SUB-SAHARAN AFRICA

HIV and AIDS statistics and features, end of 2002 and 2004

	Adults and children living with HIV	Number of women living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adult and child deaths due to AIDS
2004	25.4 million [23.4–28.4 million]	13.3 million [12.4–14.9 million]	3.1 million [2.7–3.8 million]	7.4 [6.9–8.3]	2.3 million [2.1–2.6 million]
2002	24.4 million [22.5–27.3 million]	12.8 million [11.9–14.3 million]	2.9 million [2.6–3.6 million]	7.5 [7.0–8.4]	2.1 million [1.9–2.3 million]

The AIDS epidemics coursing through this region are highly varied. There is no single, "African" epidemic.

Sub-Saharan Africa has just over 10% of the world's population, but is home to more than 60% of all people living with HIV—some 25.4 million [23.4 million–28.4 million]. In 2004, an estimated 3.1 million [2.7 million–3.8 million] people in the region became newly infected, while 2.3 million [2.1 million–2.6 million] died of AIDS. Among young people aged 15–24 years, an estimated 6.9% [6.3–8.3%] of women and 2.2% [2.0–2.7%] of men were living with HIV at the end of 2004.

Adult HIV prevalence has been roughly stable in recent years. But stabilization does not necessarily mean the epidemic is slowing. On the contrary, it can disguise the worst phases of an epidemic—when roughly equally large numbers of people are being newly infected with HIV and are dying of AIDS.

Not one epidemic, but many

While a bird's-eye view might discern overall stabilizing trends in HIV prevalence, the AIDS epidemics coursing through this region are highly varied—both between and within sub-regions. It is therefore inaccurate to speak of a single, "African" epidemic and misleading to apply insights about the epidemic gleaned from specific parts or subregions, to the entire sub-Saharan Africa region. Because the epidemics are heterogeneous in terms of their intensity, pace and impact, locally-appropriate prevention, treatment and care, and impact-cushioning strategies need to be developed (Asamoah-Odei, Garcia-Calleja and Boerma, 2004).

East Africa now boasts several examples of gradual, modest declines in median HIV prevalence among pregnant women in urban areas. These are still early days, though. Even **Uganda**, which has shown consistent declines in HIV prevalence levels since the mid-1990s, remains burdened with a serious epidemic. In West and Central Africa there is little evidence of changes in prevalence levels, which have stayed steady at 5% or lower (with the significant exceptions of **Cameroon** and **Côte d'Ivoire**, where median HIV-prevalence levels have reached and then remained at roughly the 10% mark among pregnant women at some sites in recent years) (Asamoah-Odei, Garcia-Calleja and Boerma, 2004). National prevalence statistics, though, can hide much higher levels of infection in particular provinces, states or districts.

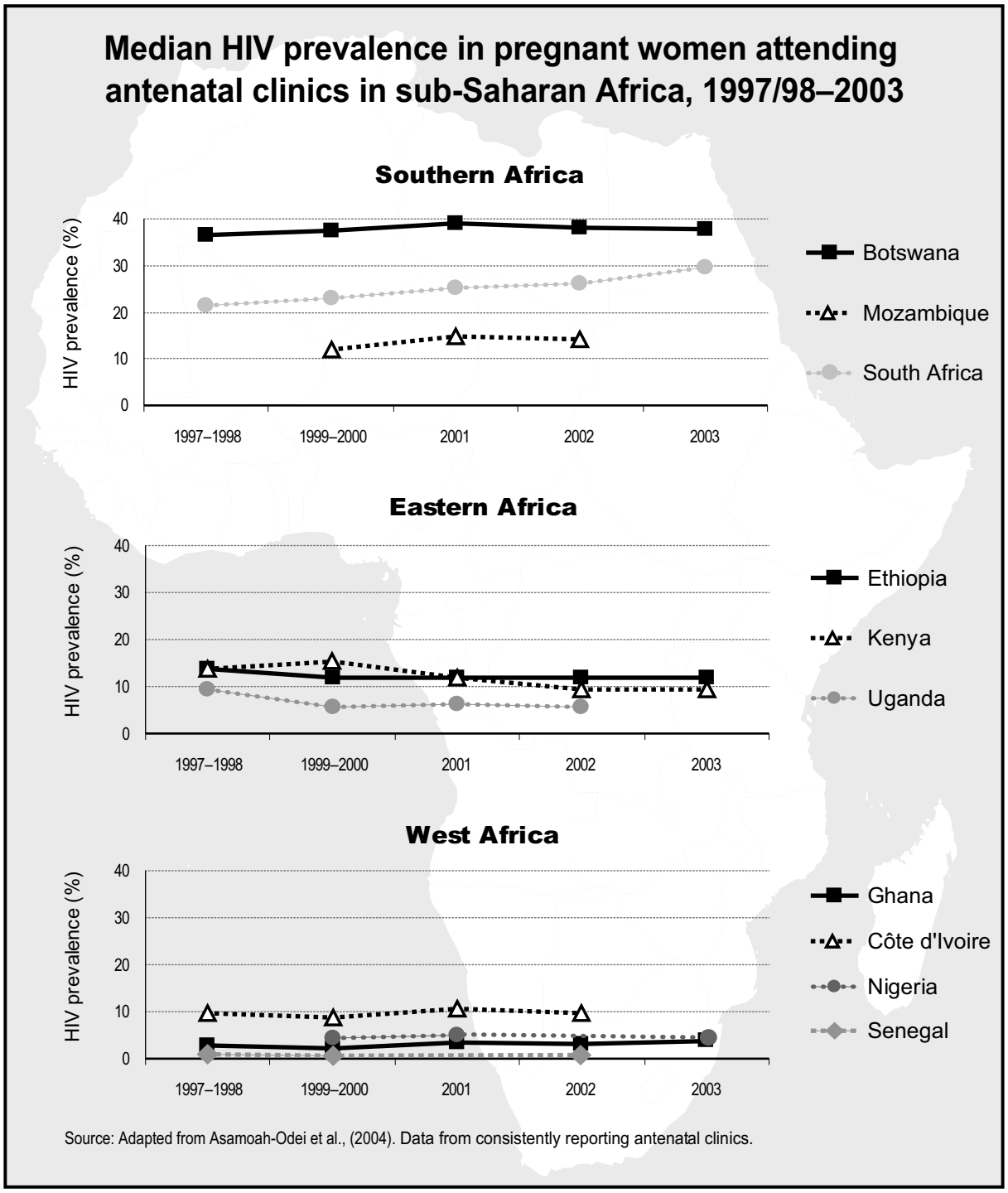


Figure 6

Unfortunately, southern Africa offers only faint hints of impending declines in HIV prevalence. With the exception of **Angola** (where the epidemic's progression may have been retarded during the country's long civil war with the result that national HIV prevalence has not exceeded 5%), each country in this subregion is experiencing national HIV prevalence of at least 10%. This means that an estimated 11.4 million (10.5 million–12.6 million) people are living with HIV in these nine countries—almost 30% of the global number of people living with HIV in an area where only 2% of the world's total population resides.

