A. and Asia. *Sico* and *Trojans* are the numbers one and two brands in the private sector, mainly because they advertise on television and radio. The following table shows the trends in the volume of condom sales and distribution.

Table 5. Condom sales and distribution, Mexico (millions).

Year	Condoms Sold	Distributed Free	Total	Percent Increase
1990	30	15	45	10
1991	40	9	49	30
1992	60	15	75	33

SOURCE: The Futures Group, SOMARC Project.

For 1993, industry estimates project a 55% growth in condoms sold, reaching approximately 90 million in the private sector alone. This growth is due to increased competition, distribution, and advertising. Retail prices run as high as US \$2.15 per packet of three Sico condoms. Normal distributor, wholesaler, and retailer profit margins are added on to the cost of goods. As mentioned above, CONASIDA also supplies condoms, but during their visit the Team learned that only an eight month's supply of USAID condoms remains and plans to gradually phase out USAID condom donations are being formulated.

#### 4. USAID support for AIDS prevention activities

A.I.D. has focused its AIDS assistance on the prevention of sexual transmission of HIV. A key component has been the participation of non-governmental organizations which effectively reach groups whose behavior puts them at increased risk; commercial sex workers (CSWs), men having sex with men (MSM), intravenous drug users, and to a limited extent, adolescents. These organizations face considerable obstacles in accessing financial support from the GOM

or other donors, despite their considerable success in promoting an active and positive public dialogue on AIDS in this very conservative country. Examples of A.I.D.- supported activities carried out by NGO's include:

- o a community-based peer education and condom distribution program targeting male and female CSW's, their clients, and men having sex with men in Ciudad Juarez and Tijuana.
- o a study on the role of pharmacies in AIDS and condom use education, followed by the production of a video and a manual to be used in nationwide pharmacy worker AIDS prevention education.
- o a series of workshops on AIDS prevention and safe sexual practices for MSM in three different cities of Mexico.
- o a series soap opera about AIDS aired in 13 cities throughout Mexico.

A.I.D. has also supported CONASIDA by:

- o funding technical assistance for developing the National AIDS Communication Plan for 1992-1994.
- o covering per diem and transportation costs for representatives of the COESIDAS to attend the National AIDS Congress in Mexico City.
- o sponsoring the attendance of four Mexican presenters at the VIII International Conference on AIDS in Amsterdam.

e. **Non-AID donors**

Apart from A.I.D. support through direct funding, buy-ins, and central contracts, a large number of other donors have been involved in Mexico. They are listed in Appendix 2. PAHO's participation is particularly significant. The WHO/PAHO-sponsored Medium Term Plan was one of its earlier activities in Mexico, and the country plan is well-written. In 1990, WHO/PAHO held a Donors' Meeting which attempted to set a framework for donor coordination. As in many countries in the Americas, little formal coordination has taken place since.

## **V. Conclusions and Recommendations for Future A.I.D. Programming**

The Team strongly recommends continued OAR/Mexico support of AIDS-prevention activities, particularly for the NGOs. Withdrawal of support now would jeopardize the investment A.I.D. has made in Mexico over the past several years. The continued support of NGO activities is critical because of its significance to the overall private sector response to AIDS.

### **A. Recommendations and Directions for Future A.I.D. Involvement in AIDS Prevention Activities in Mexico**

#### **1. Maintain Current Levels of Funding**

Although A.I.D. has not contributed high levels of resources to AIDS prevention in Mexico, the funds that have been committed have been used effectively and creatively. If this source of funding were eliminated now, much of the progress made by NGOs working in this area, especially those seeking to address the needs of marginalized at-risk populations, would suffer. World Bank studies show that the cost-effectiveness of interventions targeted at "core groups" (such as commercial sex workers and MSM) is much greater in term of number of infections avoided than interventions aimed at the general populations. It is these NGOs who are well-positioned to reach these groups.

#### **2. Maintain supplies of donated condoms**

Due to the currently depleted supply of condoms, the Team recommends that A.I.D. not cut off its donation of condoms this year. Until a social marketing program can be designed and implemented, and until another source of condom is identified, CONASIDA will need 10 million condoms to be donated by A.I.D. per year, for probably at least the next two years. The condoms should probably not be branded Sultan because of its poor quality image and high percentage of breakage. In anticipation of the branded and advertised product that the social marketing program will introduce, a generic brand for free distribution by CONASIDA and its recipient NGOs would be best.

#### **3. Provision of start-up funding and technical assistance for a condom social marketing program**

The supply of free condoms cannot continue indefinitely. Therefore, the Team recommends immediate funding for the start of an AIDS-prevention condom social marketing program.

Social marketing in Mexico is not well understood and knowledge of its methods are not widely diffused. However, there is an urgent need for such a program. Using existing distribution, packaging, communications, and market research infrastructure, social marketing sells precisely-positioned, advertised, and branded condoms with a high quality image. These condoms are available at an affordable price in convenient sales outlets to the people who need them. Given A.I.D.'s history of success in its support of condom social marketing programs, the Team

recommends that the Agency support the start-up costs and necessary technical assistance for such a program in Mexico. The program should cover as much geographical areas as funding will permit. While some of the program costs will be recovered in the retail price of the condoms, some subsidy funding will most likely always be necessary in order to keep the retail price of the condom affordable.

Educational materials will need to be more in line with the new image for condoms. The team viewed many educational materials which appeared too bland and weak in their presentation, seeking to convince the defensive, intransigent man to use condoms. What is needed is a powerfully chic, very "in" image for condoms, and by association, for those who are prudent enough to use them.

