

AIDS epidemic update

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AIDS epidemic update: December 2003



PREFACE

New estimates show increasing numbers of people living with HIV/AIDS

Two of the core functions of the Joint United Nations Programme on HIV/AIDS (UNAIDS) involve tracking the epidemic and developing strategic information to guide AIDS responses across the world. Accordingly, the UNAIDS Secretariat and the World Health Organization (WHO) produce an annual *AIDS epidemic update* that reflects the current knowledge and understanding of the epidemic.

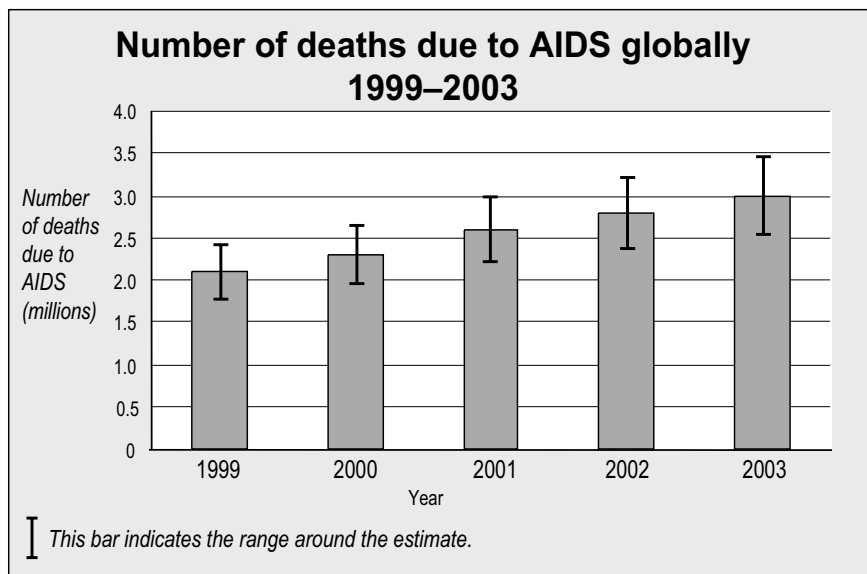
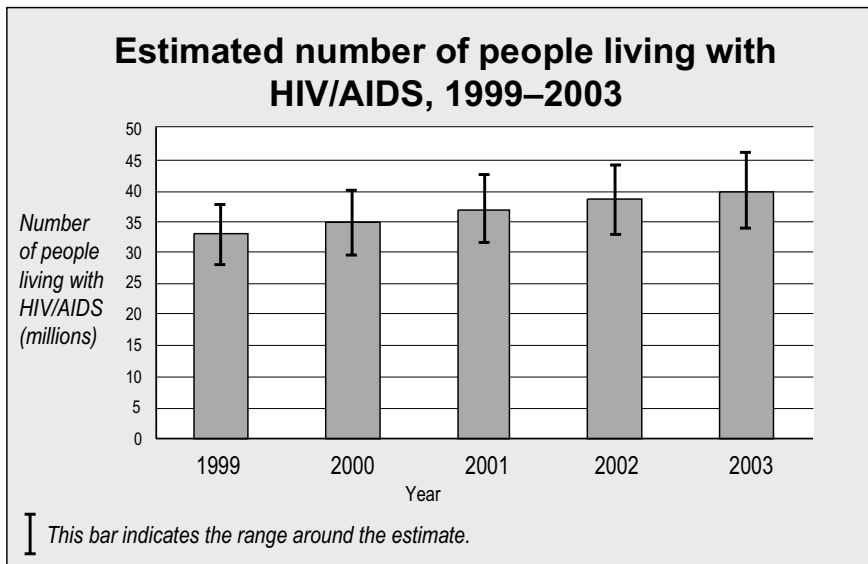
The latest UNAIDS and WHO estimates published in this *AIDS epidemic update* are lower than those published in 2002. But the number of people living with HIV/AIDS is not actually lower, nor is there a decline in the epidemic. Better data and understanding have enabled the UNAIDS Secretariat and WHO to arrive at more accurate estimates (see graphs on page 2).

This report presents both estimates and ranges around these estimates to indicate their level of precision.

During the past year, the UNAIDS Secretariat has been working with WHO, the Futures Group, the US Centers for Disease Control and Prevention, Family Health International, and the East-West Center to enhance skills for capturing, validating and interpreting HIV-related data and to build capacity for modelling and estimation in 130 countries. As well, new and different sources of data, such as national household surveys, are enabling more accurate estimates and more refined understanding of the epidemic's trends (see box on page 6). Tools and methods are constantly reviewed and improved by a group of experts in the UNAIDS Reference Group on Estimates, Modelling and Projections. Over the past three years, this group has brought together researchers and public health experts from 23 countries from all regions. In light of these continuous improvements, comparisons with previously published estimates can be misleading.

This *AIDS epidemic update* presents both estimates and ranges around these estimates to indicate their level of precision. The text refers to estimates, the maps show ranges and the tables include both. The ranges reflect the degree of uncertainty associated with estimates and define the boundaries within which the actual numbers lie, based on the best available information.

Applying the improved tools and methods to previous years shows there have been steady increases in the number of people living with HIV/AIDS, as well as in the number of AIDS deaths. The number of people living with HIV/AIDS continues to increase in several regions, most markedly in sub-Saharan Africa, with Southern Africa registering the highest prevalence. Asia and the Pacific as well as Eastern Europe and Central Asia continue to experience expanding epidemics, with the number of people living with HIV/AIDS growing year by year.



The UNAIDS Secretariat, WHO and their partners will continue to refine the tools and the processes through which data are generated and analysed. An important part of this work is to assist countries in improving HIV data collection, validation, modelling and estimates in order to guide effective responses to the global epidemic at country level.



GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC DECEMBER 2003

Number of people living with HIV/AIDS	Total	40 million (34 – 46 million)
	Adults	37 million (31 – 43 million)
	Children under 15 years	2.5 million (2.1 – 2.9 million)
People newly infected with HIV in 2003	Total	5 million (4.2 – 5.8 million)
	Adults	4.2 million (3.6 – 4.8 million)
	Children under 15 years	700 000 (590 000 – 810 000)
AIDS deaths in 2003	Total	3 million (2.5 – 3.5 million)
	Adults	2.5 million (2.1 – 2.9 million)
	Children under 15 years	500 000 (420 000 – 580 000)

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information. These ranges are more precise than those of previous years, and work is under way to increase even further the precision of the estimates that will be published mid-2004.

INTRODUCTION

The global HIV/AIDS epidemic killed more than 3 million people in 2003, and an estimated 5 million acquired the human immunodeficiency virus (HIV)—bringing to 40 million the number of people living with the virus around the world.

In sub-Saharan Africa, HIV prevalence has remained relatively steady—generally at high levels—for the past several years across much of the region. This is due to the fact that high levels of new HIV infections are persisting and are now matched by high levels of AIDS mortality. In a belt of countries across Southern Africa, HIV prevalence is maintaining alarmingly high levels in the general population. In other sub-Saharan African countries, the epidemic has gained a firm foothold and shows little sign of weakening—with the exception of some positive indications from mostly urban areas in a few countries in eastern Africa. The trend offers no comfort.

The epidemic in sub-Saharan Africa, in other words, remains rampant. How long it will stay like this will depend on the vigour, scale and effectiveness of prevention, treatment and care programmes. Urgent and dramatic headway is required on all these fronts, and in unison. Anything less will spell failure.

The global response has expanded significantly in the past two-to-three years. Spending (domestic and external) on HIV/AIDS programmes in low- and middle-income countries increased again in 2003, notably in sub-Saharan Africa. Dozens of national AIDS coordinating bodies are now in operation, and a growing number of countries (many of them in Africa) have begun extending antiretroviral and other AIDS-related medications to their citizens. But, at the moment, these developments do not match the region's epidemics in scale or pace.

Antiretroviral treatment coverage remains dismal in sub-Saharan Africa overall, despite recent

efforts in countries such as Botswana, Cameroon, Nigeria and Uganda. WHO—the convening agency for HIV care in the Joint United Nations Programme for HIV/AIDS (UNAIDS)—and partners are developing a comprehensive global strategy to bring antiretroviral treatment to 3 million people by 2005. Dramatic and sustained increases in resources and political commitment—including from hard-hit countries themselves—are needed in order to reach that goal. The policies and practices used to achieve that goal must ensure that treatment access is equitable and that it benefits the poor and marginalized sections of societies, especially women.

Alongside that huge challenge stands the urgent need to boost prevention programmes. More effective prevention and much wider treatment access should go hand in hand. Prevention efforts can slow the spread of HIV, and antiretroviral treatment blunts the impact of AIDS.

Although basic knowledge of HIV/AIDS has increased among young people in recent years, it is still disturbingly low in many countries, especially among young women. In too many places, voluntary counselling and testing services are still conspicuous in their absence, and a mere 1% of pregnant women in heavily-affected countries have access to services aimed at preventing mother-to-child HIV transmission. Coverage of these and other vital prevention services must be extended as a matter of urgency. Equally important are steps to cushion communities against the epidemic's impact. It is astounding that most countries with widespread epidemics do not yet have extensive programmes in place to provide appropriate care to orphans.

REGIONAL HIV/AIDS STATISTICS AND FEATURES, END OF 2003

Region	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult & child deaths due to AIDS
Sub-Saharan Africa	25.0 – 28.2 million	3.0 – 3.4 million	7.5 – 8.5	2.2 – 2.4 million
North Africa & Middle East	470 000 – 730 000	43 000 – 67 000	0.2 – 0.4	35 000 – 50 000
South & South-East Asia	4.6 – 8.2 million	610 000 – 1.1 million	0.4 – 0.8	330 000 – 590 000
East Asia & Pacific	700 000 – 1.3 million	150 000 – 270 000	0.1 – 0.1	32 000 – 58 000
Latin America	1.3 – 1.9 million	120 000 – 180 000	0.5 – 0.7	49 000 – 70 000
Caribbean	350 000 – 590 000	45 000 – 80 000	1.9 – 3.1	30 000 – 50 000
Eastern Europe & Central Asia	1.2 – 1.8 million	180 000 – 280 000	0.5 – 0.9	23 000 – 37 000
Western Europe	520 000 – 680 000	30 000 – 40 000	0.3 – 0.3	2 600 – 3 400
North America	790 000 – 1.2 million	36 000 – 54 000	0.5 – 0.7	12 000 – 18 000
Australia & New Zealand	12 000 – 18 000	700 – 1 000	0.1 – 0.1	<100
TOTAL	40 million (34 – 46 million)	5 million (4.2 – 5.8 million)	1.1% (0.9 – 1.3%)	3 million (2.5 – 3.5 million)

* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2003, using 2003 population numbers.

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information. These ranges are more precise than those of previous years, and work is under way to increase even further the precision of the estimates that will be published mid-2004.

Emerging epidemics

Beyond sub-Saharan Africa, more recent epidemics continue to grow—in China, Indonesia, Papua New Guinea, Viet Nam, several Central Asian Republics, the Baltic States, and North Africa. Viet Nam, for example, provides fresh evidence of how an HIV/AIDS epidemic can erupt suddenly wherever significant levels of injecting drug use occurs. It has joined a growing list of countries in Asia, Eastern Europe, the Middle East and Latin America, where injecting drug use has primed HIV/AIDS epidemics. In such settings, as in the epidemic generally, stigma and discrimination rank high among the obstacles that hinder efforts to turn the tide of AIDS (see page 31).