While HIV prevalence measured at antenatal clinics has edged lower in parts of some countries and in specific age groups (for example, Lilongwe, **Malawi**), there is no sign yet of an overall, national decline in any southern

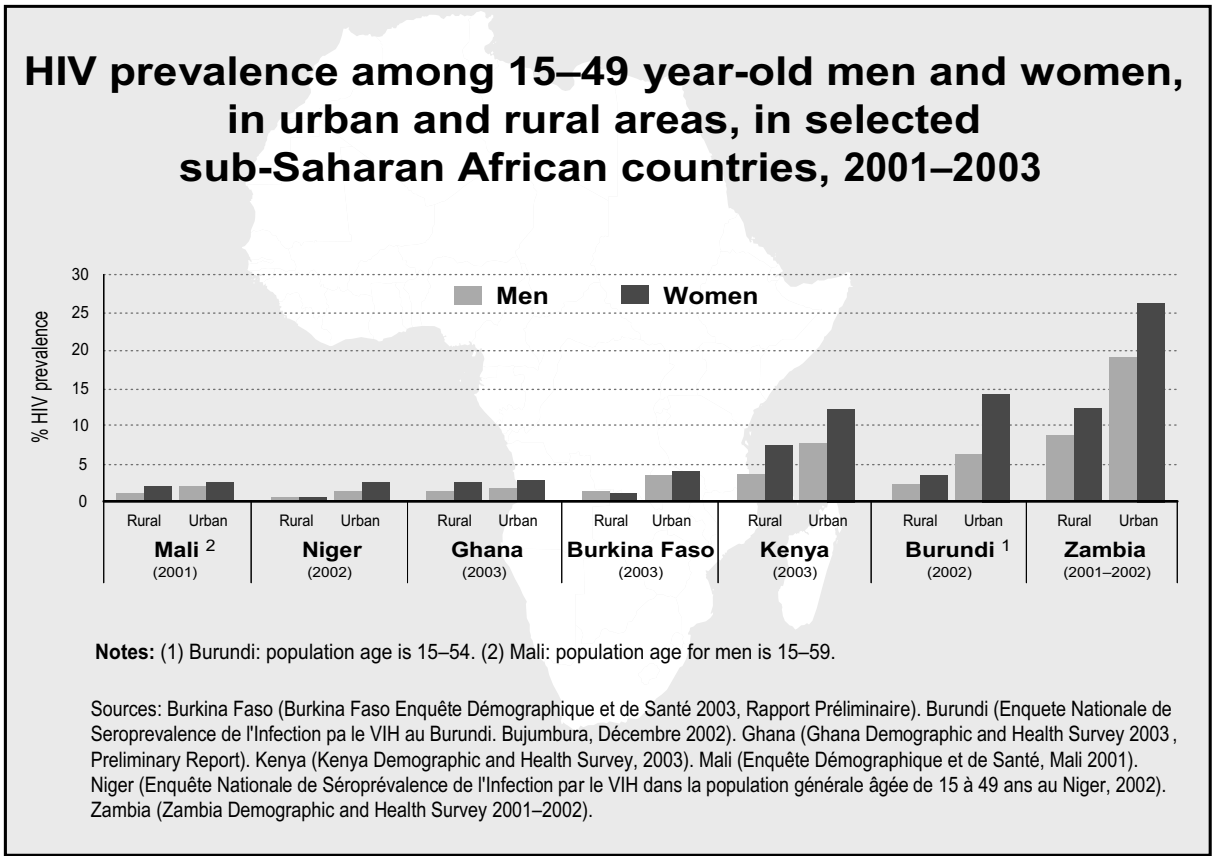


Figure 7

African country. It is vital, however, to bear in mind that prevalence levels present a delayed picture of the epidemic, since they reflect HIV incidence patterns of several years previously. HIV prevalence describes the total number of people living with HIV, irrespective of when they have been infected; incidence, on the other hand, refers to the number of people who became infected over a specific period, usually the previous year. Across the subregion, prevention and treatment efforts have grown manifold in the past five years—in both scope and scale. There is no simple and reliable method to assess HIV incidence in sub-Saharan Africa. The closest proxy would be HIV prevalence in 15–24 year-old pregnant women. In South Africa, infection levels continue to rise in that age group of women, while in the other countries in southern Africa, the indicator reveals little sign of change.

HIV infection is becoming endemic in sub-Saharan Africa. Current high prevalence levels mean that even those countries that do eventually reverse the epidemic's course will have to contend with serious AIDS epidemics for many subsequent years. The havoc wrought by AIDS will shape the lives of several generations of Africans.

"Stabilization" can disguise the worst phases of an epidemic—when roughly equally large numbers of people are being newly infected with HIV and are dying of AIDS.

But underlying this diversity are some striking consistencies. Across the region, women are disproportionately affected by HIV. On average, there are 13 women living with HIV for every 10 infected men and the gap continues to grow. In most countries, women are being infected with HIV at earlier ages than men. The differences in infection levels between women and men are most pronounced among young people (aged 15–24 years). Recent population-based studies suggest that there are on average 36 young women living with HIV for every 10 young men

in sub-Saharan Africa. In **Ghana** the ratio widens to more than nine to one. In a study among women in Harare (**Zimbabwe**), Durban and Soweto (**South Africa**), 66% reported having one lifetime partner, 79% had abstained from sex until at least their 17th birthday (roughly the average age of first sex in most countries in the world), and 79% said they used a condom.

