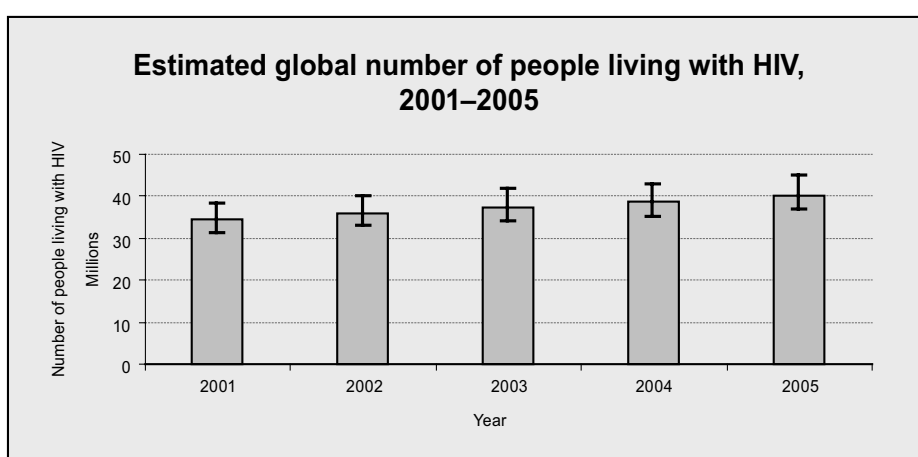


# INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) has killed more than 25 million people since it was first recognized in 1981, making it one of the most destructive epidemics in recorded history. Despite recent, improved access to antiretroviral treatment and care in many regions of the world, the AIDS epidemic claimed 3.1 million [2.8–3.6 million] lives in 2005; more than half a million (570 000) were children.

The total number of people living with the human immunodeficiency virus (HIV) reached its highest level: an estimated 40.3 million [36.7–45.3 million] people are now living with HIV. Close to 5 million people were newly infected with the virus in 2005.



**Figure 1**

There is ample evidence that HIV does yield to determined and concerted interventions. Sustained efforts in diverse settings have helped bring about decreases in HIV incidence among men who have sex with men in many Western countries, among young people in Uganda, among sex workers and their clients in Thailand and Cambodia, and among injecting drug users in Spain and Brazil. Now there is new evidence that prevention programmes initiated some time ago are finally helping to bring down HIV prevalence in Kenya and Zimbabwe, as well as in urban Haiti.

The number of people living with HIV has increased in all but one region in the past two years. In the Caribbean, the second-most affected region in the world, HIV prevalence overall showed no change in 2005, compared with 2003.

Sub-Saharan Africa remains hardest-hit, and is home to 25.8 million [23.8–28.9 million] people living with HIV, almost one million more than in 2003. Two thirds of all people living with HIV are in sub-Saharan Africa, as are 77% of all women with HIV (see pages 17-30). An estimated 2.4

million [2.1–2.7 million] people died of HIV-related illnesses in this region in 2005, while a further 3.2 million [2.8–3.9 million] became infected with HIV.

Growing epidemics are underway in Eastern Europe and Central Asia (see pages 45-53), and in East Asia. In the former, the number of people living with HIV has increased by one quarter (to 1.6 million) since 2003, and the number of AIDS deaths almost doubled (to 62 000) in the same period. In East Asia, the number of people living with HIV in 2005 increased by one fifth (to 870 000), compared with two years earlier.

The increase in the proportion of women being affected by the epidemic continues. In 2005, 17.5 million [16.2–19.3 million] women were living with HIV—one million more than in 2003. Thirteen and a half million [12.5–15.1 million] of those women live in sub-Saharan Africa. The widening impact on women is apparent also in South and South-East Asia (where almost two million women now have HIV) and in Eastern Europe and Central Asia.