The same holds true for sex between men—a reality that is as ubiquitous as it is stigmatized

and denied, and one that continues to feature in many of the epidemics coursing through the Americas, Asia, North Africa and Europe. Yet, even when evidence points to the prominence of this mode of transmission in the epidemic, HIV surveillance, research, prevention, care and support activities often by-pass men who have sex with men.

At the crossroads

Globally, the AIDS response is moving into a new phase. Political commitment has grown stronger, grass-roots mobilization is becoming more dynamic, funding is increasing, treatment programmes are shifting into gear, and prevention efforts are being expanded.

Improving the accuracy of HIV estimates

National estimates of HIV prevalence in countries with generalized epidemics are based on data generated by surveillance systems that focus on pregnant women who attend a selected number of sentinel antenatal clinics. UNAIDS and WHO, in close consultation with countries, employ a six-step method to obtain estimates of HIV prevalence for men and women, and an increasing number of countries have adopted these methods to develop national estimates.

This method assumes that HIV prevalence among pregnant women is a good approximation of prevalence among the adult population (aged 15–49). Studies conducted at subnational level in a number of African countries have provided the evidence for this assumption (by directly comparing HIV prevalence among pregnant women at antenatal clinics to that detected among the adult population in the same community).

Recently, several African countries have conducted national population-based surveys that included voluntary HIV testing. The results have been compared to estimates of adult prevalence of HIV based on sentinel surveillance systems. A comparison of data from the 2001 national survey in Zambia with data from the surveillance system has confirmed the assumption that HIV prevalence among pregnant women is roughly equivalent to the prevalence among the adult population, in both urban and rural areas.

Both sources of data have advantages and disadvantages. On the one hand, national population-based surveys capture a much wider representation of the general population than do antenatal clinics (and can yield information on HIV prevalence among men and non-pregnant women). They also provide better coverage of rural populations than antenatal clinic-based surveillance. On the other hand, the fact that some respondents refuse to participate or are absent from the household adds considerable uncertainty to survey-based HIV estimates (with non-response rates ranging from 24% to 42% in the recent surveys carried out in African countries). The estimates can be adjusted if the basic characteristics of the non-responders can be discerned. But there is still an important blind spot: the survey cannot measure the possible association between a person's absence or refusal to participate and increased HIV prevalence. The upshot is that population-based surveys are likely to underestimate true HIV prevalence in most cases (to varying extents, depending on the country).

But how accurate are HIV estimates derived from antenatal clinic data? Those are based on a set of assumptions that may not apply equally well to all countries and at all stages of the epidemic. In addition, most antenatal clinic-based surveillance systems have limited geographical coverage, which can lead to wide variations in the quality of the national estimate of HIV prevalence across countries.

There is no gold standard for HIV surveillance. All HIV estimates need to be assessed critically—whether they are based on a national survey or on sentinel surveillance data. Antenatal clinic-based data are especially useful for gauging HIV trends. National surveys help fill out our picture of the epidemic. Conducted at three-to-five-year intervals, such surveys can serve as valuable components of surveillance systems and can help improve estimates of the levels and trends in HIV prevalence.

But, measured against the scale of the global epidemic, the current pace and scope of the world's response to HIV/AIDS fall far short of what is required. The struggle against AIDS has reached a crossroads: either we inch along

making piecemeal progress, or we now turn the full weight of our knowledge, resources and commitment against this epidemic. The choice is clear.

SUB-SAHARAN AFRICA

High levels of new HIV infections are persisting and are now matched by high levels of AIDS mortality.

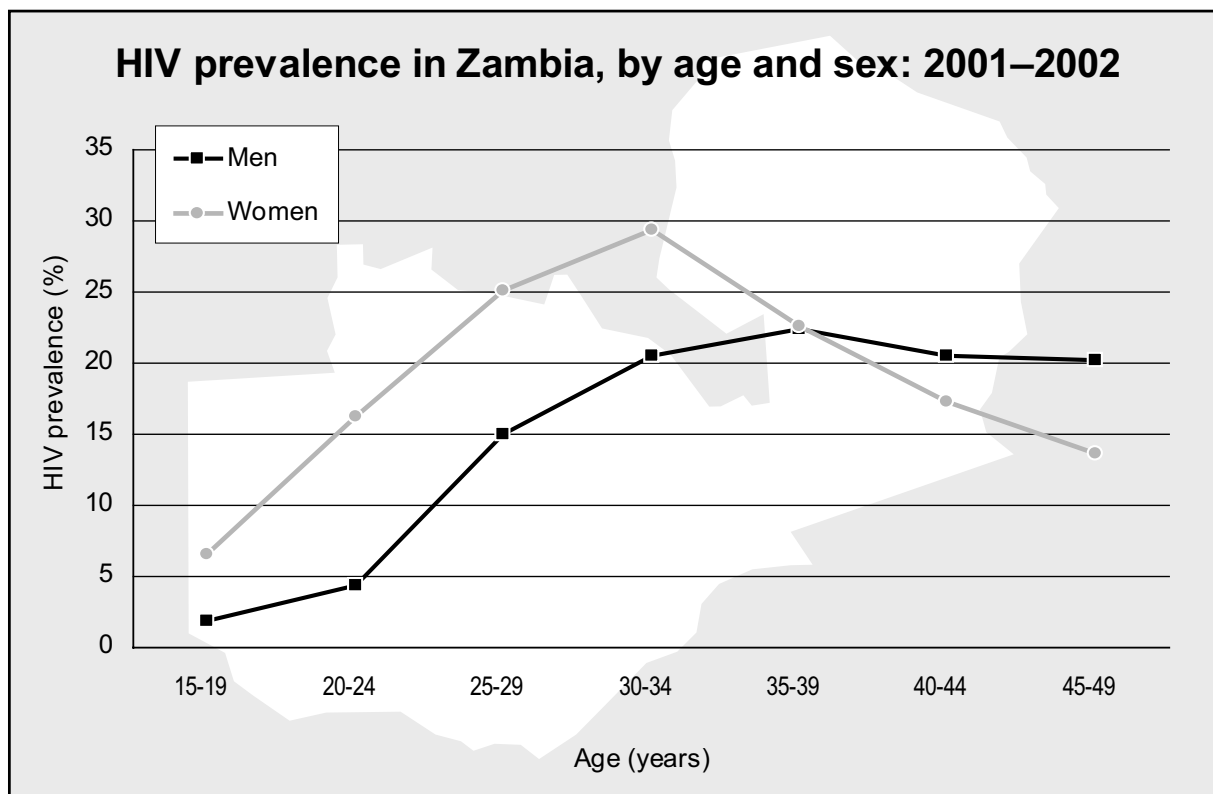
Sub-Saharan Africa remains by far the region worst-affected by the HIV/AIDS epidemic. In 2003, an estimated 26.6 million people in this region were living with HIV, including the 3.2 million who became infected during the past year. AIDS killed approximately 2.3 million people in 2003.