#### **4. Reallocation of a portion of A.I.D.'s family planning budget to AIDS prevention activities**

Both of Mexico's main family-planning NGOs (Mexfam and Profam) have made significant efforts to integrate AIDS into their mandates, using the condom as the common denominator. These organizations are well-placed to expand their HIV/AIDS prevention education. Thus, the Team recommends that a portion of the family planning AID-funded budget be redirected to specific AIDS-prevention efforts. It could be spent within these same NGOs or elsewhere. Reallocated funds of approximately \$1 million are a modest portion of the current A.I.D.-funded family planning budget (\$12 million), but would represent a sizeable increase in the modest AIDS-prevention budget, which currently amounts to approximately \$250,000.

#### **5. Support for STD Prevention and Treatment Clinics**

It is widely recognized that the presence of STDs increases the chances of HIV infection by as much as fifty times. Therefore, STD-prevention is an important step in the prevention of AIDS. Both the public and the private sectors have plans for controlling STDs by opening or expanding STD-treatment clinics. CONASIDA is part of an approved plan by five Department of Health agencies to open six STD clinics in Mexico City in 1993 and quickly expand into five provincial cities in 1994. On the other hand, FEMAP, one of the NGOs that is very active along the U.S./Mexican border, is planning the expansion of its existing women's reproductive health clinic in the border towns of Tijuana and Juarez. The Team recommends that A.I.D. support the existing FEMAP clinics.

#### **6. Support of Human Rights of People with AIDS**

It is urgently necessary to continue to fight for dignified treatment of people with AIDS as a preventative measure in Mexico. GIS-SIDA is an NGO which has made considerable progress in this area in spite of severely limited and restricted funds. Continued support of their efforts would free the organization's staff to expand their activities.

## **7. Support of NGOs involved in low-income communities**

It is important to develop and disperse materials that reach the uneducated poorer segments of Mexico in general, and gay and bi-sexual men in particular. The NGO, Colectivo Sol, has an excellent idea for a comic book designed to reach the semi-literate gay man and his sometimes discriminating or frightened family. The Team recommends that A.I.D. provide the funds.

## **8. Support of Behavioral Research on the Sexual Practices of Migrant Workers**

Surprisingly little data is available about the movements and sexual habits of the Mexican itinerant workers who flow both legally and illegally across the border and back. The poorer Mexican rural villages that supply these workers are well-known, as are the locations in the U.S. through which they pass or in which they eventually settle. However, questions about their sexual behavior far outnumber answers. This encourages the persistence of distracting accusations (like each country blaming the other for the spread of AIDS). Since this is an increasingly sensitive issue (especially in the context of the on-going NAFTA negotiations), A.I.D. could support a thorough analysis of the problem. The results of such a study could be used to develop a program aimed at increasing condom usage in areas identified as at risk from the sexual behavior of migrant workers in the U.S. and upon their return to Mexico.

## **9. Support of the Development of Educational Materials for CONASIDA**

For the past five years, A.I.D. has supplied technical assistance from Porter/Novelli/DC to CONASIDA to formulate and execute marketing and communications strategies, deal with advertising agencies, and work with commercial production houses. Another visit has been committed at \$25,000, and will take place in Fiscal Year 1993. It is therefore included in the accompanying budget.

## B. Budget Recommendations

Based on the above discussion, the Team recommends the following approximate spending levels. These figures are designed to illustrate the affordability of efforts identified above rather than to reflect precise costs.

Due consideration has been given to the past efforts, the current question of systematically withdrawing support over the near future, and the preference for funding start-up operations rather than long-term ongoing support. The costs of condom have not been included in this recommended budget.

**Table 6. Budget Guidelines for Future A.I.D. Funding for AIDS Prevention Activities in Mexico, 1993 - 1995 (thousands US \$)**

Proposed Focus Area	FY 1993	FY 1994	FY 1995
Product	--	--	--
Social Marketing	100	1,120	1,125
STD Materials/Clinics	50	150	75
Human Rights	25	30	25
Gay Men	38	50	25
Migrant Workers	50	50	50
CONASIDA Materials	--	--	--
<b>TOTAL</b>	<b>288</b>	<b>1400</b>	<b>1300</b>
From OAR/Mexico AIDS budget	288	400	300
From OAR/Mexico Family Planning budget	--	1000	1000

**APPENDIX 1 A.I.D.-Funded Projects in Mexico, 1987-1992.**

<b>A.I.D. Funded Projects</b>	<b>Recipient</b>	<b>Location</b>	<b>Source</b>
1. CSW/MSM	FEMAP	Ciudad Juarez	AIDSTECH
2. Study and train Pharmarcy workers AIDS education/condom distribution	IMIFAP	Mexico City	AIDSTECH
3. Study behavior and networking of bisexual males	CONASIDA Population Council	Mexico City	AIDSTECH
4. Train the trainers: 56 women to educate in different communities	CIDHAL	Mexico	AIDSTECH
5. Radio Soap Opera	MCSC	Mexico	AIDSTECH
6. Train HIV+ women; educate public: self-help counselling / reduce discrimination	SOLVIDA	Ciudad Neza	AIDSTECH
7. Institutional development NGOs; 100 participants, 3 NGOS received small grants for devt.; workshop manual for AIDS prevention	MCSC	Mexico	AIDSTECH
8. HIV Surveillance Survey	CONASIDA	9 states	AIDSTECH

A.I.D. Funded Project	Recipient	Location	Source
9. Workshop for CONASIDA on economic aspects of AIDS issues	CONASIDA	Mexico City	AIDSTECH
10. Study on direct health costs of AIDS	CONASIDA	Mexico City	AIDSTECH
11. 350 days of technical assistance	All	Mexico	AIDSTECH
12. O.R. relationship behavior / place / person	GOHL	Guadalajara	AIDSCOM
13. Ethnographic study of high risk males and networking	CONASIDA	Mexico City	AIDSCOM
14. Study passive versus active info dissemination	CONASIDA	Mexico City	AIDSCOM
15. Design of Metro campaign	CONASIDA	Mexico City	AIDSCOM
16. Condom positioning	Population Council	Mexico City	AIDSCOM
17. KAP study (developed pilot educational materials)	Population Council	Tijuana, Guadalajara	AIDSCOM
18. Technical Assistance	All	Mexico	AIDSCOM
19. Miscellaneous projects	All	Mexico	A.I.D.

