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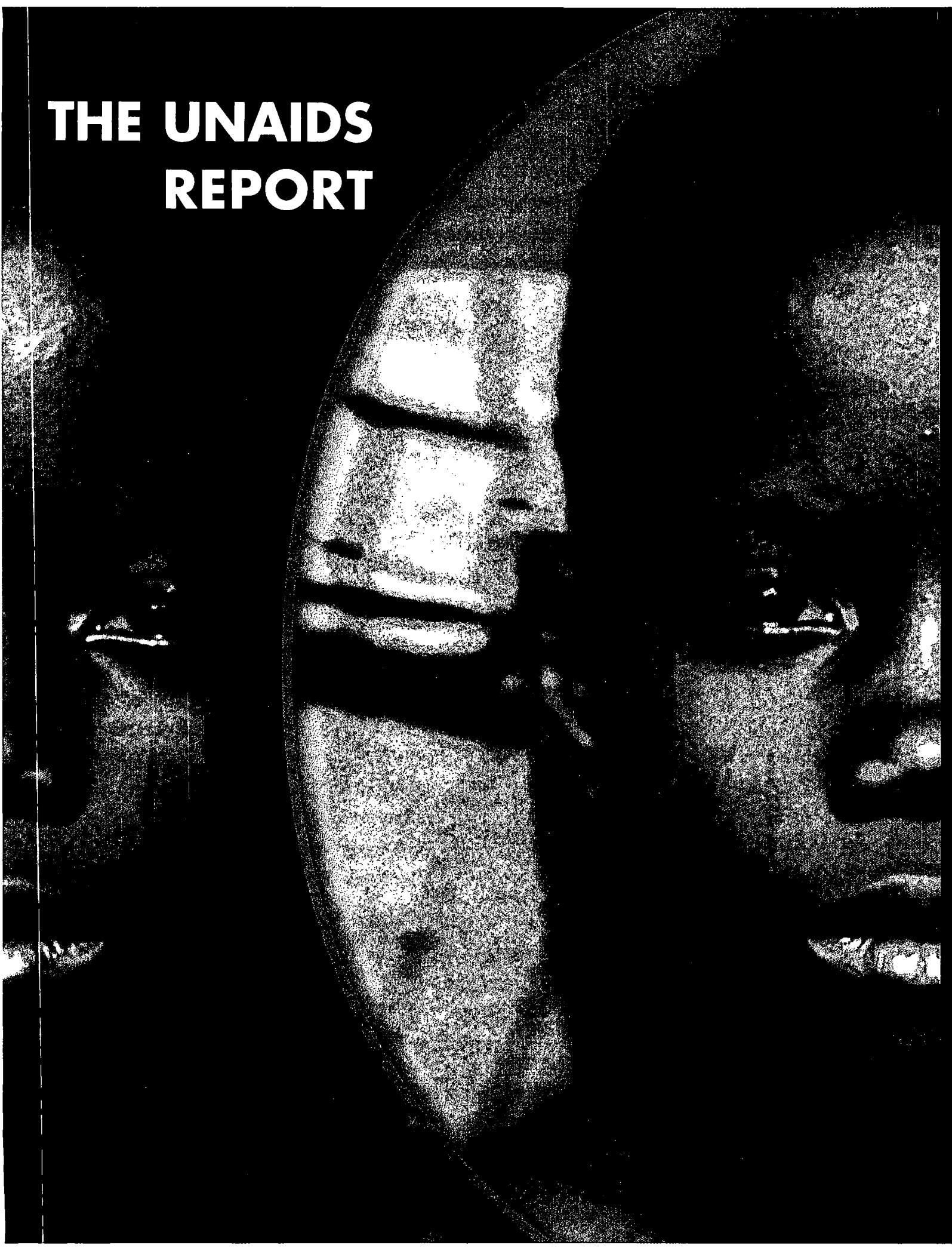
THE UNAIDS REPORT



Johannesburg, 30 November 1998

en français
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AIDS in Africa

Africa continues to dwarf the rest of the world on the AIDS balance sheet. According to UNAIDS and WHO estimates, 7 out of 10 people newly infected with HIV in 1998 live in sub-Saharan Africa; among children under 15, the proportion is 9 out of 10. Of all AIDS deaths since the epidemic started, 83% have been in the region. At least 95% of all AIDS orphans have been African.* Yet only one-tenth of the world's population lives in Africa south of the Sahara.

The sheer number of Africans affected by the epidemic is overwhelming. Since the start of the epidemic, an estimated 34 million people living in sub-Saharan Africa have been infected with HIV. Some 11.5 million of those people have already died, a quarter of them children. In the course of 1998, AIDS will have been responsible for an estimated two million funerals in Africa.

By the end of 1998, there will be an estimated 21.5 million men and women living with HIV in Africa, plus another 1 million children. Some 4 million of these people will have contracted the infection in 1998 alone.

Hot-spots of **infection**

No country in Africa has escaped the virus, and yet some are far worse affected than others. The bulk of new infections continue to be concentrated in East Africa and especially in the southern part of the continent.

The southern African region in fact holds the majority of the world's hard-hit countries:

- In Botswana, Namibia, Swaziland and Zimbabwe, current estimates show that over one person in five between the ages of 15 and 49 is living with HIV or AIDS.

- Zimbabwe is especially hard-hit. There are 25 surveillance sites in the country where blood taken from pregnant women is tested anonymously as a way of tracking HIV infection. The most recent data, from 1997, show that HIV prevalence remained below 10% in just two of these sites. In the remaining 23 sites, between a fifth and half of all pregnant women were found to be infected with HIV. At least a third are likely to pass the infection on to their baby.

- South Africa trailed behind some of its neighbours in HIV infection levels at the start of the 1990s. Unfortunately, it is catching up fast. This year, just over 50% of all new infections in southern Africa occurred in this one country.

- In South Africa, as in Malawi, Mozambique, Rwanda and Zambia, between one in seven and one in nine adults live with HIV infection.

- In Central African Republic, Côte d'Ivoire, Djibouti and Kenya, at least one in ten adults are HIV-infected.

(Source: Department of Health, South Africa)

In general, West Africa is less affected by HIV than southern or East Africa. Some countries in central Africa have also seen HIV remain relatively stable, while in neighbouring countries rates have continued to climb.

Early and sustained prevention efforts can be credited with these lower rates in some places- Senegal provides a good example. But elsewhere, where far less has been done to encourage safer sex, the reasons for the relative stability

remain obscure. Research is under way to explain differences between epidemics in various countries. Factors that may play a role include patterns of sexual networking, levels of condom use with different partners, and promptness in diagnosing and curing other sexually transmitted diseases (which if left untreated can magnify the risk of HIV transmission through sex as much as 20-fold).

Young people in **danger**

In the worst-affected countries, young people are especially at risk. In sub-Saharan Africa, as in many countries in the industrialized world and elsewhere, people embark on their sexual lives when they are in their teens-often in their early or mid-teens. In Kenya, for example, one study of nearly 10 000 schoolgirls between the ages of 12 and 24 reported that on average, girls lose their virginity when they are between 14 and 15 years old. And yet to date, there is no reproductive health education in schools that would prepare girls to avoid early sex or to adopt safer sexual practices.

The Population Reference Bureau estimates that every year babies are born to 14% of young women aged 15-19 in sub-Saharan Africa, compared with 6% of young women in other less developed countries and just 3% in the industrialized world. Many of these births are outside of marriage. A recent study in Namibia showed that close to 40% of births were to unmarried women. Single motherhood was not associated with ignorance or marginalization-over a third of single mothers were educated to secondary level or beyond, compared with just over a quarter of married mothers.

High levels of teen pregnancy, and pregnancy outside of marriage, do tell us two things: young people are very sexually active, and few of them use condoms. If young people are having unprotected sex with several partners, or if their single partner has ever had other partners, they are exposed not just to pregnancy but to infection with sexually transmitted diseases, including the one that can kill them: HIV.

Recent HIV surveillance data show how early this exposure can occur and how devastating its consequences can be. In Rwanda, over 4% of both boys and girls aged 12-14 in one community study already tested positive for HIV. In South Africa, the number of pregnant girls under 15 tested for HIV in 1997 was relatively small, but a distressing 9.5% of them were found to be infected with the virus. Among the far greater number of pregnant South Africans tested in their late teens, nearly 13% were HIV-positive.

Often, girls become infected at younger ages than boys. A recent community-based study in one area of Kenya showed that 22% of 15-19-year-old girls in the general population were already infected with HIV, compared with just 4% of boys of the same age. In a Zambian study of young city-dwellers in the same age group, HIV infection was reported in 12.3% of the girls and 4.5% of the boys. In the next-higher age bracket, 20-24 years, a study in Ethiopia found that 35.4% of young women were infected-three times higher than the 10.7% rate among the men.

This age gap at infection indicates that young girls are getting infected through sex with older men. Many girls may choose such relationships because they come with gifts, money or other favours attached. But some will simply have been powerless to resist. In Kenya, one young woman in four said she lost her virginity because she had been forced to. In the Democratic Republic of Congo, the proportion was close to a third. Unwilling sex with an infected partner carries a high risk of HIV infection for girls. When the vagina is dry or when force is used, abrasions and cuts are more likely and the virus can more easily find its way into the bloodstream. What's more, condom use is unlikely in such situations.

(Source: Taha et al. AIDS 1998 12:197-203)

As infection rises in the general population, so does the likelihood of encountering an infected partner (especially an older partner) early in one's sexual career. Over time, then, new infections become increasingly concentrated in the youngest age groups. In a recent study in Malawi, HIV prevalence had built up to high levels in older age groups, but the bulk of new infections were occurring in younger women.

People continue to be at risk for HIV throughout their sexually active lives, and all should benefit from services and information that allow them to reduce their risk of infection. However, efforts to promote safer behaviour are especially crucial for young people, who in mature epidemics are those

at greatest risk. Prevention efforts also seem to have a greater chance of success among younger people than among people whose sexual habits are well ingrained. For example, following active condom promotion and education campaigns in school and among youth groups, dramatic declines have been recorded in infection rates among teenagers in Uganda and Tanzania.

HIV and AIDS -making themselves felt

HIV can spread silently for many years before the infection develops into symptomatic AIDS and becomes a cause of recurring illness and, finally, death. During 1998 Africa held 5 500 funerals a day for people dying of AIDS, but the death rate is set to increase. Countries where the epidemic is rather recent, such as South Africa, are still far from feeling the major impact of AIDS, despite already high levels of HIV in the general population. But South Africans can anticipate the likely impact by looking at countries where the epidemic has been longer established-Uganda in East Africa, Zambia and Zimbabwe in southern Africa. Millions of adults are dying young or in early middle age. They leave behind children grieving and struggling to survive without a parent's care. Many of those dying have surviving partners who are themselves infected and in need of care. Their families have to find money to pay for their funerals, and their employers-schools, factories, hospitals-have to train other staff to replace them at the workplace.

