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Organisation mondiale de la Santé

EXECUTIVE BOARD
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EB95/32
17 November 1994

Implementation of the global AIDS strategy

Report by the Director-General

This report has been prepared in response to resolution WHA42.33 (1989), which requested the Director-General to report annually to the Health Assembly, through the Executive Board, on the implementation of the global AIDS strategy.

It provides a review of the global HIV/AIDS situation, underlining the predominance of heterosexual transmission worldwide and the increasing spread to new areas. It describes the activities of the WHO Global Programme on AIDS during the past year at country, regional and global levels.

It also provides information on the important role played by nongovernmental organizations, which is the subject of resolution WHA42.34 (1989); the avoidance of discrimination in relation to HIV-infected people and people with AIDS in response to resolution WHA41.24 (1988); and the implications of HIV/AIDS for women as highlighted in resolution WHA43.10 (1990).

The report on progress in the establishment of the joint and cosponsored United Nations programme on HIV/AIDS (document EB95/48) will be considered under provisional agenda item 22.2.

WHO —
Global AIDS Strategy

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I. GLOBAL AIDS SITUATION

1. The cumulative number of AIDS cases reported to the WHO Global Programme on AIDS (GPA) through the WHO regional offices and WHO collaborating centres on AIDS, as of 30 June 1994 was 985 119 from 190 countries. However, the actual total in mid-1994 was estimated to be over 4 million. Reasons for the discrepancy include less-than-complete diagnosis and reporting to public health authorities, as well as delays in reporting.
2. WHO estimates that 17 million men, women and children had been infected with HIV worldwide by mid-1994. Two-thirds or more of all HIV infections to date have been the result of heterosexual transmission; and this proportion will increase to 75% or 80% by the year 2000. By mid-1994 about half of all HIV infections in the world had been acquired in adolescence and young adulthood.
3. Approximately one out of three children born to an HIV-infected woman is HIV-infected and dies of AIDS, usually by the age of five years; the remainder eventually become orphans when their mothers or both parents die of AIDS. As of mid-1994 about one million infected children had been born to HIV-infected women, and over half of them had developed AIDS. Most of these children are in sub-Saharan Africa.
4. Conservatively, WHO projects that by the year 2000 a world total of at least 30 to 40 million men, women and children will have been infected with HIV since the start of the pandemic. Even as a conservative estimate, this represents more than double the present total. If these estimates are accurate, by the end of the 1990s, nearly 10 million AIDS-related deaths may be expected.

II. TECHNICAL COOPERATION

5. One of the reasons for a reorganization of GPA at WHO headquarters undertaken in January 1994 was the need to streamline the Programme's technical cooperation and research and development activities into two distinct divisions: one responsible for research and intervention development, as described in section III, and one for technical cooperation, as described below. The new Division of Technical Cooperation is thus concerned with planning, coordinating and implementing GPA's technical and operational support to national AIDS programmes and with supporting operational research in selected areas to ensure the practical application of findings in the field. Although there were some regional differences, globally two-thirds of technical cooperation funds were used primarily for country activities and one-quarter for intercountry ones.

Coordination and monitoring of national programme support

6. During 1994 technical cooperation provided to national AIDS programmes was closely monitored to ensure that it responded to priority needs identified by countries, whose activities continued to involve an increasing number of participating sectors, funders and implementers. The Programme's computerized database containing "country profiles" initiated in 1993 was further developed to meet the needs of users - national programmes, donors and staff at headquarters and in regional offices - and now includes information from WHO and other sources on demographic, socioeconomic and epidemiological trends, sexually transmitted diseases (STDs), condom programming, and blood transfusion services, among others. The financial monitoring system was also refined to permit analysis of GPA resources allocated to specific components of national programmes such as nongovernmental activities, STD prevention and women and youth initiatives. The following are some examples of activities in the different WHO regions.

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Africa

7. Despite the distribution of information and educational materials for AIDS prevention and care, behaviour change remains a challenge for national AIDS programmes in the Region. Nevertheless, there has been a dramatic rise in the number of condoms sold or distributed over the past five years.
8. Some countries made special efforts during the year to assess the safety of blood transfusion in health care settings with a view to developing a national policy. Sentinel surveillance activities are being implemented as planned in many countries, but in some they are hampered by a lack of resources to purchase HIV test kits or maintain equipment. Community mobilization continued to receive attention at the national and district levels with the active participation of UNICEF, UNDP, WHO, many nongovernmental organizations and other partners. World AIDS Day activities and consensus workshops for the preparation of updated medium-term plans were often presided over by heads of state or ministers of health.
9. The number of women's organizations and associations becoming involved in AIDS work is growing rapidly and more external resources are required for their support. Several models of community-based home care now exist which aim to provide a continuum of care for AIDS patients and their families.

The Americas

10. During 1994 protocols for HIV sentinel surveillance were prepared and implemented for the first time in Argentina, Bolivia, Chile, Paraguay, Peru and Uruguay. An external review was carried out in Mexico; and Cuba prepared a draft of its first medium-term plan.
11. Training activities included two programme management courses (Antigua and Barbuda, June - English; Uruguay, November - Spanish); a workshop on surveillance (Chile, October); a condom promotion and logistics workshop (Costa Rica, November); and a course on home-based care for HIV-infected children (Bahamas, June). Protocols to determine the effectiveness of syndromic STD clinical management were developed in Brazil and Peru; and Honduras and Suriname will submit similar protocols shortly. A regional network to monitor susceptibility patterns of curable STDs and to update treatment guidelines is being implemented jointly with the WHO/PAHO coordinating centre for gonococcal susceptibility testing in Canada.

South-East Asia

12. The Programme continued to emphasize HIV prevention and care and the improvement of AIDS programme planning and management, providing technical support in various fields to all countries of the Region. Guidelines for national programme managers on HIV sentinel surveillance were prepared and a training manual on counselling was finalized following field-testing in India and Nepal.
13. Intercountry training activities were conducted on programme management (Thailand, April); condom marketing (Nepal, November); and cross-border migration and AIDS (Myanmar, December). A consultation was organized to develop an information, education and communication strategy for AIDS prevention (India, March).

Europe

14. In 1994 country workplans for HIV/AIDS activities were agreed with 26 Member States in central and eastern Europe. Assessment visits were carried out in Armenia, Azerbaijan, Belarus, Czech Republic, Kazakhstan, Kyrgyzstan, Republic of Moldova, Turkmenistan and Uzbekistan. The trend is towards giving more emphasis to health promotion and ensuring the participation of nongovernmental organizations in programme implementation.

15. A Russian version of the GPA programme management course was produced and used to train staff from Belarus, Bulgaria, Croatia, Poland, Republic of Moldova, Romania, Russian Federation, The Former Yugoslav Republic of Macedonia, and Ukraine. The European conference on methods and results of psychosocial AIDS research, jointly sponsored with the Commission of the European Communities (Germany, September), provided guidance on what works in prevention and what does not. The eighth European meeting of national AIDS coordinators (Greece, October) focused on border and mobility issues, which are of increasing concern in the Region.

Eastern Mediterranean

16. During 1994 health promotion activities continued to receive the highest priority, particularly for the prevention of sexual transmission of HIV. Technical support was provided to national AIDS programmes in the areas of health education, clinical management of HIV/AIDS, planning and evaluation, and STD control. Lebanon drew up its first medium-term plan, and second medium-term plans were prepared by Cyprus, Egypt, Jordan, Morocco and Syrian Arab Republic. An external review was carried out in the Islamic Republic of Iran.

17. Intercountry and regional training activities were conducted on the following subjects: programme management (Cyprus, April); management of HIV/AIDS and care of persons with HIV (Tunisia, September); and the role of media in AIDS prevention (Egypt and Pakistan, November). Other activities included a regional meeting on the role of women in prevention and control of AIDS (Egypt, May) and a meeting of directors of national AIDS reference laboratories (Egypt, November). The regional AIDS information exchange centre continued to produce educational and information materials and distribute them to Member States.

Western Pacific

18. During 1994 the national AIDS plans of Cook Islands, Marshall Islands and the territories of French Polynesia and New Caledonia were reviewed, and China formulated its second medium-term plan. A regional workshop on condom logistics (Manila, February) emphasized the importance of condom quality and the continuity of supply. Two meetings of national AIDS programme managers were held during the year (Guam, March; Manila, August-September).

19. Viet Nam and Papua New Guinea introduced HIV/AIDS into the curriculum of secondary schools as part of health education or science subjects. In the Philippines the secondary school curriculum was revised to include HIV/AIDS. STD prevalence studies were conducted in Fiji and the Philippines. Technical support was provided to Cambodia on STD case management.

Planning, management and training

20. During 1994, 30 facilitators for the GPA programme management course were trained in four courses; they in turn helped train participants from 80 countries in seven intercountry courses and two national courses (Botswana, Kenya). Translations of the 12-module course were completed in Chinese, French, Russian and Spanish. Arrangements were made for field-testing of the first training modules for strengthening district-level management of AIDS prevention, care and support activities in two countries of the South-East Asia and Eastern Mediterranean regions during the fourth quarter of the year. The first course for training trainers on safe blood and blood products, using distance learning materials, was held in Zimbabwe in October.

21. The procedures for national AIDS programme reviews and medium-term planning were updated to reflect the changed environment facing national programmes. Reviews were carried out in 26 countries during 1994. Of the 129 countries and territories that had prepared an initial medium-term plan, 70 have used a consensus-building approach to formulate a second-generation, more multisectoral plan.

22. Support was provided to strengthen national networks of nongovernmental organizations in India, Kenya, Malaysia, Philippines and Zimbabwe. A list of essential AIDS information resources was prepared and distributed in English, French and Spanish in collaboration with the Appropriate Health Resources and Technologies Action Group (AHRTAG), United Kingdom.

Prevention

23. A guide on designing and conducting interventions for young people not attending school will be completed by mid-1995. A supplement on youth peer education was published in August 1994 in the AHRTAG newsletter *AIDS action*, and proposals are being finalized to expand pilot peer education interventions in Ghana and Jamaica. In collaboration with an international insurance company, a series of national workshops were organized in Hong Kong, Indonesia and Malaysia to encourage the private sector to play a more active role in AIDS prevention and care. In April the technical content and format of the WHO specifications and guidelines for condom procurement were revised. A set of condom programming materials for national managers, including manuals on rapid assessment, promotion and logistics, was finalized and will be available in early 1995. A study was conducted to project future condom needs, as part of an overall contraceptive needs study. Global requirements for STD and HIV/AIDS prevention through 2005 were estimated to be as high as 20 000 million condoms, costing some US\$ 1200 million.

Health care and support

24. An expert consultation on care held in September re-emphasized the rationale for giving access to comprehensive care, including clinical, nursing, counselling and social support in a continuum from home to hospital, and stressed the close link between such care and prevention. The report of an evaluation of medical counselling and social services rendered by The AIDS Support Organisation (TASO), Uganda, will help nongovernmental organizations and governments to learn from a success story - and a participatory approach to evaluation.

25. A handbook on integrating comprehensive AIDS care into district health services was prepared for Ghana and district planning of care is under way in Thailand and Uganda. The development of clinical guidelines was completed with the printing of a French version of the GPA paediatric guidelines. Additional material to facilitate adaptation of the clinical guidelines to country needs was produced including a short guide on adapting flow-charts; a clinical slide set for teaching purposes; and a paper on selecting commonly used drugs in HIV/AIDS care. Guidelines for policy-makers, programme managers and service providers on appropriate infant feeding modes in the light of the HIV epidemic were finalized and will be available in early 1995.

26. Technical support was provided to India on the training of trainers in care and counselling for all states, including an evaluation of methodology at state and district level. Operational studies are in progress in Kenya on the feasibility of integrating HIV/AIDS care into the existing urban governmental and nongovernmental health systems, and in India on the training of hospital personnel and community volunteers to provide care at the appropriate level and refer patients when necessary.

Surveillance, evaluation and forecasting

27. As of mid-1994 sentinel HIV surveillance has been implemented in 80 developing countries, 17 of which now have extensive systems in place. Trainers from all WHO regions attended a course on surveillance data management (United States of America, June) organized with financial support from the World AIDS Foundation. To assist national AIDS programmes, a methods package for the evaluation of preventive activities was finalized, and training workshops in its use will be conducted in all regions. In addition, protocols were developed for measuring indicators related to discriminatory practices and care for HIV/AIDS patients in health facilities, and they will be field-tested in two countries.

28. Collaboration began with the London School of Hygiene and Tropical Medicine to develop techniques for estimating the cost-effectiveness of six HIV prevention strategies relating to mass media communication, social marketing of condoms, blood safety, school health education, STD services, and sex worker projects. Costing guidelines for each strategy have been prepared. Techniques to estimate effectiveness, now being designed, will be field-tested next year.

29. HIV/AIDS forecasting research has focused on achieving a better understanding of the changing patterns of HIV incidence in diverse epidemics. Through collaborative investigations with national AIDS programmes, HIV/AIDS case data from Rwanda, Uganda, United Republic of Tanzania and Zambia have been analysed. The resulting epidemiological model of HIV incidence suggests a dramatic shift of new infections to younger populations in these countries and provides insight into the dynamics of endemicity. A computer-based programme management information system was field-tested in Namibia and Uganda.

III. RESEARCH AND INTERVENTION DEVELOPMENT

30. The Programme's other division is responsible for coordinating and supporting its biomedical and behavioural research activities, which are described below.

Clinical research and product development

31. An interagency working group on the development of vaginal microbicides, established in collaboration with the Special Programme of Research, Development and Research Training in Human Reproduction, established prototype protocols for safety and efficacy testing of such products. A safety study of a vaginal microbicide containing a low dose of the spermicide nonoxynol-9 was successfully completed in several European countries and Thailand, paving the way for a study in Asia and Africa on its efficacy in preventing sexual transmission of HIV and other STDs. A comparative trial of the user-effectiveness of two strategies using male and female condoms to prevent gonorrhoea, chlamydial infection, vaginal trichomoniasis and genital ulcer diseases among sex workers began in Thailand.

32. A meeting to discuss prevention of mother-to-infant transmission of HIV by use of antiretrovirals was convened in June; protocols were prepared for research on short-term peripartum antiretroviral interventions that are feasible, affordable and sustainable in developing countries, and the studies will be initiated shortly. An interagency working group on the prevention of mother-to-infant transmission of HIV was established to ensure suitability and complementarity of worldwide research efforts in this field.

33. Research on the prevention of tuberculosis continued in Thailand and Zambia, and studies on cost-effective maintenance treatment were started in Uganda for oropharyngeal candidiasis and in Thailand for *Penicillium marneffei* infections. Protocols on cost-effective prophylaxis of multiple opportunistic infections were developed.

34. A meeting on implications of the newly identified HIV-1 subtype O viruses for HIV diagnosis was convened in June. An interagency working group has been established to expedite and coordinate global surveillance and characterization of newly recognized HIV subtypes and to facilitate timely adaptation of HIV antibody tests. Evaluations of such tests in oral fluid (saliva) in Burundi and Rwanda were successfully completed. Field assessments of WHO testing strategies were started in Argentina, Mexico and Uruguay. Field assessments of alternative simple methodologies for CD4+ lymphocyte determinations were initiated in Brazil, Thailand, United Republic of Tanzania and Venezuela.

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Vaccine development

35. Field sites for future HIV vaccine efficacy trials are being strengthened in Brazil, Thailand and Uganda. For the purpose of the trials, studies on eight cohorts of HIV-negative volunteers are being supported (three in Brazil and Uganda, and two in Thailand) to obtain accurate HIV incidence rates reflecting the protective effect of current non-vaccine interventions (i.e. counselling, education, promotion of condoms, STD treatment) and to determine the feasibility of compiling information on recruitment and follow-up. Protocols were prepared for repeat phase II trials of two HIV candidate vaccines which have already been tested in their country of origin. One such trial, involving a peptide-based candidate vaccine in Thailand, has been endorsed by the GPA Steering Committee on Vaccine Development. A meeting in October examined the scientific and public health rationales for the conduct of efficacy trials of HIV vaccines, especially in developing countries, and concluded that they could be undertaken with the presently available envelope-based candidate vaccines, provided strict scientific and ethical standards are respected.

36. The WHO network for HIV isolation and characterization completed a pilot study to characterize HIV-1 isolates from WHO-sponsored vaccine evaluation sites. A rapid and reliable method for virus genotyping was validated (heteroduplex mobility assay) and is now being used, in conjunction with V3 peptide serology, in more extensive molecular epidemiology studies at the sites. HIV-1 subtypes have different geographical distributions, and subtype C strains were identified for the first time in South America. Complete and functional molecular clones from different HIV-1 genetic subtypes were obtained and are being made available to researchers and the pharmaceutical industry, to stimulate the development of candidate HIV-1 vaccines.

Social and behavioural studies and support

37. On the advice of the GPA Steering Committee on Social and Behavioural Research, research proposals were supported in the following areas: contextual factors affecting risk-related sexual behaviour among young people; household and community responses to HIV and AIDS; and gender relations in the area of sexual negotiation. Studies were funded in 13 developing countries.

38. A report on sexual behaviour and knowledge about AIDS in the developing world, detailing findings from studies supported by WHO in 15 countries, was completed and will shortly be published.

39. A generic research protocol for studies of the determinants of HIV/AIDS-related discrimination, stigmatization and denial is being finalized, and assessment visits to identify institutions to carry out the study have so far been conducted in nine countries.

Prevention research

40. Research continued to focus on assessing the effectiveness of various HIV prevention approaches for populations most vulnerable to HIV infection, in particular, socially marginalized populations. Situation assessments to help design and plan interventions were conducted in Malaysia (focusing on risk reduction among homosexually active men) and India (focusing on injecting drug users), and are under way in Papua New Guinea (focusing on new sex-work settings).

41. Intervention-linked prevention research was undertaken at several sites. For example, studies are under way in Mexico to determine the effectiveness of condom promotion in migrant sex worker and client populations; in India to assess the feasibility and effectiveness of outreach measures among injecting drug users; and in Uganda, where the additional benefit of STD treatment is being compared with the effect of educational approaches alone. Research began in Zambia to assess the feasibility and impact of economic interventions as a means of minimizing the HIV transmission risk to women traders who are sexually exploited in the course of their work.

42. Preparations are being made for a collaborative multicentre study on the effectiveness of voluntary counselling and testing as a prevention strategy. This study, the first randomized controlled trial to be undertaken on this subject, will take place in conjunction with AIDSCAP, the AIDS control and prevention project.

IV. PROGRAMME DIRECTION

Women and AIDS

43. UNDP and WHO, in consultation with the United Nations Division for the Advancement of Women, prepared a position paper on women and AIDS reflecting concerns throughout the United Nations system; and it was used at regional conferences organized during 1994 by the five regional economic and social commissions in preparation for the 1995 fourth world conference on women in Beijing. Further input to the Beijing conference included arrangements for a consultation in early 1995 that will bring together politicians and senior policy-makers on gender issues and AIDS and produce recommendations for transmission to the Commission on the Status of Women, the body responsible for preparing the conference.

44. A paper was written on the epidemiology of biological, behavioural, sociodemographic and sociocultural gender-related risk factors for HIV/AIDS. Research on the development of female-controlled barrier methods and gender relations is described in paragraphs 31 and 37.

Sexually transmitted diseases

45. In January 1994 WHO assumed responsibility for providing the secretariat of the Sexually Transmitted Diseases Diagnostic Initiative (SDI) - a group of agencies, laboratory and public health experts and participating centres which, through a directed programme of research, seeks to design and make available rapid diagnostic tests that can be used at first-line health facilities in developing countries. An information meeting, attended by 32 companies interested in such tests, was held in September; and follow-up research and development activities were initiated.

46. A database for estimating the global annual incidence of STDs was assembled for use by national AIDS programmes, donors, academic institutes, foundations and others. In addition, guidelines were developed on assessing the extent of STDs and the delivery of prevention and control services, and on establishing a surveillance system to monitor future trends and anticipated need for services. Information on policies, features of STD services (e.g. vertical or horizontal, primary or secondary) and existing laws related to STD control programmes in individual countries was analysed and a report is in preparation.

47. A training module on syndromic case management was developed and field-tested in November. Operational research studies were initiated in Thailand and Viet Nam on the feasibility of integrating HIV/STD services into maternal and child health/family planning programmes. Assistance was also given in the formulation by the Special Programme of Research, Development and Research Training in Human Reproduction of a proposal to analyse reproductive health needs and conduct appropriate research within WHO.

Avoidance of discrimination/promotion of human rights

48. During 1994 the Programme continued to assess national AIDS programmes on the basis of medium-term plans and reports of external reviews, to ensure their adherence to human rights principles, and to provide technical advice where necessary. At the request of three governments, comments were provided on draft HIV/AIDS legislation. During the year the GPA country-specific human rights database was strengthened to improve the Programme's follow-up capacity. A meeting of experts working in the fields

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of HIV/AIDS, human rights, public health and the movement of populations was held in October 1994 as part of the development of a WHO policy on long-term travel restrictions imposed on people living with HIV/AIDS.

Collaboration with nongovernmental organizations

49. During 1994 the Programme continued to consult a variety of nongovernmental organizations, community-based organizations and groups representing people living with HIV/AIDS in order to determine ways of working with them more effectively, and also to produce guidelines on how to improve their collaboration with national AIDS programmes. Support was provided to major networks of nongovernmental organizations actively concerned with HIV/AIDS, and consultations were held with religious and other networks not yet active in order to stimulate their involvement. The role of nongovernmental organizations as partners in policy and programme development at global and national levels was supported in a variety of ways. Activities to support community responses focused on collaboration and partnership-building between governments and nongovernmental organizations and also amongst such organizations, as well as capacity-building within the nongovernmental sector (see also paragraph 22).

Advocacy

50. During 1994 the Programme continued to focus the world's attention on HIV/AIDS in order to combat complacency and denial of the problem. Further to the Dakar declaration on the AIDS epidemic in Africa adopted by the Heads of State and Government of the Organization of African Unity (OAU) in 1992, the thirtieth assembly of OAU Heads of State and Government (Tunisia, June 1994) adopted a declaration on AIDS and the African child, based on a background document prepared by WHO and reviewed by the OAU ministers of health. Other international and regional meetings where WHO took the opportunity to advocate a stronger response to the pandemic included the Kuwait fourth international conference on AIDS (March); a meeting on the role of women in AIDS prevention and control in the Eastern Mediterranean (Egypt, May); the Economic Commission for Africa panel on HIV/AIDS in Africa (Ethiopia, June); and the tenth international AIDS conference (Japan, August). In addition several missions were fielded at a high level in order to promote greater political commitment by individual governments to national AIDS control efforts.

51. Arrangements were made for a summit of heads of government or their representatives, to be convened jointly by the Government of France and WHO in Paris on 1 December 1994. A draft declaration was prepared for submission to the representatives of the 42 countries expected to attend, whereby they would endorse basic principles with regard to AIDS prevention, care and human rights, commit themselves to national action along the same lines, and launch international initiatives to accelerate the worldwide response to AIDS. Five preparatory meetings were organized on the subjects of blood safety; research into prevention technologies; care and support; prevention; and vulnerability to HIV infection and its consequences.

52. Public information continued to play a significant role in advocacy. Emphasis was placed on stimulating media coverage of key messages about HIV/AIDS and providing information to policy-makers and the general public. During 1994, 15 press releases were distributed, video news footage was prepared for the Tenth International Conference on AIDS and, in cooperation with UNDP, two short video features were distributed to more than 180 countries and broadcast worldwide by satellite. Media strategies were developed for several major events including the international AIDS conference and the Paris AIDS summit. By the end of 1994 the Programme's quarterly newsletter, *Global AIDSnews*, was being distributed in 36 000 copies per issue - 28 500 in English, 5750 in French and 2000 in Arabic. In addition, the People's Medical Publishing House of Beijing translated each 1993 issue and distributed 2000 copies to addresses in China.

53. Reflecting the fact that 1994 was the International Year of the Family, the theme chosen for the seventh World AIDS Day on 1 December was "AIDS and the family". After consulting nongovernmental and United Nations system organizations, and incorporating contributions from these sources, three World AIDS Day

newsletters were published focusing on the effect of AIDS on families and the role they can play in AIDS prevention and care, together with a small colour poster bearing the slogan "Families take care". Comprehensive resource packs of relevant documents were dispatched to all national AIDS programmes.

Advisory bodies

54. At its tenth meeting in May 1994, the GPA Management Committee reviewed the steps taken to establish a joint and cosponsored United Nations programme on HIV/AIDS in accordance with resolution EB93/R5 (see paragraph 57 and document EB95/48); recommended that the revised strategic plan for GPA in 1994-1999 be used as major input to a plan for the new programme; recommended that GPA continue developing HIV/AIDS programme targets and soliciting broad input into the process; urged that sufficient attention and resources continue to be given to STDs (whether HIV-related or not) under the new programme; and commended GPA for its action in including 10 priority research areas on women and AIDS in its research agenda.

55. During its three meetings in 1994 the Task Force on HIV/AIDS Coordination, established by the Management Committee in November 1992, approved for distribution in four languages a "Framework of guiding principles for HIV/AIDS coordination at country level"; continued its active participation in the development of the joint and cosponsored United Nations programme on HIV/AIDS; and prepared a database for production of the "Task force biennial report on external resources for HIV/AIDS (1992-1993)" in early 1995.

V. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM

56. The Inter-Agency Advisory Group on AIDS, for which WHO serves as secretariat, met twice during the year (Geneva, April; New York, November). The existing 15 United Nations system programmes and organizations which are members welcomed a request for membership from the United Nations International Drug Control Programme. Among the items considered at the meetings were the preparation of a joint position paper on women and AIDS for the fourth world conference on women (Beijing, September 1995); the development by WHO, in consultation with the United Nations Medical Service and the Department of Peace-Keeping Operations, of health education materials related to the prevention of HIV infection among peace-keeping forces; and the production by UNHCR and WHO of a minimum package for HIV/AIDS prevention and care in emergency situations.

57. The six cosponsors of the proposed joint and cosponsored United Nations programme on HIV/AIDS (UNDP, UNICEF, UNFPA, UNESCO, WHO and the World Bank) held planning meetings throughout 1994, initially as an interagency working group, and subsequently as the Committee of Cosponsoring Organizations (CCO). The proposal to set up the programme was endorsed by the WHO Executive Board in January, by the UNESCO Executive Board in April and by the Executive Boards of UNDP, UNICEF and UNFPA thereafter. The World Bank has also formally indicated its intention to be a cosponsor of the programme. In July 1994 the Economic and Social Council endorsed the creation of the programme and called on the six organizations to work together to prepare a detailed proposal for submission to the Council and the WHO Executive Board in January 1995.

58. In September 1994 the executive heads of the six cosponsors met to form the CCO and decided upon a process to select the director of the programme and to set up an interagency transition team in Geneva to prepare the detailed proposal requested by the Economic and Social Council.

59. At the 1994 session of the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities, WHO provided technical advice on the drafting of a resolution on HIV/AIDS and non-discrimination, and organized a briefing on HIV/AIDS and human rights. Briefing sessions were also

organized for the United Nations Committee on the Rights of the Child, and the United Nations Committee on Economic, Social and Cultural Rights. At a meeting organized by ILO in October 1994 on population and development, the Programme provided technical input on the subjects of family planning, mobility of populations and the socioeconomic impact of AIDS, including human rights issues.

60. A project on the control of maternal and congenital syphilis in Lusaka Province, Zambia, launched by UNICEF with technical assistance from WHO, was reviewed and a decision made to extend it to other provinces in 1995. Joint WHO/UNICEF intervention guidelines for the control of maternal and congenital syphilis are to be published in 1995. WHO also participated in meetings of UNICEF's five technical support groups for HIV/AIDS in the following areas: mass communication and community mobilization; sexual and reproductive health promotion; family and community care; school-based interventions; and youth and health development promotion. The aim of each group is to provide technical advice and some financial support for pilot activities in selected countries. WHO staff were designated as members of each of the groups.

