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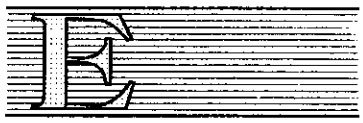

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JOINT ECA/OAU/ADB SECRETARIAT IN COLLABORATION WITH UNFPA

Fourth Meeting of the Follow-up Committee
on the implementation of the DND and the ICPD-PA

Yaounde, Cameroon
28-31 January 2002

HIV/AIDS IN SUB-SAHARAN AFRICA: AN OVERVIEW

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I. Current situation

1.1 The pandemic[1]

1. Sub-Saharan Africa is by far the worst affected region in the world (Annex: Table 1). An estimated 28.1 million Africans were living with HIV/AIDS at the end of 2001. Among them, an estimated 2.4 million children under 15 years were living with HIV/AIDS, largely due to mother-to-child transmission. Since the beginning of the epidemic and by the end of 2001, a cumulative 19 million people have already died of AIDS – over three times the number of AIDS deaths in the rest of the world. Moreover, on the continent in 2001, two million more women than men carry HIV and some 13 million children have lost their mother or both parents to the epidemic.

2. The region is experiencing diverse epidemics in terms of scale and maturity. HIV prevalence rates have risen to alarming levels in parts of southern Africa. In several southern African countries, at least one in five adults is HIV positive. Adult prevalence rates rise as high as 20% in Namibia and Zambia, 24% in Lesotho, 25% in Swaziland and Zimbabwe, and almost 36% in Botswana. In East Africa – Djibouti, Ethiopia and Kenya, for example - prevalence rates are still in double digits. In West Africa, at least five countries - Burkina Faso, Cameroon, Côte d'Ivoire, Nigeria and Togo - are experiencing serious epidemics, with adult HIV prevalence exceeding 5%.

3. All countries have, at some point in their epidemic histories, been low-prevalence countries. HIV prevalence among pregnant women attending antenatal clinics in South Africa was less than 1% in 1990 (almost a decade after the first HIV diagnosis in 1982). Yet, a decade later, the country was experiencing one of the fastest growing epidemics in the world, with prevalence among pregnant women at 24.5% by the end of 2000. Several parts of southern Africa have now reached a prevalence rate among pregnant women exceeding 30%. In Swaziland, HIV prevalence among pregnant women attending antenatal clinics in 2000 ranged from 32.2% in urban areas to 34.5% in rural areas; in Botswana, the corresponding figures were 43.9% and 35.5%.

4. Uganda remains the only African country to have turned a major epidemic around. Its extraordinary effort of national mobilization pushed the adult HIV prevalence rate down from around 14% in the early 1990s to 8% in 2000. HIV prevalence in pregnant women in urban areas has fallen for eight years in a row, from a high of 29.5% in 1992 to 11.3% in 2000.

[1] Sources: UNAIDS, December 2001, AIDS epidemic update.

1.2 Impact of the pandemic[2]

(i) HIV/AIDS and development

5. The AIDS epidemic has a profound impact on economic growth, income and poverty. It is estimated that the annual per capita growth in sub-Saharan countries with an HIV prevalence rate of more than 20%, is falling by 0.5–1.2% as a direct result of AIDS. People at all income levels are vulnerable to the economic impact of HIV, but the poor suffer most acutely as the epidemic is driving a ruthless cycle of impoverishment. AIDS pushes people deeper into poverty as households lose their breadwinners to AIDS, livelihoods are compromised, and savings are consumed by the cost of health care and funerals. In the most affected countries, estimates indicate that the number of people living in poverty has already increased by 5% as a result of the epidemic.

6. One quarter of households in Botswana, where adult HIV prevalence is over 35%, can expect to lose an income earner within the next 10 years. A rapid increase in the number of very poor and destitute families is anticipated. Per capita household income for the poorest quarter of households is expected to fall by 13%, while every income earner in this category can expect to take on four more dependents as a result of HIV/AIDS. Studies in Rwanda have shown that households with a HIV/AIDS patient spend, on average, 20 times more on health care annually than households without an AIDS patient. Only a third of those households can manage to meet these extra costs.

7. Women and girls are more vulnerable to HIV/AIDS and are disproportionately affected by the epidemic. In rural areas, as in cities, the epidemic further adds to the already formidable burdens women bear—as workers, caregivers, educators and mothers.