Children on the brink

Africa is experiencing a growing tide of children living in AIDS-affected households or attempting to survive after the death of their mother, or both parents, to AIDS. Often, the

extended family- itself decimated by AIDS-can or will no longer cope. But institutions are not the answer either, not to a problem of this scale. Solutions have to be found in the community.

In Zimbabwe, people are rising to the challenge. Many village heads have designated land to be cultivated by all villagers to feed orphans and families of those suffering from debilitating illness, usually AIDS-related. In some areas, church groups have begun orphan-visiting programmes. Women are trained to identify the neediest orphan households in their area; they then visit them on a regular basis, providing all-important guidance and emotional support and helping with basic necessities. Because these programmes work from within the community they are affordable, costing an average of just 68 US cents per child per month-a small price to pay for a service that will help keep orphans woven into the fabric of society. Fostering initiatives have also begun on commercial farms.

The challenge to business

Since many economies in the region are in flux, it is hard to determine exactly what the impact of HIV is on national economies as a whole. However it is clear that businesses are already beginning to suffer. In Zimbabwe, for instance, life insurance premiums quadrupled in just two years because of AIDS deaths. Some companies report a doubling of their health bills. In Botswana, companies estimate that AIDS-related costs will soar from under one percent of the wage bill now to five percent in six years' time, because of the rapid rise in infection in the last few years. In Zambia, one large company reported in 1995 that its costs from AIDS illness and death exceeded its total profits for the year. There is a similar report from a large Tanzanian company.

Prevention programmes for workers have been shown to cut costs as well as infections in Africa. While costs vary significantly between countries, it is estimated that a worker with AIDS costs a business in southern Africa around US$ 200 a year in lost productivity, treatment, benefits and replacement training. The costs for senior and skilled staff

will be far higher. And yet a study in Tanzania has demonstrated that treatment of other sexually transmitted diseases costing as little as US$ 2.11 per case can cut the number of people getting HIV by over 40%. New HIV infections in Zimbabwean factories with worker-driven prevention campaigns were a third lower than in factories without such campaigns. The campaigns cost US$ 6.00 per worker-less, in other words, than a single set of protective overalls.

Caring for orphans on Zimbabwe's commercial farms

Some 2 million people-a fifth of the nation's population-live on Zimbabwe's commercial farms. Many are immigrants or the children of immigrants, and many more are Zimbabweans who have moved there from their native villages. Because the majority no longer have any regular contact with their extended families back home, this leaves children with no one to take them in if their parents should die-an increasingly frequent occurrence. A survey at the beginning of 1996 estimated 2.1 orphans per farm. Now a new registration system shows that numbers have climbed to around 10 orphans per farm. The average age of these children is 10.

That is the downside. The upside is that many farm owners are increasingly concerned about the welfare of farm workers and their families, and are supporting initiatives to care for these orphans on their farms. Most of these initiatives centre on finding other farm families to foster abandoned children and orphans. This is more difficult than it sounds, since many people believe orphaned children will bring bad luck.

"After two months my husband wanted me to turn the children away," recounted Monica Kamombe, who, with limited support from the farmer who employs her, provides a home for four orphaned brothers. "Everyone in the village came knocking at the door to say if we kept these unlucky children the ngozi, the bad spirits, would get us". She persisted and now others in the village have followed her example.

The country will need many, many more caring foster parents like Mrs Kamombe. In two years' time, because of AIDS the country will be burying some 350 people a day,

and by the year 2005 the government estimates there will be over 900 000 children under 15 struggling to survive without a mother.

A hard-to-break silence

For all the palpable effects of AIDS, a silence born of shame and blame continues to shroud the epidemic in many of even the hardest-hit countries.

A recent study of voluntary counselling and testing offered to pregnant women in developing countries found that in many places with extremely high HIV prevalence, women refused testing or did not return for their test results. This was the case even when interventions that might help them give birth to a healthy baby were being offered to those who tested HIV-positive. In Côte d'Ivoire, for instance, fewer than half of more than 13 000 pregnant women in two study sites accepted to be tested and then came back for their results. More worrying still, in a majority of sites it was the HIV-positive women who were less likely to return. This correlation was seen in South Africa's Soweto, too, where almost all pregnant women in the study agreed to be tested, four-fifths overall came back for their test results, but only half of those who were HIV-positive sought out their results. These systematic differences suggest that women who may be aware that they have been exposed to infection, or who have taken risks, shrink from learning their HIV status.

There is evidence that the fear and denial provoked by AIDS extends even to people working in the health sector. One study in southern Africa sought to record the number of needlestick injuries in primary health care clinics. Researchers found almost none-an unlikely scenario in overworked clinics with poor facilities. Senior staff then explained that, under clinic policy, anyone who reported a needlestick injury had to undergo HIV testing to measure the danger of sero-conversion through exposure to infected needles. Nurses did not report needlestick injuries because they did not want to be tested.

Silence can continue to reign even when people with HIV are ill and dying. Because AIDS is just the name for a cluster of diseases that immunodeficient people develop, patients and their carers can choose to view the illness as just tuberculosis, or diarrhoea, or pneumonia. An example from southern Africa is telling. In one study of home-based care schemes, fewer than 1 in 10 people who were caring for an HIV-infected patient at home acknowledged that their relative was suffering from AIDS. Patients themselves were only slightly more likely to acknowledge their status.

"For too long we have closed our eyes as a nation, hoping the truth was not so real," South African Deputy President Thabo Mbeki told South Africans in October. "At times we did not know that we were burying people who had died from AIDS. At other times we knew, but chose to remain silent."

With this major speech, South Africa's leadership joined those who have spoken out loudly and clearly about AIDS, have sought to demystify it, and have encouraged discussion about safe sex everywhere from the classroom to the boardroom. It is in such countries-of which Uganda is probably the best known example in the developing world-that most progress has been made not just in putting a brake on new infections but in ensuring the wellbeing of those people who are already living with the virus.

Act before it is too late

In Madagascar, an island of 16 million people, HIV is just beginning to raise its head. Surveillance among pregnant women shows exceptionally low levels of infection-perhaps 1 in 5000 (as compared with 1 in 4 in some countries in sub-Saharan Africa, off whose south-eastern coast Madagascar lies). Even among sex workers and patients with other sexually transmitted infections, HIV rates are negligible. An island nation with no need for HIV prevention programmes? Far from it. Madagascar may have been protected by its relative isolation from an early onslaught of HIV, but the high levels of risk in the population are sending alarm bells ringing. The time to act is now.

According to behavioural surveys, sex starts young (at around 15 for the majority of women) and premarital pregnancy is common. Some 14% of pregnant women in a recent survey reported casual partners, and over 9 out of 10 never used condoms in those encounters. Most patients at STD clinics were married, but 16% reported regular extramarital partners and another 14% reported casual partners. Fewer than 10% consistently use condoms in any of these relationships.

STD microbes are already finding plenty of scope for spread. Some 10% of pregnant woman tested positive for syphilis in the most recent round of surveillance-an unusually high rate. Around 15% of STD clinic patients had syphilis. Among sex workers syphilis prevalence ranged up to 28%-not surprising, considering that 35% of sex workers say they never use condoms with any type of clients, and nearly two-thirds never use them with regular partners. Only 14% report using condoms with all of their sex work clients. The potential scope for both STD and HIV spread is alarming.

The government and nongovernmental partners are responding actively. For example, special reproductive health services for 10 to 24-year-olds have been set up in youth centres around the country. The aim is to use these special youth-friendly clinics to spread the word about HIV and to instil a norm of safe behaviour quickly, before the virus can take hold.

For more information, please contact Anne Winter, UNAIDS, Geneva, mobile (+41 79) 213.4312, Richard Delate, UNAIDS, Johannesburg, (+27 12) 338 5294, mobile (+27 82) 902 0256, Lisa Jacobs, UNAIDS, Geneva, (+41 22) 791.3387 or Karen O'Malley, UNAIDS, New York, (+1 212) 899.5575. You may also visit the UNAIDS Home Page on the Internet for more information about the programme (http://www.unaids.org).

Johannesburg, 30 November 1998

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UNAIDS Executive Director warns of Unprecedented Emergency in Southern Africa

Speaking in Johannesburg on the eve of World AIDS Day, Peter Piot, the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), warned that southern Africa is facing an unprecedented emergency as the numbers of people becoming infected with HIV continue to climb at alarming rates in many countries of the region.

This year, 1.4 million people between the ages of 15 and 49 were infected in the nine countries of southern Africa. Nearly three-quarters of a million of these new infections - just over 50% -- were in South Africa alone.

In the four worst-affected countries of the region -- Botswana, Namibia, Swaziland and Zimbabwe - between 20% and 26% of adults in this age group are now estimated to be living with HIV or AIDS, and other countries are catching up fast. Zimbabwe is especially hard-hit. In 23 HIV surveillance sites out of a total of 25, between 25% and 50% of all pregnant women were found to be infected with HIV. At least a third are likely to pass the infection on to their babies.

"We now know that despite these already very high levels of HIV infection the worst is still to come in southern Africa. The region is facing human disaster on a scale it has never seen before", said Dr Piot.

A development **disaster**

In African countries with long-standing epidemics, the death toll from HIV is mounting as people who were infected many years ago develop the life-threatening illnesses typical of the end-stage of HIV infection known as AIDS. Altogether, in 1998 alone, 2 million people died of AIDS in Africa south of the Sahara, and millions of new HIV infections are occurring every year, foreshadowing even greater repercussions from the epidemic.

Whether measured against the yardstick of falling life expectancy, deteriorating household income, overburdened health systems, child deaths, orphanhood, or bottom-line losses to business, AIDS has never posed a bigger threat to development :

- In the world's nine most-affected countries (all of them located in Africa) where at least a tenth of the adult population has HIV, a child born in 2000-2005 can expect to survive only to the age of 43, instead of to age 60 as would have been expected in the absence of AIDS.

- By the first decade of next century Namibia's infant mortality rate would normally have fallen to 45 per 1000; instead, the epidemic will raise it to 72 per 1000. Already by 1996, the direct and indirect costs of AIDS represented around 8% of Namibia's gross domestic product, and the figure is set to rise much higher.

- In Côte d'Ivoire's urban households where the breadwinner has AIDS, calculations show that family income is cut by two-thirds and consumption goes down, notably for schooling, which drops by more than 50%.

- Because of AIDS, Zimbabwe expects to be burying 350 people a day in just two years' time and to have over 900 000 AIDS orphans under age 15 struggling to survive without their mothers by the year 2005. By then, AIDS patients will be occupying two-thirds of the country's public hospital beds.

