



## Fact Sheet: HIV/AIDS

### I. HIV/AIDS Basics

**HIV/AIDS** is one of the most destructive diseases humankind has ever faced and with profound social, economic and public health consequences, and has become one of the world's most serious health and development challenges. HIV is a leading cause of death worldwide. The first cases were reported in 1981 and since the beginning of the pandemic more than 30 years ago, nearly 30 million people have died of AIDS-related illnesses. There are an estimated 34 million people living with HIV (PLHIV).

**HIV** stands for Human Immunodeficiency Virus, and is the virus that causes AIDS. HIV destroys certain blood cells that are crucial to the normal function of the immune system, which defends the body against illness.

**AIDS** stands for Acquired Immunodeficiency Syndrome. It occurs when the immune system is weakened by HIV to the point where a person is susceptible to any number of Opportunistic Infections (OIs) or diseases. Having AIDS is defined as having HIV and one or more OIs.

#### **HIV Testing**

HIV infection is detected through the test of a sample of blood or oral fluid (oral mucosa). If the blood or oral fluid sample contains HIV antibodies – proteins the body produces in an attempt to fight off the infection – the person is HIV positive (also referred to as HIV infected or seropositive). Several rapid HIV tests are available, including ones developed for use with oral fluid or blood plasma samples. All rapid tests provide results in less than 30 minutes; however, positive results require confirmatory blood tests. Pre- and post-test counselling can help individuals assess their personal risk for infection and develop strategies for coping with their test results. When a person already knows that she or he is infected with HIV, they may also have a viral load test to detect HIV genetic material and estimate the amount of virus in the blood. Viral load tests are an important tool in the clinical management of HIV disease.

#### **HIV Transmission**

HIV does not survive well outside the body. Therefore, it cannot be transmitted through casual, everyday contact. Mosquitoes and other insects do not transmit HIV. HIV is primarily spread through unprotected vaginal or anal intercourse with someone who is HIV positive, by sharing contaminated needles, syringes and/or other injecting equipment and, less commonly, through transfusions of infected blood or blood clotting agents (in countries where blood is not screened for HIV antibodies). Babies born to HIV positive women may become infected before or during birth or through breast-feeding after birth.

**Opportunistic Infections (OIs)** are illnesses caused by organisms that do not usually cause disease in persons with normal, healthy immune system. The most common OIs in PLHIV/AIDS include:

- Candidiasis (Thrush), a fungal infection that usually affects the mouth, throat, lungs or vagina.
- Cryptosporidiosis (Crypto), a diarrheal disease caused by the protozoal infection.
- Cryptococcal Meningitis, a fungal infection of the membranes surrounding the brain and spinal cord.
- Cytomegalovirus (CMV), a herpes virus that can cause infections in most organs of the body, though HIV people are more susceptible to CMV retinitis, which can lead to blindness.
- Herpes Simplex Viruses (HSV), which can cause oral or genital herpes. These are common infections, but outbreaks for PLHIV can be more frequent and more severe.
- Mycobacterium Avium Complex (MAC or MAI), a bacterial infection that can cause recurring fevers, problems with digestion and serious weight loss.
- Pneumocystis Carinii Pneumonia (PCP), now known as Pneumocystis Jiroveci Pneumonia, is a fungal infection that can cause a fatal pneumonia. This is a fairly common OI in people who have not been tested or treated for HIV.
- Toxoplasmosis (also referred to as Toxo), a protozoal infection that can infect many parts of the body but most commonly causes an infection of the brain.
- Tuberculosis (TB), a bacterial infection that attacks the lungs and can cause meningitis.

## II. The HIV Epidemic

### Global highlights

#### General facts

In 2010:

- 34 million people were living with HIV worldwide, including 3.4 million children.
- The global prevalence rate (the percentage of people aged 15 - 49 who are infected) was 0.8%.
- About 2.7 million people were newly infected with HIV, including 390 000 children.
- Young people (people aged 15–24) represented 42% of new HIV infections in adults (15 and older).
- A total of 1.8 million people died of AIDS.
- Although testing capacity has increased over time, the majority of people with HIV are still unaware that they are infected.
- In resource poor countries, 6.6 million PLHIV were receiving treatment, representing only 47% of the people eligible for treatment.