61. The UNDP/WHO joint consultative group, established for the UNDP regional project on strengthening multisectoral and community responses to the HIV epidemic in Asia and the Pacific, met twice during the year (New Delhi, April; Viet Nam, December) with the participation of WHO headquarters and the three regional offices concerned. WHO also provided technical input to the project in respect of legal and economic networking and nongovernmental organizations. Following an evaluation of the UNDP regional project on confronting the socioeconomic impact of HIV/AIDS in sub-Saharan Africa, WHO participated with other United Nations bodies in drafting a new project document including activities such as training and support to legal networks.

62. WHO provided technical assistance to the World Bank in country assessment missions for STD programme development and support in four countries. Both organizations collaborated closely in the formulation of a World Bank-financed regional HIV/AIDS project for South-East Asia, which will serve Cambodia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Thailand and Viet Nam, particularly in promoting regional policy analysis and dialogue and supporting the implementation of priority strategies and multisectoral initiatives. The World Bank and WHO are also developing a regional initiative for Sahelian countries, focusing on intervention projects related to migration.

63. During the year, in collaboration with UNESCO, a resource package on the design of school AIDS education for use by curriculum planners, teachers and students (12-16 years) was published, and the final evaluation report of WHO/UNESCO pilot projects on school AIDS education (1988-1993) was issued.

VI. ACTION BY THE EXECUTIVE BOARD

64. The Executive Board is invited to take note of the report.

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GLOBAL PROGRAMME ON AIDS

The Current Global Situation of the HIV/AIDS Pandemic

3 July 1995

As of 30 June 1995, 1 169 811 cumulative AIDS cases in adults and children have been reported to the World Health Organization Global Programme on AIDS since the onset of the pandemic. This represents a 19% increase from the 985 119 cases reported in the 1 July 1994 Report.

The accompanying tables provide, by country and WHO Region, the number of reported AIDS cases to date, by year of diagnosis.

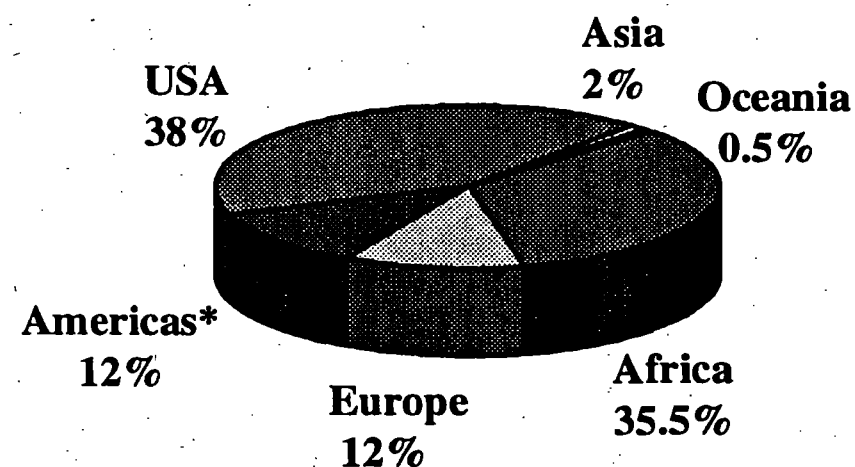
Figure 1 presents the global distribution of reported and estimated AIDS cases as of mid 1995. Allowing for under-diagnosis, incomplete reporting and reporting delay, and based on the available data on HIV infections around the world, it is estimated that over 4.5 million AIDS cases in adults and children have occurred worldwide since the pandemic began.

As of mid 1995, it is estimated that around 18.5 million adults, and more than 1.5 million children, have been infected with HIV since the beginning of the pandemic (late 1970s to early 1980s). Figure 2 presents the estimated regional distribution of total HIV infections in adults to date. The continued increase in HIV infections, particularly in southern and central Africa and South Asia, will accentuate the disproportionate impact of HIV/AIDS on the developing world.

Figure 3 shows the estimated regional distribution of HIV-infected adults (including AIDS cases) alive as of mid 1995.

Figure 1
Total number of AIDS cases in adults and children from
late 1970s/early 1980s until mid-1995

Reported: 1 169 811



Excluding USA

Estimated: 4 500 000 +

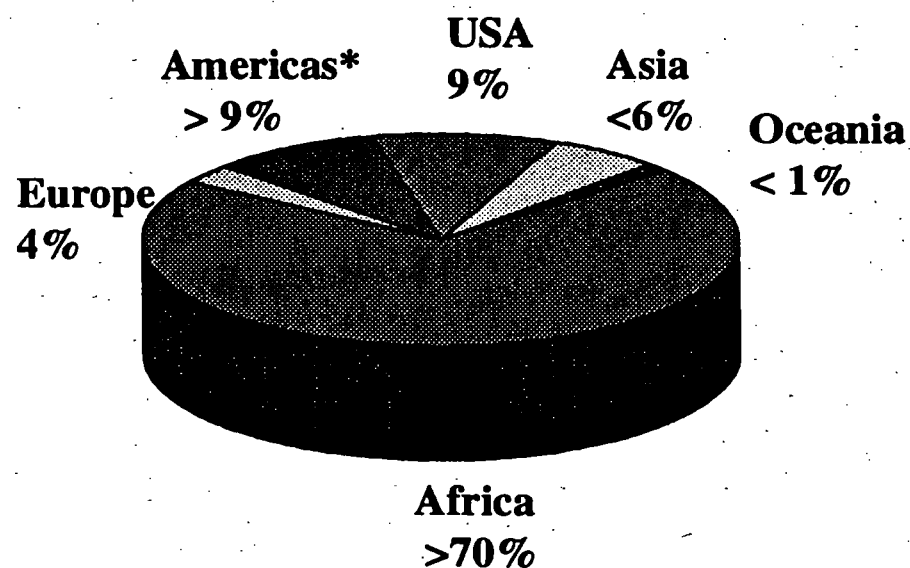
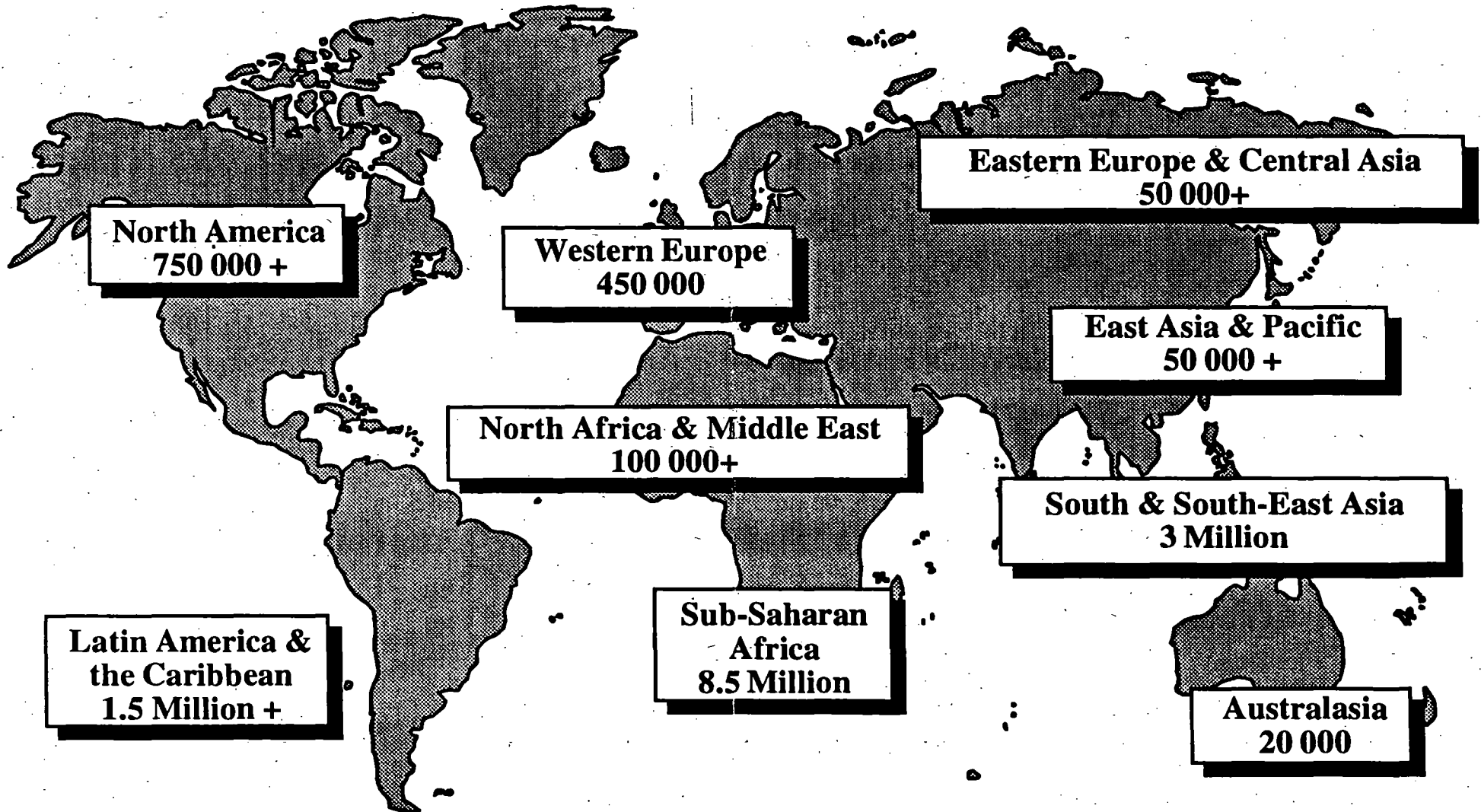


Figure 3
Estimated distribution of HIV-infected adults
alive as of mid-1995



Global Total: 14-15 M'll'on

Regional Office for Africa (AFRO)

AIDS Cases Reported to WHO by Country/Area Based on Reports Received through 30 June 1995

Country	1979-92	1993 Rate	1994 Rate	1995	Total	Last Report	Comments
Algeria	98	40 0.1	79 0.3	0	217	31/12/94	
Angola	588	135 1.2	157 1.4	35	895	31/03/95	
Benin	485	277 5.3	114 2.1	0	856	14/12/94	
Burkina Faso	2886	838 8.5	0 0.0	0	3722	31/12/93	
Botswana	1078	870 81.0	968 85.8	194	3110	05/08/95	
Burundi	8763	117 2.0	144 2.4	0	7024	31/12/94	
Cameroon	2197	1761 14.4	1417 11.3	0	5375	31/12/94	
Central African Rep.	3730	0 0.0	0 0.0	0	3730	30/11/92	
Cape Verde	85	17 4.1	10 2.3	0	92	31/12/94	
Chad	587	1010 18.5	1268 20.2	582	3457	31/05/95	
Congo	5267	1206 55.7	1300 58.4	0	7773	22/04/95	
Comoros	3	0 0.0	2 0.3	0	5	31/08/94	
Equatorial Guinea	19	24 5.1	16 3.3	15	74	07/06/95	
Eritrea	389	300 ***.*	825 ***.*	245	1539	31/05/95	
Ethiopia	4884	5124 10.1	5558 10.7	2476	18042	12/05/95	
Gabon	393	128 9.9	204 15.3	156	881	29/05/95	
Gambia	236	38 4.1	53 5.5	13	340	31/03/95	
Ghana	10305	2371 14.4	2330 13.7	0	15006	31/12/94	
Guinea-Bissau	288	185 15.8	254 23.5	0	707	31/12/94	
Guinea	677	328 4.4	543 7.1	0	1548	04/01/95	
Cote d'Ivoire	14655	4015 28.3	6586 44.6	0	25236	31/05/95	
Kenya	37029	11560 40.7	7347 24.8	637	56573	25/04/95	
Lesotho	182	297 15.4	38 1.8	0	515	31/12/94	
Liberia	28	163 5.8	0 0.0	0	191	31/03/94	
Madagascar	5	6 0.0	7 0.1	0	18	31/03/95	
Mali	1313	872 8.6	609 5.8	0	2594	10/01/95	
Malawi	26955	4916 52.8	4732 49.2	1070	37673	05/06/95	
Mauritius	15	3 0.3	9 0.8	0	27	31/12/94	
Mauritania	40	10 0.5	9 0.4	0	59	30/09/94	
Mozambique	662	164 1.0	534 3.1	455	1815	31/05/95	
Namibia	3622	1479 71.8	0 0.0	0	5101	31/12/93	
Nigeria	705	256 0.2	630 0.5	0	1591	31/05/95	
Niger	809	453 5.8	429 5.3	0	1691	07/03/95	
Reunion	85	0 0.0	0 0.0	0	85	20/03/92	
Rwanda	9486	1220 15.2	0 0.0	0	10706	30/06/93	
Senegal	848	349 4.4	100 1.2	0	1297	22/11/94	
Seychelles	0	1 1.5	5 7.6	0	6	12/09/94	
Sierra Leone	88	23 0.5	22 0.5	22	155	31/05/95	
South Africa	1891	1567 4.2	391 1.0	0	3849	27/07/94	
Sao Tome & Principe	11	2 1.8	0 0.0	0	13	25/03/94	
Swaziland	250	163 18.6	0 0.0	0	413	15/02/94	
United Rep. Tanzania	42422	3327 10.9	219 0.7	0	45968	30/06/94	Provisional distribution of cases by year
Togo	2142	1330 35.1	1284 32.8	353	5109	08/06/95	
Uganda	38552	2641 12.9	4927 23.2	0	46120	31/12/94	
Zaire	22159	588 1.5	3384 8.3	0	26131	06/07/94	Provisional distribution of cases by year
Zambia	7124	22610 239.3	0 0.0	0	29734	20/10/93	Provisional distribution of cases by year
Zimbabwe	18731	9174 86.0	10647 96.7	0	38552	31/12/94	
Total for the Region	270667	81736	56929	6263	415595		

***.* in the rate column indicates no population data available

Regional Office for Eastern Mediterranean (EMRO)

AIDS Cases Reported to WHO by Country/Area Based on Reports Received through 30 June 1995

Country	1979-82	1993 Rate	1994 Rate	1995	Total	Last Report	Comments
Afghanistan	0	0 0.0	0 0.0	0	0	15/02/92	
Bahrain	11	4 0.7	5 0.9	0	20	15/04/95	
Cyprus	24	6 0.8	11 1.5	0	41	26/04/95	Consolidated report
Djibouti	309	144 32.4	196 42.7	63	712	30/05/95	
Egypt	62	29 0.1	22 0.0	0	113	23/01/95	
Iran (Islamic Rep.)	60	32 0.1	19 0.0	3	114	07/06/95	
Iraq	13	11 0.1	12 0.1	2	38	11/04/95	
Jordan	24	7 0.1	7 0.1	0	38	07/02/95	
Kuwait	8	2 0.1	5 0.2	0	15	22/01/95	
Lebanon	37	32 1.0	14 0.4	0	83	18/04/95	
Libyan Arab J.	10	2 0.0	3 0.1	0	15	10/04/95	
Morocco	128	44 0.2	77 0.3	18	265	03/05/95	
Oman	30	4 0.2	14 0.8	3	51	07/05/95	
Pakistan	26	12 0.0	8 0.0	0	46	08/01/95	
Qatar	90	10 2.5	12 2.8	0	112	22/03/95	
Saudi Arabia	50	12 0.1	38 0.2	6	106	30/05/95	
Somalia	13	0 0.0	0 0.0	0	13	01/01/91	
Sudan	692	191 0.7	201 0.7	45	1129	31/01/95	
Syrian Arab Republic	23	3 0.0	4 0.0	0	30	31/05/95	
Tunisia	130	36 0.4	43 0.5	0	209	24/02/95	
United Arab Emirates	8	0 0.0	0 0.0	0	8	12/02/93	
Yemen	4	4 0.0	3 0.0	2	13	23/04/95	
Total for the Region	1752	585	694	140	3171		

Above statistics do not include 8 cases reported for UNRWA

Rate = per 100,000 population

Regional Office for South-East Asia (SEARO)***AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995**

	1979-92	1993	Rate	1994	Rate	1995	Total	Last	Comments
Country	Report								
Bangladesh	1	0	0.0	0	0.0	0	1	17/04/95	
Bhutan	0	0	0.0	0	0.0	0	0	17/04/95	
India	242	252	0.0	391	0.0	151	1038	17/04/95	
Indonesia	34	17	0.0	9	0.0	7	67	17/04/95	
Dem.P.Rep. of Korea	0	0	0.0	0	0.0	0	0	17/04/95	
Maldives	0	0	0.0	1	0.5	1	2	17/04/95	
Myanmar	47	142	0.3	198	0.5	90	475	17/04/95	
Nepal	12	12	0.1	8	0.0	3	35	17/04/95	
Sri Lanka	20	13	0.1	8	0.0	8	47	17/04/95	
Thailand	2141	8312	10.9	10303	17.5	339	18095	30/04/95	
Total for the Region	2497	6748		10916		597	20758		

* Mongolia is a member of the WHO Western Pacific Region as of 1.7.95

Rate = per 100,000 population

**AIDS Cases reported to WHO by Continent/year
Based on Reports Received through 30 June 1995**

NEW CASES							CUMULATIVE CASES						
Year	Africa	America	Asia	Europe	Oceania	TOTALS	Africa	America	Asia	Europe	Oceania	TOTALS	
1979	0	2	0	0	0	2	0	2	0	0	0	2	
1980	0	185	1	17	0	203	0	187	1	17	0	205	
1981	0	322	1	20	0	343	0	509	2	37	0	548	
1982	2	1156	1	80	91	1330	2	1665	3	117	91	1878	
1983	17	3352	8	295	6	3678	19	5017	11	412	97	5556	
1984	207	6680	8	570	76	7541	226	11697	19	982	173	13097	
1985	518	12682	27	1475	142	14844	744	24379	46	2457	315	27941	
1986	4108	21322	85	2416	269	28200	4852	45701	131	4873	584	56141	
1987	13401	34562	150	9508	419	58040	18253	80263	281	14381	1003	114181	
1988	24605	45880	174	10774	590	82023	42858	126143	455	25155	1593	198204	
1989	37941	49360	289	14307	679	102576	80799	175503	744	39462	2272	298780	
1990	49301	69882	482	17251	758	137674	130100	245385	1226	56713	3030	436454	
1991	77012	77641	833	18824	866	175176	207112	323026	2059	75537	3896	611630	
1992	64899	97968	2052	20477	810	186206	272011	420994	4111	96014	4708	797836	
1993	82182	96958	7376	21528	865	208909	354193	517952	11487	117542	5571	1006745	
1994	57471	60991	11718	21377	871	152428	411684	578943	23205	138919	6442	1159173	
1995	6387	1186	707	2356	2	10638	418051	580129	23912	141275	6444	1169811	
TOTALS	418051	580129	23912	141275	6444	1169811	418051	580129	23912	141275	6444	1169811	

Reporting Countries by continent

Reporting countries by WHO Region

	One or more cases	No of cases		One or more cases	No of cases
AFRICA	54	418051	AFRICA	47	415595
AMERICAS	45	580129	AMERICAS	45	580129
ASIA	42	23912	EASTERN MEDITERRANEAN	21	3171
EUROPE	37	141275	EUROPE	45	141768
OCEANIA	14	6444	SOUTH-EAST ASIA	8	20758
			WESTERN PACIFIC	26	8390
TOTAL	192	1169811	TOTAL	192	1169811



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AIDS's Economic Impact Contradictory, Complex

Conferees Discuss Epidemic's Possible Benefits

By David Brown

Washington Post Staff Writer

Thursday, July 11 1996; Page A03

The Washington Post

VANCOUVER, B.C., July 10 — The relationship between the AIDS epidemic and national economies is complicated and contradictory, and economists must look at the disease's effect on villages and households to observe its true impact, an expert asserted here today.

Predictions of the AIDS epidemic's dire effects on the economies of African nations have largely proved false, Josef Decosas, a physician and health economist, told delegates to the 11th International Conference on AIDS. Some recent studies in Africa have failed to detect the expected economic damage.

"National economies can be stimulated by many different events, some of them outright nefarious, such as wars and epidemics," Decosas said. "Measures of macroeconomic performance do not suffice as indicators of a society's well-being."

Many projections made a decade ago predicted higher rates of human immunodeficiency virus (HIV) infection in Africa than have occurred, and overestimated the disease's effects on the richer and more educated classes.

In addition, some of these projections did not take into account a large surplus labor force in Africa, capable of filling the jobs of AIDS victims who die while still young and productive. A study published last year by the National Bureau of Economic Research, a consulting company in Cambridge, Mass., found that AIDS was having no measurable effect on the growth of gross domestic product (GDP) in 51 countries.

Though beneficial economic effects from the AIDS epidemic haven't been noted, Decosas said people shouldn't be surprised if they eventually emerge. He gave two examples from history.

"The plague epidemic of the 14th Century killed one-third of Europe's population, caused wages to rise, and was a decisive factor in ending the feudal system and heralding the rise of Europe's global economic dominance," he told people attending a plenary session of the conference.

"Similarly, the syphilis epidemic which followed in the 16th Century caused widespread death among Europe's population. But it allowed the emerging bourgeoisie to finally overcome the stranglehold of the aristocracy and clear the way for the merchant empires of the Victorian era."

Decosas made his provocative comments, he said, not to promote complacency about the epidemic in developing countries. Instead, he said he wants to direct the attention of economists and researchers to the disease's profound effects on "microeconomic"

structures such as families and households.

For example, he cited the shift from protein-rich but labor-intensive crops to starchy but lower-maintenance crops in some areas hard-hit by the epidemic. This change affects the nutrition of family members who are not infected with the virus. Similarly, the loss of male wage-earners in Africa has left many households led by young women — a trend that is leading to the "feminization" of poverty that impedes social and educational advancement for women.

These impacts can be detected, Decosas argued, when something other than GDP is used to measure HIV's effects on a nation. A new yardstick, called the "human development index" (HDI), was formulated in 1990. It takes into account four variables: life expectancy at birth, adult literacy rate, mean years of schooling, and an adjusted measure of per capita economic production. Some economists are now using HDI to assess the AIDS epidemic's effects, and Decosas called this "an important conceptual achievement."

Research presented here this week both contradicts and supports Decosas's thesis.

An analysis of Kenya projects that AIDS is having a profound effect on that country's economy. Researchers projected the GDP in 2005 will be one-sixth less than it would have been without the disease. Per capita income will be 10 percent lower and personal savings 15 percent lower, they found.

Two studies of the rural Rakai district in Uganda illustrated AIDS's effects on households. In the first, researchers found that while 19 percent of the population was infected, 31 percent of households had at least one infected individual. The other found that 15 percent of children under age 15 had lost at least one parent. Those families had lower incomes than unaffected families; and only 47 percent of the girls and 67 percent of the boys in the affected families went to school.

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GLOBAL PROGRAMME ON AIDS

The Current Global Situation of the HIV/AIDS Pandemic

15 December 1995

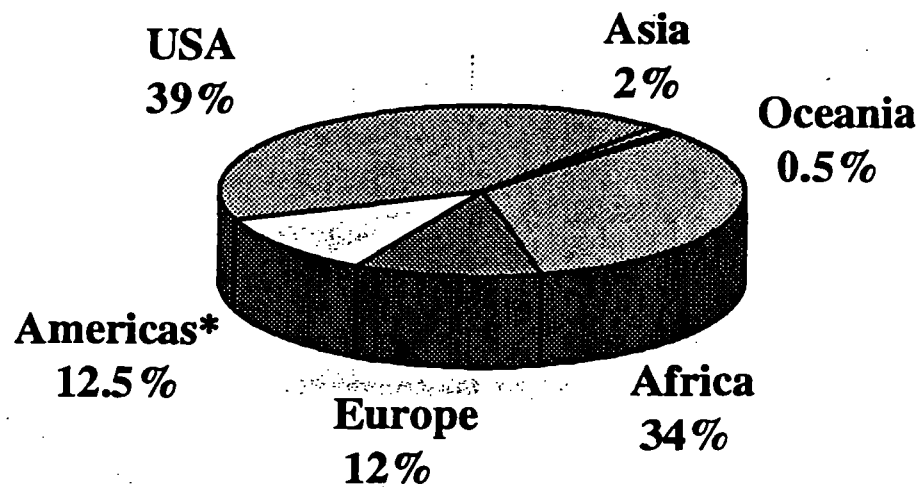
As of 15 December 1995, 1 291 810 cumulative AIDS cases in adults and children have been reported to the World Health Organization Global Programme on AIDS from 193 countries. This represents a 26% increase from the 1 025 073 cases reported in the 3 January 1995 Update (and in the *Weekly Epidemiological Record* of 13 January 1995).

The accompanying tables provide, by country and WHO Region, the number of reported AIDS cases to date, by year of diagnosis.

In January 1995, WHO estimated that there were 13-15 million HIV-infected adults alive as of late 1994 (*Weekly Epidemiological Record*, No. 2, 13 January 1995). In 1995, following a country-by-country review of HIV/AIDS data, WHO revised its estimate of 1994 adult HIV prevalence to 16.9 million (see "Provisional Working Estimates of Adult HIV Prevalence as of end 1994 by Country", attached, and in the *Weekly Epidemiological Record*, 15 December 1995). Based on these revised prevalence estimates, and allowing for under-diagnosis, incomplete reporting, and reporting delay, WHO provisionally estimates that 6 million adult and paediatric cumulative AIDS cases have occurred as of late 1995 (see Figure 1 for reported and estimated AIDS cases). As new data have been incorporated, and a more detailed estimation has been made, this estimate should not be compared with previously published estimates of cumulative AIDS cases.

