AIDS epidemic update

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GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC DECEMBER 2002

Number of people living with HIV/AIDS Total		**42 million**
	Adults	38.6 million
	Women	*19.2 million*
	Children under 15 years	3.2 million
People newly infected with HIV in 2002 Total		**5 million**
	Adults	4.2 million
	Women	*2 million*
	Children under 15 years	800 000
AIDS deaths in 2002	**Total**	**3.1 million**
	Adults	2.5 million
	Women	*1.2 million*
	Children under 15 years	610 000

INTRODUCTION

The AIDS epidemic claimed more than 3 million lives in 2002, and an estimated 5 million people acquired the human immunodeficiency virus (HIV) in 2002—bringing to 42 million the number of people globally living with the virus.

As the world enters the third decade of the AIDS epidemic, the evidence of its impact is undeniable. Wherever the epidemic has spread unchecked, it is robbing countries of the resources and capacities on which human security and development depend. In some regions, HIV/AIDS, in combination with other crises, is driving ever-larger parts of nations towards destitution.

The world stood by as HIV/AIDS swept through these countries. It cannot be allowed to turn a blind eye to an epidemic that continues to expand in some of the most populous regions and countries of the world.

Progress towards realizing the Declaration of Commitment

The Declaration of Commitment on HIV/AIDS is a potential watershed in the history of the HIV/AIDS epidemic. Adopted by the world's governments at the Special Session of the United Nations General Assembly on HIV/AIDS in June 2001, it established, for the first time ever, time-bound targets to which governments and the United Nations may be held accountable.

UNAIDS and its Cosponsors have established a set of yardsticks for tracking movement towards those targets. Work on the first report measuring progress against these indicators starts in 2003, and will be based on progress reports provided in March 2003 by the 189 countries that adopted the Declaration.

Already, though, there is substantial evidence of progress. More countries are recognizing the value of pooling resources, experiences and commitment by forging regional initiatives to combat the epidemic. Examples are multiplying, among them the following:

The Asia Pacific Leadership Forum, which is tasked with improving key decision-makers' knowledge and understanding of HIV/AIDS and its impact on different sectors of society.

Members of the Commonwealth of Independent States have developed a regional Programme of Urgent Response to the HIV/AIDS epidemic, which government leaders endorsed in May 2002.

In mid-2002, the Pan-Caribbean Partnership against HIV/AIDS signed an agreement with six pharmaceutical companies as part of wider-ranging efforts to improve access to cheaper antiretroviral drugs.

In sub-Saharan Africa, 40 countries have developed national strategies to fight HIV/AIDS (almost three times as many as two years ago), and 19 countries now have National AIDS Councils (a six-fold increase since 2000).

Additional resources are being brought to bear by the new Global Fund to Fight AIDS, Tuberculosis and Malaria, which has approved an initial round of project proposals, totalling US$616 million, about two-thirds of which is earmarked for HIV/AIDS. Governments and donors have pledged more than US$2.1 billion to the fund.

But the world lags furthest behind in providing adequate treatment, care and support to people living with HIV/AIDS. Fewer than 4% of people in need of antiretroviral treatment in low- and middle-income

countries were receiving the drugs at the end of 2001. And less than 10% of people with HIV/AIDS have access to palliative care or treatment for opportunistic infections.

In many countries, especially in sub-Saharan Africa and Asia, competing national priorities inhibit allocation of resources to expand access to HIV/AIDS care, support and treatment. Unaffordable prices remain the most commonly cited reasons for the limited access to antiretroviral drugs. Insufficient capacity of health sectors, including infrastructure and shortage of trained personnel, are also major obstacles to health service delivery in many countries.

In Eastern Europe and Central Asia, the number of people living with HIV in 2002 stood at 1.2 million. HIV/AIDS is expanding rapidly in the Baltic States, the Russian Federation and several Central Asian republics.

In Asia and the Pacific, 7.2 million people are now living with HIV. The growth of the epidemic in this region is largely due to the growing epidemic in China, where a million people are now living with HIV and where official estimates foresee a manifold increase in that number over the coming decade. There remains considerable potential for growth in India, too, where almost 4 million people are living with HIV.

In several countries experiencing the early stages of the epidemic, significant economic and social changes are giving rise to conditions and trends that favour the rapid spread of HIV—for example, wide social disparities, limited access to basic services and increased migration.

Best current projections suggest that an additional 45 million people will become infected with HIV in 126 low- and middle-income countries (currently with concentrated or generalized epidemics) between 2002 and 2010—unless the world succeeds in mounting a drastically expanded, global prevention effort. More than 40% of those infections would occur in Asia and the Pacific (currently accounts for about 20% of new annual infections).