**APPENDIX 2****OTHER NON-USAID DONORS**

World Health Organization (with the direct support of, and via the Panamerican Health Organization)

European Community and some member governments, e.g. NORAD, Holland

Red Cross (particularly the Norwegian and Swiss Red Cross)

Rockefeller Foundation

Kellogg Foundation

Getty Foundation

McArthur Foundation

Japanese Overseas Development Agency

Hard Rock

Televisa

Deutsche AIDS Hilfe

AMFAR

**APPENDIX 3****ASSESSMENT TEAM MEETINGS (April 12 - 23, 1993): LIST OF CONTACTS****Office of the USAID Representative**

Art Danart, Director  
Nancy Alvey Sweeney, Project Coordinator

**Mexican Government**CONASIDA

Dr. Carlos del Río, Director  
Dr. Baez, Private Secretary to Director  
Dra. Blanco Rico Galinda

Office of International Affairs, Ministry of Health

Dr. Federico Chavez Peon, former director CONASIDA

INDRE

Dra. Maria Lourdes García García

IMSS

Dr. Abraham Santa Cruz, Director of Preventive Medicine

Non-Governmental OrganizationsCasa Ghilberta

Yolanda Resinas

Colectivo Sol

Juan Jacobo Hernandez, General Coordinator  
Rafael Manrique  
Francisco Rosas  
Victor Hernandez Chavez  
Anuar Luna  
Raymundo Rosales

**FEMAP**

Guadalupe de la Vega, President  
Enrique Suarez, Vice-President  
Graciela de la Rosa  
Marco Castro Reyes  
Eduwiges Ramos  
Leticia Hernandez

**Fundación Panamericana de SIDA**

Dra. Gloria Ornelas Hall, Executive Director  
Dra. María Isabel Carles, National Coordinator

**GIS-SIDA**

Rodolfo Morales Sanchez, Secretario

**IMIFAP**

Susan Pick de Weiss, Director

**Mexicanos Contra La Sida**

Ana María Hernandez Cardenas, President  
Oscar Chavez Lanz, Vice-President

**Population Council**

Dr. Kathryn Tolbert, Regional Program Director

**Individuals**

Arturo Diaz Betancourt, former President MCCA  
Marco Antonio Palet Sanchez, former Director MCCA

**Annex 4**  
**Scope of Work**

## SCOPE OF WORK

### LAC Health and Nutrition Sustainability

#### AIDS Program Assessment: Mexico

Total Level of Effort: 42 consultant days (3 consultants, 12 days each;  
1 consultant, 6 days)  
Timing of Activity: April 11 - 24, 1993  
Travel: 4 trips to Mexico, D.F., 4 trips to Ciudad Juarez  
Contractor: URC 3701-322  
Source of Funding: Core/Management Technical Assistance

## BACKGROUND

In preparation for the formulation of its FY 1994 Action Plan, the Office of the A.I.D. Representative (OAR) in Mexico has requested that LAC HNS conduct an "objective assessment of ongoing AIDS prevention activities in Mexico to date." This assessment will identify the current status of the HIV/AIDS epidemic and prevention activities in Mexico; examine alternate options for Agency funding in the face of potentially reduced budget levels; and recommend priorities among those options. The assessment will summarize the existing situation, and elaborate on future options and consequences of each. The intention is not an evaluation of the current program so much as a look toward alternative futures and recommendation of the best course, based on limited field access and desk review of existing documents.

## CONTENT

The team will address the following issues:

### I. Situational Analysis

#### A. Epidemiology

Review and summarize existing information about the nature and extent of the HIV/AIDS epidemic in Mexico, especially US border areas, including: the epidemiology, trends, and projections of HIV and AIDS prevalence/incidence; modes of transmission; populations and geographic areas affected; and the epidemiology of other relevant sexually transmitted diseases (STDs) as co-factors for HIV transmission. Review existing surveillance systems: data collection, analysis, and use for program guidance.

#### B. Behavioral, Cultural, Social, Economic, and Political Aspects of HIV/AIDS

Describe how the epidemic is influenced by, and influences these aspects. What are the

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most important possible social and economic impacts of the epidemic? Describe the political and social sensitivities related to commerce and travel across the border with the US. What are the most common current patterns and determinants of condom availability, access, and use? What are the most common current patterns and determinants of the diagnosis and treatment for STDs? What forms of risky behavior are most prevalent, and what are their determinants?

### C. Government Policy Context

Describe the official position and strategy of the Government of Mexico (GOM), and as relevant, state governments (especially in border areas) in responding to the HIV/AIDS epidemic and discuss legal, regulatory and policy constraints to controlling the epidemic. Identify important policy issues related to prevention efforts in the U.S. border areas.

## II. Program Responses to Date

A summary of the responses to the HIV/AIDS epidemic is needed. The team will examine activities related to a) condom availability, access and use; b) treatment of STDs; and c) communication / education for change of risky behavior. The OAR/Mexico will assist the team to identify major initiatives, programs and organizations to be included. Potential areas for collaboration and any existing gaps in AIDS prevention activities should be identified.

### A. Public Prevention Efforts

Describe the nature, scope, funding, and trends of federal and representative state government efforts to prevent HIV transmission; reflect on the appropriateness, adequacy, likely effectiveness and sustainability of those efforts; identify constraints, gaps and opportunities.

