GLOBAL SUMMARY OF THE AIDS EPIDEMIC DECEMBER 2004

Number of people living with HIV in 2004	**Total**	**39.4 million (35.9–44.3 million)**
	Adults	37.2 million (33.8–41.7 million)
	Women	17.6 million (16.3–19.5 million)
	Children under 15 years	2.2 million (2.0–2.6 million)
People newly infected with HIV in 2004	**Total**	**4.9 million (4.3–6.4 million)**
	Adults	4.3 million (3.7–5.7 million)
	Children under 15 years	640 000 (570 000–750 000)
AIDS deaths in 2004	**Total**	**3.1 million (2.8–3.5 million)**
	Adults	2.6 million (2.3–2.9 million)
	Children under 15 years	510 000 (460 000–600 000)

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information.

INTRODUCTION

The total number of people living with the human immunodeficiency virus (HIV) rose in 2004 to reach its highest level ever: an estimated 39.4 million [35.9 million–44.3 million] people are living with the virus (Figure 1). This figure includes the 4.9 million [4.3 million–6.4 million] people who acquired HIV in 2004. The global AIDS epidemic killed 3.1 million [2.8 million–3.5 million] people in the past year.

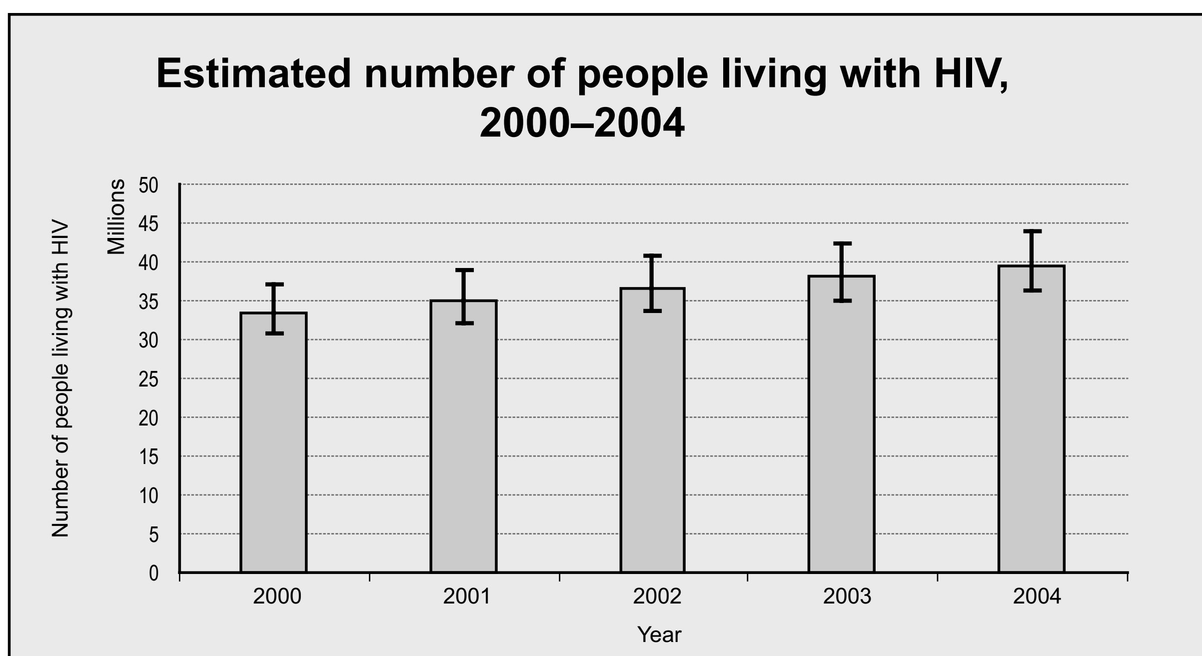

Figure 1

The number of people living with HIV has been rising in every region, compared with two years ago, with the steepest increases occurring in East Asia, and in Eastern Europe and Central Asia (see Table, page 3). The number of people living with HIV in East Asia rose by almost 50% between 2002 and 2004, an increase that is attributable largely to China's swiftly growing epidemic. In Eastern Europe and Central Asia, there were 40% more people living with HIV in 2004 than in 2002. Accounting for much of that trend is Ukraine's resurgent epidemic and the ever-growing number of people living with HIV in the Russian Federation.