Which are the more accurate: antenatal clinic- or national population-based data?

In countries with generalized epidemics, estimates of HIV prevalence have primarily been based on blood samples left over from syphilis tests of pregnant women in antenatal clinics (or "sentinel surveillance"). Until very recently, these have provided the best available estimates of HIV prevalence in the population.

However, national population-based or household surveys are increasingly becoming available. Such surveys have the potential to improve the accuracy of estimates of HIV because they can provide countrywide data on HIV prevalence for both sexes including samples from remote rural areas rarely covered by sentinel surveillance systems. Population survey data have been used to help refine the estimates for several countries in the UNAIDS/WHO 2003 estimates (including the Dominican Republic, Kenya, Niger, South Africa, Zambia and Zimbabwe). They have also enabled the improvement of assumptions about urban-rural and sex differences in HIV prevalence that are used to determine HIV estimates in other countries in the same region.

Both antenatal clinic and population-based survey data, though, have advantages and disadvantages.

National population-based surveys, on the one hand, capture a much wider representation of the general population than do antenatal clinics. They can yield information on HIV prevalence among men and non-pregnant women, and they can 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 (non-response rates ranged from 24% to 42% in recent surveys carried out in some African countries.) The estimates can be adjusted if the basic characteristics of the non-responders can be discerned. The problem is that the survey itself cannot measure the possible association between a person's absence or refusal to participate, and that person's HIV status. It might be that a person's refusal to participate or absence from the household is correlated with a stronger likelihood of HIV infection. (For example, mobile men, who generally have higher levels of HIV infection, are less likely to be found at home for these surveys.)

Meanwhile, antenatal clinic data form the basis for HIV estimates that rest on a set of assumptions that may not apply equally well to all countries and at all stages of the epidemic. (It is assumed, for example, that HIV prevalence among pregnant women is roughly the same as in the adult population overall, that the ratio of women with HIV to men with HIV is 1.3:1, and that adult survival time is roughly nine years. Assumptions about age distribution of HIV infections are also factored in.) In addition, most antenatal clinic-based surveillance systems have limited geographical coverage, which can lead to significant variations in the quality of the national estimate of HIV prevalence across countries.

With the exception of South Africa, such surveillance systems often select clinics located in urban or peri-urban areas, both for ease of access and because those clinics serve a larger number of pregnant women and can yield sufficient sample sizes during data collection. Often this leads to few data being available from pregnant women in rural areas. This bias can be corrected, but it introduces a further layer of uncertainty (the extent of the differences between HIV prevalence levels in urban and in rural areas).

Nevertheless, antenatal clinic-based data are especially useful for gauging HIV trends over the years. National household 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.

All in all, 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. Using all available data to arrive at HIV estimates ensures the best possible quality.

Yet, 40% of the young women were HIV-positive (Meehan et al., 2004). Many are being infected despite staying loyal to one partner.

Sexual abuse and violence—much, but not all of it directed against females—are serious problems that transcend economic, social, ethnic and geographical lines. Adolescents, children and young women and girls in particular experience increased abuse in the form of domestic violence, rape and sexual assault, and sexual exploitation or undergo female genital mutilation. In some **Ugandan** surveys, 46% of women said they have endured regular physical abuse, while in **Kenyan** and **Zambian** studies more than 40% of women have reported abuse. For some young women, their first sexual encounter occurs under coercion or force, which can be associated with an increase in HIV transmission.

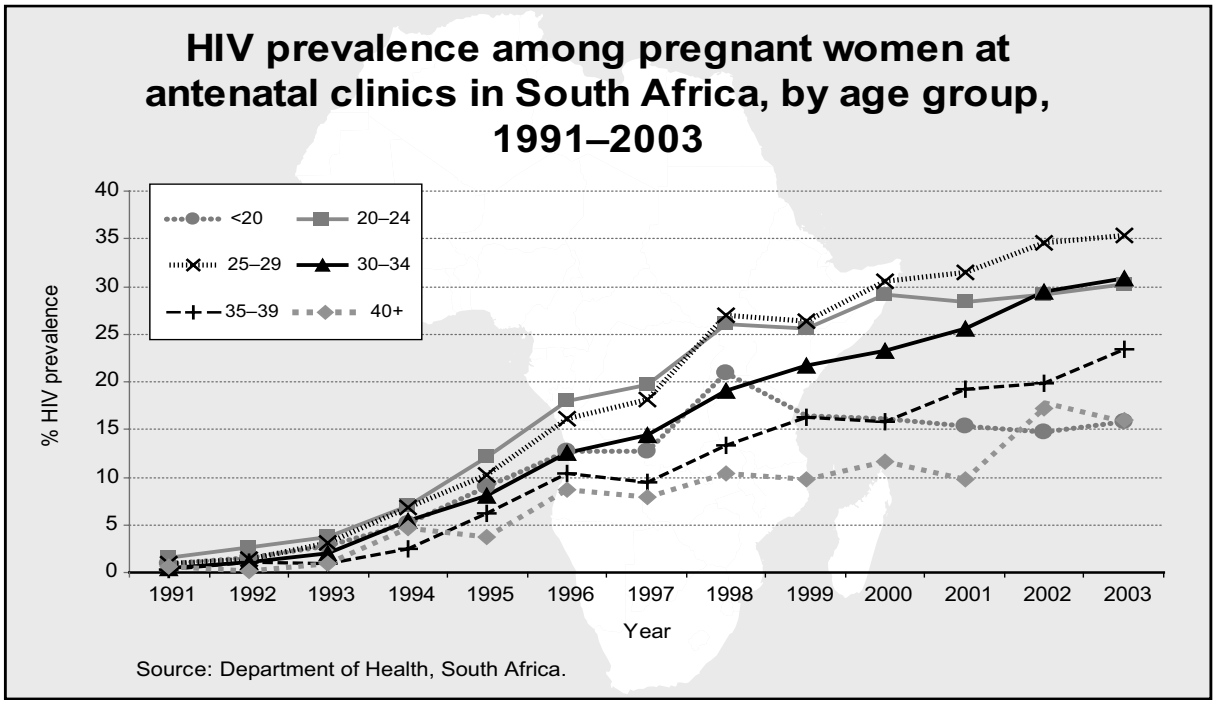
Southern Africa

Southern Africa remains the worst affected subregion in the world, with data from selected antenatal clinics in urban areas showing HIV prevalence surpassing 25%, having risen sharply from around 5% in 1990.