### B. Private Prevention Efforts

Describe the nature and extent of private initiatives to prevent HIV/AIDS. Identify key organizations; characterize the strategies and program features, as well as the levels and trends of resource inputs. Address appropriateness, complementarity with public efforts, adequacy, likely effectiveness, gaps and opportunities.

### D. Multilateral and Bilateral (Non-AID) Assistance

Describe the strategies, nature, extent and trends of multilateral and other bilateral assistance. Assess their appropriateness and complementarity with other national efforts, their adequacy and likely effectiveness.

### E. AID Assistance

Summarize the strategy, nature, extent and trends of assistance funded by the Office of the A.I.D. Representative (OAR)/Mexico, by the LAC Bureau/Washington, and by the

R&D/H/AIDS Division, including actions by AIDSTECH, AIDSCOM, and AIDSCAP. Summarize the overall contribution and accomplishments of A.I.D. assistance in HIV/AIDS prevention, under the coordination and accomplishments of OAR/Mexico. What are the strengths and weaknesses of the strategies and activities to date? Describe activities by program content (eg. condom availability, reducing STDs, and/or communications to reduce risky behaviors), implementing agencies, source of TA proposed, geographic location (with special attention to border areas), at-risk populations targeted, and funding levels. Assess the implementation status and appropriateness, adequacy and likely effectiveness of these efforts.

### III. Alternatives for Future AID programming

Based on the above findings, the team will identify and evaluate alternative programming options for future AID funding, in the face of potentially reduced levels of U.S. assistance. Descriptions will include information regarding program content (eg. condom availability, reducing STDs, and/or communications to reduce risky behaviors), implementing agencies, source of TA proposed, geographic location (with special attention to border areas), at-risk populations targeted, and approximate funding required.

The team will assess the consequences of discontinuation of A.I.D. inputs implied by some options. Note any initiatives that are judged to be particularly effective or promising and any which are necessary to the success of national (public or private) prevention efforts. Indicate whether the organizations implementing these initiatives will be able to absorb and sustain promising AID-assisted prevention activities. Identify the mutually beneficial opportunities for prevention activities in and around the U.S. - Mexico border.

### IV. Recommendations for Future AID Programming

The team will recommend options regarding the position, role, nature and extent of the OAR's activities in HIV/AIDS prevention in Mexico, from among the options explored. These options will be specific regarding program content areas, proposed implementing agencies, sources of technical assistance, and budget levels of OAR programming for HIV/AIDS prevention, as well as at-risk populations targeted and recommended geographic focus, especially border areas. Should A.I.D., under the OAR coordination continue assistance in HIV/AIDS prevention? What implementation mechanisms should be used? Discuss the issues from the point of view of protecting the viability of prior A.I.D. investments and assistance in date, and from the point of view of the benefits to both Mexico and the U.S.

## ROLES AND RESPONSIBILITIES

The team will consist of an epidemiologist, a (TBD), a public health specialist, a communications specialist, and AID Program Analyst. HNS will contract the communications specialist and public health specialist, and will pay direct costs (beyond salary and benefits, which will be contributed by his employer) for the epidemiologist. The AID Program Analyst will be the Personal Services Contractor (PSC) who works on AIDS issues in the OAR, who will

participate at no cost to HNS.

The first week the epidemiologist will serve as "outside" team leader during the week he participates in this assessment, making appointments with interviewees, introducing the team's purpose on visits, etc. The AID Program Analyst will take this role during the second week of the assessment visit.

The (TBD) will serve as the "inside" team leader, organizing the writing of the report, and assembling the written contributions of the team members into a final product in English. Specifically, he or she will:

Develop a detailed outline of the report, and finalize which team member will write which sections.

Assist team members to develop their sections in a consistent fashion.

Assemble team member contributions into a coherent whole.

Write the executive summary.

Present the draft report to OAR/M and AID/W. (This may not be possible to do in person.)

Within their respective disciplines, each team member will be responsible for gathering relevant documents and information, interviewing appropriate representatives from key institutions, and writing assigned portions of the report for delivery to the "inside" team leader as scheduled.

The following list is intended as a guide to a division of labor:

**The Epidemiologist** will a) conduct the epidemiologic situational analysis, b) examine the social and economic dimensions of the HIV/AIDS epidemic in Mexico.

**The Communications Specialist** will a) examine behavioral and cultural aspects of HIV transmission and prevention; and b) examine, assess, and recommend 1) communications strategies for HIV and STD control; 2) condom access strategies; and 3) training activities for AIDS educators and community workers.

**The Public Health Specialist** will a) describe general features of public and private sector efforts to prevent HIV/AIDS transmission, including STD programs; b) other donor programs and coordination; and c) program budget information.

**The A.I.D. Program Analyst** will a) describe the political aspects of HIV/AIDS in Mexico; b) assess the government policy context; b) describe and analyze existing

A.I.D.-funded activities; c) work with other team members to assess the outputs, effectiveness and sustainability of these contributions and to identify what might be the impact of discontinuation or modification.

In addition to the duties described above as "internal team leader," the (TBD) will contribute a section to the Final Report which summarizes the team's response to the points raised in Sections III and IV above, using focused discussions with other team members, OAR/M, and staff of projects visited, etc. as a base.

As the OAR is interested in assessing the problems and activities in border areas, consultants will undertake travel to Ciudad Juarez on the U.S. border to visit project sites as specified by the OAR.

LAC HNS Management Supervisor Jack Galloway will supervise the consultant team, who will work under the direction of OAR/Mexico in-country. Using comments from OAR/M, LAC/DR/HPN and RD/H/AIDS, LAC HNS will edit the report for OAR/Mexico.