8. Companies of all types face higher costs in training, insurance, benefits, absenteeism and illness. A survey of 15 firms in Ethiopia has shown that, over a five-year period, 53% of all illnesses among staff were AIDS-related. There are many forecasts of health care costs increasing as much as tenfold within a few years. This slows private sector development, a fundamental element in the development strategies of many countries. Moreover, AIDS is reducing the ratio of healthy workers to dependants. Productivity growth may be cut as much as 50% in hard-hit countries. Combined with the erosion of human capital and loss of skilled and experienced workers, this will result in a mismatch between human resources and labour requirements.

(ii) HIV/AIDS and the social sectors

9. In the worst affected countries, life expectancy has fallen by up to 20 years. Four countries (Botswana, Malawi, Mozambique and Swaziland) now have a life expectancy of less than 40

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[2] Sources: UNGASS, June 2001, HIV/AIDS Fact Sheet: HIV/AIDS and Development;
UNGASS, June 2001, HIV/AIDS Fact Sheet: HIV/AIDS, food security and rural development.

years. Were it not for HIV/AIDS, average life expectancy in sub-Saharan Africa would be approximately 62 years; instead, it is about 47 years. In South Africa, it is estimated that average life expectancy is only 47 years, instead of 66, if AIDS were not a factor. Moreover, as more infants are born HIV-positive in badly affected countries, child mortality rates are also rising. In Zimbabwe, it is estimated that some 70% of deaths among children under the age of five are due to AIDS.

10. This increasing mortality and the growth of the number of orphans pose unprecedented social welfare demands for countries already burdened by huge development challenges. The epidemic destabilizes societies in profound ways. AIDS overburdens social systems and hinders health and educational development. The epidemic increases the strain on state institutions and resources, while undermining the social systems that enable people to cope with adversity. As parents and workers succumb to AIDS-related illnesses, the structures and divisions of labour in households, families, workplaces and communities are disrupted, with women bearing an especially heavy burden. From there, the effects cascade across society, reducing income levels, weakening economies and undermining the social fabric.

11. Health care systems in many countries are overstretched as they deal with a growing number of AIDS patients and the loss of health care personnel. In some countries, health-care systems are losing up to a quarter of their personnel to the epidemic. In Malawi and Zambia, for example, five-to-six-fold increases in health worker illness and death rates have reduced personnel, increasing stress levels and workload for the remaining employees.

12. Teachers and students are dying or leaving school, reducing both the quality and efficiency of educational systems. In 1999 alone, an estimated 860 000 children lost their teachers to AIDS in sub-Saharan Africa. In the Central African Republic, AIDS was the cause of 85% of the teacher deaths that occurred in 2000. Already, by the late 1990s, the toll had forced the closure of more than 100 educational establishments in that country. In Zambia, teacher deaths caused by AIDS are equivalent to about half the total number of new teachers the country manages to train annually. Faltering education services will also diminish human capital in every other sector.

13. Moreover, families often remove girls from school to care for sick relatives or assume other family responsibilities, jeopardizing the girls' education and future prospects. In Swaziland, school attendance is reported to have fallen by 36% due to AIDS, with girls most affected. The effect on girls' development is especially detrimental, leaving girls even more vulnerable to HIV infection. Reduced education for women also impedes national development.

(iii) HIV/AIDS, food security and rural development

14. AIDS is becoming a greater threat in rural areas than in cities: in absolute numbers, more people living with HIV/AIDS reside in rural areas. According to a FAO report, 7 million farm workers have died from AIDS-related causes since 1985. Namibia is reported to be the worst affected country after losing 26 % of its farm workers in the past 15 years. Zimbabwe and

Botswana are the second most affected countries with a loss of 23 % while South Africa and Mozambique have lost 20 % of their workforce.

15. While the impact of the disease on farming communities differs from village to village and country to country, the epidemic is undermining the progress made during the last 40 years of agricultural and rural development. In contrast to other diseases, AIDS kills mostly members of the productive age group (people aged 15-49 years). AIDS cuts productivity as more people become ill and as more time has to be devoted to caring for the sick and for funeral rituals. In agriculture, HIV/AIDS is reducing investments in irrigation, soil enhancement and other capital improvements, thereby inhibiting production. The shortage of labour leads to inadequate time being dedicated to farm operations such as weeding, mulching, pruning and clearing of the land. Labour-intensive farming systems with a low level of mechanization and agricultural input are particularly vulnerable to the epidemic. Households are shifting to crops that are less labour-intensive but also less nourishing. Rural families and households hit by the epidemic often are forced to sell productive assets in order to pay for health care and funerals. Replacing those assets is very difficult. The price paid can be the long-term development of rural enterprises and communities. Agricultural output—especially of staple products—cannot be sustained in such circumstances. Lower food production is already being reported in some areas. As a result, nutrition levels tend to drop and people's health is compromised further.