Since the beginning of the epidemic:

- More than 60 million people have been infected with HIV.
- Nearly 30 million people have died of HIV-related causes.
- Each day more than 7,000 individuals worldwide are infected with HIV.

Many of the countries hardest hit by HIV also suffer from other infectious diseases, poverty, food insecurity, and other serious problems.

#### HIV and Tuberculosis

- HIV is the strongest risk factor for the development of tuberculosis (TB). One third of PLHIV are co-infected with TB.
- In 2010, Sub-Saharan Africa accounted for 82% of the people living with HIV and TB.
- TB is estimated to cause one in four AIDS-related deaths.
- A majority of these deaths occur in Africa, where the mortality rate from HIV-related TB is more than 20 times higher than in other world regions.
- TB is preventable and curable with inexpensive drugs and evidence has showed that early initiation of antiretroviral therapy significantly reduces the risk of death amongst HIV-positive people with TB.

- In 2010, only 20% of the estimated number of people with TB and HIV were receiving antiretroviral therapy.

### **Vulnerable communities and populations at higher risk of HIV**

- In 2010, women represented 50% of the adults living with HIV worldwide. Women are biologically more susceptible to HIV, in addition to suffering from gender inequalities, discrimination and violence that increase their vulnerability to HIV.

- Young women (women aged 15-24) have an especially high risk of acquiring HIV, with infection rates twice as high as in young men. In 2010, about 3.2 million young women were living with HIV, and young women accounted for 22% of all new HIV infections. HIV is the leading cause of death of women of reproductive age and every minute, a young woman is newly infected with HIV.

- Although globally, most new infections are transmitted heterosexually, in some countries HIV continues to disproportionately affect three categories of populations: people who inject drugs, men who have sex with men and sex workers.

Several structural factors, including poverty, discrimination and stigma interact to prevent a better access to essential information, prevention and treatment services amongst these vulnerable communities.

### **Mother-to-child transmission (MTCT) of HIV**

In 2010:

- In countries representing 98% of the pregnant women living with HIV, the coverage of pregnant women receiving the most effective regimens for preventing MTCT was 48%.
- An estimated 32% of the 1.49 million pregnant women with HIV needing antiretroviral medicine to prevent MTCT were unaware of their HIV status.
- In low- and middle income countries, 35% of pregnant women received an HIV test (26% in 2009).

### **HIV knowledge**

- In 2010, in low- and middle-income countries, only 24% of young women and 36% of young men responded correctly when asked five questions on HIV prevention and HIV transmission.
- Despite an increased HIV-related knowledge, globally less than 30% of young women have comprehensive and correct knowledge of HIV.
- Only 49% of young females know that using a condom helps to prevent HIV infection, compared to 74% of young males.
- One aggravating factor in the lack of basic HIV knowledge amongst women is that they account for two-thirds of the world's illiterate adults.

### **HIV response funding**

The HIV response is funded by various stakeholders, including multilateral institutions, the private sector, low and middle income country governments, but donor governments account for most of the funding for HIV in many hard hit countries, mainly through the Global Fund to Fight AIDS, Tuberculosis and Malaria and other channels such as UNAIDS. Despite the rise in resources in the last decade to address HIV in low- and middle-income countries, UNAIDS estimates a resource gap of \$6 billion annually. In 2010, the resources available globally to fund the HIV response declined, while there is growing evidence of effectiveness and impact.

## **Regional highlights**

*(Enclosed: "Regional HIV and AIDS statistics, 2010 and 2001")*

**Sub-Saharan Africa** continues to be the region most affected by HIV:

- The region is home to 67% of all PLHIV but only about 12% of the world's population.
- Almost all of the region's nations have generalized HIV epidemics (i.e. national HIV prevalence rates which are higher than 1%).
- Women comprise 59% of PLHIV in this region.
- Sub-Saharan Africa is the region with the highest number of pregnant women living with HIV.
- More than 90% of children with HIV live in this region, where the epidemic has orphaned more than 14 million children.
- Nearly 80% of young PLHIV and 74% of newly infected young people lived in this region in 2010.
- Young women are eight times more likely than men to be living with HIV. In 2010, young women accounted for 71% of the young PLHIV in Sub-Saharan Africa.

### **Middle East and North Africa**

- HIV prevalence remains low in the Middle East and North Africa (0.2%).
- Most of the women with HIV in this region are infected by their husbands/partners who engage in high-risk behaviours and are mostly not aware of their status (97% in Saudi Arabia, 76% in Iran).