Pinning down HIV trends

The most common measure of the HIV/AIDS epidemic is the *prevalence* of HIV infections among a country's adult population—in other words, the percentage of the adult population living with HIV. Prevalence of HIV provides a good picture of the overall *state* of the epidemic. Think of it as a still photograph of HIV/AIDS. In countries with generalized epidemics, this image is based largely on HIV tests done on anonymous blood samples taken from women attending antenatal clinics.

But prevalence offers a less clear picture of recent *trends* in the epidemic, because it does not distinguish between people who acquired the virus very recently and those who were infected a decade or more ago. (Without antiretroviral treatment, a person might survive, on average, up to 9–11 years after acquiring HIV; with treatment, survival is substantially longer.)

Countries A and B, for example, could have the same HIV prevalence, but be experiencing very different epidemics. In country A, the vast majority of people living with HIV/AIDS (the prevalent cases) might have been infected 5–10 years ago, with few recent infections occurring. In country B, the majority of people living with HIV/AIDS might have been infected in the past two years. These differences would obviously have a huge impact on the kind of prevention and care efforts that countries A and B need to mount.

Similarly, HIV prevalence rates might be stable in country C, suggesting that new infections are occurring at a stable rate. That may not be the case, however. Country C could be experiencing higher rates of AIDS mortality (as people infected a decade or so ago die in large numbers), and an *increase* in new infections. Overall HIV prevalence rates would not illuminate those details of the country's epidemic.

So a measure of HIV *incidence* (i.e. the number of new infections observed over a year among previously uninfected people) would help complete the picture of current trends. Think of it as an animated image of the epidemic.

The problem is that measuring HIV incidence is expensive and complicated—to the point of it being unfeasible at a national level and on a regular basis in most countries.

None of this means, however, that recent trends are a mystery. Regular measurement of HIV prevalence among groups of young people can serve as a proxy, albeit imperfect, for HIV incidence among them. Because of their age, young people will have become infected relatively recently. Significant changes in HIV prevalence among 15–19- or 15–24-year-olds can therefore reflect important new trends in the epidemic.

The steadily dropping HIV prevalence levels in 15–19-year-olds in Uganda, for example, indicate a reduction in recent infections among young people, and provide a more accurate picture of current trends in the epidemic (and, in this instance, of the effectiveness of prevention efforts among young people).

Such outcomes can be avoided. Implementation of a full prevention package by 2005 could cut the number of new infections by 29 million by 2010. It could also help achieve the target of reducing HIV prevalence levels among young people by 25% by 2010 (as set in the Declaration of Commitment on HIV/AIDS, which the world's governments adopted in June 2001). But any delay in implementing a full prevention package will slash the potential gains.

Responses that involve and treat young people as a priority pay off, as evidence from Ethiopia, South Africa, Uganda and Zambia shows. HIV prevalence levels among young women in Addis Ababa declined by more than one-third between 1995 and 2001. Among pregnant teenagers in South Africa, HIV prevalence levels shrank a quarter between 1998 and 2001. Prevalence remains unacceptably high, but these positive trends confirm the value of investing in responses among the young.

The future trajectory of the global HIV/AIDS epidemic depends on whether the world can protect young people everywhere against the epidemic and its aftermath.

Just as certain sectors of society are at particular risk of HIV infection, certain conditions favour the epidemic's growth. As the current food emergencies in southern Africa show, the AIDS epidemic is increasingly entangled with wider humanitarian crises. The risk of HIV spread often increases when desperation takes hold and communities are wrenched apart. At the same time, the ability to stall the epidemic's growth also suffers, as does the capacity to provide adequate treatment, care and support.

It is vital that HIV/AIDS-related activities become an integral part of wider-ranging efforts to prevent and overcome humanitarian crises, as this publication shows (see 'HIV/AIDS and humanitarian crises').

REGIONAL HIV/AIDS STATISTICS AND FEATURES, END OF 2002

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence rate (*)	% of HIV-positive adults who are women	Main mode(s) of transmission (#) for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s early '80s	29.4 million	3.5 million	8.8%	58%	Hetero
North Africa & Middle East	late '80s	550 000	83 000	0.3%	55%	Hetero, IDU
South & South-East Asia	late '80s	6.0 million	700 000	0.6%	36%	Hetero, IDU
East Asia & Pacific	late '80s	1.2 million	270 000	0.1%	24%	IDU, hetero, MSM
Latin America	late '70s early '80s	1.5 million	150 000	0.6%	30%	MSM, IDU, hetero
Caribbean	late '70s early '80s	440 000	60 000	2.4%	50%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	1.2 million	250 000	0.6%	27%	IDU
Western Europe	late '70s early '80s	570 000	30 000	0.3%	25%	MSM, IDU
North America	late '70s early '80s	980 000	45 000	0.6%	20%	MSM, IDU, hetero
Australia & New Zealand	late '70s early '80s	15 000	500	0.1%	7%	MSM
TOTAL		**42 million**	**5 million**	**1.2%**	**50%**	

* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2002, using 2002 population numbers.