## **LOGISTICS**

Each team member, except the epidemiologist, is expected to spend 12 working days in Mexico, for a total of 42 person days (6 day workweek assumed). The epidemiologist will spend six work days with the team. It is proposed that the team will visit the border city of Ciudad Juarez for two days.

## **DELIVERABLES**

The final report will contain sections analogous to the outline of CONTENT above, or a substitute organization with the same content. Emphasis will be on options and recommendations for the future, not an exhaustive evaluation of previous programming.

The team will brief appropriate OAR staff at the beginning and conclusion of the assessment, at a minimum.

**Annex 5**  
**Team CV's**

**PAUL RAZA EAST, M.D., M.P.H., J.D.**  
**Private Sector Promotion Specialist**

**Profile**

Paul Raza East is a trained health economist with an extensive background in cost recovery, financial management, and public/private sector relations. A native of Great Britain who is fluent in French, Dr. East holds an M.D. from University College Medical School, London, law degrees from Grays Inn, London, and George Washington University Law School, and an M.P.H. with specialization in international health from Johns Hopkins University's School Hygiene and Public Health.

Dr. East has worked in both the public and private sectors in the United States, Eastern Europe, and the developing world. His positions have been varied. As Director of the U.S. Veterans' Administration's (V.A.) Central Office Education Programs Service, for example, Dr. East oversaw a \$300,000,000 budget and policy system in support of 30,000 medical and dental residents in 1,650 training programs affiliated with approximately 100 medical schools. In this position, he developed and implemented a streamlined budget process that remains in effect today. As Public Advisor/Latin American Coordinator for AIDSTECH, Dr. East worked closely with his host country counterparts and private sector collaborators in a sweeping AIDS education program encompassing 10 Latin American countries and Haiti.

Dr. East has trained in accounting procedures, budget development, and waste reduction while conducting clinical and research work in areas such as family planning. Perhaps most importantly, Dr. East understands and appreciates the value of private sector involvement in public sector initiatives.

**Education**

M.P.H., Johns Hopkins, School of Hygiene and Public Health, Baltimore, MD, 1972  
 Masters in Law, with Honors, George Washington University Law School, Washington, DC, 1970.  
 M.D., University College Hospital Medical School, London, England, 1968.  
 Barrister-at-Law, Grays Inn, London, England, 1966.

**Experience**

Independent Advisor on Health and Community Development, Mexico, 1989 - present

- Responsible for financial and administrative reorganization of Red Cross in Delegación Chapala. Liaison with local and state governments and private sector individuals and institutions for fundraising and other community development activities. Emphasis on negotiation of collaborative enterprises between government and private sector.

AIDSTECH - Family Health International, Chapel Hill, N.C., Washington, 1987 - Jan. 1989

- Public Health Advisor and Latin American Coordinator

Responsible for the start-up of centrally funded AIDS assistance project to 10 Latin American countries and Haiti. Collaborated with government officials on program development, financial planning, and management. Contributed to public education campaigns, worked in collaboration with private sector organizations, and served with Pan American Health Organization. Drafted initial legal ethical standards used for country evaluation of AIDS programs.

**PAUL RAZA EAST, M.D., M.P.H., J.D.**

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Veterans Administration Central Office, Washington, D.C., 1982 - 1987

- Acting Director and Director

Primary control of \$300,000,000 budget and policy to support 30,000 medical/dental residents in 1,650 training programs affiliated with Veterans Administration medical centers. Also oversaw policy, budget control, and management of 50,000 associated health trainees. Supervision of 80 field physician/dentist, as well as 13 professional and 13 support staff. Streamlined and put in place new budgeting process.

U.S. Veterans Administration, 1977 - 1982

- Chief of the Medical/Dental Division, 1979 - 1982
- Associate Chief, Graduate Medical Education, 1977 - 1979

As Associate Chief, focused on waste reduction by streamlining policies pertaining to the allocation of resident physicians in the V.A. hospital system. Overseeing the residency programs at 125 V.A. hospitals, restructured the relationship between the V.A. and its affiliated medical schools in favor of a residency policy based upon national versus V.A. and medical school needs. As chief of the V.A.'s Medical/Dental Division, continued to tackle the difficult task of revamping the residency system. In addition, he assumed responsibility for all dental residencies.

National Health Service Corps, Department of Health, Education, and Welfare, Washington, D.C., 1977

- Chief Medical Officer

Responsible for oversight of and policy formulation for 1,000 physicians working in underserved areas. Involved in daily policy operations of loan-guarantee program for medical/dental education of physicians and dentists. Emphasis on development of policy to enable physicians to pay back loan by service in underserved areas. Maintained system of intensive initial education prior to service and continuing education during service. Maintained contact with American Medical Association for Continuing Medical Education Credits. Liaison with Federal Scholarship Program for recruitment of health manpower to serve in underserved areas.

Quality Improvement Branch, Department of Health, Education, and Welfare, Washington, D.C., 1976

- Chief

Designed policy on quality improvement for federally funded community health care clinics dealing with family planning and migrant health issues in both urban and rural areas.

University Faculty, University of Maryland Medical School, 1974

- Wrote testimony on National Health Insurance for Governor Mandell and state regulations for "Sheltered housing." Taught medical students, residents, and others various public health subjects. Lectured on the Soviet health care system, relevant aspects of federal and state reimbursement, quality assurance, insurance, health manpower, federal planning, and the federal legislative process.

National Cancer Institute, U.S.S.R., Faculty of University of Maryland, with grant from National Cancer Institute, 1974 - 1975

- Researcher on Cancer Epidemiology with Soviet Union National Cancer Institute

Worked with leading researchers in Ukraine, Estonia, Lithuania, Latvia, Georgia, Kazakstan, Russia, and other republics. Conducted extensive study of the Soviet health care system.

