

UNAIDS Questions & Answers provide information on UNAIDS, its work and issues related to the AIDS epidemic.

Q&A I: Facts about the AIDS epidemic and its impact

Section I: The status of the global epidemic

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Section I: The status of the global AIDS epidemic

In 2005, an estimated 38.6 million (range 33.4-46.0 million) people around the world were living with HIV. 4.1 million (range 3.4-6.2 million) people became newly infected with HIV and the epidemic claimed an estimated 2.8 million (range 2.4-3.3 million) lives in 2005.

For more information on the global AIDS epidemic please refer to chapter 2 of the 2006 Report on the Global AIDS Epidemic: <http://www.unaids.org/>

FIGURE 2.3 Regional HIV and AIDS statistics and features, 2003 and 2005				
Country	Adults (15+) and children living with HIV	Adults (15+) and children newly infected with HIV	Adult (15-49) prevalence (%)	Adult (15+) and child deaths due to AIDS
Sub-Saharan Africa				
2005	24.5 million [21.6-27.4 million]	2.7 million [2.3-3.1 million]	6.1 [5.4-6.8]	2.0 million [1.7-2.3 million]
2003	23.5 million [20.8-26.3 million]	2.6 million [2.3-3.0 million]	6.2 [5.5-7.0]	1.9 million [1.7-2.3 million]
North Africa and Middle East				
2005	440 000 [250 000-720 000]	64 000 [38 000-210 000]	0.2 [0.1-0.4]	37 000 [20 000-62 000]
2003	380 000 [220 000-620 000]	54 000 [31 000-150 000]	0.2 [0.1-0.3]	34 000 [18 000-57 000]
Asia				
2005	8.3 million [5.7-12.5 million]	930 000 [620 000-2.4 million]	0.4 [0.3-0.6]	600 000 [400 000-850 000]
2003	7.6 million [5.2-11.3 million]	860 000 [560 000-2.3 million]	0.4 [0.2-0.6]	500 000 [340 000-710 000]
Oceania				
2005	78 000 [48 000-170 000]	7200 [3500-55 000]	0.3 [0.2-0.8]	3400 [1900-5500]
2003	66 000 [41 000-140 000]	9000 [4300-69 000]	0.3 [0.2-0.7]	2300 [1300-3600]
Latin America				
2005	1.6 million [1.2-2.4 million]	140 000 [100 000-420 000]	0.5 [0.4-1.2]	59 000 [47 000-76 000]
2003	1.4 million [1.1-2.0 million]	130 000 [95 000-310 000]	0.5 [0.4-0.7]	51 000 [40 000-67 000]
Caribbean				
2005	330 000 [240 000-420 000]	37 000 [26 000-54 000]	1.6 [1.1-2.2]	27 000 [19 000-36 000]
2003	310 000 [230 000-400 000]	34 000 [24 000-47 000]	1.5 [1.1-2.0]	28 000 [19 000-38 000]
Eastern Europe and Central Asia				
2005	1.5 million [1.0-2.3 million]	220 000 [150 000-650 000]	0.8 [0.6-1.4]	53 000 [36 000-75 000]
2003	1.1 million [790 000-1.7 million]	160 000 [110 000-440 000]	0.6 [0.4-1.0]	28 000 [19 000-39 000]
North America, Western and Central Europe				
2005	2.0 million [1.4-2.9 million]	65 000 [52 000-98 000]	0.5 [0.4-0.7]	30 000 [24 000-45 000]
2003	1.8 million [1.3-2.7 million]	65 000 [52 000-98 000]	0.5 [0.3-0.6]	30 000 [24 000-45 000]
TOTAL				
2005	38.6 million [33.4-46.0 million]	4.1 million [3.4-6.2 million]	1.0 [0.9-1.2]	2.8 million [2.4-3.3 million]
2003	36.2 million [31.4-42.9 million]	3.9 million [3.3-5.8 million]	1.0 [0.8-1.2]	2.6 million [2.2-3.1 million]

Section II: Children orphaned by AIDS: estimates and projections

The joint UNICEF, UNAIDS and USAID report *Children on the Brink 2004* contains the most current and comprehensive statistics on children orphaned by AIDS and other causes. Unlike previous editions of *Children on the Brink*, which included data for children under the age of 15, this edition provides data for children under the age of 18.