Unlike women in other regions in the world, African women are considerably more likely—at least 1.2 times—to be infected with HIV than men. Among young people aged 15–24, this ratio is highest (see Figure 1): women were found to be two-and-a-half times as likely to be HIV-infected as their male counterparts, according to six recent national surveys. These discrepancies

have been attributed to several factors. They include the biological fact that HIV generally is more easily transmitted from men to women (than vice versa). As well, sexual activity tends to start earlier for women, and young women tend to have sex with much older partners.

HIV prevalence varies considerably across the continent—ranging from less than 1% in Mauritania to almost 40% in Botswana and Swaziland. More than one in five pregnant women are HIV-infected in most countries in Southern Africa, while elsewhere in sub-Saharan Africa median HIV prevalence¹ in antenatal clinics exceeded 10% in a few countries. And while sustained prevention efforts in a few

Figure 1



Source: Zambia Demographic and Health Survey, 2001-2002

¹ Median prevalence represents a middle point, with equal numbers above and below that point

countries in West and East Africa (principally Senegal and Uganda) continue to demonstrate that HIV/AIDS can be checked with human intervention, signs that similar inroads might be building in **Southern Africa** remain tenuous, at best.

A trend analysis of antenatal clinic sites in eight countries (between 1997 and 2002) shows HIV prevalence among pregnant women levelling

As elsewhere on the continent, prevention (and, increasingly, treatment and care) programmes have been stepped up in this subregion. Even when effective, such efforts can take several years to manifest in declining HIV prevalence trends. At the moment, there is scant evidence of such a decline in Southern Africa. However, there has been a trend of falling HIV prevalence among young women attending antenatal care in

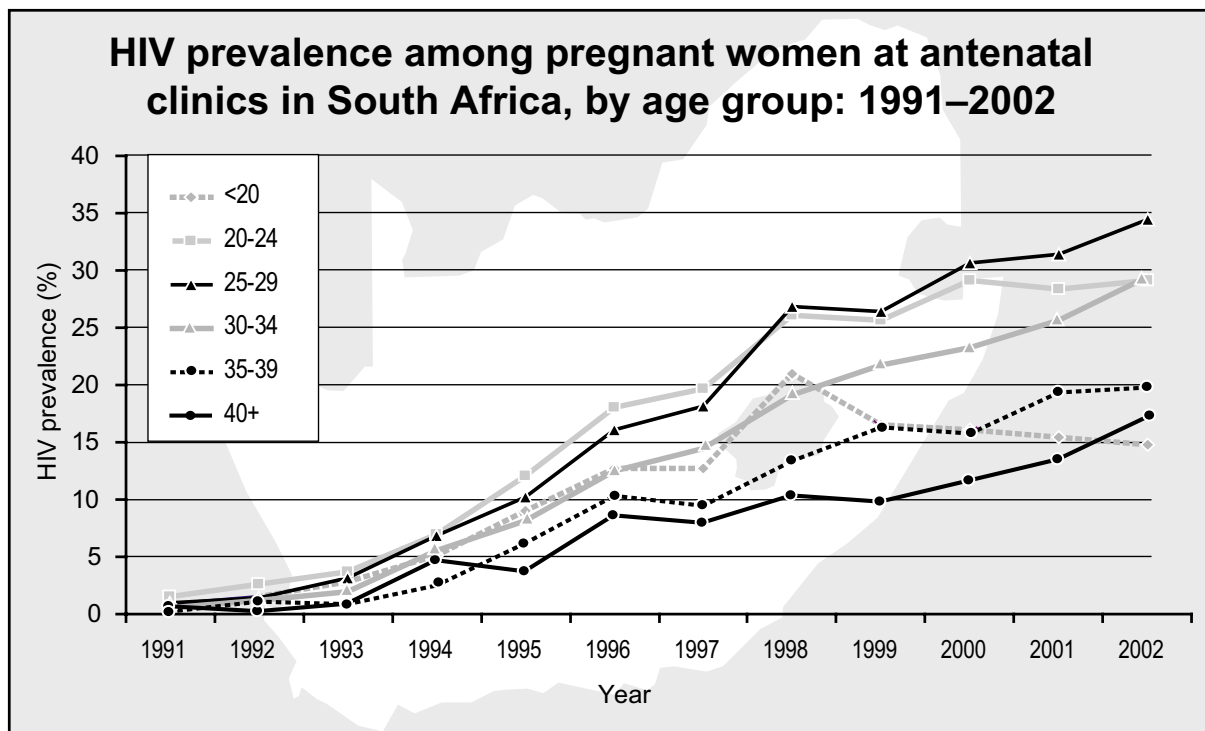
Southern Africa is home to about 30% of people living with HIV/AIDS worldwide, yet this region has less than 2% of the world's population.