<b>Regional HIV and AIDS statistics and features, 2003 and 2005</b>				
	<b>Adults and children living with HIV</b>	<b>Adults and children newly infected with HIV</b>	<b>Adult prevalence (%)*</b>	<b>Adult and child deaths due to AIDS</b>
<b>Sub-Saharan Africa</b>				
<b>2005</b>	25.8 million [23.8–28.9 million]	3.2 million [2.8–3.9 million]	7.2 [6.6–8.0]	2.4 million [2.1–2.7 million]
<b>2003</b>	24.9 million [23.0–27.9 million]	3.0 million [2.7–3.7 million]	7.3 [6.7–8.1]	2.1 million [1.9–2.4 million]
<b>North Africa and Middle East</b>				
<b>2005</b>	510 000 [230 000–1.4 million]	67 000 [35 000–200 000]	0.2 [0.1–0.7]	58 000 [25 000–145 000]
<b>2003</b>	500 000 [200 000–1.4 million]	62 000 [31 000–200 000]	0.2 [0.1–0.7]	55 000 [22 000–140 000]
<b>South and South-East Asia</b>				
<b>2005</b>	7.4 million [4.5–11.0 million]	990 000 [480 000–2.4 million]	0.7 [0.4–1.0]	480 000 [290 000–740 000]
<b>2003</b>	6.5 million [4.0–9.7 million]	840 000 [410 000–2.0 million]	0.6 [0.4–0.9]	390 000 [240 000–590 000]
<b>East Asia</b>				
<b>2005</b>	870 000 [440 000–1.4 million]	140 000 [42 000–390 000]	0.1 [0.05–0.2]	41 000 [20 000–68 000]
<b>2003</b>	690 000 [350 000–1.1 million]	100 000 [33 000–300 000]	0.1 [0.04–0.1]	22 000 [11 000–37 000]
<b>Oceania</b>				
<b>2005</b>	74 000 [45 000–120 000]	8200 [2400–25 000]	0.5 [0.2–0.7]	3600 [1700–8200]
<b>2003</b>	63 000 [38 000–99 000]	8900 [2600–27 000]	0.4 [0.2–0.6]	2000 [910–4900]
<b>Latin America</b>				
<b>2005</b>	1.8 million [1.4–2.4 million]	200 000 [130 000–360 000]	0.6 [0.5–0.8]	66 000 [52 000–86 000]
<b>2003</b>	1.6 million [1.2–2.1 million]	170 000 [120 000–310 000]	0.6 [0.4–0.8]	59 000 [46 000–77 000]
<b>Caribbean</b>				
<b>2005</b>	300 000 [200 000–510 000]	30 000 [17 000–71 000]	1.6 [1.1–2.7]	24 000 [16 000–40 000]
<b>2003</b>	300 000 [200 000–510 000]	29 000 [17 000–68 000]	1.6 [1.1–2.7]	24 000 [16 000–40 000]
<b>Eastern Europe and Central Asia</b>				
<b>2005</b>	1.6 million [990 000–2.3 million]	270 000 [140 000–610 000]	0.9 [0.6–1.3]	62 000 [39 000–91 000]
<b>2003</b>	1.2 million [740 000–1.8 million]	270 000 [120 000–680 000]	0.7 [0.4–1.0]	36 000 [24 000–52 000]
<b>Western and Central Europe</b>				
<b>2005</b>	720 000 [570 000–890 000]	22 000 [15 000–39 000]	0.3 [0.2–0.4]	12 000 <15 000
<b>2003</b>	700 000 [550 000–870 000]	20 000 [13 000–37 000]	0.3 [0.2–0.4]	12 000 <15 000
<b>North America</b>				
<b>2005</b>	1.2 million [650 000–1.8 million]	43 000 [15 000–120 000]	0.7 [0.4–1.1]	18 000 [9 000–30 000]
<b>2003</b>	1.1 million [570 000–1.8 million]	43 000 [15 000–120 000]	0.7 [0.3–1.1]	18 000 [9 000–30 000]
<b>TOTAL</b>				
<b>2005</b>	40.3 million [36.7–45.3 million]	4.9 million [4.3–6.6 million]	1.1 [1.0–1.3]	3.1 million [2.8–3.6 million]
<b>2003</b>	37.5 million [34.0–41.9 million]	4.6 million [4.0–6.0 million]	1.1 [1.0–1.2]	2.8 million [2.5–3.1 million]

## Regional HIV statistics and features for women, 2003 and 2005

		Number of women (15–49) living with HIV	Percent of adults (15–49) living with HIV who are women (%)
<b>Sub-Saharan Africa</b>	2005	13.5 million [12.5–15.1 million]	57
	2003	13.1 million [12.1–14.6 million]	57
<b>North Africa and Middle East</b>	2005	220 000 [83 000–660 000]	47
	2003	230 000 [78 000–700 000]	50
<b>South and South-East Asia</b>	2005	1.9 million [1.1–2.8 million]	26
	2003	1.6 million [950 000–2.4 million]	25
<b>East Asia</b>	2005	160 000 [82 000–260 000]	18
	2003	120 000 [59 000–190 000]	17
<b>Oceania</b>	2005	39 000 [20 000–62 000]	55
	2003	27 000 [14 000–43 000]	44
<b>Latin America</b>	2005	580 000 [420 000–770 000]	32
	2003	510 000 [370 000–680 000]	32
<b>Caribbean</b>	2005	140 000 [88 000–250 000]	50
	2003	140 000 [87 000–250 000]	50
<b>Eastern Europe and Central Asia</b>	2005	440 000 [300 000–620 000]	28
	2003	310 000 [210 000–430 000]	26
<b>Western and Central Europe</b>	2005	190 000 [140 000–240 000]	27
	2003	180 000 [150 000–220 000]	27
<b>North America</b>	2005	300 000 [150 000–440 000]	25
	2003	270 000 [130 000–400 000]	25
<b>TOTAL</b>	2005	17.5 million [16.2–19.3 million]	46
	2003	16.5 million [15.2–18.2 million]	47