Hetero (heterosexual transmission), IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men).

ASIA AND THE PACIFIC

The window of opportunity for bringing the HIV/AIDS epidemic under control is narrowing rapidly in Asia.

Almost 1 million people in Asia and the Pacific acquired HIV in 2002, bringing to an estimated 7.2 million the number of people now living with the virus—a 10% increase since 2001. A further 490 000 people are estimated to have died of AIDS in the past year. About 2.1 million young people (aged 15–24) are living with HIV.

With the exception of Cambodia, Myanmar and Thailand, national HIV prevalence levels remain comparatively low in most countries of Asia and the Pacific. That, though, offers no cause for comfort. In vast, populous countries such as China, India and Indonesia, low national prevalence rates blur the picture of the epidemic.

Both China and India, for example, are experiencing serious, localized epidemics that are affecting many millions of people.

India's national adult HIV prevalence rate of less than 1% offers little indication of the serious situation facing the country. An estimated 3.97 million people were living with HIV at the end of 2001—the second-highest figure in the world, after South Africa. HIV prevalence among women attending antenatal clinics was higher than 1% in Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu.

New behavioural studies in India suggest that prevention efforts directed at specific populations (such as female sex workers and injecting drug users) are paying dividends in some states, in the form of higher HIV/AIDS knowledge levels and condom use (see box). However, HIV prevalence among these key groups continues to increase in some states, underlining the need for well-planned and sustained interventions on a large scale.

The epidemic in China shows no signs of abating. Official estimates put the number of people living with HIV in China at 1 million in mid-2002. Unless effective responses rapidly take hold, a total of 10 million Chinese will have acquired HIV by the end of this decade—a number equivalent to the entire population of Belgium.

Officially, the number of reported new HIV infections rose about 17% in the first six months of 2002. But HIV incidence rates can soar abruptly in a country marked by widening socioeconomic disparities and extensive migration (an estimated 100 million Chinese are temporarily or permanently away from their registered addresses), with the virus spreading along multiple channels.

There is a vital need to expand activities that focus on people most at risk of infection. But targeted interventions alone will not halt the epidemic. More extensive HIV/AIDS programmes that reach the general population are essential.

Several HIV epidemics are being observed among certain population groups in various parts of this vast country. Serious localized HIV epidemics are occurring among injecting drug users in nine provinces, as well as in Beijing Municipality.

Mixed lessons from India

A new national behavioural survey conducted in 2001–2002 in India highlights important facets of the country's bid to curtail its epidemic. The survey shows clearly that where interventions have occurred and been sustained, behavioural change has been possible. But it also points to the difficulties in reaching some key groups (such as men who have sex with men), and large sections of the wider population (notably women living in rural areas).

Countrywide, awareness of HIV/AIDS is high, with roughly three-quarters of adult Indians (aged 15–49) aware that correct and consistent condom use can prevent sexual transmission of HIV.

But, in general, awareness and knowledge of HIV/AIDS remain weak in rural areas and among women. More than 80% of urban men recognized the protective value of consistent condom use, compared to just over 43% of rural women. There are marked exceptions, though, such as in Andhra Pradesh and Kerala, where awareness levels among women and men are approximately the same. Yet, even in those states, women report low levels of condom use (37% and 22%, respectively)—an indication that many are not able to negotiate safer sex with male partners. The gender divide remains wide.

The survey data show that Indians who cannot read are six times less likely to use a condom during casual sex than are their compatriots who are educated beyond secondary school. And rural residents are half as likely as their urban peers to use a condom with casual partners.

Striking, too, are the high levels of awareness and knowledge about HIV/AIDS, and the evidence of high condom use among vulnerable populations in states that have mounted consistent prevention efforts. For example, Maharashtra is home to a longstanding, generalized epidemic. There, HIV/AIDS responses appear to have resulted in higher levels of awareness and behavioural change among female sex workers, their clients and injecting drug users (66%, 77% and 52% of whom, respectively, said they consistently use condoms—among the highest rates in India). This may have helped prevent the state's epidemic from spinning out of control.

Similarly, Gujarat's focused programmes have helped ensure that some three-quarters of female sex workers used condoms the last time they had sex with a commercial or casual partner. But the state also reminds that HIV/AIDS responses have to reach the wider population if the epidemic is to be kept under control. (Knowledge levels among women and rural inhabitants, for example, are very low: only about 8% had no misconceptions about how HIV is transmitted.) By contrast, where interventions for general *and* marginalized populations have taken place together—as in Kerala—they have helped keep HIV prevalence low.

The survey shows that a significant proportion of men who have sex with men in India also have sex with women (almost 31% had sex with female partners in a six-month recall period), and many (36% during a month's recall) have sex with commercial male partners—hitherto hidden facets of the epidemic. Condom use rates, though, were low both with commercial partners (39% during last sexual intercourse) and with female partners (36%). This points to the need for urgent action, given the potential for wider and more rapid HIV spread through such multiple sexual networks.