16. The loss of assets and productive workers severely affects household capacities to produce and purchase food. Some 20% of rural families in Burkina Faso are estimated to have reduced their agricultural work or even abandoned their farms because of AIDS. Evidence from Namibia shows widespread sale and slaughter of livestock to support the sick and provide food for mourners at funerals. This jeopardizes the livestock industry, as well as communities' long-term food security and survival options.

17. By striking people in the prime of their working and parenting lives, AIDS also hinders knowledge and expertise on indigenous farming methods from being passed on to subsequent generations. The effects are particularly harsh in sub-Saharan Africa. A study in Kenya has shown that only 7% of farming households headed by orphans have adequate knowledge of agricultural production.

18. In addition, most governments in sub-Saharan Africa depend on a small number of highly skilled personnel in the area of rural development. Badly affected countries are losing many of these valuable workers to AIDS. In Kenya's Ministry of Agriculture, an estimated 58% of all staff deaths are caused by AIDS, while some 16% of staff in Malawi's Ministry of Agriculture and Irrigation are living with the disease. Researchers have calculated that HIV/AIDS is causing the loss of up to 50% of agricultural extension staff time in sub-Saharan Africa.

19. In rural communities, women - especially the young and the elderly – are facing the extra burdens of care and work, given their traditional responsibilities for growing much of the food and caring for the sick. In some cases, traditions meant to ensure widows' access to land might contribute to the spread of HIV. An example is the custom that obliges a man to marry his brother's widow. Unfortunately, initiatives to stop these practices, while effective in slowing the

transmission of HIV, may also leave widows without access to land and food. Studies in several countries have found that some rural women whose husbands have died of AIDS have resorted to commercial sex as a means of survival, because they had no legal rights of inheritance to their husbands' property.

II. National responses for coping with AIDS crisis[3]

20. Countries across the region are expanding and upgrading their responses. Thirty-one countries in the region have now completed a national HIV/AIDS strategic plan and another 12 are developing such a plan. The political commitment to turn the tide of AIDS appears stronger than ever.

21. Some of the most heavily affected countries there is growing evidence that prevention efforts are bearing fruit. Focusing heavily on information, education and communication, and decentralized programmes that reach down to village level, Uganda's efforts have also boosted condom use across the country and decrease of the rate of infection. HIV prevalence is declining among urban residents in Zambia, especially among young women aged 15–24. Determined prevention efforts in Senegal continue to bear fruit, thanks to the prompt political support for its programmes. In South Africa, large-scale information campaigns and condom distribution programmes appear to be bearing fruit. In recent surveys, approximately 55% of sexually active teenage girls reported that they always use a condom during sex. But these developments are accompanied by a troubling rise in prevalence among South Africans aged 20–34, highlighting the need for greater prevention efforts targeted at older age groups, and tailored to their realities and concerns.

22. Progress is also being made on the treatment and care front. As of the end of 2001, more than 10 African countries were providing antiretroviral therapy to people living with HIV/AIDS, through their public health systems, albeit on a limited scale, at first. Nevertheless, access to affordable treatment and adequate health services remains one of the main challenges for people living with HIV/AIDS in poor countries and communities.

23. But despite such success, huge challenges remain. Millions of young African women remain dangerously ignorant about HIV/AIDS. According to UNICEF, more than 70% of adolescent girls (aged 15–19) in Somalia and more than 40% in Guinea Bissau and Sierra Leone, for instance, have never heard of AIDS. In countries such as Kenya and Tanzania, more than 40% of adolescent girls harbour serious misconceptions about how the virus is transmitted.

24. The vast majority of Africans living with HIV do not know they have acquired the virus. One study has found that 50% of adult Tanzanian women know where they could be tested for HIV, yet only 6% have been tested. In Zimbabwe, only 11% of adult women have been tested for the virus. Moreover, many people who agree to be tested prefer not to return and discover the outcome of those tests. However, other obstacles remain. A study in Abidjan, Côte d'Ivoire, shows that 80% of pregnant women who agree to undergo a HIV test return to collect their

[3] Sources: UNAIDS, December 2001, AIDS epidemic update.

results. But of those who discover they are living with the virus, less than 50% return to receive drug treatment for the prevention of mother-to-child transmission of the virus.