Committee Memberships/Consultancies

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**PAUL RAZA EAST, M.D., M.P.H., J.D.**

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Between 1977 and 1987, served the following United States national private and public sector committees involved with health care and finance issues:

- Graduate Medical Education National Advisory Council
- Association of American Medical Colleges
- Task Force on Graduate Medical Education
- National Residency Matching Program
- Educational Council for Foreign Medical Graduates
- Robert Wood Johnson Clinical Scholars Program
- White House Task Force: National Health Care Policies for the Handicapped
- Accreditation Council for Graduate Medical Education
- American Medical Association
- Joint Commission on Accreditation of Hospitals

USAID/Poland - 1987

- Member of three-person team to evaluate Project Hope

Ministry of Health, Hungary, 1973

- Guest of Minister of Health to study of health care system
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### **Reports, Papers, and Monographs**

Compendium of State Legislation on Sudden Infant Death Syndrome, BCHS, Department of Health, Education and Welfare, 1977.

Ambulatory Health Care Standards. Bureau of Community Health Services, Department of Health, Education and Welfare, 1976.

Monograph on Soviet Cancer Epidemiology; restricted distribution for National Cancer Institute, National Institutes of Health, 1975.

Standards for Sheltered Housing, issued by the Office on Aging, State of Maryland, 1973.

Testimony by Governor Mandel before the House Ways and Means Committee on National Health Insurance (Congressional Record), 1973.

### **Collaborative Works:**

Report of the Veterans Administration Task Force on Cardiovascular Surgery, VACO, 1986.

Report of the Association of American Medical Colleges Task Force on Graduate Medical Education, AAMC, 1984.

Report of the Federal Interagency Task Force on Foreign Medical Graduates, 1983.

Final report and various sub-reports of the Graduate Medical Education National Advisory Committee (GMENAC), Department of Health, Education and Welfare, 1982.

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**PAUL RAZA EAST, M.D., M.P.H., J.D.**

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Interim Report of the Graduate Medical Education National Advisory Committee (GMENAC),  
Department of Health, Education and Welfare, 1979/80.

Report, White House Task Force on the Handicapped, 1978.

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### **Languages**

English: Native language  
French: Fluent  
Spanish: Fluent  
German: Basic knowledge  
Russian: Basic knowledge  
Urdu: Rudimentary knowledge

**SYS T. MORCH**

55 West 16th Street, New York, NY 10011

~~Office: (212) 692-8567~~

Home: (212) 924-7335

FAX: (212) 907-6819

**SUMMARY**

**International Marketing Consultant with senior management experience in major U.S. corporations, advertising agencies, and non-government organizations.**

Created and managed total marketing and advertising programs for consumer products and services for multi-national corporations and clients. Particular expertise in creating unique marketing positions, whether for corporate and product relaunches or for new product introductions. A specialist in planning new business and developing international tourism. An accomplished speaker and speech writer.

Capable of conducting meetings and communicating fluently in French, Danish, and German. Conversationally comfortable in Norwegian and Spanish. Studying Japanese.

**EMPLOYMENT**

Horan Morch Stahl, Inc., New York, NY President	1986 to Present
Polaroid Corp., Cambridge, MA Director of International Advertising	1984-1986
American Home Products, New York, NY Director of New Product Marketing	1981-1984
James Jordan, Inc., New York, NY Vice President, Management Supervisor	1979-1981
J. Walter Thompson, Inc., New York, NY, and Frankfurt, Germany Vice President, Management Supervisor	1972-1979
Compton Advertising, New York, NY Account Manager	1971-1972
The Marschalk Company, New York, NY Account Executive	1968-1971

**EDUCATION**

- New York University: Japanese and graduate linguistics.
- Harvard University: MBA Equivalent.
- Sorbonne University: Diplome de la Civilisation Francaise.
- Shimer College (University of Chicago): B.A.

**SYS T. MORCH**

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**REPRESENTATIVE ACHIEVEMENTS****MANAGEMENT**

- Analyzed goals of a highly specialized promotional agency and restructured its objectives. Expansion of its expertise and the services it offered resulted in attracting a wider client base.
- Identified potential partners and conducted negotiations on behalf of American management for a public relations partnership network in Europe.
- Created business plan and solicited investor funding for a new company that sought unique products, obtained their patents, develop, tested, and marketed the products.
- Managed complicated government approvals process of advertising campaigns in Chile and Argentina.

**STRATEGIC MARKETING**

- Repositioned a consumer camera line to reverse low consumer quality perceptions of corporation's products prior to the worldwide launch of a new product. Results were increased usage of the original line plus strengthening of consumer believability in the corporation's ability to manufacture a technically-superior new product.
- Directed and analyzed attitude and usage research on personal and professional photographic habits in China, and of consumer motivation and response to a new product category in photography.
- Directed all aspects of adaptations in 28 countries of U.S. marketing strategies, product formulations, packaging, advertising campaigns, and sales plans of several consumer product and services categories.

**TRAVEL AND TOURISM**

- Created and taught a 4-week course for 65 Vietnamese tourist professionals on how to market Vietnam effectively to international tour operators. Delivered in Ho Chi Minh City.
- Wrote marketing analysis for Master Plan for Tourism to Vietnam for the United Nations Development Program (UNDP), the World Tourism Organization (WTO), and the Vietnamese government in Hanoi.
- Conducted evaluation of Madagascar as a potential destination for the American travel market for the Ministry of Tourism in Antananarivo. Resultant report recommend ecological tourism.

**BUSINESS DEVELOPMENT**

- Helped manage growth of two advertising agencies from inception to medium-sized companies ready for merger.
- Wrote detailed communications procedures manual for a dual international advertising network. Analysis was based on comparison of similarities in the business and cultural environments of 45 countries. Manual was published worldwide.
- Created lectures and multi-media materials for a series of training programs in communications and sales, including regular follow-up procedures.