South Africa continues to have the highest number of people living with HIV in the world. An estimated 5.3 million [4.5 million–6.2 million] people were living with HIV end-2003 in South Africa—2.9 million [2.5 million–3.3 million] of them women. Unfortunately, there is no sign yet of a decline in the epidemic. Overall HIV prevalence among pregnant women was 27.9% in 2003, compared with 26.5% in 2002 and 25% the year before that. Latest data suggest prevalence levels are still increasing in all age groups, except for pregnant women older than 40 years of age, as Figure 8 shows. One recent population-based survey has indicated possible shifts towards safer sex among young South Africans (Reproductive Health Research Unit, Medical Research Council, 2004). However, prevalence levels among pregnant women aged 15–24 years have continued to rise—from 23.1% in 2001 to 24.3% in 2003. The survey reveals significant regional variation, with prevalence among pregnant women exceeding 30% in three provinces (Free State, Mpumalanga and KwaZulu-Natal, reaching 37.5% in the latter) while ranging between 13% and 17.5% in Western Cape, Northern Cape and Limpopo. Since 2001, HIV prevalence has risen in all but two provinces (Free State and Gauteng) (Ministry of Health South Africa, 2004).

Very high HIV prevalence—often exceeding 30% among pregnant women—is still being recorded in four other countries in the region, all with small populations: **Botswana, Lesotho,**

Figure 8



Namibia and **Swaziland.** There, comparisons of prevalence levels at selected antenatal clinics have shown no evidence of a decline. In Swaziland, for example, HIV prevalence among pregnant women was 39% in 2002, up from 34% in 2000 and only 4% in 1992. Elsewhere in the subregion, HIV infections in pregnant women appear to be stabilizing at lower levels—around 18% in **Malawi** (2003), 16% in **Zambia** (2003), and 25% in **Zimbabwe** (2003)—but there is little evidence of an impending decline. In Zimbabwe's case, it is estimated that new HIV infections have stayed roughly steady since 1996-1997. As in the other countries in the region, women are disproportionately bearing the brunt. An earlier population-based survey in Zimbabwe found that twice as many of the surveyed women aged 15–24 years as men in this age group were living with HIV (prevalence was 22% and 10%, respectively). Overall, almost 57% of people with HIV in 2003 were women and an equal proportion of AIDS deaths were among women (Ministry for Health and Child Welfare Zimbabwe, 2004). It is worth noting, though, that the epidemic's severity can vary considerably within countries—even in a small country such as Malawi, for example, where a recent review of HIV data found district-level prevalence among adult women ranged from 4% to 18%, with the highest prevalence found in the south (Montana et al., 2004).

Angola is an exception in the region. During nearly two generations of war, civilians' movements were restricted, transport links severed, and parts of the country were intermittently cut off from the outside world. Available data suggest that those conditions probably slowed the spread of HIV. Median HIV prevalence of approximately 3% has been measured at antenatal clinics in the capital, Luanda (HIV-surveillance systems elsewhere are still being assembled). However, high levels of HIV—roughly 33%—have been detected among sex workers in the capital, a clear sign that the virus could take hold in networks where the risk of HIV transmission is particularly high. After two years of relative peace and with normal life resuming for

Across the region, women are disproportionately affected by HIV. On average, there are 13 women living with HIV for every 10 infected men.

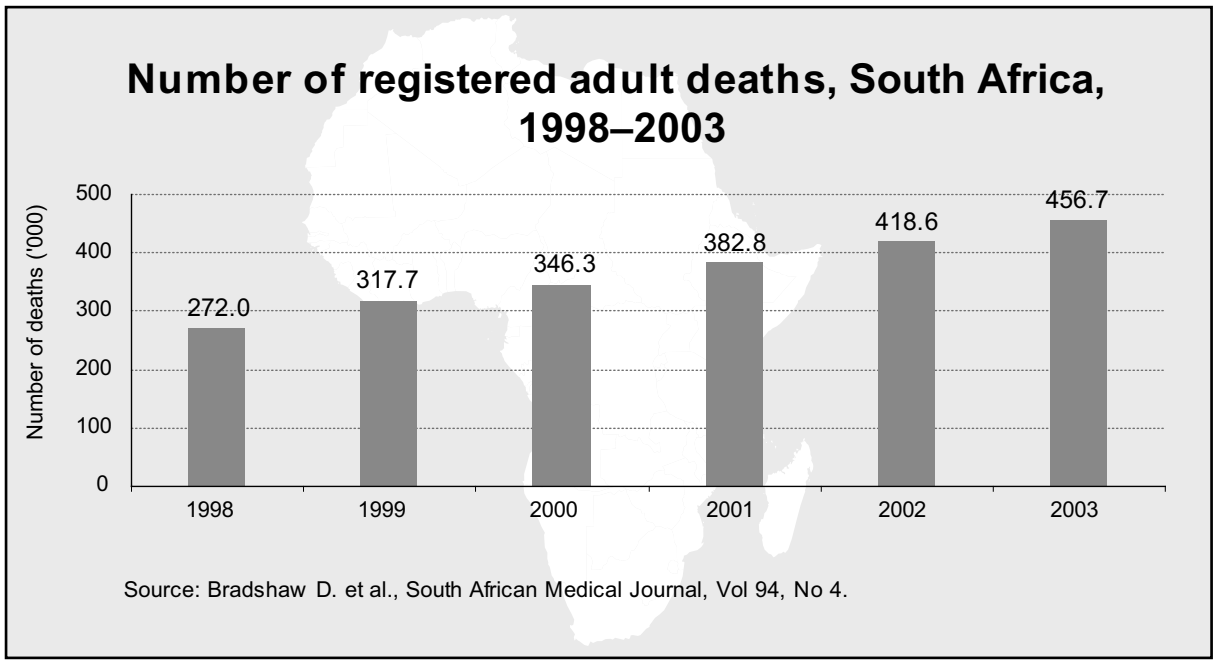
Youth, sex and HIV in South Africa

Effective prevention among young people is essential. Throughout southern Africa, HIV prevalence sharply increases once people reach their twenties. The trend is vividly captured in a new, comprehensive study on HIV and sexual behaviour among young South Africans (conducted by the Reproductive Health Research Unit and Medical Research Council).