### **Asia Pacific**

- Nearly 5 million people are living with HIV across South/South-East Asia and East Asia.
- Sex work is the key driver of HIV in Asia Pacific.
- 35% of PLHIV are women in Asia and an estimated 50 million women at least are at risk of acquiring HIV from their male intimate partner.

### **Latin America**

- In this region, the epidemic is mainly concentrated amongst men who have sex with men.
- 22% of men who have sex with men reported having sex with both men and women, thus increasing the risk of the spread of HIV infection through heterosexual sex.
- More than 36% of adults living with HIV in the Latin American region are women.

### **Caribbean**

- Women account for 53% of PLHIV in the Caribbean.
- Young women are about two and a half times more likely to be infected with HIV than young men.

There are an estimated 1.7 million PLHIV in Latin America and the Caribbean combined.

**Eastern Europe & Central Asia** is home to an estimated 1.5 million PLHIV.

- In this region, the main drivers of the epidemic are injecting drug use and sex work.
- In 2010, half of HIV infections were due to drug users sharing needles.
- Ukraine and the Russian Federation have the largest epidemics in the region with Russia having the highest number of PLHIV. They account, together, for 90% of the people newly infected in the region.
- HIV prevalence is twice as high amongst young women as amongst young men.

### **North America**

- The estimated rate of new HIV infections for African American women is more than 15 times as high as the rate for Caucasian women.
- 85% of African American women living with HIV acquired HIV through heterosexual sex.

### III. Trends in the last decade

#### Global trends

The number of PLHIV (34 million in 2010) - has increased by 17% since 2001 (28.6 million), the result of continuing new infections, people living longer with HIV, and general population growth.

The global prevalence rate (0.8% in 2010) - has levelled since 2001.

The number of people newly infected with HIV has declined in the last decade, contributing to the stabilization of the epidemic. In 2010, this number (2.7 million) fell down by 21% from the peak of the global epidemic in 1997. The estimated numbers of children acquiring HIV in low- and middle-income countries have decreased since 2000: 536 000 in 2000, 535 000 in 2005, and 390 000 in 2010.

The number of AIDS-related deaths has also declined in the last decade. In 2010, the number of HIV-related deaths - 1.8 million - fell down from a peak of 2.2 million in the mid-2000s, due to the more widespread availability of antiretroviral therapy, since it was introduced in 1996. As of December 2009, Highly Active Antiretroviral Therapy had saved an estimated 14.4 million life-years worldwide since 1996.

The number of PLHIV treated in resource poor countries has increased more than 20-fold since 2001. However, despite significant progress in the last decade that led to dramatic reductions in morbidity and mortality, only 47% of the 14.2 million people eligible for treatment in resource poor countries were getting it in 2010 (39% in 2009).

#### Mother-to-child transmission (MTCT)

- MTCT has declined in low- and middle income countries from 35% in 2001 to 26% in 2010.
- The number of pregnant women living with HIV has remained relatively stable since 2005.
- In 2009, in low- and middle income countries, 53% of pregnant women living with HIV received antiretroviral drugs to prevent transmission to their children, versus 10% in 2004.
- Providing antiretroviral prophylaxis to pregnant women living with HIV has enabled more than 350 000 children to avoid acquiring HIV infection since 1995.

In low- and middle-income countries, the availability and uptake of HIV testing have increased considerably in recent years. Yet, a large proportion of people infected with HIV are still unaware of their HIV status, and despite high levels of testing in some contexts (in antenatal care clinics for example), key populations at higher risk of HIV infection are often not reached. Maximizing coverage of these populations requires more innovative, appropriate and cost-effective approaches.

#### Regional trends

- Caribbean, Latin America, North America and Western Europe: New HIV infections have remained relatively stable since 2001.
- Eastern Europe and Central Asia: After decreasing in the early 2000s, HIV incidence has been accelerating again since 2008. The number of PLHIV grew up by 250% since 2001 in this region.
- East Asia has seen a 25% decrease in new infections during this period.
- Asia Pacific: the proportion of women with HIV compared to men has stabilized at about 35% since 2002.
- In the Middle East and North Africa, the annual number of people newly infected with HIV was 59 000 in 2010, versus 43 000 in 2001.