## NEW DEVELOPMENTS

The epidemic continues to intensify in southern Africa (see pages 20–25). HIV infection levels among pregnant women are 20%—or higher—in six southern African countries (Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe). In two of them (Botswana and Swaziland), infection levels are around 30%. South Africa's epidemic,

in Zimbabwe, though infection levels in pregnant women remain exceptionally high (at 21% in 2004). Great effort will be needed to sustain the overall downward trend.

In East Africa, where historically HIV prevalence has been considerably lower than in countries

*Indications are that some of the treatment gaps will narrow further in the immediate years ahead, but not at the pace required to effectively contain the epidemic... gaining the upper-hand against AIDS epidemics around the world will require rapid and sustained expansion in HIV prevention.*

one of the largest in the world, shows no sign of relenting. In neighbouring Mozambique, HIV infection levels are rising alarmingly. There are hopeful signs of declining national HIV prevalence

further south, the decline in HIV prevalence among pregnant women seen in Uganda since the mid-1990s is now evident in urban parts of Kenya, where infection levels are dropping. In

both countries, behavioural changes probably have contributed to these trends. They remain exceptional cases, though: elsewhere in East (as in West and Central) Africa, HIV prevalence has remained stable in the past several years.

Several of the epidemics in Asia and Oceania are increasing (see pages 31-44 and 74-75), particularly in China, Papua New Guinea and Viet Nam.

However, over one million people in low-and middle-income countries are now living longer and better lives because they are on antiretroviral treatment. Because of the recent treatment scale-up since the end of 2003, between 250 000 and 350 000 deaths were averted in 2005. The full effects of the dramatic treatment scale-up during 2005 will only be seen in 2006 and subsequent years.

*Achieving universal access  
will require coordination of different approaches.*

There are also alarming signs that other countries—including Pakistan and Indonesia—could be on the verge of serious epidemics. Across Asia, the epidemics are propelled by combinations of injecting drug use and commercial sex. Only a handful of countries are making serious-enough efforts to introduce programmes focusing on these risky behaviours on the scale required. The same applies in Eastern Europe and Central Asia, where the number of people living with HIV rose in 2005, and in the Americas, where growing numbers of women, especially those living in poverty, are being affected (see pages 45-52 and 65-69).

## **NARROWING THE GAPS**

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AIDS responses have grown and improved considerably over the past decade. But they still do not match the scale or the pace of a steadily-worsening epidemic.

In the past two years, access to antiretroviral treatment has improved markedly. It is no longer only in the wealthy countries of North America and Western Europe that persons in need of treatment have a reasonable chance of receiving it. Treatment coverage in countries such as Argentina, Brazil, Chile and Cuba now exceeds 80%. Despite progress in some places, however, the situation is different in the poorest countries of Latin America and the Caribbean, in Eastern Europe, most of Asia and virtually all of sub-Saharan Africa. At best, one in ten Africans and one in seven Asians in need of antiretroviral treatment were receiving it in mid-2005.

Indications are that some of the treatment gaps will narrow further in the immediate years ahead, but not at the pace required to effectively contain the epidemic. It has long been recognized that gaining the upper hand against AIDS epidemics around the world will require rapid and sustained expansion in HIV prevention. In fact, the goal must be to ensure that countries everywhere come as close as possible to achieving universal access to HIV prevention, treatment, care and impact mitigation.

Achieving universal access will require coordination of different approaches. Prevention, treatment, care and impact mitigation goals will have to be pursued simultaneously, not sequentially or in isolation from each other. Countries will need to focus on programme implementation, including strengthening of human and institutional resources, and initiate strategies that allow for the greatest possible level of integration of services.

All of this must be done with great urgency. But it forms part of a larger, more long-term challenge. Bringing AIDS under control will require tackling with greater resolve the underlying factors that fuel these epidemics—including societal inequalities and injustices. It will require overcoming the still serious barriers to access that take the form of stigma, discrimination, gender inequality and other human rights violations. It will also require overcoming the new injustices created by AIDS, such as the orphaning of generations of children and the stripping of human and institutional capacities. These are extraordinary challenges that demand extraordinary responses.