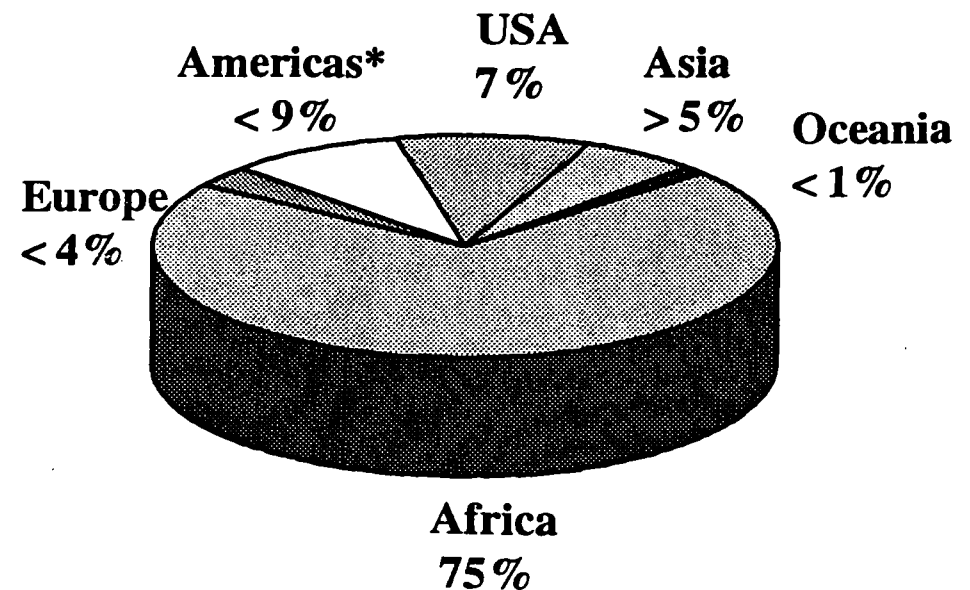
Figure 1
Total number of AIDS cases in adults and children from
late 1970s/early 1980s until late 1995

Reported: 1 291 810



***Excluding USA**

Estimated: 6 000 000**



****Adjusted following review of global estimates**



Regional Office for Africa (AFRO)

AIDS Cases Reported to WHO by Country/Area Based on Reports Received through 15 December 1995

Country	1979-92	1993 Rate	1994 Rate	1995	Total	Last Report	Comments
Algeria	98	40	0.1	79	0.3	0	217 31/12/94
Angola	588	135	1.2	157	1.4	35	895 31/03/95
Benin	465	277	5.3	324	6.0	0	1066 10/07/95
Burkina Faso	2886	838	8.5	0	0.0	0	3722 31/12/93
Botswana	1078	870	61.0	968	65.6	194	3110 05/06/95
Burundi	6763	117	2.0	144	2.4	0	7024 31/12/94
Cameroon	2197	1761	14.4	1417	11.3	0	5375 31/12/94
Central African Rep.	3950	290	9.2	50	1.6	173	4463 10/11/95
Cape Verde	65	17	4.1	10	2.3	0	92 31/12/94
Chad	587	1010	16.5	1268	20.2	592	3457 31/05/95
Congo	5267	1206	55.7	1300	58.4	0	7773 22/04/95
Comoros	3	2	0.4	2	0.3	0	7 15/11/95
Equatorial Guinea	19	24	5.1	16	3.3	98	157 09/11/95
Eritrea	369	300	***.*	625	***.*	370	1664 31/07/95
Ethiopia	4884	5124	10.1	5558	10.7	3867	19433 30/07/95
Gabon	393	128	9.9	204	15.3	265	890 27/10/95
Gambia	236	38	4.1	53	5.5	42	369 30/09/95
Ghana	10285	2371	14.4	2330	13.7	904	15890 30/06/95
Guinea-Bissau	288	165	15.6	254	23.5	0	707 31/12/94
Guinea	677	328	4.4	543	7.1	133	1681 31/03/95
Cote d'Ivoire	14655	4015	28.3	8566	44.6	0	25236 31/05/95
Kenya	37029	11560	40.7	7347	24.8	637	58573 25/04/95
Lesotho	182	297	15.4	38	1.8	0	515 31/12/94
Liberia	28	163	5.8	0	0.0	0	191 31/03/94
Madagascar	5	6	0.0	7	0.1	4	22 14/11/95
Mali	1313	672	6.6	609	5.8	0	2594 10/01/95
Malawi	26955	4916	52.8	4732	49.2	3386	39989 06/11/95
Mauritius	15	3	0.3	9	0.8	0	27 31/12/94
Mauritania	63	27	1.2	24	1.1	18	130 22/08/95
Mozambique	662	164	1.0	534	3.1	455	1815 31/05/95
Namibia	3622	1479	71.8	0	0.0	0	5101 31/12/93
Nigeria	705	256	0.2	630	0.5	0	1591 31/05/95
Niger	809	453	5.8	467	5.8	0	1729 13/10/95
Reunion	65	0	0.0	0	0.0	0	65 20/03/92
Rwanda	9466	1220	15.2	0	0.0	0	10706 30/06/93
Senegal	648	263	3.3	534	6.5	128	1573 27/06/95
Seychelles	0	1	1.5	5	7.6	0	6 12/09/94
Sierra Leone	88	23	0.5	22	0.5	29	162 31/10/95
South Africa	2065	1721	4.6	3499	9.1	1120	8405 03/08/95
Sao Tome & Principe	11	2	1.8	1	0.9	4	18 28/08/95
Swaziland	247	165	18.9	120	13.2	58	590 28/10/95
United Rep. Tanzania	42884	7599	24.9	2764	8.7	0	53247 18/05/95
Togo	2142	1330	35.1	1284	32.8	853	5609 30/06/95
Uganda	38552	2841	12.9	4927	23.2	0	46120 31/12/94
Zaire	22159	588	1.5	3384	8.3	0	26131 06/07/94 Provisional distribution of cases by year
Zambia	27898	2901	30.7	1692	17.3	0	32491 02/06/95
Zimbabwe	18731	9174	86.0	10647	96.7	2746	41298 19/10/95
Total for the Region	292097	66678		85142		16109	440026

***.* in the rate column indicates no population data available

Rate = per 100,000 population

Regional Office for the Americas (AMRO)

AIDS Cases Reported to WHO by Country/Area Based on Reports Received through 15 December 1995

Country	1979-92	1993 Rate	1994 Rate	1995	Total	Last Report	Comments
Antigua Barbuda	27	7 8.5	6 7.3	1	41	31/03/95	
Anguilla	5	0 0.0	0 0.0	0	5	31/03/95	
Argentina	2880	1381 4.1	1888 5.6	688	8835	30/09/95	
Bahamas	1092	297 121.2	322 131.4	165	1876	30/06/95	
Barbados	330	88 32.9	119 44.1	49	586	30/06/95	
Bermuda	208	15 26.3	44 77.2	24	291	30/06/95	
Belize	68	24 13.6	8 4.5	0	100	30/06/94	
Bolivia	68	20 0.3	13 0.2	4	105	30/06/95	
Brazil	43328	13214 8.3	11871 7.3	2698	71111	02/09/95	
Canada	8841	1518 5.6	1271 4.6	489	12119	30/09/95	
Cayman Islands	15	0 0.0	3 17.6	0	18	30/06/95	
Chile	735	225 1.6	216 1.5	114	1290	30/09/95	
Colombia	3714	725 2.2	1143 3.3	181	5763	30/06/95	
Costa Rica	458	125 3.9	156 4.7	112	851	30/09/95	
Cuba	179	80 0.8	89 0.8	31	379	08/07/95	
Dominica	12	14 16.1	5 5.7	0	31	30/06/94	
Dominican Republic	2093	337 4.4	311 4.0	207	2948	30/09/95	
Ecuador	265	85 0.7	117 1.0	24	491	31/03/95	
El Salvador	429	176 3.1	387 6.7	256	1248	30/09/95	
French Guiana	315	58 65.9	55 62.5	61	489	30/08/95	
Grenada	35	21 20.2	7 6.7	0	63	31/12/94	
Guadeloupe	337	93 27.1	110 31.9	83	623	30/09/95	
Guatemala	366	118 1.2	110 1.1	0	594	31/12/94	
Guyana	390	107 9.8	105 9.5	96	698	30/06/95	
Haiti	4967	0 0.0	0 0.0	0	4967	31/12/92	
Honduras	2448	964 17.1	793 13.7	219	4424	30/06/95	
Jamaica	433	236 9.0	359 13.5	286	1314	30/09/95	
Martinique	226	34 10.1	48 14.3	36	344	30/09/95	
Mexico	14112	5094 5.4	4048 4.2	3406	26660	30/09/95	
Montserrat	6	1 10.0	0 0.0	0	7	30/06/95	
Netherlands Antilles	124	48 25.7	0 0.0	5	177	30/09/95	Includes 20 cases reported in Aruba
Nicaragua	54	17 0.4	37 0.8	9	117	30/09/95	
Panama	479	176 6.9	187 7.2	105	947	30/09/95	
Paraguay	98	45 1.0	24 0.5	9	176	30/06/95	
Peru	1724	381 1.6	415 1.7	189	2709	30/06/95	
Saint Lucia	41	12 8.4	13 9.1	7	73	30/09/95	
Saint Vincent	46	8 7.1	8 7.1	5	67	30/06/95	
Saint Kitts & Nevis	37	3 6.5	5 10.9	2	47	30/06/95	
Suriname	134	35 8.3	20 4.7	20	209	30/06/95	
Turks and Caicos Is.	25	14 140.0	0 0.0	0	39	30/09/93	
Trinidad & Tobago	1231	243 18.1	269 19.7	149	1892	30/06/95	
Uruguay	335	103 3.2	119 3.7	101	658	30/09/95	
USA	331772	73774 29.0	58255 22.7	37509	501310	31/10/95	Provisional distribution of cases by year
Venezuela	3176	813 3.8	518 2.4	453	4960	30/09/95	
British Virgin Is.	5	2 20.0	1 10.0	2	10	30/06/95	
Total for the Region	427683	100731	83475	47793	859862		

Rate = per 100,000 population

Regional Office for Eastern Mediterranean (EMRO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 15 December 1995

Country	1978-82	1983	Rate	1984	Rate	1985	Total	Last	Comments
								Report	
Afghanistan	0	0	0.0	0	0.0	0	0	15/02/82	
Bahrain	11	4	0.7	5	0.9	8	28	21/11/85	
Cyprus	34	4	0.8	9	1.2	0	47	29/10/95	Consolidated report
Djibouti	309	144	32.4	198	42.7	119	768	30/10/95	
Egypt	82	29	0.1	22	0.0	7	120	01/08/85	
Iran (Islamic Rep.)	80	32	0.1	19	0.0	7	118	29/11/95	
Iraq	13	11	0.1	12	0.1	6	42	02/11/95	
Jordan	24	7	0.1	7	0.1	1	39	28/10/85	
Kuwait	8	2	0.1	5	0.2	3	18	05/11/95	
Lebanon	37	32	1.0	14	0.4	8	91	02/11/95	
Libyan Arab J.	10	2	0.0	3	0.1	0	15	10/04/85	
Morocco	128	44	0.2	77	0.3	31	280	27/08/95	
Oman	30	4	0.2	14	0.8	7	55	13/11/95	
Pakistan	26	12	0.0	8	0.0	6	52	05/11/95	
Qatar	62	7	1.7	6	1.4	5	80	11/11/95	
Saudi Arabia	50	12	0.1	38	0.2	37	137	15/11/95	
Somalia	13	0	0.0	0	0.0	0	13	06/07/95	
Sudan	692	191	0.7	201	0.7	174	1258	30/10/95	
Syrian Arab Republic	23	3	0.0	4	0.0	0	30	08/07/95	
Tunisia	130	36	0.4	43	0.5	46	255	11/08/95	
United Arab Emirates	8	0	0.0	0	0.0	0	8	12/02/93	
Yemen	4	4	0.0	3	0.0	9	20	18/10/95	
Total for the Region	1734	580		686		474	3474		

Above statistics do not include 8 cases reported for UNRWA

Rate = per 100,000 population

Regional Office for Europe (EURO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 15 December 1995

Country	1979-92	1993 Rate	1994 Rate	1995 Total	Last Report	Comments
Albania	0	0 0.0	3 0.1	2	5 30/09/95	
Armenia	2	0 0.0	0 0.0	0	2 30/04/93	
Austria	950	224 3.0	155 2.1	113	1442 30/09/95	
Azerbaijan	0	0 0.0	1 0.0	1	2 30/09/95	
Belgium	1384	244 2.4	229 2.3	73	1930 30/09/95	
Belarus	8	2 0.0	2 0.0	2	14 30/09/95	
Bulgaria	18	6 0.1	10 0.1	1	35 30/09/95	
Croatia	50	10 0.2	17 0.4	12	89 30/09/95	
Czech Republic	32	15 0.2	12 0.1	10	69 30/09/95	
Denmark	1158	239 4.7	233 4.5	151	1781 30/09/95	
Germany	9744	1737 2.9	1547 2.6	637	13665 30/09/95	
Estonia	2	1 0.1	1 0.1	2	6 30/09/95	
Finland	122	25 0.5	44 0.9	25	216 30/09/95	
France	25288	5347 9.4	5284 9.3	2453	38372 30/09/95	
Georgia	2	0 0.0	0 0.0	0	2 30/04/93	
Greece	742	195 1.9	184 1.8	115	1236 30/09/95	
Hungary	115	33 0.3	23 0.2	24	195 30/09/95	
Iceland	26	6 2.3	3 1.1	2	37 30/09/95	
Ireland	349	69 1.8	59 1.5	14	491 30/09/95	
Israel	240	49 1.0	28 0.6	23	340 30/09/95	
Italy	17127	4741 8.2	5348 9.3	3231	30447 30/09/95	
Kazakhstan	0	2 0.0	3 0.0	0	5 30/09/95	
Kyrgyzstan	0	0 0.0	0 0.0	0	0 30/04/93	
Lithuania	4	1 0.0	0 0.0	1	6 30/09/95	
Luxembourg	57	20 5.4	13 3.5	10	100 30/09/95	
Latvia	4	3 0.1	2 0.1	0	9 30/09/95	
Malta	26	3 0.8	5 1.4	1	35 30/09/95	
Republic of Moldova	4	0 0.0	0 0.0	2	6 30/09/95	
Monaco	23	7 25.9	4 14.8	3	37 30/09/95	
Netherlands	2584	459 3.1	450 3.0	241	3734 30/09/95	
Norway	311	63 1.5	71 1.7	37	482 30/09/95	
Poland	131	68 0.2	94 0.2	53	346 30/09/95	
Portugal	1454	493 4.8	530 5.1	249	2726 30/09/95	
Romania	2307	430 1.8	471 2.0	393	3601 30/09/95	
Russian Federation	130	13 0.0	27 0.0	21	191 30/09/95	
San Marino	1	0 0.0	0 0.0	0	1 30/09/95	September 1992 data
Spain	20208	5123 12.9	6388 18.0	2901	34618 30/09/95	
Slovak Republic	6	1 0.0	3 0.1	2	12 30/09/95	
Slovenia	24	7 0.4	6 0.3	10	47 30/09/95	
Sweden	799	179 2.1	182 2.2	116	1276 30/09/95	
Switzerland	3496	588 9.0	523 8.0	188	4795 30/09/95	
Tajikistan	0	0 0.0	0 0.0	0	0 30/09/95	March 1995 data
Turkmenistan	1	0 0.0	0 0.0	0	1 30/04/93	
Turkey	98	33 0.1	33 0.1	8	172 30/09/95	
Ukraine	12	10 0.0	10 0.0	16	48 30/09/95	
UK	7629	1621 2.8	1526 2.7	718	11494 30/09/95	
Uzbekistan	1	1 0.0	0 0.0	0	2 30/09/95	
Yugoslavia*	280	70 0.3	82 0.3	77	509 30/09/95	
Total for the Region	98947	22138	23606	11938	154629	

*Refers to states/areas of the former Socialist Federal Republic of
Yugoslavia not otherwise listed separately

Rate = per 100,000 population

Regional Office for South-East Asia (SEARO)

AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 15 December 1995

Country	1979-92	1993	Rate	1994	Rate	1995	Total	Last	Comments
								Report	
Bangladesh	1	0	0.0	0	0.0	6	7	22/11/95	
Bhutan	0	0	0.0	0	0.0	0	0	22/11/95	
India	242	252	0.0	391	0.0	1210	2095	22/11/95	
Indonesia	34	17	0.0	8	0.0	22	82	22/11/95	
Dem.P.Rep. of Korea	0	0	0.0	0	0.0	0	0	22/11/95	
Maldives	0	0	0.0	1	0.5	1	2	22/11/95	
Myanmar	47	142	0.3	196	0.5	185	570	22/11/95	
Nepal	12	12	0.1	8	0.0	16	48	22/11/95	
Sri Lanka	20	13	0.1	8	0.0	11	52	22/11/95	
Thailand	2141	6312	10.9	10303	17.5	3379	22135	22/11/95	
Total for the Region	2497	6748		10916		4830	24991		

Rate = per 100,000 population

Regional Office for Western Pacific (WPRO)

**AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 15 December 1995**

Country	1979-92	1993 Rate	1994 Rate	1995	Total	Last Report	Comments
American Samoa	0	0 0.0	0 0.0	0	0	0 30/03/95	
Australia	4170	792 4.6	811 4.6	110	5883	31/03/95	
Palau	0	1 10.0	0 0.0	0	1	20/10/95	
Brunei Darussalam	5	1 0.4	0 0.0	0	6	30/04/95	
Cambodia	0	1 0.0	9 0.1	76	86	15/10/95	
China	13	23 0.0	28 0.0	12	77	30/06/95	
Cook Islands	0	0 0.0	0 0.0	0	0	31/12/94	
Fiji	4	1 0.1	2 0.3	0	7	20/03/95	
French Polynesia	33	9 4.9	3 1.6	0	45	31/12/94	
Guam	14	5 4.0	11 8.9	1	31	31/08/95	
Hong Kong	73	19 0.3	38 0.6	18	148	30/06/95	
Japan	538	147 0.1	204 0.2	173	1062	31/10/95	
Kiribati	0	0 0.0	0 0.0	0	0	27/09/95	
Republic of Korea	10	6 0.0	11 0.0	5	32	31/05/95	
Lao People's Dem Rep	2	4 0.1	4 0.1	3	13	30/08/95	
Malaysia	77	40 0.2	72 0.4	70	259	31/07/95	
Macao	4	2 0.4	2 0.4	0	8	30/06/95	
F. States Micronesia	2	0 0.0	0 0.0	0	2	11/10/95	
Mariana Islands	4	0 0.0	2 20.0	0	6	01/10/95	
Mongolia	0	0 0.0	0 0.0	0	0	01/10/95	
Rep.Marshall Island	2	0 0.0	0 0.0	0	2	30/09/95	
New Caledonia	28	6 3.9	7 4.6	2	43	08/06/95	
New Zealand	389	52 1.5	42 1.2	28	511	30/09/95	
Niue	0	0 0.0	0 0.0	0	0	26/04/95	
Nauru	0	0 0.0	0 0.0	0	0	08/06/95	
Philippines	95	32 0.0	56 0.1	37	220	31/08/95	
Papua New Guinea	71	12 0.3	28 0.6	32	141	28/09/95	
Singapore	53	22 0.8	48 1.7	22	145	30/06/95	
Samoa	1	0 0.0	0 0.0	1	2	31/07/95	
Solomon Islands	0	0 0.0	0 0.0	0	0	29/09/95	
Tokelau	0	0 0.0	0 0.0	0	0	19/09/95	
Tonga	3	1 1.0	1 1.0	0	5	02/11/94	
Tuvalu	0	0 0.0	0 0.0	0	0	31/12/94	
Vanuatu	0	0 0.0	0 0.0	0	0	10/04/95	
Viet Nam	0	104 0.1	109 0.1	78	292	20/09/95	Provisional distribution of cases by year
Wallis and Futuna Is	0	0 0.0	1 12.5	0	1	28/09/95	
Total for the Region	5591	1280	1488	689	9028		

Rate = per 100,000 population

AIDS Cases reported to WHO by Continent/year
Based on Reports Received through 15 December 1995

NEW CASES							CUMULATIVE CASES					
Year	Africa	America	Asia	Europe	Oceania	TOTALS	Africa	America	Asia	Europe	Oceania	TOTALS
1979	0	2	0	0	0	2	0	2	0	0	0	2
1980	0	185	1	17	0	203	0	187	1	17	0	205
1981	0	322	1	20	0	343	0	509	2	37	0	548
1982	2	1156	1	80	91	1330	2	1665	3	117	91	1878
1983	17	3352	8	295	8	3678	19	5017	11	412	97	5556
1984	187	6680	8	570	76	7521	206	11697	19	982	173	13077
1985	521	12682	27	1475	142	14847	727	24379	46	2457	315	27924
1986	5438	21322	86	2395	252	29493	6185	45701	132	4852	567	57417
1987	16854	34562	150	9640	324	61530	23019	80263	282	14492	891	118947
1988	28212	47697	176	10811	598	87494	51231	127960	458	25303	1489	206441
1989	41295	56202	288	14355	699	112839	92528	184162	746	39658	2188	319280
1990	54528	65041	478	17311	770	138128	147054	249203	1224	56969	2958	457408
1991	72756	78579	838	18937	897	172007	219810	327782	2062	75906	3855	629415
1992	73631	99881	2039	20697	866	197114	293441	427663	4101	96603	4721	826529
1993	67124	100731	7368	22053	879	198155	360565	528394	11469	118656	5600	1024684
1994	65684	83475	11707	23541	906	185313	426249	611869	23176	142197	6506	1209997
1995	16486	47793	5454	11906	174	81813	442735	659662	28630	154103	6680	1291810
TOTALS	442735	659662	28630	154103	6680	1291810	442735	659662	28630	154103	6680	1291810

Reporting Countries by continent

Reporting countries by WHO Region

	One or more cases	No of cases		One or more cases	No of cases
AFRICA	54	442735	AFRICA	47	440026
AMERICAS	45	659662	AMERICAS	45	659662
ASIA	42	28630	EASTERN MEDITERRANEAN	21	3474
EUROPE	38	154103	EUROPE	46	154629
OCEANIA	14	6680	SOUTH-EAST ASIA	8	24991
			WESTERN PACIFIC	26	9028
TOTAL	193	1291810	TOTAL	193	1291810

PROVISIONAL WORKING ESTIMATES OF ADULT HIV PREVALENCE AS OF END 1994 BY COUNTRY*

Following a country-by-country review of HIV/AIDS data, the World Health Organization estimates that globally approximately 17 million adults were living with HIV infection at the end of 1994. The majority (66%) of these infections were in sub-Saharan Africa (11.2 million) followed by South and South-east Asia (3 million) with Australasia having the fewest infections (12 000). In 50 countries the estimated HIV prevalence rate was less than 5 per 10 000 sexually active adults and in 15 countries (all in sub-Saharan Africa) the prevalence rate was over 500 per 10 000. The lowest prevalence rates were seen in Central and East Asia and the highest in Central and Southern Africa.

WHO uses several methods and a variety of data sources to make estimates of the current and future extent of the HIV/AIDS pandemic (*submitted for publication*). Official country estimates of HIV prevalence made by national experts or national AIDS programmes are used when available. When not available, WHO makes estimates based upon a review of HIV sero-prevalence studies, reported AIDS cases, estimates of under-reporting, population size and structure (including the age/sex distribution and urban/rural differentials in HIV spread), and the predominant modes of transmission. HIV sero-prevalence rates for populations at increased risk of HIV infection are used to set an upper limit for the national estimate. Sero-prevalence data from studies of groups thought to be more representative of the general population are used as the basis of the national estimate. When appropriate, HIV prevalence is estimated for sub-populations of a country and then aggregated for a national estimate.

Estimates of HIV prevalence are intended to give an indication of the magnitude of the HIV pandemic but should be considered provisional, due to the difficulties in accurately assessing levels of HIV infection in national populations.

***Countries with adult populations of over 100 000**

**PROVISIONAL WORKING ESTIMATES OF ADULT HIV PREVALENCE
AS OF END 1994, BY COUNTRY***

WHO Region	Country	Number of adult HIV infections	Percent adult HIV prevalence rate
AFRO	Algeria	10,000	.073
	Angola	48,000	1.040
	Benin	27,000	1.190
	Botswana	125,000	18.012
	Burkina Faso	300,000	6.682
	Burundi	75,000	2.675
	Cameroon	175,000	3.029
	Central African Rep	85,000	5.794
	Chad	75,000	2.685
	Comoros	250	.093
	Congo	80,000	7.188
	Cote d'Ivoire	390,000	6.767
	Equatorial Guinea	2,000	1.143
	Eritrea	50,000	3.175
	Ethiopia	588,000	2.494
	Gabon	13,000	2.273
	Gambia	11,000	2.124
	Ghana	172,000	2.251
	Guinea	17,000	.594
	Guinea-Bissau	15,000	3.145
	Kenya	1,000,000	8.314
	Lesotho	28,000	3.080
	Liberia	17,000	1.325
	Madagascar	2,500	.063
	Malawi	650,000	13.624
	Mali	58,000	1.261
	Mauritania	7,000	.678
	Mauritius	500	.080
	Mozambique	400,000	5.755
	Namibia	45,000	6.456
	Niger	40,000	1.046
	Nigeria	1,050,000	2.159
	Reunion	150	.043
	Rwanda	250,000	7.153
	Senegal	50,000	1.355
	Sierra Leone	60,000	2.994
	South Africa	650,000	3.230
	Swaziland	15,000	3.778
	Togo	150,000	8.460
	Uganda	1,300,000	14.541
	United Rep Tanzania	840,000	6.444
	Zaire	680,000	3.744
	Zambia	700,000	17.102
	Zimbabwe	900,000	17.354

**PROVISIONAL WORKING ESTIMATES OF ADULT HIV PREVALENCE
AS OF END 1994, BY COUNTRY***

AMRO	Argentina	60,000	.359
	Bahamas	6,000	3.922
	Barbados	4,000	2.778
	Belize	2,000	2.020
	Bolivia	2,000	.058
	Brazil	550,000	.652
	Canada	30,000	.191
	Chile	10,000	.134
	Colombia	40,000	.213
	Costa Rica	9,000	.518
	Cuba	1,300	.021
	Dominican Republic	40,000	.987
	Ecuador	16,000	.280
	El Salvador	15,000	.564
	Guatemala	20,000	.428
	Guyana	6,000	1.293
	Haiti	150,000	4.444
	Honduras	40,000	1.568
	Jamaica	12,000	.915
	Mexico	200,000	.418
	Nicaragua	1,500	.079
	Panama	8,000	.591
	Paraguay	2,600	.110
	Peru	30,000	.248
	Suriname	2,500	1.163
	Trinidad & Tobago	6,000	.885
	Uruguay	5,000	.325
	USA	700,000	.514
	Venezuela	35,000	.318
EMRO	Afghanistan	50	.001
	Bahrain	500	.155
	Cyprus	1,000	.271
	Djibouti	8,000	3.008
	Egypt	7,500	.025
	Iran (Islamic Rep)	1,000	.003
	Iraq	250	.003
	Jordan	600	.024
	Kuwait	1,000	.115
	Lebanon	1,350	.090
	Libyan Arab J.	1,300	.055
	Morocco	5,000	.036
	Oman	1,000	.111
	Pakistan	40,000	.063
	Qatar	290	.086
	Saudi Arabia	1,000	.012
	Somalia	10,000	.252
	Sudan	125,000	.992

**PROVISIONAL WORKING ESTIMATES OF ADULT HIV PREVALENCE
AS OF END 1994, BY COUNTRY***

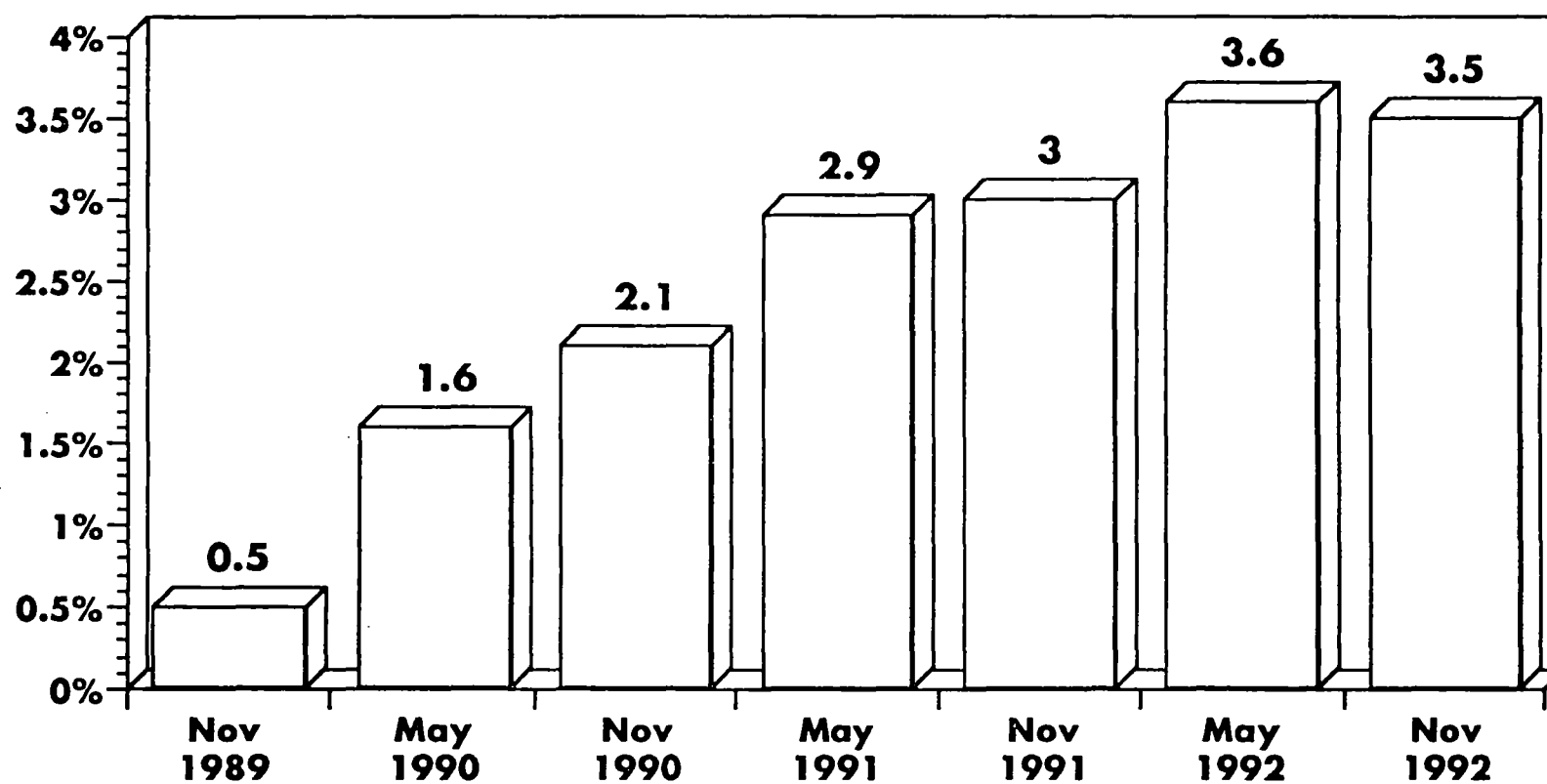
	Syrian Arab Republic	700	.011
	Tunisia	2,000	.044
	United Arab Emirates	2,000	.184
	Yemen	750	.012
EURO	Albania	100	.006
	Armenia	20	.001
	Austria	8,000	.197
	Azerbaijan	50	.001
	Belarus	200	.004
	Belgium	10,000	.197
	Bosnia & Herzgova.	750	.039
	Bulgaria	300	.007
	Croatia	300	.013
	Czech Rep.	2,000	.037
	Denmark	4,000	.151
	Estonia	40	.005
	Finland	500	.019
	France	90,000	.307
	Georgia	500	.019
	Germany	43,000	.106
	Greece	5,000	.098
	Hungary	3,000	.058
	Iceland	200	.143
	Ireland	1,700	.094
	Israel	2,000	.073
	Italy	90,000	.308
	Kazakhstan	50	.001
	Kyrgyzstan	25	.001
	Latvia	100	.008
	Lithuania	200	.011
	Luxembourg	300	.142
	Malta	200	.106
	Netherlands	3,000	.036
	Norway	1,250	.057
	Poland	10,000	.050
	Portugal	8,000	.159
	Republic of Moldova	40	.002
	Romania	500	.004
	Russian Federation	3,000	.004
	Slovakia	250	.009
	Slovenia	150	.015
	Spain	120,000	.580
	Sweden	3,000	.072
	Switzerland	12,000	.324
	Tajikistan	25	.001
	TFYR Macedonia	500	.044
	Turkey	500	.002

**PROVISIONAL WORKING ESTIMATES OF ADULT HIV PREVALENCE
AS OF END 1994, BY COUNTRY***

	Turkmenistan	25	.001
	UK	25,000	.087
	Ukraine	1,500	.006
	Uzbekistan	100	.001
	Yugoslavia**	5,000	.093
SEARO	Bangladesh***	15,000	.026
	Bhutan	75	.010
	DPR Korea****	100	.001
	India	1,750,000	.377
	Indonesia	50,000	.049
	Maldives	60	.057
	Myanmar	350,000	1.541
	Nepal	5,000	.051
	Sri Lanka	5,000	.052
	Thailand	700,000	2.115
WPRO	Australia	11,000	.115
	Brunei Darussalam	300	.196
	Cambodia	90,000	1.938
	China	10,000	.002
	Fiji	150	.038
	Hong Kong	3,000	.089
	Japan	6,200	.010
	Lao People's Dem R	550	.026
	Malaysia	30,000	.305
	Mongolia	150	.013
	New Zealand	1,200	.065
	Papua New Guinea	4,000	.190
	Philippines	18,000	.054
	Republic of Korea	2,000	.008
	Singapore	1,200	.072
	Viet Nam	25,000	.069
* Countries with adult populations of over 100,000			
** Refers to states/areas of the former Socialist Federal Republic of Yugoslavia not otherwise listed separately			
***The government of Bangladesh has officially reported 44 HIV-infected adults. The estimate of 15,000 is speculative but represents what WHO believes to be the actual number of HIV-infected adults in Bangladesh.			
****Despite extensive testing, no confirmed cases of HIV have been detected in the Democratic People's Republic of Korea. WHO believes HIV to be present in the country, but at a very low level.			