To download the full report go to: http://www.unicef.org/publications/index_22212.html

II/1 How many children are orphaned by AIDS?

By the end of 2005, an estimated 15 million children had lost one or both parents to AIDS—the vast majority in Africa—and many millions more were affected. Risk factors such as missed opportunities for education, ill health, abuse and exploitation threaten their most fundamental rights and keep them enmeshed in poverty. The pandemic is deepening poverty in entire communities and societies, with children often being the first to feel the brunt of the deprivation.

For more information see the Joint UNICEF/UNAIDS publication *Children: The missing face of AIDS - A call to action* http://www.unicef.org/uniteforchildren/files/U77HIV_letter.pdf

II/2 Do patterns of orphaning vary currently?

Yes. In sub-Saharan Africa the highest percentages of children orphaned are in countries with high HIV prevalence levels or those that have recently been involved in armed conflict. With 20% of its children orphaned, Botswana has the highest rate of orphaning in sub-Saharan Africa. In 11 of the 43 countries in the region, more than 15 percent of children are orphaned. The 11 countries are: Angola, Botswana, Burundi, Central African Republic, Democratic Republic of Congo, Lesotho, Mozambique, Rwanda, Swaziland, Zambia and Zimbabwe.

II/3 Have we already seen the worst of the AIDS orphan problem?

By no means. The effect of AIDS on children and orphaning is a long-term issue. The number of children orphaned by AIDS in sub-Saharan Africa – currently 1 in 20 children – will continue to increase through 2010 (although a massive increase in the availability of antiretroviral therapy could bring the projected figures down to some extent).

II/4 What do the various orphan estimates mean?

The following terms are used for statistical purposes in estimating orphan subpopulations. The terms are not meant to define target populations of programmes to assist all orphans and vulnerable children.

- **Maternal orphans** are children under the age of 18 whose mothers and perhaps fathers, have died (includes double orphans);
- **Paternal orphans** are children under the age of 18 whose fathers and perhaps mothers, have died (includes double orphans);
- **Double orphans** are children under 18 who have lost both parents; and
- **Total orphans** are children under 18 whose mothers or fathers have died. The total number of orphans is equal to the sum of maternal orphans and paternal orphans,

minus double orphans (because they are counted in both the maternal and paternal categories).

- **New orphans** are children under age of 18 who have lost one or both parents in the last year.
- **Vulnerable children** refers to those children whose survival, well-being or development is threatened by AIDS.

II/5 Can one add the numbers of maternal AIDS orphans and paternal AIDS orphans to get a total number of children orphaned by AIDS?

No. Given the way we calculate orphans, we cannot produce estimates of the children who have lost their mother only or their father only. Instead we have estimates of children who have at least lost their mother (and perhaps their father) and children who have at least lost their father (and perhaps their mother). We have an estimate of children who have lost both parents, which includes some of the maternal or both and paternal or both orphans. You cannot simply add these three (maternal or both, paternal or both, and both) to get the total number of orphans. There is an estimate of the total number of children orphaned by AIDS, but it was not arrived at by adding these three categories.

Section III: Children orphaned by AIDS: interventions

For more information on interventions regarding children orphaned by the AIDS epidemic please refer to chapter 8 of the 2006 Report on the Global AIDS Epidemic:
<http://www.unaids.org/>

As the number of adults dying of AIDS rises over the next decade, increasing numbers of orphans will grow up without parental care and love, and be deprived of their basic rights to shelter, food, health and education. Greatly increased steps must be taken to strengthen protection, care and coping capacities within extended families and communities; build the capacity of children to meet their own needs; pay attention to the roles of girls and boys, and address gender discrimination; ensure that governments provide essential services; and reduce stigma and discrimination against these children.