## IV. HIV Prevention

A number of prevention tools are available and should be used or combined to avoid HIV transmission.

**Condom use** is one of the least expensive, most cost-effective methods for preventing HIV transmission. Consistent, correct use of condoms significantly reduces the risk of transmission of HIV and other STIs. There are condoms available for use by both men and women. Ongoing R&D work in the area of women condoms includes product development, HIV research, clinical trial preparation, education and advocacy. In 2010, global investment in R&D related to female condoms totalled US\$3.1 million.

**Socio-behavioural interventions** include educational programs designed to encourage individuals to change their behaviour to reduce their exposure to HIV and risk for infection. Such efforts include encouraging proper and consistent condom use, a reduction in the number of sexual partners, abstinence and the delaying of sexual initiation amongst youth. On a broader scale, social/cultural interventions are used to change norms that contribute to HIV risk and vulnerability, such as gender inequality, homophobia and HIV-related stigma.

**Blood screening** aims at ensuring that people have access to safe donated blood. While screening of all blood donations should be mandatory for HIV and other Transfusion-Transmissible Infections (TTIs), in 39 countries blood donations are not routinely tested for TTIs including HIV, hepatitis B and C and syphilis, and in low-income countries 47% of blood donations are tested in laboratories without quality assurance. Blood screening is part of blood transfusion safety, which also includes access to blood that is available at reasonable cost, adequate to meet the patients' needs, transfused only when necessary, and provided as part of a sustainable blood programme within the existing health care system (WHO criteria).

**Mother-to-child transmission (MTCT)** of HIV can occur before or during delivery, or after delivery via breast milk. The risk of MTCT can be reduced significantly through the use of antiretrovirals by HIV-positive women during pregnancy and delivery, and by their infants following birth, as well as by refraining from breast-feeding. These regimens reduce the risk of MTCT by decreasing viral replication in the mother and through prophylaxis of the infant during and after exposure to the virus.

➤ In 2010, funding for operations research related to prevention of vertical transmission from mother to child at birth and during breast feeding was US\$59.7 million.

**Male Circumcision** has been shown to reduce the risk of HIV transmission by approximately 60%. In March 2007, WHO and UNAIDS recommended that male circumcision be considered an important intervention - as part of a comprehensive prevention package - to reduce the risk of heterosexually acquired HIV infection in men, based on studies conducted in Kenya, Uganda and South Africa.

➤ Investment in circumcision operations research grew significantly in 2010. Global public-sector and philanthropic investment in R&D and operations research in this field totalled US\$59 million over the last five years.

**Post-Exposure Prophylaxis (PEP)** involves the short-term use of antiretrovirals to prevent infection in people who have recently been exposed (such as health care workers through needlestick injuries, women who have been raped, or sex where the condom breaks). PEP reduces the risk of infection, but is not 100% effective.

**Pre-Exposure Prophylaxis (PrEP)** involves taking antiretrovirals before engaging in behaviour(s) that place one at risk for HIV infection (such as unprotected sex or sharing contaminated needles) in order to reduce or prevent the possibility of HIV infection.

➤ In 2010, global public-sector and philanthropic investment in Pre-Exposure Prophylaxis (PrEP) equalled US\$58.27 million. It totalled US\$205 million over the last five years.

**Treatment-as-Prevention (TasP)** refers to the use of antiretroviral therapy (ART) by PLHIV to lower their viral load and hence the potential to transmit HIV. Recent research has shown that providing HIV treatment to PLHIV significantly reduces the risk of transmission to their negative partners. The recent HPTN052 study showed that if an HIV-positive person adheres to an effective ART regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96%. Evidence has also emerged on the fact that ART reduces the incidence of TB.

➤ In 2010, R&D invested in the field of HIV prevention effect of ART was US\$19.6 million.

### **Harm reduction efforts for Injecting Drug Users (IDUs)**

In many countries, drug injecting is a major driver of HIV epidemics. Preventing HIV and other harms amongst IDUs - and providing them with effective HIV and drug dependence treatment - are essential in the HIV response. Avoiding the rapid spread of HIV amongst IDUs and transmission of the virus to other populations requires combining various harm reduction strategies such as needle and syringe programmes; opioid substitution therapy; prevention and treatment of sexually transmitted infections; condom distribution; targeted information, education and communication; vaccination and treatment of viral hepatitis1; prevention and treatment of TB, HIV testing and counselling and antiretroviral therapy.