The study shows HIV prevalence to be comparatively low among 15–19 year-olds, at 4.8%. This is not that surprising, given that the mean age of first sex reported by respondents was 16.4 years for young men and 17 years for young women. It's in the next age group—among 20–24 year-olds—that HIV prevalence soars, reaching 16.5%. In this age group, HIV infections are massively concentrated among women. About one-in-four (24.5%) women surveyed was HIV-positive, compared to one-in-thirteen (7.6%) men. Indeed, more than three quarters (77%) of young South Africans living with HIV are female, a discrepancy that only begins to fade among South Africans 30 years and older. Similar to young people around the world, many young South Africans (62%) who learn they are HIV-positive believed they had faced little or no risk of contracting the virus.

Young women were found to be disproportionately at risk of HIV infection. Sexual aggression is common, with more than one quarter (28%) of the women saying their first sexual experience was unwanted, and one in ten (10%) saying they had been forced to have sex. Almost half (49%) the young women who'd had sex said they had been pregnant at some point—suggesting that condom use was not the norm. Indeed, fully one third of those youth who had had sex in the previous 12 months never used a condom, and two thirds had not used one with their most recent sexual partner (Reproductive Health Research Unit, Medical Research Council, 2004).

Figure 9



millions of Angolans, there is every reason to fear much more widespread and rapid HIV transmission in this country.

Newly published study findings show southern Africa to be firmly in the grip of the AIDS epidemic, as more people succumb to HIV-related illnesses and die. Life expectancy at birth has dropped below 40 years in nine African countries—**Botswana, Central African Republic, Lesotho, Malawi, Mozambique, Rwanda, Swaziland, Zambia** and **Zimbabwe**. All are severely affected by AIDS (UNDP, 2004). By 2000, adult mortality among women in northern **Namibia** was 3.5 times and among men 2.5 times the 1993 level. For men, the probability of dying between the ages of 15 and 60 years increased from 220 per 1000 to 550 per 1000, while for women it rose from 95 per 1000 to 335 per 1000. With the increases concentrated among young adults (there were no mortality increases among adolescents and older men and women), AIDS is the major factor causing this trend (Notkola, Timaeus and Siiskonen, 2004). In Zimbabwe, meanwhile, life expectancy at birth was 34 years in 2003, compared with 52 years in 1990 (Chitate and Muvandi, 2004). Analysis of **South Africa's** death registration data shows a rise in the total number of adult deaths in the past six years (see Figure 9)—an increase of more than 40% and, in the case of women aged 20–49 years, an increase of more than 150% once population growth and possible improvement in death registrations are taken into account (Bradshaw, 2004).

Detailed demographic surveillance is providing further evidence of steep rises in mortality. One such survey, conducted in a rural area of KwaZulu-Natal province, which has high HIV prevalence among pregnant women, has confirmed a sudden and massive rise in adult mortality starting in the late 1990s, with AIDS (with or without TB) constituting the leading cause of adult death (48%) by 2000. The risk of dying from AIDS for women peaks among women aged 25–39 years and among men aged 30–44 years. These AIDS mortality rates will almost certainly worsen in the coming years, since HIV-prevalence levels in this particular district rose steeply in the late 1990s. AIDS mortality reflects HIV incidence roughly a decade or so earlier (Hosegood, Vanneste and Timaeus, 2004).

East Africa

Some countries in East Africa do display signs of real declines in HIV infection levels. **Uganda**, where national prevalence fell from 13% in the early 1990s to 4.1% (2.8–6.6%) by end-2003, is the most notable, but by no means the only example. Comparisons of HIV prevalence among antenatal clinic attendees across the subregion show an overall significant decline from a median of 12.9% (7.0–16.9%) in 1997-1998 to 8.5% (5.3–14.0%) in 2002 (Asamoah-Odei, Garcia-Calleja and Boerma, 2004). There

Inside the factory gates

Antenatal clinic-based surveillance captures relatively few demographic details. Population-based surveys, though, can help fill out the picture of the epidemic. Findings from 34 such surveys among mining and manufacturing workers in southern Africa were recently published and offer a suggestive picture of HIV spread among wage-income workers. Conducted in 2000-2001, the surveys found HIV prevalence of 24.6% (23.6–25.7%), 14.5% (14.1–14.9%) and 17.9% (17.1–18.7%) among 44 000 workers in **Botswana, South Africa** and **Zambia**, respectively. Workers in the mining sector had the highest levels of infection. Within workforces, infection levels varied significantly—with contract (23%, 21.9–24.1%), unskilled (18.3%, [17.5–19.1%]) and semi-skilled workers (18.7%, [18.1–19.4%]) much more likely to be HIV-positive than skilled workers (10.5%, [9.5-11.4%]) and managers (4.5%, [3.4-5.6%]). Research has suggested that less skilled workers (including contract workers) in the mining sector are more likely to be migrants (living away from home for extensive periods) and more likely to frequent sex workers. Zambia's mining sector, though, was an exception. There, skilled workers had very high infection prevalence of 26.4% (11.4–41.3%). Also striking was the high HIV level among workers older than 49 years: just over 10% in South Africa and Zambia, and 18% in Botswana (Evian et al., 2004).

Other recently published research ascribes the increase in TB infections among both HIV-positive and HIV-negative gold miners in South Africa to the HIV epidemic. Conducted at four mines during the 1990s, the study found TB incidence rose from 0.5% in 1991 to 1% in 1997 and 2% in 2000. Incidence among HIV-negative miners more than doubled between 1991-1992 and 1995–1997 (from 0.5% to 1.3%), an increase that was likely caused by the onward transmission of TB from the larger numbers of HIV-positive miners with TB (Sonnenberg et al., 2004).

are exceptions, such as Madagascar, where an apparent rise in HIV prevalence among pregnant women has been detected—reaching 1.1% in 2003 compared with 0.3% just two years earlier (Ministère de la santé Madagascar, 2003). However, it is too early to know whether this heralds a trend, since other HIV indicators (such as prevalence among sex workers) have remained low.