III/1 What is being done for children orphaned by AIDS?

Many children are being taken care of in extended families. Many are struggling to survive on their own in child-headed households. Many fend for themselves on the streets. Intervention efforts have been largely mounted by nongovernmental organizations and faith-based groups but as the epidemic impoverishes communities and families, less and less resources are available for these children.

III/2 What should be done?

First-line efforts should involve increasing care and support to families before parents die, as this enables parents to live longer and prepare for death and succession (prepare "memory books" with their children), and decreases the care-giving burden and trauma experienced by children. For orphaned populations and children in need, efforts should be made to target all children in need in a community; increase the capacity of communities, extended families and child-headed households to be able to take care of the children (credit schemes, income

generation, etc); enable the children to continue attending school (waiving or reducing school fees, buying books, etc.), or receive skills-training; and change practices and legislation so as to protect children's rights, particularly inheritance.

Section IV: The impact of AIDS

At the economic, social, security and demographic levels the AIDS epidemic is having an impact far more devastating than ever imagined. In addition to the untold grief and human misery caused by AIDS, the epidemic is wiping out development gains, decreasing life expectancy, increasing child mortality, orphaning millions, setting back the situation of women and children, and threatening to undermine national security in highly-affected societies.

For more information on the impact of the AIDS epidemic please refer to chapter 8 of the 2006 Report on the Global AIDS Epidemic: <http://www.unaids.org/>

IV/1 What is the economic impact of AIDS?

Because AIDS kills people in the prime of their working and parenting lives, it represents a grave threat to development. By reducing growth, weakening governance, destroying human capital, discouraging investment, and eroding productivity, AIDS erodes the foundations on which countries seek to develop their societies and improve living standards. In the worst-affected countries, the epidemic has already reversed many of the development achievements of the past generation. Now, AIDS threatens to thwart the hopes of the next.

AIDS has a pronounced impact on growth, incomes, and poverty. Although different estimates exist, the World Bank calculates that AIDS may now be costing 24 African countries 0.5% to 1.2% of per capita growth each year. In some countries, conservative estimates indicate that the number of people living in poverty has already increased by 5% as a result of the epidemic.

Governments are suffering a drain on skills, reduced revenues, lower return on social investment, and reduced national security - while facing vast expenses on health and orphan care. Businesses of all types face higher costs in training, insurance, benefits, absenteeism, and illness. Reports are common of health care costs rising five- or tenfold within a few years. AIDS is reducing the ratio of healthy workers to dependents and may cut productivity growth by as much as 50% in the hard-hit countries. In households, AIDS is impoverishing entire families as income-earners grow sick and die and families sell all their assets for care and for funerals. In agriculture, food security is lost as there are fewer people to tend the fields and fewer to pass on their skills to the next generation.

In South Africa and Zambia, studies of AIDS-affected households—most of them already poor—found monthly income fell by 66%–80% due to coping with AIDS-related illness (Steinberg et al., 2002; Barnett and Whiteside, 2002). In Thailand, a 1997 study showed when a person with steady employment died of AIDS, the household's lifetime income loss was more than 20% greater than a household with non-AIDS-related deaths (Pitayanon et al., 1997).

IV/2 What is the social impact of AIDS?

AIDS overtaxes social systems and impedes the health and educational development that enables poor people (especially children) to escape poverty. Life expectancy has plummeted by 20 years in some countries and the number of orphans is expected to more than double by 2010. This will pose unprecedented social welfare demands for countries already burdened by vast development challenges. Whole families dissolve as the parents die and children and dependent elderly are dispersed to others that might care for them.