Businesses are suffering, too. While costs vary significantly

between countries, it is estimated that a worker with AIDS costs a business in southern Africa around US$ 200 per year in lost productivity, treatment, benefits and replacement training. The costs for senior and skilled staff are far higher. In labour-intensive companies in Kenya, such as the transport sector, AIDS costs translated into 6% of all profits by 1994 and will represent around 15% of profits by 2005. By the same year, South African firms will be paying out AIDS-related employee benefits equivalent to 19% of salaries, up from 7% in 1995.

"More and more reports are reaching us of the bottom-line impact of AIDS in Africa", says Dr Piot. "Companies in hard-hit countries are losing trained staff at rates unheard of in the industrialized world. Extra staff are hired in anticipation of workforce losses to AIDS. Profits are eaten up by health care costs and work-hours lost to illness and attendance at funerals."

Young people in **danger**

In sub-Saharan Africa, as in many countries elsewhere, people often embark on their sexual lives in their early teens. In Kenya, for example, one study of nearly 10 000 schoolgirls aged 12-24 found that, on average, girls first have sex when they are between 14 and 15 years old. This early exposure is increasingly being seen to have devastating consequences. In South Africa, for example, a study of pregnant teenagers aged 15-19 found nearly 13% to be HIV-positive; among those under age 15, already 9.5% were infected.

Yet sexual health education is now proven to be effective in reducing infection risks - especially among young people, who can adopt safer behaviour from the start of their sexual lives. In countries such as Uganda and Tanzania, dramatic declines in infection rates among teenagers are now being recorded following successful condom promotion and AIDS education campaigns in school and in the community.

"The tragedy is that young people are being infected in increasing numbers, and yet it is with young people that prevention efforts are most successful", said Dr Piot.

Overcoming silence and denial

Southern Africa can also point to successful initiatives in prevention, care and support. In hard-hit villages, creative schemes are being devised for setting aside land to be cultivated to feed orphans and AIDS-affected households. Prevention efforts in the workplace are not only effective, they are also cost-effective. A recent study in Zimbabwe showed that prevention campaigns in factories costing just US$ 6 per worker significantly reduced the number of new infections.

But the shame associated with AIDS continues to blocks progress by making people reluctant to talk about HIV, recognize the risks and confront the epidemic openly. Political leaders can be slow to acknowledge the threat facing their country. Ordinary citizens may hesitate to raise the issue of condom use with their spouse for fear of acknowledging HIV infection. Pregnant women can be reluctant to learn about their HIV status even when offered zidovudine (AZT) and other support to help them give birth to a healthy baby. For example, when voluntary counselling and HIV testing were offered to pregnant women in South Africa's Soweto, almost all accepted testing, four-fifths overall returned to find out their HIV status, but only half of those who tested positive came back for their test results.

The visible causes of illness in severely immunodeficient people are often diseases such as tuberculosis and pneumonia which are also common in HIV-negative individuals. Because of this unusual feature of AIDS, the silence that surrounds the epidemic can persist even when AIDS patients are ill and dying. A recent study in southern Africa showed that fewer than 1 in 10 people caring for an HIV-infected relative at home acknowledged that the person was suffering from AIDS, and the patients themselves were only marginally more likely to speak about the underlying cause of their illness.

"All too often we know what needs to be done, but we do not

act on this knowledge. We need to help people find ways to overcome the discomfort they feel when talking about sexual issues and HIV infection. We need to bring AIDS out into the open", said Dr Piot.

The head of UNAIDS welcomed the recent move to greater openness about AIDS in Zimbabwe, where the Head of State has publicly expressed concern about the scale of the epidemic and called for more action to counter it. In Botswana and South Africa, appeals for greater awareness and openness by the top leadership have been coupled with a decision to step up government funding on AIDS. The challenge now will be to translate these into effective prevention and care programmes.

For more information, please contact Anne Winter, UNAIDS, mobile (+41 79) 213.4312, Richard Delate, UNAIDS, Johannesburg, (+27 12) 338.5294, mobile (+27 82) 902.0256, Lisa Jacobs, UNAIDS, Geneva, (+41 22) 791.3387 or Karen O'Malley, UNAIDS, New York, (+1 212) 899.5575.
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Paris, Wednesday, June 24, 1998

AIDS Is on Course To Ravage Africa

UN Agency Issues Grim Report: Some Areas Face 25% Infection

By Lawrence K. Altman *New York Times Service*

GENEVA - AIDS is hitting Africa so fiercely that it now rivals history's greatest and deadliest epidemics - plague in the Middle Ages and influenza in 1918-1919, United Nations officials said Tuesday.

They also said the AIDS epidemic would worsen before it improved.

The overwhelming majority of the 30 million people infected with HIV, the virus that causes AIDS, are doomed to die because they live in countries that cannot provide adequate health care.

National leaders will have to take tougher stands than they have in the past to institute effective prevention programs, which take many years to get into full gear, the UN officials said.

At a news conference here, Unaids officials painted one of the gloomiest pictures of the HIV epidemic since it was first recognized in 1981.

HIV now infects one in four adults in two African countries, Botswana and Zimbabwe. HIV infection rates exceed one-third of the adults in some major African cities and reach 70 percent of women tested in prenatal clinics. Many infected women pass the virus on to their babies.

Countries south of the Sahara account for the world's 21 highest rates of HIV among adults aged 15 to 49, the most sexually active segment of the population. In 13 of the countries, HIV has infected at least 10 percent of adults.

South Africa, Namibia and other countries could soon reach a 25 percent adult infection rate unless national leaders initiate strong prevention programs similar to those in Senegal, Tanzania, Thailand and Uganda, UN officials said.

Worldwide, 5.6 million people were infected last year, while 2.3 million died from AIDS. Of the 30 million people living with HIV, 21 million are in Africa and 90 percent do not know they are infected because testing is not widely available. Nearly all are doomed to die from AIDS because few can afford basic care, including the costly combinations of drugs that have helped keep the virus in check among HIV-infected people in developed countries.

AIDS is now on the verge of moving into the top five leading causes of death in the world, overtaking diarrheal diseases. AIDS kills as many people as malaria, and is second only to tuberculosis. But tuberculosis is a common complication of AIDS.

The African figures compare to a worldwide adult HIV infection rate of 1 percent for adults. The rate is 0.76 percent in the United States and 0.33 percent in Canada.

The figures come from the first country-by-country analysis of the global AIDS epidemic that Unaids released ahead of the 12th international AIDS conference that begins here Sunday. The Unaids program is run by several United Nations agencies, the World Health Organization and the World Bank.

Dr. Peter Piot, head of the Unaids Program; Bernhard Schwartlander, the UN epidemiologist who led the analysis, and Dr. David Heymann, a WHO official, all said in separate interviews that the new report provides convincing evidence that AIDS rivals the great epidemics of history.

Plague, the Black Death of the Middle Ages, killed 20 million people, or one-quarter of Europe's population, in four years. In 1918-1919, a worldwide influenza epidemic killed 20 million people.

Plague and influenza can kill in days, but death from untreated AIDS can take a decade.

AIDS is a more silent epidemic, Dr. Piot said, because the massive, long-term mortality from AIDS has less of a visible impact on society than the sudden deaths of the plague and influenza type epidemics.

"If HIV killed as rapidly as plague and influenza, the epidemic would be controlled by now," Dr. Piot said.

But the AIDS epidemic, Dr. Schwartlander said, "has no end in sight."

Dr. Piot, a Belgian who has worked with AIDS in Third World countries for more than 15 years, called the new HIV figures staggering. He said he was "shocked" when he learned that 25 percent of an entire country's adults were infected.

At that time, both Dr. Piot and Dr. Schwartlander said they questioned a statistical error. But checks found the statistics to be accurate, erring on the side of underestimates, the doctors said.

It took the Unaids program more than a year to gather and verify the figures with each country, and its figures on AIDS are considered the most reliable of any international health statistics. Health officials have long been hampered in getting a handle on such information by the notoriously poor quality of health statistics in most of the world.

The report also includes the first country-by-country information about availability and use of condoms and reported nonregular sexual partnerships.

The UN report cites successes in Senegal, Tanzania, Thailand and Uganda as evidence that strong prevention programs could reverse the HIV epidemic.

Uganda was the first country to respond to a huge burden of HIV infection, and cut HIV prevalence to 9.5 percent in 1997 from 13 percent in 1994.

Thailand, which has experienced what the UN said was probably the best-documented epidemic in the developing world, cut its prevalence to 2.3 percent in 1997 from 2.7 percent in 1994. A drop in new infections was noted especially among sex-trade workers and their clients.

"Even in the industrialized world, reductions of this magnitude are virtually unheard of," Dr. Piot said.

Senegal instituted campaigns for safer sex that have kept its rate of HIV prevalence low at about 2 percent. "Senegal acted before it had a major problem, but there are not enough of those countries," Dr. Piot said.

Matching such efforts elsewhere will take more than money, Dr. Piot said. "The overriding need is political courage - deciding to move ahead with effective approaches despite cultural constraints, such as

promotion of condom use, sex education in schools and widespread health education programs," he said.

Last year, deaths from AIDS left 1.6 million children without at least one parent. From 1981 to the beginning of 1998, 8.2 million children lost their mothers to AIDS.

In East Africa, 40 percent of children aged 15 or younger have lost their mother or both parents.

"As the number of orphans grows and the number of potential caregivers shrinks," the UN report said, "traditional coping mechanisms stretch to the breaking point."

The Unaids program cited four reasons for the high infection rates in Africa.

One is that more women of childbearing age are infected with HIV in Africa than elsewhere.

A second is that African women have more children on average than those on other continents. Thus, one infected woman may pass the virus on to a higher number of children.

A third reason is that nearly all children in Africa are breast-fed. Breast-feeding is thought to account for between a third and a half of all HIV transmission from mother to child.

A fourth reason is that new drugs are less readily available in Africa than in industrialized world.

The United Nations said the figures for Asia, where HIV is a latecomer, are less reliable than elsewhere because only a few Asian countries have developed sophisticated systems for monitoring the spread of the virus.

India has the largest number of HIV-infected people - 4 million - in the world.

With a vaccine against HIV a distant hope, Dr. Piot said, "AIDS is with us to stay for a long time."

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UNAIDS '99 DATA

EMBARGOED TILL JUNE 30th

(RELEASED TO BE PRESENTED AT DURBAN)

FYI !! EMBARGOED TILL JULY 2000 (AFTER AIDS CONF.)