**ADVERTISING AND COMMUNICATIONS**

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- Conducted evaluation and negotiated reassignment of advertising agency network in 35 countries for a global account with a \$45 million budget in 6 months.

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Federico G. de Cosio, M.D., M.P.H.  
6006 N. Mesa, Suite 600  
El Paso, TX 79912

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**RESUME**

<b>NAME</b>	Federico G. de Cosio
<b>AGE</b>	36 years
<b>Race</b>	Hispanic
<b>Social Security</b>	477-96-7160

**JOB OBJECTIVE:** To become part of an organization in which creativity and drive are required

**EDUCATION**

6/1982 - 12/1983	Master in Public Health Area: Administration Epidemiology School of Public Health University of Minnesota Minneapolis, Minn.
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3/1975 - 12/1980	Medical Degree National University of Mexico Mexico City, Mexico.
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**OTHER STUDIES**

09/1990	Strategies and Management for the Implementation of Local Health Systems (SILOS) Instituto Centro Americano de Administración de Empresas (INCAE), San José, Costa Rica
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12/1989	Tuberculosis Along the U.S./Mexico Border: Strategies for Treating the Foreign-Born, Texas Tech University Health Sciences Center, El Paso, Texas, USA
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07/1988	Hansen's Disease Course Gilles W. Long Hansen's Disease Center Carville, Louisiana
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03/1987	International Course of Diarrheas General Hospital (Mexico)
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05/1986	Diarrheas Course University of Tlaxcala, Tlaxcala, Mexico
04-06/1985	Economic Analysis Colegio de Mexico, Mexico, City
09-11/1984	Advance Course of Epidemology School of Public Health (Mexico)
07/1984	Demographic Analysis School of Public Health (Mexico)

#### PROFESSIONAL EXPERIENCE

04/1992 - Present Position:	Special Project Coordinator for the U.S-Mexico border
Work description:	Assist the U.S.-Mexico governments to develop a binational health strategy along the U.S.-Mexico border. Activities include the Border Sister Cities Projects which are related to immunizations, tuberculosis, environment health issues, and health promotion. Responsible of the activities of the U.S.-Mexico Border Health Organization and their network groups such as universities, state health officers.
11/1991 - 3/1992 Position:	AIDS Consultant in Mexico at Pan American Health Organization in Mexico City.
Work description:	Assist the Mexican Government Health Care System to develop AIDS prevention and control activities. Promote the development of HIV/AIDS policies that contribute to the improvement of quality of care for people living with HIV infection. Assist non-government organizations to conduct HIV/AIDS activities.
Reason for leaving:	Search for a more challenging opportunity
10/1990 - 10/1991 Position: Place:	Chief, Area of Health Programs Development El Paso Field Office of the Pan American Organization

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**Work Description:** Responsible for the Area of Health Programs Development for the U.S.-Mexico Border, there are seven units under my direct supervision (AIDS, Maternal and Child Care, Epidemiology, Infectious Epidemiology, Environmental Health, Veterinary Public Health and Substance Abuse), also the organization of the US-Mexico Border Health Association Annual Meeting, with an expected attendance of 500 participants.

**Reason for leaving:** Consulting AIDS activities at request of the Mexican Government to the Pan American Health Organization.

10/1987 - 10/1990  
**Position:**

**Place:**

**Work Description:**

Coordinator of U.S.-Mexico Border Epidemiology Program  
 El Paso Field Office of the Pan American Health Organization/U.S.- Mexico Border Health Association

- Epidemiological Surveillance for the U.S.- Mexico border
- Training to health trainers (Epidemiology, Diarrheas, Immunizations, AIDS, Substance Abuse)
- Project Coordinator of: Substance Abuse, Tuberculosis and AIDS
- Project Consultant IV drug use and AIDS prevention, MCH-AIDS Health Education Clearinghouse, Maternal and Infant Research Assessment
- Responsibility for the edition of the Border Epidemiological Bulletin
- Coordinator for the Annual Meeting of the U.S.-Mexico Border Health Association
- Coordinator of the Annual Meeting of Epidemiology of the U.S.-Mexico border of the Pan American Health Organization
- Consultant in Epidemiology as required and proposal writer

**Reason for leaving:** Promotion to Chief of the Health Programs Development Area

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11/1985 - 10/1987

Position:

Place:

Work Description:

Health Consultant

Programa Impacto (PAHO initiative)

PAHO-Secretariat of Health

- Consultant for decentralized states of Mexico in Primary Health Programs (Diarrheas, Immunizations, Malaria, Rabies, AIDS, etc).

- Program development

- Establishment of Supervision Routes and Supervision Guidelines of Diarrheas Programs and Immunizations

- Training of Health Professionals with emphasis in state program coordinators.

Reason for leaving: Promotion to Coordinator of U.S.-Mexico Border Epidemiology Program

05/1984 - 10/1987

Position:

Place:

Work Description:

Chief of Internal Affairs of a General Direction

Direccion General de Apoyo a la Coordinacion Sectorial, Secretariat of Health (Mexico)

- Follow up of health project developed by the General Direction

- Development of technical health reports to be presented to the Secretary of Health of Mexico

- Coordinator of the Area Directors in order to work as a unit for a common goal

Reason for leaving: Promoted by the Undersecretary of Health Planning to health officer

01/1984 - 10/1985

Position:

Place:

Work Description:

Professor of Public Health

School of Medicine, National University of Mexico

Professor of Introduction to Public Health to first year students of the Master of Health Services Administration. The course included analysis of primary health programs, use of statistics for Public Health Administration, and development of a health program for a given community

Reason for leaving: Work as health officer required extensive travels.