A major challenge for India now is that of rapidly expanding the coverage of its HIV/AIDS programmes to all vulnerable groups. Flanking that is the broader challenge of ensuring that the response reaches young, illiterate populations and rural communities, especially women.

(Based on Nationwide Behavioural Surveillance Survey of general population and high-risk groups, 2001–2002, National AIDS Control Organization, India/ORG MARG)

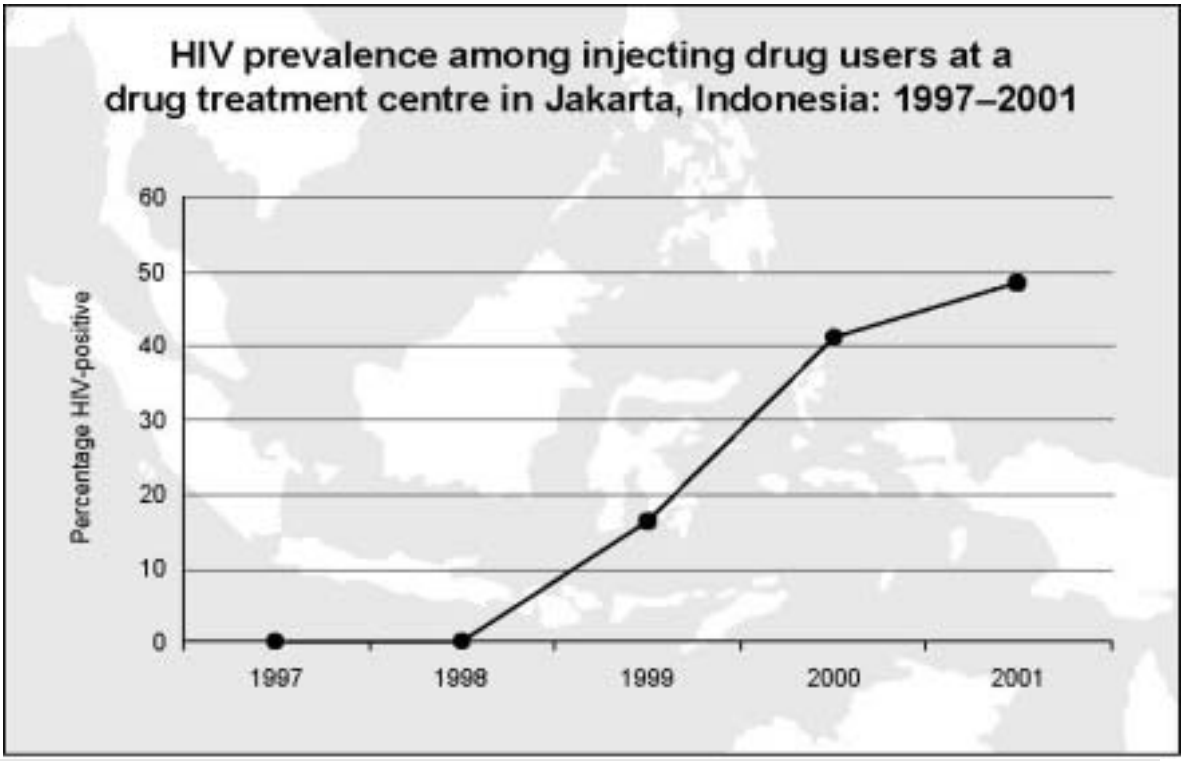
The most recent reported outbreaks of HIV among injecting drug users have been in Hunan and Guizhou provinces (where sentinel surveillance among users has revealed HIV prevalence rates of 8% and 14%, respectively). There are also signs of heterosexually transmitted HIV epidemics spreading in at least three provinces (Yunnan, Guangxi and Guangdong) where HIV prevalence in 2000 was as high as 11% among sentinel sex worker populations.

A dangerous new trend in Indonesia

Recent social and economic upheavals in Indonesia appear to be fuelling a sharp rise in injecting drug use—and, with it, the risk of rapidly increasing HIV spread.

Virtually unknown in Indonesia just a decade ago, drug injection is now a growing phenomenon in urban areas. Official estimates suggest that between 124 000 and 196 000 Indonesians are now injecting drugs. And data from the largest drug treatment centre in Jakarta reveal that HIV prevalence is rising very steeply in this population, as the graph below shows.

National estimates indicate that some 43 000 injecting drug users are already infected with HIV. With needle-sharing the norm, HIV is likely to spread much more widely throughout this population in the next few years. If current high-risk injecting behaviour continues, it is estimated that the number of injecting drug users living with HIV could almost double in 2003, accounting for more than 80% of new HIV infections nationwide.