Country	Population 1999		Estimated number of people living with HIV/AIDS, end 1999						Estimated AIDS Deaths		Orphans
	Total (thousands)	Adults 15-49 (thousands)	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)	Young People (15-24)	Adults and children 1999	Adults and children, cumulative	Orphans Cumulative
Western Europe	401,675	191,841	530,000	530,000	0.23	130,000	4,100	0	6,800	170,000	8,700
Albania	3,126	1,662	<100	<100	0.003				<100	<100d	
Austria	8,169	3,965	9,000	9,000	0.23	2,000	<100		<100	1,200d	
Belgium	10,146	4,801	7,700	7,400	0.15	2,600	300		<100	1,700d	
Denmark	5,279	2,469	4,300	4,300	0.17	900	<100		<100	1,800d	
Finland	5,162	2,401	1,100	1,100	0.05	300	<100		<100	280d	
France	58,868	28,245	130,000	130,000	0.44	35,000	1,000		2000	39,000d	
Germany	82,108	38,328	37,000	37,000	0.10	7,400	500		600	16,000d	
Greece	10,614	5,122	8,000	8,000	0.16	1,600	<100		<100	1,600d	
Iceland	278	142	200	200	0.14	<100	<100		<100	<100d	
Ireland	3,706	1,924	2,200	2,000	0.10	600	170		<100	350d	
Italy	57,306	27,083	95,000	95,000	0.35	30,000	700		1000	34,000d	
Luxembourg	426	209	330	330	0.16				<100	<100d	
Malta	386	191	220	220	0.12				<100	<100d	
Netherlands	15,721	7,794	15,000	15,000	0.19	3,000	100		100	5,000d	
Norway	4,442	2,092	1,600	1,600	0.07	360	<100		<100	520d	
Portugal	9,871	4,872	37,000	36,000	0.74	7,000	500		280	4,800d	
Slovenia	1,987	1,008	200	200	0.02	<100	<100		<100	<100d	
	39,618	20,062	130,000	130,000	0.65	25,000			2000	41,000d	
Sweden	8,868	3,925	3,000	3,000	0.08	600	<100		<100	2000d	
Switzerland	7,337	3,582	17,000	17,000	0.46	5,500	<100		150	5,600d	
TFYR Macedonia	2,012	1,034	<100	<100	0.00	<100	<100		<100	<100d	
United Kingdom	58,725	27,390	31,000	30,000	0.11	6,700	500		450	15,000d	
Yugoslavia	10,625	5,202		5,000*	0.10*						
North Africa & Middle East	336,496	171,943	210,000	200,000	0.13	40,000	7,000		13,000	42,000	14,000
Algeria	30,788	15,998		11,000*	0.07*						
Bahrain	605	337		500*	0.15*						
Cyprus	778	382		400	0.26*						
Egypt	67,232	34,342		6,100	0.02	850	110		930	5,400	750
Iraq	22,511	10,850		300*	<0.005*						
Israel	6,087	3,024		2,600*	0.07*						
Jordan	5,482	3,120		660*	0.02*						
[illegible]	1,916	1,051		1,100*	0.10*						
Lebanon	3,227	1,729		1,500*	0.09*						
Libyan Arab Jamahiriya	5,477	2,790		1,400*	0.05*						
Morocco	27,874	15,147		5,000*	0.03*						
Oman	2,465	1,094		1,200*	0.11*						

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	Population 1999		Estimated number of people living with HIV/AIDS, end 1999						Estimated AIDS Deaths		Orphans
Country	Total (thousands)	Adults 15-49 (thousands)	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)	Young People (15-24)	Adults and children 1999	Adults and children, cumulative	Orphans Cumulative
Qatar	589	308		300*	0.10*						
Saudi Arabia	20,936	9,539		1,100*	0.01*						
Sudan	28,915	14,226		140,000*	0.96*						
Syrian Arab Republic	15,740	7,766		600*	0.01*						
Tunisia	9,457	5,179		2,200*	0.04*						
Turkey	65,528	36,198		2,500	0.01						
United Arab Emirates	2,395	1,250		2,400*	0.19*						
Yemen	17,494	7,613		900*	0.01*						
sub-Saharan Africa	596,272	273,488	24,500,000	23,400,000		12,900,000	1,000,000		2,200,000	14,200,000	
Angola	12,497	5,389	160,000	150,000	2.78	82,000	7,900		15,000	110,000	19,000
)	5,945	2,730	70,000	67,000	2.45	37,000	3,000		5,700	27,000	11,000
Botswana	1,592	775	290,000	280,000	35.80	150,000	10,000		25,000	95,000	28,000
Burkina Faso	11,633	5,116	350,000	330,000	6.44	180,000	20,000		43,000	370,000	200,000
Burundi	6,587	3,006	360,000	340,000	11.32	190,000	19,000		39,000	280,000	160,000
Cameroon	14,704	6,723	540,000	520,000	7.73	290,000	22,000		52,000	340,000	74,000
Central African Republic	3,550	1,649	240,000	230,000	13.84	130,000	8,900		23,000	140,000	65,000
Chad	7,462	3,283	92,000	88,000	2.69	49,000	4,000		10,000	86,000	55,000
Comoros	676	327		400*	0.12*						
Congo	2,867	1,277	86,000	82,000	6.43	45,000	4,000		8,600	66,000	64,000
Cote d'Ivoire	14,534	6,785	760,000	730,000	10.76	400,000	32,000		72,000	530,000	320,000
Dem. Republic of Congo	50,407	21,564	1,100,000	1,100,000	5.07	600,000	53,000		96,000	750,000	#REF!
Djibouti	631	299	37,000	35,000	11.75	19,000	1,500		3,200	12,000	3,900
Equatorial Guinea	442	200	1,100	1,000	0.51	560	<100		120	1,000	1,600
Eritrea	3,717	1,705		49,000*	2.87*						
Ethiopia	61,123	26,931	3,000,000	2,900,000	10.63	1,600,000	150,000		280,000	1,400,000	840,000
Gabon	1,196	527	23,000	22,000	4.16	12,000	780		2,100	12,000	4,800
Gambia	1,266	616	13,000	12,000	1.95	6,600	520		1,400	12,000	8,400
Ghana	19,699	9,164	340,000	330,000	3.60	180,000	14,000		33,000	230,000	130,000
Guinea	7,375	3,414	55,000	52,000	1.54	29,000	2,700		5,700	35,000	18,000
Guinea-Bissau	1,188	532	14,000	13,000	2.50	7,300	560		1,300	7,800	990
Kenya	29,507	14,217	2,100,000	2,000,000	13.95	1,100,000	78,000		180,000	960,000	440,000
Lesotho	2,108	998	240,000	240,000	23.57	130,000	8,200		16,000	52,000	9,500
Liberia	2,941	1,335	39,000	37,000	2.80	21,000	2,000		4,540	34,000	21,000
Madagascar	15,502	7,199	11,000	10,000	0.15	5,800	450		880	3,460	1,300
Malawi	10,674	4,733	800,000	760,000	15.96	420,000	40,000		71,000	470,000	360,000
Mali	10,976	4,770	100,000	97,000	2.03	53,000	5,000		9,900	56,000	33,000
Mauritania	2,602	1,209	6,600	6,300	0.52	3,500	260		620	2,900	1,400

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Mauritius	1,149	647		500*	0.08*						
Mozambique	19,222	8,607	1,200,000	1,100,000	13.22	630,000	52,000		99,000	430,000	170,000
Namibia	1,689	790	160,000	150,000	19.54	85,000	6,600		18,000	89,000	7,800
Niger	10,414	4,524	64,000	61,000	1.35	34,000	3,300		6,500	38,000	20,000
Nigeria	108,995	50,705	2,700,000	2,600,000	5.06	1,400,000	120,000		250,000	1,700,000	410,000
Reunion	690	370			0.00*						
Rwanda	7,238	3,338	400,000	370,000	11.21	210,000	22,000		40,000	370,000*	120,000
Senegal	9,251	4,268	79,000	76,000	1.77	40,000	3,300		7,900	53,000	49,000
Sierra Leone	4,721	2,164	68,000	65,000	2.99	36,000	3,300		8,200	67,000	47,000
Somalia	9,718	4,280			0.00*						
South Africa	39,796	20,630	4,200,000	4,100,000	19.94	2,300,000	95,000		250,000	730,000	200,000
Swaziland	981	480	130,000	120,000	25.25	67,000	3,800		7,100	20,000	8,000
Togo	4,515	2,013	130,000	120,000	5.98	66,000	6,300		14,000	110,000	110,000
Uganda	21,209	9,222	800,000	750,000	8.17	410,000	48,000		110,000	1,200,000	1,700,000
United Rep. of Tanzania	32,799	15,068	1,300,000	1,200,000	8.09	670,000	59,000		150,000	1,300,000	730,000
Zambia	8,974	4,137	870,000	830,000	19.95	450,000	40,000		99,000	800,000	470,000
Zimbabwe	11,509	5,771	1,500,000	1,400,000	25.06	800,000	58,000		160,000	1,100,000	450,000
South & South-East Asia	1,920,326	993,465	5,800,000	5,700,000	0.61	1,500,000	81,000		250,000	730,000	200,000
Afghanistan	22,109	10,148		<100*	<0.005*						
Bangladesh	127,047	68,021	13,000	13,000	0.02	1,900	130		1,000	4,000	810
Bhutan	2,069	938		<100*	<0.005*						
Brunei Darussalam	321	178		<100	0.2*						
Cambodia	10,931	5,253	220,000	210,000	4.04	71,000	5,400		14,000	42,000	7,300
India	997,663	509,007	3,700,000	3,500,000	0.70	1,300,000	160,000		340,000	2,000,000	120,000
Indonesia	209,178	113,960	53,000	52,000	0.05	13,000	920		3,000	8,800	1,000
Iran (Islamic Republic of)	66,626	34,486		1,000*	<0.005*						
Lao People's Dem. Rep	5,301	2,402	1,400	1,300	0.05	650	120		120	420	150
Malaysia	21,817	11,449	49,000	48,000	0.42	4,800	550		1,900	5,600	1,500
Maldives	279	131		<100*	0.05*						
Myanmar	45,064	25,768	530,000	510,000	1.99	180,000	14,000		48,000	190,000	14,000
Nepal	23,388	11,259	34,000	33,000	0.29	10,000	930		2,500	8,300	750
Pakistan	152,435	72,466	74,000	73,000	0.10	15,000	1,600		6,600	27,000	5,000
Philippines	74,444	38,428	28,000	26,000	0.07	11,000	1,300		1,200	3,400	480
Singapore	3,518	2,027	4,000	3,900	0.19	790	<100		210	850	<100
Sri Lanka	18,846	10,367	7,500	7,300	0.07	2,200	200		490	2,600	450
Thailand	60,841	35,166	755,000	740,000	2.15	305,000	13,900		67,000	360,000	48,000
Viet Nam	78,539	42,009	100,000	99,000	0.24	20,000	2,500		2,500	7,400	1,900