25. In addition, only 30,000 people in Africa, out of the more than 28 million infected, are receiving the antiretroviral tritherapy drugs. Prices remain too high for public-sector budgets in low-income countries where, in addition, health infrastructures are too frail to bring life-prolonging treatments to the millions who need it. Moreover, not only are voluntary counselling and testing services in short supply across the region, but stigma and discrimination continue to discourage people from discovering their HIV status.

III. International initiatives against HIV/AIDS in Africa

3.1 International Partnership against AIDS in Africa (IPAA)[4]

26. Prominent among the partnerships assembled to fight the epidemic is the International Partnership against AIDS in Africa (IPAA) established in December 1999. IPAA is a coalition that works under the leadership of African governments and harnesses the resources of the United Nations, donors, and the private and community sectors. The venture harnesses the strengths of its partners, with UN organizations providing support to country-level efforts.

27. The Partnership is based on the premise that, in isolation, none of its constituencies — either governments or civil society and the various national and international organizations working against AIDS — can turn the epidemic around. A coalition or partnership approach can magnify the contribution of all partners, while giving a clear leadership role to African governments.

28. The Partnership's mission aims, over the next decade, to contribute to global efforts to curtail the spread of HIV in Africa, sharply reduce its impact and halt the setbacks in human, social and economic development. The Partnership's scope is continent-wide, but its most important role is at country level, where it supports national plans to fight AIDS and boost existing initiatives. With the various participants sharing their experiences and success stories, the Partnership can help transform isolated actions into coherent plans of action. The venture builds on the strengths of each partner in the following ways:

- By providing national leadership, African governments are spearheading broad-based national responses;

- United Nations organizations are coordinating the global response and providing programme and financial support to country-level efforts;

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[4] Sources: UNGASS, June 2001, HIV/AIDS Fact Sheet: The International Partnership against AIDS in Africa. UNAIDS, Peter Piot intervention at the 12th International Conference on AIDS and STIs in Africa, Ouagadougou, Burkina Faso, December 2001.

- Donor governments are backing action at all levels, mainly by supporting the development of the Partnership and providing financial assistance;

- The private sector is contributing expertise and resources;

- The community sector is working to boost the roles of local civil society groupings in the Partnership and strengthen regional and country networks.

3.2 The New Partnership for Africa's Development (NEPAD) [5]

28. One of the priority sectors of the New Partnership for Africa's Development (NEPAD) is human development, with a focus on health, education and skills development. The NEPAD (NAI document approved by the OAU Summit on 11 July 2001) calls for increased investment by both African governments and development partners to build effective health interventions and secure health systems.

29. The NEPAD calls also for strengthening Africa's participation in processes aiming at making drugs affordable, including those involving the international pharmaceutical companies and the international civil society, and explore the use of alternative delivery systems for essential drugs and supplies.

IV. International Commitments to fight HIV/AIDS in Africa

4.1 ADF 2000

30. The African Development Forum 2000, on the theme *"AIDS the greatest leadership challenge" was* organised by ECA and held in Addis Ababa from 3 to 7 December 2000. ADF 2000 provided a platform for the commitment of leaders at all levels in an expected effort to fight against AIDS. More than 1,500 African leaders and policy makers, private sector and development partner representatives, people living with HIV/AIDS and other civil society representatives were brought together from the continent to commit themselves to strategies to halt the epidemic's advance and to come up with strategies on how to galvanize leadership at all levels of society in upscaling the response to HIV/AIDS.

31. The primary outcome of ADF 2000 was the adoption of the *"African Consensus and Plan of Action: Leadership to overcome HIV/AIDS"*[6]. The document spells out commitments made by governments, international organisations, Civil Society Organisations and individuals, and how to implement them. The ADF 2000 Consensus and Plan of Action calls for a strong involvement by all stakeholders in the fight against HIV/AIDS in Africa. It outlines how

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[5] Sources: The New Partnership for Africa's Development (NEPAD) October 2001. Document incorporating the MAP/NAI and the Omega Plan, http://www.dfa.gov.za/events/nepad.pdf

[6] UNECA, African Consensus and Plan of Action: Leadership to overcome HIV/AIDS, ADF 2000, Addis Ababa, Ethiopia. http://www.uneca.org/adf2000/

leadership can overcome HIV/AIDS pandemic in Africa, considering five levels of commitment: personal, community, national, regional and international.