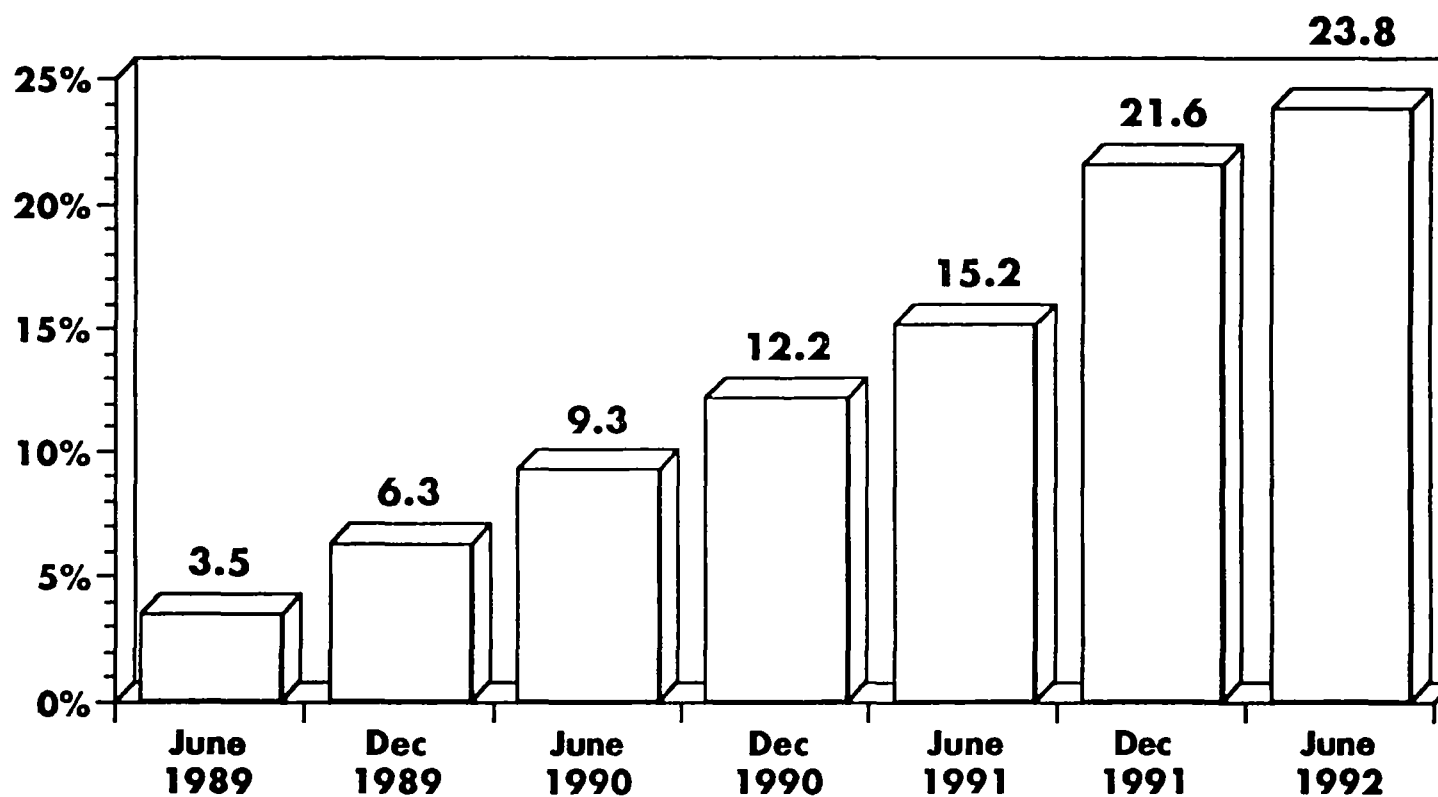
Thai AIDS Control Program

Percent of army conscripts HIV positive



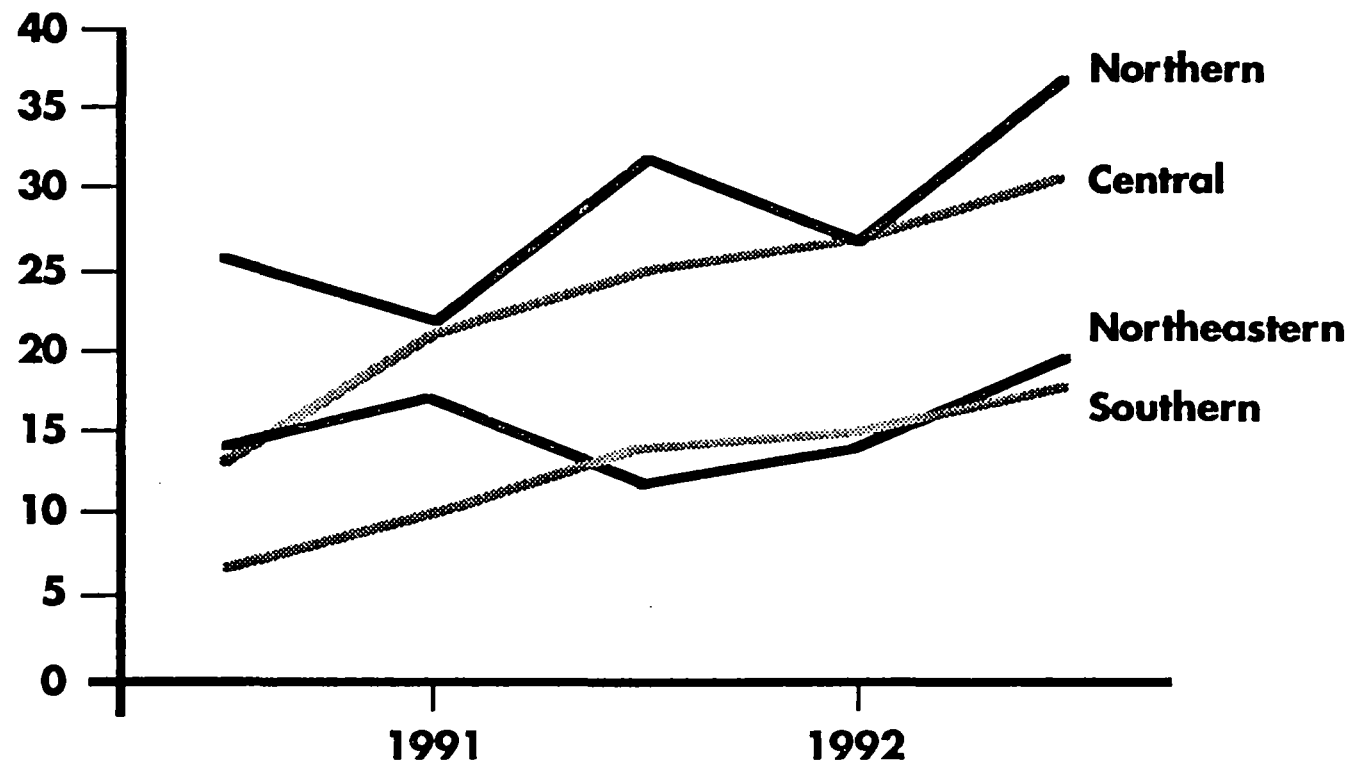
Thai AIDS Control Program

Percent of "direct" prostitutes HIV positive



HIV prevalence among commercial sex workers in Thailand

By region: 1990 - 1992



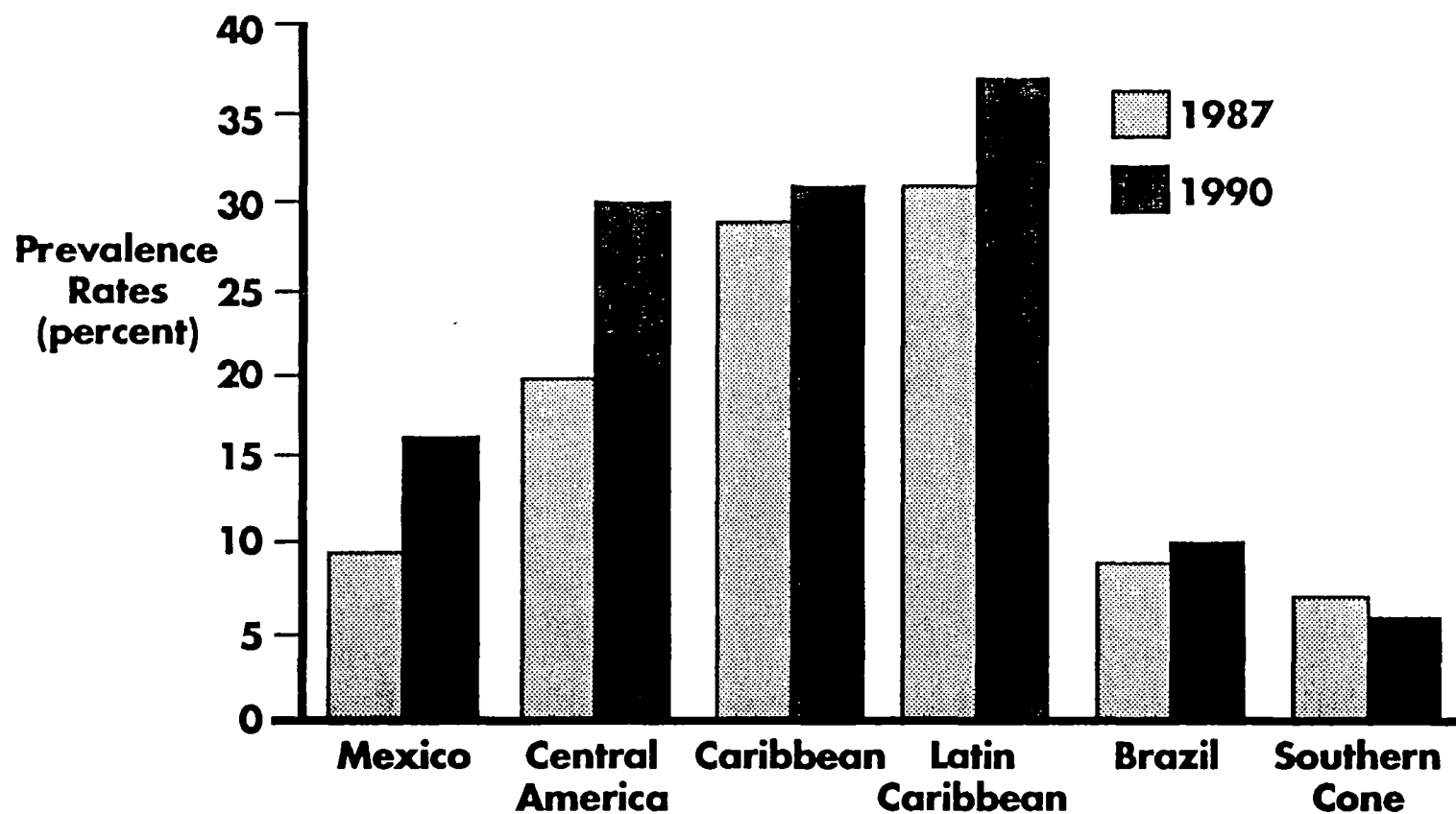
Source: U.S. Bureau of the Census

Number of reported AIDS cases by risk category

Brazil: 1980 - 1992

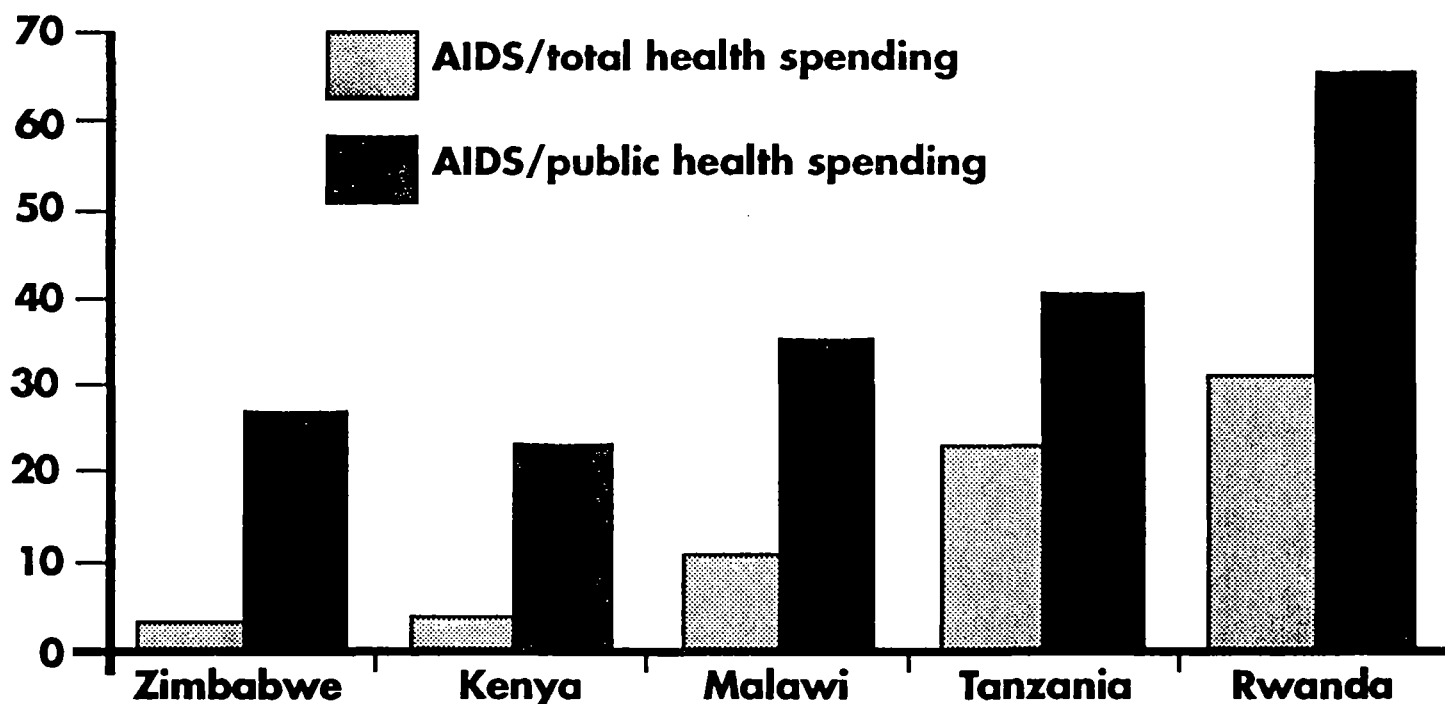
<u>Category</u>	<u>No. of cases</u>	<u>Percent</u>
Sexual	20,135	60.4
Homosexual	9922	29.7
Bisexual	4987	15.0
Heterosexual	5226	15.7
Blood	9017	27.0
Perinatal	701	2.1
Unknown	3507	10.5
Total	33,360	100

Women increasing proportion of Latin America's AIDS Cases



Source: *AIDS in the World*, 1992

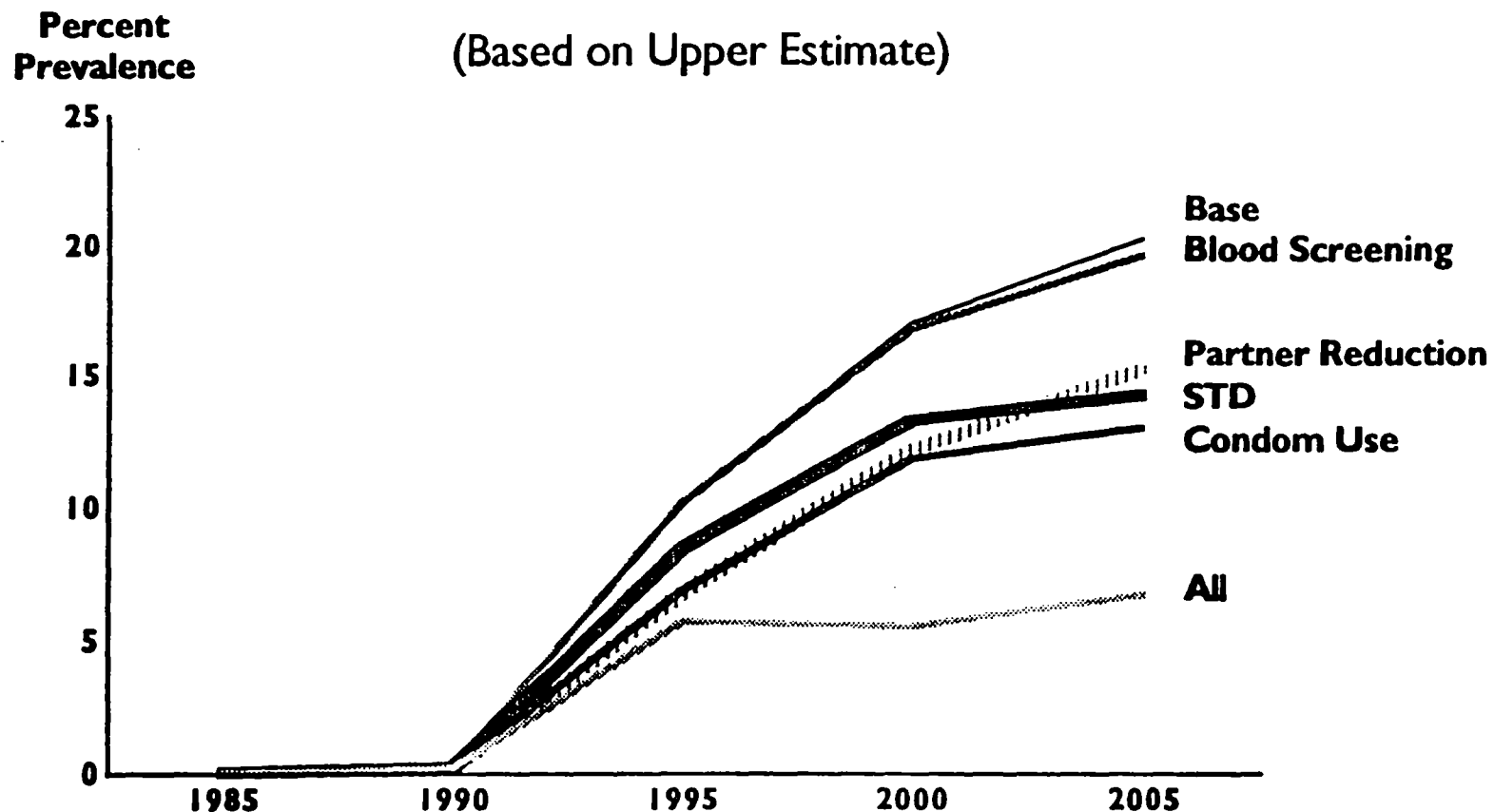
Potential cost of treating AIDS patients in 1990 as a share of total and public health expenditures



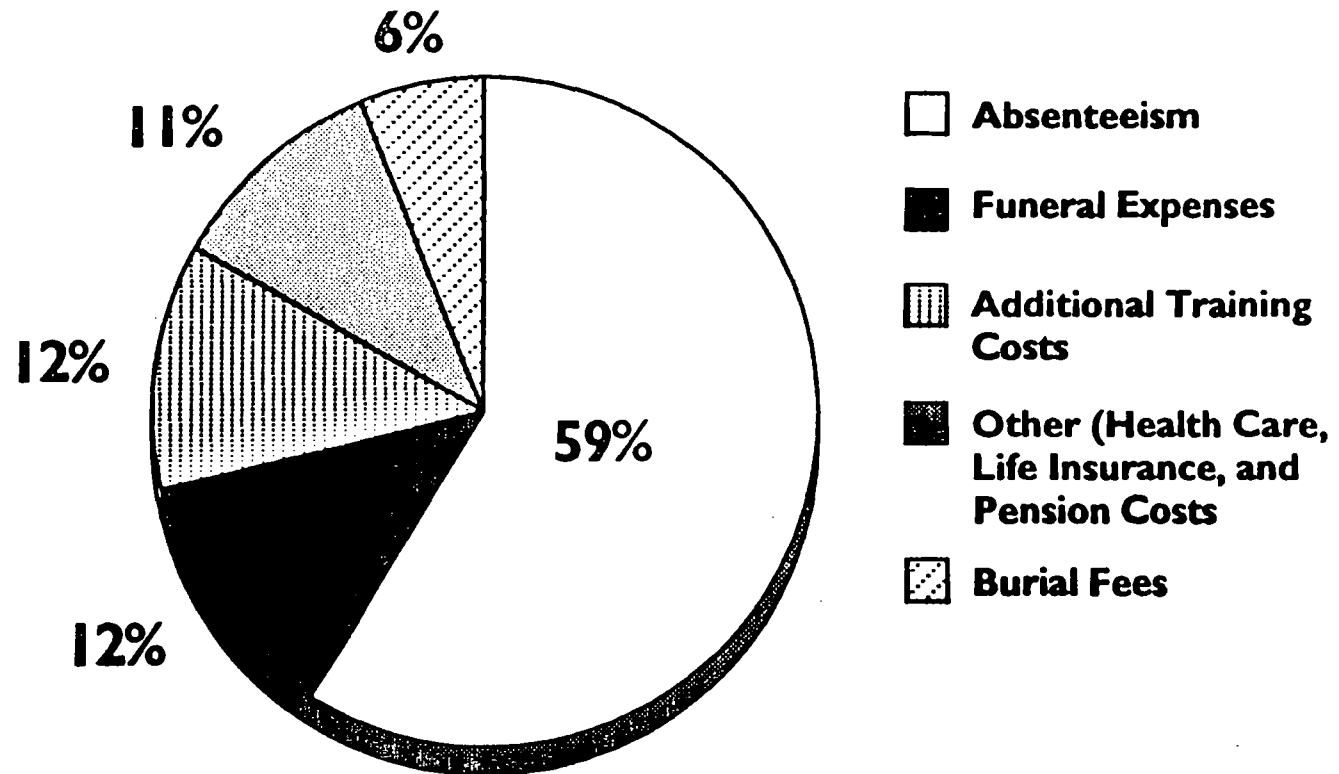
Source: "The Economic Impact of AIDS on Africa," Over and Ainsworth