Source: RSKO hospital and Indonesian Ministry of Health, Directorate General of Communicable Disease Control and Environmental Health, 2002.

The vast majority of injectors are male, and behavioural data indicate that over two-thirds of them are sexually active. Already, an estimated 9000 women have been infected sexually by men who inject drugs.

The onward sexual transmission of HIV by people who became infected when they sold their blood to collecting centres that ignored basic blood-donation safety procedures poses a massive challenge, as does the need to provide them with treatment and care. Signalling the gravity of the situation, one 2001 survey in rural eastern China found alarmingly high HIV prevalence—12.5%—among people who had donated plasma. Most of the country's estimated 3 million paid blood donors live in poor rural communities, and those now living with HIV/AIDS in provinces such as Henan (as well as Anhui and Shanxi, where similar tragedies might have occurred) face limited access to health-care services while having to endure severe stigma and discrimination.

There is a clear need for urgent action. By expanding prevention, treatment and care efforts across the entire nation, China can avert millions of HIV infections and save millions of lives in the coming decade. The five-year AIDS action plan promulgated in mid-2001 signalled a growing commitment to take up that challenge, as did the recent moves towards negotiating affordable antiretroviral treatment with pharmaceutical companies.

High HIV infection rates are being discovered among specific population groups (chiefly injecting drug users, sex workers, and men who have sex with men) in countries across the length and breadth of Asia and the Pacific.

Cambodia's epidemic appears to be stabilizing, thanks to sustained prevention programmes that link government and civil society and that span various sectors of society.

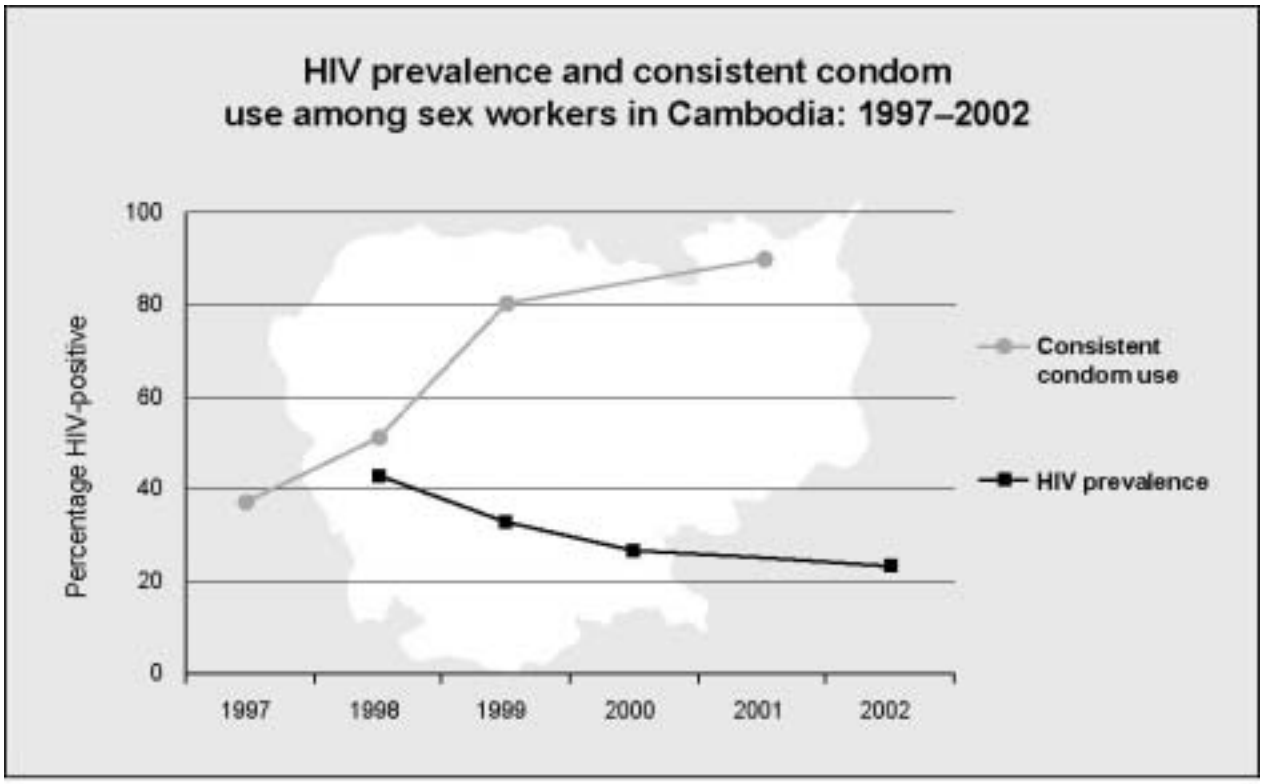
Throughout the region, injecting drug use offers the epidemic huge scope for growth. Upwards of 50% of injecting drug users already have acquired the virus in parts of Malaysia, Myanmar, Nepal, Thailand and in Manipur in India, while HIV infections among Indonesia's growing population of injecting drug users is soaring (see box, page 9). Very high rates of needle-sharing have been documented among users in Bangladesh and Viet Nam, along with evidence that a considerable proportion of street-based sex workers in Viet Nam also inject drugs (a phenomenon detected in other countries, too). If the epidemic is to be stemmed, it is vital that injecting drug users gain access to harm reduction and other prevention services.