99	Estimated number of people living with HIV/AIDS, end 1999						Estimated AIDS Deaths		Orphans
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85,610	190,000	180,000	0.09	38,000	4,700		<1000	5,400	<100
1,910	<500	<100	0.01				<100		
4,158	<500	<100	<0.005				<100	<100	
5,068	14,000	9,000	0.18				400	600	
2,117		750*	0.04*				<100		
3,971		300*	0.01*				<100		
2,153		340*	0.02*				<100	180	
5,079	2,200	2,200	0.04				<100	<200d	
679	<500	<100	0.01				<100	<100	
2,457	<500	<100	<0.005				<100	<100	
4,852	2,500	2,500	0.05				<100	220d	
8,479	3,500	2,500	0.03				<100	110	
2,340	<100	<100	<0.005				<100		
1,126	1,250	<100	0.01				<100	<100	
1,777	<500	<100	0.01				<100	<100	
19,871	13,000	12,000	0.06				<100	500d	
2,262	4,500	2,500	0.11				<100	100	
11,423	7,000	2,000	0.02				350	4,000d	
73,907	130,000	40,000	0.05				1,300	2000d	
2,797	400	<100	<0.005				<100	<100d	
2,959	<100	<100	<0.005				<100		
2,226	<100	<100	0.01				<100		
23,999	240,000	110,000	0.46				6,400	9400d	
12,114	<100	<100	<0.005				<100	<100	
21,647	420,000	420,000	0.05	53,000	1,800		5,000	11,000	2,200
15,375	500,000	500,000	0.07	61,000	4,800		17,000	48,000	720
13,270		<100*	<0.005*						
429	300	300	0.07						<100
3,918	2,500	2,500	0.09	630	<100		<100	500	110
68,098	10,000	10,000	0.02	1,300	<100		150	1,200	<100
1,411	<100	<100	0.01						
2,336	5,400	5,200	0.22	2,600	220		450	1,600	1,300
26,610	3,800	3,800	0.01	490	<100		180	570	<100
11,482	12,000	12,000	0.11	700	<100		700	7,000	<500
9,543	14,000	14,000	0.14	900	140		100	5,800	
1,939	1,200	1,200	0.07	180	<100		<100	550	120
53,738	850,000	850,000	0.55	170,000	8,500		29,000	420,000	70,000

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Country	Total (thousands)	Adults 15-49 (thousands)	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)	Young People (15-24)	Adults and children 1999	Adults and children, cumulative	Orphans Cumulative
Canada	30,841	15,969	49,000	49,000	0.33	5,600	500		400	16,000	1,000
United States of America	276,090	137,769	850,000	840,000	0.79	170,000	10,000		20,000	450,000	70,000
Caribbean	32,025	16,860	310,000	300,000	1.82	98,000	9,000		18,000	110,000	46,000
Bahamas	302	164	6,900	6,800	4.13	2,200	150		500	3,900	760
Barbados	269	147	1,800	1,700	1.17	570	<100		130	920	470
Cuba	11,154	6,076	1,950	1,950	0.02	450	<100		120	700	160
Dominican Republic	8,361	4,468	130,000	130,000	2.80	59,000	3,800		5,000	17,000	3,700
Haiti	8,090	3,917	210,000	200,000	5.17	67,000	5,200		23,000	180,000	40,000
Jamaica	2,561	1,366	9,900	9,700	0.71	3,100	230		650	3,600	180
Trinidad and Tobago	1,288	722	7,600	7,600	1.05	2,500	180		530	3,200	760
Latin America	473,387	252,270	1,300,000	1,300,000	0.52	240,000	15,000		81,000	470,000	91,000
Argentina	36,579	17,880	130,000	120,000	0.69	27,000	2,200		1,800	30,000	2,400
Belize	235	117	2,400	2,400	2.01	590	<100		170	1,200	340
Bolivia	8,146	3,943	4,200	4,100	0.10	680	<100		380	2,000	150
Brazil	167,961	93,252	540,000	530,000	0.57	130,000	9,900		19,000	190,000	
Chile	15,011	7,833	15,000	15,000	0.19	2,600	260		1,000	3,000	530
Colombia	41,565	22,412	71,000	70,000	0.31	10,000	900		1,700	18,000	1,500
Costa Rica	3,929	2,080	12,000	11,000	0.54	2,800	290		750	4,500	940
Ecuador	12,409	6,534	19,000	19,000	0.29	2,700	330		1,400	10,000	1,100
El Salvador	6,155	3,170	20,000	19,000	0.60	4,800	560		1,300	8,700	2,200
Guatemala	11,103	5,152	73,000	71,000	1.38	28,000	1,600		3,600	10,000	3,600
Guyana	855	489	15,000	15,000	3.01	4,900	140		900	3,400	560
Honduras	6,319	3,043	63,000	58,000	1.92	29,000	4,400		4,200	27,000	6,100
Mexico	97,334	52,327	150,000	150,000	0.29	22,000	2,400		4,700	56,000	16,000
Nicaragua	4,944	2,388	4,900	4,800	0.20	1,200	<100		350	1,400	120
Panama	2,811	1,499	24,000	23,000	1.54	9,400	670		1,200	5,600	1,000
Paraguay	5,362	2,649	3,000	2,900	0.11	520	<100		230	1,600	340
[redacted]	25,236	13,325	76,000	75,000	0.56	11,000	580		8,000	69,000	990
Suriname	415	228	3,000	2,900	1.26	950	110		210	1,400	390
Uruguay	3,313	1,561	6,000	5,900	0.33	1,500	<100		150	1,000	340
Venezuela	23,705	12,388	62,000	61,000	0.49	9,200	580		2,000	5,900	1,200
Total:	5,965,506	3,085,119	30,600,000	29,400,000	0.97	12,200,000	1,100,000		2,300,000	11,700,000	8,200,000

Joint United Nations Programme on HIV/AIDS
UNAIDS
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US Media Office (212) 584-5024

MEDIA ADVISORY

REPORT EMBARGOED UNTIL
JUNE 27, 12 Noon. EST

CONTACT: Andrew Shih
(212) 584-5024

** MEDIA ADVISORY – TELEPHONE MEDIA BRIEFING **

NEW UNAIDS REPORT ON THE GLOBAL EPIDEMIC TO BE RELEASED IN ADVANCE OF WORLD AIDS CONFERENCE IN SOUTH AFRICA

-- Half of all 15-year-olds will ultimately die of AIDS in countries such as South Africa and Zimbabwe –

-- Prevention efforts show clear results, but only with sustained application; Current global AIDS funding is woefully insufficient --

Telephone Briefing, Tuesday, June 27, 12 Noon EST

WHAT: Telephone press briefing to review comprehensive new UNAIDS *Report on the global HIV/AIDS epidemic: June 2000.* Participants will discuss:

- Long-term demographic impacts of AIDS, particularly in Africa
- The epidemic's devastating effect on agriculture and education systems
- Growing epidemics in the Baltic states, Russia, India and the Carribean
- AIDS prevention successes in Latin American and Asia

WHO: Speakers include:

- Peter Piot, Executive Director, UNAIDS
- Bernhard Schwartlander, Senior Epidemiologist, UNAIDS
- Noerine Kaleeba, Community Mobilization Advisor, UNAIDS

WHEN: **Tuesday, June 27, 2000**
12 Noon EST

To register for the conference call, please call Andrew Shih at (212) 584-5024 or Mark Aurigemma at (212) 584-5017

Note: Information from the UNAIDS Report is embargoed until June 27 at 12 noon EST.

B-ROLL: UNAIDS footage, addressing stigma, access to care, and the impact of HIV/AIDS on development in Africa, India, Southeast Asia, and Latin America, is available.

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AIDS epidemic update:

December 1999

Joint United Nations Programme on HIV/AIDS

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Joint United Nations Programme on HIV/AIDS

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- Peter Piot, Executive Director, UNAIDS
- Bernhard Schwartlander, Senior Epidemiologist, UNAIDS
- Noerine Kaleeba, Community Mobilization Advisor, UNAIDS

WHEN: **Tuesday, June 27, 2000**
12 Noon EST

To register for the conference call, please call Andrew Shih at (212) 584-5024 or Mark Aurigemma at (212) 584-5017

Note: Information from the UNAIDS Report is embargoed until June 27 at 12 noon EST.

B-ROLL: UNAIDS footage, addressing stigma, access to care, and the impact of HIV/AIDS on development in Africa, India, Southeast Asia, and Latin America, is available.

AIDS widows may have no legal rights to land and property after their husbands' death due to customary inheritance laws. Many women therefore often have to leave their homes and are facing severe poverty.

"Rural HIV often remains silent and invisible," according to the report, because of poor health infrastructure, restricted access to health facilities and inadequate surveillance. For this reason, HIV in rural populations often remains "an unknown entity for policy-makers and development planners."

Where people are exposed to poverty, food insecurity, gender inequality, migration, war and civil conflict, their vulnerability to HIV increases, FAO/UNAIDS said. In rural areas of most developing countries, therefore, the spread of HIV is accelerated by migration, trade, the movement of refugees and strengthened rural-urban linkages. Considerations relating to HIV/AIDS should be incorporated in agricultural and rural development, the UN organizations urged. Ministries of Agriculture and Rural Development should be sensitised about HIV/AIDS education and advocacy, and where required, should review their policies and activities. Households affected by the pandemic should have better access to and control over resources such as extension, credit and land.

The study mentions two types of rural areas particularly vulnerable to HIV: those along truck routes and those that are sources of migrant labour to urban areas. Many traditional subsistence areas are also vulnerable if people are migrating from there in the agricultural lean season. Nomadic pastoralists are at increased risk of contracting HIV due to their mobility, marginalization, and limited access to social services. Women remaining on farms with seasonal migrant husbands are also vulnerable to HIV infection if their husbands bring the disease back with them.

According to UNAIDS, an estimated 33.6 million people were living with HIV/AIDS at the end of 1999, of which over 90 percent were in developing countries. Africa, which accounts for only one tenth of the world's population, bears the brunt of the epidemic with more than 80 percent of all deaths to date. In Asia, HIV seropositivity rates are still comparatively low but the spread of the pandemic is rapid. Almost 6 million people are believed to be infected with HIV.

For more information please contact Anne Winter, UNAIDS, Geneva, (+41 22) 791 4577, Dominique de Santis, UNAIDS, Geneva, (+41 22) 791 4509, Andrew Shih, UNAIDS, New York, (+1 212) 584.5024 or Erwin Northoff, FAO Media Officer, Rome, (+39 06) 5705 3105, e-mail Erwin.Northoff@FAO.Org. You may also visit the UNAIDS' or FAO's Home Page on the Internet for more information on the programme (http://www.unaids.org and http://www.fao.org).