Projected Effect of AIDS Interventions

Modeling of an African City

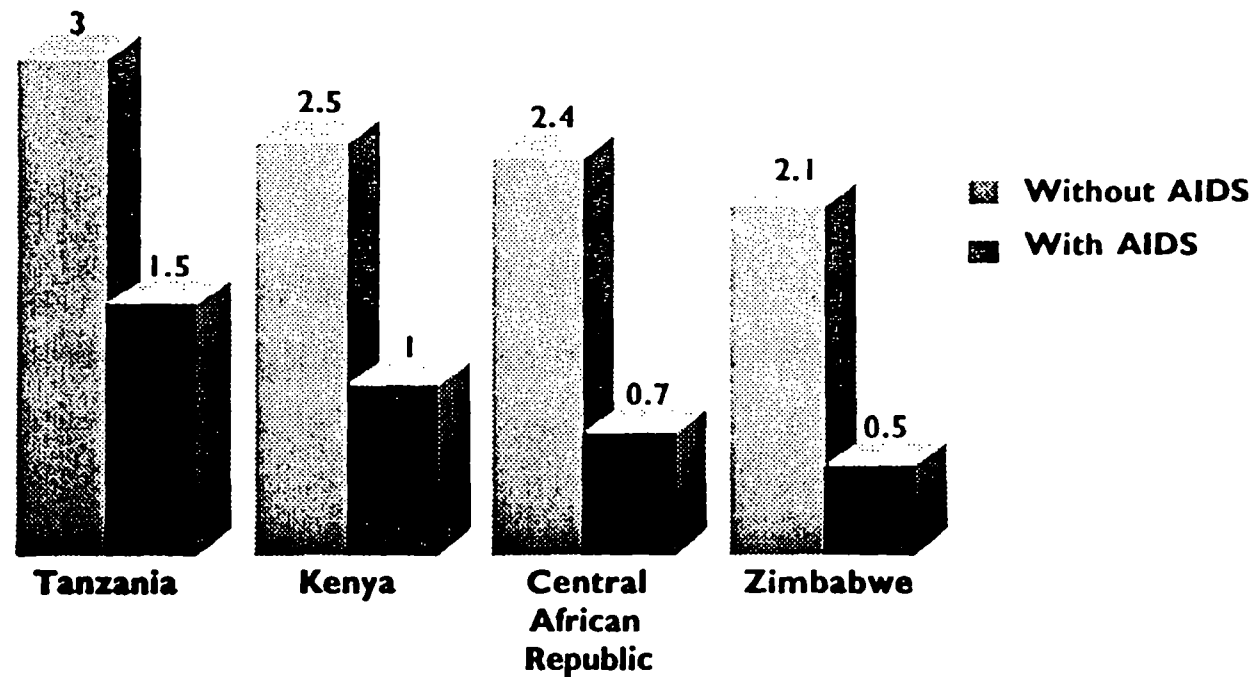


The Financial Costs of AIDS to a Kenyan Business



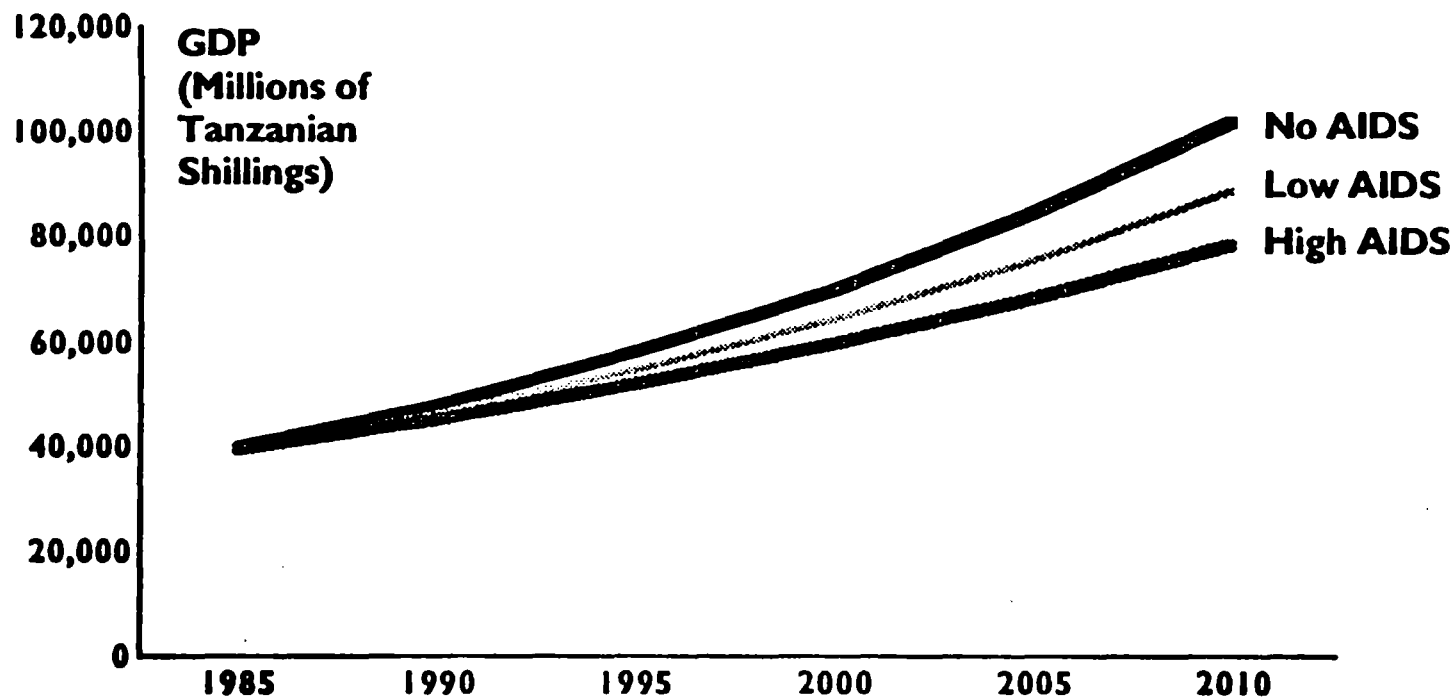
AIDS Epidemic Will Slow Growth Dramatically in a Number of Countries

*Projected Population Growth Rate With and Without AIDS,
Selected Countries: 2010*



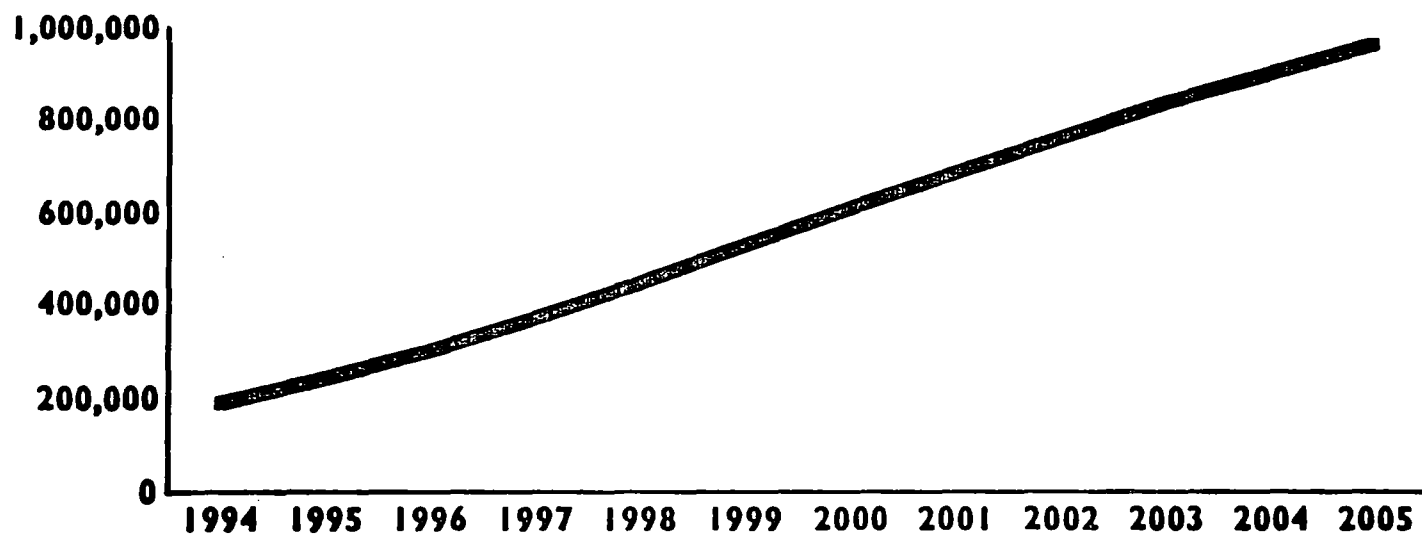
Source: U.S. Bureau of the Census

Macroeconomic Impact of HIV/AIDS in Tanzania



Source: "Modeling the Macroeconomic Effects of AIDS, with an Application to Tanzania"

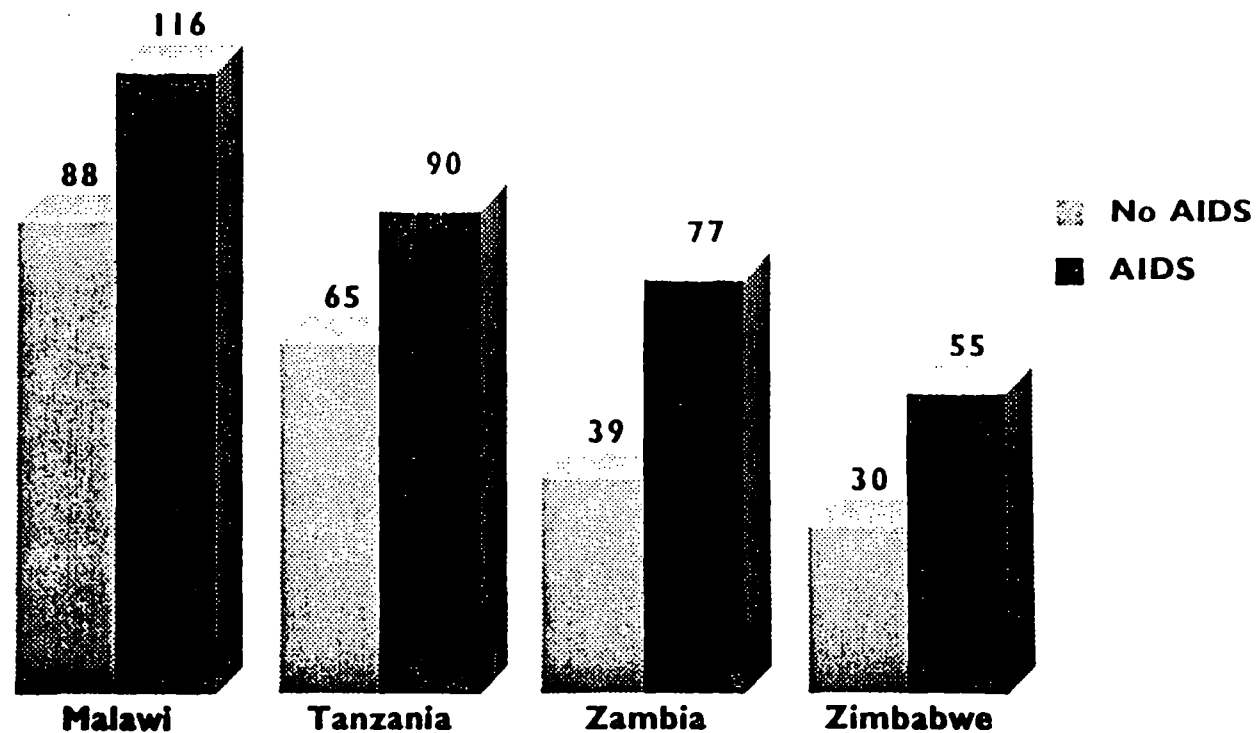
Orphans of Parents Who Have Died of AIDS in Kenya



Source: AIDSTECH/AIDSCAP and the Futures Group

Projected Infant Mortality Rates

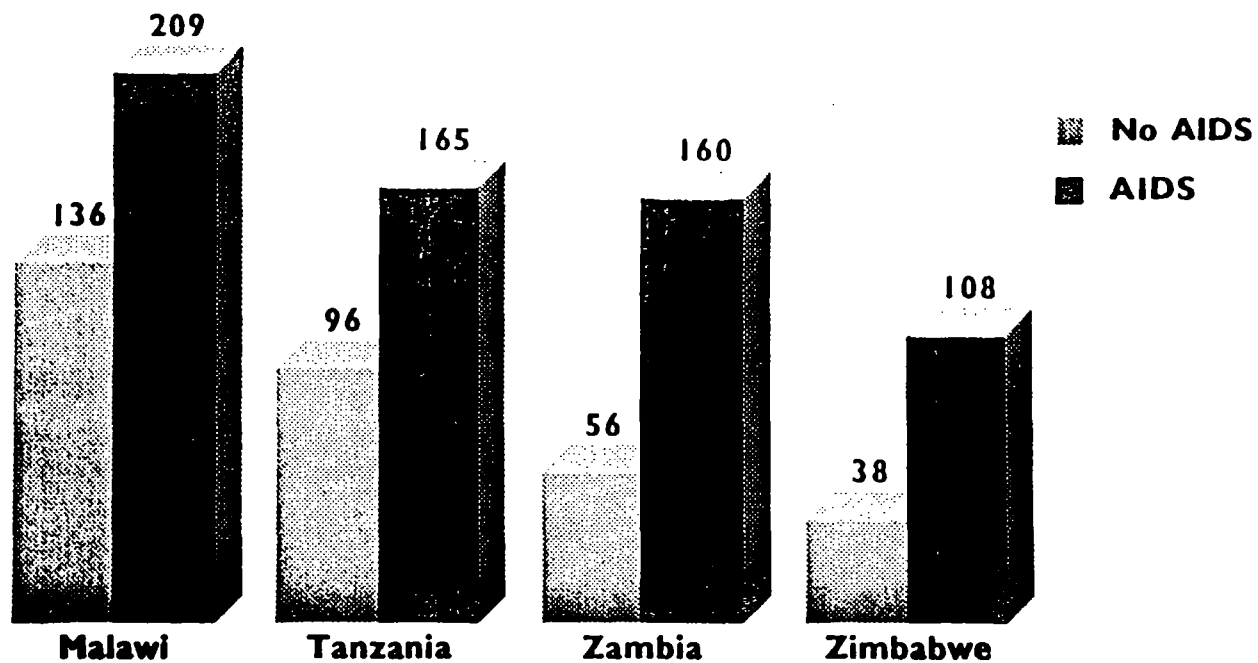
With and Without AIDS: 2010



Source: U.S. Bureau of the Census

Projected Child Mortality Rates

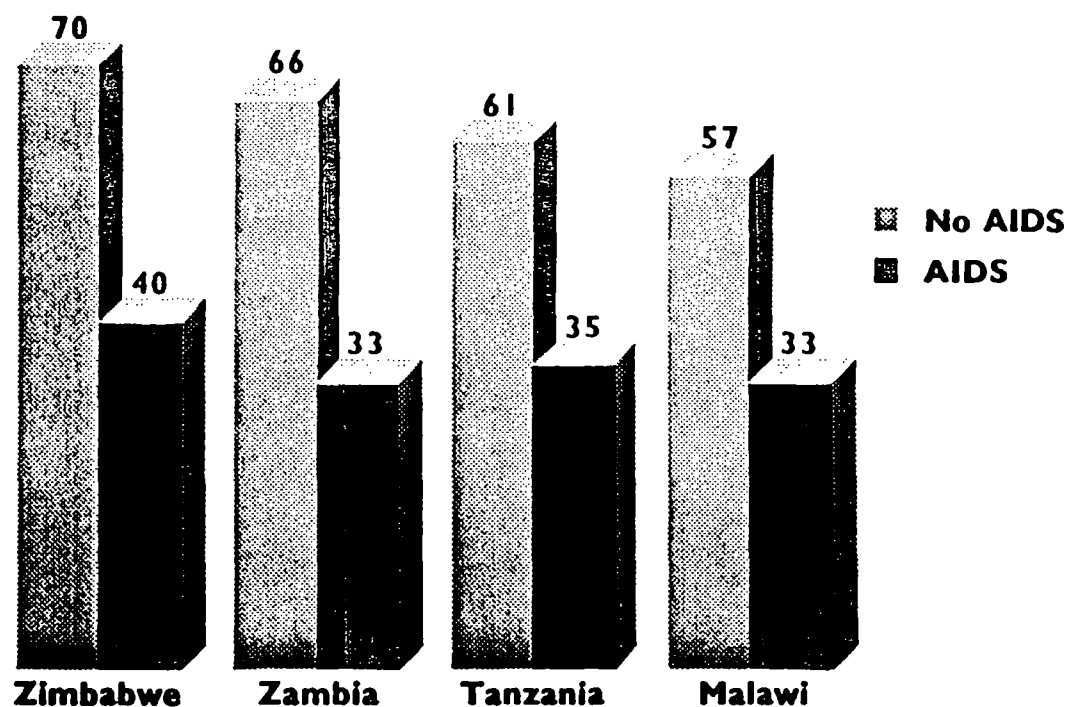
With and Without AIDS: 2010



Source: U.S. Bureau of the Census

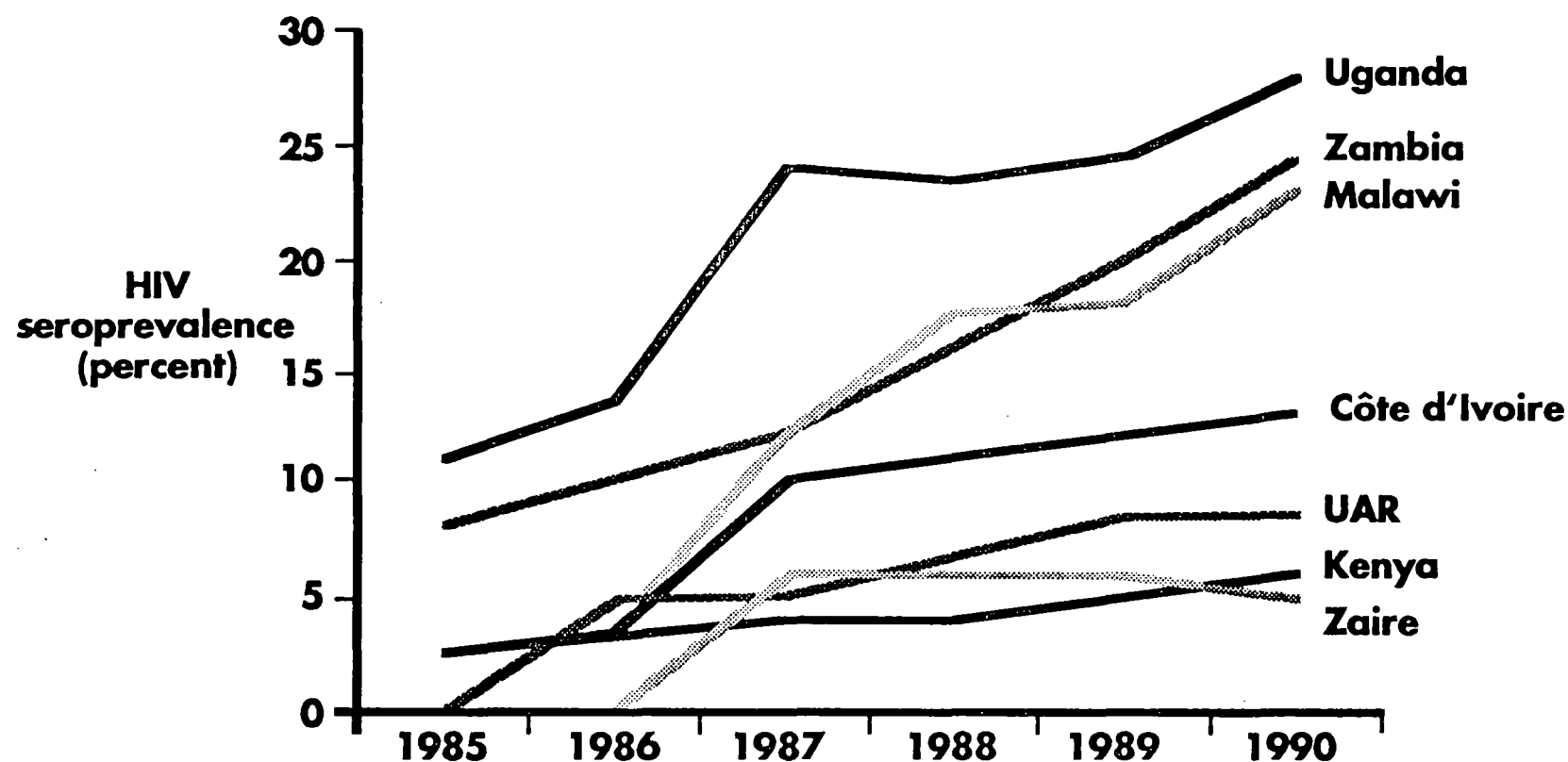
Projected Life Expectancy at Birth

With and Without AIDS: 2010



Source: U.S. Bureau of the Census

Increasing seroprevalence among women in Africa



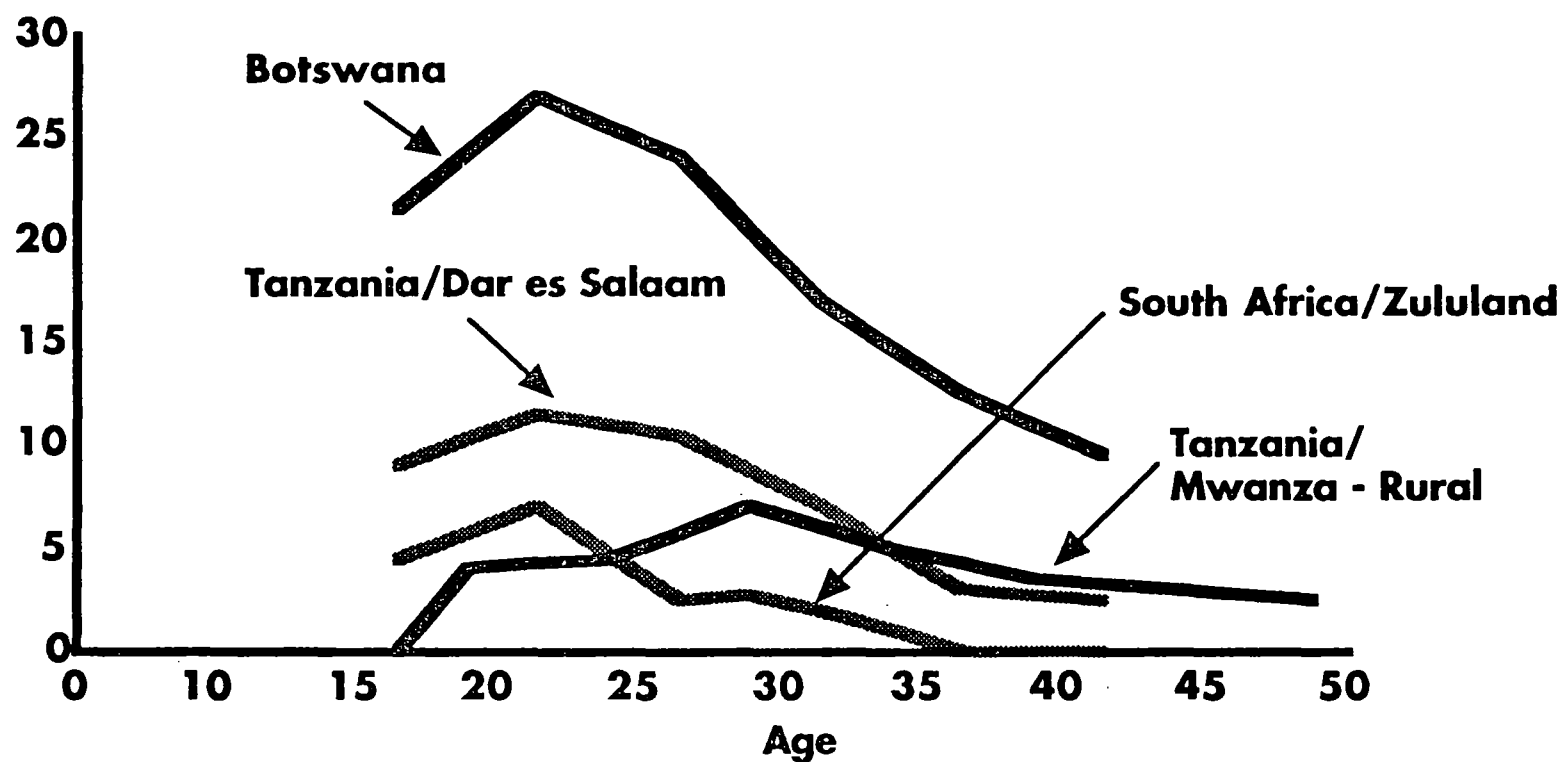
Source: *AIDS in the World*, 1992

HIV seroprevalence for pregnant women in selected urban areas of Africa, 1985 - 1990

HIV prevalence by age

Selected sites: 1989 - 1993

HIV Seroprevalence (%)

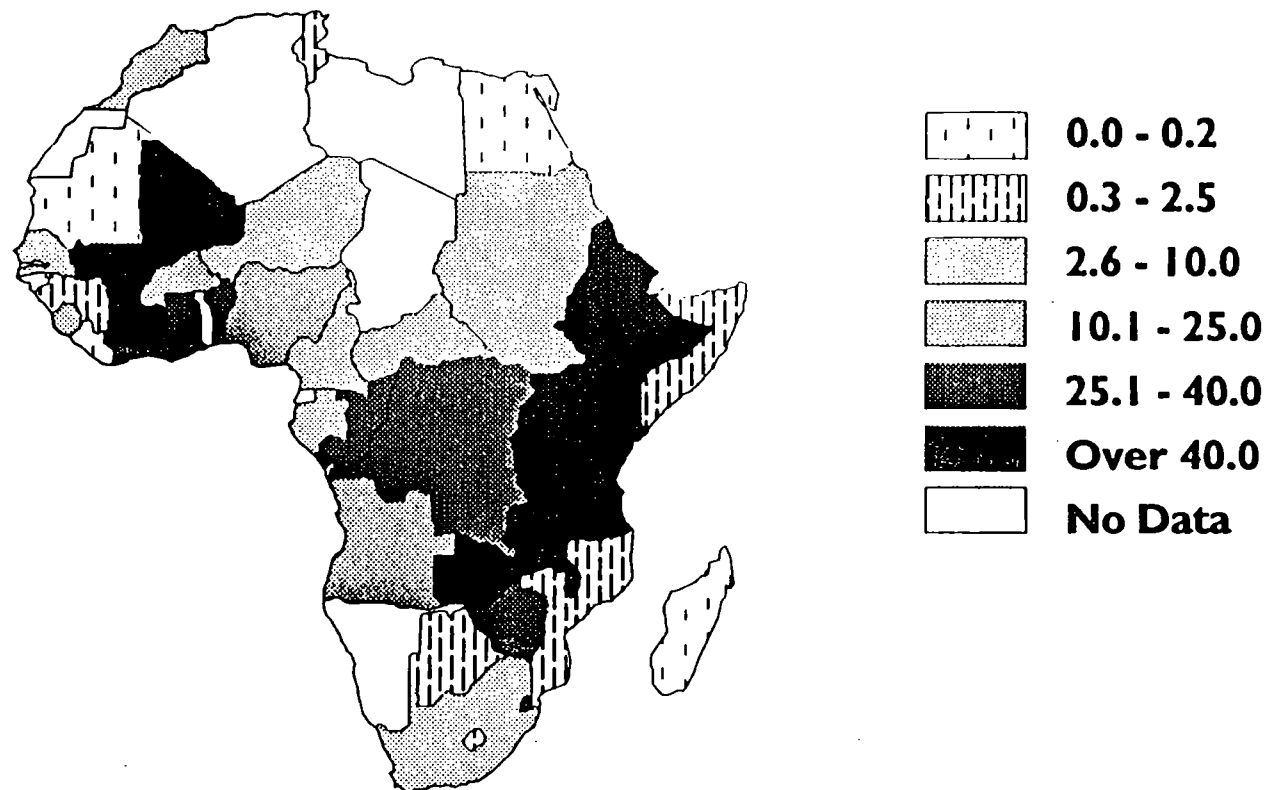


HIV Prevalence by Gender and Age in Sub-Saharan Africa



Source: DeCosas and Pedneault

African HIV-1 Seroprevalence for High-Risk Urban Populations



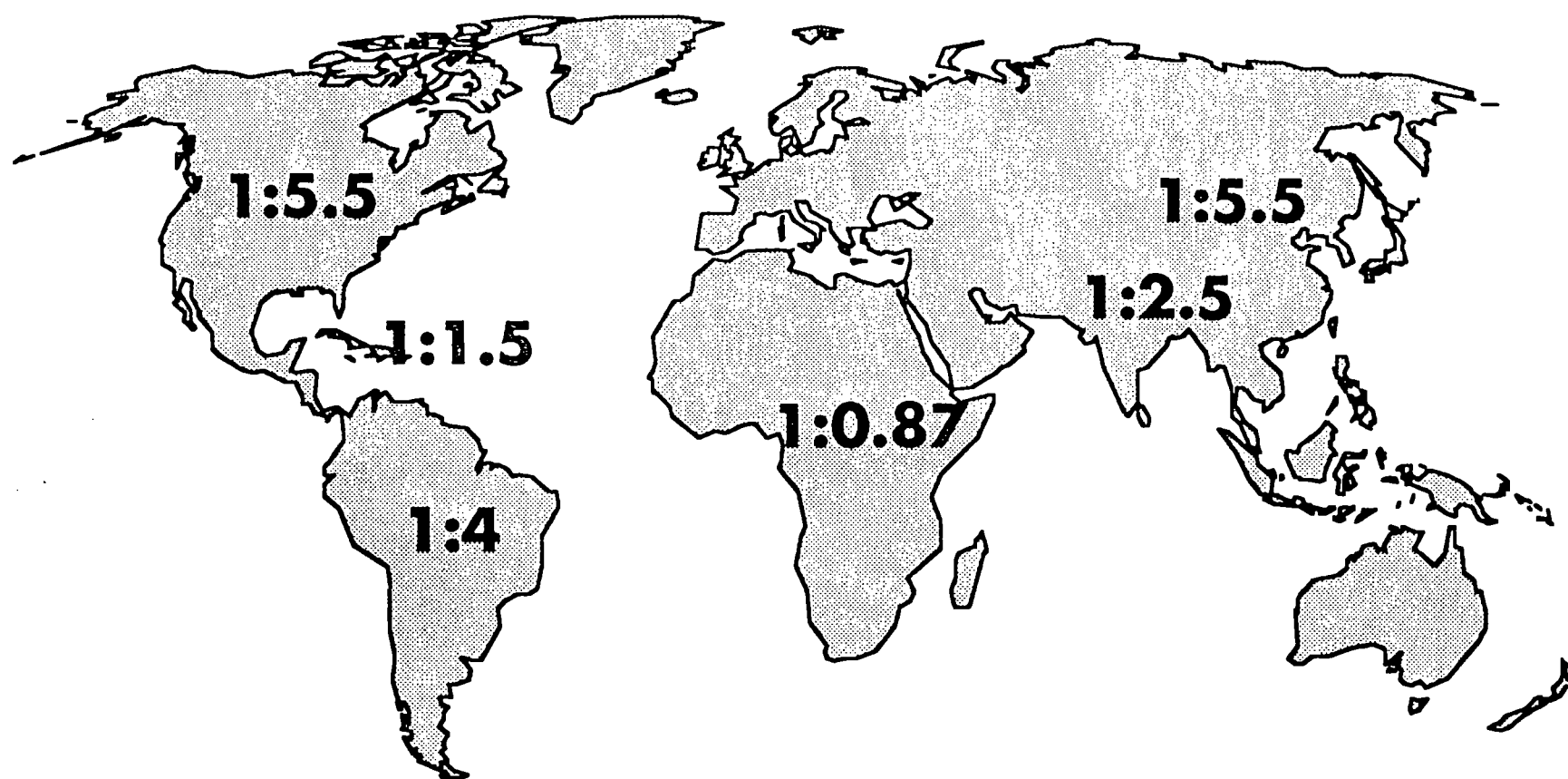
Source: U.S. Bureau of the Census, Center for International Research, HIV/AIDS Surveillance Data Base, November, 1992