4.2 ADF 2000 Follow-up

32. As part of ADF 2000 follow up, African countries were asked to hold a representative national workshop to determine how the ADF 2000 Consensus and Plan of Action could be turned into action at the country level. Recommendations of the national workshops included the following:

- Political leaders should be committed to allocate enough resources at the national and local levels to fight HIV/AIDS.

- Countries should enforce the respect of human rights for people living with HIV/AIDS, and strengthen support to HIV/AIDS infected and affected people.

- Inter-country and inter sub-regional networks should be established and/or reinforced.

- African countries should formulate a common position toward international donors and pharmaceutical companies for the provision of affordable essential anti-retroviral drugs and treatments for opportunistic infections.

33. Moreover, one of the ECA post ADF 2000 activities, is the mainstreaming of HIV/AIDS issues in ECA Programme of Work. ECA activities related to HIV/AIDS that have been implemented or that have been planned are the following:

- Africa's Regional Organisations, spearheaded by the ECA, are ensuring that the ADF 2000 Consensus and Plan of Action are kept high on the agendas for meetings of African leaders including Heads of State, at regional, sub-regional and supra-regional levels. ECA has played an advocacy role on HIV/AIDS in its participation in the Lusaka OAU Summit in July 2001. The same role will be played in subsequent annual OAU Summits.

- The Conference of Ministers of Finance and Planning convened by ECA every two years will also play a monitoring role vis-à-vis HIV/AIDS and resource commitment and provision. ECA has used the Conference of Ministers of Algiers, May 2001, to ensure that the fight against HIV/AIDS is kept at the forefront of the development agenda.

- As a regional organisation, ECA plans to publish an annual report on the status of HIV/AIDS in Africa in close collaboration with UNAIDS and the OAU. This report would reflect progress achieved by African countries based on commitments they made during ADF 2000, the Abuja Summit and the Lusaka Summit.

- ECA in compliance with its mandate to promote economic and social development in the region, is addressing the implications of HIV/AIDS for development policies and incorporating HIV/AIDS dimension into all its socio-economic policy analyses. ECA has

also began to mainstream HIV/AIDS concerns into the work programme of the biennium 2002-2003: In particular ECA is:

- Ensuring that future African Development Forums will include a HIV/AIDS component. The ADF III, that will be held in Addis Ababa, Ethiopia in March 2002 on the theme "*Defining Priorities for Regional Integration*", will take into consideration HIV/AIDS issues that would be more effectively addressed through regional approaches;

- Analysing the demographic impact of AIDS;

- Analysing the implications of HIV/AIDS on the state of food security;

4.3 Abuja Summit

34. The African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases met in Abuja, Nigeria from 26-27 April 2001. The Summit's objectives were to translate the commitments made by African leaders into social and domestic and external resource mobilisation for prevention, care and treatment of the diseases and sustainable programming of primary health care. African Heads of State and Government endorsed the ADF 2000 Consensus and Plan of Action and committed themselves to its implementation.

35. African Heads of State and Government at the Abuja Summit agreed[7]:

- To consider AIDS as a State of Emergency in the continent.

- To take all necessary measures to ensure that the needed resources are made available from all sources and that they are efficiently and effectively utilized. In addition, to pledge to set a target of allocating at least 15% of their annual budget to the improvement of the health sector.

- To undertake to mobilize all the human, material and financial resources required to provide care and support and quality treatment to populations infected with HIV/AIDS, Tuberculosis and Other Related Infections, and to organize meetings to evaluate the status of implementation of the objective of access to care.

- To resolve to enact and utilize appropriate legislation and international trade regulations to ensure the availability of drugs at affordable prices and technologies for treatment, care and prevention of HIV/AIDS, Tuberculosis and Other Infectious Diseases. To also resolve to take immediate action to use tax exemption and other incentives to reduce the prices of drugs and all other inputs in health care services for accelerated improvement of the health of the populations.

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[7] OAU, Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, Abuja, Nigeria, April 2001. http://www.oau-oua.org/afrsummit/index.htm

4.4 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS[8]

36. The UNGASS on HIV/AIDS, held in New York in June 2001, set in place a framework for national and international accountability in the struggle against the epidemic. Each government pledged to pursue a series of many benchmark targets relating to prevention, care, support and treatment, impact alleviation, and children orphaned and made vulnerable by HIV/AIDS, as part of a comprehensive AIDS response. These targets include the following:

- To reduce HIV infection among 15–24-year-olds by 25% in the most affected countries by 2005 and, globally, by 2010;
- By 2005, to reduce the proportion of infants infected with HIV by 20%, and by 50% by 2010;
- By 2003, to develop national strategies to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including affordability and pricing. Also, to urgently make every effort to provide the highest attainable standard of treatment for HIV/AIDS, including antiretroviral therapy in a careful and monitored manner to reduce the risk of developing resistance;
- By 2003, to develop and, by 2005, implement national strategies to provide a supportive environment for orphans and children infected and affected by HIV/AIDS;
- By 2003, to have in place strategies that begin to address the factors that make individuals particularly vulnerable to HIV infection, including under-development, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys;
- By 2003, to develop multisectoral strategies to address the impact of the HIV/AIDS epidemic at the individual, family, community and national levels.