Joint United Nations Programme on HIV/AIDS
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US Media Office (212) 584-5024

JOINT UNAIDS/FAO PRESS RELEASE

NOTE TO EDITORS: **The FAO/UNAIDS report is being presented to the media at a press conference in Rome at 11.00hrs (local time) today.**

HIV/AIDS EPIDEMIC IS SHIFTING FROM CITIES TO RURAL AREAS – NEW FOCUS ON AGRICULTURAL POLICY NEEDED

Rome, 22 June 2000 – The fight against the HIV/AIDS pandemic in developing countries has been mostly perceived as an "urban problem", but the absolute numbers of people living with HIV are actually increasing rapidly in many rural areas, the UN Food and Agriculture Organization (FAO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) said today.

In some countries, the gap in HIV infection rates between urban and rural areas is narrowing. But so many people in developing countries live in rural areas that, in terms of absolute numbers, the numbers of rural inhabitants who are infected are very high.

In a new publication entitled ***Sustainable Agricultural/Rural Development and Vulnerability to the AIDS Epidemic*** FAO/UNAIDS called upon governments to pay more attention to the real burden of HIV/AIDS on local communities and to ensure that rural development also aims at combating the epidemic. "HIV/AIDS is not only a health but also a development problem," FAO/UNAIDS said.

The report concludes that the rural epidemic has been underestimated: in India, where 73% of the population is rural, recent studies have shown that HIV is spreading faster in some rural areas than in urban ones. In many countries in Africa, urban and rural HIV prevalence rates are similar.

The report says it is urgent to address rural HIV prevention and care needs. Though HIV prevalence is rising in rural areas, the infrastructure needed for prevention programmes – counselling and testing, condom availability and AIDS information – is less developed.

Moreover, health facilities are often inadequate in rural communities, which bear the main burden of care for people with HIV. Many HIV infected people return from the cities to their villages when they fall ill. Rural families provide most of the care for AIDS patients; the households mostly bear the costs for food, medicine and funeral expenses. Agricultural development policies rarely take this fact into consideration.

Besides the human suffering, AIDS threatens sustainable agriculture and rural development. Sickness and death of an adult family member can result in the inability of a household to cultivate the land. Tending for the sick can take a considerable amount of time, which is then no longer available for agriculture. As a result, more remote fields tend to be left fallow, and switching from labour-intensive to less labour-intensive crops is more likely. Families can wind up having to sell off their livestock.

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PRESS RELEASE

*****UNDER EMBARGO UNTIL 12h00 GMT, THURSDAY, 29 JUNE 2000*****

AIDS EPIDEMIC THREATENS WSSD GOALS, UNAIDS SAYS

Geneva, 29 June 2000 – The AIDS epidemic is a major threat to achieving the goals set by the World Summit for Social Development (WSSD), warned Kathleen Cravero, Deputy Executive Director of the Joint UN Programme on HIV/AIDS (UNAIDS).

"AIDS is clearly an unprecedented development crisis which is undermining achievement in social development and jeopardizing the goals set at the Summit," warned Dr Cravero. "Especially in Africa, decades of gains in education and health are being eradicated by this epidemic." Dr Cravero was speaking at the panel discussion, *Combatting HIV/AIDS*, at the Geneva 2000 Forum, the NGO venue for the Special Session of the United Nations General Assembly on the Implementation of the Outcome of the WSSD.

In many developing countries but particularly in sub-Saharan Africa, the impact of AIDS on social development is being harshly felt. Education is hard hit, yet young people are in the forefront of the epidemic, with nearly 7 million young people aged 15-24 in sub-Saharan Africa now living with HIV. As household income drops, young people are forced out of school and into the workplace earlier. Children are also hard hit by the epidemic. So far, some 13.2 million children under 15 have been orphaned by AIDS, 95% of them in Africa. Teachers are also dying – in Côte d'Ivoire, 7 in ten teacher deaths are due to HIV. In the first ten months of 1998, Zambia lost 1300 teachers to AIDS.

Throughout the continent, increased demand for health care for HIV-related illness is adding pressure to already over-stretched health services. In some countries HIV-positive patients occupy 40-70% of all beds in big city hospitals. Like teachers, hospital staff deaths are on the rise. One study in Zambia found that deaths among hospital workers, largely due to HIV, increased 13-fold over a ten-year period.

In 1995, governments at the WSSD in Copenhagen made commitments to eradicate poverty, improve education and access to primary health care, and accelerate development in Africa and less developed countries.

"One of the most significant outcomes of the Summit was the placement of poverty eradication at the centre of national and international agendas," Dr Cravero said. "We have learned that AIDS and poverty are closely connected. Unless we address AIDS we cannot make progress on poverty and unless we do more to eradicate poverty, AIDS will remain a major threat."

A key commitment of the Special Session on the outcomes of the WSSD is to develop a plan of action to reduce HIV infection levels among young people by 25% in the 25 most affected countries in Africa by 2005. But meeting these targets will require increased social spending on education and primary health care to reduce vulnerability to HIV/AIDS, Dr Cravero said.

Particular forms of support should include:

- mainstreaming AIDS education into basic education and into non-formal education programmes;
- strengthening services for sexual and reproductive health and life skills, especially for young people;
- ensuring that migrant populations have access to basic health and education services;
- promoting further study the impact of AIDS on national development; and
- strengthening national legislation which protects against HIV-related discrimination.

Turning commitments into reality will require translating global commitments into concrete country-level policies, Dr Cravero said. These policies should change the socio-economic conditions that contribute to the epidemic, while increasing care and support and mitigating the epidemic's impact.

To fight the epidemic on all fronts UNAIDS recently launched an initiative to shore up the international and national response to AIDS in Africa. The International Partnership Against AIDS in Africa is a highly innovative alliance made up of African and donor governments, the UNAIDS Secretariat, its seven cosponsoring agencies -- UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO and the World Bank, civil society and the private sector. The Partnership hopes to produce a multiplier effect on AIDS interventions by bringing together the range of social and government actors involved in them.

In the five years since the Social Summit, the AIDS epidemic has continued to grow, with sub-Saharan Africa -- which has some 24.5 million adults and children living with HIV – bearing the brunt. South Africa alone now has 4.2 million people living with HIV/AIDS, the highest number in the world.

For more information, please contact Anne Winter, UNAIDS, Geneva, (+41 22) 791.4577, Dominique De Santis, UNAIDS, Geneva, (+41 22) 791.4509 or Andrew Shih, UNAIDS, New York, (+1 212) 584.5024. You may also visit the UNAIDS Home Page on the Internet for more information about the programme (http://www.unaids.org).

Embargoed until
1 December 1999 - 9:30 a.m. EST

Call to Action for 'Children Left Behind' by AIDS

A plea for communities, governments, civil society, the private sector and international partners to vigorously address the plight of children who are affected by the AIDS epidemic.

Issued by the Joint United Nations Programme on HIV/AIDS (UNAIDS),
The United Nations Children's Fund (UNICEF) and the
National Black Leadership Commission on AIDS, Inc. (BLCA)

Background

The new millennium dawns on a world facing an unprecedented human tragedy - the loss of millions of people to the AIDS epidemic. More than 16.3 million people have died. By the end of the year 2000, a cumulative total of 13 million children will have lost their mother or both parents to AIDS, and 10.4 million of them will still be under the age of 15.

More than 90 per cent of children orphaned by AIDS are in sub-Saharan Africa, and the numbers are increasing daily. In the next decade, the numbers of orphans are also expected to increase in Asia, the Americas, Central and Eastern Europe and the countries of the Commonwealth of Independent States. In industrialized countries, deaths have declined significantly, but AIDS remains a deadly menace in the absence of an effective cure.

The onslaught of AIDS on people of reproductive age is increasing the numbers of orphans at such a rate that communities cannot rely on traditional means of caring for these children. This is particularly true in many sub-Saharan African countries lacking adequate basic social welfare services. The inability of communities to respond adequately and appropriately to the situation has resulted in social, psychological and economic deprivation for the children, and this is likely to continue for the long term. Such deprivation is worse for girls whose parents have died, as these girls often have to care for their siblings and take on extra work, thereby reducing their opportunities for schooling.

Of course, AIDS affects children long before their parents die. The toll taken by the disease begins during the period of illness, continues through death and bereavement and will likely persist into adulthood if adequate support and protection are lacking. These extremely vulnerable children can suffer myriad problems and human rights abuses: the terrible stress of watching parents fall ill and die, grief for lost family members; a decline in nutritional status; loss of health care; increased demands for their labour; reduced opportunities for education; loss of inheritance; homelessness; discrimination; physical abuse; and sexual abuse, which in turn exposes them to HIV infection.

The absence of parental protection and care, combined with HIV-related illnesses, has contributed significantly to the increase in deaths of children under five in the countries most affected. AIDS has undermined the capacity of communities and households to cope and is hindering efforts to achieve goals for the survival and development of children, including the year 2000 goals agreed to by world leaders at the 1990 World Summit for Children.

Specific needs of children and families affected by HIV/AIDS

The onset of AIDS, in many developing countries, marks the beginning of a transition from poverty to complete destitution. The reality is most bleak in the worst-affected areas of sub-Saharan Africa, where over 50 per cent of the population lives below the poverty line.

Despite many obstacles, however, threatened communities around the world are struggling to support orphans and families affected by HIV and AIDS. However, among the constraints are the sheer numbers of orphans, which have the potential to overwhelm these efforts, the urban focus of many programmes, which therefore reach relatively few people, and limited coordination with government. These constraints have prevented the needs and rights of many children and families from being addressed.

With the relentless toll of AIDS reducing the ability of families and communities to support and care for children, we now face troubling scenarios: grandmothers struggling to care for orphans; households headed by children, many of them primary-school age, who are caring for younger siblings; and worse, children with nowhere at all to turn. Often compounding the devastation caused by AIDS is armed conflict, which poses the additional challenges of forced migration, displaced populations and further violations of rights.

These multiple crises surrounding AIDS call for the urgent and full engagement of all levels of society, which have a guide for action in two key international conventions: the Convention on the Rights of the Child (CRC), ratified by 191 countries, and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), ratified by 165 countries as of November 1999. By ratifying, countries have made themselves accountable for addressing the rights and needs of children and women, including those affected by HIV or AIDS.

Call to Action

This call is a plea for communities, governments, civil society, the private sector and international partners to vigorously address the plight of children who are affected by AIDS epidemic. Urgent action to meet their needs and ensure the realization of their rights is needed at three levels: family and community, government and global.

I. Family and community level

'Keep families and communities at the front line' **by empowering and supporting them to care for orphans.** Lessons from community initiatives over the past 15 years point to the following actions as essential:

- **Foster active participation of the community,** including people living with HIV or AIDS, in identifying and implementing actions to strengthen community-based care and support for orphans.