off at almost 40% in Gaborone (Botswana) and Manzini (Swaziland), and at almost 16% in Blantyre (Malawi) and 20% in Lusaka (Zambia). Prevalence exceeded 30% in South Africa's mainly urban Gauteng province (which includes Johannesburg), while median HIV prevalence in Maputo (Mozambique) was 18% in 2002. (Note that HIV prevalence among pregnant women in rural areas of Southern Africa is, on the whole, significantly lower than among their urban counterparts. The subregion, though, is the most urbanized on the continent, with more than 40% of the population living in urban areas.)

Lilongwe (Malawi), where prevalence among young women (aged 15–24) was almost 23% in 1996 and dropped to 15% in 2001. Whether this is an aberration or is associated with safer sexual behaviour remains to be seen.

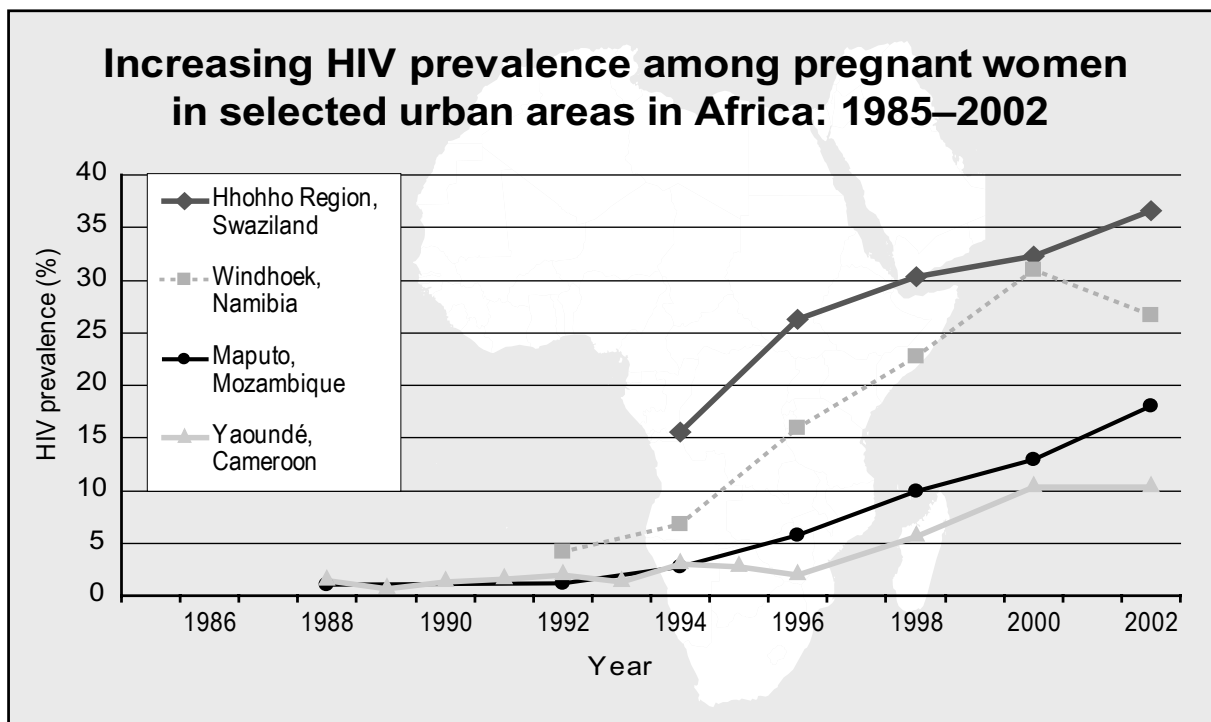
In South Africa, 2002 surveillance data show that, countrywide, the average rate of HIV prevalence in pregnant women attending antenatal clinics has remained roughly at the same high levels since 1998—ranging between 22% and 23% in 1998–1999 and then shifting even higher to around 25% in 2000–2002. A

Figure 2



Source: Department of Health, South Africa

Figure 3



Source: National AIDS Programmes (partly compiled by the US Census Bureau)