Annual revenue costs of interventions

	<u>Monthly Cost</u>	<u>Cost/Person</u>
Outreach/Targeted Condom Distribution		
Ciudad Juarez, Mexico	\$ 5,894.00	\$ 6.05
Bulawayo, Zimbabwe	4,740.00	0.33
Santo Domingo, D.R.	4,316.00	2.67
Puerto Plata, D.R.	1,858.00	9.68
St. John's Antigua	1,448.00	30.17
Niamey, Niger	1,305.00	0.25
STD Clinic Interventions		
Port of Spain, Trinidad	6,266.00	4.58
Niamey, Niger	2,567.00	0.86
St. John's, Antigua	811.00	31.19
Dar es Salaam, Tanzania	604.00	8.51

Source: AIDSTECH/AIDSCAP

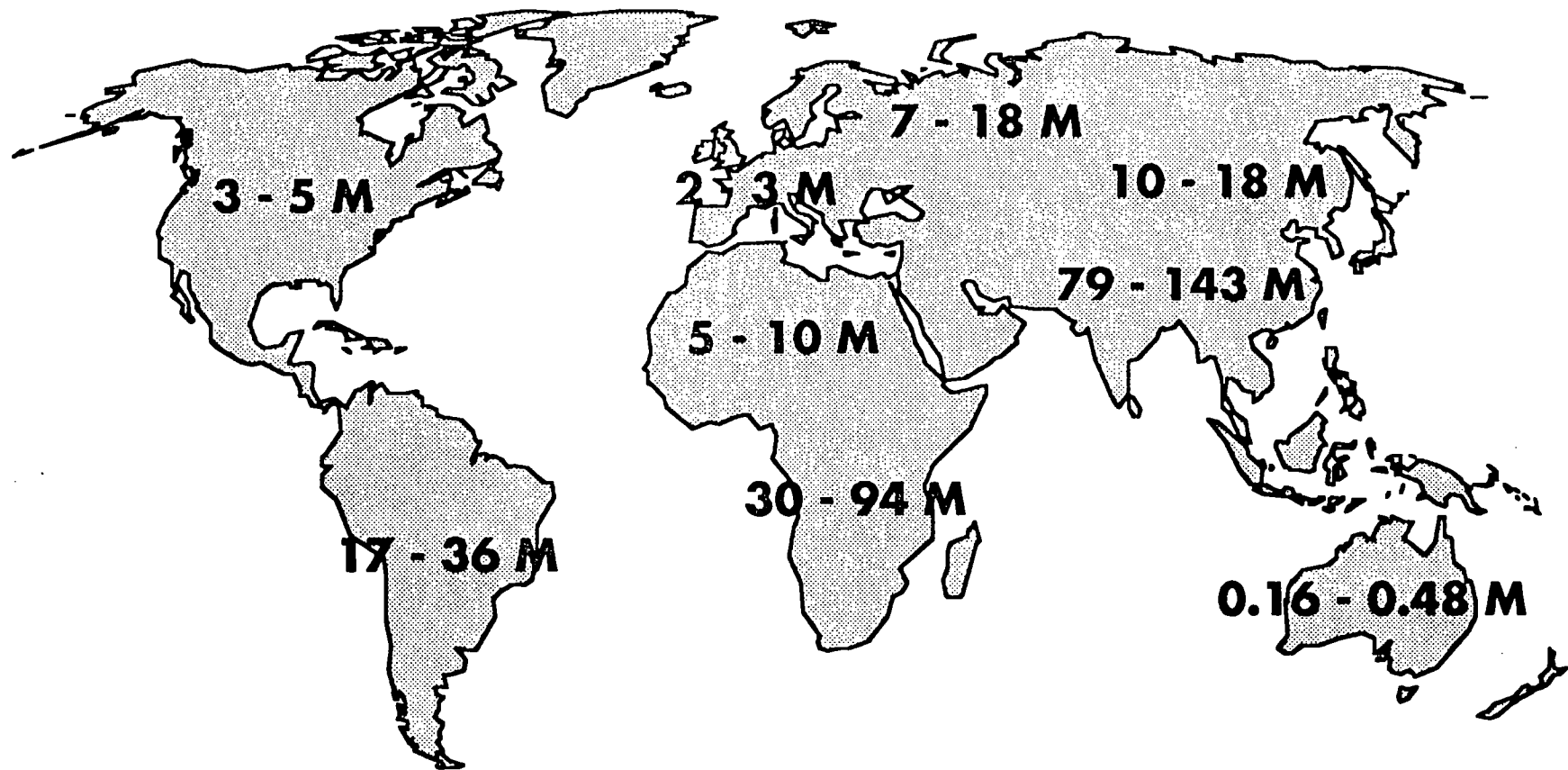
Estimated female to male adult HIV infections by geographic areas of affinity



Source: WHO/GPA

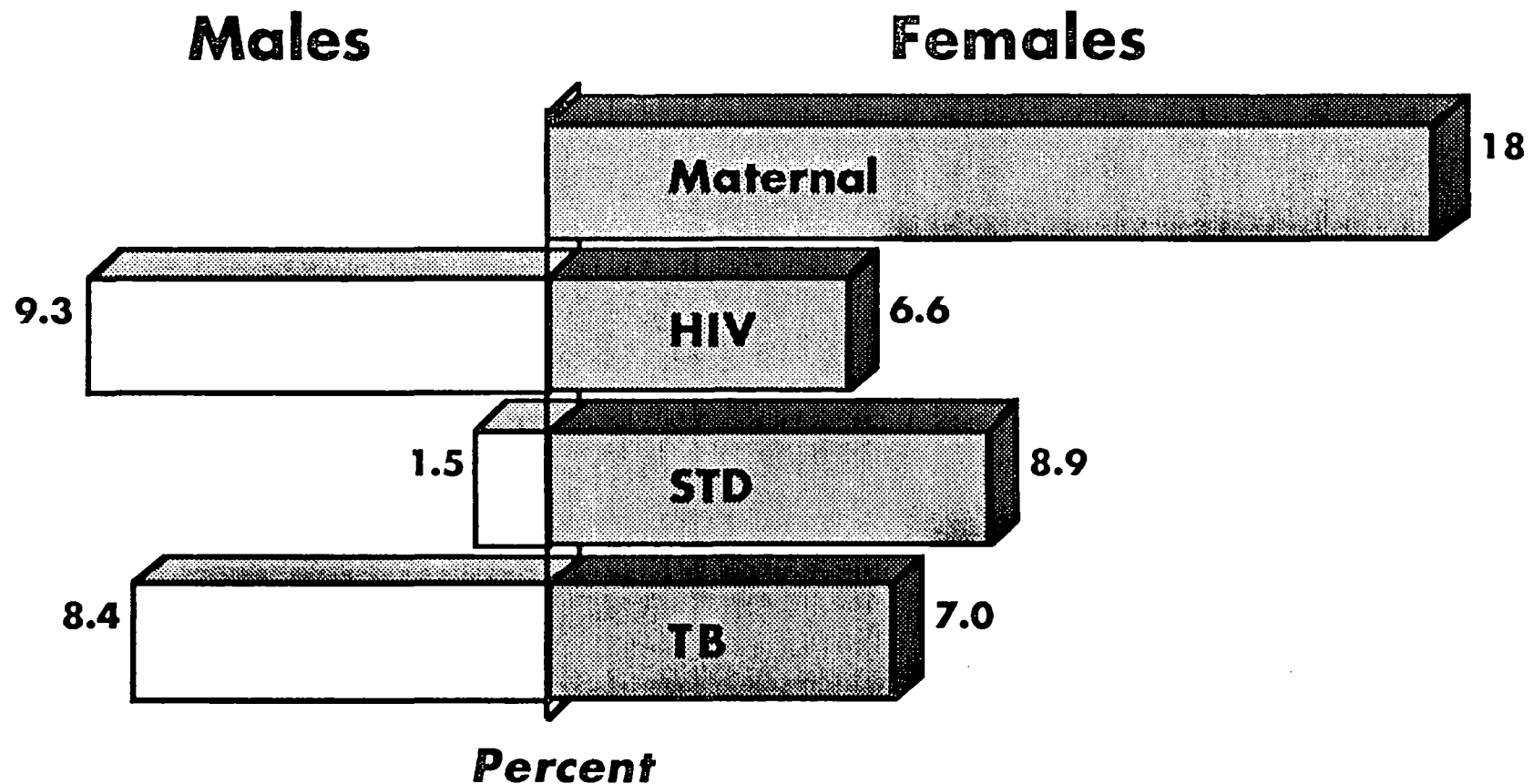
Curable new cases of STD/year in the world

Global: 153.2 - 327.4 million

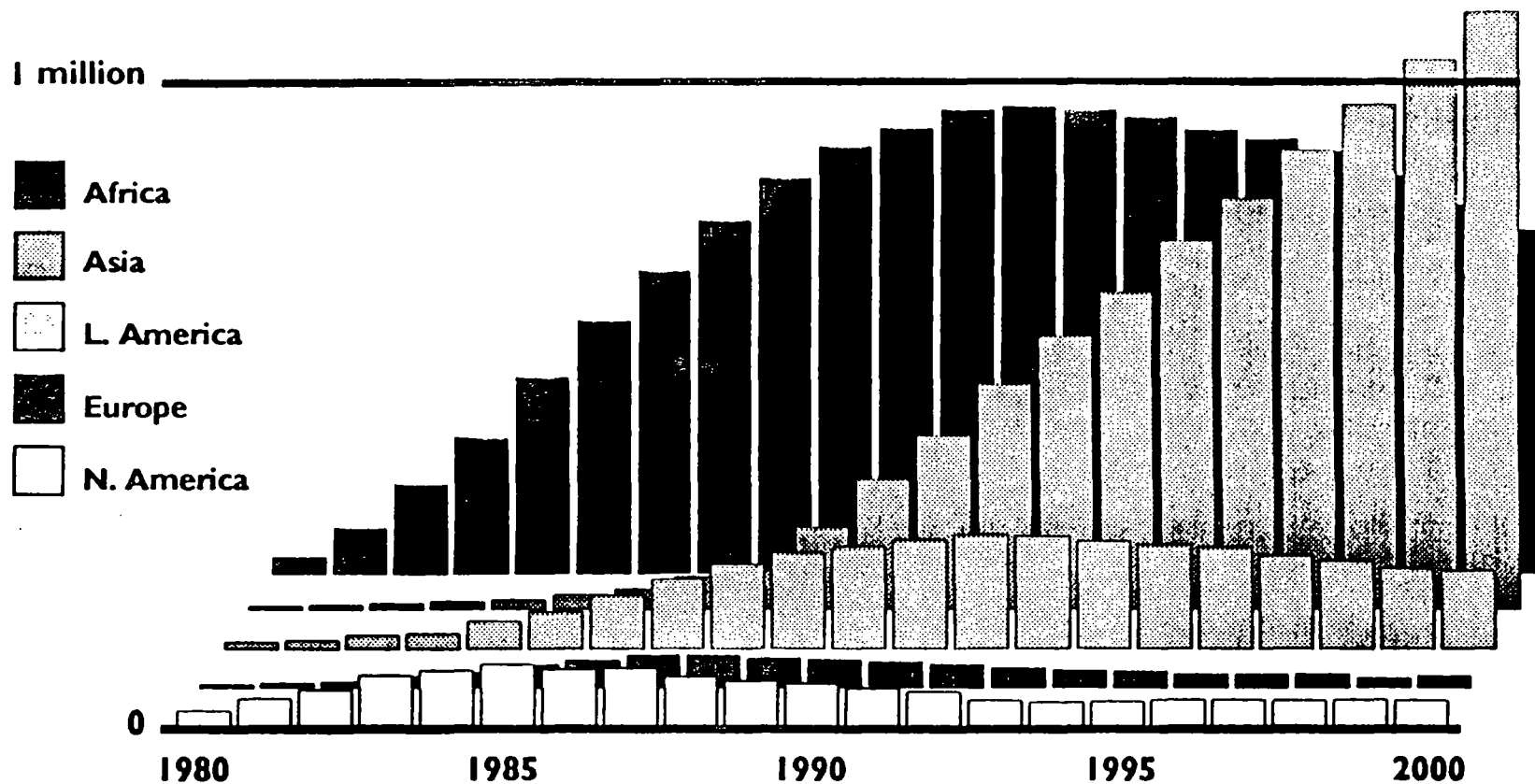


Source: WHO/GPA

Disease burden in the developing world (adults 15 - 44 years)

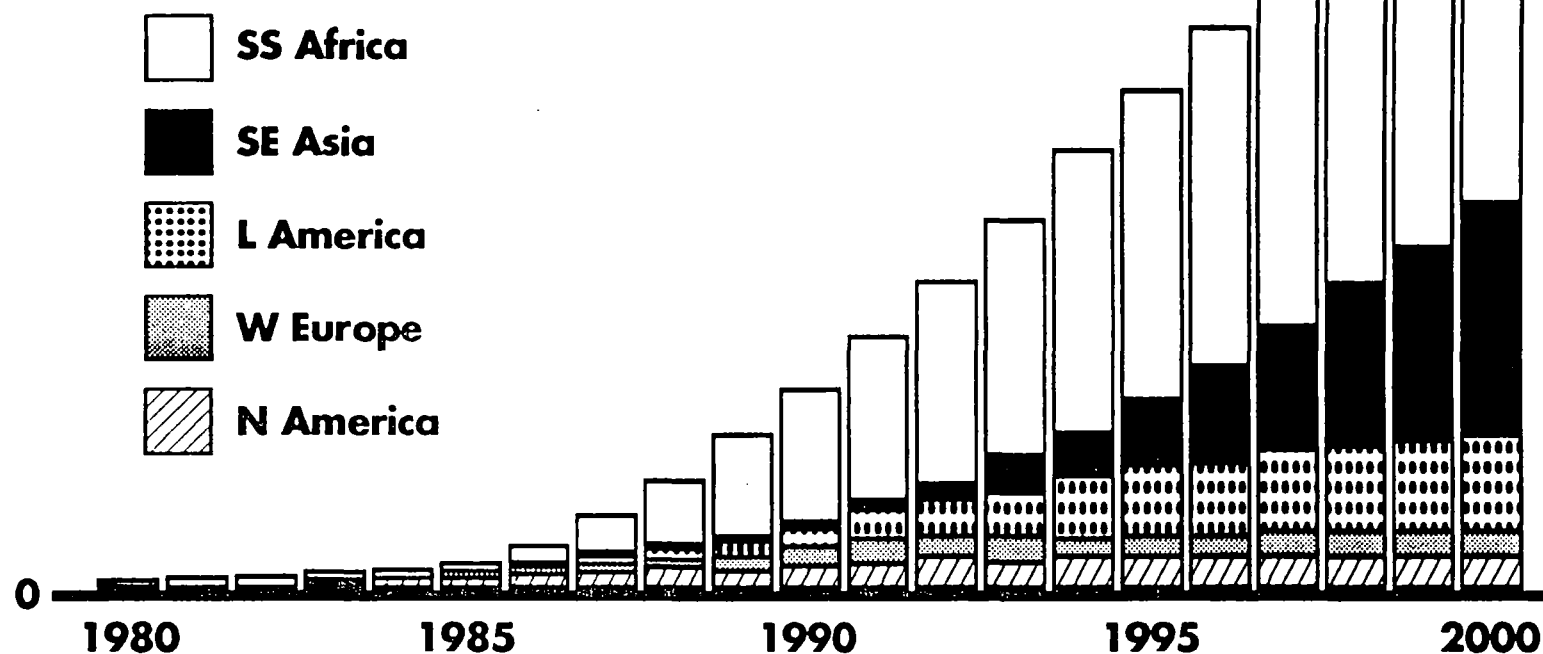


Estimated/Projected Annual New Adult HIV Infections

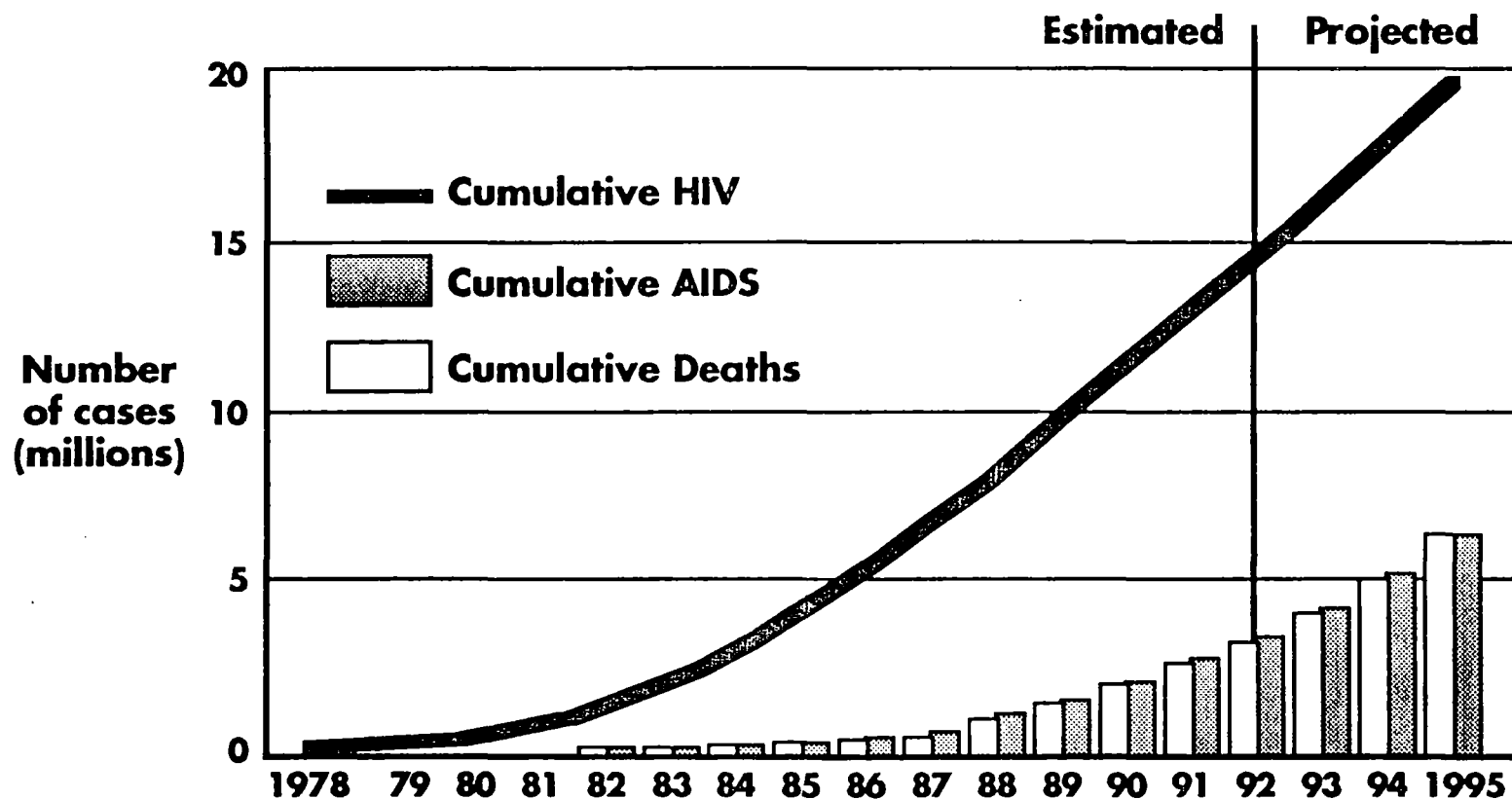


Estimated/projected annual adult AIDS cases

1 million



Cumulative pediatric and adult HIV, AIDS cases, and deaths worldwide, 1978 - 1995

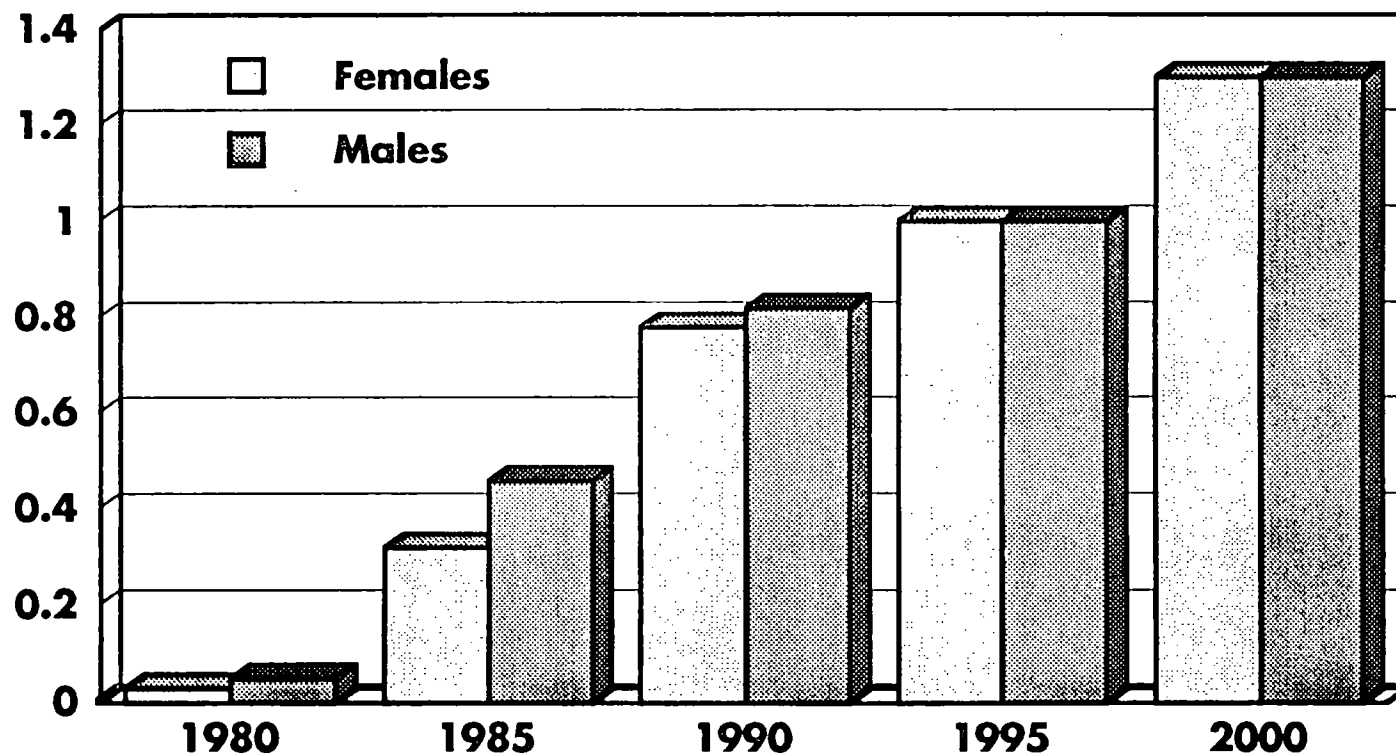


Note: Pediatric infections/cases refer only to mother-fetus/infant transmission.