Scientists are exploring **microbicide** development as a potential HIV prevention method. Microbicides are substances (usually delivered via gels or foams) that, when applied to the vagina, can substantially reduce transmission of one or more sexually transmitted infections (STIs). They work by either destroying the microbes or preventing them from establishing an infection. An HIV microbicide would provide a female-controlled method of prevention. There is also research exploring rectal microbicides.

➤ In 2010, total global investment in microbicides R&D was US\$247 million, a 5% increase from 2009 that returned it to a level that exceeded its highest previous level equalling US\$244 million in 2008.

There still are no **vaccines** to prevent HIV or improve the ability of the immune system to defend itself against HIV. Vaccines are currently being tested by researchers, who reported in 2009, for the first time, that an experimental HIV vaccine modestly reduced the risk of HIV infection, bolstering long-term prospects for vaccine research. Yet, it is likely that a successful vaccine is still a number of years away.

➤ In 2010, total global investment in HIV vaccine R&D was US\$859 million, a 1% decrease from 2009.

→ In 2010, global funding for HIV prevention research as a whole remained stable in 2008 and 2009. At no previous time during the pandemic has HIV prevention research found itself in a better position to capitalize the promising opportunities in this field.

## **V. HIV Treatment**

### **Treatment tools**

Despite significant advances in HIV treatment and prevention, there is still no cure, only treatment.

**ARV** stands for Antiretroviral and refers to a type of drug that works by interfering with the replication of HIV.

**ART** refers to Antiretroviral Therapy.

**HAART** (Highly Active Antiretroviral Therapy) is a modality of ART that involves the use of three or more ARVs in a single regimen. HAART helps to slow the growth of HIV in the body by interfering with the ability of the virus to replicate, which allows the body's immune system to maintain or recover its ability to produce the white blood cells necessary to respond to OIs. HAART emerged in 1996.

The main classes of antiretroviral drugs currently available are:

- Nucleoside Reverse Transcriptase Inhibitors (NRTIs), which block the replication of HIV by interfering with a protein called Reverse Transcriptase (RT), essential for the reproduction of HIV.
- Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs), which also block RT, but in a slightly different way than NRTIs.
- Protease Inhibitors (PIs), which block the function of a protein called protease, essential for HIV reproduction.
- Entry Inhibitors, also known as Fusion Inhibitors, which block HIV from entering target cells.
- Integrase Inhibitors, which prevent HIV from integrating its genetic message (RNA reverse transcribed into DNA) into the nucleus of cells.

## **Treatment figures**

In 2010, in low- and middle-income countries:

- There were 6.65 million people receiving ART, an increase of 27% from 2009.
- 10 countries had achieved universal access (coverage of at least 80% of people eligible for ART).
- In Sub-Saharan Africa, ART coverage rose by 20% between 2009 and 2010.
- Globally, despite the progress made, only 23% of the children who needed ART received it.
- A considerable proportion of people were still lost to follow-up after starting ART. The average retention rate was 81% at 12 months, 75% at 24 months and 67% at 60 months.
- Outside the Americas, 97% of adults were receiving first-line ART regimens and 3% second-line regimens. In the Americas, 28% of adults received second-line regimens and 3% third-line regimens.
- The weighted median price of antiretroviral drugs was 60% lower than in 2006, probably due to the scaling up of treatment programmes that led to higher transaction volumes and increased competition amongst manufacturers.

## **Testing and counselling**

In 2010:

- HIV testing and counselling services were provided by 131,000 health facilities versus 107,000 in 2009 (118 reporting countries).
- About 72 million HIV tests were performed, versus 64 million in 2009 (87 reporting countries).
- Only 28% of infants born to mothers with HIV received an HIV test within the first two months of life (65 reporting countries).
- 35% of pregnant women in low- and middle-income countries received HIV testing and counselling, up from 26% in 2009. This coverage increased from 35% to 42% in Sub-Saharan Africa.

A significant proportion of PLHIV continue to present late for treatment because they are unaware that they are seropositive, including in high-income countries, thus reducing the effectiveness of ART on morbidity, survival and preventing HIV infection.