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**OTHER PROFESSIONAL ACTIVITIES**

**Position:** Acting Chief of the El Paso Field Office of the Pan American Health Organization, U.S.-Mexico Border.

**Work Description:** To take over duties of Chief when he is outside of the office or on annual leave.

**TEACHING EXPERIENCE**

1984-1985 Professor of Public Health  
National University of Mexico

1986 Professor of the course: Diarrheas

1987 Professor of the courses:  
Diarrheas and Epidemiological Principles

1988-present Guest Professor of Public Health  
Universidad Autonoma de Ciudad Juárez

1988-present Courses of El Paso Field Office of the Pan American Health Organization/United States Border Health Association (Coordinator)  
Diarrheas  
Epidemiological Principles  
Impact of Oral Rehydration  
AIDS  
Substance Abuse  
Maternal and Child Health Care

1992 Guest Speaker on U.S.-Mexico Border Health  
University of Texas at El Paso  
Universidad Autonoma de Juarez

**FUNDED PROJECTS**

1988 AIDS Situation in the Northern Border of Mexico  
Funded by: Pan American Health Organization  
with US\$25,000.00

1989 AIDS Health Education Clearinghouse  
Funded by: George Town University with  
US\$60,000.00

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**El Paso, TX 79912**

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- 1989                    **Substance Abuse Current Situation along the U.S.-Mexico Border Report**  
**Funded by: National Institute on Drug Abuse with U.S.\$60,000.00**
  
- 1990                    **Project Consenso (identification of the U.S.-Mexico border health priorities)**  
**Funded by: U.S. Public Health Services with US\$100,000.00**
  
- 1991                    **Binational Tuberculosis Project for the El Paso, Texas/Juarez, Mexico Area (Project JUNTOS)**  
**Funded by: Centers for Disease Control with 360,000.00 for three years**
  
- 1992                    **Tuberculosis Control Between Border Cities of San Luis Rio Colorado, Mexico and Yuma County, Arizona**  
**Funded by: U.S. Public Health Services with US\$25,000.00**
  
- HIV/AIDS Border Epidemiological Center (Imperial Valley, California/Mexicali, Mexico)**  
**Funded by: U.S. Public Health Services with US\$10,000.00**

**EDITORIAL EXPERIENCE**

- Oct. 1987 - Oct. 1992    **Coordinator of the "BORDER EPIDEMIOLOGICAL BULLETIN" a Pan American Health Organization Publication**
  
- Oct. 1987 - present    **Member of the Editorial Board of the "BORDER HEALTH JOURNAL"**
  
- Oct. 1992 - present    **Member of the Editorial Board of the "BORDER EPIDEMIOLOGICAL BULLETIN"**

**LANGUAGE**

English	Excellent
Spanish	Excellent
French	Working knowledge

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**PUBLICATIONS AND PRESENTATIONS**

1. Analysis of Disease Trends in the U.S.-Mexico Border for the last Five Years  
Border Epidemiological Bulletin Jan-Feb 1988 15(1):1-11
2. Comments on Poliomyelitis  
Border Epidemiological Bulletin Jan-Feb 1988 15(1):12-13
3. How Maternal-Child Health Indicator are interpreted  
Border Epidemiological Bulletin Mar-Apr 1988 15(2):1-6
4. The Epidemiology of AIDS and its impact on the Maternal and Child Population  
Paper presented during the XLVI Annual Meeting of the U.S.-Mexico Border Health Association June 7, 1988
5. U.S.-Mexico Border Mortality Trends: An Overview  
Border Epidemiological Bulletin Jan-Feb 1989 15(1):1-7
6. Current situation of AIDS along the northern Mexican Border to be presented for the 117th Annual Meeting of the American Public Health Association October 23, 1989 at Chicago, U.S.A.
7. Measles Update  
Border Epidemiological Bulletin Mar-Apr 1990 17(2):1-6
8. Chronic Degenerative Diseases Outlook on the U.S.-Mexico Border  
Border Health Journal Jul-Aug-Sep 1990; (3):18-20
9. Cervical Cancer: a present problem  
Border Health Jul-Aug-Sep 1990; (3):21-25
10. Substance Abuse Outcomes From Project Consenso and an Overview of the Problem Along The U.S. Border.  
Paper presented during the International Conference on Prevention of Medical Emergencies Along the U.S.- Mexico Border at Puerto Peñasco, Mexico June 28, 1991
11. Patterns of Drug Consumption among Users in the Juarez Juvenile Detention Center. Border Health (Special Issue) 1991; 7(3):95-99
12. Reaching Health Priorities through a Consensus Process Border Epi. Bulletin Mar-Apr, 1992; (3):1-10
13. Substance Abuse Along the U.S.-Mexico border. Paper presented

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at the "Hands Across the Border" Conference, El Paso, Texas,  
June 16, 1992

14. Juntos: Un programa de demostración para el control de la tuberculosis en la frontera México-Estados Unidos. "Foro Internacional de Atención Primaria de la Salud" Juárez, México March 4, 1993
15. Panorama Mundial del SIDA: Lecciones Aprendidas. "IV Jornadas Médicas 1993" Juárez, México, March 12, 1993
16. Binational Health, "Quality of Life Conference" El Paso, Texas March 12, 1993
17. "JUNTOS" (Together): A demonstration project on tuberculosis control along the U.S.-Mexico border--A binational Strategy, Submitted for presentation "120th Annual Meeting of the American Health Association Annual Meeting" Washington, D.C. 1993 (pending)

#### MEMBERSHIPS

1. American Public Health Association
2. U.S.-Mexico Border Health Association
3. World Health Association

RECOMMENDATIONS  
On request.