Source: *AIDS in the World*, 1992

Estimated annual adult HIV

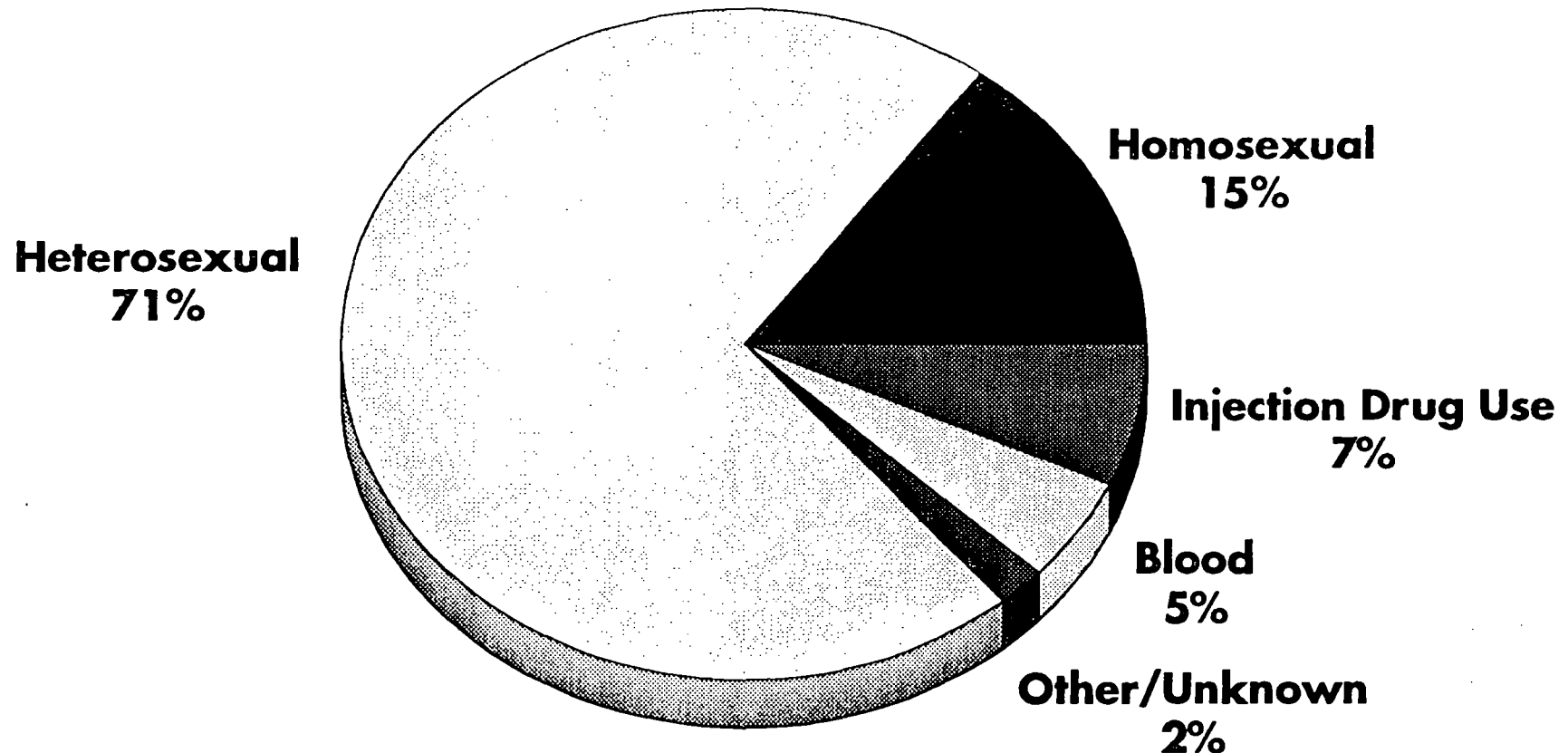
By sex



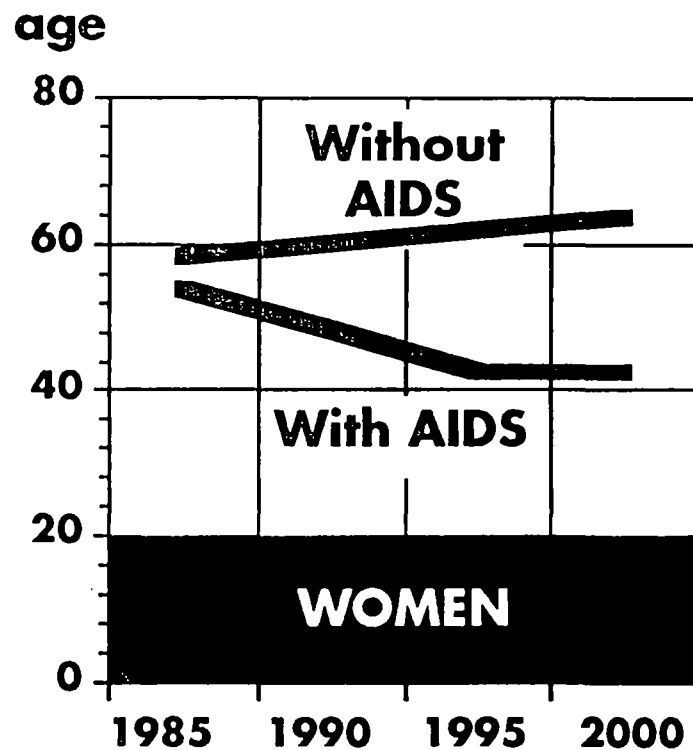
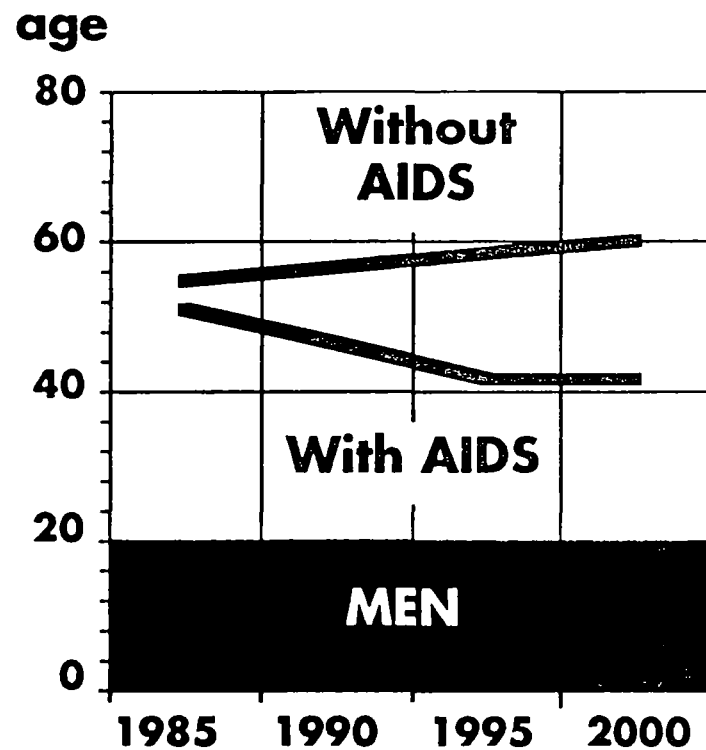
Source: WHO/GPA

Modes of transmission

Proportion of cumulative adult HIV infections by mode of transmission

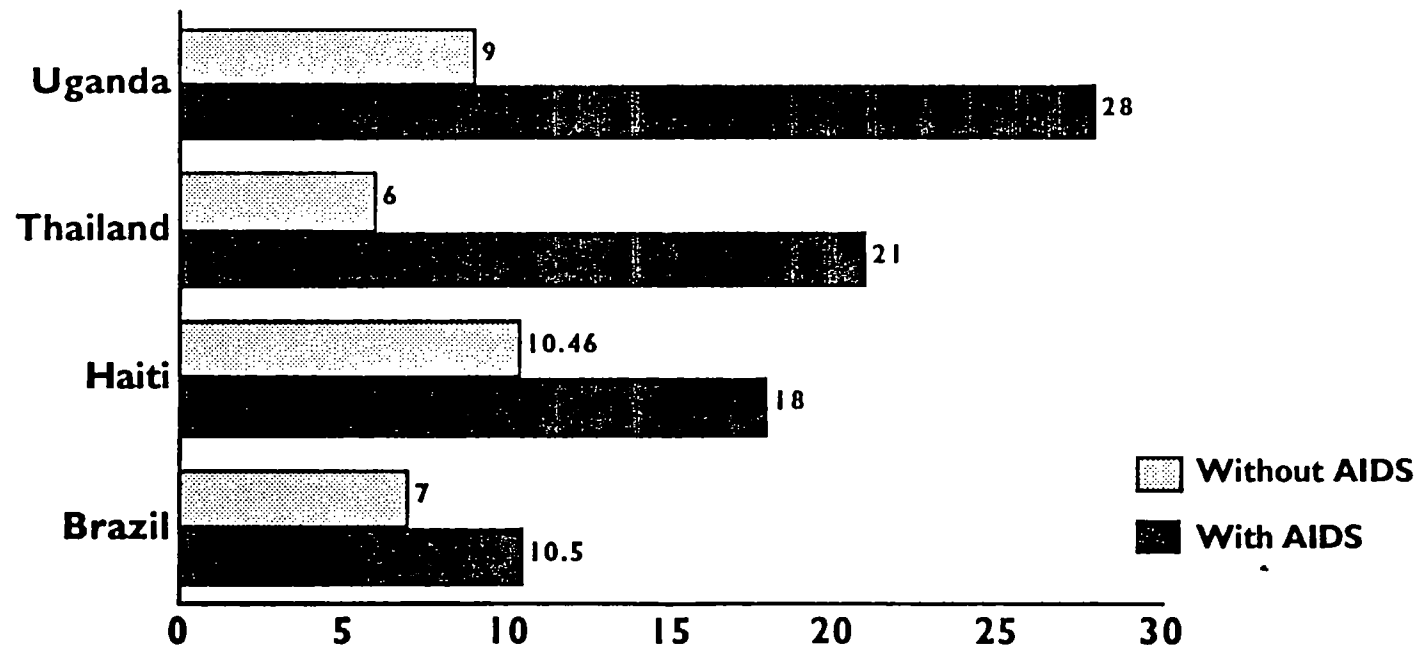


Impact of AIDS on life expectancy



Crude Death Rate With and Without AIDS

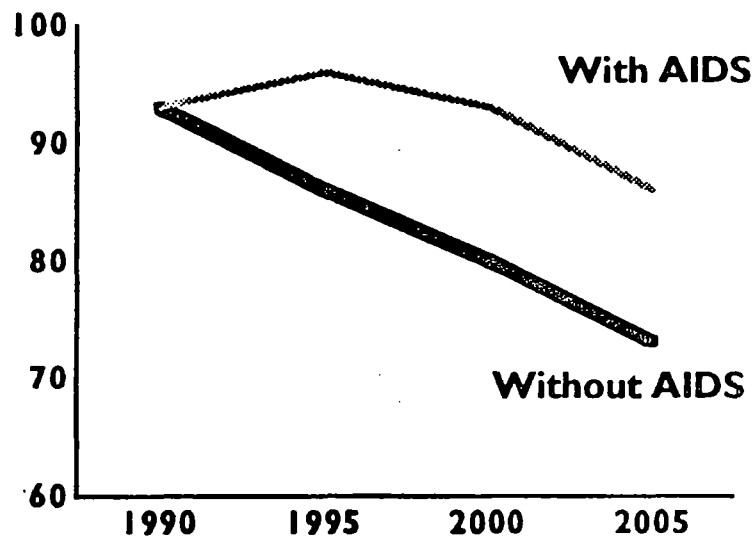
For Selected Countries: 2010



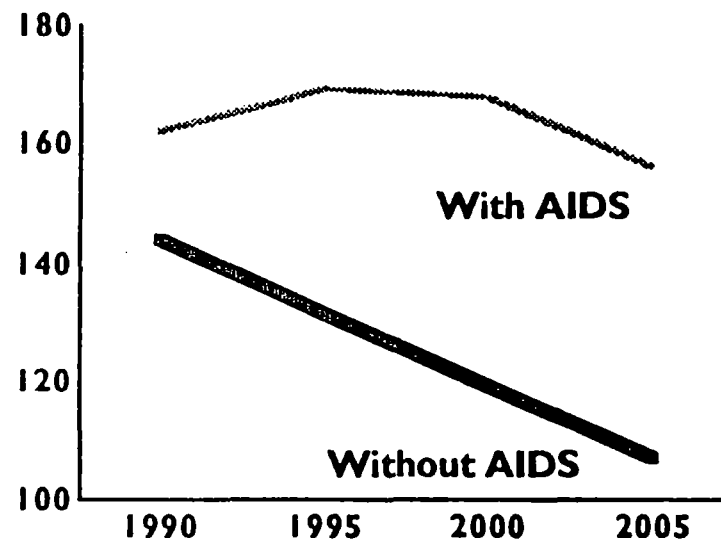
Source: U.S. Bureau of the Census

Deaths per 1,000 population

Impact of AIDS on Infant and Child Mortality



Infant Mortality

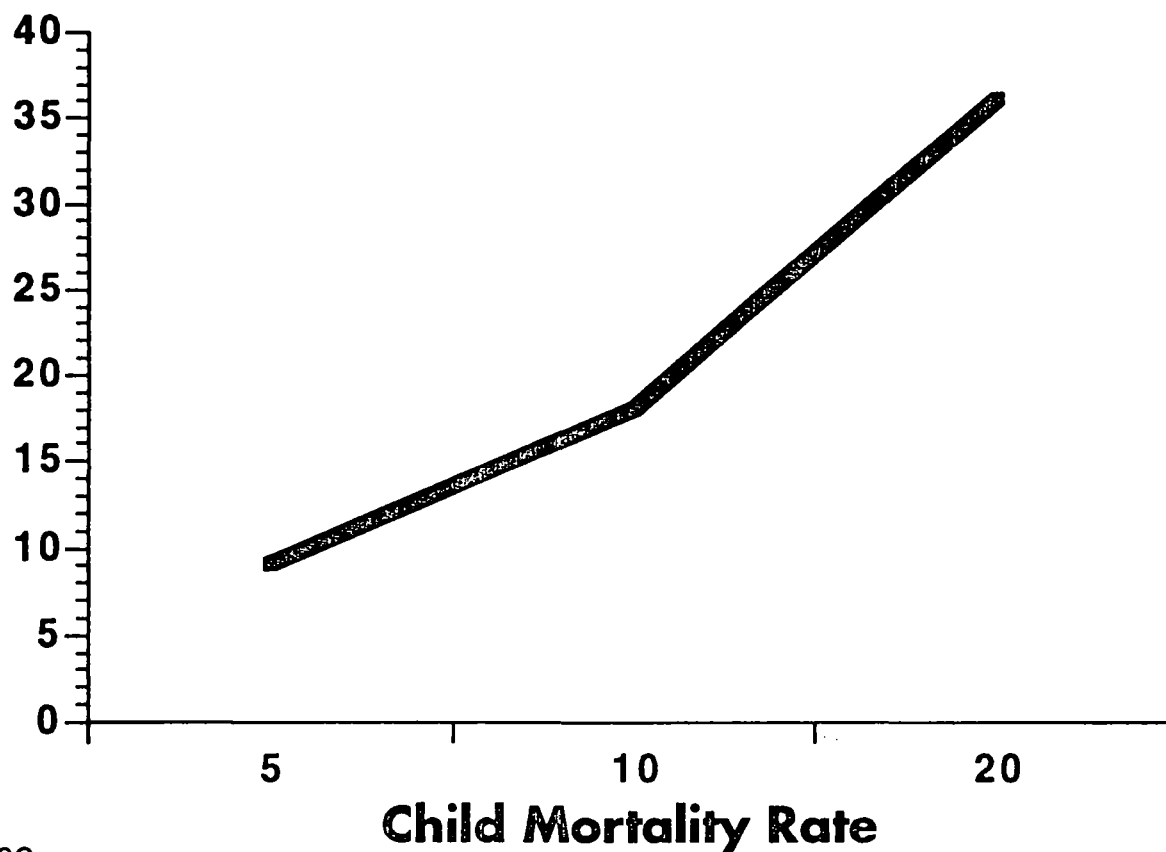


Child Mortality (< 5 years)

Increase in child mortality

In a population with an under-5 child mortality rate of 100/1000:

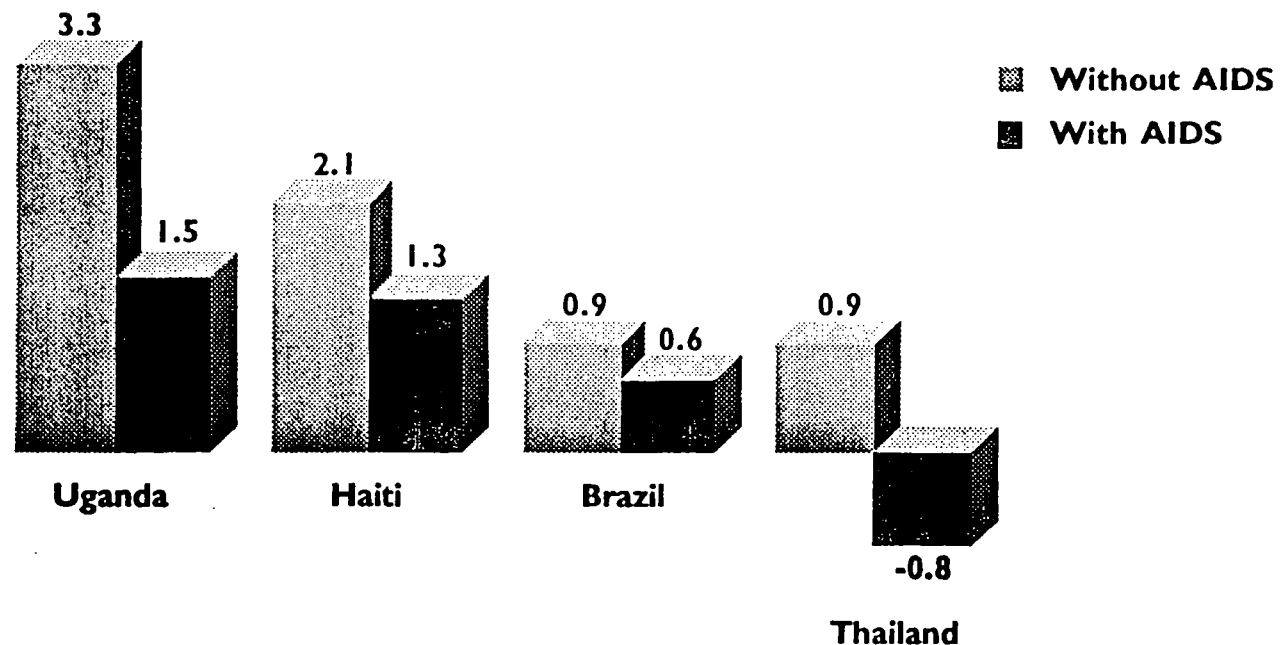
HIV Prevalence



Source: Mann, 1989

AIDS Epidemic Will Slow Growth Dramatically in a Number of Countries

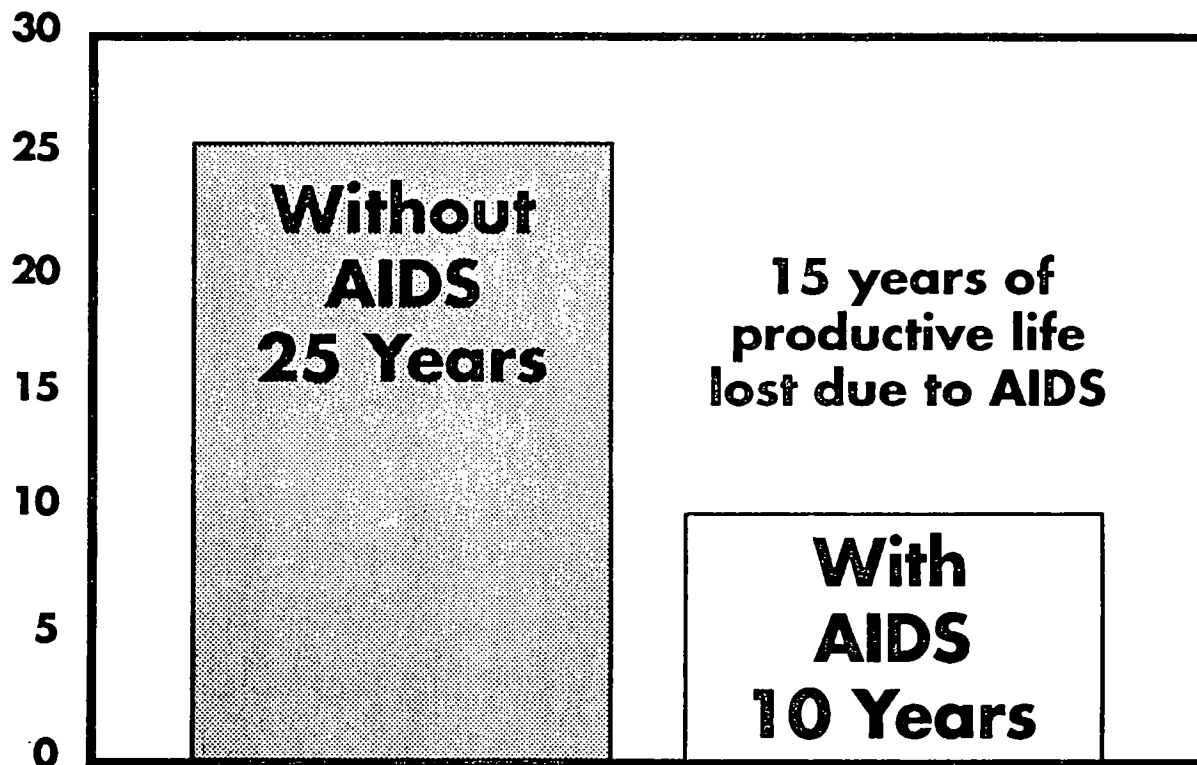
*Projected Population Growth Rate With and Without AIDS,
Selected Countries: 2010*



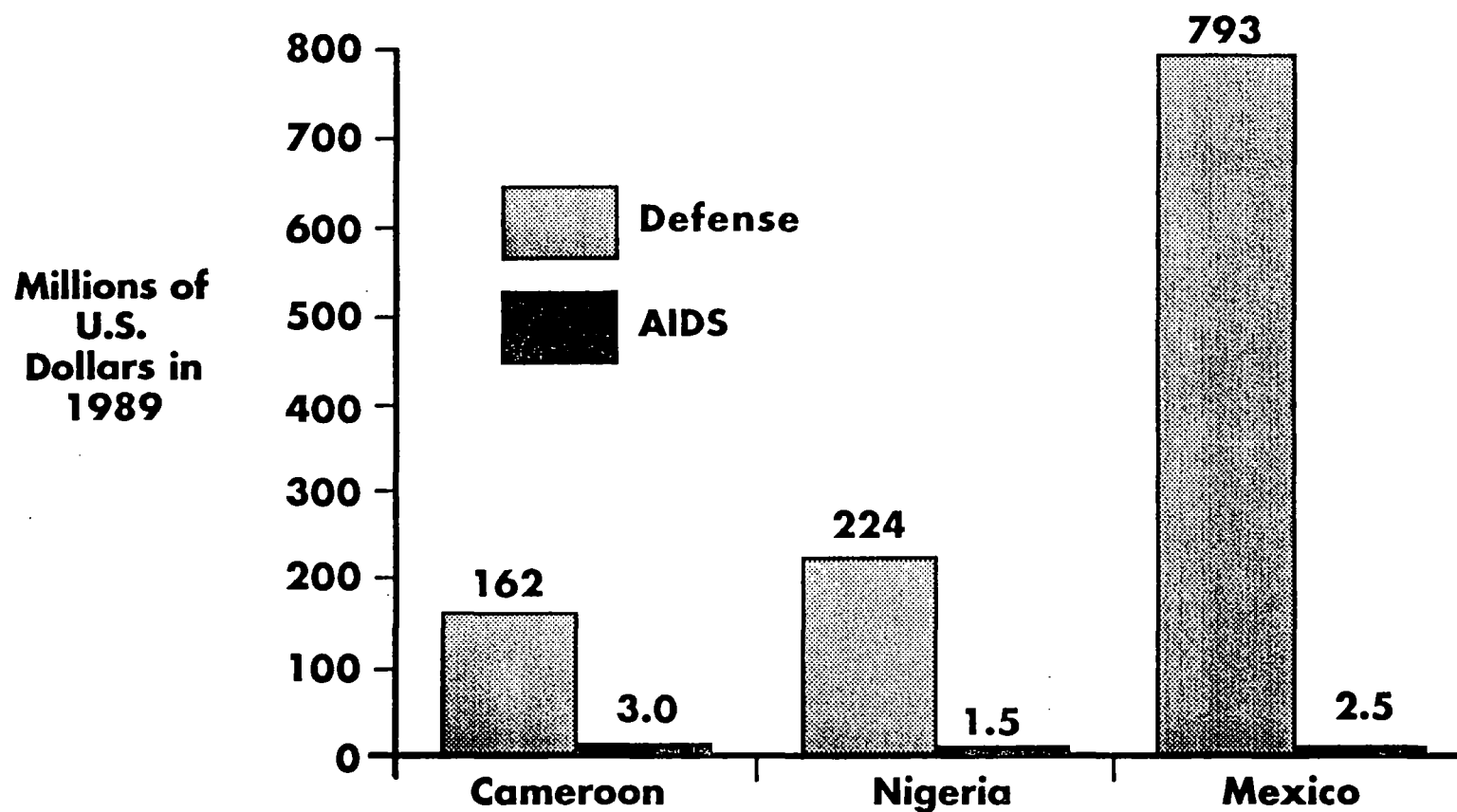
Source: U.S. Bureau of the Census

Average years of productivity of a person with and without AIDS

Years of Productivity



National annual AIDS prevention expenditures and defense spending



^BC-AIDS-AUSTRALIA@

^AIDS past peak in Australia but fight goes on - PM@

CANBERRA, Australia (Reuter) - Australia's AIDS infection has passed its peak, due largely to a relentless campaign against the disease, Prime Minister Paul Keating said Wednesday as he announced funding for a new phase of the fight.

Keating said his government would fund a third five-year national strategy from July next year, when the \$75 million second strategy ends.

''Australia's response to HIV/AIDS is recognized as being among the best in the world,'' he said in a speech. ''A decade of hard and unremitting effort in this country has resulted in a welcome reduction in the rates and incidence of both HIV and AIDS.

''And as we look to the future, Australia also seems to have passed the peak incidence of AIDS infection while the United Kingdom and the United States appear to be experiencing continuing increases.''

The strategies, co-ordinated by the national government, bring together state governments, health workers and community groups to combat AIDS and HIV, the virus which can cause AIDS.

Keating said details of the new program would be decided after reviewing an evaluation of the strategies handed to him Wednesday.

But it would focus on research, care and treatment for sufferers, education and prevention within Australia, and helping the international fight against HIV/AIDS.

The Australian National Council on AIDS puts the total number of diagnosed HIV/AIDS infections at 18,989 from the start of records in 1985 to March 31. This includes 5,883 diagnosed AIDS cases, which have so far led to 4,196 deaths.

The council says the rate of new HIV infections appears to have leveled out at about 600 a year.

^REUTER@
Reut10:15 09-27-95

Comparison of USAID AIDS Programs and WHO/GPA

1. USAID provides support to both bilateral and multilateral organizations primarily for AIDS prevention activities. WHO functions as a multilateral organization.
2. USAID provides support to both the public and private sectors, including private voluntary organizations (PVOs) and nongovernmental organizations (NGOs). WHO provides support primarily to the public sector.
3. USAID focuses support on interventions for prevention of sexually-acquired HIV infections. WHO provides support for AIDS-related activities, regardless of type of transmission, including prevention, care and management, biomedical research, etc.
4. USAID functions as a donor agency. WHO functions as a coordinating agency for countries.
5. USAID provides support to countries with USAID Missions and/or countries approved by the State Department to receive U.S. funds and technical assistance. WHO provides assistance to all member countries of the United Nations.
6. USAID provides support for AIDS activities as part of the U.S. Government's development assistance package to countries. WHO's assistance is restricted to health activities.
7. USAID assistance is provided through subcontractors and cooperating agencies as well as directly to governments. WHO works primarily through governments and has serious difficulty in contracting out.

conscription pool is necessary to maintain a healthy military.

AIDS has decimated many African countries, and in turn has disproportionately affected those in the military. In Africa the militaries (largely made up of young, sexually-active adults) tend to have a higher incidence of HIV and AIDS than the general population. Most African military bases are located in or near urban areas, which tend to be focal points for prostitution and intravenous drug use, two high-risk activities that help spread HIV. In Zimbabwe, a study in 1989 indicated that up to one half of the soldiers were infected with HIV. Another sub-Saharan country has lost so many pilots to AIDS that it has reportedly recruited soldiers from Yugoslavia to compensate for the loss.

In Rwanda it was found that HIV prevalence in the military was between 40 and 65 percent. Rates were found to be the highest among the officer corps. Many of those in the officer corps had already died, leading to a reported breakdown in military discipline. At one military camp in Rwanda, 70 percent of soldiers reported being more afraid of HIV/AIDS than of being at war. Yet during wartime, rapes spread HIV and other sexually transmitted diseases. For example, when the atrocities began in Rwanda, women were often told they were about to get HIV before they were raped by soldiers.

HIV/AIDS is a tremendous drain on military health systems. Almost 65 percent of the military hospital beds in one country are occupied by patients. In 1991 60 percent of the wounded in a hospital in the Sudan tested positive for HIV. One side effect is the reluctance of paramedics and others to treat soldiers wounded in peacekeeping missions and training exercises, resulting in the loss of skilled military personnel. Without urgently needed education programs for the armed forces, military downsizing might result in a fresh infusion of the virus into civilian society. The World Health Organization warned in 1992 that the 150,000 demobilizing military personnel in Angola could spread HIV when they returned to their families and workplaces. Indeed, HIV/AIDS was the second most prevalent disease among soldiers who returned to Cuba after serving in Angola. Clearly, HIV/AIDS has the potential not only to destabilize the military, but likewise, HIV-infected military have the potential to assist the destabilization of societies they have been trained to defend.