2004). **Ethiopia**'s epidemic is most severe in urban areas, including in the capital Addis Ababa. However, there are encouraging signs that the declining HIV trend among pregnant women in the capital (first detected in 1997) is continuing. By 2003, HIV prevalence in the city had fallen to 11%, less than half the level (24%) it had reached in the mid-1990s. Overall, in 10 antenatal clinics in Ethiopia, median prevalence dropped from

East Africa boasts several examples of gradual, modest declines in HIV prevalence among pregnant women in urban areas. Unfortunately, there is no sign yet of an overall, national decline in any southern African country.

The downward trend is most firmly established in **Uganda**, which saw HIV prevalence decline steeply during the mid- and late-1990s, remaining subsequently at 5% to 6%. Recent data suggest **Kenya** could be on a similar path. There, data from antenatal clinics show median HIV prevalence falling from 13.6% (12.2–27.1%) in 1997-1998 to 9.4% (6.6–14.3%) in 2002 and then staying largely unchanged in 2003. Figures for **Burundi** also suggest a decline in HIV prevalence, but this is based on limited data from only six clinics (Asamoah-Odei, Garcia-Calleja and Boerma, 13.7% in 1997-1998 to 11.8% in 1999-2000, and has remained at about 12% since then (Asamoah-Odei, Garcia-Calleja and Boerma, 2004).

These are heartening developments but still-high HIV-prevalence levels underscore the need to redouble and extend prevention efforts throughout these countries. It is much too early to claim that these recent declines herald a definitive reversal in these countries' epidemics and, furthermore, the need for treatment, care and support will continue to increase for years to come.

Meanwhile, a clearer picture is emerging of the epidemic in **Eritrea**, where the most detailed round of HIV sentinel surveillance to date has fixed prevalence at 2.4% in 2003. Overall HIV prevalence in the country appears to be stabilizing. However, infection levels vary considerably—highlighting a need to intensify and to refine the focus of prevention efforts. Prevalence reached 7.2% along the country's southern coastal strip, and was more than three times as high in urban than in rural areas. Prevalence was highest overall among young unmarried women in urban areas (7.5%), most of whom had partners in the military. Women working in bars, hotels and teashops or as housemaids appeared to be particularly susceptible to infection (Ministry of Health Eritrea, 2004).

Overall, there is no evidence of nationwide HIV prevalence decline in **Tanzania**. However, in Mbeya region, which has been the focus of intense prevention efforts over the past 13 years, HIV prevalence among 15–24 year-old women fell from 20.5% in 1994-1995 to 14.6% in 2000, while condom use rose and treatment for other sexually transmitted infections increased, and a significant delay in age at first sex was noted over the same period. In contrast, in the urban parts of neighbouring Rukwa region, where only sporadic prevention efforts were mounted, prevalence in this age group rose from 22.5% in 1994 to 30.2% in 1999 (Jordan-Harder et al., 2004). This suggests that the specific interventions mounted in Mbeya probably helped drive down HIV prevalence there. Other research in Tanzania has encountered a marked lack of behaviour change in areas where low-intensity HIV-prevention programmes have been introduced. A district HIV-prevention programme launched in the mid-1990s in Mwanza, for example, appears to have made little headway against the epidemic. A recently published study found that HIV prevalence increased gradually from 5.9% in 1994-1995, to 6.6% in 1996-1997 and 8.1% in 1999-2000. There was a small increase in condom use and in knowledge about the epidemic, but sexual risk behaviour was unchanged and most people felt they were not at risk of HIV infection (Mwaluko et al., 2003). Low-cost, standard district and community-level prevention programmes are clearly not sufficient to change the course of the epidemic.

West Africa

Although varying in scale and intensity, the epidemics in **West Africa** appear to have stabilized in most countries. Median HIV prevalence measured among women in 112 antenatal clinics in the subregion remained at an average 3% to 4% between 1997 and 2002 (Asamoah-Odei, Garcia-Calleja and Boerma, 2004). Overall, HIV prevalence is lowest in the Sahel countries and highest in **Burkina Faso, Côte d'Ivoire** and **Nigeria**—the latter having

Commercial Sex and HIV in West Africa

Commercial sex remains the main driver of West Africa's epidemics. Very high prevalence rates are being found among women who sell sex, even in countries where infection levels remain generally low among adults. **Ghana**, where adult national HIV prevalence was estimated at just over 3% in 2003, is a case in point. In the capital, Accra, approximately 80% of HIV infections among men have been acquired from women who sell sex. Prevalence ranged from 15% among men buying sex from mobile sex workers to 32% among the boyfriends of sex workers. At least one study has suggested that a successful 100% condom-use programme could turn the country's epidemic around (Cote et al., 2004). In **Niger**, meanwhile, adult national HIV prevalence was just over 1% in 2003, yet a survey among sex workers in three regions the year before found that between 9% and 38% of them had tested HIV-positive. The lowest levels were in Komabangou, and the highest in Maradi, while in Arlit 30% of the surveyed sex workers were infected (Sanda et al., 2004). **Senegal**, long-feted as an HIV success story, has been seeing slowly-rising HIV levels among women who sell sex. In the capital, Dakar, prevalence stood at 14% in 2002, while among sex workers in other areas (such as Kaolack and Ziguinchor) it had risen to over 20% by the same year, as Figure 10 shows—underscoring the need to intensify prevention work both among sex workers and their clients (UNAIDS/WHO, 2004).