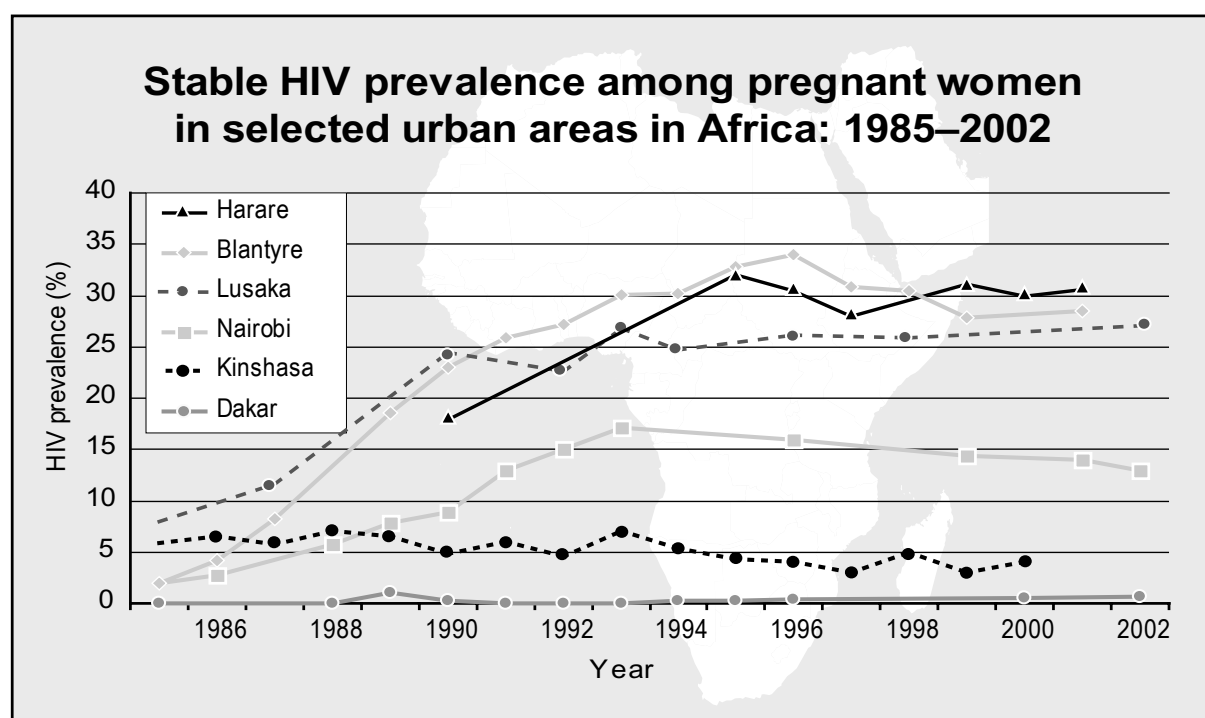
slight decline in prevalence among teenage pregnant women aged 15–19 has been offset by consistently high HIV levels among 20–24-year-old pregnant women and rising levels among those aged 25–34. In five of the country's nine provinces—including the most populous ones—at least 25% of pregnant women are now HIV-positive. The epidemic varies within South Africa, however. At almost 37%, HIV prevalence among antenatal clinic attendees in KwaZulu-Natal is about three times higher than in the Western Cape—the province with the lowest prevalence. Based on the country's latest national round of antenatal clinic-based surveillance, it is estimated that 5.3 million South Africans were living with HIV at the end of 2002. Because of South Africa's relatively recent epidemic, and given current trends, AIDS deaths will continue to increase rapidly over the next five years at least; in short, the worst still lies ahead. A speedily-realized national antiretroviral programme could significantly cushion the country against the impact.

In four neighbouring countries—Botswana, Lesotho, Namibia and Swaziland—the epidemic has assumed devastating proportions. There, HIV prevalence has reached extremely high levels without signs of levelling off. In 2002, national HIV prevalence in Swaziland matched that

found in Botswana: almost 39%. Just a decade earlier, it had stood at 4%. Neither Botswana nor Swaziland presents signs of incipient decline in HIV prevalence among young pregnant women aged 15–24. HIV prevalence in antenatal sites in Namibia rose to over 23% in 2002, while Lesotho's most recent data (collected in 2003) show median HIV prevalence among antenatal clinic attendees climbing to 30%.

Figures released in Zimbabwe this year have been interpreted to suggest that national adult HIV prevalence has dropped from the end-2001 estimate of 34% to 25% and that the country is turning its epidemic around. Unfortunately, there appears to be no basis for this view. The new figure represents a statistical correction of the 2001 estimate, which had relied on antenatal data that included a significant proportion of testing irregularities. (In addition, new data have become available for some rural areas, and the latest census has indicated that Zimbabwe has a smaller total population than previously assumed.) The corrected estimates therefore show no actual decline in HIV prevalence in the country, but do confirm the levelling off of prevalence rates at very high levels since the late 1990s. Also, an assessment of trends in the same 13 antenatal clinics with data since 1997 shows little evidence of a decline.

Figure 4



Source: National AIDS Programmes (partly compiled by the US Census Bureau)

There are signs that the epidemic has levelled off in Zambia, where national HIV prevalence has remained stable since the mid-1990s. A national population-based survey in 2001–2002 found that almost 16% of 15–49-year-olds who agreed to be tested were HIV-positive. The findings of the survey were consistent with the antenatal clinic-based surveillance data for 2001.

In Mozambique, median HIV prevalence varied from 8% among pregnant women in the north, to 15% and 17%, respectively, in the centre and south. Median HIV prevalence among antenatal clinic attendees from 36 sites was 14%, with the prevalence rate among antenatal clinic attendees highest in Mabote (Inhambane province) at 36%. The lowest rate—4%—was found among pregnant women in Mavago (Niassa province).