Sub-Saharan Africa remains by far the worst-affected region, with 25.4 million [23.4 million–28.4 million] people living with HIV at the end of 2004, compared to 24.4 million [22.5 million–27.3 million] in 2002. Just under two thirds (64%) of all people living with HIV are in sub-Saharan Africa, as are more than three quarters (76%) of all women living with HIV.

The epidemics in sub-Saharan Africa appear to be stabilizing generally, with HIV prevalence at around 7.4% for the entire region. But such a summary perspective hides important aspects. First, roughly stable HIV prevalence means more or less equal numbers of people are being newly

Regional HIV and AIDS statistics and features, end 2002 and 2004

	Adults and children living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult and child deaths due to AIDS
Sub-Saharan Africa				
2004	25.4 million [23.4–28.4 million]	3.1 million [2.7–3.8 million]	7.4 [6.9–8.3]	2.3 million [2.1–2.6 million]
2002	24.4 million [22.5–27.3 million]	2.9 million [2.6–3.6 million]	7.5 [7.0–8.4]	2.1 million [1.9–2.3 million]
North Africa and Middle East				
2004	540 000 [230 000–1.5 million]	92 000 [34 000–350 000]	0.3 [0.1–0.7]	28 000 [12 000–72 000]
2002	430 000 [180 000–1.2 million]	73 000 [21 000–300 000]	0.2 [0.1–0.6]	20 000 [8300–53 000]
South and South-East Asia				
2004	7.1 million [4.4–10.6 million]	890 000 [480 000–2.0 million]	0.6 [0.4–0.9]	490 000 [300 000–750 000]
2002	6.4 million [3.9–9.7 million]	820 000 [430 000–2.0 million]	0.6 [0.4–0.9]	430 000 [260 000–650 000]
East Asia				
2004	1.1 million [560 000–1.8 million]	290 000 [84 000–830 000]	0.1 [0.1–0.2]	51 000 [25 000–86 000]
2002	760 000 [380 000–1.2 million]	120 000 [36 000–360 000]	0.1 [0.1–0.2]	37 000 [18 000–63 000]
Oceania				
2004	35 000 [25 000–48 000]	5000 [2100–13 000]	0.2 [0.1–0.3]	700 [<1700]
2002	28 000 [22 000–38 000]	3200 [1000–9600]	0.2 [0.1–0.3]	500 [<1000]
Latin America				
2004	1.7 million [1.3–2.2 million]	240 000 [170 000–430 000]	0.6 [0.5–0.8]	95 000 [73 000–120 000]
2002	1.5 million [1.1–2.0 million]	190 000 [140 000–320 000]	0.6 [0.4–0.7]	74 000 [58 000–96 000]
Caribbean				
2004	440 000 [270 000–780 000]	53 000 [27 000–140 000]	2.3 [1.5–4.1]	36 000 [24 000–61 000]
2002	420 000 [260 000–740 000]	52 000 [26 000–140 000]	2.3 [1.4–4.0]	33 000 [22 000–57 000]
Eastern Europe and Central Asia				
2004	1.4 million [920 000–2.1 million]	210 000 [110 000–480 000]	0.8 [0.5–1.2]	60 000 [39 000–87 000]
2002	1.0 million [670 000–1.5 million]	190 000 [94 000–440 000]	0.6 [0.4–0.8]	40 000 [27 000–58 000]
Western and Central Europe				
2004	610 000 [480 000–760 000]	21 000 [14 000–38 000]	0.3 [0.2–0.3]	6500 [<8500]
2002	600 000 [470 000–750 000]	18 000 [13 000–35 000]	0.3 [0.2–0.3]	6000 [<8000]
North America				
2004	1.0 million [540 000–1.6 million]	44 000 [16 000–120 000]	0.6 [0.3–1.0]	16 000 [8400–25 000]
2002	970 000 [500 000–1.6 million]	44 000 [16 000–120 000]	0.6 [0.3–1.0]	16 000 [8400–25 000]
TOTAL				
2004	39.4 million [35.9–44.3 million]	4.9 million [4.3–6.4 million]	1.1 [1.0–1.3]	3.1 million [2.8–3.5 million]
2002	36.6 million [33.3–41.1 million]	4.5 million [3.9–6.2 million]	1.1 [1.0–1.2]	2.7 million [2.5–3.1 million]

* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2004, using 2004 population numbers.