4.5 A Global AIDS and Health Fund[9]

37. Following commitments made at the Okinawa summit of G8 countries in July 2000, work began in earnest to devise new financial mechanisms for increasing the flow of resources to developing countries. Consensus gradually emerged that a single fund—with an initial focus on HIV/AIDS, tuberculosis and malaria—would be the best starting point. The efforts to create the fund received a huge boost when UN Secretary General called for the establishment of a global fund on AIDS and health at the Organization of African Unity summit in Abuja in April 2001. The meeting achieved a high degree of consensus that the new fund would focus on HIV/AIDS,

[8] Sources: UNGASS, June 2001, HIV/AIDS Fact Sheet: The United Nations at work: the fight against AIDS.
[9] Sources: UNGASS, June 2001, HIV/AIDS Fact Sheet: A Global AIDS and Health Fund.

tuberculosis and malaria, would promote an integrated approach to the three diseases, and would be geared at strengthening and expanding existing development processes rather than designing new projects.

38. Such a fund promises to help leverage additional political engagement and financial commitment, ease the procurement of commodities and draw new partners into struggles to bring the diseases under control. The fund is intended to serve as a means for collecting, managing and disbursing new and additional resources. Exact financial targets for the fund have not been fixed. The new fund is an additional mechanism intended to complement existing flows of finance, and is not intended to supplant existing bilateral and international assistance flows. Nor is it intended to supplant developing countries' own investments to control these diseases.

38. The fund would be underpinned by a set of principles—including the need to achieve better coordination of battles against the diseases, to improve the transparency and flexibility of those efforts, and to support national-level decision-making and leadership. Equally important is the opportunity to lower transaction costs for national governments and donors, to achieve more equitable allocation of resources and to enable a clearer focus on results.

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http://www.oau-oua.org/afrsummit/index.htm

United Nations General Assembly Special Session (UNGASS) on HIV/AIDS
http://www.un.org/ga/aids/coverage/

XIIth International Conference on AIDS and STIs in Africa
http://www.cisma2001.bf/index.htm

NEPAD: http://www.dfa.gov.za/events/nepad.pdf

Annex: Table 1

HIV/AIDS STATISTICS

	Adults & children living with HIV/AIDS As of end 2001	Children (< 15 years) living with HIV/AIDS As of end 2001	Adults & children newly infected with HIV During 2001	Children newly infected with HIV During 2001	Adult prevalence rate As of end 2001	% of HIV+ adults who are women As of end 2001	Adult and child deaths from HIV/AIDS During 2001	Deaths in children (< 15 years) from HIV/AIDS During 2001
Sub-Saharan Africa	28.1 million	2.4 million	3.4 million	700 000	8.4 %	55 %	2.3 million	500 000
North Africa & Middle East	444 000	20 000	80 000	12 000	0.2 %	40 %	30 000	6 000
South and South-East Asia	6.1 million	200 000	800 000	65 000	0.6 %	35 %	400 000	40 000
East Asia & Pacific	1 million	7 000	270 000	3 000	0.1 %	20 %	35 000	1 500
Latin America	1.4 million	40 000	130 000	10 000	0.5 %	30 %	80 000	8 000
Caribbean	420 000	20 000	60 000	6 000	2.2 %	50 %	30 000	5 000
Eastern Europe & Central Asia	1 million	15 000	250 000	1 000	0.5 %	20 %	23 000	100
Western Europe	560 000	4 000	30 000	500	0.3 %	25 %	6 800	100
North America	940 000	10 000	45 000	500	0.6 %	20 %	20 000	100
Australia & New Zealand	15 000	200	500	100	0.1 %	10 %	120	100
TOTAL	40 million	2.7 million	5 million	800 000	1.2 %	48 %	3 million	580 000

Source : UNAIDS, December 2001, AIDS epidemic update.