Male-to-male sex occurs in all countries of the region and features significantly in the epidemic. Countries that have measured HIV prevalence among men who have sex with men have found it to be high—14% in Cambodia in 2000 and roughly the same level among male Thai sex workers. Homophobia or dominant cultural norms mean that many men who have sex with men hide that aspect of their sexuality. Many might marry or have sexual relationships with women.

Among the Pacific Island countries and territories, Papua New Guinea has reported the highest HIV infection rates. New surveillance data reveal an HIV prevalence of 1% among women attending antenatal clinics in the capital Port Moresby, indicating that a broadened epidemic is under way in the city. Among people seeking treatment for other sexually transmitted infections in the capital, HIV prevalence was 7% in 2001 (double the level in 2000). Very low levels of condom use and wide sexual networking (amid low awareness and knowledge of HIV/AIDS) mean the country could be facing a severe epidemic. Heightening that prospect are findings that 85% of surveyed sex workers in Port Moresby and in Lae did

not use condoms consistently in 2001, and that rates of other sexually transmitted infections ranged as high as 36%. There is a dire need for rapid expansion of prevention efforts.

In Thailand, meanwhile, recent modelling sug-gests that the main modes of transmission have been changing. Whereas most HIV transmission in the 1990s occurred through commercial sex, half of the new HIV infections now appear to be occurring among the wives and sexual partners of men who were infected several years ago. There are also indications that unsafe sexual behaviour is on the increase among young Thais. This underlines the need to expand and revitalize strategies that can prevent this highly adaptable epidemic from spreading further in Thailand. In addition, adequate treatment and care should remain priority.



Source : HSS,1998-2002. Cambodia BSS, 1997-2002

The Asian country with the highest adult HIV prevalence—Cambodia—has reported stabilizing levels of infection, along with still-decreasing levels of high-risk behaviour. HIV prevalence among pregnant women in major urban areas declined slightly from 3.2% in 1996 to 2.8% in 2002, according to the latest available data. Prevalence among sex workers declined from 42% in 1998 to 29% in 2002, according to the latest surveillance data, with the decline most pronounced among sex workers under 20. Given the high turnover of sex workers in Cambodia (almost three-quarters engage in sex work for less than two years), this steady de-cline suggests that prevention efforts focused on sex workers are yielding positive results among the succession of new entrants into sex work. Consistent condom use by sex workers appears to be the most important behavioural change achieved; it rose from 37% in 1997 to 90% in 2001.

Focussed efforts that protect vulnerable populations against HIV/AIDS are important and cost-effective. Alone, though, they cannot halt the epidemic. It is vital that AIDS responses everywhere extend also into

the wider population, imparting the knowledge and providing the services that people need to protect themselves and each other against HIV/AIDS.

Despite sweeping epidemics among injecting drug users, minimum services that can protect those drug users against HIV infection are not available in most of the region.

Given that many of the factors facilitating HIV transmission (including periodic economic upheaval and high rates of population mobility) are rife throughout this region, no country is immune to a rapidly spreading and wide-scale epidemic. Most countries, though, still have a window of opportunity for mounting and sustaining HIV/AIDS initiatives that could avert such an outcome.

EASTERN EUROPE AND CENTRAL ASIA

The epidemic continues to expand rapidly in most countries of this vast region.

The unfortunate distinction of having the world's fastest-growing HIV/AIDS epidemic still belongs to Eastern Europe and Central Asia. In 2002, there were an estimated 250 000 new infections, bringing to 1.2 million the number of people living with HIV/AIDS.

In recent years, the Russian Federation has experienced an exceptionally steep rise in reported HIV infections. In less than eight years, HIV/AIDS epidemics have been discovered in more than 30 cities and 86 of the country's 89 regions. Up to 90% of the registered infections have been attributed officially to injecting drug use, reflecting the fact that young people face high risks of HIV infection as occasional or regular drug injectors. Indeed, almost 80% of registered new infections in the Commonwealth of Independent States between 1997 and 2000 were among people younger than 29. In the Russian Federation, the total number of reported HIV infections climbed to over 200 000 by mid-2002—a huge increase over the 10 993 reported less than four years ago, at the end of 1998.