- **Increase women's access to credit, income-generating activities and property, including land,** because the burden of care tends to fall on poor women with few resources. In many cases, such action will require changing laws and policies regarding inheritance and property ownership.

- **Establish widespread confidential counselling and voluntary testing** for HIV. The benefits of such counselling include prevention of mother-to-child-transmission, promotion of the rights of girls and women to make informed decisions and realization of people's right to know their HIV status.

- **Target social assistance to all families in need, not just those grappling with AIDS,** as a way of ensuring equity and discouraging discrimination against orphans and others affected by AIDS.

- **Reduce demands on the labour of girls and women:** In many parts of Africa, for example, improving access to water and fuel for heating and cooking would free up more time for girls and women, allowing more girls to obtain a basic education, as is their right.

- **Respond to the psychosocial needs of orphans** through counselling services for children and families in need. School and home-based care and services should ensure in particular that children develop emotionally and intellectually through play and other activities and that they feel a sense of belonging to their communities.

- **Encourage community leaders to protect the legal rights of children and women,** especially those of widows and orphans. This will involve changing harmful practices and customary laws that are discriminatory or exploitative.

II. Government level

'Break the conspiracy of silence'**: The success of governments will be measured by their ability to prevent HIV and to enable families and communities to cope with the effects of the epidemic.** Governments need to take action in three key areas:

Advocacy and social mobilization

- **Actively combat discrimination.** Raise the visibility of AIDS while combating the shame and stigma associated with the disease.

- **Raise public awareness** of the nature of the crisis and mobilize resources locally and internationally.

- **Encourage the full participation of communities in all aspects of the response to AIDS.** Ensure that people living with HIV or AIDS and those caring for them are involved at every step — including planning, implementation, monitoring and evaluation.

Priorities and reform

- **Develop priority national policies in support of HIV prevention and mitigation of the impact of AIDS.** Focus on protecting younger children and girls and on providing young people with *effective* education on HIV and AIDS and on related reproductive health issues. Encourage prevention programmes involving peer educators.

- **Mobilize widespread support for the fight against AIDS** and establish frameworks linking efforts of government, civil society, including religious organizations, non-governmental organizations, the private sector and communities to use resources most efficiently.

- **Ensure access to education, especially for girls,** by introducing specific measures such as subsidies, scholarships and the provision of alternative avenues for high-quality education, such as community schools.

- **Reform the education sector to respond better to the needs of orphans and their communities.** The traditional approach to education needs to be overhauled to make schools more participatory and responsive to the everyday needs of students and more relevant to their lives. It is essential that schools help students acquire skills that can enable them to make informed decisions and avoid risks. Teacher training and support is pivotal to this effort.

- **Reform the health sector to emphasize HIV prevention and the provision of quality health care services** that can address the needs of children and communities affected by AIDS.

- **Introduce and enforce laws that realize the rights of children and women,** emphasizing social welfare and the best interests of the child. Focus on protection issues such as child abuse and rape, children in commercial sex work, exploitative child labour, juvenile justice, and children and women who lack secure tenure and are denied property ownership.

Monitoring and evaluation

- **Identify, assess and document successful community-based initiatives** with a view to expanding them into effective national or intercountry programmes.

- **Monitor the impact of HIV and AIDS on children and families at all levels** and use the information gathered to take targeted action.

- **Equip communities to monitor the local impact of the epidemic, facilitate action and evaluate interventions.**

III. Global level

'Keep children orphaned by AIDS high on the global agenda': Governments, donors, the private sector and international organizations have a moral obligation to act comprehensively and quickly in addressing the rights and needs of AIDS orphans. Their efforts can focus on these actions:

- **Make AIDS central to development assistance,** especially for the most affected countries in Africa. **Ensure that resources are allocated in such a way that countries can do more** than merely stave off increased poverty and the deterioration of social services.

- **Make AIDS orphans a priority in plans to accelerate debt relief** and also in sector-wide lending initiatives.

- **Provide financial support for long-term human development projects.**

- **Promote and advocate for the rights of children and women** as articulated in CRC and CEDAW.

- **Encourage the development of resource networks** to facilitate the sharing of human, technical and financial resources regionally and globally.

Level and flow of international resources for the response to HIV/AIDS:

1998 Update

Introduction

During its sixth meeting in May 1998, the UNAIDS Programme Coordinating Board recommended that the UNAIDS Secretariat continue to monitor national and international resource flows to HIV/AIDS on a long-term basis. The Secretariat was advised to build on its experience with the UNAIDS Secretariat/Harvard School of Public Health study on 1996-1997 HIV/AIDS financing to establish sustainable monitoring processes.

Following this recommendation, in mid-1999, the UNAIDS Secretariat joined an ongoing collaboration between UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI) to collect information on the official development assistance disbursed to HIV/AIDS by donor countries. In the aftermath of the International Conference on Population and Development, UNFPA and NIDI have been collecting on a yearly basis data on the national and international resource flows to population activities including HIV/AIDS. UNAIDS collaborated in the 1998 data collection. During this process, the UNAIDS Secretariat has collaborated closely with UNFPA, NIDI and the donor country members of the Development Assistance Committee (DAC) to improve existing HIV/AIDS data collection methodologies.

In addition to these efforts to collect information on donor country allocations to HIV/AIDS, the UNAIDS Secretariat is also collecting information on UNAIDS Cosponsor HIV/AIDS allocations as well as country-level resource flows. Data on the Cosponsor HIV/AIDS expenditure were collected during the preparations for the Unified Budget and Workplan, 2000-2001 (see the Unified Budget and Workplan, 2000-2001, Addendum 1). Efforts to further improve the quality of these data will be part of the joint United Nations planning and programming process. Finally, the Secretariat has made substantial progress in the development of a country database on the national responses to the epidemic including data on country-level resource flows to HIV/AIDS.

This paper presents the 1998 HIV/AIDS official development assistance collected from fourteen of the twenty-two DAC member countries. Almost 80% of the official development assistance disbursed by DAC member countries in 1998 came from these fourteen countries - Australia, Belgium, Canada, Denmark, Finland, Germany, Japan, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom and the United States. All available data suggest that they also provide at least 80% of the official development assistance disbursed for HIV/AIDS activities in 1998.[1]

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[1] *All information on level and flow of official development assistance was taken from "Development Assistance Committee International Development Statistics." OECD website: http://www.oecd.org/dac/htm/dcdrsd-e.htm, 22 May 2000*

Level of 1998 official development assistance to HIV/AIDS

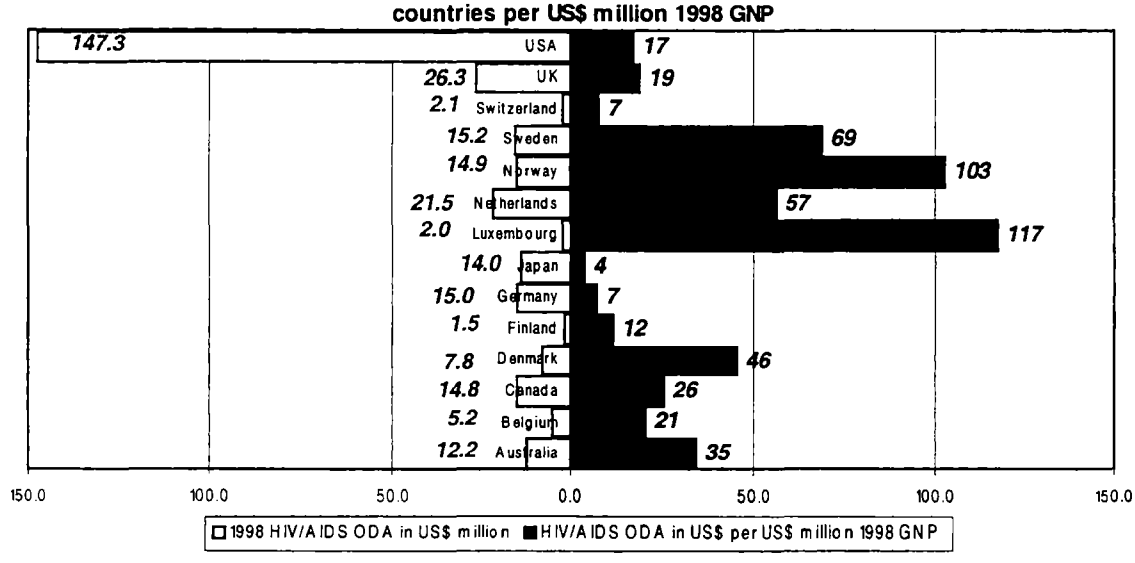
Australia, Belgium, Canada, Denmark, Finland, Germany, Japan, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom and the United States reported having disbursed almost US$ 300 million for HIV/AIDS activities in developing countries and countries in transition in 1998 (Table 1).

Table 1. HIV/AIDS ODA Disbursements for Selected Donor Countries at Current Prices and Exchange Rates, 1998

Donor country	1998 HIV/AIDS ODA (US$ million)	Percent of total 1998 HIV/AIDS ODA
Australia	12.2	4%
Belgium	5.2	2%
Canada	14.8	5%
Denmark	7.8	3%
Finland	1.5	<1%
Germany	15.0	5%
Japan	14.0	5%
Luxembourg	2.0	1%
Netherlands	21.5	7%
Norway	14.9	5%
Sweden	15.2	5%
Switzerland	2.1	1%
UK	26.3	9%
USA	147.3	49%
Total	**300.0**	**100%**

The United States was by far the largest donor of HIV/AIDS ODA, disbursing US$ 147.3 million (49%). The United Kingdom and the Netherlands were the next largest donors disbursing US$ 26.3 million (9%) and US$ 21.5 million (7%) respectively. But when allocations are broken down as a proportion of gross national product (GNP) for each country, the picture is quite different.[2] Luxembourg and Norway disbursed the largest proportion of their country's GNP to HIV/AIDS activities in developing countries with US$ 117 and US$ 103 per US$ million GNP respectively (Figure 1). The United States and the United Kingdom disbursed US$ 17 and US$ 19 per US$ million GNP respectively.