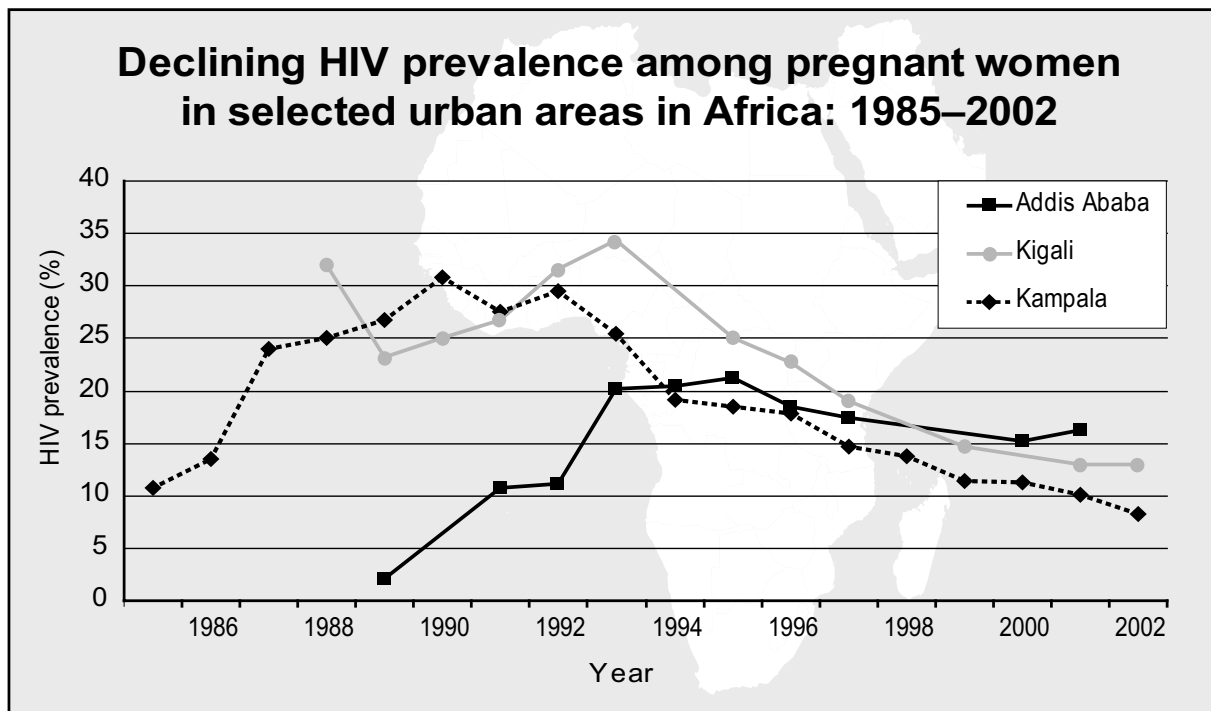
Angola gives cause for concern despite the comparatively low HIV levels detected to date. After almost four decades of war, huge population movements are under way. Millions of people have been able to leave the cities and towns they had been trapped in, internal and cross-border trading movements are resuming, and an estimated 450,000 refugees are returning (many from neighbouring countries with high HIV prevalence rates). Such conditions could prime a sudden eruption of the epidemic. In

Luanda, preliminary results of HIV prevalence testing in five antenatal clinics suggest a median HIV prevalence of around 3%, although a 2001 survey of sex workers in Luanda indicated that 33% of them were HIV-positive. While too little accurate information is available on the epidemic's advance elsewhere in Angola, there is no doubt that the country's HIV/AIDS response leaves much room for improvement. Prevention activities are few and far between, very few voluntary testing centres have been established, and levels of HIV/AIDS knowledge are very low.

A distinct picture emerges in **East Africa** and parts of **Central Africa**. HIV prevalence continues to recede in Uganda, where it fell to 8% in Kampala in 2002—a remarkable feat, considering that HIV prevalence among pregnant women in two urban antenatal clinics in the city stood at 30% a decade ago. Similar declines echo this accomplishment across Uganda, where double-digit prevalence rates have now become rare.

To date, no other country has matched this achievement—at least, not nationally. But the proportion of pregnant women found to be HIV-positive in antenatal clinic sites has fallen to 13% in the Rwandan capital, Kigali (from a high of almost 35% in 1993). However, given the

Figure 5



Source: National AIDS Programmes (partly compiled by the US Census Bureau)

massive population movements after the 1994 genocide, comparisons over time in Rwanda should be drawn with caution. In Addis Ababa, among 15–24-year-old pregnant women, HIV prevalence has dropped almost as sharply—down to about 11% in 2003 after having peaked at approximately 24% in 1995. This could mark a significant development, given that the country's epidemic is largely concentrated in its cities (with HIV prevalence at less than 2% in Ethiopia's rural pregnant women). In Ethiopia, almost 72,000 army recruits were tested for HIV during 1999–2000. In urban and rural recruits, HIV prevalence was 7.2% and 3.8% respectively. Elsewhere in this subregion, the epidemic retains a foothold. Kenya's 2002 national survey found that 10% of pregnant women were HIV-positive. In addition, trends in consistent surveillance sites have shown a modest decline in HIV prevalence among pregnant women in the past three years.

HIV prevalence in pregnant women has remained at low levels in Kinshasa (Democratic Republic of the Congo). More recent data from other urban and rural sites from the government-controlled parts of the Democratic Republic of the Congo suggest that HIV prevalence in 2003 may, in fact, be at 5% or less across large parts of the Republic, with the exception of Katanga province in the

south-east, which shares a border with Zambia and where there is a prevalence of 6%, and possibly the eastern parts of the country where surveillance activities were delayed in 2003.

In **West Africa**, diverse epidemics are under way. Still paying off is Senegal's decision early in its epidemic to invest massively in HIV-prevention-and-awareness programmes in the 1980s (when HIV infection rates were still very low). Sustained programme efforts have stabilized HIV prevalence levels among pregnant women at around 1% since 1990, with these levels holding fast through 2002, but HIV prevalence among sex workers has increased slowly over the past decade. In Dakar, prevalence among sex workers rose from 5% in 1992 to 14% in 2002, while, in the city of Kaolack, it increased from 8% in 1992 to 23% in 2002. Population-based and other surveys suggest that adult HIV prevalence levels remain relatively low in other countries of the Sahel—around 2% in Mali, and 1% or lower in Gambia, Mauritania and Niger. Like Burkina Faso, Ghana shows stable trends. In the latter case, median HIV prevalence among pregnant women attending antenatal clinics has fluctuated between 2% and just over 3% since 1994 (and barely exceeding 4% in the capital, Accra, in 2002).