It must be noted that registered HIV cases likely underestimate the number of people living with HIV by a large margin. Indeed, the first community survey of injecting drug users—in Togliatti City—has revealed shockingly high HIV prevalence (see box). In addition, the reported cases might not accurately reflect the possible changes in the patterns of HIV transmission (in terms of the modes of transmission, and the gender and age groups of people who are being infected). The inadequacy of sentinel surveillance and voluntary counselling and testing services means that most HIV tests occur as part of routine screening of people who encounter the law enforcement system or use health-care services.

A huge problem slips into focus

A clearer picture of the HIV epidemic has emerged in the Russian city of Togliatti, revealing the true scale of the country's HIV/AIDS epidemic.

A study in late 2001 among injecting drug users recruited from their communities (the first of its kind in the Russian Federation) has revealed a very recent and explosive HIV/AIDS epidemic among injecting drug users in this city of 1 million inhabitants. Fully 56% of the users participating in the study were found to be HIV-positive, and a large share of them had acquired the virus in the previous two years. The survey revealed that three-quarters of those found to be living with the virus were unaware of their status. In addition, 40% of female sex workers who injected drugs did not use condoms consistently with their regular partners, and about 25% failed to do so with commercial sexual partners.

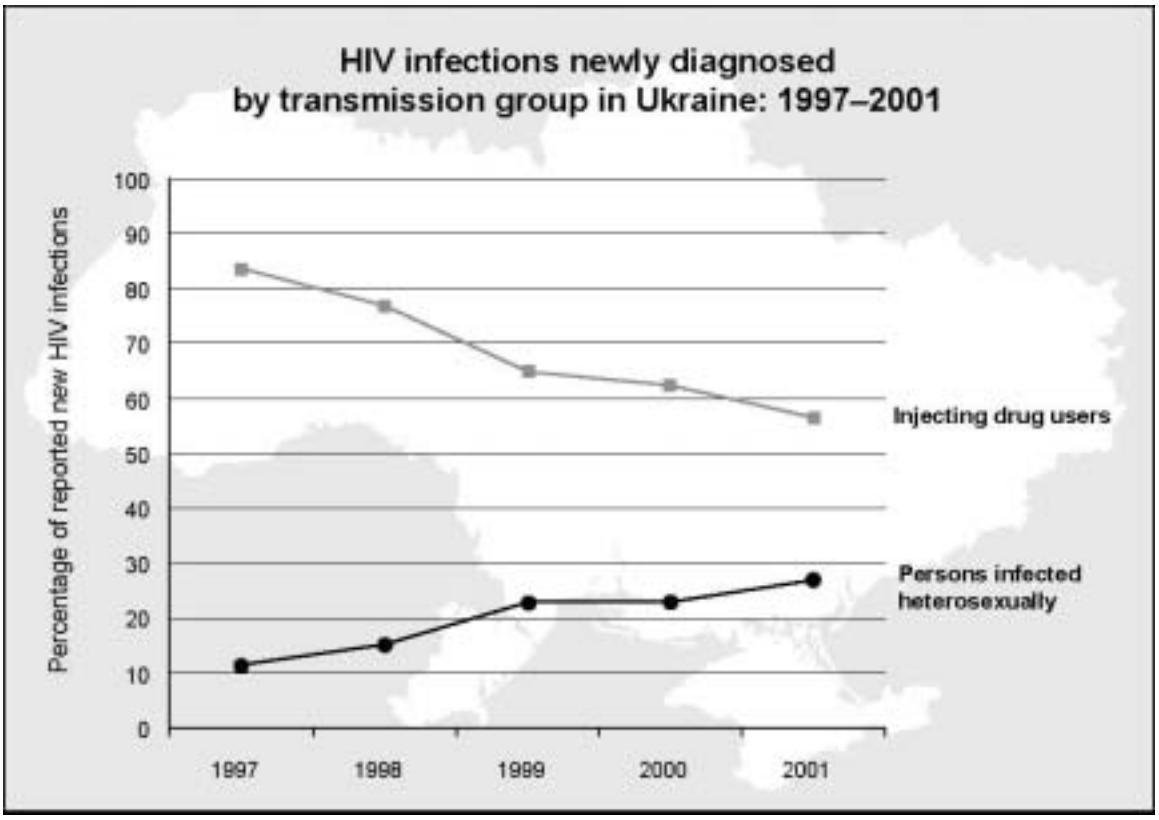
The study lends further credence to concerns that the HIV/AIDS epidemic in Russian cities could be considerably more severe than the already-high official statistics indicate. Harm reduction and other HIV prevention programmes have proliferated in the past two years; yet, their coverage remains narrow and, in cases like Togliatti City, inadequate. Authors of the study have stressed the need to expand access to sterile injecting equipment, and to step up efforts to reduce the risk of sexual transmission of HIV between injecting drug users and their partners.

Throughout Eastern Europe and Central Asia, young people are particularly hard-hit by the epidemic. It is estimated that up to 1% of the population of those countries is injecting drugs, placing these people and their sexual partners at high risk of infection. Those injecting drugs can be very young—some a mere 13–14 years old. One study among Moscow secondary-school students revealed that 4% had injected drugs.