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information.

infected with HIV and are dying of AIDS. Beneath the apparent constancy of steady prevalence levels lie devastating realities—especially in southern Africa, which accounts for one third of all AIDS deaths globally. Second, the epidemics in Africa are diverse, both in terms of their scale and the pace at which they are evolving. There is no single "African" epidemic. Some urban parts of East Africa display modest declines in HIV prevalence among pregnant women, while in West and Central Africa prevalence levels have stayed roughly steady at lower levels than in the rest of sub-Saharan Africa. National HIV data, though, hide much higher levels of infection in parts of countries, as Nigeria illustrates. Southern Africa, unfortunately, offers only slight hints of possible future declines in HIV prevalence (see pages 19-30).

HIV prevalence in the Caribbean is the second-highest in the world, exceeding 2% in five countries, and AIDS has become the leading cause of death among adults aged 15–44 years in this region. Yet, a growing number of Caribbean countries are showing that the epidemic does yield to appropriate and resolute responses (see pages 31-35).

Many prevention opportunities

Virtually every region, including sub-Saharan Africa, has several countries where the epidemic is still at a low level or at an early enough stage to be held in check by effective action. This calls for programmes that can thwart the spread of HIV among the most vulnerable population groups. But in many countries, inadequate resources and a failure of political will and leadership still bars the way—especially where HIV has established footholds among marginalized and stigmatized population groups such as women who sell sex, drug injectors and men who have sex with men. Unless reticence is rapidly replaced with pragmatic and forward-looking approaches, HIV will spread more extensively in many countries which until now have escaped with only minor epidemics.

Also blocking the way forward is the lack of coherent, nationally-led AIDS responses in many heavily-affected countries. Given the rising numbers of implementing structures and increased funding, it is essential to pre-empt the risk of duplication and fragmentation in AIDS responses. To that end, major donors in April 2004 endorsed three key principles that would underpin their support for nationally-led action against AIDS. Known as the "Three Ones"*, those principles are geared to strengthen the coordination and coherence of AIDS responses. The principles are intended to underpin a simple system that can enable various approaches for fighting AIDS to converge effectively.

Women are increasingly affected

The AIDS epidemic is affecting women and girls in increasing numbers (see pages 7-18). Globally, just under half of all people living with HIV are female. Women and girls make up almost 57% of all people infected with HIV in sub-Saharan Africa, where a striking 76% of young people (aged 15–24 years) living with HIV are female. In most other regions, women and girls represent an increasing proportion of people living with HIV, compared with five years ago.

These trends point to serious gaps in the AIDS response. Services that can protect women against HIV must be expanded. Women and girls need more information about AIDS. A recent UNICEF survey found that up to 50% of young women in high-prevalence countries did not know the basic facts about AIDS. Yet the vulnerability of women and girls to HIV infection stems not simply from ignorance, but from their pervasive disempowerment. Most women around the world become HIV-infected through their partner's high-risk behaviour, over which they wield little if any control. The plight of women and children in the face of AIDS underlines the need for realistic strategies that address the interplay between inequality—particularly gender inequality—and HIV.

* The "Three Ones" principles refer to one agreed national action framework to provide the basis for coordinating the work of all partners, one national AIDS coordinating authority with a broad-based multisectoral mandate, and one country-level monitoring and evaluation system.