Political and Military Impacts of HIV/AIDS

Political

Government responses to HIV/AIDS in many developing countries have been hampered by three problems--fear and lack of knowledge of the epidemic, insufficient capacity within countries to develop effective prevention and care strategies, and limited financial resources to cope with the growing epidemic. In the early stages of the AIDS epidemic, many government officials were no better informed than the average citizen on the causes of AIDS and ways to prevent transmission of HIV. Few were aware of how quickly the disease would spread and the impacts it would have on all sectors of the present and future economy. Sexual behaviors and drug use were implicated as modes of transmission, and many developing country leaders did not want to risk admitting the existence of a public health crisis. They were afraid of the effects on them and their regimes if they acknowledged a growing societal problem from a virus that was transmitted by behaviors unacceptable to religious tradition and cultural mores.

The reluctance of national leaders to confront the HIV/AIDS epidemic in their countries is starting to diminish. In Southeast Asia, for example, strong government policies in support of HIV/AIDS prevention activities have been developed in some countries. Nevertheless, there remains a tentativeness by most developing world leaders to fully commit to the widespread strategies needed to control HIV/AIDS. The effects of this are resource limitations, policy limitations that inhibit prevention efforts, a lack of national concern with the growing problem and disenfranchisement of those infected with and affected by HIV.

While industrialized nations may lose less than one percent of their expected total gross national product by the year 2000, developing nations will lose two percent or more of theirs and will sacrifice more of their expected economic base. Widespread civil unrest is not an unlikely result in regions hardest hit by the epidemic. The tragedy of Rwanda, with its disproportionately high HIV/AIDS prevalence, may cease to be an isolated occurrence. Without the necessary increase in human, technical and financial resources to truly make a difference in the epidemic, the implications in a world already burdened by increasing societal stresses and local and regional conflicts are frightening.

Military

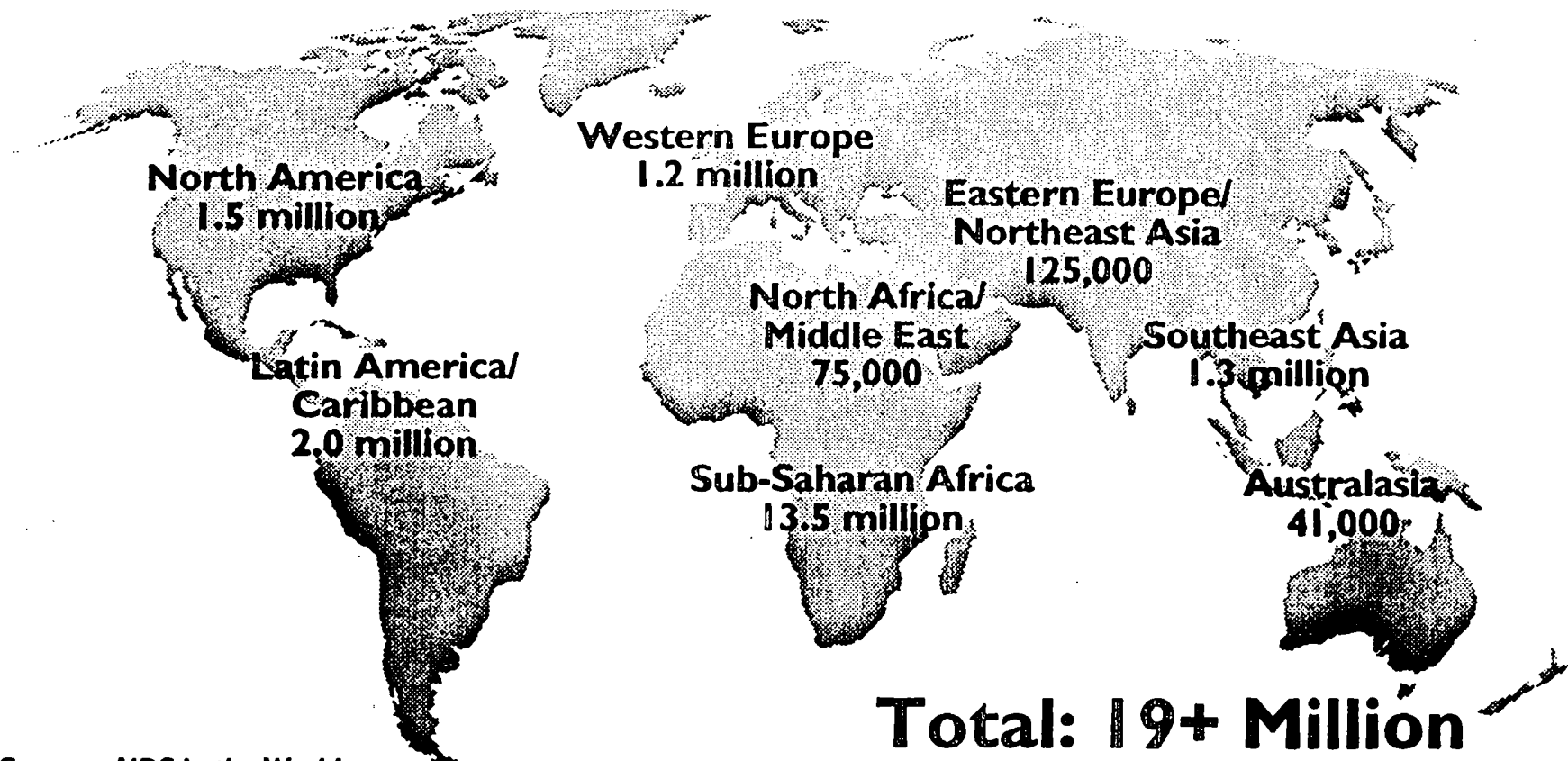
War is the harbinger of AIDS; as populations are displaced during war, servicemen turn to prostitutes for sex, and women sell sex to provide for their families. A study in Thailand found that military recruits were disproportionately infected with HIV, and that more than a third visited commercial sex workers at least once a month.

The increase in HIV-infected military has potential security implications because a weakened military has a weakened capacity to defend their nations and maintain civil order. In addition, they have limited personnel available for training overseas. And, a healthy

Potential Impacts of the AIDSCAP Program

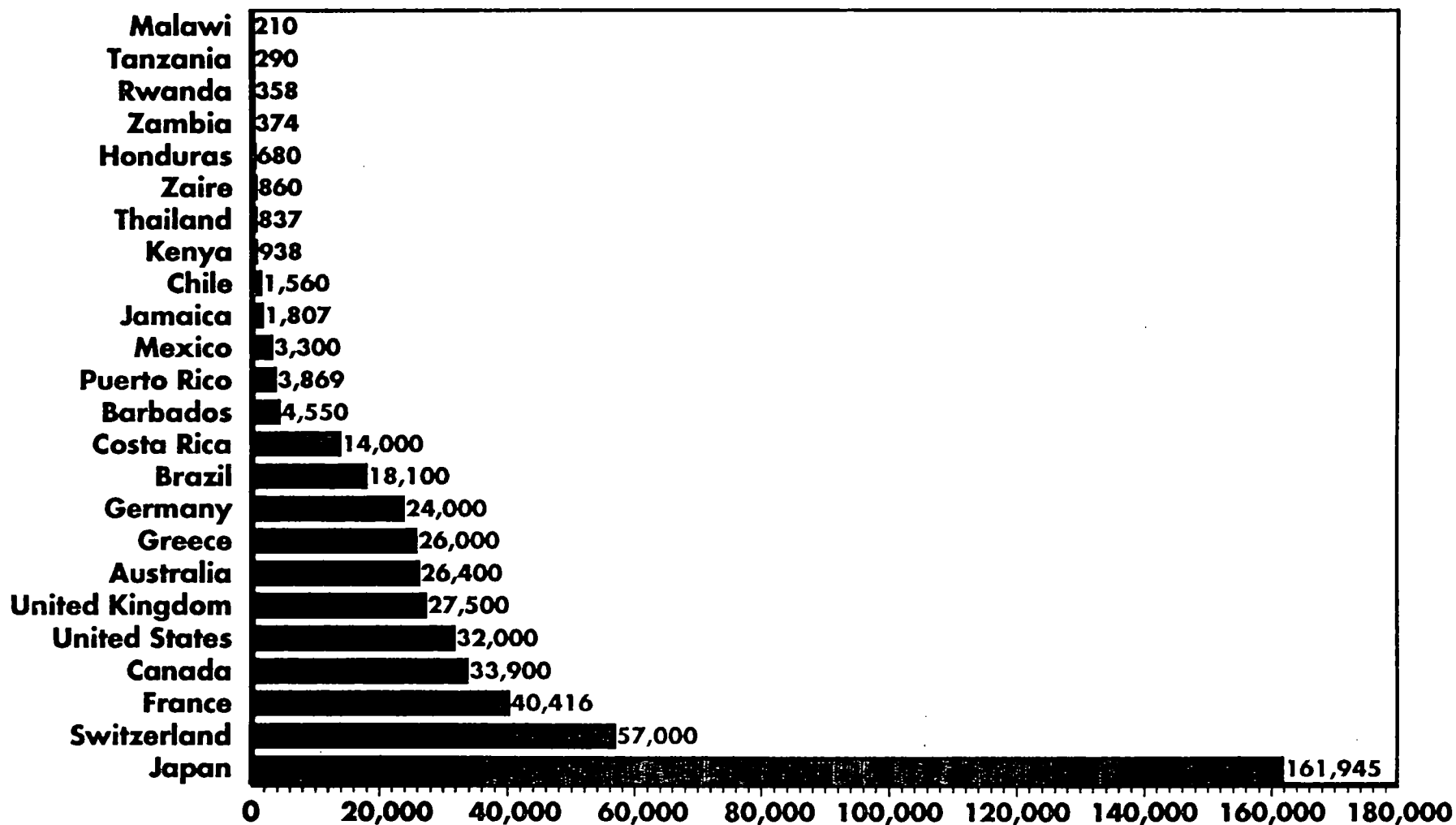
- USAID leadership in AIDS prevention activities worldwide.
- Setting the standards for and advancing the quality of HIV/AIDS prevention programs in the developing world.
- Innovative design of a comprehensive and integrated HIV/AIDS prevention program that includes behavior change communication, STD treatment, condom provision, policy dialogue, relevant behavioral research, and evaluation.
- Capacity building and institutional strengthening of over 200 private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) and public sector institutions in 35 countries to design, implement, and evaluate AIDS prevention programs, including:
 - Program design and management;
 - Financial management;
 - Program evaluation.
- Successful AIDS prevention programs in selected populations in 35 countries, i.e., a reduction in the number of HIV infections in targeted populations in selected countries.
- Replication of successful demonstration projects in several countries.
- Sharing of lessons learned and experiences in the design, implementation and evaluation of successful AIDS prevention programs.
- Research results in the study of determinants of high-risk sexual behavior in a variety of cultural settings, and results in the study of the impact of counseling and testing on reducing high-risk behavior.
- Promotion and acceptance of syndromic management in the treatment of sexually transmitted diseases (STDs) in developing countries.
- Establishment of extremely successful private sector condom social marketing programs in several countries.
- Improvement in the logistics management of commodities including condoms and drugs.
- Sharing of experiences and lessons learned between domestic U.S. and international HIV/AIDS prevention programs.

Projected Geographical Distribution of HIV Infections: 1995



Source: *AIDS in the World*

Annual cost of AIDS treatment



Source: AIDS in the World, 1992. Various AIDSTECH/AIDSCAP studies of Mexico, Honduras, Barbados, Kenya and Malawi



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service



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Current Trends

Heterosexually Acquired AIDS — United States, 1993

From 1991 through 1992, persons with acquired immunodeficiency syndrome (AIDS) who were infected with human immunodeficiency virus (HIV) through heterosexual transmission accounted for the largest proportionate increase in reported AIDS cases in the United States (1). During 1993, a total of 103,500 persons aged ≥ 13 years with AIDS were reported to CDC. This report summarizes the characteristics of persons reported with AIDS in the United States in 1993 attributed to heterosexual contact, compares data with those for 1992, and presents trends in heterosexual exposure categories.*

From 1985 through 1993, the proportion of persons with AIDS who reported heterosexual contact with a partner at risk for or with documented HIV infection increased from 1.9% to 9.0%, respectively (Figure 1). During the same period, the proportion of cases attributed to male-to-male sexual contact decreased from 66.5% to 46.6%, while the proportion attributed to injecting-drug use among women and heterosexual men increased from 17.4% to 27.7%. In 1993, AIDS cases attributed to heterosexual contact ($n=9288$) increased 130% over 1992 ($n=4045$). Cases in all other exposure categories combined increased 109% in 1993, when the expanded AIDS surveillance case definition resulted in substantial increases in reported cases in all demographic and exposure categories (2,3). These reports include present AIDS cases diagnosed in 1993 and in earlier years.

In 1993, most heterosexually acquired AIDS cases were attributed to heterosexual contact with an injecting-drug user (IDU) (42.3%) or with a partner with HIV infection or AIDS whose risk was unreported or unknown (49.7%) (Figure 2). Men were more likely than women to report contact with a partner with HIV infection or AIDS whose risk was unreported or unknown (60% versus 44%); this group may include persons whose sex partners were IDUs or bisexual men for whom risk was not known or reported and persons whose sex partners were themselves infected heterosexually. Compared with 1992, during 1993 the number of cases associated with heterosexual contact with an IDU ($n=3916$) increased 79%, and the number of cases associated with heterosexual contact with a partner with HIV infection or AIDS whose risk was unknown or unreported ($n=4617$) increased 195%. Increases also occurred in the number of cases associated with heterosexual contact with a bisexual man (171%), a person with hemophilia or other coagulation disorder (200%), or a transfusion or transplant recipient (132%). However, the number of cases in these latter three categories is

*Single copies of this report will be available free until March 11, 1995, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

small, and they represent a decreasing proportion of all heterosexual-contact cases (Figure 2).

In 1993, heterosexual HIV transmission accounted for 6056 AIDS cases reported among women (median age: 33 years) and 3232 cases among men (median age: 38 years). In addition, 55% of men and 50% of women were non-Hispanic black, and 23% of men and 24% of women were Hispanic (Table 1). Rates were highest for non-Hispanic blacks (20 per 100,000 population) and Hispanics (10 per 100,000) than for non-Hispanic whites (1 per 100,000), Asians/Pacific Islanders (1 per 100,000), and American Indians/Alaskan Natives (2 per 100,000). During 1992 and 1993, persons aged 13–29 years accounted for 25% and 27%, respectively, of heterosexual-contact cases, while representing 18% of total adolescent and adult AIDS cases each year.

The highest proportions of cases associated with heterosexual contact during 1993 were in the South[†] (42%) and Northeast[‡] (31%); these areas also accounted for 24% and 53%, respectively, of cases reported among heterosexual IDUs (n=28,687). States reporting the largest number of heterosexually acquired AIDS cases in 1993 were Florida (1772 cases), New York (1336), and New Jersey (855).

As of December 31, 1993, of 34,952 persons with AIDS ever reported without a behavioral risk factor, 14,787 (42%) had been reclassified; of these, 10% of men and 63% of women were reclassified as having acquired AIDS through heterosexual transmission of HIV (Figure 3). By comparison, in 1993, 4% of men and 37% of women with AIDS were reported as having HIV infection associated with heterosexual transmission.

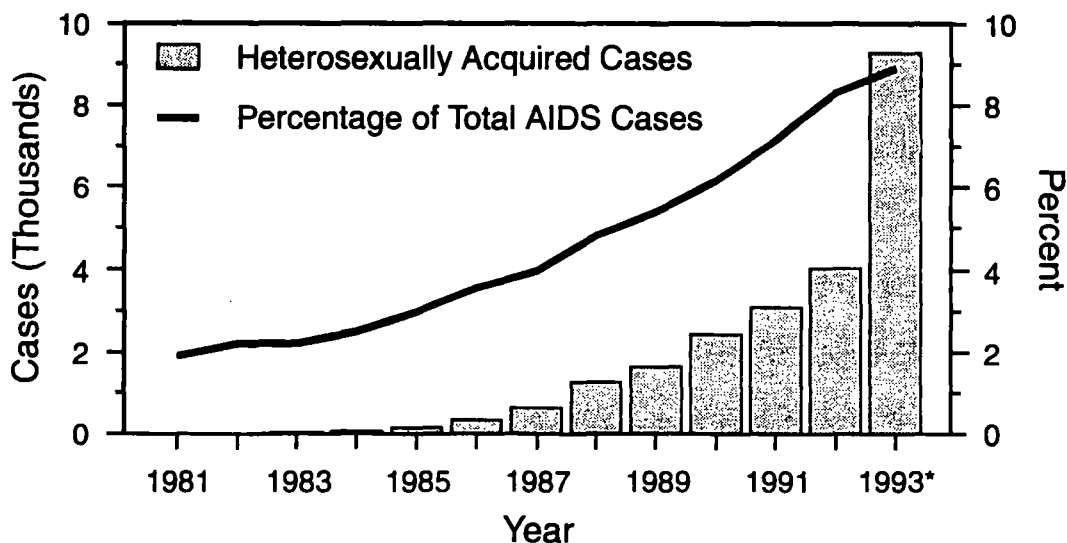
Reported by: Local, state, and territorial health depts. Div of HIV/AIDS, National Center for Infectious Diseases, CDC.

Editorial Note: This report documents the continued increase in the number and proportion of AIDS cases attributed to heterosexual HIV transmission. Persons at highest risk for heterosexually transmitted HIV infection include adolescents and adults with multiple sex partners, those with sexually transmitted diseases (STDs), and het-

[†]South Atlantic, East South Central, and West South Central regions.

[‡]New England and Middle Atlantic regions.

FIGURE 1. Number of AIDS cases attributed to heterosexual HIV transmission and percentage of total AIDS cases — United States, 1981–1993

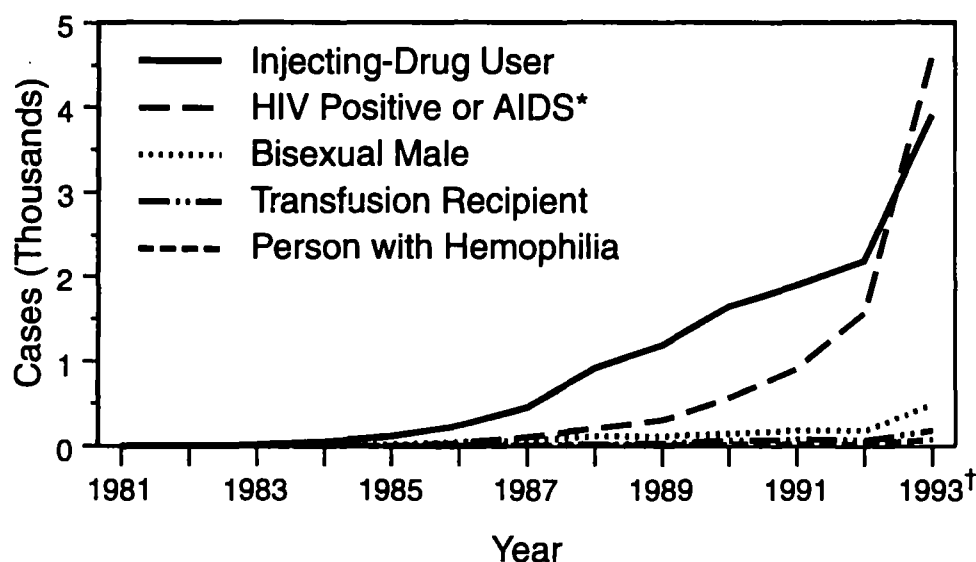


*Expanded AIDS surveillance case definition implemented (2).

erosexually active persons residing in areas with a high prevalence of HIV infection among IDUs (4). In addition, a disproportionate number of persons with AIDS who acquired HIV infection through heterosexual contact are black or Hispanic; monitoring HIV prevalence and AIDS incidence in different racial/ethnic populations can assist in developing culturally and linguistically appropriate HIV-prevention messages.

Among heterosexuals at high risk for HIV infection (e.g., heterosexually active clients at STD clinics and drug-treatment centers), the seroprevalence of HIV infection is higher among men than women (5). However, serosurveillance findings indicate that rates of HIV infection are increasing among women in some populations and geographic areas. For example, among disadvantaged young women who enter the Job Corps and among childbearing women in the South, seroprevalence rates were higher during 1991–1992 than during earlier years (5). Therefore, to understand the extent of

FIGURE 2. Number of AIDS cases attributed to heterosexual HIV transmission, by partner's risk factor — United States, 1981–1993



*Partner's risk unknown or not reported.

†Expanded AIDS surveillance case definition implemented (2).

TABLE 1. Number and percentage of adolescents and adults with heterosexually acquired AIDS, by race/ethnicity and percentage increase — United States, 1992–1993

Race/Ethnicity	Males					Females				
	1992		1993		% Increase from 1992 to 1993	1992		1993		% Increase from 1992 to 1993
	No.	(%)	No.	(%)		No.	(%)	No.	(%)	
White, non-Hispanic	331	(22)	681	(21)	106	616	(24)	1510	(25)	145
Black, non-Hispanic	845	(56)	1789	(55)	112	1308	(52)	3022	(50)	131
Hispanic	325	(22)	736	(23)	126	584	(23)	1444	(24)	147
Asian/Pacific Islander	3	(<1)	16	(<1)	*	20	(<1)	52	(<1)	*
American Indian/ Alaskan Native	1	(<1)	6	(<1)	*	5	(<1)	23	(<1)	*
Total†	1509	(100)	3232	(100)	114	2536	(100)	6056	(100)	139

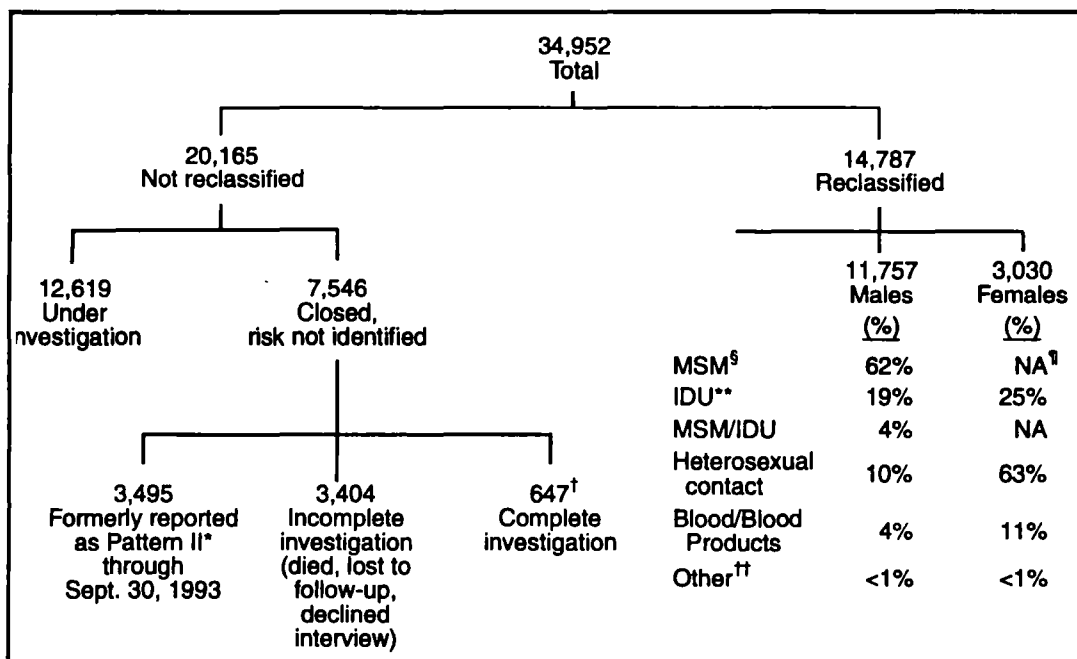
*Estimate of percentage change is unreliable because of small number of cases.

†Includes eight men and eight women for whom race/ethnicity was unknown.

heterosexual transmission and to develop targeted prevention programs, health officials must account for local variations in population characteristics and behaviors that may affect the risk for HIV transmission.

Although some persons classified as having acquired HIV infection through heterosexual contact may have other unreported risk factors (6), the proportions of AIDS cases attributed to heterosexual contact (9% and 6%, respectively, of persons reported in 1993 and cumulatively) probably are a conservative estimate of heterosexual contact AIDS cases. The classification for heterosexual transmission requires a history of heterosexual contact with a partner who has HIV infection, AIDS, or risk factors for HIV infection (i.e., male-to-male sexual contact, injecting-drug use, or receipt of HIV-contaminated blood or blood products). In addition, persons whose origin is a country where heterosexual transmission was presumed to be the predominant mode of HIV transmission (i.e., formerly classified by the World Health Organization as Pattern II countries [7]) and persons who had sex with a person whose origin is such a country are no longer automatically classified as having acquired AIDS through heterosexual contact. To promote more consistent risk ascertainment among persons reported with

FIGURE 3. Results of investigations of adolescents and adults with AIDS classified as "risk not reported" — United States, December 1993



*Persons whose origin is a country where heterosexual transmission was presumed to be the predominant mode of HIV transmission or who had sex with a person whose origin is such a country.

†Investigations on these persons included patient interviews. These persons could not be reclassified into an exposure category. This group includes persons possibly infected through heterosexual contact; persons who may choose not to disclose high-risk information; persons with possible occupational exposure to blood; and persons who report heterosexual contact, sexually transmitted disease infections, noninjecting-drug use, and hepatitis infections.

§Men who have sex with men.

¶Not applicable.

**Injecting-drug user.

††Includes health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; patients who developed AIDS after exposure to HIV within the health-care setting, as documented by epidemiologic and laboratory studies; persons who acquired HIV infection perinatally but did not have AIDS diagnosed until after age 13 years; and one person who acquired HIV infection through intentional self-inoculation of blood from an HIV-infected person.

AIDS, all persons who have no specific risks for HIV infection are classified as "no risk reported."

Other persons with AIDS also may have become infected through heterosexual contact. For example, of the 86,961 persons cumulatively classified as IDUs, approximately 12,600 also reported heterosexual contact with a person at risk. In addition, after follow-up investigations are completed, some persons currently classified as "risk not reported" will be found to have risks for heterosexual transmission. To develop more accurate estimates of the proportion of AIDS cases resulting from heterosexual transmission, CDC is collaborating with six local and state health departments to evaluate the validity and accuracy of heterosexual risk information reported to surveillance programs.

Compared with persons who acquired HIV infection through other modes of transmission, the number of persons infected through heterosexual transmission is increasing rapidly. Increased awareness of these trends and concerns about STDs and unintended pregnancies among adolescents and young adults should result in enhanced efforts to promote safer-sex behaviors. These behaviors include postponing sexual activity among youths, restricting sexual contact to a mutually monogamous relationship with an uninfected partner, and consistently and correctly using latex condoms during intercourse (8). Because promotion of such behavior change is influenced by community norms (9), CDC has expanded efforts to assist local and state health departments in planning HIV-prevention programs at the community level.

References

1. CDC. Update: acquired immunodeficiency syndrome—United States, 1992. *MMWR* 1993;42: 547–51,557.
2. CDC. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. *MMWR* 1992;41(no. RR-17).
3. CDC. Update: impact of the expanded AIDS surveillance definition for adolescents and adults on case reporting—United States, 1993. *MMWR* 1994;43:160–1, 170.
4. CDC. Update: heterosexual transmission of acquired immunodeficiency syndrome and human immunodeficiency virus infection—United States. *MMWR* 1989;38:423–4,429–34.
5. CDC. National HIV serosurveillance summary: results through 1992. Vol 3. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1993:29–30.
6. Nwanyanwu OC, Conti L, Ciesielski CA, et al. Increasing frequency of heterosexually transmitted AIDS in southern Florida: artifact or reality? *Am J Public Health* 1993;83:571–3.
7. Mertens TE, Burton T, Stoneburner R, et al. Global estimates and epidemiology of HIV infection and AIDS. *AIDS: A Year in Review, 1993–1994* (in press).
8. CDC. Update: barrier protection against HIV infection and other sexually transmitted diseases. *MMWR* 1993;42:589–91,597.
9. National Commission on AIDS. Behavioral and social sciences and the HIV/AIDS epidemic. Washington, DC: National Commission on AIDS, July 1993:44–9.