Uzbekistan is experiencing explosive growth—in the first six months of 2002, there were almost as many new HIV infections as had been recorded in the whole of the previous decade.

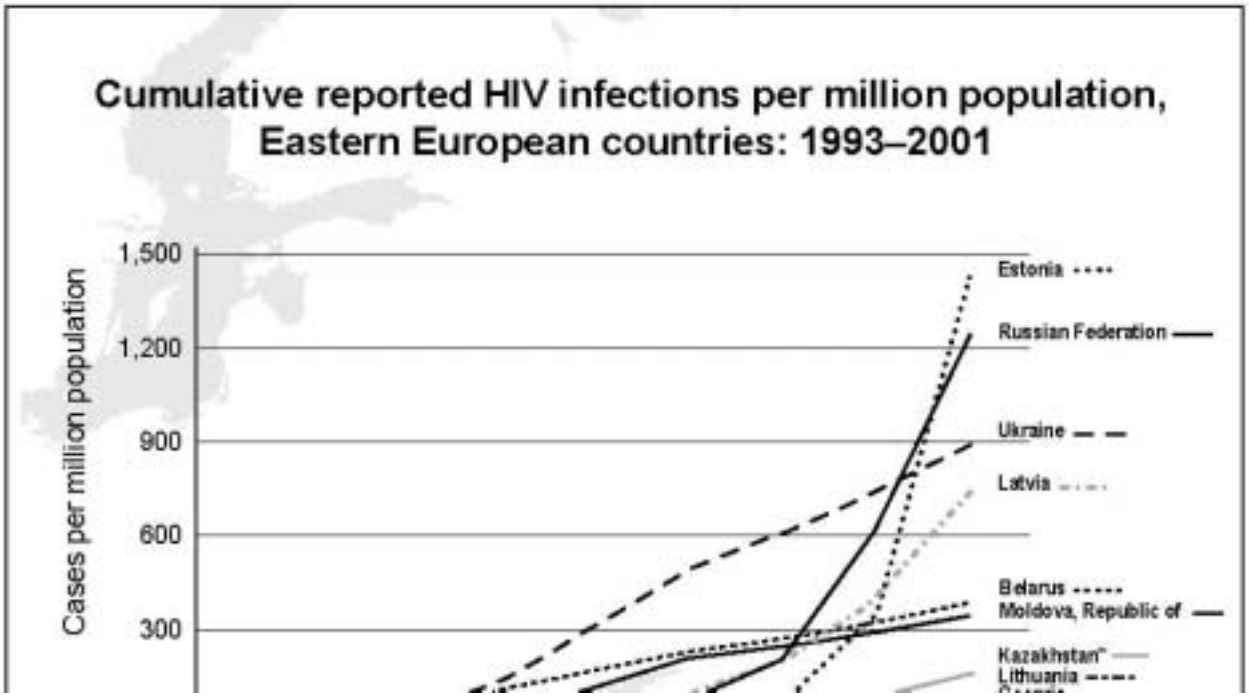
In the Russian Federation, and in many of the Central Asian Republics, the wave of injecting drug use is closely correlated with socioeconomic upheavals that have sent the living standards of tens of millions of people plummeting, amid rising unemployment and poverty levels. Another factor has been the four-fold increase in world production of heroin in the past decade, along with the opening of new trafficking routes across Central Asia.

The epidemic is growing in Kazakhstan, where a total of 1926 HIV infections had been reported by June 2001. More substantial spread of HIV is now also evident in Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan. In the latter two republics, recent evidence of rising heroin use heightens concerns that they could be on the brink of larger HIV/AIDS epidemics. Already, a steep rise in reported HIV infections has been noted in Uzbekistan, where 620 new infections were registered in the first six months of 2002—six times the number of new infections registered in the first six months of 2001.



Source: National AIDS Programmes. Data compiled by the European Centre for the Epidemiological Monitoring of AIDS.
HIV/AIDS surveillance in Europe. End-of-year report 2001; Saint-Maurice: Institut de Veille Sanitaire, 2001. No 66.

Reported HIV incidence is rising sharply elsewhere. In Estonia, reported infections soared from 12 in 1999 to 1474 in 2001. (Relative to population size, Estonia now has the highest rate of new HIV infections in this region—50% higher than the Russian rate). A burgeoning epidemic is visible, too, in Latvia, where new reported infections rose from 25 in 1997 to 807 in 2001, and where a further 308 new HIV cases had been registered by the end of June 2002.


Cumulative reported HIV infections per million population, Eastern European countries: 1993–2001
Cases per million population
1,500
1,200
900
600
300
Estonia
Russian Federation
Ukraine
Latvia
Belarus
Moldova, Republic of
Kazakhstan
Lithuania