Figure 1.HIV/AIDS ODA as reported by 14 donor countries: Total amount obligated, 1998, in US$ million and obligations reported by donor countries per US$ million 1998 GNP



[2] *Information on donor country GNP was taken from "Development Assistance Committee International Development Statistics." OECD website: http://www.oecd.org/dac/htm/dcdrsd-e.htm, 22 May 2000*

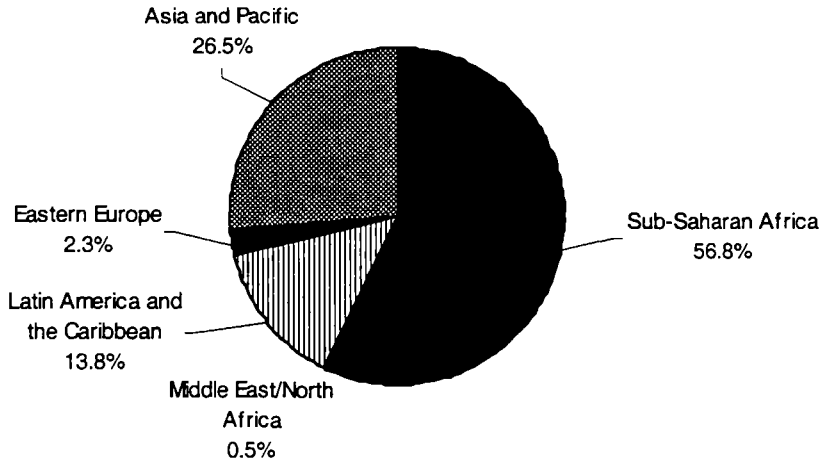
Another way to assess the level of HIV/AIDS ODA by individual donors is to consider HIV/AIDS ODA as a percentage of total ODA. In this case, Luxembourg, the United States and Australia disbursed the highest percentage of total ODA to HIV/AIDS activities with 1.8%, 1.7% and 1.3% respectively. On the other end of the scale, Japan, Switzerland and Germany disbursed 0.1%, 0.2% and 0.3% of total ODA to HIV/AIDS activities respectively. Overall, the US$ 300 million allocated to HIV/AIDS by the fourteen DAC member countries in 1998 represent 0.7% of the US$ 41 450 million that they disbursed in total ODA for that year.

Flow of 1998 official development assistance to HIV/AIDS

Of the US$ 300 million in ODA that were allocated to HIV/AIDS in 1998, 20% was channeled through multilateral agencies. Of the funds channeled through the Untied Nations and its specialized agencies, almost all (95%) were core budget contributions or supplemental funding for general agency HIV/AIDS activities. Only 5% of the funds channeled through multilateral agencies were multi-bilateral – or channeled through multilateral agencies for projects in specific countries. The large majority of the 1998 HIV/AIDS ODA reported (80%) was transferred directly to recipient governments or channeled through non-governmental organizations and other private institutions.

An additional way to assess the flow of HIV/AIDS ODA is to review the regional distribution of these funds. Over one third (35%) of the US$ 300 million reported was earmarked for "global or inter-regional activities." It is not possible to disaggregate these funds though a substantial proportion - including core contributions to the UNAIDS Secretariat – are eventually allocated to regions. Of the remaining 65% (US$ 195 million), 56.8% was earmarked for activities in sub-Saharan Africa (Figure 2), 26.5% was allocated to activities in Asia/Pacific; 13.8% to activities in Latin America/Caribbean; 2.3% to activities in Eastern Europe; and 0.5% to activities in the Middle East/North Africa region.

Figure 2. Distribution of regionally allocated HIV/AIDS ODA disbursements for selected donor countries, 1998

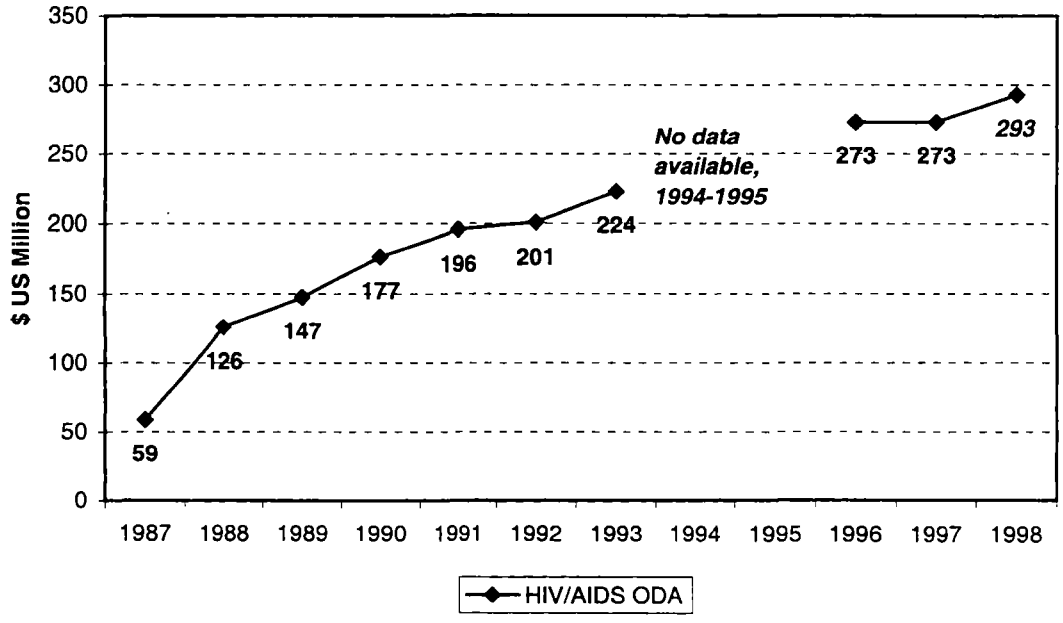


Trends in official development assistance to HIV/AIDS, 1987-1998

The 1998 data for the 10 donor countries for which data are available over time - Australia, Canada, Denmark, Germany, Japan, the Netherlands, Norway, Sweden, the United Kingdom and the United States - confirm most of the trends highlighted in the "Level and flow of national and international resources for the response to HIV/AIDS, 1996-1997."[3]

When inflation and changes in purchasing power parity are taken into account, the flow of HIV/AIDS ODA from these 10 countries increased each year from 1987 to 1996, remained stable between 1996 and 1997and continued to increase between 1997 and 1998 (Figure 3).

Figure 3. Total HIV/AIDS ODA Disbursements by Selected Donor Countries at 1997 Prices and Exchange Rates, 1987-1998



Similarly, when trends in the flow of HIV/AIDS ODA are compared to the trends in overall ODA for these countries, the proportion of HIV/AIDS ODA within the total pot of ODA does increase slightly between 1987 and 1998 from 0.2% to 0.7%.

Finally, the trend in the decreasing flow of HIV/AIDS ODA through United Nations agencies is also confirmed with the 1998 data. This trend has been longstanding (since 1987), but reviewing only the last 3 years; donor countries decreased the HIV/AIDS ODA that they channeled through multilateral and multi-bilateral channels from 26% of all HIV/AIDS ODA in 1996 to 22% in 1997 to 20% in 1998.

[3] *Trend information also based on Mann J & Tarantola D, ed., AIDS in the World II (New York, Oxford: Oxford University Press, 1996) and Mann J, Tarantola T, eds., AIDS in the World (Cambridge, London: Harvard University Press, 1992)*

Issues and next steps in the monitoring of official development assistance to HIV/AIDS

- The UNAIDS Secretariat has made significant progress in establishing sustainable processes for the monitoring of donor country resource flows to HIV/AIDS on a long term and sustainable basis, but some key issues remain.

- Some major DAC members including France and the European Commission continue to have major difficulties in the reporting of their official development assistance allocated to HIV/AIDS.

- There continue to be differences in the ways that different donors define HIV/AIDS activities. This is particularly problematic the monitoring of HIV/AIDS components within integrated development projects or HIV/AIDS allocations within sector wide approaches and common basket funding schemes.

- Because of administrative differences among the DAC member countries, including differences in fiscal years, there is a significant delay in reporting. It is only possible to report on donor country HIV/AIDS expenditures almost 2 years late (i.e. reporting on 1998 data in mid 2000).

- Working closely with the DAC, UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI), the UNAIDS Secretariat plans to convene a meeting of donor country representatives to agree on a common methodology for reporting on HIV/AIDS components within integrated development projects and HIV/AIDS allocations within sector wide approaches and common basket funding schemes.

- To supplement its monitoring of donor country HIV/AIDS obligations, the UNAIDS Secretariat is in the process of establishing a process to systematically monitor pledges and allocations to HIV/AIDS.

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PRESS RELEASE

AIDS IS KEY ISSUE FOR NEW CENTURY, ON PAR WITH GLOBALIZATION, PEACE, ENVIRONMENT

London, 4 September 2000 – AIDS is one of the key issues shaping the world today and should rank as high on the list of human concerns as globalization, peace and the environment, said Dr Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

"AIDS is no longer simply a public health issue: it cuts across agencies, disciplines, and national boundaries," Dr Piot said. "There is no part of society in the hardest hit areas that is not in some way touched by the epidemic. We are talking not only about health, but about education, agriculture, the economy. AIDS threatens to roll back decades of hard-won development. Indeed, it has become a full-fledged development crisis."

Dr Piot was speaking at a symposium in London entitled *We The Peoples: The UN In the 21st Century*, which he attended on his way to the UN Millennium Summit being held on 6-8 September in New York. The symposium, organized by the Royal Institute of International Affairs, provides a venue for debate on the role of the UN at the start of a new century.

During the symposium, Dr Piot addressed the concerns expressed in *We The Peoples*, the report prepared by UN Secretary-General Kofi Annan for the Millennium Summit on the UN's role in the new century.

"Reform is a two-way process," Dr Piot said. "The United Nations cannot reform without change in the member states." In his speech to the pre-summit symposium, Dr Piot highlighted the "deadly inequalities" of health that continue to divide the world, pointing to the growing AIDS epidemic in developing countries and calling for political will and commitment from governments.

UNAIDS is one example of the kind of collaborative arrangement needed in today's international environment, Dr Piot said, and called for continued and broadened partnerships in the response to AIDS. Since it was launched in 1996, UNAIDS has worked closely with a number of groups representing religious communities, civil society and community organizations, the business sector, governments, academia and the broad public.

The need for a collaborative approach to cross-sectoral issues is evidenced by the continuing spread of AIDS. Already, 18.8 million people around the world have died of AIDS, 3.8 million of them children. Nearly twice that many – 34.3 million – are now living with HIV, the virus that causes AIDS. In 1999 alone, 5.4 million people were newly infected with HIV.

According to *We The Peoples*, AIDS is "rapidly becoming a social crisis on a global scale". The Secretary-General, building on the agreement reached by the UN General Assembly, calls for a

strategy that focuses on young people aged 15 to 24 and on providing care to those living with HIV. He explicitly recommends action to reduce HIV infection rates among young people by 25% in the most affected countries before 2005, and globally by 2010. He also challenges countries to set specific prevention targets: "By 2005 at least 90% and by 2010 at least 95% of young men and women must have access to the information, education and services they need to protect themselves against HIV infection."

For more information, please contact Anne Winter, UNAIDS, Geneva, (+41 22) 791 4577 or Ben Plumley, UNAIDS, Geneva (+41 22) 791 4770. You may also visit the UNAIDS Home Page on the Internet for more information about the programme (http://www.unaids.org).