In education, teachers and students are dying or leaving school, reducing both the quality and efficiency of educational systems. Health care systems in many countries are stretched beyond their limits as they deal with a growing number of AIDS patients and the loss of health personnel. Women in general, and girls in particular, are more vulnerable to HIV and are disproportionately affected by the epidemic. They bear the greatest burden of care. Families remove girls from school to care for sick relatives or assume family responsibilities, thereby jeopardizing recent gains in female health, nutrition and education. This has an especially detrimental impact on girls' own development and leaves them more vulnerable to the epidemic. Girls who have not completed their schooling are less likely to obtain the earning power to increase their economic independence, and more likely to resort to transactional sex in order to survive. Reduced education for women also impedes national development.

IV/3 How is AIDS affecting life expectancy and the age structure of populations?

AIDS is the world's leading cause of premature death among both men and women aged 15-59.

Sub-Saharan Africa has the world's highest HIV prevalence and faces the greatest demographic impact. In the worst-affected countries of eastern and southern Africa, the probability of a 15-year-old dying before reaching age 60 has risen dramatically.

HIV's impact on adult mortality is greatest on people in their twenties and thirties, and is proportionately larger for women than men. In low- and middle-income countries, mortality rates for 15–49-year-olds living with HIV are now up to 20 times greater than death rates for people living with HIV in industrialized countries. This reflects the stark differences in access to antiretroviral therapy. In low- and middle-income countries, mortality generally varies between two and five deaths per 1000 person years (PY) for people in their teens and twenties. However, HIV-infected individuals in these age groups experience death rates of 25–120 per 1000 PY, rising to 90–200 per 1000 PY for people in their forties (Porter and Zaba, 2004).

Until recently, low- and middle-income countries had extended life expectancy significantly. However, since 1999, primarily as a result of AIDS, average life expectancy has declined in 38 countries. In seven African countries where HIV prevalence exceeds 20%, the average life expectancy of a person born between 1995 and 2000 is now 50 years— 12 years less than in the absence of AIDS. In Swaziland, Zambia and Zimbabwe, the average life expectancy of people born over the next decade is projected to drop below 40 years in the absence of antiretroviral treatment (UN Population Division, 2004).

Current projections suggest that by 2015, in the 60 countries most affected by AIDS, the total population will be 115 million less than it would be in the absence of AIDS. Africa will account for nearly three quarters of this difference in 2050, and although life expectancy for the entire continent will have risen to 65.4 years from the current 49.1 years, it will still be

almost 12 to 17 years less than life expectancy in other regions of the world (UN Population Division 2005b).

IV/4 What makes AIDS a security issue?

On 17 July 2000, the UN Security Council made history by discussing a health issue for the first time—the AIDS epidemic—and adopting Resolution 1308, which identifies the spread of AIDS as a threat to global peace and security, notably in the context of peacekeeping operations. Indeed, the links between AIDS and security are many.

Conflicts generate and entrench many of the conditions and the human rights abuses in which the AIDS epidemic flourishes. Poverty, powerlessness and social instability, all of which can facilitate HIV transmission, are exacerbated during wars and armed conflict. Physical and sexual violence, forced displacement and sudden destitution, the collapse of social structures and the breakdown of rule of law can put people at much greater risk of HIV infection.

People in such situations have less access to prevention and health services, and less control over their sexual life, either because hardship can force resort to transactional or commercial sex, or because of rape. Armies, militias, rebel troops and other uniformed services consistently rank among the population groups most infected by HIV, probably because they are young, male, away from home and families, have money to spend on commercial sex, and are risk-takers in situations of danger and high uncertainty. In conflict areas, refugees, sex workers, women, girls, children, young people, and humanitarian workers also face increased risk of infection.

At the end of 2005, there were 9 million refugees and 25 million displaced persons in the world (UNHCR). In some countries affected by conflict, HIV prevalence is already relatively high (e.g. around 5% in Congo). In others, prevalence is relatively low (e.g. Afghanistan, Colombia and countries of the Balkans). Better data collection, and more research and analysis is urgently needed to establish a stronger understanding of what countervailing factors might be at work in some settings.