Lack of knowledge of serostatus by PLHIV is a major obstacle to realizing the goal of universal access to treatment and prevention.

Besides, in many circumstances, people informed of their HIV-positive status are not adequately linked with the appropriate services, thus preventing immediate enrolment in care.

## **VI. Focus on vulnerable communities**

### **Key populations at higher risk of HIV infection**

HIV continues to disproportionately affect Injecting Drug Users (IDUs), Men who have Sex with Men (MSM) and sex workers, including transgendered people.

These communities are targeted with specific interventions. Yet, despite significant progress in improving HIV surveillance amongst them, they continue to face high levels of stigma and discrimination and laws that criminalize their behaviour, thus preventing access to health care and prevention.

In 2010, the median percentage of key populations at higher risk of HIV infection receiving HIV testing and counselling was 23% amongst IDUs, 32% amongst MSM and 49% amongst sex workers.

#### **Injecting Drug Users**

In 2010, coverage of harm reduction programmes for IDUs remained limited. Amongst 107 reporting countries, only 42 had needle and syringe programmes and 37 offered opioid substitution therapy.

In Europe and Central Asia, inequity in the access of IDUs to ART continued in 2010. This community represented only 22% of those receiving ART.

#### **Men who have Sex with Men**

In 2010, in a subset of 113 low- and middle-income countries, the availability of targeted interventions for MSM regionally was higher in Latin America and the Caribbean, in Europe and Central Asia and in East, South and South-East Asia.

#### **Sex workers**

In 2010, in a subset of 113 low- and middle-income countries, the availability of programmes and policies engaging sex workers was highest in East, South and South-East Asia and was substantially more limited in North Africa and the Middle East.

### **Gender-based inequity, discrimination and violence**

#### **Against women and girls**

In many countries, a number of gender inequality factors contribute to the risk of the spread of HIV infection by further increasing women's vulnerability to HIV and by limiting their capacity to access information and treatment. These factors include limited decision-making power; lack of control over financial resources and limited economic opportunities; restricted mobility and child-care responsibilities; denial of property and inheritance rights; and early marriage.

In addition, violence against women and girls through physical and/or sexual violence, including by an intimate partner, reduces their ability to protect themselves from HIV infection.

As a consequence of HIV infection, women living with HIV are more likely to experience violations of their sexual and reproductive rights, for example forced sterilizations.

Only 46% of all countries allocate resources for the specific needs of women and girls in their national response to HIV. In Sub-Saharan Africa, only one female condom is available for every 36 women.

**Women who have sex with women**, including lesbians, bisexual women, transgendered people - constitute a neglected and invisible minority in policy and programming around HIV, despite evidence showing that this community is at risk. Besides facing stigma, discrimination and even sexual violence, women who have sex with women lack access to HIV services and information due to neglect within the HIV policy and programming environment.

**Women who inject drugs** are particularly vulnerable to HIV transmission and the overlap of different stigma from injecting drug use and related risk behaviours make it difficult for them to access their sexual reproductive health and rights.