The situation is graver in Côte d'Ivoire, which is still saddled with the highest HIV prevalence in West Africa. More than 1 in 10 pregnant women have HIV infections in some of the country's regions, although, in 2002, HIV prevalence among pregnant women in Abidjan dropped to its lowest level (7%) for a decade. Nigeria's most recent surveillance data (2001) suggest an anomaly, with the country's major cities having a lower HIV prevalence (below 5%, in fact) than several smaller cities classified as rural—most noticeably in the south.

Despite widespread improvements across Africa in recent years, the coverage of HIV surveillance systems in a few countries remains too sparse to provide data that capture the epidemic's actual spread and trends. In most cases, war and

conflict have been the main culprits—notably in Angola, the Democratic Republic of the Congo, Liberia and Somalia, where surveillance data remain scant.

It is now clear that across most of sub-Saharan Africa (including parts of Southern Africa), HIV prevalence among pregnant women visiting antenatal clinics has been roughly level for several years—albeit at very high levels in Southern Africa. This apparent 'levelling off' of HIV prevalence has been interpreted by some observers as an indication that the HIV/AIDS epidemic might have reached a turning point in sub-Saharan Africa. Unfortunately, available evidence does not offer grounds for such conclusions.

Improved estimates show that the number of people living with HIV in sub-Saharan Africa continues to rise

The latest UNAIDS and WHO estimates suggest that the number of people living with HIV/AIDS this year in sub-Saharan Africa is lower than the estimate published in 2002. Better data and understanding have enabled the UNAIDS Secretariat and WHO to arrive at a more accurate estimate in this region, correcting the over-estimate for 2002. However, the number of people living with HIV/AIDS in sub-Saharan Africa has continued to rise.

- Improved and expanded surveillance has shown that HIV prevalence in rural areas is lower than anticipated and that the differences between infection levels in rural and urban areas in some countries are greater than previously thought. Expanded HIV surveillance systems and national surveys have provided new data in remote rural areas in several countries, including Burundi, Ethiopia, Rwanda and Zambia, resulting in lower estimates of national prevalence in these countries. Such improvements in data collection and analysis will continue to enhance our understanding of the epidemic, a key objective of UNAIDS.
- In line with new census data, the estimated total populations of some countries have been adjusted downwards by the United Nations Population Division. In such countries, e.g. Mozambique and the Democratic Republic of the Congo, an adjustment indicating a smaller population also means that the total number of people living with HIV is smaller, even though the estimated percentage remains the same.

An example of a country where there was a major downward adjustment in the estimate of people living with HIV/AIDS is Zimbabwe. Figures released this year have put national adult HIV prevalence in Zimbabwe at 25% while it had been estimated at 34% at the end of 2001. Unfortunately, this does not correspond to a real decline of 9% in prevalence. The new figure represents a statistical correction of the 2001 estimate, which had relied on antenatal data that included a significant proportion of testing irregularities. In addition, new data have become available from a national survey. The corrected estimates, although lower, therefore show no actual decline in HIV prevalence in the country.

Applying such improved data and understanding of the epidemic to previous years shows a steady increase in recent years in the number of people living with HIV in sub-Saharan Africa, even though the prevalence is roughly stable. The number of AIDS deaths has also been growing, corresponding to increases in prevalence many years ago and poor access to life-prolonging antiretroviral medications.

Two factors are causing the apparent stabilization of prevalence rates observed in much of the region: AIDS mortality rates and HIV incidence. The combination of high (and, in some countries, rising) rates of AIDS mortality and continuing high HIV incidence has caused HIV prevalence to remain roughly level. In Zambia, for example, national HIV prevalence appears to have stayed relatively stable for the past 8–10 years. Since it is estimated that close to 80,000 people living in Zambia have been newly infected annually over that period, overall prevalence has remained steady because AIDS has killed as many people each year. HIV prevalence might therefore appear stable, but it hides the fact that the persistently high number of annual, new HIV infections is matching the equally high number of AIDS deaths.

We are not, therefore, witnessing a decline in this region's epidemic. There is no cause for complacency. In the absence of effective interventions, the epidemic will continue to wreak havoc in these countries.

The region's epidemics are varied and diverse, which means that the driving factors—along with the circumstances and interventions that might inhibit HIV spread—must be better understood. This seems particularly true for Southern Africa, where structural factors—including socioeconomic and sociocultural inequalities—appear to be bedevilling effective responses.

National reports tracking progress towards implementation of targets established in the

Declaration of Commitment on HIV/AIDS (agreed to at the United Nations General Assembly Special Session in June 2001) show that a large number of countries have no national orphan policies in place, voluntary counselling and testing coverage is threadbare, and prevention of mother-to-child transmission is virtually non-existent in many of the hardest-hit countries. Over 70% of countries reporting from Africa on efforts to reduce HIV transmission to infants and young children have virtually no programmes to administer prophylactic antiretroviral therapy to women during childbirth and to newborns. Almost half the African countries reporting have not adopted legislation to prevent discrimination against people living with HIV/AIDS, and only one in four countries report that at least 50% of patients with other sexually transmitted infections (co-factors for HIV infection) are being diagnosed, counselled and treated. Although treatment coverage remains low (with only an estimated 50,000 people having access to antiretroviral drugs in 2002), some countries, such as Botswana, Cameroon, Eritrea, Nigeria and Uganda have made serious efforts to increase access to antiretroviral drugs through both the public and private sectors.

But the past two-to-three years have also seen an upsurge of political support, stronger policy formulation, boosted funding, and moves towards cushioning societies against the impact of the epidemic—a momentum that has to be maintained if the epidemic is to be reversed.