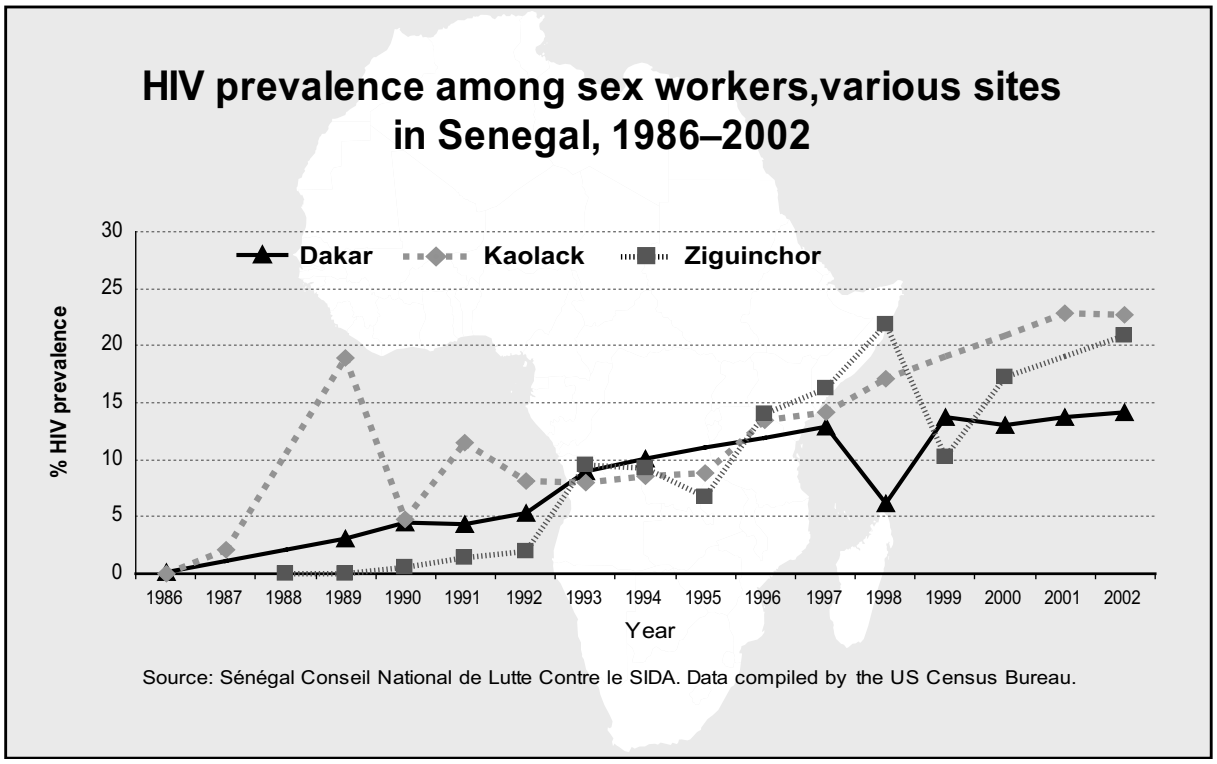


Figure 10

the third-largest number of people living with HIV in the world (after South Africa and India).

Nigeria's 2003 HIV sentinel survey put national HIV prevalence at 5%, a rise from the 1.8% found in 1991 but roughly level with the 5.4% recorded in 1999. Prevalence levels are highest among young people, particularly women aged 20–29 years. However, the apparent stabilization at national level hides strong regional differences in this vast and socioeconomically diverse country, where prevalence ranges from a low of 2.3% in the South West to a high of 7% in the North Central parts. At state level, the variations are even greater. In Osun and Ogun, for example, prevalence among pregnant women was 1.2% and 1.5%, respectively, while in Benue it was 9.3% and in Cross River 12% (Federal Ministry of Health Nigeria, 2003). This suggests that several, more or less distinct, epidemics are underway in Nigeria. If prevention efforts are to succeed, they will need to be informed by improved data and analysis in order to address the specific dynamics of these various epidemics.

Côte d'Ivoire has continued to report the highest level of HIV prevalence in West Africa since the beginning of the epidemic—although prevalence in the capital Abidjan in 2002 was the lowest it had been in five years, at 6.4% compared with 13% in 1999. National adult HIV prevalence in **Togo** has stayed roughly steady at around 4%. The most recent sentinel surveillance, though, shows an epidemic that is largely concentrated

Changing behaviour?

Comparisons of the most recent data concerning sexual behaviour among young people paint a mixed picture. Gathered from Demographic and Health Surveys over a five-year period, the data show young men in **Uganda** and **Zambia** and young women in **Malawi**, **Uganda** and Zambia were most likely to use condoms (see Figure 11). But in **Tanzania** there was no change in the proportion using a condom at last sex. And, while the proportion of women engaging in sex with a non-marital, non-cohabitating partner declined in Zambia, it declined only for men in Uganda and increased for both men and women in Tanzania (see Figure 12). These data (like the Tanzanian study, discussed earlier) indicate that additional efforts achieving high coverage levels are needed to achieve the behavioural change needed to lower prevalence levels. Interventions that are piecemeal and that do not address the contexts in which people live their lives are unlikely to significantly alter behaviour or influence the course of the epidemic. In addition, for many women, remaining faithful to a single partner does not protect them against infection; they run the risk of being infected by that very partner.