## Appendix: Regional HIV and AIDS statistics, 2010 and 2001

		Adults and children living with HIV	Adults and children newly infected with HIV	Adult and child deaths due to AIDS	Adult HIV prevalence (%)	Young people (15–24) HIV prevalence (%)	
						Male	Female
Sub-Saharan Africa	2010	22.9 million [21.6–24.1 million]	1.9 million [1.7–2.1 million]	1.2 million [1.1–1.4 million]	5 [4.7–5.2]	1.4 [1.1–1.8]	3.3 [2.7–4.2]
	2001	20.5 million [19.1–22.2 million]	2.2 million [2.1–2.4 million]	1.4 million [1.3–1.6 million]	5.9 [5.6–6.4]	2 [1.6–2.7]	5.2 [4.3–6.8]
Middle East and North Africa	2010	470 000 [350 000–570 000]	59 000 [40 000–73 000]	35 000 [25 000–42 000]	0.2 [0.2–0.3]	0.1 [0.1–0.2]	0.2 [0.1–0.2]
	2001	320 000 [190 000–450 000]	43 000 [31 000–57 000]	22 000 [9 700–38 000]	0.2 [0.1–0.3]	0.1 [0.1–0.2]	0.1 [0.1–0.2]
South and South-East Asia	2010	4.0 million [3.6–4.5 million]	270 000 [230 000–340 000]	250 000 [210 000–280 000]	0.3 [0.3–0.3]	0.1 [0.1–0.2]	0.1 [0.1–0.2]
	2001	3.8 million [3.4–4.2 million]	380 000 [340 000–420 000]	230 000 [200 000–280 000]	0.3 [0.3–0.4]	0.2 [0.2–0.2]	0.2 [0.2–0.2]
East Asia	2010	790 000 [580 000–1.1 million]	88 000 [48 000–160 000]	56 000 [40 000–76 000]	0.1 [0.1–0.1]	<0.1 [0.1–0.1]	<0.1 [0.1–0.1]
	2001	380 000 [280 000–530 000]	74 000 [54 000–100 000]	24 000 [16 000–45 000]	<0.1 [0.1–0.1]	<0.1 [0.1–0.1]	<0.1 [0.1–0.1]
Oceania	2010	54 000 [48 000–62 000]	3 300 [2 400–4 200]	1 600 [1 200–2 000]	0.3 [0.2–0.3]	0.1 [0.1–0.1]	0.2 [0.1–0.2]
	2001	41 000 [34 000–50 000]	4 000 [3 300–4 600]	1 800 [1 300–2 900]	0.2 [0.2–0.3]	0.1 [0.1–0.2]	0.2 [0.2–0.3]
Latin America	2010	1.5 million [1.2–1.7 million]	100 000 [73 000–140 000]	67 000 [45 000–92 000]	0.4 [0.3–0.5]	0.2 [0.1–0.4]	0.2 [0.1–0.2]
	2001	1.3 million [1.0–1.7 million]	99 000 [75 000–130 000]	83 000 [50 000–130 000]	0.4 [0.3–0.5]	0.2 [0.1–0.6]	0.1 [0.1–0.2]
Caribbean	2010	200 000 [170 000–220 000]	12 000 [9 400–17 000]	9 000 [6 900–12 000]	0.9 [0.8–1.0]	0.2 [0.2–0.5]	0.5 [0.3–0.7]
	2001	210 000 [170 000–240 000]	19 000 [16 000–22 000]	18 000 [14 000–22 000]	1 [0.9–1.2]	0.4 [0.2–0.8]	0.8 [0.6–1.1]
Eastern Europe and Central Asia	2010	1.5 million [1.3–1.7 million]	160 000 [110 000–200 000]	90 000 [74 000–110 000]	0.9 [0.8–1.1]	0.6 [0.5–0.8]	0.5 [0.4–0.7]
	2001	410 000 [340 000–490 000]	210 000 [170 000–240 000]	78 000 [60 000–11 000]	0.3 [0.2–0.3]	0.3 [0.2–0.3]	0.2 [0.1–0.2]
Western and Central Europe	2010	840 000 [770 000–930 000]	30 000 [22 000–39 000]	9 900 [8 900–11 000]	0.2 [0.2–0.2]	0.1 [0.1–0.1]	0.1 [0.1–0.1]
	2001	630 000 [580 000–690 000]	30 000 [26 000–34 000]	10 000 [9 500–11 000]	0.2 [0.2–0.2]	0.1 [0.1–0.1]	0.1 [0.1–0.1]
North America	2010	1.3 million [1.0–1.9 million]	58 000 [24 000–130 000]	20 000 [16 000–27 000]	0.6 [0.5–0.9]	0.3 [0.2–0.6]	0.2 [0.1–0.4]
	2001	980 000 [780 000–1.2 million]	49 000 [34 000–70 000]	19 000 [15 000–24 000]	0.5 [0.4–0.7]	0.3 [0.2–0.4]	0.2 [0.1–0.3]
TOTAL	2010	34.0 million [31.6–35.2 million]	2.7 million [2.4–2.9 million]	1.8 million [1.6–1.9 million]	0.8 [0.8–0.8]	0.3 [0.3–0.3]	0.6 [0.5–0.6]
	2001	28.6 million [26.7–30.9 million]	3.1 million [3.0–3.3 million]	1.9 million [1.7–2.2 million]	0.8 [0.7–0.8]	0.4 [0.4–0.4]	0.8 [0.7–0.8]

Source : UNAIDS WORLD AIDS DAY REPORT (November 2011)

## Sources

This material was prepared by the AIDS 2012 Communications Department using the following sources:

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