Regional HIV statistics and features for women, end 2002 and 2004

		Number of women (15–49) living with HIV	Percent of adults (15–49) living with HIV who are women (%)
Sub-Saharan Africa	2004	13.3 million [12.4–14.9 million]	57
	2002	12.8 million [11.9–14.3 million]	57
North Africa and Middle East	2004	250 000 [80 000–770 000]	48
	2002	200 000 [62 000–620 000]	48
South and South-East Asia	2004	2.1 million [1.3–3.1 million]	30
	2002	1.8 million [1.1–2.7 million]	28
East Asia	2004	250 000 [120 000–400 000]	22
	2002	160 000 [79 000–250 000]	21
Oceania	2004	7100 [4100–11 000]	21
	2002	5000 [3000–7500]	18
Latin America	2004	610 000 [470 000–790 000]	36
	2002	520 000 [390 000–690 000]	35
Caribbean	2004	210 000 [120 000–380 000]	49
	2002	190 000 [110 000–360 000]	49
Eastern Europe and Central Asia	2004	490 000 [310 000–710 000]	34
	2002	330 000 [220 000–480 000]	33
Western and Central Europe	2004	160 000 [120 000–200 000]	25
	2002	150 000 [110 000–190 000]	25
North America	2004	260 000 [140 000–410 000]	25
	2002	240 000 [120 000–390 000]	25
TOTAL	2004	17.6 million [16.3–19.5 million]	47
	2002	16.4 million [15.2–18.2 million]	48

AIDS response needs to keep growing

There has been a sea-change in the global AIDS response since 2001. Global funding has increased from roughly US$ 2.1 billion to an estimated US$ 6.1 billion in 2004[†], and access to key prevention and care services has improved markedly (UNAIDS, 2004). The number of secondary-school students receiving AIDS education has nearly tripled, the annual number of voluntary counselling and testing clients has doubled, the number of women offered services to prevent mother-to-child transmission has increased by 70%, and the number of people receiving antiretroviral therapy has increased by 56%, according to a recent survey in 73 low- and middle-income countries which represent almost 90% of the global burden of HIV (Policy Project et al., 2004). Most people who need antiretroviral treatment in South America and some Caribbean countries now can access it. Efforts to expand treatment and care, including the “3 by 5” initiative of the World Health Organization, UNAIDS and their partners, hold the promise of further increases in coverage.

Despite the improvements, however, coverage remains uneven and, in several respects, highly unsatisfactory. Approximately 440 000 people in low- and middle-income countries were receiving antiretroviral treatment as of June 2004 (WHO, 2004). This means that nine out of every ten people who need antiretroviral treatment—the majority of them in sub-Saharan Africa—are not receiving it. If this low level of coverage

[†] Sources of funding include domestic spending (including public sector funds and spending by individuals and families affected by AIDS), bilateral donors (including, since 2003, the United States of America President’s Emergency Plan for AIDS Relief), multilateral agencies (including the United Nations system, World Bank and Global Fund to Fight AIDS, TB and Malaria), and the private sector (including foundations, international non-governmental organizations and the business community).

continues five to six million people will die of AIDS in the next two years (UNAIDS, 2004).

Ultimately, AIDS treatment will only be affordable and sustainable if HIV prevention is effective. And only then can the global spread of AIDS be halted. Enough is known about effective, cheap and relatively simple HIV programmes. Yet, in too many places such programmes are not being implemented. Less than 1% of adults aged 15–49 years are accessing voluntary counselling and testing services in the 73 low- and middle-income countries most affected by AIDS. Fewer than 10% of pregnant women are currently offered services of proven effectiveness to prevent HIV transmission during pregnancy and childbirth. Fewer than 3% of orphans and vulnerable children are receiving public support for most services (except in the Eastern European region where coverage is higher).

Countries in some regions still display a mismatch between AIDS spending priorities and the main epidemiological features of their epidemics. As a result, population groups such as injecting drug users and men who have sex with men are often neglected in AIDS activities, even in places where they are heavily affected by the epidemic. Overall, coverage of prevention programmes is very low for injecting drug users (fewer than 5% can access essential prevention services) and only 10% to 20% for sex workers, men who have sex with men, and street children (Policy Project et al., 2004). This stems largely from social discrimination and political indifference. Part of the problem, however, lies also with still-inadequate HIV surveillance systems—a shortcoming which is evident in every region and which is undermining countries' abilities to tailor their responses to an ever-evolving epidemic.

Business as usual spells disaster. A massive effort is needed to achieve a response on a scale that matches that of the global AIDS epidemic. Without invigorated HIV prevention strategies that deal boldly with the epidemic, and that also address the wider imperatives of social justice and equality, the world is unlikely to gain the upper-hand over AIDS in the long run.