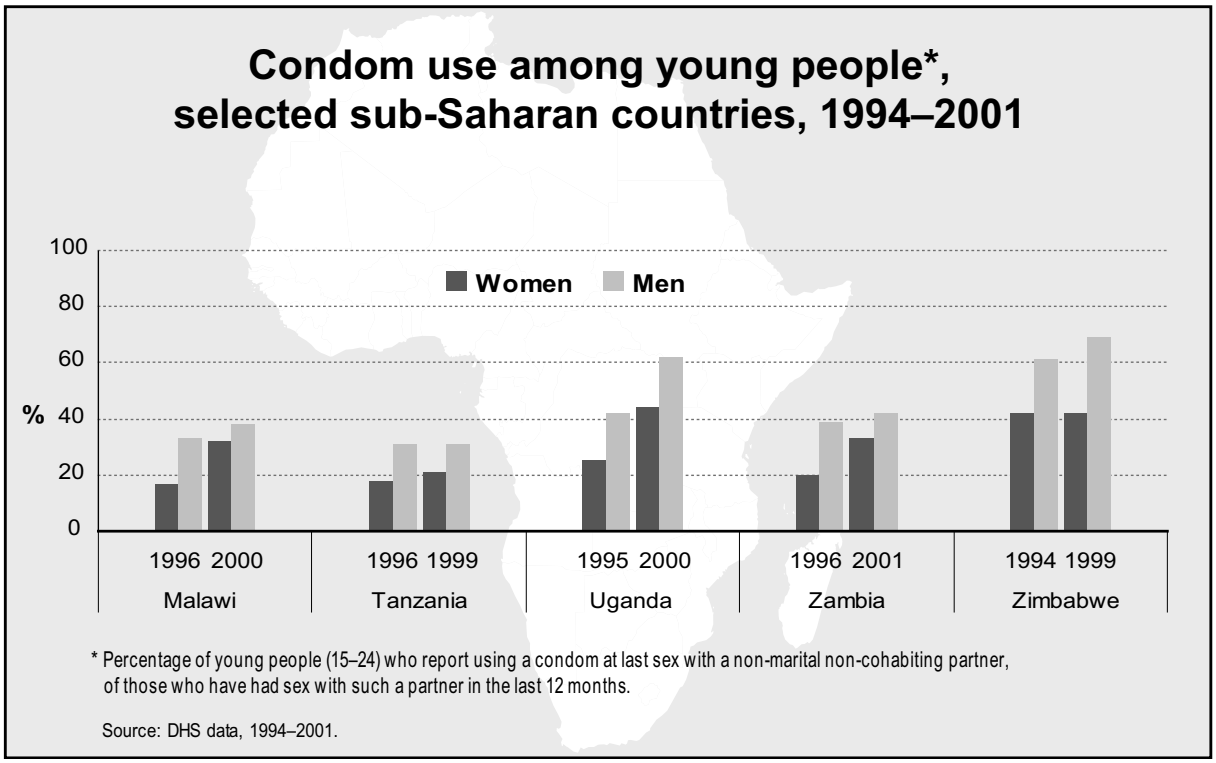
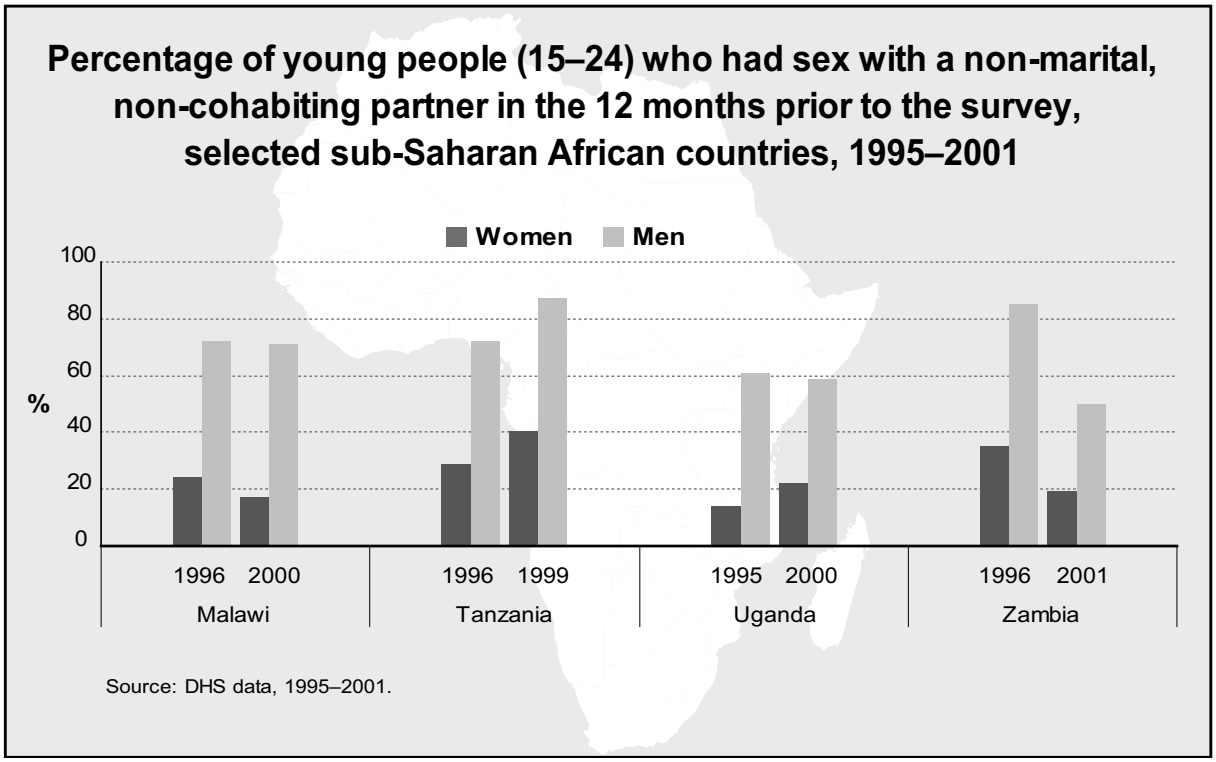


Figure 11

in urban areas, in some of which HIV prevalence among pregnant women exceeded 8% in 2003 (Ministère de la Santé Togo, 2004). In the two countries flanking it—**Ghana** and **Benin**—HIV prevalence is in the 2% to 4% range with little change noted over time (Cote et al., 2004).

Serious epidemics are underway in **Central Africa**, with **Cameroon** and the **Central African Republic** worst-affected. Here, too, HIV prevalence among pregnant women appears to have stabilized—albeit at high levels (of roughly 10%). In the **Congo**, meanwhile,

Figure 12



national adult prevalence has edged below 5%—with new estimates putting it at 4.2% (3.5–4.8%) with parts of the south of the country remaining the worst-affected. Unusually, HIV prevalence peaks in older age groups (reaching 10% among men aged 35–49 years and 7% among women aged 25–39 years). But younger women remain disproportionately affected: those younger than 35 years are twice as likely to be HIV infected than are men in that age group—once again highlighting the need to ensure that effective prevention efforts are tailored to reach and benefit younger women. (Ministère de la Santé du Congo, 2004). Median HIV prevalence in **Chad** has remained at about 5% since the late 1990s to the early 2000s (the most recent available data) (Asamoah-Odei, Garcia-Calleja and Boerma, 2004). In the **Democratic Republic of Congo**, two recent rounds of HIV testing among pregnant women attending antenatal clinics showed overall prevalence ranging between 4.1% and 4.9%. However, HIV levels varied considerably in different parts of the country—from as low as 1.8% in rural Mikalayi and roughly 3% in urban Bukavu and Bunia, to 6.3% and 7%, respectively, in the cities of Kisangani and Lubumbashi. Striking, too, were the high HIV levels recorded in some rural areas, such as Lodja and Neisu, where prevalence was 6.5% and 6.7% (Ministère de la Santé République Démocratique du Congo, 2004).