It is now evident that AIDS has different epidemiological patterns in every society and that societies react to AIDS differently, according to their social context. So it is important to study both the behaviours of the disease as well as that of the society in order to better contend with the problem.

In the case of Mexico, we now know from retrospective studies that the first cases of AIDS in this country occurred in 1981. At the beginning of the epidemic, practically all cases had a history of sexual contacts in the United States, and most of them were affluent homosexuals. Nowadays the cases are not so clearly stratified, as they have spread progressively to lower social and economic groups, both in the cities and in the countryside. The number of cases has increased exponentially, numbering over 1,000 by the end of 1987. In fact the total has doubled every eight months so far, which allows us to estimate that there will have been up to 25,000 cases by 1991.

Mexico has the distinct peculiarity of sharing 2,000 miles of border with the United States. And after Mexico City and Guadalajara, the two largest metropolitan areas in the country, the highest rates of AIDS are found in those states which border our giant neighbour.

As happens everywhere, the age groups most affected are young adults, by virtue of being sexually active. In Mexico, AIDS has affected men predominantly, with a sex ratio of 20 males for each female with the disease. Close to 90 per cent of the cases have occurred in homosexual or bisexual men. The rest are recipients of blood products (7 per cent), and heterosexual people (3 per cent). Very few cases have been associated with intravenous drug abuse, since this form of drug addiction is almost nonexistent in our country—a fact explained more by the high costs associated with this habit than by moral constraints.

Among the regional variants of the AIDS pandemic, one aspect peculiar to Mexico concerns both the nature of the problem and the public health response to it: this is the existence of professional blood donors. Until recently, one-third of the blood supply in Mexico came from people who made a living—however precarious—by selling their blood. It was not until May 1986, when a law making HIV screening mandatory in all blood units was passed, that we started noticing a high sero-prevalence among professional blood donors. This social phenomenon is not, as yet, fully understood, and is the subject of current research. Not all donors everywhere were infected; there was a marked clustering in a few metropolitan areas, with a mean sero-prevalence of about seven percent. Compared with altruistic donors, who had a sero-prevalence of HIV infection of 0.1 per cent, the professional donors therefore constituted a high risk group.

Given the magnitude of the problem with the blood supply, the authorities decided not to wait for an explanation of this phenomenon, but simply to curtail it. Our Congress banned all commerce with blood in the country, in April 1987. This measure, along with the screening of all blood units, has made our blood supply safe. It has also made us face two predictable consequences: opposition from those who made juicy profits by commercialising blood and blood products, and a transitory short supply of blood.

The blood bank owners did not in fact present a major problem, because of the overwhelming support that the public showed for the new...
The supply of blood has now been secured through altruistic donation campaigns and by encouraging donation from relatives of those in need. In addition, guidelines for the proper prescription of blood transfusions have been distributed to doctors and hospitals.

This story illustrates the value of epidemiological surveillance in detecting an emerging problem, but also the extensive public health benefits that can stem from a simple (though politically complicated) legal action.

In the absence of vaccines or drugs, we have to rely on two measures to prevent the spread of AIDS: education and sanitary control. The former is aimed at changing the behaviour of individuals, while the latter protects society as a whole.

I believe it is the responsibility of governments worldwide to ensure a safe blood supply. Some simple measures only require political will to be implemented. Self-exclusion of blood donation from members of high-risk groups is both effective and advisable. Inactivation of the virus in blood products is easy and also very effective. Banning commerce with blood—where it occurs—is highly recommendable. The last and most effective measure to ensure safety in blood is to screen all blood units for HIV antibodies. Although this is expensive for the budgets of most developing countries, prevention will always be less onerous than the costs of keeping people in hospital.

Educational campaigns for AIDS should be designed and oriented towards specific audiences: the general population, medical care providers, and people with high-risk behaviour. The scope and contents of the education materials should vary accordingly. In Mexico, given the inherent delicacy of the topic and the prevailing moral values, we decided to take a “step by step” approach in mass media messages for the general population. The first step was to combat the myths about the disease, and to inform people how it can be transmitted. Thereafter, we recommended ways to prevent acquiring AIDS, including the use of condoms. This has been a landmark in mass media communication, since even partial nudity is prohibited on television screens, and the word “condom” is still shocking to many. Doctors have received guidelines for the medical care of AIDS patients and recommendations on how to prevent transmission. Finally, members of high risk groups have received explicit material about “safe sex” and a supply of condoms.

Mexico’s National AIDS Committee (CONASIDA) is formed by representatives of public and private institutions in the health sector and by experts in the field and operates within the Ministry of Health to advise health institutions throughout the country. Its mandates are many, including the epidemiological surveillance of the epidemic; supervision and evaluation of all related activities; research on epidemiological, laboratory, social and educational issues; guidelines and recommendations for preventing transmission; and administration of budget and fundraising. It is still too soon to evaluate the benefits of CONASIDA’s actions, but my own view is that they are very positive.

In less developed nations AIDS is competing for resources with other diseases, at a time when resources are most meager in the health sector. In Mexico, we are convinced that it is better to allocate resources to preventive actions—at a time when the problem is still one that can be curbed.