At the same time, it is possible that in some cases the end of war or conflict can spur more rapid spread of HIV—as combatants and refugees move back to their homes, and as migration, trading and other forms of population mobility resume.

The humanitarian response and post-conflict reconstruction in such countries must address these heightened vulnerabilities to HIV.

AIDS is also undermining social cohesion in many countries, and is increasingly recognized as a factor that can undermine social and political stability.

Widespread AIDS epidemics may exacerbate national security issues by fuelling unrest due to lack of development, decreasing social support, and spreading distrust of government, fear and hopelessness.

IV/5 What is UNAIDS doing to address AIDS and security?

With the growing security threat of AIDS at all levels, as recognized by the UN Security Council in its adoption of Resolution 1308, the UNAIDS Secretariat established the UNAIDS Office on AIDS, Security and Humanitarian Response in July 2000.

As a follow up to the Declaration of Commitment on HIV/AIDS, adopted in June 2001 at the UN Special Session on HIV/AIDS, the UNAIDS Secretariat, through the UNAIDS Office on AIDS, Security and Humanitarian Response, developed a strategic workplan to strengthen leadership and partnerships on AIDS as a security issue. The UNAIDS Office on AIDS Security and Humanitarian Response focuses on the following main areas:

- International security, including international peacekeepers;
- National security, including national uniformed services such as armed forces and civil defence forces;
- Humanitarian response focusing on vulnerable populations affected by conflict and humanitarian workers.

To mark the fifth anniversary of the adoption of UN Security Council Resolution 1308, UNAIDS Executive Director Dr Peter Piot briefed the Security Council on 18 July 2005 in New York on the progress made in implementing the resolution on AIDS and peacekeeping.

At the same time, UNAIDS released a report entitled, *On the Front Line*, which outlines progress in this area.

The 15 Member States of the Security Council recognized that significant progress has been made in implementation of Resolution 1308 but that many challenges remain. The Council reaffirmed its commitment to the full implementation of the resolution it further encouraged Member States to employ best practices in AIDS education, prevention, awareness, countering stigma and discrimination, voluntary confidential counselling and testing, care and treatment.

Today there are over 66,000 uniformed personnel, and more than 13,000 international and national civilian serving in 17 peacekeeping and related field operations. They need to be advised and trained on how to protect themselves against HIV as well as serve as the agents of change in the response to AIDS.

Resolution 1308 paved the way for UNAIDS to engage uniformed services as key partners in the response to AIDS. UNAIDS is today assisting 57 countries with comprehensive programmes to address AIDS amongst uniformed services and has signed formal partnerships with 15 Ministries of Defence. UNAIDS is also working closely with United Nations Department for Peacekeeping Operations to support the AIDS response in all UN peacekeeping missions around the world.

Although significant inroads have been made in educating peacekeepers and national uniformed services about the risks of HIV, AIDS is still not part of military core business everywhere.

IV/6 How is AIDS related to humanitarian crises and complex emergencies?

Humanitarian crises take many forms—some involving violent conflict, others resulting from a combination of natural and man-made disasters—all threatening lives on a scale that defy people's capacities to cope.

Increasingly, it is becoming evident that the AIDS epidemic can be a potent factor in, or cause of, such crises.

The epidemic itself constitutes a major crisis and where prevalence is high, it is plunging millions of people deeper into destitution and desperation as their labour power weakens, incomes dwindle, assets shrink and households disintegrate. Weakened by AIDS, traditional coping strategies become too frail to cope with further threats such as armed conflict, crop failures or natural disasters. This interplay of the impact of HIV with other threats can then converge to create a crisis and/or to make it impossible to cope with a crisis. The current food crisis in southern Africa highlights the potentially dynamic interplay between HIV/AIDS and other crises, and the need to tackle them in unison.